COMMENTS

A NEW APPROACH TO INSANITY ACQUITTEE RECIDIVISM: REDEFINING THE CLASS OF TRULY RESPONSIBLE RECIDIVISTS

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INTRODUCTION

After receiving verdicts of not guilty by reason of insanity, John McGee and Ronald Manlen were committed to Michigan mental hospitals.[1] The center for forensic psychiatry later determined that McGee and Manlen were "no longer mentally ill and dangerous" and released them.[2] Shortly after being released, McGee kicked his wife to death[3] and Manlen raped two women.[4]

The public outcry that followed these tragic events prompted the Michigan legislature to statutorily authorize the "guilty but mentally ill" (GBMI) verdict in cases where a defendant raises the insanity defense.[5] The verdict permits the jury to find that although the defendant is mentally ill, she is not legally insane, and she may be given a full criminal sentence. A defendant who receives a GBMI verdict must receive appropriate psychiatric treatment while imprisoned.[6]

Several other states, faced with similar high-profile crimes committed by released insanity acquittees, also adopted the GBMI ver-

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[1] Sharon Morey Brown & Nicholas J. Wittner, *Criminal Law*, 25 WAYNE L. REV. 335, 356-57 (1979).

[2] *Id.* at 357.

[3] *Id.*

[4] *Id.* (citing George D. Mesritz, Comment, *Guilty but Mentally Ill: An Historical and Constitutional Analysis*, 53 J. URB. L. 471, 483 (1976)).

[5] *Id.* (citing MICH. COMP. LAWS ANN. § 768.36 (West Supp. 1978)).

[6] *Id.*

dict.[7] Some state legislatures considered the complete abolition of the insanity defense,[8] while others heightened the requirements for release from post-insanity acquittal commitment (PIAC)[9] or implemented conditional release programs.[10]

This Comment evaluates the current methods employed by states to cope with insanity acquittee recidivists and proposes a new solution that strikes a balance between rehabilitating insane offenders and protecting the public from dangerous acquittees. Part I evaluates the basic problem of insanity acquittee recidivism and explores the roles played by inaccurate release decisions and post-release medication noncompliance in exacerbating the problem. Part II addresses various approaches adopted by state legislatures and courts to deal with insanity acquittee recidivism. This Comment will argue that these approaches are impractical, inequitable, or unconstitutional. Finally, in Part III, this Comment proposes a new method of minimizing insanity acquittee recidivism: abolishing the insanity defense for acquittee recidivists who are deemed sane upon release and who subsequently fail to abide by their post-release treatment regimen.

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[7] *See, e.g.*, Vicki L. Plaut, *Punishment Versus Treatment of the Guilty but Mentally Ill*, 74 J. CRIM. L. & CRIMINOLOGY 428, 435 (1983) ("[P]ublic outrage over post-release criminal behavior by two insanity acquittees spurred the creation of Illinois' guilty but mentally ill alternative."); Christopher Slobogin, *The Guilty but Mentally Ill Verdict: An Idea Whose Time Should Not Have Come*, 53 GEO. WASH. L. REV. 494, 498 n.18 (1985) ("[A] precipitating factor behind Georgia's guilty but mentally ill legislation was a multiple murder commited [sic] by an insanity acquittee shortly after his release." (citing NAT'L CTR. FOR STATE COURTS, THE "GUILTY BUT MENTALLY ILL" PLEA AND VERDICT: AN EMPIRICAL STUDY: FINAL REPORT SUBMITTED TO THE NATIONAL INSTITUTE OF JUSTICE, U.S. DEP'T OF JUSTICE 2-3 (working draft Nov. 15, 1984) (on file with the George Washington Law Review))).

[8] *See, e.g.*, Lisa Callahan, Connie Mayer & Henry J. Steadman, *Insanity Defense Reform in the United States—Post-Hinckley*, 11 MENTAL & PHYSICAL DISABILITY L. REP. 54, 54-59 (1987) (discussing insanity defense reforms considered by legislatures after John Hinckley was acquitted by reason of insanity for the attempted assassination of President Reagan); Cynthia A. Hagan, Commentary, *The Insanity Defense: A Review of Recent Statutory Changes*, 3 J. LEGAL MED. 617, 618 (1982) (explaining that the Idaho legislature abolished the insanity defense because of the public outrage over an attempted murder committed by an insanity acquittee); Ira Mickenberg, *A Pleasant Surprise: The Guilty but Mentally Ill Verdict Has Both Succeeded in Its Own Right and Successfully Preserved the Traditional Role of the Insanity Defense*, 55 U. CIN. L. REV. 943, 972 (1987) ("Within two weeks of . . . shootings [by an insanity acquittee], proposals were introduced in the [Alaska] state legislature to abolish or restrict the use of the insanity defense . . . .").

[9] *See infra* Part II.A.1 (detailing two approaches adopted by states: evaluating an acquittee for release in an unmedicated state, and taking the likelihood of medication compliance into account in making release decisions).

[10] *See infra* Part II.A.2.

I. THE PROBLEM OF INSANITY ACQUITTEE RECIDIVISM

Insanity acquittee recidivism is a problem of grave concern for both the criminal justice system and the mental health profession. Although "[i]nsanity acquittees have been the focus of intense study" since the mid-1970s,[11] researchers have found it difficult to determine precise meta-analysis recidivism rates.[12] One source of difficulty is that the actual definition of recidivism varies significantly from study to study: some researchers define recidivism broadly, including any incidents of rehospitalization based on acts for which the acquittee could have been rearrested;[13] others define it more narrowly, only including rearrests.[14] Furthermore, "[l]ocal and jurisdictional nuances [may] have a dramatic effect on the rate[s] of rearrest,"[15] thereby making it more difficult for researchers to deduce statistical trends from the recidivism data available.

Despite the methodological inconsistencies among the studies, one general conclusion may be drawn. The recidivism rate of insanity acquittees roughly corresponds to the recidivism rate of the general prison population.[16] Thus, many of the standard risk factors commonly employed to predict criminal recidivism are equally applicable

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[11] Victoria L. Harris, *Insanity Acquittees and Rearrest: The Past 24 Years*, 28 J. AM. ACAD. PSYCHIATRY & L. 225, 225 (2000).

[12] *See id.* at 229-30 ("Numerous articles have commented on the difficulty of comparing the rearrest rates of insanity acquittees.").

[13] *See, e.g.*, Marnie E. Rice & Grant T. Harris, *A Comparison of Criminal Recidivism Among Schizophrenic and Nonschizophrenic Offenders*, 15 INT'L J.L. & PSYCHIATRY 397, 404 (1992) (defining recidivism as including "any acts which brought the offender back to [the] hospital, but for which the offender could have been criminally charged").

[14] *See, e.g.*, Harris, *supra* note 11, at 230 (noting that rehospitalizing (rather than rearresting) an offender poses problems for recidivism analysis).

[15] *Id.*

[16] *See In re* George L., 648 N.E.2d 475, 480 (N.Y. 1995) ("[The] recidivism rate [of insanity acquittees is] equal to that of prison populations." (quoting Warren J. Ingber, Note, *Rules for an Exceptional Class: The Commitment and Release of Persons Acquitted of Violent Offenses by Reason of Insanity*, 57 N.Y.U. L. REV. 281, 296 (1982))); Harris, *supra* note 11, at 230 ("In studies spanning decades, the rearrest rates of released insanity acquittees are as high as those persons released from jail and prison."); Mark L. Pantle et al., *Comparing Institutionalization Periods and Subsequent Arrests of Insanity Acquittees and Convicted Felons*, 8 J. PSYCHIATRY & L. 305, 313 (1980) (finding a twenty-four percent recidivism rate for insanity acquittees and a twenty-seven percent recidivism rate for convicted felons over a six-year period). *But see* Mary Robinson, *The Insanity Defense: Does It Serve Justice? Does It Protect the Public?*, 71 ILL. B.J. 306, 309 (1983) (describing the statements of Dr. Jay LeBow, a panelist at an Illinois Bar Association forum on the insanity defense, who asserted that the recidivism rate of insanity acquittees is substantially lower than the recidivism rate of convicted defendants).

to insanity acquittees.[17] Past criminal violence is of particular salience as "the clinical consensus is that a history of violent behavior in an individual is the single best predictor of future violence."[18]

This suggests that an insanity acquittee's history of prior violence—and not her mental illness per se—will increase the likelihood that she will act violently in the future. If, as many researchers assert, insanity acquittees as a class are no more violent than convicted defendants,[19] then the similarity between the recidivism rates makes sense: "the number and nature of prior violent acts," and not one's diagnosis, is the most accurate predictor of future violence.[20] However, several important factors distinguish imprisonment from PIAC and make the insanity acquittee recidivism rate more troubling.

First, state legislatures have adopted various statutes to deal with the problem of convicted recidivists.[21] By 1992, the federal system and all fifty states had enacted some form of sentence-enhancing recidivism statute.[22] Although the effectiveness of such laws is hotly debated,[23] the fact remains that institutional mechanisms are in place to deal with repeat convicted offenders. Under a "three strikes law," for example, a third-time convicted felon generally will be subjected to a substantially longer term of imprisonment.[24]

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[17] *See* Harris, *supra* note 11, at 226 ("[R]earrest among insanity acquittees [is] likely to be influenced by factors that influence repetitive criminal behavior . . . . Past criminal behavior, age, and gender have consistently been shown to be highly influential factors in the determination of future criminal behavior.").

[18] Ingber, *supra* note 16, at 295.

[19] *See* Bernard L. Diamond, *The Psychiatric Prediction of Dangerousness*, 123 U. PA. L. REV. 439, 448 (1974) (noting "the lack of a clear-cut association between mental illness . . . and dangerous behavior"); Slobogin, *supra* note 7, at 504 ("[T]here is only a very weak correlation between severe mental illness and violent behavior . . . .").

[20] Slobogin, *supra* note 7, at 504. *But see* Ingber, *supra* note 16, at 297 ("[V]iolent insanity acquittees comprise a particularly dangerous class of individuals.").

[21] *See, e.g.*, N.J. STAT. ANN. § 2C:43-7.1 (West 2005) (providing that certain third-time offenders will be sentenced to life imprisonment with no eligibility for parole); N.Y. PENAL LAW § 70.10 (McKinney 1998) (providing sentence enhancement for "persistent felony offender[s]"); 42 PA. CONS. STAT. ANN. § 9714 (West Supp. 2005) (providing for minimum ten-year sentences for violent recidivists).

[22] *See* Parke v. Raley, 506 U.S. 20, 26-27 (1992) ("[Sentence-enhancing recidivism] laws currently are in effect in all 50 states and several have been enacted by the Federal Government, as well." (citations omitted)).

[23] *See, e.g.*, Daniel Katkin, *Habitual Offender Laws: A Reconsideration*, 21 BUFF. L. REV. 99, 105 (1971) (arguing that recidivism statutes fail both to deter repeat offenders and to protect the public adequately).

