PRACTICE RESOURCE FOR FORENSIC TRAINING IN GENERAL PSYCHIATRY RESIDENCY PROGRAMS

DRAFT DOCUMENT: DO NOT DISTRIBUTE OR CIRCULATE.

PRACTICE RESOURCE TASK FORCE:

Julie S. Alonso-Katzowitz, MD

William Cardasis, MD

Cathleen A. Cerny, MD

Jessica Ferranti, MD

Jeffrey S. Janofsky, MD

Stephen Noffsinger, MD

Richard Martinez, MD

Katherine Michaelsen, MD

Melissa Spanggaard, DO

Tobias Wasser, MD

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."1[1] 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 *Medical Knowledge 2 Psychopathology B* thread focuses on "knowledge to assess risk and determine level of care." Confidentiality and informed consent falls under the *Professionalism 1 B Ethics* thread. 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."

Despite ACGME general training forensic requirements, general psychiatrists may perceive forensics as irrelevant to their daily practice. In reality, general psychiatrists routinely perform "forensic" skills in clinical practice including patient safety evaluations, informed consent, and disability assessments. Psychiatrists need to understand the legal regulation of mental health practice within their state and to appreciate the role of psychiatrists in court (e.g. when called upon to testify in civil commitment or guardianship proceedings). Further, with the trend toward caring for forensic patients in the community[2] and lack of adequate forensic psychiatrists to care for this special population,[3] 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 general psychiatry residency may help generate interest in forensic psychiatry and ease the transition from "healer to evaluator" for future fellows. [4,5] Thus, it is critical that we work to improve psychiatry residents' understanding of medicolegal questions and processes.

Some general psychiatry training programs face significant challenges to training general psychiatry trainees in forensics. The primary obstacle for many training programs is availability of resources. There are over 200 ACGME accredited general training programs in the United States but only about 46 institutions have forensic

fellowships. Not all programs have forensic-trained faculty members who can provide didactic training and experiential rotations to trainees. Not all programs are located in close proximity to state hospitals, correctional facilities or forensic evaluation centers thus limiting the availability of clinical training sites. General residencies are burdened by other ACGME rotation and education requirements, clinical and educational work hour rules (formerly duty hours) and over 300 individual milestones.

Forensic psychiatry and the daily clinical practice of general psychiatry are inseparable. As forensic psychiatry is ever present in clinical practice across all settings, forensic training is essential for all psychiatry trainees. This document provides guidelines for forensic psychiatry education and training for general psychiatry residents.

II. Basic Forensic Training for General Psychiatrists

Clinical rotations. Early forensic clinical experiences during psychiatry residency are important not only for generating interest in forensic psychiatry, but for preparing future general psychiatrists. Currently, the types of forensic experiences offered to general psychiatry residents vary greatly. The variation is often a reflection of the availability of forensic resources such as forensically trained faculty and forensic treatment settings.

While some residency programs offer required clinical forensic experiences in dedicated forensic settings, many programs meet the ACGME requirements for a forensic experience through general psychiatry rotations (e.g. on a psychosomatic medicine service) or classroom-based activities.[5, 6] For example, Marrocco et al. found that of the 150 program directors responding to their survey, 82% offered some type of forensic experience to trainees but only 35% of these experiences were mandatory.[6] Another survey of residency program directors found that most programs meet the ACGME requirements for “exposure” to forensic psychiatry via educational and didactic experiences such as classroom lectures or analysis of written case studies.[7] These programs provided little exposure to direct patient contact for the purpose of performing forensic evaluations, providing treatment in a forensic setting, testifying in court, or writing 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. [ibid] The topics least likely to be covered were providing courtroom testimony and writing a forensic report. [Ibid]

Forensic training in general psychiatry residency programs has received more attention recently due to the volume of persons with mental illness that are involved with the criminal justice system, including the overrepresentation of psychiatrically ill individuals in prisons. These conditions underscore the critical need for general psychiatry residents to be comfortable treating justice-involved individuals as well as possessing 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[8];[9] while others propose novel approaches to teaching forensic topics in the classroom, including joint classes with law students [10]and problem-based learning.[11] More recently, a survey found that Canadian residents' education in forensic psychiatry correlated positively with positive attitudes and less avoidance with forensic patients, more so with clinical experience than with classroom didactic exposure, though this study may be confounded by self-selection.[12] A recent commentary noted that even if all board certified forensic psychiatrists were working full time to provide services in jails and prisons, it would still not be enough, and advocated for required clinical forensic training for general psychiatrists.[3]

