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Improving Insanity Aftercare

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IMPROVING INSANITY AFTERCARE

Amanda Joy Peters[†] and Indira Azizi Lex^{††}

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[T]he public’s acceptance of the insanity defense rests upon confidence in a rational and responsible system to manage insanity acquittees.¹

– Stuart B. Silver & Christiane Tellefsen

I. INTRODUCTION

More than a decade ago, Martin Smith² walked into a Texas grocery store and began to violently stab the man standing in front

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1. Stuart B. Silver & Christiane Tellefsen, *Administrative Issues in the Follow-Up Treatment of Insanity Acquittees*, 18 J. MENTAL HEALTH ADMIN. 242, 242 (1991).

2. This man’s name has been changed to protect confidentiality.

of him in the checkout line. Smith never spoke to the man, nor made eye contact with him before assaulting him. Fortunately, the man lived. Smith was arrested and charged with aggravated assault. Psychiatrists later determined that, at the time of the offense, Smith was suffering from schizophrenia and was psychotic. Along with schizophrenia, he was diagnosed with bipolar disorder and antisocial personality disorder. Smith was found not guilty by reason of insanity (NGRI) and acquitted of aggravated assault.

After spending more than five years in a state hospital, Smith returned to his community to receive outpatient treatment. He moved into a group home. While in the group home, he received minimal treatment and had little support. He was allowed to come and go as he pleased. He was unsupervised when he was away from the home.

Within four months, Smith committed another crime and his outpatient treatment was revoked. Psychiatrists concluded that while he was living in the group home, he decompensated and began using drugs and alcohol in an effort to self-medicate his illness. The trial court revoked Smith's conditional release due to his recidivism and substance abuse. He spent the next ten years in a state hospital. Overall, Smith has lived more than twenty-five of his forty-something years of life in psychiatric hospitals or prisons. Smith's brief four-month conditional release ended in failure—as did Kenneth Pierott's.

In 1997, Pierott brutally murdered his sister who suffered from cerebral palsy.³ The prosecutors, defense attorneys, forensic psychiatrists, and judge believed that Kenneth was not legally responsible for the crime due to his untreated paranoid schizophrenia. After a bench trial, the judge found him NGRI.⁴

Following his acquittal, Pierott was committed to a maximum security state hospital, but he was transferred to a minimum security hospital two months later.⁵ After a short, six-week stay in the second hospital, he was conditionally released home to receive outpatient treatment.⁶ He was encouraged to continue taking his

3. Ramon Rodriguez & Ed Shettle, *The Trial of Kenneth Pierott*, TEX. PROSECUTOR, July–Aug. 2005, at 11, <http://www.tdcaa.com/sites/default/files/newsletter/JA05Prosecutor.pdf>.

4. Brian Shannon, *The Time is Right to Revise the Texas Insanity Defense*, 39 TEX. TECH L. REV. 67, 77 (2006).

5. Rodriguez & Shettle, *supra* note 3, at 11.

6. *Id.*

antipsychotic medication when he left the hospital.⁷ The government agency charged with overseeing NGRI acquittees was supposed to ensure Pierott took his prescribed anti-psychotic medication. However, the agency's supervision of him was later deemed "lax" by investigators.⁸

Pierott committed criminal acts of forgery and family-violence assault, yet his conditional release was not revoked.⁹ It appears the original trial judge had no knowledge about Pierott's subsequent criminal offenses.¹⁰ Pierott's conditional release treatment team terminated his supervision in 2003; there is no evidence the trial court was informed of this termination.¹¹ One year later, Pierott murdered his girlfriend's six-year-old son by asphyxiating him with a pillowcase and placing his body in an oven.¹² In his second murder trial, the jury sentenced Pierott to sixty years in prison, where he remains today.¹³ Pierott's second murder attracted media attention and public outrage. The Texas legislature would later determine that, although NGRI aftercare should be "a simple process," it sometimes produced "aberrations" and "early releases of unstable and potentially dangerous individuals."¹⁴

Not every insanity acquittee is violent or dangerous; some are charged with misdemeanors or petty crimes. Many acquittees are able to successfully comply with conditions of release, manage their illness, and not reoffend.¹⁵ Yet, the aftercare system failed Smith and Pierott—not to mention the young boy Pierott murdered.

7. Shannon, *supra* note 4, at 77.

8. *Id.*

9. Rodriguez & Shettle, *supra* note 3, at 11.

10. For practical purposes, insanity acquittals are akin to regular "not guilty" acquittals, and thus may be difficult for arresting agencies to find. Unfortunately, it is not uncommon for the original trial court to be unaware of subsequent charges and for arresting agencies to likewise be unaware of previous insanity acquittals.

11. Rodriguez & Shettle, *supra* note 3, at 11.

12. *Id.*; Shannon, *supra* note 4, at 77.

13. See *Pierott v. State*, No. 09-05-215-CR, 2007 WL 2683586 (Tex. Crim. App. Apr. 23, 2008); see also Pam Easton, *Man Sentenced to 60 Years in Oven Death*, HOUS. CHRON. (May 12, 2005, 5:30 AM), <http://www.chron.com/news/houston-texas/article/Man-sentenced-to-60-years-in-oven-death-1944214.php>.

14. TEX. S. JURIS. COMM. INTERIM REP. 37, 79th Sess. (Tex. 2004) [hereinafter TEXAS SENATE REPORT], http://www.senate.state.tx.us/75r/Senate/commit/c550/PDF/rpt_c550_dec2004.pdf.

15. George F. Parker, *Outcomes of Assertive Community Treatment in an NGRI Conditional Release Program*, 32 J. AM. ACAD. PSYCHIATRY & L. 291, 291 (2004).

These true accounts illustrate the flaws with insanity aftercare: inadequate support, poor communication between the supervisors and agencies responsible for the acquittee, and lack of continuity of care between inpatient and outpatient care. It is time to rethink aftercare programs and conditional release.

This article examines the number of individuals acquitted or otherwise excused due to insanity. It explores the insanity aftercare process, which has remained stagnant in most jurisdictions for twenty-plus years, despite evidence-based research and treatment models that point to newer, more effective methods of treatments for mentally ill criminal offenders. This article investigates why post-acquittal conditional release is most often revoked. It considers the problems with the traditional aftercare model. By incorporating mental health courts, assertive community treatment, and programs that address criminogenic needs, conditional release programs may be able to reduce hospitalizations and arrests, as well as increase mental wellness and overall life quality. The authors hope to encourage states to consider incorporating elements of risk assessment, cooperation, and greater accountability into existing insanity aftercare programs.

II. INSANITY ACQUITTEE POPULATIONS

In the 1980s and 1990s, researchers estimated that less than 1% of all felony cases ended with an insanity acquittal.¹⁶ It is likely this number has risen in the past two decades. Arrest rates for mentally ill persons are high.¹⁷ Individuals with mental illness are more likely to end up in the criminal justice system than in the mental health system.¹⁸ In the last decade, they have been

16. E.g., Lisa A. Callahan, *The Volume and Characteristics of Insanity Defense Pleas: An Eight-State Study*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 331, 334 (1991) (finding 0.93% of felony cases raised the insanity defense and acquittal rates as high as 87% in cases where insanity was raised as a defense in Washington and as low as 7% in Montana, where the insanity defense was abolished, for an average of 26% across eight surveyed states); Marnie E. Rice & Grant T. Harris, *The Predictors of Insanity Acquittals*, 13 INT'L J.L. & PSYCHIATRY 217, 217 (1990) (citing 1980s studies).

17. E. Lea Johnston, *Theorizing Mental Health Courts*, 89 WASH. U. L. REV. 519, 567–68 (2012).

18. Robert D. Morgan et al., *Treating Offenders with Mental Illness: A Research Synthesis*, 36 L. & HUM. BEHAV. 37, 37 (2012).

“incarcerated at disproportionately increasing rates.”¹⁹ At both state and federal penal institutions, mental health treatment efforts have been unable to keep up with incarceration rates.²⁰ For these reasons, it is possible that the defense is raised and successful more frequently than ever before.

Insanity findings in the criminal context are not common,²¹ but they occur more often than one might believe. Given the number of individuals with mental illness that are being incarcerated,²² it should come as no surprise that persons with mental illness are making their way to criminal courts and jails in higher numbers than ever before. Finding out exactly how many individuals have been found insane in a criminal court, however, is difficult.²³

The Bureau of Justice Statistics (BJS) keeps crime data on virtually every crime committed in America;²⁴ but it does not retain statistics on successful insanity defenses.²⁵ For whatever reason—

19. *Id.*

20. *Id.*

21. *E.g.*, Carmen Cirincione et al., *Rates of Insanity Acquittals and the Factors Associated with Successful Insanity Pleas*, 23 BULL. AM. ACAD. PSYCHIATRY & L. 399, 402 (1995) (finding approximately one successful insanity acquittal per 400 felony indictments across seven states); Donald M. Linhorst, *The Unconditional Release of Mentally Ill Offenders from Indefinite Commitment: A Study of Missouri Insanity Acquittees*, 27 J. AM. ACAD. PSYCHIATRY & L. 563, 563 (1999) (stating that the insanity defense was raised in less than 1% of felony cases and was successful in only 25% in the 1990s); Richard A. Pasewark, *Criminal Recidivism Among Insanity Acquittees*, 5 INT'L J.L. & PSYCHIATRY, 365, 371 (1982) (asserting that 25% of insanity pleas in New York in the early 1980s were successful; whereas during the same time, only 0.9% of insanity pleas in Wyoming resulted in an acquittal).

22. Amy Blank Wilson et al., *Criminal Thinking Styles Among People with Serious Mental Illness in Jail*, 38 L. & HUM. BEHAV. 592, 592 (2014).

23. *E.g.*, Callahan, *supra* note 16, at 334 (stating that a number of researchers traveled to jails, counties, and government facilities to comb through criminal files in forty-nine counties located within eight states to determine the prevalence of the defense, which the authors described as an “expensive and extremely time-consuming” endeavor); TEXAS SENATE REPORT, *supra* note 14, at 37 (noting that members of the Texas legislature were “disturbed by the lack of data regarding the NGRI population. The data is inconclusive and spotty at best”).

24. *See generally* BUREAU JUST. STAT., <http://www.bjs.gov> (last visited Mar. 9, 2016) (collecting data on type of crime, characteristics of parolees and probationers, emergency room statistics of intentional violence, among many others).

25. E-mail from Tracey Kyckelhahn, BJS Statistician, to author (July 27, 2015, 4:56 AM) (on file with author).

politics or medical privacy—it is difficult to obtain this data. In order to discover the number of people acquitted due to insanity, one must research each jurisdiction separately. Even then, finding the agency that retains these numbers is challenging. Given the public perception of the insanity defense and controversy,²⁶ state actors seem to make this information hard to obtain.

