Collaboration Between Psychiatry and the Law: A Study of 100 Referrals to a Court Clinic

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Introduction

Society's division of the priestly functions of healer and law-giver into medicine and law created two disciplines whose concerns with human behavior often overlap. Since the logic, methods and goals of the two professions differ, it is not surprising that there is difficulty in achieving a smooth and effective interaction. Yet this interaction is essential if each discipline is to fulfill its responsibilities.

Lipowski[1] has pointed out that one of consultation-liaison psychiatry's major roles is to maintain a link between psychiatry and medicine, a role which involves knowledge of and participation in the system to which one is a consultant. The sociolegal psychiatric consultation may be conceptualized in similar terms: one of its major roles is to maintain a link between psychiatry and law. This active collaboration requires familiarity with the legal system and a rapport with individuals working within it.[2-4] The sociolegal psychiatric consultant is not limited to responding to forensic questions, *i.e.*, "the application of psychiatry to legal issues for legal ends,"[5] but also responds to the psychiatric needs of individuals who have run afoul of the law. The collaborative relationship with judges, lawyers, and other members of the legal system leads to a shared interest in individuals whose behavioral problems concern both medicine and law, and to solutions which neither discipline alone could achieve.

The purpose of this paper is to report the results of the use of the sociolegal psychiatric consultation strategy to evaluate individuals referred to a court clinic. In addition to describing the population in terms of sex, race, age, diagnosis, referral source, referral question, psychiatric recommendations, and legal outcome, the paper will divide the population into three major groups, according to whether their behavior is predominantly the responsibility of psychiatry, of the law, or of both psychiatry and the law.

Settings and Methods

The Monroe County Mental Health Clinic for Courts and Probation was established in 1963 by the Department of Psychiatry of the University of Rochester Medical Center and the Monroe County Board of Mental Health to provide consultative and educational services to the judges and probation officers. The Clinic gradually developed the capacity to provide diagnostic and treatment services to individuals referred from a number of sources. To reflect this modification, the clinic's name was changed in 1974 to the Monroe County Mental Health Clinic for Sociolegal Services.

The clinic is located within the complex of buildings which house the courts, the

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probation department, the district attorney, the public defender, the police, the county jail, and rehabilitative services for inmates. The clinic receives over 800 referrals per year. The central location of the clinic, coupled with the staff's familiarity and interaction with individuals working in the legal system, encourages referrals from all divisions of that system.

The population to be studied was drawn from 100 consecutive referrals to the clinic in the summer of 1974. A one-year follow-up was done to determine the outcomes of the individuals' legal charges and the psychiatric recommendations. Each chart was carefully reviewed to determine the nature of the major referral question and to assign the case to one of the three divisions of responsibility: psychiatry; the law; or both psychiatry and the law.

Results

Of the 100 consecutive referrals, four failed to participate in a psychiatric evaluation and are excluded from the study.

Age Distribution. Table 1 presents the age distribution of the population studied. Eighty-three (87%) of the population studied is between 15 and 35 years of age. This high percentage contrasts sharply with the population breakdown of Monroe County, where 42% of the over-14 population is under 35. This over-representation of adolescents and young adults corresponds to their over-representation in both the local and national arrest rates, and is entirely attributable to males between the ages of 15 and 34. Young men make up 72% of the study population but only 20% of the people in Monroe County over the age of 14. Females in the 15-34 age range make up 15% of the study population and 21% of the county's over-14 population.

