MENTALLY ILL CRIMINALS AND THE INSANITY DEFENSE

A Report to the Minnesota Legislature

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Executive Summary

This report is about how the criminal justice system deals with people who have a severe mental illness, such as schizophrenia, bipolar (manic-depressive) illness, or depression. These brain diseases cause a profound loss of a person's ability to plan, think, and make decisions. The law recognizes that some people may be too mentally ill to know what they are doing when they commit a crime and, therefore, cannot be held morally responsible. In a criminal trial, such a person can use the insanity defense and plead "not guilty by reason of insanity." The legal test for insanity, however, is not the same as a medical diagnosis of mental illness. Minnesota uses a test for insanity that came from a 19th century English court case.

Many people in the state's prisons and jails are mentally ill but not legally insane. Indeed, the number of mentally ill people in prisons and jails is a substantial problem in Minnesota, as it is throughout the country. In 1997 about 685 of 5,300 prison inmates in Minnesota (13%) were mentally ill. Many authorities believe that deinstitutionalization of mental hospitals, highly restrictive civil commitment laws, and the lack of community services have resulted in a shift of mentally ill people from the mental health system to the criminal justice system.

The number of mentally ill people in the criminal justice system, and the fact that mentally ill people sometimes commit highly sensational crimes, raise public concerns about what should be done with mentally ill people who commit crimes. Should they be punished like other criminals, or treated more like people who are sick? The challenge for public policy is to find the right balance between these two options. In this report we discuss some of the alternatives.

The report begins with a review of the relationship between mental illness and violence, and then examines how often mentally ill people are acquitted for insanity in criminal

cases. We find that there is a small but significant connection between serious mental illness and crime. We also learn that in Minnesota it is very rare for someone to be acquitted by reason of insanity. This happens so infrequently, in fact, that it raises questions about the viability of the insanity defense here. A comparison of Minnesota with other states shows that it is more difficult to prove insanity under Minnesota law than in many other states, but other factors may also inhibit use of the insanity plea.

Some states have adopted an alternative to the verdicts of guilty or not guilty by reason of insanity — the "guilty but mentally ill" verdict. Its purpose is to reduce the number of insanity acquittals by giving jurors another option when a defendant is mentally ill. We examine the effect of "guilty but mentally ill" in states that have it and project what might happen if it were adopted in Minnesota. Because insanity acquittals are rare in Minnesota, however, we conclude that it would not have much impact here.

The report also discusses ways to restore viability to Minnesota's insanity defense. Even if changes were made to the insanity defense, however, the criminal justice system will still have to deal with substantial numbers of mentally ill people. Correctional institutions in Minnesota provide mental health treatment to inmates, but there is a gap in services for mentally ill offenders when they return to their communities. Few community mental health programs are suited to the mentally ill offender, who often has the dual diagnosis of chemical dependency and may be violent or disruptive. The report describes model programs in other parts of the country that provide a continuum of specialized treatment for mentally ill offenders in the community. Such programs can benefit both the public and the offender.

This report fulfills a request from the 1998 Minnesota Legislature for a study of the "guilty but mentally ill" verdict and "other issues involving mental health and the criminal justice system." The Legislature commissioned this report in establishing the Center for Applied Research and Policy Analysis at the School of Law Enforcement, Criminal Justice and Public Safety, Metropolitan State University.

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MENTALLY ILL CRIMINALS AND THE INSANITY DEFENSE

A Report to the Minnesota Legislature

This report is about how the criminal justice system deals with people who have a severe mental illness. Mental illness is a conundrum for the courts. People with schizophrenia, for example, have a profound loss of ability to think, plan, and make decisions because their brains don't work correctly. Some may have a delusion that their life is in danger and commit a crime to protect themselves. Others may hear over-powering voices commanding them to do something wrong. Are such people competent to stand trial or agree to a plea bargain? Do they meet the legal standard of intent to commit a crime? Does their illness excuse them or mitigate the severity of punishment? What should happen to them if convicted, or if not convicted?

Because no clear answers exist to these questions, states have taken different legal paths with mental illness. Minnesota, for instance, uses a legal test for judging whether someone is not guilty by reason of insanity that came from a 19th century British court case. Other states, however, have adopted newer tests for insanity or have added the verdict "guilty but mentally ill." Some states allow a defendant to claim mental illness as a mitigating factor; others do not. A few states have abolished the insanity defense. Usually these changes reflect shifting public sentiments about whether mentally ill criminals should be punished or treated for their illness, and about how best to protect the public from mentally ill criminals.

New discoveries about mental illness might also cause us to re-examine the treatment of mentally ill people in criminal justice. Until recently, the biological basis of serious mental illness was virtually unknown. Now, high-tech brain scans show the exact areas of a sick brain that are not working properly, and biochemists have discovered some of the

chemical pathways in the brain that malfunction in mental illness. These discoveries have increased public awareness of mental illness and helped reduce the social stigma that is often attached to those who suffer these illnesses.

In 1998 the Minnesota Legislature appropriated funds to Metropolitan State University to establish the Center for Applied Research and Policy Analysis in the School of Law Enforcement, Criminal Justice and Public Safety (*Laws 1998*, Chapter 367). The Legislature asked the Center to:

> conduct a study of the guilty but mentally ill verdict . . . (and) consider other issues involving mental health and the criminal justice system such as the mental illness defense, current mental health treatment provided to inmates at state correctional facilities, and current use of the civil commitment process.

The Legislature called for a preliminary report in March 1999 and a final report in November 1999. This is the final report, and it covers the following issues:

- **The connection between mental illness and crime.**
- **The frequency that people are acquitted by reason of insanity.**
- **How criminal law deals with mental illness in Minnesota and other states.**
- **Outcomes for mentally ill defendants in states with the "guilty but mentally ill" verdict, and the potential impact if it were adopted in Minnesota.**
- **Policy and program alternatives for mentally ill criminals.**

The analysis draws primarily on empirical and legal research that others have done on the relationship between crime and mental illness, the insanity defense, and the "guilty but mentally ill" verdict. We also compare what happens to mentally ill defendants in

Minnesota with those in other states and review the availability of services for mentally ill offenders. The report concludes with ideas for the Legislature on improving the insanity defense and treatment of mentally ill criminals.

