# PLACED IN PURGATORY: CONDITIONAL RELEASE OF INSANITY ACQUITTEES

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## I. INTRODUCTION: PUNISHING THE UNPUNISHABLE?

Our criminal law assumes that people have the ability to choose between socially acceptable and socially unacceptable behavior. Thus, they can be held responsible and punished for socially unacceptable behavior that violates the criminal law. Individuals who engage in the same criminal behavior but who lack the ability to choose are not blameworthy and are not subject to punishment. If the disability is caused by an individual's severe mental disorder, then the insanity defense precludes criminal responsibility. Each state's definition of insanity establishes the line separating the "bad"—criminals who can be punished for their conduct—from the "mad"—insanity acquittees who cannot.

Unlike other acquittees who are free to rejoin society, insanity acquittees are almost invariably detained for treatment to prevent repetition of their irresponsible behavior.[1] In fact, the United States Supreme Court has categorized insanity acquittees as a special class who can be processed differently from other candidates for involuntary civil commitment.[2] The Court upheld a statute authorizing the indefinite commitment of an insanity acquittee upon an insanity verdict even though that statute did not require a precommitment assessment of the acquittee's current mental condition. The insanity verdict itself was held to be sufficiently probative of the acquittee's mental disorder and dangerousness to

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1. AMERICAN BAR FOUND., THE MENTALLY DISABLED AND THE LAW 725–26, 786–95 tbl. 12.7 (Samuel J. Brackel et al. eds., 1985).

2. Jones v. United States, 463 U.S. 354, 370 (1983).

justify commitment to treat the acquittee and to protect society.[3]

Historically, individuals acquitted of serious crimes by reason of insanity were institutionalized for life. For example, after Daniel M'Naghten's celebrated trial in 1843 resulted in an insanity verdict,[4] M'Naghten was placed in a mental institution where he remained until his death in 1865.[5] During this twenty-two-year period, no court considered whether his mental condition had improved and his sanity had been restored, precluding his continued confinement.[6]

With the advent of powerful psychotropic medications, restoration of sanity and release from institutional confinement became therapeutically possible for many insanity acquittees. The public, however, seems adamantly opposed to this development. As one author noted, the public doubts that treatment for dangerous mental illness is effective or that dangerous mentally ill people can get better.[7] "And if someone seems to have gotten better, they doubt that he was ever sick at all; therefore, he must have been scamming, so he should be punished."[8]

After John Hinckley's attempted assassination of President Ronald Reagan, the public became outraged when Hinckley successfully relied upon the insanity defense and avoided any punishment. It seemed inconceivable that Hinckley, who planned to, and did, shoot the President, could be found not guilty of any crime. Surely, the jury must have been duped by Hinckley's clever attorneys who hired mental health professional expert witnesses to testify that Hinckley was insane.[9] The author of a book on the Hinckley trial asserted that if Hinckley had been lynched soon after the shooting, such an event would probably have caused no more anguish to society than did his acquittal.[10] The public's fury was directed not only at Hinckley, however, but also at his lawyers, their forensic experts, and especially at the insanity defense itself. In response, Congress and many state legislatures enacted legislation that narrowed the substantive test of insanity, placed the burden of proving insanity upon the defendant, restricted the scope of expert testimony, and established strict procedures for the confinement and release of insanity acquittees.[11]

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3. *Id.* at 366.

4. Daniel M'Naghten's Case, 8 Eng. Rep. 718 (H.L. 1843).

5. M'Naghten was placed in Bethlehem Hospital in 1843. JOHN BIGGS, THE GUILTY MIND 102 (1955). Bethlehem Hospital was popularly known as "Bedlam." 3 ENCYCLOPEDIA AMERICANA 434 (1993). In 1864, one year before his death, M'Naghten was transferred to Broadmoor Hospital. BIGGS, *supra.*

6. Benham v. Edwards, 501 F. Supp. 1050, 1057 (N.D. Ga. 1980), *aff'd in part, vacated in part,* 678 F.2d 511 (5th Cir. 1982), *vacated sub nom,* Ledbetter v. Benham, 463 U.S. 1222 (1983).

7. DENIS WOYCHUK, ATTORNEY FOR THE DAMNED 109 (1996).

8. *Id.*

9. Michael L. Perlin, *The Insanity Defense: Deconstructing the Myths and Reconstructing the Jurisprudence, in* LAW, MENTAL HEALTH, AND MENTAL DISORDER 341, 347 (Bruce D. Sales & Daniel W. Shuman eds., 1996).

10. LINCOLN CAPLAN, THE INSANITY DEFENSE AND THE TRIAL OF JOHN W. HINKLEY, JR. 116 (1984).

11. *See, e.g.,* The Comprehensive Crime Control Act of 1984, Pub. L. No. 98–

The public's fear that a horde of insanity acquittees will be unleashed to murder, rape, and pillage with impunity is unfounded. There is no horde. Contrary to popular belief,[12] insanity is pleaded in less than one percent of all felony cases and is successful in only one-quarter of the cases in which it is pleaded.[13] Thus, for every 1000 felony cases, insanity is pleaded in approximately nine cases and is successful in only two.

Insanity is rarely pleaded because of the consequences that follow an insanity acquittal. Unlike guilty defendants whose confinement is limited to a specified term of years, insanity acquittees face an uncertain fate. They are confined for an indeterminate period—potentially for life—until they are no longer dangerous. Typically, insanity acquittees are confined for lengthy periods of time,[14] often spending more time confined than persons found guilty of the same crimes.[15] For example, in New York, the median length of confinement for guilty defendants is 819 days; for insanity acquittees, 1729 days. In California, the median length of confinement for guilty defendants is 610 days; for insanity acquittees, 1359 days.[16]

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473, 98 Stat. 1976, 2057, 2067, 2059 (1984) (codified at 18 U.S.C. § 17(a) (1994) (insanity test), § 17(b) (1994) (burden of proof), FED R. EVID. 704 (scope of expert testimony), 18 U.S.C. § 4243 (1994) (confinement and release of insanity acquittees)). For a discussion of this legislation and similar legislation enacted by state legislatures, see 3 MICHAEL L. PERLIN, MENTAL DISABILITY LAW: CIVIL AND CRIMINAL §§ 15.39 & 15.41 (1989). Some states enacted legislation creating a "guilty but mentally ill" verdict for the jury to consider as an alternative to an insanity acquittal verdict. A few even abolished the insanity defense, retaining only a limited *mens rea* defense. PERLIN, *supra*, § 15.41. For a discussion of these insanity defense reforms, see generally PERLIN, *supra*, §§ 15.09–15.10.

12. The public dramatically overestimates the use, and success, of the insanity defense. In one study, the public estimated that 37% of felony defendants plead insanity and that 44% of those pleas are successful. Thus, for every 1000 felony cases, the public estimates 370 insanity pleas of which 163 are successful. Eric Silver et al., *Demythologizing Inaccurate Perceptions of the Insanity Defense*, 18 LAW & HUM. BEHAV. 63, 67–68 (1994); *see also* Valerie P. Hans, *An Analysis of Public Attitudes Toward the Insanity Defense*, 2 CRIMINOLOGY 393, 406 (1986) (The public estimates that 38% of criminal defendants plead insanity and that 36% of those pleas are successful.).

13. An evaluation of 586,063 felony indictments in four states revealed 5302 insanity pleas (0.90%) and 1375 insanity acquittals (0.23%). HENRY J. STEADMAN ET AL., BEFORE AND AFTER HINCKLEY: EVALUATING INSANITY DEFENSE REFORM 27–28 tbl.2.2 (1993). An evaluation of 967,209 felony indictments in eight states revealed 8953 insanity pleas (0.93%) and 2555 insanity acquittals (0.26%). *Id.* at 173, 175 tbl.A4; *see also* Lisa A. Callahan et al., *The Volume and Characteristics of Insanity Defense Pleas: An Eight-State Study*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 331, 334–35 (1991).

14. Eric Silver, *Punishment or Treatment? Comparing the Lengths of Confinement of Successful and Unsuccessful Insanity Defendants*, 19 LAW & HUM. BEHAV. 375, 382 tbl.3 (1995).

15. A Canadian study of 280 insanity acquittees and 238 convicts revealed that, for homicide and attempted homicide, insanity acquittees spent the same length of time in custody as their convicted counterparts; for less serious offenses, insanity acquittees spent significantly more time in custody than did their convicted counterparts. *See* Grant T. Harris et al., *Length of Detention in Matched Groups of Insanity Acquittees and Convicted Offenders*, 14 INT'L J.L. & PSYCHIATRY 223, 225, 234 (1991).

16. Silver, *supra* note 14, at 382 tbl.3. Additionally, in most states, defendants

A multistate, longitudinal study revealed that the seriousness of the insanity acquittal offense significantly influenced the insanity acquittee's length of confinement.[17] In each of the seven states studied, longer confinements resulted from insanity acquittals of more serious offenses.[18] In fact, seriousness of the offense was a more significant release factor than seriousness of the patient's mental disorder.[19] Thus, the study suggested that insanity acquittees are being labeled as dangerous and punished for the serious offenses for which they were found insane and supposedly not punishable.[20]

The public's fear of insanity acquittees, although unfounded, is real. Legislatures have responded, permissibly, to alleviate those fears by redefining insanity so as to encompass a smaller group of criminal defendants and by assuring that those who successfully plead insanity are hospitalized and treated until they are no longer dangerous. The public's desire to punish insanity acquittees, while also real, is an impermissible basis for decision making. The Supreme Court has ruled that insanity acquittees have been exempted from criminal responsibility and may not be criminalized or punished.[21] Predictions of dangerousness do not substitute for criminal convictions to permit the continued incarceration of those insanity acquittees who are no longer mentally ill.[22]

In recent years, some states have created conditional release programs for insanity acquittees.[23] These programs provide a transitional step between institutional confinement and community freedom. Conditional release programs

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found guilty of crimes are more likely to be released at the conclusion of their trials than are defendants found not guilty by reason of insanity. *Id.* at 382–83.

17. *Id.* at 384.

18. *Id.* at 385.

19. *Id.* at 386.

20. *Id.* at 385.

21. Foucha v. Louisiana, 504 U.S. 71, 80 (1992).

22. *Id.* at 82–83. In *Foucha*, the insanity acquittee was diagnosed as having an antisocial personality disorder, a disorder that sometimes leads to criminal conduct. Nevertheless, the Court ruled that antisocial personality disorder does not constitute a mental illness sufficient to justify continued confinement. *Id.* at 82. *But see* Parrish v. Colorado, 78 F.3d 1473 (10th Cir.), *cert. denied*, 116 S. Ct. 2536 (1996). A Colorado statute authorized the continued commitment of insanity acquittees whose abnormal mental condition would be likely to cause them to be dangerous either to themselves, to others, or to the community. The Tenth Circuit upheld the constitutionality of this statute and its application to an insanity acquittee diagnosed with an antisocial personality disorder.

In *Kansas v. Hendricks*, 117 S. Ct. 2072 (1997), the Supreme Court upheld a statute that authorized the civil commitment of sexually violent predators. For a person to be declared a sexually violent predator, the statute required proof beyond a reasonable doubt that the person was likely to engage in predatory acts of sexual violence due to a mental abnormality or personality disorder. *Id.* at 2076–77. The statute was applicable to prisoners convicted of a sexually violent offense who were scheduled for release, criminal defendants charged with a sexually violent offense but found incompetent to stand trial, and insanity acquittees found not guilty of a sexually violent offense. *Id.* at 2077.

23. In 1980, outpatient treatment of insanity acquittees was permitted in only 18 states and the District of Columbia. Barbara A. Weiner, *Not Guilty by Reason of Insanity: A Sane Approach*, 56 CHI.-KENT L. REV. 1057 app. B at 1085 (1980).

advance therapeutic objectives by providing a continuity of supportive services in an outpatient context. They also respond to legitimate public safety concerns by monitoring the community treatment of insanity acquittees and assuring rapid reinstitutionalization should that treatment prove unsuccessful. Conditional release programs, however, may not be used to inflict impermissible punishment on insanity acquittees. When patients are retained in conditional release programs after they are no longer dangerous, society imposes affirmative disabilities in order to achieve deterrence—a traditional aim of punishment.[24]

Part II of this article briefly discusses studies of conditional release programs in various states. Those studies focus on whether such programs have achieved the objective of enhancing community security.

Part III reports on a study that I conducted of all insanity acquittee patients processed through the San Diego County Conditional Release Program since its inception in 1986. Unlike other studies, this study focuses on whether insanity acquittee patients are being punished in order to assure community security. I examine the recommendations of the program's mental health professionals on the determinative issues of patient status: Should the patient's conditional release be revoked; should the patient be restored to sanity; should the patient be retained in the program for an additional year? In making their recommendations, did these professionals use appropriate standards? Did they apply those standards consistently to all patients? Did they present sufficient evidence to support their judgments in individual cases? The article concludes with recommendations to assure that the San Diego program, and any other conditional release program, achieves its legitimate objectives without inflicting impermissible punishment on the patients it treats.

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24. In *Kennedy v. Mendoza-Martinez*, 372 U.S. 144 (1963), the Supreme Court identified the following factors to be considered in determining whether a statutory sanction is punitive in nature:

> [w]hether the sanction involves an affirmative disability or restraint, whether it has historically been regarded as a punishment, whether it comes into play only on a finding of *scienter*, whether its operation will promote the traditional aims of punishment—retribution and deterrence, whether the behavior to which it applies is already a crime, whether an alternative purpose to which it applies is already a crime, whether an alternative purpose to which it may rationally be connected is assignable for it, and whether it appears excessive in relation to the alternative purpose assigned....

*Id.* at 168–69 (citations omitted).

The state may incapacitate a dangerous, mentally disordered person through its civil commitment process. In this context, the person's loss of freedom is considered a nonpunitive and legitimate exercise of governmental authority. *Hendricks*, 117 S. Ct. at 2083–84. The civil commitment process may not be used, however, to incapacitate mentally disordered persons who are not dangerous and who may live safely in freedom. O'Connor v. Donaldson, 422 U.S. 563, 575 (1975).

## II. CONDITIONAL RELEASE PROGRAMS: VARIATIONS ON A THEME

In 1967, Maryland became the first state to develop a comprehensive treatment program for insanity acquittees.[25] Defendants who are found not criminally responsible because of mental disorder are detained for an evaluation of their current mental condition. If the evaluation report indicates that the individual will not be a danger, as a result of mental retardation or mental disorder, to himself or herself, or to the person or property of others, the court may order the individual released, with or without conditions.[26] Otherwise, the individual is committed to the Department of Health for inpatient care[27] until he or she is no longer dangerous.[28] A statute specifically authorizes conditional release of a confined individual if he or she will not be a danger if released with conditions imposed by the court.[29] These conditions may not continue for more than five years[30] unless the court, after a hearing on the issue, extends the conditional release by an additional five-year period.[31] If an individual violates a condition, the state's attorney may petition for, and the court, after a hearing on the issue, may order that conditional release be revoked and the individual returned to inpatient treatment.[32]

Maryland established an inpatient treatment program for insanity acquittees at Clifton T. Perkins Hospital Center, a secure facility in Baltimore.[33] As treatment progresses, patients are given increased freedom and increased responsibility. For example, a patient may be permitted to work in the community during the day and return to the hospital in the evening. If the patient succeeds, the facility may consider placing the patient in a suitable community living arrangement, such as a halfway house administered by the hospital.[34] When the hospital believes the patient is ready for outpatient care, it petitions the court that

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25. AMERICAN BAR FOUND., *supra* note 1, at 732.

26. MD. CODE ANN. HEALTH–GEN. § 12–111(c) (1994).

27. *Id.* § 12–111(a).

28. *Id.* § 12–113(b). A release hearing is conducted after the insanity acquittee's current mental condition is assessed. *Id.* § 12–114. Subsequent applications for release may be made not more frequently than once a year. *Id.* § 12–118(a). At those hearings, the insanity acquittee has the burden of proving eligibility for release by a preponderance of the evidence. *Id.* § 12–118(c)(4)(i). After hearing the evidence, the trier of fact renders a verdict for continued commitment, conditional release, or discharge from commitment. *Id.* § 12–118(c)(4)(ii).

29. *Id.* § 12–113(c).

30. *Id.* § 12–117(c).

31. *Id.* § 12–121(c). Similarly, in New York, the court's order of conditions is valid for five years but may be extended by the court for an additional five years. N.Y. CRIM. PROC. LAW § 330.20(o) (McKinney 1994).

32. MD. CODE ANN. HEALTH–GEN. § 12–120.

33. Michael K. Spodak et al., *Criminality of Discharged Insanity Acquittees: Fifteen Year Experience in Maryland Reviewed*, 12 BULL. AM. ACAD. PSYCHIATRY & L. 373, 373 (1984). The treatment program includes vocational, educational, and recreational components. Weiner, *supra* note 23, at 1076.

