Court Clinics and Defendants' Rights*

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If operated with trained personnel, with the cooperation of interested judges, and with safeguards of confidentiality, Court Clinics can serve as an alternative to imprisonment or nontherapeutic probation.

The term "Court Clinic" has been used to describe a variety of facilities providing services for the courts. Some Hospitals for the Criminally Insane are called Court Clinics because defendants are sent there for court-ordered evaluations of competency to stand trial or of criminal responsibility. Some in-prison psychiatric services have been referred to as Court Clinics.

A better use of the title "Court Clinic" is to reserve it for a collection of services designed not only to assist the court in evaluation but also to continue to serve the court in its further contact with the defendant and sometimes to be the therapeutic agency that can obviate the need for imprisonment. This more sophisticated variety of Court Clinic offers promise as a means of relieving the burden on corrections. It is often housed in the court building and it offers services to the court on a number of levels—pre-trial, during trial, at sentence, during probation. It offers therapy to defendants and probationers. It acts as a source of community referral.

Chicago, Cleveland, Baltimore, and Cincinnati have had Court Clinic programs for many years. Most programs are on an individual court basis; in New York State, for example, there are a number of Court Clinics, but they are not integrated into a single system. Massachusetts, which began a statewide program in 1956, was a pioneer in this broader utilization of Court Clinics and has the only state system with a long history. It deserves special attention as an example of how a state-wide system of psychiatric help to the courts can be attained and of the legal safeguards it must provide.

In 1966, Manfred Guttmacher, in his article, "Adult Psychiatric Court Clinics," listed 26 American clinics and one Canadian clinic which served adults or a combination of adults and juveniles; his list started with the Chicago Municipal Court in 1914 and continued with Philadelphia, Detroit, Baltimore and Cleveland from 1918 to 1925. In the 40 years from 1914 until the first Massachusetts Court Clinic in 1954, only nine Court Clinics were listed, three in Pennsylvania, two in Chicago, and the rest scattered throughout the country. Since Massachusetts began its statewide program in 1956, it has been a leader in the Court Clinic movement. Of 17 American clinics in the remainder of Guttmacher's list, covering 1954-1962, eleven were in the Massachusetts state system,[1] which has since expanded further.

Massachusetts was a natural locale for an innovative statewide program because a state law passed over a half century ago, the Briggs Law, had made psychiatric examination of defendants a commonplace.

Unlike most laws, which are named after legislators, the Briggs Law was named after the psychiatrist L. Vernon Briggs who framed it and fought for its passage, which occurred in 1921.[2] The law provided for the psychiatric examination of persons indicted

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for capital offenses, those known to have been indicted for any other offense more than once, and those previously convicted of a felony. Under this law large numbers of defendants received psychiatric evaluations.

The Briggs Law provides for examinations to be made by two neutral psychiatrists, appointed neither by the parties nor by the court, but by the Department of a Mental Health. Most of the examinations are conducted at the jail where the accused is being detained for trial. The report is filed with the clerk of court and is accessible both to the judge and to the counsel for each party. The report itself is not admissible in evidence, but the examiners may be called upon to testify.

One of the chief purposes of the Briggs Law was to divert mentally ill defendants from the criminal justice system. If the psychiatrist reports that the accused is "insane," he is usually not subjected to trial; rather a civil commitment to a mental institution is used as an alternative. If the accused is declared to be "sane," the question of the insanity defense is rarely raised at trial.[3]

The Briggs Law has been praised because it has brought about a decrease in the use of conflicting expert testimony in insanity cases, and has avoided the unnecessary prosecution of mentally ill offenders.[4]

The concept that judges should be advised at time of disposition of the future dangerousness, potential for rehabilitation, and psychological dynamics of the convicted defendant was such a common-sense concept with so many obvious advantages that most people did not question it, but recent critics have pointed out in it a potential threat to the civil liberties of the defendant. It is obvious that a judge in passing sentence should know as much as he can about the defendant and his characteristics. It would seem artificial to assert that a judge should not have access to reports of truant officers, probation authorities, social workers, psychologists, and psychiatrists. Much of the material in these reports, however, is hearsay, based not on proven fact but on evidence which does not rise to the standards which would entitle it to admission in the trial process; and other data, such as the result of psychological testing, may be reasonably correct when applied to large groups of people but may not accurately apply to a particular individual. In other jurisdictions, under the theory that the people who help the court in the compilation of a pre-sentence report are agents or arms of the court, the reports are purely for the use of the judge, not to be questioned by the cross-examination of those who compiled it, and in fact not even to be made available to the defendant or his attorney. The possibility is raised that two defendants will receive very unequal prison sentences on the basis of differences in their Rorschach test results. Massachusetts makes these reports available to defendants.

