

## American Psychiatric Association Statement on the Insanity Defense

### Insanity Defense Work Group

Long before there was psychiatry, there was the insanity defense. The idea that the insane should not be punished for otherwise criminal acts began to develop in the twelfth century as part of the more general idea that criminal punishment should be imposed only on persons who were morally blameworthy. In the thirteenth century, Bracton, the first medieval jurist to deal with the subject of insanity and crime, stated, "For a crime is not committed unless the will to harm be present." The earliest documented case of a jury acquittal on grounds of unsound mind occurred in 1505 (1).

In his treatise on the *History of the Pleas of the Crown* (2) published posthumously in 1736, England's Lord Mathew Hale explained that the insanity defense was rooted in the fundamental moral assumptions of the criminal law:

Man is naturally endowed with these two great faculties, understanding and liberty of will. . . . The consent of the will is that which renders human actions either commendable or culpable. . . . [I]t follows that, where there is a total defect of the understanding, there is no free act of the will.

Thus it is a longstanding premise of the criminal law that unless a defendant intentionally chooses to commit a crime, he is not morally blameworthy, and he should not be punished. By singling out certain defendants as either lacking free will or, alternatively,

lacking sufficient understanding of what they do, the insanity defense becomes the exception that proves the rule. In the law's moral paradigm, other criminal defendants, those who do not receive an insanity defense, are thus found blameworthy.

Despite these general premises in the criminal law, many questions have persisted about the insanity defense such as how best to define criminal insanity (what the legal test should be) and what should happen to criminal defendants once they are found "insane." The history of the insanity defense has been one of periodic revisions of standards, public debate, and contention. This has been the case especially when the insanity defense is highlighted by a case involving a defendant who has attempted to harm a well-known person.

The modern formulation of the insanity defense derives from the "rules" stated by the House of Lords in Daniel M'Naghten's case in 1843. M'Naghten was indicted for having shot Edward Drummond, secretary to Robert Peel, the Prime Minister of England. The thrust of the medical testimony was that M'Naghten was suffering from what today would be described as delusions of persecution symptomatic of paranoid schizophrenia. The jury returned a verdict of not guilty by reason of insanity. This verdict became the subject of considerable popular alarm and was regarded with particular concern by Queen Victoria. As a result, the House of Lords asked the judges of that body to give an advisory opinion regarding the answers to five questions "on the law governing such cases." The combined answers to two of these questions have come to be known as M'Naghten's Rules.

[T]o establish a defense 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.

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M'Naghten quickly became the prevailing approach to the insanity defense in England and in the United States, even though this formulation was criticized often because of its emphasis on the defendant's lack of intellectual or cognitive understanding of what he was doing as the sole justification for legal insanity. M'Naghten's case was followed by a public response not unlike that of the public's response to the John Hinckley case.

Ye people of England exult and be glad  
 For ye're now at the will of the merciless mad . . .  
 For crime is no crime—when the mind is unsettled. (3)

Over the last 150 years, legal formulations for insanity other than M'Naghten have, from time to time, been adopted in certain jurisdictions, e.g., the "irresistible impulse" formulation (4, 5). Judge David Bazelon was midwife to the "product of mental illness" test for insanity employed in the District of Columbia from 1954 through 1972 (6). However, the "product of mental illness" test was originally formulated in New Hampshire in 1869 (7, 8).

The alternative formulation for the insanity defense best known besides M'Naghten is that proposed by the drafters of the Model Penal Code during the 1950s, the so-called ALI (American Law Institute) test. Section 4.01 of the Model Penal Code provides:

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

This was the test employed in the Hinckley case.

The ALI (Model Penal Code) approach to insanity differs from M'Naghten in three respects. First, ALI substitutes the concept of "appreciation" for that of cognitive understanding in the definition of insanity, thus apparently introducing an affective, more emotional, more personalized approach for evaluating the nature of a defendant's knowledge or understanding. Second, the ALI definition for insanity does not insist upon a defendant's total lack of appreciation (knowledge) of the nature of his conduct but instead that he only "lacks substantial capacity." Finally, ALI, like the "irresistible impulse" test, incorporates a so-called volitional approach to insanity, thus adding as an independent criterion for insanity the defendant's ability (or inability) to control his actions.

