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INSANITY ACQUITTEES IN THE COMMUNITY: LEGAL FOUNDATIONS AND CLINICAL CONUNDRUMS

*Michael J. Vitacco**

ABSTRACT

This Article will provide an in-depth discussion of legal cases that have shaped American policy dealing with individuals found not guilty by reason of insanity (NGRI) and deemed fit to return to the community. This Article will discuss several aspects of conditional release relevant to the legal community. Such factors include societal attitudes, relevant legal case law, and data-supported outcomes of individuals placed back in the community. In addition, this Article will deal with issues related to violence risk assessment and evaluate risk assessment effectiveness in determining who may be an appropriate candidate for community return. Contrary to popular belief, individuals adjudicated NGRI, even for violent offenses, are generally not at high-risk for future violence. This review will present information demonstrating the low recidivism risk by individuals adjudicated NGRI and released back to the community. This Article demonstrates the promise of conditional release for insanity acquittees from both public safety and fiscally responsible positions. This Article summarizes and lays out arguments for continued, and potentially even expanded, use of conditional release to properly manage insanity acquittees.

TABLE OF CONTENTS

Introduction	848
I. Insanity Defense Attitudes, Conditional Release, and the Law	849
II. Violence Risk Assessment with Insanity Acquittes	856

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III. Post- <i>Foucha</i> Issues: Dangerousness, Diagnoses, and Commitment.....	861
Conclusion.....	868

INTRODUCTION

The not guilty by reason of insanity defense (NGRI) remains one of the most debated and contested areas of mental health law, replete with legal, moral, and political overtones. The idea that someone can commit a crime, even a violent one, and be found non-responsible in the eyes of the law, has created a public backlash against the insanity defense, including its abolition in four states (Kansas, Montana, Idaho, and Utah).¹ Despite the unpopularity of the NGRI defense, there has been an increasing trend toward discharging insanity acquittees from the hospital back to community placements.² Although society is often against a return to the community for insanity acquittees, it is fiscally and clinically prudent to allow such conditional discharges to continue. These individuals are not simply discharged to the community with unfettered access to the community. Instead, insanity acquittees must follow a series of conditions in order to maintain their newfound freedoms. Known as conditional release, insanity acquittees typically must remain medication compliant, attend specialized therapy, not possess weapons, abstain from substance abuse, and, of course, not engage in criminal behavior.

Several landmark cases over the previous twenty-five years have paved the way for the development of specialized programs to treat and maintain NGRI acquittees in their respective communities.³

1. Daniel J. Nusbaum, *The Craziest Reform of Them All: A Critical Analysis of the Constitutional Implications of Abolishing the Insanity Defense*, 87 CORNELL L. R. 1509, 1515 (2002); see generally Patricia K. Fox, *Commentary: Biases That Affect the Decision to Conditionally Release an Insanity Acquittee*, 36 J. AM. ACAD. PSYCHOL. & L. 337 (2008).

2. See Michael J. Vitacco et al., *Evaluating Conditional Release in Not Guilty by Reason of Insanity Acquittees: A Prospective Follow-Up Study in Virginia*, 38 L. & HUM. BEHAV. 346, 353 (2014).

3. See, e.g., *Foucha v. Louisiana*, 504 U.S. 71 (1992). See generally Stephen Bieber et al., *Predicting Criminal Recidivism of Insanity Acquittees*, 11 INT'L J.L. & PSYCHIATRY 105 (1998) (supporting the need for the treatment of mental illness in eliminating violent and nonviolent recidivism); J. Steven Lamberti et al., *The Role of Probation in Forensic Assertive Community Treatment*, 62 PSYCHIATRIC SERVS. 418 (2011) (demonstrating how probation agents mandating treatment can play a critical

Additionally, many legislatures have acted in accordance with this judicial shift through the provision of legal mechanisms for releasing individuals adjudicated NGRI back to the community. This Article focuses on substantial areas of conditional release. Part I unpacks attitudes toward the insanity defense and its influence on the treatment of insanity acquittees. This part considers the growing trend of allowing insanity acquittees to be returned to their respective communities, even in light of substantial misinformation perpetuated regarding the relationship between violence and mental illness. Part II provides an overview of violence risk assessment, specifically as it relates to potential danger with insanity acquittees and potential community placement. This part outlines limitations of current risk assessment methodology for predicting violence and recidivism with insanity acquittees in the community on conditional release. An important limitation of violence risk assessments is that most items on such risk assessment measures are unrelated to actual conditional release outcomes. Finally, Part III provides summaries of recent data related to the success of conditional release across multiple states. Such outcomes could provide an impetus for creating empirically-informed public policies related to the treatment and management of insanity acquittees.

I. INSANITY DEFENSE ATTITUDES, CONDITIONAL RELEASE, AND THE LAW

The proper way to treat and manage individuals adjudicated NGRI remains an evolving area of public policy and the law. However, even before policy-makers and legislatures consider how to best manage insanity acquittees, it is important to point to numbers showing the general discontentment with the insanity defense as a whole, which is often viewed as an abused loophole allowing individuals to avoid their just deserts for criminal behavior.

Several research studies have demonstrated society's disdain for the defense as a whole, and there have even been numerous efforts to accurately capture attitudes. For example, the Insanity Defense Attitude-Revised (IDA-R) was developed to evaluate overall attitudes toward the defense.⁴ The authors who designed the study

role in ensuring insanity acquittees follow through on court-mandated community-based treatment).

4. See generally Jennifer L. Skeem, et al., *Venirepersons Attitudes Toward the Insanity Defense: Developing, Refining, and Validating a Scale*, 28 L. & HUM. BEHAV. 623 (2004) (demonstrating how insanity defense attitudes can be measured

found the scale was underpinned by two factors: (1) orientation toward strict liability and (2) concern about perceived injustice and danger.⁵ The authors found general discontent regarding the insanity defense among this sample of jurors.⁶

In another article, Valerie Hans conducted a survey with 330 individuals who were recruited using random digit telephone calls in a county in Delaware.⁷ Results of this telephone survey were mixed. For instance, 49% of surveyed individuals were in favor of abolishing the insanity defense, and almost 95% were in favor of reforming the insanity defense.⁸ Yet, in an unexpected finding, just over three-fourths of surveyed individuals endorsed that there are times when an insanity defense is justified, and 64% endorsed the insanity defense as a necessary part of our legal system.⁹

Studies looking at characteristics underpinning negative attitudes have found that a positive view of capital punishment and overestimating the use of the insanity defense are linked to a stronger negative attitude toward the defense.¹⁰ In discussing what he attributed as the “insanity defense problem,” Michael Perlin wrote about a very salient issue affecting attitudes toward the insanity defense.¹¹ With the use of so-called “designer defenses,” the public

and individuals having poor attitudes toward the insanity defense can have real world applications; negative attitudes toward the insanity defense reflect beliefs that the letter of the law is not being followed in conjunction with the idea that criminally insane individuals are being discharged from hospitals and harming society).

