
PROCEEDINGS

THE AFFIRMATIVE DEFENSE OF INSANITY IN TEXAS

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CONTENTS

1.	<i>Welcome</i> David Axelrad, MD	1
2.	<i>Review of the Insanity Statutes in the United States and Introduction to the Practice Guidelines for the Forensic Evaluation of Defendants Raising the Insanity Defense, American Academy of Psychiatry and Law</i> Howard V. Zonana, MD	4
3.	<i>M’Naghten and Its Variations</i> Christopher Slobogin, JD, LLM	18
4.	<i>Expanding the Current Texas Insanity Defense to Include a Volitional Standard: Going Back to the Future</i> Brian Shannon, JD	35
5.	<i>Why “Appreciation of Wrongfulness” is a Morally Preferable Standard for the Insanity Defense</i> Richard J. Bonnie, JD	50
6.	<i>Disposition: The Insanity Defendant Found NGRI. Overview of Methods of Intervention and Management for Defendants Found NGRI; What Happens After NGRI</i> James E. Smith, LMSW-ACP, DCSW	65
7.	<i>Panel Discussion</i>	80
	Cathy Burnett, JD, Moderator Richard J. Bonnie, JD Lyn McClellan, JD John Niland, JD Brian Shannon, JD Christopher Slobogin, JD, LLM James E. Smith, LMSW-ACP, DCSW Howard V. Zonana, MD	
8.	<i>Conference Summary</i> Victor Scarano, MD, JD	116
9.	<i>Closing Remarks</i> David Axelrad, MD	120

APPENDIX 121

Expanding the Current Texas Insanity Defense to Include a Volitional Standard:
Going Back to the Future Brian D. Shannon, JD

Disposition: The Insanity Defendant Found NGRI. Overview of Methods of
Intervention and Management of Defendants Found NGRI;
What Happens After NGRI James E. Smith, LMSW-ACP, DCSW

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The Affirmative Defense of Insanity in Texas

AXELRAD: Hello. On behalf of the Texas Society of Psychiatric Physicians, I welcome you to this symposium on The Affirmative Defense of Insanity in Texas. I'm David Axelrad, Chairman of the Forensic Psychiatry Committee of the Texas Society of Psychiatric Physicians and Past President of that society. As a result of the Andrea Yates case last year, the public and policymakers in Texas began raising questions about the application of the insanity defense in Texas. It was the subject of much commentary in the national media, both print media as well as the broadcast media, and we have conducted interviews with forensic psychiatrists and attorneys in Texas concerning the outcome of that trial.

Members of the Texas Legislature publicly stated in various forums that the Legislature would study the insanity defense and consider reforms. And it is my understanding that several bills are currently in preparation that are going to address the insanity question in Texas. Because of this interest in the insanity defense, last spring TSPPs Forensic Psychiatry Committee requested that the governing body of the TSPP, the Executive Council, authorize the development of a comprehensive and balanced program to explore the application of the insanity defense in Texas and provide a forum for our Legislature, as well as the policymakers in the appellate court. The TSPP Executive Council approved our proposal and a Planning Committee was convened. And our affiliated non-profit foundation, the Texas Foundation for Psychiatric Education and Research, provided us a grant to fund this conference so that we could provide this forum without any registration fee.

Soon thereafter, our Association approached several organizations in Texas who had an interest in criminal law, as well as insanity, to join with us in sponsoring this program. We are very pleased that this program is now a project of the State Bar of Texas' Committee on Legal Services to the Poor in Criminal Matters and the Committee on Disability Issues; the Texas Criminal Defense Lawyers Association; the Texas District and County Attorneys Association; and the *American Journal of Criminal Law*, which intends to publish these papers in an upcoming journal. The conference committee discussed the various topics and issues that would be of interest to both practicing attorneys in Texas, as well as practicing forensic psychiatrists in those issues that would be relevant for study by the policymakers in both the appellate court and the Legislature.

Our conference steering committee, composed of all of these organizations, identified the legal authority in the area of insanity and criminal responsibility in the United States, as well as individuals who have been well known for being very good speakers to this issue. They are all here with us today. Howard V. Zonana, Medical Director of the Academy of Psychiatry and Law, Christopher Slobogin, Professor of Law at the University of Florida, Brian Shannon, Professor of Law at Texas Tech Law School, Richard J. Bonnie, Professor of Law at the

University of Virginia Law School, James E. Smith, who is the Superintendent of the forensic hospital here in Texas at the North Texas Psychiatric Hospital, Catherine Green Burnett, Associate Dean of the Law School at South Texas, who has been a leading authority in criminal law, Lyn McClellan, who is the Supervising Assistant District Attorney in Harris County, who had some supervisory responsibilities over the Andrea Yates case, and John Niland, who is the Director of the Capital Sentencing Project here in Texas. This conference will present authorities in the field of both law and forensic psychiatry. It will present information about the affirmative defense of insanity in the criminal law in Texas and the United States. This program is designed to provide important information about the insanity defense, both its policy implications and procedural implications, to the policymakers and the Legislative and judicial branches of the State of Texas government.

This Program is also designed to provide an educational experience for attorneys engaged in the practice of criminal law, forensic psychiatrists practicing in the State of Texas, the general public, and the media. This conference will focus solely on the issue of the affirmative defense of insanity. Although there are numerous other issues affecting persons with mental illness and mental retardation in the criminal justice system, we will not attempt to address these other issues during this narrowly focused conference.

We are very pleased with the amount of interest expressed in this conference. Because of the number of registrations we've had to start a waiting list. And unfortunately we could not accommodate all who would have an interest in participating as participants in this conference. This audience is a good cross-section of interested parties in Texas in regards to criminal law and insanity. We have criminal defense attorneys, prosecuting attorneys, forensic psychiatrists, and mental health advocates. We are also pleased that members of the Texas Legislature and their staff members are here with us today. I especially want to recognize the following Legislators who have registered for the conference, and I must inform you that they may be coming in and out since this program is in Austin and they have other responsibilities. But if any of the Representatives are here, I would please request that you stand.

Representative Garnet Coleman, will be in and out. Senator Bob Deuell, Senator Rodney Ellis of Houston, and I know Representative Larry Phillips is here because we talked. Larry, thank you for coming.

We also have Legislative staff members, and I'm just going to mention them by name. M.L. Calcote from the Office of Senator Jeff Wentworth, Gerardo Castillo from the Office of Representative Eddie Rodriguez, Amanda Copeland from the Office of Representative Jodie Laubenberg, Lisa Kauffman from the Office of Senator Robert Duncan. And for those of you who may not be aware, Senator Duncan Chaired the Task Force on Incompetency to Stand Trial in Texas, which is presenting a bill. Many forensic psychiatrists and the TSPP participated in

that conference. And we have one with us on the program today, Dr. Scarano. Scot Kibbe from the Office of Senator Bob Deuell, Kari McAdams from the Office of Senator Jon Lindsay, Erica Phillips from the Office of Representative Arlene Wohlgemuth, Chris Steinbach from the Office of Representative Lois Kolkhorst, Kelley Stripling from the Office of Senator Todd Staples, Audra Tafoya from the Office of Representative Eddie Rodriguez, Tessa Zavala from the Office of Representative Beverly Woolley, and Jana Sharp from the Office of Representative Dawna Dukes. I must advise you that many of these Representatives and their staff who are here are going to be responsible for writing the bill as it comes out of Legislature on what insanity will look like for the citizens of Texas after this Legislature.

For the attorneys in the audience, the program has been accredited for CLE. Information about the accreditation and the appropriate forms will be at the conference registration table outside. We will break for lunch today from 12:10 until 1:30. I must advise you that since we started late, it will be probably around 12:15, 12:20. There are several restaurants in the area, including the Hotel La Vista Restaurant located on the second level. After each speaker, we will have a brief question and answer session. This afternoon we will also have a panel composed of all speakers which will entertain your questions. We are audio taping this program in order to prepare a transcript of the proceedings. It is important that if you address the panel this afternoon that you identify yourself and what your discipline is so that the audio transcript will be reflective of your participation.

If you wish an audio transcript, an order form is in your packets; if you'll give them to the staff at the registration table. I have advised you of this before, but the *American Journal of Criminal Law* will be publishing the prepared papers that are being presented today in an upcoming Journal. Thank you for joining us for this educational conference. We hope you will find it informative and beneficial.

We are going to be providing a \$5 discount on the parking fee. So at the registration table there is a sticker that says "Parking, \$5 charge." So if you want to save a little money today, you can pick up a sticker.

Our first speaker today is Howard Zonana. Dr. Zonana is the current Medical Director of the American Academy of Psychiatry and Law. Throughout his experiences with the Academy, he has been a leader and an inspiration for all forensic psychiatrists in this country, and has been pretty much responsible for the development of forensic psychiatry fellowship training in the United States. Howard, how many programs exist now in the country?

ZONANA: Over 30.

AXELRAD: Over 30. He was very instrumental in the development of the ethical guidelines for forensic psychiatry. He has served as the President of the American Academy of Psychiatry and Law, as well as the President of the Connecticut Psychiatric Society. He has Chaired both of the relevant councils and commissions in the American Psychiatric Association, and has provided leadership throughout psychiatry in the area of psychiatry and law. He was very actively involved as a participant, and I think an inspiration, for the Journal publication of the practice guidelines for forensic psychiatric evaluation of defendants raising the insanity defense. This practice guideline is now the official guideline to the American Academy of Psychiatry and Law, which is the relevant Psychiatric Association of Forensic Psychiatrists in this country. I would encourage all practicing attorneys to obtain this guideline, which is available from the American Academy of Psychiatry and Law, and also all forensic psychiatrists. I'd like at this time to bring Dr. Zonana to this program for his presentation.

[APPLAUSE]

ZONANA: Thanks a lot. I guess I'm here as the leader. It's sort of my job to try to get us to first base, at least, in understanding some of this complicated area. I've been told that you have to be crazy to plead insanity in Connecticut, but in Texas it's more deceptive. Hopefully, by the end of this you'll have a better understanding about why I say that. After the Yates case, this cartoon, I think appeared, which I think exemplifies some of the problems in trying to mix medical psychiatric language with the legal system. Let me start. Long before there were psychiatrists, societies have struggled with finding the appropriate standards for the insanity defense. And while a lot of the psychiatrists and scientists began to explore the nature and origin of mental disorders, society still struggled with the necessity for and the contours of a defense. That is to say, scientists cannot and will never be able to answer the questions about who will, in our collective conscious, be able to give appropriately imposed blame, but the compensatorial or penal proportionality, however, requires that fair criminal punishment is measured not only by the amount of harm caused or threatened, but by the person's blame worthiness. Attempts on the lives of kings, queens, and major political figures have led to the new modifications of the insanity defense standards, and it is an important statement of our culture that a mother of no particular renown beyond her immediate family with a severe mental disorder who killed her children has become the impetus to this state and national debate of our insanity defense processes. Ultimately, whether legal insanity should be exculpatory or litigated is not a psychiatric decision, but decisions involving psychiatric conditions should be informed by our current understandings.

I'd like to review several things. First I have some comments about the Yates case that I thought would be useful to at least sort of sketch a little bit of that issue. And then I'm going to try and do a little bit of review of the landscape and development of the standards. Then finally, with a broader context, guide the discussion that was to not just focus solely on the standards questions, which I believe is too narrow, and then maybe take a little time to talk somewhat about the guidelines.

This is the last review, or at least in the mid-part of the century, when the English Commission looked at capital punishment. It talks about their feelings about that somehow, in spite of the difficulties with local law to standards, or the details about a compensatory fee, it seems to be relatively still well accepted. Which when we get into the latter part of the century a number of states have decided to abolish it in some form.

On June 20, 2001, Andrea Yates, the mother of five children ranging in age from six months to seven years, and who was by all accounts a devoted mother, fixed breakfast, put salve on her son's mouth, and helped her husband leave for work so that he could be there at 8:00 a.m. She had been hospitalized in a psychiatric ward on four prior occasions, twice after the birth of her fourth child, and twice after the birth of Mary, her youngest, born six months earlier. The doctors and husband felt she was incapable of caring for the five children at that time, so her mother-in-law was helping with the children from 9:00 to 5:00. Her husband returned at 6:00, so there were only two hours during the day when she was alone with the children.

Between 8:00 and 9:00 a.m. she gave Mary a bottle and then proceeded to drown each of the children and place them side-by-side on the bed. She left the last, the eldest, in the tub, and called 9-1-1, saying that the police had to come, but gave no reason. When they arrived, she volunteered that she had drowned her children and directed the incredulous officer to the bedroom. At the police station she gave a confession and related all of the children's names and dates of birth. When asked why, she was silent, seeming at a loss to articulate her thoughts.

Two years earlier in June of 1999, while breast feeding, she experienced impulses to harm her children and said that Satan was directing her. At that time, she attempted to kill herself rather than harm the children. Her physician suggested that she was likely to have a reoccurrence of the psychosis if she became pregnant again and counseled against more children. Her husband opposed this and she became pregnant again.

In May of 2001, she filled a bathtub saying only that "she might have need of it," and was hospitalized again with suicidal impulses and feelings of not being a good mother. During the last two months she had ideas which referenced again that Satan was communicating directly to her and that there was surveillance cameras in her home. She felt the presence of Satan within her and had impulses to kill the children.

On June 4th she saw her physician, denied psychotic symptoms, feeling that if she stated her impulses out loud Satan would make them happen. Her husband, who was aware of her ideas and references about the TV and cameras, said nothing. The doctor decreased the anti-psychotic medication because of some side affects. She was seen two weeks later, was more depressed, but again denied psychotic symptoms. Two days later, the drownings occurred.

In her confession she stated she not a good mother and needs to be punished. Two jail psychiatrists took detailed notes during the first 48 hours of her incarceration outlining her belief that her children were not on a righteous path and were doomed to be punished in the fires of hell. Probably in Texas law, I'd have to say, in Luke 17:2, and most of you probably know this, but for those of you that don't, "He felt it were better for him that a millstone were hanged around his neck and he crashed into the sea than to offend one of these little ones." By taking them to God, she felt that she was saving them from hell because she would be punished by being executed and Satan within her would be destroyed.

At the trial, there were 34 witnesses who spoke to her mental condition. Two well-known forensic psychiatrists testified. Dr. Phillip Rensick for the defense, and Dr. Claud Deats for the prosecution. They both agreed she had a serious mental disorder of psychotic proportions, which affected psychosis, and that she was a good mother with no prior history of abuse. She had made extraordinary efforts to home school her children because of her husband's fear of the bad influences in the local schools. Dr. Deats's report was 103 single spaced pages.

The current insanity defense standard in Texas is the stiff M'Naghten standard. It states that to be insane the actors that have developed mental disease or defects did not know that his conduct was wrong. The defense attorney noted that Texas does not define the word "know." This, as we shall see, is probably a critical definition. But even undefined, both experts agreed that she knew what she did was legally wrong by virtue of the fact that she waited for an empty house before attempting the drownings, and called the police, as well as by her statement in custody that she expected to be punished by execution. Yet none felt she had any rational ulterior motive. There was no history of prior abuse on her part and her illness was seen as playing a substantial role in her behavior. Few people who are seriously delusional are so deranged as not to have some appreciation of society and the error of their beliefs in spite of being intermittently overwhelmed by these beliefs. Dr. Rensick believed that in spite of her ability to plan and appreciate some of the consequences, she was overwhelmed by her beliefs at the time and that if she did nothing her children would be in the fires of hell for all eternity. In that sense, this was an altruistic infanticide and she believed what she was doing what was right.

Dr. Deats, on the other hand, was the consummate skeptic. She tended to credit nothing the defendant said after speaking with her attorney. She denied the access of video tapes of every contact with the defense psychiatrist. And although concluding she was severely

psychotic in jail two days after the homicide, she was reluctant to say that she was as psychotic at the time of the homicide. Furthermore, he expected that she would be rationale with her delusional beliefs. Since it was Satan telling her what to do, she should have immediately known and appreciated that it was wrong. She focused on her waiting until the house was empty, calling the police, and her statement that she was expecting to be executed for her acts, saying she knew what she was doing was wrong. Both psychiatrists agreed, however, I think, that the legal standard ultimately made the insanity defense not viable in Texas. She, of course, was charged with capital murder and was thus entitled to a death trial by jury, which also may have shifted some of the weight and balance in there.

Is it fair to hold such a person criminally responsible? That of course is the question we're trying to consider. Is the threshold being employed set so high that only the defendants capable of meeting a cryptic criteria of the Wild Beast test used in the 18th century. Society is the leader of setting the standard too low, and U.S. standard in Texas were set by New York justices in the wake of a public outcry and Queen Victoria's anger when M'Naghten shot and killed her secretary, whom he believed to be the Prime Minister, and he was found not criminally responsible. M'Naghten himself would not have been found NGRI by the test that bears his name, and critiques of it being too cognitive had been wide-spread since its inception and adoption. The fuel that maintains this high threshold seems to be based on-- well, I have a couple of other comments about the testimony, but we'll maybe leave those for the discussion later this afternoon.

Some of the public fears have to do with distrust with both attorneys and the psychiatrists, that people will get away with or fake or malingering and they will be quickly released. Insanity is frequently proffered and is successful, and experts can be found to say anything. The fact that these are by and large myths does not change the public opinion in a large measure, and several states have gone as far as to abolish the defense all together.

Consider the data on the issue that experts can be found to say anything. The critics say the battle of the experts prove that psychiatric testimony is unreliable, given that experts rarely agree at trial. There have been a couple of dramatic statements, and I just picked one from as late as 1981 where a psychiatrist in Oklahoma, on the basis of a one-hour interview during which the participant was claiming he was President and refused to allow questioning about his mental status on the day of the shooting, that at the time that he pulled the trigger he was acting as a 7-year-old seeking revenge and rebellion against his step-father, a policeman. And he stated categorically that the defendant was pre-ordained to commit the murder from the time his parents were divorced when he was five. This deterministic approach is I think now rejected, by an overwhelming majority of psychiatrists, but it just takes a few cases like that to cast great

doubts both on the profession and on the quality of testimony. And that was one of the reasons we worked to develop some of these guidelines.

The figures, though, show that the vast majority of insanity cases do not feature a battle of the experts. Then again, almost 35 years ago in Washington, they found that between 66% and 75% of all insanity defenses acquittals were uncontested. In a more recent survey, experts agree that's in 92% of the insanity cases. Another found that prosecutors agree to insanity in 92% of all cases in which it was raised, and the small percentage were experts who disagreed; the difference of opinion usually centers on whether the defendant meets to a legal test, not on the medical diagnosis, as was true in the Yates case.

The second public concern is that the defendant was found NGRI and hospitalized would spend very little time in the hospital. Once a defendant is found NGRI, they spend almost double amount of time hospitalized that defendants convicted of similar charges spend in prison, and they often face a lifetime of post-release judicial oversight.

Another study in California showed that 1% of insanity pleas were released following the verdict, 4% placed on unconditional release, and the remaining 95% were hospitalized for a relatively long period of time. In that same study defendants found NGRI for violent crimes other than murder were confined twice as long as those found guilty on the same charges. And those found NGRI of non-violent crimes were confined nearly 10 times as long. Given this large disparity, the conclusion was defendants suffering from mental disease would be better off by pleading guilty, and that certainly occurs in a number of jurisdictions.

And finally, consider the overuse despite the widespread publicity as well as recent polls of judges and prosecuting defense attorneys, in addition to the growing literature showing that about a half to one percent of criminal trials and probably prevailed in about two-tenths of a percent of the cases. There's not a lot of data out there but what is, I think, supports that.

Let me spend just a little bit of time running through some of the history around this. We'll hear more about this so I'm just going to do this briefly. In the 13th century, crimes were defined more as requiring not just an act, but also the presence of a guilty mind, the so-called "*mens rea*" which we struggle to understand, but some state of mind that goes along with they're intending to do that. The insanity defense clearly represents an exception to that postulate that we're all capable of choice, of free choice, and therefore we choose to be punished if we choose to do wrong. And again, before psychiatry, most people felt that children under seven lacked capacity, and they based it on the old Biblical Garden of Eden—if you knew good from evil then you are capable of deserving punishment. So a long time children between seven and fourteen had the capacity to represent culpability, and you had to then show whether that child had it or didn't have it, and that could be argued, and we're still in the midst of that in a number of states in this country, whereas 10-year-olds can be convicted of murder.

The “Wild Beast” test, which is probably the test the public favors in general, is that someone has to be so totally mad that he’s deprived of his understanding and memory and does not know what he’s doing no more than an infant or a wild beast. Such a one is never the object of punishment. And short of that, you see the kind of questions that come up and what we do when we try to argue details of understanding.

The M’Naghten Test, which your state has, says someone has to be 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, that he did not know he was doing anything wrong.

You’ll see in the back-up material part of our practice guidelines. We did an actual state-by-state survey of every standard as of the time of 2000, and we tried to organize it somewhat in which states had sort of strict M’Naghten lines, and we found that a lot of the states have tinkered with the language, so much so that the core of one or the other is not as meaningful as it used to be, when you start mixing some of this language with some of the RLI or other tests. This test was in three jurisdictions that someone would not be held responsible if his unlawful act was a product of his mental disease or defect. This led, either the result-- I mean, everybody blames both the psychiatrist for testifying in such a broad fashion as to make this meaningless as well as attorneys who when asked for their conclusion or questions around this, that it was repealed in the District of Columbia as well as in some form in the Virgin Islands and New Hampshire.

We have a major test in contrast with the M’Naghten test, with the Model Penal Code, which substituted the language that a person is not responsible if it’s a crime if such conduct as a result of mental disease or defect, if the person lacks the substantial capacity either to appreciate the criminality of the conduct they have performed as the conduct of the requirements of law. And key to this is that “appreciation” means something different than “know.” Exactly how different it is is not crystal clear, but most of us take it to it’s fair under the meaning into more of an emotional understanding and how much a person can offer or relate what they know to what they then might cognitively understand, like Andrea, that the police may be interested, even though she was overwhelmed by delusional beliefs.

There was an 1800 case in a similar way to Andrea, where a man felt he couldn’t commit suicide because that was against church rules. But he had to die, and he knew if he took a shot at the King, that that was a capital crime. And he did that. He wasn’t intending to kill the King, but shot at the King. And his attorney argued that delusion was more a pretest of insanity, and that prevailed in his case, but did not in other cases after that.

