The Insanity Sentence: Oregon's Psychiatric Security Review Board

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In response to the dilemma of management of mentally ill persons who commit crimes, Oregon has created the Psychiatric Security Review Board (PSRB) to administrate the supervision and treatment of insanity acquittees. This paper presents an overview of the PSRB structure and examines the quasi-criminal justice features of Oregon's Insanity Sentence. The primary goal of the PSRB is the protection of society. The maximum sentence, had the individual been found guilty, becomes the PSRB's jurisdictional period for that former defendant. A review of the administrative rules for conditional release and revocation of release that the PSRB is now in the process of adopting are described. The authors conclude that the PSRB is a promising approach which offers better community protection and better treatment for mentally ill offenders (NGRIs) than does the present prison parole system.

We believe that neither the law, the public, psychiatry, nor the victims of violence have been well served by the general approach and reform of the last ten years, which has obscured the quasi-criminal nature of the insanity defense and of the status of insanity acquittees.

In this respect, the American Psychiatric Association is impressed with a model program presently in operation in the State of Oregon under the aegis

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of a Psychiatric Security Review Board. In Oregon a multidisciplinary board is given jurisdiction over insanity acquittees. The board retains control of the insanity acquittee for a period of time as long as the criminal sentence that might have been awarded were the person to have been found guilty of the act. Confinement and release decisions for acquittees are made by an experienced body that is not naive about the nature of violent behavior committed by mental patients and that allows a quasi-criminal approach for managing such persons.

*American Psychiatric Association Statement on the Insanity Defense*¹

**INTRODUCTION**

For decades society has struggled to fashion appropriate legal, medical and moral responses to mentally ill persons who commit crimes. A fundamental issue is whether mentally ill offenders should be regarded primarily as patients or as criminals. As the prevailing opinions in this "mad or bad" debate fluctuate over time, the societal mechanisms for handling mentally ill offenders are modified accordingly.

All jurisdictions in the United States have established several legal processes for mentally ill offenders. The most specialized of these is the insanity defense. In most states a successful insanity defense leads to a follow-up mechanism which combines elements of the other two common processes for handling mentally ill offenders, namely, civil commitment and criminal conviction.

Civil commitment focuses on the presence of mental illness. Some persons undergoing civil commitment have committed acts which could have led to criminal charges. However, because of the exercise of discretion by relatives, mental health professionals, police, prosecutors, and others the individual is processed civilly rather than criminally. If those encountering the individual focus their concern on the harmful acts rather than the mental illness, the subject will likely be prosecuted criminally. Thus both civil commitment and criminal prosecution are utilized to handle mentally ill offenders, although the criminal system also processes defendants who are not mentally ill, and civil commitment processes mentally ill persons who have committed no crime.

The insanity defense can be regarded as a separate system located on a spectrum between civil commitment and criminal conviction. Insanity defense systems handle exclusively those individuals who are both charged with crimes and thought to be mentally ill. Thus it is the only one of the three mechanisms which is designed specifically for mentally ill offenders. As such, it most clearly mirrors the "mad or bad" debate, and is affected by swings in public and professional opinion.

During the 1960's and 1970's many states modified their post-insanity defense systems so they more closely resembled civil commitment. At its extreme, this trend resulted in equating a successful insanity defense with a not guilty verdict.

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with no subsequent sanctions other than a hearing with criteria and procedures substantially similar to civil commitment.\(^2\)

This movement began falling into disrepute by the late 1970’s and was officially decried by the American Psychiatric Association in its 1984 position statement on the insanity defense quoted previously. The reversal reflected growing public and professional belief that the pendulum had swung too far towards treatment rather than punishment. Accordingly, by the late 1970’s, states began modifying their mechanisms for mentally ill offenders so as to re-emphasize the quasi-criminal aspects of such processes.

Some states followed Michigan’s lead\(^3\) and created a new verdict, “guilty but mentally ill,” which was added to existing criminal systems. This verdict gives a jury or judge a way to proclaim that while a particular defendant should be punished as a criminal, he or she is mentally ill and should also be given psychiatric treatment. Other states have narrowed the standard for legal insanity so as to decrease the number of defendants eligible to successfully plead insanity. Especially popular since the Hinckley case are recommendations to eliminate the so-called volitional prong of the ALI test,\(^4\) shift the burden of proof to defendants, or abolish the insanity defense.\(^5\) These changes are designed to decrease the number of insanity acquittees. If successful, the result will be a shifting of mentally ill offenders from the insanity defense system into the criminal system. This is a reversal of the practice during the previous two decades when many insanity defense reforms aimed at transferring mentally ill offenders into the civil system.