5. *Id.*

6. *Id.*

7. See generally Valerie Hans, *An Analysis of Public Attitudes Toward the Insanity Defense*, 24 CRIMINOLOGY 393 (1986). Given that the study occurred within a relatively small area of the United States, the generalizability of such findings are certainly open for discussion. This is especially true since political affiliation may play a role in attitudes toward the insanity defense. See *id.*

8. *Id.*

9. *Id.* at 396–410.

10. Michael J. Vitacco et al., *Measuring Attitudes Toward the Insanity Defense in Venirepersons: Refining the IDA-R in the Evaluation of Juror Bias*, 8 INT’L J.L. FORENSIC MENTAL HEALTH 62 (2009) (presenting similar results from two different samples: sample one included 567 university students at a medium-sized college in the Midwest; sample two consisted of 239 jurors from a small area in North Carolina); Brooke Butler & Adina Wasserman, *The Role of Death Qualification in Venireperson’s Attitudes Toward the Insanity Defense*, 36 J.L. APPLIED SOCIAL PSYCHOL. 1744 (2006).

11. Michael Perlin, *Myths, Realities, and the Political World: The Anthropology of Insanity Defense Attitudes*, 24 BULL. AM. ACAD. PSYCHIATRY L. 5 (1996) (regarding the insanity defense, explaining: “Because we continued to do precisely what we have done for decades, centuries, and perhaps millennia. We spout

has seemingly grown less tolerant of mental health issues, including the use of the insanity defense amongst the most seriously and persistently mentally ill. The concerns over faking the insanity defense as a legal loophole are now firmly engrained.

In a thoughtful attempt at overcoming problematic attitudes toward the insanity defense, one researcher suggested that a flowchart, demonstrating the consequences and “time” completed with an insanity defense would ultimately prove useful in the reduction of biases.¹² As noted in this thesis, the presentation to college students of information regarding dispositional outcome had an unattended effect: those seeing the information about dispositional outcome became harsher in their sentence and less inclined to support an insanity finding.¹³ This paradoxical finding underscores a central issue in the field of mental health and the law: How to ensure fair consideration of appropriate pleas for mentally ill individuals? It also raises a critical question: If education does not influence juror attitudes, what will? On this front, it appears views regarding the insanity defense are very resistant to change.¹⁴

platitudes, we rectify myths, we create straw men, we talk angrily about insanity defense ‘abuse,’ we look longingly to insanity defense ‘abolition’ or ‘reduction’ as panaceas (not simply to the question at hand, but fantastically, as a means of solving all contemporary crime problems); we speak scornfully of slick lawyers and deceitful experts; we automatically assume that a defendant who raises the insanity defense must be faking (although, at least one court opinion and one voter survey reveals—somewhat remarkably, I thought, that it doesn’t matter if the plea is ‘real’ or ‘faked’; our antipathy is almost identical); finally, we deride psychodynamic behavioral explanations of ‘crazy’ behavior when it appears ‘obvious’ to one and all that the defendant, in fact, ‘did it.’”).

12. See Lauren M. Schlumper, *Using a Flowchart to Reduce Juror’s Preexisting Biases in Cases Utilizing the Insanity Defense* (2011) (unpublished M.S. thesis, Georgia Southern University), <http://digitalcommons.georgiasouthern.edu/cgi/viewcontent.cgi?article=1442&context=etd> [https://perma.cc/LF99-5GWK]. The use, and ultimate effectiveness, of such a system remains very much an empirical question. As noted in the body of this review, the presentation of the flowchart went against the desired result and increased the likelihood a defendant would receive a prison sentence. *Id.* Certainly, it could be argued the use of university students as your lone sample limits the generalizability of these results; however, consistent findings have been reported using both samples of undergraduates and venirepersons. *Id.*

13. *Id.*

14. See generally Marc F. Abramson, *The Criminalization of Mentally Disordered Behavior: Possible Side Effects of a New Mental Health Law*, 23 HOSP. & COMM. PSYCHIATRY 13 (1972). This article notes that when it comes to issues with individuals with mental illness, financial concerns (both of the individual patient and of the state) are frequently highlighted, but the high social cost of stigmatization is not considered to an appropriate extent. *Id.* Likewise, individuals who are released from prison after completing their sentence generally return to their respective communities with little to no follow-up. *Id.* In comparing insanity acquittees to

The importance of understanding insanity defense attitudes when considering the conditional release of acquittees is evident. If society is opposed to individuals being adjudicated not criminally responsible on the basis of their mental illness, their subsequent integration to the community would seemingly evoke more problematic responses. The idea that society is opposed to the return of NGRI acquittees is a logical downward extension stemming from the strong negative attitudes toward the insanity defense. Yet, specific research has not been conducted on attitudes toward the return of insanity acquittees to the community. Moreover, understanding the nature of the insanity defense lays critical groundwork for furthering knowledge of how conditional release functions.

The majority of society, based on research regarding the insanity defense, does not seem to be unopposed to a return to the days where the primary methodology of dealing with NGRI acquittees was by not dealing with them at all. The typical method revolved around placing them in long-term forensic hospitals with minimal to no chance of release. Warehousing the mentally ill was the norm for many years, until the 1960s when there was a concerted effort to move patients from hospitals to the community. Such warehousing had dire and, likely, unintended consequences, including poor mental health treatment, higher mortality, and greater victimization, to name a few.¹⁵ During this time, insanity acquittees were sentenced to indeterminate sentences, which generally meant little-to-no chance of actual release from the hospital. Once found not responsible for their criminal behavior, these individuals were presumed dangerous and were not afforded appropriate due process that would provide an avenue for release. Yet, this area of law remains in flux.

A variety of legal cases have lit the path for insanity acquittees to be released into the community, even though there remain substantial challenges from the legal system and a high level of public distrust

individuals released from prison, statistically the former are more likely to commit a follow-up offense, specifically a violent offense. *Id.*

15. See Joanne Karger, "Don't Tread on the ADA": *Olmstead v. L.C. Ex Rel. Zimring and the Future of Community Integration for Individuals with Mental Disabilities*, 40 B.C. L. REV. 1221, 1224-27 (1999); Nancy K. Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory*, 31 EMORY L.J. 375, 380-81 (1982); Kenneth B. Noble, *Deciding Consequences of Insanity Defense*, N.Y. TIMES (Apr. 19, 1987), <http://www.nytimes.com/1987/04/19/weekinreview/deciding-consequences-of-insanity-defense.html?mcubz=0> [<https://perma.cc/9X78-U43C>]; see also *Jackson v. Indiana*, 406 U.S. 715 (1972) (prohibiting the pre-trial commitment, or warehousing, of those deemed incompetent to stand trial on the charges filed against them).

regarding mentally ill individuals with criminal records, often with multiple crimes, including violent crimes, returning to their home communities. This area of law not only requires a focus on defining the limitations to government's power relative to mandated hospitalization, but also delving into the law's role in conditional release decisions requires analysis into legal definitions of mental illness and dangerousness.