Severe Mental Illness

Authorities distinguish severe or serious mental illnesses, which are physical diseases of the brain, from less serious mental conditions that are usually psychological but not physical in origin.[1] Serious mental illness includes schizophrenia, bipolar (manic-depressive) illness, and major depression. Obsessive-compulsive disorder and panic attacks are often added to the list. Together, these illnesses are more common than cancer or heart disease and, over a lifetime, affect one in five families. About 20 percent of the nation's hospital beds are taken by people with a mental illness. Severe brain disorders have both hereditary and environmental causes that are not yet fully understood.

Serious mental illness does not include mental retardation, hyperactivity, multiple personality, personality or character disorder, psychopathic personality, sexual psychopathology, pedophilia, addiction, or similar conditions, although research points increasingly to the likelihood that some of these, too, are related to brain disorders.

Serious mental illness disrupts a person's ability to think, feel, and relate to other people and the physical environment. Many people with a severe mental illness lose their jobs, become estranged from their families, are homeless, or commit suicide. About 160,000 people with severe mental illnesses are in the nation's jails and prisons.[2]

Schizophrenia is the most chronic and disabling mental illness, affecting 1 percent of the population. It usually strikes people in their late teens or early twenties, although victims may have subtle signs of brain dysfunction in childhood. Typical symptoms are hallucinations, delusions, and bizarre thinking, collectively referred to as psychosis. People with the illness may believe that their thoughts are under control of someone else

or coming from outside their head. Poor brain functioning also causes a breakdown of social relationships, poor communication skills, and lack of motivation. Schizophrenia has different subtypes; one is paranoid schizophrenia, in which the victim has intense fears or feelings of persecution accompanying hallucinations. Although many people with schizophrenia are helped by drug therapy and social assistance, few recover from the disease.

Bipolar illness and depression affect a person's mood more than thinking ability. In bipolar illness, a person's mood cycles between extreme depression, normal mood, and extreme euphoria or mania. In the manic stage a person may have grandiose delusions or psychotic thought processes similar to those of schizophrenia and may abuse illegal drugs or alcohol. At the other extreme, a person who is extremely depressed may feel life is hopeless and have difficulty concentrating or making decisions; suicide is a strong possibility. Mood disorders can usually be treated successfully with drugs and electroconvulsive therapy, but the illness may return intermittently.

Mental Illness and Crime

Crimes by mentally ill people are sometimes very sensational, which may give the public the misperception that mentally ill people often commit violent crimes. Researchers have closely examined the link between mental illness and violent crime. They have found that most people who commit violent crimes are not mentally ill and most mentally ill people do not commit crimes. One study found that about 3 percent of the variation in violent crime in the United States is related to mental illness.[3] In general, mentally ill people are more likely to be victims of violent crime than perpetrators. But research has pointed to a small group of people with severe mental illness who are at higher risk for violent behavior.

People with psychoses — bizarre thinking, hallucinations, and delusions — as found in schizophrenia and, less often, in mood disorders, are more likely to commit violent

crimes than people with no mental disorder. This has been reported in many research studies.[4] A connection with violence also applies to people with some neurological brain diseases, such as Huntington's chorea, and to people who have had head injuries that damaged the brain.

A recent study of mentally ill people looked at their use of medication and alcohol in relation to violence.[5] Results showed that when mentally ill people stop taking their medicine and abuse alcohol or illegal drugs, they are more likely to be violent. Violent behavior is also more likely among people with paranoia who hear command voices telling them to kill someone, or who believe their mind is dominated by forces beyond their control. The victims of mentally ill people are often members of their own family.

Frequency of Insanity Pleas and Acquittals

For centuries the law has encompassed the widely held belief that some people are too mentally deranged to know what they are doing and, therefore, cannot be held morally responsible for a crime. This principle came from English common law, which presumed that an illegal act was not a crime unless performed with criminal intent. In a criminal trial, a mentally ill person might be found not guilty by reason of insanity, despite proof that the person had committed a crime.

Insanity pleas and acquittals are relatively uncommon. An eight-state study of 581,000 indictments found 8,979 insanity pleas — a rate of 1.5 percent.[6] A different study of insanity cases in four states (California, Georgia, Montana, and New York) showed that of 586,000 felony indictments, only 5,300 (0.9%) had a plea of insanity by the defendant.[7] And of the 5,300 insanity pleas, there were 1,385 acquittals by reason of insanity — 0.23 percent of indictments and 26 percent of insanity pleas. A study of adult defendants represented by the Public Defender's office in New Jersey found 52 insanity pleas for 32,000 defendants (less than 0.2%) and of the 52 cases, 15 were successful.[8]

The connection between serious mental illness and successful insanity pleas is well documented. The eight-state study of almost 2,600 criminal defendants who were found not guilty by reason of insanity (NGRI) reported that 68 percent had schizophrenia and 16 percent had a severe mood disorder — a total of 84 percent with a severe mental illness.[9] The others were mentally retarded (5%), had another mental illness (5%), a personality disorder (3.5%), or were chemically dependent. The crimes they had been charged with were murder (15%), physical assault (38%), other violent crimes (12%), robbery (7%), property crimes (18%), and other minor crimes (10%).

Successful insanity pleas in Minnesota are very rare. We obtained data from Minnesota's Supreme Court administration on the frequency of successful insanity pleas in recent years. (No data is available in the state's judicial information system on unsuccessful insanity pleas.) For 1995 and 1997, there were no insanity acquittals; in 1996 there was one acquittal in a felony case.[10] It is more likely for a defendant to be found mentally incompetent to stand trial than to be acquitted. Court data shows, for example, that in 1997 there were 12 felony cases where the defendant was found mentally incompetent to stand trial or the case was dismissed because of mental incompetence.

The rarity of insanity acquittals in Minnesota is a puzzle. A contributing factor is certainly the stringent requirements that a defendant must meet to prove insanity — requirements that go well beyond the medical standards for severe mental illness. But as we look at the standards, and information from other states, we will see that there must be other reasons why so few defendants in Minnesota are acquitted by reason of insanity.

