Informed Decision Making in Persons Acquitted Not Guilty by Reason of Insanity

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Deciding to raise an insanity defense carries serious consequences. This is especially true for persons charged with minor offenses, for whom an acquittal not guilty by reason of insanity (NGRI) might lead to a longer period of incarceration than would conviction. Before raising an insanity defense, a defendant should be provided with information necessary to make an informed decision and should be competent to understand the consequences of the verdict. This study attempted, through retrospective review and concurrent evaluation, to determine the degree to which trial courts in Virginia attended to these important aspects of informed decision making before finding defendants charged with misdemeanors NGRI. The study also attempted to assess the degree to which defendants were competent and informed at the time of adjudication. In most instances, trial courts did not consider defendants' competence to make decisions regarding the insanity defense and did not consider whether defendants were informed about the consequences of a successful insanity defense at the time of adjudication. The average length of stay for these patients was (at least) 21 months; most would have been released earlier had they been committed civilly rather than committed as a result of insanity pleas. We stress the need to educate judges, attorneys and forensic evaluators to the importance of considering defendants competence to plead insanity and of providing information about the consequences of a successful plea. We also propose that laws be changed to recognize the importance of these elements in the decision making process regarding pleas of insanity.

Acquittals by reason of insanity are unlike other acquittals in criminal law. The criminal defendant who wins an outright acquittal is free of state control and may simply walk away from the courthouse after the trial, but the defendant found not guilty by reason of insanity (NGRI) typically remains confined. In a few states laws permit such confinement only to initiate civil commitment proceedings and forbid extended confinement unless pursuant to a valid civil commitment order. Most state laws,

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however, treat NGRIs (persons found not guilty by reason of insanity) very differently from persons subject to ordinary civil commitment. The hurdles to commitment typically are much lower, and the barriers to release much higher. Especially when charged with misdemeanors, insanity acquittees generally remain hospitalized far longer than ordinary civil committees and may remain confined for periods greater than the maximum sentence that would have been possible on conviction of the criminal charges. [1-3] Finally, unlike criminal offenders who are seen simply as "bad," NGRIs suffer a double stigma: in the eyes of society, they are both "mad" and "bad."

Given that the consequences of an insanity acquittal are serious and, for many defendants charged with misdemeanors, less preferable than a criminal conviction, one might expect that the decision making process leading to a successful insanity defense would be well studied. This is not so. Although considerable attention has been given to other aspects of the insanity defense (e.g., standards for insanity, burdens of proof, dispositional consequences), empirical studies of the decision making process related to NGRI pleas appear to be lacking. There is a sharp contrast between heightened concerns about criminals "beating the rap" by using an insanity defense and limited awareness and study of persons languishing in state hospitals after being acquitted by reason of insanity.

One might also expect, given the consequences of the defense, that NGRI acquittals for persons charged solely with misdemeanors would be minimal. Again, this is not so. A survey conducted in 1989 by the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services identified 137 persons, 135 of them inpatients, in the custody of the Department under NGRI status.[4] In all, these individuals had been charged with 193 offenses, of which 56 were misdemeanors. In Central State Hospital (CSH), which has Virginia's only maximum security forensic unit, 21 of the 95 NGRI patients had been charged only with misdemeanors. It is likely that the proportion of misdemeanant NGRIs at the other state hospitals was higher because patients charged with more serious offenses are sent to CSH.

Several elements are key to making an informed decision to enter a plea of insanity: the competence of a defendant to understand consequences of the plea, the degree to which a defendant is informed about the consequences of the plea, and the degree to which the plea is voluntary. The study is further focused on defendants charged only with misdemeanors, a group of special interest as they may be subject to the greatest potential for abuse. The offenses with which they are charged often differ little from acts that lead to civil commitment on the grounds of dangerousness to others, e.g., simple assault, abusive language, and disorderly conduct. Yet these defendants often spend much more time incarcerated than their civilly committed counterparts and may, in some states, have greater barriers to release.

We begin by reviewing the legal issues,

especially those relevant to the questions of voluntariness and competency. For example, can an insanity defense be imposed on an unwilling or incompetent defendant? We conclude with an exploratory study conducted in Virginia to assess the degree to which a population of hospitalized misdemeanant NGRIs had the capability to make an informed decision whether to interpose an insanity defense at their trials.