Limitations to mandated hospitalization of mentally ill defendants with criminal charges began in the 1970s, a decade that witnessed substantive challenges to the procedure and duration states used to commit individuals, and the rights provided to individuals undergoing commitment proceedings. The 1972 *Jackson v. Indiana* decision is considered a landmark case in competency to proceed to trial opinions.¹⁶ In reality, the case goes far beyond competency, establishing that a state could not indefinitely commit an individual on the sole basis of their incompetency to proceed to trial.¹⁷ The *Jackson* case emphasized the necessity of treatment for individuals deemed not competent to proceed to trial, while at the same time curbing rights of the state to hold an individual indefinitely as not competent absent of due process. The *Jackson* case was limited to individuals not competent to proceed to trial, but this case was one of the first to deal with the rights of criminal forensic patients.

The detainment of individuals adjudicated NGRI was taken up in *Foucha v. Louisiana*.¹⁸ In *Foucha*, the United States Supreme Court undertook the question of criteria needed to justify the continued commitment of Terry Foucha, a man adjudicated NGRI on charges of aggravated burglary and illegally discharging a firearm.¹⁹ Foucha was

16. *Jackson*, 406 U.S. 715 (1972). Jackson was deaf and intellectually disabled, possessing extreme difficulties in communication. *Id.* at 717. The charges brought against him were relatively minor and included two counts of petty theft after allegedly robbing two women. *Id.* Although the crimes themselves were not serious, the finding of not competent to proceed was essentially a life sentence for Mr. Jackson as there was only a small likelihood he would be released from the state psychiatric facility, given the governing legal framework. *Id.* at 719-20. The United States Supreme Court ruled it was a violation of Mr. Jackson's Constitutional rights to be retained in a psychiatric facility on a finding of incompetency alone. *Id.* at 731, 738. In order to continue to detain Mr. Jackson there would have needed to be a finding of dangerousness that would have justified continued hospitalization. *Id.* at 733-36.

17. *Id.* at 720.

18. 504 U.S. 71 (1992).

19. *Id.* at 73.

hospitalized at a psychiatric hospital in Louisiana.²⁰ The law in Louisiana indicated he would remain hospitalized until he was no longer a danger to himself or others, without reference to mental illness.²¹ Foucha was diagnosed with a drug-induced psychosis and antisocial personality disorder and denied release by Louisiana due to existing dangerousness (he was involved in several fights when hospitalized); however, the hospital clinical staff was of the opinion that his mental illness had remitted.²² The United States Supreme Court ruled, in a 5-to-4 decision, that dangerousness was insufficient to retain an NGRI acquittee in the hospital, and that there needed to be continued mental illness in order to satisfy the Fourteenth Amendment.²³ In oft repeated words from *Jackson*, the Court in *Foucha* stated:

Due process requires that the nature of commitment bear some reasonable relation to the purpose for which the individual is committed Foucha is not suffering from a mental disease or illness. If he is to be held, he should not be held as a mentally ill person.²⁴

Yet, the decision in *Foucha* is not without problems. Despite the Court's guidance, the decision failed to provide an exacting standard, so *Foucha's* criteria were very pliable by policy- and decision-makers. As such, individual states demonstrate the satisfaction of due process by showing the nature of the commitment is both reasonable and in relation to the purpose of the commitment. In reaction to *Foucha*, states have developed procedures for the release and management of NGRI acquittees. Although states interpret *Foucha* differently, the continued hospitalization of insanity acquittees is guided by determinations of whether the individual remains mentally ill and dangerous.²⁵

While *Foucha* provided new-found protections, NGRI acquittees can nevertheless find themselves in a unique legal category of

20. *Id.* at 74.

21. *Id.* at 73.

22. *Id.* at 74-75.

23. *Id.* at 86.

24. *Foucha*, 504 U.S. at 79 (citing *Jones v. United States*, 463 U.S. 354 (1983); *Jackson v. Indiana*, 406 U.S. 715 (1972)).

25. Vitacco et al., *supra* note 10, at 1788-1789. See also James W. Ellis, *Limits of the State's Power to Confine "Dangerous" Persons: Constitutional Implications of Foucha v. Louisiana*, 15 U. PUGET SOUND L. REV. 635 (1991) (noting Constitutional issues remain regarding the hospitalization and, subsequent release of insanity acquittees to supervised placements in the community).

presumptive dangerousness, which is often predicated on the basis of an insanity finding.²⁶ In *Jones v. New York*, the United States Supreme Court allowed the hospitalization of insanity acquittees for crimes, even if those crimes were relatively minor in nature.²⁷ Mr. Jones was arrested in 1975 for petty larceny and found NGRI.²⁸ He was committed to St. Elizabeth's Hospital where a psychologist opined Mr. Jones was in need of continued hospitalization as a result of dangerousness stemming from a diagnosis of "Schizophrenia, paranoid type."²⁹ The Court in *Jones* made a clear distinction between placement in a mental health facility and the nature of the crime.³⁰ The Court wrote:

A particular sentence of incarceration is chosen to reflect society's view of the proper response to commission of a particular criminal offense, based on a variety of considerations such as retribution, deterrence, and rehabilitation . . . Different considerations underlie commitment of an insanity acquittee. As he was not convicted, he may not be punished. His confinement rests on his continuing illness and dangerousness. Thus, under the District of Columbia statute, no matter how serious the act committed by the acquittee, he may be released within 50 days of his acquittal if he has recovered. In contrast, one who committed a less serious act may be confined for a longer period if he remains ill and dangerous. There simply is no necessary correlation between severity of the offense and length of time necessary for recovery. The length of the acquittee's hypothetical criminal sentence therefore is irrelevant to the purposes of his commitment.³¹

The Court understood that even individuals who commit minor crimes may be potentially dangerous and warrant commitment for the purposes of providing mental health treatment in order to reduce the likelihood of violence to others or oneself. As communicated in *Jones*, the mere fact that the insanity acquittee has committed a criminal act minimizes the likelihood the individual will be committed

26. However, there has not been significant scholarship devoted to the latency between rights granted for civil commitment and a legal decision minimizing the state's power regarding the detainment of individuals adjudicated NGRI. As delineated in *Jones*, the mere presence of overt criminal activity places a higher burden on the insanity acquittee to demonstrate they are not a danger to society. See *Jones*, 463 U.S. 354 (1983).

27. *Id.*

28. *Id.* at 359.

29. *Id.* at 359-60.

30. *Id.* at 370.

