The Insanity Defense as Defined by the Proposed Federal Criminal Code*

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Mr. Chairman and members of the Subcommittee, I am grateful for the opportunity to appear before you to discuss the insanity defense under the proposed Federal Criminal Code. I am appearing today as president of the American Academy of Psychiatry and Law, a national society of almost 400 psychiatrists who are very much (although not exclusively) involved with forensic psychiatry and whose collective experience in this field provides much of the everyday input related to the insanity defense in the State and Federal Courts of the nation. I appear before you to testify with regard to our Academy's position on Senate Bills 1 and 1400, as these Bills are concerned with the defense by Mental Illness or Defect (S. 1, sec. 1–3C2 *et seq.*) and the defense by Insanity (S. 1400, sec. 502 *et seq.*).

The Academy of Psychiatry and Law is strongly in favor of the S. 1 definition of the insanity defense and is strongly opposed to the S. 1400 definition.

I appear also as a professor of psychiatry and director of the Institute of Psychiatry, Law and Behavioral Science at the University of Southern California School of Medicine Department of Psychiatry, engaged full-time in the teaching and training of forensic psychiatry, a professor of psychiatry in the School of Public Administration, teaching in the Center for the Administration of Justice at the same University, and a psychiatrist with extensive experience in the practice of forensic psychiatry in both State and Federal Courts, State hospitals for the criminally insane, and State and Federal prisons.

The express goal of both the American Academy of Psychiatry and Law and the Institute of Psychiatry, Law and Behavioral Science is to advance the teaching, training, and practice of forensic psychiatry. This goal has significance for the implementation of the insanity defense and is intimately related to the recommendations I am led to offer on both S. 1 and S. 1400 of the Federal Criminal Code under consideration by this Committee. My remarks will draw heavily upon my experience as a teacher of forensic psychiatry to psychiatrists, attorneys, and judges as well as upon my experience as a forensic psychiatrist.

In the latter academic and practitioner roles I also strongly support the S. 1 definition of the insanity defense and oppose the S. 1400 definition; and in these latter roles I would like to address my remarks to three areas: (1) in defense of the insanity defense as defined under S. 1, and observations and recommendations on the procedural mechanisms related to the mentally ill acquitted and convicted offender under S. 1; (2) general observations on the issue of the insanity defense; and (3) the bases for opposition to the S. 1400 definition of exculpatory mental illness, and observations on the procedural mechanisms related to the exculpated and convicted mentally ill offender under S. 1400.

I. In Defense of the Insanity Defense under S. 1

The desire and need to codify, revise, and reform title 18 of the United States (Criminal) Code led to a proposed new Federal Criminal Code prepared by the National Com-

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mission on Reform of Federal Criminal Laws, chaired by the Hon. Edward G. Brown, past Governor of the State of California. With modifications, the Commission's recommendations were submitted by Senator McClellan, Ervin, and Hruska on January 4, 1973 to the 93d Congress 1st session of the United States Senate under S. 1 as the Criminal Justice Codification, Revision and Reform Act of 1973.

Chapter 3, Subchapter C.—Defenses, under section 1-3C2, Mental Illness or Defect, of S. 1 defines the insanity defense that would be applicable to all federal jurisdictions under this proposed Federal Criminal Code as follows:

> It is a defense that when a defendant engages in conduct which otherwise constitutes an offense, as a result of mental illness or defect *he lacks substantial capacity* to appreciate the character of his conduct or to control his conduct. 'Mental illness or defect' does not include an abnormality manifested by repeated criminal or otherwise antisocial conduct. [Emphasis added.]

This formulation is essentially the American Law Institute Model Penal Code's standard for criminal responsibility that is now followed in the majority of federal jurisdictions.

Subchapter C.—Mental Incapacity of S. 1 provides a description of the psychiatric panel and psychiatric examination (section 3-11C2); referral to the panel and psychiatric report (sections 3-11C3 and 3-11C5); and civil commitment of the defendant acquitted under section 1-3C2 to the Secretary of Health, Education and Welfare (section 3-11C8).

Subchapter D.—Sentencing (section 3-11D2) of S. 1 provides for psychiatric examination of the person convicted of a crime who is believed to be mentally ill, and for such psychiatric report to be considered in the sentencing recommendations to the court.

I will comment on these specific procedural sections, of which I generally approve with some modifications, after observations on the S. 1 definition of exculpatory mental illness or defect.

We are in favor of the S. 1 definition because this legal standard directs itself to the two most important areas of mental functioning involved with the social concept of criminal responsibility. If at the time of commission of an illegal act, an accused person is significantly impaired in either of these two mental functions as a result of mental illness or defect, social policy identifies him as suffering from exculpatory insanity, i.e., a condition which renders him criminally non-responsible for the commission of his illegal act by virtue of his mental illness or defect. The two impaired mental functions that most closely approximate the social policy concept of insanity and, therefore, merit the legal definition of exculpatory insanity are: (1) the person's impaired mental capacity to understand the social significance of the offending act with respect to an inability to appreciate that society has identified this act as being illegal (or wrong) and that its execution will lead to punitive legal sanctions; and (2) the person's impaired mental capacity to control his conduct related to the offending act.