After the Hinckley trial there was a great review again. Every state went through a major revision, and that’s when it became an affirmative defense. Before that, if a defendant showed some evidence of a mental disorder, the state then had to prove he was sane beyond a reasonable

doubt. And after Hinckley people said, “How can you prove anybody is sane beyond a reasonable doubt?” and the standard shifted to an affirmative defense where the burden is on the defendant to show, either by a preponderance of clear and convincing evidence that he was insane at the time. And the federal rule dropped the volitional component, that he was unable to control his behavior, and argued that it was sufficient to have a lack of appreciation of the mental quality of the criminality or wrongfulness of his acts. Actually, just the wrongfulness, I believe.

The federal rules also, I think both the APA was embarrassed by the argument of the experts, or the so-called battle of the experts, and supported that expert witnesses testifying should not state an ultimate issue testimony. That is, whether someone was insane or exactly what the ultimate issue is has been under great debate. I think most of us agree that whether or not someone is insane is an ultimate question, but is it an ultimate question to say whether or not someone can appreciate something or whether someone has a mental illness. In some federal jurisdictions they have gone so far as to preclude any testimony about the defending state of mind at the time of the crime, but just allow discussion about what someone with schizophrenia may do, or something like that, which I think obviates the whole purpose of the expert testimony.

Likewise, another issue that comes up is that the consequences of a plea, whether or not a jury should know whether that if someone is found not guilty by reason of insanity that they will go to a hospital and not just be released. A number of states have different variations on this. Some permit that, and a number don't, saying juries really should have nothing to do with punishment but should only be concerned about guilt, yet people feel that juries that have some idea or misunderstanding about that, and are less likely if they don't know that. Most people read the press and see things like people like Lorena Bobbit walking out of the hospital almost within a month after the trial, and that's what they remember.

Over the past 20 some-odd years, a number of states have abolished the defense. That's a more complicated issue, I think, and they have altered it to saying if someone didn't have the *mens rea* then they can't be convicted. If they didn't have the guilty mind. Which certainly ups the threshold. But I think, even in states like Montana, if they are found to not have the *mens rea*, that fits in a detention so they don't just walk. And so there's something there that still resembles that the standard is even much harder than the M'Naghten standard.

The *mens rea* approach is you must really show that someone didn't have the capacity to formulate that intent. And the one example I found was in Utah, a previously undiagnosed schizophrenic man said he believed his wife was a mannequin when he fired two bullets into her head was not held responsible for her murder. And that's the extent and nature where you have to go to do that.

What I'd like to do for the remaining few minutes is to say that I feel it's not just the standards that govern how the insanity defense is used. The Supreme Court early on said that if someone is found not guilty by reason of insanity, how long that they can be held does not bear any relationship to what they might have been sentenced to had they been found guilty. So that someone could theoretically be held indefinitely. In our state, by contrast to Texas, we have a very broad...we have an ALI standard. So someone is not responsible if they don't appreciate or if they can't control their conduct. So this is about as broad as it gets. We have some of the usual exclusions, such that if you voluntarily ingest drugs or alcohol, and that accounts for your mental disorder, you're precluded from using the defense. And with the criminal behavior designed to keep out anti-social personality disorder.

But our solution after to Hinckley was not to change the insanity defense standard, but to put in what was called a Psychiatric Security Review Board which would monitor insanity acquittees. We were the second state to adopt such a Board. And that's been in operation now for about 17 years. By statute, the primary concern of this Board is the protection of society. And as you can see, there are about six or seven members of the Board—an attorney, a psychiatrist, a psychologist, a probation officer, a member of the general public, and a victim advocate.

After the acquittal, the acquittee, is committed to the PSRB for a period of time that the judge sets as to what he would of sentenced had the person been convicted. So there's very little incentive for the judges to give anything less than the maximum sentence because the Review Board can release people earlier. So by and large, anyone who is acquitted, the judge sets the maximum sentence that the Board has jurisdiction over the acquittee. And then there has to be an evaluation within 45 days about whether the person still needs confinement, and that status is reviewed periodically. These hearings are quasi-judicial. There is some challenge to that at the present time at the Connecticut Supreme Court that testimony, whether it makes determinations about any change in status. Families are notified and they participate. Any change in where somebody is moved has to be approved by the Review Board. And in Connecticut, this is the one place where we have a full out-patient commitment statute, so that if someone is on conditional release and they don't show up for the program, the Board has the authority to bring them back into the hospital.

So the commitment term was set by the court. The prosecutors were very successful in lobbying, if you would, time for the original legislation allowing an extension beyond the maximum if they apply and show that the person is still dangerous at the end of the original commitment time. And that can be initiated by the state's attorney and then approved by the superior courts. The burden of proof at that point, switches to the state, like the civil commitment standard—they have to show the person is dangerous and mentally ill.

Now, the Board was somewhat conservative to begin with, but it became even more so. All you need is one case, and in Connecticut, we had a man who was hospitalized and had not been out on conditional release, but this is before-- we only had a maximum security and then the regular state hospital with minimal security. We didn't have any intermediate level. And this man, who did not have privileges, managed to leave the building, walk down to the main street in Middletown, bought a knife, and then walked and stabbed and killed a 9-year-old girl. You can imagine what that did in Connecticut. Following that, though, there was one other case where they took a group out to a movie and one of the acquittees went out through the back window of the bathroom and disappeared for about six months. So every acquittee was pulled back into the hospital and reviewed, and the whole system was almost put on hold. There was a law suit saying that we had overly been restrictive in the state by virtue of that.

The burden during the confinement after the acquittal is on the defendant to show he's not dangerous. These were some of the details which I won't go into here. And the powers of the PSRB are actually to control where the person is confined, whether there is release, whether there is conditional release, and whether they recommend discharge. And just to give you a brief summary of what our figures show, we've had about 273 acquittals over the period, and we can see a number are still confined in the hospital: 50%, 13% released to the community, and 35% discharged from the PSRB, a number of whom have died.

We have a fairly typical statistic, mostly men. And in our state you don't plead insanity unless you have a significant crime. People don't do it for misdemeanors. 97% of the violent offenses, 63% for homicide and assault. And you can see further down, arson and robberies and sex offenses. The victims are primarily family members and friends; in 75% of the cases are victim unknowns. In terms of the population, this is those people who have gotten out on conditional release. And you can see that 60% have never been out on conditional release. So it's a very tight system. And those who had been released, you can see that about 36% have been revoked, but they haven't followed through in one way or another. Most of these have been for drug offenses. And to show you the affect of the Board has been to see a steady and insignificant dropping down in the number of times that the insanity defense is used.

As you can see, the amount of time that people spend in the hospital since the Board has significantly gone up, so that now we're upwards of about—the mean length of hospitalization is about 12 years. The Board, in terms of public safety, has been enormously successful. People who got arrested have been mostly for misdemeanors or very minor felonies. The arrest rates are low. And some of the defendants now say, "I never should have gone this route; it's backfired." And the system has become so tight that I think it undermines the use of the defense.

This is all to say that the tailoring of the defense and how it's used is not just based on the standards, but the whole system has to get looked at, and what to do with the system makes

an enormous difference. I've had... [inaudible] ...would be significantly more. So they don't regard it as the law that most prosecutors feel is as the result of the defense.

Let me just say that our practice guidelines have been evolved to try to undercut some of the poor performances that occur. And like that other example, when you see our guidelines and what it takes to do one of these evaluations in an appropriate fashion, you know, it's not just a one-hour evaluation. You need to spend a substantial amount of time to review things. And we review a number of ethical conflicts and obligations, things like whether or not if you're a treating psychiatrist, we fully recommend that you not plead or testify in that space. You may be a factual witness, but you shouldn't be testifying expert. You don't usually do the same kind of evaluations, and it destroys treatment relationships. And people, even though they may be charged with crimes, I know a lot of doctors who continue to treat people even after they are incarcerated. But things like that that are not included, obviously the attorneys who think the treating doctor knows the person the best is the way things ought to be done.

I'll leave open more questions that we can get into the details. So we've certainly outlined the standards, we've outlined whether it will go into a report. The details of the contacts, fees, the whole detailed process by which this should be done responsively. Let me stop here and open this for some questions. Thank you.

[APPLAUSE]

AXELRAD: Thank you, Dr. Zonana. I might mention that Dr. Zonana is a Professor of Law at Yale Law School, as well as a Professor of Psychiatry Yale. And he is responsible for training of the law students at Yale as well as the forensic psychiatrists that are in his fellowship program.

I open the floor to questions. Please go to the microphone if you have any questions. And please identify yourself so that we can have a legible transcript of the proceedings.

DR. STEVEN SHANFIELD (Psychiatrist from San Antonio): Could you comment on the cognitive diagnosis we're dealing with? Also, really, the process of generic issues, psychosis and explosive personality.

ZONANA: One of the terms that's used in the federal standard is that the mental disorder should be serious. And by that it means that it usually should be something that tends to something of psychotic proportions. No one has drawn strict limits with that. And, you know, borderline personality disorders can sometimes difference the psychotic state. But by and large, it ought to be something where there is some disruption of reality testing and things like that.

Some states more specifically require that, some don't. In our state, the vast proportion has psychotic diagnosis or severe retardation.

DR. JOEL SILVERBERG (Psychiatrist from San Antonio): You mentioned about videotaping in the Yates case. Could you comment on, number one, the importance of videotaping, and number two, the timing of the videotape. Because I know that that was important in the Yates case that the videotape was only done much later after the crime.

ZONANA: This has been an issue of great debate. We also have a classic guideline on the question of videotaping of evaluations. I myself videotape all of my interviews when I do forensic evaluations. Some people feel more leery about that. I tend to feel that if my conclusion is not supported by the whole evaluation, then it's not going to stand, and I'm comfortable. I've done it long enough that I don't think it materially affects the dynamic of the images. I will have some discussions with the person sometimes after the tape is off, if there's some question, or I ask people if there are things they feel that they can't really say. But I prefer to have a record.

A lot of people don't like to do it. A lot of prisons and jails make it extraordinarily difficult for you to go in with a camera. And so you have to be willing to spend a lot of time in setting that up and working it out. By and large, I've not been unsuccessful in getting the prisons to do that. I basically say that's my way of taking notes and that's what I need to do, and eventually you'll get it worked out. But I don't know if that should be a forced requirement on everyone. I'm not sure of the fact that ultimately it's going to answer the doubts that people feel that as soon as someone talks to their attorney nothing can be trusted. Then it doesn't matter what time or place. So the integrity of the whole process is, I think, less than real important.

DR. TERRI SILVERBERG (Psychiatrist from San Antonio): I noticed in your handout that the number of NGI acquittals seems to be a decreasing in trend.

ZONANA: Yes.

DR. SILVERBERG: And that a person was staying confined longer in a medical facility. But I'm wondering, are they waving the defense less frequently then? Or is there some other factor that is taking place that's taking place?

ZONANA: The legal system is over-accommodating. What happens now is that we get called in to do responsibility evaluations. If we say that someone is eligible for the defense, the defense

attorney sits down with the prosecutor and says, “We really don’t want an insanity defense, but look at this situation, and can we work out some plea agreement that takes that into account?” And so they prefer to have a fixed sentence, because they see what happens with the Review Board that can go on so indefinitely that most defense attorneys, recommend that you go to jail rather than go to a hospital.

Now, the system is complex. We’ve brought several law suits against the Department of Corrections for not providing adequate mental health care in the system. And we’ve been successful in two or three of the prisons so that the quality of the mental hospital in the women’s prison now is probably equal to or as good as it is in the state hospitals. So again, it makes a difference. Some people prefer one and some people prefer the other. And we see both sides of that. Some people hate therapy and so they say, “Just leave me alone and let me sit in jail.” Other people prefer a hospital, seems less threatening. So that’s a hard concept. So issue is used in that kind of light. People negotiate and work out rather than-- That questions what the defense means though, and what the justice system is doing.

DR. MITCH YOUNG (Psychiatrist from Houston): There’s a limited budget per evaluation. There’s the version of the so-called organic versus functional illness in the development of neural and radiographic studies and CAT scans, and the like. You have defense attorneys who feel a picture is worth a thousand words, the prosecutor says most of the studies have been negative. Do you have guidelines to address that issue? At what point do you stop in terms of your evaluation?

ZONANA: Yes. I remember a joke said one night when we were discussing a Texas/Oklahoma case—they said down here in Texas you can’t get a psychiatrist to come in out of the rain for \$500, which was not unheard for the exam. I’d say you need to be clearer at the outset about what is available. But if you undertake to do the evaluation, you have an obligation to do it responsibly.

Now, the whole issue of scans is another whole complicated arena these days. We’ve had people in Connecticut who’d love to show up for pictures, like you said, and say, “This guy has a broken brain.” He went on national TV with that. And I suggested at that point to the state that they raise a bonus question about whether that was scientifically valid at that point, and the defense was furious. Now, they’re supposed to let in more expert testimony. It’s clearly said the opposite. It cuts out more things than it lets in. It’s much tighter than the Fry standard of ever was. Now, whether that’s good or bad is not clear yet. But certainly it cuts out some bad stuff. And I think they just have to follow that. I think you have to let somebody know at the outset what it is you may need to do in order to do a comprehensive evaluation. And if you need to do

scans, you'd better do them. I mean, if somebody's got a tumor or somebody's got something else, I think you have an obligation, once you start, to not abandon it in half fashion. There's actually been a couple of suits against expert witnesses where they haven't followed through on something that they need to do. But I think from an ethical point of view, once you start something like that, you should finish.

DR. JAIME QUINTANILLA (Psychiatrist from Kilgore): What is your opinion about the use of translators in criminal cases?

ZONANA: Well, you need to understand somebody. I've always found it somewhat more difficult to do those evaluations. And in a couple of cases where people have malingered, in my experience it's often been where people have not spoken the language and don't know how to evaluate the criteria to any range that we are accustomed to in picking up a lot of the nuances and getting the histories from people. So I think it is a complication that makes the evaluation much more difficult.

We've been bringing our residents over to the Immigration Clinic at the law school, where the law students represent people who have to show they have a well founded fear of going back to their country. And they've often been exposed to a lot of terrible abuse. And there's a nice video tape that the INS did. And on that you'll see translators—there's generally that break, you know, someone talks for five minutes and then the translator says, "She said 'yes,'" or something like that. And a lot of the translators that you get are not professionally trained. They're from the community. And they often quickly develop feelings about the person that you're seeing. And so unless you get a literal translation, you're in trouble. So we try to get docs or other professionals to somehow facilitate that process. It is a significant factor.

DR. MITCH DUNN (Medical Director of the Forensic Program at Terrell State Hospital in the Dallas area): It's been my experience that the success of insane defense, at least in the Dallas area, is more dependent frequently not on whether the individual meets the test specifically, but rather on the notoriety of the case and the attorney's desire to get an expert after the initial court appointed expert, so that frequently, as you mentioned, a lot of the cases don't end up being about experts, there's just simply acceptance by the DA's office. But only in those cases where there is a greater degree of notoriety or a greater degree of success in terms of the individual's actual act. So in other words, if Ms. Yates, for instance, had attempted to drown all the children, but her mother-in-law had walked in and her mother-in-law was a nurse and had revived the children, then that would be she would be seen as not a more pathetic figure, but a less

successful figure, and therefore the insane defense might have been more acceptable to the DA's office. I know somebody who may speak to that. Is that your experience nationally as well?

ZONANA: The figures are clear about that. That if the prosecutor does not agree and you go to trial, the chances of being successful in the defense drops dramatically. Maybe 10% to 15% chance that we would be successful. In Pennsylvania, for example, the state does not have the ability to have a psychiatrist go in and evaluate the defendant. Only the defense does. But the prosecutors don't care. They know the public is so adverse to looking at this issue, that if they challenge it that they are likely to be successful, and they haven't pushed to really change that.

AXELRAD: We have time for one more question.

DR. JEF NELSON (Psychiatrist in Private Practice in Austin): I was a correctional psychiatrist on a part-time basis in the Travis County Jail for 17 years, and was also Medical Director of the local Mental Health Center in the 1980s. I have a couple of comments. One is that it seems to me that the plan in Connecticut should be very seriously considered for Texas by the policymakers and legislators. I can give you one example of why I think that. There was a case in 1984 in Austin where a man on furlough from the Austin State Hospital, diagnosed with schizophrenia, was stopped by police on the State Capitol grounds one day with a knife. The blade on the knife was not quite too long to arrest him. Later that night, he stabbed a man at the Salvation Army six times, and the man died. He was found not guilty by reason of insanity. In Texas at that time, and I believe it's still the case, he had to be re-determined to be dangerous under the civil commitment statutes each year. This was a public case. There was no public people to continue to testify to this. And that standard is a very strict standard. This man was subsequently released after serving no more than two years in a state mental facility. At that time, he committed many other crimes: assaults, no murders; he contracted AIDS, he continued to be sexually active. And I believe that this kind of a person would probably not have been released so easily if Texas had a review system like Connecticut. So I would urge that the policymakers consider this plan that you have in Connecticut as a serious one.

AXELRAD: If we don't do anything else except promulgate the practice guidelines in the State of Texas, we will have accomplished a very important contribution to the administration of insanity evaluations in Texas. So I would encourage all the practicing attorneys to obtain it, to give it to the psychiatrists when they are hired for the purposes of improving the system. I've served on two state medical boards, both in California and Texas, and I can share with you that the ongoing problem that the Boards have is referrals and complaints on forensic psychiatrists

that weren't practicing ethically. And now that we have a guideline, we can improve the quality of the psychiatrists.

Our next speaker is Professor Christopher Slobogin. Chris has been a very prolific writer in the legal literature. He also has served as the Reporter for the Insanity Defense section of the ABA Criminal Justice Mental Health Standards, which also deal with a number of other issues relevant to the involvement of people with mental illness in the criminal justice system. I might add that another faculty member, Professor Bonnie, was on the Advisory Committee for this project; and my mentor, Bernard Diamond, was also on the Advisory Committee on this project.

Professor Slobogin is currently the Stephen C. O'Connell Chair and Professor of Psychiatry at the University of Florida. He has also been involved in training programs in Florida throughout his time in Florida in which he undertakes forensic training for mental health professionals in the State of Florida. His CV has numerous publications. I think the publication that has very high relevance for us, for this program, is the first paper, which actually was co-authored with Professor Bonnie, on the role of mental health professionals and the criminal process, in the University of Virginia Law Review. He has also published on the guilty but mentally ill verdict. And he also has published a paper in 2000 in the Virginia Law Review, called "And End to Insanity: Recasting the Role of Mental Illness in Criminal Cases", which I'm sure he'll address today in this program. Professor Slobogin, we appreciate you coming.

[APPLAUSE]

SLOBOGIN: Dr. Axelrad told me that my mission, should I choose to accept it, would be to defend the M'Naghten formulation, as well as two variations of M'Naghten, the so-called "Mens Rea Alternative," and what I call the Integrationist Approach, which limits the defenses available to people with mental illness to those available to defendants who are not mentally ill. Foolhardily, I agreed to take on this somewhat contradictory set of tasks. My principal method of defending M'Naghten, the Mens Rea Alternative and the Integrationist Approach will be to attack all other formulations of the insanity defense. But I will also say a few positive things about M'Naghten and its variations. I will be particularly enthusiastic about the Integrationist scheme, an approach that I first advocated in the second Virginia Law Review article mentioned by Dr. Axelrad.

It is best to start with the insanity tests that preceded the M'Naghten formulation. All of these tests were focused on cognitive impairment as opposed to volitional impairment, and all of them required an extremely high degree of cognitive impairment. In the 13th century, Bracton defined an insane person as one who "lacks sense and reason." In the 17th century, Lord Coke stipulated that to be insane the person must not have known what he was doing and "lack the

ability of mind and reason,” and Lord Hale demanded “an absence of understanding.” A century later, Justice Tracy equated insane people with wild beasts, and required “a total deprivation of understanding their memory.” The early 1800s saw the development of the right-wrong test that eventually developed into M’Naghten. Under this test as well, it was very difficult to win an insanity claim. Typically if the person intended to commit the crime, he was convicted, no matter how crazy he may have been at the time of the offense.

Finally in 1843 came the M’Naghten case. Daniel M’Naghten felt he was being harassed by members of the Tory Party, so he tried to kill the head of the Party, Prime Minister Peel, instead killing his secretary. He raised the insanity defense and was acquitted at trial. On appeal, the House of Lords devised the so-called “M’Naghten Test,” which we’ve all come to know and love. The first part of M’Naghten excuses “a defect in reason that results in the inability to know the nature and quality of the act,” a formulation that is very similar to the medieval test that I described earlier. But the second part allows an excuse even if the person did know the nature and quality of the act, as long as he or she “did not know that the act was wrong.”

Another part of the House of Lords’ opinion is not as well-known. The Lords developed a special test for cases of partial delusion, or what we might call today cases involving an encapsulated delusion. According to the Lords, people with partial delusions should be considered “in the same situation as to responsibility as if the fact with respect to which the delusion exists for real.” Putting that concept in modern English, a person is insane if, assuming the delusion to be true, the person would be justified in committing the crime. The Lords also gave an example of this situation. Assume a person killed another individual because he delusionally believes that the victim was about to kill him. That kind of person would be excused under this formulation, the Lords said, because killing someone who is about to kill you is justified. In contrast, if a person kills another person delusionally believing that person is besmirching his character, the Lords opined there would be no legal excuse, because killing someone just because they’re slurring your good name is not justifiable. I’m going to return to the so-called “partial delusion test” in a few moments, because it’s very closely related to the Integrationist Approach that I have proposed.

The M’Naghten Test was criticized from its inception as being too rigid. Under M’Naghten, a person is excused only if he or she doesn’t “know” about the wrongfulness of the act. The most famous expansion of M’Naghten is the Model Penal Code test developed by the American Law Institute, a group of lawyers and judges and other legal professionals. In its Model Penal Code the ALI provided that insanity exists when, as a result of mental disease or defect, an offender “lacked substantial capacity to appreciate the criminality or wrongfulness of his conduct.” (There is also a voluntary prong to the ALI test, but I’m deferring discussion of

that for the moment.) There are two differences between this test and the M'Naghten Test. One is that, on its face, it doesn't require the black-or-white analysis that M'Naghten does. It speaks in terms of substantial lack of experience and capacity, as opposed to an inability to know the wrongfulness of the act. And it uses the word "appreciate" as opposed to the word "know," a move the drafters of the Model Penal Code stated was an attempt not only to excuse those who know the act is wrong, but also those who don't have an emotional, affective appreciation of the wrongfulness of the act, or who are unable to internalize the wrongfulness of the act. So this modification of the M'Naghten Test attempted to broaden the scope of the insanity defense.

