

The Legal Psychiatry Consultation Service: A New Service Model for "Forensic" Psychiatry†

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The interaction between psychiatry and the law was, for many years, almost entirely limited to the courtroom setting. Those psychiatrists who chose to become specialists in the area of overlap between the two disciplines acknowledged the scope of their activity in the name they selected to describe themselves: "Forensic."¹ The term originally was derived from the Latin "forum," the place where public debate took place, and is generally used to denote activities pertaining to judicial or other argumentative contexts. To be sure, the various evaluations and treatments at which forensic psychiatrists became adept might take place in a private office, psychiatric clinic, hospital, or prison, but the nexus of all this work remained the court, as it was performed either at the court's behest or for the purpose of presentation there.

The recent revolution in patients' rights has expanded the interface between psychiatry and the law well beyond the courtroom walls.² Rather than the interaction being restricted to a small group of psychiatrists who immerse themselves in the application of psychiatry to the law, we are faced with a situation in which, of necessity, the vast majority of psychiatrists working in organized settings have become profoundly concerned with the effect of the law on psychiatry. Their concerns extend to such issues as the right to treatment, the right to refuse treatment, informed consent, competency to consent to treatment, the use of guardianship and other forms of substituted judgment, and confidentiality.

Psychiatrists and other care providers require expert guidance in negotiating their way through this maze of issues. Although the advice of a lawyer is often useful, most lawyers lack empathy with the needs of both patients and clinicians and the clinical expertise to respond to the clinical issues inherent in most difficulties that arise. What this new situation calls for is a return of those psychiatrists interested in legal issues to the mainstream of psychiatry, their return to the psychiatric setting, and an expansion of their sphere of activity. Such a dramatic

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change requires a new model of service provision, akin to the consultation model long used in medical settings.³ Similarly, the name "forensic psychiatry" ought to be replaced with one more consonant with the broader involvements that will ensue. Although used in the past to denote a variety of interests,^{2,4} the name "legal psychiatry" seems more appropriate here. Thus, this innovative approach to the interactions between psychiatry and the law is embodied in the aptly-named "legal psychiatry consultation service."

The Consultation Service

This paper will report the experience of the Legal Psychiatry Consultation Service (LPCS) at the Massachusetts Mental Health Center (MMHC). MMHC is a state-operated community mental health center with a complete range of in-patient and out-patient services; it is also a major teaching hospital for the Harvard Medical School. The LPCS was established in July 1979, under the direction of the author, who has a special interest in legal-psychiatric issues.

By memo and personal contacts, staff members from each unit of the Center were encouraged to direct questions about legal-psychiatric issues to the LPCS. It was made clear to the clinicians who sought assistance that the nature of the response that they would receive would be a "consultation"; that is, they would receive a recommendation as to the suggested course of action, but the decision on how to handle the case would clearly remain with them and with their supervisors in the clinical chain of command. It was felt that clinicians would be more likely to present troubling problems if there were no fear that their control of the case would be superseded.

Consultees were invited to meet with the director of the LPCS to present a brief clinical history, as well as to outline the nature of their dilemma. In those instances in which the problem appeared not to be primarily legal-psychiatric, but rather clinically-based, that was pointed out to the consultee and the appropriate clinical measures were suggested. An attempt was made to respond to all consults on the day that they were placed, and in any case, no later than the following day.

From the beginning it was clear that certain kinds of questions would be directed to the LPCS that would require additional input: (1) intricate legal-psychiatric issues that required consultation with a lawyer; (2) queries that were essentially legal with no psychiatric component; and (3) questions that raised issues of policy on an institutional or departmental level. An important component of the service was the back-up availability of the hospital's consulting attorney, the legal office of the Department of Mental Health, and key administrators in the center. Questions of an entirely legal nature (*i.e.*, a patient-tenant threatened with eviction) were referred to the appropriate legal services office.

To decrease the confusion that results when several sources are

consulted about complicated issues and inevitably return varying answers, MMHC staff were encouraged to direct all their legal-psychiatric queries to the LPCS and to allow the consultant to elicit and to filter conflicting views when necessary. The LPCS also requested, as a matter of routine, in exchange for its services, that the consultee provide follow-up data as to the ultimate resolution of the case.

