# Final Report of the National Institute of Mental Health (NIMH) Ad Hoc Forensic Advisory Panel

*September 28, 1987*

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## Executive Summary

### Background

In April 1987, the National Institute of Mental Health (NIMH) selected an Ad Hoc Forensic Advisory Panel to review the policies and procedures governing the St. Elizabeths Hospital Forensic Division. The Panel, chaired by Loren H. Roth, M.D., M.P.H., Professor of Psychiatry and Director of the Law and Psychiatry Program at the University of Pittsburgh School of Medicine, included 7 mental health and legal experts with extensive knowledge and understanding of relevant legal and patient-care issues. St. Elizabeths Hospital is now a Federal facility, but will be turned over to the District of Columbia government October 1.

While the Panel addressed questions raised by recent court proceedings and hearings related to a proposed unescorted Easter pass for presidential assailant, John W. Hinckley, Jr., the Panel's work focused on the general policies and procedures with respect to requests for changes in patient status or privileges, with special emphasis on patients found not guilty of criminal charges by reason of insanity (NGRI).

The Panel was asked to consider how, in the context of its patient-care role, the Hospital discharges its responsibilities to the court and its officials. In addition, the Panel was asked to recommend actions or changes in policies that appear to be indicated in fulfilling Hospital responsibilities to the court, while preserving patient rights and ensuring appropriate patient care.

The Panel met in an initial orientation and organizational meeting in May and convened 7 subsequent working sessions in June, July, and August.

In fulfilling its charge, the Panel reviewed relevant literature, experience in practice, and legal cases that have had a significant impact on the practice of forensic psychiatry. The Panel identified, reviewed, and analyzed numerous relevant documents including Hospital procedures manuals and Federal and District of Columbia statutes governing commitment and release proceedings.

Additional information was obtained through interviews with key hospital staff, consultants, and patients; the review of hospital records and patient charts; and attendance at a Treatment Planning Conference and Review Board meeting.

Before the formal release of the Panel's recommendations, the Panel's Report was sent in Draft for comment to the United States Attorney, District of Columbia; the Acting Superintendent and Director, Forensic Division, St. Elizabeths Hospital; and the Commissioner, District of Columbia, Commission on Mental Health Services. The Panel carefully considered its comments and has incorporated several of these suggestions in the Panel's Final Report.

### Summary of Recommendations

The following recommendations are organized and focused on the key issues identified and addressed by the Panel.

#### Instituting of Status Changes and Privileges — Release Decisionmaking

In general, the Panel was impressed with the decisionmaking process at the Forensic Division that results in the treatment of forensic patients and their release in a graduated supervised fashion. The Panel notes that the Review Board performs a particularly useful function. In addition, it has made a major contribution toward more systematic decisionmaking in the Hospital and in coordinating status change recommendations with the necessary court processes.

The Panel also notes, however, that assessing the likelihood of future violent behavior of forensic patients requires the calibration of multiple factors including the patient's medical progress, underlying personality characteristics, and the environmental stresses that will likely be encountered upon release. The dynamics of a patient's committing offense may offer certain clues toward understanding and prediction.

The Panel believes that in forensic assessment, when effective treatment requires less security, the treatment staff needs to consider detailed information not only about the patient's medical progress but how multiple factors come together to make the next step safe. Some of the relevant information may be best understood and known by the patient's therapist. The Panel believes that this information should, therefore, be integrated into the forensic assessment and prediction process and documented.

#### Review Board

The Panel believes that anyone who has a significant role in the patient's clinical care should attend the meeting of the Treatment Team and, where necessary, the Review Board to contribute what is relevant to patient assessment and a recommendation for a status change.

The Panel noted that there is no written summary of the discussion that takes place at the Review Board. While some of this information may be contained in the letter that is forwarded to the court, the Panel recommends that substantive discussions that occurred at the Review Board also be summarized in the patient's chart.

#### Aftercare

The Panel noted that perhaps the most exciting development in the treatment of forensic patients has been

the development of well-monitored release programs with community followup. These have been effective in reducing violent patient behavior and ensuring continuity of care. The Panel believes that the proportion of resources devoted by the Forensic Division to the Outpatient section is insufficient.

Because of positive experiences in other communities, the Panel recommends that the District of Columbia establish a halfway house residence for the community treatment of forensic patients. The Panel also recommends that the Commission on Mental Health Services make every effort to increase available drug and alcohol counseling programs for discharged forensic patients.

**Therapist/Administrator Split**

The Hospital employs a system of psychotherapy called the Therapist/Administrator (T/A) split that includes elements of confidentiality of patient therapeutic communications. There are limited exceptions to patient confidentiality related to imminent patient dangerousness to self or others. In practice, depending on the therapist's judgment, many patient communications in therapy are not recorded on charts, shared directly with others on the treatment team nor do they become open later to court scrutiny and review.

The Panel believes that the option to continue patients in treatment under a Therapist/Administrator split can be continued at the Hospital. However, additional safeguards need to be implemented to make this system a more viable, credible one. The safeguards should ensure that all clinically relevant information (even that learned in therapy) does go forward and is at least potentially available to the court in its role in release decision-making.

To this end the Panel suggests the following:

- The Hospital should develop and promulgate a formal policy that more clearly delineates the variety of "splits" that occur in practice regarding the extent of confidentiality that can be promised patients.
- Rules need to be developed about what information is clinically relevant to the assessment and treatment process; information that is recorded in substantive notes, shared with staff, and is ultimately reviewable by the courts.
- Rules for supervision should be formulated.
- In developing such rules, Peer Review and group supervision of psychotherapy may be necessary to calibrate the therapist's judgement about what is relevant and what should be documented.
- The Panel suggests that the T/A split be individually prescribed by the patient's treatment team.
- Practitioners should be trained in the T/A split with focus on knowledge of confidentiality and relevant hospital policy.
- The Panel believes the therapist should attend meetings of the Treatment Team and, where necessary, attend the meeting of the Review Board.
- Concerning record-keeping, the Panel recommends the therapist make regular therapy notes, documenting patient progress, dynamics, and psychology. These notes could be recorded in a separate portion of the chart and would be available to other staff. If notes are subpoenaed, the Hospital can request in-camera review of the notes by the court as to relevancy to the recommendation.
- The Panel recommends that patients' therapists not be subpoenaed to court to testify at release hearings.

**Confidentiality and Privacy Controversies**

The Panel makes the following recommendations regarding past hospital concerns about potential misuse of patient communications in the legal process, or whether information should be released to the attorneys prior to court hearings:

- Information that is released to one side (defense counsel or prosecutor) should also be released to the other side. Ideally, all parties concerned should get the information at the same time.
- Information should include all clinically relevant material. If there is any doubt as to the relevance of certain information to the court's determination, the Hospital should resolve the doubt in favor of disclosure.

The Panel believes that, by and large, the Hospital's present policy on scrutiny of mail has been adequate and generally satisfactory in preserving patients' rights. However, this may not be so for the exceptional case where, on clinical grounds, the patient's mail and/or writings appear highly relevant to assessing progress. Although there is ongoing controversy about the right and desirability of staff to read patients' mail, the Panel does not consider it a violation of patients' rights to log in mail.

In special cases, for example White House cases or in other cases where staff deem it relevant to inspect and read patients' mail, the Panel believes that the Forensic Division has the right and in some cases the obligation to do so, assuming the decision is reasonable and necessary for adequate assessment and prediction.

The Panel recommends a Review Procedure for mail scrutiny such as the review by the Review Board of proposed status changes. In addition, the Panel recommends that the reason for the staff's need to read patients' mail should be recorded in the chart. Notice should be given to the patient before the decision is implemented. If the Forensic Division requires more clear-cut "legal authority" to read patients' mail in selected cases, the Panel recommends that the court be asked to add to the order following the first mandatory review hearing, language sufficient to meet the hospital's needs.

Inspection of a patient's property, *other than to ensure the patient's own safety or the safety of others,* is generally unnecessary or unwarranted in the therapeutic assessment enterprise. To do so without the patient's permission should require a court order.

**Communication to Court and Attorneys**

In interviews with the Panel, court officials have indicated a desire for more information earlier in the process, beyond that of the two-page letter that the Forensic Division routinely sends in the case of a 301(e). The

Panel believes that consideration should be given to appending to the Division's letter the relevant Treatment Team Report that is sent to the Review Board. The patient's Aftercare plan (Plan of Outplacement/Discharge) should also be appended to the two-page letter.

In addition, the Panel recommends that the Hospital send more information forward on 301(k) cases than is present practice. Although a full meeting of the Review Board may not be possible, the Hospital's evaluation of 301(k) requests should be formally communicated to the court prior to the hearing.

**Representation—Conduct of Hearings**

The appropriateness of Hospital Counsel participation at release hearings is a question that will continue to be debated, especially considering the stated desire of the District's Office of the Corporation Counsel to have the Forensic Division represented in the future.

The Panel believes that the Hospital and its legal staff have made a credible argument that the Hospital should "have the option" to be represented by counsel in selected cases. The Panel does not, however, believe the Hospital Counsel should be present in cases merely because the Hospital recommendation will be strongly contested by the prosecutor.

Hospital Counsel should request to appear in cases (1) where issues will arise pertaining to internal hospital policies and administrative matters that fall within the expertise of Hospital Counsel or (2) when the Hospital reasonably believes that it has facts relevant to court decisionmaking that are not likely to be presented by the parties. The Panel does not believe it is necessary for the Hospital to formally intervene or become a party to the proceeding. Hospital Counsel should request to appear specially as an Amicus Curiae, or in the case of subpoena issues, as representative of the custodian. In all such cases, the Hospital should communicate beforehand in writing to the parties and the court its desire to participate through counsel.

**Quality Assurance**

In general, the Panel was impressed with the Quality Assurance Activities in place at the Hospital. As stated in earlier recommendations, formulation of a protocol for psychotherapy, prescription of the Therapist/Administrator split by the Treatment Team, supervision of the Therapist/Administrator split, including Peer Review of this treatment modality, would enhance the implementation of psychotherapy.

The Panel also recommends that the Forensic Division periodically invite the U.S. Attorney and the Public Defender to do training of staff through grand rounds, case reviews, mock trials, etc. Collaborative training and education between the Office of the U.S. Attorney, Public Defender, and the Hospital would promote better communication between parties and improve rapport.

The Panel also believes that the Joint Commission on Accreditation of Hospitals (JCAH) has a crucial and appropriate role to play in the administration of forensic hospitals and makes the following recommendations:

1. The survey process should include surveyors experienced and credentialed in surveying forensic hospitals.
2. The survey process should remain consultative and educative in nature.
3. Standards should be included that address the nonmedical aspects of care (range of psychosocially therapeutic specialties and quality of therapeutic environment).
4. Standards should be developed that take into account issues specific and unique to forensic hospitals.

**Conclusion**

The Panel is impressed with the quality of care delivered to the patients at St. Elizabeths Hospital Forensic Division and the careful and thorough way in which its program of graduated patient release to the community takes place. St. Elizabeths Hospital Forensic Division is a hospital, not a prison. The effective treatment of dangerous patients, not just the provision of security through custody, is central to the purpose of the Division.

The Panel hopes that its recommendations will be of use to NIMH, the District of Columbia, the Hospital and the courts in enabling the St. Elizabeths Hospital Forensic Division to meet its dual mandate in the treatment of insanity acquittees.

## I. INTRODUCTION

Controversy is no stranger to forensic psychiatry, nor to St. Elizabeths Hospital Forensic Division. Thus it was not surprising that when the Division proposed that presidential assailant John W. Hinckley, Jr., receive his first unescorted pass to visit his parents at Easter 1987, the public was intensely interested. This interest heightened when, at the mandatory court hearing reviewing the propriety of the pass, it was revealed that, in the past year, Mr. Hinckley had corresponded with multiple murderer Theodore Bundy. The Hospital's judgment in making its recommendation and assessment of Mr. Hinckley's progress was questioned, as was the chain of events that led to this "surprise" information about Mr. Bundy being revealed to the court and prosecutor for the first time, (albeit the information was known to the Hospital and Mr. Hinckley's defense counsel prior to the court hearing). The Hospital subsequently withdrew its request for the pass for Mr. Hinckley, and his treatment as a full-time hospital inpatient continues.

The shopworn but relevant axiom "bad cases make bad law" comes to mind when contemplating the above events. The treatment and rehabilitation of notorious cases places a special burden on treatment staff at forensic facilities, which facilities for the most part have been under-supported, under-appreciated, and generally not in the "main stream" of American psychiatry or of the criminal justice system (Roth, 1980). Release or progressive relaxation of restrictions placed upon insanity acquittees reawakens public, even professional, uncertainties about forensic psychiatry and the viability of the insanity defense — whether it is fair or just (Steadman and Cocozza, 1978; Slater and Hans, 1984; Insanity Defense Work Group, 1983). Therapeutic passes are, of course, symbolic of a forensic hospital's legitimate mission to rehabilitate its patients, as well as provide the security necessary to protect the public.

The above sequence of events has raised certain questions about how therapeutic progress and patient dangerousness is assessed for insanity acquittees at St. Elizabeths Hospital Forensic Division — also how the hospital staff, defense counsel, prosecutor, and courts can best work together, within legal mandates, to achieve the dual goals of effective treatment of insanity acquittees and protection of the public. To this end, the National Institute of Mental Health, which has oversight responsibility for the Hospital until October 1, 1987, assembled this Ad Hoc Forensic Advisory Panel to review the policies and procedures of St. Elizabeths Hospital Forensic Division.

### Charge to the Panel

The Panel was to review the policies and procedures of the St. Elizabeths Hospital Forensic Division. The Panel was asked to:

- Review and evaluate relevant policies and procedures of the SEH forensic program with respect to status and privilege changes for patients committed to the Hospital for evaluation and treatment, with special focus on patients found not guilty of criminal charges by reason of insanity.
- Consider how, in the context of its patient-care role, the Hospital discharges its responsibilities to the court and its officials in recommending and putting into place changes in patient status.
- Recommend actions or changes, if any, in policies and procedures that appear to be indicated in fulfilling hospital responsibilities to the court, while preserving patient rights and ensuring appropriate patient care.

In fulfilling its charge, the panel could, at its discretion, review relevant records; interview hospital staff, consultants, patients, and court officials; and participate in hospital meetings.

### Caveat

It should be emphasized that the purpose of the Panel's work, in accord with the above charge, has not been to investigate or critique all the events leading to, or occurring in conjunction with, Mr. Hinckley's proposed Easter pass. The NIMH has itself reviewed Mr. Hinckley's case and communicated its findings elsewhere about the circumstances of the proposed Easter pass. Mr. Hinckley's case is not the focus of this report to NIMH. Instead, the Panel has used Mr. Hinckley's case as a take-off point to clarify certain issues relevant to the Panel's charge or at times for purposes of example regarding findings and recommendations. The Panel believes its findings and recommendations do have general applicability to policies and procedures within the Forensic Division of the Hospital.

The Panel also wishes to state from the outset that its findings constitute, in the main, a vote of confidence for the Hospital, which in our estimate does a difficult job well. The policies and procedures at St. Elizabeths Hospital Forensic Division meet, and in many cases exceed, national standards. Nearly all the persons we interviewed were positive about the accomplishments of the Hospital and its careful and thoughtful approach to patient assessment, instituting of status and privilege changes, and procedures for progressive release.

### Panel Composition and Procedures

*Panel Composition*

The NIMH Ad Hoc Forensic Advisory Panel was formally established in April 1987. The Panel was selected to include mental health and legal experts with extensive experience, knowledge, and understanding of the relevant and important legal and patient-care issues involved. The following are the members of the Panel:

1. Loren H. Roth, M.D., M.P.H., Chairman
   Professor of Psychiatry
   University of Pittsburgh School of Medicine
   Director of the Law and Psychiatry Program
   Western Psychiatric Institute and Clinic
   Pittsburgh, Pennsylvania
2. John D. Aldock, J.D.
   Shea and Gardner
   Washington, D.C.
3. Kenneth K. Briggs, Ex Officio Member

Chief-Designate
Office of System Implementation
Commission on Mental Health Services
Department of Human Services
District of Columbia Government
Washington, D.C.

4. Joel A. Dvoskin, Ph.D., Director
Bureau of Forensic Services
New York State Office of Mental Health
Albany, New York
5. John W. Parry, J.D.
Staff Director
Commission on the Mentally Disabled
American Bar Association
Washington, D.C.
6. Robert T.M. Phillips, M.D., Ph.D.
Director of Forensic Services
Department of Mental Health
State of Connecticut
Associate Clinical Professor
Yale University School of Medicine
Middletown, Connecticut
7. Stuart B. Silver, M.D.
Superintendent
Clifton T. Perkins Hospital
Jessup, Maryland
8. Barbara A. Weiner, J.D.
Katten, Muchin, and Zavis
Chicago, Illinois

Eugenia P. Broumas, Special Assistant, Office of the Director, NIMH, served as Executive Secretary to the Panel.

