Examining the Past and Advocating for the Future of Forensic Psychiatry Training

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The American Academy of Psychiatry and the Law (AAPL) has been devoted to the teaching of forensic psychiatry, and as AAPL celebrates its 50th Anniversary, it seems fitting to examine the history and the current status of forensic psychiatry teaching in general psychiatry residencies and forensic psychiatry fellowships. After a brief review of the history of AAPL and forensic psychiatry training, this article explores the current state of graduate medical education (GME) in the United States, the growing popularity of psychiatry as a specialty and forensic psychiatry as a subspecialty, the Accreditation Council for Graduate Medical Education's requirements for forensic training, and the methods currently used to teach forensic psychiatry to general psychiatry residents. This article also examines the current status of forensic psychiatry fellowship training in the United States. Finally, future challenges to forensic training in both residencies and fellowships will be discussed, as well as the need for AAPL and others in the profession to advocate for increased forensic teaching in a manner that leads to the production of both general and forensic psychiatrists who are competent to practice independently and who are sufficient in number to meet the growing demands for forensic expertise.

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The American Academy of Psychiatry and the Law (AAPL), founded in 1969, was conceived and established by training directors in forensic psychiatry, long before the field of forensic psychiatry was formally recognized as a specialty by either the American Board of Medical Specialties (ABMS) or the American Board of Psychiatry and Neurology (ABPN). The teaching of our profession remains an essential part of AAPL's mission statement: "The American Academy of Psychiatry and the Law (AAPL, pronounced 'apple') is an organization of psychiatrists dedicated to excellence in practice, teaching, and research in forensic psychiatry" (Ref. 1, para. 1). AAPL's founder and first president, Jonas Rappeport, MD, had the idea to form a group to promote interest and training in forensic psychiatry, and in December 1967 he began correspondence to locate directors of forensic psychiatry fellowship programs in the United States.[2] When 10 of these fellowship directors sat around a table in a hotel conference room at the American Psychiatric Association (APA) Annual Meeting in Miami in May 1969, they decided to create an organization to further forensic psychiatry (Table 1).[3] AAPL was born.

By 1975, due to a lack of rigor in expert testimony in a variety of forensic specialties, and in response to the APA Committee on Psychiatry and the Law calling for the establishment of a forensic psychiatry certification board, the Forensic Sciences Foundation, a nonprofit organization that received and administered research grants for the American Academy of

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Table 1 Founding Members of AAPL

Eugene Balcanoff	Ames Robey
Howard Davidman	Robert Sadoff
Seymour Halleck	Joseph Satten
Melvin Heller	John Suarez
Jonas Rappeport	Herbert E. Thomas

Forensic Sciences, received grants from the U.S. Department of Justice to establish a planning process for certification in several forensic specialties, including pathology, odontology, anthropology, and psychiatry.[4] At a joint meeting with members of the American Academy of Forensic Sciences, founded 1948,[5] and AAPL in June 1976, the American Board of Forensic Psychiatry (ABFP) was established. This organization administered written and oral certification examinations in forensic psychiatry and certified 260 forensic psychiatrists during the next 16 years. Additionally, AAPL sponsored the Accreditation Council on Fellowships in Forensic Psychiatry, which accredited forensic psychiatry training programs through established standards and site visits.[4] For training directors in forensic psychiatry to meet as a group, the Association of Directors of Forensic Psychiatry Fellowships, a component of AAPL but an organization with its own bylaws, was formed in 1987.[6]

Forensic psychiatry was officially recognized by the ABMS in 1992, 23 years after the founding of AAPL and 16 years after the founding of the ABFP, making forensic psychiatry a relatively young specialty compared with other specialties recognized by ABMS. This recognition made it possible for the ABPN to take over the certification process for forensic psychiatrists, and the first ABPN certification examination in forensic psychiatry was administered in 1994.[3,4] Since that time, ABPN has certified more than 2,300 psychiatrists in forensic psychiatry.[7] Official ABMS recognition of forensic psychiatry as a subspecialty also allowed for the Accreditation Council for Graduate Medical Education (ACGME) to take over the accreditation process for forensic psychiatry training programs, commonly known as fellowships.