Through court rulings, the ALI approach to criminal insanity has been adopted in all federal jurisdictions. It has been adopted by legislation or judicial ruling in about half the states. Some variation of M'Naghten is the exclusive test of insanity in about one-third of the states. A handful of states (six) supplement M'Naghten with some variation of the "irresistible impulse" test. Only New Hampshire continues to use the "product of mental illness" test. Montana and Idaho have abol-

ished the insanity defense in recent years or at least that form of the defense that requires the defendant to meet one of the above-mentioned special legal tests or formulations for insanity.

Interestingly, the United States Supreme Court has never ruled whether the availability for defendants of an insanity defense is constitutionally compelled. Nor has the legislature of the United States (the Congress) yet adopted one or another of the traditional insanity defense formulations for use in the federal courts. Earlier in the twentieth century, three state courts (Washington, Mississippi, and Louisiana) ruled that recognition of the insanity defense was constitutionally required.

Despite the attention given to the insanity defense by legal scholars and the continuing debates about the role that psychiatry should play in the administration of defense, it should be noted that successful invocation of the defense is rare (probably involving a fraction of 1 percent of all felony cases) (9, 10). While philosophically important for the criminal law, the insanity defense is empirically unimportant. Making changes in the insanity defense will hardly be the panacea for reducing crime.

Historically, defendants who were found insane also did not usually regain their freedom. Instead, they often spent many years, if not their whole lifetimes, locked away in institutions for the criminally insane. Information also suggests that despite the prominence given the insanity defense through well publicized trials, the majority of such successful defenses, rather than being awarded by juries after criminal trials, occur instead by concurrence between the prosecution and defense. Thus, in many instances, the insanity defense functions in a noncontroversial manner to divert mentally ill offenders from the criminal justice system to the mental health system.

As has recently been summarized by persons testifying before Congress in the wake of the John Hinckley verdict, there is also a great deal that is unknown and not very well studied about the insanity defense. For example, contrary to popular belief, what little evidence there is suggests that the insanity defense is not solely or exclusively a defense of the rich (11). Nor is it a defense that is confined to defendants who are accused only of violent crimes.

During the last ten years, interest in abolishing or modifying the insanity defense has been renewed because of several factors. Public officials, speaking for a growing conservative consensus and a public understandably disturbed by the failures of the entire criminal justice system, have championed the cause that the insanity defense is one more indication that the country is "soft on crime." Thus, in 1973 President Nixon called for the abolition of the insanity defense, noting that this proposal was "the most significant feature of the Administration's proposed criminal code."

A 1981 Attorney General's Task Force on Violent Crime proposed federal legislation to create a verdict of "guilty but mentally ill," similar to legislation that

had been passed in a few states such as Illinois and Michigan.

The hardening of American attitudes about crime has not been, however, the only cause of concern about the insanity defense. Over the last decade, as a consequence of some civil libertarian-type court rulings that insanity acquittees may not be subjected to procedures for confinement that are more restrictive than those used for civil patients who have not committed criminal acts, the insanity defense became a more attractive alternative for defendants to plead. As noted by Stone, over the last decade and for the first time in history, a successful plea of insanity had "real bite" (12). Modern psychiatric treatment, particularly the use of antipsychotic drugs, permits the seeming restoration of sanity for many defendants, even if it cannot be known with certainty whether such acquittees still remain dangerous.

The consequence of the aforementioned trends has been the rapid release from hospitals for a segment of insanity acquittees in some states. In Michigan, following the McQuillan (13) decision, 55.6 percent of "not guilty by reason of insanity" patients were discharged following a 60-day diagnostic commitment (14). In contrast, over 90 percent of insanity acquittees are hospitalized in Illinois after the 30-day diagnostic hearing, with their average length of hospitalization being 39 months. Once their release is approved by the court, it is almost always under the condition of participation in a mandatory, court-ordered outpatient program. The exodus of insanity acquittees in some states has alarmed both the public and the psychiatric profession, which traditionally has been expected to play some continuing role in the social control of persons found not guilty by reason of insanity. The public's perception that a successful plea of insanity is a good way to "beat the rap" contributes to a belief that the criminal insanity defense is not only fundamentally unfair ("for after all, he did do it") but also that insanity is a dangerous doctrine.