The ALI test was very popular; it ended up being adopted in well over half the states. But, as Dr. Zonana pointed out, after the Hinckley acquittal, a number of states revisited the insanity defense. Representative of the kinds of changes that came after Hinckley's insanity acquittal is the federal test, which requires a severe mental illness, not just any old mental defect. It also moves back toward M'Naghten's either/or approach by limiting insanity to those cases where the person was unable to appreciate the wrongfulness of the act; the word "substantial" has been removed. On the other hand, the federal test continues to use the appreciation language. Accordingly, the federal test is arguably broader than the original M'Naghten formulation, which uses the word "know."

Also worth mentioning is one other kind of cognitive test, developed by academics, which I will call the "Irrationality Test." As is often the case with suggestions made by academics, no state has ever come close to adopting any version of the Irrationality Test. But it's still worth talking about, because it represents a distinct approach to the insanity question. The underlying theme of the various irrationality formulations, of which there are several, is that knowledge of wrongfulness is not at the core of criminal insanity. Instead, these professors suggest, we should be focusing on the desires and beliefs that motivate the crime, in particular, the intelligibility, consistency and coherence of the desires and beliefs that motivate a crime. If those desires and beliefs are unintelligible and inconsistent with one another, or otherwise the result of a seriously defective reasoning process, then a person should be considered insane.

Those are the most significant modern variations on the cognitive impairment tests represented by M'Naghten. There are also, of course, volitional tests of insanity. A second criticism of M'Naghten besides its rigidity was that it didn't take into account people who might know right from wrong, who might not be significantly cognitively impaired, but who nonetheless were "compelled" to commit the criminal act. As a result there developed the so-called "Irresistible Impulse Test," which focuses on whether the person "has lost the power to choose between the right and wrong and to avoid doing the act in question, such that free agency is destroyed." This test looks at volitional impairment, as opposed to cognitive impairment.

Like M'Naghten, the irresistible impulse defense was criticized as too rigid. It required an irresistible impulse, an overwhelming impulse. Accordingly, the Model Penal Code drafters, as they did with cognitive impairment, broadened the volitional impairment test by providing that a person is insane if he or she "lacked substantial capacity to conform behavior to the requirements of the law."

There is one final volitional test that I think is worth mentioning. This is the product test, first proposed by Isaac Ray back in the 19th century. Dr. Ray suggested that a person should be insane simply if the crime is the product of a mental disease or defect. The basic idea is that the mental disorder takes over the individual and controls what he does.

These are the cognitive and volitional tests on insanity, the predominant ones, that have been adopted or proposed. What I want to do now, in order to fulfill my mission of defending M'Naghten and the variations of it that I mentioned before, is to attack all the post-M'Naghten formulations: the Appreciation Test, the Irrationality Test, and the Volitional Test.

I will start by posing arguments against the Volitional Test. There are both conceptual and practical arguments against tests that focus solely on volitional impairment. To start with, a truly involuntary act is extremely rare. The classic involuntary act is represented by a seizure, when the person literally has no control over body movements. But this kind of action very rarely results in crime. Aside from this group, a large number of people who commit crime claim they have very strong urges, and they probably do subjectively experience them. But most of these people know right from wrong. And all have some control over their action at the time of their crime. Most of these people intend their crime and many plan it. And most have alternatives to criminal activity. In other words, they would not commit their crime if a policeman were standing at their elbow.

Consider the issue from another perspective. Some psychotic people experience very strong urges. But are those urges any stronger than those experienced by the greedy corporate executive who wants to manipulate accounts when he doesn't think he's going to get caught? Or the urge that a teenage boy feels on a Friday night when he wants to have intercourse with his girlfriend? Or the impulses of a pedophile? Arguably these latter urges are just as strong as the compulsions a psychotic person feels. We don't consider the executive, the teenager or the pedophile non-responsible so we shouldn't call psychotic people insane, at least based simply on volitional impairment.

Even if compulsion should be an excuse, the practical problem, to use the old adage, is that it's impossible to distinguish between the irresistible impulse and the impulse that is not resisted. Considerable work has been done on impulsivity over the years. But the bottom line is we still don't know how to measure the phenomenon. One review of the methodology used to measure impulsivity concluded that, "Researchers need to be very cautious when selecting

impulsivity measures, because the different measures appear to be assessing very different constructs, even when they use the same methodologies." Another review found that, "Studies of adults, adolescents, and children show that impulsivity measures are often uncorrelated with one another, and that impulsivity is a multi-dimensional construct. There have been too few studies to determine the nature of the underlying factors." In other words, we literally don't know what we're talking about when we talk about impulsivity.

Sometimes one sees defense attorneys make the volitional impairment argument in the following manner: "I have a client who has characteristics that, research shows, almost always lead to criminal behavior; therefore my client was compelled." In this vein, consider a recent article in the journal *Science*, which indicated that 85% of those individuals who have been abused as children and have low serotonin levels commit violent crimes. That's a pretty exciting finding for a behavioral scientist, because it is rare to find such a high correlation between just two variables and crime. But does that mean these people are strongly predisposed, or compelled, to commit crime? First note 15% of the sample did not commit violent crimes. I suppose what the authors of the *Science* article might say in response is, "Well, there's bound to be some variable or combination of variables (say, increased substance abuse, or lower socio-economic status) that differentiates the 85% from the 15%." The problem with that line of reasoning is that it destroys the premise of the criminal justice system. Because, given enough variables, we can explain *all* criminal behavior. Therefore, all crime (and all conduct) is compelled, and we should excuse everyone. Maybe those of you who are strict determinists think that's what we should do, but that's not the system we have. Unfortunately, there probably is no meaningful way to distinguish causation from compulsion.

In short the Volitional Test creates a huge potential for abuse in the culpability-based system we have today. If we're going to say that some psychotic individuals are so compelled that they should be excused, then we'd probably have to excuse pedophiles as well, because they certainly experience very strong urges. If we're going to excuse those people in the *Science* article, the 85% that commit violent crimes, then we probably ought to excuse everyone with anti-social personality disorder, because 85% of them, at least 85% of them, commit serious crimes. And obviously that doesn't make sense if we're going to have a limited insanity formulation.

I'm going to stop with my criticism of the Volitional Test and go on to arguments against the ALI's Appreciation Test. The principal problem with the ALI Test is the same one I've raised with the Volitional tests: if the Appreciation Test is applied honestly, it will excuse numerous people we don't want to excuse. Exhibit A is psychopaths. Here is what Dr. Robert Hare, who is the leading researcher on the topic, says about psychopaths: "They seem unable to get into the skin or walk in the shoes of others except in a truly intellectual sense. They are

glibly superficial, lack remorse or guilt, lack empathy, have shallow emotions." To me, this is a classic description of an individual who lacks appreciation. This type of person does not meet the M'Naghten Test. Psychopaths know right from wrong. They know when they're committing a crime. They know society views their crime as wrong. But they don't internalize the wrongfulness of the act. By definition, they don't emotionally appreciate its wrongfulness. If we apply the Appreciation Test honestly, we have to excuse them. And I think that fact argues against the Appreciation Test.

Another class of people who commit a large amount of crime is comprised of people with mild retardation, people, say, with an IQ between 60 and 80. What does the research show about them? This is a quote. "Mildly retarded persons may be able to distinguish right from wrong in the abstract, but they have difficulty applying abstract concepts in specific actual settings and are unable to appreciate the wrongfulness of what they do." Thus, they are sane under M'Naghten, but they are insane under the Appreciation Test. I think many people would have trouble with that conclusion. People with mild mental retardation should perhaps escape execution, as the Supreme Court recently held, but not conviction.

Even if we look at people who have fairly significant, classical mental illness, the Appreciation Test may excuse people we don't think should be excused. Charlie Manson and his gang killed several rich white people, including the actress Sharon Tate. Why? According to Manson, the world will eventually be taken over by African-Americans, who will kill off most of the white race in a blood-bath. The Manson gang was going to prevent that by slaughtering a bunch of white people and then planting evidence designed to frame African-Americans for the crimes. This would alert the white world to the upcoming disaster and the dangers presented by African-Americans. Charlie Manson knew it was wrong to kill Sharon Tate. He would not meet the M'Naghten Test. But a plausible argument can be made that he didn't appreciate the wrongfulness of his conduct. He felt justified in doing what he did. He wanted to stop the impending massacre by African-Americans, and the way he was going to do it was by killing white people.

The same kind of analysis could be applied to Ted Kaczynski, a.k.a. the Unabomber. From what we know from the papers, the reason he mailed letter bombs to those dozen individuals is because they all were somehow involved with technology. He wanted to send a message that if people like them, and society generally, didn't curb the reliance on technology, the world as we know it will come to an end. His crimes were his way of preventing the destruction of the world by technology. He knew it was wrong to kill people. He knew it was against the criminal law. He knew that sending those letter bombs would result in other people's death. So he did not meet the M'Naghten Test. But he had a strong argument he didn't appreciate the wrongfulness of his actions, because he felt justified in doing what he was doing.

One final example. The Cruse case, a case you probably haven't heard about, involved a man in Florida who gunned down several people in a mall because he thought they were trying to turn him into a homosexual. Again, like Manson and Kaczynski, he knew it was legally wrong to kill these individuals. But arguably he did not appreciate the wrongfulness of his actions, because he felt justified in preventing these people from changing who he was.

Now, maybe some of you are saying, "we should excuse all three of these people." That's fine. But I'm suggesting that a lot of people wouldn't agree with you. In fact, none of these people was found not guilty by reason of insanity. All of them were convicted, Kaczynski with a guilty plea, Manson and Cruse at a jury trial.

Another problem with the Appreciation Test is that it, if honestly applied, it excuses people who do not have serious mental disorder. Take the individual who discovers his wife in bed with someone else and kills the paramour, the wife, or both. He knows it's wrong to kill at the time he did it, but he doesn't care. He wants to kill the SOBs, and thus doesn't appreciate the wrongfulness of his actions. He does not have a serious mental disorder, but the Appreciation Test, honestly applied, might lead to his acquittal.

The same thing can occur with cases of strong urges. The cognitive tests aren't supposed to excuse people who are not cognitively impaired and only have strong impulses. But consider this case, involving a person who was diagnosed with a pathological gambling disorder and was charged with embezzlement. Apparently he had embezzled money to support his pathological gambling habit. This is the testimony in the case that eventually led to his acquittal: "Well, here's a man who is a law enforcement officer, who knows the law well, who knows about right and wrong, [and therefore would not meet the M'Naghten Test]. But a man who was in desperate straits. He's under a tremendous amount of stress at this point. Did not consider right and wrong. I don't think that becomes part of the thinking process. His process is to survive. He's losing his job, his family, his children, his reputation. Everything is going down." This person was acquitted by reason of insanity under the Appreciation Test. In other words, under the Appreciation Test, even persons with a primarily volitional impairment can be described and excused in terms of cognitive impairment. People under a lot of stress, the argument goes, don't really think through the consequences of their actions, they don't appreciate the wrongfulness of what they're doing.

In short, the Appreciation Test doesn't limit insanity to that universe of people who are very disturbed, supposedly the people the insanity defense is focused upon. Perhaps that could be dealt with by requiring, as a predicate for insanity, a "severe" mental disorder, as the federal test does. But the DSM has over 300 diagnoses, and it's very easy to slap a mental disorder label on anybody who commits a crime. The individual who kills after finding his wife in bed

with another individual may have an "explosive personality" disorder. And pathological gambling certainly sounds severe.

That gets us to the Irrationality Test which, as I said, hasn't been adopted in any jurisdiction, but is worth talking about in some detail because it raises a number of interesting issues about the insanity defense. I want to say a couple of positive things about the Irrationality Test before I start criticizing it. One positive thing about the Irrationality Test is that it deals fairly well with the problem that I just described. Compared to the Appreciation Test, it better differentiates between persons with serious mental disorders and persons who don't have serious mental disorder, because it focuses on the unintelligibility and inconsistency of the person's motivations for crime. The Irrationality Test, in other words, limits the number of cases in which insanity can be raised in a way the Appreciation Test fails to do.

Another nice aspect of the Irrationality Test is that it helps deal with the whole determinism problem that Dr. Zonana alluded to and that the Volitional Test directly raises. Strict determinists say that all behavior is caused, if not compelled, and therefore all should be excused. That position, I noted earlier, could pose a real dilemma for the criminal justice system. But the people who advocate the Irrationality Formulation deal with it straightforwardly. They admit that all behavior is caused by environmental or biological factors. But they also insist that the only legally relevant cause for purposes of the insanity defense are the desires and beliefs that motivate the crime. These are the "proximate" causes, the final causes, of the crime. All other causes are irrelevant as far as the law is concerned. If the desires and beliefs that link to the crime are irrational, then we excuse. If the desires and beliefs are rational, then we have to convict regardless of what the other causes of crime are.

Those are the positive contributions of the Irrationality Test. But there are a number of negative aspects to the Irrationality Test as well. Once again, as with the Volitional and Appreciation Tests, it might excuse people who probably shouldn't be, despite its focus on unintelligible and inconsistent beliefs. Take, for instance, the case of David Berkowitz, the "Son of Sam." He stalked and killed a large number of women. Why? According to one theory, because he was turned on by their blood. After he killed them, he would actually masturbate to the blood stains their bodies left on the pavement. Jeffrey Dahmer would kill people, cut them into little pieces, put the pieces in the refrigerator and occasionally snack on them. Why? Because, according to him, he wanted to keep these people close to him. He did not want them to leave him. Mark David Chapman killed John Lennon. Why? Because he thought killing Lennon would improve his self-esteem; it would make him feel better about himself. I think a very strong argument can be made that the motivations of all these people were not "intelligible." And the beliefs of these people were also inconsistent with one another. For instance, Chapman, literally in the same breath in which he said killing John Lennon would

make him feel better about himself, also said that, "I also knew that if I killed John Lennon I'd feel extremely guilty and very depressed." That result is hardly conducive to improving one's self-esteem. In other words, Chapman had unintelligible and inconsistent beliefs simultaneously. That's the definition of irrationality. The same thing could be said of Dahmer and Berkowitz. Should these people be excused? Again, some of you might think yes. Yet all these people were, in fact, convicted. They were not found insane, even though an Irrationality Test might well lead to their acquittal.

A few other comments about the Irrationality Test address more directly the fundamental issue of whom we should and should not excuse. Those who advocate for the Irrationality Test argue, I think correctly, that people who are irrational find it particularly hard to access the right reasons for acting, the reasons why crime should not be committed. But the key question should be how hard it is to do this, compared to people who are not "irrational." The MacArthur Foundation and other groups have carried out very interesting research on people with paranoid schizophrenia that bears on this question. The research looks at the correlation between violence and various symptoms such as command hallucinations, threat/control delusions and other types of serious symptoms. What's particularly pertinent about this research for present purposes is that it finds that most people with command hallucinations and schizophrenic delusions do not act on the commands, and do not act on the threats posed by the delusions. In other words, apparently they are able to access the right reasons for acting.

On the other hand, some non-mentally ill people—some relatively "normal" people—have a very difficult time accessing the right reasons for acting. Take the typical very dependent personality, who commits crimes at the behest of another individual. This kind of person, studies show, has a very difficult time accessing the right reasons for acting because of their blind allegiance to the leader. This might explain, for instance, the behavior of the individuals who followed Manson. In other words, it's not clear that irrationality, in the sense of serious mental disorder, is the reason people have a hard time accessing the right reasons for acting.

One final interesting aspect of the irrationality defense, and the insanity defense generally, is the underlying notion that people who are mentally ill, who are irrational, are basically good people. It's the mental disease that makes them do bad things, the thinking goes. This assumption is worth challenging. In a book entitled *LOOKING THROUGH THE EYES OF KILLER: A PSYCHIATRIST'S JOURNEY THROUGH THE MURDERER'S WORLD*, Dr. Drew Ross claims, as most people do, that people who are mentally ill usually have a good heart underlying their loss of reality. But he goes on to describe a large number of cases where mentally ill people commit homicide for reasons that don't sound so innocent. For instance, there is the case of Mark, who killed out of delusional jealousy; the case of Ned, who killed in large part because of anger at his mother; the case of Leo, who killed a hated uncle; and the case of Ernest, who

stabbed a young girl perhaps to prevent detection or perhaps out of envy. These are the same kinds of motivations that might lead a normal person to kill someone else. Is it really irrationality/mental illness that is causing people to commit these crimes? Or is it something else? I think it's at least worth raising that question when talking about the insanity defense.

The bottom line is that M'Naghten is better at capturing the essence of insanity than all of these other formulations. The Volitional Test doesn't work because compulsion shouldn't be an excuse; or if it should be, because of the impossibility of distinguishing resistible impulses from impulses that aren't resisted. The Appreciation Test doesn't work because it's too broad and it doesn't distinguish between people with significant mental disorder and people who do not have significant mental disorder. The Irrationality Tests don't adequately identify people who can access the right reasons for acting, and itself is too vague.

So that's my defense (by negative inference) of the M'Naghten Test. But I think there's an even better test, the Integrationist Approach that I mentioned at the outset. Again, this approach attempts to integrate people with mental illness into the system of punishment that we already have for people who are not mentally ill.

The Integrationist Approach recognizes that modern criminal statutes have vastly expanded the defenses that are available to non-mentally ill people. By modern criminal statutes, I mean statutes modeled after the Model Penal Code. We've already talked about the impact of the Model Penal Code in the insanity area. But the Model Penal Code also had a very significant impact with respect to other defenses that are available to criminal defendants, defenses like self-defense and duress and lack of mens rea. The Model Penal Code has established the principle that if blameworthiness is the key inquiry of the criminal law, we should look at the subjective beliefs of the individual when he or she commits a crime. So for instance, the Model Penal Code has developed what I call the excuse of "Subjective Justification." Here is the language from the Model Penal Code that deals with the use of deadly force against another. "The use of deadly force is excused whenever the actor believes such force is necessary to protect himself against death, serious bodily harm, kidnapping, or sexual intercourse compelled by force or threat." What this language says is that even if the individual is not actually threatened with death or these other consequences, the individual still has an excuse for crime if he honestly thinks that he's threatened with them. This notion is virtually identical to the Partial Delusion Test that the House of Lords came down with in the M'Naghten case. We look at what people believe, and if what they believe amounts to justification, then they are excused. That's the subjective justification defense under the Model Penal Code.

The Model Penal Code also subjectifies the duress defense. Classically, the duress defense exists when a person is coerced into committing a crime by a serious threat, as when someone holds a gun to the defendant's head saying, "commit this robbery or I'll kill you." But

the duress defense under the Model Penal Code also provides an excuse when an actor mistakenly believes that a threat to use unlawful force has been made. Even if the individual isn't actually being threatened with deadly force or some other kind of serious force, if the individual thinks he's been threatened with such force, then the individual will have a defense under the Model Penal Code. Thus the code adopts a subjective duress defense.

Finally, there is the subjectification of mens rea. In the old days, if an individual committed a criminal act, the criminal law pretty much assumed that the person had the intent to commit it. But the Model Penal Code requires that we inquire into the individual's actual intent and awareness at the time of the crime. That's the only way we can truly assess blameworthiness, as far as the drafters of the MPC were concerned. So for instance, if the individual didn't intend or wasn't aware he was committing the conduct that caused the crime, there is a defense. The individual who didn't intend or wasn't aware of the results of the crime may also have a defense. And most importantly for present purposes, if the individual wasn't aware of the circumstances that comprise elements of the offense, then that can be an excuse as well. An example of the latter defense: Assume an individual takes someone else's umbrella and keeps it for his own. In the old days that individual would be convicted of theft if a reasonable person would have known that that umbrella belonged to someone else. But the Model Penal Code expands the inquiry. It looks not at what a reasonable person would or would not have known, but rather at what this particular individual thought at the time. And if this particular individual thought it was his umbrella — honestly made a mistake and thought it was his umbrella and not someone else's — then he is not guilty of theft.

How does all this apply to people with mental illness? The argument I'm making here, the Integrationist argument, is that if we apply these defenses to mentally ill people, we don't need the insanity defense. Those mentally ill people who have a subjective justification, subjective duress, or lack of subjective mens rea defense constitute the universe of people with mental illness who should be excused.

Before exploring that point further, there is one further aspect of the Model Penal Code that is relevant here. The Code's section on defenses provides that a person cannot be exculpated if they're responsible for bringing about the situation requiring a choice of harm or evil or a lack of mens rea. For example, let's say we have an individual who kills someone because the victim is about to use deadly force against him. Generally, this would be self-defense. But the MPC provision I just described states that if the perpetrator of the crime provoked the victim into using deadly force, a self-defense defense should not succeed. Because the perpetrator started the whole mess, he is not entitled to a defense.

Putting this all together, the Integrationist Test might look something like this: A person shall be excused from an offense if at the time of the offense, by reason of mental disease or

defect, he lacked the subjective mental state for the conduct, circumstance, or result element crime; or he believed circumstances existed that, if true, would have justified the offense; or he believed circumstances existed that, if true, would have amounted to duress, and provided that he did not cause any of these mental states by purposely avoiding treatment aware that such states would occur without such treatment.

Here are some examples of how the Integrationist Test works in actual cases. Consider first cases involving lack of subjective mental state. The Wetmore case out of California involved an individual who was found in another person's apartment wearing that person's clothing. He was charged with burglary and breaking and entering. It turns out he was mentally ill. He actually thought the apartment was his and that the clothing he found there was his as well. Someone like Wetmore could be excused by reason of insanity. But he also could be excused because he lacked the requisite mental state. More specifically, he did not have the mens rea for burglary, which requires breaking into the house of another knowing it is another's and intending to commit a crime therein. An insanity defense is not needed to excuse him under the Integrationist Approach.

Another example of the mens rea component of the Integrationist Test is the Barclay case, described by Isaac Ray. According to Ray, Barclay was a mentally retarded individual who killed another person, apparently thinking the person was akin to an animal, specifically, an ox. If so, he was probably insane under any test of insanity. But we also could acquit him on lack of mens rea grounds. He did not have the mens rea for homicide, because he did not intend to kill a person; he intended to kill an ox.

