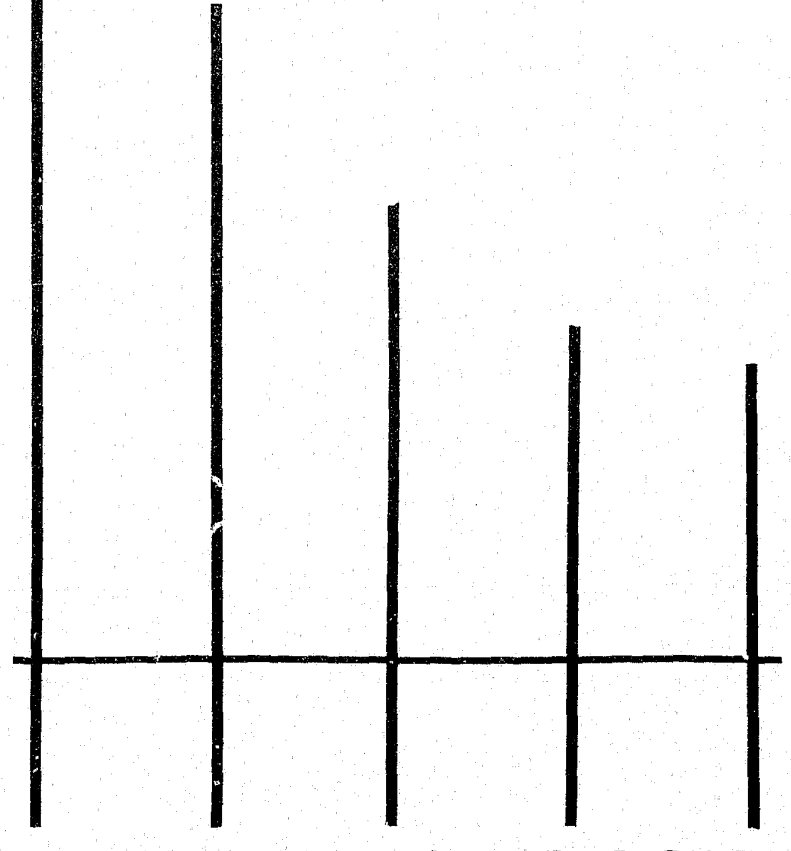
the Insanity Defense in New York



A REPORT TO GOVERNOR HUGH L. CAREY

New York State Department of Mental Hygiene

State of New York

DEPARTMENT OF MENTAL HYGIENE

James A. Prevost, M.D.
Acting Commissioner

A Report to Governor Hugh L. Carey

on

the Insanity Defense in New York

Prepared under the direction of
William A. Carnahan, Deputy Commissioner and Counsel

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Participants:

Lawrence C. Kolb, M.D.
William A. Carnahan, LL.M.
Henry J. Steadman, Ph.D.
John B. Wright, D.P.M.

In recent years, there has been widespread concern that the legal defense of insanity in criminal proceedings does not protect the public.

At my direction, the Department of Mental Hygiene is preparing a report which will examine the types of cases in which the defense has been invoked, the outcome, and the subsequent treatment of the offenders. Specifically, I directed the Department to consider the need for limits on a legal defense of insanity. Should change be necessary, we will propose alternatives adequate to serve the public interest and be fair to the defendant.

Governor Hugh L. Carey
Message to the Legislature
of the State of New York,
13-14 (January 4, 1978)

ACKNOWLEDGMENTS

The Department wishes to acknowledge Frank J. Rogers, Commissioner of the Division of Criminal Justice Services, for his collaboration in securing the data appearing in Chapter 3 of this report and to acknowledge both Clarence J. Sundram, Esq. and Paul Litwak, Esq. of the New York Bar for generously devoting their legal skills and talents in refining the complex legal issues presented in this report.

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FOREWORD

In Anglo-American jurisprudence, the insanity defense has traditionally had at least one outcome in common with conviction of a crime - it resulted in the social isolation of the person invoking it, often for as long or longer than the permissible period of incarceration for the crime. This feature, the indefinite and protracted removal of the offender from society, made acceptance of the defense by legislators, judges, lawyers and laymen possible. Society was free to indulge its humane concern that the mental abnormality, believed to result in the commission of a crime, be treated and that the normal rule of holding a person responsible for his actions be relaxed in such cases. Measured by modern standards, there was little general concern over the treatment actually accorded to such offenders. Once removed from society, they ceased to be objects of societal scrutiny.

Legal inroads made in recent years have upset this comfortable state of affairs. For example, persons acquitted of crimes by reason of insanity may no longer be placed indefinitely with the criminally insane. They must be

treated as any other civil patient and accorded both the substantive and procedural protections afforded by the Mental Hygiene Law. Civil hospitalization itself has undergone a radical transformation. No longer the remote asylums for containing a grab-bag of misfits, deviants and vagabonds and no longer de facto alternatives to prisons and poor houses, state hospitals today are enjoined by law to provide highly specific treatment plans for patients who are found to need inpatient care and treatment. The advent of psychotropic medication and the concomitant changing nature of psychiatric hospitalization have resulted in drastically reducing the length of stays in state psychiatric centers. Increasingly characterized by open atmospheres rather than locked wards, psychiatric centers today are no longer appropriate facilities for the containment of social deviants.

More importantly, the "liberalization" of the insanity defense in 1965 has resulted in the placement in psychiatric centers of a larger number of acquittees, who are not amenable to psychiatric treatment and yet who require confinement. Releasing them requires a psychiatric prediction of a lack of continuing dangerousness to self or others - a prediction that psychiatrists are understandably reluctant to make and courts equally understandably reluctant to accept, given the historic inability of mankind to foretell the future.

In sum, the insanity defense today provides no assurance of the prolonged social isolation of an insane offender who is perceived as a danger to the community; yet, to the extent that the procedural mechanisms fail to achieve the removal of an inappropriately placed acquittee from a psychiatric center when he cannot be treated, it results in fundamental unfairness not only to the offender but to the other patients and staff in the center as well.

While the state's mental health system has been undergoing a steady diminution of its ability to provide treatment of persons acquitted by reason of insanity in secure facilities, the state's corrections system has developed a sophisticated complex of mental health services unparalleled in the country.

The closing down of the Matteawan Hospital for the Criminally Insane and the establishment of the Central New York Psychiatric Center and seven satellite clinics in the major correctional facilities has created a capacity within the correctional system for providing a wide range of inpatient and outpatient psychiatric services in secure settings.

This realignment of responsibility for providing psychiatric services to those in correctional facilities makes it possible to undertake a reassessment of the purpose and uses of the insanity defense with an understanding of the

real alternatives available to provide the necessary treatment to those requiring it.

The professional criticism and the public condemnation of the insanity defense is widespread. The disrepute into which the insanity defense appears to be falling has profound impact upon both the criminal justice system and the mental health system. The invocation of the defense in sensational cases not only enrages the public mind by raising the prospect of acquittal of the offender, but sows the seeds that generate a pervasive perception of mental illness and dangerousness as synonymous. This perception is manifested in and at least partly responsible for the vociferous opposition heard in some quarters to care of the mentally ill in the community. With the mental hygiene systems facing critical choices in the implementation of their objectives of seeking the care of the mentally disabled in the least restrictive environment, the impact of such a perception cannot be underestimated.

This study by the Department of Mental Hygiene of the use of the insanity defense is the first in-depth examination undertaken since the revision of the law in 1965. The examination and analysis of the cases in which the plea of insanity was successfully invoked over a ten-year period is unprecedented in this state. The thoughtful conclusions of

the participants in this report are entitled to the most serious consideration by the executive, legislative and judicial branches of government and by professionals in the criminal justice and mental hygiene fields.

Albany, New York
February 17, 1978

JAMES A. PREVOST, M.D.

THE INSANITY DEFENSE IN NEW YORK

SUMMARY

A. Background

At Governor Carey's request, the Department of Mental Hygiene has prepared this report and recommendations concerning the mentally abnormal adult criminal offender.

His request comes at a time of widespread professional and public perception that the legal defense of insanity in criminal proceedings ensures neither adequate care for the offender nor adequate protection to the public.

Specifically, the Governor has directed the Department to consider whether there is a justifiable need for continuing a legal defense of insanity in this State; and should change be desirable, to prepare alternative proposals which are fair to the offender and adequate to serve the public interest.

The Department has surveyed the use of the defense in this State during the last ten years focusing upon the types of crimes involved, the characteristics of the defendants and victims and the hospitalization and release practices of the Department. In collaboration with the Division of Criminal Justice Services, the views of trial judges, district attorneys and defense attorneys have been obtained.

B. Conclusions

From the following pages, several conclusions may readily be drawn concerning the continuing viability of an insanity defense in this State.

Legal Perspectives on the Defense

- An insanity defense is not required constitutionally to be maintained.

- The state has "wide freedom to determine the extent to which moral culpability should be a prerequisite to conviction of a crime." Powell v. Texas, 392 U.S. 514, (1968) (Black, J., concurring).

Use of the Defense

- During the last ten years, successful use of the defense has increased markedly from fifty-three (53) cases during the first five years to two hundred and twenty-five (225) cases during the last five years.
- The defense is not uniformly applied throughout this state.
- The defense has tended to be used as a guilt avoidance device for certain empathetic segments of the population.
- The legal standards for use of the defense may not be deciding factors in its successful use.

Perceptions of the Defense

- Legal professionals found problems with the defense in terms of poor statutory definitions, vagueness, uneven application, lack of understanding by juries and the public, and superficial and incompetent psychiatric testimony.
- Legal professionals felt that the defense should be modified by removing the ambiguity and vagueness of psychiatric testimony in the determination of guilt or innocence.
- Legal professionals felt that treatment of acquittees within a correctional setting was preferred to psychiatric hospitalization.

Reassessment of the Defense

- The defense rests upon the legally dubious premise that the medical specialty of psychiatry can answer the question of the capacity of the defendant to understand the nature of his act or to evaluate whether at the time of its commission he was capable of distinguishing "right" from "wrong".
- Harm may be done to the rule of law through the use of an insanity defense, with its implied permissiveness for violent and other crimes committed.

- Public determination of guilt may do much to sustain the faith of citizens at large in the rectitude and equity which should exist in all social bodies in their efforts to sustain justice under law.

- By abrogation of the defense, an individual would not be a candidate for automatic placement in a psychiatric hospital, a disposition which can be -- and often is -- inappropriate not only for custodial but also for therapeutic reasons.

- The use of the defense in highly publicized criminal cases can foster an impression that all mentally ill individuals are dangerous, thus significantly inhibiting community acceptance of a policy of providing care and treatment of persons suffering from mental illness -- who are neither violent nor dangerous -- in surroundings less restrictive than secure facilities.

Impact of the Defense

- Psychiatric participation in the determination of legal guilt or innocence is premised upon false assumptions of psychiatric expertise in what are essentially legal, moral and social judgments.

- Continued placement of individuals in psychiatric hospitals has become undesirable due to the changing nature of our psychiatric hospitals, the type of offenders being placed and the difficulties of articulating psychiatric standards for release.

- Capacity for treating such individuals within correctional settings renders continued placement within psychiatric hospitals not only undesirable, but unnecessary.

C. Recommendations

In this report, we have examined the need for continuing the insanity defense, have considered optional approaches, and recommend for adoption a rule of diminished capacity under which evidence of abnormal mental condition would be admissible to affect the degree of crime for which an accused could be convicted. Specifically, those offenses requiring

intent or knowledge could be reduced to lesser included offenses requiring only recklessness or criminal negligence.

Additionally, a psychiatrist would be limited to testimonial and documentary evidence of an accused's capacity for culpable conduct. For example, where knowledge is a required culpable mental state, the psychiatrist would be permitted

> to describe the defendant's mental condition and symptoms, his pathological beliefs and motivations, if he was thus afflicted, and to explain how these influenced or could have influenced his behavior, particularly his mental capacity knowingly to [commit the crime charged]....
>
> Rhodes v. United States, 282 F.2d 59, 62 (4th Cir. 1960)

No longer would he be permitted to address the issues of complete exculpation or forced to assume the role of post-acquittal custodian.

While abolishing mental disease or defect as a complete defense, recognition would still be given to higher degrees of culpability affected by the presence of abnormal mental condition. The result would entail conviction and processing in the correctional system for serious offenders, and acquittal -- perhaps civil commitment -- for minor offenders. Convictions would be for lesser included criminal offenses not requiring an accused to have acted either intentionally or knowingly. The sentencing court would then take the present mental condition of the offender into account in determining an appropriate disposition, viz., conditional discharge, probation or penal confinement.

Critical to our consensus that change is necessary is the fact that we now have in place the most advanced model for mental health treatment in prisons in the United States.

Thus it is no longer necessary to utilize a defense of insanity as "a device for triggering indeterminate restraint." J. Goldstein and J. Katz, "Abolish 'The Insanity Defense' -- Why Not?", 72 Yale L.J. 852, 858 (1963).

The effect of these recommendations would be to recognize the Department of Correctional Services as the primary control agency, to avoid dysfunctional psychiatric involvement in adjudicative and dispositional processes and to ensure that the fate of those found dangerous to society be determined by the proper agencies and the judiciary.

Presently, the defense is a device for diversion into the mental health treatment system. As such, it is not only inappropriate; but, with our capacity to provide treatment within a correctional context, unnecessary.

LAWRENCE C. KOLB, M.D.

WILLIAM A. CARNAHAN, LL.M.

HENRY J. STEADMAN, Ph. D.

JOHN B. WRIGHT, D.P.M.

Chapter 1

Legal Perspectives on the Insanity Defense

William A. Carnahan

I understand by responsibility nothing more than actual liability to legal punishment. It is common to discuss this subject as if the law itself depended upon the result of discussions as to the freedom of the will, the origin of moral distinctions, and the nature of conscience. Such discussions cannot be altogether avoided, but in legal inquiries they ought to be noticed principally in order to show that the law does not really depend upon them.

Stephen, 2 A History of the Criminal Law of England 96 (1883).

Introduction

A primary purpose of substantive criminal law is to list those types of activities whose occurrence may entail a penalty.[1] For a host of reasons, most crimes require the presence not only of proscribed conduct, but also of a specified "accompanying mental state."[2]

Under a label of what might be called "excusing conditions,"[3] this chapter will discuss such conditions as voluntary conduct, culpable mental states, intoxication, and mental disease or defect as each may affect, diminish, or preclude an individual's liability to punishment under the criminal law.[4]

A. Voluntary Conduct

In New York, an essential minimal element of every criminal act is "the performance by a person of conduct which includes a voluntary act or the omission to perform an act which he is physically capable of performing."[5] This threshold requirement is of fairly modern origin. Professor Hart attributes it to a doctrine

> concerning criminal responsibility, which has descended from the philosophy of conduct of the eighteenth century, through Austin, to modern English writers on the criminal law. This is the doctrine that, besides the elements of knowledge of circumstances and foresight of consequences, in terms of which many writers define mens rea, there is another "mental" or at least psychological element which is required for responsibility: the accused's "conduct" (including his omissions where these are criminally punishable) must, so it is said, be voluntary and not involuntary.[6]

It cannot be noted too strongly that voluntary conduct requirements are not concerned with either acts in the nature of psychic compulsion or those in the nature of duress. What is required is a complete absence of an opportunity for conscious choice. Examples of involuntary acts include "reflex actions, bodily movements during unconsciousness, hypnosis, epileptic fugue and the like...."[7]

As Professor Goldstein has commented, a defense of involuntary conduct "permits the insanity defense to be circumvented and the mentally ill offender to win his release" since "[t]he insanity defense has ordinarily been regarded

as inapplicable either because there was some doubt whether the conditions qualified as 'mental disease' or 'mental defect' or because the absence of a 'voluntary' act or a 'conscious' act kept the insanity issue from arising."[8]

B. Culpable Mental States

The meaning of the term "mens rea" is a constant source of confusion. Often it is equated with either "moral guilt" or thought of as a particular state of mind required to criminalize any activity. In fact, mens rea is nothing more than a statutorily required particular mental state, if any, required to make criminal a particular activity:

> It is frequently though ignorantly supposed to mean that there cannot be such a thing as legal guilt where there is no moral guilt, which is obviously untrue, as there is always a possibility of a conflict between law and morals.
>
> It also suggests the notion that there is some state of mind called a "mens rea," the absence of which, on any particular occasion, deprives what would otherwise be a crime of its criminal character. This is also untrue. There is no one such state of mind, as any one may convince himself by considering the definitions of dissimilar crimes. A pointsman falls asleep, and thereby causes a railway accident and the death of a passenger: he is guilty of manslaughter. He deliberately and by elaborate devices produces the same result: he is guilty of murder. If in each case there is a "mens rea", as the maxim seems to imply, "mens rea" must be a name for two states of mind, not merely differing from but opposed to each other, for what two states of mind can resemble each other less than indolence and an active desire to kill?
>
> The truth is that the maxim about "mens rea" means no more than that the definition of all or nearly all crimes contains not only an outward and visible

> element, but a mental element, varying according to the different nature of different crimes. Thus, in reference to murder, the "mens rea" is any state of mind which comes within the description of malice aforethought. In reference to theft the "mens rea" is an intention to deprive the owner of his property permanently, fraudently, and without claim of right. In reference to forgery the "mens rea" is anything which can be described as an intent to defraud. Hence the only means of arriving at a full comprehension of the expression "mens rea" is by a detailed examination of the definitions of particular crimes, and therefore the expression itself is unmeaning.[9]

Constitutionally, the United States Supreme Court has not resolved the question of whether a doctrine of mens rea is required.

> [T]his Court has never articulated a general constitutional doctrine of mens rea.
>
> We cannot cast aside the centuries-long evolution of the collection of interlocking and overlapping concepts which the common law has utilized to assess the moral accountability of an individual for his antisocial deeds. The doctrines of actus reus, mens rea, insanity, mistake, justification, and duress have historically provided the tools for a constantly shifting adjustment of the tension between the evolving aims of the criminal law and changing religious, moral, philosophical, and medical views of the nature of man. This process of adjustment has always been thought to be the province of the States.
>
> [F]ormulating a constitutional rule would reduce, if not eliminate, that fruitful experimentation, and freeze the developing productive dialogue between law and psychiatry into a rigid constitutional mold. It is simply not yet the time to write the Constitutional formulas cast in terms whose meaning, let alone relevance, is not yet clear either to doctors or to lawyers.[10]

Presently, criminal liability may be imposed regardless of knowledge or scienter.[11] While mere status, such as that of being a narcotic addict, may not be criminalized,[12] an addict's activity, such as being publicly intoxicated, may be criminalized.[13]

In New York, particular crimes may require conduct to be performed "intentionally", "knowingly", "recklessly", or with "criminal negligence". If so, the crime is one requiring a "particular culpable mental state" or mens rea. If all that is required is the performance of the conduct or actus reus, the crime is one of the strict liability.[14]

1. Intentionally

In New York, "[a] person acts intentionally with respect to a result or to conduct described by a statute defining an offense when his conscious objective is to cause such result or to engage in such conduct."[15]

In discussing the historical preference for intentional conduct as a basis for criminal liability, Mr. Justice Jackson has observed:

> Crime as a compound concept, generally constituted only from concurrence of an evil-meaning mind with an evil-doing hand, was congenial to an intense individualism and took deep and early root in American soil. As the states codified the common law of crimes, even if their enactments were silent on the subject, their courts assumed that the omission did not signify disapproval of the principle but merely recognized that intent was so inherent in the idea of the offense that it required no statutory affirmation. Courts, with little

> hesitation or division, found an implication of the requirement as to offenses that were taken over from the common law. The unanimity with which they have adhered to the central thought that wrongdoing must be conscious to be criminal is emphasized by the variety, disparity and confusion of their definitions of the requisite but elusive mental element. However, courts of various jurisdictions, and for the purposes of different offenses, have devised working formulae, if not scientific ones, for the instruction of juries around such terms as "felonious intent", "criminal intent", "malice aforethought", "guilty knowledge", "fraudulent intent", "willfulness", "scienter", to denote guilty knowledge or "mens rea", to signify an evil purpose or mental culpability. By use or combination of these various tokens, they have sought to protect those who are not blameworthy in mind from conviction of infamous common-law crimes.[16]

Minimally, intentional conduct requires conscious activity, the design of which is to cause the proscribed act or omission.

