Commitment Versus Confinement: Therapeutic Passes in the Management of Insanity Acquittees

Stephen A. Young, MD, Richard L. Frierson, MD, R. Gregg Dwyer, MD, EdD, and Amishi Shah, MD

J Am Acad Psychiatry Law 30:563–7, 2002

Despite documented changes in the not-guilty-by-reason-of-insanity (NGRI) defense during the past 15 years, most states and the federal government continue to recognize the underlying principle that some mentally ill defendants must be viewed in a different light when assigning criminal responsibility.[1] Although the NGRI defense is rarely invoked and is not usually successful,[2] some individuals nationwide are found NGRI each year, creating complex dispositional questions for mental health agencies, courts, and patient advocacy groups. In most states that recognize some version of the NGRI verdict, statutory guidelines direct procedures for a disposition after NGRI acquittal. Although the general nature of these statutes mandates immediate commitment to a treatment facility, the parameters of commitment vary significantly between jurisdictions. Frequently, these statutes fail to cover the use of therapeutic passes, a clinical tool used to ease the transition of patients into the community before conditional release. Specifically, statutory language frequently fails to address the crucial matter of who bears decision-making responsibility for allowing patients to have therapeutic passes: clinicians or the courts.

In this article, we explore a recent case in South Carolina in which the very definition of the word commitment was in dispute, leading to a larger discussion about how decision-making authority regarding therapeutic passes was to be divided between the department of mental health, the office of attorney general, and the original trial court. A detailed review of the case will be followed by a discussion of the results of a state-by-state survey on the question of therapeutic passes for this population. Finally, a discussion of the broader issues involving this area of post-trial management of insanity acquittees will be presented.

Dr. Young is Associate Professor of Clinical Psychiatry, Drs. Dwyer and Shah are General Psychiatry Residents, University of South Carolina School of Medicine, Columbia, SC, and Dr. Frierson is Associate Professor of Clinical Psychiatry, William S. Hall Psychiatric Institute, University of South Carolina School of Medicine, Columbia, SC. Address correspondence to: Stephen A. Young, Associate Professor of Clinical Psychiatry, University of South Carolina School of Medicine, 3555 Harden Street, Columbia, SC 29203. E-mail: syoung@actcorp.org

Facts of *State v. Hudson*

On April 1, 1995, Ui Sun Hudson, a 39-year-old Korean female, was wandering through a Charleston, South Carolina, shopping mall and attacked three children with a pair of scissors, causing significant injury. One child suffered permanent loss of vision in one eye. The parents, who eventually subdued Ms. Hudson, were also injured. Ms. Hudson had immigrated to the United States several years earlier in the context of a brief marriage to a U.S. serviceman. Although initially able to maintain a job and a home, her history in the years prior to the offense revealed a gradual but severe deterioration in her ability to function. By 1995, she had been homeless for at least a year and had joined a group of people who moved semiannually between Florida and Washington, D.C., to avoid cold weather. On the day of the offense, she reportedly had become so paranoid that she frightened her traveling companions and ended up hitching a ride to South Carolina on her own.

Ms. Hudson was eventually indicted on four counts of assault and battery with intent to kill and was found NGRI after a bench trial in October 1995. In South Carolina, a criminal defendant is not criminally responsible if, at the time of the commission of the act constituting the crime, as a result of mental disease or defect, he or she lacks the capacity to distinguish legal or moral right from legal or moral wrong or to recognize the act charged as legally or morally wrong.[3] Consistent with South Carolina statutes, Ms. Hudson was immediately committed to a facility of the Department of Mental Health (DMH).