Now to examples of the subjective justification component of the Integrationist Test, which provides an excuse if the individual believed circumstances existed that, if true, would have justified the offense. This is the Partial Delusion defense announced by the House of Lords in M'Naghten, and the M'Naghten case itself provides an illustration of how it might apply. As noted earlier, M'Naghten thought he was being harassed by the Tory Party. In fact, he thought the Tory Party was trying to assassinate him. He actually went to the police on several occasions and said in effect, "Look, the Tory Party is trying to kill me. Do something about it." Of course, the police didn't pay any attention to him, so M'Naghten felt he had to take things into his own hands and tried to kill Prime Minister Peel. He might very easily have had a subjective justification defense on those facts.

Contrast that to the Hinckley case. Hinckley supposedly tried to kill President Reagan because he thought that, if he did, Jodie Foster would fall in love with him, or at least come to live with him. It's harder for Hinckley to make a subjective justification argument on those facts. No jury is likely to think it's justifiable to kill the President of the United States so that an actress will fall for you.

Consider other examples I mentioned earlier. Was Kaczynski justified in doing what he did to prevent destruction of the world through technology? Was Cruse justified in doing what he did to prevent himself from being turned into a gay person? Those are the kinds of inquiries that would take place under the second component of the Integrationist Test.

The third component of the Integrationist Test looks at whether a person believed circumstances existed that, if true, would have amounted to duress. The most relevant kinds of cases here, I think, are the command-from-God cases. Say, for instance, the mentally ill person believed God commanded him to commit a crime because otherwise the world would be destroyed. That might be a viable defense under the Integrationist Test. On the other hand, if the command from God was, "Commit the crime or I'll be very angry with you," there might not be a defense.

Finally, consider the exception to the Integrationist Test that I mentioned earlier, the provision that if the individual purposely avoids treatment, knowing that delusional mental states would occur without such treatment, then there might not be a defense. Here the Yates case might be a good case to discuss. Andrea Yates had a strong subjective justification defense, if you believe what some of the psychiatrists in that case said. For instance, Dr. Resnick believed she killed her children because she thought that if she didn't they would go to hell, whereas if she did kill them, they would go to heaven. If you believe she had those delusions, and you assume them to be true, she had a good subjective justification defense. She might still not be excused under the Integrationist Test, however, if she was responsible for the delusions that she was experiencing and knew they might lead to hostility toward the children. She twice refused electric shock treatments. She often did not take her medication, against medical advice. She hid her symptoms from the doctor, knowing that when she didn't take her medication she became very irritable with her children. These kinds of facts could make it difficult for her to have a defense under the Integrationist Test. On the other side of the coin, if she really did not believe she was ill, or was not aware that failure to take treatment would exacerbate her violent delusions, then she might still be excused.

Whatever you might think about how these various cases came out under the Integrationist Test, the bottom line is that its adoption would get rid of the insanity defense, and instead apply the same defenses to people with mental illness that we apply to people who are not mentally ill. There might be several beneficial consequences to adoption of the Integrationist Approach. First, it may improve public perception of the criminal justice system. Right now, conspicuous insanity acquittals prompt a huge outcry, not just against the insanity defense, but against the entire criminal justice system. People complain "How can the criminal justice system excuse people because they're 'crazy' — if they do the crime they should do the time." The Integrationist Approach would make these acquittals easier to swallow, because they would

occur only in those cases where the individual thought he needed to commit the crime due to the threat of a greater harm, or where he lacked intent to commit the crime. The typical lay person should find it easier to understand that type of acquittal, compared to an acquittal based on the concept of volitional impairment, lack of appreciation or irrationality.

The Integrationist Test also might help de-stigmatize people with mental illness, because it treats them the same way we treat non-mentally ill people. The worst possible label an individual can be saddled with in today's society is "criminal insanity." The criminally insane are reviled and feared. If we get rid of the insanity defense we no longer have that category, which might be a small step toward de-stigmatizing people with mental illness.

The third possible benefit of the Integrationist Test is that it might improve treatment of people with mental illness. We all know that no matter what the formulation of the insanity defense is, there will be large numbers of mentally ill people in our prisons and jails. Yet many lay people and politicians think, "If mentally ill people need treatment they'll be found insane, and they'll be treated." Elimination of the insanity defense might focus more attention on the treatment of all mentally ill people, as opposed to just those found insane.

There may be at least one practical downside to the Integrationist Test, however. It may ask juries questions they can't answer. Is it justifiable to kill others because they're trying to turn you into a homosexual? Is it justifiable to send out letter bombs in an effort to prevent the destruction of the world through technology? These are the types of inquiries the Integrationist Test demands juries answer. Perhaps juries won't be able to take these kinds of inquiries seriously, or be able to deal with them sensibly.

That criticism leads to the last test that I promised to talk about, the Mens Rea Alternative. The Mens Rea Alternative would only excuse if the individual lacked mens rea, and thus overlaps only with the first part of the Integrationist Test.. It would not excuse people because they lacked volition or lacked appreciation and it would not excuse people based on subjective justification or duress. Thus, it would avoid the conundrums connected with the Integrationist Test I just discussed.

There are at least four states that have this approach, so we know something about how it works. Not surprisingly, it has reduced acquittals based on mental state defenses. In the state of Montana before the Mens Rea Alternative was adopted, about 23% of all mental state defenses succeeded and about 50% of those who asserted such a defense were convicted. After the adoption of the Mens Rea Alternative, only 2.3% of mental state defenses succeeded. So there was a huge drop off in the number of acquittals by reason of mental state. But, at the same time, after the Mens Rea Alternative was adopted in Montana the people who were convicted were much less likely to go to prison and much more likely to get probation than before the adoption of the Mens Rea Alternative. Additionally, today there are many more dismissals based on an

incompetency to stand trial finding. In other words, Montana experienced a balloon-squeezing phenomenon — an adjustment to one part of the system resulted in accommodations in other parts of the system. Mental state issues are still affecting Montana decisions despite the adoption of the Mens Rea Alternative.

The Mens Rea Alternative has been attacked on constitutional grounds. The principal argument has been that getting rid of the insanity defense in this fashion infringes due process. But most state courts that have heard these arguments have rejected them. The Montana supreme court said, for instance, that so long as mental disease is considered at sentencing, abolition of the insanity defense is not unconstitutional.

Nonetheless, it's interesting to speculate what the United States Supreme Court would say about the Mens Rea Alternative. In the *Leland (v. Oregon)* decision, the Court said that the due process clause does not prohibit forcing a defendant to prove insanity beyond a reasonable doubt. If it's permissible to put the burden of proving insanity on the defendant beyond reasonable doubt, the defense must not be a very crucial component of the criminal justice system. Based on *Leland*, one could predict that the Court would say the defense is not a fundamental aspect of due process. But then we get the *Egelhoff (v. Montana)* decision, which came down in 1996. Montana, apparently a state that likes to eliminate defenses, had done away with the intoxication defense, a move that was challenged as a violation of due process in *Egelhoff*. The Supreme Court disagreed. But what's interesting about the case for our purposes is the reason the court gave for its decision. The Court essentially stated that since the intoxication defense is of "recent vintage," it's okay to get rid of it. Of course, the insanity defense is not of recent vintage; it's ancient. So perhaps when the Supreme Court gets a case challenging the Mens Rea Alternative and has to decide its constitutionality, it will say the insanity defense is a fundamental aspect of due process. But even if it does, both the M'Naghten test and the Integrationist test should survive challenge.

Thanks very much. [APPLAUSE]

AXELRAD: Thank you, Professor Slobogin. We'll have questions or comments now from the audience. Please identify yourself for the transcript.

DR. JOEL KUTNICK (Psychiatrist from Corpus Christi): I've often thought that what we're after is fairness and justice. And immediately when you say "not guilty by reason of insanity," in fact, the public believes that they're going to get off and be found not guilty, and in fact you also set the psychological state for the jury that it's going to find them not guilty even though

they did a horrendous crime. We'd be better off saying guilty, they did a crime, but were mentally ill rather than "not guilty by reason of insanity."

SLOBOGIN: Your question raises a lot of interesting issues. One verdict form that has been proposed that might address some of the problems you're talking about is to simply change the name of the verdict from "not guilty by reason of insanity," to "guilty, except insane." That verdict sends a message to society that the person committed the criminal act, and that the only reason we're not sending them to prison is because of insanity. In fact, Oregon has adopted that approach. Whether, in fact, the verdict has this symbolic effect I've mentioned is unknown. There hasn't been any empirical work on that.

Another possible approach, which is very radical but is suggested by your question, is to have a two-stage, bifurcated process. The first stage would be devoted entirely to whether the person has committed a criminal act. The second stage would look at what to do with the individual who is convicted at the first stage — perhaps put them in a mental hospital, maybe prison, maybe conditional release. Arguably that is a better way to proceed because we avoid these very murky issues surrounding criminal responsibility.

A related point: I've very quickly gone through all of these various insanity formulations as if they actually have some impact on acquittal rates. And of course, we analysts like to think that there are actual differences in terms of possible impact between these various formulations. But, as Dr. Zonana alluded to, in fact it probably doesn't make that much difference exactly what formulation we apply. And if that's true, why worry about all this? Why not instead just adopt a system that focuses on the proper disposition of the individual in front of the criminal court?

AXELRAD: Could you identify yourself, please?

DR. MIKE ARAMBULA (Psychiatrist from San Antonio): I wanted to pick your brain about something. At least in my practice and what I know from my colleagues, almost all of the offenses committed by someone with mental illness have some intent behind them, whether it's an auditory hallucination or a frank delusion, an idea reference, whatever you call it. Within that ball of irrationality there's intent. And before a jury, you know, when we're examining the intent, did someone intend to do that, I mean, it sticks out like an elephant in the kitchen. It doesn't matter, many times, whether there's a mental illness, as long as there's intent, and that's in almost all of the cases. How might we be able to split hairs on this?

SLOBOGIN: Your observations may explain why we're talking about the Andrea Yates case. Over and over again in that case it was drummed into the jury's mind, "This woman intended to

kill her children." To some jurors, perhaps that resolved the insanity issue. But, of course, if you pay attention to the insanity language, that defense has nothing to do with intent. It has to do with the reasons the person committed the act, not whether the person intended to commit the act. You're right that virtually all people who are insane, all "crazy" people, if I may use that word, intend to commit their acts. That's why in Montana we see such a small number of acquittals after the Mens Rea Alternative was adopted. The defense attorney must make clear to the jury that the defendant's intent is irrelevant, and argue that the act was committed for crazy reasons.

DR. MITCH YOUNG (Psychiatrist from Houston): First of all, surely you're not arguing to eliminate the academics to find an easier solution. Second point, the accused states, "I am a soldier in a holy war and I must kill the infidels in order for God to allow me into heaven." Am I not guilty by reason of insanity under the Integrationist Test?

SLOBOGIN: As to your first question, I'm not seeking unemployment. I do think, unfortunately, that academics are too often ignored by the legal system. As to your second question, you're right, the Integrationist Test require analysis of whether the persons that committed the offenses of 9/11, had they survived, had a defense, although it wouldn't be called an "insanity" defense. And the question for the jury would be, "Is it justifiable to kill 3,000 people to get rid of the infidels?" What do you think an American jury would say in response to that?

Thanks very much. [APPLAUSE]

AXELRAD: Thank you, Professor Slobogin. We're going to have a ten minute break. It's now 10:11. In ten minutes, at 10:21, we'll be back starting with our next speaker. Thanks.

[10 MINUTE BREAK]

AXELRAD: Brian Shannon. He is the Associate Dean for Academic Affairs and the Charles Tex Thornton Professor of Law at Texas Tech University School of Law, where he has been a member of the law faculty since 1988. He earned his JD degree in 1982 from The University of Texas, graduating first in his class, by the way, in Law School, and he received a B.S. from Angelo State University in 1979. Prior to joining the Texas Tech Law School, he practiced at the Office of General Counsel for the Secretary of the Air Force at the Pentagon and at the Hughes and Luce Law Firm in Austin. In the mental health field, Professor Shannon has served as Board Chair for the Lubbock Regional Mental Health and Mental Retardation Center, where

he has been a Board Member for over ten years. He is the Past Chair and current Vice Chair of the State Bar of Texas Disability Issues Committee, and he's a former member of TEXAMI, now known as NAMI-Texas. And he happens to be the son of Jackie Shannon, one of the founders of NAMI-Texas. She's here with us, by the way. He's also served with the Texas Council of MHMR Centers and Advocacy, Inc. He was appointed by Lt. Governor Ratliff to serve on a task force to study and report on competency evaluations in Texas, which at the present time is in the form of a bill that has been authored by the task force that Senator Duncan has been chairing. He is a frequent speaker and writer on mental health law topics, and he teaches a law and psychiatry seminar on a regular basis at Texas Tech. He is the co-author of this book, *Texas Criminal Procedure and the Offender with Mental Illness, an Analysis and Guide, Second Edition*, which was made possible by a grant from the State Bar. And I must share with you that every forensic psychiatrist who practices in Texas should have this book, and it's published by NAMI-Texas and the Texas State Bar. And it's still in print, correct? Professor Shannon, the people can still get it?

SHANNON: Actually, they're gone. But it's on-line.

AXELRAD: It's on-line. All right. Anyway, Professor Shannon is here to speak with us on expanding the insanity test to include the Volitional Prong. Professor Shannon.

[APPLAUSE]

SHANNON: Thanks David. Since he mentioned the book, I know I can't plug it, because I can't give them away any more. These were Texas Bar Foundation funded projects, the first edition and second edition. There were several print runs, but they were all given out. The text, however, is on-line. I'm sorry I don't have that in the slides. But it's <http://www.noelke.org>. Mr. Noelke is actually a colleague, and former student, in the State Bar Disabilities Issues Committee. He parks it on his own web site. But you can get there through Google. We didn't seek another print run because we're hoping that it will be very out of date after this Legislative Session, and that we'll be going back to the Bar Foundation for another grant opportunity or writing opportunity.

It's a thrill for me to be on this program. When David first called me I thought it was an excellent idea to put on this program. And, it's also fun for me to get to meet some of those folks whom I've only seen their names in print or talked to on the phone in the past. In fact, when I first learned about this conference, I realized that in my own law and psychiatry seminar I was using the casebook that was co-authored by Professor Slobogin. I was also using the little

booklet on John Hinckley and the insanity defense co-authored by Professor Bonnie, and we studied in detail a case involving Virginia and its Board of Law Examiners where Dr. Zonana was the chief expert who testified in the case. So, it's a thrill to be here. And, I also have gotten to know Dr. Scarano over this last year working on the Task Force and through the Disability Committee. It's also great to see some old friends here today as well as a number of former students. Then finally I have to say, "Hi, Mom."

Law schools are, of course, great for jokes that quickly circulate through the building, as well as rumors. We won't go there. But one of the jokes that went through the building the other day was, "Why is it that in Iraq right now they're shutting down all the Wal-Marts and K-Marts?" "Because they're turning them into Targets." [LAUGHTER] Not particularly pertinent to today's topic. But, I bring it up for the reason that when we think of the big insanity defense cases and when the public has talked about the insanity defense and has been interested, that has been when the case has taken the forefront in the media. Today, of course, the stories are nothing but stories about Iraq and the potential for war in Iraq. And, when some high profile case, often a homicide situation or one of those notorious cases that we've discussed, takes center stage in the media, that's when we again start talking about the defense.

In the past, going back to the M'Naghten case, for example, that was a high profile case. "Somebody got away with murder." 1983, Hinckley. "Somebody got away with it." It's ironic that when we're now focusing on whether we've gone too far with this pendulum, it is when another high profile case was in the media. Of course, we're here because of the Andrea Yates case. And, that's why we're focusing on this. Should that be the case? Should we have waited for another case to see if the pendulum has perhaps swung too far? I think that's the only time it will happen, because it's front, center stage. Perhaps the case will be a catalyst for reform. At the very least, it should be a catalyst for thinking about these issues - a catalyst for discussion.

Some of the facts that Dr. Zonana talked about earlier, I'm not going to reiterate at this point. But some of you, like I have, have had the opportunity to hear some of the defense lawyers talk about the case. George Parnham spoke at the NAMI-Texas conference in September, and brought with him the audio tape that was played at the trial, which was, of course, recorded by the 9-1-1 operator. He also talked about some of his initial interview. It's remarkable to me, hearing that tape and the flat affect, the monosyllabic responses that were being given to questions. When a very capable, one of the best investigators in the Department as I understand it, was questioning her, and he got to the question about why she killed her kids, the tape just rolls through this long period of silence. Even some of the videotapes, which of course weren't taken right away, but after some of the treatment began a few days later, again, showed these classic symptoms—flat affect, detachment, and the like. At the trial, in part of the closing arguments, defense lawyer Wendell Odom identified that a number of the 34 doctors that

we heard about talked about her being one of the sickest patients they had ever seen. And, George Parnham - as part of the defense's closing arguments - also added, "If Andrea Yates doesn't meet the test for insanity, then nobody does. We might as well wipe it from our books."

In Texas, as we've talked about, the defense is effectively gone, or has been since 1983. Although in some cases there are NGRI acquittals, and Jim Smith will be talking about some of those in recent years and the processes that take place, the vast majority of those are in cases where there's been concern by the prosecutor that, "Yes, this person belongs in the hospital." And the matter has not been contested. When the defense is contested and goes to the jury, we've got, obviously, the narrowest form of the M'Naghten Test, plus a number of other types of narrowing. And quite frankly, some of that was, of course, the reaction to Hinckley. As I will talk about, "We fixed it." It's like in the 1840s after Daniel M'Naghten's attempt on the Prime Minister and the killing of the secretary. Queen Victoria was aware that she might be next! "We don't want to have this open door. So, let's fix it. Bring in some experts and narrow this test. This guy got away with it." And Congress after Hinckley, "It's gone too far. The pendulum has swung too far." Again, in '83 and '84, among many states, "We've got to fix it. This far opened trap. People are walking out the door, going scott-free." And, of course, we've heard already this morning, it's largely meaningless—seldom raised, seldom successful, typically only successful, at least in this state, when there's some type of agreement.

Let's look at that Texas test. The variation. Texas has only the M'Naghten standard, but a narrow form of M'Naghten: whether as a result of severe mental disease or defect, the actor did not know that his conduct was wrong. Of course, Professor Bonnie will be speaking to us in a little bit about the choice Texas made as to "know" versus "appreciation," which is the federal approach. As we've heard already, the federal test is arguably a broader approach, with our "know" being interpreted as the least, narrow approach that there is.

It's also a test involving knowledge of a legal wrong. What do we mean by legal wrong? One description that I've read on several occasions is whether if the conduct had taken place with a policeman sitting in the room, would the actor have some sense that, "Oh, I'd better not do that," at some level. Then, we have the "B" part of our statute that's not talked about too much, but basically excludes the repeat criminal behavior, the anti-social personality disorders, and the like that's spelled out.

For ten years Texas experimented with a broader test. We adopted a variation on the ALI test as part of the adoption of the Texas Penal Code in 1972. It became effective then, in 1973, and it lasted for a decade, until after the Hinckley trial. It was different in some ways from the ALI test. We had it as an affirmative defense. The burden was on the defense to go forward with the test, which was not necessarily the ALI approach. We also had retained a "did not know" formulation, so when there was the change in '83 eliminating the volitional prong, we left

the narrower “did not know” language. But, the ALI’s “appreciation” approach had not been adopted at the beginning. This was the test in 1983. Plus, in Texas we didn’t have the “lacks substantial capacity” language that we saw earlier. Instead, it talked in terms of “as a result of mental disease or defect,” with no reflection of “lacks substantial capacity to appreciate it,” etc., that we saw in the ALI test.

But for 10 years, we had this approach. Was it used very often? No. Studies that were done prior to the changing of the test talk about how in the year immediately preceding the elimination of the two-pronged approach, there was something in the order of, I believe, ten NGRI acquitees within the state. Not a vast number of folks. Of course, we then had the John Hinckley situation. And, I remind my students that Hinckley had been a Texas Tech student at one time. And one of the, I guess, rallying cries for Tech, maybe our own variation of UT’s “Hook’em Horns” is “Guns up.” So we talked about John Hinckley and, you know, “Guns up. Texas Tech. Okay.” They sign my paychecks. And I’m a loyal Red Raider and the like. Although I do remember hearing about capacity to control one’s conduct and the like and worrying about anger management issues and our basketball coach. But that’s for another-- I must say, he’s been very successful and he’s sold a lot of tickets.

In addition to the Hinckley situation, it’s interesting to note the bill sponsor for the 1983 legislation - Ray Farabee. And, for some of you who have followed mental health policy in this state over many years, you’re all familiar with the Farabee name. Of course, Helen Farabee was an integral part of the creation of our Mental Health Code in this state, and she was very involved in that during her lifetime. In fact, the MHMR Center for the Wichita Falls region is the Helen Farabee Center, and that district now is well represented by her son. Well, certainly then Senator Ray Farabee is well known to many of you, as well, and continues to work for The University of Texas. He was also the sponsor of the Texas reform legislation in 1983, which came as a bit of a surprise to me knowing some of the other involvements of his family in mental health law. And, one of his motivations for acting wasn’t necessarily the Hinckley case, but in this regard, there had been a situation, a case, that had arisen out of the district in which he resided roughly contemporaneously with the Hinckley decision. The irony is real when we think about Andrea Yates. It involved a case where a woman, who was suffering from post-partem psychosis, had cut out the heart of her young daughter to exorcise a demon, and had been found not guilty by reason of insanity. I don’t know further background on whether this was a case that was largely uncontested by the prosecution or not. What caused the notoriety was that around the same time as the Hinckley case, this woman had been released from the state hospital after two years. And this led to much discussion, concern, etc. Senator Farabee said his primary reason for getting involved was he wanted more procedures post-acquittal. Thus he was necessarily focusing on what our statute said, but what do we do afterwards. And we’ll hear

much more about that from Jim Smith later today. That's been our law, and the changes in our law from 20 years ago. Now, 20 years later, we have the Andrea Yates case and we're looking at it again.

As part of the "reform" efforts in 1983, we, of course abandoned the volitional prong. We got rid of this "capable of conforming conduct to law" language, which was consistent with the direction of the U.S. Congress a little later, as well as many other states. Clearly Andrea Yates, at some level, knew right from wrong. But as we've heard and talked about, did she at least at some level know what she was doing was wrong? Did she really appreciate it? Understanding that she had to do it to save them from hell, etc.? Some of the comments of the jurors afterwards (of course, who were instructed on the right/wrong test), I thought were interesting. And, a lot of popular media quickly interviewed these jurors. As I quoted in the paper for you, one juror stated, "Andrea Yates in her interview said she knew it was wrong in the eyes of society. She knew it was wrong in the eyes of God. She knew it was illegal. I don't know what 'wrong' means if all those three things aren't factored in." Another juror said, "She was able to describe what she did. I felt she knew exactly what she was doing. She knew it was wrong, or she wouldn't have called the police." And a third juror, consistent with that sentiment, said, "I think she should be punished for what she did, considering she did know right from wrong. I think prison is the way to go." Well, I don't think that's terribly surprising to any of us given the narrowness of the test - the right/wrong test that we have under Texas law.

