

Establishing a Law and Psychiatry Clinic

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INTRODUCTION

Psychiatry¹ and law are interdependent to an extent exceeded by few other pairs of professions.² As a result, psychiatrists and other mental health professionals (“MHPs”) can wield tremendous power in legal settings. In their Law and Psychiatry Clinic, William Mitchell College of Law and the Department of Psychiatry of the University of Minnesota School of Medicine work at the boundaries of their fields. By adopting a centralized and integrated model for interdisciplinary clinical education, the clinic allows both professions to gain professional and cross-professional competence and

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1. In this Article, we focus mainly on psychiatrists and psychiatry, though other professionals (e.g., psychologists and social workers) can, and often do fill the same forensic roles that we discuss. We think that much of what we say could be applicable to forensic training for these other professionals, and occasionally in the Article we refer to the entire group as mental health professionals, or MHPs.

2. See generally MICHAEL L. PERLIN, 2 MENTAL DISABILITY LAW: CIVIL AND CRIMINAL (2d ed. 1999). Psychiatrists provide critical testimony in a variety of sensitive legal contexts, see, e.g., Eric S. Janus, *The Use of Social Science and Medicine in Sex Offender Commitment*, 23 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 347, 368-69 (1997) (describing central role for psychiatry in sexually violent predator proceedings), and the law sets important standards in the practice of psychiatry. Further, in some significant part of their work, psychiatrists also rely on the coercion of the law—or the threat thereof—to accomplish their professional treatment goals. See, e.g., Bruce J. Winick, *Coercion and Mental Health Treatment*, 74 DENV. U. L. REV. 1145 (1997).

understanding. Given the determinative role often played by psychiatry in law, the clinic hopes that its work will lead to more transparency and mindfulness in the use of psychiatric expertise, and therefrom, to an increase in the quality of justice.

We begin with a brief description of the development of the clinic, describing its functioning and the particular structure we have adopted for it. We then turn to the educational objectives of the clinic, which leads to our discussion of implementation problems. After offering some evaluative comments about the clinic, we close by discussing the ways in which it might contribute to an increase in justice.

I. THE HISTORY AND DEVELOPMENT OF THE CLINIC

A. An Informal Survey of Forensic Training for Psychiatric Residents

Psychiatric residency is a post-M.D., four-year program aimed mainly at developing proficiency at diagnosing and treating individuals with mental illness. Though the Accreditation Council for Graduate Medical Education (“ACGME”) requires that psychiatric residency training programs include certain medical-legal or forensic topics³ (e.g., confidentiality and privacy, malpractice, and involuntary commitment and forced treatment), residency programs show great variability in the type of training that they offer in this area.

A search of the MEDLINE database reveals a wide range of approaches to forensic psychiatry training—from self-training through reading to structured programs consisting of didactic and practical training throughout residency, and other variations in between. The training is offered in a variety of educational programs, including medical schools, general psychiatry residency programs, forensic psychiatry subspecialty programs, and advanced training for practicing psychiatrists.

3. See ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC., PROGRAM REQUIREMENTS FOR RESIDENCY TRAINING IN PSYCHIATRY 22-23 (effective Jan. 2001), at <http://www.acgme.org/req/400pr101.pdf> (on file with the Washington University Journal of Law & Policy) (requiring knowledge “of relevant issues in forensic psychiatry” and “[e]xperience under the supervision of a psychiatrist in evaluation of patients with forensic problems”).

Most of the literature supports the need to provide training that utilizes both a didactic curriculum and supervised clinical experience. The topics covered, however, vary widely depending upon the type and length of programs. Most courses appear to cover some mental health law-specific issues, such as civil commitment, competence to stand trial, and the insanity defense, as well as more general topics, such as medical malpractice, informed consent, and confidentiality.⁴ The length of programs also varies widely—from fewer than ten hours to full four-year seminars.

In 1995, Marrocco et al. conducted a survey of all 191 psychiatry residency programs.⁵ The response rate was 78.5%.⁶ Ninety-five percent of those responding reported that they provided some teaching in forensic psychiatry.⁷ However, such training consisted of fewer than ten hours in almost half of the programs.⁸ In addition, the majority of forensic rotations were optional.⁹ The most common forensic rotation settings included forensic inpatient units, prisons or jails, court clinics, and private or state hospitals.¹⁰ The survey concluded that “most programs are providing exposure; however, some programs barely meet the criteria for ACGME accreditation, whereas others appear to fall below the ACGME requirements.”¹¹

Among the most extensive forensic curriculum is that reported by the University of Oregon for its general psychiatry residency program.¹² There, first and second year residents on emergency room and acute intensive care psychiatric treatment services attend weekly seminars. The program starts with a didactic lecture in the first seminar, and moves on to a presentation of cases involving forensic

4. See, e.g., Ronald Schouten, *Law and Psychiatry: What Should Our Residents Learn?*, 9 HARV. REV. PSYCHIATRY 136-38 (2001) (advocating a curriculum consisting of an introduction to the legal system, informed consent, right to refuse treatment, civil commitment, violence risk assessment, confidentiality, duty to protect third parties, and boundary violations).

5. Mary K. Marrocco et al., *Teaching Forensic Psychiatry to Psychiatric Residents*, 23 BULL. AM. ACAD. PSYCHIATRY LAW 83 (1995).

6. *Id.* at 85.

7. *Id.* at 90.

8. *Id.* at 89.

9. *Id.* at 85.

10. *Id.* at 86.

11. *Id.* at 89.

12. Joseph D. Bloom et al., *Residency Curriculum in Forensic Psychiatry*, 137 AM. J. PSYCHIATRY 730 (1980).

issues during subsequent classes.¹³ “Residents are [also] encouraged to attend civil commitment hearings as observers.”¹⁴ During the third year of residency, the training program offers eight didactic lectures on forensic psychiatry, some of which are co-taught with law school faculty. Third-year residents also participate as court examiners in a community psychiatry training program.¹⁵ In the fourth year, residents are offered opportunities to participate in electives that include hands-on experience with a public defender’s office, correctional facility, or family court services.¹⁶ Other programs use mock trials, describing them as “valuable” and “useful for teaching health and mental health professionals not only about the interface between medicine and the law, but also about many ethical and clinical issues.”¹⁷ Finally, some programs include collaboration with other mental health professionals in their forensic training.¹⁸

B. Organizing the Law and Psychiatry Clinic

Like many others, the University of Minnesota’s psychiatric residency program lacked a systematic way to offer residents exposure beyond the basics of forensic practice. To remedy this situation, in early 1999, Dr. Thomas Stapleton, an experienced forensic psychiatrist and supervisor of the forensic component for the residency program, approached Professor John Sonsteng of William Mitchell College of Law with a proposal to run a joint educational program for both law students and psychiatric residents. An agreement to operate an inter-institutional clinic was signed by the two institutions in early fall 1999.

In its original conception, the students for the clinic would consist of third-year psychiatric residents and fifth-year child psychiatry fellows from the Department of Psychiatry, as well as law students

13. *Id.* at 731.

14. *Id.*

15. *Id.*

16. *Id.* at 731-32.

17. Stewart Levine & Henry Pinsker, *The Mock Trial in Psychiatric Staff Education*, 22 BULL. AM. ACAD. PSYCHIATRY & LAW 127, 127 (1994).

18. Thomas Grisso, *The Differences Between Forensic Psychiatry and Forensic Psychology*, 21 BULL. AM. ACAD. PSYCHIATRY & LAW 133, 141 (1993).

from William Mitchell. Each institution would provide an instructor, and these two faculty members would serve as the “co-directors” of the clinic. Though the instructors would be “cross-appointed” to the adjunct or clinical faculty of the other institution, there would be no exchange of money and each institution would pay its own staff. Similarly, each institution would evaluate and give credit to its own students for their participation in the clinic.

Under the original plan, the law school would provide outreach to lawyers and courts, seeking referrals of cases requiring a mental health evaluation in a legal setting. The clinic directors would screen the referred cases and jointly select appropriate cases for the clinic’s students. The law students would serve as “law clerks” for the referring lawyer or judge, while the residents, under the teaching psychiatrist’s supervision, would perform the actual forensic evaluation of the client. The psychiatrists would write a report and, if necessary, testify in court. Thus, as will be described more fully below, the two professions would work independently, but in parallel, on the clinic cases.

The clinic began operation in mid-fall semester of 1999. Three law students and three psychiatric residents were first supervised by William Mitchell Professor Eric Janus, Dr. Stapleton, and Dr. Jonathan Jensen, an associate professor of Child and Adolescent Psychiatry at the Department of Psychiatry. As the clinic began operation, several aspects of the original plan changed. The most significant change developed as we attempted to work out what role the law students would play in the clinic. As we worked on this issue, we came to see the pedagogical value in a centralized (rather than distributed) model for the clinic. Under a *distributed* model, the “clinic” is a collection of relatively isolated students and supervisors, working on cases in a variety of places and times, and coming together in a “seminar” to talk about their work. In the *centralized* model that we came to adopt, the clinic becomes a time and a place where the work is done with the participation, or at least observation, of all the members of the clinic.

