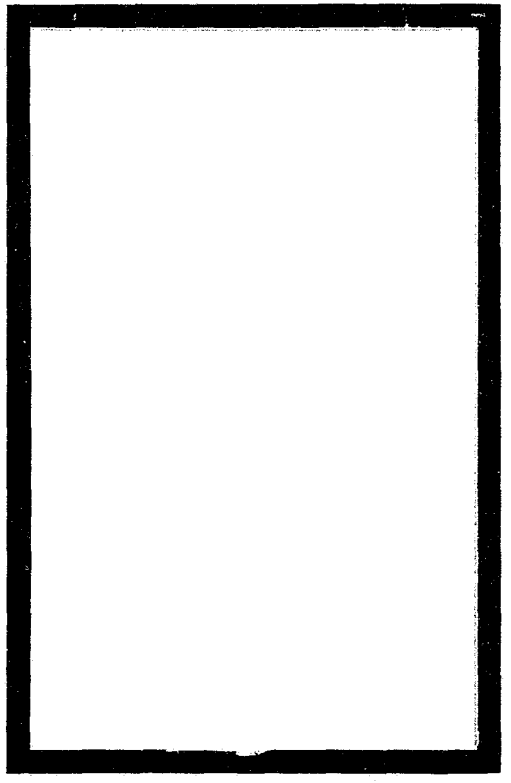

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Final Report of the Guilty But Mentally Ill Project

November 1984

(Revised July 1985)

THE GUILTY BUT MENTALLY ILL VERDICT: AN EMPIRICAL STUDY

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THE GUILTY BUT MENTALLY ILL VERDICT: AN EMPIRICAL STUDY

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

PART ONE. CURRENT STATE OF THE KNOWLEDGE

PART TWO. A TELEPHONE SURVEY OF ELEVEN STATES

THE GUILTY BUT MENTALLY ILL VERDICT: AN EMPIRICAL STUDY

ABSTRACT

Twelve states (Alaska, Delaware, Georgia, Indiana, Illinois, Kentucky, Michigan, New Mexico, Pennsylvania, South Carolina, South Dakota, and Utah) have adopted a "guilty but mentally ill" (GBMI) verdict to be considered alongside the traditional verdicts of guilty, not guilty, and not guilty by reason of insanity (NGRI). Since 1975, when Michigan became the first state to enact GBMI legislation, approximately 800 criminal defendants who made claims of mental disorder have been found GBMI. They tend to be relatively young, white males convicted of serious crimes against persons. Most are charged with multiple crimes and have a history of previous contacts with the criminal justice system and the mental health system. Eighty percent have a recognizable mental disorder and most are treated accordingly once in the corrections system. The GBMI provisions of the twelve statutes differ significantly in such fundamental matters as the standard for GBMI determinations, the type of cases in which they apply, and the procedures by which they are administered. There is no single GBMI statute or concept. Nor is there a uniform perception of GBMI among those responsible for implementing it. Except for a possible increase in plea negotiations, the GBMI provisions have resulted in little change in the manner in which the criminal justice and the mental health systems handle mentally disordered defendants during and after criminal proceedings. Although touted by its proponents as an attractive alternative to the NGRI verdict for juries to consider, most GBMI findings (like NGRI findings) resulted from pleas and bench trials. Contrary to the views held by much of the public, jurors, and many members of the mental health and criminal justice systems, GBMI offenders are not guaranteed treatment under law, nor are they any more likely to receive treatment than other mentally ill offenders in the general inmate population to whom the GBMI label has not been applied. Indeed, they are given stiffer sentences than their guilty counterparts without any better access to mental health treatment. GBMI offenders appear to be imprisoned for longer periods than insanity acquittees are involuntarily hospitalized. Despite the hopes of its proponents and the fears of its critics, the GBMI option has not spelled the demise of the insanity defense. Indeed, it appears not to have appreciably disturbed the frequency of NGRI findings. These are the conclusions of a one-year study completed in July 1985 of the antecedents, legislative and judicial development, implementation, and consequences of GBMI laws, conducted by the Institute on Mental Disability and the Law, National Center for State Courts, under a grant (No. 83-IJ-CX-0042) from the Institute of Justice, United States Department of Justice.

THE GUILTY BUT MENTALLY ILL VERDICT: AN EMPIRICAL STUDY

Institute on Mental Disability
National Center for State Courts

November 1984
(Revised June 1985)

EXECUTIVE SUMMARY[1]

I. INTRODUCTION

Throughout their history, the laws providing for an insanity defense have faced opposition. One form of opposition is legislation creating an alternative verdict that acknowledges a defendant's unsound mind yet does not absolve him or her of criminal responsibility. Such a verdict may either supplant or supplement the verdict of "not guilty by reason of insanity." Queen Victoria's displeasure with the acquittal by reason of insanity of notorious defendants like Daniel McNaughtan, who in 1843 attempted to assassinate the British Prime Minister Sir Robert Peel, and Roderick MacLean, who in 1882 attempted to kill the Queen herself, led to the passage of the Trial of Lunatics Act in 1883. This act supplemented the verdict of not guilty by reason of insanity with that of "guilty but insane."

Almost a hundred years passed before any jurisdiction in the United States followed the English lead. In 1975, in response to public outcry over the release of approximately 150 insanity acquittees following the Michigan Supreme Court's decision in People v. McQuillan, Michigan became the first state to enact a "guilty but mentally ill" (GBMI) statute. This enactment served as a prototype for other states. By 1984, eleven states (Alaska, Delaware, Georgia, Indiana, Illinois, Kentucky, New Mexico, Pennsylvania, South Carolina, South Dakota, and Utah) had followed the precedent in Michigan by adopting a GBMI verdict to be considered alongside the traditional verdicts of guilty, not guilty, and not guilty by reason of insanity (NGRI). Other states have considered or are currently considering adopting similar legislation.

Unlike an NGRI verdict, which holds a mentally ill defendant blameless, a GBMI verdict holds the defendant criminally responsible and

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1. This summary was prepared under Grant No. 83-IJ-CX-0042 from the National Institute of Justice, U.S. Department of Justice. Points of view expressed in this summary, and the full report upon which it is based, are those of the authors and do not necessarily represent the official positions or policies of the U.S. Department of Justice. For further information, contact the Institute on Mental Disability and the Law, National Center for State Courts, 300 Newport Avenue, Williamsburg, Virginia 23185.

allows imposition of the same punishment that could be given a defendant found guilty of the same offense, yet promises mental health evaluation and treatment during the term of the criminal sentence. Prompted by highly publicized cases, typically involving insanity acquittals of defendants perceived to be threats to public safety, legislators hoped that the GBMI verdict would offer juries an attractive alternative to the NGRI verdict and, thereby, curb the use of the insanity defense and prevent the early release of dangerous offenders.

Despite its adoption in twelve states, the GBMI verdict has been criticized roundly by scholars and professionals as conceptually flawed and procedurally problematic. Major professional organizations, including the American Bar Association, the American Psychiatric Association, the American Psychological Association, the National Commissioners on Uniform State Laws, and the National Mental Health Association, have taken positions opposing GBMI laws.

This is a summary of a final report of an empirical one-year study of the antecedents, legislative and judicial developments, implementation, and consequences of the GBMI laws adopted in eleven states. (South Carolina, which enacted GBMI legislation on May 16, 1984, was not included in the empirical study. It was, however, included in the review of legislation.) The study was commissioned by the National Institute of Justice, United States Department of Justice, and was conducted by the Institute on Mental Disability and the Law (hereinafter Institute), National Center for State Courts. The final report was submitted to the National Institute in November 1984 and revised in July 1985.[2]

To carry out the study, the Institute conducted research in three phases. First, it made an extensive review of statutory law, case law and social science research. This resulted in a description of the relevant substantive standards, definitions, and procedural mechanics of the GBMI laws in twelve states and a review of the empirically-based social science research of the GBMI provisions.[3] Second, telephone interviews were conducted with individuals familiar with GBMI provisions and their implementation. A total of 141 interviews were conducted with legislators and legislative staff, defense attorneys, prosecutors,

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2. Institute on Mental Disability and the Law, the Guilty But Mentally Ill Verdict (1985) (Available from the Publications Department, National Center for State Courts, 300 Newport Avenue, Williamsburg, Virginia 23185. The cost is $41.85). Unless otherwise noted, all subsequent footnotes refer to the section or subsection of the full report which is being summarized.

3. Part One, "Current State of the Knowledge," of the final report which describes the result of this first phase has been revised and published in two separate articles: McGraw, Farthing-Capowich & Keilitz, The "Guilty But Mentally Ill" Plea and Verdict: Current State of the Knowledge, 30 Villanova Law Review 117 (1985); and McGraw & Keilitz, Guilty But Mentally Ill: A Legislative Response to the Insanity Defense, 8(3) State Court Journal 4 (1984).

judges, psychiatrists, psychologists, mental health treatment personnel and administrators, and corrections officials, including probation and parole officers. The qualitative data obtained from these telephone interviews helped establish the perceived intent of GBMI legislation, its implementation in the eleven states, and its perceived successes and failures, and provided insights into the catalysts of reform that ushered in the legislation and the exogenous factors that might affect its impact on practice. Finally, data were gathered from official case file records of GBMI offenders in Georgia, Illinois, and Michigan, three states where relatively large numbers of defendants have been found GBMI. Virtually the entire population of defendants found GBMI and committed to the departments of corrections in the three states through mid-1984--a total of 519--were identified and studied. For purposes of comparison, groups of defendants found NGRI in the three states and a group of Michigan defendants found guilty after raising the issue of mental aberration were also studied. Descriptive and inferential statistics were derived from these data and summarized to make understandable the characteristics of GBMI offenders and their handling by the criminal justice and mental health systems, and to help draw inferences about the effect of the GBMI alternative on the criminal justice process.

This report first summarizes the GBMI laws, their antecedents, legislative and judicial development, and then turns to their intermediate outcomes, such as their reception and perception by functionaries in the criminal justice and mental health systems, their administration and practical application, and, finally, their ultimate impact.

II. THE GBMI LAWS

A. Antecedent Events

In 1974, in the case of People v. McQuillan, the Michigan Supreme Court struck down the state's automatic commitment statute because it provided stricter standards and procedures for criminal defendants acquitted by reason of insanity than for persons civilly committed as dangerous and mentally ill. The court ruled that the insanity acquittees were denied equal protection under law since they were treated differently from patients who are civilly committed. The court ordered that 270 insanity acquittees previously committed and still hospitalized be provided judicial hearings to insure that they met the civil commitment standards (i.e., present mental illness, dangerousness, or inability to meet basic needs). Many were subsequently released because they did not meet these criteria for involuntary civil commitment. Shortly after their release, two committed violent crimes. One raped two women. The other killed his wife. The resulting public outcry spurred the Michigan legislature to adopt the GBMI plea and verdict.

Similarly, in Alaska, Georgia, Indiana, South Dakota, and Utah, highly publicized cases were the catalysts for the enactment of GBMI legislation. All the cases involved violent crimes committed by mentally disordered individuals. Several involved defendants who had committed particularly heinous crimes after their acquittal by reason of insanity

and subsequent release from mental hospitals. The publicity surrounding the trial and acquittal of John W. Hinckley, Jr. in the shooting of President Ronald Reagan, also influenced the enactment of GBMI legislation in some states. For example, the day after the verdict was announced, the Delaware legislature passed the bill adopting the GBMI provisions in that state. If nothing else, public dissatisfaction with the verdict in the Hinckley case may have created a political climate conducive to the creation of alternatives to the insanity defense.

The primary purposes of the GBMI legislation were to curtail the assertion of the insanity defense, to reduce the incidence of insanity acquittals, and thereby to protect society by imprisoning mentally disturbed, dangerous defendants who might otherwise be found NGRI and released shortly thereafter. Related to the legislative purpose to close the perceived loophole whereby allegedly criminally responsible defendants escape punishment for their misconduct, was the intent to offer juries a compromise verdict that would ensure that such defendants would not be released before a minimum prison term had been served and mental health treatment has proved effective. Some commentators argued that the real intent of GBMI laws is punishment cloaked in the guise of mental health treatment.

B. Statutory Provisions

The GBMI provisions of the twelve states reveal similarities as well as critical differences.[4] Whether similarities and distinctions among the formulations of the GBMI verdict reflect different legislative purposes is unclear. It is clear, however, that there is no single GBMI statute or concept, but several different types.

In all the states, when the issue of mental disorder has been properly raised, the GBMI alternative may also be considered by the triers of fact alongside the traditional findings of guilty, not guilty, and NGRI. Following a finding of GBMI, the defendant may be sentenced like any other guilty defendant, and then may be transferred to the supervision or custody of a corrections department or state mental health department or unit where he or she receives mental health care and treatment, if warranted on the basis of post-conviction mental health evaluation. Once the defendant is determined to have recovered from his or her mental disorder, he or she serves the remainder of the sentence.

An examination of this general scheme, however, reveals a number of sharp differences in the provisions among the states. In Georgia and Michigan, for example, the GBMI plea and finding are available only in felony cases. No such restrictions are applied in the other states. Only Alaska, Delaware, and Illinois actually define the standard for GBMI determinations. In Alaska and Delaware, a defendant may not be found NGRI on the grounds that he or she lacked the behavioral controls necessary to conform to the requirements of the law, but may be found GBMI on that basis. Presumably, the GBMI standards of these two

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4. Part One, "II. Legislative Developments," pp. 1-9 to 1-21.

states encompass a much broader concept of mental disease or defect, including what is meant by "irrestible impulse" or "volitional capacity," than the states' NGRI standards, which focus on the extent to which a defendant could appreciate the wrongfulness of his or her conduct. Illinois, on the other hand, allows a NGRI finding on the basis of volitional impairment, but disallows a GBMI finding on that basis. The NGRI and GBMI verdicts in these states thus appear to be distinguishable by the types of mental aberration upon which they can be based. In Alaska and Delaware, but not in Illinois, criminal responsibility may be assigned to a defendant even if he or she suffered from mental aberration that impaired behavioral control or willpower.

In all states but Alaska, a criminal defendant may plead GBMI at the outset. All but Alaska and Georgia provide specific prerequisites to the acceptance of a GBMI plea, including notice of intent to introduce claims of mental disorder, waiver of the right to a jury trial, pre-trial mental health examination, and judicial hearing on the issue of the defendant's mental condition. Only Kentucky specifies which party bears the burden of proof regarding mental illness at trial; six states require proof beyond a reasonable doubt, two require a preponderence of the evidence, and three are silent on the issue. Although only the Indiana, Kentucky and Delaware statutes fail to provide specifically for jury instructions regarding the availability of the GBMI verdict, only Alaska and Michigan provide for instructions regarding the dispositions available upon a GBMI or NGRI verdict. Only Georgia and Indiana do not provide for mental health examinations before the acceptance of a GBMI plea or the rendering of a GBMI finding.

Despite the widespread belief that a GBMI finding guarantees mental health treatment, the finding does not ensure treatment beyond that available to other offenders. Most GBMI statutes, with the possible exceptions of those in Alaska and Utah, give discretion to the correctional or mental health facility having custody of the offender to provide treatment "as it deems necesary" or "as psychiatrically indicated." The Georgia statute includes the caveat that treatment shall be provided "within the limits of state funds appropriated therefor." As a statutory matter, therefore, GBMI offenders may be no more likely to received treatment than other offenders.

Of particular note are the uniform provisions among the states allowing or mandating the imposition on a GBMI convict of any sentence that would be imposed on any other defendant convicted of the same offense. That the GBMI sentencing provisions do not expressly preclude the death penalty may present the courts with a conflict between the rehabilitative ideals of the GBMI legislation and the possible imposition of the death penalty. In at least one case, currently on appeal with the Indiana Supreme Court, the death penalty has been imposed on a GBMI offender.[5] Subtle but important differences in sentencing

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5. See 2 Mental Health L. Rep. 1-2 (May, 1984). See also Giampetro, Guilty But Mentally Ill Statutes, Treatment Promises, and Capital Punishment, AAPL Newsletter, in press.

procedures do exist, however, among the states. For example, in Utah, if a court finds a defendant is currently mentally ill, it must sentence him or her as a mentally ill offender. The Utah courts may order hospitalization of the defendant at the Utah State Hospital or other suitable facility. If a defendant in Michigan or Utah is placed on probation, the period of probation shall not be less than five years or until expiration of the sentence, which ever comes first.

In most states, probation, pre-release, or parole is granted under the same terms and laws applicable to any other offender. In Alaska, however, a GBMI convict receiving treatment may not be released on furlough, work release, or parole. In Michigan, probation granted to a GBMI offender must be for a minimum period of five years, regardless of the maximum sentence of the crime for which the defendant was convicted. These laws make it possible for GBMI convicts to stay under the jurisdiction of the court or department of corrections for longer periods than their counterparts who are found guilty of the same crime.

C. Judicial Development of GBMI Provisions

As of May 1984, when the Institute's legal research on the GBMI finding was completed, approximately 90 appellate decisions involving or discussing the GBMI plea or verdict had been rendered.[6] The vast majority of these decisions understandably were made in Michigan, the state with the longest experience with the alternative verdict. Many, however, concern issues having little or only tangential significance to the GBMI laws' development.

Constitutional challenges to the GBMI statutes have ranged from arguments based on equal protection and due process guarantees to prohibitions against cruel and unusual punishment and ex post facto laws. These challenges have been predicated on both federal and state constitutional guarantees. Although the relevant Michigan case law involves equal protection, due process and cruel and unusual punishment issues, Indiana case law deals only with equal protection and due process challenges. Illinois case law reveals challenges based on due process guarantees in the federal constitutional prohibition against ex post facto laws, and Georgia cases involved only ex post facto law challenges. To date, the Illinois, Indiana, and Michigan statutes have withstood constitutional attack in the supreme courts of those states, while the Georgia statute has been reviewed only by the intermediate appellate court. The courts also have ruled on substantive and procedural matters including pleading procedures, the applicable burden of proof, jury instructions, inconsistent verdicts, the right to treatment, and probation provisions. The various challenges waged against the GBMI statutes since 1977--substantive, procedural, and constitutional--have resulted in the judiciary approving and preserving the legislative purpose of offering treatment to mentally disturbed offenders and of protecting the public from mentally disturbed and dangerous offenders. During this testing period, the courts have had little negative to say about the GBMI statutes. In concluding that the statutes rationally further proper

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6. Part One, "III. Judicial Developments," pp. 1-21 to 1-54.

legislative objectives, the courts have not looked beyond the verdict to see if GBMI offenders actually receive beneficial mental health treatment. In the near future, such concerns may be addressed in writ of mandamus or civil rights proceedings arising in the various states.

D. Exogenous Factors

A general caveat regarding the pitfalls of interpreting changes after major statutory reform is warranted before discussion of the intermediate and ultimate impact of GBMI laws. An assessment of legislative impact can be judged by the extent to which its findings are interpretable and generalizable. A critical question is whether its findings can be reasonably attributed to factors other than the legislation. A myriad of exogenous forces may parallel the legislation affecting its implementation and outcome. Among the states that have enacted GBMI legislation, all states but Kentucky made other changes that affected the handling of mentally disordered defendants.[7] These changes present possible alternative explanations for apparent effects of the GBMI legislation. For example, in Alaska the adoption of GBMI provisions coincided with a number of significant changes in the state's mental health laws, including a narrowing of the definition of insanity and a shift of the burden of proof in insanity cases from the prosecution to the defense. Delaware and Utah modified the standards for insanity, and Pennsylvania shifted the burden of proof in insanity cases from the prosecution to the defense. Although the GBMI legislation in Georgia and Indiana did not coincide with any other specific changes in mental health law, the legislation was part of a broad reform of mental health laws spanning several years. It would be difficult, if not impossible, to separate the effects of these changes on such ultimate outcomes as the reduction in the rate of insanity acquittals.

These exogenous factors present possible alternative explanations of effects of the GBMI legislation in most of the eleven states. This complicates properly attributing consequences to GBMI legislation to the extent that exogenous factors could reasonably be expected to have generated outcomes similar to those expected of the GBMI legislation.

III. PERCEPTION AND RECEPTION OF GBMI LAWS

There can be no guarantee that the intent of criminal justice reforms will materialize in legislation and no guarantee that the legislation will correspond to mandates or resources of agencies responsible for

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7. Part Two, "III.D. Exogenous Factors Affecting Outcomes," pp. 2-23 to 2-25; "Appendix E. Exogenous Factors," pp. A-77 to A-91. See also Petrella, Benedek, Bank, & Packer, Examining the Application of the Guilty But Mentally Ill Verdict in Michigan, 36 Hosp. & Community Pschiatry 254, 256 (1985)("[S]ince the guilty but mentally ill statute was one of three independent variables (legislative changes) implemented simultaneously, its influence on the dependent variable (the number of acquittals) cannot be determined.)

implementation. Indeed, the legislative process may be complicated by political considerations. The content of legislation that is enacted often has no simple or direct relationship to the legislators' motivations. For these reasons, the fundamental values to be upheld, the major goals, and the social harms to be avoided by a legislative measure may best be reflected by how it is perceived by the individuals charged with its implementation.

One of the most striking results of the survey of perceptions and reception of GBMI laws conducted by the Institute is the variety of responses to GBMI provisions within each state. This may reflect a general ignorance or a lack of consensus about the consequences of the actions of those responsible for implementing GBMI laws. Decisions apparently are being made by lawyers, judges, and juries on the basis of beliefs (e.g., GBMI offenders will receive treatment) which are totally at odds with reality. This underscores the importance of empirical data to inform policymakers about what professionals, the public, and special interest groups believe is occurring as a result of the use of the GBMI plea and verdict and to point out the discrepencies between beliefs and reality.[8]

Forty-two percent of the 136 survey respondents in the eleven states thought that the GBMI legislation in their state was created to limit the insanity defense either by a reduction of NGRI pleas, by elimination of perceived abuses in the administration of the defense, or by reduction in the incidence of insanity acquittals. One-quarter of the respondents perceived the provision of treatment of mentally disordered offenders as a major purpose underlying the GBMI provisions. Forty-two respondents believed that the purpose behind the GBMI alternative was to increase the criminal justice system's control of mentally disordered offenders or to protect the public. Given the public furor that ushered in the GBMI legislation, fueled mostly by concern for public safety and not necessarily for the plight of mentally disordered offenders needing treatment, the actual or perceived treatment ideals of the GBMI legislation may have been no more than the sugar coating to make the GBMI pill easier to swallow. Illustrating that the content of legislation may bear no direct relationship to legislators' motivations, two Alaska attorneys stated that the purpose of that state's GBMI legislation was to ward off a move toward total abolition of the insanity defense and to facilitate the passage of legislation to change the state's insanity standard.

The major perceived strengths of the GBMI laws were their provisions for mental health treatment, increased control over and protection from mentally ill offenders, and the availability of an alternative verdict in criminal proceedings. Of 136 survey respondents, 55 (40 percent) viewed provisions for treatment as the major strength of GBMI laws. These provisions were cited most often as strengths by attorneys, judges, mental health professionals, and corrections personnel, a view which may reflect no more than wishful thinking. The second most frequently

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8. Part Two, "A Telephone Survey of Eleven States," pp. 2-1 to 2-342.

mentioned strength of the GBMI provisions was the increased public protection they offered (22 percent). Surprisingly, only five respondents mentioned the curtailment of the insanity defense as a viable means toward the outcome of increased public protection. That so few respondents viewed the limitation of the insanity defense as a strength of GBMI legislation is at odds with the perception that limitation of the insanity defense was a major legislative intent of the GBMI provisions.

Thirty-four (27 percent) of 125 respondents expressing an opinion about the weaknesses of the GBMI legislation said that the actual provision of treatment to GBMI offenders was inadequate. These respondents considered mental health treatment provided to GBMI offenders to be no better or worse than the generally inadequate mental health treatment provided to other prisoners. Approximately one out of five respondents (22 percent) cited abusive or improper implemenation of GBMI provisions as a major weakness. Other weaknesses cited included problems in the administration of the GBMI provisions, a general irrelevancy or redundancy of the provisions, victimization and stigmatization of mentally disordered offenders, the curtailment of proper insanity defenses, and the overall unfairness, immorality, and unconstitutionality of the provisions.

IV. THE EFFECTS OF GBMI PROVISIONS

A. GBMI Findings To Date

The most easily recognizable effect of GBMI laws is the actual use of the GBMI plea and verdict. This obvious consequence should not be trivialized because attorneys, judges, and juries could have easily refused to use the GBMI option despite its provision in law. There is an important distinction between the lack of impact of a statutory reform because no one attempted to apply its provisions and because such attempts were made but failed.

Table 1, on the next page, represents the "best estimates" by survey respondents of the number of GBMI findings rendered since enactment of the GBMI laws in the twelve states; the figures for Georgia, Illinois, and Michigan represent official numbers of GBMI findings provided by the corrections officials in those states.

Like NGRI findings, GMBI findings are relatively rare.[9] Even in the four states with relatively large numbers of GBMI offenders, most jurisdictions have had little direct experience with the GBMI alternative. For example, of the 102 counties in Illinois, only 43 (42 percent) have had criminal defendants found GBMI; only three experienced

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9. For example, in Michigan from 1976 through 1983, an average of 26 defendants per 100,000 male arrests were acquitted by reason of insanity, compared to 16 defendants found GBMI. Blunt & Stock, Guilty But Mentally Ill: An Alternative Verdict, 3 Behavioral Science & the Law 49 (1985).

Table 1

Estimated Number of GBMI Findings from the
Effective Date of GBMI Legislation to May 1984

State	Effective Date	GBMI Findings	Findings Per Month
Alaska	October 1, 1982	15	0.75
Delaware	July 2, 1982	4	0.17
Georgia	July 1, 1982	172	7.48
Indiana	September 1, 1980	150	3.33
Illinois	September 17, 1981	133	4.09
Kentucky	March 26, 1982	35	1.35
Pennsylvania	December 15, 1982	15	0.86
Michigan	August 6, 1975	239	2.55
New Mexico	May 19, 1982	12	0.49
South Carolina	May 16, 1984	0	0.00
South Dakota	March 19, 1983	5	0.34
Utah	March 31, 1983	17	1.21
Total Findings		797	

more than five GBMI cases. Also, most (83 percent) of the GBMI findings occurred in urban counties.[10]

B. Characteristics of Defendants Found GBMI

Data derived from the case files of GBMI offenders in Georgia, Illinois, and Michigan reveal a demographic profile typical of the GBMI offender in the three states.[11] The typical incarcerated GBMI offender in these three states is a relatively young (i.e., under 32 years old), white male. Though age and gender did not vary among the states, 70 percent of GBMI offenders in Illinois were white as opposed to approximately 50 percent in Georgia and Michigan. Also, the typical GBMI offender has been convicted of serious crimes against persons (especially murder and sex crimes), as opposed to property crimes. There is an even chance that he was charged with more than one crime, and a greater chance that he has a history of previous contacts with the criminal justice system. More than likely (approximately a 75 percent chance), he also has had at least some prior contact with the mental health system, usually hospitalization in a state hospital. Once in the corrections

10. Part Three, "II.A. Descriptive Data," pp 3-20 to 3-62.

11. Part Three, "III.A.2. GBMI Offender Characteristics," pp.3-44 to 3-62.

system, there is approximately an 80 percent chance that he was diagnosed as having a recognizable and serious mental disorder, with a fifty percent chance of a diagnosis of psychotic or nonpsychotic disorder. The typical GBMI offender appears to be more similar to the typical NGRI acquittee on some variables and more like the guilty offender on others; on most he is somewhere between the two.

When survey respondents were asked what characteristics distinguish GBMI offenders, their answers did not present a clear composite picture. In agreement with the typical profile of a GBMI offender drawn from the case file records of GBMI offenders in Georgia, Illinois, and Michigan, however, a number of survey respondents associated GBMI offenders with serious, violent crimes against persons, as well as sex offenses, especially against minors. Other respondents stated that GBMI offenders tended to be convicted of drug-related crimes, shoplifting, and other offenses for which corrections treatment programs existed. Still others said that the GBMI label is applied to all types of offenders and offense categories.

C. Implementation of GBMI Provisions

Although the principal aim of GBMI legislation appears to have been to protect the public by incarcerating mentally disordered offenders who might otherwise be released following NGRI findings, proponents also intended that the GBMI plea and verdict to have some intermediate effects on trial procedures. For example, some suggested that the GBMI provisions would simplify the criminal proceedings in which mental aberration is an issue.

That at least some changes have occurred in the manner in which mentally disordered individuals are handled by the criminal justice system was confirmed by most of the survey respondents. A significant minority of respondents, however, denied that the GBMI laws had altered business as usual. Most survey respondents in Alaska and Indiana, for example, said that the GBMI alternative failed to change significantly the processing of mentally disordered offenders through the mental health-justice system. An Indiana attorney said that the GBMI alternative "offers no advantage, it is the same as a guilty plea or verdict." Whether such opinions are true assessments of practices and procedures or simply reflect dissatisfaction with the GBMI law is arguable. Given that the majority of survey respondents reported actual changes in practice, it is unlikely that existing practices were not altered somewhat as a result of the GBMI legislation. The most noticeable changes attributable to the availabilty of the GBMI alternative appear to be in the area of plea negotiation.

1. Plea Negotiation

Most of the GBMI findings in Georgia (86 percent), Illinois (58 percent), and in Michigan (51 percent) resulted from pleas as opposed to bench trials and jury verdicts. The same appears to be true in other states. According to survey respondents, the GBMI provisions have had a measurable impact on the plea process in cases involving mental aberration. Even in Alaska, where the GBMI statute does not provide

expressly for a plea of GBMI (as opposed to a court ruling or jury finding), or in Indiana, where policy discourages plea negotiation, the availability of the GBMI alternative increases the willingness of parties to enter into plea negotiation. Reportedly, this willingness seems to stem from several sources. First, whether it is illusory or not, the promise of treatment draws defense counsel to the GBMI plea in cases in which an insanity defense is unlikely to succeed. Some attorneys apparently believed that a GBMI plea increases the chances that a court will take notice of a defendant's mental disorder as a mitigating factor in sentencing. Another source of willingness to plea is the fear that a jury would be less likely to render an NGRI verdict because of the availability of the GBMI alternative.

2. Pretrial Mental Health Examination

Before acceptance of a plea or a finding of GBMI, a court may require that the defendant be evaluated by a psychiatrist, psychologist, or some other mental health practitioner. As noted earlier, the statutory prerequisites to the acceptance of a GBMI plea, the procedures for pretrial mental health examination, and prerequisite for a finding of GBMI vary from state to state. Nevertheless, all but three survey respondents who conducted pretrial mental health evaluations said that their methods and procedures for conducting and reporting mental health examinations were not affected by GBMI legislation.

3. Trial Procedures

With the possible exception of jury behavior and the text of jury instructions in GBMI cases, trial procedures appear largely unaffected by GBMI provisions. When asked whether the availability of the GBMI alternative had changed the involvement of mental health experts in criminal cases, 44 (75 percent) of the respondents felt it had not. Also, respondents generally reported no special criteria or factors that judges and juries use in making GBMI determinations other than those that would be expected based on the requirements of substantive law (e.g., the presence of mental illness not meeting the standard for insanity).

How has the availability of the new verdict affected jury trials? Do juries understand and make appropriate distinctions between the definitions of insanity and mental illness? Do juries generally understand the expert testimony presented at trial? Do juries understand the typical jury instructions provided to them? Do they understand the dispositional differences between an NGRI and a GBMI finding? Have the GBMI laws increased or decreased the number of jury trials in cases involving mental aberration? Great variability characterized the answers to these questions provided by judges, attorneys, and forensic mental health examiners. No clear consensus emerged.

Most respondents were unaware of jury trials involving GBMI findings. One point of agreement was that only a minority of GBMI findings result from jury verdicts. Only four of the approximately 56 GBMI findings in Alaska, Delaware, Pennsylvania, South Dakota, and Utah were thought to be jury verdicts. In New Mexico, survey respondents could not identify a single GBMI case that did not result from a plea.

This is consistent with case processing data from the states with considerably more GBMI cases. Only 9, 12, and 29 percent of the GBMI findings in Georgia, Illinois, and Michigan, respectively, were rendered by juries. This predominance of plea negotiation and bench trials is noteworthy because the GBMI verdict was created, in part, to simplify jury deliberations.

According to survey respondents, in the relatively few jury trials involving the GBMI alternative, jury behavior varied depending upon the quality of mental health expert testimony, the presentation of other evidence, and jury instructions. Survey respondents were of the opinion that jurors were no more confused and no more enlightened by the availability of the GBMI alternative. Trial procedures, when they take place, seemed to be largely unaffected by GBMI provisions.

D. Case Disposition

Undoubtedly, the societal values to be protected, the goals to be obtained, and the harm to be avoided by the adoption of GBMI laws reflect a much greater concern over what happens to a GBMI offender at the conclusion of the criminal proceedings than during them. Generally speaking, a sentencing judge may impose any sentence on a defendant found GBMI that could be imposed on a defendant found guilty, including probation and the death penalty. This egalitarian provision seems to have been translated into practice. Indeed, the data suggests that GBMI offenders may be receiving longer sentences than non-GBMI offenders.

In Georgia, the average sentence GBMI offenders received was 11.76 years, compared to an average of just over nine years for all offenders committed to the Department of Rehabilitation. In Michigan, GBMI offenders also received longer sentences than those imposed on defendants found guilty. Twenty-three percent of the GBMI offenders, as opposed to 36 percent of other Michigan inmates, received sentences between one and five years in length. On the other hand, 21 percent of the GBMI offenders received sentences of 16 years or more, in comparison with 12 percent of the non-GBMI prison population. This suggests that GBMI offenders, the vast majority of whom are convicted following pleas, are receiving longer sentences than those imposed on guilty offenders. The relationship between sentence length and verdict--with GBMI offenders receiving longer sentences than their guilty counterparts--remains even when offense and mental health histories are controlled.[12]

When asked whether the length or type of sentence imposed on GBMI offenders and guilty offenders differed in practice, 58 percent of the survey respondents stated that they did not. In contrast, 11 percent felt that GBMI offenders received lighter sentences. Only fifteen percent of the respondents were in agreement with the case processing results in Georgia and Michigan insofar as they said that GBMI offenders would receive stiffer sentences. Sixteen percent of the respondents stated that it was too early to know whether the actual sentences varied. Reflecting the views of the majority of the respondents, a Georgia prosecutor

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12. Part Three, "II.B. Comparisons Within States," pp.3-62 to 3-93.

contended that no compelling reasons existed to justify different sentences for GBMI and guilty offenders.[13]

A question which is perhaps closer to public concern than the comparative sentences imposed on GBMI and guilty offenders is whether defendants found GBMI are separated from society for longer periods than insanity acquittees. Since the GBMI law was instituted in Michigan, approximately 75 offenders convicted under the law have been released from prison before June 15, 1984. Their confinement averaged 3.99 years as compared to 1.43 years for insanity acquittees. This difference in confinement periods could not be generalized to Georgia and Illinois, however, because the GBMI laws are too recent in these two states to allow any meaningful comparisons. Survey respondents were split in their opinions about whether GBMI offenders or NGRI acquittees are confined for longer periods. Of the 42 respondents who addressed the issue, 57 percent said that GBMI offenders are imprisoned longer; 38 percent said that, all things being equal, NGRI acquittees are hospitalized longer. Five percent believed that confinement periods are roughly equal.

E. Treatment

Contrary to the views held by the public, jurors, and many members of the mental health-justice system, a GBMI finding does not guarantee treatment. As a matter of law and practice in all twelve states, a defendant found GBMI is likely to receive mental health care and treatment only if the need for treatment is indicated by a post-conviction mental health evaluation and, in some states, only if available mental health resources permit.

Official records in Georgia, Illinois, and Michigan indicate that at least 90 percent of the GBMI offenders actually received a post-conviction mental health evaluation. Roughly two-thirds (64 percent in Georgia; 65 percent in Illinois; and 72 percent in Michigan) of the offenders evaluated were recommended for some form of mental health treatment and care.[14] In most cases (80 percent), the departments of corrections provided treatment to convicts for whom such treatment was recommended. However, according to survey respondents with direct knowledge of available mental health services, GBMI offenders are no more likely to receive treatment than mentally disordered offenders in the general inmate population to whom the GBMI label is not applied.

V. CURTAILMENT OF THE INSANITY DEFENSE

The major purpose of GBMI legislation was to curtail the insanity defense.[15] Have GBMI provisions accomplished this purpose? In

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13. Part Two, "III.F.4.a. Sentencing," pp.2-35 to 2-38.

14. Part Three, "II.A.2. GBMI Case Processing Characteristics," pp. 3-22 to 3-44.

15. Part One, "II.A. Legislative Purposes," pp. 1-9 to 1-12; Part Two, "IV. State Profiles," pp. 2-59 to 2-342 (each of the eleven state profiles contains a section describing the historical context and purposes of the GBMI legislation).

Michigan, the raw frequency of NGRI findings was left undisturbed by the introduction of the alternative verdict. In Illinois, the number of insanity acquittals actually increased from 124 during a 33-month period before enactment of GBMI legislation, to 154 during a comparable period after the effective date of the legislation. Insanity acquittals in Georgia dropped from 95 in the 18 months before the effective date of the GBMI provision to 67 afterward, a 29 percent reduction. Looking only at the data from 1983, however, the first full year the GBMI alternative was available in Georgia, a total of 88 defendants were found GBMI while 42 defendants were acquitted by reason of insanity, two more than in 1982. In Alaska, where the GBMI provisions were enacted into law at the same time that the insanity standard was narrowed and the burden of proof was shifted from the prosecution to the defense, only one insanity defense has succeeded since the effective date of the legislation.

These data lead to the conclusion that GBMI legislation, in combination with other changes in the laws affecting mentally disordered offenders, has not resulted in a reduction of the frequency of insanity acquittals in two states (Illinois and Michigan), and that the slight decrease in insanity acquittals in the other state (Georgia) may or may not have had anything to do with the enactment of GBMI legislation.[16] A reasonable argument can be made that if GBMI legislation, in combination with other legislative measures aimed at reducing the success of insanity defenses (e.g., a narrowing of the standard of insanity), did not reduce the frequency of insanity acquittals, the enactment of GBMI legislation alone would not do so either.

By examining the characteristics of defendants found GBMI, NGRI, and guilty, it is possible to determine if the GBMI defendants are more similar to those found NGRI or guilty and thereby further test the conclusion that GBMI findings have not appreciably displaced NGRI findings. Notwithstanding the confounding factors discussed earlier, GBMI findings would be shown to have displaced NGRI findings (as intended by GBMI supporters) if (a) significant differences exist between the classes of defendants found GBMI and those found NGRI and (b) the GBMI provisions can be shown to have changed the composition of the NGRI class. In Georgia, where insanity acquittals dropped by almost a third after the enactment of the GBMI legislation, one would expect GBMI findings to have a displaced NGRI findings. On the other hand, in Illinois where acquittals rose, no such displacement would be expected. Analysis of these effects did little to disturb the conclusion that the GBMI provisions have minimal effects on the frequency of insanity acquittals, yet it does suggest that they may have had subtle effects on the composition of the class of insanity acquittals.

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16. It is important to note that the study employed "frequency of insanity acquittals" as an index of whether or not GBMI legislation curtailed insanity defenses. Unfortunately, no data on the frequency of insanity pleas before and after the enactment of GBMI legislation was collected.

In Illinois, the two groups of defendants found NGRI differed in post-trial mental health diagnoses and in lengths of confinement. The proportion of insanity acquittees diagnosed as suffering from psychosis decreased from 70 to 51 percent after the enactment of the GBMI law. The average length of confinement dropped from a little over two years to a little over six months.[17] In Georgia, where the decrease in insanity acquittals would be consistent with a displacement effect, the two groups were essentially the same.

Although the data generally support the conclusion that the GBMI provisions have failed to curb the frequency of insanity acquittals, that conclusion must be qualified. As noted earlier, in most states the enactments of GBMI legislation was accompanied by other changes in legislation, policy, and procedures that confounded the effects that GBMI provisions had on the insanity defense. Another qualification has less to do with the cogency of the conclusion that the GBMI provisions have done little to curb the insanity defense than with the measure used to test it. Given that the GBMI plea and verdict supplement rather than supplant the insanity defense as a matter of law, the underlying assumption is that some but not all criminal defendants should be found GBMI instead of NGRI. In other words, retention of the insanity defense, supplemented by the GBMI alternative, reflects the moral judgment that some defendants do not deserve criminal sanctions because of their mental aberration. Therefore, a true measure of the success of GBMI provisions is the elimination or substantial reduction of inappropriate insanity pleas and verdicts, i.e., cases in which defendants who deserve to be held criminally responsible for their actions are instead exculpated. Unfortunately, only in hindsight does agreement exist about what constitutes "appropriate" insanity acquittals. That is, an insanity determination may be deemed retrospectively inappropriate in cases in which an insanity acquittee commits a serious crime shortly after his or her release from a hospital. Even if the GBMI alternative is shown to curtail the insanity defense, the question remains whether it has such effects in appropriate cases.

VI. CONCLUSION

Approximately 800 defendants who raised claims of mental disorder in criminal proceedings have been found GBMI in the twelve states in which this alternative verdict is available. They tend to be relatively young, white males convicted of serious crimes against persons. Most are charged with multiple crimes and have a history of previous contacts with the criminal justice system and the mental health system. Eighty percent have a recognizable mental disorder and most are treated accordingly once in the corrections system.

Although inspired by similar circumstances--usually involving insanity acquittees perceived as threats to public safety--the GBMI laws of the

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17. This data may appear counterintuitive given the expectation that the GBMI verdict would displace insanity acquittals in cases involving non-psychotic defendants, thereby increasing the proportion of insanity acquittees with psychoses.

twelve state differ significantly in fundamental ways such as the standard for GBMI determinations, the type of cases in which they apply, and the procedures by which they are administered. It is clear that there is no single GBMI statute or concept. Nor is there a uniform perception of GBMI among those responsible for implementing it. A striking outcome of the survey of lawyers, judges, mental health and corrections officials, and others who deal with GBMI offenders, is the variety of responses within each state and the degree to which they reflect beliefs at odds with reality. The differences in the GBMI laws among the states and the varying perceptions of those laws underscore the importance of empirical data (and expedient mechanisms to collect such data) to inform policy makers about what professionals, the public, and special interest groups believe is occurring with the use of the GBMI provisions and to point out the discrepancies between beliefs and reality. States without GBMI laws should carefully consider variations in existing GBMI laws and their implications before attempting legislative reform.

Except for an increase in plea negotiations, the GBMI provisions have resulted in little change in the manner in which the criminal justice and the mental health systems handle mentally disordered defendants in criminal proceedings. Despite the hopes of its proponents and the fears of its critics, GBMI legislation has not spelled the demise of the insanity defense. Indeed, it appears not to have appreciably disturbed the frequency of NGRI findings. Although touted by proponents as an attractive alternative to the NGRI verdict for juries to consider, most GBMI findings (like NGRI findings) result from pleas and bench trials. And, contrary to views held by much of the public, jurors, and many members of the mental health and criminal justice systems, GBMI offenders are not guaranteed treatment by GBMI laws. GBMI offenders are no more likely to receive treatment than mentally offenders in the general inmate population to whom the GBMI label is not applied. Indeed, being found GBMI instead of guilty seems to offer few advantages to mentally disordered criminal defendants. They are given stiffer sentences than their guilty counterparts without any greater access to mental health treatment. GBMI offenders also appear to be imprisoned for longer periods of time than NGRI acquittees are involuntarily hospitalized. Clearly, lawyers for defendants should consider whether they might be misleading their clients by urging them to plead GBMI.

Guilt, insanity, and mental illness are not merely characterizations of behavior but expressions of society's attitudes toward criminal defendants and proposals for handling those so characterized. A constant tension exists in the criminal justice system between the need to control crime and society's unwillingness to impose condemnation and punishment when extenuating circumstances mitigate against imposing blame. The perception that we are as a society today more vulnerable to crime than in the past may have eroded public sympathy for mentally disordered persons who commit crimes. The GBMI alternative may be a sign of this change in public attitude. However, while such a change is clearly reflected in legislation and policy, it has yet to be translated into fundamental practical changes in the way mentally disordered defendants are handled by the criminal justice system.

PART ONE. CURRENT STATE OF THE KNOWLEDGE*

*Revised versions of this part have been published in two separate articles: McGraw, Farthing-Capowich & Keilitz, The "Guilty But Mentally Ill" Plea and Verdict: Current State of the Knowledge, 30 Villanova Law Review 117 (1985); McGraw & Keilitz, Guilty But Mentally Ill: A Legislative Response to the Insanity Defense, 8(3) State Court Journal 4 (1984). The review of the statutes in these articles includes South Carolina's GBMI statute, enacted in May 1984. South Carolina's legislation is not included in the review of current GBMI statutes in Part One. See note 11 infra.

I. INTRODUCTION

> Punishment deters not only sane men but also eccentric men, whose supposed involuntary acts are really produced by a diseased brain capable of being acted upon by external influence. A knowledge that they would be protected by an acquittal on the grounds of insanity will encourage these men to commit desperate acts, while on the other hand certainty that they will not escape punishment will terrify them into a peaceful attitude towards others.
>
> Queen Victoria, 1882[1]

The criminal law's efforts to place mentally disabled defendants in a separate category can be traced back centuries.[2] By the beginning of the nineteenth century, the criminal law of England treated the insane much as they are treated today in the United States -- a successful insanity defense resulted in acquittal and, usually, confinement in a mental hospital.[3]

Throughout its history, the insanity defense has faced opposition. One form of opposition has been the adoption of an alternative verdict, either to supplant or supplement the verdict of not guilty by reason of insanity, that would acknowledge a defendant's unsound mind at the time of the misconduct yet not absolve him or her of criminal responsibility. Queen Victoria's displeasure with the acquittal by reason of insanity of notorious defendants like James Hadfield, who in

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1. Letter from Queen Victoria to Prime Minister Gladstone (April 23, 1882), cited in, N. Walker, Crime and Insanity in England 189 (1968).

2. See D.H.J. Hermann, The Insanity Defense: Philosophical, Historical, and Legal Perspectives (1983); N. Walker, supra note 1.

3. See Criminal Lunatics Act, 40 Geo. 3, ch. 94 (1800).

1800 attempted to murder King George III,[4] Daniel M'Naghten, who in 1843 attempted to assassinate the British Prime Minister Sir Robert Peel,[5] and Roderick Maclean, who in 1882 attempted to kill Queen Victoria herself,[6] led to passage of the Trial of Lunatics Act in 1883.[7] This Act supplanted the verdict of not guilty by reason of insanity with that of "guilty but insane."[8]

Almost a hundred years passed before any jurisdiction in the United States adopted an alternative verdict. In 1975, in response to extreme public outcry over the release of approximately 150 insanity acquittees following the Michigan Supreme Court's decision in People v. McQuillan,[9] Michigan became the first state to enact a "guilty but

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4. Hadfield's Case, 27 Howell 1281, 27 St. Tr. 1281 (1800).

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

6. See S. L. Golding & C. Roberts, The Interface of Ethical and Clinical Decision-Making: An Historical and Empirical Analysis of the Attribution of Criminal Respnsibility 7-8 (1984) (Department of Psychology, University of Illinois, Champaign, Illinois); Robey, Guilty But Mentally Ill, 6 Bull. Am. Acad. Psych. & L. 374, 377 (1978).

7. Trial of Lunatics Act, 46 & 47 Vict., ch. 38 (1883) (repealed by Criminal Procedure (Insanity) Act (1964)).

8. Under the Trial of Lunatics Act, a person determined to be "insane, so as not to be responsible, according to the law, for his actions at the time when the act was done" would be found "guilty of the act or omission charged against him, but ... insane ... at the time when he did the act or made the omission." Id. at ch. 38 4(2). A person receiving this special verdict was to be "kept in custody as a criminal lunatic" in accordance with the same "rules or orders ... having reference to a person or persons acquitted on the ground of insanity." Id. at ch. 38 2(2) & (4). Because a guilty but insane finding had the same dispositional consequences as a not guilty by reason of insanity verdict (i.e., acquittal), see id. at ch. 38 2(4), whether the Trial of Lunatics Act of 1883 was any more than a change in semantics is arguable. See Felstead v. Rex, 1914 A.C. 534 (guilty but insane verdict is an acquittal, not a conviction).

9. 392 Mich. 511, 221 N.W. 2d 569 (1974). See infra notes 25-29 and accompanying text.

mentally ill" (GBMI) statute.[10] This enactment has served as a prototype for other states. By 1984, eleven states[11] had followed Michigan's lead by adopting the GBMI verdict to be considered alongside the traditional verdicts of guilty, not guilty, and not guilty by reason of insanity (NGRI). At least eleven other states have considered or are considering adopting similar legislation.[12] In 1982, numerous bills that included some version of a GBMI verdict were introduced in the United States Congress.[13] Its ready acceptance by twelve states,

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10. 1975 Mich. Pub. Acts 180. For an account of the GBMI verdict's development in Michigan, see Smith & Hall, Evaluating Michigan's Guilty but Mentally Ill Verdict: An Empirical Study, 16 U. Mich. J. L. Ref. 77, 80-85 (1982).

11. Alaska Stat. §12.47.040 (Cum. Supp. 1983); Del. Code Ann. tit. 11, §408 (Cum. Supp. 1982); Ga. Code Ann. §17-7-131 (Cum. Supp. 1983); Ill. Ann. Stat. ch. 38, §115-2(b) (Smith-Hurd 1983); Ind. Code Ann. §35-35-2-1 (Burns Cum. Supp. 1982); Ky. Rev. Stat. §504.120 (Cum. Supp. 1982); N.M. Stat. Ann. §31-9-3 (Cum. Supp. 1983); 18 Pa. Cons. Stat. Ann. §314 (Purdon 1983); S.D. Codified Laws Ann. §23A-7-2 (Pocket Supp. 1983), and Utah Code Ann. §77-13-1 (Pocket Supp. 1983). South Carolina adopted GBMI legislation, Ratification 458, on May 16, 1984.

12. See, e.g., S. B. 323, 7th Leg. 2d Reg. Sess. (1982, Florida) (defeated in committee); H.B. 710, 7th. Leg. 2d Reg. Sess. (1982, Florida) (defeated in committee); S.B. 2073-80, 10th. Reg. Sess. (1980, Hawaii) (passed House, defeated in committee); H.F. 24, 70th Gen. Assem. Reg. Sess. (1983, Iowa) (legislation withdrawn); S.B. 806, Reg. Sess. (1978, Maryland); S.B. 11765, 203rd. Sess. (1980, New York); S.B. 4013, 202nd. Sess. (1979, New York); S.B. 7185, 201st. Sess. (1978, New York); H.B. 9705, 201st. Sess. (1978, New York); S.B. 148, 114th Gen. Assem. Reg. Sess. (1982, Ohio) (defeated in committee); S.B. 297, 113 Gen. Assem. Reg. Sess. (1979, Ohio); S.B. 169, Reg. Sess. (1979, New Hampshire) (referred to study in the Senate); H.B. 234, 57th Biennial Sess. (1983, Vermont) (defeated in committee); H.B. 398, Reg. Sess. (1982, Virginia) (defeated in committee); S.B. 107, 66th Reg. Sess. (West Virginia, 1983) (amended by committee, reported to Senate, rejected at third reading).

13. S.2672, H.R.5395, 6653, 6702, 6709, 6716, 6717, 6718, 6726, 6742, 6947, 6949, 97th Cong., 2d Sess. (1982). See also infra note 33.

within the short span of eight years, has made the GBMI verdict the most popular solution to perceived defects of the traditional insanity defense.[14]

Unlike an NGRI or a "guilty but insane" verdict, which holds the defendant blameless,[15] a GBMI verdict holds the defendant criminally responsible for the offense and allows imposition of the same sentence that could be given a defendant found guilty of the same offense, yet promises mental health evaluation or treatment during the term of the sentence. Prompted by highly publicized cases, usually involving acquittals by reason of insanity of defendants perceived to be threats to public safety, legislators hoped that the GBMI verdict would offer juries an attractive alternative to the NGRI verdict and, thereby, undercut the use of the insanity plea and verdict and prevent the early release of dangerous insanity acquittees.[16]

Despite its rapid adoption in twelve states, the GBMI verdict has been criticized roundly by scholars and professionals as conceptually flawed and procedurally problematic. Several professional organizations

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14. A few states have adopted laws reminiscent of the Trial of Lunatics Act of 1883. Maryland has judicially developed a "guilty but insane" verdict. See infra note 45-52 and accompanying text. Oregon now has a "guilty except for insanity" verdict. See H.B. 2075, 62nd Or. Legis. Assem., Reg. Sess. (1983). Connecticut enacted and later repealed a "guilty but not criminally responsible" verdict. See Conn. Gen. Stat. §53a-13 (Cum. Supp. 1983) (repealed 1983). All these verdicts have the same dispositional consequences as an NGRI verdict.

15 See supra notes 8 & 14.

16. See infra notes 24-33 and accompanying text.

have taken positions opposing the verdict.[17] The American Bar Association, for example, has adopted as official policy the standard recommended by its Standing Committee on Association Standards for Criminal Justice: that "[s]tatutes which supplant or supplement the verdict of not guilty by reason of insanity with a verdict of guilty but mentally ill should not be enacted."[18] The commentary accompanying this standard concludes:

> The "guilty but mentally ill" verdict offers no help in the difficult question of assessing a defendant's criminal responsibility. This determination in insanity cases is essentially a moral judgment. If in fact the defendant is so mentally diseased or defective as to be not criminally responsible for the offending act, it would be morally obtuse to assign criminal liability. The "guilty but mentally ill" verdict also lacks utility in the forward-looking determination regarding disposition. Guilty defendants should be found guilty. Disposition questions, including questions concerning the appropriate form of correctional treatment, should be handled by the sentencing tribunal and by correctional authorities. Enlightened societal self-interest suggests that all felony convicts should receive professional mental health and mental retardation screening and that, whenever indicated those convicts should receive mental health therapy. Identifying convicts in need of such treatment or habilitation and following up that identification process with actual treatment has nothing to do with the form of verdict.[19]

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17. See American Bar Association Standing Committee on Association Standards for Criminal Justice, First Tentative Draft, Criminal Justice Mental Health Standards 295-297 (1983) (Standard 7-6.10(b)); American Psychiatric Association, Statement on the Insanity Defense, (1982); Text of Position on Insanity Defense, 15 APA Monitor 11 (1984); and National Mental Health Association, Myths & Realities: A Report of the National Commission on the Insanity Defense 32-34 (1983).

18. This standard reflects the policy enacted by the ABA's House of Delegates on February 9, 1983. See American Bar Association Standing Committee on Association Standards, supra note 17.

19. American Bar Association Standing Committee on Association Standards, supra note 17 at 297.

Except for a recently completed study of Michigan's GBMI verdict,[20] no empirical data on the operation and practical consequences of the GBMI plea and verdict have been reported. Indeed, beyond law reviews commenting on the statutory provisions of a few states,[21] no comprehensive picture of the GBMI plea and verdict as currently used by the states that have adopted it has been presented.

The purpose of this article is to present a comprehensive description of the current state of the knowledge about the GBMI plea and verdict. Three sources of knowledge will be explored: statutory law, case law, and social science research. The first section of this article describes the relevant substantive standards, definitions, and procedural mechanics of the GBMI plea and verdict prescribed by the statutes of the states that have enacted GBMI legislation. The accompanying tables present the various GBMI laws, allow a comparison of provisions for the plea and verdict across jurisdictions, and provide guidance for those legislatures considering adoption of GBMI statutes or modification of existing GBMI provisions. The second section briefly traces the judicial development of the GBMI laws as expressed in appellate court rulings. Finally, as a prelude to more systematic study of the uses and consequences of the GBMI plea and verdict envisioned by a number

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20. Smith & Hall, supra note 10.

21. Because Michigan has had the longest experience with the GBMI verdict, its statutes have been the subject of the most extensive legal analyses. See e.g., Brown & Wittner, 1978 Annual Survey of Michigan Law: Criminal Law, 25 Wayne L. Rev. 335 (1979); Corrigan & Grano, 1976 Annual Survey of Michigan Law: Criminal Law, 23 Wayne L. Rev. 473 (1977); Hoek, 1980 Annual Survey of Michigan Law: Criminal Law, 27 Wayne L. Rev. 657 (1981); Sherman, Guilty But Mentally Ill: A Retreat from the Insanity Defense, 8 Am. J. L. & Med. 237 (1981); Comment, Guilty But Mentally Ill: An Historical and Constitutional Analysis, 53 Det. J. Urb. L. 471 (1976); Comment, Insanity--Guilty But Mentally Ill--Diminished

of professional groups,[22] the third section reviews the current state of empirically-based research in this area and discusses the salient issues surrounding the operation of the GBMI plea and verdict that warrant more extensive study.

II. LEGISLATIVE DEVELOPMENTS

A. Legislative Purposes

The GBMI concept made its debut in the United States in 1975 when Michigan enacted its GBMI statute.[23] The primary purposes of the legislation were to curtail the assertion of the insanity defense, to reduce the incidence of insanity acquittals, and to protect society by incarcerating mentally disturbed, dangerous defendants who might

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Capacity: An Aggregate Approach to Madness, 12 J. Mar. J. Prac. & Proc. 351 (1979); Comment, The Constitutionality of Michigan's Guilty But Mentally Ill Verdict, 12 U. Mich. J. L. Ref. 188 (1978); Note, Guilty But Mentally Ill: A Critical Analysis, 14 Rutgers L. Rev. 453 (1983).

Reviews of GBMI provisions in other states, however, have begun to appear in law reviews. See e.g., Northrup, Guilty But Mentally Ill: Broadening the Scope of Criminal Responsibility, 44 Ohio St. L. Rev. 797 (1983). Stelzner & Piatt, The Guilty But Mentally Ill Verdict and Plea in New Mexico, 13 N. M. L. Rev. 99 (1983); Watkins, Guilty But Mentally Ill: A Reasonable Compromise for Pennsylvania, 85 Dick. L. Rev. 289 (1980-81); Comment, Indiana's Guilty But Mentally Ill Statute: Blueprint to Beguile the Jury, 57 Ind. L. J. 639 (1982).

22. The American Psychological Association's Committee on Legal Issues, for example, adopted the recommendation that the APA "reserve judgment about the use of the verdicts of guilty but mentally ill to supplement the verdict of not guilty by reason of insanity until such time as empirical research on effects of this supplementary verdict form is available." See More on Insanity Reform, Division of Psychology and Law Newsletter, Summer 1983, at 6, Col. 2; see also National Mental Health Association, supra note 17, at 44; I. Keilitz & J. P. Fulton, The Insanity Defense and Its Alternatives: A Guide for Policymakers 46 (1984).

23. 1975 Mich. Pub. Acts 180, §1; Mich. Comp. Laws §768.36 (1982).

otherwise be found NGRI and released shortly thereafter.[24] In People v. McQuillan,[25] the Michigan Supreme Court struck down the state's automatic commitment statute because it provided stricter standards and procedures for insanity acquittees than for persons civilly committed as dangerous and mentally ill. The court ordered that the approximately 270 insanity acquittees[26] previously committed automatically and still hospitalized at that time be provided judicial hearings to ensure that they met the civil commitment standards (i.e., present mental illness, dangerousness, or inability to meet basic needs).[27] Many of the patients were subsequently released because they failed to meet the criteria for involuntary civil commitment.[28] Shortly after their release, two former patients committed violent crimes: one raped two women and the other murdered his wife. The resulting public outcry spurred the Michigan legislature to adopt the GBMI plea and verdict.[29]

In 1981, largely in response to a highly publicized case in which the defendant raised the insanity defense after committing a violent offense,[30] Indiana became the second state to enact GBMI

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24. See Smith & Hall, supra note 10, at 83-85.

25. 392 Mich. 511, 221 N.W. 2d 569 (1974).

26. Smith & Hall, supra note 10, at 82.

27. Supra note 25 at 586.

28. Smith & Hall, supra note 10, at 82-83.

29. Id. See also Comment, Guilty But Mentally Ill: An Historical and Constitutional Analysis, 53 Det. J. Urb. L. 471, 482-483 (1976).

30. State v. Judy, Ind. , 416 N.E. 2d 95 (1981). See Comment, Indiana's Guilty But Mentally Ill Statute: Blueprint to Beguile the Jury, 57 Ind. L.J. 639, 639 (1982).

legislation.[31] Similarly, the trial and acquittal of John W. Hinckley, Jr., in the shooting of President Ronald Reagan,[32] apparently influenced many federal and state legislators to introduce GBMI legislation.[33]

Related to the legislative intent to close the perceived loophole whereby responsible defendants escape punishment for their misconduct is the intent to offer juries a compromise verdict permitting condemnation of a defendant's actions yet acknowledgment of his or her need for mental health treatment.[34] The Michigan Court of Appeals has stated that the GBMI verdict was enacted as an "in-between classification."[35] Jurors reaching this verdict could feel satisfied that the public was protected and that the defendant would be provided treatment. Jurors have reportedly felt constrained by the limited choice between acquittal on the grounds of insanity and a finding of

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31. 1981 Ind. Acts, P.L. 298, §4. Ind. Code Ann. §35-35-2-1 (Burns Cum. Supp. 1982).

32. United States v. Hinckley, Crim. No. 81-306 (D.C. Cir. 1982).

33. See Note, supra note 21 at 453 n.3 ("The dissatisfaction with the Hinckley verdict created an atmosphere that was ripe for adoption of alternatives to the insanity defense. The day after the Hinckley verdict, the Delaware legislature passed a bill adopting the GBMI verdict."); see also Limiting the Insanity Defense: Hearings Before the Subcomm. on Criminal Law of the Comm. on the Judiciary, 97th Cong., 2d Sess., on S.818, S.1106, S.1558, S.1995, S.2658, and S.2669, June 24, 30, and July 14, 1982 (hereafter cited as Subcommittee Hearings); and The Insanity Defense: Hearings Before the Comm. on the Judiciary, 97th Cong., 2d Sess., on S.818, S.1106, S.1558, S.2669, S.2672, S.2678, S.2745, and S.2780, July 19, 28, and August 2 and 4, 1982 (hereafter cited as Committee Hearings).

34. See Comment, supra note 30 at 645-646.

35. People v. Jackson, 80 Mich. App. 244, 246, 263 N.W. 2d 44 (1977).

guilty.[36] For example, when questioned after their decision following John Hinckley's trial, several jurors stated they would have preferred to reach a GBMI verdict had that option been available to them.[37]

The treatment and punishment goals of the GBMI verdict have been seriously questioned on both conceptual and practical grounds.

> [The GBMI] verdict does not ensure in any way that persons found guilty under it, as opposed to persons found simply guilty, will be treated any differently when the trial is over. If persons convicted under either statute are treated the same way in terms of disposition, we have developed different verdicts without any distinction. This may further mislead juries into believing that a 'guilty but mentally ill' verdict will somehow insure treatment and at the same time protect the community.[38]

B. Current GBMI Statutes

Tables 1, 2, and 3 present the GBMI provisions of eleven state statutes in effect at this writing.[39] They reveal basic similarities as well as critical differences among the versions of the GBMI plea and

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36. See R. Simon, The Jury and the Defense of Insanity 144-45; see also infra notes 283-304 and accompanying text.

37. Subcommittee Hearings, supra note 33 at 155-170.

38. National Mental Health Association, supra note 17, at 34. See also Comment, supra note 29 at 645-46 ("[The GBMI verdict] implies a false promise to the jury that a guilty but mentally ill defendant will be punished for his crime and at the same time compassionately treated for his mental illness, thereby satisfying competing social policies of the criminal law -- responsibility and treatment. However, such a ruling in actuality guarantees no such treatment for defendants convicted under it. A 'guilty but mentally ill' offender is simply a 'guilty' offender for purposes of disposition upon conviction."); see also supra notes 17-19, and accompanying text.

39. In constructing the tables, the most current versions of the relevant statutes available to the authors were used. The tables give statutory citations by section number only, without identifying the statutory compilations or indicating the year of the volume, replacement volume, supplement, or legislative service. The citations refer to the

verdict adopted by the eleven states. For the sake of clarity and brevity, many of the entries in the tables have been abridged or paraphrased. Special care has been taken, however, either to duplicate the wording of a particular statutory passage or to paraphrase its meaning concisely, especially if shades of meaning may be particularly important, as in the statutory standards or definitions presented in Table 1.

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following compilations, which are current through the volume indicated: Alaska Statutes -- 1983 Advance Legislative Service, II; Delaware Code Annotated -- 1982 Cumulative Supplement; Georgia Code Annotated -- 1983 Cumulative Supplement; Illinois Annotated Statutes (Smith-Hurd) -- 1983-1984 Cumulative Supplement; Indiana Code Annotated (Burns) -- 1982 Cumulative Supplement; Kentucky Revised Statutes -- 1982 Cumulative Supplement; Michigan Compiled Laws Annotated -- 1982 Replacement Volume; New Mexico Statutes Annotated -- 1983 Cumulative Supplement; Pennsylvania Consolidated Statutes Annotated (Purdon) -- 1983 Advance Legislative Service, III; South Dakota Codified Law Annotated -- 1983 Pocket Supplement; and Utah Code Annotated -- 1983 Pocket Supplement. The South Carolina provisions are not included in the tables. South Carolina enacted its GBMI statute after this Article went to press. See supra note 11.

TABLE 1
GUILTY BUT MENTALLY ILL AND NOT GUILTY BY REASON OF INSANITY
STATUTORY STANDARDS AND DEFINITIONS

STATE	GBMI[1] Standard	Mental Illness[2] Defined	NGRI[3] Standard	Insanity[4] Defined
ALASKA	†As a result of mental disease or defect, lacked substantial capacity either to appreciate wrongfulness of the conduct or to conform conduct to the requirements of law. § 12.47.030.	†A disorder of thought or mood that substantially impairs judgment, behavior, capacity to recognize reality, or ability to cope with ordinary demands of life; includes mental retardation. § 12.47.130(3).	†Unable, as a result of mental disease or defect, to appreciate the nature and quality of the criminal conduct. § 12.47.010(a).	Same as "Mental Illness Defined."
DELAWARE	Psychiatric disorder substantially disturbed thinking, feeling or behavior and/or left person with insufficient willpower to choose whether to do act. § 401(b).	No	As a result of mental illness or mental defect, lacked substantial capacity to appreciate the wrongfulness of conduct. § 401(a).	No
GEORGIA	None	†A disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with ordinary demands of life; includes mental retardation. § 17-7-131(a)(2). See § 17-7-131(c)(2).	Did not have mental capacity to distinguish between right and wrong in relation to the act, omission, or negligence. § 16-3-2. Because of mental disease, injury, or congenital deficiency, acted as did because of a delusional compulsion as to the act which overmastered will to resist committing the crime. § 16-3-3.	†Meeting the criteria of § 16-3-2 or § 16-3-3 (see "NGRI Standard"). § 17-7-131(a)(1).
ILLINOIS	Not insane but suffering from a mental illness. § 6-2(c).	A substantial disorder of thought, mood, or behavior which impairs judgment, but not to extent unable to appreciate wrongfulness of behavior or conform conduct to the requirements of law. § 6-2(d).	†As a result of mental disease or mental defect, lacked substantial capacity either to appreciate the criminality of conduct or to conform conduct to the requirements of law. § 6-2(a).	Lacks substantial capacity either to appreciate the criminality of conduct or to conform conduct to the requirements of law as a result of mental disorder or mental defect. § 1005-1-11.
INDIANA	None	A psychiatric disorder which substantially disturbs thinking, feeling, or behavior and impairs ability to function; includes mental retardation. § 35-36-1-1.	†As a result of mental disease or defect, lacked substantial capacity either to appreciate the wrongfulness of the conduct or to conform conduct to the requirements of law. § 35-41-3-6.	The defense set out in § 35-41-3-6 (see "NGRI Standard"). § 35-36-1-1.
KENTUCKY	None	Substantially impaired capacity to use self-control, judgment, or discretion in conducting one's affairs and social relations, associated with maladaptive behavior or recognized emotional symptoms where condition can be related to physiological, psychological, or social factors. § 504.060.	†As a result of mental disease or defect, lacked substantial capacity either to appreciate the criminality of the conduct or to conform conduct to the requirements of law. § 504.020(1).	As a result of mental condition, lacks substantial capacity either to appreciate the criminality of conduct or to conform conduct to the requirements of law. § 504.060(4).
MICHIGAN	None	>A substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life. § 330.1400a.	†As a result of mental illness or mental retardation, lacked substantial capacity either to appreciate the wrongfulness of the conduct or to conform conduct to the requirements of law. § 768.21a(1).	Same as "Mental Illness Defined". See § 768.21a(1). Also, "mental retardation" means significantly subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior. § 330.1500(g). See § 768.21a(1).
NEW MEXICO	None	A substantial disorder of thought, mood, or behavior which impaired judgment, but not to extent that defendant did not know what he was doing or understand the consequences of his act or did not know that his act was wrong or could not prevent himself from committing the act. § 31-9-3A.	None	No
PENNSYLVANIA	None	As a result of mental disease or defect, lacks substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of the law. § 314(c)(1).	M'Naghten rule applies. Did not repeal or otherwise abrogate the common law defense of insanity. § 314(d).	Laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act or, if he did know it, he did not know he was doing what was wrong. § 314(c)(2).
SOUTH DAKOTA	None	A substantial psychiatric disorder of thought, mood or behavior which affects a person at the time of the offense and which impairs a person's judgment, but not to the extent that he is incapable of knowing the wrongfulness of his act. § 22-1-2(22).	Insane at the time of the act charged. § 22-3-1(3).	The condition of a person temporarily or partially deprived of reason, upon proof that at the time of committing the act charged, he was incapable of knowing its wrongfulness. § 22-1-2(18A).
UTAH	None	A psychiatric disorder as defined by the current Diagnostic and Statistical Manual of Mental Disorders which substantially impairs mental, emotional, behavioral, or related functioning. § 64-7-28(1).	As a result of mental illness, lacked the mental state required as an element of the offense charged. § 76-2-305(1).	"Mental illness" means a mental disease or defect. Mental defect may be a congenital condition or one the result of injury or a residual effect of a physical or mental disease. § 76-2-305(3).

†Table entry, or portion thereof, represents the general import of the provision, although details are excluded.
>Table entry arguably applies to GBMI defendants, although the provision does not expressly apply.
[1]GBMI (Guilty but Mentally Ill) includes "Guilty but Mentally Ill at the Time of the Crime," "Guilty and Mentally Ill," and "Not Guilty of the Crime Charged but Guilty of a Lesser Included Offense and Mentally Ill," as applicable.
[2]Includes "mentally ill," "mental disease or defect," and "psychiatric disorder," when such terms are used in GBMI context.
[3]NGRI (Not Guilty by Reason of Insanity). If no statutory standard exists, one may have been established by case law.
[4]Includes "mental disease or defect," "mental capacity," "delusional compulsion," and similar terms, when such terms are used in NGRI context. If no statutory definition exists, one may have been established by case law.

TABLE 2
GUILTY BUT MENTALLY ILL PROCEDURES
FROM PLEADING TO FINDING

STATE	Plea Available	Prerequisites to Acceptance of Plea[1]	Plea Agreements	Finding[2] Available
ALASKA	No	Not applicable.	Not applicable.	Yes[3] § 12.47.040(a).
DELAWARE	Yes § 408(a).	Trier of fact must examine all appropriate reports (including the presentence investigation), hold a hearing on mental illness issue, and be satisfied defendant was mentally ill at time of offense. If trier is not so satisfied, plea is stricken or withdrawn and defendant has right to trial by jury or new judge. § 408(a).		Yes § 408(a).
GEORGIA	Only in felony cases. See § 17-7-131 (b), (g).	Not specified.		Only in felony cases. § 17-7-131(b).
ILLINOIS	Yes § 115-2(b).	Defendant must be examined by clinical psychologist or psychiatrist and waive right to trial; judge must review examination report(s), hold hearing on mental health issue, and be satisfied there is a factual basis for the plea. § 115-2(b).		Yes § 115-3(c).
INDIANA	Yes § 35-35-2-1.	In every case, court must address defendant and determine that plea is voluntary and must be satisfied there is a factual basis for plea. § 35-35-1-3. †In felony case, court must address defendant to determine if he understands nature of charge, inform him regarding waiver of certain rights and duration of sentence, and determine if prosecutor and defendant have executed recommendation. In misdemeanor case, defendant may waive rights without first being addressed. § 35-35-1-2. If unrepresented by counsel, defendant must have freely and knowingly waived right to counsel. § 35-35-1-1. †Subject to conditions, defendant may withdraw plea. § 35-35-1-4.		Yes § 35-36-2-3.
KENTUCKY	Yes § 504.130(2).	Defendant must waive right to trial and court must find that defendant was mentally ill at time of the crime. § 504.130(2).		Yes § 504.120.
MICHIGAN	Only in felony cases. See § 768.36(2) and § 768.20a(1).	Defendant must assert insanity defense and waive right to trial. Prosecutor must approve of acceptance of plea. Judge must, with defendant's consent, examine report(s) of center for forensic psychiatry or other qualified personnel regarding whether defendant was insane, mentally ill, or mentally retarded at time of offense; hold hearing on issue of defendant's mental illness; and be satisfied that defendant was mentally ill. § 768.36(2).		Only in felony cases. See § 768.36(1) and § 768.20a(1).
NEW MEXICO	Yes § 31-9-3B; Crim. P. R. 21(c).	Clinical psychologist or psychiatrist must examine defendant. Court must review examination reports, hold a hearing on issue of defendant's mental condition, and be satisfied there is a factual basis that defendant was mentally ill at time of offense. § 31-9-3C. †Court must address defendant in open court to inform him and determine his understanding of nature of charge, duration of sentence, pleading rights, and waiver of right to trial, and to determine that the plea is voluntary. Crim. P. R. 21(e), (f), (h). Verbatim record of proceedings required. Crim. P. R. 21(f).	†Prosecutor and defense attorney or pro se defendant may discuss reaching an agreement that, upon the entering of a GBMI plea to a charged offense or a lesser or related offense, prosecutor will move for dismissal of other charges, recommend or not oppose particular sentence, or both. Court may accept or reject agreement. Crim. P. R. 21(g).	Yes § 31-9-3B.
PENNSYLVANIA	Yes § 314(b).	Defendant must waive right to trial. Judge must examine all reports prepared pursuant to the Rules of Criminal Procedure, hold hearing on mental illness issue, and be satisfied defendant was mentally ill at time of offense. If judge refuses to accept plea, defendant may withdraw plea and has right to trial by jury or new judge. § 314(b).		Yes § 314(a).
SOUTH DAKOTA	Yes § 23A-7-2.	If defendant intends to introduce expert testimony relating to mental illness, he shall notify prosecutor not less than 30 days before trial, or at a later time if court directs, and file copy with clerk. § 23A-10-3. If defendant fails to give notice, court shall exclude the testimony. § 23A-10-5. In felony case, licensed psychiatrist must examine defendant, court must examine psychiatric reports and hold hearing on defendant's mental condition; if there is a factual basis, court can conclude defendant was mentally ill at time of offense. †*Court must address defendant in open court to inform him and determine his understanding of nature of charge, duration of sentence and certain due process rights, and to determine that the plea is voluntary. In misdemeanor case, defense attorney may enter plea and court may impose sentence immediately. §§ 23A-7-4, 23A-7-5. See § 23A-7-16.	*Court must inquire whether defendant's plea results from prior discussions between prosecutor and defendant or his attorney. § 23A-7-5. See § 23A-7-16.	Yes § 23A-26-14.
UTAH	Yes §§ 77-13-1, 77-35-11.	†Court may order defendant evaluated at Utah state hospital or other suitable facility. Court must: hold hearing within a reasonable time on mental illness claim; find that plea is voluntary, that defendant knowingly waives certain due process rights, and that defendant knows duration of sentence; advise defendant that a GBMI plea is not a contingent plea and that if defendant is found to not be mentally ill, a guilty plea otherwise lawfully made, remains a valid plea; and conclude that defendant is currently mentally ill. § 77-35-21.5(1). See § 77-35-11(e).	Court must make finding regarding whether plea is a result of a prior plea discussion and agreement and, if so, what agreement was reached. § 77-35-11(e)(6). See § 77-35-21.5(1).	Yes[4] § 77-35-21(a).

†Table entry, or portion thereof, represents the general import of the provision, although details are excluded.
*Although entry reflects a special GBMI provision (i.e., one that expressly applies to GBMI defendants), the provision is vague.
[1]Includes procedures for withdrawal of plea, if withdrawal is permitted by statute.
[2]Includes judgment of court, in absence of GBMI plea, and verdict of jury.
[3]Alaska also permits a post-conviction finding of GBMI. If insanity defense was not raised and evidence of mental illness was not admitted, following conviction, defendant, prosecutor, or court may raise GBMI issue. At a hearing it must be shown by a preponderance of the evidence that defendant is GBMI. § 12.47.060.
[4]Includes "Not Guilty of Crime Charged but Guilty of a Lesser Included Offense and Mentally Ill" finding.

TABLE 2 (CONTINUED)

STATE	Prerequisites To Finding	Burden of Proof Regarding Mental Illness[5]	Jury Instructions	Mental Examinations[6]
ALASKA	Assertion of insanity defense or admissibility of evidence of mental disease or defect. § 12.47.040(a). If NGRI verdict is reached as to charged offense because of reasonable doubt regarding culpable mental state that is an element of the crime, defendant is automatically GBMI of lessar included offense. § 12.47.020(c).	Preponderance of the evidence. § 12.47.040(b).	When court instructs jury regarding possible verdicts, it shall also instruct regarding dispositions available upon a GBMI or NGRI verdict. § 12-47.040(c).	†Court must appoint two qualified psychiatrists or two certified, forensic psychologists to examine defendant and report on his mental condition. Court may order defendant committed to a secure facility for examination up to 60 days or longer if necessary. § 12.47.070.
DELAWARE	Trier of fact must examine all appropriate reports (including the presentence investigation), hold a hearing on mental illness issue, and be satisfied defendant was mentally ill at time of offense. § 408(a).	Not specified.	At the conclusion of trial, where warranted by the evidence, charge to the jury should include instructions regarding the GBMI verdict. § 3905.	*Trier of fact must examine all appropriate reports, including the presentence investigation. § 408(a).
GEORGIA	Defendant must assert insanity defense. § 17-7-131(b). Trier of fact must find that defendant is guilty of crime charged and was mentally ill or mentally retarded at time of crime. § 17-7-131(c)(2).	Beyond a reasonable doubt. § 17-7-131(c)(2).	If defendant contends he was insane or otherwise mentally incompetent at time of crime, judge must instruct jury that they may consider NGRI and GBMI verdicts. § 17-7-131(c).	
ILLINOIS	Defendant must assert insanity defense. § 115-3(c). Court must find that defendant is guilty of offense charged, was mentally ill at time of offense, and was not legally insane at the time. § 115-3(c).	Beyond a reasonable doubt. § 115-3(c).	When defendant has asserted insanity defense, the court, when warranted by the evidence, shall provide jury with a special GBMI verdict form as to each offense charged and shall separately instruct the jury that a GBMI verdict may be returned instead of a general verdict, but that such a verdict requires finding beyond a reasonable doubt that defendant committed the acts charged, was not legally insane at the time, but was mentally ill. § 115-4(j).	†Before or during trial a GBMI plea may be accepted if defendant has undergone an examination by a clinical psychologist or psychiatrist. § 115-2(b). †*In certain circumstances, court shall, on motion of the state, order defendant to submit to examination. § 115-6.
INDIANA	Defendant must assert insanity defense. § 35-36-2-3.	Not specified.		†When notice of an insanity defense is filed, court must appoint 2 or 3 competent, disinterested psychiatrists to examine defendant and to testify. § 35-36-2-2.
KENTUCKY	At least 20 days before trial, defendant must file written notice of intent to introduce evidence of mental illness. § 504.070. Defendant must provide evidence at trial of his mental illness or insanity at time of offense. § 504.120. Prosecution must prove that defendant is guilty of an offense; defendant must prove he was mentally ill at time of offense. § 504.130(1).	Defendant must prove mental illness by a preponderance of the evidence. § 504.130(1)(b).		Prosecution may move for mental examination after defendant files notice of intent to introduce evidence of mental illness. § 504.070. See "Prerequisites to Finding."
MICHIGAN	Defendant must assert insanity defense and trier of fact must find that defendant is guilty of an offense, was mentally ill at time of offense, and was not legally insane at the time. § 768.36(1).	Beyond a reasonable doubt. § 768.36(1).	At the conclusion of trial, if warranted by the evidence, the court shall instruct the jury to consider separately the issues of the presence of mental illness and of insanity, and shall instruct as to the verdicts of guilty, guilty but mentally ill, not guilty by reason of insanity, and not guilty. § 768.29a(2).	*Before accepting GBMI plea, judge must examine report(s) of center for forensic psychiatry or other qualified personnel regarding whether defendant was insane, mentally ill, or mentally retarded at time of offense. § 768.36(2). See § 768.20a(2).
NEW MEXICO	Defendant must assert insanity defense and court must find that defendant is guilty of the offense charged, was mentally ill at time of offense, and was not legally insane at the time. § 31-9-3D.	Beyond a reasonable doubt. § 31-9-3D.	When defendant has asserted insanity defense, the court, where warranted by the evidence, shall provide jury with a special GBMI verdict form and shall separately instruct the jury that a GBMI verdict may be returned instead of a verdict of guilty or not guilty, and that such a verdict requires finding beyond a reasonable doubt that defendant committed the offense charged, was not legally insane at the time, but was mentally ill. § 31-9-3E.[7]	Before court may accept a GBMI plea, clinical psychologist or psychiatrist must examine defendant. § 31-9-3C.
PENNSYLVANIA	Defendant must assert insanity defense and trier of fact must find that defendant is guilty of an offense, was mentally ill at time of offense, and was not legally insane at the time. § 314(a).	Beyond a reasonable doubt § 314(a).		*Before trial judge may accept GBMI plea, he must examine all reports prepared pursuant to the Rules of Criminal Procedure. § 314(b).
SOUTH DAKOTA	If defendant intends to introduce expert testimony relating to mental illness, he shall notify prosecutor not less than 30 days before trial, or at a later time if court directs, and file copy with clerk. § 23A-10-3. If defendant fails to give notice, court shall exclude the testimony. § 23A-10-5. Defendant must assert insanity defense; trier of fact must find tht defendant is guilty of an offense, was mentally ill at time of offense, and was not insane at the time. § 23A-26-14.	Beyond a reasonable doubt. § 23A-26-14.	If defense of insanity or mental illness presented during trial, court shall provide jury with a special GBMI verdict form for each offense and shall instruct that a GBMI verdict may be returned instead of a general verdict. Court shall also instruct that the verdict requires finding beyond a reasonable doubt that defendant committed the offense, was not insane at the time, but mentally ill. § 23A-25-13.	Court may not accept a GBMI plea until defendant has been examined by a licensed psychiatrist. § 23A-7-16.
UTAH	Defendant must assert insanity defense. § 77-35-21.5(2).	Not specified.	If defendant asserts insanity defense, court shall instruct jury that they may find defendant GBMI or guilty of a lesser offense due to mental illness ... not such ity. illness as would warrant full exoneration. § 77-35-21.5(2).	†Upon a GBMI plea, court may order defendant evaluated at Utah state hospital or other suitable facil- § 77-35-21.5(1).

[5]Unless otherwise specified, cited provisions are silent regarding which party bears the articulated burden of proof.
[6]Includes only mental examinations which occur before the acceptance of a GBMI plea or the rendering of a GBMI finding. Provisions for subsequent examinations are presented in TABLE 3.
[7]New Mexico has standardized jury instructions for GBMI and NGRI cases. See Uniform Jury Instructions/Criminal 41.00, 41.01, 41.02.

TABLE 3
GUILTY BUT MENTALLY ILL PROCEDURES
SENTENCING THROUGH RELEASE

STATE	Sentencing Procedure	Mental Examinations[1]	Rights of GBMI Convicts	Custody and Treatment After Sentencing
ALASKA	Court shall sentence defendant as provided by law. § 12.47.090(a).			The Department of Mental Health and Social Services shall provide mental health treatment to a defendant found GBMI, and shall determine the course of treatment. § 12.47.050(b).
DELAWARE	Court may impose any sentence on GBMI defendant which may lawfully be imposed upon any defendant for the same offense. § 408(b).	Defendant shall undergo such further evaluation as is psychiatrically indicated. § 408(b).	Defendant may refuse in writing to take any drugs prescribed for treatment of his mental illness, except when refusal will endanger life of defendant, or the lives or property of other persons with whom the defendant has contact. § 408(b). Defendant is not eligible for any privileges not permitted in writing by the Commissioner (including on-grounds and off-grounds privileges) until eligible for parole. § 408(c).	Defendant is committed to custody of Department of Corrections with Commissioner having exclusive jurisdiction over defendant in all security matters. Defendant shall receive such immediate and temporary treatment as psychiatrically indicated. Commissioner shall confine defendant in Delaware state hospital. Treatment decisions are the joint responsibility of the Director of Mental Health and the hospital staff. § 408(b).
GEORGIA	Court shall sentence GBMI defendant in same manner as a defendant found guilty of the offense. § 17-7-131(g).	If defendant is committed to an appropriate penal facility, he shall be further evaluated. § 17-7-131(g).		If defendant is committed to an appropriate penal facility, he shall be evaluated and then treated, within the limits of state funds appropriated therefor, in such manner as is psychiatrically indicated. Treatment may be provided by penal facility or Department of Human Resources after transfer. § 17-7-131(g).
ILLINOIS	Court may impose any sentence which could be imposed on non-GBMI defendant convicted of same offense. Court may order presentence investigation of any defendant, but shall order a written presentence report in felony cases. Court shall conduct a sentencing hearing. § 1005-2-4(a).	Presentence investigation shall include mental examination when so ordered by court. See §§ 1005-3-2(b), 1005-2-4(a). Periodic examinations required after commitment to Department of Corrections. § 1005-2-6(b).		If court imposes a sentence of imprisonment, Department of Corrections shall provide such treatment as it determines necessary. § 1005-2-6(b). See "Transfer Among Facilities."
INDIANA	Court shall sentence defendant in same manner as a defendant found guilty of the offense. § 35-36-2-5(a).	If defendant is committed to the department of correction, he shall be further evaluated. § 35-36-2-5(b).		If defendant is committed to the department of correction, he shall be further evaluated and treated as psychiatrically indicated. Treatment may be by the department of correction or the department of mental health after transfer. § 35-36-2-5(b). See "Transfer Among Facilities."
KENTUCKY	Court shall sentence defendant in same manner as a defendant found guilty. § 504.150.	Court shall appoint at least one psychologist or psychiatrist to examine, treat, and report on defendant's mental condition at time of sentencing. § 504.140.		See "Duration of Treatment or GBMI Status."
MICHIGAN	Court shall impose any sentence which could be imposed upon a defendant convicted of the same offense. § 768.36(3).	If defendant is committed to the custody of the department of corrections, he shall undergo further evaluation. § 768.36(3).		If defendant is committed to the custody of the department of corrections, he shall undergo further evaluation and be given such treatment as is psychiatrically indicated for his mental illness or retardation. Treatment may be provided by the department of corrections or the department of mental health after transfer. § 768.36(3). See "Transfer Among Facilities."
NEW MEXICO	Court may impose any sentence which could be imposed upon a defendant convicted of the same offense. § 31-9-4.	If defendant is sentenced to the custody of the corrections department, the department shall examine the nature, extent, continuance, and treatment of defendant's mental illness. § 31-9-4.		The corrections department shall provide psychiatric, psychological, and other counseling and treatment for defendant as it deems necessary. § 31-9-4.
PENNSYLVANIA	Court may impose any sentence which may be imposed upon any defendant convicted of the same offense. Before imposing sentence, court shall hear testimony and make a finding of whether defendant at time of sentencing is severely mentally disabled and in need of treatment. § 9727(a).			*Defendant is committed to Bureau of Correction. § 9727(b)(2). Consistent with available resources defendant shall be provided such treatment as is psychiatrically or psychologically indicated. Treatment may be provided by the Bureau of Correction, the county, or the Department of Public Welfare in accordance with the "Mental Health Procedures Act." †The cost of treatment is borne by the Commonwealth. § 9727(b).
SOUTH DAKOTA	Courts shall impose any sentence which could be imposed upon a defendant pleading or found guilty of the same charge. § 23A-27-38.	If defendant is sentenced to the state penitentiary, he shall undergo further examination. § 23A-27-38.		If defendant is sentenced to the state penitentiary, he shall undergo further evaluation and may be given treatment that is psychiatrically indicated. If treatment is available, it may be provided through facilities under the jurisdiction of the board of charities and corrections. § 23A-27-38.
UTAH	Court shall impose any sentence which could be imposed upon a defendant convicted of same offense. Before sentencing, the court shall conduct a hearing to determine defendant's present mental state. § 77-35-21.5(3). If court finds defendant is currently mentally ill, it shall sentence him as a mentally ill offender. § 77-35-21.5(2). †Court shall order hospitalization if it finds by clear and convincing evidence: that defendant is mentally ill and, therefore, poses an immediate physical danger to others or self or lacks ability to provide the basic necessities of life; that defendant lacks ability to engage in a rational decision-making process regarding acceptance of treatment; that there is no appropriate treatment alternative to hospitalization; and that the hospital can provide adequate and appropriate treatment. § 77-35-21.5(4).		If defendant is hospitalized for an indefinite period [see "Duration of Treatment or GBMI Status"], he is entitled to petition the sentencing court for a rehearing at 6-month intervals. § 77-35-21.5(6).	Court may order hospitalization at the Utah state hospital or other suitable facility. § 77-35-21.5(4). See "Sentencing Procedure."

†Table entry, or portion thereof, represents the general import of the provision, although details are excluded.
*Table entry, or portion thereof, reflects a special GBMI provision, but the provision is vague.
[1]Includes only mental examinations which occur after the acceptance of a GBMI plea or the rendering of a GBMI finding. Provisions for prior examinations are presented in TABLE 2.

TABLE 3 (CONTINUED)

STATE	Transfer Among Facilities	Duration of Treatment or GBMI Status	Probation	Parole
ALASKA		Treatment must continue until defendant no longer suffers from a mental disease or defect that causes him to be dangerous to the public peace or safety. When treatment terminates, defendant is required to serve remainder of sentence imposed. †Not less than 30 days before expiration of sentence, involuntary civil commitment proceedings should be commenced if defendant is still receiving treatment or is still dangerous. § 12.47.050 (b), (c), (e).[2]		Notwithstanding any contrary provision of law, a GBMI convict receiving treatment may not be released on furlough, work release, or parole. § 12.47.050(d).
DELAWARE	See "Duration of Treatment or GBMI Status."	The Delaware State Hospital, or other residential treatment facility to which defendant is committed, has authority to discharge defendant and return him to physical custody of Commissioner if facility believes discharge is in defendant's best interests. § 408(b). †If the discharge is before expiration of defendant's sentence, facility shall transmit a report on defendant's mental condition to the Commissioner and the Parole Board. § 408(c).	If defendant is placed on probation, court, upon Attorney General's recommendation, shall make treatment a condition of probation. Reports specified by trial judge shall be filed with probation officer and sentencing court. Treatment provided by state agency or, with sentencing court's approval and at individual expense, by private agency. § 409(c).	†Prerelease or parole status is under same terms and laws applicable to any other offender. Counseling or treatment may be a condition of such status. § 409(a), (b).
GEORGIA	Transfer is pursuant to procedures in regulations of the Department of Offender Rehabilitation and the Department of Human Resources. § 17-7-131(g)(2).		If defendant is on probation under the "State-wide Probation Act," court may require defendant to undergo available treatment as condition of probation. Provider of services may charge defendant fees. § 17-7-131(h).	
ILLINOIS	†Department of Corrections may transfer custody to Department of Mental Health and Developmental Disabilities, which shall return defendant when sentence has not expired and hospitalization is no longer needed. § 1006-2-6(c), (d)(1).	†When Department of Corrections notifies Director of Mental Health and Developmental Disabilities of the expiration of the sentence of a transferred defendant, if defendant requires further hospitalization, the Department of Mental Health and Developmental Disabilities shall file a petition for involuntary civil commitment. § 1006-2-6 (d)(2).	†A defendant subject to probation, periodic imprisonment, or conditional discharge shall be required to submit to treatment prescribed by the sentencing court. § 1006-2-6(a)(1).	
INDIANA	Defendant may be transferred to the department of mental health under § 16-14-8.[3] § 35-36-2-5(b)(2).		†If defendant is placed on probation, court may require that he undergo treatment. § 35-36-2-6(c).	
KENTUCKY		Treatment shall be provided defendant until he is no longer mentally ill or until expiration of his sentence, whichever occurs first. § 504.150.	Treatment shall be a condition of probation, shock probation, conditional discharge, parole, or conditional release so long as defendant is mentally ill. § 504.150(2).	See "Probation."
MICHIGAN	Defendant may be transferred to the department of mental health under §§ 330.2000 or 330.2002.[4] § 768.36(3).	†If defendant is discharged before expiration of sentence, he shall be returned to the state correctional facility for balance of sentence. § 768.36(3). Discharge occurs whenever defendant ceases to require intensive care or treatment or when criminal sentence expires. §§ 768.36(3), 330.2006(1)(d), (b). At least 14 days before expiration of sentence, head of department of mental health facility may file involuntary civil commitment petition. §§ 768.36(3), 330.2006(3).	†If defendant is placed on probation, the trial judge, upon recommendation of the center for forensic psychiatry, shall make treatment a condition of probation. Probation should continue for not less than 5 years. Treatment is provided by a department of mental health facility, or with court approval and at individual expense, by a private agency. Reports should be filed every 3 months. § 768.36(4).	†If defendant is placed on parole, upon recommendation of the treating facility, treatment shall be a condition of parole. While considering parole, the parole board should consult the treating facility and obtain reports on defendant's condition. § 768.36(3).
NEW MEXICO				
PENNSYLVANIA	*Defendant may be transferred to a mental health facility. § 9727(b)(2). See "Duration of Treatment or GBMI Status."	†When treating facility discharges defendant prior to expiration of his maximum sentence, it shall transmit a report to the Board of Probation and Parole, the correctional facility, or the county jail to which the defendant is being returned. § 9727(c).	†When placing defendant on probation, court may, upon recommendation of the district attorney or upon its own initiative, make treatment a condition of probation. Probation should continue for the maximum period permitted by law. Treatment shall be by a Department of Public Welfare-approved facility, or with sentencing court's approval and at individual's expense, by private parties. § 9727(f).	†A defendant discharged from treatment may be placed on prerelease or parole status under the same terms and laws applicable to any other defendant. Treatment may be required as a condition. Paroling authority shall consult with treating facility when considering parole. § 9727(d), (e).
SOUTH DAKOTA	The board of charities and corrections may transfer defendant from the penitentiary to other facilities under its jurisdiction and return defendant to the penitentiary after completion of treatment for the balance of defendant's sentence. § 23A-27-38.	†If a treating facility discharges defendant prior to expiration of his sentence, it shall forward to the board of persons and paroles a report on defendant's condition. § 23A-27-39.	†If defendant is placed on probation, the sentencing court, upon recommendation of a licensed psychiatrist, shall make treatment a condition of probation. § 23A-27-40. Treatment shall be provided by local mental health agencies if available, or by a facility under the jurisdiction of the board of charities and corrections. Defendant must pay for the treatment unless he is indigent. § 23A-27-41.	
UTAH	†If hospital proposes to discharge defendant prior to expiration of sentence, the board of pardons shall direct that defendant serve any or all of unexpired term of sentence at the Utah state prison, or place defendant on parole. § 77-35-21.5(8).	†Hospitalization shall not exceed 6 months without a review hearing. If at the review hearing the court finds by clear and convincing evidence that the conditions of § 77-35-21.5(4) [see "Sentencing Procedure"] still test for an indeterminate period, it may order an indefinite period of hospitalization, which shall in no circumstance be longer than the maximum sentence imposed. § 77-35-21.5(5), (7).	†If defendant is placed on probation, trial judge shall make treatment a condition of probation if defendant is shown to be treatable and facilities exist for treatment of defendant on probation status. Probation shall not be for less than 5 years, or until expiration of sentence, whichever comes first, and shall not be reduced without sentencing court considering a current mental status report. § 77-35-21.5(9).	†If board of pardons considers parole, board shall consult the treating facility and a report on defendant's condition may be filed with the board. Defendant shall remain hospitalized pending board's decision. If defendant is placed on parole, treatment shall, upon hospital's recommendation, be made a condition of parole. Parole shall not be for less than 5 years, or until expiration of sentence, whichever comes first, and shall not be reduced without board of pardon's considering current mental status report. § 77-35-21.5(8).

[2]Alaska statute provides that nothing in the GBMI provisions restricts mental health treatment of non-GBMI convicts. See §12.47.055.
[3]Section 16-14-8 has been repealed.
[4]Sections 330.2000 and 330.2002 have been repealed.

Provisions for the GBMI plea and verdict of each state represented in the tables may appear in a number of places in the statutes. Except for the NGRI provisions in Table 1, a statutory provision is noted in the tables only if the state has a relevant provision that expressly applies to GBMI defendants or convicts. Provisions not explicitly applicable to GBMI defendants or convicts are not included even though, in practice, they may apply. For example, the general sentencing provisions to which all offenders, not just those found GBMI, are subject are not reflected in Table 3. Similarly, entries under "Probation" and "Parole" are included only if special provisions are made for GBMI offenders.

Table 1 is meant to facilitate comparison of the GBMI statutory standards and definitions with the NGRI statutory standards and definitions applicable in the eleven states. In Alaska and Delaware, for example, a defendant may not be found NGRI on the ground that he or she lacked the behavioral control to conform his or her conduct to the requirements of the law, but may be found GBMI on that basis. The GBMI standards of these two states thus encompass a much broader concept of mental disease or defect, including "irresistible impulse" or "volitional capacity," than the NGRI standards, which focus instead on the extent to which a defendant could appreciate the wrongfulness of his conduct.[40] Illinois, on the other hand, allows a finding of NGRI on the basis of volitional impairment, but disallows a finding of GBMI on that basis.

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40. See commentary accompanying Standard 7-6.1., American Bar Association Standing Committee on Association Standards for Criminal Justice, supra note 17, at 264-273 (In 1983, the ABA endorsed an NGRI standard that focused on the lack of "appreciation" of criminal wrongdoing and rejected "volitional" incapacity as an independent basis for exculpation).

The NGRI and GBMI verdicts in these states thus appear to be uniformly distinguishable by the types of mental aberration upon which they can be based. In Alaska and Delaware, but not in Illinois, criminal responsibility may be assigned to a defendant even if he or she suffered from mental aberration that impaired behavioral control or willpower. Whether such basic similarities and sharp distinctions among the formulations of the GBMI verdict reflect different legislative purposes is unclear. It is also unclear whether juries and judges will be any better at sorting out the types and degrees of mental impairment applicable to the GBMI and NGRI verdicts than the legislatures.[41]

Tables 2 and 3 present special GBMI procedural provisions that apply from the initial pleading stage through the ultimate release of an offender. Table 2 differentiates the procedures applicable when a defendant pleads GBMI from the procedures when a defendant does not enter such a plea but, rather, the court or jury finds him or her GBMI after trial. Prerequisites to the court's acceptance of a GBMI plea are very different from the prerequisites to a GBMI finding in most states. The provisions for the burden of proof regarding mental illness reflected in Table 2 are illustrative of the variety of GBMI statutes among the eleven states. Only Kentucky specifies which party bears the burden of proof; six states require proof beyond a reasonable doubt, two require a preponderance of the evidence, and three are silent on the issue.

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41. See Stelzner & Piatt, supra note 21, at 106 ("The jury's meaningful choice between the two verdicts might be difficult due to the jury's confusion over the similarities and differences in the definitions of the two alternatives. Both verdicts require two showings--a mental condition and a consequence caused by that condition. The conditions may be similar; the requisite results quite different."); id. at 106-108; Note, supra note 21, at 471 ("The overlap of these definitions makes a meaningful choice between the two verdicts a difficult task to assign to a lay jury.").

Table 3 presents statutory provisions applicable during the time of sentencing, incarceration, and the eventual release of an offender by means of probation and parole. Of particular note are the uniform provisions among the states allowing imposition on a GBMI convict of any sentence that could be imposed on any other defendant convicted of the same offense. That the GBMI sentencing provisions do not expressly preclude imposition of the death penalty may present the courts with a conflict between the rehabilitative ideals of the GBMI legislation and the possible imposition of the death penalty.[42]

The next section of this Article explores the judicial development of the GBMI plea and verdict. Most of the cases discussed resulted from conflicts or questions arising after GBMI legislation was enacted in a particular state.

III. JUDICIAL DEVELOPMENTS

At this writing, approximately 90 appellate level decisions involving or discussing the GBMI plea or verdict have been rendered in this country.[43] The vast majority of these decisions understandably come from Michigan, the state having the longest experience with the

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42. Cf. infra note 116.

43. Ball v. State, 167 Ga. App. 546, 306 S.E. 2d 353 (1983); Jackson v. State, 166 Ga. App. 477, 304 S.E. 2d 560 (1983); Kirkland v. State, 166 Ga. App. 478, 304 S.E. 2d 561 (1983); People v. Kaeding, 98 Ill. 2d 237, 456 N.E. 2d 11 (1983); People v. Dewit, No. 81-3019 (Ill. App. Ct. March 30, 1984); People v. Neely, 121 Ill. App. 3d 616, ___ N.E. 2d ___ (1984); People v. Gore, 116 Ill. App. 3d 780, 452 N.E. 2d 583 (1983); People v. Testa, 114 Ill. App. 3d 695, 449 N.E. 2d 164 (1983); People v. Dalby, 115 Ill. App. 3d 35, 450 N.E. 2d 31 (1983); People v. Lillard, 116 Ill. App. 3d 1062, 449 N.E. 2d 938 (1983); People v. Marshall, 114 Ill.

alternative verdict. Many of these decisions concern issues having little, if any, significance to the GBMI plea and verdict's

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App. 3d 217, 448 N.E. 464 (1983); Shiro v. State, __ Ind. __, 451 N.E. 2d 1047 (1983); Taylor v. State, __ Ind. __, 440 N.E. 2d 1104 (1982); Turner v. Turner, __Ind. App.__, 454 N.E. 2d 1247 (1983); Strader v. State, __ Ind. App. __, 453 N.E. 2d 1032 (1983); Gall v. Commonwealth, 607 S.W. 2d 97 (Ky. 1980); Pouncey v. State, __ Md. __, 465 A.2d 475 (1983); Langworthy v. State, 284 Md. 588, 399 A.2d 578 (1979); Gorton v. Johnson, Civ. No. 82-60422 (E.D. Mich. Feb. 16, 1984); People v. Robinson, 417 Mich. 231, 331 N.W. 2d 226 (1983); People v. Langworthy, 416 Mich. 630, 331 N.W. 2d 171 (1982); People v. Murphy, 416 Mich. 453, 331 N.W. 2d 152 (1982); People v. Booth, 414 Mich. 343, 324 N.W. 2d 741 (1982); People v. Cocuzza, 413 Mich. 78, 318 N.W. 2d 465 (1982), rev'g, 105 Mich. App. 761, 307 N.W. 2d 414 (1981); People v. McDonald, 409 Mich. 110, 293 N.W. 2d 588 (1980), aff'g, 86 Mich. App. 5, 272 N.W. 2d 179 (1978); People v. McLeod, 407 Mich. 632, 288 N.W. 2d 909 (1980); People v. Helzer, 404 Mich. 410, 273 N.W. 2d 44 (1978); People v. Darden, No. 67069 (Mich. Ct. App. Feb. 16, 1984); People v. John, No. 67154 (Mich. Ct. App. Oct. 11, 1983); People v. Williams, ___ Mich. App. ___, 341 N.W. 2d 854 (1983) (per curiam); People v. Siebers, ___ Mich. App. ___, 341 N.W. 2d 530 (1983); People v. Clark, No. 65838 (Mich. Ct. App. Sept. 27, 1983); People v. Doyle, No. 70477 (Mich. Ct. App. Sept. 27, 1983); People v. Kinard, No. 64155 (Mich. Ct. App. Sept. 26, 1983); People v. Delaughter, 124 Mich. App. 356, 335 N.W. 2d 37 (1983); People v. Toner, 125 Mich. App. 439, 336 N.W. 2d 22 (1983); People v. Davis, 123 Mich. App. 553, 333 N.W. 2d 99 (1983); People v. Caldwell, 122 Mich. App. 618, 333 N.W. 2d 105 (1983); People v. Wehrer, 121 Mich. App. 501, 329 N.W. 2d 37 (1982); People v. Frost, 120 Mich. App. 328, 328 N.W. 2d 44 (1982); People v. Leblanc, 120 Mich. App. 343, 327 N.W. 2d 471 (1982); People v. Korona, 119 Mich. App. 364, 326 N.W. 2d 143 (1982); People v. Fisher, 119 Mich. App. 445, 326 N.W. 2d 537 (1982); People v. Smith, 119 Mich. App. 91, 326 N.W. 2d 434 (1982); People v. Giuchici, 118 Mich. App. 252, 324 N.W. 2d 593 (1982); People v. Gasco, 119 Mich. App. 143, 326 N.W. 2d 397 (1982) (per curiam); People v. Thompson, 117 Mich. App. 210, 323 N.W. 2d 656 (1982); People v. Shively, 116 Mich. App. 323, 323 N.W. 2d 383 (1982); People v. Blue, 114 Mich. App. 137, 318 N.W. 2d 498 (1982); People v. Bazzi, 113 Mich. App. 606, 318 N.W. 2d 702 (1981); People v. Linzey, 112 Mich. App. 374, 315 N.W. 2d 550 (1981); People v. Fultz, 111 Mich. App. 587, 314 N.W. 2d 702 (1981); People v. Broadnax, 111 Mich. App. 46, 314 N.W. 2d 522 (1981); People v. Rone, 109 Mich. App. 702, 311 N.W. 2d 835 (1981); People v. Henry, 107 Mich. App. 632, 309 N.W. 2d 922 (1981); People v. Ritsema, 105 Mich. App. 602, 307 N.W. 2d 380 (1981); People v. Mack, 104 Mich. App. 560, 305 N.W. 2d 264 (1981); People v. Gasco, 104 Mich. App. 594, 305 N.W. 2d 552 (1981); People v. Rone, 101 Mich. App. 811, 300 N.W. 2d 705 (1980); People v. Murphy, 100 Mich. App. 413, 299 N.W. 2d 51 (1980); People v. Drossart, 99 Mich. App. 66, 297 N.W. 2d 863 (1980); People v. Philpot, 98 Mich. App. 257, 296 N.W. 2d 229 (1980): People v. Girard, 96 Mich. App. 594, 293 N.W. 2d 634 (1980); People v. Hicks, 96 Mich. App. 610, 293 N.W. 2d 646 (1980); People v. Thomas, 96 Mich. App. 210, 292 N.W. 2d 523 (1980); People v. Willsie, 96 Mich. App. 350, 292 N.W. 2d 145 (1980); People v. Gemill, 95 Mich. App. 139, 290

development.[44] This section reviews only those appellate court pronouncements that are apparently significant regarding the constitutionality of the GBMI plea and verdict and its substantive and procedural development. First, however, we contrast the American progeny of the English Trial of Lunatics Act.

A. Maryland's "Guilty But Insane" Verdict

The Maryland Court of Appeals has recognized a "guilty but insane" verdict on two occasions. In Langworthy v. State,[45] the court said that a guilty verdict is not inconsistent with a special verdict of

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N.W. 2d 104 (1980): People v. Seefeld, 95 Mich. App. 197, 290 N.W. 2d 124 (1980): People v. Parney, 98 Mich. App. 571, 296 N.W. 2d 568 (1979); People v. Tenbrink, 93 Mich. App. 326, 287 N.W. 2d 223 (1979); People v. Ramsey, 89 Mich. App. 468, 280 N.W. 2d 565 (1979); People v. Crawford, 89 Mich. App. 30, 279 N.W. 2d 560 (1979); People v. Sorna, 88 Mich. App. 351, 276 N.W. 2d 892 (1979); People v. Sharif, 87 Mich. App. 146, 274 N.W. 2d 17 (1978); People v. Booth, 86 Mich. App. 646, 273 N.W. 2d 510 (1978); People v. Long, 86 Mich. App. 676, 273 N.W. 2d 519 (1978); People v. Staggs, 85 Mich. App. 304, 271 N.W. 2d 211 (1978); People v. Manyiapane, 85 Mich. App. 374, 271 N.W. 2d 240 (1978); People v. Mikulin, 84 Mich. App. 705, 270 N.W. 2d 501 (1978); People v. Darwall, 82 Mich. App. 652, 267 N.W. 2d 472 (1978); People v. Jackson, 80 Mich. App. 244, 263 N.W. 2d 44 (1977); People v. McLeod, 77 Mich. App. 327, 258 N.W. 2d 214 (1977); Novosel v. Helgemoe, 118 N.H. 115, 384 A.2d 124 (1978); State v. Page, ___ N.M. ___, 676 P. 2d, 1353 (1984); State v. Garcia, 99 N.M. 466, 659 P.2d 918 (1983); Commonwealth v. Musolino, __Pa. Super. __, 467 A.2d 605 (1983); and State v. Stacy, 601 S.W. 2d 696 (Tenn. 1980).

44. See e.g., People v. Cocuzza, 413 Mich. 78, 318 N.W. 2d 465 (1982)(whether trial judge who presided over prior incomplete guilty plea proceedings must sua sponte disqualify himself from conducting the same defendant's subsequent bench trial); and People v. McDonald, 409 Mich. 110, 293 N.W. 2d 588 (1980)(whether usage and application of common law definition of rape to male defendants only represent an arbitrary classification and violate due process).

45. 284 Md. 588, 399 A.2d 578 (1979).

insanity. The issue before the court was whether the intermediate appellate court erred in dismissing the defendant's appeal from a rape conviction on the grounds that the trial court's special finding of insanity was tantamount to an acquittal.[46] In holding that the conviction was appealable, the Court of Appeals said: "... the clear legislative intent regarding the successful interposition of a plea of insanity is not that an accused is to be found not guilty of the criminal act it was proved he committed, but that he shall not be punished therefor."[47] The court also cited Maryland Rule of Procedure 731a, which states that a defendant "may plead not guilty, guilty, or, with the consent of the court, nolo contendere. In addition to any of these pleas, the defendant may interpose the defense of insanity as permitted by law." Thus, although the court held that a defendant found guilty of the crime charged, yet successful in asserting an insanity defense, could appeal from the conviction, implicit in that holding is a finding that a guilty verdict is not inconsistent with an insanity verdict.

In Pouncey v. State,[48] the Maryland Court of Appeals specifically held that a defendant may be found guilty but insane. The defendant had drowned her five-year-old son because she believed that the devil was pursuing him and that the only way to prevent her son from going to hell was to kill him. In holding that the defendant was properly found both guilty of murder and legally insane at the time of the offense, the court relied on the rationale of Langworthy and stated

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46. Id., 399 A.2d at 583-84.

47. Id. at 584. See Md. Code Ann. 59 §25(b) (Repl. Vol. 1972).

48. __Md.__, 465 A.2d 475 (1983).

that "a finding of insanity is not tantamount to an absence of mens rea, or inconsistent with a general intent to commit a crime."[49]

Bearing striking similarity to the nineteenth century Trial of Lunatics Act,[50] Maryland's judicially developed guilty but insane verdict appears merely to replace the not guilty by reason of insanity wording with wording that suggests blameworthiness. The dispositional consequences of a guilty but insane finding are no different than those of a finding of not guilty by reason of insanity.[51] Although predicated on a finding of guilt, the consequences are nonresponsibility for the criminal conduct and no punishment under the criminal law. The court, in its discretion, may either release the defendant or commit him or her for treatment in a mental institution until it is determined that release would not constitute a danger to the individual or others.[52] Semantics aside, Maryland's judicially developed guilty but insane verdict is clearly distinguishable from the legislatively developed GBMI verdict described in the previous section and is almost indistinguishable from the traditional not guilty by reason of insanity verdict which the GBMI verdict was meant to supplement. The same is true of the Oregon and Connecticut variations of the guilty but insane verdict.[53] We now turn to the judicial development of the GBMI plea and verdict.