34. Weiner, *supra* note 23, at 1076–77.

committed the individual.[35] If the court grants conditional release, typically its order specifies the patient's place of residence, mandates outpatient treatment, prohibits substance abuse, and limits travel outside the state.[36]

Because the Maryland conditional release program has existed longer than other similar programs, researchers have been able to study Maryland insanity acquittees over lengthy periods of time and to speculate on the success of that program. For example, in one study, researchers examined the arrest, conviction, and incarceration record of all insanity acquittees who had been discharged from inpatient treatment for at least five years. Of ninety-one patients, sixty had been discharged between five and ten years, and thirty-one between ten and fifteen years.[37] All had participated in and completed Maryland's conditional release program.[38] Of the eighty-six patients on whom reliable data was found, eighty-one had been found not guilty by reason of insanity of felonies that represented a clear potential for physical harm to others in the community.[39]

The researchers found that forty-eight of the eighty-six patients (55.8%) had been arrested within the fifteen-year study period,[40] but that only twenty-six of the eighty-six patients (30.2%) were convicted.[41] In all but three cases, the subsequent convictions were for less serious offenses with less potential for physical harm than the original offense that resulted in an insanity acquittal.[42] In fact, only eleven individuals in the study group (12.8%) were incarcerated.[43] As a result of treatment in the hospital and the conditional release program, the insanity acquittees were arrested 2.5 times less frequently after their insanity acquittal, and thirty-eight acquittees (44.2%) were not rearrested at all.[44]

Nearly sixty percent of the new criminal charges were brought within five years of hospital discharge.[45] Thus, the researchers concluded that the five-year limitation on conditional release appropriately covers the period of greatest risk for criminal recidivism in the insanity acquittee population.[46]

A subsequent study compared the arrest records of 127 Maryland insanity acquittees with a matched prisoner control group of convicted felons and a comparison group of prisoners who were treated for mental disorder at Perkins and returned to prison after treatment.[47] Five years after institutional release, 54.3% of

35. MD. CODE ANN. HEALTH–GEN. § 12–119(a).
36. Spodak, *supra* note 33, at 374.
37. *Id.* at 375.
38. *Id.* at 374.
39. *Id.* at 375.
40. *Id.*
41. *Id.* at 376.
42. *Id.*
43. *Id.*
44. *Id.* at 380.
45. *Id.* at 381.
46. *Id.* at 382.
47. Stuart B. Silver et al., *Follow-up After Release of Insanity Acquittees, Mentally Disordered Offenders, and Convicted Felons*, 17 BULL. AM. ACAD. PSYCHIATRY & L. 387, 389 (1989).

the insanity acquittees had been rearrested, compared with 65.4% of the prisoner control group and 73.3% of the mentally disordered prisoners.[48] At the end of a seventeen-year follow-up period,[49] the rearrest rate was 65.8% for insanity acquittees, 75.4% for the prisoner control group, and 78.4% for mentally disordered prisoners.[50] Although all three groups had high rearrest rates, the insanity acquittee rate was significantly lower than the other two groups.[51] Additionally, insanity acquittees were arrested for less serious crimes.[52]

Illinois' conditional release program is substantially similar.[53] Researchers conducted a two-year longitudinal study of all insanity acquittees placed in the Cook County conditional release program.[54] Of forty-four individuals studied, thirty-five (79.5%) were acquitted by reason of insanity of murder or attempted murder.[55] During the two-year study period, no acquittee was rearrested for a violent crime or a crime against another person. Only two acquittees (4.5%) were even arrested—one for a misdemeanor shoplifting occurring during a psychotic episode (the patient was not convicted), and the other for contempt of court for refusing to comply with a court order for outpatient treatment.[56]

The researchers concluded that conditional release programs can safely manage insanity acquittees in the community. They attributed the success of the Illinois program to two factors. First, individuals with treatable mental disorders were specifically selected for outpatient treatment; individuals diagnosed primarily with personality disorders who were minimally motivated or antagonistic to community monitoring were excluded. Second, the conditional release program closely monitored the outpatients, quickly rehospitalizing those who failed to comply with medication requirements or whose mental condition was

48. *Id.* at 393 tbl.3.

49. The post-release follow-up period for insanity acquittees ranged from 7 to 17 years, with an average of 10.5 years. *Id.* at 396.

50. *Id.* at 393 tbl.3.

51. *Id.* at 399.

52. *Id.* at 394–95 & tbl.5. Another study of the same insanity acquittees revealed that fewer of the variables traditionally related to criminality were associated with rearrest of these patients. However, variables related to mental illness, such as prior hospitalization, alcoholism, drug dependence, and adaptation to the hospital environment, were related. Marcia I. Cohen et al., *Predicting Outcome of Insanity Acquittees Released to the Community*, 6 BEHAV. SCI. & L. 515, 528–29 (1988).

53. AMERICAN BAR. FOUND., *supra* note 1, at 732. Under the Illinois statute, conditional release lasts for a period of five years but may be extended by the court for an additional three years. Conditional release may not exceed eight years. 730 ILL. COMP. STAT. ANN. 5/5–2–4(a)(1)(D) (West Supp. 1997).

54. James L. Cavanaugh, Jr. & Orest E. Wasyliw, *Adjustment of the Not Guilty by Reason of Insanity (NGRI) Outpatient: An Initial Report*, 30 J. FORENSIC SCI. 24, 25 (1985). The insanity acquittees were treated at the Isaac Ray Center, an outpatient forensic clinic of the Department of Psychiatry, Rush Medical College. The Center opened in August, 1978. Richard Rogers & James L. Cavanaugh, *A Treatment Program for Potentially Violent Offender Patients*, 25 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 53, 53 (1981).

55. Cavanaugh & Wasyliw, *supra* note 54, at 26 tbl.1.

56. *Id.* at 26.

deteriorating.[57] Eleven of the forty-four patients (25.0%) had to be rehospitalized during the study period.[58]

In 1978, Oregon implemented a new model for the disposition of insanity acquittees. The statutes created a Psychiatric Security Review Board (PSRB) consisting of a psychiatrist, a psychologist, a lawyer experienced in criminal trial practice, a lay person, and an individual with substantial experience in parole and probation.[59] After an insanity verdict is rendered, the trial court determines whether the insanity acquittee currently has a mental disorder and is a substantial danger to others.[60] If so, the court places the person within the jurisdiction of the PSRB[61] and either commits the person for inpatient treatment or orders conditional release.[62] Thereafter, the Board is empowered to make all confinement, conditional release, or discharge decisions without any court involvement.[63] The legislation instructs the PSRB that, in making its determinations, "the board shall have as its primary concern the protection of society."[64] The Board's jurisdiction over an insanity acquittee extends for a period of time equal to the maximum sentence that could have been imposed had the acquittee been found sane.[65]

A forensic hospital administered by the Mental Health and Developmental Disability Services Division provides inpatient services.[66] That Division contracts with community mental health programs to provide outpatient treatment to insanity acquittees who have been conditionally released.[67]

The Oregon program has been the subject of numerous studies and reports.[68] Of particular interest are studies examining the results of PSRB decision

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57. *Id.* at 29.

58. *Id.* at 26.

59. OR. REV. STAT. § 161.385(1)–(2) (1995).

60. *Id.* § 161.327(1).

61. *Id.*

62. *Id.* § 161.327(2). If the court determines that the insanity acquittee no longer has a mental disorder or no longer is a substantial danger to others, the court orders the person discharged from custody. *Id.* § 161.329.

63. *Id.* §§ 161.341 (commitment), 161.336 (conditional release), 161.351 (discharge), 161.346 (hearings on changes in status).

64. *Id.* § 161.336(10).

65. *Id.* § 161.327(1).

66. Joseph D. Bloom & Mary H. Williams, *Oregon's Experience with Insanity Acquittees*, 22 PSYCHIATRIC ANNALS 579, 580 (1992).

67. *Id; see also* OR. REV. STAT. § 161.390(3); Joseph D. Bloom et al., *Evaluation and Treatment of Insanity Acquittees in the Community*, 14 BULL. AM. ACAD. PSYCHIATRY & L. 231, 234–35 (1986) (describes community hospital day treatment program in Portland, Oregon).

68. *See, e.g.*, JOSEPH D. BLOOM & MARY H. WILLIAMS, MANAGEMENT AND TREATMENT OF INSANITY ACQUITTEES: A MODEL FOR THE 1990S (1994); Jacqueline L. Bloom & Joseph D. Bloom, *Disposition of Insanity Defense Cases in Oregon*, 9 BULL. AM. ACAD. PSYCHIATRY & L. 93 (1981); Bloom & Williams, *supra* note 66; Joseph D. Bloom et al., *Monitored Conditional Release of Persons Found Not Guilty by Reason of Insanity*, 148 AM. J. PSYCHIATRY 444 (1991); Joseph D. Bloom et al., *Lifetime Police Contacts of Discharged Psychiatric Security Review Board Clients*, 8 INT'L J.L. & PSYCHIATRY 189

making during periods of three, five, and nine years. During its first three years, PSRB had jurisdiction over 440 insanity acquittees.[69] During that time, 165 (37.5%) were placed on conditional release.[70] Revocation of conditional release status was ordered for sixty-six of the 165 (40.0%).[71] PSRB discharged 144 patients (32.7%), but fifty-six of the 144 (38.9%) were discharged because PSRB jurisdiction had expired and not through PSRB decision making regarding these patients' mental condition or dangerousness.[72]

While on conditional release status, few patients were arrested for criminal activity. One study found that only six of 126 conditionally released patients (4.8%) were charged with new crimes. Four of the six were charged with misdemeanors. In all six cases, the charges were dismissed and the patients returned to PSRB jurisdiction.[73] Another study reported that sixteen of 165 conditionally released patients (9.7%) were arrested during PSRB's first three years. Six of the sixteen were found guilty.[74] To a large extent, insanity acquittees avoided police contacts while on conditional release or after discharge from that status. The "police contacts" category included arrests, contacts for juvenile problems, public drunkenness, and behaviors symptomatic of mental illness.[75] Prior to PSRB jurisdiction, the group averaged seven police contacts per person. During PSRB jurisdiction, police contacts dropped to .6 per person and after discharge from PSRB jurisdiction the number rose to 1.4 contacts per person.[76]

Subsequent studies continue to report a low criminal recidivism rate for insanity acquittees on conditional release. During its first five years, PSRB conditionally released 295 of the 630 (46.8%) insanity acquittees under its jurisdiction.[77] During the five-year study, thirty-nine (13.2%) were charged with new crimes—eighteen (6.1%) with felonies and twenty-one (7.1%) with

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(1986); Bloom et al., *supra* note 67; Joseph D. Bloom et al., *After Oregon's Insanity Defense: A Comparison of Conditional Release and Hospitalization*, 5 INT'L J.L. & PSYCHIATRY 391 (1982); Jeffrey L. Rogers & Joseph D. Bloom, *The Insanity Sentence: Oregon's Psychiatric Security Review Board*, 3 BEHAV. SCIENCE & L. 69 (1985); Jeffrey L. Rogers & Joseph D. Bloom, *Characteristics of Persons Committed to Oregon's Psychiatric Security Review Board*, 10 BULL. AM. ACAD. PSYCHIATRY & L. 155 (1982); Jeffrey L. Rogers et al., *Oregon's Psychiatric Security Review Board: A Comprehensive System for Managing Insanity Acquittees*, ANNALS AM. ACAD. POL. & SOC. SCI., Mar. 1986, at 86; Jeffrey L. Rogers et al., *Oregon's New Insanity Defense System: A Review of the First Five Years, 1978 to 1982*, 12 BULL. AM. ACAD. PSYCHIATRY & L. 383 (1984).

69. Rogers & Bloom, *Characteristics of Persons Committed to Oregon's Psychiatric Security Review Board*, *supra* note 68, at 157.

70. *Id.* at 161.

71. *Id.* at 162.

72. *Id.*

73. Bloom et al., *After Oregon's Insanity Defense*, *supra* note 68, at 400.

74. Rogers & Bloom, *Characteristics of Persons Committed to Oregon's Psychiatric Security Review Board*, *supra* note 68, at 161 tbl.7.

75. Bloom et al., *Lifetime Police Contacts of Discharged Psychiatric Review Board Clients*, *supra* note 68, at 193.

76. *Id.* at 201.

77. Rogers et al., *Oregon's New Insanity Defense System*, *supra* note 68, at 384, 393–94.

misdemeanors.[78] Charges were dismissed in fourteen of the thirty-nine reported cases.[79] The low criminal recidivism rate was attributed to the PSRB's ability to revoke conditional release status before a patient's problems developed into criminal activity. For example, of the sixty-one patients treated in the Portland outpatient program, only four (6.6%) were charged with new crimes, but conditional release status was revoked within one year for twenty-nine patients (47.5%).[80]

During a nine-year period, 381 of the 758 Oregon insanity acquittees were placed on conditional release.[81] Approximately fifteen percent were charged with new crimes, almost equally divided between felonies and misdemeanors.[82] Conditional release status was revoked in 48.6% of the cases.[83] Revocation occurred most frequently when patients did not comply with their treatment program or violated some other condition of their conditional release plan, suffered a deterioration in mental condition, or exhibited signs of dangerousness. Typically, revocation for dangerousness resulted from a clinical assessment that the patient's mental condition had deteriorated or from a patient's threat, not from a patient's dangerous behavior.[84] For patients whose conditional release status was revoked, the mean period of outpatient treatment was ten months.[85]

In 1985, Connecticut enacted legislation creating a Psychiatric Security Review Board.[86] The Connecticut Board's authority to make confinement and conditional release decisions is virtually identical to the Oregon Board's authority.[87] However, the Connecticut Board can only recommend to the court that insanity acquittees be discharged from custody.[88] The court makes all discharge decisions.[89]

In California, the court makes the initial decision to place the insanity

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78. *Id.* at 394.

79. *Id.* at 396.

80. *Id.* at 401 tbl.20. Another study of Portland's Day Treatment Program revealed that within two years, conditional release status was revoked for 46 of the 91 patients (50.5%) in the program. Bloom et al., *supra* note 67, at 235.

81. BLOOM & WILLIAMS, *supra* note 68, at 58.

82. *Id.* at 68. Researchers studied data on 366 patients. *Id.* at 65. Fifteen percent of that number is 55 patients. These patients were charged with 41 felonies and 43 misdemeanors. *Id.* at 68. Dispositional information on those arrests was not provided.

83. *Id.* at 65. The PSRB revoked conditional release status for 178 of the 366 patients studied. Conditional release was terminated by revocation or voluntary hospitalization in 56% of all cases. *Id.* at 58.

84. *Id.* at 58–59; *see id.* at 59 tbl.4–1.

85. *Id.* at 58.

86. CONN. GEN. STAT. ANN. § 17a–581 (West 1992).

87. *Id.* §§ 17a–584(2)–(3) (order of conditional release or confinement), 17–588 (conditional release), 17a–591 (modification of conditional release), 17a–594 (summary modification or termination of conditional release).

88. *Id.* §§ 17a–584(1), 17a–592.

89. *Id.* § 17a–593. The legislation directs the court that in deciding whether to discharge an insanity acquittee, "its primary concern is the protection of society." *Id.* § 17a–593(g).

acquittee in a state hospital, other public or private treatment facility, or on outpatient status.[90] The court also makes all decisions on any change in status, including discharge when a patient's sanity has been restored.[91] Before an insanity acquittee may be discharged as sane, the court must determine that he or she will not be a danger to the health and safety of others, due to mental disorder, while under supervision and treatment in the community. Upon such a finding, the court orders the insanity acquittee placed in a conditional release program for one year.[92] A trial to determine whether an acquittee's sanity has been restored is conducted only after the acquittee has completed one year in the conditional release program.[93] If the court determines that the acquittee's sanity has not been restored, the court may order the person confined to a treatment facility or may renew its approval of outpatient status.[94]

The California Department of Mental Health is responsible for community treatment and supervision of insanity acquittees.[95] Community treatment services may be provided by the Department directly or through contract with private providers or counties.[96] In Los Angeles, San Diego, and many of California's most populous counties, conditional release programs are administered through the county mental health agency.

In 1985, the California Legislature declared that institutional and community treatment programs for mentally disordered persons who commit serious crimes should reasonably ensure that such persons do not commit other crimes.[97] The Legislature ordered the Department of Mental Health to evaluate the conditional release program to determine its effectiveness in successfully

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90. CAL. PENAL CODE § 1026(a) (West Supp. 1997). If the defendant was found to be insane at the time of the alleged crime but at the time of the verdict it appears to the court that defendant's sanity "has been recovered fully," the defendant is remanded to the sheriff's custody until the issue of sanity is decided. *Id.* § 1026(a)–(b).

91. *Id.* §§ 1026(b) (An insanity acquittee shall not be released from confinement or outpatient status unless and until the court determines that the acquittee's sanity has been restored.); 1026(c) (The court decides whether an insanity acquittee who has been confined in a state hospital can be transferred to a public or approved private treatment facility.); 1026.2(e) (The court decides whether to place the insanity acquittee in outpatient treatment in a forensic conditional release program. At the completion of outpatient treatment, the court also decides whether the defendant's sanity has been restored.); 1603(a)(3) (An insanity acquittee may be placed on outpatient status only after the court specifically approves the outpatient treatment plan.); 1604(d) (An insanity acquittee may be placed on outpatient status only if the court approves the recommendation for outpatient status.); 1606 (At the end of the one-year period of outpatient status, the court determines whether the insanity acquittee is to be discharged, confined in a treatment facility, or retained on outpatient status.); 1608 (The court determines whether to approve a request for revocation of outpatient status.).

92. *Id.* § 1026.2(e).

93. *Id.* The restoration of sanity trial may be conducted sooner than one year upon the recommendation of the community program director. *Id.* § 1026.2(e), (h).

94. *Id.* § 1606.

95. *Id.* § 1615.

96. *Id.*

97. Act of Oct. 1, 1985, ch. 1416, § 1, 1985 Cal. Stat. 5003, 5004.

reintegrating patients into society. In making this evaluation, researchers were statutorily mandated to determine the rates of reoffense for persons on conditional release status and after discharge from that status.[98]

The Department conducted a longitudinal study of all patients conditionally released during the seven-year period from January 1, 1986 through December 31, 1992.[99] Eight hundred and six of the 1207 patients (66.8%) were insanity acquittees.[100] Only fifty-nine of 781 insanity acquittees studied (7.6%) were rearrested while on conditional release status.[101] The annualized rate of rearrest for this group was only 4.8%.[102] Rearrest rates remained low for those insanity acquittees who successfully completed the conditional release program and who were discharged as restored to sanity. Only 6.8% were arrested within one year of discharge, 9.4% within two years, and 19.0% within three years.[103] Even when conditionally released patients were arrested, they often were charged with less violent crimes than the crime that resulted in their insanity acquittal or in their arrest prior to that event.[104]

Under California law, when a person is acquitted of a crime by reason of insanity, the court specifies in its commitment order the maximum term of commitment. That term equals the longest term of imprisonment that could have been imposed for the underlying crime or crimes.[105] The insanity acquittee may not be detained longer than that maximum term unless a petition for extended commitment is filed and at a trial the person is found to be a substantial danger of physical harm to others by reason of mental disorder.[106] The researchers compared a group of conditionally released insanity acquittees with a group of insanity acquittees whose commitment had not been extended and who had been discharged at the end of their maximum terms without undergoing conditional release.[107]

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98. CAL. PENAL CODE § 1617 (West Supp. 1997).