#### THE HINCKLEY VERDICT

The ruling of the District of Columbia jury in the John Hinckley case catalyzed many of the above and related issues concerning the insanity defense and its administration. Following the Hinckley verdict, some twenty bills were under discussion or were introduced in the Congress that would codify, for the first time, a federal approach towards insanity and also restrict the defense. The debate has focused on the wording of the insanity defense, its potential abolition, and on post-trial mechanisms for containing the insane. The Reagan administration has proposed, in effect, to abolish the traditional insanity defense and to substitute instead a "mens rea" approach. A person would be found not guilty by reason of insanity only if the person lacked "mens rea," the required mental state that is part of the definition of a crime. Another

approach proposes a limited M'Naghten-type criterion to define insanity.

Other debates have focused upon procedural issues in the law of insanity. In Mr. Hinckley's case, as is presently the case in about half the states, the government had the burden of persuasion to prove the defendant's sanity beyond a reasonable doubt. The other states include insanity among the so-called "affirmative defenses," placing the burden of proving insanity upon the defendant rather than making the government prove sanity. One proposed change of the insanity defense is to shift the burden of proof to the defendant, rather than to the state.

Another focus of discussion, both prior to and following Mr. Hinckley's case, has been on the nature and quality of psychiatric testimony in insanity trials. In particular, there has been criticism of psychiatric testimony about whether defendants meet (or fail to meet) the relevant legal test for insanity in a given jurisdiction. To some extent the public appears confused by the so-called "battle of the experts." Unfortunately, public criticism about the "battle of the experts" fails to recognize or acknowledge advances in psychiatric nosology and diagnosis that indicate a high degree of diagnostic reliability for psychiatry—80 percent or so—so long, that is, as psychiatric testimony is restricted to medical and scientific, and not legal or moral, issues (see, for example, reference 15). Sanity is, of course, a legal issue, not a medical one. The "battle of the experts" is also to a certain extent foreordained by the structure of the adversary system. Experts often disagree in many types of criminal and civil trials. For example, other medical experts may disagree on the interpretation of X-rays, engineers on structural issues, and economists on market concentration issues. American jurisprudence requires that each side (defense and prosecution) make the best case it can in the search for the just outcome.

#### THE APA POSITION

##### *Should the Insanity Defense Be Abolished?*

The American Psychiatric Association, speaking as citizens as well as psychiatrists, believes that the insanity defense should be retained in some form. The insanity defense rests upon one of the fundamental premises of the criminal law, that punishment for wrongful deeds should be predicated upon moral culpability. However, within the framework of English and American law, defendants who lack the ability (the capacity) to rationally control their behavior do not possess free will. They cannot be said to have "chosen to do wrong." Therefore, they should not be punished or handled similarly to all other criminal defendants. Retention of the insanity defense is essential to the moral integrity of the criminal law.

The aforementioned points do not, of course, mean that the insanity defense is necessarily "good for

psychiatry," "good for all criminals" who invoke the plea, or even always "good for the public." In fact, the opposite may be the case. Psychiatrists, indeed even some psychiatric patients, might be less stigmatized, less susceptible to criticism by the media and the public were the insanity defense to be abolished. Thus the Association's view that the insanity defense should not now be abolished is not one that it takes out of self-interest. Only a minority of psychiatrists testify in criminal trials. Members of the American Psychiatric Association, however, recognize the importance of the insanity defense for the criminal law, as well as its importance for genuinely mentally ill defendants who on moral and medical grounds require psychiatric treatment (in addition to restraint), rather than receiving solely custody and punishment.

