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AFTER THE VERDICT: DISPOSITIONAL DECISIONS REGARDING CRIMINAL DEFENDANTS ACQUITTED BY REASON OF INSANITY

Samuel Jan Brakel*

INTRODUCTION

The insanity defense has been a topic of much controversy since its conception and earliest application.1 Periodically the controversy has been intensified when the defense is invoked in notorious criminal cases. At such times, long standing academic doubts about the defense, both conceptual and practical, are brought into public focus. John Hinckley's case is the most recent such instance of national note.2 The product of these periodic

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1. There is a bit of a revisionist trend in recent writings on the subject that, while continuing to acknowledge the philosophic and symbolic importance of the insanity defense in the scheme of criminal justice, goes to some lengths to downplay its practical significance by citing the small number of defendants who raise the defense and the even smaller percentage who succeed with it. See, e.g., Steadman, Monahan, Hartstone, Davis & Robbins, Mentally Disordered Offenders: A National Survey of Patients and Facilities, 6 LAW & HUM. BEHAV. 31, 33 (1982) (estimating that in 1978 some 1,625 defendants were placed in mental institutions because they had been found not guilty by reason of insanity and contrasting this figure with the 6,420 defendants institutionalized because of their incompetency to stand trial).


Following the Hinckley decision, 27 bills were introduced in the United States Congress to abolish the insanity defense or to change it, and numerous state legislatures changed or considered changing their laws, The Subcommittee on Criminal Law of the Senate Judiciary Committee held hearings two days after the verdict. Limiting the Insanity Defense: Hearings on S. 818, S. 1106, S. 1558, S. 1995, S. 2572, S. 2658, & S. 2669 Before the Subcomm. on Criminal Law of the Senate Comm. on the Judiciary, 97th Cong., 2d Sess. (1982). Legislatures in Alabama, Alaska, Delaware, Georgia, and Pennsylvania, among others, introduced bills to change the insanity defense or to adopt a guilty but mentally ill verdict.

Id.
raisings of the public consciousness is often more heat than light. Large amounts of intellectual energy get spent dragging not-so-new ideas over yet older ground. Some of that energy goes toward rekindling the idle hope that a foolproof test can be found that will separate once and for all the culpable bad from the exculpable mad. New definitions of insanity and elaborations on its requisite effects on the mental capacity of the offender at the time of the crime are proposed. Other efforts focus on the interstitial matter of rearranging the various procedural rights and burdens affected when the defense is asserted. Yet other reformist eggs are placed in the intellectual basket of alternatives to the insanity verdict option, though neither recent nor more distant experience holds out much promise that these new options (some being just old ones newly dyed) will make "the difference." Finally, a host of new voices is added to the chorus that for generations has been calling, with varying resonance, for total abolition of the defense, notwithstanding the fact that both historical reality and logic indicate that abolishing the defense would fail to dispose of the essential state-of-mind conundrum in criminal cases.

In the midst of the various ups and downs of public awareness and intellectual mood surrounding the insanity defense, a central question endures, the resolution of which is particularly resistant to the legal tinkering that accompanies these ephemeral states: what should the state do with persons who succeed in "getting off" by way of the defense, or its alter-

3. If there is any consensus at all among the leading thinkers on the subject, it is that such a foolproof test is out of reach. Continual disagreement and changing alignments on any of the presently operating tests of insanity underscore this basic fact of legal life. Large questions persist about whether the different formulations even have an affect on the ultimate court or jury decisions. See, e.g., R. Simon, The Jury and the Defense of Insanity (1967).

4. See J. Brakel, J. Parry & B. Weiner, supra note 2, at 719-25 for a detailed discussion of procedural issues surrounding the insanity defense and recent recommendations for change.

5. For example, the insanity plea was recently eliminated as an affirmative defense in Idaho, Montana, and Utah. Idaho Code § 18-207 (Supp. 1986); Mont. Code Ann. § 46-14-201 (1985); Utah Code Ann. § 76-2-305 (Supp. 1987). Expert testimony regarding the defendant's mental state remains admissible on the issue of criminal intent in these jurisdictions. Id. This leaves these jurisdictions with a scheme that is not unlike the "diminished capacity" defense, which has been tried as an alternative doctrine conjointly with traditional insanity in several jurisdictions, but without evidence that it yielded the desired results. The short history of the new Guilty-But-Mentally-Ill (GBMI) verdict option, which today is available along with the traditional Not-Guilty-By-Reason-of-Insanity (NGRI) verdict in twelve states, is no more promising. Analyses of the evidence so far suggest that the GBMI alternative apparently selects a group of offenders who previously would have been convicted, but that: (1) the treatment of this group is not much different or better than that accorded to convicted offenders; and (2) there is little, if any, effect on the numbers of offenders who plead insanity or on their subsequent disposition. See J. Brakel, J. Parry & B. Weiner, supra note 2, at 714-16 (citations to empirical studies); McGraw, Farthing-Capowich & Keilitz, The "Guilty But Mentally Ill" Plea and Verdict: Current State of the Knowledge, 30 Vill. L. Rev. 117, 122 n.21 (1985).

6. See J. Brakel, J. Parry & B. Weiner, supra note 2, at 716-17. See also supra note
The point of this Article is to address the issues surrounding the post-verdict treatment of so-called “insanity acquittees:” where to place them; when, by what criteria, and on what conditions to discharge them; and whether and how to monitor their behavior after discharge. Each state has statutory law on this issue, although some states have far more elaborate and more up-to-date laws than other states. There are also a number of model statutes on the subject, promulgated by agencies oriented toward interstate legal reform and uniformity. There is a growing amount of case law covering the main issues and various subissues, including opinions that address the problem in terms of its constitutional dimensions. Finally, a few jurisdictions have well established, visible programs designed to implement laws controlling the post-verdict handling of insanity acquittees. This Article examines the statutes, cases, programs, and scattered analyses of the programs’ results. There will be particular emphasis on laws that represent the latest trend in this area. The empirical evidence available to date also will be analyzed, especially for what that evidence can or cannot tell about the practical effectiveness of these modern statutory solutions. This Article represents a necessary first step toward deciding whether, and how, to conduct further studies on dispositional alternatives for insanity acquittees.

I. The Statutory Schemes

The law governing the post-verdict treatment of insanity acquittees springs from two basic concerns—one concern derives from legal principle, the other is rooted more in human reality—which are to some degree in tension if not in direct conflict with one another. One side recognizes that legally, the defendant has been found sick rather than guilty and hence needs, or is entitled to, treatment rather than punishment. Punishment in this sense includes either outright penal incarceration or indeterminate and possibly life long commitment to the locked wards of a hospital for the criminally insane or some other euphemistically labeled institution where little or no mental treatment is offered. The other side recognizes the reality of the criminal action, which is that the criminal charge against the defendant and the natural presumption of dangerousness that flows from that charge produces understandable uneasiness about dispositional decisions where amenability to treatment is the only consideration and quick discharge, with scarce attention to general societal interests, is a possible consequence. The temper

7. Steadman, in a recent article, Insanity Defense Research and Treatment of Insanity Acquittees, 3 Behav. Sci. & Law 37 (1985), has labeled legal change in the post-verdict handling of insanity acquittees “disposition” or “back-end” reform, to distinguish it from “adjudicative” reform made at the “front end” of the insanity defense process. Some states have attempted what he calls “combination” reform, a term that should need no further explanation.

8. This is the agenda that underlies the writing of this Article. The funding provided for it by the agencies listed in the headnote was specifically designated to support preliminary research that would lay the groundwork for further study on the model dispositional programs.
of recent times is to put the stress on human reality and on protecting society. This emphasis results in diminished concern over whether or not persons acquitted by reason of insanity, who are after all only technically innocent as the common citizen would see it, wind up confined without appropriate treatment or for a longer time than necessary.

The modern statutes reflect these twin concerns. In preparation for the statutory analysis, my research assistants and I constructed a chart tabulating the relevant provisions of each of the fifty states and the District of Columbia, plus those of two model acts, one sponsored by the American Bar Association (ABA Standards), the other by the National Conference of Commissioners on Uniform State Laws. The fact that the chart in its final form comprised 105 columns attests to the level of detail of some of the state statutory schemes on the post-verdict treatment of insanity acquittees. For most states, however, there were entries for fewer than half of the columns. Both the length of the chart and its numerous empty spaces preclude its presentation here. The act of putting it together, however, was a profitable analytic exercise that helped a great deal in writing this Article.

A. Dispositional Provisions—General Alternatives

The laws dealing with insanity acquittees are, for purposes of discussion, most usefully divided into two major sections: those provisions having to do with the disposition of the acquittee; and those governing release, prototypically after a period of commitment as opposed to immediately following the verdict. We start with the former.

By law and logic, a defendant acquitted by reason of insanity has not been found guilty and can in theory go free. As recently as ten to fifteen years ago, however, the vast majority of states had statutes providing for mandatory, or automatic, commitment to a hospital facility for any such acquittee. This mandatory commitment precluded applying the legal logic of immediate release. Recent reform efforts have resulted in the repeal of these automatic commitment provisions in most states and they survive in only some jurisdictions, leaving the present law in what might be viewed as having a more permissive or progressive bent than previously. It is important to understand the focus of recent statutory reform efforts and how they have impacted the treatment of insanity acquittees.

9. The American Bar Association's CRIMINAL JUSTICE MENTAL HEALTH STANDARDS (ABA Standing Committee on Association Standards for Criminal Justice, August, 1984 Draft) [hereinafter ABA STANDARDS], whose provisions relevant to the topic of this Article are discussed at various points in the text, are a good reflection of this temper. They are in several respects more prosecution oriented than one would have expected in an earlier, more permissive era from such a "progressive" undertaking, which this and other standard-setting efforts invariably aspire to be.


11. Statutes providing for automatic commitment of acquittees: COLO. REV. STAT. § 16-8-105(4) (1986); CONN. GEN. STAT. ANN. § 17-257c(a) (West Supp. 1987); D.C. CODE ANN. § 24-301(d)(1) (1981); KAN. STAT. ANN. § 22-3428(1) (Supp. 1986); LA. CODE CRIM. PROC. ANN. art. 654 (West Supp. 1987) (if acquitted in a capital case); ME. REV. STAT. ANN. tit. 15, § 103
as a state of higher theoretical purity. That of course, does not mean that
the present law really contemplates, much less demands, the immediate and
automatic release of all persons acquitted of crime by reason of insanity.
The modern disposition laws merely put the enduring societal safety concern
into a different perspective. The currently prevailing statutes, while abjuring
automatic confinement, provide for the acquittee's commitment on one or
two specifically enumerated grounds that are quite readily, if not automati-
cally, provable.

Where automatic commitment following an insanity acquittal is not the
law, the same end can, as indicated above, be accomplished through one or
more of three alternate statutory routes. Under one scheme, the criminal
court can, based on relevant facts developed at the criminal trial, make a
separate decision to commit the acquittee immediately after the verdict. By
the second route, which is favored today in an increasing number of states,
the criminal court can hold a special hearing to consider evidence, often
developed during a special evaluation period or via a special evaluation
procedure, specifically on the point of the acquittee's present committability.
The third alternative is to commit the acquittee via regular civil proceedings,
conducted not by the criminal trial court but by a civil court that normally
handles these matters, such as the probate court, where the acquittee occupies
a legal position identical to that of any other person proposed for insti-
tutionalization. In general, these commitment options for insanity acquittees
are not mutually exclusive since two or even all three routes are available in
a number of states.\footnote{12}
The relationship among the various nonautomatic commitment options is sometimes explicit in the statutes, but more often the relationship is a matter of inference. In states where the criminal trial court is empowered to commit the acquitted forthwith, the authority is typically discretionary, to be exercised if the court or jury finds that the trial proceedings uncovered grounds sufficient to support this disposition, such as continued mental illness and/or dangerousness, and that the development of further evidence is unnecessary. At least two states permit this type of immediate commitment only if the acquitted does not contest, a proviso that may be implicit in the other statutes as well. Given the somewhat perfunctory nature of the procedure, commitment under this statutory scheme should be limited to comparatively short periods, such as a maximum of thirty days, with longer confinements preferably predicated on more elaborate and specifically focused inquiries.

Such pointed inquiries into the need to commit the acquitted are the essence of the special hearing procedures, which is the increasingly favored route whereby the states' criminal trial courts may render the dispositional decision. In the ABA Standards, the special procedure is reserved for felons who are both mentally ill and dangerous, while the fate of misdemeanants and defendants "acquitted of felonies which did not involve acts causing, threatening, or creating a substantial risk of death or serious bodily harm" can be decided only via regular civil commitment proceedings. With an isolated exception or two, such distinctions are not duplicated in the state statutes, which typically apply to all insanity acquittedees, undifferentiated by type of crime. The conceptual heart of the special hearing statutes is that more evidence on the acquitted's present committability needs to be developed and considered, because the court itself, the prosecution, or the defendant believes that the available information is insufficient for, or contradictory

15. ABA Standards, supra note 9, § 7-7.3(b).
16. See supra note 12. See, e.g., Washington (felony/misdemeanor distinction); Texas (dangerousness of acquitted); New York (dangerousness of acquitted).

to, a decision to commit. This concept is expressed in a variety of ways: the statutes may speak directly to the court’s discretion to determine the desirability of hearing further evidence, sometimes phrasing the issue in terms of the court’s having “probable cause” to believe that the acquittee needs to be committed; the statutes may frame the issue in terms of determining who has the authority to move or to petition for the special evaluation and hearing; or the statutes may focus on whether or not the acquittee contests or denies any need for commitment. Alaska’s statute takes the unique position that a special hearing is required if the acquittee, when raising the insanity defense, simultaneously denies being dangerous due to mental illness.

The third dispositional alternative, committing insanity acquittees in a civil proceeding, is in a final sense always available. The law does not say that insanity acquittees or any other group of persons shall not be civilly committed. The historic quasi-criminal treatment of insanity acquittees via dispositional decisions made by the criminal court committing the acquittee to institutions for the criminally insane suggests, however, that today’s statutes that specifically authorize civil commitment of this population are a necessary redundancy. Nebraska’s statute may be viewed as prototypical, if not of today’s law, then of its likely form in the years ahead. In that state, the director of a state hospital may initiate civil commitment proceedings following the initial ninety day commitment ordered by the criminal trial court.

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20. See, e.g., Mass. Gen. Laws Ann. ch. 123, § 16(b) (West 1987) (prosecutor or mental health official); Hawaii and Oregon, supra note 13 and Utah, infra note 21, allow the prosecutor to so move.


In Indiana, regular civil commitment is an alternative to temporary commitment by the criminal court. Implicit in most statutes is the requirement that the proceedings are to be conducted by a civil court, which may include the probate court, a special mental health court, or as in Mississippi, the chancery court. As mentioned, some jurisdictions, as well as the ABA Standards, make civil commitment available only to misdemeanants or non-dangerous felony acquittees. Most states, however, do not restrict the reach of the statutes along these lines. Two states in particular, Kentucky and North Carolina, provide that civil commitment should be the only route by which a court can commit insanity acquittees, although the Kentucky statute authorizes the criminal courts to order special short term detention (ten days) in order to provide time to initiate the civil commitment proceedings. If the acquittee is a proper candidate for civil commitment, he is presumably to be confined in a civil hospital, although most laws are not explicit here. The acquittee shares the rights accorded to all civil patients. The newer law on the post-verdict treatment of insanity acquittees—the special standards, rights and restrictions attendant to their commitment, institutional treatment, and release—comes into play primarily for acquittees committed by the criminal court. Because the trend is toward increasing numbers of these special commitments, the remainder of this Article concentrates on the provisions that comprise this new procedure.

B. Details of the Special Disposition Statutes

The new law on the commitment of insanity acquittees specifically addresses the following issues: (1) who initiates the commitment procedure; (2) the nature of the psychological evaluation for determining what to do with the acquittee; (3) the specific criteria for determining committability; (4) the proof required and other evidentiary rules to be applied at the hearing; (5) the need for legal representation; (6) the range of facilities appropriate for placement of the acquittee and the principles to be used in choosing the facility; (7) the duration of commitment; (8) periodic reviews of the acquittee's condition in order to determine the need for continued confinement; (9) the authority to grant "leaves" from the institution of confinement; and (10) notification requirements.

1. Responsibility for initiating the special procedures

Referred to in passing in the discussion of the concept underlying the special commitment procedures, the issue of who moves or petitions for

27. See supra notes 15 & 16.
special commitment deserves some elaboration. In a majority of the states that are explicit on the point, it is the criminal trial court that initiates the special evaluation and hearing process. The reason presumably is that the court, having presided as neutral arbiter over the trial that delved at length into the defendant's mental condition (at the time of the crime, technically, but with hard-to-resist implications for present mental state), is in the best position to determine whether or not more and better evidence is needed for the dispositional decision. Some statutes require, rather formalistically, that the court have probable cause to initiate the special inquiry. Some states also authorize the defense or the prosecution to petition for the special evaluation and hearing, presuming that the assertion of adversarial perspectives will provide additional assurance that the use of the special process will be made in appropriate cases. Massachusetts gives authority to apply for a hearing not only to prosecutors, but also to officials of the department of mental health, in deference to the propriety of medical judgment on this issue.

2. The nature of the evaluation procedure

One primary purpose of the special commitment statutes is to assure a thorough evaluation of the acquittee's mental condition, in order that the dispositional decision be a thoroughly informed one. Statutory provisions that speak to the qualifications of the examiners and the time allowed for completing the evaluation effect this purpose. With the exception of Montana, which designates the probation officer as the person to do the investigation into the acquittee's current mental condition, the states that have provisions on this issue require an evaluation by mental health professionals. The language of the California statute is just that general. Other statutes are more specific, usually requiring at least one of the evaluators be a psychiatrist or a clinical psychologist. Rhode Island designates the director of the state department of mental health as the person to give an opinion on the acquittee's mental condition. Utah's statute appears to require examiners qualified in forensic mental health. In Indiana, the physicians

30. See supra note 18.
31. See supra note 19.
32. See supra notes 20 & 21.
or psychologists who testified at the criminal trial, and any other persons with knowledge of the commitment issues, must provide the testimony at the hearing on the acquittee's present mental state. 39 In Michigan, the trial court commits insanity acquittedes, for a period not to exceed sixty days, to the state's special Center for Forensic Psychiatry, which conducts evaluations of all criminal defendants about whom a question of mental condition arises. Examinations of the acquittedes, to determine their fitness for commitment by civil commitment standards, are done by two physicians of this Center, one of whom must be a psychiatrist. 40 The statutory time allowed for the evaluation, where it is specified, is of significant length, suggesting a process akin to observational hospitalization in civil cases. The range is generally from 15 to 120 days. 41 States in the middle range, such as New York, which allows thirty days, provide for a possible time extension of another period of identical length. 42

As exemplified by the ABA Standards, the progressive model requires the evaluation be performed in accordance with the "least restrictive alternative" principle, 43 meaning either on an inpatient or outpatient basis, as determined by the condition of the acquittedee and the availability of evaluation resources. Not many state statutes have as yet picked up on this example, at least not with the specificity of the ABA Standards. 44 The statutory language of a good number of states, however, that designate the state hospital or any appropriate facility as the evaluation site, could conceivably be stretched to permit outpatient examinations.

