A Clinical Evaluation of Maximum Security Hospital Patients by Staff and Independent Psychiatric Consultants

MELVIN S. HELLER, MD
WILLIAM H. TRAYLOR, JD
SAUNDRA M. EHRLICH, MS
DAVID LESTER, PhD

The psychiatric evaluation of mentally ill offenders and defendants has become a major task at the crossroads of the Criminal Justice and Mental Health Systems. Criminal courts, often burdened and backlogged, are further handicapped in the trial and sentencing of criminal offenders and defendants by the lack of readily available, uniform, high quality psychiatric and psychological diagnostic services on a pretrial and presentence level. Since courts often lack such services, they use medium and maximum forensic security hospitalization, and extravagant and frequently inappropriate placement for many pretrial defendants and presentence offenders who could be evaluated under less restrictive and less costly circumstances.

The inappropriate use of limited state forensic mental hospital facilities is further compounded by other problems. Once a state has a facility designated to house mentally ill persons involved with the Criminal Justice System, the facility then tends to receive a clinically difficult group of civilly committed persons who are assaultive or considered "troublemakers" by the staffs of other state mental hospitals. These clinically difficult patients have been assessed as requiring "maximum security," or at least greater surveillance than the ordinary state hospital claims it can provide. However, in recent years, the right to treatment[1,2] in the least restrictive setting has received a great deal of attention and now must also be considered for patients housed in forensic hospital facilities.[3,4]

Added to the problem of inappropriate referral is one of undue retention. Psychiatrists often lack legal direction or guidance with respect to their actual or imagined vulnerability to civil rights' violations if the patient is involuntarily treated for longer than necessary.[5] Similarly, a psychiatrist who discharges or provides leave for the patient who shortly proceeds to murder or seriously assault someone can then be faced with a lawsuit.[6,7]

Community fear and political response also add to the pressure for retention of mentally ill persons involved with the Criminal Justice System, even for nonviolent offenses.[8] The double label of mentally ill and charged or convicted is translated into the label "criminally insane" by both the press and the public. Bentz

Heller is Clinical Professor of Psychiatry and Director, Institute of Law and the Health Sciences; Traylor is Professor of Law; and Ehrlich is Research Psychologist, Institute of Law and the Health Sciences; all three are at Temple University, Philadelphia, Pennsylvania. Lester is Professor of Psychology and Criminal Justice, Richard Stockton State College, Pomona, New Jersey.

Reprint requests: Dr. M. S. Heller, Institute of Law and the Health Sciences, Room 616 Klein Hall, School of Law, Temple University, Broad and Montgomery Avenue, Philadelphia, PA 19122.

and Edgerton[9] reported that 70 percent of the general public saw the primary role of the psychiatric hospital as that of protecting the public from the mentally ill, and Aviram and Segal[10] have described some of the strategies used by communities to prevent the release of the mentally ill (such as bureaucratic maneuvering and long-term penal commitment).

However, studies of patients released from mental-penal institutions have not found evidence to support the fears of the community. Steadman[11-13] and his associates followed up the patients released after the *Baxstrom*[14] decision in New York State and found a low incidence of reconvictions. Of 121 patients released, only nine were reconvicted for criminal offenses in the follow-up period averaging 28.5 months.[15]

While the Steadman studies following the release of post-*Baxstrom* cases reported a low incidence of reconvictions, the present study deals with a population of mentally ill defendants and offenders, many of whom have active involvement with the criminal justice system. Accordingly, considerations of security requirements are not based on clinical considerations but on a court's determination of the patient's need for criminal justice system security, which is based on the nature of the offense, charges, and other legal considerations.

Long after the *Baxstrom* decision[16] and the removal of inappropriate populations from Matteawan and Dannemora, a number of states continued to treat similar populations involuntarily in inappropriate maximum security hospital facilities. Pennsylvania reacted to such litigation as *Baxstrom v. Herold*[17] and *Jackson v. Indiana*[18] and to community pressure by considerably reducing the number of patients from more than 1,000 to approximately 200 by the time this study was undertaken.