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49. Id. at ___.

50. See supra notes 7-8, and accompanying text.

51. See Langworthy v. State, 399 A.2d at 581-82.

52. Id. at 582.

53. See supra note 14.

B. Constitutional Questions

Constitutional challenges to GBMI statutes have ranged from arguments based on equal protection and due process guarantees to prohibitions against cruel and unusual punishment and ex post facto laws. These challenges have been predicated on both federal and state constitutional guarantees.[54] Although the relevant Michigan case law involves equal protection,[55] due process,[56] and cruel and unusual punishment issues;[57] Indiana case law only deals with equal protection[58] and due process challenges;[59] while Illinois case law reveals challenges based on due process guarantees[60] and the federal

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54. In People v. Sharif, 87 Mich. App. 196, 274 N.W. 2d 17 (1978), the defendant attacked the Michigan GBMI statute as violative of the Michigan Constitution's title object clause, Article 4, Section 24, which required that no law embrace more than one object. The defendant argued that the statute provided for both treatment and parole of GBMI offenders. The Michigan Court of Appeals rejected this argument, stating that a statute may include provisions that implement its principal object, which, in this case, was to provide for judgments and sentences of offenders. 274 N.W. 2d at 19. In other cases, defendants have asserted concurrent violations of state and federal constitutional provisions. See e.g., People v. Marshall, 114 Ill. App. 3d 217, 448 N.E. 2d 969 (1983) (defendant argued GBMI statute violative of state and federal prohibition argument ex post facto laws).

55. E.g., People v. McLeod, 407 Mich. 632, 228 N.W. 2d 909 (1980); People v. Darwall, 82 Mich. App. 652, 267 N.W. 2d 472 (1978); People v. Sharif, 87 Mich. App. 196, 274 N.W. 2d 17 (1978).

56. People v. McLeod, 288 N.W. 2d at 917.

57. Id. at 915.

58. Taylor v. State, __ Ind. __, 440 N.E. 2d 1109 (1982).

59. Id., 440 N.E. 2d at 1111.

60. People v. Kaeding, 98 Ill. 2d 237, 456 N.E. 2d 11 (1983); People v. Dewit, No. 81-3019 (Ill. App. Ct. March 30, 1984).

constitutional prohibition against ex post facto laws;[61] and Georgia case law involves only ex post facto law challenges.[62] To date, the Illinois, Indiana, and Michigan statutes have withstood constitutional attack in the supreme courts of those states,[63] while the Georgia statute has been reviewed only by the intermediate appellate court.[64]

1. Equal Protection

The basic premise of equal protection arguments against GBMI statutes has been that they create irrational classifications leading to discrimination against defendants found GBMI.[65] In Michigan, a variety of equal protection arguments have been advanced. In People v. Darwall, for example, the defendant argued that it was discriminatory to subject mentally ill defendants pleading insanity to the risk of GBMI verdicts, while similar defendants may escape GBMI verdicts by not pleading insanity.[66] The Court of Appeals rejected this argument, stating that

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61. People v. Dewit, No. 81-3019 at 14. People v. Dalby, 115 Ill. App. 3d 35, 450 N.E. 2d 31 (1983); People v. Marshall, 114 Ill. App. 3d 217, 448 N.E. 2d 464 (1983).

62. Kirkland v. State, 166 Ga. App. 478, 304 S.E. 2d 561 (1983).

63. People v. Kaeding, 98 Ill. 2d 237, 456 N.E. 2d 11 (1983); Taylor v. State, __ Ind. __, 440 N.E. 2d 1104 (1982); People v. McLeod, 407 Mich. 632, 288 N.W. 2d 909 (1980).

64. Kirkland, 304 S.E. 2d 561.

65. See People v. Rone, 109 Mich. App. 702, 311 N.W. 2d 835, 841 (1981); People v. Ramsey, 89 Mich. App. 468, 280 N.W. 2d 565, 566 (1979); People v. Sorna, 88 Mich. App. 351, 276 N.W. 2d 892, 896 (1979); People v. Darwall, 82 Mich. App. 652, 267 N.W. 2d 472, 476 (1978); People v. Jackson, 80 Mich. App. 244, 263 N.W. 2d 44, 44-45 (1977).

66. 267 N.W. 2d at 476.

the statute bears a reasonable relationship to the state's valid interests in protecting the public and in treating mentally ill criminals.[67]

The Michigan Court of Appeals rejected another equal protection argument in People v. Sharif.[68] The defendant argued he was denied equal protection because he did not receive a hearing before treatment, yet prisoners transferred to the department of mental health were entitled to such hearings.[69] The court rejected this argument, reasoning that the purpose of such a hearing was to determine if treatment could best be provided by a mental health facility rather than a correctional facility and that GBMI offenders received evaluations before treatment.[70] Thus, the court stated, it was reasonable for the legislature to require a hearing only for offenders whom corrections officials were considering transferring to a mental health facility.[71]

A third general type of equal protection challenge, based on the overlap of definitional criteria for NGRI and GBMI, is that no reasonable basis exists for allowing the incarceration of GBMI defendants and the exculpation of NGRI defendants. The Michigan Court of Appeals considered this argument in People v. Sorna.[72] The defendant claimed that it was

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67. Id. In People v. Jackson, 263 N.W. 2d at 45, the Michigan Court of Appeals said that the legislature need not provide an all-inclusive classification for defendants who are both guilty and mentally ill.

68. 87 Mich. App. 196, 274 N.W. 2d 17 (1978).

69. Id. at 19-20.

70. Id. at 20.

71. Id.

72. 276 N.W. 2d at 896. See also People v. Darden, No. 67069 (Mich. Ct. App. Feb. 16, 1984);

"irrational to consider a defendant found 'mentally ill' to be criminally responsible for his acts while excusing a person adjudged 'legally insane' from similar responsibility."[73] The court rejected this contention and held that the GBMI statute merely established an "intermediate category to deal with situations where a defendant's mental illness does not deprive him of substantial capacity sufficient to satisfy the insanity test ... . The fact that these distinctions may not appear clear cut does not warrant a finding of no rational basis to make them ... ."[74]

A similar argument was rejected in Indiana in Taylor v. State.[75] In Taylor the defendant argued that Indiana's GBMI statute violated his equal protection and due process rights because "the definitions of 'insanity' and 'mentally ill' are so vague and susceptible to misinterpretation by persons of ordinary intelligence that the verdicts [of NGRI and GBMI] are one and the same."[76] The Supreme Court of Indiana rejected this argument, stating that, even though the two definitions[77] involve similar behavioral characteristics, the two do not describe the same mental condition.[78] Although the two terms do

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73. 276 N.W. 2d at 896.

74. Id.

75. __Ind.__, 440 N.E. 2d 1109, 1111-13 (1982).

76. Id., 440 N.E. 2d at 1111.

77. See Ind. Code §35-41-3-6 (Burns Repl. Vol. 1979.) ("insanity" defined); and Id. at §35-5-2-3 ("mentally ill" defined).

78. Taylor, 440 N.E. 2d at 1111.

overlap, "the existence of a mental disease or deficiency does not ipso facto render a defendant legally insane."[79]

A fourth type of equal protection argument was asserted in an Illinois case. In People v. Kaeding,[80] the defendant argued that the applicable statutes invidiously discriminated against incarcerated GBMI offenders vis-a-vis GBMI probationers. The defendant construed the applicable statutes as requiring the sentencing court to prescribe the specific mental health treatment for every GBMI offender not sentenced to prison but giving the Department of Corrections the discretion to treat or not to treat GBMI inmates.[81] The Illinois Supreme Court rejected this argument, stating that the defendant had misconstrued the provisions which required only that the probationer submit to treatment.[82] The court said the only difference in the way incarcerated and nonincarcerated defendants are treated is the entity empowered to make treatment decisions. It added that allocation of this decision-making power to the entity having custody and responsibility for supervising the offender was rationally related to one of the purposes of the statutes, that is, to "prescribe sanctions proportionate to the seriousness of the offenses and permit the recognition of differences in rehabilitation possibilites among individual offenders."[83] The court found no fundamental right or suspect classification involved and, accordingly,

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79. Id.

80. 98 Ill. 2d 237, 456 N.E. 2d 11 (1983).

81. Id., 456 N.E. 2d at 15-16.

82. Id. at 16.

83. Id. at 17 (citing Ill. Rev. Stat. 1981, 38 §1001-1-2(a) (1981)).

held that the statutes did not deprive GBMI inmates of equal protection of the laws.[84]

In People v. McLeod,[85] the Michigan Supreme Court seemingly laid to rest all possible equal protection challenges to that state's GBMI statute. The defendant in McLeod claimed that the legislatively created GBMI classification must be substantially related to a compelling state interest, not just rationally related as required by the Court of Appeals in Darwall and Sorna. The court found, however, that because persons found GBMI necessarily have been found guilty beyond a reasonable doubt, they have "no right to the exercise of unfettered liberty."[86] Similarly, the "mentally ill" classification has none of the marks of a suspect class.[87] Consequently, the classification did not deprive them of any fundamental right nor any special status that would require strict scrutiny by the courts. The court held, therefore, that the constitutionality of the GBMI classification must be upheld if it rationally furthers the legislative objective.[88] The court found that "this classification rationally furthers the legislative object of providing supervised mental health treatment and care to guilty but mentally ill defendants."[89]

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84. Id.

85. 407 Mich. 632, 288 N.W. 2d 909 (1980).

86. Id., 288 N.W. 2d at 919.

87. Id.

88. Id. Strict scrutiny of the Michigan statute would probably have led to different results in McLeod and the prior equal protection cases because the statute was admittedly under-inclusive.

89. Id.

2. Due Process

The GBMI statutes of Michigan, Indiana, and Illinois have thus far withstood due process challenges.[90] In Michigan these challenges have been based on People v. McQuillan[91] and federal authority,[92] suggesting that insanity acquittees are entitled to hearings regarding present mental condition prior to involuntary mental treatment because insanity at the time of the offense cannot be presumed to continue to the time of acquittal. The defendant in People v. McLeod argued that due process entitled GBMI defendants to a presentence hearing regarding present mental condition.[93] The Michigan Supreme Court rejected this argument by distinguishing between the liberty interests of GBMI convicts and NGRI acquittees, the later being entitled to such a hearing under McQuillan because an NGRI verdict only establishes a reasonable doubt regarding a defendant's sanity at the time of the crime. The court stated that involuntary commitment of NGRI acquittees without a finding regarding present mental condition constitutes a significant restriction on their right to liberty, a right that GBMI convicts do not possess because they "have been found beyond a reasonable doubt to have been 1) guilty of an offense, 2) mentally ill at the time of the commission of

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90. People v. Kaeding, 98 Ill. 2d 237, 456 N.E. 2d 11 (1983); People v. Sharif, 87 Mich. App. 196, 274 N.W. 2d 17 (1978); Taylor v. State, __ Ind. __, 440 N.E. 2d 1109 (1982); People v. McLeod, 407 Mich. 632, 288 N.W. 2d 909 (1980).

91. 392 Mich. 511, 221 N.W. 2d 569 (1974). See text accompanying supra note 24.

92. Baxtrom v. Harold, 383 U.S. 107 (1966); Bolton v. Harris, 395 F. 2d 642 (D.C. Cir. 1968).

93. 288 N.W. 2d at 917.

the offense, and 3) not legally insane at the time of the offense."[94] The court concluded that due process is satisfied if prior to sentencing the court obtains a report regarding the GBMI defendant's present mental state.[95]

In Indiana the alleged "broad and vague" definitions of "mental illness" and "insanity" also have been challenged on due process grounds. In Taylor v. State,[96] the defendant based his equal protection and due process arguments on this perceived definitional difficulty.[97] As previously discussed, the Supreme Court of Indiana rejected these arguments.[98]

The Illinois Appellate Court, First District, has rejected a similar argument, which was couched in terms of jury confusion. In People v. Dewit,[99] a defendant previously found GBMI of murder contended that because of the definitional overlap between "mental illness" and "insanity" the statutes failed to provide adequate standards for the jury to consider. He asserted that this deficiency promoted jury confusion, encouraged a GBMI verdict as a compromise, and thus rendered the GBMI provision unconstitutional on its face.[100] The State argued that since the insanity defense came into existence, juries have been

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94. Id.

95. Id. at 918.

96. Ind. , 440 N.E. 2d 1109 (1982). Accord, People v. Sharif, 87 Mich. App. 196, 274 N.W. 2d 17 (1978).

97. See supra notes 76-79 and accompanying text.

98. Taylor, 440 N.E. 2d at 1111.

99. No. 81-3019 (Ill. App. Ct. March 30, 1984). See also infra notes 171-176 and accompanying text.

100. Id. at 17.

implicitly finding whether a defendant is insane or suffering from less severe mental illness and that the GBMI provision merely made this finding explicit.[101] Also, the provision actually reduces jury confusion by clarifying the legal meaning of "insanity," which has acquired a less precise meaning in common usage.[102] The court found the state's arguments persuasive. It said that the GBMI provision expressed its requirements in simple and clear language and that it provided sufficiently definite standards.[103] The court added that the possibility of a compromise verdict is not a constitutional infirmity under these circumstances.[104]

In People v. Kaeding,[105] the Illinois Supreme Court rejected, with little discussion, the defendant's argument that the court should strictly scrutinize the disputed GBMI statute because the statute implicated "the fundamental right to fair treatment in criminal proceedings guaranteed by due process."[106] The court held that due process did not encompass a right to supervision of incarcerated GBMI offenders by the sentencing court rather than by the Department of Corrections.[107] Even though the defendant did not argue that GBMI inmates were a suspect class, the court stated that such an argument

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101. Id. at 17-18.

102. Id. at 18.

103. Id.

104. Id. at 19.

105. 98 Ill. 2d 237, 456 N.E. 2d 11 (1983). See supra notes 80-84 and accompanying text.

106. Kaeding, 456 N.E. 2d at 15-17.

107. See id. at 17.

would lack merit.[108] In the absense of a fundamental right or suspect classification, the court upheld the Illinois GBMI statute as rationally related a legitimate state interest.[109]

3. Cruel and Unusual Punishment

An eighth amendment cruel and unusual punishment challenge has been made against a GBMI statute on only two occasions. One challenge arose in the trial court in People v. McLeod.[110] The Recorder's Court, Wayne County, set aside a GBMI verdict, and declared the verdict form a nullity, after conducting hearings regarding the type and availability of mental health treatment necessary for the defendant.[111] The court found that conditions within the Department of Corrections and the Department of Mental Health made compliance with the statute impossible.[112] It reasoned that if the stated purpose of the GBMI statute was treatment of mentally ill criminals, failure to treat amounts to cruel and unusual punishment in violation of the eighth amendment.[113] The Michigan Supreme Court in McLeod avoided this issue by finding that the evidence in the trial record was insufficient to sustain the challenge to the statute.[114] On the second occasion that a

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108. Id.

109. See id. and supra text accompanying note 83.

110. See People v. McLeod, 407 Mich. 632, 288 N.W. 2d 909, 912 (1980).

111. Id. at 913.

112. Id.

113. See id. at 915. See also, Hermann, supra note 2, at 96-99.

114. 228 N.W. 2d at 915.

cruel and unusual punishment challenge was raised, the Indiana Court of Appeals summarily dismissed it, saying that the proper remedy was a writ of mandamus or a 42 U.S.C. §1983 action, not a direct appeal.[115] Thus, the question remains unresolved.[116]

4. Ex Post Facto Laws

In Georgia and Illinois, the retroactive application of newly enacted GBMI statutes to defendants who committed crimes prior to their enactment has precipitated constitutional challenges based on the constitutional prohibition against ex post facto laws.[117] In Kirkland v. State,[118] the defendant claimed that retroactive application of the Georgia GBMI statute unconstitutionally deprived her of an NGRI verdict. The Georgia Court of Appeals upheld the verdict, reasoning that it did not increase her punishment, but rather, had an ameliorative

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115. Stader v. State, __Ind. App.__, 453 N.E. 2d 1032, 1036 (1983).

116. Another possible eighth amendment challenge is pending in Indiana. An Indiana trial court recently sentenced a defendant found GBMI of murder to die in the electric chair. Harris, Harris Given Death Penalty in Precedent-Setting Case, Indianapolis Star, Feb. 10, 1984, at __, col. __. This case raises the question of whether mental illness, adjudged as part of the GBMI conviction, should mitigate against the death penalty. Of the twelve states having GBMI statutes, all but Alaska and Michigan permit the death sentence. All these GBMI statutes permit the sentencing court to impose any sentence that could be imposed on a guilty defendant. See supra Table 3.

117. See Kirkland v. State, 166 Ga. App. 478, 304 S.E. 2d 561 (1983); People v. Dewit, No. 81-3019 (Ill. App. Ct. March 30, 1984); People v. Dalby, 115 Ill. App. 3d 35, 450 N.E. 2d 31 (1983); and People v. Marshall, 114 Ill. App. 3d 217, 448 N.E. 2d 969 (1983). An ex post facto law is a law passed after the occurrence of a fact or deed, which retrospectively changes the legal consequences of the fact or deed. Black's Law Dictionary 529 (5th ed. 1979). For example, a law that increases the punishment for a prior act is an ex post facto law.

118. 304 S.E. 2d at 565.

effect.[119] The court stated that a GBMI verdict "decidedly lessens the stigma of criminal guilt and provides for the treatment of [the defendant's] mental illness."[120] It added that "[w]here the verdict is authorized by the evidence, the application of the 'guilty but mentally ill' act is procedural, not substantive; it leaves untouched the substantive right to the insanity plea as an absolute defense."[121] The court concluded that the GBMI verdict was not an ex post facto law.

In People v. Marshall, the Illinois Appellate Court, Fourth District, used a similar rationale in upholding application of the GBMI statute even though the defendant's crime took place seven months before its enactment.[122] The court stated that the application of the GBMI statute in this case did not increase the defendant's punishment, but merely altered the conditions of confinement by ensuring adequate mental health treatment.[123] The court reasoned that "statutes which change the conditions under which punishment for an offense is imposed but which do not significantly alter the fundamental nature of the punishment are not ex post facto laws."[124]

The court in Marshall faced another ex post facto law argument. The defendant asserted that the GBMI statute had the possible effect of making criminal an action that was previously innocent by depriving her

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119. Id.

120. Id.

121. Id.

122. 448 N.E. 2d at 980-81.

123. Id.

124. Id. at 981.

of available defenses.[125] Specifically, if she had known that asserting the insanity defense opened the door to a possible GBMI verdict, she might have used a self-defense or lack-of-specific-intent defense instead.[126] The court rebuffed this argument, stating that a statute that does not "completely" deprive a defendant of an available defense is not an ex post facto law.[127]

C. Substantive and Procedural Provisions

1. Pleading Procedures

The Michigan Supreme Court[128] and Court of Appeals[129] have rendered decisions construing the statutory provisions for acceptance of a GBMI plea. In People v. Booth,[130] two defendants pleaded GBMI to charges of first-degree criminal sexual conduct. Because the defendants were unable at trial to recall some events surrounding the perpetration of the crime, the trial judge referred to the preliminary examination transcript in concluding that a sufficient factual basis for acceptance

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125. Id.

126. Id. A defendant may be found GBMI in Illinois only if he or she has asserted the insanity defense at trial. Ill. Ann. Stat. 38 §115-3(c) (Smith-Hurd 19__).

127. 448 N.E. 2d at 981.

128. See People v. Booth, 414 Mich. 343, 324 N.W. 2d 741 (1982).

129. See People v. Williams, ___ Mich. App. ___, 341 N.W. 2d 854 (1983); People v. Siebers ___ Mich. App. ___, 341 N.W. 2d 530 (1983); People v. Bazzi, 113 Mich. App. 606, 318 N.W. 2d 484 (1981) (per curiam); Peole v. Fultz, 111 Mich. App. 587, 702 N.W. 2d 702 (1981); People v. Seefeld, 95 Mich. App. 197, 290 N.W. 2d 123 (1980); People v. Long, 86 Mich. App. 676, 273 N.W. 2d 519 (1979). rev'd sub nom. People v. Booth, 414 Mich. 343, 324 N.W. 2d 741 (1982).

130. 324 N.W. 2d at 744.

of the pleas existed.[131] On appeal to the Michigan Supreme Court, the issue was

> whether a defendant who is unable to recall some or all of the events surrounding the commission of a particular crime may enter a plea of guilty but mentally ill to that crime, and, if so, what procedure is to be utilized at the plea-taking proceeding to establish a factual basis for the plea.[132]

The court concluded that a forgetful defendant could plead GBMI and that a trial court could consider a transcript of the preliminary examination or trial testimony, if any, but that in all other respects a court should follow the procedures applicable to guilty pleas.[133] The court reasoned that to deny forgetful defendants the opportunity to plead GBMI and, thereby, to receive the mental health treatment due them would undercut the legislative intent behind the GBMI statutes.[134] The court upheld both defendants' convictions.[135]

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131. Id.

132. Id. at 743.

133. Id. The court was apparently only addressing procedures applicable to the "guilty" aspect of a "guilty but mentally ill" plea-taking proceeding. Although the court failed to address how the determination of mental illness fits into the procedures for accepting a guilty plea, it stated that the GBMI statutory language "suggests that ... questions of mental illness must be determined in addition to the usual questions of criminal liability ... ." See id. at 746. It also cited Michigan Compiled Laws section 768.36(2) (1982), which requires the judge to examine psychiatric reports, hold a hearing on the mental illness issue, and be satisifed that the defendant was mentally ill at the time of the offense.

134. Id. at 745-46.

135. Id. at 750. The court said that the standard of review to be applied by an appellate court in reviewing the adequacy of a plea's factual bsis is "'whether the trier of fact could properly convict on the facts' elicited from defendant at the plea-taking proceeding, or from alternate reliable sources." Id. at 748 (citation omitted).

In People v. Bazzi,[136] the Michigan Court of Appeals also considered whether a forgetful defendant could plead GBMI. The court stated that external evidence could be used to establish the factual basis for certain elements of an offense and proceeded to outline the required plea-taking procedure.[137] The court must (1) directly question the defendant to determine if he or she is guilty of the offense, (2) examine psychiatric reports,[138] and (3) hold a hearing to determine if the defendant was mentally ill at the time of the offense.[139] This result is consistent with Booth, which was decided after Bazzi.

Arguably, however, Booth only addressed the factual basis for the "guilt" determination in a GBMI plea-taking procedure.[140] In Bazzi and People v. Fultz,[141] the Court of Appeals directly addressed the "mental illness" determination. The defendant in Bazzi challenged the factual basis of the mental illness finding, arguing that the Center for Forensic Psychiatry concluded that he was neither mentally ill nor insane, while two independent examiners concluded that he was insane at the time of the crime.[142] The court rejected this challenge, stating

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136. 318 N.W. 2d at 485.

137. Id.

138. Accord, People v. Seefeld, 95 Mich. App. 197, 290 N.W. 2d 123, 124-25 (1980). But see, People v. Williams, 341 N.W. 2d at 855 (court need not examine reports if defendant fails to assert insanity defense).

139. 318 N.W. 2d at 485.

140. See supra notes 130-135 and accompanying text.

141. 111 Mich. App. 587, 314 N.W. 2d 702 (1981).

142. 318 N.W. 2d at 485-86.

that although none of the examiners concluded that the defendant was mentally ill but not insane, psychiatric evaluations admitted as evidence serve only as an aid to the court.[143] The substance of the psychiatric reports and the defendant's statements at the time of pleading supported the trial court's decision.[144]

The court found the factual basis for a mental illness finding to be insufficient in People v. Fultz, however. Erroneously[145] citing Michigan Compiled Laws section 768.36(1), the court stated that, before accepting a GBMI plea, the trier of fact must find beyond a reasonable doubt that the defendant is guilty, was mentally ill at the time of the crime, and was not insane.[146] The only evidence in the record of the defendant's mental state was the forensic report that said he was insane.[147] The court held that a finding of no insanity was essential and that such a finding was not supported by the record.[148]

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143. Id. at 486.

144. Id.

145. The court was incorrect in citing subsection 768.36(1) because the prerequisites listed in that subsection apply only to a GBMI finding following a trial on the merits. The court should have cited subsection (2), which applies to GBMI pleas and does not require an affirmative finding that the defendant is not insane. The prosecution correctly argued that no finding of sanity is required for a court to accept a GBMI plea. 314 N.W. 2d at 704.

146. Id. at 703.

147. Id. at 704.

148. Id. Contra, People v. Williams, 341 N.W. 2d at 855 (no specific finding of insanity required if defendant does not raise the issue).

2. Burden of Proof

Two decisions have addressed the prosecution's burden to prove a defendant's sanity beyond a reasonable doubt before a GBMI finding may be entered following a trial on the merits.[149] A jury found the defendant in People v. Murphy[150] GBMI of breaking and entering an occupied dwelling with intent to commit a felony and of first-degree criminal sexual conduct. The Michigan Court of Appeals stated that the prosecution improperly introduced evidence regarding the defendant's sanity because a defendant is presumed sane until he introduces contrary evidence and because the prosecution failed to lay a proper foundation for introduction of the evidence.[151] Without this inadmissible evidence, that is, testimony by the arresting police officers that they observed no abnormal behavior during the arrest, the record was devoid of evidence that the defendant was sane.[152] Expert testimony subsequently introduced by both the prosecution and the defense strongly supported an insanity finding.[153] Thus, the court held that the prosecution had failed to meet its burden of proving sanity beyond a reasonable doubt.[154] The Supreme Court of Michigan affirmed.[155] The Court said

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149. People v. Gore, 116 Ill. App. 3d 780, 452 N.E. 2d 583 (1983); People v. Murphy, 100 Mich. App. 413, 299 N.W. 2d 51 (1980), aff'd, 416 Mich. 453, 331 N.W. 2d 152 (1982).

150. 299 N.W. 2d at 52.

151. Id.

152. Id.

153. Id.

154. Id. at 53. See Mich. Comp. Laws §768.36(1)(c) (1982).

155. 331 N.W. 2d 152.

that even if the prosecution's evidence of sanity were admissible, its probative value was insufficient to convince a rational trier of fact that the defendant was sane.[156] The court said that, to some extent, the evidence necessary to prove sanity beyond a reasonable doubt is determined by the strength of the case for insanity.[157] Because of the strong showing of insanity, the police officers' testimony was insufficient.

In People v. Gore,[158] the defendant appealed from the trial judge's finding that he was GBMI of attempted indecent liberties with a child. He asserted that the state failed to rebut his insanity defense beyond a reasonable doubt.[159] The Illinois Court of Appeals concluded that although an expert witness believed a valid insanity defense existed, the trial court was not required to accept this conclusion.[160] The court stated that the trial court's finding of sanity was "not so improbable or unsatisfactory as to create a reasonable doubt of the defendant's sanity."[161]

3. Jury Instructions

Case law on GBMI jury instructions has focused on three questions: (1) when are instructions on the GBMI verdict mandatory or permissible, (2) do GBMI instructions confuse a jury and lead to a

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156. Id. at 153.

157. Id. at 157.

158. 452 N.E. 2d at 585.

159. Id. at 588.

160. Id.

161. Id.

compromise verdict, and (3) may the verdict's dispositional consequences be included in the instructions. The Michigan Court of Appeals has addressed all three questions; the Court of Appeals of New Mexico has addressed the first; the Illinois Appellate Court, First Division, has addressed the second; and the Indiana Court of Appeals, Third District, has addressed the third.

In People v. Girard,[162] the Michigan Court of Appeals observed that whenever a defendant asserts an insanity defense, the trial court at the conclusion of trial must instruct

> ... (1) that the jury is to consider separately the issues of the presence or absence of mental illness and the presence or absence of legal insanity, and (2) on the possible verdicts of guilty, guilty but mentally ill, not guilty by reason of insanity, and not guilty.[163]

In People v. Ritsema,[164] the trial court granted the defendant's request that the GBMI instruction be omitted. The Michigan Court of Appeals held that whenever the evidence supports an instruction on the insanity defense the relevant statute made the GBMI instruction mandatory and thus not subject to waiver by the defendant.[165] The court said, however, that retrial was unnecessary to remedy the trial court's error. It reasoned that the only prejudice suffered by the guilty defendant was in not being entitled to the mental health evaluation and treatment

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162. 96 Mich. App. 594, 293 N.W. 3d 639 (1980).

163. Id., 293 N.W. 2d at 641 (citing Mich. Comp. Laws §768.29a(2) (1982)). See also, People v. Mikulin, 84 Mich. App. 705, 270 N.W. 2d 500, 501-502 (1978) (GBMI instruction required whenever an NGRI instruction is warranted by the evidence).

164. 105 Mich. App. 602, 307 N.W. 2d 380 (1981).

165. Id., 307 N.W. 2d at 385. Accord, People v. Thomas, 96 Mich. App. 210, 292 N.W. 2d 523, 527 (1980).

required after a GBMI verdict.[166] To eliminate this prejudice the court amended the defendant's sentence to require evaluation and psychiatrically indicated treatment.[167]

The Court of Appeals of New Mexico has addressed the narrow issue of whether a GBMI instruction may be given in the absence of an NGRI instruction.[168] The relevant statute provides that when a defendant has asserted an insanity defense, the court should instruct the jury regarding the GBMI verdict if such an instruction is warranted by the evidence.[169] The court interpreted this provsion as not precluding such an instruction if, although the defendant did not plead insanity, he did request an instruction on his ability to form the requisite mens rea.[170]

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166. Ritsema, 307 N.W. 2d at 385.

167. Id. In a later decision, People v. Gasco, 119 Mich. App. 143, 326 N.W. 2d 397 (1982) (per curiam), the Michigan Court of Appeals criticized its own decision in Ritsema that the error did not require reversal. With minimal discussion, the court said that the Ritsema decision was "unsound." Id. at 399. In Gasco, the court reversed a guilty finding, stating that the trial court's erronious instruction on the definition of "sanity" left the jury with discretion to find the defendant either guilty or GBMI. Id. "Thus, the guilty verdict [did] not preclude the possibility that the jury thought the defendant was mentally ill." Id. It is unclear on the face of the Gasco opinion why the error in the instruction resulted in this discretion or why the Ritsema remedy was unsound.

168. State v. Page,___ N.M.___, 676 P. 2d 1353 (1984).

169. N.M. Stat. Ann. §31-9-3E (Cum. Supp. 1983).

170. 676 P. 2d at 1356.

The issue of juror confusion has been addressed in three Michigan cases[171] and one Illinois case.[172] People v. Thomas[173] is illustrative. The defendant in this case argued that the trial court erroneously instructed the jury on the GBMI verdict because it "unconstitutionally confuses the jury in its resolution of the issue of criminal responsibility and encourages a compromise verdict."[174] The Court of Appeals noted that statute required the instruction and that the trial court complied with the statute by giving the standard Criminal Jury Instructions 7:8:01 and 7:8:09, which offered sufficient guidance to the jury.[175] The court found no evidence that the jury was misled.[176]

Whether a court may instruct a jury regarding the consequences of a GBMI verdict was addressed in Indiana in Stader v. State.[177] The defendant alleged that the trial court erred by refusing jury instructions on the consequences of a GBMI or NGRI verdict.[178] The Court of Appeals held that no error had occurred.[179] As a general rule, "it is erroneous to inform the jury of the possible penalties which

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171. People v. Delaughter, 124 Mich. App. 356, 335 N.W. 2d 37 (1983); People v. Thomas, 96 Mich. App. 210, 292 N.W. 2d 523 (1980); People v. Sorna, 88 Mich. App. 351, 276 N.W. 2d 892 (1979).

172. People v. Dewit, No. 81-3019 (Ill. App. Ct. March 30, 1984). See supra notes 104a-104f and accompanying text.

173. 96 Mich. App. 210, 292 N.W. 2d 523 (1980).

174. Id., 292 N.W. 2d at 527.

175. Id.

176. Id

177. __Ind. App.__, 453 N.E. 2d 1032 (1983).

178. Id., 453 N.E. 2d at 1035-36.

179. Id. at 1036.

may be imposed upon conviction."[180] A trial court has discretion, however, to instruct a jury on the consequences of a verdict if it deems it necessary.[181] Such an instruction is mandatory if "an erroneous view of the applicable laws becomes implanted in the minds of jurors."[182] In applying these rules, the court stated that the jury had not been presented with an erroneous statement of the law and it was within the trial court's discretion to refuse the instruction.[183]

In a Michigan case,[184] the trial court sua sponte instructed the jury regarding the possible dispositions after GBMI and NGRI verdicts.[185] The defendant failed to make a timely objection to the instruction. Therefore, the Court of Appeals said it would only reverse to prevent manifest injustice.[186] Under these circumstances, the court said the instruction was proper, adopting the rationale of Lyles v. United States.[187] In Lyles, the United States Court of Appeals for the District of Columbia distinguished guilty verdict instructions, which could not include dispositional information, from NGRI instructions, which could.[188] The court said:

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180. Id. (citing State v. Williams, __Ind.__, 430 N.E. 2d 756 (1982)).

181. Id. (citing Montague v. State, 266 Ind. 51, 360 N.E. 2d 181 (1977); Lockridge v. State, 263 Ind. 678, 338 N.E. 2d 275 (1975)).

182. Id. (citing Dipert v. State, 259 Ind. 260, 286 N.E. 2d 405 (1972)).

183. Id.

184. People v. Tenbrink, 93 Mich. App. 326, 287 N.W. 2d 223 (1979).

185. Id., 287 N.W. 2d at 224.

186. Id.

187. 254 F. 2d 725 (D.C. Cir. 1957).

188. Id. at 728-29 (cited in Tenbrink, 287 N.W. 2d at 224).

> Jurors, in common with people in general, are aware of the meanings of verdicts of guilty and not guilty. It is common knowledge that a verdict of not guilty means the prisoner goes free and that a verdict of guilty means that he is subject to such punishment as the court may impose. But a verdict of not guilty by reason of insanity has no such commonly understood meaning. ... We think the jury has a right to know the meaning of this possible verdict as accurately as it knows by common knowledge the meaning of the other two possible verdicts.[189]

The Michigan Court of Appeals concluded that this rationale applied equally to NGRI and GBMI dispositional instructions and that, absent timely objection by defense counsel, the instructions were proper.[190] The court did not suggest whether its decision would have been different had defense counsel objected to the instructions.

4. Inconsistent Verdicts

Another issue the Michigan Court of Appeals has addressed is the appropriate remedy for two legally inconsistent verdicts reached by a jury. In People v. Philpot,[191] the jury found the defendant guilty of assault with intent to murder and GBMI of possession of a firearm in the commission of a felony.[192] The court held that the inconsistency should be remedied by adding the "but mentally ill" language to the assault conviction with leave to the prosecution to seek a new trial on the assault charge.[193] It reasoned that a legislative intent of the

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189. Id.

190. 287 N.W. 2d at 224-25.

191. 98 Mich. App. 257, 296 N.W. 2d 229 (1980).

192. 296 N.W. 2d at 230-31.

193. Id. at 231.

GBMI statute was to provide help to defendants who have committed crimes while suffering from mental illness and that the present defendant could benefit from treatment beyond the relatively short sentence imposed for the firearm conviction.[194] Judge Riley dissented on this point, stating that the "fact that the evaluation and treatment triggered by such a finding would be beneficial to the accused is irrelevant. We should not substitute our judgment of what is 'best' for the defendant for that of the jury."[195] Normally, he stated, he would advocate vacating of the firearm conviction but, because the relevant sentence was nearly expired, such action was unnecessary.[196] In a more recent case,[197] the court followed the Philpot majority opinion, but chose not to correct similarly inconsistent verdicts because the resulting sentences were co-extensive and treatment would be provided throughout their term.[198]

Thus, inconsistent guilty and GBMI verdicts have not troubled the courts. The courts have not yet decided, however, whether inconsistent NGRI and GBMI verdicts would be so easily handled. The Alaska statute provides that if a defendant is found NGRI because reasonable doubt exists regarding the requisite mens rea, yet all other elements of the offense are staisfied, the defendant should automatically

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194. Id. at 230-31.

195. Id. at 232 (concurring in part, dissenting in part).

196. Id.

197. People v. Blue, 114 Mich. App. 137, 318 N.W. 2d 448 (1982).

198. Id., 318 N.W. 2d at 499-500.

be found GBMI of any lesser included offense.[199] No other states have a similar provision. Even the Alaska provision does not govern if NGRI and GBMI verdicts are returned on separate counts.

5. Right to Treatment

Although allegations based upon lack of adequate treatment have been rejected as a basis for constitutional attack on GBMI statutes,[200] several courts have recognized a qualified statutory right to treatment. For example, the Supreme Court of Michigan has recognized an "unequivocal statutory right" to such treatment as is psychiatrically indicated for mental illness or retardation.[201] Specifically, the GBMI statute requires treatment, but only when indicated by mental health screening and evaluation performed by correctional officials.[202] No court, however, has yet overturned a GBMI conviction of, or provided post-conviction relief to, a defendant asserting that he or she has

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199. Alaska Stat. §12.47.020(c) (Cum. Supp. 1983). Upon completion of the sentence for the lesser included offense, a hearing is held to determine if, based on the acquittal for the greater offense, further commitment is necessary. Id.

200. People v. Marshall, 114 Ill. App. 3d 217, 448 N.E. 2d 969, 980 (1983) (GBMI inmates have no separate constitutional right to mental health treatment beyond the constitutional right to minimally adequate medical care applicable to all prisoners); People v. McLeod, 407 Mich. 632, 288 N.W. 2d 909, 915 (1980) ("Department of Corrections noncompliance with the statutory mandate for evaluation and treatment cannot render an otherwise constitutional statute unconstitutional.").

201. McLeod, 288 N.W. 2d at 914. See also, People v. Philpot, 98 Mich. App. 257, 296 N.W. 2d 229, 230 (1980).

202. Id. See also, People v. Kaeding, __ Ill. __, 456 N.E. 2d 11, 15-16 (1983); Marshall, 448 N.E. 2d at 979-80. Cf. People v. Sharif, 87 Mich. app. 196, 274 N.W. 2d 17, 19 (1978) (trial court disclaimed authority to assure that department of corrections would evaluate and treat defendant and stated it could only recommend such treatment).

received no treatment. In People v. Tenbrink,[203] the defendant contended that if the Department of Corrections is unable to provide the required psychiatric care in a particular case, the conviction is rendered invalid and must be reversed. The Michigan Court of Appeals disagreed.[204] The court said that a writ of mandamus to enforce the Department of Corrections' duty was the proper remedy, not a reversal of the conviction.[205]

In Stader v. State,[206] the Indiana Court of Appeals similarly found that lack of treatment was relevant not to "the legality of ... incarceration but merely the conditions of ... detention"[207] and, accordingly, was not properly raised as an issue on direct appeal. The court went slightly beyond the Michigan Court of Appeals finding in Tenbrink, however, by saying that an inmate may challenge the conditions of custody by not only a petition for writ of mandamus but also a civil rights action under 42 U.S.C. §1983.[208] Taken altogether, these decisions suggest the limited nature of the statutory right to treatment afforded to GBMI offenders.

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203. 93 Mich. App. 326, 287 N.W. 2d 223, 225 (1979).

204. Id.

205. Id. Accord, People v. Siebers, ___ Mich. App. ___, 341 N.W. 2d 530, 532 (1983); People v. Toner, 125 Mich. App. 439, 439, ___ N.W. 2d ___ (1983); People v. Tenbrink, 93 Mich. App. 326, 287 N.W. 2d 223, 225 (1980); People v. Willsie, 96 Mich. App. 350, 292 N.W. 2d 145, 147 (1980); People v. Sorna, 88 Mich. App. 351, 276 N.W. 2d 892, 897 (1979).

206. ___Ind. App.___, 453 N.E. 2d 1032 (1983).

207. Id., 453 N.E. 2d at 1036.

208. Id.

A potentially significant challenge to the application of the right to receive "such treatment as is psychiatrically indicated" is currently pending in Michigan.[209] In Gorton v. Johnson, the plaintiffs alleged

> ... that all persons who have been convicted under the GBMI statute have not been provided treatment that is "psychiatrically indicated," because the Department of Corrections lacks the resources to provide any psychiatric treatment whatsoever to any prisoners other than those who present the most extreme disciplinary problems.[210]

The plaintiffs are GBMI inmates who sought class certification under Federal Rule of Procedure 23(b)(2).[211] The defendants, the Department of Corrections and its director, among others, argued that class certification was improper because each inmate presents unique treatment problems and the court would be unable to fashion an equitable remedy applicable to all members of the class.[212] The United States District Court for the Eastern District of Michigan granted the plaintiff's motion for class certification, but only as "to those issues of institutional policy, practice, process, and procedure that are 'generally applicable' to all members of the proposed class," and not as to actual acts of evaluation and treatment that are a function of individual disorders.[213] Specifically, the court can

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209. See Gorton v. Johnson, Civ. No. 82-60422, slip op. (E.D. Mich. Feb. 16, 1984).

210. Id.

211. Id.

212. Id.

213. Id.

> ... determine whether the Department of Corrections, as a threshold matter, has instituted policies which render the provision of psychiatrically indicated treatment impossible, regardless of the particular needs and problems of the individual class members and whether the defendants have policies, practices, processes, and procedures to evaluate and provide psychiatrically indicated treatment.[214]

Gorton v. Johnson is the first reported class action suit challenging any facet of a GBMI statute's application.

6. Probation

In People v. McLeod,[215] the defendant's final challenge to Michigan's GBMI statute addressed the probation provision, which reads, in part:

> The period of probation shall not be for less than 5 years and shall not be shortened without receipt and consideration of a forensic psychiatric report by the sentencing court.[216]

The defendant argued that the five-year minimum period of probation denied GBMI offenders equal protection by adversely affecting their fundamental liberty interests vis-a-vis defendants found guilty of the same offenses, without a compelling state interest for the differing treatment.[217] As discussed earlier,[218] the Michigan Court of Appeals found no fundamental right or suspect classification that would require

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214. Id.

215. 407 Mich. 632, 288 N.W. 2d 632 (1980)

216. Mich. Comp. Laws §768.36(4) (1982).

217. McLeod, 288 N.W. 2d at 916.

218. See supra notes 85-89 and accompanying text.

strict scrutiny of the provision.[219] The court noted that the statute authorized a sentencing court to discontinue probation on the defendant's motion when the treatment is no longer needed,[220] thus, creating a "rebuttable five-year period" of probation.[221] The court upheld the provision as rationally furthering the legislative objective of providing supervised mental health treatment for GBMI probationers.[222]

7. Conclusion

The various challenges waged against GBMI statutes since 1977 -- substantive, procedural, and constitutional -- have resulted in the judiciary approving and preserving the legislative purposes of providing treatment to mentally disturbed offenders and of protecting the public from mentally disturbed and dangerous offenders. During this testing period, the courts have had little negative to say about the GBMI statutes. In concluding that the statutes rationally further proper legislative objectives, the courts have not looked beyond the verdict to see if GBMI offenders actually receive beneficial mental health treatment. In the near future, such concerns may be addressed in writ of mandamus or civil rights proceedings arising in the various states. Empirical research may provide another forum for more comprehensive analysis of such concerns.

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219. 288 N.W. 2d at 919.

220. Id. at 918.

221. Id. at 919.

222. Id.

IV. SOCIAL SCIENCE RESEARCH

> Whether a measure relating to the public welfare is arbitrary or unreasonable, whether it has no substantial relationship to the end proposed is obviously not to be determined by assumptions or by a priori reasoning. The judgement should be based upon a consideration of relevant facts, actual or possible --ex facto jus oritur. That ancient rule must prevail in order that we may have a system of living law.[223]

The previous sections of this article summarized the legislative and judicial development of the GBMI plea and verdict. Legislative and judicial mandates for legal and policy reform are distinguishable from the impact on practice that results.[224] This article would be incomplete without a look beyond legislative and judicial directives to the practical consequences that follow. The GBMI plea and verdict's actual implementation and effects on individuals and criminal justice system components have not been examined extensively. Legal reform, informed public policy, and practice should depend, at least in part, on the results of scientific research.[225] Whether the GBMI plea and

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223. Adams v. Tanner, 244 U.S. 590, 600 (1917) (Brandeis, J., dissenting).

224. See Lottman, Enforcement of Judicial Decrees: Now Comes the Hard Part, 1 Mental Disability L. Rep. 69 (1976); Lottman, Whatever Happened to Kenneth Donaldson?, 1 Mental Disability L. Rep. 288 (1977); Shah, Legal and Mental Health System Interactions: Major Developments and Research Needs, 4 Inter. J. of L. and Psych. 219, 255-256 (1981) ("[A]s important as reforms in legal policies (viz., the "law on the books") certainly are, these accomplishments must not be confused with the end result (viz., the "law in practice"). It is therefore essential that a wide range of evaluative research efforts be undertaken to ascertain the outcomes stemming from various policy and programmatic changes.")

225. Shuman, Decisionmaking Under Conditions of Uncertainty, 67 Judicature 326 (1984).

verdict have undercut the insanity defense, facilitated the provision of mental health treatment to mentally disturbed offenders, offered juries an equitable alternative to NGRI and guilty verdicts, and served the interest of societal protection remain to be empirically examined. The purposes of this section are to examine the limited empirical research in this area and to place the GBMI plea and verdict in an appropriate framework for scientific inquiry.

A. Curtailment of the Insanity Defense

The major purpose of the GBMI plea and verdict appears to be to curtail use of the insanity defense.[226] To date, attempts to appraise whether the GBMI plea and verdict have accomplished this purpose have centered primarily on Michigan's nine-year experience. Ames Robey, a psychiatrist who was one of the original drafters of Michigan's GBMI statutes,[227] stated three years after passage of the new law that the "dire predictions by some lawyers that the NGRI acquittal would fall into disuse have not been borne out."[228] Although Robey provided only sketchy data to support his conclusions, he stated that after the Michigan law took effect the number of referrals for criminal responsibility evaluations at the Forensic Center actually jumped

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226. See supra notes 24-33 and accompanying text.

227. Robey, supra note 6, at 374, 375.

228. Id. at 380.

dramatically,[229] the rate of NGRI acquittals dropped,[230] and the percentage of defendants found civilly committable rose.[231]

Other Michigan researchers suggest that the proportion of defendants found NGRI following insanity pleas in Michigan remained relatively stable following the introduction of the GBMI plea and verdict in 1975.[232] Criss and Racine, researchers at the Center for Forensic Psychiatry, found that between 1976 and 1979 the proportion of defendants who were examined for criminal responsibility at the Center and were subsequently acquitted by reason of insanity ranged from 6.6% (N=49) in 1978 to 8.6% (N=48) in 1977 (mean = 8.1%).[233] Criss and Racine were unable to collect reliable comparative data for the period before the law's enactment. Based on more current data, Smith and Hall reported a

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229. "In 1974, before the law was passed, there were 49 evaluations for criminal responsibility performed at the Forensic Center. After the law took effect, in the remaining five months of 1975, there were 93 such referrals. By June 1, 1978, after the law had been extant for less than three years, a similar five-month period had 271 referrals, for an average of over 50 per month." Id.

230. Robey stated that he knew of 21 cases in which GBMI pleas were offered and accepted "in lieu of almost certain NGRI veridicts." Id. at 379-380.

231. Id. at 380.

232. Criss & Racine, Impact of Change in Legal Standard for Those Adjudicated Not Guilty by Reason of Insanity 1975-1979, 8 Bull. Am. Acad. Psych. & L. 261, 265 (1979); Smith & Hall, supra note 10, at 93; S.C. Bank, In Defense of GBMI, Presentation at the Convention of the American Psychology-Law Society, Chicago (October 6-8, 1983).

233. Criss & Racine, id. at 264-265. Of the 2,389 individuals evaluated by the Forensic Center between 1974 and 1979, 223 (8.1%) were subsequently found NGRI.

range of 5.0% (N=54) in 1981 to 8.4% (N=47) in 1977 (mean = 6.7%) between 1976 and 1982.[234] These findings suggest that the availability of the GBMI plea and verdict does not necessarily result in fewer NGRI acquittals.

Two points might be considered in interpreting these findings. First, Smith and Hall and, to a lesser extent, Criss and Racine based their conclusions regarding the GBMI law's effect on the incidence of NGRI acquittals on proportional comparisons based on arrests. Recognizing that comparisons of raw numbers of GBMI findings and NGRI acquittals may be misleading,[235] Smith and Hall determined the percentages of defendants found NGRI out of the total number of arrests in Michigan.[236] From 1972 to 1982, the percentage of adult males arrested who were ultimately found NGRI ranged from 0.012% in 1976 to 0.035%.[237] Similarly, Criss and Racine based some of their conclusions about the frequency of NGRI acquittals in Michigan on proportional comparisons of NGRI acquittals and arrests for index offenses.[238] For example, they state that only 0.11% of all individuals arrested in Michigan for index offenses raised the insanity defense.[239] This comparison excludes at least 15.7% of the 223 NGRI acquittees in their

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234. Smith & Hall, supra note 10, at 93.

235. Id. at 92 n.66.

236. Id. at Appendix A, Table A.

237. Id.

238. Criss & Racine, supra note 232, at 264-266. Murder, rape, robbery, aggravated assault, breaking and entering, larceny, and auto theft are index offenses. Id. at 271 n.13.

239. Id. at 264.

study population who were acquitted of charges that were not index offenses.[240]

Arrest figures may not be the most appropriate base for calculating such percentages in studies of the NGRI or GBMI verdict. Many arrests do not result in prosecutions for a variety of reasons. For example, the arresting agency may not file formal charges or the prosecuting attorney may decide not to pursue the case. Research on the use of the insanity defense and related alternatives should examine outcomes of court processing, which are several steps removed from law enforcement activities. Future research in this area might use criminal filings and dispositions as a more appropriate base of comparison.

A second, perhaps more important, consideration in evaluating the research on the effect of the GBMI laws on the incidence of NGRI aquittals is that it is preliminary. Although this formative research is valuable, further study of the GBMI plea and verdict's effects on NGRI acquittals requires a more complex form of analysis. It is possible, for example, that an apparent decrease in the proportion of NGRI acquittals may be due to other events that occurred more or less simultaneously with the enactment of GBMI legislation. The strength of a researcher's conclusions depends on whether the researcher was aware of such rival phenomena and was able to discount competing hypotheses.[241] Observers have noted the potential confounding effects of certain legislative changes that accompanied the introduction of the GBMI plea and verdict in Michigan. These included new definitions of mental illness and insanity, a procedural timeline for defendants wishing to plead insanity, and new

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240. See id. at 265, Table 3.

241. See D.T. Campbell & J. Stanley, Experimental and Quasi-Experimental Design for Research (1966).

guidelines for short-term detention and release of insanity acquittees.[242] Packer noted that the 1975 Michigan statutory revisions also mandated that the Center for Forensic Psychiatry act as the state's centralized facility for conducting forensic evaluations.[243] Future research should explore the possibility that such changes occurring with the enactment of GBMI laws increase or decrease the proportion of defendants found NGRI or change the types of individuals acquitted on the basis of insanity apart from effects caused by the availability of the GBMI finding.

The confounding effect of events proceeding the enactment of GBMI laws should also be considered. Once again, an example from Michigan is instructive. After the United States Supreme Court's decision in Dusky v. United States[244] and subsequent lower court decisions challenging the extended commitment of defendants found incompetent to stand trial, Michigan enacted statutes[245] that clarified the relevant NGRI criteria and revised the NGRI release provisions.[246] As a result, hundreds of individuals previously found incompetent to stand trial were returned to the Michigan courts for disposition of their cases. According to Robey, these changes caused NGRI verdicts to increase from only 12 in 1967 to 203 by mid-1973.[247] A study of the

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242. See Comment, supra note 21, at 458 n.40 & 471; R.C. Petrella, Guilty But Mentally Ill--A Negative View, Presentation at the Convention of the American Psychology-Law Society, Chicago (October 6-8, 1983).

243. I.K. Packer, Guilty But Mentally Ill in Michigan, Its History and Practice, Presentation at the Convention of the American Psychology-Law Society, Chicago (October 6-8, 1983).

244. 362 U.S. 402 (1960).

245. Michigan Public Acts 175 and 266 (1966).

246. See Robey, supra note 6, at 374-375.

247. Id. at 374.

effects of the GBMI plea and verdict on the insanity defense that includes comparisons of NGRI findings before and after GBMI enactment should take this type of increase in the NGRI population into account.

To understand the effects of definitional and procedural changes on NGRI and GBMI findings, a comprehensive study design is essential. At a minimum, the task of identifying competing hypotheses should encompass a review of pertinent court rulings, statutory changes, and organizational and administrative changes. The methodology should be designed to measure systemic effects and alternative explanations should be addressed, recognizing that potentially confounding variables or factors affecting generalizability will differ among states. For example, as noted previously, the effect of the GBMI plea and verdict on insanity acquittals in Michigan may be related significantly to the centralized evaluation responsibilities of the Center for Forensic Psychiatry.[248]

B. Displacement

To further test the conclusion that the GBMI laws did not undercut the insanity defense, which was contrary to the expectations of legislators who supported the GBMI laws,[249] Smith and Hall questioned whether defendants adjudicated GBMI would have been found NGRI or guilty if the GBMI finding had been unavailable.[250] In the absence of the

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248. See Smith & Hall, supra note 10, at 104; Petrella, supra note 242, at 2.

249. Supra notes 24-29 and accompanying text.

250. See Smith & Hall, supra, note 10, at 95-100. This question was also posed in a very recent study of simulated juror decision making; see infra notes 287-289 and accompanying text.

GBMI finding, all defendants would receive one of three traditional findings: guilty, not guilty, or NGRI. The addition of the GBMI finding necessarily displaces some defendants from one or more of these finding categories. If the GBMI laws reduce the incidence of NGRI acquittals, displacement of defendants from the NGRI category would occur. On the other hand, if the GBMI finding has little or no effect on NGRI findings, one would expect displacement from the guilty group instead.

Smith and Hall attempted to answer this displacement question by comparing samples of GBMI, NGRI, and guilty offenders in Michigan on the basis of selected demographic variables. The results of their discriminant analysis indicated that the GBMI group more closely resembled the guilty group on six variables (drug use, previous psychiatric treatment, criminal history, sexual offenses, employment status, and education) and the NGRI group on two variables (age and prior referrals for forensic evaluation). Smith and Hall cautiously concluded that "the majority of GBMI defendants were more similar to the guilty group than the NGRI group. It is likely that at least a majority of the GBMI defendants would have been found guilty in the absence of the GBMI statute."[251]

Several technical questions can be raised about the methodology Smith and Hall used to reach this conclusion. First, Smith and Hall measured only the type of drug use, not the extent and duration of use.[252] Data on the type of drug use is more useful than no

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251. Smith & Hall, supra note 10, at 100.

252. See Id. at 96 n.93 & Appendix A, Table I.

information at all; however, grouping occasional users of hallucinogens, for example, with daily users may result in misleading comparisons. Occasional drug users may be very different psychologically (and in other ways) from habitual users. Whether GBMI offenders more closely resemble NGRI acquittees or guilty offenders when compared on extent and duration of drug use remains to be seen.

Second, Smith and Hall operationalized previous psychiatric contacts and prior criminal history by counting the number of contacts and charges.[253] They did not differentiate the types of psychiatric contacts (e.g., voluntary or involuntary; outpatient or inpatient) or the charges that resulted in convictions. Important differences may exist between someone who voluntarily sought family counseling at a community mental health center on two occasions and someone who was involuntarily committed as dangerous to himself or others. The number of previous criminal charges filed should be used and interpreted carefully, realizing that, as noted previously, charges often do not result in convictions.[254] Further, it might be enlightening to explore more fully the effect of the seriousness of prior criminal activity because, in Smith and Hall's scheme, offenders with three auto theft charges could be grouped with those with one prior manslaughter charge.[255]

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253. Id. at Appendix A, Tables H, J & K.

254. Data collected from corrections files, at least that on prior felony convictions for which commitment occurred, might offer a useful, more direct measure of official criminal history, especially if supplemented by misdemeanor conviction and probation records.

255. See infra notes 287-289 and accompanying text.

Third, questions arise from the discriminant analysis Smith and Hall used to address the displacement issue. The variables and the analytical steps employed in their analysis may not fulfill the underlying assumptions and requirements of the technique. For example, Smith and Hall describe initial bivariate analyses[256] yet do not indicate that further analyses, such as an examination for spuriousness or intercorrelation among variables, were conducted prior to the discriminant analysis. Further, discriminant analysis is a statistical technique for analyzing interval level data.

Typically, analysts using the technique can make adjustments that provide reliable results when discrete data are used.[257] Smith and Hall describe no such adjustments in their analysis.[258]

Smith and Hall did note that their displacement analysis might be suspect if the post-GBMI population of NGRI acquittees were different from the pre-GBMI population.[259] Relying upon earlier research, however, Smith and Hall presumed that defendants acquitted on the basis of insanity between 1975 and 1979 were "quite similar" to those acquitted between 1967 and 1972.[260] Our examination of the data produced by that earlier research, particularly that of Cooke and Sikorski,[261]

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256. It is assumed that a chi square test was used.

257. See W. Goldstein & W.R. Dillon, Discrete Discriminant Analysis (1978); W. Klecker, Discriminant Analysis (1980).

258. See supra note 10, at 96-100.

259. Smith & Hall, supra note 10, at 96 n.98.

260. Id.

261. Cooke & Sikorski, Factors Affecting Length of Hospitalization in Persons Adjudicated Not Guilty by Reason of Insanity, 2 Bull. Am. Acad. Psych. & L. 251 (1975).

reveals that the study populations did differ in several significant ways.[262]

If the GBMI laws have displaced NGRI defendants, one might expect a change in the NGRI population as a result. Comparison of the data presented by Cooke and Sikorski,[263] and Criss and Racine[264] suggest that at least some of the less seriously disturbed and more

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262. See Criss & Racine, supra note 232, at 263-68; Cooke & Sikorski; supra note 261, at 252-59.

	Cooke and Sikorski (1967- 1972)	Criss and Racine (1975-1979)	Comments
1)	32.3% of the NGRI population was black	44.8% of the NGRI population was black	The 13.9% decrease amongst blacks reported by Criss and Racine apparently resulted from subtracting percentages across populations rather than calculating a percentage change.
2)	45.5% had prior psychiatric hospitalizations	65.9% had previous psychiatric hospitalizations	
3)	59.9% were acquitted of murder	29.6% were acquitted of murder	Suggests that use of the insanity defense broadened. Also, women comprised 15% of Criss and Racine's study population yet 30% of the murderers.
4)	24.5% diagnosed as personality disordered	21.8% diagnosed as personality disordered	The aggregate data mask that acquittees with personality disorder diagnoses decreased from 43.8% in 1975 to 12.2% in 1979.

263. Supra note 261, at 253-54.

264. Supra note 238, at 265, 268-69.

violent offenders may have been screened out of the NGRI population as a result of the availability of the GBMI alternative in Michigan. In addition, changes may have occurred in the racial composition and mental health diagnoses.[265]

The design of additional research in this area would be strengthened by incorporating psychiatric diagnosis as an independent variable and by including pre- and post-GBMI groups for purposes of comparison. The displacement question highlights, once again, the need to examine competing explanations of observed effects.

In summary, Smith and Hall's Michigan data suggest that the GBMI laws have not displaced offenders as proponents expected. However, such data is formative, not necessarily conclusive. Conclusions based on data from Michigan may not generalize to other states. Also, statistical questions about the data analysis may require replication of the findings. Finally, a more complex, comprehensive research design is necessary to consider and possibly refute competing hypotheses.

C. Effect on the Criminal Justice Process

Although a major purpose of GBMI legislation appears to be to protect society by incarcerating defendants who might otherwise be released following NGRI findings, proponents of such legislation also intended that the GBMI plea and verdict simplify criminal proceedings. For example, supporters of GBMI legislation suggested that it would

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265. See supra note 262.

greatly simplify jury deliberations.[266] This section explores the limited research regarding whether the GBMI plea and verdict simplifies criminal proceedings and poses questions that might be addressed in future research.

1. Plea Bargaining

Plea bargaining may result in a GBMI plea if an insanity acquittal appears unlikely.[267] A defendant may agree to a GBMI plea because he or she expects mental treatment or believes that a GBMI finding offers more advantageous sentencing than a guilty finding.[268] Whether such expectations are reasonable remains to be tested.

Based on a limited survey of attorneys that had handled GBMI cases,[269] Smith and Hall found that 61% (N=36) of GBMI findings in Michigan were obtained through plea bargains.[270] Because many criminal cases are resolved regularly through plea bargaining, this finding is not surprising. That such a large proportion of GBMI findings result from pleas, however, appears to be unintended because the GBMI literature suggests that legislators intended to provide juries, rather than judges,

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266. See Michigan House Legislative Analysis Section, Third Analysis of Mich. H.B. 4363, 78th Leg., July 18, 1975; see also Note, supra note 21, at 492; Robey, supra note 6, at 378.

267. Stelzner & Piatt, supra note 21, at 101; Robey, supra note 266, at 379-80.

268. Id.; Petrella, supra note 242, at 4-5.

269. Smith & Hall, supra note 10, at 93 n.73.

270. Id. at 94 & Appendix A, Table C.

with an alternative.[271] The role of plea bargaining in obtaining a GBMI finding should be examined systematically, including the frequency with which such bargaining occurs and that effect it has on sentencing.

2. Involvement of Psychiatric Experts

The widespread use of psychiatrists and psychologists as expert witnesses and the often confusing, technical nature of their testimony have spawned much opposition to the insanity defense. Criticism has focused on two major concerns: (1) the imprecise methods upon which such testimony is based and (2) the perceived tendency of mental health experts to usurp the function of the judge or jury by providing conclusory opinions.[271]

One purpose of GBMI legislation is to rectify these problems by reducing the involvement of mental health experts. Bank suggested that the availability of the GBMI verdict might serve to ease the pressure on psychiatrists to inappropriately force mental health diagnoses into strict legal categories.[272] Hermann and Sor have suggested, however, that instead of reducing the involvement of psychiatric experts in such cases, the addition of the GBMI verdict not only requires the continued use of experts but expands their involvement.[273]

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271. Id. at 94.

271. Keilitz & Fulton, supra note 22, at 27-8.

272. Bank, supra note 232, at 4.

273. Herman & Sor, Convicting or Confining Alternative Directions in Insanity Law Reform: Guilty But Mentally Ill versus New Rules for Release of Insanity Acquitties, __ B.Y.U.L. Rev. __ (in press 1984).

Smith and Hall surveyed 36 attorneys who represented defendants found GBMI and 38 attorneys who represented defendants found NGRI and concluded that mental health experts were significantly involved in both NGRI and GBMI cases in Michigan. More specifically, their findings indicate that NGRI defendants may rely more upon expert testimony in bench trials than do GBMI defendants and that "both NGRI and GBMI defendants rely heavily upon testimony from private psychiatrists in the absence of Forensic Center testimony."[274]

Methodological limitations restrict the generalizability of Smith and Hall's findings, however. Their attorney samples were small; the testimony's effect on the verdict was not assessed (instead, the effect of the Forensic Center's pretrial evaluation recommendations were analyzed); the sample of attorneys was skewed because no attorney who unsuccessfully represented his or her client was included[275] and, consequently, no data were presented on the use of expert testimony in cases in which defendants were found guilty after raising the insanity defense.

In sum, although Smith and Hall assessed the influence of Michigan's Center for Forensic Psychiatry, they shed little light on the GBMI plea and verdict's impact on the involvement of mental health experts in general. To determine whether the use of mental health experts has decreased as a result of GBMI legislation, pre- and post-GBMI comparisons need to be made. After this determination is made, the effect of such involvement on the finding, treatment, and length of confinement in GBMI cases will remain to be examined.

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274. Smith & Hall, supra note 10, at 95; see also id. at Appendix A, Table D.

275. Id. at 93 n.73.

3. Bench versus Jury Trials

A secondary purpose of the GBMI verdict is to simplify jury deliberations.[276] Smith and Hall, again, provide the only published findings in this area. Their data, which are based on the survey responses of 74 defense attorneys, provide information on the case outcomes (GBMI or NGRI) by method of adjudication (plea, bench trial, or jury trial). Smith and Hall concluded that "defendants found GBMI after trial were evenly divided between bench and jury trials."[277] Of course, whether juries tend to find defendants GBMI rather than NGRI cannot be determined simply by counting the methods of adjudication or comparing raw frequencies of jury outcomes.[278] In an attempt to make such a determination, we conducted a chi square test using Smith and Hall's data. Our calculations[279] indicate that the proportion of

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276. See Smith & Hall, supra note 10, at 84 n.33 & 93; Petrella, supra note 242, at 4.

277. Smith & Hall, supra note 10, at 94.

278. See Herman & Sor, supra note 273.

279. Excluding defendants who pleaded GBMI (we have already addressed the plea bargaining issue and focus here solely on bench and jury trials) and accepting the authors' contention that NGRI acquittals are not reached through plea bargaining, Smith and Hall's data (see Smith & Hall, supra note 10, at Appendix A, Table C) can be presented as follows:

Verdict	Type of Trial: Bench	Jury	
GBMI (N=14)	7 (17%) [50%]	7 (64%) [50%]	[100%]
NGRI (N=38)	34 (83%) [89%]	4 (36%) [11%]	[100%]
	41 (100%)	11 (100%)	

defendants acquitted by reason of insanity in bench trials (89%) was significantly greater than those found GBMI in bench trials (50%). Furthermore, the proportion of defendants that juries determined to be NGRI (11%) is significantly smaller than the proportion of those found GBMI (50%). A statistically significant difference exists in the proportion of individuals found GBMI as opposed to NGRI by type of trial, suggesting a relationship between type of trial and verdict. A larger sample and further analysis examining the effect of other variables on the relationship would be required, however, before drawing conclusions. Smith and Hall's data may support Hermann and Sor's hypothesis that juries tend to find defendants who raise the insanity defense GBMI rather than NGRI.[280]

4. Jury Decision Making

Juries torn between an NGRI verdict, with its perceived threat to public safety, and the standard guilty verdict may view the GBMI

[ ] Indicates row percentages.
( ) Indicates column percentages.
X^2 = 8.863
df = 1
p .01

Correction for continuity was made during calculation due to the small cell sizes. The above table is presented according to the logic of causal relationships among variables to increase interpretative value. As displayed, the data suggest that the type of trial affects the verdict rendered. Conversely, many tables that Smith and Hall presented, id. at 109-113, suggest that the verdict affects age, crime location, prior criminal charges, and so forth; this makes interpretation difficult and ignores the time sequence relevant to possible causal relationships; see E.R. Babbie, The Practice of Social Research 382-387 (1977); H.M. Blalock, Social Statistics (2nd ed. 1979); see also Hermann & Sor, supra note 272, at ___; Stelzner & Piatt, supra note 21, at 110.

280. Hermann & Sor, supra note 272, at ___.

verdict as an attractive compromise.[281] A jury may use the GBMI verdict intentionally when it is unable to reach consensus on whether a NGRI verdict or a GBMI verdict is appropriate, or a jury may use it mistakenly due to confusion about the meaning of the two verdicts.[282]

The potential for "jury compromise" has been discussed by a number of commentators. Several commentators have suggested that instructions to the jury regarding dispositional consequences may contribute to compromise verdicts.[283] According to Fullin and Fosdal, for example, jurors believe that an individual found GBMI will serve a specified sentence in prison but an insanity acquittee may be released depending on the outcome of a post-trial evaluation.[284] Petrella[285] and Hermann and Sor[286] have hypothesized that if jurors believe a defendant found GBMI will receive treatment a GBMI finding is more likely. Therefore, jurors may opt for the GBMI verdict based on the perception that psychiatric treatment will be combined with incarceration. The GBMI verdict is perceived as achieving both objectives by promising treatment and ensuring the defendant's segregation from society.

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281. See Note, supra note 26, at 469; Stelzner & Piatt, supra note 21, at 110.

282. Note, supra note 21, at 469.

283. See id.; Herman & Sor, supra note 272, at ___.

284. F. Fullin & F. Fosdal, Guilty But Mentally Ill Verdict and Disposition, Memorandum to Insanity Defense Committee, Wisconsin Judicial Council (September 12, 1980).

285. Petrella, supra note 242, at 5.

286. Hermann & Sor, supra note 272, at ___.

In a recent study, Roberts and Golding simulated jurors' decision making by asking 181 undergraduate students attending the University of Illinois to choose among the verdicts of NGRI, guilty, and GBMI in response to 16 vignettes describing the facts and circumstances of a murder case.[287] Each of the vignettes included the same description of a fictitious victim and the circumstances of his life but varied in the description of the defendant's mental disorder and the alleged crime. Three types of mental disorder were represented without diagnostic labels: antisocial personality disorder, schizotypal personality disorder, and paranoid schizophrenia. The alleged crime varied in "bizarreness" (in the bizzare version, the victim's heart is cut out; in the "nonbizarre" version, the victim dies of a stab wound) and "planfulness," two aspects of a crime which Golding and Roberts hypothesized are emphasized by jurors.[288]

To assess the effect of various decisional alternatives on the verdicts reached, students were asked to consider the "facts of the case" presented by the vignettes under two conditions. In Condition I they could choose only between the two traditional verdicts of guilty and NGRI; in Condition II they could choose among guilty, NGRI, and GBMI.

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287. C.F. Roberts & S.L. Golding, An Empirical Analysis of the Attribution of Criminal and Moral Responsibility and the "Guilty But Mentally Ill" Option (1984) (Department of Psychology, University of Illinois: Champaign, Illinois); also reported in C.F. Roberts & S.L. Golding, Insanity, Responsibility, and the Morality of "Guilty But Mentally Ill," Paper delivered during Paper Session, The Insanity Defense: Public Opinion and Public Policy, at the Meeting of the American Psychological Association in Toronto, Canada (August 25, 1984).

288. See Golding & Roberts, supra note 6, at 3; see also supra note 287.

The results of the study indicate that jurors' attribution of criminal responsibility is, not surprisingly, fundamentally related to the severity of a defendant's mental disorder and, in a more complex manner, to aspects of the actus reus. Regardless of whether they had GBMI among their verdict choices, more students judged the schizophrenic defendants NGRI than the defendants with "less severe" mental disorders (i.e., antisocial or schizotypal personalities).[289] Though not unrelated to the mental disorder of the defendant, and depending on whether GBMI was among the verdict options, the students' attribution of criminal responsibility tended to be greater the more the defendant deliberately planned his actions and the more bizarre the crime.

An overwhelming majority of the students (86%) felt that the "GBMI sentencing alternative was moral, just, and an adequate means of providing for the treatment needs of mentally ill offenders."[290] This sentiment was reflected in their verdicts. The students were two-and-a-half times more likely to use the GBMI verdict than either the guilty or NGRI verdict. Those who chose that verdict also tended to be more confident in their choice.[291] The more disordered defendants were more likely to be found GBMI than guilty; and the defendants who committed crimes in a bizarre fashion were more likely to be found GBMI than guilty.[292]

When given the GBMI option in Condition II, the students tended to find GBMI most of those defendants with personality disorders who were

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289. Golding & Roberts, supra note 6, at 11.

290. Id. at 12.

291. Id. at 11-12.

292. Id. at 11.

adjudged guilty in Condition I.[293] This displacement effect is consistent with the results of Smith and Hall's study of actual cases in Michigan.[294] This displacement of guilty verdicts with GBMI verdicts between Condition I and II, however, did not occur in cases involving defendants with severe disorders, "such as in the prototypic insanity vignette where an obvious paranoid schizophrenic individual with delusion related to the victim is combined with a relative lack of planfulness."[295] Ninety-five percent of the students found such a defendant NGRI when GBMI was not a sentencing option available to them; however, when the GBMI option was available only 18% of the students found the same defendant NGRI, while 77% found him GBMI.[296] Hence, GBMI verdicts displaced NGRI findings. Apparently, most of the subjects of Golding and Roberts' study, like Queen Victoria a hundred years ago, considered it just to attribute criminal guilt even to a psychotic defendant whose unplanned offense was caused by a delusional system.[297]

This displacement of NGRI acquittals with GBMI verdicts, although generally consistent with the purposes of GBMI legislation, is in contrast to the data collected in Michigan where NGRI acquittals appear undisturbed by the availability of the GBMI alternative.[298] One

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293. Id. at Figure 3.

294. See supra notes 250-251 and accompanying text.

295. Golding & Roberts, supra note 6, at 12.

296. Id.

297. See infra note 1 and accompanying text.

298. See supra notes 226-234 and accompanying text.

possible explanation of this difference, mentioned by Golding and Roberts,[299] is that the data collected by Smith and Hall in Michigan represented findings reached primarily by bench trials or plea bargains based on mental health evaluations performed by Michigan's Center for Forensic Psychiatry instead of findings reached by students simulating jurors' decision making. Given the relative rarity of NGRI acquittals in Michigan, another explanation for this difference may be that there were few actual NGRI verdicts to displace in Michigan. This also is a plausible explanation for Golding and Robert's failure to find a shift from NGRI to GBMI verdicts in cases involving defendants with personality disorders.[300]

The conclusion reached in what is perhaps the most comprehensive study on jury decision making in insanity cases concluded before enactment of GBMI legislation suggests that the compromise provided by the GBMI verdict is precisely what jurors desire.

> Many of the jurors [studied] felt constrained by the verdict limitations placed upon them by the court. They would like to have a way of easing the choice between acquitting the defendant on grounds of insanity and finding him guilty. The former designation goes further than they want to go in distinguishing the defendant from the ordinary criminal, and the latter allows for no distinction. In many instances the jury would have liked to declare the defendant guilty, but insane. That kind of verdict would permit the jurors to condemn the defendant's behavior ... [and fulfill] ... their desire to commit the defendant to an institution that both punished and treated.[301]

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299. Supra note 6, at 10-11.

300. See Golding & Roberts, supra note 6, at Figure 3.

301. R. Simon, The Jury and the Defense of Insanity 178 (1967).

If jurors base their decisions on public safety concerns and their belief that needed treatment will be provided, instead of on the legal requirements for insanity and nonresponsibility, defendants who qualify for NGRI acquittals may be denied legally appropriate findings.[302] Robey reviewed 57 Michigan GBMI cases, however, and concluded that only two GBMI convicts were improperly denied insanity acquittals because jurors feared possible release following an NGRI finding.[303] Robey does not, however, present the criteria used in his review nor the basis for his conclusion.

In her studies of jury decision making published in 1967, Simon found that instructions regarding the dispositional consequences of an NGRI finding do not significantly affect a jury's choice between NGRI and guilty verdicts.[304] It remains to be seen how this relationship is affected by availability of the GBMI verdict.

5. Sentencing

No data have been reported that focus on the effect a GBMI finding has on the sentence imposed. Wether the adjudication of mental illness as part of a GBMI finding shortens or lengthens an offender's sentence may be answered by comparing the sentences imposed on offenders

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302. See Note, supra note 21, at 471; Herman & Sor, supra note 273, at ___.

303. Robey, supra note 6, at 380.

304. Simon, supra note 301, at 92-93. The validity of this finding has been questioned. See Morris, Bozzetti, Rusk, & Read, Wither Thou Goest? An Inquiry Into Jurors' Perception of the Consequences of a Successful Insanity Defense, 14 San Diego L. Rev. 1058 (1977); Schwartz, Should Juries Be Informed of the Consequences of the Insanity Verdict? 8 J. Psych. & L. 167 (1980).

found GBMI and guilty after raising the insanity defense with the sentences imposed on defendants who did not raise the insanity defense but were convicted of comparable crimes. The results may be similar to those reported by Braff and her colleagues[305] who found that defendants found guilty after entering NGRI pleas received significantly longer sentences than those who had not asserted the defense. Interestingly, defendants who plead NGRI risk a greater chance of being institutionalized regardless of whether their plea is successful than defendants who never enter the plea.[306]

Generally, a sentencing judge may impose any sentence on a GBMI defendant that could be imposed on a guilty defendant.[307] At least one commentator has suggested that the provision of probation following a GBMI finding may offer advantages both to the public and the defendant that an NGRI verdict does not offer.[308] If an NGRI acquittal is likely in a particular case, a prosecutor may wish to offer GBMI conviction and probation with treatment in a plea bargain. A defendant may view such an offer as acceptable because favorable disposition is assured. The public may favor GBMI conviction with probation over NGRI acquittal because of

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305. Braff, Arvanites & Steadman, Detention Patterns of Successful and Unsuccessful Insanity Defendants, 21 Criminology 439 (1983). See also Rodriguez, LeWinn & Perlin, The Insanity Defense Under Siege: Legislative Assaults and Legal Rejoinders, 14 Rutgers L.J. 397, 401-02 (1983).

306. Id. at 446. But cf. Pasewark, Pantle & Steadman, Detention and Rearrest Rates of Persons found Not Guilty By Reason of Insanity, 139 Am. J. of Psych. 892 (1982) (hospitalization time for NGRI acquittees in New York was the same as imprisonment periods of felons between 1965 and 1971 but between 1971 and 1973 acquittees were confined for shorter periods (533 days) than felons convicted of similar offenses (837 days).

307. See Table 3, supra.

308. See Robey, supra note 6, at 379.

the assurance of some protection during a period of mandatory treatment and supervision of the defendant by the criminal justice system.[309] How frequently courts grant probation and what factors influence the granting of probation to GBMI offenders, however, have not yet been determined.

D. Disposition of the GBMI Offender

1. Provision of Treatment

Despite the widespread belief that a GBMI finding guarantees an offender mental health treatment, a review of the relevant statutes[310] indicates that the finding does not ensure treatment beyond that available to other offenders. Most GBMI statutes, with the possible exceptions of the Alaska and Utah statutes,[311] give discretion to the correctional or mental health facility having custody of the offender to provide treatment "as it deems necessary" or "as is psychiatrically indicated."[312] The Georgia statute includes the caveat that treatment shall be provided "within the limits of state funds appropriated therefor."[313] As a statutory matter, therefore, GBMI offenders may be no more likely to receive treatment than other offenders.[314]

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309. Id.

310. See Table 3, supra.

311. Id.

312. Id.

313. Ga. Code Ann. §17-7-131(g) (Cum. Supp. 1983).

314. See Hermann & Sor, supra note 273, at ___; Smith & Hall, supra note 10, at 105 n.137.

Several explanations can be offered about the difference between the number of GBMI offenders determined to be mentally ill during criminal proceedings and those who actually receive treatment after conviction. A GBMI finding generally is based on mental illness at the time of the offense while post-conviction mental health evaluation focuses on an offender's present mental health treatment needs. The diagnoses of mental disorder may change over time as a function of changes in the offender's condition or environment, as well as differences in the policies and practices of pre- and post-conviction mental health evaluations.[315] Another explanation, which may be related to the first, is based upon research showing that mental health treatment received by NGRI acquittees during pre-trial detention following a finding of incompetence to stand trial may result in a reduced need for treatment after an NGRI acquittal.[316] In the case of GBMI offenders, treatment under similar circumstances may result in an improvement in an offender's mental condition and a decreased need for treatment following conviction.[317] A third possible explanation is that some defendants entering GBMI pleas, especially when such pleas are unchallenged by the prosecution, may not be treatable or may not need treatment. Finally, treatment simply may be unavailable to GBMI offenders in the correctional system.[318]

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315. See Petrella, supra note 242, at 8.

316. See Criss & Racine, supra note 232, at 266.

317. Petrella, supra note 242, at 8.

318. A Michigan Department of Corrections psychiatrist, the only full-time psychiatrist for a prison population of 12,000 in 1980, indicated that he attended to offenders only if they presented extreme management problems. Treatment generally was provided only to patients who were psychotic or suicidal and consisted mainly of crisis intervention. People v. McLeod, 407 Mich. 632, 667-68 n.5, 288 N.W. 2d 921 n.5 (1980) (Levin, J., concurring). See also Smith & Hall, supra note 10, at 89 n.49; supra note 38 and accompanying text.

Adding the GBMI alternative to the traditional array of verdicts may mislead offenders, their attorneys, the courts, and the public by building false treatment expectations.[319] A review of the frequency of treatment provided to GBMI offenders and the nature of the treatment provided is necessary to determine whether legislative revisions or additional appropriations for treatment are needed. Variables that might influence the provision of post-conviction treatment, including pretrial treatment, correctional resources, and the use and effect of transfer provisions, should also be examined. This research should be structured to allow for comparisons across states.

2. Length of Confinement and Release

No available data address how long GBMI offenders are incarcerated or how their confinement compares with (1) that of offenders found guilty who did not raise the insanity defense, (2) that of offenders who raised the insanity defense or pleaded GBMI but were found guilty, and (3) the length of hospitalization of NGRI acquittees. In Erie County, New York, Braff and her associates found no statistically significant difference in the length of institutionalization between defendants hospitalized following an insanity acquittal and those incarcerated after unsuccessfully raising an insanity defense.[320] This finding may not be supported in a comparison among the three groups noted above and GBMI offenders.

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319. See Fullin & Fosdal, supra note 284, at 11.

320. See supra notes 305-306 and accompanying text. It should be noted that Braff and her associates were unable to draw conclusions concerning any variations among misdemeanants due to the small size of the population.

Factors related to the release of GBMI offenders into the community are of obvious interest to policy makers. Confinement for a specified period in the name of societal protection was an underlying objective in the creation of the GBMI finding.[321] In most states, GBMI offenders do not face the prospect of indefinite commitment[322] that insanity acquittees may face.[323] Unlike NGRI acquittees, however, GBMI offenders cannot petition for release.[324] Exploration of such differences may provide valuable information on the GBMI laws' success regarding punishment and public protection.

The effect of mental health treatment provided GBMI offenders on recidivism is particularly important to policy makers and practitioners. Treatment provided during incarceration may facilitate an offender's successful return to society. Hermann and Sor have hypothesized that mentally ill offenders may be more violent following release from prison if they have not received mental health treatment.[325] Also important are the effects of parole decisions and a state's sentencing structure on the release of GBMI offenders.

Recidivism and public safety may best be studied using data collected in Michigan. The enactment of GBMI legislation in other states may be too recent for the collection of any meaningful data on recidivism.

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321. See supra notes 23-38 and accompanying text.

322. But cf., Alaska Stat. §12.47.50(e) (Cum. Supp. 1983); Ill. Ann. Stat. ch. 38, §105-2-6(d)(2) (Smith-Hurd 1980); see Mich. Comp. Laws Ann. §§768.36(3); 330.2006(3) (West 1982) (provisions authorize initiation of involuntary civil commitment at expiration of sentence).

323. See Jones v. United States, 51 U.S.L.W. 5041 (1983).

324. Petrella, supra note 242, at 2.

325. Hermann & Sor, supra note 273, at ___.

V. CONCLUSION

Guilt, mental illness, and insanity are not merely characterizations of behavior but proposals about how to handle those so characterized. Traditionally, the guilty are punished and the mentally ill are treated. Good intentions aside, it is difficult to do both. The struggle with this moral dilemma and practical problem is reflected in the legislative and judicial developments of the GBMI plea and verdict reviewed in this article. Despite widespread criticism from scholars and professionals that the GBMI alternative is ill-conceived, constitutionally unsound, redundant and unnecessary in practice, and despite early returns from social research suggesting that the laws do little to undercut the traditional insanity defense and do even less to enhance available treatment options for mentally disordered offenders, the GBMI laws seem to be alive and well in at least twelve states. They have survived constitutional attacks in Michigan, Indiana, Illinois, and Georgia and seem likely to overcome similar sallies in other states.

While first-generation substantive issues, such as the conceptual soundness and constitutional validity of the GBMI plea and verdict, will remain controversial, second-generation issues[326] that deal with procedures and practices are likely to be preeminent as the focus of attention moves from legislative and judicial mandates to what has actually beem accomplished by those mandates.[327] As Professor David B. Wexler has noted, "policymakers are perhaps most likely to become informed of actual practices and of workable alternatives by

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326. See D. Wexler, Mental Health Law: Major Issues 257-61 (1981).

327. See generally, Shah, supra note 224, at 255-56.

mental health law scholars and students who undertake empirical investigations of mental health law in operation and who compare and contrast the workings of one system with the workings of alternative systems in operation elsewhere."[328]

328. Wexler, supra note 327, at 260.

PART TWO. A TELEPHONE SURVEY OF ELEVEN STATES

I. INTRODUCTION

> [T]he importance of obtaining extensive qualitative data cannot be overstated. For example, we have suggested that criminal justice reforms are often jeopardized during the legislative process through the myriad compromises that are almost inevitable. That is, the intended treatment [legislation] is not the treatment that materializes in the law. It is precisely for these sorts of processes that qualitative data may be especially instructive; one may learn about the mismatch between original intent and actual reform and come to understand why a reform was perhaps doomed to failure even before implementation.[1]

The major purpose of the Guilty But Mentally Ill (GBMI) Project was to study the nature, implementation, and consequences of the legislation in eleven states providing for a finding of "guilty but mentally ill" (GBMI). An important study question was what impact, if any, the legislation has had on outcomes of interest (e.g., actual use of the alternative finding, insanity acquittals). This question is addressed primarily, but not exclusively, by quantitative case file data collected in Michigan, Illinois, and Georgia. The results of the analyses of these data are described in Part Three of this report.

This part of the report links the characterization of the GBMI legislation and the discussion of the social science research in Part One with the impact study described in Part Three. It attempts to determine how the GBMI legislation is actually implemented and, hopefully, conveys some insights about the mechanisms whereby the GBMI laws do and do not affect practices. Issues addressed include perceived legislative intents and the fit between what legislators were trying to accomplish and what actually has been accomplished by implementation of the GBMI laws. Data

were gathered by telephone interviews of individuals familiar with GBMI provisions in each of the eleven states that enacted GBMI legislation. Interviews were conducted with state legislators and others familiar with the legislation, defense attorneys, prosecutors, judges, psychiatrists, psychologists, mental health program administrators, and corrections officials, including probation and parole officers.

Presumably, it is the statutory text from which implementation will follow. From a methodological point of view, the GBMI laws are, in essence, the legislative "treatment" whose impacts are to be measured. Part One of this report characterizes this legislative treatment by describing the relevant substantive standards, definitions, and procedural mechanics of the GBMI plea and verdict prescribed by the laws of the eleven states. It also describes the judicial development of the GBMI legislation as expressed in appellate court rulings. As others have noted,[2] the thorough documentation of legislative treatment is essential to an assessment of any criminal justice legislation.

Criminal justice legislation typically reflects a conscious, systematic response to a perceived social problem.[3] Several highly publicized cases in which defendants were acquitted of violent crimes by reason of insanity or had committed violent crimes after being released following insanity acquittals were the catalysts for a widespread public perception that something was amiss with the insanity defense. One reaction to this perception called for abolition of the insanity defense.[4] Another reaction, implicit in GBMI legislation, acknowledges that the defense is used appropriately in some cases, but assumes that in a significant and troublesome number of cases the defense is abused; that

is, defendants who should be held criminally responsible avoid responsibility through the insanity defense.

GBMI laws were enacted to eliminate or substantially reduce inappropriate insanity pleas and verdicts. Other remedial mechanisms with the same goal include changing the standard for insanity, shifting the burden of proof from the prosecution to the defense in insanity cases, and limiting mental health expert testimony in such cases.[5]

The qualitative data derived from the telephone survey described in this part are used to determine how the GBMI legislation is applied. Obviously, the GBMI laws do not produce automatically the desired outcomes. Knowledge of new laws must be disseminated to those who would implement them. Furthermore, the knowledge about the new laws must change individual and organizational behavior. In other words, the messages must be sent, received, understood, and acted on. Knowledge and behavior resulting from the legislative message, however, may be inconsistent with legislative purposes and provisions. Ultimate outcomes may be mediated through intermediate outcomes or occur through unintended mechanisms. What one may attribute to formal legislation may stem from other causes. Thus, it is important to identify and, if possible, distinguish between the immediate outcomes of GBMI legislation (e.g., interpretations of statutory intents by persons responsible for implementing the legislation), the ultimate outcomes (e.g., curtailment of the insanity defense), and intermediate outcomes (e.g., agency policy changes).

Evaluation of impact is complicated by outcomes intervening between the legislation variable and the ultimate outcome. That is, exogenous

factors may have affected outcomes. Program and policy changes (e.g., the creation of a new department of corrections in Alaska[6]), legislative enactments coincidental with the legislation in question (e.g., a shift in the burden of proof in insanity cases in Indiana[7]), and a host of other exogenous factors may confound the legislation's effect on outcome variables. Public officials pressured by their constituency to cure a perceived ill are unlikely to share researchers' concern for causal attribution. Hence, they will pursue concurrent remedies, such as changing the burden of proof in insanity cases and enacting GBMI laws, that may frustrate the ascertainment of causal relationships by research efforts such as this one.

In short, the descriptive qualitative data collected in the telephone survey aim to specify the mechanisms or intermediate outcomes through which legislative impact occurs. The next section describes survey methods and is followed in Section III by a summary of the survey results. Section IV contains eleven profiles describing in more detail the results of the telephone survey in each of the eleven states that have enacted GBMI legislation.

II. SURVEY METHODS

A. Survey Sample

From July through September 1984, project staff conducted telephone interviews of 141 individuals, including eight legislators, 44 attorneys, 22 judges, 25 mental health forensic examiners, 12 mental health program providers, 17 corrections personnel, six probation officials, six parole officials, and one criminal justice researcher. The survey sample is identified by state and position in Table 1.

In constructing Table 1, each interviewee was placed in a single position-category according to his or her major responsibilities under the GBMI provisions even though he or she may have had other responsibilities. For example, an interviewee may have been the major sponsor of GBMI legislation and an attorney in private practice. Due to his or her major involvement in the legislative process, he or she may have been considered a legislator for purposes of the survey. Similarly, mental health forensic examiners may have had administrative duties in addition to their responsibilities as evaluators of GBMI offenders at the pre-trial, sentencing, or post-conviction stage of the criminal proceedings. Respondents' specific roles in the mental health-judicial system are presented in greater detail in the state profiles following this section.

Survey respondents were identified by means of an iterative process initiated by contacting state court administrators, chief justices, mental health experts and others known to project staff in each of the eleven states. Further contacts with those persons identified as either well-informed about the implementation of GBMI provisions or influential in the enactment of GBMI legislation resulted in the identification of a sample of "key informants."[8] The key informants, or survey respondents, were selected purposively to provide a complete picture of the mental health-criminal justice system's response to the GBMI alternative. Of course, the sample is not representative in a statistical sense. If no key informant that held a particular position (e.g., legislator) in a particular state, no attempt was made to select an individual to represent that position in the subsample.

Once the roster of key informants was developed, potential respondents were contacted by telephone and asked to participate in the

Table 1

Telephone Survey Sample by Position and State of Respondent

Position of Respondents	State											
	AK	DE	GA	IN	IL	KY	PA	MI	NM	SD	UT	Total
Legislators	1	2	1	--	--	1	1	--	1	--	1	8
Attorneys	4	2	6	4	4	6	3	5	3	6	1	44
Judges	3	2	2	3	1	1	3	2	1	2	2	22
Mental Health Forensic Examiners	2	4	3	1	2	3	2	1	2	3	2	25
Mental Health Program Providers	1	1	--	2	3	--	2	1	--	1	1	12
Corrections Personnel	1	1	5	1	2	2	1	2	1	1	--	17
Probation Officials	--	--	1	1	--	--	1	1	--	1	1	6
Parole Officials	--	1	1	1	1	--	--	--	--	2	--	6
Other	--	--	--	--	--	--	1	--	--	--	--	1
Total	12	13	19	13	13	13	14	12	8	16	8	141

survey. The purposes of the telephone survey were outlined and the GBMI Project was described. Those willing and able to participate were mailed a letter confirming their participation and scheduling a specific time when the telephone interview would take place. A copy of the interview schedule (protocol) to be used accompanied each letter. Seven categories of respondents, representing different positions in the criminal justice system (legislators, attorneys, judges, pre-trial mental health forensic examiners, post-conviction/post-acquittal examiners, corrections and mental health treatment personnel and administrators, probation officials and parole officials) received different schedules. The schedules served in advance to structure both the format and content of the telephone interviews.

It was not feasible for project staff to validate, in any formal manner, whether the interviewees' responses coincided with actual practices. It is acknowledged, that the responses of interviewees may not necessarily represent normative practices. Some perspectives may have been underrepresented or not represented at all. Thus, a limitation of this approach is that it has a built-in bias toward the individual or organizational perspective of those surveyed. On the other hand, the expressed perspectives may help to specify the mechanisms through which legislative impact occurs or fails.

B. Interview Schedules

Interview schedules (see Appendix A) were designed to obtain information and impressions about the antecedents, implementation, and impact of the GBMI provisions in the eleven states. Interview questions were developed from the issues project staff identified during the literature review and statutory analysis completed during the first phase of the project (see Part One). Among other things, interviews were

designed to identify statutory or administrative changes that might have affected the implementation of the GBMI laws and to enrich interpretation of the data gathered. Also, information about perceived purposes and effects of the alternative finding, individual experiences and concerns, and system processing was sought. Different interview schedules were designed to elicit information about knowledge and experiences most appropriate to the positions or job responsibilities of the respondents. For example, only attorneys and judges were asked about juror decision making and only parole officials were asked about any changes in parole practices as a result of the availability of the GBMI alternative. On the other hand, all respondents regardless of their job classifications were asked about what they perceived to be the purposes of the GBMI legislation in their state and what they viewed as its strengths and weaknesses.

C. Telephone Interviews

Five interviewers conducted all interviews. Except for interviews conducted in Georgia, a single interviewer conducted all the interviews in a particular state. Because the interview schedules were standardized in advance and because interviewers were project staff familiar with the goals of the GBMI Project, no formal training of interviewers was conducted. Informal staff discussions and periodic checks were made, however, to ensure that standard procedures of questioning and recording prevailed in all the interviews.

Interviewers began each interview with an assurance that the interviewee's responses would not be identified with the interviewee by name. Interview length varied depending upon the category of interviewee

(e.g., parole officials were asked only 10 questions while attorneys were asked 21 questions) as well as the individual interviewee's knowledge and willingness to share that knowledge. Although interviews were structured, the questions were open-ended and interviewees were allowed considerable flexibility in their responses.

D. Analysis of Results

The results of the telephone interviews were organized and analyzed using a two-step aggregation process. First, the responses were summarized by state and topical category in textual and tabular form as follows: (1) the historical context and perceived purposes of the GBMI provisions; (2) perceived characteristics of the GBMI offenders; (3) specific procedures and practices, including mental health examinations, jury decision making, sentencing, treatment practices, and parole practices; (4) the costs of administering the GBMI provisions; and (5) the perceived strengths and weaknesses of the GBMI legislation. The emphasis in this first step was on the presentation of interview results, rather than interpretation. The interviewer who conducted the interviews for a particular state completed this first step of the survey data aggregation and prepared the state profile.

Draft state profiles were reviewed first by project staff and then submitted for review to all survey respondents. Those receiving the draft profile were invited to make suggestions for change and urged to correct any statements that were factually incorrect. Review comments were taken into account in preparing the final versions of the state profiles. It should not be inferred, however, that the profiles are the official position of any individual, agency, group, or organization, or

that the reviewers had a unanimous concurrence of opinion on the issues raised.

In the second step in the aggregation process, the state profiles were summarized using approximately the same categories of analysis. The results of this step are discussed in the next section. The profiles for each of the eleven states summarizing the results of the telephone interviews are contained in Section IV, "State Profiles," of this part of the report.

III. RESULTS AND DISCUSSION

A. Estimated Number of GBMI Findings

The most recognizable response to the GBMI legislation is the actual use of the alternative finding. This response is not a trivial one. It is conceivable, for example, that attorneys, judges, and juries may choose to not use the GBMI finding despite its provision in law. If no GBMI findings occur, one may conclude either that the legislation was irrelevant or ineffective or that changes in outcomes of interest (e.g., curtailment of the insanity defense) were caused by intermediate mechanisms (e.g., public pressure against insanity acquittals). An important distinction exists between the failure of a criminal justice reform because no one attempted to apply it and because attempts to apply if failed.

In how many cases have GBMI findings been rendered? Not surprisingly, in view of the recency of GBMI legislation and the general dearth of reliable data on the insanity defense and its alternatives,[9] no accurate and reliable state-wide data were available at the beginning

of the GBMI Project to answer this question, except perhaps in Georgia and Michigan. Table 2 represents the "best estimates" by survey respondents of the number of GBMI findings rendered since enactment of the GBMI laws in each of the eleven states. When informants within a state gave different estimates, the number most frequently given is the number shown in Table 2. These estimates are likely to be most accurate with regard to the most visible and easily-counted GBMI offenders, that is, those currently incarcerated under the jurisdiction of departments of corrections. They are low estimates, however, inasmuch as they might exclude GBMI offenders who have been released following expiration of their sentences or offenders who have received probation or parole. Reliable estimates of the number of released offenders were unavailable.[10]

B. Perceived Legislative Purposes

Presumably, proclamations of legislative intent will lead to their articulation in administrative policy objectives, procedures, and implementation. In the absence of well-articulated and widely-disseminated proclamations of legislative intent, however, the goals of a legislative act as perceived by people responsible for its implementation may be far more important than the legislature's motivations. Indeed, the legislative process may be complicated by political considerations and the content of legislation may have no simple relationship to legislators' motivations.[11] Also, there can be no "guarantee that the intent of the original reforms will materialize in the legislation, and no guarantee that the final product will correspond to mandates or resources of agencies responsible for implementation."[12] Thus, the fundamental values to be upheld by a piece of legislation, the major goals to be obtained, and the social

Table 2

Estimated Number of GBMI Findings from the Effective Date of GBMI Legislation to May 1984

State	Effective Date	GBMI Findings	Findings Per Month
Alaska	October 1, 1982	15	0.75
Delaware	July 2, 1982	4	0.17
Georgia	July 1, 1982	172*	7.48
Indiana	September 1, 1980	150	3.33
Illinois	September 17, 1981	133*	4.09
Kentucky	March 26, 1982	35	1.35
Pennsylvania	December 15, 1982	15	0.86
Michigan	August 6, 1975	239*	2.55
New Mexico	May 19, 1982	12	0.49
South Carolina	May 16, 1984	0	0.00
South Dakota	March 19, 1983	5	0.34
Utah	March 31, 1983	17	1.21
Total Findings		797	

*Official number provided by corrections officials of state. See infra PART THREE.

harms to be avoided, may best be reflected by how they are perceived by those individuals charged with implementation.

Survey respondents perceived statutory purposes of the GBMI provisions in terms of outcomes of interest, but articulated these purposes with varying degrees of immediacy and precision. That is, respondents' perceptions of GBMI legislation were associated with ultimate targets (e.g., public safety), immediate targets (e.g., knowledge of the new law, availability of the alternative finding), and intermediate targets (e.g., a reduction of insanity pleas). Table 3 summarizes the purposes of GBMI legislation as perceived by the various functionaries within the criminal justice-mental health system. The perceived purposes are grouped into five substantive categories and an "other" category. Because each respondent may have expressed opinions about more than one perceived legislative purpose, the total number of responses exceeds the total number of respondents.

The first category, the provision of an alternative to the traditional verdicts of "guilty," "not guilty," and "not guilty by reason of insanity," comprises the creation of statutory text providing for the alternative verdict and procedures for its administration. Such perceptions of legislative intent may assume that judges and juries would avail themselves of the GBMI alternative and thereby serve justice. The second category, limiting the insanity defense, includes reducing NGRI pleas, eliminating perceived abuses of the defense, and reducing the frequency of insanity acquittals. The third category includes purposes aimed at the intermediate outcomes of stricter social control over mentally ill and dangerous defendants. The fourth category of perceived

Table 3

Perceived Purposes of GBMI Legislation by Position of Respondent

Purpose	Position								Total Responses
	Legislators	Attorneys	Judges	Mental Health Examiners	Mental Health Administrators	Corrections Personnel	Probation/ Parole Personnel	Other	
Provision of Alternative Verdict	4	7	3	5	2	1	--	1	23
Limitation of Insanity Defense	3	23	10	9	2	5	4	1	57
Treatment of Mentally Disordered Offenders	1	11	3	12	--	6	1	--	34
Increased Control of Mentally Disordered Offenders	2	8	4	5	4	5	2	--	30
Public Safety	--	6	1	1	1	1	1	1	11
Other	--	2	2	1	--	--	--	--	4
Number of Respondents	8	44	22	23	13	13	12	1	136

legislative purposes concerns the achievement of the ultimate outcome of treatment and care for mentally disordered offenders. The final category, public safety, embodies the value that was seen as threatened by the absence of an alternative to the insanity defense.

A few of the perceived intents in the "other" category are worth mentioning before discussing the survey responses in the substantive categories. Illustrating that the content of legislation may bear no direct relationship to legislators' motivations, two Alaska attorneys stated that the purpose of the state's GBMI legislation was to ward off a move toward total abolition of the affirmative defense of insanity and to facilitate the passage of legislation to change Alaska's standards for insanity.[13] Whether GBMI legislation was, in at least a few states, a compromise measure between the extremes of abolition and retention of existing insanity defenses is arguable. In Pennsylvania, for example, the legislation creating the GBMI plea and verdict was originally introduced as an attempt to eliminate the state's common-law defense of insanity.[14] As an example of perceived legislative intent at odds with expressed purposes, an Alaska mental health program administrator noted that the Alaska legislation was aimed at a reduction of the patient population of the Alaska Psychiatric Institute, a treatment facility administered by the Division of Mental Health of Alaska's Department of Health and Social Services.[15]

Approximately one in five (17 percent) of the respondents said that the major purpose of the GBMI legislation was achieved solely by the statutory expression of the alternative finding. A sponsor of the Kentucky GBMI legislation stated that Kentucky law prior to the GBMI

legislation forced a "black or white" determination of mental disorder. "I think there is a grey mental state in between sane and insane called mental illness," he stated. "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."[16]

Almost half of the survey respondents (42 percent) thought that the GBMI legislation was intended to limit the insanity defense. An implicit assumption of the legislative intent to curtail the insanity defense is that significant numbers of insanity defenses exist to curtail. That legislators may act on mistaken assumptions is apparent in several states that enacted GBMI legislation to undercut the insanity defense. Although no precise statistics were available, the general consensus among survey respondents was that the number of insanity acquittals in some states is very low. Professionals in New Mexico, for example, agreed that only one defendant has succeeded with an insanity defense in the last ten years.[19] The low incidence of successful insanity defenses makes the legitimacy of a legislative intent to curtail insanity defenses questionable. The highly publicized cases that led to public outcry over the insanity defense probably were isolated cases rather than normative cases.

Twenty-five percent of the survey respondents perceived treatment of mentally disordered offenders as a major legislative purpose underlying the GBMI provisions. Other respondents (22 percent) believed that either increasing control of mentally disordered offenders or protecting the public (8 percent) was the purpose behind the GBMI alternative. Given that the public furor over the insanity defense that ushered in the GBMI

legislation was fueled mostly by concern for public safety and not for the treatment needs of mentally disordered offenders, that actual or perceived treatment ideals of the GBMI legislation may have been no more than the sweet coating making the GBMI pill easier to swallow. One survey respondent, an Indiana mental health examiner, was strong in his denunciation of the GBMI legislation on this score. He contended that GBMI offenders are not afforded preferential treatment in Indiana and that the state's GBMI law is a "fraud produced in response to public outrage."[20]

After survey respondents were asked to indicate their perception of legislative intents, they were asked whether those legislative intents had been fulfilled. Their responses are summarized in Table 4. Many responses were difficult to categorize, however. Some respondents said, for example, that the legislation had limited insanity defenses, but that the defense was used infrequently before the GBMI law. Others said that the treatment ideals had not been realized but that the legislation had focused attention on the treatment needs of mentally ill offenders. The aggregated data in Table 4 may, therefore, be less useful than the unaggregated data contained in each of the state profiles. Although responses varied substantially from state to state, close to one-third of the respondents (29 percent) said that the GBMI provisions had succeeded in limiting the insanity defense. The respondents did not reach this level of agreement regarding any other perceived impact. For example, all respondents in New Mexico answered the question of legislative impact by stating either that legislative goals had not been met or that they did not have sufficient information to make an assessment. On the other

Table 4

Survey Responses By State to "Have the Legislative Intents of GBMI Provisions Been Fulfilled?"

Response	State											Total Responses
	AK	DE	GA	IN	IL	KY	PA	MI	NM	SD	UT	
Yes												
Provision of Alternative Verdict	--	--	--	2	2	2	--	3	--	--	3	10
Limitation of Insanity Defense	6	4	4	7	2	3	2	3	--	1	3	34
Treatment of Mentally Disordered Offenders	--	--	--	1	--	3	--	--	--	--	3	7
Increased Control of Mentally Disordered Offenders	--	--	3	--	--	--	--	3	--	--	--	6
Public Safety	--	2	3	1	--	--	2	--	--	--	--	8
Other	--	2	--	--	--	--	--	--	--	4	--	6
No												
Provision of Alternative Verdict	--	--	--	--	--	1	--	--	--	--	--	1
Limitation of Insanity Defense	--	--	--	--	3	1	3	3	3	--	--	13
Treatment of Mentally Disordered offenders	2	--	2	4	--	3	--	2	2	--	--	15
Increased Control of Mentally Disordered offenders	--	--	--	--	--	--	--	--	--	--	--	0
Public Safety	2	--	--	1	--	--	--	--	--	--	--	3
Other	--	6	4	--	--	--	1	--	--	--	--	11
Not Enough Data for Determination	4	--	3	--	--	1	3	1	5	4	1	22
Number of Respondents	12	12	19	12	7	11	9	12	8	9	8	119

hand, the majority of responses in Indiana indicated that the legislative purposes have been met. All seven Indiana respondents who had indicated that the legislative intent of the Indiana GBMI law was to curtail the insanity defense and prevent its abuse believed that the intent had been fulfilled. Two respondents in Indiana pointed out, however, that although the GBMI alternative apparently curtailed insanity acquittals, the actual number of acquittals had already been very small. Thus, the GBMI legislation may have further limited the already infrequent success of insanity defenses in the state.[21]

Fifteen survey respondents (13 percent) expressed serious doubts about whether the legislative purpose of providing treatment to mentally disordered offenders was accomplished. Under the New Mexico GBMI statute, the Department of Corrections is required only to evaluate the mental condition of GBMI offenders and provide such care "as it deems necessary."[22] One survey respondent from New Mexico, a forensic mental health examiner, stated that he knew of no treatment programs for GBMI offenders in the state. Reportedly, of about 200 mentally ill offenders in the corrections system in New Mexico, about one-half are considered treatable.[23] The state has beds, however, for only about one-third of the treatable GBMI offenders. Finally, many survey respondents were unable to say whether the intents of the GBMI provisions had been fulfilled.

C. Catalysts of Reform

The violent crimes committed by two insanity acquittees shortly after their releases were the catalysts for Michigan's enactment of GBMI legislation.[24] The public outcry following these crimes made it clear

that society's interest in protection from potentially dangerous insanity acquittees was at stake in calls for reform. To explore the fundamental societal values to be protected, the goals to be obtained, and the social harms to be avoided[25] by GBMI legislation, survey respondents were asked whether a particular case, incident, or problem led to the enactment of GBMI legislation in their states.

In Alaska, Georgia, Indiana, Kentucky, South Dakota, and Utah well-publicized cases like those in Michigan reportedly led to enactment of GBMI legislation. The trial and acquittal of John W. Hinckley, Jr., in the shooting of President Ronald Reagan apparently influenced the enactment of GBMI legislation in some states. All Delaware respondents agreed that the Hinckley verdict was the precipitating factor that enabled the passage of that state's GBMI legislation. The day after the Hinckley verdict the Delaware legislature passed the bill adopting the GBMI provisions.[26] Although all of the survey respondents in Pennsylvania were unable to point to a particular case or incident that led to the enactment of Pennsylvania's GBMI legislation, one survey respondent noted that the Hinckley verdict was returned about the time that the Pennsylvania legislature was considering a GBMI bill.[27] If nothing else, the public dissatisfaction with the Hinckley verdict may have created an atmosphere conducive to the adoption of alternatives to the insanity defense.[28]

Successful implementation of legislation is enhanced when legislative intent reflects fundamental societal values.[29] In contrast, if no consistency exists between legislative goals and societal values the chances of ready implementation is impeded; for example, the necessary

resources are not allocated to allow the attainment of legislative goals. The legislative goal of providing treatment to mentally disordered offenders does not appear to reflect a fundamental societal value.

D. Exogenous Factors Affecting Outcomes

A crucial question is whether the perceived impact of the GBMI legislation reasonably can be attributed to factors other than the GBMI legislation. Exogenous forces paralleling the legislation may affect implementation and intermediate outcomes of that legislation, as well as the ultimate outcomes of interest. Therefore, properly characterizing true causal relationships is problematic. What is attributed to GBMI legislation (e.g., a reduction in the rate of insanity acquittals) may in fact stem from other variables (e.g., a shift in public opinion, the creation of a new department of corrections). Plausible explanations other than the hypothesized causal relationship (e.g., GBMI legislation caused a curtailment of the insanity defense) that threaten the internal validity of an impact assessment must be explored and, if possible, discredited to increase confidence in conclusions. As Berk and his colleagues have suggested, "there is no substitute for a causal understanding of the relevant processes and an effort to include a range of confounding factors."[30]

To this end, survey respondents were asked whether statutory, judicial, or administrative changes relating to the handling of mentally disordered defendents or offenders coincided with the enactment of a state's GBMI legislation. According to survey respondents in most of the states, the enactment of GBMI legislation was accompanied with other

changes that could have generated outcomes similar to those caused by the legislation. Survey respondents verified relevant legislative changes in Michigan, Illinois, and Georgia that Project staff had identified by reviewing those states' statutes. The results of the statutory review are summarized in Appendix E.

Among the eleven states that have enacted GBMI legislation, all states but Kentucky[31] and New Mexico[32] made other changes that, according to survey respondents, may have affected the handling of mentally disordered defendants. The adoption of GBMI provisions in Alaska, for example, coincided with several significant changes in Alaska's mental health laws.[33] In addition to providing for a GBMI finding, the Alaska legislation narrowed the definition of insanity and shifted the burden of proof from the prosecution to the defense in insanity cases.[34] Reportedly, no insanity acquittals have occurred in Alaska since the enactment of the GBMI provisions. All three changes meet the necessary conditions for demonstrating causal relationships, however. First, the hypothesized causes precede the outcome in time. Second, the hypothesized causes co-vary with the outcome. Third, no plausible explanations for the outcome other than the three changes exist. Unfortunately, the effects of these three changes on insanity acquittals appear hopelessly confounded--no conclusions can be drawn about the relative effects of these changes. Survey responses, as highlighted in Section F below, do, however, provide information about how the GBMI laws have affected procedures and practices.

Similar though less severe changes occurred in the other states. Delaware[35] and Utah[36] modified the standards for insanity, and Pennsylvania shifted the burden of proof in insanity cases from the

prosecution to the defense.[37] Although the GBMI legislation in Georgia and Indiana did not coincide with other specific changes in mental health law, the legislation was part of a broad reform movement spanning several years.[38] A prosecutor in Indiana said that any curtailment of the insanity defense in his county was more attributable to a shift in the burden of proof than to the availability of the GBMI alternative.[39]

E. Characteristics of GBMI Offenders

The purpose of the GBMI alternative probably was not simply to reduce or eliminate insanity acquittals, but to reduce inappropriate insanity acquittals.[40] With the purpose so stated, its success or failure depends not upon whether the number or percentage of NGRI acquittals is reduced, but upon whether defendants found NGRI or GBMI are appropriately so found. What are the characteristics of defendants for whom the NGRI finding would be inappropriate? In the absence of the GBMI alternative, would these defendants be found guilty or NGRI? Both questions address whether the GBMI provisions have succeeded in limiting the class of defendants found NGRI to those who are "appropriately" so found.