[24] *See, e.g.*, CAL. PENAL CODE ANN. § 667(b) (West 1999); Ewing v. California, 538 U.S. 11, 20, 30-32 (2003) (upholding the defendant's sentence of twenty-five years to life for stealing three golf clubs under California's three strikes law); State v. Oliver,

In contrast, there is no similar guarantee of incapacitation in the context of insanity acquittee recidivists. Most likely, a reoffending acquittee will be reinstitutionalized. Unlike the statutorily imposed sentence enhancement that a convicted recidivist will receive, however, the length of an acquittee's confinement is far less definite.[25] Perhaps a court will consider an acquittee's past recidivism when it eventually decides whether or not to release her. However, recidivism will be only one factor among many that the court will take into account in assessing the current dangerousness of an acquittee and her suitability for release.[26]

Furthermore, and perhaps most significantly, consideration of recidivism in a release decision may raise constitutional issues that will prevent the continued confinement of an insanity acquittee who still poses a danger to society. In *Foucha v. Louisiana*, the United States Supreme Court held that under the Due Process Clause of the Fourteenth Amendment, a state may not continue to hold an insanity acquittee who is still considered dangerous but is no longer mentally ill.[27] The Court reiterated the rule it set forth in *Jones v. United States* that a "'committed acquittee is entitled to release when he has recovered his sanity or is no longer dangerous,' i.e., [that] the acquittee may be held as long as he is both mentally ill and dangerous, but no longer."[28] Thus, if a judge were to prolong an insanity acquittee's confinement solely because the acquittee was a known recidivist, such action would violate *Foucha* if the acquittee were no longer considered mentally ill.[29] Therefore, although recidivism will generally guarantee

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745 A.2d 1165, 1167-68 (N.J. 2000) (affirming a third-time offender's sentence of life imprisonment without parole after he was convicted of first degree robbery and aggravated assault under New Jersey's three strikes law).

[25] Because an insanity acquittee may only be committed so long as she is *both* mentally ill *and* dangerous, Jones v. United States, 463 U.S. 354, 368 (1983), the length of an acquittee's confinement is unpredictable: she may be committed for only a few weeks or perhaps indefinitely. *See, e.g.*, People v. Pastewski, 647 N.E.2d 278, 283 (Ill. 1995) (allowing an acquittee's past recidivism to enhance his maximum commitment period, but noting that the acquittee "may be released anytime he regains his sanity").

[26] *See, e.g.*, *In re* George L., 648 N.E.2d 475, 481 (N.Y. 1995) (listing a "history of prior relapses into violent behavior" as *one* type of evidence to be considered in determining if an acquittee currently poses a danger to herself or others).

[27] 504 U.S. 71, 80 (1992) (citing *Jones*, 463 U.S. at 362).

[28] *Foucha*, 504 U.S. at 77 (emphasis omitted) (quoting *Jones*, 463 U.S. at 368).

[29] *See, e.g.*, *In re* Gafford, 903 P.2d 61, 65 (Idaho 1995) (holding that a state statute permitting acquittees to be confined on the basis of dangerousness alone violated *Foucha*). *But see* State v. Randall, 532 N.W.2d 94, 106-07 (Wis. 1995) (interpreting *Foucha* to permit the continued confinement of an insanity acquittee based on dangerousness alone, as long as the commitment is limited to the maximum term the acquit-

a longer sentence for a convicted offender, the role recidivism will play in determining the length of an acquittee's confinement is less definitive.

A second factor that distinguishes insanity acquittee recidivism from convicted offender recidivism—and makes the similarity in recidivism rates more troubling—is that PIAC focuses on treating the problems of acquittees, whereas ordinary imprisonment does not specifically seek to rehabilitate prisoners.[30] In *Jones*, Justice Powell observed that PIAC is intended to "treat the individual's mental illness and protect him and society from his potential dangerousness."[31] Thus, one would hope that when the acquittee is eventually released from confinement (i.e., she is no longer considered both mentally ill and dangerous), many of the problems that resulted in commitment would be resolved, or at the very least, substantially improved.[32] The rehabilitation efforts of the PIAC system should, in theory, improve the irrational thought process that led the acquittee to commit criminal acts that resulted in her initial commitment. The same hope cannot be fostered with regard to the prison system, which values retribution and incapacitation over the rehabilitation of inmates.[33] American prisons "rehabilitate[] no one."[34] Rather, "[m]ost criminal offenders who change for the better do so in spite of prison not because of it."[35]

If PIAC treats the acquittee's underlying problems and imprisonment merely punishes and confines convicts, what accounts for the

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tee would have received if convicted and the commitment statute is reasonably related to the purpose for which the acquittee is committed).

[30] *See* Sharon M. Bunzel, Note, *The Probation Officer and the Federal Sentencing Guidelines: Strange Philosophical Bedfellows*, 104 YALE L.J. 933, 952 (1995) ("[I]n light of current knowledge . . . imprisonment is not an appropriate means of promoting correction and rehabilitation. . . . [A]lmost everyone involved in the criminal justice system now doubts that rehabilitation can be induced reliably in a prison setting . . . . [N]o one can really detect whether or when a prisoner is rehabilitated." (internal quotation marks omitted) (footnotes omitted) (quoting S. REP. NO. 98-225, at 38, 76 (1983))).

[31] *Jones*, 463 U.S. at 368.

[32] *See* Stephen J. Morse, *Blame and Danger: An Essay on Preventive Detention*, 76 B.U. L. REV. 113, 128 n.44 (1996) (noting that in cases of extreme mental illness, medication can reduce the risk of further violence by "ameliorating the crazy thinking").

[33] *See, e.g.*, Richard Lowell Nygaard, *Crime, Pain, and Punishment: A Skeptic's View*, 102 DICK. L. REV. 355, 363 (1998) ("The ugly truth is that we punish because it makes us feel good to get even."); Debra Todd, *Sentencing of Adult Offenders in Cases Involving Sexual Abuse of Children: Too Little, Too Late? A View from the Pennsylvania Bench*, 109 PENN ST. L. REV. 487, 518 (2004) (citing the argument that "America has never truly been committed to [the] rehabilitation" of criminals).

[34] Nygaard, *supra* note 33, at 362.

[35] *Id.* at 362-63.

similar rates of post-release recidivism among the two groups of offenders? The premature release of insanity acquittees and post-release medication noncompliance are two possible explanations.

A. *Inaccurate, Premature Release Decisions*

An acquittee must be released from PIAC when she is adjudged no longer to be both mentally ill and dangerous.[36] Expert testimony regarding the acquittee's current mental health and future dangerousness will often be decisive in the release decision.[37] However, the ability of experts to predict accurately the mental stability and safety of an acquittee upon release from the hospital is questionable. Studies on expert risk assessment suggest different rates of accuracy,[38] the most favorable study reporting that expert predictions are correct just over fifty percent of the time.[39] Thus, approximately half of all insanity acquittees will either be prematurely released or unnecessarily confined.

Although the development of more advanced actuarial risk assessment tools may improve the accuracy of experts' predictions,[40] inherent limitations remain that will inevitably produce some inaccurate decisions. No expert can account for every future precipitating factor that may cause an insanity acquittee to decompensate and act dangerously. The mind is exceedingly complex, and psychological diseases are not amenable to precise scientific explanation. Thus, even the most experienced expert, utilizing the most advanced tools, will find it

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[36] *Jones*, 463 U.S. at 368.

[37] Many state statutes *require* that mental health professionals evaluate the acquittee and report their findings to the court before a release decision is made. *See, e.g.*, HAW. REV. STAT. § 704–414 (Supp. 2004) (requiring that three experts examine the defendant prior to conditional release); N.Y. CRIM. PROC. LAW § 330.20 (McKinney Supp. 2004) (mandating submission of a psychiatrist's report before a defendant can be released).

[38] *See, e.g.*, JOHN MONAHAN, THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR 47 (1981) ("[P]sychiatrists and psychologists are accurate in no more than one out of three predictions of violent behavior . . . ." (emphasis omitted)); Joseph T. McCann, *Risk Assessment and the Prediction of Violent Behavior*, FED. LAW., Oct. 1997, at 18, 18 (stating that predictions of mental health professionals are "better than chance").

[39] *See* Charles W. Lidz et al., *The Accuracy of Predictions of Violence to Others*, 269 J. AM. MED. ASS'N 1007, 1009 (1993) ("[C]linicians were above chance in their predictions of violence (equivalently, we can reject the null hypothesis that sensitivity and specificity equaled 50%).").

[40] *Id.* at 1010-11.

difficult to assess the future behavior of many acquittees.[41] This is particularly true when the only context in which the acquittee has been observed is the safe, controlled environment of the hospital.

Although inaccurate release decisions certainly affect the rate of insanity acquittee recidivism, solutions to this problem are beyond the scope of this Comment,[42] which focuses on *post-release* means of reducing recidivism.

B. *Post-Release Medication Noncompliance*

Professor Stephen Morse has opined that "[i]n the case of seriously crazy people, whose irrational practical reasoning leads to the intent to do harm, ameliorating the crazy thinking through proper medication should in fact reduce the risk of harmdoing."[43] If Morse's postulation is accurate, then what accounts for the recidivism of insanity acquittees after they have been released from the hospital and their sanity presumably has been restored?

The most sensible explanation is that many insanity acquittees fail to abide by the treatment regimen developed for them while they were hospitalized. For a mentally ill individual, medication compli-

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[41] *See* Diamond, *supra* note 19, at 452 ("Neither psychiatrists nor other behavioral scientists are able to predict the occurrence of violent behavior with sufficient reliability . . . ."); Michael L. Perlin, *Unpacking the Myths: The Symbolism Mythology of Insanity Defense Jurisprudence*, 40 CASE W. RES. L. REV. 599, 693 (1990) ("The voluminous literature examining the ability of psychiatrists (or other mental health professionals) to predict dangerousness in the indeterminate future has been virtually unanimous: 'psychiatrists have absolutely no expertise in predicting dangerous behavior . . . .'" (footnote omitted) (quoting Bruce J. Ennis & Thomas R. Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CAL. L. REV. 693, 734-35 (1974))).

[42] Some commentators have argued for the wholesale exclusion of expert testimony on the issue of future dangerousness. *See, e.g.*, Diamond, *supra* note 19, at 452 (contending that experts should not be permitted to testify that an acquittee is dangerous, but rather that experts should only be permitted to give their opinions on the relationship between the acquittee's dangerousness and mental illness, as well as the effectiveness of a treatment program in remedying the acquittee's dangerousness). Others have argued that experts should only be permitted to make predictions if they are based on "hard, methodologically sound quantitative data" rather than clinical judgment. *E.g.*, Stephen J. Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527, 620 (1978). For another proposed solution to the problem of inaccurate expert predictions, see Slobogin, *supra* note 7, at 527 n.158 (advocating a rule that would allow the admission of clinical predictions of dangerousness only if the defendant introduces expert testimony on the issue first).