31. *Id.* at 369.

for “idiosyncratic behavior.”³² The law has been made clear: behavior, regardless of how atypical or idiosyncratic, cannot itself justify commitment absent dangerousness.³³

II. VIOLENCE RISK ASSESSMENT WITH INSANITY ACQUITTEES

Prior to returning to the insanity defense and the *Jones* decision, it is worth reviewing violence prediction in some detail. One prime example is Seung-Hui Cho, the Virginia Polytechnic Institute and State University student who killed thirty-two people (twenty-seven students and five teachers) and wounded seventeen others in a campus shooting on April 16, 2007.³⁴ During his childhood, he was isolative, with clear social awkwardness with both adults and peers, and was frequently bullied.³⁵ Prior to the shooting, Seung-Hui Cho exhibited symptoms consistent with mental illness; these symptoms manifested in the following ways: disruptive class behavior, bothering and harassing female students (taking pictures of their legs), and suicidal ideations.³⁶ These behaviors led to a civil commitment hearing where Cho was deemed to pose an imminent danger, but a danger that could be managed and treated through outpatient treatment.³⁷ The outcome of the commitment hearing and subsequent killings resulted in a change to civil commitment procedures in the state of Virginia.³⁸

32. *Id.* at 367.

33. *Id.* In a commitment case, idiosyncratic behavior was previously used as a justification for civilly committing someone. At times, civil commitment was used to ‘put away’ relatives who were engaging in behavior that may be most aptly described as embarrassing, but did not constitute a danger to themselves or others.

34. N.R. Kleinfeld, *Before Deadly Rage, A Life Consumed by a Troubling Silence*, N.Y. TIMES (Apr. 22, 2007), <https://nyti.ms/2p7lQCM> [<https://perma.cc/7C8Q-LRLS>].

35. *Id.*

36. *Id.*

37. Alison Pfeffer, *‘Imminent Danger’ and Inconsistency: The Need for National Reform of the ‘Imminent Danger’ Standard for Involuntary Civil Commitment in the Wake of the Virginia Tech Tragedy*, 30 CARDOZO L. REV. 277, 291–92 (2008).

38. See generally Jane D. Hickey, et al., *A New Era Begins: Mental Health Law Reform in Virginia*, 11 RICH. J.L. & PUB. INT. 101 (2008) (explaining the shooting was the impetus for significant changes in the Virginia laws dealing with civil commitment; changes were made in five areas of commitment law, including: commitment criteria, mandatory outpatient treatment, firearm purchases and reporting, privacy disclosures, and procedural changes; maybe the most significant change was the \$41 million added to the mental health budget to improve treatment in an attempt to prevent a similar incident).

In conceptualizing how the Virginia Tech and other cases could have been prevented, it is imperative to not have hindsight bias and think, “we knew it all along.”³⁹ Such thinking is often prevalent after a major event. Obviously, if violent events were predictable they could be prevented. This argument has been a central theme in cases dealing with the prediction of violent behavior. In *Barefoot v. Estelle*, the primary question the Supreme Court considered centered on the ability and appropriateness of mental health practitioners to predict violent behavior.⁴⁰ In fact, the American Psychiatric Association (APA) submitted an amicus brief on behalf of Barefoot, advocating the position that mental health practitioners are unreliable at predicting violence.⁴¹ The amicus brief stated mental health practitioners are incorrect more often than they are correct when making predictions of violent behavior.⁴² The Court was not persuaded by this argument.⁴³

In recent arguments, the APA has not advocated for the abolition of violence risk assessments, even in death penalty cases. Instead, the APA has supported the use of empirically-based and appropriately validated violence risk assessments. Consider the American Psychological Association’s brief for Sherman Lamont Fields.⁴⁴ As

39. See generally Colleen Cannon & Vernon Quinsey, *The Likelihood of Violent Behaviour: Predictions, Postdictions, and Hindsight Bias*, 27 CANADIAN J. BEHAV. SCI./REVUE CANADIENNE DES SCIENCES DU COMPORTEMENT 92 (1995) (demonstrating how hindsight bias may influence predictions of violence by providing clinicians a false sense of confidence in the accuracy of their predictions).

40. 463 U.S. 880 (1983). The decision in *Barefoot*, although it allowed predictions of violent behavior to be made in court, was not an overwhelming endorsement of the practice by mental health professionals. To the contrary, the Court allowed such predictions of violence almost as a default. See also Randy K. Otto, *On the Ability of Mental Health Professionals to “Predict Dangerousness”: A Commentary on Interpretation of Dangerousness in the Literature*, 18 L. & PSYCHOL. REV. 43 (1994); Jennifer L. Skeem & E. Mulvey, *Psychopathy and Community Violence Among Civil Psychiatric Patients: Results from the MacArthur Violence Risk Assessment Study*, 69 J. CONSULT. CLIN. PSYCHOL. 358 (2001).

41. See Amicus Curiae Brief at 5, *Barefoot v. Estelle*, 463 U.S. 880 (1983) (No. 82-6080).

42. *Id.* at 4 (“Contrary to the claims of the prosecution psychiatrists who testified in this case, psychiatric predictions of long-term future dangerousness, even under the best of conditions and on the basis of complete medical data—are of fundamentally low reliability.”).

43. *Barefoot*, 463 U.S. at 901.

44. See Amicus Curiae Brief at 11-12, *U.S. v. Sherman Lamont Fields*, 483 F.3d 313 (5th Cir. 2007) (No. 04-50393). In *United States v. Fields*, the APA submitted an amicus brief disagreeing with the methodology of a testifying psychiatrist, Dr. Richard Coons, who opined the defendant was likely to be a danger, but he based his opinion on inadequate methodology, namely clinical judgment. *Id.* Since *Barefoot*,

evidenced over the previous two decades, there have been changes in the conceptualization and implementation of violence risk evaluations. Moreover, these changes have led to more confidence in the results of risk assessments and greater precision in their use and accuracy.⁴⁵ As such, the use of clinical judgment as a substitute for empirically-supported violence risk assessments is inadequate and without proper foundation for making such weighty decisions.

Ultimately, the question of the efficacy of risk assessment with any population is an empirically-based question. With the case of insanity acquittees in the community, the answers coming in have not provided a bevy of support for the use of full-on, traditional risk-based measures. A quick review of extant data raises significant questions about the current state of the science regarding predicting violence and aggression with mentally disordered offenders, specifically individuals found not guilty by reason of insanity and conditionally released.

Currently, the Historical, Clinical, Risk-20, typically referred to as the HCR-20, is frequently used in violence risk assessments with insanity acquittees.⁴⁶ In an article by Debbie Green and colleagues,

there have been dramatic improvements in violence risk assessments. As part of the iterative process of risk assessment instrument development, the idea of clinical judgment for violence prediction has gone by the wayside due to the statistical superiority of structured measures.

