FORENSIC PSYCHIATRY

RESIDENCY PROGRAM

2024 - 2025

UNIVERSITY OF ARKANSAS
FOR MEDICAL SCIENCES
COLLEGE OF MEDICINE
DEPARTMENT OF PSYCHIATRY

AND

THE DIVISION OF BEHAVIORAL HEALTH SERVICES

FORENSIC PSYCHIATRY RESIDENCY PROGRAM HANDBOOK

2024 – 2025

Ben Guise, M.D.
Program Director

Table of Contents

University of Arkansas for Medical Sciences (UAMS) Forensic Psychiatry Residency Program

Sponsoring Institution

Our Forensic Psychiatry Residency Program is sponsored by the UAMS College of Medicine and funded by the Arkansas Division of Behavioral Health Services. The University of Arkansas for Medical Sciences' College of Medicine is one of six academic units of UAMS, the state's principal biomedical research center. The college's faculty members are on staff not only at the UAMS Medical Center but at Arkansas Children's Hospital, Arkansas State Hospital, the McClellan Veterans Administration Hospital, the Central Arkansas Radiation Therapy Institute and the Area Health Education Centers around the state.

It is the goal of the UAMS College of Medicine to help tomorrow's health-care professionals acquire not only the ultimate in medical skills but also professional and ethical standards that will aid them in their careers.

Participating Institutions

1. Arkansas State Hospital – This 218-bed hospital is located next to the UAMS campus and serves as a statewide referral center. The forensic inpatient service at the Arkansas State Hospital is an 80-bed, four-unit complex. It houses the entire inpatient forensic population of the state and serves as the primary base for the program.

2. Arkansas Department of Correction Special Programs Unit – This is a minimum security prison facility located approximately 45 miles from the UAMS campus. The Special Programs Unit provides housing, work supervision and treatment for up to 62 inmates with mental illness. In addition to the Special Programs Unit, there are psychiatric clinics in other prison facilities.

3. UAMS Walker Family Clinic – Our adult outpatient treatment clinic, located at the Psychiatric Research Institute on the UAMS campus, provides comprehensive mental health care - from grief and divorce counseling to medication management and treatment of psychiatric disorders and is the site of the court clinic.

Program Goals & Objectives

The primary goal of our program is to familiarize residents with all aspects of forensic psychiatry and to prepare them for forensic psychiatric practice, teaching, research, and system consultation. This goal involves objectives in three areas: knowledge, skills, and attitudes. See Appendix III for the UAMS Department of Psychiatry Forensic Fellowship Goals and Objectives for the ACGME General Competencies for Forensic Fellows.

Knowledge

The forensic psychiatry residents will:

- Develop a working knowledge of the principles and practice of legal dispute resolution in the United States. (Medical/Legal Knowledge,)
- Understand the legal standards and concepts governing civil and criminal forensic psychiatric evaluations. (Medical/Legal Knowledge, Systems-Based Practice)
- Learn the principles and current trends in the legal regulation of psychiatric practice; e.g. civil commitment, confidentiality, liability, duty to third parties, physician/patient relationships, ethics, right to refuse treatment and informed consent. (Medical/Legal Knowledge, Professionalism)
- Become familiar with the special issues involved with mental health treatment in jail, prisons, maximum-security treatment centers and public sector administration. (Medical/Legal Knowledge, Systems-Based Practice, Professionalism, Patient Care)
- Develop a knowledge base in special areas of psychiatry relevant to forensic evaluation, such as malingering, hypnosis, neuropsychiatric disorders, dissociative disorders, sexual disorders, substance abuse, parental capacity, and others. (Medical/Legal Knowledge)
- Understand the ethical issues surrounding psychiatric participation in the legal system. (Professionalism)

Skills

The forensic psychiatry residents will:

- Develop expertise in conducting criminal and civil forensic psychiatric evaluations. (Interpersonal Communication, Professionalism)
- Develop expertise in communication with courts and attorneys, preparing forensic reports, and testifying as an expert witness. (Systems-Based Practice, Interpersonal Communication)
- Develop expertise in teaching and consulting on forensic issues to general psychiatrists and other mental health professionals. (Practice-Based Learning, Interpersonal Communication, Systems-Based Practice)
- Develop skills in working with criminal justice populations with mental disorders. (Patient Care, systems-Based Practice)
- Develop skills in consulting to governmental bodies regarding public policy concerning psychiatric disorders and the law. (Systems-Based Practice, Interpersonal Communication, Professionalism)

- Develop skills in conducting scholarly research, either empirical or involving review of the legal and/or psychiatric literature. (Practice-Based Learning)

Attitudes

The forensic psychiatry residents will:

- Demonstrate attitudes that promote honesty, objectivity, and respect for persons in the practice of forensic psychiatry. (Professionalism)
- Demonstrate professionalism in working with mental health workers, courts, attorneys, and public agencies. (Systems-Based Practice, Interpersonal Communication, Professionalism)
- Demonstrate a commitment to the advancement of professional knowledge in forensic psychiatry. (Practice-Based Learning)
- Demonstrate a commitment to lifelong, self-directed leaning in forensic psychiatry. (Practice-Based Learning)
- Develop an appreciation for the limits of their own and their profession's knowledge and skills, a toleration of uncertainty, and a readiness to seek appropriate consultation and education. (Professionalism)

Faculty

Program Director

Ben Guise, MD, serves as the Director of Forensic Residency Education and an Assistant Professor in the Department of Psychiatry. As the Program Director, Dr. Guise is responsible for the oversight and organization of all educational activities within the Forensic Psychiatry program as well as the selection of residents and the monitoring of their progress. Dr. Guise provides supervision for residents in the court clinic, on the inpatient forensic civil consult service and at the Arkansas Department of Corrections.

Dr. Guise received his M.D. degree from UAMS in 1990. He is certified by the American Board of Psychiatry and Neurology (ABPN) with subspecialty certification in Addictions and Forensics. His research interests include the areas of civil commitment and the criminalization of the mentally ill, co-occurring substance use and mental health disorders, and educational research.

Key Teaching Faculty

Steve Domon, MD, is an Assistant Professor at UAMS and the Medical Director of the Arkansas State Hospital. Dr. Domon is Board-certified in adult psychiatry and child and adolescent psychiatry; one of his current areas of interest is the trend of increasing forensic activity on acute adolescent units.

April Coe Hout, PhD, is a Clinical Instructor of Psychiatry who serves as a didactic presenter and provides supervision in the relapse prevention group for adolescent sexual offenders. Her current areas of interest include efficacy of sexual offender treatment and assessment of personality characteristics of sexual offenders.

Josh King, JD, is an Adjunct Professor for the Department of Psychiatry. He provides legal consultation to the program and presents a yearly legal seminar for the fellows.

Thomas Sullivan, JD, LLM, is an Adjunct Professor of Psychiatry at UAMS and a Professor of Law at the University of Arkansas at Little Rock School of Law. His responsibilities within the Forensic Residency program include presenting didactics and acting as a consultant to the Court Clinic at the UAMS Adult Outpatient Clinic. Dr. Sullivan's current areas of interest include criminal law, law and psychiatry, and criminal procedures.

DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES
FACULTY ROSTER

CHAIR

Marie Wilson Howells Professor — Laura Dunn, MD

UNIVERSITY HOSPITAL DIVISION

Professor & Chair Emeritus:	Frederick G. Guggenheim, M.D.
Professor Emeritus:	Roscoe A. Dykman, Ph.D.
Professor:	James Clardy, M.D.
	Jeffrey Clothier, M.D.
	Lawrence Miller, M.D.
	G. Richard Smith, M.D.
	John Spollen, M.D.
	Zachary Stowe, M.D.
Associate Professor:	Jennifer Fausett, Ph.D.
	Ben Guise, M.D.
	Greg Krulin, M.D.
Assistant Professor:	.
	Lou Ann Eads, Ph.D.
	Caris Fitzgerald, M.D
	Lewis Krain, M. D.
	Irving Kuo, M.D.
	Shona Ray, M.D.

DIVISION OF HEALTHCARE SERVICES RESEARCH

Professor:	Brenda Booth, Ph.D.
	JoAnn Kirchner, Ph.D.

	Teresa Kramer, Ph.D.
	Richard R. Owen, M.D.
	Jeffrey Pyne, M.D.
	Greer Sullivan, M.D.
Associate Professor:	Geoffrey Curran, Ph.D.
	Ellen Fischer, Ph.D.
	Teresa Hudson, Pharm.D.

DIVISION OF PEDIATRIC PSYCHIATRY

Professor Emeritus:	Patricia Youngdahl, Ph.D.
Director :	
Professor:	
Associate Professor:	Molly Gathright, M. D.
Assistant Professor:	Mark Andersen, M.D.
	.
	Steven Domon, M.D.
	Jennifer Gess, Ph.D.
	Angie Shy, M.D.
	Veronica Williams, M.D.

VA MENTAL HEALTH DIVISION

ACOS for Mental Health, VAMC and Assistant Professor:	Erica Hiett, MD
Professor:	Richard Owen, M.D.
	Greer Sullivan, Ph.D.
	John Spollen, M.D.
Associate Professor:	Tim A. Kimbrell, M.D.
	Eugene Kuc, M.D.
Assistant Professor:	Erica Hiett, M.D.
	Irving Kuo, M.D. .
	Shanna Palmer, M.D.
	Shane Sparks, M.D.

	Joshua Woolley, M.D.

ARKANSAS STATE HOSPITAL

Assistant Professor and Medical Director:	Steve Domon, M.D.
Professor:	.
Assistant Professor:	April Coe-Hout, Ph.D.
	Brandon Wall , M.D.
	Veronica Williams, M.D.
	Veronica Williams, M.D.
Adjunct Professor:	Josh King, J.D.
	J. Thomas Sullivan, J.D.

CENTER FOR ADDICTION RESEARCH

Professor:	Michael Mancino, M.D.
	Alison Oliveto, Ph.D.

BRAIN IMAGING RESEARCH CENTER

Professor:	.
Assistant Professor:	Andy James, Ph.D.

Residents

Selection Procedure

The UAMS Forensic Psychiatry Residency Program is currently approved for two full-time resident positions. Applicants to the program must have satisfactorily completed an ACGME-accredited general psychiatry residency to be considered for admission.

Program applicants must submit:

- A current CV
- At least three letters of reference, with one of them being from the general psychiatry residency training director stating date of completion (or anticipated date) and standing in the program (sent directly by the authors)
- An original copy of the applicant's medical school transcript (must be sent by medical school)
- Official USMLE transcript with Step I, II & III scores and all attempts
- ECFMG certificate (for foreign medical school graduates)
- A personal statement regarding the applicant's interest in the field of forensic psychiatry
- Two writing samples – preferably previous forensic evaluations such as competency to stand trial or insanity evaluations, but if applicants do not have previous forensic reports, then a copy of a discharge summary or a patient's evaluation would also be useful. Applicants may also include copies of any articles he or she has written.

The deadline for applications for the 2014-2015 academic year is December 1, 2013. Materials should be sent to the main office of the Forensic Psychiatry Residency Program at: 4301 W. Markham St #589, Little Rock, AR 72205. The application packet is reviewed by the Program Director when all of the above materials are received. Applicants who are selected for an interview will be contacted by phone at the number listed in their application packet unless they request notification by email. All interviewees will be given written notification of the terms, conditions, and benefits of appointment and employment on the day of the interview. Acceptance into the Forensic Psychiatry Residency Program is contingent upon the ability to obtain a valid Arkansas medical license.

The complete policy of the UAMS College of Medicine Graduate Medical Education Committee on recruitment and appointment of residents may be viewed online at http://www.uams.edu/gme/1.200.html.

Other Program Personnel

Office of Education Staff

Janis Cockmon	Program Coordinator General Psychiatry Program	526-8148
LaTanya Poole	Education Coordinator	526-8161

UAMS Housestaff Office

Dwana McKay, Director	686-5356

Arkansas State Hospital

Main number	686-9000
Medical Director's office	

Walker Family Clinic

Main number	526-8200

Arkansas Department of Corrections

Educational Program

Block Diagram of Rotation Schedule

6 Months	6 MONTHS
Inpatient Forensics—Arkansas State Hospital 35%	Inpatient Forensics—Arkansas State Hospital 45%
Outpatient Forensics—Arkansas State Hospital 40%	Outpatient Forensics—Arkansas State Hospital 50%
Correctional—Arkansas Department of Corrections 20%	Court Clinic—University of Arkansas for Medical Sciences Adult Psychiatry Outpatient Clinic 5%
Court Clinic—University of Arkansas for Medical Sciences Adult Psychiatry Outpatient Clinic 5%	

ROTATION DESCRIPTIONS

ROTATION: *Forensic Inpatient*

ATTENDING: Raymond Molden, MD & Robert Forrest, MD; Stacy Simpson, MD; Rush Simpson, MD; Natalie Brush-Strode, MD

TELEPHONE: 501-686-9034

MAIL SLOT: 703

LOCATION: Arkansas State Hospital (ASH) Forensic Units

ROTATION DESCRIPTION

Fellows spend most of their time at ASH. Fellows perform inpatient competency and responsibility evaluations with opportunities to participate in the legal proceedings that follow such evaluations. They rotate through the inpatient forensic service which includes adult inpatient forensics and adolescent sexual offender forensics, and inpatient consultations. Most of the forensic faculty work at Arkansas State Hospital. All rotations are required. Most didactic time is given during rotations at the ASH.

