SECOND REGULAR SESSION
112TH MAINE LEGISLATURE
JOINT STANDING COMMITTEE ON JUDICIARY

THE INSANITY DEFENSE AND RELATED STATUTES AND PROCEDURES STUDY SUBCOMMITTEE

JANUARY 1986

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PREFACE BY THE JUDICIARY COMMITTEE

A tragedy occurs when any innocent person becomes the victim of violent criminal behavior. The magnitude of the tragedy remains the same whether the perpetrator's actions resulted from malevolence or mental disease or defect. And we always wish that either tragedy could have been averted.

Yet treatment of the perpetrator by our criminal justice system has traditionally differed if the perpetrator's criminal behavior resulted from mental disease or defect. We have long recognized that a person's mental illness may, in some cases, prevent him from being responsible for his conduct.

Still, the public deserves protection from dangerous mentally ill individuals. The report of the Insanity Defense and Related Statutes and Procedures Study Subcommittee seeks to strengthen that protection for Maine people in several ways.

The Judiciary Committee wishes to thank the Subcommittee for the fine work represented in the following report. We commend the report to all those concerned with Maine's insanity defense and the handling of insanity acquittees in Maine.

PREFACE
TO THE SUBCOMMITTEE
REPORT

The Insanity Defense and Related Statutes and Procedures Study Subcommittee of the Joint Standing Committee on Judiciary of the 112th Maine Legislature conducted this study from August to December of 1985. Rep. Patrick E. Paradis served as chair of the Subcommittee. Sen. Charlotte Zahn Sewall, Rep. Charles R. Priest, Rep. Carol Allen, and Rep. Mary H. MacBride also served as Subcommittee members. Martha E. Freeman, legislative counsel to the Judiciary Committee, served as the Subcommittee's staff.

SUMMARY RECOMMENDATIONS

Standards and Procedures

1. The Subcommittee recommends the elimination of the volitional test from Maine's insanity defense.

2. The Subcommittee recommends that the standard of proof for the defendant who asserts an insanity defense should not be raised to clear and convincing evidence but should remain at a preponderance of the evidence.

3. A Majority of the Subcommittee recommends against enactment of a "guilty but mentally ill" verdict.

Minority Recommendation

Rep. Paradis recommends enactment of a "guilty but mentally ill" verdict.

4. The Subcommittee recommends that the verdict for an insanity acquittee be "not criminally responsible by reason of insanity" rather than "not guilty by reason of insanity."

5. The Subcommittee recommends the continuation of the limitation on the ability of mental health experts to give opinions on the issue of criminal responsibility in a trial where the insanity defense has been raised.

6. The Subcommittee recommends that examinations of the mental condition of criminal defendants on behalf of the court on the issues of competency to stand trial and criminal responsibility be conducted by mental health professionals designated by the Commissioner of the Department of Mental Health and Mental Retardation.

7. The Subcommittee recommends that the Department of Mental Health and Mental Retardation create a Release Review Committee to develop release criteria for insanity acquittees that focus on predicting dangerousness.

8. The Subcommittee recommends that responsibility for supervising released insanity acquittees be given to the Department of Mental Health and Mental Retardation rather than the Department of Corrections.

9. The Subcommittee recommends that the local law enforcement agency of a community into which an insanity acquittee is partially or completely released be informed of the release.

Resources

10. The Subcommittee recommends the establishment, under the authority of the Department of Mental Health and Mental Retardation, of a forensic service: mental health professionals who do examinations for the courts and who are not involved in the treatment of insanity acquittees.

11. The Subcommittee recommends the establishment of another secure treatment unit at the Augusta Mental Health Institute for the long-term treatment of insanity acquittees who remain dangerous.

12. The Subcommittee recommends improvements in the forensic facilities and programs available at the Bangor Mental Health Institute.

13. The Subcommittee recommends that the jails employ additional mental health staff.

14. The Subcommittee recommends that prosecutors be given the authority and funding to consult with independent mental health professionals when an insanity acquittee petitions the court for release from institutionalization.

INTRODUCTION

During the First Regular Session of the 112th Legislature, the Judiciary Committee heard several bills proposing changes in Maine's insanity defense and statutes concerning the handling of persons acquitted of criminal charges by reason of insanity. Through LD 1213, the Judiciary Committee recommended, and the Legislature enacted, revisions in procedures relating to control by the Commissioner of Mental Health and Mental Retardation over insanity acquittees who have been released from institutionalization by a court order. While bills seeking to alter the insanity defense - such as LD 278, LD 370, LD 1035, and LD 1331 - were not enacted during the First Regular Session, the Judiciary Committee did determine that several issues surrounding the defense warranted study. Toward that end, the Judiciary Committee recommended, and the Legislative Council approved, the establishment of the Insanity Defense and Related Statutes and Procedures Study Subcommittee.

The Subcommittee conducted its study in five meetings. At these meetings, the Subcommittee heard from, among others, the staff of the Augusta Mental Health Institute and the Bangor Mental Health Institute; personnel from the Department of Mental Health and Mental Retardation; members of the Maine Society of Forensic Psychologists, the Maine Psychological Association, and the Maine Civil Liberties Union; and members

of the public. The Subcommittee's study included a tour of the Augusta Mental Health Institute and the viewing of a videotape of the facilities of the Bangor Mental Health Institute.

The following pages contain the report of the Subcommittee. The report first presents a brief history of the insanity defense. It next describes Maine's current insanity defense and the statutes governing commitment of an insanity acquittee. A third section seeks to dispel public misperceptions concerning the use of the defense and the disposition of insanity acquittees in Maine. Finally, the report presents recommendations for the tightening of the insanity defense, the provision of appropriate treatment for mentally ill persons who commit crimes, and the protection of the public from insanity acquittees who remain mentally ill and dangerous.

I. BRIEF HISTORY OF THE INSANITY DEFENSE

In 1843 an English jury found Daniel M'Naghten not guilty by reason of insanity for the death of the secretary of the British Prime Minister. M'Naghten had mistakenly shot and killed the secretary, believing him to be the Prime Minister. During the trial, the defense proved that M'Naghten suffered from paranoid schizophrenia, though the disease did not carry that label in 1843.[1] From the M'Naghten case came the first modern articulation of an insanity defense: a defendant is relieved of criminal responsibility if, at the time of the crime, he "was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or if he did know it, that he did not know he was doing what was wrong."[2] The M'Naghten rule's right-wrong test is the insanity defense available in several states.[3]

In some jurisdictions, the M'Naghten rule has been modified by addition of the irresistible impulse test. The irresistible impulse test provides that, even if a defendant knew what he was doing at the time of the crime, and knew that what he was doing was wrong, he can be relieved of criminal responsibility if he could not resist the impulse to commit the crime. This test adds to the M'Naghten rule the defense of an inability to control one's actions, while the M'Naghten test alone concerns

the inability of the defendant to comprehend the nature or wrongfulness of his actions.[4] A few states permit an insanity defense based on the M'Naghten rule modified by the irresistible impulse test.[5]

In 1954 the Court of Appeals for the District of Columbia adopted a new insanity test aimed at clarifying the use of an insanity defense. The Durham test, named after the case in which it was created, seeks to determine whether a person's criminal conduct was the product of mental illness. After eighteen years of experience with the Durham rule, the Court of Appeals for the District of Columbia abandoned its use: trials involving the insanity defense had become battles of experts providing differing opinions on whether the defendant's mental disease produced his criminal actions.[6] Only one state currently maintains an insanity defense based on the "product" concept.[7]

