An Investigation of Treatment Recommendations Made by a Court Clinic

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Psychiatric services have been available to the criminal courts since 1909.[1] The first adult psychiatric clinic was established in Chicago in 1914; by 1950, there were eight such clinics in operation.[2] In addition to pre-trial questions of competency and criminal responsibility, court clinics also provided pre-sentence mental health evaluations to aid the court in its disposition of the offender and recommend treatment when appropriate.[2]

Although it is generally accepted that the pre-sentence report is one of the factors influencing sentencing,[3] research examining the effect of a mental health evaluation variable is sparse. Russell[4] contends that mental health intervention is indicated in as many as 90% of court-referred cases to court clinics. Cook and Pogany[5] found that referral for, and findings of, the mental health evaluation do in fact influence the probability of a sentence and, if sentenced, the sentence imposed.

Turner and Jerry[6] found that treatment was recommended in more than half of the cases processed through the Toronto Forensic Clinic. This recommendation was accepted by the Court in the disposition of 72% of the cases. Treatment was actually carried out in 70%.

Bearcroft and Donovan[7] found that in cases where treatment recommendations were made, 92% were followed by the Court.

A related issue is whether supervising probation officers agree with treatment recommendations made. Wolf[1] suggests that the amount of influence of clinic recommendations on the views of probation officers is not clear, but that officers tend to accept clinic suggestions when those suggestions correspond with the officers' own convictions.

If courts do indeed follow treatment recommendations of mental health professionals, what is the evidence that treatment impacts on recidivism and probationary compliance? Cassel[8] compared recidivism rates of 100 white males treated by a court clinic with those for offenders not receiving treatment. Treatment was defined as psychotherapy, vocational rehabilitation, housing or financial assistance or help with family problems. While trends in post-sentence adjustment and rearrest rates generally favored the clinic's clients, none of the differences were statistically significant.

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In an evaluation of the Medical Service of the Supreme Bench of Baltimore, Olsson[9] assessed the extent to which the recommendation of probation combined with treatment coincided with dispositions of the District Court and the Supreme Bench. The disposition of the Court agreed completely in 54.9% of the cases, agreed partially in 29.5% and disagreed with Medical Service recommendations in 15.6%. Probation officers completely implemented 52% of the treatment recommendations, implemented 17% to some degree, and did not follow 28%.

While no significant relationship was found between treatment and recidivism, there was a significant relationship between treatment and probation adjustment, with those subjects who had at least two months of treatment having greater stability in employment, residence and social behavior.

This study investigates the above variables at a court clinic in Tucson, AZ, a city of one-half million people in 1979. The degree to which treatment recommendations made at the pre-sentence level are followed by sentencing judges and agreed with by supervising probation officers was evaluated. It was hypothesized that treatment would impact positively on probationary compliance and recidivistic behavior.

Method

In late 1979, 100 files were randomly selected from the Court Clinic files of cases referred for pre-sentence evaluation from 1975 through 1977. Only cases where treatment was recommended were included in the sample. Of the 100 files selected, 67 were studied. The remaining 33 were disqualified because of unavailability or failure to meet criteria of the study. Of these, 11 subjects did not receive probation. Of the remaining 22, one subject chose prison rather than to continue in alcohol treatment and two subjects committed suicide while on probation and in treatment. The remaining 19 subjects were transferred to other jurisdictions during the probationary period and followup information was unavailable.

Instrument

A 12-item questionnaire was developed to collect the necessary information (see Appendix). Specific information was requested regarding the degree to which probation officers followed the Clinic's recommendations. This ranged from: 1) not followed; 2) followed minimally (e.g., the recommendation specified outpatient counseling, alcohol treatment with Antabuse, and a GED, but the only area pursued by the probation officer was to refer the subject to a GED program); 3) followed with a major change (e.g., the recommendation specified alcohol treatment with Antabuse and the subject entered an alcohol program, but was not required to take Antabuse); 4) followed with a minor change (e.g., outpatient counseling with a behavioral orientation was recommended, but the subject entered eclectic outpatient treatment); 5) followed completely (e.g., subject entered the exact type of treatment specified).

