Recent Political and Research Appraisals of the Psychiatric Security Review Board Model

Katherine Michaelsen, MD, MASc, Chandrika Shankar, MD, and Michael A. Norko, MD, MAR

Professional, political, and public debates are ongoing regarding the best way to assess risk and monitor individuals who have been found not guilty by reason of insanity (NGRI). Political and public impressions are often confounded by few, often dramatic and highly publicized cases of NGRI acquittees reoffending, rather than by an accurate understanding of the process and actual rearrest rates. States have implemented their own policies and practices for NGRI pleas (if allowed) and the subsequent evaluations, monitoring, and care for acquitted individuals, resulting in significant variation across jurisdictions. In the last five years, Arizona dissolved its Psychiatric Security Review Board (PSRB) and there were calls for ending the Connecticut PSRB. We review some of the past and current practices and evidence from PSRBs in Oregon, Arizona, Connecticut, and Washington. We discuss the challenges of comparing state practices because of variation in the connections between policy and practice and competing stakeholders' interests.

J Am Acad Psychiatry Law 54(1) online, 2026. DOI:10.29158/JAAPL.260006-26

Key words: insanity acquittees; conditional release; discharge; Psychiatric Security Review Board; community monitoring; recidivism

Disposition of individuals found not guilty by reason of insanity (NGRI) requires balancing timely discharge with community safety. The Journal has published several articles on concerns about hospital length of stay for acquittees,[1,2] especially given the decline in state hospital beds,[3] with 43 states reporting a shortage in 2025;[4] their increasing use for forensic purposes;[5] and the utility of conditional release.[2,6,7]

The public, policy makers, and professionals debate the management and monitoring of individuals found NGRI for violent crimes, with reforms often following high-profile cases. For example, after the *Hinckley* case,[8] 34 states revised NGRI pleas, commitment, or release policies, typically adding restrictive measures, such as shifting the burden of proof to the defendants, requiring additional review before release, and narrowing the insanity test criteria, with similar changes in the federal system.[9,10] In the late 1970s through 90s, Kansas, Montana, Idaho, and Utah abolished the defense, although the last three permit "guilty but insane" verdicts.

Most acquittees are initially hospitalized in state facilities for treatment and safety.[11] Although they can only be held while "both mentally ill and dangerous" (Ref. 12, p 77), debate remains over who should make this determination and on what basis,[13,14] as well as what postdischarge oversight is necessary versus permitted. States that allow the defense have a variety of procedures and resources to balance public

Published online March 2, 2026.

Dr. Michaelsen is an assistant professor, Center for Mental Health, Policy, and the Law, Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, WA. Dr. Shankar is an associate professor, Department of Psychiatry and Behavioral Sciences, Northwestern Memorial Hospital, Feinberg School of Medicine, Northwestern University, Evanston, IL. Dr. Norko is Professor Emeritus, Division of Law and Psychiatry, Department of Psychiatry, Yale School of Medicine, New Haven, CT. Address correspondence to: Katherine Michaelsen, MD, MASc. E-mail: michaelk@uw.edu.

Dr. Norko is involved in the editorial leadership of The Journal; however, he did not participate in any aspect of this article's review and acceptance.

Disclosures of financial or other potential conflicts of interest: None.

Dr. Michaelsen is Vice Chair of the Washington PSRP; Dr. Shankar is the former Vice Chair of the Arizona PSRB; Dr. Norko co-chaired the Working Group in Connecticut that produced Reference 52.

Copyright 2026 by American Academy of Psychiatry and the Law.

safety with acquittees' rights and treatment needs, resulting in multiple models.

Over four decades ago, the American Psychiatric Association's "Statement on the Insanity Defense"[15] supported broader adoption of the Psychiatric Security Review Board (PSRB or Board) model, echoed more recently by the Treatment Advocacy Center's (TAC) state survey and ranking, which highlighted very low rearrest and reoffense rates, standardized release criteria, and treatment plans for acquittees discharged under board jurisdiction.[16] The TAC reflected on the then existing Boards (Oregon, Connecticut, Arizona, and Washington), noting that a state had to have such a designated body to receive the highest grading.[16] Despite initial interest in PSRBs and expectation of broader adoption in the 1980s and 90s,[17] very few states have implemented them. Further, the Arizona legislature dissolved its Board after concerns about public safety following a repeat murder by an individual newly granted conditional release.[18] Recently, advocates called for dissolving Connecticut's PSRB, citing concerns over excessively long hospital stays.[19] Given recent scrutiny of board oversight and diverging concerns, we review current and past PSRB practices, available evidence, and limitations for guiding practice and policy decisions, along with procedures in states using alternative models for managing insanity acquittees.

PSRBs

PSRBs are official bodies authorized in state statute to monitor and govern the management of insanity acquittees, apart from the treatment services that acquittees receive. The Connecticut and Oregon Boards are well described in the literature and have reported low rates of recidivism (see below). Both Boards have members representing various professions, including psychiatrist, psychologist, probation or parole officer, attorney, and member of the public, although the Connecticut Board also includes a member of the public with victim advocacy experience.

Oregon

The Oregon Board was created in 1978. Individuals acquitted as "guilty except for insanity" (GEI) and deemed mentally ill and dangerous are assigned by the trial court to the jurisdiction of the Board for a term no longer than the maximum sentence the individual could have received for a criminal conviction. The court may also determine that an individual can be adequately controlled in the community and order a direct conditional release under the jurisdiction of the PSRB.[20] The Board has jurisdiction over the duration of inpatient treatment, conditional release, and final discharge. Starting in 2012, it no longer had jurisdiction over GEI for misdemeanor charges,[21] and instead, judges could commit GEI misdemeanants to the state hospital if they remain mentally ill and a "substantial danger to others."[22] As of January 1, 2024, there were 613 GEI adults, 42 percent of whom were inpatients at Oregon State Hospital and 57 percent on some sort of conditional release in the community, including 11 percent (of the 613) in locked residential treatment facilities.[23]

Of men with schizophrenia or schizoaffective disorder under the Oregon Board who were discharged between 1981 and 1985, 15 percent had a criminal charge while under the Board.[24] For those with final discharge and at least one year of follow-up data during this time, 53 percent had criminal charges (43% for felonies).[24] In a later 10-year review of all the acquittees under the Board, Oregon reported that only 2.6 percent of 494 revocations were related to new felony-level charges.[21] A more recent report to the legislature indicated an average of .61 percent recidivism rate from 2011 to 2021 for individuals on conditional release (using only convictions for felonies and misdemeanors as evidence of recidivism).[25]

A few highly publicized cases, where individuals who were discharged from the Board after being deemed not mentally ill subsequently committed violent crimes, promoted scrutiny of the PSRB along with lawsuits by victims' families.[26] In 2019, the Oregon legislature commissioned a work group to "address concerns about the PSRB process" (Ref. 27, p 4). The workgroup raised concerns about GEI evaluator training and recommended stricter certification. It also raised concerns about discharges when individuals lacked a qualifying mental health condition yet posed a substantial danger to others (Ref. 27, p 15). They considered several legislative remedies, including a malingering statute, rereferring fraudulent pleas for prosecutions, or provisional or deferred GEI adjudication (allowing time for monitoring symptoms), but ultimately chose not to recommend any (Ref. 27, p 26-8).

