KENTUCKY'S EXPERIENCE WITH THE "GUILTY-BUT-MENTALLY-ILL" VERDICT: A REVIEW AND SOME EMPIRICAL OBSERVATIONS

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I. Introduction

On June 30, 1983, Kentucky completed the first year of legal enforcement of House Bill 32 (HB 32), K.R.S. 504.120. This law provides for an entirely new verdict in criminal cases, that of "guilty-but-mentally-ill" (GBMI), in addition to the previously existing "guilty", "not-guilty", and "Not-guilty-by-reason-of-insanity" (NGRI) verdicts. In the first year of experience with the law, Kentucky Correctional Psychiatric Center, which provides treatment for all individuals with felony cases designated as GBMI, admitted thirteen individuals with the GBMI designation. In addition to describing the method by which Kentucky obtained the GBMI law, this report is intended to describe certain characteristics of the GBMI population, and to compare them with other comparable populations. Finally, the need for ongoing controlled research is discussed, as well as the implications of the study at hand.

II. Legal and Political History of HB 32

Prior to 1974, Kentucky had no statutory provisions for the adjudication of those suffering from a substantial mental disease or defect in criminal proceddings. As established in case law, the standard for the individual involing the insanity defense in a criminal action must ".....be so bereft of mind as to render him incapable of knowing right from wrong, or, if knowing, incapable of controlling his actions."[1] This standard was no more than a reiteration of the M'Naghten Rule.[2]

With the enactment of the Penal Code in 1974, Kentucky adopted a new standard for the insanity defense, the American Law Institution (ALI) standard. Taken verbatim from the Institute's Model Penal Code, this law states: "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 of his conduct or to conform his conduct to the requirements of law....As used in this chapter, the term "mental disease or defect" does not include an abnormality manifested only by repeated criminal or otherwise anti-social conduct."[3]

Without digressing into an overly technical discussion of these two standards, a few observations are in order. First, both standards are partly alike in that they include a provision for the individual who cannot mentally distinguish between right and wrong ("...appreciate the criminality of his conduct..." in Penal Code language). The ALI standard goes beyond the pre-1974 standard by including the clause: "...or to conform his conduct to the requirements of law." This latter inclusion is a variant of the "Irresistable Impulse Rule."[4] The ALI standard differs from the M'Naghten Rule in its use of the expression "mental disease or defect", which is probably a reflection of changing scientific and legal perceptions of mental illness and mental retardation, and in the ALI standard's prescription that "substantial capacity" is the only degree of impairment required to justify lack of criminal responsibility for the defendant, while the M'Naghten Rule requires total impairment.[5] Neither standard makes provision for the contingency that might occur when an individual has a mental condition falling

somewhere between "no mental illness" and the degree of impairment required to satisfy the insanity defense.[6]

The period following the enactment of K.R.S. 504.020 saw increasing debate about the validity of the insanity defense. "Horror stories" about instances where the defense was abused were widely publicized, as were legal decisions affecting the application of the defense. In 1974, the Michigan Supreme Court revoked the legal requirement that individuals found NGRI must be civilly committed to a state mental hospital as violation of the defendant's civil liberties.[7] Subsequently, some 150 individuals declared NGRI were released from Michigan mental hospitals and two of these people committed violent crimes. The public outcry resulting from this occurrence prompted the Michigan State Legislature to pass its "GBMI Law" in 1975.[8] In 1977, the Michigan Court of Appeals upheld the constitutionality of the GBMI law.[9] By February 9, 1983, seven other states had followed suit in passing similar laws.[10] Two states, Idaho and Montana, abolished the insanity defense altogether.[11]

The legislative history of H.B. 32 is interesting and will be recounted here. Dissatisfaction with the Kentucky provisions for the insanity defense was probably simmering in certain quarters for years, but certain instances wherein mentally disturbed individuals committed violent crimes in Kentucky provided impetus for legislative reform. In particular, the 1979 slaying of 80-year-old Ida W. Datillo, a "...white-haired matriarch of a large Louisville family"[12] by her mentally deranged daughter and the subsequent finding that this daughter was NGRI, committed to Central State Hospital, and eventually declared

eligible for release from the hospital[13] apparently added to the motivation of the Supreme Court of Kentucky to take the unusual step of recommending the legislation of a GBMI statute. The opinion in which this recommendation appears states, in part, "...the real problem lies in the very nature of the defense of insanity. It may be too much to ask of any set of men or women to make a dispassionate assessment of a criminal defendant's mental condition, especially in the setting of a revolting offense he has committed. Some of our sister states have endeavored to meet the problem by authorizing a verdict of "guilty but mentally ill" (short or legal "insanity") under which the sentence is not affected but the defendant,while serving it,may be confined as may be necessary in a mental institution. We commend that approach to our own General Assembly."[14] Shortly thereafter, The Louisville Times published an editorial reiterating this recommendation, noting that the Indiana legislature had passed such a law partially in response to the 1978 case of Anthony Kiritsis, the Indianapolis man who was declared NGRI after abducting a mortgage executive, using a shotgun to ward off would-be rescuers.[15] The Courier-Journal[16] and WHAS[17] (radio and television stations) issued similar opinions. In addition to this social pressure, the General Assembly was also subject to lobbying for the passage of a GBMI law by the Datillo family[18] and other concerned individuals and groups. This action led State Representative Roger C. Noe to propose GBMI legislation, noting that a GBMI verdict "...furthers the interests of society and of the criminal justice system but doesn't ignore the defendant's civil rights and liberties. It is true that a defendant found GBMI experiences more sanctions than one found 'not guilty by reason of insanity' - but the sanctions are directed toward

his needs and he receives due process protections at each step along the way."[19] (Additionally, the proposed legislation permitted psychiatrists or psychologists to examine and report on the mental conditions of defendants in such proceeedings.)[20] Later this proposed legislation was withdrawn and was replaced by very similar proposed legislation, 82 BR 429,[21] which still proposed GBMI legislation.

In a speech comparing the two pieces of proposed legislation, Representative Noe mentioned the influence of the Datillo family and the Gall decision in making his proposals, noting that 82 BR 51 had been prefiled in April, 1981 and withdrawn in the following July. He declared that the earlier bill had the Michigan and Indiana GBMI statutes as models, but that he decided to alter the proposed legislation "...after I reflected long and hard on testimony and other communications of interested citizens on the earlier bill."[22] Representative Noe states that the bills are essentially the same, but that they were different in several respects. First of all, chronological order was used in describing the sequence of events leading up to a GBMI verdict, facilitating reading of the bill by interested parties. The new bill was shortened to ten pages in length from the original bills' seventeen. In BR 429, sentencing options were clearly specified. Representative Noe stated, "Any sentence that could be imposed on a guilty defendant can be imposed on a GBMI defendant who is still mentally ill at the time of sentencing." Also, Noe asserted that "...the GBMI verdict may be triggered in any case in which the defendant provides evidence of his mental illness or insanity at the time of the offense."[23] BR 429 clarified who has the burden of proof in reaching the GBMI verdict.

(The new bill stated, "The defendant may be found guilty but mentally ill if: (a) The prosecution proves beyond a reasonable doubt that the defendant is guilty of an offense, and (b) The defendant proves by a preponderance of the evidence that he was mentally ill at the time of the offense."[24]) In 82 BR 429, the treatment for the mental illness of the GBMI individual was forbidden to be electroshock therapy and psychosurgery. Finally, the new bill was different from the old in that BR 429 removed the provision allowing a court to order a competent defendant to submit himself to treatment to maintain his competency to stand trial.[25] Noe defended his new bill by saying, "I am concerned that there is a 'gap' in the present law. That gap lets some people who need treatment go free (with 'not guilty by reason of insanity' verdicts) and it sentences some people who need treatment with very little chance that they will receive it."[25] The provision that the mental evaluation for the defendant could be provided by a psychologist was in the new bill and the subsequent law.[27] Noe concluded his defense of 82 BR 429 by stating, "The present law forces juries to judge mental states as black or white. I think there is a gray mental state in between sane and insane, called mental illness. I also think that someone who is guilty, but less than insane, should be responsible for his crime--he should be sentenced--but he should also be treated for his mental illness."[28]

Considerable controversy surrounded the proposed legislation, and this was magnified by various pronouncements across the country. On August 17, 1981, shortly after the filing of 82 BR 429, the United States Attorney General's Task Force on Violent Crime published its Final Report. Recommendation thirty-nine of that report concerns the reform of the

insanity defense, and includes an endorsement of GBMI legislation: "...Under these laws, a jury may recognize a defendant as being mentally ill, but nevertheless hold him responsible for his criminal actions, provided the mental illness does not negate the defendant's ability to understand the unlawful nature of his conduct and his ability to conform his actions to the requirements of the law... A similar statute should be adopted by the federal government that would enable federal juries to recognize that some defendants are mentally ill but that their mental illness is not related to the crime they committed or their culpability for it. It would also enable a jury to be confident that a defendant who is incarcerated as a result of its verdict will receive treatment for that illness while confined."[29]

Such publications may have been an influencing factor in the debate which followed the filing of 82 BR 429. On September 8 and 9, 1981, the Kentucky Interim Joint Committee on Health and Welfare, Subcommittee on Mental Illness and Mental Incompetency held its twelfth meeting of the 1980-81 Interim, and the proposed GBMI legislation was the principal topic of discussion.[30] In this meeting both opposition and support of the proposed measure was voiced. Kentucky Attorney General Steven L. Beshear voiced support of the bill, saying that his office supported a statute providing for a GBMI verdict. Ronald Zellar, Assistant Attorney General and one who had experience with the Michigan GBMI law, said that the bill's substance was consistent with the recommendations of the U.S. Attorney General's Task Force on Violent Crime. Mr. Zellar was asked if the bill would cause more people to use the insanity defense, and Zellar said it would not, in all likelihood, since that was not the

experience in Michigan.[31] Then Chief Justice John S. Palmore of the Supreme Court of Kentucky testified on 82 BR 429. Justice Palmore was reported by The State Journal of Frankfort as saying that the bill was progressive because it went against the notion that some people who commit crimes are sane. Further, Palmore stated that, "If a man runs out here and kills someone he needs to be taken into custody, period, whether he is sane or insane...For the protection of society we should take them all in and not ask if they are sane or insane."[32] Palmore also predicted that within one hundred years, the "...whole business of trying to draw a line between sanity and insanity will be laughed at..."[33] Then William Radigan of the Office of Public Advocacy spoke against the bill, saying that it made bad law because: (1) it makes no practical difference from the current state of affairs; (2) the General Assembly is able to legislate the right to treatment for mentally ill convicts.[34]

A little more than one week later, The Courier-Journal editorialized that Kentucky needed GBMI legislation. The editorialist said, "... Kentucky now has a chance to joint the handful (of states) that have bridged the gap (in services for the criminally insane). State legislators should seize this opportunity for sagacity...The way is simple, really. Instead of allowing the plea of not guilty by reason of insanity, the state would substitute guilty but mentally ill. That way, a disturbed criminal would be assured treatment. And society could know that a person responsible for a crime, while insane, was in custody--either in a secure treatment center or, if judged cured, serving the remainder of a sentence behind bars."[35]

