Acquittal by Reason of Insanity Is a Positive Outcome for Defendants Who Cannot Be Restored

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Bloom and Kirkorsky discuss three models of special commitment procedures in use today in California, Oregon, and Ohio, regarding the management of individuals found incompetent to stand trial, not restorable (IST/NR) and considered dangerous. They suggest that a fourth model, one merging the population of dangerous IST/NR individuals into the system of insanity acquittees, would offer this group the advantages of a definitive legal disposition, more equal treatment, and improved chance of recovery. This commentary explores their proposal by reviewing recovery outcomes for forensic patients and insanity acquittees and discusses possible improvements such as intensive community monitoring and large-scale data collection. Although both groups face obstacles to recovery and release, the population of dangerous IST/NR individuals would benefit from the more conclusive forensic legal status and pathway to recovery offered insanity acquittees.

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What to do with defendants who are found not competent to stand trial and not restorable (IST/NR) on violent charges is a well-documented[1–3] dilemma faced by many jurisdictions. There are numerous pressures to not release such defendants to the community, but instead to continue their confinements in psychiatric hospitals for extended periods. In this issue of The Journal, Bloom and Kirkorsky[4] review approaches taken by three states (California, Oregon and Ohio) in which various aspects of civil commitment law were modified to allow for legal detainment of a subpopulation of individuals found IST/NR: those with charges dismissed without prejudice, and considered dangerous.

In California, this was achieved through creation of a legislative conservatorship, in which the statutory definition of gravely disabled was modified to include persons found IST/NR for charges involving death or great bodily harm/threat.[5] This confinement may be continued yearly, so long as there exists a continuation of the findings of incompetence or dangerousness.[5–6] In Oregon, a new section was created in statute to expand the oversight of the Psychiatric Security Review Board to those found IST/NR and extremely dangerous.[7] In Ohio, a modified civil commitment procedure was created that extended trial court jurisdiction over IST/NR mentally ill persons found by clear and convincing evidence to have committed a high-level, violent offense as charged.[4]

Bloom and Kirkorsky echo concerns expressed by other reviewers[3] that these modifications of civil commitment law are unfair and dysfunctional in their reliance on altered definitions of dangerousness. They additionally note that in jurisdictions such as Ohio, where recovery could lead an IST/NR individual back into competency and the correctional system, this indeterminate legal status is an impediment to patient progress. Instead, they recommend that states considering the use of a special procedure for IST/NR not only adopt the 2016 ABA Criminal Justice Standards on Mental Health for insanity acquittees,[8] but apply them as per the 1989 ABA standards[9] that recommended similar treatment for

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those found IST/NR. These standards would apply to individuals in both groups where the original criminal charge involved death or threat of serious bodily harm as established in a full adversarial hearing, beyond a reasonable doubt. If the possibility of future criminal proceedings existed, such as in Ohio, the defense would be allowed to raise an insanity plea. As noted by Hoge[3] this plan would consider both the public's interest in safety, and the need for hospitals and evaluators to manage committed patients in the least restrictive setting. Furthermore, Bloom and Kirkorsky contend that merging the fate of IST/NR defendants and insanity acquittees not only will help settle the question of what is to be done with this population, but also try to give such defendants "a fairer opportunity for recovery" (Ref. 4, p 6). These assertions lead the reader to question what the experience of recovery is for insanity acquittees, and whether this proposed fourth model would offer any benefit to those found IST/NR and dangerous.

Recovery in a Forensic Setting

Recovery in a forensic mental health setting for individuals of any legal status is challenging. Although the definition of recovery can vary according to an individual patient's symptoms, goals, and other factors, there are several recurring themes in the recovery literature: autonomy and self-empowerment; sense of identity; hope for the future; and safety.[10] The most central of these is arguably autonomy, as it forms the basis of medical ethics in activities such as obtaining informed consent.[11] In the general psychiatric setting, autonomy can be difficult for a patient to achieve, especially if hospitalization and perhaps treatment is involuntary. In the forensic mental health setting, where hospital and community safety rival individual recovery as a priority, autonomy is limited at best. For example, forensic patients may have more restricted access to property, communication, and movement.