[43] Morse, *supra* note 32, at 128 n.44.

ance is the most effective means of avoiding relapse.[44] Frequently, an acquittee's failure to consistently take her medication results in a "revolving door" patient:

> After being involuntarily hospitalized and stabilized on medication, such patients no longer meet the dangerous criterion for commitment. Sometime after release, however, they start to question both the value and necessity of their medications and eventually stop taking them. Predictably, their condition deteriorates to the point at which they again require inpatient care. For too many patients, this becomes a vicious cycle that is never broken.[45]

Such patients, once released into society, are essentially "time bombs ready to explode."[46]

A number of reasons may explain an insanity acquittee's failure to continue her course of medication after leaving the hospital. The most commonly cited include "the many unpleasant side effects present in most of the medications, forgetfulness, a feeling of improved condition due to the medications that makes [her] believe [she] is no longer ill, . . . or a simple desire not to be medicated."[47] Although many patients may harbor negative attitudes toward antipsychotic medication, medication compliance is an indispensable feature of reducing insanity acquittee recidivism, and is a main focus of this Comment.

II. CURRENT APPROACHES TO REDUCING INSANITY ACQUITTEE RECIDIVISM

Current efforts to reduce insanity acquittee recidivism may be divided into two general categories: those that seek to enhance post-release medication compliance directly, and those that attack the validity of the insanity defense itself.

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[44] *See* Veronica J. Manahan, *When Our System of Involuntary Civil Commitment Fails Individuals with Mental Illness: Russell Weston and the Case for Effective Monitoring and Medication Delivery Mechanisms*, 28 LAW & PSYCHOL. REV. 1, 20 (2004) ("Systems that are successful in keeping individuals with mental illness out of the hospital have found medication compliance to be the single most important factor in achieving such success.").

[45] Ronald L. Wisor Jr., *Community Care, Competition and Coercion: A Legal Perspective on Privatized Mental Health Care*, 19 AM. J.L. & MED. 145, 159-60 (1993) (footnotes omitted).

[46] Brown & Wittner, *supra* note 1, at 356 (quoting DETROIT NEWS, Oct. 1, 1978, at 47).

[47] Manahan, *supra* note 44, at 20 (footnote omitted).

A. *Approaches Aimed at Enhancing Medication Compliance*

Since the advent of psychotropic medication, states have grappled with the problem of ensuring that insanity acquittees abide by their treatment regimens after release. Two primary methods of dealing with medication noncompliance have gained popular support in a number of states: taking medication compliance into account in making release decisions, and implementing conditional release programs.

1. Taking Medication Compliance into Account in Making Release Decisions

Courts that take medication compliance into account in making release decisions will assess the acquittee's sanity and dangerousness by (1) evaluating the acquittee in an unmedicated state, or (2) defining dangerousness in terms of post-release medication compliance.

a. *Evaluating the Acquittee in an Unmedicated State*

In an effort to minimize insanity acquittee recidivism, a minority of courts, in making release determinations, will consider whether the acquittee's mental stability or nondangerousness is solely dependent upon continued compliance with a medication regimen. In *State v. Zarrella*, a Rhode Island superior court held that when deciding if an acquittee should be released from PIAC, "medication and treatment should [not] be considered on the issue of either present sanity or dangerousness."[48]

Although adopting such an approach will most likely reduce insanity acquittee recidivism, it is highly problematic because it will result in the indefinite commitment of a significant number of acquittees who are capable of functioning safely in society if properly medicated. A substantial percentage of insanity acquittees suffer from a psychotic mental disorder.[49] Psychosis refers to a mental state char-

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[48] No. P2/82-1885, 1984 WL 560319, at *4 (R.I. Super. Ct. June 19, 1984)*; see also* State v. Johnson, 753 P.2d 154, 157 (Ariz. 1988) (stating that although the defendant's schizophrenia was in remission because of treatment, the court would still consider him to be suffering from a mental illness); People v. De Anda, 114 Cal. App. 3d 480, 490 (Ct. App. 1980) (holding that in an initial commitment hearing for an insanity acquittee, "psychopharmaceutical restoration of sanity should not be considered a 'full' recovery").

[49] *See* Richard A. Pasewark et al., *Characteristics and Disposition of Persons Found Not Guilty by Reason of Insanity in New York State, 1971-1976*, 136 AM. J. PSYCHIATRY 655, 658

acterized by a gross loss of contact with reality, and it is a feature of various mental disorders, including schizophrenia, schizoaffective disorder, and delusional disorder.[50] Antipsychotic medications have a "powerful ameliorative effect on active psychotic symptoms"[51] and are the most effective treatments known to date for such illnesses.[52]

The average insanity acquittee will be treated with antipsychotic medication during her post-acquittal commitment.[53] In most cases, after an initial phase of trial and error,[54] the treating medical professionals will settle upon an effective course of medication that successfully alleviates or substantially reduces the patient's psychotic symptoms and ultimately restores her sanity.[55]

Requiring such a patient to demonstrate her sanity in an unmedicated state will likely be unsuccessful. The mental health community has yet to develop an effective, nonpharmacological means of restoring a psychotic patient's mental health.[56] Thus, it will essentially be impossible for a substantial number of acquittees ever to establish their sanity if they are evaluated without medication. "[I]t is senseless to deny persons fully functional on medication their rightful place in

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(1979) (finding that approximately seventy percent of insanity acquittees studied in New York between 1971 and 1976 suffered from psychosis); Jeffrey L. Rogers et al., *Insanity Defenses: Contested or Conceded?*, 141 AM. J. PSYCHIATRY 885, 886 (1984) (noting that seventy percent of insanity acquittees in Oregon between 1978 and 1981 suffered from psychosis).

[50] *See* AM. PSYCHIATRIC ASS'N, DSM-IV-TR: DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 312, 323, 329 (4th ed. 2000) (listing the diagnostic criteria for schizophrenia, schizoaffective disorder, and delusional disorder).

[51] Marnie E. Rice et al., *Treatment for Forensic Patients*, *in* MENTAL HEALTH AND LAW: RESEARCH, POLICY AND SERVICES 141, 169 (Bruce D. Sales & Saleem A. Shah eds., 1996).

[52] *See* MELISSA K. SPEAKING, NAT'L INST. OF MENTAL HEALTH, SCHIZOPHRENIA 13 (Aug. 2002), *available at* http://www.nimh.nih.gov/publicat/NIMHschizoph.pdf ("Antipsychotic drugs are the best treatment [for schizophrenia] now available . . . ."); *cf.* Manahan, *supra* note 44, at 20 ("[S]ixty to seventy-five percent of [schizophrenics] who stop taking their [antipsychotic] medication relapse within a year's time.").

[53] One of the main goals of PIAC is treatment of the acquittee's mental illness. Jones v. United States, 463 U.S. 354, 368 (1983). Medication is an essential component of treatment. *See* People v. Williams, 198 Cal. App. 3d 1476, 1482 (Ct. App. 1988) (noting that the purpose of PIAC is treatment "including medication").

[54] *See* RALPH REISNER ET AL., LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 27-28 (4th ed. 2004) ("The neuroleptic of choice for any given patient must be determined to a considerable degree by trial and error.").

[55] *See id.* at 38 (noting that traditional antipsychotic medication will help seventy-five percent of schizophrenics improve).

[56] *Cf.* SPEAKING, *supra* note 52, at 17 (noting "[f]ar higher relapse rates . . . when medication is discontinued").

the community . . . ."[57] Moreover, evaluating acquittees in an unmedicated state provides acquittees with the perverse incentive to "gamble" with their mental health and stop taking their medication.[58] This is an inappropriate and ineffective response to the recidivism dilemma.

In addition, assessing the sanity of the acquittee in an unmedicated state is inconsistent with the way the law evaluates mentally disordered offenders in other contexts. When determining if a defendant is competent to stand trial or face execution, many courts do not differentiate between unmedicated competence and medicated competence.[59] In fact, the Supreme Court has held that under certain circumstances, states may forcibly medicate an incompetent defendant for the sole purpose of restoring her competence to stand trial.[60]

Admittedly, competency and sanity are different mental conditions,[61] and states are not compelled to adopt uniform standards to

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[57] *Williams*, 198 Cal. App. 3d at 1482.

[58] *Id.*

[59] *See, e.g.*, Singleton v. Norris, 319 F.3d 1018, 1027 (8th Cir. 2003) (holding that restoring an inmate's competency to be executed by medicating him did not violate the Eighth Amendment or principles of due process); State v. Hampton, 218 So. 2d 311, 312 (La. 1969) (observing that to find a defendant incompetent to stand trial merely because her competence was chemically induced would "erase improvement[s] produced by medical science").

[60] In *Sell v. United States*, the Supreme Court held that "the Constitution permits the Government involuntarily to administer antipsychotic drugs to a mentally ill defendant facing serious criminal charges in order to render that defendant competent to stand trial." 539 U.S. 166, 179 (2003). In order to forcibly medicate, the following conditions must be met: (1) the treatment must be medically appropriate; (2) the treatment must be "substantially unlikely to have side effects that may undermine the fairness of the trial"; and (3) taking into account less intrusive alternatives, the treatment must be "necessary significantly to further important governmental trial-related interests." *Id.* The Supreme Court has yet to decide whether the state may forcibly medicate a mentally ill defendant for the sole purpose of restoring the defendant's competence to be executed. Lower courts are divided on the issue. *Compare Singleton*, 319 F.3d at 1024-25 (8th Cir. 2003) (holding that under certain circumstances an incompetent defendant may be forcibly medicated in order to restore her competence to be executed), *with* State v. Perry, 610 So. 2d 746, 761 (La. 1992) (ruling, with some consideration of United States Supreme Court precedent that interprets analogous provisions of the United States Constitution, that the forcible medication of an incompetent defendant for the sole purpose of restoring competence to be executed is cruel and unusual punishment under Louisiana's constitution).