3. Criteria for commitment

Commitment of insanity acquittedees, as for any person of ordinary civil status, is legally authorized only if certain specifically enumerated conditions are proved at the commitment proceedings. The special acquittedee commitment criteria are not radically different from the civil standards, but there are a few wrinkles that reflect special legislative concerns with this particular population and the threat that they may pose to society's safety. To be a proper subject for commitment in the majority of states, the insanity ac-

43. ABA Standards, supra note 9, § 7-7.2(b).
quittee must be both mentally impaired and dangerous.45 “Dangerous to self or others,” or some close paraphrase of this, is the most common formulation of the latter criterion. In Illinois, the statute defines dangerousness to self as the inability to provide for basic needs so as to guard against physical harm to oneself.46 A number of states premise commitment on the criterion of danger to others only, perhaps because the danger to self standard is deemed appropriate exclusively in civil cases.47 At least five states, however, explicitly base the commitment of insanity acquittees on the same criteria that determine civil commitment.48 In a small number of states, such as Ohio, proof of the acquittee's mental impairment alone, without reference to dangerousness, is sufficient to authorize commitment.49 The ABA Standards require the court to find, beyond a reasonable doubt, that the acquittee committed the crime before commitment can be ordered.50 So far, however, the states have not followed this lead. Hawaii and Wyoming frame the issue negatively, providing that in order to qualify for commitment, the acquittee must not be a proper subject for supervised or unsupervised release.51 The Oregon statute explicitly instructs the court to have the protection of society as its primary concern in making the decision to commit or release.52


48. Statutes with the same requirements for commitment of acquittees as for civil commitment: GA. CODE ANN. § 27-1503(e) (Harrison Supp. 1986); MASS. GEN. LAWS ANN. ch. 123, § 16(b) (West 1987); MICH. COMP. LAWS ANN. § 330.2050(2) (West 1980); NEB. REV. STAT. § 29-3702 (1985); TEX. CRIM. PROC. CODE ANN. §§ 46.03(4)(a), (d)(2) (Vernon Supp. 1987); VT. STAT. ANN. tit. 13, § 4822(a) (Supp. 1986).


50. ABA STANDARDS, supra note 9, § 7-7.4(c).


4. Proving the case

Some of the special commitment statutes for acquittees include special provisions on the issue of proof, such as what the specific standard is, which party has the burden, and whether in presenting the case the evidentiary rules of ordinary trials apply.

The preponderance of evidence standard, used to resolve issues in civil trials, prevails in most of the states where the legislature has addressed the question of what burden the state must meet in order to commit the acquittee. This is appropriate enough to the extent that the acquittee's commitment is viewed as a civil issue. The elusiveness of determinations involving the mental health of persons, be it their need for treatment, present or future dangerousness, likelihood of recovery, and so forth, also supports a standard of proof that is not too onerous. For these same reasons, the beyond a reasonable doubt standard of criminal proceedings would appear to be inappropriate. Four states take an intermediate position, providing for a clear and convincing standard of proof that falls somewhere between the traditional civil and criminal burdens. Following the United States Supreme Court's lead in Addington v. Texas, a civil commitment case, and the position espoused in the ABA provisions, this standard may be the model for future insanity acquittee statutes.

Few state statutes specify which party has the burden of persuasion in commitment proceedings. The norm in civil commitment cases is that the state has this burden. The acquittee statutes of four jurisdictions, as well as the ABA Standards, specifically endorse this position, and the logic of the law would seem to be that this also is true where it is not explicitly stated. Where the lawmakers feel that the legal or factual situation is sufficiently different to shift the burden of persuasion to the acquittee to prove to the court that he should not be committed, the legislature must expressly enact provisions authorizing this departure from the norm. This position has been

56. ABA Standards, supra note 9, § 7-7.4.  
adopted by at least three states.\textsuperscript{58} Given that automatic commitment without a special hearing is still authorized by statute in some jurisdictions and has recently been upheld by the United States Supreme Court,\textsuperscript{59} there would appear to be no constitutional obstacle to the middle-ground position of holding a hearing, but placing the burden of persuasion on the defendant acquittee.

The right to confront adverse witnesses is one of the essential aspects of a fair hearing. Some characteristics of commitment hearings, however, argue for making exceptions to this right: (1) the relevant medical evidence may be hard to obtain directly because much of it is contained in written patient records, and doctors and other mental health personnel, particularly those working in populous institutions, cannot be burdened with giving direct testimony on each point in every case; (2) commitment proceedings are ostensibly in the best interest of the proposed patient—they are not adversarial and there are no adverse witnesses. These arguments have been accepted by the courts in a number of jurisdictions and case law has carved out exceptions to the rules of evidence for the purpose of commitment hearings. The position favoring these exceptions is less secure, however, than it was a decade or two ago. Emphasizing the potential for serious deprivations of liberty, the recent trend is toward reasserting procedural protections for persons involved in commitment proceedings.\textsuperscript{60} The quasi-criminal nature of committing insanity acquittees may provide particular justification for reasserting procedural safeguards. In line with this reasoning, the ABA Standards\textsuperscript{61} expressly provide that the ordinary rules of evidence apply in insanity acquittee hearings. Only two states, New Mexico and Washington, duplicate this position, but others may follow.\textsuperscript{62}

In states with no statutory provisions on the subject, any exceptions to the rules of evidence in civil commitment proceedings presumably apply with equal force to dispositional hearings for insanity acquittees.

5. \textit{Legal representation}

That a proposed patient has a right to legal representation in civil commitment proceedings is today beyond question. If anything, this right is even more compelling in quasi-criminal proceedings to determine the disposition of insanity acquittees. The operative issues today are whether or not such


\textsuperscript{60} For a discussion of the trend and citation to the cases, see J. \textit{Brakel}, J. \textit{Parry} \& B. \textit{Weiner}, \textit{supra} note 2, at 67-68.

\textsuperscript{61} \textit{ABA Standards}, \textit{supra} note 9, § 7-7.5(d).

representation is mandatory, and whether or not the state is required to provide counsel in cases where the person cannot pay for it. The vast majority of jurisdictions have statutes mandating representation for civil cases and, logically, such a requirement is even more appropriate for insanity acquittees. It comes as no surprise that the ABA Standards and the special acquittee statutes in eight states explicitly provide for mandatory appointment of counsel. Even in states without specific provisions to this effect, the argument that a similar mandate exists as a logical extension of the civil commitment requirement appears virtually unimpeachable.

Several of the more interesting questions on the issue of legal representation remain largely untouched in both the special acquittee statutes and the regular civil commitment provisions, namely: (1) who should provide the representation; (2) what the compensation level should be; (3) when the appointment should be made; and (4) what the role of legal counsel should be in this setting. Legislative resolution of the first three issues would be helpful. The question of the lawyer’s role, however, is perhaps better left to evolving professional norms and customs.

6. Place of treatment

Provisions designating where the insanity acquittee is to be treated are an important feature of the special statutory schemes covering this population. In the large majority of states, the state facilities are singled out as the appropriate place for treatment. A number of states specify that it must be a secure facility. The preoccupation with security for the sake of public order is not only understandable, but it is also practicable in the vast majority of cases. However, the question arises whether the states should not explore and adopt a more humane approach, where possible, in providing for these individuals. It should be noted that there are a number of states that have adopted a more liberal approach to the placement of insanity acquittees. For example, in the state of California, the law provides that an insanity acquittee may be placed in a secure facility, a nonsecure facility, or a conditional release program. This approach allows for flexibility and allows the court to consider the specific needs of the individual.


safety is a traditional feature of the law. The modern trend reflected in these statutes is toward more selectivity, as in the Illinois statute for example, that requires confinement in a secure setting unless the court determines that there is compelling evidence that such placement is not necessary.\textsuperscript{66} In such cases, the possible alternatives include outpatient treatment, treatment in a community adjustment facility, or participation in a special drug, alcohol, or family therapy program.\textsuperscript{67} Six states, in addition to Illinois, explicitly provide for the outpatient treatment option in appropriate cases.\textsuperscript{68}

Placement decisions made in accordance with the principle of the least restrictive treatment alternative, a major development in the civil commitment law, are mandated in the insanity acquittee statutes of four states.\textsuperscript{69} In New Jersey, the principle is articulated in terms of transferring appropriate cases to a less restrictive setting, as distinct from its application in the initial placement decision.\textsuperscript{70} Presumably, the application of this principle could lead to outpatient treatment even where the statutes do not specifically allude to this option. The ABA Standards emphasize treatment under conditions comparable to those afforded persons whose fate is decided under general civil commitment statutes,\textsuperscript{71} a requirement that, given the shape of today's civil commitment laws, would in most states encompass outpatient and other treatment options that are least restrictive of liberty and take into account the acquittee's condition and needs. Finally, the insanity acquittee provisions of a few states exhibit unique features that are not found in the statutes of most states. The Texas law, for example, permits the court to place the acquittee in the care of a responsible private person pending disposition by the regular civil process.\textsuperscript{72} Delaware explicitly provides for the possibility of special treatment activities, including off-grounds employment, for insanity acquitees.\textsuperscript{73} New Jersey law prohibits confinement of insanity acquitees in penal facilities.\textsuperscript{74} At least three states, Arkansas, California, and Hawaii, explicitly provide for the possibility of out-of-state placement of insanity acquitees, on the theory, one supposes, that other states may have better,

\begin{itemize}
  \item \textsuperscript{66} ILL. REV. STAT. CH. 38, PARA. 1005-2-4(a) (1985).
  \item \textsuperscript{67} Id.
  \item \textsuperscript{69} Statutes mandating treatment in the least restrictive setting: HAW. REV. STAT. § 704-411(1)(a) (1985) (for misdemeanors and nonviolent felonies); NEB. REV. STAT. § 29-3701(4) (1985); N.J. STAT. ANN. § 2C:4-9(a) (West 1982); WASH. REV. CODE ANN. § 10.77.110 (Supp. 1987).
  \item \textsuperscript{70} N.J. STAT. ANN. § 2C:4-9(a) (West 1982).
  \item \textsuperscript{71} ABA STANDARDS, supra note 9, § 7-7.6.
  \item \textsuperscript{72} TEX. CRIM. PROC. CODE ANN. § 46.03(4)(a) (Vernon Supp. 1987) (if crime did not involve serious injury).
  \item \textsuperscript{73} DEL. CODE ANN. tit. 11, § 403(c)(1) (Supp. 1986).
  \item \textsuperscript{74} N.J. STAT. ANN. § 2C:4-8(c) (West 1982).
\end{itemize}
more specialized treatment programs for this special population.75

7. Duration of commitment/treatment

Traditionally, both the law and practice have been that a person acquitted by reason of insanity is committed for an indeterminate period. In cases that involved serious crimes, or in cases where the acquittee’s mental condition was not responsive to available treatment, indeterminate commitment often meant commitment for life. At least eleven legislatures applying the constitutional principle of equal protection under the laws, however, have been moved in recent years to enact provisions that limit the duration of the acquittee’s confinement to no more than the maximum prison sentence the defendant could have received if convicted on the underlying charge.76 If, at the expiration of this period, the acquittee still needs to be confined or treated, the statutes generally provide for civil commitment proceedings to effect continued confinement. In a few states, there are special commitment extension procedures, such as in California, where the court may order an additional two years of confinement after a hearing initiated by the prosecutor’s petition.77 In Arkansas, an automatic recommitment hearing is required at the expiration of the acquittee’s maximum confinement term.78 The practical option of mandating outpatient treatment and monitoring after confinement is made explicit in statutes such as the one in Illinois which authorizes the court to grant a conditional release, the terms of which may remain in force for a period of five years.79

In six states, the traditional disposition of indeterminate commitment for insanity acquittees, recently upheld by the United States Supreme Court in Jones v. United States,80 remains on the books, at least technically.81 By


law, the commitment continues until the acquittee has recovered. However, modern judicial review procedures in those states, varying from mandatory reassessment of the patient's condition every six months to once every five years, have significantly altered the practical meaning of the indeterminate term. Periodic mandatory review guards against the acquittee's becoming lost in the institution's back wards and greatly decreases the likelihood of lifetime confinement. Administrative review requirements complement the judicial safeguards that the law has erected around the acquittee.

8. Administrative review procedures

In virtually all of the states, the state mental health agency or the particular institution where the acquittee is confined is responsible for implementing the administrative review safeguards. Often, the directors of these entities are designated as the responsible party. Oregon and Connecticut are among the few states that have special review bodies that appoint independent mental health professionals to monitor and review the acquittee's condition. The state of Washington designates a wide range of potential reviewers, such as qualified professionals, experts retained by the acquittee, the physician in charge of the acquittee's case, or the probation officer, in cases where the acquittee has been conditionally released.

Administrative review generally must be conducted more often than judicial review, once every six months being the average frequency required.

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82. R.I. GEN. LAWS § 40.1-5.3-4(f) (1984) (every six months); N.H. REV. STAT. ANN. § 651:11-a (1986) (five years).
Illinois and Iowa, the first review must take place thirty days after the acquittee’s commitment and every sixty days thereafter. Oregon’s special system, providing for supervision by its Psychiatric Security Review Board (PSRB), guarantees the most frequent reviews. “Any time” after the acquittee is committed, the hospital superintendent may apply for the acquittee’s release, if warranted, triggering a full hearing before the Board. The Board also conducts a hearing on any other application for the acquittee’s release. The Board may appoint a psychiatrist or licensed psychologist on its own initiative to review the acquittee’s condition at any time. The condition of an acquittee on conditional release must be reviewed and reported to the Board monthly and the Board must hold a full hearing for any acquittee who has been under its jurisdiction for five years, whether confined or on conditional release, in order to determine whether full release from its jurisdiction is appropriate.

Except in Oregon, where the PSRB has final decision making authority, and in Connecticut, which in 1985 adopted a modified version of the Oregon review board model, findings produced by the administrative review process in all states must be reported to the court. The court then, on its own motion, must decide what, if any, action to take. A number of states also require that the findings be presented to the prosecutor. Other states require that, in addition, the findings be presented to the defendant’s attorney. In these states, the adversaries in the case thus have the power to act on the basis of the review, supplementing the more neutral interest of the court in the matter. Finally, in two or three states where the central mental health agency itself does not conduct the review, that agency must receive the results.

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88. ILL. REV. STAT. ch. 38, para. 1005-2-4(b) (1985); IOWA R. CRIM. P. 21(8)(e) (codified at IOWA CODE ANN. § 813.2 (West Supp. 1987)).
90. CONN. GEN. STAT. ANN. § 17-257g (West Supp. 1987). By this provision, the results of the administrative review are reported to the PSRB. The PSRB in turn furnishes copies to the state’s attorney and counsel for the acquittee.
94. CAL. PENAL CODE § 1026(e) (West Supp. 1987) (County Mental Health Director); WASH. REV. CODE ANN. § 10.77.140 (1980).
9. Institutional leaves

Granting institutional leaves for mental patients has traditionally been an administrative decision. The decision is based, at least in theory, on a medical assessment of the individual's condition and the health benefits that flow from the leave. Typically, state statutes designate the hospital superintendent as the official responsible for the decision to authorize the leave. The essence of this scheme has been retained in the insanity acquittee statutes. Delaware and Maine are unique in that they empower the acquittee to petition for a leave. In Delaware, the acquittee's power supplements the hospital superintendent's authority to move for the patient's leave. In Maine, the initiative apparently resides in the acquittee exclusively, although the hospital retains some responsibility because the statute requires that the recommendation of the facility's psychiatrists accompany the petition.

The primary distinction between the special acquittee statutes and the civil commitment procedures is that with the special acquittee statutes the decision regarding patient leaves is not solely an administrative prerogative, but requires court approval. Such judicial endorsement is mandatory in all states that have laws on this subject, with the exception of Connecticut and Oregon, whose centralized review bodies are the ultimate and independent decision making authority. In Kansas, a judicial hearing on the issue is required if the prosecution requests it. The underlying rationale for requiring judicial approval is the presumption that the acquittee population poses special risks to the public safety that are not adequately met by leaving decisions regarding this population's eventual release to medical judgment alone.

Provisions that specify the length and frequency of the leaves vary widely. New York's law contemplates authorized institutional absences of no more than fourteen days. The Delaware statute provides for six months, and Michigan's statute allows five year extensions. In Illinois, the court must

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re-evaluate the desirability of the acquittee’s leave every sixty days in order for the leave to continue.104 Other states authorize leaves “whenever it would advance treatment” or for any period deemed appropriate by the acquittee’s medical supervisors.105

10. Notification requirements

Notification requirements are among the central features of the special acquittee disposition statutes. Such laws almost invariably have provisions for notification. Public safety is the underlying rationale for these provisions. The perceived danger posed by this special population mandates wide disclosure of the acquittee’s situation or any changes in it. The requirements are diverse, varying significantly from state to state in terms of what changes in status require notification and to whom notice should be given.

Motivated by concern for public safety, most statutes require that the prosecutor’s office be given notice of changes that affect the acquittee.106 This is because the prosecutor’s office has the authority to take any required remedial action. A few states require notifying the Attorney General, which presumably achieves on a more centralized level the same purpose that notifying the local prosecutor does.107 Several states also require notifying the victim, presumably the specific target of any danger posed by the acquittee.108 Victim notification is part of a more general trend to involve, notify, and compensate crime victims in the process of doing criminal justice. Other states require notifying the committing court,109 the county sheriff,110 or as Michigan does, a unique evaluation and disposition body such as the Center for Forensic Psychiatry.111

The events that trigger notification also run the gamut. The more specific and comprehensive statutes require disclosure of the acquittee’s whereabouts, transfers, authorized temporary leaves of more than twenty-four hours,
unauthorized absences,\textsuperscript{112} the results of psychiatric evaluations, applications for furlough, and the state's petition for the acquittee's retention.\textsuperscript{113} Other states more generally mandate disclosure of any formal review of the acquittee's status, placement, or condition.\textsuperscript{114} The purpose behind disclosure is to enable the various interested parties to prepare for any change in the acquittee's situation. Some consider these provisions inappropriately punitive for a population not convicted under any criminal charge. Others hail the procedure as a proper acknowledgement of the "human realities."

C. Post-Commitment Release Provisions—General Characteristics

The release provisions of the special insanity acquittee statutes are unique in several important respects. First, the judiciary dominates the process. Whereas a dwindling number of states (about half) have judicial discharge procedures following civil commitment, with administrative discharge increasingly favored,\textsuperscript{115} the precise opposite is true of the insanity acquittee statutes. In the latter, judicial discharge is the primary route\textsuperscript{116} and the administrative discharge option, if it is available at all, is a secondary

procedure employed only if there is no contest on the issue. Only three states deviate from this pattern. In Connecticut and Oregon, discharge decisions are made by the PSRB, although in Connecticut the Board's decision is final only as to conditional releases, with full discharge requiring judicial approval of the Board's recommendation. In Michigan, the state's civil commitment laws govern the release of insanity acquittees, except that a special Forensic Center must evaluate the acquittee and approve decisions to discharge.

Another critical feature of the release provisions for insanity acquittees is the emphasis on the conditional discharge option, as distinct from regular, absolute discharge. Conditional discharge may include supervision, outpatient treatment, modification, and revocation provisions. The length and detail of these provisions is itself a major characteristic of the laws on the release of insanity acquittees.

D. Details of the Special Release Statutes

The law on the release of insanity acquittees in many important respects mirrors its counterpart on initial disposition. Among the areas addressed here are: (1) who initiates the release procedure; (2) when it can be invoked; (3) the nature of the hearing process; (4) the specific criteria for determining whether the acquittee is fit for release; (5) who may present evidence and what type; (6) the burden and standard of proof at the release hearing; (7) requirements for legal representation; (8) the type of release available, i.e., unconditional or conditional; and in the latter case (9) types of conditions; (10) procedures for modifying the conditions; (11) procedures to revoke the release; (12) time limits; (13) the outpatient treatment option; and (14) notification requirements. In addition to these special procedures, habeas corpus is available to insanity acquittees, as it is for all involuntarily confined persons. The only issue is whether there is specific reference to the availability of the writ in the special acquittee statutes. There is such reference in five jurisdictions: D.C., Illinois, South Dakota, Virginia, and Washington.