Legal Background

There are surprisingly few cases on the question of a defendant's competency to make decisions about presenting an insanity defense. A few courts have found this question of competency is subsumed by the question of competency to stand trial. (See, for example, *State v. Champagne.* [5] Thus, if a defendant were found competent to stand trial, it would be conclusively presumed that the defendant was also competent to make this decision. As a corollary, if the defendant lacked the capacity to make an informed choice about pleading insanity, he or she presumably would be declared incompetent to stand trial. Whether, in practice, the competency of defendants to make such an informed choice is regularly addressed when the question of competency to stand trial is raised is highly doubtful.

Many courts have simply ignored the question of competency to make decisions about raising the insanity defense. They have permitted, and in some cases required trial courts to impose the defense in order to avoid the "injustice" of convicting a defendant who is morally blameless because of mental nonresponsibility. (See *Whalem v. United States.* [6]) Most courts that have addressed the question, however, clearly distinguish between competency to decide whether to raise the defense of insanity and competency to stand trial. These courts restrict the right of judges to impose an insanity defense in cases where the defendant, although competent to stand trial, is found to be incompetent to decide whether to assert the defense. The leading case in point is *Frendak v. United States.* [7] The defendant, Paula Frendak, was found competent to stand trial and convicted of first degree murder during the first phase of a bifurcated trial. Troubled by evidence heard at Frendak's competency hearing and at her trial, the court proceeded to hear evidence concerning her sanity at the time of the offense. Based on this evidence, the court decided—over Frendak's objection—to interpose an insanity defense at the second, "insanity" phase of her trial. The jury found Frendak NGRI. She appealed the decision to impose the defense over her objection. The appellate court reversed, articulating a range of legitimate reasons competent defendants may choose to forgo an insanity defense. "Because the defendant must bear the ultimate consequences of any decision, we conclude that if a defendant has acted intelligently and voluntarily, a trial court must defer to his or her decision to waive the insanity defense . . . [W]henever the evidence suggests a substantial question of the defendant's sanity at the time of the crime, the trial judge must conduct an

inquiry designed to assure that the defendant has been fully informed of the alternatives available, comprehends the consequences of failing to assert the defense, and freely chooses to raise or waive the defense." The American Bar Association, in its Criminal Justice Mental Health Standards (Standard 7-6.3(b)) implores the courts to follow the *Frendak* rule: "Neither the court nor the prosecution should assert a defense based on abnormal mental condition over the objection of a defendant who is competent to make a decision about raising the defense." [8]

To date, nearly all the cases on this issue have involved defendants whose choice was to forgo the defense of insanity. Only one recent case, *Walls v. United States*, [9] considers whether a successful insanity defense initiated by an unwitting defendant should be subject to subsequent invalidation at the defendant's request on the ground that the defendant was incompetent to make an informed decision when he or she interposed the defense. The defendant, Anthony Walls, was found not guilty by reason of insanity for misdemeanor assault and was committed to a psychiatric hospital for an indeterminate period. Realizing the significance of what he had done, Walls sought relief. The District of Columbia Court of Appeals found that Walls suffered "manifest injustice" because of the trial court's failure to ascertain whether the defendant understood the consequences of his insanity plea before accepting it. The court reversed and remanded the case to the trial court to vacate the plea.

Although some appeals courts have become more sensitive to the defendant's interests in these cases, in practice it appears that most trial courts give little attention to defendant's competency to decide whether to pursue an insanity defense. The study that follows describes the practices in one state, Virginia.

Methods

Subjects Inpatients at Central State Hospital in Petersburg, Virginia, who had been found NGRI on misdemeanor charges were asked to participate in the study. All eligible patients (N = 21) agreed. One patient died before completing the study.

Procedure Each subject was interviewed by a psychiatrist, clinical psychologist, or psychiatric resident experienced in forensic assessment. Subjects were questioned about their mental condition at the time of the trial and about their interactions with the legal system. Interviewers paid particular attention to subjects' understanding of the process of interposing an insanity defense and the consequences of being found NGRI. They verbally administered the Competency to Plead NGRI Questionnaire (see below) to each subject and recorded the responses. Raters also drew on information in the relevant clinical and legal charts (diagnostic and treatment information, criminal record, and prior reports on competence to stand trial and NGRI).

After integrating all available information, interviewers rated whether subjects: (1) at the time of the trial had been capable of making an informed decision

about pleading NGRI and (2) at the time of the interview met criteria for civil commitment.