When asked what characteristics of GBMI defendants most distinguished them from defendants found NGRI or guilty, survey respondents did not present a clear composite picture. Some respondents merely cited the statutory distinctions between the standards for findings of GBMI and NGRI. Two Delaware attorneys, for example, stated that those mentally disordered defendants who appreciate the wrongfulness of their offenses would be found GBMI, those who did not would be found NGRI.[41] Several respondents associated GBMI offenders with serious, violent crimes against persons, and sex offenses, especially against minors. Others

stated that GBMI offenders tended to be convicted of drug-related crimes, shoplifting, sex crimes, and other offenses for which corrections treatment programs existed. Two respondents from Alaska indicated that the most salient characteristic of GBMI offenders is their conviction of low-order felonies and public nuisance crimes.[42] Still other respondents felt that the GBMI label is applied to all types of offenders and offense categories.

A Utah mental health programs specialist, who compiled demographic information on thirteen defendants found GBMI in Utah, stated that GBMI offenders tended to be undereducated, underemployed, and to have a history of contact with the criminal justice and mental health systems.[43] Among the group of thirteen were eleven men and two women; six were single, three married, two divorced, and two widowed. Their ages ranged from 21 to 59 years.[44] A mental health examiner in Delaware felt that the poor, unemployed, and Black defendants charged with serious crimes were most likely to be found GBMI.[45]

When survey respondents attempted to distinguish GBMI offenders on the basis of mental disorder no clearer picture emerged. A history of prior instutionalization, personality disorders, non-psychotic disorders, and specific diagnostic categories, such as borderline schizophrenia and depression, were associated with the GBMI label by some respondents. Several respondents implied that cases involving mental aberration do not turn on strict definitional distinctions but tend to be situation-specific. A Pennsylvania public defender voiced the opinion that the most important factor in distinguishing those defendants found GBMI and those found NGRI was the juries' perceptions of the danger the defendants posed to society. He stated that if defense counsel could

successfully depict a defendant as non-violent and as an "unfortunate victim of mental disease," the probability of an NGRI acquittal, as opposed to a GBMI finding, was greatly increased.[46] One corrections administrator from South Dakota believed that all of the state's GBMI findings were "cop-out pleas" involving defendants who did not need psychiatric care.[47]

What factors characterize GBMI offenders and differentiate them from defendants found NGRI and guilty was addressed indirectly by survey respondents' answers to whether, in the absence of an alternative verdict, GBMI offenders would be found NGRI or guilty. The survey responses to this question also inform whether GBMI findings have displaced NGRI findings, as expected by legislators who supported the GBMI alternative.

Despite survey respondents' apparent inability to identify those characteristics that would distinguish GBMI offenders from those defendants found NGRI or guilty, a clear majority of respondents (76 percent) believed that GBMI offenders would have been found guilty if the GBMI alternative were not available. This finding was uniform across states; in several states, respondents unamiously agreed that GBMI findings had displaced guilty findings and left NGRI findings undisturbed. Several respondents in Kentucky stated that the GBMI verdict was a convenient compromise for easing the conscience of jurors, but in the absence of the GBMI alternative they would have reached guilty verdicts.[48]

Recividism rates of GBMI offenders who are either placed on probation or released after serving their time are of obvious relevance to society's interest in protecting itself from dangerous and mentally ill

persons. Do recividism rates vary among released insanity acquittees, GBMI offenders, and guilty offenders? Given the limited opportunity to gain experience with comparative recividism rates, most survey respondents were unable or unwilling to address this question. Answers respondents gave varied substantially. Several respondents felt that recidivism rates among mentally disturbed offenders would vary in relationship to the availability of mental health services after release. Others speculated that the treatment afforded GBMI offenders during confinement would lower their recidivism rates compared to guilty offenders.[49] Several respondents felt that GBMI offenders would exhibit higher recidivism rates than NGRI acquittees and guilty offenders. According to one Indiana Department of Corrections official, GBMI offenders tend to be charged with "emotional crimes against people" caused by mental health problems that persist over time.[50] Other respondents believed that no difference would exist in the recidivism rates among released NGRI acquittees, GBMI offenders, and guilty offenders.

F. Procedures and Practices

1. Introduction

The purpose of this subsection is to highlight the implementation of the GBMI legislation as described in the eleven state profiles in Section IV. As Shah has noted, "[i]t is one thing to legislate or judicially mandate legal and other policy changes; it is quite another matter to secure their actual implementation."[51] Most respondents indicated that the GBMI provisions had altered the manner in which mentally disordered individuals are handled by the criminal justice system, albeit not always

as one might have expected. A significant minority of survey respondents denied, however, that the GBMI laws had altered "business as usual" in the handling of mentally disordered offenders. The Indiana GBMI provision "does not do anything," contended one Indiana attorney, "it offers no advantage. It is the same as a guilty plea or verdict."[52] The next several sections summarize the most salient changes in the practices and procedures resulting from GBMI legislation as perceived by the majority of survey respondents.

2. Pre-trial Procedures

a. Plea Negotiation

According to survey respondents, regardless of their ultimate effect on NGRI findings, GBMI provisions have had an impact on the plea process in cases involving mental aberration. Reportedly, even in Alaska, where the GBMI statute does not expressly provide for a plea of GBMI,[53] and in Indiana, where policy discourages plea bargains,[54] the availability of the GBMI alternative increases the willingness of parties to enter into plea negotiations. This willingness stems from several sources. First, regardless of whether it is true or false, the promise of treatment draws defense counsel to the GBMI plea in cases in which an insanity defense is unlikely to succeed. In New Mexico, where GBMI cases are handled almost exclusively through plea bargains, which typically result in a GBMI plea to a lesser included offense plus a recommendation of treatment, defense attorneys apparently use plea negotiation to their clients' advantage.[55]

> If a public defender knows that a defendant has a history of mental illness, he or she gets the available psychiatric records. If the defendant has a history of mental illness but an insanity defense is

> inappropriate because the defendant is lucid about the crime, the public defender discusses with the defendant the possibility of a GBMI plea. The attorney explains that if the judge accepts the GBMI plea the defendant would go to the hospital rather than the penitentiary. If the defendant is receptive to the idea of a GBMI plea, the attorney contacts the district attorney to negotiate. The attorneys attempt to agree in regard to sentencing. The most frequent resolution involves probation with treatment conditions. For example, the defendant might agree to probation with voluntary admission to a state hospital or with outpatient treatment from a specific mental health center.[56]

Another source of the greater willingness to engage in plea bargaining is the belief that, after a defendant enters a GBMI plea, the court will take notice of a defendant's mental disorder as a mitigating factor in sentencing. For example, two Pennsylvania attorneys believed that the opportunities for probation are enhanced by the availability of the GBMI plea. Both attributed this to a greater tendency of judges to recognize mental illness and grant probation conditioned upon treatment when a defendant pleads GBMI.[57]

Another source of willingness to enter or negotiate a GBMI plea, suggested by several respondents, is the belief that a jury would be less likely to render an NGRI verdict because of the availability of the GBMI alternative. Hence, an attorney would counsel a client to not pursue an NGRI acquittal in front of a jury but, instead, negotiate a GBMI plea. A prosecuting attorney in Indiana suggested that the GBMI verdict is an "asset to prosecutors" because it allows prosecutors to get more guilty verdicts. Based on his experience, he said that not as many insanity pleas are entered because of the availability of the GBMI alternative and that when the NGRI plea is made, a guilty verdict is much more likely.[58]

Under what circumstances would attorneys advise their clients to enter GBMI pleas? The survey respondents who answered this question

agreed that such advice, if given at all, should only be given in limited circumstances. Circumstances survey respondents mentioned included: (1) a successful insanity defense seems highly unlikely; (2) the prosecution's case against the defendant is very strong; (3) the court probably would consider the defendant's mental disorder as a mitigating factor in sentencing; (4) the defendant or his or her family wants to "save face" and facilitate greater acceptance or tolerance by the community after release; and, finally, (5) the defendant would receive treatment and care following a GBMI finding.

Several survey respondents said that the GBMI laws mislead clients and their attorneys into the plea bargaining process. For example, one Kentucky respondent represented the view that some defense attorneys are misled into entering GBMI pleas by a false promise of treatment.[59] Concerns over the potential misuse of the GBMI plea has led the Kentucky Public Advocate's Office to institutionalize educational programs aimed at preventing inappropriate use of the GBMI plea.[60]

b. Mental Health Evaluation

Although statutory requirements vary from state to state,[61] before accepting a plea or finding of GBMI, a court generally may require that the defendant receive a mental health evaluation. The Georgia and Pennsylvania statutes contain no explicit provisions for pre-trial mental health examinations.[62] All but three survey respondents who conducted two pre-trial mental health evaluations reported that their methods and procedures for conducting and reporting mental health examinations were unaffected by the GBMI laws. That is, they reported that the examination procedures for defendants who had pleaded GBMI and defendants who had

asserted the insanity defense were no different. Among the three exceptions, a New Mexico mental health examiner stated that the examination procedures for defendants who plead GBMI differ from those who plead NGRI because the presumed type of mental disorder differs. Based on the presumption that NGRI defendants tend to be psychotic while GBMI defendants tend to have non-psychotic disorders, this examiner varied his clinical focus depending upon whether a defendant had pleaded GBMI.[63] Similarly, two Utah forensic psychologists stated that in NGRI cases they look for specific thought or behavior disorders associated with the alleged criminal activity whereas in GBMI cases their examinations tend to be more comprehensive and longlitudinal.[63a]

3. Trial Procedures

With the possible exception of jury instructions and behavior, trial procedures generally have been unaffected by the GBMI laws. Survey respondents reported no special criteria or factors that judges and juries use in reaching GBMI determinations other than those that would be expected based on the requirements of substantive law (e.g., the presence of mental illness not meeting the standard for insanity) or in any case in which a claim of mental aberration is involved (e.g., the "bizarreness" of the crime[64]). When asked whether instituting the GBMI laws had changed the involvement of mental health experts in criminal cases, 44 (75 percent) respondents felt it had not. Five respondents believed that the GBMI alternative had increased (or would increase) the involvement of psychiatrists and psychologists. Reflecting the views of several survey respondents, a superior court judge in Alaska expected on the basis of logic that the GBMI alternative would provide a new

opportunity for introduction of evidence of mental disorder and, hence, a corresponding increase in the involvement of mental health experts.[65] A New Mexico assistant public defender believed that the New Mexico GBMI law had increased the involvement of mental health experts because they are called upon more frequently in GBMI cases regarding determinations about suitability for treatment.[66] Only one respondent, a superior court judge in Alaska, felt that the availability of the GBMI alternative would reduce the involvement of mental health experts in criminal proceedings. Because a GBMI finding is "more consistent with treatment needs," he said that the availability of the GBMI option would clarify or reduce treatment options that must be considered by mental health experts and thereby reduce the need for their involvement.[67]

As discussed earlier in this report,[68] when faced with the decision between an NGRI verdict, associated with a threat to public safety, and a GBMI verdict, juries may embrace the GBMI alternative as a welcome compromise. No clear consensus emerged among respondents, however, regarding how the GBMI laws have affected jury trials. Many survey respondents had not participated in jury trials involving GBMI findings. Only four of the approximately 56 GBMI findings in Alaska, Delaware, Pennsylvania, South Dakota, and Utah were jury verdicts; respondents in New Mexico were familiar only with GBMI findings resulting from pleas. Some respondents were willing to answer the questions about juror decision making only after they were invited to speculate.

Except in Indiana,[69] and perhaps some jurisdictions in Michigan,[70] where most GBMI findings are rendered by juries, most GBMI findings result from plea agreements or bench trials, not jury trials.

Survey respondents were able to shed little light on whether the availability of the GBMI verdict significantly altered jurors' understanding and decision making in the minority of cases that do involve juries. Some respondents felt that jurors generally understand the distinctions between insanity and mental illness as used to define the NGRI and GBMI verdicts. Other respondents did not credit jurors with the ability to make such distinctions. Similar differences of opinion were expressed by respondents regarding jurors' understanding of expert mental health testimony. For example, most respondents in South Dakota said that jurors would be able to understand mental health expert testimony presented at trial.[71] Three respondents from Georgia, reflecting the views of a number of respondents in other states, said that jurors tend to ignore mental health expert testimony or place little or no credibility in it.[72] Disparities of opinion were also reflected in survey respondents' answers to questions about jurors' understanding of jury instructions in GBMI cases, as well as their understanding of dispositional differences of a GBMI and a NGRI finding.

In conclusion, although jury behavior tends to vary across states depending upon the quality of mental health expert testimony and presentation of other evidence as well as the jury instructions provided, jurors appear no more confused and yet no more enlightened by the availability of the GBMI alternative in cases involving mental aberration. Jurors apparently often fail to appreciate the nuances of the wording of various psycholegal definitions and standards and, as a general rule, their comprehension of jury instructions is less than perfect.[73] This state of affairs has not been changed by the

introduction of the GBMI alternative. A number of survey respondents' opinions reflected the views of Professor Goldstein, who stated almost twenty years ago that jurors are not "blank slates--to be written on by witnesses and counsel and moved inevitably in one direction or another by the words of the judge's charge on the insanity issues." Jurors will be influenced, he continued, in their decisions by the "manner of men [and women] they are, the attitudes toward crime and insanity which they bring with them from the popular culture, [and] the extent to which they know the consequences for the defendant and for society of the verdict 'not guilty by reason of insanity.'"[74]

4. Disposition

Undoubtedly, the fundamental societal values to be protected, the goals to be attained, and the harms to be avoided by the adoption of the GBMI alternative focus much greater concern on what happens to a GBMI case at the conclusion of trial than what happens during trial. This subsection summarizes the telephone survey results that pertain to the post-conviction stages of the criminal justice process in which the court imposes sentence. Particularly, this section will focus on survey respondents' comparisons of GBMI cases with cases in which the defendant makes claims of mental disorder and is found guilty or NGRI.

a. Sentencing

Generally speaking, a sentencing judge may impose any sentence on a defendant found GBMI that could be imposed on a defendant found guilty.[75] This egalitarian provision of law seems to have been well translated into practice. When asked whether the length or type (e.g., probation, incarceration, split sentence) of sentence imposed on GBMI

offenders and guilty offenders differed in practice, 58 percent of the survey respondents stated that they did not. In contrast, 11 percent felt that GBMI offenders receive lighter sentences and 15 percent thought that GBMI offenders would receive heavier sentences. Sixteen percent of the respondents stated that it was simply too early to know whether actual sentences varied by group.

Reflecting the views of the majority of the respondents, a Georgia prosecutor contended that no compelling reasons existed to justify different sentences imposed on GBMI and guilty offenders. He stated that lighter sentencing would undermine the enhanced prosecutorial control provided by the GBMI plea and verdict and would, as a general rule, be unacceptable.[76] Other reasons respondents offered in support of their belief that GBMI offenders receive the same sentences as guilty offenders include: a close tracking of statutory provisions for the imposition of any sentence on a convicted GBMI offender that could be imposed on any other offender convicted of the same defense;[77] parole board control over release causing sentencing to become essentially meaningless;[78] and determinate sentencing practices.[79]

Several of the survey respondents who said that sentences for GBMI offenders would be lighter than for similarly situated guilty offenders believed that judges would view defendants' mental illnesses as mitigating factors. An Indiana superior court judge agreed, but noted that those sentences would depend upon several factors including the severity of the offense and the "treatability" of the defendent. He stated that if a particularly heinous crime was involved, the sentence given a GBMI offender might, in fact, be more severe. Similarly, if a defendant were considered as untreatable, the sentence might be longer.[80]

Survey respondents painted a similar picture regarding differences in probation provided to GBMI and guilty offenders. Except for statutory provisions in all but Alaska and New Mexico permitting a court to require a GBMI defendant to undergo mental health treatment as a condition of probation, and the requirement in Michigan and Utah that probation not be for less than five years, survey respondents gave no clear indication of different criteria, policies, or procedures between GBMI offenders and other offenders placed on probation.

Data on cases in which GBMI defendants were placed on probation are scant, even in states such as Michigan and Georgia, states with a considerable number of GBMI cases.[81] Based on the results of a survey conducted by the Probation Division of the Georgia Department of Rehabilitation and estimates provided by an Atlanta attorney, it appears that less than one percent of the defendants found GBMI in Georgia are placed on probation.[82] A chief probation officer in Indiana noted that out of 30 GBMI cases in which his office performed presentence investigations only one case resulted in probation. Despite the Indiana statutes' provision for treatment as a condition of probation in GBMI cases, the use of the provision may be rare regardless of the type of case. Out of 700 offenders on probation in this probation officer's jurisdiction in 1983, only twelve were ordered to undergo psychological counselling as a condition of probation.[83] A Georgia judge noted that a GBMI offender was unlikely to receive probation because GBMI offenses, in his experience, tended to be serious.[84] A New Mexico judge believed that probation for GBMI offenders would be very rare in his state because of the lack of adequate non-jail treatment options.[85] Similarly, a Delaware judge explained that he would explore the resources available to

GBMI defendants in the community (e.g., family, friends) in considering probation.[86]

In conclusion, it appears based on the survey responses that, as a general rule, sentences imposed on GBMI offenders are no different than those imposed upon defendants found guilty, all other things being equal. A question that perhaps is closer to public concern, however, is whether defendants found GBMI are removed from society for longer periods than insanity acquittees. That is, disregarding the locus of confinement (prison or mental hospital), do GBMI offenders or NGRI acquittees who have similar backgrounds remain under involuntary confinement for longer periods? The 42 respondents who answered this question were split in their opinions. Twenty-four (57 percent) said that GBMI offenders were likely to be confined longer than NGRI acquittees; 16 (38 percent) said that, all things being equal, NGRI acquittees spend longer periods in involuntary confinement than GBMI offenders; two respondents (5 percent) believed that the periods of confinement would be roughly equal. Even though these answers are without empirical verification, the respondents' perceptions are, nonetheless, intriguing. Given that the basis of much of the dissatisfaction with the insanity defense and the impetus behind GBMI legislation was a fear that defendants who have been acquitted of violent acts by reason of insanity will shortly be free to walk the streets and threaten public safety, it is noteworthy that a significant number of respondents (38 percent) believed that the GBMI legislation would not remove GBMI offenders from society for longer periods than similarly situated NGRI acquittees.

b. Treatment

The GBMI provisions have been severely criticized for creating the misconception that a GBMI finding guarantees mental health treatment for the defendant. For example, the National Mental Health Association's National Commission on the Insanity Defense recommended that the GBMI alternative not be adopted in large part because mental health services are no more readily available for those found GBMI than for other convicts. It noted:

> [T]he "guilty but mentally ill" verdict does not ensure in any way that persons guilty under it, as opposed to persons found simply guilty, will be treated any differently when the trial is over. If persons convicted under either statute are treated the same in terms of disposition, we have developed different verdict without any distinction. This may further mislead juries into believing that a "guilty but mentally ill" verdict will somehow insure treatment and at the same time protect the community.[87]

Contrary to the misconception of the public, jurors, and many members of the mental health-justice system, a GBMI finding does not guarantee treatment. The GBMI laws generally provide that defendants found GBMI be provided with mental health care and treatment as determined by a post-conviction mental health evaluation. A defendant found GBMI is likely to receive mental health care and treatment only if the need for treatment is indicated by this evaluation and, in some states, only if available mental health resources permit it.[88] In practice, according to those survey respondents that have direct experience with mental health services available to GBMI offenders, defendants found GBMI are not guaranteed treatment, even if by post-conviction examination they are determined to be mentally disordered. Explanations survey respondents

offered included: (1) precious few treatment resources, especially within departments of corrections; (2) the diagnostic and classification systems of the departments of corrections, which have been left largely unchanged to accommodate GBMI offenders; (3) obstacles[89] and cumbersome procedures for providing treatment for GBMI offenders outside the departments of corrections;[90] and (4) the inability of the relatively small numbers of GBMI offenders to command the attention of the departments of corrections.[91]

In view of the foregoing, the survey responses to whether GBMI offenders are more likely to receive treatment than offenders with mental health problems in the general prison population is intriguing. The 96 respondents who answered this question were split in their opinion. Fifty-two percent indicated that GBMI offenders were more likely to receive mental health care and treatment; 48 percent were much more pessimistic, agreeing that GBMI offenders were no more likely to receive treatment than offenders with mental health problems in the general prison population. Though the impression of approximately half of the survey respondents that GBMI offenders receive preferential treatment seems at first at odds with the foregoing description of actual practices, the discrepancy becomes understandable by a closer look at the identity of the respondents who express optimism about GBMI offenders receipt of treatment. Of the 50 respondents who felt that GBMI offenders would receive preferential treatment, all but eight were attorneys and judges. Several mental health officials who were among the eight respondents indicating that GBMI offenders are more likely to receive mental health treatment indicated that such preferential treatment would

only be provided insofar as GBMI offenders may be given more attention during the post-conviction evaluation. In Indiana, for example, the identified mental disorders of offenders and their specific treatment needs, rather than the GBMI label, is determinative of treatment. GBMI offenders are differentiated from other offenders, however, at the point entry into the Department of Corrections in that as they automatically are provided intensive mental health evaluation (i.e., they are examined by a psychologist and a psychiatrist on an individual basis, whereas other offenders are subjected only to group psychological testing).[92]

In conclusion, based on the experience of corrections and mental health personnel responsible for the provision of mental health services to GBMI offenders, the GBMI label does not necessarily lead to preferential mental health treatment and care. Nonetheless, attorneys, judges, and others less familiar with the handling of GBMI offenders once they leave the courtroom cling to the misconception that the GBMI finding will deliver something that is not already available for any other prisoner.

c. Parole

Sentencing, including probation, relates to judicial action taken before the prison door is closed on an offender, whereas parole relates to executive action taken after the door has been closed on an offender. Much like sentencing laws and practices (with the exception of Alaska's statutory restriction on parole, furlough, and work release of GBMI offenders receiving treatment[93]), the same statutory criteria, procedures, and actual practices for parole appear to apply to both GBMI and guilty offenders.[94]

The typical parole review procedure in Georgia may be a illustrative.[95] It begins with an investigation into the case, including obtaining information about the offense, interviewing the inmate, conducting a social investigation, and reviewing the offender's prison record. The information obtained is then applied to the parole guidelines used by the parole board. The guidelines encompass factors such as the severity of the offense, the criminal record, and the offender's adjustment in prison. Past or current mental health problems of the offender are not specified variables included in the guidelines. Such information may be used, however, as a reason to deviate from the guidelines. For example, unpredictable violent behavior would provide a justification for a continued incarceration. Also, that an offender who was recommended for mental health treatment refused such treatment might indicate to the parole board that the offender is unaware of his or her treatment needs and might therefore be a difficult individual to supervise while on parole. Such behavior might also suggest the offender's inability or lack of commitment to compliance with conditions of parole.

The available data to compare the parole practices of GBMI offenders and other guilty offenders is virtually non-existent. According to survey respondents, no GBMI offenders have become eligible for parole in Kentucky, Pennsylvania, South Dakota, and Utah. In 1978, a year after the enactment of a determinate sentencing law, Indiana abolished its parole provisions, at least in theory. According to an Indiana parole board official, only six GBMI offenders (presumably those offenders found GBMI after the abolishment of parole) have come before the parole board.[96] Hence, any conclusions drawn about parole practices with GBMI offenders are highly speculative.

Nonetheless, survey respondents were asked whether GBMI offenders were more frequently or less frequently paroled than guilty offenders. Although survey respondents differed in their opinions, their opinions were based largely upon the presence or absence of mental disorder rather than upon the offender's GBMI classification. Survey respondents made little distinction between mentally disordered offenders who had been found GBMI and those coming before the parole board without the GBMI label. For example, a New Mexico corrections administrator speculated that GBMI offenders may have greater difficulty in receiving parole due to the lack of mental health treatment resources in the community.[97] Presumably, the lack of resources would impact on all mentally ill offenders under consideration for parole, regardless of the GBMI designation. Two Pennsylvania judges suggested that the GBMI finding may be considered a mitigating factor in parole decision making. If a GBMI offender can demonstrate that he or she is no longer mentally ill, suggested one of the judges, the likelihood of parole after serving only the minimum sentence may be increased.[98] Several survey respondents in Georgia, a prosecutor, a judge, and a corrections employee, suggested that parole decisions were tied to the degree of an individual offender's mental illness and adjustment to prison conditions, rather than to the GBMI label.[99]

5. Costs

Have GBMI provisions increased or decreased costs to the mental health-justice system? In a report issued early in 1982, the Kentucky Legislative Research Commission addressed the potential impact of GBMI legislation in Kentucky.[100] The commission predicted a fiscal impact

but was unable to estimate the ultimate cost to the taxpayer. The commission report, based largely on Michigan's experience with the GBMI alternative, highlighted potential additional costs for increased forensic mental health evaluations or competency to stand trial as the major fiscal impact that should be anticipated. The Kentucky Commission estimated that approximately ten GBMI findings would occur annaully, an estimate not totally at odds with the 35 GBMI findings that have actually been rendered in the first 25 months since the enactment of Kentucky's GBMI law.

In Pennsylvania, where the fiscal impact of the proposed GBMI legislation was the focus of spirited debate, the Pennsylvania Commission on Crime and Delinquency estimated that the GBMI provisions would increase costs by approximately $2,000,000.[101] This cost estimate was based on a projected base of 69 GBMI findings annually. According to a research associate with the Pennsylvania Commission on Crime and Delinquency, the actual costs have been significantly lower primarily due to the relatively low number of GBMI findings (15 since the GBMI law went into affect on December 15, 1982) in Pennsylvania.[102]

When asked whether the GBMI provisions had increased or decreased costs to the mental health-justice system in any way, almost all of the 76 survey respondents stated that costs would either increase (51 percent) or remain unaffected (43 percent). Only four respondents (5 percent) felt that the availability of the GBMI alternative would decrease the overall costs for handling mentally disordered defendants. The allocation of appropriate mental health resources to allow the attainment of the proclaimed treatment goals of the GBMI legislation was cited as the major reason for increased costs by survey respondents. Needed additional resources for

an increase in post-conviction forensic mental health evaluations, additional transfers between correctional and mental health facilities, supervision of GBMI probationers undergoing treatment as a condition of probation, additional and extended dispositional hearings, increased treatment demands, and the costs of imprisonment after release from treatment were noted as factors contributing to rising cases.

One Alaska corrections administrator noted that in 1983 the bed costs for jails and prisons in Alaska were approximately $75 per day while the costs associated the stay in the Alaska psychiatric institute was approximately $206 per day.[103] Insofar as GBMI offenders are more likely to receive treatment in mental health facilities, costs would rise, he stated.[104] In the same vein, a Alaska superior court judge noted that "rehabilitation is expensive."[105]

Explanations survey respondents offered of why costs would remain unaffected by the GBMI provisions included (a) the relatively low number of GBMI offenders; (b) the necessity to provide treatment to mentally disordered offenders regardless of the label applied to them or the locus of treatment; and (c) the accommodation of GBMI offenders by existing mental health evaluation and treatment resources. All four survey respondents who felt that the GBMI provisions would lead to a decrease in the costs believed that decreased costs would be realized by a displacement of mentally disordered offenders treated in hospitals by GBMI offenders incarcerated in jails and prisons. An attorney in private practice in Indiana made the point when he noted that "jail is cheaper than a hospital."[106]

G. Conclusion: The Perceived Strengths and Weaknesses of the GBMI Provisions

Obviously, the translation of GBMI legilsation into practice is relevant to whether the legislation succeeds in achieving its intent and purpose. Law is more than the written rule. It is also the written rule translated into action by people and institutions. Knowledge of the provisions of the GBMI laws must be disseminated to those who are to implement them. Then that knowledge must be faithfully put to use. Thus, the content of the provisions may be less important than the substance and intent of those provisions that actually are communicated, and the validity of the provisions may be less important than the body of opinion that a particular provision is valid. If a provision is seen as invalid or weak, its implementation may suffer; if it is seen as strong, implementation may be facilitated.

This section concludes with a summary of the strengths and weaknesses of the GBMI provisions as they were perceived by the telephone survey respondents. The perceptions of the survey respondents provide rich insights not only into the present and future impact of GBMI legislation, but also into the ways in which such impact is both facilitated and hindered.

The preceived strengths and weaknesses of the GBMI laws and practices in eleven states are summarized in the accompanying two tables. Table 5 shows the perceptions of survey respondents according to their role in the mental health-justice system; Table 6 presents the perceptions of strengths and weaknesses by state. As shown in the tables, 136 respondents expressed their opinions regarding the strengths of the GBMI

Table 5

Perceived Strengths and Weaknesses of GBMI Laws and Practices According to Position of Respondents

	Position								
Strengths	Legislators	Attorneys	Judges	Mental Health Examiners	Mental Health Administrators	Corrections Personnel	Probation/ Parole Personnel	Other	Responses
Treatment Provision	3	12	9	14	5	5	6	1	55
Curtailment of Insanity Defense	--	2	2	--	1	--	--	--	5
Public Protection/Control	5	9	3	5	2	3	3	--	30
Public Satisfaction/ Confidence	2	2	3	4	1	1	3	--	16
Verdict Option/Alternative	1	10	3	1	2	3	2	1	23
Creation of Logical Subgrouping	2	4	5	3	--	3	2	-	19
Simplification of Criminal Proceedings	--	4	1	--	--	1	1	--	7
No Strengths	--	9	2	7	2	2	--	--	22
Other	--	5	1	2	1	1	1	--	11
Number of Respondents	8	42	21	26	11	15	10	1	136
Weaknesses									
Irrelevant/Meaningless	--	8	3	3	4	4	1	--	23
Unconstitutional/ Unfair/Immoral	--	6	--	1	2	1	--	--	10
Abuse/Improper Implementation	--	11	1	5	6	5	--	--	28
Victimization/Stigmatization of offenders	1	4	1	1	3	1	1	--	12
Curtailment of Proper Insanity Defenses	1	5	4	1	2	1	1	--	15
Absence/Lack of treatment	2	15	3	5	1	3	5	--	34
Administration Problems	4	12	3	4	3	3	2	--	31
No Weaknesses	3	6	4	1	--	2	--	--	16
Other	--	1	1	1	2	--	--	--	5
Number of Respondents	8	43	18	19	11	14	10	--	125

Table 6

Perceived Strengths and Weaknesses of GBMI Laws and Practices by State

	AK	DE	GA	IN	IL	KY	PA	MI	NM	SD	UT	Total Responses
Strengths												
Treatment Provision	1	4	11	4	3	5	7	1	6	7	6	55
Curtailment of Insanity Defense	--	1	1	--	--	--	1	1	1	--	--	5
Public Protection	6	--	6	1	1	3	6	2	1	1	3	30
Public Satisfaction/ Confidence	2	3	1	3	--	--	2	--	--	1	4	16
Verdict Option/ Alternative	--	1	--	5	--	7	6	1	--	3	--	23
Creation of Logical Subgrouping	3	5	4	4	--	--	--	3	--	--	--	19
Simplification of Criminal Proceedings	1	2	2	--	--	--	--	--	2	--	--	7
No Strengths	1	--	--	2	5	2	3	4	1	4	--	22
Other	--	--	3	--	5	2	--	--	--	1	--	11
Number of Respondents	11	13	19	13	13	13	14	12	8	13	7	136
Weaknesses												
Irrelevant/ Meaningless	2	--	4	2	6	1	3	2	1	--	2	23
Unconstitutional/ Unfair/Immorality	3	1	1	--	--	2	--	3	--	--	--	10
Abuse/Improper Implementation	5	1	8	--	--	5	5	--	1	3	--	28
Victimization/ Stigmatization of Offenders	1	2	--	--	--	3	--	1	--	4	1	12
Curtailment of Proper Insanity Defenses	1	1	7	1	3	--	1	1	--	--	--	15
Absence/Lack of Treatment	2	--	10	7	3	2	2	1	5	2	--	34
Administration Problems	--	2	7	1	4	4	5	2	2	2	2	31
No Weaknesses	1	3	2	--	1	2	2	4	--	--	1	16
Other	1	--	--	2	1	--	--	1	--	--	--	5
Number of Respondents	12	8	18	12	13	12	14	12	7	11	6	125

provisions and practices and 125 respondents expressed their opinions about weaknesses. The number of responses, that is, opinions expressed about strengths and weaknesses, exceeds the number of respondents because many respondents expressed their opinion about more than one strength or weakness in the law or its implementation.

As shown in Table 5, the major perceived strengths of the GBMI laws are their provisions for treatment, the increased control over and protection from mentally disordered offenders, and the provision of an alternative verdict in criminal proceedings. Fifty-five of the respondents (40 percent) viewed the treatment provisions as the major strength of GBMI laws. Treatment was cited as a strength most often by attorneys, judges, mental health examiners and administrators, and probation and parole personnel. Interestingly, the opinions that the strength of the GBMI laws are in their treatment provisions may reflect no more than wishful thinking on the part of survey respondents. Almost one-third of the respondents viewed the treatment provisions as illusory. They apparently saw the treatment provisions of GBMI laws as a false promise and considered mental health treatment provided to defendants found GBMI as no better or worse than the generally inadequate mental health treatment provided any other defendant found guilty.

Not surprisingly, the second most frequently mentioned strength of the GBMI provisions was the increased public protection they offered. Almost one-quarter of the respondents felt that public protection was a definite strength of GBMI legislation. What is surprising, however, is that only four survey respondents mentioned curtailment of the insanity defense as a strength. That so few respondents viewed the limitation of

the insanity defense as a strength of the GBMI legislation seems peculiar because it is at odds with the predominant perception that the limitation of the insanity defense is the major legislative intent of the GBMI provisions.[107] Many respondents cited two intermediate outcomes, the creation of a verdict alternative (17 percent) and a logical subgrouping of offenders (14 percent), as major strengths.

Seven respondents (5 percent) saw strength in the GBMI provisions' clarification of the distinction between mental disorder and legal insanity and the provisions' overall simplification in the criminal proceedings involving mentally disordered offenders. Thirteen respondents (10 percent), mostly attorneys and mental health examiners, saw no strengths in the GBMI provisions.

Besides a lack of actual mental health treatment provided GBMI offenders, survey respondents cited abusive or improper implementation of the GBMI provisions, problems in their administration, irrelevancy, meaninglessness, and redundancy of the GBMI provisions as major weaknesses. Also viewed as weaknesses were the victimization and unnecessary stigmatization of mentally disordered offenders, the curtailment of proper insanity defenses, and the overall unfairness or immorality of the GMBI provisions. Finally, just as approximately one in ten respondents saw no strengths in the GBMI provisions, approximately one in ten of the respondents saw no weaknesses.

Table 6 reveals no glaring variation of perceived strengths and weaknesses of GBMI laws and practices across states. The treatment provisions of the GBMI laws were mentioned most frequently as strengths by respondents in Delaware, Georgia, Pennsylvania, New Mexico, South

Dakota, and Utah. Lack of actual treatment and abusive or improper implementation of the GBMI provisions were seen as the major weaknesses in all states except Delaware and Utah. Notwithstanding significant variation in the statutory provisions and practices across the eleven states, the perceived strengths and weaknesses of the provisions appear remarkably uniform across the eleven states.

Notes

1. Berk, Burstein, & Nagel, Evaluating Criminal Justice Legislation, in Handbook of Criminal Justice Evaluation 611 (M.W. Klein & K.S. Teilman eds. 1980).
2. Id. at 615.
3. Id. at 611.
4. See I. Keilitz & J.P. Fulton, The Insanity Defense and Its Alternatives: A Guide for Policymakers 12 (National Center for State Courts 1984).
5. Id. at 14-20.
6. See infra, Part Two, § IV., A.2.a.
7. See infra, Part Two, § IV., E.2.a.
8. H.J. Hagedorn, K.J. Beck, S.F. Neubert, S.H. Werlin, A Working Manual of Simple Program Evaluation Techniques for Community Mental Health Centers, 101 (National Institute of Mental Health 1976).
9. See for example, Steadman, Monahan, Hartstone, Davis & Robbins, Mentally Disordered Offenders: A National Survey of Patients and Facilities, 6 L. & Human Behav. 31, 32 (1982) ("Most of the 52 jurisdictions suveyed ... did not keep even simple descriptive statistics on admissions or census of mental disordered offenders.").
10. Smith and Hall, in their 1982 evaluation of Michigan's GBMI law, did not include in their study sample defendants adjudicated GBMI who were placed on probation, nor were they able to estimate the size or determine the characteristics of this subgroup, because

records on these defendants were unavailable. Smith & Hall, Evaluating Michigan's Guilty But Mentally Ill Verdict: An Empirical Study, 16 U. Mich. J.L. Ref. 77, 91 (1982). They acknowledged that GBMI offenders who are placed on probation may "exhibit different characteristics than the group sampled, and if surveyed might have altered the conclusions drawn regarding the characteristics of the GBMI group." Id. at 91 n.58.

11. See Berk et al., supra note 1, at 614.

12. Id. See also Shah, Dangerousness: Some Definitional, Conceptual, and Public Policy Issues, in 1 Perspectives in Law and Psychology 91, 96-98 (B.D. Sales ed. 1977).

13. See infra, Part Two, §IV., A.2.c. (Alaska).

14. See infra, Part Two, §IV., I.2.a. (Pennsylvania).

15. See infra, Part Two, §IV., A.2.c. (Alaska).

16. See infra, Part Two, §IV., A.2.c. (Kentucky).

17. See generally, Shuman, Decisionmaking Under Conditions of Uncertainty, 67 Judicature 326 (1984).

18. See infra, Part Two, §IV., H.2.c. (New Mexico); see also Stelzner & Piatt, The Guilty But Mentally Ill Verdict and Plea in New Mexico, 13 N.M. L. Rev. 99, 113 (1983).

19. See infra, Section D, for a discussion of factors precipitating the GBMI laws.

20. See infra, Part Two, §IV., D.2.c. (Indiana).

21. See infra, Part Two, §IV., E.2.c. (Indiana).

22. N.M. Stats. Ann. §31-9-4 (Cum. Supp. 1983).

23. See infra, Part Two, §IV., I.3.c. (New Mexico); see also Stelzner & Piatt, supra note 18, at 115-116.

24. See supra, Part One, §II.A, notes 23-29 and accompanying text.

25. These factors are one part of an analytical framework against which societal practices can be evaluated. See Shah, supra note 13, at 96.

26. Note, Guilty But Mentally Ill: A Critical Analysis, 14 Rutgers L. Rev. 453 (1983).

27. See infra, Part Two, §IV., I.2.a. (Pennsylvania).

28. See supra, note 29, at 453.

29. See Shah, supra note 13, at 96.

30. Berk, et al., supra note 1, at 616.

31. Though survey respondents did not associate them with the GBMI legislation by Kentucky, the following changes were made in 1982, the year of GBMI enactment in Kentucky: modification of incompetency to stand trial proceedings, changes in involuntary civil commitment, and reorganization of kentucky's Department for Human Resources." See infra, Part Two, §IV., F.4. (Kentucky).

32. See infra, Part Two §IV., H.2.a. (New Mexico).

33. See infra, Part Two, §IV., A.2.a. (Alaska).

34. Id. at n.1.

35. See infra, Part Two, §IV., B.2.a. (Delaware).

36. See infra, Part Two, §IV., K.2.a. (Utah).

37. See infra, Part Two, §IV., G.2.a. (Pennsylvania).

38. See infra, Part Two, §§IV., C.2. (Georgia); D.2.a. (Indiana); H.2.a. (New Mexico).

39. See infra, Part Two, §IV., D.2.a. (Indiana).

40. See Boyle & Baughman, The Mental State of the Accused: Through A Glass Darkly, 2 Adelphia __ (forthcoming 1984) ("If the legislative purpose were to abolish NGRI, the legislature could have directly accomplished that result to the extent the Constitution would have permitted it.")

41. See infra, Part Two, §IV., B.3. (Delaware).

42. See infra, Part Two, §IV., A.3. (Alaska).

43. See infra, Part Two, §IV., K.3. (Utah).

44. Id.

45. See infra, Part Two, §IV., B.3. (Delaware).

46. See infra, Part Two, §IV., I.3. (Pennsylvania).

47. See infra, Part Two, §IV., J.3. (South Dakota).

48. See infra, Part Two, §IV., F.3. (Kentucky).

49. See, e.g., infra, Part Two, §§IV., J.3. (South Dakota); H.3. (New Mexico).

50. See infra, Part Two, §IV., D.3. (Indiana).

51. Shah, Legal and Mental Health System Interactions: Major Developments and Research Needs, 4 Int'l. J.L. & Psychiatry 219, 255 (1981); see also Shah, supra note 13, at 96-97 ("The real and true importance of professed values and the sincerity of stated policy objectives can much better be assessed in terms of the resources actually provided than the extravagence of the rhetoric used to proclaim such benevolent intentions.").

52. See infra Part Two, §IV., D.4.a. (Indiana).

53. See supra, Part One, §II.B.

54. See infra, Part Two §IV., D.4.e. (Indiana). Most GBMI findings in Indiana, however, are rendered by juries. Id.

55. See infra, Part Two §IV., H.4.a. (New Mexico).

56. Id.

57. See infra, Part Two, §IV., I.6. (Pennsylvania).

58. See infra, Part Two, §IV., D.4.a. (Indiana).

59. See infra, Part Two, §IV., F.4.a. (Kentucky).

60. Id.

61. See supra, Part One, §II.B; Table 2; see also the description of pre-trial mental health examinations in the eleven profiles in infra, Part Two, §IV.

62. Id.

63. See infra, Part Two, §IV., H.4.b. (New Mexico).

63a. See infra, Part Two, §IV., K.4.b. (Utah).

64. See supra, Part One, notes 287-300 and accompanying text.

65. See infra, Part Two, §IV., 4.c. (Alaska).

66. See infra, Part Two, §IV., 4.c. (New Mexico).

67. See infra, Part Two, §IV., 4.c. (Alaska).

68. Supra, Part One, §IV., C.4.

69. See infra, Part Two, §IV., D.4.e. (Indiana).

70. See Boyle & Baughman, supra note 40, at __ ("Ninety percent of all GBMI convictions in Wayne County, Michigan are the result of litigation in which the defendant is asserting the complete defense of insanity.").

71. See infra, Part Two, §IV., J.4.e. (South Dakota).

72. See infra, Part Two, §IV., C.6. (Georgia).

73. See infra, Part Two, §IV., D.4.e. (Indiana), notes 19-22 and accompanying text; see also, supra, Part One, §IV., C.4.

74. A. Goldstein, The Insanity Defense 5 (1967).

75. See supra, Part One, §VI., C.5. at Table 3; see also the description of sentencing practices in individual states in Part Two, §IV., A-K.

76. See infra, Part Two, §IV., C.7. (Georgia).

77. See infra, Part Two, §IV., H.4.f. (New Mexico).

78. See infra, Part Two, §IV., C.7. (Georgia).

79. See infra, Part Two, §§IV., D.4.f. (Indiana); I.4.e. (Pennsylvania).

80. See supra, Part One, §IV., C.5., at Table 3.

81. See supra, Table 2.

82. See infra, Part Two, §IV., C.7. (Georgia).

83. See infra, Part Two, §IV., D.4.f. (Indiana).

84. See infra, Part Two, §IV., C.7. (Georgia).

85. See infra, Part Two, §IV., H.4.f. (New Mexico).

86. See infra, Part Two, §IV., B.4.f. (Delaware).

87. National Mental Health Association, Myths and Realities: A Report of the national Commission on the Insanity Defense 34 (1983).

88. See supra, Part One, §II, B, at Table 3.

89. For example, unlike the stautes in other GBMI states, Kentucky law does not specify who is empowered to determine whether treatment is warranted and, if warranted, who is to provide it. See infra, Part Two, §IV., F.4.f. (Kentucky). According to a sponsor of Pennsylvania's GBMI legislation, a current debate in the state surrounds the question of which state agency should provide treatment to GBMI offenders. See infra, Part Two, §IV., I.4.g. (Pennsylvania).

90. In Utah, for example, before a GBMI offender can be treated in a mental hospital outside of prison, a hearing must be held to determine if he or she meets the criteria for involuntary civil commitment. This procedure is viewed as an obstacle to treatment by several survey respondents in Utah. See infra, Part Two, §IV., K.4.h. (Utah).

91. See generally, the subsection describing postconviction processing and treatment provisions in the eleven states, Part Two, §V.

92. See infra, Part Two, §IV., D.i. (Indiana).

93. See infra, Part Two, §IV., A.4.h. (Alaska).

94. See supra, Part One, §II, B., at Table 3.

95. See infra, Part Two, §IV., C.8. (Georgia).

96. See infra, Part Two, §IV., D.4.h. (Indiana).

97. See infra, Part Two, §IV., H.4.h. (New Mexico).

98. See infra, Part Two, §IV., I.4.h. (Pennsylvania).

99. See infra, Part Two, §IV., F.5. (Kentucky).

100. Id.

101. See infra, Part Two, §IV., I.5. (Pennsylvania).

102. Id.

103. See infra, Part Two, §IV., A.5. (Alaska).

104. Id.

105. Id.

106. See infra, Part Two, §IV., D.5. (Indiana).

107. See supra, Table 3.

IV. STATE PROFILES

This section presents the results of the telephone survey in each of the eleven states. Each state profile begins by explaining the categories of respondents interviewed. Each respondent is identified generically using a letter designation corresponding to the interview schedule used for his or her interview:

A: Legislator

B: Attorney

C: Judge

D: Pre-trial Forensic Examiner/Expert Witness

E: Post-Conviction/Post-Acquittal Evaluator

F: Corrections and Mental Health Personnel

G: Probation Official

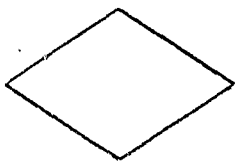
H: Parole Official

Subscripts are used when more than one person was interviewed using the same schedule (e.g., A_1, A_2, A_3). Next, each profile presents a brief overview of the GBMI law's legislative background, including a discussion of other changes in the jurisdiction's mental health laws. Each profile also includes discussions of the characteristics of defendants found guilty but mentall ill (GBMI), GBMI practices and procedures, costs of the GBMI law's administration, and perceived strengths and weaknesses of the GBMI law. Figures in each profile contain flow charts depicting the GBMI procedures as envisioned in statute. Only GBMI provisions are reflected in these flow charts; no general non-GBMI provisions are included even though in practice they may be used. Symbols used in the figures are defined below.

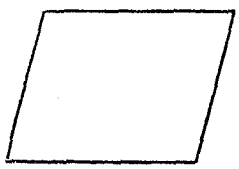
SYMBOLS USED IN FIGURES

Processing

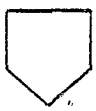
Document



Decision/Alternative



Enter/Exit procedure



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No provision in statute

A. Alaska

1. Introduction

Effective October 1, 1982, Alaska enacted legislation providing for a plea and verdict of guilty but mentally ill (GBMI).[1] During July 1984, twelve (12) individuals were interviewed by telephone concerning the history, operation, and consequences of Alaska's GBMI law: a legislator (A); four attorneys (B), including an assistant attorney general, a public defender, a prosecutor, and a private attorney; three superior court judges (C); two mental health forensic examiners (E), one associated with the Division of Mental Health, the other with the Deparment of Corrections; a mental health program administrator (F); and a corrections administrator (F). Together, these twelve individuals directly or indirectly were involved in the estimated total of 12 to 15 cases in which GBMI findings have been rendered in Alaska. At the time of the interviews, only one jury verdict had been rendered.[2]

2. Legislation: Historical Context and Purposes

a. Changes Coincidental with GBMI Enactment

With the enactment of the GBMI law, several significant changes were made to Alaska's mental health laws, including a narrowing of the insanity standard and a shift in the burden of proof in insanity cases.[3] The not guilty by reason of insanity NGRI standard was repealed[4] and replaced.[5] The new standard eliminates the volitional component of the old standard: the capacity of a defendant to control his or her behavior. Only the cognitive component, that is, the ability of the defendant "to appreciate the nature and quality of [his]

conduct,"[6] is included in the current standard. Alaska's GBMI law[7] uses essentially the same criteria for a GBMI finding as the former statute used to establish insanity.[8] The new law also shifted the burden of proof in insanity cases from the state[9] to the defendant.[10]

Individuals interviewed noted several other statutory and administrative changes potentially affecting mentally disturbed defendants in Alaska. A presumptive sentencing scheme was enacted as part of Alaska's revised criminal code. Prior to 1982, Alaska used presumptive sentencing for offenders with previous convictions. At the same time that the GBMI provisions were enacted into law, Alaska extended its presumptive sentencing to all Class A felons, including first-time offenders. Reportedly, procedural changes in the involuntary civil commitment laws substantially increasing the rights of mentally disordered individuals were also made. Finally, a separate Department of Corrections was created in March of 1984. Prior to that change, the Department of Corrections was a unit of the Department of Health and Social Services.

Although respondents viewed the changes in Alaska's presumptive sentencing, the tightening of involuntary civil commitment laws, and the creation of the Department of Corrections as separate and distinct from the enactment of the GBMI laws, they viewed the changes in the insanity standard, the shift in the burden of proof, and the provision of the GBMI finding as "part and parcel" of a "new limited affirmative defense of insanity."[11]

b. Precipitating Factors

When asked whether a particular case, incident, or problem led to the enactment of Alaska's GBMI statute, respondents stated that several

cases, most notably State v. Meach,[12] led to its enactment. A state senator who was one of the authors of Alaska's GBMI legislation indicated that these cases, involving defendants who had committed violent crimes after their release from mental hospitals, most certainly highlighted the problem and were a contributing factor to the change in Alaska's insanity defense laws.

c. Legislative Purposes

When asked about the purpose of Alaska's GBMI legislation, most of the respondents mentioned dissatisfaction with Alaska's insanity defense. Their responses regarding the legislative intent fell into the following categories:

(1) limitation of the insanity defense (A, B, B, B, C, F);

(2) reduction in perceived abuses and poor uses of the insanity defense (A, C);

(3) protection of public from released mentally disordered offenders (A, B, C, E, F);

(4) increased accountability of mentally disordered offenders (A);

(5) treatment of mentally disordered offenders (B, C, E);

(6) shift of attention on mental disorder from adjudication phase to disposition phase of criminal proceedings (B);

7) compromise verdict attributing guilt yet acknowledging mental disorder (C);

(8) enabling legislation for a change in Alaska's insanity standard (B, B); and

(9) reduction of the patient population of the Alaska Psychiatric Institute (F).

Have these legislative intents been fulfilled? Four respondents (A, B, B, B) said that the GBMI laws were too recent to allow an assessment

of their effects. Six respondents said that at least some of the legislative purposes had been met (B, C, C, C, E, F). One of these, a superior court judge, believed that the alternative verdict is a "workable tool." All of the respondents who stated that the legislative purpose of the GBMI provision had been met, linked that purpose to the curtailment of the insanity defense in Alaska. A mental health administrator indicated that no insanity acquittals had occurred since the enactment of the GBMI provision. He stated, however, that this may be due to the change in Alaska's insanity standard and not the GBMI provision.

Four respondents expressed doubts about the intended effects of the GBMI legislation (C, E, E, F). A judge and a mental health administrator questioned whether the GBMI provision made mental health care and treatment more likely for mentally disordered offenders. Two administrators, one from the Department of Mental Health and the other from the Department of Corrections, doubted whether the GBMI provision has led to greater public protection. Reportedly, of the nine GBMI cases in the system, none were convicted of serious crimes; most of the GBMI convictions were for low-order felonies and misdemeanors. According to one mental health administrator, these GBMI offenders simply have been "transinstitutionalized" from mental hospitals to prisons. That is, in the absence of the GBMI finding, they may have been found NGRI or subject to involuntary civil commitment proceedings.

According to one legislator interviewed, no specific opposition to the GBMI provisions emerged during the legislative deliberations; however, sentiment opposing the legislation centered on the argument that mentally disordered individuals should not be treated as criminals and

that the new insanity standard was too restrictive. Reportedly, no legislative actions in the mental health area currently are pending or have been proposed in Alaska.

3. Characteristics of GBMI Offenders

What are the characteristics of the defendants most likely to be found GBMI, as opposed to NGRI or guilty? Despite the opinion of two attorneys (B, B) that defendants charged with serious crimes are most likely to be found GBMI, a mental health administrator (E) responsible for mental health evaluation of GBMI offenders and a Department of Corrections official (F) indicated that the most salient characteristic of GBMI offenders is their conviction of low-order felonies and "public nuisance" crimes.

Although this may be true, explained one attorney (B), such a result may be misinterpreted. He explained that defendants charged with very serious crimes may be subject to long periods of confinement, and may, therefore, be disinclined to plead GBMI, especially considering that gradual release is unavailable following GBMI conviction in Alaska. Those charged with less serious crimes, however, may plead GBMI because confinement is shorter and they may gain the advantage of treatment. Therefore, the legislative intent to curtail the insanity defense may have been met in cases involving serious crimes, because the defendants may opt for a guilty plea instead of the GBMI alternative. As a result, most of the GBMI offenders in Alaska may have been convicted of less serious crimes.

One attorney (B), citing statutory distinctions between GBMI conviction and insanity acquittal, said that those defendants found NGRI

in Alaska under current law would be the most severely disturbed. A mental health administrator (F) noted that because no NGRI acquittals have occurred since enactment of the Alaska GBMI law, limited data exists to determine the characteristics of defendants most likely to be found NGRI, GBMI, and guilty. One corrections official (E) believed that no differences exist between defendants found GBMI and those found NGRI. One superior court judge (C) said that defendants who were mentally disordered yet rational would be found GBMI. Two other judges (C, C) said that they had insufficient information to ascertain the dominant characteristics distinguishing GBMI offenders from insanity acquittees and guilty offenders.

Would those defendants found GBMI under Alaska law be found NGRI or guilty if the GBMI alternative were unavailable? All four attorneys (B), three superior court judges (C), and one mental health professional (E) responding to this question said that the defendants found GBMI in Alaska would have been found guilty under present Alaska law had the GBMI alternative been unavailable. Five of these respondents stated, however, that under Alaska's previous standard for insanity these defendants may have been acquitted by reason of insanity, suggesting that the displacement of NGRI acquittals by GBMI findings may be attributable primarily to a change in Alaska's insanity standard and not the GBMI provisions per se. Two corrections officials (E, F) were unable to express an opinion, except to indicate that several of the GBMI offenders in custody were "quite mentally ill." One mental health program administrator (E) said that some GBMI offenders would be found guilty and others NGRI.

Asked whether recidivism rates would vary among released NGRI, GBMI, and guilty offenders, five respondents offered speculations. Only one respondent, a mental health program administrator (F), said that most GBMI offenders have prior convictions and their high recidivism rate is likely to continue. In contrast, he added, NGRI acquittees tend to be one-time offenders. On the other hand, two judges (C, C) and one attorney (B) said that recidivism would be lower among GBMI offenders. One judge believed that recidivism rates among GBMI offenders would be lower because of the treatment and care provided as part of their sentences. Another respondent, a state prosecutor (B), believed that recidivism rates among GBMI offenders who committed serious crimes would be low but that GBMI offenders convicted of less serious crimes would tend to continue at a high rate.

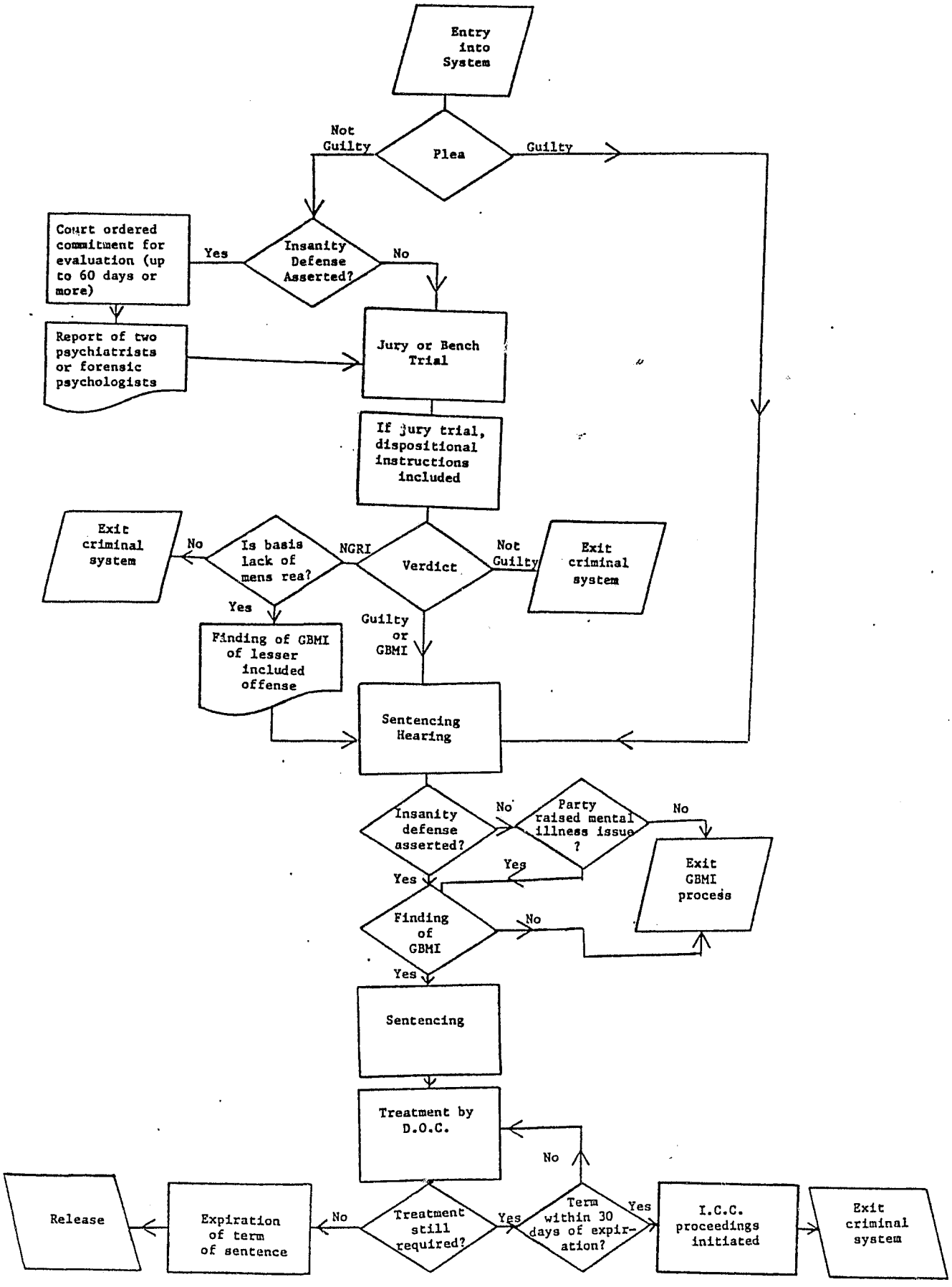
4. Procedures and Practices

a. General

Alaska's statutory GBMI procedures are depicted in Figure 1. As is true of the other figures in this part that depict statutory provisions in other states, Figure 1 is a simplification summarizing GBMI statutory provisions only. Other relevant provisions are omitted or collapsed.

Notwithstanding the statutory provisions depicted in Figure 1, most respondents said that the GBMI alternative did not significantly change the processing of mentally disordered offenders (B, B, C, E, E, F, F). Three respondents qualified their opinions by statements concerning the recency of the Alaska GBMI legislation (F) or the differential treatment of GBMI offenders required by statute (E, F). One attorney (B) indicated that because no plea bargaining is used in Alaska as a matter of policy,

Figure 1. Alaska's Statutory GBMI Procedures



plea procedures have not changed. Another attorney (B) said that although the manner in which he handled cases involving mental disorder generally was unchanged, the GBMI law did focus client conferences on additional options.

One private attorney (B) and one superior court judge (C) said that the processing of mentally disordered offenders has changed dramatically because of the GBMI alternative. The attorney noted that the number of defendants asserting the insanity defense had dropped significantly since the enactment of the GBMI legislation. The judge said that the GBMI alternative specifically recognized a defendant's treatment needs, which before frequently were neglected. He stated that before the GBMI alternative it was "easy for defense counsel to assume a defendant's mental health." Three respondents (A, B, C) stated that it was simply too early to tell whether the GBMI alternative in Alaska has changed the processing of mentally disordered offenders.

b. Pre-trial Mental Health Examination

In Alaska, if a defendant has given notice of intention to make his or her mental health an issue at trial, the court appoints at least two mental health evaluators to examine and report on the defendant's mental condition.[13] One mental health examiner (E) who regularly receives requests for mental health evaluations from the superior court, stated that his methods of evaluating GBMI defendants were no different from the methods employed with other defendants. He stated that no difference should be expected because the pre-trial issues that the examiner must address are the defendant's competency to stand trial, appreciation of the nature and quality of the misconduct, and capacity to have a culpable

mental state,[14] but not necessarily the defendant's appropriateness for a GBMI finding.

c. Mental Health Expert Involvement

When asked whether the GBMI law in Alaska had changed the involvement of mental health experts in criminal proceedings, five of seven respondents stated that the GBMI provisions have had little effect (B, B, B, C, C). One attorney suggested that because the GBMI alternative raises the same issues as the insanity defense, the involvement of mental health experts would be the same. Another attorney stated that the same number of defendants will be mentally ill regardless of the availability of the GBMI finding; therefore, although the involvement of mental health experts may have shifted somewhat from the adjudication stage to the disposition stage of the criminal proceedings, the amount of mental health resources are approximately the same.

One respondent, a superior court judge (C), stated that the GBMI alternative would reduce the involvement of mental health experts because a GBMI finding is "more consistent with treatment needs," suggesting that the GBMI alternative would clarify or reduce the treatment options that mental health experts must consider. Only one respondent, a public defender (B), said that the availability of the GBMI finding would require more mental health expert involvement.

d. Criteria Used by Judges

Four attorneys (B) responded to a question about criteria or factors judges use in reaching GBMI, as opposed to NGRI and guilty, determinations. One attorney noted two criteria: the commission of a very serious, perhaps heinous offense, and a history of unsuccessful mental health treatment and care. The other three attorneys were unable

to specify criteria or factors but indicated that the availability of the GBMI alternative may have caused mitigating factors, below the threshhold for an insanity determination, to become more salient. One attorney indicated that, knowing that a GBMI offender would receive a prison sentence, judges are less reluctant to determine that some type of mental disorder exists. Another attorney suggested that while the evidence in insanity cases is always the same, regardless of the availability of the GBMI finding, judges may be "less punctilious" about deciding close cases.

When asked their opinion about whether judges generally understand and make the appropriate distinctions between the definitions of insanity and mental illness as used in the GBMI determination, two of the four attorneys (B, B) indicated that judges do make clear distinctions between these two concepts. Two attorneys (B, B) believed that it was too early to tell whether judges properly understand and make appropriate distinctions between insanity and mental illness. One of these attorneys stated that the concepts were good but their articulation in the Alaska statute did not facilitate understanding. He said that the language was unduly complicated and required reading of the commentary to the statute for a proper understanding.

e. Juries

Contrary to a strict reading of Alaska's GBMI statutory provisions, as depicted in Figure 1, a jury makes a GBMI determination only after it has rejected an affirmative defense of insanity or has found a defendant not guilty of the crime charged for lack of mens rea. One respondent, an assistant attorney general (B), pointed out, however, that "[t]his is not to say that the jury actually returns to court to annouce a verdict and then is directed to renew deliberations on the GBMI issue."

As noted earlier, only one of the 12 to 15 GBMI findings reached in Alaska since the enactment of the GBMI legislation has been a jury verdict;[15] the other GBMI findings have been reached by plea agreements or bench trials. Asked whether the GBMI law in Alaska has increased or decreased the number of jury trials in cases involving mental aberration, five of nine respondents said either that it has had no effect on jury trials (B, B) or that they were unable to make a determination (C, E, E). One of these respondents suggested that fewer jury cases occur, but noted that the change is more likely attributable to the change in the insanity standard in Alaska, not the availability of the GBMI finding.

Three respondents (B, C, C) believed that the GBMI law has decreased the number of jury trials in cases involving mental aberration. One respondent, a private attorney, suggested that the availability of the GBMI alternative provided a disincentive for defendants to raise the insanity defense because the chances for success were smaller. Also, jury trials may be avoided because the availability of the GBMI alternative may increase the incentive to raise the issue of mental disorder at the dispositional stage of the criminal proceedings rather than in the adjudication stage. A judge said that the availability of the GBMI finding may decrease the number of jury trials because defense attorneys may consider the result of a GBMI finding inevitable.

One attorney (B) speculated that although Alaska may have experienced a decrease in the number of jury trials in cases involving mental aberration shortly after enactment of the GBMI legislation, jury trials may increase in the future due to the perceived loophole of the mens rea defense.[16] This attorney's response suggests that he did not attribute any change in the number of jury trials to the GBMI provision per se.

Alaska does not have standardized jury instructions regarding mental disease or defect. With only one GBMI verdict having been rendered since the enactment of the GBMI statute, only two respondents (C, C) were willing to speculate about specific aspects of juror understanding and decision making in GBMI cases. One superior court judge believed that jurors could handle the GBMI concept. He stated that the GBMI verdict "gets jurors off the horns of a dilemma." He said that the GBMI alternative "saves a lot of distortion of the system." Another judge, who heard the only jury trial in a GBMI case in Alaska, and who had debriefed the jury after the trial concluded, stated that the jurors understood and made the appropriate distinctions between the definitions of insanity and mental illness as applied in the GBMI verdict. He said that the jury in the case was bright, felt sympathy for the defendant, and was very concerned about treatment. He also felt that the jury understood the expert testimony at trial and understood the instructions given to them. Further, he stated that the jurors understood the dispositional differences between an NGRI and a GBMI finding.

Three attorneys (B, B, B) speculated that jurors would understand and make the appropriate distinctions between the definitions of insanity and mental illness as used in the GBMI verdict. They were less sure about jurors' understanding of expert testimony presented at trial. One attorney said that jurors generally understand expert testimony, another was unable to answer, and the third said that jurors would understand expert testimony when it is consistent, suggesting that conflicting testimony might confuse jurors.

The same attorneys (B, B, B) disagreed about whether jurors understand the dispositional differences between a finding of NGRI and a

finding of GBMI. Two of the respondents said that jurors generally understand these dispositional differences; the third respondent said that jurors probably misunderstand the differences. The latter respondent, a prosecutor, admitted that shortly after the enactment of the GBMI legislation many of the Alaska prosecutors incorrectly assumed that all GBMI offenders were placed in a mental health facility, instead of the Department of Corrections, for treatment and care. Two attorneys (B, B) said that jurors typically understand the jury instructions provided to them in GBMI cases; a third (B) said that he had too little information to answer the question.

One respondent, a private attorney with extensive experience as a jury trial lawyer, said that insufficient data exists to answer questions about juror decision making in GBMI cases. He contended that a major weakness of the GBMI legislation is its complexity when administered through a jury trial. He indicated that the original proposed legislation allowed for a GBMI determination by a judge, not a jury, at the time of disposition only. He feared that the GBMI question would confuse jurors.

f. Sentencing

Alaska law provides for the imposition of any sentence following a GBMI finding that could be imposed on any other defendant convicted of the same offense.[17] When asked whether the length or type of sentence for guilty and GBMI offenders differ in practice, five out of seven respondents (B, C, C, C, F) indicated that they did not. Two respondents, both attorneys (B, B), said that GBMI defendants may receive less severe sentences. One of these respondents, a public defender, said that judges may view GBMI offenders' mental illnesses as mitigating

factors. In contrast, one mental health examiner, who believed that sentencing generally did not differ between GBMI and other offenders, noted that in the only case in which he testified during the sentencing hearing the GBMI defendant was dealt with harshly; that is, he was given the maximum sentence plus five years probation.

Two out of three of the superior court judges (C, C) interviewed stated that the criteria used for placing offenders on probation do not differ between GBMI offenders and guilty offenders. One judge (C) indicated, however, that different criteria may be used for GBMI offenders, noting Alaska's statutory requirement for mental health screening before probation[18] and the statutory limitation of gradual release of GBMI offenders.[19]

g. Comparative Lengths of Confinement

Respondents were split regarding whether GBMI offenders or NGRI acquittees who have similar backgrounds generally remain in involuntary confinement longer. Five out of nine respondents said that GBMI offenders are likely to be confined longer (B, B, C, C, F). One respondent, an assistant attorney general (B), stated that although GBMI offenders generally are confined longer, insanity acquittees who committed very serious crimes may be confined longer. A mental health administrator (F) stated that although NGRI acquittees are committed for longer periods, confinement is subject to modification in periodic review hearings. Therefore, GBMI offenders may be sentenced longer simply because they are not eligible for early release under Alaska law.

Four respondents stated that, all things being equal, NGRI acquittees spend longer periods under involuntary confinement than GBMI offenders (B, B, C, F). A superior court judge speculated that although the

original sentence given GBMI offenders typically will be longer than the initial period of confinement of insanity acquittees, with continued confinement following periodic reviews, insanity acquittees may in fact be detained for longer periods than GBMI offenders. The more serious the offense, the more likely an insanity acquittee is going to be confined for longer periods of time than a GBMI offender with similar background, stated one prosecutor. In cases involving minor offenses (e.g., disorderly conduct), however, the length of confinement of insanity acquittees and GBMI offenders should be about the same.

h. Parole

When asked whether GBMI offenders are paroled more frequently than similarly situated guilty offenders, most respondents noted Alaska's statutory restriction on furlough, work release, and parole of GBMI offenders receiving treatment.[20] Notwithstanding this restriction on parole of GBMI offenders receiving treatment, however, one private attorney (B) argued that GBMI offenders will, except for their receipt of treatment, be considered for parole like any other inmate. He stated that GBMI offenders must receive treatment until they are no longer mentally ill and dangerous. As long as they are considered mentally ill and dangerous and are receiving treatment, they may not participate in gradual release programs, including parole. An argument against any equal protection challenge to Alaska's statutory restriction of gradual release for GBMI offenders is, according to this attorney, that any other prison inmate who is considered dangerous would also not be eligible for gradual release. Furthermore, any equal protection challenge must also compare the class of GBMI offenders with mentally ill and dangerous individuals who may have been involuntarily hospitalized by civil

commitment proceedings. Both groups are not subject to release, he contended.

According to two of the respondents (B, C), GBMI offenders may be paroled earlier than guilty offenders. One prosecutor speculated that GBMI offenders may be paroled more frequently due to the parole board's consideration of the success of treatment and care prior to parole. Another respondent, a superior court judge (C) said that although GBMI offenders generally may not be considered for parole any differently than other offenders, GBMI offenders may come before the parole board earlier. For example, a GBMI offender may receive a sentence of 15 years. For the first five years, he or she may receive mental health treatment and care with credit for time during treatment. Upon successful completion of treatment and care, the GBMI offender may return to the general inmate population and become eligible for parole as would any other offender. His or her time during treatment may cause the case to come before the parole board earlier.

The state legislator, who was one of the authors of the GBMI legislation, stated that the statutory provision limiting the gradual release of GBMI offenders[21] was not a major consideration for the original drafters of the legislation. Reportedly, the original authors did not specifically include a provision for limitation of gradual release. He believed that the Alaska House, not the Senate, included the restrictions.

i. Treatment

According to one corrections administrator (F), 1500 inmates are in the Alaska corrections system. Nine GBMI offenders are in the system. A mental health official (F) put the number of GBMI offenders within the

correctional system at ten as of July 6, 1984. The Alaska statute provides that the Department of Health and Social Services "shall provide mental health treatment to a defendant found guilty but mentally ill ... [and] shall determine the course of treatment."[22] In practice, treatment for GBMI offenders is provided by Alaska's Department of Corrections with the assistance from the Department of Health and Social Services, which administers the Alaska Psychiatric Institute. Effective March 1, 1984, the Department of Corrections became a separate unit; before that it was a division of the Department of Health and Social Services. The Department of Corrections has formal custody of all GBMI offenders and retains the ultimate responsibility for them. The Division of Mental Health of the Department of Health and Social Services is, however, responsible for providing treatment of GBMI offenders at the Alaska Psychiatric Institute.

When asked how determinations are made about which offenders will receive mental health treatment and care and whether the label of "guilty but mentally ill" plays a role in such determinations, both an official of the Department of Corrections and a mental health program administrator (F, F) stated that such determinations are the same whether an offender has been adjudged GBMI or not. All inmates are evaluated by a forensic team and treatment and care is provided only when clinically indicated, not necessarily when legally determined. According to the mental health program administrator, "no changes have yet been made with regard to GBMI offenders having a greater right to treatment" than other offenders. Currently, three GBMI offenders are receiving treatment at the Alaska Psychiatric Institute.

The mental health program administrator, who is involved in developing and providing mental health treatment to GBMI offenders and insanity acquittees, stated that GBMI offenders would, as a matter of course, be provided with a treatment plan. He noted, however, that such a plan may be nothing more than a plan to provide no treatment at all. Again, he stated that treatment is provided only when clinically indicated. He noted a currently pending major class action suit, Cleary v. State,[23] charging inadequate mental health treatment for mentally disordered offenders.

If treatment is provided GBMI offenders, that treatment is the same as that available to any other inmate within Alaska's correctional system: inpatient treatment at the Alaska Psychiatric Institute; treatment within the correctional setting including chemotherapy, behavior therapy, counselling, education and group therapy; treatment provided by private contractors under arrangement with the Department of Corrections. Currently, the Department of Corrections has four mental health workers.

Both officials of the Department of Corrections and the Department of Mental Health and Social Services (F, F) agreed that even though GBMI offenders are not more likely to receive treatment than offenders in the general inmate population, they may be more likely to be evaluated because the records of previous mental health examinations may "flag" their mental health histories. Also, according to the Department of Corrections official, public attention on the GBMI offenders may have prompted a more careful, albeit informal, scrutiny of GBMI offenders that may have some bearing upon the likelihood of their treatment and care. Another mental health program administrator (E), who also performs

court-ordered mental health evaluations and works as part of a consultation team associated with the Department of Corrections, noted that GBMI offenders are ensured mental health evaluation on an inpatient basis prior to the expiration of their sentence. He also shared the sentiment expressed by the mental health program administrator and corrections official that GBMI offenders may receive more attention because of the recency and uniqueness of the GBMI finding and the public attention that has been focused upon it. One respondent (E), a psychological counselor in the Department of Corrections, indicated that no difference exists in the types of treatment provided GBMI offenders and others. They are "equally crazy in the general population," he stated.

Although corrections and mental health personnel (E, E, F) agreed that offenders adjudged GBMI are no more likely to receive treatment than prisoners with mental disorders in the general inmate population, the four attorneys (B, B, B, B) and two judges (C, C) who addressed the issue had different perceptions. Only one attorney and one judge agreed with their colleagues in the corrections and mental health systems that GBMI offenders would not receive preferential treatment (B, C). Three attorneys (B, B, B), including a prosecutor, an assistant attorney general, and a private attorney, and a judge (C) believed, however, that GBMI offenders would be more likely to receive treatment. The prosecutor contended that GBMI offenders had a right to treatment within the correctional system and would, perhaps, receive slightly preferential treatment. The assistant attorney general indicated that GBMI offenders would receive preferential treatment because such treatment is mandatory for GBMI offenders and only discretionary for offenders in the general

inmate population. A private attorney said that the Department of Corrections had taken their statutory obligation to provide treatment very seriously. He noted that changes were underway to dedicate a wing of a hospital for treatment of GBMI offenders. A superior court judge, who was less sure about the preferential treatment that might be afforded GBMI offenders, nonetheless said that he sincerely hoped that GBMI offenders would be more likely to receive treatment than offenders in the general prison population. He said that he would be "ticked off and disappointed if GBMI offenders get the same treatment."

j. Transfers Between the Corrections and Mental Health Systems

Transfer of GBMI offenders from the general prison population to a mental health or mental retardation facility or the return of a GMBI offender from a mental health or mental retardation facility to the general prison population is accomplished by administrative procedures without formal evidentiary hearings. Typically, communications are made regarding an offenders readiness for transfer and any treatment or aftercare arrangements that need to be made. Given that the Department of Corrections only became a separate entity, apart from the Department of Health and Social Services, in March of 1984, no formal transfer procedures for GBMI offenders have been developed.

5. Costs

Four out of seven respondents said that the availability of the GBMI alternative would increase the overall costs to the mental health-judicial system in Alaska (B, C, F, F). One mental health program administrator said that the increased costs associated with more evaluations and more transfers would be inevitable. He did not, however,

object to these increased costs, indicating that the mental health-judicial system should shoulder the responsibility for forensic patients, a responsibility that he said is reflected in upcoming budget requests for a forensic mental health unit within the corrections system.

A corrections administrator noted that in 1983 the bed costs for jails and prisons were approximately $75 per day, while the costs associated with a stay in the Alaska Psychiatric Institute was approximately $206 per day. When offenders receive treatment in the latter facility, costs would rise. One superior court judge (C) noted that "rehabilitation is expensive." One attorney noted that increased costs may be associated with the GBMI alternative, it may have the positive tradeoff of forcing public attention on the inadequate mental health treatment and care provided in prisons in Alaska.

Only one respondent, a superior court judge (C), said that the availability of the GBMI alternative in Alaska would decrease costs based upon his assumption that "jails are less expensive than hospitals." Two attorneys and one judge (B, B, C) agreed in their opinion that the availability of the GMBI alternative would utlimately have no effect on the costs of the mental health-judicial system. One attorney noted that the concern for rising costs in Alaska may not be as acute as in other states because the Alaska public treasury is "filled by oil money and not a personal income tax."

6. Perceived Strengths and Weaknesses of GBMI Provisions

Asked about what they perceived as the strengths and weaknesses of Alaska's GBMI legislation, respondents offered differing opinions. These opinions are reflected in Table 7.

Table 7

Perceived Strengths and Weaknesses of

Alaska's GBMI Provisions

	Respondents												
		B				C			E		F		
Strengths	A	1	2	3	4	1	2	3	1	2	1	2	Total
Increased Public Protection	X			X					X			X	4
Treatment Provisions										X			1
Reduction of NGRI Acquittals				X									1
Shift of Focus on Disposition			X	X									2
More Rational Classification					X		X	X					3
Reflection of Public Sentiment						X			X				2
No Strengths		X											1
Weaknesses													
Unconstitutionality/Immorality		X										X	2
Avoidance of Difficult Moral Decisions		X											1
Emphasis of Punishment over Treatment		X											1
Curtailment of Proper Insanity Defense								X					1
Victimization of Less Serious Offenders									X				1
Practical Unneccessity			X							X			2
Jury Instead of Judge Determination					X								1
No Actual Treatment						X	X						2
Increased Mental Treatment Health Liability											X		1
No Gradual Release Provision				X						X	X		3
No Weaknesses	X												1

When attorneys were asked under what circumstances they might advise a client to enter a GBMI plea, one attorney (B) stated that he would never advise a client to do so, while two other attorneys (B, B) beleived that they would not do so unless the defendent "is looking at a lot of prison time and he has nothing to loose" by entering a GBMI plea. On the other hand, one attorney in private practice (B) said that he might advise a client to enter a GBMI plea if he or she had been charged with a less serious crime associated with a short sentence during which a client may benefit from a period of treatment and care or if he thought that the GBMI plea might influence a judge "to go light on the defendant."

The three judges interviewed also differed in their views about the advantages and disadvantages offered by the GBMI finding. Two judges (C, C) said that the GBMI finding may hold out a promise of treatment; however, no advantage would accrue to the convict if that promise is not fulfilled. One judge noted that if Alaska's insanity laws were indeed tightened with the enactment of the GBMI provisions such that NGRI acquittals are drastically curtailed, and no treatment is actually provided under the GBMI provisions for those who might otherwise be found NGRI, than much would be lost. Another judge (C) could not imagine any advantages offered by the GBMI plea and verdict. He stated that the sentence is the same and the priority for treatment within the correctional system is the same regardless of the presence of the GBMI law. He noted that even if treatment is provided to GBMI offenders within the mental health system, the offender returns to prison when treatment is over. "Why get well if cure results in imprisonment?" he asked.

Notes

1. 1982 Alaska Sess. Laws 143. See Alaska Stat. §12.47.040 (Cum. Supp. 1983).

2. State v. Patterson, No. 3ANS-83-5043 CR (Alaska Sup. Ct. May 9, 1984), appeal filed, No. A-573 (Alaska Ct. App. July 31, 1984).

3. See House Journal Supp. No. 63, S.B. 535, 5 (June 1, 1982).

4. Alaska Stat. §12.45.083 (1980) (repealed 1982).

5. Id. at §12.47.010 (Cum. Supp. 1983).

6. Id.

7. Id. at §12.47.030.

8. Id. at §12.45.083 (1980) (repealed 1982).

9. Alaska Stat. §12.45.083(b) (1980) (repealed 1982); this section has been interpreted as placing a requirement on the defendant to present evidence supporting the defense of insanity. Once this evidence has been presented, the burden of disproving defendant's insanity is placed on the state. Kinsman v. State, Sup. Ct. Op. No. 914 (File No. 1506), 512 P.2d 901 (1973); Dolchok v. State, Sup. Ct. Op. No. 1006 (File No. 1828), 519 P.2d 457 (1974); Alto v. State, Sup. Ct. Op. No. 1443 (File No. 2339), 565 P.2d 492 (1977); Johnson v. State, Sup. Ct. Op. No. 888 (File No. 1477), 511 P.2d 118 (1973); McKinney v. State, Sup. Ct. Op. No. 1451 (File No. 2758), 566 P.2d 653, remanded on rehearing on other grounds, 570 P.2d 733 (1977).

10. Alaska Stat. §12.47.010 (Cum. Supp. 1983).

11. See House Journal Supp. No. 63, supra note 3, at 5.

12.

13. Alaska Stat. §12.47.070 (Cum. Supp. 1983).

14. Id.

15. See supra note 2 and accompanying text.

16. Alaska Stat. §12.47.020 (Cum. Supp. 1983).

17. Id. at §§12.47.050(a), 12.47.060(b).

18. Id. at §12.55.025.

19. Id. at §12.47.050(d).

20. Id. at §12.47.050(d).

21. Id.

22. Id. at §12.47.050(b).

23. No. 3 AN-81-5274 (Alaska Super., 3rd Dist.).

B. Delaware

1. Introduction

Effective July 2, 1982, Delaware enacted legislation providing for a plea and verdict of guilty but mentally ill (GBMI).[1] During August and September, 1984, thirteen (13) individuals, including a Department of Justice official (A_1), a legislator (A_2), a deputy attorney general (B_1), a public defender (B_2), two superior court judges (C_1, C_2), four mental health evaluators (D_1, D_2, E_1, E_2), one corrections official (F_1), one Department of Mental Health official (F_2), and one parole official (H_1), were interviewed about the history, operation and consequences of Delaware's GBMI law. Together, these thirteen individuals directly or indirectly were involved in the estimated four cases in which a GBMI finding has been rendered in Delaware. At the time of the interviews, no jury verdicts of GBMI had been rendered; all findings had been reached as a result of pleas or bench trials.

2. Legislation: Historical Context and Purposes

a. Changes Coincidental with GBMI Enactment

Delaware's enactment of 63 Del. Laws. ch. 328 brought into existence the GBMI law while substantially altering the existing not guilty by reason of insanity (NGRI) statute.[2] Under the new provisions, the volitional prong of the former NGRI criteria was removed and transferred to the GBMI criteria.[3] This change significantly has narrowed the ability of a defendant to be found NGRI in Delaware. The new statute did not alter burden of proof requirements in insanity cases; the defense has remained an affirmative defense, requiring the defendant to prove his insanity.[5]

When asked whether any other statutory or administrative changes had been effected affecting mentally disordered defendants, respondents all agreed that the only changes to date had been those contained within the actual GBMI provisions. No other external factors have affected application of the law to mentally disordered defendants (A_1, A_2, B_1, B_2, C_1, C_2).

b. Precipitating Factors

When asked whether a particular case, incident, or problem led to enactment of Delaware's GBMI statute, respondents all agreed that the national attention focused on the "problem" of the insanity defense after the Hinckley decision was the precipitating factor that enabled passage of the bill (A_1, A_2, B_1, B_2, C_1, C_2, F_2). One legislator pointed out, however, that the bill originally had been offered in the General Assembly in 1978, three years before Hinckley, in response to a local NGRI case. He conceded, though, that not until after Hinckley was sufficient impetus gained to enable passage.

c. Legislative Intents

When asked about the purpose of Delaware's GBMI legislation, respondents' replies fell into the following categories:

(1) to undercut insanity defense (A_1, D_2, F_2, H_1);

(2) to provide a compromise verdict (A_1, B_1, D_1, E_1);

(3) to close loopholes (A_2, E_2);

(4) to eliminate insanity malingering (A_2, E_2);

(5) to abolish irresistible impulse test (B_2, C_1);

(6) to answer politial constituents' concerns (B_2, C_2, D_2); and

(7) to provide for criminal responsibility despite mental illness (D_3, E_2, F_2, H_2).

Have these legislative intents been fulfilled? The respondents were evenly split on this question: six believed that the intents had been fulfilled (A_2, B_2, C_1, C_2, D_1, D_2) while six others believed they had not (A_1, B_1, E_1, E_2, F_1, F_2). Two respondents, a legislator (A_2) and a superior court judges (C_1), both said that the law had succeeded because no pleas of irresistible impulse as a result of temporary insanity had occurred since enactment. A mental health evaluator (D_2) agreed that the definitional shift had made it much more difficult to be adjudicated NGRI. He also said that the intent had been fulfilled in that the General Assembly had responded to a perceived need of the general populace. The public defender (B_2) agreed; if the intent of the legislation was to placate constituents then passage of the bill itself fulfilled that intent. One mental health evaluator (D_1) said that the law had gone even farther than fufilling its intention. His opinion was that the statute was an assault on the whole concept of mens rea and was merely an expedient way to get mentally ill offenders into the prisons and off the streets without facing the issue of adequately evaluating the mental condition of a defendant. A superior court judge (C_2) observed that the law may have fulfilled its intent but still may not have accomplished anything; he said that Delaware never had a problem with the insanity defense.

Of those respondents that said the law had not fulfilled the legislative intent, two respondents, a Department of Justice official (A_1) and a mental health evaluator (E_1) both believed that utilization of the law was so low that it could not have done its job. The prosecutor (B_1) said that the distinction between mental illness

and insanity was too fine for a lay jury to appreciate, consequently the GBMI law's potential was not being reached. A mental health evaluator (E_2) observed that, based on his perception of the number of people convicted with severe thought disorders and their subsequent treatment within the correctional system, GBMI had made no difference at all. The Department of Corrections official (F_1) stated that, in his opinion, the law was unnecessary. Delaware, he explained, had a de facto GBMI law as far back as 1969 when mentally ill criminal offenders were incarcerated at the state hospital rather than the prison. Finally, the Department of Mental Health (DOMH) official (F_2) said that attorneys would continue to push for NGRI findings instead of GBMI as long as they had a chance for acquittal, so the law would do nothing to decrease assertion of the insanity defense.

According to the Department of Justice official who helped to draft the legislation (A_1), noone opposed to the bill; it was viewed as "law and order" legislation. The legislator (A_2) observed that the only opposition to the bill as he saw it came from a small coalition of minority interests.

3. Characteristics of GBMI Offenders

What are the characteristics of the defendants most likely to be found GBMI, as opposed to NGRI or guilty? A prosecutor (B_1) and a public defender (B_2) said that mentally ill defendants who were unable to appreciate the wrongfulness of their actions probably would be found NGRI while those who were aware of the wrongfulness of their actions would be GBMI. A judge (C_1) said that an offender with a history of

minor offenses and mental disorders who otherwise could function within society probably would be found GBMI. The other judge (C_2) and a mental health evaluator (D_2) said that too few defendants have been found GBMI or NGRI to permit characterization. Another mental health evaluator (E_1) said that GBMI offenders are temporarily insane due to short-term stress, perhaps coupled with personality disorder, or have long histories of mental disorders with dependency on psychotropic medications. He added that the mental illness must be related to the crime. Another mental health evaluator (E_2) said that poor, unemployed, Black defendants charged with serious crimes, were most likely to be found GBMI. A Department of Corrections official (F_1) believed a direct correlation exists between financial independence and the ability to convince a jury of a defendant's insanity. The more resources at a defendant's disposal, he said, the more likely he was to persuade a jury to render a NGRI verdict. Finally, one mental health evaluator (D_1) refused to speculate on characteristics; he said that the "whole [GBMI] concept [was] a cop out; one either has mens rea or not."

The respondents disagreed regarding whether those defendants found GBMI under Delaware law would have been found NGRI or guilty if the GBMI option had been unavailable. Three (C_1, C_2, F_2) said they would have been found NGRI, two (B_2, D_2) said guilty, and three (B_1, C_1, F_1) said generally that neither finding was more likely than the other. A prosecutor (B_1) speculated that in marginal cases the relative number of NGRI acquittals versus convictions would remain unchanged. The defense attorney (B_2) said that his GBMI client would

have been found guilty because he knew the act was wrong and would, therefore, have failed the lack of cognition requirement for an NGRI finding. One mental health evaluator (D_1) believed that a verdict could have gone either way; a jury, in his opinion, will sometimes find a defendant guilty who should be found NGRI because they want a compromise verdict. Another mental health evaluator (E_1) cited a defendant's long mental illness background as a sufficient basis for an NGRI acquittal. The Department of Corrections official (F_1) reiterated his point that financial resources dictate the end product. He said that if the defendant had more money to support his defense, a finding of NGRI might have been effected. If he had less, he would have been found guilty.

Asked whether recidivism rates would vary among released NGRI, GBMI, and guilty offenders, respondents offered the following observations. The prosecutor (B_1) related that he was aware of a high degree of recidivism among people whose behavior was influenced by mental illness. He believed that hospitalization had made little impact on the behavior of those people and that an individual's failure to take prescribed medications was probably the single greatest factor affecting recidivism within both the GBMI and NGRI groups. On the other hand, the defense attorney (B_2) believed that treatment provided the GBMI offenders would tend to lower that group's recidivism rate. One superior court judge (C_1) said that recidivism had not been a problem among NGRI acquittees because their crimes tend to be single, isolated incidents. Under such circumstances, he said, the patient tends to respond favorably to treatment. He speculated that in cases involving repetitive behavior where defendant's are found GBMI, such as child molestation, treatment

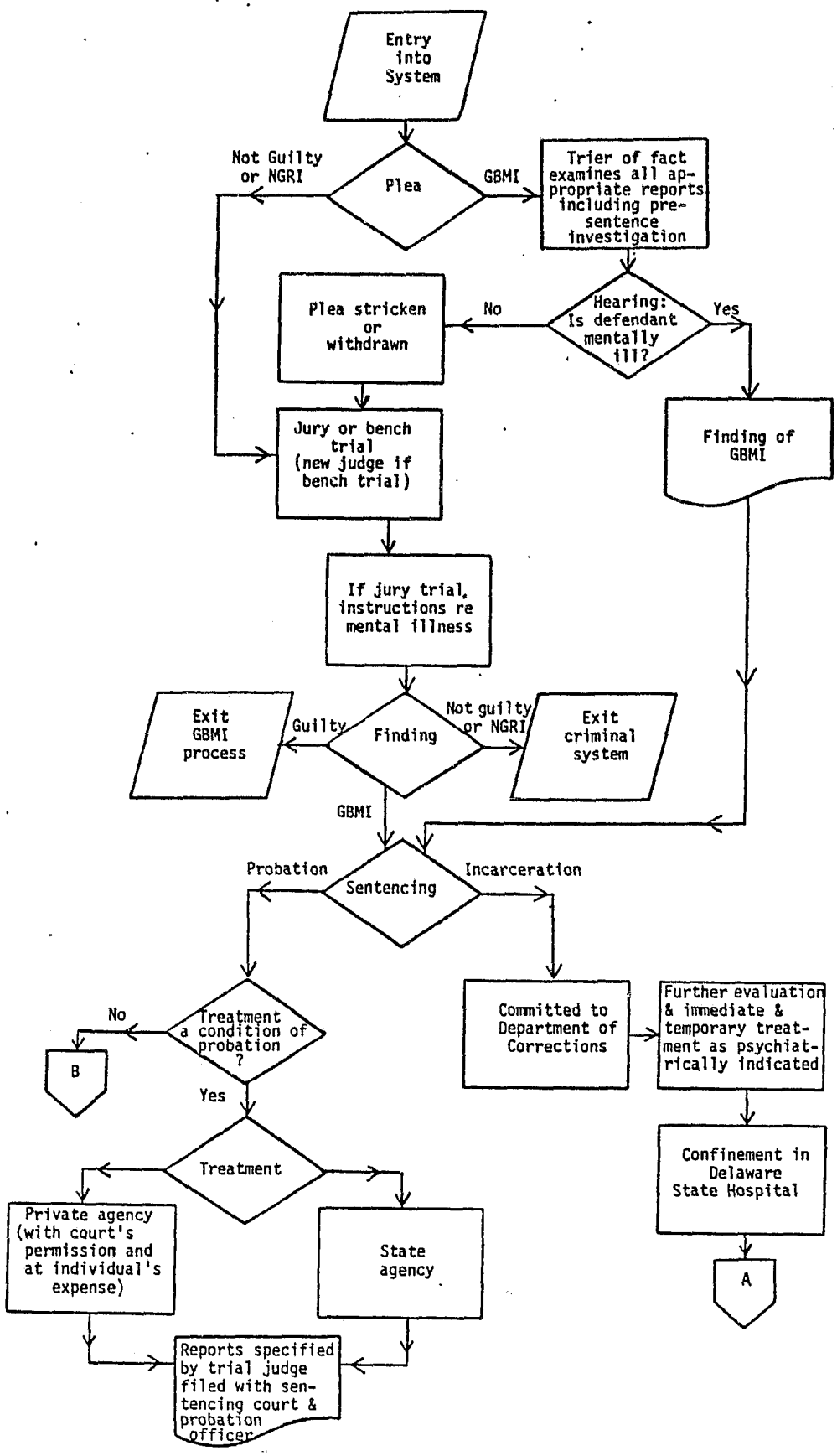
may cut down on recidivism by curing the illness. The other judge (C_2) said, however, that the quality of the treatment and the defendant's participation determined the treatment's effectiveness and its impact on recidivism. One mental health evaluator (E_1) commented that NGRI acquittees remain in the state hospital for extensive periods because their psychiatrists fear future violent behavior. He said that several NGRI acquittees had been removed from the maximum security ward and placed in open wards but that very few have actually been released. The few that have been released back into the population "have not caused much trouble." Another mental health evaluator (E_2) said that recidivism rates among released NGRI acquittees and GBMI offenders suffering from severe psychoses would not differ. The Department of Mental Health official (F_2) reported that the sample size was insufficient to permit speculation because only three out of 20 NGRI acquittees had been released by the time of the interview.

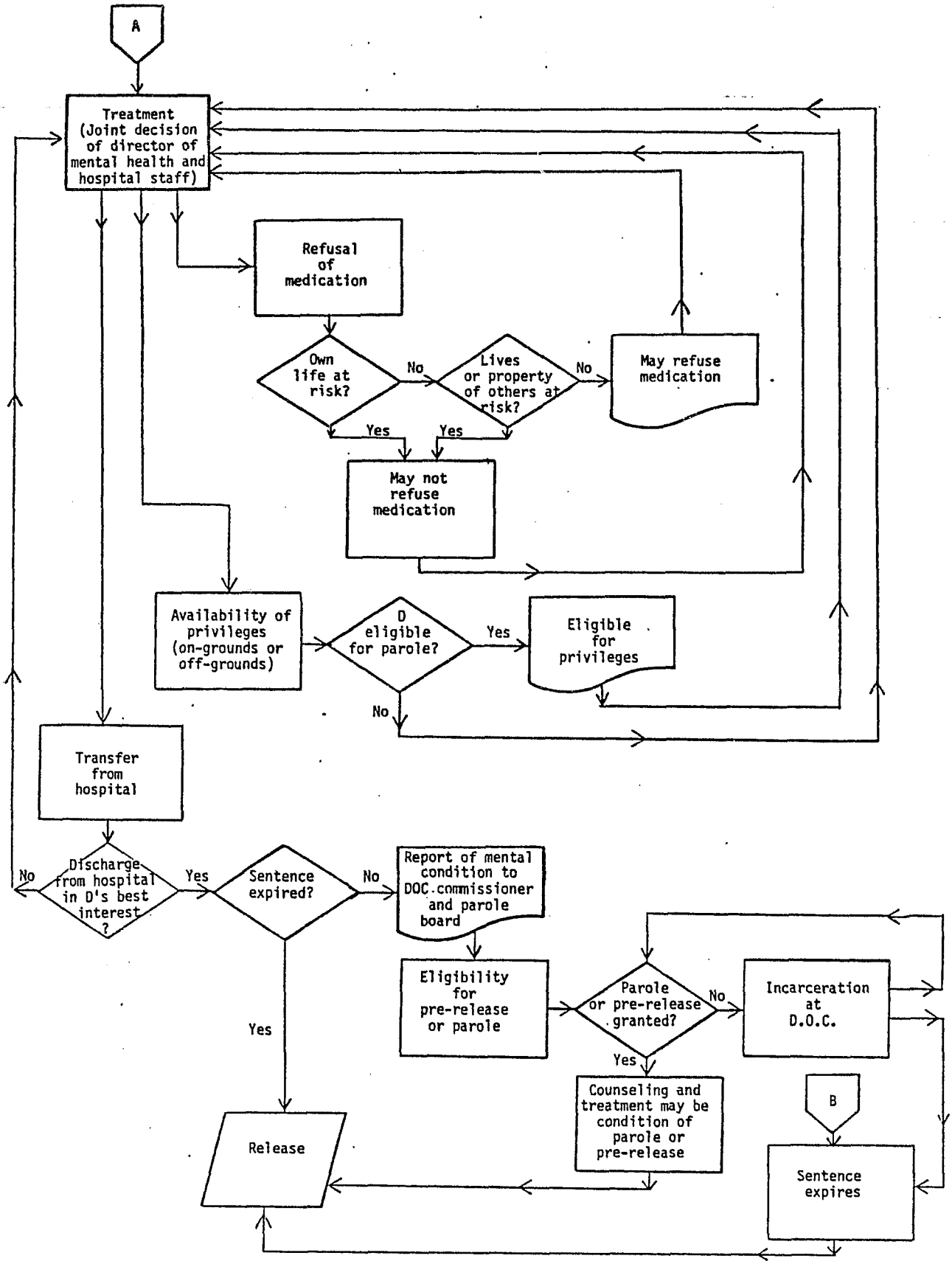
4. Procedures and Practices

a. General

Delaware's statutory GBMI procedures are depicted in Figure 2. When asked whether the GBMI alternative significantly changed the processing of mentally disordered offenders through the mental health-justice system, most respondents (A_1, B_1, C_1, C_2, F_1, F_2) replied that little or no change had occurred. Only one respondent, a defense attorney (B_2), commented that although no changes in the pretrial and trial phases had occurred, post-conviction processing of mentally disordered offenders had changed.

Figure 2. Delaware's Statutory GBMI Procedures




A
Treatment (Joint decision of director of mental health and hospital staff)
Refusal of medication
Own life at risk?
No
Lives or property of others at risk?
No
May refuse medication
Yes
Yes
May not refuse medication
Availability of privileges (on-grounds or off-grounds)
D eligible for parole?
Yes
Eligible for privileges
No
Transfer from hospital
No
Discharge from hospital in D's best interest ?
Yes
Sentence expired?
No
Report of mental condition to DOC commissioner and parole board
Yes
Eligibility for pre-release or parole
Parole or pre-release granted?
No
Incarceration at D.O.C.
Yes
Counseling and treatment may be condition of parole or pre-release
Release
B
Sentence expires

b. Pre-Trial Mental Health Examinations

In Delaware, pre-trial mental health screening is conducted through the Public Defender's office. This screening generally occurs before a bail hearing (D_2). When asked whether the method for conducting evaluations of GBMI defendants differed from the methods used with other defendants, one mental health evaluator (D_1) replied that his procedures were the same. Another mental health evaluator (D_2) said that because preliminary evaluations are performed without knowledge of the offender's intended plea, no difference would exist between evaluation techniques for NGRI or GBMI pleas. A third mental health evaluator (E_2) stated that his methods of evaluation were not dependent on a client's status; he always administered his testing and evaluation using a "continuous variable" view of the client which takes into effect all of the external forces affecting a client's behavior but which does not necessarily create any distinction based on GBMI or NGRI assertions by the client.

c. Mental Health Expert Involvement

When asked whether the GBMI law in Delaware had changed the involvement of mental health experts in criminal proceedings, both attorneys surveyed replied yes. The prosecutor (B_1) said that experts would have to make finer distinctions in pointing out the differences between GBMI and NGRI. The defense attorney (B_2) observed that experts now were testifying even in pleadings procedures to help judges in making decisions regarding mental illness. He asserted that, before GBMI, mental health expert testimony never would have been used if a defendant entered a guilty plea. One superior court judge (C_1) said that involvement of mental health experts had not increased while the other

(C_2) said that, especially as the mental health evaluation resource in the Public Defender's office became more sophisticated, the involvement of experts definitely would increase. He also said that as the courts become more sophisticated in dealing with mentally disordered defendants, they might demand more expert testimony.

d. Criteria Used by Judges

Two respondents addressed the criteria or factors judges use in making GBMI decisions. The prosecutor (B_1) said that a judge listens to any expert testimony presented and then applies the statutory criteria analytically to that testimony. In other words, the facts presented in each individual case would constitute the criteria judge considered in making GBMI determinations. The defense attorney (B_2) observed a case in which the judge referred to a copy of the GBMI statute and asked the expert to frame his testimony within the statute. By doing this, the judge was better able to determine whether the defendant's mental illness fell within the scope of the law. The criteria he used, then, were those set forth in the statute.

When asked whether judges generally understand and make the appropriate distinctions between insanity and mental illness, both attorneys replied affirmatively. The defense attorney (B_2) said that judges were very careful in this area and the prosecutor (B_1) replied that he was "extremely impressed with the sensitivity expressed by judges in handling GBMI pleas; the nature of questioning showed a clear and thorough understanding."

e. Juries

Because no jury verdicts of GBMI have occurred in Delaware, the respondents speculated based on their experiences and observations of

jury practices in similar circumstances. When asked whether the GBMI law might increase or decrease the number of jury trials involving mental aberration, the two attorneys each said no. One (B_1) said that GBMI availability might reduce the potential number of jury trials. The other (B_2) thought that judges could better make the necessary distinctions, so he would opt for a bench trial in a potential GBMI case. One judge (C_1) said that no change would occur because the insanity defense rarely is raised. He added, however, that GBMI could be a fairly effective plea-bargaining tool for the state and thereby implied that a decrease in jury trials might result. One mental health evaluator (E_2) speculated that the number of defendants raising the insanity defense might decrease under GBMI and cause a lowering of the number of jury trials.

The respondents were evenly split regarding whether jurors would be able to understand and make appropriate distinctions between insanity and mental illness. One judge (C_1), who had presided over a jury trial in which the insanity defense was asserted, said that the jury did not understand the difference between guilty and GBMI; he believed that "the expressions on their faces and looks from their eyes" conveyed their lack of understanding. The defense attorney (B_2) agreed that the distinction would be too fine and difficult for jurors to understand. The prosecutor (B_1), on the other hand, speculated that the jurors would have no trouble understanding the concept, but probably would fail in objectively applying the law to the facts. Another judge (C_2) stated, however, that he has "been amazed by how a jury, given the proper instructions, has been able to handle complex issues."

The respondents also were split regarding whether jurors understand the expert testimony presented at trial. One judge (C_1) said that jurors did not understand while the other (C_2) said they did. The defense attorney (B_2) said that expert testimony tended to be too technical for lay jurors to understand. The prosecutor (B_1) observed that jurors are "always impressed when an expert testifies and always pay attention." He opened, however, that a jury construes the testimony to support the result it prefers. When asked whether jurors understood the dispositional differences between a finding of GBMI and NGRI, all four respondents (B_1, B_2, C_1, C_2) agreed that jurors were not permitted instructions regarding the dispositional differences. At the time of the interviews standardized instructions had been drafted but had been adopted yet. One attorney (B_1) said, however, that the well-informed jury might be aware of the differences anyway.

f. Sentencing

Delaware law provides for the imposition of any sentence on a GBMI defendant that lawfully could be imposed on any defendant found guilty of the same offense.[6] When asked whether the length or type of sentence for guilty or GBMI offenders differ in practice, all six respondents agreed that the GBMI label would indeed effect a discrepancy in sentencing. Two respondents (B_1, H_1) said that GBMI offenders receive longer terms while three others (B_2, C_1, F_2) said the opposite was true. The prosecutor (B_1) and a parole official (H_1) said that longer sentences would be imposed because the public perceived GBMI defendants as being great risks to society. A defense attorney (B_2), a superior court judge, and a Department of Mental Healh official (F_2) said that GBMI convicts receive less severe sentences because of the mitigating effect of the mental illness.

Both superior court judges (C_1, C_2) indicated that their criteria for placing GBMI offenders on probation might differ from those for guilty offenders. One (C_1) observed that the severity of the offense would temper his decision of whether to place a GBMI offender on probation. The other judge (C_2) originally said that his criteria for consideration of GBMI probation would not be significantly different but then explained that he would look at the resources available to the defendant in the community (e.g., family, friends) in considering probation. He further said that he also would consider a defendant's intention to cooperate with mental health treatment.

g. Comparative Lengths of Confinement

Three (B_1, C_1, F_2) out of five respondents said that NGRI acquittees remain in involuntary confinement longer than GBMI offenders with similar backgrounds. One attorney (B_1) commented that the length of the confinement of an NGRI acquittee was contingent upon that patient's no longer being perceived as a threat to the community. A GBMI offender, on the other hand, is sentenced for a specified period of time. The judge (C_1) and a Department of Mental Health official (F_2) said that GBMI offenders would be released much sooner than NGRI acquittees because doctors who make release decisions are reluctant to release insanity acquittees. The public defender (B_2) said that the periods of confinement would be comparable for the two groups and that each patient's response to rehabilitation and treatment would dictate release.

h. Parole

Would GBMI offenders be paroled more frequently than similarly situated guilty offenders? The defense attorney (B_2) said that a GBMI

offender would have a better chance for parole than a guilty offender. The prosecutor (B_1) said the reverse was true; he contended that society feared mentally ill offenders and was cautious about their release into the community. The parole official (H_1) agreed with this, saying that even under normal circumstances, parole and reentry into a community is difficult and that the GBMI label might make parole more difficult because of the public's attitude towards mental illness.

i. Treatment

The Delaware GBMI statute provides that, upon conviction, a defendant shall undergo such further evaluation as is psychiatrically indicated. The GBMI law also calls for commitment of the GBMI to the custody of the Department of Corrections, which maintains exclusive jurisdiction over him, even while undergoing treatment at a hospital. Treatment usually is provided at the Delaware State Hospital, which is the only state hospital in Delaware. Occasionally, the Veteran's Administration Hospital treats GBMI veterans.

When asked how determinations are made about which offenders will receive mental health treatment and care and whether the GBMI label plays a role in such determinations, both attorneys (B_1, B_2) said that GBMI offenders are more likely to receive treatment. Both judges (C_1, C_2) agreed that the GBMI label would trigger a greater awareness, and consequently, treatment within the correctional system. One of them (C_1) believed that the awareness of the offender's mental condition effected by the mandate for evaluation would trigger treatment. The Department of Corrections official (F_1) observed that the GBMI label coupled with the "clout" of the court's finding would create a greater urgency for treatment of GBMI offenders as opposed to other offenders. A

Department of Mental Health official (F_2) said that too few GBMI findings had occurred to assess the issue accurately but speculated that treatment would be the same for any mentally ill offender in prison.

j. Transfers Between Corrections and Mental Health Systems

Transfer from the Department of Corrections to the state hospital involves a hearing. According to a Department of Corrections official (F_1), a prison mental health evaluator and a Department of Mental Health evaluator jointly examine the mentally ill offender and determine whether hospital services are needed. If treatment is indicated by the examination, the court conducts a hearing to determine whether to commit the prisoner to the hospital. According to the respondent, this hearing should be unnecessary if the defendant has been found GBMI. A Department of Mental Health official (F_2) said, however, that a recent superior court ruling[7] had made the hearing mandatory. Return to the prison from the hospital occurs when the hospital staff determines that an inmate is no longer in need of treatment.

5. Costs

Only one (F_2) out of eight respondents thought that the availability of GBMI would decrease the overall costs to the mental health-judicial system in Delaware. The Department of Mental Health official (F_2) said that because most NGRI acquittees remain confined longer than GBMI offenders, the availability of the GBMI alternative would effect a lower cost to the taxpayer. One prosecuting attorney (B_1) thought that costs would increase at least to the extent that a prison term would still have to be served following hospitalization. The remaining respondents (B_2, D_1, D_2, C_1, C_2, F_1) all said that costs would remain the same.

6. Perceived Strengths and Weaknesses of GBMI Provisions

Asked about what they perceived as the strengths and weaknesses of Delaware's GBMI provisions, respondents offered differing opinions. These opinions are reflected in Table 8.

When the attorneys were asked under what circumstances they might advise a client to enter a GBMI plea, one (B_1) replied that he would request evaluation of the defendant by his own retained psychiatrist. If the defendant fit within the mental illness criteria, he would then apply the facts of the case to his perception of what a jury would do. Only then, if the crime was not a serious one, would he consider recommending a plea of GBMI. The defense attorney (B_2) would recommend a GBMI plea only if the facts were indisputable, no psychiatric testimony supported a claim of insanity, and he believed he could get a better break for his client by entering the plea.

Finally, in discussing what he believed was the benefit of the GBMI law, one judge (C_2) focused on the shift in the philosophical view regarding responsibility for criminal behavior. For years, he explained, our system has insisted on excusing mentally incompetent people when they committed crimes against society. He views the enactment of GBMI as a shift in this philosophical underpinning and believes that society no longer is willing to sever responsibility from action in the law. He said that a person should be held responsible for his actions no matter what his mental state. If GBMI represents the shifting of this philosophy away from non-responsibility toward responsibility, he observed, it is a change for the good.

Table 8

Strengths and Weaknesses of
Delaware's GBMI Law

Strengths	A 1	A 2	B 1	B 2	C 1	C 2	D 1	D 2	E 1	E 2	F 1	F 2	H	Total
Responsibility for acts	X				X		X				X		X	5
Satisfies the public		X					X						X	3
Alternative verdict			X											1
Plea bargain tool				X	X									2
Curtails insanity defense					X									1
Provides treatment									X	X	X	X		4
Weaknesses														
Definitions weak/unclear			X				X							2
Compromise verdict				X										1
Eliminates valid defense (Irresistible impulse)					X									1
Avoids confrontation of mental illness issue							X							1
"Labels" offender for life											X		X	2
None	X	X									X			3

Footnotes

1. Del. Code Ann. tit. 11 §401(b) (Supp. 1983).

2. Id. at §401 (1979) (amended by 63 Del. Laws, ch. 328 §1, effective July 2, 1982).

3. The criteria included whether "the accused . . . lacked sufficient will power to choose whether he would do the act or refrain from doing it." Id. The new GBMI provision calls for consideration of whether "such person . . . [had] insufficient willpower to choose whether he would do the act or refrain from doing it." Id. at §401(b) (1983).

4. See id. at §401(a).

5. The courts have held that the burden of proof properly has been placed on the defendant. State v. Jack, Del. Gen. Sess. 58 A. 833 (1903): Longoria v. State, 168 A.2d 695 (Del. Super.), cert. denied, 368 U.S. 10 (1961); Mills v. State, 256 A. 2d 752 (Del. Super. 1969); United States ex rel. Hand v. Redman, 416 F. Supp. 1109 (D. Del. 1976).