Mentally Ill Persons in Minnesota's Prisons

In sharp contrast to the infrequency of insanity acquittals, many of Minnesota's prison inmates are mentally ill — as many as a large state hospital for the mentally ill might have, or did have in the past before deinstitutionalization of the mentally ill. A mental health survey of inmates by the Minnesota Department of Corrections in 1997 found that 685 of 5,262 adult inmates (13%) had a "thought" or "mood" disorder, which would be

consistent with a severe mental illness.[11] And of the 685 mentally ill inmates, 153 were acutely ill — 2.9 percent of adult inmates. Similarly, a survey of prison inmates in 1994 reported that 441 of 4,028 (11%) were using psychiatric medications.[12]

Minnesota is similar to other states in the rate of mental illness among prisoners. A new report by the federal Bureau of Justice Statistics estimated that 10 percent of inmates in the nation's state prisons and 10 percent of those in local jails currently have a mental illness; another 6 percent have previously had a mental condition.[13] These data are based on self-reporting by inmates in a national survey. About 19 percent of inmates reported that they have taken a prescribed medication for a "mental or emotional condition." Mental illness was reported more often by female prisoners than males, and more often by white prisoners than other races. Alcohol and drug use were more strongly associated with mentally ill inmates than others, and nearly 6 of 10 mentally ill inmates reported that they were under the influence of alcohol or drugs at the time of their current offense. Mentally ill inmates in state prisons serve longer than average sentences because they are more frequently involved in fights and have more disciplinary problems than other inmates.

Legal Dimensions of Mental Illness and Crime

The large numbers of mentally ill inmates in jails and prisons show that the legal concept of "insanity" is not the same as a medical diagnosis of mental illness, such as schizophrenia or paranoia. In fact, few people who are mentally ill meet the legal standard of insanity. The courts use one of several legal tests — not medical tests — to determine whether people meet the standard of insanity that would excuse them from guilt for a crime. The legal tests vary depending on the state or federal court. States also differ on several other dimensions of the legal process:

- Which side has to prove insanity — defense or prosecution.

- The standard of proof, as by a preponderance of evidence or beyond a reasonable doubt.
- Trial procedure.
- Whether mental illness can be a mitigating factor.
- Dispositions available for people found not guilty by reason of insanity.

We first review the most common tests for insanity, then other dimensions of legal process.

McNaughtan test

In 1843 Daniel McNaughtan shot and killed the secretary of the British Prime Minister by mistake while intending to kill the Prime Minister. At trial, McNaughtan was found "not guilty, on the ground of insanity." Public outcry and royal concern about the acquittal led a panel of justices to establish a standard for insanity, which is still used by British courts. The test was meant to be used by a jury after hearing medical testimony from prosecution and defense experts. Under this rule a defendant was presumed sane unless the defense proved that:

> At the time of committing the act, the party accused was laboring 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 what he was doing was wrong.[14]

About half of American states, including Minnesota, use the test.[15] Notice, however, that it does not excuse mentally ill people who knew what they did was wrong but were unable to control their actions. To allow for this possibility, several states have added an exculpatory provision for a person who could not control himself because of an "irresistible impulse."

American Law Institute test

In 1972 the Court of Appeals for the District of Columbia endorsed a Model Penal Code standard, which the American Law Institute had proposed in the 1950s. Under the ALI test,

> 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 the law.[16]

The ALI test is less stringent than McNaughtan because it does not require a total lack of self-control or inability to know right from wrong, but only that someone with mental illness "lacks substantial capacity" to act and reason normally. The ALI test is used in about 20 states, and it was used in federal courts until 1984, when a more stringent test was adopted.

Appreciation test

In 1984 the appreciation test was made law in all federal courts by act of Congress.[17] A few states have adopted similar laws. These changes were largely a response to public dismay when John Hinckley was found NGRI after his attempted assassination of President Reagan. Federal law requires that a defendant prove by clear and convincing evidence that:

> At the time of the commission of the acts constituting the offense, the defendant, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his acts.[18]

The requirement of "unable to appreciate" is tougher than ALI's "lacks substantial capacity."

No test

Three states have abolished the insanity defense: Utah, Montana, and Idaho. In these states, however, defendants can offer evidence at trial that they lacked the mental capacity to form the intent to commit the crime they are charged with.[19] The prosecution must rebut this claim beyond a reasonable doubt.

Civil commitment test

Sometimes mentally ill persons who commit crimes go through the civil commitment process instead of being prosecuted. This option might be pursued by the county attorney after an arrest for a misdemeanor, or a mentally ill person might be diverted into the medical system without being arrested or charged for the crime. Mentally ill persons can be committed to supervision and care by the state in a state hospital when they are a danger to themselves or others. (Commitment is also possible for mentally ill persons who are unable to care for themselves.) Behavior that meets the test of dangerousness for civil commitment overlaps with behavior that might be prosecuted as a criminal offense.

Several decades ago, the standards for civil commitment were less stringent than today, and people with a severe mental illness were often committed to care in a state hospital before they would have met today's test of dangerousness. Now, restrictive commitment laws make it more likely that people with severe mental illness are caught up in the criminal justice system. This is a well recognized and often debated national phenomenon.[20]

The Legislature moderated the state's commitment policy in 1997, when it allowed court-ordered early intervention for mentally ill people under limited circumstances before they

reach the level of dangerousness required for commitment.[21] A mentally ill person who refuses appropriate treatment and is overtly disturbed may meet the criteria for early intervention if the person has been committed twice in the previous three years for similar reasons, and can be reasonably expected to deteriorate to the point where commitment is needed. Mentally ill persons with grossly disturbed behavior who cannot care for themselves can also be eligible if they would have chosen similar treatment under these circumstances. In practice, these requirements — especially for two prior commitments in three years — severely limit the number of mentally ill people who meet these criteria. After about the first half year of operation in 1998 under this law, Hennepin County had not identified a single person who met the criteria for early intervention.[22]