[61] A person may be sane but incompetent, or competent but insane. To be found competent to stand trial, the defendant must be able to reasonably assist counsel and must possess "a rational as well as factual understanding of the proceedings against him." Dusky v. United States, 362 U.S. 402, 402 (1960) (internal quotation marks omitted). The test for insanity varies among jurisdictions. The federal test provides

govern both of them. Furthermore, from a pragmatic viewpoint, it makes perfect sense to evaluate a defendant's competence in a medicated state but to assess an acquittee's sanity in an unmedicated state; public safety is implicated in the latter context, but not the former. However, the mere fact that states are permitted to *forcibly* administer antipsychotic drugs to incompetent defendants suggests that psychotropic medication plays an invaluable role in restoring the mental health of mentally ill individuals. It is inconsistent to allow the state to benefit from the effectiveness of antipsychotic medication in the competency context, but to withhold the same benefit from the acquittee in the insanity release context.

b. *Assessing Future Dangerousness in Terms of Post-Release Medication Compliance*

Other courts have concluded that an insanity acquittee's likelihood of complying with a treatment program and her history of prior relapses are appropriate factors to consider when determining if the acquittee should be released.[62] The Nebraska legislature considered a similar approach in 1993 by proposing a bill that purported to "make[] failure to comply with treatment or to take prescribed medication appropriate evidence for the court to consider in assessing [an acquittee's] dangerousness."[63]

Considering whether an acquittee is likely to comply with a treatment regimen is a logical means of minimizing insanity acquittee recidivism. If post-release medication noncompliance substantially contributes to such recidivism, then courts should be able to take this factor into account when determining whether an insanity acquittee will pose a danger to society upon release. In practice, however, pre-

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that a defendant is legally insane if "the defendant, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his acts." 18 U.S.C. § 17 (2000).

[62] *See* Williams v. Wallis, 734 F.2d 1434, 1437-38 n.4 (11th Cir. 1984) ("[I]f an acquittee is no longer dangerous only because he or she is on medication or in a structured environment, then clearly whether he or she will take his or her medication or be in a structured environment after release can and should be considered prior to release."); State v. Rambin, 427 So. 2d 1248, 1253 (La. Ct. App. 1983) (denying the acquittee's application for release from PIAC because, among other reasons, he exhibited a propensity to resist medication); *In re* Francis S., 663 N.E.2d 881, 884 (N.Y. 1995) (noting that, in making release decisions, courts may take into account an acquittee's "history of prior relapses into violent behavior and of recurrent substance abuse and noncompliance with treatment programs").

[63] Sherin S. Vitro, Comment, *Promoting Therepeutic Objectives Through LB 518: A Sane Amendment to Nebraska Law Governing the Disposition of Insanity Acquittees*, 72 NEB. L. REV. 837, 856 (1993). The bill was never signed into law.

dicting whether an acquittee will continue to take her medication is quite difficult and may result in the unjustified and inequitable confinement of acquittees. As Part I.A discussed, mental health experts often make inaccurate predictions and, if anything, tend to overpredict the future dangerousness of insanity acquittees.[64]

Moreover, courts often rely on weak evidence in predicting future compliance, particularly in the case of first-time insanity acquittees where courts do not have a history of compliance to consider in evaluating the acquittee.[65] For example, in *State v. Perez*, the Supreme Court of Louisiana held that an insanity acquittee's petition for conditional release was properly denied because if the acquittee "stop[ped] taking [her] medication, [she] could become mentally ill again . . . [and] could discontinue [her] medication at any time."[66] But the fact that an insanity acquittee *could* stop taking her medication at any time merely establishes that the acquittee has free will. It does not establish that, if released, an acquittee *would* stop taking her medication. Refusing to release an acquittee on the basis of such tenuous evidence is inequitable, particularly in the case of Ricky Perez, who, as the evidence established, had been "a model patient for over eleven years" and had "successfully functioned in society as a peaceful, law abiding citizen while on many weekend and ten day passes."[67]

Furthermore, in the cases in which an insanity acquittee has already been deemed sane,[68] it is unnecessary to assess the acquittee's dangerousness and thus take medication compliance into account.

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[64] *See* Donald H.J. Hermann, *Barriers to Providing Effective Treatment: A Critique of Revisions in Procedural, Substantive, and Dispositional Criteria in Involuntary Civil Commitment*, 39 VAND. L. REV. 83, 98 (1986) ("Empirical studies reveal that psychiatrists and sociologists are notoriously inaccurate at predicting dangerousness and in fact have a pronounced tendency to overpredict."); Morse, *supra* note 42, at 598 ("Nearly always, professionals err in the direction of *overpredicting* the occurrence of legally relevant behavior, of overproducing false positives."); Henry J. Steadman & Joseph Cocozza, *Psychiatry, Dangerousness and the Repetitively Violent Offender*, 69 J. CRIM. L. & CRIMINOLOGY 226, 231 (1978) ("Psychiatrists can demonstrate no special expertise in making predictions of future violent behavior.").

[65] Courts frequently stress the importance of an acquittee's history of compliance or noncompliance when making release decisions. *See, e.g.*, State v. Dudley, 903 S.W.2d 581, 587 (Mo. Ct. App. 1995) (listing "whether the individual has a successful history of taking medication while on conditional release" as an important factor to consider when making a release determination).

[66] 563 So. 2d 841, 845 (La. 1990).

[67] *Id.* at 846 (Dennis, J., dissenting).

[68] Although an acquittee may have regained her sanity because of medication, this should not prevent her from being deemed sane for the purpose of release from PIAC. *See supra* Part II.A.1.a.

Only the *concurrent* presence of a mental illness and dangerousness justifies continued confinement under PIAC.[69] Thus, as the dissenting opinion in *Perez* noted, if an acquittee such as Mr. Perez no longer suffers from a mental illness, then the "propensity for danger alone is not [a] sufficient constitutional basis for [his continued] confinement."[70]

Although courts may certainly take medication compliance into account in assessing the dangerousness of an insanity acquittee, they should (1) only base their predictions on substantiated evidence, such as an acquittee's prior history of noncompliance or express "threats of future noncompliance,"[71] and (2) only make such predictions when dangerousness is a constitutionally relevant issue (i.e., when the acquittee has not been deemed sane).

2. Implementing Conditional Release Programs

In recent years, a number of states[72] and Congress[73] have adopted statutes providing for the conditional release of insanity acquittees from the hospital. Conditional release statutes generally "authorize the release of an insanity acquittee upon such conditions of medical care or treatment as the court deems appropriate to ensure that the acquittee will not present a danger to himself or others, such as a regimen of medication."[74] If an acquittee fails to abide by the prescribed treatment regimen, the state may revoke the conditional release and rehospitalize the acquittee.[75]

Upon first glance, conditional release programs seem to be a logical response to the problem of insanity acquittee recidivism. Closer examination of conditional releases, however, reveals that they can be constitutionally problematic. Before evaluating the flaws of conditional release provisions, it is important to reiterate the constitutional standard for PIAC: "[D]ue process requires that the nature and dura-

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[69] *See supra* notes 27-29 and accompanying text (discussing the Supreme Court's holding in *Foucha v. Louisiana*, 504 U.S. 71, 80 (1992), that a state may not confine an insanity acquittee who, though possibly dangerous, is no longer mentally ill).

[70] *Perez*, 563 So. 2d at 846 (Dennis, J., dissenting).

[71] *In re* George L., 648 N.E.2d 475, 481 (N.Y. 1995).

[72] *See, e.g.*, CAL. PENAL CODE §§ 1602–1603 (West 2000) (providing for conditional release); HAW. REV. STAT. § 704-411 (1993 & Supp. 2000) (same).

[73] *See* 18 U.S.C. § 4243(f) (2000) (establishing a federal conditional release provision).

[74] 21 AM. JUR. 2D *Criminal Law* § 89 (1998) (footnote omitted).

[75] *See, e.g.*, 18 U.S.C. § 4243(g) (2000) (providing for revocation of conditional discharge).

tion of commitment bear some reasonable relation to the purpose for which the individual is committed."[76] In the PIAC context, the purpose for committing the acquittee is to deal nonpunitively with her mental illness and dangerousness. Thus, if *either* the acquittee's illness *or* her dangerousness is alleviated, the state loses any interest in continuing to confine the acquittee under the rubric of PIAC. Insanity and dangerousness are two distinct concepts and only their concurrent presence justifies commitment.[77] All too often, courts and legislatures conflate the two concepts, defining insanity in terms of dangerousness and vice versa.[78] Although insanity and dangerousness may be interrelated in some individuals, that is not always the case; it is perfectly plausible for a person to be sane and dangerous or insane and nondangerous.

The conditional release of insanity acquittees can violate the constitutional standard for PIAC in a number of important ways. First, under some conditional release statutes, an insanity acquittee must be found nondangerous before the state will conditionally release her.[79] "[N]o trial judge in his or her right mind would release a patient to outpatient status on the theory that, because of the supervision and treatment the patient is supposed to receive, he or she will no longer be dangerous to others."[80]

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[76] Jackson v. Indiana, 406 U.S. 715, 738 (1972).

[77] *See supra* notes 27-29 and accompanying text (discussing the Supreme Court's holding in *Foucha v. Louisiana*, 504 U.S. 71, 80 (1992), that a state may not confine an insanity acquittee who, though possibly dangerous, is no longer mentally ill).

[78] For example, the California conditional release statute defines sanity as no longer being "a danger to the health and safety of others, due to mental defect, disease, or disorder." CAL. PENAL CODE § 1026.2(e) (West Supp. 2005).

[79] *See, e.g.*, MO. ANN. STAT. § 552.040.14 (West 2002) ("No committed person shall be conditionally released until it is determined that the committed person is not likely to be dangerous to others while on conditional release."). Some states do not require a finding of nondangerousness before an acquittee may be conditionally released. For example, Hawaii's conditional release statute provides that if an acquittee is found to be either nondangerous or not mentally ill, she must be *unconditionally* released. HAW. REV. STAT. § 704-411 (1993 & Supp 2000). She may be *conditionally* released if she is mentally ill *and* presents a danger to herself or others, *but* can be "controlled adequately and given proper care, supervision, and treatment." *Id.* Hawaii's conditional release statute therefore meets the constitutional requirements set forth in *Foucha* because it requires both mental illness and dangerousness as a prerequisite to confinement.

[80] Grant H. Morris, *Placed in Purgatory: Conditional Release of Insanity Acquittees*, 39 ARIZ. L. REV. 1061, 1107 (1997) (citing People v. Harner, 262 Cal. Rptr. 422, 431 (Ct. App. 1989) (Kline, J., dissenting)).

But, if the acquittee is adjudged nondangerous at the end of her inpatient commitment, then the state has no further interest in limiting the acquittee's liberty, as an inpatient or an outpatient. Although the state may wish to monitor the acquittee to ensure that she is in fact nondangerous, it may not do so by prolonging PIAC—even on an outpatient basis—when the initial justificatory grounds for commitment (i.e., concurrent presence of insanity and dangerousness) no longer exist. The state could resort to civil commitment if the requisite criteria were met,[81] but PIAC of any form would no longer be permissible.

Second, even if the initial conditional release could be construed as constitutional, the revocation procedures followed in many states certainly are not. The California statute governing revocation of conditional release does not require a finding of dangerousness before the acquittee may be rehospitalized.[82] In *In re McPherson*, an appellate court in California held that the statute's failure to require a finding of dangerousness was *not* the result of a "legislative oversight."[83] Rather, the court noted, the state may revoke an insanity acquittee's conditional release upon determining that the acquittee "requires extended inpatient treatment" or that she "refuses to accept further outpatient treatment and supervision."[84] Under the California court's interpretation of the statute, therefore, dangerousness is not a prerequisite to recommitment.[85]

In response to the California courts' interpretation of the state's conditional release statute, the San Diego County Conditional Release Program (CONREP) has revoked the conditional release status of acquittees who never violated the law while they were outpatients.[86] Quite often, CONREP has based its revocation decisions on the suspi-

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[81] *See infra* note 91 (describing the criteria for involuntary civil commitment).