In practice, also, problems have arisen in the administration of the Briggs Law. Glueck has said that it is difficult to obtain psychiatrists qualified by modern clinical education and experience to devote much time to this public service for the modest fee involved, and that appointees are likely to be retired institutional psychiatrists who spent most of their active years in public mental hospitals in the rather routine care of patients.[5]

In the 1950s, there was much enthusiasm in Massachusetts for the concept of psychiatric intervention encompassed in the Briggs Law, and Massachusetts at that time decided to take another step and to develop Court Clinic services for both adult and child offenders, so that well-qualified professionals would be available to the courts on a salaried rather than fee-for-fee service basis; thereby more defendants could have the benefits of behavioral science help.

Donald Hayes Russell and James Devlin were largely responsible for this development. Devlin was appointed Chief Probation Officer for the newly created Norfolk Juvenile Probation District in 1946. He quickly found himself disillusioned with the practice of sending disturbed youngsters to hospitals only to have them returned with the report that they were disturbed but not committable. Psychiatric services in the community were not generally available, and when available they often did not meet the

needs of the court. He developed the concept of locating psychiatric clinics within the court itself to serve the court population; a meeting with Donald Hayes Russell, a psychoanalyst and child psychiatrist, led to the working relationship that inaugurated the system, in which Russell evaluated and treated children at the Probation Office for Juveniles at Dedham.

In 1950 the Massachusetts legislature requested that the Department of Mental Health make a study of the advisability of providing such psychiatric services to the District Courts of the Commonwealth.[6]

A committee made up of members of the Boston Bar Association and the Suffolk (Boston) District Medical Society had been considering this question, and the Department of Mental Health sought the services of this group. Reports from this group surveyed the administration of criminal justice as it applied to mentally abnormal offenders,[7] and the relationship of the state mental hospital system to the courts.[8] These reports recommended a demonstration Court Clinic to test the feasibility of providing not only diagnostic but therapeutic services to certain offenders when the judge or his probation officer and the physician assigned to the court felt that a therapeutic approach would serve justice.

The Legislature appropriated funds for a demonstration Clinic, which was set up in the Cambridge District Court by the Department of Mental Health; it was modeled upon the existing experimental Court Clinic for juveniles that had been operating in Norfolk County. The initial experience was encouraging, and followup reports stated:

> Experience with this clinic demonstrated two things. That the courts had a great use for the services of this clinic and that many cases were better managed by the use of the clinic by the probation Officer and by the Court. The clinic is used by the court for information as to motives in certain crimes, but more importantly as a source for referral of cases which the court felt were in need of psychiatric treatment. It became obvious that the court wished to use the clinic for many types of offenders.[9]

During this study period it was decided that the services should be offered on a wider basis, to juveniles as well as adults, to inmates as well as to those before the court. The Department of Mental Health in a letter to the Governor recommended that such wide services be made available to most of the district courts on the request of the courts and to the Department of Correction and Parole and to the Division of Youth Services. This plan was put into action, under a newly created State Division of Legal Medicine, in 1956. No new legislation was passed for this program because it was decided that the general powers of the Department of Mental Health, which was directed to provide appropriate mental health services to the Commonwealth, provided authority.[10]

The State Division of Legal Medicine paid the salaries of the Clinic personnel and provided Clinic policy supervision, but in all other ways the Clinics were dependent on the courts. They provided diagnostic and treatment services within courts, with the Clinical services located in the courthouse and in close working relationship with court personnel. (Massachusetts personnel feel that physical location in the courthouse is helpful and perhaps even essential for the success of the program; Guttmacher, on the other hand, says, "It seems essential that separate agencies, employing special techniques and skills, be created to carry out . . . treatment. Preferably, such a treatment agency should not be located in the courthouse. Propinquity to the courts would tend to make these patients employ suppressive and repressive defenses which would prove obstacles to therapy."[11]) The judge determined for each Clinic the number and kinds of cases that his Clinic should receive. In addition to budgetary limitations, four factors determined the number and the location of the Court Clinics. These were (1) the court's desire for a Clinic, (2) the court's ability to utilize fully the services of the Clinic, (3) the availability of qualified personnel in the location, and (4) the desire of the community for help with its crime and delinquency problem.