6. Del. Code Ann. tit. 11 §408 (b) (Supp. 1983).

7. Vickers v. Jones (Del. Super.).

C. Georgia

1. Introduction

On July 1, 1982, Georgia's GBMI statute[1] went into effect. Documentation and review of the process by which defendants move through the mental health-criminal justice system prior to and following a GBMI verdict was achieved primarily through telephone interviews with knowledgeable respondents. Interviews were conducted with nineteen (19) individuals including a legislative source, three prosecutors, two public defenders, one private attorney, two judges, three county and state mental health professionals (knowledgeable with regard to pretrial and postacquittal evaluation procedures, and treatment and administrative concerns), six Department of Offender Rehabilitation representatives (encompassing diagnostics and classification, treatment, probation, and administrative personnel), and a respondent familiar with the procedures and concerns of the Board of Pardons and Paroles. Interviews were completed between August 21 and September 14, 1984, following on-site case file data collection in the Department of Human Resources (DHR) and the Department of Offender Rehabilitation (DOR). The respondents selected represent the entire state system rather than a particular metropolitan area or jurisdiction. Taken as a whole, the interviewees' experiences encompass all of the incarcerated GBMI defendants (172) and a majority of the NGRI acquittees since 1982. Additional insights incorporated into the following process description and accompanying discussion were drawn from personal conversations and a review of administrative regulations of the involved agencies and descriptive materials provided by state sources.

2. Legislation: Historical Context and Purposes

a. Legislative Background

In 1980, a federal district court ruling in an important class action suit[2] resulted in major changes in the disposition and confinement of NGRI acquittees. Prior to the Benham decision, an acquittee could petition for release 30 days after hospitalization. If he or she was not released, the petitioner was not eligible for a second review hearing until one year had passed.[3] One DHR staff member noted a specific abuse of the existing procedural framework as the numerous refusals by many judges to release individuals who were acquitted of minor offenses and were not considered dangerous. The federal district court required that a hearing be held 30 days after admission to a state hospital to determine whether an NGRI acquittee met the criteria for involuntary civil commitment (ICC). If not, release from confinement was mandated.[4]

According to five of the eight respondents that provided legislative background information, one practical outcome of Benham was the increased difficulty of confining NGRI acquittees for significant periods. The public and professional consensus was that only the most violent individuals met ICC standards.

Four interviewees noted that one individual who was released following the Benham decision committed a multiple murder shortly after his release. Members of the judiciary registered frustration which was echoed by vociferous public outcry.[5] After several revisions of proposed legislation, the active support of the Attorney General's Office and the Prosecuting Attorneys' Council culminated in the passage of

Georgia's GBMI provision. The new statute was viewed as a remedy to the perceived problems surrounding the NGRI verdict, including dissatisfaction with the Hinckley decision, and the practical implications of Benham.[6]

b. Legislative Intent

An analysis of interview responses that focused on the intent(s) of the GBMI statute reveals a general consensus that the alternative verdict was conceptualized as both a method of rectifying the practical inadequacies of the NGRI verdict and a symbolic means of defusing the concomitant negative public sentiment. Comparison of the more detailed system and offender-related responses discloses a strong perception on the part of knowledgeable system actors that the GBMI provision was intended to result in the penal confinement of mentally disordered offenders. This perception is held by both legal (legislative, attorneys and judges) and direct service (mental health and corrections) respondents. There is less agreement, however, concerning the specific intention to provide treatment for such offenders, as is evident from a review of the following data.

Intent	Legal	Direct Service
Custody/Control[7]	9 (100%)	7 (70%)
Treatment	3 (37%)	5 (50%)
# Respondents	9	10

Those interviewed were also asked whether the perceived purposes of the state were being fulfilled. Half of the informants felt that the statutory intentions were being realized in practice. Six interviewees

(33%) responded negatively or stated that GBMI made no difference in practice and 3 (17%) expressed uncertainty. A breakdown by type of respondent is presented below.

Intent Fulfilled	Legal	Service
Yes	6 (66%)	4 (40%)
No	3 (37%)	3 (30%)
Uncertain	--	3 (30%)
# Respondents	9	10

Of those responding affirmatively, related comments tended toward statements about a perceived decrease in NGRI findings, an increase in prosecutorial and judicial control, or an increase in the confinement of dangerous mentally disordered offenders. Negatively disposed respondents, on the other hand, cited a lack of adequate funding, an inability to provide effective mental health treatment in a prison environment, or that the addition of the GBMI verdict did not result in any meaningful changes in the processing or treatment of mentally ill offenders.

Very little change in respondent attitudes toward the GBMI verdict was detected. The four informants (22%) that reported an attitudinal shift were evenly divided in terms of favorable and unfavorable changes. One judge stated the verdict was a sham since no treatment was being provided to GBMI offenders. The second negative response, put forth by a public defender, noted that some nonviolent individuals who did not belong in prison were being incarcerated under the auspices of the GBMI verdict. In contrast, both interviewees who reported a favorable shift

were DHR staff members. One felt that the increased control over mentally disturbed offenders was a plus. Although the other respondent felt that the GBMI verdict had no practical utility, an acknowledgement of the political expediency of the change was expressed.

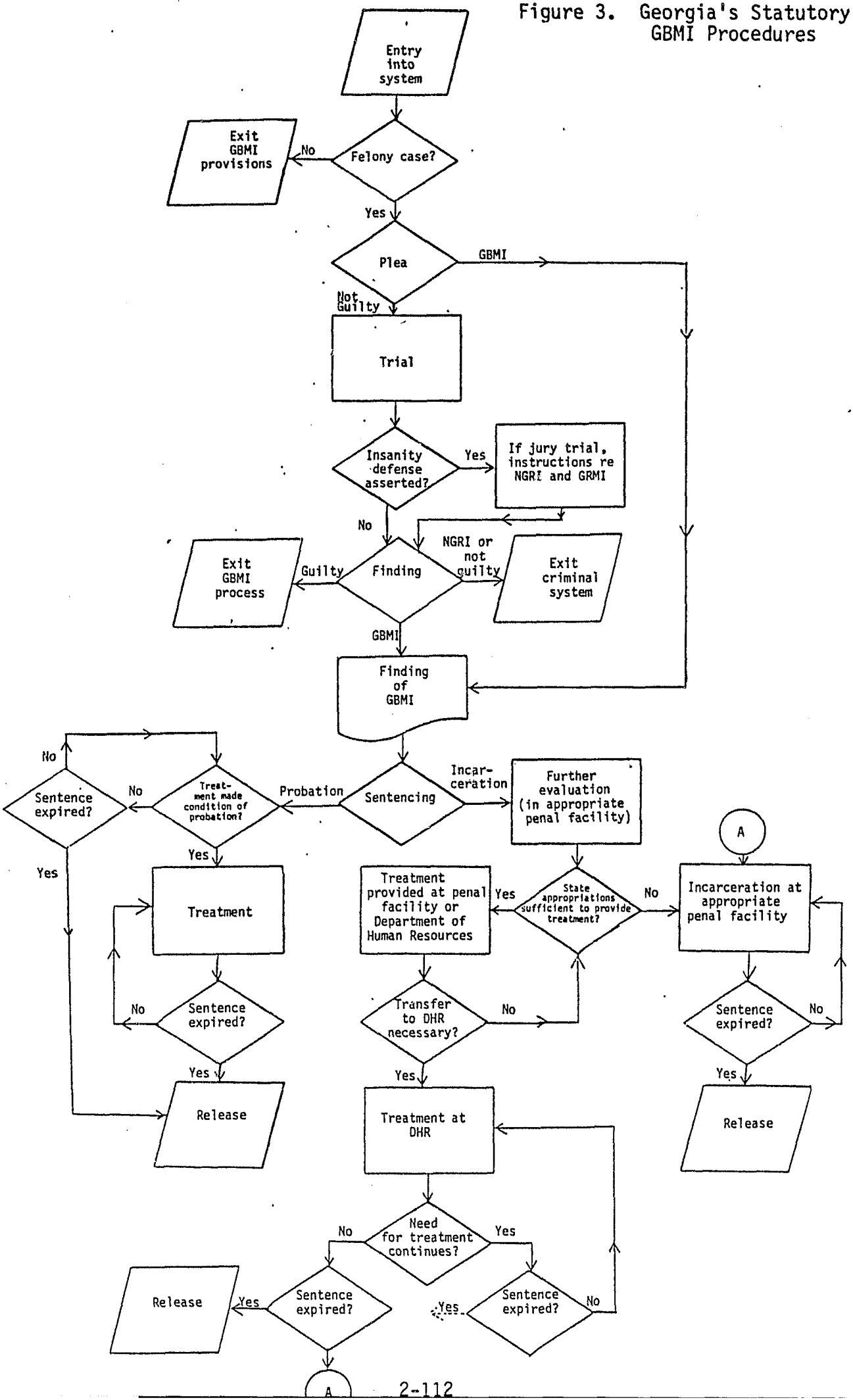
3. Procedures and Practices

a. Raising the Issue of Mental Aberration

Concerns about mental stability or defect generally arise during pretrial activities and hearings. The judge, prosecutor, or defense attorney can request a pretrial forensic evaluation if there is reason to question (1) a defendant's competence to stand trial or (2) the existence of the necessary intent to assign criminal responsibility. One prosecuting attorney reported that, in that particular jurisdiction, formal concerns about mental status were usually brought to the court's attention by the state. (It should be noted, however, that the GBMI statute does not require a pretrial evaluation prior to a finding of GBMI.[8])

All pretrial forensic evaluations are initiated by a court-order forwarded by the court clerk to the DHR forensic team responsible for evaluation for the forensic unit at Grady Memorial Hospital[9] in Atlanta. According to one evaluator, evaluations are usually conducted within 10 days of receiving the request and the necessary supporting documentation. Often the prosecutor and/or defense attorney are contacted for additional background information as well. The mental health professionals interviewed agreed that most evaluations are conducted in jail. In exceptional circumstances, a defendant can be admitted to a mental health facility for evaluation. This generally occurs when the defendant is in a state of mental crisis or when reliable test results can not be otherwise obtained.

Figure 3. Georgia's Statutory GBMI Procedures



Prior to an examination, a defendant is advised of the nature of the evaluation and the potential use of its results in the disposition of the case. Examinations consist of formal psychological testing, observation of behavior and orientation to time, person, and place, a memory check, and an interview focusing on the instant offense. Following the evaluation, a report is prepared for the court that addresses the examiner's diagnostic opinion, treatment recommendations (if appropriate), and forensic considerations of competency and criminal responsibility. All respondents involved in or familiar with pretrial forensic examinations stated that evaluation procedures are identical for all defendants and such procedures have not been altered since passage of the GBMI statute. Two defense attorneys did, however, report a perceived change in evaluation findings. Both felt that defendants were less likely to be found incompetent to stand trial since the institution of the GBMI verdict. No explanation was offered for this perceived change.

b. Plea Bargaining

Each of the three prosecutors interviewed reported both accepting GBMI pleas when offered by the defense and offering such a verdict as a plea bargain. One district attorney noted that offers involving a GBMI finding were made liberally whenever there was evidence of prior mental health problems or when the criminal behavior seemed somewhat bizarre. The rationale for such offers, simply stated, was that it might help the defendant and it certainty could not hurt. A staff member with the DOR, however, noted that attorneys are unaware of the fact that the GBMI label may actually limit the treatment options available to the offender.

All prosecutors interviewed felt that the existence of the GBMI verdict made their jobs a little easier. Since it appears to most of the respondents that juries are unlikely to return NGRI verdicts, a defense attorney has little or nothing to gain by going to trial. In most cases, the facts are clear as to factual (as opposed to legal) guilt. Therefore, defense attorneys are more accepting of a GBMI finding.

When specifically asked why or under what conditions a defendant would plead GBMI, the three prosecutors reiterated their belief that defendants tend to recognize the futility of pursuing an NGRI trial verdict. Of the eleven respondents that answered this question, eight (72%) noted that the need for or expectation of receiving treatment was a significant factor. The provision of treatment is assumed to make a GBMI verdict more attractive to defendants than a guilty verdict. In fact, one judge reported accepting GBMI pleas on occasion solely because the defendant wanted to receive treatment while incarcerated. (There may, however, be a misconception about the type and location of treatment to be provided. One respondent reported that several defendants who entered GBMI pleas had been told they would serve their sentences in a mental health facility instead of a prison. Furthermore, a GBMI verdict does not guarantee a defendant treatment once incarcerated.)

Three respondents (two defense attorneys and one judge) suggested that defendants or their families might save face with a GBMI verdict. For example, if the individual is convicted of child molestation, a GBMI finding with its focus on mental illness is easier to accept or tolerate in a small rural community in Georgia. Furthermore, formal recognition of the mental illness may ease the offender's integration into the

correctional system since child molesters are often outcasts even in prison. The tenth respondent, a DOR staff member, thought that defendants might plead GBMI with the expectation of receiving a lighter sentence since mental illness can be considered a mitigating factor.

c. Juries

Of the ten interviewees responding to the series of questions concerning juries, six (60%) expressed the view that juries are more likely to render a GBMI verdict rather than an NGRI acquittal, particularly in sensational and/or exceptionally violent cases. This perception even encompasses those findings pertaining to defendants whom the respondents felt met the NGRI criteria. A statement by one judge succinctly summarizes the general consensus: "If [the defendant] is sick but it's certain he committed the crime, [the jury] wants him in prison." In fact, two of the three prosecutors contacted reported that they had not witnessed even one NGRI finding by a jury since the GBMI statute went into effect.

Jurors were generally credited with being able to understand the differences between the statutory NGRI and GBMI definitions. That does not mean, however, that the letter of the law prevails. As representatives of the community, jurors try to do what is right in the eyes of the public, which does not include excusing someone who is guilty of criminal behavior. Two defense attorneys expressed the view that jurors ignore the substance of the mental illness and insanity definitions entirely and focus solely on guilt. In their opinion, this can and does result in defendants being found GBMI who meet the legal criteria for insanity.

The impact of expert testimony on juror decision-making was also explored. Of the five individuals who felt competent to respond, three thought that jurors tend to ignore expert testimony or place little or no credibility in such testimony. One judge and one prosecutor felt that jurors do understand and weigh the expert testimony presented during trial. The same two interviewees reported that conflicting expert testimony is rare, thereby automatically reducing the potential for confusion.

It should be noted that no respondent perceived a change in the nature of the testimony presented. One pretrial evaluator employed by DHR has noticed that conclusions concerning criminal responsibility are not sought as frequently. This shift was viewed as positive since it is more in line with the capabilities and responsibilities of forensic mental health professionals. Three additional respondents reported a decrease in the need for expert testimony due to fewer requests for jury trials. This result appears to be linked with the perception that many GBMI verdicts are achieved through plea bargaining.

Pattern jury instructions, formulated by the Council of Superior Court Judges, serve as guidelines for trial judges. The consensus among the interviewees was that in practice, most judges use the pattern charge without modification. All of those who responded to the question about juror comprehension of the jury instructions reported that jurors usually do not understand the charge (two prosecutors, two public defenders, one private attorney, and one judge).

Although the relevant pattern jury instructions do not include information about the disposition of GBMI and NGRI defendants, one

prosecutor and one judge believed that there are usually a few jurors that know NGRIs may be released from the hospital after a short time period. On the other hand, two defense attorneys reported that after rendering a GBMI finding, several jurors were disconcerted upon realizing the offender would be sent to prison rather than a mental hospital. The private attorney expressed the opinion that jurors are totally unfamiliar with the dispositional consequences of a GBMI verdict.

Only four respondents were willing to directly compare bench and jury findings. One judge and one prosecutor felt that the factors considered in reaching a verdict were identical regardless of type of trial: (1) if the defendant knew right from wrong and (2) if there was evidence of mental illness. The two defense attorneys perceived a major difference in the criteria considered and the ultimate outcomes. Since judges focus on the legal criteria for establishing intent, judges are viewed as more likely to return an NGRI verdict when appropriate. Juries, in contrast, focus on factual guilt and therefore, are more likely to render a GBMI or a guilty verdict. One respondent felt that the lack of an articulated statutory GBMI standard was a problem in this regard.

d. Sentencing

Eleven of the nineteen interviewees responded to questions about differential sentencing between GBMI and guilty offenders. Of the eleven, 45% indicated that, in their experience, the sentences received did not vary by group. One prosecutor elaborated by stating that no reason existed for offering different sentences in plea bargaining and that a shorter sentence for GBMIs would be unacceptable. This position

is directly related to the feeling of enhanced prosecutorial control discussed earlier. The one judge who responded in a similar fashion did so for a different reason. He felt that since the Parole Board controls actual release, the sentence given is virtually meaningless anyway. It was noted, however, that if the mental illness component of the plea were considered separately, most judges would probably view it as a mitigator, thereby resulting in somewhat shorter sentences for GBMI offenders. The second judge agreed with the latter expectation. Four respondents felt it was too early to know how the GBMI verdict would impact sentencing patterns, if at all. One respondent suggested that GBMI offenders would receive longer sentences than guilty offenders. Indirect information from defense attorneys assigned to prison cases indicated that no differences in sentence length were evident thus far.

A traditional alternative to sentencing an offender to prison is to place the offender on probation. In Georgia, probation is a state function provided by a separate division of the DOR. (Fulton County used to operate an independent probation department, however, it was incorporated into the state system as of July 1, 1984.) No probation policies or procedures were changed or added due to the implementation of the GBMI alternative. The standard needs and risk assessment instrument used for all probationers includes a category focusing on mental problems. Probation officers carefully track those offenders with conditions of probation that mandate treatment. Furthermore, each of the ten probation districts has a psychologist who monitors caseload records to verify mental health referrals, identify specific needs, and followup concerning the provision of services. In addition, treating facilities

routinely provide the Probation Division with progress reports which provide another monitoring mechanism. Offenders who do not fulfill their mental health treatment requirements can, and often do, have their probation revoked.

The use of probation for felony defendants found GBMI was discussed with respondents. Both of the judges interviewed reported that a GBMI offender was unlikely to receive probation because GBMI offenses tend to be serious, and in some cases violent. The concern for public protection in such cases excludes the granting of probation. One judge also concluded that if a GBMI offender were placed on probation, it was almost certain that he or she would have a special condition included requiring mental health treatment. The probation official interviewed agreed with this reasoning as well.

The other two respondents that provided a viewpoint on probation were prosecutors. One individual's interpretation was that probation was inappropriate for a GBMI offender. (A DHR representatitve reported awareness of particular cases in which probation was granted inappropriately.) The finding was viewed solely as an aid for prison classification. Furthermore, a defendant could receive probation without being labeled GBMI. The second district attorney was in agreement with this statement, also noting that a forensic evaluation would be necessary prior to placing a GBMI offender on probation. For this reason, it would be more efficient to grant probation without the GBMI label.

Only one interview respondent reported direct knowledge of a GBMI offender receiving probation. The defense attorney involved was somewhat surprised when the defendant was placed on probation following a GBMI

conviction for robbery. In this particular case, the offender was so mentally ill that his probation was revoked after a very short time due to the bizarre behavior he exhibited.

Data on GBMI probationers are scant. According to the results of a Probation Division survey, only six GBMI offenders have been placed on probation in Georgia. (These figures do not include the metropolitan Atlanta area due to the county's recent merger with the state probation system. An Atlanta area district attorney estimated that 1% of the GBMI cases from the metropolitan area actually receive a sentence of probation.) Of the six known GBMI probationers, one was from northern Georgia and the other five are all from the same circuit court in southern Georgia. In each case, the purpose of granting probation was the provision of mental health services on an out-patient basis.

Georgia's sentencing scheme also allows for the imposition of split sentences. The form split sentencing has assumed in Georgia is one of initial incarceration followed by a period of probation. In most cases, the total sentence is split equally between prison and probation or the period of incarceration is slightly longer than the probated portion of the sentence.

Of the four respondents who addressed split sentencing issues during the interview, two (a prosecutor and a DOR administrator) indicated that GBMI offenders probably would not receive such sentences very often. The other two interviewees (also a prosecutor and a DOR staff member) suggested that split sentences would be quite appropriate for GBMI offenders. This sentence form would enhance reintegration into society and ensure the continuation of treatment after incarceration.

e. Confinement and Parole

Comparing perceptions about the length of confinement of NGRI, GBMI, and guilty offenders also involves perceptions about sentencing and parole. The previous discussion of sentencing patterns pertains solely to guilty and GBMI offenders. As noted above, five respondents felt that sentences received by similar GBMI and guilty offenders would be the same. The actual period of confinement, however, could vary depending on the practices of the Board of Pardons and Parole. On the other hand, NGRI acquittees are released by the court. In all three types of cases, the recommendations and concerns of mental health professionals are weighed prior to the actual decision-making process.

Four interviewees responded to the question about comparative confinement periods between NGRI and GBMI offenders. The two public defenders and one judge that answered were in agreement that GBMIs would be held for a longer period of time. This perception was based primarily on the differences in the release mechanisms. NGRI acquittees are released from state mental health facilities by the court either (1) after an initial 30 day observation period, the results of which indicate that the individual does not meet the criteria for ICC, or (2) after an on-going treatment regimen has resulted in progress such that the acquittee no longer meets the ICC standard. One DHR representative expressed concern that, after the initial 30 day period of observation, some judges won't release an NGRI acquittees because they feel he or she is dangerous even though a mental health professional has testified that th individual does not meet ICC criteria. The private attorney interviewed expected the different release procedures to have an opposite effect since GBMI offenders have a specified sentence yet NGRI's can be held indefinitely.

It should be noted, however, that the eight state treatment facilities are not identical in their NGRI admission criteria. All DHR mental health patients are housed in the regional hospital for their cachement area unless exceptional circumstances warrant other placement. In the case of NGRI acquittees, the most violent and seriously ill individuals will be transferred to the Binion Building (males) or the Powell Building (females) at Central State Hospital (CSH) in Milledgeville.[10] Therefore, the average length of confinement for acquittees placed at CSH will tend to be longer than that at other DHR facilities.

The GBMI-guilty side of the confinement coin depends upon parole practices. Seven interviewees discussed their expectations with regard to this point. Three respondents (a prosecutor, a judge, and a DOR employee) suggested that parole decisions were more likely to be tied to (1) the degree of an individual offender's mental illness and improvement and (2) his or her adjustment to prison, rather than to the GBMI label. Secondarily then, the actual prison term served would depend upon whether the GBMI finding itself were appropriate (i.e., the offender is in fact mentally ill) and one's willingness to accept treatment (if treatment were recommended).

The two other prosecutors expressed the viewpoint that the Parole Board probably treats guilty and GBMI offenders in much the same way. One of these district attorneys stated that there might, however, be a general tendency to view offenders with the GBMI label as less able to control their behavior in the community. The perceptions of the two remaining respondents (public defenders) were in harmony with this

approach in that mental illness would indeed be a negative factor in the parole decision-making process. It was assumed that the Parole Board would be reluctant to release a GBMI offender due to the increased risk associated with parolees who have mental problems. One attorney specifically feared that GBMIs would "max out" before the Parole Board would agree to release them.

A review of the practices and procedures employed by the Parole Board indicates that many of the respondents' concerns are addressed routinely. According to an administrator with the Board of Pardons and Parole, special care is taken when reviewing GBMI offenders. This attention, however, is not unique; rather, the same care is taken with any individual who has experienced mental health problems in prison or whose offense involved particularly bizarre aspects.

The typical parole review procedure begins with an investigation into the case including gathering information about the offense(s), interviewing the inmate, conducting a social investigation, and reviewing the offender's prison record. The data collected are then applied to the parole guidelines used by the Board. The guidelines encompass factors such as the severity of the offense, criminal record, and prison adjustment. Past or current mental health problems are not specific variables included in the guidelines. However, since the guidelines are only internal recommendations, such information could be used as a reason for deviation from the guidelines.[11] For example, unpredictable violent behavior would provide justification for continued incarceration. In the same vein, the fact that an offender who was recommended for mental health treatment refused such assistance might

indicate to the Board that the offender is unaware of his or her treatment needs and might be a difficult person to supervise on parole. Such behavior might also indicate the inability or lack of commitment to follow through with required out-patient treatment after released. Once the information is gathered and applied to the parole guidelines, the Board members vote.

The special attention accorded GBMI offenders and other inmates with mental health problems generally takes the form of obtaining a current mental health status evaluation. The results of this testing are included with the other data assembled for review. The second distinctive consideration might involve inclusion of a special parole condition requiring outpatient treatment. As mentioned earlier, neither of these practices represents a change in organizational behavior caused by passage of the GBMI statute nor a practice unique to GBMI offenders. The Board's major concern is the mental and social stability and potential for success of individuals who are paroled.

f. Without GBMI . . .

One of the major purposes of the GBMI verdict discussed in the relevant literature is the reduction of NGRI findings. This goal is inextricably related to the question of displacement: Do GBMI offenders actually represent individuals who would have been found NGRI in the absence of the GBMI verdict? This question was posed to the interviewees.

Of the thirteen respondents that offered a reply, eight (61%) expressed the opinion that the majority of GBMI offenders would have been guilty. Several bases for this belief were noted. One prosecutor and two DHR officials drew this conclusion based on the inherent difficulty

of obtaining an NGRI verdict. These three respondents noted that human nature mandates that a finding including the words "not guilty" will be aversive to jurors regardless of whether an individual qualifies for the insanity defense in a legal sense. Two DOR representatives arrived at the same conclusion by virtue of their knowledge of the incarcerated GBMI population. Both intimated that the majority of GBMI offenders are not seriously mentally ill (if they are ill at all). Additional support for this position included the statement that "only a handful of GBMIs were previously found to be NGRI." A third DOR employee suggested that without the GBMI option, most offenders would receive guilty verdicts because the majority achieved their GBMI finding through a plea bargain they thought would lead to mental health treatment.

Two interviewees (both public defenders) felt that most GBMI offenders would be found NGRI without the new verdict. The two legally-oriented respondents based their statements on their lack of awareness of an NGRI jury verdict since the GBMI statute went into effect. Within their combined experience, they were aware of only two NGRI bench findings during the same time period.

One prosecutor and two mental health professionals stated that GBMI verdicts would have been divided between NGRI and guilty findings along specific lines. The attorney speculated that the more serious, violent cases would have received guilty verdicts due to public protection concerns, regardless of the extent and nature of the defendants' mental illness. The less serious cases could be expected to split into the two traditional verdict categories based on such factors as the defendants' criminal history, mental health history, and nature of the offense. The

DHR respondent focused more on the mental illness of the offender. This respondent stated that the chronically mentally ill who also happened to be chronic offenders were more likely to be found guilty. Those who would receive NGRI verdicts were more likely to be in an acute stage of mental illness at the time of the offense and would be less likely to be chronic offenders.

Grouped by type of respondent, the responses provided can be presented as follows:

	Legal	Direct Service
Most guilty	2 (40%)	5 (72%)
Most NGRI	2 (40%)	1 (14%)
Split	1 (20%)	1 (14%)
# Respondents	5	7 (100%)

g. Post-conviction Evaluation

Once a GBMI verdict has been rendered, male offenders are transported to one of three DOR facilities: Georgia Diagnostic and Classification Center (GDCC), Coastal Correctional Institution (CCI), or Georgia Industrial Institution (GII). The GDCC handles the majority of incarcerated male offenders in the state and evaluates and classifies all of the male GBMI offenders. All female offenders are sent to the Georgia Women's Correctional Institution (GWCI) for post-conviction evaluation and classification. The diagnostic procedures employed by the two facilities are quite similar. The GBMI screening process differs from that used for guilty offenders in only one respect. Due to the label,

all GBMI offenders receive complete psychological and psychiatric assessments whereas other offenders receive such evaluation only as indicated by the findings of preceding screening procedures.

Following initial intake activities such as photographing, fingerprinting and showering, each inmate is given a preliminary medical examination. Very soon thereafter, generally within the first week, a comprehensive medical exam is conducted and diagnostic testing is initiated. This generally includes the administration of standardized intelligence and achievement tests, psychological batteries (such as the MMPI), and vocational aptitude tests. Sociological interviews are conducted to obtain family background information, identify substance abuse history, and assess security risks. A mental status exam is conducted that includes assessments of the offender's orientation to person, place, and time and a memory check. The results of the psychological testing and the preliminary mental status exam are (1) in the case of guilty offenders, used to determine the need for referral to the psychiatrist and/or psychologist, or (2) in the case of GBMI offenders, forwarded to the psychiatrist and psychologist for use in the full mental health evaluation that follows. According to a DOR representative, the goal of this process is to determine the type and degree of any existing mental disorder for placement and treatment decision making. Based on their findings, the psychiatrist and/or psychologist provide institutional placement and treatment recommendations.

The diagnostic procedure for female felons begins with a preliminary review by a behavior specialist. A questionnaire is completed that

provides information about past and present medical and mental health problems, related treatment, and any suicide attempts. A referral to the mental health team leader is made on all GBMI offenders and for appropriate guilty offenders. A referral form is completed that addresses daily functioning, current thought processes, any test results available, and specific problems encountered. The team leader reviews the referral and screens the individual more thoroughly before arranging for psychological and psychiatric evaluation for all GBMIs and those guilty offenders that require a complete work-up.

h. A New Evaluation Component

Four respondents (all direct service staff) mentioned a new post-conviction evaluation procedure that would soon go into effect. The forthcoming change, the result of an interagency agreement between DHR and DOR, will create an additional mental health evaluation component for inclusion in the processing of GBMI offenders. Following a GBMI conviction, DHR regional forensic team staff will conduct a preliminary mental exam at the jail prior to admission to DOR. This evaluation is designed to fulfill two purposes: (1) provide a solid foundation for the DOR screening process that follows, and (2) identify immediate mental health needs and crises with an eye toward recommendations concerning hospitalization, medication, and institutional adjustment concerns. The DHR report will accompany the inmate to the DOR diagnostic center. According to one DHR representative, the new evaluation procedure will provide immediate professional mental health assessment that is in the best interests of the clients and the two involved agencies. All of the respondents that discussed the pending institution of this procedure were favorably disposed to the modification.

i. Placement

In the case of male offenders, a classification specialist reviews all the data gathered during the diagnostic phase and determines each individual's security and basic mental health treatment needs.[12] Actual institutional placement is then based on the MH/MR classification standards promulgated by the DOR.[13] The authority for making assignments to the various MH/MR supportive living units are vested jointly in the MH/MR team leaders and the consulting psychiatrist or psychologist.

The GBMI label serves to limit the institutional assignment of males to one of the nine institutions that provides the level of specialized mental health services a GBMI offender is assumed to require.[14] Inmates who exhibit significant impairment in adaptive functioning although their symptoms are generally under control are assigned to institutions[15] that provide Level Two MH/MR services. Use of physical and chemical restraints is not the norm and services focus on re-establishing adequate psychological functioning. Level Three services are required for inmates who have a major thought or mood disorder and who are incapable of managing everyday activities, thereby resulting in the need for placement in a mental health supportive living unit.[16]

Level Four is reserved for inmates experiencing uncontrollable psychotic behavior. In such cases, formal documentation and clinical observations of severe dysfunctional behavior are necessary to justify transfer[17] to the closed DHR forensic unit noted earlier, the Binion Building at CSH.[18]

The development of individual treatment plans by interdisciplinary treatment teams occurs at the receiving institution and is based on the diagnostic data and observations after arrival at the designated facility. Treatment plans identify management needs, the appropriate security level, and psychiatric (including medication) and counseling services required. Mental health treatment is then provided in accordance with this plan and is adjusted as necessary following periodic review.

j. Mental Health Staffing

According to a DOR official, between 750 and 800 inmates (including GBMIs) are on the MH/MR caseload at any given time. This special group represents about 5% of the total prison population in Georgia (approximately 16,000 offenders). Clinical mental health services are provided by private psychologists and psychiatrists on consulting contracts with DOR. Using this approach, the state believes quality services that meet typical community standards can be provided at less cost with less staff turnover.

A psychiatrist provides clinical screening assistance at the GWCI diagnostic center eight hours a week. A licensed clinical psychologist is present six hours a week. The much heavier evaluation load at GDCC is met by the services of a psychologist two days a week and a psychiatrist one day per week. Each professional handles an average of 12 inmates a day.

Clinical consultation at the Level Two institutions varies depending on the size of the institution and the number of inmates requiring specialized services at any given time. On the average, a psychologist

or psychiatrist is available eight hours a week at each institution. In contrast, the Level Three facilities receive approximately 25 hours of psychiatric consultation and 15 hours of psychological services every week. These specialized clinical services are in addition to that provided on an on-going basis by full time DOR mental health team leaders, social workers, and behavior specialists. In Level Two institutions, the counselor/inmate ratio standard is 1:30. This goal has been achieved in only two of the seven facilities. The Level Three standard, which is met in one of the two institutions, is 1:15-20.

k. Treatment

Each of the DOR staff interviewed stated that mental health treatment is provided based on individual inmate needs and functioning levels. The types of services available to inmates include individual and group counseling, specialized psychiatric and psychological services, psychotropic medication, activity therapy, and milieu therapy (for those housed in supportive living units). Specialized treatment groups focus on suicide prevention, substance abuse, and stress management. Although formal sex offender programs do not exist, many counselors address the dynamics of child molestation, rape, and so forth on an ad hoc basis. In addition to standard and remedial educational[19] and vocational training programs, treatment services include prerelease activities and coordination with public mental health professionals upon discharge.

Considering the extensive discussion about the provision of mental health treatment to GBMI offenders, respondents were asked if inmates so labeled were more likely to receive treatment than guilty offenders in

the general prison population. The responses obtained were:

	Legal	Direct Service
Yes	5 (63%)	1 (13%)
No/Individualized	3 (37%)	7 (87%)
# Respondents	8 (100%)	8 (100%)

A larger proportion of judges, prosecutors, and defense attorneys than direct service staff responded that GBMI offenders were more likely to receive treatment. Although this is not the case, one prosecutor specifically stated that the GBMI statute requires the provision of mental health services. The one judge and two public defenders that responded negatively referred to the lack of sufficient treatment resources and the unfulfilled expectation that a separate DOR treatment unit would be established for GBMI offenders.

The DHR and DOR staff that responded were more inclined to expect the provision of individualized treatment. Each of these seven interviewees noted that mental health services are made available solely as a function of the degree of mental illness. The GBMI label was viewed as a legal designation that does not and should not dictate the provision of treatment.

1. Transfer Procedures

Inmates that require Level Four mental health services are transferred to the Forensic Services Center at CSH through DOR and DHR administrative procedures. Transfers are initiated by the MH/MR unit involved. Documentation of current mental status and needs, including specific behaviors observed, is assembled in order to justify

hospitalization. If the transfer is considered routine, the completed referral form, supplementary materials, and the inmate's file are forwarded to the DOR Psychiatric Screening Board. The Board convenes every Wednesday to review the referrals. If there is agreement, the inmate is admitted to CSH for psychiatric treatment. If an inmate's mental disorder is so severe that he or she (1) presents a substantial risk of imminent harm to self or others, or (2) is so unable to care for his or her own health and safety as to create an imminently life threatening situation, an emergency transfer is initiated. The inmate is then immediately transferred to the Forensic Services Center for a comprehensive evaluation. The CSH medical staff evaluate the inmate to ensure appropriate referrals. All transfer procedures meet due process requirements including notice of rights, provision of a hearing, and notice of and access to an appeals process.

Admission evaluations conducted at CSH, (identical to NGRI postacquittal evaluations), include an immediate medication review, full psychiatric assessment, and social history. Various standardized tests are employed depending on the psychological aspects to be addressed. Following evaluation, treatment plans based on identified individual needs are developed by a team comprised of a psychiatrist, psychologist, administrator, and social worker. The range of treatment options encompasses individual and group counseling, psychotropic medication, token economy program, and recreational and occupational therapy. All inmate transfers are housed on the forensic unit that also houses defendants admitted for inpatient pretrial evaluation, NGRI acquittees

(the largest single group), individuals found incompetent to stand trial, and violent involuntary civil committees. The average unit population is 75 males and 10 females, of which 25-30 are NGRI acquittees.

Once the inmate's condition has stabilized, CSH notifies DOR for return transfer. The actual transfer is usually held in abeyance for four days to two weeks due to space and assignment problems. Standard DOR procedure requires that returning inmates enter a Level Three institution unless CSH advises that other placement is acceptable. Even though the individual's condition has stabilized, DOR staff assume that he or she still has severe mental health problems that require the specialized services of a Level Three facility.

4. Recidivism

None of the nineteen respondents felt comfortable responding to questions concerning comparative recidivism rates among NGRI acquittees, GBMI, and guilty offenders. Their inability to respond was due to the relatively short timeframe since the enactment of GBMI. One attorney did note that recidivism would depend on the receipt of adequate treatment rather than any legal label.

5. Costs to the System

Fourteen of the nineteen respondents discussed actual or anticipated costs to the system related to implementation of the GBMI statute. One prosecutor was under the impression that additional funding had been provided by the state legislature. A second respondent, a DOR representative, reported that no additional expenses would be incurred due to integration of GBMI processing into the existing evaluation and

treatment schemes. In contrast, five interviewees (one prosecutor, two defense attorneys, a judge, and a DOR official) expressed concern about the lack of fiscal appropriation necessary to adequately implement the new GBMI-related procedures. The two defense attorneys speculated that a reallocation of treatment resources might be appropriate. This conclusion was based on the assumption that DHR costs would decrease due to the (expected) accompanying decrease in NGRI findings and commitments while DOR costs would increase in order to provide mental health treatment for the new subgroup of offenders.

A mental health professional with DOR drew attention to costs related to developing and instituting the necessary GBMI-related administrative procedures, including the resources required to provide computerized tracking capabilities. Six respondents (four service-oriented professionals, the private attorney, and one prosecutor) were specifically concerned about the need for additional evaluation and treatment personnel. The four respondents affiliated with DHR and DOR pointed directly to the increased demand for intensive post-conviction evaluation resources. While it is true that DOR evaluates and classifies all newly admitted offenders, the provision of comprehensive psychological and psychiatric assessments for all GBMI offenders, regardless of the actual need for a complete workup, has placed a strain on the diagnostic center staff. This concern is particularly relevant since a records check by DOR staff indicated that approximately a third of the incarcerated GBMI offenders exhibit no active mental health problems at the time of classification.

Two DHR representatives discussed the anticipated costs of implementing the new post-conviction evaluation procedures.[20] The workload for most of the regional forensic teams is expected to be manageable. Concerns were raised, however, about the effect of this workload in the Atlanta area. Two additional staff positions have been requested although there is no real expectation of receiving approval.

6. Perceived Strengths and Weaknesses of GBMI Provisions

The perceived strengths and weaknesses of Georgia's GBMI provisions and actual implementation, as reported by the nineteen respondents, varied considerably. The opinions expressed are grouped and presented in Tables 9 and 10.

It is interesting to note that eight of the nineteen interviewees (42%) perceived the treatment emphasis of the GBMI verdict as a strength. At the same time, however, five respondents (28%) lamented the lack of actual treatment, thereby implying the existence of a gap between intent and practice. This is related to the perception that the GBMI finding is misunderstood by counsel, judges, defendants, and the public. Four respondents (22%) reported that this misconception encourages unrealistic expectations about the provision of mental health treatment. One of the perceived strengths cited by six interviewees (33%) is the increase in public protection. If, in fact, additional treatment is not provided or the GBMI finding is being used inappropriately, the perception of heightened public safety may be unfounded.

There appears to be significant variation between legally-oriented actors and providers of direct services concerning the treatment focus.

Table 9

Perceived Strengths of Georgia's
GBMI Provisions and Processing

	Respondents											
	Legis.	Atty. P	Atty. D	Judge	LEGAL SUB-TOTALS	Pret. Eval.	Post. Eval.	Trmt.	Prob.	Parole	DIRECT SERVICES SUBTOTALS	Total Responses
Creates Logical Subgroup	1	1		1	3	1					1	4
Treatment Emphasis		1	1	1	3	1	1	2		1	5	8
Increase Public Protection		2	1	1	4		2				2	6
Balances Penal Goals		1			1							1
Improved Attitudes of Public				1	1							1
Improved Interagency Coordination						1		1			2	2
Visibility of mentally ill offenders' needs							1	1		1	3	3
Expedites Case Processing		1			1			1			1	2
More Valid NGRI Findings								1			1	1
No Strengths			1		1							1
No Opinion									1		1	1
Number of Respondents	1	3	3	2	9	2	2	4	1	1	10	19

Table 10

Perceived Weaknesses of Georgia's
GBMI Provisions and Processing

	Respondents											
	Legis.	Atty. P	Atty. D	Judge	LEGAL SUB-TOTALS	Pret. Eval.	Post. Eval.	Trmt.	Prob.	Parole	DIRECT SERVICES SUBTOTALS	Total Responses
Philosophically unacceptable								2.			2	2
Avoidance of difficult moral decisions								1.			1	1
Conceptually confusing		1			1							1
Curtailment of proper insanity findings	1		3		4			2	1		3	7
Inappropriate findings of mental illness							1	2			3	3
No actual treatment		2	2	1	5							5
Encourages unrealistic expectations of treatment			2		2			2			2	4
Insufficient resources provided		2	1	1	4				1		1	5
Inappropriate treatment priorities		1			1							1
Operationalized ineffectively		1	1		2	1		1			2	4
No pretrial evaluation requirement							1	1			2	2
Lack of interagency coordination								1			1	1
Unnecessary practically								2			2	2
No weaknesses				1	1	1					1	2
Number of Respondents	1	3	3	2	9	2	2	4	1	1	10	19

Of the seven respondents who pointed to GBMI's emphasis on treatment, five (71%) were treatment-oriented interviewees. The data indicate that this perception on the part of mental health and corrections staff is related to the secondary effect of the GBMI verdict's increasing the visibility of mentally ill offenders' needs. On the other hand, the legal actors in the system seem disappointed or surprised that all GBMI offenders do not automatically receive mental health treatment during incarceration. One respondent may have identified the key problem here by stating that "the GBMI verdict may be a legal tool but it is not a clinical tool and it should not be viewed as such."

Of the nineteen respondents in Georgia, only one was whole heartedly opposed to the GBMI verdict and only two expressed no reservations about the verdict's use. If use of the verdict is going to continue in Georgia, the positive and negative comments of those who participated in these interviews may well serve as the foundation for discussion and fine tuning of the alternative verdict's statutory provisions and actual procedures. The fact that a new postconviction evaluation procedure that addresses perceived inadequacies will soon be operational may indicate that mental health and criminal justice practitioners in Georgia have already initiated the necessary on-going collaboration that results in improved service delivery, legal reform, and social change.

Notes

1. Ga. Code Ann. §17-7-131 (Cum. Supp. 1983).

2. Benham v. Edwards, 501 F. Supp. 1050 (N.D. Ga. 1980).

3. I. Ermulu, GBMI: In Search of Perspective (1983) (unpublished paper).

4. 501 F. Supp. at 1059.

5. Ermulu, supra note 3.

6. None of the 19 respondents were able to cite other statutory or judicial changes that would affect mentally disordered defendants that occurred in juxtaposition to passage of the GBMI statute. One attorney mentioned revisions to the involuntary civil commitment statutes other than application to insanity acquittees. No effect on criminal offenders was expected, however. See Appendix E for a description of changes in Georgia law that might be coincidental with GBMI enactment.

7. The custody and control category includes responses that focused on confinement, punishment, and public protection.

8. See Ga. Code Ann. §17-7-131 (Cum. Supp. 1983).

9. Grady Memorial Hospital is jointly funded by Fulton and DeKalb counties. The forensic unit includes a teaching component affiliated with the Emory University School of Medicine.

10. The CSH operates the central closed forensic unit for the dangerous criminally insane. The Binion Building also houses individuals found incompetent to stand trial, violent involuntary civil committees, voluntary and involuntary inmate transfers, individuals committed for in-patient pretrial forensic evaluations, and defendants experiencing a mental health crisis while in jail awaiting trial or sentencing.

11. The Board agrees with the parole guidelines recommendation in approximately 80% of all cases reviewed. When there is variation, it is generally in the direction of longer confinement.

12. GWCI provides all levels of mental health treatment as well as meets the varying security needs. Therefore, placement decisions focus mainly on general population or mental health unit assignment concerns.

13. These procedures, detailed in internal DOR operational procedures are consistent with the classification standards of adaptive functioning for mental health and mental retardation as delineated in the Diagnostic and Statistical Manual of Mental Disorders, third edition.

14. Level One, reserved for inmates who have no serious or permanent emotional problems and who can function in the normal prison environment, excludes GBMIs by administrative policy.

15. Central Correctional Institution (CI), Coastal CI, GII, Georgia State Prison, Augusta Correctional and Medical Institute, Rutledge CI, and Youthful Offender CI.

16. Women who meet these criteria are assigned to the 22 bed supportive living unit at GWCI. Men with similar needs are placed at Metro CI.

17. See infra, "Transfer Procedures," for a description of inmate transfer procedures.

18. It should be noted that the mental health/mental retardation classifications discussed here were in place before the GBMI verdict went into effect.

19. No special institutions exist for mentally retarded offenders. If an offender's level of functioning is low, he or she is placed on the MH/MR caseload. If the individual is functioning at an acceptable level, assignment to the general population is appropriate. However, special education services are provided for the mentally retarded.

20. See supra, "A New Evaluation Component," for a discussion of this modification.

D. Indiana

1. Introduction

On September 1, 1980, Public Law 204 became effective, thus making Indiana the second state to enact guilty but mentall ill (GBMI) legislation.[1] During July through August 1984, project staff interviewed fourteen (14) individuals in Indiana concerning the history, operation, and consequences of Indiana's GBMI law. Persons interviewed included three superior court judges (C_1, C_2, C_3), two prosecutors (B_1, B_2), a public defender (B_3), a private attorney (B_4), a pre-trial forensic mental health examiner (D), a mental health administrator (F_1), an administrator of a forensic unit of a state mental hospital (F_2), an administrator of a reception and diagnostic center within the Department of Corrections (F_3), a probation officer (G), and a parole department official (H).[2]

Although no accurate state-wide statistics were cited, interview respondents estimated that as many as 150 GBMI findings have been rendered in Indiana. One mental health administrator (F_1), citing statistics available to the Department of Mental Health, stated that 43 GBMI offenders (less than 1 percent of the 4,989 commitments) were committed to the Department of Corrections since January 1983. Eighteen (18) GBMI offenders were committed to the Department of Corrections in Fiscal Year 1983 (July 1983 to June 1984), including two offenders receiving inpatient treatment at the Department of Corrections' mental health unit in Westville and sixteen offenders in the general inmate population. A Department of Corrections official (F_3) stated that many more GBMI offenders, approximately 50 to

60, are committed to the department each year. Another respondent, a prosecuting attorney (B_2), provided the data on insanity plea filings and dispositions in felony cases in Lake County, Indiana from 1978 to 1983 summarized in Table 11.

In early 1984, the Indiana Judicial Center's Judicial Reform Committee conducted a mail survey concerning the GBMI findings in Indiana. The committee sent surveys to Indiana's 231 circuit courts requesting informatiom about GBMI cases in the period between September 1980 and July 1983. Eighty-one courts (35 percent) responded to the survey, 33 of which reported GBMI cases involving a total of 64 persons. Of that number 46 persons (72 percent) were sentenced to the Indiana Department of Corections for terms of two to 130 years. Thirteen (20 percent) received some form of probation. Four were sent to the Department of Mental Health, one was allowed to become a voluntary civil patient, and one was found not competent to stand trial. The majority of reporting courts had handled only one or two GBMI cases during the three-year period.

2. Legislation: Purposes and Historical Context

This section describes the changes in law coincidental with the enactment of Indiana's GBMI law, the precipitating factors leading to the enactment, and the legislative purposes of the GBMI provisions as perceived by survey respondents. The Indiana legislature provides no formal record of its intent.

a. Changes Coincidental with the Indiana GBMI Legislation

Even though Indiana's GBMI law occupies a distinct point in Indiana's legislative history, according to one prosecuting attorney (B_2), the

Table 11

Disposition of Insanity (Felony[a]) Cases
In Lake County Indiana, 1978-1983

	Year						
Filings/Dispositions	1978	1979	1980	1981	1982	1983	Total
Insanity Pleas	32	17	27[b]	15	17	7	115
Dispositions:							
GBMI	--	--	3	4	4	2	13
NGRI	3	2	2	0	1	1	9
Guilty	21	15	15	10	10	4	75
Not Guilty	1	0	1	0	1	0	3
Dismissed	7	0	6	1	1	0	15
Total	32	17	27	15	17	7	115

Notes: a. Approximately 900 to 1,000 felony cases are filed each year in Lake County.
b. Most of these filing occurred before the GBMI legislation took effect September 1, 1980.

enactment of the GBMI law in Indiana was only one part of broad reform of Indiana's mental health law spanning several years. In 1978, two years before the GBMI law took effect, the Indiana legislature shifted the burden of proving insanity from the prosecution to the defendant.[3] Significantly, the prosecuting attorney who provided the data from Lake County (F_1) summarized in Table _, believed that the reduction of insanity plea filings in felony cases in Lake County was in large part attributable to the shift in the burden of proof, at least more so than to the availability of the GBMI alternative.

b. Precipitating Factors

When asked whether a particular case, incident, or problem was the catalyst for the Indiana legislature's adoption of the GBMI alternative, several respondents mentioned two cases: State v. Kiritsis[4] and State v. Judy.[5] The defendant in Kiritsis kidnapped an Indianapolis businessman and held him at gunpoint before television cameras. This much-publicized case led to the legislative proposal, dubbed the "Kiritsis Bill," to shift the burden of proving insanity to the defendant.[6] Interestingly, even though Kiritsis predated Indiana's enactment of the GBMI law by several years, several survey respondents linked the case to the GBMI legislation.

State v. Judy involved a defendant who murdered a mother and her three small children.[7] Public reaction to the case contributed significantly to the passage of the GBMI provision in Indiana.[8] Public safety, perceived to be threatened by the possibility that defendants in cases like Judy and Kiritsis would escape prosecution by means of the insanity defense, appears to have been the catalyst, at least in the

view of several respondents,[9] for the passage of Indiana's GBMI law. One mental health administrator (F_1) made the connection between these cases and the GBMI legislation when he stated that the intent of the GBMI law was to "prevent defendants like Kiritsis from getting off 'scott-free.'"

Another case linked to the passage of the Indiana GBMI law is the 1979 killing of major league baseball player Lyman Bostock in Gary, Indiana. The defendant in the case, Leonard Smith, was acquitted of the murder charge by reason of insanity and subsequently was released less than seven months after his trial.[10]

c. Legislative Purposes

Respondents associated the perceived legislative intents of the GBMI provisions in Indiana with a threat to public safety engendered by the insanity defense. Respondents' answers to a question about the legislative purposes of the provision fell into nine categories:

(1) curtailment of insanity acquittals (F_2, B_3, H, G, C_3);

(2) elimination of the perceived abuses of the insanity defense (B_2, C_2);

(3) increase in public safety (F, B_2);

(4) appeasement of the public (B_4);

(5) provision of a "middle-ground" finding lying between "guilty" and "not guilty by reason of insanity" (B_1);

(6) more flexibility to the judiciary in its handling of mentally ill offenders (F_3);

(7) treatment for mentally ill offenders (B_1, D, B_2, C_3, F_2);

(8) response to complaints by the psychiatric community that the insanity defense forced psychiatrists to "cross over" into a legal arena where they felt uncomfortable (B_4); and

(9) legislative purposes obtuse and difficult to fathom, because nothing is wrong with the insanity defense (C_1).

Reactions to the perceived impact of the GBMI provisions in Indiana were mixed. When asked whether the intents of the GBMI legislation had been fulfilled, all seven respondents who had indicated that the legislative intent was to curtail the insanity defense and prevent it's abuse, (1) and (2) above, said that the intent had been fulfilled, at least to some degree. Two of these respondents, a public defender (B_3) and a probation officer (G), were quick to point out, however, that although the GBMI finding had curtailed insanity acquittals, the actual number of acquittals had remained very small.[11] Another respondent, a parole official (H), stated that the GBMI provision had fulfilled its intent to curtail the insanity defense insofar as it had provided the courts an alternative to sending defendants to jail or putting them back on the streets.

Similarly, two respondents (B_1, F_3) agreed that the GBMI finding had provided a "middle-ground" that gave judges and jurors more flexibility in making decisions about mentally disordered offenders. One attorney (B_4), who believed that Indiana's GBMI law was meant only to appease the public, saw no signs that the law had accomplished this purpose. Two respondents (F_1, B_2), who saw public protection as the major purpose of the legislation, disagreed regarding the actual effect of the law.

Four out of five respondents expressed serious doubts about whether the legislative purpose of providing treatment to mentally disordered offenders had been accomplished in Indiana (B_2, C_3, D, F_2). One respondent (D) was strong in his denunciation of the GBMI law on this score. He stated that GBMI offenders are not provided preferential

treatment and that Indiana's GBMI law is a "fraud produced in response to public outrage." Only one prosecuting attorney (B_1), who acknowledged the legislative intent of providing treatment to GBMI offenders, said that the intent was being fulfilled.

3. Characteristics of GBMI Offenders

When asked what characteristics of GBMI defendants most distinguished them from defendants found NGRI or guilty, respondents did not present a clear composite picture. Acknowledging that the GBMI label is applied to all types of offenders and cuts across all offense categories, three respondents (B_2, F_2, F_3) stated that GBMI offenders tend to be more frequently convicted of sex crimes and other crimes of violence than NGRI acquittees. One judge (C_1) believed that defendants accused of drug-related crimes, sex crimes, and shoplifting were most likely to be found GBMI largely because of the existence of treatment programs within the Department of Corrections for these categories of defendants. Other distinguishing characteristics of defendants most likely to be found GBMI that respondents mentioned included defendants with a history of prior institutionalization (B_1), defendants with personality disorders (B_4), and defendants whose mental health forensic examinations resulted in a unanimity of psychiatric opinion (C_2). Four respondents were unable to form an opinion regarding the characteristics most likely to be found among GBMI offenders (B_3, C_3, D, F_1).

The primary aim of the GBMI law, in Indiana[12] and elsewhere,[13] is to decrease the number of insanity acquittals and thereby assuage public concern that insane and dangerous offenders, released after a short period of hospitalization, will be free to prey upon the community. This

aim appears to be based at least in part upon the assumption that a significant class of mentally disordered offenders exists who have sufficient knowledge, appreciation, and control of their actions that they should be held responsible but that they avoid criminal responsibility with successful insanity defenses. It is possible, however, that the relatively small number of insanity acquittals throughout the country accurately reflect community sentiments about criminal blameworthiness and that the GBMI findings will go to a new subclass of offenders who are clearly mentally disordered but who would not escape punishment by successful insanity defenses.

Would those defendants found GBMI under present Indiana law be found NGRI or guilty if the GBMI alternative were not available? A conclusion that GBMI offenders would have been found guilty in the absence of the GBMI law would suggest that the GBMI finding had not fulfilled the purpose of undercutting NGRI findings.

Ten respondents answered the question. Seven respondents believed that defendants found GBMI under Indiana law would have been found guilty had the GBMI alternative been unavailable (B_1, B_3, C_1, C_3, D, F_1, F_2). Several respondents cautioned, however, against the conclusion that the adoption of the GBMI statute did <u>not</u> effect insanity acquittals by noting that a finding that the majority of GBMI offenders would have been found guilty in the absence of the GBMI alternative may simply be an artifact of the very small number of insanity acquittals throughout the state.

Three respondents (B_2, B_4, C_2) believed that the majority of GBMI offenders would have been found NGRI in the absence of the GBMI

law. One mental health forensic examiner (D) noted that a sub-group of GBMI offenders may have been successful with an insanity defense had it not been for their attorneys "convincing" them that a GBMI plea was in their best interest. According to this respondent, the attorneys in these cases may have been reluctant to risk an unsuccessful insanity defense and may have considered the GBMI plea a "safer route."

Finally, the question of recidivism rates of GBMI offenders who are either placed on probation or released after serving their time is of obvious relevance to society's interest in protecting itself from dangerously mentally ill persons. Asked whether recidivism rates would vary among NGRI, GBMI, and guilty offenders, only four of twelve respondents were able to offer an opinion. Two respondents, a private attorney (B_4) and a judge (C_3), said that recidivism rates probably would not vary. Two respondents, a Department of Corrections official (F_3) and a probation officer (G), said that GBMI offenders would exhibit higher recidivism rates than NGRI and guilty offenders. According to the Department of Corrections official, GBMI offenders tend to be charged with "emotional crimes against people" caused by mental health problems that persist over time. Acknowledging that his experience with GBMI probationers was limited, this probation officer suggested that it is likely that GBMI offenders would have "a tough time" during probation. He estimated that his department has conducted pre-sentence investigations of approximately 40 GBMI cases. In only one of these cases was the GBMI offender placed on probation. Probation was revoked in this case because the probationer "could not adjust to life in the community."

4. Procedures and Practices

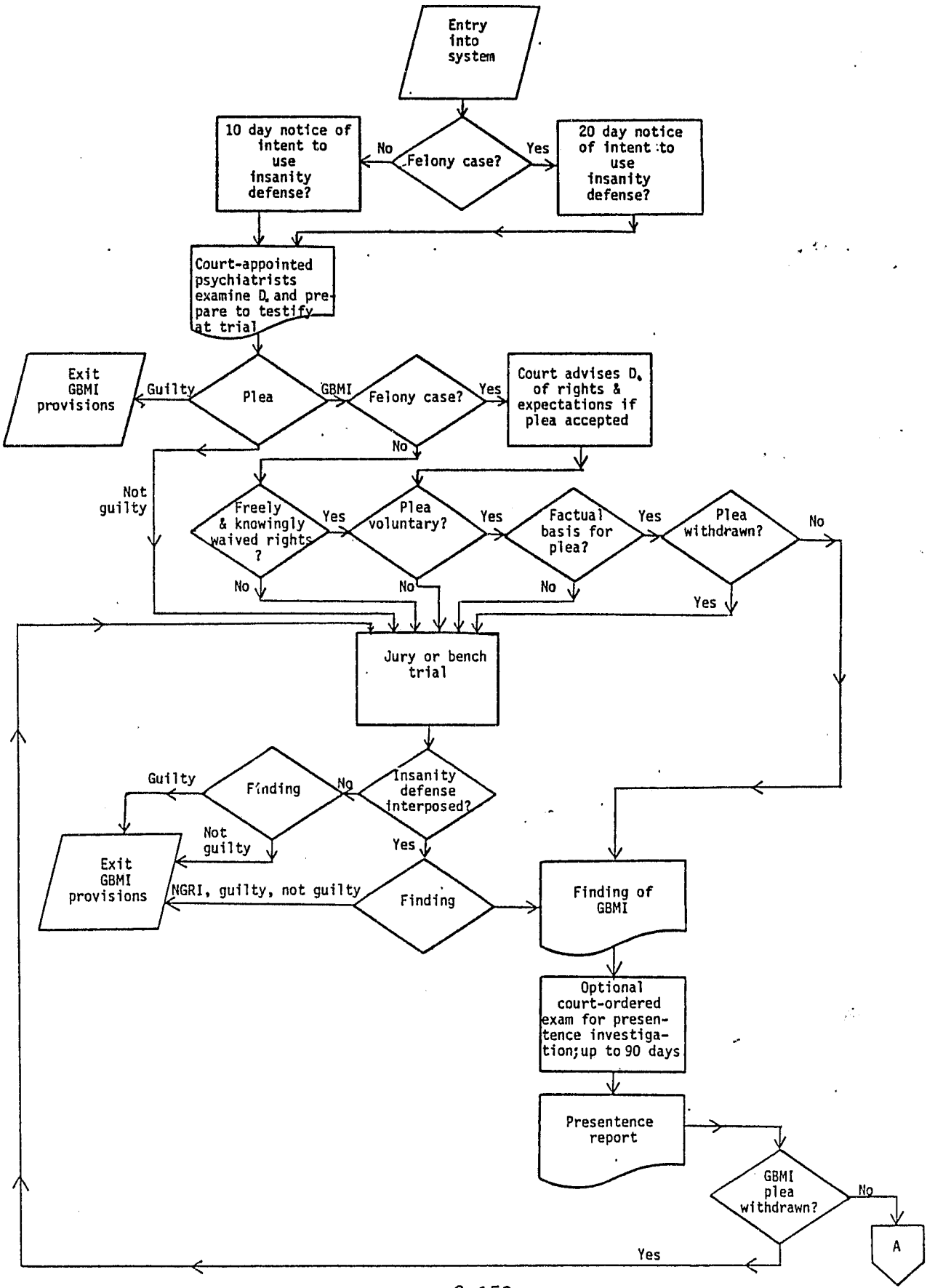
a. General

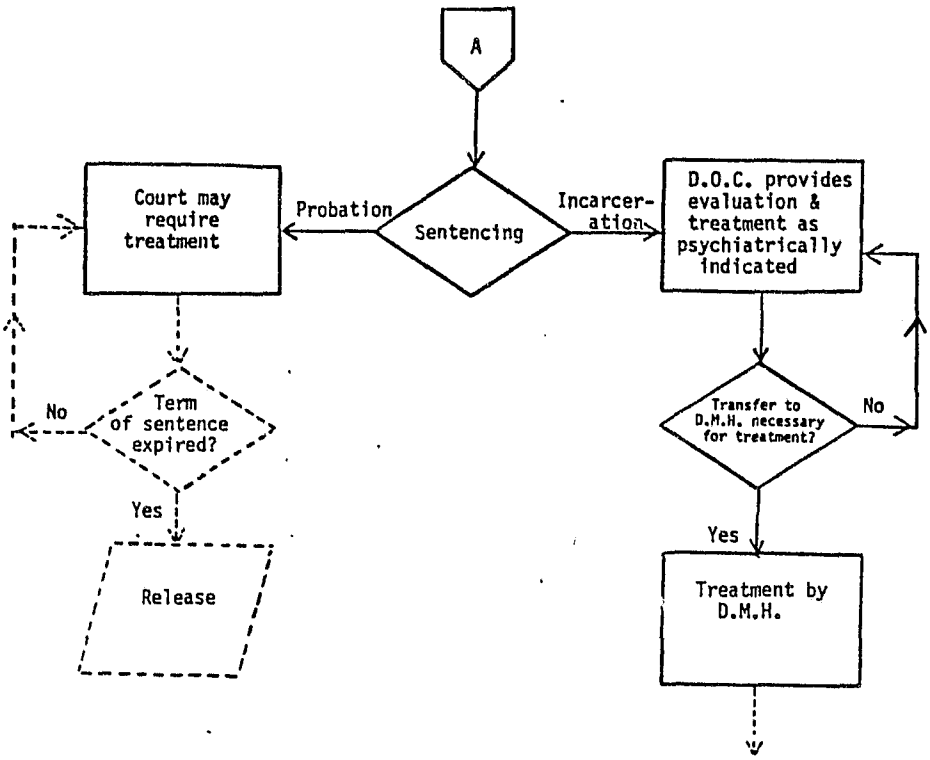
Indiana's statutory scheme for handling GBMI defendants is depicted in Figure 4 . Notwithstanding these procedures, when asked whether cases involving mental aberration are handled differently because of the availability of the GBMI finding in Indiana, all but two of the respondents said that the GBMI alternative in Indiana did not significantly change the processing of mentally disordered offenders through the mental health-judicial system.

One attorney (B_3) stated that the GBMI provision "does not do anything. It offers no advantage. It is the same as a guilty plea or verdict." A prosecuting attorney (B_1) indicated that severely disturbed defendants would be transfered to a mental health facility for a determination of competency to stand trial, regardless of the availability of the GBMI alternative. A judge noted that, although the law generally had not changed the handling of cases involving mental aberration, he recalled one case in which the GBMI law made a difference by providing a viable alternative to "either the street or prison."

Only two respondents, a prosecuting attorney (B_2) and an attorney in private practice (B_4), stated that their dealings with mentally disordered offenders was altered by the availability of the GBMI alternative. The private attorney stated that he would counsel clients that a jury would be less likely to render an NGRI verdict because of the availability of the GBMI alternative. This attorney said that he would not pursue an NGRI acquittal in front of a jury. He noted, however, that the same would not be true in a bench trial. The prosecuting attorney

Figure 4. Indiana's Statutory GBMI Procedures




A
Sentencing
Probation
Incarcer-
ation
Court may
require
treatment
D.O.C. provides
evaluation &
treatment as
psychiatrically
indicated
No
Term
of sentence
expired?
Yes
Release
Transfer to
D.M.H. necessary
for treatment?
No
Yes
Treatment by
D.M.H.

suggested that the GBMI verdict clearly is an "asset to prosecutors" because it allows prosecutors to get more guilty verdicts. Based on his experience, he said that not as many insanity pleas are made because of the GBMI provision; and when the plea is made, a guilty verdict is much more likely.

b. Pre-trial Mental Health Examination

In Indiana, if a criminal defendant has given notice that he or she intends to interpose the defense of insanity, the court "shall appoint two or three competent disinterested psychiatrists to examine the defendant and to testify at the trial."[14] A mental health examiner (D) who participated in approximately 25 cases involving a GBMI plea or verdict stated that his methods of conducting pre-trial forensic mental health examinations of GBMI defendants were no different from the methods employed with other defendants. Similarly, he stated that though he infrequently is asked to testify at trial, his testimony in GBMI cases is no different than in other cases. Asked whether attorneys and the court tend to follow his recommendations following pre-trial examinations, he said that they are more likely to regarding GBMI defendants than regarding other defendants.

c. Mental Health Expert Involvement

Judges and attorneys differed in their opinions about whether the GBMI alternative in Indiana has altered the involvement of mental health experts in criminal proceedings. Three attorneys (B_2, B_3, B_4) and one judge (C_2) said that it had no effect. One attorney (B_2) commented, however, that a reduction of insanity pleas resulting from the GBMI provisions may cause mental health expert involvement to decrease.

Two superior court judges (C_1, C_3) said that the GBMI laws increase the involvement of mental health experts. One of the judges (C_1) based his opinion not on experience but on the logic that the GBMI alternative provides a new opportunity for introduction of evidence of mental aberration and, therefore, a concomitant increase in the involvement of mental health experts.

d. Criteria Used by Judges and Juries

When asked their opinions about whether judges generally understand and make the appropriate distinctions between definitions of insanity and mental illness as used in GBMI determinations, all four attorneys interviewed indicated that judges, much more so than jurors, carefully follow the statutory provisions and make appropriate distinctions. One prosecuting attorney (B_2) said that most jurors, rather than adhering to the letter of the law, ask themselves whether the defendant poses a clear and imminent danger to them or their community. If they answer this question in the affirmative, the defendant is more likely to be judged guilty or GBMI. "He's going away no matter what," is the manner in which the attorney characterized the typical jurors' approach to GBMI cases. Alternatively, jurors may be sympathetic to a defendant whose actions appear worthy of excuse simply because the jurors identify with those actions.

Other than the criteria specified by statute,[15] do judges and juries use different criteria or factors in making GBMI, as opposed to NGRI and guilty, determinations? All four attorneys responding to this question said that the criteria or factors do not differ. One attorney (B_1) correctly noted, however, that mental retardation is included in the statutory definition of mental illness[16] but not in the insanity

standard.[17] Therefore, defendants may be found GBMI but not NGRI on the basis of mental retardation.

e. Juries

As a matter of policy, plea bargaining does not exist in Indiana. As a matter of practice, however, some plea bargaining does occur. In contrast to Michigan where most GBMI findings may be obtained through plea bargains,[18] most GBMI findings in Indiana have been reached by jury or bench trials. Asked whether the GBMI laws in Indiana increased or decreased the number of jury trials in cases involving mental aberration, all four of the attorneys interviewed (B_1, B_2, B_3, B_4) and one of the three judges (C_1) indicated that it has had no effect. Two judges said that the law had decreased jury trials. Although little plea bargaining occurs in Indiana cases involving mental aberration, one judge believed that the GBMI alternative would decrease jury trials because it would increase plea bargaining. Another judge said that the GBMI alternative would decrease jury trials because it reduces insanity pleas. This judge reasoned that because little plea bargaining occurs in Indiana, bench trials in GBMI cases would displace jury trials of NGRI cases. One private attorney (B_4) suggested that the GBMI verdict may sound "too good" to jurors and, as a result, generate "GBMI business."

Some evidence exists to suggest that jurors often fail to appreciate the nuances of the wording of various insanity standards,[19] and, as a general rule, their comprehension of jury instructions is low.[20] At this writing, no empirical studies have determined the effects of the GBMI laws on the jury decision making. Some proponents of the GBMI laws argue that the GBMI verdict clarifies the distinctions between mental

illness and insanity and thereby simplifies jury decision making.[21] Opponents of the verdict say it provides jurors a convenient compromise and an "easy way out,"--that it is disingenuous, promoting a moral sleight of hand that "hoodwinks the jury in the decisional process, and ... hoodwinks the public."[22]

Indiana has no standardized jury instructions. According to one attorney (B_1), however, each court has written instructions that it uses as matter of course. For example, the following instructions were delivered in Indiana v. Pittman,[23] a case in which the defendant was charged with attempted murder, a Class A felony:

> To convict the defendant of the crime of attempted murder, the state must have proof of the following elements:
>
> 1. The defendant knowingly or intensionally
> 2. Took a substantial step to accomplish
> 3. A knowing or intentional killing of Ronald J. Wagonblast.
>
> If the state failed to prove each of these elements beyond a reasonable doubt, you should find the defendant not guilty. If the state did prove each of these elements beyond a reasonable doubt, and the defendant also proved by a preponderance of the evidence that at the time of such conduct, as a result of a mental disease or defect, he lacks substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of law, then you should find the defendant not responsible by reason of insanity.
>
> If you find the State did prove each of these elements beyond a reasonable doubt and you further find that the time of such conduct, he did not suffer from any mental disease or defect and that he did have the substantial capacity to appreciate the wrongfulness of his conduct and to conform his conduct to the requirements of law, but you do find at the time of said acts he had a psychiatric disorder which substantially disturbed his thinking, feeling or behavior and impaired his ability to function, then you should find the defendant guilty of attempted murder, a Class A felony, but mentally ill at the time of the offense.[24]

When asked whether jurors understand the typical jury instructions in GBMI and NGRI cases, only two attorneys (B_1, B_3) and one judge (C_2) ventured opinions. Only the judge believed that jurors understand the instructions. Both attorneys disagreed. One prosecutor (B_1) asked rhetorically, "Do they ever understand any?"

When asked whether jurors understand and make the appropriate distinctions between the definitions of insanity and mental illness, the respondents answered in a similar fashion. Both attorneys were very skeptical about jurors' ability to make the difficult distinctions required for GBMI determinations. They added that jurors may apply these concepts illogically. One of the four judges believed, however, that jurors are able to make the appropriate distinctions.

Two additional questions regarding juror decision making were asked of respondents. Do jurors generally understand the expert testimony presented at trial? And, do jurors understand the dispositional differences between an NGRI and a GBMI finding? Only one respondent (C_2) responded to the first question in the affirmative. Three attorneys (B_1, B_2, B_3) and one judge (C_3) stated that jurors' understanding of expert testimony presented at trial is limited. A prosecutor (B_1) stated that jurors' understanding of expert testimony depended largely upon the ability of the mental health expert and the quality of his or her testimony. A public defender (B_3) acknowledged his own frequent disbelief of mental health expert testimony. He noted that, in any event, "psychiatrists are difficult to understand." A prosecuting attorney (B_2) felt that juries, more often than not, disregard mental health experts.

Whether jurors in Indiana are aware of the different consequences of NGRI and GBMI verdicts may determine their decisions. As a matter of law in Indiana, jurors are not instructed regarding dispositional consequences. Whether juries in insanity cases should be instructed about the consequences of an insanity acquittal remains today a matter of debate.[25] All four respondents who answered the question (B_1, B_2, B_3, C_2) felt that jurors generally do not understand the dispositional differences between an NGRI and a GBMI verdict. One prosecuting attorney noted that jurors tend to have the misperception that GBMI offenders will always end up in a mental hospital, not a prison.

f. Sentencing

In Indiana, when a defendant is found GBMI or enters a plea to that effect, he or she will be "sentenced in the same manner as a defendant found guilty of the offense."[26] When asked whether the length or type of sentence for guilty and GBMI offenders differs in practice, five out of the nine respondents (B_1, B_3, B_4, C_2, H) stated that it did not. A parole official (H) indicated that this was due to the enactment of Indiana's determinate sentencing laws in 1977. In contrast, a prosecuting attorney and a judge felt that GBMI offenders would, all things being equal, receive lighter sentences than guilty offenders. One reason for this, according to the prosecutor (B_2), is that judges are able to consider mental illness and criminal responsibility openly without "getting heat from the public." A superior court judge (C_3) agreed that, generally speaking, sentences for GBMI offenders would be lighter than for similarly situated guilty offenders, but noted that sentences would depend upon several factors including the severity of the offense and the "treatability" of the defendant. He stated that if a

particularly violent crime was involved the sentence given a GBMI offender might be longer. Similarly, if a defendant were considered not "treatable," the sentence might be longer. Two respondents were unsure of differences in the length or types of sentences given GBMI and guilty offenders. A judge (C_1) noted that under Indiana's determinate sentencing provisions the type of sentence (e.g., probation or imprisonment) may vary but the length may not. A Department of Corrections official speculated that some offenders may have used the GBMI provisions to get a less severe sentence.

Indiana statute specifically provides that the court may require treatment as a condition of probation. Two out of three judges interviewed (C_2, C_3) stated that the criteria used for placing offenders on probation do not differ in practice between GBMI offenders and guilty offenders.[27] One judge (C_1) speculated, however, that different criteria may be used for GBMI offenders and that such offenders would most certainly have specific conditions placed upon them. A chief probation officer, who participated directly or indirectly in the presentence investigations of 30 GBMI cases, agreed that no differences exist in the criteria used for placing GBMI and other offenders on probation. He noted that out of the 30 GBMI cases in which his department performed presentence investigations only one case resulted in a GBMI offender being placed on probation. He speculated that the rarity of the event may make it likely for the offender to be sentenced to a longer period of probation, especially in well-publicized cases. Despite the Indiana statute's provision for treatment as a condition of probation in GBMI cases,[28] the use of the provision may be rare in any type of cases, as suggested by statistics cited by the chief probation officer

interviewed. Reportedly, out of 700 offenders on probation in this probation officer's jurisdiction in 1983, only 12 were ordered to undergo psychological counseling as a condition of probation.

g. Comparative Lengths of Confinement

Respondents were split on the fundamental question of whether GBMI offenders or NGRI acquittees who have similar backgrounds remain either in prison or in a hospital under involuntary confinement for longer periods of time. Four out of nine respondents felt that GBMI offenders were likely to be confined longer than NGRI acquitters (B_1, B_2, B_4, C_3). One respondent, an attorney in private practice (B_4), suggested that since GBMI offenders who remain under the jurisdiction of the trial court at the end of their sentences for determination of whether they meet involuntary civil commitment standards, GBMI offenders who meet those commitment standards may be subject to much longer periods of confinement than similarly situated insanity acquittees.

Five respondents felt that, all things being equal, NGRI acquittees spend longer periods in involuntary confinement than GBMI offenders (B_3, C_2, F_1, F_2, F_3). A forensic mental health official said that NGRI acquittees would be hospitalized for longer periods of time because of the indeterminate "sentence" given to them in contrast to the determinate sentencing of GBMI offenders.

h. Parole Provisions and Procedures

In 1978, a year after the enactment of a determinate sentencing law, Indiana abolished its parole provisions, at least in theory. Nonetheless, according to an Indiana Parole Board official (H), approximately six GBMI offenders (presumably those offenders found GBMI between 1975 and 1978) have come before the parole board. As a matter of

policy and practice, these GBMI offenders were handled no differently than any other offender. The parole board official stated, however, that the Indiana Parole Board is "very mindful of any psychiatric reports" on the condition of the offender. Coordination with the department of mental health is encouraged, he added, but the parole board has traditionally been very conservative in discharging offenders to the department of mental health. Reportedly, the Indiana Parole Board has not given special preferential treatment to GBMI offenders.

i. Treatment Provisions

The Indiana GBMI law, like most GBMI statutes, gives discretion to the courts and allied agencies having custody of the offender to provide treatment.[29] In Indiana, if a defendant found GBMI is committed to the Department of Corrections, he or she must be "further evaluated and then treated in such a manner as is psychiatrically indicated for his mental illness."[30] Treatment may be provided by the Department of Corrections or, after transfer, by the Department of Mental Health.[31]

According to statistics reported by a Department of Mental Health official (F_1), 18 individuals adjudicated GBMI were committed to the Department of Corrections in the fiscal year ending June 1983. On the basis of testing and evaluation of these GBMI offenders by the Reception and Diagnostic Center of the Department of Corrections, only two of these GBMI offenders were shown in need of inpatient mental health treatment and assigned to the Department of Corrections' psychiatric unit in Westville, Indiana. No GBMI offenders were transferred to the Department of Mental Health during the same fiscal year.

When asked how determinations are made about which offenders will receive mental health treatment and care and whether the GBMI label plays

a role in such determinations, a Department of Corrections official familar with such determinations (F_3) stated that GBMI offenders "get closer scrutiny" than offenders in the general inmate population. Insofar as the GBMI offenders are given more attention during the initial mental health evaluation by the Department of Corrections, he added, they are more likely to receive mental health treatment.

The point of intake for all adult, male offenders is the Reception and Diagnostic Center, a Department of Corrections facility located in Plainfield, Indiana. It is at this facility that male offenders will spend the initial ten to 14 days of their sentences. After medical and dental examinations, all offenders are given mental health evaluations by psychiatrists or psychologists. Based upon these evaluations, the Reception and Diagnostic Center identifies mental health problems among offenders, makes recommendations for treatment, if necessary, and then makes the necessary arrangements for treatment to be provided by one of the facilities in the Department of Corrections. According to one Department of Corrections official (F_3), if the evaluation conducted at the reception and diagnostic center reveals a psychotic disorder or other mental disorder that would make it impossible for the offender to live in the general inmate population, the offender would be sent to the Department of Corrections' inpatient psychiatric unit in Westville, Indiana. Otherwise, offenders may be sent to a number of facilities within the state.

The identified mental disorders of the offenders and their treatment needs, rather than the GBMI label, is determinative of treatment. GBMI offenders, sex offenders, offenders who have a history of mental disorder, and those who have committed crimes against persons are

differentiated from other offenders at intake insofar as they automatically are provided intensive mental health evaluation (i.e., examination by a psychologist and a psychiatrist on an individual basis). All other offenders are subjected only to group psychological testing unless they specifically refuse. Evaluation procedures at the Reception and Diagnostic Center are the same for mentally retarded defendants classified as GBMI offenders. According to one Department of Corrections official familiar with the department's mental health evaluation procedures, however, mentally retarded offenders are given more attention. "They are seen as more vulnerable," he stated. Reportedly, a program designed specifically for mentally retarded inmates is in the formative stages at the Deparment of Corrections facility in Westville.

Mental health staff are available in each of the Department of Corrections facilities to treat and care for offenders with mental health problems. Staff include correctional officers, institutional counselors, behavorial specialists, psychologists, and psychiatrists. Of course, not all these classes of personnel are present at each facility; thus, placement of an offender becomes determinative of the quantity and quality of mental health care and treatment provided to meet mental health needs.

Respondents differed in their impressions regarding the likelihood of preferential treatment of GBMI offenders relative to other offenders. Five respondents (B_1, B_4, C_2, F_2, F_3) felt that GBMI offenders were likely to receive at least slightly more mental health treatment, if only because of the publicity surrounding the alternative verdict. Four respondents (B_2, B_3, C_3, F_1) were less optimistic, agreeing that

GBMI offenders were no more likely to receive treatment than offenders with mental health problems in the general prison population.

j. Transfers Between the Corrections and Mental Health Systems

If "psychiatrically indicated" by the Reception and Diagnostic Center, mental health treatment may be provided by the Department of Corrections or by the Department of Mental Health after transfer of the GBMI offender from the Department of Corrections to the Department of Mental Health.[32] Furthermore, any prisoner who believes himself or herself to be mentally ill and in need of treatment may be transferred to the Department of Mental Health if a Department of Corrections' psychiatrist or psychologist determines that he or she is in need of such transfer.[33] According to data cited by a Department of Mental Health official, since September 1, 1980, the effective date of Indiana's GBMI law, 29 transfers have occurred. Of these, only two were GBMI offenders (F_1).

According to a Department of Corrections official, transfer of GBMI offenders from the Department of Corrections to the Department of Mental Health is accomplished in four steps: (1) a recommendation for the offender's treatment in a Department of Mental Health facility by a licensed psychiatrist; (2) notice to the inmate of the proposed transfer; (3) an administrative hearing which may be waived by the inmate; and (4) the actual physical transfer. According to a Department of Mental Health official (F_1), one of the two GBMI transfers was a female inmate transferred from the women's prison to Central State Hospital; the other was a male inmate transferred from the Westville Correctional Center to Evansville State Hospital. Both of the GBMI offenders were transferred to the Department of Mental Health after spending only a short time under

the jurisdiction of the Department of Corrections; the female inmate after 35 days and the male inmate after only five days. Both were placed in "secure" wards. As is the case with mentally disordered GBMI offenders under the jurisdiction of the Department of Corrections, the GBMI label is not nearly so important for GBMI offenders transferred to the Department of Mental Health as the mental health needs of the transferred inmate. That is, once transferred, the GBMI offender is treated in a manner similar to other hospital patients.

5. Costs

Asked whether the availability of the GBMI plea and verdict in Indiana has increased or decreased the costs of handling mentally disturbed offenders, most respondents said that, due to the small number of individuals involved, any increases or decreases in costs would be negligible (B_1, B_2, B_3, C_2, F_1, F_2). Four respondents (C_1, C_3, D, G) said, however, that the availability of the GBMI alternative would increase the overall costs of handling mentally disordered offenders in Indiana. A superior court judge (C_1) speculated that the costs would increase, but not substantially. Another superior court judge suggested that an increase in costs would be inevitable if adequate treatment were provided to GBMI offenders. A mental health professional (D) thought that the costs would increase largely due to an increase of the resources required to provide mental health evaluations of GBMI offenders at the Reception and Diagnostic Center. In a similar vein, a probation officer anticipated that an increase in GBMI probationers would require additional resources (G).

Only one respondent, an attorney in private practice (B_4), suggested that the availability of the GBMI alternative in Indiana would decrease the costs of handling mentally disturbed defendants. He noted that "jail is cheaper than a hospital." In support, he cited the staff-to-patient and staff-to-inmate ratios that became known to him as part of his work on the Lawyers Commission in Indiana. Reportedly, the Department of Mental Health maintains a 1:1 ratio of staff-to-patients whereas the Department of Corrections maintains a 4:140 staff-to-inmate ratio.

6. Perceived Strengths and Weaknesses of the Indiana GBMI Law

Respondents offered divergent opinions about what they perceived as the strengths and weaknesses of the Indiana GBMI law. The addition of an alternative to the traditional verdicts of guilty, not guilty, and not guilty by reason of insanity, the treatment provisions of the GBMI law, and the appeasement of public concerns about the abuses of the insanity defense were perceived as its major strengths. Notwithstanding the statutory provision for treatment, the lack of treatment actually provided was seen as the major weakness of Indiana's GBMI law. The strengths and weaknesses of Indiana's GBMI law perceived by survey respondents are summarized in Table 12.

One superior court judge (C_2) expressed a concern that was unique among the weaknesses of the GBMI law perceived by survey respondents (the third weakness listed in Table 12). Noting the statutory provision that those defendants who are adjudicated GBMI "shall be further evaluated and

Table 12

Perceived Strengths and Weaknesses of
Indiana's GBMI Law

Strengths	Respondents																	Total
	B				C			D	F			G	H					
	1	2	3	4	1	2	3		1	2	3							
1. Separation of Criminal Responsibility and Mental Illness Issues	X																	1
2. Coverage of Dual Concerns for Confinement and Treatment of GBMI Offenders						X					X	X						3
3. Provision of Compromise/ Alternative Verdict		X	X			X					X	X						5
4. Public Protection													X					1
5. Treatment Provisions			X			X		X					X					4
6. Appeasement of Public								X	X	X			X					4
7. No Strengths				X				X										2
Weaknesses																		
1. Absence/Lack of Treatment	X	X	X					X		X		X	X					7
2. Irrelevancy/ Meaninglessness						X			X									2
3. Reversal of Trial Determination by Post-Conviction Screening Decision						X												1
4. Definition of Mental Illness			X					X										2
5. Curtailment of Legitimate Insanity Defenses							X											1
6. Public Misunderstanding									X									1

then treated in such a manner as is psychiatrically indicated,"[34] this judge expressed the concern that the post-conviction evaluation performed by the Department of Corrections would "overturn" the decision made at trial where a judge or jury may have deliberated all the facts and circumstances of the case. In contrast, he contended, the Department of Corrections' examiners may have relatively little information upon which to make a determination of mental disorder and need for treatment. He expressed his preference for provisions that would allow defendants who are found GBMI to be committed to a mental health facility instead of the Department of Corrections, at least for the initial part of their sentence.

Under what circumstances would attorneys advise their clients to enter a GBMI plea? The three attorneys who answered this question agreed that such advice should only be given in limited circumstances. A prosecuting attorney (B_2) said that such advice should only be given when the prosecution has an extremely strong case for establishing guilt and imposing the death penalty. Another respondent, a public defender (B_3), agreed that he only would advise clients who are facing the death penalty to enter a GBMI plea. He added that he would consider advising clients to enter GBMI pleas only if provisions for mental health treatment could be made as part of the plea agreement. Another attorney in private practice (B_4) said that he would advise a client to enter a GBMI plea if the client exhibited serious mental disorders but the prosecution could not be convinced that the defendant "should be hospitalized without litigation."

When asked what advantages or disadvantages the GBMI finding held for mentally disturbed defendants and whether the defendants understood them,

the two judges who answered this question agreed that, if properly implemented, the treatment provisions of the GBMI law offered mental health treatment without the hazards that an offender must encounter in the general inmate population (C_2, C_3). One judge noted that because insanity is very difficult to prove, the treatment provisions of the GBMI law may be very attractive (C_3). Another judge who responded (C_2) conceded, however, that a defendant might not understand or care about such advantages at the time a plea is entered.

Most perceptions of the desirability and impact of the GBMI law have not altered since the passage of the law. Six respondents stated that their minds were not changed by their experience with Indiana's GBMI provisions (C_1, C_2, D, F_1, G, H). However, two respondents currently felt more positive toward Indiana's GBMI law than they did when it was enacted. One judge (C_3), who viewed the promise of treatment as the major strength of the GBMI law, conceded that he was dissatisfied with the GBMI law when it went into effect but now saw some benefits to the promise of treatment. A prosecuting attorney (B_2), who was skeptical about the GBMI law at the time of its enactment, became more positively inclined toward the law with increased experienced. He stated that the GBMI provisions were "good for prosecutors," resulting in an increase in prosecutions in cases involving claims of mental aberration. Four respondents became more disillusioned with the GBMI provisions over time (B_1, B_3, B_4, F_2). One prosecuting attorney (B_1) complained that the GBMI law does not allow for a uniform standard of application and interjects difficult and complicated legal issues with regard to the imposition of the death penalty. Another attorney (B_4) stated that Indiana's Department of Corrections simply does not have the talent or

facilities to deal with mentally disordered offenders. A forensic mental health official (F_2) acknowledged her initial liking of the GBMI provisions. She stated that she first viewed the "treatment plus punishment" provisions of the GBMI statute as highly attractive. When she discovered that no actual treatment was provided to GBMI offender, however, her attitude toward Indiana's GBMI law quickly changed.

Notes

1. See Indiana Acts 1981, P.L. 298; Ind. Code Ann. §§35-35, 35-36 (Burns Cum. Supp. 1982); see also, Comment, Indiana's Guilty But Mentally Ill Statute: Blueprint to Beguile the Jury, 57 Ind. L. J. 639 (1982).
2. One of the prosecuting attorneys was unable to participate in the entire scheduled interview and requested that a colleague, another prosecuting attorney, complete the interview. The interview of these two individuals was combined and counted as a single interview.
3. Indiana Acts, P.L. 145, §9, effective April 1, 1978. See Ind. Code Ann. §35-41-41-1 (Burns Cum. Supp. 1982).
4. 269 Ind. 550, 381 N.E. 2d 1245 (1978). See Comment, supra note 1, at 639 n.2.
5. ___ Ind. ___, 416 N.E. 2d 95 (1981). See Comment, supra note 1, at 639 n. 4.
6. See Comment, supra note 1, at 640 n. 2.
7. See supra note 5.
8. Id.
9. See infra § c. Legislative Purposes.
10. See Comment, supra note 1, at 640 n.6.
11. See, e.g., supra Table 11 (Insanity Plea Filings).
12. See supra Part Two, Legislation: Purposes and Historical Context, Section IV., E.2.
13. See supra Part One, this volume, notes 23-38 and accompanying text; see also Slovenko, Commentaries on Psychiatry and Law: "Guilty But Mentally Ill," ___ J. Psych. & L. 541, 543 (1982).

14. Ind. Code Ann. §35-36-22 (Burns Cum. Supp. 1982). The Indiana statute does not require, though it does not preclude, pretrial examination of defendants who plead GBMI, as provided in §35-35-2-1, id., but who do not intend to impose the insanity defense.

15. For example, the definition of mental illness, Ind. Code Ann. §35-36-1-1 (Burns Cum. Supp. 1982) or the insanity standard, Id. §35-41-3-6.

16. See id. at §35-36-1-1.

17. See id. at §35-41-3-6.

18. Smith & Hall, Evaluating Michigan's Guilty But Mentally Ill Verdict: An Empirical Study, 16 U. Mich. J. L. Ref. 77, 94 & Appendix A, Table C; see also supra, Part One, this volume, notes 267-271 and accompanying text; but see cf., Boyle & Baughman, The Mental State of the Accused: Through A Glass Darkly, 2 Adelphia __ (1984), where it is noted that in Wayne County, Michigan, ninety percent of all GBMI convictions are the result of litigation, a finding in contrast to Smith and Hall's results.

19. See Arens, Granfield & Susman, Jurors, Jury Changes, and Insanity, 14 Cath. U. Amer. L. Rev. 1 (1965).

20. See generally, A. Elwork, B.D. Sales, & J. Alfini, Making Jury Instructions Understanable (1982).

21. See Smith & Hall, supra note 16, at 81; Boyle & Baughman, supra note 18, at ___.

22. Slovenko, supra note 18, at 546; see also supra Part One, this volume, notes 34-38, 281-286 and accompanying text.

23. Cause No. 2 CR-14-184-66 (Ind. Superior Court, Lake County [date]), Final Instructions, Instruction 2.

24. Id. (emphasis added). It should be noted that this instruction is only one of 22 given to the jury including instructions on burdens of proof, definitions of various terms (e.g., "intentionally"), a reference for intent and purpose, and lesser included offenses.

25. See, e.g., Lyles v. United States, 254 F. 2d 725 (D.C. Cir. 1957), cert. denied, 356 U.S. 961 (1958), cert. denied, 362 U.S. 943 (1960), cert. denied, 368 U.S. 992 (1962); Commonwealth v. Mutina, 323 N.E. 2d 294 (Mass. 1975).

26. Ind. Code Ann. §35-36-2-5(a)(Burns Cum. Supp. 1982).

27. Id. §35-36-2-5(c).

28. Id.

29. Id. §35-36-2-5(b); cf. Part One, this volume, supra, Table 3 & notes 310-319.

30. Ind. Code Ann. §35-36-2-5(b)(Burns Cum. Supp. 1982).

31. Id.

32. Id.

33. Id. §11-10-4-4.

34. Id. §35-36-2-5 (emphasis added).

E. Illinois

1. Introduction

Effective September 17, 1981, Illinois became the third state to enact legislation providing for a guilty but mentally ill (GBMI) plea and verdict.[1] From September 1980 to June 1984, 131 defendants were adjudicated GBMI.

During August and September 1984, thirteen (13) individuals familiar with the GBMI legislation participated in a telephone survey addressing Illinois's GBMI experience. The interviewees included two public defenders (B_1, B_2), two states attorneys (B_3, B_4) a supreme court judge (C_1), two pre-trial mental health evaluators (D_1, D_2), a mental health professional providing post-conviction treatment (E_1), a mental health professional (F_1) and an administrator (F_2) with the Department of Mental Health and Development Disabilities (DMHDD), two administrators with the Department of Corrections (F_3, F_4), and an administrator with the Department of Parole (H_1). These individuals, together, have been involved directly or indirectly in all the GBMI cases in Illinois.

2. Legislation: Historical Context and Purposes

a. Changes Coincidental with GBMI Enactment

The enactment of the GBMI legislation did not alter either the existing definition of insanity[2] or the burden of proof[3] requirements in cases involving mental aberration. Effective January 1, 1984, however, the burden of proof shifted to the defense to prove insanity by a prepondance of the evidence.[4] Insanity, as defined by the American

Law Institute (ALI) standard, remains an affirmative defense in Illinois.[5]

b. Precipitating Factors

None of the respondents in the survey indicated that a particular Illinois case or incident led to the enactment of the GBMI legislation. Two respondents (B_2, F_4) stated that the legislation was a direct result of the John W. Hinkley, Jr.'s acquittal of shooting President Reagan. Two respondents (D_1, F_1) stated that the former director of DMHDD attempted originally to get legislation introduced to abolish the insanity defense. That legislation was defeated and the GBMI legislation subsequently introduced.

c. Legislative Purposes

During Senate debate on the bill, the bill's co-sponsor, Senator Sangmetster, explained that the "meat and guts" of the bill was that defendants who are mentally ill but are not "totally out of it" will both get treatment and serve out the same sentence as defendants found guilty.[6] When asked about the purpose of Illinois' GBMI legislation, the respondent's replies fell into the following categories:

(1) to reduce the number of NGRI findings (B_2, B_3, E_1);

(2) to provide a "middle ground" verdict (C_1, F_4);

(3) to provide treatment for offenders (B_4, D_1, F_4);

(4) to assist prosecutors in obtaining convictions (B_1); and

(5) to protect public by preventing early release of NGRI acquittees (B_3, D_2, H_1).

A public defender (B_2), who perceived the legislation as an attempt to reduce the number of NGRI findings, said that intent was a

reaction to public hysteria following NGRI acquittals. Accordingly, he reported a decrease in successful NGRI defenses in his jurisdiction. Likewise, a states attorney (B_3) believed that the legislation was a response to public outcry over people being acquitted on technicalities and being back on the streets shortly thereafter. He was not aware of any jury acquittals since passage at the GBMI legislation and only a handful of bench trial acquittals. Three respondents, an administrator at a court psychiatric clinic (D_2), an administrator at a state hospital (D_1), and an administrator in the Department of Corrections (F_4), reported no decrease in the number of NGRI findings since passage of the GBMI legislation.

3. Characteristics of GBMI Offenders

To be found NGRI in Illinois, a defendant must lack substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law. Conversely, a defendant may be found GBMI if he has raised the insanity defense and at the time of the offense was suffering from a substantial disorder of thought, mood or behavior that impaired his judgment.[8]

The respondents had little difficulty describing the characteristics of defendants most likely to be found GBMI as opposed to NGRI or guilty. A public defender (B_2) and a state's attorney (B_3) stated that in most cases in which an NGRI finding is appropriate, it plainly is evident to all concerned. The state's attorney (B_3) indicated that he could not recall a single case in the last six years in which an NGRI finding was returned inappropriately. He believed that most often defendants that are "treatable" are found GBMI and those that are "crazy" are found

NGRI. Conversely, a superior court judge (C_1), with considerable experience in the mental health field, was much more sceptical about the ability of forensic psychiatrists to render definitive diagnoses. He stated that "who gets to the psychiatrist first often greatly influences the diagnosis and outcome of the defendant."

The characteristics of GBMI and guilty offenders are indistinguishable in some cases, according to several respondents. Describing the majority of his clients as psychopaths, one public defender (B_1) stated that GBMI offenders resemble the "run of the mill offender." A mental health professional (D_2) added that because 80 percent of the GBMI adjudications are plea bargains, most GBMI offenders display characteristics similar to other guilty offenders.

A high level corrections administrator (F_4) who is directly or indirectly familiar with all the incarcerated GBMI offenders stated that three equal sub-groups of GBMI offenders exist. The first sub-group are those that probably should not have been found GBMI; "at best the diagnosis should be antisocial personality disorder." He speculated that the GBMI label is attached when the judge or jury cannot determine why the defendant committed the offense unless he was mentally ill. The second sub-group are those that show signs of long-term character disorder, often associated with drug or alcohol abuse. Although substance abuse may qualify these offenders for GBMI, the administrator (F_4) described them as suffering from character pathology rather than chronic mental illness. Finally, a third group of the GBMI offenders are those who actually need mental health treatment. This group consists of inmates who are chronically psychotic; many of whom display characteristics of insanity.

According to a public defender (B_2), an important dispositive factor is the nature of the offense. He believed that a GBMI finding is likely when the crime is particularly heinous and the jury wants to find the defendant criminally esponsible. A states attorney (B_3) agreed, stating that given the conservative nature of Illinois jurors in criminal litigation, he believed that when a violent crime is involved, the jury will ignore the insanity issue altogether and return a guilty verdict.

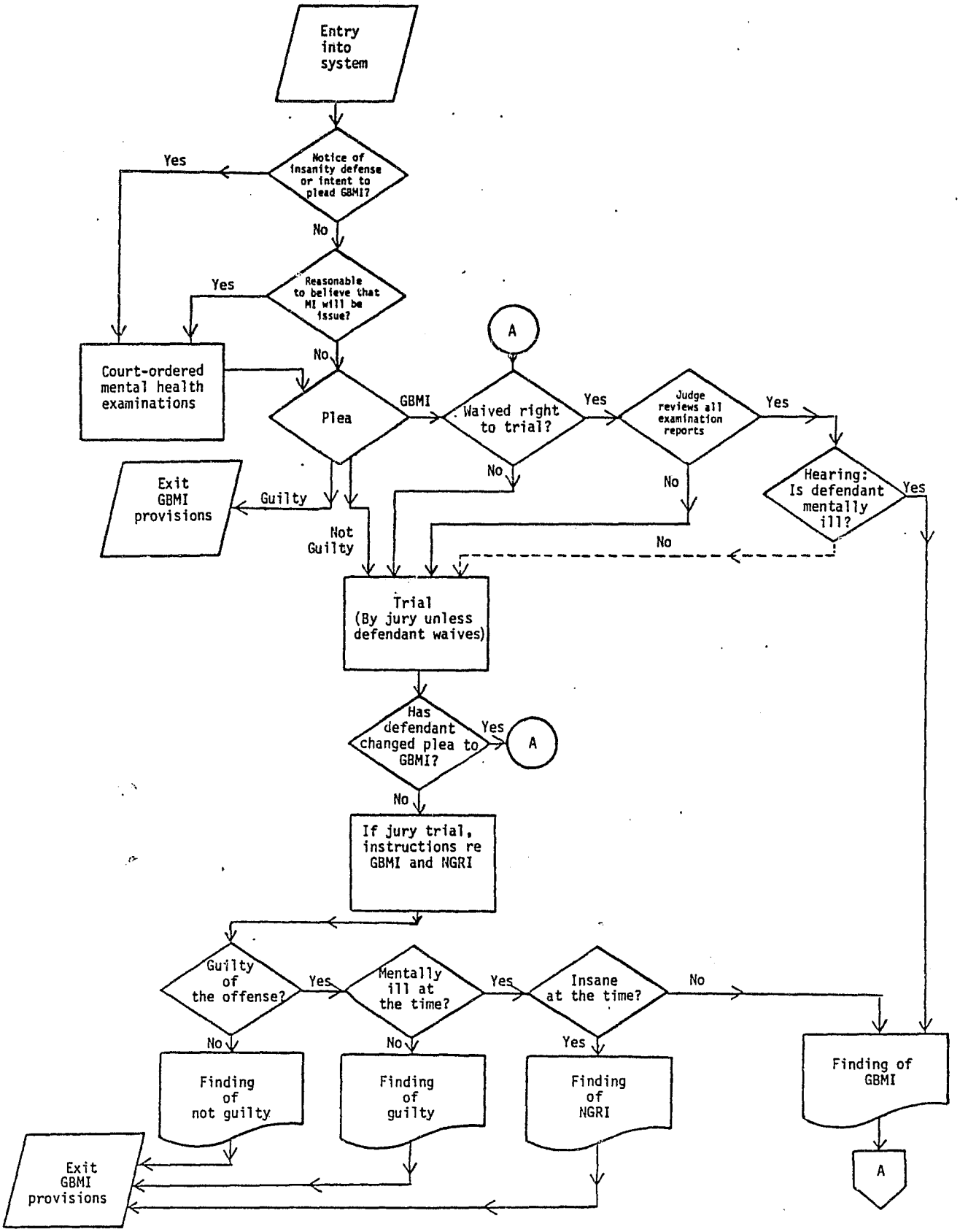
Six (B_1, B_2, B_4, D_1, D_2, E_1) out of ten of the interviewees indicated, however, that the GBMI offenders would be found guilty rather than NGRI if the GBMI plea or verdict were unavailable. Only one interviewee (C_1) believed that the GBMI "compromise" had reduced the number of NGRI findings. Conversely, an administrator at a state hospital (F_2) projected no impact on the frequency of successful NGRI defenses. He stated that the criteria for insanity had not changed; therefore, if a defendant was eligible for the NGRI finding two years ago he should still be eligible. An administrator with the Department of Corrections (F_4) believed that 25 to 30 percent of the GBMI offenders would have been found NGRI. Another corrections official (E_1) believed, however, that most of the GBMI offenders do not meet the NGRI standards. He added that the majority of the GBMI offenders have prior criminal convictions.

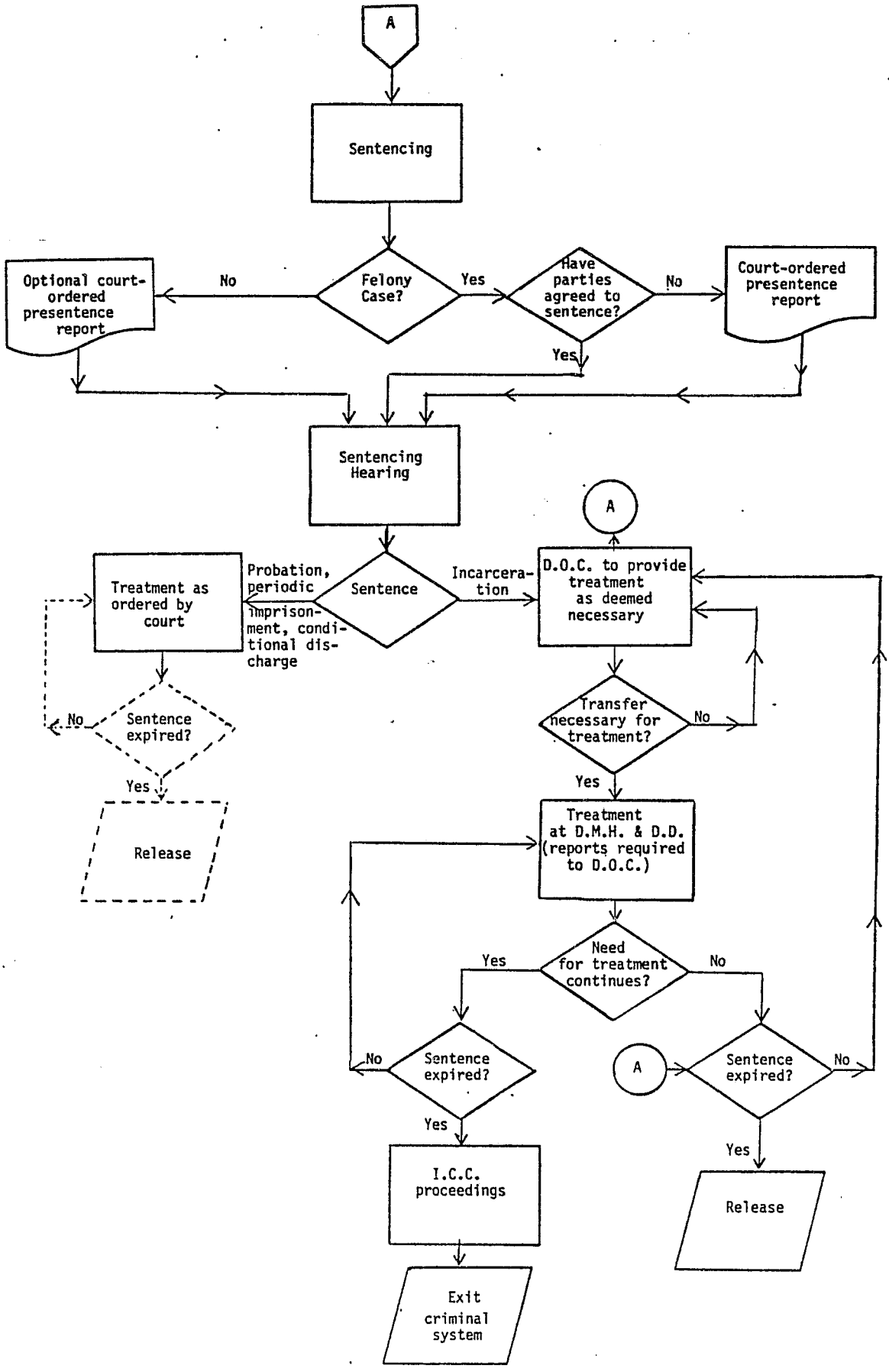
4. Procedures and Practices

a. General

Figure 5 depicts the statutory GBMI procedures in Illinois. When asked whether these procedures had changed the way in which cases involving mental aberration are handled, a states attorney in St. Clair

Figure 5. Illinois' Statutory GBMI Procedures




A
Sentencing
Felony Case?
No
Optional court-ordered presentence report
Yes
Have parties agreed to sentence?
No
Court-ordered presentence report
Yes
Sentencing Hearing
A
Sentence
Probation, periodic imprisonment, conditional discharge
Incarceration
Treatment as ordered by court
D.O.C. to provide treatment as deemed necessary
No
Sentence expired?
Yes
Release
Transfer necessary for treatment?
No
Yes
Treatment at D.M.H. & D.D. (reports required to D.O.C.)
Need for treatment continues?
Yes
No
No
Sentence expired?
A
Sentence expired?
No
Yes
I.C.C. proceedings
Yes
Release
Exit criminal system

County (B_3) reported that the number of jury trials in that jurisdiction has drastically decreased. He cited 25 cases in the past two years in which the GBMI finding resulted from plea agreements. Additionally, in three jury trials involving mental aberration during the same period, the jury rejected the NGRI and GBMI alternatives in opting for a guilty finding. The states attorney (B_3) noted that in addition to the unlikelihood of success in a jury trial, GBMI plea agreements are common because it provides the defendant a crutch. He explained that socially and philosophically, defendants find it easier to enter a GBMI plea than a guilty plea. The superior court judge (C_1) agreed that the GBMI plea makes plea bargaining more accessible, thus eliminating the need for some jury trials. Three attorneys (B_1, B_2, B_4) and the superior court judge (C_1) indicated, however, that the number of requests for jury trials had not changed.

None of the attorneys expressed an increased willingness to enter into plea negotiations because of the availability of the GBMI plea. One public defender (B_1) indicated that he would rarely, if ever, recommend entering a GBMI plea. Another public defender (B_2) said he might recommend entering a GBMI plea but stressed that the decision would remain a case-by-case decision. Both states attorneys (B_3, B_4) stated that the defense's offer of a GBMI plea did not influence their willingness to plea bargain. One attorney (B_4) stated that the policy was to negotiate only when it was beneficial to the state. He explained that one reason why his office is generally agreeable to a GBMI plea is that when the Department of Corrections provides treatment, a GBMI plea is in effect no different than a guilty plea.

Before a court can accept a GBMI plea, the defendant must undergo an examination by a clinical psychologist or psychiatrist.[9] In addition, the trial court judge must conduct a hearing on the issue of the defendant's mental health.[10] The judge must be satisfied that there is a factual basis that the defendant was mentally ill at the time of the offense.[11]

b. Pre-trial Mental Health Evaluation

A defendant must file timely notice of his intent to raise the affirmative defense of insanity.[12] The court then orders the defendant to submit to examination by at least one clinical psychologist or psychiatrist; to be named by the prosecuting attorney.[13] If the defendant fails to cooperate in the examination and if after a hearing the court determines to its satisfaction that the defendant's refusal was unreasonable, at its discretion the court may bar any or all evidence of insanity.[14]

A variety of organizations conduct pre-trial mental health examinations in Illinois. In Cook County evaluations are performed by the Psychiatric Institute, a court clinic, and by private psychologists and psychiatrists. Additionally, state mental hospitals and masters-level psychologists perform evaluations.

Requests for pre-trial examinations typicaly originate from the circuit courts. According to one examiner (D_5), however, defense attorneys directly request about ten percent of his evaluations. Both pre-trial examiners (D_1, D_2) stated that their methods of conducting evaluations of GBMI defendants are no different than the methods employed with other defendants. According to one mental health professional (D_1), examinations for insanity and mental illness and typically are performed together and address many of the same issues.

Although evaluation procedures do not vary, reporting methods and report content is subject to wide variation. According to a psychiatrist in Cooke County (D_2), his evaluations and recommendations address only the specific area requested by the court (e.g., competency, insanity, mental illness). Conversely, a psychiatrist at Chester State Hospital (D_1) indicated that his reports recommend the GBMI plea if the defendant does not meet the NGRI criteria. He stated that on seven occasions during the last year he has recommended that the defendant plead GBMI.

c. Mental Health Expert Involvement

Both psychiatrists (D_1, D_2) and a state's attorney (B_4) stated that the GBMI legislation has not changed the involvement of mental health experts in criminal proceedings. Two attorneys (B_2, B_3) in other parts of the state believed, however, that mental health expert involvement has increased. The attorneys based their opinions on the mandatory mental health evaluations required with GBMI pleas. One attorney (B_3) qualified his response stating that the impact may be marginal because judges in his area are very conscious of the defendants' mental status and freely have ordered examinations.

d. Juries

Juror's ability to comprehend expert testimony is always an unknown variable, but rarely is it more important than in an NGRI case. Four (B_2, B_3, C_1, D_2) of the five respondents questioned believed that jurors do not understand mental health expert testimony nor do they make appropriate distinctions between the definitions of insanity and mental illness.

A superior court judge (C_1) stated that although it is difficult for the court to understand the expert testimony, it is extremely difficult for jurors and often likely that they will fail to understand it. Also, he indicated that conflicting expert testimony compounds the jurors' difficulty in understanding the statutory definitions and jury instructions. An state's attorney (B_4) disagreed. He stated that when the expert did not use psychological jargon the jury would understand in most cases.

One states attorney (B_3) suggested that psychiatrists and psychologists should not be part of the guilt determination process. Citing jury confusion, he believed that expert mental health testimony is appropriate only at the sentencing phase. This proposal may be in the defendant's best interest if one respondent's (B_2) theory of expert testimony is correct. The public defender (B_2) speculated that jurors respond adversely to the expert testimony in some circumstances. Accordingly, they view the defendant as attempting to use the expert to "get off scott-free."

Although the GBMI jury instructions are not standardized, most of the respondents did not consider jury instructions a source of misunderstanding. The court is required to instruct the jury not to consider whether the defendant has shown that he was insane, unless it has first determined that the state has proven the defendant guilty beyond a reasonable doubt.[15] Additionally, the court may not instruct the jurors on the dispositional outcomes of the alternative verdicts. One respondent, a public defender (B_2) believed that jurors try to arrive at a just result regardless of the instructions because they are not provided enough information to use the instructions adequately.