To the extent that changes need to be made in the insanity defense, the Association, therefore, recommends consideration of some of the ideas discussed below concerning the legal definition of insanity, the burden of proof, the role that psychiatrists can or should play within the insanity defense, and the post-verdict disposition of persons found insane.

*Should a "Guilty But Mentally Ill" Verdict Be Adopted in the Law to Either Supplement or Take the Place of the Traditional Insanity Defense?*

While some psychiatrists believe that the "guilty but mentally ill" verdict has merit for dealing with problems posed by the insanity defense, the American Psychiatric Association is extremely skeptical of this approach. Currently nine states are experimenting with a "guilty but mentally ill" verdict or its equivalent. They permit a "guilty but mentally ill" verdict as an alternative choice for jurors to the traditional insanity defense. Were, however, "guilty but mentally ill" to be the *only* verdict possible (besides guilt or innocence), this would be the abolitionist position in disguise. The idea of moral blameworthiness would be diminished within the law. This does not seem right.

There are also problems with "guilty but mentally ill" as an alternative choice to the traditional insanity defense. "Guilty but mentally ill" offers a compromise for the jury. Persons who might otherwise have qualified for an insanity verdict may instead be siphoned into a category of "guilty but mentally ill." Thus some defendants who might otherwise be found not guilty through an insanity defense will be found "guilty but mentally ill" instead.

The "guilty but mentally ill" approach may become the easy way out. Juries may avoid grappling with the difficult moral issues inherent in adjudicating guilt or innocence, jurors instead settling conveniently on "guilty but mentally ill." The deliberations of jurors in deciding cases are, however, vital to set societal standards and to give meaning to societal ideas about responsibility and nonresponsibility. An important symbolic function of the criminal law is lost through the "guilty but mentally ill" approach.

There are other problems with "guilty but mentally ill." Providing mental health treatment for persons in jails and prisons has, over the years, proved a refractory problem (16). Yet the "guilty but mentally ill" approach makes sense only if meaningful mental health treatment is given defendants following such a verdict. In times of financial stress, the likelihood that meaningful treatment for persons "guilty but mentally ill" will be mandated and paid for by state legislatures is, however, slight. This has been the outcome in Michigan (the state that first embarked upon the "guilty but mentally ill" approach) where even though they have been found "guilty but mentally ill," felons have received no more treatment than they would have prior to the new law.

Alternatively, whatever limited funds are available for the treatment of mentally ill inmates may be devoted to "guilty but mentally ill defendants," ignoring the treatment needs of other mentally ill but conventionally sentenced prisoners who require mental health treatment in prison.

The "guilty but mentally ill" plea may cause important moral, legal, psychiatric, and pragmatic problems to receive a whitewash without fundamental progress being made. We note that under conventional sentencing procedures already in place, judges may presently order mental health treatment for offenders in need of it. Furthermore, a jury verdict is an awkward device for making dispositional decisions concerning a person's need for mental health treatment.

*Should the Legal Standards Now in Use Concerning the Insanity Defense Be Modified?*

While the American Psychiatric Association is not opposed to state legislatures (or the U.S. Congress) making statutory changes in the language of insanity, we also note that the exact wording of the insanity defense has never, through scientific studies or the case approach, been shown to be the major determinant of whether a defendant is acquitted by reason of insanity (9). Substantive standards for insanity provide instructions for the jury (or other legal decisionmakers) concerning the legal standard for insanity which a defendant must meet. There is no perfect correlation, however, between legal insanity standards and psychiatric or mental states that defendants exhibit and which psychiatrists describe. For example, while some legal scholars and practitioners believe that using the word "appreciate" (rather than "knowing" or "understanding") expands the insanity dialogue to include a broader and more comprehensive view of human behavior and thinking, this may not necessarily be so. Of much greater practical significance is whether the standard employed is interpreted by individual trial judges to permit or not permit psychiatric testimony concerning the broad range of mental functioning of possible relevance for a jury's deliberation. But this matter is not easily legislated.

