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Cognitive Dissonance: Have Insanity Defense and Civil Commitment Reforms Made a Difference

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1994]

COGNITIVE DISSONANCE: HAVE INSANITY DEFENSE AND
CIVIL COMMITMENT REFORMS MADE
A DIFFERENCE?

JOHN Q. LA FOND*
MARY L. DURHAM**

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This Article develops concepts from our book, *Back to the Asylum: The Future of Mental Health Law & Policy in the United States*, published by Oxford University Press in 1992. An earlier version of this article was presented as a paper at the XVIIIth International Congress on Law and Mental Health on June 26, 1992 in Vancouver, B.C., Canada.

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I. INTRODUCTION

BETWEEN the 1970s and late 1980s, the attitudes and values of the majority of Americans grew increasingly conservative.¹ The Liberal ideologies popular in the 1960s and 1970s were sharply criticized and were replaced by a neoconservative social philosophy and political agenda.² Evidence of this pendular swing of public opinion may be found in the increasing public support for capital punishment,³ the success of political candidates espousing "law and

1. For a discussion of neoconservative ideology, see generally DANIEL BELL, *THE CULTURAL CONTRADICTIONS OF CAPITALISM* (1976); PETER STEINFELS, *THE NEOCONSERVATIVES: THE MEN WHO ARE CHANGING AMERICA'S POLITICS* (1979); Irving Kristol, *What Is a 'Neo-Conservative'?*, *NEWSWEEK*, Jan. 19, 1976, at 17.

2. For a full discussion of the development and entrenchment of neoconservatism, see JOHN Q. LA FOND & MARY L. DURHAM, *BACK TO THE ASYLUM: THE FUTURE OF MENTAL HEALTH LAW AND POLICY IN THE UNITED STATES* 46-81, 100-16 (1992). We recognize that our use of two distinct eras of mental health policy over the last three decades runs the risk of both oversimplification and overstating the case. We acknowledge that phases of reform are not packaged in tight time compartments and that there are counter-examples to our generalizations. Nonetheless, we think our rough-cut use of these eras is approximately correct and, more importantly, we assert that reforms in mental health law and policy are influenced significantly by changes in the larger social and political context.

3. See, e.g., Hans Zeisel & Alec M. Gallup, *Death Penalty Sentiment in the United States*, 5 *J. QUANTITATIVE CRIMINOLOGY* 285, 287 (1989) (stating that public opinion polls indicate that support for death penalty declined from 68% in 1953 to 42% in 1966). After 1966, however, support began to increase. *Id.* By 1986, a Gallup poll indicated that 71% to 72% of Americans favored the death penalty. *Id.*

order,"⁴ the growing intolerance of the homeless,⁵ and Supreme Court decisions upholding laws which limited the availability of abortions.⁶

This Article analyzes mental health law reform in the United States during the past three decades. In the 1960s and 1970s, lawmakers changed criminal law dramatically to permit more mentally ill offenders to avoid criminal responsibility for their harmful conduct. Civil commitment laws were also revised to restrict involuntary hospitalization of the mentally ill.

In the 1980s, with neoconservative ideology dominating American politics, lawmakers again modified the criminal law, but this time to limit the use of defenses based on mental illness. Additionally, lawmakers revised commitment laws to make it easier to hospitalize involuntarily the mentally ill, or to commit them as outpatients to community care facilities.

Part I of this Article explores those transitions in mental health law over the past thirty years. Part II examines whether legal changes enacted during this time of swift transition were based on sound empirical evidence and whether these changes have had the impact their architects intended. This Article concludes that criminal law reforms enacted during the 1980s were generally unsuccessful in holding more mentally ill offenders criminally responsible for their actions. Instead, the changes were primarily of symbolic value and had little practical effect. Changes in involuntary commitment laws during this same period, however, have had a significant impact by subjecting more mentally ill people to involuntary civil commitment.

4. One of the best examples is the candidacy and presidency of Ronald Reagan (1980-88) who promised a "war on crime."

5. See Donald E. Baker, Comment, "Anti-Homeless" Legislation: Unconstitutional Efforts to Punish the Homeless, 45 U. MIAMI L. REV. 417, 426 (1990-91) (arguing that, while local governments have significant public health, safety and welfare interests in regulating behavior of homeless individuals, courts should not enforce anti-homeless legislation that is facially unconstitutional or unconstitutional as applied).

6. See *Rust v. Sullivan*, 111 S. Ct. 1759, 1773-78 (1991) (holding that federal government may, as condition of funding family-planning clinics, prevent doctors and other professionals from recommending abortions or referring clinic patients to abortion providers); *Webster v. Reprod. Health Serv.*, 492 U.S. 490, 507-11 (1989) (holding that state may constitutionally prohibit use of public facilities and publicly employed staff from performing abortions); *Planned Parenthood Ass'n v. Ashcroft*, 462 U.S. 476, 490-94 (1983) (holding that parental consent may be required for minors to obtain an abortion); *Harris v. McCrae*, 448 U.S. 297, 312-26 (1980) (upholding constitutionality of Hyde Amendment, which severely limits use of federal Medicaid funds for abortion).

II. TRANSITIONS IN MENTAL HEALTH LAW

A. *The Liberal Era*

The 1960s and 1970s in the United States—a period we call the Liberal Era—were times of intense social and political upheaval. Reforms designed to protect constitutional rights, which began with the civil rights movement, infused almost every aspect of American life.⁷ Individual rights took precedence over government rights and the community's need for order and security. Safeguards against the abuses and mistakes of government action were implemented to protect minorities,⁸ prisoners,⁹ the poor¹⁰ and the mentally ill.¹¹

During the Liberal Era, judges decided cases involving important public policy questions that had been previously considered beyond the scope of judicial authority.¹² They also went beyond

7. See generally TAYLOR BRANCH, *PARTING THE WATERS: AMERICA IN THE KING YEARS, 1954-63* (1988) (political and social biography of life and times of Martin Luther King, Jr., including discussion of impact of civil rights movement on American social fabric of 1960s); WILLIAM H. CHAFE, *THE UNFINISHED JOURNEY: AMERICA SINCE WORLD WAR II* (1986) (tracing political, economic and social events that shaped post-war period, depicting civil rights movement as watershed event of twentieth century); TODD GITLIN, *THE SIXTIES: YEARS OF HOPE, DAYS OF RAGE* (1987) (discussing civil rights movement in context of other political and social reform activities).

8. For women: See *Reed v. Reed*, 404 U.S. 71 (1971). In *Reed*, the Court struck down an Idaho statute that gave preference to males over females as estate administrators. *Id.* at 76. The Court held that giving mandatory preference to either sex to reduce judicial workload was an arbitrary legislative choice that violated the Equal Protection Clause of the Fourteenth Amendment. *Id.*

For handicapped children: See *Mills v. Board of Educ.*, 348 F. Supp. 866 (D.D.C. 1972). In *Mills*, the court held that the state must provide each child with free, suitable and publicly supported education regardless of the degree of the child's impairment or the lack of sufficient funding. *Id.* at 873-74.

9. See *Palmigiano v. Garrahy*, 443 F. Supp. 956 (D.R.I. 1977). In *Palmigiano*, the District of Rhode Island required state prison officials to remedy constitutional violations and appointed a master to review, monitor and report on programs designed to ensure that state prison officials were, in fact, remedying constitutional violations at the Rhode Island Correctional Facility. *Id.* at 989.

10. See *Goldberg v. Kelly*, 397 U.S. 254 (1970). In *Goldberg*, the Court held that due process guarantees welfare recipients an evidentiary hearing before termination of benefits. *Id.* at 261. The Court reasoned that a recipient's interest in uninterrupted assistance, coupled with the state's interest in not terminating payments erroneously, outweighed the state's interest in conserving fiscal and administrative resources. *Id.*

11. See *Wyatt v. Aderholt*, 503 F.2d 1305, 1316 (5th Cir. 1974) (implementing safeguards for mentally ill persons by holding that persons committed to state mental institutions have constitutional right to treatment). For a collection of related cases, see Gerald Frug, *The Judicial Power of the Purse*, 126 U. PA. L. REV. 715, 718 & n.15 (1978).

12. See Colin Diver, *The Judge as Political Powerbroker: Superintending Structural Change in Public Institutions*, 65 VA. L. REV. 43, 49-64 (1979). Diver has analyzed the

merely issuing orders to correct past violations of rights,¹³ often granting comprehensive injunctive relief that specified in great detail how government institutions had to be run in the future.¹⁴

role of judges as political powerbrokers and has examined recent lawsuits involving institutions for the confinement and rehabilitation of dangerous, deviant or helpless people. *Id.* at 51. Diver has noted that these judges have issued far-reaching decrees that involve almost every aspect of institutional life while claiming to stay within the symbolic structure of adjudication. *Id.* at 52.

The prior reluctance of courts to become involved in major government institutions had been known popularly as the "hands-off" judicial philosophy. See Note, *Decency and Fairness: An Emerging Judicial Role in Prison Reform*, 57 VA. L. REV. 841, 842-44 (1971) (discussing "hands-off" doctrine as product of limitations on federal review of conditions in state prisons). For a Supreme Court case rejecting the "hands-off" doctrine, see *Procunier v. Martinez*, 416 U.S. 396, 404-06 (1974) (rejecting "hands-off" doctrine).

13. See DONALD HOROWITZ, *THE COURTS AND SOCIAL POLICY* 293-98 (1977) (examining several instances in which courts have heard disputes generally considered beyond their jurisdiction and competence, and cautioning that judicial resources are inadequate to this task); Abram Chayes, *The Role of the Judge in Public Law Litigation*, 89 HARV. L. REV. 1281, 1288-1304 (1976) (analyzing emerging use of public law litigation to establish new regimes ordering relations between public institutions and citizens); Owen M. Fiss, *The Social and Political Foundations of Adjudication*, 6 LAW & HUM. BEHAV. 121, 121-22, 126-28 (1982) (analyzing emerging use of constitutional litigation to achieve structural reform of bureaucratic state); Henry Friendly, *The Courts and Social Policy: Substance and Procedure*, 33 U. MIAMI L. REV. 21, 29-34 (1978) (criticizing courts that are increasingly deciding cases on basis of overriding desire to make "good" public policy rather than conforming to traditional jural principles).

14. See *Hawkins v. Town of Shaw, Miss.*, 461 F.2d 1171, 1174 (5th Cir. 1972) (directing town officials to submit plan to eliminate disparities in municipal services provided to inhabitants who were discriminated against because they were poor and black); *Pugh v. Locke*, 406 F. Supp. 318, 334 (M.D. Ala. 1976) (requiring minimum living space for each prisoner); *Hart v. Community Sch. Bd.*, 383 F. Supp. 699, 755-58 (E.D.N.Y. 1974) (restructuring schools to achieve racial integration); *Wyatt v. Stickney*, 344 F. Supp. 373, 384 (M.D. Ala. 1972) (requiring individualized treatment plans for patients in psychiatric hospitals).

Using a new theory of rights, federal courts became actively involved in public education, employment policies, natural resources management and the administration of general and psychiatric hospitals. See HOROWITZ, *supra* note 13, at 106-70 (analyzing and critiquing process by which public policy issues traditionally considered appropriate for resolution by legislation are transformed into claims of legal right so that courts are empowered to resolve them, thereby redistributing power and influence in political arena and bringing about social change); STUART SCHEINGOLD, *THE POLITICS OF RIGHTS: LAWYERS, PUBLIC POLICY AND POLITICAL CHANGE* 7-8 (1974) (same); Diver, *supra* note 12, at 44-48 (discussing expansion of judicial participation in implementation of public policy); Robert Nagel, *Separation of Powers and the Scope of Federal Equitable Remedies*, 30 STAN. L. REV. 661, 661-64 (1978) (analyzing potential separation of powers issues raised by judiciary's intrusion into administration of state mental health systems and state prisons, among other institutions, and arguing that judiciary is not constitutionally entitled to function as legislature); Robert Katzman, Note, *Judicial Intervention and Organizational Theory: Changing Bureaucratic Behavior and Policy*, 89 YALE L.J. 513, 513-14 (1980) (recognizing that courts have attempted to restructure institutions by changing their policies and procedures, and noting that judges should be better prepared for task of restructuring bureaucracies).

For example, in *Wyatt v. Stickney*,¹⁵ a federal district court became involved in the daily operation of a state mental institution in Alabama in order to improve conditions of patients involuntarily confined there. After state officials failed to correct hospital conditions, the court issued detailed orders specifying 'constitutional' requirements for the hospital's physical plant, its staffing levels and also required individualized patient treatment plans.¹⁶ This case was representative of others throughout the country, in which courts forced legislatures either to improve conditions in state psychiatric institutions or to release patients.¹⁷ Courts also prodded legislatures to pass laws protecting those groups who have traditionally lacked political power, such as prisoners, poor people, minorities and patients.¹⁸ The criminal justice and mental health systems created legal and administrative review procedures for these disadvantaged clients, to ensure protection of their newly recognized rights.¹⁹

1. *Mentally Ill Offenders in the Liberal Era*

During the Liberal Era, the criminal law embraced what Francis Allen called the "Rehabilitative Ideal."²⁰ This philosophy assumes that deviant behavior primarily results from antecedent

15. 344 F. Supp. 373 (M.D. Ala. 1972).

16. *Id.* at 379-86.

17. See, e.g., *Davis v. Hubbard*, 506 F. Supp. 915, 921 (N.D. Ohio 1980) (ordering state authorities to improve staff training and overall institutional environment); *Eckerhart v. Hensley*, 475 F. Supp. 908, 928 (W.D. Mo. 1979) (ordering state to remedy constitutional deficiencies in state mental hospital); *Rone v. Fireman*, 473 F. Supp. 92, 133-35 (N.D. Ohio 1979) (ordering state to significantly improve conditions for patients at state mental hospital).

18. For a discussion of how courts prodded legislatures to pass laws to protect those who have been disadvantaged historically, see *supra* notes 8-11 and accompanying text.

19. See THE MENTALLY DISABLED AND THE LAW 49-55 (S.J. Brakel & Ronald Rock eds., 3d ed. 1971) [hereinafter MENTALLY DISABLED] (describing procedural protections generally available to patients during and after civil commitment proceedings including: right against self-incrimination, right to notice and opportunity to be heard, right to judicial hearings and jury trials, right to independent counsel, right to placement in least restrictive environment, right to periodic review and placement of burden of proof on state). Even the terminology of social control changed so that "parolees" and "patients" became "clients" of the welfare state. See PETER CONRAD & JOSEPH SCHNEIDER, *DEVIANCE AND MEDICALIZATION: FROM BADNESS TO SICKNESS* 17-37 (1980). Conrad and Schneider have noted that the etiology of disease theories has changed from causation based on "sin" to biological and external forms of causation that are beyond individual control. *Id.* at 32-34. This change has led to changes in the language and status of people who vary from the norm. *Id.*

20. See Francis Allen, *Criminal Justice, Legal Values, and the Rehabilitative Ideal*, 50 J. CRIM. L. CRIMINOLOGY & POLICE SCI. 226, 226-29 (1959) (describing "rehabilitative ideal" as "revolution in public conceptions of the nature of crime and the

factors that are beyond an individual's control, such as social and family environment or individual pathology.²¹ Consequently, under the rehabilitative model, convicted individuals should be offered treatment designed to change their behavior rather than to punish their deviant acts as they would be under a retributive model.²² Moreover, criminologists of the Liberal Era believed that effective technologies existed to transform offenders into functioning, productive members of the community.²³

Consistent with these new assumptions about human behavior and treatment, the insanity defense was expanded dramatically during that era. A narrow test of insanity—the *M'Naghten* test²⁴—had been used since the mid-19th century. It limited the defense of legal insanity to criminal defendants who, as a result of mental illness at the time, did not know the nature or the wrongfulness of their acts.²⁵ During the Liberal Era, however, courts in over half of the states adopted broader tests of insanity that were intended to expand the number of mentally ill offenders who would be found legally insane, and therefore treated rather than punished.²⁶

The first major reformulation of the test of insanity was *Durham v. United States*.²⁷ The *Durham* rule, as it is generally known, asks whether the defendant's mental disease or defect caused the criminal behavior.²⁸ If so, the defendant is not responsible for his or her conduct and should not be punished. Because it probes so broadly into the defendant's psychiatric profile and because of its causal relationship to his or her criminal behavior, this inquiry tremen-

criminal, and in public attitudes toward the proper treatment of the convicted offender").

21. *Id.* at 226-27.

22. *Id.* at 228-29.

23. *Id.* at 226.

24. *Daniel M'Naghten's Case*, 8 Eng. Rep. 718 (H.L. 1843).

25. *Id.* at 722. The *M'Naghten* test of insanity specified that a criminal offender could not be convicted and punished if, at the time of the offense, he was suffering from a mental illness that made him unable to know what he was doing or to know that it was wrong. *Id.* The test excused only severely mentally ill individuals who suffered complete cognitive impairment; either they did not comprehend what acts they had committed or, if they did, they could not understand that their conduct was wrong. *Id.*

26. See RITA SIMON & DAVID AARONSON, *THE INSANITY DEFENSE: A CRITICAL ASSESSMENT OF LAW AND POLICY IN THE POST-HINCKLEY ERA* 44-45 (1988) (noting that all federal circuit courts had adopted ALI test by early 1970s and half of states adopted ALI by 1980).

27. 214 F.2d 862 (D.C. Cir. 1954).

28. *Id.* at 874-75. The *Durham* rule was patterned on the insanity test used by New Hampshire for over a century. See *State v. Jones*, 50 N.H. 369 (1871) ("An act produced by mental disease is not a crime."); *State v. Pike*, 49 N.H. 399, 443 (1870) ("There is no legal guilt in a [crime] solely caused by a mental disease.").

dously expanded the scope and prominence of clinical opinions in the courtroom.²⁹ Because it was so indeterminate, however, no other court embraced this rule.

Instead of the *Durham* rule, most courts adopted a test proposed by the American Law Institute in 1962 (the "ALI" test).³⁰ This test specifies that an offender should be found "not guilty by reason of insanity" if, at the time of the act, mental illness significantly interfered with the defendant's ability to understand the nature of his conduct, to appreciate its wrongfulness *or* to conform his conduct to the requirements of the law.³¹ The ALI test expanded the range of mental functions considered relevant to a determination of criminal responsibility beyond those permitted by the *M'Naghten* rule; but without the sweeping inquiry into causation sanctioned by the *Durham* rule. Consequently, the ALI test, like the *Durham* rule, also enhanced the role of psychiatrists and other mental health specialists in the courtroom.