When the affirmative defense of insanity is presented, the court is required to provide the jury with a special verdict form.[16] The court must then separately instruct the jury that the special verdicts of NGRI or GBMI may be returned instead of the general verdict required in all other criminal cases.[17]

e. Sentencing

The court may order a presentence investigation of any defendant, but is required to order a written presentence report in felony cases.[18] A mental health examination may be included in the presentence investigation at the discretion of the court.[19] The court may impose any sentence that could be imposed on a non-GBMI offender convicted of the same offense.[20] Since February 1978, Illinois has used determinate sentencing for all offenders. When asked whether the length or type of sentence of guilty and GBMI offenders differs in practice, four (B_1, B_2, F_3, F_4) out of seven respondents indicated that the sentences do not. Three respondents (B_3, B_4, C_1) believed that a defendant's mental illness may reduce the length of sentence.

A state's attorney (B_3) stated that although the GBMI label has no significance itself, the defendant's mental illness may mitigate the sentence if he can be stabilized on medication and may be a positive factor in society thereafter. A superior court judge (C_1) believed that a GBMI offender is less likely to receive an "extended term sentence." He stated that if the defendant is indeed mentally ill, he lacks the required criminal intent to justify an extended term sentence. One respondent, a public defender (B_1), indicated, however, that extreme emotional or mental distress had always been a mitigating factor even prior to the GBMI legislation.

A superior court judge (C_1) stated that the criteria for placing a GBMI offender on probation are the same as for other offenders. The probation stipulations almost always require that the GBMI defendant receive mental health treatment. According to the judge (C_1), the availability of outpatient treatment programs and the mitigating factor of the mental illness, combined with the statutory authorization of probation in certain offenses, could be a positive factor influencing the court's willingness to grant probation.

f. Post-Conviction Processing

Following sentencing, GBMI offenders are transferred to one of the regional Department of Corrections (DOC) reception and classification centers. DOC policy requires that GBMI inmates be screened by a mental health professional within 48 hours of arrival.[21] According to a DOC administrator (F_4), the mental health professional is usually a psychologist or a psychiatrist. The review usually takes place within 24 hours of arrival for an non-emergency admission. A complete psychiatric examination is performed within three days of arrival. These evaluations occur not only sooner than those of other guilty inmates but also are more extensive, according to another DOC official (F_3).

The focus of this evaluation is on the inmate's current functioning and need for treatment, according to a DOC administrator (F_4). A determination is made whether the inmate requires transfer to a psychiatric unit. Male inmates would be transferred to Manard Psychiatric Center and female inmates to White Correctional Center; both are DOC facilities. A DOC administrator (F_3) stated that after the evaluations only an estimated 50 percent of the GBMI offenders require psychiatric treatment.

An official at Manard Psychiatric Center (E_1) reported that originally all GBMI inmates were sent inappropriately to Manard. The same admission criteria now applies to GBMI inmates and other inmates. The inmate must be dangerous to himself or others before he is eligible for transfer to Manard. He (E_1) speculated that the GBMI offenders being transfered to Manard are those that would have been transferred anyway. He stated, however, that significant dissimilarities between GBMI admissions and general psychiatric admissions do exist in several areas. He summarized those differences in the chart below:

	GBMI ADMISSIONS 11/81 to 4/84		NON-GBMI ADMISSIONS 1982 & 1983	
	#	%	#	%
ADMISSIONS	69		1012	
Average Age	30.2 years		27.6 years	
Average Education	10.9 years		10.1 years	
County: Cook	22	30.1	482	47.6
Others	51	69.9	530	52.4
Race: White	50	72.5	485	47.9
Black	16	23.2	477	47.1
Hispanic	3	4.3	50	4.9
Previous MPC Placement	14	20.3	382	37.8
Previous Inpatient Mental Health Treatment	56	81.2	473	46.7
Primary Admitting Symptom Patterns:				
Cognitive Dysfunction, Hallucinations, Delusions	26	37.8	413	40.8
Depression, Suicidal Ideation, Sucide Attempts	28	40.6	399	39.4
Anxiety	3	4.3	45	4.5
Hostility, Aggressive Acting-Out Behavior	5	7.2	81	8.0
Other	7	10.1	74	7.3

GBMI inmates are eligible to be transferred to any DOC institution consistent with their security status if transfer to Manard is not clinically indicated. The DOC has established a program to monitor the status of GBMI offenders in general population. The regulations provide:

> Once placed in a general institutional setting, these committed persons shall be examined or evaluated by a mental health professional at a minimum every three months for the first six months and then every six months thereafter.
>
> These committed persons may be referred by appropriate staff or may request an examination or evaluation more frequently.
>
> More frequent evaluations may also be performed at the discretion of the examining mental health professional as determined to be clinically necessary.[22]

A DOC administrator (F_4) explained that the monitoring visits are in addition to whatever treatment visits that are taking place. An administrator at Manard (E_1) stated that these monitoring visits must be documented and that compliance with the program is audited both internally and by an external organization at least once a year. He added that depending on the seriousness of the inmate's illness, the monitoring may last through his incarceration or may be terminated after six to nine months.

g. Treatment

If the court imposes a sentence of imprisonment, the Department of Corrections is to provide such treatment as it determines necessary.[23] The DOC may transfer custody to the DMHDD until hospitalization is no longer needed or until the inmate's sentence has expired.[24] Although transfer is authorized by statute, the DOC has not transferred any offenders to the DMHDD prior to expiration of their sentence in the last eight years, according to a Manard official (E_1). A DOC administrator

(F_4) confirmed that the DOC provides 100 percent of the mental health treatment to inmates with the possible exception of juvenile offenders. Over the past eighteen months, the DOC has doubled the number of mental health professionals on staff. A DOC administrator (F_4) stated that the increase was an effort to improve mental health services to all inmates and was not related directly to the GBMI legislation.

The inactive role of the DMHDD is the subject of debate in Illinois. To date, only one GBMI offender has received treatment at a DMHDD facility; this offender currently is incompetent to be sentenced. Much of the dissatisfaction with the GBMI legislation in Illinois centers around the perception that GBMI offenders are not receiving treatment because they are not transferred to DMHDD facility.[25]

Three respondents, a superior court judge (C_1), a psychiatrist performing pre-trial examinations (D_2), and a DOC administrator (F_2) stated that the legislation would be enhanced if GBMI offenders were transferred to a DMHDD facility following trial. Under this senerio, the inmate would remain there until he no longer required acute mental health treatment. At that point, he would be transferred to a DOC facility to serve out his sentence. An administrator at Chester State Hospital (F_2) did not view the proposal as necessary. He believed that the DOC's psychiatric network was very good. In his opinion, even though the DMHDD client-staff ratio is higher, GBMI offenders were receiving adequate mental health treatment.

All of the DOC facilities have the capacity to provide mental health treatment. A DOC official (F_4) stated that all facilities currently employ at least one full-time mental health professional, typically a psychologist, or are in the process of recruiting to fill vacant positions. All facilities also employ one or more psychiatrists on a contractual basis from few hours per week to a total of 80 hours

depending on the size of the facility and the needs of its population. The treatment available at these facilities includes: individual and group therapy, psychotropic medication, sex offender therapy, and substance abuse support groups. Treatment planning is restrained, however, by security level considerations. Noting that "we must be able to control as well as treat the inmate," a DOC official (F_4) stated that at times security considerations prevent delivery of the optimum level of treatment.

All GBMI offenders in need of acute mental health treatment are transferred to Manard Psychiatric Center. According to an administrator at Manard (E_1), treatment provided GBMI inmates does not differ, however, from that provided other inmates. All treatment is provided on a voluntary basis. The treatment staff at Manard consists of twelve mental health professionals. This staff is supplemented by vocational, educational and physical training personnel.

Transfers from DOC facilities to Manard are coordinated through a central division at DOC headquarters. An inmate has an opportunity to appear before the Psychiatric Review Committee to contest the transfer. The committee consists of a mental health professional, a representative of the DOC clinical services staff and an individual from outside the DOC. The inmate may present oral or written testimony of a mental health professional or call lay witnesses.[26]

The decisions of the committee are controlling and the mental health professionals at Manard cannot overrule the committee, according to a Manard official (E_1). He stated, however, that in most cases he agrees with the committee's decisions except that in border-line cases the Board has a propensity to sustain an inmate's protest and deny the transfer.

The Manard staff performs periodic reviews to determine whether the inmate continues to require acute care treatment. The reviews are

performed by a psychiatrist, psychologist, representatives from the medical and nursing staff, in addition to other treatment team members and representatives from the admissions department. The case is reviewed at least once every six months. The inmate has the right to request at any time to be seen by the review board; alternatively, the psychiatrist can recommend that the inmate no longer needs to be at Manard and that he be transferred to general population.

According to the administrator (E_1), Manard staff almost always are looking for inmates to ship back due to the lack of available beds at Manard. He stated, however, that a limited class of inmates are maintained at Manard for want of a better place within the system. Although they do not meet the criteria to be at Manard, they are not transferred because they would deteriorate rapidly in a general population setting.

The Illinois Court of Appeals has not recognized GBMI offenders' constitutional right to treatment.[27] GBMI offenders are entitled only to the same level and standards of treatment as other offenders. An estimated 50 percent of the incarcerated GBMI offenders actually received mental health treatment in the past year, according to a high level DOC administrator (F_4). He added that only 25 or 30 percent of those GBMI inmates received any "psychotherapy" (6 to 9 percent of all GBMI offenders). At any given time, approximately one-fourth to one-third of the GBMI offenders are receiving some type of treatment.

The respondents were split evenly regarding whether GBMI offenders are more likely to receive treatment than other guilty offenders with mental health problems. In addition, the basis of their responses varied widely. A states attorney (B_4), a superior court judge (C_1), a Manard administrator (E_1), and a DOC administrator (F_4) believed that

GBMI inmates were more likely to receive treatment. Conversely, a states attorney (B_3), two public defenders (B_1, B_2), and a DOC administrator (F_3) believed that GBMI offenders did not have an advantage in access to treatment over inmates in the general population.

A public defender (B_1) suggested that GBMI should be retitled "GBU--Guilty but Ugly." Describing the legislation as a sham, he stated that the GBMI label fails to assist the offender in obtaining treatment. Another attorney (B_3) agreed, stating that many of his former GBMI defendants are back in general population receiving the same treatment as other inmates. A third attorney (B_2) stated that because GBMI offenders were not receiving treatment at DMHDD, he did not preceive any difference in treatment between GBMI offenders and other offenders eligible for the same treatment within the DOC.

Three respondents (C_1, E_1, F_4) credited the DOC monitoring system with increasing the opportunities for GBMI offenders to received treatment. All three believed that the manditory closer scrutiny and resulting increased sensitivity to potential mental health problems would result in greater likelihood of treatment.

h. Parole

At this writing, approximately 25 GBMI offenders have been released on parole. Another ten are in the process of being paroled. Like all offenders in Illinois, the period of supervision following parole for GBMI offenders is established under the determinate sentencing system. The maximum period is three years and the minimum is one year. No statutory requirement exists to handle GBMI parolees differently than other parolees.

An administrator in the Department of Parole (H_1) reported, however, that an internal procedure has been established. He stated that all GBMI cases are reviewed by the Area Superintendent before the case is turned over to the parole field offices. All field offices, with the exception of those in Chicago, are under the direction of the Area Superintendent. The objective of the review is to provide increased coordination and monitoring of GBMI parolees to determine what if any unique problems are associated with GBMI parolees.

The period of post-release supervision may be longer for GBMI parolees, however, as a result of this internal procedure. All offenders upon release are placed on intense supervision. At the discretion of the parole board, however, the level of supervision may be reduced to regular and eventually to low supervision. Only parolees on low supervision are eligible to petition the parole board to terminate their supervision period. A parole official (H_1) explained that all recommendations to reduce the level of supervision for GBMI parolees must be approved by the Area Superintendent. He added that GBMI parolees are less likely to receive low supervision. He explained that GBMI parolees are given closer scrutiny due to the potential for adverse public opinion. To date, no GBMI offenders have been placed on low supervision. In August 1980, approximately 20 GBMI parolees were on intense supervision and five on regular supervision.

According to a parole official (H_1), GBMI parolees receive higher levels of post-release assistance than the average parolee, but not necessarily more than other parolees who are mentally ill. He stated, however, that it is often more difficult to obtain assistance for GBMI offenders. He explained that community programs for the mentally ill

typically exclude ex-offenders and that many programs for ex-offenders are not equipped to handle mentally ill offenders. Although these problems are common to any offender with mental illness, GBMI offenders face unique job discrimination. Even employers who are willing to employ ex-offenders shy away from GBMI offenders according to the parole administrator (H_1). In recent months, the Department of Parole has made an intensive effort to coordinate with the DMHDD to increase opportunities for post-release assistance available to GBMI offenders.

5. Perceived Strengths and Weaknesses of GBMI Provisions

The participants in the survey offered numerous and differing opinions about what they perceived as the strengths and weaknesses of the GBMI legislation. The opinions of all respondents interviewed are reflected in Table 13.

Table 13

Perceived Strengths and Weaknesses of Illinois GBMI Statutes

	B					D			F					
Strengths	1	2	3	4	C	1	2	E	1	2	3	4	H	Total
Increases likelihood of treatment				X				X			X			3
Provides increased public protection													X	1
Useful in mitigating sentence		X			X	X								3
Eliminates possibility of death sentence		X			X									2
None	X					X	X			X		X		5
Weaknesses														
Lack of treatment		X				X				X				3
Lack of DMHDD involvement	X				X							X	X	4
Avoids issue of criminal responsibility	X						X							2
Provides no measurable benefits	X	X	X			X				X		X		6
Lacks funding for pre-trial examinations		X										X		2
Creates compromise verdict				X										1
None								X						2

Notes

1. See Ill. Ann. Stat. ch. 38 §6-2(c) (Cum. Supp. 1983).
2. Id. at §6-2(a) (Cum. Supp. 1983).
3. Id. at §3-2(b).
4. Id. at §§3-2(b), 6-2(e).
5. Id. at §6-2(a).
6. Report of Proceedings of the 82nd General Assembly, Regular Session, Third Reading in the Senate of Senate Bill No. 867, at 133 (May 27, 1981).
7. Ill. Ann. Stat. ch. 38 §6-2(a) (Cum. Supp. 1983).
8. Id. at §6-2(d).
9. Id. at §115-2(a)(b)(1).
10. Id. at §115-2(2)(b)(3).
11. Id. at §115-2(2)(b)(3).
12. Id. at §115-6.
13. Id.
14. Id.
15. Id. at §6-2(e).
16. Id. at §115-4(j).
17. Id.
18. Id. at §5-2-6(a).
19. Id.
20. Id.
21. Illinois Department of Correction Rules, Title 20, Chapter 1, sub chapter (d), §415.50(a).
22. Id. at §415.50(c)(1)-(2).
23. Ill. Ann. Stat. ch. 38 §1005-2-6(b) (Cum. Supp. 1983).

24. Id. at §§1005-2-6(c), (d)(1).

25. See Table of Strength and Weaknesses at the end of this section.

26. Illinois Department of Correction Rules, Title 20, Chapter 1, sub chapter (d), § 503.150(b)(2)(a)-(f).

27. People v. Marshall, 114 Ill. App. 3d 217, 448 N.E. 2d. 969, 980 (1983).

F. Kentucky

1. Introduction

On March 26, 1982 Kentucky enacted legislation providing for a GBMI plea and verdict when Governor John Y. Brown, Jr. signed House Bill 32 (effective July 15, 1982).[1] Since that time thirty-five (35) defendants have been adjudicated GBMI and have been or are currently incarcerated. The number of GBMI offenders which have received probated sentences was not available.

During July and early August 1984, thirteen (13) individuals familiar with the GBMI law participated in a telephone survey addressing Kentucky's experience during the first two years of its use. The interviewees included a state representative (A_1), an assistant public advocate (B_1), two private attorneys (B_2, B_3), three assistant commonwealth attorneys (B_4, B_5, B_6), a circuit court judge (C_1), two mental health professionals performing pre-trial evaluations (D_1, D_2), a mental health professional providing post-conviction treatment (E_1), a Corrections Cabinet classification official (F_1), and a Corrections Cabinet administrator (E_2).

2. Legislation: Historical Context and Purposes

a. Changes Coincidental with GBMI Enactment

The enactment of House Bill 32 did not alter either the existing definition of insanity[2] or the burden of proof[3] requirements in cases involving mental aberration. In 1974 the Kentucky legislature adopted the Model Penal Code's provision on insanity.[4] This action did not change pre-existing Kentucky law. It followed the Kentucky Court of

Appeals adoption of the ALI standard by eleven years.[5] Kentucky case law also previously placed the burden of proving insanity in NGRI cases on the defendant.[6]

b. Precipitating Factors

In conjunction with a reported general disdain for the insanity defense in Kentucky, two highly publicized cases appear to have provided additional initiative in passage of the GBMI legislation. The case most often referred to during the interviews was Commonwealth v. Datillo (cite).[8] The case apparently added to the motivation of the Supreme Court of Kentucky to take the unusual step of recommending to the Kentucky legislature passage of a GBMI statute.[9] The opinion in which this recommendation appears states, in part,

> [T]he 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 of 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.[10]

The state representative responsible for drafting and introducing the GBMI legislation also cited the "Gall"[11] case as an influencing factor behind the legislation.[12] The representative expressed the opinion that if the GBMI verdict had been available to the jury which returned the defendant's earlier NGRI finding, both the victim's life and the defendant, currently scheduled to be executed, could have been spared.

Debate within the Kentucky legislature was both extensive and at times highly emotional. The original GBMI bill, modeled after Michigan's

and Indiana's GBMI legislation, was an outgrowth of the House Sub-committee on Mental Illness and Mental Incompetency established in the spring of 1981. A revised version of the GBMI bill was filed in August, 1981. In September 1981, the Kentucky Interim Joint Committee on Health and Welfare, Subcommittee on Mental Illness and Mental Incompetency held open discussions relating to the GBMI legislation. The following January, the House Judiciary Criminal Committee conducted public hearings which generated vocal support and equally vocal opposition to the proposed legislation. The GBMI bill passed the Kentucky House on February 22, 1982, and later passed the Kentucky Senate without debate on March 15, 1982.

c. Legislative Purposes

Perhaps not unexpectedly in light of the highly publicized cases outlined above, many of the respondents (75%) mentioned perceived dissatisfaction with the uses and results of Kentucky's insanity defense when asked about the intent of GBMI legislation. The respondents' opinions of the legislative intent of the GBMI provision fell into the following categories:

(1) Reduce the number of NGRI findings (B_1, B_2, B_3, B_5);

(2) "Gap Filler" (i.e. recognize degree of mental illness that falls short of insanity standards) (A_1, B_4, D_1, D_2, E_2);

(3) Recognize need for and provide mental health treatment for convicted offenders (A_1, B_1, B_2, C_1, D_1, D_2, E_1); and

(4) Reaction to existing procedures for release of NGRI acquittees (i.e., increase judicial control over offenders with mental disorders) (B_6).

The intent as expressed by the bill's sponsor was to explicitly recognize and attempt to deal with the fact that "the present law forces juries to judge mental states as black or white." He added, "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."[16] The desire on the part of the legislature to fill a "gap" in existing laws thereby creating a middle ground verdict was also mentioned by three other respondents (B_4, D_2, E_2).

The defense bar perceived that the legislative intent was to curtail or otherwise restrict the use of the NGRI defense (B_1, B_2, B_3, B_5). An assistant public advocate (B_1) and one private attorney (B_2) said the provision of treatment was the overt or expressed intent but the underlying objective was to reduce the number of NGRI acquittals. Mental health professionals said that the intent was to provide treatment to mentally disturbed offenders (D_1, D_2, E_1).

Historically, the Kentucky judicial system has produced a surprisingly low number of NGRI acquittals. While no percise figures were available, the general consensus was the number of actual acquittals by reason of insanity "averaged less than a handful per year." One experienced mental health professional (D_2) estimated the number of NGRI findings at about a half dozen total over the past twenty (20) years. The perceived legislative attempt to eliminate the effectiveness of the NGRI defense can therefore best be explained by the public outcry and subsequent political pressure resulting from isolated NGRI acquittals.

The opinions among the interviewees regarding whether any of the major perceived intentions had been fulfilled varied widely:

(1) Treatment:

(a) GBMI label assists in identifying those needing treatment (B_5, D_2, E_1);

(b) GBMI offender is not assured mental health treatment will be provided (B_1, B_2, D_1);

(2) Curtailment of NGRI:

(a) NGRI findings reduced (B_1, B_3, B_5, D_1);

(b) NGRI findings unaffected (B_2);

(3) Middleground Verdict:

(a) GBMI verdict used properly (B_4, B_6);

(b) GBMI verdict used improperly (E_2); and

(4) Too early to assess impact (C_1).

Some respondents speculated that the existence of the GBMI alternative may in the long run increase the number of NGRI findings. An assistant public advocate (B_1) and an assistant commonwealth attorney (B_5) stated the juror's increased awareness of mental aberration combined with both the defense and prosecution implicitly recognizing the defendant's mental illness would lead juries to be more inclined to return NGRI findings in the future.

3. Characteristics of GBMI Offenders

Kentucky statute requires that the defendant prove by a preponderance of the evidence that he was mentally ill at the time of the offense.[17] The definition of mental illness under Kentucky statute is as follows:

> "Mental illness" means substantially imparied capacity to use self-control, judgment or discretion in the

> conduct of one's affairs and social relations, associated with maladaptive behavior or recognized emotional symptoms where impaired capacity, maladaptive behavior or emotional symptoms can be related to physiological, psychological or social factors.[19]

As discussed earlier, the definition of "insanity" was slightly modified by the GBMI legislation. The current definition of insanity is as follows:

> "Insanity" means that, as a result of mental condition, lack of substanital capacity either to appreciate the criminality of one's conduct or to conform one's conduct to the requirements of law.[20]

As discussed throughout this report, the existing definition of insanity was derived by the legal system whereas the definition of mental illness has been borrowed from the mental health system. However, in Kentucky, as well as in other states, the definitions appear to bend together along a continuum separated only by subtle nuances rather than distinct categorizations. An assistant commonwealth's attorney (B_6) and an assistant public advocate (B_1) described mental illness as "a lesser included of insanity."

Somewhat surprising in light of the definitional similarities, the respondents appeared to have little difficulty in describing the characteristics of defendants most likely to be found GBMI as opposed to NGRI or guilty. According to one mental health professional (D_2), who has conducted between forty-five (45) to fifty (50) pretrial evaluations over the past two years:

> People who stand a best chance of being found NGRI are those who are just obviously very, very psychotic, and there is no question about that, when there is no criminal history involved, and they have made no attempt to conceal what they have done which sort of adds to the idea that they really were insane.
>
> Now, I think the GBMI often times occurs when the person is seen by the jury as being odd, peculiar, but also

> aggressive, dangerous. They are not the kind of person that they would want living next door to them by any means. They may have had some sort of mental health contact throughout their life, but it is not at all clear that the individual was so sick at the time of the offense, that he didn't know what he was doing. Somebody who has been in and out of the state hospital quite a bit, and would generally carry a diagnosis of maybe drug abuse, alcohol abuse, some sort of character diagnosis, marginal kinds of adjustments throughout their life, they might very well be a GBMI.

The idea that the NGRI finding is reserved for the severely mentally ill was echoed by an assistant commonwealth attorney (B_4). The interviewee (B_4) quickly added that people were "fed-up" with NGRI findings and were more inclined to return GBMI verdicts even when the defendant should be found insane. Similarly, two respondents (B_1, D_1) indicated that the characteristics of NGRI acquittees and GBMI offenders in particular cases are indistinguishable. A mental health professional (E_1) who has treated all thirty-five (35) GBMI offenders indicated that at least in a limited number of cases the GBMI offenders clearly pass the statutory test of insanity. He said, however, that to conclude that the GBMI offender would have been found NGRI in the absence of the GBMI legislation would be erroneous.

Over eighty percent (80%) of the respondents indicated that in light of the limited use of the NGRI finding, if the GBMI option had been unavailable, almost without exception the GBMI offenders routinely would have been found guilty. A private attorney (B_2), an assistant commonwealth attorney (B_5), and a mental health professional (D_2) all indicated that the GBMI verdict was a compromise verdict and a way for jurors to ease their conscience, but in its absense they still would have found the defendants guilty. On the other hand, two respondents, a private attorney (B_3) and an assistant commonwealth attorney (B_4)

indicated that half of the GBMI cases they were familiar with may have resulted in acquittals if the GBMI alternative did not exist.

One respondent, an assistant commonwealth attorney (B_5), indicated that NGRI findings were most often the result of where the judge had "blown it" and the defendant really was not fit to stand trial to begin with. Alternatively, a private attorney (B_2) stated that he thought cases resulting in NGRI finds were entirely unique situations distinct from GBMI cases. Furthermore, he did not feel the characteristics of the defendant were controlling but rather stated:

> I think that the things that are determinative in an NGRI finding are the experts that are used, the attorneys involved, and probably most importantly the education level of the jury. A well-educated jury will be more sensitive to mental illness and will have less of a gut reaction to it than a less educated jury.

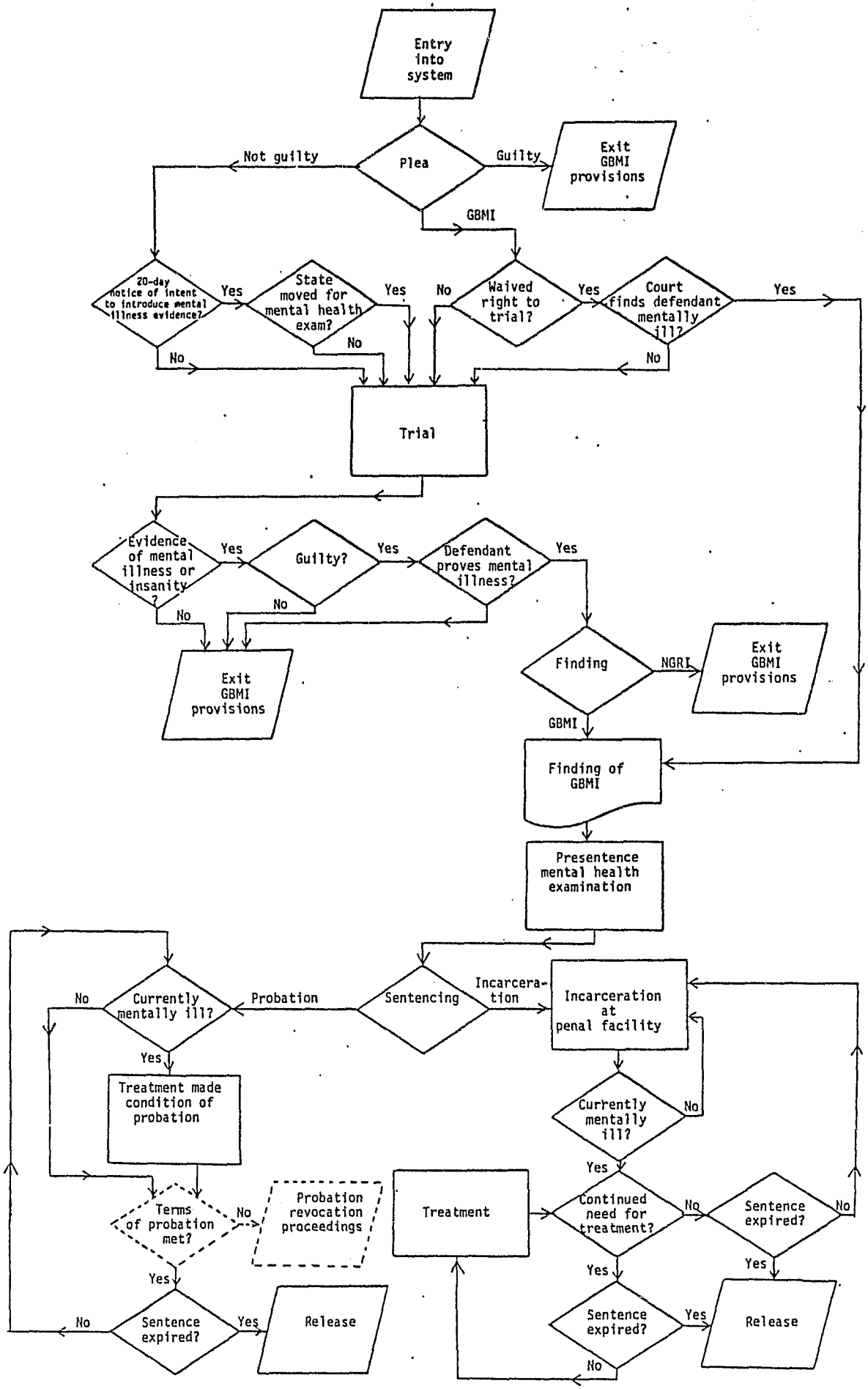
Interestingly, three (3) attorneys (two (2) assistant commonwealth attorneys, B_4, B_5, and a private attorney, B_3) describe the severity or nature of the offenses as the distinguishing characteristic of GBMI offenders. One of the assistant commonwealth attorneys (B_5) indicated those most likely to be found GBMI or to plead GBMI are pedophiles (i.e., child molesters, rapists, and child abusers) and in some cases cleptomaniacs.

4. Procedures and Practices

a. General

The flow chart in figure 6 depicts the processing procedures promulgated by the Criminal Law of Kentucky, Chapter 504.[21] The enactment of the GBMI legislation was not accompanied by any other statutory, judicial or administrative rule changes of major significance.

Figure 6. Kentucky's Statutory GBMI Procedures



A technical change to Kentucky's procedural rules to incorporate the availability of the new verdict was made in mid-1982. Also, unrelated changes in Kentucky's involuntary commitment standards and incompetency to stand trial proceeding did occur in 1982. In addition, in 1982 the "Department for Human Resources" became the "Cabinet for Human Resources."[22]

The most notable change brought about by the GBMI legislation is the way in which cases involving mental aberration are now handled. The change referenced most often was an apparent increased willingness on the part of defense counsel to enter into plea agreements. Of the six (6) interviewees asked to predict the impact on the number of jury trials involving mental aberration, four (4) (B_2, B_4, B_6, C_1) predicted a decrease in occurrence. While bench trials customarily have been the most often requested medium for trials involving mental aberration, a majority of the survey participants projected most of GBMI findings to be generated through plea agreements.

A circuit court judge (C_1) indicated that he had been involved in two GBMI plea agreements which prior to passage of the GBMI legislation would have fully adjudicated. As explained by an assistant commonwealth attorney (B_6), a realistic assessment of the likelihood of a successful insanity defense has led many attorneys to attempt to benefit their client through plea negotiations. He further indicated, however, that the existence of the GBMI plea did not necessarily influence his willingness to reduce the severity of the charges pending. Nevertheless, a private attorney (B_2) reported that in another part of the state, he has seen attorneys use the defendant's mental illness as a mitigating factor in plea negotiations. The same attorney stated he would never

advise a client to enter a GBMI plea for reasons to be developed later in this section.

Concerns over the potential misuse of the GBMI plea has led the public advocate's office to institute educational programs aimed at preventing inappropriate use of the GBMI plea. One assistant public advocate (B_1) felt that some defense attorneys misled by the "promise" of treatment had been lured into entering GBMI pleas in situations where they never would otherwise have pleaded guilty.

b. Pre-trial Mental Health Examination

A defendant who intends to introduce evidence of his mental illness or insanity at the time of the offense is required to file written notice of his intention at least twenty days before trial.[23] The prosecution then has a reasonable time to move for examination of the defendant, or the court may order an examination on its own motion.[24] In such cases, the statute requires the court to appoint at least one psychologist or psychiatrist to examine, treat and report on the defendant's mental condition. If it appears the examination will not be completed before the trial date, the court may, on its own motion or on motion of either party, postpone the trial date until after the examination.[25]

The court may commit a defendant to a treatment facility for up to thirty (30) days so that a psychologist or psychiatrist can examine, treat and report on the defendant's mental condition.[26] The majority of the pretrial examinations requiring hospitalization are conducted at the Kentucky Correctional Psychiatric Center (KCPC) located on the grounds of Luther Lucket Correctional Facility in La Grange, Kentucky. The entire process often takes over three (3) months according to one private attorney (B_2). He indicated the procedure had been used as a delay tactic in the past.

Generally, a circuit court requests pretrial examinations at the KCPC. Occasionally, however, the request will be generated by the county jail system. The Cabinet for Human Resources bears the cost of the KCPC examination or alternatively at the option of the court is required to pay a reasonable fee to any private psychologist or psychiatrist.[27]

Approximately fifty of the one hundred inpatient beds at the KCPC are allocated for pretrial evaluations. The evaluations include competency evaluations, criminal responsibility evaluations, assessments of the defendant's "dangerousness to self or others," and medication and stabilization treatment planning. A psychologist or psychiatrist retained by the defendant must be permitted to participate in any court order examination.[28] The two mental health professionals (D_1, D_2) who participated in the survey between them have conducted approximately 100 of the 150 pre-trial evaluations performed at the KCPC over the past two years. Each reported that their methods and procedures for conducting psychological/psychiatric evaluations had not been directly impacted by the passage of the GBMI legislation. Also, each indicated that their basic reporting methods had not been drasticly modified.

Kentucky statute requires that all court ordered reports on a defendant's mental condition be filed within ten days of the conclusion of the examination.[29] According to one respondent (D_1), KCPC personnel do not make recommendations to either the attorneys involved in the case or the court with regard to which verdict should be sought. He indicated that the reports did clearly address the criteria needed to make the determination and that often their findings were the dispositive factor in making the determination.

c. Mental Health Expert Involvement

Kentucky statute requires that the psychologist or psychiatrist conducting the pretrial examination appear at any hearing on a defendant's mental condition unless the defendant waives his right to have him appear.[30] One mental health professional (D_1) indicated the frequency of his testimony had increased with the initial popularity of the GBMI verdict but has decreased in recent months. The other interviewee (D_2) stated that he is required to testify in only approximately 20 percent of the cases in which he conducts evaluations and that the percentage had remained fairly constant. Other interviewees (B_2, B_3, B_5, C_1) all responded that instituting the GBMI plea and verdict had not changed the involvement of mental health experts in criminal proceedings.

Two situations were noted which could have the long run impact of increasing the role of mental health experts. First, according to one private attorney (B_2), defense attorneys have become more "inquisitive into the defendant's mental status" and as a result may request pretrial examinations more frequently.[31] Secondly and more specifically, concern over the apparent dichotomy between a finding of competency and acceptance of a GBMI plea has led two of the assistant commonwealth attorneys (B_4, B_6) to try to insure that a very recent ("usually within one week of entering plea") psychological report is available prior to accepting a GBMI plea.

In a related area, an assistant commonwealth attorney (B_4) did point out the GBMI legislation requires that if a defendant is found GBMI, the court is required to appoint at least one psychologist or psychiatrist to examine, treat and report on the defendant's mental

condition at the time of sentencing.[32] In many instances the pre-sentencing evaluations would be conducted by the same KCPC assessment personnel who conducted the pretrial evaluation. Only two other states, Pennsylvania and Utah, require similar pre-sentence evaluations.

d. Jury Understanding

The definitional differences between insanity and mental illness may be understood only by experienced mental health professionals and the rare attorney who specializes in this area. Five (B_1, B_2, B_3, B_5, B_6) of the six attorneys participating in the survey said that in their opinion jurors do not understand and make appropriate distinctions between the definitions of insanity and mental illness. According to one attorney (B_1), the definitions contain "a lot of legal and psychological jargon." The lone dissenting attorney (B_4) qualified her response by stating, "in my opinion, people are tired of the insanity defense and I think that this is one that they want to understand." A circuit court judge (C_1) responded that he believed jurors did understand the differences.

The emphasis on definitional distinctions in the previous paragraph presupposes jurors focus on the statutory definitions in arriving at a verdict. Two attorneys, an assistant commonwealth attorney (B_5) and a private attorney (B_2), expressed the view that understanding the definitional differences was not of paramount importance. One attorney (B_2) stated that he believed jurors do not look to the legal definitions but rather were more "outcome oriented." In his opinion, jurors generally assume that GBMI offenders will be incarcerated and are persuaded by the fact that a defendant found GBMI "is just like someone who is found guilty." In the view of another attorney (B_5), "juror

evaluation is made on community mores and customs and therefore juries don't necessarily need to understand the legalistic language."

Jury instructions given when the insanity defense has been raised incorporated the definition of insanity discussed earlier. The instructions in Kentucky are standardized and read as follows:

> Even though you might otherwise find the defendant guilty [of one of the offenses mentioned in these instructions], if you believe from the evidence that at the time he shot [and killed] X (if he did so) he was of unsound mind, you shall find him not guilty and say in your verdict that you find him not guilty on the ground of insanity.
>
> The law presumes every man sane until the contrary is shown by the evidence. Before the defendant can be excused on the ground of insanity you must believe from the evidence that at the time of the act in question the defendant, as a result of mental disease or defect, (a) did not have substantial capacity to appreciate the criminal nature of the act, or, (b) if he did have such capacity, did not have substantial capacity to conform his conduct to the requirements of the law.[33]

At this writing, no standard instructions on the GBMI verdict are available in Kentucky. With two exceptions (B_1, B_3) those interviewees (B_2, B_4, B_5) asked believed that jurors could understand the instructions actually given. The potential for jury confusion, however, was summarized by an assistant public advocate (B_1) who said:

> I think it would be real easy for a jury to look at it and say, well the person here had substantially impaired capacity and used self control [mental illness standard] and as a result of that they couldn't conform their conduct to the requirements of the law [insanity standard] so I guess it could be either/or.

According to one mental health professional (D_1) who frequently testifies in trials involving mental aberration, his testimony now centers around "explaining the differences between mentally insane and

mentally ill." Obviously due to the very nature of the trials involving mental aberration, expert testimony plays an important role. The majority of attorneys (B_1, B_2, B_3, B_4, B_6), however, doubted jurors' ability to understand expert testimony. The determining facts appear to be the mental health expert's experience in testifying, his ability to communicate clearly to a lay jury, and the lawyer's pretrial preparation and ability to question the expert in an intelligible and straightforward fashion. Despite the foregoing criticism and problems associated with jury trials, some consolation exists in that in the opinion of six (B_2, B_3, B_4, B_6, C_1, E_1) of the interviewees, the number of jury trials has decreased due to the availability of the GBMI plea and verdict. Several respondents (B_1, B_2, B_5) expressed concern about judges' ability to understand and make appropriate distinctions between the definitions of insanity and mental illness. Judges, like attorneys, who do not have mental health backgrounds are likely to find the distinctions confusing as well according to one private attorney (B_2). This attorney (B_2) and an assistant public advocate (B_1) both stated that in their opinion some judges view insanity as a "technicality in the law" (B_2) and are "biased against the insanity defense" (B_1).

e. Sentencing

Under Kentucky law a defendant found GBMI must be sentenced in the same manner as a defendant found guilty.[35] This statute should, however, be read in light of existing Kentucky statutes[36] recognizing "extreme emotional disturbance." A defendant successfully introducing evidence of an extreme emotional disturbance at the time the crime may qualify for a reduction in the severity of the charge (i.e., first degree

murder is typically not available in such circumstances). Despite the probability that a defendant found to be mentally ill at the time of the act will meet the extreme emotional disturbance criteria, GBMI offenders are subject to sentences imposing the same periods of confinement as similarly situated guilty offenders.

The statutory language would presumably allow a GBMI defendant to receive the death sentence. It is generally recognized, however, that even prior to the GBMI legislation only in the rarest of circumstances would the death penalty be returned if the defendant suffered from a mental illness. According to the drafter of the legislation (A_1), the failure to explicitly exclude the death sentence in GBMI cases is one of the weaknesses of the law. The exclusion would clearly influence defense attorneys contemplating alternative pleas to a charge carrying a possible death penalty.

In Kentucky jury trials, the jury determines the sentence. Although individual juror sentiment will play a role in sentencing, all of the interviewees asked (B_1, B_2, B_4, B_5, B_6, C_1, F_1) thought that the length or type of sentence (e.g., probation, split sentence) for GBMI offenders did not vary from those imposed on offenders found guilty. Two assistant commonwealth attorneys (B_5, B_6) did qualify their answers by saying that if a defendant had committed a crime and his attorneys were successful in creating jury sympathy, the jury might view the defendant's mental illness as a mitigating factor. Both were quick to point out, however, that this was a consideration that existed prior to the GBMI legislation.

The respondents were split regarding the impact of the GBMI law on the availability of probation. At least two respondents, an assistant

commonwealth attorney (B_6) and a corrections classification official (F_1), believed the GBMI label would negatively impact the offenders opportunity to obtain probation. A circuit court judge (C_1) indicated, however, that the GBMI offender's mental illness could be a mitigating factor if the illness did not "cause him to be a person of violence."

f. Post-Conviction Processing

KRS §504.140 requires a pre-sentence evaluation of the defendant's present mental status. The legislative intent of this requirement, according to the drafter (A_1), was to assist the presiding judge in making sentencing and placement determinations. If the defendant is found mentally ill at the time of sentencing, the language of the statute declares treatment shall be provided the defendant until he is no longer mentally ill or until expiration of his sentence, whichever occurs first.[37]

Similar statutory mandates requiring treatment of GBMI offenders have caused considerable debate and confusion around the country and Kentucky is no exception. Unlike the statutes in many states,[38] however, the Kentucky statute does not specify who is impowered to determine whether treatment is necessary for a particular offender and, if necessary, what agency is to provide the treatment.

Turning first to the question of authorization of treatment, a literal reading of the statute would mandate treatment in all cases in which the judge determined (presumably based on a report from a psychologist or psychiatrist)[39] the offender continues to suffer from a mental illness.[40] This interpretation was clearly contemplated by a circuit court judge (C_1) who expressed confidence that GBMI offenders who needed treatment received treatment in that when appropriate he would "specifically order such treatment be provided."

An alternative interpretation and key to the legislative intent was provided by the bill's drafter who explained:

> Judges do not have the power to determine what kind of treatment or where the treatment is going to be provided, their recommendations are strongly considered by the department of corrections.

In practice, determining the necessity for treatment and the type and location of treatment is a joint venture by the Kentucky Corrections Cabinet and Cabinet for Human Resources. Responsibility for conducting the post-conviction evaluations has fallen on the assessment/classifications centers of the Kentucky State Reformatory (KSR-male inmates), the Kentucky Correctional Institution for Women, and the Kentucky Correctional Psychiatric Center (KCPC).

All guilty and GBMI offenders committed to the custody of the Corrections Cabinet routinely are incarcerated at one of the assessment/classification centers.[41] The close physical proximity of KSR and KCPC has made the cooperative evaluation process feasible.[42]

Both the Corrections Cabinet[43] and Cabinet for Human Resources[44] have established policies and procedures for handling the initial assessment of GBMI offenders. These policy statements are substantially identical and both establish a mandatory psychological/psychiatric evaluation at KCPC of all persons entering the system with the "GBMI label."

The GBMI evaluation procedure begins prior to the actual arrival of the GBMI inmate in many instances. According to a classifications administrator (F_1) at KSR, initial preparation and coordination is begun when the GBMI verdict is communicated to the assessment center by the circuit court. Like all other inmates, upon arrival the GBMI

offender is assigned a case manager. In addition to the routine admission procedures, an evaluation by a KSR's psychologist is arranged shortly after the arrival of the inmate.

The early identification and targeting of GBMI offenders as potentially in need of mental health services is a major strength of the GBMI law specified by many of the participants in the telephone survey (B_3, B_6, C_1, D_1, E_1, E_2, F_1).[45] As explained by a high ranking administrator within the Corrections Cabinet (E_2) this early identification is:

> Particularly important in a state [Kentucky] which has limited funds available for initial post-conviction evaluations. . . . Other inmates are evaluated on a tier screening system where as many as five to six different levels of examination may be required [before referral to KSR's or KCPC's psychologist] depending on the overt need for mental health treatment displayed by the inmate.

An initial assessment is made to determine if the GBMI offender is acutely mentally ill and in need of emergency referral to KCPC.[46] In all cases involving the GBMI verdict the Corrections Cabinet's and Cabinet for Human Resources' procedures provide for the following:

> Within 72 hours after admission, excluding weekends and holidays, a written request for evaluation must be submitted to the Director of the Kentucky Correctional Psychiatric Center.[47] Observations of behavior and other relevant material should be submitted in this request.[48]
>
> The KCPC Director shall forward the request for evaluation to the KCPC Admission/Discharge Coordinator who shall make arrangements for the referral to be admitted to KCPC within seven (7) working days.[49]
>
> If the referral cannot be admitted within 7 working days due to lack of beds or other reasons, the Admission/Discharge Coordinator shall notify the KCPC Outpatient Department who shall see the referral, make an initial evaluation, and initiate treatment as necessary until admission to inpatient status can be accomplished.[50]

> GBMI referrals shall be requested to admit themselves voluntarily for evaluation and treatment on an inpatient basis at KCPC. If an individual refuses to admit themself voluntarily, proceedings for an involuntary admission pursuant to KRS 202A may be initiated by the Corrections Cabinet if the patient meets the criteria for involuntary hospitalization.[51]
>
> The initial evaluation of a GBMI patient shall last a minimum of ten (10) days. At the end of this period, a decision shall be made by the treatment staff and patient, based on the person's psychiatric condition, whether to continue the person in inpatient status or discharge them back to the Corrections Cabinet with outpatient follow-up.[52]

During the GBMI inmates' mandatory ten day evaluation period, a detailed psychological profile is assembled on each inmate. As described by a mental health professional (E_1) actively participating in the evaluations at KCPC, the evaluations include but are not limited to: (1) a review of prior hospitalization and diagnostic treatment history, (2) an analysis of psychometric data (WAIS-R or Beta IQ Test; MMPI and IGPF personality inventories), (3) a detailed, structured social history interview, (4) a blood test and routine medical diagnostic workups, and (5) individual examinations by graduate level social workers and psychologists. The determination of the inmate's need for hospitalization following the evaluation period is at the discretion of the KCPC treatment staff based solely upon treatment need according to an experienced member of the KCPC staff (E_1).

g. Treatment

The availability of treatment, the necessity of providing treatment, and the adequacy of the treatment rendered are among the most controversial aspects of the GBMI legislation. The statutory language mandates that treatment be provided a GBMI offender until he is no longer mentally ill.[53] As discussed earlier, seven respondents (A_1, B_1,

B_2, C_1, D_1, D_2, E_1) indicated that they thought the legislation was motivated in part by the legislature's desire to see that mentally ill offenders receive needed treatment.

The ambiguous nature of the word 'treatment' has caused confusion and disillusionment in Kentucky.[55] The expectancy created in the minds of many was inpatient treatment at KCPC. A thorough review of the inpatient treatment provided in the first year of the verdict to the thirteen (13) GBMI inmates evaluated by KCPC reveals the following:

> 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 . . . 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 thirty 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.[55.5]

The conception (or misconception) of the treatment GBMI offenders receive varies greatly among those involved in the system. Interestingly, all three assistant commonwealth attorneys (B_4, B_5, B_6) and the circuit court judge (C_1) felt that GBMI offenders would receive treatment because the statutes mandates treatment. Conversely, the defense bar (B_1, B_2, B_3) expressed a more cynical view. The defense attorneys indicate that treatment was either "less than it should be" or "spotty at best." All the attorneys agreed that because the GBMI offender enters the system with a "red flag" he is more likely to receive a mental health evaluation. Two attorneys (B_1, B_2) with considerable experience with GBMI offenders stated, however, that once the inmate is

returned to the general prison population he is no more likely than other offenders with mental health problems to receive treatment.

The treatment issue from the mental health or corrections perspective focuses on the clinical necessity of treatment. The treatment provided to GBMI inmates "does not vary much from that provided an inmate transferred to KCPC from the general population as all treatment is based upon need," according to a KCPC treatment staff member (E_1). Typically, only about two to three GBMI offenders are interned at KCPC at any given time. GBMI offenders are not segregated from the other inmates at KCPC.

In the opinion of two respondents (E_1, E_2), who have delt with the GBMI offenders on a clinical basis, to speak of GBMI offender as if they are a unified, homogenious population is inaccurate. A KCPC treatment staff member (E_1) indicated that as many as fifty percent (50%) of the GBMI offenders "displayed only anti-social behavior or personality disorders as opposed to mental illness traits . . . that for the most part they are sociopaths as opposed to psychotic and therefore from a treatment prioritization standpoint, do not justify long-term hospitalization." These views were echoed by a corrections official (E_2) who suggested that in reality there are two categories of GBMI offenders: (1) "those that are profoundly disturbed" and (2) "those that have plea bargained GBMI." Both respondents (E_1, E_2) questioned whether the GBMI determination was being "misused" and "abused" in light of their experiences to date.

h. GBMI Placement

Following the KCPC evaluation and treatment, those GBMI offenders deemed not to require continued hospitalization are returned to KSR. An

inmate is referred to the KCPC outpatient department, which assumes responsibility for future treatment needs.[56] According to a KSR administrator (F_1), GBMI offenders are eligible for assignment to minimum security facilities. A "case-by-case" analysis is conducted and the "GBMI label" does not prevent the offender from "benefiting from minimum security status provided he meets the other constraints and criteria." In practice, however, the majority of GBMI offencers are placed at the Luther Lucket facility and occasionally at KSR.

Subsequent inmate transfers from general population to KCPC would be coordinated through the Corrections Cabinet Classifications Department in Frankfort. The usual process is a voluntary transfer, however, if necessary an involuntary commitment order can be obtained from the circuit court.[58] The Cabinet for Human Resources GBMI procedures provide that:

> At any time during the continuing period of incarceration, the former patient or a Corrections Cabinet staff member may request further services or evaluation from the KCPC inpatient or outpatient departments.[57]

i. Parole

At this writing, no GBMI offenders have become eligible for review by the parole board. According to a high level administrator in the Department of Probation and Parole, special policies and procedures for GBMI offenders have not been developed. The only guidance provided by the legislature was that treatment shall be a condition of probation, shock probation, conditional discharge, parole or conditional release so long as the defendant is mentally ill.[59]

An analysis of the impact of the "GBMI label" on the parole board's decision-making process at this point can only be speculative. It is,

however, an important matter facing a defendant contemplating a GBMI plea. A high level corrections administrator (E_2) strongly stated that he believed the GBMI offender's case would be subject to much closer scrutiny and the GBMI label would be a "negative factor." He added that the parole board's primary responsibility is to protect the public and anticipated that the board would be "very hesitant" to grant pre-release status to a GBMI offender although technically it was available. The potential for strong public outcry was explained as the motivating factor behind the hesitancy.

The majority of the other respondents (A_1, B_1, B_2, B_3, B_5) agreed that GBMI offenders would be less frequently paroled than guilty inmates. Two attorneys (B_1, B_5) qualified their responses, saying that the GBMI offender's mental illness may be considered a mitigating factor when minor offenses were involved. Conversely, a circuit court judge (C_1) and an assistant commonwealth attorney (B_4), unhappy with the commonwealth's "lenient" Parole Board, indicated that the GBMI label would only increase the board's tendency to "turn inmates loose right and left." The attorney (B_4) "could not think of anything which would hurt an inmate's chance of early release."

j. Comparative Lengths of Confinement

Under Kentucky statute, when a defendant is found not guilty by reason of insanity, the court is required to conduct an involuntary hospitalization proceeding under KRS Chapter 202A or 202B.[60] Dangerousness of the individual to self or others is the criterion used in Chapter 202 to determine whether a person should be committed. The initial period of hospitalization can not exceed one year and early discharge is at the "sole discretion" of the treating psychiatrist or

psychologist, according to a private attorney (B_3) who helped draft the ICC legislation. That attorney (B_3) and one other (B_2) indicated that without question the period of confinement for NGRIs would be shorter than for GBMIs who have similar backgrounds. They believed that NGRI acquittees could be stabilized and released within two to three months whereas GBMIs must serve out their entire sentence. Other interviewees (B_1, B_4, B_5, B_6, C_1, F_1) all declined to speculate which group would be confined longer.

According to the drafter and sponsor of the GBMI legislation (A_1), the Corrections Cabinet is responsible for initiating "automatic" ICC proceedings against GBMI offenders upon expiration of their sentence.

In Kentucky, like most states, comparison of recidivism rates among guilty and GBMI offenders and NGRI acquittees are not readily available. With only two years experience under the GBMI legislation any comparison would be misleading in any event. One respondent, a private attorney (B_2), indicated that recidivism among mentally disturbed offenders would vary in relationship to the availability of local mental health facilities to the inmate or acquittee upon release. A KCPC evaluator (E_1) speculated that due to inappropriate use of the GBMI plea, he expected GBMI recidivism rates to resemble those of guilty offenders.

5. Costs

The Kentucky Legislative Research Commission attempted to address the potential impact of the GBMI legislation in a Fiscal Analysis Note dated January 11, 1982. The Commission predicted a fiscal impact but was unable to estimate the cost to the taxpayer.[62] The report, based largely on the Michigan experience, highlighted potential additional

expenditures for increased incompetency evaluations as the major new cost anticipated.[63] The Commission projected around ten GBMI findings annually in Kentucky.[64] Despite challenges by those predicting greater frequency,[65] it appears the Commission's projections were nearly accurate. Thirty-five (35) GBMI findings have been rendered in the first twenty-five (25) months under the new legislation.

Seven (7) of the eleven (11) respondents believed that the availability of the GBMI alternative will increase the overall cost to the mental health-judicial system in Kentucky (B_1, B_2, B_5, C_1, D_1, D_2, E_1). Despite the general consensus that the number of jury trials would decrease,[66] several respondents (B_1, B_5, C_1) attributed the cost increase to the statutorily mandated pretrial evaluations.[67] Others (D_1, D_2, E_2) attributed the increase to the minimum ten-day evaluation mandated by Cabinet for Human Resources policy. The other respondents (B_3, B_4, B_6, F_1) believed either that it was to early to project or that they were not qualified to speculate on the overall cost impact.

6. Strengths and Weaknesses of GBMI Legislation

The participants in the survey offered numerous and differing opinions about what they perceived as the strengths and weaknesses of the GBMI legislation. The opinions of all respondents interviewed are reflected in Table 14.

Assistant commonwealth attorneys (B_4, B_5, B_6) who believed that GBMI offenders received adequate mental health treatment expressed more of a willingness to advise a hypothetical client to enter a GBMI. Conversely, the three (3) defense attorneys (B_1, B_2, B_3) all

TABLE 14

Perceived Strengths and Weaknesses of Kentucky GBMI Law

	Respondents												
		B						D		E			
Strengths	A	1	2	3	4	5	6	C	1	2	1	2	F	Total
Provides alternative to NGRI/Guilty dichotomy	X					X	X				X	X		5
Reduces recidivism through treatment	X					X								2
Provides opportunity to delay trial			X											1
Increases likelihood of treatment				X	X		X	X						4
Provides defense attorneys additional options			X	X										2
Allows both sides to "cut their risks"					X									1
Allows early identification of mentally ill offenders										X			X	2
Provides greater public protection								X						1
None		X							X					2
Weaknesses														
Insane defendant may be convicted	X		X											2
Statutory language implies death sentence available	X													1
Parole may be negatively impacted	X								X		X			3
Lack of treatment		X							X					2
Redundant and meaningless		X												1
GBMI plea possibly unconstitutional		X												1
GBMI plea used inappropriately										X	X	X		3
Creates "gray area" in the law				X										1
Pre-sentence evaluation wasteful						X								1
Mental illness not required to be related to crime									X				X	2
Creates stigma for offender											X			1
None					X		X							2

indicated a reluctance to enter GBMI pleas on the part of their clients. Entering a GBMI plea does not provide the defendant any additional options and only serves to stigmatize the offender, according to one assistant public advocate (B_1). He indicated the same charge reduction considerations were available through the extreme emotional disturbance defense[68] and the same advantageous probation terms could be bargained for through voluntary submission to mental health treatment. Two attorneys (B_1, B_2) stated that they would rarely, if ever, advise a client to enter a GBMI plea because the likelihood of receiving the necessary treatment is low and the "negative implications would outweigh the possible benefits."

Notes

1. Act 1982, ch. 133 §§1-10 Ky. Stat. Ann. Cum. Supp. §504.60-504.150 (Bobbs-Merrill 1982).
2. Ky. Rev. Stat. §504.020(1) (Repl. Vol. 1975).
3. Id. at §504.020(3).
4. Id. at §504.020(1).
5. See Terry v. Commonwealth, 371 S.W.2d 862, 864-65 (1963). See also Commentary to Ky. Rev. Stat. §504.020 (Repl. Vol. 1975).
6. Ky. Rev. Stat. §504.020(3) (Repl. Vol. 1975). See also Edwards v. Commonwealth, 544 S.W.2d 380 (Ky.), cert. denied, 434 U.S. 999, 985 S. Ct. 642, 54 L.Ed.2d 495 (1977); Helmes v. Commonwealth, 558 S.W.2d 162 (Ky. 1977); Wainscott v. Commonwealth, 562 S.W.2d 628 (Ky.), cert. denied, 439 U.S. 868, 99 S. Ct. 196, 58 L.Ed.2d 179 (1978); Brewster v. Commonwealth, 568 S.W.2d 232 (Ky. 1978).
8. The defendant was adjudicated not guilty by reason of insanity (NGRI) of killing her eighty-year-old mother in Louisville in 1979. The defendant was committed to Central State Hospital and was subsequently certified as eligible for release.
9. Stephens, Veron L., ACSW, Kentucky's experience with the "Guilty But Mentally Ill" Verdict: A review and some empirical observations (unpublished manuscript, September 2, 1983).
10. Gall v. Commonwealth, 607 S.W. 2d 97, 113 (Ky. 1980).

11. Gall v. Commonwealth, 607 S.W. 2d 97 (Ky. 1980). This case involved a defendant who had previously been acquitted by reason of insanity of assault charges in Ohio. The defendant subsequently assaulted and killed a young girl in Northern Kentucky. The defendant was found guilty of murder and is currently scheduled to become the first inmate to be executed in Kentucky in the past decade.

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

16. Ky. Stat. Ann. §504.130(2) (Cum. Supp. 1982).

17. Id. at §504.130(1)(A).

19. Id. at §504.060(5).

20. Id. at §504.060(4).

21. Id. at chapter 504.

22. 1982 Pub. Acts 393, §50(5) (effective July 15, 1982).

23. Ky. Stat. Ann. §504.070(1) (Cum. Supp. 1982).

24. Id. at §504.070(2).

25. Id. at §504.070(3).

26. Id. at §504.080(1).

27. Id. at §504.080(6).

28. Id. at §504.080(5).

29. Id. at §504.080(2).

30. Id. at §504.080(4).

31. A similar occurrence has been noted by interviewees in several states.

32. Ky. Stat. Ann. §504.140 (Cum. Supp. 1982).

33. Palmer, Standard Jury Instructions §10.31 Mental Disease or Defect. Under Kentucky case law, jurors are not permitted to be informed of the dispositional consequences of any verdict. Presumably, therefore, many jurors are unaware of the statutory requirement that the court conduct an involuntary commitment proceeding when a defendant is found not guilty by reason of insanity. See Ky. Rev. Stat. §504.030(1) (Cum. Supp. 1982). The proceedings are to be conducted in accordance with Ky. Rev. Stat. Chapter 202A or 202B (Kentucky's civil commitment standards).

35. Ky. Stat. Ann. §504.150(1) (Cum. Supp. 1982).

36. Ky. Stat. Ann. §532.025(2)(b)(2) (Cum. Supp. 1984).

37. Ky. Stat. Ann. §504.150(1) (Cum. Supp. 1982).

38. See Table 3 comparitive statutes (Custody and Treatment After Sentencing) page X.

39. In a recent case, Commonwealth of Kentucky v. James Wellman, Pendleton Circuit Court, a pre-sentence evaluation was not performed. This case is currently on appeal on this and other issues.

40. See Ky. Stat. Ann. §504.150 (Cum. Supp. 1982).

41. In light of the fact that approximately 85 to 95 percent of all GBMI offenders in Kentucky are male, the remaining discussion will focus on the Kentucky State Reformatory (KSR).

42. KCPC is located adjacent to the Luther Luckett Correctional Facility and within a half-mile of KSR. All three facilities are located in La Grange, Kentucky.

43. Corrections Policies and Procedures, Policy Number 18.12 (It is the policy of the Corrections Cabinet that all admissions to the adult correctional system adjudicated guilty but mentally ill by the courts shall be referred to the Kentucky Correctional Psychiatric Center (KCPC) for evaluation) (effective June 1, 1983).

44. General Hospital Policy and Procedure. Subject: Evaluation/Treatment of Persons Sentenced Under Guilty But Mentally Ill. (Effective date: May 7, 1984). Policy: Each person convicted of a felony crime and sentenced under the Guilty But Mentally Ill (GBMI) statute, and committed to the Corrections Cabinet, shall receive an evaluation and treatment assessment by the Kentucky Correctional Psychiatric Center (KCPC).

45. The misconception between early targeting for evaluation and mandatory treatment will be addressed later in this section. See page X.

46. See note 43, IV. Procedure B: An emergency transfer will be deemed appropriate in cases where an inmate presents imminent danger to himself or others because of a psychiatric disturbance. See also note 44, Procedure F.

47. See note 43, VI Procedure A.1. and note 44, Procedure C.

48. Bata Test are routinely administered, in addition, any inmate scoring below 80 on the Bata Test is administered an OACE.

49. See note 44, Procedure D and note 43, VI Procedure A.3.

50. See note 44, Procedure E. According to one interviewee, (E_2) the GBMI inmate added to KCPC's waiting list and it may "be a week or as long as five (5) to six (6) weeks" before the inmate is admitted to KCPC.

51. See note 44, Procedure G. In many cases, the necessary involuntary hospitalization procedures would have been doncuted at the sentencing hearing.

52. See note 44, Procedure I.

53. Ky. Stat. Ann. §504.150(1) (Cum. Supp. 1982).

54. See page X.

55. KRS §504.060(9) defines "treatment" to mean medication or counseling, therapy, psychotherapy and other professional services provided by or at the direction of psychologists or psychiatrists. Also, KRS §504.060(10) defines treatment facility to mean an institution or part thereof, approved by the department of human resources, which provides evaluation, care and treatment for insane, mentally ill or mentally retarded persons on an inpatient or outpatient basis or both.

55.5. See note 9.

56. See note 44, Procedure J: GBMI persons will automatically be referred to the KCPC Outpatient Department for continuing services upon discharge from KCPC. These services shall continue until such time as the person paroles or serves out, or the individual and/or the KCPC Outpatient staf feels that services from the KCPC Outpatient Department are no longer necessary. At that time, the individual may be discharged from outpatient status.

57. See note 44, Procedure K.

58. Also, see note 44, Procedure G.

59. Ky. Stat. Ann. §504.150(2) (Cum. Supp. 1982).

60. Id. at §504.030(1). This legislation became effective simultaneously with the GBMI legislation (effective 7-15-82). Prior to this legislation, the decision to initiate ICC proceedings was within the court's or prosecuting attorney's discretionary power under Rule 9.90 of the Rules of Criminal Procedure.

62. See note 9.

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

64. Ibid.

65. 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. Judge Pennington, then President of the Kentucky Circuit Judges Association, claimed that he could have "12 people in a month found guilty under that." 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.

66. See supra, Part Two, §II.F.4.a. (Kentucky).

67. Ky. Stat. Ann. §504.140 (Cum. Supp. 1982).

68. See supra, Part Two, §II.F.4.a. (Kentucky).

G. Michigan

1. Introduction

Michigan's guilty but mentally ill (GBMI) statute became effective on August 6, 1975.[1] During August and September 1984, twelve (12) individuals familiar with the GBMI law and its application in Michigan participated in a telephone survey regarding Michigan's nine-year experience with the law. The interviewees were two defense attorneys (B_1, B_2), three prosecutors (B_3, B_4, B_5), two judges (C_1, C_2), a forensic psychologist (D_1), and four Department of Corrections staff members, including two mental health care administrators (E_1, F_1), a mental health counselor (F_2), and a probation administrator (G_1). This paper documents the results of the survey.

Most individuals interviewed (B_2, B_4, B_5, C_1, C_2, D_1, E_1, F_2) had been involved directly in an average of three to ten cases in which GBMI findings have been rendered. These individuals had participated in GBMI pleas, bench trials, jury trials, appeals, pre-trial examinations, post-conviction examinations, sentencing, probation, and treatment of GBMI defendants. Other individuals had been indirectly involved in 20 to 30 cases (D_1) and 50 to 70 cases (B_1). Three persons (B_3, F_1, G_1) work in supervisory or administrative capacities and have not handled GBMI cases directly. The probation administrator (G_1) said that in the Department of Corrections Region One, which accounts for about 40 percent of the criminal dispositions from the recorder's and circuit courts in Michigan, 28 defendants have been found GBMI in the last two years. See Part Three, Section III below

for detailed information regarding the number of GBMI cases in Michigan and their characteristics.

2. Legislation: Historical Context and Purposes

a. Changes Coincidental with GBMI Enactment

At the same time that the Michigan Legislature enacted the GBMI law, it modified the common-law standard for not guilty by reason of insanity (NGRI).[2] The old standard, the "M'Naghten plus irresistible impulse" standard,[3] was replaced by a "modified ALI" standard (B_2, B_5).[4] Also, mental illness or mental retardation replaced "disease of mind" as an element of the insanity test (B_2, B_5).[5] Other changes included new requirements for commitment hearings for NGRI acquittees (B_1, B_2)[6] and for responsibility examinations by the Center for Forensic Psychiatry (B_1, B_2, B_3).[7] These changes and others are discussed more fully in Appendix E.

b. Precipitating Factors

All the respondents (B_1, B_2, B_4, B_5, C_1, C_2, F_1, G_1) who commented regarding whether a particular case, incident, or problem led to enactment of Michigan's GBMI statute said that People v. McQuillan[8] and its aftermath[9] triggered the legislation.

c. Legislative Purposes

The respondent's comments regarding the Michigan legislature's intent in enacting the GBMI law focused on problems with the insanity defense in Michigan. Their perceptions of the legislative intent fell into the following categories:

(1) to provide a political response to the public outcry following McQuillan (B_1, B_2, B_4);

(2) to reduce or eliminate NGRI acquittals (B_1, C_1);

(3) to reduce or eliminate inappropriate NGRI acquittals (B_3, B_5);

(4) to prevent premature release of mentally ill defendants (C_2, E_1, F_1, G_1); and

(5) to provide treatment for mentally ill defendants who do not meet the NGRI criteria (D_1, F_2).

When asked whether the legislative intent had been fulfilled, three respondents (B_1, B_2, B_4) said that the intent to satisfy the public outcry following McQuillan had been fulfilled. These respondents said, however, that the new law was successful as a political maneuver only--that it did not, in fact, reduce or eliminate NGRI acquittals. One of them (B_2) said that, ironically, because a defendant must raise the insanity defense before he or she may be found GBMI,[10] the insanity defense is raised more often and, consequently, more insanity acquittals might occur. Another respondent (C_1) disagreed, saying that because the number of defendants found GBMI was greater than the number found NGRI, the law had been successful in reducing NGRI acquittals. Two respondents (B_3, B_5) said that the law had reduced inappropriate insanity acquittals. Both said that the law has caused the number of insanity acquittals to remain constant even though the insanity defense has been raised more frequently.

Two respondents (C_2, E_1) said that the intent to prevent premature release of mentally ill defendants has been fulfilled because the law permits judges and juries to compromise inappropriately and find defendants GBMI rather than NGRI. Another respondent (G_1) was unsure whether this intent had been fulfilled but stated that a subjective

review of the data available to him led him to believe that GBMI offenders received much longer sentences than guilty offenders do. He speculated that GBMI offenders would have been confined for shorter periods had they been found NGRI. Another respondent (F_1) was unable to determine whether this intent had been fulfilled.

The respondents who said the legislative intent was to provide treatment for mentally ill defendants who do not meet the NGRI criteria said that this objective generally had not been realized. One (D_1) said that although the legislation had focused attention on the treatment problem, the legislature failed to provide funding for treatment. The other (F_2) said that, although the law improved the corrections intake response to mentally ill offenders, treatment often was unavailable.

3. Characteristics of GBMI Offenders

When asked to compare the characteristics of defendants most likely to be found GBMI as opposed to NGRI or guilty, respondents gave diverse descriptions. Citing a study conducted by Smith and Hall,[11] two respondents (B_1, B_3) said that GBMI offenders are indistinguishable from guilty offenders. Also citing Smith and Hall, for the assertion that the recommendation of the Center for Forensic Psychiatry is often determinative of a case's outcome, another respondent (B_2) said that GBMI offenders simply are those defendants whom the Center says are GBMI. He added that insanity acquittees are those defendants who do not frighten a jury into returning a GBMI verdict hoping to prevent their release. A judge (C_2) agreed that the GBMI law permits both judges and juries to "put away frightening defendants." Several respondents said

that the mental conditions of GBMI offenders and NGRI acquittees differ only in degree (B_4, C_1, D_1), and that sometimes the differences are minimal (C_2). A forensic psychologist (D_1) said that both groups are seriously mentally ill but that insanity acquittees tend to be strongly antisocial.

Other respondents distinguished the mental conditions not by degree but by duration. One (E_1) said that NGRI acquittees are "unrelentingly psychotic," but that GBMI offenders are psychotic at the time of the crime but not later. A Department of Corrections mental health care administrator (F_1) confirmed that many GBMI offenders are not mentally ill at the time of their intake evaluation at the correctional facility. A mental health counselor (F_2) said that insanity acquittees generally have an established history of mental illness before the offense but that the mental illness of GBMI offenders only has become apparent at the time of the offense. He added that mentally retarded persons may be found NGRI in Michigan but that mental retardation cannot be the basis for a GBMI finding.[12]

When asked whether defendants found GBMI under Michigan law would be found NGRI or guilty if the GBMI alternative were unavailable, all (B_1, B_2, B_4, C_1, D_1) but two (B_5, E_1) said they would be found guilty. One dissenting respondent (E_1) said they would be found NGRI. The other (B_5) said that eliminating the GBMI alternative would cause jury confusion and result in both guilty and NGRI verdicts. The majority of respondents believed guilty findings would result because many non-mentally ill defendants have been pleading GBMI hoping to receive beneficial dispositions (B_1), because their mental illnesses are

insufficiently severe to warrant NGRI findings (D_1), or because insanity findings are rare (C_1). One of these respondents said that a defendant might be found NGRI if his criminal behavior had been bizarre (B_4).

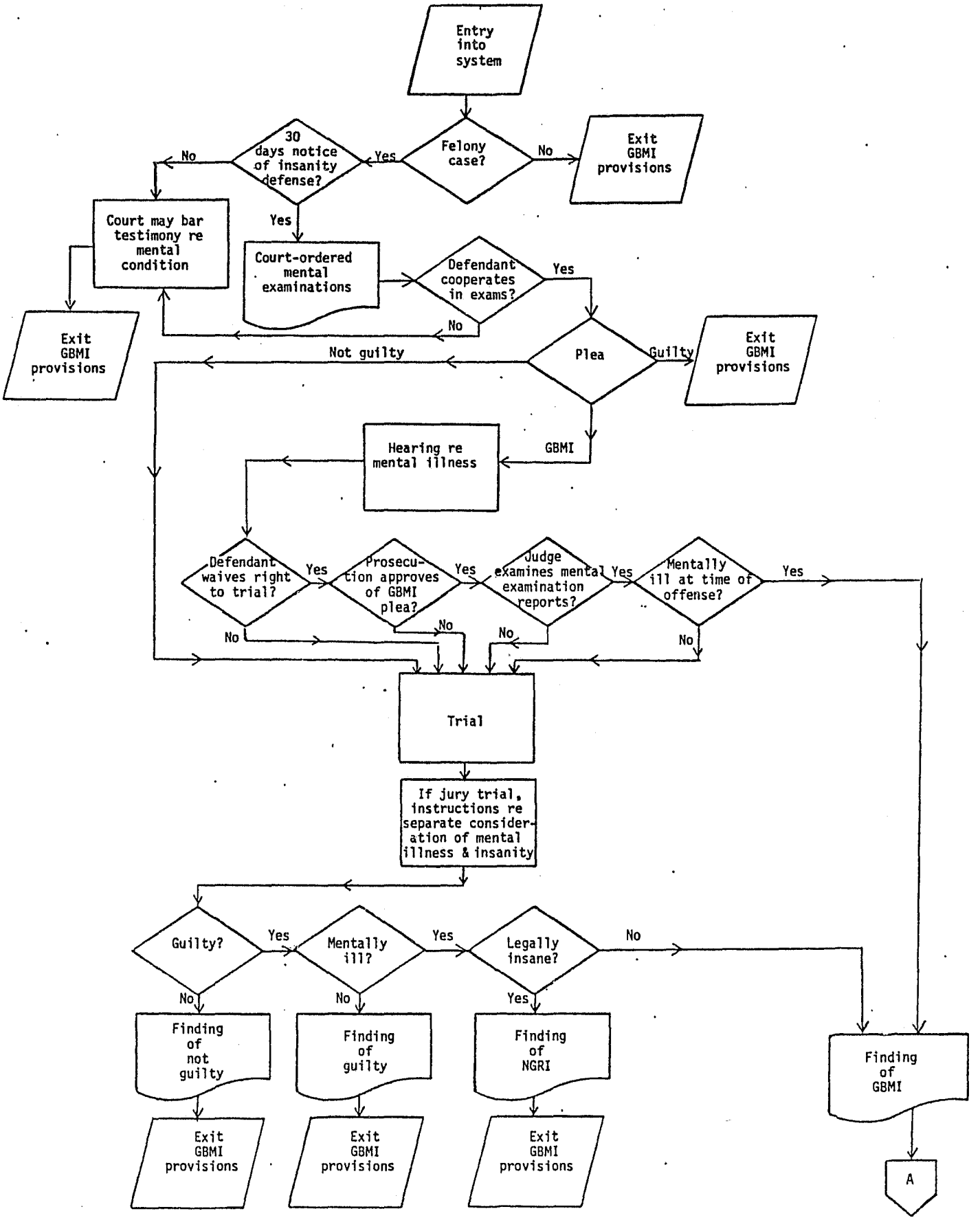
When asked whether recidivism rates vary among released NGRI, GBMI, and guilty offenders, most respondents (B_1, B_2, B_3, B_4, B_5, C_2, E_1, F_1, F_2, G_1) said they had no information on the issue. One respondent (C_1) said any difference in recidivism rates would not be based on whether the person was NGRI, GBMI, or guilty, but on whether he or she continued participating in therapy or taking prescribed medication.

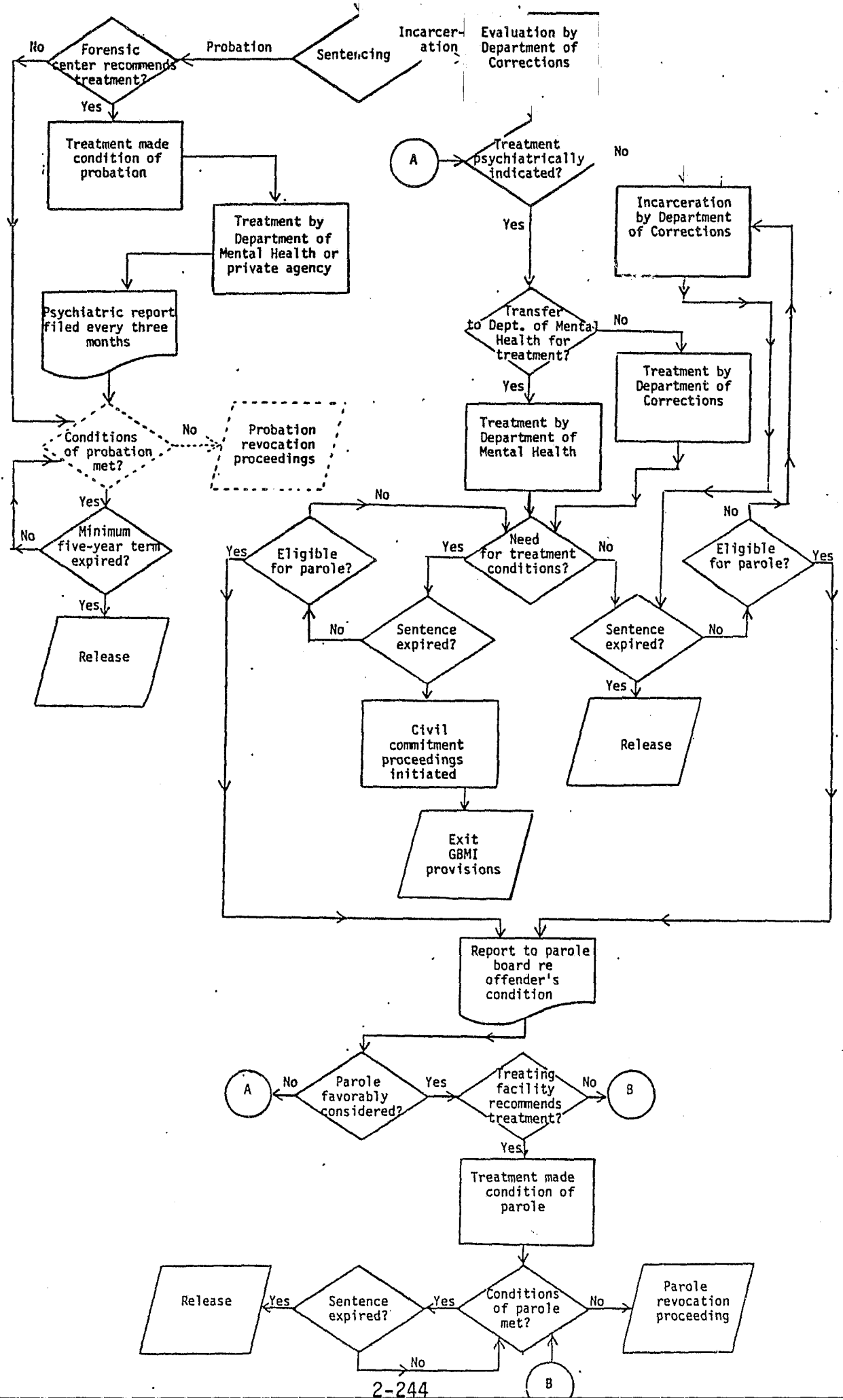
4. Procedures and Practices

a. General

Michigan's statutory GBMI procedures are depicted in Figure 7. The respondents offered differing opinions regarding how and whether these procedures had changed the processing of mentally ill offenders. Although one judge (C_2) said that plea bargaining has increased under the GBMI law, three prosecutors (B_3, B_4, B_5) said no increase had occurred. The judge said that plea bargaining has increased because defense attorneys advise defendants that GBMI is "the best you are going to get," suggesting that a GBMI plea would have a mitigating effect. Because of this, he added, some defendants who would have been found NGRI are pleading GBMI. A prosecutor (B_3) said that most GBMI findings are not plea-based. He said that Wayne County handles about 50 percent of the criminal cases in the state and that 90 percent of the convictions

Figure 7. Michigan's Statutory GBMI Procedures




Sentencing
Probation
Incarceration
Evaluation by Department of Corrections
Forensic center recommends treatment?
No
Yes
Treatment made condition of probation
Treatment by Department of Mental Health or private agency
Psychiatric report filed every three months
Conditions of probation met?
No
Probation revocation proceedings
Yes
Minimum five-year term expired?
No
Yes
Release
A
Treatment psychiatrically indicated?
No
Yes
Incarceration by Department of Corrections
Transfer to Dept. of Mental Health for treatment?
No
Yes
Treatment by Department of Corrections
Treatment by Department of Mental Health
No
Eligible for parole?
Yes
No
Need for treatment conditions?
Yes
No
Eligible for parole?
No
Yes
Sentence expired?
No
Sentence expired?
No
Yes
Civil commitment proceedings initiated
Release
Exit GBMI provisions
Report to parole board re offender's condition
A
No
Parole favorably considered?
Yes
Treating facility recommends treatment?
No
B
Yes
Treatment made condition of parole
Release
Yes
Sentence expired?
Yes
Conditions of parole met?
No
Parole revocation proceeding
No
B

result from trials. He, therefore, criticized Smith and Hall's [13] finding that most of these cases are plea-based, saying that their survey sample, which consisted of defense attorneys throughout the state, was skewed. Another prosecutor (B_4) said that the GBMI alternative rarely is involved in plea bargaining because the presence of mental illness has no effect on the offense charged. The third (B_5) said that the defendants who now plead GBMI would have pleaded guilty had the law not been enacted.

The respondents noted three additional changes. Two defense attorneys (B_1, B_2) said that defendants waive jury trials more frequently when pleading NGRI because they fear that juries will return compromise GBMI verdicts. As one attorney (B_2) put it, "Defendants who seek an NGRI finding are denied a right to a jury trial because of the virtual certainty of a compromise GBMI verdict." He continued, "The GBMI law enables ill-informed attorneys to fool clients into plea bargaining a GBMI plea." The other attorney (B_1) said that defendants plead GBMI because they fail to understand that the plea provides no benefits and, in fact, involves detriments. For example, the parole board might refuse to release GBMI offenders unless they have been undergoing a program of treatment, which they often do not receive. The second change, which a judge (C_1) noted, is that preliminary responsibility examinations occur more frequently.

Finally, the Department of Corrections has adopted a new intake evaluation procedure for GBMI offenders (E_1, F_1, F_2).[14] Although at least three respondents (B_1, B_4, C_1) were unaware of this new procedure, it supported two other respondents (B_5, C_2) beliefs that

the GBMI law would focus attention on mentally ill offenders and encourage the Department of Corrections to provide more services. This new procedure, which became effective July 1, 1984, is intended "[t]o ensure that GBMI prisoners are provided comprehensive psychiatric evaluations, to describe the format and content of such evaluations, and to ensure that required information is submitted to the Parole Board."[15] The procedure requires that a psychiatrist give each GBMI prisoner a comprehensive psychiatric examination within 10 working days after the prisoner arrives at a reception center. The report resulting from each examination should include, among other things, the examiner's recommendation regarding indicated treatment or services, such as inpatient, protective environment, or outpatient treatment, referral to psychological services, or routine institutional programming.

b. Pre-trial Mental Health Examination

Unlike post-conviction examinations, pre-trial examination procedures have not changed as a result of the GBMI law. Although the Center for Forensic Psychiatry performs these examinations, they are accomplished under the same procedures prescribed for responsibility examinations following assertion of the insanity defense (D_1).[16]

c. Mental Health Expert Involvement

Although four respondents (B_4, B_5, C_2, C_1) said that the GBMI law has not changed the involvement of mental health experts in criminal proceedings, four (B_1, B_2, B_3, C_1) said that the law had increased the involvement of the Center for Forensic Psychiatry. This increase has occurred because whenever a defendant pleads GBMI, he or she must submit to a responsibility examination by the Center (B_3).

According to a defense attorney (B_1), the Center's recommendation following this examination generally determines whether the court will accept the GBMI plea. A judge (C_1) said, however, that the additional examination had little effect on judicial resources--that it simply resulted in one additional report for the court to consider.

d. Criteria Used by Judges

When asked whether judges understand and make appropriate distinctions between the definitions of insanity and mental illness, three respondents (B_3, B_4, B_5) said that they do, but two (B_1, B_2) said they do not. The latter two respondents said that because of the definitional overlap between the two terms, even Michigan Supreme Court judges do not understand the differences. One (B_1) added, however, that the Michigan Supreme Court has not addressed directly this definitional problem, although the Court of Appeals has. According to these two respondents (B_1, B_2), the criteria that judges use in making GBMI or NGRI determinations are not the definitional differences, but the dispositions that would follow the decisions. Another respondent (B_5) said that judges use the statutory requirements, expert testimony, and facts to reach their decisions.

e. Juries

When asked what criteria juries use, one respondent (B_5) said they use the same criteria as judges: the statutory requirements, expert testimony, and facts. Another respondent (B_4) said that the facts but not the expert testimony determine a jury's decision. This respondent and another (B_1) added that the bizarreness of the criminal act predominates a jury's decision-making process. They said that the more

bizarre the criminal behavior was, the more likely a jury would find the defendant insane. A final respondent (B_2) said that disposition was controlling.

The respondents disagreed regarding whether juries understand and make appropriate distinctions between the definitions of insanity and mental illness. Three (B_3, B_4, B_5) said that the GBMI law enables jurors to make better distinctions. Four respondents (B_1, B_2, C_1, C_2) disagreed. Three of these (B_1, B_2, C_2) reasoned that distinguishing between insanity and mental illness was difficult if not impossible as a matter of definition. The other (C_1) said simply that jurors recognize bizarre behavior. Because of the definitional problem, all (B_1, B_2, B_3, C_1, C_2) but two (B_4, B_5) respondents said that juries do not understand Michigan's standard jury instructions on NGRI and GBMI.

The respondents (B_3, B_4, B_5, C_2) also generally agreed that juries do not understand expert testimony regarding mental aberration. Two respondents disagreed, however, regarding the effectiveness of expert testimony by mental health professionals from the Center for Fornensic Psychiatry: one (B_4) said that juries understood only these experts' testimony, but another (C_2) said their testimony was poor. An attorney (B_3) said that even though juries do not understand expert testimony, they do understand the basic issues of mental illness and criminal responsibility. One respondent (B_4) said that the GBMI law was irrelevent to whether juries understood expert testimony.

Despite their disagreements on the issues discussed above, the respondents (B_1, B_2, B_3, B_4, B_5, C_1, C_2) unanimously agreed

that dispositional concerns overwhelm and govern a jury's decision-making process. As one respondent (C_2) put it, the jury understands that "one goes to jail and the other does not." An attorney (B_2) gave an example of a case in which disposition governed the jury's decision. He said that the defendant once before had been found NGRI and later released by the Forensic Center. He said the jury reasoned that if they found the defendant NGRI again, he would be released again; therefore, they found him GBMI. The standard jury instructions provide great detail about the dispositional differences between GBMI and NGRI verdicts (B_2, B_3).

Finally, respondents offered differing views about whether the GBMI law had increased or decreased the number of jury trials in cases involving mental aberration. Four (B_1, B_2, B_3, C_2) said generally that the frequency of jury trials probably had decreased because defendants fear that juries will compromise and return GBMI rather than NGRI verdicts. Two of these respondents qualified their statements by saying that the percentage of jury trials had decreased but, because the insanity defense is now raised more frequently, the actual number may have increased (B_2), or that the GBMI law merely had stopped an existing increase in jury trials (B_3). Three respondents (B_4, B_5, C_1) said the law made no difference.

f. Sentencing

Several respondents noted differences in the length or type of sentences that guilty and GBMI offenders receive. The most dramatic difference is the length of probation (B_5, C_1, C_2, G_1). GBMI offenders have a minimum-mandatory five-year probation period. This period can be shortened only if the court can give reasons for shortening

it. All other offenders can receive a maximum of two years probation for misdemeanors or a maximum of five years for felonies. Therefore, because the GBMI finding is available only in felony cases, five years probation is the maximum for guilty offenders and the minimum for GBMI offenders. A probation administrator (G_1) said this difference is magnified because guilty probationers generally receive only two-year terms. He added that treatment is emphasized more heavily for GBMI probationers, but that probation is revoked more readily for treatment condition violations by GBMI probationers than by guilty probationers. (Reportedly, only two of the 40 GBMI defendants in Region 1, Wayne County, received probation.)

Two respondents (B_1, B_2) suspected that GBMI offenders receive longer sentences than guilty offenders. One of these respondents (B_1) based his view on the observation that GBMI offenders who appeal their convictions tend to have long sentences. The other (B_2) added that GBMI offenders probably have greater difficulty being paroled. A third respondent (B_3) disagreed, saying that GBMI offenders receive shorter sentences because of mitigation for their mental illness, but that they rarely are placed on probation. The judges interviewed (C_1, C_2) said, however, that the criteria used for placing guilty and GBMI offenders on probation were the same. Most of the respondents (B_4, B_5, C_1, C_2, F_2) agreed that except for probation, the sentences received by guilty and GBMI offenders were the same.

g. Comparative Lengths of Confinement

When asked whether the period of confinement for NGRI acquittees and GBMI offenders differ, all (B_1, B_2, B_4, B_5, C_1, F_2) but one (B_3) respondent said that NGRI acquittees are released much sooner than

GBMI convicts. The respondents attributed the earlier release of NGRI acquittees to the 60-day review hearing in the probate court and to the periodic hearings thereafter, at which the acquittees must be found committable. One respondent (B_5) estimated that at the 60-day review hearing, as many as 50 to 80 percent of acquittees are not committable. One respondent (B_3) did not know which group was confined longer. He did say, however, that if any NGRI finding is appropriate the subsequent confinement is very long, but that if it is inappropriate release will occur shortly thereafter.

h. Parole

The three respondents (B_1, B_2, B_3) who addressed the issue said that GBMI offenders probably were less frequently paroled than guilty offenders. Reasons they gave to support this conclusion were that the parole board requires the Department of Mental Health or an offender's treatment providers to certify that the offender is ready for parole (B_1) and that GBMI offenders are unpredictable and rational deterents will not control their behavior (B_2).

i. Treatment

When asked whether GBMI offenders are more likely to receive treatment than guilty offenders with mental health problems, six respondents (B_1, B_2, B_4, E_1, F_1, F_2), including three (E_1, F_1, F_2) involved in the provision of treatment, said that they are not. Two attorneys (B_3, B_5) and two judges (C_1, C_2) believed that GBMI offenders are more likely to receive treatment. Two of these respondents (B_3, C_2) believed that the statutes provide GBMI offenders with a right to treatment. The other two (B_5, C_1) said that the statutes provide GBMI offenders with a right to a

post-conviction evaluation that, in turn, would lead to treatment. Respondents who said treatment was no more likely gave three reasons: (1) insufficient treatment resources hinder the treatment of all offenders (B_1, B_4, E_1); (2) the post-conviction evaluation, not the GBMI status, determines whether an offender receives treatment (F_1, F_2); and (3) the legislature allocated no additional funds for the treatment of GBMI offenders (E_1).

Both the Department of Corrections and the Department of Mental Health provide treatment for GBMI offenders. The Department of Corrections' policy is that all offenders, regardless of whether they are GBMI or guilty, receive the necessary treatment (F_1). In practice, however, the Department of Corrections has insufficient resources to provide this treatment (E_1, F_1). Because the law requires that incoming GBMI offenders be evaluated, each is evaluated by a psychiatrist; guilty offenders receive only team screening (F_1).

Both GBMI and guilty offenders receive indicated treatment, as resources permit (F_1). The Department of Corrections provides most treatment itself, but may transfer an inmate to the Center for Forensic Psychiatry (E_1, F_1, F_2). The decision to transfer is based upon an inmate's clinical condition, not upon whether the GBMI or guilty label applies. Generally, a transfer occurs only if an offender has a severe psychiatric disorder (F_1, F_2). Transfers may be voluntary, but if the offender contests the transfer, the Department must seek an involuntary civil commitment order (F_1, F_2).

5. Costs

All (B_3, B_5, C_1, C_2, D_1, F_1, F_2) but two (B_1, B_4) respondents who addressed the issue said that the availability of the GBMI finding had

increased or would increase costs to the mental health-justice system. The respondents attributed this increase to the necessity to provide more mental health treatment and services to offenders. The two dissenting respondents said no increase had occurred because the costs had merely shifted from the mental health system to the correctional system (B_1) or because, although the law potentially required an increase, no additional funds were allocated (B_4).

6. Perceived Strengths and Weaknesses of GBMI Legislation

Asked about what they perceived as the strengths and weaknesses of Michigan's GBMI Legislation, respondents offered differing opinions. These opinions are reflected in Table 15.

Table 15
Perceived Strengths and Weaknesses of
Michigan's GBMI Provisions

	Respondents												
	B					C				F			
Strengths	1	2	3	4	5	1	2	D	E	1	2	G	Total
Focuses Attention on Mentally Ill Offenders								X		X	X		3
Encourages Treatment							X						1
Requires Discrete Mental Illness Determination					X								1
Protects Public from Mentally Ill Defendants				X								X	2
Reduces NGRI Findings			X										1
None	X	X				X			X				4
Weaknesses													
Creates Illusion of Benefits	X	X								X			3
Hampers Offenders' Release		X											1
Adds Nothing to Prior Law	X					X							2
No Treatment Requirement												X	1
Confusing/Vague	X								X				2
Leads to Compromise Verdicts							X						1
Lacks Funding								X					1
None		X	X	X							X		4

Notes

1. Mich. Comp. Laws Ann. §768.36 (1982) (added by 1975 Mich. Pub. Acts 180, §1).

2. See 1975 Mich. Pub. Acts 180, §1.

3. See People v. Martin, 386 Mich. 407, 418, 192 N.W. 2d 215 (1971).

4. See Mich. Comp. Laws Ann. §768.21(a) (1982).

5. Id.

6. Id. at §767.27b. See also People v. McQuillan, 392 Mich. 511, 221 N.W. 2d 569 (1974).

7. Mich. Comp. Laws Ann. §768.20a(2) (1982).

8. 392 Mich. 511, 221 N.W. 2d 569 (1974)

9. See supra Part One, 1-10 nn.25-29 and accompanying text.

10. Mich. Comp. Laws Ann. §768.36(1) (1982).

11. Smith & Hall, Evaluating Michigan's Guilty but Mentally Ill Verdict: An Empirical Study, 16 U. Mich. J.L. Ref. 77, 80-85 (1982).

12. Compare Mich. Comp. Laws Ann. §768.21a(1) (1982) with id. at §768.36(1) & (2).

13. See supra note 11.

14. Michigan Department of Corrections, Procedure No. OP-OHC-42.03, Psychiatric Evaluation of Prisoners Committed as Guilty but Mentally Ill (GBMI) (effective July 1, 1984).

15. Id. at 1.

16. See Mich. Comp. Laws Ann. §§768.36(2); 768.20a(2).

H. New Mexico

1. Introduction

New Mexico's guilty but mentally ill (GBMI) statute became effective on May 19, 1982.[1] During July 1984, eight (8) individuals familiar with the GBMI law and its application in New Mexico participated in a telephone survey regarding New Mexico's two-year experience with the law. The interviewees included a legislative staff attorney (A_1), a deputy district attorney (B_1), a chief public defender (B_2), an assistant public defender (B_3), a district court judge (C_1), two forensic evaluators (D_1, D_2), and a corrections administrator (F_1). This paper documents the results of that survey.

Interviewees had been involved in as few as two (2) cases involving GBMI pleas or findings (B_1) to as many as 12 cases (D_2). None could estimate the total number of GBMI cases in New Mexico, although three (B_1, B_2, B_3) suggested that GBMI pleas were more frequent than GBMI findings following a bench or jury trial. An assistant public defender (B_3) said that the GBMI plea was gaining popularity in New Mexico.

2. Legislation: Historical Context and Purposes

a. Changes Coincidental with GBMI Enactment

Since 1978, the Interim Legislative Committee on Criminal Justice Matters of the New Mexico Legislature has received two proposals to reform the insanity defense laws (A_1). One would have abolished the not guilty by reason of insanity (NGRI) defense and the other would have resulted in bifurcation of trials in which the insanity defense was raised. Under the second proposal, guilt or innocence would be

determined in one hearing and then insanity would be determined in a later hearing. The committee defeated both proposals. In 1980, a proposed state constitutional amendment to abolish NGRI also was defeated. The GBMI law then was passed in 1982. No additional legislative actions in the mental health area have been proposed or are pending.

When asked what the positions of legislators opposed to the GBMI legislation were, a staff attorney of the Legislative Counsel Service (A_1) said very few opposed the legislation. The Senate passed it 31 to seven and the House passed it 59 to eight. Although the attorney was not present during committee testimony regarding the legislation and no record was kept of that testimony, he suspected that opponents of the legislation said it was a sham, that it would promote jury compromise, that it left treatment discretionary with the Department of Corrections, or that more appropriate measures would reform the NGRI laws.

According to three persons interviewed (B_1, B_2, B_3), the only rule change affecting mentally ill or insane defendants that has occurred since the GBMI enactment has been the rewriting of the Uniform Jury Instructions to accomodate the GBMI verdict. The first version of the GBMI instruction was effective May 19, 1982.[2] An attorney (B_1) who participated in drafting this and a later version of the instruction said that the first version failed to provide a jury with a step-by-step method for determining whether a defendant was GBMI. He said that the second version[3] requires sequential decisions: first, whether the defendant is guilty and, second, whether he or she is mentally ill. Another person (B_2) who participated in the drafting was aware of no problems in practice that required the first instructions to be redrafted.

b. Precipitating Factors

Two persons interviewed (A_1, F_1) said that no particular case, incident, or problem led to enactment of the GBMI statute. One (A_1) said that public dissatisfaction with the acquittal of John W. Hinckley, Jr., in the shooting of President Reagan,[4] was not a factor because the legislation was passed early in 1982 before the Hinckley verdict. He suggested that the GBMI legislation resulted from the frustrated attempts to reform New Mexico's insanity laws.

c. Legislative Purposes

Most of the respondents said that the primary legislative intent behind the GBMI statute was to eliminate or limit NGRI acquittals. Responses fell into several categories:

1) to reduce or eliminate NGRI acquittals (A_1, B_1, B_2, B_3, D_2, F_1);

2) to avoid release of NGRI acquittees (C_1);

3) to hold mentally ill offenders responsible for their actions (D_1);

4) to permit a compromise verdict in difficult cases (B_1);

5) to increase treatment for mentally disordered offenders (B_1, B_2, D_1); and

6) to make mentally ill offenders more readily identifiable and to facilitate creation of treatment programs in the Department of Corrections (D_2).

The drafter of the legislation (A_1) said that Senator Caleb Chandler, the assistant chief of police in Clovis, New Mexico, who sponsored the original senate bill, sought to undercut the insanity defense in New Mexico. Because the primary intent was to undercut the insanity defense and not to provide GBMI offenders with treatment, the drafter deemphasized the treatment provisions in the law (A_1). The treatment

of GBMI offenders was left entirely within the discretion of the Department of Corrections (A_1). A forensic evaluator (D_2) presented a partially conflicting account of the sponsor's intent. Before this survey, he spoke with Senator Chandler regarding the intent behind the bill. Reportedly, Senator Chandler said the purpose was twofold: (1) to reduce the incidence of insanity pleas and acquittals, and (2) to make mentally ill offenders more readily identifiable and to enable the Department of Corrections to set up specific treatment programs for them.

When asked whether the legislative intents had been fulfilled, three respondents (A_1, B_1, C_1) said the enactment was too recent to permit an assessment. Two (B_1, D_2) said the incidence of NGRI acquittals had been so low before the enactment that its effect would be difficult or impossible to assess. Two (B_2, F_1) said the GBMI law was used infrequently. An assistant public defender (B_3) said that the law did not reduce NGRI acquittals directly, but that defense attorneys actually used it in plea bargaining to their clients' advantage.

Two respondents (D_1, D_2) said that the law had not resulted in better treatment for mentally ill offenders. A forensic evaluator (D_2) knew of no new treatment programs for GBMI offenders in the state. Another forensic evaluator (D_1) emphasized that more programs are needed desparately. Of about 200 mentally ill offenders in the corrections system, about 100 are treatable (D_1). The state has beds, however, for only about one-third of these (D_1).

3. Characteristics of GBMI Offenders

Persons interviewed did not agree regarding the characteristics of defendants most likely to be found GBMI, as opposed to NGRI or guilty.

Three (B_1, B_3, F_1) said NGRI and GBMI cases were too infrequent to permit generalizations. One (D_1) said that NGRI defendants tended to be overtly psychotic, but that GBMI offenders were personality disordered. Another (D_2) said that the same mental condition might, under different circumstances, lead to either an NGRI acquittal or a GBMI conviction. The distinction turned on whether the mental condition was related to the offense. For example, if the crime was a product of a delusion, an NGRI acquittal would result. If no relationship existed between the crime and the mental condition, a GBMI conviction would result. Therefore, according to the respondent, the severity of the mental illness did not necessarily determine whether an NGRI or GBMI finding would result. A district court judge (C_1) agreed that the defendant's mental illness need not be related to the commission of the offense.

When asked whether defendants found GBMI under New Mexico law would be found NGRI or guilty if the GBMI alternative were unavailable, all (B_3, C_1, D_1) but one (B_1) respondent said they would be found guilty. The reasons were that the defendants would not satisfy the NGRI standard (B_3, C_1), that New Mexico juries are reluctant to grant NGRI acquittals (B_3), and that only one defendant had been found NGRI in New Mexico in the last five years (D_1). The dissenting respondent (B_1) speculated that defendants accused of violent crimes, such as murder, would be found guilty, but that defendants accused of non-violent crimes, such as burglary or credit-card fraud, might be found NGRI. He offered no supporting reasons.

Respondents were unable to comment on whether recidivism rates varied among NGRI, GBMI, and guilty offenders. Three (B_3, C_1, F_1) said

that not enough time had elapsed since passage of the GBMI law to assess recidivism rates and one (B_1) said he had no information on recidivism. An assistant public defender (B_3), who had handled four GBMI cases, each of which resulted in probation, said that no probation revocations had occurred in her cases. She speculated that the offenders had received successful mental health treatment, which might, in turn, reduce recidivism.

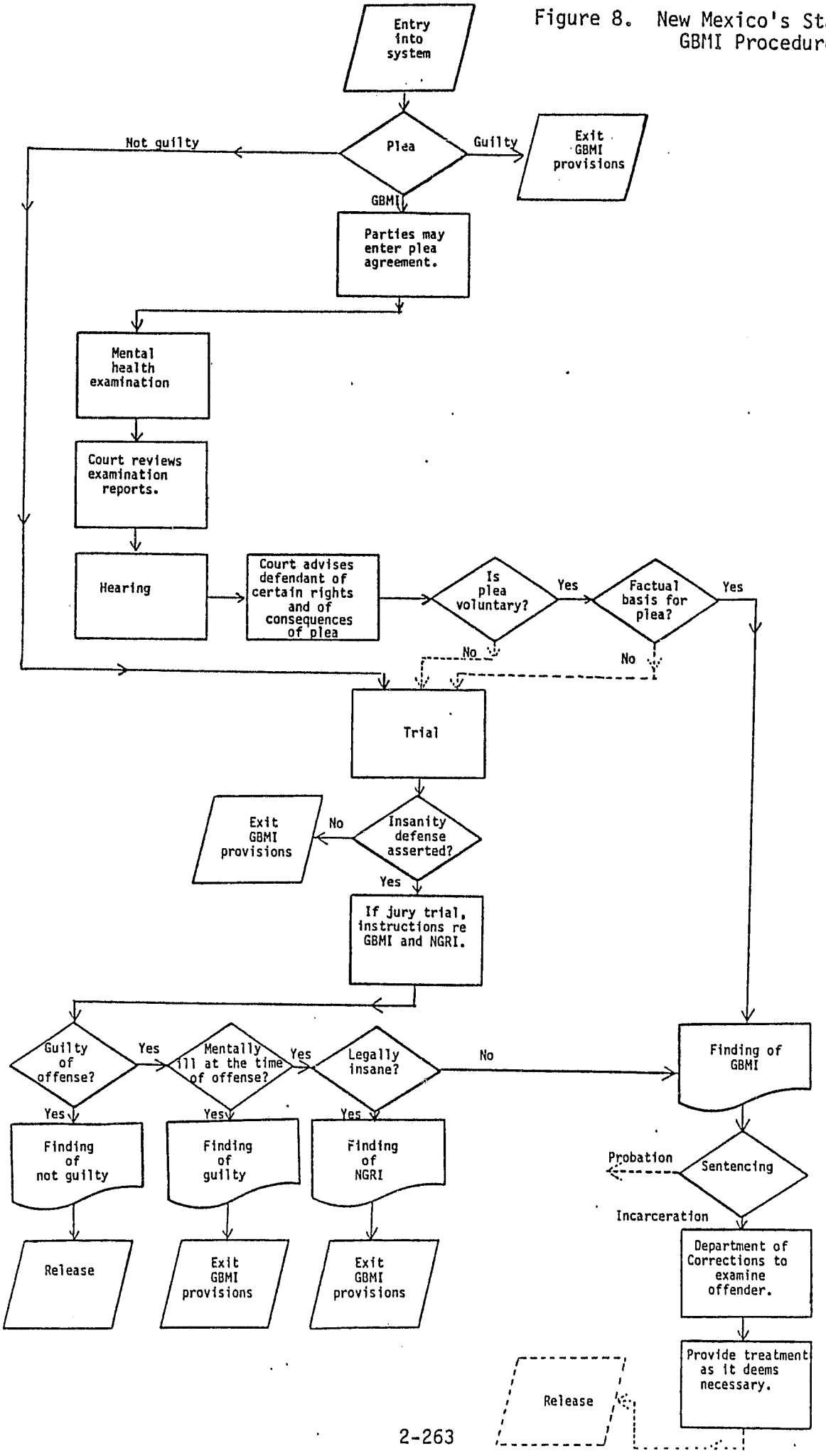
4. Procedures and Practices

a. General

New Mexico's statutory GBMI procedures are depicted in Figure 8. The most significant way in which these procedures have changed the handling of mentally disordered offenders is that plea bargaining is used more frequently (B_1, B_2, B_3, C_1). Five respondents (B_1, B_2, B_3, C_1, D_2) suggested that GBMI cases are handled almost exclusively through plea bargains. GBMI also might be presented at trial as a defense theory (C_1). Plea bargains generally result in a GBMI plea to a lesser included offense plus a recommendation of treatment (B_2).

An assistant public defender (B_3) described the negotiation process. If a public defender knows that a defendant has a history of mental illness, he or she gets the available psychiatric records. If the defendant has a history of mental illness but an insanity defense is inappropriate because the defendant is lucid about the crime, the public defender discusses with the defendant the possibility of a GBMI plea. The attorney explains that if the judge accepts the GBMI plea, the defendant would go to the hospital rather than the penitentiary. If the

Figure 8. New Mexico's Statutory GBMI Procedures



defendant is receptive to the idea of a GBMI plea, the attorney contacts the district attorney to negotiate. The attorneys attempt to agree regarding sentencing. The most frequent resolution involves probation with treatment conditions. For example, the defendant might agree to probation with voluntary admission to a state hospital or with outpatient treatment from a specific mental health center.

A deputy district attorney (B_1) said that his office has willingly accepted GBMI pleas so long as some evidence exists to support it. He knew of no reason that a prosecutor should disfavor a GBMI plea as opposed to a guilty plea, except if he is attempting to get the death penalty. He suggested that mental illness might serve as a mitigating factor.

The assistant public defender (B_3) said that judges more readily accept conditional probation under a GBMI plea than they would under a guilty plea. A GBMI plea recognizes the component of mental illness in the commission of the crime. Because of that recognition, a judge is more likely to send a GBMI offender to a hospital rather than a penitentiary. If the same defendant had been found guilty, the judge would not necessarily know about the mental illness and, therefore, the judge might send the offender to the penitentiary.

Three respondents (A_1, C_1, F_1) said that instituting the GBMI law generally had not changed the policies or procedures for handling mentally disordered offenders. A district court judge (C_1) commented that mental health expert testimony is handled no differently in GBMI cases than in any other case involving mental illness. A corrections administrator (F_1) said that seven to eight percent of all incoming inmates are mentally ill even though they were found guilty rather than

GBMI. He said that the GBMI offenders are treated no differently than other mentally ill offenders. The drafter of the GBMI law (A_1) said that because the law requires only that the Department of Corrections provide such treatment as it deems necessary,[5] the law added nothing to the law applying to the general guilty population. He said that the United States District Court consent decree issued in Duran v. King[6] two years be enactment of the GBMI law set out stringent requirements for treatment of mentally ill offenders.

b. Pre-trial Mental Health Examinations

Preliminary mental health examinations generally are performed by forensic evaluation teams in the community or by the forensic division at the State Hospital (C_1). The forensic evaluation teams, which have been used in New Mexico for about seven years, eliminate the necessity of transporting defendants to the state hospital for examinations. According to one forensic evaluator (D_2), before 1977, if a forensic evaluation was needed, the defendant was sent to the State Hospital for a sixty-day evaluation. This was a very costly process and the waiting list for evaluations was very long. In 1977, forensic evaluation teams began doing evaluations at the community jail or on an outpatient basis. Now only about ten percent of all defendants need to go to the State Hospital for evaluations. The forensic evaluation teams worked effectively for five years before the GBMI law was passed.

The forensic evaluators (D_1, D_2) interviewed disagreed regarding whether evaluation procedures differ for NGRI and GBMI defendants. One (D_2) said that the procedures are exactly the same: a comprehensive examination is done and only the clinical opinion and recommendation are different. The other (D_1) said that the procedures do vary because

NGRI defendants generally are overtly psychotic but that GBMI defendants are personality disordered. Thus, if a person has pleaded NGRI, the first question in the evaluation is whether the defendant is overtly psychotic. If the person has pleaded GBMI, the question is merely whether his condition is classifiable as a mental illness. Thus, the evaluation is focused depending upon the question the court has posed to the forensic evaluator.

c. Mental Health Expert Involvement

When asked whether the GBMI law in New Mexico had changed the involvement of mental health experts in criminal proceedings, four (B_1, C_1, D_1, D_2) of five respondents said that it had not. A district court judge (C_1) said that, because it is difficult to provide legal definitions for medical phenomenon, expert testimony has always been problematic. He said that the GBMI law has not mitigated this problem. Both forensic evaluators interviewed (D_1, D_2) said that the nature and frequency of their testimony and recommendations regarding forensic examinations had not changed since enactment of the GBMI law. One (D_1) said that evaluators make recommendations to attorneys or the court in virtually all cases in which evaluations are conducted and that they testify in approximately half of these cases. The other (D_2) said he personally had recommended GBMI findings about 12 times and NGRI findings about six times. Both forensic examiners said that the courts generally follow their recommendations. Only one respondent, an assistant public defender (B_3), believed that the GBMI law had increased the involvement of mental health experts in criminal proceedings. In particular, he said that defendants use mental health experts more frequently to seek determinations that they are suitable for treatment.

d. Criteria Used by Judges

Two attorneys interviewed (B_1, B_3) believed that so long as some evidence of mental illness appears in the record, the courts tend to accept GBMI pleas. The deputy district attorney (B_1) said that although judges understand the legal distinctions between insanity and mental illness, they actually follow their intuitive understanding of the differences. The assistant public defender (B_3) did not comment on the criteria judges use in reaching NGRI and GBMI findings.

e. Juries

Two respondents (B_1, B_3) said that because the GBMI law has led to an increase of plea bargaining in cases involving mental aberration, jury trials, and bench trials, probably are less frequent than before the GBMI law became effective. As noted earlier, three additional respondents (B_2, C_1, D_2) said that GBMI cases are handled almost exclusively through plea bargaining. All the cases in which interviewees participated involved GBMI pleas, not verdicts.

Respondents who speculated regarding the conduct of jury trials disagreed about whether jurors would understand the standardized jury instructions discussed earlier. A district court judge (C_1) said the instructions are clear and should not confuse juries. He added, however, that the instructions do not reduce the general problems with mental health expert testimony. He noted that juries cannot be instructed regarding the dispositional consequences of their verdict. Another respondent (B_1), who was not aware of any practical problems resulting from the first version of the GBMI instructions,[7] said that the Committee on Jury Instructions had difficulty giving legal definitions to the medical issues involved. Although, according to the respondent, the

second version of the instruction was better, the legalese and the psychiatric jargon used by expert witnesses might result in a confusing mix. For example, expert witnesses might discuss "neuroses" and "psychoses" while the instructions use the terms "mental illness" and "insanity." He suggested, however, that jurors would tend to follow their intuitive reaction to a defendant's condition rather than the strict legal criteria.

f. Sentencing

Respondents sharply disagreed regarding whether the length or type of sentences differ for guilty and GBMI offenders. Two respondents, an attorney (B_1) and a judge (C_1), believed that no significant differences exist. The judge based his opinion on the statutory provision that courts may impose any sentence for a GBMI offender that could be imposed upon a defendant found guilty of the same offense.[8] The attorney said, however, that sentencing could potentially differ depending on a particular judge's objectives in sentencing. If a judge's objective is punishment, then the sentences are unlikely to vary. If the goal is rehabilitation, however, then alternatives to incarceration might be used more frequently. He added, though, that probation for GBMI offenders would be very rare in New Mexico because of the lack of adequate non-jail treatment options.