The majority of American jurisdictions, including Maine, currently employ some version of the Model Penal Code insanity defense.[8] Recommended in 1962 by the American Law Institute, the test states that, "A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity to either appreciate the criminality (wrongfulness) of his conduct or to conform his conduct to the requirements of the law."[9] The

test includes a statement that mental disease or defect may not be shown, for the purposes of the law, simply through repeated criminal or other anti-social acts.[10]

II. MAINE'S CURRENT INSANITY DEFENSE

The Insanity Defense: Substance and Procedure

Competence to Stand Trial

Prior to the commencement of a criminal trial, questions may arise concerning the competence of the criminal defendant to stand trial. In Maine, the court may order such a defendant to undergo an examination to determine his mental condition. If the defendant is found incompetent, the court must continue the case until the defendant becomes competent, and may have the defendant committed to a mental institution, or may order the defendant, if he is not charged with murder, released on bail with or without a condition of treatment. If the defendant is found competent, the criminal trial proceeds. Whenever the report of a person ordered by the court to conduct an initial examination of the mental condition of the defendant indicates that the defendant's criminal responsibility may be questioned, the court must order further psychological examination of the defendant.[11]

The Insanity Defense

A criminal defendant who enters a plea of insanity to the criminal charges against him relies on the defense established

in the Maine Criminal Code, Title 17-A, section 39, subsection 1, of the Maine Revised Statutes, which states:

> A defendant is not criminally responsible if, at the time of the criminal conduct, as a result of mental disease or defect, he either lacked substantial capacity to conform his conduct to the requirements of the law, or lacked substantial capacity to appreciate the wrongfulness of his conduct.

This defense contains two tests: a volitional test and a cognitive test. The volitional test addresses the defendant's inabilty, because of his mental condition, to control his actions. The cognitive test speaks to the defendant's inability, because of his mental condition, to understand the wrongful nature of his actions. Section 39 also contains a definition of "mental disease or defect" in its second subsection.

Maine's insanity defense places the burden of proving insanity on the defendant. Having raised an insanity defense, the criminal defendant must prove, by a preponderance of the evidence, that he lacked criminal responsibility due to his mental condition at the time of the crime.[12] In contrast, for example, the federal law under which John Hinckley was tried and found not guilty by reason of insanity of attempting

to assassinate President Reagan required the federal prosecutors to prove that Hinckley was sane beyond a reasonable doubt.[13]

The Trial

In Maine, the criminal defendant who raises an insanity defense may choose to have the issues of guilt and insanity tried together or separately. Under the first option, the issue of whether or not the defendant committed the crime is first tried. If the defendant is found to have committed the criminal act, the fact-finder must then hear evidence on and determine whether the defendant should be absolved of criminal responsibility because his mental condition at the time of the crime met the test of the insanity defense. Under the second option, evidence concerning guilt and insanity are presented at the same stage of the trial. The questions of whether the defendant committed the crime and whether he should be found not criminally responsible due to insanity are presented to the fact-finder for decision at the same time.[14]

The Insanity Acquittee: Commitment and Release

Immediate Commitment

When a Maine criminal defendant is found not guilty by reason of insanity, he is not discharged from custody. The judge presiding at the criminal trial places the insanity

acquittee under the supervision of the Commissioner of Mental Health and Mental Retardation. The Commissioner is required by law to place the insanity acquittee in an institution for treatment of his mental disease or defect.[15] An insanity acquittee may gain expanded liberty after commitment only upon review of his mental condition by the Superior Court:

1. The court may order the person's discharge from the custody of the Commissioner. Under such an order, the Commissioner retains no responsibility for or authority over the person.[16]

2. The court may order the release of the person. Under such an order the person remains in the custody of the Commissioner, but is permitted to return to permanent residency in the community. The release may be conditioned by the court on the patient meeting several requirements, including continuation of treatment and acceptance of supervision.[17]

3. The court may permit a modified release treatment program for the person. Under such a program the person may be off institutional grounds for up to 14 days. The program addresses continued treatment and supervision of the person.[18]

Discharge and Release

At least once a year, the person in charge of the institution in which the insanity acquittee is placed provides the Commissioner with a report on the person's mental condition. The report states whether, in the opinion of a staff psychiatrist, the person may be released or discharged from the institution without likelihood that he will cause injury to himself or others due to mental disease or defect. This report is forwarded to the Superior Court. The court determines if the report makes it appear that the insanity acquittee may be ready for release or discharge. If it so appears, a hearing is held by the court on the issue. At the hearing, the court receives testimony from at least one psychiatrist who has observed or treated the person and any other relevant testimony. If the court finds that the person may be released or discharged without likelihood that he will cause injury to himself or others, the court orders release, with or without conditions, or discharge.[19]

Modified Release Treatment

An insanity acquittee may petition the Superior Court for a modified release treatment program. The petition must contain a report from the institutional staff, including at least one psychiatrist. The report describes the patient's present condition, the treatment program planned and requiring absence

from the institution, the duration of the person's absence from the institution and the amount of supervision during that absence, expected results, and the duration of the program. The prosecutor in the criminal trial in which the person was acquitted is informed of the petition by the court. If the court does not respond to the petition within sixty days, and the prosecutor files no objections, the program may be put into effect. If the court instead questions the program or the prosecutor requests a hearing, the court must schedule a hearing at which it may approve or disapprove the petition.[20]

Reinstitutionalization

Any insanity acquittee on release from the institution or being treated under a modified release treatment plan may be returned immediately to the institution upon order of the Commissioner. When the person has been released, the Commissioner may issue a return order upon receipt of evidence that the person is failing to comply with any condition of release. The person may be detained in the institution for seven days before a hearing on his continued detention is required. If a hearing is held, the court may modify or rescind its release order.[21] If the Commissioner orders the return of a released patient to the institution, any law enforcement officer requested by the Commissioner to assist in returning the patient must render such assistance.[22]

III. PERCEPTIONS AND FACTS ABOUT MAINE'S INSANITY DEFENSE

PERCEPTION # 1: Many criminal defendants go unpunished because they are found not guilty by reason of insanity.

FACT

Insanity acquittals represent no more than .02% of the criminal dispositions that occur in Maine each year.[23]

All insanity acquittees, by law, are committed to one of Maine's mental health institutions. The following figures represent the number of insanity acquittees sent to the Augusta Mental Health Institute and the Bangor Mental Health Institute during the last five years:[24]

INSANITY ACQUITTEES

	AMHI	BMHI	STATE TOTAL
1981	4	0	4
1982	1	3	4
1983	6	0	6
1984	4	0	4
1985	9	1	10

The above numbers of insanity acquittees are extremely

small compared with the numbers of criminal cases disposed of by the Superior and District Courts in Maine from 1981 through 1984:[25]

CRIMINAL DISPOSITIONS

	SUP. CT.	DIS. CT.[26]	STATE TOTAL
1981	8,794	29,239	38,033
1982	8,142	30,766	38,908
1983	9,416	30,052	39,468
1984	8,939	27,777	36,716

PERCEPTION #2: Insanity acquittees are quickly released from institutionalization.

FACT

On the average, insanity acquittees currently on modified release treatment at the Augusta Mental Health Institute spent over two and one-half years restricted to institutionalization prior to being permitted any release time.

Modified release treatment permits an insanity acquittee to gain limited release from institutionalization as part of a treatment plan. The plan must receive court approval, and may provide for no more than fourteen days consecutive absence from the institution.[27] Under modified release treatment, some insanity acquittees are permitted to take a first step away from full-time institutionalization.