It should be noted that interviewers did not rate separately either defendants' competence to raise an insanity defense or defendants' knowledge about the insanity defense at the time of trial. Rather, because of problems described below in assessing retrospectively the separate concepts of competence and knowledge, the combined construct "capability to make an informed decision at the time of the trial about an insanity defense", henceforth abbreviated as "capability," was employed.

Assessing defendants' knowledge at the time of trial was confounded by memory effects and lack of documentation. Besides defendants' accounts months or years later about what they had been told about the insanity defense, we had no independent means of verifying what information had been provided. However, we made the assumption that there would be a relationship between patients' current knowledge of the defense and its consequences and knowledge they possessed at the time of trial: we assumed that, in general, patients would have greater knowledge at the time of the interviews than they did at the time of their trials due to exposure to subsequent evaluations and hearings related to their status, exposure to discussions with treatment teams, participation in hospital groups designed to improve patients' understanding process, and because they were at least partially treated and thus were more able to acquire and process information available to them. Thus, we assumed that patients would not have been significantly more knowledgeable about the defense at the time of their trials than they were at the time of our interviews. This assumption has not been validated independently but is consistent with our clinical experience. The semi-structured interview used to assess patients' knowledge about the insanity defense and its consequences is described below.

Assessing competence retrospectively was impaired by not knowing what information had been provided to defendants. Competence is related to a specific task, in this case being able to understand the consequences of the defense and to make a rational decision about it. It would have been helpful to have known exactly what information was presented to defendants and to have determined how that information was manipulated in arriving at their decisions (if they were ever consulted). With this unavailable to us, several assumptions were made. First, if a defendant had been found incompetent to stand trial, and if there was no evidence of restoration to competence, the defendant was likely to have been incompetent to have raised an insanity defense. Second, if clinical or legal records showed the defendant to have been floridly psychotic around the time of the trial, the defendant was likely to have been incompetent to have raised an insanity defense.

Since the capability to make an informed decision requires both competence and knowledge, a lack in either leads to an incapability in informed decision making. Thus, the combined rat-

ing of "capability" is likely to be more reliable than separate retrospective assessments of competence and knowledge.

Committability was rated based on Virginia's criteria that include mental illness and either danger to self or others or inability to care for self. Raters were asked to apply the criteria in the most anti-libertarian manner, i.e., to lower the threshold for committability. Since our hypotheses inclined us to believe most misdemeanant NGRI acquittees should be released, an anti-libertarian interpretation of the commitment standards minimized the effect of our biases.

Development of the Competency to Plead NGRI Questionnaire The questionnaire used in this research was designed by the authors to assess defendants' knowledge about the consequences of an insanity defense. Through consensual validation, 23 questions were selected from a pool of items that pertained to understanding of the legal system, understanding of plea options, and understanding of the NGRI commitment and release process. Each item was scored on a four-point Likert scale (0 = no understanding or knowledge, 1 = minimal understanding or knowledge, 2 = fair understanding or knowledge, 3 = good understanding or knowledge). A description of each point on the Likert scale was available to help anchor the meaning of the scores and increase interrater agreement. Raters met to assure mutual understanding of administering and scoring the new measure. Although attempts were made to word the questions simply, the nature of the material made it likely that some defendants would need additional information. Therefore, permission was given to the interviewers to provide additional explanations to patients that were necessary to facilitate understanding. After the questionnaire was piloted on several subjects and the wording of some items modified, several subjects were interviewed on separate occasions by different raters blind to each others' ratings; reasonably high interrater agreement was obtained (Winer reliability mean of the scores, .84).

Results

Demographics Subjects were generally middle-aged (M = 39.0, SD = 10.7), male (19 men, 2 women), and African American (13 blacks, 8 whites). The mode (N = 7) and median level of intelligence, as gleaned from statements in the charts, was below average. The median length of stay at the time of the interview was 21 months (χ = 21.8, SD = 15.5), ranging from 0.5 to 60 months.

Fifteen of the subjects had only one criminal charge, whereas the remainder had two or more charges. Petty larceny (N = 5) and assault (N = 4) were the most frequent charges.

Classification of the subjects' diagnoses was difficult because clinicians responsible for treatment and pretrial evaluations did not uniformly adhere to DSM-III-R nomenclature. Nonetheless, we determined that 15 of the subjects had primary diagnoses in the schizophrenic spectrum and three were bipolar. The remaining primary diagnoses

were dementia, alcohol hallucinosis, and schizoaffective disorder. Secondary diagnoses of alcohol abuse or other substance abuse were common, as were personality disorders.