It was easy to start Clinics in the metropolitan Boston area, but it was more difficult to extend them out into the state. By 1959, however, nine Court Clinics were in operation, six of them in the Boston area, one in Framingham, one in Worcester, and one in Springfield. During 1960-1967, seven more Clinics were established.[12] There are now thirty.

Eight Court Clinics have been discontinued because the judges or the court atmosphere created an unfavorable climate. One of the most obvious sites for a Court Clinic, the Boston Juvenile Court, did not receive a Clinic until 1965, when a newly appointed judge insisted that a Clinic be instituted there. So the cooperation of the judges turned out to be a very important factor in the institution and the maintenance of the Clinics. Dr. Donald Hayes Russell, who had been head of this program for many years, surveyed the Clinics for an article which appeared in 1970,[13] and discovered that all the judges with Clinics expressed a positive interest in their Clinics but that the Clinic personnel in about half of the Clinics felt that the court was not making full use of the facility. About a quarter of the judges had a close working relationship with the Clinics and participated occasionally in Clinical conferences. All the judges agreed that having their psychiatric services within the court was preferable to the system of farming the work out, as had been done previously.

Russell's paper in the Offender Therapy Series APTO Monographs presents many of the problems and much of the procedure concerning the setting-up of these Clinics. A little more than half the cases are referred during the pre-dispositional stage, a little less than half in the post-dispositional stage, and various courts refer from one per cent to ten per cent of their cases for treatment, with an average of 3.5%. (An original estimate had stated that the Clinics would provide service for approximately 5% of the courts' total case loads, and this turned out to be a fairly accurate figure.) Russell in his report indicated that the Clinics had not succeeded in establishing relationships with as many other community services as would be desirable, although the contact with such official agencies as Aid to Dependent Children was on-going and frequent. A later development in the program was the providing of consultation services to jails, houses of correction, and Youth Service Detention Centers.

Court Clinics were originally set up for District Courts which dealt with misdemeanors and juvenile delinquents, where problems were seen as primarily familial, psychological, and sociological; but the program was extended to one Superior Court which dealt with felonies. Glueck describes the capacities in which the Clinics serve: they obviate the need for commitment to a mental hospital for observation for 35 days, they render an informed evaluation of the make-up and background of the individual offender, aiding the judge in making effective sentencing decision, and they help the probation officer in supervising both adult and juvenile probationers by providing the opportunity for some psychotherapy.[14] In addition, they provide consultation services to other agencies.

The psychotherapy which is undertaken at the Court Clinics is enforced psychotherapy, and that is the title, "Enforced Psychotherapy," that Frederick Whiskin gives to his contribution to the monograph on Massachusetts Court Clinics published by the *International Journal of Offender Therapy*.[15] Sometimes a judge will continue a case without a finding of guilty on condition that the offender see the Court Clinic; sometimes psychotherapy is made a part of the probation plan; in other cases a defendant is sentenced but the sentence is suspended on the condition that he participate in psychotherapy at the Court Clinic. In spite of the fact that offenders thus have no choice about therapy, Whiskin believes that in most cases, particularly in those involving juveniles and adolescents, the result is beneficial rather than harmful. Negativistic and unapproachable delinquents would not admit that they desire therapy, but when it is forced on them they often find it useful and they can thus be in treatment and save face.

> Most juvenile offenders would never seek professional help voluntarily. Even if their parents were enlightened enough to ask for such help, the patients themselves would

most likely attend once or twice and then stop. In private practices there is little the parents or the psychiatrist can do to ensure that visits continue.[16]

Whiskin also sees as a plus, although many others would disagree with him concerning this, the tremendous disciplinary power that the therapist has in dealing with enforced psychotherapy patients.