*Procedures*

An initial orientation meeting of the full Panel was held on May 19, 1987. The Panel developed a timetable for proposed panel activities and delineated the specific areas to be addressed. The Panel scheduled seven subsequent working sessions:

June 10-11, 1987
June 23-26, 1987
July 20-21, 1987
August 20, 1987

An additional meeting of the Panel Chairman and 2 Panel members was held on July 31 to interview a court official and review specific patient records and written procedures of the Forensic Division at St. Elizabeths Hospital.

In fulfilling its charge, the Panel reviewed the relevant literature, experience in practice, and legal cases that have had significant impact in the practice of forensic psychiatry. The Panel identified relevant reports, published and unpublished studies, hospital procedures manuals, District of Columbia and Federal statutes governing commitment and release proceedings, reports of accrediting or licensing bodies, and the American Bar Association Criminal Justice Mental Health Standards. All Panel members received, reviewed, and commented on the basic documents which also included overall policies on patients' rights and recent reports to Congress regarding hospital transition to the District of Columbia. Additional documents related to the procedures and organization of the Forensic Division were analyzed and are included in the detailed discussion.

In order to gain a balanced perspective, the Panel interviewed key hospital staff, court officials, representatives of the U.S. Attorney's Office, the Public Defender's Office, and patient advocate and mental health organizations. The Panel visited and toured the Forensic Division at the John Howard Pavilion, attended a Review Board Hearing and a Treatment Planning Conference, interviewed 4 patients, and reviewed 10 randomly selected patient records, as well as other outpatient records. A complete list of the individuals interviewed is appended (Appendix 2).

The following, therefore, represents the considered judgment of the Panel based on extensive information gathered during the interviews and the numerous documents reviewed.

**Mission of Forensic Hospitals and St. Elizabeths Hospital Forensic Division**

Before proceeding to the next section of this report, which describes the treatment and release process at St. Elizabeths Hospital Forensic Division and its relationship to the courts, some comments on the role of the forensic hospital are in order.

**The Dual Mandate of Forensic Hospitals**

Forensic hospitals are saddled with a difficult dual mandate that law and society impose central to the treatment and custody of mentally ill offenders. Citizens, legislatures, and courts have made clear their desire to have persons found not guilty by reason of insanity removed from the community to prevent them from harming innocent persons. From the time of Hadfield's case (1800), a finding of not guilty by reason of insanity has resulted not in freedom for the acquittee but in a period of institutionalization, often a lengthy one (Moran, 1985). On the other hand, the courts have made it clear that long-term restrictions on a person's liberty place several burdens on the state, not the least of which is the provision of adequate psychiatric treatment (*Davis v. Watkins,* 384 F. Supp. 1196 (N.D. Ohio 1974)). Over the last two decades, due process protections have been progressively extended to insanity acquittees (Brakel et al., 1985).

This dual mandate is made more difficult by several complicating factors. There is a strong data base that casts doubt upon the ability of forensic clinicians and the court to make long-term predictions about the dangerousness of individual patients upon release (APA Task Force, 1974; Cocozza and Steadman, 1976; Monahan, 1981; Steadman, 1983). The inability to predict dangerousness is compounded by practical restraints that limit the number of patients who can be housed in maximum security settings without overcrowding hospitals and endangering staff and patients. Many forensic patients are clinically indistinguishable from other chronically mentally ill persons (Bloom et al., 1986). As the mental health disciplines have improved in their ability to provide treat-

ment for the chronically ill, there has been an increasing acknowledgment of the incapacitating effect of years of institutionalization. Logically, the best treatment may often require movement to a less structured, more independent setting. In addition, many workers in this field believe that the best way to ensure an eventual safe return to freedom is to allow patients to experience graduated decreases in structure and increases in freedom and responsibility (e.g., Roth, 1987; Brakel et al., 1985, pp. 731-734).

The desire to move patients to less secure settings may appear to run in direct contradiction to public safety considerations that demand that the system "cure" these patients. Clinicians respond that in order to "cure" (i.e., properly treat) patients, it may be necessary to release them, albeit under close supervision. Finally the stakes in this conflict of interest are raised astronomically by the fact that occasionally patients released from forensic hospitals will again commit highly publicized violent acts. The fact that these incidents are infrequent rarely diminishes the effect on public perceptions about the dangerousness of the mentally ill, especially those with prior histories of violent crime who have been hospitalized in a forensic setting.

One way of looking at what we do know about prediction to meet the dual mandate of the forensic hospital is to view decisionmaking in terms of risk/benefit analysis. Arguably, there are three kinds of data about an individual patient that are of value in making release decisions: (1) prior acts; (2) response to treatment, and (3) necessary conditions of release. Prior acts, especially the offense that led to the current hospitalization, tend to define the possible costs of failure. Therefore, the risk of inappropriately releasing a murderer is seen as greater than it would be in the case of a person who has committed a simple assault. A second type of data is descriptive of ways in which the patient has changed, especially in response to treatment. This information serves to lessen the perceived risk and obviously needs to be more impressive with severe committing offenses. Included here are the general course of hospital treatment and successful adaptations to less structured situations. The third type of data involves managing the risk, which is to say the conditions under which the proposed release is to be accomplished and supervised. Thus patients with more severe offenses need to demonstrate a higher degree of clinical improvement prior to release, and upon release will likely receive a greater degree of scrutiny and hopefully supervision and support, than those with less serious offenses. To what extent the treatment and release process at the Forensic Division, acting in concert with the courts, corresponds to this logic will be discussed below.

In evaluating St. Elizabeths Hospital Forensic Division with respect to procedures for status and privilege changes, it is also important to know that District of Columbia law makes it clear that the court is the ultimate guarantor of public safety. It must rule on the appropriateness of all release statuses (such as Conditional Release (CR), Convalescent Leave (CL), or Unconditional Release (UL)) that permit unescorted patient access to the community (D.C. Code Ann. Section 24-301(e), (k) (1981)).

By way of background, we now turn to other legally relevant considerations to further clarify what a forensic hospital's obligation is toward its patients. To a great extent, this obligation turns on the nature of insanity commitments.

## The Civil/Criminal Dichotomy in Insanity Commitment and Release Proceedings at St. Elizabeths Hospital

The civil-criminal distinction in insanity commitment and release proceedings is founded on a paradoxical principle of law: a person found to be not guilty by reason of insanity of the crime alleged lacks criminal responsibility without which the behavior is not considered criminal. Once insanity is accepted as the verdict, then by definition the commitment and release proceedings that follow cannot be essentially criminal in nature.

Not being criminal in nature, however, does not necessarily mean the same thing as being essentially civil. There is a possibility that insanity commitment and all its trappings are either quasi-civil — civil but with a substantive twist — or something that is neither civil nor criminal.

What that status *should be* has long been debated by philosophers, legal theorists, policy makers, and ultimately legislatures. However, because the nature of insanity acquittal is also a constitutional concern, impinging on fundamental human rights, the definition of this split is a legal matter and one that has been addressed by the U.S. Supreme Court, the District of Columbia Courts, and other jurisdictions. It is from these cases that we must draw our conclusions.

## The Legal Parameters of Insanity Commitment and Release

### *The U.S. Supreme Court*

In 1983, a 5-4 majority of the U.S. Supreme Court upheld the continued commitment of a defendant who had been acquitted of attempted shoplifting by reason of insanity, even though he was hospitalized for a longer time than he could have been imprisoned as a convicted misdemeanant (*Jones v. United States,* 463 U.S. 354 (1983)). The majority approved the preponderance of the evidence standard for the indefinite commitment of insanity acquitees based on rational differences between candidates for civil commitment and the class of persons acquitted by reason of insanity. Since punishment was deemed inappropriate for persons acquitted by reason of insanity, and insanity acquittees could be confined as long as their mental illness and dangerousness continued, the length of an acquittee's hypothetical criminal sentence was held to be irrelevant to the inmate's length of stay that had been defined by his recovery.

Three essential components of the majority's holding distinguished insanity commitments from criminal proceedings: (1) a preponderance of the evidence standard, as opposed to proof beyond a reasonable doubt, (the criminal standard) or clear and convincing evidence (the civil commitment standard) was viewed as an acceptable basis for extended confinement; (2) punishment was

found to be inappropriate for persons acquitted of a crime; and (3) insanity acquittees could be confined for as long as their mental illness and dangerousness continues because the length of time acquittees would have served if convicted of their crimes bore no relationship to their recovery time.

While it distinguished insanity acquittees from criminal convictees, the Supreme Court also acknowledged that insanity acquittees are distinguishable from individuals who are civilly committed: insanity acquittees may be treated differently from persons in the civil commitment system for whom it has never been determined by proof beyond a reasonable doubt that they have engaged in criminal-like behavior. Insanity acquittees are a "special class" of civil committees, hospitalized and treated under a system of necessary "therapeutic restraint."

Within those constitutional parameters, the legislatures and courts in the District of Columbia and elsewhere have been left to design and build their own systems for insanity commitment and release.

*The Law in the District of Columbia*

Throughout the major cases defining the rights of insanity acquittees in the District of Columbia — spanning the years between 1959 and 1987 — an underlying premise stands out clearly: the commitment and release of insanity acquittees are governed by *special* civil procedures that authorize the involuntary hospitalization of acquittees for treatment until they become nondangerous and eligible to be returned to the community.

In 1959, Judge Bazelon, writing for the U.S. Court of Appeals for the District of Columbia Circuit, in *Hough v. United States,* 271 F.2d 458 (D.C. Cir. 1959), defined the respective roles of St. Elizabeths Hospital and the courts in the release process. *Hough* held that when the Hospital's authorities decide that a patient has reached the stage where increased freedom is necessary and proper (the patient is appropriate for conditional release under supervision), they are required to certify that fact to the Court. It is the role of the courts, however, to decide whether the proposed conditions of release will ensure that in the reasonable future the insanity acquittee will not be dangerous to himself or others.

Interestingly enough, the first judicial articulation of a possible constitutional right to treatment for institutionalized mentally disabled persons came in dicta from *Rouse v. Cameron,* 373 F.2d 451 (D.C. Cir. 1966), a 1966 case from the District of Columbia addressing the rights of a person acquitted by reason of insanity. Judge Bazelon ultimately founded his right to treatment in the District of Columbia statute, which, he wrote, required a bona fide effort to provide treatment that would cure or improve the patient. In terms of psychiatric care, he saw no distinction between insanity acquittees and other civilly committed patients. They both needed treatment that would allow them the opportunity to recover and be released.

The decision of the D.C. Court in *United States v. Ecker,* 543 F.2d 178 (D.C. Cir. 1976), spoke to three issues that are important in defining the role of St. Elizabeths Hospital Forensic Division. First, the case held that insanity acquittees have a right to treatment under the least restrictive conditions consistent with the community's safety.

Second, *Ecker* held that "[i]n order to approve a conditional release. . . the district court must independently 'weigh the evidence' and make a de novo determination that the patient will not in the reasonable future endanger himself or others." (*Id.* at 187). Conditional or Unconditional Release, and other situations involving public safety are to be determined by the court independently, particularly "an 'affirmative finding that it is at least more probable than not that he [the patient] will not be violently dangerous in the future.'" (*Id.* at 188 quoting from Judge Leventhal in *Dixon v. Jacobs,* 427 F.2d 589, 602 (D.C. Cir. 1970)). "[T]he same policy rationale underlies judicial review of conditional and unconditional releases, *i.e.,* providing for the treatment and cure of the mentally ill in a manner which affords reasonable assurance for the public's safety." (*Id.* at 186).

Finally, *Ecker* addressed the burden of proof — both the burden of persuasion and the burden of going forward — in insanity release proceedings. With regard to hospital-initiated conditional release proceedings

> there is no assignable burden of proof as we would know it in a criminal or civil case. These are truly investigatory proceedings in which traditional notions of proof are simply inapplicable. The district court, the hospital, the patient, and the government share an obligation to elucidate and explore all the relevant facts. *Id.* at 193.

Where the patient initiates the proceedings, because presumably the hospital will not do so, the burden on the patient increases. The patient must show by a preponderance of the evidence that his Conditional Release will not endanger the community.

*DeVeau v. United States,* 483 A.2d 307 (D.C. 1984), refined previous rulings on the court's role in release proceedings by holding that trial courts must make a de novo determination of the patient's future dangerousness based on the weight of all the evidence including such factors as: hospital records, files, and the patient's psychiatric history; demonstrated past behavior, including related prior crimes or bad acts; the time elapsed since the person was deemed unfit for release; the protection of the public provided by the proposed conditions; and the testimony presented at the hearing.

## II. FORENSIC SYSTEM RELATED TO INSANITY ACQUITTEES

The following section presents a brief history of St. Elizabeths Hospital and its Forensic Division (John Howard Pavilion) and gives an overview of statistics and the treatment and release process relating to insanity acquittees. In this section, we summarize what the Panel has learned descriptively from its interviews with key staff; review of documents, policies and procedures; and visits to the Hospital, including patient interviews. The concluding section of the report then summarizes the Panel's evaluation of this material and the Panel's conclusions.

**History**

St. Elizabeths Hospital opened in 1855 as a result of an $100,000 appropriation for the expense of purchasing a site, "erecting furnishing and fitting up of an asylum for the insane of the District of Columbia and for the Army and for the Navy," which was approved by Congress in 1852 (Overholser, 1956, p. 3). First titled the Government Hospital for the Insane, it was later renamed St. Elizabeths Hospital (informally in 1861; formally by Act of Congress in 1916). Dorthea Dix played a large role in the establishment of the Hospital. The seventh patient admitted was Richard Lawrence, the man who had attempted to assassinate President Andrew Jackson twenty years earlier. He remained at the Hospital until his death in 1861.

From the beginning, expectations were that the institution would be a leader in the field. The Secretary of the Interior reported to Congress in 1859:

> When all the buildings shall have been erected, the grounds enclosed, and the appointments completed, the institution will be a model of its kind, and with the continuance of the successful management it has hitherto received it will be an honor to the Government and an inestimable blessing to that unfortunate class for whose benefit it was designed. (Overholser, 1956, p. 6)

The original building was designed to care for 90 patients at a time when the official view was that 250 beds should be the maximum capacity of any mental hospital. In its early days, the Hospital provided "Moral Treatment" with emphasis on

> the regular occupation of the mind and body with some work not too hard of comprehension, nor too taxing to the strength in its performance. Rides, walks and sunbaths are prominent modes of treatment at the hospital. (Overholser, 1956, p. 11)

Other modes of treatment in the late 1800s included hydrotherapy and drug therapy. The drug therapy of the time was of the palliative variety, e.g., bromides or opium.

By the mid-1930s, St. Elizabeths Hospital was probably the best known public mental health hospital in the nation and was recognized as one of the few outstanding public mental health hospitals in the world. The Hospital had attained a leadership position in the field early in its existence and has maintained that position to this day.

Howard Hall was established in 1891 as one of the very early special facilities in the United States for the care of the "criminal insane" (Overholser, 1956, p. 11). Some of the earliest American writing on forensic psychiatry emanated from St. Elizabeths Hospital. By the twenties and thirties, there were very active forensic literary work and lectures being done by St. Elizabeths' staff. In 1917, individual psychotherapy was introduced (Overholser, 1956, p. 16). Today, both group and individual psychotherapy are an important part of patient treatment throughout the Hospital, including the Division of Forensic Programs.

The present John Howard Pavilion, a maximum security facility, opened in 1959 and now houses the Division of Forensic Programs. Like other similar programs (Kerr and Roth, 1986), the Division evaluates and treats incompetency to stand trial cases, insanity acquittees, prisoners found to be mentally ill while serving sentence, and a small number of dangerous patients transferred from the civil side of the Hospital.

The John Howard Pavilion is a nationally known facility. The names of its clients are part of the history of forensic psychiatry. Examples include Mr. Monte Durham (adoption of the "product of mental illness" test for criminal insanity — *Durham v. United States,* 214 F.2d 862 (D.C. Cir. (1954)), Mr. Archie Brawner (rejection of the *Durham* Test in favor of the American Law Institute test for criminal insanity — *United States v. Brawner,* 471 F.2d 969 (D.C. Cir. (1972)), and Mr. Michael Jones *Jones v. United States,* 463 U.S. 354 (U.S. Sup. Ct. 1983).