With the tide of opinion seemingly in favor of 82 BR 429, the Interim Joint Committee on Health and Welfare approved the bill and recommended that it pass the General Assembly.[36] However, opposition to the bill was expressed in various quarters. Louisville attorney Frank E. Haddad, Jr. said, "There's no question of it...The whole purpose of the act is to get rid of not guilty by reason of insanity....the chance of a truly insane berson being found not guilty will be virtually nil."[37] Boyle County Circuit Judge Henry V. Pennington challenged the Department for Human Resources statistic that ten to twelve people per year would be found GBMI. Pennington, then President of Kentucky Circuit Judges Association, claimed that he could have "...12 people in a month found guilty under that."[38] Dr. John Gergen, then legislative representative for the Kentucky Psychiatric Association, estimated that as many as one hundred defendants per year might be found GBMI.[39]

At the opening of the General Assembly in early 1982, 82 BR 429 became HB 32. A "Fiscal Analysis Note" by the Legislative Research Commission dated January 11, 1982, held that there would be a fiscal impact created by the proposed GBMI legislation, but the Commission was unable to derive any estimate as to how much the legislation would cost the taxpayer. The report states, "To the extent any new cost is anticipated at all, it is associated with a possible increase in the number of incompetency evaluations requested by the courts. Michigan did experience a 25% increase in the number of evaluations requested the year after the GBMI legislation passed in that state; however a new state evaluation facility opened that same year (none had been available previously). According to a speaker from Michigan who addressed the subcommittee,

most of that increase may be associated with the availability of that resource."[40] Elsewhere the report states, "...it seems logical to expect around ten (10) such verdicts annually in Kentucky." [41] This estimate was based on the Michigan experience of having 30 GBMI verdicts per year in the five years since the passage of the GBMI law.[42]

Hearings were conducted on HB 32 by the House Judiciary-Criminal Committee on January 27, 1982. Debate on the bill was lively, with vocal opponents and equally vocal supporters of the measure. In favor of the GBMI bill were: Ida Zinam, a daughter of Ida Datillo, The Honorable Olga Peers, Circuit Judge in the Datillo case, Geoff Morris, Assistant Commonwealth Attorney for Jefferson County, Ashar Tullis, Executive Director of the Kentucky Association for Mental Health, Richard Klem, Ph.D., representing the Kentucky Psychological Association, and Raymond Larson and Ronald C. Zellar of the Office of the Attorney General. Speaking against HB 32 were: W. Robert Lotz, Chairperson, Advocacy Committee, Mental Health Association of Northern Kentucky, Rev. M. Taylor Bach, D. Min., President, Mental Health Association of Kentucky and Director, Northern Kentucky Pastoral Counseling Institute, Robert Noelker, Ph.D., a Florence, Kentucky psychologist, Frank E. Haddad, Jr., a Louisville lawyer, Oliver H. Barber, Jr., a Louisville lawyer instrumental in bringing about the "Consent Decree" affecting the Kentucky Corrections Department, J. Vincent Aprile, II, representing the Defender Committee of the National Legal Aid and Defender Association, and William Radigan of the Office of Public Advocacy.[43]

Members of the House Judiciary-Criminal Committee were not all in favor

of expediting the HB 32. An investigation was sought into the handling of the bill by Representative Aubrey Williams of Louisville, who refused to let the Committee vote on the bill. Toward the end of the meeting of the Committee, on Wednesday, February 3, a motion was made for the Committee to approve the bill, but Williams refused to hear seconds, telling the Committee members that "...we are not going to take action on the bill today."[44] Nevertheless, despite this action, the GBMI bill cleared the House Judiciary-Criminal Committee on Wednesday, February 10, and was sent to the floor of the House. The Committee approved the measure 10-3 with Representative Williams passing.[45] The full House approved the bill 76-11 on February 22, and sent it to the Senate for approval.

In a rather surprising turn of events, The Courier-Journal reversed its editorial position on HB 32 about four days after passage of the bill by the House. Admitting that the newspaper had favored the GBMI law in the past, the new position was:

> "...we no longer think it's the wisest answer. In our judgement, everyone's best interests would be served by derailing House Bill 32 and creating a study group to find a direct, trouble-free solution in time for the 1984 General Assembly...The problem with House Bill 32 is two fold: it's not needed to achieve one of the aims of its sponsor, and it could unjustly punish those who may be guilty in fact but not in law... In Michigan, the first of three states to adopt the new verdict, the legitimate aim was to force the provision of psychiatric services to disturbed inmates. But Kentucky's corrections system already has such an obligation--and a new criminal psychiatric-care facility at LaGrance to help fulfill it. ...Secondly, and worse than being merely duplicative, HB 32 could cause harm...juries might feel that a verdict of 'guilty but mentally ill' is a quick and easy substitute for the complex notion of 'not guilty by reason of insanity.' Poor defendants, especially, could suffer, since they might not be able to pay lawyers and experts for the effort necessary to make this distinction." 47

Despite this objection by one of Kentucky's most influential newspapers, the Senate passed HB 32 on Monday, March 15, 1982. The vote was twenty-nine in favor of the bill, four opposed. There was no debate on the measure. One Senator, David Karem of Louisville, suggested that the impact of the law should be closely evaluated to determine whether the law achieves its express goals.[48] Governor John Y. Brown, Jr., approved the bill on March 26, 1982.[49]

Response to the new law across the state was varied, but law enforcement officials generally endorsed the idea of having a GBMI verdict. In an interview with the policeman's newspaper The Silver Shield, Thompkinsville Judge Jack D. Wood probably voiced the opinion of the majority of the law enforcement community: "...with the other insanity plea, you were forced into proving a defense. This way, you can take the automatic 'guilty'. You can plead guilty, alleviating the problem of adversary."[50] A minority opinion was uttered by Greenup County Sheriff Earl Marshall, who said in the same publication, "I just feel like we're going to have a lot of people, everyday criminals, that are going to use this as a crutch. They will holler 'insane' and get free treatment and all-- and there'll be nothing wrong with them, and they'll get out of jail or prison quicker."[51]

III. The Kentucky GBMI Survey

As was mentioned in the "Introduction", thirteen individuals came to the Kentucky Correctional Psychiatric Center (KCPC) with a GBMI designation during the first year of legal enforcement of K.R.S. 504.130 (82 HB 32).

In this section of our report, we shall analyze the characteristics of these 13 individuals, and the circumstances surrounding their obtaining GBMI verdicts. Comparisons will be made with other relevant surveys.

We shall begin our discussion with a statement about the reasons for undertaking the Kentucky GBMI Survey, our methods, and a description of the scope of the study.

Shortly after the passage of the GBMI law, certain staff members at KCPC wondered about the impact the new law would have on service delivery to the mentally ill inmate. In particular, staff pondered about treatment needs of the GBMI population, and how the label "Guilty But Mentally Ill" would affect the so-designated individual's trajectory through the correctional system. Questions about the background of these individuals arose when the first GBMI's arrived at KCPC: it was apparent that the first GBMI's were not particularly "mentally ill" at all, and that they had pled GBMI on the belief that they would spend most, if not all, of their sentence in KCPC or some other mental hospital. This stimulated an organized attempt to ascertain the social and psychological characteristics of the GBMI population in an effort to determine whether the pattern which presented itself in the first GBMI cases would persist.

Specifically, it was proposed that the first one hundred GBMI cases be evaluated in the following fashion: (1) psychiatric diagnoses were to be acquired on all GBMI admissions (admission and discharge diagnoses were both collected); (2) detailed demographic characteristics were collected on these individuals[52]; (3) psychometric data was assembled

on each GBMI individual (WAIS-R or Beta IQ tests; MMPI and 16PF personality inventories); (4) a detailed, structured social history interview was taken on each GBMI (based on the "Standard Recording of Psychiatric Case Study" of the Mental Examiner's Handbook)[53]. With regard to the last mentioned instrument, the social history, the format was updated and altered to meet the needs of the survey. The Psychological Corporation permitted this alteration.[54] Questions surrounding the reliability of psychiatric diagnosis[55] led to the utilization of psychological testing to supplement diagnostic information. The demographic and social history data was cross-validated by reference to the institutional and medical record insofar as was possible.

The project was designed before it was known that another survey of GBMI patients had been done in Michigan by Gare Smith and James Hall.[56] The Michigan study was published late in 1982 and apparently has not yet been listed in the Index of Legal Periodicals. Smith and Hall examined demographic characteristics of all 204 male defendants who were found GBMI in Michigan forensic facilities after 1975 (the year the GBMI law was instituted in Michigan) until 1981, comparing these characteristics with the total population of NGRI acquittees (316 individuals) and with a random sample of 211 subjects referred to the Michigan Center for Forensic Psychiatry who subsequently got "guilty" verdicts. Among other findings, Smith and Hall learned that the number of NGRI acquittals remained roughly constant, and that the GBMI population tended to have demographic characteristics more similar to the "guilty" population than to the NGRI's. This led the authors of the Michigan study to conclude that the GBMI's would have been declared "guilty" if the law had not been in effect. An

additional finding was that 60% of the GBMI's had received their verdict through a plea-bargaining arrangement.

Throughout the remainder of this report, comparisons will be made to the Michigan GBMI study. It represents the most systematic investigation to date of the GBMI population from am empirical point of view. However, as useful as the Michigan study is, it is not perfect. First of all, strictly speaking, the findings of the Michigan study may not apply to the Kentucky experience with the GBMI verdict. The Kentucky experience therefore needs to be evaluated. The Michigan study does not consider diagnostic information, and makes no use of psychometric or detailed social history information. Women are not considered in the Michigan GBMI study, nor is the trajectory of the GBMI patient through the corrective-psychiatry-criminal-justice system evaluated. All these areas need to be addressed, and all of them could be addressed by the Kentucky project.

Of the GBMI admissions to KCPC, none were admitted during the first quarter the law was in effect, two came in the second quarter, five during the third quarter, and six during the last quarter. (Refer to Figure 1.) This finding suggests that momentum for using the GBMI verdict initially was low, but is building. (This impression is borne out by the fact that from July 1 - September 1, 1983, another six GBMI patients have been admitted. However, the trend observed may be an artifact due to the backlog of admission of county and city jails to the correctional system. Further investigation is necessary to clarify this point.) This statistic also corresponds with the Michigan

survey's findings, for Smith and Hall noted that at first, the rate of GBMI admissions was slow. Counties represented by the Kentucky GBMI's were: Fayette (3), Butler, Mercer, Knox, Harlan, Calloway, Pulaski, Kenton, Graves, Boone, and Johnson. One individual came from a county of less than 15,000 in population, two from counties with populations between 15,000 and 30,000, four from counties with populations between 30,000 and 45,000, two from counties with populations between 45,000 and 100,000, and four from counties with populations greater than 100,000. (Refer to Figure 2.) These statistics correspond roughly with both population-percentage[57] in each population bracket, and with arrest data.[58] (Refer to Table 1.) Comparison with the Michigan GBMI study on this point is hampered by the fact that it breaks its population categories into brackets of: less than 50,000; 50,000 - 100,000; 100,000 - 400,000; and more than 400,000. This categorization may not seem bothersome until one confronts that statistic that the mean population of a Kentucky county is 30,506 -- in other words, the Michigan categories create a condition where it would appear that most GBMI's come from underpopulated areas, whereas the classification is probably more reflective of the fact that Michigan's counties tend to be larger, and more populated.