We came to see the clinic in this way because we needed to address the role of the law students early on. As indicated, under the original plan, the law students were to be assigned to work as “law clerks” with the lawyers or judges who referred cases to the clinic for

evaluation. The lawyers would therefore be responsible for supervising the work of the law students. Pedagogically, the law students' experience would be akin to an externship, where the focus of the learning experience is assumed to be the interaction with the field supervisor.¹⁹

This model had two deficiencies. First, as discussed in more detail below, we realized that this model might introduce an undesirable set of incongruent roles into the clinic. Second, we felt that the "externship" aspect of this structure would tend to bifurcate the focus of the clinic. In other words, the law students would feel that their "real" work was with their assigned lawyers in the external law office, while the "real" work of the residents would be with their supervising psychiatrists in the "exam room." Instead, we wanted the principal focus of the clinic to be the interface between the two professions. We wanted law students to experience the inside of the psychiatric method of approaching problems, and vice versa.

Our thinking led us to restructure the program in an effort to locate the "clinic" *within* the cross-disciplinary relationship, rather than *outside* of it. The new structure required a change in perspective for the law school. Instead of pairing a law clinic with a medical clinic, the new structure much more clearly would be a medical clinic. The principal product of the clinic would be forensic psychiatry examinations, and not legal representation. Thus, the clinic would not constitute a "multidisciplinary practice," as defined by the ABA Commission on Multidisciplinary Practice, because it would not "deliver legal services" to a client.²⁰ The law students (and

19. See Margaret Martin Barry, *Clinical Supervision: Walking That Fine Line*, 2 CLINICAL L. REV. 137, 165 (1995) ("Central to the clinic experience is the relationship between supervisor and student.").

20. See J. Michael Norwood & Alan Paterson, *Problem Solving in a Multidisciplinary Environment? Must Ethics Get in the Way of Holistic Services?*, 9 CLINICAL L. REV. 337, 342 (2002). The ABA Commission on Multidisciplinary Practice for the purposes of its Final Report defined an MDP as:

a partnership, professional corporation, or other association or entity that includes lawyers and nonlawyers and has as one, but not all, of its purposes the delivery of legal services to a client(s) other than the multidisciplinary practice itself or that holds itself out to the public as providing nonlegal, as well as legal, services.

Id. (quoting the ABA Commission on Multidisciplinary Practice Report and Recommendation, available at <http://www.abanet.org/cpr/mdpfinalrep2000.html> (on file with the Washington

law professors) would be adjunct to, or supportive of, the mental health professional's role. By placing the law students inside the medical clinic, rather than outside, our aim was to encourage the law and psychiatry groups to work together to understand the questions that the law asks and to develop answers based on the forensic evidence.

C. The Clinic's Current Functioning

The clinic is, as we write this Article, in its fourth year of operation. We regularly enroll four or five law students and about the same number of residents. The enrollment period is one semester. The clinic is a required rotation for residents, but a two-credit elective for law students. Usually, one of the residents is a Child and Adolescent Fellow, undergoing a period of sub-specialization after the normal psychiatry residency. We meet weekly at the law school for about 3 to 3-1/2 hours. When this Article was written in the spring of 2003, the faculty for the clinic consisted of the two co-authors, two other psychiatrists who attended regularly (Drs. Thomas Stapleton and Jonathan Jensen), a neuropsychologist (Dr. Donna Minter), and several faculty members who attended several sessions per semester to teach specialized areas (e.g., Professor John Sonsteng and Dr. William Orr).

The clinic aims to accept three or four cases each semester. Once or twice per year, we distribute a brochure describing the clinic's services to courts and public defenders. The most reliable source of cases has been public defender offices. Several cases have been brought directly by members of the faculty, and several cases have come on referral from the psychiatry clinic at the University of Minnesota's affiliated hospital. In general, these latter cases have involved clients who either had no lawyers or else were working independently of their lawyers. We tend to be wary of these lawyerless cases because of the increased potential for ambiguity regarding the nature of the questions being asked and the client's expectations regarding the role of the clinic.²¹

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21. As forensic examiners, the psychiatrists in the clinic do not enter into a treatment role

Requests for clinic services are channeled to one of the co-authors, Professor Janus. He performs an initial screening and, if the case looks suitable, asks for a referral letter setting out the nature of the consultation desired and requesting as complete a set of documentation as possible. Upon receipt, we distribute copies of the file to the clinic faculty. At the next meeting, the group discusses the case and decides whether to accept it. Though the faculty dominates these case-acceptance discussions, the entire clinic is present when they are conducted. The discussions focus on whether the clinic has the capacity to handle the case, whether it would be pedagogically useful, and whether our services might assist the client.

When a case is accepted, we assign it to a team, generally consisting of two law students and a resident. The law students have several responsibilities. They act as liaisons to the referring attorney, working with him or her to ensure that the clinic has full documentation on the case and that the legal context for the referral is clear. We expect the law students to write a memorandum, directed to the resident, setting out the legal context and outlining the facts of the case. Further, they must understand the legal context and help the residents to develop an understanding of the legal concepts that are central in the case. Finally, the law students are instructed to become the experts on the facts of the case.

After the case is accepted at the general clinic meeting, the interdisciplinary team meets and confers on the case. Working together, the team prepares to present the case to the clinic, outlining the legal context and questions presented, as well as the clinical history of the client. Then, in a discussion facilitated by one of the faculty, the members of the clinic jointly discuss the case. The object of the joint discussion is to develop a plan for the evaluation based on an understanding of the questions posed by the legal system and the factual circumstances of the case as presented by available documentation. The law students set a time for the client interview and make logistical arrangements.

For educational reasons, we want all members of the clinic to

with our clients. In several cases, the psychiatrists have felt that the absence of an attorney to mediate the relationship with the client might result in unfounded, and potentially harmful, client expectations of the nature of the help that the clinic could furnish.

observe the interview of the client. When we first opened the clinic, we sought and obtained client consent for all members of the clinic to be present during interviews. More recently, we have been using closed-circuit television. The resident and her or his supervisor are in the room with the client, while the remaining members of the clinic observe on a television from an adjacent room. While many of the interviews are conducted at the law school, a substantial number of clients are in custody, requiring that the interviews be conducted off-campus at the custodial facility.

Following the interview, the clinic often meets with the referring attorney for an initial debriefing, and then begins the process of formulating its report. These post-interview meetings have been the most stimulating aspect of the clinic's work. They often involve participation by all members of the clinic, as the group attempts to fit psychiatric observations and evaluations into the legal framework. It is in these meetings that the critical and difficult questions of professional role are closest to the surface and are most directly discussed.

Of course, the essence of clinical pedagogy is that these discussions cannot be merely abstract and indeterminate, but rather must resolve into concrete action. Through the process of discussion, the group arrives at a consensus position. The resident then drafts a report, which is reviewed by the supervisors and the group, finalized, and sent to the referring attorney. Where the clinic's position is unfavorable to the client, the attorney may instruct the clinic to close the case without writing a report.²² In a small percentage of cases, the resident (or supervising psychiatrist) has been called to testify in court.

About one-third of clinic class hours are devoted to "didactic" lectures and discussions on the law-psychiatry boundary and the problems of translation at the boundary, the specific areas of law (e.g., criminal responsibility) that our cases are likely to touch upon, fundamentals of trial advocacy skills (with a focus on expert witnesses), and the role of a forensic examiner (with particular emphasis on how the forensic role differs from the therapeutic role to

22. This has occurred on at least one occasion.

which psychiatrists are accustomed). The clinic visits a mental health court to observe a forensic evaluation and the ensuing testimony by faculty member Dr. William Orr, an experienced forensic psychiatrist. Finally, the students perform a direct and cross-examination exercise based upon one of the clinic's cases from that semester, or on a case related to the one observed in court.

During its four years of operation, the clinic has handled twenty-two cases. In all but one case, a resident and supervising psychiatrist conducted an evaluation of the client and prepared a forensic report. In one instance, only an initial draft report was provided. In three cases, members of the clinic performed psychological testing. Clinic psychiatrists testified in court in four of the cases.

The clinic typically completed cases within a period of one to four months. On a few occasions, however, a case spilled over into the next semester, and one even required attention for a couple of years. The clinic evaluated a wide age range of individuals. There were five juveniles (ranging in age from ten to seventeen). Four of the juveniles' cases involved serious criminal matters, and one involved a dispositional question in a CHIPS case. The remaining seventeen clients were adults, with the oldest being seventy-seven.

