Disposition of Insanity Acquittees in Illinois

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Little attention has been paid to the processing of insanity acquittees subsequent to criminal trial. This study first obtained descriptive data on new insanity acquittees (N = 137) in Illinois between January 1982 and July 1984 and then examined the criminal commitment criteria used by evaluating psychiatrists and criminal courts in the disposition of insanity acquittees. Acquittees in Illinois were largely male, chronic schizophrenics who had been acquitted for murder or attempted murder. Judges tended to use criminal criteria that were more demanding than those which had been recommended by psychiatrists. Stepwise discriminant analyses revealed that psychiatric diagnosis was the most influential factor in determining psychiatrists' recommendations and court dispositions. Psychiatrists and committing judges failed to comply with the requirements of the committment law in one quarter of the cases.

The not guilty by reason of insanity (NGRI) verdict has been the subject of heightened public and professional interest in recent years. Debate about its rationale, deployment, and extent of appropriateness has appeared regularly with recent attention paid particularly to macrolevel reviews of outpatient programs and facilities like those in Oregon, Maryland, and Illinois.[1] Little solid information exists, however, regarding either the characteristics of insanity acquittees or the treatment decisions made about these individuals.[2,3] Although the subject of considerable legal commentary, including a recent US Supreme Court decision,[4] empirical analyses of the disposition of insanity acquittees by state and federal courts are rare.[5]

Much of the difficulty in obtaining useful information about the processing of insanity acquittees is due to the numerous ways in which they are managed. Dispositions of insanity acquittees vary widely throughout federal and state jurisdictions. These range along a broad continuum of least restrictive dispositions (equal treatment of insanity acquittees and civil committees) to most restrictive dispositions (automatic and indefinite commitment of acquittees, with the burden of proof of nondangerousness for release placed on the committee).[6-8] Moreover, as in the case of civil commitment, criteria for criminal commitment also vary across jurisdictions, with different definitions and con-

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sideration given to the constructs of mental illness and "dangerousness."[9,10] Given these inconsistencies and the multifaceted nature of dangerousness predictions,[11] it is not surprising that there are considerable empirical problems and little conclusive data regarding the assessment and disposition of insanity acquittees.

The present investigation attempts to provide a descriptive view of the handling of insanity acquittees in a single state jurisdiction. This study is an initial step in formulating views about the processes and outcomes connected with insanity acquittee disposition. A clearer picture of who is acquitted under a particular statute and how these individuals are handled after acquittal is a critical prerequisite to informed speculation about the impact of existing and proposed statutes.

The sample of acquittees examined here was evaluated pursuant to the Illinois dispositional criteria, which uses two "dangerousness to others" criminal commitment criteria. These two commitment standards differ in the imminence of the predicted violent behavior and the presence or absence of mental illness. To understand the relevance of the data obtained in the study to other statutory arrangements, it is necessary to briefly present the relevant sections of the Illinois statute.

Illinois Procedure

After a verdict of not guilty by reason of insanity in Illinois, established by American Law Institute criteria, with the burden of proof on the state to prove that the defendant was legally sane beyond a reasonable doubt,[12]

> The defendant shall be ordered to the Department of Mental Health and Developmental Disabilities for an evaluation as to whether he is subject to involuntary admission or in need of mental health services. The order shall specify whether the evaluation shall be conducted on an inpatient or outpatient basis. . . . The Department shall provide the Court with a report of its evaluation within 30 days of the date of this order. The Court shall have a hearing as provided under the Mental Health and Developmental Disabilities Code to determine if the individual is: a) subject to involuntary admission; b) in need of mental health services on an inpatient basis; c) in need of mental health services on an outpatient basis; d) a person not in need of mental health services. . . .[13]