Connecticut

Connecticut created its PSRB in 1985 after scrutiny of post-NGRI monitoring following two significant

legal cases: the attempted assassination of President Ronald Reagan by John Hinkley Jr. and a local case of a man found NGRI for killing his wife who was charged five years later with killing his second wife.[28] The Connecticut Board oversees felony insanity acquittees similar to the Oregon Board, although the criminal court decides final discharge based on PSRB recommendations. Commitments cannot exceed the crime's maximum sentence. The PSRB may grant temporary leave from the hospital or conditional release. Hearings require a written progress report from the treaters and testimony by a forensic expert, and allow questioning by defense and prosecution. In March 2023, 145 acquittees were under the jurisdiction of the Connecticut PSRB, with 73 percent hospitalized and 25.5 percent in the community under conditional release.[29]

Over 30 years, almost one-third of acquittees (31.1%) had their conditional release revoked, but there were only four arrests out of 177 acquittees (2.3%), with no felony charges.[28] After final discharge, the arrest rate increased to 32 of 196 individuals (16.3% arrested at least once), with 17 of these initial arrests related to felony charges. In one of the few direct state comparisons of which we are aware (looking at individuals found NGRI from 1985 to 1987 and followed for at least five years in Connecticut, New York, Maryland, and Ohio), Connecticut showed longer hospital stays and more difficulty obtaining conditional release, regardless of original offense.[30]

Recently, the Connecticut Board faced scrutiny after officials uncovered abuse of an inpatient acquittee at the state forensic hospital.[31,32] The state created a task force to review hospital practices, and a majority of the members recommended considering abolishing the Board, citing prolonged hospitalization, rights violations, and nonclinical decision-making.[19] The legislature convened a working group to review PSRB processes and procedures[33,34] and, in the interim, enacted and proposed legislation to change the Board's case review procedures.[34,35] The work group report ultimately concluded that the Connecticut PSRB system was not inferior to other state practices.

Arizona

In 1993, Arizona established its PSRB modeled on Oregon and changed the NGRI verdict to "guilty except insane" (GEI). The Board had a similar structure to Oregon's but lacked an attorney, and the fifth position was an additional psychologist or psychiatrist. Once adjudicated GEI for a crime that caused or threatened death or serious physical injury, the acquittee was placed under the jurisdiction of the Board for a period equal to the sentence for the crime[36] and could not be discharged before the end of the presumptive sentence.

If the Board determined an acquittee was in stable remission and no longer dangerous, it could order conditional release to either remain in Arizona State Hospital (ASH) with the ability to leave the grounds with varying privileges and passes or discharge to the community under a mental health agency's supervision.[36] Violation of community treatment plans allowed the Board to revoke conditional release and return individuals to the hospital.[36] For their reviews, the Board mostly relied on written hospital reports, with occasional testimony from the acquittee or other interested parties.

Starting in 2007, the legislature required judges to sentence individuals found GEI first to a term of incarceration under the Department of Corrections and then commit the individual to the jurisdiction of the Board for the term of their sentence.[37] The PSRB could then order an individual deemed "dangerous or [having] a propensity to reoffend" but no longer mentally ill to be "transferred to the state department of corrections for the remainder of the sentence."[38]

In 2018, the Office of the Auditor General's (AG) Performance Audit and Sunset Review of the PSRB raised concerns about the Board's ability to gather relevant and timely information from the hospital.[39] In response, the Board standardized hospital reporting, defined risk assessment criteria, and created ongoing education to ASH and community providers. The AG's 2020 follow-up report noted that the audit concerns were satisfactorily addressed.[40] These improvements coincided with changes in the ASH leadership, who were more collaborative and appreciative of the Board's oversight (James P. Clark, former PSRB chair, personal communication, May 2024).

In 2020, the PSRB had jurisdiction of 115 individuals (mistyped as 113 in the report), with 96 housed at ASH (83.5%), 32 on conditional release (18 residing in the community), and one member confined in the Department of Corrections.[41] Since its inception, only two individuals under PSRB had been rearrested (Clark, personal communication, May 2024).

In 2021, a GEI acquittee who killed his grandparents in 2005, and who was released to a step-down

facility less than a year prior, was charged with the murder of his group home roommate.[42] With growing scrutiny of the Board, Arizona approved Senate Bill 1839 (2021), scheduling the start of the PSRB repeal for July 1, 2023,[18] with transfer of GEI jurisdiction to the superior courts. Coupled with the COVID-19 pandemic, resignations, and difficulty filling open positions, the Board lacked a quorum to meet after January 2022, effectively abolishing the PSRB ahead of the planned repeal.

Washington

In 2010, after a person found NGRI for homicide left a group outing and went missing for three days, Washington created the Public Safety Review Panel (PSRP)[43] to ensure that the Secretary of the Department of Social and Health Services (DSHS) and courts receive an objective second opinion regarding the risks to public safety. Unlike the PSRBs, the PSRP is only advisory and has no decision-making authority. The PSRP reviews hospital recommendations related to leaves, conditional release, revocation, and unconditional release of acquittees as well as least restrictive placements for acquittees and individuals found incompetent to stand trial and not restorable for violent crimes. The panel consists of a psychiatrist, licensed clinical psychologist, Department of Corrections representative, prosecutor, public defender, law enforcement representative, and consumer and family advocate representative.

