Regular Articles

Monitored Conditional Release of Persons Found Not Guilty by Reason of Insanity

Joseph D. Bloom, M.D., Mary H. Williams, M.S., and Douglas A. Bigelow, Ph.D.

This article reviews the recent literature documenting changes that have taken place in the management and treatment of insanity defense acquitees with the development of conditional release and monitored community treatment. The review demonstrates that conditional release is particularly important as a means of balancing the protection of society with the treatment of insanity defense acquitees in the least restrictive environment. The review also highlights the development of community programs based on treatment models for the chronically mentally ill. In addition, monitored community treatment programs appear cost-effective when compared with hospital-based programs. These factors point to the development in the 1990s of program standards for the release of insanity defense acquitees.


This paper explores 1) the question of the release of persons found not guilty by reason of insanity from hospitals into the community and 2) how this can be achieved on a practical basis while balancing the public policy interests of societal protection and individual rights. The dilemma posed by the release of insanity defense acquitees was clearly illustrated by State v. Fields in New Jersey:

If at any periodic review proceeding the State is unable to meet its burden of justifying the continuance of the currently prevailing restraints upon the liberty of the patient, it becomes the task of the reviewing judge again to "mold" an appropriate order. . . . The new order should provide for the least restrictive restraints which are found by the judge to be consistent with the well-being of the community and the individual. . . . However, even where the [patient's] condition shows marked improvement, only the most extraordinary case would justify modification in any manner other than by a gradual de-escalation of the restraints upon the [patient's] liberty. (1)

Although it is generally accepted that this balance between protection and liberty must be struck, there is great difficulty in implementing workable procedures that can achieve these goals. In our view, conditional release, which allows insanity defense acquitees to be released from hospitals into monitored community treatment programs, is the most acceptable mechanism for meeting the policy goals described in State v. Fields.

Tensions between protection of the public and least restrictive treatment of the patient are built into all the major law and mental health interactions, from voluntary hospitalization and civil commitment on one end of the continuum to the criminal justice system on the other. Along this continuum, different weights are given to factors related to protection and treatment in least restrictive settings. In voluntary hospitalization, the primary focus is on treatment. In civil commitment, treatment is also the most important focus, although this has been greatly attenuated in the past 20 years with the increasing focus on dangerousness as the major criterion both for hospitalization and release (2, 3). This increased focus on protection of the public has been further emphasized in the legal doctrine of the
duty to protect emanating from the Tarasoff decision (4, 5). In the criminal justice system, protection is even more heavily weighted, and there is less emphasis on treatment concerns (6).

RELEASE PROCEDURES AFTER THE INSANITY DEFENSE

Procedures governing the release of insanity defense acquittees have tended to occupy the middle ground between traditional civil commitment and criminal justice system models. However, over the last three decades, this ground has not been constant, as release procedures first moved closer to the civil commitment model and then, in more recent years, moved toward the criminal justice system model. The major changes in civil commitment statutes in the late 1960s and early 1970s, with their increased focus on individual rights and current dangerousness (7–9), drew insanity defense procedures along with them. In some jurisdictions this resulted in the application of civil commitment standards to the release of insanity defense acquittees.

Prior to the pivotal case of John Hinckley, Jr., in 1982, dissatisfaction with various aspects of the insanity defense was already being expressed (10). This dissatisfaction was exemplified by the adoption of the “guilty but mentally ill” verdict, first implemented in Michigan (11), the alteration of the insanity defense in Montana (12), and the introduction of the Psychiatric Security Review Board in Oregon in 1978 (13).

The Hinckley case (14) dramatically shifted the weight given to protection of the public and drew the management of insanity defense acquittees even closer to the criminal justice model. Three major professional organizations rapidly published position papers calling for restrictions on the insanity defense (15–17 and American Medical Association resolutions 15 and 21, 1983). These reactions to Hinckley led to important changes in federal statutes (18) and statutory changes in many jurisdictions (19, 20). Eight states subsequently adopted the more restrictive option of guilty but mentally ill, bringing the total number of such states to 12 at the end of 1985 (20). In several jurisdictions, a number of other changes occurred in the dispositional provisions for insanity defense acquittees, including the provisions governing length of commitment and release through court proceedings or more traditional civil commitment proceedings (21).

Another important influence on release procedures came from the 1983 U.S. Supreme Court decision in Jones v. U.S. (22), which upheld the right of states to commit a person acquitted by reason of insanity for an indefinite period, as long as the individual remains mentally ill and dangerous.