The following insanity acquittees (NGRIs) currently committed to the Augusta Mental Health Institute, identified by the crimes for which they were acquitted, received their first modified release treatment permission after spending the following periods of time in full-time institutionalization:[28]

NGRIs (by crime for wh/acquitted)	INSTITUTIONALIZATION prior to <u>any</u> modified release treatment (in yrs. unless months indicated)
murder	23
"	6
"	5
"	7 months
"	2 months
manslaughter	3
aggravated assault	5
" "	4
" "	4
" "	3
" "	2
" "	2
arson	6
"	6 months
"	1
"	7 months
rape	4 months
kidnapping	2
robbery	3
burglary	15 months
criminal trespass	4
possession of a bomb	16 months

The average time spent by these insanity acquittees within an institution prior to even minimal release time is two years and six months.[29] The average of over two and one-half years for continuous initial institutionalization of insanity acquittees demonstrates that insanity acquittees are not quickly released.

PERCEPTION #3: Insanity acquittees who are released are not supervised.

FACT

Released insanity acquittees receive supervision from the mental institution staff, other state or residential staffs, or a patient's family.

Currently, twenty-three of the insanity acquittee population at the Augusta Mental Health Institute are permitted some release from institutionalization. These insanity acquittees (NGRIs) receive the following supervision during their release time:[30]

NO. NGRIs	SUPERVISION During Release Time
3	0 hrs. unsupervised by hospital staff
1	4 hrs. unsupervised by hospital staff
1	4 hrs. unsupervised by hospital staff but must be with family
3	72 hrs. unsupervised by hospital staff but must be with family
2	1 wk. unsupervised
3	2 wks. unsupervised
5	required treatment and weekly or bi-weekly return to hospital for review of mental condition by staff

3	24 hr. supervision in nursing or boarding home
2	required treatment and supervision by Div. of Probation & Parole

Several of the insanity acquittees currently permitted some release time are closely supervised. The plans under which constant supervision is not required, as well as those permitting any release even when constantly supervised, have all been presented to and approved by the Superior Court. It should also be emphasized that insanity acquittees on modified release treatment or conditional release may be returned to the institution prior to the expiration of their release time upon order of the Commissioner.[31]

PERCEPTION #4: Many insanity acquittees have been completely discharged from custody.

FACT

Only seven insanity acquittees have been completely discharged from custody in recent times through typical court procedures.

Modified release treatment is the first release step for an insanity acquittee; conditional or partial release is the next step; complete discharge from the custody of the Commissioner of Mental Health and Mental Retardation is the final step.

Only discharged insanity acquittees are free from any conditions of supervision, treatment, or other limitation of their freedom.

Since 1972, fifty-three insanity acquittees have been placed in the custody of the Commissioner of Mental Health and Mental Retardation.[32] From 1972 to 1985, fourty-four insanity acquittees have been discharged: one by natural death; five by suicide; one after escape, recapture and incarceration in another state; and thirty-seven by the court.[33] Of those thirty-seven, approximately thirty were discharged by the court between 1972 and 1977 in response to the closing of AMHI's maximum security unit.

That Unit had operated as a maximum security prison for insanity acquittees Many of the thirty-two patients incarcerated there in 1972, held under the indefinite commitment permitted for insanity acquittees, had spent decades in the unit. Upon review, the court discovered that many of these patients were not dangerous due to mental disease or defect.[34]

The discharge of approximately thirty from the maximum security unit patients thus represents the vast majority of insanity acquittee discharges from the Augusta Mental Health Institute and Bangor Mental Health Institute since 1972. Only seven insanity acquittees, then, have been discharged through normal court review; only one of those has been discharged

since 1981.[35] Thus, complete discharge of an insanity acquittee from custody of the Commissioner does not occur frequently.

PERCEPTION #5: Insanity acquittees are likely to engage in criminal conduct again.

FACT

The repeated criminal behavior rate of insanity acquittees is about one half that of people convicted and incarcerated for criminal conduct.

Of the fifty-three insanity acquittees who have been in the custody of the Commissioner of Mental Health and Mental Retardation since 1972, only twelve have been charged with any criminal behavior.[36] Of the twelve, seven committeed the acts while in the custody of the Commissioner. Three of those acts were the crime of escape. The other four involved charges of assault, aggravated assault and attempted murder, and two charges of murder. Of the seven, four have been convicted of the new charges, two are awaiting trial, and one was acquitted by reason of insanity.[37]

Of the insanity acquittees discharged since 1972, five have been charged with criminal behavior. The charges include sexual contact, two charges of theft, robbery, and disorderly

conduct. These charges have resulted in two convictions and one finding of incompetent to stand trial. Two of the charges were not prosecuted.[38]

Based on the above figures, the recidivism rate for insanity acquittees is approximately 23%. The Maine State prison reports a recidivism rate of, on average, almost 47% of the prisoner population within adult correctional institutions.[39] Clearly, the public has more to fear from the likelihood that a convicted and imprisoned criminal defendant will commit a crime upon release than it has from the likelihood of insanity acquittees repeating criminal behavior upon release.

IV. RECOMMENDATIONS

Standards and Procedures

1. The Subcommittee recommends the elimination of the volitional test from Maine's insanity defense.

Under Maine's insanity defense, a criminal defendant may claim that he should be absolved from criminal responsibility for either of two reasons:

1) because he lacked substantial capacity, due to mental disease or defect, to conform his conduct to the requirements of the law (the volitional test); or

2) because he lacked substantial capacity, due to mental disease or defect, to appreciate the wrongfulness of his conduct (the cognitive test).

The volitional test pertains to the defendant's ability to control his actions. An accused relying on the volitional test might argue, for example, that he realized that he was striking a person, but that his mental illness prevented him from controlling his rage. The cognitive test focuses on the defendant's ability to comprehend the nature of his actions. A defendant claiming insanity under the cognitive test might

argue that he did not know that he was aiming his gun at an innocent person: he believed he was engaged in combat in the middle of a war.

The volitional test was recommended in the Model Penal Code's insanity defense, on which Maine's insanity defense is patterned. The Comments to the Model Penal Code state:

> The application of the principle [behind the volitional test] will call, of course, for a distinction between incapacity, upon the one hand, and mere indisposition on the other. Such a distinction is inevitable in the application of a standard addressed to impairment of volition. We believe that the distinction can be made.[40]

The above Comments were made in 1955. In 1983, the American Psychiatric Association recommended abolition of the volitional element of state and federal insanity defenses. In doing so the APA wrote:

> Many psychiatrists... believe that psychiatric information relevant to determining whether a defendant understood the nature of his act, and whether he appreciated its wrongfulness, is more reliable and has a stronger scientific basis than, for example, does psychiatric information relevant to whether a defendant was able to control his behavior.... The concept of volition is the subject of some disagreement among psychiatrists. Many

> psychiatrists therefore believe that psychiatric testimony... about volition is more likely to produce confusion for jurors than is psychiatric testimony relevant to a defendant's appreciation or understanding.[41]

The American Bar Association and the American Psychological Association also recommend elimination of the volitional test.[42] The United States Congress and some states have removed the volitional test from their insanity defense statutes.[43]

In deciding whether or not to recommend abolition of the volitional test, the Subcommittee took into consideration arguments for its retention.[44] However, the Subcommittee concluded that several factors argue for elimination of the volitional test:

> 1) mental health professionals, represented in the comments of national groups and some who spoke to the Subcommittee, are uncomfortable with what the volitional test asks of them;
>
> 2) the jury's task under the volitional test, of determining whether the defendant was unable to control himself or whether he chose not to control himself, is an impossible one;

3) persons with organic mental problems that cause uncontrollable behavior will not be hurt by elimination of the volitional test because, should they engage in criminal conduct, other facets of the criminal justice system and the Criminal Code offer them protection.[45]

2. The Subcommittee recommends that the standard of proof for the defendant who asserts an insanity defense should not be raised to clear and convincing evidence but should remain at a preponderance of the evidence.