The mean length of stay at KCPC for the GBMI patients was 34.2 days. However, this statistic is probably best regarded with some circumspection, due to the fact that one GBMI patient resided 141 days of the first year of legal enforcement of the GBMI law; a more representative figure is to be found in the median length of hospitalization, or nineteen days, around two-thirds of the mean. Four of these patients (30.8%) stayed

at KCPC less than fifteen days; four admissions (30.8%) between fifteen and 30 days; three admissions (23.0%) between thirty-one and sixty days, and two patients (15.4%) more than sixty days. (See Figure 3.) The relatively abbreviated period of hospitalization may be reflective of the diagnostic situation with the GBMI patient and not policy considerations of KCPC. (See Table 2. Note that most patients are not diagnosed as acutely psychotic and thus less likely to need the maximum-security hospital environment of KCPC. Such patients characteristically are served on an outpatient basis, remaining in prison, taking medication (if necessary) and receiving counseling from a KCPC outpatient mental health worker, with some contact with a psychiatrist.) While such information might have been helpful, Smith and Hall do not consider length of hospitalization in their study, and therefore, we cannot make a comparison with the Michigan study on this variable.

Insofar as the demographic variable of race is concerned, we are left with a different story. We may compare our findings not only with the Michigan study, but also with statistics on the racial composition of Kentucky prisons circulated by the Kentucky Corrections Cabinet,[59] and with the 1982 Uniform Crime Report (UCR) for Kentucky. (See Table 3.) Unfortunately, due to peculiarities in the way these statistics were compiled, the only common discernable classification which might have been applied is: black/other. The Corrections statistics may include Orientals, Indians, or Hispanics, but they are not mentioned; either there are no such individuals in Kentucky prisons (one would expect to find several such people) or they were not included in the count. To be safe in assessment, using the black/other classification was

utilized. The principal finding on this score is that so far the number of blacks being declared GBMI is proportionately low compared with the Michigan study's GBMI and "Guilty" population, and with the demographics of the Kentucky prison population, but the difference is less noticeable when comparison is made with UCR arrest data.

Another pattern is discernable when the "age" variable is taken into consideration. Here the range of ages for the thirteen Kentucky GBMI patients is twenty-three to fifty; the mean age is 34.1 years. Of this group, no patients were younger than twenty-one (0.0%), four were between the ages of twenty-two to thirty (30.8%), eight were in the thirty-one to forty age bracket (61.5%), and one was over forty-one (7.7%). (See Figure 4. The typology of classification used here corresponds to that used in the Smith and Hall study.) Again, we are able to compare these statistics to the Michigan survey and to the Corrections Cabinet figures. (See Table 4.) Note that the typology (thirty-one or less/thirty-one to forty/ over forty-one) used is not as refined as the classification presented above: at one point, the age brackets for the Kentucky prison statistics and that of the Michigan study were not identical; the only useful option was to lump the pertinent categories together, making broader comparison possible. We see that compared to the Michigan "Guilty" and GBMI populations, and to the Kentucky prison population, Kentucky GBMI's have tended to be somewhat older as a group. Whether this pattern will persist as the study progresses remains to be seen.

The income variable presents an interesting set of statistics in the Kentucky GBMI survey, although comparable data is not available from

either the Michigan study or the Corrections Cabinet. The finding here is that Kentucky GBMI's admitted during the first year of legal enforcement of HB 32 were substantially poorer than most Kentuckians. Five individuals in the GBMI group (38.5%) made no income whatsoever during the year preceding arrest; four (30.8%) earned from one dollar to four thousand dollars per year; three (23.0%) earned from four thousand to twelve thousand dollars per year; and one (7.7%) earned more than twelve thousand dollars. (See Figure 5.) The mean annual income of the GBMI's was $3,903.69; the range of annual incomes was from zero to twenty thousand dollars per year. According to the U.S. Census Bureau, the 1979 median income for Kentucky head-of-household was $13,965; the mean income for the same year and the same population was $17,074. The poverty of the Kentucky GBMI group was further evaluated by making note of the statistic that nine of the group (69.2%) were unemployed at the time of arrest.

Twelve (92.5%) of the Kentucky GBMI group were males; this figure corresponds well with figures from the Corrections Cabinet concerning the demographics of the Kentucky prison population. (See Table 5.) UCR data also sugges a similar outcome.

On the variable of "marital status", we can compare our findings to the Michigan survey, since Smith and Hall took note of that factor. We see no significant differences except that the "married" proportion of the Kentucky GBMI group is larger than the "married" group of Michigan "Guilty" individuals. (See Table 6.)

The Michigan study also considers the "education" variable. We used the same classification system in bracketing education level as Smith and Hall. The results are presented in Table 7. From this presentation we see that the Kentucky GBMI group is substantially less-educated than either of the two Michigan groups reported; very likely this is a reflection of lower educational attainment in this state rather than a finding on the specific nature of the Kentucky GBMI population. The Kentucky GBMI group had a mean of nine years of formal education; the range was five to thirteen grades of schooling.

Although the Michigan survey mentions that 60% of their GBMI's had plea-bargained for their verdict, no systematic comparison of this factor with the NGRI or "Guilty" groups was made. In the Kentucky GBMI group, we learned that one individual (7.7%) had pled "not guilty", one person (7.7%) had pled "guilty", and eleven (84.6%) pled GBMI. The statistical tendency here for apparent plea-bargaining is even stronger than is the case in the Michigan study, and this finding is in fact the strongest pattern observed so far in the Kentucky GBMI survey.

This brings us to the factor of prior arrest data. Here we are also able to compare findings with the Smith and Hall study. (Refer to Table 7.) We learn from an examination of the data that one Kentucky GBMI (7.7%) had no arrest record whatsoever, five (38.5%) had one to three arrests, none (0.0%) had four to five arrests, and seven (53.8%) had six or more arrests. This was a bi-modal distribution, a pattern reflected (though less forcefully) in the Michigan study.

Other forensic statistics are noteworthy. (See Table 8.) Nine of the Kentucky GBMI's (69.2%) had court-appointed lawyers, while four (30.8%) had hired attorneys. All thirteen (100%) had trial competency evaluations -- one had a competency evaluation at Western State Hospital in Hopkinsville, the rest at the Pre-trial Unit at the Kentucky Correctional Psychiatric Center. All thirteen had been evaluated by psychiatrists. Only ten (76.9%) were additionally evaluated by psychologists. All psychological evaluations included psychological tests.

A perusal of the diagnoses of the GBMI individuals (Table 2) reveals that most disorders involved are not those requiring prolonged hospitalization. Rather, most are disor-ers traditionally served in an outpatient setting. A breakdown of primary diagnoses into major DSM-III categories reveals 2 Adjustment Disorders, one Mental Retardation (Mild), four Schizophrenic Disorders, two Organic Mental Disorders, two Substance Use Disorders, and one Disorder of Impulse Control. In addition, four secondary personality disorder diagnoses appear: one Paranoid Personality, two Antisocial personalities, and one Histrionic personality. This explains the relatively brief psychiatric hospitalization. Once a person is diagnosed and any psychosis alleviated, unless specific treatment interventions have been initiated, he is discharged from KCPC back into other areas of the penal system, leaving his maximum security hospital bed for the many others in the system needing it.

Consistent with the diagnostic division, 53.8% of the GBMI's reported previous psychiatric hospitalization for treatment. This is appropriate for the defined population where mainly psychotic, organic and substance abuse disorders would be expected to have been hospitalized previously, 35.5% of the Kentucky GBMI population reported a history of alcohol abuse and 38.5% reported drug abuse. Both types of abuse seem in large part to overlap each other. (Table 8).

Regarding psychometric test data, Figure 6 demonstrates a breakdown of the population according to measured intelligence. This places two GBMI's in the Mild Mental Retardation range, five in the Borderline range, two Low Average, three Average, and one above Average (according to DSM - III and WAIS-R classifications), with a mean in the Low Average range. These figues seem consistent with what would be expected by the income and education variables.

Personality descriptions are beyond the scope of this report but a summary description made up of mean MMPI and 16PF standard scores is included in Appendix D. The most salient features of the average GBMI are that he is perceived by others as narcissistic or peculiar and is inclined toward antisocial behavior, usually within a family structure reflecting some underlying dependency and a deteriorating sense of control. A very destructive family background is probable and he appears to see the world as a jungle, thus perceiving his own acting out as a matter of survival. He is prone to violence if cornered and prefers a nomadic and transient existence with few responsibilities.

Obviously very little can actually be said of the effectiveness of the GBMI statute based on these results because of the small number of subjects and the lack of inferential statistics. Despite the lack of design strength, certain trends can be seen in the initial Kentucky GBMI population.

All the defendants did have diagnosable mental disorders at the time of their admission. All these disorders are potentially treatable though most do not require hospitalization.

The average GBMI tended to be a white male in his thirties, who had a history of hospitalization and arrest. There was also a tendency for GBMI defendants to be poor, without high school educations, of low intelligence, represented by cour appointed attorneys, and convicted by plea bargaining. Several of the GBMI's did tell the researchers that the decision to plead GBMI was encouraged by their attorneys and that they had been told by their attorneys that their sentences would be shorter than if another verdict were reached. Results are generally consistent with findings in the Michigan study.

As stated initially, the present study is only a pilot for further research. It is the only one of its kind in this state. Using it to spark interest, we are hoping to get administrative approval to collect data from random samples of other comparison populations such as NGRI's and Guilty's as in the Michigan study. This would involve considerable time in data collection and require establishment of new

state record keeping. To date there is no central record of NGRI verdicts. It this is seen as impossible because of the fantastic expenditure of money and effort that would be required, our best option may be to seek a comparison/control group in the Kentucky prison population, perhaps a random sample of prisoners at Kentucky State Reformatory and Kentucky Correctional Institute for Women, or on a larger scale, random sampling of the total Kentucky penal population. Such comparisons could focus on mental status and treatment differences according to verdict.

One final observation seems pertinent. While our study described characteristics of the GBMI population as it enters the correctional system, it appears more critical to follow the course of the GBMI individual through the system. Comparing factors such as security classification, frequency of parole, and length of incarceration would be central to such a study and would greatly enhance current findings.

Other forensic statistics are noteworthy. (See Table 8) Nine of the Kentucky GBMI's (69.2%) had court-appointed lawyers, while four (30.8%) had hired attorneys. All thirteen (100%) had trial competency evaluations -- one had a competency evaluation at Western State Hospital in Hopkinsville, the rest at the Pre-trial Unit at the Kentucky Correctional Psychiatric Center. All thirteen had been evaluated

by psychiatrists, only ten were additionally evaluated by psychologists. All psychological evaluations included psychological tests.

FOOTNOTES

1. Sharp v. Commonwealth 308 KY. 768 (1948).

2. 22 C.J.S. 203-204.

3. K.R.S. 504.020.

4. Kenneth Slowinski, "Criminal Responsibility: Changes in the Insanity Defense and the 'Guilty but Mentally Ill' Response", Washburn Law Journal 21:523, 1982.

5. Ibid., p. 523.

6. Gall v. Commonwealth 607 S.W. 2d 97, 113 (1980).

7. People v. McQuillan 392 Mich. 511 (1974).

8. Gare A. Smith and James A. Hall, "Evaluating Michigan's Guilty but Mentally Ill Verdict: An Empirical Study", University of Michigan Journal of Law Reform 16(1):75-112, Fall, 1982. The law was actually codified into several statutes.