On a forensic unit, even confidentiality may be limited; as long as the patient is under the order and jurisdiction of the criminal court, the treatment team is required to provide status updates, which will include personal information. This third-party involvement of the court can make developing a trusting and therapeutic relationship with treatment providers difficult. A patient may feel inhibited to fully share matters such as trauma, which in turn affects sense of identity. A patient who is aware of court and treatment team expectations may preferentially share thoughts that match these views, potentially sacrificing personal recovery for external approval.

Limitations on recovery for the forensic patient are especially apparent regarding movement and discharge.[12] The court, as well as the community, may have opinions that negatively affect patient movement, despite progress achieved by the patient and treatment team. Furthermore, these opinions will likely differ according to situation-specific factors, such as type of crime, media attention, and community reaction. It may be difficult for patients to understand why one peer is moving forward while their own advancement stalls. Such patients feel powerless, and in perceiving that any progress toward discharge is capricious, may find that hope for the future is elusive.[13]

Although recovery can therefore seem misplaced in a forensic hospital, positive patient engagement has been found to be a useful tool. The respect of listening to a patient's narrative and opinions may be enough to start a dialogue that leads to development of mutual treatment goals. Shared decision-making between patient and providers is an important approach to all treatment goals, including reduction of risk, a key consideration for forensic discharge planning. One literature review[14] identified five studies measuring shared risk formulation for violence. Although study methodologies varied, all concluded that patient involvement in staff assessment of risk is not only feasible but also may have predictive validity. It therefore appears that any risk discussion and formulation involving both staff and patients may be beneficial. As put by Papapietro, the best forensic approach to risk-reduction and recovery may be to focus on "treating and understanding violence and its causes, rather than simply providing management in the hope of preventing violence" (Ref. 12, p 40).

Recovery and Conditional Release

An important measure of recovery for forensic patients is hospital discharge. For insanity acquittees, this process typically begins with progressive freedoms inside the hospital, and culminates in a conditional release with varying degrees of community monitoring. The success of this release has been reviewed

through numerous studies looking at rehospitalization and recidivism.[15–18] In contrast, there is no typical path to discharge for individuals found IST/NR and considered dangerous, as their detainment and subsequent release depends on state-specific commitment approaches.[1] This lack of unified approach may help contribute to long lengths of stay for this population that may or may not be related to current dangerousness.[2] As noted by Bloom and Kirkorsky, the group of individuals found IST/NR and considered dangerous mirrors insanity acquittees in key areas, including having a severe mental illness (usually psychosis[2,15]) serious charges, and perceived dangerousness. Since they are more like insanity acquittees than civil committees, it is logical that they be allowed the same opportunity for conditional release.

Before consigning an additional group of forensic patients to the insanity acquittee population, it is worth reviewing the current success of recovery in this group as measured by conditional release. Overall, recidivism for insanity acquittees released into the community is low, especially when compared with non-mentally ill offenders.[16,17] Violent reoffending is rare;[15,18] in one study reviewing dynamic risk factors in forensic patients transitioned to the community, none engaged in serious violence in the year following release, although 25 percent required rehospitalization.[19] When re-arrest does occur, it is usually for minor and nonviolent crimes.[17,18] In a 2016 review of 35 studies from 10 countries by Fazel and colleagues,[20] forensic patients had lower rates of reoffending compared with general prisoners. The authors noted that this finding could stem in part from the fact that probability of reoffending is low for individuals with late-onset offending, few prior convictions, violence exclusively against family, and offending associated with acute symptoms (i.e., characteristics more typical of forensic patients than general prisoners).

A 2019 review by Adjorlolo and colleagues[15] of 58 studies related to the insanity defense found that most discharged patients were able to successfully maintain their community status. Revocation of release, when it occurred, was largely due to rule violation rather than reoffending. Rehospitalization as a consequence of revocation is far more common than incarceration.[19] Factors that appear to consistently predict revocation and rehospitalization include history of previous failed conditional release, violation of conditional release rules, and substance abuse.[15]

The success of an insanity acquittee remaining in the community appears to be positively influenced by intensive community treatment services.[15,21] These programs monitor insanity acquittees after release into the community for compliance with treatment and other release conditions such as abstinence from drugs and alcohol. If an individual begins to decompensate, either through rule violation or illness progression, the program allows for rapid rehospitalization.