120. The availability of the writ to insanity acquittees is not to be confused with the limits to which it may be used. For example, the Nebraska Supreme Court recently ruled that the state's commitment statute, as applied to persons acquitted by reason of insanity, was not subject to collateral attack by means of the habeas corpus procedure. Mayfield v. Hartmann, 221 Neb. 122, 375 N.W.2d 146 (1985).
as well as in the ABA Standards. Further discussion of the habeas corpus option will not appear here.

1. Who initiates the release procedure

In the vast majority of states, the acquittee or a representative of the treatment provider can initiate the release. The provider is usually represented by the director of the facility where the acquittee is confined, or occasionally by someone from the central department of mental health.


In three states, the court may initiate the process. Four states specifically allow any interested party to file on behalf of the acquittee, and Maine explicitly includes the spouse or next of kin. In Colorado and Nebraska, the prosecutor also may apply for the acquittee’s release. This unique authority clashes with the assumption that the prosecution’s role, at least in the traditional adversary setting, is to oppose the release.

2. **Time parameters for use of the release procedure**

To prevent flooding the courts with repetitive applications for release, most statutes prescribe waiting periods for both the first and subsequent applications for release. Generally, there is a relatively brief wait (thirty days to a year) after the initial disposition for the first filing, and longer waits (an average of about one year) for any subsequent applications for release. The ABA Standards and at least two states add the proviso that the period may be shortened by a special court order. Five states permit filing for release at ‘‘any time.’’

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126. An interested party may initiate release on behalf of the acquittee as provided by: DEL. CODE ANN. tit. 11, § 403(b) (Supp. 1986); ILL. REV. STAT. ch. 38, para. 1005-2-4(e) (1985); ME. REV. STAT. ANN. tit. 15, § 104-A(3) (Supp. 1986); OR. REV. STAT. § 161.341(4) (1985).

127. The prosecutor may initiate release as provided by: COLO. REV. STAT. § 16-8-115(1) (1986); NEB. REV. STAT. § 29-3703(1) (1985).

128. Waiting periods for applications for release are provided by: ALASKA STAT. § 12.47.090(e) (1984) (one year for both first and subsequent applications); ARIZ. REV. STAT. ANN. § 13-3994(B), (D) (Supp. 1986) (fifty days for first application, six months for subsequent release hearings with acquitees whose crimes involve serious physical injury having to wait 230 days for their first application); ARK. STAT. ANN. § 41-613(2) (1977) (ninety days, one year); CAL. PENAL CODE §§ 1026.2(d), 1026.2(j) (West Supp. 1987) (180 days and one year until Jan. 1 1989; ninety days and one year thereafter); COLO. REV. STAT. § 16-8-115(1) (1986) (180 days, one year); CONN. GEN. STAT. ANN. § 17-257n(a) (West Supp. 1987) (six months for both); D.C. CODE ANN. §§ 24-301(d)(2)(A), 24-301(k)(5) (1981) (fifty days, six months); GA. CODE ANN. § 27-1503(f)(3) (Harrison Supp. 1986) (one year for subsequent applications); HAW. REV. STAT. § 704-412(2) (1985) (ninety days, one year); ILL. REV. STAT. ch. 38, para. 1005-2-4(e) (1985) (sixty days for subsequent applications); KAN. STAT. ANN. § 22-3428a(1) (Supp. 1986) (one year for both); LA. CODE CRIM. PROC. ANN. art. 655(B) (West Supp. 1987) (six months, one year); ME. REV. STAT. ANN. tit. 15, § 104-A(3) (Supp. 1986) (six months for subsequent applications); MD. HEALTH-GEN. CODE ANN. § 12-118(a)(1) (Supp. 1986) (one year for both unless application supported by physician’s affidavit); MO. ANN. STAT. § 552.040(7) (Vernon 1987) (180 days for subsequent application); MONT. CODE ANN. § 46-14-303 (six months, one year); NEV. REV. STAT. §§ 175.521(2), 178.450(2) (1985) (six months for subsequent applications); OR. REV. STAT. § 161.341(5), (7) (1985) (six months for subsequent applications with mandatory hearings at least every two years); TEX. CRIM. PROC. CODE ANN. § 46.03(4)(d)(5) (ninety days for subsequent applications) (Vernon Supp. 1987); UTAH CODE ANN. § 77-14-5(3) (Supp. 1987) (six months, one year); VA. CODE ANN. § 19.2-181(4) (Supp. 1986) (six months, one year); WYO. STAT. ANN. § 7-11-306(f) (1977) (ninety days, six months).

129. The waiting period for release may be shortened by court order as provided by: ABA
Three of the states that permit unlimited applications for release specify, however, that this right is available only to persons other than the acquittee, such as the hospital director. Thus, Utah provides that the director may apply anytime, while the acquittee is required to wait six months after the initial disposition and one year for every filing thereafter. In view of the fact that the medical determination of the acquittee's readiness for release could indeed come anytime, while the acquittee likely has a perpetual desire to be out of the institution, such differentiation in the law seems sensible. Maryland's law has a special variation on the same theme in that the acquittee is required to wait one year between the first and successive filings for release, unless the application is supported by a physician's affidavit that the acquittee is ready to go free. Rhode Island specifies that either the acquittee or the hospital director may apply for release at anytime.

3. Type of hearing

As mentioned, judicial domination of the release process is a central feature of the special insanity acquittee statutes. Only Oregon and Connecticut depart from the discharge model where the court has the central role. In those states, special psychiatric review boards make most of the critical decisions regarding acquittees. Michigan's law, requiring central administrative endorsement of any discharge decision made at the release hearing, presents a special twist.

The traditional theory, if not always the practice of judicial decision making, is that the decision making process occurs in the context of a formal hearing complete with various set procedures for taking and weighing the evidence. This is indeed the operative concept of the majority of acquittee statutes providing for a judicial hearing. A number of states, however, specifically do not require full hearings. Hawaii and Virginia, for example,
provide that the court may base release on the psychiatric report alone.\textsuperscript{137} Courts showing such deference toward the medical/administrative decision are in effect reducing their role to a ministerial one. The statutes of a few other states appear to go further yet, eliminating in certain instances even the court's ministerial role where there is no genuine issue or contest. These provisions require judicial involvement only if the prosecutor objects to the administrative decision to discharge the acquittee.\textsuperscript{138}

4. Criteria for release

The release provisions of the insanity acquittee statutes posit three basic criteria that must be met before an acquittee can be legally discharged. The acquittee must be (1) no longer dangerous to others, (2) no longer dangerous to himself, and (3) no longer mentally ill. A substantial majority of the states require satisfaction of all three conditions, though the dangerousness to self and mental illness components are not quite as prevalent as the requirement that the acquittee be no longer dangerous to others.\textsuperscript{139} By and

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  \item 137. HAW. REV. STAT. § 704-415 (1985); VA. CODE ANN. § 19.2-181(3) (Supp. 1986). In Montana, also, the court may release the acquittee on the basis of the psychiatric report, but only if application was made by a mental health official. MONT. CODE ANN. § 46-14-302(3) (1985).
  \item 138. A judicial hearing on release is not required unless the release is objected to as provided by: D.C. CODE ANN. § 24-301(e) (1981) (by prosecutor or court); KAN. STAT. ANN. § 22-3428(3) (Supp. 1986); MASS. GEN. LAWS ANN. ch. 123, § 16(e) (West 1987); Mo. ANN. STAT. § 552.040(5) (Vernon 1987); NEV. REV. STAT. § 178.460(1) (1979 & Supp. 1984); N.H. REV. STAT. ANN. § 135:28-a (1977) (by prosecutor or court); N.Y. CRIM. PROC. LAW § 330.20(13) (McKinney Supp. 1987); OHIO REV. CODE ANN. § 2945.40(D)(4) (Anderson 1987) (committing court will conduct a hearing at the trial court's request); OKLA. STAT. ANN. tit. 22, § 1161 (West 1986); S.D. CODIFIED LAWS ANN. § 23A-26-12.5 (Supp. 1987) (by prosecutor or court); TEX. CRIM. PROC. CODE ANN. § 46.03(4)(d)(5) (Vernon Supp. 1987); W. VA. CODE § 27-6A-4 (1986) (if court objects to proposed release).
large, the release criteria state the inverse of the specific standards for the commitment of insanity acquittees. These criteria also are not very different from the civil commitment release criteria, which in recent years have gravitated toward a comparably heavy emphasis on the issue of the patient’s dangerousness to others.

Deviations from this general pattern are relatively few. Illinois employs the criterion that the acquittee be no longer in need of treatment as one of several possible measures, while New Hampshire and Vermont use it as the sole standard.\footnote{An acquittee must no longer be in need of treatment prior to release as provided by: Ill. Rev. Stat. ch. 38, para. 1005-2-4(b) (1985); N.H. Rev. Stat. Ann. § 135:28 (1977) (further detention unnecessary in superintendent’s opinion); Vt. Stat. Ann. tit. 13, § 4822(c) (Supp. 1986).} Six states state the criteria for release in terms of the acquittee no longer meeting the standards for involuntary civil hospitalization.\footnote{A release is permissible if the acquittee no longer meets the criteria for civil commitment as provided by: Ariz. Rev. Stat. Ann. § 13-3994(C) (Supp. 1986); Fla. R. Crim. P. 3.218 (West Supp. 1987); Fla. Stat. Ann. § 916.15(2) (West Supp. 1987); Ga. Code Ann. § 27-1503(3)(f) (Harrison Supp. 1986); Mass. Gen. Laws Ann. ch. 123, § 16 (West 1987); Mich. Comp. Laws Ann. § 330.2050(5) (West 1980); Tex. Crim. Proc. Code Ann. § 46.03(4)(d)(5) (Vernon Supp. 1987).} Another three jurisdictions add that the acquittee must no longer be dangerous to property.\footnote{An acquittee must no longer be dangerous to property prior to release as provided by: Ark. Stat. Ann. § 41-613(5) (1977) (but may still be mentally ill); Haw. Rev. Stat. § 704-415 (1985); Md. Health-Gen. Code Ann. § 12-113(b) (Supp. 1986).} Colorado employs the unique requirement that the acquittee must be capable of distinguishing right from wrong and have substantial capacity to conform conduct to the requirements of the law. In other words, the acquittee must recover the sense of criminal responsibility.\footnote{Colo. Rev. Stat. § 16-8-120(3) (1986).} The rationale for this provision appears dubious. Even though criminal irresponsibility was the ground for the defendant’s acquittal, it is not technically the reason for confinement. In Oregon and Wyoming, the statutes hedge on the dangerousness to others criterion by adding that the acquittee may be released conditionally even though still a risk, so long as control with appropriate supervision and treatment is feasible.\footnote{Or. Rev. Stat. §§ 161.336(1), 161.341(4)(c), 161.346(1)(b) (1985); Wyo. Stat. § 7-11-306(g) (1977).}

5. Producing the Evidence

Most of the insanity acquittee statutes specify what type of evidence may be presented and who may present it at the acquittee’s release hearing. The
majority of states list two or three authorities who may give evidence, typically including the director of the hospital where the acquittee is confined,\textsuperscript{145} one or several physicians or clinical psychologists,\textsuperscript{146} and occasionally a central administrative figure such as the director or commissioner of the department of mental health.\textsuperscript{147} The physicians who may testify include the treating psychiatrists\textsuperscript{148} and independent professionals retained or requested by the acquittee, or even those retained by the prosecutor, and approved by the court.\textsuperscript{149} Several states ensure independent or impartial testimony via statutory stipulations to the effect that at least one of the testifying psychiatrists not be affiliated with the treating institution.\textsuperscript{150} States that operate with special administrative entities for determining the placement and treatment of mentally disordered offenders have more unusual provisions. Thus, Louisiana and Nevada require testimony on release from a special "sanity

\textsuperscript{145} A hospital director may give evidence at a release hearing as provided by: \textit{ARK. STAT. ANN.} \textsection 41-613(3) (1977); \textit{CAL. PENAL CODE} \textsection 1026.2(b) (West Supp. 1987); \textit{CONN. GEN. STAT. ANN.} \textsection 17-257c(b) (West Supp. 1987); \textit{FLA. R. CRIM. P.} 3.218 (West Supp. 1987); \textit{FLA. STAT. ANN.} \textsection 916.15(3) (West 1985) (hospital administrator’s report); \textit{ILL. REV. STAT.} ch. 38, para. 1005-2-4(d) (1985); \textit{IOWA R. CRIM. P.} 21(8)(e) (codified at \textit{IOWA CODE ANN.} \textsection 813.2 (West Supp. 1987)); \textit{KAN. STAT. ANN.} \textsection 22-3428a(1) (Supp. 1986); \textit{LA. CODE CRIM. PROC. ANN. art. 655(C) (West 1981)}; \textit{MO. ANN. STAT.} \textsection 552.040(4) (Vernon 1987); \textit{OR. REV. STAT.} \textsection 161.341(2) (1985); \textit{R. I. GEN. LAWS} \textsection 40.1-5.3-4(h) (1984); \textit{UTAH CODE ANN.} \textsection 77-14-5(3) (Supp. 1987); \textit{VA. CODE ANN.} \textsection 19.2-181(2) (Supp. 1986) (director’s report); \textit{WYO. STAT.} \textsection 7-11-306(e), (f) (1977) (facility head’s report).

\textsuperscript{146} Physicians or psychologists may give evidence at a release hearing as provided by: \textit{ARK. STAT. ANN.} \textsection 41-613(3) (1977); \textit{COLO. REV. STAT.} \textsections 16-8-106(1), 16-8-108 (1986); \textit{CONN. GEN. STAT. ANN.} \textsections 17-257c(c), 17-257q(a) (West Supp. 1987); \textit{D.C. CODE ANN.} \textsection 24-301(e) (1981); \textit{HAW. REV. STAT.} \textsection 704-414 (1985); \textit{ILL. REV. STAT.} ch. 38, para. 1005-2-4(f) (1985); \textit{KAN. STAT. ANN.} \textsection 22-3428a(2) (Supp. 1986); \textit{ME. REV. STAT. ANN. tit. 15, \textsection 104-A(1) (Supp. 1986); \textit{MONT. CODE ANN.} \textsection 552.040(4) (Vernon 1987); \textit{MON. CODE ANN.} \textsection 46-14-302(2) (1985); \textit{NEV. REV. Stat.} \textsections 175.521(2), 178.455 (1985); \textit{N.J. STAT. ANN.} \textsections 2C:4-9(a) (West 1982); \textit{N.Y. CRIM. PROC. LAW} \textsection 330.20(20) (McKinney 1983); \textit{OR. REV. STAT.} \textsections 161.341(3), 161.346(3) (1985); \textit{VA. CODE ANN.} \textsection 19.2-181(2) (Supp. 1986).

\textsuperscript{147} A central administrator may give evidence at a release hearing as provided by: \textit{MO. ANN. STAT.} \textsection 552.040(4) (Vernon 1987) (Director of Department of Mental Health); \textit{NEV. REV. Stat.} \textsections 175.521(2), 178.455 (1985) (mental health administrator); \textit{R. I. GEN. LAWS} \textsection 40.1-5.3-4(h) (1984) (Director of Department of Mental Health, Retardation and Hospitals).

\textsuperscript{148} \textit{ME. REV. STAT. tit. 15, \textsection 104-A(1) (Supp. 1986).}

\textsuperscript{149} Independent professionals are permitted at a release hearing as provided by: \textit{COLO. REV. STAT.} \textsections 16-8-106(1), 16-8-108(1) (1986) (at request of prosecutor or acquittee); \textit{CONN. GEN. STAT. ANN.} \textsections 17-257c(c), 17-257q(a) (West Supp. 1987) (prosecutor or acquittee); \textit{FLA. R. CRIM. P.} 3.218(b) (West Supp. 1987) (prosecutor or acquittee); \textit{HAW. REV. STAT.} \textsection 704-414 (1985) (acquittee); \textit{KAN. STAT. ANN.} \textsection 22-3428a(2) (Supp. 1986) (acquittee); \textit{LA. CODE CRIM. PROC. ANN. art. 656 (West 1981) (acquittee or prosecutor); \textit{MO. ANN. STAT.} \textsection 552-040(4) (Vernon 1987) (acquittee or prosecutor); \textit{VT. STAT. ANN. tit. 13, \textsection 4822(c) (Supp. 1986) (prosecutor).

\textsuperscript{150} \textit{NEV. REV. STAT.} \textsections 175.521(2), 178.455(1) (1985) (at least one of three physicians appointed by court must be a psychiatrist not affiliated with state mental health office); \textit{N.J. STAT. ANN.} \textsection 2C:4-9(a) (West 1982) (court may appoint at least two psychiatrists not on the hospital’s staff); \textit{VA. CODE ANN.} \textsection 19.2-181(2) (Supp. 1986) (one of two qualified psychiatrists must be an employee of a state hospital other than acquittee’s).
commission,” which in Louisiana, plays a role in the original trial. In Nevada, the commission is not involved in the original trial. Oregon admits the reports of psychiatrists or psychologists appointed by its PSRB. Maryland provides for a special hearing officer to take evidence on release and report it to the court.

Where specified, the most common statutory formulation on the type of evidence that may be presented at the release hearing is that which speaks to the mental condition of the acquittee. Several states add that any other relevant or pertinent evidence may be included. Three states provide that the testimony address and resolve the release issue in terms of whether the acquittee meets the release criteria, which as spelled out in at least one statute, amount to no longer meeting the criteria for commitment. The ABA Standards explicitly apply the normal rules of evidence in release hearings for insanity acquittees, a statutory detail adopted so far only in the state of Washington.

6. Burdens and standards of proof

In the majority of states, proof of the acquittee’s fitness for release requires only a preponderance of the evidence, the traditional standard of proof in civil matters. Six states require clear and convincing evidence, the modern

151. LA. CODE CRIM. PROC. ANN. art. 656 (West 1981).
152. NEV. REV. STAT. § 175.521(2) (1985).
155. See, e.g., ARK. STAT. ANN. § 41-613(3) (1977); COLO. REV. STAT. § 16-8-107 (1986); D.C. CODE ANN. § 24-301(e) (1981); HAW. REV. STAT. § 704-414 (1985) (physical and mental condition); KAN. STAT. ANN. § 22-3428(3) (Supp. 1986) (mental evaluation); MO. ANN. STAT. § 552.040(4) (Vernon 1987); MONT. CODE ANN. § 46-14-302(2) (1985); N.J. STAT. ANN. § 2C:4-9(a) (West 1982); N.Y. CRIM. PROC. LAW § 330.20(12) (McKinney Supp. 1987); R.I. GEN. LAWS § 40.1-5.3-4(h) (1984); VA. CODE ANN. § 19.2-181(2) (Supp. 1986); WYO. STAT. § 7-11-306(h) (1977).
156. ARK. STAT. ANN. § 41-613(4) (1977) (any party may offer other evidence on the issues presented); CONN. GEN. STAT. ANN. § 17-257q (West Supp. 1987) (all material evidence); IOWA R. CRIM. P. 21(8)(e) (codified at IOWA CODE ANN. § 813.2 (West Supp. 1987)); R.I. GEN. LAWS § 40.1-5.3-4(h) (1984); WYO. STAT. § 7-11-306(h) (1977).
158. ABA STANDARDS, supra note 9, § 7-7.5; WASH. REV. CODE ANN. § 10.77.100 (1980).
159. Fitness for release must be established by a preponderance of the evidence as provided by: CAL. PENAL CODE § 1026.2(k) (West Supp. 1987) (this provision only in effect until Jan. 1, 1989); COLO. REV. STAT. § 16-8-115(2) (1986); CONN. GEN. STAT. ANN. § 17-257(f) (West Supp. 1987); D.C. CODE ANN. § 24-301(d)(2)(B) (1981); MD. HEALTH-GEN. CODE ANN. §§ 12-113(d), 12-117(a) (Supp. 1986); MONT. CODE ANN. §§ 46-14-301(3), 46-14-302(4) (1985); N.J. STAT. ANN. § 2C:4-9(b) (West 1982); OR. REV. STAT. § 161.341(5) (1985) (if acquittee applies); S.D. CODIFIED LAWS ANN. § 23A-26.12.3 (Supp. 1987) (with respect to any offense involving
standard in civil commitment cases. Given the importance of preserving physical liberty, a higher standard for commitment than for release may be justified. South Dakota raises the standard of proof in release proceedings to clear and convincing only for acquitees whose offenses involved bodily injury, property damage, or the substantial risk of either. The ABA Standards require the preponderance of evidence standard when the state or the hospital petitions for the acquittee's release, while requiring the slightly higher clear and convincing proof when the acquittee applies. New Hampshire, up until repeal of the provision only a year or two ago, remained the only state requiring proof beyond a reasonable doubt of fitness for release. This criminal process standard may in the past have seemed more appropriate for insanity acquittee cases than it does in today's more "progressive" era.