TABLE 1
AGE DISTRIBUTION OF THE EVALUATED INDIVIDUALS

	White Male	Nonwhite Male	White Female	Nonwhite Female	Total	(Percent)
15-24	27	18	3	4	52	(54%)
25-34	13	11	5	2	31	(32%)
35-44	4	2	–	–	6	(6%)
45-54	1	2	2	–	5	(5%)
55-64	2	–	–	–	2	(2%)
65+	–	–	–	–	–	–

Diagnoses. The distribution of diagnoses in Table 2 is not significantly different from the distribution found by Barry *et al.*[6] in their study of 5,600 referrals to the Munroe County Mental Health Clinic for Sociolegal Services. Both this distribution and that of Barry reveal nearly twice the use of the diagnosis of character disorder (41%) than that found in the Monroe County Cumulative Psychiatric Case Register (20%). This register, initiated in 1960, has been described in detail elsewhere.[7-9] It is a case register to which all public psychiatric facilities and 80% of the private practitioners report diagnostic and treatment contacts. The no-mental-disorder category is also over-represented, with 9% in the study population and 2% in the register. Organic brain syndrome is diagnosed in 5% of the patients in the study and 11% of the patients in the register. Likewise, neurosis is under-represented in the study population (3%) when compared to the register population (22%). It is not clear whether these differences in diagnostic categories are entirely attributable to the source from which the study population was drawn (predominantly young males are referred to the clinic) or whether diagnostic inconsistency on the part of the mental health professionals plays a role. A systematic attempt to answer this question is not within the scope of this paper.

TABLE 2
DIAGNOSTIC DISTRIBUTION OF THE EVALUATED INDIVIDUALS

	White Male	Nonwhite Male	White Female	Nonwhite Female	Total	(Percent)
Organic Brain Syndrome	1	4	–	–	5	(5%)
Affective Psychosis	1	–	1	–	2	(2%)
Other Psychosis	4	10	1	–	15	(16%)
Neurosis	1	–	2	–	3	(3%)
Character Disorder	25	8	3	3	39	(41%)
Situational Disorder	5	3	3	3	14	(15%)
No Mental Disorder	2	7	–	–	9	(9%)
Other	8	1	–	–	9	(9%)

Referral Source. The referral source distribution found in Table 3 shows that 61 (64%) of the group were court referrals. The remaining 36% were referrals from a family member, 10%; from probation officer, 10%; self-referral, 6%; from jail medical staff, 5%; from police, 5%; and from community agencies, 4%. The probation officers make direct referrals to the clinic. A referral was credited to only one source. When a referral was completely or predominantly initiated as the result of the efforts of a family member, the individual, a community agency or the police, it was credited to the appropriate sub-group. A referral was credited to the jail medical staff only if the clinic did not receive a referral on that individual from another one of the above sources.

TABLE 3
REFERRAL SOURCE DISTRIBUTION OF THE EVALUATED INDIVIDUALS

	White Male	Nonwhite Male	White Female	Nonwhite Female	Total	(Percent)
Courts	30	21	6	4	61	(64%)
Family	2	7	–	1	10	(10%)
Probation	3	2	1	–	6	(6%)
Self	3	–	1	1	5	(5%)
Jail Medical Staff	2	2	1	–	5	(5%)
Police	4	–	1	–	5	(5%)
Community Agency	3	1	–	–	4	(4%)

Referral Question. An important part of the evaluation occurs at the Referral Conference. At this conference, a clinic staff member meets with the referrer. He not only gets as much background information as is available but also helps the referring individual, if necessary, to ask an answerable question or to restate the question so that the appropriate evaluation will be performed. For example, a court order requesting a competency to stand trial evaluation may arrive at the clinic when the referring individual really wanted a pre-sentence investigation. Thirty-seven (39%) of the referrals requested an answer to a forensic question, *i.e.*, clarification of "the relationship of psychiatric material to legal issues in which the patient is involved for the specific purposes of law . . . ." These requests included those for evaluation of a patient's drug addiction, 15 (16%); competency to stand trial, 11 (12%); dangerousness, 7 (7%); able to have custody or visitation rights, 3 (3%); and criminal responsibility for alleged acts, 1 (1%). However, the majority of the requests, 59 (61%), were for the evaluation of the individual's need for treatment. 55 of the 59 requests occurred at the pre-trial stage. An