Acquittees are committed up to the maximum sentence for the crime but may be released early if no longer mentally ill or dangerous. When a treatment team or an acquittee requests a change in status, each facility has a Risk Review Board (RRB) composed of clinicians not directly involved in the patient's care that reviews the case before it goes to the PSRP. The PSRP only reviews hospital information for acquittees under consideration for status change. It meets monthly to discuss cases and vote to support, not support, or provisionally support a proposed change (typically partial support or support with particular conditions in place). The courts then adjudicate the request, and the hearings may be agreed upon or contested. As the PSRP is a purely consultative body, its recommendations may be disregarded by the courts (and the hospital), sometimes in favor of acquittees' requests.

Although data about acquittees are sparse, a 2014 report for the state suggested that Washington's acquittees had lengthier hospitalizations than other states, inadequate processes for evaluating and moving acquittees through hospitalization and into the community, gaps in inpatient treatment, and inadequate community services to facilitate the transition to outpatient care.[44] Since then, DSHS and the two state hospitals have taken steps to address some of these concerns.

According to the 2014 report, Eastern State Hospital documented three arrests of individuals on conditional release over the past 10 years (with roughly 45 individuals on conditional release at any point in time: 35 in the community and 10 still residing in the hospital).[44] Western State Hospital also reported a low recidivism rate (less than one percent, although recidivism was not defined) for its conditional release population (encompassing roughly 75 individuals).[44] According to the state's data for December 31, 2023, roughly 71 percent of the 272 acquittees were hospitalized in one of the state hospitals (Lisa Wolph, PSRP Executive Director, personal communication, May 2024).

The PSRP has expressed concerns about the need to improve consistency between the two hospitals (and now an additional treatment facility), implement changes to hospital risk assessment and supervision practices, improve the hospitals' collection of data, and develop a forensic culture (e.g., using the correct legal standard rather than civil commitment criteria).[45,46] Further challenges include limited supportive housing available in the community and inconsistent treatment resources for risk factors like substance use and cognitive impairments.[46]

Another concern is the increasing demands on the all-voluntary PSRP members, including recent efforts to subpoena its chair by defense attorneys and the escalating number of referrals.[46] A 2017 bill granting PSRP quasi-judicial authority similar to PSRBs failed.[47]

Comparing Practices and Evidence

The 2014 National Association of State Mental Health Program Directors (NASMHPD) report, one of the largest surveys to date, identified significant variation in states' practices[11] (echoed in TAC's 2017 report[16]). Notably, 41 of 42 respondents to the survey indicated that the insanity defense is recognized in their state, including three states where it was abolished;[11] NASMHPD concluded that these responses may reflect practical use of the insanity defense, conceivably through increased use of the *mens rea* approach or increased dismissals for incompetency to stand trial.[48,49] The TAC report

suggested that these responses may be a result of respondent confusion about state regulations.

According to the 2014 NASMHPD survey, 14 of 33 states responding had zero to 10 new insanity inpatient commitments annually and four states had more than 60, with the rest falling in between.[11] Three of 28 states reported that greater than 20 percent of NGRI acquittees were conditionally released at verdict.[11] The criteria for hospital commitment in all states is based on mental illness and dangerousness, with Georgia's statute being most explicit about using civil commitment criteria: "(i). . . presents a substantial risk of imminent harm to that person or others, as manifested by either recent overt acts or recent expressed threats of violence which present a probability of physical injury to that person or other persons; or (ii) Who is so unable to care for that person's own physical health and safety as to create an imminently life-endangering crisis,"[50] and in either situation, the person must also be "in need of involuntary inpatient treatment."[51]

In addition to obtaining information from our own states and reviewing the literature on other states, one of the authors (MAN) surveyed the NASMHPD forensic directors' listserv in 2023 to request information about current practices as part of a review for the Connecticut legislature. Two email requests were sent. Seventeen states responded with information; thereafter, specific questions were posed to responding forensic directors to clarify statutes, policies, and procedures as necessary. The following details are derived from these queries.[52]

Many states set maximum possible criminal sentence as the maximum commitment period. A few use indeterminate commitment with release hearings when clinically indicated. Several others have no set limit, but annual or earlier recommitment hearings are required[52] (see Table 1[53,54]).

Length of hospitalization is an often-referenced metric for acquittee care. In the NASMHPD survey, 2 of 27 states had average length of stay of up to one year and eight states had more than seven years, with the rest falling in between.[11]

The data on average length of stay vary widely with no clear connection to PSRBs or use of conditional release, ranging from 4.1 to 10.7 years[52] (see Table 2[55,57]). A New York study found no benefit from longer hospitalization,[1] whereas Connecticut data suggested that longer hospitalization and conditional release periods seemed protective against future rearrest[28] but could not determine whether longer hospitalization, *per se*, was the relevant factor (e.g., whether shorter periods of hospitalization with equally long periods of conditional release would have been associated with lower recidivism rates).[28]

A related metric is the proportion of acquittees in hospitals in states permitting conditional release, ranging from 36 to 88 percent, although available data show no clear link to system features, including the presence of PSRB[52] (see Table 2; Wolph, personal communication, May 2024).

Data on rehospitalization after release are limited (see Table 2). Conditional release revocation rates range from 31 percent in Connecticut (since PSRB inception) to .63 percent in 2020 for Oregon (although they note 25% of court-ordered conditional releases fail within six months).[52] Thirty individuals with conditional release were returned over five and a half years in Washington (87 individuals were conditionally released at least once over the 10-year span from 2014 to 2023 that encompasses these five years) (Wolph, personal communication, May 2024). Revocation of conditional release varies between 1 and 31 percent among states (Table 2).[52] In North Carolina, where there is no conditional release system, the rate of rehospitalization was 28 percent (from 1 to 22.6-year follow-up, median time to rehospitalization was 1.8 years).[2]

Criminal recidivism rates are difficult to compare because of limited, inconsistently defined data (see Table 2). Recidivism may be used to refer to rehospitalization, rearrests, reconviction (any or violent offenses), or reincarceration. States with PSRBs report relatively low criminal recidivism rates, although this increases after final discharge from Boards' oversight. Maryland reported a 2.5 percent arrest rate over five years of community exposure (.53% for violent crime), whereas New York reported 21 percent over an average of 14 years of community exposure (11% for violent offense, two-thirds occurred by five years).[52] By comparison, North Carolina has a 15 percent reconviction rate after discharge (4.9% for violent offenses, with the follow-up from 1 to 22.6 years), with a median time to reconviction of 2.0 years.[2]

In contrast, state prisoners from 30 states released in 2005 and followed for nine years showed high recidivism rates, defined as rearrest for a new crime: 68 percent first rearrest by three years after release, 83 percent by nine years after release (with many individuals rearrested multiple times).[58] In the Connecticut study of acquittees released from the PSRB, rearrest rates averaged 16.3 percent over a