99. SYSTEMS OF CARE RESEARCH & EVALUATION, CAL. DEP'T MENTAL HEALTH, THE EFFECTIVENESS OF THE CONDITIONAL RELEASE PROGRAM, SECOND REPORT (DRAFT) 10–11 & tbl.1 (1993) [hereinafter SYSTEMS OF CARE]. Mark R. Wiederanders, Ph.D., was the principal investigator of this report.

100. *Id.* at 11 tbl.1. Other patients treated in the conditional release program were 194 criminal defendants found incompetent to stand trial (16.1%), 117 mentally disordered sex offenders (9.7%), and 90 mentally disordered offenders (7.5%).

101. *Id.* at 14 tbl.3.

102. *Id.*

103. *Id.* at 26 fig.4.

104. *Id.* at 15 tbl.5. Of the 1159 conditionally released patients studied, 90.2% were arrested for a violent crime prior to their commitment, and 80.2% were arrested for a violent crime that resulted in their commitment. Of the 96 patients who were arrested while on conditional release, 52.1% were arrested for a violent crime. Arrests for murder, attempted murder, and manslaughter declined from 25.3% prior to commitment and 18.9% as the commitment crime, to 1.0% while on conditional release. *Id.*

105. CAL. PENAL CODE § 1026.5(a)(1) (West Supp. 1997).

106. *Id.* § 1026.5(b).

107. SYSTEMS OF CARE, *supra* note 99, at 16–19. There were 152 insanity acquittees in the conditionally released group and 83 in the group discharged without conditional release. *Id.* at 16–17.

Across a three-year period, the conditionally released patients had a significantly lower rearrest rate—but a significantly higher rehospitalization rate—than did the group discharged without conditional release.[108] The researchers concluded that the ability of the conditional release program to revoke conditional release status and return patients to in-hospital treatment when warranted "appears to have effectively prevented some criminal acts from occurring."[109]

When researchers examined a sample of fifty-two decisions to revoke conditional release status, they discovered that thirty-nine (75.0%) were precipitated by patients who left the program without permission, whose mental condition decompensated, who refused to comply with treatment or other program requirements, or who made threats. Thus, in most cases, revocation occurred after troublesome, rather than illegal, behavior.[110] Of the thirteen patients who engaged in arrestable conduct, eleven were not arrested (84.6%); the remaining two (15.4%) were charged with nonviolent crimes.[111]

Although the California Legislature established a one-year period of conditional release, few patients successfully complete the program in one year.[112] In a longitudinal study of all patients conditionally released between 1986 and 1991, researchers discovered that only 6.3% were discharged after one year.[113] The percentage of patients successfully completing conditional release remained surprisingly low in years two through five: 12.1% after two years, 17.1% after three years, 19.2% after four years, and 22.2% after five years.[114] In each of the five years, the percent of patients whose conditional release status was revoked was substantially higher: 19.5% after one year, 26.5% after two years, 31.3% after three years, 34.0% after four years, and 36.0% after five years.[115] These data raise questions about the adequacy of decision making at three distinct points: first, on decisions to place patients on conditional release status who may be poor risks for success; second, on decisions to revoke conditional release status for patients who may be safely retained in a community setting;[116] and third, on decisions to renew conditional release status for patients who may be safely discharged.

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108. *Id.* at 17–18 figs. 2 & 3.

109. *Id.* at 18.

110. *Id.* at 19–20 tbl.5. The 52-patient sample was derived from internal "special incident" reports gathered in 1990 and 1991. *Id.* at 19.

111. *Id.* at 19 tbl.5. One was arrested on a vice charge and the other on a drug charge. *Id.*

112. CAL. PENAL CODE § 1026.2(e) (West Supp. 1997). See discussion in text accompanying notes 92–94, *supra.*

113. SYSTEMS OF CARE, *supra* note 99, at 21 tbl.6.

114. *Id.*

115. *Id.*

116. *Id.* at 27.

## III. THE SAN DIEGO CONDITIONAL RELEASE PROGRAM: A STUDY OF REVOCATION, RETENTION, AND RESTORATION DECISIONS

### *A. Methodology*

This portion of the article reports on a retrospective study of all insanity acquittees processed through the San Diego Conditional Release Program (CONREP) between October 10, 1986, when patients were first accepted into CONREP, and July 15, 1995. In that nine-year period, ninety-one insanity acquittees were admitted to CONREP[117] and data were obtained on eighty-seven.[118] The eighty-seven patients were divided into three groups: eighteen patients whose CONREP status was revoked and not reinstated,[119] thirty-eight patients who successfully completed CONREP and were restored to sanity, and thirty-one patients who were currently in the program.

Under California law, CONREP is required to submit to the court quarterly progress reports and annual reports on each patient.[120] The annual reports contain CONREP's recommendation on whether the patient's CONREP status should be renewed for one year, revoked and the patient returned for inpatient treatment, or terminated and the patient discharged as restored to sanity.[121] The Research Committee of the San Diego County Department of Mental Health Services granted permission to examine these quarterly and annual reports on each patient, and the data obtained serve as the basis for this report.

My research methodology has two components. First, I present and discuss tables comparing the three patient groups. In making such tabular comparisons, I attempt to identify factors that predispose patients to success, i.e.,

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117. In San Diego County, 91 of the 127 patients admitted into CONREP during the study period (71.7%) were insanity acquittees. The remaining 36 patients (28.3%) were categorized as criminal defendants found incompetent to stand trial, mentally disordered sex offenders, and mentally disordered offenders. For statewide patient statistics, see note 100 and accompanying text.

118. Data were not included on four insanity acquittee patients. No information was available on one patient. One patient was transferred into the Los Angeles conditional release program after being treated for nine months in the San Diego program. One patient died after one year and four months in CONREP, and one patient died after five years in CONREP.

119. CONREP status was revoked for four of the 31 current CONREP patients. They are categorized as current patients because they were readmitted to, and are currently patients in, CONREP. They are not included within the 18 patients categorized as revoked.

One of the 18 individuals categorized as a revoked patient was released to parole status in October 1983, transferred into CONREP in October 1986, and revoked within three months. He was readmitted to CONREP in November 1987, but revoked a second time in June 1990.

120. CAL. PENAL CODE §§ 1605(d) (quarterly reports), 1606 (annual reports) (West Supp. 1997).

121. *Id.* § 1606.

restoration of sanity, or to failure, i.e., revocation of CONREP status. Current patients may be regarded as neither successes nor failures. However, to the extent that these patients have been retained in their limbo status for lengthy periods of time without restoration to sanity, they too may be characterized as failures. Of the thirty-one patients currently in CONREP, twenty-one (67.8%) have been retained in the program for more than three years.[122] If these twenty-one are viewed as treatment failures and are combined with the eighteen revoked patients, then CONREP has been unsuccessful in treating almost half (44.8%) the patients in the program since its inception.

Second, I present several case studies and consider whether, in making clinical judgments in individual cases, CONREP applies standards appropriately and documents adequately the reasons for its decisions. Clinical judgment involves a careful consideration of the individual's strengths and weaknesses, not just an identification of the individual's peer group characteristics. CONREP patients are not statistics; they are individuals whose cases present distinctive issues for resolution by decision makers.

In some cases, CONREP's clinical judgments are not supported by the data contained in CONREP's court reports. These judgments invite criticism, and I accepted the invitation. In my critique, I suggest possible explanations for CONREP's decision making. My speculation is clearly identified as such. Empirical research on the real reasons for CONREP's unsubstantiated judgments, though clearly needed, is beyond the scope of this article.

A patient's CONREP status is inexorably bound to a recurring assessment of dangerousness. Patients may be placed in CONREP only if they are not a danger to others while under supervision and treatment in the community.[123] Patients are discharged from CONREP as restored to sanity when they are no longer dangerous.[124] The status of CONREP patients is reviewed annually, and those who are not dangerous under supervision but who would be dangerous without supervision are retained within the program.[125] Although revocation of CONREP status does not require proof of dangerous behavior,[126] revocation often occurs for

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122. One of the individuals included in the group of 21 is a patient who was released into CONREP only one month before the July 15, 1995 cut-off date. This patient, however, had been treated unsuccessfully in CONREP on two previous occasions, once for three years and once for two years and one month. On those occasions, her CONREP status was revoked, and she was returned to inpatient treatment. Because of those prior CONREP experiences, this patient was included within the group of 21 current patients who have been treated by CONREP for lengthy periods without restoration to sanity.

123. CAL. PENAL CODE § 1026.2(e) (West Supp. 1997).

124. *Id.*

125. *Id.* § 1606. The standard is implicit.

126. Revocation may be ordered if the patient requires extended inpatient treatment or refuses to accept further outpatient treatment. *Id.* § 1608. The trial court is not required to find that the patient is a danger to self or others. *In re* McPherson, 222 Cal. Rptr. 416, 419–20 (Ct. App. 1985). A finding of dangerousness, however, may be constitutionally required. *See infra* text accompanying notes 208–35. Another statute empowers prosecutors to petition for revocation of CONREP status only on the ground that

violations of conditions imposed on patients or for changes in mental condition that signal an increase in potential dangerousness. In analyzing the statistical tables and individual case studies, I assess the extent to which the data support or refute a finding of dangerousness.

### *B. Statistical Data and Commentary*

Researchers have identified individual and situational factors that correlate with violent behavior.[127] By applying these factors to a group of patients, one may consider whether decision making is statistically supportable for the patients within that group. But decision making about a group does not equate to decision making about the individuals within the group. Use of group data to predict an individual's dangerousness has been challenged on constitutional grounds, as well as for policy reasons.[128] At best, the research suggests that members of a group with certain characteristics have increased probabilities of engaging in violent behavior, but the research does not permit an absolute prediction that a particular individual within that group will be violent.

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the person is a danger to others while on that status, and the court determines dangerousness in a hearing on that issue. CAL. PENAL CODE § 1609 (West Supp. 1997).

127. *See generally* JOHN MONAHAN, THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR (1981). Dr. Monahan identified the following individual correlates of violence: past violence, age, gender, race, socioeconomic status, and opiate or alcohol abuse. *Id.* at 89. Dr. Monahan also identified the following situational correlates of violence: disturbances or deficits in family, peer, and job support systems, and the easy availability of victims, weapons, and alcohol. *Id.* at 100.

After examining more recent studies, Dr. Monahan concluded that mental disorder experienced through active psychotic symptoms, e.g., hallucinations or delusions, may be a significant, albeit modest, risk factor for violence. John Monahan, *Mental Disorder and Violent Behavior*, 47 AM. PSYCHOLOGIST 511, 511, 519 (1992).

For other studies on factors that correlate with violent behavior, see DAVID A. BRIZER & MARTHA CROWNER, CURRENT APPROACHES TO THE PREDICTION OF VIOLENCE (1989); JAMES Q. WILSON & RICHARD J. HERRNSTEIN, CRIME AND HUMAN NATURE (1985); George B. Palermo et al., *On the Predictability of Violent Behavior*, 36 J. FORENSIC SCI. 1435 (1992).

128. *See, e.g.*, Daniel S. Goodman, *Demographic Evidence in Capital Sentencing*, 39 STAN. L. REV. 499, 508–27 (1987). *See generally* JOHN MONAHAN & LAURENS WALKER, SOCIAL SCIENCE IN LAW 281–319 (2d ed. 1990).

**TABLE 1: DEMOGRAPHIC DATA**

| | 18 Revoked Patients (age on date of revocation) | 38 Restored Patients (age on date of restoration) | 31 Current Patients (age on July 15, 1995) | All 87 CONREP Patients |
|---|---|---|---|---|
| A. AGE | | | | |
| 21–29 | 3 (15.8%) | 2 (5.3%) | 1 (3.2%) | 6 (6.9%) |
| 30–39 | 6 (31.6%) | 18 (47.4%) | 7 (22.6%) | 31 (35.6%) |
| 40–49 | 8 (42.1%) | 12 (31.6%) | 12 (38.7%) | 32 (36.8%) |
| 50–59 | 0 (0.0%) | 3 (7.9%) | 3 (9.7%) | 6 (6.9%) |
| 60–69 | 1 (5.3%) | 1 (2.6%) | 8 (25.8%) | 10 (11.5%) |
| 70–79 | 1 (5.3%) | 1 (2.6%) | 0 (0.0%) | 2 (2.3%) |
| 80+ | 0 (0.0%) | 1 (2.6%) | 0 (0.0%) | 1 (1.1%) |
| Average Age | 40.9 | 42.7 | 48.5 | 44.3 |
| B. SEX | | | | |
| Male | 17 (94.4%) | 36 (94.7%) | 25 (80.6%) | 78 (89.7%) |
| Female | 1 (5.6%) | 2 (5.3%) | 6 (19.4%) | 9 (10.3%) |
| C. RACE | | | | |
| Caucasian | 8 (44.4%) | 22 (57.9%) | 23 (74.2%) | 53 (60.9%) |
| African-American | 4 (22.2%) | 11 (28.9%) | 4 (12.9%) | 19 (21.8%) |
| Hispanic | 3 (16.7%) | 3 (7.9%) | 4 (12.9%) | 10 (11.5%) |
| Asian | 3 (16.7%) | 2 (5.3%) | 0 (0.0%) | 5 (5.7%) |

Demographic data on the eighty-seven insanity acquittee patients are presented in Table 1. Table 1A identifies, in ten-year increments, the ages of patients at the time they exited CONREP through revocation of CONREP status[129] or restoration to sanity, or, for patients currently in the CONREP program, their ages on July 15, 1995. Patients range from twenty-three years (a current patient in the CONREP program for four months) to eighty-one years (a patient restored to sanity after two years and four months of CONREP treatment). The average age of all patients was 44.3 years, and the average age of all revoked patients (40.9 years) was only slightly less than the average age of all restored patients (42.7 years). Current CONREP patients were older on average, 48.5 years, than patients in either of the other two groups.

Research confirms a significant statistical correlation between youth and proneness to violence.[130] Specifically, violent behavior increases in frequency

129. CONREP status was revoked twice for one of the 18 patients categorized as revoked patients. This patient's age at the date of each revocation is included in the data. Thus, the percentages in the revoked patient column are based on 19 revocations, not 18.

130. WILSON & HERRNSTEIN, *supra* note 127, at 126–48.

during adolescence and decreases substantially during the middle thirties.[131] According to the *1994 FBI Uniform Crime Reports*, persons under age forty account for 87.2% of violent crime arrests.[132]

Twenty-three of the thirty-one current patients (74.2%) were more than forty years of age. Although, surely, some individuals in their forties, fifties, and even sixties may be dangerous, the high number of older current patients in the study sample warrants concern that some patients are being retained in CONREP even though they are no longer dangerous. Age, however, is only one violence assessment factor. Other factors were undoubtedly considered in the decision to retain patients in CONREP.

To the extent that revocation of CONREP status occurs as a result of a patient's violent behavior or concern about a patient's violence potential, revocation could be anticipated to occur more frequently for younger patients than for older ones. As expected, a high percent of revoked patients were young—47.4% were under age forty at time of revocation and 89.5% were under age fifty. But patients who were restored to sanity were also relatively young at date of restoration—52.6% were under age forty and 84.2% were under age fifty. These data indicate that restoration decisions were not improperly delayed by an undue concern over the age factor.

As reported in Table 1B, 89.7% of all CONREP patients were male. This gender disparity is consistent with research correlating male gender to violent behavior. Nationally, 86.0% of the individuals arrested for violent crimes in 1994 were men.[133] Although 94.4% of revoked patients and 94.7% of restored patients were men, only 80.6% of current patients were men. Even though the number of current women patients is small (six), the percent of current women patients (19.4%) is surprisingly high compared to all women patients treated in CONREP (10.3%).[134]

Researchers have identified lower socioeconomic status as a factor that correlates with an increased risk of violence.[135] African Americans, who are significantly overrepresented in lower socioeconomic statuses, are also significantly overrepresented among persons arrested, convicted, and imprisoned for street crimes.[136] For example, although African Americans constitute only

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131. *Id.* at 129.

132. 1994 FBI UNIFORM CRIME REP., CRIME IN THE UNITED STATES 227–28 tbl.38.

133. *Id.* at 229, 231.

134. As analyzed by a binomial distribution test, the result is statistically significant at the 6% level of certainty. This result occurs by chance only six times out of 100. For a discussion of the binomial distribution test, see generally GEOFFREY R. LOFTUS & ELIZABETH F. LOFTUS, ESSENCE OF STATISTICS 113–37 (1982).

135. *See generally* Robert J. Sampson, *Urban Black Violence: The Effect of Male Joblessness and Family Disruption*, 93 AM. J. SOC. 348 (1987); Ira Sommers & Deborah Baskin, *Sex, Race, Aging and Violent Offending*, 7 VIOLENCE & VICTIMS 191 (1992).