> In this situation the court clinic has a resource at its disposal which to me is the reason behind so many of our successes with boys and girls who otherwise could not be influenced. We can point out to the probation officer or the judge that a certain boy will not respond to therapy until his fantasies about omnipotence have been deflated. . . . The judge may then use this authority and send the boy to the detention center for a varying length of time and often enough patients emerge from such a stay with a much more reasonable attitude. . . .

Whiskin states that after such an experience, therapy is often much more successful.

It should be noted that this compulsory quality is one of the most controversial aspects of Court Clinic service. Because so many of the clients are considered to have a defective superego structure, to be "sociopathic" or "amoral," many authorities see some enforcement pressure as the only way to make psychotherapy go. Other authorities are convinced that in such a one-sided relationship, the expression of hostility against authority figures, the development of the trusting relationship that promotes regression in the interests of therapy, and other aspects of conventional psychotherapy cannot be achieved. However, Melitta Schmideberg, the President of the Association for the Psychiatric Treatment of Offenders, has repeatedly written about her opinions, which have been accepted by many people working in correctional therapy, that dynamically oriented psychotherapy or psychoanalytically oriented therapy is not appropriate for most offenders and that instead "reality" therapy is appropriate. Reality therapy deals with the here-and-now aspects of the patient's current life situation. It deals with conscious rather than unconscious factors and it assumes that a defective or deficient sense of reality leads people to make inappropriate responses to society. Very probably the factor of coerciveness in the treatment situation is less important in reality therapy than it would be in other kinds of psychiatric treatment.

A study of the Court Clinic operating in connection with the Suffolk County (Boston) Superior Court appeared in *Mental Hygiene* in 1971; in it Dr. Eugene Balcanoff, Director of the Court Clinic, states that he encountered a good deal of initial resistance, that it took many years of work before the court gave the Clinic a full measure of acceptance, and that this acceptance was facilitated when an interdisciplinary person with both law and social work degrees was added to the Clinic staff.[17]

It is apparent that in contrast to the District Court Clinics, this Superior Court Clinic, which deals with more serious offenses and with felons, has a very small number of cases in treatment. Balcanoff estimates that only about twenty cases a year are treated and that they are seen anywhere from 12 to 30 times each.

Balcanoff goes on to say that despite the relatively low number of treatment cases, the Clinic is primarily seen as treatment-oriented by the court, by defense attorneys, and by the defendants themselves.

> We have been particularly impressed by the large number of defendants at the pretrial level who are eager to talk about what motivated them to become involved with the law—and this even before the days of privileged communication regarding the alleged crime. This eagerness and willingness to talk is a reflection of a number of factors. First and foremost, it reflects the reputation for integrity that the court psychiatrist has by way of the court, defense attorneys, district attorneys and prior defendants. It also reflects one of the goals of the Clinic: mainly, that any evaluation interview is invariably a therapeutic encounter. Regardless of the legal questions of innocence or guilt, we have confronted defendants on some of the major conflicts that have led to destructive behavior on their part. What has been picked up by the ma-

jority of defendants is the fact that the psychiatrist is not sitting in moral judgment, is not condemning, is *actively* interested and will not reveal material that might prejudice his case during the pretrial or trial period. . . .[18]

The Superior Court is the Massachusetts Jury Court, which serves the entire state. It sits in the various county seats with headquarters in Suffolk County (Boston). The Superior Court handles all felonies and appeals from convictions from the lower or District Courts of Greater Boston. Other Court Clinics in Massachusetts are associated with the juvenile justice system, but this is the Court Clinic that deals with adult offenders, many of whom are recidivists.

Dr. Balcanoff feels that the psychiatrists can fulfill a very important function working in the court system, but also that there is a great deal of initial resistance that must be overcome. The psychiatrist who is too aggressive will increase this resistance, but a psychiatrist who has good ability at human relations can gradually win a place "as a member of the court family." Balcanoff sees the resistance as a natural phenomenon and as something that can be worked through and indeed must be worked through, something that is not insuperable as long as it is expected and as long as one is not too aggressive in trying to beat it down.