The number of insanity acquittees in each state varies significantly, perhaps due to the rigidity or liberalness of the defense,²⁷ or frequency in which the defense is raised.²⁸ For example, in July of 2015, California had 1417 acquittees residing in state hospitals, but this number does not include the number of acquittees living in communities pursuant to a judicial order of conditional release.²⁹ In 2014, the Texas Department of State Health Services reported that 354 insanity acquittees resided in state hospitals or had only recently been conditionally released for outpatient treatment.³⁰ The Oregon Psychiatric Services Review Board monitors only violent felony offenders who have been found Guilty Except Insane.³¹ At the end of June 2015, it had 530 active

26. Michael L. Perlin, “*The Borderline Which Separated You from Me*”: *The Insanity Defense, the Authoritarian Spirit, the Fear of Faking, and the Culture of Punishment*, 82 IOWA L. REV. 1375, 1404 (1997) (citing “media distortions” as causing the dramatic and grossly overestimated frequency and success rates of the defense in the public’s perception); Stephen G. Valdes, *Frequency and Success: An Empirical Study of Criminal Law Defenses, Federal Constitutional Evidentiary Claims, and Plea Negotiations*, 153 U. PA. L. REV. 1709, 1723 (2005) (“While surveys have shown that the public believes the [insanity] defense is raised in as many as 50% of all trials, in reality the defense is raised infrequently . . .”).

27. *E.g.*, Shannon, *supra* note 4, at 69–70 (describing the Texas insanity defense as one that is rarely successful due to the high burden defendants have in proving it, based on the wording of the defense).

28. Cirincione et al., *supra* note 21, at 402 (stating that the more frequently the defense was raised, the less successful it was; the less frequently it was raised, the more successful it was).

29. Telephone Interview with Ralph Montano, Info. Officer, Cal. Dep’t of State Hosp. (July 28, 2015) (reporting that census numbers are updated weekly and this census number was for the week of July 13, 2015).

30. Chris Lopez, Texas De-Identified List of NGRI Persons for Fiscal Year 2014 (July 28, 2015) (unpublished manuscript) (on file with author). This number does not include acquittees who have lived long-term within the community. *Id.*

31. Telephone Interview with Jane Bigler, Or. Psychiatric Servs. Review Bd. (July 28, 2015) (reporting that 530 total GEI clients who have been convicted of person-to-person violent felony offenses, 378 of which are on conditional release).

clients, 387 of whom were living outside of hospitals, jails, or prisons on conditional release.³²

In 2014, a Virginia study identified 127 NGRI acquittees living in communities on conditional release.³³ Maryland, on the other hand, has over 700 acquittees on conditional release.³⁴ Even older studies suggest a significant number of acquittees live in the community. For example, a 1999 Missouri study identified 1066 insanity acquittees living in hospitals or in the community.³⁵ The data suggest there are thousands, perhaps ten thousand or more people in our country who have been found NGRI, or guilty but insane. With numbers this high, it is important to ascertain whether the systems designed to treat them are adequate.

III. INSANITY ACQUITTAL PROCEDURE

The general process of being acquitted by reason of insanity and being treated post-acquittal is fairly straightforward. When a defendant is found NGRI or guilty but insane, she is usually sent to a state psychiatric hospital to be evaluated.³⁶ This initial commitment may last between ten and sixty days.³⁷ She remains committed for mental health treatment until she is no longer deemed dangerous.³⁸

Some insanity acquittees, particularly those who have committed violent crimes with lengthy sentences,³⁹ may reside within state hospitals for the entirety of their maximum

32. *Id.*

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

34. E-mail from Dr. Larry Fitch, Nat'l Ass'n of State Mental Health Program Dirs. (NASMHPD), to Dr. Brian Sims, NASMHPD Senior Dir. of Med. & Behavioral Health (Aug. 20, 2015, 6:23AM EDT) (on file with author).

35. Linhorst, *supra* note 21, at 567.

36. Jana R. McCreary, *Not Guilty...Until Recommitment: The Misuse of Evidence of the Underlying Crime in NGRI Recommitment Hearings*, 2009 UTAH L. REV. 1253, 1256.

37. *Id.* at 1259.

38. *Id.* at 1256.

39. *Id.* at 1257 (arguing that the underlying crime's facts are an unfair and inappropriate factor for recommitting insanity acquittees); *see also* Grant T. Harris et al., *Length of Detention in Matched Groups of Insanity Acquittes and Convicted Offenders*, 14 INT'L J.L. & PSYCHIATRY 223, 234 (1991) (finding that insanity acquittees with charges of murder and attempted murder spent as much time in the state hospital as sane men convicted of the same offenses).

hypothetical sentence.⁴⁰ However, most do not.⁴¹ The inpatient treatment commitment is designed to restore health—not to punish the acquitted person.⁴² The acquittee has the right to be treated in the least restrictive setting.⁴³ When and if the person’s mental health is restored and he is no longer considered dangerous, conditional release is an option.⁴⁴

Trial courts and states are increasingly releasing insanity acquittees into the community due to smaller mental health budgets and better access to outpatient treatment.⁴⁵ The government is permitted to exercise greater autonomy in determining when and if a person should be conditionally

40. The phrase, maximum hypothetical sentence, refers to the lengthiest incarceration sentence the person would have received had he been convicted. Most states use the maximum hypothetical sentence as a yardstick to measure the trial court’s duration of jurisdiction over the acquittee. Grant H. Morris, *Escaping the Asylum: When Freedom Is a Crime*, 40 SAN DIEGO L. REV. 481, 529–30 (2003). Not every jurisdiction uses this measure. For example, military courts lose jurisdiction over the acquittee once he is found NGRI; he is transferred immediately to the medical division of the military. Raymond G. Lande, *Disposition of Insanity Acquittes in the United States Military*, 18 BULL. AM. ACAD. PSYCHIATRY & L. 303, 306–07 (1990).

41. Compare Silver & Tellefsen, *supra* note 1, at 243 (reporting that the average hospital stay for acquittees in Maryland was between 2.5 and 3 years at the time of the study), with Linhorst, *supra* note 21, at 570 (reporting that 98% of acquittees were still committed to the state hospital for inpatient care one year after the acquittal, 85% were committed five years post-acquittal, and 76% were still confined ten years after acquittal).

42. See *Jones v. United States*, 462 U.S. 354, 355 (1983); Stephen M. LeBlanc, *Cruelty to the Mentally Ill: An Eighth Amendment Challenge to the Abolition of the Insanity Defense*, 56 AM. U. L. REV. 1281, 1283 (2007) (“The insanity defense, however, serves a purpose higher than the punishment of those committing otherwise criminal acts: it represents society’s moral and social judgment that individuals unable to understand or control their conduct deserve treatment, not punishment.”).

43. E.g., Michael L. Perlin, *For the Misdemeanor Outlaw: The Impact of the ADA on the Institutionalization of Criminal Defendants with Mental Disabilities*, 52 ALA. L. REV. 193, 228 n.254 (2000) (analyzing the least restrictive requirement in various states pre-*Olmstead*); E-mail from Dr. Larry Fitch, *supra* note 34 (stating that of thirty-seven states who replied to a national survey, thirty-one used conditional release to provide less restrictive alternatives to inpatient treatment).

44. Patrick K. Fox, *Biases that Affect the Decision to Conditionally Release an Insanity Acquittee*, 36 J. AM. ACAD. PSYCHIATRY & L. 337, 338 (2008).

45. Vitacco et al., *supra* note 33, at 346; Michael J. Vitacco et al., *Developing Services for Insanity Acquittes Conditionally Released Into the Community: Maximizing Success and Minimizing Recidivism*, 52 PSYCHOL. SERVS. 118, 118 (2008).

released.⁴⁶ “Determining when an acquittee is ready for . . . release is not easy, nor should it be”⁴⁷ One psychiatrist described the method of determining who should be released and when as “daunting.”⁴⁸

Evaluating an acquittee for release requires forensic professionals to determine whether the acquittee’s mental health will decompensate; how long before decompensation occurs; whether there is a chance of recidivism, and if so when; and how the person may reoffend.⁴⁹ If the trial court determines, based upon the forensic evaluation and psychiatrist’s treatment plan, to release an acquittee, the release almost always has many conditions.

Courts are permitted to place conditions on release.⁵⁰ The court, in its judgment, may protect:

the public while serving the defendant’s interest in remaining in the least restrictive environment possible. “[T]he order of conditions is the vehicle by which the . . . court effectuates its continuing supervisory authority over” a defendant found not responsible for a crime by reason of mental disease or defect.⁵¹

During release, the acquittee “remains under court or agency jurisdiction, such that, should the acquittee violate the conditions of the release, he or she can be returned to an institutional setting.”⁵² Conditional release is not punishment; it is considered an extension of the treatment that began in the hospital and will be completed in the community.⁵³ As long as “the conditions surrounding that confinement do not suggest a punitive purpose on the State’s part,”⁵⁴ but instead relate to the “prescribed regimen of medical, psychiatric, or psychological care or treatment,”⁵⁵ the

46. Vitacco et al., *supra* note 45, at 119.

47. Fox, *supra* note 44, at 339.

48. *Id.* at 337.

49. *Id.* at 337–39.

50. Allen B. v. Sproat, 14 N.E.3d 970, 977 (N.Y. 2014).

51. *Id.* (quoting *In re Jill ZZ.*, 629 N.E.2d 1040, 1042 (N.Y. 1994)).

52. Parker, *supra* note 15, at 291.

53. Bergstein v. State, 588 A.2d 779, 784 (Md. 1991). *But see* Jocelyn A. Lymburner & Ronald Roesch, *The Insanity Defense: Five Years of Research*, 22 INT’L J.L. & PSYCHIATRY 213, 228 (1999) (“[O]ffense seriousness was a stronger predictor of length of confinement than was mental disorder, suggesting that punishment is a higher priority than treatment.”).

54. Kansas v. Hendricks, 521 U.S. 346, 363 (1997).

55. United States v. Crape, 603 F.3d 1237, 1247 (11th Cir. 2010).

court may attach conditions to the release.⁵⁶ In some jurisdictions, courts are free to add conditions to release, even when they are not enumerated by statute, as long as they are reasonable.⁵⁷

Conditions may include pharmacological treatment, therapy, alcohol and drug abstinence, placement with probation or parole officers, working conditions, living conditions, and other conditions.⁵⁸ These conditions are designed to maintain the acquittee's restored mental health and the community's safety.

While many acquittees successfully complete their term of conditional release, courts may place a noncompliant acquittee in a mental health crisis center⁵⁹ or revoke the release entirely.⁶⁰ There are several reasons an acquittee's conditional release would either be discharged or revoked. First, the person has exceeded the maximum hypothetical sentence she would have served had she been convicted of the crime.⁶¹ In this instance, the acquittee is discharged from release and permitted to live freely in the community. Second, the release may be revoked for committing a new offense⁶² or violating the judge's conditions (not following the treatment plan, using drugs, etc.).⁶³ Revocation may also be warranted when the acquitted person becomes dangerous due to mental decompensation or the return of psychosis.⁶⁴

56. *Hendricks*, 521 U.S. at 363.