136. The overrepresentation of African Americans in the criminal population may be attributable to structural linkages among unemployment (especially African-American male joblessness), economic deprivation, and family disruption. Sampson, *supra* note 135, at 376–78. When researchers compared people in the same socioeconomic level, they found

12.6% of the population of the United States,[137] in 1994, African Americans accounted for 44.7% of arrests for violent crimes.[138] African Americans constitute only 7.4% of California's population,[139] and thus, as reported in Table 1C, a CONREP patient population that is 21.8% African American is not surprising.[140] The percent of African-American patients whose CONREP status was revoked (22.2%) or who were restored to sanity (28.9%) seems consistent with the total pool of African-American patients treated, suggesting that race was not used inappropriately as a factor in CONREP decision making.[141]

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that racial differences were not a significant risk factor for violent behavior. Jeffrey S. Swanson et al., *Violence and Psychiatric Disorder in the Community: Evidence from the Epidemiologic Catchment Area Surveys*, 41 HOSP. & COMMUNITY PSYCHIATRY 761, 764 (1990). For example, one study found that, regardless of race, women who lived in areas characterized by high concentrations of poverty were involved disproportionately in violent crime. Because African-American women were significantly more likely to reside in those neighborhoods, it was not surprising to find higher levels of violent crime involvement by African-American women than by Hispanic or white/Caucasian women. Sommers & Baskin, *supra* note 135, at 199.

137. In March 1993, there were 32,036,000 African Americans in a total United States population of 252,241,000. Bureau of the Census, U.S. Dep't of Commerce, *United States Population, by Selected Characteristics, March 1993*, in 1996 WORLD ALMANAC AND BOOK OF FACTS 391 (Robert Famighetti ed., 129th ed. 1995).

138. Violent crimes were defined as murder, nonnegligent manslaughter, forcible rape, robbery, and aggravated assault. 1994 FBI UNIFORM CRIME REP., *supra* note 132, at 237 tbl.43 & n.2. In 1994, African Americans accounted for 56.4% of arrests for murder and nonnegligent manslaughter, 41.7% of arrests for forcible rape, 60.8% of arrests for robbery, and 39.2% of arrests for aggravated assault. *Id.* at 235.

139. 1996 WORLD ALMANAC AND BOOK OF FACTS, *supra* note 137, at 657.

140. California's racial/ethnic distribution, as of 1990, is 57.2% white/Caucasian, 25.8% Hispanic, 9.1% Asian, 7.0% African American, and 0.8% other. CALIFORNIA DEPT. OF FINANCE, CALIFORNIA STATISTICAL ABSTRACT 19 tbl.B–5 (1995). As reported in Table 1C, persons identified as Hispanic were underrepresented in the CONREP patient population.

141. The percent of African-American patients currently in CONREP, 12.9%, is unexpectedly low. As analyzed by a binomial distribution test, this result is statistically significant at the 10% level of certainty.

TABLE 2: HISTORICAL VIOLENCE RISK FACTORS

| | 18 Revoked Patients | 38 Restored Patients | 31 Current Patients | All 87 CONREP Patients |
|---|---|---|---|---|
| A. REPORTED PRIOR CRIMINAL ACTIVITY | | | | |
| Yes | 12 (66.7%) | 21 (55.3%) | 20 (64.5%) | 53 (60.9%) |
| No | 6 (33.3%) | 16 (42.1%) | 10 (32.3%) | 32 (36.8%) |
| Unknown | 0 (0.0%) | 1 (2.6%) | 1 (3.2%) | 2 (2.3%) |
| B. REPORTED DRUG OR ALCOHOL ABUSE | | | | |
| Yes | 14 (77.8%) | 28 (73.4%) | 25 (80.6%) | 67 (77.0%) |
| No | 4 (22.2%) | 10 (26.3%) | 5 (16.1%) | 19 (21.8%) |
| Unknown | 0 (0.0%) | 0 (0.0%) | 1 (3.2%) | 1 (1.1%) |
| C. REPORTED PRIOR PSYCHIATRIC HISTORY | | | | |
| Yes | 14 (77.8%) | 26 (68.4%) | 26 (83.9%) | 66 (75.9%) |
| No | 4 (22.2%) | 11 (28.9%) | 4 (12.9%) | 19 (21.8%) |
| Unknown | 0 (0.0%) | 1 (2.6%) | 1 (3.2%) | 2 (2.3%) |

In predicting a person's future violence potential, the one factor that overshadows all others is a history of violent behavior.[142] In fact, researchers have concluded that, in the absence of an established pattern of violence, dangerousness simply cannot be predicted.[143] As disclosed in Table 2A, fifty-three of the eighty-seven CONREP patients (60.9%) had a history of reported criminal activity prior to their insanity acquittal. As might be anticipated, revoked patients had a slightly higher percent of reported prior criminal activity (66.7%) than did patients who were restored to sanity (55.3%).

Undue reliance should not be placed on the data in Table 2A. In many instances, the reported crimes were not violent ones. They included possession of marijuana, public intoxication, possession of a controlled substance, trespassing, violation of immigration laws, possession of a false identification, failure to appear, defrauding an innkeeper, and prostitution.[144] Additionally, the reports of criminal activity were merely reports—typically, the patient records did not distinguish between arrests and convictions. In some instances, the alleged criminal activity, while reported, did not even result in the patient's arrest.

As disclosed in Table 2B, most CONREP patients had a reported history of drug or alcohol abuse (77.0%). Fifty-five of the sixty-seven patients with a substance abuse history (82.1%) abused more than one substance. Ten of the

142. MONAHAN, *supra* note 127, at 71, 107.

143. Nathan L. Pollack, *Accounting for Predictions of Dangerousness*, 13 INT'L J.L. & PSYCHIATRY 207, 211 (1990).

144. In some instances, the reported crimes were violent ones. They included homicide (patient was found not guilty by reason of insanity), sodomy with force, oral copulation with force, arson, robbery, burglary, and assault with a deadly weapon.

twelve patients who abused only one substance (83.3%) abused alcohol. Although alcohol and opioid abuse are statistically correlated with dangerousness, a history of substance abuse is insufficient to justify a dangerousness prediction. Typically, CONREP patients spend many years in a secure mental hospital before they are placed in CONREP,[145] and spend several years in CONREP before they are discharged.[146] While in CONREP, patients are subjected to frequent urine toxicology screenings. Without new evidence of current substance abuse, a dated history of substance abuse does not, in and of itself, provide an adequate basis to predict future violence.

As disclosed in Table 2C, most CONREP patients had a reported history of mental disorder (75.9%). An examination of the individual patient records reveals a wide disparity in the severity and duration of those psychiatric problems. At one extreme were reports that some patients had "minor psychological problems as a child," or underwent "brief treatment," or were "treated on an outpatient basis," or "saw a therapist for anxiety issue." At the other extreme were reports that some patients underwent "many," or "numerous," or "several" hospitalizations or had a "long history of mental disorder." Often, reports specified the number of prior hospitalizations, ranging from one to twelve. Suicide attempts were recorded for seven patients.

Although mental disorder is statistically correlated with violent behavior, the research discloses that an increased risk of violence exists only among those mentally disordered persons who are currently experiencing psychotic symptoms.[147] Psychotic symptoms experienced in the past bear no relationship to violence.[148] Therefore, although a history of mental disorder should be considered in diagnosing and treating a patient's present mental condition, that history does not, in and of itself, justify a prediction of future dangerousness.

Thirty-nine of the eighty-seven patients (44.8%) had all three Table 2 historical factors. The prevalence of all three factors was highest in current patients (58.1%) and lowest in restored patients (34.2%).[149] Perhaps these data suggest that, for some current patients, the existence of the combined historical factors was unduly influential in generating a prediction of dangerousness necessary to continue CONREP treatment. Six of the eighty-seven patients had none of the three historical factors (6.9%), and five of those six were in the restored patient category (83.3%). Perhaps these data suggest that the absence of historical violence risk factors was unduly influential in decisions that found patients restored to sanity. Six of the eighty-seven patients (6.9%) had a reported prior psychiatric history, but no history of reported criminal activity or drug or alcohol abuse. Five of those six (83.3%) were current patients. Perhaps these data suggest that some current

145. *See infra* Table 5.

146. *See infra* Table 6.

147. Bruce G. Link et al., *The Violent and Illegal Behavior of Mental Patients Reconsidered*, 57 AM. SOC. REV. 275, 290 (1992).

148. Monahan, *supra* note 127, at 519.

149. All three historical factors were found in 18 of the 31 current patients (58.1%), 8 of the 18 revoked patients (44.4%), and 13 of the 38 restored patients (34.2%).

patients were retained in CONREP for further treatment of their underlying mental disorder even though they were not dangerous. Although the historical factors data permit such speculation, other factors may have been more influential in decision making on individual cases.

**TABLE 3: INSANITY ACQUITTAL CRIMES (N=120)**

| | 18 Revoked Patients | 38 Restored Patients | 31 Current Patients | All 87 CONREP Patients |
|---|---|---|---|---|
| Murder | 3 (12.0%) | 8 (14.5%) | 10 (25.0%) | 21 (17.5%) |
| Man-slaughter | 3 (12.0%) | 1 (1.8%) | 5 (12.5%) | 9 (7.5%) |
| Assault with deadly weapon | 8 (32.0%) | 22 (40.0%) | 12 (30.0%) | 42 (35.0%) |
| Other assault including attempted murder | 5 (20.0%) | 10 (18.2%) | 5 (12.5%) | 20 (16.7%) |
| Arson | 2 (8.0%) | 3 (5.5%) | 3 (7.5%) | 8 (6.7%) |
| Burglary or robbery | 1 (4.0%) | 4 (7.3%) | 1 (2.5%) | 6 (5.0%) |
| Other | 3 (12.0%) | 7 (12.7%) | 4 (10.0%) | 14 (11.7%) |
| Total crimes | 25 (100.0%) | 55 (100.0%) | 40 (100.0%) | 120 (100.0%) |

The eighty-seven CONREP patients were found not guilty by reason of insanity of 120 crimes. Most of these crimes were violent felonies for which lengthy terms of imprisonment are imposed. For example, CONREP patients were found not guilty by reason of insanity of first- or second-degree murder in twenty-one cases (17.5% of 120 crimes). If their insanity defense had not been successful, they would have been sentenced to twenty-five years to life for first-degree murder and fifteen years to life for second-degree murder.[150]

Current patients were charged with murder in 25.0% of the crimes charged against them, a substantially higher percent than murder charges against revoked (12.0%) or restored (14.5%) patients. Similarly, the percent of all homicide charges against current patients was substantially higher (37.5%) than against revoked (24.0%) or restored (16.4%) patients.[151] Perhaps these data suggest

150. CAL. PENAL CODE § 190(a) (West Supp. 1997).

151. Thirty of the 120 crimes charged against all CONREP patients (25.0%) involved some form of homicide. Three of these 30 were for murder in the first degree, 14 were for murder in the second degree, 4 were for an unspecified degree of murder, 5 were for voluntary manslaughter and 4 were for vehicular manslaughter. Voluntary manslaughter

that decisions to retain patients in CONREP are unduly influenced by a charge of homicide that resulted in an insanity acquittal. Fifteen of the thirty-one current patients (48.4%) were found not guilty by reason of insanity of a homicide.[152]

Assault with a deadly weapon was the most popular insanity acquittal crime, occurring in forty-two of the 120 crimes charged (35.0%). Almost half of the CONREP patients (47.1%) were found not guilty by reason of insanity of assault with a deadly weapon,[153] and for twenty patients (23.0%), this was the only crime charged.[154]

The prevalence of insanity acquittals for assault with a deadly weapon is surprising. When a criminal conviction will not result in a long prison sentence, the defendant is ill-advised to plead insanity and risk indeterminate and often lengthy confinement followed by an often lengthy period of conditional release.[155] In California, a defendant found guilty of an assault committed either with a firearm or with some other deadly weapon is subject to imprisonment for two, three, or four years.[156] In the absence of aggravating circumstances, the middle term of three years is imposed.[157] Proof that the defendant's mental disorder influenced his or her actions might mitigate the sentence to two years. With good behavior and work time credits,[158] a convicted defendant would serve only a portion of the sentence imposed.

The least serious crime that resulted in a patient's insanity acquittal involved a charge of cruelty to animals committed in July, 1984. If the patient had been convicted of this charge, he would have been sentenced as a misdemeanant to no more than one year in the county jail or, as a felon, to sixteen months, two years, or three years in a state prison.[159] As a felon, he would have been sentenced to two

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is punishable by imprisonment for 3, 6, or 11 years. *Id.* § 193(a) (West 1988). Vehicular manslaughter is punishable by imprisonment for two, three, or four years. *Id.* § 193(b).

152. In contrast, only nine of 38 restored patients (23.7%) were found not guilty by reason of insanity of a homicide.

153. Of the 87 CONREP patients, 41 were found not guilty by reason of insanity of assault with a deadly weapon.

154. Assault with a deadly weapon was the only crime charged for 4 of the 18 revoked patients (22.2%), 12 of the 38 restored patients (31.6%), and 8 of the 31 current patients (25.8%).

155. *See supra* text accompanying notes 14–16.

156. CAL. PENAL CODE § 245(a)(1)–(2) (West Supp. 1997). Of the 41 patients, 36 (87.8%) were charged with assault with a deadly weapon other than a firearm and three (7.3%) were charged with assault with a firearm. One patient (2.4%) was charged with assault with a semiautomatic rifle, which is punishable by imprisonment for three, six, or nine years. *Id.* § 245(b). One patient (2.4%) was charged with assault with a firearm on a peace officer, which is punishable by imprisonment for four, six, or eight years,. *id.* § 245(d)(1), and with assault with a semiautomatic rifle on a peace officer, which is punishable by imprisonment for five, seven, or nine years. *Id.* § 245(d)(2).

157. When a statute specifies three possible terms of imprisonment, the court is required to impose the middle term, unless aggravating or mitigating circumstances are established. *Id.* § 1170(b) (West Supp. 1997).

158. CAL. CODE REGS. tit. 15, § 3043 (1996).

159. CAL. PENAL CODE § 597(a) (West Supp. 1997). Cruelty to animals is a

years in the absence of aggravating or mitigating circumstances, and he would have served only a portion of the sentence imposed. Instead, upon his insanity acquittal, the patient was placed in the community on hospital parole, an outpatient status that predated the conditional release program. Two years later, this parole status was revoked, and the patient was hospitalized. After three years of hospital treatment, he was placed in CONREP. After two years and seven months, the patient's CONREP status was revoked, and he was rehospitalized. Three years and three months later, when this study was conducted, the patient remained hospitalized. The state had retained control over this individual for eleven years—and continued to do so.

**TABLE 4A: AXIS I CLINICAL DISORDERS**

| | 18 Revoked Patients | 38 Restored Patients | 31 Current Patients | All 87 CONREP Patients |
|---|---|---|---|---|
| Paranoid Schizophrenia | 8 (24.2%) | 15 (25.4%) | 10 (16.4%) | 33 (21.6%) |
| Other Schizophrenia | 1 (3.0%) | 0 (0.0%) | 7 (11.5%) | 8 (5.2%) |
| Schizoaffective Disorder | 4 (12.1%) | 5 (8.5%) | 6 (9.8%) | 15 (9.8%) |
| Other Psychotic Disorders | 4 (12.1%) | 6 (10.2%) | 5 (8.2%) | 15 (9.8%) |
| Polysubstance Dependence | 8 (24.2%) | 7 (11.9%) | 10 (16.4%) | 25 (16.3%) |
| Other Substance Related Disorders | 4 (12.1%) | 12 (20.3%) | 6 (26.2%) | 32 (20.9%) |
| Other Disorders | 4 (12.1%) | 14 (23.7%) | 7 (11.5%) | 25 (16.3%) |
| Total Disorders | 33 (100.0%) | 59 (100.0%) | 61 (100.0%) | 153 (100.0%) |

"wobbler"—it can be prosecuted as a felony or a misdemeanor. If prosecuted as a felony, conviction results in imprisonment in the state prison for an unspecified term. In California, a felony is defined as a crime that is punishable by death or by imprisonment in a state prison. *Id.* § 17(a). When a specific punishment is not prescribed for a felony, then the crime is punishable by imprisonment in a state prison for 16 months, 2 years, or 3 years. *Id.* § 18 (West 1988).

TABLE 4B: AXIS II PERSONALITY DISORDERS

| | 18 Revoked Patients | 38 Restored Patients | 31 Current Patients | All 87 CONREP Patients |
|---|---|---|---|---|
| Personality Disorder NOS | 4 (26.7%) | 10 (50.0%) | 7 (38.9%) | 21 (39.6%) |
| Antisocial Personality Disorder | 4 (26.7%) | 1 (5.0%) | 5 (27.8%) | 10 (18.9%) |
| Dependent Personality Disorder | 4 (0.0%) | 2 (10.0%) | 4 (22.2%) | 6 (11.3%) |
| Other Personality Disorder | 7 (46.7%) | 7 (35.0 %) | 2 (11.1%) | 16 (30.2%) |
| Total Disorders | 15 (100.0%) | 20 (100.0%) | 18 (100.0%) | 53 (100.0%) |

To diagnose mental disorder, psychiatrists use the multiaxial assessment system described in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*.[160] Clinical disorders, often referred to as "mental illnesses," and other conditions that may be a focus of clinical attention are reported on Axis I.[161] Personality disorders and mental retardation are reported on Axis II.[162]

The eighty-seven CONREP patients were diagnosed with 153 Axis I mental disorders. By far, the most frequent diagnosis was schizophrenia, found in forty-one of the eighty-seven patients (47.1%). Schizophrenia is a disturbance that includes at least one month of active-phase symptoms of delusions, hallucinations, or other psychotic symptoms.[163] Thirty-three of the forty-one (80.5%), were diagnosed with the paranoid type of schizophrenia. The essential feature of this disorder is the presence of prominent delusions or auditory hallucinations even though cognitive functioning and affect are preserved.[164] In the *DSM-IV*, schizophrenia is categorized with other psychotic disorders including

160. AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM–IV) 25–35 (4th ed. 1994).
161. *Id.* at 25.
162. *Id.* at 26.
163. *Id.* at 273.
164. *Id.* at 287.

schizoaffective disorder and delusional disorder. Of the eighty-seven CONREP patients, seventy-one (81.6%) were diagnosed with either schizophrenia or some other psychotic disorder.

