Impact of Change in Legal Standard for Those Adjudicated Not Guilty by Reason of Insanity 1975-1979

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Introduction

In Michigan, during the middle of the last decade, a combination of new legislation and a state supreme court ruling significantly altered the definition of legal insanity and the disposition of those individuals that were adjudicated Not Guilty by Reason of Insanity (NGRI). In early September 1974, the Michigan Supreme Court upheld a lower court's ruling in *People v. McQuillan* that found the state's automatic commitment statute for those persons adjudicated NGRI was in violation of their right to due process and equal protection under the law.[1] The court ruled that an individual acquitted by reason of insanity could be held for a specified period of time (sixty days) for the purpose of observation and evaluation of their current mental status. However, at the conclusion of this diagnostic commitment, the defendants are entitled to receive the same due process and equal protection, regarding commitment and release criteria, as provided for those individuals that have not perpetrated a crime and are civilly committed for psychiatric treatment.

In anticipation of the *McQuillan* ruling, the Michigan Legislature passed the revised Mental Health Code of 1974,[2] which provides for the diagnostic evaluation of all persons acquitted by reason of insanity. Psychiatrists then make recommendations to the probate court as to whether they meet the criteria for involuntary civil commitment. Essentially, this meant that an NGRI must be released, regardless of the severity of the offense, unless he/she is considered "a person requiring treatment."[3] In 1975, additional legislation was promulgated which provided a new definition for legal insanity[4] and created the Guilty but Mentally Ill (GBMI) verdict.[5] The new test for insanity was a modified version of that offered by the American Law Institute Model Penal Code and was ratified with the legislative intent of ensuring that defendants with personality disorders or no mental illness would not qualify for an NGRI acquittal. The GBMI legislation provided the judicial system with

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an alternative verdict that would result in probation or incarceration for those defendants who exhibited signs of mental illness but were not legally insane as defined by the statute.

Despite these modifications, or as a result of them, the NGRI adjudication continues to be extremely controversial. This controversy is exacerbated when an NGRI patient, acquitted of a capital offense, is released into the community after a relatively short period of confinement. At times, although relatively infrequently, the controversy is heightened when a released NGRI subsequently commits additional serious offenses. The purpose of this study is to determine the effects these legislative changes have had on the judicial system's use of the NGRI verdict, the composition of the NGRI population and other related issues. The authors propose to accomplish this task by a comprehensive examination of the NGRI population for the five-year period subsequent to the *McQuillan* ruling. We are quite fortunate in that Cooke and Sikorski have studied a pre-*McQuillan* population (1967-1972) of NGRI patients in Michigan.[6] Their purpose was to identify variables related to the length of hospitalization; however, during the course of their work, data was generated that we have drawn on heavily for comparative purposes.

Method

The Center for Forensic Psychiatry (CFP) is a maximum security psychiatric hospital in Michigan's Department of Mental Health. This facility provides inpatient and outpatient psychiatric services for the state's judicial system. It performs diagnostic evaluations regarding competency to stand trial, criminal responsibility, diminished capacity, and other related issues. It also provides inpatient mental health services for those defendants adjudicated incompetent to stand trial, civilly committed NGRIs and prisoners transferred by the Department of Corrections. This study was made possible because the CFP is mandated by statute to evaluate all defendants adjudicated NGRI to determine if they meet the criteria for involuntary civil commitment.[7] The psychiatric/medical records of the 223 defendants who were adjudicated NGRI from September 1, 1974, to August 31, 1979, were examined. In addition to basic demographic data, descriptive statistics were obtained in the areas of length of hospitalization, yearly rate of acquittals, diagnosis, psychiatric history, prior criminal history, and other relevant variables. On the cutoff date of the study, 124 (55.6%) of the NGRI population had been discharged after the sixty-day diagnostic evaluation period as they did not meet the criteria for involuntary civil commitment for psychiatric treatment. Of the 99 NGRI patients who had been involuntarily committed for treatment, 44 were subsequently discharged following remission of their symptomatology. The remaining 55 were hospitalized and receiving mental health treatment at either the CFP or in other Michigan Department of Mental Health psychiatric facilities.