GOALS AND OBJECTIVES (including competency language)

A. Develop expertise in performing a wide range of forensic psychiatric evaluations on inpatients with a great variety of psychiatric disorders and medical/legal involvements. These include evaluations which concern competency to stand trial, criminal responsibility, suitability for conditional release, civil commitment, right to refuse treatment, violence risk assessment, guardianship, and others. (Medical/Legal Knowledge, Interpersonal Communication, Systems-Based Practice, Patient Care/Evaluation)

B. Participate in the education of general psychiatry residents and other mental health professionals and students. (Practice-Based Learning, Professionalism, Interpersonal Communication)

C. Provide consultation to physicians, administration and staff of Arkansas State Hospital on medical/legal issues. (Systems-Based Practice, Interpersonal Communication, Medical/Legal Knowledge)

D. Develop expertise in managing patient/defendants who are under orders of restoration or are post-acquitees awaiting conditional release. (Patient Care/Evaluation, Medical/Legal Knowledge, Systems-Based Practice)

E. Develop expertise in the assessment of dangerousness, suitability for release, and testifying to the same. (Interpersonal Communication, Medical/Legal Knowledge, Systems-Based Practice, Professionalism)

SPECIFIC DUTIES OF THE RESIDENT

***Inpatient Forensics* – Adult - Raymond Molden, MD & Robert Forrest, MD; Natalie Brush-Strode, MD; & Brian Rush Simpson, MD**

Fellows conduct forensic evaluations of Arkansas State Hospital forensic inpatients under the supervision of forensic psychiatry faculty. Evaluations include: competency to stand trial, responsibility for criminal actions, violence risk assessment, suitability for conditional release, and civil commitment evaluations. Fellows also have responsibility for up to four inpatients who may be under orders to restore to competence and/or post acquittal patients. Fellows each have one hour per week of individual case based supervision and teaching with one of the three faculty members mentioned. There is additional less formal teaching that occurs on a continuing basis. This includes supervision in forensic psychiatric evaluation, psychopharmacologic treatments, and the use of psychological, neurodiagnostic and other testing. Fellows have the opportunity both to observe the court testimony of experienced psychiatrists, and also to testify themselves in court.

HANDOVER/TRANSFER PROTOCOL

Beginning of shift:
The fellow is informed of overnight events via RN and attending physician on-call.

End of Shift:
The fellow can communicate any pertinent information to the attending physician on- call.

End of rotation:
Continuity of care is provided by the attending psychiatrist when the fellow rotates off the unit. The fellow works for 6 months longitudinally on the inpatient unit, thus minimizing end of rotation transfer issues. Rotations are not reliant on the fellow's presence.

Who is responsible for responding to urgent or crisis issues after hours (or when the resident is not on shift):
Attending and on call physicians are responsible for urgent or crisis issues after hours.

When are fellows required to communicate clinical information with attendings?
The fellow is required to communicated/review all evaluations or patient issues with the attending. Issues that develop after the fellow is off duty are handled by the inpatient attending on-call.

***Inpatient Forensics* –Adolescent Sexual Offender - Stacy Simpson, MD;**

Fellows are involved with the Adolescent Sexual Offender unit and attend a multidisciplinary treatment team. During the team meetings, fellows are involved in discussions regarding progress and prognosis, modification of treatment, risk assessment, discharge planning and

placement and assist in creating recommendations for adolescents and families regarding legal encumbrance and sexual offender registration. They gain experience in the appropriate use and interpretation of forensic testing as relates to juvenile sexual offenders. They gain experience in collaborating with other mental health specialties in developing forensic opinions for present and future dangerousness and assist in the coordination of the various state divisions related to juvenile sexual offenders. Fellows also co-lead the relapse prevention group weekly. Child and Adolescent trained fellows have more opportunity to be involved in additional clinical work in the program. Fellows do not have any responsibility for clinical care on this rotation. Fellows each have two hours per month of individual supervision and teaching with the child and adolescent attending who is always available for less formal supervision on an ongoing basis. This includes supervision in forensic psychiatric evaluation, psychopharmacologic treatments, and the use of psychological, neurodiagnostic and other testing.

HANDOVER/TRANSFER PROTOCOL

Beginning of shift:

Fellow(s) observe attending interactions with team and patient and assumes no responsibility for patient care.

End of Shift:

Fellow(s) observe attending interactions with team and patient and assumes no responsibility for patient care.

End of rotation:

Fellow(s) observe attending interactions with team and patient and assumes no responsibility for patient care.

Who is responsible for responding to urgent or crisis issues after hours (or when the resident is not on shift):

The treatment team is responsible for responding to urgent or crisis issues after hours.

When are fellows required to communicate clinical information with attendings?

As the fellow observes the attending and treatment team, information is discussed in a weekly supervision session with the forensic attendings.

Inpatient Forensics – Consultation - Rush Simpson, MD;

Fellows may spend up to four hours per week responding to consults from the Arkansas State Hospital (ASH) acute adult and adolescent units and the UAMS consult liaison service. Fellows conduct consults related to the legal regulation of psychiatric practice. These include, but are not limited to issues of: civil commitment, confidentiality, refusal of treatment, decision-making capacity, and guardianship.

HANDOVER/TRANSFER PROTOCOL

Beginning of shift:

Consult to fellow begins with request of consulting ASH or UAMS Consult/Liaison staff physician.

End of Shift:
The ASH Primary team is responsible for all care of ASH inpatients. The UAMS Primary team (not UAMS C/L service) is responsible for all care of inpatients at UAMS.

End of rotation:
Consults to ASH inpatient service and C/L are typically specific and circumscribed questions. If there were repeat questions when the fellow leaves the service the new forensic fellow and or attending will respond.

Who is responsible for responding to urgent or crisis issues after hours (or when the resident is not on shift):
The primary care team at ASH or at UAMS is responsible for responding to urgent or crisis issues after hours.

When are fellows required to communicate clinical information with attendings?
All information gathered when a fellow is performing a consult is discussed with the appropriate supervisor.

SUPERVISOR'S RECOMMENDED READING MATERIALS

Principles and Practice of Forensic Psychiatry by by Richard Rosner
Psychological Evaluations for the Courts by Melton, Petrila, Poythress, & Slobogin

HOURS PER WEEK:

Patient Care/Evaluation: 12 hours

Case Conference/Staffing: 1 hours

Supervision: 1 hours

Administrative (Record Keeping): 1 hours

Total Number of Hours Per Week: 15 hours

ROTATION: Forensic Outpatient & Evaluation

ATTENDING: Raymond Molden, MD, Robert Forrest, MD, Brian Rush Simpson, MD, & Stacy Simpson, MD

TELEPHONE: 501-686-9034

MAIL SLOT: 703

LOCATION: Arkansas State Hospital (ASH) Forensic Units

ROTATION DESCRIPTION

Fellows spend most of their time at ASH. Up to 50% of their time is spent on the outpatient forensic service where they perform competency and responsibility evaluations with opportunities to participate in the legal proceedings that follow such evaluations. Fellows have opportunities to observe the court testimony of experienced forensic psychiatrists and testify themselves in criminal court proceedings as the forensic expert of record. Most of the forensic faculty work at Arkansas State Hospital. All rotations are required and insurance is provided as part of the residents' bulk benefits package. Most didactic time is given during rotations at the ASH.

GOALS AND OBJECTIVES (including competency language)

A. Develop expertise in performing a wide range of forensic psychiatric evaluation on outpatients with a great variety of psychiatric disorders and medical/legal involvements. These include evaluations which concern competency to stand trial, criminal responsibility, and diagnosis. (Medical/Legal knowledge, Interpersonal Communication, Systems Based Practices, Patient Care/Evaluation)

B. Develop expertise in generating reports for the court specific to the question before the court which cogently justify the opinion of the fellow examiner (Patient Care/Evaluation, Interpersonal Communication, Systems Based Practices, Medical/Legal Knowledge).

C. Develop skill to verbally convey findings to other mental health professionals, attorneys, and judges. (Interpersonal Communication, Professionalism Systems Based Practices, Medical/Legal Knowledge)

SPECIFIC DUTIES OF THE RESIDENT

<u>Outpatient Forensics</u> – Supervisors: Raymond Molden, MD, Robert Forrest, MD, Brian Rush Simpson, MD, & Stacy Simpson, MD

Fellows conduct forensic evaluations of Arkansas State Hospital forensic outpatients under the supervision of forensic psychiatry faculty. Evaluations include: competency to stand trial and responsibility for criminal actions. Fellows perform 1-2 forensic evaluations per week on an outpatient basis. Fellows then create reports for the court regarding their expert opinions which are reviewed and edited for content with supervisors. Fellows each have one hour per week of individual case based supervision and teaching with one of the four faculty members

mentioned. Fellows both observe the court testimony of experienced psychiatrists and also testify themselves in court.

HANDOVER/TRANSFER PROTOCOL

Beginning of shift:
Fellow assumes no patient care-giving role; evaluations are done per court order. If defendant is receiving care, treatment continues with their provider.

End of Shift:
Since there is no patient care-giving role after the evaluation is completed, the defendant returns to jail or home if on bond.

End of rotation:
There are no patient care-giving roles to handover at the end of the rotation.

Who is responsible for responding to urgent or crisis issues after hours (or when the resident is not on shift):
Fellow assumes no patient care-giving role; evaluations are done per court order. If defendant is receiving care, treatment continues with their provider.

When are fellows required to communicate clinical information with attendings?
Fellows communicate with supervisors on each case.

SUPERVISOR'S RECOMMENDED READING MATERIALS

Principles and Practice of Forensic Psychiatry by by Richard Rosner
Psychological Evaluations for the Courts by Melton, Petrila, Poythress, & Slobogin

HOURS PER WEEK:

Patient Care/Evaluation: 25 hours

Case Conference/Staffing: 3 hours

Supervision: 1 hours

Administrative (Record Keeping): 1 hours

Total Number of Hours Per Week: 30 hours

ROTATION: Department of Corrections/Jail

ATTENDING: Robert Forrest, MD, Raymond Molden, MD, & Natalie Brush-Strode, MD

TELEPHONE: 501-686-9470

MAIL SLOT: 703

LOCATION: Pulaski County Detention Center & Arkansas Department of Corrections - Malvern

ROTATION DESCRIPTION

Arkansas Department of Corrections Special Programs Unit and the Pulaski County Detention Center - Residents participate in initial psychiatric evaluations to include assessments of dangerousness. In addition, they observe medication checks in ongoing psychopharmacology cases, consult-liaison work with other units wherein medical issues are the primary focus of care, and medication review panel hearings regarding the involuntary administration of medications. Supervision is constant and ongoing with the local site director and formal supervision occurs at least one hour per week.

GOALS AND OBJECTIVES (including competency language)

A. Develop skills in the psychiatric evaluation of individuals in a correctional setting. The evaluation process will include diagnosis, assessment of dangerousness to self or others, and assessment as to housing needs within the institution and other dispositional matters. (Systems-Based Practice, Interpersonal Communication, Medical/Legal Knowledge)

B. Develop expertise in the psychiatric treatment of correctional populations. (Patient Care)

C. Develop an understanding of the role of correctional mental health care in the mental health-criminal justice system. (Systems-Based Practice, Medical/Legal Knowledge)

D. Develop an understanding of the correctional institution as a social system influencing inmate behavior. (Systems-Based Practice)

SPECIFIC DUTIES OF THE RESIDENT

Department of Corrections/Jail – Supervisor – Robert Forrest, MD

Fellows participate in psychiatric evaluations and observe medication checks for inmates. They also evaluate the need for and develop opinions regarding involuntary administration of medications. Fellows assess inmates for dangerousness and the subsequent need for housing changes.

HANDOVER/TRANSFER PROTOCOL

Beginning of Shift:

The fellow is seeing patients with an attending. On this rotation, the fellow does not have independent responsibility.

End of Shift:
At the end of each shift, all responsibility returns to the attending.

End of Rotation:
All patient care responsibilities return to the attending.

Who is responsible for responding to urgent or crisis issues after hours (or when the resident is not on shift):
All patient care responsibilities are that of the attending.

When are fellows required to communicate clinical information with attendings?
The fellow consults with attending to communicate clinical information.

SUPERVISOR'S RECOMMENDED READING MATERIALS

Principles and Practice of Forensic Psychiatry by by Richard Rosner
Psychological Evaluations for the Courts by Melton, Petrila, Poythress, & Slobogin

HOURS PER WEEK:

Patient Care/Evaluation: 9 hours

Case Conference/Staffing: 0 hours

Supervision: 1 hours

Administrative (Record Keeping): 0 hours

Total Number of Hours Per Week: 10 hours

ROTATION: Forensic Court Clinic

ATTENDING: Ben Guise, MD

TELEPHONE: 501-526-8150

MAIL SLOT: 589

LOCATION: UAMS Psychiatric Research Institute

ROTATION DESCRIPTION

Fellows on this service conduct outpatient forensic evaluations concerning a wide variety of medical/legal issues within the civil and criminal law areas. Residents conduct psychiatric evaluations of pre-trial defendants on issues of trial competency and criminal responsibility and other criminal justice issues. They also conduct evaluations of psychiatric disability, compensability under state worker's comp laws, guardianship issues, parental fitness, testamentary capacity and other civil law matters.

GOALS AND OBJECTIVES (including competency language)

A. Develop expertise in performing a wide range of forensic psychiatric evaluations on outpatient basis. (Systems-Based Practice, Professionalism, Medical/Legal Knowledge, Interpersonal Communication, Patient Care/Evaluation)

B. Develop expertise in conducting court-appointed forensic psychiatric evaluations. (Systems-Based Practice, Professionalism, Medical/Legal Knowledge, Interpersonal Communication)

C. Develop expertise in conducting evaluations for the civil bar. (Systems-Based Practice, Professionalism, Medical/Legal Knowledge, Interpersonal Communication, Patient Care/Evaluation)

SPECIFIC DUTIES OF THE RESIDENT

Fellows on this service may conduct outpatient forensic evaluations concerning a wide variety of medical/legal issues within the civil and criminal law areas including: psychiatric evaluations of pre-trial defendants on issues of trial competency and criminal responsibility, psychiatric disability, compensability under state worker’s compensation laws, guardianship issues, parental fitness, testamentary capacity, and other civil law matters. Fellows receive at least one hour per week of individual supervision by the faculty psychiatrists during active cases. Involvement may include review of documents, interviews of outside informants, forensic examinations of evaluees, consultation and discussion with referral source, report preparation, and court and deposition testimony. All training activities are conducted under the close supervision of the faculty psychiatrists. Dr. Sullivan is an expert in mental health law and serves as a consultant and resource.