2. Knowingly

In New York, "[a] person acts knowingly with respect to conduct or to a circumstance described by a statute defining an offense when he is aware that his conduct is of such nature or that such circumstance exists."[17]

Knowledge is distinguished from intent in that the latter mental state encompasses the result obtained. Professor Weinreb offers this example:

> In some situations, however, it seems reasonable that the law should distinguish between a man who wills that a particular act or result take place and another who is merely willing that it should take place. The distinction is drawn between the

> main direction of a man's conduct and the (anticipated) side effects of his conduct. For example, a man might intentionally blow up the grocery store next to the Post Office, with knowledge that the Post Office will be blown up as well. A category of conduct in which a person engages knowingly is warranted not only to allow a distinction between purposeful and knowing conduct but also because in most cases it will be sufficient for liability that the person engaged in prohibitive conduct knowingly, whether or not it was his purpose to do so.[18]

Thus to act knowingly requires conscious activity, the natural or probable effect of which is the occurrence of the proscribed act or omission.

The distinction between acting "intentionally" and acting "knowingly" is that the first "entails a conscious desire to cause a particular result by one's conduct and the second an awareness that the result 'is practically certain' to follow from that conduct...."[19]

3. Recklessly

In New York, "[a] person acts recklessly with respect to a result or to a circumstance described by a statute defining an offense when he is aware of and consciously disregards a substantial and unjustifiable risk that such result will occur or that such circumstance exists."[20]

To act recklessly involves "conscious risk creation":

> A broader discrimination is perceived between acting either [intentionally] or knowingly and acting recklessly. As we use the term, recklessness involves conscious risk creation. It resembles acting knowingly in that a state of awareness is involved but the awareness is of risk, that is of probability rather than certainty; the matter is contingent from the actor's point of view. Whether the risk relates to the nature of the actor's conduct or to the existence of the requisite attendant circumstances or to the result that may ensue is immaterial; the concept is the same. The draft requires, however, that the risk thus consciously disregarded by the actor be "substantial" and "unjustifiable"; even substantial risks may be created without recklessness when the actor seeks to serve a proper purpose, as when a surgeon performs an operation which he knows is very likely to be fatal but reasonably thinks the patient has no other, safer chance....[21]

4. Criminal Negligence

In New York, "[a] person acts with criminal negligence with respect to a result or to a circumstance described by a statute defining an offense when he fails to perceive a substantial and unjustifiable risk that such result will occur or that such circumstance exists."[22]

This fourth term of statutory culpability is distinguished from acting either intentionally, knowingly or recklessly in that these latter culpable mental states require a state of awareness on the part of the actor:

> The criminally negligent offender, on the other hand, is not aware of the risk created and, hence, cannot be guilty of consciously disregarding it. His liability stems from a culpable failure to perceive the risk. His culpability, though obviously less than that of the reckless offender, is

> appreciably greater than that required for ordinary civil negligence by virtue of the "substantial and unjustifiable" character of the risk involved and the factor of "gross deviation" from the ordinary standard of care.[23]

Contrary to popular belief, motive is not an essential element of criminal activity. Nor is motive synonymous with "intent". Motive may be characterized simply as "an inducement, or that which leads or tempts the mind to indulge the criminal act."[24] However, if relevant, a particular motive may be admissible on the question of presence or absence of a probability that the accused did the act.[25] Motives cannot be incorporated into themes of culpable mental states because of their infinite variety.[26]

C. Intoxication

In New York, evidence that an accused was intoxicated at the time he engaged in prohibited conduct may affect the degree of crime for which he can be convicted.[27] Specifically, where either intent or knowledge is an essential element of the crime charged, evidence of self-induced intoxication may be used in denial of that element. Should the effect of such evidence produce a reasonable doubt in the mind of the trier of fact as to the element in question, the result would be a finding of guilt as to a lesser included offense not requiring such intent or knowledge. For

policy reasons, evidence of voluntary intoxication would not preclude a finding that the accused acted recklessly.[28]

D. The Insanity Defense

1. Historical Overview

Early in January 1843, Daniel M'Naghten, beset by long standing delusions of a Tory conspiracy, mistakenly shot Edward Drummond, private secretary to his intended victim, Sir Robert Peel, the Home Secretary of England. M'Naghten was acquitted by reason of insanity upon, in part, this charge to the jury:

> The question to be determined is whether at the time the act in question was committed the prisoner had or had not the use of his understanding so as to know that he was doing a wrong or wicked act.[29]

M'Naghten's acquittal produced a hostile public opinion. The House of Lords sought an advisory opinion from the judiciary concerning the extent to which "insanity" relieved an individual from criminal liability. In response, the judiciary elaborated the now famous M'Naghten or right-wrong rule:

> [E]very man is presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes until the contrary be proved to their satisfaction, and that to establish a defence on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or, if he did know it, that he did not know he was doing what was wrong.[30]

This rule embraced an offender who lacked understanding. But what about the delusional M'Naghten? The judiciary responded as follows:

> [T]he answer must, of course, depend on the nature of the delusion, but, making the same assumption as we did before, namely, that he labours under such partial delusion only, and is not in other respects insane, we think he must be considered in the same situation as to responsibility as if the facts with respect to which the delusion exists were real. For example, if under the influence of his delusion he supposes another man to be in the act of attempting to take away his life, and he kills that man, as he supposes, in self-defence, he would be exempt from punishment. If his delusion was that the deceased had inflicted a serious injury to his character and fortune, and he killed him in revenge for such supposed injury, he would be liable to punishment.[31]

In essence, a delusional offender could claim excuse from criminal liability under a judicially created rule of mistake of fact.

2. The Rule in New York

Prior to 1965, New York steadfastly adhered to the M'Naghten rule.[32] Presently, criminal responsibility may be negated by mental disease or defect which results in a lack of substantial capacity to know or appreciate either the nature or consequences or wrongfulness of one's conduct.[33] By judicial decision, the delusional defendant may seek to absolve himself from criminal liability due to a mistake of fact.[34]

While statutorily recognizing cognitive impairment and judicially allowing delusional impairment, New York has

never permitted volitional impairment as a ground for acquittal under an insanity defense.[35] Thus, an accused may not successfully assert that through mental disease or defect he is "incapable of conforming his conduct to the requirements of law."[36]

Since lack of criminal responsibility due to mental disease or defect is statuorily classified as a "defense", the burden of persuasion rests upon the prosecution to prove criminal responsibility beyond a reasonable doubt.[37]

3. Notice Required

Formal notice is required by an accused of an intent to rely upon the defense.[38] Upon receiving such notice, the prosecution is entitled to move for a pre-trial psychiatric examination of the accused.[39]

4. Prosecutorial Pre-Trial Psychiatric Examination

The assertion of the defense results in the waiver of a privilege against self-incrimination relative to a prosecutorial pretrial psychiatric examination.[40] The effect of this waiver is to allow a psychiatrist to elicit verbal and nonverbal responses bearing upon "the facts which formulate the basis of his medical opinion on the question of sanity."[41]

5. Psychiatric Trial Testimony

Where the defense is asserted, an examining psychiatrist must be

> permitted to make a statement as to the nature of the examination, the diagnosis of the mental condition of the defendant and his opinion as to the extent, if any, to which the capacity of the defendant to know or appreciate the nature and consequence of such conduct, or its wrongfulness, was impaired as a result of mental disease or defect at that time.[42]

Additionally, he

> must be permitted to make any explanation reasonably serving to clarify his diagnosis and opinion, and may be cross-examined as to any matter bearing on his competency or credibility or the validity of his diagnosis or opinion.[43]

6. The Nature of the Verdict

The defense is sui generis in that it is the only defense to which the jury must refer as a basis for acquittal.[44] One explanation is that, in reality, the defense is not an exculpatory vehicle but rather a "device for triggering indeterminate restraint".[45]

> [T]he insanity defense is not designed, as is the defense of self-defense, to define an exception to criminal liability, but rather to define for sanction an exception from among those who would be free of liability. It is as if the insanity defense were prompted by an affirmative answer to the silently posed question: "Does mens rea or any essential element of an offense exclude from liability a group of persons whom the community wishes to restrain?" If the suggested relationship between mens rea and "insanity" means that "insanity" precludes proof beyond doubt of mens rea then the "defense" is designed to authorize the holding of persons who have committed no crime. So conceived, the problem really facing the criminal process has been how to obtain authority to sanction the "insane" who would be excluded from liability by an overall application of the general principles of the criminal law.

> Furthermore, even if the relationship between insanity and "mens rea" is rejected, this same purpose re-emerges when we try to understand why the consequences of this defense, unlike other defenses, is restraint, not release. Even though each of the elements of an offense may be established, release will follow acquittal or dismissal if, for example, entrapment, self-defense, or the statute of limitations are successfully pleaded. Assuming, then, that all elements of an offense are to be established before the insanity defense becomes operative, the question remains: "Why restrain rather than release?" Restraint cannot be attributed to potential "dangerousness" associated with the crime charged, no matter how serious, for that kind of "dangerousness" is characteristic of defendants whose defenses prevail. The crucial variable leading to restraint seems to be "insanity at the time of the offense", i.e., a fear of danger seen in the combination of "mental sickness" and "crime".
>
> . . . . .
>
> That mandatory commitment, not release, generally follows the insanity defense becomes then particularly striking since, to the extent "insanity at the time of offense" is related to "mental health at the time of acquittal", the state is authorized to select from the mentally ill those who require civil restraint for custody and care. Thus the insanity defense is not a defense, it is a device for triggering indeterminate restraint.[46]

In essence, the verdict is not concerned with the present mental condition of a defendant, but merely reflects a reasonable doubt on the part of the trier of fact as to whether an accused had the requisite capacity for criminal responsibility at the time of the alleged criminal act.[47] Indeed, a jury may not be told of the dispositional effect of such a verdict.[48]

7. Post-Verdict Confinement and Release

If an accused pleads not guilty by reason of mental disease or defect, and is acquitted by special verdict, the court must order a period of post-acquittal temporary observational detention under the custody of the Commissioner of Mental Hygiene in a department facility.[49] The constitutionality of such detention has been upheld.[50]

When the Commissioner of Mental Hygiene determines that a mentally ill or mentally retarded patient may be discharged or conditionally released from custody "without danger to himself or others", the Commissioner must apply for such discharge or conditional release to the committing court.[51] Should the court be satisfied that discharge or conditional release is warranted, it may so order. If not, a prompt hearing is necessary to determine whether the patient "may safely be discharged or released".[52] A feature of conditional release is a five-year quasi-probationary status. During this time, the patient may be recommitted for "the safety of [himself] or the safety of others".[53]

Should the Commissioner fail to apply for discharge or conditional release, the patient may apply for his release.[54] In such an instance, the patient must convince the court of his eligibility for release by a fair preponderance of the evidence.[55] Since the patient has in fact been acquitted of

the crime charged, albeit by special verdict, he is a civilly committed patient, and, as such, may only be transferred to an appropriate institution in the Department of Mental Hygiene.[56]

Despite the admissibility of psychiatric testimony predicting future likelihood of dangerousness[57] there is no scientifically reliable or valid evidence of a clinical or statistical ability in psychiatry to predict a particular person's future dangerous behavior.[58]

E. Diminished Capacity

Whether viewed as a doctrine of substantive law or as a rule of evidence, an issue of diminished capacity arises whenever the evidence might raise a reasonable doubt whether an accused, by reason of mental disease or defect, lacked a particular mental state required for the crime charged. This doctrine has also been referred to as one of "diminished responsibility":

> Some of the cases following this doctrine use the term "diminished responsibility", but we prefer the example of the cases that avoid this term. . ., for its convenience is outweighed by its confusion: Our doctrine has nothing to do with "diminishing" responsibility of a defendant because of his impaired mental condition, but rather with determining whether the defendant has the mental state that must be proved as to all defendants.
>
> Procedurally, the issue of abnormal mental condition negativing a person's intent may arise in different ways: For example, the defendant may

> offer evidence of mental condition not qualifying as mental disease.[59]

Approved by the American Law Institute,[60] diminished capacity has been judicially recognized in New York. In People v. Colavecchio,[61] the Appellate Division, in reversing a larceny conviction, expressly approved the admissibility of psychiatric testimony

> not for the purpose of exempting defendant from criminal responsibility under the insanity test, but as bearing upon the question of whether he possessed, at the time he committed the act, the necessary criminal intent proof of which was required to convict under the first count of the indictment.

With regard to framing the questions of diminished capacity, one United States Court of Appeals stated:

> [t]he proper way would have been to ask the witness to describe the defendant's mental condition and symptoms, his pathological beliefs and motivations, if he was thus afflicted, and to explain how these influenced or could have influenced his behavior, particularly his mental capacity knowingly to [commit the crime charged]....[62]

Conclusion

New York has adopted voluntary conduct as the touchstone of criminal liability, degrees of culpability as mitigating factors in criminal conduct and an insanity defense to deal with situations of cognitive and delusional impairment due to mental disease or defect. Thus, the insanity defense is

but one of a variety of "excusing conditions" of the criminal law.

In directing this project, Governor Carey has directed the Department of Mental Hygiene "to consider the needs for limits on a legal defense of insanity."[63] The thrust of this chapter is that New York itself may address a need for change since - as the late Mr. Justice Black has expressed - the states have "wide freedom to determine the extent to which moral culpability should be a prerequisite to conviction of a crime."[64]

1. N.Y. Penal Law § 1.05 (McKinney 1975).

2. Id. §1.05-3.

3. H.L.A. Hart, Punishment and Responsibility, 14 (1968).

4. See, 2 Stephen, A History of the Criminal Law of England, 96 (1883).

5. N.Y. Penal Law § 15.10 (McKinney 1975).

6. H.L.A. Hart, Punishment and Responsibility, 90 (1968).

7. Commission Staff Notes on the Proposed New York Penal Law, Gilbert Criminal Law and Procedure, 2-277 (1973).

8. A. Goldstein, The Insanity Defense, 202-203 (1967).

9. 2 Stephen, A History of the Criminal Law of England, 95 (1883).

10. Powell v. Texas, 392 U.S. 514, 535-537, (1968).

11. See, e.g., Unites States v. Park, 421 U.S. 658 (1975) (food adulteration); United States v. Feola, 420 U.S. 671 (1975) (assaulting a federal officer); Williams v. North Carolina, 325 U.S. 226, (1945) (bigamy); United States v. Dotterweich, 320 U.S. 277, (1943) (mislabeling of drugs); United States v. Behrman, 258 U.S. 280, (1922) (prescribing of narcotics); but see Lambert v. California, 355 U.S. 225, 229, (1957) (ex-felon could not properly be convicted for failure to register under an ordinance requiring her to so register without proof of her "actual knowledge of the duty to register or proof of the probability of such knowledge").

12. Robinson v. California, 370 U.S. 660, (1962).

13. Powell v. Texas, 392 U.S. 514, 532, (1968):

> "[A]ppellant was convicted, not for being a chronic alcoholic, but for being in public while drunk on a particular occasion. The State of Texas thus has not sought to punish a mere status, as California did in Robinson; nor has it attempted to regulate appellant's behavior in the privacy of his own home. Rather, it has imposed upon appellant a

> criminal sanction for public behavior which may create substantial health and safety hazards, both for appellant, and for members of the general public, and which offends the moral and esthetic sensibilities of a large segment of the community."

14. N.Y. Penal Law § 15.15 (McKinney 1975).

15. Id. § 15.05-1.

16. Morrissette v. United States, 342 U.S. 237, 251-252, (1962) (footnotes omitted).

17. N.Y. Penal Law § 15.05-2 (McKinney 1975).

18. L. Weinreb, "Comment on Basis of Criminal Liability; Culpability, Causation: Chapter 3 Section 610" Working Papers of the Nat'l Comm'n on Reform of Federal Criminal Laws, 124 (Gov't Printing Office 1970).

19. Commission Staff Notes on the Proposed New York Penal Law, Gilbert Criminal Law and Procedure 2-277 (1973). See Model Penal Code § 2.02 Comment, at 124-125 (Tent. Draft No. 4, 1955):

> Knowledge that the requisite external circumstances exist is a common element in both conceptions. But action is not [intentionally] with respect to the nature or the result of the actor's conduct unless it was his conscious object to perform an action of that nature or to cause such a result.

20. N.Y. Penal Law § 15.05-3 (McKinney 1975).

21. Model Penal Code § 2.02, Comment, at 125-126 (Tent. Draft No. 4, 1955).

22. N.Y. Penal Law § 15.05-4 (McKinney 1975).

23. Commission Staff Notes on the Proposed New York Penal Law, Gilbert Criminal Law and Procedure, 2-278 (1973).

24. People v. Fitzgerald, 156 N.Y. 253, 258, 50 N.E. 846, 847 (1898). See also People ex rel. Hegeman v. Corrigan, 195 N.Y. 1, 12, 87 N.E. 792, 796 (1909). ("'Motive is that which incites or stimulates a person to do an act. . . . Motive is never an essential element of a crime. A good motive does not prevent an act from being a crime.'")

25. People v. Fitzgerald, 156 N.Y. 253, 258-259, 50 N.E. 846, 847 (1898).

26. See Hendrickson v. People, 10 N.Y. 13, 31-32 (1854).

27. N.Y. Penal Law § 15.25 (McKinney 1975).

28. N.Y. Penal Law § 15.05-3 (McKinney 1975).

29. Daniel M'Naghten's Case, 8 Eng. Rep. 718 (1843).

30. Id. at 721.

31. Id. at 722.

32. Former N.Y. Penal Law § 1120 excused an individual from criminal responsibility if "at the time of committing the alleged criminal act, he was laboring under such defect of reason, as either (1) not to know the nature and quality of the act he was doing or (2) not to know that the act was wrong." (L. 1881, Ch. 676, § 21, repealed eff. July 1, 1965, L. 1965, Ch. 593 § 1)

33. N.Y. Penal Law § 30.05 (McKinney 1975).

34. See People v. Taylor, 138 N.Y. 398, 406-407, 34 N.E. 275, 278 (1893). ("An insane delusion with reference to the conduct and attitude of another cannot excuse the criminal act of taking his life, unless it is of such a character, that if it had been true, it would have rendered the homicide excusable, or justifiable.")

35. See State of N.Y. Temporary Comm'n on Revision of the Penal Law and Criminal Code, 4th Interim Rep., at 15 (Leg. Doc. 25, 1963).

