

Foreign report

Psychiatric court clinics in the United States

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The conditions endured by mentally disordered defendants remanded in custody have been the subject of mounting concern in England. The Home Office has issued guidelines which encourage the diversion of the mentally disordered from the criminal justice system whenever possible. In an attempt to reduce the number of custodial medical remands, new schemes have been set up which target the magistrates' court, instead of the remand prison, as the site for psychiatric assessment (Joseph & Potter, 1990; James & Hamilton, 1991). These schemes are in their infancy and currently suffer from a lack of funding and have yet to find general acceptance from hospital based psychiatric services.

In contrast, the practice of court based psychiatric assessment is well established in the United States. It is estimated there are approximately 250 court psychiatric clinics, corresponding to the number of major metropolitan areas in the United States (Keilitz, 1989). Recently I had the opportunity to visit three clinics in Baltimore, New York City, and Cambridge, Massachusetts in order to see how such clinics are administered and to learn from the American experience. The trip was funded by the Home Office.

Baltimore

In 1917, John Oliver, a young psychiatrist attached to Baltimore's Johns Hopkins Hospital, began to give advice to magistrates regarding the mental state of defendants appearing at the local court. Oliver was soon regularly visiting the court, sitting beside the magistrate on the bench as cases were being heard. As news of this innovative scheme spread, Oliver was invited to advise other magistrates' courts in Baltimore.

This informal arrangement continued for several years, during which time Oliver received a small salary, but had no office, secretary, or funds for purchasing materials. However, following judicial pressure, the Maryland State legislature passed a bill creating the Medical Service of the Supreme Bench of Baltimore City, which was headed by Oliver. He served as chief medical officer until 1930, when he was succeeded by Manfred Guttmacher, who headed

the clinic from 1930 until his death in 1966. During that time Guttmacher achieved international recognition as a forensic psychiatrist. After his death the tradition of leadership in the field of forensic psychiatry continued with Jonas Rappeport, the founder of the American Academy of Psychiatry and the Law (AAPL), who has held the position of chief medical officer of the Medical Service of the Circuit Court for Baltimore City, as it is now known, from 1967 to the present.

Today the clinic is situated in a suite of offices in the Clarence Mitchell Courthouse in downtown Baltimore. This is a circuit court which is similar to an English Crown Court. The clinic operates daily and offers a variety of psychiatric services to the court. These can be broadly divided into pre-trial screening, which consists of an evaluation of competency to stand trial; and pre- or post-sentence evaluations. Referrals are made by judges either at the time of first court appearance, which takes place at the arraignment court, when the issue of bail is considered, or subsequently, following a remand in custody, at the circuit court.

Following psychiatric assessment, if the psychiatrist or psychologist considers the defendant possibly incompetent to stand trial, based on criteria similar to those used in assessing fitness to plead, then there is a mandatory commitment to hospital for a full competency evaluation, for seven days in the first instance, but usually extended to three or four weeks. For those defendants charged with more serious offences, admission is to the State forensic facility, Perkins Hospital; others are admitted to the locked ward of the general psychiatric hospital.

I observed the assessment of a young black man who had been arrested for waving a placard with a nail on it at a policeman. He had been charged with assault with a deadly weapon. The interview was most notable for the fact that he was wearing handcuffs and legchains. He was clearly psychotic and arrangements were made for his immediate admission to hospital for competency evaluation.

For those defendants who do not require hospital admission, there is close liaison with community based facilities to organise treatment. In some

cases defendants will be met at the court house by community mental health workers in order to ensure contact is established.

The staff employed at the court clinic comprises psychiatrists, psychologists, social workers, secretaries and administrators. There is a separate staff for juvenile work. Trainees from each discipline rotate through the clinic and there is an extensive teaching programme. The clinic is funded by Maryland Department of Health and Mental Hygiene. Its annual budget is \$650,000, but the scheme is estimated to save the health department more than this by screening out those who do not require hospitalisation.

New York City

The forensic psychiatry clinic in Manhattan is an operating unit of the Department of Mental Health, Mental Retardation and Alcoholism services of the City of New York, providing mental health consultation services to the Criminal Court and the Supreme Court of the First Judicial District of the State of New York.

The clinic was created in the 1930s and is housed in the Supreme Court building which is situated in the heart of the judicial and administrative centre of Manhattan. Although referred to as the supreme court, this court in fact corresponds to the circuit court of Baltimore, i.e. it is equivalent to an English Crown Court, conducting jury trials of a wide variety of criminal cases.