Burden of proof

After John Hinckley's acquittal in 1982, many states changed their laws on the insanity defense to make acquittal more difficult, as the federal government had done. By 1990, 36 states, including Minnesota, had put the burden of proof on the defense.[23] This had the intended result. Researchers have shown that fewer defendants are likely to claim insanity when they must prove it rather than the state, and in these cases a serious mental illness is virtually a prerequisite to success.[24]

Standard of proof

In general, the standard of proof varies from one state to another and depends on whether the burden of proving insanity is on the defense or prosecution. As of 1990, 32 states required proof of insanity by a "preponderance of the evidence" (in each case by the defense); this is the lowest standard. Another 3 states used "clear and convincing evidence" as the standard (by the defense), and 14 used "beyond a reasonable doubt" — all with the state having the burden of proof. Minnesota uses preponderance of the evidence.[25]

Trial procedure

Trial procedures are another difference among states. Some states, including Minnesota, have a two-stage or bifurcated trial if the defendant pleads both not guilty to the crime and NGRI. The first stage deals with the alleged crime. If the defendant is found to have committed the crime, the insanity issue is taken up at the second stage.[26] Evidence about the defendant's mental state can be introduced only at the second stage. If the defendant pleads mental illness as a defense but does not choose to bifurcate the trial in Minnesota, all evidence as to the guilt of the defendant must be heard in court prior to the defendant offering evidence relating to mental capacity.[27]

The standard of competency to stand trial was decided by the U.S. Supreme Court and also applies to plea bargaining. A mentally ill defendant is not competent who lacks sufficient ability to consult with a reasonable degree of rational understanding with defense counsel, or is so mentally ill as to be incapable of understanding the proceedings or participating in the defense.[28] The Court also decided that the appropriate standard for defendants to rebut the presumption of competency to stand trial should be "preponderance of the evidence."[29]

Dispositions

In the 1970s and 1980s many states were concerned that they might not be able to keep dangerous mentally ill criminals locked up if they were found NGRI. Increasingly, courts at that time were treating them like people who had a civil commitment.[30] Under rules for civil commitment, once persons who had been under treatment no longer posed a risk of violence, they had to be released. In 1983, however, the U.S. Supreme Court ruled that an insanity acquittal is enough to justify automatic commitment when the defense has the burden of proof, and that the maximum sentence has no bearing on the decision to release.[31] Furthermore, the court ruled that persons found NGRI do not have the same

protections as persons under civil commitment and can be confined for longer, indeterminate periods.

Minnesota also places more stringent requirements on NGRI acquittees in felony and gross misdemeanor cases than in civil commitments. If the person is already under a civil commitment when found NGRI, the court continues the civil commitment; if the person is not under commitment, the court institutes it. But the trial court retains continuing supervision over the case and must be informed about any proposed discharge of commitment.[32]

Mitigation

The idea of mitigation for mental illness is not to excuse the defendant but to reduce the charge or ameliorate the sentence. English law, for example, stipulates that a person whose mental illness, disease, or defect substantially impairs his mental responsibility for a murder can be convicted only of manslaughter.[33] That is, a mentally ill defendant might be incapable of the premeditation required for a murder charge. A similar approach has been taken in a number of American states. In 1992 the Minnesota Supreme Court identified 24 states that allow psychiatric evidence on the question of whether a mentally ill defendant intended, or had the necessary mental state, to commit the crime charged.[34] But courts in Minnesota and many other states have rejected the concept of diminished or partial responsibility for a crime owing to mental illness. A problem for many courts is that it is hard to connect a person's mental illness, which is a general condition, with the specific mental state at the time of the crime.

Tougher laws against mentally ill criminals after the Hinckley case also resulted in more jurisdictions refusing to accept the defense of diminished responsibility. Congress abolished this defense in federal courts in the Insanity Defense Reform Act of 1984.[35] California, which had been a leader in setting legal precedents for diminished responsibility, abolished it as a defense in 1982.[36] The California Supreme Court has

since upheld the constitutionality of this change, just as it had upheld the principle of diminished responsibility before the California legislature changed the law.

Minnesota courts do not allow the defense of diminished responsibility for mentally ill defendants. The state's Supreme Court has ruled decisively on this in several cases.[37] This is consistent with the court's stand against allowing expert psychiatric testimony on the mental state of the defendant during the first stage of a trial, which deals with elements of the crime. On this point, the Minnesota Supreme Court stated:

> The law recognizes no degree of sanity. Applying socially and morally acceptable standards a line has been drawn — on one side are the legally sane, on the other side are the legally insane.[38]

The court went on to acknowledge, however, that:

> There are exceptions. An example is intoxication. *See* Minn. Stat. 609.075 (1980). There are, however, significant evidentiary distinctions between 'partial or relative insanity' and conditions such as intoxication, medication, epilepsy, infancy, or senility. These are susceptible to quantification and lay understanding.[39]

In support of this view, the court's opinion cited a 1973 federal court decision that "The esoterics (*sic*) of psychiatry are not within the ordinary ken."[40]

The court's opinion that, unlike intoxication, degrees of insanity and psychiatry are beyond lay understanding seems to be contradicted in a more recent decision: " . . . expert opinion testimony about the general effects of mental illness or intoxication is ordinarily inadmissible because most jurors have some experience with these conditions."[41] Here the court put mental illness and intoxication in the same category with regard to knowledge by lay jurors. The court asserted, therefore, that not that all testimony on the defendant's mental state might be disallowed in the first stage of a trial, but *expert* testimony is forbidden, and testimony by psychiatrists is expert testimony.

Minnesota's policy on mentally ill criminals

Minnesota's policy on mentally ill criminals is based on its statutes, court rules, and legal precedents.[42] In comparison with other states, Minnesota has one of the most stringent policies, making it very difficult for a mentally ill person who has committed a crime to be acquitted by reason of insanity. Minnesota uses the strict McNaughtan test for insanity, with the burden of proof on the defense, and forbids any psychiatric testimony that might mitigate the seriousness of the crime charged. The rarity of insanity acquittals in Minnesota supports this interpretation.

Despite the court's denial of diminished responsibility for mental illness, this is not fundamentally an issue of law but of public policy. Other states have decided to allow diminished responsibility or have changed their policy from one view to the other with shifting public sentiments.