> Definitions: for the purposes of this section: a) "subject to involuntary admission" means: a defendant has been found not guilty by reason of insanity; and who is mentally ill and because of his mental illness is reasonably expected to inflict serious harm upon himself or another in the near future; or who is mentally ill and because of his mental illness is unable to provide for his basic physical needs so as to guard himself from serious physical harm; b) "in need of mental health services on an inpatient basis" means: a defendant who has been found not guilty by reason of insanity who is not subject to involuntary admission, but who is reasonably expected to inflict serious physical harm on himself or another and who would benefit from inpatient care or is in need of inpatient care; c) 'in need of mental health services on an outpatient basis' means: a defendant who has been found not guilty by reason of insanity who is not subject to involuntary admission or in need of mental health services on an inpatient basis but is in need of outpatient care, drugs, and/or alcohol rehabilitation, community adjustment programs, individual, group, or family therapy or chemotherapy.[13]

It is important to note that the two "dangerous to others" criteria above, that is, the "subject to involuntary admission" (SIA) criterion and the "in

need of mental health services on an inpatient basis" (INPT) criterion, differ with regard to the imminence of dangerousness as well as the presence of mental illness for the acquittee. The SIA criterion is the basis for civil commitment in Illinois and was the only basis for the commitment of insanity acquittees before the statutory change in 1980. This criterion requires that the dangerousness be both expected "within the near future" and based upon a mental illness. The INPT criterion, applicable only to insanity acquittees since 1980, states only that the defendant is reasonably expected to inflict serious harm at any time in the future. No mental illness need be present for commitment to occur under this criterion. The first criterion is obviously more stringent, requiring both a limited time frame for prediction and a demonstrated link of the likely violent behavior to a mental disorder. Evidence of any of the commitment criteria must be established through clear and convincing evidence.

It is equally important to note, however, that there is no difference in the operational handling in the hospital of an acquittee under these two criteria. Despite the difference in stringency of commitment criteria, insanity acquittees hospitalized under either of these two standards are accorded identical rights and privileges regarding their treatment. Thus, from a utilitarian perspective, these two criminal commitment criteria can be seen as equally restrictive.[14]

As noted earlier, this investigation attempted to provide descriptive information about the application of these criminal commitment standards. Five questions were addressed: First, what are the characteristics of individuals who have been adjudicated not guilty by reason of insanity of criminal charges in Illinois? Second, what criminal commitment criteria do examining psychiatrists appear to use in their evaluations of new insanity acquittees? Third, what criminal commitment criteria do Illinois criminal court judges appear to use in adjudicating the disposition of new insanity acquittees? Fourth, what is the consensus between recommendations by physicians and court-ordered dispositions of these cases? Fifth, what demographic, mental health, or criminal justice variables relate to the criminal commitment determinations made by examining psychiatrists or judges? Taken together, answers to these questions should provide a preliminary understanding of the process by which insanity acquittees are handled under this statutory design.

Methods

Hospital records and criminal court orders were reviewed on all new insanity acquittees who were admitted to the facilities of the Illinois Department of Mental Health and Developmental Disabilities between January 1, 1982, and July 1, 1984. During this period, new acquittees were admitted to one of three Illinois department facilities and data on virtually all new insanity acquittees evaluated in Illinois during this period was thus obtained. A very small number of new acquittees, as permitted by statute, may have been examined as outpatients and were thus outside the reach of the sampling procedure, although experi-

ence indicates that this would be extremely rare. The study focused on the psychiatric evaluation of new acquittees; those who had earlier been acquitted and conditionally released but required readmission during the study period were excluded. Those acquittees who had been transferred between Department of Mental Health and Developmental Disabilities facilities after an initial postacquittal commitment were also excluded.

Data from hospital records included demographic variables, criminal charges for which the patient had been acquitted, number of past state hospital admissions, present and past psychiatric diagnoses, past criminal convictions and incarcerations, and the psychiatric recommendation regarding current disposition. Review of criminal court orders revealed the actual disposition, the criminal commitment criteria used by the court, and the time interval from acquittal to legal disposition.