The medical director of the clinic, Dr Richard Rosner, a forensic psychiatrist attached to the Department of Psychiatry at New York University School of Medicine, has been in post for 18 years. He told me that the clinic originally grew out of a therapeutic diversion project for teenagers. Its main aim now is to provide an alternative to the hospital-based evaluation services which had previously conducted all forensic examinations for the courts. This had resulted in the overcrowding of state mental hospitals by defendants whose competency to stand trial had been raised, even though many were not in need of hospital treatment. Thus the clinic screens out defendants who do not require hospital admission. The priority is to cut costs to the health service and not necessarily to reduce the time spent in custody.

The clinic receives approximately 1,500 referrals per year, half for competency evaluations and half for pre-sentence assessment. Most of the referrals have been arrested in Manhattan, taken to an arraignment court, and from there remanded to Riker's Island, the prison serving the city. According to Dr Rosner, this is the largest prison in the 'free' world, with an average daily population of 20,000

and 120,000 receptions per annum. Defendants are then brought to the clinic from the prison for assessment and if thought to be mentally incompetent, they are transported back to the prison and then to hospital. Admissions are either to the Kirby Forensic Psychiatric Centre, a State hospital, or to Belle Vue, the local city hospital. The time from arrest to hospital averages four weeks.

Dr Rosner stated that psychiatric assessments are rarely carried out at Riker's Island, as the prison is difficult to get to and the conditions unsuitable for psychiatric interviews. Nearly all assessments on incarcerated defendants, either for the prosecution or the defence, are carried out at the court clinic.

The staff consists of the medical director and an assistant medical director, both forensic psychiatrists, and six other psychiatrists, of whom a further two are forensic psychiatrists. There are two full-time psychologists, an administrator and eight secretaries. Although there are no social workers there are three para professional mental health workers. Surprisingly, probation officers are not represented, but their role has much more to do with law enforcement than in England and they have no social work training. One psychiatrist undergoing a forensic training programme is attached. There is also a teaching programme for medical students and interested medical practitioners. The budget is \$800,000 per annum paid for out of mental health funding and the clinic is currently undergoing a \$4 million refurbishment.

Cambridge, Massachusetts

The last clinic I visited differed from the previous two as it is situated in the Middlesex County Courthouse in Cambridge, a district court which conducts arraignments and is therefore an inferior court, similar to our magistrates' courts.

The clinic was established in 1954 and was the first fully operating psychiatric court clinic in the Commonwealth of Massachusetts. It provides mental health services to individuals in Cambridge and the neighbouring district of Somerville. It is affiliated to Cambridge Hospital and Harvard Medical School. Court clinics throughout Massachusetts have been based at district court level and 36 of the 94 courts in the Commonwealth have some clinic services.

The emphasis of this court clinic is on emergency work, namely responding to requests from the arraignment court for assessments of defendants making their first appearance. The case is put back for assessment which takes place within an hour of referral. The psychiatrist gives oral testimony in court. This model of working is identical to the new schemes attached to magistrates courts in Central

London. However the Cambridge clinic provides a daily service whereas the ones in London are only weekly.

There are 6,000 arraignments at the court each year from which the clinic receives 150 referrals, a figure similar to our experience in London. Of these, 25% are admitted directly to hospital, again similar to the London scheme (Joseph & Potter, 1990). In addition to emergency assessments the clinic carries out work for the juvenile and family courts. They also provide a civil commitment service which in contrast to the English procedure requires a judicial hearing.

For those defendants thought to be mentally incompetent to stand trial there is again a mandatory commitment to hospital for an initial 20 days with an option of a 20 day extension. Admissions are either to the forensic facility, Bridgewater State Hospital, or to the local hospital, and take place on the day of assessment. The police transport patients to and from hospital. There have been some tensions admitting patients to the local, non forensic hospital, owing to pressure on beds, but this has not resulted in delays or refusal of patients.

The medical director of the clinic is Dr James Beck, a forensic psychiatrist attached to Harvard Medical School. He heads a team consisting of a second forensic psychiatrists, one psychologist and three social workers. There are also two trainees from each discipline attached. Research is an important activity of the clinic.

Comment

The three clinics represent a tiny minority of court clinics in the United States and therefore conclusions about American court clinics in general cannot be made. Although there are differences between them, notably the Cambridge clinic which because of its situation in the district court most closely fits the model of court diversion schemes adopted in London, certain conclusions can be drawn which are applicable to them all.