The above commentary does not mean that given

the present state of psychiatric knowledge psychiatrists cannot present meaningful testimony relevant to determining a defendant's understanding or appreciation of his act. Many psychiatrists, however, believe that psychiatric information relevant to determining whether a defendant understood the nature of his act, and whether he appreciated its wrongfulness, is more reliable and has a stronger scientific basis than, for example, does psychiatric information relevant to whether a defendant was able to control his behavior. The line between an irresistible impulse and an impulse not resisted is probably no sharper than that between twilight and dusk. Psychiatry is a deterministic discipline that views all human behavior as, to a large extent, "caused." The concept of volition is the subject of some disagreement among psychiatrists. Many psychiatrists therefore believe that psychiatric testimony (particularly that of a conclusory nature) about volition is more likely to produce confusion for jurors than is psychiatric testimony relevant to a defendant's appreciation or understanding.

Another major consideration in articulating standards for the insanity defense is the definition of mental disease or defect. Definitions of mental disease or defect sometimes, but not always, accompany insanity defense standards. Under Durham (6), the "product of mental illness" approach, a series of legal cases in the District of Columbia suggested that (for purposes of criminal insanity) "sociopathy" or other personality disorders could be "productive" of insanity. It was assumed by the law that such disorders could impair behavior control. But this is generally not the experience of psychiatry. Allowing insanity acquittals in cases involving persons who manifest primarily "personality disorders" such as antisocial personality disorder (sociopathy) does not accord with modern psychiatric knowledge or psychiatric beliefs concerning the extent to which such persons do have control over their behavior. Persons with antisocial personality disorders should, at least for heuristic reasons, be held accountable for their behavior. The American Psychiatric Association, therefore, suggests that any revision of the insanity defense standards should indicate that mental disorders potentially leading to exculpation must be *serious*. Such disorders should usually be of the severity (if not always of the quality) of conditions that psychiatrists diagnose as psychoses.

The following standard, recently proposed by Bonnie (17), is one which the American Psychiatric Association believes does permit relevant psychiatric testimony to be brought to bear on the great majority of cases where criminal responsibility is at issue:

A person charged with a criminal offense should be found not guilty by reason of insanity if it is shown that as a result of mental disease or mental retardation he was unable to appreciate the wrongfulness of his conduct at the time of the offense.

As used in this standard, the terms mental disease or mental retardation include only those severely abnormal

mental conditions that grossly and demonstrably impair a person's perception or understanding of reality and that are not attributable primarily to the voluntary ingestion of alcohol or other psychoactive substances.

In practice there is considerable overlap between a psychotic person's defective understanding or appreciation and his ability to control his behavior. Most psychotic persons who fail a volitional test for insanity will also fail a cognitive-type test when such a test is applied to their behavior, thus rendering the volitional test superfluous in judging them.

#### *Should the Burden of Proof in Insanity Cases Always Rest With the Prosecution?*

The case of John Hinckley brought renewed attention to who has the burden of proof in insanity cases. In the Hinckley case, the state had the burden to prove Mr. Hinckley's sanity beyond a reasonable doubt. This was a considerable burden for the state to overcome. Legal scholars believe that who bears the burden of proof in a legal case is a matter of considerable import. This is especially so when what is to be proven is inherently uncertain. And if anything can be agreed upon about criminal insanity, it is that insanity is a matter of some uncertainty.

At present about half of the states and all the Federal Courts require that once a defendant introduces into the proceeding any evidence of insanity, the state then bears the burden to prove the defendant was instead sane. An equal number of states and the District of Columbia, however, assign the burden of proof to the defendant, who must then prove his insanity by "a preponderance of the evidence" or by an even higher standard of proof.

The American Psychiatric Association is exceedingly reluctant to take a position about assigning the burden of proof in insanity cases. This matter is clearly one for legislative judgment. For public policy, the issue is, in part, whether the rights of the individual or the rights of the state are to be given more or less weight in criminal insanity trials or, as is sometimes stated, which types of errors do we deem more or less tolerable in insanity trials. Given the inherent uncertainties involved in psychiatric testimony regarding the defense and the ever-present problems relating abstract legal principles to controversies of such emotion, who bears the burden of proof in insanity trials may be quite important. This is particularly so when what must be proved must also be proved "beyond a reasonable doubt." As suggested by the United States Supreme Court in the *Addington* case (18), psychiatric evidence is usually not sufficiently clear-cut to prove or disprove many legal facts "beyond a reasonable doubt."

