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Judicial Oversight of Release of Patients Committed After Being Found Not Competent to Stand Trial or Not Guilty by Reason of Insanity in Violent Crimes

REFERENCE: Miller, R. D., Ionescu-Pioggia, R. M., and Fiddleman, P. B., "**Judicial Oversight of Release of Patients Committed After Being Found Not Competent to Stand Trial or Not Guilty by Reason of Insanity in Violent Crimes,**" *Journal of Forensic Sciences*, JFSCA, Vol. 28, No. 4, Oct. 1983, pp. 839-845.

ABSTRACT: In 1981, North Carolina joined a growing number of states in passing legislation requiring judicial concurrence with discharge decisions for civilly committed patients who had been found either not competent to proceed to trial or not guilty by reason of insanity. The authors studied all such patients at one of North Carolina's four state mental hospitals during the first year of the new law's operation, and found that there were only 16 of them. These patients were compared to a control sample of civilly committed patients without criminal charges; it was found that the forensic patients spent longer in the hospital than the controls, but still significantly less time than reported in studies from other states. The authors discuss possible reasons for these differences and comment on the effectiveness of such legislation.

KEYWORDS: jurisprudence, psychiatry, mental illness

There has been a growing trend in recent years either to abolish or to restrict significantly the participation of mental health professionals in the criminal justice system, and to restrict or eliminate the jurisdiction of mental health systems over persons charged with crimes. Although by comparison with nondisordered recidivist criminals the proportion of mentally disordered offenders (MDOs) who commit subsequent crimes is still small [*1,2*], the bizarre nature of a few offenses and the public perception that MDOs spend relatively little time incarcerated have resulted in considerable public pressure to exercise more control over these individuals. Legislatures have already responded by abolishing the diminished capacity defense [*3*], abolishing or restricting the use of not guilty by reason of insanity (NGRI) [*4-6*], and creating mechanisms for judicial oversight over the release of patients committed after being found not competent to proceed to trial (NCP) or NGRI [*7-9*].

North Carolina has a central state forensic evaluation unit on the grounds of one of the four state mental hospitals; over 90% of evaluations for NCP and NGRI in the state are

Presented at the 35th Annual Meeting of the American Academy of Forensic Sciences, Cincinnati, OH, 15-19 Feb. 1983. Received for publication 16 Dec. 1982; revised manuscript received 15 Feb. 1983; accepted for publication 28 Feb. 1983.

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made in this unit. Once the evaluations are complete, defendants are returned to the courts for disposition. If the court finds a defendant either NCP or NGRI, civil commitment procedures identical in criteria to those required for nonforensic patients must be initiated by the court, or the patient must be released [*10*]. Until 1981, such persons, if committed, could be released at any time that their treating physicians felt that they were no longer both mentally ill and dangerous. In fact, the statutes *required* that they be released once they no longer met *both* criteria [*11*]. North Carolina only infrequently examines the mental conditions of its criminal defendants.

There has been an average of only one successful NGRI defense per year in the state over the past 15 years, and NCP determinations amount to fewer than 50 per year. Despite these facts, and the fact that there have been very few violent acts committed by such persons after release from hospitals, public concern over the "easy release" of such persons resulted in the passage of legislation in 1981 that required that patients committed after being found either NCP or NGRI when charged with a violent crime could not be discharged by hospital staff without judicial concurrence in a formal hearing [*12*]. This statute was generally welcomed by the legal community as well as by the hospital staffs, who felt that it afforded them some protection against possible allegations that they had prematurely released a patient who subsequently committed a violent crime.

There were concerns, however, that such a law might be used by the criminal justice system as a method of insuring lengthy incarcerations for persons charged with crimes for whom psychiatric hospitalization is neither appropriate nor effective. We undertook this study of the experience during the first year of HB 95's operation to determine what, if any, effects it has had in the mental health system.