We recommend the combination of practice-based forensic experiences, didactic learning, and faculty supervision optimize the learner's educational experience. Lectures, seminars, and supervision are typically more feasible to develop for residency programs seeking to develop a forensic curriculum. Ideally, board-certified forensic psychiatrists, by their training, have special expertise for teaching forensic topics to residents. However, while programs will require general psychiatry faculty with a solid knowledge of forensic topics (including suicide and violence risk assessment, assessment for civil commitment, capacity and disability assessment), excellent forensic training in general residency does not require a particular training site or even a faculty forensic psychiatrist. We outline here examples of a variety of clinical forensic experiences that expose trainees to forensic settings and practice.

General Clinical Experiences:

Forensic training in general psychiatry residency could occur across the entire range of usual clinical settings. For example, inpatient psychiatry rotations provide opportunities for learning about civil commitment, suicide and violence risk assessment, 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. Assessment of malingering, diagnosis of psychopathy, principles of reasonable standard of care and medical malpractice including appropriate documentation could be addressed on all clinical rotations for longitudinal training in these important forensic aspects of practice. The opportunities for forensic training in daily general psychiatry practice are abundant and should not be underestimated.

III. ACGME General Psychiatry requirements relevant to forensic psychiatry

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.

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

Core Forensic Psychiatry Competencies in General Psychiatry

Clinical Rotation or Experience	***Forensic Training Topics***	***Didactic Learning***	***Experiential Learning***	***General Psychiatry Milestone***
PGY-1				
Inpatient Psychiatry	Introduction to Forensic Psychiatry	Principles and Practice of Psychiatry	Applying basic principles of consent, capacity and commitment	
Inpatient Psychiatry	Suicide Risk Assessment	Suicide Risk Tools, Suicide Risk Management & Documentation	Inpatient supervision of care of suicidal patients, level of precautions, disposition plan	PC3, MK2
Inpatient Psychiatry	Violence Risk Assessment	Violence Risk Tools, Violence Risk Management & Documentation, Evaluation of Psychopathy	Inpatient supervision of care of violent patients, level of precautions, disposition plan	PC3, MK2
Inpatient Psychiatry	Civil Commitment	Voluntary and Involuntary Commitment	Civil Commitment Court Filings & Proceedings, opportunity to testify	
Inpatient Psychiatry	Liability	Malpractice & Other Forms of Liability	Standard of care; Documentation in medical record	SBP1

Clinical Rotation or Experience	**Forensic Training Topics**	**Didactic Learning**	**Experiential Learning**	**General Psychiatry Milestone**
PGY-2				
Emergency Psychiatry	Malingering	How to Detect Malingering	Assessment and documentation of suspected malingering	ICS2
Emergency Psychiatry	Suicide Risk Assessment	Suicide Risk Tools, Suicide Risk Management & Documentation	Emergency care of suicidal patients, disposition plan	PC3, MK2, ICS2
Emergency Psychiatry	Violence Risk Assessment	Violence Risk Tools, Violence Risk Management & 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
Psychosomatic Medicine	Informed Consent	Competency, Consent and Substituted Decision Making	Obtaining informed consent for medical procedures	MK6, SBP4, PROF1
Psychosomatic Medicine	Substituted Decision Making	Competency, Consent and Substituted Decision Making	Issues of medical guardianship, medical POA, advanced directives	SBP4, PROF1
Psychosomatic Medicine	Right to Die	Withdrawal of Care	Psychiatric Consultation of Palliative Care Patients	SBP4
Psychosomatic Medicine	Right to Refuse Treatment	Refusing Medical Treatment in Competent Patients	Advance Directives, Medical POA	SBP4