In addition to the fact that this legal formula in S. 1 includes the two mental functions most significant for the issue of criminal responsibility, the terminology in S. 1, specifically the use of the term, substantial, allows the psychiatrist to apply his psychiatric data more readily and more adequately to this test than to other legal formulations, e.g., the M'Naghten rule, that of Irresistible Impulse, or the Durham rule.

In my opinion the trier of fact is also more able to understand the S. 1 definition and more capable of relating the psychiatric evidence to this formulation than to other legal tests of insanity. Although a few research studies indicate that the trier of fact is relatively uninfluenced by terminologic differences in the legal standards of insanity, nevertheless our forensic experience indicates that the ALI test allows the psychiatrist to describe more fully and clearly to the trier of fact those evidences of mental impairment that relate to these two sections of the standard as offered in S. 1, thereby providing the

trier with as much professional material as is available for his assessment of moral culpability and determination of criminal responsibility.

It is most important to note that this S. 1 standard of insanity focuses on the concept of *mental impairment*, specifically the lack of capacity for certain mental functions significant for criminal responsibility. It cones down on the scope, severity, and relationship of these mental impairments to the issue of criminal responsibility; it is concerned with whether these mental impairments result from mental illness or defect or from other causes, but it is not concerned with the concept and identification of mental illness or defect, *per se*.

The concept of mental impairment provides the psychiatrist with the opportunity to clarify those mental dysfunctions that relate to the issue. It draws the guidelines for his clinical word picture to the trier of how the defendant's impaired mental functioning related to the specific mental impairments that carry legal significance by the formulation of the insanity test. The trier of fact then has full opportunity to assess the psychiatric expert witness' appraisal of these psychological functions and their relationship to the issue and compare this appraisal with other evidence brought to bear on the same question.

It is unfortunate that the concepts of insanity and criminal responsibility have been misunderstood to such a remarkable degree by both psychiatrists and attorneys. It has been widely and incorrectly assumed that the insanity defense is a medical defense and can be established by proof of a mental illness or defect. Many believe that the presence of mental illness or defect, *per se*, is exculpatory. This is not so. Much time and energy, therefore, have been misdirected to ascertaining the presence or absence of mental illness or defect as these conditions are defined by the psychiatric profession for treatment purposes. An equal amount of time and energy has been misspent in trial in pursuing similar mistaken objectives. What has not been recognized is that mental illness and defect defined for treatment purposes are quite different from these conditions defined for legal purposes and that the latter are constricted and limited to those kinds of mental impairments due to mental illness or defect that are accorded legal significance for the special issue of criminal responsibility.

(Legal) insanity has been misunderstood as the legal equivalent of mental illness or defect. This is not so. Identifiable mental illness or defect is a necessary condition for the substrate of mental impairment that qualifies the defendant for exculpatory insanity. Absent mental illness or defect, insanity can not exist. In other words, the condition of mental illness or defect, *per se*, is a necessary but not sufficient condition for exculpatory insanity. In addition social policy sets a very high level of mental impairment that must be present for the condition to be identified as one that qualifies the defendant for exculpation from criminal responsibility. My experience with the ALI definition of insanity in the 9th Circuit unequivocally demonstrates that, when accompanied by the concepts I have outlined above, this standard of insanity fully satisfies the social policy considerations of contemporary society. The S. 1 definition of mental illness or defect also completely fulfills the concerns of public policy.

The S. 1 formulation focuses upon the concept of responsibility, and especially that of criminal responsibility, as a basic concept crucially significant in the humanization of society. The concept of criminal responsibility derives its force and long life from the value judgments inherent in the sense of social obligation and mutual responsibility. These are values that society wishes to support. They are values whose support requires that at some point in time a line be drawn differentiating that social conduct identified as bad from that which is good and setting out the implications and consequences of such a differentiation. The insanity defense and the S. 1 definition of insanity support these concepts, reinforce these values, and direct themselves to the differentiation of those who are morally culpable from those who are not because of their serious mental impairment.

Society wishes to hold most persons criminally responsible for their violations of law.

Exculpation from criminal responsibility is a social policy issue determined by public policy and not professional considerations. The insanity defense is not based on professional psychiatric policy but rather on the value judgments implicit in social and legal justice. It is based on century-old concepts that in the absence of sanity there can be no crime; and prevalent concepts of social justice still hold that some persons, albeit few in numbers, are so mentally impaired as a consequence of their mental illness or defect that they should be exculpated from criminal responsibility. The insanity defense and the S. 1 definition of mental illness or defect continue to promote this concept of social justice.

The concept of insanity, therefore, is seen to have developed as a tool of social policy, and only in relatively recent years has society looked to the psychiatrist to help define and refine this social tool. The S. 1 definition of insanity is such a contemporary tool. The concept of insanity is thus that of a definition or label for legal identification and dispositional purposes, i.e., a means of identifying the accused either as a criminal offender or a patient, and a procedure for referring the actor either to the criminal justice system for punishment or to the mental health system for treatment. Under the S. 1 definition of insanity and the procedures outlined in S. 1, the relatively few persons who qualify for insanity can be reliably identified and referred for treatment in the mental health system.