The Subcommittee does not believe that raising the standard of proof the criminal defendant must meet if he is to successfully demonstrate that he was insane at the time of the crime will have any impact on the use or success of insanity defenses. Under current Maine law, the defendant bears the burden of proving his insanity by a preponderance of the evidence.[46] The crucial factor here is that the defendant has the burden of proof; the prosecution does not have the burden of proving the defendant sane beyond a reasonable doubt once an insanity defense has been asserted. The standard of proof applied to the defendant's burden is not sufficiently significant to warrant changing Maine's law on this point.

3. A Majority of the Subcommittee recommends against enactment of a "guilty but mentally ill" verdict.

None of the twelve states that currently permit a criminal defendant to be found guilty but mentally ill (GBMI) have abolished the insanity defense.[47] In these states, a defendant found to have committed a crime and found to be mentally ill, but not to meet the standards for lack of criminal responsibility under the insanity defense,[48] receives a GBMI verdict. The person found guilty but mentally ill is sentenced as if he had been found simply guilty; by statute, he must also be evaluated to assess his treatment needs or be given treatment.[49] A defendant found not guilty by reason of insanity (NGRI) in the GBMI states is relieved of criminal responsibility and, as in Maine, treated, not punished.

In 1975, Michigan became the first state to enact a GBMI verdict.[50] The legislative intent in Michigan in enacting the GBMI verdict was to reduce the number of insanity acquittees and to protect the public by incarcerating criminal defendants who might otherwise be found not guilty by reason of insanity.[51] Only one study on the impact of the GBMI verdict in Michigan has been completed.[52] No data has been gathered on the effect of GBMI statutes in other states.[53] The Michigan study appears to show that the GBMI verdict has not reduced the amount of NGRI verdicts occurring in Michigan: rather, persons found GBMI in Michigan would most likely have been found guilty if the GBMI verdict did not exist.[54]

GBMI verdicts also do not guarantee that the person so convicted will receive mental health treatment. Most of the

GBMI statutes do not mandate treatment: they require that the person receiving a GBMI verdict be evaluated and provided treatment as deemed necessary.[55] In Michigan, GBMI prisoners are evaluated for their treatment needs; the same evaluation is provided other prisoners.[56] Similarly, in Maine, the opportunity for mental health treatment is available to prisoners.[57]

A lawsuit is currently underway in Michigan arguing that the State has not, as required by the GBMI statute, provided the treatment "psychiatrically indicated" for GBMI prisoners. These prisoners claim they have a right to treatment which is not being fulfilled by the State due to lack of resources. The United States District Court for the Eastern District of Michigan has agreed to hear the case.[58]

Finally, many professionals who have studied the GBMI verdict have concluded that it is not helpful in providing for appropriate criminal dispositions, and that it is misleading to the public. Groups that have spoken out against adoption of GBMI statutes include the National Mental Health Association's National Commission on the Insanity Defense,[59] the American Psychiatric Association,[60] the American Bar Association,[61] and the American Psychological Association.[62]

All Subcommittee members sympathize with the concerns for public safety that underlie much of the support for a "guilty but mentally ill" statute. A majority of the Subcommittee does

not believe enactment of such a statute will truly accomplish what its proponents desire. The data that currently exist show that GBMI verdicts do not displace NGRI verdicts, they displace guilty verdicts. These GBMI defendants are incarcerated, as they would have been had they been found simply guilty; the difference is that their treatment needs may have to be addressed.

While the Subcommittee majority believes all prisoners should receive needed mental health services, the majority cautions against permitting a jury verdict that may mandate treatment before the resources are in place to provide such treatment to all those requiring it. The question of mental health treatment for prisoners is one that must be considered by the Legislature in looking at correction's policy and funding. However, we should not force a commitment of the resources of the people of Maine to such treatment through the backdoor of creation of a new criminal verdict.

If GBMI statutes are determined not to mandate treatment, then a GBMI verdict presents an option that eases the choice for a jury, and soothes the fears and conscience of the public, without creating any real difference in the handling of persons who commit criminal acts and claim insanity. A majority of the Subcommittee believes that other recommendations contained in this report offer a greater possibility than a GBMI verdict of

protecting the public, reducing the number of insanity acquittees, and assuring the proper handling of and treatment for insanity acquittees and prisoners.

MINORITY RECOMMENDATION

Rep. Paradis recommends enactment of a "guilty but mentally ill" verdict.

The Legislatures of twelve states have found it appropriate to create the option of a GBMI verdict in a criminal trial.[63] In doing so, they responded in part to public interests in reducing the number of insanity acquittals and protecting society from mentally ill, dangerous offenders.[64] They also responded to discomfort with a choice of verdicts deemed by the public to be too stark.[65]

We are told by authorities that the insanity defense asks for a moral judgment from a jury, that the jury must decide if the criminal defendant is to be held responsible for his conduct, if he is blameworthy.[66] These same authorities argue that a GBMI verdict obscures this moral choice, diminishes the importance of blameworthiness in the criminal law.[67] These authorities, and the recommendation of the Subcommittee majority, fail to recognize that the criminal law is a creation of public policy, the sentiment of the people expressed by the Legislature. It is appropriate for the public to assert that one possible moral judgment of a criminal

defendant is a finding that the person committed a criminal act, is guilty, but that the person should also be publicly recognized as mentally ill, as in need of mental health assistance. A survey of the jurors in the John Hinckley trial found that several of those jurors would have preferred having the option of finding Mr. Hinckley guilty but mentally ill.[68] Why would that not have been a proper moral choice, a choice condemning his actions but demonstrating compassion?

The widely-reported study of Michigan's GBMI verdicts, which claims to show that GBMI verdicts replace guilty verdicts and not insanity acquittals, has been questioned by some.[69] The questions include whether the conclusions from the Michigan study apply to other states, whether the study employed proper statistical analyses, and whether factors other than the GBMI verdict may have contributed to the finding that insanity acquittals did not diminish through use of the GBMI verdict.[70] Research related to the Michigan study suggests that "at least some of the less seriously disturbed and more violent offenders may have been screened out of the NGRI population as a result of the availability of the GBMI alternative in Michigan."[71] In a study with simulated jurors, researchers found that these jurors replaced NGRI verdicts with GBMI verdicts, in contrast to the Michigan study's findings.[72] Much more investigation of GBMI states' experiences must occur before the verdict's effect can be conclusively determined.

None of the states that have adopted GBMI statutes have experienced breakdowns in their corrections or mental health systems as a result. In this report, all Subcommittee members support recommendations that, if adopted, would provide greater resources for the treatment of insanity acquittees and prisoners. If a GBMI verdict is enacted in Maine, these resources would also serve the GBMI population of prisoners.

However, enactment of the GBMI verdict should not await the approval of the experts or the final calculation of all the possible resources that the creation of such a verdict may require. If the people of Maine support the enactment of a GBMI verdict, they will support appropriation of the funds necessary to make the GBMI statute effective. The people of Maine desire a GBMI option;[73] the Legislature should permit juries this choice.

4. The Subcommittee recommends that the verdict for an insanity acquittee be "not criminally responsible by reason of insanity" rather than "not guilty by reason of insanity."