It is commonly believed that the likely effect of assigning the burden of proof (burden of persuasion) to defendants rather than to the state in insanity trials will be to decrease the number of such successful

defenses. This matter clearly requires further empirical study.

*Should Psychiatric Testimony Be Limited to Statements of Mental Condition?*

This area for potential reform of the insanity defense is one of the most controversial. Some proposals would limit psychiatric testimony in insanity defense trials to statements of mental condition, i.e., to statements of conventional psychiatric diagnoses, to provision of accounts of how and why the defendant acted as he did at the time of the commission of the act, to explanations in medical and psychological terms about how the act was affected or influenced by the person's mental illness. However, under this approach, psychiatrists would not be permitted to testify about so-called "ultimate issues" such as whether or not the defendant was, in their judgment, "sane" or "insane," "responsible" or not, etc. A further limitation upon psychiatric "ultimate issue" testimony would be to restrict the psychiatrist from testifying about whether a defendant did or did not meet the particular legal test for insanity at issue. Thus the law could prevent psychiatrists from testifying in a conclusory fashion whether the defendant "lacked substantial capacity to conform his behavior to the requirements of law," "lacked substantial capacity to appreciate the criminality of his act," was not able to distinguish "right from wrong" at the time of the act, and so forth.

The American Psychiatric Association is not opposed to legislatures restricting psychiatric testimony about the aforementioned ultimate legal issues concerning the insanity defense. We adopt this position because it is clear that psychiatrists are experts in medicine, not the law. As such, the psychiatrist's first obligation and expertise in the courtroom is to "do psychiatry," i.e., to present medical information and opinion about the defendant's mental state and motivation and to explain in detail the reason for his medical-psychiatric conclusions. When, however, "ultimate issue" questions are formulated by the law and put to the expert witness who must then say "yea" or "nay," then the expert witness is required to make a leap in logic. He no longer addresses himself to medical concepts but instead must infer or intuit what is in fact unspeakable, namely, the *probable relationship* between medical concepts and legal or moral constructs such as free will. These impermissible leaps in logic made by expert witnesses confuse the jury (19). Juries thus find themselves listening to conclusory and seemingly contradictory psychiatric testimony that defendants are either "sane" or "insane" or that they do or do not meet the relevant legal test for insanity. This state of affairs does considerable injustice to psychiatry and, we believe, possibly to criminal defendants. These psychiatric disagreements about technical, legal, and/or moral matters cause less than fully understanding juries or the public to conclude that psychiatrists cannot agree. In fact, in many criminal insanity trials

both prosecution and defense psychiatrists do agree about the nature and even the extent of mental disorder exhibited by the defendant at the time of the act.

Psychiatrists, of course, must be permitted to testify fully about the defendant's psychiatric diagnosis, mental state, and motivation (in clinical and commonsense terms) at the time of the alleged act so as to permit the jury or judge to reach the ultimate conclusion about which they, and only they, are expert. Determining whether a criminal defendant was legally insane is a matter for legal fact-finders, not for experts.

*What Should Be Done With Defendants Following "Not Guilty by Reason of Insanity" Verdicts?*

This is the area for reform where the American Psychiatric Association believes that the most significant changes can and should be made in the present administration of the insanity defense. We believe that neither the law, the public, psychiatry, nor the victims of violence have been well served by the general approach and reform of the last ten years, which has obscured the quasi-criminal nature of the insanity defense and of the status of insanity acquittees.