The clinic provided evaluations for both civil and criminal matters. Of the twenty-two cases handled, seven involved civil matters.²³ The other fifteen cases involved criminal or quasi-criminal matters.²⁴

In addition to the twenty-two cases handled by the clinic, we received requests for service in twenty-five matters that were not handled to completion. Most of these were rejected after an initial review by clinic faculty, who determined that they were too complex, presented too vague a legal question, required too much time, or could not be completed in the time requested. In a handful of cases, the client no longer needed clinic services. The following chart summarizes the clinic cases.

23. The civil matters included foster care placement, failure to pay child support, civil commitment for mental illness, child custody, and capacity to give informed consent.

24. The criminal matters included commitments as mentally ill and dangerous or sexually dangerous persons, placement disposition in juvenile adjudication, certification to adult court, competency to stand trial, criminal sexual conduct, dangerousness, and legal responsibility.

Table 1

Cases in which a forensic evaluation was completed	Number
Criminal	
Competency	2
NGRI	2
Disposition	3
Civil commitment	5
Juvenile court proceedings	
Delinquency	4
CHIPS	1
Family court	2
Other	3
Total evaluations	22
Cases not completed by clinic	
Rejected by clinic	16
Client withdrew	7
Total cases	45

II. EDUCATIONAL OBJECTIVES

As noted earlier, this clinic aims its pedagogical focus at the border area between law and psychiatry. We can divide our objectives into those aimed primarily at the residents, those aimed at the law students, and the joint goals aimed equally at both. The existence of professionally disparate agendas might suggest some inefficiency in our “centralized” clinic format, as doctors are required to listen to the legal content and law students are required to listen to the medical content. However, our perspective, borne out by experience, is that each profession benefits from the inside view of how the other looks at a common issue.

A. Educational Objectives Aimed Specifically at the Residents

The primary educational goal for the residents is to understand how their role within the legal setting compares with the role to which they are accustomed as a psychiatrist providing treatment to patients in clinical settings. Both roles are rooted in the practice of

medicine; the role of the forensic examiner, however, does not involve treatment, and thus requires a different framework in which to perform the tasks of evaluation and case formulation necessary in the legal context.

Like most sophisticated professional roles, the normal work of the psychiatrist is nuanced, characterized by values and constraints that are, at times, mutually incommensurate. Though the primary ethic underlying their work is patient care, psychiatrists often must negotiate the balance between respecting patient autonomy, protecting patients from their own incompetent decisions, and protecting the public from the potential for danger caused by their patients.²⁵ Nonetheless, the central focus of general psychiatry is to “care for” and “do no harm to” patients.

In the forensic role, the usual relief-of-suffering and do-no-harm ethics, while still present, assume a secondary role in the relationship between the evaluatee and the psychiatrist.²⁶ The difference in roles is reflected most apparently in nomenclature: in the forensic context, the subject of the psychiatrist’s attention is referred to as “client” or “evaluatee,” rather than “patient.” More subtly, the ethics of forensic psychiatry, while rooted in the same fundamental medical ethics as the treating psychiatrist’s, take on a different hue. Issues such as confidentiality, informed consent, honesty, and objectivity all become the emphasis of the psychiatrist’s working relationship with the evaluatee and the referring attorney. While these principles are also part of the practice of medicine, the fact that the evaluation is performed in a forensic setting changes the entire framework for the doctor-patient interaction.

Most challenging and fundamental for residents to understand is that their role as a forensic examiner is no longer to “take care of” the

25. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 261-62, 272-73 (4th ed. 1994) (describing principles of autonomy, beneficence, and utility).

26. See Thomas G. Gutheil, *Ethics and Forensic Psychiatry*, in *PSYCHIATRIC ETHICS* 346 (Sidney Bloch et al. eds., 3d ed. 1999) (describing the “profound ethical implications” in the forensic setting of the “altered relationship between the psychiatrist and the object of psychiatric attention. For the general psychiatrist, that relationship is the traditional one of doctor and patient, wherein the customary duties, obligations, and standards apply, as in general medicine. In most forms of forensic psychiatry, however, the doctor-patient relationship does not apply; rather, the relevant relationship is ‘examiner-examinee’ or ‘evaluator-evaluee’ . . .”).

evaluate's psychiatric needs. Their primary obligation is to objectivity; the legal questions often have little or nothing to do with the client's psychiatric needs or best interests. Rather, the focus of forensic evaluation is often the safety of the public or of third parties, such as minor children. Even when the question focuses more centrally on the client's best interests (e.g., whether the client is competent to make his or her own medical decisions), the presence of the court as an audience disrupts the normal primacy of the doctor-patient relationship. In fact, in their function as retained or appointed expert witnesses, the doctors have no obligation, or even authority, to "take care of" the client. For young professionals who have spent years learning to treat therapeutically the real suffering of their mentally ill patients, the shift to a forensic role can be wrenching.

Equally challenging questions of professional ethics arise in the so-called "dual-role" situations that psychiatrists sometimes confront.²⁷ These arise when a treating psychiatrist invokes the coercive power of the state, or else is asked to become a witness respecting his or her own patient. In either situation, the therapeutic alliance that is the cornerstone of the doctor-patient relationship can be severely strained.

The clinic addresses the implications of both the forensic examiner and the dual-role situations. Both are characterized by a shift from an ethic of care to a fidelity to honesty and objectivity in an adversarial context. Despite the appealing definitiveness of these values, adherence to them poses fundamental questions and forms the most important aspect of our clinic's teaching objectives, a subject to which we return below.

Although the priority of the clinic is to have real-life cases that give the residents experience in the actual performance of forensic evaluations, we teach certain core topics more didactically through lectures. The challenge for the staff is to balance the real caseload with didactics, such that the residents are given enough core

27. See THOMAS G. GUTHEIL & PAUL S. APPELBAUM, *CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW* 285-90 (3d ed. 2000); Robert D. Miller, *Ethical Issues Involved in the Dual Role of Treater and Evaluator*, in *ETHICAL PRACTICE IN PSYCHAITRY AND THE LAW* 129-50 (Richard Rosner & Robert Weinstock eds., 1990).

educational material both to satisfy their residency requirements²⁸ and to educate them on topics important to their roles as general psychiatrists. For example, the rules of informed consent and confidentiality are modified in the forensic setting. Residents learn that they must inform the client that the information discussed will not remain private as it would if they were treating them as patients, and that the information will be disclosed in a report prepared by the resident. Further, they learn that obtaining thorough information both from the evaluatee and from collateral sources is crucial to reaching an informed opinion. Other areas covered by didactic lecture and discussion include psychiatric malpractice, expert witness testimony, the evaluation of the child in a forensic setting, civil commitment, guardianship, criminal competency, and insanity.

An important area of instruction that bridges didactical and clinical teaching concerns the preparation of the forensic report, which differs in some fundamental ways from the notes residents are accustomed to preparing in a therapeutic setting. Emphasis is placed on imparting information in an organized and thorough report that creates a narrative picture of the evaluatee, supports the psychiatric opinion, and addresses the questions relevant to the legal context.²⁹ This requires identifying, understanding, and ultimately answering questions that are inherently legal. In contrast, general psychiatry focuses on how best to address the psychiatric issues presented by the patient in a therapeutic way. Equally important, the residents must understand that the report is used in an advocacy setting that differs substantially from the collaborative context of the medical clinic. Respect for principles of procedural due process, as well as for the potential of vigorous cross-examination, requires more thorough documentation of the basis for, and forthrightness about the limitations of the residents' opinions than are normally involved in a clinical note.³⁰

28. See ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC., *supra* note 3 and accompanying text.

29. Robert Weinstock et al., *Forensic Psychiatric Report Writing*, in PRINCIPLES AND PRACTICE OF FORENSIC PSYCHIATRY 30-33 (Richard Rosner ed., 1994).

30. See, e.g., Comm. on Ethical Guidelines for Forensic Psychologists, *Specialty Guidelines for Forensic Psychologists*, 15 LAW & HUM. BEHAV. 655, 661 (1991) (emphasizing the need for careful documentation to support the opinions of forensic psychologists).

The clinic strives to have every resident prepare at least one report. For the rare case that actually requires the testimony of the clinic, the assigned resident is afforded an opportunity to testify under the direct supervision of a clinic staff psychiatrist. The staff psychiatrists are also available to testify, if needed, because the residents' novice status may provide cross-examination fodder for the opposing side. Because most of our cases do not require testimony, however, the clinic performs an exercise in which the law students examine and cross-examine the residents in a mock trial setting. A lecture on trial practice teaches some basic principles for coping with this peculiar format for presenting information. The mock trial affords the residents, who are in the process of becoming acculturated to the physician's top-of-the-food-chain status, the simple but critical lesson that the judge, not the doctor, occupies that high spot in the courtroom.

In addition to lectures and casework, the residents have a unique opportunity to question forensic psychiatrists and attorneys on issues and clinical dilemmas that they face in their role as resident psychiatrists. The clinic provides one of the few opportunities for the residents literally to have hours both to observe evaluations performed by other professionals and to have their own interviews observed and critiqued. Because medical training continually struggles with time and the availability of adequate supervision, the clinic offers a rare supervisory and, for some residents, mentoring experience.