Some courts also adopted a new defense called "diminished capacity." It permits criminal defendants to introduce psychiatric testimony to prove that they lacked the requisite criminal state of mind for conviction on the offense charged.³² If successful, mentally disordered defendants would go free or be convicted of less

29. See David Bazelon, *New Gods for Old: "Efficient" Courts in a Democratic Society*, 46 N.Y.U. L. REV. 653, 658 (1971) ("The immediate impact of our *Durham* experiment was to open the courtroom door to a wide range of information bearing on the question of criminal responsibility.").

30. See *United States v. Brawner*, 471 F.2d 969, 973 (D.C. Cir. 1972) (adopting ALI test); *Wade v. United States*, 426 F.2d 64, 70 (9th Cir. 1970) (same); *Blake v. United States*, 407 F.2d 908, 916 (5th Cir. 1969) (same); *United States v. Smith*, 404 F.2d 720, 727 (6th Cir. 1968) (same); *United States v. Chandler*, 393 F.2d 920, 927 (4th Cir. 1968) (same); *United States v. Shapiro*, 383 F.2d 680, 685 (7th Cir. 1967) (same); *Pope v. United States*, 372 F.2d 710, 735 (8th Cir. 1967) (same); *United States v. Freeman*, 357 F.2d 606, 624 (2d Cir. 1966) (same); *Wion v. United States*, 325 F.2d 420, 427 (10th Cir. 1963) (same); *United States v. Currens*, 290 F.2d 751, 774 (3d Cir. 1961) (same); see also SIMON & AARONSON, *supra* note 26, at 44-45 (discussing ALI test).

31. See MODEL PENAL CODE § 4.01 (Proposed Official Draft 1962). Section 401 provides:

(1) a person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law.

(2) As used in this Article, the terms "mental disease or defect" do not include an abnormality manifested only by repeated criminal or otherwise anti-social conduct.

Id.

32. See generally George Dix, *Psychological Abnormality as a Factor in Grading Criminal Liability: Diminished Capacity, Diminished Responsibility and the Like*, 62 J. CRIM. L. CRIMINOLOGY & POLICE SCI. 313 (1971) (discussing diminished capacity).

serious crimes and receive reduced sentences. By 1975, about twenty-five states and several federal courts of appeal had adopted some form of this diminished capacity defense.³³ Many courts also embraced similar defenses based on mental illness—such as the Battered Woman Syndrome,³⁴ pathological gambling³⁵ and Post-Traumatic Stress Disorder³⁶—that could excuse defendants charged with a myriad of crimes, including serious crimes like armed robbery and homicide.

2. *Civil Commitment During the Liberal Era*

During this era, reformers also succeeded in restricting the government's legal authority to hospitalize mental patients involuntarily. Only persons determined to be mentally ill *and dangerous* could be confined to a psychiatric hospital without their consent. Requiring involuntary commitment of the mentally ill to be based solely on dangerousness was at the heart of the movement to deinstitutionalize mental patients and to encourage treatment in their community.³⁷ Proponents of these civil commitment reforms emphasized the civil liberties of the mentally ill, especially their right to freedom and choice.

This approach differed dramatically from the previous commitment laws of most states, which permitted the commitment of anyone considered to be mentally ill and in need of treatment. Prior to these restrictive commitment laws, physicians could legally com-

33. See Travis Lewin, *Psychiatric Evidence in Criminal Cases for Purposes Other Than the Defense of Insanity*, 26 SYRACUSE L. REV. 1051, 1105-15 (1975) (providing survey of jurisdictions adopting partial responsibility or diminished responsibility defense).

34. See *Ibn-Tamas v. United States*, 407 A.2d 626, 635 (D.C. 1979) (holding that exclusion of evidence relevant to battered woman syndrome constitutes reversible error); *Smith v. State*, 277 S.E.2d 678, 683 (Ga. 1981) (same); *People v. Minnis*, 455 N.E.2d 209, 217 (Ill. App. Ct. 1983) (same); *State v. Anaya*, 438 A.2d 892, 894 (Me. 1981) (same); *State v. Kelly*, 478 A.2d 364, 375-76 (N.J. 1984) (same).

35. See A. Louis McGarry, *Pathological Gambling: A New Insanity Defense*, 11(4) BULL. AM. ACAD. PSYCHIATRY & L. 301, 303-05 (1983) (describing use of pathological gambling defense in several criminal trials).

36. See Elliott Milstein & Keith Snyder, *PTSD: The War Is Over, the Battles Go On*, TRIAL, Jan. 1983, at 86 (examining Post-Traumatic Stress Disorder and how it has been used as defense for plea bargaining and at sentencing in cases involving defendants who are Vietnam veterans); Jack Welborn, Jr., *The Vietnam Connection: Charles Heads' Verdict*, CRIM. DEF., Jan.-Feb. 1982, at 7-9 (describing use of Post-Traumatic Stress Disorder to obtain not guilty by reason of insanity verdict for Vietnam veteran charged with murder).

37. See LA FOND & DURHAM, *supra* note 2, at 82-99 (discussing shift from hospitalization solely for benefit of treating mentally ill and shift to community-based treatment).

mit mentally ill individuals whom they thought needed treatment without meaningful judicial supervision. Moreover, once committed, patients, many of whom remained in hospitals for years, had few legal protections.³⁸

These new restrictive laws also departed from the traditional medical model of hospitalization wherein physicians dominate every decision concerning detention, treatment, and release. Instead, these laws adopted a legal model of commitment in which judges or juries often decided whether someone should be committed. Moreover, detainees were often afforded many of the same basic procedural protections afforded defendants in a criminal trial, including the right to an attorney and to present their own evidence.³⁹ In addition to narrower commitment criteria and generous due process protections,⁴⁰ patients could be confined only for short periods of time (e.g., every ninety days); the government then had to reestablish grounds for commitment or discharge the patient.⁴¹

B. *The Neoconservative Era*

During the 1980s, a distinct political ideology gained strength in the United States: neoconservatism.⁴² This ideology emphasized

38. See Mary L. Durham & John Q. La Fond, *The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Commitment*, 3 YALE L. & POL'Y REV. 395, 397-402 (1985) [hereinafter *Empirical Consequences*] (reviewing procedural protections added during Liberal Era, and contrasting those with pre-reform era); John Q. La Fond, *An Examination of the Purposes of Involuntary Civil Commitment*, 30 BUFF. L. REV. 499, 506-09 (1981) (analyzing major constitutional attacks made on state civil commitment laws during Liberal Era).

39. See DURHAM & LA FOND, *supra* note 2, at 397-98 (describing movement to build safeguards into involuntary commitment system to ensure fairness and to prevent mistakes); La Fond, *supra* note 38, at 506-08 (discussing failure of pre-Era system to ensure adequate procedural due process to mental patients).

40. See La Fond, *supra* note 38, at 508 (noting that many state statutes require state to provide persons it intends to commit with prior notice, opportunity to be heard, right to judicial hearing, right to counsel and right to judicial review).

41. See, e.g., WASH. REV. CODE ANN. §§ 71.05.180, 71.05.240 (West 1992) (providing that state may obtain emergency commitment for 72 hours without judicial hearing after which time state must obtain judicial order committing patient for 14 days or 90 days).

42. Innovative social experimentation with entitlement programs and reformation of existing policies emerged along with important social and economic changes. The 1970s brought accelerating unemployment, an increase in the cost of living and growing competition from foreign markets. See generally CHAFE, *supra* note 7 (tracing political, economic and social events that shaped post-war period, including standard of living plunge and increase in competition from foreign markets); GITLIN, *supra* note 7 (discussing impact of accelerating unemployment and changing standard of living by end of 1960s). Americans were not only laid off from work, but their jobs disappeared without prospects for replacement. See

stability, order and conservative values, such as family, religion and the free market. Its proponents advocated a minimized role for government, particularly courts, in reshaping society.⁴³

Neoconservatives were unwilling to protect individual rights at the expense of majoritarian interests. They strenuously objected to expansive welfare benefits, affirmative action and the "rights" of criminals that, in their view, jeopardized the safety of law-abiding taxpayers. Under this ideology, individual responsibility and community safety took precedence over individual freedom and autonomy.⁴⁴

1. *Mentally Ill Offenders in the Neoconservative Era*

Against this backdrop, conservative critics began to challenge the conceptual underpinnings of the rehabilitative ideal.⁴⁵ Some claimed that the individualized treatment model was inconsistent with basic concepts of fair and equal justice.⁴⁶ Others concluded there was simply no evidence that rehabilitation was effective.⁴⁷

Neoconservatives rejected the rehabilitative model in favor of a "just deserts" model of punishment. According to this view, the se-

KATHERINE NEWMAN, *FALLING FROM GRACE: THE EXPERIENCE OF DOWNWARD MOBILITY IN THE AMERICAN MIDDLE CLASS* 25 (1988) (explaining that downward mobility is increasingly frequent among middle class Americans due to contraction of economic and social opportunities).

Consequently, public support for the social programs and liberal ideologies popular in the 1960s and 1970s cooled, while conservative values gained strength. See GEORGE GILDER, *WEALTH AND POVERTY* 114-27 (1981). Americans complained that Lyndon Johnson's Great Society had created an uncontrollable and highly undesirable welfare state. Many assumed that burgeoning public assistance rolls were causally connected to soaring crime rates, indicating that America's social programs and the legal reforms of the 1960s and 1970s had failed miserably. See generally DANIEL MOYNIHAN, *MAXIMUM FEASIBLE MISUNDERSTANDING: COMMUNITY ACTION IN THE WAR ON POVERTY* (1969) (arguing that social programs associated with war on poverty backfired, resulting in greater poverty and dependence on welfare state).

43. See generally BELL, *supra* note 1; STEINFELS, *supra* note 1; Kristol, *supra* note 1.

44. For a thorough discussion of the Neoconservative Era, see LA FOND & DURHAM, *supra* note 2, at 15-20, 46-81, 100-16, 150-71.

45. For a discussion of the Rehabilitative Ideal, see *supra* notes 20-23 and accompanying text.

46. See AMERICAN FRIENDS SERVICE COMMITTEE, *STRUGGLE FOR JUSTICE: A REPORT ON CRIME AND PUNISHMENT IN AMERICA* 12 (Hill & Wang 1971) (stating that "the individualized treatment model, the ideal toward which reformers have been urging us for at least a century, is theoretically faulty, systematically discriminatory in administration, and inconsistent with some of our most basic concepts of justice").

47. See ANDREW VON HIRSCH, *DOING JUSTICE: THE CHOICE OF PUNISHMENTS* 11-18 (1976) (countering notion that rehabilitation has been statistically effective in United States).

verity of punishment should depend on the seriousness of the offense and the criminal's prior record.⁴⁸ As such, the primary goal of the criminal justice system is not to prevent future crimes through rehabilitation, but to dispense appropriate punishment to those who had earned it.⁴⁹ The just deserts ideology presumes people are responsible moral agents who can choose between right and wrong. Excuses based on mental illness, therefore, should be limited, lest too many individuals avoid the punishment they deserve.⁵⁰

These views supported a broad campaign of conservative law reform in the criminal justice system. Several states passed mandatory sentencing laws for serious crimes,⁵¹ others enacted "make my day" laws that allowed citizens to use deadly force to defend themselves in their homes against intruders.⁵² A large majority of states also reinstated the death penalty after a four-year hiatus.⁵³ The Supreme Court created numerous exceptions to the constitutional rights previously conferred by the Warren Court on criminal suspects and defendants.⁵⁴ Even the juvenile justice sys-

48. For a discussion of the "just deserts" model of punishment, see LA FOND & DURHAM, *supra* note 2, at 51-53.

49. See ERNEST VAN DEN HAAG, PUNISHING CRIMINALS: CONCERNING A VERY OLD AND PAINFUL QUESTION 8-50 (1975) (noting that criminal ideal is retributive).

50. *Id.*

51. See MICHAEL TONRY, SENTENCING REFORM IMPACTS 25-35 (1987).

52. For example, in 1985 the Colorado legislature passed a law permitting an occupant of a dwelling to use deadly force against an intruder if the occupant has a "reasonable belief" that a crime has been or will be committed and that the intruder "might use any physical force, no matter how slight." COLO. REV. STAT. § 18-1-704.5 (1986). See generally WILLIAM WILBANKS, THE MAKE MY DAY LAW: COLORADO'S EXPERIMENT IN HOME PROTECTION (1990) (examining several instances in which citizens used deadly force after enactment of Colorado law and concluding that many legislative objectives were never attained).

Utah also provides liberal protection to occupants who exert deadly force against intruders. See UTAH CODE ANN. § 76-2-405 (1985) (providing that person using deadly force against an intruder is "presumed" to have acted reasonably and to have had reasonable fear of death or serious bodily injury if unlawful entry or attempted entry was made by "force," "surreptitiously" or by "stealth"). See generally, JOHN Q. LA FOND, *The Case for Liberalizing the Use of Deadly Force in Self-Defense*, 6 U. PUGET SOUND L. REV. 237, 274-83 (1983) (arguing that right of self-defense should be expanded to permit innocent victims to use deadly force whenever necessary to repel unlawful violence irrespective of whether aggressor uses deadly force, or threatens death or grievous bodily injury).

53. See *Gregg v. Georgia*, 428 U.S. 153, 179-80 & n.23 (1976) (citing statutes from 35 states that had recently enacted some form of death penalty).

54. See LEONARD LEVY, AGAINST THE LAW: THE NIXON COURT AND CRIMINAL JUSTICE 1-16 (1974) (criticizing President Nixon's appointees to Supreme Court—Justices Burger, Blackmun, Powell and Rehnquist—as biased and result-oriented judges who through their decisions in constitutional criminal procedure cases have narrowed constitutional rights for individuals and expanded police and other government agency power); Stephen Salzburg, *The Flow and Ebb of Constitutional Criminal Procedure in the Warren and Burger Courts*, 69 GEO. L.J. 151, 151-53 (1980)

tem, once the paradigm of the rehabilitative ideal, experienced a fundamental shift to a responsibility model.⁵⁵

From these reforms, it was a short step for lawmakers to attempt to assert much more control over mentally ill offenders.⁵⁶ By the time that John Hinckley shot President Ronald Reagan and Press Secretary James Brady in 1981, several states had already enacted laws intended to reduce the number of insanity acquittals.⁵⁷ After a jury found John Hinckley "not guilty by reason of insanity," thirty-four states subsequently amended their insanity defense laws.⁵⁸ Congress passed federal legislation imposing a single, extremely narrow insanity test on all federal courts.⁵⁹ The new fed-

(stating that many constitutional protections for criminal suspects established by Warren Court generally survived during Burger Court and concluding that Burger Court's disagreement with its predecessor court was "at the margin").

55. See *In re Gault*, 387 U.S. 1, 14-24 (1967) (analyzing evolution of United States' juvenile court system); see also Sanford J. Fox, *Juvenile Justice Reform: An Historical Perspective*, 22 STAN. L. REV. 1187, 1188-95 (1970). Fox has examined the evolution and reform of the juvenile justice system and has concluded that many of these systems no longer view juvenile delinquents as unfortunate children who are not responsible for their misbehavior. *Id.* at 1193-94. Rather, juvenile delinquents are viewed as juvenile criminals hardly less threatening than their adult counterparts. *Id.*; Martin Gardner, *Punitive Juvenile Justice: Some Observations on a Recent Trend*, 10 INT'L J.L. & PSYCHIATRY 129, 133-41 (1987) (discussing emergence of punitive sanction and its corresponding emphasis on personal responsibility in juvenile justice theory); Andrew Walkover, *The Infancy Defense in the New Juvenile Court*, 31 UCLA L. REV. 503, 505-07 (1984) (arguing that because legislatures have increasingly enacted laws that hold juveniles responsible for their conduct and subject them to punishment, government should have burden of proving that young children have capacity to be held accountable for their conduct).

56. Demand for greater control was displayed by the public's reaction after Dan White was found guilty of two counts of voluntary manslaughter rather than first-degree murder based on his claim that mental problems, aggravated by erratic junk food binges, had caused him to shoot and kill Mayor George Moscone and Harvey Milk of San Francisco. See generally MIKE WEISS, *DOUBLE PLAY: THE SAN FRANCISCO CITY HALL KILLINGS* (1984) (providing vivid account of homicides committed by Dan White and subsequent criminal trial); Cynthia Gorney, *Waiting for Dan White*, WASH. POST, Jan. 3, 1984, at B1 (discussing homicides committed by Dan White).

57. For example, Michigan in 1975, Indiana in 1981 and Illinois in 1981 passed legislation providing for a guilty but mentally ill (GBMI) verdict. See 1981 Ill. Laws 82-553 (codified at ILL. ANN. STAT. ch. 38, para. 115-2(b) (Smith-Hurd 1990)); 1981 Ind. Acts 298, § 5 (codified at IND. CODE ANN. § 35-36-2-3 (Burns 1985)); 1975 Mich. Pub. Acts 180 (codified at MICH. COMP. LAWS § 768.36 (1982)). The GBMI defense was intended to decrease the frequency of "successful" insanity pleas. See *infra* notes 145-62 and accompanying text. Montana abolished its insanity defense in 1979. See MONT. CODE ANN. § 46-14-102 (1993).

58. See Lisa Callahan et al., *Insanity Defense Reform in the United States - Post Hinckley*, 11 MENTAL PHYSICAL DISABILITY L. REP. 54, 56-57 (1987) [hereinafter Callahan, *Insanity Defense Reform*] (summarizing insanity test used, burden of proof, standard of proof and reform status in 50 states).