After NGRI acquittal, the statute directs that the acquittee be hospitalized for a period of 120 days, after which a hearing is held to determine whether the acquittee should remain hospitalized. The criminal court maintains jurisdiction and may order continued hospitalization if it finds that the acquittee lacks sufficient insight or capacity to make responsible decisions regarding treatment or that there is a likelihood of serious harm to self or others.[4] The statute contains no language governing the conditions of confinement. There are no statutory provisions or exclusions for therapeutic passes. The patient remains in the hospital until DMH notifies the court that the patient is no longer in need of confinement. After notification, the original court holds a release hearing. An insanity acquittee may remain under the jurisdiction of the original trial court for as long as the maximum sentence for the crime with which he or she was charged. To be held longer, the acquittee must be subjected to standard civil commitment procedures.[5]

Despite the statutory requirement that a hearing be held within 120 days, Ms. Hudson did not appear before a judge again until April 25, 1997, 18 months after her initial commitment. In the interim, Ms. Hudson had been enrolled in a specialized treatment program for NGRI acquittees. The program consisted of a level system through which patients gradually moved in accordance with their clinical progress. The initial levels involved housing on locked units with constant supervision, equivalent to a high-acuity inpatient treatment setting. Over time, the patients were allowed gradual increases in freedom of movement consistent with their clinical status. Advancement within the system was based solely on clinical criteria, determined by a psychiatrist-led treatment team. The higher levels within this system allowed for unsupervised time in the community for structured work and social activities—for example, "buddy" passes, home visits, and supervised employment.

By the time Ms. Hudson returned to court in 1997, she was traveling unsupervised into the community to a structured employment setting on a regular basis. She continued to be housed in a DMH facility on South Carolina State Hospital (SCSH) grounds. At her hearing, the administrative judge raised concerns about the patient's lack of supervision during her daily commutes to work. In his ruling, he allowed DMH to maintain the patient at her current treatment level, but ordered that further increases in her freedom be approved by the court after proper notification and hearing. He also ordered that DMH review the system of treatment levels and obtain court approval prior to the unsupervised release of other patients into the community.

This mixed result was unsatisfactory to the South Carolina attorney general (AG) who appealed the decision and filed a civil action requesting declaratory and injunctive relief against DMH. Specifically, the AG asked the court to require "continuous, supervised confinement of the NGRI defendants" and to forbid any type of unsupervised activity in the community, including therapeutic passes.[6] Two months later, DMH and the AG entered into a consent decree that significantly limited DMH discretion in granting unsupervised community treatment for NGRI acquittees. DMH agreed to obtain court approval for all passes.

The consent decree, however, did not settle the question of the meaning of commitment and specifically allowed the AG to appeal the original ruling. Ultimately, the South Carolina Court of Appeals agreed with the AG, specifically stating that:

> Words must be given their plain and ordinary meaning. . . . A defendant with unsupervised leave privileges could not, within the plain meaning of the statute, be considered committed. Indubitably, the statute demonstrates the legislature never envisioned that a committed NGRI patient could be released to societal freedom on unsupervised, albeit temporary, leave from the state hospital [Ref. 7, p 581].

Ms. Hudson appealed this decision to the South Carolina Supreme Court, which granted *certiorari* and heard oral arguments in June 2001. However, in August 2001 the South Carolina Supreme Court dismissed the *certiorari* as "improvidently granted," letting stand the ruling by the court of appeals.

The literal effect of this decision was dramatic, ending all unsupervised passes for insanity acquittees. When the South Carolina Court of Appeals opinion was published in June 1999, roughly 40 NGRI acquittees were enrolled in the latter stages of the NGRI treatment program. Some had been living independently in the community, with outpatient monitoring, for months to years. These patients were physically returned to the state hospital over a two-day period. This caused an immediate problem with bed space and other basic needs. It took more than a year before court hearings could be scheduled for all of the returned patients, most of whom were returned to community settings after judicial review. Ms. Hudson was eventually placed in a monitored group home in the community in December 2001.

U.S. Appellate Cases Regarding Therapeutic Passes for Insanity Acquittees

Although many courts have grappled with the competing goals of community safety and treatment in the NGRI population,[8–10] few have addressed the specifics of how commitment is actually defined. In the case of NGRI acquittees, commitment could simply mean consignment or transfer of care to a mental health provider or state hospital. As in *Hudson*, commitment could be interpreted as meaning physical confinement. Insanity acquittees have sought judicial relief to be allowed passes in several contexts, including religious freedom,[11] proper venue,[12] and the importance of furloughs in treatment.[13] When the issue has been raised, most courts relegated the question of passes to judicial control. The *dicta* in *People v. Cross* typifies this approach:

> We agree with the State that requiring the trial court to grant the passes any time a defendant's treatment team requests because the *team* believes they should be granted would defeat the purpose of the statute's language mandating that the passes *may* only be granted on the *trial court's* approval [Ref. 13, p 772; emphasis in original].