Under the Maine Criminal Code, when a jury or judge determines to acquit a defendant of criminal charges due to the defendant's lack of responsibility for his conduct because of mental disease or defect, the jury or judge must return a verdict of "not guilty by reason of insanity."[74] Yet the language of the insanity defense does not speak in terms of the insane defendant's lack of guilt: section 39, subsection 1 of

Title 17-A, the Maine Criminal Code, states that a defendant is not criminally responsible for his conduct if he meets the test of the insanity defense. The verdict a judge or jury returns when a defendant has succeeded in proving an insanity defense should be consistent with the language of the defense: an insanity acquittee should be declared not criminally responsible, rather than not guilty, by reason of insanity.[75]

Another reason for altering the wording of an insanity acquittal arises from public reaction to a verdict that states that a criminal defendant is not guilty by reason of insanity. A declaration that the insanity acquittee is not guilty, when it is clear that the defendant has caused a criminal act to occur, is difficult for many people to rationalize. For example, millions of people saw John Hinckley shoot President Reagan in front of television cameras. Hinckley's actions caused the President's injuries, yet his mental condition was found to be such that he could not be held responsible for his actions. Still, the Hinckley verdict of not guilty by reason of insanity bothered many people, in part because the words "not guilty" imply: 1) that the defendant did not commit the act, and 2) that the defendant is being absolved of all blame - not just legal blame, but all social blame, too - for his actions.

If the verdict for an insanity acquittal is changed to "not criminally responsible" by reason of insanity, the public may feel that the defendant's being the cause of a criminal act is

still recognized, that some type of blame may still attach to the defendant, but that he is not being held responsible for his actions within the framework of the criminal law. The Subcommittee agrees with the recommendation of the National Commission on the Insanity Defense that "'not responsible' in its public usage would help alleviate the public's confusion and misunderstanding surrounding the finding of 'not guilty'."[76]

5. The Subcommittee recommends the continuation of the limitation on the ability of mental health experts to give opinions on the issue of criminal responsibility in a trial where the insanity defense has been raised.

Almost all who have studied the issue agree that mental health witnesses testifying at criminal trials involving the insanity defense should not be permitted to give their opinions as to whether or not the defendant was responsible for his actions at the time of the crime.[77] The question of criminal responsibility is one for the trier of fact, the judge or jury, and not the experts. Psychiatric or psychological experts should certainly assist the fact-finder by testifying with regard to their diagnosis of the defendant, and his mental state, in clinical terms, at the time of the crime. However, the judge or jury, and not the experts, must determine whether the defendant was legally insane when he engaged in the criminal conduct.

A reading of Maine's Rules of Evidence gives the impression that all witnesses may, under the proper conditions, give an opinion on the ultimate issue to be decided by the fact-finder. However, Maine Rule of Evidence 704 has been limited by the Maine Supreme Judicial Court with regard to the opinions of mental health experts on the issue of criminal responsibility.[78] In Maine, expert witnesses may not state whether or not they believe a criminal defendant to have been legally insane at the time of the crime. The Subcommittee recommends that this limitation on expert opinion testimony as it applies to the insanity defense continue.

6. The Subcommittee recommends that examinations of the mental condition of criminal defendants on behalf of the court on the issues of competency to stand trial and criminal responsibility be conducted by mental health professionals designated by the Commissioner of the Department of Mental Health and Mental Retardation.

When a court questions a criminal defendant's competence to stand trial, or the issue of the defendant's criminal responsibility is raised, the court orders a preliminary, or Stage I, examination of his mental condition.[79] The Stage I exam may be conducted at the Augusta Mental Health Institute, the Bangor Mental Health Institute, the Pineland Center, a mental health clinic of or recommended by the Department of Mental Health and Mental Retardation, or by a psychiatrist or licensed psychologist independent of the Department. If, after

the Stage I exam, it appears to the court from the Stage I report that the defendant has or had a mental disease or defect affecting his competence or criminal responsibility, the court must order a further examination (Stage II) of the defendant to be conducted by a psychiatrist and psychologist designated by the Commissioner of Mental Health and Mental Retardation.

The Subcommittee recommends that Stage I exams, like Stage II exams, be conducted by a mental health professional or facility designated by the Commissioner of Mental Health and Mental Retardation. The Subcommittee believes that the Department, which has responsibility for Stage II exams, must know when a Stage I exam, which may well lead to a further examination, is conducted. The best way to assure that the Department is aware of and has information from Stage I exams is to make the assignment of Stage I examinations consistent with the assignment of Stage II examinations: i.e., the Commissioner should have authority to designate who will conduct the exam at both stages.

The Subcommittee wishes to stress that this shifting of responsibility for assigning mental health professionals for Stage I exams from the court to the Commissioner is not intended to require that all of these examinations be conducted by state-employed mental health professionals. Rather, the Subcommittee hopes the practice of using independent psychiatrists and psychologists, on an independent contractor basis, to do some Stage I and Stage II exams will continue.

The difference will be that the Commissioner, rather than the court, will designate who the mental health professional conducting Stage I, as well as Stage II, exams will be.

The Subcommittee also wishes to note that this recommendation does not affect the ability of the defense or prosecution to employ mental health professionals to conduct other examinations of the defendant which may be helpful in successfully asserting or defeating an insanity defense.

7. The Subcommittee recommends that the Department of Mental Health and Mental Retardation create a Release Review Committee to develop release criteria for insanity acquittees that focus on predicting dangerousness.

The standard the Superior Court must apply when an insanity acquittee petitions for release from institutionalization is whether the person may be released without likelihood that he will cause injury to himself or others due to mental disease or defect.[80] In making this determination, the court receives as evidence a report from a psychiatrist of the institution in which the insanity acquittee is hospitalized giving the psychiatrist's opinion on the question of the dangerousness of the insanity acquittee.[81]

The creation of a Release Review Committee within the Department of Mental Health and Mental Retardation to refine predictive factors relating to dangerousness will provide

needed tools to mental health professionals making recommendations regarding release. Articulation of these factors will also assist the Commissioner of Mental Health and Mental Retardation, who has the ultimate responsibility for determining whether or not the Department should seek release for an insanity acquittee. The Release Review Committee should be composed of persons, from within the Department and from without, who, in the judgment of the Commissioner, can contribute expertise to the development of criteria reflecting dangerousness.

In its work, the Subcommittee has gathered some information on predicting future dangerousness of insanity acquittees. For example, an insanity acquittee who has a criminal record prior to his acquittal may prove more likely to be dangerous in the future than other insanity acquittees.[82] Similarly, an insanity acquittee who poses problems through "acting-out" behavior while institutionalized may be indicating a possibility of dangerousness.[83] By looking at the comparatively few cases where released insanity acquittees have repeated criminal conduct, the Release Review Committee may also learn through hindsight about factors that indicate possible future dangerousness.[84] Thus, the Release Review Committee should, along with developing dangerousness criteria, keep informed about recidivism by insanity acquittees.

8. The Subcommittee recommends that responsibility for supervising released insanity acquittees be given to the

Department of Mental Health and Mental Retardation rather than the Department of Corrections.

When the Superior Court orders the release from institutionalization of an insanity acquittee, the court may apply conditions to that release. The current statutes state that one of those conditions may be that the Division of Probation and Parole of the Department of Corrections supervise the released insanity acquittee.[85]

Statutory reference to supervision of released insanity acquittees by the Division of Probation and Parole is a vestige of the times when the Department of Corrections and the Department of Mental Health and Mental Retardation were one department. Though the statute currently refers only to the Probation and Parole Division as supervisor of released insanity acquittees, in actuality all insanity acquittees are also monitored by the Bureau of Mental Health of the Department of Mental Health and Mental Retardation.

Supervision of released insanity acquittees by the Bureau of Mental Health is clearly more appropriate. The Subcommittee recommendation that the statute be amended to refer to supervision of insanity acquittees by the Bureau of Mental Health, rather than the Division of Probation and Parole, does not reflect badly upon the Division. Rather, the recommendation reflects the proper placement of responsibility for insanity acquittees.