We examined the use of one such maximum security hospital in 1979 — thirteen years after *Baxstrom* and two years after a revised mental health procedures act,[19] which spelled out in legislative language the many due process reforms and court decisions bearing on treatment of involuntary committed persons.[20-26]

Background

Because of the ability of courts to commit mentally ill offenders and defendants to Pennsylvania's single maximum security state hospital (for evaluation and treatment of pretrial defendants and treatment of mentally ill, convicted state prisoners serving sentences — with maximum security being stipulated by the court), the Office of Mental Health became increasingly concerned about the population level and the possibility of at least some patients being managed elsewhere. Alternative placements included regional forensic hospitals (designated as medium security civil hospitals) or community placement.

Several years before the study, Pennsylvania had established four regional forensic facilities that were designated as "medium" security, largely to dispell political and community concern about harboring the "dangerous, criminally insane" in their regions. In addition, during many decades of relative neglect by courts and clinicians alike, a number of mentally ill defendants languished at the

maximum security state hospital,[27] receiving neither trial nor treatment prior to the *Jackson* decision.[28]

At the time of the present survey, the state hospital population of approximately 204 included some 46 civilly committed patients, the great majority of whom were elderly, untried defendants and included at least one who had been in the hospital since 1913. As long as these people failed to become competent, Pennsylvania courts were content to keep them in the hospital, and clinicians (even if they were so minded) could not treat them in less secure facilities without a change in legal status. Prior to *Jackson,*[29] mentally ill defendants often remained committed to such state hospitals "for the criminally insane" for three, four, or five times the length of any sentence they might have received had they been tried and found guilty.[30]

Method

At the time this study was undertaken, one of the authors[31] then serving as Director of Forensic Psychiatry of the Pennsylvania Office of Mental Health, undertook a patient survey to evaluate the clinical and legal status of all patients confined in the state's sole maximum security psychiatric hospital. To accomplish this in a reasonably speedy and economical fashion, it was determined that each patient would be evaluated independently by "in-house" state maximum security hospital clinicians and again by "outside" mental health professionals not on that hospital staff. The "outside" clinical psychiatrists included two approximately equal groups: experienced clinicians from other state hospitals and nonstate hospital clinicians with extensive academic and forensic psychiatric background and interests.

An examination and data-recording checklist was devised: eight double-spaced pages provided for the uniform consideration of comparable data — identifying data; admission history; background of illness; diagnosis; recent symptoms and behavior; patient's recent adjustment in the hospital; involvement with staff, other patients, family or friends; medication; other therapies; concurrent medical problems, if any; and the history of criminal offenses and current legal status. (This clinical assessment form is available on request.)

The hospital staff evaluating teams and "outside" consultants then independently addressed themselves to specific clinical/forensic questions regarding each patient's "present state of mind," competency and prospects for treatment under less restrictive circumstances. These included medium security forensic hospitals,[32] nonforensic state hospitals, partial hospitalization programs, mental retardation facilities, nursing homes, other community facilities, or outpatient management. In addition, each checklist specifically inquired as to the present prognosis for gaining competency, and if the patient was a sentenced prisoner, whether the prisoner could be responsibly managed at a penitentiary. Finally, for those patients without criminal justice system involvement, the survey elicited specific recommendations for transfer to facilities other than a forensic hospital or community placement.

Prior to the arrival of outside clinicians, the professional staff at the facility

completed the questionnaire on each of the 204 patients. Thereafter, independent consultants[33] were assembled from distant parts of the state to participate in a two-day evaluation and discussion seminar. During this time, again using the identical reporting format, clinicians were randomly assigned to the various wards where they directly examined each patient and reviewed the ward chart and central file record containing both clinical and legal materials.

The two sets of examination data on each patient (those of the staff and the independent consultants) were then assembled and studied to identify areas of congruity and disparity between staff and consultant teams, as well as common areas of agreement on the need for continued maximum security hospitalization versus other appropriate dispositions that might be available under the patient's legal circumstances.