Most states put the burden of persuasion on the acquittee, presumably the most likely person to petition for release. States such as Illinois, Oregon, and Wyoming place the burden on the acquittee as the applicant, but shift it when the state or the hospital is the moving party. The ABA Standards, whether through oversight or some calculation involving the higher than usual burden of proof on the acquittee, put the burden of persuasion on the state, without regard to who petitions for release.

160. Fitness for release must be established by clear and convincing evidence as provided by: ALASKA STAT. § 12.47.090(e) (1984); ARIZ. REV. STAT. ANN. § 13-3994(C) (Supp. 1986); ILL. REV. STAT. ch. 38, para. 1005-2-4(g) (1985); R.I. GEN. LAWS § 40.1-5.3-4(h) (1984); S.C. CODE ANN. § 17-24-40(c)(2)(c) (LAW. CO-OP. 1985); S.D. CODIFIED LAWS ANN. § 23A-26-12.3 (Supp. 1987) (with respect to offenses other than one involving bodily injury or damage to another's property or the substantial risk thereof).


162. ABA STANDARDS, supra note 9, § 7-7.9(e).

163. Id. § 7-7.8(b).


166. The burden of persuasion is shifted when the state seeks a hearing as provided by: ILL. REV. STAT. ch. 38, para. 1005-2-4(g) (1985) (when state seeks review of facility director's plans for acquittee); OR. REV. STAT. § 161.341(5) (1985) (burden shifts to the state if the acquittee applies more than two years after the state last had the burden of proof); WYO. STAT. § 7-11-306(e), (f) (1977) (when state opposes facility's application for discharge).

167. ABA STANDARDS, supra note 9, § 7-7.8(b).
7. Legal representation

The statutes of some fourteen jurisdictions explicitly provide that the insanity acquittee has a right to counsel at the release hearing. This number lags significantly behind the nearly universal endorsement of the right to counsel at the commitment stage. The reasons may be (a) that the need to ensure procedural due process and to protect against commitment without good grounds is more compelling than the right to seek release once properly committed, and (b) that release procedures are sometimes, or ought to be, of such informality as not to require the presence of counsel. Be that as it may, it is difficult to believe that the court in a formal release hearing would deny the acquittee counsel, irrespective of whether there is statutory language on the question.

The ABA Standards and the statutes of four states explicitly provide that the state shall pay for the counsel of indigent acquittees. The ABA Standards further propose that such counsel be available at the locus of confinement, but this provision has not yet been duplicated in the state statutes. Maryland, which requires an initial hearing on release in front of a hearing officer, before the issue goes to the court, provides for the right to counsel at both junctures.

8. Type of release: unconditional, conditional

The classic practice and theory on institutional release are to provide for the absolute, unconditional discharge of inmates once the law or behavioral indicators dictate that the time is right. The classic pattern applies whether the confining institution is a prison or a mental hospital, and whether the person confined has been civilly or criminally committed. At the same time, however, there exists a well established alternative tradition providing for the conditional discharge of institutionalized persons. The animating principle is that the state may take an early chance on certain inmates by releasing

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169. See supra note 63 and accompanying text.

170. Statutes providing for payment for an acquittee's counsel at a release hearing: ABA STANDARDS, supra note 9, §§ 7-7.5(b), 7-7.8(c); ME. REV. STAT. ANN. tit. 15, § 104-A(6) (Supp. 1986); N.H. REV. STAT. ANN. § 135:30-a(I) (1977); S.D. CODIFIED LAWS ANN. § 23A-46-3 (Supp. 1987); WASH. REV. CODE ANN. § 10.77.020(1) (1980).

171. ABA STANDARDS, supra note 9, § 7-7.8(c).

them on parole or some similar supervision scheme. Release may be contingent on: submission to a prescribed regimen of treatment; observation of various restrictions, including reporting requirements on the acquittee's whereabouts; and/or adherence to any of a wide range of other stipulations imposed in response to specific aberrant behavior to which the inmate may be prone. In recent years, a particular emphasis has been placed on the conditional discharge alternative, in both the criminal and civil confinement contexts, in reaction to overflowing institutions as well as for broader economic and humanitarian reasons. The conditional discharge concept appears to have special advantages in cases involving insanity acquittees, given the special public safety concerns posed by this population and the perceived need to allow their re-entry into the community only if continued treatment, tight supervision, and regular monitoring of their condition are assured. As a result, a large majority of the states that have enacted special insanity acquittee statutes include an elaborate set of conditional release provisions as an alternative to classic unconditional discharge. The remainder of this Article's statutory discussion focuses on the details of these conditional release provisions.

9. Types of conditions

The statutes describing the kinds of conditions placed on the acquittee as part of his release often (in at least twelve jurisdictions) make specific reference to a supervision program or supervising agent entrusted with this oversight responsibility. In four states, the probation authority is designated


either as the responsible agency or as one possible supervisor. In Kansas and Washington, a physician may undertake the supervisory responsibility. In New York, the Commissioner of Mental Health serves as the acquittee’s supervisor. And in Oregon, it is up to the PSRB to designate the appropriate agent to monitor the conditionally released acquittee.

The courts typically have the authority to impose and choose the conditions for the acquittee’s release. The state statutes give the judiciary wide discretion in exercising this authority. At least eleven states simply provide that the court may order such conditions as it deems necessary or appropriate. In some states this judicial discretion may not go beyond the recommendations of a special administrative agent, such as a hearing officer in Maryland or the commissioner of mental health and retardation in Virginia. By statute, these officers have the responsibility to make the initial evaluation in this regard. Some nine states make specific reference in their statutes to the court’s power to order outpatient treatment as a condition of release. New York’s law is unique in that it requires the conditions to be in the form of a written service plan prepared and approved by the court. The ABA Standards embody a particular focus in that they require acquittees whose...
sanity appears to be a direct result of treatment to continue such treatment when conditionally released. Kansas, in a unique provision, requires that the acquittee, as a condition of release, waive extradition proceedings in case an arrest warrant is issued.

10. Modification of conditions

Eleven states have laws that specifically address the possibility of modifying the release conditions imposed on the insanity acquittee. It is probable, however, that modifications can be made even in states without such statutory provisions. Eight of the jurisdictions having such laws designate that the acquittee may apply to modify the terms of release. Other parties with a compelling interest in the matter are the court (listed in the statutes of three states), the prosecutor (two states), the person supervising the acquittee while on conditional release (four states), and interested parties, such as the acquittee’s spouse and next of kin (Maine). In addition, six jurisdictions also grant an official of the department of mental health services the authority to apply for a change in release conditions.

184. ABA STANDARDS, supra note 9, § 7-7.4(d).
Several states and the District of Columbia have limits on how soon or how often modifications may be requested. A six month wait between applications is the most common frequency limitation. Hawaii requires the applicant to wait one year before applying for modification. In Kansas, a request is permissible "any time," while Wyoming's unique provision says that modifications may be applied for "from time to time."

The criteria for modifying conditions of release fall into four basic categories. Most states employ the failure of the released acquittee to meet or comply with the conditions imposed as one standard of modification. Louisiana is unique in that its statute provides that modification may be granted because the acquittee is about to violate the conditions, a reasonable preventative measure that may be operative even in jurisdictions that provide no such statutory authorization. The other basic criteria reflect the acquittee's need for additional or new conditions, either because of renewed dangerousness or because of deteriorating mental health. Finally, and appropriately enough, three states also permit modifications based on improvement in the acquittee's mental condition that would make a continuation of the original restrictions unnecessary, and possibly justify unconditional discharge.


201. Modification may be based on improvement in mental health as provided by: Ark. Stat. Ann. § 41-614(1) (1977); Haw. Rev. Stat. § 704-413(2) (1985); Or. Rev. Stat. § 161.336(7)(a) (1985). The statutory formulation is no longer mentally ill or, if still so affected, no longer presents a substantial danger, and as in Oregon, "no longer requires supervision, medication, care or treatment." Id.
Modifying the release conditions is an action of considerable moment to the acquittee, to the supervising or treating agent, and to the general public which expects protection against persons who have a history of dangerous behavior. As a result, modifications require formal legal procedures to protect the competing interests. The relevant statutes generally mandate a judicial hearing. Connecticut and Oregon, however, vest the responsibility and the authority to hear the petitions in special review boards.

11. Revocation of release

There are substantial similarities between the provisions on modification of release conditions and those that govern the possibility of revocation of release or its conditions. However, the logic of the law also dictates certain differences. For a comparative analysis, it is perhaps most instructive to focus on the differences.

The revocation statutes, logically enough, do not designate the acquittee as a possible applicant. The thrust of revocation is not to free the acquittee from the conditions imposed as part of the release, but to revoke the release and to order reinstitutionalization, something very few acquittees will perceive as being in their own interest. Also, revocation is intended principally as a response to the exigencies of the situation, frequently an emergency, and as such there is no limit on how frequently the revocation process may be initiated, as there is in respect to modifications.

The criteria for revocation of release also differ in certain respects from those guiding modification decisions. Based on the same logic that precludes the acquittee from being listed as an applicant for revocation, the main difference is that improvement in mental condition is not a ground for revocation, whereas it is a legal basis for modification in several state statutes. The objective of the revocation statute is not discharge, but its precise opposite. Beyond this difference, the similarities dominate. Just as they can be grounds for modification, the acquittee's deteriorating mental health, renewed dangerousness, or failure to meet the conditions of


204. See supra note 201.

all can be grounds for revocation. Presumably, there is a difference of degree, with the greater changes in the acquittee's condition or the larger shortfalls from compliance calling for revocation, whereas modification is the answer for smaller deviations, but the statutes do not spell this out. Texas has a unique provision that requires the acquittee to meet the criteria for involuntary civil commitment in order to be reinstitutionalized. Wyoming has a unique provision that uses inability to control the acquittee adequately by supervision alone as the explicit criterion for revocation.

Perhaps the most critical legal difference between revocation and modification decisions is that the former may be made, at least in a number of states, without a formal judicial hearing. The rationale no doubt is that the drastic step of revocation is often a response to an emergency situation, while the intermediate action of modifying the release conditions rarely is, and thus can be more deliberate. The statutes that permit revocation without formal proceedings contemplate an eventual formal hearing on the revocation decision, but only after passage of a reasonable period of time. In general, the time prescribed is short: seventy-two hours in Hawaii; seven days in Maine; and, in Texas and Washington simply until such time as a hearing can be scheduled. The Maryland statutes contain the unique provision that


208. WYO STAT § 7-11-306(c), (g) (1977).

209. WYO STAT § 7-11-306(c), (g) (1977).


212. ME. REV. STAT. ANN. tit. 15, § 104-A(5) (Supp. 1986) (apparently a person may be rehospitalized for up to seven days without a hearing).

the parties may agree to waive the revocation hearing. Uniformly, the statutes prescribe a judicial proceeding to test the initial revocation decision, and Connecticut and Oregon prescribe a hearing before their administrative review boards.

12. Maximum period for release conditions

Consistent with the legal trend against indeterminate confinement, many of today's release conditions spell out limits for how long the conditions may remain in force. Five years is a common statutory maximum, with provisions in Maryland and New Hampshire adding that the court, upon a hearing, may extend the limits for another five years. In Connecticut, the release conditions may remain in force as long as the maximum authorized period of confinement. In Oregon and South Carolina, the release conditions imposed on an insanity acquittee may not persist beyond the time of the maximum sentence that the acquittee could have received if convicted on the criminal charge. In Maine and Texas, the statutes provide simply that the duration of the conditions is set by the court, with the added proviso in Texas that the court may, upon expiration of the original period, order a new time limit. Louisiana law provides that the time for release conditions may be either fixed or indeterminate.

13. Mandatory outpatient treatment

For economic, rehabilitative, and humanitarian reasons, the law has recently given voice to the theory that, in a variety of personal and legal circumstances, mentally disabled individuals may best be treated on an outpatient basis. The insanity acquittee statutes reflect this trend with provisions that permit outpatient evaluations and outpatient treatment as an alternative to institutionalization. The flip side of the coin is that insanity acquittees who are ready for release may be required to follow a regimen of outpatient treatment as a condition of their discharge. As mentioned, several state statutes explicitly give the court the option to impose such treatment.

217. Such at least was the explicit law under the old code. CONN. GEN. STAT. ANN. § 53(a)-47(g) (1972). The same limitation is still implied. CONN. GEN. STAT. ANN. § 17-257c(e)(1)(A) (West Supp. 1987).
221. See supra notes 66-75 and accompanying text.
222. Id.
The law could, however, mandate outpatient treatment not as a judicial option, but as a statutory requirement that automatically applies to every insanity acquittee who is released from an institution. The courts and special programs in several states operate as if such a statutory mandate existed, the practice being to assign all released insanity acquitees to a regimen of outpatient treatment. So far, however, only California has actually enacted a law to this effect. In California, just to be eligible for a formal release hearing, the acquittee must have undergone a probationary 180 days of outpatient care.\textsuperscript{223} If the court then finds the acquittee ready for formal release, it requires as part of the release order, outpatient treatment for an additional one year period unless unconditional release is ordered within that time.\textsuperscript{224}

14. Notification requirements

Finally, notification requirements are an important feature of the law governing the disposition of insanity acquitees. These requirements apply to facts or developments at various stages of the disposition process, including the final stages of conditional release and full discharge. Most states require that notice be given of any application for release, or of the release hearing itself, including the time and place for the hearing.\textsuperscript{225} Perhaps because of these full preliminary notice requirements, relatively few states explicitly require notice of the outcome of the process.\textsuperscript{226} A few states, in addition, require notice of modification of release conditions and of revocation of conditional release.\textsuperscript{227} Oregon’s statute requires notice to various parties of periodic progress reports made by the treatment provider regarding the acquittee’s response to the outpatient treatment program.\textsuperscript{228} Minnesota man-

\textsuperscript{223} CAL. PENAL CODE § 1026.2(d) (West Supp. 1987) (ninety days, after Jan. 1, 1989).
\textsuperscript{224} Id. § 1026.2(e) (in effect until Jan. 1, 1989).
\textsuperscript{225} Notice of a hearing on release is required by: ALASKA STAT. § 12.47.090(e) (1984); ARIZ. REV. STAT. ANN. § 13-3994(B) (Supp. 1986); ARK. STAT. ANN. § 41-613(1) (1977); CAL. PENAL CODE § 1026.2(a), (e) (West Supp. 1987); COLO. REV. STAT. § 16-8-115(3)(b) (1986); D.C. CODE ANN. § 24-301(d)(2)(B) (1981); HAW. REV. STAT. § 704-412(1), (2) (1985); ILL. REV. STAT. ch. 38, para. 1005-2-4(d)(3) (1985); LA. CODE CRIM. PROC. ANN. arts. 655(C), 657 (West 1981 & Supp. 1987); ME. REV. STAT. ANN. tit. 15, § 104-A(6) (Supp. 1986); MD. HEALTH-GEN. CODE ANN. § 12-114(c)(2), (d)(1) (Supp. 1986); MO. ANN. STAT. § 552.040(4) (Vernon 1987); MONT. CODE ANN. § 46-14-301(3) (1985); N.H. REV. STAT. ANN. § 135:30-a(IV) (1977); N.J. STAT. ANN. § 2C:4-9(a) (West 1982); N.Y. CRIM. PROC. LAW § 330.70(8), (9), (12), (13), (18) (McKinney 1983 & Supp. 1987); R.I. GEN. LAWS § 40.1-5.3-4(h) (1984); VT. STAT. ANN. tit. 13, § 4822(c) (Supp. 1986); VA. CODE ANN. § 19.2-181(2), (4) (Supp. 1986); W. VA. CODE §§ 27-6A-3(c), 27-6A-4 (1986); WIS. STAT. ANN. § 971.17(2) (West 1985); WYO. STAT. § 7-11-306(e), (f) (1977).
\textsuperscript{226} Oregon does. OR. REV. STAT. § 161.346(9) (1985).
\textsuperscript{228} OR. REV. STAT. § 161.336(4)(d) (1985) (acquittee and counsel).
dates notice of discharge only in cases involving felonies or gross misdemeanors.229

The main target of the various notification requirements, for reasons that are self-evident, is the state's prosecutorial machinery, that is, the Attorney General or county prosecutor.230 The ABA Standards and one state, Arkansas,232 also mandate notice to the defendant and to counsel, on the assumption that in some cases the defense may not be the moving party, or perhaps simply to inform the defendant of the time and place of the hearing. Other parties are also targeted for notice in some of the states: the supervisor of the acquittee's treatment regimen,233 the court,234 the county sheriff or municipal police,235 the facility superintendent,236 the director of the mental health department,237 and, in New Hampshire, the nearest relative or guardian

231. ABA STANDARDS, supra note 9, § 7-7.9(f).
235. Notice to the sheriff or police is required by: CAL. PENAL CODE § 1026.6 (West 1985 & Supp. 1987); ILL. REV. STAT. ch. 38, para. 1005-2-4(m) (1985); KAN. STAT. ANN. § 22-3428(2) (Supp. 1986). See also infra note 241 and accompanying text.
237. Notice to the director of mental health is required by: CAL. PENAL CODE § 1026.2(a), (e) (West Supp. 1987); ILL. REV. STAT. ch. 38, para. 1005-2-4(m) (1985); MD. HEALTH-GEN.
of the acquittee.238 Uniquely, New York requires that notice of changes in the acquittee's situation also be given to its Mental Hygiene Legal Service, an agency of the court that functions as a guardian of patients' rights.239 Washington's statute requires notice of conditional release to be given to the trial court.240 Wisconsin appears to be alone in requiring notice to the police or sheriff's department for the area where the acquittee will reside following release.241

II. The Case Law

There have been reported cases on many of the issues touched upon in the discussion of the statutes. The purpose of this section is to set out the way the cases have interpreted the various individual provisions of the states' statutory schemes for handling insanity acquittees. Some of the cases present the opportunity for a more integrated analysis, one that emphasizes the interdependence of the various substantive and procedural components of the post-verdict treatment of insanity acquittees, and that discerns their largely unarticulated relationship to pre-verdict standards and procedures.