Of course, in 1983 the volitional prong was eliminated. Some of the rationale for that, something that was talked about at the time, was that diagnostics were not where they are today. DSM III and the like were certainly distinct from what we see now. The doctors could probably tell us far better than I that it's not a hard science, but there have certainly been vast improvements with the DSM IV and current variations in terms of diagnosis. Also, confusing expert testimony gave a potential for conclusory opinions. We've heard about some, and the ultimate issue has been talked about somewhat. The occasional mistakes were related to the open-ended nature of the volitional prong more often than otherwise. I think at the bottom of all of it, and this hasn't really been talked about, is that in actuality the policy was set by poll. There was outrage. Just like Queen Victoria and the folks in England; John Hinckley was another notorious case with outrage across the country. "We've got to fix that. The prison doors are being thrown wide open." At the time that the Farabee bill was filed in Texas, a poll in his district said 90% supported elimination of the insanity defense. I suspect that similar polls were taken generally—there's some literature where these are done. There are still high numbers. High numbers of people have misconceptions that it's a wide open door. I think if we also took a poll today on should there be some retooling of the insanity defense, a revamping in light of the Andrea Yates situation, I doubt if you'd have a very high response even there. There were

some informal things suggested, but again, there's not been the huge outcry. Yet in terms of setting policy, is that the best way to go in terms of coming up with policy that seems to be morally right or appropriate? Policy by polls?

Of course, we also had some of the problems that I won't go into much, such as the notion of whether there was an impulse resisted or not, whether you can really tell, some of the other uncertainties that were there, and some of the things that Christopher Slobogin set forth in attacking what was wrong. With respect to the prospect, though, of restoring the volitional test, I need to give credit to my co-author Daniel Benson, regarding the chapter of our book that was focused on the insanity defense. He largely drafted it. I concur with his positions there and I just wanted to make some reference to his work.

Ironically, the volitional test has never been abandoned in Texas for juveniles. In fact, not only was the volitional prong retained for juveniles, the ALI type test, it never changed. I've always speculated that perhaps it was just an oversight in the rush to change it for adults. Nonetheless, it was retained for juveniles. In fact, in 1995, the Legislature came back and re-tooled the provisions for juveniles to provide updated language. So in the current language in the Family Code in Texas in Section 55.51a, we got rid of the antiquated terms "mental disease or defect," which I think is very highly stigmatizing and is problematic in itself. The statute now talks about "as a result of mental illness or mental retardation." It also has the "lacks substantial capacity" language that's pure ALI. And, it has the word "appreciate," which doesn't show up for adults, as well as the volitional prong of "incapable of conforming conduct to the requirements of the law." So, that's the juvenile test, but when they're older, or if tried as an adult, that test is not there. It's an interesting dichotomy in the approaches that have been taken.

So one possibility is to consider is that if it works for juveniles in this state, it doesn't seem to be much of a problem. The Legislature, in fact, in '95 re-adopted and bolstered the provision, using some updated language for juveniles. Why not carry that forward for adults? It's one possibility.

Also, with respect to considering the prospect of restoring the volitional test, even at the time of elimination, although there had been some anecdotal theories and the like, there had not really been findings of systematic abuse of the ALI test, no systematic abuse, no wide-scale indications of problems. There were concerns, that we've talked about already, about the exclusion of defendants with serious neurobiological mental diseases. These concerns were in terms of whether that was an appropriate response or not. Professor Bonnie, of course, whom we'll hear from in a little bit on the appreciation aspect of the defense, also raised a lot of the concerns about the volitional prong. Even Professor Bonnie, however, in a very important piece in the ABA Journal, stated that the volitional test could probably be manageable if the insanity defense was permitted in cases involving psychotic disorders. Perhaps though its language was

so broad that the risk of error was present. Although, again, there was not a lot of evidence of systematic abuse. But even there, are we narrowing it too much by eliminating the possibility of applying the defense to persons with psychotic disorders marked by delusional issues and the like?

Well, I'll certainly advocate some change. I think the current test is largely meaningless. It's very interesting to me that most of the writers and commentators have by and large opposed the notion of "guilty but mentally ill." The rationale for that is because the aftermath of a guilty but mentally ill finding is that once the person is found guilty, the person is in prison and treated in a prison setting as opposed to a hospital setting - although it may be in all likelihood a hospital setting within the prison. The ABA certainly was opposed to the notion of guilty but mentally ill. I submit that's what we have in Texas. The right/wrong standard as we've got in Texas coupled with some of the other matters, except for the situations where the prosecutors agree, isn't going to be successful in jury trials except in very rare kinds of situations. So, for all practical purposes, we've got a "guilty but mentally ill." Individuals who are found guilty do end up, not immediately always, but eventually, within the psychiatric facilities within the prison system. For example, outside of Lubbock we've got the 550- bed Montford Unit, as many of you know, that's set up for men within the TDCJ prison system who also have psychiatric problems. Now, for some of those folks the mental illness didn't manifest itself until after conviction. But for all practical purposes, I think that's where we are.

Under our current test, mistakes can and will be made without the volitional prong. It limits some of the areas of the inquiries. This is particularly true with the cognitive test as we have it with its narrow right/wrong standard. And, from my understanding, diagnostics are much improved, and they're only going to get better in time. We've learned more about the brain in the last 10-15 years than in all of history. Think of the time when M'Naghten was established, 1843; think of the state of the medical profession at that time. I assume there were the humors and the bleedings and the leeches (oh, and leeches are back, by the way). But, the more enlightened teachings of the Isaac Ray and the like were cast aside through the political judgment that was present at the time. We're far more advanced than we were at that time, and things are going to improve.

So I've tried to think about ways in which we might come up with some possible amendments. One way would be to just flat-out adopt the juvenile test for adults. But, perhaps it ought to be done in a more tailored approach. And so in creating a possible amendment that I included in my paper, is that we take the current test, as we have it now, include this prong about cognition, the "know" test. Of course, I'd rather see "appreciate" as well. But, my talk today is supposed to be on volition, so we'll learn more about "appreciate" from Professor Bonnie. But, I support that entirely. And, then I propose adding a form of the volitional prong that tries to pick

up on Professor Bonnie's idea that we limit it to situations, or at least make it available in situations, where we're talking about persons with severe psychotic disorders. There are other variations, I'm assuming, that we might improve upon. I suggest talking about the actor's lacking substantial capacity to conform the conduct with the requirements of the law because the individual has experienced symptoms of a serious mental illness, such as schizophrenia, bi-polar disorder, schizo-affective disorder, or other major psychotic disorder diagnosed through accepted scientific criteria. That last part is to try and roll in Daubert to try to keep it limited to valid testimony that might come in and the like. I think that that would be something to consider very seriously as a possibility for reform.

Although, again, it's academic—what a jury is going to do is another matter. As George Parnham, the defense attorney, has later written, "We can talk all day long about mental health, medications, delusions and psychosis. But by golly, when you take a picture of a 7-year-old boy who is lying face down in a tub, rigor mortis has set in, and you flip him over and you see the agony on his poor face, that's a toughie." How a jury is going to react, regardless of the test, is still to some degree speculation. This certainly opens the door to juries. And I think it gives them a better picture of the issues that may be present.

I also want to talk about some other possible alternatives, things that can go along or coincide. We've heard already about the pre-conceived notions of jurors. I tend to think we ought to fully inform the jury of these issues. I'll also talk about relating to allocation of burden of proof. It's an interesting area that I think merits some study. And, then, I'll address the possibility of an altogether different approach. And in answering the question Professor Slobogin had mentioned, the Oregon approach, I want to say just a word or two about that.

First, informing the jury. Why don't we trust jurors? You know, part of this I think was a reaction, again, to the Hinckley case. If you go back and read some of the proceedings from the Hinckley case, and it's well-collected in Professor Bonnie's little booklet on the Hinckley case, the law at the time in the Federal Court in D.C., included some specific instructions to the jury. So, it wasn't just left up in the air to the jurors to ask, "Well, I wonder what's going to happen to this person if we find him not guilty by reason of insanity?" There was an instruction informing them that he'd be brought back for later hearings with respect to mental commitment and the like. And, of course, we know his mental commitment has lasted since that time. There was certainly no guarantee of that under the provisions that existed in D.C. at that time, but for all practical purposes, probably were guaranteed.

But as far as the reaction, "Oh, Hinckley got away with it. Let's don't inform the juries." "We informed the jury in the Hinckley case and, 'Let's throw that out! Let's not have that.' " But my goodness, why can't we trust them? We trust 12 citizens enough that we're going to let them decide to kill somebody. And, in Texas we trust folks to do that a lot more than anyplace

else in the country. If we're going to trust our citizens to make a life and death decision, why can't we trust them with information that, "Oh, this person may go to the hospital and is not necessarily going to walk out the door?" There is a general misconception that a "not guilty by reason of insanity" verdict, without any kind of instruction by the court, will lead reasonable jurors, or most jurors, to believe that, "They're going to walk out the door. They're going to walk out the door." Of course, there's arguments on the other side. Interestingly, the ABA, as part of their recommendations, laid out both sides and concluded that the jurors should be informed. Some states allow these instructions, some don't. The majority rule probably is that they don't.

One of the arguments in support of such an instruction is that we do inform jurors about lesser included offenses. Is there the potential for confusion there? A possibility of a compromise verdict there as well? But, that hasn't seemed to be particularly problematic for example, if we instruct on both murder and some lesser included offense that might be present. We've had the same debate in Texas with respect to informing jurors about parole as well. I don't think it's a particularly big problem. I'd rather have informed juries. That seems to be, at least, fair. And this provision could be added/changed without tinkering with the actual substance of the insanity defense at all. It could stand as it's own stand-alone bill, or be coupled with some of the other recommendations. There should be this opportunity to inform jurors. So, I pulled the section that covers this. And for some reason, while I was doing my PowerPoint, it wouldn't do the nice font that shows the strike out, so I have put in italics the current language that I'd eliminate from the statute. Of course, now lawyers can't inform jurors or prospective jurors; we should change it and say they shall—the court shall, rather than the counsel.

Another possible reform, if you don't have a broader reform of the insanity defense, such as adding the volition prong along the tailored lines I suggested, is to take a look at its current treatment as an affirmative defense. That has long been the practice in Texas. The ABA has an interesting kind of two-pronged approach. If the state uses the two-prong ALI approach, then the defense has to bear the burden, in the ABA's view. Because they've got two bites at the apple, as it were—two ways to try and show the defense maybe it's more fair. But, if it is narrowed to pure M'Naghten, then the burden should be on the prosecution to avoid the risk of error. And perhaps there's a way to have some balance. I think we're on page 13 or so of the paper, if you can't see the words on the screen. There's probably too many words for the screen. I'd propose that we come up with some language as far as shifting the burden in the narrow situation. If we kept the pure M'Naghten standards, this might be another alternative to consider. Thus, where the defense is in doubt and the evidence has been produced about the delusional behavior tied to mental illness, then the burden rests with the prosecution. I would

say this is a more narrow tinkering approach than going back and adding some type of volitional prong.

The other way that I think is intriguing is the Oregon approach. Oregon uses the ALI rubric except it styles its defense as “guilty except for insanity.” This is not “guilty but mentally ill.” Some folks have adopted “guilty but mentally ill.” “Guilty but mentally ill” is just another variation of guilty. The person is going to prison, and probably going to be destined for a hospital within the prison system, but if they get better, if they’re treated, get on medications and the like, they’re doing better, any kind of relief, it’s back to the general prison population. This is much like most of our persons who are convicted who have mental illness and need treatment now within Texas. The Oregon approach is they basically have the two-prong ALI test, the pure two-prong volitional as well as cognitive test, but instead of calling it “not guilty by reason of insanity,” they’ve just changed the rubric. It’s called “guilty except for insanity.” And, I think that’s rather an intriguing thing to think about in terms of, again, jurors’ perceptions. I’m not aware of a lot of hard data in terms of their studies about differentiations of how jurors respond or don’t respond there, but I have seen it turn more on the specific facts of specific cases. But this notion, perhaps it’s a mental block, if you will, regardless of all the evidence and psychiatric testimony, it’s just difficult for a juror to check off “not guilty,” regardless of what reasons. I think that would go back to the “integrationist” approach, too. And, it may be more appealing for jurors to accept the notion of the defense if, “Yeah, they’re guilty. They did it. Guilty, but insane, or except for insanity. Except for the mental illness.”

Now, the implication, too, is that Oregon then has-- I’m not sure how close it tracks to the system in Connecticut, but they have a Psychiatric Review Board, and the person generally ends up at the State Hospital there in Salem, Oregon, for treatment. There also are some provisions, like we have, post-NGRI findings. They have more developed, post-guilty “except for insanity” procedures in the hospital setting. Plus, they have additional statutory language that tries to get at some of the worries about a broad volitional test. It’s some language that, for example, excludes anti-social personality disorder, pedophiles, gambling addictions, and the like. So they’ve tried to categorically exclude some of these individuals as well.

I’d submit there is a moral imperative to review this, whether it’s a study or something like the Oregon approach, or adding some form of volitional inquiry. My strongest recommendation is to give some consideration to changing the mode of “appreciation,” which we’ll hear more from Professor Bonnie, and trying to tailor some type of language on the volitional aspect as I’ve suggested for persons with delusional symptoms tied to an acute psychotic disorder. This is the appropriate and moral response of our society. It’s not intended as a “get out of jail free” card. There weren’t many folks, even under the ALI approach during the 10 years that we had it in Texas, and we’re still not talking about very many numbers. In

fact, the work that Senator Duncan has led involving competence and trying to rewrite our competency test and make it something modern and usable, by and large in some ways is far more important because it affects so many more people in terms of the issues that are there.

Other criminal justice issues are beyond our scope today—diversion of non-violent offenders, special needs parole, trying to have more treatment, and the fact that the local underfunded public mental health system in this state has been asked to give back 10% of existing current-year budget dollars. We're going to see more criminal justice issues. Pay for treatment now or look through the back door at some of the issues that will arise. Those kinds of issues, I think, really ought to be the ones at the forefront of the state's mental health and public mental health issues. But, as I've said, this one gets the public's attention, particularly when we have something displacing the front-page stories. And, do you know what the front-page story was on September 11th, 9-11, in the *USA Today*? It was a banner headline about Andrea Yates—her competency hearing was about to take place. And of course later, in the next weeks' papers, the news was about something very different. As long as these cases occupy some of our mindset, we do owe it to review the issue, to consider the issue, and come up with, I think, the best policy we can as a state, and I don't think we're there at this present time. [APPLAUSE]

AXELRAD: We have 10 minutes for discussion if anybody would like to make a comment, ask a question. Again, please identify yourself before you speak in the microphone. Thank you.

LYNDA FROST (Attorney from San Antonio): My name is Lynda Frost and I'm an attorney in San Antonio. I'd like to go back to your proposed amendment to Section 8.01 of the Texas Code where you're adding a narrowly tailored volitional prong. I agree with you that if you were to add a volitional prong it would be important to have it restricted in the way that you do, that it's based on a serious mental illness, in order to avoid, in my mind, that outcomes like the Lorena Bobbit case where there isn't a serious mental illness.

My question is, if you restrict the volitional prong in that way, does it really get you much more than a good cognitive prong? And in asking that, I would distinguish Texas's cognitive prong from a good cognitive prong in its interpretation of the word "wrong." That in Texas if a person has to know that their actions were legally wrong, to me, that's not an affective cognitive prong. And to me an amendment I think might be interesting would be to change that so that if the person did not know that it was morally wrong, then they would be insane. If that were the case, would adding a volitional prong, as you've proposed, give you anything other than what you would get if you interpreted "wrong" as "morally wrong" as well as "legally wrong"?

SHANNON: You've brought up a lot of issues there. Let me see if I can address, quickly, a couple of them. To ask jurors to form judgments and seek testimony about moral right and wrong might be even a greater challenge. I see a couple of doctors shaking their heads in terms of how we'd get at that. In terms of the slide I had up here about the narrow volitional prong, I think there is some need for really trying to create a tailored volitional prong. You've hit the nail on the head about whether there is some overlap with a broader cognitive prong. It brings up the appreciation concept. You know, "appreciation" without a definition, "know" without a definition, still leaves it up in the air for the jurors to guess without some degree of further discussion by the court. But, I tend to agree with you.

DR. SETH SILVERMAN (Psychiatrist from Houston): My name is Seth Silverman and I practice in Houston. I wanted to, guess, emphasize your point about allowing the juries to know what the consequences are. I had the unique experience of testifying in a case where the jury wanted to find the person absolutely not guilty by reason of insanity, but they were afraid that the person would walk. So they found him guilty of reckless endangerment and gave him probation so they knew that he would get treatment on probation.

SHANNON: That's one of the very reasons for not informing juries, at least as it's been articulated. It worries about the potential for compromise verdicts and focusing on things other than the events in question. In a situation like, Doctor, the one you raised, the jury apparently did reach a compromise verdict. I think there is some sense the person might walk, and I feel we've got some duty to protect society better.

DR. SETH SILVERMAN: Yeah. They didn't think that was in the person's best interest, to get released, because they thought he was still ill. The other thing is that I've had the opportunity to testify in a number of different states and also some federal courts, and by far the hardest definition is in Texas. And I think everybody's said that. The federal definition, I think, is much more reasonable. Plus the judges seem to be a little bit more enlightened. [Murmuring in audience] Well, it's just been my experience, is that they're a little bit more accepting of what the definition is. And then the third thing is that in Seattle I did a forensics fellowship there, and they have a wonderful system there where there's actually a dorm, a kind of quasi-hospital on the grounds of the hospital, for these NGRI acquitees. And they're actually followed much more selectively. And the problem that a number of courts have had is that there's not something in place where they know where the person can go and they're going to get followed. So that's one of the concerns, I think, the judges have had.

DR. MITCH DUNN: (Psychiatrist from Terrell State Hospital. I've trained in Maryland, which is an ALI state, and it seems to me that the volitional prong does lend itself to the potential for a greater battle of the experts because of the possibility that like trained and education individuals would simply have a different inherent feeling about what it meant to resist an impulse. And therefore, you had the opportunity for them to make subjective arguments about what they have learned growing up about being able to withhold activity, rather than necessarily taking a look at the specific actions of that individual and circumstances of the offense. The funny thing is that while that would seem to be the case, it didn't actually occur. There weren't that many battles of the experts, even though the round table at our fellowship ended up being quite lively.

JIM JENKINS: (Lawyer from Waxahachie): First of all, I recognize that this is a room full of extremely intelligent people, and I know that everybody here knows more about this than me. Therefore, this is a perfect opportunity for me to ask this question. First of all, Professor, I appreciate your prudence, and especially the part about changing the definition. But from a practical point of view, the most important thing to me is the fact that we impound 12 jurors and their oath is to determine a true verdict based on the facts, and yet we don't tell them the truth about the affect of a not guilty by reason of insanity verdict. That's always concerned me to a great extent. Now, having said that, getting that off my chest, my question to you is, since the ABA has endorsed telling them, what is the possibility that our Legislature is going to address that? Because I figure there's a lot of people here that know, is that being considered? Is it going to be brought up? Is it even in the works? Or are we just kind of talking about it in this room? Thank you.

SHANNON: Thank you. Far be it for me to presume what our Legislature will do. But I'm very pleased that some of the members and some of their key aides have joined us today, and certainly seem to have a very concerned interest in reviewing this issue. So, I think there will be attention given during this Session. The likelihood of passage I think is much more difficult to say. I think one possibility is, like the Task Force on Competency that came out of the last Session, that perhaps at the very least some similar kind of task force or study might be undertaken if something did not pass. Now, as far as the jury issue itself, the jurors' being informed, that seems to be a more direct issue that might be addressed. Given the fiscal crisis, I still suspect strongly, as those aides and members are nodding their heads, that the budget is going to dominate this Session.

DR. VICTOR SCARANO (Psychiatrist from Houston): I was wondering if you would comment on the increased burden on the defense attorney raising an affirmative defense insanity with a

volitional arm, which we know in the majority of the cases would not be accepted by the jury, and then used by the prosecution to increase punishment.

SHANNON: That's a very good question. And I always get nervous when Dr. Scarano asks a question, because it's going to be a very difficult one to try to answer, because he raises such good points. That's one of the things that has to be weighed, I think, by the defense counsel to determine the extent that his or her client is competent to be able to come up with and formulate some of the defense strategies. It will potentially open a door to such evidence coming forward, and potentially being used then down the road in punishment, etc. It ought to be weighed as part of that determination.

DR. MIKE ARRAMBULA (Psychiatrist from San Antonio): Just a couple of comments. Regarding changing the language, you know, I think most of us in this audience would agree that our state is a conservative one. And so appropriately the word "know" or "knowledge" is used as one of the criteria within the statutes for insanity. If the wording is changed, but then example diagnoses are given in which there are delusions of psychotic symptoms in all of those diagnoses, then for someone like myself who is a fellowship trained clinician, that's the same as "knowledge" or "know."

Using the word "appreciate" on the other hand, just by itself, starts taking into account things like maybe depression, possibly post-traumatic stress disorder, etc. I think that the first part can probably work as it is right now, but that there might be some give-way with what one of the attorneys suggested earlier, also within my fellowship training I learned to interpret the word "wrong" as looking at both criminality as well as morality.

There's been a firm call of the moral insanity defense, which is probably what would happen in the Yates case, i.e. that she was delusional, did something that was morally correct, but legally or criminally wrong. And then it would be up to the jury to decide whether they wanted to use one or both or other. And that could potentially soften it. But at the same time, by using the word "know," that would constrain the use of diagnoses where a psychotic symptom is present. And that's about it. That's all.

AXELRAD: You've just segued the next talk.

