Commentary: Biases That Affect the Decision to Conditionally Release an Insanity Acquittee

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The care and management of hospitalized insanity acquittees can be quite challenging. As patients progress in treatment, clinicians must invariably address whether the patient is ready to be returned to the community, balancing the liberty interests of the acquittee with the protection of society. The process by which this determination is made is far from simple and involves review of clinical interview and collateral information, identification of indicators of outcome post-discharge, and the use of structured risk assessment instruments. The decision to release an acquittee conditionally is also influenced by an array of factors that emanate from within the clinician, within the institution, the mental health system, the courts, and the broader society. While such biases affect a clinician's objectivity, they are also a natural part of the evaluation process. Their identification is essential so that the degree to which such biases influence the conditional release decision can be more fully understood and addressed.

J Am Acad Psychiatry Law 36:337–9, 2008

It is a daunting task for hospitals that treat persons adjudicated not guilty by reason of mental disease or defect to decide when and under what circumstances to release an acquittee conditionally. McDermott and colleagues[1] have studied the factors that affected conditional release decisions for persons committed to the Napa State Hospital in California over a period spanning 32 years. Through retrospective analysis of patient records, they categorized and evaluated those factors that clinicians considered to be indicators that an acquittee was ready for conditional release and identified patterns in decision-making over time. They found that in making release decisions, clinicians relied heavily on two factors: an acquittee's remediation of mental illness and risk of dangerousness. They noted that in recent decades, clinicians paid greater attention to substance use as an independent risk factor.

The justification for an acquittee's discharge, as noted in the patient's medical record, tells only part of the story, as it documents only those factors that the clinician chooses to include. While I agree that treatment response and compliance, risk of substance abuse relapse, and future recidivism risk are central to the determination of an acquittee's appropriateness for conditional release, other noteworthy factors, both personal and societal, influence the decision to varying degrees, and warrant further examination.

The decision to release an insanity acquittee conditionally does not reside entirely within the realm of medicine. States have differing procedures governing the management and conditional release of insanity acquittees.[2] Legislative definitions of the terms mentally ill and dangerous, and the judicial interpretation of their meaning, influence how a health care system approaches release decisions. While the U.S. Supreme Court's decision in *Foucha v. Louisiana*[3] established that an acquittee cannot be confined solely on the basis of potential dangerousness in the absence of a mental illness to justify the continued commitment, it did not provide further instruction as to how to go about making release decisions. Nor did it provide guidance as to how dangerousness is to be defined.[1]

Connecticut has begun a review of its regulatory definition of dangerousness for insanity acquittees following a recent Connecticut Supreme Court ruling that found no meaningful difference between the definition of dangerousness as it relates to the con-

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tinued commitment of insanity acquittees and the definition of dangerousness as it relates to civil committees.[4] Connecticut lacks an outpatient civil commitment statute. Conditional release under the state's Psychiatric Security Review Board represents the only mechanism for mandated outpatient commitment. The state's definition of dangerousness for civil commitment is explicitly predicated on the need for "immediate care and treatment in a hospital."[5] The Connecticut Supreme Court's ruling has created a situation whereby an insanity acquittee may have to be discharged from the state's Psychiatric Security Review Board once the acquittee is no longer deemed so dangerous as to require an inpatient level of hospital care, effectively eliminating the state's capacity to utilize conditional release.

Public pressure to ensure community safety on the one hand and increased patient rights advocacy on the other affects conditional release decision-making in ways that are at times subtle, at other times more overt. Media attention and public outcry focused on a heinous act committed by a conditionally released acquittee may compel a state mental health system to conduct a comprehensive review of its policies and procedures governing release and revocation decisions. This pressure could result in the modification of the current assessment process to one that is more conservative in its approach. Even without such a response, clinicians may favor a conservative approach that gives greater consideration to societal protection as a means of limiting their personal liability. Similarly, the assessment of an acquittee's readiness for discharge may be influenced by the clinician's sense of personal duty to ensure that so-called justice is served. Countering this bias, the fear of legal action from a patient or the patient's legal advocate may influence the clinician to give relatively greater consideration to the patient's liberty interests.

Ethnodemographic bias may also bear on the analysis of an acquittee's readiness for conditional release. It is doubtful that clinicians would openly acknowledge and document in a patient's record to what extent the patient's ethnicity, gender, or socioeconomic status have affected the conditional release decision. Yet it has been shown that minority status plays a significant role in conditional release revocations.[6] Ongoing supervision of clinicians treating forensic populations is crucial for identifying problems and intervening promptly to reduce the potential influence from these forms of bias.

The strength of the relationship between hospital mental health providers and the community mental health agency to which the acquittee is to be referred can also factor into the release decision. Hospital clinicians are more apt to consider a forensic patient's conditional release if they are confident that the prospective outpatient treatment providers are competent and have a proven track record of assessing and managing challenging, high-risk clients.

Recent advances in the development of actuarial instruments for assessing probabilities of recidivism provide some measure of quantifiable risk assessment. The accuracy of a selected risk instrument in determining probability estimates depends on its use in the population in which it was validated. When the proper actuarial instrument is applied to a population in which its validity has been tested and shown, the results can provide the clinician with useful data to aid in the conditional release decision.

While helpful, the probability estimate generated by an actuarial instrument presents the clinician with a dilemma. What constitutes an acceptable probability of recidivism? How much recidivism risk is society willing to accept? A clinician may determine that a seven-year probability of violent recidivism of 12 percent is acceptable, although society or the courts may take issue with this determination, based on prevailing attitudes and intolerance of instances of criminal recidivism.

Ultimately, the court determines whether to release an acquittee conditionally based on the evidence presented at hearing, and its rulings can shape a hospital's approach to release decisions. A court's decision to grant or deny a hospital's petition for conditional release provides the hospital with a glimpse into the court's orientation and attitude with respect to the balancing of societal protection and personal liberty interests. These revelations can influence the hospital's readiness or reluctance to submit subsequent conditional release petitions. For instance, the hospital may refrain from submitting an application for conditional release of an acquittee whose risk factors, diagnosis, treatment progress, and criminal history resemble those of an acquittee whose petition for conditional release the court has denied.

Taking a detailed history, obtaining sufficient collateral information, and using structured assessment instruments remain the standard of good forensic evaluation. Structured assessments of a forensic patient's appropriateness for discharge will provide cli-

nicians with a more evidence-based determination of risk probability, which may mitigate the personal, social, political, and ethnodemographic biases inherent in such decisions. While structured risk assessment instruments may provide clinicians with a common methodology and language with which to assess the forensic population, the information must also be translated in such a way as to be of use to judicial decision-makers.

There is no doubt that a multitude of factors unrelated to treatment progress, substance abuse relapse risk, and dangerousness influence the decision-making process. The extent to which these factors guide a clinician's decision with respect to the conditional release of insanity acquittees is difficult to quantify.

Conditional release assessments do not occur in a vacuum; they occur within a contextual framework that is influenced by generally accepted information about risk management and recidivism, as well as the political and social climate of the area into which the acquittee will be discharged. Determining when an acquittee is ready for conditional release is not easy, nor should it be; for decisions reached too easily generally fall too far from the fulcrum across which community safety and the patient's liberty interests are poised.

References

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