In 1978 Oregon revised its insanity defense mechanisms in a way consistent with the emerging trend towards criminalization of mentally ill offenders. Yet, Oregon’s approach was different in that it was not designed to narrow the insanity defense. Oregon retained its existing, and typical, trial procedures and ALI insanity defense test. The legislature created an innovative mechanism for supervising and treating defendants who were successful with their insanity defense.\(^6\) The cornerstone of that mechanism is the Psychiatric Security Review Board (PSRB).

The PSRB has received national attention as a potentially viable solution to the dilemma of how to preserve the medical, moral, and legal values of the insanity defense, while simultaneously honoring the growing contemporary consensus that security measures should be substantially improved for insanity acquittees. The insanity defense remains intact. However, the consequences of a successful insanity plea are dramatically different from all other defenses. Defenses such as self-defense or alibi result in not guilty verdicts with no subsequent official sanctions or supervision. Partial defenses such as diminished capacity result in criminal

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\(^3\) Michigan Comp. Laws Annotated 768.36(1) et.seq., enacted in Public Act 1980 of 1975.


\(^5\) See, e.g., Idaho Code 18-207(a), enacted in s. 1396, 46th Idaho Legislature, 2d reg. sess. 1982.

sentences, albeit for less serious crimes than originally charged. The Oregon insanity defense results in a period of supervision and treatment which, while neither part of the criminal nor civil commitment system, has much in common with both. In effect, Oregon's insanity defense results in an "'insanity sentence.'"

We have reported a series of empirical studies of Oregon's system. First, we presented an overview of characteristics of those placed under PSRB during its first three years of operation. We then examined in detail several subjects of particular interest: PSRB conditional release decisions, the ways in which the characteristics and courses of women supervised by PSRB differ from men, the trial process leading to insanity acquittal, and contacts with police of discharged PSRB assignees.

In this paper we present a review of the PSRB structure and then examine the quasi-criminal features of Oregon's insanity sentence. In addition to describing those aspects, which have drawn attention to Oregon's system, we will discuss briefly some of the troublesome questions presented by the Oregon system. Are its quasi-criminal features constitutional? Are they consistent with effective treatment? Are they sound public policy or a futile attempt to combine psychiatric treatment, criminal sanctions, and public protection?

OVERVIEW OF THE PSRB

We have described the basic features of Oregon's system in several articles. We now briefly review that system. The Psychiatric Security Review Board, whose only function is to manage insanity acquittees, began operation on January 1, 1978. The PSRB is composed of five members appointed by the Governor to four-year terms. The statute requires the members to be: (1) a lawyer with substantial criminal trial experience, (2) a psychiatrist experienced in the criminal justice system, (3) a licensed psychologist experienced in the criminal justice system, (4) a parole or probation expert, and (5) a member of the general public. The PSRB is independent of the court system and of the Oregon Mental Health Divi-

sion; neither the psychiatrist nor the psychologist member can otherwise be a full-
time employee of the Mental Health Division or a community mental health pro-
gram. The attorney member cannot be a district attorney, deputy district attorney 
or public defender. The members receive per diem and expenses for their meetings 
which are usually conducted during one-half day each week, most often at the 
Oregon State Hospital in Salem. The Board has an attorney as executive director 
and two additional full-time staff. The Board members themselves are part-time, 
each pursuing their own occupation in addition to their PSRB work.

After an insanity verdict is rendered at trial, the judge decides whether the de-
fendant continues to be affected by a mental disease or defect and presents a sub-
stantial danger to others. If so, the judge places the person under the jurisdiction 
of the PSRB, which then assumes sole authority to determine whether the person 
should be hospitalized in a secure state facility, released into a community with 
conditions, or discharged from PSRB jurisdiction. The judge has no further au-
thority over those placed with the PSRB. Unless discharged first, the person re-
 mains under the jurisdiction of the PSRB until the expiration of a period of time 
equal to the maximum sentence he or she could have received if found guilty. 

