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The Treating Psychiatrist as Forensic Evaluator in Release Decisions

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ABSTRACT: In a previous paper, the author argued that clinicians who perform initial forensic evaluations might be better able to assume subsequent treating relationships with those they have evaluated than independent evaluators. In this paper, the author discusses the problems involved when clinicians who have established treatment relations with patients are then called upon to testify in release hearings. He concludes that the conflicts potentially are more significant in this situation, and that treating clinicians should not evaluate their patients for release.

KEYWORDS: psychiatry, jurisprudence, mental illness

I have discussed previously the situation in which psychiatrists evaluate defendants for the courts and subsequently treat those same patients [*1,2*]. I have argued that in some cases there might be advantages to this arrangement compared to evaluations by independent psychiatrists, because psychiatrists who treat the same patients that they evaluate have the benefit of continued observation to monitor the accuracy of their opinions, and because those treating psychiatrists have the opportunity to develop expertise with certain conditions which are uncommon in nonforensic practice.

In this paper, I will discuss the converse situation in which psychiatrists who have already established a treating relationship with forensic patients are called to testify in release hearings for those patients. I will use my experience in Wisconsin for illustrative purposes; although the specific situations may vary from one jurisdiction to another, the arguments apply across the country.

Wisconsin has four categories of involuntarily committed mental patients: those committed under civil procedures, those found incompetent to stand trial, those found not guilty by reason of mental disease or defect (insanity acquittees), and sex offenders committed under the Sex Crimes Law which was repealed in 1980. In civil commitment, treating physicians may release patients at any time that they feel that the commitment criteria are no longer met [*3*]. In most cases, patient and psychiatrist are in agreement in such releases, although there are patients whose goals are not to regain sufficient control to be able to leave the hospital, but rather to live in a protected environment [*4*]. When hospital staff feel that continued commitment is clinically indicated and a patient disagrees, however, Wisconsin statutes mandate the appointment of a clinician independent of the treating facility to evalu-

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ate the patient for the court [5]. The treating clinicians frequently testify at the probable cause hearing held within 72 h of an emergency admission, but are rarely involved in the subsequent court commitment hearing.

Defendants admitted to public facilities for evaluation and treatment to restore competency to stand trial are frequently evaluated by the same clinicians who treat them [6]. The evaluation here is not to determine whether a patient is clinically ready for release, but rather whether a defendant has regained competency. It is not uncommon for defendants to be returned to court while still suffering from significant mental disorders, if they are capable of satisfying the specific criteria for competency. And since most defendants admitted for competency evaluation desire to be found competent, the frequency of conflicts is lower than in other types of release evaluations. In addition, the majority of defendants committed for evaluation for competency to stand trial have brief admissions as compared to insanity acquittees or sex offenders (the initial evaluation period is 15 days in Wisconsin), and there is typically little time to develop the type of therapeutic alliance which might be disrupted by subsequent testimony.

Release Evaluations

The major conflicts between the treating and evaluating roles arise in the cases of patients committed for treatment after being found not guilty by reason of mental disease or having been convicted of sexual assault under the former Sex Crimes Law. In both cases, patients have the right to petition for release before the mandatory release date of their commitments. The sole criterion in both cases is whether the patient would be dangerous if released. In the case of insanity acquittees, the statutes provide for the appointment of independent psychiatrists at county expense to perform the evaluations, but do not specifically prohibit the court or attorneys from subpoenaing the treating psychiatrist to testify as well [7]. And although sex offenders are permitted to engage independent clinicians to evaluate them prior to release hearings before the independent Special Review Board [8] or the departmental hearing examiner [9], the state is under no obligation to provide indigent petitioners with evaluations at public expense, as the counties are for civilly committed patients or for insanity acquittees.

Nevertheless, treating clinicians frequently are called to testify at both types of release hearings, often on short notice, and without any time to prepare patients to deal with the significant change in the treatment relationship.