However, some opinions reflect clear ambivalence. In *Hennepin v. Levine*,[14] a case in which the Supreme Court of Minnesota upheld the treatment team's authority to issue passes without approval of a special review board, the Court stated: "This case epitomizes the tension that exists between the state's role in protecting its citizens and the state's role in rehabilitating mentally ill individuals in its custody" (Ref. 14, p 219).

Two recent cases highlight the ongoing confusion in this area. The D.C. Court of Appeals has frequently ruled on specific issues involving the treatment of John Hinckley, a man acquitted and hospitalized at St. Elizabeth's Hospital after an assassination attempt on President Reagan. In *Hinckley v. U.S.*[15] the court was faced with a request from Hinckley's treatment team for a supervised six-hour home visit. Hinckley was to be accompanied by two hospital employees at all times. The U.S. Attorney opposed the pass request on grounds that it was equivalent to a conditional release. The district court agreed and the pass was denied. On appeal, the D.C. Circuit Court studied the issue of therapeutic passes at some length, ultimately deciding that Hinckley's accompanied pass was not considered a conditional release and could be allowed without district court approval. Notably, the court focused on the area of conditional release, rather than on passes in its analysis, stating: "Indeed, a demarcation line between a Hospital escort and supervision by some other third party in the community has signaled the point at which the requirements of conditional release come into play since conditional releases first became available for insanity acquittees in 1955" (Ref. 15, p 655).

This opinion essentially expands the definition of confinement to include passes to leave hospital grounds as long as hospital personnel accompany the patient. The notoriety surrounding Hinckley's possible passes resulted in Congress's further amending the federal NGRI statutes in 1998. The current federal guidelines include a section on furloughs that states:

> [A]n individual who is hospitalized. . .after being found not guilty by reason of insanity. . .may leave temporarily the premises of the facility in which that individual is hospitalized only. . .with the approval of the committing court. . .in an emergency; or when accompanied by a Federal law enforcement officer.[16]

In another case, a group of patients attempted to bring a class action suit against the state of Illinois, requesting individual review of pass requests.[17] All passes for patients judged NGRI were permanently suspended in 1990 after two insanity acquittees escaped from an Illinois state hospital while on unsupervised grounds privileges. The patients' class action suit was based on alleged violations of the least-restrictive-treatment doctrine, lack of individualized treatment plans, and deprivation of liberty interests. The appellate court agreed that a blanket rule deny-

ing passes to all insanity acquittees was inconsistent with a "constitutionally protected liberty interest in freedom of bodily movement." The court expressed frustration with the lack of legislative guidance and specifically noted the lack of definition of an "unsupervised on-grounds pass," the question of a possible ongoing "lock-down," and whether "professional judgment is being exercised in making individual recommendations regarding unsupervised on-grounds passes" (Ref. 17, p 1218).

Treatment Models Presented in the Literature

The forensic literature has long recognized the clinical necessity of a transitional period between the forensic inpatient setting and the long-term goal of unconditional release of insanity acquittees into the community.[18] However, most work has focused on the model of conditional release, which attempts to balance public safety with the right of the individual to function in the least-restrictive environment. In this model, patients are actually released into the community, but monitored closely by mental health professionals. Release status can be revoked as a response to noncompliance or signs of relapse. The need for ongoing risk assessment has been stressed.[19] Often, these individuals lack the social skills necessary to function in less structured environments, particularly when they first leave the highly organized forensic hospital. Wiederanders and Choate[20] have documented that patients in monitored conditional release programs show significant improvement on scales measuring employment, social supports, and independence and compliance during their first year of community treatment. However, the granting of therapeutic passes prior to conditional release has not attracted as much attention or analysis.