The American Psychiatric Association is concerned particularly about insanity acquittals of persons charged with violent crime. In our view, it is a mistake to analogize such insanity acquittees as fully equivalent to civil committees who, when all has been said and done, have not usually already demonstrated their clear-cut potential for dangerous behavior because they have not yet committed a highly dangerous act. Because mental illness frequently affects the patient's ability to seek or accept treatment, we believe that civil commitment, as a system of detention and treatment, should be predicated on the severity of the patient's illness and/or in some instances on the mental patient's potential for perpetrating future violence against others. The usual civil committee has not, however, committed nor will he commit in the future a major crime. Most mentally ill persons are not violent (20). By contrast, the "dangerousness" of insanity acquittees who have perpetrated violence has already been demonstrated. Their future dangerousness need not be inferred; it may be assumed, at least for a reasonable period of time. The American Psychiatric Association is therefore quite skeptical about procedures now implemented in many states requiring periodic decisionmaking by mental health professionals (or by others) concerning a requirement that insanity acquittees who have committed previous violent offenses be repetitively adjudicated as "dangerous," thereupon provoking their release once future dangerousness cannot be clearly demonstrated in accord with the standard of proof required.

While there are no easy solutions to these problems, the following are some potential alternatives for the future.

First, the law should recognize that the nature of in-hospital psychiatric intervention has changed over the

last decade. Greater emphasis is now placed upon psychopharmacological management of the hospitalized person. Such treatment, while clearly helpful in reducing the overt signs and symptoms of mental illness, does not necessarily mean, however, that "cure" has been achieved—nor that a patient's "non-dangerousness" is assured. Continuing, even compelled, psychiatric treatment is often required for this population once the patient is released from the hospital.

Although some insanity acquittees will recover in such facilities, there can be no public guarantee. Therefore, the presumption should be that after initial hospitalization a long period of conditional release with careful supervision and outpatient treatment will be necessary to protect the public and to complete the appropriate treatment programs. Unfortunately, however, many jurisdictions have neither the trained personnel nor appropriate outpatient facilities and resources to provide for such close management of previously violent persons who are conditionally released. Where statutes provide for conditional release and judges allow it without these necessary resources, the public is subjected to great risk and the insanity acquittee is deprived of an opportunity for a necessary phase of treatment.

At any hearing that might order the conditional release of an insanity acquittee, the following questions must be answered affirmatively. Has a coherent and well structured plan of supervision, management, and treatment been put into place? Is this plan highly likely to guarantee public safety while maximizing the chances for rehabilitation of the insanity acquittee? Are the necessary staff and resources available to implement the plan? Is there in place a procedure to reconfine the insanity acquittee who fails to meet the expectations of the plan?

For some acquittees contingent release is not possible because of the risk to society, the lack of resources, or other relevant legal considerations. Yet because psychiatry has no more to offer the acquittee, continued confinement cannot be justified on therapeutic or psychiatric grounds. When there exists no realistic therapeutic justification for confinement, the psychiatric facility becomes a prison. The American Psychiatric Association believes this hypocrisy must be confronted and remedied. One appropriate alternative is to transfer the locus of responsibility and confinement for such acquittees to a nontreatment facility that can provide the necessary security.

The American Psychiatric Association believes that the decision to release an insanity acquittee should not be made *solely* by psychiatrists or *solely* on the basis of psychiatric testimony about the patient's mental condition or predictions of future dangerousness. While this may not be the only model, such decisions should be made instead by a group similar in composition to a parole board. In this respect, the American Psychiatric Association is impressed with a model program presently in operation in the State of Oregon under the

aegis of a Psychiatric Security Review Board (21, 22). In Oregon a multidisciplinary board is given jurisdiction over insanity acquittees. The board retains control of the insanity acquittee for a period of time as long as the criminal sentence that might have been awarded were the person to have been found guilty of the act. Confinement and release decisions for acquittees are made by an experienced body that is not naive about the nature of violent behavior committed by mental patients and that allows a quasi-criminal approach for managing such persons. Psychiatrists participate in the work of the Oregon board, but they do not have primary responsibility. The Association believes that this is as it should be, since the decision to confine and release persons who have done violence to society involves more than psychiatric considerations. The interest of society, the interest of the criminal justice system, and the interest of those who have been or might be victimized by violence must also be addressed in confinement and release decisions.

In line with the above views, the American Psychiatric Association suggests the following guidelines for legislation dealing with the disposition of violent insanity acquittees.