Chart Review Only 11 of the 21 (52%) subjects had a competency to stand trial report (CST) in their charts. Eight of the 11 (73%) reports contained language implying that the evaluator believed the subject was incompetent to stand trial. No data were available for the remaining 10 subjects; thus, it is unclear whether competency to stand trial was never assessed in these cases or an assessment was conducted elsewhere, and records were not forwarded to the hospital.

CST reports and other records were carefully examined for any evidence that competency to plead NGRI was specifically assessed before trial. None of the subject's records revealed such evidence; therefore, if competency to plead NGRI was formally assessed, reports to the court failed to address the question.

Only four of the subjects had reports on their mental status at the time of the offense (MSO) in their charts. These contained language suggesting that the defendant met the criteria for an NGRI defense.

Upon completion of the study (5/92), we reviewed the hospital census again to ascertain length of stay. Seven subjects had been released from the hospital with a median stay of 29.7 months (χ = 22.3 months, SD = 11.0, range of 7.8 to 32.5 months). However, many of these subjects were released not to the community but were transferred to other, less restrictive psychiatric facilities. Some were returned to the community, but continued to be supervised by the courts because of their NGRI status. Eleven subjects remained hospitalized, with average length of stay to date of 32.6 months (χ = 38.9 months, SD = 19.7, range of 15.0 to 77.1 months).

Rater's Judgments of Capability and Committability With respect to the capability of subjects to make an informed decision to interpose an insanity defense, the results (see Table 1) showed that most subjects (16 of 20, or 76%) were likely to have been incapable to make this decision. This was based both on the presence of severe psychotic symptoms at the time of trial that likely impaired decision making capacity, and on a marked lack of information about the consequences of the insanity defense.

With respect to committability at the time of the study, approximately half (9 of 20 subjects) were viewed as meeting markedly anti-libertarian civil commitment standards. Most of the patients were not considered dangerous to selves

Table 1
Capability of Making an Informed Decision to Plead NGRI at the Time of the Trial by Rating of Civil Committability at the Time of the Interview

Capability	Ability to Meet Criteria for Civil Commitment		Row Total
	Committable	Not Committable	
Capable to plead NGRI	0	4	4
Not capable to plead NGRI	11	5	16
Column total	11	9	

or others, and of those considered committable, all but two met only the criteria for mental illness and inability to care for themselves. However, because commitment criteria were applied in such an anti-libertarian manner, it was the opinion of the raters that all but one or two patients would have been released had actual civil recommitment hearings been held.

The crosstabulation of these ratings holds particular interest. Only four subjects were judged to have been capable of making an informed decision to plead NGRI at the time of their trial. These same individuals were perceived as not meeting civil commitment criteria at the time of the interview. Eleven of the 16 subjects (69%) rated as incapable of making this informed decision were perceived as meeting standards for civil commitment at the time of the interviews. (However, because they did not generally meet criteria for dangerousness to self or others they likely would have been released had they been civilly committed).

The Competency to Plead NGRI Questionnaire Mean scores and standard deviations for each of the 23 questions from the interview survey form are shown in Table 2. The low scores on most of the items indicate that most subjects had a poor understanding of the NGRI plea and its consequences.

To permit general comparison between subjects, a total score was obtained, based on the average scores from all 23 items (supported by a Cronbach Alpha internal consistency of .96 for the 23-item scale). The mean and standard deviation for the total sample can be found in Table 2. A t-test supported the expectation that subjects deemed incapable of making an informed decision by the raters would score significantly lower than those judged capable ($t = 3.8$, $df = 18$, $p < .001$). Judgments of capability and total score on the interview schedule were highly correlated ($r = .68$), as expected, because raters had the benefit of knowledge from the interview when retrospectively judging capability. Despite its limitations, the scale may prove useful in further research by standardizing interview data and conclusions.