Results

Table 1 outlines the results of the first year of LPCS operation. Each contact with the LPCS has been recorded by the subject matter with which it dealt. Examples of the issues raised include:

- 1) *Competency to stand trial and criminal responsibility evaluations* — assisting residents in performing evaluations and in writing reports.
- 2) *Civil commitment* — reviewing appropriateness of proposed petitions with residents; interviewing patients; discussing alternative options; preparing residents for court appearances.
- 3) *Confidentiality and access to records* — handling patients' requests for records; advising therapists what information can be released to a variety of inquirers.
- 4) *Legal-administrative issues* — acting as liaison with the state hospital for the criminally insane to arrange transfers.
- 5) *Guardianship* — aiding residents in assessing the appropriateness and the consequences of a petition for guardianship, particularly in response to an incompetent refusal of treatment.
- 6) *Patients' rights* — responding to questions from staff concerning right to refuse treatment, access to visitors and phone calls, *etc.*
- 7) *Difficulties with patients' legal status* — clarifying status of patients with conflicting court papers, with court commitments not authorized by statute, *etc.*
- 8) *Didactic services* — formal lectures to and discussions with residents, social workers, out-patient clinic staff, and continuing care staff on civil commitment, guardianship, informed consent, *etc.*; providing papers and references to interested staff.
- 9) *Communications with other agencies* — helping clinicians identify proper loci for inquiries; reviewing communications for clarity and appropriateness (see also #3).
- 10) *Malpractice* — responding to queries about the liability inhering in various courses of action and the means of minimizing the risk of liability.
- 11) *Relations with patients' attorneys* — meeting with or briefing clinicians prior to their meeting with patients' attorneys to discuss legal matters.
- 12) *Emergencies* — advising clinicians on the extent of their powers to respond to emergencies, such as an out-patient who is threatening family members in the community.
- 13) *Rights of staff members* — discussing options with staff who have been assaulted, subpoenaed to testify in court, *etc.*

14) *Patients' requiring legal help* — referring therapists to the proper sources of assistance for their patients' legal problems.

TABLE 1
CONTACTS WITH LEGAL PSYCHIATRY CONSULTATION SERVICE BY SUBJECT MATTER
JULY 1979 — JUNE 1980

	Number	% of Total
1. Competency to stand trial and criminal responsibility evaluations	125	22.8
2. Civil commitment	63	11.5
3. Confidentiality and access to records	62	11.3
4. Legal-administrative issues	60	10.9
5. Guardianship	47	8.6
6. Patients' rights	43	7.8
7. Difficulties with patients' legal status	40	7.3
8. Didactic services	36	6.6
9. Communications with other agencies	27	4.9
10. Malpractice	14	2.6
11. Relations with patients' attorneys	9	1.6
12. Emergencies	9	1.6
13. Rights of staff members	8	1.5
14. Patients requiring legal help	5	0.9
TOTAL	548	100%*

*Total is less than 100% because of rounding off to nearest whole number

The following case examples, in which the identity of the patients involved has been disguised, may give a better sense of the multifaceted nature of legal-psychiatric consultation.

Case #1: This 49-year-old single woman had been followed as an out-patient for only one month before her therapist went on vacation. During her initial contacts she seemed mildly paranoid, though not psychotic. A past history of psychosis was elicited, as was the information that the patient was currently on probation for assault and was living in an ex-offenders' half-way house. Upon her return from vacation the therapist received information that the patient had deteriorated. In the two weeks since the therapist's return the patient had not resumed her appointments. Fearing that the patient was again psychotic and dangerous, the therapist asked what measures could be taken to bring her back to treatment, specifically if she could contact the patient's probation officer. The patient had never given consent for such contact.

Consultant's response — The therapist was advised that her first move should be to attempt to contact the patient, through the half-way house, with the intention of persuading her to return voluntarily. Failing that, the patient should be asked for permission for the therapist to contact the probation officer. In the absence of consent, and without any hard evidence that the patient was indeed dangerous, any communication with the probation officer would violate the patient's right to confidentiality. Even with the patient's consent, however, the therapist should seriously consider the effect on the therapeutic alliance with the patient of involving a coercive branch of the court in the patient's treatment.

Should the half-way house staff contact the therapist, she would be free to suggest to them that they speak with the probation officer.

Case #2: A 38-year-old male patient was referred for hospitalization after two months in an alcoholism treatment program where he became grandiose and psychotic. There was no previous history of psychosis. Following involuntary emergency admission, the patient was mute, appearing catatonic. Five days later, at the time of the consult, he remained catatonic, had consistently refused medication, and had refused food for three days, accepting only small amounts of water. The resident in charge of the case desired to begin treatment with medications and inquired as to what procedures needed to be followed.

Consultant's response — Involuntary administration of medication is permitted in this state only in two instances: (1) when the patient presents an acute danger to himself or others; or (2) with the consent of a court-appointed guardian. Although the patient's catatonia, which resulted in his refusal of medication, as well as food, could certainly lead to a life-threatening situation, the presence of normal serum electrolytes and some fluid intake indicated that involuntary medication was not yet justified under the first rationale. The preferable option was to petition the court for the appointment of a guardian after a formal finding of legal incompetency. The resident was advised how to work with the Legal Office of the Department of Mental Health to arrange the court hearing; in addition, since the ten-day emergency commitment would soon be expiring, the procedures for filing for court-ordered civil commitment were reviewed.