Results

Characteristics of Acquittees The original sample consisted of 137 acquittees, 112 men (81.8%) and 25 women (18.2%). Age ranged from 19 to 77 years, with a mean of 33.9 years and a standard deviation of 11.4 years. There were 69 blacks (50.7%), 57 whites (41.9%), six Hispanics (4.4%) and four others (2.9%). More than two thirds of acquittees (68.7 %) had been hospitalized in the state psychiatric hospitals in Illinois before the instant offense, on an average of 4.0 times (median 2.0) with a range of two to 29 hospitalizations exclusive of hospitalization for incompetency to stand trial for the instant offense. Seventy-four individuals (54.4 %) had previously been adjudicated incompetent to stand trial on the instant offense before their acquittal. Fifty-nine of the sample had been acquitted in 1982, and 53 had been acquitted in 1983, the two years for which year-long data were available.

Table 1 reveals that individuals charged with murder and attempted murder constituted more than half of the sample. This was the case for men and women. Misdemeanors represented at least 4.4 percent of the acquittal offenses and at most 14.6 percent, depending upon the extent of property loss for several offenses, data for which were unavailable. As seen in Table 2, primary psychiatric diagnoses (DSM-III, Axis 1) at the time of the psychiatric evaluation were nonaffective psychoses in 73.7 percent of individuals (schizophrenic disorder, schizoaffective disorder, brief reactive psychosis, paranoid disorder and atypical psychosis), with an emphasis upon schizophrenia and schizoaffective disorder (67.1%). As expected, men were more frequently diagnosed as having a schizophrenia disorder, and women were more frequently diagnosed as having an affective disorder.

Psychiatric Recommendations and Court Dispositions Table 3 presents the psychiatric recommendations and criminal court dispositions according to the three statutory commitment criteria (SIA, INPT, OUTPT). Data in this regard are presented for 97 of the 137 subjects; 20 were missing information on the psychiatric recommendation, 16 were missing information on the court disposition, and four were recom-

Table 1
Single Most Serious Criminal Charge for Which Acquitted by Sex

Charge	Men		Women		Total	
	No.	%	No.	%	No.	%
Murder	29	25.9	8	32.0	37	27.0
Attempted murder	25	22.3	5	20.0	30	21.9
Rape	3	2.7	0	0.0	3	2.2
Attempted deviant sex assault	1	0.9	0	0.0	1	0.7
Armed robbery, attempted armed robbery	2	1.8	0	0.0	2	1.5
Robbery	2	1.8	0	0.0	2	1.5
Armed violence	1	0.9	1	4.0	2	1.5
Home invasion	2	1.8	0	0.0	2	1.5
Aggravated arson	5	4.5	3	12.0	8	5.8
Arson	2	1.8	0	0.0	2	1.5
Indecent liberty with child	1	0.9	0	0.0	1	0.7
Kidnapping	0	0.0	1	4.0	1	0.7
Aggravated battery	11	9.8	2	8.0	13	9.5
Battery	4	3.6	0	0.0	4	2.9
Aggravated assault	2	1.8	0	0.0	2	1.5
Intimidation	1	0.9	0	0.0	1	0.7
Burglary, attempted burglary	8	7.1	0	0.0	8	5.8
Forgery	1	0.9	0	0.0	1	0.7
Auto theft	1	0.9	1	4.0	2	1.5
Theft	2	1.8	1	4.0	3	2.2
Criminal damage property	5	4.5	0	0.0	5	3.6
Disorderly conduct	1	0.9	2	8.0	3	2.2
Unlawful use, weapon	1	0.9	0	0.0	1	0.7
Violation probation	2	1.8	1	4.0	3	2.2
Totals	112	100	25	100	137	100

Table 2
Primary DSM-III Axis I Diagnosis at Time of Postacquittal Evaluation by Sex

