Teaching Forensic Psychiatry⊕

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Forensic psychiatry may be defined as that subspecialty of psychiatry that deals with individuals with mental or emotional difficulties who are involved in legal problems of either a civil or criminal nature. Robitscher[1] has described the broader term, social-legal psychiatry, and others have referred to the discipline as psychiatry and law. Whatever label is given, the field is one which has been growing rapidly during the recent decade.

Spurred by changes in the criminal law of insanity in 1954, the field was aided by training programs through the National Institute of Mental Health in the 1960's. The recent rapid growth, however, is due primarily to changes in law which have affected the care and treatment of the mentally ill patient. Changes in commitment law, right to treatment and other laws regulating psychiatric practice have necessitated and expanded educational programs for psychiatrists in general and for forensic psychiatrists in particular. Since 1969 the American Academy of Psychiatry and the Law has grown from an original seven to its current seven hundred-plus members, all dedicated to the teaching and learning of forensic psychiatry. In 1976 the American Board of Forensic Psychiatry was initiated to continue the high standard of practice in the field by certifying a number of specialists in legal psychiatry.

Early surveys of training programs have indicated a relative lack of depth and breadth of formal training programs in forensic psychiatry, and little or no field experiences. More recent surveys have indicated that there are a number of seminars and lectures given, but only a few programs offer practical experiences and those are primarily in criminal forensic psychiatry within prisons and court clinics.[2] Very little practical experience in civil law, commitments, domestic relations, personal injury and competency determinations are provided in the medical schools and psychiatric residency training programs.

At the University of Pennsylvania, with the help of NIMH, a comprehensive training program in forensic psychiatry was initiated, entitled "Center for Studies in Social-Legal Psychiatry." The mandate from NIMH

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was a comprehensive training program which provided practical experiences and seminars in all phases of legal psychiatry. Evaluation of the effectiveness of this training was the key to the funding source. Assessment of two critical areas of change in the training, (a) knowledge received from the training and (b) skills acquired, was conducted by an independent evaluation team. A description of the training program may be found in a previous publication entitled "Comprehensive Training in Forensic Psychiatry."[3] The purpose of this paper is to present (a) the manner in which the training was presented; (b) the effectiveness of the teaching; (c) the significance of this type of training for psychiatric residents; (d) proposals for intensifying and expanding this particular type of program.

Initially the only field experience in this program was gained through affiliation with the Bucks County Prison, where assessments of prisoners and detentioners were made, including recommendations concerning treatment, hospitalization, discharge on probation, and so forth. In addition, a civil court experience for commitment procedures was instituted at Philadelphia General Hospital. A series of lectures was given at all stages of residence training, but the important teaching was not implemented until the development of the Forensic Psychiatry Clinic at the University of Pennsylvania. Here, the resident could examine, under the supervision of an experienced forensic psychiatrist, individuals who were involved in all phases of forensic psychiatry. When required, testimony in court was also provided by the resident. At the beginning of training a questionnaire was given to all residents; it was then repeated at the end of training to determine changes in attitude and knowledge gained. To evaluate the significance of skills developed, reports written by each resident were reviewed by an independent team of experienced forensic psychiatrists who were unaware of the identity of the resident and length of time the resident had been in training when the report was written. They scored the quality of the reports for completeness, effectiveness and help given to the referring source. Results of these evaluations indicated that those residents who had greater exposure to the Clinic and to the training program learned a great deal more about forensic psychiatry than those whose contact was limited. There was a direct correlation between knowledge acquired in forensic psychiatry and time involved in the program. Skill development also was shown to be significantly related to the amount of training. The residents learned how to evaluate and assess an individual who was involved in a legal matter and how to communicate both assessment and recommendations to the judge or to the referring attorney.