A second question examined whether probation officers agree with the Clinic's recommendations and whether agreement was related to the degree that recommendations are followed. Another item measured the officer's assessment of a subject's compliance in treatment, ranging from: 1) not compliant; 2) marginally compliant (e.g., subject participated in treatment plan to some degree); 3) compliant (e.g., subject participated fully in recommended treatment). Item seven inquired as to whether or not a petition was filed to revoke a subject's probation; this was the measure of recidivism for the purpose of this study. A petition could be filed with an administrative charge (a violation of current terms of probation) or a new charge of criminal conduct. Item 10 was designed to measure stability of employment, education, training, residence and family situation. Item 11 requested current status information on the subject. Items four and 12 asked subjective opinions of the officers as to whether they agreed with treatment recommendations and how they would assess the subject's chances for remaining free from criminal justice system contact (1) very unlikely, 2) unlikely, 3) 50-50, 4) likely and 5) very likely).

Procedure

The questionnaire was completed by the subject's supervising probation officer and returned to the clinic. All questionnaires were completed.

Results

Table 1 presents demographic information as to subject's sex, age, marital status, ethnicity and education level.

As can be seen, subjects were predominantly single, male Caucasians. They ranged in age from 18-57, with fewer under 25 than anticipated. The typical subject was a high school graduate or had a GED.

All but six of the subjects had prior convictions. At the time of the study, the majority of subjects (60%) were still on probation. Length of probation

Table 1: Demographic Data
(N=67)

Sex					
Male	90%	(60)			
Female	10%	(7)			
Age					
18-25	48%	(32)			
26-57	52%	(35)			
Marital Status					
Single	52%	(35)	Separated	2%	(1)
Married	25%	(17)	Divorced	21%	(14)
Ethnicity					
Caucasian	69%	(46)	Black	9%	(6)
Mexican-American	18%	(12)	American Indian	4%	(3)
Education					
8 years or less	10%	(7)	Some College	24%	(16)
9-11 years	39%	(26)	College Graduate		—
12 years or GED	24%	(16)	Graduate Degree	3%	(2)

term varied greatly, ranging from six months to 20 years, with the mean 3.7 years. Probation had been terminated for 22% and 18% had absconded or were incarcerated.

A total of 79 charges were brought against the 67 subjects, with 12 subjects receiving two each.

Table 2 presents the various types of charges filed against the subjects.

Table 2: Types of Charges
(N=67)

Violence	28%	(22)
Theft	20%	(16)
Drug	23%	(18)
Public Order	8%	(6)
Other	21%	(17)

As can be seen, violent charges were the most prevalent. The "other" category included such charges as fraud, forgery, contributing to the delinquency of a minor, child molestation, lewd and lascivious acts and driving while intoxicated.

A total of 20 subjects had petitions for probation revocation filed against them and are, for the purpose of this study, considered to be recidivists. Administrative charges (violations of current terms of probation) were filed against 55%; new offenses were committed by 10%; 35% of the sample had both new and administrative charges filed against them.

A total of 93 treatment recommendations were made by the Court Clinic; 26 subjects received two each and 41 subjects receive one. There was no significant relationship between the number of recommendations and any of the other variables.

The majority of treatment recommendations (43%) were for outpatient counseling. An additional 23% were for alcohol treatment, and 24% for "other" types of treatment, including behavior modification, medical treatment, etc.

The relationship between type of recommendation and degree to which it was followed by the subject's supervising probation officer was also assessed and is shown in Table 3. Results are not statistically significant.

As can be seen, drug and alcohol treatment recommendations were completely followed more often than other types of recommendations. Overall, 68% of the total treatment recommendations were followed completely, 4% followed with a minor change, 2% followed with a major change, and 26% were not followed.