Diagnosis	Men		Women		Total	
	No.	%	No.	%	No.	%
Schizophrenia	69	61.6	9	36.0	78	56.9
Schizoaffective	11	9.8	3	12.0	14	10.2
Brief reactive psychosis	2	1.8	0	0.0	2	1.5
Bipolar	7	6.3	5	20.0	12	8.8
Major depressive	3	2.7	0	0.0	3	2.2
Dysthymic	1	0.9	1	4.0	2	1.5
Paranoid	1	0.9	0	0.0	1	0.7
Atypical psychosis	4	3.6	2	8.0	6	4.4
Dementia	3	2.7	0	0.0	3	2.2
Mental retardation	1	0.9	1	4.0	2	1.5
Substance abuse	3	2.7	1	4.0	4	2.9
Post traumatic stress	1	0.9	0	0.0	1	0.7
Explosive personality	1	0.9	0	0.0	1	0.7
No diagnosis axis I; personality diagnosis	4	3.6	2	8.0	6	4.4
Organic brain syndrome	0	0.0	1	4.0	1	0.7
Malingering	1	0.9	0	0.0	1	0.7
Totals	112	100	25	100	137	100

Table 3
Frequency of Statutory Classifications in Psychiatric Recommendations and Court Dispositions

Court Disposition	Psychiatric Recommendation						Totals	
	SIA*		INPT		OUTPT			
	No.	%	No.	%	No.	%	No.	%
SIA	36	37.1	12	12.4	4	4.1	52	53.6
INPT	3	3.1	16	16.5	3	3.1	22	22.7
OUTPT	0		0		23	23.7	23	23.7
Totals	39	40.2	28	28.9	30	30.9	97	100

* SIA, subject to involuntary admission; INPT, in need of mental health services on an inpatient basis; OUTPT, in need of mental health services on an outpatient basis.
† Represents cases for which both psychiatric recommendation and court disposition were available. There are no significant differences observed when cases in which neither, or only one, outcome variable is included.

mended for or given either substance abuse treatment or no treatment. On occasion, some judges held the criminal commitment hearing on the same date as the criminal trial, without the benefit of the contemporaneous psychiatric evaluation by the Department of Mental Health and Developmental Disabilities. Acquittees were then referred to the department as committed for treatment rather than evaluation. This accounted for some of the cases in which no psychiatric recommendation had been recorded. Accounting for some of the cases in which no court order for treatment was recorded was that some court orders were too vague or ambiguous to be interpreted (for example, "the defendant is committed to the Department of Mental Health and Developmental Disabilities"). Some courts reversed the statutory sequence and remanded the acquittee initially for treatment and then for evaluation.

In 10 cases for which data on both psychiatric recommendations and court dispositions were available, judges, contrary to law, checked more than one dispositional criterion. This usually took the form of checking both SIA and INPT. These cases were included within the subsample and coded as if the recommendation or disposition for SIA had been selected.[15]

Psychiatrists selected the SIA standard in 40.2 percent of the cases (39 of 97), while judges did so in 53.6 percent (52 of 97; Table 3). Psychiatric examiners recommended the INPT standard in 28.9 percent of the cases; judges did so in 22.7 percent. Psychiatrists indicated that 30.9 percent of cases were suitable for OUTPT treatment, although just 23.7 percent were so ordered.

As seen in Table 3, the overall rate of agreement between the psychiatrists and the court (the sum of the values on the diagonal) was relatively high (77.3%). The greatest disagreement occurred between recommendations and dispositions for INPT status versus SIA. Looking at the large proportion of disagreement that occurred in the upper right portion of the table, it is clear that the psychiatrists' recommendations tended to be based more on an indefinite judgment of dangerousness and an absence of mental illness than those that were finally ordered.