More recently, Mr. Hinckley's case has again brought national attention to John Howard, ever since his hospitalization there in 1982.

**Demography and Statistics**

Between July 1, 1985, and June 30, 1986, 195 patients were admitted to the Forensic Division at the Hospital. The average inhouse population, which numbers about 280 patients, has been increasing slightly of late in part due to greater length of stay and greater delay in transfer of forensic patients to civil divisions of the Hospital.

A 1986 evaluation report prepared by Dr. Seitz for the Division gives the mean length of stay for all forensic patients at the Hospital to be 65 months (5.4 years), 12 percent longer than the previous year. The median stay is 43 months. These figures, however, include Pre-trial patients who stay for a much shorter period of time than Post-trial patients (e.g., persons who are insanity acquittees). For Post-trial patients, the median length of stay is 76 months or more than 6 years. There is some uncertainty, however, in Seitz's report because, on the basis of a similar previous report (Baridon et al., 1983, p. 14), the Panel believes that these length of stay figures may include time spent by patients in supervised community release status. The Division's 1985 orientation booklet for employees states that Post-trial patients stay an average 4.5 years Inhouse and 2.5 years on Convalescent Leave (CL). The above figures do indicate that the Graduated Release process at the Division is certainly as slow and "conservative," if not more "conservative," than is the case for other jurisdictions. While national figures are lacking (and there are many methodological problems in assessing lengths of stay), Steadman found that the average length of stay for a cohort of New York insanity acquittees followed from 1971-1981 was 3.5 years (Steadman, 1985). Length of stay for acquittees in other jurisdictions is far shorter, e.g., in Connecticut (Steadman, 1985) and in Massachusetts (Phillips and Hornik, 1984). As is so everywhere, acquittees at the Hospital whose original offenses are more serious tend to stay for longer periods of time (Baridon et al., 1983).

The most frequent psychiatric diagnosis among patients

in the Forensic Division is schizophrenia. A high proportion of forensic patients also have current or a history of drug and alcohol problems.

Dr. Seitz's 1986 evaluation of the Division also documents that the majority of hospitalized patients in the Post-trial category are insanity acquittees. These equaled 182. At this time (1986), 91 patients were also on Convalescent Leave (outpatient status).

With reference to the offenses committed by the patients, 75 percent of the patients on the roles had committed offenses (acts that would be crimes) against persons. Nearly 11 percent were charged with homicide, 14 percent with robbery, 8 percent with rape, and 30 percent with various types of assault. Thus Forensic Division patients constitute a group of seriously mentally ill and potentially very dangerous patients. Table 1 summarizes the Forensic Division patient activity and census in 1986.

**Recidivism**

The Division has also made studies of the recidivism rate of patients along various stages of its graduated release program. This study (Seitz and Baridon, undated) found that over a 9-21 month followup period in 1977-1978 (N = 227 patients), 29 patients (12.8%) had acquired new criminal charges and/or had been involved in incidents of criminal mischief. There was an 8 percent probability of a patient on a leave status being arrested for a crime against the person. These figures compare favorably with other jurisdictions. For example, Steadman summarizes data to show that New York NGRI recidivism rates are comparable to those of matched felon groups (20-29% rearrest rates) (Steadman, 1985). Data from Maryland found a 13 percent reincarceration rate for NGRIs and a far higher rearrest rate over an almost 10 year follow-up period (Spodak et al., 1984). It should be recalled that national figures show that one-third of state prisoners released return to prison within three years, and more than a quarter do so in two years or less (Bureau of Justice Statistics, 1984).

While there are numerous methodological problems in making such comparisons, St. Elizabeths Hospital Forensic Division recidivism statistics appear in line with other jurisdictions. Of note, however, for purposes of this report, is that evaluation reports done for the Hospital over the years demonstrate a high proportion of patients who at some time are on Unauthorized Leave (UL) from the Hospital, also that the risk of recidivism rises with the granting of Convalescent Leave (CL) when the patient lives in the community, returning to the Hospital periodically (Seitz and Baridon, undated). More will be said on this in the Recommendations section of the report.

**Transition to the District**

Although St. Elizabeths Hospital has been a Federal institution for its entire history, on October 1, 1987, St. Elizabeths Hospital is being transferred to the District of Columbia in accordance with Pub. L. No. 98-621 (Saint Elizabeths Hospital and District of Columbia Mental Health Services Act, Pub. L. No. 98-621, Section 2, 98 Stat. 336-3371 (1984)) passed by Congress in 1984.

The District of Columbia is in the second year of a Congressionally mandated six-year reorganization of mental health services that will incorporate the Federal St. Elizabeths Hospital into the local service system. The District's Mental Health System Implementation Plan calls for a complete restructuring of all mental health services.

Public mental health services in the District of Columbia are now delivered by a divided system: (1) two District-managed Community Mental Health Centers (CMHCs) covering two-thirds of the city and (2) the federally managed St. Elizabeths Hospital that covers the other third of the city through its CMHC and that delivers all public psychiatric hospital care.

A long debate over this past relationship ended in November 1984 with the passage by Congress of Pub. L. No. 98-621. This legislation mandates the end of Federal management of the Hospital and the assumption of full District responsibility for all patient care in October 1, 1987. By 1991, all direct Federal appropriations will have been phased out, and the District will be fully responsible for funding its comprehensive mental health system.

The new District of Columbia Mental Health Authority, the Commission on Mental Health Services, will be officially established and be responsible for all patient care on October 1, 1987.

The Commission is structured into three administrations that manage care for three important groups of clients: Children and Youth, Adults, and those in the Forensic system.

The plan calls for the gradual, planned development of an integrated community-based system to replace the current divided system that is largely institutionally based. The new system will emphasize care for those most in need: the chronically mentally ill, children and youth, the homeless mentally ill, and mentally ill elders.

One consequence of transition to the District will be the possible greater involvement in the affairs of the Hospital of Corporation Counsel representing the District of Columbia and its Commission on Mental Health Services. The Office of Legal Counsel of the Hospital, which formerly reported to HHS, will become a part of the Office of Corporation Counsel. It seems likely that, in the future, Corporation Counsel will take an active advocacy interest in the Hospital and its Forensic Division.

**The Treatment Process at the Division of Forensic Programs**

Dr. Seitz's 1986 report identifies two major goals for the Division: (a) to provide quality comprehensive mental health evaluation, care, and treatment of patients referred as a result of special proceedings within the Criminal Justice System and (b) to optimally coordinate the delivery of treatment and services within the Division and with other hospital and community services. Both of these goals emphasize the concern for successful reintegration of patients into the community while providing appropriate safeguards and security for the com-

munity's residents.

To accomplish these general purposes, the treatment program for insanity acquittees at the John Howard Pavilion attempts to duplicate treatment that is otherwise available to acutely and chronically mentally ill persons in long-term public hospital settings. One patient whom we interviewed told the Panel that, from his experience, he found little difference between the treatment afforded at the John Howard Pavilion versus that which is available in the civil side of St. Elizabeths Hospital. From our observations the Forensic Division provides conventional and needed psychiatric treatment for mental illness.

In practice, this is an eclectic mix, including pharmacological treatment directed toward the alleviation of the symptoms of major mental illness, individual and group psychotherapy, and milieu treatment. There are recreational and occupational therapy programs. Additionally, as described in Dr. Seitz's 1986 evaluation report, and vital to long-term care, is a Vocational Rehabilitation Section under the Post-Trial branch that has the objective of developing educational and vocational therapeutic services that are coordinated with other hospital and community treatments.

Patients interact not only with the psychiatrists, psychologists, and a variety of trainees, but also with nurses and forensic technicians on the ward, who daily counsel and observe patients and who play a vital role in treatment. There is a medical clinic and psychological testing. Psychologists play an important role in patient care, administration, and in delivering individual therapy. The Social Services Branch does supportive community placement and evaluative work with families.

All patients interact with a multidisciplinary treatment team located on each ward, a team consisting of the patient's psychiatrist, nurse, ward administrator (a psychiatrist or psychologist), forensic technician, social worker, and other relevant personnel.

The ward has an administrator who plays an important role in treatment team decisionmaking, in formulating recommendations to the Division's Review Board (see below) regarding changes in patient status, and in writing reports to the courts.

The multidisciplinary team formulates a treatment plan that is developed with the patient's participation and that is divided into a standard format relating to Problems, Objectives (specific measurable, observable steps toward goals), Interventions, and Target dates. There is an active Problem List. As is described below, there is an outpatient department that integrates its care with inpatient treatment.

The essence of this integrated system of care is, as one person we interviewed states, "to treat the patient's illness, not the crime."

It is beyond the scope of the Panel's charge to comment on the details of the various Division treatment programs. We do note that there are some additional special programs relating more specifically to offender types or offender-type problems, e.g., an educational program (Human Sexuality), and drug and alcohol-related programs.

As pertains to the Panel's charge, the major feature of interest regarding the assessment and treatment process for insanity acquittees at the Forensic Division is that there is a well structured program for gradually awarding patient privileges, monitoring patient performance and progress under reduced security status (while the patient is an inpatient), and a graduated release process integrated with the courts that allows patients progressively greater contact with the community. The patient's potential dangerousness to self or others is thereby constantly addressed and evaluated throughout the treatment process.

This process, subsequently referred to as the "A-D classification process," is also integrated with placement of patients on maximum, medium, and minimum security wards. Patients progress through different wards and security statuses under observation, while gradually receiving more privileges, depending upon their classification (A, B, C, D). These statuses are:

> *Class* A patients are not permitted to leave the maximum security facility (John Howard Pavilion) except when it is necessary to obtain medical, laboratory, or other services that cannot be performed within the facility. Two Division of Forensic Program employees accompany patients when they leave the facility.
>
> *Class B* patients have demonstrated the capacity to assume some responsibility for their own actions. They may attend or participate in activities outside the maximum security facility under accompanied hospital supervision. This means that patients are permitted staff accompanied access to the grounds of the Hospital, but they are not entitled to be without supervision outside of John Howard Pavilion.
>
> *Class C* patients may attend or participate in activities outside the maximum security facility under minimum supervision. They do not require constant surveillance, nor do they have to be accompanied in all situations by a hospital employee. Class C patients for example, can go back and forth unaccompanied from a specific destination on the grounds of St. Elizabeths Hospital such as travel to a work assignment on the hospital grounds (with telephone checks). They can have one-hour canteen privileges. The patient's status is known at all times to the staff.
>
> *Class D* patients may be granted various levels of unaccompanied status on the Hospital grounds only. In practice, such patients can be by themselves (but only on the grounds of the Hospital) for between 2-8 hours a day.

An essential feature of treatment and assessment at St. Elizabeths Hospital is evaluation by the patient's treatment team (and other ward personnel) of patient adaptation, mental state, and behavior under the various statuses. In its interviews, the Panel learned that the Status A to Status B transition is viewed as very significant by hospital staff because this means that the patient is now permitted out of the security perimeters of the John Howard Pavilion, albeit under supervision. A most important status change that, however, requires court permission is the transition from Classification D to Condi-

tional Release (CR). Conditional Release (CR) means that the patient may, for various periods of time, be off the hospital grounds for purposes of family visits, work assignments, visits to programs, etc. This is an unescorted status. Staff do not usually accompany the patient.

John Hinckley's proposed Easter pass was, in essence, a type of Conditional Release (CR) (albeit a very small step). This is why court approval of the pass was required.

Patients who are on Conditional Release (CR) status continue to live at the Hospital. Their treatment remains the responsibility of their ward treatment team.

Following Conditional Release (CR) is the status of Convalescent Leave (CL). This status permits the patient to live at home or elsewhere while continuing to report back to the Hospital for therapy and monitoring on a frequent basis. As noted above, some patients stay on Convalescent Leave (CL) status for many years.

Finally there is Unconditional Release (UR) status. The patient no longer requires treatment or supervision and can be given a final discharge from the Hospital.

The statuses of Conditional Release, Convalescent Leave, and Unconditional Release must all be decided by a court, either the U.S. District Court or the D.C. Superior Court, after a hearing under 18 U.S.C. Section 4243(f), Section 301(e) (the hospital petitions for change in patient status) or Section 301(k) (the patient petitions for release under a habeas corpus type proceeding). This is discussed below.

Typically, court orders for various release statuses are detailed and specific about the requirements that patients must meet in the community. The court order specifies where in the community the patient will visit or work, at what times, under what general supervision, with whom, etc. In the Forensic Division, a change in a patient's release plan, whether on CR or CL status, furthermore requires another court hearing and approval.

All changes in patient status, A-D, CR-UR, must initially be recommended by the patient's treatment team. On the basis of their observations, the team concludes that the patient is ready for the next status. It is therapeutically indicated and would not be too dangerous or risky to permit the patient to be treated at a lesser security status.

The transition between patient statuses is not accomplished, however, solely on the recommendation of the patient's treatment team. There is another mandatory step. This involves review of the case and the wisdom of the treatment team's judgment by a Review Board.

**Review Board**

All changes from Class A-D and from CR-UR must be recommended in writing and submitted through channels to the Division of Forensic Programs Review Board. This Forensic Review Board functions as a clinical review body that oversees the granting of privileges to patients within the Division (A-D) and reviews requests for Conditional Release from the Hospital.

The Review Board was developed in 1981 in order to assure consistency in the administration of the Division's graduated release program and to guarantee that release decisions appropriately reflect all relevant clinical and safety (dangerousness) concerns. The Review Board is currently composed of the Division Director, the medical director, the chief nurse, the chief of psychology, the chiefs of the Post-trial and Pretrial branches, and the social worker of the Division. The Review Board has high credibility with the courts. It meets regularly twice per week to act on clinical recommendations for release or grounds privileges presented to it by the treatment teams.

Typically, the Review Board approves 60-70 percent of the requests brought to it by the treatment teams. To some extent, the Board acts as a "brake" to combat possible staff over identification with patients to the detriment of security concerns or the overall viability of the Division's graduated release program. As discussed below, the Review Board is also a vital part of the Quality Assurance Activities of the Division.

During the course of its work, the Panel interviewed relevant St. Elizabeths Hospital staff to understand the above process. It also interviewed patients on A,B,C, and D statuses, attended a treatment team meeting in which a patient was recommended for change from C to D status, and a meeting of the Review Board in which it was recommended that a patient change from Conditional Release to Convalescent Leave.

The processes that we observed taking place at these meetings conformed to the policies that describe their purpose. The meeting of the Review Board that we observed was particularly impressive because a good deal of observational work had taken place in the community, including family contact and surveillance of patient adaptation before the next step was taken. The process of decisionmaking regarding status changes is thus a thorough and careful process that is repetitive, drawn out, and has multiple decision points.

As will be discussed below, it is not always the case that the patient's therapist attends multidisciplinary treatment team meetings which decide on patient progress. Nor, for reasons to be discussed, do the therapists usually attend meetings of the Review Board. The content of the Review Board's discussions is not recorded. Later in this report, the Panel makes some suggestions in these areas.

In making its recommendations to the Review Board, the treatment team submits a report summarizing the patient's previous history, response to treatment, and rationale for recommended status change. This report later becomes the nucleus of a two-page letter of recommendation that the Division sends to the court when the Hospital proposes certain privileges (e.g., transition to CR, CL, UR) about which the court must rule.

The transition between Conditional Release status (CR) and Convalescent Leave status (CL) causes the patient's care to be transferred from the inpatient to outpatient section of the Division.

The outpatient section is staffed by a nurse, two counselors, a social worker, and two part-time psychiatrists. This section is responsible for following patients on Convalescent Leave. Under court order, the patient returns to the outpatient section of the Hospital, located on the third floor of John Howard Pavilion, on

a weekly basis. The patient's progress is monitored; urine testing for drugs may take place. Patients typically attend the outpatient department on a weekly basis for up to three months. Subsequent visits may be less frequent if the patient has a job. Most patients are seen about every two weeks. All are seen at a minimum of once per month.

All along the above graduated release process, patients can, on the basis of their failures and behavior, go backward instead of forward. If the patient's illness exacerbates, if behavior is improper, then privileges are withdrawn. For example, the patient may go backward from B to A status and no longer be permitted on the grounds of the Hospital. Or the patient abuses privileges and is no longer permitted unescorted time on the grounds, e.g., the patient's C or D status is cancelled. Patients can also go backward from CR or CL to A-B-C-D. Loss of CL (Convalescent Leave) status means that the patient is returned as an inpatient to the Hospital.

Return to inpatient status is usually promptly accomplished through notification of the court and the issuing of a bench warrant for the patient to be returned to the Hospital. There is no due process requirement for return to the Hospital. Unfortunately, some patients who go on unauthorized leave cannot be found. This accounts for the relatively large number of persons who at any one time are listed as being on Unauthorized Leave (see Table 1).