HANDOVER/TRANSFER PROTOCOL

Beginning of shift:
Cases are time limited and completed by the fellow with supervision. The Supervisor is responsible for arranging to take a civil case with the referring attorney and deciding the level of involvement of the fellow.

End of Shift:
There are no end of shift Handover/Transfer.

End of rotation:
If new questions arise, they are covered by the new fellow with supervision. (happens once per year)

Who is responsible for responding to urgent or crisis issues after hours (or when the resident is not on shift):
There is no treatment relationship with clients. If there are urgent legal questions or issues, they are handled by the supervisor with or without the fellow involvement.

When are fellows required to communicate clinical information with attendings?
All cases are discussed with attendings.

SUPERVISOR'S RECOMMENDED READING MATERIALS

Principles and Practice of Forensic Psychiatry by by Richard Rosner
Psychological Evaluations for the Courts by Melton, Petrila, Poythress, & Slobogin

HOURS PER WEEK:

Patient Care/Evaluation: 2 hours

Case Conference/Staffing: 0 hours

Supervision: .5 hours

Administrative (Record Keeping): 0 hours

Total Number of Hours Per Week: 2.5 hours

SITE-SPECIFIC GOALS

See Appendix III for the UAMS Department of Psychiatry Forensic Fellowship Goals and Objectives for the ACGME General Competencies for Forensic Fellows.

Arkansas State Hospital

A. Develop expertise in performing a wide range of forensic psychiatric evaluations on inpatients with a great variety of psychiatric disorders and medico-legal involvements. These include evaluations which concern competency to stand trial, criminal responsibility, suitability for conditional release, civil commitment, right to refuse treatment, violence risk assessment, guardianship, and others. (Medical-Legal Knowledge, Interpersonal Communication, Systems-Based Practice)

B. Participate in the education of general psychiatry residents and other mental health professionals and students. (Practice-Based Learning, Professionalism, Interpersonal Communication)

C. Provide consultation to physicians, administration and staff of Arkansas State Hospital on medico-legal issues. (Systems-Based Practice, Interpersonal Communication)

Arkansas Department of Corrections

A. Develop skills in the psychiatric evaluation of individuals in a correctional setting. The evaluation process will include diagnosis, assessment of dangerousness to self or others, and assessment as to housing needs within the institution and other dispositional matters. (Systems-Based Practice, Interpersonal Communication, Medical/Legal Knowledge)

B. Develop expertise in the psychiatric treatment of correctional populations. (Patient Care)

C. Develop an understanding of the role of correctional mental health care in the mental health-criminal justice process. (Systems-Based Practice, Medical/Legal Knowledge)

D. Develop an understanding of the correctional institution as a social system influencing inmate behavior. (Systems-Based Practice)

Department of Psychiatry, Adult Outpatient Clinic

A. Develop expertise in performing a wide range of forensic psychiatric evaluations on outpatient basis. (Systems-Based Practice, Professionalism, Medical/Legal Knowledge, Interpersonal Communication)

B. Develop specific expertise in conducting fitness for duty evaluations. (Systems-Based Practice, Professionalism, Medical/Legal Knowledge, Interpersonal Communication)

C. Develop expertise in conducting evaluations for the civil bar. (Systems-Based Practice, Professionalism, Medical/Legal Knowledge, Interpersonal Communication)

Scholarly Paper/Formal Presentation

Every resident is required to complete a scholarly paper (or equivalent) prior to graduating. The purpose of this requirement is to educate residents in critically reviewing the current psychiatric literature, as well as to offer residents the opportunity to submit papers for publication. We ask for scholarly literature reviews, reports of ongoing or completed research, or similar documents.

Residents may substitute for the scholarly paper a publication which is accepted and presented at a national meeting. This may include a poster, paper, presentation or workshop. If there is question as to the nature or quality of a "national" meeting, this must be approved by the Residency Education Director beforehand. Some examples of national meetings include, but are not limited to:

APA – American Psychiatric Association
AADPRT – American Association for Directors of Psychiatry Residency Training Programs
AAP – Association for Academic Psychiatry
AACAP – American Association for Child and Adolescent Psychiatry
AAPL – American Academy of Psychiatry and the Law
AAGP – American Association for Geriatric Psychiatry

Residents may also present at UAMS Psychiatry Grand Rounds as part of their Scholarly Project.

Education Policy Committee/Residency Education Committee for Forensic Psychiatry

The Forensic Residency Education Committee shall meet once monthly to consider business relating to the Forensic Psychiatry Residency Education Program. The members of this committee shall include the Residency Education Director, Assistant Education Director and Program Coordinator, Faculty Representatives from each of the major training sites and the current fellows. This committee shall be responsible for planning, developing, implementing, and evaluating all significant features of the residency program including curricular goals and objectives and the selection of fellows. This committee will also specifically evaluate the residents, the teaching faculty, and the program (see below). This committee shall act as an advisory body to the Director of the Program and the Department Chair. The activities of the committee will also include, but not be limited to the following:

YEARLY FORENSIC RESIDENCY EDUCATION COMMITTEE CALENDAR

July August Report from fellow(s) regarding performance, problems and or any orientation issues Evaluate Teaching Staff (PE) Review Fatigue Policy (PE) September Discuss recruitment efforts Review Evaluations of Lectures Clinical Competence Committee meets October Review Program Improvement/Program Evaluation (PE) November Selection Committee meets December Selection Committee meets Clinical Competence Committee meets January Discuss Didactic Scheduled Day/Time Selection Committee meets	February Discussion of MOC results and program implications (PE) Clinical Curriculum – the effectiveness of the teaching experience (structure, case mix, meets residents' needs) (PE) Selection Committee meets March Review Goals & Objectives for sites and rotations(PE) Discuss Program Improvement (PE) Clinical Competence Committee meets April Review Resident anonymous evals, Recorded Faculty Comments, Board pass rate (PE) Review Evaluation System (Resident formative & summative, Faculty and program evaluations) (PE) May Review didactic schedules for the new year (PE) June Review Rotation Schedule (PE) Review In-House and ACGME survey (PE) Clinical Competence Committee meets

REC meetings are generally held on the first Monday of every month from 12:00 until 1:00 pm.

Note:

The **Clinical Competence Committee** meets quarterly of each academic year (September, December, March, and June) to discuss fellows' performance, competency, and professional growth. All REC faculty members are invited to attend. Required members are Ben Guise, MD, Raymond Molden, MD & Robert Forrest, MD.

The Selection Committee meets in November, December, January, and February to evaluate and select candidates for the fellowship program. All REC faculty members and fellows are invited to attend these meetings.

The **Program Evaluation Committee** will meet monthly throughout the year to discuss the program evaluation as recommended by the GME office. The committee will consist of members of the Forensic Residency Education Committee. Required members are Ben Guise, MD, Raymond Molden, MD & Robert Forrest, MD.

Evaluations

Faculty Evaluation of Residents
Forensic attendings submit quarterly evaluations of fellow performance for each rotation. These are discussed with the Residency Director at the required semi-annual review sessions.

At quarterly Promotion Committee (faculty members of the Residency Education Committee) meetings the fellows' academic progress and professional development is discussed.

Fellow Evaluation of Faculty and Program
Fellows complete evaluations of the rotations semi-annually. The program director formally shares direct feedback from fellows' written evaluations to the faculty with respect to educational and supervisory issues. These evaluations are performed semi-annually and discussed in August at the forensic residency education meeting after the fellow(s) have been dismissed from the meeting. Fellows are encouraged to give direct feedback. In addition to the feedback which occurs between teacher and student, each fellow meets semi-annually with the Director of Residency Education to discuss the fellow's performance and educational progress. The fellow is asked for direct feedback regarding faculty and the program at the semi-annual review.

Anonymous Evaluation Method
Anonymous Evaluations are performed by fellows annually. Items evaluated include the educational quality of the rotations, faculty, and program. Due to the size of the Forensic Psychiatry Fellowship, these evaluations are reviewed every year with all previous year's evaluation's combined.

360 Evaluations
Evaluations on elements of professionalism are performed by support staff, including nurses, social workers, non-attending faculty, etc., annually.

See **Appendix IV** for samples of the above evaluations.

Evaluation and Promotion Policy

The evaluation and promotion of residents is the responsibility of each Program Director and Departmental Chairperson. Each Program Director must establish and implement formal written criteria and processes for the evaluation and promotion of residents according to the procedure below. Faculty members and attending physicians evaluate the resident to determine progressive scholarship and professional growth in order to support increased responsibility of patient care. In some cases, other professional health care staff, peers and medical students also evaluate residents.

The Program Director must notify the Associate Dean for GME if he/she intends to non-reappoint or non-promote a resident. The Program Director must notify the resident of the decision to non-promote or non-reappoint by a written notice at least **four** months prior (usually March 1) to the expiration of the current period of appointment, regardless of PGY level of the resident. However, if the primary reason(s) for the non-reappointment occur(s) within the **four** months prior to the end of the current appointment, the resident will be provided with as much written notice of the intent not to renew as the circumstances will reasonably allow, prior to the expiration of the current period of appointment. A resident involved in non-reappointment or non-promotion has a right to appeal according to the GMEC Policy, 1.410, Adjudication of Resident Grievances.

The GMEC, through its internal review process, will monitor each program's written policies, procedures and guidelines for evaluation and promotion of its residents.

Evaluation Plan

Each residency program (includes fellowships) must have an effective plan for assessing resident performance throughout the program and for utilizing the results to improve resident performance. This plan should include:

1. The use of methods that produce an accurate assessment of residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice,
2. Mechanisms for providing regular and timely performance feedback to residents that includes at least written semiannual evaluation that is communicated to each resident in a timely manner,
3. A process involving use of assessment results to achieve progressive improvements in residents' competence and performance,
4. The maintenance of a record of evaluation for each resident that is accessible to the resident.

Procedure

The Program Director, with participation of members of the teaching staff and Department Chair shall:

1. Communicate the written criteria and processes for evaluation and promotion to each resident;
2. Evaluate the knowledge, skills and professional growth of the residents, using appropriate written criteria and processes to determine advancement in the

program. The methods of evaluation used to assess the knowledge, skills and professional growth in to order to determine promotion may vary among the training programs;

3. Prepare a written semiannual evaluation, or more often as dictated by the residency review requirements;
4. Communicate each evaluation to the resident in a timely manner;
   Advance the resident to a position of higher responsibility on the basis of satisfactory progressive scholarship and professional growth;
5. Maintain a permanent record of evaluation for each resident and have it accessible to the resident and other authorized personnel including the internal review panel;
6. Provide a written, final evaluation for each resident who completes the program as part of the resident's permanent record maintained by the department. The final evaluation must include a review of the resident's performance during the final period of education and should include the following statement signed by the program director: "*I verify that the resident has demonstrated sufficient professional ability, and therefore, should be able to practice competently and independently."*
7. Notify the Associate Dean for GME if he/she intends to non-promote or non-reappoint a resident.
8. Notify the resident of the decision to non-promote or non-reappoint by a written notice at least four months prior to the expiration of the current period of appointment unless the primary basis for such action occurs within the final four months of the current appointment.

Policy on Academic and Other Disciplinary Actions (Probation, Suspension and Dismissal)

Definitions

Probation: a trial period in which a resident is permitted to redeem academic performance or behavioral conduct that does not meet the standard of the program.

Suspension: a period of time in which a resident is not allowed to take part in all or some of the activities of the program. Time spent on suspension may not be counted toward the completion of program requirements.

Dismissal: the condition in which a resident is directed to leave the residency program, with no award of credit for the current year, termination of the resident's Agreement of Appointment, and termination of all association the University of Arkansas for Medical Sciences College of Medicine and its participating teaching hospitals.

Policy

Each Program Director, in consultation with the Departmental Chairperson and Departmental Education Committee, must implement written criteria and processes for academic and other disciplinary actions within the program including, but not limited to, probation, suspension and dismissal from the residency program. The specific actions of probation, suspension, and dismissal must follow the guidelines listed below. The particular administrative action imposed shall be based on individual circumstances and will not necessarily follow the sequential order in which they are described below. A resident involved in any of the actions of probation, suspension, dismissal has the right to appeal according to the GMEC Policy, 1.410, Adjudication of Resident Grievances..

Procedure

Probation

1. A resident may be placed on probation by a Program Director for reasons including, but not limited to any of the following:
   a) failure to meet the performance standards of an individual rotation;
   b) failure to meet the performance standards of the program;
   c) failure to comply with the policies and procedures of the GME Committee, the UAMS Medical Center, or the participating institutions
   d) misconduct that infringes on the principles and guidelines set forth by the training program;
   e) documented and recurrent failure to complete medical records in a timely and appropriate manner;
   f) when reasonably documented professional misconduct or ethical charges are brought against a resident which bear on his/her fitness to participate in the training program.

2. When a resident is placed on probation, the Program Director shall notify the resident in writing in a timely manner, usually within a week of the notification of probation. The written statement of probation will include a length of time in which the resident must correct the deficiency or problem, the specific remedial steps and the consequences of non-compliance with the remediation.

3. Based upon a resident's compliance with the remedial steps and other performance during probation, a resident may be:

   a) continued on probation;

b) removed from probation;
c) placed on suspension; or
d) dismissed from the residency program.