[82] *See* CAL. PENAL CODE § 1608 (West 2000) (providing for judicially determined revocation when the treatment supervisor finds that the acquittee requires extended inpatient treatment or refuses to accept further outpatient treatment and supervision).

[83] 176 Cal. App. 3d 332, 339 (Ct. App. 1985).

[84] *Id.* (quoting CAL. PENAL CODE § 1608).

[85] Although a finding of dangerousness is not a necessary prerequisite to revocation under the California conditional release statute, it is a permissible consideration. *See, e.g.*, People v. DeGuzman, 33 Cal. App. 4th 414, 420 (Ct. App. 1995) (upholding the trial court's decision to revoke an acquittee's conditional release status in part because he "posed a possible danger to public safety").

[86] *See* Morris, *supra* note 80, at 1095 (noting cases in which CONREP recommended "revocation of outpatient status . . . for patients who had not engaged in criminal activity").

cion that an insanity acquittee is no longer taking her antipsychotic medication or regularly attending therapy sessions.[87] In one case, "CONREP sought revocation of [an acquittee's] outpatient status even though the patient had not committed any criminal act or violated any terms and conditions of his outpatient status."[88] In justifying the revocation, CONREP asserted that the acquittee lacked insight into his mental disorder and was "medically fragile."[89]

California's approach to the revocation of an insanity acquittee's conditional release status is unconstitutional. As previously noted, the state's nonpunitive interest in confining and monitoring an insanity acquittee is inextricably tied to the continued existence of a mental disorder that renders the acquittee dangerous. If the acquittee is simply mentally ill, but not dangerous, the state's PIAC interest is terminated.[90] The state may pursue civil commitment if its law permits the involuntary commitment of a nondangerous mentally ill person for the purpose of treatment.[91] However, PIAC in any form for an acquittee who is no longer dangerous is impermissible.

A third critique of the conditional release system is that by "retain[ing] indeterminate control over insanity acquittees . . . [it] inflicts impermissible punishment" on a group of offenders who have proven beyond a reasonable doubt that they are not criminally responsible.[92] Most conditional release programs require that acquittees live in a particular residence, take certain medications, receive therapy at specified times and places, refrain from the use of alcohol and

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[87] *See id.* (describing revocation based on CONREP's belief that an acquittee was not receiving treatment).

[88] *Id.* at 1096-97.

[89] *Id.* at 1096.

[90] *See supra* note 77 and accompanying text (stating the constitutional prerequisites for confinement).

[91] Civil commitment is the involuntary treatment or care of mentally disabled persons outside of the criminal context. REISNER ET AL., *supra* note 54, at 666. Civil commitment laws come in two varieties: the police power model and the *parens patriae* model. *See generally id.* at 678-746. Statutes rooted in the state's police powers permit the commitment of a person who "as a result of mental illness . . . is dangerous to others or to self." *Id.* at 670 (internal quotation marks omitted). Almost every state has a civil commitment law based on the police power model. Approximately twenty-five states also have *parens patriae* commitment laws, which "permit commitment of a mentally ill person who is shown to be, as a result of mental illness, unable to provide for his or her basic needs, gravely disabled or likely to deteriorate." *Id.* (internal quotation marks omitted).

[92] Morris, *supra* note 80, at 1113.

drugs, and remain in the county and/or state at all times.[93] These stringent requirements, combined with the fact that conditional release decisions are often made in an arbitrary and unconstitutional manner,[94] render the conditional release system more punitive than rehabilitative.[95]

Although parole and conditional release are theoretically distinct,[96] in practice they are sometimes indistinguishable. For example, studies have shown that insanity acquittees who committed homicide are kept on conditional release for longer periods of time than persons acquitted of less serious crimes.[97] As Professor Grant H. Morris has noted, "[p]erhaps these data suggest that decisions to retain patients in [conditional release] are unduly influenced by a charge of homicide that resulted in an insanity acquittal."[98] If this is so, then

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[93] *See id.* at 1092-93 (describing the general mandates of conditional release programs).

[94] *See supra* text accompanying notes 79-91 (describing how revocation decisions are often made without regard for the constitutional requirement that the state may only exercise control over insanity acquittees who are both mentally ill and dangerous).

[95] The primary purpose of a punitive system is to punish an offender for committing a specific crime. *See generally* REISNER ET AL., *supra* note 54, at 525-27 (discussing rationales for criminal punishment based on the commission of a particular act). Systems that govern the release of insanity acquittees may not be punitive in nature because the acquittee has not been found guilty of committing a crime and therefore may not be punished. Rather, one of the main reasons the acquittee is confined is so that she may be rehabilitated. *See id.* at 530-31 (implying that confinement provides for rehabilitation and incapacitation). Rehabilitation focuses on helping the acquittee through counseling, medication, training, etc., to change her behavior so that she may be safely reintegrated into society.

[96] *See* Bergstein v. State, 588 A.2d 779, 783-84 (Md. 1991) ("[T]here are significant differences between . . . conditional release and . . . parole or probation. Parole and probation are essentially a product of punitive sanctions imposed for the commission of a criminal act . . . . Conditional release, however, is not a tool of the penal system. Rather, it is a therapeutic release . . . ." (citations omitted)).

[97] *See* Morris, *supra* note 80, at 1083-84 (noting the high proportion of CONREP patients who were acquitted of homicide as opposed to other crimes).

[98] *Id.* It is certainly possible that insanity acquittees who committed homicide suffer from more severe and pervasive mental disorders and are therefore more dangerous than acquittees who commit minor offenses. However, courts sometimes consider the fact that the acquittee committed a homicide to be the "foremost" piece of evidence in assessing the acquittee's current dangerousness. *See, e.g.*, Warren v. Harvey, 632 F.2d 925, 934 (2d Cir. 1980) (pointing out that the acquittee had already "committed the most extreme form of violence"); State v. Perez, 563 So. 2d 841, 845 (La. 1990) ("When the crime is a serious one like murder, a court should be especially cautious before releasing an insanity acquittee."). These courts will also discount the fact that a homicidal acquittee has not behaved violently while committed, noting that the acquittee has been in custody and thus her dangerousness cannot be properly assessed. *See,*

states are employing conditional release as a punitive—rather than a rehabilitative—means of dealing with acquittees. This approach directly conflicts with the Supreme Court's holding in *Jones*:

> [Because the acquittee] was not convicted, he may not be punished. His confinement rests on his continuing illness and dangerousness. Thus, . . . no matter how serious the act committed by the acquittee, he may be released . . . if he has recovered. In contrast, one who committed a less serious act may be confined for a longer period if he remains ill and dangerous. There simply is no necessary correlation between severity of the offense and length of time necessary for recovery.[99]

Thus, although conditional release seems to be a practical solution to the problem of insanity acquittee recidivism, certain release statutes violate the constitutional standards for acquittee commitment established in *Jones* and *Foucha* and are impermissibly penal in nature.

B. *Approaches that Attack the Validity of the Insanity Defense Itself*

The second general category of approaches to reducing insanity acquittee recidivism entails modification of the insanity defense itself. Modifications include adoption of the guilty but mentally ill (GBMI) verdict and complete abolishment of the insanity defense.

1. The Adoption of the Guilty but Mentally Ill Verdict

In response to highly publicized violent acts of recidivism committed by insanity acquittees,[100] several states adopted the GBMI verdict as an alternative to a finding of legal insanity.[101] The GBMI verdict per-

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e.g., *Warren*, 632 F.2d at 934 ("[T]he lack of evidence that appellant has engaged in more recent violent acts or threats must be viewed in light of the fact that he has been in custody ever since he killed his neighbor."). Although the commission of a prior violent act is certainly probative of current dangerousness, it cannot be the sole piece of evidence relied upon by courts. If that were the case, then acquittees who committed homicide would be deemed perpetually dangerous, regardless of the strides they made while committed. The fact that some courts rely on an acquittee's prior homicide as the "foremost" piece of evidence in assessing an acquittee's current dangerousness suggests that the motivation behind the confinement may be more punitive than rehabilitative.

[99] Jones v. United States, 463 U.S. 354, 369 (1983) (footnote omitted).

[100] See *supra* text accompanying notes 1-7 (discussing violent recidivist acts by two insanity acquittees and the resulting public outcry).

[101] For statutes defining the GBMI verdict, see, for example, KY. REV. STAT. ANN. § 504.130 (LexisNexis 1999); MICH. COMP. LAWS ANN. § 768.36 (West 2000); 18 PA. CONS. STAT. ANN. § 314 (West 2002); S.C. CODE ANN. § 17-24-20 (2003); S.D. CODIFIED LAWS § 23A-26-14 (2004).

mits a jury to find that a defendant is mentally ill, yet criminally responsible for the crime charged.[102] The defendant must then receive proper psychological treatment while imprisoned.[103]

The GBMI verdict is a "useless, confusing alternative" to the insanity defense.[104] A mentally ill defendant who does not meet the legal criteria for insanity and is convicted of a crime will receive psychopharmacological treatment in prison *regardless of the availability of a GBMI verdict*.[105] Thus, there is no meaningful distinction between a defendant who receives a GBMI verdict and one who receives a straightforward guilty verdict. In fact, in some jurisdictions, a person receiving a GBMI verdict may even be executed.[106]

The only plausible explanation for the widespread adoption of the GBMI verdict is that legislatures hope it will induce juries to return GBMI verdicts in cases where they ordinarily would have acquitted the defendant by reason of insanity.[107] "[I]mpermissibly allow[ing] juries

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[102] *See, e.g.*, 18 PA. CONS. STAT. ANN. § 314(a) (West 2002) ("A person . . . may be found 'guilty but mentally ill' at trial if the trier of fact finds, beyond a reasonable doubt, that the person is guilty of an offense, was mentally ill at the time of the commission of the offense and was not legally insane at th[at] time . . . .").

[103] *See, e.g.*, 42 PA. CONS. STAT. ANN. § 9727(b) (West 2002) ("An offender who is severely mentally disabled and in need of treatment at the time of sentencing shall, consistent with available resources, be provided such treatment as is psychiatrically or psychologically indicated for his mental illness.").