B. Educational Objectives Aimed Specifically at Law Students

The central objective for the law student is to begin understanding and demystifying the powerful role that forensic mental health experts play in the legal system, and to begin developing the skills necessary to exert appropriate and ethical control, or at least influence, over the process for the benefit of future clients. It is fair to say that many lawyers and judges operate with a *New Yorker*-cartoon prototype for psychiatrists: a goateed older male "psychoanalyst," sitting beside the reclining patient, probing dreams to discover unconscious explanations for the patient's neurotic behaviors. Under this stereotyped image, the psychiatrist embarks on a "journey into a

patient's mind,"³¹ a metaphor that suggests an unattainable and almost mystical form of knowledge.

In contrast to this image, law students learn that a great deal of the work of forensic psychiatry is concrete and observable, relying heavily on "history"—past accounts concerning the client—and first-person observations of the client. Many of the questions psychiatrists seek to answer are relatively concrete as well. Courts want to know about a person's level of functioning, his or her capacity to perform certain legally critical functions, and his or her risk of future dangerous behavior. Of course, psychiatrists make "clinical judgments," which often exhibit a certain opacity, apparently springing whole from the exercise of "expertise." But even these judgments—on questions, for example, of risk assessment and treatment amenability—are rather concrete. As an example, in one recent case, the residents opined whether a fourteen-year-old who killed a peer could be successfully (and safely) treated in the remaining seven years of the juvenile court's jurisdiction.

We would like our law students to learn not that the demystified psychiatrist has no expertise, but rather that such expertise is grounded in the real world. It is based on facts that are equally accessible to law students, and is therefore within the realm of understanding attainable by those in the legal profession. By witnessing (and participating in) the gathering of facts and the formulation of judgments, the law students see that psychiatric evaluations are, in many ways, just like legal interviews—designed to gather facts and to judge emotions, credibility, and other non-verbal information. Law students also see that there is skill involved in psychiatric interviewing comparable to that in conducting lawyer interviews. The supervising psychiatrists are much more skilled than the residents not because of some mysterious knowledge, but rather for the same reason that experienced lawyers are better than beginners: because they have practiced and developed a more nuanced set of skills in communication and judging human behavior.

31. *People v. Stoll*, 783 P.2d 698 (1989) ("No precise legal rules dictate the proper basis for an expert's journey into a patient's mind to make judgments about his behavior." (internal citation omitted)).

Along the same lines, the clinic also seeks to show law students the immense power that psychiatrists can exercise in legal settings. This power arises in part from the habitual attribution to psychiatrists of the mystical, inexplicable expertise discussed above. However, another equally robust source of power is the interpretive and evaluative role that forensic psychiatrists often play, a topic to which we shall return later in this Article.

In addition to these big-picture lessons about mental health professionals, we also aim for our law students to learn concrete lessons about working with forensic experts. These lessons include the importance of obtaining complete documentation about the client and effectively organizing the often massive pile of paperwork involved.³² Just as the residents may learn about the reality of the courtroom, the law students begin to learn about the logistics of working with experts, such as the acrobatics necessary in scheduling an expert's scarce (and potentially expensive) time while dealing with the uncertainties and delays in court schedules. We also give the law students a taste of both the relevant law and the trial skills involved in examining and cross-examining experts. Both of these topics, however, are covered more fully in other courses.

C. Joint Educational Objectives

The central educational objective for all participants in the clinic is to understand the role forensic psychiatrists play in the courtroom, so that the power they exercise is more visible, more clearly understood, more mindfully exercised, and, ultimately, more shared. Though this power often touches individual autonomy and physical liberty, it is largely obscured by the opacity of professional or clinical "judgment." A major goal of the clinic is to expose the sources of this power and the power's mechanisms so that all involved can be more mindful of its exercise. A second and related goal is to facilitate a fuller understanding of the notion of "objectivity" for forensic

32. For example, the clinic students may prepare linear timelines of critical events or trace the "genealogies" of critical historical reports about the client. The ultimate goal is to gain some command over the extensive files.

psychiatrists, and how objectivity and, more broadly, professional integrity fit into the inherently adversarial context of litigation.

We identify four sources of the power of MHPs in the legal system. First, as we have mentioned, is the clinical nature of their expertise. That is, their professional judgments are produced, at bottom, by an opaque application of “education, experience, and training.”³³ The claim that psychiatry is “art” and not “science” is a sophisticated way of disclaiming the need to cite a scientific or other falsifiable foundation for one’s conclusions.³⁴

The second source of power arises from the MHP’s opportunity to apply a set of highly consequential and categorical labels to the client. These are labels that carry legal consequences; they are heavily loaded with legal and/or value content. Examples include “responsible,” “competent,” “able,” “willing,” “dangerous,” and their opposites (as well as their variants, because these categories are dimensional rather than bimodal). The application of these labels entails at least implicit thresholds or cut points.³⁵ An MHP must determine, for example, at precisely what level of functioning the label “able,” rather than “unable,” applies. On a more complicated plane, MHPs must often translate and apply concepts that have deep philosophical ambiguity, such as “inability to control” one’s behavior. Examiners are asked, for example, to determine whether an individual was *unable* to work, or simply *unwilling*, which often requires characterizing the dysfunctions of an individual as either “mental disorders” (i.e., not under the person’s control) or character flaws (for which we hold people responsible).³⁶ These judgments are

33. See Eric S. Janus & Robert A. Prentky, *Forensic Use of Actuarial Risk Assessment with Sex Offenders: Accuracy, Admissibility and Accountability*, 40 AM. CRIM. L. REV. (forthcoming 2003).

34. *Compare* *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 152 (1999) (requiring trial judge to check the reliability of expert clinical testimony), *with* *People v. Ward*, 83 Cal. Rptr. 2d 828, 831 (Cal. Ct. App. 1999) (refusing to apply admissibility tests “to expert medical testimony, such as a psychiatrist’s prediction of future dangerousness or a diagnosis of mental illness”), *and* *Westerheide v. State*, 767 So. 2d 637, 657 (Fla. Dist. Ct. App. 2000), *aff’d*, 831 So.2d. 91 (Fla. 2002).

35. John Monahan & Henry J. Steadman, *Violent Storms and Violent People: How Meteorology Can Inform Risk Communication in Mental Health Law*, 51 AM. PSYCHOLOGIST 931, 934 (1996).

36. Eric S. Janus, *Sex Offender Commitments and the ‘Inability to Control’—Developing Legal Standards and a Behavioral Vocabulary for an Elusive Concept*, in 2 THE SEXUAL

as much about values as they are about psychology. For example, some mental health professionals view substance dependence problems as somewhat of a character flaw or a “lack of moral fiber” problem, and thus do not see the condition as a mental health disability.³⁷

One particularly difficult case illustrates this aspect of the MHP’s power. The clinic was retained by the public defender of a fourteen-year-old boy accused of murder. The question was whether the boy should be tried in juvenile court or “waived” to adult court. We clarified the legal context for the question: if he was adjudicated in the juvenile system, he would most likely be contained in a rehabilitation setting until age twenty-one, at which point he would be released without supervision; if transferred to the adult system, upon conviction he would be confined for a much longer period of time. The core of the question presented to the clinic was whether the juvenile system would provide sufficient protection for the public. To answer the question, the clinic examined the client’s prior violence, illicit drug use, previous behavior during treatment attempts, educational achievements, family setting, emotional development, role within both his family and his peers, and, finally, his remorse and motivation concerning the crime.

From a therapeutic perspective, the juvenile system more adequately would have met our client’s social and emotional needs. From a humanistic perspective, many people in the clinic felt strongly about the possibility of redemption for such a young boy. However, the key question was public safety, which required us to opine whether, after seven years of juvenile system treatment, he would be “safe enough” to release. This issue, in turn, involved a rather indefinite but complex calculus that combined estimates of the likelihood and severity of violence seven or more years into the future, with an ill-defined threshold of how much risk the public should tolerate. In the end, the clinic decided that it could not write a report supporting the boy’s bid to stay in juvenile court because the

PREDATOR: LEGAL ISSUES, CLINICAL ISSUES, SPECIAL SITUATIONS 1-1, at 1-2 to 1-4 (Anita Schlank ed., 2001).

37. See generally Michael Corrado, *Addiction and Causation*, 37 SAN DIEGO L. REV. 913 (2000).

risk of future severe violence was “too high.” This simple conclusion masked a set of judgments not only about the shape of the boy’s future behavior, but also about the appropriate public tolerance for risk and the possibility of redemption for such a young boy.