36. People v. Hakner, 34 N.Y.2d 822, 359 N.Y.S. 2d 52, 316 N.E.2d 337 (1974).

37. N.Y. Penal Law § 25.00 (McKinney 1975).

38. N.Y. Crim. Proc. Law § 250.10 (McKinney 1971).

39. Lee v. County Court of Erie County, 27 N.Y.2d 432, 318 N.Y.S.2d 705, 267 N.E.2d 542, cert. denied, 404 U.S. 823 (1971).

40. Id. at 441, 318 N.Y.S.2d at 705, 267 N.E.2d at 457: "[W]e hold that the privilege is waived when a defendant interposes his insanity defense."

41. Id.

42. N.Y. Crim. Proc. Law § 60.55 (McKinney 1971).

43. Id.

44. N.Y. Crim. Proc. Law § 330.10-2 (McKinney 1971).

45. J. Goldstein and J. Katz, Abolish "The Insanity Defense" -- Why Not?, 72 Yale L.J. 853, 868 (1963). Reprinted by permission of The Yale Law Journal Co. and Fred B. Rothman & Co. from the Yale Law Journal.

46. Id. at 865-868 (footnotes omitted).

47. See Bolton v. Harris, 395 F.2d 642, 649 (D.C. Cir. 1968). ("The plea is neither an express nor implied admission of present illness, and acquittal rests only on a reasonable doubt of past sanity, i.e., at the time of the offense.")

48. People v. Adams, 26 N.Y.2d 129, 138-139, 809 N.Y.S.2d 145, 150-152, 257 N.E.2d 610, 614, cert. denied, 399 U.S. 931 (1970).

49. N.Y. Crim. Proc. Law § 330.20-1.

50. People v. Henig, No. 76-620 slip op. (N.Y. Ct. App. December 19, 1977).

51. N.Y. Crim. Proc. Law § 330.20-2 (McKinney Supp. 1977).

52. Id. § 330.20-3.

53. Id. § 330.20-4 (McKinney 1971).

54. Id. § 330.20-5 (McKinney Supp. 1977).

55. In re Lublin, No. 77-621 slip op. (N.Y. Ct. App. December 19, 1977).

56. N.Y. Crim. Proc. Law § 330.20-1 (McKinney 1971).

57. See e.g., Cross v. Harris, 418 F.2d 1095, 1100-1101 (D.C. Cir. 1969) (Bazelon, C.J.):

> Psychiatrists should not be asked to testify, without more, simply whether future behavior or threatened harm is "likely" to occur. For the

> psychiatrist "may--in his own mind--be defining 'likely' to mean anything from virtual certainty to slightly above chance. And his definition will not be a reflection of any expertise; but * * * of his own personal preference for safety or liberty." Of course, psychiatrists may be unable or unwilling to provide a precise numerical estimate of probabilities, and we are not attempting to so limit their testimony. But questioning can and should bring out the expert witness's meaning when he testifies that expected harm is or is not "likely" (footnote omitted).

58. See, e.g., Rubin, Prediction of Dangerousness in Mentally Ill Criminals, 27 Archives of General Psych. 397 (1972); Steadman, Some Evidence on the Inadequacy of the Concept and Determination of Dangerousness in Law and Psychiatry, 1 J. of Psych. and L. 409 (1973); J. Ziskin, Coping With Psychiatric and Psychological Testimony (2 ed. 1975).

For an excellent analysis of the deficiencies of psychiatry in predicting dangerous behavior in legal settings, see Ennis & Litwack, Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom, 62 Cal. L. Rev. 693 (1974).

59. United States v. Brawner, 471 F.2d 969, 998 (D.C. Cir. 1972) (footnote omitted).

60. Model Penal Code § 4.02(1) provides:

> Section 4.02 Evidence of Mental Disease or Defect Admissible When Relevant to Element of the Offense. . . .
>
> (1) Evidence that the defendant suffered from a mental disease or defect is admissible whenever it is relevant to prove that the defendant did or did not have a state of mind which is an element of the offense.

61. People v. Colavecchio, 11 App. Div. 2d 161, 165, 202 N.Y.S.2d 119, 123 (4th Dep't 1960).

62. Rhodes v. United States, 282 F.2d 59, 62 (4th Cir. 1960).

63. Hugh L. Carey, State of New York Message to the Legislature, 13 (January 4, 1978).

64. Powell v. Texas 392 U.S. 514, 545 (1968) (Black, J., concurring).

Chapter 2

The Use of the Insanity Defense

Henry J. Steadman, Ph. D.
Richard A. Pasewark, Ph. D.
Mark L. Pantle, M.A.

Introduction

A recurring problem in developing rational social policy in any area is the decision-maker's lack of access to relevant information.

Prior to the collection of these data, there were few areas where the scarcity of solid research had been a more significant problem than in legal and psychiatric discussions of the insanity defense. Legal tracts and psychiatric polemics abound, but solid empirical facts about the use of the insanity defense and the results of acquittal are rare.

In order that our current endeavor to develop an informed revision of New York's statutes dealing with the insanity defense might avoid this common flaw, a study was undertaken by DMH's Special Projects Research Unit under the supervision of Dr. Richard Pasewark of the University of Wyoming in collaboration with Dr. Henry Steadman, Director of SPRU. The project compiled a comprehensive picture of all defendants acquitted by reason of insanity during the

last five years of the Code of Criminal Procedure (CCP) and the first five years of the Criminal Procedure Law (CPL). With this information, New York now has in its possession the most comprehensive picture of insanity acquittals of any state in the United States.

In compiling such information about the actual insanity acquittals in New York between 1965-1971 and 1971-1976, a number of trends were clear:

- Insanity acquittals have increased dramatically from 53 in the first six years to 225 in the second period of five years.
- Murder is the most frequent acquittal charge in both time periods constituting slightly more than half of all insanity acquittals.
- There is remarkable consistency in the characteristics of aquitted defendants and their victims in both periods.
- NGRI (not guitly by reason of insanity) acquittees were older, more often white and more often female than comparable prison populations.
- Victims in all offense categories were almost always family, friends, neighbors and co-workers.
- Of the 278 acquitted defendants, 113 (41 percent) were released through June 30, 1976.
- The average length of stay in DMH facilities for all defendants released was 369 days.
- The estimated average length of stay for the 145 defendants residing in DMH facilities on June 30, 1976 was 962 (2-1/2 years). For the seven defendants still active from the first five year period, the average hospitalization period was 10 years.
- Of the 113 released defendants, one subsequently committed murder. The victims were his aunt and uncle, with whom he lived.

The format of this chapter will be to describe the 53 persons acquitted between April 1, 1965 and August 30, 1971 and the 225 persons acquitted between September 1, 1971 and June 30, 1976 in terms of seven major dimensions: (1) demographic characteristics; (2) prior hospitalizations; (3) prior arrests; (4) offenses on which they were acquitted; (5) victims of the acquitted offenses; (6) course of hospitalizations after acquittal; and (7) in the 1965-1971 group, their criminal activity and hospitalization after release. After we have examined each of the two study groups individually, some of the trends in insanity acquittals over the past decade will be discussed.

The data for both acquittal groups were compiled through the cooperation of the New York State Departments of Mental Hygiene, Correctional Services and Criminal Justice Services. This effort exemplifies the type of project whose importance cuts across the responsibilities of multiple state agencies and demonstrates how their cooperation can lead to research that contributes significantly to policy decisions affecting all agencies involved.

A. Insanity Acquittals 1965-1971

From April 1, 1965 to August 30, 1971, 53 persons were found NGRI in New York courts. This is substantially at odds with the figure of 11 persons found NGRI during the decade of the 1960's reported by Foster and then quoted by Stone.[1] That such a large error could be made and subsequently reported in the professional literature is indicative of the inconsistent and incomplete records kept on the acquittals prior to the current research.

Unfortunately, since New York allows the NGRI defense to be interposed at any point in a criminal trial, it was not possible to determine the frequency with which NGRI pleas were entered. Such determination would require examining transcripts of all criminal cases in New York, a task beyond the resources of the investigators.

1. Demographic Characteristics

Of the 53 NGRI subjects, 43 (81%) were male and 10 (18%) female. Despite the limited number of women, females are over-represented in the NGRI population, for during the same time period 95% of the persons admitted to the state's correctional facilities were male and 5% female.

For both males and females, predominately more whites appear in the NGRI group than in the prison admission group. In the case of men, 65% of the NGRI group are white, 30% are

black, and 5% are Puerto Rican, while the respective percentages for the prison group were 35%, 50%, and 15%. For females, 80% of the NGRI's are white and 20% black, while the corrections population comprises 36% whites, 54% black, and 10% Puerto Ricans.

Also in sharp contrast to prison admissions, NGRI subjects represent an older population, with an age range of 19-67 years. For males, the mean age of NGRI's was 33, while the mean age for the male corrections group was 26. Although 49% of the male NGRI cases were above 30 years old and 28% over 40, only 26% of the incarcerated population were over 30 and 9% over 40. For the women NGRI's, the average age was 37. For female prisoners, mean age was 27. Thus, on all three demographic characteristics examined, the NGRI subjects were significantly different from the corrections group.

2. Prior Hospitalizations

Of the 53 NGRI cases, 19 (36%) had prior psychiatric hospitalizations in facilities operated by New York State. Thirteen were known to have been hospitalized exclusively under civil procedures - ten subjects on three occasions; two on two occasions; and one on three occasions. Two individuals were hospitalized once under a criminal procedure while one subject had been hospitalized under both a criminal

and civil commitment. Three other subjects had also been hospitalized on a single occasion, but the type of hospitalization was unknown. In all, the 19 subjects hospitalized had accumulated a total of 26 admissions: 18 civil, 3 criminal, and 5 of unknown type. Among males, 17 (40%) had been hospitalized for a total of 23 admissions: 17 civil, 3 criminal, and 4 unknown type. Two (21%) of the females had a total of two hospitalizations--one under civil and one under criminal procedures.

3. Prior Arrests

Of the 53 males, 18 had at least one apprehension by police previous to the crime of concern. These varied from nine individuals with one arrest to one subject with nine arrests. The number of arrests for these 18 subjects totaled 44. Fourteen (32%) of the arrests were for crimes against the person; 41% were property offenses; 11% were victimless crimes; 5% were drug offenses; and 11% were for unspecified misdemeanors or violations. One female had a prior arrest, and her alleged offense was arson.

Of the 43 men, only two had served previous terms of imprisonment. One had been convicted of assault and the other of petit larceny. No female had prior incarcerations.

4. Target Crimes

The data reported in Table 1 indicate the most serious crime for which NGRI subjects were tried and the one which resulted in their acquittal by reason of insanity. Crimes against the person constituted the largest offense category for both men (86%) and women (90%). Of the 43 males, 23 (54%) were tried for some type of homicide; 10 (23%) for assault; two (5%) for robbery; one (2%) for rape; and one (2%) for resisting arrest. Property crimes accounted for 12% of the charges against males. Eight of the ten women were tried for homicide, one for robbery, and one for possession of burglary tools.

Table 1

Offenses for Which NGRI Subjects 1965-1971 Tried

	Males		Females		Total	
	N	%	N	%	N	%
Against Person						
Murder	22	51.2	6	60.0	28	52.8
Manslaughter	1	2.3	2	20.0	3	5.7
Assault	10	23.3	0	0.0	10	18.9
Rape	1	2.3	0	0.0	1	1.9
Robbery	2	4.6	1	10.0	3	5.7
Resisting Arrest	1	2.3	0	0.0	1	1.9
Sub-Total	37	86.1	9	90.0	46	86.8
Against Property						
Burglary	3	7.0	0	0.0	3	5.7
Forgery	1	2.3	0	0.0	1	1.9
Arson	1	2.3	0	0.0	1	1.9
Poss. Burg. Tools	0	0.0	1	10.0	1	1.9
Sub-Total	5	11.6	1	10.0	6	11.5
Drugs						
Selling Cont. Substances	1	2.3	0	0.0	1	1.9
TOTAL	43	100.0	10	100.0	53	100.0

5. Victims

In 43 of the 53 cases, the relationship of the offender to the victim was specified in the records. In those cases in which the victim, or lack thereof, was identified, 31 cases (72%) involved persons who were well known to the victim. One offense (2%) involved a person known casually to the offender, and only 11 cases (26%) involved strangers, 3 of whom were police officers. So only 26% of all cases involved crimes against someone unacquainted with the offender. Of those victims known to the patient, members of the immediate family composed the largest victim group: spouses, 5; children, 6; and parents, 6.

Table 2

Relationship of Victim to 1965-1971 NGRI Subjects

	Male		Female		Total	
	N	%	N	%	N	%
Spouse	3	7.0	2	20.0	5	9.4
Child or Children	2	4.6	4	40.0	6	11.3
Parent or Parents	5	11.6	1	10.0	6	11.3
In-Law	1	2.3	0	0.0	1	1.9
Boy or Girl Friend	5	11.6	1	10.0	6	11.3
Acquaintance, Well Known	7	16.4	0	0.0	7	13.2
Acquaintance, Casual	1	2.3	0	0.0	1	1.9
Stranger	7	16.3	1	10.0	8	15.1
Police Officer	3	7.0	0	0.0	3	5.7
No Victim	3	7.0	1	10.0	4	7.6
Unspecified	6	14.0	0	0.0	6	11.3
TOTALS	43	100.0	10	100.0	53	100.0

6. County of Trial

Fifteen of the state's 62 counties produced all 53 insanity acquittals between 1965 and 1971. Generally, there appears to be little relationship between the population of a county and the frequency of NGRI verdicts. Considering the limited number of cases involved (i.e., 53), it seemed reasonable to anticipate that NGRI cases would be concentrated in more populated counties. Although it is true that most cases occur in counties with larger populations, surprising anomalies are noted. Thus, for example, 2 cases occurred in both Chenango and Sullivan counties with respective populations of 46,368 and 52,580, giving these two counties the highest rates per 10,000 population, .43 and .38. Erie County with a 1970 population of 1,113,491 persons contributed 16 NGRI cases for a rate of .14. In contrast, Bronx County, with a population of 1,471,701, had but two NGRI cases for a rate of .01 per 10,000, while Suffolk and Westchester Counties, with respective populations of 1,124,950 and 894,104, had no successful NGRI cases.

7. Hospitalization Following Acquittal

On June 30, 1976, the cutoff date for this research, six (11%) of the 53 subjects remained hospitalized; 47 (89%) had been released, including three from conditional release

status, three from escape status, and one from unauthorized absence status; five (9%) males were on conditional release status; one (2%) was on escape status; and one (2%) was known to be deceased.

Total time that the 40 subjects directly discharged had remained hospitalized ranged from 6 to 3106 days. Specific hospitalization times, by sex and offense category, are given in Table 3. For the six males still remaining on an in-hospital status, four had been acquitted of murder and two of an assault charge. For those acquitted of murder, the total in-hospital stay varied from 1015 to 2698 days.

TABLE 3

Hospitalization Time, in Days, of 1965-1971 Patients Discharged From Hospital Commitment (N-46)

	MALES			FEMALES		
	Days in Hospital			Days in Hospital		
	No.	Range	Mean	No.	Range	Mean
Murder	16	53-3106	1013.00	6	28-1698	825.83
Manslaughter	1	-	446.00	1	-	92.00
Criminal Negligence Homicide	-	-	-	1	-	61.00
Robbery	2	6-262	134.00	1	-	110.00
Possessing Burglary Tools	-	-	-	1	-	191.00
Assault	8	89-1033	391.75	-	-	-
Burglary	3	20-549	249.67	-	-	-
Rape	1	-	42.00	-	-	-
Arson	2	239-1434	836.50	-	-	-
Forgery	1	-	152.00	-	-	-
Selling Drugs	1	-	58.00	-	-	-
Resisting Arrest	1	-	76.00	-	-	-

Examination of Table 3 reveals a strong relationship between the severity of the criminal act and length of hospitalization. The released murder acquittees averaged 1013 days, nearly three years, while those acquitted of assault averaged 392 days and the one of forgery 152 days. Of course, four acquitted murderers were still hospitalized at the end of the research. Although some might be critical of the short period of hospitalization of some subjects, especially those charged with homicide, the results should not prove surprising if it is remembered that, under the philosophy of the NGRI plea, the criterion for release is not that of punishment for a criminal act but rather: (1) remission of symptomatology associated with commission of the act; and, (2) certification that the individual is no longer dangerous.

Table 4 also suggests that females found NGRI are discharged earlier than males, although the limited number of females makes such a generalization not possible at this time.

8. Subsequent Hospitalizations and Arrests

Of the 30 males discharged, only three were later admitted to a state mental hospital. Two males had one subsequent civil admission, and one male had two civil admissions. Among the ten discharged women, three had subsequent

psychiatric hospitalizations, all of a civil nature. Two of these females had one subsequent admission each, while one underwent six hospitalizations.

Following release from hospitalization, no females incurred an arrest. Eleven of the 30 discharged males were apprehended by the police following their discharge. Arrests for this group totaled 34 or an average of 3.1 per person. Frequency of arrests ranged from four persons with one apprehension to a subject with nine post-hospitalization arrests. Reasons for arrests varied from a subject charged with murder and subsequently convicted in another state, to five apprehensions for misdemeanors. Crimes against the person accounted for 26% of the 34 subsequent arrests: murder (1); assault (1); rape (1); robbery (2); endangering a child's welfare (2); and resisting arrest (2). Property crimes constituted 35% of the post-hospitalization apprehensions: burglary (7); grand larceny (2); and possession of stolen property (3). Drug charges accounted for 24% of the subsequent arrests: possession (7); and selling (1). Other misdemeanors contributed 15% of the arrests.

Of the eleven men arrested, six had also been arrested prior to apprehension for the target crime, and, in all, had accumulated eight pre-hospital arrests.

Table 4

Subsequent Arrests of Male NGRI Subjects

	N	%
Against Person		
Murder	1	2.9
Assault	1	2.9
Rape	1	2.9
Robbery	2	5.9
Endanger Child Welfare	2	5.9
Resisting Arrest	2	5.9
Sub-Total	9	26.4
Against Property		
Burglary	7	20.6
Grand Larceny, not auto	2	5.9
Possession Stolen Property	3	8.8
Sub-Total	12	35.2
Drugs		
Possession	7	20.6
Selling	1	2.9
Sub-Total	8	23.5
Other Misdemeanors	5	14.7

Following hospital release, none of the females and three of the males were incarcerated in the state's prison system. One male served two sentences for burglary, one was imprisoned for robbery, and one for arson. For only one of these individuals was the crime for which he was imprisoned (robbery) the same as the crime for which he was acquitted by reason of insanity.

B. Insanity Acquittals 1971-1976

On September 1, 1971, the Criminal Procedure Law went into effect. While this revision did not change the criteria for an NGRI defense, its sequela in relationship to radically revised mandates for the treatment of defendants unfit to proceed to trial led to the development of a maximum security mental hospital within the DMH system that permitted detention different from that possible under the CCP. Thus, September 1, 1971 is an appropriate place to designate a second study group, one which reflects current conditions in New York. June 30, 1976 was selected as the cutoff date since the final data collection was terminated at that time.

In the nearly five years during which this CPL NGRI group was selected, there were 225[2] individuals who were acquitted by reason of insanity in New York. In the last

four months of 1971, there were 15 cases; in 1972, 25 cases; in 1973, 37 cases; in 1974, 55 cases; in 1975, 61 cases; and in the six months studied in 1976, 32 cases.