[104] Stephen J. Morse, *Excusing and the New Excuse Defenses: A Legal and Conceptual Review*, 23 CRIME & JUST. 329, 401 (1998). According to Professor Christopher Slobogin, proponents of the GBMI verdict contend that it will (1) "reduce, if not eliminate, inappropriate insanity acquittals"; (2) "prevent, or at least postpone, the further commission of violent acts by mentally ill individuals"; (3) "assur[e] more effective treatment for mentally ill offenders"; and (4) "discourag[e] the insanity plea" thereby minimizing battles between experts. Slobogin, *supra* note 7, at 505. For an analysis of the GBMI verdict's failure to fulfill these goals, see *id.* at 506-17.

[105] *See* Slobogin, *supra* note 7, at 512-13 (providing examples from Illinois and Indiana of laws requiring the Department of Corrections to provide psychiatric treatment for prisoners who require it); *see also* Gare A. Smith & James A. Hall, *Evaluating Michigan's Guilty but Mentally Ill Verdict: An Empirical Study*, 16 U. MICH. J.L. REFORM 77, 104-05 (1982) (finding that the "GBMI prisoner is not more likely to receive mental health treatment than the prisoner with a simple guilty verdict; the GBMI prisoner in Michigan is tested and evaluated like any other prisoner" (footnote omitted)).

[106] *See* People v. Crews, 522 N.E.2d 1167, 1172-75 (Ill. 1988) (holding that a verdict of guilty but mentally ill does not preclude the trial judge from sentencing a defendant to death because GBMI is not the equivalent of an insanity plea and the legislature did not intend such preclusion).

[107] Although one of the goals of the GBMI verdict is to decrease the number of "not guilty by reason of insanity" verdicts, research suggests that "most defendants found GBMI would probably have received guilty verdicts in the absence of the GBMI statute." Smith & Hall, *supra* note 105, at 104.

to avoid finding a defendant not guilty by reason of insanity in cases in which legal insanity appears justified"[108] is an inappropriate means of reducing insanity acquittee recidivism. If the insanity defense is available and the defendant meets the requisite criteria, then she should be able to take full advantage of it. The GBMI verdict distracts juries from evaluating the appropriateness of the insanity defense in a particular case and dupes them into believing that they are striking a fair balance between public safety and the mental health needs of the defendant. In reality, they may be imprisoning defendants who do not meet the requirements for criminal responsibility.

2. Complete Abolishment of the Insanity Defense

Four states have completely abolished the insanity defense and admit evidence of mental illness only to negate mens rea.[109] Complete abolishment of the insanity defense is an overreaction to the recidivism problem. It fails to take into account the fact that some offenders are truly not capable of rational thought and are thus unable to be deterred by the criminal law. In an effort to protect public safety, such an approach utterly ignores the mental capacity of the offender and inappropriately attaches criminal blame and punishment to undeserving defendants.

Admitting evidence of mental illness to negate criminal intent is an inadequate replacement for the insanity defense. To be acquitted under this approach, a defendant must establish that her mental incapacity prevented her from formulating the requisite mens rea to commit the crime.[110] The classic example is the man who strangles his

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[108] Morse, *supra* note 104, at 401.

[109] Kansas, Montana, Idaho, and Utah have passed legislation abolishing the insanity defense and providing that evidence of mental illness may only be admitted to negate a defendant's mens rea. *See* IDAHO CODE ANN. § 18-207 (2004) (establishing a mental disease or defect as defenses to prosecution insofar as they negate the mental state element(s) of the crime charged); KAN. STAT. ANN. § 22-3220 (1995) (same); MONT. CODE ANN. § 46-14-102 (2003) (same); UTAH CODE ANN. § 76-2-305 (West 2003) (same). The highest court of each of the four states has upheld the constitutionality of the abolishment. *See* State v. Searcy, 798 P.2d 914, 919 (Idaho 1990) (ruling that the availability of the insanity defense is not guaranteed by the state constitution); State v. Bethel, 66 P.3d 840, 851 (Kan. 2003) (same); State v. Korell, 690 P.2d 992, 1002 (Mont. 1984) (same); State v. Herrera, 895 P.2d 359, 366 (Utah 1995) (same). *But see* Finger v. State, 27 P.3d 66, 80 (Nev. 2001) (finding that the abolishment of the insanity defense violated federal due process).

[110] *See* Marc Rosen, Student Article, *Insanity Denied: Abolition of the Insanity Defense in Kansas*, 8 KAN. J.L. & PUB. POL'Y 253, 255 (1999) ("This approach permits a defendant to introduce expert psychiatric witnesses or evidence to litigate the intent ele-

wife to death, but—as a result of mental illness—believes that he is squeezing a lemon.[111] His mental illness prevents him from possessing the intent to kill, and the mens rea necessary for homicide is negated. But in reality, "defendants rarely lack mens rea because they believe they are squeezing a lemon."[112] Rather, most mentally ill defendants commit crimes intentionally, but do so for crazy reasons (e.g., they heard voices commanding them to kill).[113] Thus, the mens rea approach is an unsatisfactory alternative to the insanity defense and "unfairly punishes people who are completely unable to understand the nature and consequences of their actions."[114]

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Thus far, I have examined five approaches adopted by states to reduce insanity acquittee recidivism. The first three approaches aim at ensuring that insanity acquittees abide by their medication regimen after release.[115] I concluded that evaluating acquittees in an unmedicated state when making release decisions is both impractical and inequitable. The remaining two methods (taking medication compliance into account when assessing the dangerousness of an acquittee and implementing conditional release programs) *are* effective means of reducing insanity acquittee recidivism, but only if they are applied in an equitable fashion and in accordance with constitutional norms.[116]

In addition, I have concluded that the two methods that attack the validity of the insanity defense itself (the GBMI verdict and the complete abolition of the insanity defense) are inadequate.[117] Studies of the GBMI verdict demonstrate that it does not alter the number of in-

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ments of the crime. If the evidence negates the requisite intent, the defendant is entitled to an acquittal.").

[111] *See* MODEL PENAL CODE § 4.01 cmt. 2 (1980) (providing the lemon example).

[112] Rosen, *supra* note 110, at 261 (emphasis omitted).

[113] *See id.* at 261 ("[E]vidence of mental disease or defect would still be of no help since the hearing of voices has nothing to do with whether [a defendant] acted with intent, purposefully or knowingly."); *see also*, Stephen J. Morse, *Excusing the Crazy: The Insanity Defense Reconsidered*, 58 S. CAL. L. REV. 777, 801-02 (1985) ("[V]irtually all crazy persons know, in the strictest sense, what they are doing and intend to do it. A person who kills another because of a delusional belief is aware of killing a human being and does so intentionally.").

[114] Rosen, *supra* note 110, at 262.

[115] *See supra* Part II.A.1.a–b, II.A.2.

[116] *See supra* Part II.A.1.b, II.A.2.

[117] *See supra* Part II.B.1–2.

dividuals found not guilty by reason of insanity, and thus it has no effect on the rate of insanity acquittee recidivism.[118] Even if the GBMI verdict reduced the number of acquittals by reason of insanity, it would do so at the unjustifiable cost of imprisoning individuals who are not criminally responsible for their actions. Similarly, abolishing the insanity defense places criminal blame and punishment on an undeserving class of offenders.

III. A NEW APPROACH TO INSANITY ACQUITTEE RECIDIVISM

I propose a new means of dealing with insanity acquittee recidivism which, in conjunction with certain methods currently employed by the states,[119] would serve as an effective "external accountability control[]"[120] for acquittees. Before I set forth my proposal, it is necessary to delineate five key assumptions that I have made in its development.

A. *The Assumptions*

First, the insanity defense is a valid affirmative defense. Although opponents of the insanity defense claim that it produces inaccurate verdicts, is overused, and permits guilty people to avoid punishment,[121] such criticism is untenable.[122] In our society, "[c]onviction

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[118] *See supra* note 107 (citing research suggesting that most defendants found GBMI would probably have received guilty verdicts in the absence of the GBMI statute). If individuals who would have otherwise been found guilty are imprisoned under a verdict of GBMI, then it is not exerting any deterrent effect on insane acquittees.

[119] Such methods include implementing conditional release programs that are constitutionally appropriate or assessing the acquittee's dangerousness on the basis of firm evidence and only when the issue is constitutionally relevant. *See, e.g.*, *supra* note 79 (arguing that Hawaii's conditional release statute meets the constitutional requirements as set forth in *Foucha*); *cf. supra* text accompanying notes 64-70 (discussing courts' use of medication compliance evidence in determining whether an acquittee should be conditionally released).

[120] State v. Dudley, 903 S.W.2d 581, 587 (Mo. Ct. App. 1995).

[121] For example, former Attorney General Edwin Meese argued that abolishing the insanity defense would "rid . . . the streets of some of the most dangerous people that are out there and committing a disproportionate number of crimes." *See* MICHAEL L. PERLIN, THE JURISPRUDENCE OF THE INSANITY DEFENSE 18 (1994) (quoting *Reagan Adviser Meese Enunciates Administration's Crime Control Goals*, 12 CRIM. JUST. NEWSLETTER 4 (1981)).

[122] *See id.* at 73-142, 229-62 (1994) (explaining why avoidance of punishment is an erroneously perceived result of the insanity defense); *see also* Morse, *supra* note 113, at 797 ("Insanity acquittals are far too infrequent to communicate the message that the criminal justice system is 'soft' or fails to protect society.").

and punishment are justified only if the defendant deserves them."[123] The "actor's responsibility as a moral agent" is a "basic precondition for desert."[124] Thus, if a person, because of a severe mental illness, does not possess the requisite capacity for rationality, she cannot be considered responsible for her actions or deserving of criminal blame and punishment. The insanity defense properly reflects the notion that a defendant whose mental disorder renders her irresponsible is not in fact culpable.

Second, there are genuine differences between convicting a defendant and sending her to jail, and acquitting a defendant by reason of insanity and hospitalizing her. In the case of the convicted defendant, society has deemed her criminally responsible for her actions. Because she is fully culpable for her behavior, society may "extinguish" her "right to freedom from confinement" and imprison her for an established period of time.[125] The insanity acquittee, however, has been found criminally *nonresponsible*. The state may confine the acquittee—not because she is culpable, but because she is nonresponsibly dangerous.[126] The length of her commitment will not depend on the severity of the crime she committed.[127] Rather, it will "rest[] on [her] continuing illness and dangerousness."[128] The distinction between criminal conviction and acquittee hospitalization is significant, and it plays an indispensable role in my proposal.

Third, insanity and dangerousness are two distinct concepts. Admittedly, at the time of initial commitment, an acquittee is presumably both insane and dangerous.[129] However, by the time the state consid-

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[123] *Id.* at 781.

[124] *Id.*

[125] Vitek v. Jones, 445 U.S. 480, 493-94 (1980).

[126] *See supra* text accompanying notes 76-77, 99 (explaining that acquittees may only be confined so long as they are both mentally ill and dangerous).