Two respondents, an attorney (B_3) and a corrections administrator (F_1), said that sentences do differ, but disagreed regarding how they differ. The attorney said that GBMI offenders generally receive probation, following plea bargaining in which the parties agree to condition probation on the defendant participating in a treatment

program. The corrections administrator said that GBMI offenders are confined but they may have difficulty being paroled because of the lack of treatment resources in the community.

g. Comparative Lengths of Confinement

Respondents also disagreed regarding whether the lengths of confinement for NGRI acquittees and GBMI convicts who have similar backgrounds differ. Their opinions were that NGRI acquittees are confined longer (B_3), that GBMI convicts might be confined longer (F_1), and that no reliable comparison can be made at this time (C_1). The first respondent (B_3) said that three factors result in GBMI offenders having shorter periods of confinement: (1) GBMI offenders generally receive probation, (2) NGRI acquittees tend to be hospitalized for long periods, and (3) GBMI offenders generally are convicted of crimes less serious than those involved in NGRI cases. The second (F_1) said that GBMI offenders might be confined longer because of the difficulty they may have in obtaining parole. The third (C_1) said that comparisons are difficult because the length of confinement of NGRI acquittees is determined by the Department of Hospitals and Institutions while the determination is made for GBMI offenders under the regular sentencing laws.

h. Parole

When asked whether GBMI offenders are more frequently or less frequently paroled than guilty offenders, two respondents (B_1, C_1) said they are not. The respondent noted that New Mexico has determinate sentencing and the same criteria applied to both GBMI and guilty offenders. As mentioned above, however, a third respondent (F_1) suggested that GBMI offenders may have greater difficulty getting parole because of the lack of treatment resources in the community.

A forensic evaluator (D_2) said that he has done evaluations at the request of the parole and probation departments. He said that GBMI offenders generally are handled no differently by parole and probation officers, except that these officers are more likely to defer to mental health experts regarding disposition of a parolee or probationer. For example, an officer might consult with a mental health expert before seeking revocation of the status because of the violation of a treatment condition. He might also push enthusiastically to get the needed treatment for the client. With a non-GBMI parolee or probationer, the officer more readily would seek revocation of the status because of non-compliance with conditions.

i. Treatment

If a GBMI offender is sentenced to the custody of the Department of Corrections, the department "shall provide psychiatric, psychological and other counseling and treatment for the defendant as it deems necessary."[9] As indicated by the drafter of New Mexico's GBMI legislation (A_1), this provision leaves the treatment of GBMI inmates entirely within the discretion of the Department of Corrections. The law makes no provision for treatment of GBMI probationers or parolees. The drafter said that treatment was not a priority of the bill's sponsor and that both the House and the Senate passed the law exactly as he had drafted it.

All respondents (B_2, B_3, C_1, F_1) who addressed the issue said that GBMI offenders are no more likely to receive treatment than offenders with mental health problems in the general prison population. GBMI offenders are handled no differently than guilty offenders (F_1). All offenders receive a series of psychological tests and an interview with a psychologist at a Department of Corrections receiving unit

(F_1). Whether an offender will receive treatment is determined by this evaluation, not by whether the offender is labeled guilty or GBMI (F_1). One respondent (B_3) noted that because of overcrowding at a central New Mexico facility, 165 inmates are now on a waiting list for therapy. Whenever offenders receive mental health treatment, although they remain under the jurisdiction of the Department of Corrections, they may be transferred to the forensic unit of the State Psychiatric Hospital in Los Vegas, New Mexico (B_1, C_1, F_1). That facility is operated by the Department of Hospitals and Institutions. Treatment may also be provided by the Department of Corrections at the penal institution itself (B_1, C_1, F_1).

j. Transfers for Mental Health Treatment

A corrections administrator (F_1) described the procedures for transferring inmates for mental health treatment. The same procedures apply to GBMI and guilty offenders. A transfer may occur from the general prison population to the Department of Corrections mental health unit or from the Department of Corrections to the state hospital. In either case, if the transfer is voluntary, the inmate merely signs an informed consent or voluntary transfer form. If the transfer is involuntary, one of two procedures applies. First, a court order of transfer may follow appointment of counsel for the inmate and a judicial hearing. Second, a "Vitek" hearing may be conducted within the Department of Corrections by a committee appointed by the Secretary of Corrections. This committee is chaired by a representative of the Attorney General's Office. It makes a recommendation to the Secretary of Corrections, who either approves or disapproves it. During this process, a guardian may be appointed for the inmate.

5. Costs

All the respondents (B_1, B_3, C_1, D_1, D_2, F_1) generally agreed that application of the GBMI law has resulted in little if any increase in costs to the mental health-justice system. Two (D_1, F_1) attributed this to the very small number of GBMI findings that have occurred. Two (B_3, C_1) suggested that costs may have increased because the forensic evaluation process is used more frequently than before the GBMI law became effective. A district court judge (C_1) said that defense attorneys often seek mental health evaluations even when a defendant is not overtly mentally ill and that the courts pay for these evaluations. A forensic evaluator (D_2) said, however, that this increase is probably minimal because forensic evaluation teams were used before enactment of the GBMI law.

6. Perceived Strengths and Weaknesses of GBMI Legislation

Asked about what they perceived as the strengths and weaknesses of New Mexico's GBMI legislation, respondents offered differing opinions. These opinions are reflected in Table 16.

Table 16

Perceived Strengths and Weaknesses of
New Mexico's GBMI Provisions

		B				D			
Strengths	A	1	2	3	C	1	2	F	Total
Early Identification of Mental Illness					X	X		X	3
Increases Treatment Options	X			X	X		X		4
Probation Availability Enhanced			X	X					2
Public Satisfaction					X				1
Undercuts Insanity Defense					X				1
None		X							1
Weaknesses									
Provides No Additional Right to Treatment	X	X		X		X			4
Funds No Treatment Programs		X					X		2
Promotes Juror Confusion and Compromise	X		X						2
Potential Abuse to Avoid Incarceration								X	1
Unnecessary Because NGRI Defense Not Abused		X							1

Notes

1. 1982 N.M. Laws 55; N.M. Stat. Ann. §31-9-3 (Cum. Supp. 1983).

2. N.M. Uniform Jury Instructions UJI Crim. 41.00 & 41.02 (superseded October 1, 1983).

3. Id. at UJI Crim. 41.00 & 41.02 (effective October 1, 1983).

4. United States v. Hinkley, Crim. No. 81-306 (D.C. Cir. 1982).

5. N.M. Stats. Ann. §31-9-4 (Cum. Supp. 1983).

6. No. 77-721-C (N.M. D.C. July 14, 1980).

7. See supra notes 2-3 and accompanying text.

8. N.M. Stats. Ann. §31-9-4 (Cum. Supp. 1983).

9. Id. (emphasis added).

I. Pennsylvania

1. Introduction

On December 15, 1982 Pennsylvania enacted legislation providing for a plea and verdict of GBMI when Governor Dick Thronburgh signed Senate Bill 171 (effective March 15, 1983).[1] Since that time an estimated fifteen (15) offenders have been adjudicated GBMI.

During July and early August 1984, fourteen (14) individuals familiar with the GBMI law participated in a telephone survey addressing Pennsylvania's experience in the first eighteen months of its existence. The interivewees included a state senator (A_1), an assistant commonwealth attorney (B_1), a county district attorney (B_2), an assistant public defender (B_3), three court of common pleas judges (C_1, C_2, C_3), two pre-trial evaluators (D_1, D_2), a mental health professional providing post-conviction treatment (E_1), a research associate with the Pennsylvania Commission on Crime and Delinquency (PCCD) (F_1), a department of corrections administrator (F_2), a state mental hospital administrator (F_3), and a county probation officer (G_1). These individuals, together, have been directly or indirectly involved in all the GBMI cases in Pennsylvania.

2. Legislation: Historical Context and Purposes

The legislation creating the GBMI plea and verdict as originally introduced was an attempt to eliminate the common-law defense of insanity. House Bill 1162, introduced on May 2, 1979, would have eliminated not only insanity as a defense but also would have prohibited evidence of mental aberration from being introduced "to negative the

element of intent of the offense." House Bill 1162 was later amended when, according to the bill's sponsor, public hearings indicated that abolishing the insanity defense probably would be unconstitutional. The revised version passed the house in the summer of 1980.

In addition to creating for the GBMI plea and verdict, the amendment codified the existing common-law insanity defense (M'Naghten Rule). It specified that nothing in the GBMI legislation "shall be deemed to repeal or otherwise abrogate the common-law defense of insanity.[2] The legislation was then introduced in the Pennsylvania Senate as Senate Bill 171 in early 1981. Senate Bill 171 amended Titles 18 (Crimes and Offenses) and 42 (Judiciary and Judicial Procedure) of the Pennsylvania Consolidated Statutes. The legislation shifted the burden of proof in cases involving insanity. Under Pennsylvania case law when a criminal defendant introduces sufficient evidence of insanity, the commonwealth must establish sanity beyond a reasonable doubt.[3] Currently the burden of proving insanity[4] by a preponderance of the evidence is on the defendant. The burden of proving mental illness beyond a reasonable doubt in a GBMI case is on the prosecution.[5]

a. Precipitating Factors

None of the respondents in the survey indicated that a particular case or incident led to the enactment of the legislation. One respondent, a Bureau of Corrections official (F_2), pointed out that the Hinckley verdict was returned about the time the House was considering the bill. According to the bill's sponsor (A_1), however, the bill had passed the senate and was "moving" in the house prior to the Hinkley verdict.

b. Legislative Intent

In light of the legislative history, many of the respondents (64%) indicated that the legislative intent of the GBMI legislation was to reduce the number of NGRI acquittals. The perceived legislative intent of the GBMI provision fell into the following categories:

(1) Reduce the number of NGRI findings (A_1, B_2, B_3, C_2, C_3, D_1, D_2, F_1, F_2);

(2) Provide alternative verdict recognizing defendant's mental illness (A_1, B_1, C_1, E_1, F_1);

(3) Provide increased community protection (C_1, F_3); and

(4) Provide treatment to mentally ill offenders (B_1, B_2).

The legislation's sponsor (A_1) stated that he recognized the need for the verdict when he was an assistant district attorney. In a 1982 memorandum to the House Judiciary Committee, the sponsor explained that passage of the Mental Health Procedures Act (MHPA) in 1975

> encouraged greater use of NGRI because if successful an individual would be incapacitated for a far shorter duration... . The verdict of guilty but mentally ill, as proposed in Senate Bill 171, would recognize an individual's criminal responsibility and need for mental health treatment while ensuring that a person received treatment.

The impact of the GBMI legislation in reducing the number of NGRI findings is subject to disagreement. Three respondents (B_1, C_1, C_2) believed it was "two early" to assess the impact, three (D_1, D_2, F_2) believed the number had remained constant and two (B_3, F_3) believed the number had decreased. The impact is difficult to assess because at present no organization monitors the number of NGRI acquittals. The general consensus is, however, that the number of

acquittals both before and after the GBMI legislation has been very low, perhaps two dozen a year.

One pretrial mental health professional (D_1) stated that he believed the verdict was a "cop out" on the part of the criminal-justice system. He described the verdict as an "attempt to duck the issue of whether mental illness affects criminal responsibility."

The GBMI verdict, in the opinion of a court of common pleas judge (C_2), has succeeded in creating a "surface satisfaction" that the legislature has responded in some fashion at least. He indicated that no new legislation in the mental health field was under consideration.

3. Characteristics of GBMI Offenders

The definition of 'mental illness' adopted in Pennsylvania is the American Law Institute's (ALI) definition of 'insanity.'[6] As discussed earlier, Pennsylvania has retained the M'Naghten definition of insanity.

In light of the similar nature of the definitions, survey respondents (other than mental health professionals) had difficulty identifying the specific characteristics of defendants most likely to be found GBMI, as opposed to NGRI or guilty. One assistant commonwealth attorney (B_1) stated that to be found NGRI the characteristics and actions of the defendant would have to be "beyond jury comprehension." Two other respondents (B_3, F_1) implied that cases involving mental aberration may not turn on the strict definitional distinctions. The public defender (B_3) believed that the most important factor was the juries' perception of the danger the defendant represented to society. He indicated that if the defense counsel could depict the defendant as

non-violent and an "unfortunate victim of mental disease" the probability of an NGRI finding was drasticly increased. A PCCD research associate (F_1) said that in some counties the NGRI defense never would work.

All ten respondents who were asked indicated that, in their opinion, GBMI offenders would be found guilty rather than NGRI if the GBMI plea or verdict were unavailable. An administrator within the Bureau of Corrections (F_2) described GBMI offenders within the corrections system as "not having nearly the level of psychosis or mental illness expected of an NGRI acquittee." This opinion was echoed by a mental hospital official (E_1) who stated that in two of his four GBMI cases the defendants "would clearly have been found guilty as neither involved mental illness." He believed the other two might have been found NGRI. He quickly added, however, that in the past he has also treated guilty offenders who "should have qualified for NGRI."

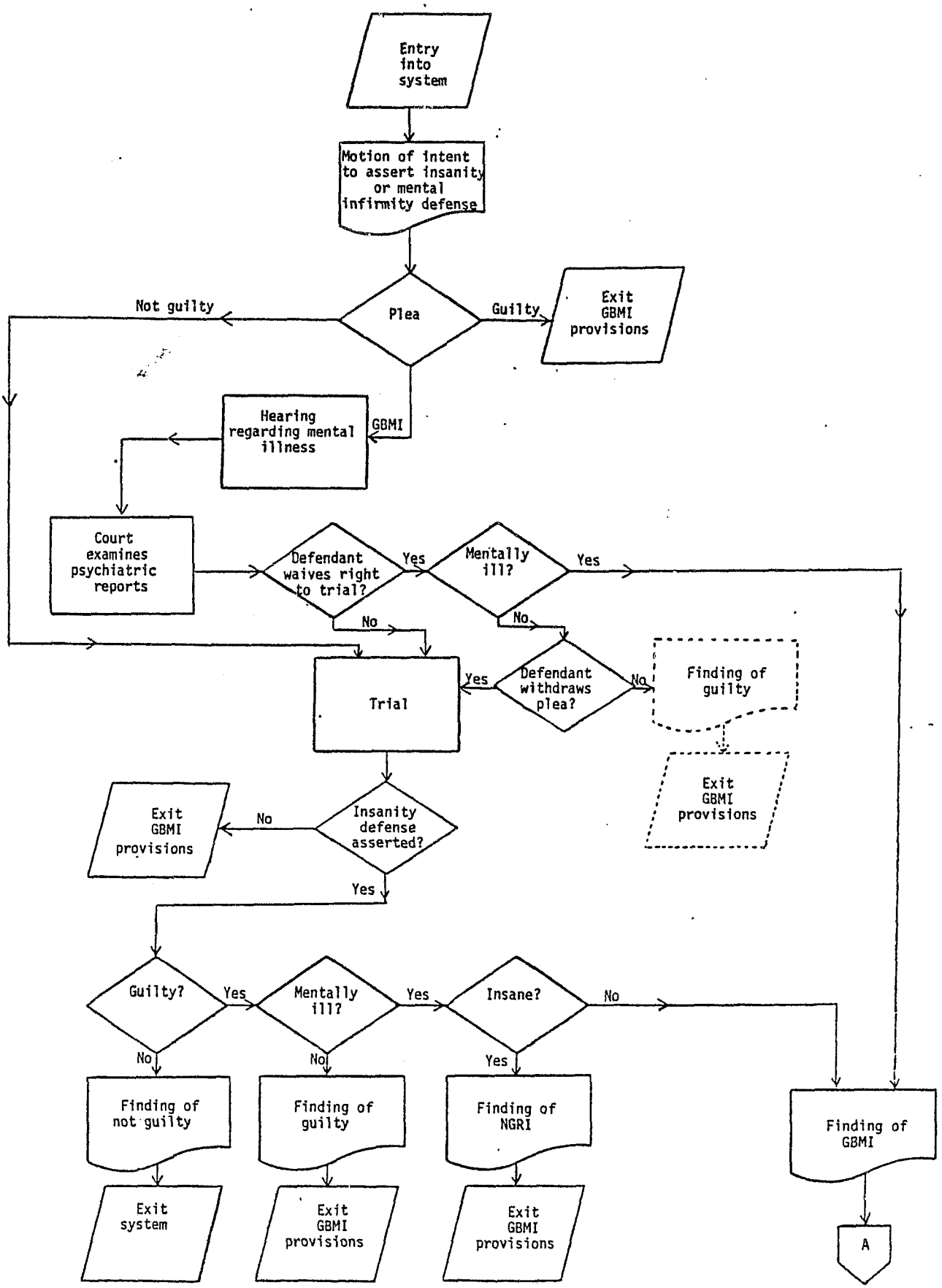
A court of common pleas judge (C) pointed out that an NGRI jury finding was extremely rare. A public defender (B_3) cited the change in the burden of proof in insanity cases as a contributing factor that would mitigate towards a guilty finding independent of the GBMI legisation.

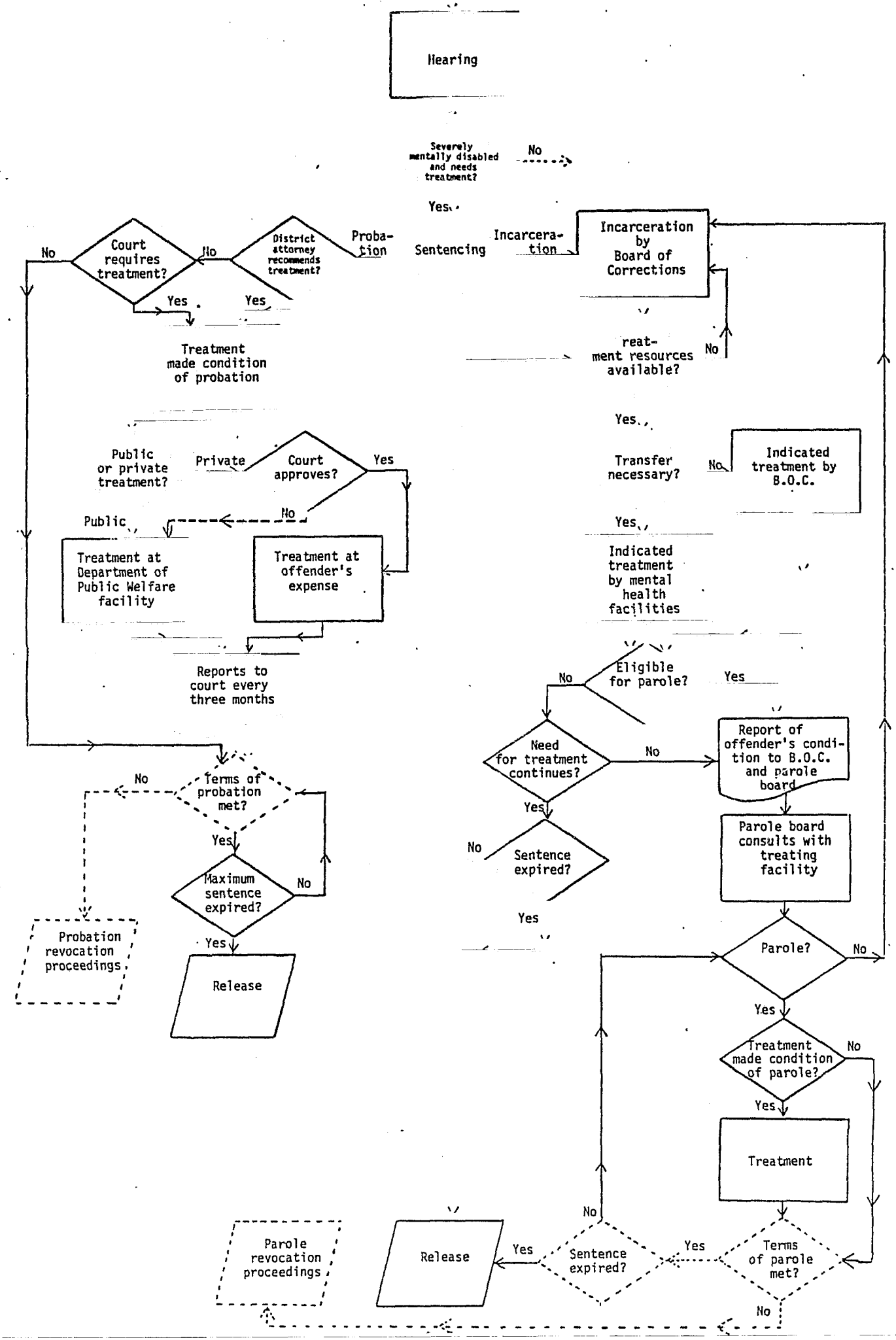
4. Procedures and Practices

a. General

The flow chart in Figure 9 depicts the GBMI processing procedures promulgated by Titles 18 and 42 of the Pennsylvania Consolidated Statutes. The GBMI legislation was not accompanied by any additional legislative requirements or mandates according to the bill's sponsor (A_1). He indicated that the Criminal Rules Committee did review the

Figure 9. Pennsylvania's Statutory GBMI Procedures




Hearing
Severely mentally disabled and needs treatment?
No
Yes
Sentencing
Probation
Incarceration
Court requires treatment?
No
District attorney recommends treatment?
Yes
Yes
Treatment made condition of probation
Incarceration by Board of Corrections
reat-ment resources available?
No
Yes
Public or private treatment?
Private
Court approves?
Yes
No
Public
Treatment at Department of Public Welfare facility
Treatment at offender's expense
Reports to court every three months
Transfer necessary?
No
Indicated treatment by B.O.C.
Yes
Indicated treatment by mental health facilities
Eligible for parole?
No
Yes
Need for treatment continues?
No
Report of offender's condition to B.O.C. and parole board
Yes
Parole board consults with treating facility
No
Sentence expired?
Yes
Parole?
No
Yes
Treatment made condition of parole?
No
Yes
Treatment
Terms of probation met?
No
Yes
Maximum sentence expired?
No
Yes
Probation revocation proceedings
Release
No
Sentence expired?
Yes
Yes
Terms of parole met?
No
Release
Parole revocation proceedings

GBMI legislation and did not believe any changes in existing criminal procedures were required.

The most notable change brought about by the GBMI legislation is the way that individual cases involving mental aberration are now handled. The change mentioned most often was the defense counsel's increased willingness to enter into plea agreements. All of the cases identified by the interview process in Pennslyvania involved plea agreements.

Of the seven interviewees asked to predict the impact on jury trials involving mental aberration, four (B_1, B_2, B_3, C_3) predicted a decrease in occurrence. Two respondents (C_1, E_1) believed it was too early to predict and one (C_2) did not foresee any impact. While bench trials traditionally have been requested most often in cases involving mental aberration, all three attorneys (B_1, B_2, B_3) projected a decrease in the number of all types of trials. Two attorneys (B_2, B_3) attributed the decrease to the general belief that the "GBMI compromise verdict was the probable outcome" in a trial proceeding. These projectons were supported by a district attorney (B_2) who has accepted six GBMI pleas. In his opinion, an NGRI defense could have been raised in three of these cases. Additionally, he (B_2) expressed an increased willingness to enter into plea negotiations with mentally ill defendants under appropriate circumstances. By statute a trial judge can not accept a GBMI plea until he has examined all reports prepared pursuant to the Rules of Criminal Procedure and has held a hearing on the sole issue of the defendant's mental illness at the time of the commission of the offense.[7] One judge (C_3) stated that in one of his three GBMI cases the GBMI plea was contested and subsequently rejected following the hearing.

A court of common pleas judge (C_1) described the GBMI plea as an advantage over the "go-for-broke" situation involved in the NGRI defense. He stated, "defense attorneys would plead GBMI in situations where guilt is overwhelmingly evident and they fear that the jury may reject the concept of mental illness and return a strict guilty verdict."

b. Pre-trial Mental Health Evaluations

The GBMI legislation stipulates that a defendant who offers a timely defense of insanity is eligible to be found GBMI.[8] The statute does not prescribe specific evaluation requirements or allocate the cost of such evaluations. The pre-trial mental health evaluations are performed, however, by a variety of organizations throughout the state. In the major metropolitan areas the evaluations are conducted by court mental health clinics. In addition, court-ordered evaluations are performed by forensic psychologists and psychiatrists at the University of Pennsylvania Hospital, at the Mental Health Services Division of the Bureau of Corrections, and at the regional state mental hospitals.

The lack of legislative direction combined with confusing judicial orders are major weaknesses of the legislation in the opinion of one pre-trial evaluator (D_1). He cited lack of clearly defined evaluation requests and ambigious reporting requirements as factors that complicate cases involving GBMI offenders. Reportedly, "three separate evaluations involving three distinct types of reporting often are required." The first level evaluation addresses the defendant's competency, the second, his criminal responsibility, and finally, the convicted offender's need for inpatient treatment.

The GBMI legislation has not impacted the actual criminal responsibility evaluation procedures according to a mental health

professional (D_2) who has conducted approximately two hundred evaluations over the past two years. He explained the initial threshold question is the defendant's ability to understand the nature and quality of his action and his ability to distinquish right from wrong (i.e., the M'Naghten Test). He estimated that approximately five percent of the defendants he evaluates qualify as legally insane. An additional five percent of the defendants clinically qualify as mentally ill under the ALI standard used in the GBMI legislation.

The mental health pre-trial evaluators (D_1, D_2) indicated that the basic substance of their reporting methods has not changed. One (D_1) limits his recommendations strictly to the responsibility issue. Conversely, the other evaluator (D_2) often specifically recommends against GBMI pleas in the limited number of cases that the option is clinically justified. He opposes the GBMI legislation, saying that it changed nothing in existing requirements and procedures.

c. Mental Health Expert Involvement

The Pennsylvania statute requires a hearing solely on the defendant's mental illness prior to accepting a GBMI plea.[9] Also, before imposing sentence the court must conduct hearings into the defendant's mental status at the time of sentencing.[10] Only two states, Kentucky and Utah, have similar mandatory pre-sentence evaluations. Dispite the statutory language, four respondents (B_1, B_2, C_1, C_3) speculated that the GBMI provisions will have little effect on the involvement of mental health experts in criminal proceedings. One attorney (B_1) suggested that since the GBMI alternative raises the same issues as the insanity defense, the involvement of mental health experts should be the same.

d. Jury Understanding

At this writing, no GBMI jury verdicts have been rendered.[11] An assistant commonwealth attorney (B_1), a public defender (B_3), and a forensic psychologist (D_2) speculated, however, about specific aspects of juror understanding and decision making in GBMI cases. The public defender (B_3) had little confidence in jurors' ability to understand and make appropriate distinctions between the "subtle definitional differences" of insanity and mental illness.

In the opinion of a forensic psychologist (D_2), the ability of the jury to understand the expert testimony is directly dependent upon the expert's and lawyer's ability to "communicate in English." He added, however, that jurors do not necessarily try to understand the legal definitions or expert testimony. Instead, in his view, cases often turn on the "degree of identification and sympathy" the jurors feel for the defendant.

The GBMI legislation places the burden of proof on the prosecution of showing beyond a reasonable doubt that the defendant was guilty of the offense and was mentally ill at the time.[12] An assistant commonwealth's attorney (B_1) predicted, however, that the jury would return a GBMI finding "anytime any degree of mental aberration is displayed by the defendant." A public defender (B_3) believed the criteria jurors would use were the nature of the crime and the characteristics of the mentally ill defendant. He believed a "passive-type individual committing a non-violent crime without the use of a deadly weapon" stood a much better chance of being found NGRI.

e. Sentencing

A GBMI offender may receive any sentence which may lawfully be imposed on any defendant convicted of the same offense.[14] When asked

whether the length or type of sentence (e.g., probation, split sentence) of guilty and GBMI offenders differs in practice, four respondents (B_2, B_3, C_1, C_3) indicated that they did not. Others (B_1, C_2, F_1, F_2, F_3) believed it was too early to tell or did not have enough experience to speculate.

The only variation that may arise in practice, according to a public defender (B_3), is if the defense can convince the judge to use his discretionary power to mitigate the statutory minimum sentence. He explained, the sentencing grid used in Pennsylvania incorporates only the number of prior offenses and the nature of the current offense. The defendant's mental illness, therefore, "presumably would permit the sentencing judge to go outside the grid and impose a shorter sentence." A common pleas judge (C_1) indicated that the defendant's mental status should be only one factor in determining if treatment should be ordered and should not impact the type of sentence.

Mental health treatment may be made a condition of probation upon recommendation of the district attorney or upon the court's own initiative.[16] The period of probation shall be the maximum permitted by law and shall not be reduced without receipt and consideration by the court of a comprehensive mental health status report.[17] The statute, however, allows the probationer to petition to discontinue probation prior to the maximum period.[18] The purpose of requiring the maximum period, according to the bill's sponsor (A_1), was to increase the court's ability to ensure the probationer was participating in the stipulated treatment. The sentencing court may revoke probation for failure to continue treatment.[19]

No official policies or procedures have been promulgated for handling GBMI probationers, according to the county probation officer (G_1) assigned to the only known GBMI probationer in Pennsylvania. He (G_1) indicated that quarterly mental health status reporting by the treating facilities to the probation office and the sentencing court is in the process of being implemented as required by statute.[20] The GBMI plea and verdict has only a "marginal impact" on the availability of probation in the opinion of the county probation officer (G_1). He believes that while the GBMI label may be a mitigating factor in some cases, it is likely that this particular offender would have been placed on probation even prior to the GBMI legislation. He (G_1) believed, however, that judges may be more willing to enter a probated sentence following a GBMI plea than following a guilty plea. He speculated that probation will be granted most often when the crime is non-violent, the defendant has a documented history of mental illness, and treatment alternatives exist.

Before imposing sentence, the court must hear testimony and make a finding regarding whether the defendant is severely mentally disabled at the time of sentencing and is in need of treatment under the provisions of the Mental Health Procedures Act (MHPA).[21] The legislative intent of this requirement, according to the bill's sponsor (A_1), was to assist the presiding judge in making sentencing and placement determinations as well as to serve as the mandatory "Vitek" hearing.

f. Post-Conviction Processing

The GBMI legislation stipulates that treatment may be provided by the Bureau of Correction, by the Department of Public Welfare, or by the county.[22] The statute, however, does not specifically authorize a

sentencing judge to commit GBMI offenders directly to a Department of Public Welfare facility. Judicial authority is limited to "ordering that treatment be provided." According to a common pleas judge (C_2), the most important practical advantage of the GBMI plea and verdict is that the judge may tailor the defendant's disposition to meet the individual circumstances. He cited a case in which he had the defendant admitted directly to a mental hospital by working with the corrections superintendent and the hospital staff.

The Bureau of Corrections has incorporated the treatment mandate into a series of intergrated procedures for handling GBMI inmates.[23] The procedures provide that upon arrival at one of the regional diagnostic and classification centers, GBMI offenders are to be categorized based on the court's finding at the pre-sentence hearing. 'Category One' ofenders are those whom the court found mentally disabled and in need of inpatient treatment pursuant to the provisions of the MHPA.[24] 'Category Two' offenders are those found not to be seriously mentally ill.

Category One offenders are "transferred to a Department of Public Welfare facilty within a matter of days," according to an administrator within the Bureau of Corrections (F_2). Category One offenders do not require a psychiatric reevaluation before transfer to a mental health facility unless 90 days or more have passed since the court order.[25] One respndent (D_1), actively involved in providing mental health treatment within the prison system, stated that the general consensus was that GBMI offenders should be initially transferred to the hospitals. The hospitals could then make the decision regarding who should be hospitalized. GBMI offenders are transferred to one of four regional,

medium security forensic units in state hospitals at Norristown, Philadelphia, Mayview, or Warren, or to the maximum security, forensic mental hospital (Farview) in Waymart. A GBMI monitoring system has been established to facilitate and track transfers between facilities.[26]

Category Two offenders, as the classification criteria would imply, are treated like other guilty inmates, according to a corrections administrator (F_2). He indicated that following the normal reception process a thorough screening process is initiated. The facility's mental health coordinator (MHC) visits the GBMI inmate as soon after reception as possible.[27] The MHC then arranges for an initial evaluation by the facility's psychologist as soon as possible.[28] A psychiatric evaluation is conducted within five days of admission. If routine psychiatric services are not available at that facility, a psychological evaluation may be substituted.[29] Following the evaluation process, if the inmate needs to be hospitalized, the normal commitment procedures of the MHPA are initiated. One corrections official (F_2) stated that the classification period for Category Two offenders is usually the same as for guilty offenders.

g. Treatment

The GBMI statute provides that GBMI offenders who are severely mentally disabled and in need of treatment at the time of sentencing shall, consistent with available resources, be provided psychiatrically or psychologically indicated treatment for his or her mental illness.[30] According to the bill's sponsor (A_1), the current debate in Pennsylvania is which agency should provide treatment. As of July 1984, seven inmates were receiving treatment in forensic units of Department of Public Welfare facilities. Four of the seven were

hospitalized in Waymart, Pennsylvania at Farview, the commonwealth's only maximum security mental hospital.

All of the state penal institutions have the capability to provide mental health treatment. According to a high ranking corrections official (F_2), approximately twenty psychologists are available throughout the system. Aided by approximately seventy inhouse counselors and thirteen consultant psychiatrists, the psychologists serve a growing prison population of approximately 12,000 inmates. A member of the PCCD staff (F_1) reported that the prison system would be expanding by approximately 2,800 cells over the next few years. The expansion will permit the Bureau to provide additional short term acute mental health care. Inpatient acute care is currently limited to twenty-five days and will remain limited, according to a Bureau administrator (F_2). In the opinion of a mental health treatment provider within corrections (D_1), long-term care is the responsibility of the Department of Public Welfare (DPW).

Evaluation and screening policies and procedures at DPW facilities have not changed according to administrators (E_1, F_3) at two of the state hospitals. Because the pre-sentence mental health hearing serves as an involuntary civil commitment proceeding, the inmates are "treated like all other clients." A Farview administrator (F_3) reported that the legislation had "gone into effect with hardly a ripple".

The hospital admission process for a GBMI offender starts with an interview by a social worker. The social worker then prepares a detailed history workup generated from discussions with family members and a review of medical charts from prior hospitalizations. Initial psychiatric evaluations are usually performed "very shortly after

admission." A battery of physical tests and lab work, as well as a neurological examination when appropriate, are conducted. Staff from all areas that will be interacting with the offender (i.e., psychologists, social workers, recreational and vocational personnel, and security officers) perform individual assessments. Treatment plans are then established and remain in effect for the thirty days barring an unforeseen events.

According to a treatment director at a regional hospital (E_1), GBMI offenders typically have available the following types of treatment: (1) antipsychotic or antidepressant medications, (2) anti-convulsive medication, (3) electro-convulsive therapy, (4) recreation and occupational training, and (5) individual and group therapy. An administrator at Farview (F_3) indicated that because Farview has a long waiting list, the patients hospitalized at Farview are among the most psychotic in the system. Forty-eight percent (48%) of all admissions to Farview during the first six months of 1984 were readmissions. Consequently, many require high levels of medication and are unable to participate in psychological treatment. He (F_3) also believed that, because of the overcrowding at Farview, offenders are "returned to general population prematurely."

Currently, eight (8) GBMI inmates have been treated at DPW facilities and returned to the county jails or general prison population. The GBMI legislation mandates that upon release from the hospital the:

> [T]reating facility shall transmit to the Pennsylvania Board of Probation and Parole, the correctional facility or county jail to which the offender is being returned and the sentencing judge a report on the condition of the offender together with the reasons for its judgements, which describes:

(1) The defendant's behavior.
(2) The course of treatment.
(3) The potential for recurrence of the behavior.
(4) The potential for danger to himself or the public.
(5) Recommendations for future treatment.[31]

The Bureau of Corrections has established the procedures reproduced below to monitor GBMI offenders within the corrections system. The procedures apply to Category One offenders, upon return from the state hospitals, and to Category Two offenders.

> Reception:
>
> Upon reception of a GBMI inmate from the [Diagnostic and Classification Center], his/her cases should be reviewed by appropriate intake staff. This staff should initially make the proper housing assignment and should refer the inmate to the mental health review team or counselor, as the case warrants. GBMI inmates should not be double celled.
>
> Based on a review of the case and the recommendations of the DCC staff, the intake staff of the programming institution should develop an appropriate program for the inmate. If follow-up psychiatric/psychological treatment is needed, arrangements should be made, subject to available resources, to provide needed treatment when possible.
>
> Programming:
>
> For the first month after reception, the counselor assigned to the case should see the inmate on a weekly basis. The institutional psychologist should see the GBMI inmate at least once during the first month; more frequently if necessary.
>
> After the first month the counselor in conjunction with his supervisor and the institutional psychologist, should determine the continued frequency of counselor contacts. However, counselor contacts should be no less than once a month for the first year.
>
> The GBMI inmates should receive a staff review every six (6) months for the first year. Thereafter the frequency of staff reviews should be determined by the staff based on the inmate's stability, needs, and Bureau policy.

> After the first year, GBMI inmates should be evaluated by the institutional psychologist and psychiatrist on an annual basis.
>
> Any GBMI inmate who decompensates emotionally to the point where inpatient care is required should be considered for commitment to a mental health facility via Acts 143/324 of 1976 [ICC proceedings], and usual commitment procedures should be followed... .[32]

Eight out of the nine interviewees responding (B_3, C_1, C_2, D_2, E_1, F_1, F_2, F_3) believed that GBMI offenders are more likely to receive treatment than offenders with mental health problems in the general prison population. All attributed the increased likelihood to the early identification and targeting resulting from the pre-sentence hearings. A common pleas judge (C_2) believed that the "odds [of receiving treatment] for GBMI offenders are vastly higher." Two mental health professionals (D_1, E_1) outside the corrections system expressed confidence that all offenders who need treatment eventually receive it.

Only one respondent, a county district attorney (B_1), expressed concern over the Commonwealth's ability to provide adequate long-term care. He noted the limited amount of resources and funds allocated to treatment. A Farview administrator (F_3), however, reported that the legislature appropriated funds to expand Farview by fifty beds when the GBMI bill was passed. Farview's capacity remains at 225 beds, however, because the authorized construction has not yet begun. A treatment professional within the Bureau of Corrections (D_1) indicated that due to overcrowding at Farview it is extremely difficult to get inmates admitted. He also stated that overcrowding at other DPW facilities has often forced the delay of transfers out of the prison clinics longer than the desired time periods.

h. Parole

At this writing, no GBMI offenders have become eligible for review by the parole board. According to a high level administrator in the Department of Probation and Parole, special policies and procedures for GBMI offender have not been developed. The legislation stipulates that an offender who is discharged from treatment may be placed on prerelease or parole status under the same terms and laws applicable to any other offender. Psychological and psychiatric counseling and treatment may be required as a condition of such status. Failure to continue treatment, except by agreement of the supervising authority, is a basis for terminating prerelease status or instituting parole violation hearings.[33]

The impact of the GBMI label on the parole board's decision-making process can be only speculative. Two judges (C_1, C_2) discussed whether GBMI offenders more frequently or less frequently are paroled than guilty offenders. They believed that the GBMI label may be a mitigating factor. One judge (C_1) said that if the offender can show he or she is no longer mentally ill, that may increase the likelihood of being paroled after serving the minimum sentence.

i. Comparative Lengths of Confinement

Due to the relative newness of the GBMI law, many of the respondents did not speculate regarding whether the period of confinement for NGRIs and GBMIs who have similar backgrounds differ. Two respondents, a judge (C_1) and a district attorney (B_2) pointed out that GBMIs must serve out their minimum status regardless of their subsequent mental status. The attorney (B_2) stated that while release of NGRI acquittees requires a court order, the courts must rely on the mental health professionals and "rubber stamp" their recommendations.

5. Costs

The respondents were divided regarding whether the GBMI plea or verdict has increased costs to the total mental health-justice system in Pennsylvania. Four respondents (B_3, C_2, D_2, F_3) projected no overall change because GBMI offenders would have received treatment anyway; however, a commonwealth's attorney (B_1) cautioned that if the verdict is abused it could "open the floodgates" and result in overcrowding at the state hospitals.

A research associate with the PCCD (F_1) said that the cost to the Commonwealth would increase but would be offset by a cost savings to the counties. The GBMI legislation provides that the cost of treatment at a DPW facility be paid in full by the state.[33] The counties continue to contribute 120 dollars per day for treatment provided guilty offenders at DPW facilities.[34] According to the bill's sponsor (A_1), spirited debate took place on the floor of the house over the fiscal impact of the law. Representatives from small counties opposed shifting the cost of treatment from large counties with high crime rates to the state.

Many people feared the "perverse cost incentive" to the counties would lead to inappropriate use of the GBMI law, according to a PCCD staff member (F_1). Based in part on this suspicion and in part on the Michigan GBMI experience, the PCCD projected an annual cost of 1.7 to 1.9 million dollars.[35] This projection was based on an estimated sixty-nine GBMI pleas or verdicts per year. According to the PCCD staff member (F_1), the actual cost has been much less due primarily to the infrequent use of the law.

6. Strengths and Weaknesses of GBMI Legislation

The participants in the survey offered numerous and differing opinions about what they perceived as the strengths and weaknesses of the GBMI legislation. The opinions of all respondents interviewed are reflected in Table 17.

Two court of common pleas judges (C_1, C_2) believed that the GBMI plea or verdict was an advantage to defendants by providing an alternative to the "go-for-broke" situation which otherwise exists. One judge (C_1) explained that defense counsel now can enter a GBMI plea if the evidence of guilt is overwhelming and the jury might reject the insanity defense. The other judge (C_2) stressed that the law allows him more flexibility to tailor the sentence to the defendant's needs.

All three attorneys (B_1, B_2, B_3) expressed a willingness to advise their clients to enter a GBMI plea if an NGRI defense is unavailable and treatment is needed. Two attorneys (B_2, B_3) believed that the opportunities for probation are enhanced by the availability of the GBMI plea. Both attributed this to an increased willingness of judges to recognize mental illness and grant probation conditioned upon treatment. A probation officer (G_1) believed, however, that although the GBMI label provided him an avenue to obtain treatment, local treatment facilities often are reluctant to work with GBMI offenders.

Table 17

Perceived Strengths and Weaknesses of
Pennsylvania GBMI Statutes

	Respondents													
		B			C			D			F				
Strengths	A	1	2	3	1	2	3	1	2	E	1	2	3	G	Total
Increases Access to Treatment	X	X	X		X	X					X			X	7
Protects Public	X											X			2
Provides Alternative Finding	X	X			X					X	X			X	6
Prevents NGRI Findings			X												1
Restores Public Confidence					X	X									2
Provides Judges and Lawyers New Options	X						X								2
Increases Judicial Control													X		1
None				X				X	X						3
Weaknesses															
Insufficient Resources to Provide Treatment			X											X	2
Impercise Statutory Language			X					X							2
Compromise Verdict				X					X						2
Reduces Effectiveness of Insanity Defense				X			X								2
Administrative Problems		X			X							X			3
Avoids Issue of Insanity								X							1
Unnecessary and Provides No Additional Benefit									X				X		2
Contrary to Established Mental Health Concepts									X						1
Potential for Abuse and Inappropriate Use										X					1
Definitions Too Confusing for Jury											X				1
None	X					X									2

Notes

1. 1982 Pa. Laws 286-82; 18 Pa. Cons. Stat. Ann. §314 (Purdon 1983).
2. Id. at §314(c)(2)(d).
3. Commonwealth v. Ruth, 455 A.2d 700 (Pa. Super. 1983).
4. 18 Pa. Cons. Stat. Ann. §315(A) (Purdon 1983).
5. Id. at §314(C)(1).
6. Senate Bill 171--Establishing A Verdict of Guilty But Mentally Ill (Memorandum to House Judiciary Committee from Senator D. Michael Fisher).
7. 18 Pa. Cons. Stat. Ann §314 (Purdon 1983).
8. Id. at §314(A).
9. Id. at §314(b).
10. Id. at tit. 42 §9727(A).
11. Respondents were directly involved in the judicial phase of eight of the estimated fifteen cases.
12. 18 Pa. Cons. Stat. Ann. §314(A) (Purdon 1983).
13. Id. at §315(A).
14. Id. at tit. 42 §9727(A).
15. See page x.
16. 42 Pa. Cons. Stat. Ann. §9727(f)(1) (Purdon 1983).
17. Id. at §9727(f)(2).
18. Id. at §9727(f)(3).
19. Id. at §9727(f)(2).
20. Id. at §9727(f)(3).
21. Id. at §9727(A).
22. Id.

23. Pennsylvania Bureau of Corrections; Administrative Manual, Vol. VII, OM-107.05 (procedures for handling guilty but mentally ill inmates).

24. Id. at X-02 A2 (involuntary civil commitment provisions).

25. Id. at X-02 C1.

26. Department of Public Welfare, Mental Health Bulletin 99-83-25 (effective August 8, 1983).

27. See supra note 18, at X-02 B.2.

28. Id. at X-02 B.9.

29. Id. at X-02 C.2.

30. 18 Pa. Cons. Stat. Ann. §9727(b)(1) (Purdon 1983).

31. Id. at §9727(e)

32. Supra note 18, at X-03 A.1 & 2; X-03 8.1, 2, 4 & 5.

33. 42 Pa. Cons. Stat. Ann. §9727(e) (Purdon 1983).

33. Id. at §9727(b)(2).

34. Id. at §7408 (Purdon 1983).

35. Pennsylvania Commission on Crime and Delinquency, Fiscal Impact of Senate Bill 171: The Guilty But Mentally Ill Option (May 15, 1982).

J. South Dakota

1. Introduction

With the passage of the Senate Bill 90 on March 19, 1983, South Dakota enacted legislation providing for a plea and verdict of guilty but mentally ill (GBMI).[1] During August 1984, sixteen (16) individuals including four prosecutors (B_1, B_2, B_3, B_4), two defense attorneys (B_5, B_6), two circuit court judges (C_1, C_2), three mental health evaluators (D_1, D_2, D_3), one community services administrator (F_1), one corrections administrator (F_2), one probation official (G_1), one Department of Charities and Corrections official (H_1), and one parole official (H_2), were interviewed about the history, operation, consequences, and perceptions of South Dakota's GBMI law. These sixteen individuals have had either direct or indirect involvement in the estimated three to five cases in which a GBMI finding has been reached in South Dakota. At the time of the interviews, no jury verdicts of GBMI had occurred.

2. Legislation: Historical Context and Purposes

a. Changes Coincidental with GBMI Enactment

The GBMI enactment amended the existing criminal code by allowing for a determination of GBMI,[2] revising the definition of mental illness,[3] and defining insanity.[4] The insanity defense was preserved with only semantic changes.

b. Precipitating Factors

When asked whether a particular case, incident, or problem led to the enactment of South Dakota's GBMI statute, respondents stated that a

general dissatisfaction with the insanity defense coupled with a local NGRI case and the Hinckley decision all contributed to the change in the law.

c. Legislative Purposes

Respondents perceptions regarding the purpose of South Dakota's GBMI law fell into the several categories:

(1) limitation of the insanity defense (B_1, B_2, B_6, C_1, C_2, D_2, F_1, F_2, H_1);

(2) reduction in perceived abuses of the insanity defense (B_5, C_2, D_2, F_1, F_2);

(3) need for fairness to both victims and offenders (G_1);

(4) prevention of recidivism of mentally ill offenders (D_1); and

(5) compromise verdict attributing guilt yet acknowledging mental disorder (B_4).

When asked whether these legislative intents had been fulfilled, four respondents (B_1, B_3, D_3, G_3) believed that not enough cases had occurred in South Dakota to make a valid comment. Five other respondents (B_2, B_4, B_5, B_6, D_4) believed that the intents had been fulfilled, although two (B_4, D_4) agreed that this conclusion was speculative because of the extremely limited history of the statute's use. Another of these respondents, a defense attorney (B_5), stated that a substantial drop in the number of NGRI pleas had occurred since GBMI was enacted, thereby showing fulfillment of the intent to curtail use of the insanity defense. He also said that if the legislators' intent in passing the GBMI statute was politically motivated (i.e., addressing a perceived need of the electorate to "do something about the insanity defense"), then the very passage of the legislation fulfilled that intent.

Five respondents (C_3, D_1, F_1, F_2, H_1) believed that the legislative intents had not yet been fulfilled. Two (F_1, F_2) believed that none of the offenders already found GBMI in South Dakota would have been found NGRI under any circumstances, so the existence of GBMI has made no difference. Another respondent, a mental health evaluator (D_1), said that an insufficient number of cases had occurred to permit an objective evaluation.

Although the GBMI statute was originally vetoed by the governor in 1982 and was not finally passed until 1983, none of the respondents could identify any specific reasons for opposition to the bill. One prosecutor (B_3) stated that the State's Attorney Association had opposed the bill but never gave a definite reason for this opposition. A mental health evaluator (D_2) stated that the psychiatric community withdrew its support of the bill between the veto and the second offering. He said that they had realized that GBMI might be too powerful a weapon to place in the hands of prosecutors; an argument such as, "A finding of GBMI will ensure treatment while protecting the community," might possibly sway a jury away from the hard evaluation of the accused's actual mental condition in favor of this easier compromise verdict.

3. Characteristics of GBMI Offenders

Although the eleven respondents who addressed the characteristics of defendants most likely to be found GBMI, as opposed to NGRI or guilty, had essentially eleven different views, the one characteristic common to all of their responses was that defendants charged with serious offenses would be more likely to be found GBMI. One prosecutor (B_3) speculated that GBMI rarely would be found in property offense crimes; he believed

that the public was concerned only with the mental health status of those offenders who had committed serious crimes against the person, such as murder or child molestation, and that the less serious offenders would be found simply guilty. A prosecutor (B_2) and a defense attorney (B_5) also expressed the view that sex offenders were likely candidates for a GBMI finding. A mental health evaluator (D_3) speculated that GBMI was appropriate in all cases involving sexual contact with minors. One prosecutor (B_1) said that an offender charged with a very serious crime evidencing dangerousness to society would be most likely to be found GBMI. A defense attorney (B_5) said that minority defendants were most likely to be found GBMI. One prosecutor (B_4) believed that in all cases in which mental aberration was involved but cognition was not at issue, a GBMI finding would be appropriate. One mental health evaluator (D_2) agreed with this, adding that an NGRI finding should occur only after successful application of the M'Naghten test.

Several respondents offered specific mental illness diagnoses as being characteristics of GBMI offenders. One mental health evaluator (D_1) believed that borderline schizophrenics or manic depressives whose crimes involved poor judgment were likely candidates for GBMI. He added, however, that the illness would have to influence the behavior constituting the crime before GBMI could be allowed. One prosecutor (B_2) thought that pyromaniacs and pedophiles almost always would be found GBMI. Another prosecutor (B_3) ventured the opinion that sex offenders with a previous history of offenses probably would be found GBMI. A community services administrator (F_1) drew the line between NGRI and GBMI at the occurrence of "blatantly psychotic" behavior. Any evidence of a history of mental illness, especially accompanied by some

hospitalization, that falls short of the psychotic label would make an offender a likely candidate for a GBMI finding.

Finally, two respondents made divergent comments regarding offender characteristics. One corrections administrator (F_2) believed that all of South Dakota's GBMI findings to date were "cop out pleas" involving defendants who did not need psychiatric care. He also said that one "always can buy a psychiatrist's opinion," and that these particular offenders would have been found guilty under any other circumstances. A defense attorney (B_6) said that no profile of characteristics could be established because of the law population density of South Dakota. The density is so low, he explained, that everyone knows everybody else in any given jurisdiction; the background of any individual charged with a crime is known to all. He believed that a jury, faced with this familiarity, would be unable to apply objectively any of the mental health distinctions necessary in finding GBMI. Because of this individualized approach, he believed that a quantification of characteristics would be impossible.

Would those defendants found GBMI in South Dakota have been found NGRI or guilty had GBMI not been available? Eight of ten respondents to this question (B_2, B_4, B_6, C_2, D_1, D_2, F_1, F_2) believed that the offenders would have been found guilty. One prosecutor (B_2) speculated that the severity of the offender's illness would determine whether a finding of NGRI or GBMI would be reached; he believed that the availability of GBMI might reduce the number of defendants found NGRI, especially if the mental health condition was not severe. Another prosecutor (B_4) saw the reverse as true; he said that GBMI would not affect NGRI findings at all but would instead serve to decrease the

number of guilty findings. The only defense attorney to venture an opinion (B_6) stated that, in the cases with which he was familiar, the offenders would have been found guilty unless a sympathetic jury had wanted to "let them off." This was the same attorney who previously had mentioned South Dakota's population density and familiarity problems. He said that because of the intimate knowledge of any defendant's personal history, a jury might return a verdict of, "We find the guy who stole the pigs Not Guilty," if the jury felt sympathetic to the defendant's plight. No amount of psychological testimony could be expected to sway a jury's decision in this type of case, he contended. A circuit court judge (C_2) stated that, based on the personal opinion of the judge hearing a particular GBMI case, the defendant would have been found guilty if the GBMI verdict had been unavailable. Two mental health evaluators (D_1, D_2) agreed that insanity was not in issue in either case they knew of. In one, "there was no evidence of mental illness whatsoever" (D_1) and in the other, "psychiatric testimony was very clear as to the absence of insanity" (D_2). Both evaluators said that GBMI findings in both cases had been inappropriate and the respective defendants should have been found guilty. Another mental health evaluator (D_3) speculated that a finding of NGRI would have been more appropriate if GBMI had not been available. He believed that the addition of a mentally ill label to a defendant's guilty conviction was no different than simply finding him guilty. He said that true assessment of the defendant's mental condition probably would not take place where the compromise of GBMI is available.

When asked whether recidivism rates would vary among released NGRI, GBMI, and guilty offenders, eight respondents offered their

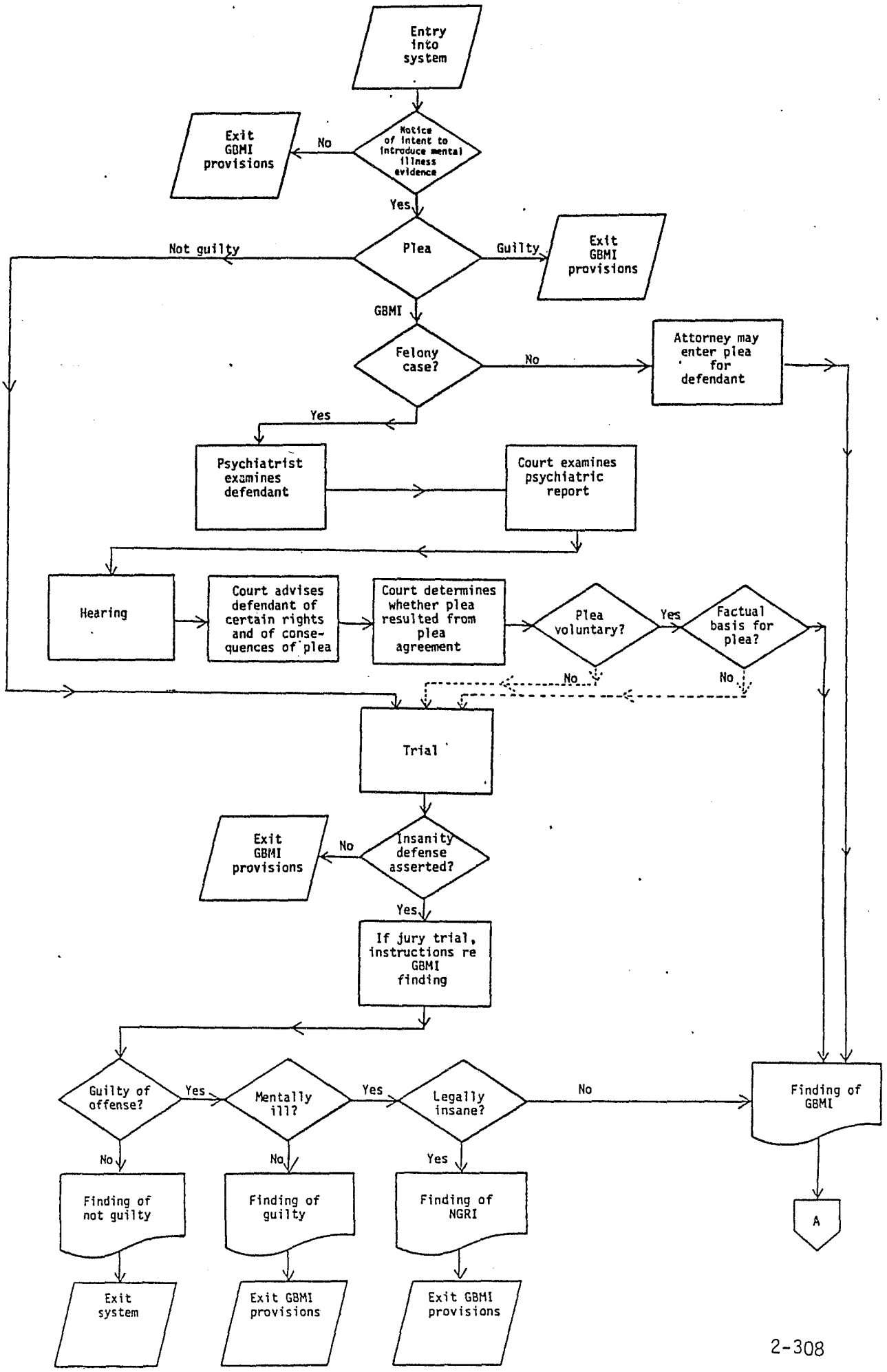
speculations. Only three respondents said that the rates would vary. Both circuit court judges (C_1, C_2) speculated that the treatment afforded GBMI offenders would lower that group's recidivism rate. This view was echoed by a prosecutor (B_2). The other respondents believed either that the rates would stay the same among groups (B_3, B_4, F_1, H_1) or that no recidivism existed among released NGRI's (B_5). A defense attorney (B_5) stated that of the three released NGRI's of whom he was aware, two were doing fine in the community and one had committed suicide. A Department of Charities and Corrections official (H_1) stated that the overall recidivism rate in South Dakota was among the lowest in the United States. Because all individuals needing rehabilitative treatment were receiving it, he believed that the recidivism rate would not vary among groups. Another respondent, a prosecutor (B_3), conceded that he had little faith in the mental health profession to help some people; he could foresee little change in recidivism rates.

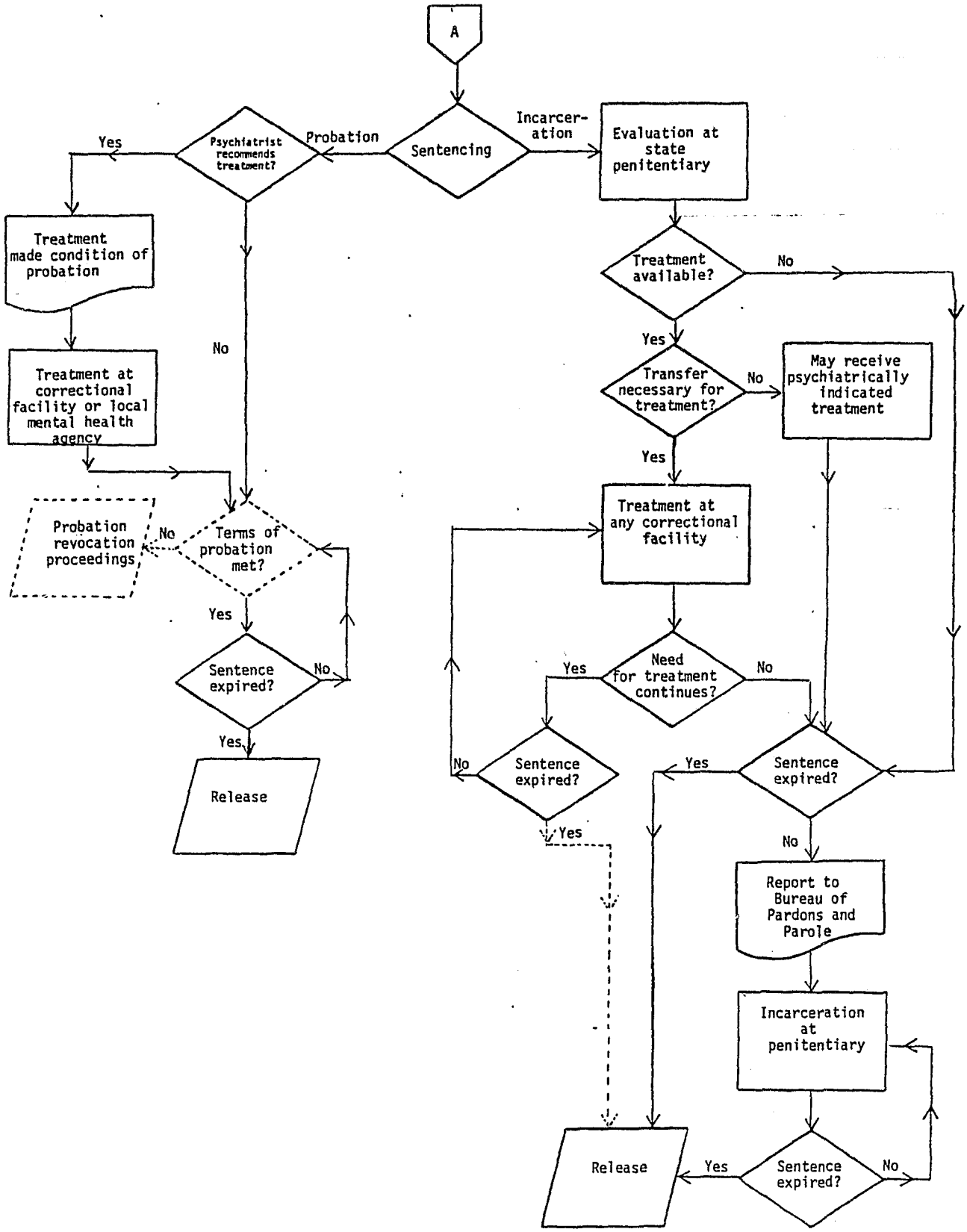
4. Procedures and Practices

a. General

South Dakota's statutory GBMI procedures are depicted in Figure 10. When asked whether these procedures had significantly changed the processing of mentally disordered offenders through the mental health-justice system, the majority of respondents agreed that processing was indeed different. One defense attorney (B_5) presumed that processing would take much longer because of a need for an additional presentencing examination. In the same vein, a prosecutor (B_3) offered a case history as an example: If a defendant pleas NGRI but the mental

Figure 10. South Dakota's Statutory GBMI Procedures




A
Sentencing
Probation
Incarcer-
ation
Psychiatrist recommends treatment?
Yes
No
Evaluation at state penitentiary
Treatment made condition of probation
Treatment at correctional facility or local mental health agency
Treatment available?
No
Yes
Transfer necessary for treatment?
No
May receive psychiatrically indicated treatment
Yes
Treatment at any correctional facility
Probation revocation proceedings
No
Terms of probation met?
Yes
Sentence expired?
No
Yes
Release
Need for treatment continues?
Yes
No
No
Sentence expired?
Yes
Yes
Sentence expired?
No
Report to Bureau of Pardons and Parole
Incarceration at penitentiary
Release
Yes
Sentence expired?
No

health evaluators report to the court that the defendant is not insane, the defendant may decide to change his plea to GBMI. Before the judge can accept this plea, he or she must find a factual basis for the plea.[5] Because the defendant previously was evaluated for insanity only, the existence of mental illness may not have been diagnosed. For the court to find the defendant is mentally ill, another examination would be necessary. Two other respondents, a prosecutor (B_2) and a mental health evaluator (D_3), believed that the treatment and disposition of mentally ill offenders changed in that treatment now would be afforded and that this treatment would be afforded at the state hospital rather than the penitentiary. Another attorney (B_5) said that no significant change had occurred in processing but that the process was less discretionary than before. All of the prosecutors (B_1, B_2, B_3, B_4) believed that cases involving mentally disordered offenders would be handled differently. Two (B_2, B_3) saw GBMI as an effective plea bargaining tool. One (B_4) speculated that defense attorneys believed that their clients might receive better treatment or preferential sentencing if they admitted guilt but asked for treatment of their mental problems. The fourth prosecutor (B_1) saw GBMI as providing a way for people to feel more comfortable with the process of trying a mentally disordered offender. He thought that juries especially would feel comfortable in choosing the "middle option" of GBMI. He did express concern, however, that juries might take the "easy way out" and honestly fail to consider the harder question of a defendant's insanity. One defense attorney (B_5) believed that the defendant's mental condition had always been taken into account by the courts, especially in serious crimes, even before enactment of GBMI. Because of this, he reasoned, cases would not be handled any differently under the new law.

b. Pre-trial Mental Health Examination

In South Dakota, if a defendant has given notice of his intent to raise the issue of his mental health in a criminal proceeding, and the charged offense is a felony, the court must examine the report of a licensed psychiatrist before it can find the defendant to be mentally ill.[6] Both mental health evaluators who regularly perform pre-trial mental health examinations (D_1, D_2) stated that their methods of conducting these exams had not changed with the adoption of GBMI. Because they evaluate the defendant's mental condition and competency to stand trial just as before GBMI, no reason exists to change their methodology.

c. Mental Health Expert Involvement

Only one of eight respondents, a prosecutor (B_3), believed that the GBMI law had changed the involvement of mental health experts in criminal proceedings. He cited the requirement for examination of the defendant by a licensed psychiatrist[7] as the source of this increased involvement and stated that mental health experts (and in particular, psychiatrists) were needed much more frequently than in pre-GBMI days, especially if a plea of GBMI was involved. He also believed that defense attorneys would be more inclined to use mental health experts than they had before in an attempt to mitigate a defendant's behavior. A circuit court judge (C_1) said, however, that mental health expert involvement had not changed because the same experts had been used regularly in the past whenever a serious crime was being tried; the GBMI examination requirement merely codified the existing practices within his court. One defense attorney (B_6), who believed that involvement had remained the same, said that psychiatrists tended to be more specific in their testimony to

distinguish accurately between a defendant's being mentally ill or being insane. The remaining respondents (B_1, B_2, B_4, B_5, C_2) all agreed that the involvement of mental health experts would be unchanged.

d. Criteria Used by Judges and Juries

Five attorneys (B_1, B_3, B_4, B_5, B_6) addressed the criteria or factors judges use in making GBMI, as opposed to NGRI and guilty, determinations. One defense attorney (B_6) asserted that, because cases involving the insanity defense are rare, judges apply extreme scrutiny to all the factors presented in such a case. The other defense attorney (B_5) believed that defense lawyers, not judges, made the GBMI determination. He said that when a GBMI plea is entered, the judge orders an evaluation and is bound by the results of that evaluation. In the same vein, a prosecutor (B_1) believed that judges use a defendant's assertion of a mental problem as the criteria for making a determination. Another prosecutor (B_4) said that judges use the M'Naghten test in making GMBI determinations. The recurring question of the compromise verdict was raised by another prosecutor (B_3). He said that neither judges nor juries used any special criteria because the statute gives them an "easy way out of making tough decisions," that is, deciding whether the defendant is insane or mentally ill.

These same attorneys were then asked whether judges generally understand and make the appropriate distinctions between the definitions and insanity and mental illness as used in making the GBMI determination. With the exception of one defense attorney (B_6), who believed that the bench did not differentiate effectively between these two areas, the respondents (B_1, B_3, B_4, B_5) said that judges do understand and make the appropriate distinctions. One prosecutor (B_3)

said, however, that judges could make the distinctions effectively only when guided by proper expert testimony.

e. Juries

As noted earlier, no jury trials involving GBMI had occurred in South Dakota at the time of the interviews. The comments offered by the respondents regarding the GBMI law's impact on the number of jury trials and the behavior of juries themselves are, therefore, speculative. Five of seven respondents said that the GBMI law would decrease the number of jury trials in case involving mental aberration. Only one respondent, a prosecutor (B_3), thought that the number of jury trials would increase. One circuit court judge (C_2) said that GBMI would have no effect. Of the respondents projecting a decrease, four (B_1, B_2, B_4, C_1) said that the opportunity for plea bargaining caused this decrease. One prosecutor (B_1) speculated that none of the GBMI cases heard in the state so far would have gone to jury trial; he believed that the defendants probably emphasized the need for treatment (as mitigation for their behavior) rather than an attempt to be found not criminally responsible. This same attorney said that GBMI might be conducive to plea bargaining, especially on lower grade offenses, because of this emphasis being directed away from responsibility and onto mitigation.

While most respondents said that jurors were able to understand expert testimony presented at trial (B_2), B_3), B_4, B_5, B_6, C_1, C_2), they were evenly split regarding whether jurors could understand and make the appropriate distinctions between the definitions of mental illness and insanity as used in the GBMI verdict. On the issue of expert testimony, one respondent, a prosecutor (B_1), commented, "I don't think any jury understands any psychiatric testimony." He did,

however, feel that juries would probably be able to make the distinction between mental illness and insanity even though the instructions to do so would necessarily have to be "very complicated" because of the "fine legal issue" involved. Another prosecutor (B_3) observed that jurors generally tended to understand expert testimony except when the experts' opinions conflicted. He further said that jurors' abilities to understand and make appropriate distinctions hinged on the ability of an expert to clarify the grey areas in the difference between mental illness and insanity. The remaining respondents (B_2, B_3, B_4, B_5, B_6, C_1, C_2) all believed that jurors were able to understand the expert testimony. A circuit court judge (C_1) said that the statute clearly distinguished mental illness and insanity and that the jury pool, which was made up from a university and business community base, was "quite capable of making the decision." A second judge (C_2) believed that jurors could understand expert testimony but was unsure that they would be able to make the appropriate distinctions in cases involving mental aberration. A prosecutor (B_2) said that the GBMI statute had clarified the grey areas and would give jurors the appropriate means by which to understand and distinguish between insanity and mental illness. Although one defense attorney (B_6) believed that jurors generally understood and accepted expert testimony, he said that the ability of a jury to make appropriate distinctions rested more on the trial attorney's abilities to voir dire the jury. The proper selection of veniremen to a jury can easily, in his opinion, determine the outcome of a trial much more effectively than any amount of expert testimony. He perceived his particular area within South Dakota as being an agrarian, low-income area with less ethnic merging than in other areas of the country. As such, he

believed, the population tended to be more narrow-minded than the average population and could be led to draw whatever conclusion was desired. He also stated, however, that such an insular society might ignore the distinctions and find however it wanted despite the facts presented.

When questioned as to whether jurors understood the dispositional differences between a finding of GBMI and guilty, two respondents, a defense attorney (B_5) and a judge (C_2), stated that jurors were not permitted to know disposition, except in cases where capital punishment could be imposed. Two respondents, both prosecutors (B_2, B_3), were not sure whether disposition was understood, but another prosecutor (B_3) believed that instructions to a jury would not address the issue. The remaining respondents (B_1, B_4, B_6) all believed that jurors were aware of the differences in disposition resulting from either finding. One defense attorney (B_6) cited a pre-GBMI case in which the jury sent a note to the judge asking for an alternative to the only two allowed verdicts: NGRI or guilty. The jury's desire not to release a defendant whom they knew to be mentally ill indicated to the respondent that the jury was aware of the disposition resulting from its finding. Two prosecutors (B_1, B_4) believed that juries work backwards from their perception of a desired result in reaching a verdict.

South Dakota currently has no standardized GBMI instructions. According to one defense attorney (B_5), however, a drafting committee is currently preparing instructions for consideration by the bar association. Most respondents (B_2, B_3, B_5, C_1, C_2) could not comment on whether jurors understood typical instructions, but those who did comment (B_1, B_4, B_6) said that jurors would understand.

f. Sentencing

South Dakota law provides for the imposition of any sentence on a convicted GBMI offender that could be imposed on any other offender convicted of the same offense.[8] Four respondents (B_2, C_2, D_3, F_1) said that the length or type of sentence for guilty and GBMI offenders did not differ in practice. A judge (C_2) said that treatment should be provided if necessary, but that the sentence should not be reduced. He did say, however, that other judges might not take as strict an approach. Indeed, another judge (C_1) said that if an offender is willing to cooperate in treatment, that would mitigate in favor of a reduced sentence. One prosecutor (B_1) agreed.

Both judges interviewed were asked whether the criteria they used for placing offenders on probation differed between GBMI and guilty offenders. One (C_2) replied that no difference existed. The other (C_1) said that if a defendant admitted he was mentally ill and it appeared that he would cooperate with treatment, then probation was more likely.

g. Comparative Lengths of Confinement

Only one respondent, a prosecutor (B_4), ventured an opinion regarding whether GBMI offenders or NGRI acquittees with similar backgrounds generally remain in involuntary confinement longer. He said that the comparative lengths would be about equal. The remainder of the respondents said they had either insufficient contact with NGRI's or that the GBMI statute had not been in operation long enough to provide a valid comparison.

h. Parole

Because of the short time that the GBMI law has been in effect, the interviewees were unable to say whether GBMI offenders would be paroled more frequently than similarly situated guilty offenders.

i. Treatment

According to one Department of Corrections official (F_2), the South Dakota correctional system has over 900 inmates excluding probationers and parolees. Of this number, no more than five offenders are GBMI. The South Dakota statute provides that "if a GBMI defendant is sentenced to the state penitentiary, he shall undergo further evaluation and may be given treatment that is psychiatrically indicated. If treatment is available, it may be provided through facilities under the jurisidction of the board of charities and corrections."[9] The Board of Charities and Corrections, according to respondent, is the executive power over several state institutions, including both the penitentiary and the state mental hospital. Treatment for mentally ill offenders generally is provided at the state hospital, the Human Services Center, although post-conviction evaluations and emergency psychiatric services are performed at the prison, according to one mental health evaluator (D_3).

When asked how determinations are made about which offenders will receive mental health treatment and care and whether the label of "guilty but mentally ill" plays a role in such determinations, a community services administrator (F_1) said that all offenders, once in prison, had an equal chance to receive treatment. He said that the GBMI label made no difference in determining whether an inmate would receive treatment. A corrections official (F_2) perceived the law as mandating treatment for GBMI offenders but failed to mandate when that treatment

was to be provided. He said that if an offender received some treatment at some point during his incarceration, then the letter of the law had been met. A mental health evaluator (D_3) believed that the GBMI label would play a role in determining receipt of treatment. His reasoning: although a judge normally only recommends treatment for GBMI's when he or she makes that finding, the recommendation is normally perceived as a mandate by corrections officials and treatment is provided. He also related, however, that three to five inmates from the general population receive treatment every month, particularly those pending release.

GBMI offenders receive the same treatment as that provided to the general population at the Human Services Center, except the offenders were kept on a locked ward. GBMI probationers who are undergoing outpatient treatment are indistinguishable from any other outpatient. The Human Services Center is the only state mental hospital in South Dakota and, as such, provides a full-range of treatment modes by a full staff complement.

Even though community services and corrections officials (F_1, F_2) agreed that GBMI offenders were no more likely to receive mental health treatment than offenders with mental health problems in the general prison population, a survey of attorneys and judges revealed the opposite perception to be the case. Two prosecutors (B_1, B_4) said that the statute mandates treatment. Another (B_2) observed that, before GBMI, the criminal justice system lacked treatment for mentally ill offenders. Now, he believed, at least the GBMI offenders would receive some kind of treatment. A fourth prosecutor (B_3) said that the criminal justice system was obligated, especially if a GBMI plea had been entered and accepted, to provide the treatment a defendant had bargained for. One

circuit court judge (C_1) said that GBMI's would have the first opportunity for treatment because of their cooperativeness in seeking help while the other judge (C_2) stated that treatment for GBMI's was both more likely and more preferential. He cited the one case he had heard, noting that the GBMI offender involved was transferred out of state for treatment because the appropriate treatment program did not exist in South Dakota. He asserted that this would never happen for a regular convict. A corrections administrator (F_2) said, however, that South Dakota had never transferred a GBMI offender out of state for any reason but had transferred three guilty offenders out of state for the express purpose of receiving intensified psychiatric treatment. One defense attorney (B_5) said that if a defendant was certified as mentally ill, the judge would order his treatment and the warden would follow through with it. The other defense attorney (B_6) speculated that fewer than two dozen mentally ill offenders were in the entire penal system and that the state was capable of providing treatment for such a small number. He questioned the wisdom, though, of attempting to rehabilitate someone at the state hospital and then returning him to the prison to finish out his term. His question: "How do you rehabilitate someone to cope with being in jail after successful completion of treatment?"

j. Transfers Between the Corrections and Mental Health Systems

Because the Board of Charities and Corrections administers both the state penitentiary and the Human Services Center, transfer between these facilities is easily effected in South Dakota. Generally, a prisoner is transferred upon recommendation by the warden and agreement to receive by the Human Services Center (D_3). One corrections official (F_2) viewed

the transfer as merely the carrying out of the judge's order for treatment. The community services administrator (F_1) said that transfers might be voluntary or involuntary. Return from the Human Services Center is a simple procedure; all it requires, according to this administrator, is a release from the hospital, a station wagon, and a guard.

5. Costs

Nine out of eleven respondents said that the availability of the GBMI alternative would increase the overall costs to the mental health-judicial system in South Dakota (B_1, B_2, B_3, B_4, B_5, B_6, C_1, C_2, D_3). Most believed that the increase would be minimal (C_1, C_2, B_1, B_3, B_4, B_5). Some said that any rise in mental health treatment costs would be offset by decreases in costs to the judicial system due to decreased recidivism (B_2) and decreased costs of prosecutions (B_4). The only respondents who believed no change in costs would occur were the corrections (F_2) and community services (F_1) administrators.

6. Perceived Strengths and Weaknesses of GBMI Provisions

Asked about their perceptions of the strengths and weaknesses of the GBMI provisions, respondents offered many differing opinions. These opinions are reflected in Table 18.

When attorneys were asked under what circumstances they might advise a client to enter a GBMI plea, the following replies were made. Two prosecutors (B_1, B_4) said that if a hypothetical client was guilty and had a mental problem (but was not insane), he would encourage the

Table 18

Perceived Strengths and Weaknesses of
South Dakota's GBMI Law

	Respondents															
	B						C		D			F		H		
Strengths	1	2	3	4	5	6	1	2	1	2	3	1	2	1	2	Total
Treatment Provisions	X			X					X	X	X	X			X	7
Alternative Verdict	X	X		X												3
Reduces Recidivism				X												1
Responsiveness of Legislators														X		1
Reduce Stigma									X							1
None			X		X			X					X			4
Weaknesses																
Treatment Provisions Weak	X													X		2
Prone to Misuse in Plea Bargains		X														1
Definitions Vague			X													1
Increases Costs				X												1
Victimizes Less Serious Offenders					X	X			X				X			4
Limits Expert Testimony					X											1
Potential for Abuse												X				1
None							X									1

plea for the sake of receiving treatment. Another prosecutor (B_2) said that in cases involving sex offenses in general, and child molestation in particular, he would encourage a client to avoid a jury trial and plead GBMI. A fourth (B_3) stated that he would encourage the plea to reduce stigma, especially if no alternative was available. One defense attorney (B_5) offered the case of a first or second offender who was young with no chance for diminished capacity and charged with a sex crime as a prime candidate for a GBMI plea. Finally, the other defense attorney (B_6) speculated that he might encourage a GBMI plea if the judge hearing the case seemed attuned to mental health rehabilitation and a favorable sentence might be passed.

Of the two judges interviewed, one (C_2) said that GBMI enactment was simply a "knee jerk" reaction to a perceived national concern. He believed that most people in South Dakota were unaware of its existence and that it would never have much impact on the state. The other (C_1) said that GBMI was a step in the right direction because it provided criminals the opportunity to tell people of their crimes yet save face in the process. He believed that this chance to allow mental illness to mitigate a guilty plea would provide the first step on the road to rehabilitation.

Notes

1. See generally S.D. Codified Laws Ann. ch. 23A-7 (Supp. 1983).
2. Id.
3. Id. at §22-1-2 (22) (1983).
4. Id. at §22-1-2 (18A) (1983).
5. Id. at §23A-7-5 (1983).
6. Id. at §23A-7-16 (1983).
7. Id.
8. Id. at §23A-27-38 (1983).
9. Id.

K. Utah

1. Introduction

Utah's guilty and mentally ill (GAMI)[1] statute became effective on March 31, 1983.[2] During August 1984, eight (8) individuals familiar with the GAMI law and its application in Utah participated in a telephone survey regarding Utah's 16-month experience with the law. The interviewees included a legislator (A_1), a private attorney (B_1), two district court judges (C_1, C_2), two forensic psychologists (D_1, D_2), a mental health programs specialist (F_1), and a probation and parole official (G_1).

Together, the individuals interviewed have been involved directly or indirectly in the 17 cases in which GAMI findings have been rendered in Utah. The forensic psychologists (D_1, D_2) evaluated all 17 defendants at the Utah State Hospital. The mental health programs specialist (F_1), who is compiling statistics on the GAMI defendants, reported that between July 1, 1983 and June 30, 1984, 13 defendants were found GAMI in Utah. At least 10 of the 17 GAMI findings resulted from pleas rather than trials; at least four resulted from bench trials (B_1, C_1, C_2), GAMI findings have been rendered in four of Utah's seven judicial districts (F_1). The second judicial district, although it is not the largest, has used GAMI most frequently.

2. Legislation: Historical Context and Purposes

a. Changes Coincidental with GAMI Enactment

At the same time that the Utah Legislature enacted the GAMI law, it repealed and reenacted the insanity defense standard (A_1, C_1).[3]

The repealed standard was that "the defendant, at the time of the proscribed conduct, as a result of mental disease or defeat, lacked substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of law."[4] The new standard is that as a result of mental disease or defect, the defendant "lacked the mental state required as an element of the offense charged."[5]

According to the legislator interviewed (A_1), three groups of people opposed the legislation. First, psychiatrists alleged that the GAMI provisions "made empty promises without guaranteeing treatment." Second, criminal defense lawyers wanted the not guilty by reason of insanity (NGRI) standard broadened rather than narrowed. Finally, a third group wanted the insanity defense abolished. Another respondent (F_1) said that opponents to the GAMI legislation argued that it inappropriately created a separate class of citizens. They said, for example, that the Legislature also could create a separate category of "guilty and diabetic." The respondent said also that the problems the GAMI law sought to address could be resolved administratively, for example, through the pre-sentence investigation and report, without resort to the Legislature.

Two respondents (A_1, F_1) said that amendments to the GAMI law will be proposed in the next legislative sessions. One amendment would redefine the term "mental illness"[6] to exclude alcohol abuse and personality disorder (A_1, F_1). A second would reword a GAMI provision, although the respondent did not know the details (A_1).

b. Precipitating Factors

According to a legislator (A_1) public dissatisfaction with the insanity defense led to enactment of the GAMI legislation. He said that

two tragic cases involving NGRI acquittals occurred in his area. In one case an acquittee escaped from the hospital and, in an attempt to kill himself, ran his car into another car killing four people. In the second case, a father read the Old Testament story about Abraham offering his son as a sacrifice; he then killed his own 18-month-old son. The father later was found NGRI.

The legislator (A_1) and the mental health programs specialist (F_1) both said that although Legislature was considering GAMI legislation before the acquittal of John W. Hinckley, Jr., in the shooting of President Reagan,[6] the Hinckley verdict probably was the decisive factor in moving the legislation ahead. Following the Hinckley acquittal, the Utah governor appointed a blue ribbon democratic committee to study the NGRI law in Utah and to make recommendations for changes. A republican committee was formed later. Negotiations between these committees resulted in House Bill 225, which was enacted as the GAMI statute.

Another respondent (D_2) provided a different picture of the problem the new legislation was meant to address. He said that the problem was not that NGRI acquittees were being released from the hospital too quickly, but that once a person was found NGRI, it was very difficult for him to get out of the hospital. Before enactment of the GAMI statutes, NGRI acquittees were committed for an average of 10 to 15 years.

c. Legislative Purposes

The respondents' articulation of the legislative intent behind the GAMI legislation supports that the law was a response to public dissatisfaction with the insanity defense. Responses fell into three categories:

(1) to make the insanity defense understandable (A_1, C_1, F_1);

(2) to undercut the insanity defense (B_1, C_1, C_2, D_1, D_2); and

(3) to facilitate treatment for defendants who do not meet the NGRI standard (D_1, D_2, G_1).

The legislator (A_1) said that under the old NGRI standard, the cognitive prong was easily understandable but the volitional prong was difficult. The new law eliminated the volitional prong and limited the cognitive prong to the mens rea test.[7] Another respondent (F_1) said that the Legislature attempted to provide a restrictive "legal" definition of NGRI and to provide a "psychiatric" definition of the "mentally ill" portion of GAMI. Respondents who said that the intent was to undercut the insanity defense gave three reasons for this objective: (1) to limit the release of persons found NGRI (C_1), (2) to hold mentally ill persons responsible for their criminal acts (C_2), and (3) to protect society (D_1, D_2). One respondent (B_1) said that the GAMI law was "a ploy by the Legislature to soften the blow of the insanity defense."

When asked whether the legislative intent had been fulfilled, three respondents (A_1, C_2, F_1) said that the intent to make the insanity defense understandable had been fulfilled. Three (C_2, D_1, D_2) said that the intent to undercut the insanity defense had been fulfilled. An attorney (B_1) and a district court judge (C_1) said, however, that the incidence of successful insanity defenses before the GAMI enactment was too low to permit a reliable assessment of the new law's impact. The judge (C_1) said that the public perception that NGRI acquittals occur frequently simply is not true. He suggested, though, that the incidence of NGRI pleas might have decreased.

Two forensic psychologists (D_1, D_2) and a probation and parole official (G_1) said that the intent to facilitate treatment had been fulfilled. According to one of these respondents, each defendant found GAMI has received treatment at the Utah State Hospital. The others (D_1, D_2) said that before the GAMI enactment mentally ill offenders who did not meet the NGRI criteria did not receive treatment. The GAMI statute acted as a catalyst for the development of a comprehensive mental health services unit at the Utah State Prison. A separate building has been designated to house that unit. The upstairs of the building houses a sex offender program. The downstairs has the mental health unit. The unit has been staffed and began operations in May 1984. It provides treatment to mentally ill offenders, regardless of whether the offender is labelled GAMI. Also, the Utah State Hospital has developed its forensic ward. These advances occurred because, with the enactment of the new law, it became obvious at the prison and the hospital that GAMIs would be coming into the system. The respondents (D_1, D_2) said that the law forces the court to address mental illness issues and the defendant to comply with a treatment order. They said also that an offender's GAMI label is a constant reminder to corrections personnel that the offender requires special treatment.

3. Characteristics of GAMI Offenders

The mental health programs specialist (F_1), who is compiling statistics on 13 defendants found GAMI between July 1, 1983 and June 30, 1984, said that they tend to have little education, to be underemployed, and to have a prior history with both the criminal and mental health systems. The group includes 11 men and two women, six of whom are

single, three married, two divorced, and two widowed. Their ages range from 21 to 59 years. A probation and parole official (G_1) said that GBMI offenders are underemployed and have a history of criminal behavior. A district court judge (C_1) said that a defendant who enters a GAMI plea generally knows that he or she needs help and does not want to go to jail. Another judge (C_2) said simply that a GAMI offender is mentally ill but does not meet the NGRI criteria. The forensic psychologists (D_1, D_2) said that a GAMI offender is currently mentally ill but may recover, but that NGRI acquittees probably would not recover.

When asked whether defendants found GAMI under Utah law would be found NGRI or guilty if the GAMI alternative were unavailable, all (C_2, D_1, D_2, F_1) but one (B_1) respondent said they probably would be found guilty. The dissenting respondent (B_1) qualified his view, however, by saying that an NGRI finding would result in "borderline" cases. The other respondents said that the defendants would be found guilty because their mental illnesses were insufficiently severe to warrant NGRI findings (C_2) or because the new mens rea test of insanity was too limited (F_1), but that the change in the insanity test made the determination difficult (D_1, D_2).

Respondents generally were unable to comment on whether recidivism rates would vary among NGRI, GAMI, and guilty offenders. All (B_1, C_1, C_2, F_1, G_1) said that not enough time had elapsed since passage of the GAMI law to assess recidivism rates. One (F_1) said that no one found GAMI had been released yet. A probation and parole official (G_1) speculated that GAMI offenders might be higher recidivists, because after being stabilized with medication and released, they would not continue taking their medication.

4. Procedures and Practices

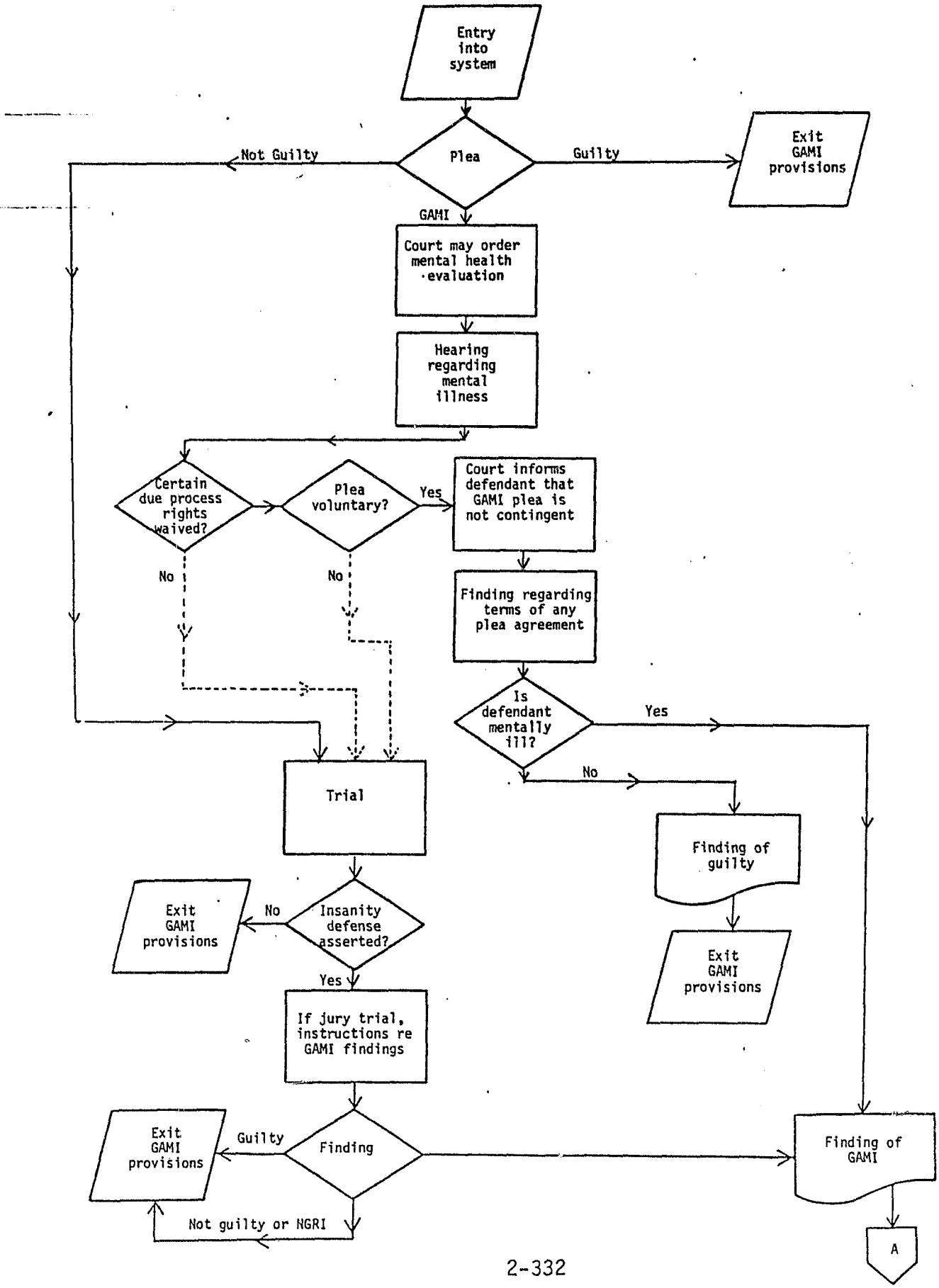
a. General

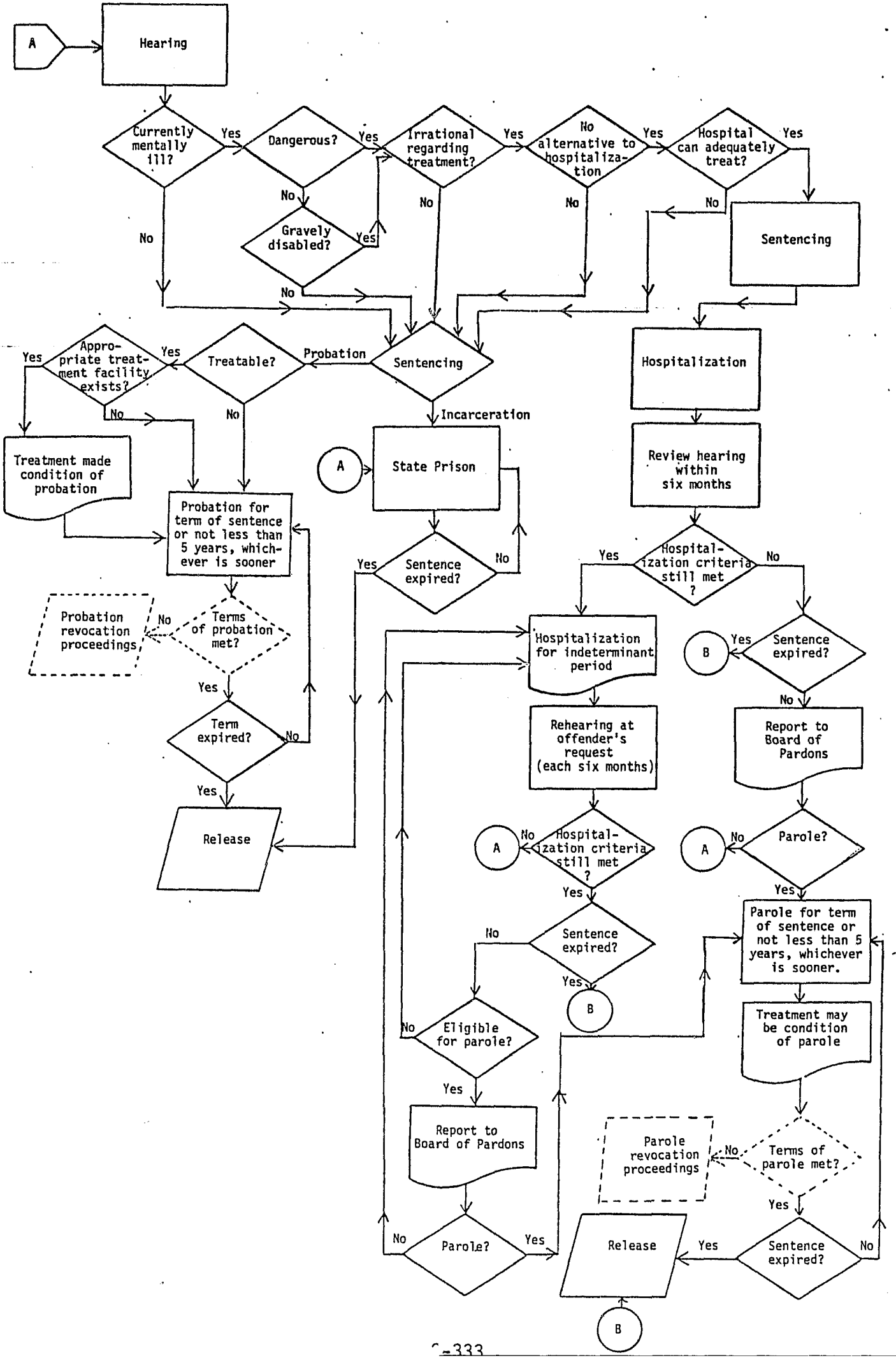
Utah's statutory GBMI procedures are depicted in Figure 11. When asked generally whether these procedures had changed the processing of mentally ill offenders, three respondents (C_1, C_2; F_1) said that no significant changes had occurred. One (C_1) said that before the GAMI law was enacted, extensive preliminary screening was done; that is, a preliminary psychiatric examination was conducted and a report to the court was made. Then as now, the report was not considered conclusive, although the court generally followed its recommendations. That respondent suggested, however, that plea bargaining occurred more frequently under the GAMI law. A district court judge (C_1) said that a GAMI plea had at least one disadvantage for a defendant. That is, a GAMI plea is not a contingent plea: if the court finds the defendant to not be mentally ill, the court simply accepts the guilty portion of the plea.

b. Pre-trial Mental Health Evaluations

After a GAMI plea is entered, the court may order a defendant evaluated at the Utah State Hospital or at another suitable facility.[8] According to two forensic psychologists who work at the Utah State Hospital (D_1, D_2), all 17 GAMI defendants in Utah have come to the hospital for evaluations. They were all referred from the court, usually on motions of the defendant. The evaluation procedures are different for GAMI defendants than for NGRI defendants (D_1, D_2). In an NGRI evaluation, the evaluator is looking for a specific thought or behavior problem that is related to the criminal activity. In a GAMI situation, the evaluator conducts a more longitudinal and comprehensive evaluation.

Figure 11. Utah's Statutory GAMI Procedures




A
Hearing
Currently mentally ill?
Yes
Dangerous?
Yes
Irrational regarding treatment?
Yes
No alternative to hospitalization
Yes
Hospital can adequately treat?
Yes
No
Gravely disabled?
Yes
No
No
No
No
No
Sentencing
No
Sentencing
Probation
Treatable?
Yes
Appropriate treatment facility exists?
Yes
No
No
Treatment made condition of probation
Probation for term of sentence or not less than 5 years, whichever is sooner
Incarceration
A
State Prison
Yes
Sentence expired?
No
Probation revocation proceedings
No
Terms of probation met?
Yes
Term expired?
No
Yes
Release
Hospitalization
Review hearing within six months
Yes
Hospitalization criteria still met ?
No
Hospitalization for indeterminant period
Rehearing at offender's request (each six months)
A
No
Hospitalization criteria still met ?
Yes
No
Sentence expired?
Yes
B
No
Eligible for parole?
Yes
Report to Board of Pardons
No
Parole?
Yes
B
Yes
Sentence expired?
No
Report to Board of Pardons
A
No
Parole?
Yes
Parole for term of sentence or not less than 5 years, whichever is sooner.
Treatment may be condition of parole
Parole revocation proceedings
No
Terms of parole met?
Yes
Release
Yes
Sentence expired?
No
B

c. Mental Health Expert Involvement.

Although two (B_1, C_1) respondents said that the GAMI law has not changed the involvement of mental health experts in criminal proceedings, three (C_2, D_1, D_2) said that a new dispositional hearing required by statute[9] increases expert involvement. A dispositional hearing is held to determine whether a GAMI offender should be sent to the hospital. The offender must meet the involuntary civil commitment criteria before he or she may be hospitalized.[10] Although mental health professionals who evaluate GAMI offenders rarely testify at these hearings, evaluators report to the court regarding an offenders mental condition by using a letter in lieu of testimony (D_1, D_2). The recommendations contained in a letter in lieu of testimony differ from pre-GAMI only by addressing more specific issues. When a letter favors hospitalization, the parties generally stipulate to that disposition, thereby eliminating the need for a full hearing (D_1, D_2).

d. Juries

At least 14 of the 17 GAMI findings that have occurred in Utah were not jury verdicts (B_1, C_1, C_2); no one interviewed had been involved in a GAMI jury trial. Although a district court judge (C_2) speculated that, if properly instructed, juries would be able to distinguish between the definitions of insanity and mental illness, another judge (C_1) and a defense attorney (B_1) said that juries would be unable to follow such instructions. The attorney suspected that a jury would opt for a GAMI rather than an NGRI verdict in a difficult case. GAMI instructions are not standardized in Utah and would be very difficult to construct (C_1), but could not include information regarding the dispositional consequences of a GAMI verdict (C_2).

e. Sentencing

Respondents generally agreed that the length of sentence for GAMI offenders not placed on probation does not differ from that of guilty offenders (C_1, C_2, F_1, G_1). A probation official (G_1) said that the probation provisions are different from the regular probation provisions in two respects: (1) the GAMI law requires more frequent periodic reports to the court and, more importantly, (2) the GAMI law requires a probation period of at least five years, whereas the regular probation provision provides an 18-month limit on the duration of probation. He said, however, that no GAMI offenders have been placed on probation in Utah. He added that although no GAMI offenders have been placed on probation, probably 75 percent of all guilty probationers receive some type of mental health treatment. A judge (C_2) said that he does not use probation, but sentences GAMI offenders to the Utah State Prison with treatment at the Utah State Hospital. Another judge (C_1) said that he imposes sentence on a GAMI offender as if the finding had been simply guilty; he then orders treatment. A mental health programs specialist (F_1) said that the only difference between the confinement of GAMI and guilty offenders is that GAMI offenders go to the hospital and guilty offenders go to the prison.

f. Comparative Lengths of Confinement

Only two respondents expressed an opinion regarding whether the period of confinement of NGRI acquittees and GAMI offenders who have similar backgrounds differ. A district court judge (C_2) said simply that NGRI acquittees are placed in the hospital until they regain their sanity, but that GAMI offenders serve fixed sentences. A mental health programs specialist (F_1) said that NGRI acquittees are confined much

longer, often long beyond the term of the sentences they might have received had they been found guilty.

g. Parole

The parole official interviewed (G_1) said that no GAMI offenders have become eligible for parole yet. He said, however, that the parole criteria that the district courts and the parole board have adopted apply equally to both guilty and GAMI offenders. He foresaw no differences in parole practices for guilty and GAMI offenders.

h. Treatment

Of the 17 defendants found GAMI in Utah, 15 were found to be in need of treatment at the Utah State Hospital after evaluations at the hospital (D_1, D_2). Pursuant to the standard procedure, the two not needing treatment were referred to the Board of Pardons for disposition. The Board sent one of the two to prison; disposition of the other was pending as of August 6, 1984. Because a GAMI offender on probation status remains under the jurisdiction of the court, a GAMI probationer would go back to the court rather than to the Board of Pardons for disposition following a determination that treatment is no longer needed.

When asked whether GAMI offenders are more likely to receive treatment than guilty offenders with mental health problems, a district court judge (C_1) said that they were not. He said that both guilty and GAMI offenders receive treatment. The judge said that the pre-sentence investigation and report done following guilty findings involve psychiatric evaluations and provide guilty offenders as good an opportunity of receiving treatment as GAMI offenders have. A mental health programs specialist (F_1) said, however, that GAMI offenders are given priority. He said that the courts send GAMI offenders directly to

the hospital, displacing some of the traditional patients from the forensic unit at the state hospital. He said that the GAMI label plays a crucial role in the placement decision. He added that courts sentence GAMI offenders directly to the Utah State Hospital in two ways: (1) for an undetermined period, with the provision that the clinical director may release the offender to the Board of Pardons for further disposition when he believes it appropriate to do so, and (2) for a definite period, usually six months, after which the offender automatically goes to the Board of Pardons for disposition.

GAMI offenders can receive treatment at the Utah State Hospital or at the mental health unit of the Utah State Prison (D_2). As mentioned above, however, to date GAMI offenders have gone to the hospital (F_1). Before a GAMI offender may go to the hospital, a hearing must occur in which the offender is found to meet the involuntary civil commitment criteria (B_1, C_2, D_1, D_2).[11] According to a forensic psychologist (D_2), the reason for this hearing is that even though an offender has a diagnosible mental illness, he or she may not be in need of treatment in the hospital. Therefore, the hearing is to determine where an offender can best be treated.

A defense attorney (B_1) and a judge (C_1) said that the requirement that a GAMI offender meet the involuntary civil commitment criteria provides a major obstacle to treatment. The criteria that must be met are that the offender poses an immediate physical danger to self or others or lacks the ability to provide the basic necessities of life, that the offender lacks the ability to engage in rational decision making regarding accepting treatment, that no appropriate alternatives to hospitalization exist, and that the hospital can provide adequate

treatment (B_1).[12] The interviewed attorney (B_1) had represented a defendant who was found GAMI but later was found to not meet the involuntary civil commitment criteria. According to the attorney, the offender, therefore, was not sent to the hospital but was sent to the prison and has been receiving no treatment. The offender had been found to be mentally ill but not dangerous and to have the ability to engage in rational decision making regarding treatment. The attorney translated this last factor to mean that "if a defendant knows he needs help, he can't get it." He also said that the requirement of no available alternatives can be read broadly to mean that alternatives always are available. The judge (C_1) agreed that use of the involuntary civil commitment criteria was misplaced. He said that the requirement that the court consider alternative settings has nothing to do with a criminal conviction and that whether a defendant has insight into his or her need for treatment is irrelevant. The attorney said that a defendant would have more success getting treatment if he were found merely guilty than if he were found GAMI. In the other GAMI cases that the attorney has handled the defendants were civilly committed while the criminal proceedings were pending; therefore, no one challenged the commitments following the GAMI findings.

i. Transfers for Mental Health Treatment

GAMI offenders are not transferred from the prison to the hospital but, rather, are sentenced directly to the hospital (F_1). When a GAMI offender is transferred back to the prison, however, one of two procedures is used (F_1). If the offender is on probation and the clinical director of the hospital determines that he no longer needs treatment, the offender is sent back to the court for further

disposition. If the offender is not on probation, he or she is sent to the Board of Pardons for further disposition. So far, only the latter procedure has been used (D_1, D_2)

5. Costs

The respondents disagreed regarding whether application of the GAMI law has increased or decreased costs to the mental health-justice system. Four (B_1, C_1, D_1, D_2) said that the law has had no effect on costs. One of these respondents (B_1) said that if the GAMI offenders had been NGRI or guilty, they still would have required treatment and would have burdened the system to the same extent. Two (D_1, D_2) agreed that the offenders would have received treatment somewhere, but that under the GAMI law they were consolidated. As one (D_1) put it, "it's the same pie being divided differently, not a bigger pie." These respondents (D_1, D_2) hoped, however, that treatment of GAMI offenders would prepare them for earlier parole, thereby reducing costs.

Two respondents said that costs had gone up. A judge (C_2) attributed the increase to the cost of the new dispositional hearings required under the GAMI law. The mental health programs specialist (F_1) gave a more detailed accounting of the increase. He said that the 13 persons found GAMI between July 1, 1983 and June 30, 1984, have cost the system approximately $750,000 this year. That is based on $151 per day for each offender's stay at the state hospital for one year. He said that the state made no appropriation to cover this cost, but that the cost probably was being absorbed by the hospital by displacement of non-GAMI patients.

6. Perceived Strengths and Weaknesses of GAMI Legislation

Asked about what they perceived as the strengths and weaknesses of Utah's GAMI legislation, respondents offered differing opinions. These opinions are reflected in Table 19.

Table 19
Perceived Strengths and Weaknesses of
Utah's GAMI Provisions

	Respondents								
			C		D				
Strengths	A	B	1	2	1	2	F	G	Total
Public Satisfaction	X		X		X	X			4
Catalyst for Treatment and Resources					X	X			2
Enhances Treatment				X			X		2
Guarantees Treatment	X								1
Treatment Precedes Punishment								X	1
Avoids Premature Release	X				X	X			3
Weaknesses									
Adds Nothing to Existing Law		X	X						2
Increases Financial Burden	X								1
Mental Illness Definition Too Broad								X	1
Inappropriate Incarceration							X		1
Might Cause Overcrowding at State Hospital	X								1
None				X					1

Notes

1. Utah uses the term "guilty and mentally ill." All other states having similar laws use the term "guilty but mentally ill."

2. 1983 Utah Laws ch. 49.

3. See Utah Code Ann. § 76-2-305 (1983).

4. Id. at § 76-2-305 (1978) (repealed 1983).

5. Id. at § 76-2-305 (1983).

6. United States V. Hinckley, Crim. No. 81-306 (D.C. Cir. 1982).

7. See supra notes 3-5 and accompanying text.

8. Utah Code Ann. § 77-35-21.5(1) (1983).

9. Id. at § 77-35-21.5(3).

10. See id. at § 77-35-21.5(4). See also infra text accompanying note 11.

11. See supra notes 9-10 and accompanying text.

12. Utah Code Ann. § 77-35-21.5(4) (1983).

PART THREE: CASE FILE DATA FROM GEORGIA, ILLINOIS, AND MICHIGAN

I. METHODOLOGY

A. Introduction

Offender-specific data were gathered from official records in three states: Georgia, Illinois, and Michigan. These states were selected because, of the states that have enacted GBMI statutes, their legislation was passed relatively early (1982, 1981, and 1975 respectively). Time must pass following the enactment of a new law for assessments of its effects to be possible. This time lapse is necessary for relevant cases to surface and proceed through the courts and into social service agencies. Furthermore, it takes time for a sufficient number of cases to accumulate to allow meaningful comparisons within and among states to be made. The three states noted above were the most likely of the eleven possible states to have sufficient numbers of GBMI offenders for social research purposes.

During preliminary site visits to each state, contact was made with state mental health and corrections officials to assess their interest in project participation, the availability of data, and the resources required to complete data collection. Depending on various agency requirements, formal or informal research proposals were submitted to gain access to official records. Confidentiality agreements were executed for each state agency involved (see Appendix E).

In each state, an attempt was made to track offenders from the point of pretrial forensic evaluation. This sampling method was chosen in an effort to divide those who raised mental aberration in pretrial proceedings by case outcome (GBMI, NGRI, guilty). The success of this approach varied greatly depending on the level of centralization of forensic mental health services. Due to this variation, the resulting

study populations differ somewhat among the states. Details of the sampling frames are presented below. Anonymity of individual offenders was guaranteed by means of a standard research procedure of assigning case identification numbers using a master sampling list for each state. Following the coding and verification of all data, the lists linking individuals to case numbers were destroyed.

B. Instrument Development

Although the data available from each state varied considerably, one data collection instrument was designed for use in all three states. The variables selected and the operational definitions used were based on 1) a thorough review of the literature (see generally, Part One) and, 2) the data definitions employed by each state agency. After discussions with informed officials in the three study sites, project staff, drawing upon their knowledge of the relevant issues and prior research, developed a set of research questions to be addressed. The questions were then reviewed to determine the specific data elements necessary to fulfill the research needs. The data collection instrument ultimately included 98 variables, encompassing both offender and case processing characteristics.

In addition to the collection of typical demographic information, specifics were sought about an offender's prior mental health history and criminal history. Extensive information about the instant offense, mental status, and system processing was also included. Data elements beyond the point of conviction were incorporated in an effort to provide a complete picture of GBMI case processing and outcomes. The data collection instrument and accompanying code manual are located in Appendices B and C.

C. Sample Selection

1. Georgia

The Mental Health Division of the Georgia Department of Human Resources (DHR) is responsible for conducting virtually all pretrial forensic examinations. As noted in the state profile in Part Two, such evaluations are conducted by eight regional forensic teams operating out of the eight regional state hospitals and mental institutes. In addition, the forensic unit at Grady Memorial Hospital in Atlanta is authorized to conduct pretrial evaluations.

An attempt was made to identify each individual evaluated by one of these nine facilities between January 1, 1981 and December 31, 1983. This time period was selected to allow a comparison of NGRI acquittees over the 1 1/2 year periods both before and after institution of the GBMI verdict. Two difficulties were encountered, however.

The first difficulty that surfaced was the method used by DHR to track pretrial evaluations: handwritten logs maintained by each facility. In some cases, the logs were difficult to read. Use of the manually-kept logs was further exacerbated by two factors: 1) the logs were arranged chronologically (a logical system requirement that would, however, necessitate reordering for research purposes to eliminate seasonal effects when sampling); and 2) it was not always possible to trace a defendant's movement from facility to facility as he or she was admitted for inpatient evaluation, treated for mental illness in jail, incompetence to stand trial, transferred for continued treatment, etc. Furthermore, the computerized information system maintained by DHR is client-based and does not indicate the reason(s) for referral or admission. Understandably, DHR does not systematically receive, and therefore cannot gather, dispositional information beyond its needs

(e.g., NGRI finding, incompetent to stand trial, involuntary or voluntary civil commitment).