9. People v. Jackson 263 N.W. 2d 44 (1977).

10. American Bar Association on Standing Committee on Association Standards for Criminal Justice, "American Bar Association Policy on the Insanity Defense". Approved by House of Delegates, Wednesday, February 9, 1983, p. 7. The states were Indiana, Illinois, Kentucky, Georgia, Delaware, Alaska, and New Mexico.

11. Smith and Hall, supra note 8, cf. 79. See Idaho Code 18-207 (Supp. 1982) and Montana Code Annotated 46-14-101 to -401 (1981).

12. Carolyn Colwell and Mike Brown, "Not Guilty by Reason of Insanity -- A Gap in the Legal System Leaves a Family Fearing for their Lives", The Courier-Journal, Louisville, Kentucky, Thursday, August 28, 1980.

13. Joyce Dehli, "Woman who Killed Mother to be Eased back into Society", The Courier-Journal, Louisville, Kentucky, Friday, May 22, 1981, B7.

14. Gall v. Commonwealth, supra note 6, at 113.

15. "The Gap in Kentucky Insanity Laws", The Louisville Times, Louisville, Kentucky, Wednesday, September 17, 1980, "Opinion" page.

16. "A Gap in the Legal System", The Courier-Journal, Louisville, Kentucky, Wednesday, September 17, 1980, "Opinion" page.

17. Bob Morse, "Reform of Insanity Laws", WHAS editorial, Louisville, Kentucky, November 12-13, 1980.

18. Roger C. Noe, "Comparison and Comments on Representative Noe's Old and New Versions of Bills Creating a 'Guilty but Mentally Ill' Verdict", Unpublished speech, August 24, 1981.

19. Roger C. Noe, "Explanatory Summary and Speech on 82 BR 51 - Creating a Verdict Called 'Guilty but Mentally Ill' ", unpublished speech, May 8, 1981.

20. Ibid.

21. Roger C. Noe, "Comparison...", supra note 18.

22. Ibid.

23. Ibid.

24. 82 HB 32, Section 8.

25. Noe, "Comparison...", supra note 18.

26. Ibid.

27. 82 HB 32, supra note 25, Section 2(3).

28. Noe, "Comparison...", supra note 18.

29. Attorney General's Task Force on Violent Crime, Final Report, U.S. Department of Justice, Washington, D.C., August 17, 1981, p. 54.

30. Interim Joint Committee on Health and Welfare, Subcommittee on Mental Illness and Mental Incompetency, "Minutes of the Twelfth Meeting of the 1980-81 Interim", unpublished report, September 8, 1981.

31. Ibid.

32. Herbert Sparrow, "Bill on Mental Condition 'Progressive', Palmore Says", The State Journal, Frankfort, Kentucky, September 9, 1981, p.10.

33. Ibid.

34. Interim Joint Committee on Health and Welfare, Subcommittee on Mental Illness and Mental Incompetency, supra note 30.

35. " 'Guilty but Mentally Ill': A Verdict we Need", The Courier-Journal, Louisville, Kentucky, Friday, September 18, 1981, "Opinion" page.

36. "Panel Backs New Verdict of Mentally Ill", The Courier-Journal, Louisville, Kentucky, Thursday, October 15, 1981, p.A8.

37. Carolyn Colwell, "Some Want New Verdict: Guilty but Mentally Ill", The Courier-Journal, Louisville, Kentucky, Sunday, December 20, 1981, "Kentucky" section.

38. Ibid.

39. Ibid.

40. Vinson Straub, "Fiscal Analysis Note #11", Legislative Research Commission, Frankfort, Kentucky, January 11, 1982.

41. Ibid.

42. Ibid.

43. "Speakers On House Bill 32...", Unpublished report, Legislative Research Commission, Frankfort, Kentucky, January 27, 1982.

44. Anne Pardue, "Williams' Handling of Bill Assailed", The Courier-Journal, Louisville, Kentucky, Thursday, February 4, 1982, p. B4.

45. Anne Pardue, "House Gets Bill for New Verdict on Insanity Plea", The Courier-Journal, Louisville, Kentucky, Thursday, February 11, 1982, p. B4.

46. Robert T. Garrett, "House Approves Guilty-but-Ill Verdict", The Courier-Journal, Louisville, Kentucky, February 23, 1982.

47. " 'Guilty but Mentally Ill': An Appealing Idea, but Seriously Flawed", The Courier-Journal, Louisville, Kentucky, Friday, February 26, 1982, "Opinion" page.

48. Richard Wilson, "Senate Approves Bill Permitting Verdict of 'Guilty but Mentally Ill' ", The Courier-Journal, Louisville, Kentucky, March 16, 1982, p.B2.

49. "Certificate...House Bill 32..." witnessed by Secretary of State Frances Jones Mills, Frankfort, Kentucky, April 26, 1982.

50. Silver Shield 2(4):17, 1982.

51. Ibid., p. 25.

52. The variables were: date of admission; age; race; county of conviction; permanent address; annual income; whether the individual drew SSI or SSDI; whether he or she was employed at the time of arrest; occupation; marital status; whether veteran and if so type of discharge; sex; level of education; legal status -- charges and sentence length; type of plea; type of legal advocate (hired or court-appointed lawyer); history of arrests; arrest dates and dispositions of prior charges; whether there was a jury trial; whether there was a competency evaluation prior to conviction; if so, the nature of the evidence for mental disorder presented to the court; occupation of mental health profession(s) performing the competency evaluation (evaluation by only a Ph.D. psychologist is legally permissable); amount of jail time and whether jail time was credited to sentence; and finally, history of psychiatric hospitalizations (name of hospital, address of hospital, and diagnosis if known.)

53. F.L. Wells and Jurgen Ruesch, Mental Examiners' Handbook, Second Edition, The Psychological Corporation, New York, N.Y., 1945, pp.5-19.

54. Correspondence from Donna Cimmino, Supervisor, Rights and Permissions, The Psychological Corporation, dated March 14, 1983.

55. N. Kreitman, "The Reliability of Psychiatric Diagnosis", Journal of Mental Science 107:876-886, 1961.

56. Smith and Hall, supra note 8.

57. Data based on 1980 Census of Population, Volume 1, Chapter A, "Number of Inhabitants", Part 19; 'Kentucky', PC80-1-A19,U.S. Department of Commerce, Washington, D.C., Table 2.

58. Data from 1982 Uniform Crime Reports -- Commonwealth of Kentucky, Kentucky State Police, Frankfort, Kentucky, 1983, pp. 74-103.

59. "Profile of Institutional Population--April 7, 1983", unpublished report, Planning and Evaluation Branch, Department of Corrections, Frankfort, Kentucky.

60. Robert B. McCall, Fundamental Statistics for Psychology, Harcourt, Brace and World, Inc., New York, N.Y., 1970, pp. 285-288.

APPENDIX A: STRUCTURED PSYCHIATRIC HISTORY INTERVIEW

STRUCTURED PSYCHIATRIC HISTORY INTERVIEW FORMAT

IDENTIFYING CHARACTERISTICS:

Code #:_____ Date of Admission:_____

Age:_____ Race:_____ County of Conviction:_____

Permanent Address:_____

Annual Income:$_____ SSI or Disability:_____

Employed at time of arrest:_____ Occupation:_____

Marital Status:_____ Veteran:_____

If veteran, type of discharge:_____ Sex:_____

Level of Education:_____

LEGAL STATUS:

Charge(s):	Sentence Length:

Plea:

Guilty:_____ Not Guilty:_____ NGBRI:_____ GBMI:_____

Type of Legal Advocate:

Hired Lawyer:_____ Public Defender:_____

History of Arrests:	Date of Arrest:	Case Disposition

(If there are additional charges, record information on separate paper).

Was there a jury trial on current charge(s):_____

Was there a competency evaluation ordered prior to conviction:_____

Nature of evidence for Mental Disorder Presented to the Court:

Psychological Testing:_____ Interview_____

Occupation of Mental Health Professional Performing Evaluation:

Psychiatrist_____ Psycologist_____

Jail time:_____ Was jail time credited to Sentence:_____

HISTORY OF PSYCHIATRIC HOSPITALIZATIONS:

Date:	Name of Hospital:	Address of Hospital	Diagnosis (if known)

(If there are additional psychiatric hospitalizations, list on separate paper).

CHILDHOOD HISTORY:	Yes	Unknown
1. Premature birth	_____	_____
2. Instrumental or operative birth	_____	_____
3. Malformations (cleft palate, spina bifida, etc.)	_____	_____
4. Birth injuries	_____	_____

	Yes	Unknown
5. Congenital mental deficiency	_____	_____
6. Allergic diseases (asthma, eczema, urticaria)	_____	_____
7. Nervous diseases (myopathies, poliomyelitis, Little's disease)	_____	_____
8. Head injury	_____	_____
9. Loss of consciousness (fainting, coma)	_____	_____
10. Convulsions	_____	_____
11. Accidents	_____	_____

HOME, PARENTS AND ENVIRONMENT

1. Adopted child or one step-parent	_____	_____
2. Raised in foster home or orphanage	_____	_____
3. Only child	_____	_____
4. Birth order: _____ of _____ children.		
5. Sheltered childhood	_____	_____
6. Dissension at home	_____	_____
7. Broken home (one parent left before age 16)	_____	_____
8. Strick father	_____	_____
9. Strick mother	_____	_____
10. Rejection by father	_____	_____
11. Rejection by mother	_____	_____
12. Overprotective father	_____	_____
13. Overprotective mother	_____	_____
14. Dominant father	_____	_____
15. Dominant mother	_____	_____
16. Death of parent before age 16	_____	_____
17. Bicultural background (parents speak different languages)	_____	_____
18. Intimate contact with diseased persons	_____	_____

	Yes	Unknown
19. Unfavorable social environment (slum, substandard, or delinquency neighborhood)	_____	_____
20. Premature sex experiences (intercourse before 16, assault, witness to coitus)	_____	_____
21. Excessive parental ambition for child	_____	_____

NEUROPATHIC TRAITS

1. Minor neuropathic traits (nailbiting, thumbsucking)	_____	_____
2. Nervous breakdown (depression, states of excitement)	_____	_____
3. Persistent fears	_____	_____
4. Persistent nightmares	_____	_____
5. Persistent obsessions	_____	_____
6. Persistent obsessions	_____	_____
7. Tics, stammering, stuttering	_____	_____
8. Behavior problems (truancy, fights, disciplinary problems	_____	_____
9. Antisocial behavior (criminal assault, stealing)	_____	_____
10. Enuresis beyond 3 years	_____	_____
11. Emotional overreactions, sudden outbursts (temper tantrums)	_____	_____

12. Hemispheric dominance: Right handed_____ Left handed_____

Mixed_____

PERSONALITY

1. Difficulties with other children	_____	_____
2. Difficulties at school	_____	_____
3. Sibling rivalry	_____	_____
4. Shy, withdrawn	_____	_____