As AAPL celebrates its 50th Anniversary, in light of AAPL's founding purpose and its current mission to foster excellence in practice, teaching, and research in forensic psychiatry, a review of how forensic psychiatry is currently taught in the United States seems warranted. Indeed, since 1969 the teaching of forensic psychiatry has evolved and expanded. Despite this expansion, there may be some serious challenges for the future of training in forensic psychiatry involving both general psychiatry residencies and forensic psychiatry fellowships. In this review, I will examine the current status of graduate medical education (GME) in the United States, paying particular attention to psychiatric training in general, how forensic psychiatry is taught in general psychiatric residencies, the current status of forensic psychiatry fellowship training, and challenges that lie ahead for the teaching of the profession. I will also advocate for changes in the status quo regarding forensic psychiatry training, especially as it relates to meeting the needs of justice-involved individuals with mental illness and providing quality forensic psychiatrists who are competent to practice independently in the evaluation of many common forensic questions.

GME in the United States

Forensic psychiatric training in both general psychiatric residencies and forensic psychiatry fellowships occurs within the larger context of GME. There are major challenges facing GME in the United States at a time when there are projected physician shortages across the nation. Since 2002, there has been a 31 percent increase in U.S. allopathic medical school enrollment because of the development of new medical schools and the expansion of medical school class sizes.[8] When combined with the increasing enrollment at osteopathic medical schools, overall total medical student enrollment is 52 percent higher than in 2002.[8] This increase was planned for many years due to growing concerns about a future physician shortage in the United States, particularly in rural areas, but even with this increase in the number of medical school enrollees, the United States may still see a shortage of up to nearly 122,000 physicians by 2032.[9]

Despite this rapid increase in medical school enrollment, increases in GME residency positions have not occurred at the same pace. This has led to a bottleneck in physician training, and many medical school deans have expressed concerns about graduating medical students not being able to find a residency position in their desired specialty.[10] These concerns are occurring at a time when the median debt of graduating medical students is $200,000.[11] As a result of this problem, the Resident Physician Shortage Reduction Act of 2019 has been introduced

Table 2 The Five Fastest Growing Medical Specialties by Percentage of New Training Programs (2013–2018)

Specialty	Total Programs in 2018, *n*	5-Year Increase, % (*n*)
Emergency medicine	231	40.9% (67)
Internal medicine	529	33.9% (139)
Psychiatry	248	31.9% (60)
Family medicine	620	31.6% (149)
Dermatology	138	20.0% (23)

From Ref. 26.

in both the U.S. House and the U.S. Senate.[12,13] If enacted, this legislation calls for an increase of 3,000 residency positions per year for the next five years, with 1,500 of these in shortage specialty programs as defined by the Health Resources and Services Administration.[13] It is likely that psychiatry would be considered a shortage specialty as indicated by a supply-and-demand projection published in 2016.[14] Until there is a substantial increase in residency positions, however, the greater competition for these positions will be significant, and residency programs, including psychiatry, may see better-qualified applicants. Furthermore, stronger candidates for general psychiatry residencies will likely lead to better-quality candidates for forensic psychiatry fellowships as well.

At the time of this writing, there are 249 ACGME-accredited general psychiatry residency programs in the United States, and over the past five years psychiatry has been the third fastest growing medical specialty, with 60 new residencies accredited since 2013 (Table 2). The number of psychiatry positions has grown every year since 2008, and the 1,740 positions offered in 2019 represent a 62.8 percent increase over those offered in 2008.[15] In addition to the growth in positions, general psychiatry has recently become one the most sought-after and competitive medical specialties among medical graduates in the United States. Between 2014 and 2018, psychiatry residency programs saw a 65 percent increase in applications from U.S. medical school seniors.[16] In the 2019 National Resident Matching Program, among applicants who ranked only one specialty type, general psychiatry was surpassed only by dermatology and general surgery (preliminary) for the percentage of applicants who did not match (27%, 36%, and 35%, respectively), and general psychiatry had a 98.9 percent fill rate in the National Resident Matching Program.[16] Why psychiatry has become increasingly popular in recent years is not known. According to one large study, having a positive psychiatry clerkship, having had a psychology major in college, and valuing work-life balance were the factors most strongly associated with a career choice in psychiatry.[17] Another study found that sympathy toward psychiatric patient stigma, exposure to psychiatry in medical school, diagnostic complexity in the specialty, and an encouraging job market were motivators in choosing psychiatry as a specialty.[18]