TABLE 4
DISTRIBUTION OF THE REFERRAL QUESTION

	White Male	Nonwhite Male	White Female	Nonwhite Female	Total	(Percent)
Pre-trial Psychiatric Evaluation	36	12	6	1	55	(57%)
Drug Addiction	5	5	1	4	15	(16%)
Competency to Stand Trial	2	9	–	–	11	(12%)
Dangerousness	3	4	–	–	7	(7%)
Pre-Sentence Psychiatric Evaluation	1	2	–	1	4	(4%)
Custody and Visitation	–	–	3	–	3	(3%)
Criminal Responsibility	–	1	–	–	1	(1%)

individual has the right not to participate in the clinic's evaluation, and four of the one hundred chose either not to keep their appointments at the clinic or, if in custody, not to speak with the clinic staff member.

Psychiatric Recommendations. The clinic has a significant liaison function with other facilities providing mental health care. As shown in Table 5, therapy was recommended for 60 (63%) of the individuals, and 53 of the 60 individuals entered treatment: 6 were hospitalized; 10 were treated in jail; and 37 were treated on an outpatient basis. Twelve of the 37 outpatients were treated at the clinic; these patients either requested that they be treated at the clinic, or their complex difficulties required the active and continued collaboration of the mental health and criminal justice systems, collaboration best provided by the clinic.

The biggest hurdle to referring a patient to outpatient care is the attitude expressed in the often heard statement, "Let's wait until the patient's legal troubles are over before we get involved." Actually it is usually an error to wait until adjudication to begin therapy. The patient facing legal difficulties is often in a time of crisis and may require intervention either to prevent further regression and decompensation or to take advantage of the opportunity to encourage emotional maturation and increase the individual's capacity to cope. The school of thought that favors waiting asserts further, "The wait will be a good test of the patient's motivation." Clearly, however, a court order cannot create a therapeutic alliance. The complaints of an exasperated parent, an exhausted spouse, or a fed-up employer cannot create a therapeutic alliance either, but in these instances we do not wait until the problem is solved and the external pressure is eliminated to begin treatment. Indeed, the external force may become part of the treatment (as in family therapy) or encourage the therapy (by providing financial support or granting some time off from work). Likewise, the legal pressures may encourage the individual to enter therapy; indeed, a significant number of patients who entered therapy at the time of their legal problems developed a sturdy therapeutic alliance and continued in therapy long after their legal problems had been resolved.

TABLE 5
DISTRIBUTIONS OF THE PSYCHIATRIC RECOMMENDATIONS

	White Male	Nonwhite Male	White Female	Nonwhite Female	Total	(Percent)
No Treatment Indicated	13	18	2	3	36	(38%)
Treatment Indicated	34	15	8	3	60	(63%)

Legal Outcome of Charges. Table 6 shows the distribution of the legal outcomes of the study group: 27 (28%) had their charges dropped for a variety of reasons; 8 (8%) were referred with no charges pending; and 5 (5%) were found not guilty. Of those 48 (50%) individuals found guilty, 21 (22%) were given jail sentences; 15 (16%) were placed on probation; and 12 (13%) were given conditional discharges. Because the sociolegal clinic receives all the psychiatric referrals generated by the criminal justice system in Monroe County, the individuals evaluated faced charges ranging from serious felonies to petty violations. The individuals evaluated who were facing no current charges were referred by probation officers.