	Yes	Unknown
5. Extreme day-dreaming	_____	_____
6. Cruelty	_____	_____
7. Fights and aggressiveness	_____	_____
8. Hyperactivity	_____	_____
EDUCATIONAL HISTORY		
1. Started school late (after 7)	_____	_____
2. Less than eighth grade education	_____	_____
3. Less than high school	_____	_____
4. Repeated grades	_____	_____
DISEASES		
1. Head injury (one or more)	_____	_____
2. Nervous disease (poliomyelitis, multiple sclerosis, neurosyphilis, etc.)	_____	_____
3. Convulsive disorder	_____	_____
4. Migraine	_____	_____
5. Major functional psychosis (schizophrenia, manic-depressive psychosis)	_____	_____
6. Major operations (2 or more)	_____	_____
7. Major operations (3 or more)	_____	_____
8. Accidents (2 or more)	_____	_____
9. Fractures (2 or more)	_____	_____
10. Industrial poisoning	_____	_____
11. Venereal infection	_____	_____
12. Cardiovascular disease	_____	_____
13. Respiratory disease	_____	_____

	Yes	Unknown
14. Endocrine disease	_____	_____
15. Rheumatic disease	_____	_____
16. Gastrointestinal disease	_____	_____
17. Allergic disease	_____	_____

ENVIRONMENT, HOME AND SOCIAL STATUS

1. Living alone	_____	_____
2. Unfavorable environment (slum or substandard housing)	_____	_____
3. Change of resident (more than 3 changes in last 3 years)	_____	_____
4. Conflict with the law (arrests, sentences)	_____	_____
5. Behavior problem	_____	_____

OCCUPATIONAL HISTORY (last 3 years)

1. More unemployed than employed	_____	_____
2. More than 6 jobs	_____	_____
3. More than 3 occupations	_____	_____
4. Known to social agencies	_____	_____
5. Last job held terminated within 6 months	_____	_____

HABITS

1. Tobacco abuse (more than 20 cigarettes, 5 cigars, 10 pipes daily)	_____	_____
2. Drug abuse	_____	_____
3. Coffee abuse (more than 5 cups in one session or more than 3 occasions daily)	_____	_____
4. Alcoholism (more than 1 qt. whiskey, or 20 bottles beer, or 5 bottles wine per week)	_____	_____

	Yes	Unknown
5. Abstainer		
6. Occasional drunkenness only (little alcohol consumption be-between)		
7. Low alcohol tolerance, emotional manifestations after 2 drinks of whiskey, strong liquor or its equivalent		
8. Injured while drunk		
9. Injured in fight		
SEX		
1. Impotence or ejaculatio praecos		
2. Frigidity		
3. Coitus interruptus		
4. Sexual promiscuity after 25		
5. Persistent masturbation after 25		
6. Regular extramarital relations		
7. "Unhappy sex experiences"		
8. Homosexuality		
9. Other perversions		
10. First intercourse before 16		
11. Divorce or separation		
NEUROPATHIC TRAITS AND SYMPTOMS		
1. Nervous breakdown (drepssions, states of panic and excitement, catatonic episodes)		
2. Easily upset		
3. Easily tired		
4. Anxiety attacks		

	Yes	Unknown
5. Anxiety tension (muscular tensions with agitation and "nervousness")		
6. Nightmares		
7. Fears or phobias		
8. Obsessive thoughts and compulsions		
9. Mood swings		
10. Transitory affective disturbances		
11. Speech disturbances (stammering, stuttering)		
12. Tics		
13. Metapsychic interests (mindreading, hypnotism, astrology, etc.)		
INTERESTS		
1. No interests		
2. Gambling		
3. Television, radio, newspapers only		
RELIGION		
1. Atheist or no religion		
2. Member of small sect		
3. Change of religion		
DISEASES		
1. Suicide		
2. CNS disease		
3. Mental disease		
4. Mental deficiency		
5. Nervousness		

	Yes	Unknown
6. Nervous breakdown		
7. Heart attacks		
8. High blood pressure		
9. Sterility		
10. Convulsions		
11. Fainting		
12. Chronic invalidism		
13. Malformations		
14. Allergic diseases		
15. Crime		
16. Alcoholism		
17. Venereal disease		
18. Tuberculosis		
19. Accidents, war casualties		
20. Neoplasms		

FEELINGS

1. Feelings of apprehension		
2. Feelings of isolation		
3. Feelings of guilt		
4. Lack of guilt feelings after misbehavior		
5. Feelings of inadequacy and insecurity		
6. Fear of losing love objects		
7. General unhappiness		
8. Mourning		

	Yes	Unknown
PHYSICAL SYMPTOMS		
1. Poor health	_____	_____
2. General nervousness	_____	_____
3. Fatigue	_____	_____
4. Weakness	_____	_____
5. Sleeplessness	_____	_____
6. Crying spells	_____	_____
7. Sweating	_____	_____
8. Trembling	_____	_____
9. Flushes	_____	_____
10. Vomiting	_____	_____
11. Diarrhea	_____	_____
12. Extreme constipation	_____	_____
13. Poor appetite	_____	_____
14. Anorexia	_____	_____
15. Hyperexia	_____	_____
16. Urinary frequency	_____	_____
17. Enuresis	_____	_____
18. Impotence--frigidity	_____	_____
19. Headache	_____	_____
20. Dizziness	_____	_____
21. Loss of consciousness	_____	_____
22. Convulsions	_____	_____
23. Diffuse aches and pains	_____	_____

	Yes	Unknown
24. Paraesthesia, itching	_____	_____
25. Breathlessness	_____	_____
26. Smothering	_____	_____
27. Paralysis	_____	_____
28. Low back pain	_____	_____
29. Difficulties of expression (speech)	_____	_____
30. Gritting teeth, clenching fists	_____	_____
IDEAS AND CONTENT OF THOUGHT		
1. Disappointment about failure	_____	_____
2. Intellectual inefficiency	_____	_____
3. Self-accusation and condemnation	_____	_____
4. Ideas of persecution	_____	_____
5. Ideas of reference	_____	_____
6. Excessive self-observation	_____	_____
7. Doubts and inability to make decisions	_____	_____
8. Fears	_____	_____
BODY REGIONS INVOLVED		
1. Head	_____	_____
2. Face	_____	_____
3. Mouth	_____	_____
4. Neck	_____	_____
5. Chest	_____	_____
6. Abdomen	_____	_____
7. Back	_____	_____
8. Genitalia	_____	_____

	Yes	Unknown
9. Anus	_____	_____
10. Arms and hands	_____	_____
11. Legs and feet	_____	_____
12. Pelvis	_____	_____
13. Diffuse	_____	_____

SYMPTOMS INVOLVED

1. Motor system	_____	_____
2. Somatic sensory system	_____	_____
3. Smell and taste	_____	_____
4. Vision	_____	_____
5. Hearing	_____	_____
6. Skin	_____	_____
7. Respiratory tract	_____	_____
8. Circulatory system	_____	_____
9. Gastrointestinal tract	_____	_____
10. Urinary tract	_____	_____
11. Joints and bones	_____	_____
12. Sex apparatus	_____	_____
13. Equilibrium and vestigular apparatus	_____	_____
14. Diffuse	_____	_____

MENTAL EXAMINATION

EXPRESSION AND POSTURE

1. Masklike face	_____	_____
2. Sterotyped posture	_____	_____
3. Signs of distress	_____	_____

	Yes	Unknown
4. Sad expression	_____	_____
5. Childish expression	_____	_____
6. Lack of mimic modulation (rigidity of facial expression)	_____	_____
7. Silly smile	_____	_____
8. Sloppy appearance	_____	_____
BEHAVIOR DURING INTERVIEW		
1. Hostile or belligerent	_____	_____
2. Indifferent or passive	_____	_____
3. Eagerness to make a good impression	_____	_____
4. Tendency to avoid topics	_____	_____
5. Exaggeration, pseudologia, confabulation	_____	_____
6. Erratic	_____	_____
7. Lack of insight	_____	_____
8. Marked insight	_____	_____
MOVEMENTS AND SPEECH		
1. Generalized muscular tension	_____	_____
2. Underactivity or retardation	_____	_____
3. Overactivity, restlessness or acceleration of movements	_____	_____
4. Involuntary movements	_____	_____
5. Overtalkative	_____	_____
6. Monosyllabic	_____	_____
7. Mute	_____	_____
8. Mannerisms	_____	_____
9. Stammering, stuttering, tics	_____	_____

	Yes	Unknown
GENERAL BEHAVIOR		
1. Irritability, explosiveness	_____	_____
2. Combativeness and violence	_____	_____
3. Withdrawn	_____	_____
4. "Sticky", pestering	_____	_____
5. Excitability	_____	_____
6. Malingering	_____	_____
7. Incontinence of urine and feces	_____	_____
BEHAVIORAL DIAGNOSIS		
1. Coma or semicoma	_____	_____
2. Stupor	_____	_____
3. Drowsiness	_____	_____
4. Simple confusional state	_____	_____
5. Delirium	_____	_____
6. Agitation	_____	_____
7. Panic	_____	_____
8. Twilight state	_____	_____
9. Behavior problem	_____	_____
10. Antisocial or criminal behavior	_____	_____
MOOD AND EMOTIONS		
1. Poor rapport	_____	_____
2. Flat affects	_____	_____
3. Inappropriate affects	_____	_____
4. Emotional rigidity	_____	_____
5. Emotional lability	_____	_____

	Yes	Unknown
6. Mood swings	_____	_____
7. Transitory affective disturbances	_____	_____
8. Mania or hypomania	_____	_____
9. General overapprehension	_____	_____
10. Depression or retardation	_____	_____
11. Apathy	_____	_____
12. Euphoria	_____	_____
13. Anxiety attacks	_____	_____
INTELLECT		
1. Disturbed awareness and grasp	_____	_____
2. Disturbance of memory	_____	_____
3. Disturbance of reasoning and judgement	_____	_____
4. Disorientation	_____	_____
5. Aphasia	_____	_____
6. Inadequate intelligence (level of aspiration higher than abilities)	_____	_____
7. Unresourceful intelligence (inability to adapt, impractical)	_____	_____
8. Activity below intelligence level	_____	_____
THINKING		
1. Facilitation of thought	_____	_____
2. Inhibition of thought	_____	_____
3. Blocking of thought	_____	_____
4. Abstract--vague thinking	_____	_____

	Yes	Unknown
5. Loss of ability to abstract		
6. Autistic, egoistic and introspective thinking		
7. Difficulty of verbalization		
8. Slow mental speed		

ABNORMAL MENTAL TRENDS

1. Persistent fears		
2. Phobias		
3. Obsessions, compulsions		
4. Feelings of unreality and depersonalization		
5. Overconcern with body functions		
6. Hypochondriacal delusions		
7. Feelings of passivity		
8. Somaesthetic delusions		
9. Ideas of self-accusation and condemnation		
10. Ideas of reference		
11. Paranoid ideas		
12. Grandiose delusions		
13. Hallucinations		
14. Illusions		

PERSONALITY TRAITS

1. Infantile		
2. Suggestible		
3. Sensitive		
4. Self-conscious		
5. Seclusive		

	Yes	Unknown
6. Uncommunicative		
7. Suspicious		
8. Bigoted		
9. Imposing		
10. Resentful		
11. Fatigued		
12. Lack of initiative		
13. Distractible		
14. Fanatic		
15. Imaginative		
16. Imaginatively dull		
17. Meticulous, pedantic		
18. Sloppy		
19. Undependable		
20. Dissatisfied		
21. Loquacious		
22. Erratic		
23. Impulsive		
24. Emotionally intense		
25. Emotionally flat		
26. Emotionally uncontrolled		
27. Emotionally inhibited		
28. Warmhearted		
29. Cold		
30. Strict		

	Yes	Unknown
31. Miserly		
32. Resigned		
33. Contented		
34. Self-pitying		
35. Stubborn		
36. Profane		
37. Eccentric		
38. Jealous		

POSTMORBID PERSONALITY CHANGES

1. Decline in intellectual sphere (temporary)		
2. Increased emotionality, lability, incontinence		
3. Deterioration (permanent)		
4. Became behavior problem or showed conduct disorder		
5. More fatigued		
6. More seclusive, withdrawn		
7. Decline in occupational level		
8. More unemployed or unable to work		
9. Increased difficulties in interpersonal relations		
10. Fewer interests		
11. Dulling of finer sentiments and emotions		
12. Exaggeration of previous personality traits		
13. Autonomic imbalance		

	Yes	Unknown
14. More erratic	_____	_____
15. More promiscuous	_____	_____
16. Loss of potency	_____	_____
17. Increase of physical symptom formation	_____	_____

APPENDIX B: GRAPHS

FIGURE 1. GBMI Admissions by Quarter of the First Year of Legal Enforcement.