Forensic Training in Psychiatric Residency

The amount of exposure to forensic psychiatry that general psychiatry residents receive varies tremendously depending on the individual residency program. Given that there are 249 general psychiatry residency programs and only 48 forensic psychiatry fellowships, the majority of general psychiatry residencies (81%) do not have an associated forensic psychiatry fellowship program. The ACGME program requirements for forensic training in general psychiatry have been substantially weakened. For example, in 2007 the standards required exposure to "the evaluation of forensic issues 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" (Ref. 19, p 784). By contrast, the current requirements merely mandate a forensic experience: "Resident experience in forensic psychiatry must include experience evaluating patients' potential to harm themselves or others, appropriateness for commitment, decisional capacity, disability, and competency" (Ref. 20, p 29). Although a requirement for conducting suicide and violence risk assessment and acting to emergently hospitalize patients is clear, what is meant by "decisional capacity, disability, and competency" is not further defined. There is no requirement for a specific clinical rotation in forensic psychiatry. Additionally, there is no required amount of time devoted to a forensic experience, unlike required training experiences in child psychiatry (two months), geriatric psychiatry (one month), addiction psychiatry (one month), and consultation liaison psychiatry (two months).[20]

How the ACGME forensic requirements are implemented in general psychiatry training is unknown because little research has addressed this topic. In 1995, Marrocco *et al.*[21] surveyed general psychiatry program directors regarding how forensic psychiatry was taught in their programs. Only 35 percent had a

mandatory forensic rotation; 18 percent of programs offered no rotation in forensic psychiatry, and the remainder offered electives. Of all programs offering a clinical forensic experience, 40 percent offered a forensic inpatient unit rotation, and 35 percent had a jail or prison rotation.[21] In a more recent 2014 survey of general psychiatry program directors, results indicate that residents were more likely to receive clinical experiences in violence risk assessment, followed by civil commitment and capacity to stand trial evaluations.[22] They were less likely to be involved in criminal responsibility evaluations, report writing, or providing testimony. In this study, directors were not asked about resident clinical and didactic exposure to civil forensic topics other than civil commitment. Forensic training in general residency may also be influenced by the types of questions encountered on the Psychiatry Resident in Training Examination (PRITE), which first recognized forensic psychiatry as a specific domain in 2004.[23]

Numerous reports have touted the benefits of a required forensic rotation for general residents. While only a minority of general psychiatry residents will choose to pursue a career in forensic psychiatry, almost all psychiatrists will face legal matters in practice, including, but not limited to, providing informed consent, the duty to protect, working with patients receiving disability payments, and working with patients who have had experience with the criminal justice system.[19] Additionally, requiring a mandatory rotation in forensic psychiatry rather than just an unspecified experience is associated with an increased interest among trainees in working with forensic populations after graduation and in pursuing additional fellowship training in forensic psychiatry.[24] In fact, having a clinical experience rather than a classroom didactic experience may be more beneficial in cultivating positive attitudes and less avoidance of forensic patients.[25]

In 2019, AAPL published a Practice Resource for Forensic Training in General Psychiatry Residency Programs.[26] This resource outlines a variety of potential forensic experiences, presents a model of core forensic psychiatry competencies by year of residency, and presents a variety of forensic topics that can be covered in a didactic forensic curriculum, including a list of useful references for each topic. Additionally, online modules have been developed and have been shown to be effective in improving medical knowledge of core forensic topics.[27]

Table 3 The Growth of Psychiatry Subspecialties by Percentage of New Training Programs (2013–2018)

Subspecialty	Total Programs in 2018, *n*	5-Year Increase, % (*n*)
Forensic psychiatry	47	20.5% (8)
Consultation-liaison psychiatry	61	13.0% (7)
Child and adolescent psychiatry	138	12.2% (15)
Geriatric psychiatry	60	7.1% (4)
Addiction psychiatry	49	6.5% (3)

From Ref. 26.