1. Demographic Characteristics

Of the 225 NGRI cases, 196 (87%) were male and 29 (13%) female. In contrast, during the period September 1, 1971 to December 31, 1975, 96% of admissions to the state adult correctional facilities were men and 4% women, again suggesting a possible over-representation of women in the NGRI population despite their limited absolute number.

Blacks constituted 27% (60) of the 225 NGRI cases; whites, 65% (146); Puerto Ricans, 5% (12); and other ethnic backgrounds, 0.4% (1). In six cases (2.6%), ethnicity was unknown. Comparable ethnicity of prison admissions were 56% black; 27% white; 16% Puerto Rican; and 0.4% other, indicating an over-representation for Caucasians and an under-representation of blacks and Puerto Ricans in the NGRI group as compared to the prison admission group.

NGRI subjects ranged from 16-77 years with a mean of 36. For males, average age was 36 and for females it was 33. Distribution of age did not differ significantly between the sexes. The average age of the prison group was 27. Males had a mean age of 27 years and females had a mean age

of 33. Thus, the male NGRI group represents a much older population than the general criminal population, while the ages of the two groups of women are similar. Whereas criminal activity is typically regarded as "a young person's game" and a preponderance of persons arrested and convicted are in the 15-30 age bracket, 62% of the NGRI group are more than 30 years old and 28% are over 40.

2. Prior Hospitalization

Among the 196 male patients, 109 (56%) had no psychiatric hospitalizations in a facility of New York prior to the arrest date for the crime of concern. Eighty-seven had been hospitalized and accounted for a total of 221 separate hospitalizations. Of these, the type of commitment, whether civil or criminal, was known in 80 cases. Fifty had pre-arrest hospitalizations that were exclusively civil in nature. In all, they totaled 125 civil hospitalizations, ranging from 19 subjects with one prior civil hospitalization to one individual with 14 previous civil hospitalizations. Twelve individuals had been hospitalized pursuant to solely criminal procedures for a total of 19 criminal hospitalizations. The remaining 18 subjects, prior to their target arrest, had been hospitalized under both civil and criminal procedures. They totaled 42 civil and 38 criminal hospitalizations.

In the female NGRI group, 21 (72%) of the 29 subjects had no hospitalizations before their arrest. Seven had been hospitalized previously under civil statutes for a total of 15 hospitalizations. One had been hospitalized civilly on five occasions and twice under criminal provisions.

3. Prior Arrests

One hundred twenty-five (56%) of the 225 NGRI patients had no arrest record prior to the target crime while 100 (44%) had at least one previous arrest. Only five females (17%) had previously been apprehended by the police while 95 of the males (44%) had a prior arrest record. The entire male group, including those without previous arrests, averaged 2.4 arrests while the comparable mean for females was 0.4. For only those 95 males with previous arrests, the mean number of arrests was 5.0 and ranged from 18 men with one arrest to one defendant with 21 prior apprehensions. The five females with prior arrests averaged 2.4 arrests.

The 100 persons previously arrested produced 492 arrests. Of these 492, 9 arrests had been for murder and 1 for negligent homicide. Another 65 (13%) were for assault and 30 (6%) were for robbery. Property offenses were the most frequent previous arrest charges with 152 (31%). Sex crimes were involved in 19 cases (4%). One hundred and sixteen

(24%) were victimless offenses; 40 (8%) were drug law violations; and 33 (7%) were other offenses (possession of weapon or burglar tools and unspecified).

4. Offenses and Victims

Table 5 provides the distribution for the most serious crime for which NGRI subjects were tried. From Table 5, it is apparent that crimes of violence or potential violence against persons, and most specifically some form of homicide, represented the most frequent charge. Thus, for the group as a whole, murder and manslaughter accounted for 133 or 59% of all criminal charges, while assualt, rape, and robbery contributed another 53 or 24% of the cases. With females, the situation is even more stiking with 90% of this group being charged with some type of homicide.

Table 5

Most Serious Crime for Which Persons
Committed Under Section 330.20 Were Tried

	Males		Females		Total	
	N	%	N	%	N	%
Murder	96	49.0	24	82.7	120	53.3
Manslaughter	11	5.6	2	6.9	13	5.8
Robbery	15	7.6	1	3.4	16	7.1
Assault	32	16.3	0	0.0	32	14.2
Kidnapping	1	0.5	0	0.0	1	0.4
Reckless Endangerment	4	2.0	0	0.0	4	1.8
Menacing	1	0.5	0	0.0	1	0.4
Rape	5	2.6	0	0.0	5	2.2
Sexual, Other	5	2.6	0	0.0	5	2.2
Endanger, Child Welfare	1	0.5	0	0.0	1	0.4
Arson	12	6.1	2	6.9	14	6.2
Weapon Possession	1	0.5	0	0.0	1	0.4
Burglary	4	2.0	0	0.0	4	1.8
Escape, Absconding	3	1.5	0	0.0	3	1.3
Possessing Forged Instrument	1	0.5	0	0.0	1	0.4
Criminal Mischief	1	0.5	0	0.0	1	0.4
Motor Vehicle Violation	1	0.5	0	0.0	1	0.4
Crim. Selling Cont. Subs.	2	1.0	0	0.0	2	0.9
Total	196	100.0	29	100.0	225	100.0

A comparison with the prison admission group in respect to criminal charges is relatively meaningless, because the NGRI population was almost uniformly tried for the crime for which they were arrested. On the other hand, crimes for which the inmate group were tried and convicted most typically represented the termination of a plea-bargain process in which the initial charge is often reduced drastically.

In 103 cases (71%) of the 146 in which there was a victim identifiable from the information in hospital records, the victim was known to the patient prior to the crime. In this category of previously known victims, members of the patient's family constituted the largest target group: children - 13%; parents - 12%; spouses - 10%; other relatives - 3%; and in-laws - 3%. By far, the most frequent victims of females were their progeny (57%), and this mainly the result of infanticidal acts. Other victims known to the victim included: well-known acquaintances - 12%; boy or girl friends and/or members of their family - 2%; co-worker - 2%; employer 1%; and, casual acquaintances -5%. Stangers, other than police officers, constituted 20% of the victims. Law enforcement officers represented an identifiable target group (7%). In all but one case, the officer became a

victim while pursuing his official duties. However, one case involved the slaying of an officer by a fellow patrolman.

Table 6

Relationship of Victims to Patient in Cases Where Victim-Patient Relationship was Specified (N=163)

	Males		Females		Total	
	N	%	N	%	N	%
Spouse	14	10.4	2	7.1	16	9.8
Child or Children	5	3.7	16	57.1	21	12.9
Parent or Parents	17	12.6	2	7.1	19	11.7
Other Relative	5	3.7	0	0.0	5	3.1
In-Law	5	3.7	0	0.0	5	3.1
Boy or Girl Friend	2	1.5	1	3.6	3	1.8
Relative or Girl Friend	1	0.7	0	0.0	1	0.6
Employer	2	1.5	0	0.0	2	1.2
Co-Worker	3	2.2	0	0.0	3	1.8
Acquaintance, Well Known	18	13.3	2	7.1	20	12.3
Acquaintance, Casual	8	5.9	0	0.0	8	4.9
Stranger	29	21.5	3	10.7	32	19.6
Police Officer	11	8.1	0	0.0	11	6.8
No Victim	15	11.1	2	7.1	17	10.4
Total	135	100.0	28	100.0	163	100.0

5. County of Trial

Table 7 lists the frequency of NGRI acquittals by county during the study period, as well as the rate of the plea (per 10,000 population) for each county.

Table 7

Frequency and Rate per 10,000 Residents,
of Successful NGRI Pleas by County

County	Population[1]	No.	Rate
Albany	286,742	18	.63
Steuben	99,546	4	.40
Erie	1,113,491	39	.35
Genesee	58,722	2	.34
Chautauqua	147,305	4	.27
New York	1,539,233	38	.25
Ontario	78,849	2	.25
Wayne	79,404	2	.25
Cattaraugus	81,666	2	.24
Broome	221,815	5	.23
Franklin	43,931	1	.23
Allegany	46,458	1	.22
Delaware	44,718	1	.22
Dutchess	222,295	5	.22
Columbia	51,519	1	.19
Sullivan	52,580	1	.19
Montgomery	55,883	1	.18
Putnam	56,696	1	.18
St. Lawrence	111,991	2	.18
Monroe	711,917	12	.17
Madison	62,864	1	.16
Herkimer	67,633	1	.15
Onondaga	472,746	7	.15
Clinton	72,934	1	.14
Ulster	141,241	2	.14
Tompkins	76,879	1	.13
Oswego	100,897	1	.10
Suffolk	1,124,950	11	.10
Queens	1,986,473	18	.09
Oneida	273,037	2	.07
Richmond	295,443	2	.07
Bronx	1,471,701	9	.06
Nassau	1,428,080	8	.06
Kings	2,602,012	13	.05
Orange	221,657	1	.05
Niagara	235,720	1	.04
Westchester	894,104	4	.04
All Others			.00

1. 1970 Census

As can be seen, the rate of successful NGRI pleas varies widely among counties.[3] In 25 counties, there were no successful pleas. There was no significant association between county population and successful NGRI rate. For example, the highest rates occurred in Albany (.63, 286,742 population) and Steuben (.40, 99,546 persons). In like manner, New York and Kings Counties, both heavily populated, had respective rates of .25 and .05.

Unfortunately, the manner in which New York criminal justice data are compiled does not permit the computation of NGRI rates based upon arrest, indictment, acquittal and dismissal data for each county. If, however, it can be assumed that the typical pattern of urban, suburban and rural crime prevails in New York, a reasonable inference can be drawn that high NGRI rates do not necessarily occur in counties having high arrest and indictment rates. Again, unfortunately, the mode of compilation of criminal justice data in New York does not permit a direct analysis in a manner comparable to that of Pasewark and Lanthorn,[4] who found that frequency of the insanity plea in Wyoming was unrelated to either population magnitude or density but was inversely related to the arrest and indictment rate within a county. Thus, the more brisk the criminal justice business in a county, the less likely it was that the NGRI plea would

be entered. Additionally, they found the plea to be more powerful than commonly supposed in that a larger proportion of NGRI defendants had their indictments dismissed than did persons not entering the plea.

The variable rate of NGRI's among New York counties tends to suggest the possibility that the appropriate legal statutes concerning the plea are not applied uniformly throughout the state. Although present data do not permit determination of reasons for the differential rate observed, a number of considerations warranting investigation include: (1) differences in arrest and indictment rates; (2) the presence of judges, prosecutors and/or defense counselors from given counties who harbor a strong orientation toward a psychodynamic explanation of behavior; or, (3) the presence of articulate groups of psychiatrists who serve as expert witnesses in particular counties. In any event, the differential rate of successful NGRI pleas among counties should be noted when considering the wisdom of altering the statutory language governing the plea if a goal of such change is to ensure uniform and consistent application of the law.

6. Hospitalization Following Acquittal

On June 30, 1976, the cutoff date for this research, 133 patients (59%) remained hospitalized and 67 (30%) had received complete discharges, including two from conditional

leave status, three from absent without leave status, and three from escape status. Two (0.9%) were in a family care program; 8 (4%) on conditional release; and 1 (0.4%) on leave over 60 days. Three had escaped and two were absent without leave. Nine patients (4%) were deceased, a fairly high mortality rate for persons of this age group. Of these, five were known to have committed suicide.

Time in days of 330.20 hospitalization by offense category for the 67 persons discharged by June 30, 1976 is given in Table 8. Times were quite variable, ranging from 1 to 1235 days, both cases involving murder. Hospitalization times do not seem specifically related to the severity of the offense, as would be expected when criteria for discharge are recovery from the mental state leading to the NGRI adjudication and lack of dangerousness rather than punishment for the commission of the criminal act.

Table 8

Hospitalization Time, in Days, of Persons
Discharged from 330.20 Commitment (N=67)

	Male				Female			
	No.	Range	Mean	Median	No.	Range	Mean	Median
Murder	23	1-1235	278.48	218.00	8	56-621	245.62	304.00
Manslaughter	2	143-160	151.50	169.00	-	-	-	-
Robbery	3	14-160	104.67	140.00	1	-	62.00	62.00
Assault	14	33-639	332.29	371.00	-	-	-	-
Reckless Endanger	2	78-91	84.50	84.00	-	-	-	-
Burglary	2	154-201	177.50	299.00	-	-	-	-
Arson	3	45-141	93.33	94.00	-	-	-	-
Sexual Abuse	3	36-614	256.33	199.00	-	-	-	-
Poss. Weapon	1	-	863.00	863.00	-	-	-	-
Driving, Intoxicated	1	-	7.00	7.00	-	-	-	-
End. Welfare Child	1	-	322.00	322.00	-	-	-	-
Criminal Mischief	1	-	71.00	71.00	-	-	-	-
Escape	1	-	39.00	39.00	-	-	-	-
Absconding	1	-	94.00	94.00	-	-	-	-

Work is now underway to examine the arrest and re-hospitalization rates of these persons acquitted by reason of insanity under the CPL. Preliminary indications suggest that they are arrested less often than comparable groups of felons and felony defendants incompetent to stand trial.

7. Comments

From the prior and current hospitalization and criminal records of the NGRI subjects, it appeared that those individuals determined NGRI comprise a number of sub-groups which include individuals who are neither medically psychotic nor legally insane. Most noteworthy of these sub-groups are two particular occupational categories with which society seems to invest special status -- mothers and police officers. In the CCP study group, there were four mothers who killed their children, while among the CPL study group, of 28 female NGRIs, 16 had been tried for infanticide. While from psychiatric reports, it is apparent that some of these mothers were grossly insane at the time of the infanticidal act (e.g., believed child was turning into evil beings), there are others whose primary difficulty seemed to be one of personal inadequacy and, more specifically, an inadequacy in the wife-mother-homemaker roles, with resulting stress. Basically, it is our belief that society, in its desire to preserve an illusion of "mother love", is hesitant to care-

fully scrutinize the mother-child relationship and recognize realistically that the most reasonable target for a mother's frustration and anger is her child. Instead, to preserve our illusions about "mother love", we categorize women who murder their children as "insane".

A comparable situation also seems to prevail with respect to the law enforcement officers. In the CCP study, one of 43 male NGRI's was a police officer while three of 169 males found NGRI from 1971 to 1976 were policemen. Charged with the noble task of protecting society, the policeman is provided with weapons and authority. Yet, in doing this, we are reluctant to accept the increased probability of the policemen to utilize such weapons and authority when confronted with a personal problem situation. Thus, in this series of cases, an officer killed a woman with whom he was conducting an extra-marital affair and who had been "making too many demands" upon him. A review of the 1971-76 cases involving policemen suggests similar circumstances regarding the crime of concern (e.g., slew fellow officer in drinking argument; killed homosexual lover in fear that lover would report affair to authority). Additionally, it is also probable that those concerned with the trial of law enforcement officials display a reluctance to place police officers in prison with their former felon enemies and

instead, shunt them from the criminal justice system to the safer mental hospital.

We also believe that as we continue our investigations of the NGRI plea, we shall find two other sub-groups. The first of these we tentatively label the "I-can-feel-sorry-for-you" subject. These are individuals with no previous psychiatric or criminal history, whose crimes appear reactive to an immediate stressful situation - for example, a young man who, feeling ugly and uncertain of his masculinity, decided to rape a female, and after much vascillation committed the act.

Another sub-group of questionable "insane status" in our population appears to be "persons of respectability" for whom citizens can feel considerable empathy. Among this group were, for example, a professional who, hounded by racketeers for debts from compulsive gambling losses, committed robbery, and a bumbling, uncertain middle class youth rebuffed by female contemporaries who committed rape to determine whether he could, in fact, have an erection and ejaculation with a woman.

Basically, these latter classes of individuals, as well as the differential rate of successful NGRI pleas among counties, cause us to question seriously whether the particular language of a given statute governing the insanity plea

is the deciding factor in whether or not a person is so adjudicated. Instead, it seems more reasonable to us that more "humane", less legalistic variables are operative and that, whatever the law might be, these factors will continue to operate.

1. Foster, NYU Colloquium: President Nixon's Proposal on the Insanity Defense, 1 J. Psychiatry & Law 297 (1973).

2. This group of 225 includes two individuals who may not have been found NGRI by the courts, but who were committed to and detained in DMH facilities under section 330.20 of the Criminal Procedure Law. One robbery defendant was acquitted on October 17, 1974, but that order was rescinded on November 4, 1974 when the court noted that it had inadvertently acquitted by reason of insanity when it should have found the defendant unfit to stand trial. Although a confused order rescinding the 330.20 commitment was transmitted to DMH, the defendant was admitted under Section 330.20 and was so retained on the hospital records until his death in November, 1975. A second case involved a defendant charged with a motor vehicle offense who was also admitted under 330.20 and detained for a couple of days before being shifted to a voluntary alcohol status. The patient was admitted as a 330.20 case and is included in the study group, although certainly it is an atypical case.

3. The vast differences between Albany County and the rest of New York should be noted in the context of the study of the increased frequency of insanity acquittals reported by Grunberg and colleagues [Grunberg, Klinger, Grumet, Homicide and the deinstitutionalization of the mentally ill. 134 Amer. J. Psych. 685-687 (1977)]. Albany County is so atypical that any inferences drawn from these data, particularly when they are so global as these investigators', should not be generalized to the rest of New York.

4. Pasewark & Lanthorn, Disposition of Persons Utilizing the Insanity Plea in a Rural State, J. Humanics (in press).

Chapter 3

Perceptions of the Insanity Defense

Nancy M. Burton and
Henry J. Steadman, Ph. D.

Introduction

The New York State Department of Mental Hygiene and the Division of Criminal Justice Services surveyed legal professionals across the state to obtain information on the use of the insanity defense.

From the responses to the 293 returned questionnaires, it appears that the main problems legal professionals have with the defense center on poor statutory definitions and vagueness in the law which cause its uneven application; perhaps as a result of this vagueness, a lack of understanding of the law by juries and the public; reliance on psychiatric testimony which is imprecise, superficial and usually rendered by the same experts; and the perceived lack of judicial review over the release of acquitted defendant/patients to the community by the Department of Mental Hygiene. It is felt by the respondents that the insanity defense is used predominantly for murder and other violent crimes, that it is used infrequently, often without a jury, and that it is usually unsuccessful. The respondents do not wish to see elimination of the defense, but would prefer changing to a

"Guilty, but Insane" statute, or a bifurcated trial mechanism. These two options would change the role of psychiatric testimony and might more frequently commit the defendant to a correctional facility, where his release would not be determined by the Department of Mental Hygiene.

A number of questions about the functioning of the insanity defense have been left unanswered by the previous chapter. Data has been reported which indicate how often the insanity defense has been successful, but not how often the defense is attempted. It has been suggested from prior research that the statute has been unevenly applied across the state, but there is no information about legal professionals' differential use of the NGRI defense. There was no data reported on what lawyers, district attorneys, and judges view as the major problems which legal professionals have with the insanity defense, although there seems to be chronic dissatisfaction with it.