9. The Subcommittee recommends that the local law enforcement agency of a community into which an insanity acquittee is partially or completely released be informed of the release.

By statute, when release from full-time institutionalization is sought for an insanity acquittee, the prosecutor who tried the charges against the person for which he was acquitted by reason of insanity is informed by the court of the release petition, and provided the opportunity to appear at the release hearing.[86] Thus, the original prosecutor is made officially aware that an insanity acquittee may be released.

However, if the person is released, he may very well be released into a community other than one where the crime occurred or where he was prosecuted. Law enforcement officials in the community of release may have had no prior contact with or knowledge of the insanity acquittee. As a means of adding another safeguard for the public, the Subcommittee recommends that the public safety officer of the municipality or sheriff's department of the county into which an insanity acquittee is released be informed of that release by the Department of Mental Health and Mental Retardation.

Resources

10. The Subcommittee recommends the establishment, under the authority of the Department of Mental Health and Mental

Retardation, of a forensic service: mental health professionals who do examinations for the courts and who are not involved in the treatment of insanity acquittees.

Currently, the mental health professionals employed at the Augusta Mental Health Institute (AMHI) and the Bangor Mental Health Institute (BMHI) provide three services concerning criminal defendants who may plead not guilty by reason of insanity and those who have been acquitted by reason of insanity. First, state mental health professionals evaluate criminal defendants for competency to stand trial and criminal responsibility, and report their assessments to the court. Secondly, they treat defendants found not guilty by reason of insanity. Finally, they evaluate insanity acquittees for release and report their opinions to the Commissioner of Mental Health and Mental Retardation and the Superior Court.

The number of pre-trial evaluations, treatment hours, and release reports required of the mental health professionals at AMHI and BMHI is on the increase. In 1983, the AMHI and BMHI staff conducted seventy-five pretrial evaluations of the mental condition of criminal defendants; in 1985, the state mental health staff conducted 142 such evaluations.[87] In 1983, thirty-four insanity acquittees were in the custody of the Commissioner and receiving treatment; in 1985, forty-four insanity acquittees were in custody and receiving

treatment.[88] Annual reports must be prepared by staff mental health professionals concerning the suitability for release of each insanity acquittee.[89]

AMHI and BMHI each currently employ a part-time psychiatrist and a psychologist to do the work described above.[90] More professional help is clearly needed to meet this workload. However, an increase in the number of mental health professionals available to the state to evaluate and treat the mental conditions of criminal defendants must be accompanied by a separation between the professionals who provide forensic services and those who provide treatment.

The current state psychiatrists and psychologists must all do double duty: all supply forensic services, evaluating criminal defendants and insanity acquittees for the courts, and all act as clinicians with insanity acquittees as their patients. The combining of these two roles in one mental health professional does not serve the public or the insanity acquittee as they should be served.

The mental health professional as treater must be free to gain the patient's trust, to encourage the patient to speak honestly, to act as the patient's advocate. When the treating mental health professional is asked also to serve as the patient's evaluator on behalf of the court, to assess criminal responsibility and recommend for or against release, the psychotherapist-patient relationship is hampered.

The mental health professional engaged in forensic services is asked to provide the court with an objective evaluation of a person's mental condition, to provide information on criminal responsibility or dangerousness. When a state psychiatrist or psychologist has formed an opinion through forensic assessments that a defendant is criminally responsible, yet the person is acquitted at his trial by reason of insanity, it is difficult to then ask that mental health professional to treat that person; yet that is what we currently do. When a mental health professional has been treating an insanity acquittee, working for his return to as normal a life as possible, it is difficult to require that professional to evaluate that person for release with primary concern for protection of the public; yet that is what we currently do.

The Subcommittee's recommendation that more mental health professionals be provided the Department so that a forensic service, separate from treating professionals, can be created is not intended to mandate the hiring of more state employees. Whether the need for more mental health professionals to evaluate criminal defendants and insanity acquittees should be met by the hiring of more state employees, or by greater funding for contracting with independent mental health professionals, is an open question. The Subcommittee recommendation focuses simply on the need for a forensic service.

11. The Subcommittee recommends the establishment of another secure treatment unit at the Augusta Mental Health Institute for the long-term treatment of insanity acquittees who remain dangerous.

The Augusta Mental Health Institute (AMHI) is now responsible for thirty-five insanity acquittees in the custody of the Commissioner of Mental Health and Mental Retardation.[91] Of those thirty-five, on September 1, 1985, twenty were hospitalized, with only two housed in AMHI's eight-bed secure treatment unit. The secure treatment unit held, on that date, ten other patients, including six prisoners transferred from jails and correctional centers and three criminal defendants found incompetent to stand trial.[92]

The number of insanity acquittees in the custody of the Commissioner has increased by one-third over the last five years. Admissions to AMHI account for most of this increase.[93] Currently, 50% of the insanity acquittees in the custody of the Commissioner have a prior criminal record; in 1975 only one-third of the insanity acquittees had such a background, and in 1964 none of the insanity acquittees had prior criminal records.[94] Admissions of prisoners to AMHI in a year have increased by approximately 25% over the last five years.[95]

The above figures demonstrate the need for additional secure treatment beds for the placement of insanity

acquittees. Criminal defendants found incompetent to stand trial and prisoners transferred to AMHI must be housed in AMHI's most jail-like unit. Therefore, the use of these facilities for insanity acquittees must give way to the admission of prisoners. Yet, current knowledge indicates that insanity acquittees with prior criminal records are more likely to require greater security than other insanity acquittees. AMHI's eight-bed secure treatment unit is clearly inadequate given the multiple pressures on use of that unit. The Subcommittee therefore recommends the provision of another eight secure treatment unit beds at AMHI.

12. The Subcommittee recommends improvements in the forensic facilities and programs available at the Bangor Mental Health Institute.

The Bangor Mental Health Institute (BMHI) has a fifteen-bed secure treatment unit currently being used to house prisoners transferred for assessment and treatment, criminal defendants referred to the hospital by the court for examination, persons who have been found incompetent to stand trial, and insanity acquittees who remain dangerous.[96] This forensic unit, while currently large enough to meet BMHI's needs for secure placement, is the one area of the hospital that has not been renovated in modern times. The Subcommittee recommends needed improvement in the BMHI forensic unit physical plant -- improvements such as the covering of sprinkler pipes,

replacement of glass windows with nonbreakable windows, and replacement of aging window grates -- so that this secure unit can be as secure as possible from dangerous behavior and escape.

The forensic programs available at BMHI for incompetent persons and insanity acquittees requiring long-term treatment in a secure setting must be improved. Opportunities for meaningful work, education, and for social skills training for the insanity acquittees and incompetent persons in the BMHI secure treatment unit are necessary. Without these improvements in programs, it will continue to be difficult for BMHI to accomplish changes in the ability of these people to control themselves and to succeed in the rehabilitation of incompetents so that they can stand trial.

13. The Subcommittee recommends that the jails employ additional mental health staff.

While some of Maine's counties are able to provide mental health services to inmates at the jails through the employment of mental health and social service staff, or through contracting for these professional services from independent agencies, many counties are unable to supply these on-site services.[97] As a result, when an inmate at many county jails is in need of evaluation or treatment the inmate must be transferred to the Augusta Mental Health Institute (AMHI) or the Bangor Mental Health Institute (BMHI) for assessment.

