The Barriers and Benefits to Developing Forensic Rotations for Psychiatry Residents

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Psychiatry residents' experiences in forensic psychiatry vary greatly across the country, and many psychiatry programs meet the Accreditation Council for Graduate Medical Education requirements for a forensic experience through general psychiatry rotations (e.g., on a consult-liaison service) or classroom-based activities. Forensic clinical experiences during psychiatry residency are important for preparing future general psychiatrists for practice with justice-involved patients, generating interest in forensic psychiatry, and easing the transition from "healer to evaluator" for future fellows. Unfortunately, residency programs interested in expanding their forensic training may face many challenges because of current regulatory frameworks, the nature of forensic practice, and competing demands within residency training programs. This article describes these challenges, and the experience of the authors at one institution with developing a novel forensic experience in a criminal justice diversion setting. The authors conclude with some practical considerations for educators interested in developing forensic experiences at their institutions.

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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," but adds that "almost all psychiatrists may, at some point, have to work within one of the many areas in which the mental health and legal system overlap."[1]

General psychiatrists use patient safety assessments, informed consent, and disability assessments, and perform other activities with legal implications every day in clinical practice and are expected to understand the legal regulation of practice within their state. Psychiatrists testify in civil commitment proceedings and may be called on to testify in criminal or civil court. Further, the movement of forensic patients from institutions to the communities and the resulting transition of care to general psychiatry units and community clinics,[2] means that general psychiatrists are increasingly likely to work with justice-involved individuals. A recent commentary noted that even if all board-certified forensic psychiatrists were working full time to provide services in jails and prisons, there would still not be enough to meet the psychiatric needs of this expanding population.[3] Thus, it is critical that general psychiatry training programs prepare general residents to meet these growing demands.

However, psychiatry residency programs vary greatly in the types of forensic clinical experiences offered. One survey found that, of the 150 programs responding, 82 percent offered forensic rotations, but only 35 percent of those were mandatory rotations.[4] The most common setting for mandatory rotations was a court clinic and for optional rotations was a forensic inpatient unit. The rotation length varied from just a few hours to full time for several months.[4] The hours spent in forensic didactics also differed greatly between programs. Another survey of psychiatry training programs found that most met Accreditation Council for Graduate Medical Educa-

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tion (ACGME) requirements for exposure to forensic psychiatry via educational and didactic experiences, such as classroom lectures or analysis of written case studies.[5] These programs provided little exposure to direct client contact in forensic settings, evaluation of criminal responsibility, courtroom testimony, or writing forensic reports.

Unfortunately, a survey of Canadian psychiatry residents, with a similar minority of residents reporting required forensic psychiatry rotations, found discomfort with and lack of experience in forensic psychiatry.[6] However, forensic education correlated positively with more positive attitudes and less avoidance of forensic topics and patients. This correlation was stronger with clinical experiences than with classroom didactic exposures (although the results may be confounded by self-selection bias).

Ideally, the combination of practice-based forensic experience, faculty supervision, and didactic learning optimize a trainee's educational experience. Some articles on forensic education in general psychiatry training emphasize the importance of forensic didactics and supervision within general psychiatry rotations.[7,8] Others propose novel approaches to teaching forensic topics in the classroom, including joint classes with law students[9] and problem-based learning.[10] However, recent advocacy efforts have focused more specifically on creating a required forensic rotation for all general psychiatry residents.[3] Forensic clinical experiences during psychiatry residency may help generate interest in forensic psychiatry,[6] increase psychiatry resident understanding of the individuals involved in the criminal justice (CJ) system,[3,6] prepare future general psychiatrists for practice,[3] and ease the transition from "healer to evaluator" for future fellows.[11,12]

Although forensic lectures, seminars, and supervision are more readily available for programs seeking to develop a forensic curriculum, successful execution relies on instructors and supervisors in general rotations with significant forensic interest and knowledge. The focus on the classroom and supervision also neglects multimodal and experiential learning in forensic clinical and evaluative settings, which may provide opportunities unavailable in general rotations or didactic series and, as noted above, have greater impact on resident attitudes and comfort with forensic concerns. Unfortunately, some general psychiatry training programs face significant challenges to implementing forensic clinical experiences.