To obtain answers to these questions about the perceptions of the functioning of the insanity defense, the New York State Department of Mental Hygiene and the Division of Criminal Justice Services jointly administered a survey to legal professionals across the state. In addition to determining how the insanity defense works statewide, the intent of the research was to discover the primary problems legal

professionals have with the defense, perceptions of how often and in what situations the NGRI defense is used, impressions of the time defendants spent in mental hygiene facilities after acquittal, and the desirability of change in the current statute.

Approximately 1,000 questionnaires on the insanity defense were sent to a sample of the 5,000 subscribers to the Criminal Law Review, published by the New York State Division of Criminal Justice Services. Roughly 30% of the questionnaires were sent to defense attorneys, 40% to district attorneys and 30% to judges. Thirty-five percent of the questionnaires were returned, of which two hundred and ninety-three were usable. Thirty-one percent of the usable questionnaires were answered by public defenders and private attorneys, 38% were answered by D.A.'s, 22% were returned by judges, and 10% were returned by those who were some combination of attorney, public defender or D.A. and by those who did not indicate type of position held. Thus, the sample population of 293 quite closely approximates the population to which the questionnaires were sent.

This group of respondents may be over-represented by those who have more experience with the NGRI defense or by those with strong views on its use. The somewhat low response rate may indicate that those who did return the questionnaire

were more motivated to do so by their firm opinions on the insanity defense. Also, 87% (46 out of 53) of the unusable questionnaires were returned by attorneys and judges who felt that they didn't have enough experience with the statute to give accurate answers to the questions. The non-respondents, therefore, may be those who have either no experience with the statute, or no opinions on its use.

The respondents' practices were quite evenly divided between the four major geographic areas of the state. Thirty-five percent are from New York City, 26% from suburban New York City, 22% from upstate cities and 17% from rural areas upstate. Private attorneys were disproprortionately from N.Y.C., and rural upstate areas had an over-representation of public defenders. The mean number of years in the bar for the sample was 16 years. As expected, 91% of the D.A.'s had fewer than 16 years, while 93% of the judges had more than 16 years in the bar.

A. How the Defense is Working

Only 14 out of 239 respondents (5%) felt that the insanity defense worked very well statewide. The respondents were almost evenly split between thinking that the defense works fairly well (34%) and fairly poorly (40%). Nearly 21% of the respondents felt that it worked very poorly. When

the responses are broken down by type of position held, it appears that judges are most favorable: 58% feel that the insanity defense works very well or fairly well statewide. In contrast, only 21% of the public defenders and 39% of the D.A.'s think that it works very well or fairly well.

TABLE 1

How Does Insanity Defense Work Statewide	Judges	Atty's	DA's	Comb.	Pub. Def.
Well, Fairly well	32 (58.2)	23 (37.7)	33 (37.1)	7 (42.1)	5 (20.8)
Fairly poor, Poor	23 (41.8)	37 (62.3)	56 (62.9)	15 (57.9)	19 (79.2)

The main reasons given for dissatisfaction with the insanity plea were: a lack of understanding of the statute on the part of juries or the public (15%); poor statutory definitions and vagueness of the law which casue its uneven application (15%); medical testimoney which is incompetent, superficial or conservative, which is always given by the same experts, or which pits one expert against another in a "battle of the experts" (15%); and preconceived ideas about the acquittal by reason of insanity letting defendants out too soon (13%). Less often mentioned criticisms of the insanity defense included a lack of understanding of the statute by judges, lawyers or doctors, the confusion of

medical and legal issues under the statute, and inadequate treatment and inadequate detention institutions for mentally ill defendants. Thirteen percent had no criticism, feeling that the plea was used appropriately or provided appropriate safeguards for the defendant. It seems, then, that dissatisfaction with the insanity defense is caused by poor statutory definitions which in turn make it difficult for the public, juries, or legal professionals to understand how the law works. The statute also requires psychiatric testimony which the respondents feel is imprecise, superficial, and usually rendered by the same experts. (Eighty-six percent of the respondents felt that there is a tendency to use the same expert witnesses in insanity cases in their county or judicial district.)

When asked for their opinions on the major problem with New York State's insanity defense statute, the respondents echoed this dissatisfaction. Poor statutory definitions (20%), superficial and incompetent medical testimony(19%), and preconceived ideas about the defendant "getting off" (17%) were the main problems cited. When asked to name what they considered the best or most <u>beneficial</u> feature of the insanity defense, 30% of the respondents answered "none". Twenty-eight percent felt that it protects the mentally ill defendant and 27% felt that the statute was appropriately limited or strict.

B. How the Defense is Used

While the previous chapter presented comprehensive data on actual insanity acquittals, there is no information available on the use of the plea. Therefore, the respondents were asked a series of questions on how the plea is used in their county or jurisdiction. Eighty percent of the respondents felt that there are specific offenses for which the insanity defense is used particularly often. Murder was cited most frequently (60% of the offenses cited). Other offenses cited were assault (10%), arson(6%), sex crimes (6%), manslaughter(5%), and other crimes, which included family offenses, drugs, and other felonies not in the above categories, (5%).

These estimates are very close to the actual percentages of crimes for which people were tried and acquitted under the N.Y.S. insanity statute reported in the previous Chapter. Between 1971 and 1976, murderers accounted for 53.3% of the NGRI acquittals, those who committed assault accounted for 14%, arsonists were 6.2% of the NGRI population, and those who committed manslaughter accounted for 5.8% of the NGRI acquittals. Rapists and other sex criminals together accounted for only 4.4% of the NGRI acquittals, so that the respondents to the survey over-estimated by 250% the occurrence of the defense for those crimes (11%). Almost 9% of the NGRI

acquittals were for robbery or burglary, but the estimate given by the respondents to the survey was only 3%.

The main reasons why the respondents felt that the insanity defense was used frequently in cases involving murder, assault, arson, etc., were that the crimes necessarily imply a mental disorder or irrationality (40%), and that the defendant receives a better sentence given the seriousness of the crime for which he is being tried (25%). Another 14% felt that the insanity defense was only used when the prosecution case was very strong and insanity was the only defense.

The respondents were asked for their estimate of the percentage of successful pleas of insanity that are the result of a nonjury trial. For the population as a whole, the mean estimate was 37% and the median was 20.3. The large standard deviation of this variable (38.8) and the large difference between the mean and median indicate that there is wide variation among the estimates. The estimates ranged from 0% (26% of the sample) to 99% (8% of the sample). This perhaps shows the differential use of the statute statewide among counties or else tremendous misinformation. Estimates varied dramatically by the area of practice of the respondent. Respondents from upstate urban areas estimated that 53.8% of successful insanity pleas are the result of a

non-jury trial. Those from New York City estimated 37%, those from upstate rural areas estimated 28.4% and those from the surburban areas around New York City estimated 23%. Given the accuracy of the respondents' estimates on offenses involving insanity pleas, one would have to take these reports on non-jury trials as usable estimations.

Estimates of the percentage of criminal cases in which the insanity defense is raised in the county or judicial district of the respondent ranged from 0% to 50%, with a mean of 4.8% and a median of 2.4%. Estimates of successful pleas of insanity ranged from 0% to 99%, with a mean of 22.1% and a median of 5.5%. Since the mean is much more sensitive to extremes, the large difference between the mean and the median shows a wide range in responses, and shows a perception of uneven application of the statute statewide.

As a whole, the respondents seem to perceive the NGRI defense as one used infrequently, often without a jury, and one which is usually unsuccessful.

C. Perceptions of Acquittal and Release

To assess their opinions on what happens to the defendant at the end of the trial, the respondents were asked questions about their perceptions of the ease of acquittal, the length of time spent hospitalized, and the release to the

community of the NGRI defendant. Twenty-five percent of the respondents felt that it was too easy, and twenty-five percent felt that it was too difficult to be acquitted under the New York State insanity defense statute. Almost one-half felt that an acquittal was neither too easy nor too difficult, but "about right". When responses are broken down by type of position of the respondent, some substantial differences emerge. Almost half (45%) of the D.A.s feel that it is too easy to be acquitted, while 60% of the attorneys and 65% of the public defenders think that it is too difficult. Seventy percent of the judges feel that it is about right.

Table 2

How Easy Is It To Be Acquitted	DA's	Comb.	Judges	Atty's	Pub. Def.
Too Easy	44 (45.4)	5 (29.4)	11 (19.0)	3 (5.1)	1 (4.3)
About Right	49 (50.5)	6 (35.3)	41 (70.7)	21 (35.6)	7 (30.4)
Too Difficult	4 (4.1)	6 (35.3)	6 (10.3)	35 (59.3)	15 (65.2)

At the other end of the dispositional process, seventy-four percent of the respondents felt that the current standards of release of NGRI defendants from Mental Hygiene facilities were too lax. Although most of the respondents felt that current release standards are too lax, the responses varied widely among the groups of legal professionals. D.A.'s and judges were most critical, with 90% of the D.A.'s and 79% of the judges feeling that release standards are too lax, compared to sixty percent of the public defenders and 52% of the private attorneys.

Half of the respondents felt that the committing court should make the decision about release of the acquitted person to the community, while two-fifths of the respondents felt that the decision to release an acquitted defendant should rest with some combination of the committing court with expert psychiatric testimony, with advice of the Commissioner of Mental Hygiene or the hospital director, or both, or with a committee including laymen. What is most apparent from these responses is the dissatisfaction with current procedures for release of these defendant/patients. Very few of the respondents felt that the decision should rest with only the hospital director (4%) or the Commissioner of Mental Hygiene (8.3%).

CONTINUED

1 OF 2

Fully 70% of the respondents felt that the time spent in hospitals by these acquitted defendants is much shorter than if they had been convicted. From the data in the previous chapter, it would appear at first glance that this perception is a correct one. At the conclusion of the research, 67 of the 225 had been released, leaving three-quarters of the study group still hospitalized at the end of the study period. For example, the three released robbers had been hospitalized for an average (median) of 140 days. While this is indeed much less than the maximum sentence for Robbery 1°, this comparison is perhaps an inappropriate one. If these NGRI defendants had traveled through the criminal justice system the way 92% of felons do in New York State, their conviction charge would have been plea-bargained down to a lesser one. These figures on time spent hospitalized also do not include the other ten NGRI robbers who are still in the hospital, whose time continues to accrue. Also, maximum sentences are not always given. Thus, it is nearly impossible, given the criminal justice and research data available at this time, to assess whether or not NGRI defendants spend less time or more time hospitalized than they would spend behind bars if convicted. It is clear, however, that many totally inappropriate comparisons are made both by legal professionals and the public.

Thus, from these responses to the questions about how the respondents feel the current New York insanity defense statute is working, it appears that a majority of the legal professionals surveyed are fairly dissatisfied with the statute. Their criticisms center mainly on poor statutory definitions so that application of the statute is uneven; a lack of understanding of the law by juries and the public; the problems of including mental health professionals in courtroom procedures; and the problems posed by a perceived lack of judicial review over the release of the acquitted defendant/patient to the community by the Department of Mental Hygiene.

D. Options for Change

Respondents to the questionnaire were asked a series of questions about how they would like to see the New York State insanity defense statute changed. The options given were: (1) shifting the burden of persuasion of finding insanity from the prosecution to the defense; (2) substituting a standard of diminished capacity; (3) introducing a bifurcated trial mechanism to first determine whether the crime was committed and second to determine penal or non-penal disposition; (4) introducing the verdict of "guilty, but insane" with mental health treatment in the penal system; (5) eliminating the insanity defense completely from the criminal process; and (6) no change.

Table 3

A number of suggestions have been offered for revising New York's insanity defense, some of which are currently operative in other jurisdictions. For each of these possibilities, respondents were asked to indicate, by placing the appropriate number on the line next to each suggestion, whether each is:

1. Very desirable
2. Somewhat desirable
3. Neutral
4. Somewhat undesirable
5. Very undesirable

MEAN	
2.9	a. Shifting the burden of persuasion required to permit finding of NGRI from the prosecution to the defendant.
3.4	b. Substituting the standard of diminished capacity for the lack of criminal responsibility as a result of mental disease or defect.
2.5	c. Introducing a bifurcated trial mechanism to first determine whether act was committed and second to determine penal or non-penal disposition.
2.2	d. Introduce the verdict of "Guilty, but Insane" with mental health treatment required in the penal system.
4.1	e. Eliminate the insanity defense completely from criminal process.
3.9	f. No change.

The table above shows the mean of the responses to the six options. The higher the mean, the less desirable the option. The least favored change is that of eliminating the insanity defense completely. "No change" in the statute is also found to be undesirable. While it appears that the respondents would not like to see the insanity defense completely eliminated, they would like to see it modified. The favorable responses to

the other options showed a preference to reduce the importance of psychiatric opinions in determining guilt or innocence or in the final disposition of the case. The most favored alternative was that of introducing the "guilty, but insane" verdict with mental health treatment in the penal system. This option would change the role of psychiatric testimony in the determination of guilt and would remove the defendant from the jurisdiction of the Department of Mental Hygiene upon conviction. Whether this option would seem to neatly eliminate some of the major criticisms of the statute made by the respondents, including the problem of the defendant's release to the community by the Department of Mental Hygiene, remains unclear.

The second most favored option was that of the bifurcated trial mechanism. Again, this might eliminate psychiatric testimony about guilt or innocence, and would provide a second trial to consider the mental status of the defendant and whether or not he could be treated best within the penal system or the mental health system. Contrary to other opinion areas, there were few differences between the five groups of legal professionals in their responses to these two options. However, there were differences in responses to the option of diminished capacity.

Table 4

Substituting Diminished Capacity	Pub. Def.	Atty's	Judges	Comb.	DAs
Very, somewhat desirable	17 (70.8)	37 (64.9)	15 (25.0)	5 (25.0)	18 (17.3)
Neutral	1 (4.2)	9 (15.8)	10 (16.7)	4 (20.0)	14 (13.5)
Somewhat, very undesirable	6 (25.0)	11 (19.3)	35 (58.3)	11 (55.0)	72 (69.2)

Seventy-one percent of the public defenders and 65% of the private attorneys found this option very or somewhat desirable, compared to 42% of the judges and 31% of the D.A.'s. This defense, which is a guilty plea to a lesser included offense, would remove psychiatric testimony from the determination of guilt or innocence, since the defendant is, in fact, admitting that he committed the crime. Perhaps attorneys and public defenders feel that this standard of diminished capacity would be an easier legal defense to argue successfully, and one which would net the defendant a shorter sentence than if he were convicted of the original charge.

E. Comments

In spite of the problems they saw with the insanity defense, few respondents felt that it should be eliminated from New York criminal law. The felt that it should be modified so that it still protects the rights of the defendant while removing the ambiguity and vagueness of psychiatric testimony from the determination of guilt or innocence. The most favored alternatives to the current law were a "Guilty, but Insane" plea and a bifurcated trial mechanism. Both alternatives would alter the role of psychiatrists in the determination of criminal responsibility. In the former case, the defendant would plead guilty to the crime and psychiatric testimony would only be used to assess the need for psychiatric treatment within the penal system. In the latter, psychiatric testimony would be used only to determine whether the defendant could best be treated within the correctional system or the mental health system after a determination of guilt.

Both of these alternatives might also reduce the number of insane acquitted defendants to be treated by the Department of Mental Hygiene. After a successful plea of "Guilty, but Insane", treatment would be given within the penal system. In a bifurcated trial, the defendant/patient's mental status would be assessed to see if he could be successfully treated within the penal system. Fully half the sample felt that the committing

court and not hospital directors or the Commissioner of Mental Hygiene should have the final say in the release of an acquitted person. Either of these two options for change would tend to remove the defendant from the purview of DMH and keep him within the penal system. There the length of time the defendant is kept incarcerated depends on the crime he has committed, the sentencing judge and a parole board. This would address the objections raised by our respondents who apparently were unhappy with the criteria for release from DMH facilities which are based on the absence of a treatable mental illness and on a lack of dangerousness to oneself or others. With such decisions ultimately based on the concept of dangerousness, they are necessarily based on vague and ill-defined criteria and therefore must remain unsatisfactory to the legal community and in many cases to the public.

Chapter 4

Reflections on the Insanity Defense

Lawrence C. Kolb, M.D.

Introduction

The insanity defense came into being at a time when knowledge was lacking of both conscious and unconscious forces conducive to healthy personality development. The appearance of the insanity defense was expressive of the dawning recognition of the impairing consequences of mental disease and defect as related to specific individuals' capacity to conform to social codes. As such it represented a compassionate and humanitarian move which allowed escape from the death penalty. It typified the then revolutionary effort toward civil rights that characterized the late 18th and 19th centuries and the initiation within Western society of more equitable standards of justice recognizing each person as an individual with particular variations in the capacity for social responsibility.

Today, the insanity defense demands reassessment in terms of its effects upon society, individuals, and the psychiatric profession.

A. Effects Upon Society

Origins of Social Values

From the first dawnings of social organization, customs, moral codes, and later laws were established by groups to control the innate aggressiveness of mankind so as to defend the cohesion of the families, groups, and later societies. In the laying down of these social control mechanisms, there came about the application of varieties of punishments and deprivations upon the individuals who violated the codes of their social group. Such codes were transmitted through the family group as they attempted to guide the development of their growing children and to inculcate in them methods of adaptation into the society wherein they were to live as adults. It was these punishments and advices given in the family group which led to the development of man's conscience or, as is known in psychoanalytic circles, his superego, approximately 4,000 years B.C. Darwin regarded this development as one of the most significant in man's evolutionary progress.

It is now widely accepted amongst personality theorists that the establishment of conscience occurs first in the transactions which take place in family life. The absence of parents to serve as models for identification and to

provide advice, tutoring, admonishment or punishment open the potential for antisocial behavior in the child deprived of their influence. Support for these conclusions of the effects of parental deprivation in opening the potential for later antisocial behavior comes from the studies of thousands of developmental histories of criminals and delinquents conducted over the last 50 years by psychiatrists, psychologists, psychoanalysts and others. The number of variations in human nurturing that allow for aggressive behavior toward others or toward property have been reported in the scientific literature.

Beyond the primary influence of family transactions as a means of instilling the control of agression and associated violence existing in all societies, there are the secondary but equally important reinforcing institutions within these societies -- the precepts taught by religious groups and the precepts required to achieve membership in a variety of groups proffering personal support or prestige. Above all these, however, is the reinforcing value system of the codes of law which defines limits of aggression allowable against others and against property in each society. Beyond these codes are the operations of the instruments of the society established to find and detain those who violate the laws; the processes of judging the occurrence of each alleged

violation; and the prison and probationary systems established to provide appropriate detention, punishment, and supervision for those found guilty of violations.

In those societies where both family life and the societal institutions are well established and are constant in their function, antisocial aggressivity of all kinds, including violent and destructive behavior, are well contained. Antisocial expressions of self-centered aggressivity become more evident where the family life is tenuous and children are deprived of healthy parental guidance or where the institutions of the society are defective in their reinforcing the precepts of conduct as first ingrained in family transactions.

There exists now much evidence of growing disrespect for the law and of increasing violence practiced by citizens against both men and property. The explanations for this increasing disrespect for the law are many. One explanation is the failure on the part of those in positions of political preeminence to provide the sustaining force of their own strict adherence to the law and prevailing moral codes. Such failures lead to either a breakdown or contempt for the law amongst the young who interpret hypocrisy in those sworn to uphold it. Passage of laws that cannot be enforced due to biological and cultural factors mocks justice by over-

whelming the system with absurd numbers of offenders and making ineffective the agents of enforcement, the courts and the correctional institutions. The action of courts when judgment of heinous acts is mitigated excessively and perceived by the public as allowing the individual to escape punishment is another. Thus, the national or state conscience or superego is publicly damaged. The public at large, as well as some of those who are responsible for the development of children and adolescents, then derogate the system of justice and tend toward increasing permissiveness in the hopeless abrogation of their responsibilities in sustaining the laws and moral codes.