Methods

A list of all patients in the HB 95 class during the year following the effective date of the new law, 1 July 1981, was compiled by the associate attorney general at John Umstead Hospital. The charts of these patients were then examined to obtain demographic information, diagnoses, numbers of admissions before and after the index admission, nature of the criminal charges, lengths of stay, and hospital courses. A computer-generated random table of numbers was used to select a sample of involuntarily committed patients without criminal charges who were admitted during the same one-year study period to serve as controls; and the Division of Statistics of the North Carolina Division of Mental Health, Mental Retardation, and Substance Abuse Services (DMH) provided statistical information concerning all committed patients at John Umstead during the study period. Information concerning the frequency of HB 95 patients at the North Carolina's other three state mental hospitals was obtained from the directors of those hospitals, although no formal statistics had been kept.

Results

There were 16 patients at John Umstead Hospital who fell under HB 95 provisions during the 1-year study period. Three were already in the hospital on 1 July 1981, but were determined to be covered by HB 95 for release; the other thirteen were newly admitted during the study period. Five of the patients had had multiple prior admissions for evaluation or treatment or both connected to the criminal charges that led to their being included under HB 95.

There were no statistically significant demographic differences between the HB 95 patients, the randomly selected controls, and the total sample of all committed patients (Table 1). Although there were no significant differences in numbers of prior admissions between the HB 95 and control patients (data were not available for the total sample of committed patients), there were significant differences in the character of these admissions between the two groups. As shown in Table 2, HB 95 patients were more likely to have had involuntary

TABLE 1—*Demographic data.*

Characteristic	HB 95	Controls	All Committed Patients
Gender			
Male	13 (81%)	9 (56%)	1300 (65%)
Female	3 (19%)	7 (44%)	694 (35%)
Age, mean	39.0	43.8	40.8
Race			
White	11 (69%)	12 (75%)	1200 (60%)
Black	5 (31%)	4 (25%)	794 (40%)
Marital status			
Married	1 (6%)	3 (19%)	477 (24%)
Single/separated	10 (63%)	5 (31%)	1062 (53%)
Divorced	3 (19%)	5 (31%)	307 (15%)
Widowed	2 (12%)	3 (19%)	148 (8%)

TABLE 2—*Prior admissions.*

	Average Admissions per Patient	
Type of Admission	HB 95	Control
Voluntary	0.44	2.31
Involuntary	4.06	3.31
Forensic	1.63	0

and forensic admissions, while control patients were more likely to have had voluntary admissions.

There were also differences in admission diagnoses for HB 95 and control patients (Table 3). All the HB 95 patients were diagnosed as psychotic, while the control sample was more likely to have been admitted for detoxification.

As shown in Table 4, there were significant differences between the alleged acts of HB 95 and control patients that had led to hospitalization; by definition, in order to be classified under HB 95, a patient must have been charged with a violent crime (although there are some questions raised by the six patients, 38% of the sample, charged with larceny or property destruction). Under North Carolina law, all civilly committed patients must have demonstrated some type of dangerous behavior. The petitions for commitment for 9 of the 16 control patients revealed behavior that could as easily have resulted in the criminal charges shown in Table 4 as in involuntary civil commitment. (The remaining seven patients were alleged to have been dangerous to themselves.)

As shown in Table 5, John Umstead physicians recommended continued commitment at

TABLE 3—*Diagnoses.*

Diagnosis	HB 95	Control
Schizophrenia	10	1[a]
Manic-depressive	5	4[b]
Substance abuse	1	8[a]
Organicity	0	1[b]
Personality disorder	0	1[b]
Mental retardation	0	1[b]

[a] $P = 0.007$, χ^2.
[b] Not significant.

TABLE 4—*Alleged offenses.*

Population	Murder or Attempted Murder	Assault with a Deadly Weapon	Assault	Threats of Assault	Property Damage	Larceny	Driving Under the Influence of Alcohol
HB 95 patients	4	2	4	0	4	2	0
Control patients	0	1	4	2	0	1	1

TABLE 5—*Physician recommendations for disposition (initial hearings).*

Physician Recommendation	HB 95 Patients	Control Patients
Inpatient commitment	15	8[a]
Outpatient commitment	0	1
Release	1	7[a]

[a] $P = 0.021$, χ^2.

the initial hearing (held within ten days of admission) for significantly more HB 95 patients than for controls. The court concurred with all physician recommendations for both groups. For subsequent hearings during the same admissions, the physicians ultimately recommended release for ten HB 95 patients, nine of whom were released by the court. The only patient not released was committed after he told the judge during the hearing that he would become violent if released.