59. See Insanity Defense Reform Act of 1984, Pub. L. No. 98-473, § 402, 98 Stat. 2057 (codified as amended at 18 U.S.C. § 4243 (1988)) (providing that severe

eral test was even narrower than the original *M'Naghten* test because it excused only "severely" mentally ill individuals who were completely "unable" to appreciate that their conduct was wrong.⁶⁰ Three states did away with the insanity defense altogether.⁶¹

Similarly, thirteen states enacted new laws that created a guilty but mentally ill (GBMI) defense.⁶² Under one form of this defense, the jury has the option of finding a criminal defendant who has raised the insanity defense either "not guilty by reason of insanity" (NGRI) or GBMI.⁶³ A defendant found NGRI will not be imprisoned, but will be evaluated to determine if he is presently mentally ill and dangerous.⁶⁴ He may be held in a psychiatric institution if found to be mentally ill. The defendant must be released, however, if he is no longer *either* mentally ill *or* dangerous.⁶⁵ In contrast, if the defendant is found GBMI, he may be sent *either* to a psychiatric facility for treatment *or* to prison for punishment.⁶⁶ GBMI is a harsher alternative because the offender may be kept in custody for the maximum prison term authorized for his crime, even if he is no

mental disease or defect is affirmative defense if at time of offense, defendant was unable to appreciate wrongfulness of his acts).

60. *Id.*

61. See IDAHO CODE § 18-207(a) (1987) (abolishing insanity defense); MONT. CODE ANN. § 46-14-102 (1991) (same); UTAH CODE ANN. § 76-2-305 (Supp. 1987) (same). See generally Henry Miller, Comment, *Recent Changes in Criminal Law: The Federal Insanity Defense*, 46 LA. L. REV. 337, 347 (1985) [hereinafter Miller, Comment, *Recent Changes in Criminal Law*] (stating that Idaho, Montana, and Utah have abolished insanity defense).

62. The states are: Alaska, Delaware, Georgia, Illinois, Indiana, Kentucky, Michigan, Montana, New Mexico, Pennsylvania, South Carolina, South Dakota and Utah. See ALASKA STAT. § 12.47.040 (1990); DEL. CODE ANN. tit. 11, §§ 401(b), 408 (1990); GA. CODE ANN. § 17-7-131 (1985); ILL. ANN. STAT. ch. 38, para. 115-2(b) (Smith-Hurd 1990); IND. CODE § 35-36-2-3 (Supp. 1982); KY. REV. STAT. ANN. § 504.120 (Michie/Bobbs-Merrill 1990); MICH. COMP. LAWS § 768.36 (1982); MONT. CODE ANN. § 46-14-312 (1993); N.M. STAT. ANN. § 31-9-3 (Michie 1984); 18 PA. CONS. STAT. § 314 (1983); S.C. CODE ANN. § 17-24-20 (Law. Co-op. 1985 & Supp. 1993); S.D. CODIFIED LAWS ANN. § 23A-26-14 (1988); UTAH CODE ANN. § 77-16a-102 (Supp. 1993). As many as 20 other states considered enacting similar legislation. See Christopher Slobogin, *The Guilty But Mentally Ill Verdict: An Idea Whose Time Should Not Have Come*, 53 GEO. WASH. L. REV. 494, 496 (1985) (discussing proposed legislation in other states enacting GBMI verdict).

63. See Slobogin, *supra* note 62, at 495 (noting that if jury finds defendant who asserts insanity defense guilty and not insane, it may find him guilty but mentally ill at time of offense).

64. *Id.* at 500 (noting that these defendants rarely obtain quick release given limited ability to predict future behavior).

65. *Id.* ("Virtually all states automatically confine insanity acquittees for an initial evaluation period up to 90 days and they may continue to detain the acquittees until they are no longer mentally ill or dangerous.")

66. *Id.* at 513 (noting that although some statutes give guilty but mentally ill offenders statutory right to treatment, most guilty but mentally ill statutes provide less definite access to treatment).

longer mentally ill.⁶⁷

An even harsher version of the GBMI defense simply allows the jury to convict the defendant while also expressing its opinion that he was mentally ill at the time of the offense.⁶⁸ Following conviction, offenders found GBMI may, but need not, be offered psychiatric treatment while incarcerated.⁶⁹ Courts have upheld both types of GBMI laws, rejecting challenges based on equal protection, due process, cruel and unusual punishment, *ex post facto* and right to treatment.⁷⁰

Insanity defense reforms have not only narrowed this defense, they have imposed procedural obstacles for defendants, making it more difficult to assert it successfully. These reforms include shifting the burden of proof of insanity from the prosecution to the defendant;⁷¹ requiring that defendants establish their insanity by a higher standard of persuasion;⁷² requiring that defendants assert-

67. *Id.* at 518 (stating that sentence length is not affected by guilty but mentally ill verdict because verdict is not "a finding of diminished responsibility").

68. *Id.* ("In deliberating upon the applicability of the [guilty but mentally ill] verdict, the factfinder's evaluation is limited to the defendant's mental illness at the time of the offense.").

69. *Id.* at 513 (noting that mentally ill finding does not improve post-conviction treatment status because guilty but mentally ill legislation recognizes that treatment determination is more appropriately made by experts after conviction rather than by jury at trial).

70. See Linda Fentiman, "Guilty but Mentally Ill": *The Real Verdict Is Guilty*, 26 B.C. L. REV. 601, 615-16 (1985) (arguing that GBMI statutes deny criminal defendant his or her right to due process because they attempt to undercut ability to present successful insanity defense and also deny criminal defendant his or her right to equal protection because "persons found not guilty by reason of insanity will be incarcerated only as long as their insanity continues, while persons found 'guilty but mentally ill' are committed to their state's department of corrections for a full prison term, regardless of whether they have recovered their sanity"); Bradley McGraw et al., *The "Guilty But Mentally Ill" Plea and Verdict: Current State of the Knowledge*, 30 VILL. L. REV. 117, 147 (1985) (listing bases for constitutional challenges to GBMI verdict statutes).

71. See Jeffrey Burger, Comment, *Due Process and the Insanity Defense: The Supreme Court's Retreat from Winship and Mullaney*, 54 IND. L.J. 95, 98 (1978) (discussing burden of proof structure for insanity defense in criminal cases); Miller, Comment, *Recent Changes in Criminal Law*, *supra* note 61, at 358 (noting that such an approach is based on belief that if rule were different, then it would be too easy for sane defendants to avoid criminal responsibility merely by creating some doubt as to their sanity).

72. By 1985, 36 states and the District of Columbia made defendants establish their insanity by a preponderance of the evidence. See Miller, *Recent Changes in Criminal Law*, *supra* note 61, at 357-58 n.132 (listing states that place burden of proof on defendant and each state's required burden of persuasion). Only 10 states still require the government to prove beyond a reasonable doubt that the defendant is sane. *Id.* at 356 n.127 (Colorado, Florida, Iowa, Kansas, Massachusetts, Michigan, New Mexico, Oklahoma, South Dakota and Tennessee). Arizona jury instructions require a defendant to prove insanity by clear and convincing evidence. ARIZ. REV. STAT. ANN. § 13-502(b) (1989). In the three states that have

ing the insanity defense submit to government psychiatric evaluations;⁷³ and restricting the scope of expert testimony.⁷⁴

Legislative and public concern in the Neoconservative Era was not limited to the definition of legal insanity or to the manner in which the defense was litigated; it also focused on what happened to successful insanity defendants *after* their trial. During the Liberal Era, a number of courts concluded that states lacked the authority to confine a successful NGRI defendant for any significant length of time.⁷⁵ After a brief period of detention for further evaluation, if the state did not civilly commit NGRI defendants, they had to be released. Furthermore, as previously noted, legal reforms made it

abolished the insanity defense, neither the prosecution nor the defense is permitted to prove insanity. For a compilation of the states that have abolished the insanity defense, see *supra* note 61.

In Montana, which abolished the insanity defense in 1979, evidence of mental disease or defect is now considered at three phases of a criminal proceeding. See *State v. Korell*, 690 P.2d 992, 996 (Mont. 1984). First, it may be relevant to determine whether a criminal defendant is competent to stand trial. Second, it also may be relevant to determine whether the defendant had the requisite criminal state of mind required for conviction. Finally, at sentencing, it may be relevant to determine whether the defendant appreciated the nature of his actions. *Id.* Such evidence, however, may not be used to establish the defense of insanity. *Id.*

73. See, e.g., *United States v. Byers*, 740 F.2d 1104, 1113 (D.C. Cir. 1984) (reasoning that if defendant raises insanity defense and introduces psychiatric testimony for that purpose, state must be able to follow where defendant has led). The Insanity Defense Reform Act of 1984 modified 18 U.S.C. § 4244 and deleted language that had guaranteed that "[n]o statement made by the accused in the course of any examination into his sanity or mental competency . . . shall be admitted in evidence against the accused on the issue of guilt in any criminal proceeding." See Insanity Defense Reform Act of 1984, Pub. L. No. 98-473, 98 Stat. 2057, 2061 (codified as amended at 18 U.S.C. § 4244 (1988)).

74. The Insanity Defense Reform Act of 1984 amended Rule 704 of the Federal Rules of Evidence. See Insanity Defense Reform Act of 1984 § 406.

75. See *People v. McQuillan*, 221 N.W.2d 569, 580 (Mich. 1974). In *McQuillan*, the court opined:

Equal protection demands that differences in treatment of classes be based on a rational basis. The lack of a hearing cannot be justified by the contention that the defendant because of his acquittal by reason of insanity is so potentially dangerous at that time that he must be committed without further hearing. *Baxstrom* held that past criminal actions could not serve as a rational basis of classification for purposes of determining commitment procedure Thus, based on equal protection of the laws, we hold that defendant is entitled to a sanity hearing when found not guilty by reason of insanity after completion of observation and examination.

Id.; see *Benham v. Edwards*, 678 F.2d 511, 516-29 (5th Cir. 1982) (holding Georgia's NGRI disposition scheme to be violative of Equal Protection because scheme applied presumption of continuing insanity to NGRI class, denied NGRI class hearings provided to those committed in civil proceedings, required class to bear burden of proof at release hearings and required court approval for release of all NGRI defendants), *vacated sub nom. Ledbetter v. Benham*, 463 U.S. 1222 (1983), *rev'd on remand*, 609 F. Supp. 125 (N.D. Ga. 1985).

difficult to hold patients very long after civil commitments.⁷⁶ Thus, despite the public's desire to confine insane offenders for long periods,⁷⁷ the state's hands seemed to be tied.

That potential problem ended with the Supreme Court's decision in *Jones v. United States*.⁷⁸ The Court held that states did not have to seek civil commitment of insanity defendants either after their acquittal or after their prison term expired.⁷⁹ Rather, states could criminally commit mentally ill offenders to secure psychiatric facilities indefinitely using different procedures than those used for civil commitment because the insanity verdict proved that they were mentally ill and dangerous—even if their crime had been a minor property offense as in *Jones*.⁸⁰

The *Jones* decision had a significant impact on insanity defense reforms. Most notable was a provision of the Insanity Defense Reform Act of 1984,⁸¹ which provided for automatic, indeterminate commitment of successful insanity defendants charged with serious crimes.⁸² Numerous states also amended their laws to ensure greater control over NGRI defendants.⁸³

76. For a discussion of legal reforms that made it difficult to hold patients very long after civil commitment, see *supra* notes 37-41 and accompanying text.

77. For example, the public was outraged when a Washington, D.C. mental hospital announced that it would release John Hinckley on a weekend pass. See *Insane Risk*, N.Y. TIMES, Apr. 15, 1987, at A26. The pass was later revoked because of adverse public reaction. *Id.*

78. 463 U.S. 354 (1983).

79. *Id.* at 363-65.

80. *Id.* In *Jones*, the defendant, who had shoplifted a jacket, had been held for eight years in St. Elizabeth's Hospital even though the maximum sentence for his crime was one year in jail. *Id.* at 359-61.

81. Pub. L. No. 98-473, 98 Stat. 2057, 2059 (codified as amended at 18 U.S.C. § 4243 (1988)).

82. 18 U.S.C. § 4243(c) provides that a successful insanity acquittee charged with:

an offense involving bodily injury to, or serious damage to the property of another person, or involving a substantial risk of, such injury or damage, has the burden of proving by clear and convincing evidence that his release would not create a substantial risk of bodily injury to another person or serious damage of property of another due to present mental disease or defect.

Id. This section provides for mandatory, automatic commitment of a successful insanity defendant. *Id.* A trial judge has no discretion. See *United States v. Palesky*, 855 F.2d 34, 35 (1st Cir. 1988) (finding that defendant should have been committed after establishing innocence only by reason of insanity, and that after she was committed she would be entitled to hearing within 40 days to establish that she no longer poses risk to person or property of another).

83. See LA FOND & DURHAM, *supra* note 2, at 79-81.

2. *Civil Commitment in the Neoconservative Era*

Many Neoconservative criticisms of Liberal Era insanity reforms also applied to civil commitment reforms of that same period. They thought that both the insanity and civil commitment reforms were excessively deferential to individual rights at the expense of community security. Neoconservatives, therefore, supported expanded state authority to hospitalize the mentally ill in need of treatment.⁸⁴

In 1979, the state of Washington led a wave of conservative legal reform concerning involuntary commitment. Washington expanded the state's authority to hospitalize mentally ill people who need treatment due to a significant loss of cognitive or volitional control, even though they were not dangerous to themselves or others.⁸⁵ Other states, also, enacted laws authorizing commitment of patients whose everyday functioning was deteriorating, but who posed no immediate danger to anyone.⁸⁶ Seven other states au-

84. A Task Force Report on the mentally ill homeless prepared under the auspices of the American Psychiatric Association recommended that state commitment laws be modified to make it easier to commit mentally ill patients for treatment of their mental illness. *THE HOMELESS MENTALLY ILL: A TASK FORCE REPORT OF THE AMERICAN PSYCHIATRIC ASSOCIATION* 267 (H. Richard Lamb ed., 1984); see H. Richard Lamb & J.A. Talbott, *The Homeless Mentally Ill: The Perspective of the American Psychiatric Association*, 256 *JAMA* 498, 501 (1986). There also have been popularized attacks on restrictive civil commitment laws and calls for revising them to include the need for treatment commitment criteria. R.J. ISAAC & V.C. ARMAT, *MADNESS IN THE STREETS* 332 (1990). Public opposition to deinstitutionalization grew as the number of homeless people skyrocketed. See Peter Rossi et al., *The Urban Homeless: Estimating Composition and Size*, 235 *Sci.* 1336, 1341 (1987) (attributing increase in homeless population to several factors including: decrease in real income of working poor, reductions in support programs for disabled, scarcity of low-cost housing, lack of demand for low-skill workers and changes in number of disabled due to increases in substance abuse and deinstitutionalization of mentally ill). Deinstitutionalization and the inability of mentally ill people to live autonomously in the community received much of the blame for the increase in homelessness. See LEONA BACHRACH, *ISSUES IN IDENTIFYING AND TREATING THE HOMELESS MENTALLY ILL*, LEONA BACHRACH SPEAKS: SELECTED SPEECHES & LECTURES, *NEW DIRECTIONS FOR MENTAL HEALTH SERVICES* No. 35 (H. Richard Lamb ed., 1987). Some observers claimed incorrectly that virtually all homeless people were mentally ill and that restrictive commitment policies had placed a stranglehold on American cities. *Id.*

85. See WASH. REV. CODE ANN. § 71.05.020(1) (West 1992), which was amended in 1979 to read as follows:

(1) "Gravely disabled" means a condition in which a person, as a result of a mental disorder: (a) Is in danger of serious physical harm resulting from a failure to provide for his essential human needs of health or safety, or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety;

Id. (emphasis added to reflect new statutory language).

86. See ALASKA STAT. §§ 47.30.700-05 (1990); ARIZ. REV. STAT. ANN. § 36-

thorized commitment based on "need for treatment,"⁸⁷ a completely opposite approach from that of the Liberal Era "dangerousness" standard. Other states may follow.⁸⁸

Some jurisdictions simply reinterpreted existing laws to allow broadened commitment authority. New York City, for example, implemented a "cold weather emergency" policy that allowed police to pick up homeless people who refused to go to public shelters voluntarily and to transport them either to a shelter or to a psychiatric hospital.⁸⁹ New York City also authorized teams of psychiatrists, nurses and social workers to remove seriously mentally ill individuals from the streets and place them in hospitals.⁹⁰ Both plans seemed to assume that simply living on the streets was sufficiently

520(A) (1993); HAW. REV. STAT. § 334-60.2 (1985 & Supp. 1992); WASH. REV. CODE ANN. § 71.05.240 (Supp. 1994).

87. See ALASKA STAT. §§ 47.30.700-705, 30-915(7)(B) (1990); ARIZ. REV. STAT. ANN. §§ 36-501(5), (6), (14), (15) (1993); HAW. REV. STAT. § 334-60.2 (1985 & Supp. 1992); KAN. STAT. ANN. §§ 59.2902(a)(2), 2908(a) (1983 & Supp. 1993); N.C. GEN. STAT. § 122C-261(a) (1993); 1987 Ore. Laws Adv. Sh. No. 2324; TEX. REV. CIV. STAT. ANN. art. 5547(b)(2)(iii) (West 1987).

88. See, e.g., Wisc. 1993 Assembly Bill 652 (1993-94 Legislature). Introduced July 28, 1993, the bill would permit involuntary commitment of a person who has mental illness and, as shown by evidence of specific recent overt behavior or conduct that indicates that he or she suffers from a significant disorder that impairs substantially his or her behavior or judgment and by evidence of the person's treatment history that indicates that he or she needs treatment to prevent further disability or deterioration, all of the following are true:

1. The mental illness renders the person a proper subject for treatment.
2. If left untreated, the mental illness has a substantial probability of resulting in severe and abnormal mental, emotional or physical harm that will significantly impair the person's judgment, reasoning, behavior, or capacity to recognize reality.
3. The mental illness renders the individual incapable of expressing understanding of the advantages and disadvantages of accepting medication or treatment and of the alternatives to accepting the particular medication or treatment offered, after the advantages, disadvantages and alternatives have been explained to the individual.

Id.

Other states including California, considered expanding the statutory commitment authority. The California attempt likely failed because the program would have been too costly. See ANN ARNEILL, CALIFORNIA COUNCIL ON MENTAL HEALTH, COMPREHENSIVE ANALYSIS OF PROPOSED REVISIONS TO THE LANTERMAN-PETRIS-SHORT ACT 40 (Oct. 1987) (unpublished draft, on file with Authors).

89. Josh Barbanel, *Saving Homeless from Themselves: A New Policy Creates New Disputes*, N.Y. TIMES, Dec. 7, 1985, at A29.