Approximately 95 persons per year are placed under PSRB jurisdiction. This 
appears to be a much higher per capita rate than in most states. Thus, although 
Oregon has a small population (approximately 2.6 million), it has to manage a 
sizeable population of insanity acquittees.

The statutes provide substantial procedural safeguards for individuals under 
PSRB jurisdiction. These include the rights to periodic hearings, to be present at 
hearings, to have counsel appointed, to cross-examine, to subpoena witnesses, to 
obtain free independent professional evaluation prior to hearings, and to appeal 
PSRB decisions to the Oregon appellate courts. In addition, as discussed herein, 
the PSRB seeks to provide effective, individualized psychiatric treatment and so-
cial services to each person under its jurisdiction.

Nonetheless, the primary goal of the PSRB, as directed by statute, is the "pro-
tection of society." This concern for public security is reflected in many aspects 
of the system. For example, the PSRB must retain jurisdiction over those individu-
als whose mental illness and resulting dangerousness is in remission, if there is 
a reasonable medical probability that the disease may occasionally become active 
and render the person a danger to others. This statutory section attempts to deal 
with medication induced remission, which results in termination of supervision in 
many other states' post-insanity defense systems.

The fundamental mechanism for protecting society is PSRB's conditional re-
lease program. When an insanity acquittee is hospitalized, the PSRB conducts 
periodic hearings to determine, among other things, whether the person has be-

come sufficiently stable to allow release into the community. Even if ready for conditional release, a person cannot be released by the PSRB until there is a plan developed to provide the supervision and treatment needed by that individual in the community.\(^2^2\) The Oregon legislature appropriates money specifically designated for the State Mental Health Division to contract for a range of mental health services for insanity acquittees. Using this money, the major Oregon counties have created programs designed to provide needed treatment and supervision for insanity acquittees. In the past these clients, who by definition are considered potentially dangerous, have been particularly problematic for community mental health agencies. However, the staffs of PSRB supervised release programs accept from the outset that they will be playing a monitoring and reporting role. There is a frank recognition that PSRB is, just as its name implies, primarily concerned with providing security from dangerous psychiatric patients. This helps to diminish the confusion and frustration experienced by many mental health professionals when they work in the criminal justice system and struggle with ambiguous dual loyalties to the patient and to the system.

The attention to security is reflected in the procedure for prompt revocation of conditional release if a patient violates the condition of release or if the patient’s mental health deteriorates.\(^2^3\) The summary nature of the initial revocation process raises constitutional questions which will be addressed herein. This revocation process is parallel to, but much less cumbersome than, the revocation of parole for criminal offenders. In subsequent sections of this article we look more closely at certain features affecting PSRB’s ability to protect the public.

**VERDICT NAME AS SYMBOL**

The trend of the past decade leading to Oregon’s adoption of a quasi-criminal model is reflected in the evolution of the label applied to the insanity verdict. Although the name changes did not result from the creation of new types of verdicts—such as guilty but mentally ill in certain other states—the present name symbolizes the nature of the PSRB system. Therefore, we pause to consider names before moving to a discussion of the substantive aspects of PSRB security mechanisms.

In 1978, the same year PSRB was created, Oregon abandoned the traditional label of “not guilty by reason of insanity,” and adopted the term “not responsible.”\(^2^4\) The following six years saw growing public confusion about labeling a person “not guilty” or even “not responsible” for a criminal act they had obviously committed.

In response to these concerns in the post-Hinckley furor, Oregon’s 1983 leg-

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\(^{2^2}\) Oregon Revised Statutes, sec. 161.336(1).
\(^{2^3}\) Oregon Revised Statutes, sec. 161.336(5).
The legislature again reviewed the name of the verdict. After a debate which engendered more heat than any of the substantive changes being proposed, the legislature adopted a new name—"guilty except for insanity." Oregon is the first state to adopt this terminology.

The new verdict name is easily confused with the "guilty but mentally ill" verdict in which defendants are convicted. By contrast, a defendant found "guilty except for insanity" in Oregon is acquitted of the crime. They are guilty in all respects except for their insanity which prevents conviction.