Now, in the 1990s, public policy has shifted toward protection. However, the legitimate civil liberty interests of insanity defense acquittees need to be recognized and a balance achieved. A system that places too much emphasis on protection of the public runs the risk of unfairly confining an individual beyond the period when confinement is necessary for treatment, a form of “preventive detention” (23) in psychiatric facilities. In addition to the important question of individual rights, inordinately long and potentially unnecessary hospitalization results in substantially higher costs at a time when mental health funds are desperately needed in the public sector (24). On the other hand, insufficient weight given to protection may result in an unrealistic view of the typical insanity defense acquittee’s ability to live independently in the community (25–29) and an underestimation of the danger that the mentally ill may present to society (30).

Between the extremes it seems that concerns about public protection, individual rights, and cost are best handled in a system that is designed to give serious consideration to both protection and liberty. Such an approach would provide the largest gain in public protection together with the largest gain in individual liberty, and at the same time it would provide a significant gain in mental health treatment.

OREGON'S PSYCHIATRIC SECURITY REVIEW BOARD

The following description of the Oregon Psychiatric Security Review Board is presented as an example of a comprehensive program for the management and treatment of persons judged not guilty by reason of insanity. Conceptually similar programs are developing in other jurisdictions.

In the mid-1970s, Oregon reexamined its procedures governing the release of insanity defense acquittees. There was growing public and professional concern that the system placed the public in jeopardy because of premature hospital release and lack of community monitoring of conditionally released patients. After several years of study, the 1977 legislature created the Psychiatric Security Review Board (31) as a means of addressing the concerns regarding the release of insanity defense acquittees.

The board is composed of five part-time members and functions independently of the court system. Once a person is assigned to its jurisdiction, the board assumes sole authority to determine client placement, either in the hospital or on conditional release in the community. The trial court judge determines the maximum length of jurisdiction of the board on the basis of the sentence that the individual might have received had there been a finding of criminal responsibility. We have referred to this as the “insanity sentence” (32). The trial court judge also determines whether the initial placement will be in the forensic hospital or in the community on conditional release.

The board controls placement and movement between hospital and community through procedures that govern conditional release and revocation of conditional release. The board may discharge an individ-
ual before the end of its jurisdiction, but it is required to discharge an individual once the period of jurisdiction elapses.

The Oregon Psychiatric Security Review Board has been especially important in developing the large-scale and systematic use of conditional release and monitored community treatment. The board closely coordinates its activities with the Oregon Mental Health and Developmental Disability Services Division. The division is responsible for providing psychiatric treatment for insanity defense acquitees either in the forensic hospital or on conditional release in the community. Community services are secured by means of contracts between the division and community mental health service providers. Funds are contracted to specific programs for the care of specific individuals—a type of capitated funding system (24).

While developing the conditional release program, the Oregon board nonetheless retains an overall orientation toward protection of the public, and thus it is representative of the direction taken in many jurisdictions. Oregon statutes state, “In determining whether a person should be committed to a state hospital, conditionally released or discharged, the Board shall have as its primary concern the protection of society” (33). In addition to this statutory mandate, the Oregon Supreme Court upheld this legislative priority in a widely reported case, Cain v. Rijken (34).

CONDITIONAL RELEASE

In our opinion, the development of the conditional release of insanity defense acquitees into monitored community treatment programs was a major advance in the 1980s. Conditional release, monitored community treatment, and the availability of workable revocation procedures provide a practical means of addressing the issue of balanced dispositions for insanity defense acquitees. In addition to our work in Oregon (35, 36), there are data from Maryland (37, 38), Illinois (39, 40), California (41, 42), New York (43), Washington, D.C. (44), and a recent review article (45) that support this position.

The availability of conditional release and monitored treatment is extremely important in both a conceptual and a practical way in several critical areas related to the question of hospital release.

1. Prediction of dangerousness. There is no single topic in the interaction between law and mental health issues that has raised more concern than the accuracy of predictions of future dangerousness. The inaccuracy of such predictions was brought forcefully to the attention of behavioral scientists after the Baxstrom decision in 1966 (8, 46). The dominant position in the scientific community now is that a long-term prediction cannot be made with any acceptable degree of accuracy (47–49).

An effective mechanism for conditional release and revocation makes the issue of predicting dangerous behavior less pressing. A treatment system that has limited community options will inevitably be pressed into placing greater weight on the prediction of dangerousness because of the substantial negative consequences of an erroneous release. Given the difficulty in predicting dangerousness, such systems will tend to hospitalize more individuals for longer periods of time. Having an option to use conditional release with supervision and prompt revocation if necessary gives the decision maker more latitude in relation to future dangerousness. This system is designed to compensate for the inaccuracy of predictions of dangerousness, thus reducing their importance.