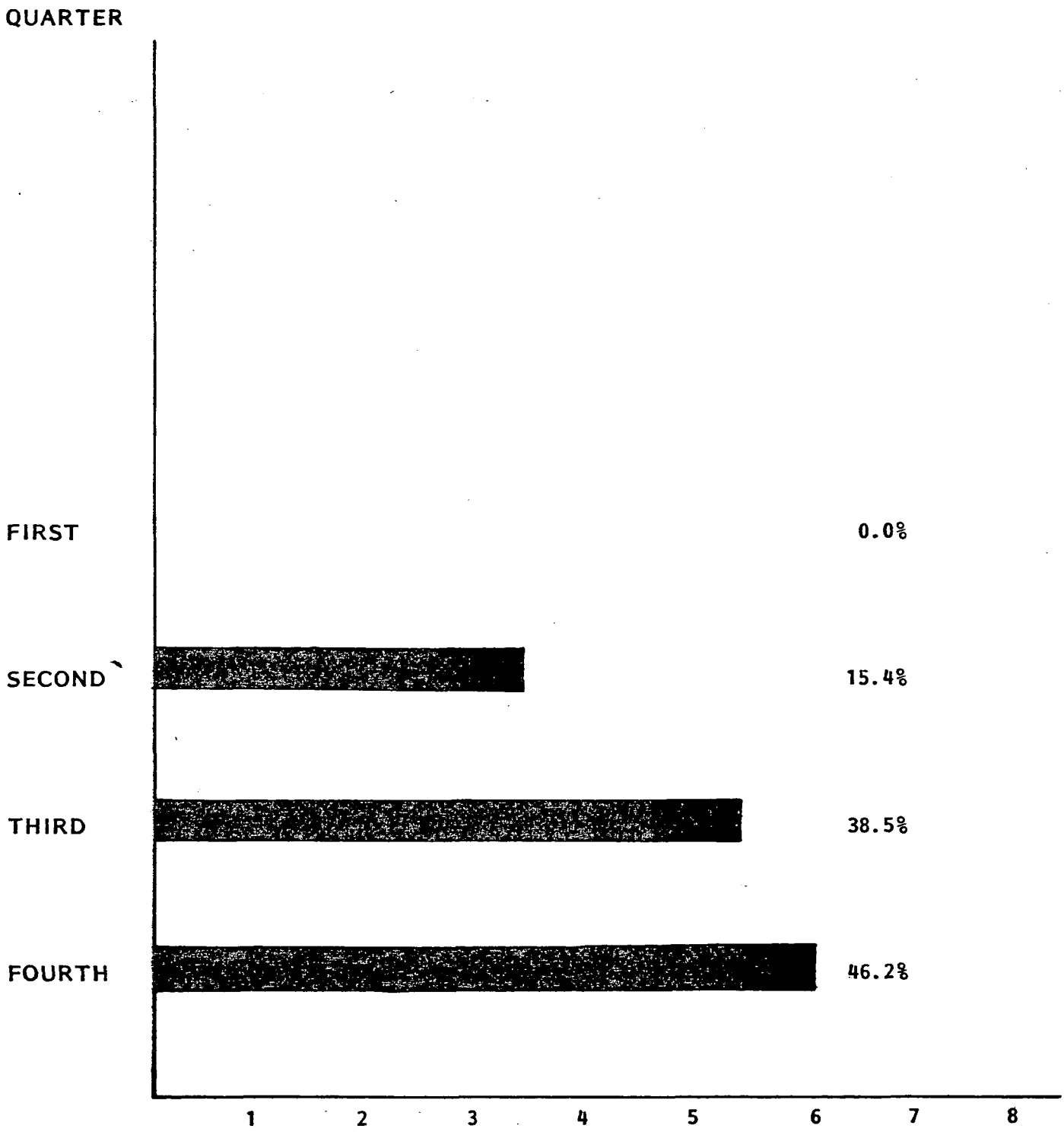


FIGURE 2. Admissions by County Population-Bracket.

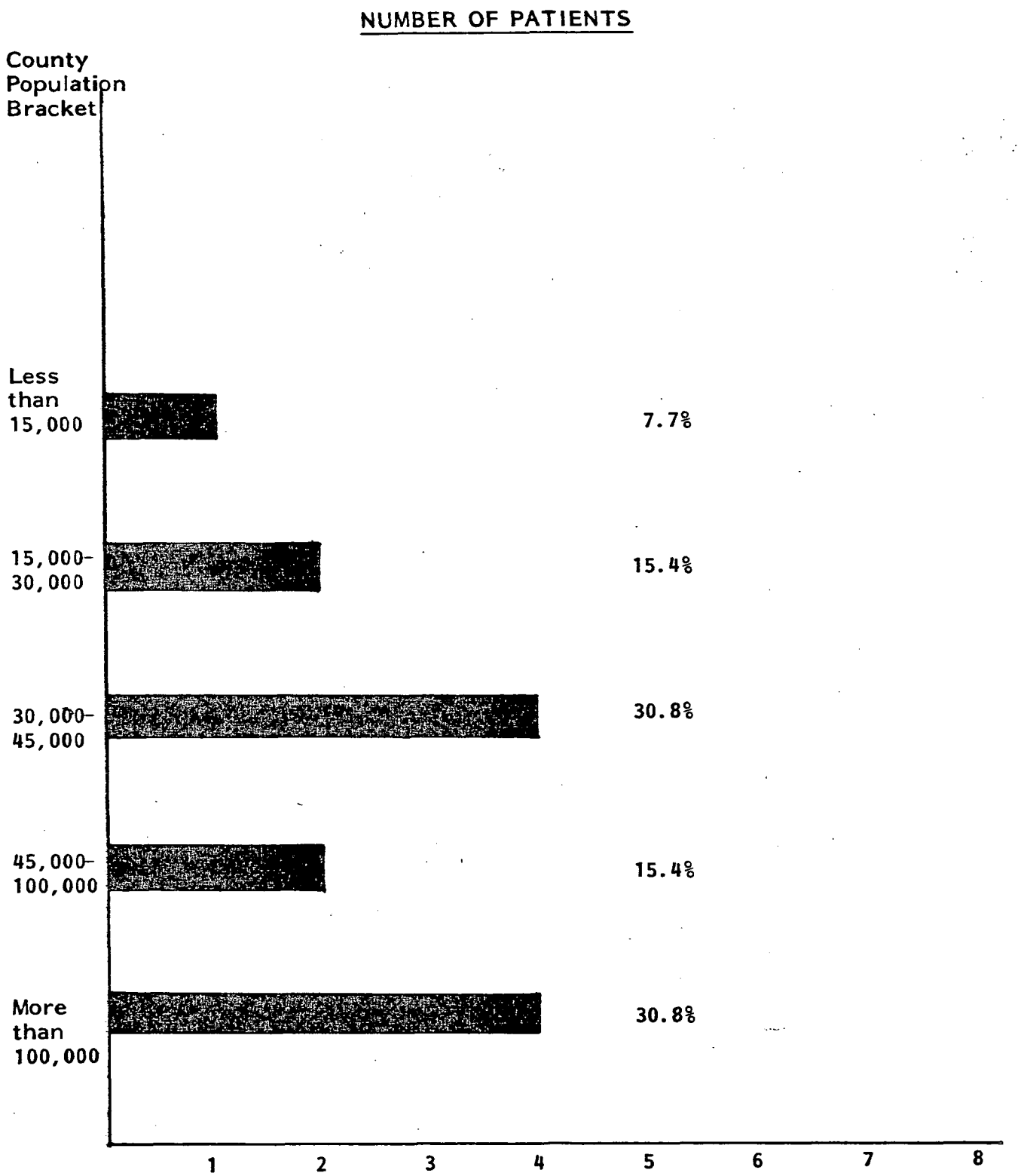


FIGURE 3. Length of GBMI Hospitalization.

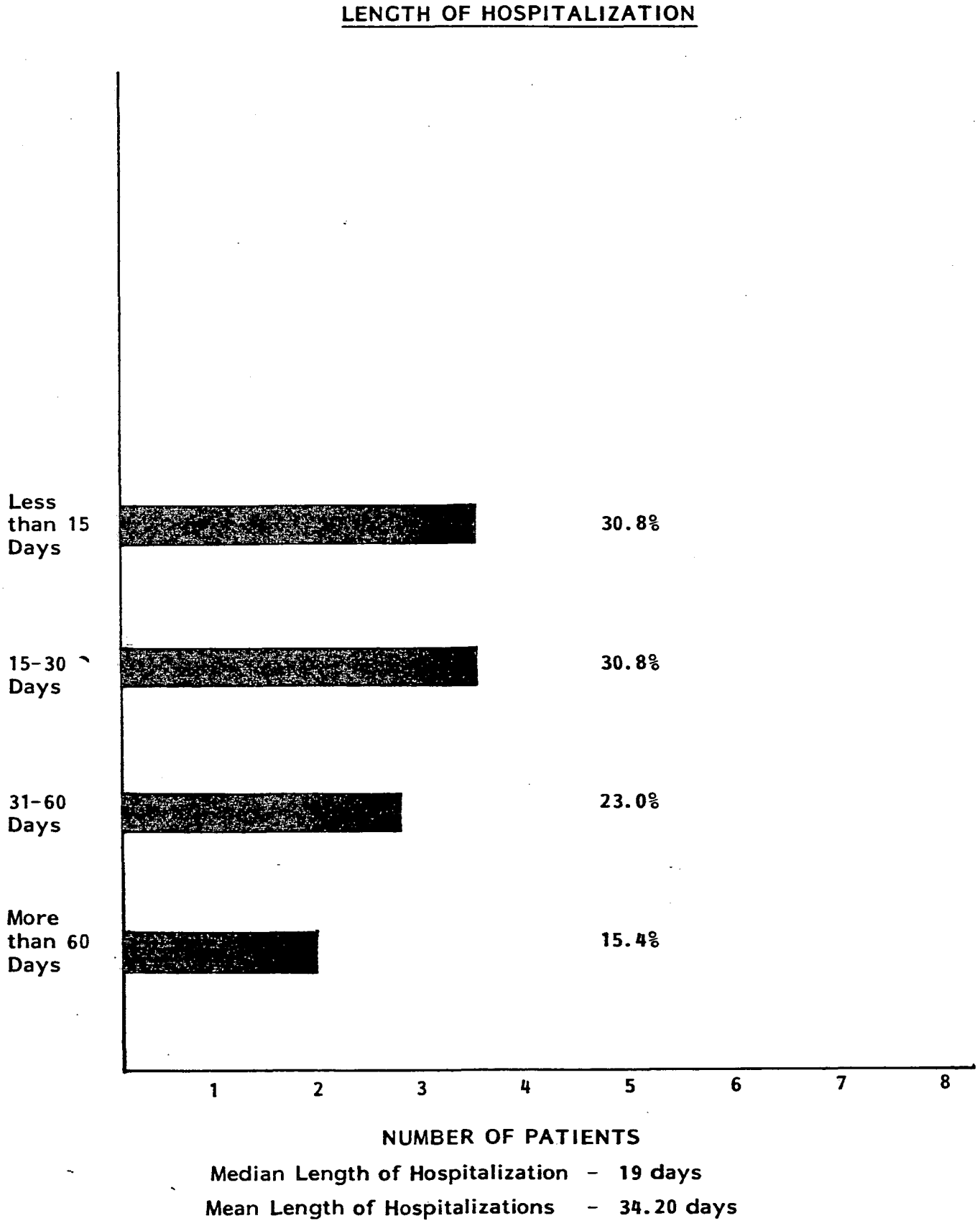


FIGURE 4. GBMI Admissions by Age-Bracket.