Forensic Psychiatry Fellowship Training

There are currently 48 ACGME-accredited forensic psychiatry fellowships in the United States, and over the past five years forensic psychiatry has been the fastest growing psychiatric subspecialty in terms of new programs (Table 3).[28] Although there has been a 20.5 percent increase in the number of forensic psychiatry fellowships in the last five years, there has only been a 14.5 percent increase in the total number of forensic psychiatry fellows.[28] This may be explained by the fact that newer programs usually have a lower number of trainees. Additionally, forensic psychiatry fellowships utilize an average of four participating training sites but have the lowest mean number (4.9) of faculty members of all psychiatric subspecialties.[28] Finally, there is a relative lack of geographic diversity; although there are 48 forensic fellowship programs in the United States, 24 states lack a fellowship program altogether (Fig. 1).

In contrast to the recent increase in applicants to general psychiatry residencies, psychiatric subspecialty training has seen a decline in applicants and filled positions (Table 4).[29] For example, child psychiatry applications have declined, and between 2008 and 2017 unfilled positions in child and adolescent fellowships have ranged from 28 to 39 percent.[30] Geriatric psychiatry fellowship programs also have experienced a decline in applicants; between the years 2006 and 2016, fewer than half of geriatric psychiatry fellowships were filled.[31] Consult-liaison fellowship recruitment is also struggling; between 2014 and 2018, the unfilled rate for programs ranged from 39 to 48 percent.[30] Finally, an increase in addiction psychiatry fellowships over the past decade has been accompanied by a lower fill rate (70% in 2016 and 2017).[28]

Because forensic psychiatry fellowships do not participate in the National Resident Matching Program, it is more difficult to know the percentage of

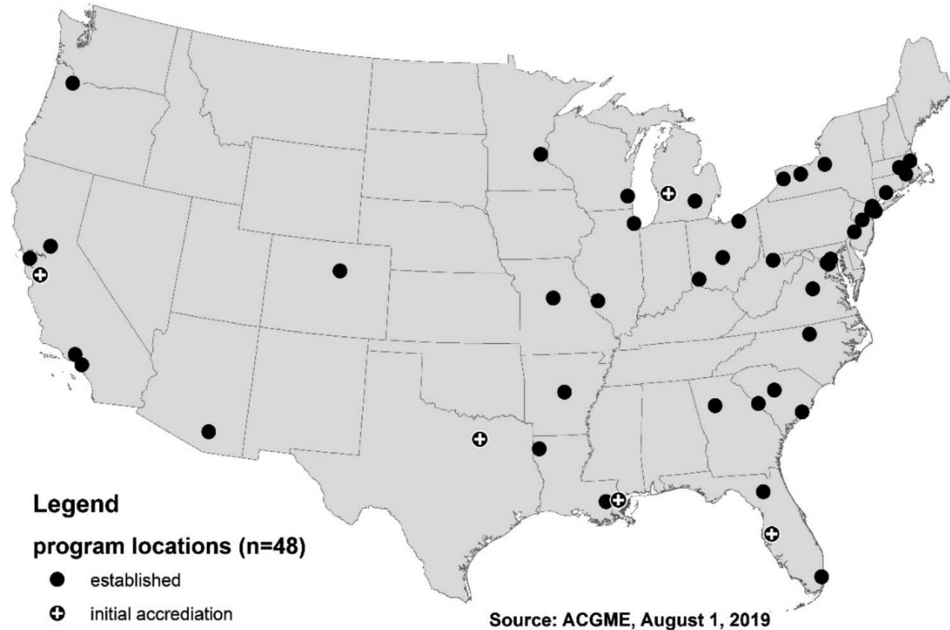

Figure 1. Locations of forensic psychiatry fellowship programs in the United States.

filled and unfilled positions each year. The APA has collected data from the National GME Census or the GME Track, an online survey jointly sponsored by the Association of American Medical Colleges and the American Medical Association, to track fill rates across psychiatry and the psychiatric subspecialties. According to the APA, in 2017 there was a complement of 123 forensic fellowship positions, and 84 (68.30%) were filled. In 2018 there was a complement of 127 positions, but only 73 (57.50%) were filled.[32] This low fill rate may be misleading, however, because even though a program can potentially offer a certain number of ACGME-approved positions (i.e., the program's approved complement of positions), some of these positions may not be funded in a given year and thus are not available to be filled. Based on information contained on the AAPL web site, there are a total of 106 available positions in forensic psychiatry fellowships, and, according to the GME Track, in 2018 there were 73 forensic fellows. Using these two data points, an estimated rate of filled forensic psychiatry training positions would be somewhat higher, at 68.8 percent. An overview of all psychiatry subspecialty fill rates may be found in Table 4.