Table 1 Policy and Practice Comparisons Between States[52]

	Time Limit on Original Commitment	Conditional Release Process	Internal Review Process for Release or Discharge	Statutory Language Re Priority or Goals in Decision-Making	Release from Hospital Decisions
OR	As ordered, not to exceed max prison sentence	Internal review process grants "CR readiness" privilege prior to requesting that the Board order evaluation for CR by community MH agency; results in hearing before PSRB	Internal review process grants "CR readiness" privilege prior to requesting that the Board order evaluation for CR by community MH agency	From PSRB Work Group: "protect the public and balance the public's concern for safety with the rights of the client" (Ref. 27, p 13); from ORS 161.351(3): "the board shall have as its primary concern the protection of society"	PSRB
CT	As ordered, not to exceed max prison sentence	Hospital or patient petition PSRB; results in hearing before PSRB	Consulting forensic psychiatrists and forensic review committee	Safety of public and well-being of patient	PSRB
AZ	Committed for length of possible sentence	Court and community treatment provider must agree on CR plan; court orders CR and conditions	State hospital, community provider, and court agree on plan for CR	Public safety and protection are primary	Court
WA	Not to exceed max prison sentence	Hospital or patient petition court; hospital's materials, recommendations sent to PSRP for review and recommendation, which is sent to the court and designee of Secretary of DSHS	Forensic evaluator from OFMHS, hospital-based care coordinator, and hospital-based Risk Review Board	Safety of the public primary; petitioner must show by a preponderance of the evidence	Court
CA	Max possible sentence (for inpatient commitment); conditional release program (CONREP) portion indeterminate	Hospital medical director recommends CONREP; court decides	Hospital medical director or community program director, as applicable	Danger to the health and safety of others	Court
GA	Court may order commitment for six mos; chief medical officer may apply for order of continued hospitalization	Team drafts CR plan; reviewed by hospital forensic director, external FRC (if serious violent felony), then FRC, then clinical director, then hospital administrator, then to court for hearing and review	Team drafts CR plan; reviewed by hospital forensic director, external FRC (if serious violent felony), then FRC, then clinical director, then hospital administrator	Civil commitment criteria	Court
HI	No	After 90 days, hospital director or patient may apply	Three concurrent, independent forensic evaluations completed as part of CR involving felony charges (including at least one psychiatrist)[53]	Danger to persons or property	Court
MA	Six mos; then one yr recommitments	None	Medical director or superintendent, after independent forensic risk assessment	Likelihood of serious harm	Court
MD	Indeterminate	Hospital requests release hearing with ALJ, who makes recommendation to criminal court. Initial CR is five yrs, can be extended	Forensic Review Board for inpatients; "Central Admissions Office" for those on CR	Danger to self, others, or property	Court

Table 1 Continued

	Time Limit on Original Commitment	Conditional Release Process	Internal Review Process for Release or Discharge	Statutory Language Re Priority or Goals in Decision-Making	Release from Hospital Decisions
ME	No	Psychiatrist files report to Comm'r as soon as person may be released; Comm'r applies to court. In practice, patient encouraged to apply through attorney to facilitate a court date	Treatment team or psychiatrist to Comm'r; review by State Forensic Service	Likelihood of injury to self or others	Court
MN	Indeterminate	SRB and Comm'r make decision; called "provisional discharge"	SRB and Comm'r	Reasonable degree of safety for the public; will enable person to adjust successfully to community	SRB and Comm'r
MO[54]	Indeterminate	Treatment team to facility FRC, to COO, to state forensic director, to court. Courts generally grant release when DMH supports it. Patient may also request	Treatment team to FRC of facility, to COO, to state forensic director	Not now or likely in reasonable future to commit another violent crime because of mental illness; has capacity to conform behavior to requirements of law in future	Court
NC	Indeterminate	None; 1st release hearing at 50 days, then 90, then 180, then one yr	Periodic discharge panel meetings	No longer dangerous or no longer mentally ill	Court
NY	One yr for hospital commitment	Comm'r applies to court; hearing held. CR order for five yrs, may be renewed for five yrs indefinitely	Treating clinicians and OMH staff; court rarely disagrees with OMH recommendation	Presence of dangerous mental disorder	Court
OH	Max prison sentence; almost always committed for full time	Review by FRT, Forensic Center, and trial court	FRT and Forensic Centers review	LRA consistent with public safety and welfare of person; preference to public safety	Trial court
SC	Max possible sentence	Hospital director requests of court	Not specified in state interagency protocol	Likelihood of serious harm; lacks insight or capacity to make responsible decisions re treatment	Court
TN	No	Reviewed by COO and RMRC; court may hold hearing, where COO decision presumed correct but may be challenged	RMRC, COO	Likelihood of harm unless under court-ordered treatment, other factors	RMRC ± court
VA	Indeterminate; first hearing re continued commitment at one yr; for misdemeanors, max one yr	Petition by Comm'r, with CR plan jointly prepared by hospital and community service board	If one examiner (psychologist or psychiatrist) recommends release, 2nd examiner appointed; if 2nd agrees, recommend release to court and detailed CR plan created with community	Does not need inpatient, needs outpatient monitoring to prevent deterioration, appropriate outpatient available and significant reason to believe acquittee would comply with conditions and CR will not present "undue risk to public safety" (VA Code § 19.2-182.7)	Court

ALJ, administrative law judge; Comm'r, Commissioner; COO, Chief Operating Officer; CR, conditional release; DMH, Department of Mental Health; DSHS, Department of Social and Health Services; FRC, forensic review committee; FRT, forensic review team; LRA, least restrictive alternative; MH, mental health; mos, months; OFMHS, Office of Forensic Mental Health Services; OMH, Office of Mental Health; ORS, Oregon Revised Statutes; PSRB, Psychiatric Security Review Board; RMRC, Risk Management Review Committee; SRB, Special Review Board; yr, year.
We have noted where we used statutes or additional references outside the survey.