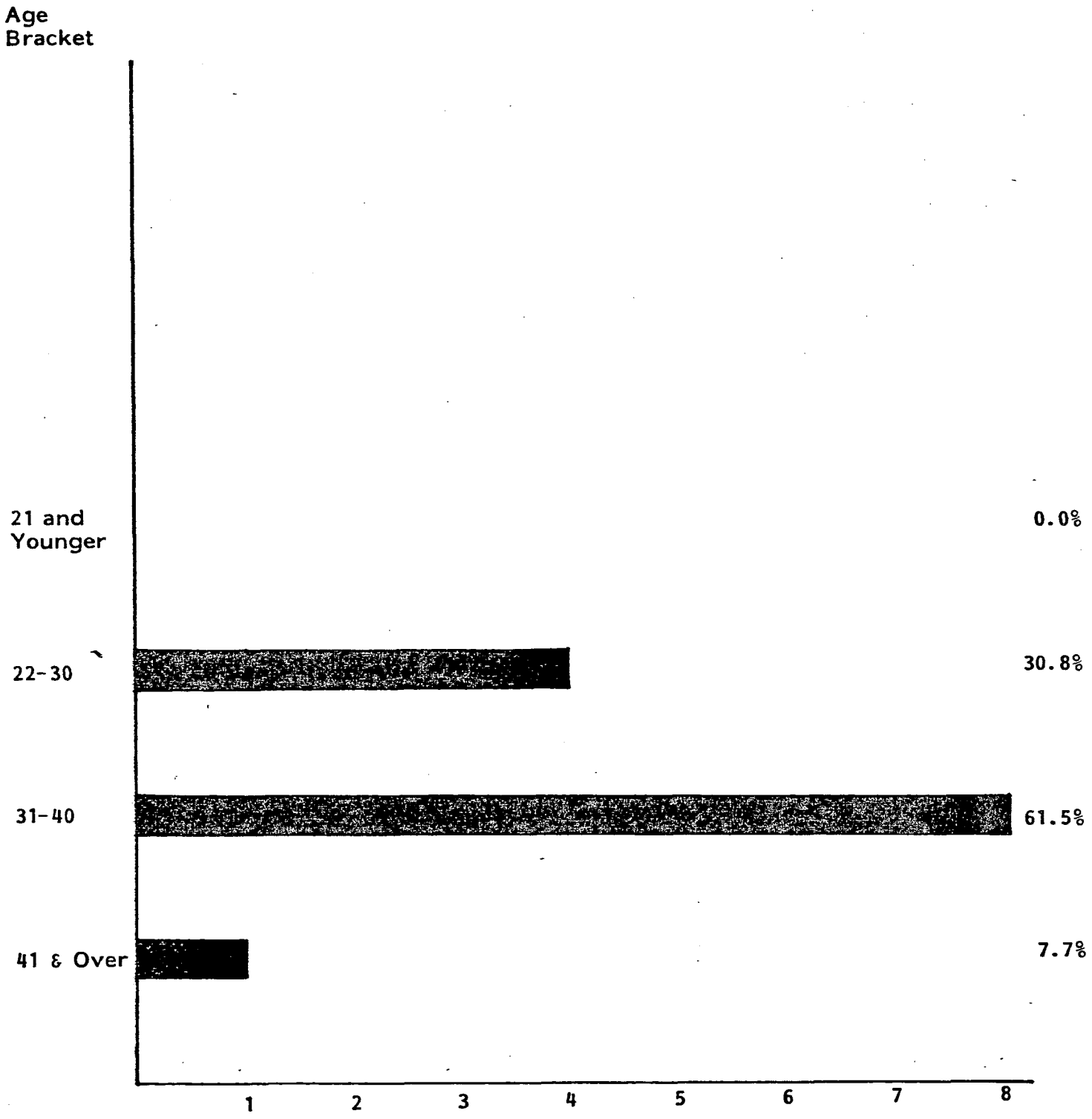
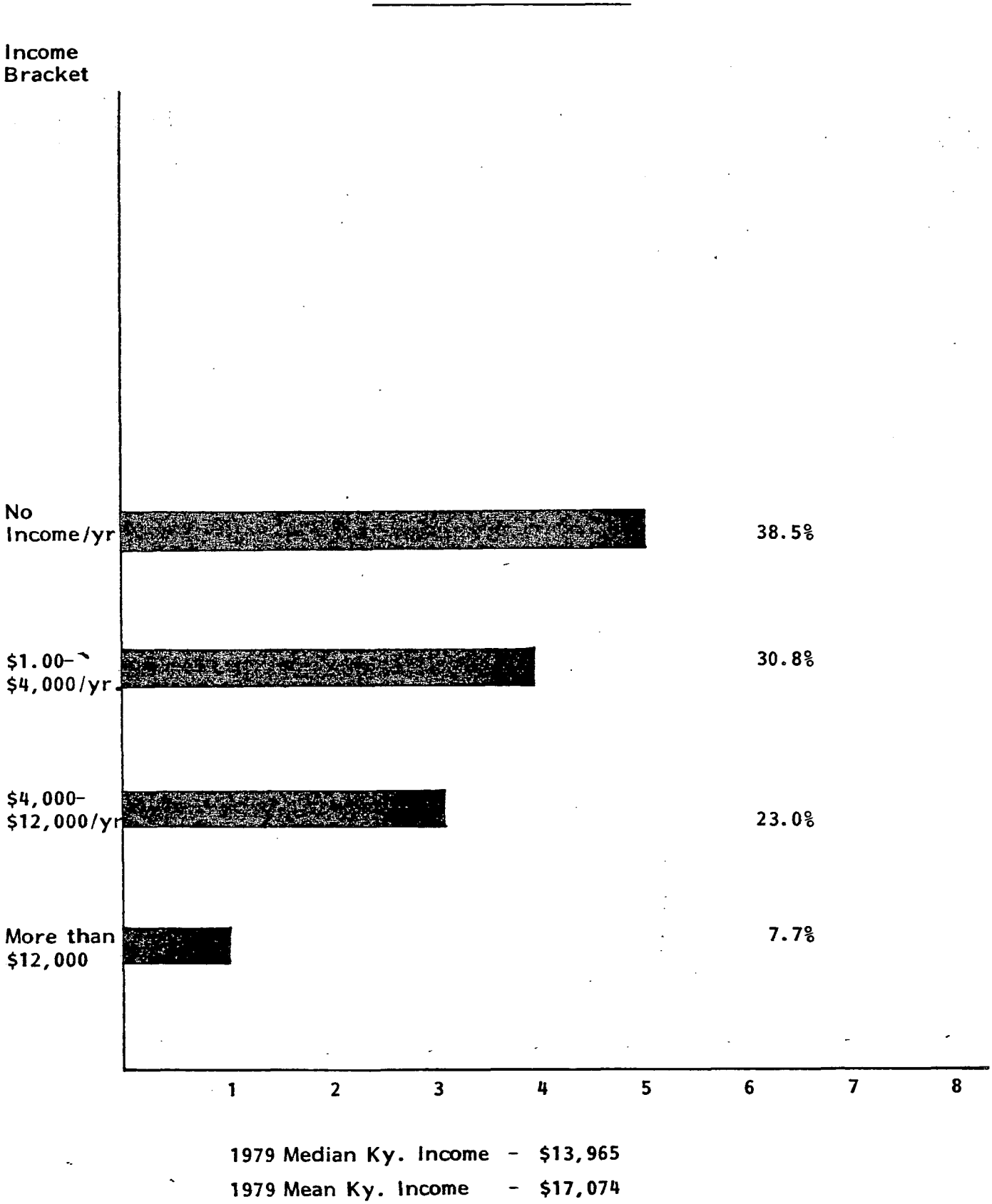


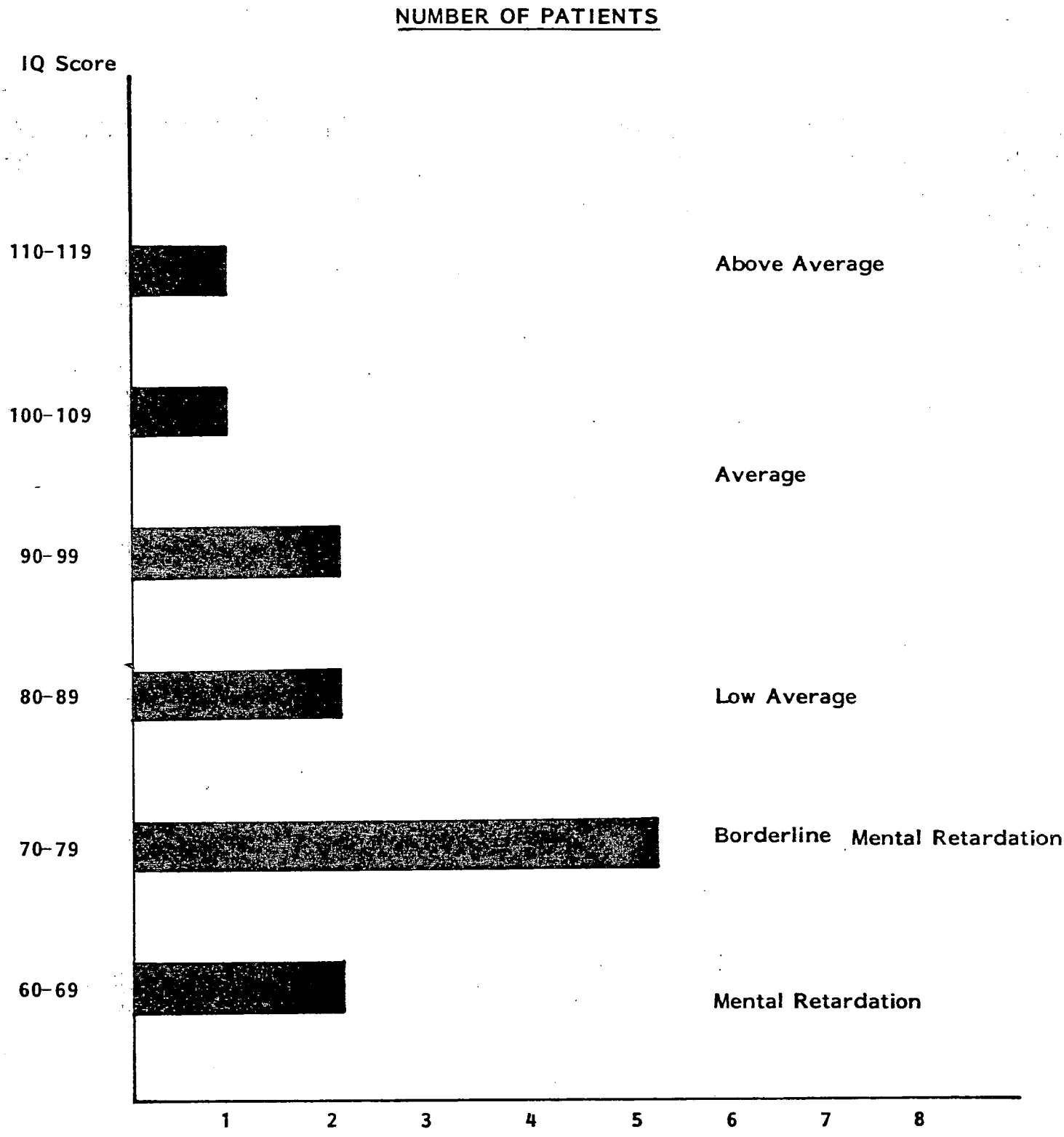
FIGURE 5. Kentucky GBMI Patients by Income-Bracket.