Forensic psychiatry fellows have characteristics that differentiate them from other psychiatric subspecialty trainees. There is a higher percentage of graduates in forensic psychiatry (58.1%) from medical schools accredited by the Liaison Committee on Medical Education than in other psychiatric subspecialties, and forensic psychiatry is the only psychiatry subspecialty where the majority of trainees (65%) are of white, non-Hispanic ethnicity.[28] While a slight majority of forensic psychiatry trainees are female (53.2%), males represent a greater percentage of trainees than in any other psychiatric subspecialty except addiction psychiatry.

Table 4 Complement of Approved Positions and Filled Positions by Psychiatry Subspecialty (2018–2019)

Subspecialty	Total Programs, *n*	Approved Positions, *n*	Filled Positions, *n*	Percent Filled, %
Addiction psychiatry	50	132	85	64.4
Child and adolescent psychiatry	140	1132	883	78.0
Consultation-liaison psychiatry	62	144	78	54.2
Forensic psychiatry	48	127	73	57.5
Geriatric psychiatry	61	157	55	35.0

From Ref. 28.

The curricula of forensic psychiatry fellowships must comply with the ACGME program requirements in forensic psychiatry.[33] The requirements state that fellows must demonstrate procedural proficiency in the psychiatric evaluation of individuals with criminal behavior, including evaluations of competency to stand trial, criminal responsibility, dangerousness, and sexual misconduct. They are silent regarding required procedural proficiency in civil forensic evaluations, although they require competence in medical knowledge related to a variety of civil evaluations. Fellows are also required to have a six-month longitudinal experience managing patients in a correctional system. There must also be an opportunity to testify in mock trial or real trial situations.

How these specialty requirements are implemented by fellowship programs remains unknown because little research exists in this area. From what research does exist, it appears that implementation may vary considerably among programs. In a recent survey of 24 forensic psychiatry fellowship programs (53% of all active programs), the majority reported using multiple training sites, including outpatient forensic assessment clinics, private forensic offices, state hospitals, correctional settings, mental health courts, sex-offender treatment facilities, and others.[34] This survey also revealed significant variations in the types and quantities of forensic evaluations that fellows complete, as well as the degree to which forensic fellows are involved in providing clinical treatment. In short, there are significant differences in the amount of criminal evaluations, civil evaluations, correctional treatment, and consultations that are required of forensic fellows, depending on the individual program.

In addition to the specialty-specific program requirements, fellowship programs must comply with the ACGME's Common Program Requirements for One-Year Fellowships.[35] Most importantly, according to these common requirements, upon completion of the fellowship the program director must "verify that the fellow has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice" (Ref. 35, p 24). The meaning of the phrase "knowledge, skills, and behaviors" is not specified further, although, as mentioned previously, the specific program requirements list four types of criminal evaluations: competency to stand trial, criminal responsibility, dangerousness (i.e., violence risk assessment), and evaluation of sex offenders.

Challenges and Professional Advocacy

Because forensic training in both general psychiatry residency training programs and forensic psychiatry fellowships has expanded since the creation of AAPL 50 years ago, perhaps it is time not only to take stock of the current state of forensic psychiatry education in the United States, but also to consider the challenges that lie ahead and the need to further advocate for our profession. The challenges facing forensic training in general psychiatry residency are significantly different from those challenges encountered in forensic fellowship programs. Therefore, it makes sense to examine them.