2. Monitored community treatment program. Another major advance in the 1980s was the development of more focused community treatment programs for the chronically mentally ill. These programs are critically important for insanity defense acquitees, since it appears that a large number of them are chronically ill (25, 50–52). Community programs based on the principles of psychosocial rehabilitation are critical to the treatment of patients with chronic mental illness (28, 29, 53).

The treatment approach to the chronically ill patient is applicable to the chronically ill person acquitted by reason of insanity. For example, in the Oregon system, a conditional release plan spells out the agreement among the Psychiatric Security Review Board, the Mental Health and Developmental Disability Services Division, the community program, and the insanity defense acquittee regarding conditional release. The plan contains provisions for housing, case management, and psychiatric treatment. The case manager also sends progress reports to the board on a monthly basis and if an emergency arises. The conditional release plan may also specify special conditions, such as prohibitions against driving, use of alcohol or drugs, and/or contacts with certain persons. Violation of the release plan can lead to immediate revocation of the conditional release order and the return of the individual to the forensic hospital.

3. Costs of hospitalization. Finally, from another public policy viewpoint, conditional release is a potentially cost-effective means of managing these patients, with their high utilization of resources (24). This is a critical concern, since mental health resources are finite, and hospital care is more expensive than care in the community. If the goals of striking a balance between protection of the public and treatment of the individual in the least restrictive environment can be achieved with an additional benefit of cost savings, then the resulting program should have a great deal of appeal to policy makers. We calculated costs of conditional release and monitored community treatment and compared those costs with those of a hypothetical program lacking that option (24). In our model, conditional release substantially lowered costs; community care was estimated to cost about 14% of the costs of the hospital stays it replaced.
DISCUSSION

We have attempted to define the major changes during the past decade in procedures for release of persons acquitted by reason of insanity. The traditional task of balancing protection of society with the civil liberty interests of insanity defense acquitees remains a continuing challenge. In most jurisdictions, the protection of society has assumed dominance over the acquitees' liberty interests. Although protection of society was emphasized during the 1980s, great strides were made during this period in the treatment of these persons.

The Oregon Psychiatric Security Review Board remains an important national model. Originally cited in a 1983 APA position paper (15) as a potential national model, the board still attracts a high level of interest. In 1985 Connecticut became the second state to implement a psychiatric security review board. In 1989 Utah passed analogous legislation, and such legislation is now pending in Kentucky and Florida. Each of these states has found it worthwhile to consider establishing a centralized body to handle matters involving insanity defense acquitees. This centralization of authority allows the development of policy, expertise, and experience that is not possible to achieve when these decisions are left in the hands of a diverse group of trial court judges.

Beginning in Maryland and Oregon, we have seen the systematic development of structured community care for insanity defense acquitees. Conditional release procedures and monitored community treatment, with the availability of prompt revocation procedures, are the hallmarks of this system. Monitored community treatment allows for the protection of society and at the same time serves the liberty of the insanity defense acquitee by developing treatment in the least restrictive setting. These programs are also cost effective when compared to hospitalization, which is an extremely important point in view of the increasing dilemma of funding mental health services.

In addition, the melding of procedures that allow for monitored community care with a developing treatment technology for chronic mental illness is a significant step forward in the treatment of insanity defense acquitees. Community programs designed to reflect the needs of patients with chronic mental illness control some of the situational factors that might lead to violence, and these programs make the prediction of dangerousness less critical in release decisions. Further, lessons learned from monitored care of this population can inform the developing area of outpatient civil commitment.

The conclusions drawn from the growing body of experience in states with monitored treatment will result in the development of standards for programs for the care of insanity defense acquitees. Most state forensic systems still concentrate resources on inpatient services. According to the evidence marshaled for this paper, such systems inadequately address the legitimate civil liberty interests of a large number of insanity defense acquitees who could be safely treated in monitored community treatment programs. Many states will have to work to meet the standards that are currently being developed.

REFERENCES

18. 18 United States Code, Section 22.
MONITORED CONDITIONAL RELEASE

33. Oregon Revised Statutes, Section 161.336 (10) (1977)
34. Cain v Rijken, 74 Or App 76, 700 P 2d 1061 (1985); Cain v Rijken, 300 Or 706, 717 P 2d 140 (1986)