Although the concept of individual responsibility, and its basis in the concept of freedom of the will and action, can be questioned and can be opposed by the concept of scientific determinism, nevertheless many believe that our values supporting social order and social justice require us to live with and operate under the concept of individual responsibility. The model of individual responsibility likewise leads to the concepts of good and evil (acts), sick and bad (actors), patient and criminal offender (roles), and treatment and punishment (as measures of social response) as if these exist as disparate polar extremes when, in fact, they are present as continuing gradations. The same social values, however, promote the need to operate as if these concepts at some point are polar extremes. The S. 1 definition of insanity acts as an operational tool to aid the trier of fact to deal with the concept of individual responsibility in the mentally ill offender but permits the concept of gradations of mental impairment to be utilized by the trier in his assessment of moral culpability and determination of criminal responsibility.

Recapitulating, I believe that support for the insanity defense can be perceived as supporting and reinforcing concepts of mutual interdependence and responsibility as well as the value system upholding the concepts of social order and social justice. There are many who deny the social need for this tool, who maintain that the tool does a disservice to society in sharply differentiating good from bad, etc. and who believe that other and better conceptual tools can be developed to maintain our social values. These persons are in the forefront in repudiating the insanity defense, and they see support for their position in the abolition of the insanity defense.

If we accept the insanity defense as a concept supporting basic social values, we next may ask if psychiatrists have the professional expertise reliably and validly to provide the special data that apply to this legal concept. Does the technical skill exist? And is the field of psychiatry, i.e., its practitioners, interested in applying itself to this social-legal question? The American Academy of Psychiatry and Law replies with a strong affirmative to these questions; and I strongly concur with this position as a result of my academic and forensic psychiatry experience. The past ten years have witnessed a marked increase of interest and activity in forensic psychiatry. Advanced training programs in forensic psychiatry have developed in universities; the American Board of Psychiatry and Neurology, the specialty accreditation committee for psychiatry, has required more academic and clinical forensic psychiatry for psychiatrists in their formal psychiatric residency training programs; forensic psychiatry as a specialty is close to subspecialty accreditation; more and more psychiatrists are entering the field, promoting

the development of the American Academy of Psychiatry and Law and a growing list of journals and periodicals in psychiatry and law; and most recently the State of California has funded forensic psychiatry training in two of its universities and a bill has been entered in the State legislature to certify forensic psychiatrists.

Nevertheless, strong differences of opinion about these questions do exist among American psychiatrists. The Committee is already cognizant of the fact that a large number of psychiatrists are opposed to the insanity defense; and the Committee is probably interested in why this is so. I would like to answer this question and offer my understanding of the reasons for this, using the Committee's own material for my explanation.

A staff survey was conducted by the Committee on the Judiciary, Subcommittee on Criminal Laws and Procedure of the United States Senate on March 24, 1972. The departments of mental health in each of the 50 states and the District of Columbia plus a few individual psychiatrists were surveyed as to their position on the insanity defense. Fifty-five letters of inquiry were mailed out. Its report, as published in the first session of the Hearings before this Senate Subcommittee on July 18, 1973, presents the 32 respondent letters in which substantive responses were made to the inquiry. These replies, in my opinion, are representative of the attitudes and opinions of a large number of psychiatrists in the United States but are not shared by the membership of the American Academy of Psychiatry and Law.

Over fifty percent (53.1%) of the psychiatrist respondents recommended that the insanity defense be abolished, but most of this group (46.9%) favored that it become mandatory that in case of his conviction the defendant be treated or hospitalized and not sent to prison if he were suffering from mental disease or defect. Twenty-five (25%) of the respondents recommended the ALI's Model Penal Code formulation, which was also recommended by the National Commission on Reform of Federal Criminal Laws and strongly favored by the American Academy of Psychiatry and Law.

This high percentage of psychiatrists who favor abolishing the insanity defense may have surprised Committee members. It is important to note, however, that although they favored the abolition of the insanity defense, many did not support the S. 1400 definition of insanity and none supported the procedural approach under S. 1400 in which the mentally ill acquitted party is committed to the custody of the Attorney General of the United States, i.e., none favored the concept that the mentally ill offender be "treated" as a criminal offender but rather supported the concept that all mentally ill offenders be treated as mentally ill patients and recommended that such treatment be provided in mental hospitals and not prisons or "prison hospitals."

I would like to direct attention to these replies and assess their significance in light of the fact that so large a number of American psychiatrists are opposed to the insanity defense.