Suspension

1. A resident may be suspended from a residency program for reasons including, but not limited, to any of the following:

   a) failure to meet the requirements of probation;
   b) failure to meet the performance standards of the program;
   c) failure to comply with the policies and procedures of the GME Committee, the UAMS Medical Center, or the participating institutions;
   d) misconduct that infringes on the principles and guidelines set forth by the training program;
   e) documented and recurrent failure to complete medical records in a timely and appropriate manner;
   f) when reasonably documented professional misconduct or ethical charges are brought against a resident which bear on his/her fitness to participate in the training program;
   g) when reasonably documented legal charges have been brought against a resident which bear on his/her fitness to participate in the training program;
   h) if a resident is deemed an immediate danger to patients, himself or herself or to others;
   i) if a resident fails to comply with the medical licensure laws of the State of Arkansas.

2. When a resident is suspended, the Program Director shall notify the resident with a written statement of suspension to include:

   a) reasons for the action;
   b) appropriate measures to assure satisfactory resolution of the problem(s);
   c) activities of the program in which the resident may and may not participate;
   d) the date the suspension becomes effective;
   e) consequences of non-compliance with the terms of the suspension;
   f) whether or not the resident is required to spend additional time in training to compensate for the period of suspension and be eligible for certification for a full training year.

A copy of the statement of suspension shall be forwarded to the Associate Dean for Graduate Medical Education and the Director of Housestaff Records.

3. During the suspension, the resident will be placed on "administrative leave", with or without pay as appropriate depending on the circumstances.

4. At any time during or after the suspension, resident may be:
   a) reinstated with no qualifications;
   b) reinstated on probation;
   c) continued on suspension; or
   d) dismissed from the program.

Dismissal

1. Dismissal from a residency program may occur for reasons including, but not limited to, any of the following:

a) failure to meet the performance standards of the program;
b) failure to comply with the policies and procedures of the GME Committee, the UAMS Medical Center, or the participating institutions;
c) illegal conduct;
d) unethical conduct;
e) performance and behavior which compromise the welfare and of patients, self, or others;
f) failure to comply with the medical licensure laws of the State of Arkansas;
g) inability of the resident to pass the requisite examinations for licensure to practice medicine in the United States, if required by the individual residency program.

2. The Program Director shall contact the Associate Dean for GME and provide written documentation which led to the proposed action.

3. When performance or conduct is considered sufficiently unsatisfactory that dismissal is being considered, the Program Director shall notify the resident with a written statement to include:

   a) reasons for the proposed action,

   b) the appropriate measures and timeframe for satisfactory resolution of the problem(s).

4. If the situation is not improved within the timeframe, the resident will be dismissed.

5. Immediate dismissal can occur at any time without prior notification in instances of gross misconduct including, but not limited to theft of money or property; physical violence directed at an employee, visitor or patient; use of, or being under the influence of alcohol or controlled substances while on duty, patient endangerment, illegal conduct.

6. When a resident is dismissed, the Program Director shall provide the resident with a written letter of dismissal stating the reason for the action and the date the dismissal becomes effective. A copy of this letter shall be forwarded to the Associate Dean for GME and the Director of Housestaff Records.

Objectives and Criteria for Graduation

Criteria for graduation include successful completion of objectives set forth in all essential teaching rotations in the Forensic Psychiatry Residency Manual. Fellows must successfully complete all fellowship assignments for the prescribed 12 months of education as dictated by the Residency Review Committee for Forensic Psychiatry. Fellows must satisfactorily demonstrate competency as defined by the ACGME and measured by the fellowship. This includes any mechanism for measuring competencies, such as portfolios, 360° evaluations or any other means that the fellowship uses for evaluation purposes.

The training objectives for graduation are reached when a fellow is viewed as a solid clinician, able to use current literature, and able to negotiate a forensic psychiatric practice. This includes demonstrated competency in the ACGME competency areas. The faculty on the Residency Education Committee (REC), the residency director, and the Chairman determine resident promotions.

General Competencies

At its February 1999 meeting, the ACGME endorsed general competencies for residents in the areas of:

- patient care,
- medical knowledge,
- practice-based learning and improvement,
- interpersonal and communication skills,
- professionalism, and
- systems-based practice.

Identification of general competencies is the first step in a long-term effort designed to emphasize educational outcome assessment in residency programs and in the accreditation process. During the next several years, the ACGME's Residency Review and Institutional Review Committees will incorporate the general competencies into their Requirements. The following statements will be used as a basis for future Requirements language. If you have any questions, comments and other requests for assistance, please address them to outcomes@acgme.org.

ACGME GENERAL COMPETENCIES Vers. 1.3
(9.28.99)

The residency program must require its residents to develop the competencies in the six areas below to the level expected of a new practitioner. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate the competencies. See Appendix III for the UAMS Department of Psychiatry Plan to Meet the ACGME General Competencies for Forensic Residents.

PATIENT CARE

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to:

- communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families
- gather essential and accurate information about their patients
- make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment
- develop and carry out patient management plans
- counsel and educate patients and their families
- use information technology to support patient care decisions and patient education
- perform competently all medical and invasive procedures considered essential for the area of practice

- provide health care services aimed at preventing health problems or maintaining health
- work with health care professionals, including those from other disciplines, to provide patient-focused care

MEDICAL KNOWLEDGE

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:

- demonstrate an investigatory and analytic thinking approach to clinical situations
- know and apply the basic and clinically supportive sciences which are appropriate to their discipline

PRACTICE-BASED LEARNING AND IMPROVEMENT

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:

- analyze practice experience and perform practice-based improvement activities using a systematic methodology
- locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems
- obtain and use information about their own population of patients and the larger population from which their patients are drawn
- apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
- use information technology to manage information, access on-line medical information; and support their own education

- facilitate the learning of students and other health care professionals

INTERPERSONAL AND COMMUNICATION SKILLS

Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates. Residents are expected to:

- create and sustain a therapeutic and ethically sound relationship with patients
- use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
- work effectively with others as a member or leader of a health care team or other professional group

PROFESSIONALISM

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:

- demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
- demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities

SYSTEMS-BASED PRACTICE

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:

- understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice
- know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources
- practice cost-effective health care and resource allocation that does not compromise quality of care
- advocate for quality patient care and assist patients in dealing with system complexities
- know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance

http://www.acgme.org/http://www.acgme.org/

General Information

Contractual Agreement

House staff appointments are for a period not exceeding one year. A house staff agreement outlining the general mutual responsibility of the College of Medicine and house staff member is signed at the beginning of the term of service and is in effect for the full term of service. Please see Appendix II for a sample contract.

Due Process

Procedure for raising concerns in a confidential and protected manner

If the issue is of such a nature that it cannot be discussed at the program level or the resident desires additional discussion, the resident should follow the following procedure:

1) The resident contacts either the Associate Dean for GME or a member of the Resident Council.
2) If the resident wishes assistance from the Resident Council, the following steps should be followed:
    1. The resident should contact at least two members of the Resident Council to schedule a meeting to discuss the problem confidentially.
    2. The Resident Council members will meet with the resident and offer advice on how to resolve or handle the problem and if further steps are necessary. Based on the discussion and advice at this meeting, the resident may resolve the problem, and no further action is necessary.
    3. If the resident's problem cannot be resolved or is of such a nature that further information is needed, the Resident Council members should discuss the problem with the Associate Dean for GME or the GMEC Chair.
    4. In order to ensure easy access to Resident Council members, they are posted in the Resident Handbook on the GME website
3) The procedure for resolution will vary depending on the type of issue:
    1. For issues related to general work environment, the Associate Dean for GME or Resident Council may discuss the issue and make recommendations for resolution through the GMEC.
    2. Issues related to disciplinary action will be addressed according to the procedure outlined in the GMEC policy on Academic and Other Disciplinary Actions (Probation, Suspension and Dismissal).
    3. Issues related to maltreatment will be addressed according to the procedure outlined in the GMEC policy on Appropriate Treatment of Residents in an Educational Setting.
    4. Should a resident believe that a rule, procedure, or policy has been applied to him/her in an unfair or inequitable manner or that he/she has been the subject of unfair or improper treatment, the resident should refer to the GMEC policy on Adjudication of Resident Complaints and Grievances.

4) Discussions and recommendations by the Resident Council and/or the GMEC are confidential to the extent authorized by law and handled in a manner to protect the resident.

Work Hours, Duty Hours and Work Environment

Work and duty hours are approximately 50 hours per week Monday through Friday with no required call and no weekends. Optional supplemental call is available at ASH on a voluntary basis.

In compliance with the UAMS COM GME Committee policies on duty hours/work environment and moonlighting and, considering that the care of the patient and educational clinical duties are of the highest priority, the following guidelines apply:

Duty Hours

1. Duty hours are limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.
2. Residents are provided one day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
3. Duty periods fellows will not exceed 24 hours of continuous duty in the hospital. If needed, a resident may stay up to an additional 4 hours to effect transitions in care. No new clinical duties will be assigned during these 4 hours.
4. In order to ensure adequate time for rest and personal activities, a 10-hour time period is provided between daily duty periods and a 14 hour time period is provided after any 24 hour duty period.

On-Call Activities

The goal of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period.

1. **In-house call:**
   a. Occurs no more frequently than every third night, averaged over a four-week period.
   b. On psychiatry rotations, in-house call will occur no more frequently than every fourth night, averaged over a four week period.
   c. Does not exceed 24 consecutive hours of continuous on-site duty. However, residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity care.
   d. No new patients, defined as any patient not on the resident's service prior to the present 24-hour continuous duty period, may be accepted after 24 hours of continuous duty.
2. **At-home call (pager call):**
   a. The frequency of at-home call is not subject to the every third night limitation.
   b. Residents taking at-home call are provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period.

c. When residents are called into the hospital from home, the hours spent in-house are counted toward the 80-hour limit.
d. The Program Director and the teaching faculty will monitor the demands of at-home call and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

The resident is expected to be on duty during normal working hours, as established by each rotation, Monday through Friday. Additional duty hours include on-call duties. Residents must be available by telephone or pager while on-call. Specific call schedules and responsibilities are delineated in the written goals/objectives of each rotation, which are reviewed with the resident at the beginning of the rotation.

Forensic Fellows do not have any required call responsibilities.

Work Environment

1. **Call rooms:** call rooms are provided for all residents who take in-house call.

2. **Ancillary support:** adequate ancillary support for patient care is provided. Except in unusual circumstances, providing ancillary support is not the resident's responsibility except for specific educational objectives or as necessary for patient care. This is defined as, but not limited to, the following: drawing blood, obtaining EKGs, transporting patients, securing medical records, securing test results, completing forms to order tests and studies, monitoring patients after procedures.

Fatigue

We are committed to preventing and counteracting the potential negative effects of fatigue in this training program.

Residents are required to take the L.I.F.E. Curriculum modules on fatigue, available online, at the beginning of residency.

Faculty and residents are given instruction in fatigue via educational materials which are distributed by the UAMS Office of Psychiatry Education.

In the event a resident experiences fatigue severe enough to interfere with his/her ability to function normally or to impair patient care or safety, the fellow or a faculty member will contact the Program Director. If the Program Director is not available, the report may go to the faculty member in charge of the rotation, or the director of fellow education at that facility.

The program director or faculty member will relieve the fellow of duty and arrange coverage if needed. The fellow or faculty will report the incident to the Program director by e-mail or phone if the program director was not involved in the original report.

The Program Director determines when the resident should return to the education program.

The Program Director notifies the attending faculty physician about these arrangements.

In the event a fellow experiences recurrent problems with sleepiness/fatigue, the Program Director will refer the fellow for medical evaluation.

Moonlighting

External moonlighting is defined as any professional activity arranged by an individual resident, which is outside the course and scope of the approved residency (includes fellowships) program, whether or not the resident receives additional compensation. For purposes of accreditation, 'moonlighting' covered by this policy is 'external moonlighting', which is outside the University of Arkansas for Medical Sciences (UAMS) system. (UAMS system includes the participating teaching hospitals.)

Policy

External moonlighting is not permitted at this program. A variety of internal moonlighting options are available. Internal moonlighting is defined as clinical work at a facility with an affiliation with UAMS, and for which there is some level of supervision from a UAMS attending. Because internal moonlighting opportunities vary over time, they will not be listed here. Available opportunities can be obtained from the chief resident for the core program. In order to be eligible for internal moonlighting, residents must meet all program requirements including attendance at didactics/grand rounds and compliance with administrative responsibilities such as keeping up with charting, etc. Internal moonlighting cannot interfere with a resident's ability to function on required rotations, and time spent moonlighting counts towards ACGME limits on duty hours.

The Program Director maintains the right to remove a resident from internal moonlighting opportunities should there be evidence that internal moonlighting interferes with educational training or with clinical or administrative responsibilities

Holidays

Official UAMS holidays are:

- New Year's Day (January 1)
- Martin Luther King Day (third Monday in January)
- Presidents' Day
- Memorial Day (fourth Monday in May)
- Independence Day (July 4)
- Labor Day (first Monday in September)
- Veteran's Day (November 11)
- Thanksgiving Day (fourth Thursday in November)
- Christmas Eve (December 24)
- Christmas Day (December 25)

ID Badges

Each house officer will be furnished with an ID badge.

Leave

Professional / Educational Leave

Time spent attending meetings or taking Board examinations or other examinations will not be counted as vacation if the activity is sanctioned by the home department.