This article will describe the challenges created by current regulatory frameworks, forensic practice, and residency training programs. With this backdrop, the authors will present their experience creating a novel forensic clinical rotation as a case example highlighting potential solutions to some of these barriers. The article will conclude with recommendations for other general psychiatry residency programs contemplating developing their own forensic rotations.

Challenges

Regulatory

The ACGME mandates that all psychiatry residency training programs provide an educational experience that includes "evaluating patients' potential to harm themselves or others, appropriateness for commitment, decisional capacity, disability, and competency (core)".[13] The 2015 General Psychiatry Milestones incorporate but do not explicate forensic competencies.[14] For example, the Medical Knowledge (MK)-2, Psychopathology B thread focuses on "knowledge to assess risk and determine level of care" and the MK 6, Practice of Psychiatry A, Ethics thread covers confidentiality and informed consent. The Systems Based Practice (SBP)-4 milestone covers the ability to assess and report on decisional capacity. Although the word "disability" is not found in the general psychiatry milestones, MK-1, B thread 4.1 asks whether trainees can describe the "influence of acquisition and loss of specific capacities in the expression of psychopathology across the lifecycle."

The above ACGME language on forensic experiences is general and, unlike other subspecialties (including addictions, geriatrics, child and adolescent, and consult-liaison), lacks a time requirement for the experience. Many of the ACGME examples of forensic experiences relate to civil matters (e.g., disability, capacity determinations) and legal regulation of psychiatry (commitment, risk assessment, and third-party warnings), which may be fulfilled in nonforensic settings. The ACGME requirements neglect criminal or forensic evaluations and do not consider treatment of forensic or otherwise legally-involved patients as a type of forensic experience.

Psychiatry training programs are already burdened by other ACGME rotation and education requirements, duty hours, and over 300 individual milestones. Practically, the ACGME language allows residency programs without significant forensic

resources to meet more easily the forensic requirements. However, as currently defined, these experiences do not require a particular duration or forensic-specific setting and, as a result, can be met through other nonforensic experiences (e.g., decisional capacity assessments on a consult–liaison service or suicide risk assessment in an emergency room), which may contribute to low motivation for residency programs to devote the time, energy, and resources needed to create dedicated forensic rotations as core components of the crowded training schedule.

Forensic Practice

Forensic consultative evaluations can present scheduling, confidentiality, and geographic barriers to trainees. Fluid and last-minute schedules and prolonged timelines for forensic evaluations create challenges for residents and program administrators who need rotations to occur in a regular and predictable fashion. In some areas, problems with licensure may preclude trainees from testifying. Evaluations involving very sensitive or highly publicized events may make referring parties hesitant to allow trainees during the examination. Evaluations may also occur far from other training sites and, especially in the case of correctional settings, may have limited space for evaluators. The authors' experience in speaking with forensic fellowship directors indicates that opportunities to participate in civil cases are scarce, even for forensic fellows and are unlikely to be readily available for general residents. Record review may be more accessible to residents, although without direct contact with an evaluee, the work may lack interactive or contextual experiences that enrich resident learning.

Clinical care in forensic and correctional settings occur on a regular schedule, but geographic distance and safety concerns may create barriers to resident access. In addition, the bureaucratic hurdles, such as background checks and security clearances, may make clearing serial groups of residents impractical.

Program

Psychiatry residency programs may struggle with lack of resources and will to develop new rotations. There are over 200 ACGME-accredited general training programs in the United States, but only 46 institutions have forensic training fellowships. Not all programs have forensically trained faculty members who can provide didactic training, supervision, or experiential rotations for trainees; or easy access to traditional forensic sites, such as forensic hospitals, prisons, or court clinics. As noted above, residency programs, already balancing the demands of numerous other rotation and education requirements, may prefer simply to address forensics through didactics and general psychiatry rotations. Program directors may also face resistance from other subspecialty stakeholders whose clinical rotations may lose time to a dedicated forensic rotation. Finally, the reputation of forensic psychiatry as a subspecialty with little relevance to the clinical psychiatrists or of forensic psychiatrists as "hired guns,"[15–22] may also dampen interest in developing new forensic offerings and experiences.