Table 2 State Data on Hospitalization, Recidivism

	Average Length of Hospitalization	% Acquittees in Hospital	Rehospitalization Rate	Rearrest Rate under Supervision	Rearrest Rate after Discharge from Monitoring
OR[27]	4.1 yrs	36%	In 2020, 0.63% were revoked and returned to hospital; separately, 25% of court-ordered CR fail within six mos	3.6% (felonies and misdemeanors) over seven yrs; annual recidivism rate 0.87%	Over seven yrs, 37.8% total (21.9% for felonies; 16% for misdemeanors); n.b. 29% of discharges still in hospital at time of discharge (i.e., no CR time)
CT[28]	10.7 yrs for those not arrested after discharge from PSRB; 5.8 yrs for those arrested after discharge	73%	31%	2.3% (half dismissed; half for misdemeanor; none for violence)	16.3% over avg of 12.5 yrs community exposure (11% for those on CR at time of discharge; 27.9% for those not on CR at discharge)
AZ[41]	—	83.5%	—	—	—
WA	—	71%	Over 5.5 yrs, 30 conditional release returns (variety of reasons)	—	—
CA[6]	4.3-8.2 yrs[a]	—	9%[16]	8.2%-44% during avg of 4.8 yrs follow-up[a]	—
MD[55]	—	—	31% per yr	0.53% for violent crimes; 2.5% per yr for all arrests over five yrs community exposure	—
MO[54,56]	7+ yrs at min security; 75.3 mos mean for most serious felonies in those who achieved CR, 92.3 mos for same crimes in those who did not achieve CR	54% (1997)	2016: 7% per yr (most voluntarily); 2023: 1% (3% highest in recent yrs)	—	—
NC[2]	8.1 yrs for those in hospital; 4.9 yrs for those released	100%; once released, no monitoring	28% (after final discharge)	na	15% reconviction (4.9% for violent offenses)
NY[1]	6.33 yrs	60% (1/2 in forensic hospitals, 1/2 in civil hospitals)	—	21% over avg 14 yrs community exposure (11% for violent offense); nearly half during 1st two yrs, 2/3 by yr five	—
VA[57]	61.6 mos	—	24.4% had CR revoked over three yr period	—	—

Blank cells represent data that were unavailable. No data available for GA, HI, MA, ME, MN, OH, SC, and TN.
avg, average; CR, conditional release; mos, months; PSRB, Psychiatric Security Review Board; yr, year.
[a]Depending on conditions of release.

mean follow-up period of 12 years, compared with 56 percent rearrest in two-year follow-up for released convicted offenders and 28.3 percent for released mentally ill offenders over 6 months follow-up.[28]

Thirty-one of the 37 states in the NASMHPD survey[11] reported conditional release programs. Significant discharge barriers noted were court or prosecutor opposition, lack of housing, risk assessment scores, limited

treatment resources, and community objection. Based on responses from 17 states (Table 1), decisions to release individuals from the hospital are generally made by the court, except for Connecticut and Oregon (the Board makes the decision) and Minnesota (the Commissioner of Mental Health and a special review board make the decision). Four states report their public mental health systems can release individuals without court authorization.[11] Most states utilize a multilayered internal review process consisting of clinicians, clinical leaders, hospital administrators, special review boards, and expert consultants (Table 1). Aside from Oregon, the decision to release someone from all supervision is generally made by the court, although in Massachusetts, the hospital medical director or hospital director may make that decision unless the court decides to hold a hearing on the matter.[52]

Most states' statutes prioritize public safety in their decisions regarding changes in acquittees' status, with variations having unclear practical impact (Table 1). Oregon adds "rights of the client." Ohio includes the welfare of the person (patient) but gives preference to public safety. In 2022, Connecticut added "well-being" of the patient as either a primary or secondary concern. Georgia's seemingly lower statutory bar (civil commitment criteria) implies the potential for easier release of acquittees, but according to its former Director of Forensic Services, their processes remain as lengthy as elsewhere (Ref. 52, p 28).

Three states have statutory schemes for cases where the individual is deemed inappropriate for insanity acquittal (e.g., having conditions excluded from the defense criteria). Arizona's process for transferring individuals to the correctional system[38] and Oregon's requirement for discharging a person (regardless of danger) are described above (Ref. 27, p 15). In contrast, Hawaii allows detention of acquittees based on dangerousness, even when no longer ill.[59]

In addition to the diversity of practices and metrics collected, state comparison has proved difficult because of the lack of consistent connection between official statues, policies, and the resulting practices.[30,56,60] Brakel's review of insanity acquittees' dispositions in Illinois, Maryland, and Oregon concluded that the programs were loosely connected to the law, some of the programs' key features were not legally bound, and program administrators and treatment providers had limited awareness of the regulatory nuances.[60] Similarly, a review of four states noted factors associated with conditional release varied by state, with certain diagnoses, seriousness of the offense, and personal characteristics each associated with lower likelihood of conditional release in some, but not others.[30] It also highlighted that system features, including centralization and adequacy of conditional release services and monitoring, affect program utilization. Gowensmith and colleagues found little uniformity among practices of conditional release evaluators from nine states.[13]

Reviews of policy also suggest disconnects between reforms and practice. For example, California, in 1982, shifted from the American Law Institute model to a modified M'Naughten standard, but it did not affect insanity plea or acquittal rates, defense characteristics, or confinement lengths in the three years after the reform.[61] Similarly, abolishing the insanity defense in Montana did not alter practical outcomes but led to more dismissals for incompetence to stand trial.[49,62]

In 1997, Linhorst conducted a comprehensive review of Missouri's acquittees, using data from other states to assess impact of their system design.[56] For the most part, variation in acquittee populations could not be connected with the system design. For example, Linhorst noted high rates of NGRI pleas despite restrictive acquittee release criteria. He speculated that responses to restrictive policy or policy changes could be confounded based on poor defense attorney awareness and communication about restrictive release criteria, lengthy hospitalizations incentivizing prosecutors and judges to allow and negotiate more NGRI acquittals, and individual variation in implementation (e.g., differences in frequency with which individual judges release acquittees directly to the community).[56] Variation in diagnoses, offense severity, and length of hospitalization also could not be explained by system design. Linhorst reflected that future research needs to evaluate both policy changes and implementation and concluded that some legislative changes may be enacted for optics (e.g., to appear tough on crime).[56]

Similar reviews of individuals found not criminally responsible on account of mental disorder (NCR) in Canada suggest that, despite a federally legislated criminal code, different provinces had distinct applications of legislation and practices for processing individuals through the forensic system, resulting in variations in length of hospital stay and time under supervision of a review board.[63]

McDermott and colleagues provided evidence for the value of conditional release after hospitalization

from a California state hospital with an average length of follow-up (date of discharge from the hospital to end of study) of 4.83 years.[6] Almost 45 percent of the acquittees released to the community without court-mandated supervision were arrested for another offense in the study period compared with 25 percent of those "restored to sanity" *via* treatment before being unconditionally released, versus just over eight percent of patients released under the supervision of the conditional release program.[6] They identified mandated community treatment as highly relevant to rearrest risk, even many years later, with a lengthy average time between discharge and arrest (median 3.5 years), presumably after years of relative stability. McDermott and colleagues also noted that, once mandated treatment ended, arrest rates became statistically comparable with those released from the hospital without supervision. A Connecticut study also noted higher rearrest rates for those who were discharged from the PSRB while not on conditional release compared with those who were on conditional release (27.9% versus 11%).[28]

Discussion

Despite APA's initial encouragement[15] and subsequent advocacy,[16] few states adopted PSRBs. In policy reforms, states often prioritize cost and recidivism as outcomes rather than psychological improvement or community adjustment.[60] Successful conditional release systems require adequate investment in community resources, including treatment and structured housing.[11,17,20,64,65] The best available data support conditional release monitoring and extending the oversight several years postrelease.