Results

Demographic Characteristics

TABLE 1
DEMOGRAPHIC DATA FOR NGRI POPULATION

VARIABLE		FREQUENCY	%
AGE	Mean Years — 38.1		
RACE			
White		120	53.8
Black		100	44.8
Other		3	1.4
	Total	223	
SEX			
Male		189	84.8
Female		34	15.2
	Total	223	
EDUCATION			
0 – 8		36	16.4
9 – 11		76	34.5
High School Graduate		78	35.5
Some College		23	10.4
College Graduate		7	3.2
	Total	220*	
EMPLOYMENT STATUS			
Unemployed		173	78.6
Employed		47	21.4
	Total	220*	
MARITAL STATUS			
Single		114	51.1
Married		37	16.6
Separated		23	10.4
Divorced		31	13.9
Widowed		18	8.0
	Total	223	

*Data not available for 3 patients

In general, the NGRI population was quite similar to that studied by Cooke and Sikorski in most areas.[8] The typical member of the current study group is a thirty-eight-year-old, single, white male with some high school education, who was unemployed at the time of the NGRI offense. The Metropolitan Detroit area, which has a large population of indigent blacks that must utilize court-appointed counsel in the judicial system, referred 51.1% of the NGRI population. Since the legislative changes, there has been a change in the racial composition of the population. The pre-*McQuillan* NGRI population was 67.7% white and 32.3% black. When compared with the data in Table 1, the racial distribution reflects a 13.9% decrease amongst whites and similar increase amongst blacks. One explanation for this change may be the procedural guidelines mandated by statute. Currently, all defendants that file notice of intent to assert the insanity defense must be evaluated by CFP personnel regarding the issue of criminal responsibility.[9] These defendants are evaluated at the state's expense, regardless of their

financial resources. The filing of a motion is accomplished with minimal effort on the part of defense counsel particularly in the event the defendant is presenting symptoms of mental illnes or has a history of having received psychiatric care. Most importantly, no costs are encumbered as was likely the case prior to statutory change. Given the supposition that a free examination is available to minorities and the economically deprived, it would appear that the legislative change may have made the insanity defense more readily available to the indigent mentally ill person. This is diametrically opposed to the assertion of one mental health professional that felt the legislation would deprive this group of the insanity defense.[10]

Our study reveals that 65.9% of the NGRI subjects had required previous psychiatric hospitalizations, which is a significant increase from that studied by Cooke and Sikorski. They found that 45.5% of their population had a prior history of psychiatric hospitalizations. The rates for those persons adjudicated incompetent to stand trial for the NGRI offense and having a previous criminal history, 44.8% and 33.2% respectively, have increased slightly relative to that obtained by Cooke/Sikorski, which was 40.1% and 26.3%.[11] Of the total population, eight were found to be recidivists, having been adjudicated NGRI previously.

Frequency of NGRI Adjudications

Many individuals, the authors included, are concerned about society's protection from the perpetrators of heinous or bizarre crimes against people. Media representatives tend to portray "news-worthy" items, which are in many cases sensationalized. Subsequently, NGRIs given notoriety leave the public with the impression that there are many perpetrators of crime that "get away with murder." In reality, the insanity defense is rarely interposed. One author reports that .1% of all criminal cases raise the issue of insanity each year.[12] In Michigan, the insanity issue is raised in .11% of those arrested for "Index Offenses."[13]

TABLE 2
CRIMINAL AND CIVIL DISPOSITION OF CRIMINAL RESPONSIBILITY
Cases Using The ALI Standard

	CRIMINAL RESPONSIBILITY EXAMS	NOT GUILTY BY REASON OF INSANITY	%	INVOLUNTARILY COMMITTED	%
1974 (Sept-Dec)	—	11	—	5	45.4
1975 (Jan-July)	—	18	—	2	11.1
1975 (Aug-Dec)	92	15	16.0	4	27
1976	401	32	8.0	13	40.6
1977	561	48	8.6	27	57.4
1978	746	49	6.6	19	37.3
1979 (Jan-Aug)	589	50	8.5	29	58.0
	2389	223	8.1	99	44.4

As is reflected in Table 2, the court referral rate for criminal responsibility examinations is ever increasing. In preparing this paper, we considered several factors which may affect the referral rate, to include cost/benefit issues alluded to earlier. While calling attention to this subject, we feel that it requires separate and meticulous study.