[127] Although this statement is true in theory, it is not always so in practice. *See* Ronald Roesch & James R.P. Ogloff, *Settings for Providing Criminal and Civil Forensic Mental Health Services*, *in* MENTAL HEALTH AND LAW, *supra* note 51, at 191, 199 (noting a study that compared the length of time for which insanity acquittees were confined to the sentences of defendants who were found guilty after raising the insanity defense, and that the study found that insanity acquittees, with the exception of murder cases, were "confined for considerably longer periods of time"). Some state statutes explicitly provide that "commitment of acquittees be limited to the maximum sentence the acquittee would have received had he or she been found responsible for the crime charged." REISNER ET AL., *supra* note 54, at 842.

[128] Jones v. United States, 463 U.S. 354, 369 (1983).

[129] *See id.* at 363-64 ("A verdict of not guilty by reason of insanity establishes two facts: (i) the defendant committed an act that constitutes a criminal offense, and (ii)

ers whether or not to release the acquittee, it is perfectly plausible that she may be sane and dangerous, or insane and nondangerous. Although states sometimes take one factor into account in assessing the existence of the other (e.g., the acquittee is still mentally ill—therefore, she must also still be dangerous), this approach is neither required nor appropriate in all cases.[130] The distinction between sanity and dangerousness is particularly important to the validity of my proposal because my proposal only applies to those acquittees pronounced sane at the time of release. Thus, if an acquittee is deemed mentally ill but nondangerous upon release, my proposal would not govern her post-release recidivism.[131]

Fourth, my proposal only reaches acquittees who are mentally ill when they recidivate. Acquittees who maintain their sanity but continue to commit crimes after release are quite clearly responsible and should be dealt with according to the standard rules of the criminal justice system.

Fifth, I am presuming that the prima facie case of the recidivist crime the acquittee is charged with has been proven. Thus, the only element in dispute is whether the acquittee possesses a valid affirmative defense based upon her mental state at the time of the crime.

B. *The Proposal: Abolishing the Insanity Defense for Certain Acquittee Recidivists*

My basic proposal is the following: if an insanity acquittee, who is judged sane at the time of release from PIAC, subsequently commits a crime while mentally ill, she will be unable to raise the insanity defense.

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he committed the act because of mental illness. . . . [T]hese findings constitute an adequate basis for hospitalizing the acquittee as a dangerous and mentally ill person.").

[130] *See* Carlisle v. State, 512 So. 2d 150, 160 (Ala. Crim. App. 1987) (ordering the release of a mentally ill but nondangerous acquittee).

[131] I believe, however, that in practice states release very few acquittees whom they consider to be insane but nondangerous. Accurate dangerousness predictions are very difficult to make. Clinicians will often overpredict dangerousness, "especially when the consequence of a finding of dangerousness is that an obviously mentally ill patient will remain within their control." *Carlisle*, 512 So. 2d at 159 (quoting *Jones*, 463 U.S. at 378-79) (internal quotation marks omitted). Furthermore, the mental stability of an acquittee is often a factor considered in making the dangerousness prediction itself. Thus, although no data are currently available on this issue, I contend that nondangerous, mentally ill acquittees make up a small minority of acquittees released from PIAC. The scope of my proposal, then, is still quite broad and will effectively reach most acquittee recidivists.

Generally, when an insanity acquittee is released, she has been deemed sane by the state.[132] This finding of sanity entails a recognition that the acquittee now possesses the capacity for rationality and the ability to be guided by reason.[133] In this rational state, the acquittee is capable of comprehending that she previously committed a crime while suffering from a severe mental disorder, and, if proper precautions are not taken, that she may potentially become insane (and dangerous) again.[134] Accordingly, she must take all steps within her power to prevent herself from deteriorating into a state of mental instability. My proposal would require the acquittee to abide by the following mandates upon release from PIAC.

First, the acquittee must strictly adhere to the treatment regimen that was developed for her while she was hospitalized. Medication compliance is the single most important factor in avoiding mental illness relapse.[135] Thus, even if the acquittee dislikes the side effects of her medication, she *must* continue to take it.[136] She must also comply with any other form of treatment that her doctors have prescribed for

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[132] *See supra* notes 129-31 and accompanying text.

[133] *Cf.* Benjamin B. Sendor, *Crime as Communication: An Interpretive Theory of the Insanity Defense and the Mental Elements of Crime*, 74 GEO. L.J. 1371, 1391 n.95 (1986) (explaining that a legally insane defendant must lack "rationality [with regard to] the conduct with which he is criminally charged" (citing HERBERT FINGARETTE, THE MEANING OF CRIMINAL INSANITY 210-11 (1972))).

[134] It is often asserted that many mentally ill people (particularly schizophrenics) do not have insight into their disorders, and thus do not believe they are mentally ill. *See* Manahan, *supra* note 44, at 20 & n.123 (noting that many mentally ill people are not aware of their mental illness). This should not be a concern for the group of acquittees my proposal is targeting. Once an acquittee has regained her sanity she is capable of rational thought and will thus be able to understand the effects of her illness and the proper ways to manage them.

[135] *See id.* at 20 ("Systems that are successful in keeping individuals with mental illness out of the hospital have found medication compliance to be the single most important factor in achieving such success.").

[136] I am not minimizing the side effects that a patient may suffer from antipsychotic medication. However, the advent of atypical antipsychotic medications, which have a lower risk of the side effects that are generally associated with traditional medicines, provides patients with less-unpleasant options. *See* REISNER ET AL., *supra* note 54, at 28-29, 948-49 (discussing the impact of the new antipsychotic medications on right-to-refuse jurisprudence); SPEAKING, *supra* note 52, at 18 (explaining that newer antipsychotic drugs have a lower risk of tardive dyskinesia, a serious side effect of traditional medicines). Furthermore, "[a]lthough the side effects of medications for treatment of mental disorders are real and should not be underestimated, the overall benefit of the effectiveness of such medication in helping people with mental illness live as non-dangerous, functioning members of society seems to outweigh the side effects' negative impact." Manahan, *supra* note 44, at 20.

her (e.g., participating in cognitive behavioral therapy, self-help groups, or vocational training).

In addition to rigorously adhering to a specified treatment regimen, the acquittee must actively work to eliminate any potentially destabilizing risk factors from her life. She must refrain from drinking alcohol,[137] ingesting narcotics,[138] and smoking nicotine.[139] Regular attendance at either school or work would also be mandatory.[140]

The state will expect the acquittee to cooperate fully with the above directives, and to take an active, responsible role in preserving her own mental health. If the acquittee fails to do so, and she recidivates, the state will hold her criminally responsible, even though she may be insane at the time of the recidivist crime. Her criminal responsibility lies not in the commission of the crime itself,[141] but rather in her failure to take the necessary precautions to avoid going insane again.

Several courts have adopted a similar approach in dealing with epileptic drivers. An epileptic who is aware of her condition and suffers from a seizure while driving may be held liable for any resulting accidents.[142] An epileptic, of course, is not responsible in the tradi-

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[137] *See* Rice & Harris, *supra* note 13, at 405 ("Alcohol has been found to be related to criminality and especially to violence in a number of . . . studies." (citation omitted)).

[138] *See* SPEAKING, *supra* note 52, at 8 (stating that substance abuse can both exacerbate the symptoms of, and reduce the effectiveness of treatment for, schizophrenia).

[139] *See id.* ("[S]moking has been found to interfere with the [patient's] response to antipsychotic drugs.").

[140] *See* Rice et al., *supra* note 51, at 177 (noting that "attendance at school or [a] job [has been] listed by clinicians as a recommended security precaution" for some forensic patients).

[141] I am assuming that the acquittee is insane at the time she recidivates. Thus, she lacks the capacity for rationality at the time of the crime. She, therefore, will not be responsible in the traditional sense for the commission of the crime.

[142] *See, e.g.*, Holcomb v. Miller, 269 N.E.2d 885, 887-88 (Ind. Ct. App. 1971) (en banc) (holding that in order for an epileptic defendant's seizure to "effectively excuse her failure to control the vehicle, [she] must . . . show[] by a preponderance of the evidence [that it] occurred without fair warning or under such circumstances as to preclude her from taking reasonable precautions"); Martino v. Aetna Cas. & Sur. Co., 351 So. 2d 204, 204-05 (La. Ct. App. 1977) ("Where it has been demonstrated that drivers have had prior blackout experience from epileptic convulsion . . . the courts have found negligence based on foreseeability." (footnotes omitted)); People v. Decina, 152 N.Y.S.2d 169, 171 (App. Div. 1956) (stating that awareness of a foreseeable condition that will "deprive [one] of effective control over the operation of [her] vehicle" is sufficient for responsibility); Vinci v. Heimbach, Nos. 73440, 73464, 1998 WL 895381, at *3 (Ohio Ct. App. Dec. 17, 1998) ("[C]ontinued driving, with knowledge of a diagnosed epileptic condition and prior seizures, would provide sufficient evidence of ig-

tional sense; she is unconscious at the time of the seizure and thus is neither negligent nor reckless during the accident itself. Both negligence and recklessness presuppose voluntary action. Nonetheless, the epileptic is deemed responsible for failing to do everything within her power *before the accident* to avoid a grave risk of which she was consciously aware—the risk of having a seizure while driving. "It suffices if [an epileptic] is aware of a condition which will deprive [her] of effective control over the operation of the vehicle and can foresee that such condition is likely to occur."[143]

Similarly, the acquittee should be held responsible because of her conscious failure to avoid the serious risk of becoming insane again and recidivating. Like the epileptic who is aware of her medical history, the insanity acquittee is deemed to be on notice of her potential mental instability, and she must take the appropriate steps to guard against it.

C. Exceptions to the Proposal

Under my proposal, not all insanity acquittee recidivists will be considered criminally responsible. To be deemed nonresponsible, and thus to be able to assert the insanity defense, an acquittee must have (1) rigorously abided by her prescribed treatment regimen yet decompensated, (2) lapsed from the treatment regimen through no fault of her own, or (3) committed a crime which truly was not foreseeable.

Although it is true that medication noncompliance is the primary reason that mentally ill individuals relapse,[144] a person's mental condition may deteriorate for an array of inexplicable reasons. Antipsychotic medication is extremely effective in treating most psychotic disorders, but it is not foolproof. Thus, an acquittee may suffer a relapse even though she consistently takes her medication.[145] If the acquittee can successfully establish that she rigidly adhered to her course of treatment, yet still mentally deteriorated, she will be able to assert the affirmative defense of insanity.

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noring a foreseeable risk to recover on a claim of negligence if the condition is untreated or the driver ignores his physician's warnings or advice.").

[143] *Decina*, 152 N.Y.S.2d at 171.

[144] *See* Manahan, *supra* note 44, at 20 (asserting that medication compliance is essential to prevent relapse).

[145] *See* SPEAKING, *supra* note 52, at 15-16 (stating that although relapses of mental illness are more likely to occur when "antipsychotic medications are discontinued or taken irregularly," patients who continue their drug treatment may suffer relapses).