[APPLAUSE]

AXELRAD: Our next speaker is Richard J. Bonnie. He is the John S. Battle Professor of Law at the University of Virginia School of Law, and he is the Director of the University's Institute

of Law, Psychiatry and Public Policy. He writes and teaches in the field of criminal law and procedure, mental health law, bio-ethics, and public health law. Professor Bonnie has been actively involved in public service throughout his academic career. Among his many other positions, he has served as the Associate Director of the National Commission on Marijuana and Drug Abuse, as a member of the National Advisory Council on Drug Abuse, as Chair of the Virginia State Human Rights Committee responsible for protecting the rights of persons with mental disabilities, as an Advisor for the American Bar Association's Criminal Justice, Mental Health Standards Project, which I referred to earlier, and a member of the John D. and Catherine T. MacArthur Foundation Research Network on Mental Health and the Law, which has made major contributions to our understanding of mental health and the law and has been utilized by policymakers throughout the country. He is currently participating in a new MacArthur Foundation Research Network on Mandated Community Treatment. Professor Bonnie has served as an Advisor to the American Psychiatric Association Council and Law since 1979, and he did receive ABA's highest honor in mental health, the Isaac Ray award in 1998 for his contributions to forensic psychiatry and the psychiatric aspects of jurisprudence.

Among his many contributions was his role as the architect of the consensus position on the insanity defense endorsed by the American Bar Association and the American Psychiatric Association in 1982 and 1983 after the Hinckley verdict, and this standard was eventually incorporated into the Federal Insanity Defense Reform Act of 1984. Professor Bonnie has been deeply interested in issues involving psychiatry and human rights. In 1989, he was a member of a delegation of the US State Department which assessed changes in the Soviet Union relating to political abuse of psychiatry. In the summer of 1991 he returned to Russia as a member of the World Psychiatric Association Delegation investigating the same problem. In 1991, he was honored by election to the Institute of Medicine at the National Academy of Sciences, and he has chaired numerous Academy studies that have also been a major contribution to policymakers throughout the country, and he was honored by the Institute of Medicine with its highest award, the Yarmolinski Medal in 2002, for his outstanding contributions to the Institute of Medicine Academy and the United States.

Now, I'm going to take a Chairperson's prerogative. During the course of my career, I taught a course at the U of H Law School from 1983 to 1989 on Forensic Medicine. And I relied very heavily, as many adjunct professors do, on Professor Bonnie's writings. I am holding the book that we used in our class -- which was a supplement to his book on Criminal Law Cases and Materials -- on the John Hinckley verdict, and its implications for psychiatry and mental health. And Professor Bonnie tells me that he has a new edition of the Hinckley book, published in 2000, called A Case Study on the Insanity Defense: The Trial of John W. Hinckley, Jr. Professor Bonnie.

[APPLAUSE]

BONNIE: Thank you very much, Dr. Axelrad. This is a subject, as you can tell, that I enjoy talking about. It's going to be difficult to confine myself to the allotted time, but I'm glad that we have a panel discussion later, so I'll be able to cover any points that I can't mention now.

I want to mention a couple of things preliminarily. First, on a scale of priorities relating to mental health and criminal justice, the insanity defense is not at the top of the list. The number of people acquitted by reason of insanity is very small. Legislatures across the country need to address many more compelling problems associated with the increasing numbers of people with mental illness now being handled by the criminal justice system. So, by focusing on the insanity defense, I don't want to be understood as implying that it's the most important issue on the agenda for reform. Having said that, it's not unimportant either -- notwithstanding the infrequency with which it is raised.

What is the social value of the insanity defense? I would say that there are two important things about it. First, as the Yates case shows, it has incredible pedagogical value. Adjudications about the insanity defense create opportunities for conversations at every dinner table, in every classroom, in every seminar across the country about the meaning of responsibility. This is an exercise in community moral education. Of course, it doesn't take many of those conversations to carry out that important educational task. So this pedagogical value has to be balanced against whatever costs are entailed by insanity adjudications. But an occasional erroneous outcome, whichever way it goes, is actually extremely useful from an educational standpoint. The Hinckley case illustrates the educational value of what most people seem to regard as an erroneous NGRI verdict, and the Yates case illustrates the educational impact of what many people seem to regard as an erroneous conviction. This measure of social value is independent of whatever concerns you might have about whether justice was served in individual cases.

In short, the insanity defense is important because it keeps the public in touch with fundamental questions about responsibility and punishment. If the general rule is responsibility and the insanity defense is the exception, why is that so? And what makes the Andrea Yates case different from, to pick a name at random, the Clara Harris case? Another important lesson embedded in insanity adjudications issue concerns the nature and social meaning of mental illness. I think it enhances public understanding of mental illness. The insanity defense, whatever else it is, represents a moral concession in the administration of criminal justice to the frailties of human nature. And it is important for people to understand the advancing knowledge about the etiology of mental illness, and particularly its neurological substrates.

I do not mean to say that the message is purely one of excusing the blameless. Nor do I mean to overlook the stigmatizing effect that being acquitted by reasons of insanity can have, or the over-reactions that can occur on the dispositional end. But I think the moral importance of the insanity defense largely derives from the disabling effects of severe mental illness.

My second preliminary comment is that discussions about the insanity defense inevitably relates to two very different questions. One is the backward looking question about responsibility (what should be the criteria of non-responsibility?) -- essentially a moral question. The second issue concerns disposition (What should we do with people acquitted by reason of insanity?) They are both very important questions, but I'm only going to talk about the first one because other presentations will address the second.

Thirdly, the main point of my talk, and I think this has already been set up quite nicely, is why the "appreciation of wrongfulness" formula is the morally preferable standard for the insanity defense. My view is positioned somewhere in between the views endorsed by Chris Slobogin and Brian Shannon.

Many arguments on either side of my view were made in the run-up to my presentation, and I'm not going to have time to respond to all of them now. I'll have to resist that temptation. However, you should know that I have satisfactory responses to every one of the criticisms that Brian and Chris have raised!

AXELRAD: That's a segue to come back for the panel discussion this afternoon.

BONNIE: Okay. So in a nutshell, here's my standard account of my views on the insanity defense. Basically the first point is that there should be one. It is necessary to have an insanity defense to uphold the moral integrity of the penal law. In the wake of the Hinckley verdict, the important challenge, I think, for those of us that felt that way, was to protect the insanity defense from the abolitionists. We've succeeded, except for a few states that don't have very many people in them. Every time this issue has come up over the years, what is most gratifying is that when people reflect on the moral basis of criminal responsibility, and on the deep roots of the insanity defense in Anglo-American law and in law other countries all over the world, they realize that abolition, generally speaking, is not a good idea.

So there should be an insanity defense. However, it should be a narrow defense because, as I've mentioned before, it is an exception to the general rule that we are all responsible for our conduct. It's a very important exception, notwithstanding the infrequency with which it is raised. But it should be a narrow exception so it doesn't swallow the rule. And I think we have to understand that basic philosophical position in order to understand the debates about the insanity defense. As I've said, by asking why there should be an exception, I think we tend to

reaffirm the basic rule that everyone should be treated the same. People are all equally accountable, notwithstanding the individual differences that exist among all of us, the variations that may exist in terms of how impulsive we are, how smart we are, how quick to anger we are, how strong our beliefs in religious or political ideas might be, just to mention a few—a lot of us are different in many of these ways. But we are all accountable for the blameworthy choices we make.

So the insanity defense should be narrow – but not quite as narrow as it appears to be in Texas. In the remainder of my comments, I will try to demonstrate why this is so.

I want to make a general comment here about a framework for evaluating alternative criteria for the insanity defense and then talk about some of the alternative tests of insanity. First and foremost, in my opinion, the insanity defense must be adequate in scope to encompass the morally significant incapacitating effects of severe mental illness. I want to emphasize all of those words. What we're talking about here is a moral judgment. In every case involving an insanity claim, a moral judgment is inescapable. That's why I say that that disputed verdicts in these cases are such useful occasions for discussing issues of punishment and responsibility in breakfast and dinner conversations. Because these are judgments turn on moral intuitions, differences of opinion are inevitable. However, I think that there is a substantial core of widespread agreement. Many of the things that I'm going to say in these remarks happen to reflect my own moral assessments. But I also think, because of the many conversations that I have had over the years, that they tend to reflect a fairly general moral viewpoint.

In my view, many of the “tests” of insanity proposed over the years are too narrow because they are under-inclusive with regard to the morally significant effect of severe mental illness. And as I'll explain in a minute, I think that's the problem with my friend Chris' approach. On the other hand, I think some of the other tests that have been proposed and used over the last half-century are over-inclusive and do not conform to commonly held moral intuitions, and certainly not to mine.

The other point that needs to be emphasized is that we are talking about severe mental illness. That's what the insanity defense historically has been about. And when we've gone wrong in my opinion, it is quite often because we have failed to realize that the moral core of the insanity defense is about psychotic symptoms associated with severe mental disorders. Mental health professionals can show us, quite persuasively, that people who commit crimes are mentally abnormal in many different ways, and that they meet the criteria for all sorts of diagnoses of mental disorder under the DSM. But these disorders and abnormalities, and the symptoms associated with them, have nothing to do with the insanity defense, properly understood.

Once we have identified the types of impairments that seem morally relevant, we also have to recognize that applying any legal formula involves some risk of adjudicative error. So, the second challenge in formulating the test of insanity is to minimize the risk of fabrication, moral mistakes, and unequal administration of the law. What this means is that we have to avoid unnecessary elasticity. In these debates, someone may present a particular case and say, “Well, you know, you need to push the criteria a little bit further. You need to make it a little bit more elastic, you need to make it a little bit more far reaching, because there are cases on the margin that might not quite fit and we might get it wrong.” But of course, every time we push out the boundary of the defense, we take the risk that the resulting category is going to be morally over-inclusive. This is not an inconsequential problem, because, as I said earlier, the more over-inclusive the test, the greater the threat to the rule of law and to equal administration of the law. So a balance has to be struck, and there’s no clear right answer. However, the basic point of my talk here is that the “appreciation formula” strikes the right balance and is morally preferable to the alternatives, and I’m going to try to defend that position.

Before doing that though, I need to make another preliminary point. The insanity defense has not been very popular over the years. So, you might ask, why hasn’t it been abolished? As in the Yates case, conviction is the usual outcome in jury trials. I said the best estimate is that insanity defenses are rejected in jury trials 75% of the time. I think, somebody earlier mentioned a figure of 80% or 90%, and the available data would support that estimate, too. Whatever the conviction rate, a jury acquittal by reason of insanity, like the one delivered in Hinckley’s case, is very rare in any adjudicated case. The Yates case is typical in this respect – many people regard the Yates conviction as morally mistaken. Another case in which I believe the jury reached a morally wrong outcome was the trial of DuPont heir John Dupont in Pennsylvania a number of years ago.

Whenever there is an acquittal by reason of insanity, there is a tremendously adverse public reaction. The good thing about such verdicts, as I’ve said, is that they stimulate useful conversations about the premises of responsibility. But they also stir up latent public sentiment for abolishing the insanity defense. For the most part, however, legislators have resisted the attack on the insanity defense because the defense has deep and secure roots in our law. This is not a matter of polls, I believe. Because if you took the polls I think it would be abolished. I think what happens is that legislators and informed participants in policymaking, like people in this room, understand the deep roots of the insanity defense and its importance and want to preserve it. The quotation that we heard earlier from the Royal Commission got it essentially right. It’s just hard to imagine a humane and just penal law that does not provide some avenue of exculpation for people with severe mental disorders.

In practice insanity acquittals are infrequent. But they are not aberrational. It doesn't happen very often, but it does happen in somewhere between 1,500 and 2,500 cases per year in the United States. It is possible that the number has tended to go down in recent years. As we've heard, it has gone down in Texas; it has gone down in Connecticut. On the other hand, it's remained fairly stable in Virginia at about 35 per year. But, even that number is not inconsequential.

The insanity defense survives even in practice. So why is that? I believe that it survives in practice because of the widely shared, if not universally shared, moral intuition that severe mental illness significantly diminishes responsibility. It is of course that intuition that brings us here today.

I want to discuss this intuition. The core of the insanity defense relates, in my view, to the effect of psychotic symptoms on what I will call the experience of choosing. The mind of an "insane" person is alienated from ordinary experience. If a person is not able to understand the difference between what is real and what is not real in a waking state, they are as a result detached from the kinds of external influences that normally would be expected to shape their conduct. Although I am referring essentially to delusions and hallucinations, I don't want to tie my argument to any particular clinical formulation. These symptoms arise from a pathological process within the brain over which the person has no control, leading to mental experience that is qualitatively different from ordinary experience. Severe mental illness characterized by this symptom picture is qualitatively different from all sorts of other psychiatric abnormalities. It represents a "category difference." And we have to understand that difference in order to be able to understand why the insanity defense applies to cases like this and doesn't apply to other types of irrationality or to other types of volitional deficiencies.

Mental illness is morally significant because of the way it affects the experience of choosing, and not because it causes criminal behavior. This is a very, very important point. The criminal law is about choice. All of our doctrines of responsibility are about choosing. And if we're going to say that someone is not blameworthy for the choices that they've made, we must look at the experience of choosing. So we ask: What were the conditions under which the choice was made? Can a person be fairly blamed or not? The insanity defense has to be understood within the framework of the vocabulary of choice. Understanding the insanity defense does not require us to use a different vocabulary. In discussions about the challenge of connecting law and psychiatry, it is often said: "We've got one vocabulary for the psychiatrists, we've got another vocabulary for the lawyers, and how are we going to put them together?" I disagree. I think we have one vocabulary—the vocabulary of choice and responsibility. And we have to incorporate our intuitions about the insanity defense into that vocabulary.

The insanity defense is not a concession to determinism. If it were, it would raise all sorts of slippery slope questions, such as “If we make this concession to determinism, based on mental illness, what about other determinants of behavior, such as “a rotten social background?” My friend, Norval Morris -- former Dean of the Chicago Law School and a well-known proponent of a narrower *mens rea* type approach – has consistently pointed out that mental illness is not as criminogenic as a lot of other conditions that predispose people for criminality. So, he asks, “Why do we single out mental illness?” In response, I say to Norval, “The question we’re asking is not about causation or criminogenesis. Instead, it is about choice, and specifically about the experience of choosing. On this score, we single out severe mental illness because of its qualitatively different impact on the experience of choosing.”

Judgments of responsibility require us to ask whether a person’s symptoms of mental illness have had a morally relevant impact on the experience of choosing. Moral judgment is essential, even when psychotic symptoms have been clearly established. Sometimes, of course, the symptoms may not be clearly established. In fact, the expert witnesses in the trial of Andrea Yates seem to have disagreed about the nature and severity of her symptoms on the day of the event. But even when those symptoms are clearly established, the effect on choice is not an established clinical fact, and ultimately the adjudication of an insanity claim is going to involve a moral judgment about how those symptoms affected the experience of choosing at the time of the offense.

The moral question that one has to ask at that point is this: “What choice would we be blaming the defendant for?” I am assuming that we are considering a person who had symptoms of severe mental illness such as delusions or hallucinations, and we want to know whether the person can fairly be blamed for having made the choice that they made. So let’s consider some possibilities. I’ll go back over this after going through the possibilities briefly. The first question is this: “Are we going to blame the defendant for having psychotic symptoms?” Surely not. Surely we are not going to blame the psychotic person for having delusions or hallucinations as a result of a pathological process in the brain over which they had no control. They didn’t choose to have mental illness; they didn’t choose to have those symptoms, and surely, we are not going to blame them for having these symptoms.

Well, maybe. We might blame them if the symptoms are attributable to voluntary ingestion of some kind of drug. We might say, “Well, under those circumstances, we might blame you for having the symptoms.” Taking the drug is a blameworthy choice, and we’ll take that into account. In fact, that is the law.

Let’s put drug-induced psychotic symptoms aside, though. Aside from that, we’re certainly not going to blame somebody who had psychotic symptoms for the first time. But what

about the person who has psychotic symptoms because they failed to seek or adhere to prescribed treatment? This line of argument was pursued by the prosecution in the Yates case, emphasizing her history of illness. Dr. Zonana mentioned it earlier. So maybe Mrs. Yates can be blamed for not having listened to the medical advice she received, and for not having brought certain symptoms to the attention of her doctors. So maybe, if we are looking for blameworthy choices, we could say, "Well, maybe the homicides could have been avoided if she had sought therapeutic intervention, and maybe she can be blamed for that."

If we go down this path, however, it would open a very, very complicated inquiry, because lack of insight about one's symptoms is characteristic of the illness. And we would need to ask how many times had it happened in the past and so on. And we would also wonder about Rusty Yates' blameworthiness in ignoring her symptoms. Asking about whether someone can be blamed for having symptoms of severe mental illness is a moral quagmire, and such an inquiry is never explicitly undertaken in court – only in classrooms or seminars such as this one.

Punishing a mentally ill person for not seeking or complying with treatment raises profound problems with proportionality. You might say, "Well, from a moral standpoint, people can be fairly blamed for not complying with treatment, especially if they have histories of psychotic violence." But by blaming them for not having gotten treatment -- blaming Andrea Yates for not having come forward in order to get treatment and having allowed herself to continue to deteriorate in this way -- essentially says, "Well, we're going to punish you, convict you, for first degree murder, and possibly give you the death penalty, because of your blameworthy choice not to get treatment." That would be pretty extreme, wouldn't it? So at a minimum, the punishment would be far out of proportion to the seriousness of the blameworthy choice that she made. In any case, as I said, the law doesn't deny an otherwise available insanity defense to people who stopped taking their medication.

For present purposes, we should assume that it is usually unfair to blame a mentally ill person for having psychotic symptoms. Let's go on, then, in our search for a blameworthy choice. Even if it is not fair to blame the person for having the symptoms, perhaps it would be fair to blame them for choosing to act on the psychotic beliefs. Perhaps they were sufficiently in touch with reality to know that other people did not share their crazy beliefs. Maybe, under some circumstances, they could be blamed for not seeking alternatives to acting on the psychotic belief. A case that I use in my casebook is a really wonderful illustration of this possibility. The case involves a woman with paranoid schizophrenia who is suffering acute deterioration and is experiencing intense fear due to a psychotic delusion. She is afraid not only of what might happen to her, but also of what she's going to do to her children because she knows she is losing her mind. In order to protect her children from her own craziness, she places a Bible in front of them, instructing them to read the 23rd Psalm. She was enough in touch with reality at

that point to try to take some measures to avoid homicidal behavior toward her children. When she eventually acted on her delusions, she shot her aunt because she feared imminent annihilation – because at this point she perceived no alternative. In any event, what this suggests is that we might sensibly ask, even in a case involving psychotic motivation, whether we can fairly blame the defendant for choosing to act on the psychotic belief.

The basic point is that mental illness is not a free pass. Whether a person can be fairly blamed for choosing to act as she did depends ultimately on the degree of “alienation” -- to use language drawn from the old English cases -- or the degree of detachment from reality, to use the contemporary clinical vocabulary. However we describe it, though, the question ultimately relates to the degree of deterioration, to the intensity of the psychotic experience. How detached was the person from reality? Were they sufficiently in touch with reality to permit us to say “Even though you were psychotic, you should have restrained yourself, you should not have acted on that delusion or hallucination.” The literature on hallucinations experienced by patients in psychiatric hospitals is illustrative: Lots of people that have auditory hallucinations, including some command hallucinations. But very few people act on them because they’re sufficiently in touch with reality that they realize that they shouldn’t do it. But sometimes they do. Then we are required to ask whether they can fairly be blamed for acting on the hallucinatory command rather than ignoring it or finding some alternative.

This is why some criterion or test for responsibility is needed. We can’t just say that the defendant had some symptom of one kind or another, including delusions or hallucinations. Ultimately the moral question is going to have to be asked -- Can they be fairly blamed for having acted on that symptom? And the answer depends ultimately on a highly individualized inquiry about their experience of choosing, and about the fairness of blaming them for choosing as they did under the circumstances. This judgment can not be made in the abstract—it can only be rendered in the context of the particular case.

This analysis also shows, by the way, why the so-called “product test” is useless. This is because in almost all cases involving a psychotic symptom, the behavior is going to be related to the symptom. But for the symptom, the behavior wouldn’t have occurred. To say that the behavior was a “product” of mental illness is to say nothing. Ultimately the question is, even though the conduct was a product of mental illness, can the person be fairly blamed for having acted on the symptom? In my judgment, you cannot escape asking this question.

Thus far, I’ve tried to demonstrate that intensity of detachment from reality is at the moral core of the insanity defense. Another question, in terms of understanding the moral basis for the insanity defense, is why mental illness is morally different from other conditions that can affect “rationality” of choice. Consider strong emotions. The law expects all of us to control our behavior, even in the face of strong emotions such as rage or jealousy, however hard it may be

for the most passionate among us to maintain control. Passion can overwhelm rationality. If the law regarded irrationality as a basis for non-responsibility, overwhelming rage or jealousy might be a defense. Clara Harris might have a defense. But that is not the law. Irrationality predicated on mental illness is a defense, but irrationality due to the impact of strong emotions is not. The moral basis for the insanity defense is that the irrationality associated with mental illness is divorced from ordinary human experience and is attributable to a pathological process within the brain. Even though we understand that ordinary people can “lose control” under the influence of extreme emotion – and we may be inclined to mitigate punishment as a concession to human frailty -- that’s not what the insanity defense is about. As Oliver Wendell Holmes said, regardless of how emotional we are, and how weak our will might be under certain conditions of temptation, we are all expected to “rise up to a certain height.” The general rule is responsibility, and each of us can be fairly blamed for failing to resist the temptation or for losing control of our anger.

The law also expects us to conform to the basic rules of organized social life, however strong or fanatical our beliefs. People who bomb abortion clinics because they believe that what is going on in those clinics is murder, are expected to conform to rules of the society, however intensely they may feel, and however difficult it may be for them to resist that temptation. If Ted Kaczynski is not mentally ill –as he claims -- his ideological beliefs are irrelevant to the penal law because he would be expected to find peaceful ways to promote them. Fanaticism, whether religious or political in nature, is not what the insanity defense is about. Fanaticism is not insanity. People are expected to conform to the norms of the society. The exception, a very narrow exception, is for mental illness, and this is because of the pathological process within the brain that generates psychotic symptoms, not because of the religious or political content of a person’s irrational beliefs.

Psychosis can break the connection between internal reality and the social world. And that is an essential condition for blameworthiness. In all those other cases that I have been discussing, that connection is intact. With psychosis, it is not. And an essential condition for blameworthiness is being sufficiently in touch with the social world to be responsive to the kinds of influences that can be expected to deter harmful behavior and otherwise keep strong emotions and beliefs within acceptable bounds. And psychosis prevents that, or can prevent it in particular cases.