Clinical Rotation or Experience	**Forensic Training Topics**	**Didactic Learning**	**Experiential Learning**	**General Psychiatry Milestone**
PGY-3				
Outpatient Psychiatry	Liability	Malpractice & Other Forms of Liability	Establishing and terminating care; Standard of care	PROF2
Outpatient Psychiatry	Forensic Referral & Consultation	When to Consult a Forensic Expert	Referrals for forensic evaluations	MK6
Outpatient Psychiatry	Patient Privacy regulations, HIPAA	Confidentiality & Privilege	Limits of confidentiality in clinical treatment; Release of information; Collateral informants	MK6
Outpatient Psychiatry	Disability	Disability Evaluations	Clinical evaluation of disability applications	
Outpatient Psychiatry	Duty to Warn, Duty to Protect	Tarasoff laws	Risk assessment	
Outpatient Child & Adolescent Psychiatry	Consent & medical guardianship	Mature Minor, Assent/Dissent in adolescent healthcare	Clinical treatment of child & adolescent patients	
Outpatient Child & Adolescent Psychiatry	Child Abuse	Child Abuse Reporting Laws	Making a child abuse report	
Outpatient Geriatric Psychiatry	Consent & medical guardianship	Competency, Consent and Substituted Decision Making	Clinical treatment of geriatric patients	
Addiction Psychiatry	Drug laws and regulations	Decriminalization of Addiction	Treatment of addiction patients	MK2

Clinical Rotation or Experience	**Forensic Training Topics**	**Didactic Learning**	**Experiential Learning**	**General Psychiatry Milestone**
Forensic Evaluation	Criminal Responsibility	Introduction to Forensic Psychiatry, McNaghten	Evaluation of criminal responsibility of criminal defendants	
Treatment of incarcerated populations	Prisoner's Rights	Principles of Treating Incarcerated Patients	Treatment of incarcerated patients	
Forensic Unit of State Psychiatric Hospital	Competency to Stand Trial	Introduction to Forensic Psychiatry	Restoration of Competency/ Sanity	
PGY-4, Elective/General: *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			

Forensic Experiences For General Psychiatry Residents:

The diverse practice of forensic psychiatry lends itself to a variety of experiential approaches. Aside from using usual clinical inpatient, outpatient and consultation-liaison sites for forensic psychiatry teaching, a common approach for residency rotations also utilizes traditional forensic settings, such as courtroom-affiliated activities, correctional facilities and county jails, or forensic hospitals.[7]

Court Clinic: Residency programs may develop a rotation in coordination with their district's local court-clinic (i.e. a mental health clinic tasked with completing competency to stand trial evaluations for the local court). The benefits of a court clinic include predictable location and schedule, fewer requirements for background checks (when compared with a correctional or institutional setting), and resident experience with evaluations, reports, and testimony.

Forensic Hospital: Another traditional clinical rotation is an experience in a forensic 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 encompass a familiar role as "treater," but in a novel arena with its own challenges. Residents learn more about the intersection of

mental health and criminal law, including statutes on competency and sanity. One drawback to experiences in forensic hospitals or correctional settings is that they may not provide as much exposure to more evaluative aspects of forensic work (i.e. report writing or testimony) that residents will experience in settings where civil forensic assessments occur.

Correctional Facility: County jails and prisons are often utilized as sites for the training of residents and medical students. This type of rotation site gives residents a unique window into mental health services in the correctional system. Because correctional facilities are now the most predominant locations in which mental health services are provided to patients in the United States, a corrections rotation can inform an important systems' linkage with provision of care to patients in the public psychiatry sector. Cultural aspects of incarceration can be experienced by the trainee first hand and can be grappled with in discussions with multidisciplinary teams. Other experiential benefits for the general resident's education include interfacing with law enforcement and dealing with security/contraband issues related to the prescribing of certain medications with abuse or diversion potential.

Innovative Forensic Experiences:

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

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 can lead to opportunities for novel resident training experiences. These programs often encompass court-ordered 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 and processes and the risks and benefits of diversion for criminally involved individuals with mental illness. The outpatient setting of most diversion programs can make half-day or other limited longitudinal experiences feasible within the existing structure of the general residency rotation schedule.

Report Writing: A reliable way for residents to solidify and apply learned forensic concepts is for them to write 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, forced medications, Civil Commitment, malpractice, Testamentary Capacity and guardianship. Testifying on the contents of the reports in a

mock trial setting (see below) and/or review in group supervision could provide valuable group learning.