The new term accurately describes the insanity defense process as set forth in Oregon statutes. Before the question of insanity need arise, the evidence must prove criminal conduct consisting of an act and one of four culpable mental states: "intentionally," "knowingly," "recklessly," or with "criminal negligence." If the prosecution proves act and culpable mental state, the defendant is guilty, unless he or she successfully raises an affirmative defense. For instance, if a defendant successfully pleads entrapment he is not guilty even though he did the act charged with the charged mental state. Another affirmative defense is insanity.

The defendant must prove by a preponderance of the evidence that he meets Oregon's insanity test. If so, then the defendant is found "guilty except for insanity." Thus, the name emphasizes the often misunderstood fact pointed out by the U.S. Supreme Court in Jones v. U.S.: "A verdict of not guilty by reason of insanity establishes ... the defendant committed an act that constitutes a criminal offense ..." The new terminology should aid public understanding of the insanity defense system. It makes common sense, for example, that a person who intentionally shot another could be found guilty in all regards except for insanity.

Although the impetus for the change was largely political, the new terminology may have collateral effects. First, the new verdict name may be more acceptable to jurors. Second, the new name will remind both defense attorneys and prosecutors that the state has to prove both act and mens rea before there is any need to consider an insanity defense. If a person's mental disease or defect resulted in their lacking the culpable mental state which is a necessary part of any criminal conduct, the person should be found not guilty or at least guilty of only a lesser included offense rather than "guilty except for insanity." Third, some mental health professionals assert that labeling defendants "not responsible" interferes with their treatment and therapy, during which therapists try to teach patients to take responsibility for their own actions. Abandoning the previously used verdict name may lessen any such problem. Finally, the new name emphasizes the quasi-criminal nature of the insanity system as it presently exists in Oregon. We turn now to an examination of several of its features.

LENGTH OF INSANITY SENTENCE

When the trial judge places a defendant under the jurisdiction of the PSRB, the judge must make a finding as to the maximum sentence the person could have received had the person been found guilty rather than guilty except for insanity. That length of hypothetical maximum sentence then becomes the length of the PSRB jurisdictional period for that defendant.29

For example, a defendant found "guilty except for insanity" of assault in the first degree would be placed under the PSRB for 20 years, since Assault I carries a maximum possible sentence of 20 years imprisonment. After 20 years under PSRB, the defendant would be automatically discharged even if he or she remained dangerous and mentally ill. This provision, of course, has its greatest impact with those found legally insane of minor felonies or misdemeanors. They are automatically discharged after only months or a few years of PSRB supervision. This is no different than the automatic release from prison or parole at the completion of maximum sentence of a person who had been convicted, regardless of that person's potential danger. In either system, criminal or insanity, civil commitment proceedings could be initiated for a discharged person. Neither system can itself retain a person past the maximum sentence.

Determining what that maximum sentence is raises several complexities. First is the lack of prescribed procedures for the judge in determining the crime or crimes for which the defendant could have been convicted. Since, as previously reported,30 over 85% of insanity verdicts are arrived at by agreement between prosecutor and defense, there is usually no formal evidentiary hearing. The judge is thus hampered in assessing whether the defendant would be guilty of all the crimes charged, or only some, and whether the defendant is guilty of the degree of crime charged or a lesser included offense, such as manslaughter, when charged with murder. Furthermore, assigning this responsibility to a judge raises the possibility of a constitutional challenge on the grounds that the procedure violates the defendant's Sixth amendment right to a jury trial. Such a claim would probably fail. The U.S. Supreme Court has never decided whether a jury trial is required in civil commitment cases, but it has held that juveniles have no right to a jury.31 By analogy, the Court would likely find insanity commitments sufficiently different from criminal convictions so as to not require a jury trial even for a determination which is frankly criminal, i.e., what crime the defendant committed.

Even if constitutional, the procedure still leaves the practical dilemmas mentioned previously and the additional issue of whether criminal sentences for multiple crimes should run concurrently or consecutively. In practice, some judges make an explicit finding on this matter; others do not. The Oregon Court of Appeals has recently held that the PSRB has no authority to modify a trial court's determination of the maximum sentence.32

30. See fn. 11, supra.
Another issue for PSRB in deciding when they must discharge an assignee for expiration of jurisdiction is whether the assignee should get "credit for time served" which is time spent in custody awaiting trial and sentencing. Convicted offenders receive this credit. The PSRB is in the process of adopting administrative rules which would give credit for such periods of custody to insanity acquittees.\(^3\)

Despite the use of the criminal sentence length to determine jurisdictional length, a PSRB assignee can be expected to have a greater length of potential exposure than convicted defendant. An insanity defendant receives no automatic credit for "good behavior," which usually results in a committed defendant completing his sentence well before the theoretical maximum time. Furthermore, insanity acquittees are "sentenced" automatically to the maximum possible time (except that multiple sentences may be merged), whereas judges routinely impose on convicted defendants less than the maximum possible sentence. In summary, although it is likely that insanity acquittees actually have longer periods of possible jurisdiction than committed defendants, the framework for the insanity system is drawn directly from the criminal process.