Although there is evidence of low recidivism in states with PSRBs, states without Boards have also reported low arrest rates on conditional release.[54,57] It is difficult to compare the impact of the PSRB models versus other states' practices on outcomes. High-profile cases have influenced states' adoption and rejection of PSRBs, fearing that Boards do not provide adequate oversight (as in Arizona) or are too restrictive (as in Connecticut). Further, Boards add expense, and it can be challenging to demonstrate cost savings or improvements because of the complexity inherent in release decisions and dependence on other elements of the system (e.g., adequate inpatient treatment prior to release or adequate housing and community mental health treatment) and specifics of individual cases (notoriety of offense, for example).

Regardless of the decision-making body, when considering policy changes, Georgia's experience with commitment criteria and the limited impact of other reforms underscores our conclusion that the systems for managing insanity acquittees are complex and have many stakeholders who can influence the outcome of any proposed statutory scheme. As with many complex systems, NGRI procedures may tend toward homeostasis, where changes lead to complementary shifts that maintain the status quo.[52] For example, eliminating recommitment to shorten time in hospital may lead to judges imposing longer initial commitments, prosecutors being more reluctant to agree to insanity defenses, and victims experiencing more distress (which may, in turn, influence prosecutorial decisions).[52]

PSRBs represent one model for the management of insanity acquittees. Available data are insufficient to compare the outcomes of this model with other methods of providing needed supervision of acquittees. Direct comparison of court versus Board outcomes is limited, but there are some suggestions that these decisions benefit from greater mental health expertise. For example, in Oregon, acquittees conditionally released directly to the community by the court, instead of being placed first in the state hospital and later conditionally released with a plan developed by the Board, were more likely to be revoked from conditional release or require transfer to a more structured level of care (e.g., from independent living to a secure residential treatment facility).[20]

The existing PSRBs provide a level of review outside the hospital care teams and infrastructure and benefit from interdisciplinary review and expertise in psychiatric knowledge, risk assessment, and community monitoring as well as dedicated time that the courts are typically lacking. Bloom and colleagues noted, "This centralization of authority allows the development of policy, expertise, and experience that is not possible to achieve when these decisions are left in the hands of a diverse group of trial court judges" (Ref. 17, p 447), a sentiment echoed by the Connecticut Law Revision Commission in the work that led to the Connecticut PSRB.[66] Some states have practically implemented Washington PSRP-style advising bodies through hospital or forensic mental health administrators, providing similar guidance to courts.[54,67] Although Boards focus on public safety, laws can also attempt to balance patients' rights and well-being, as in the Connecticut legislation discussed

above. Similarly, the composition of PSRBs or less formal bodies may influence their priorities; including defense attorneys, consumers, or patient advocates may help ensure that rights and recovery concerns are balanced with public safety concerns.

Conclusion

Although the primary goal of PSRB, court, or other release committees is often community safety, success also requires hospital collaboration and political and public trust in the system. Balancing safety with goals of shorter hospitalizations involves numerous factors, often beyond the scope of the decision-making body. These include open communication between the hospital and the decision-makers, comprehensive treatment addressing both mental health and criminogenic needs in the hospital and upon discharge, access to supportive housing and treatment programs in the community, ongoing education of outpatient treatment teams about violence risk factors, monitoring and addressing early signs of decompensation, and a statutory mechanism for rehospitalization and revocation of conditional release. As Arizona's history highlights, sharing information about risk between decision-makers, treatment teams, and evaluators requires both an official mandate and the collaboration and endorsement of stakeholders. Without it, public safety concerns cannot be adequately assessed, resulting in delays in decisions or favoring a risk-averse approach.[39] Similarly, decision-makers need confidence in the community monitoring system.

Future efforts to assess the impact of particular system features (such as PSRBs) are unlikely to yield actionable results, given the complexities and variable characteristics of mental health systems and their resources, acquittees' needs and vulnerabilities, and local legal and mental health cultures. Systems with robust conditional release procedures best address patients' rights, treatment, and public safety. Maintaining confidence in such systems requires perseverance, transparency, and continued attention to balancing competing interests supported by clinical, financial, and political commitment. Outcome data about public safety and acquittees' clinical progress and recovery can help support that confidence, especially where there are highly publicized adverse outcomes. Future research should also include qualitative studies exploring stakeholder perspectives on what constitutes system success.