1. Special legislation should be designed for those persons charged with violent offenses who have been found "not guilty by reason of insanity."

2. Confinement and release decisions should be made by a board constituted to include psychiatrists and other professionals representing the criminal justice system—akin to a parole board.

3. Release should be conditional upon having a treatment supervision plan in place with the necessary resources available to implement it.

4. The board having jurisdiction over released insanity acquittees should have clear authority to reconfine.

5. When psychiatric treatment within a hospital setting has obtained the maximal treatment benefit possible but the board believes that for other reasons confinement is still necessary, the insanity acquittee should be transferred to the most appropriate nonhospital facility.

In general, the American Psychiatric Association favors legislation to identify insanity acquittees who have committed violent acts as a special group of persons who, because of the important societal interests involved, should not be handled similarly to other civil committees.

Although efforts to treat mentally disordered offenders have met with limited success, we should also increase our commitment to developing and implementing new treatment approaches for those adjudicated insane. There are practical as well as humanistic reasons for making this recommendation. A certain number of those who plead insanity will, whatever their disposition, eventually be released to society. To whatever extent their sanity is restored or their capacity to adhere to proper conduct is enhanced, the public will receive that much more protection from crime.

REFERENCES

1. Robitscher J, Haynes AK: In defense of the insanity defense. *Emory Law Journal* 31:9-60, 1982
2. Low T, Jeffries J, Bonnie R: *Criminal Law: Cases and Materials*. Mineola, NY, Foundation Press, 1982, p 653
3. The Times, 1843: Cited in Sutcliffe and after (edtl). *Lancet* 1:1241-1242, 1981
4. Weiner BA: Not guilty by reason of insanity: a sane approach. *Chicago-Kent Law Review* 56:1057-1085, 1980
5. *Smith v United States*, 36 F 2d 548, 549 (DC Cir 1929)
6. *Durham v United States*, 214 F 2d 862 (DC Cir 1954)
7. *State v Pike*, 49 NH 399 (1869)
8. *State v Jones*, 50 NH 369 (1871)
9. Pasewark RA: Insanity plea: a review of the research literature. *Journal of Psychiatry & Law* 9:357-401, 1981
10. Steadman HJ: Testimony before Subcommittee on Criminal Justice, Committee on the Judiciary, House of Representatives, July 22, 1982
11. Steadman HJ, Keitner L, Braff J, et al: Factors associated with a successful insanity plea. *Am J Psychiatry* 140:401-405, 1983
12. Stone AA: The insanity defense on trial. *Hosp Community Psychiatry* 33:636-640, 1982
13. *People v McQuillan*, 392 Mich 511, 221 NW 2d 569 (1974)
14. Criss ML, Racine DR: Impact of change in legal standard for those adjudicated not guilty by reason of insanity 1975-1979. *Bull Am Acad Psychiatry Law* 8:261-271, 1980
15. Spitzer RL, Forman JBW, Nee J: *DSM-III* field trials, I: initial interrater diagnostic reliability. *Am J Psychiatry* 136:815-817, 1979
16. Roth LH: Correctional psychiatry, in *Modern Legal Medicine, Psychiatry and Forensic Science*. Edited by Curran W, McGarry AL, Petty C. Philadelphia, FA Davis Co, 1980
17. Bonnie RJ: The moral basis of the insanity defense. *American Bar Association Journal* 69:194-197, 1983
18. *Addington v Texas*, 99 S Ct 1804, 1811 (1979)
19. Shah SA: Some interactions of law and mental health in the handling of social deviance. *Catholic University Law Review* 23:674-719, 1974
20. Rabkin JG: Criminal behavior of discharged mental patients: a critical appraisal of the research. *Psychol Bull* 86:1-27, 1979
21. Rogers JL: 1981 Oregon legislation relating to the insanity defense and the Psychiatric Security Review Board. *Willamette Law Review* 18:23-48, 1982
22. Bloom JL, Bloom JD: Disposition of insanity defense cases in Oregon. *Bull Am Acad Psychiatry Law* 9:93-99, 1981