Post-Hinckley Insanity Reform in Oregon

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The 1983 Oregon legislature responded to public pressure to narrow the application of the insanity defense by eliminating personality disordered individuals from consideration for an insanity verdict. This article examined the effects of the statutory change, and found no significant change in the frequency of insanity acquittals of personality disordered subjects between the three pre-reform years (n = 21) and the three post-reform years (n = 14). We also reviewed how the Psychiatric Security Review Board handled these patients once committed to their jurisdiction. We constructed a matched comparison group of psychotic acquittees and found that in the pre-reform years the personality disordered subjects spent less time in the system and less time in the hospital than the psychotic patients. However, in the post-reform years their time in the system and time in the hospital was the same as the psychotic controls. There were fewer decisions to discharge personality disordered patients from the system after the reform, although this difference may be due to factors other than the statutory reform itself. The conclusion is that narrowing the insanity defense is a worthy goal which may be difficult to achieve.

Insanity laws and systems for managing insanity acquittees, frequently subject to debate and revision, are particularly vulnerable to highly publicized and controversial trials.[1-3] This was recently demonstrated in the acquittal by reason of insanity of John Hinckley, Jr., after his attack upon President Reagan. Arguments were made in the press, in state legislatures, and in Congress to reform insanity laws so that fewer persons would be acquitted. There was interest in making this defense less accessible and in applying it more selectively.

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After the Hinckley decision the Insanity Defense Work Group of the American Psychiatric Association (APA) published a statement on the insanity defense which offered several potential reforms for consideration.[4] The APA statement discussed the problem of applying the insanity test to individuals with personality disorders and suggested narrowing the insanity defense to those with "severely abnormal mental conditions," roughly synonymous with psychotic mental illness. The APA also recommended elimination of the volitional arm of the American Law Institute (ALI) standard test for insanity because it was felt to be beyond the capacity of psychiatrists to apply this standard meaningfully. The volitional arm is that portion of the test by which a person may be found insane if, due to mental disease

or defect, he lacks substantial capacity, "to conform his conduct to the requirements of the law."[5]

Further debate concerning the volitional arm of the ALI test has been advanced. Rachlin *et al.*[6] presented an argument against its use, focusing upon personality disorders and pathological gambling as controversial examples. They believed that the elimination of the volitional arm would correct much of the abuse of the insanity system. Rogers[3] voiced an opposing argument in a position taken by the American Psychological Association, arguing that the validity and reliability of the volitional component were not properly studied, making elimination premature. His preliminary studies using a standard tool for assessing volitional capacity showed approximately equal reliability between cognition and volition. Rogers' criteria for assessment of volition fell into five areas: ability to make choices, capacity for delay, disregard for apprehension, forseeability and avoidability, and the relationship to a mental disorder.

Consider the complex network of political, social, legal, and scientific forces operating on the various insanity systems in the 50 states and the federal system. Sorting and organizing some of this information, Callahan *et al.*[7] catalogued statutory changes before and after the Hinckley trial. More states reformed their laws in the years after Hinckley than before. Although more than one factor was postulated, it appeared likely that the public outcry to the Hinckley verdict was instrumental in motivating these changes. Reforms were seen in all aspects of the system, including changes in the definition of the test of insanity, whether the burden of proof falls to the state or the defendant, the standard of proof (the degree of certainty required), trial procedures, release and/or posttrial committment procedures, and the nature of the insanity verdict (as in creation of a guilty but mentally ill category).

Few data exist to assess the functioning of the insanity systems in most states. In 1978 Oregon created the Psychiatric Security Review Board (PSRB), a body similar to a parole board with jurisdiction over insanity acquittees. Oregon researchers have made use of the centralization of data by studying various aspects of the PSRB and characteristics of insanity acquittees.[8-11] Most of this data is related to the participants and the system after the trial. Less attention has been focused in Oregon and elsewhere on legal and psychiatric events which take place before trial. An exception is the 1981 study of the Missouri system by Petrila *et al.*,[12] who found problems in the pretrial exchange of information between the legal and psychiatric domains. Court orders requesting mental health input varied greatly in their specificity and relevance to individual cases. Courts usually relied on "form" orders. The mental health response was generally to ignore the court orders and to base the report upon perceived statutory requirements. When specific psychiatric input outside these statutory requirements was required, it frequently was not provided.