The patient's Convalescent Leave status (CL) is not necessarily formally revoked when a patient is returned to the Hospital. The court is put on notice that the patient has been returned for therapeutic reasons or because the patient has violated the conditions of Convalescent Leave (CL) specified by the court order. The Hospital, however, retains the option to treat the patient for up to six months as an inpatient without requesting a formal revocation of status.

Before the patient can again be returned to the community on Convalescent Leave (CL), the patient's treatment team must again present the case for review and concurrence by the Review Board. Over a year's time, perhaps 30 percent of patients on CL status become rehospitalized. This is not surprising and is in line with figures from other jurisdictions (e.g., Goldmeier et al., 1980; Bloom et al., 1986; Cavanaugh and Wasyliw, 1985; summarized in Brakel et al., 1985, pp. 732-734). Rehospitalization does not necessarily represent treatment failure but may be necessary to prevent either danger to the community or clinical deterioration of the patient.

The Forensic Division policies, that the Panel reviewed, specify that before a patient is placed on Conditional Release (following Division Review Board review), a more detailed Aftercare plan (Plan of Outplacement/Discharge) must be formulated and put on the patient's record.

Currently, the outpatient section staff is involved in aftercare planning with the inpatient treatment team. The Division requires that an aftercare plan be developed by both teams prior to submitting a recommendation for Convalescent Leave (CL) to the Review Board. The Review Board defers any decision on Convalescent Leave (CL) recommendations if this joint aftercare planning has not taken place. However, the future outpatient therapist does not treat the patient prior to the instituting of Convalescent Leave (CL). Nor do the future outpatient team members attend meetings of the Review Board.

Once care has been transferred to the outpatient department, the patient's treatment and Aftercare plans are periodically updated. For example, there are sections on the outpatient treatment plan devoted to Anticipated Problems During Outplacement Phase and Anticipated Strengths During Outplacement Phase.

The inpatient treatment teams meet at least every three months on each patient. The outpatient team meets at least every six months.

**Psychotherapy and the Therapist/Administrator Split**

In part, because of events in the Hinckley case and because the issue is generic, the Ad Hoc Forensic Review Panel devoted considerable energies toward understanding the conduct and rationale for psychotherapy, particularly individual psychotherapy within the Forensic Division. This is because all divisions at St. Elizabeths Hospital — both criminal (forensic) and civil — employ a system of individual psychotherapy that is not widely utilized today in many hospital settings, but that has strong historical associations to the Baltimore-Washington area. This system of therapy is a manifestation of the commitment of the Hospital, its psychiatrists, psychologists, and other treatment personnel to provide what, in their view, is meaningful individual and group therapy to psychiatric patients — to the greatest extent possible therapy within a "zone of privacy." The analogy is to the private practice model in the community. This practice is the Therapist-Administrator (T/A) split.

The history of this concept, its evolution from the concept of "dual management" of patients between a treating psychiatrist and an administrative psychiatrist is detailed in Appendix 1. That history will not be reproduced here. At the core of the concept is the division of psychotherapeutic and administrative tasks between persons with differing roles. Individual and group therapists view their roles, transactions, and communications with patients in a different light than do the remainder of the staff who are part of the treatment team (see above).

At St. Elizabeths Hospital, the T/A split is a "modified" one that includes elements of confidentiality of patient therapeutic communications. Forensic Division staff, in the main, believe that for psychotherapy to be meaningful, whether individual or group, patients must be promised confidentiality of their communications. Although there are exceptions to patient confidentiality, and these exceptions are told to the patient beforehand, they are limited. Exceptions relate to imminent patient dangerousness to self or others (see below).

In practice, this system means that, depending on the therapist's judgment, many, if not most, patient communications in therapy are not recorded on charts, shared directly with others on the treatment team, nor, at least in theory, do they become open to later court scrutiny and review. Interestingly, the practice of the Therapist/

Administrator split has not been questioned by the courts and prosecutors. Indeed, in the past, individual therapists have never been subpoenaed to testify at court hearings, nor are their personal therapy notes ever subpoenaed. The system of the Therapist/Administrator split has also survived court scrutiny in a "duty to protect" type case *White v. United States,* 780 F.2d 97 (D.C. Cir. 1986) (possible negligent supervision of a patient who harmed a third party while on unauthorized leave).

Virtually all of the staff interviewed at St. Elizabeths Hospital are committed to the Therapist/Administrator split as essential to the conduct of meaningful therapy. It is stated that this practice promotes trust between patients and therapists, encourages frank communication, prevents game playing, and has other advantages.

John Hinckley, Jr., was treated at the Hospital under such an individual Therapist/Administrator split. As a result of this treatment arrangement, Mr. Hinckley's therapist did not share information about the Bundy letters with the treatment team.

In the Forensic Division, individual or group therapy that is psychologically based is thus distinguished from other parts of the patient's treatment, e.g., ward discussions with other treatment personnel, medication, milieu therapy, etc. The overall therapy is coordinated by the patient's treating ward psychiatrist, who is not the patient's therapist, and by the treatment team.

While it is the practice at St. Elizabeths for the therapist to make periodic therapy notes on the patient's chart, typically these are not about the content of the therapy. Rather, they indicate only generally what themes are touched on, how often the patient is seen and what general progress is being made.

The assumption is that the patient will grow individually in therapy and that this growth will be manifested in the patient's behavior, mental state and communications to others on the ward — outcomes monitored through multiple other channels of information. During the other "23 hours of the day," ward and other treating staff are able to assess patient progress independent of detailed information given to them by the therapist. Thus for the relatively small number of patients at the Forensic Division who are being treated under a rigid Therapist/Administrator split (see below), the patient's therapist does not talk with the treating psychiatrist about the progress of the therapy, nor does the therapist attend team meetings, give feedback about progress, or participate in administrative decisionmaking.

The importance of all this for the Panel's report is that there is a type of material learned about patients in therapy, which some persons, including judges, might find relevant to their independent assessment of patient progress and dangerousness. But this information is not necessarily shared with other treatment and administrative personnel in a systematic way.

It must be stressed that all of St. Elizabeths Hospital, *not just the Forensic Division,* functions this way. For example, SEH Institute Policy No. 4500.6 on progress notes states that:

> 4.e . . . During psychotherapy the patient may reveal intimate and detailed personal information about himself/herself, and the therapist must use clinical discretion and professional judgment about the inclusion or exclusion of particular information in the patient's record.

Also Section 4.e (3) states:

> Therapists may believe that a detailed note could be detrimental at a specific time in therapy. If so, the therapist may use discretion in the content of the note.

This widespread practice at St. Elizabeths Hospital has not escaped the scrutiny of various surveyors. For example, the Panel reviewed a 1986 Medicare report. Section B16 states "Most charts show no documentation of individual psychotherapy and what occurred in group therapy."

The above information should not be taken to mean that St. Elizabeths staff is insensitive to problems of danger on the wards, nor that exceptions to confidentiality are not recognized and communicated to patients at the onset of therapy. SEH 4500.6 4.e (4) states:

> a note also is necessary at times to alert the staff of significant events within the session, such as suicide threats or life-threatening situations, which may have serious behavioral consequences. In such a situation, administrative and human needs override issues of confidentiality.

In general, at the Forensic Division, patient confidences are, however, not shared without the patient's permission to do so, except to prevent what could be termed imminent dangerousness to self or others ("management dangerousness") within the Hospital.

While this policy may appear inconsistent with the Division's mandate to treat and rehabilitate patients along the above described system of graduated release, in the staff's view any inconsistency in theory is mitigated by Hospital practice.

In practice, when the patient's treating psychiatrist or the clinical administrator concludes that a status change is necessary, the psychiatrist will talk briefly with the patient's therapist, share the proposed plan, and then ask if the therapist sees contraindications to proceeding in the recommended direction. In effect, therapists are asked to acquiesce to proposed patient change on the basis of their private knowledge of the patient. If the therapist does not acquiesce, there are several options. The therapist may return to the patient and tell the patient of the therapist's desire to share material with the team, or the therapist can encourage the patient to do so. Permission to share information is thereby obtained. Or other team members can themselves interview the patient, at which time the patient may be willing to share the material. Or the team (on the basis or nonacquiescence by the therapist) may change their mind about the recommendation. It is the opinion of the St. Elizabeths staff that the Therapist/Administrator split has caused virtually no problems over the 25 years it has been in effect. Relevant information for assessing patient progress eventually does come out through one mechanism or another.

Patients have not left psychotherapy alleging their confidences have been violated. The courts and the prosecutors respect this system. Thus the staff, interviewed by the Panel, are uniformly of the opinion that the option for a Therapist/Administrator split should be continued at St. Elizabeths Hospital.

The above system for therapy has implications for so-called "Personal Notes." In practice, there is a system of personal notekeeping at the Hospital wherein therapists may record (for their own use) informal notes from therapy sessions. The extent of this practice is variable among staff. There is no Hospital policy for a second recordkeeping system. The staff are also desirous of keeping Personal Notes confidential in the future because they view this system as needed and appropriate. They do not want such notes to be subpoenaed for use at a court hearing.

While the above information has been presented monochromatically, it must be emphasized that there is a good deal of variation in the extent and rigidity with which the Therapist/Administrator split is presently practiced within the Forensic Division. Only a very small number of patients are treated in a rigid Therapist/Administrator split. The highest frequency estimate that we received from the staff about the proportion of patients who are in any individual therapy was 20 percent. Other staff estimated that only 20 people were in individual therapy in the John Howard Pavilion — of 280 patients. Furthermore, among the therapists (approximately two-thirds are psychologists, the remainder psychiatrists and trainees), not all practice the Therapist/Administrator split in the same way. Some therapists do not promise the degree of confidentiality that other therapists do. Some therapists speak more freely with the treating psychiatrist and share information more easily. Some therapists attend treatment team meetings whereas others do not. There is a wide range of practice among therapists in the implementation of the Therapist/Administrator split. The Panel notes, however, that there is no Hospital policy outlining parameters under which this practice takes place.

The Forensic Division's devotion to confidentiality and to assuring patient privacy also extends beyond the subject matter of the Therapist/Administrator split. These concerns extend to policies on patients' mail and searches. To a limited degree, these staff attitudes may also come to affect communications with the court and attorneys. These matters are discussed more generally in a later section related to Confidentiality/Privacy Controversies.

The above system of psychotherapy, both individual and group, has implications for the Division's Quality Assurance Activities.

**Quality Assurance Activities**

"Quality Assurance" has become the watchword of the decade in hospital management and treatment. It is therefore commendable that this is a JCAH certified hospital. Specifically, in 1986, at the last survey, no deficiencies were cited by JCAH for the Forensic Division.

The Forensic Quality Assurance Plan and activities of the Quality Assurance Committee are well documented. These activities include, but are not limited to, the Quality Assurance Committee, the Review Board, Clinical Records Monitoring, Medication Reviews, Review of Special Treatment Procedures, Program Evaluation, Clinical Supervision and Patient Care Monitoring. The Quality Assurance Plan for the Forensic Division discusses these areas in depth; it is thorough.

The Panel was impressed with the overall evaluation reports, prepared for the Division by Seitz (1986) and by Baridon et al. (1983) etc. These and other program management reports enable the Hospital to evaluate its objectives and release procedures in terms of outcome. They are a valuable part of the Quality Assurance Activity.

It is beyond the scope of this report to summarize the various training opportunities that are regularly provided to St. Elizabeths Hospital Forensic Division staff. We note that these are regular and targeted to relevant areas. All staff receive 30 hours of Continuing Medical Education (CME) per year in areas directly relevant to patient care, e.g., in CPR training. This includes a six-session training course each year on legal issues conducted by the Hospital Legal Counsel related to areas such as confidentiality, liability, privacy, etc.

During its visit to the Hospital, the Panel reviewed the treatment planning format for inpatients and outpatients, including a comprehensive Aftercare planning form (Plan of Outplacement/Discharge).

The Panel inspected the Patient Care Monitoring Form. This is used throughout the Hospital. It is a checklist related to reasons for individual case review. It documents why treatment problems persist or discharge placement is not possible. The Review Board studies patient charts and completes this form at Review Board meetings.

The Review Board also completes a CHART REVIEW form on 12 different categories of information, e.g., treatment plans, assessments, progress notes, diagnosis, etc. Where information is missing or incomplete, the treatment team must complete missing items or make corrections before Review Board decisions can be implemented. This form does not, however, contain any information about Aftercare planning.

Because of the Panel's interest in the propriety of the Therapist/Administrator split, the Panel targeted some of its activities in the Quality Assurance area to reviewing the Division's policies and procedures for review of the adequacy of psychotherapy.

Here the Panel learned that a major effort of Quality Assurance control relates to assuring of competency of therapists. They must attain a formal privilege to provide psychotherapy based on training and experience (psychiatrists, psychologists, and social workers). Other persons (trainees such as psychiatric residents or psychology trainees) are permitted to do therapy only under regular individual supervision. In assuring quality, major reliance is placed on the ethics, skills, and professionalism of the individual practitioner; the level of

training and experience; overall competence, as known by general reputation; and by monitoring any bad outcomes that might occur.

SEH Policy 1220.1 defines Clinical Privileging for the Medical Staff. The system relies on several levels of training and experience: Levels One through Four relate to the physician's level of experience, whether residency training and board certification have been completed, and years of experience beyond residency. The more extensive the experience, the more independent practice, consultation with and supervision of others is permitted.

There are no special privilege requirements for psychiatrists with respect to psychotherapy. Psychotherapy is listed as among the standard types of psychiatric activities that are permitted psychiatrists, though practitioners with lower level privileges must seek guidance and consultation. While diplomas or certificates are required for psychiatric treatment such as electroconvulsive therapy, amytal interview, hypnosis, this is not the case for psychotherapy.

Awarding of privileges to clinical psychologists is a function of the psychologist's training (Ph.D. is required), completion of internship, and having 50 hours of supervised training experience or its equivalence. Such training permits the psychologist to do psychodiagnostics, individual psychotherapy, and group therapy. There are special privileges for Family Therapy and Neuropsychological Assessment and Hypnosis.

Psychiatry, psychology, social work and other trainees are supervised regularly by privileged practitioners. This appears to be a conventional form of supervision wherein the therapeutic process and content of sessions is discussed.

The Panel did not gain the impression that there is special attention given in supervision (nor are guidelines formalized or agreed upon), about what type of patient information should be recorded on charts or shared with others on the treatment team, with the exception of information related to imminent dangerousness, as described above. The necessity for sharing of the therapist's information with others is viewed as a matter of "common sense."

There is also supervision of trained and privileged psychiatrists and psychologists by the medical and psychology Chiefs of the division. The extensiveness of this supervision (in light of these supervisees being privileged to do psychotherapy) is somewhat unclear.

It is the Panel's impression that the potentially troubling, more problematic aspects of the Therapist/Administrator split may not be addressed systemtically at supervision sessions. There is considerable discretion afforded by St. Elizabeths' policies and procedures about what should be recorded in treatment notes. Decisions that need to be made by therapists about the relevancy of communications and their relationship to the forensic diagnostic and assessment enterprise are difficult to monitor under the prevailing system of Quality Assurance of psychotherapy.

**Confidentiality/Privacy Controversies**

In this section, we expand upon the devotion of St. Elizabeths Hospital Forensic Division staff to ensure privacy for its patients, to the extent possible, in furtherance of treatment, even while the staff remains aware of its responsibilities to the court and ultimately to society. In so doing, we touch on opinions of others whom the Panel interviewed about these matters.

St. Elizabeths' staff desire to preserve patient privacy finds expression in the above procedures for recordkeeping and conducting psychotherapy under the Therapist/Administrator split, in Division policies related to inspecting, monitoring, and reading patients' mail, inspection of packages, and other patient possessions. Furthermore, to a minor extent, in the past and particularly around controversial and difficult cases such as the Hinckley case, the views of Division staff and of its Legal Counsel about the importance of patient confidentiality may have influenced staff communication, particularly with attorneys prior to court hearings.

From the Panel's interviews, we learned that at least some of the Forensic Division's treatment staff are very oriented toward "knowing the law" and relevant regulations. They wish to be shown exactly what sections of law permit them to, as they see it, "violate patient confidentiality." This is not a parochial question. As the Panel's interviews demonstrated, there is disagreement among experts, advocates, and professionals of differing persuasions about how confidentiality/privacy concerns should be balanced by treatment staff and the courts in the treatment of forensic patients. Virtually all persons the Panel questioned expressed some concern or uncertainty about this area of the Panel's inquiry. The conflict is obvious. Society wishes to maintain patient privacy/confidentiality in furtherance of treatment and in order that patients not lose all rights as a consequence of being insanity acquittees. On the other hand, treatment staff and the courts need access to all medically relevant information related to the awarding of privileges and the graduated release process. As a D.C. Superior Court judge told us, we want "all the information" to do our job. Although the *Hinckley* case made this controversy more visible, the issue has arisen before. For example, one Assistant U.S. Attorney told us about similar past concerns in other cases.