Keeping in mind Minnesota's current policy and practices on the use of the insanity verdict, we next consider the potential impact of adopting another policy option, the verdict of guilty but mentally ill (GBMI), which is available in several other states.

The "Guilty but Mentally Ill" Verdict (GBMI)

The GBMI verdict is an alternative to guilty, not guilty, and NGRI; it is not meant to replace NGRI. Proponents of GBMI have asserted that it will reduce the frequency of NGRI verdicts and give juries an option between guilty and NGRI.[43] If more mentally ill defendants are found guilty, the argument goes, this will enhance public safety by allowing them to be imprisoned for longer periods than they would be under confinement following an insanity acquittal. Some advocates of GBMI believe it will lead to better care of mentally ill people once they are in correctional institutions.

GBMI statutes typically say that a defendant must first raise the insanity defense to take advantage of the GBMI law. Then, the court orders the defendant to undergo a psychiatric exam to find out whether there is a factual basis for claiming mental illness at the time the crime was committed. The statute must define mental illness, which will not be the same definition used for insanity. A defendant may plead to GBMI, if accepted by the court, or the defendant may go to trial.

At trial, the defendant may be found not guilty, not guilty by reason of insanity, guilty, or guilty but mentally ill. The prosecution has to prove beyond a reasonable doubt that the defendant is guilty of the crime charged. The defense must prove that the defendant was mentally ill. The insanity defense must also be decided, however. Depending on which side has the burden of proof of insanity in the state, a guilty or GBMI verdict also presumes that either the defense fails to prove insanity, or it requires the prosecution to prove that the defendant was not legally insane when the crime was committed. Different legal standards may apply depending on state law about which side has to prove what. A jury may find, for example, that the defendant is guilty of the crime charged beyond a reasonable doubt, was mentally ill when he committed the crime by preponderance of evidence, and that the state proved beyond a reasonable doubt that the defendant was not insane — therefore, GBMI.

The GBMI verdict was first enacted in Michigan in 1975.[44] This happened because of a unique situation in Michigan when the state Supreme Court ruled that the state could not automatically commit people who were found NGRI. Immediately about 150 people were released from custody. Two of these people soon committed violent crimes, and the Michigan legislature responded to public outrage by changing the law. A few other states followed the Michigan lead. The Hinckley case stimulated adoption of GBMI by additional states, bringing the total to 13.[45] GBMI has been adopted by states that use different tests and standards for insanity, although there are minor variations in their GBMI statutes.

The GBMI verdict has been upheld in virtually every state and federal court challenge, whether on grounds of equal protection, due process, cruel and unusual punishment, ex post facto law, or right to treatment.[46] In 1986 the U.S. Supreme Court dismissed an appeal of a conviction under Michigan's GBMI statute for want of a substantial federal question.[47] In 1987 the Seventh Circuit of the U.S. Court of Appeals ruled Illinois' GBMI statute constitutional.[48] In 1998 the Tenth Circuit upheld New Mexico's GMBI statute.[49] A lone state appeals court in 1997 in Illinois ruled the state's GBMI statute unconstitutional because it encourages compromise verdicts based on jurors' misperceptions and misunderstandings, which is a violation of due process.[50]

The court rulings have affirmed that GBMI is essentially *no different than a conventional guilty plea or verdict.* It does not guarantee a right to treatment for a mentally ill defendant, and it does not imply any diminished responsibility for the crime.

Opponents of GBMI

Despite its success in court challenges, many people remain opposed to this verdict. The American Bar Association and the American Psychiatric Association, among other groups, have declared their opposition to GBMI.[51] The ABA's position is that it does not achieve the intended goals, while adding a meaningless and unnecessary element to the criminal justice system.[52] The ABA holds that GBMI ". . . is not a proper verdict at all. Rather it is a dispositional mechanism transferred to the guilt determination phase of the criminal process."[53]

Research findings

Researchers have studied the impact of GMBI in several of the states that adopted it, investigating whether it met the goals of reducing insanity acquittals and keeping dangerous mentally ill criminals in prison for longer periods. Most of the research has

been done in Michigan — which has the longest experience with GBMI — and, to a lesser degree, in Georgia and Illinois.

A study in Michigan showed that, despite adoption of GBMI, the rate of NGRI verdicts remained stable over a ten-year period. Before GBMI was introduced, 0.024 percent of adult male defendants were found NGRI; seven years after GBMI was adopted, the percentage of NGRI verdicts was 0.032 percent.[54] This finding contradicts that belief that GBMI would decrease the rate of insanity acquittals. In the four years before GBMI, the number of insanity acquittals averaged 59 per year; in the first four years with GBMI, acquittals averaged 54 per year. The study also found that about 60 percent of GBMI cases were settled through plea bargains, while only 20 percent went to a jury. Researchers found this somewhat surprising because the verdict was supposed to help juries in their decision-making about insanity.

The researchers concluded that most defendants receiving GBMI verdicts probably would have had been found guilty without availability of the GBMI verdict. As to treatment for mental illness after conviction, over 75 percent of defendants found GBMI got no psychiatric treatment, and most of the others had only cursory psychiatric check-ups. Psychiatric testing at one Michigan prison found that only 50 percent of GBMI convicts showed signs of mental disorder.

A 1996 report in a Michigan newspaper also described the lack of treatment given to persons convicted as GBMI.[55] Of 308 inmates on GBMI convictions, 41 (13%) were receiving in-patient care; the rest got no treatment or as few as one psychiatric appointment every 60 days.

Unlike the results for Michigan, a study in Georgia found a decline in insanity verdicts as a result of GBMI.[56] Georgia and Minnesota have the same legal test and standards for insanity; Michigan uses the ALI test. The study compared pleas and verdicts from 1976 to 1981 (before GBMI) with those from 1982 to 1985 (after GBMI) and reported that the NGRI rate went from 20 percent of pleas down to 12 percent. Acquittals averaged 48 per

year before GBMI and 32 afterwards. Some defendants accused of violent crimes who formerly would have been found NGRI were being found GBMI, and they got longer sentences.