The Oregon Experience

As occurred in many state legislatures after the Hinckley verdict, the 1983 Oregon Legislature considered several bills designed to make the law responsive to public and professional opinion that problems existed in the way offenders were handled in the insanity system.[13] Legislative debate highlighted these specific concerns: (1) an insanity trial was perceived as no more than a "battle of the experts," (2) the number of insanity acquittees in Oregon was too large and continuing to grow, (3) criminals were "beating the rap" by avoiding punishment for crimes, (4) the wording "substantial capacity" in the ALI test constituted a legal rather than a medical or scientific determination, (5) the volitional arm of the test lacked professional agreement in its application to potential acquittees, and (6) the insanity system was very costly. In addition, forensic psychiatrists from the Oregon State Hospital testified to the legislature about the difficulties treating personality disordered individuals assigned to the PSRB system.

Three separate reform bills were introduced, all of which would have changed the test for insanity so substantially as to make acquittals all but nonexistent. Implicitly and parenthetically under scrutiny was the degree of confidence in the PSRB itself. Most features of the ALI test, including the "substantial capacity" language, were left intact. In fact, from a long list of original concerns the legislature amended the insanity statute in only two areas.

First, having previously (in 1978) abandoned the term "not guilty by reason of insanity" for "not responsible . . . as a result of mental disease or defect," the term was changed again, to "guilty except for insanity."[9,15] This new wording was felt to describe more accurately the legal thinking and philosophy which gives rise to the insanity defense, that "except for" the additional mental status testimony about appreciation of criminality or ability to conform conduct, the individual would be found guilty. Furthermore, to label the individual as "not responsible" was considered countertherapeutic in a clinical setting where taking responsibility for one's life is often a paramount objective. The result continues to be a traditional insanity acquittal; it is clearly distinguished from the "guilty but mentally ill" verdict developed in other states.

Second, the exclusionary section of the insanity test was expanded as follows (new wording emphasized): ". . . the terms 'mental disease or defect' do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct, *nor do they include any abnormality constituting solely a personality disorder.*"[14] This law became effective on January 1, 1984.

This article examines the effect of this second legislative change by measuring whether personality disordered offenders were eliminated from entering the insanity system. Also, since personality disordered insanity acquittees were specifically described to the Legislature as presenting significant treatment problems, we describe how these individuals, once committed to the PSRB, have fared

in the system prior to and after the 1983 legislative change.

Methods

All insanity acquittees placed under the jurisdiction of the PSRB from 1978 to 1986 have been entered into a research data base maintained by the Department of Psychiatry at the Oregon Health Sciences University and updated annually. From this larger data base a sample was taken which consists of persons:

1. committed to the jurisdiction of the PSRB in calendar years 1981 to 1986 (three "pre-reform" years and three "post-reform" years),
2. committed to Oregon State Hospital (OSH) for at least part of their jurisdictional time, and
3. diagnosed by OSH physicians as suffering from a personality disorder as the primary diagnosis.

This resulted in a sample of 35 patients, comprised of 21 pre-reform patients and 14 post-reform patients. To form a comparison group, the personality disordered subjects were matched with a group of subjects with diagnoses of psychoses. The comparison group was matched on the basis of sex, age, severity of the criminal act that resulted in an insanity acquittal, and date of entry into PSRB jurisdiction. The study and control groups were then compared with regard to total time spent under PSRB supervision, time spent in hospital, time spent on monitored conditional release, and discharge parameters in the three years pre- and post-reform.