Previous developments in the *Hinckley* case, before the proposed Easter pass, also gave rise to controversy. Prior to Mr. Hinckley's coming to the Hospital in 1982, the Hospital had no formal policy on the screening of patient mail or possessions. As the Panel understands it, the Division did not screen mail or packages, nor wish to do so save to screen for contraband on a periodic "shakedown" basis. Mr. Hinckley's case, however, stimulated the development of formal policies related to mail and monitoring his communications with the media. The treatment of Mr. Hinckley has put many pressures on the Hospital.

How best to balance the twin concerns of preserving privacy versus effective assessment of patient progress,

treatment and dangerousness is also viewed as a conundrum by the patient advocates that we interviewed, such as the representatives from the National Alliance for the Mentally Ill, the Mental Health Association, and the Mental Health Law Project. Again, these persons expressed a general desire to protect patient confidentiality/privacy to the greatest extent possible, while taking cognizance of the legal mandates and role of the Division. No one wants future harm to come to innocent victims or families because staff was not fully knowledgeable about a patient's desires.

In advocating for the protection of patient confidentiality/privacy, Division staff point to JCAH regulations and other legal mandates (D.C. and Federal statutes) with which the Hospital must comply.

> For example, the *Consolidated Standards Manual of the JCAH* P1.2.1.6.,1987, states that "Each person's personal privacy is assured and protected within the constraints of the individual treatment plan."
>
> P1.2.1.6.3 states that "Patients are allowed to send and receive mail without hindrance."
>
> P1.5 states "The maintenance of confidentiality of communications between patients and staff and of all information recorded in patient records is the responsibility of all staff."
>
> PE.2.8.3.4 states that "The patient's consent is acquired in accordance with applicable law and regulation (for the disclosure of information)."

The staff respect the JCAH. As one Division psychiatrist put it, "We are psychiatrists, this is a hospital, a JCAH accredited one."

Furthermore, the Forensic staff are very oriented and sensitive to the Federal Privacy Act of 1974, 5 U.S.C. Section 552a (1982). Staff are given instructions about this Act. Indeed, in the *Patient's Rights and Responsibilities Handbook,* as well as in staff training material, it is stated that patients have the right to keep their treatment record and all information about them confidential in accordance with the Privacy Act. The Privacy Act, in relevant part, states that:

> No agency shall disclose any record which is contained in a system of records by any means of communication to any person, or to another agency, except pursuant to a written request by, or with the prior written consent of, the individual to whom the record pertains, unless disclosure of the record (meets certain exceptions). 5 U.S.C. Section 552a(b).

Among these exceptions are the law enforcement activity exception (b)(7) (requires written request by agency head) and the exception pursuant to the order of a court of competent jurisdiction (b)(11). As the Panel learned, St. Elizabeths Division's legal staff questions whether subpoenas for records — in anticipation of court proceedings — do meet these exceptions. *See also Doe v. DiGenova,* 779 F.2d 74 (D.C. Cir. 1985), a case given to the Panel by St. Elizabeths Hospital Forensic Division Legal Counsel. (A subpoena is not a court order for purposes of the Privacy Act.)

In the course of its interviews, the Forensic Division staff also brought to the Panel's attention other legal protections of patient confidentiality, e.g.,

> (1) the D.C. Code Physician/Patient Privilege statute, D.C. Code Ann. Section 14-307 (1981), protects confidential information from being disclosed in court without patient consent, save that which can be disclosed in pretrial or post-trial proceedings involving a criminal case where a question arises concerning the mental condition of an accused or convicted person.
>
> (2) the D.C. Hospitalization of the Mentally Ill Act, D.C. Code Ann. Section 21-561 *et. seq* (1981), protects records and patients' rights to receive mail (no censorship of mail unless the Chief of Service believes the action is necessary for the medical welfare of the patient who is the intended recipient).
>
> (3) the D.C. Mental Health Information Act of 1978, D.C. Code Ann. Section 6-2003 (1981), gives strong protection for personal notes.

In general, Federal law and that of the District of Columbia afford stronger protections for patient privacy/confidentiality than does the law of other jurisdictions.

The Panel notes that while it is true that various sections of the above legislation do offer the promise of confidentiality/privacy for patients, each piece of legislation also then lists various exceptions to the rule that permits disclosure when information is needed in litigation (particularly pre-trial and post-trial criminal proceedings or actions when patients place their mental condition at issue), or when disclosure is to other staff to facilitate the delivery of services (e.g., see D.C. Mental Health Information Act, Section 6-2021). Disclosures are also permitted consesquent to court orders (e.g., see D.C. Mental Health Information Act, Section 6- 2031) (Court-ordered examinations).

Contrary to the Forensic Division's interpretation of these statutes, it is the opinion of the U.S. Attorney that the above statutes do not control in the special situation of St. Elizabeths Hospital Forensic Division. Alternatively, it can be argued that the exceptions in these statutes are broad enough to permit staff to monitor and read patients' mail, inspect personal property, and also disclose patient communications to attorneys (prosecution and defense counsel) and courts whenever such information is relevant to the court's decision about the awarding of patient privileges and release. The determination of eligibility for release "cannot be properly made without the fullest explanation from the expert witnesses of the patient's mental condition" (*Dixon v. Jacobs,* 427 F.2d 589, 600 (D.C. Cir. 1970)). The judges that we interviewed each expressed a desire to receive all information about patients at St. Elizabeths Hospital Forensic Division that is relevant to helping them do their job. The judges were also unanimous in their view that, even without additional court orders, the Hospital may take necessary steps to learn and communicate to the court what is medically relevant about the patient. For example, the judges from the D.C. Superior Court saw no necessity for court orders for scrutiny of mail when, in

their view, the Hospital already has the power and authority to do this.

As a practical matter, how are these matters now addressed by the Hospital? What problems have resulted?

One example of the above dilemma relates to Hospital and Division policies on reading of patients' mail. For therapeutic reasons and because the Hospital believes that patients do have privacy rights, it is loathe to read patients' mail or to log it in, even without opening, unless clear-cut need is defined. Thus Mr. Hinckley's mail, which was monitored until 1984, was no longer monitored after this period, following a court hearing on the subject. However, the record documents that even prior to the court hearing, the Hospital and Mr. Hinckley had together agreed to cease monitoring his mail.

SEH Policy, 5040.1E permits periodic inspection of packages and mail for contraband and also suspension of mail privileges, but only as is necessary to protect clinical treatment or the security interests involved (see Sections 12-15 of the policy).

Outgoing mail is screened only when the patient has used the mail to convey criminal threats or further criminal activity, discuss escape, or solicit contraband. A somewhat similar policy is pursued with regard to incoming mail. However, treatment staff may open and read all mail when "the patient's clinical condition is sufficiently acute that the treatment staff have clinically determined that his/her mental health will be significantly impaired by the receipt of certain correspondence" (Section 14(b)(4)).

Abridgement of mail rights requires notice to the patient. An appeal procedure can be requested by the patient in which a clinical consultant from outside of the Division of Forensic Programs independently reviews the request for monitoring or censureship of mail and makes a recommendation to the Superintendent.

This policy, originally written in 1982, (following Mr. Hinckley's hospitalization at St. Elizabeths Hospital Forensic Division) is deliberately one of narrow exception. The policy was reviewed and approved as to constitutional adequacy in September 1982 by a U.S. Department of Justice, Civil Division Memorandum (Royce C. Lamberth, Chief).

For the purposes of this report, the important point is that patients' mail is presently permitted to be monitored at St. Elizabeths Hospital Forensic Division, both incoming and outgoing, only for security reasons and to prevent harm to the patient's treatment. There is no exception in the present policy that permits mail scrutiny for purposes of assessment of a patient's mental status, routine monitoring of ongoing progress, or assessment and prediction in relationship to granting privileges. Confronted with a dilemma of values and professional practices, the St. Elizabeths staff have tilted in the direction of patients' rights. Furthermore, the Forensic Division staff do not view reading of patients' mail and learning the information in it as generally relevant to the assessment/prediction enterprise, save in exceptional cases. For example, even in White House cases where patients have been sent to the Hospital for threatening public officials, their mail is not regularly screened or read unless one of the above exceptions applies.

Another practical result of the devotion of St. Elizabeths Hospital to maintaining patient confidentiality/privacy is some lingering ambiguity in the minds of staff and Hospital Legal Counsel about the forwarding of information to attorneys and the courts. Although St. Elizabeths Legal Staff believes that the law on the subject is not entirely clear, the Hospital does regularly release, make available to the attorneys and the courts, all patient records prior to hearings. There is less certainty, however, in the mind of the staff about the obligation and propriety of St. Elizabeths Hospital staff releasing information to attorneys orally before the hearing in attorney/staff interviews. Here Legal Counsel for the Hospital cites the Privacy Act and *Doe v. DiGenova,* 779 F.2d 74 (D.C. Cir. 1985), in support of this point. Prior to the court hearing, there is no court order nor formal request from law enforcement activity exception ((b)(7)) received by the Hospital. Some St. Elizabeths' staff, the Panel was told, insist to Legal Counsel that they want "to see the statute" that permits them to talk ahead of time with the prosecutor.

*The above types of problems are not frequent.* Indeed, the great majority, virtually all cases, go rather smoothly (see below). However, these problems do symbolize certain present professional beliefs held by St. Elizabeths Hospital Forensic Division staff about what information is relevant to court decisionmaking. They also relate to staff beliefs that if certain types of patient scrutiny (invasion of privacy) are justified as necessary to meet the needs of the court, additional court orders are required. This entire controversy relates to the imprecision in judicial decisions and statutes as to what rules apply to the "special" type of patient at the Forensic Division.

**Overview of Law, Practice, and Procedures Related to Court Hearings**

This section summarizes what the Panel has learned about the conduct of hearings related to release and relaxation of restrictions placed upon patients.

Presently the Superior Court of the District of Columbia conducts release hearings under Sections 301(e) and (k). The new Federal Statute, 18 U.S.C. 4243(f) is presently applicable in the U.S. District Court and creates a similar scheme to Section 301(e) and (k).

The 301(e) process is triggered when the Hospital petitions the court for a change in patient status. The 301(k) process is a habeas corpus type procedure initiated by the patient.

Nearly all the hearings related to insanity acquittees involve the Office of the U.S. Attorney. This is because all cases that carry potential sentences of more than six months in jail (including serious misdemeanor offenses) are prosecuted by the U.S. Attorney, whether they are tried in the District Court or the Superior Court. Although cases are heard in the U.S. District Court and the Superior Court of the District of Columbia, the Superior Court hears the bulk of cases, probably more

than 90 percent. The U.S. Attorney's Office is involved in virtually all release hearings.

The volume of release hearings is approximately 120 per year, including 100 hearings in the D.C. Superior Court, approximately 20 in the U.S. District Court. There is also a difference between the District Court and the D.C. Superior Court in the assignment system for judges in these cases. In the U.S. District Court, the trial judge who presided over the original insanity trial keeps the case for subsequent release matters, and thus is very familiar with the patient and all developments related to changes in status. In the D.C. Superior Court, with its larger number of judges and cases, the judges are assigned release hearings in rotation.

The applicable statute for Section 301(e) release decisions provides as follows:

> Where any person has been confined in a hospital for the mentally ill pursuant to subsection (d) of this section, and the superintendent of such hospital certifies: (1) That such person has recovered his sanity; (2) that in the opinion of the superintendent, such person will not in the reasonable future be dangerous to himself or others; and (3) in the opinion of the superintendent, the person is entitled to his unconditional release from the hospital, and such certificate is filed with the clerk of the court in which the person was tried, and a copy thereof served on the United States Attorney or the Corporation Counsel of the District of Columbia, whichever office prosecuted the accused, such certificate shall be sufficient to authorize the court to order the unconditional release of the person so confined from further hospitalization at the expiration of 15 days from the time said certificate was filed and served as above; but the court in its discretion may, or upon objection of the United States or the District of Columbia shall, after due notice, hold a hearing at which evidence as to the mental condition of the person so confined may be submitted, including the testimony of 1 or more psychiatrists from said hospital. The court shall weigh the evidence and, if the court finds that such person has recovered his sanity and will not in the reasonable future be dangerous to himself or others, the court shall order such person unconditionally released from further confinement in said hospital . . . .Section 301(e).

As discussed above, a similar procedure can result in a Conditional Release when this status is recommended because the patient is not yet ready for Unconditional Release, and a period of community supervision is recommended.

Although holding a court hearing is optional, some form of hearing occurs in virtually all cases, to make a record, test the opinion of the Hospital and wisdom of its recommendation, and to assure protection for the public.

Characteristically, the 301(e) procedure is initiated by a two-page letter from the Director of the Forensic Division to the court, giving the recommendation and rationale for reduced security status.

The Panel reviewed several of these two-page letters and found them generally thorough and complete. They build on the previous recommendation of the treatment team, as reviewed by the Review Board. The letter provides an overview of the patient's legal history and charges, diagnosis, course of medical treatment to date, patient behavior on previous, more restrictive statuses; and these letters specify what the Conditional Release or Aftercare plan for the patient will be. While, in general, persons whom we interviewed were positive about these letters and indicated they provided good information, a concern was stated that these letters do not contain sufficient information about Aftercare planning, which only comes out at the hearing. The Superior Court judges whom we interviewed also indicated that, at times, they would like more information earlier in the process about the patient than is in the two-page letter. Eventually all the information about the patient's history — including treatment team summaries relating to proposed status changes, other patient progress notes, other information in the record about aftercare — does become available to the attorneys and courts through record review and court testimony.

The 301(k) procedure is somewhat different. In this procedure, both the Hospital and the prosecutor are usually opposed to what the patient (through his attorney) has requested, namely, change in the patient's privileges, fewer restrictions, or outright release. Such patient-initiated requests may occur as often as once every six months. In 301(k) cases, it is not always the case that the Hospital submits a letter to the court, summarizing its opinion about the case.

Customarily, when the prosecutor receives notice of a 301(k), he calls the Hospital, talks with the physicians, and finds out their view of the case. He attempts to determine whether the 301(k) might "turn into" a 301(e). The Hospital can conclude, in reviewing the patient's request, that a portion of it is medically proper, or that it will accept some intermediary position.

In the 301(k) process, the burden is placed upon the patient to show by a preponderance of the evidence that he is no longer dangerous. These petitions can be more expeditiously rejected by the court than are 301(e) requests, in the absence of the patient having a witness, an independent expert, or when the evidence is clearly against the patient's position.

As discussed below, both the 301(e) and the 301(k) processes have, in the view of the Hospital, certain potential implications for the Hospital having legal representation at the time of the court hearing. Presently, under Federal law, the U.S. government (the prosecutor and the Hospital which is under Federal control until October 1, 1987) may speak with only one voice. (28 U.S.C. Section 516). The voice is that of the U.S. Attorney. Also, it is the strongly held opinion of the U.S. Attorney's office that the only parties to a release hearing recognized by Sections 301(e) and (k) are the prosecutor (U.S. Attorney or the Corporation Counsel) and the patient — usually through his counsel. In the view of the U.S. Attorney, the Hospital is clearly not a party to the proceedings. Its role is to "trigger a process," provide in-

formation of relevance to court decisionmaking. The Hospital should not be an advocate for one position or another or for its own position.

The Panel spent a good deal of its time interviewing parties to the hearings about their general view of their adequacy, the outcome, and whether sufficient information is provided to the court and the parties by the Hospital, enabling participants to do their jobs. With the exception of the Hinckley case and in a few other notorious cases described to the Panel by an Assistant U.S. Attorney, there was general satisfaction among the parties and the judges about the conduct of these hearings and their outcomes. In the ordinary case, the flow of information is also adequate.

We have previously mentioned the Hospital's uncertainty about whether hospital staff should talk to the prosecutor before the hearing. In practice, this problem does not frequently arise. Records and information do usually go forward equally to both sides. What one side learns, the other side could learn. To some extent, what the prosecutor and defense counsel learn prior to the hearing is also a function of the individual style and desired approach of the attorney handling the case. Each attorney has the option to subpoena all the records and to come to the Hospital to review records and interview staff. An asymmetrical knowledge of the case may occur, however, prior to the hearing, when one side or another elects not to pursue information in as much depth as does the other side. The only systematic ambiguity about information disclosure and information flow that the Panel discovered (at present unresolved) relates to the discomfort that some Forensic Division staff feel about talking to an Assistant U.S. Attorney, whose interests they often view as highly adversarial to their own in particularly notorious cases. More will be discussed about this below.