The efforts of the consulting, nonstaff clinicians were further augmented by mental retardation experts from the state's Division of Mental Retardation who offered on-site input about the need for treatment in a mental retardation program of any patients determined mentally retarded rather than mentally ill. In addition, as a link to the correctional system, Bureau of Corrections consultants were avail-

Table 1. Staff and Independent Evaluation Team Placement Recommendations by Legal Status for Total Population of 201 Patients

Placement Recommendations	Sentenced Prisoners No.	(Percent)	Pretrial Detentioners No.	(Percent)	Civil Patients No.	(Percent)	Not Guilty by Reason of Insanity No.	(Percent)	Total Population No.	(Percent)
Agreement	55	(66)	41	(61)	28	(61)	1	(20)	125	(62)
Disagreement	28	(34)	26	(39)	18	(39)	4	(80)	76	(38)
Total	83	(100)	67	(100)	46	(100)	5	(100)	201	(100)

Table 2. Clinical Agreement Between Staff and Independent Evaluation Teams for Placement of 125 (62 percent) of Patients

Agreement	Sentenced Prisoners No.	(Percent)	Pretrial Defendants No.	(Percent)	Civil Patients No.	(Percent)	Not Guilty by Reason of Insanity No.	(Percent)	Total Population No.	(Percent)
To remain at maximum security facility	28	(34)	12	(18)	18	(39)	1	(20)	59	(29)
For placement elsewhere	27	(32)	29	(43)	10	(22)	0	(0)	66	(33)
Medium security facility	19	(23)	13	(19)	3	(7)	0		35	(17)
State psychiatric hospital	4	(5)	10	(15)	7	(15)	0		21	(11)
Nursing home	2	(2)	4	(6)	0	(0)	0		6	(3)
Return to community	2	(2)	0	(0)	0	(0)	0		2	(1)
Return to prison	0	(0)	2	(3)	0	(0)	0		2	(1)
Total	55	(66)	41	(61)	28	(61)	1	(20)	125	(62)

able for special situations concerning the potential return of state hospital prisoners to the state correctional system.

A population of 204 patients was available at the start of the survey. Because of intervening discharges during implementation of the study, only 201 patients remained to be clinically interviewed and evaluated by both hospital staff teams and independent consultants.

Results

The hospital treatment teams and independent consultants agreed on the clinical findings and placement recommendations in 125 of the 201 cases (62 percent), and disagreed on the remaining 76 cases (38 percent). Data are shown in Table 1. Table 2 shows data on the clinical agreement between staff and independent evaluation teams regarding patient placement. The treatment teams and the outside consultants agreed that 59 of the patients (29 percent) required continued hospitalization at the maximum security facility, whereas 66 of the patients (33 percent) should be transferred for treatment elsewhere.

Table 3 shows data on the disagreement between staff and independent evaluation teams regarding retention of the remaining 76 (38 percent) patients at the maximum security facility. For 69 of the 76 patients (34.5 percent), the difference of opinion between the "in-house" staff and "outside" teams was over retention at the maximum facility versus management elsewhere — with the outside con-

Table 3. Clinical Disagreement Between Staff and Independent Evaluation Teams for Placement of 76 (38 percent) Patients

Disagreement	Sentenced Prisoners No.	(Percent)	Pretrial Detentioners No.	(Percent)	Civil Patients No.	(Percent)	Not Guilty by Reason of Insanity No.	(Percent)	Total Population No.	(Percent)
Maximum vs. medium security forensic facility	12	(15)	8	(12)	7	(15)	3	(60)	30	(15)
Maximum security vs. state psychiatric hospital	9	(11)	9	(13)	8	(18)	1	(20)	27	(13)
Maximum security vs. prison	2	(2)	3	(5)	0	(0)	0	(0)	5	(3)
Maximum security vs. nursing home	1	(1)	1	(1)	1	(2)	0	(0)	3	(1.5)
Maximum security vs. mental retardation facility	0	(0)	1	(1)	2	(4)	0	(0)	3	(1.5)
Maximum security vs. community	1	(1)	0	(0)	0	(0)	0	(0)	1	(.5)
Medium security forensic facility vs. state psychiatric hospital	1	(1)	3	(5)	0	(0)	0	(0)	4	(2)
Prison vs. state psychiatric hospital	2	(2)	0	(0)	0	(0)	0	(0)	2	(1)
Prison vs. medium security	0	(0)	1	(1)	0	(0)	0	(0)	1	(.5)
Total	28	(34)	26	(39)	18	(39)	4	(80)	76	(38)

sultants recommending transfer to a medium security forensic facility for 30 (15 percent) patients, a state psychiatric hospital for 27 (13 percent) patients, prison for 5 (3 percent) patients, a nursing home for 3 (1.5 percent) patients, and release to the community for 1 (.5 percent) patients. For the remaining 7 patients, there was agreement as to release but disagreement as to where the patient should be transferred.