1979 Median Ky. Income - $13,965

1979 Mean Ky. Income - $17,074

FIGURE 6. GBMI Measured Intelligence Ranges (WAIS-R)



APPRENIX C: TABLES

Table 1. GBMI Admissions and Arrest Percentage Compared to Percentage of of Population in County Population Bracket.

COUNTY POPULATION	% POPULATION	% ARRESTS	% OF GBMI'S
Less than 15,000	15.0%	11.6%	7.7% (1)
15,000 - 30,000	18.8%	19.1%	15.4% (2)
30,000 - 45,000	14.7%	14.8%	30.8% (4)
45,000 - 100,000	22.8%	25.2%	15.4% (2)
More than 100,000	28.0%	29.2%	30.8% (4)

Table 2. Diagnosis, Charges and Sentences of GBMI Patients.

Case Number	Charge and Sentence	Diagnosis
1.	Criminal Possession of Forged Inst.; 2X Theft by Deception: 3 years	None
2.	Sex Abuse I: 5 years	Adjustment Disorder with Mixed Disturbance of Emotion and Conduct
3.	Assault II: 7 years	MR Mild, Paranoid Personality, Seizure Tendency by EEG
4.	Arson II: 7 years	Paranoid Schizophrenia
5.	RSP Over $100; Burglary I; Robbery I; PFO II: 20 years	Adjustment Disorder with Mixed Emotional Features
6.	Wanton Endangerment I: 2 years	Non-Psychotic OBS
7.	2X Rape: 20 years	Schizophrenia, in Remission; Anti-Social Personality
8.	RSP Over $100: 1 year	OBS due to trauma to head
9.	Possession of Controlled Substances; Trafficking in Controlled Substances: 4 years	Mixed Substance Abuse; Adj. Disorder; Histrionic Personality
10.	Rape I: 10 years	Mixed Substance Abuse by History; Anti-social Personality
11.	2X Manslaughter I: 15 years	Schizophrenia, in Remission
12.	5X Wanton Endangerment I; Burglary I: 10 years	Schizophrenia, Residual Type; Substance Abuser (Alcohol and Drugs)
13.	10X Burglary III: TBUT 2X; KRSP: 6 years	Impulse Control Disorder (Kleptomania); Psycho-sexual Disorder (Fetishism)

Table 3. Racial Composition of Kentucky GBMI Population Compared with Other Groups.

Race	Mich. Guilty	Mich. GBMI	KY. U.C.R.	KY. Prison	KY. GBMI
Black	38.1%	26.2%	11.8%	29.5%	7.7% (1)
Other	71.9%	63.8%	88.2%	70.5%	92.3% (12)

Table 4. Kentucky GBMI's Age Compared to Other Groups.

Age	Mich. Guilty	Mich. GBMI	KY. Prison	KY. GBMI
31 or less	68.8%	55.4%	63.3%	30.8% (4)
31 - 40	20.6%	28.8%	23.8%	61.5% (8)
Over 41	13.8%	15.8%	12.9%	7.7% (1)

Table 5. Kentucky GBMI Gender Compared with Other Kentucky Groups.

Gender	Kentucky U.C.R. (1982)	Kentucky Prison	Kentucky GBMI
Male	79.9%	95.7%	92.3% (12)
Female	20.1%	4.3%	7.7% (1)

Table 6. Marital Status of Kentucky GBMI's Compared with Other Groups.

Marital Status	Mich. Guilty	Mich. GBMI	KY. GBMI
Single	55.0%	44.2%	30.8% (4)
Married	17.2%	21.7%	38.5% (5)
Divorced	24.9%	28.2%	30.8% (4)
Other	2.9%	5.8%	0.0% (0)

Table 7. Educational Level of Kentucky GBMI's Compared with Michigan Group.

Education Bracket	Mich. Guilty	Mich. GBMI	KY. GBMI
0 - 6 years	5.0%	4.3%	23.0% (3)
7 - 11 years	60.8%	52.9%	38.5% (5)
High School Graduate	24.9%	22.5%	23.0% (3)
Some College	8.5%	14.5%	15.4% (2)
College Graduate	1.0%	2.2%	0.0% (0)
Post Graduate	0.0%	3.5%	0.0% (0)

Table 7. Kentucky GBMI Arrest Data Compared to Michigan Groups.

Prior Arrest #	Mich. Guilty	Mich. GBMI	KY. GBMI
None	15.8%	22.2%	7.7% (1)
1-3 Arrests	53.7%	40.1%	38.5% (5)
4-5 Arrests	14.7%	17.0%	0.0% (0)
6 or More Arrests	15.7%	20.7%	53.8% (7)

Table 8. Miscellaneous Statistics.

Variable		Percent and Number
Court-Appointed Lawyer		69.2% (9)
Prior Psy. Hospitalization (Not for Competency Evaluation)		53.8% (7)
Competency Evaluation on Currect Charge		100.0% (13)
Type of Mental Health Professional Doing Evaluation:		
	Psychiatrist	100.0% (13)
	Psychologist	0.0% (0)
Number referred by Psychiatrist to Psychogist for Additional Evaluation		76.9% (10)
Nature of Mental Health Data: (For Competency Evaluation)		
	Interview	100.0% (13)
	Psy. Testing	76.9% (10)
Handedness:	Right-Handed	76.9% (10)
	Left-Handed	7.7% (1)
	Ambidextrous	15.4% (2)
Alcoholism Reported:		38.5% (5)
Drug Abuse Reported:		38.5% (5)

Table 9. Substance Abuse Among Kentucky GBMI's Compared to Michigan Group.

	Mich. Guilty	Mich. GBMI	KY. GBMI
% Alcoholism and/or Drug Abuse	93.8%	87.2%	53.8% (7)

APPENDIX D: PSYCHOMETRIC DATA

This report represents the psychological profile of the average GBMI patient seen at KCPC during the first year of the GBMI statue's existence. There are thirteen individuals represented, twelve male and one female, twelve white and one black. Their average age is 34 years. General population norms are used. Interpretations for purposes of the composite profile are written as for an adult white male.

The average GBMI individual has measured overall intellectual functioning within the low average range according to Wechsler classification--within the upper borderline range in verbal ability and within the upper low average in areas of nonverbal expression. Wechsler subtest scatter is minimal and is not indicative of CNSI.

The general GBMI picture is one revealing deficits in ego functions. There is a general negative self-image and realization of need for psychological assistance. Significant psychological problems exist.

The mean MMPI profile suggests that the average GBMI individual does not seem to fit into his environment. He is seen by others as narcissistic, weird or very peculiar. He is nonconforming and resentful of authority and often espouses radical religious or political views. His thoughts and behaviors are erratic and unpredictable and he has marked problems with impulse control.

He tends to be irritable and resentful, with ready anger at minor obstacles and frustrations. He is prone to violence if cornered. He consistently shows antisocial behavior and when this occurs, it is usually within a family structure as in family desertion, and reflects underlying dependency and deteriorating control. Crimes committed by this person tend to be vicious and assaultive and often appear to be senseless, poorly planned and poorly executed, reflecting a self-defeating pattern. Excessive drinking and drug abuse (particularly hallucinogens) may also occur. His history indicates underachievement, uneven performance and marginal educational and vocational adjustment. He prefers a nomadic and transient existence.

Serious concerns about his sexuality are probable. He may be obsessed with sexual thoughts but is afraid he cannot perform adequately in sexual situations. He indulges in antisocial sexual acts such as prostitution, promiscuity and sexual deviation in an attempt to demonstrate sexual adequacy.

The average GBMI harbors deep feelings of insecurity and has exaggerated needs for attention and affection. He has a poor self-concept and sets himself up for rejection and failure. There are periods during which he becomes obsessed with suicidal ideation. Subtle communication problems exist. He is quite distrustful of other people and avoids close relationships. When involved interpersonally, he has impaired empathy and tries to manipulate others into satisfying his needs.

Basic social skills are lacking and he tends to be introverted, socially withdrawn and isolated. Defenses cause him to misperceive many social stimuli. Problems stem from the early establishment of this attitude of distrust toward the world. As a child, he probably learned to perceive other people as hostile, threatening and rejecting. He also learned that he could protect himself and diminish his painful anticipations by striking out in anger and rebellion. Anger demonstrated toward others tends to make others angry at him. In effect, his social behavior sets up a self-fulfilling prophecy reinforcing his alienation. He accepts little responsibility for his own behavior and rationalizes excessively, blaming his difficulties on other people.

Depression of clinically significant magnitudes exists with accompanying low activity level and tendency to worry over even minor issues. The GBMI tends to be religious, moralistic, worrisome, apprehensive, rigid and meticulous. He is intensely dissatisfied with his life, especially, his social relations. His moderate to severe level of anxiety and tension makes even day to day activities difficult. Interests and energies are scattered. As with his relationship with people, he manifests intense but short lived enthusiasm for plans and undertakings. There is significant concern about body functions with diffuse and vague somatic complaints and concerns about health.

16PF results are similar to MMPI findings and suggest difficulties in interpersonal relationships with tendencies toward introversion and tough poise. The GBMI individual also tends to have a self-sufficient resoursefulness with high tension and anxiety. Problems in behavior control are also indicated.

In summary, the average GBMI tends to be of low average intelligence and to have legally definable mental illness. Prominent features of his personality are strong schizoid tendencies and an inclination toward antisocial behavior. Interpersonal skills are lacking. Underlying dependency and low frustration tolerance exist. GBMI's tend to blame others for their problems and to act out with violence.