In the vast majority of cases, however, the court does eventually concur with the Forensic Division staff's recommendations. Thus most cases are not controversial, and it was the consensus of the persons the Panel interviewed that the procedures already in place do generally work well.

In general, the persons whom the Panel interviewed also indicated their view that the hospital's records are thorough and complete. There is generally good information in the charts on which to base independent decisionmaking with respect to patient release and change of privileges. The major dissent to this perspective was from the U.S. Attorney's office, whose view is that, in the Hinckley case and in some other similar cases, the Hospital should have known more and documented more in the patient's record.

The Hinckley case also provoked a debate, at least in the media, about whether release proceedings are "adversarial" or "nonadversarial," and whether St. Elizabeths Hospital Forensic Division has mistaken ideas about this matter. In legal theory, this matter appears clear cut by virtue of the language of D.C. Court decisions which state that " '[p]roceedings involving the care and treatment of the mentally ill are not strictly adversary proceedings,'" (*Ecker,* 543 F.2d at 192, quoting *Lake v. Cameron,* 364 F.2d 657, 661 (D.C. Cir. 1966)). *See also Dixon v. Jacobs,* 427 F.2d 589 (D.C. Cir. 1970).

The implication of case law is that all possible relevant information should be before the court so that it can balance the treatment needs of patients against the necessary protection of society. Each party to the hearing and the court has a duty to ensure a full and adequate hearing. As the Panel's interviewees explained, in practice, this means that the flow of information provided by the Hospital prior to the hearing must be nonadversarial. The attorneys that the Panel interviewed (prosecutors and defense counsel) and the Hospital, however, also indicated that in practice there does result a spectrum of "adversarial struggles" that may take place between the parties at the time of the court hearing. In noncontroversial or less serious cases, the prosecutors will frequently not put up major opposition to the Hospital's recommendations. The prosecutor may go along, or even have no position. In other better known and potentially more serious cases, a sustained adversarial battle may result in court. As an Assistant U.S. Attorney put it, the hearing, although not adversarial in theory, "may walk, talk, and sound" adversarial.

Because the Hospital is presently not recognized as a party to the hearing, its position in 301(e) cases is generally put forward by patient's defense counsel. The Public Defender's Office is viewed by all informants as doing an excellent job in this respect. In the 301(k) cases, the Hospital usually finds itself aligned with the prosecutor because both oppose the patient's request. Thus in the modal case, the Hospital's perspective is usually put forward and effectively argued either by defense counsel or the prosecutor.

But there is more to this. From the perspective of the Hospital, in controversial cases such as Hinckley, the U.S. Attorney's office can be counted upon to oppose any conditional release recommendation. In some other cases, the Hospital notes it has a point of view that is at variance with both the defense counsel and the prosecutor. The Hospital's recommendations, or preferred position, may straddle the middle ground. Because the Hospital's position is unrepresented at hearings by its legal counsel, its expert witnesses also "feel exposed" and to some extent fear cross examination. They complain that they are unable to get across their point of view, which in essence is a professional recommendation. In some cases, certain hospital policies may also be at issue, e.g., policies on mail, confidentiality, or about Aftercare. Here again, in the Hospital's view, it would "like to have the option" for representation in certain cases to ensure that all the relevant information is before the court.

As noted above, the U.S. Attorney's Office (and to a lesser extent the Public Defender's Office) is opposed to independent hospital representation because (1) the D.C. statute does not authorize parties to the hearing beyond those already listed, (2) three attorneys will complicate the proceedings, and (3) permitting the Hospital representation will raise other questions about where to draw the line.

The practice in the District of Columbia concerning

representation of the Hospital at release hearings is indeed different from other jurisdictions such as Maryland and New York. In these jurisdictions, the release recommendation is made by the Hospital to the courts, and the state's Attorney General represents the Hospital's position. The American Bar Association Criminal Justice/Mental Health Standards also recommend representation for hospitals in release hearings (ABA Standards, 1986, at 407).

The Panel reviewed the matter of hospital representation with the District of Columbia Corporation Counsel. The Office of Corporation Counsel will, in the future (post October 1, 1987), be responsible for providing legal counsel to the St. Elizabeths Hospital Forensic Division. The D.C. Corporation Counsel indicated a strong desire to have representation for the Hospital. (This is also the position of the D.C. Commission on Mental Health Services.) The Corporation Counsel notes that the Hospital is the custodian of the patient; therefore, it has an independent interest in having its recommendations followed.

The matter of representation for the Hospital should not be seen in isolation from the previously discussed controversies concerning confidentiality/privacy. Because the Hospital staff views the role of the U.S. Attorney's Office as clearly adversarial to their conditional release recommendations in serious and controversial cases and because hospital staff who testify know that their testimony will be subjected to vigorous cross examination by the U.S. Attorney, some hospital staff have developed more defensive attitudes than is necessary about the release of information to all parties.

Finally, in attempting to best understand the flow of information to the courts and its adequacy, the Panel questioned the attorneys and the judges, as well as Mr. Hinckley's defense attorney, about the matter of the Therapist/Administrator split. Interestingly, none of these parties was particularly disturbed or alarmed about the Therapist/Administrator split. They saw some justification in it. However, these parties were also not particularly knowledgeable about the terminology or the exact procedures involved in the Therapist/Administrator split. All parties acknowledged that it was not the custom to subpoena therapists to testify. To do so might conceivably jeopardize the professional-patient relationship.

## III. RECOMMENDATIONS

Having provided the above factual material and overview of policies and procedures at the St. Elizabeths Hospital Forensic Division, in accord with the Panel's Charge from NIMH, we turn now to the Panel's recommendations relating to the Charge. We have organized these recommendations in the main along the same issues that have been addressed above.

### Instituting of Status Changes and Privileges — Release Decisionmaking

In general, the Review Panel is impressed with the decisionmaking process at the Forensic Division that results in the treatment of forensic patients and their release in a graduated supervised fashion. Decisionmaking in the Division is careful, repetitive, and involves multiple inputs and observations regarding a patient's progress.

There is multidisciplinary input involved in the assessment of patient progress, dangerousness, and in release decisionmaking. Furthermore, the patient's treatment team and the Forensic Division's Review Board function in a coordinated fashion to monitor patient progress and to review the propriety of "moving to the next step." The Review Board performs a particularly useful function. It takes its work seriously and has made a major contribution towards more systematic decisionmaking in the Hospital and in coordinating status change recommendations with the necessary court processes.

The Panel is positive about what it has found in the assessment area. Nevertheless, the Panel does wish to introduce one conceptual point with respect to release decisionmaking at the Forensic Division, including the assessment of future patient dangerousness. Although, in part, this is an "academic point," nevertheless, it impacts upon later Panel recommendations with regard to Therapist/Administrator split, the sharing of potentially relevant information for release decisionmaking and the necessary role that the courts must play in the District of Columbia in assessing patient readiness for release. Here the Panel refers back to an earlier section of the report in which it has discussed the dual mandate of forensic hospitals, the prediction of dangerousness, and the necessity to consider the offense for which the patient was committed in making a risk/benefit calculus for release.

While, in good measure, it is correct to view the major effort of the Hospital's Forensic Division to be the treatment of mental illness so as to reduce a patient's potential dangerousness and thereby permit release to the community, the Panel also believes that more than mental illness must be addressed in calibrating the extent of a patient's recovery and suitability for release under a particular set of circumstances. This is because the prediction of dangerousness for both mentally ill and nonmentally ill persons involves not only assessing the extent to which a mental illness that has provoked a dangerous act is quiescent, but also the person's underlying personality characteristics and the likelihood of future violence that might occur due to the provocations of particular environments.

In addressing this issue, the Ad Hoc Panel generally agrees with John Monahan's 1981 NIMH Monograph, "The Clinical Prediction of Violent Behavior." In the final chapter, Monahan identifies 14 questions that clinicians should ask themselves when making predictions. Monahan's model (adapted from Novaco) helps the clinician think through the factors to be assessed in the prediction of violent behavior. These factors include the stressful events that may impinge upon a patient in a particular environment, how the patient views or experiences these events (the patient's characteristic thinking and mood), and his subsequent behavior. (See also Roth, 1987.)

While in many patients reduction of psychotic behavior or stabilization of mental illness will prevent symptomatic

behavior — including violent behavior if such behavior was solely "the product of a mental illness" — assessing the likelihood of violent behavior of forensic patients requires calibration of other factors. As Seymour L. Halleck notes in his 1986 NIMH Monograph,

> Experienced clinicians believe that insanity acquittees can often be characterized by mixed diagnoses, with some symptoms of psychosis and some symptoms of severe personality disorders. (As a rule, it is the presence of psychosis that leads to a finding of insanity. The presence of a personality disorder is most likely to be associated with criminal tendencies. An appreciation of the mixed disorders found among acquittees may explain the high recidivism rate of those who are released and alert clinicians to special problems of treatment.) (at 73)

Some of the most important literature emerging from other facilities, which, like St. Elizabeths Hospital Forensic Division, treat mentally abnormal offenders, also points to the importance of what the Panel calls "offense recapitulation and analysis," in trying to understand the patient's personality characteristics that led to a violent act. Such patient dynamics, if not altered, can lead to potential repetition.

Thus in evaluating dangerous persons at the Bridgewater Massachusetts Institution, Kozol et al. (1972) stress the importance of reviewing with the patient the exact circumstance of the offense and how he or she regarded and treated the victim. How the patient views past victims or how he might view future similar victims is important in prediction. Wiest (1981) has described a similar approach toward treating patients at the Atascadero State Hospital in California (the state's primary institution for sex offenders and the criminally insane). Wiest notes that a "first step should be a detailed history of the criminal act, in a process requiring the client to 'walk the therapist through the crime.' This procedure provides invaluable information both for assessing treatability and for evaluating change." Sturup's work (1968) is also relevant. He describes an "anamnestic analysis." Offenders at the Herstedvester Institution review their experiences with the therapist in order to "recognize unsatisfactory personality patterns and notice how these reoccur in a peculiarly stereotyped way in many interpersonal situations." One conclusion from this work "has been the clear recognition that the majority of our people are handicapped and hurt primarily by their special way of perceiving and reacting to external situations" (pp. 83-84).

This approach to prediction, which attempts to look at patients' past behavior and present personality characteristics and how behavioral proclivities might interact with future environments is overviewed in Roth (1987).

The Panel points to this literature because it believes, in forensic assessment when effective treatment requires less security, that not only the patient's medical progress needs to be considered but also how the above factors come together to make the next step safe. This has implications for the type of psychological material that is relevant to patient assessment. Some of this information may be best understood and known by the patient's therapist and should, therefore, in some fashion, be documented and integrated into the forensic assessment and prediction process.

The logic of this approach to prediction also has implications for Aftercare planning, which must be comprehensive and aim to identify or even control environmental provocations in the community — e.g., whether the patient drinks or with whom he lives.

**Review Board**

Concerning team decisionmaking and operation of the Review Board, the Panel recommends the following:

The Panel believes that anyone who has a significant role in the patient's clinical care should be at the meeting of the treatment team meeting to contribute what is relevant to patient assessment and a recommendation for status change. Thus the Panel believe that the patient's therapist should be at the treatment team to contribute what is relevant to assessment and prediction, to determine how the patient has changed, and what are the patient's present dynamics. (This is also discussed below.)

The Panel notes that there is no written summary of the discussion that takes place at the Review Board. While some of this may be contained in the two-page letter that goes to the court, the Panel recommends that the substantive discussion that occurred at the Review Board also be summarized in the patient's chart.

During its interviews, the Panel also heard some controversy about whether Hospital Legal Counsel should attend the Review Board. Legal Counsel was not at the Review Board meeting that we observed. We see no problem in Hospital Legal Counsel attending the Review Board, assuming that the role of counsel is advisory to the Review Board about the law.

The Panel believes that the two-page report that goes to the court (or other court reports related to release) should be targeted and contain comments about the patient's insight about the nature of the patient's mental illness and whether the patient understands how, in the past, mental illness and/or personality characteristics have led to the commission of an offense. The specific forensic question, that of the readiness of the patient for release, should be addressed. It is important to elaborate how patient dynamics differ from when the patient was first hospitalized.

**Aftercare**

The Panel notes that perhaps the most exciting development in the treatment of forensic patients has been the development of well-monitored release programs with community follow-up. Heretofore, this had been the great weakness in the system of treatment for insanity acquittees (Insanity Defense Work Group, 1983). These programs have been effective in reducing violent behavior and ensuring continuity of care. (See generally Rogers et al., 1984; Bloom et al., 1986; Cavanaugh and Wasyliw, 1985; Spodak et al., 1984; Goldmeier et al., 1980). These programs maintain frequent contact with patients, monitor patients' mental state and environmental pro-

vocations to violent behavior. They promptly rehospitalize patients, if necessary.

The Panel, therefore, has several recommendations concerning aftercare planning and implementation that may strengthen the critical phase of community treatment. These changes would reassure attorneys and the courts that the aftercare plan that the Hospital proposes will be an effective one in treating the patient and will reduce the likelihood of future dangerous behavior.

The Panel recommends that the patient's outpatient treatment team become involved in patient care earlier in the process than now occurs. For example, the outpatient counselor who will treat patients when they are on Convalescent Leave (CL) could initiate counseling sessions, even while the patient is on Conditional Release (CR). This approach would permit the outpatient counselor to attend the team meeting that recommends Convalescent Leave (CL), as well as the Review Board meeting where this recommendation is made. The outpatient counselor would thereby know the patient's strengths, weaknesses, and vulnerabilities, even before Convalescent Leave (CL) begins. This will aid in implementing the Plan of Outplacement/Discharge. Such well planned community monitoring is necessary if periods of Unauthorized Leave (UL) are to be reduced.

Even though Hospital policies and procedures now mandate that a detailed Outplacement/Discharge Plan be formulated before a patient goes on Conditional Release (CR), this procedure might be strengthened. The Outplacement/Discharge Plan follows a good format. This plan, in draft form, should be a significant focus for Review Board discussion, and the plan should be completed prior to any court hearing.

The Panel also recommends that the patient's Outplacement/Discharge Plan be attached as an addendum to the two-page letter that is customarily sent to the court. This will put the attorneys on notice even earlier in the process about exactly what is planned when the patient is on Conditional Release (CR) or Convalescent Leave (CL) status. Delineating this plan in relationship to CR and CL will integrate the above logic concerning prediction of dangerousness in the community phase of treatment.

The Panel, furthermore, believes that the proportion of resources devoted by the Forensic Division to the Outpatient Section is also insufficient compared to the Hospital's inpatient effort. The treatment of forensic patients must be regarded as part of an overall system of care. Considering the patient caseload, something like 90 patients, the Panel believes that the extent of resources and personnel available to do this difficult job may be insufficient. The transition of St. Elizabeths Hospital to the District will give further impetus towards developing an effective community system of care. Hopefully, this may make greater commitment of outpatient resources possible.

The Panel also learned that much patient rehospitalization occurs not because of loss of jobs but because of loss of housing. Because of the positive experiences in other communities, the Panel recommends that the District of Columbia establish a half-way house residence for the community treatment of forensic patients. This would permit greater community access for some patients and in our view would be a safer approach. (See generally Goldmeier et al., 1980, for the Maryland experience.)

The Panel also recommends that the District's Commission on Mental Health Services, which will shortly have operational responsibility for the Hospital, make every effort to step up available drug and alcohol counseling and other necessary community programming for discharged forensic patients. If such patients cannot be accepted elsewhere, if community resources are not available, then the Forensic Division may need to increase its own programming in the community.

The above integrated approach also has implications about who should testify in court, i.e., what type of information, from whom, is most relevant to the possibilities for success in Aftercare. This matter is discussed below.

**Therapist/Administrator Split**

The Panel devoted a good deal of effort to thinking about the Therapist/Administrator split. St. Elizabeths Hospital Forensic Division deserves much praise for the systematic, dedicated efforts that it is making towards treating patients with individual and group psychotherapy in a meaningful way. Historically, in truth, there has not been much true treatment accomplished at many forensic facilities (Roth, 1980) and the extent of individual treatment at forensic facilities has been difficult to establish even in national survey efforts. (See Kerr and Roth, 1986; see generally, Halleck, 1986.)