The Historical, Clinical and Risk Management - 20 (HCR-20) is widely used as a violence risk assessment tool by forensic practitioners, so different studies have explored if and how each of the individual HCR scales can be related to conditional release. In a study of 142 insanity acquittees in New York, Green and colleagues[17] reviewed risk factors associated with hospital recommitment in the ten years following conditional release. Recommitment was associated with higher scores on the Historical and Risk Management scales, specifically with factors such as absent or less serious mental illness, substance abuse, and prior problems with attitude, supervision compliance, or relationships. A study of 238 insanity acquittees in Oregon[22] found that two items from the Risk Management scale (exposure to destabilizers and stress) were somewhat predictive of revocation, although the HCR-20 scores were mostly unrelated to conditional release outcomes.

Although research on the utility of the HCR-20 in conditional release decision-making is ongoing, there is evidence in the current literature that the highest risk of reoffending stems from demographic and criminogenic risk factors that are not exclusive to either the forensic or the mentally ill population: male gender; young age at first offense; criminal history; history of poor treatment or supervision compliance; substance use; and social problems.[17,19] Criminal history is considered to be the best predictor of recidivism, whereas mental illness is thought to be only one of many factors.[23]

It probably is not a coincidence that individuals with characteristics associated with recidivism are also less likely to be recommended for conditional release. In one oft-cited study looking at three decades of conditional release decision-making,[24] treatment providers were most reluctant to recommend release in individuals with substance use problems,

poor treatment progress or compliance, and risk of violence. A recent literature review of insanity acquittees[15] similarly found that factors such as previous hospitalization, lack of insight or treatment compliance, aggression, age at first offense, family or relationship problems, and type of offense, including use of weapon, negatively influenced release recommendations.

It does appear that once insanity acquittees with severe mental illness achieve release, they are likely to experience success. Achieving this release, however, is not easy. As described above, the path to recovery for a forensic patient has many obstacles, which prolong hospitalization. There is evidence that length of stay for insanity acquittees is increasing, possibly because of expanded use of risk assessment tools such as the HCR-20 that may hinder discharge by greater focus on, and less tolerance of, risk.[18,24] Furthermore, this trend toward increased length of stay for insanity acquittees comes at a time when access to state hospital beds is already facing unprecedented demand for forensic services such as restoration to competence.[25] Hospitals may struggle with the question of where to prioritize their often-limited forensic resources, and conditional release planning for insanity acquittees may take a back stage to the more acute and time-sensitive needs of restoration to competence patients.

One might hope that increased length of stay would be associated with better outcomes in terms of successful release and community longevity. Unfortunately, this does not appear to be the case; length of hospitalization has been shown to have little effect on subsequent recidivism.[18] Moreover, there is evidence that long hospital stays contribute negatively to recovery. As discussed above, hope plays an important role in treatment progress, and "lack of clarity around length of stay or pathways out of care may lead to a loss of hope" (Ref. 10, p 72).

Lengthy hospital stays not only present a potential hurdle to recovery but may be contrary to the intent of the Americans with Disabilities Act (ADA) as interpreted by the U. S. Supreme Court in the 1999 decision *Olmstead v. L.C.*[26] In Olmstead, two women with developmental disabilities filed a lawsuit claiming that the state's failure to discharge them to the community despite the recommendation of treating physicians violated Title II of the ADA, which states that individuals with disabilities have the right to receive treatment in the most integrated setting. As noted by Sloan and Gulrajani in their review of *Olmstead v. L.C.* after 20 years, the Department of Justice has "increasingly championed the enforcement of *Olmstead* across the country" (Ref. 27, p 409). Although this focus has been on states, the expectation is that the Department of Justice will increasingly broaden its focus to the criminal justice system,[27] including forensic hospitals.

Concern of Dangerousness

It is clear that recovery and conditional release could be improved for insanity acquittees, but several barriers stand in the way; most significantly, concern for dangerousness. Hospital commitment is usually based on an individual being currently dangerous to self or others. In the case of an insanity acquittee, however, simply having that legal status is enough to justify initial, and ongoing, commitment. In fact, mandatory commitment of an insanity acquittee is found in federal law (Section 18.4243(a) United States Code) and in the Model Penal Code (Section 4.08 MPC).[23] In *Jones v. United States*, the U.S. Supreme Court concluded that a finding of Not Guilty by Reason of Insanity was "sufficiently probative of mental illness and dangerousness" (Ref. 28, p 363) to justify ongoing presumption of both conditions and therefore confinement. Although the U.S. Supreme Court in *Foucha v. Louisiana*[29] further refined this concept in holding that an insanity acquittee could not be confined unless both mentally ill and dangerous; it did not provide any guidance regarding how the word dangerous should be defined or determined.