Case Factors Related to Recommen-

dations and Dispositions A set of analyses was done to construct models that might represent the case factors salient in the choice of psychiatric recommendation or court disposition. Stepwise discriminant analyses for psychiatrists and judges, using the three statutory outcomes as dependent measures and various case characteristics as independent measures, were performed for all the men in the sample. The independent variables used were age, race, number of previous hospitalizations, whether the patient had been judged unfit to stand trial on the present charges, diagnosis, facility of evaluation, and criminal charge. Diagnosis, facility, and charge were entered as dummy variables.[16]

Using only men allowed for adequate sample size and eliminated the confounding of the sex variable with other case characteristics. Preliminary analyses had shown that sex was a powerful determinant of the choice of treatment, and it was our suspicion that case characteristics may be weighted differently depending on the sex of the patient. Unfortunately, the small number of women in our sample (n = 25) made impossible to test this speculation. As a result, the discriminant analyses were restricted to men to generate models applicable to the overwhelming majority of those who received verdicts of NGRI, although there is the likelihood that these models may not apply to cases involving women who received NGRI verdicts.

The discriminant analysis results for the group classifications made by the judges and the psychiatrists are presented in Table 4. Judging from these results, the case characteristics available were not overwhelmingly powerful in predicting decisions regarding statutory classification, with only slightly over half of the predictions being correct in each group (53.4% correct classification for psychiatrists; 50.5% correct classification for judges). The most influential variables in distinguishing the psychiatrists' judgments were whether the psychiatrist was working at a particular facility and whether the patient was diagnosed as having a brief reactive psychosis, paranoid disorder, or atypical psychosis. The most influential factor in the judges' decisions appeared to be

Table 4
Discriminant Functions of Classifications Made by Psychiatrists and Judges Using Three Statutory Classifications (SIA, INPT, OUTPT)

Professional Judgment	Variables in Final Function	Squared Canonical Correlation	% of Correct Classification
Psychiatrists	Diagnosis Brief reactive psychosis Paranoid disorder Atypical psychosis Facility 2	0.33	53.4
Judges	Diagnosis Schizophrenia	0.09	50.5

whether the patient had a schizophrenic disorder or not. Upon examination of the types of classification errors, it appeared that the model of the judges' dispositions was most accurate in isolating the SIA group from the OUTPT group, and the model of the psychiatrists' recommendations was most accurate in distinguishing the INPT treatment group.

The results of these preliminary discriminant analyses led us to investigate whether there was any clear model of the distinctions made by each group regarding inpatient (SIA plus INPT) versus OUTPT status. Although the greatest number of disagreements occurred when the psychiatrists recommended the INPT standard and the judges chose the SIA standard, the operational difference between these two classifications is nonexistent insofar as the treatment of the acquittees in the hospital is concerned. The choice of one status over another might simply reflect a preference of each professional group for a particular label, rather than a meaningful difference in judgment about appropriate treatment. It was our suspicion that any true differences in judgments about appropriate disposition might instead be found in the more distinct choice of a hospitalization versus nonhospitalization status.

The results of the discriminant analyses for each group's classification choice of hospital-based (SIA and INPT classifications collapsed) or outpatient treatment (OUTPT) are presented in Table 5. As shown, the psychiatrists' judgments were more easily modeled than those of the judges, with 81.8 percent of the psychiatrists' recommendations, versus 64.8 percent of the judges' dispositions correctly classified. Again, the most influential variables contributing to the correct classifications for the psychiatrists were having been evaluated at a particular facility (No. 2), and diagnosis, with outpatients more likely to have an affective disorder (major depressive disorder, bipolar disorder, dys-

Table 5
Discriminant Function of Classifications Made by Psychiatrists and Judges Regarding Need for Inpatient or Outpatient Treatment Following Acquittal*

Professional Judgment	Variables in Final Function	Squared Canonical Correlation	% of Correct Classification
Psychiatrists	Diagnosis Brief reactive psychosis Paranoid disorder Atypical psychosis Major depression Bipolar disorder Dysthymic disorder Facility 2	0.27	81.8
Judges	Diagnosis Schizophrenia	0.05	64.8

* Inpatient treatment includes SIA and INPT groups; OUTPT treatment is the outpatient group.

thymic disorder) and inpatients more likely to have a brief reactive psychosis, paranoid disorder, or atypical psychosis. For judges, the major factor distinguishing the hospital groups versus outpatient group was diagnosis, with a schizophrenia diagnosis more likely to result in a disposition for inpatient care. The low canonical correlations on these solutions, however, 0.52 for psychiatrists and 0.22 for judges (R^2 = 0.27 and 0.05, respectively) indicates that these discriminant functions have relatively limited power.