A. Due Process, Equal Protection, and the Commitment Alternatives: The View From the Top

In 1983 the United States Supreme Court decided Jones v. United States,242 a case deserving of the otherwise overused term "landmark," which seems destined to frame the debate and litigation over dispositional procedures for insanity acquittees in years to come. The decision appears to retract the mandate growing out of a line of earlier Supreme Court cases involving populations in legal circumstances similar to those of insanity acquittees. Baxstrom v. Herold,243 Specht v. Patterson,244 and Humphrey v. Cady245 had mandated the application of basic due process safeguards when deciding on the commitment of criminally convicted populations to mental facilities. They were to be treated in all critical respects like non-criminal populations and accorded the same legal protection of the law as applied to civil commitment candidates or civil patients under O'Connor v. Donaldson246 and Addington v. Texas,247 the two primary Supreme Court cases delineating

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239. N.Y. CRIM. PROC. LAW § 330.20(8), (10), (11), (12), (14) (McKinney Supp. 1987).
240. WASH. REV. CODE ANN. § 10.77.190(2) (Supp. 1987).
241. WIS. STAT. ANN. § 971.17(2) (West 1985).
244. 386 U.S. 605 (1967) (allegedly mentally ill defendants convicted of sexual crimes).
245. 405 U.S. 504 (1972) (allegedly mentally ill defendants convicted of sexual crimes).
the rights of civil committees. In effect, *Jones* withdraws support for full special hearing procedures or regular civil commitment processing as the required means for determining the post-verdict fate of insanity acquittees. While the legislative trend in the states toward making these two alternative dispositional routes available to insanity acquittees may continue, the point of the *Jones* holding is that the presumptions flowing from a defendant's successful assertion of the insanity plea are such as to permit more truncated processing of the beneficiary of the defense. Either automatic commitment of insanity acquittees or their expedited commitment by the criminal trial court based on the trial record is thereby permissible.

Specifically, *Jones* held that "[w]hen a criminal defendant establishes by a preponderance of the evidence that he is not guilty of a crime by reason of insanity, the Constitution permits the Government, on the basis of the insanity judgment, to confine him to a mental institution until such time as he has regained his sanity or is no longer a danger to himself or society."248 In other words, the result of the criminal trial itself furnishes a sufficient basis for an automatic, indeterminate commitment of the acquittee. No special hearing need be held, no new evidence or evidence specifically targeted to the present propriety of confinement or treatment need be developed, and neither the standards and procedures for committing the acquittee nor those for release need conform to the standards and procedures applicable to other potentially committable or committed populations, criminal or civil.

A number of assumptions, made explicit by the Court, form the basis for this holding: (1) the verdict of not guilty by reason of insanity is assumed to be sufficiently probative of continuing mental illness and dangerousness to justify commitment for the purposes of treatment and the protection of society;249 (2) the verdict is assumed to establish beyond a reasonable doubt that the defendant committed the criminal act that led to the charge and trial; (3) the release hearing to which the acquittee is entitled after a certain defined period250 is assumed to provide adequate, if not equal, protection as

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249. There are subsidiary assumptions here about the burden and standard of proof and the relative risk of error in the decision making process regarding insanity acquittees versus those involving persons proposed for civil commitment. As the Court put it:

[There are] important differences between the class of potential civil-commitment candidates and the class of insanity acquittees that justify differing standards of proof. The Addington Court expressed particular concern that members of the public could be confined on the basis of 'some abnormal behavior which might be perceived by some as symptomatic of a mental or emotional disorder, but which is in fact within a range of conduct that is generally acceptable . . . . ' But since automatic commitment under D.C. law follows only if the acquittee himself advances insanity as a defense and proves that his criminal act was a product of his mental illness, there is good reason for diminished concern as to the risk of error. More important, the proof that he committed a criminal act as a result of mental illness eliminates the risk that he is being committed for mere 'idiosyncratic behavior.'

463 U.S. at 367.
compared to commitment review procedures available to other committed populations; and (4) indeterminate confinement until the acquittee recovers sanity and is no longer dangerous is assumed to be more appropriate than confinements based on length of the potential criminal sentence on the underlying charge or other irrelevant indicators.

These assumptions, like the holding itself, have come under severe attack from the mental patients advocacy community. By and large the critiques have been on legal grounds, and in some instances, rather narrow legal grounds. At least one challenge, however, is behavioral/psychological in its predicates. None can be summarily dismissed as meritless.

First the behavioral contention. The assumption of continuing mental illness and dangerousness based on a finding of criminal irresponsibility for the criminal act, which not atypically may have occurred many months before the final verdict, is psychiatrically dubious. Mental illness is often episodic\(^{251}\) and the defendant's symptoms may be in remission or under control through medication and other treatments. That there is a need for post-verdict treatment and confinement, much less how much of each, is not self-evident. Furthermore, criminal irresponsibility (insanity) is a legal construct bereft of psychiatric meaning. A judicial finding that the defendant was not responsible carries no particular diagnostic implications, let alone prognostic ones that would translate into a specific treatment regimen for the acquittee.

It is on this last point—the lack of relation between criminal insanity and present committability regardless of the passage of time or any alterations in the defendant's mental state—that the psychiatric perspective merges with the legal one. The legal criteria for assessing criminal responsibility bear no direct relation to the statutory standards for mental commitment. The assumption that a finding of not guilty by reason of insanity in and of itself furnishes sufficient grounds for confining the acquittee in a mental facility involves some significant strain on the law's finer points. The defendant may have proved his inability to tell right from wrong or to conform his conduct to the requirements of the law, but that in itself, the technical legal argument goes, makes the acquittee neither dangerous nor in need of treatment. The case for the acquittee's automatic commitment is weaker yet where, as in many jurisdictions, the defense does not have the burden of proving insanity, but the state must prove the defendant sane.\(^{252}\) In such circumstances, it has been pointed out, the defendant's criminal insanity is

\(^{251}\) Not only is the episodic character of some mental illnesses a well known psychiatric reality, it is explicitly acknowledged in the criminal law via the long standing exculpatory doctrines of "irresistible impulse" and "temporary insanity," and is promoted by advocates of the notion that persons suffering from such newfangled "disabilities" as "post-traumatic stress disorder" and "premenstrual syndrome" should also be absolved of criminal accountability. See J. Brakel, J. Parry & B. Weiner, supra note 2, at 710, 713-14.

\(^{252}\) See J. Brakel, J. Parry & B. Weiner, supra note 2, at 769-77 (Table 12.5, column 9, "The Insanity Defense-Pleading and Proof").
at best only indirectly established and the more remote issue of committability
remains unproved by evidentiary standards normally in force in proceedings
where the defendant's liberty is at stake.253

The assumption that the insanity acquittee committed the criminal act
provides grounds for inferring dangerousness and hence the need for con-
finement, apart from whatever justifications can be inferred from the finding
of criminal insanity. The validity of this assumption, however, is open to
question in most jurisdictions. In the District of Columbia, as in the majority
of states, a plea of insanity is only an implicit admission that the defendant
has committed a criminal act.254 Indeed, entering the plea may be no more
than a strategic defense decision calculating that, by focusing the court's
inquiry on whether the criminal incident resulted from mental illness, the
best deal (i.e., nonpunitive treatment) will be obtained for the defendant.
Some states even allow simultaneous inconsistent pleas of not guilty and not
guilty by reason of insanity.255 At least one jurisdiction permits the intro-
duction of the insanity defense under a general not guilty plea.256 Such
procedures would preclude any inferences at all about the defendant's par-
ticipation in the criminal act. Given this procedural scenario, the ABA
Standards require a special finding by the court that the acquittee committed
the criminal act beyond a reasonable doubt, thereby underscoring the Stan-
dards' authors' judgment that entry of an insanity plea in itself provides no
grounds for binding presumptions to this effect.257 Such a requirement stands
in direct contrast to the operative assumption in Jones regarding the ac-
quittee's participation in the criminal event.

The assumption in Jones regarding the adequacy of the fifty day release
hearing following an acquittee's automatic commitment has been challenged
for ignoring a number of arguably consequential differences in procedure
and standards between commitment proceedings and release proceedings.

253. Thus, in a criminal trial, the state conceivably could present evidence that by a prepon-
derance of the evidence standard would suffice in a civil proceeding to establish sanity, but
that would not establish it beyond a reasonable doubt. If unrebutted, the same evidence in a
civil proceeding would suffice to show that the defendant could not be committed. See also
Margulies, The "Pandemonium Between the Mad and the Bad: Procedures for the Commit-
ment and Release of Insanity Acquittees After Jones v. United States, 36 Rutgers L. Rev.
(which approved the circuit court's point that "[a]ll that an acquittal by reason of insanity
establishes in law is that the People have failed to prove beyond a reasonable doubt that the
defendant was competent at the time he committed the crime which might have been months
before").

254. Some states require that the defendant's commission of the criminal act first must be
proved in a separate trial phase before the issue of his criminal responsibility is considered.
See, e.g., State v. Field, 118 Wis. 2d 269, 347 N.W.2d 365 (1984) (discusses Wisconsin's
bifurcated and trifurcated procedures when the insanity defense is invoked).


257. ABA Standards, supra note 9, § 7-7.4(c).
The burden of persuasion in a release hearing is typically, as it is under the D.C. Code, on the patient, whereas the state must generally prove the propriety of commitment or retention. In addition, the criteria for release may be something other than the direct inverse of the commitment criteria and in effect may make continued confinement more likely than when the question is whether the acquittee initially should be placed in custody. The release criteria in the District of Columbia, for example, speak in terms of the acquittee's nondangerousness "in the reasonable future," a predictive burden on the defendant that is almost certainly more onerous than having to contend with the question of present danger. There are also other divergencies in the procedures for release in several states relating to the standard of proof and the right to counsel that render a determination in favor of the acquittee's freedom less likely than under the commitment procedures. Apart from any concrete differences, the entire "psychology" in release proceedings may militate against the acquittee's going free in a way that it does not when the issue is framed in terms of commitment. The sum is that, whatever the merits of the assumption in Jones that the protection of the law for acquittees in release hearings is adequate, it is certainly not equal to that accorded to comparable populations.

As to the justification for indeterminate confinement of insanity acquittees, the Jones Court's main strategy was to compare it to an alternative, which is in effect in some states and proposed in others, that is no easier to justify, namely, confinement determined by the length of the hypothetical criminal sentence. The Court's assertion that punishment has no place in dispositional schemes devised for insanity acquittees is unassailable and there is little conceivable correlation between the possible criminal sentence and the length of time necessary for the acquittee's recovery. An interesting reversal of positions is operative here in that the Jones Court's critics, who impute punitive motives to the majority opinion, are the ones willing to utilize the length of the possible sentence as an outer limit to the length of confinement. While providing an appearance of nonarbitrariness, criminal confinement limits for the unconvicted are ultimately not defensible. The "principle" of treating insanity acquittees no worse than convicts is not a principle. Recognizing this, however, need not lead one to espouse indeterminate confinement as the solution. There is an intermediate position that has been touted

259. See supra note 57-59 and accompanying text.
260. The statutory provisions describing the fifty day release hearing speak only generally of a court finding that the acquittee is "entitled to release from custody," but later provisions on administrative and judicial release of acquittees posit the dangerous "in the reasonable future" criterion. D.C. CODE ANN. §§ 24-301(d)(2)(A), 24-301(3) (1981).
261. See generally supra notes 53-63, 159-72 and accompanying text. See also Margulies, supra note 253, at 827-35.
263. Id.
as preferable to either the inapposite standards of the criminal process or the potentially deleterious open-endedness of indeterminate confinements. That position, proposed by a number of legal commentators and adopted by several state legislatures, requires civil recommitment hearings for all acquittees a set period of time (five years is typical) after their initial confinement.264

While these criticisms of the Jones opinion and the assumptions on which it is predicated appear quite formidable, there is more to the matter than is in the eye of the beholder—critics. What follows is an attempt to construct the underlying, only partially articulated, rationales that moved the Court's majority to decide the case as it did.

Jones is best understood if it is recognized that: (1) the Court's business is not to assert its own judgment, but only to review the rational basis for the legislative judgment implicit in the statutory provisions at issue;265 and (2) its assessment that the legislation is not unreasonable is grounded on an appreciation of the rougher realities of the law as applied, as opposed to a purist effort to follow legal principle to its ultimate, technical conclusion. The holding permitting truncated processing of insanity acquittees reflects an awareness of the interconnectedness of the many parts and parcels, procedural and substantive, that comprise the insanity defense machinery from the initial plea to final release, and approves a reasonable distribution between the state and the defendant of the various burdens and strategy options that go into making legal decisions at critical points in this protracted process. The decision's underlying balancing calculus is grounded in the specifics of the D.C. law and the particular course of action the law prescribed for the Jones defendant, but it has implications for jurisdictions with similar legislative schemes. The crux of the Court's reasoning seems to be that a defendant who succeeds with a defense of insanity and who at the next legal decision making juncture proceeds to disavow insanity, is not entitled to the same presumptions of innocence (sanity) as a person who does not have this tainted background. The rough inverse of this proposition was established years before by the Court in Lynch v. Overholser,266 which held that the automatic commitment process prescribed by the D.C. Code applied only to defendants who initiated the insanity defense, and could not be used to commit those who had the defense imposed on them. This is the point of departure of Jones. It is what leads the Court to its conclusion that all the other protections of the law accorded to civil populations—the precise

264. See Margulies, supra note 253, at 826 (suggesting such a measure to mitigate harshness of automatic commitment). See also supra notes 76-82 and accompanying text.

265. The argument has been made that the rational basis test is inappropriate for reviewing legislation affecting insanity acquittees, and that the courts should apply strict scrutiny, or at least intermediate scrutiny, because of the possible punitive motive behind the legislation and the status of acquittees as a special class that has historically been subjected and continues to be subjected to social discrimination. See, e.g., Margulies, supra note 253, at 814-15.

266. 369 U.S. 705 (1962).
criteria for committing them, the explicitness of proof required to show that these criteria are met, the safeguards and standards of commitment review procedures (as distinct from release), and the statutorily set limits on the time of confinement—need not equally be applied to insanity acquittees.

Another basic rationale of Jones explicitly articulated by the Court concerns the reduced risk of dispositional error in cases that have gone the insanity defense route. The critical concern in civil commitment, according to the Court, is that a person might be confined for "mere idiosyncratic behavior," behavior that may alarm or anger others but that in and of itself is not indicative of any clinically recognized mental illness or of real dangerousness. It is to forestall the possibility of such errors that the law requires proof that the candidate for civil commitment meets certain specifically defined commitment criteria before authorizing confinement.268 The Court's argument in insanity defense cases is that proof that the acquittee committed a criminal act as a result of mental illness eliminates the risk of commitment for mere idiosyncratic behavior. It has already been noted that this argument requires a bit of a leap from the defendant's strategic decision to plead insanity to the conclusion that the defendant committed the crime, and the further jump that the finding of criminal insanity permits an inference of present mental illness and dangerousness. Persons who identify themselves as patients' advocates or who see their mission as upholding the law's theoretical purity may not appreciate such legal gymnastics, as they would brand them, but the message of Jones is that a court that identifies its role as, among other things, one of upholding the practical workability of the law or the system, will find the justification it needs in the common sense assumptions that can be made from the defendant's substantive assertions and tactical choices that mark the way through the protracted legal machinations that constitute the insanity defense. Critics of Jones have been quick to find latent desires to punish the acquittee in the subconscious of the holding's authors and supporters.269 Additionally, they have attributed to the proponents of automatic commitment of insanity acquittees an undue affinity

267. Jones v. United States, 463 U.S. 354, 367 (1983). Secondary concerns include the possible stigmatization of persons found to be in need of commitment, but the Court dismissed this in a footnote saying that, "A criminal defendant who successfully raises the insanity defense necessarily is stigmatized by the verdict itself, and thus the commitment causes little additional harm in this respect." Id. at 367 n.16. On the other side stands the societal fear of wrongful use of the defense by criminals who wish to avoid punishment and who in the bargain may escape hospital commitment as well. Id. at 364. That concern is a major part of the rationale behind the automatic commitment statutes which the Court found not unreasonable. Id.


for what is known as the "clean-up" doctrine—the readiness to do whatever it takes to keep criminals off the streets. Such ad hominem attacks fail to acknowledge, however, that the operative calculus in Jones proceeds from a broader and more defensible perspective.

B. Other Courts, Other Views

In different jurisdictions, the precise statutory allocation of the burdens of proof and persuasion between the defendant and the state, the strategic options available to each, and the substantive criteria to be met in the course of decision making at various points in the insanity defense process will differ, as will the case precedents and social or legal philosophies guiding the courts in these matters. Thus, Jones-like fact situations in other jurisdictions before other courts need not produce the precise same results as Jones. Nonetheless, the crux of the Jones holding that insanity acquittees are a distinct class, not necessarily entitled to the same protections as civil commitment candidates or populations of related legal status, will have major effects on the state and federal courts’ subsequent assessment of the statutory law in this area.

1. The requirement of a special hearing

Three major court cases suggest the impact Jones may have on the basic issue of "how much process is due" to acquittees when the state decides whether they should be committed. Chronologically, the first of the three cases is People v. McQuillan, decided by the Michigan Supreme Court before Jones. The defendant, McQuillan, was tried on charges of assault with intent to rape and indecent liberties with a minor and was found not guilty by reason of insanity. He was committed automatically to the state department of mental health and subsequently confined in Ionia State Hospital. Two years later, through the office of the state appellate defender, he filed a motion in the original trial court to vacate the commitment order. Relying on the Specht-Baxstrom line of cases, the trial judge ruled that Michigan's automatic commitment statute was constitutionally deficient. The judge then conducted a hearing that accorded the requisite procedural protections and focused on the substantively proper issue of the defendant's present sanity. Pursuant to this proceeding, the defendant was found sane and ordered discharged from the department of mental health. The state appealed, but the Michigan Supreme Court upheld the judgment below in its essential parts. The McQuillan court found that automatic commitment of insanity acquittees was permissible for a limited time for purposes of observation and examination, but that the statute should be constitutionally

270. Note, Commitment Following an Insanity Acquittal, supra note 269, at 617.
272. See supra notes 244 & 245.
construed to imply the requirement of a subsequent full hearing on the acquittee's present condition, complete with all the essential due process safeguards accorded to civil populations. The court then gave the prosecution twenty days to initiate commitment proceedings against the defendant on the terms prescribed in the civil court.

The McQuillan result was in part based on the fact that, unlike the law in the District of Columbia, the burden of persuasion on the issue of insanity is on the state, which must prove the defendant sane. An acquittal, as the McQuillan court emphasized, thus establishes only that "the People failed to prove beyond a reasonable doubt that the defendant was competent at the time he committed the crime." A presumption of continuing insanity from the acquittal verdict is particularly difficult to justify, the court added, "where there has never been a finding of insanity." Even so, McQuillan's prescription of automatic but limited observational detention followed by a mandatory full inquiry into the need for longer term commitment seemed both to reflect and secure the general direction in which the laws of the states were moving. A Georgia case, Benham v. Edwards, decided nine years after McQuillan and only a year before Jones, seemed to clinch this assessment.

In Benham, the United States Court of Appeals for the Fifth Circuit struck down parts of Georgia's insanity defense procedures and prescribed new ones closely resembling the McQuillan procedures, despite the fact that the state's existing dispositional provisions accorded greater protection to the acquittee than Michigan's and the criminal trial findings provided better evidence of the defendant's insanity. Under the laws of Georgia then in force, an insanity acquittal meant that the trial court had made an affirmative finding by a preponderance of the evidence that the defendant was mentally incapacitated at the time of the crime. Following such a finding, the trial court retained jurisdiction over the insanity acquittee and would proceed to inquire into his present mental state. Based upon a showing of good cause, the court could then order the acquittee confined in a mental hospital for not less than thirty days. This was essentially indefinite commitment, as the law did not require the state to initiate a hearing to determine the need for continued commitment after the thirty days, but left it up to the acquittee or the hospital to bring a petition for release. On the basis of these provisions and their prior interpretation, the court concluded that the Georgia commitment scheme for insanity acquittees in effect raised a conclusive presumption of continuing insanity not applied in civil procedures, in violation of the equal protection and due process clauses of the federal Constitution.