Negative criticisms and rejection of the insanity defense in these letters appear to be reflections of underlying psychiatric concerns that may be conveniently separated into two major groups: (1) the psychiatrists' concerns about maintaining the therapeutic philosophy and value system of contemporary psychiatry; and (2) the psychiatrists' rejection of the philosophy, value system, and processes of the law, especially of criminal law, and even more of the criminal justice system. Psychiatrists sometimes accentuate their concerns in the first group more than the second; but more frequently concerns in both groups are combined and interrelated either implicitly or explicitly and utilize rejection of the insanity defense as a vehicle for their expression.

(1) In the first group psychiatrists direct their concerns to the following seven areas: (a) support of their primary therapeutic thrust, the helping and healing philosophy of medicine. This is threatened by the potential for harm to the criminal defendant from the psychiatrist were the psychiatrist's opinion to be unfavorable to the defendant. The basic therapeutic thrust of medicine is believed to be undermined by the psychiatrists'

professional involvement in any and all issues of criminal responsibility that may result in possible harm to the individual. The psychiatrist's involvement with the insanity defense makes visible his breach with the Hippocratic Oath, never professionally to harm an individual.

(b) support of the deterministic philosophy that underlies the scientific structure of medical science and that of psychiatry in particular. The philosophy that man's behavior and conduct are molded and determined by individual and social forces outside of and beyond his conscious control runs counter to the holding of the individual offender culpable and punishable for his actions. Freedom of will is perceived as a fiction which the insanity defense promulgates. Many psychiatrists, therefore, are opposed to criminal actors being punished under criminal law; others accept the concept of punitive sanctions as a necessary social response but decry the psychiatrists' professional involvement and role in this social-legal process.

(c) support for contemporary psychiatry's concern with the individual and his uniqueness. The high positive value placed upon the expansion of the individual's unique capabilities, and the goal through psychiatric treatment to foster and promote these capabilities, is accompanied by a similar value accorded to the concept of individual responsibility. The development of individual responsibility is perceived operationally as a basic goal of psychiatric treatment. This goal is based upon the assumption that the expression of individual responsibility is an essential aspect of human nature and fostering such expression promotes mental health. Under this professional aegis psychiatrists wish to hold all persons responsible for their acts and reject the insanity defense because it negates this basic objective.

(d) support for the positive value accorded to the non-judgmental approach and non-moralistic attitude that colors medical practice, especially the practice of psychotherapy. Medical philosophy and the value system in psychotherapy on this account strongly oppose the psychiatrists' professional involvement with any issue of moral culpability. When this stance is coupled with the concept that all criminal acts are, in fact, symptoms of mental illness, many psychiatrists are even more opposed to the concept of the "bad" criminal offender as against the sick patient and favor the treatment of all "criminal" actors for their mental illness. Some press for decriminalization; others move for diversion of offenders from the system of criminal justice to that of mental health. The movement toward decriminalization, diversion, etc., coupled with the substitution of treatment alternatives for punishment, rests on the concept of a common matrix of deviant behavior for mental illness, delinquency, and criminality that blurs the identification of the criminal offender for the purposes of law. It blurs the lines that differentiate criminal from non-criminal conduct and the bad offender from the sick patient. The insanity defense is opposed because it sets up and perpetuates these boundaries and promulgates categories of good versus bad and bad versus sick.

(e) support for the need to treat all "criminal actors" for their psychological problems and anti-social predispositions as against the lesser need to treat those few who are exculpated under the limited rule of the insanity defense.

(f) support for the concern that psychiatrists not be directed away from their primary goals of treatment and prevention of mental illness to the legal ends of law. This is urged on economic grounds. The argument is made that the instrumental use of psychiatry for goals of law, particularly those of criminal law, is a social misuse of the psychiatrists' specially developed costly therapeutic skills. This carries special weight in light of the limited numbers of qualified mental health professionals in comparison to the need. The insanity defense is opposed because its implementation takes away needed psychiatric hands from the primary role function of psychiatric treatment.

Statements expressed by psychiatric respondents in their replies to this Committee, and frequently found in the literature, demonstrate the extent of this concern and appear as follows: that the psychiatrist should stick to his last; that he is trained as a doctor, not a

lawyer; that he is unknowledgeable, unversed, and unsophisticated in legal concepts, terms, and language; that he is not trained to apply his professional technical material, concepts, and terms to legal issues and, therefore, is unable to do so; and that his technical treatment concepts and terminology are essentially inapplicable to legal issues, particularly those of criminal law. These and similar or related objections are made against directing the psychiatrist's role/function away from treatment to that of identification for legal purposes and that of legal disposition; and such objections become visible in the specific opposition to the insanity defense.

(g) support for increasing and improving the mental health care and treatment for all patients. Coupled with recognition of the inadequate professional attention to the mentally ill offender in jail, prison, and especially patients in state hospitals for the criminally insane, this makes the psychiatrist strive to undo any measure or procedure that promotes such social and professional inequities. A strong belief that mentally ill persons are frequently harmed psychologically by institutionalization has added impetus to the move to treat the mentally ill in the open community. The common direction of all these concerns leads the psychiatrist to oppose the insanity defense because it helps develop conditions that block and counter these trends in American psychiatry.

(2) In the second group the psychiatrists' concerns are expressed as negative attitudes about law that crystallize in opposition to the insanity defense.