57. *E.g.*, *Allen B. v. Sproat*, 14 N.E.3d 970, 978 (N.Y. 2014).

58. W. Neil Gowensmith et al., *Decision-Making in Post-Acquittal Hospital Release: How Do Forensic Evaluators Make Their Decisions*, 32 BEHAV. SCI. L. 595, 595 (2014).

59. W. Neil Gowensmith, Presentation at the American Psychology-Law Society Annual Meeting: Speciality Community Supervision Practices for Insanity Acquittes: How Well Do They Work? (Mar. 2013).

60. Stuart B. Silver et al., *Follow-Up After Release of Insanity Acquittes, Mentally Disordered Offenders, and Convicted Felons*, 17 BULL. AM. ACAD. PSYCHIATRY & L. 387, 389 (1989) (advising that the judge may choose to reinstate, modify, or revoke the acquittes' conditional release per statute).

61. Mark R. Wiederanders & Paul A. Choate, *Beyond Recidivism: Measuring Community Adjustments of Conditionally Released Insanity Acquittes*, 6 PSYCHOL. ASSESSMENT 61, 64-65 (1994).

62. *Id.*

63. *Id.*

64. *United States v. Crape*, 603 F.3d 1237, 1244 (11th Cir. 2010).

IV. AFTERCARE REVOCATIONS

Revocation rates have varied significantly over the years. Whereas revocation rates hovered around 50% in the early days of conditional release programs⁶⁵ and have been as high as 63%,⁶⁶ newer programs are more effective.⁶⁷ Modern “programs are now able to respond more quickly to changes in the individual’s mental status in order to minimize mental health deterioration, criminal behavior, or violence.”⁶⁸

Even still, these second generation release programs have about a 30% revocation rate, mostly due to conditional release violations and less frequently due to recidivism.⁶⁹ A 2004 study related a 34.4% revocation rate, but only a 10.1% re-arrest rate.⁷⁰ A 2008 study reported an overall revocation rate of 33.88% and a re-arrest rate of 7.1% among 363 conditionally released acquittees.⁷¹

Recidivism rates increase substantially the longer the acquittee remains in the community.⁷² One study found that while recidivism rates among insanity acquittees was between 2% and 16% shortly after release, long-term recidivism rates were between 42% and 56%.⁷³ Recidivism data may be skewed, however, when one considers that conditional release violations typically lead to re-hospitalization.⁷⁴ Briefly curtailing freedom is effective in curbing

65. Silver & Tellefsen, *supra* note 1, at 245.

66. Vitacco et al., *supra* note 45, at 120.

67. Vitacco et al., *supra* note 33, at 347.

68. *Id.*

69. *Id.*; see also Mark L. Pantle et al., *Comparing Institutionalization Periods and Subsequent Arrests of Insanity Acquittes and Convicted Felons*, J. PSYCHIATRY & L. 305, 313, 315 (1980) (stating that approximately 25% of insanity acquittees reoffended in present study, but in another study, 37% of acquittees reoffended); Pasewark, *supra* note 21, at 371 (stating that 38 of 133 participants were arrested 131 times post-acquittal); Silver et al., *supra* note 60, at 396 (stating that 65.8% of acquittees reoffended within the seventeen-year study period following their release); see also Wilson et al., *supra* note 22, at 595 (finding that individuals with serious mental illness who are arrested exhibit patterns of “criminal thinking,” which makes them more likely to reoffend during the course of their lifetime).

70. Lisa J. Bertman-Pate et al., *The New Orleans Forensic Aftercare Clinic: A Seven Year Review of Hospital Discharged and Jail Diverted Clients*, 22 BEHAV. SCI. & L. 159, 167–68 (2004).

71. Vitacco et al., *supra* note 45, at 121.

72. Lymburner & Roesch, *supra* note 53, at 230.

73. *Id.*

74. Gowensmith et al., *supra* note 58, at 598.

more serious problems like the commission of new crimes.⁷⁵ In addition, new charges may be dismissed in lieu of civil commitment or re-hospitalization.⁷⁶

There are a few significant, wide-reaching consequences of revocation that go beyond impacting the acquittee. First, one of the most significant problems psychiatric consumers face is the low number of long-term psychiatric beds in America. In some states, over half of the long-term psychiatric beds are filled with insanity acquitees.⁷⁷ This is unfortunate news for non-forensic mental health consumers.⁷⁸

Between 2005 and 2010, there was a 14% decrease in the number of psychiatric beds.⁷⁹ By 2012, “there were 108,317 beds for 9.6 million” individuals with mental illness.⁸⁰ Without a long-term place to recover, individuals with mental illness experience shorter stays in overburdened emergency rooms, increased homelessness, violence, and “treatment” in jails and prisons.⁸¹ When acquitees are able to remain on conditional release, rather than being revoked and returned to the state hospital, there are more psychiatric beds available for non-forensic consumers.

Second, conditional release failures jeopardize insanity aftercare programs and result in public criticism, which inevitably leads to scrutiny of the insanity defense.⁸² Egregious failures involving subsequent arrests for violent offenses also impact future conditional release decisions. Release decisions may rely primarily on forensic risk assessments, but these decisions also have political implications.⁸³

75. See Vitacco et al., *supra* note 45, at 122.

76. Gowensmith et al., *supra* note 58, at 598; Jeffrey S. Janofsky et al., *Defendants Pleading Insanity: An Analysis of Outcome*, 17 BULL. AM. ACAD. PSYCHIATRY & L. 203, 205 (1989) (summarizing that, of 143 defendants who raised the insanity defense, sixteen cases were dismissed and thirteen resulted in directed verdicts).

77. See Lymburner & Roesch, *supra* note 53, at 227–28.

78. See Liz Szabo, *Psychiatric Beds Disappear Despite Growing Demand*, USA TODAY (May 12, 2014), <http://www.usatoday.com/story/news/nation/2014/05/12/disappearing-hospital-beds/9003677>.

79. *No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals*, TREATMENT ADVOCACY CTR. [hereinafter *Closing Hospitals*], <http://www.tacreports.org/bed-study> (last visited Mar. 10, 2016).

80. Szabo, *supra* note 78.

81. *Closing Hospitals*, *supra* note 79.

82. Vitacco et al., *supra* note 45, at 120.

83. See Harris et al., *supra* note 39, at 233–34.

If there has been a recent salient example of a released inmate or insanity acquittee who failed by committing some horrendous offense, all decisions for the next several months (especially decisions about offenders who resemble the horrendous failure in some way) are very conservative. If there have not been salient recent examples of failure, decision makers are more liberal in their release decisions.⁸⁴

For this reason, revocations affect not only the acquittee being revoked, but other acquittees whose release will be determined in the near and possibly distant future.⁸⁵ In other words, how well insanity aftercare works affects the acquittees, the criminal justice system, other mental health consumers, and the community at large.

V. AFTERCARE CHALLENGES

While the insanity defense and the post-acquittal procedures may follow straightforward statutory guidelines, the aftercare process is much more complicated.⁸⁶ The current system presumes that the conditions of conditional release will be followed and that if breached, the conditional release will end. Unfortunately, that is not always the case. This is because the procedures in place for post-acquittal aftercare and the various agencies and persons charged with supervising aftercare are so fractured that communication, enforcement, and follow-up are near impossible. These system imperfections, along with the complex illnesses and behaviors that many acquittees wrestle with for a lifetime, test the efficacy of insanity post-acquittal aftercare. This section will examine a few of the common problems with the aftercare process.

A. *Too Many Supervisors*

Conditional release implicates a variety of people and agencies with different professions, interests, goals, values, training, priorities, and concerns. Too often these parties do not meet

84. *Id.*

85. *Id.*

86. *See generally* Silver & Tellefsen, *supra* note 1, at 242 (discussing the challenges that forensic psychiatrists faced in designing a successful insanity aftercare program in Maryland).

together or communicate, which increases the likelihood that an acquittee might slip through aftercare cracks. To see the challenges that interested parties face in working together to supervise treatment, one need only look to New York's legal procedures surrounding conditional release.

In New York, once an acquittee is deemed to have a dangerous mental disorder (i.e., one that makes him a danger to himself or others), the trial judge must issue an order that commits the acquittee to the Commissioner of the Office of Mental Health for a six-month period.⁸⁷ At least thirty days before commitment expires, the Commissioner must decide whether to retain custody of the acquittee or to release him.⁸⁸ That decision must be sent in writing to the judge, the district attorney, the acquittee, his defense counsel, and the Mental Hygiene Legal Service.⁸⁹ By this point, at least six persons and/or agencies have been informed or involved in the matter, all of whom have different employers, interests, training, and perspectives.

The judge may order a hearing, after which he may extend commitment or release the acquittee into the community conditionally.⁹⁰ The judge can rely upon a psychiatrist's written release plan and attach conditions to it.⁹¹ But "it shall be the responsibility of the commissioner to determine that such defendant is receiving the services specified in the written service plan and is complying with [the] conditions."⁹² Thus, while two people—the judge and a psychiatrist—create the release plan, another person—the Commissioner—is charged with making sure the acquittee complies with it.

After the acquittee has been released and while the plan is in place, the Commissioner or the district attorney can request that the judge recommit the acquittee if the applicant believes the acquittee is dangerous.⁹³ "The applicant must give written notice to the [acquittee], his counsel and the Mental Hygiene Legal Service, and, if the applicant is the Commissioner, to the district attorney

87. *Allen B. v. Sproat*, 14 N.E.3d 970, 971 (N.Y. 2014).

88. *Id.* at 971–72.

89. *Id.* at 973.

90. *Id.* at 972–74.

91. *Id.* at 974; *see also* N.Y. CRIM. PROC. LAW § 330.20(12) (West, Westlaw through 2015).

92. *Sproat*, 14 N.E.3d at 974.

93. *Id.*

or, if the applicant is the district attorney, to the Commissioner.”⁹⁴ Thus, this single step implicates at least six persons or organizations, all of whom likely have not communicated with one another before the applicant made the request for recommitment.