Case #3: The attending psychiatrist of one of the in-patient units requested assistance in dealing with a phone call he had received from a local literary agent. It appeared that the agent had received a number of unsolicited manuscripts from a quite psychotic manic patient: to the physician's amazement, the agent felt that the patient had great talent and was interested in representing him in his dealings with publishers. The agent, however, knowing that the author was a psychiatric patient, was wary of getting involved in a commercial relationship with him, unless he could be reassured that the patient was stable enough that no unusual problems would result. Both the attending physician and the patient's resident psychiatrist were eager to cooperate with the agent in order not to jeopardize the patient's prospects, but they were uncertain how to proceed.

Consultant's response — The LPCS consultant recommended that the attending psychiatrist have the agent contact him. After verifying the nature of the agent's request, he discussed with him, in general terms, the rules governing the retention of the capacity of psychiatric patients to enter into contracts. As the agent was still interested in pursuing the matter, the consultant suggested that he contact the patient directly

and ask him to request that his doctor discuss the relevant details of his condition with the agent. This returned the initiative to the patient, precluding a situation wherein the unit staff appeared to be more interested in the patient's literary success than he himself.

Discussion

It should be apparent that the operation of a legal-psychiatry consultation service in a general psychiatric hospital leads "forensic" psychiatry into an enormously expanded realm. The shift in focus from the judicial-correctional system to the mental health system means a much more intensive concern with the law as it impinges on the actual treatment of the mentally ill. Even when dealing with such traditional areas for forensic psychiatry as competency and criminal responsibility assessments — still the largest single area of concern, even in a hospital setting — the legal psychiatrist acts as a teacher of residents and an explicator of the law, not as the primary evaluator. Throughout his work the emphasis is on teaching and training others.

There are, of course, potential pitfalls to this consultant's role. The temptation is frequently present to assume responsibility for the resolution of the problem, particularly with passive clinicians or those intimidated by the legal process. Whatever gains in efficiency may result from such an approach are overshadowed by the loss of the opportunity to help the clinician gain familiarity with the legal system, and thus facilitate his future interactions with it. In addition one faces the risk of covertly communicating to the patient that neither he nor his therapist knows how to cope with the situation. The consultant should therefore always attempt to be a facilitator; only when the therapist's direct involvement would endanger the therapeutic alliance or compromise confidentiality, as in Case #3 above, is a more direct role warranted.

Another potential trap is to permit the staff of the hospital to view the consultant as a lawyer, rather than as a psychiatrist. To assume the role of dispenser of purely legal advice, without inquiring into the clinical aspects of the situation, leads to both: (1) poor legal advice, since the consultant is, in fact, not a lawyer; and (2) an all too frequent collusion with the therapist in the false belief that the difficulties that the patient faces are wholly of a legal nature and involve no therapeutic elements.⁵ With astonishing frequency, difficulties that are initially presented as exclusively legal in nature appear, in the end, more easily remediable by a careful attention to the therapeutic alliance with the patient. Questions about release of information are frequently of this sort.

The response to the LPCS, after one year of operation, was overwhelmingly positive. Clinicians who previously had to spend hours of their own time tracking down answers to esoteric questions, and frequently receiving different answers from different authorities, were relieved to have one person to whom to turn. First-year residents who have known no other system frequently ask in bewilderment about how

to handle issues that arise during the consultant's absence due to vacation or for other reasons.

This response from the residents suggests that the LPCS model is an effective means of introducing the teaching of law and psychiatry into the residency program. Rather than limiting legal-psychiatric training to the classroom, or rotating residents for brief periods through unfamiliar court clinics or correctional institutions,⁶ where they are taught to perform evaluations that many of them will never again pursue, the LPCS provides a mechanism for legal-psychiatric concepts to become integrated with the everyday work of the average resident. The skills that they thereby acquire will be those of most use to them in their future work. In addition, those residents, or even medical students, with a particular interest in legal-psychiatric issues, can elect to spend a portion of their time with the consultation service.

There are implications, as well, for post-residency training of "forensic" psychiatrists. Most current programs are based in the traditional court clinic or correctional settings.⁷ A program whose primary locus is in the general psychiatric center, with opportunities for the fellows to rotate through courts and prisons, could provide a much broader training for the legal psychiatrist of the future. These more clinically-oriented experts would then be able to fill the gap in services that has been the result of the explosion in legal involvement in the mental health system.

Finally, this new service model and the experts who train in it could end the isolation of much of forensic psychiatry. Bringing forensic psychiatrists back into the psychiatric setting, though undoubtedly an unnerving thought for many accustomed to the relative isolation of the prison or court clinic, could reinvigorate the field by providing the stimulus for involvement in manifold new areas of practice and research. In a similar way, general psychiatrists may become more interested in and aware of the many contributions legal psychiatry can make to the care of the mentally ill.

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