The 201 sets of evaluation data were categorized with respect to legal status: sentenced prisoners, pretrial detentioners, civil cases (with no present involvement in the criminal justice system), and those found not guilty by reason of insanity (NGRI). The extent of agreement for each of the above groups was similar except for those found NGRI for whom the sample size was small (see Table 2). Agreement to retain patients at the maximum security facility occurred more frequently for civil patients[34] and less frequently for the pretrial detentioners.

Discussion

Aside from reasonable differences of clinical opinion, there was nevertheless a solid core of one-third (36 percent) of patients who were found to be both legally and clinically suitable for release to less secure facilities or the community. In addition, independent consultants generally regarded another 34 percent of patients suitable for management elsewhere. Thus there was agreement by both teams that at least one-third of the population did not require maximum security forensic hospitalization, and independent consultants suggested that the population could be cut by as much as two-thirds through the use of alternative facilities.

In terms of their legal status categories, only a third of the sentenced prisoners were found by both teams to require maximum security hospitalization. The most frequently recommended alternative placement for such sentenced prisoners was a medium security, regional forensic facility.

For the pretrial detentioners, maximum security hospitalization was found to be appropriate for only one-fifth of them, with essential agreement by both teams. The most frequently recommended alternative placements for pretrial detentioners were medium security state hospital facilities (34 percent).

The maximum security forensic facility was seen as appropriate for two-fifths of the civil patients (without current charges or convictions), with the most frequently recommended disposition being a regular state psychiatric hospital.

The remarkably high figure for civil patients is because prior indeterminate commitment laws allowed for the inordinate retention of patients who grew old and senile at the state maximum security hospital. Having outlived both friends and family, and with no place else to go, such persons generally begged to remain in the only familiar environment they had known — often for twenty years or more. During this time, while witnesses disappeared and the charges were dropped, such patients remained mentally ill but required no greater forensic security than ordinary state hospital patients, sometimes no more than could be handled in a nursing home.

As a result of the clinical survey and evaluation, patients were considered for transfer or release. Ten months following completion of the survey, a follow-up inquiry indicated that of the 201 patients originally examined 84 patients had been transferred to alternative facilities and 2 patients released to the community. A total of 43 percent of patients had been released to less restrictive environments.

Conclusions

A certain amount of procedural inertia often is encountered at the junction of the Criminal Justice and Mental Health Systems. This inertia, generally attributed to the ponderous nature of "the system," is most difficult for in-house staff personnel to overcome. When such inertia, often rationalized as conservative concern for the welfare of the patient and the community, results in detaining patients unnecessarily under greater restraint than is required, the results are expensive for the taxpayer and tragic for the patient.

We have provided an initial model for the rapid clinical survey of maximum security hospital populations. The outside consultant team model also lends itself to identifying and recommending treatment for the substantial numbers of mentally ill offenders known to be housed in jails and penitentiaries. We hope similar clinical forensic surveys can assist and stimulate the frequently overburdened, inhouse staff to periodically review cases with outside mental health professionals to ensure the most appropriate placement management of mentally ill offenders and defendants, and to cope with the inertia and latent "intimidation" involving the hospital staff's prospects of bucking the ponderous (often leisurely) procedures of two bureaucratic systems, mental health and criminal justice.

The use of independent consultants and a uniform interviewing and data collection checklist provided a useful mechanism for the sharing and comparison of divergent and convergent clinical findings and opinions and for the identification of decision points that specifically address the mentally ill person's involvement with the Criminal Justice System. Such an approach reduces the incidence of inappropriate hospitalization of mentally ill persons at a maximum security facility, consistent with the principle of treatment under the least restrictive environment. As a result of this survey, more than 40 percent of the maximum security hospital patients were identified as suitable for transfer elsewhere and were duly discharged and transferred to other facilities.

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32. These were specific, separate locked ward sections of specific state hospitals designated to receive cases with criminal court and correctional involvement.
33. The nonstate hospital physicians received a modest state per diem and expenses and contributed the two-day period out of their community and professional interest in the particular hospital's problems and its dual relationship with the criminal justice and mental health systems.
34. Many of these civil patients were elderly and senile persons who, by the time their charges were dropped, had outlived friends or relatives and regarded the maximum security hospital as their only home. The clinical judgment in such cases was often against the disruption of familiar surroundings in the generally incompetent senile group who begged to remain as "voluntary" patients. □