While New York’s complex aftercare procedure may have been envisioned by the legislature as a system of checks and balances, involving this many individuals in the process inadvertently increases the risk for conditional release failures. Indeed, New York, like many states, has witnessed cases that “illustrate the perils posed when [acquittees] do not follow the regime designed by mental-health professionals and imposed by courts to safeguard their stability and functioning in the community.”⁹⁵

It is not always the acquittee, but the regime that wrecks the aftercare experience. Neil Gowensmith, former Director of Hawaii’s conditional release program, reveals that not only may all of the involved agencies and actors have different priorities based on their values and training,⁹⁶ but these differences may create conflicts impossible for the acquittee to resolve.⁹⁷ This places the acquittee in a very difficult situation.⁹⁸ For instance, supervisors and agencies may schedule meetings at conflicting times, leaving the individual to ask whether to “go to my court hearing, attend my substance abuse training, meet with my case manager, or attend my housing meeting this morning?”⁹⁹ Gowensmith concludes that programs are more effective when specially trained supervisors and teams take a coordinated, multi-disciplinary approach to supervision with negotiated, non-conflicting priorities.¹⁰⁰

New York’s release and recommitment process is not a team approach, but one that nonsensically compartmentalizes responsibility. When there are too many people and agencies involved in decision making, it overly complicates matters and results in miscommunication and failure to properly supervise the

94. *Id.*

95. *Id.* at 977–78.

96. Melissa M. Purta et al., What Factors Do Professionals Use in Determining Risk for Violence in the Mentally Ill? 12–13 (2013) (unpublished manuscript) (on file with author).

97. E-mail from W. Neil Gowensmith, Clinical Assistant Professor, Univ. of Denver, to author (Aug. 18, 2015, 15:32 MST) (on file with author).

98. *Id.*

99. *Id.*

100. *Id.*

acquittee. Given the mental condition of the acquittee, conditional release programs and aftercare should simplify, not overly complicate the process.

B. Too Many Needs

To say that working with individuals who suffer from mental illness is challenging is an understatement. Beyond the illness, which itself is complicated, there are ancillary issues that must be addressed during aftercare. Before acquittees are released from inpatient care, forensic psychiatric evaluators must assess a number of criteria, so many in fact, that professional evaluators disagree on which criterion takes precedence over others.¹⁰¹ For example, is risk of violence, adherence to medication, risk of substance abuse, ability to follow the terms and conditions of release, risk of mental decompensation, or following the treatment plan most important to determine readiness for release?¹⁰²

One of the reasons why evaluators have a difficult time determining which of the above factors is most important is that there is so much pressure to make the right decision.¹⁰³ “The nature of the [conditional release] application raises several political and social issues encompassing public safety, consumer civil rights, financial costs, and public perceptions of mental illness.”¹⁰⁴

The forensic evaluators and the court must agree to release a person whose previous actions were excused by law due to the severity of his or her illness. Trusting that the person will continue treatment and not reoffend or run afoul of release conditions is a risk that the gatekeepers to the community must take over and over again, knowing they will lose the gamble once in a while. Forensic evaluators have recognized that their work occurs “within a contextual framework that is influenced by generally accepted information about risk management and recidivism, as well as the political and social climate of the area into which the acquittee will be discharged.”¹⁰⁵ Their task is not enviable.

101. Gowensmith et al., *supra* note 58, at 601–05.

102. *Id.*

103. *Id.*

104. *Id.*

105. Fox, *supra* note 44, at 339.

Acquittes might appear to experience adequate, even good mental health, yet fail in aftercare for other reasons. The type and degree of mental illness the acquittee exhibits, along with any antisocial behavior or personality disorders¹⁰⁶ he has, may play a role in his aftercare success or failure.¹⁰⁷ Antisocial thinking patterns and behaviors, which are considered a criminogenic risk factor,¹⁰⁸ are closely linked with both recidivism and revocation.¹⁰⁹

Another criminogenic risk factor that may lead to reoffending is criminal thinking, which involves scheming to commit crimes, excusing past criminal conduct, or engaging in impulsive behaviors.¹¹⁰ Criminal thinking can lead to criminal association. Acquittes need assistance in helping to form relationships with people who do not engage in criminal behavior.¹¹¹ In addition, mental health treatment affects risk factors like criminal thinking. “For example, antipsychotic medication may control hallucinations and organize thinking enough that an offender can actually benefit from cognitive-behavioral sessions that target criminal thinking.”¹¹² In this way, personality disorders, criminal thinking, therapy, and the underlying mental illness and its treatment all overlap.

Substance abuse among mentally disordered offenders is also a huge problem.¹¹³ Three-fourths of individuals with mental illnesses in jail have a substance-abuse problem.¹¹⁴ Some states may report

106. Antisocial personality disorder involves “a pattern of disregard for, and violation of, the rights of others.” Grant H. Morris, *Placed in Purgatory: Conditional Release of Insanity Acquittes*, 39 ARIZ. L. REV. 1061, 1087 (1997) (citing AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-IV) 629 (4th ed. 1994)).

107. Vitacco et al., *supra* note 45, at 119 (stating that patients with antisocial behaviors must be given conditions upon release).

108. Wilson et al., *supra* note 22, at 593.

109. Vitacco et al., *supra* note 33, at 352.

110. Glenn D. Walters & Matt DeLisi, *Psychopathy and Violence: Does Antisocial Cognition Mediate the Relationship Between the PCL: YV Factor Scores and Violent Offending?*, 39 L. & HUM. BEHAV. 350, 350–51 (2015).

111. Marnie E. Rice et al., *Recidivism Among Male Insanity Acquittes*, 18 J. PSYCHIATRY & L. 379, 388 (1990).

112. Jennifer L. Skeem et al., *Offenders with Mental Illness Have Criminogenic Needs, Too: Toward Recidivism Reduction*, 38 L. & HUM. BEHAV. 212, 222 (2014).

113. See Johnston, *supra* note 17, at 566 (“[I]ndividuals with mental illness disproportionately abuse alcohol and drugs, perhaps as a way to manage their symptoms.”).

114. Jennifer L. Skeem et al., *Correctional Policy for Offenders with Mental Illness: Creating a New Paradigm for Recidivism Reduction*, 35 L. & HUM. BEHAV. 110, 110

even higher numbers of substance abuse among acquittee populations. For example, as many as 77% of individuals on conditional release in California have a reported history of abusing drugs or alcohol.¹¹⁵ Substance abuse becomes a serious concern when a released person can easily access their substance of choice in the community, and use begins to negatively impact the efficacy of pharmacological treatment.¹¹⁶ Substance abuse is one of the primary reasons for conditional release revocation.¹¹⁷

As patients make the transition from inpatient treatment to outpatient treatment, “they typically assume greater autonomy and control over several aspects of their daily lives.”¹¹⁸ Autonomy may result in anti-therapeutic choices, which may be temporarily hidden from release supervisors or the therapy team. One study reported that “half of conditionally released felony [acquittees used] substances with abuse potential, often without the knowledge of their treatment provider.”¹¹⁹

Courts revoke conditional release more frequently for individuals with substance abuse problems, antisocial behaviors, past revocations, or aftercare infractions.¹²⁰ Monitoring the acquittees with severe mental illness is difficult enough, not to mention addressing additional behaviors, attitudes, conditions, and addictions that make release revocation more probable. It does not help that “many insanity acquittees remain unpredictable” with their treatment regimens.¹²¹ Severe mental illnesses recur sporadically and may persist, to a lesser extent, even when the acquittee is complying with the treatment regimen.¹²² But acquittees can succeed in their home communities “provided there

(2011).

115. Morris, *supra* note 106, at 1081.

116. Richard Lamb et al., *Community Treatment of Severely Mentally Ill Offenders Under the Jurisdiction of the Criminal Justice System: A Review*, 50 PSYCHIATRIC SERVS. 907, 908 (1999).

117. Vitacco et al., *supra* note 45, at 122–23 (stating that “alcohol and drug-abuse treatment is imperative for CR clients” because “substance abuse can lead to criminal behavior among mentally ill offenders”); Silver & Tellefsen, *supra* note 1, at 250 (finding that 25% of petitions requesting revocation cited substance abuse).

118. Mark Olfson et al., *Predicting Medication Noncompliance after Hospital Discharge Among Patients with Schizophrenia*, 51 PSYCHIATRIC SERVS. 216, 216 (2000).

119. Silver & Tellefsen, *supra* note 1, at 250.

120. Vitacco et al., *supra* note 45, at 121–22.

121. *Id.* at 124.

122. Silver & Tellefsen, *supra* note 1, at 242.

are appropriate supports . . . and a client-centered recovery approach.”¹²³ However, not all jurisdictions are adept at providing this kind of environment for acquittees within the community.

C. *Lax Supervision*

Over-criminalization leads to more people appearing in court. Judges have long been responsible for supervising massive dockets. In the aftercare context, this may lead to an out-of-sight-out-of-mind mentality towards insanity acquittees, who are no longer appearing in court daily, weekly, monthly, or even semi-annually.¹²⁴ Thus, responsibility for the acquittee may fall upon social workers or other professionals within the community, who may not report infractions or worrisome behavior to the judge.¹²⁵

Though insanity laws require periodic trial court review, sometimes aftercare examination may be abandoned; judges may, for whatever reason, choose not to conduct a review, nor may acquittees request one.¹²⁶ In Hawaii, for example, once a person is adjudged insane, there is no specified return date for a court appearance or future docket.¹²⁷ What each court does depends on the presiding judge and the jurisdiction’s common practices.

Earlier insanity laws and processes had similar problems. In the 1970s and 1980s, social workers in the community informed the judge about the released acquittee’s mental decompensation.¹²⁸ Even then, the person notifying the judge would “hope the judge was a person of action,” but the judicial “responses were variable and unpredictable.”¹²⁹ In some jurisdictions, it is the court that

123. Vitacco et al., *supra* note 45, at 124.

124. Annual review of acquittees is customary. *E.g.*, 18 U.S.C. § 4247 (2006) (directing forensic evaluators to prepare an annual report for the trial court); *Nebraska v. Simants*, 537 N.W.2d 346, 348 (Neb. 1995) (citing an annual review of insane persons); *Morris*, *supra* note 106, at 1105 (describing the process of annual review in California). *But see* MO. ANN. STAT. § 552.040(16) (West, Westlaw through 2014) (permitting monthly review of released acquittees).

125. *See* Silver et al., *supra* note 60, at 389.

126. *E.g.*, E-mail from Roger Donley, Harris Cty. Assistant Pub. Def., to author (July 27, 2015) (on file with author) (stating that other counties in Texas did not always review insanity acquittees annually); *see* Shannon, *supra* note 4, at 90 n.188 (describing Oregon’s period of review as “at least every two years, even if no one asks for a hearing”).

127. E-mail from W. Neil Gowensmith, *supra* note 97.

128. *See* Silver & Tellefsen, *supra* note 1, at 245.

129. *Id.*

oversees the follow-up treatment and supervision of the acquittee.¹³⁰ The judiciary should be responsible for ensuring review takes place on schedule, yet this is not always the case.