In assessing the treatment compliance variable, seven of the 67 subjects were omitted since they received no treatment. In five cases, subjects were reluctant to enter treatment and although the probation officer agreed with the recommendations, the subjects were not forced into treatment. In one case, the probation officer didn't agree with the recommendation and did not follow through. In the other instance, the probation officer felt that there

Table 3: Crosstabulations of Types of Treatment Recommendations With Degree Treatment Recommendations Were Followed by Probation Officers (N=93)

Type of Recommendation	Degree Followed			
	Not Followed	Followed with Major Change	Followed with Minor Change	Followed Completely
Outpatient Counseling	33% (13)	—	2% (1)	65% (26)
Drug Treatment	20% (1)	—	—	80% (4)
Alcohol Treatment	24% (5)	5% (1)	—	71% (15)
Vocational Rehabilitation	20% (1)	—	20% (1)	60% (3)
Other	18% (4)	5% (1)	9% (2)	68% (15)

$X^2=9.41$; df=12; N.S.

were other priorities that needed attention, such as finding the subject housing, a job and food. As was expected, it was found that the likelihood of a petition of revocation being filed varied directly with compliance with treatment ($X^2=26.65$; df=2; $p<.0001$).

It was also found that the chances of having a petition for revocation filed were higher for subjects who did not have stability in employment/education/training ($X^2=11.05$; df=1; $p<.0001$), stability of residence ($X^2=24.76$; df=1; $p<.0001$), and stability of family situation ($X^2=13.63$; df=1; $p<.0005$).

Some interesting results were obtained when subjects' treatment compliance was crosstabulated with several other variables. Treatment compliance is related to stability of employment/education/training ($X^2=25.28$; df=2; $p<.0001$), stability of residence ($X^2=27.71$; df=2; $p<.0001$) and stability of family situation ($X^2=29.48$; df=2; $p<.0001$).

In assessing how treatment compliance related to current status of the subjects, 18 of the 60 subjects were not included because the status of 15 was unknown due to probation having been terminated. One subject was unknown due to transfer, one was in a drug treatment center and one was retired.

Table 4 clearly demonstrates a positive relationship between subjects' current status and treatment compliance ($X^2=29.26$; df=4; $p<.0001$).

It is interesting to note the current status for the seven subjects who did not enter treatment for reasons previously described. Of these, four were employed, one was on welfare, and two were unknown (probation had been terminated).

Subjects' treatment compliance was also found to be related to the degree to which recommendations were followed by the supervising probation officer ($X^2=36.72$; df=6; $p<.0001$) as presented in Table 5.

Table 4: Crosstabulation of Treatment Compliance With Current Status (N=42)

Treatment	Current Status		
	Absconded	In Custody	Employed, School, Training
Not Compliant	100% (4)	75 % (6)	3% (1)
Marginally Compliant	—	12.5% (1)	40% (12)
Compliant	—	12.5% (1)	57% (17)

$X^2=29.26$; df=4; $p<.0001$

Table 5: Crosstabulation of Degree Treatment Recommendations Were Followed by Probation Officers and Subject Treatment Compliance (N=85)

Degree Recommendations Followed by PO	Treatment			
	Not Followed	Followed with Major Change	Followed with Minor Change	Followed Completely
Not Compliant	65% (11)	6% (1)	6% (1)	23% (4)
Marginally Compliant	11% (4)	3% (1)	—	86% (32)
Compliant	3% (1)	—	10% (3)	87% (27)

$X^2=36.72$; df=6; $p<.001$

The greater the treatment compliance, the more likely that the subject would remain free from new contact with the criminal justice system in the supervising probation officer's opinion ($X^2=30.23$; df=8; $p<.0005$). Subjects who had a petition for revocation of probation filed against them were assessed to be more likely to have future contacts with the criminal justice system by supervising officers ($X^2=14.19$; df=4; $p<.01$).

No significant relationships were found between type of criminal offense and a) whether a petition to revoke was filed or b) treatment compliance; nor were there significant relationships between the degree to which probation officers followed treatment recommendations and whether or not they agreed with those recommendations; however, officers agreed with 95% of treatment recommendations made by the Court Clinic.