The rate at which persons are found NGRI has been relatively stable since the enactment of Public Act 180 of 1975, which requires evaluation by CFP personnel. Of the 2389 individuals evaluated regarding criminal responsibility (legal insanity), 223 (8.1%) were determined exculpable by the court and adjudicated NGRI. We cannot draw data prior to 1975 for comparison as there was no central source for data collection. Prior to 1975, determinations as to exculpability were primarily based on independent examinations and testimony. However, raw data reveals a total of 279 NGRIs for the seven-year period of 1967 to 1974, or approximately 40 NGRI adjudications per year.[14] Relative to this data, there has been a slight increase during the post-*McQuillan* era, with 223 NGRI findings over a five-year period, or 44.6 NGRI adjudications per year. We note 78 NGRI acquittals for 1974, the year immediately preceding the landmark *McQuillan* decision, as compared to 33 for the year immediately following.

TABLE 3
CRIMINAL CHARGES OF NGRI POPULATION

CRIME	FREQUENCY Male	Female	Total	%
Murder	—	—	(66)	(29.6)
Unspecified	16	6	22	9.9
Murder I	19	11	30	13.4
Murder II	10	3	13	5.8
Manslaughter	1	0	1	.4
Assault with Intent to Murder	33	7	40	17.9
Assault with Intent to Commit Great Bodily Harm Less Than Murder	11	0	11	4.9
Felonious Assault	17	2	19	8.5
Assault with Intent to Commit Criminal Sexual Conduct	4	0	4	1.8
Criminal Sexual Conduct	10	0	10	4.5
Kidnapping	2	0	2	1.0
Arson	8	1	9	4.0
Armed Robbery	14	2	16	7.2
Unarmed Robbery	3	0	3	1.3
Breaking and Entering	11	0	11	4.9
Larceny	4	0	4	1.8
Receiving and Concealing Stolen Property	3	0	3	1.3
Carrying a Concealed Weapon	4	1	5	2.2
Unlawfully Driving Away Automobile	4	0	4	1.8
Child Cruelty	1	1	2	1.0
Malicious Destruction of Property	2	0	2	1.0
Other Felonies	8	0	8	3.6
Misdemeanors	4	0	4	1.8
Totals	189	34	223	100.0

Table 3 illustrates the frequency and percentage of NGRIs by criminal charge. The 66 murderers found NGRI represent 1.7% of

those 3948 who were arrested for a charge of murder.[15] This finding is not inconsistent with other studies in the U.S. which indicate 2-4% of all homicides result in NGRI verdicts.[16] The present study reveals that 29.6% of the population were acquitted of murder while Cooke/Sikorski reported 59.9%. A most recent New York State study suggests a similar trend in which they report a decline from 53.2% to 43.6% for those acquitted of murder.[17] The significant decrease in this category may suggest that the insanity defense is being utilized for a wider range of offenses, such as breaking and entering, larceny, UDAA (car theft). While there has been a decrease in the percentage of NGRI findings for murder, there appears to be a disproportionate number of females. Of those NGRIs acquitted of murder, there were 46 males and 20 females with 11 of the homicides being uxoricides. One might infer 17% of the homicides were the result of domestic violence. Females would appear to be overrepresented in this crime category as they represent 15% of the total population and 30% of those acquitted of murder.

Factors Affecting Release

We submit that mental health treatment afforded a defendant prior to his/her day in court is a primary antecedent to the release of an NGRI. Prior psychiatric hospitalizations were documented in 65.9% of the cases. This may suggest that the often referred to "revolving door phenomena," admission-discharge-readmission, to a psychiatric hospital is impacting on forensic psychiatry. Rather than having an individual returned to a civil hospital, we surmise that in "nuisance" type cases the individual is arrested and charged with a lesser offense. Consequently, if found to be incompetent to stand trial, there is a certainty of treatment for a longer period of time. We also observed 100 of 223 (44.8%) received treatment, while considered incompetent to stand trial, prior to acquittal. Based on personal experience, we, in addition, have knowledge of others who receive treatment in jail that, while mentally disturbed, are not considered incompetent to stand trial.

In essence, the disordered state of mind, which is the basis for acquittal, is often successfully treated prior to a defendant's going to trial. Subsequently, however paradoxical the circumstances may seem, the 55.6% discharge rate from diagnostic commitment could be largely attributed to effective mental health intervention.