Some commentators have felt that certain threats and potential threats to the civil liberties of defendants are posed by the Court Clinic system. Dr. Balcanoff sees this possibility, but he feels that in practice these threats have not developed. His service is very defense-oriented, and the defendants' lawyers have access to all evaluations and reports; they have the opportunity to confer with the Court Clinic staff. Dr. Donald Hayes Russell also feels that the system poses no major civil rights problems. He does not know of any instances in which Court Clinic reports were not made available to defense counsel.[19] Nevertheless, in another setting with less scrupulous personnel, such problems might arise, and it is worth while to point them out.

Inadmissible evidence might come to the attention of the court through the court reports; this evidence could not then be countered by information secured by cross-examination.

In other jurisdictions the evaluations might be considered the property of the court and not made available to the defense. When the defense does not know the contents of evaluation reports, it cannot effectively question the logic of the sentences imposed. A considerable problem exists with sentencing based on psychological test data and clinical impressions. Should a defendant receive harsh treatment because his Complete-A-Sentence Test or his Rorschach impresses an evaluator as ominous? Then penalties would be based not on the crime as charged but on the personality of the defendant, and the system would thereby lead to preventive detention. But what use is an evaluation if it does not predict a potential for rehabilitation and for effective use of treatment?

Although a defendant has a right to refuse a psychiatric examination and his unwillingness to cooperate cannot be held against him in any way, in some jurisdictions the judge or the defense attorney does not usually warn the defendant of this right to refuse.

Massachusetts has excellent laws safeguarding the confidentiality of material imparted to psychiatrists, and in addition has a special statute which guarantees a defendant the right to talk about previous convictions or involvement in an alleged offense with the members of the Court Clinic without this material being made available to the prosecution or to the court. (Guttmacher states that the Behavior Clinic of the Cook County [Chicago] Court is greatly restricted by a court rule which forbids the psychiatrist from discussing the alleged current offense with the defendant.[20])

Some psychiatrists or Court Clinic personnel could conceivably be so concerned with the potential dangerousness of a defendant that even though they kept damaging material concerning this offense or previous offenses out of the evaluation for the court, they might try to drop a word into the ear of a judge or of a probation officer compiling a pre-sentence report. This action of course would represent a breach of profes-

sional duty; it has not occurred in Massachusetts, but it could be a threat to defendants in other jurisdictions.

The Massachusetts Clinics are in a position to protect defendants' civil rights when there are communications problems between defendant and his lawyer. A lawyer may believe that his client is not competent to stand trial, while a psychiatrist may feel that this apparent incompetence is really the result of anxieties in an interpersonal relationship or the counter-transference problem of the attorney and that in truth the defendant meets the criteria for triability. The Court Clinic then is advancing the defendant's civil rights by helping him to receive a fair and speedy trial and the help of counsel.[21]

The policy of this Court Clinic on pre-trial evaluations is to write short reports which specifically address questions asked by the court, but on pre-sentence examinations the policy is to write a fuller kind of report providing more background, more descriptions, and more dynamics.

The Massachusetts Clinics use four types of reports. *The Pre-Trial Examination Report* is a simple psychiatric statement in answer to the court's question as to a defendant's sanity and competence. *The Pre-Sentence Evaluation Report* meets the court's desire to know about the offender's personality structure, background, and social adaptation to help in determining an appropriate sentence. *Psychiatric Follow-Up Reports* are submitted at any time on Clinical cases, either when the court requests one or when the Clinic wishes to communicate with the probation officer. *Special Reports* are made for the use of the probation officer when he needs this information to relay to other official agencies.

Because of an awareness that psychological test results may be too speculative or theoretical to provide a fair appraisal of the defendant, psychological testing is never used independent of psychiatric examination. Psychological testing is not done regularly, but according to need; the test results are used to substantiate or to elaborate on clinical impressions and are incorporated into the psychiatric report.

In some other jurisdictions reports prepared by a Court Clinic are not shared with defense counsel, and counsel may be very surprised when his client receives a much heavier sentence than he expected; he has no way of discovering that this heavy sentence is based largely on an adverse psychological, psychiatric, or social work report.