Three factors govern the circumstances under which a trip to attend a professional meeting will be approved or disapproved (Leave requests must be signed by the resident's immediate supervisor(s), and the Director of the Forensic Residency Program **prior** to attending a professional meeting): (1) whether adequate coverage is maintained for patient care responsibilities, (2) the availability of travel funds, and (3) the training value of the meeting the resident proposes to attend. Forms are available in the Education Office

If you are traveling on departmental business which will require reimbursement from the department, please tell the Education Office your departure and return dates, hotel information, etc., BEFORE you begin your trip. Upon return, all ORIGINAL RECEIPTS must be submitted to the Education Office. Failure to follow the above procedures could result in no reimbursement from the department.

Sick Leave

If you cannot come to work due to illness, notify the attending physician as well as the Office of Education. If you have a planned medical leave or appointment, a standard leave form should be submitted prior to the leave for planning purposes.

Residents have 12 days of sick leave (including weekend days) for medical reasons during each year of training. The sick leave cannot be "carried over". Sick leave in excess of 12 days requires special review by the Associate Dean and Program Director.

Vacation

Residents receive 21 days (15 work days plus weekend days) of paid vacation each year. This cannot be "carried over" from one year to the next.

Effect of Leave on Completion of Training

Resident physicians are in the unique position of having a role as students and employees. Although brief periods of leave can usually be accommodated, extended absences from the residency (fellowship) program for any reason may adversely affect both the resident’s completion of the educational program on schedule and the program’s responsibilities for patient care, allocation of clinical teaching opportunities and funding for resident stipends. Most specialty boards specify a minimum number of weeks of education (or

training) that must be completed for a resident to receive credit for the educational (or training) time. The resident must take into account these factors when requesting extended periods of leave from the program.

Library

The UAMS Library is housed in the Education II Building and occupies space on three levels with the Audio-Visual Library on the fifth floor. The library contains 38,000 books and regularly receives approximately 108 journals related to the behavioral sciences, 1,619 medical journals, and 57 neurology journals. Available databases include MEDLINE, PsycINFO, and CURRENT CONTENTS/CLINICAL MEDICINE, among several others.

A small library is located on the first floor of Building 170 at the Ft. Roots (NLR) V.A.; computer search facilities are available free of charge.

The Department of Psychiatry houses a small library of key textbooks and journals in the Psychiatry Administration building. In addition, the department's audio-visual library contains over 700 psychiatry-related audio cassettes and videotapes.

Parking

UAMS – All members of the house staff are granted parking privileges in the parking deck

Arkansas State Hospital – general employee parking permits can be obtained from the ASH administration.

Professional Liability Insurance

Each house staff physician is provided professional liability insurance when on official duty. Forms for the insurance are available in the House Staff Office. Additional coverage may be obtained from the insurance carrier. Moonlighting is not covered by residency liability insurance.

Resident Participation in Nondepartmental Activities

When engaged in non-remunerative activities in which a resident might be reasonably perceived by the public to represent UAMS or the Department of Psychiatry, advance clearance from the Residency Director is required.

Supervision

Fellows are required to receive at least two hours of direct supervision on all rotations one hour of which is one to one with attendings.

All supervisory assignments are evaluated by both supervisors and fellows.

The Department of Psychiatry Forensic Residency Education Program is committed to promoting patient safety and fellow well-being and to providing a supportive educational environment. Didactic and clinical education activities have priority in the allotment of fellows' time and energy. The learning objectives of the program will not be compromised by excessive reliance on fellows to fulfill service obligations. Duty hour assignments are made with the

recognition that faculty and fellows collectively have responsibility for the safety and welfare of patients. In compliance with the UAMS COM GME Committee policy on Fellow Supervision, the following guidelines are followed for supervision of the care of patients and backup support:

1. Qualified faculty physicians supervise all patient care and their schedules are structured so that adequate supervision is available at all times.
2. Attending faculty physician supervision is provided appropriate to the skill level of the fellows on the service/rotations.
3. Specific responsibilities for patient care are included in the written description of each service/rotation; this information is reviewed with the fellow at the beginning of the service/rotation. The site director is ultimately responsible for supervision occurring at his/her site. The faculty physician oversees the entire team and is available at all times in person, by telephone or beeper.
4. Rapid, reliable systems for communication with supervisory physicians are available.
5. The following procedure is followed to address fatigue of the resident:
    a. Any faculty or fellow who notices fatigue sufficient to negatively affect the performance of a fellow via their training will notify the chief fellow who will then contact and arrange for a backup person to relieve the fellow in consultation with the Program Director.
    b. The Program Director determines when the fellow should return to the education program.
    c. The Program Director notifies the attending faculty physician about these arrangements.
    d. Fellows are required to take the “Sleep, Alertness and Fatigue Education in Residency” (SAFER) educational module in WebCT at the beginning of residency.
    e. Faculty are given instruction in fatigue via educational materials which are distributed by the Office of Education.

Suicide by a Patient

The following are **UAMS** guidelines for management:

1) Remember that death of the patient does not necessarily end the therapist's interaction with the patient's family, and further contact with the family should be discussed with the supervisor.

2) The supervisor(s), the Residency Director and the head of the service (if different from the supervisor) should be notified immediately – at any time of the day or night.

3) The University attorney and the malpractice insurance company defense attorney should be consulted by the UAMS faculty member involved.

4) The Chief Resident should be notified by either the resident or the Residency Training Director, unless the Residency Director deems this inappropriate for some reason.

5) A chart review should be arranged, generally within 24 hours, involving the resident, the attending on the service, the supervisor, the residency training director, chairman, and any other staff with close involvement.

6) The hospital administrator should be notified.

Website

The address to access our department's website is: http://psychiatry.uams.edu.
This site contains information on our faculty, residency programs, calendar of events, and other items of interest.

Appendix I - Didactics Schedule

Special Sessions: Orientation July 1- Jul 7	**WED Jul 1 2015 1:30-3:00 PM** Fitness to Proceed Evaluations **BRUSH-STRODE** **THURS Jul 2 2015 12:30-2:45 PM** History of the Insanity Defense and Criminal Responsibility **MOLDEN** **MON Jul 6 2015** **8:30-1145 AM** Performing the Forensic Examination **R.SIMPSON** **1:45-4:30 PM** Forensic Report Writing **FORREST** **TUES Jul 7 2015** **10-12 PM** Fitness Assessment Instruments **Peacock** **2-4 PM** Malingering **FORREST**	
	Session 1: 2-3 PM	**Session 2: 3-4 PM**
Jul 8 15	Ethics, Roles & Responsibilities of Forensic Psychiatry **BEAMAN**	Landmark Case Conference: Competency to Stand Trial Dusky v. U.S. Wilson v. U.S. Jackson v. U.S.
TUES Jul 14 15 1pm-3pm	**Standardized Patient Encounters UAMS Clinical Skills Center**	
Jul 15 15	Landmark Case Conference: Insanity Defense M'Naghten's Case Durham v. U.S. Washington v. U.S.	
Jul 22 15	Dangerousness & Safe Release of Acquitees **BRUSH-STRODE**	Landmark Case Conference: Competency to Stand Trial Seiling v. Eyman Godinez v. Moran Cooper v. Oklahoma
Jul 29 15	Philosophy & Fundamentals of the law; Overview of the US Legal System **KING**	
Aug 5 15	Juvenile Justice System **BEARD**	Landmark Case Conference: Insanity Defense Frendak v. U.S. Jones v. U.S. Foucha v. Louisiana Ake v. Oklahoma
Aug 12 15	Criminal Law Overview & Outline of Evidence, Admissibility of Expert Opinion **KING**	
Aug 19 15		
Aug 26 15	The Role of Psychological Testing **Peacock**	

	Session 1: 2-3 PM	Session 2: 3-4 PM
Sep 2 15	Criminal Procedure & Constitutional Protections **BYRD**	Landmark Case Conference: Defendant's Rights Colorado v. Connelly North Carolina v. Alford Riggins v. Nevada Sell v. US
Sep 9 15	Legal Research & Civil Procedure **KING**	Civil Procedure **KING**
Sep 16 15	Landmark Case Conference: Assisted Suicide & Right to Die Vacco v. Quill Washington v. Glucksberg Cruzan v. Director	
Sep 23 15	Testifying in Court **R.SIMPSON**	Landmark Case Conference: Expert Witness Frye v. US Daubert v. Merrell GE v. Joiner Kumho Tire v. Carmichael
Sep 30 15		
FRIDAY OCT 2 15	**MOCK TRIAL**	
Oct 7 15	Family Law & Rights **NEED LECTURER**	Tort Law **NEED LECTURER**
Oct 14 15	Correctional Psychiatry **GUISE**	Landmark Case Conference: Prisoners' Rights Estelle v. Gamble Vitek v. Jones Baxstrom v. Harold Farmer v. Brennan
Oct 21 15	AAPL Meeting	
Oct 28 15	Mental Health Malpractice **MOLDEN**	Landmark Case Conference: Malpractice Liability Roy v. Hartogs Clites v. Iowa Aetna v. McCabe Mazza v. Huffaker
Nov 4 15	Confidentiality & Duty to Protect **BEAMAN**	Landmark Case Conference: Duty to Protect Tarasoff v. Regents Lipari v. Sears Jablonski v. U.S. Naidu v. Laird
Nov 11 15	Veteran's Holiday NO LECTURES	
Nov 18 15	Landmark Case Conference: Informed Consent	

	Canterbury v. Spence Kaimowitz v. Michigan DMH	
Nov 25 15	Thanksgiving Holiday NO LECTURES	

	Session 1: 2-3 PM	**Session 2: 3-4 PM**
Dec 2 15	Adolescent Sex Offenders & Violent Offenders: Assessment & Treatment **S.Simpson**	Landmark Case Conference: Sex Offenders Specht v. Patterson Allen v. Illinois
Dec 9 15	Civil Competence & Testamentary Capacity **R.SIMPSON**	Landmark Case Conference: Emotional Harm Dillon v. Legg Carter v. General Motors
Dec 16 15	Adult Sex Offender **Peacock**	Landmark Case Conference: Sex Offenders Kansas v. Hendricks In re Young & Cunningham Kanas v. CraneTruman v. Thomas
Dec 23 15	Winter Holiday NO LECTURES	
Dec 30 15	Winter Holiday NO LECTURES	
Jan 6 16	Mental Health Disability Evaluation **BEAMAN**	Landmark Case Conference: Substance Abuse & Crime Robinson v. California Powell v. Texas
Jan 13 16	Voluntary & Involuntary Admission **GUISE**	Landmark Case Conference: Civil Commitment Lessard v. Schmidt O'Connor v. Donaldson Addington v. Texas Parham v. JR & JL Zinermon v. Burch
Jan 20 16	Landmark Case Conference: Death Penalty Ford v. Wainright State v. Perry	
Jan 27 16	Death Penalty **SULLIVAN**	
Feb 3 16	Right to Treatment **GUISE**	Landmark Case Conference: Right to Treatment Rouse v. Cameron Wyatt v. Stickney Donaldson v. O'Connor Youngberg v. Romeo
Feb 10 16	Juvenile delinquency & Assessment **S.Simpson**	Landmark Case Conference: Death Penalty

		Payne v. Tennessee Estelle v. Smith Barefoot v. Estelle
	Session 1: 2-3 PM	**Session 2: 3-4 PM**
Feb 17 16	Custody Issues: Conservators & Guardianships **RAMOS**	Landmark Case Conference: Death Penalty Payne v. Tennessee Estelle v. Smith Barefoot v. Estelle
Feb 24 16	Confession & Testimonial Capacity **RAMOS**	Landmark Case Conference: Right to Refuse Treatment App. Of Pres & Directors of Georgetown Super. Of Belchertown v. Saikowitz Guardianship of Richard Roe, III
Mar 2 16	Psychological Injury **HINTON**	Landmark Case Conference: Sexual Harrassment Meritor Savings Bank v. Vinson Harris v. Forklift Systems Oncale v. Sundowner Offshore
Mar 9 16	Americans with Disabilities Act & Fitness for Duty Evals **HINTON**	Landmark Case Conference: Disabilities Bragdon v. Abbott Pennsylvania v. Yesky Olmsted v. LC ex rel Zimring
Mar 16 16		
Mar 23 16	Domestic Abuse (child, spouse, Elder) **FORREST**	Landmark Case Conference: Child Abuse State v. Andring DeShaney v. Winnebago Landeros v. Flood People v. Stritzinger
Mar 30 16	Legal Regulation of Medicine & Psychiatry **HINTON**	Landmark Case Conference:Confidentiality & Privilege Lifschutz, In Re Whalen v. Roe Doe v. Roe Commonwealth v. Kobrin Jaffee v. Redmond
Apr 6 16	Managed Care & ERISA **BRUSH-STRODE**	Landmark Case Conference: Managed Care Aetna Health v. Davila Concoran v. United Healthcare Dukes v. U.S. Healthcare NYS Conf. of B.C. & B. S. Plans, et al., v. Travelers
Apr 13 16	Memory and Eyewitness Testimony **HINTON**	Landmark Case Conference:Hypnosis State v. Hurd

		People v. Shirley Rock v. Arkansas

	Session 1: 2-3 PM	Session 2: 3-4 PM
Apr 20 16	Landmark Case Conference: Juvenile Rights Board of Education v. Rowley Irving Independent School District v. Tatro Gault, In Re Roper v. Simmons	
Apr 27 16	Visiting Professor Topic SULLIVAN	
May 4 16	Right to Refuse Treatment **GUISE**	Landmark Case Conference: Right to Refuse Treatment Rennie v. Kline Rogers v. Commissioner Washington v. Harper
May 11 16	Child Custody & Parental Rights Termination Evaluation **S.Simpson**	Landmark Case Conference: Child Custody Painter v. Bannister Santosky v. Kramer
May 18 16	Diminished Capacity & Evals in Aid of Sentencing **FORREST**	Landmark Case Conference: Diminished Capacity Defense People v. Patterson Ibn-Tamas v. U.S. Montana v. Egelhoff
May 25 16	Assessment of Stalking **Peacock**	
Jun 1 16		
Jun 8 16		
Jun 15 16		
Jun 22 16		
Jun29 16		

Journal Club and Case Conference

1. July 14: Standardized Patient Encounter
2. Aug 18: Journal Club Faculty
3. Sept 15: Case Conference Faculty
4. Oct: AAPL
5. Nov 17: Journal Club
6. Dec 15: Case Conference
7. Jan 19: Journal Club
8. Feb 16: Case Conference
9. March 15: Journal Club
10. April 19: Case Conference
11. May 17: Journal Club
12. June 14: Case Conference (All fellows)

Appendix II – Sample Contract

Appendix III

University of Arkansas for Medical Sciences
DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

Request for Vacation, Educational, and Planned Sick Leave

Resident:_____Date:_____
(Print Name)

I request_____days. Leave Date(s): _____
Type of Leave

_____Vacation _____

_____Educational leave _____ _____
Name of Conference, Exam, etc.

Does this request bring total leave on this rotation to more than 5 days in a month: **YES** ☐ **NO**☐

Leave greater than 5 days in a calendar month is not permitted in most circumstances

Rotation Responsibilities:

_____has agreed to cover my rotation assignment and my supervisor has this information.

Approval of request:

_____Date: _____
(Supervisor's(s') Signature(s))

_____
(Supervisor's(s') Name(s) PRINTED)

Return completed form to Janis Cockmon

Rev. 7/2021

Appendix IV: Evaluations

DIDACTIC EVALUATION FORM

PRESENTATION EVALUATED _____
DATE: _____ **PRESENTATION SPEAKER**: _____

This questionnaire gives you the opportunity to provide feedback on various aspects of didactic activities. This information will be used to guide scheduling of presentations in the future. Please answer all questions, if applicable, and make appropriate comments.