45. There are a variety of instruments designed to predict risk across multiple settings and populations. Multiple studies have demonstrated the superiority of structured approaches to non-structured judgments. *See generally* Michael Doyle & Mairead Dolan, *Violence Risk Assessment: Combining Structural and Clinical Information to Structure Clinical Judgments for the Formulation and Management of Risk*, 9 J. PSYCHIATRIC MENT. HEALTH NURS. 649 (2002); Jennifer L. Skeem, & John Monahan, *Current Directions in Violence Risk Assessment*, 20 CURRENT DIRECTIONS IN PSYCHOL. SCIENCE 338 (2014) (arguing for a transition from violence risk assessment to research designed to understand the causes of violence and to use information obtained from violence risk assessment to plans to reduce violence); Kevin Douglas et al., *Violence Risk Assessment: Science and Practice*, 4 LEGAL AND CRIMINOLOGICAL PSYCHOL. 149 (1999). Although there are many controversies in the field of mental health law, the area of violence risk assessment is one where there is a general consensus on the need to integrate empirically-based factors of violence risk. However, the exact content of violence risk factors has not been agreed upon, and likely never will.

46. KEVIN DOUGLAS ET AL., BRITISH COLUMBIA: MENTAL HEALTH, LAW, AND POLICY INSTITUTE, MANUAL FOR THE HCR-20^{V3} (2013). In a recent paper, Kevin Douglas supported the belief that the HCR-20 is uniquely positioned to be used with conditional release risk assessments because it encompasses many critical items that warrant consideration when evaluating whether an individual is suitable for release from a forensic hospital. *See* Kevin Douglas, *Version 3 of the Historical-Clinical-Risk Management-20 (HCR-20V3): Relevance to Violence Risk Assessment and*

the authors considered the use of the HCR-20 with 142 individuals adjudicated NGRI and released to New York communities over a ten-year period.⁴⁷ The results found very few items from the HCR-20 associated with conditional release revocation even though one of the scales (Historical) demonstrated the ability to differentiate insanity acquittees who were not revoked from those who were.⁴⁸

Another example considers the state of Virginia, which employs a customized risk assessment rating only used in Virginia for evaluating NGRI acquittees.⁴⁹ The specialized instrument, which consists of twenty items, mirrors the HCR-20 by considering both historical and dynamic risk variables.⁵⁰ In Virginia, the items related to revocation on conditional release were: previous failure on conditional release and problematic adherence to hospital treatment. As such, the expediency of the remaining items is questionable in reference to generating predictive statements of risk for revocation or violence. The results only change minimally when considering time to failure. In that case, items considering previous failure on conditional release, number of previous violence charges, and number of overall charge predicted time to conditional release revocation.⁵¹

An additional study using the HCR-20 is worthy of mention given its consistency with other findings here. In this study, the HCR-20 was the variable studied in reference to predicting release decisions with insanity forensic patients in the state of Georgia.⁵² Two items

Management in Forensic Conditional Release Contexts, 32 BEHAV. SCI. & L. 557 (2014).

47. See Debbie Green et al., *Factors Associated with Recommitment of NGRI Acquittees to a Forensic Hospital*, 32 BEHAV. SCI. & L. 608 (2014).

48. *Id.* (finding the Historical scale was significantly associated with revocation of conditional release, but the other two scales were not related to revocation of conditional release, raising questions of considering the entire HCR-20 in the determination of risk decisions suggesting the use of the other scales to make release decisions would be tantamount to adding error into the mix, stating: "Specifically, approximately half (47.5%) of those with high scores on the Historical scale were recommitted, compared with 15.4% of those with low scores. Further the Historical scale was the only HCR-20 scale associated with recommitment when combined with period of transfer.").

49. Vitacco et al., *supra* note 2.

50. Vitacco et al., *supra* note 2 (finding limited support for the entire measure; instead, finding select items were related to revocation or success of conditional release; only previous failure on conditional release and problematic adherence to hospital treatment were predictive of revocation of conditional release).

51. Vitacco et al., *supra* note 2.

52. See Michael Vitacco et al., *Projecting Risk: The Importance of the HCR-20 "Risk" Scale in Predicting Outcomes with Forensic Patients*, 34 BEHAV. SCI. & L. 308 (2016).

from the “Risk” scale, a scale designed to predict future problems, were associated with outcome. The two items were Building Stable Environments and Reducing Stress, and were predictive of release decisions when comparing insanity acquittees who were not allowed to be discharged, those discharged and revoked, and those discharged who were not returned to the hospital. Clinicians conducting evaluations of conditional release must balance the knowledge that structured instruments provide critical data, while acknowledging limitations of the instruments, even in light of apparent face validity.⁵³

In conditional release evaluations, it may be time to consider moving beyond current risk assessment measures to more specific, specialized risk items relevant to conditional release. Extant literature has identified several factors predictive of revocation of conditional release in multiple samples across states. These studies have evaluated data on conditionally released insanity acquittees from Louisiana, Maryland, Virginia, and Wisconsin.⁵⁴ Picking risk assessment items and appropriately determining which insanity acquittees are best suited for release to the community is of critical importance. In these situations, the success of entire conditional release programs is predicated on community-based insanity

53. *Id.* The Risk scale is designed to prognosticate community-problems and to try and design interventions for preventing issues. One of the keys for successful conditional release is the development and implementation of community-based programming.

54. See generally Vitacco et al., *supra* note 2; Gina Manguno-Mire et al., *What Factors Are Related to Success on Conditional Release/Discharge? Findings from the New Orleans Forensic Aftercare Clinic: 2002–2013*, 32 BEHAV. SCI. & L. 641 (2014); Daniel Marshall et al., *Predicting Voluntary and Involuntary Readmissions to Forensic Hospitals by Insanity Acquittes in Maryland*, 32 BEHAV. SCI. & L. 627 (2014); Michael Vitacco et al., *Developing Services for Insanity Acquittes Conditionally Released into the Community: Maximizing Success and Minimizing Recidivism*, 5 PSYCHOL. SERVS. 118 (2008). These studies have identified empirically-linked factors that correlate with failure on conditional release. What is noteworthy is that many factors linked to failure on conditional release are not listed on formal risk assessment measures. Much of the information gleaned from risk assessment instruments is not effective for insanity acquittees on conditional release. This is critical for clinicians to consider. Instead, several common themes have emerged and clinicians conducting risk assessments with insanity acquittees should consider the following: previous revocation of conditional release, significant history with substance use, presence of antisocial or borderline personality disorder, lack of financial resources, and problems complying with treatment. The goal when employing risk assessment is not simply to predict violence. Instead, the goal with this population is the development of risk management plans designed to successfully manage the NGRI acquittee in the community and protect the public.

acquittees not committing significant acts of violence.⁵⁵ Part III provides specific information on how well current programs do in maintaining conditionally released individuals in the community.