Data Collected

A. Knowledge Acquired

A factual knowledge questionnaire† was utilized at the beginning and the end of training to assess the degree and amount of knowledge acquired by the resident during his period of training in forensic psychiatry.* We

†The factual knowledge questionnaire consists of a number of questions on such issues as criminal and civil proceedings, recent court decisions such as *Wyatt v. Stickney*, *Baxstrom v. Herold*, etc. The full questionnaire may be found in the Final Report to NIMH from the Center for Studies in Social-Legal Psychiatry, University of Pennsylvania, April, 1977.

*A control group from an equivalent hospital without a training program in forensic psychiatry initially was used for comparative analysis; however, that comparison had to be dropped because the other hospital established its own forensic psychiatry training program.

hypothesized that the mean test score of residents who participated more actively in the program should be higher than the mean test score of those who did not. A one-tailed, difference of means test was performed which affirmed our hypothesis. (See Table I.) Higher scores indicate greater factual knowledge, and the mean test score for residents with three or more types of learning experience was 15.0, while the mean test score with fewer such experiences was 8.2. Residents with more forensic contacts scored significantly higher. We conclude, therefore, that the forensic psychiatry training program appears to increase the factual knowledge of the residents, but the increase in knowledge is contingent in part on the extent of participation within the program. The more variety and types of participation on the part of residents, the higher the score in the factual knowledge questionnaire.

TABLE I
DIFFERENCE IN MEAN TEST SCORES ON THE FACTUAL KNOWLEDGE SCALE

	Group I Fewer than 3 types of contacts* (n=11)	Group II 3 or more types of contacts (n=7)
Average Score	8.18	15.00
Standard D.	2.69	3.21

T-Test for the significance of the higher average score for residents who participated in more types of contacts with the training program:

$t = 4.522$ (d.f. = 16) $p = .0005$

*A contact is defined as an evaluation of a forensic psychiatric patient under supervision with subsequent report written to referring lawyer or judge.

Data are available on five residents who participated in the program during the three-year period. Test scores for individuals should be higher in the final phase of training if the program is effective. We hypothesize that the mean difference in scores should be greater than zero if we subtract the score an individual received in the first year from the one he received in the last year. (See Table II.) The test indicates that an average score increase of 5.4 on the test was significant to .01 level.

TABLE II
COMPARISON OF BEFORE AND AFTER SCORES ON FACTUAL KNOWLEDGE FOR RESIDENTS

Resident	(A) Factual Knowledge Score 1st Year	(B) Factual Knowledge Score 2nd Year	(B-A) Difference
A	8	19	+9
B	6	14	+8
C	12	13	+1
D	7	12	+5
E	9	13	+4
Mean Difference in scores:	+5.4		
S-D of difference:	+2.87		
t = 3.763			
d.f. = 4			
p = .01			

B. Clinical Skills

During the third year of evaluation, third year residents rotated through

the Forensic Psychiatry Clinic. Residents participated in the Clinic for part of the morning, once a week, on a fairly regular basis, interviewing clients referred to the Clinic by lawyers. Residents were requested to write reports containing psychiatric diagnoses and recommendations relevant to the litigation in which the client was involved. Reports were then sent to the referring lawyers, who, in turn, were asked to submit an evaluation of the reports. These reports from the lawyers provide a firm basis for our analysis of the ability of psychiatric residents to evaluate patients and write psychiatric reports, as well as their ability to respond to the needs and demands of other professionals requesting their services. In addition to the evaluation by the referring attorneys, the clinical reports written by the residents were also evaluated by a panel of forensic psychiatrists.

[1] Selection of Reports for Analysis and Evaluation:

All reports written by residents throughout the period June 1, 1975 to June 1, 1976 were collected, a total of 120 reports.* A sample of four reports was selected for each of six residents, using the following criteria:

(a) The report reflected the main issues in forensic psychiatry which the resident would usually encounter as part of his training.

(b) The four reports for each resident were spread throughout the period specified at fairly even intervals in order to evaluate changes in quality over time.

(c) The reports reflect the most commonly encountered sources of referrals to the residents.

(d) If two reports were written fairly close together in time, the report based on a case for which a lawyer also submitted an evaluation was selected.

