

The Development of Internal Forensic Review Boards in the Management of Hospitalized Insanity Acquittees

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Some states (or individual state forensic facilities) have established forensic review boards or panels with special responsibility for the management of insanity acquittees. The basic purpose of these boards is to assist the courts or, in several states, to substitute for the courts in making decisions about access to, or return to, the community. The first of the two primary models currently utilized can best be described as the "external board," which may have statutory authority to release to the community those acquittees who are not guilty by reason of insanity, to monitor the conditional release, and to revoke the release if necessary. The Connecticut and Oregon boards, good examples of the external review board model,

have been covered in the literature.^{1,2} Our purpose is to describe a second model, the internal review board, currently used in Washington, DC, and Maryland. This model is appropriate for states that intend to continue judicial decision-making regarding release and revocation but seek improvement in the forensic hospital system's performance in generating recommendations to the courts. States using the internal review board model have noted high marks from the judiciary for reports that address not only clinical concerns, but also administrative, legal, and public safety issues. Judicial confidence, support, and cooperation are of the utmost importance to the ability of any forensic mental health system to provide effective treatment of insanity acquittees in the least restrictive environment.

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History

Possibly the first internal forensic review board was implemented in 1975 at the John Howard Pavilion at St. Eliza-

beths Hospital, the forensic facility serving Washington, DC. Administrator Joseph Henneberry instituted the Forensic Review Board to provide relief for ward treatment teams, who had experienced conflict and even intimidation from staff, patients, and others regarding changes in privileges and discharge recommendations. This new review board heard the treatment team's presentation, reviewed the written report, allowed discussion, and then voted out of the presence of the treatment team. The team was immediately informed of the Board's decision and explanation and was given the opportunity for immediate clarification. The Forensic Review Board's recommendation was then recorded and formed the basis of the report to the court.

This process was replicated in Maryland in 1993 in the establishment of the Forensic Review Board at the Clifton T. Perkins Hospital Center, the state's secure forensic mental health facility. Modifications included a requirement that the treatment team submit a typewritten report in advance, following a prescribed format. The treatment team and other interested staff were encouraged to be present during the Forensic Review Board's deliberations and voting. Subsequent changes at Perkins have included expansion of the Board to include consultation (non-voting) by the directors of quality assurance and utilization review. In both Washington, DC, and Maryland, the internal deliberations and individual votes have been confidential to minimize risk to board members whose vote might be perceived by patients as not supportive of their release. The practice has also assured au-

tonomy, similar to peer review in other systems.

Description of Basic Operation of the Two Types of Review Boards

External review boards generally are given broad statutory authority in matters such as determination of conditions of release, monitoring of compliance and modification of specific conditions, and revocation of conditional release with re-hospitalization as an option. These boards are generally not part of the forensic hospital operations, but are staffed, funded, and operated under separate authority. Because of this jurisdictional authority, the external board's process is a legal hearing, with participation by acquittees, advocates, prosecution, defense, family members, and others. The composition of the board may include hospital representatives as well as representatives of the lay and/or legal communities. These hearings and other aspects of the process have staffing requirements and therefore involve special costs.

Internal forensic review boards essentially are in-hospital processes. These boards review treatment team recommendations for changes in hospital security levels or for conditional or unconditional release to the community. Membership typically consists of the hospital's clinical director, and clinical, security, and administrative department heads. The board is likely to be chaired by the superintendent, with consultation by legal counsel. A representative of the team typically presents a written report that follows a prescribed format, covering the patient's clinical and legal history, response to treat-

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ment, and the team's rationale for recommendations regarding status change within the hospital, hospital leave, or release to the community. (Internal review boards may or may not monitor compliance with conditional release, although they typically make recommendations to the court regarding a returned patient's appropriateness for re-release or revocation.) The board's decision is clearly explained and documented and becomes the nucleus for the report to the court, containing the hospital's recommendation regarding any status changes.