90. This effort, known as Project Help, received wide notoriety in the well-known case of Joyce Brown, also known as Billie Boggs. For a description of her commitment, see *In re Boggs*, 522 N.Y.S.2d 407, 408-09 (Sup. Ct.) (holding that involuntary commitment of street person was unwarranted absent clear and convincing evidence of mental state harmful to others), *rev'd*, 523 N.Y.S.2d 71 (App. Div. 1987).

dangerous for some disturbed individuals so as to justify coercive intervention.

In addition, by 1988, involuntary outpatient commitment was authorized in almost every state.⁹¹ This type of commitment requires outpatients to comply with specific treatment directives, such as taking prescribed medications, keeping appointments at mental health facilities or abstaining from drug and alcohol use.⁹² In many states, if a patient does not comply with an outpatient commitment order, he may be hospitalized automatically against his will.⁹³

Conservatives, along with clinicians, family members and law enforcement officials also criticized the "legalization" of the commitment process as requiring many of the same procedural protections that were provided to criminal defendants.⁹⁴ As a result, some states made adjustments in their commitment procedures thereby decreasing these protections.⁹⁵

While neoconservative dissatisfaction with Liberal Era reforms generated different "answers" to how society should respond to the mentally ill, many questions still remain. Were these legal reforms

91. See Ingo Keilitz & Terry Hall, *State Statutes Governing Involuntary Outpatient Civil Commitment*, 9 MENTAL PHYSICAL DISABILITY L. REP. 378, 380-97 (1985) (discussing various states' development of involuntary outpatient commitment); Robert Miller, *Outpatient Civil Commitment of the Mentally Ill: An Overview and an Update*, 6 BEHAVIORAL SCI. & L. 99, 101 (1988) (same).

92. See Jillane Hinds, *Involuntary Outpatient Commitment for the Chronically Mentally Ill*, 69 NEB. L. REV. 346, 358-65 (1990) (discussing outpatient commitment orders and directives); Miller, *supra* note 91, at 103-06 (same).

93. Miller, *supra* note 91, at 103-06 (discussing statutory and regulatory developments in outpatient commitment).

94. See S. Rachlin, *With Liberty and Psychosis for All*, 48 PSYCHIATRIC Q. 410, 410 (1974) (criticizing restrictive civil commitment laws and citing disadvantages to patient treatment); D.A. Treffert, *In Search of a Sane Commitment Law*, 6 PSYCHIATRIC ANNALS 56, 56-81 (1976) (arguing that legalization of commitment diverts money away from patient care).

95. See ALASKA STAT. § 47.30.715 (1990) (increasing commitment from 21 to 30 days after initial evaluation period of 72 hours); *Id.* § 47.30.770 (increasing power of court to commit respondent upon request to leave from 120 to 180 days); WASH. REV. CODE ANN. § 71.05.340(3) (West 1992) (authorizing detainment and recommitment hearing of patient on conditional release solely upon showing that patient has violated condition of his release). In Washington, the state no longer must establish that the patient also has engaged in conduct dangerous to himself or others as required by its 1973 law. WASH. REV. CODE ANN. § 71.05.340(3) (West 1992). For a thorough analysis of this change in Washington's involuntary treatment act, see Durham & La Fond, *supra* note 38, at 408-11 (discussing state's involuntary treatment act).

Some observers believe that modifying stringent commitment procedures may exert more influence on the involuntary system than changes in commitment criteria. See Paul Appelbaum, *Civil Commitment: Is the Pendulum Changing Direction?*, 33 HOSP. & COMM. PSYCHIATRY 703, 703-04 (1982) (discussing changes in procedural protections for those committed).

based on sound empirical evidence? Do they really work? Was the law an effective instrument for social change? Do these reforms help or harm the mentally ill? What unintended consequences may result from these legal reforms? These questions can only be answered by a systematic analysis of the social science research that examines the impact of these legal changes.

III. DID LEGAL REFORMS MAKE A DIFFERENCE?

A fair amount of research has been conducted which examines the impact of this law reform. While more research is certainly necessary, the studies completed thus far shed some light on the success of various changes in the insanity defense and civil commitment of the mentally ill.

A. *The Insanity Defense*

For many years, legal scholars and psychiatrists have debated the strengths and weaknesses of various insanity defense formulations. Much of the debate has focused on the theoretical implications of specific formulations for conviction or acquittal. Ironically, this debate has virtually ignored whether different insanity tests make a practical difference. The American Psychiatric Association has expressed doubts as to whether the specific verbal formulation is a major determinant of an acquittal by reason of insanity.⁹⁶ Some observers argue that the impact of any of the competing formulations depends almost entirely on how the various standards are applied in the courtroom.⁹⁷

It is also difficult to ascertain if changes in the legal formulation of the insanity defense have any subtle, yet significant, effects on the arguments made by lawyers; judicial decisions regarding the sufficiency of evidence or the opinions, reports and testimony of expert witnesses.⁹⁸ Nevertheless, determining whether liberal or conservative changes in the insanity defense effectively promote the respective goals of those ideologies requires close examination.

96. *American Psychiatric Association Statement on the Insanity Defense*, in *ISSUES IN FORENSIC PSYCHIATRY: INSANITY DEFENSE, HOSPITALIZATION OF ADULTS, MODEL CIVIL COMMITMENT LAW, SENTENCING PROCESS, CHILD CUSTODY CONSULTATION* 15-16 (1984).

97. *Id.* For a historical discussion of the insanity defense, see 3 M. PERLIN, *MENTAL DISABILITY LAW: CIVIL AND CRIMINAL* 279-317 (1989) (discussing development of insanity defense).

98. See Ingo Keilitz, *Researching and Reforming the Insanity Defense*, 39 *RUTGERS L. REV.* 289, 298-99 (1987) (reviewing and analyzing selected research on insanity defense reform and calling for more social research on effect of such changes in order to guide future law reform).

1. *Common Misconceptions About the Insanity Defense*

Many people believe the insanity defense is used too frequently by dangerous criminals to "beat the rap" for serious crimes. Many citizens also object to the acquittal of criminal defendants who have acknowledged (by pleading not guilty by reason of insanity) that they committed a harmful act. The public often thinks that acquittal simply allows dangerous offenders to avoid confinement and to prey on other innocent victims.

These common concerns about the insanity defense clearly suggest most people believe that many criminal defendants who have committed serious crimes successfully use the insanity defense to avoid conviction and punishment. In fact, a recent study of eight American cities found that the insanity plea was used in only one percent of felony cases.⁹⁹ Of those felons who plead insanity, only about twenty-six percent are successful in convincing a judge and jury to excuse them from their crime.¹⁰⁰ Although it is rarely used,

99. See Lisa Callahan et al., *The Volume and Characteristics of Insanity Defense Pleas: An Eight-State Study*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 331, 334 (1991) [hereinafter Callahan, *Volume and Characteristics*] (summarizing recent eight-state study of insanity defense practices, including rates of pleas and successful acquittals); see also Richard Pasewark, *Insanity Plea: A Review of the Research Literature*, 9 J. PSYCHIATRY & L. 357, 362 (1981) [hereinafter Pasewark, *Insanity Plea*] (noting that actual number of insanity pleas in entire United States is unknown because of pleading practices and lack of interest shown by states in maintaining any systematic record of use of NGRI pleas). For a thorough discussion of this data problem, see Callahan, *Volume and Characteristics*, *supra*, at 334.

100. Callahan, *Volume and Characteristics*, *supra* note 99, at 334. The acquittal rate varied dramatically among the states that were studied, ranging from 87% in Washington state to 7.3% in Montana. *Id.*; see Michael L. Perlin, *Whose Plea Is It Anyway? Insanity Defense Myths and Realities* 79 PHILA. MED. 1, 5-10 (1983) (noting that of 52 insanity cases in New Jersey represented by public defenders in 1982, 15 cases or 36% were successful and that fairly accurate national estimate of success rate was approximately 30%); Henry Steadman, *Empirical Research on the Insanity Defense*, 477 ANNALS AM. ACAD. POL. & SOC. SCI. 58, 60 (1985) [hereinafter Steadman, *Empirical Research*] (noting that one out of every 102 insanity pleas in Wyoming from 1971 to 1973 were successful) (citing Richard Pasewark & Mark Pantle, *Insanity Plea: Legislators' View*, 136 AM. J. PSYCHIATRY 222, 222 (1979) [hereinafter Pantle, *Insanity Plea: Legislators' View*]); Henry Steadman et al., *Factors Associated with a Successful Insanity Defense*, 140 AM. J. PSYCHIATRY 401, 401-02 (1983) (noting that in one New York court from 1970 to 1980, there were 202 cases in which insanity pleas were entered and 51, or about 25%, were successful). Callahan's more recent and comprehensive study, based on eight states rather than single jurisdictions, indicates that 26% of felons successfully plead insanity, which is a reasonably precise, contemporary figure. Callahan, *Volume and Characteristics*, *supra* note 99, at 334.

and seldom successful, attorneys and judges,¹⁰¹ legislators,¹⁰² mental health workers¹⁰³ and the general public¹⁰⁴ believe the insanity defense is widely used to avoid punishment.¹⁰⁵

Another common misconception is that insanity acquittees (though small in number) have committed extraordinarily violent and bizarre crimes, such as multiple murder, rape or assassination. Although the types of offenses most often associated with the insanity defense differ from state to state, many offenders found not guilty by reason of insanity have been charged with relatively minor and mundane offenses such as assault, drug use, shoplifting or property offenses.¹⁰⁶ Not surprisingly, crimes committed by per-

101. See Nancy Burton & Henry Steadman, *Legal Professionals' Perceptions of the Insanity Defense*, 6 J. PSYCHIATRY & L. 173, 180 (1978) (noting that in statewide survey of attorneys and judges in New York, 25% felt it was too easy to win acquittal of NGRI defendant); Richard Pasewark & Paul Craig, *Insanity Plea: Defense Attorneys' Views*, 8 J. PSYCHIATRY & L. 413, 417 (1980) (interviewing 51 Wyoming attorneys who estimated that 11-12% of criminal defendants pleaded NGRI when only approximately .31% of criminal defendants entered insanity plea during same period).

102. See Pantle, *Insanity Plea: Legislators' View*, *supra* note 100, at 222 (reporting that Wyoming legislators believed that approximately 21% of criminal defendants entered insanity plea).

103. Richard Pasewark et al., *Opinions about the Insanity Plea*, 8 J. FORENSIC PSYCHOL. 63, 68 (1981) [hereinafter Pasewark et al., *Opinions about the Insanity Plea*] (noting that estimates of frequency of NGRI pleas ranged from 13% by state hospital professional staff to 57% by state hospital aides).

104. See Valerie Hans, *An Analysis of Public Attitudes Toward the Insanity Defense*, 24 CRIMINOLOGY 393, 406 (1986) (finding that in one public opinion survey, people estimated that average of 38% of defendants who are charged with crimes plead NGRI). Pasewark has found that according to a Wyoming public opinion survey conducted in the 1970s, residents of two Wyoming communities believed that 43% of all criminal defendants entered plea when, in actuality, only .47% did so. Pasewark et al., *Opinions about the Insanity Plea*, *supra* note 103, at 69. Those community residents further believed that 38% were successful when only one of 102 defendants [.99%] entering the plea was adjudicated NGRI. *Id.*; see Richard Pasewark & Deborah Seidenzahl, *Opinions Concerning the Insanity Plea and Criminality Among Mental Patients*, 7 BULL. AM. ACAD. PSYCHIATRY & L. 199, 201 (1979) (noting that college students in Wyoming believed that 37% of defendants entered NGRI plea and 44% of criminal defendants were successful); Henry Steadman & Joseph Coccozza, *Selective Reporting and the Public's Misconceptions of the Criminally Insane*, 41 PUB. OPINION Q. 523, 532 (1978) (finding that survey of residents of Albany, New York, reflected fear of unpredictability and danger of criminally insane and their use of insanity plea to avoid punishment).

105. For a general review of opinions about the insanity defense, see Ibtihaj Arafat & Kathleen McCahery, *The Insanity Defense and the Juror*, 22 DRAKE L. REV. 538, 538 (1973) (noting that presence of stereotyped image of NGRI defendant and unfavorable attitude toward psychiatry were associated with jurors' assessment of appropriateness of insanity defense); Pasewark, *Insanity Plea*, *supra* note 99, at 357-401 (discussing commentator's views of insanity plea).

106. See Callahan, *Volume and Characteristics*, *supra* note 99, at 336 (stating that only 14.8% of acquittees had murdered their victim; approximately 50% had committed violent acts such as assault, and about 35% had committed robbery or other

sons who plead insanity are virtually identical to those committed by other offenders. The victims and offenders in homicides and assaults are usually acquainted, while in property offense cases, they are most often strangers.¹⁰⁷

Most insanity acquittees have been hospitalized in the past and have received DSM-III diagnoses for very severe impairments, such as schizophrenia.¹⁰⁸ However, many heinous crimes such as serial or multiple murders are committed by people who do *not* have lengthy criminal¹⁰⁹ or psychiatric histories;¹¹⁰ nor are they committed only by persons who are seriously mentally ill or legally

minor crimes); *see also* John Pettila, *The Insanity Defense and Other Mental Health Dispositions in Missouri*, 5 INT'L J.L. & PSYCHIATRY 81, 95 (1982) (noting that among NGRI population in Missouri, only 7.46% of charges were for murder and 1.49% were for rape); Jeffrey Rogers et al., *Women in Oregon's Insanity Defense System*, 11 J. PSYCHIATRY & L. 515, 523 (1983) (noting that women found NGRI in Oregon had committed variety of crimes including car theft, kidnapping, assault, sex offenses and arson); Jeffrey Rogers & Joseph Bloom, *Characteristics of Persons Committed to Oregon's Psychiatric Security Review Board*, 10 BULL. AM. ACAD. PSYCHIATRY & L. 155, 159 (1982) (noting that 5% of acquittees were charged with murder and another 5% were charged with attempted murder); Anne Singer, *Insanity Acquittal in the Seventies: Observations and Empirical Analysis of One Jurisdiction*, 2 MENTAL DISABILITY L. REP. 406, 406-07 (1978) (noting that charges included: assault and battery, arson, armed robbery, lewdness, larceny and weapons, and drug possession); Henry Steadman, *Insanity Acquittals in New York State: 1965-1978*, 137 AM. J. PSYCHIATRY 321, 323 (1980) (noting that from 1976-78, 43.6% of acquittees in New York were charged with murder while other charges ranged from drug sales to arson). For a general discussion of the empirical research in this area, see Jeraldine Braff et al., *Defendants Not Guilty by Reason of Insanity*, in MENTALLY DISORDERED OFFENDERS 109, 113-15 (John Monahan & Henry Steadman eds., 1983) (summarizing results of studies on characteristics of NGRI acquittees and defendants); Pasewark, *Insanity Plea*, *supra* note 99, at 366; Bruce Sales & Thomas Hafemeister, *Empiricism and Legal Policy on the Insanity Defense*, in MENTAL HEALTH AND CRIMINAL JUSTICE 253, 256 (Linda Teplin ed., 1984) (outlining characteristics of NGRI acquittees); Henry Steadman, *Mental Health Law and the Criminal Offender: Research Directions for the 1990's*, 39 RUTGERS L. REV. 323, 328 (1987) (recommending future research initiatives); Steadman, *supra* note 100, at 63 (describing characteristics of NGRI acquittees).

107. Pasewark, *Insanity Plea*, *supra* note 99, at 366-67.

108. *See* Callahan, *Volume and Characteristics*, *supra* note 99, at 336 (stating that insanity acquittees are more likely to have been previously hospitalized); Richard Jeffrey et al., *Insanity Plea: Predicting Not Guilty by Reason of Insanity Adjudications*, 16 BULL. AM. ACAD. PSYCHIATRY & L. 35, 37-38 (1988) (finding diagnosis of schizophrenia predictive of NGRI verdict).

109. *See* Pasewark, *Insanity Plea*, *supra* note 99, at 369 (discussing two Wyoming studies that indicate that only 62% and 76% of persons making NGRI plea had at least one prior apprehension). However, Callahan's research found that 70.2% of NGRI acquittees had one or more prior arrest. Callahan, *Volume and Characteristics*, *supra* note 99, at 336.

110. *See* Pasewark, *Insanity Plea*, *supra* note 99, at 370 (reporting that incidence of NGRI acquittees having prior psychiatric hospitalizations ranges from 35% to 61% in various studies). However, Callahan's findings show that 82% of NGRI acquittees had at least one prior hospitalization. Callahan, *Volume and Characteristics*, *supra* note 99, at 336.

insane.¹¹¹

Another common misperception is that people who raise the insanity plea will be excused from their crimes and, as a result, leave the courthouse as free men.¹¹² This is simply not true. Defendants who plead NGRI and are subsequently convicted of a felony spend significantly *longer* time in confinement than offenders who do not raise the defense.¹¹³ This is probably because defendants who actually go to trial and assert the insanity defense do not plea-bargain to reduce their prison terms before the verdict comes in, as many convicted criminals do.¹¹⁴ Because an insanity plea is usually perceived as an admission that he committed the offense, there is no room for the defendant to bargain for a reduced charge once the jury has rejected the NGRI plea.

A common public fear is that the "insane" criminal will be released to prey once again on society. While defendants found NGRI do have a substantial chance of rearrest, ranging from thirteen percent in Oregon to sixty-five percent in Connecticut, recidivism rates are almost identical to those of convicted felons who committed similar crimes.¹¹⁵ Similarly, NGRIs are most likely to be

111. See Pasewark, *Insanity Plea*, *supra* note 99, at 371-75 (noting that wide array of diagnoses are found among those pleading NGRI or acquitted as NGRI, many of which are not psychotic disorders, including alcoholism and transient personality disorders).

112. See HENRY STEADMAN, BEATING A RAP? DEFENDANTS INCOMPETENT TO STAND TRIAL 100-01 (1979) (presenting empirical evidence associated with pleas of insanity, including analysis of public misperception that such pleas frequently result in release of many dangerous individuals).