III. POST-*FOUCHA* ISSUES: DANGEROUSNESS, DIAGNOSES, AND COMMITMENT

Beginning with the landmark case of *Foucha v. Louisiana*, states have used conditional release to manage insanity acquittees as well as to manage budgets.⁵⁶ When done effectively, conditional release programs save a significant amount of money for already stretched state mental health budgets.⁵⁷ As described earlier, the decision in *Foucha* provided a pathway for states to set criteria for the release of insanity acquittees. These issues would appear relatively straightforward. For instance, does the individual continue to have a mental illness that results in dangerousness?⁵⁸ However, this decision is far from straightforward, and has frequently led to confusion, both for clinicians and attorneys alike. As discussed below, the courts have often decided cases in a manner clouding the diagnostic criteria relevant for conditional release decisions.

Conditional release programs in their various forms have legal precedent in both state and federal systems, but the manner in which states determine to operate them can be vastly different.⁵⁹ As a result, states have developed unique plans for how to implement conditional release. Critical to the argument are temporal issues regarding dangerousness. For instance, insanity is focused on the defendant's mental state during the time of the offense; however, in

55. Vitacco et al., *supra* note 52. Vitacco and colleagues (2008) underscored the importance of appropriate follow-up care, including housing. In fact, not having appropriate follow-up services may prove to be a valid risk factor predicting which individuals on conditional release may not ultimately be successful. It may also be possible that this potential risk factor should be utilized to determine who is a viable candidate for conditional release from a forensic hospital. More research is needed on this topic and evaluating the importance of specific dynamic variables related to successful community reintegration.

56. 504 U.S. 71 (1992).

57. See Ilan Melnick, *Passageway: A Novel Approach to Conditional Release*, 34 BEHAV. SCI. & L. 396 (2016) (describing how a conditional release effectively is cost-saving for the state of Florida).

58. DEBRA PINALS & DOUGLAS MOSSMAN, *EVALUATION FOR CIVIL COMMITMENT* (Oxford University Press 2012) (providing a history and current state of commitment standards throughout the United States).

59. Patricia Griffin et al., *Designing Conditional Release System for Insanity Acquittees*, 18 J. MENTAL HEALTH ADMIN. 231-41 (1991).

conditional release the focal issue centers on the acquittee's current mental status and dangerousness. Yet, in making this temporal distinction, some courts have allowed consideration of remote violence in the prediction of future violence when considering conditional release. As in *Jones*, once an insanity acquittee is committed he or she has the burden to prove that he or she is no longer dangerous.⁶⁰ In federal law, on the basis of the Insanity Defense Reform Act, insanity acquittees have the burden of proof to show by clear and convincing evidence their release would not cause a risk.⁶¹ In insanity release cases, "dangerousness" is an elusive, ill-defined construct that can vary significantly across jurisdictions. Along similar lines, the notion of mental illness in these cases is ambiguously defined and agreement regarding diagnoses between professionals remains elusive.⁶² It should be noted, however, that most states have statutory definitions of mental illness.⁶³ For instance, one only needs to consider the *Miller* case to understand that courts can rely on almost any diagnosis to justify continued commitment for an insanity acquittee and rely on even obscure evidence of dangerousness.⁶⁴

60. *Jones v. United States*, 463 U.S. 354 (1983).

61. See 18 U.S.C. § 4243(d) (2012) ("In a hearing pursuant to subsection (c) of this section, a person found not guilty only by reason of insanity of an offense involving bodily injury to, or serious damage to the property of, another person, or involving a substantial risk of such injury or damage, has the burden of proving by clear and convincing evidence that his release would not create a substantial risk of bodily injury to another person or serious damage of property of another due to a present mental disease or defect. With respect to any other offense, the person has the burden of such proof by a preponderance of the evidence.").

62. PINALS & MOSSMAN, *supra* note 58, at 76–77 (indicating modest kappas for major diagnoses and also underscoring that unlike other medical decisions, the decisions on psychiatric diagnoses "usually depends entirely on clinicians' observations and patients' reports about their experiences").

63. For example, in Georgia, the state in which this author primarily practices, mental illness is defined by the following, found in O.C.G.A. 17-7-131 (2010): "Mentally ill' means having a disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life. However, the term 'mental illness' shall not include a mental state manifested only by repeated unlawful or antisocial conduct."

64. *State v. Miller*, 933 P.2d 606, 616 (Haw.1997). Miller argued before the Supreme Court of Hawaii that he was inappropriately denied conditional release. *Id.* at 609. The court rejected Miller's arguments for release and made several critical statements relevant to conditional release in Hawaii, specifically as conditional release relates to dangerousness and mental illness. The Supreme Court of Hawaii ruled: "First, we see no problem with the circuit court considering the insanity acquittee's past misconduct in determining whether the insanity acquittee is still suffering from a mental illness. The court has discretion to consider all relevant

In *Miller*, a court-appointed psychologist testified that Miller suffered from sexual sadism, antisocial personality disorder, and psychoactive substance abuse and, therefore, met criteria for both mental illness and dangerousness.⁶⁵ Many mental health professionals would not consider these diagnoses to reflect the statutory definitions of mental illness or reflective of serious and persistent mental illness, but instead indicative of character pathology. Similar findings have been made in other jurisdictions, that courts have shown the propensity to rely on diagnoses to justify continued commitment, including diagnoses that would likely not qualify an individual for an insanity defense in the first place. In *State v. Klein*, the Washington Supreme Court ruled diagnoses of polysubstance dependence and personality disorder, not otherwise specified, were sufficient for the purpose of continued confinement in a state mental health facility, as long as they bore some reasonable relation to the purpose for which Klein was committed.⁶⁶ The Supreme Court of Georgia made a similar ruling regarding a diagnosis of Antisocial Personality Disorder.⁶⁷ In *Dupree v. Schwarzkophf*, despite testimony from a clinical psychologist opining a patient's schizoaffective disorder was in remission, the court ruled in

evidence, including expert testimony, the insanity acquittee's misconduct, and observations of the insanity acquittee, in determining whether the insanity acquittee is legally insane." *Id.* at 615. The court went on to state: "The focal point of the release proceeding is not on past acts, but on current diagnosis of a present mental illness, disease or disorder that renders the person dangerousness." *Id.*

65. *Id.* at 616.