- (a) The clinics are well established and are accepted by both criminal justice and health care systems as an appropriate forum for carrying out psychiatric assessments of mentally disordered defendants. They are preferred to prison based work which is considered time-consuming and less efficient, especially in Manhattan, where the prospect of assessing defendants at the prison on Riker's Island is viewed with horror.
- (b) The clinics are staffed by multidisciplinary teams consisting of psychiatrists, psychologists and social workers, or their equivalent, with secretarial and administrative staff. The

teams are led by experienced forensic psychiatrists who organise training programmes and research.

- (c) The aims of the clinics are two-fold; firstly, to provide an efficient and rapid psychiatric assessment service to the court which can facilitate access to psychiatric care for those who require it; secondly, to avoid unnecessary commitment to hospital of those defendants whose competence to stand trial is called into question by judges or lawyers. The emphasis of the three clinics varies as to which aim takes precedence. In Manhattan, the filtering out of potential hospital admissions take priority whereas in Cambridge the provision of an emergency service is stressed. The Baltimore clinic seems to steer a middle course between these two aims.
- (d) The relationship between the clinics and the hospitals to which they admit patients is shaped by the mandatory commitment laws which govern procedure for the mentally incompetent in all three states. Hospitals cannot refuse requests for admission or demand that they carry out their own pre-admission assessment. Prior to the formation of the clinics, the courts committed many defendants unnecessarily and the hospitals therefore welcome the screening carried out by the court psychiatrists even though they are not responsible for the patients' care in hospital.
- (e) Each clinic is funded out of mental health budgets. It is clearly recognised that they are part of mental health services and each clinic saves the hospitals money by reducing admissions. The impact on prison resources is not a matter of as much concern.

As Oliver sat with magistrates in Baltimore, Hamblin Smith pioneered a new unit in 1920 at Winson Green Prison in Birmingham, England providing medical reports for court on prison inmates, (Bowden, 1990). Had he chosen the court instead of the prison as the site for his new unit, the evolution of forensic psychiatry in this country might have proceeded differently. Both men started traditions and modes of practice which have persisted to this day; it may now be time to see court psychiatric clinics as a legitimate focus for the assessment of mentally disordered defendants, alongside the remand prison.

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A full list of references is available on request to the author.

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Clinical practice

Guidelines for the management of patients with generalised anxiety

A group of interested people met for two days last year in order to attempt to reach a consensus on good practice in the management of patients with generalised anxiety. The result of their efforts is published below.

Most patients presenting with anxiety, whether acute or chronic, mild or severe, were until recently treated with tranquillisers. Recognition that these drugs can cause dependence in some patients has prompted a re-evaluation of the pharmacological management of anxiety and the value of non-pharmacological treatments is now recognised. Uncertainty remains among many doctors about the efficacy of the whole range of current therapies and the place of the new classes of drugs for anxiety. However, research findings are now accruing which indicate the relative merits of these various therapies, and clarify the principles on which they are based.

The following guidelines are a consensus of the views of interested and experienced psychiatrists, general practitioners and clinical psychologists (list at end) on today's management of patients with generalised anxiety. They are not intended as rules which dictate clinical practice but as a description of the possible alternatives and their place in a balanced management plan.

It is recognised that the availability of services varies throughout the country and that local circumstances and limitations on resources often determine what treatments can realistically be offered. Nonetheless, we believe it is desirable at this time to suggest a management plan which includes the optimal treatments for people with generalised anxiety.

Description of generalised anxiety

A range of disorders come under the heading of Anxiety Disorders (see Table 1). We concentrate on the commonest, Generalised Anxiety Disorder.

These guidelines focus on the management of generalised anxiety which is defined as 'apprehensive expectation about two or more life circumstances.' Worry is the main symptom and somatic, affective, cognitive and behavioural symptoms of anxiety vary according to person and context. Bodily symptoms are often prominent and may greatly alarm the patient, magnifying the anxiety. Generalised anxiety disorder is persistent with secondary characteristics which may include depression, low self-confidence, demoralisation and social anxiety. These may increase if the anxiety is untreated. Common reactions to the problem include counter-productive ways of minimising symptoms, such as avoidance, over-dependence on others and hypochondriasis, which contribute to the maintenance of the problem. Secondary depression often resolves when the anxiety is successfully treated but primary depression requires specific treatment.

Generalised anxiety disorder is a fluctuating condition which may co-exist with, or develop into, other types of anxiety such as phobias or panic disorder for which specific methods of treatment are available; when more than one type of anxiety is present the disorders should be separately treated.