The public outcry today at this erosion of the law and its operations is blatant in our society in protest to the perceived inequities in the administration of justice. One particular focus of the public protest is the insanity defense.

Maintenance of Social Values

The harm done to the laws of society through the use of the plea "not guilty by reason of insanity" and its implied permissiveness for violent and other crimes may be mitigated by abrogation of the defense.

In the opinion of this writer, courts should render a clear judgment as to whether an accused has committed the

alleged criminal act or not. The matter of determination of existence of mental illness in the individual or individuals accused at the time of the act should be excluded completely as evidence with the trial concerned only with the judgment of the act. Furthermore, each court should determine an appropriate sentence in terms of length of confinement of the individual found guilty irrespective of the existence at the time of the crime or thereafter of mental illness.

The public presentation of a clear affirmation of guilt or non-guilt would do much to sustain the faith of citizens at large in the rectitude and equity which should exist in all social bodies in their efforts to sustain justice under the law. The public perception of the state's superego would be strengthened. There would emerge a new respect for the operation of the criminal justice system, the courts, lawyers and the mental health profession as well.

Yet it would be possible to provide for the guilty persons who suffer from impaired congnitive capacity due to psychiatric disorder or mental retardation by disposition to an appropriate thereapeutic or habilitative setting. My suggestion is that only following sentencing should the legal system allow the testimony of psychiatrists and other mental health professionals pertaining to the existence of mental illness or mental retardation or personality disorder.

After assessing the relevance of such testimony, the court could then make a determination as to the most appropriate institutional facility (prison, psychiatric center or developmental center) where the individual would serve out his sentence, should confinement be necessary.

A variety of additional salutary effects would follow in the conduct of a trial of those who presently plead not guilty by reason of insanity, in addition to that of supporting the public superego.

The likelihood of malingering of psychosis would be lessened as the party adjudged guilty would realize from the beginning that a determination of his sentence would be made by the court. Also, in New York State today with the current operations of the Department of Mental Hygiene through its newly established mental health centers in the prisons, assurance exists of availability of treatment in prison or through the facilities of the mental health system no matter what the judgment.

Another potential advantage to the delivery of criminal justice in this way is the potential for further acting humanely in protecting the health of the individual adjudged guilty. It would make possible the recognition of other processes than psychosis in determining the commitment of criminal activity. It has long been recognized that certain

neuroses lead to repetitive forms of aggressive and sexual acting out. Their correction demands treatment in a facility capable of providing such, rather than incarceration in jail with those not so suffering. As to the individuals with personality disorders, the vast majority of psychiatrists and psychologists would recommend treatment in a prison setting rather than a psychiatric center. As mentioned before, in this state prisons now have available mental health clinics to provide care even to this group of individuals who are inaptly placed in psychiatric centers.

B. Effects Upon Individuals

Current understanding of personality development, as commented upon before, holds that the establishment of internal controls against expression of aggression in terms of antisocial activity or violence depends upon the factors of positive identification with respect to the authority figures of early life, the inculcation of respect for the law through education and advice and also the aversive stimulation of detection of the individual's own transgressions and prompt deprivation or punishment within the family or social setting in which he finds himself. In short, the establishment of the capacity to abide by the law depends not only upon the positive rewards inherent in identification with others, but also upon the negative aversion through suffering by prompt punishment following transgressions.

In the instances of those individuals who carry out aggressive or violent acts, the appropriate societal corrective in all instances remains the judgment of guilt of the individual concerning commission of the act. The failure of society to allow the public expression of that guilt deprives the individual of the experience of suffering, and thus of the reinforcement of the family and societal codes needed to deter repetition and of their strengthening by this suffering. The failure, too, undercuts the self-esteem of some by publicly declaring them incompetent to make social judgments as do the rest of the population. For others, it muddles an already unclear perception of the social values related to commission of the act.

Only for the small group of repetitive offenders who commit criminal acts in order to suffer punishment may doubt as to this judgment arise. Their motivation is based on early life experiences wherein learning induces a pathological guilt complex in which relief from anxiety occurs only after judgment of guilt and punishment. For such, if judged "not guilty by reason of insanity", arousal of anxiety and repetition of similar acts acts is probable. However, removal of the insanity defense is unlikely to harm, provided corrective treatment is made available after sentencing. Whether prolonged incarceration alone is corrective for persons with this personality makeup is unknown.

While this writer does not know of actual studies of the perception of the judgment of not guilty by reason of insanity upon those so exposed and believes that such studies should be carried out in the future, he knows of others besides himself in the psychiatric/psychological field who have argued for the necessity of suffering guilt in order to bring about personality modifications. Today, most psychiatrists, psychologists and psychoanalysts would agree that the suffering of shame and guilt provide the driving forces which mold the individual's later capacity to conform his behavior to the laws of his society. Iteration and reiteration of this suffering during development increases the individual's capacity to control upsurges of aggressivity and to deflect destructive impulses in more adaptive ways. In some instances, excessive early punitive actions lead to pathological guilt, delusions of sinful action, and confessions of uncommitted crimes.

C. Effects Upon the Psychiatric Profession

As medical specialists, psychiatrists have offered testimony in the courts of law for years in trials where the insanity defense has been raised by the legal representatives of the accused. They have been willing to respond to questions based upon M'Naghten principles "at the time of

committing the act to be laboring under such a defect of reason from disease of the mind as to not know the nature and quality of the act he was doing, or if he did know it, he did not know he was doing wrong". They have also been willing to provide opinions as to the existence of "partial delusions". In spite of the professional unease in responding to such legalisms, certain psychiatrists argue that the specialty is better off compromising with the law as it stands than with any of the modifications proposed.

As one who has practiced psychiatry for a number of decades, has worked with individuals suffering both mental illness and mental retardation, and also as one who has carefully examined his own mind through the process of personal psycholanalysis, I am convinced that the competence of the specialty is exceeded by much of current practice. Psychiatric examinations of the accused are made after the fact. It is beyond the capacity of a psychiatrist to comprehend the defendant's capacity to define the rightness or wrongness of his action taken at the time the act was committed. At best he has only the recollections of the individual (distorted as we often know they may be) on which to base his judgment. Furthermore, with the generally accepted agreement that preconscious and unconscious forces influence

overt actions, he may not answer ethically the legal questions put to him if he conceived of man's actions as controlled by psychological processes often operating beyond his level of awareness. Before an Annual Conference of the Second Judicial Circuit of the United States, I declared that psychiatrists answering such questions are forced almost to the verge of unethical behavior -- forced by the insistence of legal procedures derived from a 19th century conception of the psychology of man. Nor does the specialty have the capacity to quantitate in any individual his idiosyncratic perception of threat to self nor evaluate the strength of the controls lodged within his nervous system which prohibit antisocial behavior.

As the law is currently administered, the psychiatrist appears in an adversary position. His competence rests only in the judgment he may make to the existence of mental illness or mental retardation at the time of the alleged criminal act or of its current existence. Beyond that, he has available to him expertise as regards the appropriate therapeutic or rehabilitative measures most likely to alleviate the mental disorder from which the individual is suffering.

The acceptance by the specialty of psychiatry of the adversarial position, with often competing testimony given

by several members of the same specialty, damages the public respect due the specialty. The specialty has developed much information on psychopathologic behavior - its origin, prevention and treatment. Reliability of psychiatrists has been defined in recent studies as high in terms of agreement relating to pathological behavior but of variable quality when it comes to agreement on specifying different diagnostic types. The professional posture of the specialty is debased as the public realizes the conflicting testimony of several members may have been perverted through the promise of a fee for services rendered.

There is a single place only for the psychiatrist and other mental health specialists in the courts of law. The knowledge and experience of these professions have value to the court only after the court has rendered the judgment that society desires -- a judgment which should remain the sole responsibility of the jury and the judge. Mental health testimony has use only in assisting the court as to the most effective disposition available today to attempt restoration of the defendant eventually to society.

Conclusions

The insanity defense makes possible the judgment of guilt on the basis of testimony provided by an expert witness --a psychiatrist. The use of this defense today, in

the opinion of the writer, has created consequences in terms of sustaining the laws and moral codes of our state. It erodes the social homeostasis. In many instances, it may be judged as psychologically inimical to the potential for rehabilitation of the guilty person even though mentally ill. Finally, the defense rests upon the legally dubious premise that the specialty of psychiatry is in fact competent to answer the psychologically dubious question of the capacity of the defendant to understand the nature of his act or to evaluate whether at the time of its commission the accused was capable of distinguishing "right" from "wrong".

I have long urged the abolition of the insanity defense. Increasingly, my colleagues in the psychiatric profession are coming to share my views and concerns. Since these views and concerns are addressed in part by the rule of diminished capacity which would permit evidence of abnormal mental condition to affect only the degree of crime for which an individual might be held legally accountable, such a rule is worthy of endorsement as a first step -- and perhaps a pragmatically necessary first step -- in the right legal direction.

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Chapter 5

Problems in Administering the Insanity Defense

John B. Wright, D.P.M.

Introduction

Since and even before its formal introduction into English law at the beginning of the 19th century the insanity defense has been the occasion of much controversy. Involving as it does intangible concepts and values basic to our society - moral responsibility, blame, free will - controversy is no doubt inevitable. Equally inevitable, of course, is the polemic and emotional quality of the arguments, however scholarly, offered by the various protagonists. Criticism of the defense has been constant, starting with Queen Victoria's reaction to the original McNaghten decision, much of it deriving, it seems from an impression that however "right" it may be in theory it has too many "wrong" results in practice.

Of late, this criticism has grown into a positively awesome welter of recommendations that it be abolished. The

"moralists" claim that the defense is misused, that guilty people are improperly escaping the consequences of their behavior and that it is the cause of an erosion in society's respect for the law and other institutions. The "pragmatists" hold that neither in theory nor in practice can a rational equitable answer be found to the problems inherent in the defense. The "instrumentalists" say that the minuscule number of cases is just not worth the trouble and burden of retaining it. The "sceptics" maintain that ultimately it does not really matter as society will always find devices to control and confine those whose deviant behavior offends the sensibilities of the majority.

Rather than continuing the philosophical debates, appreciation of the consequences of the defense may be gained by pragmatic examination of the attendant elements: psychiatric participation in the defense; the effect of this participation on the judicial process; and the impact of the defense on the mental health delivery system.

A. Psychiatric Participation in the Insanity Defense

Throughout the existence of the insanity defense in its present form, the formulae elaborated for its implementation and the tests used to apply these formulae have been subject to changing knowledge and purpose. It is, let it be remembered, only since the defense was introduced that psy-

chiatry has become generally recognized as a legitimate discipline. In previous centuries when the question was raised, the jury decided on an intuitive basis whether the defendant appeared to be insane by then generally accepted standards. Experts were neither available nor necessary.

Nowadays, we have the psychiatrist as an "expert" and he fills an at times dominant role in the process. That this reliance on his expertise is entirely misplaced can be demonstrated in a number of ways. It has however only too seldom prevented the psychiatrist from providing answers notable as much for their certitude as for the utter absence of any competence to sustain that certitude.

In the first place the terms and concepts used in the insanity defense are not psychiatric in nature at all. "Responsibility" is a legal, moral or social judgment not psychiatric. Similarly "right", "wrong", "good" and "evil" may be ethical, theological or even legal but they have no place in a psychiatric opinion. Asking such questions of the psychiatrist is made even less valid by the training which he undergoes where constant emphasis is placed on "understanding" the causes of behavior rather than sitting as some sort of surrogate conscience to his patients.

Secondly, by its very nature, psychiatry must be guided by an ideology based on the individual nature of human

behavior with his evaluation made in terms of that individuality. The law on the other hand, with its thrust towards equality, strives for uniform and consistent standards for evaluating behavior.

A third area of deficiency derives out of the assumption that psychiatric testimony has a scientific precision similar to that which can properly be expected from, say, the chemist, the toxicologist or the ballistics expert. Psychiatrists like to claim that theirs is the last intellectual branch of medicine. Whether or not this is true it is surely the least likely to have its endeavors quantified into "measurable" diagnoses and treatments.

A fourth practical problem is the expectation that the psychiatrist can give a competent informed opinion on the mental state of an individual months and perhaps years prior to the examination being made.

These are but some of the problems implicit in the psychiatrists' role. Others include the malingering defendant who must not only be discovered but whose malingering must be demonstrated to the court's satisfaction; the difficulty in presenting arcane and usually vague concepts in terms understandable by the layman; and the impossibility of

conforming with the notion that the definitions which the law imposes on psychiatrists have comparable psychiatric meaning and significance.

None of this should be perceived as support for the nihilistic polemics of those who claim that psychiatry is so vague as to make any opinion worthless. Psychiatry does have skill and competence which can be of use to the law - the problem is that all too seldom is that skill and competence properly used.

B. Inappropriate Psychiatric Testimony in the Judicial Process

The inherent problem which the insanity defense poses to the law can perhaps be summed up by citing from a judicial commentary on the M'Naghten rules made by the late Chief Justice Weinbraub of the New Jersey Supreme Court . . . . "I think that they (the doctrines proposed) are vague and will remain vague (or arbitrary) until someone demonstrates a rational basis for a finding of personal blameworthiness and devises a test rooted in it."[1] In the inevitably permanent absence of such an ideal situation, the law has turned more and more to psychiatry for assistance. No longer can the jury using common sense be enough - the explosion in psychiatric knowledge and appreciation of the origins of behavior must be brought to bear on the problem. Unfor-

tunately what might reasonably have been expected to make the task of the courts easier has paradoxically made it infinitely more difficult.

The mushrocming development of psychiatry, psychology and other professional disciplines has served only to confuse a legal system which assumes that psychiatric testimony derives out of an homogeneous set of premises. In reality, it is heterogeneous to the point of being at times internally inconsistent.

Hence, courts are presented too often with the perplexity of defense and prosecution witnesses giving opposite interpretations of the same agreed-on facts, symptoms and observations. Who should be believed? The psychiatrist who uses the most scientific language? Who uses the least? Who is the most articulate? Who looks and sounds most like a psychiatrist?

Another problem which has long distressed the judiciary is the vocabulary which is now used by psychiatrists. As Chief Justice Berger, while sitting as a Circuit Judge, commented, "No rule of law can possibly be sound or workable which is dependent on the terms of another discipline whose members are in profound disagreement about what those terms mean."[2] Not only is there profound disagreement on the meaning of the terms, but, worse, there is as much disagree-

ment as to the consequence in terms of behavior of using those terms. "Schizophrenia" and "psychopath", two of the most common can be at best described, never defined. The law expects precision; it can receive only vagueness.

C. The Insanity Defense and the Mental Health Service Delivery System

It has often been said that one of the major reasons for development of the insanity defense in England was to mitigate the consequences of the lengthy list of frequently minor offences for which the mandatory penalties were either execution or transportation. While that problem no longer exists, its solution lives on to impose new problems on society and its institutions. No where is this more apparent than in todays mental health delivery system.

Following repeal of these repressive penalties, the practical consequence was that the defendant remained in usually life long confinement with the place of that confinement being an asylum rather than a prison. As progress was made the asylum became more benign, but detention and lack of freedom remained much the same as would be the case in prison. However as the mental hospital functioned and was perceived as a place in which the majority of its clients spent most of their lives - little else was possible given the lack of specific treatment for mental illness - the

insanity acquittals were not overly troublesome. In New York, as with many other states, they were usually hospitalized in prison - like facilities for the criminally insane, making them even less of a problem, though at what cost in human distress is hard to say.

The advent of psychotropic medication, the concepts of community psychiatry and the granting of rights long denied to the mentally ill in the last couple of decades revolutionized the mental hospital. No longer are they warehouses confining the mentally ill in physical, social, and psychological isolation; they function as open, minimally restricting facilities, better able to treat their clientele in an ambience which gives the individual as much responsibility as his disability will permit. To this service system, insanity acquittals present a problem out of all proportion to their small though increasing numbers.

As with most other states, New York law requires that the defendant be committed to a mental hospital for an indefinite period until no longer a danger to self or others.[3] Release can only be authorized by the trial court after a complex series of procedures.

One difficulty which this presents to the service system derives out of the fact that by the time defendants

are mentally well enough to be tried they are not usually (though not necessarily) sick enough to need treatment in a psychiatric hospital. Indeed it is not uncommon for an individual to be completely free of psychiatric symptoms on admission - not only the recovered psychotic but such others as the successful malingerers or the defendant acquitted because of an epileptic equivalent syndrome. Nonetheless they must be held on continued inpatient status - in custody. Facilities have no peripheral security and have physical plants which present little obstacle to escape for a determined and intact patient. Consequently, security has to be maintained by the assignment of staff who are woefully inadequate in number and at the expense of other patients' treatment. To centralize their treatment in a single state facility while solving some problems, causes others.

A further consequence is that the very measures which are most likely to help an individual become a productive member of society -increasing responsibility, gradual social integration, vocational and educational rehabilitation and the like - are prohibited by the terms of the statute. Escape is attempted, more restrictions are imposed, more resources are tied up in fewer programs and the vicious cycle continues.

Another aspect is the conflict which these patients occasion the staff. Apart from perceiving themselves as being forced to hold people, without treatment or the need for it, who more properly are the responsibility of other agencies in society, a more cogent difficulty is that these patients must be managed contrary to all the best tenets of professional ethics.

Perhaps the greatest problem is the statutory requirement that release can only be requested from the trial court when the individual is no longer a danger to self or others. Cocozza and Steadman have repeatedly and convincingly documented that there are no empirical data on which to base a valid prediction of future dangerous behavior.[4] No matter how careful the procedures observations and tests used by facility staff to arrive at the opinion that an individual can be released without peril (and in New York they are remarkably elaborate) the fact of the matter is that the opinion can never be more than guesswork dressed up in the false cloth of reassuring pseudo-science. One eminent observer has gone so far as to say that in making such a prediction a psychiatrist borders on committing professional perjury. Once again the lack of any competence to give an informed opinion has never prevented psychiatrists from being asked, or their agreeing, to give an opinion as to future dangerous behavior.

In summary therefore, placing these individuals in mental hospitals is detrimental not only to the hospitals, but also to the other patients, the individuals themselves and, not to be forgotten, to the aims and needs of society at large.

1. State v. Lucas, 30 N.J. 37, 152 A.2d 50 (1959).

2. Campbell v. United States, 307 F.2d 597, 612 (D.C. Cir. 1962).

3. N.Y. Crim. Proc. Law §§330.20(2), (3) (McKinney Supp. 1977).

4. See, e.g., Cocazza and Steadman, The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence, 29 Rutgers L. Rev. 1034, 1085 (1976).

Chapter 6

Mental Health Services in Correctional Settings

John B. Wright, D.P.M.

Introduction

The proposal made in this report that mental disease or defect be eliminated as a complete defense is premised on the principle that, in any conviction where an accused's current mental illness is a factor, adequate treatment services should be available for that mental condition.