General Psychiatry Residency

As mentioned previously, forensic psychiatry is the only subspecialty area (unlike child, addictions, geriatric, and consultation-liaison subspecialties) that does not have a full-time equivalent time requirement or a required clinical rotation during psychiatry residency. This comes at a time when the prevalence of mental illness among incarcerated individuals is unquestionably high. Between 15 and 30 percent of prison and jail inmates have psychiatric disorders that result in significant functional disabilities, and another 15 to 20 percent will require some form of psychiatric intervention during their incarceration, especially female prisoners.[36] Perhaps most shocking, the number of persons with severe mental illness in jails and prisons in the United States has far surpassed the number in hospitals.[37]

Given the growing need for a forensically trained workforce to deal with the ongoing crisis involving the large numbers of persons with mental illness in jails and prisons throughout the United States, the time has come for AAPL and the Association of Directors of Forensic Psychiatry Fellowships to advocate to ACGME for a subspecialty experience in forensic psychiatry during residency that is at least equal to those experiences provided in geriatric and addiction psychiatry (i.e., one month). Furthermore, this required clinical experience should involve, at least in part, an experience providing treatment to justice-involved individuals, whether in jails, prisons, forensic hospitals, or mental health courts. While the pharmacotherapy and psychotherapeutic treatment of mental illness should not be different for justice-

Table 5 Unique Skills Needed to Work with in Correctional Settings

Establishing a working relationship with correctional officers who have no medical training
Understanding custody levels
Managing boundaries
Balancing patient confidentiality with the facility's security needs
Providing quality psychiatric care with formulary restrictions
Understanding prison culture
Dealing with medication diversion, including medications uniquely abused in correctional settings
Advocating for patient needs in a system that is inherently not designed as a therapeutic milieu

From Refs. 26, 39.

involved patients, the correctional environment can create significant barriers to the provision of quality treatment, and the skill sets of psychiatric providers will need to be expanded to work in that environment. The skills needed to practice successfully in a correctional setting squarely fall within the scope of forensic psychiatry (Table 5).[38]

Many psychiatrists are reluctant to consider a career in correctional psychiatry due to misperceptions about personal safety. The requirement of a correctional training experience during residency could alleviate such fears and help create a mental health workforce motivated to work in such systems.[39,40] This is only likely to occur if such a training experience is well-supervised and conducted in such a manner that it is perceived positively by the psychiatric trainee. In some programs that already have a required correctional experience, moonlighting by psychiatric residents in correctional settings is allowed after completion of the rotation and can further provide a positive experience that may motivate the resident to at least consider part-time employment in a jail or prison after residency. Finally, while the proposal of a required forensic rotation may be met with some resistance by general psychiatry training directors and academic departments of psychiatry, the partnering of academic medical centers with correctional systems may help medical centers fulfill their core missions of clinical service, education, and research. Such partnerships can also enhance the department's financial stability, to the benefit of all.[41]

Forensic Psychiatry Fellowship

There are numerous challenges facing forensic psychiatry fellowships: recruitment of good trainees, stabilization of funding sources, and improving the quality of training to produce graduates who are capable of practicing independently and without supervision. While stabilization of funding is highly individualized to each program and therefore beyond the scope of this article, challenges in recruitment and in producing quality graduates bear attention.

Unlike child and adolescent fellowships as well as consultation-liaison fellowships, which participate in National Resident Matching Program, the forensic psychiatry fellowship application and selection process is not standardized among training programs. Each program has its own application requirements, its own timeline for interviewing applicants, and its own selection process. Over the years there had been a trend for programs to begin this process earlier each year, and now the process generally begins in the middle of applicants' third postgraduate year.[42] This poses problems for applicants who are not sure about pursuing a fellowship until their fourth postgraduate year. If the fellowship application and selection process continues to occur at earlier and earlier times during residency, the fellowships may lose out in the competition with other subspecialties in attracting applicants who may be considering multiple subspecialty training opportunities. While the forensic psychiatry fellowship directors historically have never agreed to participate in the National Resident Matching Program®, there has been a recent attempt to consider a standardized application to be used by all programs. Additional measures to standardize this process among programs will likely be needed in the future if new forensic fellowships continue to develop and established fellowships offer more positions. Finally, the development of new forensic fellowships and positions is likely to increase the number of vacant positions unless the ability to recruit general residents into our subspecialty is improved.