Another factor that may have impact on the release of NGRIs is the court's utilization of the CFP recommendations regarding criminal responsibility. We find in most cases where the criminal courts do not follow CFP recommendations the rate of release increases. Of those NGRIs recommended exculpable, 43% were discharged from their diagnostic commitments following psychiatrist's recommendation that the individual was not a "person requiring treatment." This figure escalates to 72.3% for discharged NGRIs who were recommended

criminally responsible and for those rare cases where the criminal court failed to refer the defendant to the CFP for the required examination. To illustrate, in 1978 30 NGRIs were discharged because they did not meet the criteria for involuntary commitment. Of these 30 individuals, three were not evaluated as to criminal responsibility and four were recommended culpable by CFP personnel. All seven were later diagnosed as personality disorders or no mental illness. In these cases, it would appear that the definition of mental illness was not uniformly applied and thus impacted on the subsequent release of these individuals. We reiterate that the definition of mental illness,that which is applied for the present state of mind for a "person requiring treatment," is the same standard applied retrospectively to the state of mind at the time of the offense.

Length of Hospitalization

TABLE 4
MONTHS IN RESIDENCE BY CRIMINAL CHARGE

	Currently Hospitalized		Discharged From Probate Commitment	
CRIME	N	MEAN	N	MEAN
Murder	17	17.65	15	10.73
Assault With Intent To Murder	10	25.20	5	8.80
Assault With Intent To Commit Great Bodily Harm Less Than Murder	7	13.43	2	20.50
Felonious Assault	5	14.80	4	5.25
Criminal Sexual Conduct	4	20.00	1	4.00
Assault With Intent To Commit Criminal Sexual Conduct	3	13.33	1	11.00
Armed Robbery	1	18.00	5	9.40
Breaking and Entering	3	5.33	3	7.00
Others	5	11.20	8	8.38
Totals	55	16.91	44	9.48

Total MEAN = 13.60

Table 4 reflects the mean months in residence, by charge, for those NGRI patients hospitalized at the cutoff date of the study and those involuntarily committed for treatment and subsequently discharged. It should be noted that the 121 NGRI patients found not committable and discharged from the diagnostic commitment are *not* included in these computations. Cooke and Sikorski found that the mean months in residence for the pre-*McQuillan* population of NGRI patients was 19.31 months for those who were hospitalized, 24.19 months for the discharged subjects, with a total mean of 21.27 months.[18] When the companion data from Table 4 is contrasted, it is obvious that the current NGRI patient spends considerably less time in the hospital than the pre-*McQuillan* NGRI patient. However, these figures do not reflect the total months spent in confinement for the offense. An accurate computation would include time spent in jail awaiting trial and, for those defendants adjudicated incompetent to stand trial, time spent in treatment.

Diagnosis

TABLE 5
PRIMARY DIAGNOSIS FOR NGRI POPULATION

Diagnosis	Discharged from Diagnostic Commitment	Discharged from Probate Commitment	Currently Hospitalized	Total
PSYCHOSIS				
Alcohol	1	0	0	1
Drug	1	0	0	1
Manic Depressive	4	0	0	4
Organic Brain Syndrome	1	1	0	2
Schizophrenia, Paranoid Type	36	26	35	97
Schizophrenia, Undifferentiated Type	8	12	17	37
Schizophrenia, Other Types	9	1	0	10
Others	6	1	2	9
HYSTERICAL NEUROSIS	2	0	0	2
PERSONALITY DISORDERS				
Alcoholism	3	0	0	3
Antisocial	10	2	0	12
Drug Dependency	2	0	0	2
Hysterical	4	0	0	4
Inadequate	3	0	0	3
Passive Aggressive	11	0	0	11
Others	12	1	0	13
MENTAL RETARDATION	3	0	0	3
NON-PSYCHOTIC ORGANIC BRAIN SYNDROME	0	0	1	1
ADOLESCENT DISORDER	1	0	0	1
NO MENTAL ILLNESS	4	0	0	4
Totals	121	44	55	220*