A final discriminant analysis was performed to determine whether there were systematic differences between those cases that the psychiatrist and court agreed upon and those in which they disagreed. The disagreement cases were distinguishable from the consensus cases primarily according to the facility from which the acquittee was evaluated, with two facilities significantly more likely to produce disagreement. The case characteristics of these cases appeared to have little influence in determining whether the psychiatrists and judges disagreed on the dispositional criteria following acquittal.

Discussion

The results of this investigation provide a preliminary look at the treatment outcomes subsequent to acquittal by reason of insanity in a jurisdiction that uses a three-pronged set of alternatives for the evaluation of these patients. The study highlights certain factors worthy of further consideration in developing a comprehensive understanding of appropriate dispositions for this population.

Of initial interest to the two-year study was a description of insanity acquittees in Illinois. In this sample, acquittees are predominantly new who were acquitted for murder and attempted murder with a prior history of psychiatric hospitalization and a present diagnosis of a psychotic disorder, primarily schizophrenia and schizoaffective disorder. In several respects, this Illinois sample resembles acquittees in other jurisdictions. Most studies of acquittees report a diagnosis of psychosis, usually schizophrenia, in one half to two thirds of cases,[17] with a history of prior psychiatric hospitalization in about 40 percent.[18] Acquittal for misdemeanor offenses for this Illinois sample (4% to 15%) was intermediate between the 2 percent of such cases found in Michigan and the 26 percent found in Oregon (of those placed under the jurisdiction of the Psychiatric Security Review Board).[19,20] Also of interest is the observation that 20 percent of the acquittees in this sample were released following their mandatory evaluation in contrast to the 55.6 percent of the Michigan sample released following their 60-day mandatory psychiatric hospital-based evaluation.[20] Judging from the respective outcomes in Michigan and Illinois, it appears unlikely that the case characteristics of these two samples can account for much of the observed differences in outcome across states.

A second striking finding in the data was the frequency with which the psychiatrists and judges failed to comply with the dictates of the statute in selecting a treatment disposition. Data were missing in 40 cases that were eliminated from the data analysis; further, psychia-

trists or judges selected two statutory classifications in over one quarter of the original sample. One explanation of these findings is that these professionals were unaware of the requirements of the statutory classification, despite the regular involvement of many in insanity acquittals. Alternatively, psychiatrists and judges may have practiced defensively to avoid some organizational or legal repercussions from unpopular outcomes, but this explanation appears less likely because there is no operational difference between the two hospital-based treatment classifications. It seems much more likely that there was a lack of clarity about the specific distinctions and requirements of the statute.

Interest in commitment criteria has expanded significantly in the years following the decisions of most legislatures to narrow civil commitment to those individuals meeting a dangerous standard.[21] Concurrently, problems in the clinical prediction of violent behavior have been demonstrated and have in part fueled a drive to return to *parens patriae* civil commitment standards.[22] Some empirical efforts in this area have attempted to ascertain the impact of restricted or broadened civil commitment standards on involuntary hospitalizations.[23,24] A recent review of this subject concluded that legislative intent to restrict or expand involuntary hospitalization through the enactment of new commitment standards has in fact produced changes in the extent of involuntary hospitalization in the intended direction.[25]