Oregon's Psychiatric Security Review Board (PSRB) has been a national model for the management of insanity acquittees since its inception in 1978. The Oregon approach balances treatment and safety and is specifically designed to provide long-term monitoring of patients who are conditionally released. The PSRB is composed of five appointed members: a psychiatrist, a psychologist, an attorney, a parole or probation officer, and a member of the general public.[21] Once a defendant is found NGRI, the trial court judge determines initial placement and maximum length of jurisdiction. The responsibility for the patient is then transferred to the PSRB, which independently determines all elements of the defendant's care, including treatment setting, revocation of conditional release status, and presumably, passes.[22] Several advantages of this system have been observed: reductions in costly inpatient hospitalizations, development of focused psychosocial community treatments for patients judged NGRI who have chronic mental illness, and closer monitoring of patients who pose a threat to the general public.[23] Unfortunately, the actual description of where on- or off-grounds passes fit into the scheme is poorly described in the literature.

The Missouri insanity acquittee system specifically includes passes but refers to them as trial releases.[24] Patients on trial release are allowed up to 96 hours off hospital grounds without supervision, but all such releases require court approval. This attempt to incorporate passes into the conditional release model by renaming was also attempted by the *Hennepin* court, which used the term partial institutionalization to describe therapeutic passes of up to 10 days, with the patient unescorted.[14]

Discussion

The events in *Hudson* in South Carolina reveal a situation in which mental health professionals, with the best of intentions, embarked on a course of action thought to be in the patient's best interest involving treatment in the least-restrictive setting. However, the decision-making was based on the interpretation of the statutory word commitment as not requiring confinement. The risk associated with passes, according to the appellate courts, had not been endorsed by the legislature or by case precedent. Fortunately, there was not a bad outcome in this case; however, there have been other instances in which insanity acquittees have escaped from lower levels of supervision (on-grounds passes, for example) and committed serious offenses.[25] In a 1986 D.C. Circuit Court of Appeals case, the court made it clear that hospitals can be found negligent when a patient who has been judged NGRI is inadequately supervised and subsequently elopes.[26]

It makes sense to both mental health providers and the courts that some type of gradual transition back into the community best meets both goals: the patient's rehabilitation and the public's safety. At present, the discussion is dominated by the concept of conditional release programs, which clearly have a major role to play. However, some patients may be

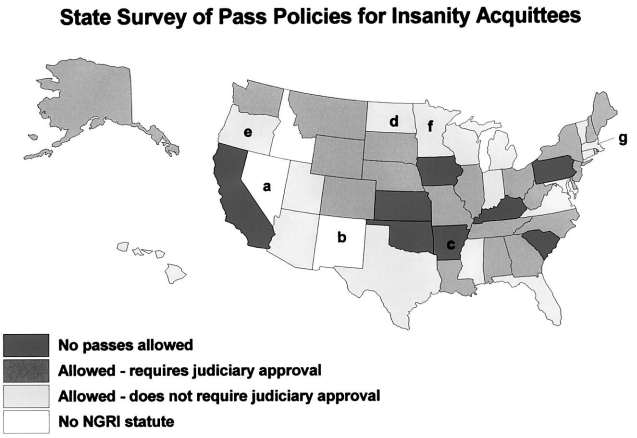

Figure 1. State survey of pass policies for insanity acquittees. *a*, Recent Nevada Supreme Court ruling that abolition of the insanity defense is unconstitutional; *b*, statute exists, but there are no insanity acquittees in the system; *c*, insanity defense abolished, applies to defendants adjudicated previously; *d*, pass for less than 12 hours decided by treatment team, but the court decides in certain situations; *e*, passes for less than 24 hours; longer passes require approval of the security review board; *f*, requires approval by special review board; *g*, court can maintain authority to grant passes in some cases.

hospitalized for years before being eligible for a conditional release. Therapeutic passes may play a role in preparing these patients for conditional release. High-profile acquittees, like Ui Sun Hudson and John Hinckley, attract more public scrutiny and frequently have adversarial court proceedings long after the initial insanity acquittal. Clinicians working with such patients will continue to press for gradual increases in freedom and privileges, and the question of granting passes will inevitably have to be decided.