Circle a number under each column that best describes your degree of agreement or disagreement with each statement.

	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
This presentation provided material beneficial to you (applied to patient care)	1	2	3	4	5
This presentation was appropriate to your education level	1	2	3	4	5
The material was presented in a stimulating manner.	1	2	3	4	5
This presentation should be given to future residents	1	2	3	4	5
The material should be given to future residents by the same presenter	1	2	3	4	5
The presenter was knowledgeable about the subject material	1	2	3	4	5
Questions were allowed and answered appropriately	1	2	3	4	5
An appropriate amount of time was provided for the topic	1	2	3	4	5
Handout materials were helpful	1	2	3	4	5

COMMENTS:

Return form to Ashley Lavender, UAMS Slot 589

360-R Multi-Rater Evaluation

Evaluator

Program **Forensic Psychiatry Residency Program**

Subject

Dear Healthcare Professional,

As you know, the clinical residency is the primary opportunity for the development of professional skills. To provide an effective residency experience, it is important to consistently evaluate residents' professional performance from a variety of perspectives (eg. patient, attending doctor, nurse, other healthcare professional, peer, and self). Your feedback is critical to understanding how it is that residents develop professional skills, and how it is that residency programs can be made more effective.

Please take 5 minutes to respond to the following survey. Base your response on how you think the resident generally performs his or her duties. Your comments are **strictly confidential.**

The resident generally:

1) Respects the roles of health care staff in patient care.

Rarely | Sometimes | Most of the time | Nearly Always | Do Not Know

2) Effectively handles difficult interpersonal situations.

Rarely | Sometimes | Most of the time | Nearly Always | Do Not Know

3) Effectively addresses cultural, language, and educational barriers to successful communication.

Rarely | Sometimes | Most of the time | Nearly Always | Do Not Know

4) Treats patients with respect.

Rarely | Sometimes | Most of the time | Nearly Always | Do Not Know

5) Completes medical records in a timely fashion.

Rarely | Sometimes | Most of the time | Nearly Always | Do Not Know

6) Accepts feedback and suggestions.

Rarely | Sometimes | Most of the time | Nearly Always | Do Not Know

360 Continued

7) Manages time well.

Rarely	Sometimes	Most of the time	Nearly Always	Do Not Know
○	○	○	○	○

8) Dresses appropriately for work.

Rarely	Sometimes	Most of the time	Nearly Always	Do Not Know
○	○	○	○	○

9) Advocates for quality patient care and optimal patient care systems.

Rarely	Sometimes	Most of the time	Nearly Always	Do Not Know
○	○	○	○	○

10) Displays sensitivity and individualizes care for diverse populations.

Rarely	Sometimes	Most of the time	Nearly Always	Do Not Know
○	○	○	○	○

Please provide your comments. Your feedback is very important for improving instruction.

My healthcare provider role is:

Nurse	Attending Physician	Peer	Administrative	Other
○	○	○	○	○

Appendix IV – UAMS Department of Psychiatry Forensic Fellowship Goals and Objectives for the ACGME General Competencies for Forensic Fellows

Competency:

Patient Care

Required Skills And Attitudes	Specific Objectives	Teaching		Evaluation		Feedback to Resident	Sites
		Method	Timing	Method	Timing		
Demonstrate ability to treat patients in inpatient forensic settings and/or corrections	Establish rapport and gather information Consider differential diagnosis in context of setting including consideration of secondary gain issues Formulate a treatment plan considering biopsychosocial factors	Supervision at ASH and Corrections while delivering patient care	Ongoing	Direct feedback from forensic faculty	Ongoing	Direct feedback from forensic faculty Quarterly global evaluations and semi-annual review	ASH ADC
Demonstrate ability to gather information from all pertinent sources in the evaluation of forensic issues including working use of relevant psychological testing	Demonstrate effective interaction with mental health and legal entities.	Supervision by forensic faculty while producing forensic evaluations Didactics	Ongoing	Direct feedback from forensic faculty during forensic evaluations	Ongoing	Direct feedback from forensic faculty Quarterly global evaluations and semi-annual review Multi-Rater evaluation	ASH
Demonstrate ability to create reasonable and justifiable forensic opinions (including risk assessments) and support/defend them.	Write, review, and edit forensic reports	Supervision by forensic faculty while producing forensic evaluations Didactics	Ongoing	Direct feedback from forensic faculty during forensic evaluations	Ongoing	Direct feedback from forensic faculty Quarterly global evaluations and semi-annual review	ASH

Competency:

Medical Knowledge

Required Skills And Attitudes	Specific Objectives	Teaching		Evaluation		Feedback to Resident	Sites
		Method	Timing	Method	Timing		
Demonstrate knowledge of legal rules and concepts and relevant case law	Utilize medical knowledge and legal parameters in decision making in the areas of: - Patient care - Forensic evaluation	Law Seminar Landmark Case Conference (conducted by Fellows)	Weekly Didactic for 2 months Ongoing	Direct feedback from forensic faculty	Ongoing	Direct feedback from forensic faculty Quarterly global evaluations and semi-annual review	Didactics/ASH

Competency:

Practice-Based Learning and Improvement

Required Skills And Attitudes	Specific Objectives	Teaching		Evaluation		Feedback to Resident	Sites
		Method	Timing	Method	Timing		
Facilitate learning of students, health care professionals, and legal professionals	Gain Experience in practical teaching	Teaching residents on Unit 3 Upper at ASH Teaching residents & medical student didactics Serving as upper level resident for a general resident doing forensic electives In-service to prison staff Co-teach Psychiatry and Law course at Law School	Every 6 weeks 10 lectures per year Variable Yearly Weekly for two months a year	Direct feedback from 3 Upper attending Didactic lecture evaluations Evaluation from resident doing elective Direct feedback from forensic faculty Direct feedback from forensic faculty and Law School faculty	Ongoing Per lecture Per elective Yearly Yearly	Direct feedback from 3 Upper attending Didactic lecture evaluations Evaluation from resident doing elective Direct feedback from forensic faculty Direct feedback from forensic faculty and Law School faculty	ASH ADC UALR School of Law
Demonstrate ability to obtain and critically evaluate and apply relevant medical and legal literature	Access and utilize medical literature Access and utilize legal literature	Scholarly Product Didactics Landmark Case Conference	Ongoing Two lectures per year Ongoing	Direct feedback from forensic faculty	Ongoing	Direct feedback from forensic faculty Quarterly global evaluations and semi-annual review	

Competency:

Professionalism

Required Skills And Attitudes	Specific Objectives	Teaching		Evaluation		Feedback to Resident	Sites
		Method	Timing	Method	Timing		
Demonstrate an understanding of ethical precepts and rules when interacting with evaluees, lawyers, and the community	Obtain appropriate consents with attention to conflicts of interest and confidentiality Manifest appreciation of roles in a variety of settings	Didactics Creation of forensic reports Management of cases in various settings	Ongoing Ongoing Ongoing	Direct feedback from forensic faculty Direct feedback from forensic faculty Quarterly global evaluations and semi-annual review	Ongoing Ongoing	Direct feedback from forensic faculty Direct feedback from forensic faculty Quarterly global evaluations and semi-annual review Multi-Rater evaluation	ASH
Manifest continued intellectual integrity in rendered opinions with the recognition of bias and conflicts	Create reports with sound and just reasoning	Discussion of forensic reports with forensic faculty Case Conference	Ongoing Quarterly	Direct feedback from forensic faculty Direct feedback from forensic faculty	Ongoing Quarterly	Direct feedback from forensic faculty Direct feedback from forensic faculty	ASH

Competency:

Interpersonal and Communication Skills

Required Skills And Attitudes	Specific Objectives	Teaching		Evaluation		Feedback to Resident	Sites
		Method	Timing	Method	Timing		
Demonstrate abilities to understand patients and evaluees utilizing verbal and nonverbal information	Demonstrate establishment of working alliance with patients and evaluees	Supervision by forensic faculty	Ongoing	Direct feedback from forensic faculty Quarterly global evaluations and semi-annual review	Ongoing Quarterly	Direct feedback from forensic faculty Quarterly global evaluations and semi-annual review	ASH
Communicate effectively with legal professionals and the court	Create reports that are complete, clear, concise, and reveal sound reasoning Demonstrate ability to give court testimony effectively as an expert witness	Supervision by forensic faculty while producing forensic reports Testifying in court on various types of cases	Ongoing Ongoing as called	Direct feedback from forensic faculty Quarterly global evaluations and semi-annual review Observation by forensic faculty in courtroom	Ongoing Quarterly Ongoing as called	Direct feedback from forensic faculty, Multi-Rater evaluation Quarterly global evaluations and semi-annual review Direct feedback from forensic faculty	ASH

Competency:

Systems-Based Practice

Required Skills And Attitudes	Specific Objectives	Teaching		Evaluation		Feedback to Resident	Sites
		Method	Timing	Method	Timing		
Advocate for patients and evaluees within systems	Prioritize the best interest of patients in a mental healthcare system with limitations	Operate an effective clinic in the correctional setting	Weekly	Direct feedback from forensic faculty Quarterly global evaluations and semi-annual review	Ongoing Quarterly	Direct feedback from forensic faculty Quarterly global evaluations and semi-annual review	ADC
Work effectively in a complex system through an understanding of the interactions between law enforcement, courts, corrections, legislative bodies, and mental health.	Ensure continuity of care in divided systems of care Work with multiple entities in the timely creation of comprehensive reports	Create effective aftercare plans for patients Supervision in the creation of forensic reports	Ongoing Ongoing	Direct feedback from forensic faculty Direct feedback from forensic faculty	Ongoing Ongoing	Direct feedback from forensic faculty Direct feedback from forensic faculty	ASH

The Forensic Psychiatry Milestone Project

A Joint Initiative of

The Accreditation Council for Graduate Medical Education and

The American Board of Psychiatry and Neurology

October 2014

The Forensic Psychiatry Milestone Project

The Milestones are designed only for use in evaluation of fellows in the context of their participation in ACGME-accredited residency or fellowship programs. The Milestones provide a framework for the assessment of the development of the fellow in key dimensions of the elements of physician competency in a specialty or subspecialty. They neither represent the entirety of the dimensions of the six domains of physician competency, nor are they designed to be relevant in any other context.

Forensic Psychiatry Milestones

Psychiatry Subspecialty Milestones Chair: Christopher R. Thomas, MD

Working Group Chair: Andrea Stolar, MD Laura Edgar, EdD, CAE Richard Frierson, MD Stephen Noffsinger, MD

Charles Scott, MD

Howard Zonana, MD

Advisory Group

Chair: George A. Keepers, MD Larry R. Faulkner, MD Christopher K. Varley, MD Robert Weinstock, MD

Milestone Reporting

This document presents Milestones designed for programs to use in semi-annual review of fellow performance and reporting to the ACGME. Milestones are knowledge, skills, attitudes, and other attributes for each of the ACGME competencies organized in a developmental framework from less to more advanced. They are descriptors and targets for fellow performance as a fellow moves from entry into fellowship through graduation. In the initial years of implementation, the Review Committee will examine Milestone performance data for each program's fellows as one element in the Next Accreditation System (NAS) to determine whether fellows overall are progressing.

For each period, review and reporting will involve selecting milestone levels that best describe each fellow's current performance and attributes. Milestones are arranged into numbered levels. Tracking from Level 1 to Level 5 is synonymous with moving from novice to expert in the subspecialty. These levels do not correspond with post-graduate year of education.

Selection of a level implies that the fellow substantially demonstrates the milestones in that level, as well as those in lower levels (see the diagram on page v).

Level 1: The fellow demonstrates milestones expected of an incoming fellow.

Level 2: The fellow is advancing and demonstrates additional milestones, but is not yet performing at a mid-fellowship level.

Level 3: The fellow continues to advance and demonstrate additional milestones, consistently including the majority of milestones targeted for fellowship.

Level 4: The fellow has advanced so that he or she now substantially demonstrates the milestones targeted for fellowship. This level is designed as the graduation target.