A majority of the time of the Massachusetts Superior Court Clinic is spent on pre-trial evaluation, the second most important priority is pre-sentence reports, and therapy is only a third priority. The Massachusetts Probate and Juvenile Courts are much more therapy-oriented. One reason for the lack of therapeutic orientation is the character of Superior Court defendants—many of them are recidivists and would not be amenable to conventional therapy. The psychiatrist can be useful in working with the probation officer, but because of heavy case loads the probation officer cannot do the best kind of job. In spite of this, the Superior Court Clinic does attempt a therapeutic approach to defendants. When a defendant has financial resources, a judge will be ready to accept a referral to a private agency or a private psychologist or psychiatrist as a condition of probation, although some judges are suspicious of outside sources of help and insist on a preliminary period of therapy with Dr. Balcanoff or his psychiatric co-worker with a transfer to a private source of help when they feel it is indicated. (One possible objection to this practice of using outside agencies is that it discriminates against indigent defendants who do not have the financial resources to pay for private help. If the practice resulted in a differential treatment by the court—less possibility of a psychiatric probation—there could be some legal objection to it, although superficially it sounds very attractive because it saves money for the state.)

Massachusetts has 72 district courts. Thirty-two of them have elected to become part of the Court Clinic program; these 32 courts and one Superior Court plus probate courts, which are concerned with divorce and child custody cases, are served by 24 Court Clinics in the state. Six thousand offenders are seen annually for diagnosis and/or treatment. In

contrast to the less treatment-orientated Superior Court program, the other Court Clinics offer individual, group, and family therapy, as well as chemotherapy, and they also work with AA and drug programs.[22]

There has been a strong and growing interdisciplinary movement within the Court Clinics, with many social workers and psychologists giving service. Court Clinics are constantly being sought out as training facilities not only for psychiatric residents but also for Master's level social work students, community mental health counselors, and graduate nurses in community mental health.

The Massachusetts Court Clinic experience has been presented in detail because information is available on its twenty-year experience. Data on other Court Clinics could also be cited. In 1957 the children's division of the Menninger Foundation began to operate a service to the juvenile court, and in 1966 the Foundation's division of law and psychiatry began a regular service to the adult court. The evolution of this service has been described in the legal psychiatric literature.[23] We can conclude that there are major civil rights problems involved in the operation of a Court Clinic but that with a high quality of personnel and a degree of sophistication these problems can be prevented from becoming troublesome. If Court Clinics are operated by untrained personnel, foreign-language-speaking personnel, or personnel unemployable in other psychiatric positions, we could expect major problems.

Judge Justine Wise Polier, New York City Family Court, has criticized the reports she has received in her court as stereotyped and not providing meaningful information.[24]

Two stratagems have promoted acceptance of the Clinics in Massachusetts. One is the utilization of a program Liaison Agent, a social worker or probation officer who coordinates the work of psychiatrist and psycholgist with court function. The second innovation was the establishment in 1959 of the Massachusetts Chapter of the Association of the Psychiatric Treatment of Offenders (APTO). Monthly meetings of the chapter throughout the year are attended by judges, lawyers, probation officers, Youth Service and Corrections Departments workers, social workers, psychologists, and psychiatrists; at each meeting a paper on some aspect of work with offenders is presented and discussed.

Trying to relate this information to a larger scene, we can conclude that with enough preparation and with the understanding that there will be resistances, Court Clinics programs can succeed in finding their place. Special problems will always be present—the problems of confidentiality, of coerced therapy, and of the admission of hearsay into the court record through the psychiatric report, and the great problem of the elevation of the psychiatrist into a kind of judicial aide whose opinions are not easily subject to questioning and criticism.

Problems of confidentiality are especially difficult. Many juvenile courts have been criticized for release of information to the armed services, employers and potential employers, colleges and universities regarding admissions, welfare agencies, and others. One aspect of the problem is the release of information authorized by parents when this release has not been in the best interest of the child. Strict confidentiality and no release of information are required because of the unequal relationship of parties; pressure from judges and probation authorities and the desire of the defendant to please could influence him to sign a release when this was not his real desire.

With all these potentials for abuse, the system is still worth trying—it presents the only practical way to eliminate unnecessary hospitalizations for court-ordered evaluation, it present a therapeutic alternative to either imprisonment or a nontherapeutic oriented probation, and it enables courts to integrate into their functioning the knowledge and expertise of behavioral scientists.

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