Experience of One Psychiatry Residency Program

Our Mission

With these challenges in mind, we now share our experience creating a required forensic rotation in our institution's general psychiatry residency. The residency had the advantage of a large forensic faculty and fellowship, but still faced several of the difficulties described above. Before the addition of a clinical rotation, our residents' exposure to forensic psychiatry occurred primarily via a longitudinal didactic curriculum during the second postgraduate year (PGY), a PGY2 mock trial experience where residents served as expert witnesses, and forensic content available in general psychiatry rotations. Residents with a special interest in forensic psychiatry could also complete forensic electives in a variety of settings, including a court clinic and correctional settings.

In 2013, the residency's education committee tasked two of the authors (K.M. and T.W.) with developing a dedicated forensic rotation to complement the established curriculum and elective opportunities. The committee's goal was to develop a more robust opportunity for experiential learning in forensic psychiatry to enhance preparation of general psychiatrists for practice. The rotation's objectives included providing residents with dedicated experience evaluating justice-involved patients, writing notes with increased consideration of the intended audience, discussing cases and forensic topics with supervisors, collaborating with interdisciplinary teams, and seeking additional consultation where appropriate.

The rotation was conceptualized as a way for residents to deepen their ability to evaluate, plan, and coordinate the care of patients with mental illness involved in the CJ system, including those diverted from the system to treatment (MK). Residents would demonstrate the ability to seek and use supervision from appropriate local experts and other sources of information on forensic clinical questions (Practice-Based Learning and Improvement) and the ability to communicate effectively with patients, families, members of an interdisciplinary team, and appropriate legal and CJ officials in the context of local statutes regulating confidentiality and reporting (Interpersonal and Communication Skills; SBP). The residents would develop an appreciation for the risks, benefits, and consequences of court-ordered treatment (SBP) and a more nuanced understanding of and skills in areas of forensic practice, including criminal responsibility, jail diversion, confidentiality, mandatory reporting duties, and risk assessment (MK and SBP).

The Development Process and Challenges

Within the busy training schedule, we identified PGY2 as the ideal time for a new clinical experience because our program's residents are still primarily in inpatient or emergency settings (but not internal medicine or neurology rotations) and they spend more time in certain rotations than is required by the ACGME. Further, an exposure to forensics early in training would allow residents to pursue additional experiences, if desired, in their PGY3 and -4 years and to consider forensic fellowship.

We approached the clinical leadership of existing PGY2 rotations with a proposal for a forensic rotation that required residents to spend one half-day per week offsite during the existing six-week rotations. We found that rotation directors appreciated being able to identify one or two half-days when residents would miss less critical aspects of the existing rotation. In addition, identifying forensic experiences that complemented the existing rotation helped address concerns about adding to the time that residents are already away for other residency obligations and increased other subspecialties' support for the new forensic rotation. Ultimately, the directors of the addictions rotation agreed to carve out time.

We also worked with residency leadership and key stakeholders within our forensic psychiatry program to identify potential forensic experiences, with an emphasis on forensic clinical sites that could provide meaningful resident experiences during a brief exposure, without overburdening residents' primary clinical rotations or the existing forensic programs. It was critical to include rotation administrators and faculty coordinators who are essential for organizing and following up with residents; these are administrative tasks that may add significantly to their workloads. In particular, administrators were invaluable for identifying clinical sites' logistical limitations.

Some of the proposed sites did not have board-certified forensic faculty available to supervise. We decided to emphasize the quality of the clinical experience and the knowledge and interest of potential on-site supervisors, rather than forensic credentialing. To complement the on-site experience, we incorporated one hour per week of off-site group supervision with a board-certified forensic psychiatrist. This supervision provides residents with additional opportunity to discuss clinical cases and relevant forensic literature.

Reviewing potential clinical sites, we faced several of the barriers described above, including difficulties obtaining security clearance, mismatches in timing between resident availability and meaningful experiences at a clinical site, geographic distance, and physical space limitations. We also encountered competition for time and space with nonresident trainees in established rotations. For these reasons, we determined that many of the traditional forensic experiences (e.g., state forensic hospital, and court evaluations clinic) were impractical and instead turned to our local diversion programs.