There were highly significant differences in average lengths of stay (Table 6), with the HB 95 patients spending some four times longer in hospital than controls. The length of stay was also positively correlated with the seriousness of the alleged crime: the average length of stay for HB 95 patients charged with violent crimes (Columns 1 to 4 in Table 4) was 192 days as opposed to 44 days for nonviolent crimes.

Although no specific records were kept of HB 95 patients at the other three North Carolina state hospitals, information from their directors indicated an average of only eight HB 95 patients at each of them during the first year of the law's operation.

Discussion

Consistent with previous history in the state, there were relatively few patients during the study year who had been found either NCP or NGRI in connection with a violent crime. Only 13 such persons were hospitalized at John Umstead during the study period, out of a population of nearly 2000 committed patients hospitalized during the same period, and the proportion of HB 95 patients appeared even lower at the other three hospitals.

Other reports on the results of forensic hospitalizations have not compared NCP and NGRI patients with other civilly committed patients. Our finding that forensic patients

TABLE 6—*Length of stay, index admission.*

Population	Mean Length of Stay, days
HB 95 patients	153
Control patients	40[a]
All committed patients	32[a]
HB 95 patients—violent crimes	192
HB 95 patients—nonviolent crimes	44[a]

[a] $P < 0.001$, χ^2.

charged with violent crimes had significantly longer stays than those charged with nonviolent crimes (400 versus 153 days) is similar to findings from other states [13-16]; but the length of time hospitalized for patients charged with both categories of crime was significantly less for HB 95 patients in North Carolina (192 and 44 days) than in Oregon (363 and 186 days) [15], New York (555 and 400 days) [16], or Connecticut (620 and 227 days) [17]. In addition, HB 95 patients, all of whom were diagnosed as psychotic, stayed significantly longer than the six control patients with psychotic diagnoses (153 versus 49 days, $P < 0.001$, χ^2).

The hypothesis that judges in commitment hearings might be more restrictive in releasing HB 95 patients than they would be in releasing nonforensic patients was not confirmed. The concurrence rate between physician recommendation and court disposition for HB 95 patients at initial hearings was actually higher than it was for all committed patients [18]. There was a difference, however, between the pattern of physician recommendations to the court for the HB 95 patients as compared with controls (Table 5), and with the total sample of committed patients [18]. Physicians recommended commitment at the initial hearing for 94% of HB 95 patients, as compared with 56% of controls and 82% of all committed patients.

Thus, judicial oversight over release of patients civilly committed after having been charged with violent crimes appeared to have no direct effect on length of stay for those patients. However, one of the major goals of the legislation, to incarcerate such patients longer than other civilly committed patients, was in fact accomplished. There are at least two possible explanations for this finding:

1. Hospital physicians, who were aware of HB 95's goals, chose to recommend longer hospitalizations for such patients than for other patients with comparable illnesses because of the history of violent crime.
2. Patients identified by the criminal justice system as belonging to the HB 95 class were in fact more severely ill than non-HB 95 patients, and thus required longer hospitalizations on clinical grounds alone. This hypothesis is consistent with the conservative policy of the state forensic evaluation unit, which recommends finding incompetence to proceed or nonresponsibility in only 5 to 10% of cases, and in practice provides the only clinical input to the court in most cases. This policy tends to ensure that only the most severely mentally disordered patients are eligible for civil commitment under HB 95. Partial support for the conclusion that HB 95 patients are more severely ill than the civilly committed controls comes from the fact that three of the HB 95 patients had already been hospitalized for periods between four and ten months before the effective date of the legislation. However, it could still be argued that the physicians treating these patients were aware of the serious charges (two first degree murder charges and one assault) and therefore based their recommendations for commitment at least partially on the legal situation. Without comparison to the total population of patients found NCP or NGRI for violent crimes before July 1981, it is not possible to discriminate between these two hypotheses. Unfortunately, prior records were not accessible by presence or absence of criminal charges, so that the comparison could not be made.