Characteristics of Internal Forensic Review Boards

The authors have experience with the operation of the internal forensic review boards in Washington, DC and Maryland. Generalizations at this point are difficult because these and other states' review boards are evolving, but the following characteristics have been observed:

1. The internal forensic review board can provide a useful review of the treatment team's thinking regarding an individual patient's progress, offering advice or new perspectives regarding treatment issues. It also provides additional continuity as the patient moves through various ward and security levels.

2. The internal forensic review board process can be easily and economically integrated into the hospital clinical/administrative structure. In Washington, DC, the review board meets twice each week for a total of two to four hours, typically reviewing 5 to 10 treatment team requests or recommendations per

week. In Maryland, the review board meets once each week for one to two hours, typically reviewing four to six cases.

3. The forensic review board membership is well suited for decision-making because it includes staff who have primary responsibility for clinical management of inpatients as well as individuals with responsibility for effective and responsive administrative support systems. Membership that includes individuals with expertise in community resources is vital. They can realistically assess the team's recommendations and requests by patients, providing a continuing link between the treatment team and community providers. The board's inclusion of security and legal consultants encourages understanding of the relevant statutes, as well as offering perspective on public safety issues. Legal concerns, such as the presence of criminal detainees, must be identified and resolved.

4. The requirement of a written report with a standardized format encourages treatment teams to present requests clearly and thoughtfully; this discourages reliance on staff memory of events that might affect their recommendations, such as patient assaults, seclusion, and use of restraint. Review of past board reports helps clarify to the teams the patient's history and adjustment to various levels of security.

5. The board's discussion process and reports clarify the entirety of the patient's status for the commissioner and/or superintendent (or their designees), who bear responsibility for the hospital's report/recommendation to the court.

6. Internal review boards can be developed without the necessity for statutory change.

7. Internal review boards are cost effective, typically necessitating no special personnel to administer or staff the board.

Continuing Questions/Concerns

One of the most interesting concerns shared by states with experience with these internal review boards is the gradual and sometimes unfortunate expansion within the hospitals of the role of these boards. Such increases in the review board's responsibilities may include utilization review, review of transfers between wards (to decrease staff conflict over a transfer even if transfer has no security implications), and clinical review purposes such as medication review, which might be better handled in clinical case conferences. Similarly, some states report a continuing debate as to the desirability of participation by patients, advocates, victims, attorneys, and others.

We recommend that the internal review board model be seen as an administrative process, reviewing requests by patients and the treatment teams. Direct participation by patients and others may appear useful but could have undesirable consequences, such as splitting the patient and the team or introducing an adversarial tone into what should be a cooperative effort. It is important that the review board process not become so cumbersome and complex that it loses its effectiveness to fulfill its primary function: to

offer the courts a timely and expert review of the patient's readiness for a less restrictive treatment environment, consistent with public safety.

Summary

When working well, internal forensic review boards generally: (1) have the support of the courts and communities; (2) consider and review effective individual treatment and public safety; (3) permit direct care treatment teams the opportunity to advocate for the patient; (4) focus clinical and security considerations on the individual patient rather than dwelling on system issues; (5) identify resource needs for inpatient and community care; (6) provide a foundation for monitoring patient adjustment to various levels of stressors, both in the hospital and the community; (7) provide a mechanism for timely crisis intervention for individual patients; (8) afford administrative and clinical staff a mechanism for peer review; (9) are cost effective compared with external review boards; (10) provide data and a tracking mechanism for quality improvement for the forensic system of care; and (11) provide an education/training function for direct care and professional staff.

References

1. Scott DC, Zonana HV, Getz MA: Monitoring insanity acquittees: Connecticut's psychiatric security review board. *Hosp Community Psychiatry*. 41:980-4, 1990
2. Bloom JD, Williams MH, Rogers JL, Barbur P: Evaluation and treatment of insanity acquittees in the community. *Bull Am Acad Psychiatry Law* 14:231-44, 1986