Discussion

Results obtained in this study indicate that the majority of treatment recommendations (72%) made by the Pima County Court Clinic were followed completely or with a minor change by supervising probation officers. This finding supports those of Turner and Jerry[6] and Olsson.[9] Results also indicate that a high percentage of subjects actually entered treatment, as did those subjects studied by Ciccone and Barry.[10]

Two subjects committed suicide while on probation and in treatment. Both were Caucasian males in their 30s; both were receiving social security benefits for 100% mental disability. The first was a bright 30-year-old community college graduate with a five-year history of hospitalizations and treatment for an affective disorder. The Court Clinic recommended long-

term psychotherapy and continuation of psychotropic medication (Lithium Carbonate). The supervising probation officer agreed with clinic recommendations, but stated "The agency I sent him to took away his Lithium because he 'really wasn't a manic depressive,' and nine days later he blew his brains out." The second subject was a 37-year-old paranoid schizophrenic with a 16-year history of mental health treatment and hospitalizations. Viewed as a community nuisance because of a long string of relatively minor offenses, he was a very difficult patient for the community mental health center, periodically refusing his medication and sporadically attending group therapy. He killed himself one year after his probationary period began.

Since the majority of subjects were still on probation at the time of this study, and scant information was available regarding the current status of the sizable number of subjects who had terminated probation, interpretation of the recidivism data must be made with caution. It is clear, however, that an increase in the following variables reduces the likelihood of having a petition for revocation of probation filed: treatment compliance, stability of employment/education/training, stability of residence, and stability of family or significant other. These findings are similar to trends noted by Cassel.[8] They are, however, in contrast to those of Olsson,[9] who found no significant relationship between recidivism (within 36 months following probation termination) and treatment compliance. These results do support Olsson's findings of a positive relationship between treatment compliance and stability of employment and residence. Borgman[11] suggests that personal maturity to maintain employment and the structure provided by a self-supporting family are minimal necessary conditions for successful treatment (defined as cessation of law-violating behavior). Present results indicate a strong correlation between probationary and treatment compliance and stability of employment and family life. Whether the latter are prerequisites for successful treatment or developed during the course of treatment cannot be inferred from present data.

Twentyman's work[12] is interesting in this regard. He found that probationers were rated as less skillful and also rated themselves as less likely to obtain employment than did a control group of randomly selected unemployed persons. Probationers assigned to a skills training program obtained employment significantly more frequently than did probationers assigned to a group in which monetary incentives for job interviews were provided.

In contrast to the findings of Wolf,[1] the results do not suggest that probation officers tend to follow treatment recommendations to a greater degree if they agree with them, since in many cases the officers expressed agreement but they did not follow recommendations completely.

Present results suggest that when probation officers followed treatment recommendations more closely, subjects were more compliant in treatment, more stable in employment, residence and family, and were assessed by supervising officers as being less likely to have future contact with the criminal justice system. The nature of the relationship between variables

may not be as direct as this statement suggests. It is possible that when officers had greater belief in a subject's "potential for rehabilitation," they chose to follow recommendations to a greater degree. If the subjects perceived that the probation officers believed in them, perhaps they behaved in a more compliant and law-abiding manner. This presents an interesting area for future study.

Another question that poses itself is whether treatment itself reduced recidivism or whether compliance in treatment is a subset of compliant responses to probationary regulations in general. Clinicians have traditionally distinguished between the client who is actively involved in treatment and the client who is merely compliant. Treatment is presumed to be more beneficial for those clients who actively participate in the treatment process.

Borgman[11] argues that the poor are favored for diversion to mental health facilities. Commentators on poverty agree that the poor are characterized in general by passive rather than active reactions to everyday situations and by dependence.[13–14] The client of low socioeconomic status, then, may be more likely to be compliant rather than an active participant in therapy. He may attend regularly, but offer little input into treatment plan or progress. If so, is treatment efficacy (measured as cessation of law-violating behavior) affected? Are we measuring behavioral change or time-limited compliant and conforming behavior? These variables pose interesting questions for further research.