113. See Jeraldine Braff et al., *Detention Patterns of Successful and Unsuccessful Insanity Defendants*, 21 CRIMINOLOGY 439, 445 (1983) (noting that male felons who pled NGRI but were convicted spent 22% longer in detention than those who did not raise plea); Steadman, *Empirical Research*, *supra* note 100, at 64-65 (noting that length of detention for those who successfully plead NGRI was approximately identical to matched group of felons).

Dr. Steadman, the most noted researcher in this area, gives a straightforward discussion of the difficulties in estimating how long defendants acquitted by reason of insanity are detained. Steadman, *Empirical Research*, *supra* note 100, at 63-66. See generally Michael Perlin, *The Supreme Court, the Mentally Disabled Criminal Defendant, and Symbolic Values: Random Decisions, Hidden Rationales, or "Doctrinal Abyss?"* 29 ARIZ. L. REV. 1 (1987) (discussing Supreme Court's uncertainty in area of criminal justice for those with mental disabilities); Joseph Rodriguez et al., *The Insanity Defense Under Siege: Legislative Assaults and Legal Rejoinders*, 14 RUTGERS L.J. 397, 401-04 (1983) (discussing statistics concerning NGRI pleas and discounting several common misconceptions surrounding insanity defense).

114. See Steadman, *Empirical Research*, *supra* note 100, at 63-66 (stating that plea bargaining should be taken into consideration when comparing sentencing of convicted criminal charges with NGRI offense charges).

115. See *id.* at 66 (stating that NGRI recidivism rates are very similar to those of matched felons); see also Mark Pantle et al., *Comparing Institutionalization Periods and Subsequent Arrests of Insanity Acquittes and Convicted Felons*, 8 J. PSYCHIATRY & L.

rearrested for assault, burglary, theft, and robbery, making their rearrest patterns look much like those of other convicted felons.¹¹⁶

Based on the available research, it appears that the public, the press and policymakers are remarkably uninformed about the actual use of the insanity defense. These misconceptions provide an inaccurate factual basis for undertaking insanity defense reform and may also help explain the shortcomings of neoconservative reform efforts. Having dispelled some of the most widely held misconceptions, this Article now turns to an assessment of both liberal and neoconservative insanity defense reforms.

2. *Assessing the Reforms of the Liberal Era*

During the Liberal Era, only one jurisdiction adopted the *Durham* rule. Most other jurisdictions adopted the American Law Institute's insanity test with the expectation that more mentally ill offenders would be acquitted and thereby be treated rather than punished.¹¹⁷ There was little research done during this period, however, that explored whether Liberal Era reforms had these results. Only four studies—each with considerable methodological limitations—investigated the effects of the switch from a strict test, like *M'Naghten*, to a more liberal version of the insanity defense.¹¹⁸ In the absence of more sound research, it is not possible to provide definitive answers on what impact Liberal Era insanity defense reforms had on the use of the insanity defense.¹¹⁹

Even with their flaws, however, the results of the four studies

305, 313 (1980) (noting that subsequent arrests of NGRI and felon subjects were comparable—24% compared to 27%); Rogers & Bloom, *supra* note 106, at 161 (noting that new crimes charged to conditionally released individuals included assault, weapons charges, DWI and wide range of other charges).

116. See Steadman, *Empirical Research*, *supra* note 100, at 66-67 (stating that NGRIs and matched felons have similar re-arrest patterns).

117. For a discussion of the developing insanity defense, see *supra* notes 27-31 and accompanying text.

118. See Richard Arens, *The Durham Rule in Action: Judicial Psychiatry and Psychiatric Justice*, 1 LAW & SOC'Y REV., June 1967, at 41 (studying District of Columbia); Pasewark, *Insanity Plea*, *supra* note 99, at 360-61 (studying Wyoming); Stacia Reynolds, *Battles of the Experts Revisited: 1983 Oregon Legislation on the Insanity Defense*, 20 WILLAMETTE L. REV. 303, 303-17 (1984) (studying Oregon); Robert Sauer & Paul Mullens, *The Insanity Defense: M'Naghten vs. ALI*, 4 BULL. AM. ACAD. PSYCHIATRY & L. 73, 73-75 (1976) (studying Maryland); see also Keilitz, *supra* note 98, at 298-303 (studying California, Maryland, Oregon and Wyoming).

119. For articles discussing the effects of different insanity defense tests, see *supra* note 118. The reforms in various states took place in the 1960s (District of Columbia), 1970s (Maryland, Wyoming) and 1980s (Oregon). For articles discussing reforms in the District of Columbia, Maryland and Oregon, see *supra* note 118. These studies provide the only empirical data available on the consequences of liberalizing the insanity defense.

do suggest that adopting a more expansive test may increase the frequency of successful use of the insanity defense.¹²⁰ For example, the number of successful insanity cases increased from less than one-half of one percent to over fourteen percent in the seven years after the District of Columbia replaced the *M'Naghten* test with the *Durham* rule.¹²¹ Although most of the increase occurred during the last two years of this period, it appears likely that *Durham* did have an expansive effect on insanity acquittals.¹²²

There is also modest evidence that switching to the ALI test from the *M'Naghten* test resulted in more successful insanity defenses.¹²³ Between 1966 and 1972, Oregon used the *M'Naghten* test and had only forty-four successful insanity defenses.¹²⁴ Between 1972 and 1982, using the ALI standard, that state had a total of 734 insanity acquittals.¹²⁵ Similarly, in Maryland, there was a 143 percent increase in the proportion of defendants found not guilty by reason of insanity in the years after that state changed from *M'Naghten* to ALI.¹²⁶

In contrast, when Wyoming changed from a combination of *M'Naghten* and the "irresistible impulse" test to the ALI standard, there were no significant changes in the number of insanity acquittals.¹²⁷ The absence of any significant impact may also have been due to the extremely small number of cases that occurred during this period.¹²⁸

120. For a discussion of the results of the four studies, see Keilitz, *supra* note 98, at 299-302.

121. Arens, *supra* note 118, at 46.

122. *Id.* It is important to note that Arens' data cannot rule out a number of factors that may have resulted in the irregular pattern of increases observed between 1954 and 1961. Most notably, the largest increases occurred more than five years after the *Durham* decision. *Id.*

123. Reynolds, *supra* note 118, at 307.

124. *Id.*

125. *Id.*

126. Sauer & Mullens, *supra* note 118, at 74. However, the Sauer and Mullens study had a very weak research design because it used single data points on either side of the legal change to represent insanity defense practices. There is, therefore, no way to rule out alternative explanations for the changes which were observed.

127. Pasewark, *Insanity Plea*, *supra* note 99, at 364.

128. See Callahan, *Volume and Characteristics*, *supra* note 99, at 331 (stating that research on insanity defense is greatly hampered by unavailability of data); Pasewark, *Insanity Plea*, *supra* note 99, at 361-62 (same); Sales & Hafemeister, *supra* note 106, at 255 (same). Because jurisdictions are not required to keep statistics on pleas or verdicts, researchers must examine criminal trial transcripts—a task requiring resources beyond those available to most researchers. The result of this situation is exemplified by Sauer and Mullens' study, in which only a single point in time on either side of the legal change is used to measure change, rather than

In sum, the data from the four studies of Liberal Era insanity defense reforms were compiled by research with significant design deficiencies. Although they cannot provide definitive answers to our question, they can support informed speculation that such legal revisions did make a difference in actual practice.¹²⁹ We do know for certain that the number of successful insanity defenses grew in the District of Columbia, Oregon and Maryland in the years following liberalization of their insanity tests. It is quite possible that adopting a more lenient insanity test resulted in more insanity acquittals.

There are, however, factors unrelated to the legal test of insanity that may also explain some or all of the observed changes. Reforms in related areas of procedural and substantive law can also have an effect on the insanity defense. For instance, revisions in New York's criminal procedures that control the disposition of NGRI acquittees may have increased the number of persons ultimately adjudicated NGRI. Prior to the revisions, when acquittees were automatically committed to a Department of Corrections facility, only a handful of persons were found insane.¹³⁰ After the 1971 revisions, when NGRI acquittees were transferred to the Department of Mental Hygiene, the number of acquittals jumped dramatically.¹³¹ Perhaps lawyers, judges and juries thought the change in the type of confinement for insanity acquittees increased the likelihood that they would receive psychiatric treatment.¹³² Consequently, lawyers may have raised the defense more often and judges and juries may have been more inclined to find such defendants insane. Conversely, it is also possible that more defendants opted to raise the insanity defense with the hope of obtaining a psychiatric disposition, thereby keeping them out of prison.

the multiple time periods required of more rigorous research. See Sauer & Mullens, *supra* note 118, at 73. The hazard of using single points in time is that the actual rate of pleas and acquittals may follow a jagged pattern of peaks and declines. Without examining multiple points over time, such a pattern may be misinterpreted. This is especially true when the number of cases is extremely small, causing wild variations in rates with the addition or loss of a single case. Pasewark, *Insanity Plea*, *supra* note 99, at 364 (noting, for example, that Wyoming only had 102 cases involving insanity defense).

129. See Keilitz, *supra* note 98, at 300 (noting methodological difficulties with studies but concluding that studies do suggest that reforms affect frequency of success of insanity defense).

130. See Richard Pasewark et al., *The Insanity Plea in New York State, 1965-1976*, 51 N.Y. St. B.J. 186, 187-88 (1979) [hereinafter Pasewark, *The Insanity Plea in New York State*] (noting that relatively low number of persons were found NGRI prior to 1971 revisions in New York's criminal procedure).

131. *Id.* at 188.

132. *Id.* at 225.

Judicial decisions can also have an influence on a defendant's confinement after an insanity acquittal. In *State v. Krol*,¹³³ the New Jersey Supreme Court held that a hearing to determine whether NGRIs are *presently* mentally ill and dangerous must take place before they can be committed to a mental hospital.¹³⁴ Before this decision, NGRI acquittees in New Jersey were hospitalized for an average of 26.3 months.¹³⁵ Following *Krol*, average hospitalization periods were reduced dramatically to 6.4 months.¹³⁶ Several successful insanity defendants were released who might never have been released without the *Krol* decision.¹³⁷

The available research indicates that in some jurisdictions, there was a small increase in the number of people excused from criminal responsibility by successfully pleading the insanity defense under Liberal Era insanity tests. Because these studies were not well designed, however, it is impossible to determine definitively whether this increase was due to changes in the insanity defense or to political, social or other factors. One conclusion, however, seems clear: the actual number of successful "insane" offenders remained so small during the Liberal Era — probably around one percent of incarcerated populations¹³⁸ — that the public uproar over the insanity defense that occurred at the dawn of the Neoconservative Era could not have been caused by extensive abuse of the insanity defense.

3. *Assessing Neoconservative Insanity Defense Reforms*

Although many people assume that John Hinckley's presidential assassination attempt and subsequent acquittal by reason of insanity was responsible for the Neoconservative insanity defense reforms of the 1980s, the reform process actually began several years earlier.¹³⁹ While the furor over Hinckley's acquittal epitomized

133. 344 A.2d 289 (N.J. 1975).

134. See Singer, *supra* note 106, at 406 (analyzing impact of *Krol* decision in New Jersey courts). This is not to suggest that court decisions always lead to measurable changes in insanity acquittal practices. In a study of 200 years of NGRI pleas in Great Britain, researchers found that the success rate of such pleas did not vary significantly following important court decisions. NIGEL WALKER, *CRIME AND INSANITY IN ENGLAND* 243 (1968). Although a national study to observe these types of patterns in the United States would be illuminating, it would be impossible due to the absence of data.

135. See Singer, *supra* note 106, at 407.

136. *Id.*

137. *Id.*

138. See Callahan, *Volume and Characteristics*, *supra* note 99, at 331, 334; Steadman, *Empirical Research*, *supra* note 100, at 59-60.

139. See Callahan et al., *supra* note 58, at 55 (analyzing insanity defense re-

mized public indignation over the law's emphasis on the rights of criminals at the expense of law-abiding citizens, antagonism toward the insanity defense was consistent with the more pervasive mood of Americans in the late 1970s and into the 1980s.¹⁴⁰

Anger with the legal system's perceived failure to protect the public increased after the Michigan Supreme Court's decision in *People v. McQuillan* in 1974.¹⁴¹ *McQuillan* led to the release of 150 insanity acquittees; two of whom subsequently committed heinous murders.¹⁴² Major neoconservative insanity defense reforms began in Michigan shortly thereafter and spread to other states and federal courts during the early 1980s.¹⁴³ Unpopular decisions like the Hinckley insanity acquittal and the Dan White "twinkie defense" became front-page headlines¹⁴⁴ and fueled public outcries for sweeping reforms to limit the insanity and diminished capacity defenses.¹⁴⁵

Though individual states approached insanity defense reforms in slightly different ways, the neoconservative reforms shared three common themes. First, all reforms were designed to reduce the number of people who might escape punishment through pleas of insanity.¹⁴⁶ Some states eliminated the defense altogether, while other jurisdictions devised a tougher test to reduce the number of

forms beginning in 1978 and explaining that reform movement began prior to Hinckley assassination attempt, but accelerated after that point).

140. For example, New Mexico, Indiana and Illinois passed legislation providing for a guilty but mentally ill verdict prior to the Hinckley verdict. *Id.*

141. 221 N.W.2d 569 (Mich. 1974).

142. For a discussion of how cases such as *People v. McQuillan*, 221 N.W.2d 569 (Mich. 1974), became catalysts for reform, see INSTITUTE ON MENTAL DISABILITY AND THE LAW, NATIONAL CENTER FOR STATE COURTS, *THE GUILTY BUT MENTALLY ILL VERDICT: AN EMPIRICAL STUDY E-1, E-3* (1984) [hereinafter INSTITUTE ON MENTAL DISABILITY]; Keilitz, *supra* note 98, at 308.

143. For a discussion of neoconservative insanity defense reforms, see *supra* notes 51-83 and accompanying text.

144. See WEISS, *supra* note 56, at 405.

145. See Gilbert Geis & Robert Meier, *Abolition of the Insanity Plea in Idaho: A Case Study*, 477 ANNALS AM. ACAD. POL. & SOC. SCI. 72, 73 (1985) (noting that in 1982, Idaho became first state to abolish insanity plea and stating that abolition of plea was partially due to popular view that people should take personal responsibility for their actions); Ted Gest, *Hinckley Bombshell: End of Insanity Pleas?*, U.S. NEWS AND WORLD REP., July 5, 1982, at 12 (finding that Hinckley verdict sparked demands to reform, limit and bar use of insanity defense in both federal and state trial courts); Walter Isaacson, *Insane on All Counts: After Torturous Deliberations, a Jury Acquits John Hinckley*, TIME, July 5, 1982, at 22 (predicting need for reform after Hinckley case). But, as Callahan and her colleagues point out, it is an empirical question as to whether or not the legal changes that occurred after Hinckley were precipitated by that case or if they were due to other developments. See Callahan et al., *supra* note 58, at 55.

146. See Keilitz, *supra* note 98, at 308, 319.

mentally ill offenders who might be excused for their crimes.¹⁴⁷ Second, the legal reforms such as GBMI sought to increase the criminal justice system's control over mentally disordered offenders. Whereas successful insanity defendants are *acquitted* of their crimes and transferred into the mental health system, GBMI defendants are *convicted* and can receive the same sentence as other defendants found guilty, including prison terms and the death penalty.¹⁴⁸ Third, reforms such as the GBMI defense were intended to enhance the likelihood of mental health treatment for that special group of severely impaired inmates.¹⁴⁹

When the GBMI verdict was established in Georgia, Illinois and Michigan, nearly half of the legislators, attorneys, judges, mental health personnel and corrections officials who were surveyed expected the use of the insanity defense to decrease.¹⁵⁰ Twenty-five percent of them believed reforms would increase the prospects of treatment for mentally disordered offenders and increase the criminal justice system's control over offenders.¹⁵¹ Some research (mostly on the use of the GBMI defense) is now available to evaluate whether these expectations were met.

a. Reductions in Insanity Acquittals

Although proponents of the GBMI defense claimed it would decrease the number of insanity acquittals, this has not always been the case. In Michigan, the frequency of NGRI verdicts was unchanged by the arrival of GBMI as an alternative verdict.¹⁵² In Illinois, the number of NGRI acquittals actually *increased* following the enactment of the GBMI legislation.¹⁵³

147. For a survey of state approaches to insanity defense reforms, see *supra* notes 57-70 and accompanying text.

148. For a discussion of the penalties a GBMI defendant may receive, see *supra* notes 62-70 and accompanying text.

149. See Keilitz, *supra* note 98, at 312-13. The effective dates of GBMI legislation are: Michigan, August 6, 1975; Indiana, September 1, 1980; Illinois, September 17, 1981; New Mexico, May 19, 1982; Georgia, July 1, 1982; Delaware, July 2, 1982; Kentucky, July 15, 1982; Alaska, October 1, 1982; Pennsylvania, March 15, 1983; South Dakota, March 19, 1983; and Utah, March 31, 1983. *Id.* at 316. The federal courts made several revisions in 1984. *Id.* at 311. The Michigan Supreme Court decided *People v. McQuillan* in 1974. See *id.* at 308. John Hinckley attempted to assassinate Ronald Reagan on March 30, 1981. The court found Hinckley not guilty by reason of insanity on June 21, 1982. See Gest, *supra* note 144, at 12.

150. See Keilitz, *supra* note 98, at 312.

151. *Id.* at 312-13.

152. Gare Smith & James Hall, *Evaluating Michigan's Guilty but Mentally Ill Verdict: An Empirical Study*, 16 U. MICH. J.L. REF. 77, 93 (1982) (finding stable rate of NGRI verdicts, even with enactment of GBMI defense).