The growing number of partnerships between the CJ system and community collaborators aimed at diverting individuals with mental illness away from the CJ system create opportunities for resident training experiences. These programs often encompass court-ordered mental health or substance abuse treatment with third-party reporting obligations. As treatment providers under 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 voluntary substance use. Residents learn about diversion criteria, diversion procedures, and the risks and benefits of diversion for criminally-involved individuals with mental illness. The outpatient setting of most diversion programs also makes half-day or other limited longitudinal experiences more feasible

within the existing structure of the general residency rotation schedule.

We ultimately identified two sites related to local diversion efforts that were compatible with our logistic needs and desired educational experiences. Residents were split between the two sites because of physical space limitations. Half of the residents spend one half-day per week during their six-week addiction psychiatry rotation at a clinic that provides court-ordered substance abuse treatment (the Forensic Drug Diversion (FORDD) Clinic) and the other half spend the same time at a jail diversion program for veterans (Veterans Justice Outreach (VJO) program).

The FORRD Clinic as a Case Example of Diversion Programs

Given our emphasis on forensic experiences that are most relevant for future general psychiatrists and enhancing other subspecialty buy-in, an approach that allowed the integration of multiple subspecialty fields in a limited time frame was appealing and available in the FORDD Clinic. The FORDD Clinic rotation builds on residents' growing clinical experience, develops residents' appreciation for the intersection of psychiatry and the law, and enriches the core addiction rotation experience. Despite its specialized skill set, forensic psychiatry lends itself well to this approach because the intersection of psychiatry and law encompasses essentially all psychiatric conditions. For example, alcohol and substance use confer increased risk of legal involvement, and many patients may be best served by clinical services with expertise under both umbrellas.

The FORDD clinic is not a drug court and does not provide forensic evaluations, but instead is a clinic that provides court-ordered treatment of substance use disorders. FORDD clinic clients are adults with current or recent substance use primarily referred by public defenders at all pretrial stages, by Family Services (a division of the Superior Court), or by offices of Adult Probation. The purpose of referral to the clinic is two-fold: a thorough clinical evaluation of substance use and mental health disorders, and if present, the provision of treatment recommendations, which may include treatment at the FORDD clinic. All forms of substance and alcohol use are represented and co-occurring psychiatric diagnoses are common. Clients' legal involvement commonly encompasses charges secondary to aggressive behavior toward others or property, unlawful motor vehicle operation, and drug possession or sales. The FORDD clinic staff includes psychologists and psychology trainees, social workers, nurses, and an attending psychiatrist. The attending psychiatrist serves as the on-site rotation supervisor and has broad experience in the field of forensic psychiatry.

New clients first consent to evaluation and treatment at the FORDD clinic and then are evaluated by a social worker or psychologist who elicits a detailed history, focusing on substance use, previous treatments, and previous legal involvement. Residents are offered the opportunity to participate in this initial component of the evaluation. During this initial meeting, clients sign releases for the referral source (e.g., public defender), and other prior or current mental and physical health treatment. Clients are educated about the type of information that will be requested and shared with the referral source, such as results of urine screening, breathalyzer screening, treatment recommendations, and compliance with treatment plans. Clients are free to revoke releases of information for the referral source; however, the lack of a release is communicated back to the referral source. Reports regarding client progress are typically requested on a monthly basis or before specific court dates.

After the initial interview, the psychiatry resident and attending evaluate the client and focus on diagnosis, suitability for outpatient treatment at the FORDD clinic, and treatment planning. Residents present biopsychosocial formulations along with diagnosis and treatment recommendations, including psychotherapeutic and pharmacological treatments. Residents write clinical notes (not forensic reports). Treatment at the FORDD clinic includes weekly therapy sessions, medication management, and urine screenings. Residents follow medication-prescribed clients longitudinally during their rotation.

Clients' evaluations and treatment needs are reviewed by the team in clinical rounds. Most clients remain at the FORDD clinic for treatment, and a minority are referred for higher levels of care such as intensive outpatient treatment or inpatient rehabilitation programs. Onsite supervision focuses on the legal concepts associated with diversion, including types of documentation, limits of confidentiality, and intended audiences. Though not performing forensic evaluations, residents still identify the challenging position of both evaluator and treater of substance use disorders and other mental health con-

ditions, balancing the reporting requirements of the court with efforts to develop a therapeutic rapport and collaborative goals with the client. Tensions between court and client goals are addressed directly with the patient and in supervision with both on-site and off-site supervisors; for example, when a client pursues a medical marijuana prescription in the setting of court-ordered substance abuse treatment.