274. MICH. COMP. LAWS ANN. § 768.20a (Supp. 1986) in the current statutes. See generally J. Braakel, J. Parry & B. Weiner, supra note 2, at 769-77 (Table 12.5, column 9).
276. Id.
277. 678 F.2d 511 (5th Cir. 1982).
It went on to hold that the state, after the expiration of the thirty day evaluation period, must initiate a full-fledged commitment hearing for all insanity acquittees and carry the burden of establishing by clear and convincing evidence that the acquittee meets the criteria for civil commitment.

It is against the background of cases such as *McQuillan* and *Benham* that the effect of *Jones* on a Wisconsin case, *State v. Field*, must be measured. In *Field*, the Supreme Court of Wisconsin relied expressly on *Jones*, and reaffirmed the constitutionality of the state's automatic commitment statute that in 1974 had been held unconstitutional in *State ex rel. Kovach v. Schubert*. Despite *Kovach*, the automatic commitment law was still on the books, as the Wisconsin legislature had never acted to repeal or modify its provisions. The defendant in *Field* had been committed following what was essentially a trifurcated criminal trial. During the first phase of the trial he was found guilty of murder; during the second phase he was adjudged not guilty by reason of mental disease; and, during the third phase he was found presently mentally ill and dangerous to others. In this last phase, the state produced no new evidence but relied solely on the evidence produced in the first two phases. The defense appealed on the basis that reversible error had occurred when the trial court ordered commitment in the absence of new evidence probative of present mental condition. On the basis of *Jones*, however, the Wisconsin Supreme Court overruled its earlier *Kovach* decision and held that the defendant's commitment could "stand regardless of any error that might have occurred during the third phase of the trial because ... a third phase ... is not constitutionally required." 

It is possible to distinguish *Field* from *McQuillan* and *Benham* by the fact that the defendant's crime and his insanity were conclusively proved via Wisconsin's bifurcated trial process, whereas they had to be inferred with greater or lesser indirection from the original proceedings in Michigan and Georgia. But the explicit reliance on *Jones* by the Wisconsin court, and the reversal of its own *McQuillan-Benham*-type holding in *Kovach*, undercut the significance of that distinction rather decisively. Instead, the lesson from *Field* is both more and less than that. It establishes the proposition that automatic commitment of insanity acquittees is permissible regardless of the length of the legal leap that must be taken from the criminal trial's prior findings to the prerequisites for present disposition.

2. The special evaluation

Litigation on the conduct of special mental evaluations for insanity acquittees has centered on the issues of their legal necessity, on whose initiative or authority they are conducted, their duration, who should do them, and the use of the results. The questions put before the courts have been not

278. 118 Wis. 2d 269, 347 N.W.2d 365 (1984).
279. 64 Wis. 2d 612, 219 N.W.2d 341 (1974).
merely questions of statutory interpretation, but more often than not, requests for the courts to fill in the gaps in the states’ statutory laws. The courts have responded with considerable activism, in some cases engaging in statutory construction in its broadest sense, that is, constructing a statute where there was none.

As seen in the discussion in the previous section, some courts have not hesitated to read into the statutes the constitutionally permissible requirement of a brief commitment for purposes of observation and evaluation where there is no reference to this concept (McQuillan), or to convert statutory authorizations for essentially indefinite commitment into more limited evaluatory commitments bounded by judicially drawn time frames (Benham). Generally, the special diagnostic problems and the public safety concerns posed by the acquittee population have furnished the rationale for these ventures in judicial law making, while at the same time rendering them impervious to constitutional challenge on due process or equal protection grounds (McQuillan). In terms of any specific case, good cause or some similar formulation has been the legal rubric supporting the acquittee’s commitment for purposes of evaluation.281

Where the statutes empower particular agencies or persons other than the court to move for the acquittee’s temporary confinement for evaluation, the question has arisen whether these powers are exclusive. In line with the case law involving other situations where the issue of the defendant’s mental condition may intrude, such as the question of the defendant’s competency to stand trial,282 the answer has been that the statutes do not preclude the court from ordering the evaluation of an acquittee on its own motion.283

Indeed, the general thrust and tenor of cases like McQuillan would suggest that the court has an obligation to see to it that an insanity acquittee, whose mental condition is by virtue of the original trial and verdict at issue, receives a proper mental diagnosis. Jones, of course, repudiated that suggestion when it held in essence that the acquittee’s mental condition can be viewed as decided by the verdict.

The courts have shown a willingness to set specific evaluation periods in states where the statutes are silent on the issue, at least for the interim between the decision and the legislature’s next opportunity to act. The judicially set time frames approximate those in jurisdictions where the legislature has spoken.284

Similarly, where the issue has been litigated, the courts have followed the legislative pattern of requiring that the evaluations be performed by mental

283. See, e.g., In re Lewis, 403 A.2d 1115 (Del. 1979).
health professionals. The *McQuillan* court reasoned that requiring a special hearing would be meaningless unless trained medical experts had a reasonable opportunity to observe and examine the acquittee and to report on their findings.\(^{285}\) More recent case law suggests more particularized entitlements for the acquittee. In *Ohio v. Thomas*,\(^ {286}\) the court spoke of the right to independent, court provided examiners, while an arguable extension of the logic of *Ake v. Oklahoma*,\(^{287}\) a death penalty case, would require courts to furnish examiners who will "assist in evaluation, preparation, and presentation" of the acquittee's side of the case.

Finally, it has been held that court ordered examinations to assess the acquittee's committability do not violate the right against self-incrimination because the proceedings are deemed to be civil in nature rather than criminal.\(^ {288}\) The psychiatric assessment is essential to the commitment decision and it seeks no information and draws no conclusions that would lead to criminal prosecution.

3. The commitment criteria and their proof

Under the automatic commitment statutes sustained in *Jones*, the allegations regarding the crime and the defendant's mental state as proven at the criminal trial or, better perhaps, the indications regarding present committability that can be inferred from them, are the criteria used to authorize confinement of the acquittee. In jurisdictions having special procedures for committing insanity acquittees, the criteria and burdens allocated for proving them are distinct from those operating at the criminal trial. *Benham* and *McQuillan*, the main cases in this area, prescribed commitment prerequisites that were identical or substantially similar to those governing civil commitment procedures. Typically, the state must prove dangerousness and mental illness by clear and convincing evidence. This is, at least, the general picture.

More particular questions of statutory or constitutional interpretation on these issues have also been litigated. In *Harris v. Ballone*,\(^ {289}\) a case involving the constitutionality of Virginia's statutory scheme for committing insanity acquittees, the court upheld the legislative judgment that a showing that the acquittee is insane *or* dangerous suffices as the predicate for commitment, even though the state's civil commitment criteria required proof of insanity *and* dangerousness. Since there had been two separate findings by a panel of experts that the acquittee was not insane, his commitment was based solely on his dangerousness, which was proved by a standard equivalent to preponderance of the evidence, the trial court being "satisfied" by the panel's


\(^{289}\) 681 F.2d 225 (4th Cir. 1982).
finding to this effect. The decision is problematic in a way that goes beyond the questions traditionally raised about present committability assumptions drawn from the criminal verdict. The *Harris* court held rather too blithely "that it is not a denial of due process for a person who has committed a criminal act to be incarcerated as long as he is considered dangerous."290 However, one whose laborious defense strategy has been to remain unconvicted cannot be incarcerated. An acquittee may be hospitalized, as the defendant was in this case, but that disposition requires at the very least an assumption regarding insanity, an assumption that in general can be made from the criminal verdict with about as much (or as little) justification as the assumption of dangerousness, but that was specifically contradicted in the case at hand. In short, *Harris* is the sort of case where the decision makers may have had strong common sense reasons for assuring that the acquittee be kept off the streets, but where the law, and the law as applied to the facts, furnished only the weakest grounds for achieving this end.

The facts of the case allowed the *Harris* court to avoid the question of whether or not insanity, rather than dangerousness alone, is a sufficient standard for committing an acquittee. In *State v. Krol*,291 a 1975 decision from New Jersey, the court answered this in the negative, asserting that specific proof of dangerousness to self or others is an essential element for confinement.

Another question that has come before the courts is whether the criteria of danger to self or others includes danger to property. In 1984, the Connecticut Supreme Court ruled in the affirmative.292 Additionally, there is language in *Jones* regarding the nonequivalence of violent and dangerous behavior which suggests the same position.293 But other courts, particularly in the civil commitment context, have come to the opposite conclusion.294

Finally, in *Illinois v. Sanchez*,295 the court held that the state statute framing the acquittee's committability in terms of "need of mental health services on an inpatient basis," coupled with the provisos that he can "reasonably be expected to inflict physical harm upon himself or others" and be found to "benefit from inpatient care," delineated sufficient grounds for commitment even though the court failed to make explicit reference to "mental illness." The main lesson from this case may be that in the mental health field big legal battles are sometimes waged on the most trivial of points.

4. *Procedural rights at the commitment hearing*

The extent to which the *Jones* decision will affect the procedural rights and safeguards accorded to insanity acquittees in the commitment process

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290. *Id.* at 228.
can only be inferred from the opinion because those rights were not at issue in the case. Pre-Jones cases, involving insanity acquittees as well as decisions on other groups of mentally disabled offenders, generally speak of according, at a minimum, substantially similar protections to those available in any proceeding, civil or criminal, where a substantial deprivation of the defendant's liberty is possible.296 These details were litigated in the Georgia insanity case of Clark v. State.297 The court's holding enumerated the following procedural entitlements: notice of the right to a hearing; notice of the right to counsel and appointed counsel in case of indigency; the right to confront and cross-examine witnesses and to offer evidence; the right to subpoena any physician on whose evaluation the decision may rest; notice of the right to be examined by a physician of one's own choosing at one's own expense; and the right to have appointed a representative or guardian ad litem. This comprehensive list, of course, would be limited to states where automatic commitment of acquittees or commitment by so called truncated process is not the norm.

The acquittee's right to counsel at the commitment proceedings has come under particular judicial attention in the last few years.298 The right to legal assistance after commitment has also been tested. Contrary to their usual posture, but in line with their argument for determinate confinements, advocates for the acquittees have again resorted to the criminal process analogy and borrowed from the rights of the convicted and imprisoned. Thus, in Ward v. Kort,299 the court extended the legal assistance precedents pertaining to prisoners to patients at Colorado State Hospital who had been found not guilty by reason of insanity. The fact that Kort in turn has been successfully used to expand the legal access rights of civil patients300 illustrates the circuitous paths along which legal developments are sometimes routed.

5. Confinement rights and restraints

There exists an elaborate body of both statutory and case law regarding the treatment and treatment related rights of institutionalized patients, as well as their right to refuse treatment under certain circumstances.301 There are also statutes and cases delineating the institution's right to treat and restrain patients, as well as restraints on the hospital's authority in these

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regards. The applicability of this law to insanity acquittees has been litigated in a number of discrete instances. Many aspects of the question remain to be answered.

In general, the rights of insanity acquittees vis-a-vis the authority of the institution are fewer and less potent than those possessed by civil patients. In Coley v. Clinton, for example, an Arkansas case decided in 1979, and one of the small number focusing specifically on insanity acquittees, the court held that members of this institutionalized population could be subjected to more restraints than civilly committed patients in order to provide for the physical safety of the other patients, the hospital staff, and the community. Sometimes insanity acquittees will gain certain rights and privileges only after the state has obtained judicial approval, while other patients gain the same rights by unchecked administrative decisions. Thus, in Commonwealth v. Killelea, the court affirmed the statutory proposition that once an acquittee is committed, the restrictions placed on his movement may not be lifted unless a court approved their removal. On the other hand, a court's initiative in imposing restrictions is, at least according to the case of Warner v. State, limited to the issues brought before it by the parties. In Warner, the Supreme Court of Minnesota held that the trial court could not sua sponte prohibit home visits by insanity acquittees confined in state hospitals.

The most recent case law on the right to treatment and the right to refuse it for involuntarily committed civil patients pulls in opposite directions. On the one hand, several major holdings emphasize the patient's autonomy in selecting and refusing the treatments applied, an autonomy that may be abrogated only under special circumstances such as a medical emergency or the patient's formally adjudicated incompetency. On the other side, stands a line of cases that reinforces the primacy of professional judgment on these questions. In reviewing issues of treatment and restraints, courts show considerable deference to decisions made by the treatment provider, the primary focus of the inquiry being not so much whether the judgment exercised was right or reasonable, but whether it was in fact a professional judgment and whether it was made by qualified professionals. While not directly contradictory, there is an obvious tension between cases stressing the patient's decision making autonomy and those supporting the primae facie wisdom of professional judgment. The extent to which either doctrine

302. See generally id. at 251-325.
305. 309 Minn. 333, 244 N.W.2d 640 (1976).
might apply to treatment decisions involving insanity acquittees is uncertain, in light of the absence of litigation specifically directed to this issue. If the law on other issues can be taken as a guide, the special characteristics of the acquittee population point toward diminished decision making rights for both acquittee patients and doctors. The presumed dangerousness of this class suggests a greater societal stake and the need for more judicial supervision over the handling of acquittees during their institutionalization, as well as before and after it.

6. Periodic review

Where the statutory law fails to provide for periodic review of the acquittee’s condition and need for continued confinement, courts have initiated such review. Thus, in 1978, the Florida court in *Hill v. State*,308 imposed on trial courts the obligation to schedule, “in the exercise of sound discretion,” full evidentiary hearings for re-examination of acquittees at reasonably separated intervals or upon the suggestion of the providers of treatment and custody. From a different angle, the court in *Government of the Virgin Islands v. Wallace*309 held that the commitment of an acquittee under a statute that was constitutionally defective for failure to require periodic review was valid, nonetheless, because the court’s commitment order required hospital officials to submit status reports to the court every six months.

7. Release issues: applications, maximum periods

An insanity acquittee may gain release from confinement after expiration of the period set by the court’s order or the time set by statutory law. In addition, the acquittee may, at designated intervals, apply for release prior to the set maximum period of confinement. Some questions, including constitutional ones, have been litigated in connection with each avenue of release.

Once the maximum period of confinement has expired, release is not automatic. The acquittee is at that point entitled, however, to a full hearing on whether or not there is a need for further confinement. The 1979 D.C. Circuit decision of *Waite v. Jacobs*310 stands for the proposition that the Constitution requires that the acquittee at this point be treated like any other civil commitment candidate. Though somewhat fuzzy on the issue—complications involving changes in the law obscure the precise point—the Illinois case of *Lee v. Pavkovic*311 seems to reject the constitutional rationale for such equal treatment of insanity acquittees, but ultimately arrives at the same result out of “considerations of fairness and substantial justice.”

309. 679 F.2d 1066 (3d Cir. 1982).
310. 475 F.2d 392 (D.C. Cir. 1979).
Although the court in *Benham v. Edwards* states that equal protection principles entitled insanity acquittees to make release applications in the interim between initial confinement and expiration of the set term with the same frequency as civil patients, the thrust of the *Jones* case is to undercut the requirement of equal treatment at this juncture. Also, the state statutory law governing acquittees generally contains separate release application provisions from those governing civil patients. The case law other than *Benham* that exists on the matter, appears to condone the differences.

### 8. Judicial approval of release

The release of civilly committed patients is generally accomplished by administrative decision alone. The statutory law governing the release of insanity acquittees, on the other hand, requires a judicial decision, or at least, judicial approval of the administrative determination. This requirement has been challenged in the courts on equal protection grounds. Uniformly, the courts have held that this special treatment of insanity acquittees is constitutionally permissible.

The court in *Hill v. State* and *Benham* addressed a couple of subissues. In *Hill*, the court elaborated on the relevance of administrative decisions, asserting that if administrative proceedings are held on the acquittee's release, the court should consider their outcomes and include them in the record. In *Benham*, an equal protection argument was made on behalf of acquittees charged with crimes indicating dangerousness. Under the laws of Georgia, their release required judicial approval, whereas the release of other acquittees and civil patients did not. The court upheld the constitutionality of this class distinction.

### 9. Release criteria, requisite evidence, and proof

Courts have had to interpret statutory requirements for obtaining the authorized release of an insanity acquittee and have had to make new law where the legislature has not acted, at least not with sufficient specificity or clarity.

Although the law on commitment of acquittees is in accord on the need to show an acquittee's mental impairment in addition to proving dangerousness, the law on release is split on whether dangerousness alone is sufficient grounds to keep an acquittee institutionalized. Two cases, *State v.*

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312. 678 F.2d 511 (5th Cir. 1982).
313. Harris v. Ballone, 681 F.2d 225 (4th Cir. 1982).
316. 678 F.2d 511, 536-39 (5th Cir. 1982).
Grebarsky and Hill v. State, suggest that mental disability does not enter into the determination, and that continued commitment of an insanity acquittee is authorized solely on proof of continued dangerousness to self or others. The Hill decision reasoned that the acquittee’s mental impairment was an invalid criterion for determining release so long as the state failed to take reasonable steps to monitor or assure the acquittee’s recovery. Most courts have come to the opposite conclusion. In In re Torsney, for example, the court stated that it is constitutionally suspect to keep acquittees confined on the vague concept of dangerousness unrelated to mental impairment and for which no inpatient treatment is required (or available, it might have added). The court in State v. Olson was even more emphatic and asserted that an acquitted rapist’s tendency toward antisocial behavior would not warrant continued hospitalization if he did not suffer also from a mental disease or defect that caused the behavior. Otherwise, the court argued, the punishment process of the criminal justice system would be adequate to handle his future conduct. In a particular twist on the relevance of the mental impairment criterion, the Walonsky v. Balson case held that an acquittee who was restored to sanity through the use of psychotropic drugs (chemical or synthetic sanity), but whose mental state was dependent on continued use of such drugs, was not sane within the meaning of the statute so as to qualify for release. However, cases where the issue is the defendant’s competency to stand trial, and the dictum of at least one acquittee release case, have reached the opposite conclusion on the legal consequence of drug induced recovery or remission. The ABA Standard appears to be in line with the latter position in that it proposes that an acquitted whose sanity is a direct result of the treatment be required to continue such treatment as a condition of his release. Generally, the case law supports the proposition that the acquittee carries the burden of proving readiness for release. One of the few cases out of line with this position is Benham v. Edwards, where the court held that as a matter of due process and equal protection, a state could not place the burden of proving the release criteria on acquittees while simultaneously

318. 90 Wis. 2d 754, 280 N.W.2d 672 (1979).
320. Id. at 211.
326. ABA STANDARDS, supra note 9, § 7-7.4(d).
327. Dorsey v. Solomon, 604 F.2d 271 (4th Cir. 1979); In re Franklin, 7 Cal. 3d 126, 496 P.2d 465, 101 Cal. Rptr. 553 (1972); Clark v. State, 245 Ga. 629, 266 S.E.2d 466 (1980). For statutes, see supra note 165.
328. 678 F.2d 511 (5th Cir. 1982).
providing that the government carry the burden in opposing the release of civil patients. The courts agree that the standard of proof for the acquittee's release should not be the beyond a reasonable doubt formulation, but the lesser burdens of clear and convincing evidence or simple preponderance of the evidence. The type of evidence that is appropriate, and the weight accorded to it, are also issues that have been litigated. Medical opinion, while relevant to the question of an insanity acquittee's release, is not necessarily dispositive. In *Application of Noel*, for example, the court held that commitment and release decisions are legal decisions rather than medical ones. As such, even undisputed medical opinion is not conclusive upon the trial court, but must be weighed with other evidence, such as past conduct and the nature and seriousness of the crime with which the acquittee was charged. Other cases such as *Hill v. State* have extolled the importance of lay testimony on the acquittee's condition and prospects as potentially more weighty and accurate than expert medical opinion on these matters. However, in *Warner v. State*, a decision that is at least out of tune with, if not directly contrary to *Noel* and *Hill*, the court held that it was not at liberty to substitute its nonprofessional judgment regarding prognosis for that of medically trained witnesses who present a different view.