TABLE 6
DISTRIBUTION OF THE LEGAL OUTCOME OF THE CHARGES AGAINST THE EVALUATED INDIVIDUALS

	White Male	Nonwhite Male	White Female	Nonwhite Female	Total	(Percent)
Charges Dropped	11	9	5	2	27	(28%)
Jail	10	10	–	1	21	(22%)
Probation	7	6	1	1	15	(16%)
Conditional Discharge	9	3	–	–	12	(13%)
Family Court Action	5	–	3	–	8	(8%)
No Charges Pending	5	–	1	2	8	(8%)
Not Guilty Verdict	–	5	–	–	5	(5%)

Legal and Psychiatric Involvement. One way to divide the study population is to ask whether the legal or medical system has been delegated the responsibility by society of dealing with the individual's behavior (Table 7). Because individuals referred to the clinic have had some involvement with the law, it is not surprising that 34 (35%) had issues which were judged to be the responsibility of the legal system and only 11 (12%) had predominantly psychiatric problems. The majority of individuals in the study, 51(53%), had problems which concerned both law and medicine. In these cases, collaboration with and a knowledge of the criminal justice system was imperative because to passively answer legal questions would have been to ignore the significant part of the individuals' needs. We find that vigorously using the skills of social psychiatry and liaison-consultation psychiatry leads to useful results.

TABLE 7
DISTRIBUTION OF RESPONSIBILITY FOR INVOLVEMENT WITH THE EVALUATED INDIVIDUALS

	White Male	Nonwhite Male	White Female	Nonwhite Female	Total	(Percent)
Legal	10	18	3	3	34	(35%)
Psychiatric	7	3	1	–	11	(12%)
Legal and Psychiatric	30	12	6	3	51	(53%)

Discussion and Summary

Psychiatrists have a continuing interest in those individuals who break the law. The wish to provide comprehensive mental health care has led to an increase in attention paid to referrals from the legal system. In fact, the passage of the Community Mental Health Center Act of 1963 (PL 88-164) changes this wish from local custom to the national expectation; CMHC's are required to provide mental health consultation to the legal system. This investigation studies a population of people referred to a court clinic who were evaluated using a sociolegal psychiatric consultation strategy. The population is composed predominantly of young males. They tend to be diagnosed as "character disorder" or "no mental disorder" more often than the general psychiatric population and less often labelled as neurotic or suffering from organic brain syndrome. No systematic study of social class was performed but it is the authors' impression that the majority studied were from Hollingshead and Redlich's Social Class IV and V.[10] Although a majority of the referrals came from the courts, all areas of the criminal justice system made some referrals. In addition, on several occasions the individual or the family requested clinic evaluations. The county has a large number of mental health facilities but the clinic was chosen to complete the evaluation either because of the individual's lack of awareness of the resources or the family's inability to get the patient to agree to an evaluation in another setting.

Most of the referrals requested an investigation of the individual's need for psychiatric treatment. Even many of the requests for "legal reasons," *i.e.*, competency to stand trial, had the question of the individual's need for treatment as an ancillary concern. Treatment was indicated for nearly two-thirds of the evaluated individuals. Only a small percentage of the individuals were institutionalized, either hospitalized or sentenced to jail. The rest of the population was able to be followed on an outpatient basis.

The majority of individuals in the study were the continuing concern of both psychiatry and the law. These individuals engaged in behavior which the courts would not or could not ignore, and it was clear that these individuals could benefit from and wanted psychiatric treatment.

The sociolegal psychiatric consultation involves an important if subtle shift in the court clinic's function: from answering the courts' need to providing psychiatric evaluation and treatment to a population which may not have access to it or be

sophisticated enough to seek it out. To permit this active collaborative approach to develop, the psychiatrist must maintain credibility by being clinically competent and knowledgeable about the criminal justice system. The psychiatrist must have rapport with members of the legal system. The sociolegal psychiatric consultation has implications for mental health centers. Because most mental health centers are remote from the criminal justice system, they have a difficult time fulfilling the prerequisites for active collaboration. This remoteness impairs their ability to comply with their obligation to supply consultation to the criminal justice system. We have found that a clinic maintained jointly by the university and county can function satisfactorily. In other localities, the mental health center may designate personnel to be in close liaison with the courts. Because the utilization of mental health services is affected by distance and availability,[11] the mental health center may wish to establish a satellite clinic near the courts. In order to meet the special needs of the people referred by the courts, each community must devise a method which takes into account the community's particular resources and its special needs.

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