In a similar vein, there has been at least a social demand in recent years for the restriction of the availability of the insanity defense, as well as a call for the restriction of the liberties of those who are so acquitted. In line with these ideas, the Illinois legislature enacted in 1980 a statute that provided for two standards for hospitalization after acquittal, as well as for court-supervised, conditional-release, psychiatric outpatient treatment of insanity acquittees. This creation of two distinct hospitalization standards, differing in the imminence of the predicted violent behavior and the presence of mental illness, resembles earlier statutory efforts in many states to confine the noncommitable but dangerous offender through sexual psychopathy, defective delinquent or indeterminate sentencing provisions.[26] The more lenient hospitalization standard, from the dangerousness point of view, also contained a "treatability" component sometimes advocated for civil commitment standards, although the absence of a requirement of mental illness renders this component nonsensical. Nevertheless, the INPT standard by which individuals who are not mentally ill but dangerous in the indefinite future (as opposed to the "near future" of the SIA standard) are committed has been upheld by the Illinois appellate courts.[27,28] Widening of the criminal commitment criteria in this manner parallels the US Supreme Court's acceptance in *Jones*[29] of criminal commitment based upon a preponderance of the evidence standard rather than a clear and convincing standard.

The present study design, however, does not permit a test of its legislative intent. Data about the extent of hospitalization of insanity acquittees before

the enactment of the law are not available. One can also not state, with regard to the cohort, that in the absence of the INPT standard, that these acquittees would have been involuntarily hospitalized even though, by statutory definition, they failed to meet the higher hospitalization standard. The data indicate, however, that clinicians used both hospital standards equally, but judges preferentially selected the stricter standard. Similarly, clinicians were more inclined to discharge insanity acquittees to outpatient care than were the judges.

One might reasonably ask why clinicians or judges would ever select the more demanding criminal commitment criterion? It is certainly easier to substantiate a prediction of violence in the indefinite future than one in the near future. Several hypotheses might be entertained. First, clinicians and judges may be unaware of the existence of the two hospitalization criteria despite the enactment of the statute in 1980; there is, no doubt, a time lag between changes in the law and its local implementation. One study has demonstrated that psychiatrists are unfamiliar in general with statutes regarding involuntary hospitalization.[30] Another study indicated that physicians and mental health professionals appeared to be ignorant of the state's criminal responsibility law when they performed responsibility evaluations.[31] Second, a new law may be ignored or rejected when those who are expected to implement it find the previous statute satisfactory. Third, clinicians and judges may be unfamiliar with the literature on the problems in the prediction of violent behavior and overestimate their ability to predict violence "in the near future" as required by the stricter standard. This is supported by the finding that one half of the patients had previously received treatment as incompetent to stand trial and presumably were in some remitted state at the time of their acquittal. Fourth, evaluators and judges may have failed to conform their decision making to the dangerousness requirements of the criminal commitment law, but rather attended to extralegal factors such as demographic, clinical or interpersonal variables. This would include the fear of social, legal and economic reprisal regarding the release and recidivism of insanity acquittees, but would have ignored the equal consequences of the two hospital criteria once the patient is hospitalized. On the other hand, the belief that psychiatric decisions to obtain *civil* commitment are based primarily on the requisite legal criteria rather than demographic or interpersonal factors has found support in two studies of the decisions to commit voluntary psychiatric patients who have signed out of the hospital.[32,33] It is by no means clear, however, that the findings of these two studies can be generalized to criminal committees entering, rather than leaving the hospital.

When ordering hospitalization for an acquittee, judges preferred the more stringent hospital standard. One might hypothesize that the same extralegal contingencies apply to the judge as to the clinicians, although the judges, as elected officials, presumably are more sensitive to public opinion about recidivism of insanity acquittees.[34] Inexperience with insanity acquittees in many

cases led judges to conclude that the INPT standard was not an involuntary treatment status. In support of clinical or judicial ignorance or difficulty interpreting and implementing the law is the finding that just 63 percent (86 of 137) of the cases were recorded and implemented as planned according to the available data.

The extent of judicial deference to professional recommendations has been a central issue in mental health law. One observational study of civil commitment reported that judges' concurrence with physicians' recommendations for commitment was 88 percent.[35] Hiday[36] found that courts agreed with such psychiatric recommendations less than half the time and argued that court agreement is not an adequate measure of deference. When procedural measures of deference such as length of commitment hearing, judges' questioning of witness, and courts' acceptance of conclusory testimony were studied, it appeared that judges acted independently in the decision to commit. In the absence of such procedural measures in the present investigation, it is difficult to assert judicial deference to psychiatric decisions regarding criminal commitments even though substantial consensus was present. In other studies of offender populations, substantial independence of judicial decision making has been demonstrated.[37] Although not verifiable with the present data, it is also likely that psychiatrists modify their own assessments according to what they anticipate will be the judicial decision in a particular case.