Results

Among the total number of persons assigned to the PSRB for whom there was a diagnosis, the personality disordered subjects comprised 10 percent (21 of 187) in the three pre-reform years and 8 percent (14 of 165) in the three post-reform years, a difference which is not statistically significant ($\chi^2 = .36$, $df = 1$, $p = .55$). No significant changes were found in the other parameters studied (Table 1): numbers of men and women, age, and crime severity based on a previously constructed scale that categorizes crime severity from 10 (for murder) to 830 (for false fire alarm).[16]

Figures 1 and 2 present the results on how the subjects and their matched controls were managed under PSRB jurisdiction. Time in the hospital may be shortened by granting conditional release to community placement, or by

Table 1
Data on Personality Disordered Patients

	1981–1983 (Pre-reform)	1984–1986 (Post-reform)
Number	21	14
Men	20	11
Women	1	3
Mean age	26	31
Mean Severity Score	313	340

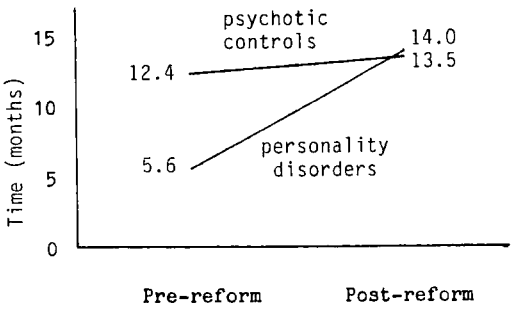

Figure 1. Mean time in hospital.

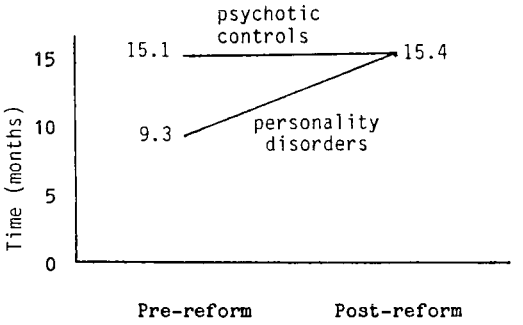

Figure 2. Mean time under PSRB.

exercising discretion to discharge the individual. Time under jurisdiction may be shortened only by discretionary discharge. (The Board employs "discretion" by finding the individual no longer mentally ill or no longer dangerous, either of which compels a discharge from jurisdiction.) In the pre-reform years the study subjects spent less time in the hospital and less time under the Board's jurisdiction than the control group. In the post-reform years this difference disappeared. Using analysis of variance for the data on time in the hospital ($df = 1$, $F = 2.69$, $p = .11$) and time under jurisdiction ($df = 1$, $F = 1.55$, $p = 0.22$), the differences are short of statistical significance, but indicate a trend in the operation of the PSRB that is consistent with other findings discussed below.

When an insanity verdict is made, the criminal court judge determines the maximum possible length of PSRB jurisdiction, based on the maximum sentence allowed for the crimes charged. When this "insanity sentence" elapses, a mandatory discharge from PSRB jurisdiction occurs. Death is another result that terminates jurisdiction outside of discretionary authority. Table 2 gives data on how often the PSRB used its discretionary power. In the three pre-reform years, there were a significantly greater number of discretionary discharges for personality disordered patients when compared with the psychotic control group. In the post-reform years the pattern of outcomes for personality disordered subjects and psychotic controls was more similar due in part to the small numbers, but also to a sharply reduced use of discretionary discharge for personality disordered patients.

Discussion

The legislative reform discussed here appears not to have succeeded in its attempt to narrow the insanity defense by excluding individuals with only personality disorder diagnoses. In fact, their relative numbers for entry into the PSRB system were not even reduced to a statistically significant degree. This conclusion is subject to several limitations. First, we are unable to assess the effectiveness of the legislative change by measuring the true negative rate, the proportion of ultimate convictions among persons raising the insanity defense. Currently we have no practical, efficient way to extract data on these individuals from the judicial system.

Second, the diagnoses used in this study may not have been the same as those considered by the trial court. Our data look at the clinical diagnosis made after the insanity acquittal. In research on the insanity defense system, there are two potential points of diagnosis, the pretrial diagnosis and the posttrial (state hospital) diagnosis. We do not yet know

Table 2
Management of Insanity Acquittees by PSRB

	Pre-Reform Years (1981–1983)					
	Retained		Discretionary Discharges		Elapsed or Died	
	n	%	n	%	n	%
Personality disorders	8	38	12	57	1	5
Psychotic controls	12	57	4	19	5	24

N = 42; $\chi^2 = 7.47$; $df = 2$; $p = .02$.