Case 1

Mr. A had been found not guilty by reason of insanity of resisting an officer. He had been on parole for a conviction for drug charges, but had violated several conditions of that parole. When his parole officer tracked him down in the community, Mr. A had attacked him, resulting in revocation of his parole and prosecution for the assault. He was admitted to the assessment unit of our forensic facility, and immediately began to demand to be released. He was diagnosed as suffering from Bipolar Affective Disorder, Manic Type, but refused to accept the diagnosis or to take medication voluntarily. He began to demand his release immediately after admission, and petitioned the court for a release hearing at his first opportunity. The treating psychiatrist was ordered by the court to perform the evaluation. When asked what he intended to do if he were released, Mr. A replied "He [his parole officer] won't be able to hurt me when he's dead." His affect during the interview and his history of violent behavior lent credence to this threat. Mr. A was told that the remark would have to be reported to the court. Mr. A's petition for conditional release was denied, and feedback from the presiding judge indicated that the reported threat was significant in his decision-making process. Mr. A became very upset after the hearing, and was disruptive and aggressive on the

unit for a period of several months. He refused to talk with his psychiatrist, and told other staff that he felt betrayed by the report from his treating psychiatrist. Even after he regained control over his behavior, his anger toward the psychiatrist persisted for over a year after the evaluation, and continued after he was transferred to another unit with a different psychiatrist. Even chance contact with the former psychiatrist would trigger anger which interfered with attempts by the treating clinicians to work effectively with him.

Case 2

Mr. B had been found (for the second time!) not guilty because of mental disease of first degree murder in the death of his partner in their illicit drug business. He was diagnosed as suffering from paranoid schizophrenia, but had demonstrated no evidence of psychosis in the six months since his transfer to our facility. While committed to a previous maximum security facility he had (by his own admission) continued to run a drug trade which grossed several thousand dollars a month. He was subsequently transferred to a medium security facility, but was transferred back to maximum security at our hospital after he again was suspected of dealing drugs. He stoutly denied these charges, and stated that he had given up dealing or taking drugs. There had been no evidence that he had been involved with drugs in the six months he had been in our facility.

After he had been committed for eleven years, he again petitioned the committing court for release. The court appointed two independent psychiatrists to evaluate him, but he also asked his attorney to subpoena me as his treating psychiatrist and the psychologist chief of the unit on which he was being treated. He wanted us to testify that he had neither shown any psychotic symptoms nor any behavior which indicated involvement with illicit drugs in the six months since his transfer to our facility. Since no such behavior had been observed up to that time, we agreed to his request.

The day before the scheduled hearing, I received an urgent telephone call from one of the clinical staff who had been coleading a drug/alcohol group on the unit. She stated that Mr. B had just admitted to the group that he still felt taking drugs had been a necessary coping device in the previous facility, and that although he continued to deny taking or dealing in drugs in our facility, he could not absolutely promise that he would not return to drugs after release. The therapist requested strongly that I transmit this information to the court at the hearing. I declined to do this, as I had not heard Mr. A make these statements. I advised her that if she felt that strongly she might talk to the district attorney who would be appearing at the hearing, which she did.

When Mr. B heard that his statement in the group would be disclosed to the court, he withdrew his petition for release. He subsequently dropped out of the therapy group (in which he had been appropriately active) because he said that he no longer felt able to talk about his feelings, knowing that anything he said might be reported to the court at a future release hearing. He was quite critical of what he perceived to be the hypocrisy involved in staff encouraging him to talk openly about his feelings in therapy, and then using his statements against him in release hearings.

Case 3

Mr. C had been found not guilty by reason of insanity in two different counties of three counts of exhibitionism, as a repeater. He was a college graduate, had paralegal training, and had been accepted to law school before his arrest. His psychiatric diagnoses were atypical paraphilia and narcissistic personality disorder. In addition to petitioning courts in both counties for release on a regular basis, he had filed a number of grievances and law suits challenging various conditions of his confinement, and had unsuccessfully sued the psychol-

ogist chief of his previous treatment unit over allegedly libelous statements she had made in a report made at his request to the Social Security Administration.

For his latest petition for release, he (acting as his own attorney) subpoenaed both his treating psychologist and the psychologist unit chief of his current unit to testify in addition to the court-appointed independent psychiatrist. Because he entered his petition before four months had elapsed since his last release hearing, the judge was not compelled to grant a hearing. The judge did decide to conduct a preliminary review of the petition by ordering the unit psychiatrist (who had not been directly involved in Mr. C's ongoing psychotherapy) to review his treatment and to write a report concerning his fitness for release.

All the evaluators who worked with Mr. C in the hospital concluded that he was not yet sufficiently in control of his exhibitionistic impulses to be released without significant risk of recidivism. Mr. C responded to these reports by threatening a malpractice suit against the psychiatrist for allegedly misrepresenting, with malice and negligence, the information in his treatment record. He also threatened various legal actions against both unit psychologists, although (to date) he has not acted on these threats.