Once the acquittee has left the courtroom, her attorney is no longer required to come to court on her behalf. The acquittee is not assigned to a probation or parole officer who reports daily, weekly, or monthly to the court. If the acquittee resides in a state hospital or group home, it is easy for her to disappear from judicial view. Yet, continuity of care is critical for released insanity acquittees.¹³¹

Even states with the best of intentions periodically grow lax in their aftercare process. Texas has a history of weak judicial and community supervision despite two revisions to the law designed to ensure greater judicial control over insanity aftercare. The state of Texas has wrestled with the insanity defense and aftercare for decades. One year after the Hinckley acquittal,¹³² in 1983, the Texas legislature revised the post-acquittal insanity laws to ensure courts had the opportunity to supervise acquittees more closely.¹³³ Twenty-two years later, the Texas legislature would again be asked to reexamine the procedures the state had in place to monitor individuals found NGRI.¹³⁴

The second legislative examination followed several tragic incidents in Texas that brought the insanity defense to the public's attention. In 2001, Andrea Yates, who was diagnosed with postpartum psychosis, killed all five of her children due to a delusional belief that Satan would condemn their souls if they continued to live.¹³⁵ Yates was found guilty during her first trial, but was retried in 2006 and found NGRI by her second jury.¹³⁶ In 2004, Deanna Laney was found NGRI after bashing her children's bodies with rocks, killing two of her sons, and permanently injuring

130. Shannon, *supra* note 4, at 80.

131. See Silver & Tellefsen, *supra* note 1, at 248 ("One of the major challenges faced by forensic mental health services is to develop consistency of treatment, monitoring and revocation procedures throughout a state.")

132. TEXAS SENATE REPORT, *supra* note 14, at 34 ("Americans' dissatisfaction with the Hinckley verdict became the impetus for change of the insanity defense.")

133. Shannon, *supra* note 4, at 73-74.

134. *Id.* at 76-77.

135. *Id.* at 67-68, 68 n.2.

136. *Id.* at 67-68.

another.¹³⁷ Also in 2004, Dena Schlosser cut off her ten-month-old daughter's arms during a psychotic episode and was later acquitted by reason of her insanity.¹³⁸ These defendants, like Hinckley in the 1980s,¹³⁹ scandalized the insanity defense.¹⁴⁰

In 2004, the Texas Senate Jurisprudence Committee was tasked with closely examining the insanity defense due to the murders of the children previously mentioned.¹⁴¹ The Committee recommended that "the release standards for NGRI patients be tightened."¹⁴² It also recommended that the trial court's authority to order outpatient treatment and supervision be clarified to increase monitoring of the acquittee and reduce the potential of recidivism.¹⁴³

The following year, the legislature adopted many of the Committee's suggestions, codifying them in the Texas Code of Criminal Procedure.¹⁴⁴ The 2005 insanity defense amendments granted the trial court jurisdiction over the acquittee for the hypothetical maximum sentence and the authority to order inpatient or outpatient treatment as needed.¹⁴⁵ These amendments were intended to create a safer community, clarify the trial court's authority, and lower recidivism.¹⁴⁶ Despite the 1983 and 2005 amendments, Texas still experiences problems when it comes to supervising acquittees. Most of those problems develop once the acquittee has been placed on conditional release.

137. *Id.* at 69.

138. *Id.*

139. George L. Blau & Richard A. Pasewark, *Statutory Changes and the Insanity Defense: Seeking the Perfect Insane Person*, 18 L. & PSYCHOL. REV. 69, 70 (1994) (describing the "post-Hinkley dissatisfaction" that came after Reagan's would-be assassin was acquitted due to insanity).

140. TEXAS SENATE REPORT, *supra* note 14, at 37–38 (reporting that the use of the insanity defense "has been debated in light of recent cases" and its application resulted in public confusion).

141. *Id.* at 36–37 (citing the public's confusion over Yates' first trial guilty verdict and Laney's acquittal, despite the fact that both women were clearly suffering from severe mental illness when they killed their children as the basis for the legislature's inquiry); Blau & Pasewark, *supra* note 139, at 70 ("Typically, the legislature introduces more stringent criteria following some notorious event that shocks the public.").

142. TEXAS SENATE REPORT, *supra* note 14, at 39.

143. *See id.*

144. *See* Shannon, *supra* note 4, at 80.

145. *Id.*

146. TEXAS SENATE REPORT, *supra* note 14, at 39.

In Texas, the Harris Center for Mental Health and IDD (HCMH) assists acquirtees with outpatient mental health treatment.¹⁴⁷ Before an acquitted person is released from inpatient treatment, HCMH develops a treatment plan, which may include therapy, classes, and programs tailored to the acquirtee's needs.¹⁴⁸

The HCMH team also assists the individual with placement in an outpatient group home, which is vital given the fact that many acquirtees are indigent.¹⁴⁹ These group homes are privately-run licensed facilities.¹⁵⁰ Though they establish curfews, patients are free to leave the home during the day.¹⁵¹ In fact, group home owners and managers have no authority to force a patient to remain inside.¹⁵² Currently, outpatient homes do not adequately provide safety measures, nor do they have authority over the patients or treatment interventions in place.¹⁵³ Although the homes distribute medication to the patients, HCMH is responsible for ensuring the patients are taking their medication as prescribed.¹⁵⁴

Group homes have a legally imposed duty to ensure conditions of release and treatment are followed.¹⁵⁵ If the acquirtee fails to comply with treatment or becomes dangerous, the facility is required to notify HCMH, which then notifies the trial court.¹⁵⁶ Unfortunately, too many outpatient group homes offer no structure—just shelter.¹⁵⁷ Many of these homes have prioritized profit over duty to warn.

“Private profit-making facilities . . . have an inherent incentive to cut expenses; this often translates into minimum staffing levels and low-paid staff,”¹⁵⁸ which may include hiring employees unable

147. Telephone Interview with Kendra Thomas, Legal Counsel, HCMH of Hous. (Apr. 2, 2015).

148. *Id.*

149. *Id.* (reporting that individuals who commit violent offenses may have difficulty finding a group home placement; if they are unable to find a place to reside, they must return to the state hospital).

150. *Id.*

151. *Id.*

152. *Id.*

153. *Id.*

154. *Id.*

155. TEX. CODE CRIM. PROC. ANN. art. 46C.265 (West, Westlaw through 2015 Reg. Sess. of the 84th Leg.).

156. *Id.*

157. Telephone Interview with Deborah Castelo, Ret. Branch Dir. of Specific Needs Branch, Harris Cty. Cmty. Supervision & Corr. Dep't (Apr. 2, 2015).

158. Gary Cordner, *People with Mental Illness*, CTR. FOR PROBLEM-ORIENTED

to handle complex mental health issues and behaviors that lead to aftercare problems. Moreover, homes often do not report missing patients and curfew violations although required by law.¹⁵⁹ When group homes fail to notify HCMH, the agency cannot and does not notify the court. This lack of communication among service providers is a common challenge inherent in aftercare programs.¹⁶⁰ Unfortunately, the acquittee will most likely to suffer in the long run as what might have been a small infraction if communicated to the agency or court earlier may turn into a larger transgression, leading to revocation or re-hospitalization. For all of these reasons, Texas courts, agencies, and privately run group homes sometimes fail to adequately supervise acquittees.

D. Rough Transitions

Conditional release is a transitional phase between inpatient treatment and complete freedom.¹⁶¹ It is designed to provide continuity of care in an outpatient context, with re-institutionalization serving as a consequence of the most serious violations.¹⁶² When conditional release is effective, it balances the interests of community safety with the acquittee's interest in successfully acclimating to living in the community again.¹⁶³

There are several steps between total dependence and complete independence. As one scholar put it, these treatment steps “not only diminish the risk of recidivism and provide security against future irrational and dangerous behavior, but also afford the public the opportunity to forgive the offender.”¹⁶⁴

The transition of leaving inpatient care and returning to the community is significant. While leaving the hospital is a joyous occasion for most acquittees, choices that derail or advance treatment await the acquittee in the community. Outside the hospital walls, acquittees experience freedom paired with

POLICING, 2006, http://www.popcenter.org/problems/mental_illness/print/.

159. Telephone Interview with Deborah Castelo, *supra* note 157.

160. Silver & Tellefsen, *supra* note 1, at 249 (“[C]ommunity mental health center personnel often lacked awareness of new charges, substance abuse and criminal activities.”).

161. Morris, *supra* note 106, at 1064.

162. *Id.* at 1065.

163. *Id.* at 1113.

164. Silver & Tellefsen, *supra* note 1, at 242.

temptations that did not exist in the structured and secure setting of the state hospital.

Many acquittees spend years residing in state-run hospitals before they transition to outpatient treatment. That is what happened to William Bruce of Caratunk, Maine, who was acquitted for the murder of his mother, Amy Bruce, in 2006 while in a psychotic state.¹⁶⁵ William spent seven years in the state hospital recovering from his paranoid schizophrenia and regaining the trust of the medical staff and judge.¹⁶⁶ He finally left inpatient care on conditional release in 2014.¹⁶⁷ His father, Joe Bruce, recalls the excitement his son experienced when he moved into a group home with other acquittees. The home was located only 500 yards from the state hospital.¹⁶⁸

Joe described the transition from inpatient care to outpatient care as a “big change” for his son.¹⁶⁹ William spent every day for years living in a state hospital with a team of professionals available around the clock.¹⁷⁰ In contrast, when he moved outside the hospital walls to Augusta, he was required to attend therapy only once a week inside the hospital.¹⁷¹ Maine assigned an assertive community treatment (ACT) team to work with William.¹⁷² The team met with him only once every three months, though it did communicate with employees at the group home more regularly about William’s progress.¹⁷³

William had to make many choices when he returned to community living. He made employment decisions for the first time in nearly a decade.¹⁷⁴ He ultimately worked three jobs with

165. Wayne Drash, “*If Only They Had Treated Him Before*”, CNN (Aug. 2014), <http://www.cnn.com/interactive/2014/08/health/mental-illness-treatment>; Elizabeth Bernstein & Nathan Koppel, *A Death in the Family*, WALL STREET J. (Aug. 16, 2008), <http://www.wsj.com/articles/SB121883750650245525>.

166. Drash, *supra* note 165.

167. *Id.*

168. Telephone Interview with Joe Bruce, father of William Bruce (Aug. 21, 2015).

169. *Id.*

170. *Id.*

171. *Id.*

172. E-mail from Joe Bruce, father of William Bruce, to author (Sept. 1, 2015, 10:11 EST) (on file with author).

173. *Id.*

174. Telephone Interview with Joe Bruce, *supra* note 168.

bosses who praised his work ethic and dedication.¹⁷⁵ However, someone suggested William work fewer hours because earning more money would cause his disability funds to decrease.¹⁷⁶ He consulted his father to determine what he should do.¹⁷⁷ His father encouraged him to work more than twenty hours a week. William did not take Joe's advice.¹⁷⁸

William had to make medication decisions for the first time in years.¹⁷⁹ Joe describes conditional release as "a system based on trust," an arrangement that gives acquirtees incremental freedom to see how they handle release.¹⁸⁰ In Maine, acquirtees can petition the trial court for permission to take medications on their own, rather than get in a pill line to receive medication from group home employees.¹⁸¹ Some residents gained this freedom and at least one abused it by pretending he was compliant, though it was obvious that he was not.¹⁸² William again consulted his father about whether he should petition the court.¹⁸³ His father encouraged him to take the medication offered by the employees.¹⁸⁴ In this instance, William followed his father's advice.¹⁸⁵

William faced drug and alcohol temptations while living in Augusta.¹⁸⁶ Believing that his son was fulfilling the terms of his conditional release, Joe was taken by surprise when he received a phone call from the ACT team suggesting William was using drugs.¹⁸⁷ William was tested for drugs only once a month.¹⁸⁸ This level of testing was arguably inadequate given the fact that substance abuse is one of the primary reasons for conditional release revocations¹⁸⁹ and William used drugs in the past.¹⁹⁰

175. *Id.*

176. *Id.*

177. *Id.*

178. *Id.*; E-mail from Joe Bruce, *supra* note 172.