This lack of guidance regarding the definition of dangerousness was referred to by the U.S. Court of Appeals for the Fifth Circuit in *Poree v. Collins.*[30] Mr. Poree applied for habeas relief in Louisiana when he was denied conditional release despite the consensus recommendation of four expert witnesses. The Court of Appeals acknowledged the finding in *Foucha* that confinement requires a determination of both mentally ill and dangerous, but added that the Louisiana trial court's decision to continue confinement based on potential dangerousness was not in conflict with precedent, since the U.S. Supreme Court had not specified how a determination of dangerousness was to be made.[31]

The criminal justice system's low threshold in considering dangerousness has some root in public

perception. The Commentaries on the Model Penal Code (American Law Institute) were developed following the NGRI acquittal of John Hinkley Jr. after the shooting of President Reagan. In these, it was noted that automatic commitment of an insanity acquittee may be "beneficial to the offender by making the defense of insanity more acceptable to the jury and the public" (Ref. 23, p 2). A literature review of insanity defense research[15] described jurors' knowledge and attitude toward the insanity defense. In one study, jurors were more likely to consider an NGRI verdict if they believed it would lead to indeterminate confinement. In short, there is an underlying assumption that those who offend, whether due to mental illness or not, cannot be trusted, are more dangerous than the general population,[11] and should remain locked up.

Resistance to Recovery

Patients and staff may also pose barriers to recovery. As reviewed above, the population of insanity acquittees who have risk factors for not being released or revocation of release are those with poor treatment outcomes and criminogenic risk factors. In the first category are treatment-resistant individuals who may lack insight into their mental illness, legal status, or both. Although the ADA states that individuals have the right to treatment in the most integrated setting appropriate to their needs, and defines an integrated setting as one incorporating both disabled and non-disabled individuals, this does not in all cases equate to community care. A hospitalized insanity acquittee with severe treatment-resistant paranoid delusions, who committed (or commits) acts of violence related to those delusions, is arguably already in the least restrictive integrated setting most suited to treatment needs and community safety. For such individuals, conditional release may not be the most appropriate recovery goal.

Individuals with prior criminal histories and criminogenic risk factors such as antisocial personality disorder may also be resistant to recovery, at least as conceptualized by treatment providers and the court. These individuals may lack insight into their forensic status, and not accept accountability for attitudes or behaviors that possibly contributed to their offense. They have spent varying amounts of time in environments such as jail or prison, where antisocial ways of thinking and behaving can be normative and even adaptive. Such beliefs and patterns are not easily changed, even when staff target them as critical to reducing risk and improving likelihood of discharge. As summarized by Adshead, "you need some shared vision of recovery and desistance from the antisocial life before you can have shared decision-making about risk" (Ref. 11, p 33).

Finally, staff can be conflicted or confused by the challenges of guiding forensic patients toward recovery. Some have negative perceptions of the patient's offense or diagnosis and are reluctant to see such individuals progress. Other clinicians, aware of responsibility not only to the patient, but the court and community, may become so risk-averse they see little benefit to any release. In sum, although the link between insanity, mental disorder, and dangerousness has been shown to be weak,[23] there are myriad strong pressures that conspire to keep insanity acquittees locked up indeterminately.

IST/NR versus NGRI

Despite the difficulties faced by insanity acquittees, are there benefits to the dangerous IST/NR individual being allowed to pursue this verdict? It does appear this model confers several advantages. First, as Bloom and Kirkorsky propose, an insanity acquittal verdict settles the question of legal status. The IST/NR patient and treatment team currently exist in a world of unclear goals, in theory working toward recovery and release, while at the same time being aware of the possibility of renewed criminal proceedings. This shadowy prospect of future incarceration adds to the challenges of recovery discussed above, providing little incentive for the IST/NR patient, and perhaps the treatment team, to collaborate in a plan that might end in imprisonment. A legal determination of acquittal by reason of insanity puts the legal question to rest so that both patient and providers can work unencumbered toward recovery goals. In this sense, the model the authors propose does offer a "fairer opportunity for recovery" (Ref. 4, p 6).