Release Decision-Making

In addition to the indirect conflict involved in making recommendations to releasing authorities, there are also situations in which clinicians serve as the actual decision-makers in release hearings. Offenders who petition for release from commitment under Wisconsin's Sex Crimes Law are heard by the Special Review Board, which for a number of years has been composed of a psychiatrist, a law professor, and a member of the state Probation and Parole Board, none of whom are directly involved with the hospital [*10*]; and also by a hearing examiner (called the ".09 hearing" after the statute number) designated by the Department of Health and Social Services (DHSS), which is responsible for the supervision of offenders committed under the law [*11*]. Technically, examiners on both of these review boards make recommendations to the Secretary of DHSS; in practice, however, recommendations of the Special Review Board are virtually always accepted [*10*], whereas recommendations of the .09 examiner are scrutinized thoroughly, and release is seldom granted. One major reason for this situation is that the .09 examiner can recommend only continued commitment or outright release, whereas the Special Review Board can grant conditional release. The Department has been reluctant to grant unconditional release to offenders unless they have concurrent longer prison terms so that if released from their Sex Crimes commitment they would be transferred to prison.

Case 4

Mr. D was a 25-year-old man who had been convicted of first degree sexual assault against a 14-year-old girl, and committed under the Sex Crimes Law. He had escaped from his commitment at a previous hospital, and had remained at liberty for over 3 years. He had a full-time job, lived with his sister, and had not gotten into any legal difficulties. He was recognized accidently by the police when they were investigating a disturbance of the peace call, and returned to the hospital. At his .09 hearing a year later, the unit social worker reported that Mr. D was actively involved in therapy, that he was making significant progress in controlling his aggressive impulses, and that there was no evidence that he was dangerous. Based on this information, the examiner (a psychiatrist) recommended release; but the Department rejected that recommendation and requested another opinion from the chief of the patient's unit. She stated that psychological testing still revealed potential problems, and that Mr. D was not yet ready for release. The original examiner was reprimanded for even making the recommendation for release.

Discussion

Halleck and Pacht [*12*], who have been directly involved with the treatment as well as the release of sex offenders in Wisconsin, pointed out in 1960 that clinicians can be expected to experience some pressure to recommend or grant release, since "none of us wish to be exposed to the constant resentfulness, barbs, and accusations of injustice which the imprisoned man is only too ready to hurl against us if his parole is refused." (Twenty-six years later, they might have added lawsuits to the list.) They point out that recommending release is gratifying for a therapist, whereas turning him down is painful and unrewarding. Discussing the Special Review Board procedures, they state that they attempt to control the tendency of clinicians to "go to bat" for offenders by not allowing them to make specific recommendations to the Board, but rather only to make detailed progress reports.

However, in practice, it is impossible to prepare a "detailed report" without in fact indicating one's opinion about whether or not a patient is ready for release. And whether or not a treating clinician directly informs the patient about the contents of the report, the patient will learn of its contents sooner or later. Since revealing information obtained in the course of a clinical interview without the patient's consent would otherwise violate his confidentiality, a number of authors have argued that clinicians who evaluate patients for legal purposes are obligated to inform the patient in advance (as far as they are themselves aware) of the goals of the interview(s) and the disposition of the opinions derived from them [*13–15*]. Professional ethical guidelines [*16,17*] and recent court opinions [*18*] reinforce this ethical principle that full disclosure of the purpose of interviews done for legal purposes may be required.

Roberts and Pacht [*14*] acknowledge the dilemma. They admit that the probability that patients' revelations in therapy will be repeated in court will reduce the freedom of that therapy; but they argue that there is little overt evidence that this issue substantially hinders introspective evaluation. There is some indirect support for this view in the preliminary data which have come out of studies of the impact of the *Tarasoff* decision [*19*]. The predicted disasters from requiring therapists to take action if their patients appeared to pose threats to third parties apparently have not occurred [*20*]; and discussing a course of action with a patient when the therapist believes that the patient might be dangerous can actually be therapeutic [*21*].

There are also data which demonstrate that warnings that information given to clinicians in a legal context might be revealed in subsequent hearings have little impact on patients' willingness to talk with clinicians [*22,23*]. Gutheil and Appelbaum [*15*] even argue that in some cases the warning itself may be so reassuring to patients that it might actually *increase* their willingness to talk openly with clinicians, even against the patients' interests in being released. On the other hand, it is also clear that when treating clinicians report conclusions with which patients, especially forensic patients, take exception, it can lead to continued difficulties in any treatment relationship on the unit.