Thirdly, MHPs can deploy the power of narrative, constructing and telling a coherent story that explains or predicts the client’s behavior. Professor Slobogin refers to this as giving “voice” to the individual, and suggests that “criminal defendants should have a special entitlement to tell their stories using mental health professionals.”³⁸ This storytelling, in turn, helps to give content to the categorical judgments of ability, control, responsibility, and competency. For example, the clinic evaluated a thirty-five-year-old man accused of breaking into a restaurant in the small town where he lived. The man’s lawyer thought he was only marginally competent, but had been unable to obtain a sympathetic mental health evaluation of the client. The man, who was unemployed and still lived with his elderly parents, had been in and out of prison throughout his adult life. He was shunned in the town, universally called by a demeaning name, and received no social services. Through interviews, psychological testing, and record reviews, the clinic was able to construct a picture of this man that related his behavior to mental retardation and the absence of appropriate habilitative services. The clinic’s written report convinced the prosecuting attorney to agree to a diversion from the criminal system to an appropriate habilitation program for persons with mental retardation. The evaluation created a coherent narrative in which the client’s antisocial behavior was, in an important sense, not his fault.

The fourth source of power is the forensic MHP’s claim to “objectivity.” Though professional guidelines recognize the pressures of the adversarial system, they clearly insist that forensic MHP’s “adhere to the principle of honesty” and “strive for objectivity.”³⁹

38. Christopher Slobogin, *Doubts About Daubert: Psychiatric Anecdotes as a Case Study*, 57 WASH. & LEE L. REV. 919, 922-23, 922 n.23 (2000) (describing forensic mental health evaluations as potentially giving “voice” to clients).

39. AMERICAN ACAD. OF PSYCHIATRY & THE LAW, ETHICAL GUIDELINES FOR THE PRACTICE OF FORENSIC PSYCHIATRY pt. 4 cmt., available at <http://www.emory.edu/AAPL/ethics.htm> (last visited Sept. 14, 2003) (noting the “special hazards” presented by the adversarial system, exposing “the forensic psychiatrist to the potential for unintended bias and

This claim to honesty and objectivity enhances the power of MHPs by implying an inevitability about the MHPs' opinions—that they are discovering, rather than constructing, truth.

Yet it is clear that advocacy, or at least a point of view, is inevitable in the forensic testimony of MHPs. Of course, MHPs are in part permitted and expected to be advocates for the truth, or even advocates for their own conclusions, although even this form of advocacy is limited by witnesses' obligation to present their findings and opinions in a "fair manner."⁴⁰ But this form of advocacy does not fully describe the contingent, chosen aspect of MHPs' forensic opinions. A significant part of an MHP's evaluation requires the deployment of value-laden, yet ill-defined, concepts; the construction of narrative requires the MHP to choose and then impose a particular meaning on the events of a person's life.

Significantly, the psychiatric residents instinctively feel that there is room for some form of advocacy other than their own ("objective") professional opinion. As they talk out loud in the clinic about their roles, the residents often express two separate self-admonitions: on the one hand, they are clear about their need to be "objective" but, on the other, they express the desire to "help this client to the extent that we can."⁴¹

Our goal in the clinic is to expose this somewhat paradoxical nature of forensic psychiatry, which strives for objectivity and honesty, yet at the same time inevitably has a point of view, and therefore maintains some room for advocacy. At a very basic level, we distinguish among the several distinct roles the MHPs can play as forensic experts. In some settings, MHPs are *appointed* by the court; in others, they are retained as *non-testifying litigation consultants*. These two roles are in some sense the purest: in the first, objectivity and neutrality are clearly required, though even here the apparent purity of the role may mask substantial indeterminacy in the commands of objectivity and neutrality. In the second, vigorous

the danger of distortion of their opinion.").

40. Comm. on Ethical Guidelines for Forensic Psychologists, *supra* note 30, at 664.

41. Interestingly, the advocacy sentiment generally arises after meeting with the client, and seems to be a combination of the ethic of care that doctors generally exhibit in their therapeutic roles with an awareness that they are working for the individual's advocate.

assistance in the retaining attorney's partisan advocacy is the plain and appropriate role.

Finally, a third role has MHPs designated or retained by one party or the other as a *testifying witness*. This role characterizes most of the cases in the clinic. It is also the most ambiguous and difficult role because it requires objectivity in a setting that has clear overtones of advocacy.

We teach that objectivity is a central value, but one that takes up only some of the MHP's work. Advocacy fills in part of the remaining space, but is understood as bounded or constrained by the objectivity. In order to see how these two roles coexist, we note that expert testimony by MHPs is a multi-layered construct. At its most concrete foundation are observable and historical "facts." In a second layer, MHPs describe those facts in terms of psychological constructs (e.g., remorse, control, mental abilities or impairments, diagnoses). Thirdly, they make judgments and interpretations (narratives) about those constructs (e.g., assessing risk of violence, diagnosing a personality as "disordered," ascribing causal relationships between behaviors and psychological constructs). Finally, they translate those constructs and judgments into legal categories (e.g., "incompetent," "dangerous," "unable to distinguish right from wrong").

Objectivity entails being straightforward and complete about the "facts," and acting with professional integrity about the psychiatric diagnosing or labeling.⁴² The interpretation and judgment that constitute the advocacy role are constrained because they must be coherent and consistent with the "objective" facts and psychiatric conclusions. Importantly, MHPs are instructed to maintain a clear demarcation between the objective and the interpretive.⁴³ Within those constraints, however, MHPs are free to attempt to construct a

42. See, e.g., Comm. on Ethical Guidelines for Forensic Psychologists, *supra* note 30, at 661 (stating that the forensic psychologist "maintains professional integrity by examining the issue at hand from all reasonable perspectives, actively seeking information that will differentially test plausible rival hypotheses.").

43. See, e.g., AMERICAN ACAD. OF PSYCHIATRY & THE LAW, *supra* note 39, at pt. 4 cmt. (stating that forensic psychiatrists ought to "communicate the honesty and striving for objectivity of their work, efforts to obtain objectivity, and the soundness of their clinical opinion by distinguishing, to the extent possible, between verified and unverified information as well as among clinical 'facts', [sic] 'inferences' and 'impressions.'").

narrative that is helpful for the client.

We teach this framework not simply as an abstraction; rather, many evaluations require the clinic to negotiate the boundaries between objectivity, interpretation, and advocacy. Our job as teachers is to insist that the tangled questions of, for example, “ability” or “willingness” or “control” be untangled, so that those parts that are contingent and subject to construction are separated from those that are “facts” or psychiatric truths *not* subject to construction.

By exposing this duality in forensic work, our aim is two-fold. In part, we hope that our law students will, as lawyers, have an increased ability to subject forensic psychiatry to the control of law. Equally important, we think that the process of ascription and narration are just as opaque to the residents as they are to the law students. By working to give some transparency to these processes, we hope that the residents, as practicing psychiatrists, will bring more mindfulness and clarity when they inevitably cross from objectivity to interpretation and advocacy.

III. CHALLENGES TO IMPLEMENTATION

A. Clinic Structure and Professional Role Clarification

The current structure of the clinic reflects two key decisions regarding professional roles and pedagogical methods. First, as we have noted, the pedagogical concern determined the professional role decision. Because our key teaching objective is to explore the boundary between law and psychiatry, we decided to position our clinic inside of that boundary area rather than outside of it. This led us to adopt a structure in which the medical role would be preeminent. Second, to take full advantage of our “insider” perspective, we adopted a centralized, rather than dispersed, pedagogical model for the clinic.

Presentations at the recent conference, “Promoting Justice Through Interdisciplinary Teaching, Practice, and Scholarship,”⁴⁴ revealed three potential structures for interdisciplinary clinical work:

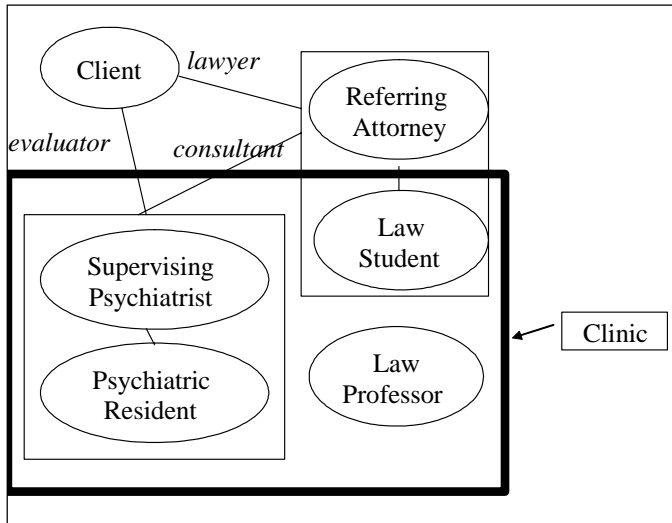
44. Washington University School of Law, March 13-15, 2003. Sponsored by the Clinical Education Program and the Center for Interdisciplinary Studies.

unified, parallel-collaborative, and single-umbrella-adjunctive. Although we will not explore these three in detail, a short explanation might help to situate our clinic's structure.