The samples of four reports written by six residents were sent for independent evaluation to forensic psychiatrists Drs. Richard Lonsdorf and Melvin Heller. Names of clients and of psychiatric residents were deleted, as well as the date on which reports were written. The evaluators had no way of knowing who had written the report or when it was written. The reports for each resident were presented to the evaluators in randomized order.

The evaluators were asked to assess each report, using a standardized evaluation form similar to one used by lawyers, which stressed the following criteria:

(a) The residents' ability to present clearly a diagnosis and recommendation.

(b) The sufficiency of information contained in each report.

*Approximately twelve residents participated in the Clinic during this time period. Six of these residents were excluded from our sample because they had either just begun training in the program or had not written enough reports from which we could choose a sample of four reports.

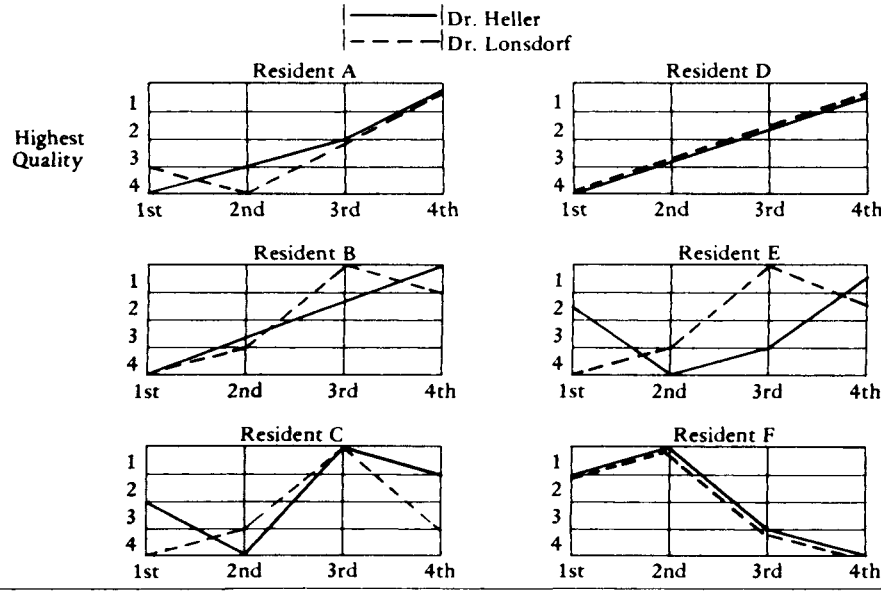
(c) The usefulness of each report to the person who made the referral as well as to the client.

After evaluating each of the 24 reports independently, the psychiatrists were then requested to rank the quality of the four reports written by each resident from a rank of 1 (the best report by a given resident) to 4 (the worst report by a given resident). By requesting the panel to rank reports in this manner we were able to analyze whether they could discern any development in behavioral skills for each resident. If the residents had increased their capabilities through time, then reports written later in the period whould be ranked higher in quality; *i.e.*, they should have lower scores than earlier reports.

[2] Evaluation of Progress in Behavioral Skills

Figure I gives a graphic description of the overall evaluation of technical skills for each resident separately. There is a high degree of consistency in the rankings of each resident through the stated time period by the panel of psychiatrists. The psychiatrists tended to rank reports written later in the period as higher in quality than earlier reports with the exception of resident F. Both independent evaluators' evaluation of resident F. indicated a decrease in the quality of reports.*

FIGURE I
OVERALL QUALITY RATINGS OF REPORTS



In general, then, two important findings should be noted. First, there is a high degree of consensus in the evaluations of residents by the panel indicating a high degree of reliability in the results. Second, based on

*Background data of resident F. indicated that he was in training predominantly at the time when the Clinic was first organized and through time began to take on more administrative responsibilities before he left.

evaluations by the psychiatrists, the residents have increased their behavioral skills and capabilities through time.