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.[13] As a simulated learning experience, the trial is enhanced if all aspects of the court are designed to closely mimic the true lived experience of providing testimony. For example, when the exercise is set in an actual courtroom, legal professionals (attorneys and judges) participate in the direct and cross-examination of the resident, who is expected to dress and behave the part. This experience could be accomplished 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 may utilize a faculty-prepared clinical scenario. Learning is maximized in the expert witness experience if the trainees themselves prepare the reports promulgating the opinions they are defending.

Shadowing Community Law Enforcement Officers: In all communities, law enforcement officers confront mental health and substance abuse issues in the field. While a psychiatrist supervisor will be essential to the structure of this type of rotation in order for it to be optimally useful to the psychiatry resident, “ride-alongs” with police officers can provide very unique experiential learning. These can be rich experiences for concurrent adjunctive instruction in criminal law topics as they often pertain to mental health disorders and concomitant volitional intoxication in the relevant jurisdiction. If there are opportunities for observing police interviews of arrestees, the activity can provide an opening for discussion of interviewing techniques outside of the clinical (biomedical) model. Working with police departments to facilitate such an experience offers the possibility of shared learning, as officers will have the opportunity to learn more about mental health disorders while the psychiatry resident learns about how law enforcement officers deal with mentally disordered individuals. For example, residents may be asked to give a presentation on a mental health topic to a group of police officers. Sharing information through giving mutual presentations on joint topics of interest can create a mutually beneficial relationship that can benefit the entire community.

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, in addition to exposing 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, or a forensic hospital setting.
4. For those programs without access to forensic resources, opportunities may be found in novel experiences within existing collaborations with the criminal justice system (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.
5. Practical considerations in developing forensic clinical experiences include:

    a. Support from the residency program's leadership is critical.

    b. Collaborate with the educational leaders of currently required rotations to facilitate focused time on the forensic learning experience.

    c. 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.

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

    e. Identify 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.

    f. Consider and troubleshoot barriers to resident access in advance: geographic distance, unpredictable schedule, long or detailed background checks, availability and quality of onsite supervision, available technology (web-based conferencing for example) and resident safety concerns.

Didactics: A didactic curriculum in forensic psychiatry for residents in 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 would 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: ethical issues in involuntary treatment of patients and civil commitment, medicolegal documentation, malpractice risk and standard of care, and disability assessments.

Practical education in and application of forensic training should be useful and ubiquitous in clinical care settings. For example, such pragmatic instruction would involve evidence-based risk assessment for violence and self-harm of patients commonly seen in all outpatient clinics, inpatient units, consultation services, and emergency settings. Management based on the risk level determined is an essential component of this training to incorporate the forensic principles seamlessly into every clinical patient care experience. High risk cases are an opportunity to address topics including best practices in medicolegal documentation and the ethical issues intrinsic in involuntary civil commitment.

Knowing how legitimate mental disorders, disease and defects present is essential to the competent practice of general psychiatry. Didactic (and clinical) instruction in consideration of malingering (feigning or exaggeration of 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 will benefit the differential diagnoses of legitimate mental health problems and specifically, malingering, factitious disorder, and somatic disorders. As disability requests are the most common non-clinical question that general practice psychiatrists encounter in the treatment setting, a didactic session focusing on occupational functioning capacity assessment will benefit residents so that they can engage disability issues with a systematic approach to decision-making. Disability issues can lead to discussion of federal laws such as the Americans with Disabilities Act (ADA) and its application to mental health disorders.

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.[14] Several publications on teaching discuss the use of innovation and technology to make lessons more impactful and fun. Taking all this into consideration along with our popular culture obsessed society, it makes perfect sense to incorporate television and movie clips into resident lessons on forensic psychiatry. Movies and television seem to frequently address and even obsess about psychiatry with particular emphasis on the interface between psychiatric illness and crime. The examples of forensic psychiatry from film and television seem almost limitless and can easily be utilized to illustrate myths, misconceptions and realities of forensic evaluations. For some creative examples, see the work of Friedman and colleagues in “Reel Forensic Experts: Forensic Psychiatrists as Portrayed on Screen.”[15]

Programs that are fortunate enough to currently have forensic experiences for general residents in forensic hospitals or centers, correctional institutions – prisons or jails, court clinics, or other settings traditionally associated with forensic psychiatry, will benefit from specific onsite didactics. In these rotations, residents can: augment their understanding of their defined role in order to promote learning; reduce their risk of injury or harm; share and manage their anxieties in treating difficult patients in challenging settings; learn about assessment and treatment of specialized institutional populations; and learn about ethical principles involving care of forensic or corrections patients and research conducted in those settings. Thirteen core subject areas for teaching forensic psychiatry in general psychiatry residency programs are delineated below.