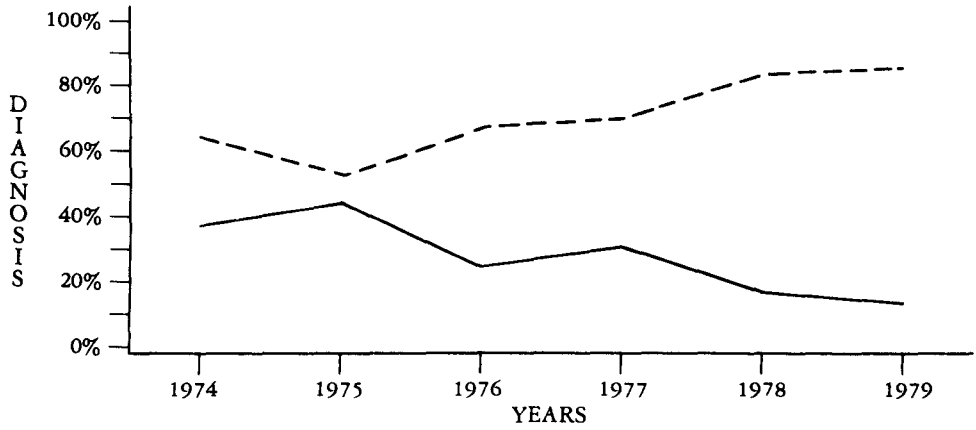
*Diagnosis not available for 3 patients

Table 5 reflects the diagnosis for the NGRI population. For the purposes of consistency in obtaining this data, the diagnosis used was that determined by the psychiatrists during the sixty-day diagnostic evaluation period. For the 220 subjects whose diagnosis was available 74.1% were diagnosed as psychotic or severely neurotic, 21.8% personality disorders, 1.8% no mental illness, and 2.3% other. Cooke and Sikorski found that the pre-*McQuillan* population was 68.2% psychosis, 24.5% personality disorders, 4.2% organic brain syndrome, and 3.1% other.[19]

For those NGRI patients found not committable and discharged from their diagnostic commitment, 56.2% were diagnosed as psychotic or severely neurotic, 37.2% personality disorders, 3.3% no mental illness, and 3.3% other. Of those diagnosed as personality disorders or having no mental illness, 94.2% were recommended not committable. If one were inclined to correlate diagnosis with NGRI findings, as we attempted to do, one might infer that those diagnosed as personality disorders result in "inappropriate" NGRI adjudications. In Robey's study of 203

NGRIs, from 1967 through 1973, he reported "... less than half of them to be both medically and legally appropriate."[20]

TABLE 6
ANNUAL % RATE OF NGRI POPULATION DIAGNOSED AS PERSONALITY DISORDERS/NO MENTAL ILLNESS AND MENTAL ILLNESS
1974-1979



KEY: ——— = PERSONALITY DISORDERS/NO MENTAL ILLNESS
– – – – = MENTAL ILLNESS (MAJOR THOUGHT AND MOOD DISORDERS)

Table 6 illustrates the percentage of NGRI acquittals, by year, diagnosed as suffering from personality disorder/no mental illness and mental illness (major thought and mood disorders). As the graph demonstrates, the yearly rate for personality disorders/no mental illness ranges from a high of 43.8% in 1975 to a low of 12.2% in 1979. Conversely, those diagnosed as suffering from mental illness range from a low of 56.2% in 1975 to 87.8% in 1979. Since 1975, the CFP staff that evaluated defendants regarding criminal responsibility found that those individuals meeting the legal standard for insanity suffer from major thought and mood disorders.[21] While the presence of mental illness in the population has been increasing yearly, given the current legal standard for insanity, the perceptive critic might suggest this in itself does not prove that insanity acquittals are becoming increasingly appropriate. However, the presence of a mental illness provides the potential for a causal link between the offense and the defendant's disordered thinking.