A telephone survey of all 50 states regarding pass policies revealed a patchwork of systemic responses (Fig. 1). When passes were defined as any time spent outside hospital grounds without supervision, we were able to classify states into one of three possible pass policies: no passes at all; passes allowed with judicial approval; and passes allowed without judicial approval.

State departments of mental health that do not have a clear understanding of the legal responsibility for issuing a pass operate to some degree at their own peril. In South Carolina, the lack of such an understanding resulted in the abrupt end of a program that had helped many people. Even something as basic as grounds privileges must be examined if there are open gates through which the patient can escape into the community. The consequences of not dealing with this situation proactively may lead to public and legislative backlash and an acute reactive decision by the legislature or AG in the face of a perceived poor outcome. For example, in *C.J. v. Department of Mental Health*[17] the complete banning of all grounds passes occurred as a result of the escape of two patients. We urge further research into this area and consideration of the development of specific practice guidelines, with the goal of a national consensus defining the parameters of commitment as well as a consistent framework for providing rehabilitation services to this difficult population of patients.

References

1. Lymburner JA, Roesch R: The insanity defense: five years of research (1993–1997). Int J Law Psychiatry 22:213–40, 1999
2. Janofsky J, Dunn M, Roskes E, *et al*: Insanity defense pleas in Baltimore: an analysis of outcome. Am J Psychiatry 153:1464–8, 1996
3. S.C. Code § 17-24-10
4. S.C. Code § 44-17-580
5. S.C. Code § 17-24-50
6. State of South Carolina ex rel Charles M. Condon v. South Carolina Department of Mental Health C.A. 97-CP-40-1812
7. State v. Hudson 519 S.E.2d 577 (S.C. Ct. App. 1999)
8. U.S. v. Baker, 155 F.3d 392 (4th Cir. 1998)
9. In Re Oswald N., 661 N.E.2d 679 (N.Y. 1995)
10. Benham v. Ledbetter, 785 F.2d 1480 (11th Cir. 1986)
11. Abraham J. v. Sarkis, 668 N.Y.S.2d 435 (N.Y. App. Div. 1997)
12. Ledbetter v. Cannon, 384 S.E.2d 875 (Ga. Ct. App. 1989)
13. People v. Cross, 704 N.E.2d 766 (Ill. Ct. App. 1998)
14. Hennepin County v. Levine, 345 N.W.2d 217 (Minn. Sup. Ct. 1984)
15. Hinckley v. U.S., 163 F.3d 647 (D.C. Cir. 1999)
16. 18 U.S.C. § 4243(h)
17. C.J. v. Department of Mental Health and Developmental Disabilities, 693 N.E.2d 1209 (Ill. Ct. App. 1998)
18. Epstein H: Providing outpatient services to criminal procedure law patients: the clinician's perspective. Psychiatr Q 64:295–302, 1993
19. Wack R: The ongoing risk assessment in the treatment of forensic patients on conditional release status. Psychiatr Q 64:275–93, 1993
20. Wiederanders MR, Choate P: Beyond recidivism: measuring community adjustments of conditionally released insanity acquittees. Psychol Assess 6:61–6, 1994
21. Gold Award Article: A model for management and treatment of insanity acquittees: Psychiatric Security Review Board, State of Oregon. Hosp Community Psychiatry 45:1127–31, 1994
22. Bloom JD, Williams MH, Bigelow DA: Monitored conditional release of persons found not guilty by reason of insanity. Am J Psychiatry 148:444–8, 1991
23. Wieranders MR, Bromley DL, Choate PA: Forensic conditional release programs and outcomes in three states. Int J Law Psychiatry 20:249–57, 1997
24. Linhorst DM: The legislative structuring of insanity acquittee policies. J Mental Health Admin 24:166–77, 1997
25. Hafemeister TL, Petrila J: Treating the mentally disordered offender: society's uncertain, conflicted, and changing views. Fla State Univ Law Rev 21:729–871, 1994
26. White v. U.S., 780 F.2d 97 (D.C. Cir. 1986)