153. See Keilitz, *supra* note 98, at 319. Even though no decrease appears to

In Georgia, however, insanity acquittals did drop from 22.1% of insanity pleas before the GBMI law to only 12.4% after enactment of the GBMI defense.¹⁵⁴ The reform also brought a significant drop in the acquittal rate for violent crimes (from 29.5% in the year prior to the legal change to 15.5% in the year the law was implemented).¹⁵⁵ Thus the evidence is mixed. In Michigan, it appears the GBMI defense had no impact on the successful use of the insanity defense, while in Illinois, it may actually have precipitated an *increase* in its successful use, frustrating a major goal of this reform. In Georgia, however, it may have caused a decline, thereby achieving a major goal.¹⁵⁶

b. Increased Control over the Mentally Ill Offender

While failing to reduce the number of successful insanity pleas, reformers were successful in enhancing control over mentally ill offenders. Research shows that GBMI offenders are given longer sentences than non-GBMI offenders.¹⁵⁷ In Michigan, 21% of GBMI offenders received sentences of sixteen or more years compared to only 12% non-GBMI prison inmates.¹⁵⁸ The average length of confinement for GBMI offenders in Michigan has been just under four years, compared to about a year and a half of detention for NGRI acquittees.¹⁵⁹ In Georgia, the average sentence for a GBMI offender is nearly twelve years, compared to just over nine years for all other offenders.¹⁶⁰ Georgia GBMI defendants were also significantly more likely than guilty defendants to receive a life sentence

have occurred in the number of insanity acquittals, Keilitz believes that the availability of the GBMI alternative may have influenced the type of person who is acquitted by reason of insanity. *Id.* at 320. In Illinois, fewer successful NGRI defendants were diagnosed as psychotic than before the enactment of the GBMI law (70% vs. 51%), and the average length of confinement dropped from just over two years to slightly over six months. *Id.* at 320.

154. See Lisa Callahan et al., *Measuring the Effects of the Guilty but Mentally Ill (GBMI) Verdict*, 16 LAW & HUM. BEHAV. 447, 452 (1992) [hereinafter Callahan, *Measuring the Effects*].

155. *Id.*

156. Of course, the research only demonstrates a correlation between enactment of the GBMI defense and the observed changes in successful use of the insanity defense. It cannot definitively establish a causal relationship because other factors may have influenced the observed changes. For a discussion of the inability to definitively establish a causal relationship, see *supra* notes 129-36.

157. See Keilitz, *supra* note 98, at 318-19.

158. *Id.* at 318.

159. See INSTITUTE ON MENTAL DISABILITY, *supra* note 142, at E-14 (finding that in Michigan, GBMI confinements averaged 3.99 years compared to 1.43 years for insanity acquittees).

160. *Id.* at E-13.

(14% versus 5.5%, respectively). Further, over 70% of Georgia GBMIs who had committed murder received life sentences, compared to 49.2% of other convicted murderers. GBMIs were also less likely than people convicted of serious crimes to return to the community.¹⁶¹ In sum, "GBMIs were more likely than guilty defendants to go to prison, to receive life sentences, and to receive longer sentences for the same crimes."¹⁶²

c. Availability of Treatment for Mentally Ill Offenders

Contrary to the expectation that accompanied GBMI legislation, GBMI offenders are no more likely to receive treatment than mentally ill offenders in the general inmate population who have not been found GBMI.¹⁶³ GBMI offenders are eligible for treatment in most states only if a post-conviction mental health evaluation indicates such a need and, then, only if resources are available to provide it.¹⁶⁴ Although at least ninety percent of GBMI offenders actually receive post-conviction mental health evaluations, studies indicate that some form of treatment is recommended in only 64-72% of cases.¹⁶⁵

d. "Front-end" v. "Back-end" Reforms

Early neoconservative reforms of the insanity defense involved changes to trial procedures and the wording of the insanity test to decrease the number of insanity acquittals or so-called "front-end" reforms.¹⁶⁶ These legal changes often included outright abolition of the insanity defense, narrowing the scope of the insanity test, enactment of the GBMI defense or shifting the burden of proof.¹⁶⁷ As noted previously, these front-end reforms have not significantly reduced the number of pleas or the number of defendants "ex-

161. Callahan, *Measuring the Effects*, *supra* note 154, at 458. This comes as a result of the courts' propensity to sentence GBMI defendants to life or long-term sentences. *Id.* at 459.

162. *Id.*

163. *Id.* at 460. Callahan and her colleagues have noted that courts in Michigan and Indiana that have ruled on right to treatment issues regarding GBMIs have decided that treatment for GBMIs is not an issue of constitutional rights. *Id.* Instead, these courts have held that legal petitions or class action suits may be used to compel the Department of Correctional Services to provide treatment. *Id.* Callahan and her colleagues also note that this has not yet occurred. *Id.* at 447-62.

164. *Id.* at 460.

165. Keilitz, *supra* note 98, at 319.

166. *See* Rogers & Bloom, *supra* note 106, at 71 (describing front-end reforms and describing Oregon's PSRB which monitors acquittees after release).

167. *See* Callahan, *Insanity Defense Reform*, *supra* note 58, at 54; Rogers & Bloom, *supra* note 106, at 71.

cused" for their crimes.¹⁶⁸

Some analysts now believe that the more effective insanity defense reforms will be the "back-end" reforms: those that ensure continued state control over successful insanity defendants by requiring them to spend more time in confinement and making their release more difficult.¹⁶⁹ Such measures are designed to prevent the release of offenders who are still mentally ill and dangerous.

Other back-end reforms concentrate on aggressive community supervision upon release. The creation of Oregon's Psychiatric Security Review Board is perhaps the best example of this kind of back-end reform. It seeks to make release of successful insanity defendants more difficult and strengthens community surveillance and control of mentally ill offenders following release.¹⁷⁰

The most successful of the back-end reforms appears to be those that enhance the "clutchability" of successful insanity defendants.¹⁷¹ These reforms require automatic commitment after trial, more stringent release standards and procedures and outpatient commitment after release from inpatient hospitalization.¹⁷² For example, the decision in *Jones v. United States*,¹⁷³ resulted in increasingly aggressive policies for confining and controlling mentally ill offenders who successfully plead insanity.¹⁷⁴

B. Civil Commitment

1. Who is Committed?

A strange irony exists between the insanity defense and involuntary civil commitment. Although relatively few people ever plead insanity, and even fewer are successful, the insanity defense is one of the most controversial and widely debated legal issues.¹⁷⁵ On the

168. For the relevant statistics on whether front-end reforms reduced NGRI pleas, see *supra* notes 152-56 and accompanying text.

169. For a discussion of "back-end" reforms, see *supra* notes 157-62 and accompanying text.

170. See generally Rogers & Bloom, *supra* note 106, at 71 (arguing that Oregon's Psychiatric Security Review Board seeks to protect society by using strict guidelines and monitoring for conditional release and revocation of release).

171. See Callahan, *Insanity Defense Reform*, *supra* note 58, at 59.

172. *Id.*

173. 463 U.S. 354 (1983).

174. *Id.* at 366-70 (holding that person acquitted by reason of insanity could be confined in mental institution so long as he continued to be mentally ill and dangerous regardless of maximum term for which he could have been sentenced if found guilty on original charge, and holding that state did not have to use same procedures to commit him as were applicable to involuntary civil commitment).

175. See, e.g., Norval Morris, *Psychiatry and the Dangerous Criminal*, 41 S. CAL. L.

other hand, civil commitment of the mentally ill—which effects millions of people every year—is virtually unknown to most Americans.¹⁷⁶

Although serious mental illness is found in all segments of society and in all social classes,¹⁷⁷ people who are involuntarily committed tend to be socially isolated even before they encounter the mental health system. Overwhelmingly, they are poor and unemployed or working in low paying jobs.¹⁷⁸ Often, they lack the education, skills or experience needed for other types of work.¹⁷⁹

Furthermore, involuntarily committed persons generally have few personal and social resources to turn to for help. They tend to be young, white males who have never married and who have been unable to form stable relationships.¹⁸⁰ Many are divorced or sepa-

REV. 514, 516 (1968) (“Rivers of ink, mountains of printer’s lead, forests of paper have been expended on this issue, which is surely marginal to the chaotic problem of effective, rational, and humane prevention and treatment of crime.”); Joseph Rodriguez et al., *The Insanity Defense Under Siege: Legislative Assaults and Legal Rejoinders*, 14 RUTGERS L.J. 397, 397 (1983) (“No aspect of our legal system has engendered a more intense level of debate than the role of the insanity defense in the criminal justice process.”).

176. According to estimates from the National Institute of Mental Health (NIMH), in 1980 there were 306,468 involuntary commitments and 838,317 voluntary commitments to inpatient psychiatric services of state and county mental hospitals and private psychiatric hospitals and the separate inpatient psychiatric services of non-federal general hospitals. Additionally, 31,773 involuntary criminal commitments also took place in these hospitals during 1980. Males make up 62% of the committed population and nonwhites are overrepresented relative to the general population (37% of committees). Schizophrenia is the most frequent diagnosis, comprising 42% of all state and county mental hospital admissions. See MARILYN ROSENSTEIN ET AL., U.S. DEP’T OF HEALTH AND HUMAN SERV., MENTAL HEALTH STATISTICAL NOTE NO. 178, LEGAL STATUS OF ADMISSION TO THREE INPATIENT PSYCHIATRIC SETTINGS 1-4 (1986).

177. Jerome Myers et al., *Six-Month Prevalence of Psychiatric Disorders in Three Communities*, 41 ARCH. GEN. PSYCHIATRY 949, 953-56 (1984) (summarizing epidemiological evidence for DSM-III psychiatric disorders based on community surveys). The Myers study found: higher rates of major depression and some phobias experienced by women as compared to men, minimal differences between blacks and others in rates of psychiatric disorder and lower rates of psychiatric disorder among college graduates. *Id.*

178. See Virginia A. Hiday, *Dangerousness of Civil Commitment Candidates: A Six-Month Follow-Up*, 14 LAW & HUM. BEHAV. 551, 558 (1990) [hereinafter Hiday, *Dangerousness*] (finding that subjects studied for six months following court hearing for civil commitment had lower socioeconomic status and were “disadvantaged by more than their mental illness”); Virginia Hiday, *Civil Commitment: A Review of Empirical Research*, 6 BEHAV. SCI. & L. 15, 18 (1988) [hereinafter Hiday, *Civil Commitment*] (noting that committees have few financial or social resources); Virginia A. Hiday, *Court Decisions in Civil Commitment: Independence or Deference?* 4 INT’L J.L. & PSYCHIATRY 159, 162 (1981) [hereinafter Hiday, *Court Decisions*] (finding committees to be characterized by low education and low income).

179. See Hiday, *Civil Commitment*, *supra* note 178, at 18.

180. *Id.* at 19. The nonmarried comprise a high percentage of the categories

rated, and may suffer from disintegrated social networks, loss of housing and heightened emotional difficulties.¹⁸¹

Involuntarily committed persons who are married generally turn to their families for help at one time or another. Nevertheless, once a mentally ill person creates a disturbance in the family or the community, the family's willingness, or lack thereof, to be responsible for him or her becomes an important factor in whether he or she is committed.¹⁸² In fact, family members tend to be the first to make contact with commitment authorities, either by bringing a mentally ill person directly to a mental hospital or by calling the police.¹⁸³

Although serious mental illness is exhibited in all socioeconomic classes, only poor people are committed to state mental hospitals.¹⁸⁴ For those of higher socioeconomic status, privileges include treatment at home or commitment to private hospitals. Except for cases where a family member is extremely dangerous, middle and upper class families generally seek civil commitment only after their resources have run out—an option not available to poor families.¹⁸⁵ Where the family member is considered dangerous, all classes see civil commitment as a necessary form of intervention that will protect the public and the patient. This consistency, however, fuels the common stereotype that hospitalized mental patients

involving involuntary commitment and involving actual commitment. *Id.* Unmarried status is most likely a cause and effect of the mental illness prevalent in these patients. *Id.*

181. *Id.* at 18-19, 38.

182. *Id.* at 19. (arguing that presence of willing family is important factor in both psychiatric and legal decisions to release); Virginia A. Hiday, *Judicial Decisions in Civil Commitment*, 17 *LAW & SOC. REV.* 517-30, 524-26 (1983) (noting that family caring is significantly associated with commitment decision); S. Splane et al., *Patients' Perceptions of the Family Role in Involuntary Commitment*, 33 *HOSP. & COMM. PSYCHIATRY*, 569, 571 (1982) (finding that when compared to hospitalized patients, released patients reported family involvement in emergency commitment and greater likelihood of acceptance by family).

183. See Mary L. Durham et al., *Police Involvement and Influence in Involuntary Civil Commitment*, 35 *HOSP. & COMM. PSYCHIATRY*, 580, 582-83 (1984) (finding that families are most frequent referral source for commitment process, initiating over 25% of referrals to commitment system in state of Washington).

184. See Hiday, *Civil Commitment*, *supra* note 178, at 18; Virginia A. Hiday, *Reformed Commitment Procedures: An Empirical Study in the Courtroom*, 11 *LAW & SOC. REV.* 651, 657 (1977) [hereinafter Hiday, *Reformed Commitment Procedures*] (finding that 68.6% of committees had not finished high school and 77% were unemployed).

185. See Hiday, *Civil Commitment*, *supra* note 178, at 18. Because the middle class' propensity to seek civil commitment as a first choice only where the family member is extremely dangerous, as one study found, middle class committees tended to be more physically violent than committees as a group. *Id.*

are all violent and uncontrollable.¹⁸⁶

2. *Assessing the Impact of Liberal Era Commitment Reforms*

Liberal Era commitment reforms were intended to achieve the goals of protecting the rights of the mentally ill, controlling hospitalization practices and returning the majority of mentally ill people to their communities.¹⁸⁷ These objectives were to be accomplished by restricting involuntary commitment to those individuals who were mentally ill and dangerous¹⁸⁸ and giving commitment candidates (and inpatients) many of the same procedural protections provided to criminal defendants.¹⁸⁹

These controversial policies became the subject of dozens of studies.¹⁹⁰ Taken as a whole, the research is useful in assessing whether or not the goals of Liberal Era reforms were met and what types of patients remained in hospitals following the legal changes.

a. Changing the Substantive Criteria for Commitment

i. Restricting Civil Commitment to Dangerous Mentally Ill People

When Liberal Era commitment laws made "dangerousness" the criterion for detention, critics predicted hospitals would become battlegrounds full of dangerous people.¹⁹¹ It is now clear, however, that these fears were unfounded. Involuntary commitment laws

186. *Id.* at 20 (criticizing stereotype because court and statutory definitions of danger include more than violence to others); Judith Rabkin, *Criminal Behavior of Discharged Mental Patients: A Critical Appraisal of the Research*, 86 *PSYCHOLOGY BULL.* 1, 2 (1979) (noting that mental patients are believed to be impulsive, violent, assaultive and disruptive).

187. See generally Gary Clarke, *In Defense of Deinstitutionalization*, 57 *MILBANK MEMORIAL FUND QUARTER/HEALTH & SOC'Y* 461 (1979) (describing intended goals of deinstitutionalization, including community-based care, and concluding that there is no solid evidence that patients have been harmed to any greater degree than if they had remained in institutions).

188. For a further discussion of restricting involuntary commitment to the mentally ill and dangerous, see *supra* note 37 and accompanying text.

189. For a further discussion of the procedural protections given to commitment candidates, see *supra* notes 39-41 and accompanying text.

190. For a summary of the research literature of this era, see Hiday, *Civil Commitment*, *supra* note 178, at 16-17 (listing several studies focusing on original civil commitment reform statutes and subsequent amendments). For a summary of the impact of law reform, see Michael Bagby & Leslie Atkinson, *The Effects of Legislative Reform on Civil Commitment Admission Rates: A Critical Analysis*, 6 *BEHAV. SCI. & L.* 45, 52-56 (1988) (surveying research results from large number of states that enacted reform and concluding that, for most part, legislative intent of narrowing commitment laws was not achieved on long-term basis) [hereinafter Bagby & Atkinson, *Effects of Legislative Reform*].

191. See Hiday, *Civil Commitment*, *supra* note 178, at 20 (finding that many psy-

that are based on dangerousness do not limit hospitalization only to those who are violent and who engage in physically or verbally assaultive acts.¹⁹²

Despite its prominence in Liberal Era commitment law, the concept of dangerousness has been poorly defined.¹⁹³ Criticisms of the dangerousness standard often imply that "danger" means violence to others.¹⁹⁴ However, virtually any behavior may be considered dangerous by some member of the community. Such behavior may range from verbal threats to violent acts against themselves, others or property.¹⁹⁵ Some commitment statutes also categorize neglect of one's bodily needs (e.g., inability to provide food, shelter, and clothing) as dangerous behavior.¹⁹⁶

Official designations of dangerousness are frequently based on conclusions about a candidate's general ability to function, rather than more objective behavioral criteria.¹⁹⁷ In one study of a California jurisdiction conducted in 1979, forty-three percent of patients were hospitalized because of annoying or bizarre behavior

chiatrists feared that dangerous people would accumulate in hospitals where they would create havoc).

192. For a discussion of the scope of behavior of involuntary commitment candidates, see *infra* notes 197-205 and accompanying text.

193. Hiday, *Civil Commitment*, *supra* note 178, at 20-21 (discussing various definitions of danger). A few courts have required proof of a recent overt dangerous act before finding a citizen to be dangerous and thereby permitting commitment. See Reed Groethe, Comment, *Overt Dangerous Behavior as a Constitutional Requirement for Involuntary Civil Commitment of the Mentally Ill*, 44 U. CHI. L. REV. 562, 569-74 (1977) (analyzing definition of dangerousness and requirement of overt dangerous behavior). The United States Supreme Court, while not directly addressing the overt dangerous behavior requirement, held in *O'Connor v. Donaldson*, 422 U.S. 563 (1975), that a state cannot constitutionally confine a person in a mental institution who is non-dangerous and capable of surviving safely alone or with the help of willing and responsible family members or friends. *Id.* at 576. Some federal courts have held overt dangerous behavior is a requirement for involuntary commitment. See *Stamus v. Leonhardt*, 414 F. Supp. 439, 451 (S.D. Iowa 1976); *Lynch v. Baxley*, 386 F. Supp. 378, 391 (M.D. Ala. 1974).

194. Hiday, *Civil Commitment*, *supra* note 178, at 20 (reviewing studies of dangerousness, including definitions of term "dangerous," and concluding that there is little agreement on terminology or methods for measuring dangerousness).

195. Danger to property is a criterion for commitment in some states, although its constitutionality has been disputed. See *Suzuki v. Yuen*, 617 F.2d 173, 176 (9th Cir. 1980) (affirming trial court decision that struck down as unconstitutional part of Hawaii's civil commitment law that authorized commitment of mentally ill persons who are dangerous to property, and concluding that protection of property is not sufficiently compelling interest to warrant involuntary civil commitment).