Under the *unified* structure, law practitioners (i.e., lawyers and law students) and other professionals (e.g., city planners) work in equal partnership within a single organizational framework with a unified relationship to the client. They freely share information and work towards mutually determined goals. Under the *parallel-collaborative* structure, law practitioners and other professionals similarly work on behalf of the same client. They coordinate and collaborate on their work and refer clients to each other; however, each profession retains a separate relationship with the client and separate rules about role and confidentiality. Under the *single-umbrella-adjunctive* structure, one profession establishes the primary relationship with the client, while the other operates under the primary profession's umbrella, serving, in a sense, in a consultant or adjunct role.

As indicated above, we spent some time trying to decide and to clarify what professional role(s) our clinic and its students would be taking. In the end, we decided on a single-umbrella-adjunctive structure, in which the medical role would be preeminent and law students and lawyers would act, in a sense, within that medical role. Although during the clinic's development we did not have the benefit of such a clear typology, in hindsight it is plain that we considered and rejected the other two structural models. At the bottom of our choice were our thoughts about pedagogy: we wanted the view of the clinic to be from *within* the intersection of law and psychiatry, not from the outside of that boundary area. This suggested either a unified or a single-umbrella structure. We rejected the unified structure because we saw the potential for role incongruity, and perhaps conflict if we attempted to combine the roles of psychiatrist-examiner and lawyer-advocate in the same clinical structure.

As previously indicated, we began by imagining that the law students would work as law clerks or interns with the referring lawyers, while the residents and their supervising psychiatrists worked together to perform the evaluations. The residents and law students might then meet together in a clinic class, as suggested in the diagram for Model I, below.

Model I

We quickly understood that the two professional roles represented in this model, psychiatrist-examiner and lawyer-advocate, entailed disparate obligations, and thus our model could not be what we have called a “unified” interdisciplinary structure.

Model I would have implicated three types of relationships within the structure of the clinic: (1) the lawyer-client relationship, (2) the lawyer-consultant relationship, and (3) the forensic evaluator relationship. The lawyer-client relationship at least potentially entails obligations that are different from, and perhaps inconsistent with the other two.

For example, though the forensic evaluator relationship entails a duty of confidentiality with respect to client information,⁴⁵ there is probably no doctor-patient privilege because the relationship is not established for purposes of treatment.⁴⁶ As a consultant to an attorney, the medical professional has some ability to protect

45. See, e.g., AMERICAN ACAD. OF PSYCHIATRY & THE LAW, *supra* note 39, at pt. 2 (stating that “[t]he psychiatrist maintains confidentiality to the extent possible given the legal context.”).

46. JOHN W. STRONG ET AL., MCCORMICK ON EVIDENCE § 99 (5th ed. 1999).

information, but the information ultimately may be discoverable.⁴⁷ In contrast, the law student, as law clerk to the attorney, would have the benefit of attorney-client confidentiality.⁴⁸ Key conflicts would include mandatory reporting obligations and the duty to protect obligations, both of which apply to doctors but not lawyers.⁴⁹ In addition, the potential discoverability of conversations between the law student and the psychiatrist would require the law student to make rather sophisticated decisions about which parts of the case to discuss in the clinic and which parts to withhold. Thus, under Model I, the two potentially incompatible confidentiality schemas might require rather sophisticated and persistent attention to the limits of information sharing *within* the functioning of the clinic.⁵⁰

Model I also would have added two somewhat different ways of negotiating the limits of advocacy into the clinic. As discussed above, forensic psychiatrists have a duty to strive for objectivity, but there appears to be some room for a form of advocacy within that role.⁵¹ Nonetheless, advocacy is not at the center of the psychiatric role. In contrast, advocacy *is* at the center of the lawyer's role, although even

47. 8 CHARLES ALAN WRIGHT & ARTHUR R. MILLER, FEDERAL PRACTICE AND PROCEDURE §§ 2029, 2031.1 (2d ed. 1984) (Federal Rule of Civil Procedure 26 generally requires disclosure of an expert's name and opinion, as well as any written data provided to the expert when retained by counsel for trial); WAYNE R. LAFAVE ET AL., CRIMINAL PROCEDURE § 20.3(f) (2003) (Federal Rule of Criminal Procedure 16 (and most state discovery provisions) require disclosure of written, and sometimes oral, reports from medical examinations when expert retained by counsel for trial).

48. See MODEL RULES OF PROF'L CONDUCT R. 5.3 (2001) [hereinafter ABA MODEL RULES] (imposing duty to ensure conduct of nonlawyer assistants is compatible with professional obligations).

49. *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 343 (Cal. 1976) (a doctor has a legal obligation to warn a third party when patient presents a serious danger if a "special relationship," such as doctor-patient relationship, exists). Compare Richard Barnu, *Managing Risk and Confidentiality in Clinical Encounters with Children and Families*, in CONFIDENTIALITY VERSUS THE DUTY TO PROTECT: FORESEEABLE HARM IN THE PRACTICE OF PSYCHIATRY 81 (James C. Beck ed., 1990) (reports of child abuse may supersede confidentiality obligations; however, jurisdictions may differ in situations where information is not obtained in treatment relationship), with ABA MODEL RULES, *supra* note 48, at R. 1.6(b)(1) (lawyer *may* reveal confidential information if he or she reasonably believes it necessary to prevent a client from committing a criminal act that the lawyer believes is likely to result in imminent death or substantial bodily harm).

50. See, e.g., Norwood & Paterson, *supra* note 20, at 354 (describing conflicting requirements for confidentiality, and resulting arms-length relationship between legal and social work community centers).

51. *Supra* notes 26-27 and accompanying text.

for lawyers, advocacy is bounded by considerations of honesty and the constraints of the law.⁵² Lawyers may need or wish to take positions that push the bounds of advocacy further than would be comfortable for psychiatrists.

For example, when the issue is risk to the public, a psychiatrist may strike a balance that is more conservative than the referring lawyer would prefer. After all, the psychiatrists are testifying about safety issues. Their judgments on those issues certainly fall, at least to a certain extent, in the “fact-psychological conclusion” area, rather than in the advocacy area. Understandably, they may feel more cautious in interpreting the facts and setting implicit risk-thresholds than lawyers would. Lawyers and psychiatrists simply have different professional outlooks, their reputations are at stake in different ways, and pronouncements of each are viewed differently by courts.⁵³

All of these factors lead them to adopt divergent views on how much advocacy can shape what they say to courts. The short of the matter is that sometimes psychiatrists will not or cannot say what lawyers want for them to say. To have the lawyer (via his or her law student or clerk) and the psychiatrist in the same clinic would have produced a negotiation between arms-length participants. In the structure ultimately adopted, the clinic is able to approach problems as a team. Though there are disagreements, these arise from different judgments, rather than from different professional roles.

Finally, Model I would have posed a problem for residents who were called to testify in court. Recall that this structure places the psychiatrist and the retaining attorney’s law clerk in the same clinic. Especially if we had adopted a “unified” structure, this association might have compromised the courtroom credibility of the psychiatrist

52. Compare ABA MODEL RULES, *supra* note 48, at R. 3.3 (2001), with *id.* at pmb1., para. 7 (lawyer can be a zealous advocate for client interests within adversary system and be assured that justice will result).

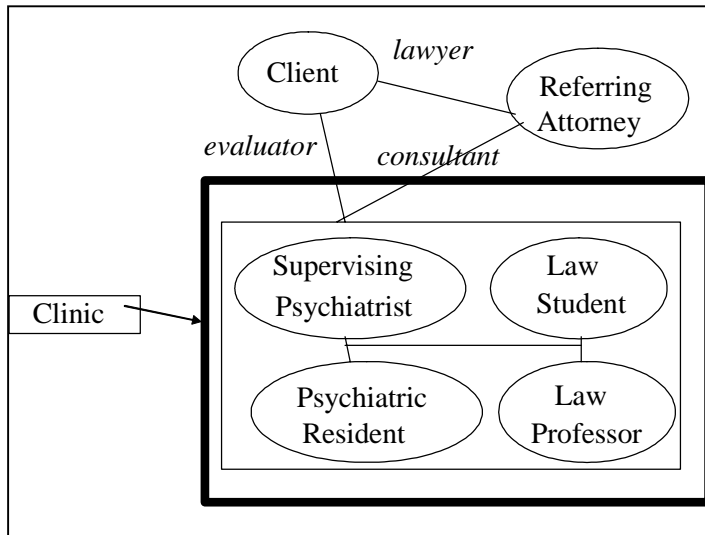
53. See, e.g., Thomas R. Litwack & Louis B. Schlesinger, *Assessing and Predicting Violence: Research, Law, and Applications*, in HANDBOOK OF FORENSIC PSYCHOLOGY 233 (Irving B. Weiner & Allen K. Hess eds., 1987) (“[O]verprediction [of violence] may occur because mental health professionals are extremely fearful of the grave consequences of a false-negative prediction and are determined to be cautious.”); Fenna H. Poletiek, *How Psychiatrists and Judges Assess the Dangerousness of Persons with Mental Illness: An ‘Expertise Bias,’* 20 BEHAV. SCI. & L. 19 (2002) (reporting that Dutch judges and doctors ascribe different meanings to the term “dangerous” in a civil commitment context).

by suggesting that the attorney and the psychiatrist had the same relationship with the client, and that the psychiatrist shared the attorney's advocacy goals.