Substance-related disorders were the second most frequently diagnosed category of mental disorder, found in forty-eight of the eighty-seven patients (55.2%). Within that category, polysubstance dependence was the most commonly diagnosed disorder, found in twenty-five of the forty-eight patients (52.1%). A diagnosis of polysubstance dependence requires repeated use of at least three groups of substances (not including caffeine and nicotine) during the same twelve-month period, but no single substance predominates.[165] Twelve of the forty-eight patients (25.0%) were diagnosed with alcohol abuse.[166]

Although the CONREP patients were diagnosed with a wide variety of nonpsychotic and nonsubstance related disorders, in most cases, these diagnoses were unique to the individual patients. Bipolar disorder was diagnosed in seven of the eighty-seven patients (8.0%),[167] and no other disorder was diagnosed in more than two patients.

Fifty-three Axis II personality disorders were diagnosed, and mild mental retardation was diagnosed in one case. Forty-eight of the eighty-seven patients were diagnosed with a personality disorder (55.2%). A personality disorder is defined as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment."[168]

The most frequently diagnosed personality disorder was personality disorder not otherwise specified, found in twenty-one of the forty-eight patients with a personality disorder (43.8%). This diagnosis is appropriate when the individual's personality pattern meets the general criteria for a personality disorder but either the criteria for any specific personality disorder are not met or the individual is considered to have a personality disorder that is not included in the personality disorder classification.[169] Ten of the forty-eight patients (20.8%) were diagnosed with antisocial personality disorder. Antisocial personality disorder is defined as "a pattern of disregard for, and violation of, the rights of others."[170] No other personality disorder was diagnosed in more than three patients.

In many respects, the psychiatric diagnoses of revoked and current patients are remarkably alike. For example, nine of the eighteen revoked patients (50.0%) and seventeen of the thirty-one current patients (54.8%) were diagnosed

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165. *Id.* at 270.

166. Nicotine dependence was diagnosed in four of the 48 patients (8.3%). No other substance-related disorder was diagnosed in more than two patients.

167. Bipolar I disorder is a mood disorder characterized by one or more manic or mixed episodes, usually accompanied by major depressive episodes. AMERICAN PSYCHIATRIC ASS'N, *supra* note 160, at 317.

168. *Id.* at 629.

169. *Id.*

170. *Id.*

with schizophrenia. Sixteen of the eighteen revoked patients (88.9%) and twenty-eight of the thirty-one current patients (90.3%) were diagnosed with either schizophrenia or some other psychotic disorder. Eleven revoked patients (61.1%) and nineteen current patients (61.3%) were diagnosed with a substance disorder. Revoked patients were diagnosed with personality disorders somewhat more frequently than were current patients—twelve revoked patients (66.7%) were so diagnosed as compared with seventeen current patients (54.8%). In contrast, patients who were restored to sanity were diagnosed with various mental disorders less frequently than were either revoked or current patients. Only sixteen of the thirty-eight restored patients (42.1%) were diagnosed with schizophrenia; twenty-seven (71.1%) were diagnosed with schizophrenia or other psychotic disorder; eighteen (47.4%) were diagnosed with a substance-related disorder and eighteen (47.4%) were diagnosed with a personality disorder. Thus, in terms of psychiatric diagnosis, current CONREP patients seem more like revoked patients than restored patients.

Revoked patients were diagnosed with antisocial personality disorder far more frequently than were restored patients. Four of the eighteen revoked patients (22.2%) were so diagnosed as compared with only one of the thirty-eight restored patients (2.6%).[171] To the extent that the antisocial personality disorder diagnosis helps to identify individuals who are likely to engage in unlawful and/or dangerous behavior,[172] one would expect to find a higher percent of revoked patients with this diagnosis and a lower percent—or perhaps an absence of any—among restored patients. The data confirm this expectation.

**TABLE 5: DURATION OF HOSPITALIZATION PRIOR TO CONREP PLACEMENT**

| | 18 Revoked Patients | 38 Restored Patients | 31 Current Patients | All 87 CONREP Patients |
|---|---|---|---|---|
| Average | 6.0 years | 4.1 years | 4.4 years | 4.6 years |
| Median | 6.0 years | 3.3 years | 3.5 years | 3.6 years |

As previously discussed, an insanity acquittal results in indeterminate commitment until the insanity acquittee is no longer dangerous.[173] A study of California insanity acquittees reported a 3.7-year median confinement period.[174] As

171. Antisocial personality disorder was diagnosed in five of the 31 current patients (16.1%).

172. Antisocial personality disorder is characterized by a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 as indicated by at least three of seven factors. AMERICAN PSYCHIATRIC ASS'N, *supra* note 160, at 649. One of those factors is a "failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest." *Id.*

173. *See supra* text accompanying notes 14–16.

174. Silver, *supra* note 14, at 382 tbl.3.

reported in Table 5, the median confinement period for San Diego CONREP patients was 3.6 years, approximating the statewide figure.[175] The average confinement period for CONREP patients was 4.6 years. This latter figure reflects an extremely lengthy hospitalization period for some patients. For example, prior to CONREP placement, two patients (2.3%) were hospitalized for almost fifteen years[176] and nine patients (10.3%) were hospitalized for more than ten years.[177]

Although restored and current patients were hospitalized for approximately the same period of time, revoked patients were hospitalized far longer. This incongruity may be attributable to an inappropriate use of CONREP to maintain control over some insanity acquittees who were not suitable for outpatient placement, but who were otherwise eligible for hospital discharge. As previously mentioned, an insanity acquittal in California authorizes hospitalization only for a period of time equal to the longest term of imprisonment that could have been imposed for the underlying crime or crimes.[178] Extended commitment beyond that maximum term requires a new trial and a finding that the insanity acquittee is, by reason of mental disorder, a substantial danger of physical harm to others.[179] At this trial, the insanity acquittee is entitled to all constitutional rights applicable to criminal proceedings.[180] The impediments to extended commitment, however, can be circumvented by placing the patient in CONREP. By statute, time spent on outpatient status does not constitute confinement and is not credited toward the person's maximum term of commitment.[181]

An examination of CONREP patient records reveals that eight of the eighteen revoked patients (44.4%) were admitted into CONREP within six months of the expiration of their maximum terms of commitment. By comparison, only seven of the thirty-eight restored patients (18.4%) and seven of the thirty-one current patients (22.6%) were admitted to CONREP within six months of the expiration of their maximum terms.[182]

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175. The CONREP figure is based on 93 placements of 87 patients. Four current patients and one restored patient were placed in CONREP a second time after the first placement resulted in revocation of outpatient status. One current patient was placed in CONREP a third time. For each of these patients, the length of in-hospital confinement was calculated as the period between rehospitalization after CONREP revocation and the new placement on outpatient status.

176. One revoked patient was hospitalized for 14 years and 11 months and one restored patient was hospitalized for 14 years and 10 months prior to CONREP placement.

177. Three revoked patients, two restored patients, and four current patients were hospitalized more than 10 years prior to CONREP placement.

178. *See supra* notes 105–06 and accompanying text.

179. CAL. PENAL CODE § 1026.5(b)(1) (West Supp. 1997).

180. *Id.* § 1026.5(b)(7).

181. *Id.* §§ 1026.5(b)(8), 1600.5. Only time spent in a locked facility is credited toward the person's maximum term of confinement. *Id.*

182. Twenty-two of the 87 CONREP patients (25.3%) were admitted into CONREP within six months of the expiration of their maximum terms of commitment. These calculations are only approximations. They are based on the maximum sentences prescribed in the statutes for the crime or crimes reported in the patients' CONREP files. The calculations are not based on the maximum terms of commitment actually established

When outpatient placement is being considered, a CONREP psychiatrist or psychologist evaluates the patient and prepares a report containing a recommendation for or against such placement.[183] In one case, the patient had been hospitalized for more than seven years before he was recommended for CONREP placement. His maximum term of commitment was due to expire within five months. In his report, the evaluator expressed concern that the extended commitment requirement of dangerousness could not be proven. Rather than risking an adverse result in an extended commitment trial, the evaluator recommended CONREP placement to assure the patient's continued treatment and supervision in an outpatient setting. The patient remained in CONREP for one year and five months before his CONREP status was revoked and he was rehospitalized.

**TABLE 6: DURATION OF OUTPATIENT PLACEMENT**

| | Average | Median |
|---|---|---|
| A. PATIENTS TREATED IN CONREP | | |
| 18 Revoked Patients (20 revocations) | 2.1 years | 1.9 years |
| 38 Restored Patients | 3.8 years | 2.3 years |
| 31 Current Patients | 5.2 years | 4.3 years |
| 87 CONREP Patients | 3.9 years | 2.6 years |
| B. PATIENTS PLACED ON HOSPITAL PAROLE PRIOR TO CONREP | | |
| 4 Revoked Patients (5 revocations) | 4.7 years | 4.3 years |
| 10 Restored Patients | 7.6 years | 6.7 years |
| 5 Current Patients | 14.4 years | 15.4 years |
| 19 Hospital Paroled CONREP Patients | 8.6 years | 8.5 years |
| C. PATIENTS PLACED DIRECTLY INTO CONREP | | |
| 14 Revoked Patients (15 revocations) | 1.2 years | 0.8 years |
| 28 Restored Patients | 2.5 years | 2.2 years |
| 26 Current Patients | 3.4 years | 3.6 years |
| 68 Nonhospital Paroled CONREP Patients | 2.5 years | 2.3 years |

Table 6A reports the median and average duration of outpatient status for insanity acquittees who were admitted into the CONREP program. For all eighty-seven patients, the average duration of outpatient status was 3.9 years; the median was 2.6 years. For each category of patient, the average was higher than the median, reflecting an extremely lengthy outpatient status for some patients. For example, two patients (2.3%) were on outpatient status for more than seventeen

by the courts in the individual commitment orders. This latter information was not always available in the CONREP patient records.

183. CAL. PENAL CODE § 1604(b) (West Supp. 1997).

years,[184] and eleven patients (12.6%) were on outpatient status for more than eight years.[185] Nineteen patients (21.8%) were transferred from hospital parole to CONREP when CONREP began accepting patients in 1986.[186] For these patients, the duration of outpatient status includes the total time the patient was on hospital parole and in CONREP.

Table 6B reports the duration of outpatient status for the hospital-paroled CONREP patients. Table 6C reports the duration of outpatient status for the sixty-eight patients who were admitted directly into CONREP without undergoing any hospital parole. The contrast is startling. For each patient category, the Table 6B median and average outpatient treatment duration was more than three times longer than the Table 6C median and average. These data suggest that CONREP's comprehensive treatment program and its close monitoring of patients enable CONREP to make patient-status decisions far more quickly than such decisions were made under the fragmented hospital parole system that predated CONREP. Outpatients are no longer lost indefinitely in limbo status. Inertia has been replaced by conscious decision making.

The duration of CONREP placement differed dramatically by patient category. Revoked patients were retained in CONREP for the shortest periods. Seven of the eighteen (38.9%) were revoked within nine months of CONREP placement.[187] Fourteen of eighteen (77.8%) were revoked within three years of CONREP placement, and the remaining four (22.2%) had been treated for lengthy periods in hospital parole before their transfer into CONREP. If the hospital parole patients are excluded from the calculation, the average length of outpatient treatment for revoked patients drops from 2.1 years to 1.2 years. These data strongly suggest that CONREP is able to identify problem patients and to secure their rehospitalization within a year or so after their release on outpatient status. These data also suggest that patients whose outpatient status is not revoked within a year or so of CONREP placement are not likely to become problem patients and to undergo revocation of outpatient status.

Restored patients remained on outpatient status approximately twice as long as did revoked patients—averaging 3.8 years for all restored patients compared to 2.1 years for all revoked patients, and 2.5 years for restored patients admitted directly into CONREP (without hospital parole) compared to 1.2 years for revoked patients admitted directly into CONREP.[188] Current patients remained

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184. One patient was on outpatient status for 17 years and seven months before he was restored to sanity; one current patient has been on outpatient status for 17 years and one month.

185. One revoked patient, five restored patients, and five current patients were on outpatient status for more than eight years.

186. Four revoked patients, 10 restored patients, and 5 current patients were transferred from hospital parole to CONREP.

187. Two of the 18 revoked patients (11.1%) were placed on CONREP status on two separate occasions and revoked on each occasion. Thus, as a group, the 18 revoked patients sustained 20 revocations. Eight of the 20 revocations (40.0%) occurred within nine months of CONREP placement.

188. One restored patient was placed in CONREP a second time after the first

on outpatient status even longer—almost three times longer than did revoked patients. The average duration of outpatient treatment was 5.2 years for all current patients compared to 2.1 years for all revoked patients, and 3.9 years for current patients admitted directly into CONREP compared to 1.2 years for revoked patients admitted directly into CONREP.[189] Additionally, current patients continued to remain on outpatient status after my study period ended.

### *C. Case Studies and Analysis*

#### *1. Recommendations to Revoke CONREP Status*

An insanity acquittee is entitled to unconditional release only when his or her sanity has been restored.[190] Before a restoration trial can be conducted, however, the insanity acquittee must undergo outpatient treatment and supervision in a conditional release program.[191] The California Court of Appeal characterized conditional release as a mandatory crucible that provides a one-year testing period in a noninstitutional setting.[192] By statute, restoration of sanity requires that the person no longer be a danger to the health and safety of others, due to a mental disorder.[193] A similar standard applies to the conditional release decision. Conditional release is ordered only if the court determines that the patient will not be a danger to the health and safety of others, due to mental disorder, if under supervision and treatment in the community.[194]

To be accepted into CONREP, patients must agree to comply with the terms and conditions of conditional release. Fourteen terms and conditions are enumerated in the standard agreement, and CONREP may choose to impose any or

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placement resulted in revocation of outpatient status. This patient fled the state and was declared AWOL one year and 10 months after he was first placed in CONREP. He was apprehended 10 years later and rehospitalized. Subsequently, he was placed on outpatient status and was restored to sanity one year and seven months later. In calculating the duration of outpatient status for this patient, the one year and 10 month period of his first pre-AWOL release was combined with the one year and seven month period of his second release.

189. Four current patients were placed in CONREP a second time after the first placement resulted in revocation of outpatient status. One of those four was placed in CONREP a third time after the second placement resulted in revocation of outpatient status. For these four patients, calculation of the duration of outpatient status includes the total time spent on outpatient status during all CONREP placements.

190. CAL. PENAL CODE § 1026.2(e), (h) (West Supp. 1997).

191. *Id.* § 1026.2(e). In *People v. Superior Court* (Woods), 268 Cal. Rptr. 379, 380 (Ct. App. 1990), the appellate court ruled that the statute precludes the trial court from considering the patient's restoration to sanity and outright release unless and until the patient has undergone treatment and supervision in a conditional release program. *Id.*

192. *People v. Superior Court*, 268 Cal. Rptr. at 380. A trial on restoration to sanity is conducted during the year of conditional release placement if the community program director is of the opinion that the patient's sanity has been restored and so informs the court. CAL. PENAL CODE § 1026.2(e), (h).

193. CAL. PENAL CODE § 1026.2(e).

194. *Id.*

all on individual patients. Surprisingly, only two terms and conditions address directly the issue of dangerousness. The patient is prohibited from violating any laws. The patient also agrees not to take any unprescribed, illicit drugs or to drink any alcoholic beverages.

Several of the terms and conditions focus on the patient's obligations toward the treatment program. The patient is required to cooperate fully with his or her treatment program and any adjunctive treatment deemed necessary by the CONREP therapist. The patient is required to take any and all medications prescribed by any medical doctor associated with CONREP. The patient is informed that the core of the outpatient program is the patient's ongoing treatment and that all personal, social, educational, and vocational concerns must, within reason, center around the core features of CONREP.

Several terms and conditions restrict the patient's activities. The patient is precluded from owning, possessing, or handling any firearms or other lethal weapons. The patient's residence is designated, and the patient is informed that the residence cannot be changed without prior CONREP staff approval. The patient is forbidden from traveling outside San Diego County without prior approval of the patient's therapist.

Many terms and conditions assure that the patient's activities can be closely monitored. The patient is required to consent to the search of his or her person or property at any time of the day or night. The search is conducted by a CONREP professional staff member, who may inspect without probable cause or a warrant. As frequently as requested by CONREP staff, the patient must submit to urine toxicology screens to detect the patient's use of drugs or alcohol. The patient is informed that approval of a CONREP staff member is mandatory for all major decisions in any areas that the staff member deems important to the patient's physical, emotional, social, educational, vocational, and financial welfare. If the patient is arrested or even questioned by the police, he or she is required to notify the CONREP therapist. The patient is also required to report to the therapist any recurrence of symptoms of mental or emotional illness.

When CONREP recommends revocation of outpatient status, it lists reasons to support its recommendation. To analyze CONREP's decision making, I divided those reasons into three categories: criminal activity,[195] deterioration of mental condition, and noncompliance with program conditions.[196] In the twenty revocation decisions involving the eighteen revoked patients,[197] noncompliance with program conditions was cited in sixteen decisions, deterioration of mental condition was cited in twelve, and criminal activity was cited in only nine.

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195. For this analysis, "criminal activity" included reports of: (1) unlawful conduct toward another person or property for which the patient either was arrested or was subject to arrest, and (2) use of illegal drugs. Because alcoholic beverages may be purchased legally, use of alcohol was not included as a criminal activity.

196. Although criminal activity is a violation of program conditions, to avoid double counting, I did not include criminal activity in the "noncompliance with program conditions" category. Prohibited use of alcohol, however, was included.

197. *See supra* note 187.