196. See MENTALLY DISABLED, *supra* note 19, at 33-37.

197. See *Durham et al.*, *supra* note 183, at 582-84 (noting that major reasons for commitment referral include many behaviors that are not harmful, but rather, are disruptive or disturbing to others).

rather than because they threatened someone's safety. Only 57% of the medical records of candidates for hospitalization contained reference to assaultive, violent or threatening behavior.¹⁹⁸

A more recent study in Florida¹⁹⁹ indicated that clients referred to commitment hearings after the 1982 Baker Act were more dangerous than clients referred before the legal change. The typical post-enactment client could be characterized by occasional agitation, unmanageability or verbal assaultiveness; in contrast, the typical pre-enactment client demonstrated no threats or violent behavior.²⁰⁰ Nonetheless, the majority (58%) of the "dangerous" acts that were the basis of committing individuals under the revised law were violent threats; only four incidents of actual harm (5%) were noted in the eighty hearings that were studied.²⁰¹

The vast majority of civil commitment candidates are not dangerous, much less violent, following their court hearings.²⁰² In a rare study that followed civil commitment candidates for six months after their hearings, Professor Virginia Hiday found that almost

198. See CAROL WARREN, *THE COURT OF LAST RESORT* 170 (1982). Although medical and legal records might be expected to contain accurate notations of the behavior that prompted commitment proceedings, these records contain serious biases in reporting. Legal records often contain allegations and conclusory statements that may be unsubstantiated in the courtroom. Medical records often document behavior that physicians or hospital officials have not observed first-hand. Research studies that collect data through courtroom observation are limited to those cases that are actually adjudicated and exclude uncontested cases or legal proceedings in which patients—faced with involuntary commitment—agree to voluntary detention. For a discussion of the sources of bias in research of this nature, see Hiday, *Civil Commitment*, *supra* note 178, at 16 (arguing that physician's and psychiatrist's testimony is often little more than unsupported conclusory statements in favor of involuntary hospitalization); Mark Mills, *Civil Commitment of the Mentally Ill: An Overview*, 484 ANNALS AM. ACAD. POL. & SOC. SCI. 28, 36-37 (1986) (discussing bias in judgment of physicians and psychiatrists); John Monahan et al., *Stone-Roth Model of Civil Commitment and the California Dangerousness Standard*, 39 ARCHIVES GEN. PSYCHIATRY 1267, 1270-71 (1982) (discussing bias of physicians and psychiatrists); Ethan Rofman et al., *The Prediction of Dangerous Behavior in Emergency Civil Commitment*, 137 AM. J. PSYCHIATRY 1061, 1063 (1980) (discussing psychiatrist's prediction of dangerousness); Lee Rubin & Mark Mills, *Behavioral Precipitants to Civil Commitment*, 140 AM. J. PSYCHIATRY 603, 603 (1983) (noting existence of bias in psychiatrists' assessment of dangerousness); Carol Warren, *The Social Construction of Dangerousness*, 8 URB. LIFE 359, 379 (1979) (discussing potential for bias in social construction of dangerousness during involuntary commitment process).

199. Roger Peters et al., *The Effects of Statutory Change on the Civil Commitment of the Mentally Ill*, 11 LAW & HUM. BEHAV. 73, 96 (1987) (noting significant impact on both process and outcomes of the commitment system in Florida after state commitment criteria changed in 1982).

200. *Id.* at 90.

201. *Id.*

202. Hiday, *Dangerousness*, *supra* note 178, at 562 (finding that three-fourths of civil commitment respondents did not engage in violent acts or threats, or inflict unintentional harm within six months of their court hearings).

three-fourths of her 700 subjects did not commit violent acts, make threats or cause intentional harm.²⁰³ The small proportion who behaved dangerously rarely inflicted actual injury on themselves or others.²⁰⁴ Hiday concluded that current practice, which reduced the number of mentally ill being committed and reduced the length of hospitalization, has not resulted in the release of large numbers of dangerous persons who disrupt and threaten our communities.²⁰⁵

ii. Decreasing the Use of Involuntary Hospitalization

Studies clearly demonstrate an immediate decrease in the number of commitments within the two years following legislative reforms that narrowed the grounds for involuntary commitment.²⁰⁶ After two years, however, admission rates eventually returned to, or exceeded, pre-reform levels.²⁰⁷ Restrictive involuntary commitment laws, therefore, appear unable to reduce the rate of involuntary hospitalization for more than a brief period.

Several theories might explain this finding. First, it is possible that restrictive commitment laws create a "revolving door" phenomenon where statutory limits on commitment terms inappropriately shorten the length of a patient's treatment, causing the same patients to return to hospitals again and again, thereby increasing commitment rates. There is, however, no sound evidence for this conclusion. Rather, studies indicate that post-reform increases are due to accelerating rates of first time commitments as well as rising readmission rates.²⁰⁸

Second, commitment standards based on dangerousness might bring only the most unmanageable patients into public mental hospitals which would increase the chance of recidivism. Public hospitals would bear the burden of such cases because, presumably, the most violent individuals are the most socially and economically iso-

203. *Id.*

204. *Id.*

205. *Id.* at 562-63.

206. See Bagby & Atkinson, *Effects of Legislative Reform*, *supra* note 190, at 53-54 (reviewing results of reform to determine if legislative intent to either expand or restrict civil commitment criteria had been met).

207. *Id.* at 55.

208. See R.M. Bagby et al., *The Effects of Legislative Reform in Ontario*, 28 CAN. PSYCHOLOGY 21, 25-26 (1987) (finding significant increase in both first admissions and readmissions following legal reform in Ontario); Larry Faulkner et al., *Effects of a New Involuntary Civil Commitment Law: Expectations and Reality*, 10 BULL. AM. ACAD. PSYCHIATRY & L. 249, 257 (1982) (finding percentage of unduplicated cases increased to 85% under the new law, which indicated that new admissions rather than readmissions may have predominated).

lated. At least one study, however, has shown that psychiatric units of private hospitals experienced the same post-reform admission patterns as public hospitals.²⁰⁹ Both types of hospitals saw rising commitment rates after the passage of restrictive reforms,²¹⁰ indicating that "the most difficult patient" hypothesis may be incorrect.²¹¹

Third, some observers have suggested that the increase in commitments following Liberal Era reforms reflected an adjustment period for mental health professionals.²¹² According to this theory, mental health workers, believing that the new laws were too restrictive, ignored them and continued to commit those that they believed needed confinement. While plausible, this explanation lacks empirical support.²¹³

Interestingly, while admission rates returned to their original levels a few years after Liberal Era reforms were enacted,²¹⁴ average length of stay²¹⁵ and the average number of residents in state mental hospitals *decreased* by almost eighty percent.²¹⁶ State mental hospitals, Veterans Administration psychiatric hospitals and even private psychiatric hospitals experienced dramatic length of stay reductions and discharged patients sooner.²¹⁷ However, despite

209. See Bagby & Atkinson, *Effects of Legislative Reform*, *supra* note 190, at 58 (finding same post-reform admission patterns in psychiatric hospitals and units of Ontario general hospitals).

210. See Bagby et al., *supra* note 208, at 25 (tracking trend of post-reform involuntary commitments).

211. *Id.*

212. See Bagby & Atkinson, *Effects of Legislative Reform*, *supra* note 190, at 58-59 (arguing increase in commitments is result of unfavorable reaction by mental health professionals to narrowing of their professional discretion).

213. One study indicated that there was less judicial deference to mental health professionals during the Liberal Era. North Carolina judges, for example, often rejected professionals' recommendations to hospitalize patients in the absence of adequate evidence that the criteria for civil commitment were met. They required evidence of dangerousness. See Virginia A. Hiday, *The Attorney's Role in Involuntary Civil Commitment*, 60 N.C. L. Rev. 1027, 1044-45 (1982) [hereinafter Hiday, *The Attorney's Role*] (finding that while attorneys in involuntary commitment proceedings deferred to psychiatric opinion, judges were more aggressive, questioning psychiatric opinion and requiring evidence of dangerousness). *But see* S.D. Stier & K.J. Stoebe, *Involuntary Hospitalization of the Mentally Ill in Iowa: The Failure of the 1975 Legislation*, 64 IOWA L. REV. 1284, 1377 (1979) (following civil commitment legislation enacted in Iowa in 1975, attorneys and referees continued to defer extensively to mental health professionals).

214. See Bagby & Atkinson, *Effects of Legislative Reform*, *supra* note 190, at 53-56 (finding that impact of reforms designed to reduce involuntary civil commitments is generally short term).

215. See CHARLES KEISLER & AMY SIBULKIN, *MENTAL HOSPITALIZATION: MYTHS AND FACTS ABOUT A NATIONAL CRISIS* 47, 98 (1987).

216. *Id.* at 47.

217. In private hospitals, fluctuations in length of stay were more likely to

these reductions in daily census, and contrary to public opinion, most hospitals did not close.²¹⁸

b. Procedural Changes: Paternalism in the Courtroom

During the Liberal Era, virtually all states enhanced procedural protections for mentally ill patients.²¹⁹ Commitment hearings became more like criminal trials and much less like the informal inquiries into the patient's best interest as they had once been. Confronted with court decisions such as *Lessard v. Schmidt*,²²⁰ which raised substantial doubts concerning the constitutionality of many state commitment laws, state legislatures passed laws that substantially revised the standards and procedures used in civil commitment. In general, these new laws conferred important new protections on patients such as the right-to-counsel, to a judicial hearing, to call witnesses and to cross-examine government witnesses.²²¹

Because these reforms included both substantive and procedural rights, it is impossible to isolate the effects of procedural reforms on civil commitment.²²² Nonetheless, studies have found

reflect the availability of beds than compliance with restrictive civil commitment laws. *Id.*; Alvin Sirrocco, *Inpatient Health Facilities as Reported from the 1971 MFI Survey*, VITAL & HEALTH STAT. SERIES 14, No. 12 (1974) (reporting findings from 1971 Master Facility Inventory Survey, including length of stay in government, public and private hospitals); J.F. Sutton & Alvin Sirrocco, *Inpatient Health Facilities as Reported from the 1976 MFI Survey*, VITAL & HEALTH STAT. SERIES 14, No. 23 (1980) (reporting findings from 1976 Master Facility Inventory Survey, including length of stay in government, public, and private hospitals); see KEISLER & SIBULKIN, *supra* note 215, at 83-103 (discussing trends in length of stay per psychiatric episode).

218. Writing in 1987, Keisler and Sibulkin concluded that the total number of state mental hospitals had not changed much over the past 35 years. KEISLER & SIBULKIN, *supra* note 215, at 46. More recent system restructuring and budgetary shortfalls have forced closure of several hospitals in Massachusetts. William Fisher et al., *The Role of General Hospitals in the Privatization of Inpatient Treatment for Serious Mental Illness*, 43 HOSP. & COMM. PSYCHIATRY 1114, 1114-19 (1992). Interestingly, the number of beds in psychiatric units of general hospitals are increasing rapidly and may become the focal point for the delivery of mental health services, replacing the state hospital. See Maurice Greenhill, *Psychiatric Units in General Hospitals: 1979*, 30 HOSP. & COMM. PSYCHIATRY 169, 169 (1979).

219. See MENTALLY DISABLED, *supra* note 19, at 35 (discussing procedures for involuntary hospitalization of mental ill).

220. 349 F. Supp. 1078 (E.D. Wis. 1972) (holding Wisconsin civil commitment procedure unconstitutional to extent that it fails to require timely and adequate notice, permits detention longer than 48 hours without hearing, does not provide for sufficient hearing, permits commitment without proof beyond reasonable doubt that patient is mentally ill and dangerous, and fails to require consideration of alternatives other than commitment), *vacated*, 414 U.S. 473 (1974).

221. See MENTALLY DISABLED, *supra* note 19, at 51-55 (discussing specific procedural protections contained in reformed civil commitment laws).

222. See Paul Appelbaum, *Standards for Civil Commitment: A Critical Review of*

significant post-reform improvements in the quality of initial commitment hearings, post-hearing commitment procedures and post-commitment release procedures.²²³ Research indicates that in the post-reform period, states increasingly had provided patients with legal representation, courts had examined evidence for commitment more carefully²²⁴ and attorneys were more likely to aggressively challenge psychiatric opinion or seek alternatives to inpatient treatment.²²⁵ As a result, patients were more likely to be released even when psychiatrists recommended hospitalization.²²⁶

Still, improved procedural protections did not necessarily make commitment hearings accurate or fair. Evidence was still not always examined thoroughly counsel often was still passive or nonadversarial and mental illness often was still assumed rather than proved objectively.²²⁷ For example, in an extensive series of studies on the role of counsel, Professor Virginia Hiday found that attorneys still are more likely to accept the role of "participant" than of adversary in commitment proceedings.²²⁸ Although some attorneys adopt an adversarial role more often than prior to the reforms, many do not, even when they are explicitly encouraged to do so by the presiding judge.²²⁹ Perhaps this is because lawyers

Empirical Research, 7 INT'L J.L. & PSYCHIATRY 133, 142 (1984) (noting that legal intervention research is hampered by inability to control changes in potentially significant variables other than those being studied).

223. See Hiday, *Court Decisions*, *supra* note 178, at 167-69 (noting that hearings lasted longer, judges questioned witnesses themselves and participants showed less deference to psychiatric opinion); Hiday, *Reformed Commitment Procedures*, *supra* note 183, at 664-65 (noting that there are fewer commitments, lengthier hearings and less judicial deference to psychiatric opinion); Peters et al., *supra* note 198, at 91-92, 95-96 (noting that hearings lasted longer, LRAs were explored and counsel became more aggressive).

224. See Hiday, *Reformed Commitment Procedures*, *supra* note 184, at 660-65 (discussing study that supported hypothesis that agreement between court decision and psychiatric recommendation was greatest when evidence of violence was substantiated in court).

225. *Id.*

226. See Hiday, *Court Decisions*, *supra* note 178, at 159, 164-65 (finding that courts agreed with less than half of psychiatric recommendations to commit patient).

227. See Hiday, *Civil Commitment*, *supra* note 178, at 27 (arguing that procedural protections have improved civil commitment process but process is still flawed); Norman Poythress Jr., *Psychiatric Expertise in Civil Commitment: Training Attorneys to Cope with Expert Testimony*, 2 LAW & HUM. BEHAV. 1, 8-13 (1978) (noting that attorneys trained to aggressively defend civil commitment patients failed to differ from their untrained counterparts).

228. Hiday, *Civil Commitment*, *supra* note 178, at 27-30.

229. *Id.* at 29 (citing Texas experiment that attempted to encourage counsel to assume adversary role when defending patients through training and directions from chief judge to act as attorney *ad litem* and to protect proposed patients' rights); Poythress, *supra* note 227, at 17 (noting that even when attorneys were

often assume their mentally ill clients do not know what is best for them. Consequently, rather than seeking what their client wants, counsel often works with the family and doctors to achieve what they collectively think is the best outcome for the client—even if this might lead to involuntary hospitalization.²³⁰ In sum, a review of the available literature reveals that Liberal Era commitment statutes provided more procedural protections for those facing commitment and that in many, though not all cases, these protections improved the quality and fairness of commitment hearings.

c. Who Remained in Hospitals?

If inpatients were discharged from hospitals and other people avoided hospitalization altogether, who remained in institutions? A number of studies have reported that the only change in the demographic profile of involuntary patients following liberal reforms was a decrease in the average age of committed patients.²³¹ This drop in the average age probably reflected the shifting of many older patients to nursing homes, board and care homes, or other alternatives.²³² Even today, state hospitals are still predominantly populated by young, poor patients similar to those patients committed before the legal changes of the 1960s and 1970s. Moreover, the few studies available on diagnostic patterns of involuntary patients show that the Liberal Era reforms did not alter the nature of patient problems.²³³ The range of bizarre, as well as benign, be-

trained to challenge aggressively psychiatric experts and were provided with materials and references to support assault on such experts, attorneys were reluctant to take adversarial stance).

230. See Hiday, *The Attorney's Role*, *supra* note 213, at 1039-45 (finding that most attorneys do not assume adversarial stance).

231. See, e.g., PAUL LERMAN, *DEINSTITUTIONALIZATION AND THE WELFARE STATE* 36-38 (1982). Lerman has found that throughout the 1950s and early 1960s, mental institutions had taken the place of almshouses as residences for the aged poor. *Id.* However, in the 1970s, there was a dramatic shift away from hospitals in their role of caretaker and custodian of the aged. *Id.*; see A. LOUIS MCGARRY ET AL., U.S. DEP'T OF HEALTH & HUM. SERV., *CIVIL COMMITMENT AND SOCIAL POLICY: AN EVALUATION OF THE MASSACHUSETTS MENTAL HEALTH REFORM ACT OF 1970* 89-90 (1981) (finding that when comparing patients committed prior to legal change and those committed under the revised (LPS) law, no differences were observed in years of schooling, percentage of male/female, or percentage of nonwhite, but average age of those involuntarily admitted was reduced by over three years, from 43.6 to 40.3 years).

232. See LERMAN, *supra* note 231, at 36-38 (analyzing association between declining age of patients in mental hospitals and growth in number of nursing home beds in United States).