The GBMI option also affected plea bargaining in Georgia. Initially there was an increase in plea bargaining to GBMI by defendants faced with a possible death sentence if they went to trial. Later, plea bargaining appeared to decline, perhaps because defense attorneys saw that their clients who pleaded to GBMI were likely to get longer sentences. The medical treatment of GBMI prisoners was no different from other mentally ill prisoners; Georgia does not mandate treatment but it does allow sentencing to the state's Department of Human Services for confinement in a state hospital instead of prison, depending on the person's mental condition.

In Illinois the Governor's Commission to Revise the Mental Health Code of Illinois called for abolition of the verdict.[57] The commission argued that it had failed to achieve its intended goals and that it had a number of negative consequences. There was little evidence that it had reduced the number of insanity acquittals and provided no special treatment for mentally ill offenders beyond what other prisoners received.[58] The commission also found that it stigmatized people in prisons, causing their maltreatment by other prisoners.

A 1997 investigation by *The Times*, an Indiana newspaper, recounted problems with the state's GBMI verdict.[59] According to the report, GBMI has practically eliminated the insanity verdict in Indiana. A person, for example, facing the death penalty is more likely to plead to GBMI than risk going for an insanity acquittal at trial. But other defendants who pleaded to GBMI did so on advice of their defense attorneys, believing that they would receive treatment for their illness — treatment often not forthcoming in prison. Indiana's Supreme Court has also ruled that a person convicted of GBMI can be executed. According to the reporter, "Growing evidence points toward an inescapable conclusion: Indiana's prisons soon will displace state mental hospitals as the dominant long-term institutional care for the seriously mentally ill." And Indiana's Department of Corrections

acknowledged that it does not have the resources to properly treat the numbers of mentally ill prisoners.

Potential impact on Minnesota

What would happen if GBMI were adopted in Minnesota? Not much. Because Minnesota already has almost no insanity acquittals, GBMI would have virtually no impact on the number. And Minnesota does not have a problem keeping persons under indeterminate commitment if they have been acquitted for insanity, so GBMI is not necessary for that purpose. If better treatment of mentally ill inmates is the goal, the Legislature could ensure that without GBMI.

GBMI might have an impact on plea bargaining, as it has in other states. The likely result would be that some people who now plead guilty would plead to GBMI instead. This might result in longer sentences for them, however, if they plead to GBMI instead of to a reduced charge under a conventional guilty plea. As seen in other states, defendants sometimes plead to GBMI under the mistaken hope or poor advice that they will receive treatment for their mental illness.

What Happens to Mentally Ill Criminals in Minnesota?

Insanity acquittals are so rare in Minnesota that it raises a question of what's going on. The strictness of Minnesota's insanity standards is certainly a contributing factor. But compare Minnesota and Georgia, which have the same insanity standards. Georgia has about 50 percent greater population than Minnesota and averaged about 40 insanity acquittals per year before GBMI was adopted. Michigan, with a population twice Minnesota's, has over 50 NGRIs per year. Given the rates in Georgia and Michigan, and Minnesota's population, one might expect to see about 25 insanity acquittals in Minnesota each year.

We also know that schizophrenia has a relatively constant rate of 1 percent in the population and that it is the illness of most insanity acquittees. So one cannot assume there are fewer severely mentally ill people in Minnesota than in other states. As discussed earlier, about 13 percent of Minnesota's prison inmates are mentally ill.

An explanation for the very low rate of insanity acquittals in Minnesota may be that mentally ill defendants find an advantage in not trying for an insanity acquittal. Consider the choices of a mentally ill defendant. The defendant can plead guilty, possibly to a reduced charge, or go to trial on the crime charged, pleading insanity. The defendant acquitted for insanity, however, still faces a potentially long indeterminate period of confinement under a mental illness commitment. Given the choices, the defendant might well choose to accept a plea bargain with jail time or a determinate prison sentence, as specified under Minnesota's sentencing guidelines, to avoid prolonged confinement for mental illness.

End of the Insanity Defense?

The rarity of insanity acquittals and the large number of mentally ill people in prison show that, in practice, Minnesota is making little use of the insanity defense for defendants with serious mental illness. Despite substantial medical progress in the understanding of mental illness, the centuries-old concept that a person can be too mentally ill to be morally accountable for a crime seems to have fallen into disregard. Since this has not happened by specific legislative intent, the Legislature might wish to consider whether the viability of the insanity defense should or could be restored.

To restore viability to the insanity defense, the Minnesota Legislature might consider the following options:

- Changing the insanity standard from McNaughtan to ALI.
- Shifting the burden on proving insanity from defense to prosecution.
- Allowing mitigation for mental illness.

We propose these ideas as being worthy of further, more comprehensive review by legislators, legal scholars, and the judiciary.

Changing the standard or burden of proof would be relatively straightforward options that are used in other states — and were used more widely before the Hinckley case. Mitigation is a much more complicated legal issue, but it opens the door to a broader approach to mentally ill defendants.

Mitigation might take the British approach of reducing murder charges to manslaughter. Or it might mean allowing psychiatric or non-expert testimony on a defendant's mental illness in the guilt-determining stage of a trial. Mitigation at sentencing might include a downward departure of sentence length under sentencing guidelines. Alternatively, a sentence might be stayed or suspended and probation granted on condition that a defendant voluntarily and faithfully keep on prescribed medication for his or her illness and abstain from alcohol and illegal drugs. Research has showed that these conditions greatly reduce the threat of violence. This option would require intensive supervision but might have the added benefit of being less costly than prison.

Services for Mentally Ill Criminals

Regardless of what type of insanity defense is allowed in Minnesota, the state must still consider how best to confine, treat, and return to the community the hundreds of mentally ill people who commit serious crimes. Their numbers are only partly related to the insanity defense and infrequency of insanity acquittals. Many people with severe mental illness are in the criminal justice system as a consequence of civil commitment laws and U.S. Supreme Court rulings that make it virtually impossible to commit mentally ill people until they become dangerous or violent — a legal situation that is unlikely to change in the near future.