Now lets return to the possible legal tests of insanity. I want to collapse the tests that we’ve hearing about here into four possibilities. Obviously there are lots of other variations, but I am going to describe them as four increasingly inclusive alternatives.

Alternative number one can be summarized as follows: “Symptoms of mental illness are relevant only if they negate *mens rea*.” This test focuses primarily on impaired perception of the

circumstances or consequences of one's conduct. It is typically characterized as "abolition" of the insanity defense because no special rules apply to mental illness. The example that Howard gave earlier involved the person who thought that his spouse was a mannequin. Another example came up in an English case in which the defendant thought that his girlfriend was a serpent and stuffed cloth down her throat. These bizarre cases involve defects of perception. But obviously very few cases of this kind actually arise. If defects of perception were all that mattered, this test would omit 99.9% of the cases involving severely incapacitating mental illness, which virtually always involve delusional motivation, not defects of perception.

Alternative number two provides as follows: "Symptoms of mental illness are relevant only if they impair the defendant's capacity to know that the conduct was a crime, or that people are punished for doing it." This is basically the *M'Naghten* formula. Although I don't have time to go into all the details, I think that the "integrationist approach" proposed by Chris Slobogin is basically similar to *M'Naghten* because it takes into account subjective beliefs, delusional motivations, that would not be taken into account by *mens rea* concepts. I say this because, by and large, *mens rea* has an objective floor. *M'Naghten* is designed to reach cases of delusional motivation that otherwise do not have exculpatory force using traditional *mens rea* concepts. But note however -- and this was very, very clear in what Chris was saying -- delusions have exculpatory force under a narrow interpretation of *M'Naghten* (and under Chris' view) only if the defendant's delusional belief tracks the moral content of the penal law. This is its distinguishing feature.

So understood, *M'Naghten* is a very narrow cognitive test. The defendant has no defense, however detached from reality, as long as he "knew" that his conduct was punishable as a "crime," or -- to be more precise -- as long as his illness did not impair his capacity to know that the conduct was a crime. Because the anchor point for asking the question is the norms that have been prescribed in the penal law, I believe that this test ignores the morally incapacitating effects of severe mental illness. When people have delusions, they have absolutely no control over the content of their delusions, and have absolutely no capacity to conform their delusions to the norms of the penal law. As a result, a narrow cognitive version of *M'Naghten* (and the integrationist view) draws arbitrary distinctions among equally severe symptoms, among equally distorted and irrational delusions, and among equally intense delusional motivations.

I do not want to be misunderstood on this point. The lines drawn by the penal laws are not arbitrary -- indeed, they are determinative under the rule of law: that is, they decline the obligations of people who are in touch with reality and who are expected -- indeed commanded -- to conform to them. But the synapses of the brain have no connection to the penal law. If we are to take adequate account of the morally incapacitating effects of severe mental illness, we have got to assess responsibility from the perspective of the psychotic person. From this

perspective, the morally relevant evidence relates to the intensity of the deterioration and the degree to which the defendant was detached from reality, not to the particular content of the delusion. And that fundamentally is the problem with *M’Naghten*, at least if it’s given a narrow interpretation. And I believe that this is also the problem with the approach that Chris has taken.

So this brings us to alternative number three. Under this view, “Symptoms of mental illness are relevant if, and only if, they impair the person’s capacity to appreciate the wrongfulness of her or his conduct.” The term “appreciate” is meant to signal a deeper understanding of the significance of the conduct than simply recognizing that a person can be punished for doing it. The question is whether this abstract knowledge (that “other people think the conduct is wrong, and I can be punished for doing it”) is connected in any morally meaningful sense to the delusional person’s feelings and thoughts, and to the experience of making choices about acting. When you look at the experience of choosing through the prism of distorted and psychotic thinking, did the defendant appreciate the wrongfulness of the behavior? Was the defendant able to connect his or her internal experiences, and feelings and beliefs, to the normal reality of the external world? That’s the issue. Is there a connection between the two? Because psychotic persons are not asleep, they’re aware of some parts of the external world. But can they connect the experiences that they’re having to what they know about the external world? This affective test is meant to reach a person who due to mental illness has become unresponsive to the moral realities ordinarily expected to illuminate why their conduct is wrong and thereby to deter it.

At this point it might be pertinent for me to say, in relation to what Chris said before, this is what “appreciation” means when we’re thinking about psychosis. As I’ve said before, the moral basis of the insanity defense relates essentially to psychotic disorders, to severe mental disorders. It is perhaps theoretically accurate to say that a free-standing “appreciation” test, not predicated on a psychotic condition, might include psychopaths. But that’s not what I’m proposing, and that’s not what the insanity defense is for. The insanity defense is for people with severe mental disorders. In this context, the appreciation test aims to take adequate account of the morally significant effects of delusional beliefs and hallucinations experienced by people with severe mental disorders. So, whether people who bomb abortion clinics and victimize other people without guilt “appreciate” the wrongfulness of their behavior has nothing to do with the insanity defense.

Let me sum up my comments about the first three tests: The first, the *mens rea* approach, is morally under-inclusive because it takes into account only defects of perception. The second, the narrow cognitive version of *M’Naghten*, takes into account some delusional motivations, but only when they track the moral content of the penal law. It is for this reason morally under-inclusive as well. The third test, the appreciation of wrongfulness test, tries to avoid under-

inclusiveness by looking at the blameworthiness of the defendant's conduct through the defendant's eyes and asking whether he or she was sufficiently connected to reality to appreciate the moral significance of his or her actions.

The fourth alternative finds the appreciation formula to be under-inclusive as well because it fails to take into account volitional impairment. Under this view, the insanity defense should be available "if and only if if the symptoms either impair the capacity to appreciate wrongfulness or the capacity to conform behavior to the requirements of the law." As you know, this is the test proposed by the American Law Institute in its Model Penal Code. By adding a volitional prong, it implies that mental illness may deprive a person of the ability to refrain from engaging in conduct even though it is recognized to be wrongful.

My view -- which as you heard, was endorsed in the early 1980s by the ABA, by the APA, and remains ABA and APA policy even today, and was also embraced by the Congress in 1984 -- is that the appreciation formula is both necessary and sufficient to encompass the range of cases for which exculpation should be considered. That last phrase ("cases for which exculpation should be considered") is very important. No test is going to dictate the outcome. We have to hear the evidence, and we have to think about how detached from reality any particular defendant might have been at the time of the offense. The test needs to be framed in a way that gives defendants a fair opportunity to present relevant evidence, including expert testimony, and to obtain full consideration of the morally relevant features of their illness by the judge or jury. On the other hand, we have to be sure that we don't go further and open the door to cases for which exculpation really should not be considered. In my view, the appreciation formula is both necessary and sufficient. As long as evidence of appreciation is fully considered, there is no need to open the door to volitional testimony.

The appreciation formula is morally necessary for the reasons that I've been discussing. Because the *mens rea* and purely cognitive approaches are morally under-inclusive, the law must be sufficiently flexible to take account of the clinical realities of severe psychotic deterioration. Those approaches draw morally arbitrary distinctions among psychotic symptoms, such as delusions that do and do not track the content of the penal law, or between perception and motivation. The appreciation formula is morally sufficient because volitional claims are superfluous in morally compelling cases of psychotic deterioration. We had a discussion about this in the previous session with Brian. Over the past two decades, proponents of the volitional formula have described cases involving people who were psychotic and said to me: "We need the volitional prong to include this case." My response, uniformly, has been that the described case can be fit within the appreciation formula. Moreover from the standpoint of rational adjudication, the argument is better framed by putting it in these terms than it would be in using the language of the volitional prong.

In short, I think the volitional prong is superfluous and confusing. True volitional claims are not morally compelling and a test without a volitional prong is not morally under-inclusive. Pure volitional claims without psychotic symptoms, such as kleptomania or pyromania do not warrant exculpation. And then finally, even if a test without a volitional prong would be morally under-inclusive, the price is too high. In this context, we have a significant risk of mistakes. Lorena Bobbit's insanity acquittal is, in fact, an example of such a moral mistake.

Now, I want to say a couple of words about the Andrea Yates case. The terms "know" and "wrong" in Texas law could be construed to mean "appreciation of wrongfulness" in the sense that I have discussed it in this talk. And this has been done in many jurisdictions all over the common law world. Courts interpreting *M'Naghten* have to decide what "know" and "wrong" mean. They're both important if the formula is to be given a morally proper interpretation. Superficial understanding that one will be apprehended and punished is too narrow. However, many courts have rejected this interpretation and said that "know" refers to a deeper understanding, and that understanding that one's conduct is a crime does not mean that the person understands that it is "wrong." Similarly, the Model Penal Code insanity formulation gives legislatures a choice between "wrongfulness" and "criminality." "Criminality" is too narrow because it ties the test to the content of the penal law. By using the term wrongfulness, the law directs the judge or jury to look at the world through the eyes of the defendant.

Thus, Texas law could be interpreted to mean that the defendant was insane if he or she was unable to appreciate the wrongfulness of the conduct at the time of the offense. The testimony of the expert witnesses and the closing arguments of the prosecution and the defense perfectly tracked the difference between the narrow cognitive test and the affective "appreciation of wrongfulness" test. As you've heard, the prosecution said this: "She knew what the law was. She what knew what other people would think. She knew that she was going to get arrested. She, in fact, wanted to be executed." So she knew it was wrong. End of discussion. By contrast, the defense said this: "Yes, but that knowledge wasn't connected to the reasons she did what she did. In fact, it was connected only in the irrational sense – that only by doing what others saw as wrong could she do what she knew to be right. She wanted to save her children from eternal damnation, and killing them was the only way that could be avoided. She didn't appreciate the wrongfulness of her behavior because she thought it was right."

These arguments reflect two different understandings about the meaning of "knowing" that what one is doing is "wrong." One is of these interpretations is erroneous and one is right. They can't both be right. Under these circumstances, it is imperative that the jury be told what the law means, as many, many jurisdictions have done. The problem is that courts in Texas have not said what it means. As a result, the meaning of the law was thrown up for grabs in the Yates case. The jury was left to decide, on its own, without any guidance, the meaning of "know" and

“wrong.” In effect, they were asked to decide whether the law of Texas was alternative number two or alternative number three in my menu. The jury was left to choose between these two different views, and to resolve a profound ambiguity in the law. Leaving it to the jury is not the way this very important issue about the meaning of criminal responsibility should be resolved. This was the court’s job.

Does Texas law need to be changed? Well, perhaps not. The Texas Court of Criminal Appeals could resolve the ambiguity in current law by elaborating on the meaning of “know” and “wrong,” embracing the affective interpretation. I hear chuckles, reflecting some skepticism about the inclination of the Court of Criminal Appeals to take such an innovative path. Maybe that won’t happen. If the Legislature is so minded, it could explicitly embrace the appreciation formula with accompanying legislative history about its purpose in doing so.

I should close by emphasizing, however, that even if the jury had been given an appreciation instruction, it still might have convicted Andrea Yates. Juries are naturally skeptical about insanity claims. Ultimately a moral judgment about the degree to which Ms. Yates was detached from reality and the degree to which we could fairly blame her for having acted on her delusions, are questions that somebody needs to answer. In our system, it’s the jury. So I am not staking out a strong claim that the jury got it wrong. What I am saying, without equivocation, is that the jury was not adequately instructed to clarify the question that they were expected to address. Under the narrow cognitive view, she was probably guilty. However, under the appreciation formula – the correct one in my view -- even this jury might have declined to convict her.

[APPLAUSE]

AXELRAD: Before we open for questions and answers, I need to recognize Representative Gordon Coleman. This will be no secret to Texas citizens, but Representative Coleman has made a major contribution to mental health legislation in the State of Texas, and he’s also a Jacob Javits honoree of the American Psychiatric Association, and he’s also been honored by our Association for his outstanding public service. Questions and answers for Professor Bonnie? And please identify yourself.

PATRICK WILSON (Ellis County District Attorney’s Office): This question about morality is certainly interesting. I think it’s legitimate here in a room full of doctors and lawyers and academics. But don’t you think the moral question that a jury is engaged in is actually simpler in that regardless of the morality or the motivation behind an individual’s actions, and the reason for holding them accountable for those actions, the immorality of the action itself is so severe

that there must be moral consequences for those actions? And in fact, don't you think that's probably a more likely thought process a jury is engaged in? As an example, Andrea Yates, they may have been free to accept that she's insane, for whatever reasons she committed her act. But the act itself was simply so heinous we cannot excuse it for any reason and she must be held accountable for those actions.

BONNIE: Well, as a description of what may be affecting jury judgments, I'm not in any position to deny that. I mean, that may be ultimately what happened in the case. The point was made earlier that if you're just standing outside the system and observing it, the most notorious cases are of course the ones that involve the most heinous crimes, and they are least likely to result in an insanity acquittal, no matter how strong the symptoms or how powerful the evidence might be. So you may be perfectly right in predicting that that's what juries are going to do, and why prosecutors ultimately feel that they have to contest an insanity claim in such a case, no matter how strong the claim may appear to be, clinically speaking.

On the other hand, I am aware of cases throughout the country which involved pretty heinous crimes, where there was a great deal of community sentiment in favor of a conviction, and which nonetheless resulted in acquittals. Let's not even talk about Hinckley, which is certainly one of a kind. But other insanity acquittals have come to my attention which have surprised me, given the natural skepticism that a jury is going to have about insanity claims and the moral sentiments favoring conviction. As policy-makers, our job is to try to get it right as a matter of moral principle, and then turn it over to the jury and ask for their judgment.

AXELRAD: Any other questions for Professor Bonnie? Everybody wants to go for lunch I see.

[LUNCH BREAK]

AXELRAD: We're about ready to begin the afternoon program. I have the distinct honor and privilege of introducing Jim Smith, who has one thing in common with John Hinckley, and that is they both attended Texas Tech University, except he graduated and pursued further training as a social worker. Jim and I go back to 1991, when I was appointed to the Quality System Oversight Team for the Class Action Lawsuit R.JD Jones out of Judge Saunders' Court in Dallas. And I have continued to work as a consultant for this program ever since. I've been informed this past week because of the budget shortfall they're going to cancel my contract because they don't need the contract employees anymore at MHMR. But I've had an occasion to have ongoing experiences with Jim, hearing the application of his instruments for quality assurance at Vernon State Hospital. And of course, it's in Jim's paper. Jim's hospital, which is

a forensics hospital in Texas, was the first hospital to exit the lawsuit because they met the appropriate quality criteria that this program administered. And he has continued to serve as the Superintendent of the forensics hospital here in Texas. He's such a good administrator they actually had him also administered another hospital in Wichita Falls. So both hospitals are called the North Texas State Psychiatric Hospital, and the Vernon Facility is the Forensics Facility. And Jim is given the responsibility to look at the whole area of disposition, which of course is an ongoing subject of concern in most jury deliberations when it comes to the question of insanity, even though they're not entitled in Texas to know what happens after you find somebody insane. Jim.

SMITH: My wife, Julie, who is here, and I have a 12-year-old son and a 10-year-old daughter. I mention that because a lot of folks say that my 12-year-old son is sort of like me. That really has encouraged me, for the sake of the upbringing of our son, to demonstrate that I have sense of humor. So I've been working on that, and some time ago I saw a speaker at a conference use this quotation before, and I thought that I'd put it up here and maybe someone would chuckle. If you can't see it on one of the screens it reads, "More than any time in history mankind faces a crossroads. One path leads to despair and utter hopelessness; the other to total extinction. Let us pray that we have the wisdom to choose correctly." I can tell by your response that I've got a little bit more work to do on that sense of humor, but please give me an A for effort at least.

Some years ago I was in a unique position, at least for me. I was invited to be a keynote speaker at a conference because the person that was lined up couldn't make it and they couldn't find anyone else. I gave a speech titled something along the lines of "The Evolution of Forensic Mental Health: From Gladiators to Good Ole Boys and Girls." I thought I did a pretty decent job. What I tried to do is connect the work that we do in this field, whether you do it as an attorney, a member of the judiciary, or as a clinician, to history. Because I think that it's important to feel connected. And of course, the philosophical underpinnings of the work we do are rooted as far back as antiquity. I also believe that we do noble work and I was so glad to hear Professor Bonnie raise the "M" word in talking about morality. I really do believe that this is noble work that we do and in some respects, it seems to me that in dealing with the insanity acquitees that arguably you could say that we're working with maybe the "least among us". I tried to connect this audience I was talking to, with the nobility of their work; I gave the speech. At the end of it, the applause was way more than I had anticipated and it kind of puzzled me to tell you the truth because I didn't understand why what I had said had been so well received. I think maybe in some ways it's because it was affirming to people. I hope if nothing else, that my remarks today are affirming to you because you are folks that have committed large parts of

your life to the issues that have been talked about, and others of you to the actual provision of services on behalf of persons found not guilty by reason of insanity.

I think in a lot of ways we live in a middle ground in terms of where this work takes us emotionally and even intellectually. It's my opinion that something inside of us, inside of us all, tends to want to see folks that we regard as the bad guys punished and dealt with in a firm way, because it satisfies some need we have for justice. Maybe it makes us feel a little safer. Maybe it makes us feel as though our families are secure. In administering justice, and in some cases punishment, perhaps there's that underlying hope that through it all someone will learn their lesson and not hurt us again and not violate us or violate our property.

On the other hand, the other side of that middle ground, seems to be a place where, when we look at a fellow human being who has harmed others, and can't bring ourselves to say that this person is morally blame worthy for what it is they've done. Then anything that we might use to feel safer such as incarceration or punishment, doesn't make sense in that context.

If you spend your life in this work, living in this middle ground, you start feeling like this is the "normal" world. But then occasionally something will happen, and perhaps it gets our attention, and makes us think a little more. To me, and I suspect to a lot of people here in Texas, the Andrea Yates case was like that.

Up to the point she was found guilty, I received lots of inquiries, as did my staff, with respect to, "What are you going to do if you get her? How are you going to handle it?" Because we all knew if Andrea Yates was found not guilty by reason of insanity, she would come to the Vernon Campus of the North Texas State Hospital. With respect to all of the questions and all of the media inquiries, the response we adopted was that we would treat her as we do any of our other patients. We said, "If that happens, we'll protect her rights, we'll knock ourselves out giving her the very best quality of care that we can, and we'll do that in a way that conforms to the rules of the hospital, the laws of the state, and that's what we'll do." As you all know that case was tried in living room courthouses all across America, but in the one that counted, she was convicted. All of the questions that my staff and I had been asked such as, "What are you going to do? How would take care of someone like that? What kinds of things could you do for her?" which I would regard as quality of care types of questions, gave way very quickly to questions regarding the quality of caring in Texas.

What I want to do over the course of time that I have is talk about quality of care kinds of issues, but I want to do it in a way that emphasizes the importance of quality of caring. In doing that, my hope is that indeed you feel affirmed. I think the work that we do is noble. And I think you are connected to great thinkers going as far back as Aristotle. I once told some folks that I thought if you work in this field you stood on the shoulders of giants. When I look at the

speakers who we've already heard from, I feel absolutely blessed and honored to have been invited. Because for a little bit of time today I feel like I've gotten to walk among giants.

From the time the 4th Congress of the Republic of Texas back in 1840, enacted the law for the appointment of guardians for idiots, lunatics, and persons non compos mentis to the 1900s, much in the way of law had been specifically enacted regarding the criminally insane. If you look at the history of law around this issue in the 1800s, it's really quite interesting. In my opinion, it was during this period that the foundations of the law that we have now were pretty clearly laid. That's not to say that there's not been significant changes. It's just to make a point that even as far back as then, it was clear that folks struggled with some of the same issues that we seem to struggle with now.

Between 1840 and 1900, as you can see, persons regarded as insane were treated differently under the law when they were charged, tried, and were convicted. It was during this period that we had three insane asylums built in Texas, and each of these three asylums accepted persons who were considered criminally insane. Also during this period there was a time in state statutes that the M'Naghten rule was referenced as a basis for the Texas statutes. It is between this period as well that Texas law addressed the issue of temporary insanity that was a result of substance abuse. The law basically said that it might mitigate when it comes time to deciding the penalty in a case, but it would not have a standing in terms of the insanity defense itself.

It is interesting to note that during this period the role of juries in cases involving the criminally insane was identified in law. It was particularly interesting, because later during this period the question of whether or not juries could even have a role was an issue. When I look at this particular period of time in terms of it giving us the foundation for the laws we now have, I think those laws resulted in a commitment to building facilities for the care of mentally ill. I should say that the three facilities that were built during this era, at the very best probably provided what would have been regarded as humane custodial care for that time. At their worst, they apparently were horrible places, because the literature documents the legislatures' concern of abusive practices. They could be fairly scary places for patients.

Early in the 1900s, again, the issue of what role, if any, juries would play was one that was repeatedly discussed. There was an important case, going back to a period in Texas when sanity was decided by Commissions. Here is how it worked, each county had a six-person commission that would determine sanity. As I understand it, the law was such that the number of physicians on the six-person commission had to be in proportion to the number of physicians in the county population. That whole process was overturned in a case involving a woman whose name was actually Lillie White. Now the Commission I gather, at the urging of her husband, found Ms. Lillie White to be a lunatic, and that's something to which she objected. This was challenged in court and that determination was thrown out. It was determined to be

unconstitutional. The court affirmed that Lillie White, indeed, had a constitutional right to a jury hearing in such matters. The issue of whether or not someone had the right, according to the Texas Constitution, to waive a hearing by jury was also considered.

During the early 1900s Texas saw several new mental hospitals open. There was a State Prison Psychopathic Hospital that was established which was in the Texas Penitentiary System. Up until the 1940s, overcrowding was in process of becoming a significant problem in Texas state facilities. From 1940 to 1960, we saw increased overcrowding at state facilities. There was some confusion as to the role of the state's psychopathic hospital that was constructed at the penitentiary in Huntsville. After the facility was constructed, it was clear that the people in the prison system thought the Legislature had given them money to build a hospital, a medical hospital, within the prison. So essentially that's what they did. They had only built about 45 beds for psychiatric patients, and it wasn't big enough. The head of the Texas Prison System, as well as the Texas Attorney General got involved and learned that some interpreted legislative intent to be to build a hospital within the prison that could take care of psychiatric patients, not a psychiatric hospital within the prison. The situation reflected the confusion of the times around who would treat the criminally insane. There was one point in time where it was thought that the prison was to have a greater role though in reality patients were going all over Texas. Some patients were going to state hospitals, while others went to prison, and it seemed to be a matter of whatever the judge in the case decided, as there was an inconsistent understanding of the law regarding what was to happen.