Discussion

The use of the insanity defense for defendants charged with misdemeanors is not uncommon in Virginia. Were these acquittees subject to commitment laws and practices no more restrictive than those applicable to civil commitment, this would not be problematic. Most of the defendants would have been released within six months, the maximum time allowed before recommitment. For the population of misdemeanants studied, only one or two met commitment criteria for dangerousness to self or others at the time of the interviews. The rest would likely have been released at a civil recommitment hearing. This is in stark contrast to the mean of 21 months they spent at CSH. Further, the time incarcerated is longer than indicated. Many patients still had not been released at the time of this report; some "releases" were actually transfers to other institutions, and time spent

Table 2
Scores on the Competency to Plead NGRI Questionnaire

Item	Overall Score	
	Mean	Standard Deviation
1. Can you tell me what the name of this place is?	2.7	0.8
2. What is the reason you are here?	2.1	1.0
3. What were you charged with?	2.2	1.1
4. Do you know what a legal plea is?	1.3	1.1
5. What possible pleas or options did your lawyer discuss with you?	1.0	1.1
6. What was your plea?	1.3	1.2
7. Can you tell me what it means to be not guilty by reason of insanity?	1.2	1.1
8. Did you consider pleading guilty or not guilty (which)?	1.9	1.2
9. What would have happened to you if you had been found guilty?	1.9	1.1
10. What would have happened to you if you had been found not guilty?	1.8	1.2
11. What did your lawyer think you should do?	1.1	1.1
12. Did you agree with your lawyer?	0.9	1.2
13. Why did you plead NGRI?	1.3	1.2
14. Was this your choice?	1.3	1.3
15. At that time, what was your understanding of what would happen to you after pleading NGRI?	1.4	1.3
16. Did you know you would have to go to Central State Hospital?	1.5	1.3
17. At that time, what did you think you would have to do to get out of the hospital?	0.6	0.7
18. How often can you apply for release?	1.0	1.3
19. What is your understanding now of what it will take for you to be released from the hospital?	0.9	0.8
20. Who evaluates you for release?	1.4	1.0
21. Who makes the decision whether to release you?	1.5	1.1
22. Do you have the right to an attorney at your release hearing?	1.6	1.2
23. What does the judge have to find in order to release you?	1.1	1.2
Average score, all subjects	1.4	0.8
Average score, subjects judged to have been capable of pleading NGRI	2.3	0.3
Average score, subjects judged to have been incapable of pleading NGRI	1.1	0.6

either in jail or in the hospital before trial was not included.

Under Virginia law, the maximum sentence on conviction of a misdemeanor is 12 months in jail. Many of these defendants would likely have been released with "time served" pretrial had they pled guilty. Some may have been civilly committed but would likely have been confined for shorter periods than they spent institutionalized as NGRI acquittees.

Another troubling finding is that as many as one-half the defendants were found NGRI without ever having had an evaluation of their competence to

stand trial. We do not know how many subjects may have been evaluated at agencies other than Central State Hospital; perhaps records of evaluations may not have reached Central State. However, as all the subjects gave clear evidence of mental illness, failure of any of the parties to request a CST contradicts constitutional expectations expressed in landmark cases such as *Drope v. Missouri*[10] and *Pate v. Robinson.*[11] Of those 11 subjects evaluated for competence to stand trial, eight were considered incompetent. There is no evidence that any was restored to competency before going to trial. Seven of these eight came from one court, a fact that suggests serious, repetitive error in that court.

No evaluation reports addressing CST and criminal responsibility submitted to the court before trial included mention of the defendant's specific capacity to understand the consequences of being acquitted NGRI. Since the defendants in our study uniformly denied having been advised of the consequences of an insanity acquittal before trial, this omission probably reflects a failure to conduct the assessment rather than mere failure to document the findings. Furthermore, some defendants participated in the study within days or several weeks of having been found NGRI. They also were found to lack capacity to understand the consequences of being acquitted NGRI and appeared to be uninformed about the consequences of an NGRI acquittal.

Sixteen of the 21 patients were deemed not capable of making an informed decision to raise an insanity defense at the time of the interview. This represents a lower estimate of the number likely to have been incapable of making this decision at the time of the trial. By the time of our study, patients had been in treatment for a mean of 21 months. Also, they had had several opportunities to acquire information about the consequences of the insanity defense by participating in evaluations for release and in release hearings, through discussions with treatment teams, and through participation in educational groups intended to help patients understand the release process.