Heretofore, psychiatric services in correctional facilities, New York and nationwide, have been at best inadequate and at worst completely absent. In the past 12-18 months there has been achieved in New York a probably unique capaccity to ensure that all inmates of state correctional facilities receive the treatment which their condition warrants and needs. A review of the history, development and preliminary results of these services will be useful in evaluating the proposals recommended.

A. Background

Until 1952 all psychiatric services for correctional inmates was provided by the Department of Corrections using

two elements -- mental health units in each state prison and two maximum security hospitals at Matteawan and Dannemora.

The prison units were never satisfactory for any of a number of reasons -- poor recruitment success (when attempted); the limited staff time being taken up making reports and evaluations required by various statutes; administrative anxieties about prescribing, dispersing and the abuse of psychotropic drugs militating against their being used; the professional isolation; and an overall approach at best characterized as benign neglect. Under these conditions treatment was minimal and for all practical purposes non-existent. None of this improved in 1952 when in response to passage of a sex-offender law (repealed in 1965) jurisdiction over the units was transferred to the Department of Mental Hygiene. The one or two specialized treatment units fell into oblivion when their energetic leaders left.

Meanwhile Dannemora and Matteawan were the focus of such treatment as was available, but the traditional bugbears of overcrowding and understaffing to which mental hospitals have always been prone was immeasurably worsened by the inevitable correctional emphasis on security at the expense of treatment. None of this was made any better by a tendency to transfer to these facilities those inmates who, whether or not mentally ill, were too troublesome for the prisons.

The census continued to rise until at one point there were over 2000 patients in Matteawan and 1200 or more in Dannemora. Starting in 1966 with the seminal Baxstrom decision and followed by other court decisions and statutory changes this upward trend was reversed till in 1972 Dannemora was closed with all in-patient programs consolidated into Matteawan. However the chronic and inherent constraints continued the poverty of treatment programs.

B. Program Predicates and Plan

The natural consequences of all this was a situation which in many ways resembled, though in a much more malevolent form, that which historically pertained to the delivery of services to the population at large. In the absence of any services where the individual resided, when a person became mentally ill -- in whatever way -- he or she was removed to a remote mental hospital where the norm was to spend many years and frequently the rest of one's life. Community psychiatry was introduced in 1963, calling for the establishment of adequately staffed mental health units in each community, able to provide a range of services which would allow the person to remain at home while receiving treatment and, thus obviate all the deleterious effects of long-term remote hospitalization. The state hospital would be limited to treating those who needed the services that could only be provided there and only for so long as they

needed and continued to benefit from that treatment. After discharge adequate services would be available in the patient's home community to provide necessary further care.

Whatever problems have been experienced in implementing this program, and they are many, they do not detract from the validity of the postulates. Properly implemented they would and indeed have solved many of the old difficulties -- though causing a new set in the process.

Given that the services in the prisons mirrored traditional programs for the community at large and that the principles of community psychiatry could, if properly applied, resolve many of the drawbacks, it was proposed that these principles be applied in the correctional system. In addition, it was felt that some of the problems of community psychiatry, deriving out of pluralistic responsibility for delivery and the need for a panoply of social programs, would be eliminated by the very nature of the correctional situation.

In short, for as long as an inmate is incarcerated, the prison, however repressive, artificial, temporary or even psychotegenic, is that inmates' community.

With this basis, a comprehensive plan was developed in association with and the active cooperation of, a number of agencies, notably the Department of Correctional Services.

By this, was established in the seven major prisons adequately staffed mental health centers which would within the obvious constraints of the prison milieu provide the same elements of service as are provided in a community mental health center: "out-patient" or "day-patient" care, crisis intervention, consultation, brief, strictly time-limited in-patient care in the 5-10 beds assigned for that purpose in the prison's general hospital unit, education and so on. Similarly, formal admission to full in-patient status at a central psychiatric center would be available for those who need acute (or chronic) in-patient care, such care being at a level and quality that would permit treatment to be brief, intensive and proper to the needs of the inmate/patient.

As part of the plan's development several factors pertaining to the role of Matteawan, then diminished to some 300-330 patients, were considered. First an evaluation of all patients currently there showed that they fell into one of four categories: the severely ill who properly belonged there; the malingerer who for a variety of reasons would rather be there than in prison; some few non-mentally ill who had been labeled sick as a device for management of disruptive behavior; and a group who were alternative available in prison would not need in-patient hospitalization. Secondly, the perennial problems which have long plagued Matteawan -- few professional staff recruitable leading to a

heightened emphasis on security making for a spiralling symbiosis in these two elements -- made it apparent that their only solution lay in closing Matteawan as a hospital, as a location and even as a concept. Only thus could a quality program at another location and without the burden of Matteawan's history, be established. Parenthetically, it would free-up several hundred spaces to assist in relieving the overcrowding in state correctional facilities. Further, to prevent the administrative slippage possible with a division of responsibility for providing treatment and the manifest virtues attendant upon a single program under one administrative auspice -- and with concommitant accountability -- it was proposed that responsibility for the in-patient program be transferred to the Department of Mental Hygiene. After a thorough and careful review of all surplus property, a building at Marcy Psychiatric Center was decided on for the relocation.

At the request of the Governor, the 1976 session of the Legislature passed the enabling legislation and appropriated funds to start establishing the seven sattelite clinics and to effect the necessary security and other construction work for the new Central New York Psychiatric Center at Marcy. The 1977 session authorized the Governor's request for funds to implement the remainder of the program, thus creating the components of a comprehensive network of mental health

services in the state correctional system: the new in-patient Central New York Psychiatric Center and the seven satellite units at Attica, Auburn, Bedford Hills, Clinton, Elmira, Fishkill and Greenhaven.

Attention should also be drawn to the ease with which educational programs (for a number of disciplines including county jail staff and resident psychiatrists) and research endeavors can be readily added at only slight extra cost. These are currently being developed.

C. Program Elements

The satellite units have the following elements:

1) Diagnosis and evaluation.

In accordance with outlined procedures staff from the unit will provide diagnostic services for inmates referred to the program. In addition, evaluation can be made of those aspects of personality which can assist in the inmates overall correctional rehabilitation; of the need for commitment to the Central New York Psychiatric Center (C.N.Y.P.C.); for the purposes of making reports necessary before certain inmates may be parolled; and pursuant to the requirements of the old sex offender law.

2) Treatment.

All usual modalities are provided including individual, group and other psychotherapies, chemo-therapy, motivational therapy and so on, all obviously within the constraints of the prison. Acute and chronic illness are provided for. Numerous studies have shown that a significant proportion of all prison inmates have some sort of mental disability which, if untreated, makes recidivism more likely when the individual, unable to survive after release, drifts back into crime. Another intention therefore is to promote for these and other inmates a return to society in which they can verbalize their feelings constructively, can manage and channel their impulses, have successful experiences with authority figures and generally become as psychologically well equipped as possible to deal with the problems of "normal" living.

This should not be taken as another manifestation of the psychiatrist trying to solve someone else's problems by arrogating the responsibility of the Correctional Department. The intention is merely, if somewhat ambitiously, to fulfill the proper function of any good mental health program.

3) Education.

As mentioned above education of a number of disciplines is readily achievable within this system. In addition, the behavioral sciences have much to offer the penal system -- and vice versa of course. In the past, traditional roles, structures, rivalries and even prejudices have mitigated against the sharing of skills and talents. The units therefore will, and are already providing instruction to correctional staff in the identification, understanding and management of behavior, in group therapy and sensitivity techniques, the nature and use of psychiatric treatments, etc. Conversely Mental Hygiene staff are learning about penal, criminal, and correctional factors and situations. A further intent is to increase the involvement of outside agencies such as universities, colleges and law and medical schools in this process.

4) Program Evaluation.

Recognizing that this system represents a new and innovative method for delivering comprehensive psychiatric services to prison inmates, the capacity to demonstrate the effectiveness and worth of

the program is vital. Equally vital is the ability to discover what is inefficient or worthless to enable corrective action to be taken. To this end, a "central" program evaluation component with a sophisticated medical records system used throughout all satellites and CNYPC has been developed at the latter facility. These data will be sent to and programmed by the Department's Office of Information Systems. The tracking and identification of all of the systems client's and the accessibility of all clinical material is another major benefit of this system.

D. Results to date:

In embarking on this project a number of major problems could be anticipated. What for example would be the effect on the prisons of having mentally ill inmates in population where previously they would have gone to Matteawan? Would it be possible to recruit the necessary staff? Would the same security requirements mandated by an individual's correctional status lead to an overemphasis on security at the expense of treatment at C.N.Y.P.C. as had long prevailed at Matteawan? Would the satellite units be able to provide the necessary service? Was it, to put it at its most synoptic, just a grand ideal with no hope of success in the

real world, as was the opinion of one authority when the proposal was outlined to him?

It is gratifying to report that the answer to the last questions is a definite negative and while there have been some problems and complete implementation is yet to be achieved, the overall program is working admirably. Disruption in the prisons is minimal, not least because of the enthusiastic support of the superintendents and their staff and the corrections central office; recruitment of all staff with the sole exception of psychiatrists at the new C.N.Y.P.C. has been accomplished; C.N.Y.P.C. has developed a quality program which already (it opened in September 1977) has a length of stay pattern the same as that in the state-wide psychiatric centers for new admissions; and education and research programs are beginning to take shape in conjunction with other elements of the state's forensic programs.

To date there has been insufficient time to develop the body of data which can be expected in the future. One set of figures however supports the above somewhat ancedotal statements. The number of individuals on the active case rolls in each of the satellite clinics as of January 5th, 1978 is:

Correctional Facility	Facility Population as of 1/5/78	# of Inmates/Patients on Active Roles
1. Attica	1,764	455
2. Auburn	1,682	310
3. Bedford Hills	430	240
4. Clinton	2,138	340
5. Elmira	1,660	325
6. Fishkill	1.198	110
7. Green Haven	1,975	390
TOTAL	10,847	2,170

In summary therefore, New York has developed a unique capacity to ensure treatment for all the mentally disabled in correctional facilities in an integrated coherent program which corrects the deficiencies of previous programs and brings enormous potential benefits in terms not only of service, education and research but also of ameliorating a chronic problem for the already overstrained correctional system.

It also, of course, makes feasible the elimination of mental disease or defect as a complete defense and the adoption of the proposed rule of diminished capacity.

Chapter 7

Changing the Insanity Defense

William A. Carnahan

This chapter will both address the need for changing the insanity defense and discuss optional approaches.

A. Need for Change

From the foregoing pages, several conclusions may readily be drawn concerning the continuing viability of an insanity defense in this state.

Legal Perspectives on the Defense

- An insanity defense is not required constitutionally to be maintained.
- The state has "wide freedom to determine the extent to which moral culpability should be a prerequisite to conviction of a crime."[1]

Use of the Defense

- During the last ten years, successful use of the defense has increased markedly from fifty-three (53) cases during the first five years to two hundred and twenty-five (225) cases during the last five years.
- The defense is not uniformly applied throughout this state.
- The defense has tended to be used as a guilt avoidance device for certain empathetic segments of the population.

- The legal standards for use of the defense may not be deciding factors in its successful use.

Perceptions of the Defense

- Legal professionals found problems with the defense in terms of poor statutory definitions, vagueness, uneven application, lack of understanding by juries and the public, and superficial and incompetent psychiatric testimony.

- Legal professionals felt that the defense should be modified by removing the ambiguity and vagueness of psychiatric testimony in the determination of guilt or innocence.

- Legal professionals felt that treatment of acquittees within a correctional setting was preferred to psychiatric hospitalization.

Reassessment of the Defense

- The defense rests upon the dubious premise that the medical specialty of psychiatry can answer the question of the capacity of the defendant to understand the nature of his act or to evaluate whether at the time of its commission he was capable of distinguishing "right" from "wrong".

- Harm may be done to the rule of law through the use of an insanity defense, with its implied permissiveness for violent and other crimes committed.

- Public determination of guilt may do much to sustain the faith of citizens at large in the rectitude and equity which should exist in all social bodies in their efforts to sustain justice under law.

- By abrogation of the defense, an individual would not be a candidate for automatic placement in a psychiatric hospital, a disposition which can be -- and often is -- inappropriate not only for custodial but also for therapeutic reasons.

- The use of the defense in highly publicized criminal cases can foster an impression that all mentally ill individuals are dangerous, thus significantly inhibiting community acceptance of a policy of providing care and treatment of persons suffering from mental illness -- who are neither violent nor dangerous -- in less restrictive surroundings than secure facilities.

Impact of the Defense

- Psychiatric participation in the determination of legal guilt or innocence is premised upon false assumptions of psychiatric expertise in what are essentially legal, moral and social judgments.

- Continued placement of individuals in psychiatric hospitals has become undesirable due to the changing nature of our psychiatric hospitals, the type of offenders being placed and the difficulties of articulating psychiatric standards for release.

- Capacity for treating such individuals within correctional settings renders continued placement within psychiatric hospitals not only undesirable, but unnecessary.

Historically, the defense was used as a device to spare an obviously deranged accused from the extreme penalty of capital punishment. More recently, it has persisted due in part to a humane concern that, if the commission of a crime is somehow related to mental abnormality, treatment should be accorded. Since treatment in correctional settings was non-existent, psychiatric hospitalization was a readily available alternative.

By virtue of a strictly construed insanity defense and a liberally construed post-acquittal detention statute, social isolation of the mentally abnormal offender was ensured. Indeed, release was often more difficult from a Mental Hygiene facility than had the accused waived an insanity defense and submitted himself to penal confinement.

A number of factors have intervened to render this socially expedient enterprise obsolete. First, no longer may acquittees be placed indefinitely in a facility for the criminally insane. They must be treated comparably to a civilly committed patient. Secondly, our psychiatric hospitals are no longer locked warehouses for prolonged storage of socially unacceptable deviates. Thirdly, a loosening of the insanity defense and a tightening of civil commitment standards have resulted in the placement within our psychiatric hospitals of some individuals acquitted of bizzare sociopathic activities who cannot be "treated"; and yet must and should be confined for the protection of society. Finally, standards for release of acquittees require a psychiatric prediction of continuing dangerousness, a feat that is, at best, chimerical. Fortunately, this enterpirse need no longer be continued. We now have the capacity to provide an alternative which will ensure adequate treatment in correctional settings consistent with the principal that

in any conviction where a defendant's mental illness is a factor, adequate treatment services should be available for that mental condition.

B. Optional Approaches

In changing the present defense of legal insanity, several approaches can be considered. First, procedurally inhibiting the use of the defense by shifting to an accused the burden of persuasion on the issue of lack of criminal responsibility due to mental disease or defect. Secondly, modifying the defense by requiring a bifurcated trial at which issues of guilt and criminal responsibility would be separately adjudicated. Thirdly, modifying the defense by adding a guilty but insane verdict. Fourthly, abolishing the defense by precluding evidence of abnormal mental condition from the trial. Fifthly, substituting a rule of diminished capacity which would allow evidence of abnormal mental condition to affect the degree of crime for which an accused could be convicted.

1. An Affirmative Defense

Since lack of criminal responsibility is statutorily classified as a "defense", the burden of persuasion rests upon the People to prove criminal responsibility beyond a reasonable doubt.[2]

Formerly, lack of criminal responsibility was in the nature of an affirmative defense with the requirement that the evidence of lack of criminal responsibility be "substantial and clear".[3] However, it was later determined that

> [T]he sanity of the defendant was an essential element of the crime. . .charged, and the law required it to be established. . .as a part of the case for the prosecution, for there can be no criminal intent when, from defect of reason, the accused cannot tell right from wrong.[4]

This doctrine which considers mens rea as an essential element of the crime charged is of common law origin.[5] Constitutionally, the law is explicit that a state may place the burden of persuasion where it will in the defense of lack of criminal responsibility.[6] In fact, in approximately one half of the states and the District of Columbia, lack of criminal responsibility due to mental disease or defect is an affirmative defense requiring an accused to shoulder the burden of establishing such a defense by a preponderance of the evidence.[7]

While this approach might lessen the number of successful insanity acquittals, it would not affect the inappropriate use of psychiatry in the trial process or lessen the problems associated with post-acquittal detention and release. Thus, it would not appear to be a solution.

2. A Bifurcated Trial

In California, the procedure for trying an accused who raises a defense of insanity is that of a bifurcated trial.[8] During the first stage of the trial, it is determined whether an accused committed the crime charged and also whether he possessed the requisite mental capacity for the commission of specific intent offenses, i.e., those crimes requiring premeditation, deliberation or intent.[9] Accordingly, psychiatric evidence relevant to the issue of capacity to commit specific intent offenses is admissible at this trial stage.

During the second stage of the trial, a formal defense of legal insanity may be raised. If acquitted by reason of insanity, psychiatric hospitalization or outpatient psychiatric treatment follows.[10]

In discussing the California approach, Professors Louisell and Hazard concluded:

> The separate trial procedure, as it stands today, results in duplication. The proof admissible to show defendant's mental state at the time of the crime is substantially the same as that admissible to show insanity. No workable rule has been formulated, and probably none can be formulated, that would effectively differentiate between the two types of evidence.

> The separate trial procedure was based on an inadequate premise of law. It assumed that the issue of guilt and the issue of mental condition are separable. We submit that reason shows they are not separable, and that experience confirms this conclusion. We therefore believe that the separate trial procedure should be abolished.[11]

As Professor Morris observes, "[t]wo governor's commissions have recommended that the California bifurcation statute be repealed as no longer serving a useful purpose".[12]

3. A Guilty But Insane Verdict

Michigan has adopted a rather complicated scheme that provides not only for a defense of legal insanity but also for a defense of guilty but mentally ill.[13] The latter defense would prevail should the trier of fact find that an accused was guilty of the offense charged, not legally insane but nevertheless, mentally ill at the time of the commission of the offense.

Such a finding would permit the imposition of any sentence were the accused to have been found guilty. Commitment would be to the Department of Corrections with such evaluation and treatment as psychiatrically indicated to be rendered by either the Department of Corrections or the Department of Mental Health. Authority to release prior to expiration of a sentence is vested in a Board of Parole based upon

> a report on the condition of the defendant which contains the clinical facts, the diagnosis, the course of treatment, and the prognosis for the remission of symptoms, potential for recidivism and for the danger to himself or the public, and recommendations for future treatment.

Treatment may be required as a condition of parole.

Should probation in lieu of imprisonment be utilized, a five-year probationary period is required and may "not be shortened without receipt and consideration of a forensic psychiatric report by the sentencing court."

This approach fails to address the problems of the insanity defense. Moreover, it adds a further class of offenders singled out for differential treatment due to "mental illness". As a Michigan attorney has observed:[14]

> A particular problem will be faced by defense counsel in advising the client on the relative benefits of pleading GMI. Given the legal hollowness of the GMI verdict, I suggest that the act of a defense counsel advising his client to plead GMI would constitute ineffective assistance, and a breach of a canonized ethical duty.

4. Abolishing the Defense

Increasingly, there is debate concerning the complete elimination of the defense. What some urge is the repeal of the insanity defense coupled with the exclusion of any psychiatric evidence of abnormal mental condition. The result would be a shifting of psychiatric involvement to the dispositional stages of criminal proceedings. While this approach has distinguished adherents, it may be unnecessary

if there is a less drastic solution that meets the fundamental inadequacies of the present defense in terms of inappropriate psychiatric involvement and post-acquittal detention and release problems. Such a solution would appear to be the rule of diminished capacity.