As previously noted in this report, the transferring of prisoners to AMHI and BMHI is one of the pressures placed on the use of secure treatment units that might better be used to house dangerous insanity acquittees. The provision of some mental health services at all of the county jails could decrease the need for hospitalization of prisoners. The availability of such services at all jails would also assist communication between correctional officials and mental health officials when a prisoner is in need of hospitalization.

14. The Subcommittee recommends that prosecutors be given the authority and funding to consult with independent mental health professionals when an insanity acquittee petitions the court for release from institutionalization.

The current statutes prescribing procedures for the determination of whether an insanity acquittee should be released from institutionalization provide for the involvement of the Attorney General or District Attorney in the release hearing.[98] However, for this involvement to be as effective as possible, the Attorney General or District Attorney who prosecuted the insanity acquittee must have access to current professional assessments of the mental condition of the person petitioning for release.

In many instances, the prosecutor will find the report provided the court by the mental health professionals of the hospital in which the insanity acquittee is institutionalized

sufficient for his or her purposes. On the basis of this report, the prosecutor will be able to argue that it is not appropriate to release the insanity acquittee, or to agree with others that release seems appropriate. Yet, in some cases, a prosecutor may feel that a second evaluation of the mental condition of the insanity acquittee should be available to the court deciding upon release, that a second professional opinion will help the prosecutor in assessing the position he or she will take on the possible release. The Subcommittee believes that a prosecutor should have the resources available to permit him or her to seek an independent evaluation of an insanity acquittee's mental condition prior to a release hearing. In this way, the public will be assured that all concerns regarding the release of an insanity acquittee have been fully aired and reviewed.

V. CONCLUSION

Since the middle of the nineteenth century, federal and state jurisdictions have struggled to develop an insanity defense that properly balances the punishment of criminal behavior with the recognition that mental illness prevents some people from being responsible for their criminal acts. Maine's current insanity defense reflects a twenty-five year acceptance of the idea that criminal defendants may be legally insane because they could not control their actions or could not understand the nature of their actions due to mental disease or defect.

However, in recent times the insanity defense has come under review once again in many jurisdictions. In Maine, this review has been conducted by the Insanity Defense and Related Statutes and Procedures Study Subcommittee of the Judiciary Committee of the Maine Legislature.

Certain misperceptions persist in Maine regarding the use of the insanity defense and the disposition of insanity acquittees. While the handling of criminal defendants who plead insanity and those who are acquitted for being insane is an important public concern, the numbers of cases with which the public should be concerned are less than popularly believed.

While the substance of Maine's current insanity defense represents a modern approach to the determination of criminal responsibility, the defense can be modified to better reflect the latest professional and public concerns. Elimination of the volitional element of the insanity defense, that part of the defense that permits a defendant to claim he could not control himself, is recommended. Further discussion of the appropriateness of a possible addition of a "guilty but mentally ill" verdict to the Maine law must occur.

Maine's current approach to the evaluation, confinement, treatment, and release of criminal defendants who plead insanity and insanity acquittees is generally effective. However, improvements in evaluation abilities, treatment, and public security can be had through a few procedural changes, some additional personnel, and some new facilities at our mental health institutions.

Maine's handling of mentally ill criminal defendants and insanity acquittees is the best it can be given the current law and resources available. The recommendations contained in this report seek to make a good system even better.

FOOTNOTES

1. J. FULTON & I. KEILITZ, THE INSANITY DEFENSE AND ITS ALTERNATIVES 6 (1984).

2. See quotation in M. Freeman, Issue Brief: The Insanity Defense 6 (August 1982).

3. J. FULTON & I. KEILITZ, supra note 1, at 15.

4. M. Freeman, supra note 2, at 2.

5. J. FULTON & I. KEILITZ, supra note 1, at 15.

6. M. Freeman, supra note 2, at 7.

7. J. FULTON & I. KEILITZ, supra note 1, at 15.

8. Id.

9. See quotation in M. Freeman, supra note 2, at 7.

10. M. Freeman, supra note 2, at 7.

11. ME. REV. STAT. tit. 15, §101 (West Supp. 1985).

12. ME. REV. STAT. tit. 17-A, §39, sub-§1 (West 1983).

13. M. Freeman, supra note 2, at 15. Federal legislation enacted in 1984 changed the burden of proof regarding the insanity defense in federal criminal cases: the federal criminal defendant pleading insanity today must prove his insanity by clear and convincing evidence. 18 U.S.C. §20, sub-§(b) (West Supp. 1985).

14. ME. REV. STAT. tit. 17-A, §40 (West 1983).

15. ME. REV. STAT. tit. 15, §103 (West 1980).

16. ME. REV. STAT. tit. 15, §104-A, sub-§1 (West Supp. 1985).

17. Id.

18. ME. REV. STAT. tit. 15, §104-A, sub-§2 (West Supp. 1985).

19. ME. REV. STAT. tit. 15, §104-A, sub-§1 (West Supp. 1985).

20. ME. REV. STAT. tit. 15, §104-A, sub-§2 (West Supp. 1985).

21. ME. REV. STAT. tit. 15, §104-A, sub-§4 (West Supp. 1985).

22. ME. REV. STAT. tit. 15, §104-B (West Supp. 1985).

23. This percentage is calculated from the figures below using the data for 1983.

24. M. DeSisto, Memo to Insanity Defense Study Committee 5 (Sept. 25, 1985) (in Subcommittee files, Office of Policy and Legal Analysis, State House, Augusta). The updated data on the number of insanity acquittees for 1985 come from Michael DeSisto. On Sept. 25, 1985, five criminal defendants had been acquitted by reason of insanity. By year's end, ten had been so acquitted. The increase in such acquittals has not yet been explained. However, in four of these cases a full evaluation of the defendant's mental condition was not requested by the court or, if it was, the examiner was not called to testify at trial. See M. DeSisto, Memo to Insanity Defense Study Subcommittee 4 (Jan. 13, 1986) (in Subcommittee files, Office of Policy and Legal Analysis, State House, Augusta). Criminal case disposition data have not been tabulated for 1985, so the number of insanity acquittals for 1985 cannot yet be compared to the number of criminal dispositions for that year.

25. STATE OF MAINE JUDICIAL DEPARTMENT, 1984 ANNUAL REPORT 111, 153 (1985)

26. The statistics for the District Court include Class A, B, C, D, and E criminal dispositions, but exclude juvenile offense and criminal traffic dispositions.

27. ME. REV. STAT. tit. 15, §104-A, sub-§2 (West Supp. 1985).

28. The figures comes from Michael DeSisto, Director of the Bureau of Mental Health of the Department of Mental Health and Mental Retardation (notes in Subcommittee files, Office of Policy and Legal Analysis, State House, Augusta).

29. In calculating this average the 23-year figure was not included since it appears to be exceptional.

30. M. DeSisto, supra note 28.

31. See text at Section II, Reinstitutionalization for further discussion of reinstitutionalization of released insanity acquittees.

32. M. DeSisto, supra note 28.

33. M. DeSisto, NGRI Statistics 1 (in Subcommittee files, Office of Policy and Legal Analysis, State House, Augusta).

34. M. DeSisto, supra note 28.

35. M. DeSisto, supra note 33.

36. Id. at 3-4.

37. Id. at 3.

38. Id. at 4.

39. See Maine State Prison Statistical Report 3 (June 30, 1984). The figures averaged are:

FY 1980	53%	recidivism
FY 1981	44%	"
FY 1982	57%	"
FY 1983	29%	"
FY 1984	51%	"

Recidivism is defined as correctional system inmates who repeated criminal behavior within three years of a release from imprisonment.