Although the primary and strongest reasons for opposition to the insanity defense arise from the defense being perceived as a legal splinter invading the integrity of the psychiatric value system, additional reasons stem from the contemporary psychiatrists' rejection of legal concepts, values, and procedures, especially those of criminal law and the criminal justice system. It is surprising to find considerable psychiatric opposition to criminal-legal concepts in the face of general ignorance and lack of sophistication about criminal law. The insanity defense is frequently misinterpreted as a medical tool, with the psychiatrist characterizing himself as a professional who is abused, misused, and exploited for the "nefarious" ends of prosecution or defense. Many psychiatrists do not approve of the system of criminal law, do not like its concepts and procedures, and oppose the value system imbedded in the concept of legal justice. When legal justice is accepted, the psychiatrist is more prone to ally himself with the goals of defense than with those of prosecution.

Promotion of understanding and knowledge about law and sophistication in criminal law have been major goals of the University of Southern California Institute of Psychiatry, Law and Behavioral Science. My experience in teaching over the past ten years in advanced training programs in forensic psychiatry has demonstrated that psychiatrists can become knowledgeable about the ends of social and legal justice and also technically skillful in applying clinical and professional material to the ends of legal justice for the social good. In addition, such education and training markedly promote an impartial, neutral, and objective attitude in the forensic psychiatrist that further underscores the concept of justice; and finally such education and training in psychiatry and law develop in the forensic psychiatrist the understanding and sophistication about law that promote acceptance with the capacity for critical analysis of substantive and procedural aspects of law and of its relationship to psychiatry.

My comments on the procedural sections related to the S. 1 insanity defense will be brief. Section 3–11C2(a) designates the panel of qualified psychiatrists for the examination. The problem of defining the qualified psychiatrist is important because of the low level of expertise in forensic psychiatry that exists among psychiatrists generally throughout the nation. This question has been addressed in California recently because of our need for adequately trained forensic psychiatrists. A Senate Bill has been introduced into the California State legislature to certify forensic psychiatrists. In my opinion, forensic psychiatry is a subspecialty of psychiatry that requires advanced education and training; and in the absence of such special training the psychiatrist's "expertise" may be so woe-

fully inadequate as to subvert and defeat attempts to improve social and legal justice through such measures as S. 1.

The need for the defendant to have the issue of insanity and subsequent commitment decided by a jury, should he so desire, is a legal question which I will leave for my legal friends to point out. The fact that it is not addressed in any part of S. 1 carries legal significance; but I can attest to the fact that in my forensic experience it has also promoted considerable difficulty for the psychiatrist as well as the defendant, and I strongly urge that the Committee direct attention to this matter and provide legal remedy for its absence in sections 3–11C3, 3–11C4, and 3–11C8.

With respect to section 3–11C5(a), I assume, if the defendant has not given notice of intention to raise an insanity defense under section 1–3C2 and is nevertheless referred for psychiatric examination by a panel psychiatrist because of the likelihood that such a defense may be raised, that unless the defense is actually raised, the psychiatric material would be inadmissible in the guilt phase of the trial. If this assumption is incorrect, then attention should be directed to include this procedural safeguard. This is important for the forensic psychiatrist because unless the defendant has already raised the insanity defense he is unlikely to be cooperative in revealing his mental state to the psychiatrist, and the psychiatrist can obtain little or no reliable data of significance for the legal issue. I, therefore, would recommend that such psychiatric examination be delayed until after the insanity plea has formally been raised by defense counsel. I also hope that my legal friends will direct themselves to the question of whether the proposal as formulated in section 3–11C5 may breach constitutional safeguards of due process.

I am fully and heartily in agreement with the provision that the defendant who is exculpated on the basis of the insanity defense under 1–3C2 be committed to the Secretary of Health, Education and Welfare. Under section 3–11C8(g) I would recommend that the required psychiatric reports be submitted every six months rather than at least once per year after commitment, because of the fact that mentally ill persons treated today with anti-psychotic drugs and other therapeutic measures may improve rapidly and merit such evaluations more frequently than once per year.

I would also like to recommend that the Committee address itself to the important question of the return to the community of the patient acquitted by reason of insanity. First I would strongly recommend that all such persons exculpated on the basis of section 1–3C2 be mandatorily followed in psychiatric out-patient clinics for a minimum of one year with reports to the court every six months after their return to the community. Such a provision would help psychiatrists in their approach to the committed patient as they consider his possible release and provide a realistic opportunity to assess the patient's capacity to cope with the everyday problems and conflicts after his return to the community while still maintaining a measure of control over him and retaining a measure of security for the community.