66. *State v. Klein*, 124 P.3d 644 (Wash. 2005). In this case, the Washington Supreme Court ruled on the continued confinement of Tina Klein, who stabbed her twenty-month old nephew with a butcher knife. *Id.* at 646. The child survived and Ms. Klein was found not guilty by reason of insanity, granted conditional release, and ultimately remanded to Western State Hospital in Tacoma, Washington for repeated violation of the terms of her release. *Id.* Ms. Klein petitioned the court for full release on the basis she no longer suffered from a mental disorder. *Id.* at 647. In a 6-3 decision, the Washington Supreme Court ruled an insanity acquittee was not required to have the same diagnoses that formed the basis for the plea. *Id.* at 654. The court ruled that Ms. Klein "presented a substantial danger to others or a substantial likelihood of committing criminal acts jeopardizing public safety." *Id.* The dissent was noteworthy as it embraced a more traditional definition of mental illness in stating substance abuse is not a mental disorder, and it is more in-line with an addiction. *Id.* at 654-58 (Sanders, J., dissenting). As such, the dissent believed Ms. Klein should have been granted release. *Id.*

67. *See Dupree v. Schwarzkophf*, No. S11A0290, 2011 WL 2519534 (Ga. 2011), *vacated as moot by Dupree v. Schwarzkophf*, 745 S.E.2d 279 (Ga. 2011). The court vacated the opinion because Dupree obtained release prior to the court's ruling on his habeas appeal. *Dupree*, 745 S.E.2d at 279. The reasoning contained within the vacated opinion illuminates the state judiciary's stance on this issue.

favor of Dupree's continued confinement in a state mental health facility because he also had antisocial personality disorder.⁶⁸ In *Dupree*, the psychologist also testified that Dupree "did not present an imminent risk of harm to [himself] or others."⁶⁹ Despite this, the court ruled the continued diagnosis of antisocial personality disorder did indeed qualify Dupree for continued commitment and hospitalization.⁷⁰

Other states have yet to document the need for a clear link between mental illness and dangerousness. For instance in the case of *State v. Huss*, the Iowa Supreme Court focused their decision to remand the case back to the district court on the need for a finding of continued dangerousness, without considering Huss's continued mental illness as a factor.⁷¹

The final area of law regarding post-commitment issues is the manner in which the court would interpret a breach of conditional release that could lead to revocation. Similar to conceptualization of dangerousness and potential diagnoses eligible for continued commitment under NGRI, there have been differing responses to what would warrant a revocation of conditional release and mandate the NGRI acquittee to return to the hospital or other secure setting. One only needs to consider the cases presented in this Article to

68. See *Dupree*, 2011 WL 2519534.

69. *Id.*

70. *Id.* (stating that Dupree's personality disorders qualify as mental illnesses as defined by OCGA § 37-1-1 (12), which defines mental illness as a "disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.").

71. See *State v. Huss*, 666 N.W.2d 152 (Iowa 2003). In *State v. Huss*, the Supreme Court of Iowa focused on a conditional release of Loren Huss, who was found not guilty by reason of insanity for the murder of his girlfriend. *Id.* at 155. He was diagnosed with Bipolar Disorder with Psychotic Features and Antisocial Personality Disorder. *Id.* at 155-56. The district court found Mr. Huss met criteria for continued commitment despite reports from a psychiatrist working with Mr. Huss who opined that he was no longer mentally ill or dangerous. *Id.* at 155. The Iowa Supreme Court reversed and remanded the case back to the district court after finding Mr. Huss remained mentally ill, but was not currently dangerous. *Id.* at 162-63. Huss had a significant history of violent behavior toward women, and the murder of his girlfriend was particularly heinous. In determining the definition of dangerousness for Huss, the court relied on an earlier ruling where they said the following: "[t]o confine a citizen against his will because he is likely to be dangerous in the future, it must be shown that he has actually been dangerous in the *recent* past and that such danger was manifested by an overt act, attempt or threat to do substantial harm to himself or to another." *Id.* at 155, 162. Based on the lack of substantial findings to support the finding of dangerousness, the Supreme Court of Iowa mandated Huss' release absent a finding of dangerousness. *Id.* at 163.

understand how various courts may differ on what constitutes a mental illness for the sake of continued inpatient treatment with an NGRI acquittee. Of course, any new criminal behavior could lead to a return to a hospital or even to prison time.

Yet, how violations are conceptualized and handled can be done quite differently across jurisdictions. Two cases focusing on the revocation of conditional release exemplify the inexact nature of the manner in which insanity acquittees can be revoked or allowed to remain in the community. In the *United States v. Crape*, the Eleventh Circuit allowed Mr. Crape to remain in the community despite behavior that in most jurisdictions would have led to a significant restriction or a loss of liberty.⁷² In this ruling, the Eleventh Circuit appears to have diminished the influence of potentially dangerous behavior as a condition of release. In a later case, *United States v. Washington*, the Fifth Circuit Court of Appeals ruled that violating court-ordered treatment was sufficient for ordering the insanity acquittee to return to an inpatient facility and his continued release constituted a danger to society.⁷³ Notably, the Fifth Circuit

72. See *United States v. Crape*, 603 F.3d 1237 (11th Cir. 2010). In this case, the Eleventh Circuit considered the case of Mr. Michael Crape, who was arrested and charged after writing threatening letters to President Bush and Vice President Cheney. *Id.* at 1239-40. Mr. Crape was found NGRI. *Id.* After being committed to a treatment facility, then conditionally discharged, Mr. Crape began writing threatening letters again, which led to the revocation of his conditional release. *Id.* at 1240. Mr. Crape appealed and the court of appeals ruled in his favor because writing threatening letters was not considered to indicate noncompliance with treatment. *Id.* at 1247. The court agreed Mr. Crape's behavior may have been illegal and could have led to his arrest, but did not warrant a revocation of his conditional release. *Id.* See also Kavya Singareddy & Reena Kapoor, *Conditional Release of Insanity Acquittes*, 40 J. AM ACAD. PSYCH & L. 141 (2012) (discussing the *Crape* ruling and noting that the case raises significant questions about how to manage insanity acquittees in the community who are treatment compliant, yet engage in potentially dangerous behavior. In this case the behavior may be considered more salient given that it is behavior consistent with acts leading him to be found NGRI.)

73. See *United States v. Washington*, 764 F.3d 491 (5th Cir. 2014). The Fifth Circuit ruled that Mr. Marvin Goodlow Washington could have his conditional release revoked after being evicted from a group home, which was part of his prescribed, court-ordered mental health treatment. *Id.* at 498-99. Mr. Washington was found not guilty by reason of insanity on a charge of bank robbery. *Id.* at 482. The court rejected the defendant's argument that placement in a group home did not constitute treatment. *Id.* Furthermore, the court ruled Mr. Washington's continued release would represent a substantial risk to the public. *Id.* at 496. As a result, Mr. Washington's conditional release was revoked. *Id.* at 500. The court's decision emphasized that Mr. Washington's placement was codified in his treatment plan, and therefore his eviction was a clear violation. *Id.* at 497-99.

considered *Crape* in their decision in *Washington*, but ultimately rejected that reasoning.⁷⁴

One such lesson to be gleaned from these decisions is that conditional release providers should be highly specific in their treatment plans regarding what behavior could warrant revocation. Conditional release plans should include specific management plans, including living arrangements and rules and regulations that must be followed.