Putting aside the significant difficulties of manually sorting through pretrial forensic evaluation logs, a more serious obstacle to the preferred sampling scheme became evident through discussions with court, DHR, and the Department of Offender Rehabilitation (DOR) officials. The Georgia GBMI statute does not require the completion of a pretrial evaluation prior to a finding of guilty but mentally ill. The consensus of knowledgeable officials was that many defendants are, in fact, found GBMI without such an evaluation being conducted. On the basis of this information, the intended sampling frame was deemed to be flawed and, therefore, was discarded. These difficulties precluded the selection of an appropriate guilty sample for comparative purposes.

Fortunately, the DHR possessed a central list of all defendants acquitted by reason of insanity since 1977. This list was subdivided on the basis of admission date and treating facility such that the population of NGRI defendants for the pre- and post-GBMI periods were identified.

The population of NGRI acquittees for the 1980-1983 time frame included 171 individuals. Of this total, the research team was able to collect data on 163 defendants found NGRI. The eight missing cases are attributed to 1) transfer of the client to a facility where the research team had already completed data collection, 2) an inability to locate the proper file, or in one case, 3) inaccurate dispositional data (i.e., charges were dropped after the defendant agreed to seek voluntary inpatient treatment). NGRI data were collected from forensic records and unit charts at each of the eight regional mental health facilities.

The Mental Health Division of the Department of Offender Rehabilitation (DOR) has identified all GBMI offenders committed to the DOR by adding a special prefix to the inmates' identification numbers. Such an indicator guaranteed identification of the entire population of GBMI offenders who have been committed to DOR. Of the 171 individuals listed, data were collected on 170 GBMI offenders. One individual appeared on the GBMI list twice. The first GBMI verdict was tracked, noting the second GBMI conviction as recidivism. The one lost case was that of an offender who entered the Georgia Diagnostic and Classification Center so near the time of data collection that no data were available. In addition, information about another GBMI offender was obtained at one of the DHR facilities, bringing the total of GBMI offenders included in the study to 171. Since DOR maintains a centralized records facility in Atlanta, project staff were able to collect GBMI case file data at one location instead of at each correctional facility that housed GBMI offenders.

2. Illinois

The pretrial evaluation process in Illinois is decentralized. Pretrial forensic evaluations are assigned and conducted at the county level, often on a contract basis with private mental health practitioners. Discussions with state and county mental health and corrections officials that focused on pinpointing on alternative sampling frame proved fruitless. The difficulty of identifying defendants receiving pretrial evaluations led to a decision by the research team that the preferred sampling scheme could not be implemented without a prohibitive expenditure of project resources.

The existence of the Illinois Mental Health Confidentiality Act further compounded the sampling difficulties. In practice, the Act prohibits individuals, including researchers, who are not employed by the Department of Mental Health and Developmental Disabilities (DMHDD) from reviewing any Department files or patient records that contain the names of patients. This restriction prohibited the collection of original DMHDD case file data.

The only alternative available to the research team was to use existing individual-level data on NGRI acquittees maintained on a personal computer at the Chester Mental Health Center. This dataset included 18 data elements for 370 NGRI acquittees admitted between February 1975 and April 1984. The completeness and quality of the data vary, improving significantly on the more recent cases. Consequently, the resulting Illinois NGRI dataset is totally different from the other GBMI project data. (See Appendix C.) Obviously, the analysis was affected by this difference; however, certain descriptive data are included and limited comparisons were made on those variables which were comparable between the two datasets (i.e., age, sex, race, offense, county, location of confinement, confinement length, and postacquittal diagnosis).

The Department of Corrections (DOC) provided a complete list of GBMI offenders committed to its custody. This list was broken down by institution, then further subdivided by institutional, supervised, and discharged populations. Of the 133 GBMI offenders, data were collected on all except two. In both of these cases, the offender had been transferred to a facility where data collection had already been completed.

3. Michigan

The centralized nature of the pretrial forensic evaluation process in Michigan accommodated the optimum sampling frame selected by project staff. The Center for Forensic Psychiatry (CFP) in Ann Arbor was, until recently, the sole facility in the state authorized to conduct competency and criminal responsibility evaluations. (See the Michigan profile, Part Two, for a description of this process, including the addition of the Detroit Recorders' Court Clinic as an authorized evaluation facility. In actuality, CFP frequently conducts follow-up evaluations for clients processed at the Court Clinic, usually at the request of the court, prosecutor, or defense attorney. In addition, if the clinic recommends a finding of incompetency that is granted by the court, the defendant is automatically committed to and evaluated by CFP.) The sampling frame employed can be assumed to be an accurate representation of those defendants who received pretrial forensic evaluations in Michigan between January 1, 1975 and December 1, 1983.

The sampling process in Michigan required multiple steps that coordinated the CFP and Department of Corrections (DOC) population and subgroup listings. Lists that included the names of all GBMI offenders committed to the DOC and all NGRI acquittees in the state were obtained from the DOC and CFP respectively. Names of these individuals were extracted from the alphabetical yearly printouts of all defendants evaluated for criminal responsibility by CFP. Then the names remaining on the evaluation lists were cross-checked against current and past DOC population lists. The DOC offender lists were delineated by year of admission and status (i.e., active, paroled, discharged, deceased).

To insure accurate identification across agencies, several comparable data elements such as sex, race, date of birth, and offense were compared. In addition, pretrial evaluation dates and DOC admission dates were checked to assure chronological consistency whenever a discrepancy concerning identity remained. This identification process resulted in three complete lists for the period of study: 1) all GBMI offenders committed to the DOC,[1] 2) all defendants found NGRI, and 3) all defendants found guilty after raising the possibility of mental aberration during pretrial proceedings and receiving a pretrial forensic evaluation.

Project staff chose to collect data on the entire population of GBMI offenders (through June 15, 1984) since this group was the central focus of study. However, the large number of forensic evaluations and the concomitant number of NGRI and guilty defendants over the nine year period precluded such an approach with the other two subgroups. The final steps, therefore, involved the systematic random selection of the NGRI and guilty samples. Sampling was accomplished using a random starting point for each subgroup. The two samples were drawn from the alphabetized computer-generated lists which were already stratified by year.

Of the 237 GBMI offenders, data were collected for 232 members of the population. One of the five excluded cases was, based on a thorough review of the records, determined to be inaccurately labeled as GBMI. Information for the remaining four offenders was not collected for one of two reasons: 1) the offender's file could not be located at CFP, the DOC, or both, or, 2) the available data for cross-referencing between the two agencies did not allow for positive identification of the individual

in question. Two additional GBMI findings were noted; one in the recidivism data and another in criminal history, bringing the number of GBMI verdicts to 239.

A sample of 163 NGRI acquittees was selected for review. Data were collected for all but two of the cases in the sample. In each of these two cases, the file could not be located. The sample of guilty offenders included 238 individuals. Attrition for this group was higher than that for the GBMI and NGRI groups, mainly due to the difficulties of tracking across agencies. Data collection was actually completed for 217 offenders. Twenty-one (21) cases were dropped from the sample for the following reasons:

Inability to accurately identify offender	8
Inability to locate file	6
DOC file destroyed due to records retention policy	3
No pretrial evaluation conducted	2
DOC file in possession of Parole Board	2
Total Cases Lost	21

D. Data Collection

The activities necessary to complete data collection in each of the three states studied varied somewhat depending on the physical location of the case files. In addition, the population and sample sizes and the extent to which relevant data elements were already computerized played a part in determining the commitment of project resources.

On-site data collection was conducted by a team of seven researchers. The principal investigator trained all staff in the proper use of the data collection instrument and supervised the actual data collection in all three states. Random reliability checks were conducted periodically throughout the data collection process.

In Georgia, information for the incarcerated GBMI population was collected by three staff members at a central DOC records office over a three day period early in August of 1984. The NGRI data were gathered by travelling to each of the eight regional mental health hospitals and institutes.

As previously noted, the Illinois NGRI dataset was obtained from the DMHDD microcomputer at the Chester Mental Health Center. The existing dataset was printed minus all individual identifiers. Two staff members collected the GBMI data by visiting the twelve correctional institutions housing the individuals in the study population. Illinois data collection was completed during a two week period in mid-June, 1984.

Michigan was the only state included in the study in which virtually all the necessary information was available from one of two central locations. As noted in the preceding section, all pretrial forensic evaluation data and NGRI acquittee data were obtained from the files at CFP. The majority of the GBMI and guilty offender data was contained in the DOC central files in Lansing. Detailed treatment information is maintained in an offender's health care record which is located at the current or last institution of confinement. The widespread institutional placement of individuals in the two study groups negated the collection of detailed treatment data for the entire sample. Due to 1) the relative proximity of the Riverside Correctional Facility and the State Prison of Southern Michigan (SPSM) and, 2) the fact that a majority of the GBMI and guilty offenders in the study population were housed and/or treated at one of these two institutions, a decision was made to continue case file data collection only at Riverside and SPSM. Treatment information for offenders assigned to other correctional facilities was, therefore,

limited to that available from the official records in Lansing. A six person research team completed data collection activities over a 3 1/2 week period during July-August 1984.

E. Analytical Design

1. Preliminary Data Analysis

The data compiled were intended to serve a variety of ends in the present study as well as provide a broadly defined database for future research in this area. The research provides data in three areas: 1) statistical profiles of the three states for which information was obtained; 2) the exploration of bivariate relationships and patterns, and 3) classification of the major effects influenced by the passage of GBMI legislation. This requires multistage analyses and presentation of results.

The first section builds statistical profiles of GBMI offenders and case processing in Illinois, Georgia, and Michigan. Within the limits of the official data that were available, frequency counts and univariate descriptors provide a picture of each state's experiences with and dispositions of GBMI offenders and cases. The time period covered in these descriptions, along with the breadth and detail of the data, varies among the states because of different implementation dates and the various reporting practices in state agencies (see the earlier presentation on sampling and data collection procedures). Despite these constraints, the data furnish a current portrait (as of mid 1984) of GBMI defendants and an outline of GBMI case characteristics in each state. Moreover, the data formed the basis for interstate comparisons.

Second, an exploratory examination of bivariate relationships in cross-tabular form was conducted. Standard tests for independence (e.g.,

chi-square) and difference of means tests, where appropriate, were used to evaluate various relationships and identify interactions and spurious associations. This portion of the analysis served two important purposes. First, it complemented the earlier presentation of univariate patterns (i.e., how many?; what kind?) by highlighting specific relationships operating in GBMI cases. We might know, for example, how GBMI cases are distributed across different types of adjudications and demographic groups, but not know how the latter two characteristics interact with relation to verdicts of GBMI. This served to enrich the descriptive data by broadening understanding of the details and processes associated with GBMI cases in each state.

The detailed treatment of different relationships found in the data formed the basis for the subsequent multivariate analysis. Specific empirical questions raised in the limited literature that explores GBMI issues, most notably Smith and Hall (1982) and Boyle and Baughman (1984), revolve around comparisons of the three subgroups (the defendants found guilty, GBMI, or NGRI) that, in part, comprise the population of criminal defendants who raise mental health issues relevant to their criminal responsibility and/or competence. Before attempting to formulate comparative models that emphasize differences and similarities among those groups, the preliminary analysis served to inform us about which variables are useful and which relationships hold some promise for later study.

Two constraints were imposed on the analysis by the ultimate forms of the available data. As noted previously, confidentiality requirements of Illinois state law prevented direct access to the case files of NGRI acquittees. Only after the data were received from officials in Illinois

was it known that very few of the variables outlining NGRI characteristics were comparable with those collected by project staff on GBMI defendants. This obviated a multivariate comparison of those two groups (no data were available on those found guilty). Consequently, treatment of the Illinois data will be limited to description at the univariate level and observation of bivariate relationships. A different limitation on the analysis of cases in Georgia arose because agency reporting procedures prevented the selection of a guilty sample. Similarly, comparisons were possible for only the NGRI and GBMI groups.

2. Multivariate Analysis

The assumption that GBMI provisions are intended to curtail perceived abuses of the NGRI defense has resulted in questions about the similarities and differences among groups of defendants who raise issues of mental health at trial. The logic underlying this assumption is that comparison of the different verdict groups (NGRI, GBMI, guilty) would address whether those found GBMI are more like defendants found guilty or those acquitted by reason of insanity. If the former is observed, then it may be assumed that GBMI offenders displaced offenders from the guilty group (see, Smith and Hall, 1982). In other words, without the option of a GBMI verdict such defendants would likely be found guilty. If the latter were found, GBMI findings may be displacing defendants who would otherwise be found NGRI, a result intended by GBMI proponents.

The subtlety of this displacement question must, however, be acknowledged. The nature and magnitude of such differences often cloud interpretation, coupled with the effect of interactions which DFA does not address adequately. Furthermore, although Michigan's GBMI statute has been in effect for almost ten years now, NGRI and GBMI findings are

comparatively rare events. Sufficient populations for construct and validation samples either do not exist or can not be obtained without committing extensive resources. Pre/post NGRI and guilty data are required to empirically address the displacement issue. Pre-GBMI insanity acquittee data from Michigan could not be gathered within the resources of this project. Pre/post data for NGRIs in Georgia were compiled but the project team was prevented from selecting an appropriate guilty sample. If the latter were available, a prediction (hazard/risk) model could be constructed for independent testing. Any attempt to address the subtle displacement question, however, would require even more information on how psychological, legal, and criminal justice system behaviors relate to legal reform generally and GBMI specifically.

Subgroup comparisons are at the heart of Smith and Hall's (1982) quantitative assessment of these issues. Using seven years of data in Michigan, these authors employed discriminant function analysis (DFA) to distinguish the three groups and based their conclusions (discussed in Part One, IV, B) on the results. Our analysis is also based on a design of subgroup comparisons although our analytic strategy seeks to refine and expand previous research.

Considered generally, we sought to construct a state-specific model of each group that best distinguishes one group of interest from the others. The basic thrust was one of classification. That is, the relative applicability of a given model is determined by the proportion of cases classified correctly according to verdict. A model which best accommodates the observed pattern of a verdict and maximally differentiates that group from the other groups is the model adopted. Discriminant function analysis seems well suited for such an analytic

task since it is a statistical technique which classifies observations into appropriate categories based on the set of variable combinations that best reveal differences between those categories. However, several complications emanating from the data's nature and format mandate careful interpretation of our efforts to refine the issues which surround the adoption of GBMI statutes and build upon earlier research findings.

The binary form of the response categories (GBMI, not-GBMI) means that the dependent variable is a simple dichotomy which can be coded as 0 or 1. Some authors consider the use of standard linear probability models (such as DFA) unrealistic in such circumstances since the potential outcome is one category or the other (Hanushek and Jackson, 1977: 179). There are no intermediate values for the linear combinations of independent variables to represent as there would be if one were, for example, estimating a grade point average from test scores. Logistic regression is often considered an appropriate strategy in such circumstances because it specifically accommodates such response variables by analyzing the probability of obtaining one or the other outcome rather than estimating a certain value for the dependent variable. In addition, specialized logistic regression software packages have been designed which adjusts its estimates when categorical predictors are used.

This alludes to an additional complicating factor; the issue of a specific estimation procedure appropriate for the data. In the case of our GBMI research, many of the explanatory variables (e.g., sex, race, clinical diagnosis, offense) are categorical and unlikely to be distributed normally. Press and Wilson (1978) examined the results of statistical simulations in this area and concluded that whenever

conditions of normality are violated, DFA estimates will be inconsistent. They go on to state,

> This means, in particular, that if the explanatory variables are binary [they later broaden this to include qualitative independent variables in general], we cannot expect, with [DFA] estimators, to predict accurately that the dependent variables will be in a given state, even with an infinite amount of data! . . . [T]he practical solution is to use a consistent method of estimation, such as MLE [maximum likelihood estimators] (p. 701).

The instability of standard least squares estimation procedures under such conditions are well documented (see, for example, Hanushek and Jackson, 1977, Chapter 3; Blalock, 1978, Chapter 20) and need not be repeated here.

In the case of the statistical and methodological issues discussed, as with many similar topics, disagreement exists among specialists in the field over which approaches are preferable in a given research setting. Early research reviewed by Press and Wilson (1978) largely reported results that were unfavorable for DFA. On the other hand, recent evidence suggests that DFA is rather robust when confronted by violations of its basic assumptions and performs quite well. Knoke (1982) agrees with one noteworthy exception: DFA does not withstand such violations as well when interactions among independent variables influence respose levels. He urges an alternative approach in such instances.

Computer programs are designed which facilitate such analyses. Specifically, the 1982 version of Biomedical Data Processing (BMDP) contains a module (PLR) that classifies the hazard/risk function of cases within a logistic functional form using maximum likelihood estimators. This technique overcomes many of the concerns about DFA that have appeared consistently in the literature. Unexpected limitations on the software available for the current research prevented the use of such methods, however.

We therefore relied on standard discriminant function estimates of group characteristics. Results of the DFA were then tested using logistic regression estimates. Methodological shortcomings notwithstanding, the present analysis represents significant advances in our knowledge of the consequences that flow from the adoption of GBMI provisions. To the extent that our work replicates that of Smith and Hall (1982), an independent assessment of their findings is available. Perhaps more importantly, the data collected during the course of this research are much more extensive than any other source. Consequently, these results expand the list of potential predictors available for subsequent research in this area.

II. RESULTS AND DISCUSSION

A. Descriptive Data

Initial data analysis focused on tabulation and review of the descriptive information contained in each state dataset. This section of the report presents these data to further develop the state profiles for Georgia, Illinois, and Michigan in Part Two. The following presentation is subdivided into three sections. The first is a general description of GBMI and NGRI verdicts over time by state. The second section focuses on GBMI case and processing characteristics (e.g., court, county, pre- and post-conviction evaluations, evaluation recommendations, confinement location, treatment, etc.). The final discussion, before addressing the relationships between and among the variables studied, will portray the characteristics of GBMI offenders (e.g., age, sex, race, offense, diagnoses, etc.) by state. This presentation lends itself to a basic understanding of each state's use of the GBMI alternative before multivariate comparisons are made.

1. GBMI Findings Over Time

In the two year period between July 1, 1982 and July 15, 1984, a total of 171 GBMI verdicts were rendered in Georgia that resulted in commitment to the DOR. The verdicts of interest in Georgia are presented in Table 1:

Table 1
Georgia GBMI Findings by Year

Year	n	Felony Filings[4]	%	Felony Dispositions[4]	%
1981					
1982[1]	27	36,954	.07%	34,540	.07%
1983	90	35,542	.25%	34,213	.26%
1984[2]	51	---[5]		---[5]	
Total	168[3]				

Notes:

1. GBMI statute effective 7/1/82; therefore, GBMI cases encompass a six month period during 1982.
2. GBMI case file data collected through findings rendered as of 7/15/84.
3. GBMI cases missing = 4.
4. Statewide felony case filings and dispositions provided by the Georgia Administrative Office of the Courts. Figures are for fiscal years.
5. Figures for FY 83-84 are unavailable.

Illinois' GBMI statute took effect on September 17, 1981 and the first GBMI finding was rendered one month later. Between the effective date and May 15, 1984, 133 offenders were found GBMI and committed to the DOC. Table 2 presents these verdicts by year.

Table 2
Illinois GBMI Findings by Year

Year	n	Felony Filings[3]	%	Felony Dispositions[3]	%
1981[1]	10	41,795	.02%	44,096	.02%
1982	43	43,467	.10%	43,258	.10%
1983	59	41,945	.14%	42,712	.14%
1984[2]	17	---[4]			
Total	129[5]				

Notes:

1. GBMI statute effective September 17, 1981.
2. Includes findings rendered through 5/15/84.
3. Statewide felony case filings and dispositions provided by the Illinois Administrative Office of the Courts. Figures do not include filings in Cook County since offenders are arraigned as misdemeanants and, if probable cause exists, an information or indictment is filed at a later date.
4. Figures for 1984 are unavailable.
5. Missing cases = 4.

In 1975, Michigan became the first state to pass a GBMI verdict. According to official CFP and DOR records, a total of 239 GBMI verdicts resulting in prison sentences were rendered between August 6, 1975 and June 15, 1984. This represents 3% of the individuals evaluated for criminal responsibility during that same period. Over the ten years since the GBMI statute took effect, the annual distribution of findings, as shown in Table 3, was:

Table 3
Michigan GBMI Findings by Year

	n	%	Felony Filings[6]	%	Felony Dispositions[6]	%
1975[1]						
1976	12	5%				
1977[2]	22	10%	25,614	.09%	25,737	.09%
1978[2]	13	6%	17,384	.07%	18,817	.07%
1979	30	13%	39,476	.08%	39,602	.08%
1980	27	12%	---[5]	--	---[5]	--
1981	42	19%	---[5]	--	---[5]	--
1982	35	16%	35,962	.10%	40,902	.09%
1983	33	15%	43,650	.08%	48,724	.07%
1984[3]	8	4%	---[5]	--	---[5]	--
Total	222[4]	100%				

Notes:

1. GBMI statute effective August 6, 1975.
2. Figures do not include the Detroit Recorder's Court.
3. Includes cases committed to the DOC through June 15, 1984.
4. Missing cases = 17.
5. Data unavailable.
6. Statewide figures provided by the Michigan Administrative Office of the Courts. Figures are for fiscal years.

This information is presented at this point solely for descriptive purposes. Once an overview is provided for each of the three states, the observed relationships will be discussed in detail.

2. GBMI Case Processing Characteristics

a. Georgia

Of the 42 circuits in Georgia, only 8 had not handled a GBMI case by July 15, 1984. The circuit court rendering the most GBMI verdicts was

Atlanta (n =29; 18%), followed by the Stone Mountain (n=14; 9%) and Augusta (n=12; 7%) circuits. As might be expected, these circuits encompass the metropolitan Atlanta area and the city of Augusta. Table 4 provides an overview of the distribution of cases by circuit.

Table 4
Georgia GBMI Cases By Circuit

Circuit	n	%	Circuit	n	%
Alcovy	5	3%	Middle	2	1%
Atlanta	29	18%	Mountain	2	1%
Augusta	12	7%	Northeastern	1	1%
Blue Ridge	5	3%	Northern	2	1%
Brunswick	3	2%	Ocmulgee	1	1%
Chattahoochee	1	1%	Ogeechee	4	2%
Cherokee	2	1%	Piedmont	4	2%
Clayton	2	1%	Rome	6	4%
Conasauga	4	2%	South Georgia	4	2%
Cordele	3	2%	Southern	7	4%
Dougherty	6	4%	Southwestern	4	2%
Eastern	7	4%	Stone Mountain	14	9%
Flint	3	2%	Tallapoosa	2	1%
Gwinnett	2	1%	Tifton	6	4%
Houston	1	1%	Waycross	2	1%
Lookout	2	1%	Western	2	1%
Macon	8	5%			
			Total	161[1]	100%

Notes:

1. Missing cases = 11.

A total of 72 judges handled the 151 cases for which a presiding judicial officer was noted. Of the 72 judges with GBMI experience, 71% (n=51) handled one or two cases. Thirteen judges (18%) had rendered three such verdicts and eight handled between four and seven GBMI cases.

The GBMI cases reviewed during data collection emanated from 57 (36%) of the 159 counties in Georgia. The counties with the most cases included Fulton (n-29; 17%), DeKalb (n=14; 9%), and Richmond (n=11; 7%). The statewide distribution by county is presented in Table 5.

Table 5
Georgia GBMI Findings by County

County	n	%	County	n	%
Appling	1	.6%	Gwinnett	2	1.0%
Bacon	1	.6%	Habersham	1	.6%
Barrow	1	.6%	Hall	2	1.0%
Bartow	2	1.0%	Haralson	1	.6%
Ben Hill	2	1.0%	Henry	1	.6%
Bibb	8	5.0%	Houston	1	.6%
Brooks	1	.6%	Jackson	2	1.0%
Bulloch	3	2.0%	Lee	1	.6%
Burke	1	.6%	Lowndes	6	4.0%
Butts	2	1.0%	Madison	1	.6%
Camden	2	1.0%	Mitchell	1	.6%
Chatham	7	4.0%	Murray	3	2.0%
Cherokee	3	2.0%	Muscogee	1	.6%
Clarke	3	2.0%	Newton	1	.6%
Clayton	2	1.0%	Paulding	1	.6%
Cobb	3	2.0%	Pickens	1	.6%
Columbia	1	.6%	Putnam	1	.6%
Decatur	2	1.0%	Rabun	1	.6%
DeKalb	14	9.0%	Richmond	11	7.0%
Dodge	1	.6%	Stewart	1	.6%
Dooly	1	.6%	Sumter	2	1.0%
Doughterty	6	4.0%	Tift	3	2.0%
Elbert	1	.6%	Walker	2	1.0%
Emanuel	1	.6%	Walton	4	2.0%
Floyd	6	4.0%	Ware	1	.6%
Forsyth	1	.6%	Washington	1	.6%
Fulton	29	17.0%	Whitfield	1	.6%
Glynn	1	.6%	Worth	3	2.0%
Grady	1	.6%			
			Total	164[1]	99%*

Notes:

1. Missing cases = 8.

*Less than 100% due to rounding.

The data pertaining to pretrial evaluations of GBMI offenders were quite limited. Review of the DOR case files revealed that pretrial forensic examination reports were rarely incorporated into the offenders' correctional records. Reports may not be forwarded routinely to DOR or, if they are, they may not be routed to the central records office. In any case, the minimal amount of information obtained is not reported here

since it is not considered to be representative and might therefore be misleading.

Available records indicate that the great majority (n=137; 86%) of GBMI verdicts in Georgia are obtained by plea. Of the 160 cases for which such information was collected, only 9% (n=14) of the verdicts were rendered by jury trial and 5% (n=9) by bench trial. Table 6 provides an annual comparison of GBMI and NGRI findings by type of adjudication.

Table 6
Type of Adjudication

Year	Bench		Jury		Plea		Totals	
	GBMI	NGRI	GBMI	NGRI	GBMI	NGRI	GBMI	NGRI
1981		13		6		37		56
1982[1]		18	3	2	22	20	25	40
1983	6	12	4	2	78	28	88	42
1984[2]	3	*	7	*	34	*	44	*
	9	43	14	10	134	85	157[3]	138[4]

Notes:

1. GBMI statute effective 7/1/82, therefore, GBMI cases encompass a six month period during 1982. NGRI cases, however, span the entire year.
2. GBMI case file data collected through findings rendered as of 7/15/84.
3. Missing GBMI cases = 15.
4. Missing NGRI cases = 33.

* NGRI data not collected for 1984.

The files of 142 of the GBMI inmates contained reports from the GDCC indicating that postconviction evaluations were conducted. Of this group, some form of mental health sevices was recommended for 91 (64%). The kinds of mental health services suggested included individual and group counseling, substance abuse and sex offender counseling, impulse control assistance, and the administration of psychotropic medication. In 18 cases, no treatment recommendations were offered. The remaining 33 GBMI offenders (23%) were deemed not in need of treatment at the time of evaluation.

In most cases, the agency providing treatment was DOR. Unlike the Illinois corrections department which has not made use of existing mental health transfer procedures, the Georgia DOR transferred at least 17 GBMI offenders to DHR for the provision of intensive mental health services. Each of these individuals was transferred to the secure forensic unit at Central State Hospital in Milledgeville (see Part Two for a discussion of interagency transfer procedures.) The DOR treatment data included in the central files were generally limited to summaries included with the DHR transfer documentation or parole review summaries. With these limitations in mind, the following DOR institutions provided initial treatment services to 40 GBMI offenders.

Table 7
DOR Institutions Providing Initial Treatment

DOR Facility	n	%
GA Diag./Class. Ctr.	8	20%
Metro CI (Atlanta)	6	15%
Central CI	6	15%
Rutledge CI	6	15%
Augusta C&MI	5	13%
Coastal CI	3	7%
GA Industrial I.	2	5%
GA State Prison	2	5%
GA Women's CI	2	5%
Total	40	100%

Twenty-two of the GBMI offenders who received mental health services did not require psychotropic medication. Of those taking such medication, the most frequently prescribed drugs were Thorazine (n=10), Prolixin (n=7), Mellaril (n=7), and Cogentin (n=7).

Internal administrative procedures limit the institutional placement of GBMI offenders that require mental health services. A number of GBMI inmates, however, are not considered to be in need of such services. Thus, it is not surprising that the current or last location of

confinement indicates widespread placement throughout the state correctional system. The following table represents the placement distribution of GBMI offenders as of August 1984.

Table 8
Location of Confinement

Facility	n	%
Augusta C&MI	26	16.0%
Central CI	11	7.0%
Coastal CI	14	8.0%
GA Industrial I.	25	15.0%
GA Diag./Class. Ctr.	24	14.0%
GA Women's CI	11	.7%
Men's CI	2	.5%
Metro CI	25	15.0%
Putnam CI	1	.5%
Rutledge CI	13	8.0%
Walker CI	1	.5%
Ware CI	1	.5%
Youth. Off. CI	1	.5%
VA Hospital	1	.5%
Central State Hospital	3	2.0%
Total	166	99%*

Notes:

* Less than 100% due to rounding.

At the time of data collection, 83% (n=132) of the GBMI offenders studied were still in DOR custody. One inmate died in custody (4%). Of the remaining 26 for whom data were available, the type of release indicated in the case files were as follows:

Table 9
Type of Release

	n	%
Paroled	11	42%
Discharged[1]	11	42%
Probation[2]	3	12%
Reversed on appeal	1	4%
Total	26*	100%

Notes:

1. Includes offenders whose sentences expired and whose sentences were commuted to time served.
2. Those released to serve the probation portion of a split sentence.
* Missing cases = 12.

Summary. Of the 36 circuit courts in Georgia that had rendered GBMI verdicts resulting in incarceration, the circuits processing the largest propotion of GBMI cases were Atlanta, Stone Mountain, and Augusta. Seventy-two judges have had GBMI case experience, however, the majority (71%) have handled only one or two cases. GBMI cases have been channeled into the criminal jutice system from only 36% of the coutnies in the state. As would be expected, 66% of the cases came from urban counties.

Virtually all of the GBMI offenders committed to the DOR received postconviction mental health evaluations. Mental health treatment was recommended for at least 64% of those examined. The majority of the offenders in need of treatment received mental health services through DOR. However, at least 17 GBMI inmates were transferred to DHR for intensive treatment.

At the time of the study, Georgia's GBMI offenders were housed in fourteen of the DOR's facilities. Four additional inmates were receiving

treatment at mental health facilities. In addition, 83% of the population studies were still in custody in August 1984.

b. Illinois

Of the 133 cases that have resulted in GBMI verdicts in Illinois, every circuit handled at least one except the Eighth Circuit Court. A plurality of the GBMI verdicts were rendered by one of three circuit courts: Cook County Circuit (26%), Tenth Circuit (10%), and Nineteenth Circuit (9%). The breakdown for the entire state is presented in Table 10:

Table 10
GBMI Cases by Circuit Court

Circuit	n	%	Circuit	n	%
Cook	34	26%	11th	3	2%
1st	5	4%	12th	8	6%
2nd	3	2%	13th	6	5%
3rd	1	1%	14th	4	3%
4th	2	1%	15th	5	4%
5th	2	1%	16th	4	3%
6th	3	2%	17th	5	4%
7th	6	5%	18th	5	4%
8th	0	--	19th	12	9%
9th	4	3%	20th	5	4%
10th	13	10%	TOTAL	130*	100%

Notes:

* Missing cases = 3.

In all, the 131 cases (for which data were available) were handled by a total of 83 judges. Seventy-four of those judges handled one or two cases each. Nine judges, however, had more extensive experience with GBMI cases, with each rendering between three and seven GBMI findings.

Of the 102 counties in the state, GBMI verdicts have been rendered in 43 (42%). As evident from the preceding data, the largest proportion were from Cook County (26%; n = 34). Lake and Peoria Counties

contributed 10 cases or 7% each. Table 11 provides a complete picture of GBMI verdicts by county.

Table 11
Illinois GBMI Findings by County

County	n	%	County	n	%
Boone	2	1%	Livingston	1	1%
Bureau	1	1%	Madison	1	1%
Clark	1	1%	Marion	2	1%
Coles	1	1%	McClean	3	2%
Cook	34	26%	McHenry	2	1%
DeKalb	1	1%	Mercer	1	1%
Douglas	1	1%	Morgan	3	2%
DuPage	5	4%	Moultrie	1	1%
Ford	1	1%	Peoria	10	8%
Franklin	1	1%	Perry	2	1%
Fulton	1	1%	Piatt	1	1%
Grundy	1	1%	Rock Island	2	1%
Hancock	1	1%	Sangamon	2	1%
Jackson	3	2%	Stark	2	1%
Jefferson	1	1%	St. Clair	3	2%
Kane	2	1%	Stephenson	3	2%
Kankakee	8	6%	Tazewell	1	1%
Kendall	1	1%	Union	1	1%
Knox	2	1%	Whiteside	1	1%
Lake	10	8%	Will	1	1%
LaSalle	4	3%	Winnebago	3	2%
Lee	3	2%			
			Total	131*	99%**

Notes:

* Missing cases = 2.
** Less than 100% due to rounding.

By grouping the counties according to the Census Bureau's urban/rural index, a measure can be obtained for the proportion of GBMI cases emanating from urban and rural areas. As one would expect, an overwhelming majority of the GBMI verdicts occur in urban counties. Specifically, 83% (n = 109) of the GBMI verdicts were rendered in counties designated by the Census Bureau as being more than 50% urban.

Due to the decentralized nature of Illinois' pretrial forensic evaluation process, information about this portion of the process is limited. DOC records for 44 offenders (33% of the GBMI population) contained data about the type of pretrial evaluation conducted. For most defendants (n=25; 56%), both competency and criminal responsibility evaluations were conducted at the same time. Official records indicate that of the 44 defendants, at least 17 (33%) were evaluated more than once prior to adjudication.

Even less data are available about the location in which pretrial evaluations occur. A certain amount of variation would be expected, considering the numerous possibilities available to the 102 counties in the state. Although such information could be obtained for only 31 cases, this expectation appears to be supported. Twelve evaluations (39%) were conducted in a county jail. The remaining 31 evaluations took place at a court clinic or specialized forensic facility (n=9; 29%), a community mental health facility (n=4; 13%), a state mental health facility (n=4;13%), or in a doctor's office (n=2; 6%).

A total of 66 pretrial evaluation reports were reviewed during data collection. Of the evaluations conducted at the request of the prosecution, 60% were completed by a mental health professional employed by a state or county agency (n = 21). The other 40% were conducted by a private practitioner (n = 14). The proportions are similar for the 31 evaluations for which records were reviewed in which defense counsel requested the examination, with 68% (n = 21) conducted by a government employee and 34% (n = 10) by a private professional.

The findings and recommendations of pretrial examinations conducted at the request of prosecutors and defense attorneys differ slightly. Of the 131 records reviewed, 29 cases contained evaluation reports submitted by both prosecution and defense counsel. In seven cases (24%), the initial issue raised was that of competency. There was complete agreement between the defense and prosecution experts in each of these cases, with four defendants recommended as unfit and three as fit for trial. Divergent recommendations were evident, however, when the issue of criminal responsibility was addressed. Experts for the prosecution found no mental illness in 10 cases as opposed to two by defense experts. In addition, findings of mental illness that did not meet the criteria for legal insanity were more frequently offered by defense evaluators (n = 15) than experts for the prosecution (n = 9). Recommendations in favor of insanity acquittals were more similar with three and five for prosecution and defense experts respectively.

Available data pertaining to the type of adjudication were sparse. Of the 89 cases in which such information was obtained, the majority of the findings (n = 65; 58%) were reached by plea. It is likely that this proportion is actually higher since at least 78 offenders entered a GBMI plea during pretrial proceedings. Bench trials resulted in another 20 GBMI findings (23%) while the smallest number were rendered by jury trial (n = 11; 12%). Table 12 summarizes this distribution by year for those cases where this was possible.

Table 12
GBMI Findings by Year and Type of Adjudication

	Bench	Jury	Plea	Unknown	Totals
1981[1]		2	5	3	10 (8%)
1982	6	3	23	11	43 (33%)
1983	8	5	23	23	59 (46%)
1984[2]	5	1	6	5	17 (13%)
	19	11	57	42	129*(100%)

Notes:

1. GBMI statute effective September 17, 1981.
2. Includes cases through May 15, 1984.
3. Missing cases = 4.

Following a finding of GBMI, presentence investigations were conducted for at least 70 of the offenders. Of these 70 individuals, only four (6%) received favorable recommendations for probation placement. (There may well be other defendants who were found GBMI and placed on probation, however, this subgroup could not be included in the study population). Each of the four individuals sentenced to probation ultimately had their probation revoked, which placed them in the DOC GBMI population studied.

Case file records of 128 GBMI offenders indicate that a postconviction mental health evaluation was conducted following commitment to the DOC. Detailed documentation was available for 121 cases, including treatment recommendations as follows:

Table 13

Treatment Recommendations for GBMI Offenders

	n	%
No Recommendation	22	18%
No Treatment	8	7%
Treatment	39	32%
Medication only[1]	52	43%
Total	121*	100%

Notes:

1. The only treatment recommendation information evident in the evaluation report pertained solely to psychotropic medication.
* Missing cases = 12.

Limited data concerning the actual provision of mental health services were also collected. (It should be noted that individual counselors and mental health professionals maintain separate treatment records that were not accessible by research staff. The extent of formal treatment documentation in each inmate file, therefore, varies considerably depending on the recordkeeping habits of each counselor.) The records of 48 of the 131 GBMI offenders studied (37%) contained information about treatment. Of these 48 offenders, the majority (n = 69; 33%) received some form of mental health services including individual and/or group counseling, sex offender programming, assistance with substance abuse problems, and psychotropic medication. Records for fifteen (31%) of the GBMI offenders indicated that no mental health treatment was provided other than psychotropic medication.

On the other hand, the administration of psychotropic medication was well documented in the case files examined. Of the 131 files reviewed, 116 offenders (89%) received at least one type of medication. The drugs

most frequently given were Sinequan (n = 15), Thorazine (n = 13), and Mellaril (n = 11).

The GBMI offenders who received mental health services were all treated by the DOC except one who was transferred to the DMHDD as incompetent for sentencing. Of the 122 individuals for whom treatment information was available, the nine primary DOC treating facilities were:

Table 14

DOC Facilities Providing Initial Treatment

Facility	n	%
Menard Psych	64	52%
Sheridan	9	7%
Dwight[1]	9	7%
Joliet	8	7%
Menard	8	7%
Logan	6	5%
Graham	3	2%
Centralia	2	2%
Pontiac	2	2%
No treatment	11	9%
Total	122*	100%

Notes:

1. Dwight Correctional Center is the DOC's female facility.
* Missing cases = 9.

An effort was made to track any institutional transfers executed for the purpose of providing mental health services. Nineteen GBMI offenders were transferred for this reason, all to the Menard Psychiatric Center. As one would expect, the data simply verify the anticipated use of the DOC's specialized psychiatric facility in Chester.

Although Menard Psychiatric Center is clearly the placement of choice for GBMI offenders requiring intensive mental health treatment, GBMI offenders are routinely assigned to DOC facilities throughout the

state. The twelve facilities representing the institution of current confinement (or last point of confinement for those released) are listed in Table 15:

Table 15

Location of Confinement

Facility	n	%
Menard Psych[1]	51	38%
Menard[1]	21	16%
Sheridan[2]	11	8%
Logan[2]	10	7%
Dwight[4]	9	7%
Centralia[2]	7	5%
Joliet[1]	6	5%
Graham[2]	5	4%
Pontiac[1]	5	4%
Stateville[1]	5	4%
Vienna[3]	2	1%
Vandalia[2]	1	1%
Total	133	100%

Notes:

1. Maximum security facility.
2. Medium security facility.
3. Minimum security facility.
4. Female facility, all custody levels.

It is clear that the majority of GBMI offenders (66%; n = 88) are assigned to maximum security facilities in Illinois. Only one GBMI offender has been placed in a minimum security institution. In addition, the data indicate that 79 (61%) of the incarcerated GBMI population are assigned to the general prison population. Those GBMI offenders (n = 39; 51%) assigned to Menard Psychiatric Center are, due to treatment needs, housed in what project staff have defined as a specialized mental health facility or unit.

Data collection activities in Illinois encompassed a two week period in the middle of June, 1984. At that time, 85 (70%) of the 133 GBMI offenders were still in DOC custody. Four inmates (3%) were released when their sentences expired. Thirty-two (26%) were released on mandatory supervised release. Finally, one GBMI offender (1%) died in custody.

Summary. Between September 17, 1981 and May 15, 1984 (2.75 years), 133 GBMI findings were rendered that resulted in DOC commitment. The verdict has been used statewide, encompassing 20 of the 21 state judicial circuits and 43 of the 102 counties.

Unfortunately, the localized pretrial forensic evaluation process hampered the collection of representative information about pretrial examinations. However, it is clear that both government and private mental health professionals are conducting pretrial evaluations in a variety of locations. It would appear that the consensus that is often achieved among defense and prosecution experts on the issue of competency does not necessarily hold for issues of criminal responsibility.

Data on the means of adjudicating GBMI offenders were also limited. The available data indicate that most GBMI verdicts are the result of a plea. Following conviction, virtually all members of the study population received a postconviction evaluation prior to institutional placement. Some form of treatment was recommended for 75% of the GBMI offenders and available data indicate that most do in fact receive treatment during their incarceration. Most GBMI inmates are assigned to

maximum security facilities and, due to the relatively short time frame involved, only 36 had been released from custody at the time of the study.

c. Michigan

Of the 239 GBMI cases that resulted in incarceration, data were collected for 232 of the offenders. These cases were spread over 33 of the circuit courts and the Detroit Recorder's Court. As would be expected, the largest proportion of GBMI cases were rendered in the Detroit Recorder's Court (31%; n = 71). The Third Circuit Court was second, deciding 13% (n = 30) of the cases in the state, with the Seventh Circuit placing a distant third at 8% (n = 19). The distribution of cases in the remaining 31 courts was as follows:

Number Cases	Number Courts
1-3	23
4-6	3
7-14	5
Total	31

Within these courts, the GBMI cases were handled by a total of 132 judges. The judge with the most experience was involved with eight cases. Ninety-two percent of the judges, however, handled between one and three cases each.

A delineation of cases by county yields a similar pattern to that noted above. Thirty-six counties in Michigan have generated GBMI cases, with 75% (n=170) coming from only six counties. As can be surmised from the court data, a plurality (43%; n=99) of the cases occurred in Wayne county. Table 16 details the GBMI findings for the state by county.

Table 16
Michigan GBMI Findings by County

	n	%		n	%
Alger	1	.4%	Macomb	6	3.0%
Alpena	1	.4%	Manistee	1	.4%
Bay	2	.8%	Marquette	3	1.0%
Berrien	1	.4%	Menominee	1	.4%
Calhoun	2	.8%	Midland	2	.8%
Cass	1	.4%	Monroe	4	2.0%
Crawford	1	.4%	Montcalm	1	.4%
Delta	1	.4%	Muskegon	3	1.0%
Eaton	1	.4%	Oakland	15	7.0%
Genesee	18	8.0%	Ontonagan	1	.4%
Gogebic	1	.4%	Ottawa	1	.4%
Huron	1	.4%	Presque Isle	1	.4%
Ingham	13	6.0%	Saginaw	11	5.0%
Iosco	1	.4%	Shiawassee	1	.4%
Iron	1	.4%	St. Clair	3	1.0%
Jackson	3	1.0%	Washtenaw	8	3.0%
Kalamazoo	6	3.0%	Wayne	99	43.0%
Kent	14	6.0%			
Livingston	2	.8%	Total	232*	100.4%**

Notes:

* Missing cases = 7.
** Greater than 100% due to rounding.

Data were available for 223 of the GBMI cases (94%). The initial pretrial evaluation records for most offenders (n=202; 85%), regardless of whether the examination was requested by the prosecution, defense, or the court itself, indicate that the exam was conducted by a state or local government mental health professional. Recalling the centralized evaluation process described earlier, it is no surprise that 74% (n=166) of the defendants were evaluated at CFP and another 22% (n=49) at the Detroit Recorder's Court Clinic. The initial examination for 95 offenders (43%) involved only a competency evaluation. Twenty-six percent (n=57) received only a criminal responsibility exam while both competency and criminal responsibility evaluations were conducted for 29%

(n=65) of the defendants. Interestingly, the records for three of the individuals indicated that a specific determination concerning the GBMI verdict was requested. At least 142 of the defendants (61%) received more than one forensic evaluation before a verdict was rendered.

Pretrial recommendations focusing on competency and/or criminal responsibility were included in the records of 225 defendants (95%). Grouped by requestor (e.g., (1) court or prosecution and (2) defense), some variation in the findings appear. For example, a larger proportion (13%) of the cases evaluated for the defense recommended NGRI findings than those conducted for the prosecution or court (5%). In addition, evaluations initiated by the state were more likely to result in a finding unfavorable to an insanity acquittal (39% as opposed to 4% for defense evaluations). The following table provides a more complete portrait of the recommendations embedded in the pretrial evaluation records of defendants ultimately found GBMI:

Table 17
Pre-Trial Recommendation by Requestor

	Requestor			
	Court/ Prosecution		Defense	
	n	%	n	%
NGRI	7	3%	8	13%
Mentally ill	32	14%	10	17%
Responsible	56	25%	1	2%
Competent	46	20%	4	7%
Incompetent	32	14%	3	5%
Competent & Sane	32	14%	1	2%
Incompetent & Insane	5	2%	--	--
No recommendation	15	7%	32	54%
Total	225	99%*	59	100%

Notes:

* Less than 100% due to rounding.

A review of the methods by which GBMI verdicts are rendered suggests that pleas are the most frequent. Of the 211 GBMI cases for which such data were collected, 51% (n=107) were obtained by plea, 29% (n=61) by jury trial, and 20% (n=43) by bench trial. Adjudication information is presented by year in Table 18.

Table 18
GBMI Findings by Year and Type of Adjudication

Year	Bench	Jury	Plea	Total
1975[1]				
1976		4	7	11
1977	3	5	11	19
1978	4	4	4	12
1979	4	9	15	28
1980	3	8	16	27
1981	10	13	18	41
1982	8	3	22	33
1983	9	12	12	33
1984[2]	2	3	2	7
	43 (20%)	61 (29%)	107 (51%)	211*

Notes:

1. GBMI statute effective August 6, 1975. Cases therefore encompass a five-month period for 1975.
2. Includes cases committed to the DOC through June 15, 1984.

* Missing cases = 28.

Official case file records indicate that, upon conviction, at least 217 GBMI offenders (91%) received mental health evaluations at a DOC diagnostic facility. Of those known to be evaluated, 171 (72%) were recommended for some form of mental health services including psychotherapy, individual or group counseling, sex offender or substance abuse assistance programs, and/or psychotropic medication. Information about the actual provision of treatment was less complete than diagnostic data.

Of the 114 files of GBMI offenders examined closely, (limited by the type and location of available treatment information), 72 (63%) received some type of mental health services in accordance with the recommendations reported above. Many (at least 25) were treated on a weekly basis, while 11 received daily professional attention. The medication most frequently administered was Thorazine (12%; n=17), followed by Prolixin (10%; n=14) and Cogentin (9%; n=12 with an N of 144). At least 67 of the incarcerated GBMI offenders required no psychotropic medication.

The initial period of mental health treatment for most of the GBMI group (76%; n=120) was provided by the DOC. It is understandable that our data would indicate the institutions most frequently providing services as the SPSM and the Riverside psychiatric facility. In at least seven instances (4%), the GBMI inmate was transferred to the DMH for intensive treatment at CFP (n=6) or Northville (n=1). In 70 cases, a second period of treatment was instituted following an administrative transfer specifically for that purpose. Of those transferred, 60% (n=42) were moved from DOC institutions to DMH facilities. The vast majority (90%; n=38) were transferred to the CFP. Again, most of those transferred within the DOC entered SPSM or Riverside for continuation of mental health treatment. As of mid-July 1984, the largest proportions of GBMI offenders were confined at SPSM (20%) and Riverside (17%). The distribution of incarcerated GBMI felons is presented in Table 19.

Table 19
Location of Confinement

Facility	n	%
SPSM	63	39.0%
Riverside	40	25.0%
Kinross	14	9.0%
HVWF	11	7.0%
Ionia	9	5.0%
CFP-DMH	8	5.0%
Marquette	7	4.0%
HVMF	2	1.0%
Muskegon	2	1.0%
Comp Ojibway	1	.6%
Cassidy	1	.6%
Ingham Med. Ctr.	1	.6%
Michigan Trng Unit	1	.6%
Parole Camp	1	.6%
Reception Center	1	.6%
Waterloo	1	.6%
Subtotal	163	100.2%**
Released to court	2	
Total	165*	

Notes:

* Missing cases = 74.
** Greater than 100% due to rounding.

Corrections case files indicated that at least 76 of the 239 GBMI offenders (24%) were no longer in custody ten years after the alternative verdict was instituted. Most of the inmates (74%; n=56) were released on parole. At least 9% (n=7) entered the community with the stipulation that outpatient mental health treatment be obtained. Data describing the type of release mechanisms for GBMI offenders in Michigan are presented in the following table:

Table 20
Type of Release

	n	%
Paroled	56	74%
Furlough/Outpatient	8	10%
Sentence expired*	7	9%
Reversed on appeal	2	3%
Absconded	2	3%
Deceased	1	1%
Total	76	100%

Notes:

* Includes five offenders whose sentences were commuted to time served.

Summary. During the ten years since the GBMI verdict was implemented in Michigan, 239 offenders have been found GBMI and committed to the DOC. The majority of the GBMI cases have come from major metropolitan areas. Fifty one percent of the GBMI findings were obtained by plea, 29% by jury trial, and the remainder by bench trial.

Once incarcerated and evaluated, 72% of the offenders were deemed in need of mental health services. Available data indicated that at least 63% actually received some form of mental health treatment while in prison. At least 7 offenders were transferred to CFP for initial intensive services. Following periods of treatment at DOC facilities, an additional 42 inmates were transferred to CFP for treatment. Only 24% of the GBMI offenders have been released from prison, the majority on parole.

3. Characteristics of GBMI Offenders

a. Georgia

The demographic composition of Georgia's incarcerated GBMI offenders is basically male and youthful. Of the offenders for whom information was obtained, 93% (n = 156) are male and a corresponding 7% (n = 11) are

female. The average age at conviction was 31, with a range from 15-74 years old. A more comprehensive look at age is presented below.

Table 21
Age at Conviction

Age Range	n	%
15 - 25 yrs.	64	39%
26 - 35 yrs.	66	40%
36 - 45 yrs.	16	10%
46 - 55 yrs.	13	8%
56 and over	5	3%
Total	164*	100%

Notes:

* Missing cases = 8.

The race of GBMI offenders is split almost evenly between whites and nonwhites with 52% (n = 88) and 48% (n = 80) falling into the two respective categories. In comparison, the overall prison population in Georgia (as of May 1984) is 95% male and 5% female, 41% and 59% white and nonwhite respectively, and the average age is 30 years old.

The data indicate that the largest proportion of GBMI offenders were both charged and convicted of crimes against persons. Fifteen percent (n = 25) were convicted of murder, manslaughter, or attempted murder and 23% (n = 39) were involved in sexual offenses. In comparison, 15% of the general prison population was also convicted of murder, however, only 7% were incarcerated for sex offenses. In addition, 20% of DOR inmates committed robberies compared with 8% of the GBMI offenders. Furthermore, 46% (n = 77) of the GBMI offenders were convicted of more than one offense, although 52% (n = 88) had originally been charged with multiple offenses. Complete charge and conviction data for the most serious offenses committed by GBMI offenders are presented in Table 22.

Table 22

GBMI Offenses by Charge and Conviction

Offense	Charge		Conviction	
	n	%	n	%
Murder[1]	25	15%	25	15%
Sexual-Adult	13	8%	10	6%
Sexual-Child	29	17%	29	17%
Robbery	16	9%	14	8%
Kidnapping	6	4%	5	3%
Assaults	30	18%	34	20%
Arson	4	2%	5	3%
Burglary	20	12%	22	13%
Theft	19	11%	19	11%
Other	6	4%	5	3%
Total	168*	100%	168*	99%**

Notes:

1. Includes manslaughter and attempted murder.
* Missing cases = 4.
** Less than 100% due to rounding.

Pretrial diagnostic data were available for only 34 (20%) GBMI offenders. Due to the risk of misrepresentation, these data will not be reported here. Postsentence diagnostic information, on the other hand, was more readily available. Of the 134 GBMI offenders whose DOR records included such data, the largest proportion (39%) were labeled as psychotic. A complete breakdown by postconviction evaluation diagnosis is presented below.

Table 23

Post-conviction Diagnoses
for GBMI Offenders

	n	%
Psychotic	52	39%
Affective Disorder	2	2%
Nonpsychotic Disorder	36	27%
Unspecified M.I.	3	2%
No mental illness	28	20%
No diagnosis	13	10%
Total	134*	100%

Notes:

* Missing cases = 38.

The average sentence received by GBMI offenders was 11.76 years, with a range of 1 - 50 years (excluding life sentences). In comparison, the average sentence for all offenders committed to DOR is just over nine years. Of the 166 offenders for whom sentencing data were collected, the largest proportion (33%; n=53) received sentences of between 6-10 years. Eleven percent (n = 18) were sentenced to life imprisonment. In addition, 54 (33%) received split sentences that required a period of between 2 and 29 years be served on probation after a period of incarceration. This is no different from the rest of the inmate population of whom 30% received split sentences. As a whole, the sentences received by GBMI and non-GBMI inmates were:

Table 24

Sentences Received by GBMI and Guilty Offenders

	GBMI		Guilty[1]	
Sentence	n	%	n	%
1 - 5 yrs.	38	23%	5,229	36%
6 - 10 yrs.	53	33%	3,779	26%
11 - 15 yrs.	21	12%	1,712	12%
16 and over	36	21%	1,788	12%
Life	18	11%	2,048	14%
Total	166*	100%	14,556	100%

Notes:

1. Data taken from aggregate DOR data for entire prison population minus GBMI offenders.
* Missing cases = 6.

As of August 1984, at least 27 GBMI offenders had been released from prison. Of the 25 for whom confinement periods could be calculated, 18 (72%) served less than one year. The remaining 7 inmates served between one and two years.

Criminal history information was available for 136 of the GBMI offenders. Of the 136, 23% (n = 31) had no prior record compared to 14% of the non-GBMI population. Of those with a prior record, only one had been convicted of murder. The majority (79%) had been convicted of property crimes. In addition, 63% (n = 85) had never been incarcerated prior to the instant offense(s). This was higher than the proportion of guilty offenders in this category (52%).

Information pertaining to the mental health history was located and collected for 109 GBMI offenders. Of the 109 inmates, 15 (13%) had no prior mental health contacts. However, 72% (n = 78) had been committed to a state mental health facility and another 15% (n = 16) received

treatment at Veteran's Administration, military, community, or private mental health facilties. At least 25% (n = 28) of those treated were in an involuntary patient status at the time. Two individuals were admitted by their parents to psychiatric facilties while minors. Five others had been found NGRI and seven were deemed incompetent to stand trial at some point prior to the instant offense(s).

Summary. Incarcerated GBMI offenders in Georgia tend to be males who are relatively young, usually under 35 years of age. The racial composition is almost a fifty-fifty split between whites and nonwhites. Furthermore, GBMI inmates tend to be convicted of serious crimes against persons as opposed to being property offenses. The majority of the offenders were sentenced to 10 years or less although 11% received sentences of life imprisonment. However, guilty offenders appear to get shorter sentences overall (36% received 1-5 year sentences as opposed to 23% for GBMIs and 12% received sentences of 16 years or longer as compared to 21% of GBMIs). In addition, most members of the GBMI population had both some prior criminal and mental health history.

b. Illinois

Of the 133 GBMI offenders incarcerated in Illinois as of June 15, 1984, 93% (n = 124) were male and 7% (n = 9) were female. This breakdown is similar to that of the total prison population (97% male, 3% female). The racial composition of the GBMI group was determined to be 70% white (n = 92) and 30% nonwhite (n = 39). This contrasts sharply with the racial composition of the overall prison population which is virtually the exact opposite (32% white, 68% nonwhite). In contrast, as Table 25

indicates, the GBMI population's proportions by age mirror that of the general prison population.

Table 25
Age of GBMI and Guilty Offenders

Age Range	GBMI Offenders	Total DOC
17-25 yrs	37%	39%
26-40 yrs	52%	52%
41 and over	11%	9%
Total	100%	100%

Of the 131 GBMI offenders for whom data were obtained, the most serious offense charged was grouped into nine categories for descriptive purposes. The largest proportion of offenders (28%) were charged with murder, followed by defendants accused of committing criminal sexual acts with a child (15%). Fifty-five percent (n = 71) were charged with only one crime while the remainder were charged with two or more offenses. Of those charged with two or more crimes, only one (1%) was charged with murder and 11 (8%) included serious sexual offenses.

Very little variation is evident between the original offense(s) charged and the offense(s) of conviction. A proportional comparison of the most serious conviction offenses reveals that 25% (n = 33) of the GBMI offenders were convicted of murder. Sex offenses accounted for another 22% (n = 28) of the convictions. The majority of the GBMI inmates (n = 85; 65%) were convicted of only one offense. Of those convicted of multiple offenses, only one included a second conviction for murder. A complete delineation of the most serious charges and conviction offenses is presented in Table 26.

Table 26

GBMI Offenses by Charge and Conviction

	Offense Charged		Conviction Offense	
	n	%	n	%
Murder[1]	36	28%	33	25%
Sex Offenses[2]	10	8%	9	7%
Sex Offenses[3]	20	15%	19	15%
Robbery	8	6%	7	5%
Personal Injury	15	11%	19	15%
Arson	7	5%	9	7%
Burglary	16	12%	15	12%
Thefts	6	5%	7	5%
Other	13	10%	12	9%
Total	131*	100%	130**	100%

Notes:

1. Includes manslaughter and attempted murders.
2. Includes all sexual offenses involving an adult victim.
3. Includes all sexual offenses involving a child victim.
* Missing cases = 2.
** Missing cases = 3.

Diagnoses offered following pretrial forensic evaluations varied depending on whether the examination was conducted at the request of the prosecution or defense. More comprehensive diagnostic data were available from the postconviction evaluation reports completed by DOC classification staff. Table 27 presents comparative diagnostic data for pretrial and postconviction evaluations.

Illinois' determinate sentencing structure involves the setting of minimum and maximum release dates. Focusing on potential minimum sentences, the majority of GBMI offenders (n = 79; 73%) fall into the 1-5 year sentence category. When maximum sentences were calculated, however, only 63% of the GBMI population remains in that category. The average maximum sentence was 5.34 years, and the average minimum sentence received by GBMI offenders was 3.44 years. The range for maximum and minimum sentences was 1-18 years and 2 months - 15 years respectively. The grouped sentencing data are presented in Table 28.

Tabel 27
Diagnosis[1] By Evaluation Type

		Psychotic[2]	Affective[3]	Non-Psychotic[4]	Organic[5]	Psycho-Sexual[6]	Subst. Abuse[7]	Mentally Ill[8]	None	Diagnosis[9]	Total
Pretrial Evaluation - Prosecution	n	9	2	5	1	2	1	2	6	15	43
	%	21%	5%	12%	2%	5%	2%	5%	13%	35%	100%
Pretrial Evaluation - Defense	n	14	2	12	1	1	1	2	1	10	44
	%	32%	5%	27%	2%	2%	2%	5%	2%	23%	100%
Post Conv. Evaluation - DOC	n	39	16	32	8	3	8	1	14	3	124
	%	31%	13%	26%	7%	2%	7%	1%	11%	2%	100%

Notes:

1. The DSM II and III were used to guide diagnostic classification.
2. Includes schizophrenia, paranoia, and other psychotic disorders.
3. Includes affective disorders such as depression and dysthymic, cyclothymic, and bipolar disorders.
4. Includes non-psychotic disorders such as personality disorders, neuroses, and schizoid personalities.
5. Includes all organically based mental disorders (except those related to substance abuse) such as mental retardation, organic brain syndrome, and developmental disabilities.
6. Includes pedophilia, sexual orientation disturbances, fetishism, etc.
7. Includes disorders related to alcohol or drug abuse.
8. Evaluation report indicated the existence of a mental illness without providing a specific diagnosis.
9. Includes those individuals who were not evaluated or for whom diagnosis was deferred.

Table 28
Minimum and Maximum Sentences Received
by GBMI Offenders

Sentence	Maximum n	Maximum %	Minimum n	Minimum %
1-5 yrs.	65	63%	73	79%
6-10 yrs.	26	25%	12	13%
11-15 yrs.	7	7%	6	7%
16-20 yrs.	5	5%	1	1%
Total	103*	100%	92**	100%

Notes:

* Missing cases = 30.
** Missing cases = 41.

The actual time served was calculated for the 26 GBMI offenders for whom the necessary data elements were available (i.e., release date minus conviction date). Of the 26, 50% (n = 13) were released in one year or less. The other 50% were confined between one and two years. The majority of the GBMI group (n = 70; 85%) were still in custody at the time of the study. In comparison, the average adult felon in 1982 was confined for 2.3 years with a range of .01-30.6 years. Although the maximum period noted is longer than any GBMI offender's sentence, the mean period of incarceration for guilty offenders is in line with that of at least 50% of the GBMI population.

The mental health history of incarcerated GBMI offenders is also of interest. Information was available for 91 of the 133 offenders in the population (68%). Of the 91 individuals, almost a third (n = 27; 30%) had no record of previous mental health treatment of any kind. Of the 62 offenders with at least one period of prior treatment, 65% (n = 40) had been treated in a state mental hospital. The remaining third were treated in private hospitals or by private mental health professional

(n = 7; 11%), at community mental health facilities (n = 7; 11%), at VA hospitals (n = 6; 10%), and in criminal or forensic facilities (n = 2; 3%). The majority (n = 56; 28%) received treatment on an involuntary basis (including two parental admissions of minors). Eighteen were held on involuntary civil commitments, four had been found incompetent to stand trial, and two had been acquitted by reason of insanity on earlier charges. Furthermore, 26% (n = 21) of the 131 GBMI offenders studied had experienced more than three prior periods of mental health treatment.

Information about the GBMI offenders' criminal history was also collected. Of the 129 individuals for whom data were available, 26% (n = 34) had no criminal history whatsoever. The most recent criminal record of the remaining 74% encompassed the following offenses:

Table 29
Prior Offenses Committed by GBMI Offenders

	n	%
Murder	1	1%
Sexual Offenses	8	6%
Serious Personal Crimes	31	24%
Serious Property Crimes	37	29%
Other	18	14%
Subtotal	95	74%
No record	34	26%
Total	129	100%

Sixty percent (n = 71) of the GBMI population had never been incarcerated before. However, 30% had served time in jail and/or prison on two or more occcasions in the past. In addition, 30% had completed at least one period of probation prior to the instant offense(s).

Of the 36 released offenders, 17% (6) had been rearrested. Three were convicted on new charges (one burglary, two public nuisance offenses) while the other three were returned to prison on parole violations.

Summary. The GBMI population in Illinois is predominantly white (70%), contrasting sharply with the racial composition of the prison population as a whole which is 68% nonwhite and 32% white. A majority of the offenders were charged with and convicted of only one offense, usually a crime against a person rather than a property crime.

Pretrial diagnostic data were limited, however, evaluations requested by the defense resulted in diagnoses of psychosis more frequently than those requested by the prosecution. Postconviction evaluations of GBMI offenders categorized 31% of the population as psychotic, 26% as nonpsychotic, and 13% as having affective disorders. Eleven percent were viewed as having no mental illness at the time of evaluation.

The typical minimum sentence imposed on a GBMI offender was within the 1-5 year range while maximum sentences ranged up to 20 years. Of the 26 GBMI offenders released thus far, 50% served one year or less. Eighty-five percent of the population was still in custody.

Approximately one third of the group had no record of prior mental health treatment while 26% had extensive treatment histories. In addition, 60% of the GBMI population had never been incarcerated before and 26% had no criminal history whatsoever.

c. Michigan

The majority of the GBMI population in Michigan, like the general prison population, is male with 220 men (95%) and 11 women (5%). Racially, the group is split 52% white (n = 121) and 48% (n = 110) nonwhite (including 103 Blacks, 3 Mideastern, 2 Hispanic, and one each Oriental and Native American). GBMI offenders range in age from 17 to 74

years old with an average age of 31 years. The age at conviction of the GBMI group can be presented as follows:

Table 30
Age of GBMI Offenders

Age Range	n	%
17 - 25 yrs.	80	36%
26 - 35 yrs.	84	38%
36 - 45 yrs.	40	18%
46 - 55 yrs.	15	7%
56 and over	3	1%
Total	222*	100%

Notes:

* Missing cases = 17.

A review of the most serious offenses with which GBMI offenders were charged indicates that many were involved in serious personal crimes. Forty-three percent (n = 99) were initially charged with murder, manslaughter, or attempted murder. Another 20% (n = 42) were accused of sex offenses. Property crimes and other less serious offenses accounted for 16% (n = 34) of the charges against the group. Fifty-two percent (n = 121) were charged with only one offense, however, of those accused of multiple crimes, 23 involved a second murder or attempted murder.

The effect of plea bargaining is evident by examining the most serious offense of conviction as compared with that charged.

Table 31
Murder Charges and Convictions Against GBMI Offenders

	Charge		Conviction	
	n	%	n	%
Murder	79	80%	43	44%
Manslaughter	4	4%	37	38%
Attempted Murder	16	16%	18	18%
Total	99	100%	98	100%

A large decrease from charge to conviction in the proportion falling into the murder category is evident. The effect of plea bargaining may also be evident in the dismissal of additional charges, which occurred on at least 32 occasions. Whereas 121 individuals (52%) were charged with only one offense, 153 offenders (66%) were convicted of only one offense. Furthermore, of those 23 offenders with second charges of murder, manslaughter, or attempted murder, only 13 were actually convicted on that second charge. A comparative table by charge and conviction is provided below.

Table 32
GBMI Offenses by Charge and Conviction

	Charge		Conviction	
	n	%	n	%
Murder[1]	99	43%	98	42%
Sex - adult	26	11%	25	11%
Sex - child	18	8%	16	7%
Robbery	33	14%	33	14%
Kidnapping	3	1%	2	1%
Assault	18	8%	22	9%
Arson	9	4%	11	5%
Burglary	11	5%	10	4%
Theft	6	3%	7	3%
Other	8	3%	8	3%
Total	231*	100%	232**	99%[2]

Notes:

1. Includes murder, manslaughter, and attempted murder.
2. Less than 100% due to rounding.
* Missing cases = 8.
** Missing cases = 7.

The pretrial and post-conviction diagnostic data vary somewhat, especially between pretrial and post-conviction evaluations. The proportion of those diagnosed as psychotic is much larger in the postconviction group. Concomitantly, a smaller proportion was

Table 33
Diagnosis[1] By Evaluation Type

		Psychotic[2]	Affective[3]	Non-Psychotic[4]	Organic[5]	Psycho-Sexual[6]	Subst. Abuse[7]	Mentally Ill[8]	None	No Diagnosis[9]	Total
Pretrial Evaluation - Prosecution/ Count	n	54	10	45	11	4	14	20	37	23	217
	%	25%	5%	21%	5%	1%	6%	9%	17%	11%	100%
Pretrial Evaluation - Defense	n	11	--	7	3	1	--	5	2	30	59
	%	19%	--	12%	5%	2%	--	8%	3%	51%	100%
Post Conv. Evaluation - DOC	n	81	8	47	13	3	8	18	11	33	222
	%	37%	4%	21%	6%	1%	3%	8%	5%	15%	100%

Notes:

1. The DSM II and III were used to guide diagnostic classification.
2. Includes schizophrenia, paranoia, and other psychotic disorders.
3. Includes affective disorders such as depression and dysthymic, cyclothymic, and bipolar disorders.
4. Includes non-psychotic disorders such as personality disorders, neuroses, and schizoid personalities.
5. Includes all organically based mental disorders (except those related to substance abuse) such as mental retardation, organic brain syndrome, and developmental disabilities.
6. Includes pedophilia, sexual orientation disturbances, fetishism, etc.
7. Includes disorders related to alcohol or drug abuse.
8. Evaluation report indicated the existence of a mental illness without providing a specific diagnosis.
9. Includes those individuals who were not evaluated or for whom diagnosis was deferred.

categorized as being free of mental illness at the postconviction stage than the pretrial point. As discussed earlier, many offenders may well have stabilized by the time they are incarcerated due to treatment during a period of incompetency to stand trial or treatment while in jail. A synopsis of the diagnostic information is provided in Table 33.

The sentencing structure in Michigan results in minimum and maximum sentences being imposed. Excluding life sentences, the average minimum and maximum sentences imposed on GBMI offenders were 7.8 years and 18.1 years respectively, with accompanying ranges of 6 months to 40 years and 6 months to 80 years. The most frequently imposed minimum and maximum sentences were 5 years and 15 years. A total of 30 GBMI offenders have received life sentences. Grouped minimum and maximum sentencing data are provided in Table 34.

Table 34
Sentences Imposed on GBMI Offenders

Sentence	Minimum		Maximum	
	n	%	n	%
1 - 5 yrs.	100	44%	34	15%
6 - 10 yrs.	55	24%	26	11%
11 - 15 yrs.	19	8%	64	28%
16 - 20 yrs.	14	6%	28	12%
21 - 25 yrs.	5	2%	14	6%
26 - 30 yrs.	2	1%	7	3%
31 and above	2	1%	24	11%
Life	30	13%	30	13%
Total	227*	99%**	227*	99%**
Range	6 mos.- 40 yrs.		6 mos. - 80 yrs.	
$\bar{x}$	7.85 yrs.		18.09 yrs.	

Notes:

* Missing cases = 12.
** Less than 100% due to rounding.

Since the GBMI verdict was instituted, at least 76 offenders convicted under the statute have been released fom the DOC (including one death). The actual length of confinement of the 69 released GBMI offenders (for whom such data could be compiled) has ranged from one year to nine years. The average period of incarceration was 4.45 years. The annual frequencies and proportions are as follows:

Table 35
Confinement in Years of GBMI Offender

Number of Years	n	%
1	3	4%
2	9	13%
3	11	16%
4	13	19%
5	14	20%
6	9	13%
7	4	6%
8	5	7%
9	1	1%
Total	69	99%*

*Less than 100% due to rounding.

An examination of the prior mental health treatment experiences of incarcerated GBMI offenders revealed that 23% (n = 48) had no mental health treatment history whatsoever. Of the 165 inmates who received treatment, the majority (53%) was treated in state mental facilities. Futhermore, fifty-one percent were treated on an involuntary basis. Of those receiving prior treatment, 38% had only one prior period of treatment. On the other hand, at least 50% experienced four or more instances of mental health treatment. Taken as a whole, the mental health history of the entire GBMI population included 6 NGRI findings, 67 findings of incompetent to stand trial, and 73 instances of involuntary civil commitment.

Criminal history records indicated that 25% (n = 54) of the 220 GBMI offenders (for whom data were available) had no prior convictions. Thirty-nine percent (n=81) had only one conviction in their records. Of the 75% (n = 166) with criminal records, 12 convictions for murder, manslaughter, or attempted murder were included. Only 5% had previous convictions for sex offenses. GBMI offenders did tend, however, to have previous convictions for personal crimes as opposed to property crimes. One offender had been found GBMI on a previous occasion in addition to the instant conviction.

Data on dispositions were available for 193 offenders. The majority (52%; n = 100) had never been incarcerated before. Fourteen percent (n = 27) served one prior prison term while the remaining 34% (n = 66) were incarcerated between two and seven times each prior to the instant confinement.

Michigan passed its GBMI statute more than nine years ago. Therefore, a review of recidivism information is more appropriate and meaningful for this state than the other two. Of the 67 offenders known to be released (excluding the one deceased inmate), the records at CFP and the DOC indicated that 9 (13%) had been rearrested. The records of 5 offenders included data pertaining to new convictions. Of the more serious offenses, the conviction offenses for this group included one murder, one sex offense, two arsons, and a robbery. Three individuals were charged with parole violations. Only one of the reconvicted offenders was found GBMI again.

In comparison, of 94 NGRIs known to be released, at least eight were rearrested. Three were convicted and incarcerated of offenses including assault, theft, and resisting a police officer. Of the 75 offenders in the guilty sample who had been released, at least 15 (20%) had been rearrested. Twelve were convicted and returned to prison. Their offenses included one arson, one burglary, four sex offenses, and seven thefts.

B. Comparisons Within States

1. Georgia

An examination of basic demographic variables in relation to findings indicated that there was no difference in the average age of NGRI acquittees ($\bar{x}$ = 31.31 years) and GBMI offenders ($\bar{x}$ = 30.75 years). In addition, as is usually the case, the majority of offenders in each verdict group were male; however, a significant difference in the corresponding proportions was evident (X^2 = 6.707, df = 1, p = .01). According to Table 36, it appears that a larger proportion of those found NGRI (16%; n = 25) than those found GBMI (7%; n = 11) are women.

Table 36
Sex of GBMI and NGRI Offenders

	Male n	%	Female n	%	Total n	%
GBMI	156	93%	11	7%	167[1]	100%
NGRI	136	84%	25	16%	161[2]	100%
Total	292	89%	36	11%	328	100%

Notes:

1. Missing cases = 5.
2. Missing cases = 10.

Unfortunately, the population of females in each group is limited and comparisons using a chi square technique may be invalid. It seems likely, however, that the relationship can be explained in terms of the offense committed. Of the murders and sex offenses committed by both verdict groups, 87% and 94% respectively were committed by men. Yet 21% (n = 4) of the NGRIs acquitted of murder and 22% (n = 2) acquitted of sex offenses were women.

Categorizing offenders on the race variable as white or nonwhite, a significant bivariate relationship is evident (X^2 = 14.776, df = 1, p = .0001). According to the following data, a larger proportion of insanity acquittees (69%; n = 111) are nonwhite than GBMI offenders (48%; n = 80).

Table 37

Finding by Race

	White n %	Nonwhite n %	Total n %
GBMI	88 (52%)	80 (48%)	168[1] (100%)
NGRI	51 (31%)	111 (69%)	162[2] (100%)
Total	139 (42%)	191 (58%)	330 (100%)

Notes:

1. Missing cases = 4.
2. Missinc cases = 9.

In an effort to explore this relationship, finding and race were examined while controlling for offense. A disproportionately large number of those found NGRI of crimes against persons ($X^2 = 5.42$, df = 1, p = .02) and minor offenses such as trespass and disorderly conduct ($X^2 = 8.25$, df = 1, p = .004) were nonwhite defendants (see Table 38). Although the expected cell sizes in the minor offense table are problematic, discussions with staff on-site and observations of the project team tend to lend credence to this finding.

Clearly, the offense committed is an important factor in case outcome. A larger proportion of defendants charged with sex offenses are found GBMI (82%; n = 42) as opposed to NGRI (18%; n = 9). As noted previously, of those obtaining NGRI verdicts, 35% (n = 56) and 17% (n=27) were acquitted of property crimes and minor offenses respectively. Whether offenders were charged with multiple offenses also played a role in the verdict rendered ($X^2 = 14.716$, df = 1, p = .0001). A much larger proportion of NGRIs (73%; n = 118) were accused of only one crime as compared with 52% (n = 88) of the GBMI offenders.

Table 38
Race by Finding Controlling Offense

	Minor Offenses					
Finding	White		Nonwhite		Total	
	n	%	n	%	n	%
GBMI	5	83%	1	17%	6	100%
NGRI	6	22%	21	78%	27	100%
Total	11	33%	23	67%	33	100%

Crimes Against Persons

Finding	White n	%	Nonwhite n	%	Total n	%
GBMI	22	43%	29	57%	51	100%
NGRI	11	22%	40	79%	51	100%
Total	33	32%	69	68%	102	100%

A relationship between prior criminal record and case outcome would be expected and does, in fact, exist. However, of those found NGRI, 96% (n = 155) as compared to 81% (n = 137) of the GBMIs had a criminal history. In contrast, a record of prior mental health treatment was not significant at the bivariate level. Ninety-one percent of the GBMI offenders and 95% of the insanity acquittees had a record of some type of prior mental health treatment.

Very little pretrial evaluation data are forwarded to the DOC by the DHR. Therefore, comparisons between the two verdict groups on such variables were quite limited. Based on 123 cases (of which 29 were GBMIs and 94 were NGRIs), a relationship appeared to be nonexistent. The data available indicate that the majority in both groups were diagnosed as psychotic (76% of the GBMIs and 70% of the NGRIs). Information

pertaining to pretrial forensic evaluation recommendations is also scant. Although caution is necessary in interpreting these data, it is interesting to note that all of those recommended as exculpable, (n = 28) were ultimately acquitted as insane at the time of the offense. Furthermore, of those initially recommended as unfit to stand trial, 79% (n = 34) were later found NGRI. Of the 17 defendants considered to be free of mental illness, however, 47% (n = 8) were eventually acquitted on the baiss of insanity.

An examination of proportional comparisons conducted on case outcome and trial type revealed a significant bivariate relationship (X^2 = 33.0, df = 2, p = .0001). Although the majority of both NGRI and GBMI findings come about through pleas, a larger proportion of the GBMI findings occur in this manner (86% as opposed to 62%). In addition, a much larger proportion of insanity acquittals (31%; n = 44) are obtained by bench trial than GBMI verdicts (6%; n = 9). A more in depth look at the effect of trial type is difficult due to the small number of jury and bench trials; however, when looking only at findings obtained through pleas, a larger proportion in each offense category are GBMI findings. This is particularly true for crimes against persons such as assaults (73%; n = 73) and murder including manslaughter, and attempted murder (67%; n = 18).

The sentences received by GBMI offenders varied depending on the offense committed as well as whether multiple convictions were involved. As would be expected, 9% (n = 16) of the life sentences were received for murder. Crimes against persons consistently resulted in longer sentences than property offenses. Furthermore, less than 25% of the GBMI population received total sentences between 1-5 years (X^2 = 95.232, df = 8, p = .0001).

Although the probability level required to attain statistical significance was not achieved, possible trends were observed in the relationships between the total sentence received and prior criminal record, mental health history, and type of adjudication. The majority of the GBMI population had some prior experience with the criminal justice and mental health systems. A possible effect of trial type on sentence is that the majority of cases decided by juries (57%) result in sentences greater than 16 years, including life sentences. (See Table 39.)

Table 39
Sentences Received By GBMI Offenders through Pleas
Controlling for Offense

	Offense							
Sentence	Murder n	%	Person n	%	Property n	%	Total n	%
1-5 years	1	3%	17	45%	20	53%	38	100%
6 -10 years	1	2%	36	68%	16	30%	53	100%
11-15 years	2	10%	12	57%	7	33%	21	100%
16 and above	6	17%	23	64%	7	19%	36	100%
Life	16	89%	2	11%	--	--	18	100%
Total	26	16%	90	54%	50	30%	166	100%

Since Georgia's GBMI verdict became effective, 38 GBMI offenders have been released from prison. The length of confinement for this limited group of releasees was compared with confinement periods for those insanity acquittees released during the same period. The length of time NGRIs were held was not significantly related to criminal history or the pretrial evaluation diagnosis. This was also true for the GBMI releasees although the number was so small as to possibly invalidate the

comparison. The average period of confinement did, however, vary significantly ($t = 2.363$; $df = 38$, $p = .002$). Insanity acquittees were released after an average confinement period of 6 months ($x = 196.44$ days, range = 1-1146 days) in comparison with a mean of nine months for GBMIs ($x = 268.6$ days, range = 45-591 days). It is likely that the average incarceration period of GBMIs will lengthen drastically with the passage of time since the alternative verdict is relatively new in Georgia. On the other hand, the average period of treatment for GBMIs ($x = 107.43$ days, range = 16-339 days) was shorter than that for NGRIs ($x = 196.44$ days, range = 1-1040 days; $t = -3.24$, $df = 68$, $p = .0018$). Further comparisons were made in an effort to determine whether the length of confinement of the two groups was affected by a record of prior mental health treatment. Examination of the data presented in Table 40 assists with the interpretation of the relationship observed ($X^2 = 8.410$, $df = 3$, $p = .038$).

Table 40
Confinement Periods of Offenders with Records of Previous Mental Health Treatment

	Length of Confinement*				
Finding	Less than 1 year n %	1 to 2 years n %	2 to 3 years n %	Greater than 3 years n %	Total
GBMI	2 8%	5 21%	17 71%	---	24 100%
NGRI	30 30%	26 26%	24 24%	21 21%	101 100%
	32 26%	31 25%	41 33%	21 16%	125 100%

Notes:

*Periods of confinement are grouped less than 365 days, 365-730 days, 731-1095 days, more than 1096 days.

Of those released who received mental health treatment in the past, a larger proportion of NGRIs (30%, n = 30) than GBMI offenders (8%, n = 2). By the end of the second year of confinement, however, a larger proportion of GBMI inmates (81%; n = 17) than insanity acquittees (24%; n = 24) were released from custody. More than half of the NGRI group were released within 730 days of admission, compared to only 29% of the incarcerated GBMI group. The small number of those released who had no mental health history precluded comparisons in this point.

The NGRI data in Georgia were collected in a manner specifically designed to allow comparisons of pre- and post-GBMI insanity acquittees. Case files of all NGRI defendants who were acquitted between January 1, 1981 and December 31, 1983 were examined to provide data for a 1 1/2 year period both before and after the GBMI statute was effective on July 1, 1982. Dividing the insanity group in this fashion, the observed frequency of NGRI acquittals appears to have decreased (95 NGRI findings in the 1 1/2 years before GBMI compared with 67 afterward). Since it is unlikely that felony dispositions in Georgia decreased between July 1, 1982 and December 31, 1983, it would appear that some displacement of NGRIs may have occurred. A review of the numerous bivariate comparisons made, however, demonstrate no significant differences between the pre-post groups.

Demographic comparisons indicate no significant shifts in the age, sex, or race of insanity acquittees (see Table 41). Nor did the type of adjudication or the average period of treatment or confinement vary significantly. No statistically noteworthy changes in the charges brought or the offenses of which the defendants were acquitted were evident, although a small increase occurred in the proportion of

acquittals for property crimes accompanied by a similarly small decrease in acquittals on murder charges. Furthermore, postacquittal evaluation diagnoses indicated that 68% of the pre-GBMI group and 72% of the post-GBMI group were considered psychotic. The number of empty or small cells precluded accurate comparisons of pretrial diagnoses and recommendations, postacquittal recommendations, and release types.

Table 41
Comparisons of Insanity Acquittees Before and After the GBMI Finding

		Before	After
Age	x	31.7 years	30.7 years
Race	White	32%	30%
	Nonwhite	68%	70%
		100%	100%
Sex	Male	86%	82%
	Female	14%	18%
		100%	100%
Type Trial	Bench	32%	29%
	Jury	10%	3%
	Plea	58%	68%
		100%	100%
Confinement Period	$\bar{x}$	.54 years	.43 years
Treatment Period	$\bar{x}$	.54 years	.52 years

The results of the discriminant analysis conducted on the pre- and post-GBMI groups support the bivariate test results which indicated that no significant differences exist between the two NGRI groups. The eight factors for which discriminant function coefficients were generated were sex, race, postacquittal diagnosis and recommendation, prior offense and mental health histories, the offense charged, and treatment length.

Comparison of the coefficients suggests that there is no difference between the two groups on these variables. The model correctly classified 56% of the pre-GBMI insanity acquittees and 65% of the post-GBMI defendants. It would appear that the two NGRI groups can not be differentiated on the basis of the variables incorporated in the discriminant analysis. The logistic regression check of the discriminant model supports this finding ($p = .0027$). The groups appear to be, for all practical purposes, the same.

Guided by the bivariate analysis, the variables preferred for inclusion in the discriminant analysis between GBMI offenders and NGRI acquittees were: sex and race (due to the somewhat complex relationships noted earlier), criminal and mental health histories, trial type, the offense committed and the existence of multiple charges, pretrial evaluation diagnosis and recommendation, and post-trial diagnosis. However, the pretrial forensic evaluation data for the GBMI population were limited (as previously discussed). The discriminant technique employed is incapable of performing when data elements are missing, therefore, it was necessary to exclude the pretrial diagnostic and recommendation variables. Comparisons between the pre- and post-GBMI insanity acquittees yielded no guidance due to the lack of observed variation between the groups.

Based on these seven variables, the discriminant function coefficients indicate that sex, type of adjudication, criminal history, and race are the main discriminators. The differentiating effect of sex appears to be due to the previously discussed point that a larger proportion of women are found NGRI than GBMI. The effect of race also appears to be tied to the issues raised earlier, especially upon

reviewing the offense coefficient. Nonwhites are more likely to be found NGRI of both crimes against persons and minor offense.

Adjudication type acts as a discriminator because of the larger proportion of GBMI verdicts obtained by plea in combination with the fact that more NGRI findings are rendered through bench trials. Criminal history continues to have a somewhat surprising effect. The fact that a larger proportion of those acquitted on the basis of insanity have criminal records than do those found GBMI is useful in our attempt to differentiate the two verdict groups. The lack of a significant bivariate relationship between previous mental health treatment and case outcome accounts for the limited assistance this variable provides as a discriminator. The effect noted, however, is that those with a record of prior treatment are slightly more likely to be found GBMI. On the surface, this would appear to be the opposite of the message provided by the proportions involved (91% of the GBMIs and 95% of the NGRIs have some type of mental health history). A closer examination of the relationships and the possible interactions involved (which can not be addressed by discriminant analysis) should be attempted.

The GBMI-NGRI model performs relatively well. Of the GBMI offenders, 77% were classified accurately while 66% of the insanity acquittees were assigned to the proper verdict group. The observed relationships between verdict and both sex and race (which are supported by the findings of the logistic regression) require careful review before applying this model. Each of the variables included in the model appear to be useful as possible predictors except mental health history. Due to the inverse relationship noted earlier and possible undetected interactions, this should be examined further.

2. Illinois

As previously mentioned, comparisons of the GBMI and NGRI groups in Illinois are limited due to the lack of comparable data elements between the datasets (see Part Three, Section I.) Therefore, the analysis here will focus on (1) basic comparisons between the NGRI and GBMI groups that are appropriate and (2) comparisons of the pre- and post-GBMI insanity acquittee groups.

Beginning with the former, the gender variable can be excluded from consideration on the basis of simple bivariate tests as well as further examination controlling for conceptually relevant variables. The lack of a significant relationship between sex and verdict continues to hold true when offense and diagnosis are held constant. This is true even though diagnosis and charge are both significantly related to case outcome. The breakdown by sex for each verdict group is:

Table 42
Sex of Offenders by Case Outcome

Outcome	Male n	Male %	Female n	Female %	Total n	Total %
NGRI	311	88%	41	12%	352	100%
GBMI	122	93%	9	7%	131	100%
Total	433		50		483	

An examination of the relationship between race and verdict, however, revealed that a significantly higher proportion of GBMIs are white as opposed to nonwhite defendants (X^2 = 16.955, df = 1, p = .0001; see Table 43).

Table 43
Race of Offenders by Case Outcome

	White n	%	Nonwhite n	%	Total n	%
NGRI	163	49%	169	51%	332	100%
GBMI	92	70%	39	30%	131	100%
Total	255		208		463	

This apparent relationship was explored further by controlling for the offense committed. Testing at each level of the offense variable (murder, sex offenses, personal crimes, property crimes, and other offenses) illustrated a continuing relationship. Comparisons were also conducted controlling for diagnosis and, once again, the relationship carried across each level of the controlling variable. Testing for an effect of age on race proved to be negative.

Examination of the pre-post NGRI groups by race demonstrated that the relationship between GBMI verdicts and race was supported. Of the post-GBMI insanity acquittee group, 59% (n = 72) were nonwhite as compared with 46% (n = 97) prior to implementation of the GBMI verdict (X^2 = 4.55, df = 1, p = .03). Since so many GBMI verdicts were obtained by plea, comparisons of race and trial type were conducted. A significant relationship was observed btween the two independent variables such that of those achieving GBMI verdicts through pleas, 70% (n = 42) were white compared with 55% (n = 16) nonwhites (X^2 = 6.273, df = 2, p = .04). The lack of comparable information about trial type for NGRI acquittees negates the opportunity to further test the verdict-race relationship controlling for type of adjudication. It would appear that white defendants are more likely to enter GBMI pleas and/or

accept plea bargains that include a GBMI verdict, thereby, at least in part, contributing to the relationship between verdict and race.

As noted in the preceding discussion, bivariate relationships were detected between verdict and both diagnosis and charge. The important levels of the diagnosis variable appear to be the nonpsychotic and organically-based categories (X^2 = 44.036, df = 3, p = .0001).

Table 44
Diagnoses by Finding Group

	Psychotic n %	Affective n %	Organic n %	Nonpsychotic n %	Total n %
NGRI	58 19%	14 4%	49 6%	191 61%	312 100%
GBMI	17 14%	16 13%	48 39%	42 34%	123 100%
Total	75	30	97	233	435

Of those diagnosed as non-psychotic, 61% are NGRI acquittees as compared to smaller proportions in the remaining three categories. In contrast, the GBMI group splits more evenly between the organic (39%) and the nonpsychotic (34%) classifications. A review of the verdict-offense relationship indicates a dominance of the murder category for NGRI offenders. The second level of the dependent variable, GBMI, instead spreads more equally across the offense groupings. An attempt to further examine the effect of these two variables on verdict was not accommodated by the available data. When a comparison of finding and diagnosis is conducted controlling for charge, the distribution of the population results in half of the cells having expected values less than five. This indicates that the results emanating from use of the chi square technique may be invalid. Therefore, no further attempt is made to here explain the relationship involved.

A final comparison of the two verdict groups turns to post-trial issues. Of the GBMI offenders released during the study period, confinement length could be computed for 26 offenders. The average period of incarceration was just over one year (372.692 days; n = 26), with a range of 118 to 716 days. The length of confinement for the NGRI group averaged just over 1 1/2 years (574.063 days; n = 128), with a range of 8 days to 2867 days (7.85 years). Analysis indicates no statistical differences between the two groups at the one year level of confinement, yet overall, NGRI acquittees would appear to be held longer than GBMI offenders. Such an interpretation is jeopardized, however, by the simple fact that the GBMI statutory provisions in Illinois were in place for only 2.75 years at the time of data collection. Length of incarceration measures are, therefore, naturally bounded at the high end of the scale.

Turning to the 370 insanity acquittees for whom data were acquired, it is evident that the majority (88%) are male. In addition, a review of the group as a whole indicates that 30% (n = 109) had no previous admissions to state mental health facilities. Of those with such a history, 58% (n = 152) had between one and three prior admissions. Another 15% (n = 40) had experienced between four and six admissons. Documentation for the remainder (27%; n = 68) indicated seven or more previous admissions each.

The Illinois NGRI population was divided into pre- and post-groups using offender admission dates and the GBMI enactment date. During the two year, nine month periods before and after institution of the GBMI verdict, 124 and 154 NGRI verdicts were rendered respectively. No differences between the two groups were evident on the basis of sex or previous admissions. One point on which variation has occurred is on the

county variable. Before the GBMI verdict was enacted, 68% (n = 151) of the NGRI verdicts statewide came from Cook County. This is to be expected considering estimates from Illinois interview respondents that 80% of the state's criminal caseload emanates from Cook County. Following implementation of the alternative verdict, the proportion of insanity acquittals coming from the Cook County courts dropped to 47% (n = 69). This decrease most likely accounts, at least in part, for the observed pre-post variation in NGRI cases hailing from urban-rural areas. On the basis of U.S. Census Bureau classifications, the county variable was recoded to serve as a population density indicator. As modified, NGRI findings (encompassing February 1975 to April 1984) can be presented as follows:

Table 45
NGRI Findings as a Function of Population Density

NGRI	Urban n	%	Rural n	%	Total n	%
Pre	195	88%	27	12%	222	100%
Post	103	70%	44	30%	147	100%
Total	298		71		369*	

Notes:

* Missing cases = 1.

A second area in which pre-post differences were evident was that of post-trial diagnosis. Prior to implementation of the GBMI verdict, 70% of the NGRI acquittees were diagnosed as psychotic. A look at the post-GBMI group of insanity acquittees, however, reveals a decrease to 51% (n = 52) diagnosed as psychotic. This result may be related to offenses and confinement periods. Pre- and post-GBMI periods of confinement differed significantly for NGRI acquittees (t = 6.22, df =

88, p = .0001). The average length of confinement for the first group was 2.05 years (749.19 days) as opposed to a mean of .55 years (202.536 days) for the second NGRI group. The decrease in psychotic acquittees may in itself explain the shorter average confinement period in that post-GBMI insanity acquittees were less seriously mentally ill than their predecessors, thus requiring treatment for a shorter period. An attempt was made to further examine this relationship by (1) reviewing any bivariate relationship between the pre/post verdicts and charge and, (2) testing the relationship between pre/post NGRI findings and diagnosis while controlling offense. The data, however, do not allow a valid comparison due to the small cell sizes that result from comparisons by offense. It is impossible to determine whether more serious offenders (who are also more mentally ill, relatively speaking) are being removed from the NGRI group by the GBMI verdict. Although certainty is lacking in interpreting the observed relationships, a definite decrease in the length of confinement of NGRIs is evident and should be explored further in a statistically and conceptually sound manner.

3. Michigan

The demographic variables age, sex, and race were examined on the basis of case outcome to identify any variation among the three verdict groups. Although the comparison by sex was significant, the relationship appears to be one in which males predominate regardless of verdict. Within the NGRI group, however, a slightly larger proportion are women compared to the GBMI and guilty groups. The data are presented below in Table 46.

Table 46
Sex of Offenders by Finding Group

Finding	Male n	Male %	Female n	Female %	Total n	Total %
Guilty	195	97%	6	3%	201	100%
GBMI	220	95%	11	5%	231	100%
NGRI	142	88%	19	12%	161	100%
Total	557		36		593	

An examination of verdict by race revealed a significant relationship in that white defendants predominated in each verdict category (X^2 = 10.831, df = 2, p = .0004). The proportion of Caucasians in the guilty group, however, was even larger than the proportions in the GBMI and NGRI categories. Further exploration of this relationship controlled for the offense charged. When offense is held constant, the relationship between race and verdict disappears. (This is congruent with the criminal justice literature and research that focuses on the effect of race.) Solely for descriptive purposes, the data are presented as follows:

Table 47
Race of Offenders by Finding Group

	White n	White %	Nonwhite n	Nonwhite %	Total n	Total %
Guilty	138	68%	66	32%	204	100%
GBMI	121	52%	111	48%	232	100%
NGRI	94	58%	67	41%	161	100%
Total	353		244		597	

The relationship between age and verdict identified by Smith and Hall's research is supported by the data. Variation among the average ages of the verdict groups was significant for comparisons between the guilty and GBMI groups ($t = -2.183$, $df = 398.7$, $p = .0049$) and the guilty and NGRI groups ($t = -4.2203$, $df = 284.1$, $p = .0001$). The average age of GBMI and NGRI offenders, however, is not significantly different. Although a trend is evident ($p = .07$), with insanity acquittees being somewhat older than those found GBMI, the difference between the means is not significant statistically. It is clear that the average age descends by group in the following order: NGRI, GBMI, guilty. Complete data are arrayed in Table 48. Older defendants may be more likely to obtain verdicts involving mental aberrations.

Table 48
Age of Offenders by Finding Group

AGE	Guilty n	Guilty %	GBMI n	GBMI %	NGRI n	NGRI %	TOTAL n	TOTAL %
15-25 yrs.	82	45%	80	40%)	39	26%	201	100%
26-35 yrs.	65	36%	64	32%)	66	44%	195	100%
36-45 yrs.	25	14%	40	20%)	25	17%	90	100%
46-55 yrs.	7	4%	15	7%)	9	6%	31	100%
56 and over	1	1%	3	1%)	9	6%	13	100%
Total	180	100%)	202	100%	148	99%*	530	
$\bar{x}$	28.56		31.18		33.14			
Range	15-60		17-74		17-72			
Missing	28		10		11			

Notes:

* Less than 100% due to rounding.

The offense committed by individuals who raised a defense based on mental disorder tend to be more serious offenses, usually crimes labeled as index offenses, (murder, rape, robbery, assaults, burglary, auto theft, larceny and arson) by the Federal Bureau of Investigation, and more specifically, tend to be crimes against persons. About 5% (n = 32), however, committed less serious offenses which were categorized as 'other' for research purposes. This group includes such offenses as breach of peace and disorderly conduct, possession of marijuana, trespass, driving under the influence, and gambling. Proportional comparisons revealed a statistically significant relationship between verdict and both the offense charged (X^2 = 57.087, df = 16, p = .0001) and the offense of conviction (X^2 = 36.266, df = 10, p = .0001). (See Table 49.)

A review of Table 49 suggests that verdict group varies by several offense categories. For example, of those charged and convicted of sex offenses, a smaller proportion consistently fell into the NGRI group. Murderers are more likely to be found GBMI. (In this respect, GBMI and NGRI offenders are more similar than guilty offenders.) Individuals who committed 'crimes against persons' (e.g., aggravated assault, battery) are more likely to be found NGRI than GBMI or guilty. Property offenders, on the other hand, are less likely to receive a GBMI verdict. Needless to say, this does not present a neat, straight forward picture of how the verdict groups differ in terms of offense.

In an effort to further clarify the results noted above, comparisons of finding by trial type and finding by offense controlling for type of adjudication were conducted. A statistically significant relationship does in fact exist at the bivariate level between the verdict rendered

Table 49
A Comparison of Offenses Charged and Conviction Offenses by Finding
Offenses Charged

Finding	Murder n	%	Sex Offenses n	%	Person n	%	Property n	%	Other n	%	Total n	%
Guilty	63	31%	41	20%	50	25%	40	20%	10	5%	204	100%
GBMI	99	43%	41	18%	54	23%	27	12%	11	5%	232	100%
NGRI	58	36%	8	5%	52	33%	31	19%	32	5%	160	100%
Total	220	37%	90	15%	156	26%	98	16%	32	5%	596	100%

Offenses of Conviction

	Murder n	%	Sex Offenses n	%	Person n	%	Property n	%	Other n	%	Total n	%
Guilty	54	27%	41	21%	48	24%	46	23%	10	5%	200	100%
GBMI	98	42%	37	16%	57	25%	29	13%	11	5%	232	100%
NGRI	59	37%	7	4%	51	32%	32	20%	11	7%	160	100%
Total	211	36%	85	14%	156	26%	107	18%	32	5%	592	100%

and type of adjudication (X^2 = 122.334, df = 4, p = .0001). The majority of insanity findings (78%) are obtained through bench trial whereas GBMI findings (52%) and guilty findings (64%) occur by acceptance of a plea. Much of the variation may well be explained in this manner, however, the limited frequency of bench and jury trials results in small cell sizes that may invalidate the findings when verdict and offense are examined in light of adjudication type. The large number of cases disposed of by plea allowed an appropriate comparison that detected a continuing significant relationship between verdict and offense for those who entered pleas that were accepted by the court, (X^2 = 0.949, df = 4,

p = .05). It would appear that offenders are more likely to plead GBMI than guilty to a murder charge. In addition, a larger proportion of those involved in property crimes pled guilty as opposed to GBMI.

The effect of multiple charges on verdict was also explored. Although guilty and GBMI verdicts are virtually split evenly, of those found NGRI, 67% (n = 108) were charged with only one offense (X^2 = 13.203, df = 2, p = .0014).

Whether an offender had a prior criminal record was also considered to be a potentially relevant factor. Here again, the insanity acquittees were different from the other two verdict groups. Of those found GBMI or guilty, 72% and 75% respectively had been charged and/or convicted of at least one prior offense. In comparison, 52% of the NGRIs had a criminal history (X^2 = 24.972, df = 2, p = .0001). The same relationship held true for those with multiple charges or convictions in their background (X^2 = 7.301, df = 2, p = .026).

Pretrial evaluation diagnosis would be expected to be an important pretrial factor related to case outcome. Statistical comparison indicates that it is in fact the case (X^2 = 97.22, df = 10, p = .0001). Of those found NGRI, 62% (n = 64) were diagnosed as psychotic, compared with 26% (n = 32) of the GBMIs and 10% (n = 11) of the guilty sample. Furthermore, of the defendants found guilty, 50% were diagnosed as nonpsychotic (primarily personality disordered) in comparison with 32% (n = 40) of the GBMIs and 13% (n = 13) of the insanity acquittees. (One would expect a low proportion of NGRIs to be labeled as nonpsychotic due to the statutory exclusion of the personality disordered from those eligible for acquittal under the insanity standard.) Defendants determined to have no mental illness tended to fall into the guilty group

(54%; n = 30) or the GBMI group (34%; n = 20). Those diagnosed as having affective disorders represented a small proportion regardless of verdict group.

Some very interesting effects are observed in the sentencing data. As noted previously, Michigan's sentencing structure involves the imposition of both a minimum and maximum sentence (See Table 50 for sentencing data.) Comparing minimum and maximum sentences imposed with the verdict (GBMI or guilty) received, no significant relationship was observed. However, a trend was detected in the relationship between verdict and maximum sentence (X^2 = 8.851, df = 4, p = .06). In search of further clarification, several comparisons were conducted controlling for variables that could be expected to be relevant such as a history of mental health treatment, criminal history, offense, and type of adjudication. Controlling for offense added nothing of interpretative value. (Although not statistically significant, a larger proportion (46%; n = 24) of those found guilty of murder received life sentences than GBMIs convicted of murder (28%; n = 26). The other factors proved helpful, however,the relationships observed appeared only with the maximum, not minimum, sentence.

Table 50
Sentences Received by GBMI and Guilty Offenders

Maximum Sentence in Years

	1-5 n	%	6-10 n	%	11-15 n	%	16 and above n	%	Life n	%	Total n	%
Guilty	42	23%	26	14%	38	21%	52	28%	27	15%	185	100%
GBMI	30	13%	26	12%	64	29%	73	33%	30	13%	223	100%
Total	72		52		102		125		57		408	100%

Minimum Sentence in Years

	1-5 n	%	6-10 n	%	11-15 n	%	16 and above n	%	Life n	%	Total n	%
Guilty	89	49%	36	20%	7	12%	22	12%	27	14%	181	100%
GBMI	94	43%	55	25%	19	9%	23	10%	30	14%	221	100%
Total	183		91		26		45		57		402	100%

When examining only those offenders with a criminal record, a significant relationship between the verdict rendered and the maximum sentence imposed became apparent (X^2 = 9.626, df = 4, p = .047). Of those found guilty, a larger proportion (24%; n = 34) received 1-5 year sentences than those found GBMI (15%; n = 24). Furthermore, GBMI offenders (31%; n = 50) were more likely to receive 11-15 year sentences than guilty offenders (18%; n = 25). No differences were evident in life sentences or sentences of 16 years or more. A second factor affecting maximum sentences is mental health history. Although there is a trend (X^2=7.692, df = 4, p = .103) toward guilty offenders with mental health history receiving shorter maximum sentences than GBMI offenders with prior treatment records, the significant relationship between verdict and maximum sentence surfaces for those without any record of previous mental

health treatment (X^2 = 9.736, df = 4, p = .045). When the latter is the case, a higher proportion of defendants found GBMI received 11-15 year sentences (33%; n = 15) and sentences of 16 years and longer (35%; n = 16) than do guilty offenders (17% and 27% respectively). Correspondingly, the guilty offenders tend to receive the shorter maximum sentences. There is no difference, however, in the proportion of offenders given life sentences. (See Table 51 below).

Table 51
Maximum Sentences for Offenders without Prior Mental Health Contacts

	Maximum Sentence in Years											
	1-5		6-10		11-15		16 and above		Life		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Guilty	10	14%	12	17%	12	17%	19	27%	17	24%	70	100%
GBMI	4	9%	1	2%	15	33%	16	35%	10	22%	46	100%
Total	14	12%	13	11%	27	23%	35	30%	27	23%	116	100%

Recalling the fact that many GBMI findings come about through pleas, the relationship under examination was studied controlling for type of adjudication. No relationship was evident when considering bench or jury trials, however, the data pertaining to cases involving pleas were of interest. Generally speaking, the GBMI offenders received longer maximum sentences than most of the guilty offenders (X^2 = 9.758, df = 4, p = .04). Of those found GBMI, 32% received 11-15 year sentences compared with 21% of the guilty offenders. In addition, 36% of the GBMI offenders were sentenced to 16 years or more while 27% of the guilty sample received such sentences. Twenty-nine percent of the guilty group were sentenced to 1-5 years compared to 17% of the GBMIs. This finding is

particularly interesting considering the fact that significant differential sentences occur only in cases determined by plea.

Post-conviction issues examined included the provision of mental health services and actual confinement length. Mental health treatment was provided to all insanity acquittees committed after the mandatory observation period. (In reality, many of those released at the end of the evaluation period had also received treatment, however, the measurement scheme employed focused on those committed specifically for a period of treatment because involuntary civil commitment standards were met.) Since post-trial evaluation recommendations were invariably followed, it is interesting to note that no relationship exists between the treatment actually rendered and the treatment recommendation made by mental health staff after conviction or acquittal. This finding supports reports of knowledegable officials in Michigan that the provision of treatment is not tied to the verdict, including the GBMI finding, but depends on individual mental health needs. A comparison of mental health services rendered by verdict demonstrated that at least two thirds of the GBMI population received treatment in prison and/or at CFP. Of the guilty sample, 46% received such services during incarceration.

The average length of confinement was calculated for those GBMI, NGRI, and guilty offenders who were released before June 15, 1984, the point of data collection (see Table 52). T tests were then used to determine whether the means were significantly different. Test results indicated statistically significant differences between each pair of means such that guilty offenders and GBMI offenders are confined longer than insanity acquittees, and GBMIs are held longer than guilty inmates. Although the difference between the average confinement lengths for

guilty and GBMI offenders are statistically significant, it may be difficult to accept a mean of 3.99 years as being realistically different from a mean of 3.26 years. Furthermore, a mean is a measure of central tendency. Therefore, additional examination of the relationship between verdict and confinement length was conducted.

Controlling for mental health history, the significance of the relationship noted above continues to hold. Of particular relevance is the fact that, of those offenders with a record of prior treatment, GBMI offenders are confined significantly longer than NGRI acquittees. This is to be expected considering the differences in release mechanisms. In addition, looking only at those with prior criminal records, GBMIs comprise 54% (n = 26) of those confined longer than four years (X^2 = 59.366, df = 8, p = .0001). Again, NGRIs are released in less time than the GBMIs or the guilty sample (X^2 = 106.063, df = 8, p = .0001; see Table 52 below.) It remains to be seen whether GBMI offenders with longer sentences than those already released will continue to be confined longer than their guilty counterparts.

Table 52
Average Confinement Periods by Finding

	x	n	Range
Guilty	3.26 yrs.	77	.68 - 8.24 yrs.
GBMI	3.99 yrs.	69	.37 - 8.99 yrs.
NGRI	1.43 yrs.	87	.12 - 6.13 yrs.

Proportional Comparisons of Confinement Length

	Confinement Period									
	Less than 1 yr.		1-2 yrs.		2-3 yrs.		3-4 yrs.		Greater than 4 yrs.	
	n	%	n	%	n	%	n	%	n	%
Guilty	3	4%	15	19%	24	31%	15	19%	20	26%
GBMI	3	4%	9	13%	11	16%	13	19%	33	48%
NGRI	37	43%	34	39%	10	11%	3	3%	3	3%
Total	42	18%	58	25%	45	19%	31	13%	56	24%

Confinement Length of Offenders
With Criminal Records

	Confinement Period					
	Less than 1 yr.	1-2 yrs.	2-3 yrs.	3-4 yrs.	Greater than 4 yrs.	Total
Guilty	1 2%	13 22%	16 27%	12 20%	17 29%	59 100%
GBMI	2 4%	5 10%	7 15%	8 17%	26 54%	48 100%
NGRI	15 35%	17 40%	6 14%	3 7%	2 5%	43 100%
Total	18 12%	35 23%	29 19%	23 15%	45 30%	150 100%)

Three models were developed using the Michigan data in an attempt to discriminate between (1) guilty and GBMI offenders, (2) guilty offenders and insanity acquittees, and (3) GBMI offenders and insanity acquittees. Guided by the previous analysis and interpretation of the observed relationships, the following variables were entered in each of the three equations:

- age at conviction
- most serious charge
- existence of multiple charges
- occurrence of a pretrial evaluation
- pretrial evaluation diagnosis
- pretrial evaluation recommendation
- criminal history
- mental health history

Since the maximum sentence received by guilty and GBMI offenders was significantly related to case outcome, it was included in the guity/GBMI model. Type of adjudication was also identified previously as an important factor and, therefore, was included as well.

The two comparisons involving the NGRI group could not, or course, include the sentencing variable. In addition, information pertaining to the type of adjudication was not consistently available in the CFP files. Since discriminant analysis discards cases with missing data, this variable was excluded from consideration. Post-trial diagnostic information was, however, incorporated into both the models involving insanity acquittees.

Employing the variables noted above, the resulting discriminant function coefficients indicate that the most important discriminators between the GBMI and guilty groups are: prior mental health treatment, criminal history, adjudication type, and multiple charge information. More subtle differences are evident in the offense committed and age. The logistic model supports the findings of the discriminant analysis

(p=.001). Of particular importance were the type of adjudication and prior mental health treatment. Examination of the coefficients in combination with a grasp of the preliminary analysis led to the following interpretation.

Defendants found GBMI tend to have had more contact with mental health treatment providers than guilty offenders whereas the opposite is true for criminal history. Although the majority of both the GBMI and guilty verdicts studied were obtained by plea, a larger proportion of the guilty group (65% as opposed to 54%) took advantage of this adjudication method. Furthermore, GBMI verdicts were more likely to be rendered following a bench trial than were guilty findings.

The role played by the existence of multiple charges was almost as large as that of adjudication type. Offenders charged with more than one offense were found guilty more often than GBMI. The instant offense was actually a more subtle differentiating factor. GBMI offenders and guilty offenders were both involved in serious offenses, usually crimes against persons. An individual charged with murder and having a history of prior psychiatric treatment is more likely to be found GBMI than guilty. Finally, defendants labeled by the court as GBMI tend to be somewhat older (x = 31.18 years) than guilty offenders ($\bar{x}$ = 28.56). The discriminant model developed classified 63% of the guilty sample and 60% of the GBMI population correctly.

Several of the discriminators used in the guilty-NGRI model proved to be somewhat stronger in differentiating these groups than the guilty-GBMI groups. The most important discriminators were criminal history and the existence of multiple charges. Defendants with these characteristics were more likely to be found guilty than NGRI. As previously discussed,

the average NGRI acquittee was older than the average guilty offender. This difference proved to be helpful in the classification scheme developed. The pretrial forensic evaluation recommendation was useful in this model as well (although it contributed very little to the differentiating power of the guilty-GBMI model). As Smith and Hall reported in their work, defendants recommended as exculpable were more likely to be acquitted than found guilty. The inclusion of the mental health history measure had a similar effect as that mentioned above: those with a prior record of receiving mental health services were also more likely to be found NGRI. The guilty-NGRI classification model was more accurate than the guilty-GBMI model. Seventy-six percent of the guilty offenders and 82% of the insanity acquittees were assigned to the appropriate verdict group. Once again, the results of discriminant analysis were supported by the regression check ($p = .033$). Particularly good predictors to be explored in future research might be criminal and mental health histories, age, and the pretrial evaluation recommendation.

The third and final model developed attempted to differentiate the GBMI and NGRI verdict groups. Of the variables included in the analysis, the most important were criminal history, the existence of multiple charges, previous mental health treatment, age, and pretrial evaluation recommendation. Once again, the existence of a criminal record seems to decrease the possibility of obtaining an insanity acquittal. The filing of more than one charge has the same effect as well. Previous criminal behavior and the commission of multiple offenses appears to tilt the scales toward conviction; in this case, a GBMI finding. Interestingly enough, those defendants who received mental health services in the past were slightly more likely to be found GBMI than NGRI.