Forensic Didactic Recommendations- 13 Core Forensic Topics for General Psychiatry Residents:

1. Basic Law: General psychiatry residents should understand a number of basic law terms and concepts, given that general psychiatrists frequently interact with the justice system on issues such as civil commitment, involuntary treatment, guardianship, disability and other commonly litigated matters. Psychiatry residents should receive instruction in:
   - Basic legal terms;
   - The differences between criminal law versus civil litigation;
   - Sources of law (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; and
   - Standards of proof

2. Suicide and Violence Risk Assessment: Didactics should cover static and dynamic risk factors, as well as ways to modify them. Residents should be able to: perform a violence risk analysis, document an effective violence risk reduction plan and manage acute and chronic dangerousness. Instructors should review the meaning of acute (short-term) risk versus chronic (long-term) risk and correlated this to clinical examples. Duties to third parties including Tarasoff reporting (see below) can be taught in conjunction with clinical aspects of violence risk assessment.

   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

- Steadman HJ, Mulvey EP, Monahan J, Robbins PC, Appelbaum PS, Grisso T, Roth LH, Silver E. Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. Arch Gen Psychiatry. 1998 May; 55 (5):393-401.
- Grisso T, Davis J, Vesselinov R, Appelbaum PS, Monahan J. Violent thoughts and violent behavior following hospitalization for mental disorder J Consult Clin Psychol. 2000 Jun;68(3):388-98.
- Appelbaum PS, Robbins PC, Monahan J. Violence and delusions: Data from the MacArthur Violence. Risk Assessment Study Am J Psychiatry. 2000 Apr;157 (4):566-72.
- Macarthur Research Network: http://macarthur.virginia.edu/home.html
- Substance Abuse and Mental Health Services Administration (SAMSHA) SAFE-T Card: 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

3. Civil Commitment: Lecture(s) should cover the history of civil commitment in the United States and any relevant statutes or case law in the jurisdiction of the residency program. Didactics should cover involuntary commitment, right to refuse treatment, and right to receive treatment should be discussed. Residents should become familiar with ethical issues such as the tension between our value of civil liberties and our decision to forcibly treat some individuals with mental illness. Students should be familiar with state statutes in their practice locations related to involuntary medication including documentation and due process.

   Suggested References:

   - Anfang, SA, Appelbaum, PS, (2006). Civil commitment - the American experience. The Israel Journal of Psychiatry and Related Sciences, 43(3), 209-18.

4. Competency to Stand Trial: Residents should understand the standard for competency to stand trial in the United States criminal justice system.

   Suggested References:

   - AAPL Practice Guideline for the Forensic Psychiatric Assessment of Competence to Stand Trial Assessments, available at: http://aapl.org/docs/pdf/Competence%20to%20Stand%20Trial.pdf

5. Criminal Behavior and Insanity defense: Lectures should review the history of the insanity defense and the relevant legal statute in the jurisdiction of the residency program. Discussion of criminal behavior should address antisocial personality disorder, sexual paraphilias and psychopathy.

   Suggested References:

   - AAPL Practice Guideline: Evaluation of Defendants for the Insanity defense, available at: http://aapl.org/docs/pdf/Insanity%20Defense%20Guidelines.pdf

6. Confidentiality: Lectures should review the difference between confidentiality and privilege. Instructors should cover common scenarios and exceptions involving Health Insurance Portability and Accountability Act (HIPAA) and exceptions including patient litigant and dangerousness (emergency). Discussions should cover special documentation practices, e.g. psychotherapy process notes related to landmark case law.

   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, available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2922345/
   - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HIPAAPrivacyandSecurity.pdf

7. Duties to Third Parties and Prediction of Future Dangerousness: Lectures should cover the Tarasoff cases and any relevant case law or statutes in the jurisdiction of the residency program.