According to the Supreme Court, commission of a criminal act "certainly indicates dangerousness."[198] Thus, one might assume that revocation of CONREP status is most appropriate for patients who engage in criminal activity. A close examination of the eight[199] criminal activity cases, however, reveals a far more questionable picture. Of the eight cases, the patient was arrested in only one. In that case, the patient left his board and care facility without permission, i.e., the patient was AWOL, and CONREP requested revocation of the patient's outpatient status. Over a year later, the patient was arrested in Vermont after he had threatened someone with a knife. Thus, even though the patient was arrested for a crime, CONREP's request for revocation of outpatient status was premised, not on that arrest, but on the patient's unauthorized departure from the program and from San Diego County.

In a second case, the patient had been found insane in the killing of her infant son. She had been using drugs and alcohol at the time of the killing.[200] After six years of inpatient treatment, the patient was placed in CONREP. Within four months, she physically attacked a resident of her board and care facility after he called her names. CONREP issued a letter of warning to the patient based on that incident. Two months later, CONREP requested revocation of the patient's outpatient status after the patient became pregnant and admitted using drugs and alcohol. In its request for revocation, CONREP relied heavily on the patient's current substance abuse problem and her inadequate adjustment to community living.[201] Although the physical attack was mentioned as one of several factors supporting CONREP's revocation recommendation, CONREP did not deem the incident to be sufficient, in and of itself, to warrant initiation of the revocation process.

In two other cases, the patients made threatening remarks or threatening gestures and one placed his hands around the throat of a female staff member and continued to harass his former girlfriend. While such activity was relied upon to support CONREP's revocation recommendation, in both cases CONREP also relied upon deterioration of the patients' mental condition (one patient made a delusional statement about having a woman in his body; the other reported that he was suicidal and homicidal) and noncompliance with program conditions (one patient missed an appointment with a CONREP psychiatrist and two appointments with other physicians; the other failed to follow through with prescribed treatment for his suicidal statements). In neither case did CONREP deem the threatening remarks or threatening gestures sufficient, in and of themselves, to warrant initiation of the revocation process.

In another case, the patient's parents reported that the patient entered their

198. Jones v. United States, 463 U.S. 354, 364 (1983).

199. Criminal activity was cited in nine revocation decisions involving eight patients.

200. The patient was diagnosed with cocaine-induced psychotic disorder, polysubstance dependence, and borderline personality disorder.

201. CONREP noted that the patient had resumed indiscriminate sexual relations and had become pregnant, had a poor attendance record at a required day treatment program, and had neglected to address her ongoing recovery program.

home, removed all furniture, clothing, and carpeting, and discarded it in local landfills. Although the patient had received three warning letters during the previous three months for traffic violations and drinking alcohol, the request for revocation was premised on the patient's property crime. The Supreme Court has ruled that the requirement of dangerousness justifying involuntary detention of an insanity acquittee is established by proof that the person committed a nonviolent property crime.[202] The Court, however, has not considered the more narrowly focused question presented by the California statute:[203] Does a nonviolent property crime constitute a danger to the health and safety of others? In construing the statute, the California Court of Appeal answered the question affirmatively, construing the word "safety" to include a right to be secure in one's person and in one's possessions.[204]

In four cases, revocation was requested after the patients experienced three positive urine toxicology screens for cocaine (three cases) or marijuana (one case). The patient who tested positive for marijuana also self-reported that on occasion he used cocaine and alcohol. Although use of illegal drugs is a criminal activity, does proof of drug use, in and of itself, establish that the patient is a danger to the health and safety of others?

When revocation of outpatient status was recommended for patients who had not engaged in criminal activity, CONREP usually asserted both deterioration of mental condition and noncompliance with program conditions. For example, in one case, CONREP asserted that the patient was suffering from an acute decompensatory episode and had missed numerous appointments. The patient was suspected of not taking psychotropic medication that had been prescribed for his condition, and he refused to continue medical care for leukemia. Although the patient had not violated any laws, he attended a therapy session carrying a golf club, which CONREP characterized as a potential weapon. Additionally, CONREP received a report from the managers of the patient's residence that claimed the patient had used foul and abusive language when he yelled at a female resident.

In some cases, CONREP used deterioration of mental condition and noncompliance with program conditions as evidence that the patient was dangerous to himself or herself. For example, in one case, CONREP asserted that the patient was experiencing auditory hallucinations and grandiose delusions. CONREP suspected an organic component to the patient's illness that made it difficult for the patient to follow through with the treatment requirements of the program. The patient missed group and individual therapy sessions and did not receive

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202. *Jones*, 463 U.S. at 364–65.

203. CAL. PENAL CODE § 1026.2(e), (h) (West Supp. 1997).

204. People v. Allesch, 199 Cal. Rptr. 314, 318 (Ct. App. 1984). The court noted that the legislature can narrow the commitment standard if it chooses to do so. *Id.* For example, to extend the commitment of an insanity acquittee beyond the maximum term that could have been imposed for the underlying crime, the statute requires a finding that the person be a substantial danger of physical harm to others by reason of mental disorder. CAL. PENAL CODE § 1026.5(b)(1) (West Supp. 1997). The court seems to suggest that revocation of CONREP status for these patients is prohibited if they only commit nonviolent property crimes while on outpatient status.

medication when he was scheduled to do so. Additionally, the patient was not eating properly and lost a considerable amount of weight. At the time of this recommendation, the statute limited eligibility for conditional release to insanity acquittees who were not "a danger to the health and safety of others, including himself or herself, if under supervision and treatment in the community."[205] At the time, restoration to sanity also required the absence of danger to others or to the insanity acquittee.[206] Thus, CONREP's concern for the patient's dangerousness to himself was justified.

In another case, the patient reportedly experienced symptoms of mental disorder even though his psychiatric medication was adjusted on several occasions. CONREP reported that outpatient treatment was increasingly stressful to the patient, that he experienced suicidal ideation, and he made suicidal plans. CONREP expressed its belief that if the patient did not obtain some relief from his psychic and emotional pain, he might resort to harming himself. CONREP also reported that the patient violated the terms and conditions of his conditional release by missing several therapy sessions. In November, 1994, CONREP recommended revocation of this patient's outpatient status because of the patient's danger to himself. However, in 1993, the legislature had amended the conditional release eligibility standard.[207] Danger to self was eliminated as a disqualifying condition for conditional release. Under the revised standard, insanity acquittees are eligible for conditional release if they are not a danger to the health and safety of others while under supervision and treatment in the community. Although the statute was amended in 1993, it became operative on January 1, 1995. Thus, CONREP's recommendation using the danger to self criterion was lawful. Nevertheless, because the recommendation was made more than a year after the legislature had eliminated that criterion and within two months of the date when the new standard would become operative, the recommendation seems far less justifiable.

In one case, the CONREP revocation recommendation was based solely on deterioration of the patient's mental condition. In this case, CONREP reported that the patient lacked insight concerning his mental illness, was experiencing active symptoms of that illness (a persecutory delusion), and remained medically fragile. CONREP expressed concern that the patient could cease taking his hypertension medications and might suffer cardiac problems. CONREP sought revocation of outpatient status even though the patient had not committed any

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205. Act of Sept. 25, 1984, ch. 1488, § 3.5, 1984 Cal. Stat. 5196, 5202 (codified, as amended, at CAL. PENAL CODE § 1026.2(e)). In *In re Franklin,* 496 P.2d 465 (Cal. 1972), the California Supreme Court held that under the statute as it then existed, a person is restored to sanity when "he is no longer a danger to the health and safety of others, including himself." *Id.* at 477. The 1984 legislation codified the *Franklin* test for restoration to sanity. *See* Barnes v. Superior Court, 231 Cal. Rptr. 158, 164 n.2 (Ct. App. 1986) (Pochee, J., dissenting) (discussing the staff analysis of the California Senate Committee on the Judiciary).

206. Act of Sept. 25, 1984, ch. 1488, § 3.5, 1984 Cal. Stat. 5196, 5203 (codified, as amended, at CAL. PENAL CODE § 1026.2(e)).

207. Act of Oct. 10, 1993, ch. 1141, § 1, 1993 Cal. Stat. (codified, as amended, at CAL. PENAL CODE § 1026.2(e) (West. Supp. 1997)).

criminal act or violated any terms and conditions of his outpatient status.

If conditional release is a one-year test of the patient's nondangerousness in a community setting, then is revocation of conditional release appropriate when the patient is not dangerous? The easy answer—perhaps too easy—is "yes." The statute that delays the sanity restoration trial until after the patient has undergone conditional release also provides that certain other statutes apply to insanity acquittees placed in a conditional release program.[208] One such statute, Penal Code section 1608, authorizes the conditional release program director to request revocation of outpatient status if the patient's supervisor "is of the opinion that the person requires extended inpatient treatment or refuses to accept further outpatient treatment and supervision."[209] The court is required to hold a hearing and either approve or disapprove the revocation request.[210]

In *In re McPherson*,[211] the California Court of Appeal rejected an insanity acquittee's argument that revocation cannot be ordered unless the trial court finds that the patient is dangerous. Without analyzing the constitutionality of the statute, the court simply noted that the statute contains the applicable revocation criteria and that those criteria do not include a finding of the patient's dangerousness.[212] Although a different statute authorizes the prosecutor to petition for revocation of outpatient status if the prosecutor is of the opinion that the insanity acquittee is a danger to the health and safety of others while on outpatient status, and specifically requires the trial judge to decide the dangerousness issue,[213] the *McPherson* court was unwilling to engraft the dangerousness requirement onto revocation requests originating from the conditional release program.[214]

In a subsequent decision, however, the California Court of Appeal admitted that public safety considerations are an integral part of the decision to place or continue a patient on outpatient status.[215] Thus, in a revocation hearing initiated by the conditional release program, the trial court did not err when it considered the patient's potential dangerousness.[216]

United States Supreme Court decisions indicate that a finding of dangerousness is not only permissible, but is required before an insanity acquittee's

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208. CAL. PENAL CODE § 1026.2(g) (West Supp. 1997). The statute provides that sections 1605–1610 of the California Penal Code are applicable, unless otherwise ordered by the court. *Id.* These statutes are part of a larger group of statutes governing outpatient status for persons designated as mentally disordered and developmentally disabled offenders. *Id.* §§ 1600–1620 (West Supp. 1997). Persons eligible for outpatient status as "offenders" include insanity acquittees, criminal defendants found incompetent to stand trial, mentally disordered sex offenders, and sexually violent predators. *Id.* § 1600.

209. *Id.* § 1608.

210. *Id.*

211. 222 Cal. Rptr. 416 (Ct. App. 1985).

212. *Id.* at 419–20.

213. CAL. PENAL CODE § 1609 (West Supp. 1997).

214. *In re* McPherson, 222 Cal. Rptr. at 419.

215. People v. DeGuzman, 39 Cal. Rptr. 2d 137, 140 (Ct. App. 1995).

216. *Id.* at 140–41.

conditional release can be revoked. In *Morrissey v. Brewer*,[217] the Supreme Court held that termination of parole status inflicts a grievous loss upon the parolee, and thus the parolee's conditional liberty interest necessitates due process protections to justify termination of parole status.[218] The Court mandated a two-step process. First, a retrospective factual question must be considered: Did the parolee in fact violate one or more conditions of parole? If the answer is "yes," then a second question must be considered: Should the parolee be recommitted to prison?[219] The second question, noted the Court, is not purely factual, but requires the parole authority to apply its expertise to predict the individual's ability to live in society without committing antisocial acts.[220]

In *Gagnon v. Scarpelli*, the Supreme Court imposed the same due process requirements on decisions to revoke probationers' probationary status.[221] The Court reiterated its two-step process, i.e., "the accurate finding of fact and the informed use of discretion."[222] Proof that a probationer violated one or more conditions of probation does not itself justify revocation of probation. An informed use of discretion is required to assure that a successful effort at rehabilitation is not unnecessarily interrupted by an unjustifiable deprivation of the probationer's liberty.[223] If a probationer or parolee is not dangerous despite the violation of a condition of parole or probation, then the safety of the community is not imprudently prejudiced by his or her continued presence in that community.

Relying on *Morrissey* and *Scarpelli*, courts have imposed due process protections on revocation decisions involving substance abusing patients[224] and civilly committed mental patients.[225] The California Court of Appeal reached the "unescapable conclusion" that the conditional liberty interest of insanity acquittee outpatients is no less entitled to due process safeguards.[226] These safeguards are applicable to all revocation decisions, regardless of whether the revocation process is initiated by the conditional release program director or the prosecutor.[227]

When the trial court considers evidence that the patient's mental condition has deteriorated or that the patient has violated the terms and conditions of

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217. 408 U.S. 471 (1972).

218. *Id.* at 482.

219. *Id.* at 480.

220. *Id.* Recently, a unanimous Supreme Court held that Oklahoma's preparole conditional supervision program was sufficiently similar to parole to require *Morrissey*'s due process protections. Young v. Harper, 117 S. Ct. 1148 (1997).

221. 411 U.S. 778, 782 (1973).

222. *Id.* at 785.

223. *Id.*

224. *See, e.g.*, United States *ex rel.* Shaban v. Essen, 386 F. Supp. 1042 (E.D.N.Y. 1974) (revocation of drug dependent person's outpatient status), *aff'd without opinion*, 516 F.2d 897 (2d Cir. 1975); *In re* Bye, 524 P.2d 854 (Cal. 1974) (revocation of civil addict's outpatient status); Ball v. Jones, 351 N.Y.S.2d 199 (App. Div. 1974) (revocation of narcotic addict's aftercare status).

225. *See, e.g.*, Lewis v. Donahue, 437 F. Supp. 112 (W.D. Okla. 1977); Meisel v. Kremens, 405 F. Supp. 1253 (E.D. Pa. 1975).

226. *In re* Anderson, 140 Cal. Rptr. 546, 550 (Ct. App. 1977).

227. *Id.* at 549–50.

outpatient status, the court does so in order to make a factual determination. But a decision to approve a request for outpatient revocation must be based on constitutionally permissible criteria. On numerous occasions, the United States Supreme Court has ruled that involuntary commitment must be justified on the basis of a legitimate state interest and must cease when that interest no longer exists.[228]

Although the insanity verdict is sufficiently probative of the defendant's continuing mental disorder and dangerousness to justify commitment without resort to civil commitment proceedings,[229] the insanity acquittee may be confined as long as he or she is both mentally disordered and dangerous, but no longer.[230] In *Foucha v. Louisiana*,[231] the Court ruled that even if an insanity acquittee remains dangerous, commitment of the individual as an insanity acquittee must end if he or she is no longer mentally disordered. Thereafter, if commitment can occur at all, it must be achieved through use of the civil commitment criteria and civil commitment procedures applicable to all other persons.[232] *A fortiori*, even if an insanity acquittee remains mentally disordered, commitment of the individual as an insanity acquittee is inappropriate if he or she is no longer dangerous. Before the insanity acquittee was placed on outpatient status, the court was required to find that the patient would not be a danger to others while under community supervision and treatment.[233] Revocation of outpatient status, and recommitment of the insanity acquittee as an insanity acquittee, requires a finding that the individual is both mentally disordered and dangerous. For insanity acquittees who are not dangerous, the ordinary civil commitment process suffices and must be used if the state seeks inpatient hospitalization because of the patient's deteriorated mental condition.

A prerevocation dangerousness finding may be required for yet another reason. Revocation of outpatient status results, not only in a loss of the insanity acquittee's conditional liberty, but also in a loss of the insanity acquittee's right to a sanity restoration trial and to unconditional release if he or she is no longer a danger to others. By statute, that trial is conducted only if the insanity acquittee completes the required one year in a conditional release program.[234] Denial of this right constitutes a grievous loss of liberty. Can it be lost without a determination that the finding of nondangerousness, which justified the insanity acquittee's

228. *See, e.g.*, Foucha v. Louisiana, 504 U.S. 71, 79 (1992); Jones v. United States, 463 U.S. 354, 368 (1983); O'Connor v. Donaldson, 422 U.S. 563, 574–75 (opinion of the Court), 580 (Burger, C.J., concurring); Jackson v. Indiana, 406 U.S. 715, 738 (1972).

229. *Jones*, 463 U.S. at 363–66. The insanity verdict established beyond a reasonable doubt that the defendant committed a criminal act and that the act was committed because of the defendant's mental disorder. Congress may determine that such findings are adequate, in and of themselves, to justify confinement of the insanity acquittee as a dangerous and mentally disordered person. *Id.*

230. *Foucha*, 504 U.S. at 77.

231. *Id.*

232. *Id.* at 79.

233. CAL. PENAL CODE § 1026.2(e) (West Supp. 1997).

234. CAL. PENAL CODE § 1026.2(f) (West Supp. 1997).

conditional release, is no longer valid? I think not.[235]

*2. Recommendations to Restore Sanity*

Of the thirty-eight patients who were restored to sanity, nine (23.7%) were restored at the completion of one year in CONREP. In all nine cases, CONREP recommended restoration, and the court approved the recommendation. For these nine patients, the conditional release program operated the way it is intended to operate.[236] As a group, they shared characteristics implying a heightened risk of dangerous behavior. The insanity defense crimes for all nine patients were serious: eight were charged with assault with a deadly weapon, two with attempted murder, and one with robbery. Eight of the nine (88.9%) had a history of prior criminal activity,[237] and six of the nine (66.7%) had a history of drug or alcohol abuse. All nine were males. Nevertheless, at the time they were placed in CONREP, the individuals in that group, evaluated as individuals, were not predicted to be dangerous if supervised and treated in the community. These evaluations proved to be accurate, and the patients were restored to sanity when they completed their one-year CONREP experience.