References

1. Wolf, J.: Legal Psychiatry and Criminal Justice: The Court Clinic in Massachusetts. Journal of Forensic Science, 12, 2, 147-171, 1967.
2. Guttmacher, M.S.: Adult Court Psychiatry Clinics. Amer. Journal of Psychiatry, 106, 881-888, 1950.
3. Flaschner, F.: Community Based Courts. International Journal of Offender Therapy and Comparative Criminology, 18, 164-170, 1974.
4. Russell, D.: From the Massachusetts Court Clinics, USA: A Study of Its Administration and Community Aspects. International Journal of Offender Therapy and Comparative Criminology, 13, 140-147, 1969.
5. Cook, C. and Pogany, E.: The Influence on Judge's Sentencing Practices of a Mental Evaluation. Bulletin of the Amer. Acad. of Psychiatry and the Law, 3, 245-251, 1976.
6. Turner, R. and Jerry, M.: Statutory Referrals to Forensic Clinic-Toronto. 3rd Research Conference on Criminology and Delinquency, Montreal, Nov. 20-24, 1962.
7. Bearcroft, S. and Donovan, D.: Psychiatric Referrals from Courts and Prisons. Br. Med. J. 2, 1519-1523, 1965.
8. Cassel, C.: Effects of Community Evaluation and Treatment on the Sentencing and Post-Sentence Adjustment of Offenders. University of Toledo Doctoral Dissertation, 1975.
9. Olsson, J.: An Evaluation of the Medical Service of the Supreme Bench of Baltimore. Unpublished Study, 1972.
10. Ciccone, J. and Barry, D.: Collaboration Between Psychiatry and the Law: A Study of 100 Referrals to a Court Clinic. Bulletin of the Amer. Acad. of Psychiatry and the Law, 4, 275-280, 1976.
11. Borgman, R.D.: Diversion of Law Violators to Mental Health Facilities. Social Casework, 56, 418-426, 1975.
12. Twentyman, C.; Jenson, M. and Kloss, J.: Social Skills Training for the Complex Offender: Employment-Seeking Skills. Journal of Clinical Psychology, 34, 320-326, 1978.
13. Weiss, J.: The Law and the Poor. Journal of Social Issues, 26, 59-68, 1970.
14. Duhl, L.: The Urban Condition. Chicago, IL. Univ. of Chicago Press, 1963.

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Appendix

Name: _____

Age: _____ Race: _____ Education: _____ Marital Status: _____

Instant Offense: _____

_____ Priors: Yes ____ No ____

Sentencing Disposition: _____

Other Conditions: _____

1. Recommendations: a. _____
   b. _____
   c. _____

2. Did you as the supervising probation officer agree with the recommendations?
   Yes ____ No ____
   (If No, Why Not?) _____

3. If Yes, were the recommendations followed and how? Please be specific (agency, medication, therapy, dates started and ended, etc.).

	Yes	No	How
a.			
b.			
c.			

4. Did the recommendations affect your probationer's progress while on probation? Yes ____ No ____

5. Your client's progress was:

	Verified Yes	Verified No
a. Compliant ____		
b. Marginally Compliant ____		
c. Not Compliant ____		

6. Probationary Period: Began/month _____ year _____;
   Terminated/month _____ year _____

7. Was a petition to revoke filed? Yes ____ No ____
   a. Administrative _____
   b. New Charge _____

8. Were his conditions modified at any time? Yes ____ No ____
   a. In favor of the probationer ____
   b. Or the community ____

9. Was probationer's supervision considered to be maximum ____ medium ____ minimum ____ or unsupervised ____?

10. Was the probationer consistent with:

	Yes	No
a. Employment/education/training	____	____
b. Residence	____	____
c. Family constellation/significant other	____	____

11. What is the current status of probationer, i.e., employed ____ in custody ____ under indictment ____ other _____?

12. At this time how would you assess your probationer's chances of remaining free of the criminal justice system? Very likely ____ likely ____ 50-50 ____ unlikely ____ very unlikely ____