Thus, if we used Model I, it would necessarily be under the second of our basic structures, parallel-collaborative, given the rather substantial differences between the professional roles involved. However, the parallel-collaborative model appeared to conflict with our educational objectives. We wanted both professions to be on the inside of the professional border area, experiencing in a direct way the nuanced power of the forensic MHP in the context of the legal system. The parallel-collaborative model would not provide that insider's view because it requires an arms-length interaction between the law practitioners and the psychiatrists.

For this reason, we turned to Model II, a single-umbrella-adjunctive model, in which the law students and law professor operate under the auspices of the psychiatric role. This allows both professions to be on the same team, fully sharing information and professional roles.

Model II



Having determined the professional-role structure of the clinic, we turned to pedagogical structure. Here, again, it may be helpful to construct a simple typology of pedagogical structures for clinics. Without belaboring the point, we suggest that clinics adopt either a distributed or a centralized approach to pedagogy. In the distributed approach, the clinic is understood as a *course* (like Contracts or Civil Procedure) that consists of class or seminar meetings and a variety of out-of-class activities. The bulk of the actual clinical work (interviewing and counseling clients, appearing in court, etc.) takes place outside of class. The class time is devoted mainly to learning skills and discussing and reflecting upon the out-of-class work (though some of the “primary” work of the clinic, such as planning, might take place during the class).⁵⁴ In the centralized model, the clinic is understood as a *time and place* for the entire membership of the clinic to gather and do most of the work of the clinic. Under this model, all members of the clinic participate in or observe most of the work. The work of the clinic and the reflection on that work are intermixed.

We have adopted the centralized model for our clinic. In this way, the law students directly experience the process of constructing a forensic opinion, and the residents see themselves and their process through the eyes of the law students, as the latter reflect on and participate in psychiatrists’ work. For us, the clinic *is* the group, meeting at a certain time and a certain place. The clinic performs the interview, debates the approach, edits the report, etc. The work is done, for the most part, in the clinic.

In some ways, this clinical structure is akin to an idealized model of medical education rather than a legal education. The medical clinic is where the work gets done, where it is supervised, and where it is reflected upon. Our clinic adopts the kind of direct teaching and mentoring that characterizes the relationship between resident and

54. See, e.g., Norwood & Paterson, *supra* note 20, at 363-64 (describing multi-disciplinary case simulations designed to enhance interdisciplinary collaboration by teaching “the professional cultures or mindsets” of each of the participating professional groups, noting that this format “had the positive effect of enhancing team problem-solving skills by using case simulations without risking harm to an actual client.”).

attending physician—a combination of watching, doing, getting feedback, and doing again.

B. Melding the Legal and Medical Educational Programs and Cultures

Medical and legal educations both seek to produce professional practitioners, but they approach their educational tasks very differently. This is not the place for a thorough discussion or evaluation of those differences; we simply note that the psychiatric residency program is a post-M.D. program and that it is largely clinical. Our residents are in their third (or, for some, their fifth) year of post-M.D. training. During their residency, residents work, under supervision, in real clinical settings with increasing levels of responsibility. They are not “in school”; their days are fully booked with “clinics” at which they have responsibility (under supervision) for real patients with serious problems. The law students, in contrast, are pre-J.D. students, who are in school full- or part-time. Law school, even at the higher levels, is essentially comprised of classroom education. Wisely or not, clinical education is interstitial.

This thumbnail sketch of the two different forms of education is enough to provide context for our discussion of the challenges in melding the two into a single clinic. The most striking observation to us is that the law students and residents, though all still learning their professions, are at very different levels of professional development. Having been practicing for about four years longer than the law students, the residents seem professionally more confident and mature than the law students.⁵⁵ In addition, the residents are accustomed to the kind of professional give-and-take that is part of their everyday work, in which they interact on real matters of consequence with their senior colleagues. Law students, on the other hand, are still in “student” mode, accustomed to receiving instruction

55. This informal observation is corroborated by comparing “before and after” self-appraisals of residents and law students. As described more fully below, clinic participants are asked to estimate their proficiency in various areas of law and psychiatry knowledge. Despite the fact that these areas of knowledge bridge the two professions, the residents’ self-appraisals are consistently higher than those of the law students on comparable areas of knowledge. See *infra* Appendix.

from their professors and bosses, rather than interacting collegially with professional peers.

When the clinic was new, this disparity seemed to produce a dynamic that left too little room for the law students. Clinic meetings would generate vigorous conversations about our cases, but the participants were only the faculty (both law and medical) and residents. Though the law students reported that they found the conversations fascinating, they were observers and not participants. More recently, we have addressed this problem in several ways. First, we explicitly acknowledge it during the initial class session, and in a separate meeting with only the law students. Second, as discussions proceed, we stop to make space for law students to participate. Third, and in our opinion most important, we have placed more emphasis on the interdisciplinary teams. We think that as the law students and residents have worked more closely together in these small groups, the law students have found their voice to a greater extent.

C. Time, Supervision, and Quality Control

There are several consequences of the choice of structure. The most positive, we think, is that all members of the clinic are either observers or participants in most aspects of each case. This collaborative approach, with vigorous and broad discussion, produces a stimulating learning environment. Students work, watch, reflect, and evaluate; each of these is helpful to learning. Our centralized method probably permits students to see and participate in a greater range of cases and styles than they would if we followed a more classic distributed approach.

There are, of course, shortcomings to the centralized approach. Chief among these is the shortage of time. We devote major portions of at least three clinic meetings to each case (initial discussion, evaluation, and debriefing). With four cases per semester, this means that there is little time left over for lecturing. In addition, if it turns out that a case is more complex than we first thought, it is difficult to devote any additional time to it.

A central issue for time and supervision concerns the balance between the clinic's educational goals and its professional and service-provision obligations. In general, we place the educational

function on an equal footing with our obligation to provide professional service, which has meant that the residents take primary responsibility for the interview and for drafting the report. In several cases, however, where we felt that the needs of the client required it, supervising MHPs took primary responsibility for either or both aspects. Educational opportunity was not lost in these cases, of course, because students had an opportunity to observe high-quality work. In many ways, the product produced in these cases was also superior to that produced when students had the primary responsibility; at the very least, it was produced more efficiently. Nevertheless, we have generally maintained the primacy of the resident's role under supervision when his or her proficiency level has matched a case's needs.

Another problem in implementation regarding quality and supervision concerns the communication between the clinic and the referring attorney. The supervising law professor establishes contact and initiates communications with the attorney. After the case is accepted by the clinic, the law students act as liaisons to the attorney. The residents and supervising psychiatrists, however, are rarely in direct communication with the attorneys. As indicated, we have adopted this arrangement for pedagogical purposes.

For many of our cases, this arrangement has proved educationally suitable and adequate to support the development of our forensic evaluations. In one particular case, however, this attenuated communication protocol probably contributed to several problems. In this case, the referring attorneys were unclear about what question they wanted the clinic to answer; they simply conveyed that they wanted help, and that part of the help was determining whether and how a psychiatric evaluation might assist the client's case. Under normal circumstances, this lack of clarity as to the ultimate questions to be answered would be handled through direct discussion and negotiations between the lawyers and the psychiatrist, most likely at the time of the psychiatrist's retention. In our setting, the discussions took place through the law students and, for that reason, were neither nimble nor nuanced. Although we did schedule direct face-to-face discussions with the attorneys involved in the case, we had some trouble getting entirely clear directions about which questions we

were answering and whether we were competent to address those questions.

As a final note, we relate two additional challenges. A problem arising out of the structure of the clinic is a rather lugubrious and inflexible timeline. Since it is the full “clinic” that does the work, we operate in one-week increments. While we disclose this limitation to referring attorneys, it does make it more difficult to nimbly change course when we discover more about a case. Second, as with any collaboratively taught clinic, our supervisors sometimes have divergent approaches and opinions about our cases. In these situations, the residents and law students have learned through observation how different experts manage the fine line between objectivity and advocacy.

D. The Ethics of “Using” Clients for Educational Purposes

All “live-client” clinical programs are grounded in the ethically problematic dual nature of their programs—on the one hand, they provide services (legal or medical); on the other, they provide education. The education seeks to serve the student and is not, at least in the immediate sense, in direct service of the client’s or patient’s interests.⁵⁶ Our clinic shares this problematic foundation.

Arguably, we exacerbate this ethical tension by asking our clients to consent to having the entire clinic observe the psychiatric interview.⁵⁷ In most circumstances, the observers are not present in the examination room,⁵⁸ but in others (particularly those in which the client is in custody and the interview is in a jail or treatment facility), the observers are present in the interview room.