In one representative case, the patient was an African-American male whose insanity defense crime was assault with a deadly weapon. The patient had a prior criminal history[238] as well as a history of drug and alcohol abuse.[239] The patient was hospitalized for five years and ten months before he was released to CONREP. The patient was diagnosed with organic mental disorder; polysubstance abuse, in remission; and antisocial traits. To support CONREP's recommendation that the patient be restored to sanity after one year of outpatient treatment, the CONREP report contained the following findings: The patient had maintained psychiatric stability during this year without requiring psychiatric medication, had

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235. A court could uphold the constitutionality of CAL. PENAL CODE § 1608 (West Supp. 1997) by construing the statutory language to impose a dangerousness finding prior to revocation of outpatient status. For example, the conditional release program director may request revocation if the patient's supervisor "is of the opinion that the person requires extended inpatient treatment." *Id.* A court could rule that a person "requires" inpatient treatment as an insanity acquittee only if he or she is dangerous in the community. Alternatively, upon receiving the revocation request, the trial court is required to hold a hearing and to "approve or disapprove the request." *Id.* A court could rule that approval can be given only if the patient is dangerous in the community. *See* Cardwell v. Psychiatric Sec. Review Bd., 590 P.2d 787, 791 (Or. Ct. App. 1979) (holding that under the Oregon statute, "unfitness for conditional release" was not an independent criterion for revocation in the absence of dangerousness).

236. The timing of CONREP recommendations and court decisions to place insanity acquittees into CONREP is beyond the scope of this Article. Quite conceivably, some patients would have been restored to sanity after one year of outpatient treatment even if they had been placed in CONREP sooner.

237. For the ninth patient, prior criminal activity was described as unknown, rather than nonexistent.

238. The patient's criminal history included: narcotics possession, burglary, automobile theft, and various weapons violations.

239. The patient reportedly abused alcohol, marijuana, heroin, and cocaine.

remained abstinent from drugs and alcohol, had attended one to two Alcoholics Anonymous and Narcotics Anonymous meetings per week throughout the year and had maintained records of each attendance. The patient had been compliant and cooperative in treatment. He had no contact with law enforcement during the year. The patient showed an ability to develop a strong social support network comprised of family, friends, and acquaintances from CONREP, Alcoholics Anonymous, Narcotics Anonymous, and religious organizations. The patient developed a structured routine for himself, showing initiative and a sense of responsibility in maintaining this routine. The patient demonstrated insight during treatment into his mental disorder and past substance abuse. His future plans included continuing mental health care to ensure emotional stability. The patient obtained maximum benefit from treatment. Psychological testing confirmed that long-term insight-oriented psychotherapy was not indicated due to his personality structure. His defenses were rigid and well constructed. Given his psychological makeup, challenging his defenses would be contraindicated.[240]

In another case, the patient was an Hispanic male whose insanity defense crimes were attempted murder, assault with a deadly weapon, felon in possession of a weapon, and use of a gun during a crime. The patient had a history of prior criminal activity[241] and a history of drug abuse.[242] The patient was hospitalized for one year and ten months before he was released to CONREP. He was diagnosed with cocaine delusional disorder and personality disorder, not otherwise specified. To support CONREP's recommendation that the patient be restored to sanity after one year of outpatient treatment, the CONREP report contained the following findings: The patient's year in CONREP was beneficial for him in many areas. He secured full-time employment at a good wage, remained alcohol and drug free, and lived independently. The patient reestablished contact with his family and contributed financially to their support. The patient complied with the terms and conditions of outpatient treatment. The patient underwent no psychiatric decompensation over the last year and had no contact with law enforcement.[243]

This CONREP recommendation is extraordinary. Unlike the other eight patients for whom CONREP recommended restoration after only one year, CONREP did not support the placement of this patient into CONREP initially. To support CONREP's recommendation opposing outpatient placement, the CONREP report contained the following findings: The patient's psychosis was not restricted to the night of the incident. Due to many inconsistencies in the patient's history, the patient probably lied about the extent of his cocaine use. The patient rationalized and tried to justify his behavior without showing insight into his illness. The patient lied about his attendance at meetings and about an incident involving drug use at Patton State Hospital. Hospital employees found the patient manipulative and evasive. The report concluded: "Until the patient comes to grips with his cocaine

240. At the date of restoration, the patient was 44 years old and was not receiving psychotropic medication.

241. The patient had been charged with smuggling aliens across the border.

242. The patient reportedly abused cocaine and marijuana.

243. At the date of restoration, the patient was 38 years old and was not receiving psychotropic medication.

addiction and the effects this drug had on him during the offense, he will continue to be dangerous to others, continuing to project and blame others for his predicament." Although the stated reasons may be sufficient, in and of themselves, to warrant CONREP's concern about the patient's dangerousness, one may also speculate that CONREP was influenced by the severity of the patient's insanity defense crime (attempted murder) and by the relatively short period of inpatient hospitalization (one year and ten months). Despite the negative CONREP recommendation, however, the court released the patient into CONREP. One year later, CONREP recommended that the patient be restored to sanity, and the court so ruled.

Of the thirty-eight patients who were restored to sanity, twenty-nine (76.3%) were not restored at the completion of one year in CONREP. For many, if not all, of these twenty-nine patients, the conditional release program did not operate the way it was intended to operate. The twenty-nine patients completed one year of outpatient treatment without engaging in any criminal or other dangerous behavior, and without suffering any serious deterioration in their mental condition, that would necessitate revocation of their outpatient status. And yet, for these twenty-nine patients, CONREP recommended that they be retained in the program for a subsequent year. For eighteen of the twenty-nine patients (62.1%), CONREP recommended that they be retained for a third year.

Ten of the thirty-eight restored patients (26.3%) were transferred from hospital parole to CONREP when CONREP began accepting patients in 1986. Several had completed many years on outpatient status before entering CONREP.[244] Nevertheless, for nine of those ten patients (90.0%), CONREP did not recommend restoration to sanity after the first year of CONREP treatment.[245] For example, in one case, the patient was a white male whose insanity defense crimes were second degree murder and arson. He had no history of prior criminal activity and no history of drug or alcohol abuse. The patient was hospitalized for eight years and ten months before being released on hospital parole in March, 1971. The patient remained on outpatient status for fifteen and one-half years before he was transferred to CONREP. The patient was diagnosed with chronic schizophrenia, paranoid type, and dependent personality disorder. At the end of one year, CONREP recommended that the patient be retained. In its report to the court, CONREP conceded that the patient's mental condition had been stable over the past year and that he had been compliant with the terms and conditions of his conditional release. CONREP also conceded that the patient kept all of his appointments and regularly accepted his medication. To justify retention, CONREP declared that the patient traveled out of the San Diego area with his sister approximately every three months, but that his travel plans had not received

244. For the 10 hospital-paroled patients, the average duration of pre-CONREP outpatient status was 4.5 years, and the median duration was 2.3 years. The longest duration of pre-CONREP outpatient status for any hospital-paroled patient was 15.5 years; the shortest was 0.7 years.

245. In the tenth case, the patient petitioned the court for restoration to sanity. CONREP supported the petition, citing the patient's excellent compliance with treatment and medication, and his stable marriage.

CONREP's prior approval. Additionally, CONREP asserted that the patient, despite receiving an adequate monthly income, had problems managing his finances and had to borrow money from his sister. Finally, CONREP noted that the patient was not interested in changing his legal status, stated that he was happy to be a CONREP client, and enjoyed his group therapy.

Can these reasons justify the prediction of dangerousness necessary to continue the patient in CONREP? After the patient's second year in the program, CONREP recommended restoration to sanity even though there was no apparent change in the patient's mental condition. In its second annual report, CONREP asserted that the patient had been cooperative and compliant throughout his outpatient treatment. According to CONREP, during the seventeen-year period since his release in 1971, the patient had not committed any act of violence against any person or property and had not had any suicidal or homicidal ideation. Over this seventeen-year period, claimed CONREP, the patient demonstrated his ability to live independently, to take medications without supervision, and to provide for his daily living needs.[246] Ironically, the report did not mention that during the patient's second year of CONREP treatment, he traveled out-of-state with his sister without receiving CONREP's prior approval.

I can only speculate on the factors that may have influenced CONREP to recommend this patient's retention for a second year. The patient was admitted into CONREP in September, 1986, when CONREP was a brand new program. At that time, CONREP assumed responsibility for all nineteen hospital-paroled patients. By the end of 1986, twenty-three insanity acquittee patients were under CONREP jursidiction—more than one-fourth (26.4%) of all patients admitted to CONREP since the program's inception. From 1987 through 1994, CONREP admitted an average of only 7.9 insanity acquittee patients per year.[247] CONREP may have been overwhelmed by the large number of patients it received at a time when the program was just beginning to function.

CONREP's early decision making may also have been influenced by the California Legislature's directive that insanity acquittees be provided with the necessary level of treatment and supervision reasonable to ensure that they do not commit other crimes.[248] CONREP's professional staff knew that the California Legislature had mandated an evaluation of the conditional release experiment[249] and that CONREP's very survival depended upon its ability to establish that insanity acquittees could be successfully reintegrated into society without reoffending.

CONREP's conservative decision making was not limited to its formative

246. At the date of restoration, the patient was 59 years old and was receiving Mellaril® and lithium carbonate. Mellaril® is the Sandoz Pharmaceuticals Corporation brand of thioridazine HCl. PHYSICIANS' DESK REFERENCE 2398 (51st ed. 1997).

247. Of the 63 insanity acquittee patients admitted for the first time to CONREP during calendar years 1987 through 1994, the fewest, four, were admitted in 1987 and in 1988; the most, 15, were admitted in 1991.

248. Act of Oct. 1, 1985, ch. 1416, § 1, 1985 Cal. Stat. 5003, 5004.

249. CAL. PENAL CODE § 1617 (West Supp. 1997).

years, but continues even today. For example, the patient treated in CONREP for the longest period prior to sanity restoration was a white male whose insanity defense crime was first-degree murder. He had no prior criminal history but did have a history of drug abuse.[250] The patient was hospitalized for nine years and three months before he was released to CONREP in November, 1986. The patient was diagnosed with schizoaffective disorder, bipolar type. He was restored to sanity in March, 1995, after eight years and four months of outpatient treatment. During that period, CONREP submitted seven annual reports each recommending the patient's retention. CONREP did not claim in any of those reports that the patient engaged in criminal activity or that he violated any terms and conditions of his outpatient status. Rather, CONREP claimed that the patient was unable to cope with the stress of being in the community after ten years of hospitalization (first annual report), that he sometimes opposed authority (second annual report), or that a psychological test showed that he exaggerated symptoms of mental disorder (third and fourth annual reports). Although these reports suggest that the patient continued to have a mental disorder, they did not suggest that this mental disorder justified a prediction of future dangerousness. The existence of mental disorder does not, in and of itself, preclude a finding that the patient's sanity has been restored. Under the statute, even a mentally disordered person should be restored to sanity if he or she is no longer a danger to the health and safety of others.[251] If needed, inpatient treatment can be achieved for a restored insanity acquittee through involuntary civil commitment procedures applicable to any other person.

After seven years of outpatient treatment, the patient's schizoaffective disorder deteriorated, and he experienced auditory hallucinations. The sixth and seventh annual reports mentioned this condition as the justification for recommending retention. In its eighth annual report, CONREP declared that the patient's mental disorder was in good remission with medication, and CONREP recommended that the patient be restored to sanity. A jury, relying on the CONREP report, found the patient restored.[252]

For patients admitted more recently to the program, CONREP continues to be reluctant to recommend sanity restoration after one year. For example, in one case, the patient was a white male whose insanity defense crimes were attempted first-degree murder and assault with a firearm. He had a prior criminal history[253] and a history of drug and alcohol abuse.[254] The patient was hospitalized for two years and three months before he was released to CONREP in June, 1992. The patient was diagnosed with psychoactive substance delusional disorder; polysubstance dependence; and depressive disorder, not otherwise specified. CONREP's first annual report contained the following findings: The patient adjusted well to community living after his release from the hospital. His substance

250. The patient reportedly abused marijuana and LSD.

251. CAL. PENAL CODE § 1026.2(e), (h) (West Supp. 1997).

252. At the date of restoration, the patient was 43 years old and was receiving risperidone and lithium carbonate.

253. The patient had been charged with drunk driving and domestic violence.

254. The patient reportedly abused alcohol, marijuana, cocaine, and amphetamines.

dependence was in remission, and he expressed a commitment to a sober lifestyle. The patient was compliant with his treatment and did not miss any appointments with CONREP. The patient was compliant with the terms and conditions of his outpatient status and had no contact with law enforcement.

Despite the patient's model behavior during his first year on outpatient status, CONREP was unwilling to recommend his restoration to sanity. Rather, CONREP recommended the patient's retention for a second year. In its only negative comment, CONREP asserted that because the patient grew up in a dysfunctional and alcoholic family, he continued to be at risk for substance abuse. Apparently, because of the patient's family history, nothing he could do in one year of outpatient treatment would satisfy CONREP that he was no longer dangerous.

After the patient's second year on outpatient status, CONREP recommended that he be restored to sanity, and the court so ruled. The CONREP report recommending restoration contained findings that were virtually identical to the findings contained in its first report. CONREP did add one new finding—that the patient had been employed for the past five months and that stable employment highly correlated to ongoing stability and the absence of criminal recidivism.[255]

When CONREP submits its annual report and recommendation to the court,[256] the court conducts a trial to determine whether the patient's sanity has been restored.[257] The patient is constitutionally entitled to a jury trial should he or she request it.[258] An examination of court and jury decisions substantiates my belief that CONREP is unduly cautious in its restoration recommendations. Of the thirty-eight patients who were restored to sanity, CONREP recommended restoration for thirty (78.9%). The court or jury agreed with the CONREP recommendation and restored the patient's sanity in twenty-eight of those thirty cases (93.3%). In the other two cases, the court ordered that additional forensic evaluations be performed and, upon receiving those evaluations, the court determined that the patients were restored to sanity. These two patients were discharged within four months of CONREP's annual report recommending restoration.

CONREP recommendations opposing restoration were far less influential. In eight of the thirty-eight cases (21.1%), CONREP opposed the patient's restoration in its most recent annual report. And yet, the court in five cases and a jury in three cases determined that the patient's sanity was restored. For example, in one case, the patient was a white male whose insanity defense crime was assault with a deadly weapon. He had a history of prior criminal activity[259] and a history of drug and alcohol abuse.[260] The patient was hospitalized for three years and nine

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255. At the date of restoration, the patient was 37 years old and was receiving Prozac® for his mental disorder. Prozac® is the Dista Products and Eli Lilly and Company brand of fluoxetine hydrochloride. PHYSICIANS' DESK REFERENCE, *supra* note 246, at 935.

256. CAL. PENAL CODE § 1606 (West Supp. 1997).

257. *Id.* § 1026.2(e).

258. *In re* Franklin, 496 P.2d 465, 479 (Cal. 1972).

259. The patient had been charged with drunk driving, manufacture and possession of dangerous weapons, assault, and resisting arrest.

260. The patient reportedly abused alcohol, marijuana, amphetamines,

months before he was released to CONREP. The patient was diagnosed with schizophrenia, paranoid type, chronic, in remission with medication; alcohol abuse, in remission; and personality disorder, not otherwise specified, with antisocial, obsessive-compulsive features. He remained in CONREP for three years and three months before he was restored to sanity. In its third annual report, CONREP admitted that the patient's schizophrenia was in good remission with medication and that the patient had been living independently and managing himself well. Nevertheless, CONREP recommended the patient's retention on outpatient status, expressing the opinion that the patient's personality disorder required continued supervision in the community. CONREP also asserted that the patient's abstinence from alcohol seemed to stem from the patient's fear of outpatient status revocation rather than from an internalization of the sobriety concept. The court ordered evaluations performed by two psychologists, and relying on their reports, the court determined that the patient's sanity had been restored.[261]

Even when CONREP's concerns are more substantial, the court or jury does not always agree with the retention recommendation. For example, in one case, the patient was a white male whose insanity defense crimes were assault with a deadly weapon and battery. Although the patient had no history of prior criminal activity, he attacked two nurses in the hospital and had to be subdued by five police officers. He was charged with the crime of battery resulting in serious bodily injury to a police officer or nurse. The patient had a history of drug and alcohol abuse.[262] The patient was hospitalized for two years before he was released to hospital parole. The patient was diagnosed with bipolar disorder, manic, without psychotic features; alcohol abuse; cocaine abuse; personality disorder, not otherwise specified, with paranoid, antisocial, narcissistic, and dependent features. The patient remained on hospital parole for one year and six months before he was transferred to CONREP. He remained in CONREP for two years and eleven months before he was restored to sanity. In opposing the patient's petition for restoration, CONREP cited the chronicity of the patient's mental disorder and his noncompliance with medical treatment. CONREP noted that the patient could be explosive and violent, as he had demonstrated recently by attacking his dog. The patient's size and strength made him a formidable foe if he lost his temper. Despite these expressions of concern, a jury determined that the patient's sanity had been restored.[263]

*3. Recommendations to Retain Patients in CONREP*

As reported in Table 6, patients currently in CONREP typically remain on

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barbiturates, and PCP.

261. At the date of restoration, the patient was 38 years old and was receiving Prolixin Decanoate® for his mental disorder. Prolixin Decanoate® is the Apothecon (a Bristol–Myers Squibb Company) brand of fluphenazine decanoate injection. PHYSICIANS' DESK REFERENCE, *supra* note 246, at 510.

262. The patient reportedly abused alcohol, heroin, and cocaine.

263. At the date of restoration, the patient was 39 years old and was receiving lithium carbonate for his mental disorder.

outpatient status far longer than do revoked or restored patients.[264] Some patients entered CONREP in September, 1986, when the program began accepting patients, and they remain in CONREP today. For these patients, CONREP has written eight annual reports, each recommending that they be retained on outpatient status. Twenty-eight of the thirty-one current patients (90.3%) have been in CONREP for more than one year, and CONREP has written one or more annual reports recommending retention of each of these patients.