The state's prisons and jails offer mental health services to prisoners; this is a legal requirement, as it is for other types of health care. Prisoners cannot be forced to take

medication for their mental illness, however, unless they are committed separately for mental illness. The Department of Corrections also has a special needs unit at Lino Lakes correctional facility that houses mentally ill inmates, offers them specific programs, and assists with placement on release from prison.

The most significant gap in services occurs when mentally ill prisoners return to the community. According to a recent study on Hennepin County, for example, there are no community corrections programs that focus on the mentally ill offender.[60] More typically, programs exist for sex offenders, chemical dependency treatment, or as halfway houses for those released from prison. Community services for all people with mental illness are deficient, but mentally ill offenders present special challenges. Many of the residential treatment programs for mentally ill people (Rule 36 programs) are less willing to admit offenders and may not be prepared to treat them.[61] Mentally ill offenders often have a dual diagnosis of chemical dependency, which should be treated simultaneously with their mental illness treatment. Another problem in returning mentally ill offenders to the community is they are often homeless at the time of their arrest.

Several jurisdictions around the country have developed model programs for the mentally ill offender. Maryland has the Community Criminal Justice Treatment Program, a multiagency collaborative that provides long-term housing, case management, and treatment services to mentally ill offenders in their communities.[62] The program was initiated to serve the jailed mentally ill but has been expanded to include persons on probation and parole, and it also has a pretrial diversion program. It will take people who are chemically dependent in addition to having a serious mental illness. In 1996, the program served 1,700 people, with a budget of about $14 million drawn from local, state, and federal sources.

Broward County (Florida) has started a "mental illness court," which is analogous to drug courts in other jurisdictions.[63] The Florida court deals with both the legal and medical issues of offenders who are mentally ill. It can divert misdemeanor offenders into treatment programs, structure and monitor the mental health treatment of convicted

offenders, ensure the competence of mentally ill defendants to stand trial, and see that the criminal justice and mental health systems work together for the benefit of offenders and the community.

In 1998 the California legislature set up a grant program to assist local communities in dealing with mentally ill offenders.[64] Initial funding was $27 million to the State Board of Corrections, which administers the program. Communities that wish to compete for the grants must establish local strategy committees of law enforcement and mental health agencies chaired by a sheriff or corrections director. The goal is to develop more cost-effective programs that provide a continuum of responses to mentally offenders, from prevention to intervention and incarceration.

These examples show that other states are beginning to respond to the problem of having large numbers of mentally ill people in the criminal justice system, while trying to promote the safety of the community when they are released from confinement. The model programs show that the criminal justice system, working in coordination with the mental health system, can build a more humane and effective path to dealing with mentally ill criminals.

NOTES

[1] National Institute of Mental Health, <<http://www.nimh.nih/gov/>>; and National Alliance for the Mentally Ill (NAMI), <<http://www.nami.org/>> are good sources of information on mental illness.
[2] NAMI.
[3] John Monahan, "Mental illness and violent crime," National Institute of Justice, October 1996.
[4] American Psychiatric Association, <<http://www.psych.org/public_info/>>. G. M. Asnis, et al., "Violence and homicidal behaviors in psychiatric disorders," *Psychiatr. Clin. North Am.*, 20 (June 1997): 405-425. Henrik Belfrage, "A ten-year follow-up of criminality in Stockholm mental patients: New evidence for a relation between mental disorder and crime," *British Journal of Criminology*, 38 (Winter 1998): 145-156. Lynn Lambert, "Mental illness and violent acts: Protecting the patient and the public," *Journal of the American Medical Association*, 280 (August 5, 1998): 407-408.
[5] M. S. Swartz, et al., "Violence and severe mental illness: the effects of substance abuse and nonadherence to medication," *American Journal of Psychiatry*, 155 (February 1998): 226-231. Or see Fox Butterfield, "Violence by mentally ill tied to substance abuse: public fears are misdirected, study finds, *New York Times*, May 15, 1998, v. 147, p A10(N), p A14(L), col 5.
[6] Lisa A. Callahan, et al., "The volume and characteristics of insanity defense please: An eight-state study," *Bulletin of the American Academy of Psychiatry Law*, 19 (1991).
[7] Henry J. Steadman, et al., *Before and After Hinckley: Evaluating Insanity Defense Refo*rm, New York: Guilford Press, 1993: 28.
[8] American Psychiatric Association, "The insanity defense," <<http://www.psych.org/public_info/insani~1.htm>>.
[9] Callahan, et al.: 336.
[10] Personal communication from Sharon A. Krmpotich, Minnesota Supreme Court, Research and Evaluation.
[11] Minnesota Department of Corrections, "Minnesota D.O.C. mental health survey — conducted 10/15/97," unpublished.
[12] Patricia Seleen, "Ombudsman for corrections investigative report on systemic issues of mentally ill inmates." Minnesota Ombudsman for Corrections, 1995.
[13] Paula M. Ditton, "Mental health treatment of inmates and probationers," Bureau of Justice, July 1999.
[14] Ingo Keilitz, "Researching and reforming the insanity defense," *Rutgers Law Review*, 39 (Winter/Spring 1987): 289-323.
[15] For Minnesota, see M.S. 611.026.
[16] Keilitz: 296.
[17] Keilitz: 296-7; it was part of the 1984 Comprehensive Crime Control Act.
[18] 18 U.S.C. Sec. 17.
[19] Keilitz: 303-4.
[20] H. Richard Lamb and Linda E. Weinberger, "Persons with severe mental illness in jails and prisons: A review," *Psychiatric Services,* 49 (April 1998): 483-492. And E. Fuller Torrey, *Out of the Shadows: Confronting America's Mental Illness Crisis*, Wiley, 1996.
[21] *Laws* 1997, Ch. 217, Art. 1. Or M.S. 253B.064-066.
[22] Martin Marty, Hennepin County staff person, speaking to a meeting of the Hennepin County Alliance for the Mentally Ill.
[23] Steadman: 37,40.
[24] Steadman: 85.
[25] Minnesota Court Rule 20.02, subd. 6(4).
[26] Minnesota Court Rule 20.02, subd. 6(2,3).
[27] *State of Minnesota v David Francis Hofman*, Supreme Court of Minnesota, 328 N.W. 2d 709 (1982).
[28] *Minnesota Court Rules*, Rule 20.01.
[29] *Cooper v Oklahoma*, 116 S. Ct. 1373 (1996).