Is such a quasi-criminal frame of reference appropriate? It is not constitutionally required. In *Jones v. U.S.*\(^3\) a divided Supreme Court held that an insanity acquittee could be confined in a mental institution until he regained his sanity or is no longer dangerous, even if that results in confinement longer than the hypothetical maximum criminal sentence. The Court reasoned that this was justified because different considerations underlie commitment of insanity acquittees and imprisonment of convicts. Since an insanity acquittee is not convicted, he may not be punished. His confinement rests on continuing illness and dangerousness, and he may be confined until one or the other no longer exists.

It is disingenuous to assert that involuntary hospitalization does not have punitive elements. Anyone who has toured the maximum security ward of a state hospital would be hard-pressed to articulate why, if prison is punitive, hospitalization is not. Hospitalization may indeed provide more than punishment but the addition of treatment doesn't remove the punishing features, only supplements them. To carry the point another step, treatment in state hospitals often consists primarily of medication; such treatment is also available in prison. In evaluating the claim that prison is punishment and hospitalization is not, one should compare the maximum security ward of the hospital with the psychiatric ward of the prison. In Oregon, at least, they are only blocks apart and are strikingly similar in physical appearance and to some extent in program. Confinement, after an insanity verdict, may not be intended as punishment, but in part it is.

Even though not now constitutionally required, it is sound policy to place a cap on confinement of insanity acquittees. This cap helps maintain support from defense attorneys and civil liberties advocacy groups for Oregon's insanity system. An insanity system which had many of the punitive and security aspects of the

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34. *See* fn. 28, supra.
correction system, without its restrictions on length, would be seen as the worst of both worlds by such groups. To the contrary, the PSRB experiment has been enthusiastically supported, in part because of its jurisdictional cap, by a strikingly wide range of observers including the American Civil Liberties Union and the county Public Defenders, as well as the Mental Health Division, prosecutors, judges and patient advocacy groups.

**CONDITIONAL RELEASE**

The statutes direct that once a defendant is placed in the hospital under its jurisdiction, the PSRB must hold a hearing within 90 days and periodically thereafter to determine if the defendant should or retained in the hospital, conditionally released to the community, or discharged altogether from jurisdiction.\(^{35}\) The Board may move a patient back and forth between hospital and release status but discharge is final. The PSRB function is quite analogous to that of the Parole Board for convicts—deciding when to release from the institution, when to revoke parole, and when to terminate the sentence.

Both the Oregon Parole Board and the PSRB are composed of five members, although the parole board members are full-time. Although the Parole Board must parole a prisoner within a range of time set by a complex matrix of criteria, the Board may shorten or extend the prison term within these guidelines. The primary consideration in granting and revoking parole is dangerousness. Both the PSRB and the Parole Board thus have public protection as its primary goal.\(^{36}\)

Other than confinement in a secure hospital, the primary management tool for the PSRB population is the conditional release mechanism. The intensity of conditional release provided by the PSRB is best summarized by quoting at some length from the administrative rules which the PSRB is now in the process of adopting.\(^{37}\)

100-015. *Evaluation and Treatment.* The Board may require the person as a condition of release to report to any state or local mental health facility for evaluation and to cooperate with and accept treatment from the facility. The evaluation shall be submitted in a written report to the Board with findings and recommendations for treatment.

Whenever a treating physician feels that the patient may be ready for conditional release, the physician or their staff should notify the PSRB staff to order an evaluation of the patient in an appropriate community facility.

80-010. *Consideration for Board Order of Conditional Release.* In determining the appropriateness of an order of conditional release, the Board shall have as its goals the protection of the public, the best interests of justice and the welfare of the person.