Thus far, resident feedback is limited but positive. Constructive feedback focused on scheduling problems, both when time was taken away from the primary addiction psychiatry rotation and when time was spent in the FORDD clinic, and a request for a more standardized educational curriculum for the experience. In response to this feedback, educators at the site are developing a more standardized series of educational modules to ensure a consistent educational experience for all residents. Residents have had similarly positive responses to working with the VJO. As these rotations progress, we hope to gather more formal feedback to maximize their educational value.

Conclusion and Recommendations

Forensic psychiatry and the daily clinical practice of psychiatry are inseparable, and educators have a duty to prepare psychiatry residents for understanding and managing the legal aspects of clinical practice. Experiential learning is an important part of this training. This article highlights several challenges to developing forensic clinical experiences that will require creative solutions.

We have described our residency program's experience with developing a novel forensic clinical rotation. Traditional forensic settings that serve as opportunities for clinical experiences include court clinics, correctional institutions, and forensic hospitals. For those programs unable to access traditional forensic resources and settings, opportunities may be found within existing community partners, such as court-ordered substance abuse clinics, jail diversion programs, mental health or drug courts, and law enforcement agencies. In particular, versatile clinics, such as the FORDD clinic, may enrich general psychiatry residencies by providing residents with clinical exposure to material that has traditionally been taught in the classroom, including confidentiality and physician–client privilege, legal implications of clinical notes, mandatory reporting duties, tensions between evaluation and reporting duties and the treatment relationship, and criminal responsibility. Such blended subspecialty clinics can also enhance another subspecialty's existing rotation by highlighting the importance and prevalence of forensic matters in the subspecialty's clinical setting.

In our program, developing the forensic rotation around CJ diversion experiences allowed the general psychiatry residency to overcome many of the obstacles described herein and to meaningfully augment the existing substance abuse rotation. Establishing a focused forensic rotation outside of more traditional forensic experiences required greater creativity and flexibility to plan and implement. However, such nontraditional models take advantage of the blossoming assortment of CJ community partnerships and may help other residency programs overcome similar barriers while still exposing residents to forensic populations, topics, and skills. Further, training in outpatient forensic treatment programs may improve residents' understanding of recovery-oriented principles and the provision of treatment in the least restrictive setting.

Our current ability to assess the effectiveness of these novel rotations in achieving their stated learning objectives is limited by the paucity of feedback and lack of comparison data that enable assessment of the experiences of residents before the implementation of these new forensic rotations. The first of these limitations will be addressed over time as a greater number of residents participate in and evaluate the rotations. To address the second limitation, we plan to collect data from present and recently graduated residents to compare the experiences and attitudes of residents regarding forensic psychiatry before and after the introduction of these forensic rotations.

Based on our experience, practical considerations for developing forensic clinical rotations include:

> Cultivate interest and support from the residency program's leadership and other rotation leaders, to help identify protected time for the forensic learning experience within the residency schedule. Identify experiences that will complement or reinforce the educational goals of existing rotations that are forfeiting time may increase buy-in.
>
> Aim high but consider alternatives: full-time experiences may be the ideal, but one dedicated half-day per week can provide a valuable clinical forensic experience.

Identify lead faculty members with time and interest who will oversee the programmatic innovation and resident mentoring. Their responsibilities may include rotation implementation and administration (e.g., establishing goals and objectives, contacting the residents in advance of the rotation, setting expectations, collaborating with on-site faculty, providing quality assurance, and responding to residents' concerns). If board-certified forensic psychiatrists are unavailable, identify a faculty member with an interest in forensic aspects of clinical practice.

Engage all stakeholders early in the planning process, including administrative assistants, clinic managers, and other attending physicians, to foster support for the new experience and to optimize planning, implementation, and coordination of the rotation.

Consider and troubleshoot barriers to resident access in advance: geographic distance, unpredictable schedule, long or detailed background checks, availability and quality of onsite supervision, and resident safety concerns.

If traditional forensic rotation sites (e.g., court clinics, forensic inpatient units, and corrections) are impractical, consider novel experiences, such as the growing number of community–CJ collaborations aimed at diverting individuals with mental illness and substance use disorders from the CJ system.

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