[30] Richard Singer, "The aftermath of an insanity acquittal: The Supreme Court's recent decision in *Jones v. United States*," in *Annals of the American Academy of Political and Social Science*, 477 (January 1985).
[31] Steadman. The court case was *Jones v United States* (1983).
[32] Minnesota Court Rule 20.02, subd. 8 (1,4).
[33] Travis H. D. Lewin, "Psychiatric evidence in criminal cases for purposes other than the defense of insanity," *Syracuse Law Review*, 26 (1975): 1051-1115.
[34] *State of Minnesota v Robert Provost, Jr.*, 490 N.W. 2d 93 (1992), footnote 2.
[35] Steadman: 41.
[36] Lewin documents the history of diminished responsibility in California courts. The current statute is *Cal Pen Code*, Sec. 28. See also *Deering's California Codes Annotated*, LEXIS Law Publishing, 1998.
[37] State of *Minnesota v David Francis Hoffman*, 318 N.W. 2d 709 (1982); *State of Minnesota v Thomas J. Bouwman*, 328 N.W. 2d 703 (1982).
[38] *State of Minnesota v Thomas J. Bouwman*, 328 N.W. 2d 703 (1982).
[39] *Ibid.*
[40] *Wharlich v State*, 479 F. 2d 1137, 1138 (9th Cir. 1973).
[41] *State of Minnesota v Robert Provost, Jr.*, 490 N.W. 2d 93 (1992).
[42] M.S. Annotated §611.026; *Minnesota Court Rules*, Minn. R. Crim. Proc. 20; *Judge's Benchbook*, State Court Administrator, 1997, 11-24 to 11-29.
[43] John Q. LaFond and Mary L. Durham, "Cognitive dissonance: Have insanity defense and civil commitment reforms made a difference?" *Villanova Law Review*, 39 (1994).
[44] Lisa Callahan, et al. "Measuring the effects of the guilty but mentally ill (GBMI) verdict," *Law and Human Behavior*, 16 (1992): 447-462. Bradley D. McGraw, Daina Farthing-Capowich, and Ingo Keilitz, "The 'guilty but mentally ill' plea and verdict: Current state of the knowledge," *Villanova Law Review*, 30 (1985): 117-191.
[45] These 13 states are Alaska, Alaska Stat. § 12.47.030; Delaware, Del. Code Ann. tit. 11, § 401(b); Georgia, Ga. Code Ann. § 17-7-131; Illinois, 725 Ill. Comp. Stat. Ann. 5/115-3(c), -4(j); Indiana, Ind. Code Ann. § 35-36-2-3; Kentucky, Ky. Rev. Stat. Ann. §§ 504.120, .130; Michigan, Mich. Comp. Laws Ann. § 768.36; Nevada, Nev. Rev. Stat. § 174.035; New Mexico, N.M. Stat. Ann. §§ 31-9-3 to -4; Pennsylvania, 18 Pa. Cons. Stat. Ann. § 314; South Carolina, S.C. Code Ann. § 17-24-20; South Dakota, S.D. Codified Laws § 23A-26-14; and Utah, Utah Code Ann. §§ 77-16a-103 to -104 ("guilty and mentally ill").
[46] Callahan, et al.; McGraw, et al.
[47] *People v Hardesty*, 424 Mich. 877, 477 U.S. 902 (1986).
[48] *United States ex rel. Weismiller v Lane*, 815 F.2d 1106, 1113 (7th Cir. 1987).
[49] *Neely v Newton*, Tenth Circuit, No. 97-2161 (June 24, 1998); <<http://lawlib.wuacc.edu/ca10/1998/06/97-2161.htm >>.
[50] *State of Illinois v Eric J. Robles*, 288 Ill. App. 3d 935; 682 N.E. 2d 194 (1997).
[51] American Bar Association, "Legislative issues," <<http://scratch.abanet.org/legadv/lgpolicy.html>> as of February 1998. American Psychiatric Association, <<http://www.psych.org/public_info/insani~1.htm>>.
[52] Christopher Slobogin, "Symposium on the ABA criminal justice mental health standards: The guilty but mentally ill verdict: An idea whose time should not have come," *George Washington Law Review*, 53 (1985).
[53] *ABA Criminal Justice Mental Health Standards*, standard 7-6.10 commentary, at 393-94 (1988).
[54] Gare A. Smith and James A. Hall, "Evaluating Michigan's guilty but mentally ill verdict: and empirical study," *University of Michigan Journal of Law*, 16 (Fall, 1982).
[55] Ron French, "Prison sentencing: Behind bars, 'guilty but mentally ill' means little," *The Detroit News*, September 30, 1996, Metro; <<http://www.detnews.com/1996/menu/stories/67362.htm >>.
[56] Lisa A. Callahan, et al., "Measuring the effects of the guilty but mentally ill (GBMI) verdict — Georgia's 1982 GBMI reform," *Law and Human Behavior*, 16 (1992): 447-462.
[57] *State of Illinois v Eric J. Robles*, 288 Ill. App. 3d 935; 682 N.E. 2d 194 (1997).
[58] See also Steadman et al., 1993.
[59] Kevin Corcoran, "Sick Justice," *The Times*, December 1997, <<http://thetimesonline.com/features/sickjustice.index.html>>.

[60] Carol Cochran, "An historical perspective of mental health and criminal justice policies: Current policies in an urban county for offenders with mental illness," unpublished master's thesis, Augsburg College, Minneapolis, 1999: 101.
[61] Cochran: 102.
[62] Catherine Conly, "Coordinating community services for mentally ill offenders: Maryland's Community Criminal Justice Treatment Program," National Institute of Justice, April 1999.
[63] R. Honberg, "Florida establishes "mental health" court," *NAMI Advocate* 1997 (2), National Alliance for the Mentally Ill, Arlington VA.
[64] California Senate Bill 1485 (*Statutes of 1998*, Chapter 501).