Conclusion

The purpose of this study was to investigate the impact of changes in case and statutory law surrounding the insanity defense in Michigan. We found that the total rate of NGRI findings is no more frequent than what has been reported historically, both nationally and compared to New York State. However, the most striking, and certain to be controversial, result is the high percentage (55.6%) of NGRIs who were discharged following a sixty-day diagnostic commitment. For those NGRIs

involuntarily committed for treatment, a significantly shorter length of hospitalization was found compared to the pre-*McQuillan* era. While this data may be alarming to everyone concerned with public safety, the primary factor affecting release appears to be effective pre-trial mental health treatment, which results in the remission of the symptomatology that provided the basis for acquittal. A yearly increase in percentage of NGRIs diagnosed as mentally ill is considered significant. While this fact alone does not imply legal appropriateness, it does suggest that the courts and juries are becoming more consistent in adhering to a strict interpretation of the definition for mental illness. Additionally, data indicates that procedural changes called for by statute have resulted in parity, by race and economic variables, in the utilization of the defense. In the course of our study it became apparent that there is need for more research and study in the areas of recidivism, factors affecting referral rate, and the impact that other court dispositions, such as the Guilty but Mentally Ill verdict, have on NGRI findings. Research in this vein would provide data on the effect these intervening variables have in the use of the insanity defense.

Footnotes

1. *People v. McQuillan,* 392 Mich 511, 221 NW 2d 569 (1974)
2. Public Act 258 of 1974, MCLA 330.1001 et seq.
3. Public Act 258 of 1974, MCL 330.1400a

   Sec. 400a. As used in this chapter, "mental illness" means 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.

   MCLA 330.1401

   Sec. 401. As used in this chapter, "person requiring treatment" means (a), (b), or (c):

   (a) A person who is mentally ill, and who as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself or another person, and who has engaged in an act or acts or made significant threats that are substantially supportive of the expectation.

   (b) A person who is mentally ill, and who as a result of that mental illness is unable to attend to those of his basic physical needs such as food, clothing, or shelter that must be attended to in order for him to avoid serious harm in the near future, and who has demonstrated that inability to attend to those basic physical needs.

   (c) A person who is mentally ill, whose judgment is so impaired that he is unable to understand his need for treatment and whose continued behavior as the result of this mental illness can reasonably be expected, on the basis of competent medical opinion, to result in significant physical harm to himself or others. This person shall be hospitalized only under the provisions of sections 434 through 438 of this act.
4. Public Act 180 of 1975, MCLA 768.21a.

   Sec. 21a. (1) A person is legally insane if, as a result of mental illness as defined in section 400a of Act 258 of the Public Acts of 1974, being section 330.1400a of the Michigan Compiled Laws, or as a result of mental retardation as defined in section 500(g) of Act 258 of the Public Acts of 1974, being section 330.1500 of the Michigan Compiled Laws, 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 his alleged offense shall not thereby be deemed to have been legally insane.
5. Public Act 180 of 1975, MCLA 768.36(1)
6. Cooke Gerald and Sikorski Cynthia R: Factors affecting length of hospitalization in persons adjudicated not guilty by reason of insanity. Bulletin of the American Academy of Psychiatry and the Law 2(4), 1975, pp. 251-261
7. Public Act 258 of 1974, MCLA 330.1050(1)

8. Cooke and Sikorski, p. 252
9. Public Act 180 of 1975, MCLA 768.20a(2)
10. Tanay E: Proposed MPS position statement on insanity defense in Michigan. Michigan Psychiatric Society Newsletter Vol. XVIII, No. 6, May-June, 1976, pp. 3-5
11. Cooke and Sikorski, p. 254
12. Barclay Rosalyn L: Criminal Responsibility: An Historical Overview, p. 11, an unpublished paper
13. "Uniform Crime Report," Michigan Department of State Police, 20th Edition, 1978, pp. 2-3. Index Offenses include murder, rape, robbery, aggravated assault, breaking and entering, larceny and auto theft.
14. Robey Ames: Inappropriate NGRI Commitments, 1974-75 Forensic Center Budgetary Message, p. 157
15. "Uniform Crime Report," 17th-21st Editions
16. Wolfgang ME and Ferracuti F: The Subculture of Violence: Towards an Integrated Theory in Criminology. London: Tavistock Publications, 1967, pp. 201-202
17. Steadman Henry J: Insanity acquittals in New York State, 1965-1978. American Journal of Psychiatry 137:3, March 1980, pp. 321-326
18. Cooke and Sikorski, p. 256
19. Cooke and Sikorski, p. 254
20. Robey Ames: Guilty but mentally ill. Bulletin of the American Academy of Psychiatry and the Law 6(4), 1978, p. 375
21. Barclay, p. 11