The discriminant models that attempted to discern case factors related to the choice of certain statutory classifications or inpatient versus outpatient treatment were notable more for what did not appear to be significant than for the power of the variables that emerged. Criminal charges showed no power in determining either the judge's or psychiatrist's choice of outpatient treatment status, while diagnosis consistently emerged as at least marginally powerful. Also, the facility at which the acquittee was evaluated appeared to play some role in these determinations. This factor was predictive of both the psychiatrist's recommendation and the congruence between the judge and the psychiatrist. One could thus speculate that sociopsychological factors related to organizational ethos or the relationship between the referring institution and the court plays a major role in the processing of these cases. This would be consistent with findings in the criminal justice system regarding the use of discretion and argues for further studies of the influence of setting on patient processing, rather than continued exploration of case factors in isolation.[38]

Finally, the investigation suffered certain limitations. The formal criminal commitment hearings were not attended, hearing transcripts were not obtained, and psychiatrists and judges were not interviewed. It is possible that courts ordered dispositions in accordance with the demands of the law but that court orders were improperly prepared. It is also possible that psychiatric testimony at the hearing, presented in an unknown number of cases in the study, followed the requirements of the criminal com-

mitment statute despite the legal irregularities of the written psychiatric evaluation. The study also did not evaluate the sufficiency of the evidence of commitability presented in the psychiatric report or at the hearing with regard to mental illness and dangerousness. Such missing data would find welcome place in investigations by others of the criminal commitment process.

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12. As of January 1, 1984, the defendant at trial in Illinois bears the burden of proving his insanity by a preponderance of the evidence.
13. Illinois Revised Statutes, Ch 38, Section 1005-2-4, St. Paul, Mn, West Publishing Company, 1986
14. Whether or not the SIA or INPT patient groups differ with regard to the ease of release from the hospital is unknown and beyond the scope of the present investigation.

    Illinois maintains other important distinctions between its management of civil and criminal committees. Civil commitments are each time limited (60 days, 60 days, 180 days, 180 days . . .) and recommittment is necessary to continue hospitalization at the end of each commitment period. Once committed, insanity acquittees remain hospitalized until the end of the corresponding criminal sentence if convicted, unless otherwise released by the criminal court upon petition that the commitment criteria are no longer present; no periodic recommitment is necessary.
15. The assignment of these ten cases in this manner seemed to most accurately reflect the choice of the appropriate criterion by the judge. For any of the cases in the study, individuals who were seen as imminently dangerous and mentally ill (SIA) would qualify for commitment under either SIA or INPT. Checking both criteria was thus interpreted as a statement that either status could apply. Assigning these ten cases to the SIA group placed them into the category to which they were more comparable.
16. Six diagnostic groups were used. They consisted of: (1) schizophrenia; (2) schizoaffective disorder; (3) major depressive disorder, bipolar disorder, dysthymic disorder; (4) brief reactive psychosis, paranoid disorder, atypical psychosis; (5) dementia, mental retardation, organic brain syndrome; and, (6) substance abuse disorders, no Axis 1 disorder with Axis 2 disorder, explosive personality disorder, malingering, posttraumatic stress disorder. Six groups of criminal charges were used: (1) murder, attempted murder; (2) rape, deviate sexual assault, indecent liberties with a child; (3) armed robbery, robbery; (4) armed violence, home invasion, aggravated battery, battery aggravated assault, intimidation; (5) burglary, forgery, auto theft, theft, criminal damage to property, aggravated arson, arson; and, (6) kidnapping, disorderly conduct, unauthorized use of a weapon, violation of probation.
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