233. See ENKI RESEARCH INSTITUTE, *A STUDY OF CALIFORNIA'S NEW MENTAL HEALTH LAW 112* (1972) [hereinafter ENKI RESEARCH INSTITUTE] (finding no differences by diagnoses following California's LPS legislation); Larry R. Faulkner et al., *The Effect of Mental Health System Changes on Civil Commitment*, 13 BULL. AM.

havior associated with involuntary detention probably continued following the narrowing of civil commitment criteria.²³⁴

Although the patient populations before and after reform were similar, there were some changes in the hospitalization process. Most notably, more patients were admitted to hospitals on a voluntary basis.²³⁵

Prior to the Liberal Era reforms of the 1960s and 1970s, the characteristics of voluntary and involuntary patients were strikingly different. For example, poor, older men with little education were more likely to be involuntarily committed than young, female, better educated patients who came to hospitals voluntarily.²³⁶ After the enactment of Liberal Era reforms, the characteristics of voluntary and involuntary patients became more alike.²³⁷ Some observers concluded from this that candidates who once would have been forcibly committed now willingly accepted hospitalization.²³⁸ More cynical observers concluded that patients formerly committed against their will were now coerced into accepting "voluntary" admission under the threat of involuntary detention.²³⁹

ACAD. PSYCHIATRY & L. 345, 353 (1985) (finding that when patients were separated into major—schizophrenia, affective disorders, organic brain syndrome—and minor—all other diagnoses—mental disorders, there were no differences before and after revisions to Oregon's civil commitment law); Howard Gudeman et al., *Changing Admission Patterns at Hawaii State Hospital Following the 1976 Revision of the Hawaii Mental Health Statutes*, 38 HAW. MED. J. 65, 70-71 (1979) (noting that diagnoses given to patients did not change as result of Hawaii civil commitment law); Mark Munetz, *Modernization of a Mental Health Act: I. Commitment Patterns*, 8 BULL. AM. ACAD. PSYCHIATRY & L. 83, 89-92 (1980) (noting that diagnoses of patients were alike before and after enactment of Pennsylvania's civil commitment law). *But see* Peters et al., *supra* note 199, at 99. Peters and his colleagues had found a slightly larger proportion of schizophrenics among civil detainees in Florida after commitment criteria were narrowed. *Id.* It should be noted that their conclusions were based on evidence submitted at hearings to prove dangerousness—a factor that severely limits the usefulness of these findings. *Id.*

234. *See* ENKI RESEARCH INSTITUTE, *supra* note 233, at 116-19.

235. *See* MENTALLY DISABLED, *supra* note 19, at 178 (noting that World Health Organization reported that while only 10% of all admissions to state and county mental hospitals in United States were voluntary in 1949, rate increased to 24% by 1961 and 48.6% by 1972); *see also* Glenn Pierce et al., *The Impact of Broadened Civil Commitment Standards on Admissions to State Mental Hospitals*, 142 AM. J. PSYCHIATRY 104, 105 (1985) (noting that by 1976, over half of admissions to Washington state mental hospitals were voluntary).

236. *See* Robert Nicholson, *Correlates of Commitment Status in Psychiatric Patients*, 100 PSYCHOL. BULL. 241, 243, 246 (1986) (noting that comparison of findings from 19 studies of civil commitments in 1950s-1960s versus 1970s-1980s revealed changes in demographic characteristics of patients during two time periods).

237. *Id.* at 246.

238. *Id.* at 247 (admitting that this question cannot be answered with certainty, but is plausible hypothesis).

239. *See id.* (arguing that distinction between voluntary and involuntary pa-

Studies indicate that a large proportion of civil committees hospitalized under Liberal Era commitment laws have arrest records²⁴⁰—a significantly greater proportion than in the years prior to reform.²⁴¹ Although the precise reason for this development is unclear, it may be due to the implementation of dangerousness as a basis for commitment or, alternatively, to the increased use of civil commitment by the criminal justice system.²⁴²

3. *Assessing Neoconservative Civil Commitment Reforms*

a. Ready for Reform

Only a limited number of studies are available to trace the outcome of recent, neoconservative changes.²⁴³ The most comprehen-

tients should not be disregarded in light of two groups' attitude toward hospitalization and treatment).

240. Recent reviews of the relationship between mental illness and criminal behavior have confirmed an increase in the arrest rate of mental patients, concluding that factors producing this increase are the same as those for criminals in general: a history of prior arrests, youthful age, male gender, minority status, low socioeconomic status, alcoholism, drug abuse and antisocial personality disorders. J. Rabkin, *Criminal Behavior of Discharged Mental Patients: A Critical Review*, 86 PSYCHOL. BULL. 1, 23 (1979); see JOHN MONAHAN, PREDICTING VIOLENT BEHAVIOR: AN ASSESSMENT OF CLINICAL TECHNIQUES 104-10 (1981) (discussing methodological problems, along with presentation of data on predictive variables SES, age, male gender, prior arrests, race and alcohol and drug use); John Monahan et al., *Police and the Mentally Ill: A Comparison of Committed and Arrested Persons*, 2 INT'L J.L. & PSYCHIATRY 509, 511-14 (1979) (arguing that police do surprisingly accurate job of triaging lawbreakers into jails or mental facilities, given that many criminals have psychiatric disorders and many mentally ill people commit crimes); Henry Steadman et al., *Explaining the Increased Arrest Rate Among Mental Patients: The Changing Clientele of State Hospitals*, 135 AM. J. PSYCHIATRY 816, 819-20 (1978) [hereinafter Steadman, *Changing Clientele*] (discussing number of explanations for increasing arrest rate among former mental patients and concluding that composition of state hospitals reflects an inpatient population with higher likelihood of post-release arrest).

241. Steadman, *Changing Clientele*, *supra* note 240, at 817; see Bruce Harry & Henry Steadman, *Arrest Rates of Patients Treated at a Community Mental Health Center*, 39 HOSP. & COMM. PSYCHIATRY 862, 864 (1988) (noting that arrest rates were higher among inpatients admitted to community mental health centers in 1983 than among inpatients admitted in 1975 in Missouri, where commitment statutes were restructured in 1979).

242. It is important to point out, however, that arrests are not a valid measure of dangerousness because most arrests are for property crimes or for felonies that do not involve the threat of serious physical harm to others. Steadman, *Changing Clientele*, *supra* note 240, at 817.

243. The research designs that actually allow measurement of the effects of a statutory commitment scheme are those which compare data collected during a period prior to implementation of the new law with those obtained after the revised law is put in place. The clinical literature is full of observational reports which describe committed patients and their confinement and treatment experiences. Unfortunately, those studies have little to offer on the question of whether or not the law had any impact on involuntary commitment practices. See Appelbaum, *supra* note 222, at 133 (discussing major limitations of research on civil com-

sive one is the study funded by the National Institute of Mental Health for Washington State's 1979 revision of its involuntary treatment law to permit involuntary commitment of mentally ill individuals in need of treatment as well as those who were dangerous.²⁴⁴

The study results are dramatic. In the first year after the broader commitment law was enacted, there was a 91% increase in involuntary admissions to state mental hospitals.²⁴⁵ In the two year period after the new law became effective, involuntary admissions increased 180% over pre-reform levels.²⁴⁶ Further, it appears that authorities were so intent on increasing their power over involuntary commitment that admissions to state hospitals actually began to rise nine months *before* the effective date of the revised statute.²⁴⁷

Other researchers have also observed increases in commitment following legislative attempts to broaden commitment criteria.²⁴⁸ These findings are less persuasive than those of the Washington State study because the legal changes that occurred in other states were a mixture of broadened and narrowed criteria.²⁴⁹

b. Have Neoconservative Reforms Accomplished their Mission?

There is little doubt that legal reforms broadening commitment authority allow involuntarily hospitalization of more patients.²⁵⁰ In the State of Washington, commitment rates rose so

mitment); Bagby & Atkinson, *Effects of Legislative Reform*, *supra* note 190, at 46 (discussing problems associated with before and after research designs and time series analysis); Mary L. Durham & John Q. La Fond, *A Search for the Missing Premise of Involuntary Therapeutic Commitment: Effective Treatment of the Mentally Ill*, 40 *RUTGERS L. REV.* 303, 327 (1988) (discussing flaws of nonrandomized or poorly controlled research designs).

244. See Durham & La Fond, *supra* note 38, at 408-10 (discussing time series analysis of change in Washington state's civil commitment law).

245. *Id.* at 47; see also Pierce et al., *supra* note 235, at 105-06 (noting that law increased involuntary admissions and led to virtual disappearance of voluntary patients).

246. Durham & La Fond, *supra* note 38, at 411-12.

247. *Id.* at 416-17. The time series research design allowed researchers to control for the effects of other factors that might have accounted for the increase in admissions before the implementation date of the law and to clarify the association between the legal change and the increase in admissions. Pierce et al., *supra* note 235, at 105.

248. See Bick Wanck, *Two Decades of Involuntary Hospitalization Legislation*, 141 *AM. J. PSYCHIATRY* 33, 36-37 (1984) (noting that three of four states whose legislatures intended to increase use of involuntary commitment through statutory revisions accomplished that objective).

249. See Appelbaum, *supra* note 222, at 141 (noting that impact of legal interventions is often confounded by simultaneous revision of procedural and substantive reforms as well as criteria which might broaden some detention criteria and narrow others, all within same bill).

250. *But see* Robert D. Miller, *Need for Treatment Criteria for Involuntary Civil*

rapidly that new admissions overwhelmed the largest state mental hospital, leading it to impose a "cap" on admissions at ninety percent of bed capacity.²⁵¹ Washington's Supreme Court made the situation even worse when it ordered the hospital to accept all incoming involuntary patients, even if there were no beds for them.²⁵²

Voluntary patients virtually disappeared from Washington's mental health system most probably due to the unavailability of beds. Because the reforms provided more expansive authority to commit gravely disabled patients, detention shifted away from dangerousness toward *parens patriae* commitments.²⁵³ By 1981, three out of four commitments relied on the grave disability standard, while the dangerousness to self or others standard accounted for only one quarter of the commitments.²⁵⁴

The increase in patients committed as gravely disabled should not, however, be interpreted as a change in the clientele of the state hospital system. In fact, following the 1979 revision of the law, the clinical and demographic profile of patients who were committed to state mental hospitals did not change at all.²⁵⁵ Only the particular legal authority used to detain incoming patients changed.²⁵⁶ Under the revised law, people who had engaged in violent behavior were more likely to be detained under the state's *parens patriae* authority as gravely disabled than under its police power as dangerous.²⁵⁷ Therefore, the measurable changes were primarily in the extraordinary increase in the number of patients hospitalized invol-

Commitment: Impact in Practice, 149 AM. J. PSYCHIATRY 1380, 1383-84 (1992) (using non-research quality data provided by states where commitment criteria were broadened and concluding that legal changes to broaden commitment criteria would not lead to substantial increases in hospital admissions).

251. See *Pierce County v. Western State Hosp.*, 644 P.2d 131, 132-34 (Or. Ct. App. 1982) (finding hospital's admissions control policy invalid and ordering hospital to accept all patients within allotted area).

252. *Id.* at 134.

253. See Durham & La Fond, *supra* note 38, at 419-21 (noting that even those patients who committed violent acts were more likely to be committed as gravely disabled after change in law).

254. *Id.* at 419-20.

255. See generally MARY L. DURHAM & GLENN L. PIERCE, NATIONAL INST. OF MENTAL HEALTH, CENT. FOR ANTISOCIAL AND VIOLENT BEHAVIOR, LEGAL INTERVENTION IN INVOLUNTARY CIVIL COMMITMENT, FINAL REPORT (1988) (noting that although large number of new clients entered system, demographic profile of detainees remained virtually identical: poorly educated, unemployed, single or divorced white males).

256. See Durham & La Fond, *supra* note 38, at 423-25 (noting that predominant authority for commitment changed from dangerousness to grave disability).

257. See *id.* at 422 (discussing trend to replace use of police power authority with use of *parens patriae* authority).

untarily and in the legal authority invoked to detain them. The behavior that brought them to the attention of commitment authorities did not change.²⁵⁸

IV. COGNITIVE DISSONANCE: THEORY VERSUS PRACTICE

Legal reform appears to have had varying effects on insanity defense and civil commitment practices. Despite the clear intentions of reformers, changes in the insanity defense law designed to reduce the number of persons excused for their criminal conduct due to mental illness have had little impact,²⁵⁹ nor have they been particularly helpful in ensuring that mentally ill offenders receive treatment during their confinement. Though the public may believe these changes made their world safer, neoconservative insanity reforms were mostly symbolic.

The impact of neoconservative changes in civil commitment law is more complex. The evidence strongly suggests that broaden-

258. *See id.* at 416-25. There have been two studies that have attempted to evaluate, on a simulated basis, what would happen to commitment rates if paternalistic commitment criteria were substituted for existing dangerousness standards. Stone has recommended that patients should be forcibly hospitalized only if the following conditions are satisfied: 1) the presence of severe mental disorder, 2) an immediate prognosis of major distress, 3) the existence of effective treatment and 4) the patient's incompetence to refuse treatment. ALAN STONE, U.S. DEP'T OF HEW MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION 76-176 (1976). Monahan evaluated a single group of patients using both dangerousness criteria and the "need for treatment" criteria suggested by Stone. Monahan concluded that significantly fewer candidates would have been committed under Stone's paternalistic criteria than under California's dangerousness standard. The requirement of severe mental illness (psychosis) appeared to limit the number of persons who would have been detained. *See* John A. Monahan et al., *Stone-Roth Model of Civil Commitment and the California Dangerousness Standard*, 39 ARCHIVES GEN. PSYCHIATRY 1267, 1267-71 (1982).

Using a similar approach, Hoge and his colleagues evaluated a group of candidates under both the Massachusetts dangerousness standard and the Stone criteria. Stone's criteria once again proved more restrictive than the dangerousness standard because Stone's criteria required the presence of major patient distress and incompetence. *See* Steven Hoge et al., *An Empirical Comparison of the Stone and Dangerousness Criteria for Civil Commitment*, 146 AM. J. PSYCHIATRY 170, 174 (1989).

While these theoretical comparisons are interesting and thought provoking, the implementation of Stone's "need for treatment" criteria has never been evaluated in a real-life setting where clinicians not participating in a research study apply the criteria to the decision to commit. We saw earlier that the actual application of dangerousness criteria may be influenced more by the *intentions* of mental health authorities than the statutory criteria for commitment. One cannot help but wonder if in actual practice Stone's "need for treatment" criteria might not lead to a situation similar to the more broadly defined "need for treatment" criteria in Washington state.

259. For a discussion of the changes in the insanity defense law designed to reduce the number of persons excused for their criminal conduct due to mental illness, see *supra* notes 152-56 and accompanying text.

ing civil commitment authority may be more successful than reforms designed to restrict involuntary confinement. Although a legislative mandate to reduce the number of patients in mental hospitals may result in an immediate short-term decline in the number of involuntary commitments, patterns of detention will, in all probability, quickly return to their pre-reform levels. Reductions in hospital census can probably be achieved only through reductions in the average length of stay rather than by limiting hospital admissions.²⁶⁰

Laws that *expand* commitment authority are very likely to increase the number of involuntary detentions. Where hospitals are full, voluntary patients will have to be discharged to make room for involuntary patients. Commitment rates may outstrip resources available for hospital care so that beds become ever more scarce as pressure grows to house patients.

It is interesting to surmise why legal reform has such a varying impact on the operations of these complex systems of social control. The criminal justice system has changed very little in the way it processes mentally disordered offenders. The civil commitment system, on the other hand, changed significantly by expanding social control over thousands of America's citizens.

One obvious explanation for the limited impact of changing or abolishing the insanity test is the small number of criminal defendants who plead insanity. Another potential explanation is that the exact formulation of the insanity test may be of less concern for jurors who apply it on a case-by-case basis. When jurors find a particular defendant NGRI, they may be motivated by the belief that the particular offender in front of them was not responsible for his conduct and will receive needed treatment.

Civil commitment reforms, on the other hand, have much broader impact because they concentrate power in the hands of state medical authorities and involve a large volume of cases. Additionally, the expert opinions of mental health professionals are far more influential in civil commitment hearings than in criminal trials. Because law reforms now permit inpatient or outpatient commitment of mentally ill persons who need treatment, mental health professionals have even broader authority to order commitment. It is not surprising that mental health professionals opposed Liberal Era legislation that sought to curtail their power, and eventually circumvented it. Within a few years after restrictive laws were enacted,

260. For a discussion of how reductions in a hospital census may be achieved, see *supra* notes 214-18 and accompanying text.

mental health professionals learned how to manipulate their recommendations to fit the law, and thus commit those they believed needed hospital treatment.²⁶¹

V. CONCLUSION

The insanity defense and civil commitment laws have been poignant expressions of societal theories of responsibility and autonomy as well as a mirror of how society values punishment, liberty and treatment. Despite the shortcomings of the research, it is possible to observe the impact of legislative changes on the way mentally disordered people are processed by the criminal justice and civil commitment systems. The consistency of the data is impressive, even though replication and elaboration of available findings is sorely needed.²⁶²

The glaring discrepancy between what is known about the impact of these legal changes, and the outcomes that were expected of them, suggests several disturbing conclusions. First, policymakers reformed laws based on ideology or misconceptions rather than on sound empirical evidence. Too often, it appears that lawmakers seemingly either ignored or were unaware of what is known about mental health law reform.²⁶³ Second, research appears to be used more often to support the arguments of advocates or opponents of change than to provide dispassionate direction for changing social policy.

Ideology will undoubtedly remain the driving force behind mental health law reform in the United States. However, history

261. See Bagby & Atkinson, *Effects of Legislative Reform*, *supra* note 190, at 58-59 (noting that effects of restrictive commitment laws have been short-lived).

262. There is widespread acknowledgment that significant limitations exist in the quality, depth and abundance of research on the insanity defense and civil commitment. The shortcomings of research designs that measure the impact of legal change—including the quality and availability of data, the choice of statistical techniques, the impossibly short time-frames and the confounding effects of extra-legal factors—have been discussed elsewhere. More research is clearly needed to untangle the plethora of questions which have had little attention via systematic study. See Appelbaum, *supra* note 222, at 142 (noting that validity and usefulness of future research depends on whether research controls extraneous variables and utilizes prospective case-oriented data); Bagby & Atkinson, *Effects of Legislative Reform*, *supra* note 190, at 53-54 (noting that results of civil commitment law investigations remained ambiguous because of inadequate statistical design and limited duration).

263. See generally J. MONAHAN & L. WALKER, *SOCIAL SCIENCES IN LAW: CASES AND MATERIALS* 129-272 (2d ed. 1984) (reviewing actual and potential uses of social science in American legal process, analyzing how those uses might be evaluated and discussing use of general conclusions from social science when making law or policy).

has shown that such reform often fails to accomplish its intended objectives and can even bring about unintended consequences. In our view the available research demonstrates that quite often insanity defense and civil commitment law reform did not always achieve the policy objectives intended and, on occasion, has even generated contrary outcomes. It is important that policy-makers pay close attention to available empirical evidence when engaging in law reform. As important, whenever major law reform is undertaken—and particularly when the lives of the mentally ill are involved—such reform should be accompanied by sound empirical research to measure its impact. Only then can we take steps to ensure that cognitive dissonance between what we expect to see after law reform and what we actually see does not materialize once again.