[3] Evaluation of Individual Reports

Each report written by the six residents was independently analyzed by the forensic psychiatrists in order to discern the particular weaknesses and strengths in the quality of the reports. The results are presented in Table III. The first column of Table III lists the specific criteria by which each report was judged. The second column presents the data for the total period in which the sample was taken. This column indicates the overall total of reports which met the standards of the psychiatrists regardless of the time the report was written. Column 3 and 4 divide the data into the first and second half of training for each resident, while the last column reports the percentage difference in reports that met the psychiatrists' standards for the two time periods.* For example, 72.9% of all reports gave convincing diagnoses, indicating that a fairly high percentage of reports met the panel's standards regardless of the time they were written. However, when broken down into two time periods of earlier and later training periods, it can be seen that 62.5% of the reports written in the first half as compared with 83.3% of the reports in the second half gave a convincing diagnosis: a difference of 20.8%. This difference is a measure of improvement in the quality of reports from the first to the second half of the period with respect to this criterion.

The aggregate totals of reports which met the various standards of the psychiatrists regardless of the time report was written, indicate that most reports were of fairly high quality. The particular strengths of the reports appear to be (1) the ability to present convincing diagnosis (72.9%), (2) ability to present relevant information (87.5%), (3) ability to present a report which a lawyer would understand (100.0%), (4) the panel agrees with the recommendation (72.9%), (5) the report was useful (72.9%), (6) the ability to write a psychiatric report (85.4%).

The relative weaknesses of the reports appear to be (1) lack of information sufficient for diagnoses (60.4%), (2) information relevant to referral reasons (66.7%), (3) ability of resident to present a convincing case for recommendation (68.8%), although the majority of these cases were written in the first half of training.

Examining the data, it can be seen that the range of differences from the first to the second half varies from 0% (Criterion No. 6, where no improvement is possible) to 41.6%, indicating a fairly consistent improvement in quality regardless of criteria used. It is clear that reports written in the second half contributed largely to the general conclusion regarding the strengths of these reports for the total time period.

Furthermore, the general pattern of improvement can also be seen when the criteria by which reports were judged the weakest are analyzed. On the average for the entire period, 60.4% of the reports contained sufficient

*Time periods were not fixed by months because residents rotated through the year and stayed in the training program anywhere from four months to eight months. There did appear to be a more stable pattern of improvement for those residents who trained for longer periods of time. Overall evaluations for residents who stayed for a shorter period of time were somewhat less positive.

TABLE III
EVALUATION OF REPORTS BY SPECIFIC CRITERIA
[PSYCHIATRISTS]

(I) Criteria	(II) Total (n=48)		(III) Reports written for First Half of Training (n=24)		(IV) Reports written for Second Half of Training (n=24)	
	PERCENTAGE MEETING CRITERIA					
	N	%	N	%	N	%
1 – Resident presented convincing diagnosis	35* (39)†	72.9% (81.3)	15 (16)	62.5% (66.6)	20 (23)	83.3% (95.8)
2. – Information relevant to diagnosis	42 (44)	87.5% (91.7)	20 (20)	83.3% (83.3)	22 (24)	91.7% (100)
3 – Information sufficient	29 (31)	60.4% (64.6)	10 (12)	41.7% (50)	19 (19)	79.2% (79.2)
4 – Recommendation clearly follows from diagnosis	34 (44)	70.8% (91.7)	14 (20)	58.3% (83.3)	20 (24)	83.3% (100)
5 – Information relevant to referral reasons	32 (37)	66.7% (77.1)	13 (15)	54.2% (62.5)	19 (22)	79.2 (91.7)
6 – Referral source would understand report	48 (44)	100.0% (91.7)	24 (20)	100.0% (83.3)	24 (24)	100.0% (100)
7 – Evaluating psychiatrist agrees with recommendations	35 (40)	72.9% (83.3%	15 (18)	62.5% (75)	20 (22)	83.3% (91.7)
8 – Report was particularly useful	35 (42)	72.9% (87.5)	14 (18)	58.3% (75)	21 (24)	87.5% (100.0)
9 – Resident presented convincing case for recommendation	33 (41)	68.8% (85.2)	13 (17)	54.2% (70.8)	20 (24)	83.3% (100.0)
10 – Report was ameaningful psychiatric report	41 (40)	85.4% (83.3)	20 (17)	83.3% (70.8)	21 (23)	87.5% (95.8)
11 – No. of reports in which psychiatrist specified criticism	24 (16)	50% (33.3)	17 (12)	70.8% (50.0)	7 (4)	29.2% (16.7)
12 – No. of reports which psychiatrist felt were excellent	5 (14)	10.4% (58.3)	1 (4)	4.2% (16.7)	4 (10)	16.7% (41.7)