36. See statutes re parole, Oregon Revised Statutes, secs. 144.005-144.785.
37. See fn, 33, supra.
1. The Board shall consider the testimony and exhibits at the hearing regarding the patient’s behavior in the hospital including the patient’s progress, insight and responsibility taken for his own behavior.

2. If a verified conditional release plan is presented to the Board and approved, the Board shall issue an order of conditional release.

3. If a verified conditional release plan is not yet ready at the Board hearing but the Board does find the person appropriate for conditional release, the Board shall specify what the specific conditions of the plan should include, and the Board shall order the person committed and appropriate for conditional release and may approve the conditional release plan at an administrative hearing.

4. If a verified conditional release plan has not been confirmed and the conditions need further examination and approval of the Board, the Board shall commit the patient, find the patient appropriate for conditional release or continue the hearing and shall consider the verified conditional release plan at another Board hearing.

80-020. Mental Health Division Responsibility to Prepare Plan. When the Board requires preparation of a preconditional release plan before a hearing or as a condition of granting conditional release for a person committed to a state hospital, the Mental Health Division is responsible for and shall prepare the plan.

In carrying out a conditional release plan, the Mental Health Division may contract with a community mental health program, other public agency or private corporation or an individual to provide supervision and treatment for the conditionally released person.

100-010. Notification. Prior to the designation, the Board shall notify the person or agency to whom conditional release is contemplated and provide them an opportunity to be heard before the Board.

80-015. Elements of Conditional Release Order. In order to approve a conditional release plan, the Board shall consider any or all of the following elements:

1. Housing: Appropriate housing must be available for the patient outside the hospital. This may include 24-hour supervised housing, supervised group home situation, foster care, family or relatives, or independent housing if that is appropriate. The Board shall determine which type of situation is necessary to best insure an appropriate conditional release plan.

2. Mental health after-care: A local mental health facility or mental health specialist, after having had the opportunity to evaluate the patient and be heard before the Board considering the conditional release plan, shall:
   a. Furnish reports to the Board in writing no less than once per month concerning the person’s compliance with all the conditions of release, and summary of treatment and supervision received by the person.
b. Agree to prescribe, monitor or administer medication as may be found appropriate.

c. Report promptly to the Board any time the patient does not comply with the conditions of release, cooperate with or accept treatment from the local mental health facility or any provider who, by contract with the local or state mental health division, is to provide treatment for that person.

3. Reporting responsibilities: A qualified person shall be designated by the Board as the person having primary reporting responsibilities in the patient’s case.

   a. The reporting person shall notify the Board at least monthly of the patient’s progress.

   b. The reporting person shall notify the Board’s executive director promptly if the person becomes aware of any violations by the patient on the conditional release plan.

   c. The Board may designate the patient to self-report to the Board in appropriate cases.

4. Special conditions: Special conditions such as no alcohol, taking of Antabuse, submitting to drug screen tests, no driving, vocational or day activities or schooling may be designated by the Board in its order. The Board shall impose special conditions it feels would be appropriate to insure the safety of the public and which would be in the best interests of the patient.

5. Parole and probation: The Board may order parole and probation supervision as a further condition.

6. General conditions of release: Patient shall agree to and sign a form promising to comply with the general conditions of release. This signed form shall be made a part of the conditional release plan. The conditions shall include notice that if the person leaves the state without authorization of the Board, the person may be charged with a new crime of Escape.

80-025. Modification or Termination of Ordered Conditional Release. Modification or termination of an order of conditional release may be proposed by the patient, supervising person, mental health facility or any other interested party, or by the staff or the Board on its own motion upon a review of the status of the patient.

   1. Modifications of conditional release may be considered by the Board at any time.

   2. Termination of conditions of release may be dealt with by a voluntary admission of the patient to a state hospital or other appropriate voluntary compliance.

   3. Termination of conditions of release may be affected by preparation of a revocation order in accordance with procedures set forth in Division 70.

   4. The reporting person shall provide the Board with a written summary of the progress, recommendations on future action to be taken, and if possible, the reporting person shall be present to testify on these issues at the Board hearing.
Unlike parole, where the plan is often "skimpy" in practice, even though the statutes authorize intensive parole supervision, the PSRB does in fact have the resources and people to implement detailed conditional release programs. Furthermore, conditional release may continue until the expiration of the maximum jurisdictional period, whereas parole is often terminated after six months. The PSRB is thus able to release people with more confidence even while admitting the difficulties of predicting long-term dangerousness. With the assurance that they will know promptly about violations of release conditions or deterioration in a person's mental health, the Board need not pretend that a person is "cured" or "rehabilitated" before release. Rather, if a patient is stabilized and a plan is in place the patient can be released.