Second, this model allows for like groups to be treated more equally. As Bloom and Kirkorsky note,[4] with regard to charges, mental illness, and consideration of dangerousness, both insanity acquittees and the population of dangerous IST/NR are more similar to each other than to either civil committees or persons found IST/NR and not mentally ill or dangerous. Allowing these groups the opportunity of comparable treatment and management is also fairer,

and does not require that civil commitment law be refashioned.

Third, the indeterminate legal status of IST/NR misdirects hospital resources. In Ohio, for example, an individual found incompetent to stand trial and unrestorable is under continued criminal court jurisdiction (ISTU-CJ) for the length of their docket, typically measured in years. During this time, the hospital is required to send regular status updates to the court. Although the literature is clear that persons who can be restored overwhelmingly achieve that restoration in under a year,[1,2] an individual found ISTU-CJ may continue to have competency evaluations as part of status updates long after the one-year mark. Given the large number of hospital forensic admissions for competence restoration requiring assessment and evaluation,[25] this arguably is not the best use of forensic resources.

Although the job of forensic hospitals is to focus on patient recovery and community safety, it is worth noting the existence of another group in the forensic system that may be affected by a patient's legal status: their victims. Victims may not like, or understand, that their offender is in a hospital versus a correctional system as a result of mental illness. Research in this area is scant, but there is evidence[32] that the ability of a victim to have information and a voice in proceedings improves their satisfaction and, perhaps, recovery. Although there are many conceptual, procedural, and ethics hurdles related to the involvement of victims with forensic patients, it can be theorized that the process of a full adversarial hearing resulting in a verdict would offer something more concrete, and therefore beneficial, to victims than the indeterminate status of IST/NR.

Improving Recovery

What can we, as forensic mental health professionals, do to improve the experience of recovery for insanity acquittees, and, if the proposal by Bloom and Kirkorsky is adopted, individuals found IST/NR and considered dangerous? Perhaps the largest barrier to recovery is community and court perception of dangerousness, which tends to be assumed universally, but, in reality, exists to differing degrees in individual patients. We know, for example, that not all violence risk is created equal: an insanity acquittee with a history of repeated predatory minor violence toward strangers presents a different risk than a patient with a history of one serious assault toward a family member. Perception, however, is difficult to overcome. Increased exploration of the use of assessment tools such as the HCR-20 may help refine how we understand and explain dangerousness in individual cases, and, in the future, possibly predict success on conditional release.

The model suggested by Bloom and Kirkorsky provides an advantage in that definitive legal statuses benefit data collection, which is critical for a better understanding of not only dangerousness, but also the makeup and needs of the expanding forensic population. Adshead correctly states, ". . . what is really needed in forensic services is a better systemic definition of the primary task of forensic systems" (Ref. 11, p 34). State hospitals house a large and increasing proportion of the forensic patient population, and struggle to reconcile patient care and recovery with concerns for hospital and community safety. An excellent start at gaining a clearer picture of this system would be adopting the Forensic Mental Health Services Census proposed by Bloom and Novosad.[33] By compiling information on different patient populations housed in state facilities, we could better understand forensic hospital systems and needs, and in turn, educate and inform courts, communities, and policymakers.

Greater focus on the success of intensive community programs would also improve recovery for insanity acquittees. Treatment in the hospital is expensive, resource-intensive, and not necessary in all cases. Hospital admission should be need-based, not automatic according to "narrow interpretations of dangerousness" (Ref. 34, p 486). Assertive community treatment and monitoring has been shown to be effective in preventing insanity acquittees on conditional release from decompensating due to mental illness, stress, or substance use. For example, Melnick[35] reported that a model residential program in Florida designed to help transition a patient into the community on conditional release demonstrated no recidivism. Although such programs require significant output of community resources, their intensity may be allowed to lessen over time, as risk of conditional release revocation appears to decline or level off with years.[21,22] As summarized by Skipworth and colleagues, it appears that "public demands for safety and accountability can probably be met by shorter inpatient periods and a longer community period of intensive monitoring and

support, with unobstructed access to hospital readmission" (Ref. 16, p 1009).

Conclusion

All forensic patients face obstacles on the path to recovery. As insanity acquittees move toward conditional release, they are confronted with challenges, including long hospital lengths of stay and low rates of release. Although their recovery is imperfect, it does present a more defined path than what currently exists in many states for the population of dangerous IST/NR individuals. Offering this group a chance to obtain a similar verdict to an insanity acquittee would indeed not only settle the matter of their indeterminate legal status, but also offer a fairer, albeit rocky, path to release.

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