Level 5: The fellow has advanced beyond performance targets set for fellowship and is demonstrating "aspirational" goals which might describe the performance of someone who has been in practice for several years. It is expected that only a few exceptional fellows will reach this level.

Additional Notes

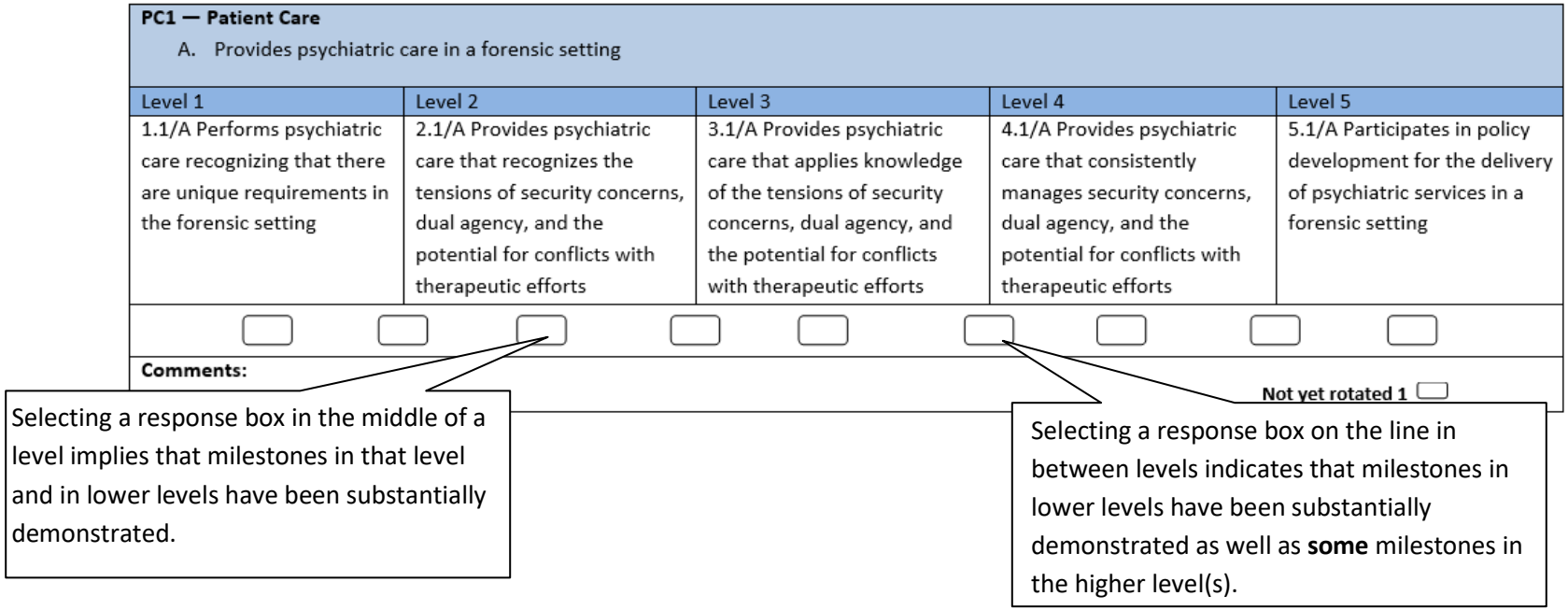
Level 4 is designed as the graduation *target* and *does not* represent a graduation *requirement*. Making decisions about readiness for graduation is the purview of the fellowship program director. Study of Milestone performance data will be required before the ACGME and its partners will be able to determine whether milestones in the first four levels appropriately represent the developmental framework, and whether Milestone data are of sufficient quality to be used for high-stakes decisions.

Examples are provided with some milestones. Please note that the examples are not the required element or outcome; they are provided as a way to share the intent of the element.

Some milestone descriptions include statements about performing independently. These activities must occur in conformity to the ACGME supervision guidelines, as well as to institutional and program policies. For example, a fellow who performs a procedure independently must, at a minimum, be supervised through oversight.

Answers to Frequently Asked Questions about the Next Accreditation System and Milestones are posted on the Next Accreditation System section of the ACGME website.

The diagram below presents an example set of milestones for one sub-competency in the same format as the ACGME Report Worksheet. For each reporting period, a fellow's performance on the milestones for each sub-competency will be indicated by selecting the level of milestones that best describes that fellow's performance in relation to those milestones.



PC1 — Patient Care

A. Provides psychiatric care in a forensic setting

Level 1	Level 2	Level 3	Level 4	Level 5
1.1/A Performs psychiatric care recognizing that there are unique requirements in the forensic setting	2.1/A Provides psychiatric care that recognizes the tensions of security concerns, dual agency, and the potential for conflicts with therapeutic efforts	3.1/A Provides psychiatric care that applies knowledge of the tensions of security concerns, dual agency, and the potential for conflicts with therapeutic efforts	4.1/A Provides psychiatric care that consistently manages security concerns, dual agency, and the potential for conflicts with therapeutic efforts	5.1/A Participates in policy development for the delivery of psychiatric services in a forensic setting

Comments:

Not yet rotated 1

PC1 — Patient Care A. Provides psychiatric care in a forensic setting				
Level 1	Level 2	Level 3	Level 4	Level 5
1.1/A Performs psychiatric care recognizing that there are unique requirements in the forensic setting	2.1/A Provides psychiatric care that recognizes the tensions of security concerns, dual agency, and the potential for conflicts with therapeutic efforts	3.1/A Provides psychiatric care that applies knowledge of the tensions of security concerns, dual agency, and the potential for conflicts with therapeutic efforts	4.1/A Provides psychiatric care that consistently manages security concerns, dual agency, and the potential for conflicts with therapeutic efforts	5.1/A Participates in policy development for the delivery of psychiatric services in a forensic setting
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments: **Not yet rotated** ☐				

PC2 — Procedural Skills

A. Conducts a forensic psychiatric evaluation in criminal and civil settings

B. Communicates the results of a forensic psychiatric evaluation through written and oral reports

Level 1	Level 2	Level 3	Level 4	Level 5
1.1/A Demonstrates knowledge of the unique evaluations that occur within the practice of forensic psychiatry 1.2/B Demonstrates knowledge of the unique requirements involved in the communication of forensic psychiatric evaluation findings	2.1/A Performs basic components of a forensic evaluation (e.g., provides statement of non-confidentiality, identifies referral source and forensic question(s), assesses the safety of the evaluation environment) 2.2/A Under supervision, and with an awareness of the appropriate legal standard, collects and synthesizes relevant data into a forensic psychiatric opinion 2.3/B Demonstrates knowledge of the need to effectively communicate a well-supported forensic psychiatric opinion	3.1/A Under supervision performs common forensic evaluations, such as competency to stand trial, criminal responsibility, civil forensic assessments, and risk assessments 3.2/B Under supervision, expresses a well-supported forensic psychiatric opinion in written and oral formats, including in the provision of testimony 3.3/B Under supervision, prepares an appropriate forensic report	4.1/A Independently performs common forensic evaluations, such as competency to stand trial, criminal responsibility, civil forensic assessments, and risk assessments 4.2/B Independently and appropriately communicates well-supported forensic psychiatric opinions in oral and written formats 4.3/B Independently prepares an appropriate forensic report 4.4/B Provides testimony in a clear and professional manner	5.1/A Supervises others in the performance of common forensic evaluations, such as competency to stand trial, criminal responsibility, civil forensic assessments, and risk assessments 5.2/B Produces reports and testimony that serve as a model for excellence that can be used to teach others 5.3/B Supervises others in the communication of well-supported forensic psychiatric opinions in oral and written formats
☐	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

Not yet rotated ☐

MK1 — Knowledge of the Law and Ethical Principles as they relate to the Practice of Forensic Psychiatry A. Basic knowledge of the legal system, sources of law, and landmark cases relevant to forensic psychiatry B. Basic knowledge of civil law as it relates to forensic psychiatry C. Basic knowledge of criminal law as it relates to forensic psychiatry D. Knowledge of ethical principles as they relate to forensic psychiatry				
Level 1	Level 2	Level 3	Level 4	Level 5
1.1/A,B,C Demonstrates basic knowledge of the legal regulation of psychiatric practice 1.2/D Discusses conflicts of interest that may arise within the practice of psychiatry	2.1/A Demonstrates basic ability to research statutes, cases, and administrative regulation relevant to psychiatry 2.2/A Demonstrates knowledge of basic concepts and sources of law and the court structure 2.3/B Demonstrates knowledge of the various types of civil legal matters relevant to psychiatry (e.g., malpractice, personal injury litigation, treatment refusal, risk assessment, and commitment) 2.4/C Demonstrates knowledge of the various types of criminal legal matters requiring psychiatric	3.1/A Demonstrates ability to read legal cases and identify procedural history and legal holdings 3.2/A Demonstrates knowledge of jurisdiction, constitutional principles, and relevant state and federal laws 3.3/A Demonstrates basic knowledge of the rules of evidence 3.4/B Demonstrates competence in the use of a law library and/or online legal reference services 3.5/B Demonstrates knowledge of the principles of civil law relevant to psychiatry (e.g., malpractice,	4.1/A Demonstrates understanding of the relevance of legal principles and holdings 4.2/A Independently applies knowledge of jurisdiction, constitutional principles, and relevant state and federal laws 4.3/B Independently applies knowledge of civil legal matters relevant to psychiatry (e.g., malpractice, personal injury litigation, treatment refusal, risk assessment, and commitment) 4.4/C Independently applies relevant psychiatric and legal knowledge to criminal proceedings (e.g., competency to stand trial, criminal	5.1/A Demonstrates sufficient knowledge to provide assistance in the drafting of legal briefs, statutes, or regulations 5.2/B,C Advances knowledge of civil and criminal law relevant to forensic psychiatry through research, presentation at national professional meetings, and/or publication 5.3/B,C Educates medical and/or legal professionals on civil and criminal law as it relates to forensic psychiatry 5.4/D Educates medical and/or legal professionals on the particular ethical

	expertise (e.g., competency to stand trial, criminal responsibility, risk assessment) 2.5/D Discusses the particular ethical issues that arise in the practice of forensic psychiatry (e.g., confidentiality, consent, objectivity, and limits of expertise)[1]	personal injury litigation, treatment refusal, risk assessment, and commitment) 3.6/C Demonstrates knowledge of the principles of criminal law and proceedings relevant to forensic psychiatry (e.g., competency to stand trial, criminal responsibility, risk assessment) 3.7/D Demonstrates an understanding of the ethical principles relevant to forensic psychiatry and their appropriate management	responsibility, risk assessment) 4. 5/B,C Recognizes limits of knowledge and seeks appropriate consultation and supervision 4.6/D Independently recognizes and applies ethical principles to conflicts that arise within the practice of forensic psychiatry	issues that arise in the practice of forensic psychiatry 5.5/D Consults or publishes about ethical dilemmas in forensic psychiatry, and participates in the development of ethical guidelines relevant to forensic psychiatry
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐				

Comments:

Not yet rotated ☐

Footnotes:

[1] American Academy of Psychiatry and the Law Ethics Guidelines for the Practice of Forensic Psychiatry Adopted May, 2005

MK2 — Knowledge of Clinical Psychiatry Especially Relevant to Forensic Psychiatry

A. Knowledge of the particular psychiatric and behavioral presentations commonly encountered in the practice of forensic psychiatry

B. Knowledge of the assessment of particular psychiatric and behavioral presentations commonly encountered in the practice of forensic psychiatry

Level 1	Level 2	Level 3	Level 4	Level 5
1.1/A Demonstrates knowledge of the diagnostic categories within the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the importance of supporting diagnoses with established criteria 1.2/B Demonstrates knowledge of the diversity of assessment approaches	2.1/A Demonstrates knowledge of the importance of identifying specific DSM criteria to substantiate a diagnosis while maintaining an awareness of potential cultural influences 2.2/B Demonstrates knowledge of the types of standardized assessment tools used in forensic psychiatry 2.3/B Demonstrates knowledge of the types of neuroimaging and psychological tests/assessments used in forensic psychiatry 2.4/B Recognizes, with supervision, the relevant areas of inquiry to appropriately address the specific forensic question	3.1/A Demonstrates familiarity with the specific DSM criteria necessary to support a diagnosis while maintaining an awareness of potential cultural influences 3.2/B Demonstrates sufficient knowledge of the various assessment methods used in forensic evaluations (e.g., psychological testing, structured assessments, neuroimaging, actuarial tools, and clinical interview) to identify where they may assist in addressing the specific forensic question	4.1/A Demonstrates knowledge of cultural influences relevant to the forensic psychiatric question 4.2/A Demonstrates an in-depth knowledge of DSM criteria for psychiatric presentations commonly encountered in forensic psychiatric practice (e.g., neurocognitive disorders, paraphilic disorders, malingering, antisocial personality disorder, and impulse control disorders) 4.1/B Demonstrates knowledge of the various assessment methods used in forensic evaluations (e.g., psychological testing, structured assessments, neuroimaging, actuarial tools, and clinical interview) and the strengths and limitations thereof	5.1/A Demonstrates knowledge of the research base from which the DSM developed 5.2/B Demonstrates knowledge of the research bases of the various assessment approaches 5.3/B Demonstrates knowledge of the admissibility of particular assessment methods across jurisdictions
☐	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

Not yet rotated ☐

SBP1 — Patient/Evaluee Safety and the Health Care Team

A. Medical errors and improvement activities
B. Communication and patient/evaluee safety/risk
C. Regulatory and educational activities related to patient/evaluee safety/risk