*The upper number represents the judgment of one independent evaluator.
†The lower number represents the judgment of the other independent evaluator.

information. Of the 19 reports that did not contain enough information, 14 were written in the first half while only 5 were written in the second half, a difference of 37.5%. Similarly, of the 16 reports where information was not relevant to referral reasons, 11 were written in the first period, while only 5 were written in the second, a difference of 25%. For those criteria by which reports were judged the weakest, the percentage differences tended to be the largest, indicating that the first half of training largely contributed to the lower aggregate percentage that met the psychiatrists' standards. These results are consistent with our earlier findings that the psychiatrists tended to rank later reports as higher in quality than earlier reports.

When a report was judged to be inadequate, the psychiatrists were asked to specify the reasons for that judgment. The most detailed criticisms were invariably given to reports written earlier. In general, these reports (N=17) were found to lack sufficient detail with respect to the history of the client, lack of dynamic material, lack of organization, and a failure to present a convincing case relative to legal issues, particularly in civil cases. Of reports written later (N=17) which did not meet the criteria, insufficient detail and a failure to present a convincing case relative to legal issues were the basic criticisms. The results of our analysis, therefore, reveal a fairly consistent

pattern of improvement in the application of knowledge in at least three areas: the ability to diagnose the problems of the client; the ability to write appropriate recommendations; and the ability to respond to the needs, as viewed by our panel, of the professionals who referred the clients to the residents.

[4] Comparative Analysis Between Evaluations of Residents by Lawyers and by Psychiatrists

Of the 24 reports evaluated by the panel of psychiatrists, lawyers' evaluations were submitted to the Clinic for 21 reports. While some assessment was made by the panel of the ability of residents to meet the needs of other professionals, it was felt that a much more direct assessment of this behavioral skill could be made by asking the lawyer who made the referral for an evaluation of the report he received. Comparative analysis of the responses of the panel and referring lawyers gives some indication of the extent of consistency between the psychiatrists' and lawyers' assessments of the reports. For the evaluating psychiatrists, determination of the relative utility and quality of the reports is somewhat more hypothetical than for the referring lawyer who, for pragmatic reasons, requests and is in need of the information contained in these reports for litigation.

Column I of Table IV presents the criteria used by lawyers, and Column III presents the equivalent criteria used by the panel of psychiatrists. In Columns II and IV the proportion of cases in the sample of 21 reports which met the standards set by the referring lawyers and the panel are presented, respectively. Thus, Criterion 1, "The lawyer understood the report," used by lawyers was considered equivalent to Criterion 1, "Referral source would understand the report." Of the 21 cases in the sample, 95.2% (n=20) met the criteria by the referring lawyers, in comparison to the mean percentage of 100% for the two psychiatrists, a difference of 4.8%. As can be clearly seen in Table IV, a higher proportion of reports met the standards set by the lawyers for all criteria, with the exception of the first. Lawyers thought all of the cases contained relevant information as compared to the mean percentage, 73.8% given by the psychiatrists. Similarly, in 85.7% of the sample, lawyers felt information was sufficient as compared to 61.9% by the psychiatrists. In addition, a lower percentage of negative responses and a higher percentage of positive responses were given by lawyers. On the whole, lawyers tended to find more reports satisfactory than psychiatrists.