Second, I would like to bring to your attention the need to define more fully and adequately the standard of 'harm' in S. 1 as this applies to the acquitted mentally ill person. Sections 3–11C8(f) and 3–11C8(g) direct that the defendant be committed to suitable and available state, local or private facilities until he is no longer likely to cause serious harm by reason of his mental illness or defect. The Committee should be aware of the revolution in mental health law concerning the civil commitment of the mentally ill that is sweeping the nation. Danger or harm to others is considered in many jurisdictions as the sole legal basis for such involuntary commitment; but the standards defining the likelihood of such harm or danger are quite variable from jurisdiction to jurisdiction. They may be narrow or broad, high or low, strict or loose. As a consequence of this state of affairs, federal defendants returned to different state jurisdictions will probably be dealt with under their differential standards that would be interpreted by state case law unless more clearly specified by the Federal Code.

As an example of the problems raised by different standards of harm or danger, in

California defendants acquitted by an insanity defense may be committed under a special provision that has standards of harm that are considerably broader than standards recently developed under the Mental Health Act of 1969 for the civil commitment of the (non-criminal) mentally ill person. If persons acquitted by reason of insanity were held to the mentally ill standard of danger in California, most would be immediately released to the community after acquittal or probably within three months, and many could still be dangerous. Very few persons could be involuntarily detained for a longer period of time under our State Code even if community safety and security demanded it. This very strict standard of danger for commitment of the mentally ill in California has created problems for the United States Attorney in his prosecution of mentally ill offenders in this district. Persons accused of federal crimes who are successful in their insanity defense most frequently do not qualify for civil commitment as mentally ill in California and, therefore, must be released to the community. At present this problem is dealt with by the transfer of the accused to the state jurisdiction for prosecution under comparable state criminal law; acquittal under this law as a result of the insanity defense subjects the defendant to the special provision with the broader definition of harm or danger. Commitment of all acquitted mentally ill persons to Saint Elizabeth Hospital in the District of Columbia or the development of other Federal Hospitals throughout the nation would obviate this problem, but S. 1 contemplates commitment to state, local, or private facilities, which not only raises the problem but compounds it. This matter must be resolved in order to assure that the insanity defense be operationally effective under S. 1.

II. General Observations on the Issue of the Insanity Defense

In my opinion, the problem of treatment of the mentally ill offender and the inadequacies in such treatment that exist in all jurisdictions throughout the nation are more significant issues that require attention than the question of standardizing the definition of legal insanity. The definition of the insanity defense is significant for legal justice; and the insanity defense should be retained for social and legal justice. But social justice must, and legal justice should, address the pressing need for adequate treatment of the mentally ill offender who is mentally incompetent to stand trial, acquitted by reason of insanity, or convicted of a crime and committed to jail, prison, or accorded probation or parole. In the absence of provisions that mandate adequate treatment for the mentally ill offender, reform of the Federal Criminal Laws related to this area can hardly be considered substantive and cannot be considered substantial. I recommend, with all of my colleagues in the American Academy of Psychiatry and Law, that this Subcommittee address additional attention to this glaring lack and pressing need in the Federal Criminal Justice System for procedures that would remedy this problem.

S. 1 under section 3–11D2 directs itself to psychiatric examination of the convicted offender who presents signs of mental illness. Unfortunately this section is less adequate and less complete than sections 4224 and 4225 of S. 1400. These latter sections describe procedures that, in my opinion, should be incorporated into sections 3–11D(1) and 3–11 D(2) of S. 1.

III. The Bases for Opposition to S. 1400

The definition of insanity and the procedures under S. 1400 are offered as alternative proposals to those made under S. 1 to revise the insanity statutes in federal jurisdictions, to set a standard of criminal responsibility that would be uniform in all federal jurisdictions, and to set a standard that would lead to a higher standard of justice (according to the Administration which submitted this Bill through the Department of Justice).

The American Academy of Psychiatry and Law strongly opposes the S. 1400 definition of insanity and its procedures for the following reasons: (1) the concept and terminology

of the S. 1400 definition of insanity and its procedures for dealing with the acquitted mentally ill offender run counter to the philosophy and concepts of contemporary society and to those of contemporary psychiatry. In the past century psychiatry has clearly demonstrated that the mentally ill person can be significantly and substantially mentally impaired without being identified as "mad" or frankly "crazy" in appearance or conduct. The S. 1400 definition of insanity reverts to the erroneous and outmoded concept that suggests that to be considered insane one must have been functioning at the level of the "lunatic" or the helpless mental retardate at the time of commission of an illegal act. Such a concept is regressive, is rejected by contemporary societal attitudes, and is rejected by the entire psychiatric profession.

(2) the procedural mechanisms under S. 1400 commit the acquitted mentally ill offender to a prison hospital, a part of the criminal justice system, rather than to a security hospital in the mental health system. Again this is a retrogressive procedure in which the mentally ill offender who is not morally culpable of a crime is nevertheless dealt with by and in the system of criminal justice. This procedure subverts and negates the social policy that these mentally ill actors are not morally culpable, have not committed a crime, and should not be dealt with under this system of criminal justice.