The therapeutic dedication of the St. Elizabeths Hospital Forensic staff is quite impressive, and the Panel is loathe to discourage this dedication in any way. Furthermore, we hesitate to recommend changes in a procedure that has not been challenged by the courts and attorneys, to which hospital staff are committed and which, except perhaps for the more exceptional case, appears to have worked well.

On the other hand, it must be said that to some extent, the system of Therapist/Administrator split, as practiced in the Forensic Division seems "counterintuitive." The responsibility of the Division is not only for treatment but for assessment for purposes of prediction and safe release of patients to the community. When information is missing that the fact finder (the courts) would find "relevant" to the decision, even if not "determinative," then that is a problem. Unfortunately, as in the Hinckley case, if information does become available that most persons would view as relevant, then questions are raised in the public mind about the adequacy of treatment and assessment at a hospital like St. Elizabeths. This scenario can contribute to the stigma and public misperception of the insanity defense.

The potential problem with the Therapist/Administrator Split turns on relevance and who is to determine it. In the present system, information is not always communicated from the therapist to others on the treatment team, unless imminent patient dangerousness is in-

volved or the therapist is opposed to an administrative decision. Even then, there may be some variability in practice.

This problem, balancing confidentiality/privacy of patients versus "relevancy" is, of course, not unique to forensic facilities. Unfortunately, a paucity of literature addresses this problem. (See generally, Miller, 1987; Roberts and Pacht, 1965; Monahan, 1980; Halleck, 1986). The extent of the testimonial "privilege" that a litigant should enjoy also arises in civil litigation (*In re Lifschutz,* 467 P.2d 557 (Cal. 1970); *Caesar v. Mountanos,* 542 F.2d 1064 (9th Cir. 1976)). In such cases, judges may be asked to rule on the relevancy of material to the question at hand before it can be released in litigation.

The ordinary forensic assessment process does assume that all relevant information will be before the fact finder: "The overriding fact of the forensic evaluation is that by definition it excludes absolute confidentiality, since its purpose is to convey information to one or more third parties concerning the subject of the evaluation" (Appelbaum, 1984). Relevant information may be known to both treatment and evaluation staff. At St. Elizabeths Hospital Forensic Division, the Treatment Team and the Review Board, in effect, play the role of independent forensic evaluator.

What suggestions does the Panel have to resolve this dilemma?

The Panel believes that the option to continue patients in treatment under a Therapist/Administrator split can be continued at St. Elizabeths Hospital. However, additional safeguards need to be implemented to make this system a more viable, credible one. The safeguards should ensure that all clinically relevant information (even that learned in therapy) does go forward, or is at least potentially available to the court in its role as release decisionmaker.

To this end, the Panel suggests the following:

(1) The Hospital should develop and promulgate a formal policy about the Therapist/Administrator split. The policy should spell out indications, perhaps delineate more clearly the variety of "splits" that in practice seem to occur regarding the extent of confidentiality that can be promised patients.

(2) Rules need to be developed about what therapeutic information is clinically relevant to the assessment and treatment process, information that is recorded in substantive notes shared with other staff and thus that is ultimately reviewable by the courts.

(3) Rules for supervision should be formulated.

(4) In developing such rules, Peer Review and perhaps even group supervision of psychotherapy may be necessary to calibrate the therapist's judgment — and the overall judgments of staff — about what is relevant and should be documented.

(5) The Panel suggests that the T/A split be individually prescribed by the patient's treatment team.

(6) Practitioners should be trained in the Therapist/Administrator split. Training would focus on the practitioner's knowledge of confidentiality, understanding of relevant hospital policy, familiarity with what needs to be told to the patient about privacy/confidentiality of therapy and the role that the therapist will play with the remainder of the treatment team.

(7) The Panel believes the therapist should attend meetings of the Treatment Team, and where necessary attend the meeting of the Review Board, and that patients should be told this. Some degree of confidentiality can still be maintained. Therapists can decide how actively they wish to contribute to team meetings. But attendance at such meetings would permit greater staff communication.

(8) Concerning record-keeping, the Panel also recommends the therapist make regular therapy notes, documenting patient progress, dynamics, and psychology. These notes could be recorded in a separate portion of the chart and would be available to other staff. Then if these notes are subpoenaed, the Hospital can request in-camera review by the Court of the notes as to relevancy to the recommendation before they are released to the parties.

As discussed above, the T/A split is already practiced in a highly variable manner among Division staff. The Panel heard no information or documentation that one or another form of a T/A split, as now practiced at St. Elizabeths Hospital, is more effective than another. Furthermore, in our interviews with four patients, the Panel was impressed that the patients were less insistent upon confidentiality, perhaps less impressed with its potential merits, than were the staff at the Hospital. What patients want is to trust their therapists and that therapists ultimately work in their best interests. While confidentiality of therapy is generally valued by patients, the limited empirical studies available do suggest that patients hold a disparity of views about the importance of absolute confidentiality in therapy (Schmid et al., 1983; Appelbaum et al., 1984. See also generally Shuman and Weiner, 1987, regarding testimonial privilege).

In therapy, patients place their greatest reliance on the ethics and ethos of therapists to do what is in their best interests. In practice, managing confidentiality conflicts in therapy, even when the patient threatens harm to another, has not proved to be so difficult as was first anticipated (Beck, 1982).

The Panel also believes that it is unlikely that, in the future, attorneys or the courts will summon therapists to court proceedings. They have not done so in the past, wishing to respect the more private dimensions of the therapist/patient relationship. The Panel recommends that this past practice be continued.

Assuming the Panel's previous recommendations are implemented, relevant information will be available to the court through other channels, i.e., it will be documented in the record and in the team reports. The therapist need not be the patient's adversary nor champion in court.

These recommendations will, if implemented, permit greater sharing of information among treatment staff.

The core of the Panel's recommendations concerning

the Therapist/Administrator split is that the Panel believes it can be continued at the St. Elizabeths Hospital Forensic Division. However, there is need for additional policy development and safeguards to ensure that all clinically relevant material is potentially available to the courts for release decisionmaking.

**Confidentiality and Privacy Controversies**

To the extent St. Elizabeths Hospital Forensic Division staff has had past concern about the potential misuse of patient communications by the courts, or whether information should be released to attorneys prior to court hearings, the Panel recommendations are straightforward.

The principle is clear. Information that is released to one side (defense counsel or prosecutor) should also be released to the other side. Communication with attorneys should be such that ideally all parties involved get the same information at the same time. Furthermore, this information should include all clinically relevant material. Whatever is given to one side, in terms of records or information, should also be given to the other. (See *United States v. Ecker,* 543 F.2d 178 (D.C. Cir. 1976); *Dixon v. Jacobs,* 427 F.2d 589 (D.C. Cir. 1970-above)).

Furthermore, prior to court hearings, the flow of information should be "nonadversarial." There should be opportunities for informal fact finding and discovery of information relevant to the court hearing afforded to both sides (defense counsel and prosecutor). If there is a doubt as to the relevance of certain information to the court's determination, the Hospital should resolve the doubt in favor of disclosure. If there is a question about the breach of a subpoena, this matter can be brought to the attention of all parties before the Hospital complies, so that one side or another can object to the court.

Forensic staff should be available for interview with prosecutors and defense counsel in an informal setting.

The Panel and others recognize that prosecutors and defense attorneys may make different use of opportunities available to them to learn information prior to the hearing. Preferably, all the information that is relevant to the court hearing should be available and come out ahead of time.

The Panel does not believe that it is appropriate for St. Elizabeths Hospital Forensic Division staff to have Hospital Legal Counsel accompany them when they are interviewed by defense counsel or by the prosecutors.

The Panel has already discussed its views concerning recordkeeping and its relationship to confidentiality above. While the Panel views it as unlikely that the courts will, in the future, subpoena any informal "Personal Notes" made by therapists, and such notes are protected under the D.C. Mental Health Information Act of 1978, D.C. Code Ann. Section 6-2003 (1981), this probably cannot be totally assured to therapists or patients. A better solution to the problem of Personal Notes is for the Division to commit itself to putting timely and informative therapy notes into the patient's chart, sharing these with staff and possibly eventually with the courts. This would make Personal Notes irrelevant.

As discussed above, the Panel recommends that there be a special section of the chart where therapy notes are placed. This section of the chart would be available for use by other staff in the collaborative treatment and assessment of the patient. If subpoenaed, the Hospital can argue that this section of the chart receive prior in-camera review by the court regarding relevancy, prior to its release to the opposing parties.

Concerning mail, the Panel recommends the following: By and large, the Hospital's present policy on scrutiny of mail has been adequate and is generally satisfactory for preserving patients' rights and assuring that relevant treatment and assessment of patients occurs. However, this may not be so for the exceptional case where, on clinical grounds, the patient's mail and/or other writings appear highly relevant to assessing progress. The Panel does not consider that it is a violation of patients' rights to log in mail, although there is ongoing controversy about the right and desirability of staff to read the patient's mail.

In special cases, for example White House cases and/or in other cases where the staff deem it relevant to inspect and read patients' mail, the Panel believes that St. Elizabeths Hospital Forensic Division has the right and in some cases the obligation to do so, assuming the decision is reasonable and "non-punitive," i.e., done for adequate assessment and prediction, and where the necessity of this step is carefully reviewed by staff. Again, there must be a threshold judgment as to relevance and necessity made by the Hospital.

The Panel recommends a Review procedure for mail scrutiny, something like that already in place, such as review by the Division's Review Board of proposed status changes. Such "second tier" review procedures would operate like a Treatment Refusal Review Panel or opportunity for a second professional opinion that now takes place in other states when there is a question of compromising the patient's rights (*see e.g., Zito et al.,* 1984; Young et al., 1987; *Rennie v. Klein,* 476 F. Supp. 1294 (D.N.J. 1979); Roth, 1986).

The reason for the staff's need to read the patient's mail should be recorded in the chart. Notice should be given to the patient before the decision is implemented so that the decision is potentially reviewable by the court — if the patient or his defense counsel objects to mail scrutiny. The Panel believes that internal review procedures for mail scrutiny, relevant to assessment and prediction, will find support in the courts (see above).

If St. Elizabeths Hospital Forensic Division requires more clear-cut "legal authority" to read patients' mail in selected cases, then the Panel recommends that the court be asked to add to the formal order following the first mandatory review hearing, language sufficient to meet the Hospital's needs, i.e.,

> In accord with the hospital's responsibility under 24 D.C. Code 301(e)(k), 18 U.S. Code 4243(f), the hospital is ordered to report back to the court; it should take all necessary steps to evaluate the patient's suitability for conditional or unconditional release, including where it is likely to be relevant

to the evaluation, the monitoring of the patients' mail.

The Panel is reluctant to take a position concerning the extent to which staff at St. Elizabeths Hospital Forensic Division may legitimately search patient's possessions, e.g., personal property in a patient's room. The Panel is aware of legal cases which markedly reduce the rights of prisoners to prevent search and seizure of their possessions, when this is necessary to preserve institutional security (*e.g., Hudson v. Palmer,* 468 U.S. 517 (1984)). But this and related cases involved prisoners, not patients.

The Panel believes that St. Elizabeths' policies are already well-developed for ensuring adequate security within the Hospital through shakedown procedures, inspection of packages. Inspection of a patient's property, *other than to ensure the patient's own safety or the safety of others,* is generally unnecessary or unwarranted in the therapeutic assessment enterprise. To do so without the patient's permission should require a court order.

None of the above means that treatment staff and patients cannot negotiate various "contracts" or approaches to monitoring patient behavior that staff and patient can consensually agree upon because, ultimately, they are in the patient's best interest and necessary for staff to adequately assess the patient. As the representative of the Public Defender's Office told the Panel, in the long run, it is difficult for patients to keep information from the court that is clinically relevant to reassure decisionmakers that they should take the next therapeutic step. By virtue of having raised an insanity defense and having been hospitalized in a system of "therapeutic restraint," patients must, by necessity, sacrifice certain rights if they wish to gain eventual release from the Hospital. In the usual case, these things can be negotiated between staff and patients without having to involve the court.

**Communication to Courts and Attorneys**

Communications between the Hospital, courts, and attorneys have generally been satisfactory in the past. We have already made certain recommendations on this subject. The Superior Court Judges whom we interviewed did indicate a desire for more information earlier in the process beyond that of the two-page letter that the Division routinely sends in the case of the 301(e), although the judges also indicated that, as a rule, all the information does eventually come out.

The Panel believes that were the Division's two-page letters to court to comment in greater depth about the dynamics of the patient's offense (whether the patient has better understanding of his past behavior) and were the patient's Aftercare plan (Plan of Outplacement/Discharge) to be appended to the Division's letter, then more information would be available to the courts earlier in the process. Consideration should be given to appending the relevant Treatment Team report — that goes to the Review Board — to the Division's letter.

In accord with the Judges' request, the Panel also recommends that the Hospital send more information forward on a 301(k) as it routinely does for a 301(e). Although pragmatics may prevent a full meeting of the Review Board or a report as thorough as that in 301(e) cases, the Hospital's evaluation of 301(k) requests should be formally communicated to the court prior to the hearing. To do so is fair to patients and will be helpful for the Judges. If the Hospital believes that the 301(k) request is on its face clearly nonmeritorious, then a brief letter would probably suffice.

**Representation — Conduct of Hearings**

The appropriateness of independent representation for the Hospital at release hearings is a question that will probably continue to be debated, especially considering the stated desire of the D.C. Corporation Counsel to have the Forensic Division represented in the future.

Despite the position of the D.C. Corporation Counsel, the Panel does note that the D.C. statute (Sections 301(e) and (k)) apparently does not contemplate the Hospital becoming a party to release hearings in the District. The statute is silent on the subject of representation for the Hospital.

While this District's approach is at variance from that which takes place in some other states (e.g., New York, Maryland) and it is contrary to national standards (American Bar Association Criminal Justice Mental Health Standards, 1986), it is also true that the present system works well for the majority of cases.

The Panel believes that the Hospital and its Legal Staff have made a credible argument that the Hospital should "have the option" to present information to the court through counsel in selected cases. We do not believe that Hospital counsel should be present in cases merely because the Hospital recommendation will be strongly contested by the prosecutor. Hospital counsel should request to appear in cases (1) where issues will arise pertaining to internal Hospital policies and administrative matters which fall within the expertise of Hospital counsel or (2) when the Hospital reasonably believes that it has facts relevant to court decisionmaking, that are not likely to be presented by the parties. We do not believe it is necessary for the Hospital to formally intervene or become a party to the proceeding (have a right to appeal). Hospital counsel should request to appear specially as an Amicus Curiae, or in the case of a subpoena issue as representative of the custodian. In all such situations, the Hospital should communicate beforehand in writing to the parties and the court its desire to participate through counsel. After October 1, 1987, the Hospital Legal Counsel will be a part of the D.C. Corporation Counsel Office, therefore, there will be no conflict with Federal law regarding the representative of the United States Government.

From interviews with both the U.S. District Court Judge and the D.C. Superior Court Judges, the Panel believes the courts will be flexible and receptive to this suggestion. The judges interviewed did not find it necessary that the Hospital be represented routinely in every case. Indeed, there may be some contraindication to this because this would tend to make this an "overly adversarial" procedure.

Finally, in accord with the Panel's view about what

type of information is relevant to assessment and release decisionmaking, the Panel also encourages the courts, at times, to hear from expert witnesses — other than psychiatrists or psychologists — at the court hearing. The input of social workers (knowledgeable about community planning), nurses, forensic counselors and technicians who are in daily contact with the patient would be quite valuable in selected cases.

**Quality Assurance**

In general, the Panel is impressed with the Quality Assurance Activities in place at the Hospital. In the previous section, the Panel recommended expansion of Quality Assurance Activities in the area of psychotherapy, relating to the Therapist/ Administrator split. Formulation of a protocol for psychotherapy, prescription of the Therapist/Administrator split by the Treatment Team, supervision of the Therapist/Administrator split, including Peer Review of this treatment modality, would enhance the implementation of psychotherapy.

The Panel has a further suggestion in the area of staff training. It recommends that the Division periodically invite the U.S. Attorney and the Public Defender to do training of staff through grand rounds, case reviews, mock trials, etc. Collaborative training and education between the Office of the U.S. Attorney, Public Defender and Hospital should have the effect of promoting better communication and understanding between the parties and thereby improve rapport. Although such attempts have been made in the past, they do not seem to have worked. This is a two-way street whereby the U.S. Attorney and the Public Defender will also become better acquainted with the daily activities and problems of the Hospital.

Another mechanism for quality assurance is that of the JCAH.