5. Diminished Capacity

Under a rule of diminished capacity, evidence of abnormal mental condition would be admissible to affect the degree of crime for which an accused could be convicted. Specifically, those offenses requiring intent or knowledge could be reduced to lesser included offenses requiring only reckless or criminal negligence. Such a rule in various formulations is judicially recognized in twenty-one (21) states and in the District of Columbia.[15]

Additionally, under a rule of diminished capacity, a psychiatrist would be limited to testimony and documentary evidence of an accused's capacity for culpable conduct. For example, where knowledge is a required culpable mental state, the psychiatrist would be permitted

> to describe the defendant's mental condition and symptoms, his pathological beliefs and motivations, if he was thus afflicted, and to explain how these influenced or could have influenced his behavior, particularly his mental capacity knowingly [to commit the crime charged]....[16]

No longer would a psychiatrist be permitted to address the issues of complete exculpation or forced to assume the role of a post-acquittal custodian.

While abolishing mental disease or defect as a complete defense, recognition would still be given to higher degrees of culpability affected by the presence of abnormal mental condition. The result would entail conviction and processing in the correctional system for serious offenders; and, acquittal -- perhaps civil commitment -- for minor offenders. Convictions would be for lesser included criminal offenses not requiring an accused to have acted either intentionally or knowingly. The sentencing court would then take the present mental condition of the offender into account in determining an appropriate disposition, viz., conditional discharge, probation or penal confinement.

In analyzing the fate of those who successfully used the insanity defense in this state during the past ten (10) years, all -- with the exception of three individuals indicted for forgery, menacing and possession of burglar tools -- would have been candidates for conviction under a diminished capacity rule.[17]

The effect of a rule of diminished capacity would be to recognize the Department of Correctional Services as the primary control agency, to avoid dysfunctional psychiatric

involvement in adjudicative and dispositional processes and to ensure that the fate of those found dangerous to society is determined by the proper agencies and the judiciary.

Presently, the insanity defense serves as a device for diversion into the mental health treatment system. Since New York has in place the most advanced model for mental health treatment in prisons in the United States, it is no longer necessary to utilize a defense of insanity as "a device for triggering indeterminate restraint."[18]

1. Powell v. Texas, 392 U.S. 514, 545 (1968) (Black, J., concurring).

2. N.Y. Penal Law § 25.00 (McKinney 1975).

3. Walker v. People, 88 N.Y. 81, 91 (1882).

4. People v. Egnor, 175 N.Y. 419, 428-429, 67 N.E. 906, 909 (1903).

5. See, e.g., Davis v. United States, 160 U.S. 469, 484 (1895).

6. Leland v. Oregon, 343 U.S. 790, 798-799 (1952); Phillips v. Hocker, 473 F.2d 395, 396-398 (9th Cir.), cert. denied, 411 U.S. 939 (1973); Hill v. Lockhart, 516 F.2d 910 (8th Cir. 1975).

7. See S. Brakel & R. Rock, Eds., The Mentally Disabled and the Law 400 (rev. ed. 1973); United States v. Greene, 489 F.2d 1145, 1152-1156 (D.C. Cir. 1973); Model Penal Code § 4.03, Comment at 194 (Tent. Draft No. 4, 1955).

8. Cal. Penal Code § 1026 (Deering Supp. 1977).

9. See, People v. Wells, 33 Cal. 2d 330, 202 P.2d 53, cert. denied, 338 U.S. 836 (1949); People v. Gorshen, 51 Cal. 2d 716, 336 P.2d 492 (1959).

10. Cal. Penal Code §§ 1026, 1026.1 (Deering Supp. 1977).

11. Louisell and Hazard, Insanity as a Defense: The Bifurcated Trial, 49 Cal. L. Rev. 805, 829-830 (1961) (footnotes omitted).

12. Morris, The Insanity Defense: A Blueprint for Legislative Reform 46 (1973).

13. Mich. Comp. Laws §768.36 (Supp. 1977).

14. Schwartz, Moving Backward Confidently, 1975 Michigan St. B. J. 847, 850.

15. Johnson v. State, 511 P.2d 118 (Alaska 1973) (murder); People v. Gorshen, 51 Cal. 2d 716, 336 P.2d 492 (1959) (murder); People v. Wells, 33 Cal. 2d 330, 202 P.2d 53, cert. denied, 338 U.S. 836 (1949) (assault); Schwickrath v. People, 159 Colo. 390, 411 P.2d 961 (1966) (felonious escape); Becksted v. People, 133 Colo. 72, 292 P.2d 189 (1956) (murder); State v. Donahue, 141 Conn. 656, 109 A.2d 364 (1954), appeal dismissed, 349 U.S. 926 (1955) (murder); Andersen v. State, 43 Conn. 514 (1876) (murder); United States v. Brawner, 471 F.2d 969 (D.C. Cir. 1972) (murder); State v. Santiago, 55 Haw. 162, 516 P.2d 1256 (1973) (murder); State v. Clokey, 83 Idaho 322, 364 P.2d 159 (1961) (murder); Donahue v. State, 165 Ind. 148, 74 N.E. 996 (1905) (murder); Bimbo v. State, 315 N.E.2d 738 (Ind. Ct. App. 1974) (assault and battery); State v. Gramenz, 256 Iowa 134, 126 N.W.2d 285 (1964) (murder); Mangrum v. Commonwealth, 39 S.W. 703 (Ky. 1897) (murder); People v. Fields, 64 Mich. App. 166, 235 N.W.2d 95 (1975) (murder, assault); State v. Anderson, 515 S.W.2d 534 (Mo. 1974) (murder); Washington v. State, 165 Neb. 275, 85 N.W.2d 509 (1957) (murder); State v. Vigliano, 43 N.J. 44, 202 A.2d 657 (1964) (murder); State v. DePaolo, 34 N.J. 279, 168 A.2d 401 cert. denied, 368 U.S. 880 (1961) (murder); State v. Padilla, 66 N.M. 289, 347 P.2d 312 (1959) (murder, rape, kidnapping); State v. Cooper, 286 N.C. 549, 213 S.E.2d 305 (1975) (murder); State v. Nichols, 3 Ohio App. 2d 182, 209 N.E.2d 750 (1965) (murder); State v. Schleigh, 210 Or. 155, 310 P.2d 341 (1957) (arson); State v. Fenik, 45 R.I. 309, 121 A. 218 (1923) (murder); State v. Green, 78 Utah 580, 6 P.2d 177 (1931) (murder); State v. Ferrick, 81 Wash. 2d 942, 506 P.2d 860 cert. denied, 414 U.S. 1094 (1973) (murder); Hempton v. State, 111 Wis. 127, 86 N.W. 596 (1901) (murder).

16. Rhodes v. United States, 282 F.2d 59, 62 (4th Cir. 1960).

17. See Table 1, Insanity Acquittals in New York State, 1965-1976; Table 2, Diminished Capacity and Robbery Acquittals in New York, 1971-1976; Table 3, Diminished Capacity and Arson Acquittals in New York, 1971-1976, all in Appendix "A" infra.

18. J. Goldstein and J. Katz, Abolish "The Insanity Defense" -- Why Not?, 72 Yale L. J. 852, 858 (1963).

APPENDIX A

TABLE 1

Insanity Acquittals In New York State 1965 - 1976

Crimes Against The Person

# Cases 1965 - 71	# Cases 1971 - 76	Total	N G R I Charges Against Person	P.L.	Class	Charge Under Diminished Capacity	P.L.	Class
28	120	148	Murder	125.25	A	Manslaughter 2°	125.15	C
						Criminally Negligent Homicide	125.10	E
3	13	16	Manslaughter	125.20	B	Manslaughter 2°	125.15	C
				125.15	C	Criminally Negligent Homicide	125.10	E
10	32	42	Assault	120.10	C	Reckless Endangerment 1°	120.25	D
				120.05	D	Reckless Endangerment 2°	120.20	A Misd.
				120.00	A Misd.			
1	5	6	Rape	130.35	B	Same - Proof of intent is not necessary		
				130.30	D			
				130.25	E			
0	1	1	Kidnapping	135.20	B	Coercion 2°	135.60	A Misd.
				135.25	A - I	Coercion 1°	135.65	D
0	4	4	Reckless Endangerment	120.25	D	Same - proof of intent is not necessary		
				120.20	A Misd.			
0	1	1	Menacing	120.15	B Misd.	Intent to frighten is a necessary element		
0	5	5	Sexual Offense Other than Rape	130.20	A Misd.	Same - proof of intent is not necessary		

TABLE 1 (Cont'd)

Insanity Acquittals In New York State 1965 - 1976

Crimes Against Property

# Cases 1965 - 71	# Cases 1971 - 76	Total	N G R I Charges Against Property	P.L.	Class	Charge Under Diminished Capacity	P.L.	Class
3	4	7	Burglary	140.30 140.25 140.20	B C D	Criminal trespass 2° Criminal trespass 3° Criminal trespass 1° (if there is a firearm)	140.15 140.10 140.17	A Misd. B Misd. D
1	0	1	Forgery	170.05 170.20	A Misd. D or C	Intent to defraud is a necessary element		
1	14	15	Arson (See further breakdown)	150.05 150.10 150.15 150.20	E C B A-I	Arson 4° Reckless endangerment 1° Reckless endangerment 2° Criminal mischief 4°	150.05 120.25 120.20 145.00	E D A Misd. A Misd.
1	0	1	Poss. Burglar Tools	140.35	A Misd.	Intent to use in commission of an offense is a necessary element		
1	2	3	Sale of controlled Substance	220.31- 220.43	D, C, B A III, A II or A I	Criminal possession of controlled substance 7° (depends on quantity) 6°	220.03 220.06	A Misd. D Felony
3	16	19	Robbery (See further breakdown)	160.15 160.10 160.05	B C D	Possession of firearm & ammunition, or of dangerous instrument, with prior conviction Reckless endangerment Reckless endangerment 2° Criminal Trespass 2° or 3°	265.05 120.25 120.20 140.10 140.15	D A Misd. D D A Misd. A Misd. A Misd.
1	0	1	Resisting Arrest	205.30	A Misd.	Reckless endangerment 2°	120.20	A Misd.

TABLE 1 (Cont'd)

# Cases 1965 - 71	# Cases 1971 - 76	Total	N G R I Charges Against Property	P.L.	Class	Charge Under Diminished Capacity	P.L.	Class
0	1	1	Endangering the Welfare of a Child	260.10	A Misd.	Same - requires knowledge but not intention		
0	1	1	Weapons Possession	265.05	D or A Misd.	Same - proof of intent is not necessary		
0	3	3	Escape Absconding from Temporary Release	205.05 205.15 205.16- 205.18	A Misd. D A Misd. E	Same - proof of intent is not necessary Intentional failure to return is a necessary element		
0	1	1	Possession of Forged Instrument	170.20- 170.30	A Misd. D or C	Intent to defraud is an essential element of the crime		
0	1	1	Criminal Mischief Criminal Mischief 4°	145.05- 145.12 145.00	E, D, B A Misd.	Criminal Mischief 4°	145.00	A Misd.
0	1	1	Motor Vehicle Violation			Apparently included in error		

TABLE 2

Diminished Capacity and Robbery Insanity Acquittals

In New York 1971 - 1976

N G R I Charge		Charge Under Diminished Capacity	
Robbery 3°, grand larceny 3° (knife)	(D)	Reckless endangerment 1° Possession of dangerous instrument	(D Fel.) (A Misd.)
Robbery 1° (insect spray)	(B)	Reckless endangerment 2° or 1°	(A Misd. or D)
Robbery 1° (toy gun)	(B)	Reckless endangerment 1° Criminal trespass 3°	(D Fel.) (B Misd.)
Robbery 1° (bank)	(B)	Reckless endangerment 1° Federal bank robbery, 18 USC2113 (a)	(D Fel.) 25 Years
Robbery 2° (hit waitress with tray)	(C)	Reckless endangerment 2°	(A Misd.)
Attempted Robbery 2°	(D)	Possession of dangerous instrument, prior offense	(D Fel.)
Assault, Possession of dangerous weapon	(D)	Reckless endangerment 1°	(D Fel.)
Robbery 2° (cab driver)	(C)	Reckless endangerment 1°	(D Fel.)
Armed robbery 1° Attempted robbery 2° Weapons possession	(B) (D)	Weapons possession Reckless endangerment 1°	(D or A Misd.) (D Fel.)
Robbery 1°	(B)	Weapons? Reckless endangerment	(D or A Misd.)
Robbery 1° Reckless endangerment	(B)	Reckless endangerment 1°	(D Fel.)
Robbery 1° Grand larceny, weapons possession	(B)	Weapons possession	(D or A Misd.)
Robbery 1° (knife & gun)	(B)	Weapons possession, reckless endangerment 1°	(D Fel.)
Robbery 1°, reckless endangerment, possession of dangerous weapon, unlawful imprisonment (discharged rifle)	(B)	Reckless endangerment 1° possession of dangerous weapon	(D Fel.) (D Fel.)
Attempted armed robbery 1°	(C)	Possession of weapon	(D Fel.)
Robbery 3° [illegible]y gun) (bank)	(D)	Reckless endangerment 2° Federal Bank Robbery, 18 USC2113 (a)	(A Misd.)

TABLE 3

Diminished Capacity and Arson Insanity Acquittals

In New York 1971 - 1976

N G R I Charge		Charge Under Diminished Capacity	
Arson 1° (seminary)	(A-1)	Arson 4° Reckless Endangerment 1°	(E) (D)
Arson 3° (abandoned mill)	(C)	Reckless endangerment 1°	(D)
Arson 3° (father's house)	(C)	Reckless endangerment 1° Arson 4°	(D) (E)
Arson 2° (mattress in jail)	(B)	Reckless endangerment 1°	(D)
Arson 2° (clothes, in own house)	(B)	Arson 4° Reckless endangerment 1°	(E) (D)
Arson 2° (own apartment, suicidal)	(B)	Arson 4° Reckless endangerment 1°	(E) (D)
Arson 2°	(B)	Arson 4° Reckless endangerment 1°	(E) (D)
Arson 3° (clothes, in father's house) Criminal mischief 2°	(C)	Arson 4° Reckless endangerment 1°	(E) (D)
Arson 1° (own apartment, suicidal)	(A-1)	Arson 4° Reckless endangerment 1°	(E) (D)
Arson 3° (house, openly)	(C)	Reckless endangerment 1° Criminal mischief 4°	(D) (A Misd.)
Arson 2°	(B)	Reckless endangerment 1°	(D)
Arson 4° Criminal mischief 4°	(E)	Criminal mischief 4°	(A Misd.)
Arson 3° Burglary 3° Possession of stolen property 1°	(C)	Arson 4° (?) Criminal trespass 3° Criminal mischief 4°	(E) (B Misd.) (A Misd.)
Arson 2° (bar room)	(B)	Arson 4° Reckless endangerment 1°	(E) (D)

Chapter 8

Proposed Rule of Diminished Capacity

This final chapter sets out a proposed rule of diminished capacity, provides for notice of an intent by an accused to rely upon the rule, requires a psychiatric examination of an accused upon motion of the people, specifies the permissible scope of psychiatric trial testimony and envisions a two-year period of systematic assessment of trial transcripts to assess the reliability and validity of psychiatric diagnoses and opinions received into evidence under this rule.

A. The Rule

A new section 15.30 would be added to the Penal Law.

§ 15.30 Effect of Mental Disease or Defect Upon Liability.

Mental disease or defect is not, as such, a defense to a criminal charge; but in any prosecution for an offense, evidence of mental disease or defect of the defendant may be offered by the defendant whenever such evidence is relevant to negative an element of the crime charged requiring the defendant to have acted intentionally or knowingly.

Comment

With the repeal of section 30.05 of the Penal Law, this section would establish a rule of diminished capacity for crimes intentionally and knowingly committed in New York State.

B. Notice and Pre-trial Psychiatric Examination

A new section 250.10 of the Criminal Procedure Law would be added replacing the present section.

§ 250.10 Notice of Intent to Rely Upon Evidence of Mental Disease or Defect.

1. If a defendant intends to offer evidence of mental disease or defect pursuant to section 15.30 of the penal law, he shall serve upon the people and file with the court a written notice of such intention. Such notice must be served and filed before trial and not more than thirty days after entry of the plea of not guilty to the indictment. In the interest of justice and for good cause shown, however, the court may permit such service and filing to be made at any later time prior to the close of the evidence.

2. After receiving such notice, the court, upon motion of the people, shall order the defendant to submit to a psychiatric examination by a psychiatrist designated for this purpose in the order of the court. No statement made by the defendant in the course of any examination provided for by this section, whether the examination shall be with or without the consent of

the defendant, shall be admitted in evidence against the defendant on the issue of guilt in any criminal proceeding.

3. If there is a failure to give notice when required by subdivision one of this section or to submit to an examination when ordered under subdivision two of this section, the court may exclude the testimony of any expert witness offered by the defendant on the issue of his mental disease or defect.

Comment

This section is adapted from section 250.10 of the Criminal Procedure Law, Rule 12.2 of the Federal Rules of Criminal Procedure and Lee v. County Ct. of Erie, 27 N.Y.2d 432, 318 N.Y.S.2d 705, cert. denied 404 U.S. 823 (1971).

C. Scope, Reliability and Validity of Psychiatric Trial Testimony

A new section 60.55 would be added to the Criminal Procedure Law replacing the present section.

§ 60.55 Rules of Evidence; Psychiatric Testimony Concerning Effect of Mental Disease or Defect Upon Liability.

1. When, in connection with evidence of mental disease or defect pursuant to section 15.30 of the penal law, a psychiatrist who has examined the defendant testifies at a trial concerning the defendant's medical condition at the time of the conduct charged to be a crime, he must be permitted to testify as to the nature of the psychiatric examination, to describe the defen-

dant's mental condition and symptoms, his pathological beliefs and motivations, if he was thus afflicted, and to explain how these influenced or could have influenced his behavior, particularly his mental capacity intentionally or knowingly to commit the crime charged. A psychiatrist must be permitted to make any explanation reasonably serving to clarify his diagnosis and opinion and he may be cross examined as to any matter bearing on his competency or credibility or the reliability or the validity of his diagnosis or opinion.

2. For a period of two years following the effective date of this section, the commissioner of mental health shall systematically assess the reliability and validity of psychiatric diagnoses and opinions received into evidence pursuant to subdivision one of this section and periodically report to the legislature his findings and recommendations. For this purpose, within thirty days following a verdict in a criminal action in which psychiatric testimony as permitted in subdivision one is presented, regardless of the verdict, the court clerk shall direct the court stenographer, and the court stenographer shall make and certify a typewritten transcript of all psychiatric

testimony presented and shall deliver the transcript to the commissioner of mental health. The expense of such transcripts shall be a state charge.

Comment

Subdivision 1 is adapted from section 60.55 of the Criminal Procedure Law and from Rhodes v. United States, 282 F. 2d 59, 62 (4th Cir. 1960).

Subdivision 2 will allow the commissioner of mental health to systematically assess the reliability and validity of psychiatric diagnoses and opinions under a diminished capacity rule. In this manner, psychiatric participation in diminished capacity adjudications can be effectively monitored; and if change becomes necessary, informed legislative action can be taken.

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