The argument is offered by some that maximum security hospitals for the criminally insane are hospitals in name only and are even worse than prison; and also the argument that having all mentally ill offenders in prison hospitals would promote the care and treatment of all mentally ill prisoners and would upgrade the treatment accorded to the acquitted insane patient in custody as well. This assumes that physicians and psychiatrists would flock to such prison hospitals to provide such treatment. Unfortunately the assumption runs counter to our experience. Professional staff have not been attracted to state mental hospitals, are far less drawn to hospitals for the criminally insane, and generally are even less interested in serving professionally in prison hospitals. As a consequence of this state of affairs we can hardly expect dramatic improvement in the treatment of the mentally ill in the prison system in the near future.

Although S. 1400 has considerable opposition, there is unquestionably considerable support for it from the legal profession and some from the psychiatric profession who are unaware of its theoretical and especially its procedural implications. Support comes from a number of different sources: (1) from prosecuting attorneys and others who share their position and point of view; (2) from psychiatrists and others who are disappointed and frustrated at the poor treatment accorded to the committed mentally ill patient in the maximum security state hospital and the almost complete lack of treatment provided for the mentally ill offender in penal custody; and (3) those who oppose the insanity defense in principle, wish to remove the psychiatrist from the role of expert witness in the trial in chief, and wish to involve the psychiatrist as a consultant in sentencing, directing the mentally ill offender away from the punishment of prison to the treatment of a prison hospital. It can be readily seen that agencies of prosecution would favor and those of defense would oppose S. 1400, both in its substantive and its procedural content related to the insanity defense.

Legal opinions about S. 1400 have been mixed. Although a majority of the National Commission on Reform of Federal Criminal Laws and of the American Bar Association Committee on Reform of Federal Criminal Laws voted for S. 1 and against S. 1400, a minority of both committees voted for the concept of legal insanity expressed in S. 1400. Eminent authorities such as Abraham S. Goldstein, Dean of the Yale Law School, and Alan Dershowitz, Professor of Law at Harvard Law School, have opposed the S. 1400 concept of insanity, but a number of Bar Associations, the National District Attorneys Association, the Department of Justice, and equally eminent authorities such as Professor David Robinson of the Washington University National Law Center have favored the S. 1400 concept and its procedural mechanisms for dealing with the acquitted mentally ill offender, as against the S. 1 definition and its procedures.

What I would like to address myself to are the beliefs among attorneys that appear to underlie their recommendation of S. 1400.

A number of different beliefs appear to lay the foundation for support of the S. 1400 concept of insanity and its procedures: (1) the belief by some United States attorneys that there is considerable abuse of the insanity defense, that many, if not most, defendants who raise the insanity defense are feigning mental illness, malingering, manipulating legal procedures, or deceiving examining psychiatrists so that a number of unjustly acquitted defendants are successfully able to avoid conviction for their wrongdoing; (2) the belief that current standards of criminal responsibility in the different federal jurisdictions are court-determined and do not accurately reflect and represent contemporary social policy, that they are too loose, too broad, and too vague; and, therefore, that abuse by defendants is developed more readily and is checked with more difficulty; (3) the belief that at the instigation of defense psychiatrists are entering the guilt phase of criminal trials in increasing numbers in order to help exculpate an increasing number of acquitted defendants; and (4) the belief that the majority of attorneys and psychiatrists are opposed to psychiatric expert witness testimony on the issue of criminal responsibility, are opposed to opinion testimony on the insanity issue, are urging the abolition of the insanity defense or at least its major modification, and are recommending instead that psychiatrists be called in as consultants after the defendant has been adjudicated as guilty to offer recommendations on his disposition at the time of sentencing.

I have already commented on belief number 4. Beliefs 1, 2, and 3 are gross exaggerations or are patently false. According to Dean Goldstein and others (Fingarette, Matthews, McGarry, and Dershowitz), the best estimates we have indicate that the insanity defense is offered in approximately 1% of the felony prosecutions in the nation and that this figure has been relatively constant for many years except for brief periods of change in certain jurisdictions, such as the District of Columbia immediately after the introduction of the Durham rule. It is important to note, however, that in other jurisdictions, such as the 9th Circuit, there was no significant change in the number of insanity pleas or acquittals on the basis of insanity after the standard of insanity changed from McNaghten plus Irresistible Impulse to the ALI rule.

Dershowitz has estimated that the total number of acquittals on the basis of insanity in all federal jurisdictions is less than 100 per year; and the best estimate from McGarry and Matthews is that in 1968 there were fewer than 1500 patients in all of the hospitals for the criminally insane in the United States who were institutionalized as a result of acquittals on the insanity defense. It can be seen, therefore, that the numbers of persons pleading insanity are few and the numbers of acquittals even fewer. Finally, as has been pointed out by all authorities, Brackel, Leavy, Matthews, Dershowitz and McGarry, almost all acquittals on the grounds of insanity are followed by involuntary commitment to security hospitals; and more frequently than not the length of time that the committed patient remains in the security hospital has exceeded the period of time that he would have served had he been committed to a prison.

Although these beliefs can hardly stand the test of scrutiny, nevertheless there is good reason to infer that they led to the Administration's proposal of S. 1400 to the 93d Congress 1st session of the United States Senate on March 27, 1973, submitted by Senators Hruska and McClellan as the Criminal Code Reform Act of 1973.