In considering changes to the law and its application in conditional release programs, it is not surprising that states and the federal government have relied on conditional release to manage insanity acquittees who no longer pose a danger to society. Data from insanity acquittees in Virginia, shows that a well-managed program leads to high levels of success,⁷⁵ which is often the result of specialized housing services and intense community management.⁷⁶ The data presented in this brief section shows the overall success of state-wide programs in providing intensive case management and supervision services. I primarily focus on data from three states: Wisconsin, Virginia, and Maryland.⁷⁷ These three diverse states have remarkable similarities. In addition, results from New York,⁷⁸ are also discussed in this section to enable the reader to evaluate conditional release programs.

This author and colleagues evaluated the files of 363 insanity acquittees on conditional release in the state of Wisconsin who were, with comprehensive plans, being monitored in community-based settings.⁷⁹ The large majority of the sample maintained their release

74. *Washington*, 764 F.3d at 498 (“[R]eliance on *Crape* is misplaced because, unlike the ancillary requirement imposed by the court in *Crape*, the residence requirement here was a component of Washington’s physician-prescribed regimen.”).

75. See Vitacco et al., *supra* note 2.

76. Marshall et al., *supra* note 54. The Marshall et al. (2014) study reported that 195 individuals out of a total of 356 were readmitted to hospitals. However, the large majority of these folks were never revoked. If programs work, hospitals are available for medication adjustments, which actually serve to decrease overall revocations.

77. See Vitacco et al., *supra* note 2.

78. See Green et al., *supra* note 47.

79. See Vitacco et al., *supra* note 52. This sample included every individual released during an extended period in the state of Wisconsin. The article focused on two primary aspects of conditional release. First, factors relevant to revocation of release. The second aspect focused on the overall success of the conditionally release program. The study found high success rates for individuals on conditional release. Most notable was the extremely low rate of new criminal behavior, and even lower rate of violent behavior. The sample itself had a significant amount of criminal behavior leading to the insanity plea. Specifically, 53.1% of the sample was arrested

for the full time of follow-up.⁸⁰ Moreover, if conditional release works as it is expected, individuals are brought back into a secure mental health setting before they decompensate back to manifesting significant mental health issues. As evidenced in this study, consistent monitoring can take a group that is at a high risk for violence, based on their history, and minimize risk. Certainly, this has both public health and public policy implications.

Another state-wide study on conditional release was conducted in Virginia.⁸¹ The results of the Virginia study, which included 127 insanity acquittees, mirrored the study in Wisconsin in several remarkable ways, including the behaviors leading to revocation. Another state-wide database was obtained from Maryland and consisted of 356 individuals on conditional release who were followed for three years.⁸² Results were consistent with those from other jurisdictions regarding factors related to revocation, but underscored the overall success of a conditional release program in maintaining individuals in the community. A state-wide study from Maryland also demonstrated the availability of appropriate community-based mental health treatment and its impact on minimizing problems with insanity acquittees.⁸³

Other research has generated similar results, especially concerning low recidivism and showing the success of community-based monitoring.⁸⁴ To be successful, programs must appropriately use

for a violent offense and 10.5% of the sample had a sexually-based offense. Of the total sample of 362 individuals on conditional release, 240 individuals maintained their release during the entire follow-up period. Of the 123 individuals revoked, only 7.11% committed a new crime and only 3.68% were revoked for a violent offense, none of which were homicides.

80. See Vitacco et al., *supra* note 52, at 121.

81. See Vitacco et al., *supra* note 2, at 348.

82. See Marshall et al., *supra* note 54.

83. See Vitacco et al., *supra* note 52. Out of the entire sample of 356 insanity acquittees on conditional release the overall recidivism rate was 14%. When comparing this number with prisoners from the state of Maryland, the overall recidivism percentage for insanity acquittees is much lower than individuals released from prison in the state of Maryland, which stood at approximately 40%. See Justin George, *Ex-Offenders Less Likely to Return to Prison, Maryland Officials Say*, BALTIMORE SUN, Sept. 30, 2013 at A1.

84. Gina Manguno-Mire et al., *What Factors are Related to Success on Conditional Release/Discharge? Findings from the New Orleans Forensic Aftercare Clinic: 2002–2013*, 32 BEHAV. SCI. & L. 641–58 (2014). In this ten-year study, over 70% of individuals maintained their conditional release. Just five individuals had their release revoked as a result of new charges. Another research study underscoring that conditional release programs, when monitoring is done correctly, are successful. In contrast to the *Crape* decision, these results show the necessity of

clinical recommendations for each individual even if the specifics of follow-up care are difficult to implement in practice.⁸⁵ Some of these difficulties appear to stem from evaluator disagreement.⁸⁶

CONCLUSION

Policy and mental health decision-makers should strongly consider the positive evidence available regarding the success of conditional release programs. Relying on empirical studies as a foundation for conditional release programs is a positive alternative to allowing fear-based perceptions of mental illness to guide policy decisions. As demonstrated by multiple empirical studies across states, the efficacy of these intensive programs that monitor and ensure treatment compliance with insanity acquittees result in a successful return to the community. Once treated, most individuals with mental illness do not commit other crimes, and returns to the hospital are the result of violations of release and not criminal recidivism. Generating new discussion and developing informed policy should be at the forefront of future discussions on the best practices for successfully managing insanity acquittees. It is hoped that this Article serves as just one step in the process of implementing empirically-informed public policy with insanity acquittees released into the community. Although weaknesses remain in how decision-making for forensic patients leaving the hospital is completed, such results do not detract from the success of conditional release programs. But the bigger question remains: Can conditional release programs be improved upon and developed enough to generate even lower rates of recidivism and revocations? The answer appears to be yes.

taking rule violations seriously with the goal of minimizing actual criminal recidivism. Based on the link between mental illness and criminal behavior in this select group of individuals it is imperative to minimize psychiatric decompensation.

85. Manguno-Mire et al., *Are Release Recommendations for NGRI Acquittees Informed by Relevant Data?*, 25 BEHAV. SCI. & L. 44, 44-45 (2007). See also Eric Elbogen, & Alan Tomkins, *From the Psychiatric Hospital to the Community: Integrating Conditional Release and Contingency Management*, 18 BEHAV. SCI. & L., 427, 430-32 (2000).

86. See Rebecca Stredny et al., *Evaluator Agreement in Placement Recommendations for Insanity Acquittees*, 30 BEHAV. SCI. & L. 297 (2012). Decision-making regarding forensic patients is an understudied phenomenon. This article pointed out issues with reliability and validity concerning conditional release evaluations. See also Neil Gowensmith et al., *Decision-Making in Post-Acquittal Hospital Release: How Do Forensic Evaluators Make Their Decisions?*, 32 BEHAV. SCI. & L. 596, 599 (2014). Both articles informed readers about the imprecision of how conditional release decisions are arrived at and substantiates the limitations of a lack of systematic structure in determining who is eligible for conditional release.