   Suggested References:

   - Steadman HJ, Mulvey EP, Monahan J, Robbins PC, Appelbaum PS, Grisso T, Roth LH, Silver E.Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. Arch Gen Psychiatry. 1998 May;55(5):393-401.
   - Grisso T, Davis J, Vesselinov R, Appelbaum PS, Monahan J. Violent thoughts and violent behavior following hospitalization for mental disorder J Consult Clin Psychol. 2000 Jun;68(3):388-98.
   - Appelbaum PS, Robbins PC, Monahan J. Violence and delusions: Data from the MacArthur Violence Risk Assessment Study Am J Psychiatry.2000 Apr;157(4):566-72.

- Johnson R, Persad G, Sisti D. The Tarasoff rule: the implications of interstate variation and gaps in professional training. J Am Acad Psychiatry Law. 2014;42(4):469-77.

8. Civil Competence (e.g. decision-making capacity and informed consent): Didactics should cover the elements required for civil competencies such as the ability to express a choice, understanding of the situation, appreciation of the options, and reasoning ability. Review of civil competence should include discussion of right to treatment and right to refuse treatment. Instructors should review relevant statutes or case law in the jurisdiction of the residency program.

   Suggested References:

   - Appelbaum PS, Grisso T. Assessing patients' capacities to consent to treatment. N Engl J Med. 1988 Dec 22;319(25):1635-8. Erratum in: N Engl J Med 1989 Mar 16;320 (11):748.
   - Appelbaum PS. Clinical practice. Assessment of patients' competence to consent to treatment. N Engl J Med. 2007 Nov 1;357(18):1834-40.

9. Malpractice: Lectures should explain the four "D's" of negligence that form the basis of medical malpractice under the law, i.e. duty, dereliction of duty, and a breach of duty that is a direct cause of the damage. They should review the most common claims of psychiatric malpractice: suicide, pharmacology side effects, third party reporting, and sexual boundary violation. Training should include conceptual understanding of errors of judgment versus errors of fact and strategies for limiting liability by good documentation practices.

   Suggested References:

   - American Psychiatric Association Resource Document on Documentation of Psychotherapy by Psychiatrists, available at: http://www.americanmentalhealth.com/media/pdf/200202apaonnotes.pdf
   - Rodgers C, Psychiatric Times Keys to Avoiding Malpractice, available at: http://www.psychiatrictimes.com/articles/keys-avoiding-malpractice

10. Disability: Lectures should emphasize that disability assessments involve the evaluation of functional impairment due to a mental health problem that is then related to the essential functions of an individual's job. They should review principles guiding disclosure and nondisclosure of clinical information in employment situations and the meaning of limitations, restrictions and reasonable accommodation. Instructors may wish to review and discuss the Americans with Disabilities Act (ADA) of 1990.

Suggested References:

- AAPL Practice Guideline for the Forensic Evaluation of Psychiatric Disability, available at: http://www.aapl.org/docs/pdf/Evaluation%20of%20Psychiatric%20Disability.pdf
- The Americans with Disabilities Act Amendments ACT, PL-110-325 (2008), available at: https://www.eeoc.gov/laws/statutes/adaaa.cfm

11. Psychopathy: Residents should understand the distinct set of personality and behavioral characteristics that define the construct of psychopathy. Topics should include the relationship between antisocial personality disorder and psychopathy. Lecturers may include the neurocognitive and neuroimaging studies of psychopathy in both institutionalized and community samples which can serve to enrich neurology knowledge base. Lecturers may also wish to explore social/relational phenomena such as empathy, guilt, risk-taking, anxiety and affect tolerance, and aggression as part of this topic.

    Suggested references:

    - Cleckley H, The Mask of Sanity, full text available free online at: http://www.cassiopaea.org/cass/sanity_1.pdf
    - Gregory S, ffytche D, Simmons A, Kumari V, Howard M, Hodgins S, Blackwood N. The Antisocial Brain: Psychopathy Matters A Structural MRI Investigation of Antisocial Male Violent Offenders. *Arch Gen Psychiatry.* 2012;69 (9):962-972.

12. Malingering: Teaching should emphasize that skilled detection of malingering involves developing expertise in understanding how major mental health disorders *do* and *do not* typically present in individuals based on our medical literature. Development of strong skills as a diagnostician will include assessment of feigning and/or exaggeration of psychopathology. Training should highlight the difference between reported versus observed symptoms, extreme symptomatology, and rare combinations of symptoms, atypical hallucinations, unusual symptom course, and suggestibility. Instructors should cover secondary gain motivations for malingering and the distinction from factitious disorder.