The proposal was heralded by President Nixon in his "State of the Union Message on Crime and Law Enforcement," March 14, 1973: "The most significant feature of this chapter (Chapter 5 of S. 1400) is a codification of the 'insanity' defense. At present the test is determined by the courts and varies across the country. The standard has become so vague in some instances that it has led to unconscionable abuse by defendants.

My proposed new formulation would provide an insanity defense only if the defendant did not know what he was doing. Under this formulation, which has considerable

support in psychiatric and legal circles, the only question considered germane in a murder case, for example, would be whether the defendant knew whether he was pulling the trigger of a gun. Questions such as the existence of a mental disease or defect and whether the defendant requires treatment or deserves punishment would be reserved for consideration at the time of sentencing.

In S. 1400, Chapter 5.—Defenses, section 502. Insanity, the definition of exculpatory mental illness is formulated as follows:

> It is a defense to a prosecution under any federal statute that the defendant, as a result of mental disease or defect, lacked the state of mind required as an element of the offense charged. Mental disease or defect does not otherwise constitute a defense.

It can be seen from this formulation that the insanity defense is not completely eliminated but markedly circumscribed and constricted. Mental disease or defect would provide no defense unless it negatived an element of the offense. Insanity in essence would be eliminated as a separate defense and would be accorded only evidentiary significance. With this formulation and its accompanying procedures the Administration hoped to overcome the above-listed "abuses" and to reduce the objectionable practices that it believed were in operation.

Chapter 312.—Determination and Effect of Insanity outlines under sections 4221 to 4225 the procedures that relate to the mentally ill offender in determining the existence of insanity at the time of the offense (section 4221); psychiatric examination, reports, etc. and the hospitalization of a person acquitted by reason of insanity by commitment to the custody of the Attorney General (section 4222); hospitalization of a convicted person suffering from mental disease or defect (section 4224); and commitment following expiration of sentence (section 4225).

I will comment on these specific sections and describe why in my opinion the S. 1400 proposal as presently formulated will not succeed in improving the administration of criminal justice and instead will probably promote the opposite of what I believe the Administration hopes to attain.

Under section 4221 of Chapter 12, psychiatrists will still be called to testify on the relationship of the defendant's mental state to his capacity to harbor the criminal intent at the time of the offense. One gains the impression that so few mentally ill persons will qualify for this standard of insanity that very few, if any, psychiatrists will be involved in the guilt phase of the trial.

There is no question in my mind but that the test of insanity as defined in S. 1400 initially will markedly reduce the number of insanity pleas and still further reduce the number of acquittals on the basis of insanity. From discussion with both prosecutors and defense counsel in both State and Federal Courts in California about this question, however, I am led to believe that this reduction would be temporary and short-lived. All have agreed that shortly after the enactment of S. 1400 the operational definition of criminal intent as this related to defendants who were significantly mentally ill would change and that in a relatively short time the functioning definition of insanity under section 502 would be reformulated by the trier of fact so that it would again provide for a broader exculpatory condition, probably similar to McNaghten or ALI insanity. Because of the absence of standards related to intent and because different levels of mental functioning are involved in the criminal intents related to different crimes, the trier of fact will be even more confused, however, not less confused as he attempts to relate the psychiatrist's material to the issue of criminal responsibility. That the above observations are not mere possibilities but are likely to occur is confirmed from our experience in California Courts following the development of the concept of diminished capacity.

Experience in California demonstrates that much more psychiatric testimony is entered on the issue of criminal intent than on the issue of insanity. Estimates range from a ratio of one instance of psychiatrist involvement in insanity to 50 instances of involvement on

the issue of intent, to a ratio of one to 500. In other words, the expectation held by the Administration that psychiatric expert witness testimony will be reduced under the S. 1400 formulation will not only fail to materialize but the contrary result will develop.

Sections 4222 and 4224 provide for the commitment of the mentally ill acquitted and convicted parties to the Attorney General. This has already been criticized and our opposition registered. In other respects these two sections represent marked advances in the disposition of the mentally ill offender in that the sentence of the convicted mentally ill person may be reduced after he has recovered sufficiently to be returned from the prison hospital and is considered no longer in need of treatment. Again neither section provides for the defendant's jury trial on these issues, should he wish, or judicial review, absences in procedure that I hope the legal profession will address itself to in order to satisfy constitutional safeguards of due process.

Finally it can be said that the insanity defense is no more than an organizing principle for a process of social decision-making through our criminal-legal system. The S. 1 formulation of insanity for purposes of criminal responsibility should not be looked upon as the final answer; rather it should be considered the preferable standard that presently satisfies the needs of society and is within the professional capabilities of the forensic psychiatrist. In this sense in the S. 1 definition and procedures it may be advisable to codify the definition of exculpatory insanity in the Federal Code in order to promote uniformity and reliability of criminal justice processes throughout the federal system.

I hope that the Committee finds these recommendations and observations of value in its considerations on the S. 1 and S. 1400 proposals related to the insanity defense.

May 15, 1974