**National Standards and the Role of the Joint Commission on the Accreditation of Hospitals (JCAH)**

There is currently a great deal of attention being paid to the development of specialized forensic standards as addenda to the various standards applied by the JCAH to psychiatric hospitals. Generally, however, advocacy for these specialized forensic standards has focused on treatment and environmental issues to the exclusion of the release decision process. In the Panel's view, this limitation of the role of the JCAH is appropriate. Release decisionmaking for forensic patients involves issues which are unique to forensic settings, and specifically involve both clinical and non-clinical decisionmakers. It is difficult to imagine a predominantly medical organization such as JCAH developing or applying one set of consistent national standards to the process of making release decisions for forensic patients.

On the other hand, there are a number of ways in which development of specific JCAH forensic psychiatric standards could indirectly improve the quality of release decisions, to the mutual benefit of the patients themselves as well as the criminal justice system and the community it serves to protect. It is for this reason that the Association of State Mental Health Forensic Directors has worked with JCAH during the past several years to develop forensic standards. Most of this work has been spearheaded by Marvin Chapman, M.D., who is the Director of Forensic Services for the State of Wisconsin's Department of Mental Health, and many of the ideas which follow originated with Dr. Chapman and other members of the NASMHFD Executive Committee.

In assessing the release decision process, one must inevitably start with the quality of the clinical services, both treatment and evaluation, being rendered at the institution in question. In the absence of a high quality of diagnostic and treatment services, any predictions will be appropriately suspect. Furthermore, if the treatment is being performed by clinicians who are inadequately trained, experienced, or supervised, any predictions based upon those treatment services will be equally unreliable. Finally, there are specific areas of competence which relate directly to forensic evaluation and which require appropriate training, experience, and supervision to be maintained (Shah and McGarry, 1986). The specific elements of such competencies will, of course, vary across settings; however, JCAH can serve a useful function by ensuring that they are at least attended to and documented by the facility and that only those clinicians who are appropriately credentialed and privileged will be performing such functions.

In its negotiations with JCAH, NASMHFD has focused on three issues: 1) Retention of a consultative and educative survey process with specifically credentialed forensic surveyors included on the survey team; 2) Inclusion of standards governing non-medical aspects of care, such as occupational therapy, recreational therapy, and therapeutic environment; and 3) Addition of new standards which are unique to forensic settings, dealing with issues such as the security needs of maximum security hospitals, treatment planning for patients who are no longer acutely or subacutely psychiatrically ill, etc. Another area where specialized standards would be helpful relates to patients' rights, such as the Confidentiality/Privacy concerns discussed above and how best they should be integrated with necessary treatment and assessment functions.

There are a few issues which relate even more uniquely to forensic facilities. These predominantly relate to the multidimensional nature of release decisionmaking, and are of most relevance to this review of St. Elizabeths Hospital and its John Howard Pavilion. Foremost among these is the presence of a group of court ordered patients who, absent that court order, would be most unlikely to be retained in a psychiatric hospital. For those patients, the treatment plan itself can become inappropriate according to normal standards. At the very least, such individuals require a range of services that is unique to forensic settings and consequently requires a unique set of standards.

In summary, the Panel believes that JCAH has a crucial and appropriate role to play in the administration of forensic hospitals and recommends the following:

(1) The survey process should include surveyors

who are experienced and credentialed in surveying forensic facilities.

(2) The survey process should remain consultative and educative in nature.

(3) Standards should be included that address the non-medical aspects of care, including the entire range of psychosocially therapeutic specialties, as well as the quality of the therapeutic environment.

(4) Standards should be developed that take into account issues specific and unique to forensic hospitals, including the multidimensional nature of release decision processes. While the specific processes should not be mandated or standardized, JCAH should require that they be addressed on a facility specific basis.

**Conclusion**

The Panel is impressed with the quality of care delivered to patients at St. Elizabeths Hospital Forensic Division and the careful and thorough way in which its program of graduated patient release to the community takes place.

In concluding this report, the Panel therefore wishes to reinforce its finding that in the great majority of cases things work very well at St. Elizabeths Hospital Forensic Division. The patients receive excellent treatment and the court is able to perform its role effectively.

To maintain the present system, but hopefully to improve it in accord with the Panel's recommendations, it will be necessary, once transition to the District of Columbia occurs, for adequate resources to continue to be provided to the Forensic Division. Staff at the Division need continuing training. The Division also needs to maintain its historical commitment to training younger persons in this field and developing affiliations with medical schools for training and teaching, thereby staying in the "mainstream" of psychiatry and forensic psychiatry. These commitments require resources.

St. Elizabeths Hospital Forensic Division is a hospital, not a prison. The effective treatment of dangerous patients, not just the provision of security through custody, is central to the purpose of the Division.

The Panel hopes that the above recommendations will be of use to the NIMH, the District of Columbia, the Hospital, and the courts in enabling St. Elizabeths Hospital Forensic Division to meet its dual mandate in the treatment of insanity acquittees.

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*Statutes*

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# TABLE 1

## Forensic Division Patient Activity and Census

| Legal Category | Admissions or Additions to Category: Annual Total | Admissions or Additions to Category: Monthly Average | Discharges or Deletions from Category: Annual Total | Discharges or Deletions from Category: Monthly Average | On Rolls at End of Evaluation Period |
|---|---|---|---|---|---|
| Pre-Trial | | | | | |
| Examination | 81 | 7 | 68 | 6 | 33 |
| Mentally Incompetent | 67 | 6 | 52 | 4 | 47 |
| | 148 | | 120 | | |
| Post-Trial | | | | | |
| Under Sentence | 19 | 2 | 29 | 2 | 5 |
| NGBRI | 21 | 2 | 34 | 3 | 182 |
| Convalescent Leave | 42 | 4 | 37 | 3 | 91 |
| Unauthorized Leave | — | — | — | — | 68 |
| Civil Commitments | 7 | — | 28 | 2 | 5 |
| In Civil Divisions | — | — | — | — | 73 |
| | | | | Total on Forensic Rolls | 504 |

# Appendix 1

## Historical Origins of the Therapist/Administrator Split

With the arrival of Harry Stack Sullivan, M.D., in the 1920s and Frieda Fromm-Reichmann, M.D., in the 1930s, the Baltimore- Washington area became the center of an effort by these and other psychoanalytic pioneers to explore the application of their young discipline to the treatment of hospitalized psychotic patients.

Much of this effort occurred at St. Elizabeths Hospital and at Chestnut Lodge, a private hospital in Rockville, MD. The need to free staff physicians from administrative duties to permit them time for intensive psychotherapeutic work became evident in the 1930s and the concept of the "dual management" of patients by a psychotherapist and clinical administrator was elaborated in a 1942 paper by Dr. Morse and Dr. Noble of the Chestnut Lodge staff.[1]

## Dual Management

> The concept of dual management. . . was first described by W. C. Menninger, and developed later by Knight, Reider, Chassell and Bullard. This concept did not arise from theoretical considerations, but through bitter experience and became a necessity when one individual attempted to combine administrative duties with intensive psychotherapy of a patient. This plan of dual therapy has been adopted at Chestnut Lodge Sanatarium, in the feeling that it offers most advantage to the patient, since administration, as well as therapy, is based upon a dynamic concept of psychiatry in which an attempt is made to understand and meet the patient's needs.[2]

Among the aspects of "dual management" noted by Morse and Noble, were the need for consultation between the therapist and administrator ". . . in some instances, daily. . . ," the particular difficulty of adherence to role definition in the treatment of psychotic patients and the consequent need for flexibility, the usefulness of the "dual method" in treating alcoholics, and its usefulness in facilitating an adjunct relationship with a patient's family.

Practicality motivated the earliest applications of "dual management" not only to free time for senior clinicians to treat inpatients analytically, but also to enhance the treatment effort.

> Dr. Bullard and Dr. Marjorie Jarvis were the only psychiatrists on the staff at that time. They, too, found that if an alcoholic patient snuck into town and got drunk, and the doctor then restricted him or her, the patient would retaliate by no longer talking collaboratively with the doctor. But if the other doctor did the dirty work of laying down the law, the analytic work with the therapist was not impeded. . . (Patients were told) this is how we do this here. You will have two doctors, one who will meet with you four times a week, with whom you will work towards understanding how things have gotten so off course, and to get things back on course, and another doctor who will be writing the orders.[3]

## The Therapist/Administrator Split

The transformation of the concept of "dual management" into the "therapist-administrator split" may be traced to a seminal work in the modern psychiatric literature, *The Mental Hospital,* by Alfred H. Stanton, M.D., and Morris S. Schwartz, Ph.D., first published in 1954.[4] The idea of separating the duties of the administrative physician from those of the therapist was popularized in many psychiatric hospitals influenced by this publication.

*The Mental Hospital* was the product of a three-year study of a ward in Chestnut Lodge conducted by a psychiatrist and a sociologist. The goal of the effort was to elucidate the features of mental hospital treatment and to attempt to understand the therapeutic and countertherapeutic factors. The authors found that "there was no disagreement" about the value of psychotherapy in the treatment of psychoses. This belief was also shared by the patients. The study revealed that psychotherapy was largely carried out by residents; senior staff members were occupied in supervision and staff conferences. The perception of this system as a "therapist-administrator split" probably was promoted by the following description:

> Apart from the treatment hour, the psychotherapist had no direct control of the patient's living, unless he was a resident on night duty; in this case he was in charge of the whole hospital. Under all other circumstances, control was in the hands of the administrator. This restriction of power was fully accepted by a large majority of the psychotherapists, although at least once it was resisted by a vocal minority. But on occasion almost all therapists were driven out of a position of strict nonparticipation in the administrative management of the patient, either by an emergency, by oversights on the part of the administration, or by a strong disagreement with the administrative management. . . The separation of the two functions was accepted and understood easily by most of the patients.
>
> . . . In counterpoint to the psychotherapeutic hour was the clinical administrative management of the patient's living during 'the other twenty-three hours.' The two were carefully separated for several reasons: the psychotherapist is freer able to deal with much the patient says if he does not have to carry the load of important decisions about the patient; these decisions themselves may interfere with the patient's freedom with the therapist; the selection of topics for presentation can be left to the patient more freely if the therapist does not have to make specific inquiries to prepare for a decision; there is less realistic value in the patient's distorting an account; the therapist can avoid direct time-consuming and difficult relations with the nurse and relatives, which may be misinterpreted by the patient; a second professional opinion is available, reached independently to some extent and on the basis of other data, to check important judgments;

the therapist's powerlessness to alter reality provides a favorable setting for focusing the patient's attention on change in himself rather than on the attractive but misleading hope that everything would be all right if the world was different.[5]

Administrative treatment attended to the "protection of the patient's opportunities for improvement" and the skillful enlistment of staff resources in the treatment effort. Related goals were stabilization of the ward milieu, minimizing staff tension, dealing effectively with crises on the unit. A further duty of the administrator was observation of the patients' behaviors, interactions, grooming, etc., in support of assessment of illness and progress.

**Confidentiality and the Therapist/Administrator Split**

Throughout the seminal literature on this subject, there is virtually no discussion of the role of confidentiality between the clinicians regarding the content of either the patient's communications on the ward or in the therapy hour. On the contrary, it was assumed that both the therapist and administrative clinicians were part of the treatment team and communicated freely. The issue of confidentiality was for another context and related to the disclosures of clinical material outside of the clinical community of the hospital. Frieda Fromm-Reichmann perhaps best analyzed the relationship of confidentiality to hospital function:

> Both successful psychoanalytic therapy and successful administrative therapy are dependent upon constructive exchange of opinion between the patient's two therapists and on intelligent information about the patient imparted to the nursing staff.
>
> It has been said that such exchange of opinion is unfair because the psychoanalyst betrays the patient's confidence. I am of the opinion that — if he is sufficiently in contact with reality to give any thought to the problem — a patient whose condition is serious enough to warrant hospitalization expects the joint therapeutic endeavors of the staff of the hospital. He soon comes to know that there are conferences of the medical and nursing staffs to discuss patients' problems. The therapeutic value of discussing a patient's problems and needs among members of the staff is far greater than an indiscriminate allegiance to a non-therapeutic concept of confidence, the sanctity of which is overestimated in our culture. . . [6]

**Summary**

The notion of dividing clinical functions between two psychiatrists treating a psychotic patient by means of psychoanalysis or intensive psychotherapy in an inpatient setting originated in the writings of Menninger[7] and Bullard[8]. The idea became popular in the 1940s and 1950s, but its application has declined in recent years. Originally promoted to accommodate the treatment of inpatients by the time consuming method of psychoanalysis, other advantages were described, particularly the facilitation of a channel by which the patient could express emotions more freely in therapy. The patient tended not to hold the therapist accountable for decisions of the administrative doctor. Conversely, the patient was afforded another channel to communicate material the expression of which was blocked in the therapy hours. The articulation of this technique recognized the importance of the "other twenty-three hours" for the patient's treatment and elaborated the administrative clinical functions which were to form the basis of the later concept of "milieu therapy."

This method provided the patient with clinical attention of two doctors who shared a "dual" responsibility for care. The discharge of this responsibility required frequent consultation and open communication between the administrator and the psychotherapist. In the absence of such interchange between the physicians, distortions of care were likely to result:

> . . . It is. . . unavoidable that from time to time the clinical administrator and the therapist will not see eye to eye on certain issues. They must then try to work out their differences. When they are unable to do so, they may ask a third person to listen to their differences. They must not lose sight of the fact that the division of labor is to assure the patient of the best possible care and is not intended to create complications.[9]

The emphasis was on collaboration, communication, and consultation among the clinicians on the inpatient team. The therapist was considered part of that team and in staff conferences on a particular patient, the therapist's contribution to the presentation was the longest and most detailed. Currently, at least at Chestnut Lodge, Fromm-Reichmann's recommendations regarding confidentiality are the norm. Patients who ask are told by therapists that there will be communication between the members of the team in the interest of patient care. This communication, however, is not indiscriminate or indiscreet, but rather is limited to clinically relevant material.[10]

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## Appendix 2

## Individuals Interviewed by the Panel

*June 10, 1987*

St. Elizabeths Hospital Staff:
Dr. William Prescott, Superintendent
Executive Committee:
Dr. Arthur Strauss, Associate Superintendent for Special Clinical Programs
Mr. Michael English
Dr. Betty Humphrey
Dr. Harold Thomas
Ms. Ann Keary, Legal Advisor
Dr. Gary Chadwick
Dr. Roger Peele, Chief Clinical Advisor

John Howard Pavilion Staff:
Mr. Joseph Henneberry,
Director of Forensic Programs
Dr. Raymond Patterson, Medical Director
Dr. Joan Turkus, Psychiatrist, Ward 4

*June 11, 1987*

Mr. Norman Rosenberg, Director, Mental Health Law Project
Mr. Harry J. Fulton, Chief, Mental Health Division, Public Defender Service of the District of Columbia
Mr. Roger A. Adelman, Assistant U.S. Attorney for the District of Columbia
The Honorable Fred B. Ugast, Chief Judge, Superior Court of the District of Columbia
The Honorable Collen Kollar-Kotelly, Associate Judge, Superior Court of the District of Columbia
Mr. Jim Havel, Director of Government Relations, National Alliance for the Mentally Ill
Mr. John Ambrose, Manager of Public Policy, National Mental Health Association

*June 25, 1987*

John Howard Pavilion Staff:
Dr. Robert C. Morin, Clinical Administrator, Ward 4
Mr. Paul Nolan, Psychiatric Nurse, Ward 4
Mr. Charles Brown, Psychiatric Technician, Ward 4
Dr. Daniel Sweeney, Chief Psychologist

St. Elizabeths Hospital Staff:
Ms. Ann Keary, Legal Advisor

Mr. Thomas E. Zeno, Chief, Special Proceedings Section, Office of the U.S. Attorney for the District of Columbia

*June 26, 1987*

John Howard Pavilion Staff:
Dr. Raymond Patterson, Medical Director

*July 20, 1987*

Mr. Roger A. Adelman, Assistant U.S. Attorney for the District of Columbia
Mr. Vincent J. Fuller, Attorney for Mr. John W. Hinckley, Jr.
Mr. Frederick D. Cooke, Jr., The Acting Corporation Counsel for the District of Columbia

*July 21, 1987*

Ms. Eleanor Heath, Acting Administrator, Outpatient Department, St. Elizabeths Hospital

*July 31, 1987*

The Honorable Aubrey E. Robinson, Jr., Chief Judge, U.S. District Court for the District of Columbia
Ms. Eleanor Heath, Acting Administrator, Outpatient Department, St. Elizabeths Hospital
Dr. David Powell, Chief, Post-Trial Unit, John Howard Pavilion