The difficulty in recruiting fellows in psychiatric subspecialties led to a call in 2016 to move subspecialty training into the fourth postgraduate year.[43] Participating trainees could qualify for psychiatry subspecialty certification and general psychiatry ABPN certification at the end of four years. This proposal led the ABPN and ACGME to seek out AAPL's position on this consideration. Unlike the addictions, consultation-liaison, and geriatric subspecialty organizations, AAPL opposed this idea for many reasons. Many states require the completion of

Table 6 Pass Rates in Psychiatry Subspecialty Examinations (2017–2018)

Psychiatry Subspecialty	Pass Rate, %
Addiction psychiatry	96
Child and adolescent psychiatry	75
Forensic psychiatry	94
Geriatric psychiatry	85
Psychosomatic medicine (consultation-liaison)	85

From Ref. 45, 46.

a residency to testify as an expert in forensic cases. If forensic training were to occur before completion of the fourth postgraduate year, fellows would lose the opportunity to assess and testify in such cases. It was also believed that, due to the rigors of forensic training, taking time away from fellowship to meet any remaining general psychiatry requirements would detract from comprehensive forensic training. Although this proposal was not adopted at that time, this topic is likely to be raised again if psychiatry subspecialty training positions continue to have low fill rates. There has also been a proposal to abolish addictions, consultation-liaison, and geriatric fellowships altogether and to increase the required training in these subspecialties by three months each during general residency, which could further erode time available to residents for a forensic psychiatry elective to gauge their interest in the subspecialty.[44]

The best way to assess the quality of forensic psychiatry fellowship graduates is debatable. It appears that the existing fellowships do an adequate job in preparing graduates to pass the board certification examination in forensic psychiatry offered by the ABPN, especially when compared with most other psychiatric subspecialties (Table 6).[45,46] For example, the pass rate for the last ABPN forensic psychiatry initial certification examination, given in 2017, was 94 percent.[46] But are pass rates on the ABPN exam a true reflection of competence to practice independently? Does correctly answering questions on a multiple-choice examination correlate with the ability to adequately perform a comprehensive forensic evaluation, to identify missing information needed to make an informed forensic opinion, to formulate an opinion with sound reasoning, to write a forensic report that clearly communicates the opinion, and to provide testimony that also communicates the forensic opinion?

Having been a forensic psychiatry fellowship director for 20 years, I have seen many graduates from my program take positions at facilities alongside new graduates from other fellowships. I have been amazed by the number of times I have received a call from a former fellow only to hear that their new colleague has never done, for example, a criminal responsibility evaluation. For all practical purposes, forensic psychiatry is a procedural specialty, with the exception of the time devoted to the provision of psychiatric services in correctional facilities. Like most procedure-based specialties, programs should produce graduates who are capable of performing certain core procedures without supervision. Forensic psychiatry programs are very diverse in their curricula, but to garner respect as a subspecialty, we must ensure that all forensic fellowship graduates are competent in performing core forensic evaluations. These core evaluations should include at minimum the following: evaluation of capacity to stand trial, criminal responsibility evaluations, violence risk assessment, and disability or fitness for duty evaluations (i.e., the most common civil evaluations). To do this, the fellowship curriculum must afford the fellow opportunities to do all of these types of evaluations under direct supervision and independently in sufficient numbers to develop competence for independent practice. For this reason, a certain number of evaluations in each category should be required.

Conclusion

The future of forensic psychiatry training is bright. As AAPL heads into the next 50 years, it should continue to honor one of its original missions and the vision of its founding father, Jonas Rappeport, to foster the provision of quality education in forensic psychiatry. AAPL should advocate for increased time devoted to forensic training in the general psychiatry residency and continue to support forensic psychiatry fellowship training through its support of the Association of Directors of Forensic Psychiatry Fellowships, the maintenance of Landmark Cases, and the AAPL review course. AAPL must also be vigilant regarding the challenges facing future training, including competition with other subspecialties for qualified fellowship trainees. Our profession should strive to improve the forensic experiences for general psychiatry residents and ensure that forensic psychiatry fellows are provided adequate and diverse opportunities to perform forensic evaluations during fellowship training so they will be prepared to practice competently and independently.

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