40. ALI MODEL PENAL CODE §4.01, T. D. No. 4, Comments, 157-58 (April 25, 1955).

41. American Psychiatric Association, Statement on the Insanity Defense, 140 AM. J. PSYCH. 681, 685 (June 1983).

42. J. FULTON & I. KEILITZ, supra note 1, at 47.

43. See, e.g., 18 U.S.C. §20, sub-§(a) (West Supp. 1985); ALASKA STAT. §12.47.010(a) (1985); DEL. CODE ANN. tit. 11, §401, sub-§(a) (Supp. 1984); IND. CODE ANN. §35-41-3-6(a) (Burns 1985); TEX. PENAL CODE ANN. §8.01(a) (Vernon Supp. 1985).

44. See written statement by Nicholas L. Rohrman, President, Maine Psychological Association to Subcommittee (Nov. 12, 1985); Letter from Edward W. Klein, Legal Director, Maine Civil Liberties Union to Subcommittee (Nov. 7, 1985); Letter from Professor Melvyn Zarr, University of Maine School of Law to Martha Freeman (Nov. 5, 1985) (all in Subcommittee files, Office of Policy and Legal Analysis, State House, Augusta).

45. For example, the Maine Revised Statutes, Title 17-A, section 38 permits evidence of an abnormal condition of the mind to raise a reasonable doubt as to the existence of the culpable state of mind required for an act to be criminal. The Maine Revised Statutes, Title 17-A, section 31, subsection 1 states that a person commits a crime only if he engages in voluntary conduct. Finally,

prosecutors exercise discretion in determining whether criminal charges should be brought in a particular circumstance.

46. ME. REV. STAT. tit. 17-A, §39, sub-§2 (West 1983).

47. Farthing-Capowich, Keilitz & McGraw, The "Guilty But Mentally Ill" Plea and Verdict: Current State of the Knowledge, 30 VILL. L. REV. 117, 128-29 (1985).

48. See id. for the different standards that must be met to receive an insanity acquittal as compared to a guilty but mentally ill verdict.

49. See id. at 136-38 for the treatment requirements of each of the 12 GBMI states.

50. MICH. COMP LAWS §768.36 (1982).

51. Farthing-Capowich, Keilitz & McGraw, supra note 47, at 124.

52. Id. at 120, n. 10.

53. Id. at 122.

54. Id. at 175, 178; Blunt & Stock, Guilty but Mentally Ill: An Alternative Verdict, 3 BEHAVIORAL SCIENCES & THE LAW 49, 63 (Winter 1985). Bank, Benedek, Packer & Petrella, Examining the Application of the Guilty but Mentally Ill Verdict in Michigan, 36 HOSPITAL AND COMMUNITY PSYCH. 254, 257 (March 1985).

55. Farthing-Capowich, Keilitz & McGraw, supra note 47, at 187.

56. Bank, Benedek, Packer & Petrella, supra note 54, at 258.

57. ME. REV. STAT. tit. 34-A, §3069 (West Supp. 1985) (transfer of prisoners to mental institution). Dr. Ulrich Jacobsohn, Clinical Director of the Augusta Mental Health Institute, told the Subcommittee that a prisoner in need of care can be seen by a psychologist within 24 hours, by a psychiatrist within a week. Minutes of Sept. 25, 1985, Subcommittee Meeting 4 (Oct. 2, 1985) (in Subcommittee files, Office of Policy and Legal Analysis, State House, Augusta).

58. Farthing-Capowich, Keilitz & McGraw, supra note 47, at 167-68.

59. NATIONAL COMMISSION ON THE INSANITY DEFENSE, MYTHS AND REALITIES 32-34 (1983) [hereinafter cited as MYTHS AND REALITIES].

60. American Psychiatric Association, supra note 41, at 684.

61. J. FULTON & I. KEILITZ, supra note 1, at 45-46.

62. Farthing-Capowich, Keilitz & McGraw, supra note 47, at 122, n. 17.

63. The 12 states are Alaska, Delaware, Georgia, Illinois, Indiana, Kentucky, Michigan, New Mexico, Pennsylvania, South Carolina, South Dakota, and Utah. See Farthing-Capowich, Keilitz & McGraw, supra note 47, at 126, n. 39.

64. Id. at 124.

65. Id. at 125.

66. J. FULTON & I. KEILITZ, supra note 1, at 46; American Psychiatric Association, supra note 41, at 684.

67. Id.

68. Farthing-Capowich, Keilitz & McGraw, supra note 47, at 125.

69. Id. at 174-78.

70. Id. at 178.

71. Id. at 177.

72. Id. at 184.

73. The number of bills seeking the establishment of a guilty but mentally ill verdict introduced into the Maine Legislature over the last three years gives some indication of the public's concern. See, e.g., from the 1st Regular Session of the 111th Legislature, LD 702; from the 1st Regular Session of the 112th Legislature, LD 278, LD 1035, and LD 1331.

74. ME. REV. STAT. tit 17-A, §40, sub-§1 (West 1983).

75. With this change in language, the criminal defendant raising an insanity defense will plead not criminally responsible, rather than not guilty, by reason of insanity. See ME. R. CRIM. PRO. 11.

76. MYTHS AND REALITIES, supra note 59, at 35.

77. J. FULTON & KEILITZ, supra note 1, at 51; MYTHS AND REALITIES, supra note 59, at 41; Crime Control Act, Offenders with Mental Disease or Defect, 9A U. S. CODE CONG. & AD. NEWS 224, 232 (Nov. 1984).

78. State v. Ellingwood, 409 A.2d 641, 645, n. 4 (Me. 1979).

79. ME. REV. STAT. tit. 15, §101 (West Supp. 1985).

80. ME. REV. STAT. tit. 15, §104-A, sub-§1 (West Supp. 1985).

81. Id.

82. Statements of Michael DeSisto, Director, Bureau of Mental Health, Department of Mental Health and Mental Retardation, to the Subcommittee at Nov. 21, 1985, meeting (notes in Subcommittee files, Office of Policy and Legal Analysis, State House, Augusta).

83. Id.

84. See text at Section III, Perception #5 in this report.

85. ME. REV. STAT. tit. 15, §104-A, sub-§1, ¶A, sub-¶(1) (West Supp. 1985).

86. ME. REV. STAT. tit. 15, §104-A, sub-§2 (West Supp. 1985).

87. M. DeSisto, Memo to the Insanity Defense Study Committee 6 (Aug. 28, 1985) (in Subcommittee files, Office of Policy and Legal Analysis, State House, Augusta). The number of evaluations in 1985 in the text represents the number as of Aug. 28, 1985.

88. M. DeSisto, Memo to the Insanity Defense Study Committee 6 (Sept. 25, 1985) (in Subcommittee files, Office of Policy and Legal Analysis, State House, Augusta). The number of insanity acquittees in the custody of the Commissioner and receiving treatment in 1985 in the text represents the number as of Sept. 1985.

89. ME. REV. STAT. tit. 15, §104-A, sub-§1 (West Supp. 1985).

90. M. DeSisto, supra note 87.

91. M. DeSisto, supra note 88.

92. Id. at 7.

93. Id. at 6.

94. M. DeSisto, NGRI Statistics 2 (in Subcommittee files, Office of Policy and Legal Analysis, State House, Augusta).

95. M. DeSisto, supra note 88, at 4, table I.

96. Id. at 9. On Sept. 1, 1985, the forensic unit at BMHI housed five of the 12 NGRIs in BMHI's custody.

97. The counties that employ mental health services for prisoners are Cumberland, Kennebec, Androscoggin, Penobscot, and Hancock. M. DeSisto, supra note 88, at 9.

98. ME. REV. STAT. tit. 15, §104-A, sub-§2 (West Supp. 1985).

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