The actual impact of the reports in terms of utility can be measured by Item 10. In 38.1% of the sample (n=21), the judges actually followed the residents' recommendations. Of those 11 cases in which decisions were made (including cases pending or no response), 72.7% (n=8) followed recommendations in the reports. The remaining 3 cases were withdrawn based on the information and recommendations of the psychiatrist.

In conclusion, there was a high degree of consistency in evaluation of reports by psychiatrists and lawyers. Lawyers responded more positively to the ability of residents to respond to their needs and demands than the panel of psychiatrists thought they would.

Further impact of the program may be ascertained by following the residents who have graduated from the training program. One who moved to

TABLE IV
COMPARATIVE ANALYSIS BETWEEN EVALUATION OF
REPORTS BY LAWYERS AND FORENSIC PSYCHIATRISTS

	Criteria by Lawyers	Percentage Meeting Lawyers' Criteria (N=21)			Criteria by Psychiatrists	Mean Percentage Meeting Psychiatrists' Criteria (N=42)	
		N	%			N	%
1 –	Understood report	20	95.2%	1 –	Referral source would understand report	21	100.0%
2 –	Information relevant to reasons for referral	21	100.0%	2 –	Clear from report the reasons for referral	13.5	73.8
3 –	Information sufficient	18	85.7%	3 –	Sufficient information contained in report	13	61.9%
4 –	Diagnosis useful	20	95.2%	4 –	Report was particularly useful	16	76.2%
5 –	Recommendation useful	18	85.7%	5 –	Report was particularly useful		
6 –	Followed report recommendations	18	85.7%	6 –	Evaluating psychiatrist agrees with recommendation	17	80.9%
7 –	No. of Reports in which lawyers specified criticisms	5	23.8%	7 –	No. of Reports in which psychiatrist specified criticisms	9	42.9%
8 –	No. of Reports which lawyer felt were excellent	5	23.8%	8 –	No. of Reports which psychiatrist felt were excellent	2.5	11.9%
9 –	No. of Reports in which lawyer specified the report was excellent	8	38.1%	9 –	No equivalent measure.		
10a –	No. Cases where judge followed recommendation of psychiatric report at testimony	8	38.1%		No equivalent measures for actual impact by psychiatrists.		
10b –	No. Cases where lawyer withdrew case because of recommendation in report	3	19.0%				
10c –	No. Cases Pending	4	19.0%				
10d –	No Answer	6	28.6%				

*Because two psychiatrists each evaluated 21 reports, a mean percentage was taken by adding the percentage of cases which met criteria for each psychiatrist and dividing by 2.

New Orleans informed us that he received his position at the hospital because of his previous experience with forensic psychiatry during his training. Another moved to a town several miles from Philadelphia and began working in a local prison. Several others have indicated that their first contacts with private patients included forensic psychiatric matters for which the experience and training they received in the program proved quite useful and helpful. Others in the psychiatric residency training program who did not receive training in forensic psychiatry have been calling on a regular basis, requesting information and consultation with patients with whom they are having difficulty.

If training is to be effective, and students and residents are to learn skills necessary in forensic psychiatry, formal training programs with adequate supervision, lectures, seminars and practical experience must be expanded in more of our medical schools and residency training programs than currently exist. With the advent of the American Board of Forensic Psychiatry, formalized training programs with standards of practice will become

necessary. Certification by the Board must include both a knowledge of the field of forensic psychiatry and competent skills in handling the diversity of cases that may arise. Well trained forensic psychiatrists will be needed to train other psychiatrists as well as to perform necessary services for lawyers, courts and for people within the legal system. We have presented a model of such formal training, indicating by independent evaluation that such training in forensic psychiatry is effective in achieving the goals stated. The number of trainees studied is small, and the results achieved must be recognized in that light.

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