In assessing whether CONREP acted correctly in recommending patients' retention, three principles must be considered. First, before a patient is conditionally released, a court must determine that the patient will not be a danger to the health and safety of others, due to mental disorder, while under supervision and treatment in the community.[265] CONREP treatment is not designed to make a dangerous patient nondangerous but, rather, to assure that the finding of nondangerousness was accurate. As a presiding justice of the California Court of Appeal noted, no trial judge in his or her right mind would release a patient to outpatient status on the theory that, because of the supervision and treatment the patient is supposed to receive, he or she will no longer be dangerous to others.[266]

Second, the California Court of Appeal, in upholding the constitutionality of the statute mandating the one-year conditional release requirement, stated: "The one-year period as an outpatient was intended to expose the insanity acquittee to intensive and prolonged evaluation in a noninstitutional setting before an unconditional release."[267] Although the public's interest in the careful evaluation of insanity acquittees before unconditional release justifies a conditional release requirement,[268] at some point, a lengthy period of restricted release exceeds the needs of reasonable evaluation.[269] The legislature's judgment establishing the one-year length of conditional release is entitled not only to judicial deference,[270] but to CONREP's administrative deference as well.

Third, as Justice Mosk noted, the only question to be decided at the sanity restoration trial "is whether the patient has spent a successful year in the community and hence no longer requires supervision."[271] In essence, the sanity restoration trial determines whether the judgment to release the patient from the hospital to the community was sound.[272] Even if the patient is mentally disordered and would benefit from additional outpatient supervision and treatment, the patient is not legally insane if he or she is not dangerous. The statute specifically provides that sanity has been restored when the patient "is no longer a danger to the health

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264. *See supra* Table 6 and notes accompanying notes 188–89.

265. CAL. PENAL CODE § 1026.2(e) (West Supp. 1997).

266. People v. Harner, 262 Cal. Rptr. 422, 431 (Ct. App. 1989) (Kline, Presiding J., dissenting). The *Harner* case involved a mentally disordered sex offender placed on outpatient status. *Id.* at 423.

267. People v. Beck, 55 Cal. Rptr. 2d 340, 342 (Ct. App. 1996).

268. *Id.* at 343.

269. *Id.* at 345.

270. People v. Tilbury, 813 P.2d 1318, 1327 (Cal. 1991).

271. *Id.* at 1332 (Mosk, J. dissenting).

272. *Id.* at 1333.

and safety of others, due to mental defect, disease, or disorder."[273]

For many current patients, CONREP's most recent retention recommendation does not appear warranted. In fact, occasionally CONREP offered no justification at all. For example, a patient who had been treated in the hospital for seven years and one month was released to outpatient status. He remained in CONREP after sixteen years and five months on outpatient status.[274] In its most recent annual report, CONREP stated that the patient complied with the terms and conditions of his outpatient status, continued to be cooperative and responsible in all aspects of his obligations to the program, demonstrated an understanding of his functional impairment, and could identify and discuss the nature of his mental illness. He also demonstrated a greater general range of affect, was appropriately functioning in his environment, and had experienced no psychiatric decompensation for almost four years. The previous year's annual report contained virtually identical findings. Nevertheless, on each occasion, CONREP recommended renewal of the patient's outpatient status.

I can only speculate on the reasons for CONREP's reluctance to recommend restoration to sanity for this patient. Perhaps it is the nature of his insanity defense crime. While in an acute psychotic state, the patient strangled his wife and then cut out her heart. But that act occurred in 1971. If mental health professionals believed he continued to pose a danger to society, he should not have been released to hospital parole in 1979. His continued retention in CONREP, despite the absence of any evidence of dangerousness, cannot be condoned.

More typically, CONREP's annual reports provide some reasons to support a retention recommendation; but the reasons, taken in the context of other CONREP findings, do not adequately support a prediction of dangerousness. For example, in one case, the patient remained in CONREP after four years and six months of outpatient treatment. CONREP's most recent annual report contained the following findings: The patient's Axis I mental illness had remained in remission. He had not received any psychotropic medication or experienced any psychiatric decompensation over the past year. He had been fully compliant with the terms and conditions of his release and continued to be sober. His random urine toxicology screens had all been negative. He continued to gain insight regarding his alcohol problem. The patient had missed no appointments with CONREP, actively engaged in his individual psychotherapy, and maintained a positive relationship with CONREP.

CONREP also found, however, that the patient continued to struggle in the areas of employment and in achieving a more independent lifestyle. CONREP noted that treatment in the coming year would focus on: increased understanding of the patient's strengths and limitations; increased understanding of his frustration tolerance, anger, and ability to control these impulses; and continued steps leading to improved self-confidence.

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273. CAL. PENAL CODE § 1026.2(e) (West Supp. 1997).

274. The patient was placed on hospital parole and remained on that status for seven years and seven months before he was placed in CONREP. He remains in CONREP after eight years and 10 months in that program.

In assessing this patient's dangerousness potential, does the lack of employment, or the need to be more independent, or the desirability of addressing further treatment issues outweigh the patient's model behavior during a full year of outpatient treatment? I doubt it.

Despite the absence of any evidence of current or recent dangerousness, CONREP frequently cites the need for additional therapy as a justification for continued retention. For example, in one case, the patient remained in CONREP after three years and two months of outpatient treatment. CONREP's most recent annual report contained the following findings: The patient's Axis I mental disorder was in good remission with medication. The patient had remained substance free and had fully complied with the terms and conditions of his outpatient status. In the last year, the patient worked to understand both the delusions that led to the crime and his flashbacks of the crime, so that he might have a healthy and more peaceful existence. The patient indicated he would never harm another individual. He wished to control his impulses better and tried to understand what triggered his crime. In its only negative comment, CONREP noted that psychological assessment results suggested that the patient had a propensity to rely on denial and repression. This propensity might account for the slow progress of psychological treatment.

In another case, the patient remained in CONREP after one year and nine months of outpatient treatment. CONREP's most recent annual report contained the following findings: The patient was free of psychiatric symptoms, received no medication, and his substance abuse was in remission. He was punctual and had not missed any of his CONREP appointments. The patient was compliant with the treatment program. He had developed a support network. The patient was compliant with the terms and conditions of his outpatient status and had no contact with law enforcement. The patient was adjusting well to community living and was handling increased responsibilities well. His responsibilities would increase further in the coming year as he moved into an independent living situation, attended a training program for refrigeration/air conditioning repair, and sought to obtain employment in this new field. The patient had established a working therapeutic alliance with his primary therapist. He needed to continue working on the following therapeutic issues in the coming year: development of assertive skills in directly expressing his needs and feelings, interpersonal relationship issues involving his judgment and choice of associates and friends, and issues relating to the Vietnam War and being a Vietnam veteran.

Although danger to self is no longer a statutory basis for denying sanity restoration,[275] CONREP continues to recommend that patients be retained in the program for that reason. For example, in one case, the patient remained in CONREP after six years of outpatient treatment. CONREP's most recent annual report, submitted in June, 1995, contained the following findings: The patient

275. CAL. PENAL CODE § 1026.2(e). Prior to 1993, the statute provided for restoration to sanity if the person would not be a danger to the health and safety of others, "including himself or herself." Legislation enacted in 1993, and operative January 1, 1995, deleted the reference to self harm. Act of Oct. 10, 1993, ch. 1141, § 2, 1993 Cal. Stat.

experienced suicidal ideations and thoughts in April of this year. She was willing to increase contact with her primary therapist for support, but she declined an increase in her antidepressant medication. Otherwise, the patient had been stable during the year, with no changes in psychiatric medications. Forgetfulness and memory impairment remained a problem. However, the patient had not missed any CONREP appointments and continued to arrive at least one hour early for her regularly scheduled appointments. The patient's supportive network remained limited and progress remained slow. The patient had a positive therapeutic relationship with CONREP staff and her primary therapist, but the patient's understanding of her limitations remained poor.[276]

An insanity acquittee who is not dangerous to others should be restored to sanity. The individual's continuing therapeutic needs can, and should, be addressed through referral to other treatment programs. If the person's mental condition deteriorates, California's involuntary civil commitment procedures may be used for that person just as they may be used for any other person.[277] If, for example, he or she becomes suicidal, detention is authorized for up to thirty-one days.[278]

A patient's violation of the terms and conditions of release may justify CONREP's concern that he or she is potentially dangerous and should be retained in the program. A minor infraction of the rules, however, does not outweigh strong evidence that the patient is not dangerous. For example, in one case, the patient remained in CONREP after three years and eleven months of outpatient treatment. CONREP's most recent annual report contained the following findings: The patient's Axis I diagnosis was in full remission. The patient had adjusted well to community living since his release from Patton State Hospital and had a strong support system. The patient continued to demonstrate a curiosity about his personality structure. He was aware of problem issues and was beginning to understand his difficulties. In March, 1992, the patient received a warning letter because, without CONREP authorization, he left San Diego County to visit a fellow patient at Patton State Hospital. After receiving that warning letter, the patient improved his participation in therapy, became more involved in treatment, and placed more trust in CONREP.

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276. In another case, CONREP expressed concern that the patient lacked insight into his anorexia, and that if he did not remain in CONREP, he would probably revert back to dangerous eating habits. This annual report was submitted in October, 1994, less than two months before the legislative change discussed *supra* in note 275 became operative.

277. *See generally*, CAL. WELF. & INST. CODE §§ 5000–5344 (West Supp. 1997). Additionally, a mental health conservatorship may be established for a person who is gravely disabled as a result of mental disorder or impairment by chronic alcoholism. *See generally, id.* §§ 5350–5371. Grave disability is defined as a condition in which a person, as a result of a mental disorder, is unable to provide for food, clothing, and shelter. *Id.* § 5008(h)(1)(A).

278. In California, a mentally disordered person who is a danger to himself or herself may be detained for evaluation and treatment for 72 hours. CAL. WELF. & INST. CODE §§ 5150, 5206 (West 1984). Thereafter, the person may be certified for intensive treatment for 14 days. *Id.* § 5250 (West Supp. 1997). If he or she is imminently suicidal, the person may be recertified for intensive treatment for an additional 14 days. *Id.* § 5260 (West 1984).

Despite these favorable findings, CONREP recommended the patient's retention, relying on a report of a positive toxicology screen for marijuana in December, 1993. Ironically, CONREP issued no warning letter to the patient concerning this positive toxicology screen. In fact, CONREP's quarterly progress reports that were submitted to the court in February, 1994 and May, 1994 made no mention of the reported positive screen. To the contrary, both reports acknowledged that all toxicology screens performed during the quarter were negative.[279]

Although I have focused on several problematic CONREP retention recommendations, I do not mean to suggest that most, or even a majority, are inappropriate.[280] Nevertheless, the number of questionable retention recommendations is sufficiently great to suggest that the problem is systemic and demands prompt attention.

## IV. RECOMMENDATIONS AND CONCLUSION

The public demands, and is entitled to receive, protection from those who commit criminal acts but who escape criminal responsibility. Protection is assured by hospitalizing insanity acquittees until they are no longer dangerous[281] and by monitoring them as they move from hospitalization to community living.[282] Conditional release programs have proven to be effective monitors of outpatient activity and treatment.[283] Conditionally released patients are arrested at a

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279. It should be noted, however, that the patient had an extensive history of substance abuse. He reportedly smoked marijuana on a daily basis for 20 years. He also abused cocaine, heroin, LSD, and amphetamines. The patient's insanity defense crime was second-degree murder. He stabbed his brother to death while they were arguing. At the time, the patient was under the influence of methamphetamines and was hearing voices commanding him to do the act.

280. In one of the 31 cases involving current patients (3.2%), CONREP recommended that the patient be restored to sanity, but a jury determined that the patient was insane, and the patient was retained in CONREP for an additional year. The patient remained in CONREP after four years and four months of outpatient treatment. CONREP's most recent annual report contained the following findings: The patient's Axis I mental disorder remained in partial remission with the use of medications. There was no evidence of positive symptoms, such as delusions or hallucinations. However, there was some evidence of negative symptoms, such as affective flattening and alogia. These negative symptoms were considered mild. The patient's insanity defense crime was precipitated by the patient's chronic paranoid delusional state. Because the patient was not experiencing positive symptoms, his risk for future violent offenses was low. Additionally, the risk was evaluated as low because of the lack of a prior criminal history, the existence of a stable income, abstinence from alcohol or narcotics use, the patient's age (39 years), and the absence of psychopathic disturbance. The patient made arrangements to be treated if he was restored to sanity. The patient had an adequate income and health insurance in order to secure an appropriate level of psychiatric care.

281. *See, e.g.*, CAL. PENAL CODE §§ 1026(a), 1026.2(e) (West Supp. 1997).

282. *Id.* § 1026.2(e).

283. *See supra* text accompanying notes 37–52 (research reporting on Maryland program), 54–58 (research reporting on Illinois program), 68–85 (research reporting on

significantly lower rate than are similar patients who received hospital discharge without undergoing conditional release.[284]

Community protection, however, comes at a cost to conditionally released patients. Their liberty is significantly restricted by the terms and conditions imposed upon them by the conditional release program.[285] Their outpatient status continues until they are restored to sanity or are rehospitalized. They are rehospitalized at a significantly higher rate than are similar patients who received hospital discharge without undergoing conditional release.[286] My study of insanity acquittees processed through CONREP indicates that the costs are impermissibly high for some patients.

To strike an appropriate balance between the public's interest in security and the insanity acquittee's interest in fair treatment, I offer six recommendations. The recommendations are derived from my research on the San Diego Conditional Release Program and are applicable to any conditional release program within California. These recommendations can be easily adapted to conditional release programs throughout the United States.

*1. In accordance with existing legislation, an insanity acquittee should be placed in a conditional release program only when the court determines that he or she will not be a danger to others, due to mental disorder, if under supervision and treatment in the community.*[287]

*2. To discourage the misuse of the conditional release program to maintain control over insanity acquittees who are not suitable for outpatient treatment, but who are otherwise eligible for hospital discharge, time spent in a conditional release program should be credited toward the insanity acquittee's maximum term of confinement.*[288]

*3. An insanity acquittee who has been placed in a conditional release program should be presumed capable of successfully completing that program within the one-year outpatient treatment period established by the legislature.*[289]

*4. Outpatient status should be revoked only if the court determines that the insanity acquittee is a danger to others, due to mental disorder, if he or she remains under supervision and treatment in the community.*[290]

*5. An insanity acquittee who completes one year without violating the terms or conditions imposed by the conditional release program should be*

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Oregon program), and 99–111 (research reporting on California program).

284. *See supra* text accompanying notes 107–08.

285. *See supra* text following note 194.

286. *See supra* text accompanying notes 107–08.

287. CAL. PENAL CODE § 1026.2(e). *See supra* text accompanying notes 265–66.

288. *See supra* text accompanying notes 178–83. This recommendation will require that CAL. PENAL CODE §§ 1026.5(b)(8) & 1600.5 (West Supp. 1997) be amended.

289. CAL. PENAL CODE § 1026.2(e) (West Supp. 1997). *See supra* text accompanying notes 267–69.

290. *See supra* text accompanying notes 208–35.

*restored to sanity.*[291]

*6. At the sanity restoration trial, the government should bear the burden of proving the insanity acquittee's dangerousness.*[292]

This is not a popular time to be advocating fair treatment for insanity acquittees. As we approach the new millennium, a frightened public's cry for vengeance is deafening. Insanity acquittees, however, are not criminally responsible and may not be punished.[293] The public is entitled to reasonable assurance that restored insanity acquittees are not dangerous,[294] but the public is not entitled to an absolute guarantee. Restoration to sanity should not require proof that the insanity acquittee is a "dangerousness eunuch"—physiologically incapable of criminal activity.

Nearly 100 years ago, Samuel J. Barrows observed, "Ask what a State does with its insane prisoners, ask how it protects society on the one hand and fulfills its duty to an irresponsible member on the other, and we may judge of its degree of advancement...by the response."[295] Conditional release programs provide a yardstick to measure society's progress. If used appropriately, conditional release balances competing interests—assuring community safety while assisting insanity acquittees in acclimating to community living. Conditional release, like purgatory, is a transitional state, not a permanent destination.

Unlike purgatory, however, conditional release is not a place for insanity acquittees to undergo suffering in order to achieve expiation for their wrongdoing. If used inappropriately, conditional release is a device to retain indeterminate control over insanity acquittees, including those who are no longer dangerous. So used, conditional release inflicts impermissible punishment. If conditional release

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291. *See supra* text accompanying notes 271–73.

292. Allocation of the burden of proof is especially important to insanity acquittees whose outpatient status was not revoked during the one-year period but who violated some term or condition imposed by the conditional release program. They are not entitled to the conclusive presumption of sanity proposed in Recommendation 5. Under existing law, the person applying for restoration to sanity bears the burden of proof by a preponderance of the evidence that sanity has been restored, *i.e.*, that he or she is no longer a danger to others, due to mental disorder. CAL. PENAL CODE § 1026.2(k) (West Supp. 1997). For two reasons, the government should bear the burden. First, an insanity acquittee may be placed in a conditional release program only if the court determines that he or she will not be a danger to others, due to mental disorder, while under supervision and treatment. *Id.* § 1026.2(e). Second, for a sanity restoration trial to be conducted, the insanity acquittee must complete the one-year period prescribed for the conditional release program without exhibiting such dangerousness that revocation of outpatient status is required. *Id.* § 1026.2(f).

293. Foucha v. Louisiana, 504 U.S. 71, 80 (1992).

294. Legislation establishing conditional release programs in California declares that the level of treatment and supervision should "reasonably ensure" that insanity acquittees do not commit other crimes. Act of Oct. 1, 1985, ch. 1416, § 1, 1985 Cal. Stat. 5003, 5004.

295. SAMUEL J. BARROWS, THE CRIMINAL INSANE IN THE UNITED STATES AND IN FOREIGN COUNTRIES 8 (1898).

is used for this purpose, then as a society, we will be regressing toward a time when insanity acquittees, like Daniel M'Naghten, were confined until they died.[296]

296. *See supra* text accompanying notes 4–6.