The second exception requires an insanity acquittee to demonstrate that she is not responsible for her failure to follow her treatment regimen. Take, for example, the following scenario: the acquittee is involved in a severe car accident and is hospitalized. The hospital doctors negligently fail to provide the acquittee with her antipsychotic medication, despite her requests for it. The acquittee quickly begins to decompensate and by the time she is released from the hospital she has lost all insight into her disorder and no longer believes that she needs medication to function properly. Under such circumstances, the acquittee is truly not responsible for her noncompliance, and she would be able to raise the insanity defense.

Finally, if an insanity acquittee commits a crime that she could not have reasonably foreseen to be a consequence of decompensation, she cannot be deemed criminally responsible. An acquittee recidivist, like an epileptic driver, should only be held responsible for the consequences of actions she could have foreseen and taken steps to prevent. Thus, an insanity acquittee who knows that she is prone to commit petty theft while insane should not be expected to foresee that she might commit murder while insane. If an insanity acquittee commits such an unforeseeable act, then she may not be held responsible and should be able to rely on the insanity defense.

D. *How to Implement the Proposal*

For my proposal to operate effectively in practice, several important changes would have to be made to our current criminal justice and PIAC systems. First, each acquittee released from PIAC would have to receive a detailed treatment regimen, outlining the specific medicines that she is to take and the psychiatrists and/or psychologists she is to meet with on a regular basis.[146] The acquittee's personal risk factors would also have to be determined and carefully explained to her so that she would be able to avoid them.[147]

Second, states would have to take a more active role in providing insanity acquittees with post-release mental health care services. An acquittee can only adhere to her treatment regimen if a high-quality, accessible regimen is firmly in place. The state, therefore, will have to

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[146] Currently, only acquittees who are conditionally released receive such instructions upon release. *See supra* Part II.A.2.

[147] *See supra* notes 137-40 and accompanying text (pointing to alcohol, nicotine, and poor school or work attendance as risk factors).

ensure that it provides acquittees with the follow-up care they need in order to preserve their mental health.[148]

Finally, the provision of mental health care services in prison would have to be significantly enhanced. Although a substantial number of prisoners are mentally ill,[149] they often fail to receive the necessary psychological treatment in jail. If my proposal were implemented, an even larger number of those suffering from mental disorders would be incarcerated. Although imprisoning such offenders incapacitates them and attaches criminal responsibility to their actions, it fails to adequately treat their mental illnesses. If the mental illness is not properly treated, the dangerousness and mental instability of the acquittee will most likely not be alleviated, and the recidivism problem may be exacerbated. Thus, prisons will have to ensure that inmates are regularly receiving the appropriate antipsychotic medication.[150]

One potential criticism of my proposal is that prisons will become overburdened with psychotic inmates with whom they are not equipped to deal. The most reasonable way to manage this problem is to treat an offender initially while she is in an acute psychotic state in the hospital. It should not take long to stabilize her, particularly because an effective treatment regimen was previously developed for her during PIAC. Once she has been stabilized, she can then be transferred to the prison, where she will continue to receive her regular course of antipsychotic medication.

E. *Constitutionality of the Proposal*

Withholding the insanity defense from certain acquittee recidivists is constitutional because (1) the Supreme Court has never held that the insanity defense is constitutionally mandated,[151] and (2) even if

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[148] If the state allows an acquittee to fall through the cracks, despite the acquittee's efforts to follow her regimen, the acquittee may qualify for an exception to the proposal.

[149] *See* REISNER ET AL., *supra* note 54, at 844 (noting estimations that approximately fourteen percent of convicted felons are psychotic and thirty-five percent suffer from character disorders).

[150] If an inmate refuses to voluntarily take antipsychotic medication, the state may medicate her without her consent "if the inmate is dangerous to [herself] or others and the treatment is in the inmate's medical interest." Washington v. Harper, 494 U.S. 210, 227 (1990).

[151] Language of prior Supreme Court opinions "suggests rather convincingly that [the] Court would conclude that the due process [clause] of the fifth amendment does not require the states to provide a criminal defendant with an independent defense of insanity." State v. Searcy, 798 P.2d 914, 918 (Idaho 1990). The Court has consistently

the insanity defense were constitutionally mandated, my proposal only restricts criminally *responsible* recidivists from employing it.

Unlike the complete abolishment of the insanity defense and the GBMI verdict, my proposal recognizes that the insanity defense is a valid affirmative defense that first-time offenders are entitled to assert. The insanity defense properly recognizes that if an individual's mental illness sufficiently deprives her of the capacity for rationality, then she is not criminally blameworthy for her resultant actions. My proposal is consistent with the basic assumption that the nonresponsibly dangerous should not be subjected to criminal blame and punishment.

Rather, my proposal recognizes that certain insanity acquittees (i.e., those adjudged sane upon their release from PIAC) must be compelled to take responsibility for their mental health in the interest of public safety. Therefore, sane acquittees who willfully fail to abide by their treatment regimen *are responsible*; if their mental decompensation is a result of their deliberate acts or omissions, then criminal blame and punishment are in fact appropriate.

IV. CONCLUSION

It is often contended that "a vital function of the 'forensic mental health system is the safe release, after confinement and inpatient treatment,'" of insanity acquittees.[152] The current state of insanity acquittee jurisprudence, however, requires the release of acquittees after they are either no longer mentally ill or no longer dangerous.[153] Thus, whether or not the acquittee may be safely reintegrated into so-

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emphasized that states have broad discretion in defining the substantive elements of their crimes and affirmative defenses. In *Leland v. Oregon*, the Court declined to constitutionally require a particular version of the insanity defense and upheld a statute that placed the burden of proving insanity beyond a reasonable doubt on the defendant. 343 U.S. 790, 798-90 (1952). In *Powell v. Texas*, the Court again stressed that states enjoy great flexibility in developing substantive criminal law doctrines. 392 U.S. 514, 535-36 (1968). Justice Marshall further cautioned in *Powell* that "[n]othing could be less fruitful than for this Court to be impelled into defining some sort of insanity test in constitutional terms." *Id.* at 536. Marshall's sentiment was later echoed by Justice Rehnquist in his dissenting opinion in *Ake v. Oklahoma*: "It is highly doubtful that due process requires a State to make available an insanity defense to a criminal defendant . . . ." 470 U.S. 68, 91 (1985) (Rehnquist, J., dissenting).

[152] Harris, *supra* note 11, at 228 (ellipsis omitted) (quoting Mark R. Wiederanders et al., *Forensic Conditional Release Programs and Outcomes in Three States*, 20 INT'L J.L. & PSYCHIATRY 249, 249 (1997)).

[153] *See supra* notes 27-29 and accompanying text (discussing Foucha v. Louisiana, 504 U.S. 71, 80 (1992), and Jones v. United States, 463 U.S. 354, 370 (1983)).

ciety may not always be the determinative factor in a release decision.[154]

An insanity acquittee's adherence to an appropriate regime of medication is vital in preventing recidivism.[155] Therefore, in order to minimize post-release acquittee recidivism, medication compliance must be ensured. The current methods adopted by states to deal with this dilemma are impractical, inequitable, or unconstitutional.

My proposal is a more appropriate method of dealing with certain insanity acquittee recidivists than is rehospitalization. First, there are distinct differences between incarcerating an offender and committing her to a state mental institution.[156] In the case of imprisonment, the offender is deemed criminally responsible; in the case of hospitalization, she is not.[157] To the extent that one believes criminal responsibility reflects society's judgment of a person's moral blameworthiness and culpability, this distinction is important. Under my proposal, the acquittee should be forced to take a certain degree of responsibility for her own mental health. If she willfully fails to do so, she should not receive the benefit of the "not guilty" verdict.

Additionally, permitting only the truly nonresponsible recidivists to employ the insanity defense may deter acquittees more effectively than the threat of rehospitalization and thereby reduce acquittee recidivism. If an acquittee is aware that failure to take her medication may result in imprisonment, she may be more inclined to abide by the prescribed treatment regimen. Although the threat of rehospitalization may also induce the acquittee to comply with her course of medication, the hospital is a more familiar environment for most acquittees and thus a less worrisome possibility.[158]

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[154] *See, e.g.*, *Foucha*, 504 U.S. at 85-86 (holding that Louisiana had to release an acquittee who was no longer mentally ill, but still dangerous).

[155] *See supra* note 44 (citing an argument on the importance of medication compliance).

[156] *See supra* notes 125-28 and accompanying text (outlining the distinction between incarceration and hospitalization).

[157] *See Jones*, 463 U.S. at 369 ("As [the acquittee] was not convicted, he may not be punished.").

[158] It is important to reiterate that my proposal is based on the assumption that at the time of her release from PIAC, the acquittee is sane and thus capable of rational thought. At that point in time, she is fully able to evaluate the advantages and disadvantages of continuing to take her medication.

Furthermore, because of the undefined nature and duration of PIAC,[159] rehospitalization often results in the "revolving-door" patient.[160] Once an acquittee regains her sanity or is no longer dangerous, the state must release her.[161] If there is no method of ensuring that the acquittee continues to take her medication after release, she may quickly become insane again, recidivate, and be rehospitalized. The advent of antipsychotic medication accelerates the cycle because the sanity of acquittees can be quickly restored in the hospital, leading to shorter, but perhaps more frequent, hospital stays.[162]

If an acquittee is particularly dangerous while insane,[163] this sequence of events is all the more troubling. My proposal addresses this problem in two respects. First, by threatening acquittees with punitive sanctions, the proposal will likely enhance medication compliance and thus reduce the likelihood that acquittees will recidivate. Second, by incarcerating certain acquittee recidivists, it ensures that they are incapacitated for a fixed period of time, thereby minimizing the number of "revolving-door" acquittees.

Ultimately, my proposal compels insanity acquittees to take responsibility for their own mental health. I am by no means suggesting that the mentally ill are responsible for *having* a mental illness. Rather, I am asserting that when their mental illness causes them to be dangerous, the acquittees must bear some of the costs and take all conceivable precautions to prevent themselves from decompensating and placing society at risk again.

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[159] *See Jones*, 463 U.S. at 370 (holding that the duration of PIAC depends on the concurrent presence of mental illness and dangerousness).

[160] *See* Wisor, *supra* note 45, at 159-60 (explaining that once a stabilized patient is released, she may stop taking her medications, requiring rehospitalization).

[161] *See Foucha*, 504 U.S. at 86 (holding that a person who is no longer mentally ill must be released, even if she is still dangerous) .

[162] *See* Wisor, *supra* note 45, at 160 ("Past studies indicate that as many as forty percent of patients released from state hospitals can be expected to need rehospitalization within six months." (footnote omitted)).

[163] But note that some research indicates that "people with mental illness are no more dangerous as a class than the general population," although "[m]ore recent research is inconclusive on this point." REISNER ET AL., *supra* note 54, at 682-83.