10. Conditional release issues

The court's authority to grant a conditional release is essentially a matter of discretion, whereas the decision on absolute discharge is at least in theory nondiscretionary; when the criteria for discharge are met, the court must order release, although there is some play, and thus discretion, in deciding whether the criteria are met. Proof that an acquittee can be safely released if certain conditions are imposed does not fall within the realm of legal conclusions that mandate a single, specific legal response. In other words, it does not generate a requirement that the court must then order the release and impose the conditions. However, there may be limits on this discretion. For example, the appellate court in *State v. Collins*, while conceding the trial court's discretion in the matter, held that the trial court did not have unbridled power to disregard uncontested evidence that the acquittee could have been safely released on supervised probation. The trial court's order

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333. 309 Minn. 333, 339, 244 N.W.2d 640, 644 (1976).
335. 381 So. 2d 449 (La. 1980).
to continue the acquittee’s institutionalization in the face of this evidence, therefore, was vacated.

Restrictions on the type and duration of conditions courts may impose on acquittees also exist. In *Hill v. State*, the court affirmed the trial court’s power to consider and order conditional release in appropriate cases, adding that it might in some instances be the best means available to secure evidence of the acquittee’s eligibility for outright release. However, the *Hill* court warned that conditional release may not be employed to extend indefinitely the trial court’s hold on acquittees who are ready for absolute release. The *Zion v. Xanthopolous* case sustained the trial court’s power to require as a release condition that the acquittee accept psychiatric outpatient care with supervision, and added that for the purpose of keeping himself properly informed, the trial judge should require regular reports to the court appointed probation officer from the treating psychiatrist and the acquittee herself. At the same time, however, *Xanthopolous* held improper the imposition on acquittees of terms designed to regulate the activities of convicted criminals, such as probation or parole terms. Reasoning that they were punitive in nature (an arguable proposition), the court invalidated the conditions that prohibited the acquittee from changing her address without approval of the parole officer and that required compliance with the existing rules and regulations of the Department of Institutions’ Parole Division.

Revocation proceedings have also come under the scrutiny of appellate courts. That release can be revoked or conditions modified on the mere prospect, rather than an actual act of violation of the conditions imposed, was affirmed in the Washington case of *State v. Thompson*. The *Thompson* court held that evidence showing that the patient was likely to commit felonious acts jeopardizing public safety in the future was sufficient to support a decision to revoke his conditional release.

Finally, litigation has affirmed the statutory trend toward notification requirements in connection with changes in the acquittee’s status. In *Commonwealth v. Killelea*, for example, the court asserted that the hospital officials must notify the judge and district attorney having jurisdiction over the criminal case if the acquittee’s discharge is contemplated. In addition, the court said that the district attorney must be apprised of any hearing relating to a person committed under court order so as to be able to represent the public interest at all such proceedings. In *In re Anderson*, the court affirmed as a matter of due process the acquittee’s right to written notice of the charges and evidence, and the right to a hearing when revocation is sought.

III. THE PROGRAMS

In three states, Illinois, Maryland, and Oregon, there exist special programs for the post-verdict handling of insanity acquittees that merit close scrutiny from the legal and psychiatric research communities as well as from law enforcement personnel, legislative actors and advocates, and other public policy makers. What makes these programs deserving of such close and concerted attention is that they are well established, working programs with a history of experience that is sufficiently long to begin to test the impact on their targeted populations. Less important is the precise shape of the law in these three states. The programs are not that closely keyed to the laws, and some of their main features are not specifically mandated by the law. In addition, the persons responsible for administering the programs, as well those who deal with the nitty-gritty of providing the treatment and other services, tend not to think in terms of the law’s finer points, nor are they even all that familiar with them. The broad outlines of the modern special acquitted laws are what matter, and in each of the three states include: (1) provisions emphasizing the option of outpatient treatment immediately after the verdict or following institutionalization; (2) special evaluation, review, and monitoring procedures to assure decision making based on better information than has traditionally been available at the commitment, discharge, and post-discharge stages; (3) judicial authority (or as its substitute, special authority of a centralized board) over discharge and post-discharge decisions that traditionally have been solely within the province of local administrative discretion; and (4) provisions emphasizing the option of conditional discharge, including procedures that can lead to a swift revocation or modification of the conditions when the circumstances call for it. Again, it is the systematic implementation of these major features of the law that make the Illinois, Maryland, and Oregon programs uniquely worth examining for their possible workability in other states, regardless of the smaller statutory differences that may exist. A brief sketch of the key historical, legal, and operational features of the three programs follows.

A. The Maryland Program

Having enacted special legislation regarding the disposition of insanity acquittedees as far back as 1967, Maryland appears to have taken the lead in this field. While there have been some changes in the law and programmatic operations over the years, the essence of the system has remained fairly constant. It works as follows. After a verdict of acquittal by reason of insanity (“not criminally responsible” in today’s statutory lexicon), the court by law must immediately commit the acquittedee to the department of mental

health for the purpose of inpatient care or treatment. A recently enacted exception permits the court to instead release the acquittee with or without conditions, if it has before it a mental evaluation conducted within ninety days preceding the verdict and indicating that it would be safe and proper to do so. The State's Attorney must agree. This is presently not an exception of much practical importance, nor is it likely to be. In the large majority of cases, the court orders inpatient treatment.

Care and treatment for acquittees is provided at Perkins State Hospital in Jessup, Maryland, the one facility in the state handling such cases. Although not prescribed in the statutes, the treatment regimen at Perkins accords progressively greater measures of freedom and responsibility until the patient is ready for discharge. What is prescribed is that the gradually increasing privileges given to the acquittee, as well as other changes in status, must be reported to the State's Attorney and recorded in a central computerized file for each committed acquittee. There are various procedures for effecting the acquittee's discharge. The first opportunity comes by way of a hearing before a hearing officer within fifty days after the acquittee's commitment. The hearing officer's report and recommendation are subject to judicial review in a full hearing, unless waived by the party adversely affected. Release may be absolute or conditional. If the acquittee remains institutionalized, he may apply for release via standard administrative or judicial discharge proceedings no earlier than a year after the initial mandatory hearing. Again, the options at this point are continued commitment, conditional discharge, or absolute discharge. Both in concept and practice, the crux of the legislative scheme is centered in the provision authorizing the hospital authorities to apply "at any time" for the patient's conditional release, the classic requirement being outpatient treatment for a period of up to five years. Such mandatory outpatient treatment assignments, which must be approved by the court and communicated to the State's Attorney, coupled with special provisions for revoking the release or changing its conditions (with similar judicial and prosecutorial involvement), permit the hospital authorities to closely monitor and control the acquittee's readjustment to life in the free community via supervision implemented in a half-way house in Baltimore. All along the acquittee's route toward reintegration into the community, the public's safety interest is thus represented by the possibility of prosecutorial intervention and the judicial check on administrative decisions.

As in virtually all jurisdictions, the number of insanity acquittees in Maryland is small. This hampers research on the critical questions regarding program success. The most recent figures, made public in a 1984 study, counted only ninety-one individuals discharged from the program over the last nine years. Indeed, the number of insanity acquittees is small nationally, a fact that stands in contrast to the preponderant philosophic signif-

343. See supra note 1.
icance of the insanity defense in the administration of criminal justice and in the literature on the criminal justice process.

B. The Illinois Program

Illinois adopted legislation similar to Maryland's in 1978. A defendant found not guilty by reason of insanity must undergo an evaluation by the Department of Mental Health and Developmental Disabilities. In proper instances this may be conducted on an outpatient basis. If found to be subject to involuntary admission or in need of mental health services, the defendant is placed in a secure facility, unless the court finds compelling reasons that such security is not necessary. Once confined, the Illinois acquittee's legal rights and liabilities attendant to release and post-release life—its possible conditions, including continued treatment requirements, the possible revocation or modification of these conditions, notification, reporting, and other monitoring requirements—are sufficiently similar to those of a Maryland acquittee so that a separate description is unnecessary.

In Illinois's acquittee program, the central functions pertaining to post-release outpatient treatment and monitoring are performed by staff of the Isaac Ray Center, a psychiatric services branch of the Rush-Presbyterian-St. Luke's Medical Center in Chicago. The Isaac Ray Center provides mental health services not only to persons acquitted by reason of insanity, but also to mentally disordered offenders of various other legal statuses. All patients seen at the Center are there by court order that, among other things, requires them to follow the rules and regulations of the Center or be subject to court imposed sanctions. Each patient is given an initial evaluation to determine general suitability for treatment and, specifically, the likelihood of benefit from the program, including need for medication or specialized treatment for drug or alcohol problems. If accepted into the Center's program, the patient is assigned to a primary therapist. During the early course of treatment, most patients come in for treatment at least once a week. Roughly 60% of the patients, on the average, are on psychotropic medications prescribed by the Center's psychiatric staff.

Unlike Maryland's, the Illinois acquittee program does not operate its own half-way house. Instead, the patients are scattered in various community based living situations. The movement and behavior of the patients are, however, closely monitored. In the course of treatment, Isaac Ray staff usually maintain an ongoing consulting relationship with the patient's family and attorney, the committing judge, and the probation officer. If there are signals that a patient's mental state is deteriorating, or if there is evidence of a violation of release conditions, the staff has the power to intervene immediately, including the authority to move for recommitment.

345. The information on the Illinois program in this paragraph was supplied to the author directly by the Isaac Ray staff.
A small acquittee population characterizes Illinois as it does Maryland, with similar consequences for quantitatively meaningful research on this population. The research problems in Illinois are further exacerbated by the fact that the Isaac Ray program is selective since not all, nor even a random portion, of the state’s acquittees receive its ministrations. A study published in 1985\textsuperscript{346} on the improvement and adjustment of Isaac Ray’s acquittee population measured success rates on these items for forty-four acquittees, reported to be “approximately 85 percent of all NGRI acquittees discharged into the community [at that time] in the Cook County area, as estimated by the state director of forensic services.” More will be said about the nature and effects of this selectivity in the next section.

C. The Oregon Program

Oregon also enacted special insanity acquittee legislation in 1978.\textsuperscript{347} Its primary distinguishing feature is the creation of what is called the Psychiatric Security Review Board (PSRB), which consists of a lawyer, a psychiatrist, a psychologist, a parole or probation expert, and a member of the general public. It is independent of both the court and the state’s mental health department. Subsequent to an insanity acquittal (“guilty except for insanity” is the phraseology devised by the Oregon legislature to send a message of assurance to the public and warning to any potentially manipulative defendant), the trial judge decides whether the acquittee continues to be mentally ill and dangerous. If yes, the judge places the acquittee under the jurisdiction of the PSRB, which then assumes sole authority over the acquittee’s fate. The PSRB decides whether and when to institutionalize or release the acquittee. It may impose a wide range of conditions authorized by the law. PSRB jurisdiction expires absolutely at the termination of the maximum criminal sentence that could have been exacted had there been a full conviction. Outpatient treatment mandated as a condition of release may be provided at any of a number of treatment clinics throughout the state. Together with modification and summary revocation procedures, the latter permittingrehospitalization without a full PSRB hearing for twenty days, the outpatient treatment option lies at the heart of the Oregon system for managing its acquittee population.

In many respects then, the Oregon scheme resembles the schemes prescribed in the statutes of Maryland and Illinois, except that the oversight and monitoring responsibilities of the court and the mental health department have been delegated to a special administrative review board. This is no minor innovation conceptually. Whether it has major practical impact can only be determined by the empirical data. A large amount of data has already been developed and analyzed in Oregon, the state of the research

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there being considerably farther advanced than it is in the other two model jurisdictions. Apart from its range, another advantage of the empirical information already available in Oregon is that it is based on significantly larger population samples than is the case in Maryland and Illinois. Because of higher commitment rates and better tracking procedures in Oregon, some of the analyses involve as many as 630 acquittees.  

IV. PRESENT FINDINGS AND FUTURE RESEARCH

An examination of the available data and findings on the programs is useful for two reasons: (1) it tells us what is known about the post-verdict treatment of insanity acquittees; and (2) it tells us what is not known, and what the gaps or flaws are in the available information and how we might go about remedying these deficiencies. It is best to do this examination state by state, as each experience yields its own unique set of findings and limitations on these findings.

Before going into this state-by-state examination, it would help to spell out with precision what the objectives of the programs are and thus what the aims (or hypotheses, if you will) of the existing studies or any future research on the subject should be. This is particularly important in view of the fact that the aims of both the programs, and the prior studies in general, have not been very clearly articulated. Articulated or not, there is an implicit assumption in each of the programs, and in the laws that stand behind and guide their operation, that insanity acquittees who come within their ambit

will do appreciably better than untreated acquittees, who have not had the benefit of the post-hospital treatment and monitoring that constitutes the essence of the special programs. Improvement is expected in the following respects: (1) incidence of criminal recidivism; (2) psychological and community functioning; and (3) economics of treatment and rehabilitation.

Ultimately, there is an elemental logic in the assumption that programs combining sustained treatment, monitoring, and recommitment capabilities over insanity acquittees will accomplish certain public safety and rehabilitative objectives that are foregone when nothing sustained or systematic is done after the verdict. The point of research, however, is to prove this assumption and to ask at what costs the accomplishments come. Only then will it be possible to determine whether these programs are worthwhile, efficient, and effective compared to other or no approaches, and whether they are worthy of replication in other jurisdictions, and perhaps of application to other offender populations.

A. Results of the Maryland Program

There have been two studies of the Maryland program. One is unpublished and will not be reviewed here, although some of its findings appear in the published study. The published work by Spodak, Silver and Wright is concerned strictly with criminal recidivism or, as the authors put it, with "the arrests, convictions, and incarcerations of a large cohort of insanity acquittees in Maryland over a fifteen-year period after discharge from the hospital." An elucidation of one of the three prime measures of success of the program would have been quite valuable. The study, however, contains a number of methodological and analytical shortcomings that limit its usefulness.

One of the problems is that the precise composition of the study's cohort never becomes clear. It totals eighty-six persons, hardly a large group. In fact, the article contains at least three different descriptions of the group's make-up. In the opening page, the targeted population is given as the "men adjudicated NGBRI of violent offenses." A few pages later it is "virtually all men who are adjudicated NGBRI after felony charges in Maryland." Three pages further, the cohort is defined as "all the men found NGBRI in connection with felony charges in Maryland between mid-1967 and mid-1976." The authors fail to provide a consistent description, much less an

350. See Spodak, Silver & Wright, supra note 342.
351. Id. at 373.
352. Actually, the cohort contained ninety-one patients, but "no data was discoverable in reference to five patients." Id. at 375.
353. Id. at 373.
354. Id. at 375.
355. Id. at 378.
explanation, of this selectivity in the program. As a result, we do not learn with any degree of precision how the program population differs from the general criminal population or from all other insanity acquitees. Such information, however, is absolutely crucial to the ability to make comparative statements about criminal recidivism and program success. Different criminal populations have different recidivism rates. To the extent that we are kept in the dark about the precise characteristics of the population studied, we do not know what level of recidivism to expect, we cannot account for the background differences so as to enable us to make valid comparisons among comparable populations which is a problem in any event given the small total numbers, and we cannot ascribe differences in the actual recidivism rates to the ministrations of the program.

Even if we put aside this basic methodological problem, there are other difficulties with the findings presented by the study and the conclusions drawn from these findings. Perhaps in recognition of the precarious validity of the external comparisons made, the study pins a good portion of its hope for meaning on internal comparisons and on a presentation of facts and figures that presumably speak for themselves. For example, the article seeks to derive much of its mileage from the finding that the "entire cohort shows substantially fewer arrests as well as other indicators of criminality, such as charges and convictions than are reported prior to the original admission."356 However, absent a comparison with untreated or unmonitored acquitees, there is no support for the implication that this is a measure of program success.357 The decreased rates could be a result of institutionalization, rather than the post-institutional treatment that is the essence of the program. Alternatively, it could simply be the aging of the acquitees, a factor associated with a reduction of criminal propensities of offender populations in general.

As for the other results reported, much of their meaning depends on what one likes to see, and thus, prefers to emphasize. One of the main findings is that forty-eight of the eighty-six acquitees (56%) were arrested at least once during the five to fifteen years subsequent to their discharge.358 To put this in context, the study makes a general reference to research done by Pasewark, Pantle and Steadman showing "comparability of outcome between exconvicts and exacquittees."359 Not only is the relevance of this finding

356. Id. at 375.
357. The implication is made explicit in the final pages of the paper:
[The acquitees] were arrested 2.5 times less frequently after their insanity acquittal as a group, and in 44 percent of cases their arrest rate became zero. It is likely this experience is a direct result not only of their hospital treatment but also of the five-year conditional release program described herein and possibly the halfway house program . . . .

Id. at 380.
358. Id. at 375.
359. Id. at 380 (citing Pasewark, Pantle & Steadman, Detention and Rearrest Rates of Persons Found Not Guilty by Reason of Insanity and Convicted Felons, 139 AM. J. PSYCHIATRY 892 (1982)).
unclear, but the actual figures in the latter study—24% rearrests for the acquittees and 27% for the convicted felons—hardly shed a favorable light on the performance of the Maryland program.

In the absolute, a rearrest rate of over 50% is not supportive of claims of program success. To the general public, and perhaps to the conscientious policy maker as well, this information is likely to come across as clear evidence of this population's continuing dangerousness. The study attempts to minimize this message by emphasizing that of the forty-eight acquittees arrested, only twenty-six were ultimately convicted and only eleven reincarcerated, and that in most cases "the subsequent convictions were for less serious offenses with less potential for physical harm than the original offense resulting in insanity acquittal." It then goes on to conclude that "insanity acquittees as a group do not present a substantial danger to public safety when discharged from the hospital" and that "a five-year frame for supervised aftercare appears to cover the period of greatest risk for criminal recidivism in this population." This conclusion is seriously undercut, if not belied, by the study's own data showing that as much as 41% of the recidivism occurred after the first five years, 39% during years six to ten, and 2% between the eleventh and fifteenth years.

Much as one would like these acquittee programs to be successful, the problem with the Maryland study is that it has not mustered the evidence to support a positive conclusion. It presents no comparative information that would enable us to trace the results to the program itself. Indeed, the absolute figures that suggest to the study's authors that the acquittees pose no substantial safety risks may suggest to the general public exactly the opposite. Subjective evaluations are of course not susceptible to proof. The mission of objective research, however, is to furnish facts that have the power to influence subjective opinion, while the task of the responsible, if inevitably subjective, researcher is to order and interpret the facts in a way that maximizes their impact on public opinion. So far the work done on the Maryland program falls short in both regards.

B. Results of the Illinois Program

The Illinois study, by Cavanaugh and Wasyliw, focuses primarily on the psychological improvements of insanity acquittees who have gone through

360. Also the number of persons in the Pasewark study is thirty-seven acquittees and the same number of convicted felons, which is so small as to make percentage comparisons close to meaningless.


362. Spodak, Silver & Wright, supra note 342, at 376.

363. Id. at 382.

364. Id. at 377 (graph).

365. See Cavanaugh & Wasyliw, supra note 346.
the program, though it also contains some impressionistic evidence and a conclusion on criminal recidivism. The sampling problems of the research, as in the case of the Maryland study, are quite serious. The cohort here is a mere forty-four acquittees whose post-discharge progress was followed for only two years. The small size of the sample renders a discriminating analysis virtually impossible. In addition, two years of relative freedom for acquittees is insufficient time to make reliable measurements on recidivism, which other studies have shown to peak in later years, and presumably, it is also too short to assess psychological functioning.