We address this issue in several ways. First, we obtain consent to the observation from both the client and the client’s attorney. In discussing the referral with the attorney, we explain that having

56. See Ann Juergens, *Teach Your Students Well: Valuing Clients in the Law School Clinic*, 2 CORNELL J.L. & PUB. POL’Y 339, 340-41 (1993).

57. As an aside, it is interesting to note that the psychologist on our faculty will not allow observers when she is administering psychological tests because the standardization of these tests does not allow it.

58. As indicated, they watch over closed-circuit television with a non-obtrusive, wall-mounted camera transmitting the picture and sound to the next room.

observers is part of the educational method of the clinic, and that we prefer to have, but do not insist on, permission to have observers. We also obtain consent from the client at the beginning of the interview. Second, as mentioned, we use closed-circuit television to reduce the intrusive quality of the observation. Third, as a clinic, we periodically discuss the practice both as a general matter and also as it pertains to specific clients.

We can make several observations about this ethical dilemma. Almost all of our clients have consented to observation.⁵⁹ There are several possible explanations for the high rate of consent. One is that referring attorneys know about the educational aspect of the clinic (from our brochure), and thus seek our assistance only when their clients are amenable to observation. A second is that clients (and their attorneys) feel some pressure to consent because they need the evaluation and think that we will be more likely to assist if there is consent.⁶⁰ The third possibility is that some clients are pleased to be able to give something back in exchange for their free evaluation. This was certainly the case with one client, who came for his interview and requested a private discussion with the supervising psychiatrist and lawyer before beginning the interview. He questioned us at some length about the nature of the clinic and the reasons for the observers. In the end, he consented to observation and explained that he was glad he could help young professionals in their education.

In discussions within the clinic of the ethics of allowing observation, the psychiatrists have made three general observations. First, having observers in evaluations is part of the culture of the teaching hospital and therefore is not, as a matter of principle, ethically or professionally questionable. Second, the psychiatrists view the interview as an opportunity to observe the client, as well as to gather information from him or her. They acknowledge that observers may produce some increase in discomfort for the client, but

59. The only exception was a situation in which one of the supervising psychiatrists was a court-appointed examiner, who had inquired whether clinic members could sit in on the exam. The client's lawyer agreed, but only for one or two clinic members.

60. This theory would explain why the one non-consenter was a client who would receive his court-appointed evaluation independently of the clinic and had no need to please us.

view such discomfort as a potentially useful tool in understanding the client. They feel that they can sense if the discomfort is excessive and exclude observers if necessary, and also believe that the remote camera setup has significantly decreased the potential for evaluatee discomfort. Third, the psychiatrists distinguish between evaluations conducted at the law school and those that are performed in an institution. They note that the situation posing the highest risk is the “open setting” of the law school evaluation. The law school is neither a hospital nor a medical setting, where clinical assistance would be available immediately. Thus, the psychiatrists are cautious in this setting because our evaluatees are not known by or in treatment with any of the psychiatrists. They feel, however, that the remote camera has helped decrease the likelihood of such potential crisis situations. The “on the road” evaluations, where members of the clinic travel to an institution such as a courthouse or juvenile detention facility, provide more controlled settings with more support available in the event that the evaluatee experiences discomfort.

Finally, we note that several features of forensic evaluations make the observation of the interviews less ethically problematic. First, at least in some settings under Minnesota practice, counsel and adverse MHPs sit in on evaluation interviews.⁶¹ Second, because of the critical place that evaluations play in some legal settings, the desirability of preserving some sort of record of the evaluation diminishes the expectation, or at least the possibility, of privacy. Some commentators urge audio- or video-taping forensic examinations in order to preserve this information,⁶² a practice which is no less intrusive than our closed-circuit viewing arrangement.

IV. EVALUATION

We have approached the clinic as a work in progress, and have sought to learn from our experiences each semester. Gradually, we have moved to a more explicitly structured format. We have treated

61. MINN. STAT. § 253B.07, subd. 5 (1998) (providing that counsel may be present during examination).

62. See AAPL Task Force, *Videotaping of Forensic Psychiatric Evaluations*, 27 J. AM. ACAD. PSYCHIATRY & L. 345, 345 (1999).

the clinic as a collectively taught course, and have moved by consensus among the law and medical supervisors.

Student feedback regarding the course has, in general, been positive, although we have collected formal evaluations from students only during the past two semesters. Students from both disciplines report that the clinic has improved their knowledge and skills in a variety of areas.⁶³ The most common suggestions from students were that law students desired more detailed instruction about what they should be doing, and residents sought more explicit instruction about how to write a forensic report. Though both of these areas have been addressed in early clinic meetings, this feedback suggests that more intense and consistent instruction and supervision on these topics are necessary.

These student comments are congruent with observations by supervisors about areas needing improvement. Despite what we thought was clear instruction about the role of law students, some did not become experts on the facts and law of the cases to which they were assigned. We think that individual and periodic meetings between the supervisor and law students on each team, where clear tasks are jointly developed, would help in this area. Similarly, we explicitly address writing a forensic report and hand out exemplars of such reports. To some extent, attendance by residents at the clinic has been spotty, and this may explain why some (who evidently missed this initial lecture) may have felt that they needed more instruction about writing reports. On the other hand, forensic reports are substantially different from the type of reports residents are accustomed to writing, and so we may need clearer, more consistently available instruction on this unique form of report-writing.

63. See *infra* Appendix, for a summary of the Fall 2002 evaluations. The one evaluation prior to Fall 2002 yielded less useful information and is not summarized here. It did not inquire about student progress in curricular objectives, and used disparate formats for the two professional groups.

V. CONCLUSION: CONNECTION TO JUSTICE

As we have discussed, our clinic has evolved to adopt a particular form of interdisciplinary clinical education. Using a single-umbrella-adjunctive approach with a centralized clinical format, we attempt to expose emerging professionals to a more transparent view of forensic psychiatry.

We think that our clinic contributes to the advancement of justice in several ways. First, and most directly, we are providing a service that has helped a number of low-income clients, who otherwise would not have had the opportunity to retain a psychiatric consultant. Second, we believe that justice works better when skill levels are higher. By helping psychiatrists to understand the legal system, and helping lawyers to understand psychiatric evaluations, justice is more likely to be achieved.

At a more abstract level, we aim to make the role and power of forensic psychiatric witnesses more transparent, so that the power may be more mindfully exercised, and attorneys—and hence, the legal system—will have more control over its exercise. Courts exercise the power of the State, and the role of the law is to express and apply the social policy judgments of the State. By making the role of forensic psychiatrists clearer, we hope to expose the nature of the judgments they make, and to facilitate legal-system control of those judgments that entail social policy issues. We aim to make the narrative or “voice-giving” role of forensic psychiatrists more obvious and accessible. In this way, forensic psychiatrists can help courts to see a client in a narrative context, which gives voice to the client’s own story of his or her life.

As we have suggested, the forensic role walks a very sensitive and nuanced edge between neutrality and objectivity on the one hand, and advocacy on the other. By helping both psychiatrists and lawyers to understand this role in its complexity, we hope that the quality of justice will improve.

APPENDIX

All participants in the Fall 2002 Law and Psychiatry Clinic completed an evaluation questionnaire after participating in the clinic. Respondents were asked to estimate their level of professional knowledge before and after the Law and Psychiatry Clinic. They were instructed to use the following 5-point scale:

1	2	3	4	5
No substantive knowledge		Adequate knowledge to handle a routine case under supervision		Professional level knowledge, able to handle complex cases under minimal supervision

The following table lists the average proficiency scores for each group of students. Since the questionnaires were filled in after students completed the clinic, scores in the “before” columns indicate students’ estimates of their pre-clinic proficiency in each area of knowledge.

	Psychiatric Residents		Law Students	
	Before	After	Before	After
Area of Knowledge				
Mental illness civil commitment	2.5	3.87	1.2	3
Involuntary treatment of mentally ill persons	3.25	4	1.2	2.75
Criminal law: competency to stand trial	2.25	3.5	1.75	3.25
Criminal law: not guilty by reason of mental illness	2	3.5	2	3.25
Forensic assessment of juveniles	2.25	3.75	1	2.75
Juvenile court proceedings	1.75	3.1	1	2.25
Assessment of sex offenders	1.5	3.25	1	3.25
Sex offender commitments	1.5	2.75	1	3.6
Medical malpractice	2.5	3.5	2	2.75

Giving or dealing with forensic testimony in a trial	2	3.75	1.75	3
Writing or interpreting a "forensic report"	1.6	3.6	1.5	3
The role, in the legal system, of a "forensic psychiatric evaluation"	1.75	4	1.75	3.75
The ways in which the professions of law and psychiatry interact in the legal system	2	4.25	2.25	4
Effective ways of interacting with psychiatrists/lawyers	2	4.1	1.75	3.75