179. Telephone Interview with Joe Bruce, *supra* note 168.

180. *Id.*

181. *Id.*

182. *Id.*

183. E-mail from Joe Bruce, *supra* note 172.

184. Telephone Interview with Joe Bruce, *supra* note 168.

185. *Id.*

186. *Id.*

187. *Id.*

188. *Id.*

189. *E.g.*, Silver & Tellefsen, *supra* note 1, at 250 (noting that 25% of petitions requesting revocation cited substance abuse).

190. Telephone Interview with Joe Bruce, *supra* note 168.

Ultimately, William confessed to the ACT team that he was using drugs. Two additional acquittees living in the community also admitted to drug use.¹⁹¹

William's confession led to a court hearing.¹⁹² After the hearing, the judge revoked his conditional release and sent him back to the state hospital—500 yards from his group home.¹⁹³ The other men who admitted to drug use were also returned to inpatient care.¹⁹⁴ William was on conditional release for only eight months.¹⁹⁵ Joe does not know when his son will be released again.¹⁹⁶

Joe describes the transition from inpatient care to conditional release as “maximum supervision to minimal supervision.”¹⁹⁷ In hindsight, he suspects his son needed more drug testing and more interaction with the ACT team.¹⁹⁸ Research demonstrates that acquittees experience longer conditional release periods when they “receive[] intensive outpatient treatment services, substance abuse services, and a continuity of care from hospital to community placement.”¹⁹⁹

Acquittees are more likely to fail during conditional release when they are given unsupervised access to their communities.²⁰⁰ A structured living arrangement helps acquittees cope with the stressors of life.²⁰¹ The ability to participate in activities curtails substance abuse and other problems acquittees may face on release.²⁰²

Joe would like to see Maine spend more money on ACT team involvement and drug testing.²⁰³ States must allocate adequate funds to intensive community based services, target substance abuse problems, and provide a continuity of mental health services

191. E-mail from Joe Bruce, *supra* note 172.

192. Telephone Interview with Joe Bruce, *supra* note 168.

193. *Id.*

194. Betty Adams, *Former Riverview Patients Reportedly Involved in Drug Dealing*, CENTRALMAINE (Jan. 26, 2015), <http://www.centralmaine.com/2015/01/26/former-riverview-patients-reportedly-involved-in-drug-dealing/>.

195. Telephone Interview with Joe Bruce, *supra* note 168.

196. *Id.*

197. *Id.*

198. *Id.*

199. Gowensmith et al., *supra* note 58, at 598.

200. Harris et al., *supra* note 39, at 227.

201. Lamb et al., *supra* note 116, at 910.

202. Vitacco et al., *supra* note 45, at 124.

203. Telephone Interview with Joe Bruce, *supra* note 168.

from inpatient to outpatient care.²⁰⁴ William's transition to freedom in the community mirrors many other acquittees' conditional release experiences: release ends shortly after it begins. The quick transition to freedom proves overwhelming for a significant number of acquittees.

VI. ADDING MORE TO AFTERCARE

Aftercare and conditional release programs were created decades ago, after the insanity defense was revised nationwide in the late 1960s to mid-1980s.²⁰⁵ In 1980, fewer than half of the states allowed NGRI acquittees to receive outpatient treatment.²⁰⁶ While conditional release programs are common nationwide today, they were novel in the 1980s and early 1990s.²⁰⁷ Several decades later, not much has changed in the configuration or business of these programs. Most of the conditional release programs and agencies involved have remained the same since their inception.²⁰⁸

The stagnant nature of these programs has not allowed for invention and experimentation. Perhaps the controversy over the insanity defense—the public's misinformed perception of its overuse and abuse²⁰⁹—has surreptitiously created resistance to modify conditional release programs. Admittedly, conditional release is effective in helping many acquittees.²¹⁰ But just because

204. Vitacco et al., *supra* note 45, at 118–25.

205. Russell D. Covey, *Criminal Madness: Cultural Iconography and Insanity*, 61 STAN. L. REV. 1375, 1419 (2009) (noting that insanity reforms began before the Hinckley verdict fallout); John Q. La Fond & Mary L. Durham, *Cognitive Dissonance: Have Insanity Defense and Civil Commitment Reforms Made a Difference?*, 39 VILL. L. REV. 71, 100 (1994); Parker, *supra* note 15, at 332 (describing insanity defense reforms as early as 1978 and as late as 1984).

206. See Morris, *supra* note 106, at 1064 n.23.

207. *Id.* at 1064.

208. See, e.g., Joseph D. Bloom & Mary Claire Buckley, *The Oregon Psychiatric Security Review Board: 1978–2012*, 41 J. AM. ACAD. PSYCHIATRY & L. 560, 564 (2013) (noting Oregon's conditional release program “functioned uninterrupted for 34 years”); Email from Henry Steadman, Ph.D., Policy Research Assocs., Inc., to author (July 27, 2015, 7:18 EST) (on file with author).

209. Henry F. Fradella, *From Insanity to Beyond Diminished Capacity: Mental Illness and Criminal Excuse in the Post-Clark Era*, 18 U. FLA. J.L. & PUB. POL'Y 7, 9, 11–13 (2007) (discussing that public perceptions of the defense are negative with many people believing the defense is widely used).

210. Vitacco et al., *supra* note 33, at 352 (“[M]ost NGRI acquittees function well in the community, with low revocation and re-arrest rates, especially when receiving mandated treatment.”).

release programs work for some does not mean they are as functional as they could be, especially given the rise of more modern programs designed to enhance treatment compliance like mental health courts and ACT. Merging aftercare with newer outpatient treatment models and addressing criminogenic needs may help reach more acquittees who are at risk for revocation.

A. *The Mental Health Court Model*

The first mental health court was created in 1997.²¹¹ Today, there are more than 300.²¹² The advent and proliferation of mental health courts postdates the conditional release program; the two exist in separate universes. Weaknesses in aftercare programs—coordination and communication between interested parties—are strengths of the mental health court and therapeutic jurisprudence models. The mental health court model has utility in the NGRI context. Just because mental health courts and insanity acquittal procedures have not yet overlapped does not mean they cannot or should not.

In a few ways, conditional release and participation in a mental health court are similar. They both enroll criminal offenders with mental illness. They are both designed to maintain therapeutic treatment. When conditions of release or probation are violated, participants and acquittees alike face consequences. Both programs attempt to lower recidivism. They seek to protect the community. However, there are also some big differences between the two models.

One major difference is that in the conditional release model, the people and agencies involved in supervision rarely act as a team. In fact, they often operate in different spheres as evidenced by New York's and Texas' conditional release programs, along with countless others. W. Neil Gowensmith stated that acquittees are placed into "a fractured system."²¹³ Agencies and supervisors have independent roles in the aftercare process. Gowensmith

211. Gregory L. Acquaviva, *Mental Health Courts: No Longer Experimental*, 36 SETON HALL L. REV. 971, 983 (2006).

212. *Mental Health Courts*, COUNCIL ST. GOV'TS, JUST. CTR., <http://csgjusticecenter.org/mental-health-court-project> (last visited on Mar. 12, 2016).

213. Telephone Interview with W. Neil Gowensmith, Clinical Assistant Professor, Univ. of Denver (Aug. 18, 2015).

concluded, “[N]o one ever talks to each other in a coordinated way.”²¹⁴

Current conditional release programs recognize that the judiciary and community mental health officials share responsibility for the well-being and continued treatment of the acquittee. What they fail to acknowledge is that more stakeholders should be involved and greater communication ensures accountability and success. It is not unusual for a mental health court team to employ social workers, probation officers, prosecutors, defense attorneys, mental health professionals, substance abuse professionals, vocational coordinators, and the judge. What the team offers—supervision, accountability, treatment, assistance with day-to-day life—is critical to the NGRI acquittee. It is likely that multiple players may have differences of opinion when it comes to supervision and revocation decisions.²¹⁵ Regardless, disagreements involve a discussion and the sharing of ideas, unlike the current approach many states employ.

While Oregon does not use an NGRI mental health court to supervise acquittees, its Psychiatric Security Review Board coordinates services and meets as a group, much like a mental health court would. Many have studied and praised Oregon’s system of insanity aftercare over the years.²¹⁶ Dr. Paul Applebaum believes “the close follow-up and the ability to re-hospitalize acquittees rapidly that characterize the Oregon system appear to have had a substantial positive effect.”²¹⁷ Oregon reports a recidivism rate of 0.2% with 99.08% of the release population residing in the community each month,²¹⁸ which is much more impressive than other states’ reports.²¹⁹

214. *Id.*

215. Gowensmith et al., *supra* note 58, at 605 (“[Forensic] evaluators may not be prioritizing the same measures of success considered by health administrators or politicians. . . . While . . . evaluators generally prioritize violence risk in their evaluations, this may not be the focus of the court. Perhaps courts place a higher priority on recidivism or re-hospitalization than the evaluators.”); Fox, *supra* note 44, at 338 (“A clinician may determine that a seven-year probability of violent recidivism of 12% is acceptable, although society or the courts may take issue with this determination, based on prevailing attitudes and intolerance of instances of criminal recidivism.”).

216. Morris, *supra* note 106, at 1069 n.68; Shannon, *supra* note 4, at 91.

217. Shannon, *supra* note 4, at 91.

218. OR. PSYCHIATRIC SECURITY REV. BOARD, <http://www.oregon.gov/prb/pages/index.aspx> (last visited on Mar. 12, 2016); *Guilty Except for Insanity (Adults)*,

Oregon's Psychiatric Security Review Board monitors acquittees who have been conditionally released.²²⁰ The legislature charges the Governor with appointing ten members to the Board, five of whom supervise adults on release and five of whom supervise juveniles.²²¹ Each group includes a forensic psychiatrist, a forensic psychologist, an expert in probation and parole,²²² an experienced criminal lawyer, and a lay citizen.²²³ The team is required to meet at least twice a month.²²⁴

Oregon appears to strike the right balance of stakeholders,²²⁵ meeting frequency, communication, coordination, and consequences. This equates to lowered recidivism and greater community safety. Even in the earliest studies of conditional release programs, close monitoring was linked to conditional release success.²²⁶ However, Oregon's close monitoring may result in more revocations than other programs.²²⁷ While a higher incidence of revocations is less than ideal,²²⁸ new criminal charges and incarceration are undesired outcomes both from the acquittee's and the community's perspective.