	Post-Reform Years (1984–1986)					
	Retained		Discretionary Discharges		Elapsed or Died	
	n	%	n	%	n	%
Personality disorders	8	57	4	29	2	14
Psychotic controls	11	79	1	7	2	14

N = 28; $\chi^2 = 2.27$; $df = 2$; $p = .32$.

the level of congruence of these diagnoses.

Why has there been no apparent effect from the legislative reform? Explanations may be based on either an assumption that the diagnoses made before and after the trial are congruent, or that they are not. The pretrial and state hospital diagnoses may both be personality disorder (theoretically precluding an insanity verdict), but the courts may be applying broad individual standards to defendants they perceive as insane. The judges may be relying less upon expert testimony and diagnosis, handing down verdicts based upon their own subjective and objective perceptions. Alternatively, the court may be given expert testimony that an Axis I mental illness is present in an individual who is subsequently diagnosed at the state hospital as suffering solely from a personality disorder. To study this further, we have begun an investigation of the pretrial mental health input in these controversial cases. Our follow-up investigation will allow us to compare pretrial and posttrial diagnoses in the prereform and postreform period and more adequately speak to the effectiveness of the 1983 legislative change.

The second part of our present study focuses on how personality disordered patients were handled by the PSRB when compared with a matched group of psychotic insanity acquittees. In the pre-reform period they were discharged significantly more than the psychotic control patients, whereas in the post-reform period this difference disappears and personality disordered subjects spent more time under the Board and more time in the hospital. We believe that the two events are unrelated to the statutory change *per se* but reflect factors that led to this statutory change. In a recent study[17] of trends in the entire PSRB population, it was demonstrated that substantial increases in the hospital census have been due in large measure to a lowered rate of discretionary discharges (of patients released from juris-

diction as either no longer mentally ill or no longer dangerous). We postulate that this phenomenon may be due to one or more of several factors, such as individual changes in the personnel comprising the PSRB, a generally conservative trend in the country that leads to greater restrictiveness in releasing mentally ill offenders, the specific social climate engendered by the Hinckley verdict, reduced community placement resources available to the insanity acquittee, and/or newly surfaced fears of civil liability with regard to opening the doors for this category of persons.

Regardless of the reason, this study demonstrates that personality disordered insanity acquittees who in the pre-reform period were, in a sense, weeded out of the system, were in the post-reform period kept significantly longer in the system. This is exactly the opposite outcome that the state hospital psychiatrists charged with the care of these patients desired when they proposed the legislative reforms.

In our opinion personality disordered patients were rightly considered a suitable target for legislative reform. Clinicians treating forensic inpatients often speak anecdotally about their inappropriateness of admission, the difficulty treating them, and the danger they often pose to the treatment environment of other patients.

The personality disordered acquittee also clogs the system. Often considered too dangerous for unconditional discharge, they have characteristics that do not favor conditional release. During the term of a conditional release in Oregon, supervision continues on an outpatient basis, and generally the following are required of the patient: a state of remission from mental symptoms, an appreciation for the mental illness, active participation in the management of the mental illness, cooperation with social structure and standards, compliance with therapies (particularly medications), and ability to live in a group home or adult foster care home. This set of guidelines for release is more readily applicable to patients with psychotic illnesses than to those with personality disorders.[18] Unable to conform to the guidelines for conditional release, these individuals spend more potentially unproductive time confined in the hospital. The retention of these patients in the hospital therefore begins to resemble preventive detention, decried recently by Applebaum.[19] They also comprise the group of individuals recommended for transfer to corrections by the APA Insanity Defense Work Group,[4] a position which has proven exceedingly difficult to implement.

Legislative changes are often in reaction to a specific case or situation. Although they may apply well to the original case, there can be consequences by which the law either does more than expected, or less. From the data available the attempt to keep the personality disordered individuals out of the insanity system by eliminating them at the front end of the process does not yet appear to have had the desired goal in Oregon. Discharging them once they have been assigned to PSRB jurisdiction, by finding that they are no longer men-

tally ill, is a method that was common in Oregon in the pre-reform period but is no longer widely applied. Appropriate and fair narrowing of the insanity defense is a worthy goal not easily realized.

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