    Suggested references:

    - Rogers, R (Ed.) Clinical Assessment of Malingering and Deception, 3rd Edition., New York: The Guilford Press, 2008.
    - Resnick, PJ Malingering of Psychiatric Symptoms, Profiles in Psychiatry, Primary Psychiatry, 13:35-38, 2006.
    - Resnick PJ, Knoll J, Faking it: How to Detect Malingered Psychosis, *Current Psychiatry*. 2005 November;4(11):12-25.

13. Forensic Issues Pertaining to Minors: Topics should include third party reporting

obligations, i.e. child protective services reports. Training should clarify children's competency to consent to treatment and a child's right to treatment when parents refuse permission for treatment. Didactics should review evaluations of capacity to parent and basic clinical issues 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/S0890-8567(09)62591-0/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/S0890-8567(15)00148-3/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

V. 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/

VI. Final Thoughts

The American Academy of Psychiatry and the Law (AAPL) strives to promote scientific and educational activities in forensic psychiatry. The goals of AAPL include facilitating the exchange of ideas and practical clinical experience through publications and regularly scheduled national and regional meetings. Another goal is to sponsor continuing education programs for both forensic and general psychiatrists. General training directors looking to deepen their own forensic knowledge are encouraged to attend our AAPL's October meeting or the regional chapter meetings that occur around

the country. At 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/
  - Tri-State Chapter of AAPL http://www.aapl.org/chapter-meetings

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

- http://www.aadprt.org/annual-meeting

VII. References

[1] Thomas CA (Chair) et al. The Psychiatry Milestone Project. 2015. Available at: http://www.acgme.org/Portals/0/PDFs/Milestones/PsychiatryMilestones.pdf

[2] National Association of State Mental Health Program Directors (NASMHPD). Forensic Mental Health Services in the United States: 2014. September 15, 2014.

[3] Forman HL and Preven DW. Evidence for Greater Forensic Education of all Psychiatry Residents. J. Am Acad Psychiatry Law. 44:422-24, 2016.

[4] Pinals DA. Forensic psychiatry fellowship training: developmental stages as an educational framework. J Am Acad Psychiatry Law. 33(3):317-23, 2005.

[5] Rotter M, Preven D. Commentary: general residency training--the first forensic stage. J Am Acad Psychiatry Law. 33(3):324-7, 2005.

[6] Marrocco MK, Uecker JC, Ciccone JR. Teaching forensic psychiatry to psychiatric residents. Bull Am Acad Psychiatry Law. 23(1):83-91, 1995.4.

[7] Williams J, Elbogen E, Kuroski-Mazzei A. Training directors' self-assessment of forensic education within residency training. Acad Psychiatry. 38(6):668-71, 2014.

[8] Lewis CF. Teaching forensic psychiatry to general psychiatry residents. Acad Psychiatry. 28(1):40-6, 2004.

[9] Schouten R. Law and psychiatry: what should our residents learn? Harv Rev Psychiatry. 9(3):136-8, 2001.

[10] Mela M, Luther G. Law and psychiatry seminar: an interprofessional model for forensic psychiatric training. Acad Psychiatry. 37(6):421-5, 2013.

[11] Schultz-Ross R, Kline A. Using Problem-Based Learning to Teach Forensic Psychiatry. Academic Psychiatry. 23(1):37-41, 1999.

[12] Booth BD, Mikhail E, Curry S et al. Factors associated with positive attitudes of Canadian psychiatry residents toward mentally disordered offenders. J Am Acad Psychiatry Law 44:xxx-xxx, 2016.

[13] Glancy CD. The Mock Trial: Revisiting a Valuable Training Strategy. J Am Acad Psychiatry Law. 44(1):19-27, 2016.

[14] Jubas, K, Taber, N, Brown, T eds. Popular Culture as Pedagogy: Research in the Field of Adult Education. Sense Publishers 2015.

[15] Friedman SH, Cerny CA, Soliman S, West SG. Reel Forensic Experts: Forensic Psychiatrists as Portrayed on Screen. J Am Acad Psychiatry Law. 39(3): 412-7, 2011.