NGRI acquittees require more intensive treatment and attention.²²⁹ To adequately treat and reduce recidivism among this

OR. PSYCHIATRIC SECURITY REV. BOARD, <http://www.oregon.gov/prb/Pages/GEI-Adults.aspx> (last visited on Mar. 12, 2016).

219. *E.g.*, Parker, *supra* note 15, at 291 (reporting that statewide recidivism rates are between 3.4 and 7.8%).

220. Morris, *supra* note 106, at 1069–70.

221. OR. REV. STAT. ANN. § 161.385(1), (6) (West, Westlaw through Ch. 848 of the 2015 Reg. Sess.).

222. Having an expert in this area is critical as parolees with mental illness are two times more likely to return to prison within a year than parolees without mental illness. *See* Skeem et al., *supra* note 114, at 110.

223. OR. REV. STAT. ANN. § 161.385 (2)(a)-(i) (West, Westlaw through 2016).

224. *Id.* § 161.385 (8) (Westlaw).

225. Morris, *supra* note 106, at 1069 (noting that Oregon includes “a psychiatrist, a psychologist, a lawyer experienced in criminal trial practice, a lay person, and an individual with substantial experience in parole and probation”).

226. *E.g.*, Pasewark, *supra* note 21, at 374; Lymburner & Roesch, *supra* note 53, at 229 (“[C]losely monitored conditional release programs offer a feasible and more ethical alternative to continued hospitalization.”).

227. Morris, *supra* note 106, at 1071 (reporting that 47.5% of acquittees experienced revocations within the first year of release).

228. *See* Skeem et al., *supra* note 114, at 118 (asserting that technical violation revocations result in the “criminalization of mental illness rather than new crime”).

229. Lamb et al., *supra* note 116, at 910.

population, there must be a balance between offering mental health treatment, evaluating criminogenic risk factors, and treating substance abuse issues.²³⁰ Violent or dangerous behavior must be addressed immediately.²³¹ Quick hospitalization is critical for acquittees who fail to follow the treatment regimen.²³² To this end, a team of professionals and lay persons must meet regularly, contribute ideas, share concerns, and take responsibility for helping at-risk acquittees recover from mental illness, criminal thinking, and destructive behavior patterns.

The process of conditional release often starts with a team approach: the inpatient facility has a team of physicians, administrators, psychologists, and therapists who must make a release decision.²³³ Inpatient discharges “require the agreement of multiple clinical and governmental oversight agencies.”²³⁴ Although the process begins with a consensus of individuals, the team approach seems to end when the acquittee leaves the inpatient setting, which may be the most critical stage of treatment continuity.

A therapeutic court model could oversee conditional release and provide the oversight that acquittees need, while offering a larger variety of programs targeted to reduce recidivism and improve compliance with conditions. The model could offer medical services, behavioral therapy, substance abuse counseling, vocational training, services that reduce criminal thinking, and more.²³⁵ It could include psychosocial treatment and offer activities.²³⁶ Aftercare programs must offer intensive services given the nature of what they do and who they supervise.²³⁷ Programs tailored to a mentally disordered offender’s personality, thinking,

230. Wilson et al., *supra* note 22, at 593.

231. See Vitacco et al., *supra* note 33, at 352.

232. Morris, *supra* note 106, at 1068–69.

233. WIS. CMTY. CONDITIONAL RELEASE PROGRAM, CASE MANAGER PROCEDURE MANUAL 4 (2015).

234. *Id.*

235. See Elnike Brand et al., *A Review of the Psychiatric Care Provided to Patients who Subsequently Offended*, 3 INT’L J. CLINICAL PSYCHIATRY & MENTAL HEALTH 31, 33–34 (2015); see also Vitacco et al., *supra* note 33, at 347 (reporting that antisocial behavior is a problem in compliance with conditional release).

236. See Vitacco et al., *supra* note 33, at 349–50; WIS. CMTY. CONDITIONAL RELEASE PROGRAM, *supra* note 233, at 4; Skeem et al., *supra* note 114, at 121 (reducing criminal thinking and building healthy social skills lowers recidivism).

237. See Vitacco et al., *supra* note 33, at 352.

learning style, and motivations are more effective at reducing recidivism.²³⁸

Excellent and personable case managers are a needed component as well; relationships with intensive supervisors are essential to successful conditional release.²³⁹ A supervisor's level of training directly impacts the acquittee's length of tenure in the community.²⁴⁰ Probation officers with mental-health training tend to re-hospitalize more often, yet they return individuals back to the community more quickly than regular probation officers, who may use hospitalization to rid themselves of a seemingly more difficult probationer.²⁴¹ Mental-health-trained probation officers are more involved in the day-to-day management of the people they supervise—attention needed by many individuals with mental illness.²⁴²

But the case manager is only one important player in the support system. One of the many benefits of therapeutic courts is that they provide “a group structure for the [participant]—offering support, rehabilitation, resources, and community—where none had existed before.”²⁴³ In the case of individuals with serious mental illness, they may have no support network intact, which makes a therapeutic model even more beneficial.

While an aftercare mental health court or a release program that mirrors one may sound like a tall order, programs that employ the considerations above are more efficient than traditional aftercare systems. For instance, accurately assessing an acquittee's risk level and treating criminogenic needs have proven to minimize recidivism and revocations.²⁴⁴ Addressing and combating antisocial behavior and values, substance abuse, and criminal thinking produce positive results among mentally disordered criminal offenders.²⁴⁵ In sum, these programs must treat more than mental

238. Morgan et al., *supra* note 18, at 38; Skeem et al., *supra* note 114, at 121 (reporting that programs “matched to the abilities, styles, and needs of offenders” with mental illness are more effective in reducing recidivism).

239. Vitacco et al., *supra* note 33, at 353; Skeem et al., *supra* note 114, at 121.

240. Gowensmith et al., *supra* note 58, at 598.

241. E-mail from W. Neil Gowensmith, *supra* note 97.

242. *Id.*

243. NAT'L DRUG COURT INST., THE DRUG COURT JUDICIAL BENCHBOOK, 11 (Douglas B. Marlowe & William G. Meyer eds., 2011).

244. Gowensmith et al., *supra* note 58, at 598.

245. See Rice et al., *supra* note 111, at 388, 396.

illness and do more than involve parties with limited roles who do not communicate with each other.

States could replicate aspects of the mental health court model in a conditional release review agency, panel, or board. They could also create specialty mental health courts with acquittee participants. States who choose to do the latter may consider placing the court in an urban area where insanity acquittees reside in greater numbers.²⁴⁶ On the other hand, having fewer participants works well in a therapeutic court model.²⁴⁷ The downsides to assigning several acquittees to one judge would be the potentially overwhelming caseload and the political wrangling necessary to place several high-risk offenders on the docket. Most judges would be reluctant to undertake such an endeavor.

There are also criticisms of mental health courts that may affect start-up. Recently, studies and legal scholars have questioned the efficacy of mental health courts.²⁴⁸ Critics suggest they wrongly attribute lowered recidivism to mental wellness.²⁴⁹ They suggest that a variety of broader factors play a role in criminal behavior and that criminogenic risk factors affect all criminals equally.²⁵⁰ For example, living in an impoverished area, as opposed to the mental illness itself, may increase the likelihood that an acquittee abuses substances, participates in criminal activity, and experiences joblessness, victimization, and health setbacks.²⁵¹ Nevertheless, these concerns could be considered and addressed in a conditional release mental health court model.

Another criticism of mental health courts is that they create false success by admitting only safe participants. An insanity-defense-based mental health court must be willing to accept all participants, not just participants who will boost measures of success while lowering recidivism rates.²⁵² Mental health courts

246. Cirincione et al., *supra* note 21, at 400 (stating that insanity acquittee populations are greater in “larger, more urban counties”).

247. Telephone Interview with W. Neil Gowensmith, *supra* note 213.

248. *E.g.*, Johnston, *supra* note 17, at 538–39, 552 (reporting that mental health courts fail to connect participants’ mental illness to the criminal acts they committed and thus incorrectly assume treatment will stop recidivism); Skeem et al., *supra* note 114, at 114.

249. Skeem et al., *supra* note 114, at 114.

250. Johnston, *supra* note 17, at 564.

251. *See* Skeem et al., *supra* note 114, at 116–17 (discussing alternative theories to recidivism among mentally ill individuals placed on probation or parole).

252. One of the largest criticisms of mental health courts and any therapeutic

serving this population must serve at-risk acquittees on conditional release; the court will not improve general conditional release outcomes unless it specifically and systematically addresses antisocial behavior, criminal thinking, and criminogenic needs. These factors place a subset of acquittees at a higher risk of revocation due to recidivism. When conditional release fails, particularly when failure involves a serious subsequent criminal act, it “can lead to public scrutiny and place conditional release programs in peril.”²⁵³ Thus, courts that fail to recognize that the riskiest acquittees need greater services ultimately risk the specialty court’s future funding and operation.²⁵⁴

Governments also have the option of bringing several professionals from various backgrounds together to discuss each acquittee’s progress on a regular basis without creating a specialty docket. This is what Oregon does. It is the Psychiatric Security Review Board’s regular meetings and centralized communication that make it unique among conditional release programs.²⁵⁵ These features and others also make it successful in curtailing recidivism and guaranteeing public safety.²⁵⁶ In sum, jurisdictions that are

court model, for that matter, is the attempt by coordinators and judges to create a false sense of success by selecting safe participants, rather than those who are more likely to reoffend or violate the conditions of probation or release. *E.g.*, Johnston, *supra* note 17, at 566–67 (stating that mental health courts typically exclude participants deemed violent or a threat to public safety but are becoming more expansive in the types of underlying criminal acts they accept); *see also* ROBERT A. SCHUG & HENRY F. FRADELLA, *MENTAL ILLNESS AND CRIME* 498 (2015) (finding that 85% of mental health courts handle misdemeanor cases, 75% handle felony cases, and only 20% accept violent cases while a mere 1% accept seriously violent cases).

253. Vitacco et al., *supra* note 33, at 352; Vitacco et al., *supra* note 45, at 118 (“Returning insanity acquittees to the community can create tensions between policy makers and their constituents, especially because many NGRI acquittees have histories of violent behavior. Any untoward outcome leads to increased scrutiny and distrust in the public mental health system.”).

254. *See also* Amanda Peters, *Resource Problem Solving in Therapeutic Courts*, 2 *MENTAL HEALTH L. & POL’Y J.* 117, 123–35 (2013) (finding continued funding of therapeutic courts hinges on success and efficiency in spending, which usually translates to cheaper than incarceration rates).