Whether the sample is representative either of other offender populations or other insanity acquittees is problematic and makes it extremely hazardous to generalize findings from the study. As mentioned earlier, this study covered "approximately 85% of the acquittees discharged into the community in the Cook County area." We do know in this case something about the selection process, the requirements for entry into the program, and the characteristics that dictate exclusion. As the researchers report, the acceptance criteria were: (1) presence of a major mental disorder, whether symptomatic or in remission; (2) existence of community supports (family, financial, housing, occupational, etc.); and (3) agreement by the patient as to the requirements of the program, including full understanding of possible legal sanctions for noncompliance. The primary exclusion criteria were: (1) continued need of intensive inpatient care; and (2) a primary diagnosis of antisocial personality or drug abuse disorder. In addition, the study reports that a full 80% of the acquittee subjects in the sample were charged with murder or attempted murder. Whether this was a result of the selection process is not clarified. On the one hand, this clearly makes the sample unrepresentative as compared to other acquittee populations, let alone the general offender population. This has fundamental implications regarding the recidivism potential and other predictors of behavior of treated acquittees versus those of any random sample of untreated acquittees or offenders. On the other hand, once we know the bias as to criminal charge in the sample, theoretically we can control for it in any comparisons we attempt. Whether this was practically feasible is a matter of speculation and the study did not control for this bias.

What the study did do is present in some detail the results of a series of standardized tests of psychological and community functioning administered to the acquittees in the program. These showed general, statistically significant improvements over time for most subjects. The absence of data on an untreated control group makes it impossible to trace the improvements to the program. While it may be reasonable to assume a connection, such an
assumption is no substitute for data in combatting counter-assumptions, such as the assumption that passage of time is the primary explanation in the case of reductions in criminal recidivism rates generally.

The study also reports the happy fact that during its two years "no arrests for violent crime or other crimes against persons occurred." This finding is contrasted with "existing studies of NGRI acquittees discharged into the community, but not followed on an outpatient basis, which have shown rearrests for the first three years following discharge, ranging from 15 to 37 percent." In reality, the work cited for these findings reports on five different studies following radically varying acquittee populations for periods ranging from two to seven years whose recidivism rates varied from 5% to 65%, results that demonstrate the primitive stage of research in this area, but not much else. Finally, the Illinois experience showed a 25% rehospitalization rate for those in the program, and program success in terms of limiting confinement is thus ambiguous.

The study concludes that "a carefully administered and closely supervised outpatient treatment program for NGRI patients may be a viable and preferable alternative either to prolonged institutionalization or to unconditional, unsupervised discharge." One can hardly disagree with this. Unfortunately, it remains essentially an article of faith. The study does not provide convincing proof. No policy maker charged with the responsibility of deciding whether scarce public funds should be allocated to the initiation or perpetuation of a program of this kind could afford to base a decision on such slim and impeachable evidence.

C. Results of the Oregon Program

As mentioned, the Oregon program has been studied more extensively than either the Illinois or Maryland experience. All of the Oregon studies have been done by the team of Bloom and Rogers, and one or two additional researchers. If there is a drawback to this sustained team effort, it is that both Bloom and Rogers have had continuing direct professional involvements with the general evaluation and disposition of Oregon's insanity acquittees and with the workings of the PSRB in particular. It may be argued, however, that what is lost in objectivity may be offset by the benefits of the researchers' intimate acquaintance with the system. This inside knowledge gives them a very large advantage over outside researchers who must educate themselves, may never fully learn about the system's finer points, and may spend so much time and energy in learning the operational basics that the ultimate analysis of the program results does not get its due. Also, the major

370. Id. at 411.
371. Id. at 413 (citing Pasewark, Insanity Plea: A Review of the Research Literature, 9 J. PSYCHIATRY & LAW 357 (1981)).
372. Cavanaugh & Wasyliw, supra note 346, at 415.
373. See supra note 348 for citations to the studies.
advantages that flow from a continuous research effort, as opposed to sporadic forays by different researchers, are not to be minimized.

The Bloom and Rogers studies\(^7\) have addressed a series of issues, some more directly on point than others to the focus of this paper. They present data and analysis on the defendants' success in using the insanity defense, including how many raise it and are found not responsible (since changed to "guilty except for insanity"), what the trial proceedings are like in successful cases, whether lack of capacity to appreciate criminality or the alternative prong, to conform conduct to the law, is responsible for the results, and the role of juries in the process. Of more direct concern here are a second series of findings concerning acquittees. These findings include: how many are placed under PSRB jurisdiction; what kinds of crimes they committed; how many are conditionally released and when; how many are not released and where they are placed; the diagnostic profile of those under PSRB jurisdiction; how many conditionally released acquittees commit new crimes; how many of the absolutely released (and not under PSRB jurisdiction) recidivate; how many PSRB acquittees escape from the hospital; the average time acquittees spend under PSRB jurisdiction; how often release conditions are revoked; and the costs of the program.

Despite the development of this considerable and valuable body of data, it nonetheless falls short of comparative, generalizable meaning in a number of critical respects. The information is not the kind that would permit confident policy making about the general post-verdict treatment of insanity acquittees. Some of this is due to the particularity of the Oregon program, some is due to the data's limits, and the rest is attributable to the paucity of comparative information from other jurisdictions. Through no fault of those who administer or have studied the Oregon program, the relevance of its results suffers from the unavailability of a solid frame of reference. The remainder of this section concentrates on the specifics that make this so.

One of the outstanding characteristics of Oregon's acquittee population is the relatively low percentage who have committed the most serious of offenses, such as murder and attempted murder which are crimes that constitute far larger, sometimes predominant, proportions of acquittee populations in other jurisdictions. It also includes a substantial number of comparatively nonserious offenders, including misdemeanants, who would in many other states be wholly absent. The proportion of Oregon acquittees under PSRB jurisdiction charged with murder and attempted murder is 10%, and it is only 5% when those acquitted prior to formation of the PSRB, but post-facto included, are dropped from the count.\(^7\) One will recall that the proportion of such offenders in Illinois was 80%\(^3\) This enormous

\(^7\) The discussion in the next few pages draws primarily from Oregon's New Insanity Defense System, supra note 348.

\(^3\) Id. at 8 & Table 3 app.

\(^3\) Cavanaugh & Wasyliw, supra note 346. See also J. Brakel, J. Parry & B. Weiner,
difference renders impossible any gross comparison of recidivism rates and other critical indicators of program efficacy between Oregon and Illinois, or for that matter between Oregon and any other more typical state. It may be possible to reanalyze the data by selecting offenders by type of crime, but among the difficulties one then runs into is that the numbers become too small to permit meaningful, discriminating conclusions. Similar problems with gross and more selective comparisons are caused by imbalances at the nonserious end of the crime scale because some 25% of the Oregon acquittees are misdemeanants, whereas in other states the proportion of such offenders ranges from small fractions to none.

The studies report that during the five years between the inception of the PSRB process and the conclusion of the research, 295 of the total of 630 acquittees (47%) were granted conditional release. A good portion of the research focuses on how this population fared in the community. One finding is that thirty-nine (13%) were charged with new crimes. The prior crimes of these recidivists are presented, but no information is made available on how long they were out on release, which is a critical omission if the object is to compare the rate with that of other released acquittee populations. Of the total charged with new crimes, twenty-one (7%) were charged with misdemeanors, eighteen (6%) with felonies, fifteen (5%) were convicted, fourteen (5%) had their charges dismissed, and five (1.7%) again were found not responsible (NGRI). An additional fifteen acquittees under PSRB jurisdiction, but not out on release, were charged with crimes, and ten of these were felonies. Of this group, nine were so called unauthorized absences (walk-outs, escapes), three committed the crime while in the hospital, two were out on temporary passes, and one was on parole. Unauthorized absences are a program problem irrespective of whether they lead to new crimes. Reports that "until recently almost every month a number of people escaped by walking away, though usually not from the maximum security wards" indicate that the Oregon approach is no foolproof remedy for this problem.

supra note 2, at 708 n.190. The note cites a variety of studies from different jurisdictions giving type-of-crime statistics for insanity acquittees. A murder/attempted murder rate of around 50% seems to approximate the norm (assuming any norms can be inferred from such few and methodologically disparate pieces of research). A recent summary article by Steadman, Insanity Defense Research and Treatment of Insanity Acquittees, 3 BEHAV. SCI. & LAW 37, 39 (1985), confirms this pattern for Michigan and New York, with murder/attempted murder rates of 57% and 51% for their insanity acquittees respectively, but also shows that in some other states, serious offenses do not dominate as much, e.g., murder rates (not including attempts) of 28%, 26%, and 5% in the acquittee populations of Connecticut, New Jersey, and Missouri respectively.

377. Oregon's New Insanity Defense System, supra note 348, at 7 & Table 4.
378. Id. at 12.
379. Id.
380. Id.
381. Id. at 13.
382. Id.
Another critical gap in the data is that no systematic information has been collected on the 313 of the 630 acquittees who were given a full discharge from the hospital and the PSRB during the period covered by the study. Recidivism and other rates on this group could provide a very useful context for assessing the meaning of the results for the conditionally released acquittees. As it is, all one is given is that there were eight suicides among the full discharges within the period covered and two more within a year after this period, a disconcerting fact, but one whose comparative significance remains unknown.

Information on the number of revocations of release remains incomplete, despite the fact that the studies' authors presumably perceive it as critical to their discussion of "how effective the community treatment programs are." The reports assert that "initial indicators are that a high percentage of those on conditional release are revoked by the PSRB but that few of those revocations result from new criminal charges." The authors then conclude that "[t]his suggests that the conditional release program is working effectively to monitor and intervene promptly so as to prevent recidivism." These are somewhat puzzling observations for a number of reasons. Presumably, every acquittee charged with a new crime is revoked. Moreover, the 13% so charged is not a negligible proportion per se. Nor is it negligible in comparison to recidivism rates cited in other studies for other criminal offender populations. Nor, in the absence of internal program comparisons that might have been possible, does it appear that the authors are justified in reaching this positive conclusion. As in the case of the Illinois and Maryland studies, the good news from Oregon remains in the realm of assertions of faith, beliefs that one may share or hope to be able to prove, but that so far remain unproved.

Cost data presented by the Oregon studies are rough, but of considerable interest. They would be even more valuable if similar data were available for the other acquittee programs and for confined and unconfined acquittee populations not monitored by such special programs. There are two separable overt cost components budgeted for the Oregon program: the costs of operating the PSRB (fees, per diem reimbursements, office space, and clinical assistance for the Board members), which come to $145,000 per year; and the costs of community treatment for the acquittees, which are $323,500 annually. The latter figure is reported to cover regular treatment services for some sixty to sixty-five acquittees at $3100 per client, plus another sixteen especially troublesome clients in intensive slots at unspecified increased costs.

383. Id. at 14.
384. Id. at 15.
385. Id. at 16.
386. Id.
387. Id. at 17.
388. See supra note 371 and accompanying text.
Of course, missing from these computations are a number of other cost factors that have not been, but might well be, counted as among the economies or diseconomies of the program. Criminal justice processing costs for the recidivist acquittees and rehospitalization costs for those who do not make it psychiatrically once released are two of the more obvious factors, although difficult to assess with precision.

D. Future Research

The directions for future research are to a large extent implied in the exposition and critiques of the research done so far. A brief discussion, much of it in the nature of a recapitulation, will suffice.

1. Characteristics of the acquittee populations studied

A major obstacle to the conduct of valid, generalizable research on the special acquittee programs is the selectivity of the population that comes within each program's ambit. The characteristics of the treated acquittees vary from program to program, as well as from untreated acquittee populations and from nonacquittee offenders with recognized mental problems. This precludes gross comparisons of the effects of the programs upon the behavior of the various populations. Any future research should carefully delineate the selection criteria of the programs and spell out their effect on the critical characteristics of the subject population. Once this is done, it may be possible to group the subjects in such a way as to permit comparisons. The size of the populations studied must be large enough to permit statistically significant analysis. Given the relatively small numbers of persons who annually enter or leave the programs, it is probably necessary to extend the study to several years of operation. The full effects, if any, of the programs are not measurable until several years after the acquittees have been discharged.

2. The meaning of the results

Agreement on the primary criteria for measuring the efficacy of the programs does not automatically guarantee agreement on the meaning of the findings. Even if the comparability problem has been solved, there will remain fundamental problems about the proper interpretation of the psychological, recidivism, and cost results.

It must be recognized at the outset that as a practical matter, data on the psychological improvement or community adjustment of treated acquittees will not suffice to persuade policy makers to support special acquittee programs. Among the reasons are that subject recidivism and program costs, the two other prime criteria on program efficacy, are given overriding importance. This priority assessment is no doubt partly based on the notion that hard information (dollar costs and numbers of arrests, charges, or convictions) is the best predicate for making hard policy decisions. There is also the complementary view that the specific types of psychological data
developed in research on the programs are not sufficiently reliable. Finally, many policy makers share a more general skepticism about the psychiatric disciplines, which moves them to discount the weight of even the firmer findings. The result is that even with definitive evidence that the programs could produce measurable psychological benefits for the subjects treated, the political support will not be forthcoming unless these benefits are matched by corresponding reductions in the subjects' recidivism and the assurance that the benefits can be achieved at politically affordable costs.

Interpreting changes in the criminal recidivism rates is subject to a number of caveats. Though elementary, the error of comparing different measures of recidivism (e.g., arrests or charges versus convictions) has not always been avoided in the prior studies. Occasionally the problem has been compounded by the researchers' disregard for how long the acquitees have been out in the community. Plenty of difficulties remain once these variables are properly accounted for. Must length of institutionalization prior to release be considered? Should the research take account of varying release conditions? Once full release is achieved, must the subjects be dropped from the cohort for purposes of research? Do they comprise a separate cohort against which the conduct of the conditionally released subjects can profitably be measured? Also, the researcher should at all times keep in mind that criminal charges, convictions, and even arrest rates are only imperfect measures of the actual incidence of recidivist conduct.

There are other interpretive pitfalls into which researchers have stumbled. A major one is the notion that there is agreement on the significance of the rates in the absolute. Academics often write glowingly that only 15% to 25% of a given monitored population has gone back to crime. It is unlikely that the general public or publicly accountable decision makers share this interpretive bias. In the public's estimation, 15% to 25% may be way too high and an indication that the programs are not succeeding, that release conditions are too lax, or that release is premature. These interpretive biases may be difficult to resolve, but the researcher should at least show an appreciation of their existence. Subjective conclusions about recidivism written from the pristine perspective where any rate less than 100% is hailed as a positive accomplishment are not salable to the public and ultimately detract from the credibility of findings for which there is firm, objective support.

Findings that criminal activity among a particular treated population is reduced relative to that population's behavior prior to treatment, either quantitatively or in the level of seriousness of the crimes, should be approached with the greatest caution. Such reductions are universal among offender populations and in large measure are attributable to the mere passage of time, in other words, the aging of the subjects, whether institutionalized, treated, or not. If not insurmountable, the difficulty of separating possible treatment effects from the general impact of time passed inside or

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390. See supra note 361 and accompanying text.
outside an institution may make it inefficient to even try. It would, among other things, involve a strictly controlled comparison procedure with an untreated group, which once set up may render the before-and-after analysis inessential. The more fruitful procedure then would be the simpler and more direct focus on the after-treatment results, only as between the treated and untreated groups. It is in this comparison that the pay-off of research lies. If it is possible to do it properly, despite all the real-world contaminations that hinder the effort, then the research results deserve serious attention from those who have the power to make or break the treatment programs in question.

Recidivism is sometimes also measured in the numbers of revocations or rehospitalizations among the treated subjects. While such information is qualitatively useful to describe program intervention patterns and procedures, it is unwise to try to interpret it quantitatively for the purpose of making direct statements, or even mere suggestions, about program success. On the one hand, the programs aim to maximize interventions in the effort to prevent regression to crime or psychiatric breakdown. From that perspective, revocations and rehospitalizations are a positive indicator of program performance, or at least not the negative measure they might be in the unprogrammed world. On the other hand, there comes a point where the interventions are so frequent that one might be forced to conclude either that the program is not working in terms of improving the subjects' conduct or else that it infringes unnecessarily on the already limited freedoms of its clients.

Finally, there are interpretive uncertainties regarding the costs of the programs. For comparative purposes in particular, it is crucial to determine precisely the goals of the programs. In the prior studies this has not been done. Is it strictly post-hospital treatment and monitoring we are concerned with or are we also counting the effects and costs of institutionalization? Is the average time of institutionalization at all shortened by the availability of systematic community control and care, or are we dealing with supervision arrangements and costs that are entirely supplementary to institutionalization norms for acquittees? Figures have been thrown around to the effect that the cost per patient of the programs is "only" $3000-4000 annually, but to assess the significance of these estimates we must first have the answers to the questions above. In addition, there are more remote costs that must be considered: criminal justice processing and possibly incarceration costs for those acquittees who return to crime; revocation process and institutional

391. Steadman, supra note 376, at 44-45, notes that the average length of institutionalization for insanity acquittees in Oregon is 363 days versus 670 days for New York's acquittees, suggesting that the emphasis on outpatient care in Oregon cuts into the time acquittees are hospitalized. He concedes, however, that the comparison is flawed, as New York's acquittees are charged with far more serious crimes. The true comparison, absent other intervening changes, would be of Oregon acquittees before and after initiation of the PSRB's operations. The data for this comparison are not presently available.
care costs for those who need to be rehospitalized; and the costs of special monitoring services and personnel, such as those incurred to support the workings of Oregon's PSRB. Some of these costs may be very difficult to pin down with any precision, a problem that is compounded when they are compared to equally elusive costs that are incurred in jurisdictions without systematic post-verdict treatment programs for acquittees. Perhaps only the roughest of projections are possible, but the researchers' obligation is to at least alert policy makers to the existence of these hidden costs.

3. The costs of future research

It is evident that there are major obstacles to the conduct of research that will yield valid, generalizable results upon which policy makers may depend. The contaminating effects of the real world that inhibit meaningful comparisons among established programs, or between the programs and states operating without special programs, are difficult and very costly to overcome. In the case of some critical measurements, they may be impossible to surmount. The variables are many and the numbers in the programs are small. Setting up experimental situations that control for these impediments to research is likely to be correspondingly difficult and costly, if not unethical.

Not only are the numbers of acquittees in the special programs small, but the total offenders of such legal status is comparatively insignificant nationally. For example, a recent study shows that in 1978, only some 1,625 offenders were committed to mental institutions throughout the country. The small total size of the acquittee population may present an obstacle of a different dimension: it may make the methodologically intricate and costly research that is necessary for the production of valid results unfundable. Even while conceding the major symbolic and philosophic importance of the law's treatment of defendants who raise and succeed with the insanity defense, those who control the research grants may conclude that money is better spent on the study of law and institutions involving larger numbers of persons.

If the requisite financial support for a major, definitive research project on the post-verdict treatment of insanity acquittees is not forthcoming, there remain a number of second-choice alternatives: (1) it is both possible and worthwhile to further analyze the data available so far on the special acquittee programs, including perhaps a more careful and limited comparison with data on untreated populations; (2) additional research on the programs is presently in progress under the direction of those who did the earlier work and it deserves the research community's continued support and attention and; (3) serious consideration ought to be given to funding discrete and

392. See Steadman, Monahan, Hartstone, Davis & Robbins, supra note 1. The overwhelming majority of acquittees are institutionalized for at least a short period, despite legislation authorizing their immediate release in some circumstances.
relatively inexpensive supplementary research forays by researchers unconnected with the programs' administration and data analyses done so far. The pay-off from such efforts in terms of adding to our knowledge and, no less important, increasing the credibility of the findings is likely to be high. There is a distinct resemblance between such a piecemeal process of adding to, aggregating, and integrating various strands of information on a common subject and the formula by which intellectual and practical progress is achieved in general. Recognizing this is to realize that loss of the ideal research approach—the comprehensive, definitive project—is something less than an unmitigated calamity.