References

1. Miraglia R, Hall D. The effect of length of hospitalization on re-arrest among insanity plea acquittees. J Am Acad Psychiatry Law. 2011 Dec; 39(4):524–34
2. Haroon H, Wolfe N, Feizi S, Barboriak P. Assessing two decades of insanity acquittee release from the North Carolina forensic program. J Am Acad Psychiatry Law. 2023 Sep; 51(3):342–52
3. Treatment Advocacy Center. Going, going, gone: Trends and consequences of eliminating state psychiatric beds [Internet]; 2016. Available from: https://www.tac.org/reports_publications/going-going-gone-trends-and-consequences-of-eliminating-state-psychiatric-beds/. Accessed April 9, 2025
4. NRI. Use of state psychiatric hospitals [Internet]; 2025. Available from: https://nri-inc.org/media/4bofjpqy/smha-use-of-state-psychiatric-hospitals-july-2025-final.pdf. Accessed November 19, 2025
5. Bloom JD, Krishnan B, Lockey C. The majority of inpatient psychiatric beds should not be appropriated by the forensic system. J Am Acad Psychiatry Law. 2008 Dec; 36(4):438–42
6. McDermott BE, Ventura MI, Juranek ID, Scott CL. Role of mandated community treatment for justice-involved individuals with serious mental illness. Psychiatr Serv. 2020 Jul; 71(7):656–62
7. Reynolds JB. The value of conditional release for insanity acquittees. J Am Acad Psychiatry Law. 2023 Sep; 51(3):353–6
8. United States v. Hinckley, 525 F. Supp. 1342 (D.D.C 1981)
9. Callahan L, Mayer C, Steadman HJ. Insanity defense reform in the United States: Post-Hinckley. Ment Phys Disabil Law Rep. 1987 Jan-Feb; 11(1):54–9
10. U.S. Department of Justice. Insanity Defense Reform Act of 1984 [Internet]. Available from: https://www.justice.gov/archives/jm/criminal-resource-manual-634-insanity-defense-reform-act-1984. Accessed March 5, 2025
11. National Association of State Mental Health Program Directors. Assessment #3: Forensic mental health services in the United States [Internet]; 2014. Available from: https://www.nasmhpd.org/sites/default/files/Assessment%203%20-%20Updated%20Forensic%20Mental%20Health%20Services.pdf. Accessed May 15, 2024
12. Foucha v. Louisiana, 504 U.S. 71 (1992)
13. Gowensmith WN, Bryant AE, Vitacco MJ. Decision-making in post-acquittal hospital release: How do forensic evaluators make their decisions? Behav Sci & L. 2014 Sep; 32(5):596–607
14. Fox PK. Commentary: Biases that affect the decision to conditionally release an insanity acquittee. J Am Acad Psychiatry Law. 2008 Sep; 36(3):337–9
15. Insanity Defense Work Group, American Psychiatric Association, Office of Public Affairs, Washington, DC. American Psychiatric Association Statement on the Insanity Defense. Am J Psychiatry. 1983 Jun; 140(6):681–8
16. Treatment Advocacy Center. Treat or repeat: A state survey of serious mental illness, major crimes and community treatment [Internet]; 2017. Available from: https://www.treatmentadvocacycenter.org/wp-content/uploads/2023/11/Treat-or-Repeat.pdf. Accessed May 15, 2024
17. Bloom JD, Williams MH, Bigelow DA. Monitored conditional release of persons found not guilty by reason of insanity. Am J Psychiatry. 1991 Apr; 148(4):444–8
18. State of Arizona Senate. Chapter 390: Senate Bill 1839 [Internet]; 2021. Available from: https://www.azleg.gov/legtext/55leg/1R/laws/0390.pdf. Accessed June 20, 2024
19. Task Force to Review and Evaluate CVH and WFH, the Psychiatric Security Review Board, and Behavioral Health Care Definitions. Final report [Internet]; 2021. Available from: https://www.cga.ct.gov/ph/tfs/20190426_CVH%20Whiting%20Task%20Force/CVH%20Whiting%20Final%20Report.pdf. Accessed June 20, 2024