Although insanity acquittees were generally older than GBMI offenders, the bivariate relationship was not significant. A trend in that direction was noted, however. It would appear that the trend toward NGRIs being older was sufficient, in combination with the other variables in the model, to add some discriminating power. And finally, obtaining the recommendation for acquittal from the CFP again tended to sway the verdict toward an NGRI finding. The discriminant model for the GBMI-NGRI groups accurately classified 70% of the GBMI offenders and 71% of the insanity acquittees. Results of the logistic regression indicate that further exploration may be necessary here. Although criminal history, age, multiple charges, and pretrial evaluation recommendations may prove to be good predictors, the model as a whole was less successful than the other two ($p = .46$). Examination of any interactions affecting the relationship between verdict and both mental health history and diagnosis will be necessary.

III. SUMMARY AND OBSERVATIONS

Although similarities exist, the results presented seem to indicate that the GBMI verdict has been used differently in each of the three states studied. In all three states, defendants found GBMI tend to be male offenders under age 35 who were convicted of personal as opposed to property crimes. In addition, the majority of the incarcerated GBMI offenders in each state had at least one prior contact with both the mental health and the criminal justice systems. Another similarity is the means of adjudication: a majority in each state obtained their GBMI findings by plea (although the proportions vary widely - 86% in Georgia, 58% in Illinois, and 51% in Michigan.) Finally, the majority of

incarcerated GBMI offenders do in fact receive mental health services. This seems to be tied to identified treatment needs rather than the GBMI label.

Thereafter, differences begin to emerge. In Georgia and Michigan, the GBMI-guilty populations split 50-50 racially, yet in Illinois, 70% of the GBMIs are white compared with a 32% white prison population overall. This racial imbalance in Illinois, which is confirmed by a shift in the pre/post-GBMI insanity acquittee population, appears to be due to larger proportions of white defendants offering or accepting GBMI pleas.

Differences in the NGRI population before and after implementation of the GBMi verdict in Illinois suggest more than racial variation in use of the alternative finding. System actors in Cook County appear to have altered their behavior such that NGRI findings have decreased. Although the GBMI verdict is used in Cook County, it is not employed to the extent one would expect given the county's criminal caseload. More importantly, however, the proportion of insanity acquittees diagnosed as psychotic decreased from 70% to 51% after the GBMI alternative was instituted. This shift was accompanied by a significant decrease in the confinement period of NGRIs.

When these results are considered as a whole in light of the fact that, over comparable time periods, the frequency of insanity acquittals has increased, it is clear that the impact of the GBMI verdict in Illinois is rather complex. Why are Caucasian defendants more willing to plead GBMI than nonwhite defendants? Are other factors affecting plea bargaining behavior? Have the more mentally ill, serious offenders been displaced from the NGRI group into the GBMI group? The lack of a comparable guilty sample makes it difficult to pursue some of these issues with certainty.

Unlike Illinois, Georgia's NGRI population does not appear to have changed following the passage of GBMI legislation. This is true in spite of a decrease in the simple frequency of NGRI findings. Insanity acquittees and GBMI offenders appear to be equally mentally ill. Yet Georgia seems to be using its NGRI verdict in a manner different from Illinois and Michigan. Far more nonwhites accused of property and minor offenses are acquitted by reason of insanity in Georgia than is true elsewhere. Furthermore, women who commit murders or sex offenses are more likely to be found NGRI than their proportions in the criminal population seem to warrant.

Although a guilty sample was not obtained in Georgia, extensive aggregate data provided by the DOR made certain comparisons with the GBMI population possible. (The data were presented such that GBMI offenders could be subtracted from the totals so that comparisons did not inappropriately include the group studied.) These data seem to suggest that GBMI offenders, the vast majority of whom are convicted by plea, are receiving longer sentences than those imposed on guilty offenders. Similarities exist, yet 21% of the GBMI population received sentences of 16 years or more in comparison with 12% of the non-GBMI prison population. Furthermore, 36% of the other prison inmates are serving sentences between one and five years in length while only 23% of the GBMI population received such sentences. Clearly, this is not conclusive evidence that GBMIs are being given longer sentences or that they will be confined longer than guilty offenders. However, further research that includes an appropriately selected guilty sample could prove enlightening.

Michigan, the state with the most experience with the GBMI verdict, is probably the most complex of all to study. Statutory and procedural

changes that accompanied institution of the GBMI verdict make it difficult to sort out the individual effects (let alone the interactions) of the various changes. Analysis and interpretation are further stymied by the difficulties of gathering pre-GBMI insanity acquittee data.

Based on internal studies conducted at CFP, Smith and Hall conclude that the insanity population has not changed since the GBMI verdict was implemented. Yet the statutory exclusion of personality disordered defendants from the potential NGRI pool would, of necessity, change the population. Indeed, the proportion of acquittees diagnosed as personality disordered decreased from 44% in 1975 to 12% in 1979 and 13% by 1984. Unless one is willing to accept the thesis that mental health professionals significantly altered their diagnostic behavior, such a population change must be accepted. Other changes evident in the pre/post NGRI groups (discussed in Part One, Section III) include an increase in the proportion of insanity acquittees 1) who were black, 2) who had more extensive mental health histories, and 3) who committed less serious offenses.

Given, at a minimum, these differences, it is not surprising that portions of our results support those of Smith and Hall. For example, age continues to be an important factor with each verdict group being progressively younger in the following order: NGRI, GBMI, guilty. Why are older defendants more likely to obtain findings based on mental aberration? Bivariate relationships observed in our data indicate that murderers are more likely to fall into the same pattern: NGRI, GBMI, guilty. Sex offenders are consistently excluded from the NGRI group and appear in the GBMI and guilty groups. Plea behavior occurred in descending order by verdict group: guilty, GBMI, NGRI. In every

instance, the GBMI verdict assumes the middle ground - a position many proponents would argue was a key purpose of GBMI.

The multivariate analysis conducted appears to support this conclusion. In most cases, the factors important to outcome are helpful discriminators (adjudication type, age, mental health and criminal histories, nature and extent of instant criminal behavior). Yet these patterns do not hold consistently because the middle ground shifts depending on the combination of factors in a particular case.

The actual effect on GBMI offenders is more clear than the effect the alternative verdict has had on the insanity finding. Offenders sentenced as GBMI in Michigan are receiving longer maximum sentences than those found guilty. This relationship continues when offense and mental health history are held constant. Furthermore, it is particularly true for those offenders who offer or accept pleas. In addition, almost ten years of data indicate that GBMI inmates are confined for longer periods as well. This is true when GBMI offenders are compared with the guilty or NGRI group.

If the intent of GBMI legislation in Michigan was to create a middle ground, it would appear it has succeeded. If the extension of confinement periods was also a goal, the GBMI verdict is doubly successful. This does not necessarily mean that a subgroup of inappropriate insanity acquittees has been displaced for deserved punishment. In fact, the opposite may be true. Sophisticated research designs (as discussed in Part Three, Section I) must be employed to answer this complex question. In any case, plea bargaining practices appear to play an important role in the use of the GBMI verdict in all three states and should be explored in depth.

Notes

1. The GBMI conviction figures presented in this report vary from those presented by Smith and Hall. The Michigan DOC list used was assembled by staff in the Office of Health Care using two sources: (1) a computer list of GBMI offenders, generated using a specific GBMI field, and (2) lists provided by the reception centers of inmates thought to be sentenced under the GBMI statute. For offenders in the latter category, the official sentencing orders were checked to determine their status. If the sentencing document did not specify 'GBMI', the court was contacted by the Office of Health Care. Many of these inmates were not, according to the sentencing court, found GBMI. The files of those offenders for whom the court had not yet responded were reviewed by project staff and coded as GBMI if available records indicated such a finding.

APPENDIX A. INTERVIEW SCHEDULES

GUILTY BUT MENTALLY ILL PROJECT

Interview Schedules

Schedule A: Legislative Information

Schedule B: Attorneys

Schedule C: Judges

Schedule D: Pretrial Forensic Evaluators/Expert Witnesses

Schedule E: Post-Conviction/Post-Acquittal Evaluators

Schedule F: Corrections and Mental Health Personnel

Schedule G: Probation Officials

Schedule H: Parole Officials

GUILTY BUT MENTALLY ILL PROJECT

Interview Schedule A: Legislative Information

State: _____ Date: ___/___/ 84

Title/Position: _____ Interviewee #: _____

Organization/Agency: _____

Duties: _____

_____

A-1. Did a particular case, incident or problem lead to enactment of your state's guilty but mentally ill (GBMI) statute(s)? If yes, what was it?

A-2. What was (is) the intent of the GBMI legislation? What is the basis of your response?

A-3. Has the intent been fulfilled? Why, or why not? What is the basis of your opinion?

A-4. Have other statutory, judicial or administrative rule changes been made affecting mentally ill or insane defendants at the same time or since that time the GBMI legislation was enacted? If yes, what are the changes? (Examples: definition of insanity changed, shifted burden of proof of insanity)

A-5. Has the GBMI plea/verdict changed the processing and/or treatment of mentally ill offenders? (Examples: administrative rules, processing time, type or frequency of treatment provided, dispositions available, change in 'incompetency to stand trial' proceedings and findings)

A-6. What were the positions of those opposed to the GBMI legislation? Have those concerns materialized?

A-7. What do you view as the strengths of the GBMI statute(s)? Why?

A-8. What do you view as the weaknesses of the GBMI statute(s)? Why?

A-9. What legislative actions in the mental health area are pending or have been proposed? (e.g., repeal of GBMI legislation, abolition of not guilty by reason of insanity (NGRI) defense)

Other Concerns and Comments:

GUILTY BUT MENTALLY ILL PROJECT
Interview Schedule B: Attorneys

State: _____ Date: / / 84

Title/Position: _____ Interviewee #: _____

Organization/Agency: _____

Duties: _____

_____

B-1. How many cases have you participated in that involved the guilty but mentally ill (GBMI) plea/verdict (i.e., pleas entered or verdicts rendered)?

B-2. What was (is) the intent of the GBMI legislation? What is the basis of your response?

B-3. Has the intent been fulfilled? Why, or why not? What is the basis of your opinion?

B-4. Have other statutory, judicial or administrative rule changes been made affecting mentally ill or insane defendants close to the time the GBMI legislation was enacted? If yes, what are the changes? (Examples: definition of insanity changed, shifted burden of proof of insanity)

B-5. Has the GBMI plea/verdict changed the processing and/or treatment of mentally ill or insane offenders? (Examples: administrative rules, processing time, type or frequency of treatment provided, dispositions available, change in 'incompetency to stand trial' proceedings and findings)

B-6. Are cases involving mental aberration handled differently because of the availability of a GBMI finding? (Examples: plea bargaining, charging practices, presentation of evidence, raising of insanity defense, expert testimony) Please explain.

B-7. Jury Information:

a. In your opinion, do jurors understand and make appropriate distinctions between the definitions of insanity and mental illness as used in the GBMI plea/verdict?

b. Do jurors generally understand the expert testimony presented at trial? Why or why not?

c. Do jurors understand the dispositional differences between a not guilty by reason of insanity (NGRI) and a GBMI finding?

d. Do jurors understand the typical jury instructions provided by trial judges in GBMI cases? In NGRI cases? Why or why not?

e. Are jury instructions for NGRI and/or GBMI cases standardized? If yes, could we obtain a copy?

B-8. Has the GBMI plea/verdict increased or decreased the number of jury trials in cases involving mental aberration? What is the basis for your response?

B-9. Has instituting the GBMI plea/verdict changed the involvement of mental health experts in criminal proceedings? If yes, how?

B-10. In your opinion, what are the criteria or factors used by judges in making GBMI and NGRI determinations? By juries? Please specify.

B-11. What are the characteristics of defendants most likely to be found GBMI, as opposed to NGRI or guilty?

B-12. In your opinion, do judges understand and make appropriate distinctions between the definitions of insanity and mental illness?

B-13. GBMI Sentencing and Confinement:

a. In practice, does the length and/or type of sentence (e.g., probation, split sentence) for guilty and GBMI offenders differ? If yes, what accounts for this?

b. In your opinion, does the period of confinement for NGRIs and GBMIs who have similar backgrounds differ? If yes, which group is generally confined longer? Why?

c. In your opinion, are GBMI offenders more frequently or less frequently paroled than guilty offenders?

B-14. GBMI Treatment:

a. Are GBMI offenders more likely to receive treatment than offenders with mental health problems in the general prison population? What is the basis for your response?

b. What agency or agencies actually provide treatment for GBMI offenders?

c. What types of treatment are provided?

B-15. In your opinion, has the GBMI plea/verdict increased or decreased costs to the mental health-law system in any way? If yes, how? If no, why not?

B-16. In your opinion, would the GBMI offenders be found guilty or NGRI if the GBMI plea/verdict were unavailable? What is the basis for your response?

B-17. Under what circumstances would you advise a client to enter a GBMI plea?

B-18. In your opinion, do recidivism rates vary among released NGRI, GBMI, and guilty offenders? How and why?

B-19. What do you view as the strengths of the GBMI statute(s)? Why?

B-20. What do you view as the weaknesses of the GBMI statute(s)? Why?

B-21. Has your perception of the desirability and impact of the GBMI plea/verdict changed since passage of the statute(s)? If yes, why?

Other Concerns and Comments:

GUILTY BUT MENTALLY ILL PROJECT
Interview Schedule C: Judges

State: _____ Date: / / 84

Title/Position: _____ Interviewee #: _____

Organization/Agency: _____

Duties: _____

_____

C-1. How many cases have you participated in that involved the guilty but mentally ill (GBMI) plea/verdict (i.e., pleas entered or verdicts rendered)?

C-2. What was (is) the intent of the GBMI legislation? What is the basis of your response?

C-3. Has the intent been fulfilled? Why, or why not? What is the basis of your opinion?

C-4. Have other statutory, judicial or administrative rule changes been made affecting mentally ill or insane defendants close to the time the GBMI legislation was enacted? If yes, what are the changes? (Examples: definition of insanity changed, shifted burden of proof of insanity)

C-5. Has the GBMI plea/verdict changed the processing and/or treatment of mentally ill offenders? (Examples: administrative rules, processing time, type or frequency of treatment provided, dispositions available, change in 'incompetency to stand trial' proceedings and findings)

C-6. In your opinion or experience, what are the characteristics of defendants most likely to be found GBMI, as opposed to not guilty by reason of insanity (NGRI) or guilty?

C-7. What advantages or disadvantages does the GBMI plea/verdict offer mentally ill defendants? Do the defendants understand these?

C-8. Are cases involving mental aberration handled differently due to the availability of a GBMI plea/verdict? (Examples: plea bargaining, charging practices, presentation of evidence, raising of the insanity defense, expert testimony)

C-9. In your opinion, would the GBMI offenders be found guilty or NGRI if the GBMI plea/verdict were unavailable? What is the basis for your opinion?

C-10. Jury Information:

a. In your opinion, do jurors understand and make appropriate distinctions between the definitions of insanity and mental illness as used in the GBMI plea/verdict?

b. Do jurors generally understand the expert testimony presented at trial? Why, or why not?

c. Do jurors understand the dispositional differences between an NGRI and a GBMI finding?

d. Do jurors understand the typical jury instructions in GBMI cases? In NGRI cases? Why or why not?

e. Are jury instructions for NGRI and/or GBMI cases standardized? If yes, could we obtain a copy?

C-11. In your opinion, has the GBMI plea/verdict increased or decreased the number of jury trials in cases involving mental aberration? What is the basis for your opinion?

C-12. Has the GBMI plea/verdict changed the involvement of mental health experts in criminal proceedings? If yes, how?

C-13. Do the criteria used for placing offenders on probation vary for guilty offenders as compared with GBMI offenders?

C-14. GBMI Sentencing and Confinement:

a. In practice does the length and/or type of sentence (e.g., probation, split sentence) for guilty and GBMI offenders differ? If yes, what accounts for this?

b. In your opinion, does the period of confinement differ for NGRIs and GBMIs who have similar backgrounds? If yes, which group is generally confined longer? Why?

c. In your opinion, are GBMI offenders more frequently or less frequently paroled than guilty offenders?

C-15. GBMI Treatment:

a. Are GBMI offenders more likely to receive treatment than offenders with mental health problems in the general prison population? What is the basis for your response?

b. What agency or agencies actually provide treatment for GBMI offenders?

c. What types of treatment are provided?

C-16. In your opinion, has the GBMI plea/verdict increased or decreased costs to the mental health-law system in any way? If yes, how? If no, why not?

C-17. In your opinion, do recidivism rates vary among released NGRI, GBMI, and guilty offenders? How and why?

C-18. What do you view as the strengths of the GBMI statute(s)? Why?

C-19. What do you view as the weaknesses of the GBMI statute(s)? Why?

C-20. Has your perception of the desirability and impact of the GBMI plea/verdict changed since passage of the statute(s)? If yes, why?

Other Concerns and Comments:

GUILTY BUT MENTALLY ILL PROJECT

Interview Schedule D: **Pretrial Forensic Evaluators/Expert Witnesses**

State: _____ Date: ___/___/ 84

Title/Position: _____ Interviewee #: _____

Organization/Agency: _____

Duties: _____

_____

D-1. How many cases have you participated in that involved the guilty but mentally ill (GBMI) plea/verdict (i.e., pleas entered or verdicts rendered)?

D-2. What categories of psychological/psychiatric evaluations do you perform? (Examples: competency evaluations, criminal responsibility evaluations)

D-3. What was (is) the intent of the GBMI legislation? What is the basis of your response?

D-4. Has the intent been fulfilled? Why, or why not? What is the basis of your opinion?

D-5. How and from whom do you receive referrals or requests for mental health evaluations?

D-6. Do examination/evaluation procedures for not guilty by reason of insanity (NGRI) and GBMI defendants differ? Please explain.

D-7. How often do you testify or make recommendations to attorneys or the court regarding examinations of NGRI or GBMI defendants? Has the nature or frequency of your activities changed since the GBMI plea/verdict was instituted?

D-8. Has the substance or extent of your testimony or recommendations changed since the GBMI plea/verdict was instituted? If yes, how?

D-9. Are the attorneys and the court usually in agreement with and/or follow your recommendations?

D-10. What are the characteristics of defendants most likely to be found GBMI, as opposed to NGRI or guilty?

D-11. In your opinion, would the GBMI offenders be found guilty or NGRI if the GBMI plea/verdict were unavailable? What is the basis for your opinion?

D-12. In your opinion, has the GBMI plea/verdict increased or decreased costs to the mental health-law system in any way? If yes, how? If no, why not?

D-13. What do you view as the strengths of the GBMI statute(s)? Why?

D-14. What do you view as the weaknesses of the GBMI statute(s)? Why?

D-15. Has your perception of the desirability and impact of the GBMI plea/verdict changed since passage of the statute(s)? If yes, why?

Other Concerns and Comments:

GUILTY BUT MENTALLY ILL PROJECT

Interview Schedule E: **Post-Conviction /Post-Acquittal Evaluators**

State: _____ Date: ___/___/ 84

Title/Position: _____ Interviewee #: _____

Organization/Agency: _____

Duties: _____

_____

E-1. How many cases have you participated in that involved the guilty but mentally ill (GBMI) plea/verdict (i.e., pleas entered or verdicts rendered)?

E-2. Which class(es) of mentally disordered offenders do you evaluate? (Examples: insanity acquittees, GBMI offenders, guilty offenders)

E-3. What was (is) the intent of the GBMI legislation? What is the basis of your response?

E-4. Has the intent been fulfilled? Why, or why not? What is the basis of your opinion?

E-5. How and from whom do you receive referrals or requests for mental health evaluations?

E-6. What are your methods or procedures for conducting psychological/ psychiatric evaluations of GBMI offenders? (Please note any standardized tests used, key pieces of information gathered for decision-making purposes, average length and frequency of examinations)

E-7. Have evaluation or screening policies and procedures been changed due to institution of the GBMI plea/verdict? If yes, what were the changes? Why were they necessary?

E-8. In your opinion, has the GBMI plea/verdict increased or decreased the number of jury trials in cases involving mental aberration? What is the basis for your response?

E-9. Have you testified in sentencing hearings involving GBMI offenders? If yes, how do these differ in nature or frequency from other sentencing hearings in which you have testified?

E-10. In your opinion, would the GBMI offenders be found guilty or NGRI if the GBMI plea/verdict were unavailable? What is the basis for your opinion?

E-11. In your experience, what are the characteristics of defendants most likely to be found GBMI, as opposed to not guilty by reason of insanity (NGRI) or guilty?

E-12. Are you involved in the development of mental health treatment plans for GBMIs and/or NGRIs? If yes, please describe the planning process, factors considered, treatment options available.

E-13. Are you involved in the provision of mental health treatment to GBMIs or NGRIs? If yes:

a. What agency or agencies actually provide treatment for GBMI offenders?

b. What is the average number of GBMIs and/or NGRIs in custody for treatment purposes on any given day? (statewide and/or your facility)

c. What types of treatment are available? How many treatment staff are available to provide treatment?

d. What types of treatment are usually provided? Does this vary by diagnosis? Please explain.

e. What is the average length and frequency of treatment?

E-14. Are GBMI offenders more likely to receive treatment than offenders with mental health problems in the general prison population? What is the basis for your response?

E-15. In your opinion, do recidivism rates vary among released NGRI, GBMI, and guilty offenders? How and why?

E-16. What do you view as the strengths of the GBMI statute(s)? Why?

E-17. What do you view as the weaknesses of the GBMI statute(s)? Why?

E-18. Has your perception of the desirability and impact of the GBMI plea/verdict changed since passage of the statute(s)? If yes, why?

Other Concerns and Comments:

GUILTY BUT MENTALLY ILL PROJECT

Interview Schedule F: **Corrections and Mental Health Personnel**

State: _____ Date: ___/___/ 84

Title/Position: _____ Interviewee #: _____

Organization/Agency: _____

Duties: _____

_____

F-1. How many cases have you participated in that involved the guilty but mentally ill (GBMI) plea/verdict (i.e., pleas entered or verdicts rendered)? Statewide?

F-2. Did a particular case, incident or problem lead to enactment of your state's GBMI statute(s)? If yes, what was it?

F-3. What was (is) the intent of the GBMI legislation? What is the basis of your response?

F-4. Has the intent been fulfilled? Why, or why not? What is the basis of your opinion?

F-5. How are determinations made about which offenders will receive treatment? Does the GBMI label play a role in such decisions?

F-6. What agency or agencies actually provide treatment for GBMI offenders? How was this determined? Are changes to the current provision of treatment anticipated?

F-7. Have policies and/or procedures for the handling of mentally disordered offenders changed due to institution of the GBMI plea/verdict? If yes, what were the changes? Why were they necessary?

F-8. In your experience, what are the characteristics of defendants most likely to be found not guilty by reason of insanity (NGRI)? GBMI? Guilty?

F-9. In your opinion, would the GBMI offenders be found guilty or NGRI if the GBMI plea/verdict were unavailable? What is the basis for your opinion?

F-10. Are you involved in the development of mental health treatment plans for GBMI and/or NGRI acquittees? If yes, please describe the planning process, factors considered, treatment options available.

F-11. Are you involved in the provision of mental health treatment to GBMIs or NGRIs? If yes:

a. What is the average number of GBMIs and NGRIs in custody for treatment purposes on any given day? (statewide and/or your facility)

b. What types of treatment are available? How many treatment staff are available to provide treatment?

c. What types of treatment are usually provided? Does this vary by diagnosis? Please explain.

d. What is the average length and frequency of treatment?

F-12. Are GBMI offenders more likely to receive treatment than offenders with mental health problems in the general prison population? What is the basis for your response?

F-13. Are mentally retarded defendants eligible to be classified as GBMI offenders in your state? If yes, are these GBMI offenders handled or treated differently? Please explain.

F-14. GBMI Sentencing and Confinement:

a. In practice, does the length and/or type of sentence differ (e.g., probation, split sentence) for guilty and GBMI offenders? If yes, what accounts for this?

b. In your opinion, does the period of confinement differ for NGRIs and GBMIs who have similar backgrounds? If yes, which group is generally confined longer? Why?

F-15. GBMI Transfer:

a. Describe the procedure for transfering GBMI offenders from the general prison population to a mental health or mental retardation facility for treatment. (Please note the frequency of occurence, the criteria employed, the organizations involved, the time required)

b. Describe the procedure for transfering GBMI offenders from a mental health or mental retardation facility to general prison population. (Please note the frequency of occurence, the criteria employed, the organizations involved, the time required)

F-16. In your opinion, has the GBMI plea/verdict increased or decreased costs to the mental health-law system in any way? If yes, how? If no, why not?

F-17. In your opinion, do recidivism rates vary among released NGRI, GBMI, and guilty offenders? How and why?

F-18. What do you view as the strengths of the GBMI statute(s)? Why?

F-19. What do you view as the weaknesses of the GBMI statute(s)? Why?

F-20. Has your perception of the desirability and impact of the GBMI plea/verdict changed since passage of the statute(s)? If yes, why?

Other Concerns and Comments:

GUILTY BUT MENTALLY ILL PROJECT
Interview Schedule G: **Probation Official**

State: _____ Date: ___/___/ 84

Title/Position: _____ Interviewee #: _____

Organization/Agency: _____

Duties: _____

_____

G-1. How many cases have you participated in that involved the guilty but mentally ill (GBMI) plea/verdict (i.e., pleas entered or verdicts rendered)? Statewide?

G-2. What was (is) the intent of the GBMI legislation? What is the basis of your response?

G-3. Has the intent been fulfilled? Why, or why not? What is the basis of your opinion?

G-4. Have probation policies or practices changed due to institution of the GBMI plea/verdict? If yes, what were the changes? Why were they necessary?

G-5. Do you handle or treat GBMI offenders differently than guilty offenders? (Examples: extent or type of supervision, willingness to revoke probation) Please explain.

G-6. Do the criteria used for placing offenders on probation vary for guilty offenders as compared with GBMI offenders?

G-7. Is a GBMI offender's period of probation likely to vary from that of a guilty offender?

G-8. How frequently is the receipt of mental health treatment and care a condition of probation for GBMI offenders? Guilty offenders?

G-9. In your opinion, do recidivism rates vary among released not guilty by reason of insanity (NGRI), GBMI, and guilty offenders? How and why?

G-10. What do you view as the strengths of the GBMI statute(s)? Why?

G-11. What do you view as the weaknesses of the GBMI statute(s)? Why?

G-12. Has your perception of the desirability and impact of the GBMI plea/verdict changed since passage of the statute(s)? If yes, why?

Other Concerns and Comments:

GUILTY BUT MENTALLY ILL PROJECT
Interview Schedule H: Parole Officials

State: _____ Date: ___/___/ 84

Title/Position: _____ Interviewee #: _____

Organization/Agency: _____

Duties: _____

_____

H-1. How many cases have you participated in that involved the guilty but mentally ill (GBMI) plea/verdict (i.e., pleas entered or verdicts rendered)? Statewide?

H-2. What was (is) the intent of the GBMI legislation? What is the basis of your response?

H-3. Has the intent been fulfilled? Why, or why not? What is the basis of your opinion?

H-4. Has the GBMI plea/verdict led to any change in parole practices? If yes, what were the changes? Why were they necessary?

H-5. Are (or will) GBMI offenders handled differently than other guilty offenders? (Examples: parole criteria differ, longer periods of incarceration required, receipt of mental health treatment as a condition of parole)

H-6. In practice does the length and/or type of sentence (e.g., split sentence) for guilty and GBMI offenders differ? If yes, what accounts for this?

H-7. In your opinion, do recidivism rates vary among released not guilty by reason of insanity (NGRI), GBMI, and guilty offenders? How and why?

H-8. What do you view as the strengths of the GBMI statute(s)? Why?

H-9. What do you view as the weaknesses of the GBMI statute(s)? Why?

H-10. Has your perception of the desirability and impact of the GBMI plea/verdict changed since passage of the statute(s)? If yes, why?

Other Concerns and Comments:

APPENDIX B. CASE FILE DATA COLLECTION INSTRUMENT

Coder _____

COMBINED CASE FILE
DATA COLLECTION INSTRUMENT

V001 Case Identification Number __/ __ __ __ __

V002 Date of Birth __ __/ __ __/ __ __

V003 Sex

Male	1
Female	2
Unknown	9

V004 Race

White	1
Black	2
Spanish	3
Oriental/Asian	4
Other _____	5
Unknown	9

V005 Date of Arrest __ __/ __ __/ __ __

V006 Crime(s) Charged

	Code
1) _____	_____
2) _____	_____
3) _____	_____

V007 Length of pretrial detention ___ ___ ___ days.

V008 Plea Entered at Arraignment

Guilty	1
Not Guilty	2
NGRI	3
GBMI	4
Other _____	
Unknown	.9

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V009 Date of Plea (Arraignment) __ __/ __ __/ __ __

V010 Date of Pretrial Forensic Evaluation __ __/ __ __/ __ __

V011 Location of Evaluation Code

_____ __ __

V012 Pretrial Evaluation conducted by:

state psychiatrist/psychologist (prosec)	1
county psychiatrist/psychologist (prosec)	2
private court-appointed psychologist (prosec)	3
private court-appointed psychologist (def)	4
retained (defense) psychiatrist/psychologist	5
other: specify _____	___
combination of above: _____	___
no examination conducted	0
unknown	9

V013 Length of Pretrial Evaluation

One day or less	1
Two days	2
Three days	3
Other: specify _____	
Unknown/Unable to determine	9
No evaluation	0

V014 & V015 Pretrial evaluation diagnosis

	Prosecution V014	Defense V015
Personality disorder	01	01
Neurosis	02	02
Organic Brain Syndrome	03	03
Manic Depressive	04	04
Schizophrenia (paranoid)	05	05
Schizophrenia (undifferentiated)	06	06
Other Psychosis	07	07
Mental Retardation	08	08
No mental illness	09	09
Other _____		
Unknown/Unavailable	99	99
N/A (no evaluation or dianosis)	00	00

V016 & V017 Pretrial evaluation recommendation

	Prosecution V016	Defense V017
Criminally responsible	1	1
Not responsible (NGRI)	2	2
GBMI	3	3
Incompetent to stand trial	4	4
Other _____		
Unknown	9	9

MENTAL HEALTH HISTORY

First

V018 Date of First Prior Treatment __ __/ __ __/ __ __

V019 Type of Facility

State Mental Hospital	1
Private Mental Hospital	2
Community Mental Health Center	3
VA Hospital	4
Private psychiatrist/psychologist	5
Other - specify _____	
Unknown	9
N/A	0

V020 Status

Court-ordered in-patient	1
Court-ordered out-patient	2
Voluntary in-patient	3
Voluntary out-patient	4
Other _____	
Unknown	9
N/A	0

V021 Reason for treatment

NGRI	1
ICC - suicidal	2
- dangerous to others	3
- unable to care for self	4
Incompetent to stand trial	5
Marital/family problems	6
Other _____	
Unknown	9
N/A	0

Second

V022 Date of Second Treatment __ __/ __ __/ __ __

V023 Type of Facility

State Mental Hospital	1
Private Mental Hospital	2
Community Mental Health Center	3
VA Hospital	4
Private psychiatrist/psychologist	5
Other - specify _____	
Unknown	9
N/A	0

V024 Status

Court-ordered in-patient	1
Court-ordered out-patient	2
Voluntary in-patient	3
Voluntary out-patient	4
Other _____	
Unknown	9
N/A	0

V025 Reason for treatment

NGRI	1
ICC - suicidal	2
- dangerous to others	3
- unable to care for self	4
Incompetent to stand trial	5
Marital/family problems	6
Other _____	
Unknown	9
N/A	0

Third

V026 Date of Third Treatment __ __/ __ __/ __ __

V027 Type of Facility

State Mental Hospital	1
Private Mental Hospital	2
Community Mental Health Center	3
VA Hospital	4
Private psychiatrist/psychologist	5
Other - specify _____	
Unknown	9
N/A	0

V028 Status

Court-ordered in-patient	1
Court-ordered out-patient	2
Voluntary in-patient	3
Voluntary out-patient	4
Other _____	
Unknown	9
N/A	0

V029 Reason for treatment

NGRI	1
ICC - suicidal	2
- dangerous to others	3
- unable to care for self	4
Incompetent to stand trial	5
Marital/family problems	6
Other _____	
Unknown	9
N/A	0

Other

V030 Number of additional treatment periods or hospitalizations

_____

CRIMINAL HISTORY

	First	Code
V031	Most recent offense charged _____	____
V032	Date of Offense __ __/ __ __/ __ __	

V033 Finding

Guilty	1
Not Guilty	2
NGRI	3
GBMI	4
Charges dropped	5
Incompetent to Stand Trial	6
Other _____	
Unknown	9
N/A	0

	Second	Code
V034	Second most recent offense _____	____
V035	Date of Offense __ __/ __ __/ __ __	

V036 Finding

Guilty	1
Not Guilty	2
NGRI	3
GBMI	4
Charges dropped	5
Incompetent to Stand Trial	6
Other _____	
Unknown	9
N/A	0

	Third	Code
V037	Third most recent offense _____	____
V038	Date of Offense __ __/ __ __/ __ __	

V039 Finding

Guilty	1
Not Guilty	2
NGRI	3
GBMI	4
Charges dropped	5
Incompetent to Stand Trial	6
Other _____	
Unknown	9
N/A	0

Other

V040 Number of total charges reflected in record _____

V041 Number of total charges reflected in convictions _____

V042 Number of prior jail commitments _____

V043 Number of prior prison commitments _____

V044 Number of prior sentences of probation _____

List three most serious offenses charged in addition to V031, V034, and V037.

		Code
V045	_____	_____
V046	_____	_____
V047	_____	_____

CURRENT OFFENSE

*** DOCKET OR CASE NUMBER - PLACE ON SAMPLE LISTING ONLY, NOT ON DATA COLLECTION SHEET.

		Code
V048 Court	_____	_____

V049 County _____ _____

V050 Judge _____ _____

V051 Type Trial/Adjudication

Bench trial	1
Jury trial	2
Plea bargain	3
Unknown	9

V052 Type Counsel

Indigent	1
Private, retained	2
Pro se.	3
Unknown	9

V053 Expert Testimony

Private expert for prosecution	1
State expert for prosecution	2
Private expert for defense	3
State expert for defense	4
Combinations: 1 & 3	5
1 & 4	6
2 & 3	7
2 & 4	8
Other _____	
Unknown	9
None	0

State/Public Expert employed by:

Code

V054 Agency _____ _____

V055 Institution _____ _____

V056 Verdict

Guilty	1
GBMI	2
NGRI	3
Other _____	
Unknown	9

V057 Date of Verdict __ __/ __ __/ __ __

V058 Conviction offense(s) Code

1) _____ _____

2) _____ _____

3) _____ _____

V059 Presentence report ordered

Yes	1
No	2
N/A (NGRI)	7
Unknown	9

V060 Agency/Office conducting PSI _____ _____

V061 Probation recommended

Yes	1
No	2
N/A (NGRI)	7
Unknown	9

V062 Post-conviction evaluation or NGRI Post-acquittal

If GBMI or Guilty:

Presentence evaluation	1
Postsentence evaluation	2
Both	3
Not evaluated	4
Unknown	9

If NGRI:

Yes	5
No	6
Unknown	9

V063 Date of presentence or post-acquittal evaluation

__ __/ __ __/ __ __

Evaluating Authority: Code

V064 Agency _____ _____

V065 Institution _____ _____

V066 Date of postsentence evaluation __ __/ __ __/ __ __

Evaluating Authority: Code

V067 Agency _____ _____

V068 Institution _____ _____

Evaluation conducted by:

V069
V070

	Presentence/ Postacquittal V069	Postsentence V070
State psychiatrist/psychologist	1	1
County psychiatrist/psychologist	2	2
Private ct-apptd. psychiatrist/psychologist	3	3
Other mental health professional _____	4	4
Physician (M.D.)	5	5
Other _____		
No examination	0	0
Unknown	9	9

Diagnosis:

V071
V072

	Presentence/ Postacquittal V071	Postsentence V072
Personality disorder	01	01
Neurosis	02	02
Organic Brain Syndrome	03	03
Manic Depressive	04	04
Schizophrenia (paranoid)	05	05
Schizophrenia (undifferentiated)	06	06
Other Psychosis	07	07
Mental Retardation	08	08
No mental illness	09	09
Other _____		
Unknown/Unavailable	99	99
N/A (no evaluation or diagnosis)	00	00

Treatment Recommendation:

V073
V074

	Presentence/ Postacquittal V073	Postsentence V074
No treatment required or not committable	1	1
Individual Counseling	2	2
Group Counseling	3	3
Other _____		
Combination _____		
NGRI-recommended as committable	6	6
N/A	7	7
Unknown	9	9
No recommendation	0	0

V075 Sentence received — Years ___ ___ Months ___ ___

V076 Placement/Disposition

If GBMI or Guilty:

Committed to DOC/DOR	1
Probation	2
Other _____	
Unknown	9

If NGRI:

Released	5
ICC	6
Other _____	
Unknown	9

V077 Location of Confinement Code

_____ _____

V078 Type of confinement:

If GBMI or Guilty:

General population	1
Psych or mental health unit	2
Other _____	
N/A (probation)	7
Unknown	9

If NGRI:

State Hospital-	
General population	5
Forensic population	6
Other _____	
N/A (released)	8
Unknown	9

TREATMENT

V079 Date Treatment Initiated __ __/ __ __/ __ __

V080 Agency

DOC/DOR	1
DMH/DHR	2
Other _____	
Unknown	9
None	0

Code

V081 Institution _____ _____

V082 Type of treatment

Individual counseling	1
Group counseling	2
Other _____	
Unknown	9
None	0

V083 Frequency of treatment

1 x per week	1
2 x per week	2
3 x per week	3
4 x per week	4
Daily	5
Other _____	
Unknown	9
None	0

V084 Medication _____ _____

V085 Medication _____ _____

V086 Date treatment completed __ __/ __ __/ __ __

TRANSFER

V087 Date of Transfer __ __/ __ __/ __ __

V088 Agency _____ _____

V089 Institution _____ _____

V090 Type of Treatment

Individual counseling	1
Group counseling	2
Other _____	.
Unknown	9
None	0

V091 Frequency of Treatment

1 x per week	1
2 x per week	2
3 x per week	3
4 x per week	4
Daily	5
Other _____	
Unknown	9
None	0

V092 Medication _____ _____

V093 Medication _____ _____

V094 Date of return transfer __ __/ __ __/ __ __

V095 Receiving agency _____ _____

V096 Receiving institution _____ _____

V097 Date of release __ __/ __ __/ __ __

V098 Type of release

GBMI or Guilty

Still in custody	0
Paroled	1
Sentence expired	2
Died in custody	3
Other _____	
Unknown	9

NGRI

Still in custody	0
No longer meets ICC criteria	6
Other	
Unknown	9

RECIDIVISM

V099 Number of arrests ____ ____

V100 Offense(s)

1) _____ _____

2) _____ _____

3) _____ _____

V101 Number of convictions _____

V102 Number of NGRI findings _____

V103 Offense(s) c/v

_____ _____ _____

_____ _____ _____

_____ _____ _____

V104 Number of DOC commitments _____

V105 Number of ICC commitments _____

APPENDIX C. CASE FILE DATA COLLECTION MANUAL

Computer Variable Name			Record 1 column(s):
ID	V001	Case ID Number - First digit signifies the state. Michigan = 1 Illinois = 2 Georgia = 3 Last four digits as assigned from master sampling lists.	1-5
DOB	V002	Date of birth - Use 9s if unknown or unavailable.	6-11
SEX	V003	Sex - Male 1 Female 2 Unknown 9	12
RACE	V004	Race - White = 1 Black = 2 Hispanic = 3 Oriental/Asian = 4 Midwestern = 6 Native American = 7 Unknown = 9	13
		CURRENT OFFENSE	
	***	These data pertain to the offense that placed the individual in the sample. Docket or Case Number - Court identification number for tracking into court system. Do not code. Place number on sample - master file list. Upon completion of data collection, list will be destroyed.	
DOA	V005	Date of Arrest-for offense that placed individual in sample.	14-19
CHARGE 1 CHARGE 2 CHARGE 3	V006	Crime(s) charged that placed offender in sample - list three most serious offenses charged [specify seriousness hierarchy] exactly as noted in the file then note the offense code to the right. Leave code blank if uncertain but always write in offense(s). [Expand offense code as necessary on-site].	20-21 22-23 24-25

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Offense Code

Murder, Homicide	01
Attempted murder	29
Manslaughter, voluntary or involuntary	30
Rape (of an adult)	02
Rape (of a minor; includes attempts & sodomy)	03
Attempted rape	37
Armed Robbery - weapon (includes attempts; bank robbery)	04
Armed Violence	32
Robbery- no weapon (including attempts)	05
Aggravated Assault	06
Aggravated Battery	23
Simple Assault; Simple Battery	07
Arson (aggravated & attempts)	08
Burglary; attempts; possession of burglary tools	09
Larceny and Theft (except shoplifting; includes theft from auto; attempts)	10
Auto Theft (UDAA)	11
Shoplifting	12
Forgery, Fraud, Deceptive practice, Extortion, Embezzlement, ISF, false insurance report	13
Stolen Property - buying, selling, receiving, possession	14
Weapons Charges, Unlawful weapon use or possession, concealed	15
Possession of Marijuana	16
Sale of Marijuana; cultivation	17
Possession - All other drugs (unspecified controlled substances)	18
Sale - All other drugs	19
Disorderly Conduct, Loitering, Vagrancy, Breach of Peace, Drunk	20
Driving under the Influence	21
Other Traffic Violations	22
Aggravated Incest & Incest	24
Child Abuse	50
Indecent liberties w/child, sexual abuse of child; attempts; child molesting	26
Deviate sexual assault, lewd behavior, public indecency; attempts; voyeurism, criminal sexual conduct	39
Contributing delinquency of minor	44
Child Pornography	43
Kidnapping, aggravated kidnapping	27
Unlawful restraint	34
Concealing a homicide	46
Criminal property damage, vandalism, malicious destruction	31
Prostitution	33
Trespass	36
Conspiracy	45
Intimidation, harrassment, malicious annoyance, threats	40
Illegal liquor sale	49
Resisting arrest/peace or corrections officer; assault of; interfering or resisting	25

		Contempt of court	35
		Violation of probation or parole	38
		Obstructing justice	47
		Bail jumping	48
		Escape (prison/jail)	41
		Draft resister	51
		Pandering/Pimping	52
		Miscellaneous federal offenses (IRS, counterfeiting, etc.)	53
		Gambling	54
		Manufacture or placement of explosives	55
		Repeat/Habitual Offender	56
		Solicit prostitution	57
		Inciting a riot	58
PLEA	V007	Plea entered at arraignment. If plea entered is not accepted by the court, code as "other" and note appropriately on-site.	26
		Guilty = 1	
		Not Guilty = 2	
		NGRI = 3	
		GBMI = 4	
		Nolo contendere = 5	
		Diminished capacity = 6	
		Nolo contendere but mentally ill = 7	
		Unknown = 9	
PLEADATE	V008	Date plea was entered - date of arraignment.	27-32
PRETVAL1	V009	Date of first pretrial forensic examination.	33-38
EVALTYP	V010	Type of evaluation or reason(s) for evaluation.	39-40
		Competency to stand trail = 1	
		NGRI = 2	
		Competency & NGRI = 3	
		GBMI = 4	
		Competency and mental status = 5	
		Mentally ill in jail = 6	
		Responsibility & diminished capacity = 7	
		Diminished capacity = 8	
		Unknown = 9	
		Competency, NGRI, & Diminished Capacity = 10	
		GBMI & Competency = 11	
		None = 0	

EVALLOC	V011	Note type of facility in which evaluation was conducted. Use 9 if unknown. Counseling center, county or private mental health center, etc. 1 Court clinic 2 Forensic center 3 Jail-municipal, county, or juvenile 4 Health Department 5 State hospital or mental health center 6 Doctor's office 7 Atty's office or defendant's home 8	41-42
OTHEREV	V012	Additional pretrial evaluations. Unknown = 9. Yes 1 No 2	43
PREVAL1 PREVAL2	V013	Type of mental health specialist conducting pretrial evaluation for the prosecution. Government 1 Private 2 Unknown 9 No exam 0	44-45
PREVAL3	V014	Type of mental health specialist conducting pretrial evaluation for the defense. [develop "other" codes on-site]. Retained 1 Appointed 2 Unknown 9 No exam 0	46
PREVST	V015	Nature of pretrial evaluation - offender's status (in- or out-patient). In-patient 1 Out-patient 2 Unknown 9 No exam 0	47

PREDIAG1 PREDIAG2	V016	Pretrial evaluation diagnosis - prosecution/state. If evaluation was conducted but finding unknown, code as 99. If not conducted, code as zeros. Criteria for grouping and collapsing categories to be based on DSM III.	48-49 50-51

Personality disorder	01
Neurosis	02
Organic Brain Syndrome	03
Manic Depressive	04
Schizophrenia (paranoid)	05
Schizpohrenia (undifferentiated)	06
Other Psychosis	07
Mental Retardation	08
No mental illness	09
Unspecified mental illness	10
Explosive disorder	11
Pedophilia	12
Chronic affect disorder	13
Unfit to stand trial	14
Personality disorder and organic brain syndrome	15
Substance abuse	16
Depression	17
Personality disorder and substance abuse	18
Delusional	19
Breakdown	20
Schizoid	21
Latent schizophrenia	22
Psychotic depression	23
Bipolar disorder	24
Schizo affective schizophrenia	25
Dysthmic disorder	26
Schizophrenia-residual type	27
Depersonalization	28
Thought disorder	29
Sexual orientation disturbance	30
Mentally retarded and character disorder	31
Paranoid, antisocial personality	32
Character disorder	33
Agoraphobia	34
Schizophrenia-catatonic type	35
Depressive neurosis	36
Mentally retarded and shizophrenic	37
Personality disorder and pedophilia	38
Sociopath	39
Mentally retarded and substance abuse	40
Multiple personality	41
Mentally retarded and personality disorder	42
Posttraumatic stress disorder	43
Unknown/Unavailable	99
N/A (no evaluation or diagnosis)	00

PREDIAG3 V017 Pretrial evaluation diagnosis - defense. If evaluation was conducted but finding is unknown, code as 99. If not conducted, code as zeros. "Other" codes same as V016. 52-53

Personality disorder	01
Neurosis	02
Organic Brain Syndrome	03
Manic Depressive	04
Schizophrenia (paranoid)	05
Schizpohrenia (undifferentiated)	06
Other Psychosis	07
Mental Retardation	08
No mental illness	09
Unknown/Unavailable	99
N/A (no evaluation or diagnosis)	00

PRTEVR1 V018 Pretrial evaluation recommendation - 54-55
PRTEVR2 prosecution/state. If N/A, code as zero. 56-57

Not mentally ill or insane	01
Insane	02
Mentally ill but not insane	03
Incompetent to stand trial	04
Fit for trial	05
Not insane	06
Fit and sane	07
Fit and insane	08
Unknown	09
Diminished capacity	10
Incompetent and insane	11
No insanity or diminished capacity	12
Competent but mentally ill	13
No diminished capacity	14
N/A (no recommended or no evaluation)	0

PRTEVR3 V019 Pretrial evaluation recommendation - defense. If N/A, code as zero. (Same codes as V018.) 58-59

Not mentally ill or insane	01
Insane	02
Mentally ill but not insane	03
Incompetent to stand trial	04
Unknown	09
N/A (no recommended or no evaluation)	0

COURT V020 Court in which case was tried - e.g., 9th Circuit Court, Chicago; Detroit Recorder's Court. 60-62

Illinois		Michigan	
1st Circuit	=10	Detroit Recorders Court	=01
2nd Circuit	=20	Hillsdale (Circuit 1)	=02
3rd Circuit	=19	Berrier (Circuit 2)	=03
4th Circuit	=18	Wayne (Circuit 3)	=04
5th Circuit	=08	Jackson (Circuit 4)	=05
6th Circuit	=01	Edton, Barry (Circuit 5)	=06
7th Circuit	=11	Oakland (Circuit 6)	=07
8th Circuit	=21	Genesee (Circuit 7)	=08
9th Circuit	=13	Toria, Montcalm (Circuit 8)	=09
10th Circuit	=05	Kalamazoo (Circuit 9)	=10
11th Circuit	=17	Saginaw (Circuit 10)	=11
12th Circuit	=15	Schoolcoaft, Chippewa, Algev, Luce (Circuit 11)	=12
13th Circuit	=12	Baraga, Keweenaw, Houghtan (Circuit 12)	=13
14th Circuit	=16	Antoim, Grand Traverse, Leelanan (Circuit 13)	=14
15th Circuit	=02	Muskegon (Circuit 14)	=15
16th Circuit	=14	Branch (Circuit 15)	=16
17th Circuit	=07	Macomb (Circuit 16)	=17
18th Circuit	=09	Kent (Circuit 17)	=18
19th Circuit	=04	Bay (Circuit 18)	=19
20th Circuit	=06	Lake, Mahistee, Mason (Circuit 19)	=20
Cook	=03	Otowaa (Circuit 20)	=21
		Chase, Osceola, Gladwin, Isabella (Circuit 21)	=22
		Washtenaw (Circuit 22)	=23
		Oscoda, Tosco, Alcona (Circuit 23)	=24
		Sanilac, Huron (Circuit 24)	=25
		Marquette (Circuit 25)	=26
		Alpena, Cheboyggan, Presque Isle, Montmorency (Circuit 26)	=27
		Mecosta, Newaygo, Oceana (Circuit 27)	=28
		Benzie, Wexford, Missankee (Circuit 28)	=29
		Gratiot, Clinton (Circuit 29)	=30
		Ingham (Circuit 30)	=31
		St. Clair (Circuit 31)	=32
		Ontonagon, Gogebic (Circuit 32)	=33
		Emmet, Charlevoix, Mackinac (Circuit 33)	=34
		Arenac, Roscommon, Ogemaw (Circuit 34)	=35
		Shiawassee (Circuit 35)	=36
		Van Buren (Circuit 36)	=37
		Calhoun (Circuit 37)	=38
		Monroe (Circuit 38)	=39
		Lenawee (Circuit 39)	=40
		Lopeeo, Tuskola (Circuit 40)	=41
		Dickinson, Iron, Menominee (Circuit 41)	=42
		Midland (Circuit 42)	=43
		Cass (Circuit 43)	=44
		Livingston (Circuit 44)	=45
		St. Joseph (Circuit 45)	=46
		Crawford, Otsego, Kalkaska (Circuit 46)	=47
		Delta (Circuit 47)	=48
		Allegon (Circuit 48)	=49

Georgia	
Alapaha	=01
Alcovy	=02
Atlanta	=03
Atlantic	=04
Augusta	=05
Blue Ridge	=06
Brunswick	=07
Chattahoochee	=08
Cherokee	=09
Clayton	=10
Cobb	=11
Conasauga	=12
Cordele	=13
Coweta	=14
Dougherty	=15
Dublin	=16
Eastern	=17
Flint	=18
Griffin	=19
Gwinnett	=20
Houston	=21
Lookout	=22
Macon	=23
Middle	=24
Mountain	=25
Northeastern	=26
Northern	=27
Ocmulgee	=28
Oconee	=29
Ogeechee	=30
Pataula	=31
Piedmont	=32
Rome	=33
South Georgia	=34
Southern	=35
Southwestern	=36
Stone Mountain	=37
Tallapoosa	=38
Tifton	=39
Toombs	=40
Waycross	=41
Western	=42

COUNTY V021 County - county in which case originated. 63-65

Illinois

Boone	18	Madison	27
Bureau	39	Marion	24
Clark	31	McHenry	34
Coles	08	McClean	41
Cook	03	Mercer	28
Clinton	40	Morgan	11
DeKalb	29	Moultrie	32
Douglas	01	Peoria	05
DuPage	09	Perry	33
Ford	21	Piatt	13
Franklin	37	Rock Island	20
Fulton	25	Sangamon	36
Grundy	14	Stark	45
Hancock	15	St. Clair	06
Henry	44	Stephenson	12
Jackson	22	Tazewell	26
Jefferson	38	Union	10
Kane	16	Whiteside	42
Kankakee	19	Will	17
Kendall	43	Winnebago	07
Knox	35		
Lake	04		
LaSalle	23		
Lee	02		
Livingston	30		

Michigan

Alger	44	Gratiot	25	Missaukee	52
Allegon	14	Huron	53	Monroe	23
Alpena	22	Ingham	05	Montcalm	36
Antrim	48	Ionia	10	Muskegon	30
Bay	13	Iosco	59	Neosta	57
Benzie	45	Iron	37	Newaygo	60
Berrien	20	Isabella	49	Oakland	11
Branch	56	Jackson	16	Ontonagan	38
Calhoun	46	Kalamazoo	09	Osceola	50
Cass	42	Kent	03	Ostego	24
Cheboygan	32	Lake	08	Ottawa	47
Clinton	51	Lapeer	55	Presque Isle	39
Crawford	35	Lenawee	12	Saginaw	06
Delta	33	Livingston	27	Sanilac	26
Eaton	31	Luce	15	Shiawassee	19
Emmett	54	Macomb	17	St. Clair	40
Genesee	02	Manistee	28	St. Joseph	43
Glodwin	18	Marquette	34	Tuscola	29
Gogebic	07	Menominee	58	Washtenaw	04
Grand Traverse	21	Midland	41	Wayne	01

Georgia

Appling	001	Evans	054	Newton	107
Atkinson	002	Fannin	055	Oconee	108
Bacon	003	Fayette	056	Oglethorpe	109
Baker	004	Floyd	057	Paulding	110
Baldwin	005	Forsyth	058	Peach	111
Banks	006	Franklin	059	Pickens	112
Barrow	007	Fulton	060	Pierce	113
Bartow	008	Gilmer	061	Pike	114
Ben Hill	009	Glascock	062	Polk	115
Berriem	010	Glynn	063	Pulaski	116
Bibb	011	Gordon	064	Putnam	117
Bleckley	012	Grady	065	Quitman	118
Brantley	013	Greene	066	Rabun	119
Brooks	014	Gwinnett	067	Randolph	120
Bryan	015	Habersham	068	Richmond	121
Bulloch	016	Hall	069	Rockdale	122
Burke	017	Hancock	070	Schley	123
Butts	018	Haralson	071	Screven	124
Calhoun	019	Harris	072	Seminole	125
Camden	020	Hart	073	Spalding	126
Candler	021	Heard	074	Stephens	127
Carroll	022	Henry	075	Stewart	128
Catoosa	023	Houston	076	Sumter	129
Charlton	024	Irwin	077	Talbot	130
Chatham	025	Jackson	078	Taliaferro	131
Chattahootchee	026	Jasper	079	Tattnall	132
Chattooga	027	Jeff Davis	080	Taylor	133
Cherokee	028	Jefferson	081	Telfair	134
Clarke	029	Jenkins	082	Terrell	135
Clay	030	Johnson	083	Thomas	136
Clayton	031	Jones	084	Tift	137
Clinch	032	Lamar	085	Toombs	138
Cobb	033	Lanier	086	Towns	139
Coffee	034	Laurens	087	Treutlen	140
Colquitt	035	Lee	088	Troup	141
Columbia	036	Liberty	089	Turner	142
Cook	037	Lincoln	090	Twiggs	143
Coweta	038	Long	091	Union	144
Crawford	039	Lowndes	092	Upson	145
Crisp	040	Lumpkin	093	Walker	146
Dade	041	Macon	094	Walton	147
Dawson	042	Madison	095	Ware	148
Decatur	043	Marion	096	Warren	149
Dekalb	044	McDuffie	097	Washington	150
Dodge	045	McIntosh	098	Wayne	151
Dooly	046	Meriwether	099	Webster	152
Dougherty	047	Miller	100	Wheeler	153
Douglas	048	Mitchell	101	White	154
Early	049	Monroe	102	Whitfield	155
Echols	050	Montgomery	103	Wilcox	156
Effingham	051	Morgan	104	Wilkes	157
Elbert	052	Murray	105	Wilkinson	158
Emanuel	053	Muscogee	106	Worth	159

JUDGE	V022	Judge - name of judicial officer that presided at trial. Assigned numbers for judges in Georgia run from 001 to 108. There are no judges with the numbers 35, 46, 49, 52, 53. Assigned numbers for judges in Illinois run from 1 to 91. Assigned numbers for judges in Michigan run from 1 to 219.	66-68
TRIALTYP	V023	Type trial/adjudication mechanism - if it is clear from the record that a plea bargain was agreed upon and accepted by the presiding judge, code as 3. Bench trial 1 Jury trial 2 Plea bargain 3 Plea taking 4 Unknown 9	69
COUNTYP	V024	Type counsel - if uncertain, note the attorney's name in pencil for verification by local officials and code later. Use 9 only as a last resort. Court-appointed 1 Private, retained 2 Pro se 3 Unknown 9	70
			Record 2 column(s):
EXPERT1	V025	Expert testimony at trial - for the prosecution. Private expert 1 Government expert 2 Unknown 9 None 0	6
			Record 2 column(s):
EXPERT2	V026	Expert testimony at trial - for the defense. Private expert 1 Government expert 2 Unknown 9 None 0 State/Public Expert employed by:	7

EMPAG EMPIN	V027 & V028	Note public agency and specify institution that employs state or public expert that testified. For example, State Department of Mental Health (agency - V027); Central State Hospital (institution - V028).	8-9 10-11

V027		V028	
DHR/DMH/IDMHDD	= 01	Alton SMH	= 01
Cook County Court Clinic	= 02	Cook County Court Clinic	= 02
Private	= 03	CFP	= 03
		CFP and Kalamazoo SMH	= 04
		Private	= 05
		GRH-Augusta	= 06
		CSH	= 07
		GRH-Savannah	= 08
		SWSH-Thomasville	= 09
		GRH-Columbus	= 10

FINDING	V029	Finding - ('Not guiltys' should not be in sample). Guilty = 1 GBMI = 2 NGRI = 3 Criminal charges dropped (DOC misconduct only) = 4 Unknown = 9	12
FINDATE	V030	Date of Finding.	13-18
CONVICT1 CONVICT2 CONVICT3	V031	Offense of which offender was convicted. If more than 3, list 3 most serious. Use offense codes for V006. Note offense(s) of which individual found NGRI as well.	19-20 21-22 23-24
PROB	V032	Probation recommendation. Yes 1 No 2 N/A (NGRI) 7 Unknown 9	25

POSTEV	V033	NGRI or postconviction mental health or mental status evaluation conducted for sentencing, placement, and/or treatment purposes. Presentence evaluations are noted only if conducted separately from pretrial evaluation. If GBMI or Guilty Presentence evaluation 1 Postsentence evaluation 2 Both 1 & 2 3 Not evaluated 4 Unknown 9 If NGRI Yes 5 No 6 Unknown 9	26
PRESVALD	V034	Date of presentence evaluation--If unknown, all 9s. If no such evaluation conducted (NGRI) , all 0s.	27-32
POSEVALD	V035	Date of postsentence evaluation - use zeros if no such evaluation conducted or if NGRI. If unknown, code as 9s.	33-38
POSAVALD	V036	Date of postacquittal evaluation--If unknown, all 9s. If no such evaluation conducted or if G or GBMI, all 0s.	39-44
PRESEVAL POSEVAL POACEVAL	V037 - V039	Diagnosis resulting from mental health evaluation: presentence, post-acquittal, postconviction. Circle one in each column. Use 99 for not applicable or unknown. Specify other.	45-46 47-48 49-50

Personality disorder	01
Neurosis	02
Organic Brain Syndrome	03
Manic Depressive	04
Schizophrenia (paranoid)	05
Schizophrenia (undifferentiated)	06
Other Psychosis	07
Mental Retardation	08
No mental illness	09
Mental illness - unspecified	10
Suicidal	11
Personality disorder and substance abuse	12
Antisocial personality	13
Substance abuse	14
Schzoid	15
Dysthmic disorder and substance abuse	16
Depression	17
Dysthmic disorder	18
Organ. Br. Syndr. and person. disorder	19
Pedophilia	20

Sociopath	21
Personality disorder and major depression	22
Bipolar disorder	23
Paranoia	24
Schizophrenia, schizo affective type	25
Schizophrenia, residual type	26
Depersonalization	27
Incompetent to be sentenced	28
Mentally retarded and personality disorder	29
Thought disorder and paranoia	30
Fetishism and Exhibitionism	31
Cyclothymic disorder	32
Schizophrenia & Org. Brain Syndrome	33
Multiple personality	34
Pyromania	35
Schizophrenia & Pers. Disorder	36
Unknown/Unavailable	99
N/A (no evaluation or diagnosis	00

Treatment Recommendation:

PRETREC, POSTREC, POACTREC — V040, V042 — 51-52, 53-54, 55-56

Treatment recommendation - Circle one in each column (presentence, postsentence, postacquittal). Use 99 for not applicable or unknown. Note type(s) of medication.

No treatment required or not committable	01
Individual Counseling	02
Group Counseling	03
Medication	04
Treatment - unspecified	05
NGRI-recommended as committable	06
Sex offender program	07
Unspecified treatment & medication	08
Unknown	09
Substance abuse program (including A.A. and drugs)	10
More testing/evaluation	11
Psychotherapy and Activity therapy	12
Counseling, Psychotherapy and Medication	13
Transfer to LRA	14
Counseling, Psychotherapy, Activity therapy, and Medication	15
Psychotherapy	16
Incompetent to be sentenced	17
Vocational training	18
Transfer to DMH/DHR	19
Substance abuse and sex offender program	20
Psychotherapy and substance abuse	21
Substance abuse and vocational training	22
Sex offender and group therapy	23
No recommendation or N/A	00

MINSEN MAXSEN MINREL MAXREL	V043	Sentence received by GBMI & guilty offenders in years and months. If NGRI, code as zeros. Use 99 for unknown. If sentence was 99 years or life, note in margin and leave for coding later. If sentence was death, check box and code as XXXX. Code Life Sentence as 88. (MINSEN AND MAXSEN represent minimum and maximum sentences in Michigan. MINREL and MAXREL are the release dates in Illinois. See last columns on Record 5 for Georgia sentencing data.)	57-58 59-60 61-66 67-72

Record 3 Column(s):

PLACE V044 First Placement/Disposition following post-conviction or post-acquittal evaluation and diagnosis. (If not commitable, code as released.) 6-7

If GBMI or Guilty

Committed to DOC/DOR	= 1
Probation	= 2
DMH/DHR	= 3
Probation revoked then incarcerated	= 4
Outpatient	= 7
Unknown	= 9
Returned to prison	=10

If NGRI

Released	= 5
ICC	= 6
Outpatient	= 7
Voluntary	= 8
Unknown	= 9
VA Hospital	=11
Voluntary after 30 days	=12

CONLOC V045 Current or last (if released) location of confinement - note facility (DMH or DOC) or prison if committed to DOC (example - Marquette Prison). If placed on probation, note probation department & branch (example - Lake County Probation Department or State Department of Probation & Parole, X county/city office). If NGRI, note hospital, mental health center, etc. (example - Eastern State Mental Hospital or Blue Ridge Mental Health Center). [develop codes on-site]. 8-9

Illinois		Michigan	
Menard Psych	01	Northville SMH	01
Joliet	02	CFP/Dept. of Mental Health	02
Menard	03	CFP (observation only)	03
Vienna	04	Ypsi RPH	04
Centralia	05	Kalamazoo SMH	05
Vandalia	06	Kent Oaks Hospital	06
Graham	07	Traverse City SMH	07
Logan	08	Battlecreek VA Hospital	08
Pontiac	09	Riverside (DOC)	09
Dwight	10	Outpatient	10
Stateville	11	SPSM	11
Sheridan	12	HVWF	12
		Cassidy Lake	13

Georgia	
Metro CI	01
GA Industrial Inst.	02
GA Diag. & Class. Ctr.	03
Central CI	04
GWCI	05
Augusta C & Med. I.	06
Coastal CI	07
Rutledge CI	08
Men's CI	09
Walker CI	10
Ware CI	11
GA State Prison	12
Putnam CI	13
Youthful Off. CI	14
GRH-Atlanta	15
GMHI-Atlanta	16
GRH-Augusta	17
VA Hospital	18
CSH	19
GRH-Savannah	20
SWSH-Thomasville	21
GRH-Columbus	22

Marquette Prison	14
Michigan Training Unit	15
Ionia (DOC)	16
Camp Gillman	17
Ingham med Ctr.	18
Muskegan	19
Parole Camp	20
Camp Ojibway	21
Monroe CC	22
Woodward CC	23
Detroit CC	24
Waterloo	25
Rec Ctr	26
HVMF	27
Phoenix	28
Mich Int Prog.	29
Lehman	30
Kinross	31

CONTYP V046 Type of current or last confinement. 10-11

If GBMI or Guilty:

General population	=01
Psych or mental health unit	=02
Health care unit	=03
Close observation	=04
Unknown	=09
Outpatient	=10
VA Hospital	=11
Prison	=12
Drug Unit	=13

If NGRI:

State Hospital-	
General population	=05
Forensic population	=06
N/A (probation)	=07
N/A (released)	=08
Unknown	=09
Outpatient	=10
VA Hospital	=11

TREATMENT

TRTBEG V047 Date treatment initiated for offense that placed individual in sample. Use 9s if unknown, zeros if no treatment provided. 12-17

TRTAG V048 Agency providing initial treatment following commitment. 18

DOC/DOR	= 1
DMH/DHR	= 2
Federal	= 3
Unknown	= 9
None	= 0

TRTINST V049 Note initial institution/facility providing treatment (other than a reception center). Example: Chester Mental Health Center. Write none if no treatment provided and code as zeros. 19-20

Illinois		Michigan	
Menard Psych	01	CFP	01
Joliet	02	Northville	02
Sheridan	03	Kalamazoo	03
Menard	04	Kent Oaks	04
Logan	05	Alternative Trmt. Prog.	05
Graham	06	Ypsilanti RPH	06
Centralia	07	Lafayette Clinic	07
Pontiac	08	Traverse City SMH	08
Dwight	09	Battlecreek VA	09
		Riverside (DOC)	10
Georgia		SPSM	11
CSH	24	Kent Community	12
Albany MHC	25	HVWF	13
ACMI	26	Dunes CF	14
Rutledge	27	Marquette Prison	15
Central CI	28	Muskegon CF	16
Coastal CI	29	Camp Waterloo	17
GRH-Atlanta	30	Cassidy Lake	18
GMHI-Atlanta	31	Ionia Reformatory	19
GRH-Columbus	32	Grand Rapids CC	20
NWGRH-Rome	33	Kinross CF	21
GRH-Augusta	34	Michigan Trng. Unit	22
GRH-Savannah	35	Washtenaw Co. Jail	23
SWSH-Thomasville	36	SHAR House	24
VA Hospital	37		

TRTTYP1 V050 Type of treatment. Use V052 & 053 for medication data. Note combinations of treatment modes. 21-22

Individual counseling	1
Group counseling	2
Sex offender program	3
Unspecified	4
Milieu	5
Substance abuse	6
Multiple (counseling/ activity, etc.)	7
Work therapy	8
Unknown	9
None	0

TRTFRQ1	V051	Frequency of treatment.	23
		1 x per week 1	
		2 x per week 2	
		3 x per week 3	
		4 x per week 4	
		Daily 5	
		Unknown 9	
		None 0	
MED1	V052	-	24-25
MED2	V053	Medication - if none, code as zero. If medication used but type unknown, code as 99. If more than two types of medication, list two used most frequently.	26-27

Aldomet	47	Motrin	46
Amitenphyhae	41	Navane	15
Artane	16	Perphenazine	40
Asendin	43	Phenobarbitol	18
Asthma medicine	22	Placidyl	42
Atarax	24	Prolixin	14
Atenol	60	Pryridoxine	45
Benadryl	28	Psychotropic-gen.	03
Benzotropine	33	Serax	27
Centrex	62	Serentil	52
Chlorpromazine	34	Sinequan	07
Chlorthalidone	49	Stelazine	12
Cogentin	02	Sodium amytal	58
Compazine	61	Talivin	50
Coumadin	55	Tegretol	19
Dalmane	20	Teractan	23
Darvon	32	Theodur	54
Desryl	26	Thiamine	48
Diazepan	31	Thioridizine	37
Dilantin	17	Thiotexene	25
Dyozide	56	Thorazine	01
Elavil	05	Tofranil	09
Fluphenazine decanoate	13	Triavil	59
Haldol	10	Trifluoperizine	36
Haloperidol	35	Trilafon	06
Imipramine	39	Valium	30
Librium	29	Vistaril	21
Lithium	08	Xanax	51
Lithobid	44		
Loxitane	11		
Ludiomil	53		
Mellaril	04		
Mesoridazine	38		
Moban	57		

DATRCOM	V054	Date treatment completed or terminated. Refers to initial treatment sequence by agency. If none, code as zeros; if unknown, code as 9s. If treatment is ongoing, code as 8s. If died in custody, 7s.	28-33
DATRANS	V055	Date of Transfer - record date of transfer for mental health treatment only. If none, code as zeros; if unknown, code as 9s.	34-39
ACCAG	V056 &		40
ACCIN	V057	Note agency and institution accepting individual transferred for purposes of mental health treatment. Example (GBMI transferred to "DMH" (agency) custody at "Forensic Center" (facility). Also appropriate to note transfer from one prison to another prison with a psych unit if transferred for treatment purposes. If no transfer, code as zeros. If transferred but date unknown, code as 9s. If more than one transfer, note all data in margin for coding later.	41-42

V056

DOR/DOC	=01
DHR/DMH/DMHDD	=02
County	=03
City	=04
Private	=05

V057 (Georgia)

Metro CI	=01
GA Industrial Inst.	=02
GA Diag & Class. Center	=03
Central CI	=04
GWCI	=05
Augusta CI	=06
Coastal CI	=07
Rutledge CI	=08
Men's CI	=09
Walker CI	=10
Ware CI	=11
GA State Prison	=12
Putman CI	=13
Youthful Off. CI	=14
CSH	=25
GMHI-Atlanta	=26
GRH-Atlanta	=27
GRH-Augusta	=28
GRH-Savannah	=29
SWSH-Thomasville	=30
GRH-Columbus	=31

V057 (Michigan and Illinois)

Logan	=01
Menard Psych	=02
Manteno	=03
Kalamazoo SMH	=04
Alt. Trmt. Prog.	=05
Traverse City SMH	=06
Ypsilanti RPH	=07
Northville SMH	=08
CFP	=09
Kent Oaks	=10
Clinton Valley Center (SMH)	=11
Detroit East MHC	=12
Ingaham Community Support Services	=13
Washtenaw County CMH	=14
West Central CMH	=15
Pine Rest Christian Rehab. Services	=16
SPSM	=17
Family & Childrens Continuing Services	=18
Riverside	=19
HVWF	=20
Genesee County Home	=21
Kinross CF	=22
Detroit Downtown Corr. Ctr.	=23
Lafayette Clinic	=24
Marquette	=25

TRTTYP2	V058	Type of treatment (excluding medication) following transfer. Note combinations of treatment modes. Individual counseling = 1 Group counseling = 2 Sex offender = 3 Unspecified = 4 Alt. Trmt. Prog. = 5 Counseling, Psychotherapy & Activity Th., (Multiple) = 6 Psychotherapy = 7 Activity Th. = 8 Unknown = 9 Substance Abuse = 10 None = 0	43-44
TRTFRQ2	V059	Frequency of treatment. [Develop "other" codes on-site]. 1 x per week 1 2 x per week 2 3 x per week 3 4 x per week 4 Daily 5 Unknown 9 None 0	45
MED3	V060 &		46-47
MED4	V061	Medication - if none used, write none and code as zero. If more than two types of medication are used, list the two used most frequently. Use 9s if unknown. Same codes as V052 & V053.	48-49
DARETR	V062	Date of return transfer, if appropriate. If none, code as zeros. If transferred but date cannot be determined, code as 9s.	50-55
RECAG	V063 &		56
RECIN	V064	Agency and institution receiving the transferred individual. If not applicable, code as zeros. If transferred but information unavailable, code as 9s.	57-58
ADDTRANS			59

V063

DOR/DOC = 01
DHR/DMH = 02

V064

Joliet	= 01
Menard	= 02
Riverside Psych.	= 03
Kalamazoo SMH	= 04
CFP	= 05
Northville	= 06
HVWF	= 07
SPSM	= 08
Muskegon (DOC)	= 10
ACMI	= 11
Metro CI	= 12
GD & CC	= 13
GWCI	= 14
CSH	= 15
GRH-Augusta	= 16

RELEASE

RELDAT V065 Date of release - use for all three offender groups. If not yet released, code as zeros. If released but date unavailable, code as 9s. 60-65

RELTYP V066 Type of release - 66-67

GBMI or Guilty

Still in custody	= 0
Paroled	= 1
Sentence expired	= 2
Died in custody	= 3
Recommitted after MSR violation	= 4
Discharged/commuted to time served	= 5
Outpatient	= 7
Unknown	= 9
Unauthorized	=10
Reversed on appeal	=11
Furlough program	=12
Probation (split sentence)	=13
Voluntary continuation (switched to prison)	=14

NGRI

Still in custody	= 0
Died in custody	= 3
No longer meets ICC criteria	= 6
Outpatient	= 7
Released after observ.	= 8
Unknown	= 9
Unauthorized	=10
Furlough program	=12
Transferred to S.O.	=15

MENTAL HEALTH HISTORY

Record 4 column(s):

DAMHTRT1 V067 Date of First Prior Treatment - all 0s if no mental health treatment prior to offense that placed individual in sample. Code as 9s if treated but date unknown. — 6-11

FACTYP1 V068 Type of facility - 0 if no prior treatment, 9 if type of facility unknown. — 12-13

State Mental Hospital	= 1
Private Mental Hospital	= 2
Community Mental Health Center	= 3
VA Hospital	= 4
Privated psychiatrist/psychologist	= 5
Jail/Prison/Forensic	= 6
City Hospital	= 7
Halfway House	= 8
Unknown	= 9
Private Hospital	=10
Social Services Facility	=11
Devmt. Disability Ctr.	=12
Foster Home	=13
Recorder's Clinic	=14
Air Force Psych Facility	=15
N/A	= 0

STAT1 V069 Status - 0 if no prior treatment; 9 if unknown. — 14

Involuntary in-patient	= 1
Involuntary out-patient	= 2
Voluntary in-patient	= 3
Voluntary out-patient	= 4
Parental voluntary admission	= 5
Criminal	= 6
Unknown	= 9
N/A	= 0

TRTREAS1 V070 Reason for treatment - 0 if no prior treatment. — 15-16

NGRI	=01	Nervous breakdown	=17
ICC-dangerous to self	=02	Inmate transfer	=18
-dangerous to others	=03	Psychotic	=19
-unable to care for self	=04	Schizoid	=20
Incompetent to stand trial	=05	Sociopath	=21
Marital/family problems	=06	Bizarre behavior	=22
Substance abuse	=07	Criminal court referral	=23
Mentally ill in prison/jail	=08	Agoraphobic	=24
Unknown	=09	Misbehavior	=25
Depressed	=10	Personality disorder	=26
Condition of probation	=11	Kleptomania	=27
Sexual deviance	=12	Assaultive	=28
Manic depressive	=13	Viet Nam Flashbacks	=29
Paranoid schizo or undiff.	=14	N/A	= 0
Suicidal	=15		
Mentally retarded	=16		

*Second

DAMHTRT2	V071	Date of second treatment - all 0s if no previous mental health treatment or only one period of treatment. 9s if treated but date unknown.	17-22
FACTYP2	V072	Type of facility - 0 if not applicable 9 if unknown. State Mental Hospital =01 Private Mental Hospital =02 Community Mental Health Center =03 VA Hospital =04 Private psychiatrist/psychologist =05 County Health Department =06 City Hospital =07 Retard./Dev. Disabl. Ctr. =08 Unknown =09 Prison =10 N/A = 0	23-24
STAT2	V073	Status - 0 if not applicable. 9 if unknown. Involuntary in-patient = 1 Involuntary out-patient = 2 Voluntary in-patient = 3 Voluntary out-patient = 4 Parental admission = 5 Unknown = 9 N/A = 0	25
TRTREAS2	V074	Reason for treatment - 0 if not applicable. NGRI = 1 ICC-dangerous to self = 2 -dangerous to others = 3 -unable to care for self = 4 Incompetent to stand trial = 5 Marital/family problems = 6 Mentally ill in prison/jail = 7 Depressed = 8 Unknown = 9 Substance abuse =10 Breakdown =11 Psychotic =12 Manic depression =13 Schizophrenia =14 Suicidal =15 Retarded =16 Bizarre bahavior =17 Sexual deviance =18 Condition of probation =19 Personality disorder =20 N/A = 0	26-27

*Third

DAMHTRT3 V075 Date of third treatment - all 0s if no previous mental health treatment or only two periods of previous treatment. Use 9s if treated but date unknown. 28-30

FACTYP3 V076 Type of facility. 34-35

State Mental Hospital	= 1
Private Mental Hospital	= 2
Community Mental Health Center	= 3
VA Hospital	= 4
Private psychiatrist/psychologist	= 5
City hospital	= 6
Army hospital	= 7
Private hospital	= 8
Unknown	= 9
Dev. Disab. Ctr.	=10
N/A	= 0

STAT3 V077 Status - 0 if not applicable. 36

Involuntary in-patient	=01
Involuntary out-patient	=02
Voluntary in-patient	=03
Voluntary out-patient	=04
Unknown	=09
N/A	= 0

TRTREAS3 V078 Reason for treatment. 37-38

NGRI	= 1
ICC-dangerous to self	= 2
-dangerous to others	= 3
-unable to care for self	= 4
Incompetent to stand trial	= 5
Marital/family problems	= 6
Depressed	=07
Substance abuse	=08
Unknown	= 9
Hearing voices	=10
Nervous breakdown	=11
Psychotic	=12
Suicidal	=13
Schizophrenia	=14
Sexual deviance	=15
Mentally ill in prison	=16
Personality disorder	=17
N/A	= 0

ADDTRT V079 Additional treatment periods or hospitalizations beyond current offense and three instances noted above - use 9 if unable to determine or information unavailable. 39

Yes	1
No	2
Unknown	9

*First

PROF1 V080 Most recent prior offense charged (not current offense)-use offense codes for V006. Write none if appropriate and code as 88. Use 99 if unknown. 40-41

DAPROF1 V081 Date of most recent prior offense charged. Use 8s if V080 is none. Use 9s if unknown. 42-47

OUTPROF1 V082 Finding - circle appropriate response; if "other", specify. If initially found IST, then finding rendered later, code as 6 and write ultimate finding under "other". 48-49

Guilty	=01
Not Guilty	=02
NGRI	=03
GBMI	=04
Charges dropped	=05
Incompetent to Stand Trial	=06
Diverted	=07
Held	=08
Unknown	=09
Parole revoked	=10
Pending	=11
Fugitive	=12
N/A	= 0

*Second

PROF2 V083 Second most recent prior offense charged - use offense codes for V006. Write none if appropriate and code as 88. Use 99 if unknown. Use zeros if none or not applicable. 50-51

DAPROF2 V084 Date of offense in V083. Use 8s if no offense, use 9s if unknown. 52-57

OUTPROF2 V085 Outcome - circle appropriate response; if "other", specify. 58-59

Guilty	=01
Not Guilty	=02
NGRI	=03
GBMI	=04
Charges dropped	=05
Incompetent to Stand Trial	=06
Parole revoked	=07
TOT DOC	=08
Unknown	=09
Pending	=10
N/A	= 0

*Third

PROF3	V086	Third most recent prior offense - use offense codes for V006. Write none if appropriate and code as 88. Use 99 if unknown.	60-61
DAPROF3	V087	Date of offense in V086. Use 8s if no offense, use 9s if unknown.	62-67
OUTPROF3	V088	Outcome - if "other", specify.	68-69

Guilty	=01
Not guilty	=02
NGRI	=03
GBMI	=04
Charges dropped	=05
Incompetent to Stand Trial	=06
Pending	=07
Parole revoked	=08
Unknown	=09
Suspended sentence	=10
N/A	= 0
Other	

Record 5 column(s):

TOTCONV	V089	Total number of convictions in record including current offense, those noted above, and others.	6-7
PRINC	V090	Number of prior jail or prison commitments - zero if none, 9 if unknown, 8 if exceeds or equals 8.	8
PRIPROB SPLITSEN	V091	Number of prior probation commitments - zero if none, 9 if unknown, 8 if exceeds or equals 8.	9 10

RECIDIVISM

RECARR	V092	Number of arrests following release from confinement (or probation) that placed individual in sample.	11-12
RECCONV	V093	Number of convictions since release. If none code as zeros.	13
RECOFF1 RECOFF2 RECOFF3 RFIND1 RFIND2 RFIND3	V094	List three most serious subsequent offenses for which individual was convicted. Use offense codes for V006. If none, code as zeros. If unavailable or unable to determine, use 9s. Note whether individual was found guilty or GBMI or a parole violator (P/V) in space provided.	14-15 17-18 20-21 16 19 22

Guilty	= 01
GBMI	= 02
Probation/Parole Violator	= 03

RECNGRI	V095	Number of NGRI findings since release.	23
NGRIOFF1 NGRIOFF2 NGRIOFF3	V096	List three most serious offense(s) of which individual was found NGRI.	24-25 26-27 28-29
DOCCOM	V097	Number of DOC commitments.	30
ICCCOM	V098	Number of ICC commitments.	31
TOTSEN	V043a	Total sentence in years (Georgia only).	32-33
PRISON	V043b	Number of years of total sentence to be served in prison (Georgia only).	34-35
GAPROB	V043c	Number of years of total sentence to be served on probation, i.e., split sentence (Georgia only).	36-37

ILLINOIS NGRI DATA

Computer Variable Name			Column(s):
ID	V01	Case Identification Number	1-3
FAC	V02	Facility	4-5

Facility Codes

Galesburg Mental Health Center	09
Tinley Park Mental Health Center	14
Dixon Developmental Center	18
Alton Mental Health Center	19
Lincoln Developmental Center	28
Anna M H & Dev. Center	29
Illinois State Psychiatric Institute	38
Chicago-Read MHC	39
H. Douglas Singer MHC	44
Waukegan Developmental Center	45
Illinois Institute for DD	48
John J. Madden MHC	54
William Healy School of Juvenile Research	55
Warren G. Murray Dev. Center	58
Elgin Mental Health Center	59
George A Zeller MHC	64
Chester Mental Health Center	66
Jacksonville Developmental Center	69
Andrew McFarland MHC	74
Shapiro Developmental Center	79
Adolf Meyer Mental Health Center	84
William W. Fox Dev. Center	88
Manteno Mental Health Center	89
Elizabeth Ludeman Dev. Center	95
William A. Howe Dev. Center	98

RACE	V03	Race	6

White = 1
Black = 2
Hispanic = 3
Asian/Oriental = 4

DIAG	V04	Diagnosis--DSM III Codes	7-12
PREVAD	V05	Previous Admissions	13-14
SEX	V06	Sex--Male = ____ Female = ____	15

COUNTY

16-18

V07 County			
Adams (ADA)	1	Logan (LOG)	54
Alexander (ALE)	2	Macon (MCN)	55
Bond (BON)	3	Macoupin (MCP)	56
Boone (BOO)	4	Madison (MAD)	57
Brown (BRO)	5	Marion (MRN)	58
Bureau (BUR)	6	Marshall (MRS)	59
Calhoun (CAL)	7	Mason (MSN)	60
Carroll (CAR)	8	Massac (MSC)	61
Cass (CAS)	9	McDonough (MCD)	62
Champaign (CHA)	10	McHenry (MCH)	63
Christian (CHR)	11	McLean (MCL)	64
Clark (CLR)	12	Menard (MEN)	65
Clay (CLY)	13	Mercer (MER)	66
Clinton (CLI)	14	Monroe (MNR)	67
Coles (COL)	15	Montgomery (MNT)	68
Cook (except Chicago)(COO)	16	Morgan (MOR)	69
Crawford (CRA)	17	Moultrie (MOU)	70
Cumberland (CUM)	18	Ogle (OGL)	71
DeKalb (DEK)	19	Peoria (PEO)	72
DeWitt (DEW)	20	Perry (PER)	73
Douglas (DOU)	21	Piatt (PIA)	74
DuPage (DUP)	22	Pike (PIK)	75
Edgar (EDG)	23	Pope (POP)	76
Edwards (EDW)	24	Pulaski (PUL)	77
Effingham (EFF)	25	Putnam (PUT)	78
Fayette (FAY)	26	Randolph (RAN)	79
Ford (FOR)	27	Richland (RIC)	80
Franklin (FRA)	28	Rock Island (ROC)	81
Fulton (FUL)	29	Saline (SAL)	82
Gallatin (GAL)	30	Sangamon (SAN)	83
Greene (GRE)	31	Schuyler (SCH)	84
Grundy (GRU)	32	Scott (SCO)	85
Hamilton (HAM)	33	Shelby (SHE)	86
Hancock (HAN)	34	Stark (STK)	87
Hardin (HAR)	35	St. Clair (STC)	88
Henderson (HND)	36	Stephenson (STE)	89
Henry (HNR)	37	Tazewell (TAZ)	90
Iroquois (IRO)	38	Union (UNI)	91
Jackson (JAC)	39	Vermilion (VER)	92
Jasper (JAS)	40	Wabash (WAB)	93
Jefferson (JEF)	41	Warren (WAR)	94
Jersey (JER)	42	Washington (WAS)	95
Jo Daviess (JOD)	43	Wayne (WAY)	96
Johnson (JOH)	44	White (WHT)	97
Kane (KNE)	45	Whiteside (WHS)	98
Kankakee (KKK)	46	Will (WIL)	99
Kendall (KEN)	47	Williamson (WLM)	100
Knox (KNO)	48	Winnebage (WIN)	101
Lake (LAK)	49	Woodford (WOO)	102
LaSalle (LAS)	50	Out of State (OUT)	103
Lawrence (LAW)	51	Unknown (UNK)	104
Lee (LEE)	52	City of Chicago (CHI)	105
Livingston (LIV)	53		

ADDATE	V08	Admission Date	19-24
DISDATE	V09	Discharge Date	25-30
DISLOC	V10	Discharge Location	31-33
USTDATE	V11	Unfit to Stand Trial Date	34-39
CRIME3	V12	Crime	40-41
CRIME2	V13		42-43
CRIME1	V14		44-45

Murder	10
Attempted Murder	11
Manslaughter	12
Involuntary Manslaughter	13
Reckless Homicide	14
Vehicular Homicide	15
Bank Robbery	16
Retail Theft	17
Attempted Theft	18
Breaking and Entering	19
Armed Robbery	20
Robbery	21
Theft	22
Home Invasion	23
Burglary	24
Residential Burglary	25
Attempted Robbery	26
Attempted Burglary	27
Auto Theft	28
Grand Theft	29
Aggravated Battery	30
Battery	31
Armed Violence	32
Unlawful Use of Weapon	33
Aggravated Battery to Child	34
Cruelty to Child	35
Assault	36
Aggravated Assault	37
Attempted Armed Robbery	38
Felony Theft	39
Rape	40
Attempted Rape	41
Deviate Sexual Assault	42
Indecent Liberties with a child	43
Purse Snatching	44
Indecent Exposure	45
Petty Larceny	46
Shoplifting	47
Strong Armed Robbery	48
Attempted Aggravated Arson	49

		Arson	50
		Aggravated Arson	51
		Attempted Arson	52
		Contribute to Delinquency of Minor	53
		Resisting Arrest	54
		Possession of	55
		Vehicular Burglary	56
		Theft by Deception	57
		Unlawful Possession of Weapons	58
		Possession of Stolen Property	59
		Aggravated Kidnapping	60
		Kidnapping	61
		Aggravated Incest	62
		Theft less then $300	63
		Aggravated Indecent Liberties with a Child	64
		Perjury	65
		Violation of Probation	70
		Bail Jumping	71
		Violation of Bail Bond	72
		No Firearms I.D. Card	73
		Criminal Damage to Property of more than $300 (felony)	74
		Criminal Damage to Property (Misdemeanor)	75
		Unlawful Restraint	76
		Attempted Escape	77
		Reckless Conduct	78
		Harassing a Witness	79
		Forgery	80
		Escape from Jail	81
		Public Indecency	82
		Delivery of Controlled Substance	83
		Distribution of Controlled Substance	84
		Violation of Parole	85
		Possession of Controlled Substance	86
		Possession of Stolen Auto	87
		Criminal Trespass	88
		Deceptive Practices	89
		Contempt of Court	90
		Failure to Appear in Court	91
		Possession of Burglary Tools	92
		Criminal Defamation	93
		Obstructing Police Offices (I11)	96
		Intimidation	97
		Disorderly Conduct	98
		Misdemeanor	99
READDATE	V15	Readmission Date	48-53
READFAC	V16	Readmission Facility	54-55
DOB	V17	Date of Birth	56-61
FINDING	V18	Finding	64

APPENDIX D. STATEMENT OF CONFIDENTIALITY

National Center for State Courts
Institute on Mental Disability and the Law

THE GUILTY BUT MENTALLY ILL EXPERIMENT: AN EMPIRICAL STUDY*

Statement of Confidentiality and Project Ethics

Protecting Confidentiality

Project staff wish to assure participants that their privacy, and that of their clients, will be protected to the maximum extent possible. The following procedures will be used to insure confidentiality of all information gathered by project staff, including research assistants:

(1) The reports that result from the information collected through interviews will not identify individuals by name. Where it is appropriate or necessary to identify statements with an individual, however, generic descriptions will be used--e.g., judge, chief probation officer, corrections official.

(2) Information obtained from case records will be deidentified. The code sheets on which information from case files will be recorded will identify cases only by identification numbers assigned by project staff. These assigned case numbers will not be associated with individuals and official case numbers or agency identifiers. Printouts and lists used in sample selection, which will contain names and official case numbers, will be destroyed upon the completion of data collection.

Research Ethics

All information gathered by project staff through interviews or coding of case documents will be used for research purposes only. Our staff is guided by three principles of ethical obligations:

(1) we are obliged to participants in protecting their privacy and accurately representing their responses;

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* A project funded by the National Institute of Justice, U.S. Department of Justice (Grant No. 83-IJ-CX-0042).

(2) we have a duty to society, in that we do not waste funds on unnecessary research and that we make public our findings and recommendations, and

(3) we are obliged to the court community, social sciences, and future researchers and practitioners in conducting reliable and valid research, and accurately documenting our methods and findings.

Ingo Keilitz
Ingo Keilitz
Project Director

6/11/84
Date

Daina Farthing-Capowich
Daina Farthing-Capowich
Principal Investigator
(Designate)

June 8, 1984
Date

APPENDIX E. EXOGENOUS FACTORS

This Appendix presents the results of a statutory and case law search by GBMI Project staff to identify exogenous factors that could confound analysis of the case file data collected in Georgia, Illinois, and Michigan. The goal of the search was to identify changes in criminal justice or mental health laws that occurred either concurrently with enactment of the GBMI statutes or close enough in time that those changes might be alternative explanations for observed changes in practice that otherwise would be attributed to the GBMI laws. Staff researched the following areas: insanity standards and definitions, burden of proof in insanity cases, commitment of insanity acquittees, jury instructions, incompetency to stand trial, diminished capacity, and forensic evalutions.

The research in each of these areas continued until staff affirmatively established either that no changes had occurred or, if they had, the nature and effective dates of the changes. The research results are presented below even for those areas in which the sources established that no changes had occurred. For each state, after presenting the effective date of the GBMI legislation, the results of the legal research are presented in summary form.

I. GEORGIA

GBMI: Ga. Code Ann. §17-7-131 (Cum. Supp. 1983), added by 1982 Ga. Laws, p. 1476 §§1, 2, effective July 1, 1982. In Kirkland v. State, 166 Ga. App. 478, 304 S.E. 2d 561, 565 (1983), the Georgia Court of Appeals held that the GBMI statute was not an ex post facto law and could be applied retrospectively.

NGRI STANDARD: Ga. Code Ann. §16-3-2 (1982) (M'Naghten), §16-3-3 (1982) (delusional compulsion), both added by 1968 Ga. Laws, p. 1249, §1, are unchanged since 1968. Before 1968, Georgia used only the M'Naghten test, which it had used since Roberts v. State, 3 Ga. 310, 326 (1847). See also Durham v. State, 239 Ga. 697, 699, 238 S.E. 2d 334 (1977); Brown v. State, 250 Ga. 66, 70 (1982) (the most recent decision of Ga. Supreme Court which discusses the issue).

INSANITY DEFINITION: Ga. Code Ann. §17-7-131(a) (Cum. Supp. 1983), added concurrently with the GBMI provision, left definition unchanged.

NGRI BURDEN OF PROOF: Unchanged since at least 1938. Under a general plea of insanity, the defendant bears the burden of proof, by a preponderance of the evidence, that he was not mentally responsible at time of alleged crime. Brown v. State, 250 Ga. 66, 70, __ S.E. 2d __ (1982); Clark v. State, 245 Ga. 629, 466 S.E. 2d 466, 477 (1980); Durham v. State, 239 Ga. 697, 238 S.E. 2d 334, 336 (1977); State v. Avery, 237 Ga. 865, 230 S.E. 2d 301 (1976), rev'g, Avery v. State, 138 Ga. App. 65, 225 S.E. 2d 454, 455 (1976); Grace v. Hopper, 234 Ga. 669, 217 S.E. 2d 267 (1975); Rozier v. State, 185 Ga. 317, 195 S.E. 172 (1938); Whitfield v. State 158 Ga. App. 660, 643 S.E. 2d 643, 644 (1981).

COMMITMENT OF NGRI'S: Since the November 14, 1980 decision, Benham v. Edwards, 501 F. Supp. 1050 (N.D. Ga. 1980), modified, 678 F.2d 511 (5th Cir. 1982), vacated and remanded sub nom., Ledbetter v. Benham, 103 S. Ct. 3565 (1983) (mem.) (instruction to reconsider in light of Jones v. United States, 463 U.S. __ (1983)), Georgia has had a mandatory, state-initiated commitment hearing that must be conducted before indefinite commitment following a 30-day postacquittal evaluation period. This requirement was

codified in Ga. Code §27-1503 as amended, effective July 1, 1982 [need Ga. Code Ann. citation].

The district court found the then-existing automatic commitment procedure to be violative of the federal Equal Protection and Due Process Clauses. Under that procedure, Ga. Code §27-1503 (1978), a hearing was held only upon the request of the acquittee or the superintendent of the state hospital no sooner than 30 days after the acquittal and commitment order. If the court found against the acquittee, the acquittee could not obtain another hearing for one year. Note that under the old procedure only defendants acquitted of violent crimes were automatically criminally committable. See Clark v. State, 245 Ga. 629, 641, 266 S.E. 2d 466 (1980); and Benham, 678 F.2d at 531. Presumably, defendants acquitted of nonviolent crimes could not be committed criminally or civilly, at least not on the basis of the criminal act. The rationale was that in violent crimes cases, NGRI acquittees were ipso facto mentally ill and dangerous, thereby meeting the criteria for civil commitment, so that no further adjudication was ncessary. This presumption of continuing insanity was what the district court found objectionable in Benham. The new procedure requires a hearing analogous to a civil commitment hearing in which evidence of the violent crime is not self-sufficient evidence of dangerousness.

The district court issued a mandatory injunction on November 14, 1980, requiring that all NGRI acquittees then in custody receive commitment hearings within 90 days of the order. On January 28, 1981, the Fifth Circuit denied the defendants' motion to stay the injunction pending appeal. See Brief for Plaintiff at 5-9, Benham (cited in Note, Commitment

and Release of Persons Found Not Guilty by Reason of Insanity: A Georgia Perspective, 15 Ga. L. Rev. 1065, 1096 n.156 (1981)). Pre-trial discovery in Benham revealed that only one of the 106 persons confined under §27-1503 at the time of trial had had a precommitment hearing. As of May 4, 1981, five months after the 90-day injunction was issued, of the 127 NGRI acquittees confined in Georgia at the time of the Benham order, 55 had been released following hearings, 51 were denied release, and 21 were at various stages of commitment proceedings. Note, supra.

The circuit court modified but substantially affirmed the district court's order. The United States Supreme Court summarily vacated and remanded the circuit court's decision for reconsideration under Jones v. United States, which the Supreme Court decided after the circuit court's order. As of August 1984, no opinion on remand has been reported. The issue should be treated as moot in light of the new statute requiring a commitment hearing in every case.

JURY INSTRUCTIONS: Ga. Code Ann. §7-7-131(c) (Cum. Supp. 1983) requires GBMI and NGRI instructions whenever a defendant contends that he or she was "insane or otherwise mentally incompetent," but fails to specify whether the court may inform the jury regarding the consequences of either verdict. The general jury provisions and case law also fail to address this issue. Standard Jury Instruction 19 does not mention the consequences of the verdicts. If juries in Georgia are not informed of the dispositional differences between NGRI and GBMI verdicts, then the impact of Benham v. Edwards on their decision-making process probably is diminished.

III. ILLINOIS

GBMI: Ill. Ann. Stat. ch. 38 §6-2(c) (Smith-Hurd Cum. Supp. 1984-1985), as amended by 1981 Ill. Pub. Acts 82-553, §1, effective September 17, 1981, authorized a GBMI finding.

NGRI STANDARD: Unchanged since 1962. See 1961 Ill. Laws §6-2 (effective January 1, 1962). Compare Ill. Ann. Stat. ch. 38 §6-2 (Smith-Hurd 1972) with Ill. Ann. Stat. ch. 38 §6-2 (Smith-Hurd Cum. Supp. 1984-1985).

INSANITY DEFINITION: Unchanged since 1973. See id. at ch. 38 §1005-1-11 (1982).

NGRI BURDEN OF PROOF: 1984 Ill. Pub. Acts 83-288, §1, effective January 1, 1984, amending Ill. Ann. Stat. ch. 38 §§3-2, 6-2 (Smith-Hurd Cum. Supp. 1984-1985), shifted the burden of proof from the state to the defendant. See Synopsis to 1984 Ill. Pub. Acts 83-288, §1.

COMMITMENT OF NGRI'S: Ill. Ann. Stat. ch. 38 §1005-2-4 (Smith-Hurd Cum. Supp. 1984-1985), which addresses the proceedings after an NGRI acquittal, has been amended nine times since January 1, 1973. See id. at Historical Note (Smith-Hurd 1982 & Cum. Supp. 1984-1985). Only one change might be significant for our purposes. 1977 Ill. Pub. Acts 80-164, §1, effective August 1, 1977, changed the initial period of commitment from a 12-month maximum, with subsequent proceedings under the civil commitment laws, to an indefinite period not exceeding the maximum possible sentence if the defendant had been found guilty, with periodic reports to the court on the defendant's progress. This amendment also prohibited the defendant's release into the community without court approval. Most of the remaining changes were nonsubstantive.

JURY INSTRUCTIONS: Ill. Ann. Stat. 38 §115-4(j) is silent regarding whether the court may or should instruct the jury regarding the consequences of an NGRI or GBMI verdict. The general rule in Illinois is that instructions regarding the consequences of an NGRI verdict are not permitted. People v. Meeker, 86 Ill. App. 3d 162, 170 (1980). See also, People v. Pitts, 104 Ill. App. 3d 451, 456 (1982); People v. Upshaw, 103 Ill. App. 3d 690, 698 (1981); People v. La Fiura, 92 Ill. App. 3d 714, 719 (1981); People v. Nelson, 92 Ill. App. 3d 35, 46 (1980). The reason such instructions are prohibited is that they would create a potential for compromise NGRI verdicts. Meeker, 86 Ill. App. 3d at 170. Whether dispositional instructions might be permitted in special circumstances, such as, to cure prejudice when a prosecutor argues to the jury that the defendant would be set free following an NGRI verdict, has not been decided. Id. at 171; People v. Hebein, 111 Ill. App. 3d 830, 837-40 (1982). No reported decision addresses whether dispositional instructions regarding a GBMI verdict are permissible.

INCOMPETENCE TO STAND TRIAL: 1979 Ill. Pub. Acts 81-1217, §3, effective December 28, 1979, repealed and replaced Illinois' incompetence to stand trial provisions. See Ill. Ann. Stat. §§1005-2-1, 1005-2-2 (Smith-Hurd 1982); Ill. Ann. Stat. §§104-1 to 104-29 (Smith-Hurd 1980). Information regarding the repealed provisions is unavailable to Project staff.

DIMINISHED CAPACITY: Since January 1, 1962, an intoxicated or drugged person is criminally responsible for his or her conduct unless his or her intoxicated or drugged condition negates the specific intent element of the crime charged. See Inn. Ann. Stat. §6-3 (Smith-Hurd 1972). Diminished capacity is not otherwise an independent defense in Illinois.

FORENSIC EXAMINATIONS: Ill. Ann. Stat. §115-6 (Smith-Hurd Cum. Pamphlet 1978-1983) was amended by 1981 Ill. Pub. Acts 82-553, §2, effective September 17, 1981, to permit preliminary forensic examinations of defendents indicating the intent to plead GBMI. NGRI examination requirements are unchanged since August 28, 1969. Compare id. with id. at §115-6 (Smith-Hurd 1977).

III. MICHIGAN

GBMI: Mich. Comp. Laws Ann. §768.36 (1982) was added by 1975 Mich. Pub. Acts 180, §1, effective August 6, 1975.

NGRI STANDARD: Mich. Comp. Laws Ann. §768.21a was changed simultaneously with the addition of the GBMI statute and was effective the same day. See 1975 Mich. Pub. Acts 180, §1. The changes in the standard are more complex than they appear at first glance. Section 768.21a was Michigan's first codification of an NGRI standard. The old common-law standard, the "M'Naghten plus irresistible impulse" standard, had been in effect since 1886. See People v. Durfee, 62 Mich. 487, 494, ___ N.W. ___ (1886):

> [W]hether or not he exhibited evidences which leave a reasonable doubt in your minds of the soundness of his mind in that transaction. Did he know what he was doing,--whether it was right or wrong? And if he did, then did he know or did he have the power, the will power, to resist the impulse occasioned?

The Michigan Supreme Court restated the Durfee standard in 1971. See People v. Martin, 386 Mich. 407, 418, 192 N.W. 2d 215 (1971):

> The salient elements of the Michigan test are: 1) whether defendant knew what he was doing was right or wrong; and 2) if he did, did he have the power, the willpower, to resist doing the wrongful act? The Michigan test encompasses not only a sudden over-powering, irresistible impulse but any situation or condition in which the power, 'the will power' to resist, is insufficient to restrain commission of the wrongful act.

The new standard is a modified ALI standard. See Mich. Comp. Laws Ann. §768.21(a) (1982):

> (1) A person is legally insane if, as a result of mental illness ... or ... mental retardation ... that person lacks substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of law.
>
> (2) A person who is under the influence of voluntarily consumed or injected alcohol or controlled substances at the time of this alleged offense shall not thereby be deemed to have been legally insane.

The Michigan Court of Appeals has viewed the statutory standard as being sufficiently different from the common-law standard to warrant reversal of a case in which the trial judge instructed the jury under the common law rather than the statute. See People v. Girard, 96 Mich. App. 594, 293 N.W. 2d 639 (1980). Analysis suggests that subsection (1) of the codification changed the common law in several respects: (1) it replaced "soundness of mind" with mental illness or retardation, (2) it replaced "total inability to distinguish right from wrong" with "lacked substantial capacity to appreciate," and (3) it replaced "total lack of will power to resist doing the act" with "lacked substantial capacity to conform conduct." Points (2) and (3) relax the cognitive and volitional prongs of the test, thereby making NGRI findings accessible to a broader range of defendants. The effect of point (1) is not so clear and is discussed under "Insanity Definition," below.

Subsection (2) apparently also changed the common-law standard. Before the enactment, voluntary intoxication was a defense if it negated a crime's requisite specific intent. See People v. Guillett, 342 Mich. 1, __ N.W. 2d __ (1955). Subsection (2) eliminates this defense. But see People v. Mahaday, 108 Mich. App. 591, 310 N.W. 2d 805, 806 (1981), which ignores subsection (2). This provision should prove to be highly controversial and possibly violative of due process.

INSANITY DEFINITION: The 1975 enactment for the first time made mental illness or mental retardation elements of the insanity test. Although the case law suggests that the common-law "soundness of mind" requirement meant "disease of mind," Durfee, 62 Mich. at 494, the common-law standard focused on the consequences of the mental state rather than on the nature of the mental state. Presumably, then, any mental "disease" that affected a defendant's cognition or volition was sufficient. Cf. Bell v. Wayne County General Hospital at Eloise, 384 F.Supp. 1085 (1974) (definition of mental illness used in involuntary civil commitment cases, which extended to all persons of unsound mind, was vague and overbroad). Adding defined terms to this facet of the NGRI standard necessarily limits the scope of the defense.

The definition of 'mental illness' that the 1975 Acts added is "a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life." Mich. Comp. Laws Ann. §330.1400a (1982). This definition is strikingly similar to the description of psychosis in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (2nd ed. 1968), which was current in 1975:

> Patients are described as psychotic when their mental functioning is sufficiently impaired to interfere grossly with their capacity to meet the ordinary demands of life. The impairment may result from a serious distortion in their capacity to recognize reality. Hallucinations and delusions, for example, may distort their perceptions. Alterations of mood may be so profound that the patient's capacity to respond appropriately is grossly impaired. Deficits in perception, language and memory may be so severe that the patient's capacity for mental grasp of his situation is effectively lost.

Id. at 23 (emphasis added). Although the legislative history of the statute is silent regarding this similarity, secondary sources suggest

that the statutory language was inteded to exclude all non-psychotic mental dysfunctions. See Brief of Amicus Curiae of Michigan Psychiatric Society, Branch of American Psychiatric Society at 5, People v. Ramsey, No. 67269 (Michigan Supreme Court, filed April 16, 1983. Thus, nonpsychotic mentally ill offenders should probably not be found NGRI under the new law. Interestingly, however, the non-psychotic defendents excluded from the NGRI's scope should not be found GBMI either, because the same 'mental illness' definition applies to the GBMI laws. See Mich. Comp. Laws Ann. §330.1400a (1982). Thus, if the law is applied strictly, non-psychotic mentally ill offenders should be found merely guilty.

The definition of 'mentally retarded' is "significantly subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior." Mich. Comp. Laws Ann. §330.1500(g) (1982). Mentally retarded defendants may be found NGRI in Michigan, see id. at § 768.21a (1), but may not be found GBMI, see id. at 768.36(1) & (2).

The net effect of these changes in the NGRI standards and definitions is that although Michigan has moved to a more relaxed standard regarding the consequences of the defendant's mental state (i.e., substantial capacity to appreciate or conform), it has also moved to a more stringent mental state standard (i.e., psychosis or mental retardation).

NGRI BURDEN OF PROOF: The requirement that the state prove the defendant's sanity beyond a reasonable doubt has remained unchanged. See People v. Woody, 380 Mich. 332, 338, ___ N.W. 2d ___ (1968); People v. Eggleston, 186 Mich. 510, 514, 152 N.W. 944 (1915); People v. McKeever, 123 Mich. App. 533, 332 N.W. 2d 596 (1983); People v. White, 81 Mich. App. 335, 265 N.W. 2d 139 (1978).

COMMITMENT OF NGRI'S: Before September 6, 1974, when the Michigan Supreme Court decided People v. McQuillan, 392 Mich. 511, 221 N.W. 2d 569 (1974), defendants found NGRI were automatically committed to the Department of Mental Health for treatment in an appropriate state hospital. 392 Mich. at 518, 518 n.1. In McQuillan, the court held that due process and equal protection required a full civil commitment hearing upon completion of a 60-day examination period following an NGRI acquittal. Id. at 528-29. The court gave this ruling prospective effect only; that is, any NGRI acquittees held more than 60 days from the date of the opinion were to receive hearings. Id. at 547. Additionally, the court found unconstitutional a statutory provision that made the release procedures that were available to civil committees unavailable to NGRI acquittees. Id. at 543-44. Generally, that provision required release of persons recovered from mental illness. See id. at 540-41 n.8. Following McQuillan, the Michigan Legislature repealed the automatic commitment statute, Mich. Comp. Laws Ann. §767.27b (1982), and replaced it with Mich. Comp. Laws Ann. §330.2050 (1980), which substantially incorporated the court's holdings. See 1974 Mich. Pub. Acts 258, §1050 (effective August 6, 1975).

JURY INSTRUCTIONS: Since People v. Cole, 382 Mich. 695, 720-21, __ N.W. 2d __ (1969), jurors in Michigan have been instructed regarding the dispositional consequences of an NGRI verdict. See also People v. Martin, 386 Mich. 407, 421-22, 192 N.W. 2d 215 (1971). A court may give either a very general or a detailed instruction regarding disposition. Compare Michigan Criminal Jury Instructions 7:8:07 (Supp. 1983) with 7:8:08. Jurors also are informed of the consequences of a GBMI verdict.

See Michigan Criminal Jury Instructions 7:8:10 (Supp. 1983) (GBMI verdict is like guilty verdict except that Department of Corrections is obligated to provide appropriate psychiatric treatment). None of these instructions is mandatory. See Michigan Criminal Jury Instructions vol. 1, Notices (Supp. 1983) (proposing amendment to the Michigan Court Rules that would require use of the instructions except in specified circumstances); Michigan Court Rules 516 (1983) (not amended per id.). If given, dispositional instructions greatly increase the potential effect of People v. McQuillan and the resulting statutory changes. See supra.

INCOMPETENCE TO STAND TRIAL: 1974 Mich. Pub. Acts 258, §1106, effective August 6, 1975, repealed Mich. Comp. Laws Ann. §767.27a (1982), Michigan's incompetence to stand trial provision, and replaced it with Mich. Comp. Laws Ann. §330.2020 (1980). The text of the repealed provision was unavailable to GBMI Project staff. Consequently, the effect of 1974 Mich. Pub. Acts 258, §1106 cannot be determined.

DIMINISHED CAPACITY: Before the enactment of 1975 Mich. Pub. Acts 179 & 180, psychiatric testimony regarding a defendant's capacity to form the requisite sepcific intent was admissible even through the defendant filed no notice of intent to claim insanity. See People v. Lynch, 47 Mich. App. 8, 20, 208 N.W. 2d 656, 662 (1971). On August 22, 1978, however, the Court of Appeals of Michigan held that the defense of diminished capacity falls within the newly enacted definition of "insanity," so that unless a defendant files notice of intent to claim insanity in conformance with Mich. Comp. Laws Ann. §768.21a (1982), evidence of diminished capacity must be excluded. People v. Mangiapane,

85 Mich. App. 379, 271 N.W. 2d 240, 248-49 (1978). The court has reiterated this holding several times. See People v. Atkins, 117 Mich. App. 430, 324 N.W. 2d 38, 41 (1982); People v. Linzey, __ Mich. App. __, 315 N.W. 2d 550, 552 (1982); People v. Gilbert, 101 Mich. App. 459, 300 N.W.2d 604, 608 (1981). Although the Michigan Supreme Court has not addressed the issue, the court of appeals interpretation might increase the number of cases in which the insanity defense is asserted.

FORENSIC EVALUATIONS: Mich. Comp. Laws Ann. §768.20a(2) (1982), which was added by 1975 Mich. Pub. Acts 180, §1, (effective August 6, 1975), requires the center for forensic psychiatric to examine for up to 30 days any defendant who properly asserts the insanity defense. The new Mich. Comp. Laws Ann. §768a(2) (Cum. Supp. 1984-1985), which was amended by 1983 Mich. Pub. Acts 42, §1 (effective May 12, 1983), authorizes "other qualified personnel" also to conduct these examinations. No primary source available to Project staff indicates whether the center for forensic psychiatry conducted these examinations before 1975. But see Petrella, Benedek, Bank & Packer, The Guilty But Mentally Ill Verdict in Michigan, __ Hospital & Community Psych. __ (1984) (the forensic center first became the centralized facility for examining defendants raising the insanity defense at the same time the GBMI legislation became law).