Yet, these findings are not surprising. Given the minimal "benefits" of an acquittal NGRI for a misdemeanor and the considerable risks, in the form of more difficult release standards, one wonders why any of these patients would rationally have chosen the insanity defense. It is our impression that these defenses were obtained either by failing to consult at all with the defendants or by misrepresenting the consequences of an insanity acquittal to them. Many defense attorneys and judges in Virginia lack experience with the insanity defense, and many appear to believe that defendants are better off acquitted NGRI than convicted of a misdemeanor. There is little appreciation for the actual time these patients spend incarcerated and for the conditions under which they are hospitalized.

A comparison of patients considered incapable to make informed decisions about use of the insanity defenses at their trials with patients considered capable is interesting. Those considered capable

had much shorter lengths of stay (χ = 6.6. months versus χ = 24.7 months). This may have largely been due to differences in diagnoses between the groups. The four patients considered capable had diagnoses of bipolar disorder, schizoaffective disorder, alcoholic hallucinosis, and paranoid schizophrenia. Those considered incapable had diagnoses of schizophrenia, chronic, undifferentiated (N = 11), schizophreniform disorder, psychotic disorder not otherwise specified, and dementia. The disorders in the first group were more likely to have responded to treatment before trial, and to have led to a greater level of decision making capability. The better response to treatment may also have led to greater understanding of the release process and participation in it. Finally, these patients were likely to have been less ill at the time of their release hearings and to have made a more favorable impression on the judge. These factors could have led to greater likelihood of release.

Although this study provides useful information on the process leading to an insanity acquittal, its retrospective design is a drawback and the results must be considered preliminary. Nevertheless, the findings are validated by several additional lines of evidence. First, data on several patients evaluated within weeks of admission indicate they were incompetent at the time of the interview to understand the consequences of their insanity defenses. They also appeared not to have received relevant information about the consequences of a successful insanity defense. This suggests that the passage of time may not have confounded our findings significantly. Second, clinical experience suggests that attorneys and judges are rarely informed about the consequences of a successful defense; accordingly, they would not usually be able to provide information to the defendant that would make an informed decision possible. Third, there was a lack of evidence in the records that competence to understand the consequences of and make a rational decision about an insanity plea was considered. These considerations support the study's primary conclusion that three-fourths (16/20) of subjects lacked, at the time of their trials, the capability of making informed decisions about an insanity defense.

Several actions are necessary to ensure that defendants are capable of making an informed decision about an insanity plea. First, education must be provided to judges, attorneys, and forensic evaluators about the importance of defendants making informed decisions about pleading insanity. Second, the same people must be educated about the consequences of a successful insanity plea. Third, because insanity pleas should not be imposed on unwilling misdemeanant defendants, laws should require that, before accepting a plea of insanity, a determination be made whether the defendant is capable of making an informed decision. This determination should be based on the defendant's competence to understand the consequences of the plea and on the defendant having received relevant information on those consequences.

In conclusion, this study provides preliminary data on a key issue in the administration of the criminal justice system. An acquittal by reason of insanity has serious consequences that must be carefully considered by any defendant facing this decision. Although the vast majority of the subjects in our study had little understanding of the consequences of being found NGRI, most were tried either without having been evaluated for CST or after an adjudication of incompetence and apparently no adjudication of restoration to competence. Also, there was no evidence that any of the subjects were evaluated for their capability to make an informed decision about presenting an insanity defense. These findings show a serious failure to protect fundamental rights of persons with mental illness facing criminal charges.

References

1. Steadman HJ: Insanity acquittals in New York State, 1965–76. Am J Psychiatry 137: 321, 1980
2. Pasewark RA, Pantle ML, Steadman HJ: Detention and rearrest rates of persons found not guilty by reason of insanity and convicted felons. Am J Psychiatry 139: 892, 1982
3. Braff J, Arvanites T, Steadman HJ: Detention patterns of successful and unsuccessful insanity defendants. Criminology 21: 439, 1983
4. Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services. NGRI Patient Profile. Richmond, VA 23214, 1989
5. State v. Champagne, 497 A.2d 1242 (N.H. 1985)
6. Whalem v. United States, 346 F.2d 812 (D.C. Cir. 1965)
7. Frendak v. United States, 408 A.2d 364 (D.C. 1979)
8. American Bar Association. ABA Criminal Justice Mental Health Standards. Washington, DC, American Bar Association, 1989
9. Walls v. United States, 601 A.2d 54 (D.C. 1991)
10. Drope v. Missouri, 420 U.S. 163 (1975)
11. Pate v. Robinson, (383 U.S. 375 (1966)