20. Novosad D, Banfe S, Britton J, Bloom JD. Conditional release placements of insanity acquittees in Oregon: 2012-2014. Behav Sci & L. 2016 Mar; 34(2–3):366–77
21. Bloom JD, Buckley MC. The Oregon Psychiatric Security Review Board: 1978-2012. J Am Acad Psychiatry Law. 2013 Dec; 41(4):560–7
22. Or. Rev. Stat. § 161.328 (2023)
23. Psychiatric Security Review Board, State of Oregon. Snapshot as of January 1, 2024 [Internet]; 2024. Available from: https://www.oregon.gov/prb/Documents/PSRB%20FAQ%20Snapshot%202024.pdf. Accessed June 18, 2025
24. Bloom JD, Williams MH, Bigelow DA. The involvement of schizophrenic insanity acquittees in the mental health and criminal justice systems. Psychiatr Clin North Am. 1992 Sep; 15(3):591–604
25. Bort A, Standiford M. Psychiatric Security Review Board: Presentation to the Oregon Senate and House Judiciary Committees [Internet]; 2023. Available from: https://olis.oregonlegislature.gov/liz/2023R1/Downloads/CommitteeMeetingDocument/264889. Accessed May 15, 2024
26. Fisher R. Pleas of insanity: The mysterious case of Anthony Montwheeler. Rolling Stone [Internet]; 2020. Available from: https://www.rollingstone.com/culture/culture-features/anthony-montwheeler-oregon-murder-annita-harmon-954479/. Accessed June 5, 2024
27. Oregon Psychiatric Security Review Board. Oregon Psychiatric Security Review Board Work Group Report, December 2021 [Internet]; 2021. Available from: https://www.oregonlegislature.gov/lpro/Publications/PSRB%20Work%20Group%20Final%20Report%20December%202021.pdf. Accessed June 18, 2025
28. Norko MA, Wasser T, Magro H, *et al*. Assessing insanity acquittee recidivism in Connecticut. Behav Sci & L. 2016 Mar; 34(2–3):423–43
29. Connecticut Psychiatric Security Review Board. Presentation by the Connecticut Psychiatric Security Review Board to the PSRB Working Group [Internet]; 2023. Available from: https://ctvideo.ct.gov/dmhas/PSRB_Workgroup_Meeting-20230321_080315-Meeting_Recording.mp4. Accessed May 28, 2025
30. Callahan LA, Silver E. Factors associated with the conditional release of persons acquitted by reason of insanity: A decision tree approach. Law & Hum Behav. 1998 Apr; 22(2):147–63
31. Tepfer D. CT settles psychiatric hospital abuse scandal for $9 million. CTPost [Internet]; 2022. Available from: https://www.ctpost.com/news/article/CT-settles-psychiatric-hospital-abuse-lawsuit-for-17276464.php. Accessed June 20, 2024
32. Dube N. Whiting Forensic Hospital patient abuse investigations [Internet]; 2018. Available from: https://www.cga.ct.gov/2018/rpt/pdf/2018-R-0077.pdf. Accessed June 20, 2024
33. Connecticut State Department of Mental Health and Addiction Services. Psychiatric Security Review Board (PSRB) Working Group [Internet]. Available from: https://portal.ct.gov/dmhas/divisions/forensic-services/psychiatric-security-review-board-workgroup. Accessed June 20, 2024
34. State of Connecticut. Substitute Senate Bill No. 450. Public Act 22-45 [Internet]; 2022. Available from: https://www.cga.ct.gov/2022/ACT/PA/PDF/2022PA-00045-R00SB-00450-PA.PDF. Accessed June 20, 2024
35. State of Connecticut General Assembly. Raised Bill No. 5509 [Internet]; 2024. Available from: https://www.cga.ct.gov/2024/TOB/H/PDF/2024HB-05509-R00-HB.PDF. Accessed June 20, 2024
36. Ariz. Rev. Stat. § 13-3994 (1993)
37. Kirkorsky SE, Shao W, Bloom JD. The migration of Arizona's post-insanity defense procedures to a modified GBMI model. J Am Acad Psychiatry Law. 2019 Jun; 47(2):217–23
38. Ariz. Rev. Stat. Ann. § 13-3994F4 (2016)
39. Perry LA. Arizona Psychiatric Security Review Board: Performance audit and sunset review. A report to the Arizona Legislature. Report 18-107 [Internet]; 2018. Available from: https://www.azauditor.gov/sites/default/files/2023-11/18-107_Report.pdf. Accessed May 23, 2024
40. Chapman D. Arizona Psychiatric Security Review Board Auditor General. Report 18-107 18-month follow-up report [Internet]; 2020. Available from: https://www.azauditor.gov/sites/default/files/2023-11/18-107_18-Mth_Followup.pdf. Accessed May 16, 2024
41. State of Arizona Psychiatric Security Review Board. 2020 annual report [Internet]. Available from: https://www.azdhs.gov/psrb/documents/2020/annual-report-2020.pdf. Accessed June 20, 2024
42. De Young L. Christopher Lambeth sentenced for killing housemate at Gilbert group home [Internet]; 2024. Available from: https://www.azcentral.com/story/news/local/gilbert-breaking/2024/12/06/christopher-lambeth-sentenced-for-killing-housemate-in-gilbert/76820968007/. Accessed June 21, 2025
43. Washington State Department of Social and Health Services. Public Safety Review Panel [Internet]. Available from: https://www.dshs.wa.gov/office-of-the-secretary/public-safety-review-panel. Accessed June 18, 2025
44. Groundswell Services, Inc. Forensic mental health consultant review final report [Internet]; 2014. Available from: https://www.dshs.wa.gov/sites/default/files/BHSIA/WSH/GroundswellReport6.30.14.pdf. Accessed May 23, 2024
45. Public Safety Review Panel. Public Safety Review Panel: Report to the legislature pursuant to RCW 10.77.270(6) [Internet]; 2014. Available from: https://www.dshs.wa.gov/sites/default/files/legislative/documents/PSRP%202014%20Report%20to%20the%20Washington%20Legislature.pdf. Accessed May 23, 2024
46. Michaelsen K, Melchiori L, Hackett D. Public Safety Review Panel. Presentation to the Washington State Office of Public Defense Contract Attorneys. Virtual presentation based in Seattle, WA, November 17, 2023
47. WA HB 1355, 65th Leg. (Wash. 2017)
48. Borum R, Fulero SM. Empirical research on the insanity defense and attempted reforms: Evidence toward informed policy. Law & Hum Behav. 1999 Feb; 23(1):117–35
49. Steadman HJ, Callahan LA, Robbins PC, Morrissey JP. Maintenance of an insanity defense under Montana's "abolition" of the insanity defense. Am J Psychiatry. 1989 Mar; 146(3):357–60
50. Ga Code Ann. § 37-3-1(9.1)(A) (2024)
51. Ga Code Ann. § 37-3-1(9.1)(B) (2024)
52. Psychiatric Security Review Board Working Group. Psychiatric Security Review Board Working Group Report, PA 22-45. (Until posted online by state, available upon request from authors.)
53. Nguyen AH, Acklin MW, Fuger K, *et al*. Freedom in paradise: Quality of conditional release reports submitted to the Hawaii judiciary. Int'l J L & Psychiatry. 2011 Sep-Oct; 34(5):341–8
54. Reynolds JB. A description of the forensic monitoring system of the Missouri Department of Mental Health. Behav Sci & L. 2016 Mar; 34(2–3):378–95
55. Maryland Mental Hygiene Administration Office of Forensic Services. Fact Sheet – Not Criminally Responsible in Maryland 2011 Oct 13 (Available in Online Supplement)
56. Linhorst DM. The impact of system design on the characteristics of Missouri's insanity acquittees. J Am Acad Psychiatry Law. 1997 Dec; 25(4):509–29
57. Vitacco MJ, Vauter R, Erickson SK, Ragatz L. Evaluating conditional release in not guilty by reason of insanity acquittees: A prospective follow-up study in Virginia. Law & Hum Behav. 2014 Aug; 38(4):346–56
58. Alper M, Durose MR, Markman J. Special Report: 2018 Update on Prisoner Recidivism: A 9-year follow-up period (2005-2014) [Internet]; 2018. Available from: https://bjs.ojp.gov/content/pub/pdf/18upr9yfup0514.pdf. Accessed December 12, 2025
59. Haw. Rev. Stat. § 704-412 (2016)

60. Brakel SJ. After the verdict: Dispositional decisions regarding criminal defendants acquitted by reason of insanity. DePaul L. Rev. 1988 Winter; 37(2):181–258
61. McGreevy MA, Steadman HJ, Callahan LA. The negligible effects of California's 1982 reform of the insanity defense test. Am J Psychiatry. 1991 Jun; 148(6):744–50
62. Callahan LA, Robbins PC, Steadman HJ, Morrissey JP. The hidden effects of Montana's "abolition" of the insanity defense. Psychiatr Q. 1995; 66(2):103–17
63. Crocker AG, Charette Y, Seto MC, *et al*. The national trajectory project of individuals found not criminally responsible on account of mental disorder in Canada. Part 3: Trajectories and outcomes through the forensic system. Can J Psychiatry. 2015 Mar; 60(3):117–26
64. Marshall DJ, Vitacco MJ, Read JB, Harway M. Predicting voluntary and involuntary readmissions to forensic hospitals by insanity acquittees in Maryland. Behav Sci & L. 2014 Sep; 32 (5):627–40
65. Salem L, Crocker AG, Charette Y, *et al*. Supportive housing and forensic patient outcomes. Law & Hum Behav. 2015 Jun; 39 (3):311–20
66. Scott DC, Zonana HV, Getz MA. Monitoring insanity acquittees: Connecticut's Psychiatric Security Review Board. Hosp Community Psychiatry. 1990 Sep; 41(9):980–4
67. Patterson RF, Wise BF. The development of internal forensic review boards in the management of hospitalized insanity acquittees. J Am Acad Psychiatry Law. 1998 Dec; 26(4):661–4