Perhaps partly as a result of the Board's ability to release patients, the census of insanity acquittees at the state hospital, which had been rising rapidly through the 1970s, dropped and then has stabilized during the past four years. This drop may also reflect the decrease in number of insanity acquittees which has occurred since the advent of the Board. Anecdotal information suggests one reason for the decline is that defense attorneys and their clients no longer regard an insanity verdict as a clear cut victory. Rather, it is seen as an alternative form of sentence which in some cases results in substantially greater and longer restrictions than does a criminal conviction. One of those restrictions is the Board's ability to revoke conditional release.

REVOCAION OF RELEASE

Conditional release may be revoked by a mechanism similar to that utilized in parole revocation. The grounds, however, for revoking conditional release are broader, and the process is less cumbersome.

When the PSRB staff receives an oral or written report of grounds for revoking a person's conditional release, the staff prepares an affidavit summarizing those grounds. The affidavit is presented to a Board member for consideration. If it appears to that Board member that the person has violated any condition of release or the person's mental health has changed, the member may sign an order directing that the person be returned to the state hospital. This written order is sufficient warrant for any law enforcement office to take the person into custody and transport him or her accordingly. In addition, a person's release supervisor, or any police officer, may take a person into custody on an emergency basis if there is reasonable cause to believe the person is a substantial danger and in need of immediate custody and treatment. Most often, however, revocation is accomplished with PSRB participation.

Case Example

A defendant who had been found "guilty except for insanity" for assaulting a stranger on the sidewalk in Portland was committed to the Oregon State Hospital in Salem, 50 miles south of Portland, under the jurisdiction of the PSRB. His maximum jurisdictional period was ten years, since Assault II carries a maximum sentence of ten years. After the patient spent two years in the hospital, the PSRB found at a hearing that, although still affected by paranoid schizophrenia, his disease was in remission but there was a reasonable probability that his disease would occasionally become active and render him dangerous to others. The PSRB retained jurisdiction over him but found he was suitable for conditional release. They, however, did not release him yet since a community treatment plan tailored to his needs had not yet been developed.

At PSRB’s request the staff of a treatment program in the patient’s home city of Portland evaluated the patient’s suitability for their program and sent a ten-page report to the Board. After another hearing to evaluate the proposed plan, the Board ordered the patient released with three pages of conditions which the patient agreed to and signed. Those conditions included a requirement that he cooperate with the day treatment program, that he participate in a program of monitored medication, and that he understood his release would be revoked if his mental health deteriorated, even through no fault of his own.

He remained successfully on release for six months. The day treatment staff submitted monthly written reports to PSRB staff and talked by telephone with them many other times to report satisfactory progress. However, during the seventh month, the case manager, as well as the treating psychiatrist, noticed a gradual increase in symptoms. This development was reported by phone to PSRB staff.

During the next week, there were frequent phone conversations about the patient’s course. After five days, the treatment staff felt the situation was continuing to worsen and alerted PSRB staff they might have to request revocation. The following morning the patient appeared at day treatment carrying a knife. He was unable to explain why he had it and his thought process was mildly disorganized.

The patient’s case manager immediately called PSRB staff, reported these developments, and recommended revocation. The executive director of PSRB had already prepared a partial affidavit in anticipation of this possibility. She promptly completed the affidavit, called the Chairman of the Board, and walked the affidavit to his office which is six blocks from PSRB’s office. The Chairman reviewed the affidavit and signed an order that the patient be returned to the state hospital. PSRB staff called Portland police, who went to the day treatment building, took the patient into custody and transported him to Salem. He was rehospitalized that afternoon to await a full revocation hearing within 20 days.
The Process

As this example illustrates, PSRB can accomplish revocation promptly, efficiently, and in a timely fashion. This ability results from several features of the system. First, because the number of persons on conditional release is relatively small, approximately 200, the specialized PSRB is able to closely monitor their progress. Secondly, the statute and related administrative regulations, now in draft form, authorize revocation for a wide variety of reasons including: (1) the person has violated conditions of release; (2) the person's mental health has changed; (3) the person absconds from the state (which by statute constitutes the crime of escape); (4) the resources required for maintenance on release are no longer available; (5) there is any change in the person or plan requiring hospitalization; and (6) the person is charged with a new crime or commits dangerous acts.