Level 1	Level 2	Level 3	Level 4	Level 5
1.1/A Describes the common system causes for errors 1.2/C Follows institutional safety policies, including reporting of problematic behaviors and processes, errors, and near misses	2.1/ A Describes systems and procedures that promote safety 2.2/B Effectively and regularly utilizes all appropriate forms of communication to facilitate safe transitions of responsibility and optimize communication across systems 2. 3/C Follows regulatory requirements related to mandatory reporting (e.g., child abuse reporting duty to protect) and prescribing practices (e.g., involuntary medications)	3.1/B Recognizes special patient/evaluee characteristics or other circumstances that may affect recommendations (e.g., potential for self-harm or harm to others, intellectual disability, need for involuntary medication to restore competency) 3.2/B Negotiates patient-centered care or evaluee safety among multiple care providers and/or stakeholders	4.2/B Facilitates safe transitions of responsibility and data communication across systems 4.3/A,C Demonstrates ability to critically analyze data to identify systems-based errors related to safety (e.g., malpractice case involving suicide, risk assessment)	5.1/A Leads multidisciplinary teams (e.g., legal systems) to address safety issues 5.2/A,C Provides consultation to organizations to improve personal and patient/evaluee safety
☐	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

Not yet achieved Level 1 ☐

SBP2 — Resource Management Costs of care and resource management				
Level 1	Level 2	Level 3	Level 4	Level 5
1.1 Recognizes differences in resources impacting care and supervision among forensic and community settings	2.1 Demonstrates knowledge of forensic and community resources	3.1 Is aware of health care funding and regulations related to forensic and community services	4.1 Considers system resources in forensic psychiatric recommendations (e.g., formulary restrictions, availability of hospital and community resources)	5.1 Advocates for improved access to, better allocation of, and, as appropriate, additional resources within forensic and community systems of care
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				**Not yet achieved Level 1** ☐

SBP3 — Consultation to Medical Providers and Non-medical systems (e.g., military, schools, businesses, forensic) A. Provides recommendations as a consultant and collaborator				
Level 1	Level 2	Level 3	Level 4	Level 5
1.1/A Provides consultation to other medical or mental health services 1.2/A Clarifies the consultation question	2.1/A Assists primary treatment care team in identifying and clarifying the forensic referral questions	3.1/A Provides, under supervision, forensic recommendations through collaboration with health care teams and/or non-medical stakeholders (e.g., attorneys, courts)	4.2/A Manages complicated and challenging consultation requests	5.1/A Provides forensic psychiatric consultations to larger systems 5.2/A Leads a forensic psychiatric consultation team
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				**Not yet achieved Level 1** ☐

PBLI1 — Development and Execution of Lifelong Learning through Constant Self-evaluation, Including Critical Evaluation of Research and Clinical Evidence

A. Self-assessment and self-improvement

B. Evidence in the clinical workflow

Level 1	Level 2	Level 3	Level 4	Level 5
1.1/A Regularly seeks and incorporates feedback to improve performance 1.2/A Identifies self-directed learning goals and periodically reviews them with supervisory guidance 1.3/B Formulates a searchable question from a clinical or forensic question	2.1/A Demonstrates a balanced and accurate self-assessment of competence in evaluations and reports, using feedback to identify areas for continued improvement 2.2/B Selects an appropriate, evidence-based information tool[1] to meet self-identified learning goals 2.3/B Critically appraises different types of research, including randomized controlled trials (RCTs), systematic reviews, meta-analyses, and practice guidelines	3.1/A Demonstrates improvement in forensic practice based on continual self-assessment and evidence-based information 3.2/B Independently searches for and discriminates evidence relevant to clinical and/or forensic practice problems	4.1/A Identifies and meets self-directed learning goals with little external guidance 4.1/A Sustains practice of self-assessment and keeping up with relevant changes in medicine and law, and makes informed, evidence-based clinical decisions and forensic recommendations 4.2/B Demonstrates use of a system or process for keeping up with relevant changes in medicine and the law[2]	5.2/B Teaches others techniques to efficiently incorporate evidence-gathering into forensic practice 5.3/B Independently teaches appraisal of clinical evidence and legal developments

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Comments:

Not yet achieved Level 1 ☐

Footnotes:

[1]Examples include: practice guidelines; PubMed Clinical Queries; Cochrane, DARE, or other evidence-based reviews; Up-to-Date, etc.

[2]Examples include: a performance-in-practice (PIP) module as included in the American Board of Psychiatry and Neurology (ABPN) Maintenance of Certification (MOC) process; attending professional meetings in the subspecialty, or regular and structured readings of specific evidence sources.

PBLI2 — Teaching

A. Development as a teacher
B. Observable teaching skills

Level 1	Level 2	Level 3	Level 4	Level 5
1.1/A Assumes a role in the clinical teaching of early, mid-level, and advanced learners; assists faculty members in providing supervision to these learners 1.2/B Communicates goals and objectives for instruction of early, mid-level, and advanced learners	2.1/A Participates in activities designed to develop and improve teaching skills 2.2/B Evaluates and provides feedback to early, mid-level, and advanced learners	3.1/A Gives informal and formal didactic presentations to groups (e.g., grand rounds, case conference, journal club) 3.2/B Organizes content and methods for individual instruction for early, mid-level, and advanced learners	4.1/A Develops and gives specialty- and subspecialty-specific presentations to groups 4.2/B Effectively uses feedback on teaching to improve teaching methods and approaches	5.1/A Educates broader professional community and/or public (e.g., presents at regional or national meeting) 5.2/B Organizes and develops curriculum materials
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

Not yet achieved Level 1 ☐

PROF1 — Compassion, Integrity, Respect for Others, Sensitivity to Diverse Patient Populations, Adherence to Ethical Principles

A. Compassion, reflection, sensitivity to diversity

B. Ethics

Level 1	Level 2	Level 3	Level 4	Level 5
1.1/A Demonstrates capacity for self-reflection, empathy, and curiosity about, and openness to, different beliefs and points of view, and respect for diversity 1.2/A Provides examples of the importance of attention to diversity in psychiatric evaluation and treatment 1.3/B Recognizes ethical conflicts in practice and seeks supervision to manage them	2.1/A Elicits beliefs, values, and diverse practices of patients/evaluees and their families, and understands their potential impact on patient care and evaluees in a legal context 2.2/A Routinely displays sensitivity to diversity in psychiatric evaluation and treatment 2.3/B Recognizes ethical/legal issues in practice and is able to discuss, analyze, and manage these in common clinical and forensic situations	3.1/A Develops an appropriate care plan or forensic recommendation in the context of conflicting interests 3.2/A Recognizes own cultural background and beliefs and the ways in which these affect interactions with patients and evaluees 3.3/A Effectively participates as a team member along with other medical and non-medical professionals while showing respect and consideration for diversity of opinion and expertise of others 3.3/B Systematically analyzes and manages ethical issues, including those specific to forensic psychiatry	4.1/A Recognizes and adapts approach based on forensic psychiatry related issues of diversity and special needs populations 4.4/A Demonstrates the ability to be an effective team member/team leader, showing respect and consideration for diversity of opinion and expertise of others 4.2/B Leads educational activities and case discussions regarding ethical issues specific to both general psychiatry and forensic psychiatry 4.3/B Adapts to evolving ethical and legal standards (e.g., can manage conflicting ethical standards and values and can apply these to practice)	5.1/A Serves as a role model and teacher of compassion, integrity, respect for others, and sensitivity to diverse patient/evaluee populations 5.2/B Identifies emerging ethical issues within forensic psychiatry practice and can discuss opposing viewpoints 5.3/B Serves as a role model for practicing forensic psychiatry consistent with ethical principles and with sensitivity to ethical conflicts and dilemmas
☐	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

Not yet achieved Level 1 ☐

PROF2 — Accountability to Self, Patients, Colleagues, Legal Systems, Professionals, and the Profession

A. Fatigue management and work balance

B. Professional behavior and participation in professional community

C. Ownership of patient care and/or responsibility for forensic evaluation

Level 1	Level 2	Level 3	Level 4	Level 5
1.1/A Notifies team and enlists appropriate coverage for clinical and non-clinical responsibilities when fatigued or ill 1.2/B Follows institutional policies for physician conduct and responsibility 1.3/C Accepts the role of the patient's physician and takes responsibility (under supervision) for ensuring that the patient receives the best possible care 1.4/C Accepts the role of the forensic evaluator and takes responsibility (under supervision) for ensuring that the special conditions of forensic psychiatric evaluations are implemented	2.1/A Identifies and manages situations in which maintaining personal emotional, physical, and mental health is challenged, and seeks assistance when needed 2.2/B Recognizes the importance of participating in one's professional community 2.3/C Is recognized by self, patient, patient's family, and medical staff members as the patient's primary psychiatric provider 2.4/C Is recognized by self, evaluee, and referral source as the responsible forensic consultant	3.1/A Knows how to take steps to address impairment in self and in colleagues 3.2/B Prepares for obtaining and maintaining board certification 3.3/C Displays increasing autonomy and leadership in taking responsibility for the provision of forensic consultation and in ensuring that patients receive the best possible care	4.1/A Prioritizes and balances conflicting interests of self, family, and others to optimize medical care and practice of profession[1] 4.2/B Participates in the primary specialty and forensic psychiatry professional community (e.g., professional societies, patient advocacy groups, community service organizations) 4.3/C Serves as a role model in demonstrating responsibility in the provision of forensic psychiatric consultation and in ensuring that patients receive the best possible care	5.1/A Develops physician wellness programs or interventions and/or participates as an active member on committees or in organizations that address physician wellness 5.2/B Develops organizational policies, programs, or curricula for forensic psychiatry professionalism
☐	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

Not yet achieved Level 1 ☐

Footnotes:

[1] Residents are expected to demonstrate responsibility for patient care that supersedes self-interest. It is important that residents recognize the inherent conflicts and competing values involved in balancing dedication to patient care with attention to the interests of their own well-being and responsibilities to their families and others. Balancing these interests while maintaining an overriding commitment to patient care requires, for example, ensuring excellent transitions of care, sign-out, and continuity of care for each patient during times that the resident is not present to provide direct care for the patient.

ICS1 — Relationship Development and Conflict Management with Patients, Evaluees, Colleagues, Members of the Health Care or Forensic Team, Attorneys, and Members of the Legal System

A. Relationship with patients and evaluees
B. Conflict management
C. Team-based care or evaluation

Level 1	Level 2	Level 3	Level 4	Level 5
1.1/A Knows the importance of building working relationships with patients/evaluees and relevant parties in uncomplicated situations 1.2/A Is aware of cultural diversity in communicating with people of different backgrounds 1.3/B Recognizes communication conflicts in work relationships 1.4/C Is able to collaborate with team members	2.1/A Develops working relationships across specialties and systems of care in uncomplicated situations 2.3/B Negotiates and manages simple conflicts within the forensic evaluation and the work environment 2.4/C Actively participates in team-based evaluations; supports activities of other team members, and communicates findings and recommendations	3.1/A Develops working relationships in complicated situations 3.2/B Sustains working relationships in the face of conflict 3.4/C Recognizes differing philosophies within and between different disciplines in forensic evaluations	4.1/A Sustains working relationships during complex and challenging situations 4.2/A Sustains working relationships across systems of care 4.3/B Manages system conflicts as a forensic consultant[1]	5.1/A, B Develops models/approaches to managing difficult communications 5.2/B Effectively mentors other professionals in leadership, communication skills (e.g., testimony), and conflict management 5.3/B Engages in scholarly activity (e.g., teaching, research) regarding teamwork and conflict management 5.4/C Leads and facilitates meetings within the organization/system 5.5/C Designs research or quality improvement project to improve team-based evaluation
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Comments:

Not yet achieved Level 1 ☐

Footnotes:

[1] Example: Leading discussion at a forensic review board about the release of an insanity acquittee when there is initial disagreement.

ICS2 — Information Sharing and Record Keeping

A. Accurate and effective communication with team

B. Effective communications with patients, evaluees, and others

C. Maintaining professional boundaries in communication

Level 1	Level 2	Level 3	Level 4	Level 5
1.1/A Ensures transitions of care are accurately documented, and optimizes communication across systems and continuums of care 1.2/A Ensures that the written record is accurate and timely, with attention to detail, and consistent with institutional policies 1.2/A,B Organizes both written and oral information to be shared as appropriate 1.4/C Maintains appropriate boundaries in sharing information by electronic communication and in the use of social media	2.1/A,B Uses easy-to-understand language in all phases of communication, including working with interpreters, patients or evaluees of all ages, and non-medical professionals 2.2/B Consistently demonstrates communication strategies to ensure understanding 2.3/B Demonstrates appropriate face-to-face interaction with patient, evaluee, or other intended audience 2.4/C Demonstrates knowledge of the importance of using discretion and judgment in electronic communication with patients, families, colleagues, and other intended audiences	3.1/A, B Demonstrates effective verbal communication, with patients or evaluees of all ages, colleagues, other health care providers, and non-medical professionals, that is appropriate, efficient, concise, and pertinent 3.2/A,B,C Demonstrates written communication with patients, evaluees, or other intended audience that is appropriate, efficient, concise, and relevant 3.3/C Uses discretion and judgment in the inclusion of sensitive or irrelevant material in the medical or legal record 3.4/C Uses discretion and judgment in electronic communication with patients, colleagues, and other intended audiences	4.1/A,B Demonstrates communication with patients or evaluees with limited communication and/or cognitive abilities that is appropriate, efficient, concise, and pertinent 4.2/B Recruits appropriate assistance from external sources when cultural differences create barriers to effective communication 4.3/B,C Recognizes, communicates, and appropriately manages conflicts of interest in forensic evaluations	5.1/C Participates in the development or modification of rules, policies, and procedures related to information sharing and technology 5.2/C Educates others through national presentations or publications about the importance of professional boundaries in communications in forensic practice

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Comments:

Not yet achieved ☐ Level 1