Another possible explanation for the observed differences between HB 95 patients and control psychotic patients is the present emphasis on dangerousness as a criterion for commitment. More committed patients than in the past are alleged to have committed acts that could have led to criminal charges rather than to commitment [2]. For example, 9 of the 16 control patients in this study were committed on the basis of alleged acts that could have resulted in criminal charges. Particularly in states such as North Carolina, where competency and responsibility issues are raised more rarely than in other states, and where they are even more rarely successful, law enforcement officers have become the major gatekeepers who decide whether to initiate criminal charges or civil commitment [19]. It may well be that these officers in fact accurately discriminate between persons who can adequately be treated in the regular civil commitment process and those more severely ill (and more dangerous)

persons who are more appropriately handled under the stricter control of the criminal justice system.

For whichever of these reasons, or for a combination of them, it appears that psychiatric patients who have been formally charged with violent criminal offenses are certainly being treated differently within the civil commitment system than patients matched for age, gender, and diagnosis but who have not been criminally charged, at least in respect to length of stay.

Systematic study of the individual treatment given to each HB 95 and control patient was not undertaken; however, one of the authors worked intensively in individual therapy with one of the index HB 95 patients during the entire study period. The details have been reported elsewhere [*20*]; the patient had been found not competent to proceed on a charge of first degree murder. He was diagnosed at our facility as suffering from manic-depressive illness and multiple personality, and was treated (quite successfully) with medications and hypnotherapy. Clinically, he was ready for discharge within a month of admission; he was transferred to an open ward and given privileges commensurate with his clinical condition, and the hospital administration pressed strongly for his discharge. However, because of pressure from the district attorney's office, we were forced to return him to a locked ward and keep him there for nearly two years until the attorneys and the court could agree to schedule his trial. Clearly, the legal charges in this case resulted in a far lengthier admission than was clinically necessary.

As we have discussed elsewhere, physicians' disposition recommendations in North Carolina commitment hearings vary widely among the four state hospitals, according to their expectations of court decisions [*18*]. Given the strong public desire for increased protection from dangerous people, especially if they are also mentally disordered, it is not at all surprising that the trend towards decreasing length of hospitalization has been reversed for persons labelled as both mentally disordered and criminal, although the data presented here certainly do not establish that such desires have caused the reversal. It is probable that law enforcement officers, judges, and hospital psychiatrists have all gradually shifted to a more conservative discharge philosophy for these patients, acting in concert to ensure longer admissions and therefore extending the period of protection afforded the public because of the incarceration alone.

The HB 95 patients presented here were not compared with a sample, matched for demographic variables and crimes charged, of convicted criminals, as has been done by other authors; the intent of the study was to compare the HB 95 sample with other patients, not others criminally charged. Had this been done, it is quite probable that the imprisoned sample would have spent significantly more time incarcerated than the HB 95 patients spent in the hospital, as was reported in studies in New York [*16*] and Connecticut [*17*]. One major reason for the brief length of stay of our HB 95 patients, as compared to other studies is that only 2 out of 16 of these patients had actually been found NGRI; those two were both still hospitalized at the end of the study period, one having been there for 5 months, the other for 22, for a minimum average of 405 days. The NCP patients averaged only 110 days of hospitalization (three were still in the hospital at the end of the study period.) Unlike many other states, North Carolina statutes do not set a maximum length of hospitalization for those committed after being found NCP or NGRI; such patients can be hospitalized indefinitely so long as they continue to meet the relatively liberal standards for civil commitment and continue to be either NCP or NGRI [*21*]. Our records did not indicate how many of the NCP patients were found competent and returned to court for trial after being discharged from HB 95 status; but the relatively brief periods of hospitalization found here cannot be taken to indicate that these patients were simply released into the community.

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