A third reason the revocation process is efficient is that by statute PSRB revocation of orders carry the force of court orders and must be executed by the police. Until the statutes were amended in 1981 to clarify the question, police often hesitated to act on PSRB orders since enforceability was ambiguous.

A fourth reason is that, unlike parole revocation, no on-site probable cause hearing is provided in PSRB revocations. Rather, no matter where the person has been on conditional release or where he is arrested, he is transported promptly to Salem for readmission to the state hospital. Does this summary procedure meet constitutional requirements of due process?

In *Morrisey v. Brewer*, the Supreme Court held that due process requires that in parole revocation some minimal inquiry, in the nature of a "preliminary hearing," must be held promptly after arrest, at or near the place of the alleged parole violation or arrest, to determine whether there is probable cause to believe the arrested parolee has committed acts that would constitute a violation of parole conditions. This is needed to avoid unwarranted transportation to a distant site for a full revocation hearing which might not occur until substantial time passes. These constitutional requirements have been embodied in many state parole statutes including Oregon's. No such procedure is set forth in Oregon's PSRB statutes or draft administrative regulations.

To date, the Oregon appellate Courts have not ruled on any challenge to the lack of on-site hearing. Although parole and conditional release are comparable in many regards, it is likely that the courts would distinguish between them so as to find that the lack of an on-site hearing does not deprive PSRB patients of due process. Following the reasoning of *Jones v. U.S.*, the courts might conclude that since insanity acquittees are not being punished, they can be returned to the institution with fewer procedural safeguards than can criminal parolees. When a

41. See fn. 33, supra., 70-010.
42. Section 5, Chapter 711, Oregon Laws, 1981.
43. 408 U.S. 471 (1972).
44. Oregon Revised Statutes, 144.343(1).
45. See fn. 28, supra.
person needs to be treated for reactivated mental illness or confined to prevent
danger to others it may be done summarily, at least for a period of time. Fur-
thermore, the courts would probably conclude that the statutory requirement of
a full revocation hearing within 20 days of rehospitalization satisfies the minimal
requirement of due process.

CONCLUSION

The American Psychiatric Association correctly pointed out that Oregon’s
PSRB system is a quasi-criminal approach to managing insanity acquittees. The
system is analogous in many respects to the parole system. The PSRB’s main
concern is security, not rehabilitation or treatment. The length of jurisdiction is
set by a court finding about the crime or crimes committed by the person, and
PSRB has the power to release, revoke, and discharge.

In several regards the PSRB system imposes greater restrictions in the name of
protection than does the criminal prison-parole process. Maximum jurisdiction is
set by reference to criminal sentence; but unlike the prisoner, the insanity acquittee
always receives a maximum sentence and does not accumulate good time. Both
may be released from confinement before the end of the sentence, one on parole,
the other on conditional release. The insanity acquittee, in almost all cases, is
placed on a program which is far more stringent and lasts longer than parole. The
person on conditional release is monitored much more closely than the parolee.
Although both are subject to revocation, PSRB can revoke more quickly, for more
reasons, with less procedural hurdles.

Any comparison between the two systems must take into account the provision
of services by the PSRB system which are absent or gravely deficient in prison-
parole. Although the difference cannot be quantified, based on any studies to date,
it appears that PSRB provides psychiatric treatment, case management, and social
support to a much greater extent than does the criminal system. Although too early
to say, it is not too early to hypothesize that the PSRB quasi-criminal approach
not only provides better community protection than does prison-parole but also
provides better treatment for mentally ill offenders.

One possible explanation for these differences between the PSRB and correc-
tions systems is simply numbers. Society can afford to manage several hundred
insanity acquittees far more intensely than several thousand convicts. No one has
clearly shown that insanity acquittees are the most dangerous among the combined
groups of offenders. The heightened security around persons supervised by the
PSRB likely reflects, at least in part, traditional fear and stigmatization of the
mentally ill. Whatever the reasons, the public demands such security. The PSRB
mechanism is a promising approach to providing protection without sacrificing
other goals of an insanity system.