255. *See, e.g.*, Bloom & Buckley, *supra* note 208, at 564 (noting Oregon’s Board “administers a comprehensive system designed to provide centralized decision-making for the postacquittal management of Oregon’s insanity acquittees”).

256. *See, e.g.*, Stewart S. Newman et al., *Oregon’s Juvenile Psychiatric Security Review Board*, 35 *J. AM. ACAD. PSYCHIATRY & L.* 247, 247, 251 (2007) (concluding that the Psychiatric Security Review Board “balances protection of the public with treatment for insanity acquittees” and maintains a safe program by monitoring

hesitant about starting a mental health court or modeling one in a revised conditional release program have other options.

B. The Assertive Community Treatment Model

Another program that may enhance the results of conditional release is the ACT model, which was created in the late 1970s.²⁵⁷ An ACT team consists of several mental health professionals who function like an inpatient treatment team caring for patients who reside in the community.²⁵⁸ They provide treatment, discipline, and support for patients in need.²⁵⁹ An ACT team may consist of social workers, case managers, registered nurses, and forensic psychologists and psychiatrists.²⁶⁰ The team meets frequently, provides services to the client where she lives, and is available day and night.²⁶¹

An important aspect of ACT is a low patient-to-staff ratio, usually ten patients per staff member.²⁶² While the effectiveness of ACT among probationers and parolees has recently been called into question by scholars who assert treatment of illness alone is not enough to reduce recidivism,²⁶³ preliminary outcome evidence of ACT is promising.²⁶⁴ Furthermore, ACT success rates increase when probation officers and court members collaborate with the treatment team.²⁶⁵

those on conditional release monthly).

257. GARY R. BOND, *ASSERTIVE COMMUNITY TREATMENT FOR PEOPLE WITH SEVERE MENTAL ILLNESS, BEHAVIORAL HEALTH RECOVERY MANAGEMENT PROJECT* (Mar. 17, 2002), <http://www.bhrm.org/guidelines/ACTguide.pdf>.

258. Morgan et al., *supra* note 18, at 39; Parker, *supra* note 15, at 292.

259. Parker, *supra* note 15, at 292.

260. *Id.* at 293.

261. *Id.*

262. *Id.* at 292.

263. *E.g.*, Jerry L. Jenkins, *Does Assertive Community Treatment Work with Forensic Populations?*, 3 *OPEN PSYCHIATRY J.* 13, 15 (2009), <http://benthamopen.com/contents/pdf/TOPJ/TOPJ-3-13.pdf>; Skeem et al., *supra* note 114, at 116–17.

264. James D. Livingston et al., *Probationers Mandated to Receive Forensic Mental Health Services in Canada: Risks/Needs, Service Delivery, and Intermediate Outcomes*, 21 *PSYCHOL. PUB. POL'Y & L.* 72, 73 (2015).

265. Kristen Davis et al., *Integrating into the Mental Health System from the Criminal Justice System: Jail Aftercare Services for Persons with a Severe Mental Illness*, 46 *J. OFFENDER REHABILITATION* 217, 223 (2008), http://www.d.umn.edu/~jmaahs/Correctional%20Continuum/Online%20Readings/mental%20illness_jail%20diversion.pdf.

Insanity conditional release outcomes, in particular, improve when combined with components of ACT. In 2004, Dr. George Parker conducted a study to determine whether incorporating ACT into the Cleveland Ohio conditional release program would reduce recidivism, hospitalization, and the number of release revocations.²⁶⁶ Out of the eighty-three acquittees who were monitored over a five-year period, there were only five arrests that resulted in short-term incarceration.²⁶⁷ The study reported a lowered revocation rate of 14% with a re-arrest rate of 1.4%.²⁶⁸ Acquittees remained in the community 83% of the time while they were on conditional release.²⁶⁹

The majority of monitored individuals in the study were acquitted of violent crimes, diagnosed with a wide range of mental illnesses, and many suffered from substance abuse problems.²⁷⁰ The ACT team was not only successful at lowering substance abuse among acquittees, but also at increasing pharmacological compliance.²⁷¹ Dr. Parker concluded that combining the ACT model with the existing conditional release program resulted in a socially and politically successful model. It allowed acquittees to experience longer tenure in the community (through lowered recidivism and fewer hospitalizations) and it also decreased the risk to public safety.²⁷² Dr. Parker concluded that the “coordinated provision of high-frequency services by a multidisciplinary team is the hallmark of an effective ACT team and may have been an important factor in the success of the [conditional release] program.”²⁷³

It is worth noting that this ACT conditional release model received consistently generous financial backing and was perhaps better able to provide a more significant level of treatment than other ACT teams nationwide.²⁷⁴ High-frequency services and a multidisciplinary team come with a cost, but the money saved from lowered rates of hospitalization and incarceration, not to mention

266. Parker, *supra* note 15, at 291–92.

267. *Id.* at 299.

268. *Id.*

269. *Id.*

270. *Id.*

271. *Id.* at 300.

272. *Id.* at 302.

273. *Id.*

274. *Id.* at 300.

the personal “savings” of freedom and better mental health to the acquittee, are worth the financial investment in the long term.

C. Combining Models and Addressing Criminogenic Needs

Conditional release programs could even combine one or more modern concepts and incorporate them into existing models of aftercare. Since the problem with conditional release programs in many states can be attributed to a lack of communication between supervisors, combining the ACT model within the mental health court structure may be the ideal solution. For example, a specialized mental health court dedicated to serving NGRI acquittees on conditional release could incorporate a specialized forensic ACT team responsible for the supervision and treatment of the acquittees in the community. The team would then report to the court on a regular basis. The court would monitor the acquittee’s progress and take appropriate action as needed. The ACT model would remain the same as far as treatment and structure, the only difference being the inclusion of the court as part of the team.

However, incorporating mental health courts and ACT or forensic ACT (FACT) teams into existing models of supervision may not be enough to reduce recidivism. This is because existing courts, ACT, and FACT teams may falsely assume that treating mental illness reduces criminal involvement. However, most individuals with mental illness do not commit crimes as a result of their psychiatric symptoms.²⁷⁵ The number of criminal offenders whose mental illness contributed to the offense is low: 7 to 11%, depending on the characteristics of the participants involved in the study.²⁷⁶ Thus, conditional release programs must also address criminogenic needs to reach at-risk acquittees.

“[W]hen programs directed at offenders with mental illnesses (such as mental health courts) do reduce recidivism, they do so by addressing offenders’ criminogenic risks, engaging in problem-solving strategies, and targeting situational factors that get an offender in trouble.”²⁷⁷ Adherence to and compliance with the treatment plan is a critical part of reducing recidivism.²⁷⁸ Yet,

275. Livingston et al., *supra* note 264, at 73.

276. Skeem et al., *supra* note 114, at 117–18.

277. Johnston, *supra* note 17, at 575.

278. See Brand et al., *supra* note 235, at 33 (reporting that about half of

acquittees who are offered a variety of services,²⁷⁹ for example, programs designed to address poverty,²⁸⁰ antisocial behavior,²⁸¹ and criminal thinking,²⁸² experience more successful tenures in the community. If conditional release programs want to produce evidence-based results, they must look to new research, new methods, and have the will to experiment with novel treatments and ideas.

VII. CONCLUSION

The impact of conditional release extends beyond the acquittee. Conditional release implicates public safety considerations, civil rights, costs to governments and taxpayers, public perceptions about mental illness, and the merits of the insanity defense itself.²⁸³ It affects the number of psychiatric beds available,²⁸⁴ the number of non-forensic consumers who have access to long-term mental health care,²⁸⁵ the administrative and security costs of state hospitals, and money that could be used to provide better mental health care to more individuals who desperately need it.²⁸⁶ For all of these reasons and more, governments have an obligation to look for ways to improve aftercare programs.

Effective conditional release programs, as evidenced by those in Oregon and Cleveland, look for ways to increase aftercare

mentally ill patients in study who reoffended were not compliant with medication or treatment).

279. Parker, *supra* note 15, at 301.

280. Skeem et al., *supra* note 114, at 116 (reporting that people with mental illness engage in crime and deviant behavior because the impoverished areas where they live are filled with drugs, unemployment, crime, homelessness, and health burdens).

281. Vitacco et al., *supra* note 45, at 119 (reporting that patients with antisocial behaviors must be supervised differently than other acquittees).

282. Skeem et al., *supra* note 114, at 114 (“[T]he one small study in our entire sample that included any emphasis on ‘criminal thinking’ . . . looked promising.”).

283. Gowensmith et al., *supra* note 58, at 602–03.

284. Linhorst, *supra* note 21, at 577–78 (finding that over half of all long-term beds available in Missouri were occupied by insanity acquittees).

285. *Id.* at 568 (concluding that, because the inpatient acquittee population grew with few releases, it “consumed an increasing proportion of [mental health] resources”).

286. *E.g.*, *id.* at 577–78 (stating that hospitals must devote more security and money to facilities that house forensic patients, and must devote more resources to risk assessment and evaluations related to conditional release).

efficiency and successes, both from personal and community perspectives. Programs like these attribute “improved outcomes to a higher frequency of contacts with clinical providers.”²⁸⁷ However, high contact should not be confused with strictness. Overly harsh programs are not necessarily more successful.²⁸⁸ Instead, acquittees need frequent contact with clinicians, treatment providers, and professionals who make the transition from inpatient care to community care seamless.

To achieve a high frequency of contacts, governments must simplify aftercare roles and procedures. All stakeholders must meet and communicate with each other about the progress of released acquittees. These stakeholders must take collective responsibility over the management and performance of acquittees and look for ways to improve continuity of care. They must make it a priority to improve conditional release outcomes by targeting acquittees who are most at risk of revocation. They can do this by meeting criminogenic needs and addressing issues like substance abuse and antisocial behavior, which are the most common reasons for recidivism.

In sum, it is important to modernize conditional release programs by incorporating newer models of outpatient treatment like mental health courts, ACT, and FACT, and enacting evidence-based programs aimed at assisting a subset of acquittees who face a greater risk of revocation. While it is true that “the legal profession alone cannot ‘solve’ the problem of criminality or rehabilitate persons involved in the criminal justice system,” it “can make a dent, salvage some lives, work with other professionals and advocate for services and changes in policy.”²⁸⁹ This article attempts to advocate for change in an untouched and fractured aftercare program that could be modernized and modified to work more efficiently, produce better results, and change lives and communities in more positive and lasting ways.

287. Parker, *supra* note 15, at 301.

288. Telephone Interview with W. Neil Gowensmith, *supra* note 213.

289. David B. Wexler, *Therapeutic Jurisprudence and the Rehabilitative Role of the Criminal Defense Lawyer*, 17 SAINT THOMAS L. REV. 743, 745 n.12 (2005).