It is understandable that courts and hearing boards want to utilize the firsthand knowledge of treating clinicians in making their decisions, and inevitable that they will continue to do so unless prohibited by statute. Although the attempt to coerce testimony has been overturned occasionally [*24*], in the majority of cases the clinician is forced to testify under penalty of contempt [*25*]. Not only are treating clinicians more familiar with their patients' behavior than an independent examiner could be, but perhaps more important, those who work in forensic facilities are also more familiar with the needs of the legal system, and more experienced in making predictions of future behavior, since they have far more chances to observe the accuracy of their opinions [*26*].

The potential conflicts are fewer in the cases of patients who are committed under explicit legal criteria, with expectations that future reports will be made to legal decision-makers. In those cases, at least both patient and therapist should know at the outset that their contacts probably will not remain completely confidential. Although this may affect the willingness of

the patient to share information in some cases, it is clearly preferable to situations in which clinicians are "ambushed" with subpoenas to testify about patients without any prior warning that such testimony will be necessary.

Most of the discussions surrounding the impact of clinicians' testimony have dealt with patients involved in insight-oriented psychotherapy. Since the majority of forensic patients involved in the criminal justice system suffer from disorders for which the major treatment modality is psychotropic medication [*27*], it is possible that the disruption in trust which may attend the sending of an adverse report may be less significant with the general population of forensic patients than with voluntary outpatients.

If treating clinicians are to be required by courts or other decision-making bodies to furnish expert testimony at release hearings, there should be additional protections built into the system to prevent or minimize the types of problems discussed above. Best would be statutory requirements that reports and testimony at release hearings come from clinicians independent of the treating facility appointed by the court, as is the case with civilly committed patients in Wisconsin [*5*]. If the legislature is unwilling to prohibit all testimony from the treating facility, then a possible compromise would be to require that the testimony from facility clinicians come from those who are not involved in a direct treatment relationship with the patient in question. The simplest way to accomplish this goal would be for the statutes to permit judges to request evaluations from the state department which supervises the facility, rather than from specific clinicians. The department could then develop administrative rules to create an evaluation procedure which prevented treating clinicians from being called to testify. This model has been used effectively with review of the right to refuse treatment in several states.

If such prohibitions cannot be accomplished, there are still steps the clinician and the treating facility can take to minimize the problems. One possibility would be to establish an institutional ethics board, similar to those created to monitor procedures such as research, organ transplants, and resuscitation. Such a board could review requests for release evaluations of patients at its facility, and advise the court as to the ethical problems posed by particular requests. Another method which can be used in situations in which the treating psychiatrist is asked by the defense attorney to evaluate a patient for release whom the psychiatrist is actively treating, and where the psychiatrist feels that the patient is not ready for release by the criteria for that jurisdiction, is to contact the attorney and advise him/her that the testimony will be unfavorable to the client's wishes. In such circumstances, attorneys frequently decide to withdraw subpoenas for the reports or testimony.

If none of these methods is effective in preventing a psychiatrist from being placed in an adversary position vis a vis a patient, then the psychiatrist in most cases should make the best of the situation by discussing his/her testimony with the patient before the hearing along the lines suggested by Wulsin et al. [*21*]. Since patients will ultimately learn of the psychiatrist's recommendation anyway, surely it is better in most cases that they hear it from the psychiatrist directly, when there is time for the psychiatrist to explain the reasoning behind the opinion, than to have it come as a surprise in court. The latter situation is far more likely to have lasting adverse effects on the treatment alliance.

In situations in which clinicians serve as examiners rather than as expert witnesses, it should be inviolable that they should have no treatment relationship with those at whose hearings they preside, and no clinical affiliation with the institution which is responsible for the treatment of the patients they evaluate. And clinicians should not be required to participate in hearings whose outcomes are predetermined, since this places political constraints on what are supposed to be professional judgments, and quite probably violates professional ethical codes. Although such political judgments are made on a routine basis in a variety of situations (the release decisions on insanity acquittees are usually made at least in part on political/social grounds rather than on the basis of the acquittee's actual present behavior),

they should be made by representatives of society, such as judges, who are chosen to make such social judgments, and whose professional ethics are consistent with such decisions.

If clinicians are to serve as hearing officers and therefore to use their clinical expertise for social purposes, then this should be explicit, and they should have no clinical relationship with the patients they review or with the facility which provides the treatment. And if they are serving by virtue of their profession, there should be no restrictions placed on the recommendations they may make within the statutory possibilities. If the final decision-making authority chooses to disregard the recommendations for political reasons, that is one thing; but if the examiners themselves are told what decisions they must render, the process becomes untenable. The result is that not only are clinicians told what professional judgments to make, but by their presence they automatically lend a false credibility to a predetermined process.

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