Over time, the Board for Texas State Hospitals and Special Schools was formed, and then in 1952, this Board, (which would now be considered the Board of the Texas Department of Mental Health and Mental Retardation), designated Rusk, Texas, and the State Hospital in Rusk to be the site for the Maximum Security Unit, and that Unit was to serve the entire state of Texas.

Now, in the 1960s and '70s we saw increased legislative attention given to the care and treatment of the criminally insane, and quite frankly, there were periods where the Legislature was obviously very concerned about the lack of quality care that was offered at the Maximum Security Unit in Rusk. There were also changes in the law, as well. Such as statutory acknowledgment of insanity as an affirmative defense for prosecution and the exclusion of repeated criminal or otherwise anti-social conduct, from the definition of mental disease or defect.

But if I had to pick one thing that, in my mind, was the most significant event in this period, as regards the care and treatment of insanity acquitees, it would be the R.A.J. vs. TDMHMR Commissioner Lawsuit. This was a lawsuit that really didn't have much to do directly with the care and treatment of folks that would have been regarded as criminally insane,

and as a matter of fact, these people seemed to be forgotten in the system. I remember, as a young social worker coming into TDMHMR in 1975, one of the first site visits that I made was to the Maximum Security Unit at Rusk State Hospital. When I left the Unit, I really thought to myself that this is a hellish place. It was hard to see across from one end to the other in the day room because of the thick cigarette smoke. The patients were lying on the floor because all of the places, all the cots and the chairs were taken. Staff were essentially posted at doorways and it was clear that the emphasis was on containment. Any of you who have worked with the Rusk State Hospital please don't feel offended because I'm not trying to denigrate that facility. The fact of the matter is you could have gone most anywhere in the State of Texas, at least to any of our state facilities, and seen much the same thing. Ultimately the lawsuit was about patient rights issues and the right to quality of care.

The next period of time that I want to talk about is the decade of the '80s. Then very shortly I'm going to make this more personal, because so much of what I'm going to tell you is history that I've lived.

In 1983, the Texas Code of Criminal Procedure was changed creating a comparatively more conservative definition of insanity by removing a volitional component. Changes also specified that following the finding of not guilty by reason of insanity in a criminal offense the court would determine whether the conduct committed by the defendant involved an act, an attempt, or a threat of serious bodily harm to another person. And if so, the statute required that that person be committed to maximum security. The statute also addressed issues related to outpatient commitment.

In 1987, something that in my estimation was like a bureaucratic perfect storm occurred. We had a severe downturn in the Texas economy that had been building for some time due to ours being a state that was driven by a failing oil economy. As you know, there was a time when if you had a connection to oil, you were somebody in this state. I can remember people that lived in little towns like Graham, Texas, that sold bait for catfishermen around Possum Kingdom Lake, having a patch of land with oil on it. And before you knew it, they along with others would become wealthy. In a place like Graham, Texas, you would see Rolls Royces cruising around town. It was a good ride, and it was a long ride for a lot of people in Texas. But when it ended it was economically devastating for this state.

Additionally, there was an extraordinary pressure to deinstitutionalize Texas State Hospitals. The R.A.J. lawsuit which had been largely disregarded by a lot of folks in the system who considered it something that would inevitably work its way through and just kind of disappear, didn't. Interestingly enough, even though nothing about that lawsuit was really focused on issues specifically related to the criminally insane (and quite frankly I think most people in our system would have been very pleased just to keep them in Rusk and keep them

there forever), the lawsuit worked out in a way that wouldn't allow that to happen. In 1987, this perfect storm of economic factors, pressures to deinstitutionalize state hospitals and the like reached its most violent period. A decision was made to close a State Hospital.

So which hospital did the leadership decide should be the hospital to close? Well, it was a hospital that arguably had done the best job of deinstitutionalizing. A lot of us who were employed with that facility at that time thought, "Gee, no good deed goes unpunished in our system."

As you can imagine, the State Hospital was a big employer, and particularly so in the rural area. Last minute negotiations between our agency's leadership, legislative leaders, and a lot of people in the community resulted in a determination that surely something could be done to amend the situation. So in 1987, it was decided that the Rusk State Hospital's mission, as a Maximum Security Unit in Texas, would be given over to the Vernon State Hospital; and the Vernon State Hospital's civil mission would be combined with that of its neighboring facility in Wichita Falls. So in 1987, we had a situation where a civil psychiatric hospital located in a north central Texas community with a population of 12,000, would become the Maximum Security Unit for the entire state of Texas.

It was quite a day in 1988, when the first insanity acquittees were transferred from Rusk State Hospital to Vernon State Hospital. The patients who were transferred were transferred by bus from Rusk to Vernon. I believe the drive was somewhere in the neighborhood of 350 miles, or thereabouts. The buses did not stop. They had a police escort. The patients that were being moved from Rusk to Vernon were shackled and handcuffed. There were no restroom breaks. I don't know if they were ever fed and the buses sped along at the fastest speed allowable. All the while a rumor running rampant among patients on the bus was that they were being transported to gas chambers for execution. In all honesty, the citizens of Vernon, who were thrilled that they still had the biggest employer that they had enjoyed for a number of years got a little bit frightened by the type of patients being transferred. A number of employees were actually transferred from Rusk to Vernon and it is no understatement to say that the hospital was very much a correctional environment.

1990 began a decade of real change and this is where I came in on the scene. In 1990, I was appointed Superintendent of the Vernon State Hospital. In all honesty, it's a job that I had wanted since 1975, when I first set foot on that campus. I hadn't been in my new role more than a couple of hours before I was wondering what in the devil I had done giving up a perfectly good job to return to work at that hospital. The conditions were almost beyond description, but I'm going to do my best, if you'll bear with me. When I got there in 1990, the hospital had 414 patients and about one-fourth of those were adolescents (they had a special adolescent program).

For 414 patients, the Vernon State Hospital employed six physicians. Two of those physicians were exclusively committed to general medical roles. That meant for 414 patients, the hospital had four physicians in psychiatric roles. Of those four physicians, two were psychiatrically trained. I am not stretching it one bit to say that I would drive to work in the mornings and I would literally pray, "God, let all of the doctors show up and, dear Lord, let them all be sober."

Staff at that North Central Texas Hospital had previously done a very fine job in treating persons referred from a largely rural area whose population was disproportionately represented by persons 60 years of age and over. They had done a terrific job. But with respect to treating persons that were committed to the Maximum Security, they were lost. Staff were very poorly trained for that role. Many people seemed to think that the way that you build a fine forensic psychiatric hospital is to put a big fence around it and then employ as many security workers as the legislature can possibly afford and bingo, you've got a great hospital. That was kind of the attitude that was present, particularly from 1987 to 1990.

I can remember shortly after arriving, hearing one administrator bemoan the fact that the state had spent the money to get what was then considered "an escape proof" fence. I found myself thinking, "Oh, this fellow is a fiscal conservative, that's not unusual in Texas." But I asked him, "Why do you not like the fence? It has no barbed wire. It curves at the top and its not horribly intrusive, compared to what you would find in other maximum security environments." The fellow looked at me and responded, "Jim, let me tell you why I don't like this damn fence. It's escape proof." And I thought, "Well, that's why we're paying \$110 per linear foot for the thing." And he said, "You know, here's the thing. Patients in a forensic hospital need to have the hope of escape. And if you take that away from them, you're going to have a violent situation, because you take away that hope." I found it shameful that a somewhat high level person in the organization was essentially saying that the best hope we can give these people entrusted to our care is that of escaping.

Women were seen quite differently. There was a fear that if women had any sort of contact with men that there would be great trouble. So the previous administration had gone to great lengths and had taken about a 35-bed unit and built another fence around it and worked to replicate everything else that was going on at the hospital on that unit. If there were going to be movies or any sort of recreational activities, they were segregated by gender because there was a decision made that women and men patients should never have contact, as it was considered too dangerous. Otherwise, patients, at least the ones that were segregated by gender, were lumped together. The largest percentage of patients served were those referred because they were incompetent to stand trial. Nevertheless, when I arrived on the scene in 1990, a patient went where there was a bed, as long as it wasn't a bed on the other gender's program. And as sad as

anything else, the one vehicle by which a patient might have hope of leaving this most restrictive environment, was through a poorly functioning Dangerousness Review Board process.

Now, there's a rich history about review boards, and if there was more time I'd do my best to tell you about that. But that's the vehicle in our statute by which a person may leave Maximum Security if they're found not competent to stand trial, and committed for an extended period and it is the vehicle by which someone not guilty by reason of insanity may leave Maximum Security unless there is a judicial release. I remember one person that served on the Review Board saying, "There's only one criteria I'll look at in making my decision, that's whether or not the patient when he comes before us shows remorse for the wrong they have done." And I thought, "My goodness, someone who is a sociopath and bright enough to know that they need to tell you this, can get out. But someone that may have trouble articulating what's going on with them, but otherwise not particularly dangerous, may be in forever."

There was also a common belief in that era that you could predict violence. That is that if you were a psychiatrist or a psychologist or a social worker or whoever else might be asked to sit on a Review Board, that somehow by looking at the patient, studying, and reading their record, as if it was a crystal ball, future violence could be predicted. Essentially, patients who didn't cause problems got to leave. And that's the way it worked.

The most shameful thing that I can point to in 1990 was the rampant abuse and neglect of our patients. There was a group reported to exist at our hospital, who referred to themselves as The Dawgs. The Dawgs was supposedly a group of staff kind of like a secret society, who enforced order in the Maximum Security environment. As horrible as it was, it was very clear, when I looked around at that hospital, that what we had were a lot of very poorly trained folks, who didn't know what in the devil they were doing, responding out of great fearfulness, out of a desire to impose some order, some control in that environment, and that it had gotten well out of hand.

So in many ways what happens when an insanity acquittee comes to Maximum Security has its roots in what I have described. What I'd like to do now is talk to you about some of the things that we've done to try to change, and how things work now.

The first thing that we did to change the emphasis from containment to real treatment is that we adopted a policy of no tolerance for patient abuse. For a while, I felt like the most hated person in the community, to the point that it was hard sometimes to go to a grocery store. It was just as hard on my wife because it's hard in a community of 12,000 to fire someone without running into their cousin, their buddy, their sister, their aunt, or their uncle. And that's what I did to enforce a no tolerance policy for abuse. That's not to say that I can give you 100% guarantee that it won't occur today at our facility. But it is to say that if it does occur, and I hear that it has occurred, that I will not tolerate it. More importantly, our staff won't tolerate it now.

We also taught the staff something new. We taught them that the best way to have a secure hospital is to have high quality treatment and high quality patient programs. That this is the best security, and that's where we began to invest our money. To tell you the truth, there was probably an extended period of time where I made staff vulnerable, because you cannot just speak the words "quality of care" and it happens. I essentially took away the means of control that some had through abusive practices, but they stuck with the initiative and built quality programs. We defined a mission and vision and values statement for the hospital. It essentially said that, "whoever comes to this hospital, in accordance with the laws of Texas has a right to high quality treatment, and by God, that's what we're going to give them." And that's what we did. I pulled in every administrator, every department head, every program director, and challenged them to justify the existence of their operation in accordance with this mission that says these human beings have a right to quality of care. They were told if they could not convince me that what they were doing supported the mission, then their operation wasn't needed. There were times that we sent people back to the "drawing board" repeatedly, but we finally got the message across that we had an expectation that caring for our patients was our first obligation.

We also made a massive commitment to recruiting professional staff and we surpassed all previous limits on what we paid psychiatrists raising salaries higher than they had ever been before, and I think it was the best money we had ever spent. We had psychiatrists that were literally commuting from California; Albuquerque, New Mexico; Dallas, San Antonio, and Austin, and taking apartments and going home on the weekends, because they enjoyed the work and they accepted the challenge to make something different and better. We made a massive commitment to ongoing staff training. While I don't know for sure, I would imagine ours is one of the few hospitals that each year provides an opportunity for many of its mental health workers to hear the likes of Dr. Phil Resnick, John Petrilla, Dr. Reid Meloy, or many other of the wonderful people we have invited to lecture at our hospital's annual forensic mental health conference.

We made a better hospital, but we weren't making better treatment as such. So in 1993 we undertook a multi-year initiative called the Program Integrity Project. We started to say, "Let's not so much think about commitment status except for where we clearly needed to focus on restoration of competency." It was more thinking in terms of, "What can we do to really help our patients move out of the hospital?" We started asking ourselves, "What's keeping them in the hospital? What's keeping them from passing the dangerous review board?" We identified four basic categories of recurrent behavior that seemed fairly easy for us to operationally define and seemed to be reasonable classifications. We identified what we call treatment tracks within the hospital, which is detailed in my paper so I'm not going to get into a lot of depth here. I'm

just going to touch on the things that I think would be important for you to know. We identified one group, Track I patients, who are essentially stimulus seeking. These are patients who by history seem to adapt to the world in ways that are oftentimes violent and they use violence, aggression, predatory behavior, and the like in ways to adapt to their environment. Interestingly enough, I think if you would ask staff if these are the most dangerous persons at the hospital, most folks would say they are. You could walk onto a unit and get a sense about that. One approach that we have used to treat this population is that in graduated amounts, we decrease external stimulus in the environment, not out of cruelty or to provoke violent behavior, but to help patients learn new adaptive skills and help staff not to get into the habit of thinking that if a patient doesn't give us "trouble" then they're a "good patient", and somehow they morally deserve to leave. Because such an approach would be shirking our responsibility. So we tried to identify what is it that keeps these folks in Maximum Security, and what we need to do to help them transition out safely by trying to understand and treat those factors that contribute to their violent behavior rather than avoid it.

One thing to note that's been very interesting over the years, and this is anecdotal, but we seem to see more patients who come in with psychotic disorders, and once their psychosis is appropriately treated with medication we see underlying personality disorders. Paradoxically, as we treat the condition that really brings these type patients into the hospital, we have someone who is more dangerous as their psychosis seems to inhibit the personality disorder. I wish I could tell you that we figured out the answer to that one; but all I can say is that we continue to work on it.

Track II patients are people who are stimulus avoidant. This is not very clinical and; you might not find it in a textbook, but I think it will make some sense if you have time to read my paper. These are persons that we find to be among the most dangerous because you don't see their violence. They adapt to the world in ways that are stimulus avoidant and they pull back. It's when something intrudes in their delusions or their world that they respond violently. Unfortunately, I think these were the kinds of patients for so many years that the Review Board passed and their conditions never really were treated. Because as long as they weren't interfering with staff or staff could back away from them, they didn't cause problems. And it was interpreted somehow that this was a safer patient population because left to their own devices they seldom threatened staff directly.

Track III is essentially our competency restoration program; and our Track IV treatment program has been set up specifically for persons with mental retardation and persons who are dually diagnosed with mental illness and mental retardation.

We've found that our patient population has the highest incidence of substance abuse. On any given day of the week when we've reviewed patient records, 65% to 75% of patients have substance abuse histories.

By 1994, this approach of using a multi-track treatment scheme produced really good results. We were seeing more patients appropriately move out of the hospital by the Review Board process into the civil facilities. I think a real hallmark was in 1995 when the Vernon Facility became the first in the state to exit the R.A.J. lawsuit, ahead of its sister civil facilities. We were quite proud of that.

In the mid-1990s we saw continuing change. We worked to further improve treatment. We saw our hospital, in many ways, drive our system and making make our system take a look at the kinds of forensic mental health issues that needed to be addressed. By the mid-90s, in addition to the Vernon Facility getting out of the lawsuit, we saw the emergence of some transitional programs developing at other state hospitals. Terrell State Hospital was one that had done a great deal of work, and Dr. Mitch Dunn, the Medical Director for the transitional forensic program at Terrell is here. He and his staff have done an incredible job. It's really been nice to see this happen. Unfortunately, in many respects, what we experience is frequent frustration as the result of knowing what we as a system are capable of accomplishing, but lacking the resources to do it. A clear vision of what our forensic mental health services continuum could be was captured in the mental health system's first strategic plan for in-patient forensic services. The strategic plan was never officially adopted, but, occasionally it is used to guide decision-making. It was this plan that I think set the stage in our system for a lot of good things. For instance, we have seen the establishment of a new forensic stepdown program at Kerrville State Hospital. It's still in the early stages of development, but it is not another "backward". We've seen that hospital successfully move insanity acquittees out into the community. We've got people like Dr. Dunn and our colleagues at other hospitals that are working very hard to provide more community alternatives for patients through effective partnering with the judiciary.

What we've run up against, however, in our system is that even though treatment has improved dramatically for this patient population, there still aren't sufficient community-based alternatives. Dr. Dunn and I have talked on several occasions about the need for conditional release programs in Texas. Our outpatient commitment statutes just don't seem to work very effectively. In all fairness to our community partners, I think it's because there aren't sufficient community mental health services out there and available, and there's great competition for whatever services do exist.

By the end of the decade, we'd seen another commitment at the Maximum Security facility in terms of patient programming, and this was to a social learning model. It's a night and day difference from the conditions that existed in 1990—positive reinforcement is the order of

the day. We are trying to acquaint patients with the opportunities they have for improving their lives and their responsibility for making changes. Our Review Board, though still having a ways to go, is increasingly reliant on good quality risk assessments for assessing manifest dangerousness, as opposed to being oriented to predicting future violence. We've come to conceptualize risk of dangerousness, sort of like a tornado—we never know when or where a tornado will strike, but we know the kind of conditions that produce tornadoes. As long as we know that, we can prepare. Similarly, we work to manage risk factors presented by our patients.

Over the course of time, we've done a lot of things that I'm very proud of. But in my estimation, we're facing a really tough time. Texas is looking at a growing fiscal crisis. Right now our state hospitals are constantly filled to capacity. I oftentimes operate the Maximum Security Unit at 100% of what I'm funded to operate, and sometimes beyond. The civil component of our hospital likewise operates at 96% to 97% of capacity. Most of the other hospitals in our system on any given day of the week are at 100% of their funded average daily census or above. Right now we've got 22,000 of our fellow citizens on waiting lists for services at our community MHMR centers. Insanity acquittees face significant competition when it comes to access to services. I am told that we have approximately 200,000 citizens that qualify for public funded mental health services, and just can't get them. Our Commissioner about a week ago was told to cut 7% from our budget, and that's for this fiscal year. I'm told that would be 14% reduction in the annual budget, as we have about six months remaining in the fiscal year.

There is another reality that I want to point out. On any given day there are likely to be fewer than 70 insanity acquittees among the 2,300 other patients in our hospitals. Of these 70, only one-third will be in Maximum Security; the others will have transitioned to less restrictive inpatient settings. And in fiscal year 2002, we had 90 people admitted to our Maximum Security hospital that were not guilty by reason of insanity, while 17,680 other persons were admitted to the state facilities in the same period.

More than I might be able to communicate to you. I desire reforms in our statutes pertaining to the insanity defense. In my heart of hearts, I wonder how many people could benefit from the kinds of things that we have done if only they had access to services. But I've got to tell you that my experience has been that we have improved the whole lot of services, for insanity acquittees in step with improvements that we've made in the rest of our system. That's not to say that it has to be that way; it's simply an observation.

If I wanted to leave you with any particular message, it is that as we move on with this good work, and I think it is good work, and as we come to better understand the nobility of what we do, we must see it in the larger context of the great need for public mental health services. Many of the insanity acquittees I see really are the least among us. They are poor, their families

have abandoned them, they have severe mental disorders, and not a heck of a lot of hope. I think that taking care of these folks is good work, and Lord knows, the roots of what we do go deep. But I've got to tell you, that in my mind many of our fellow citizens are at risk of coming to my hospital because they're at risk of getting into serious trouble because they're not treated and they're not getting services, because the services are not available and there's no money to assure their availability. My colleagues, I urge that as we pursue needed statutory reform in the laws affecting the insanity defense, that we keep our eye on the bigger prizes. I don't think we can fix this problem without addressing the others that exist. Sometimes it seems as though through neglect we allow our fellow Texans to fall into a fast river. I'm getting kind of tired of fishing them out.

So with that, thank you.

[APPLAUSE]

AXELRAD: We have a little bit of time for questions and answers for Mr. Smith. Please identify yourself when you pose a question or have a discussion.

MIKE TIFFIN: Yes, sir, Mr. Smith, my name is Mike Tiffin and I'm a prosecuting attorney from Conroe, Texas. I appreciate the work that your hospital does. I want to lay out just a brief scenario for you, and then ask you one question. About two years ago we had a capital murder trial in Conroe. The defense of insanity was raised, and the defense attorneys hired an expert, a psychologist from your shop at Vernon, to testify, to come down and evaluate the defendant both for incompetency and for insanity. The state hired a—I say hired, we got a psychiatrist out of Houston on the issue of incompetency, which we had to address first, obviously. It was the state's position that she was competent, the defense's position that she was incompetent, and that position was based on some brain damage she had had early on in her years. We went through two competency jury trials, both to a conclusion of hung jury. So the state, being me basically, said, "Look, I'm going to try to short circuit this." We then paneled a third competency jury. I agreed to a finding of incompetency, and shipped her off to your shop. Our position was that she was malingering and faking the whole competency issue.

Not more than three weeks later, and I'm pretty sure it was almost three weeks to the day, she was shipped back to Montgomery County, the defendant, and the finding was that this defendant was competent to stand trial, and they based their findings on the fact that she was malingering and faking the issues of competency.

My question to you is, how do you resolve the apparent ethical and moral conflict amongst members of your staff on an issue like this, in terms of taxpayer dollars. Because this defendant was indigent, we footed the whole bill.

SMITH: Let me take a stab at that. I appreciate it. First of all, there may have been a member of our hospital staff that was involved initially in the evaluation. My guess is if they did it, they did it freelance, because we wouldn't be involved in a pre-trial competency evaluation unless someone came to the hospital. Statutorily we don't have the authority to do that. So it may very well have been someone from the hospital acting as a free agent.

With respect to the question, if I'm hearing it correctly, it sounds like what you're saying is, "Hey, we went through a great deal of expense. We had a couple of hearings resulting in hung juries, costing even more money. Our position as prosecutors was that this girl was faking it, malingering. And then somebody from your hospital gives testimony that is used to finally determine she's incompetent. She comes to the hospital, determined to be malingering, and then in several weeks we sent her back as competent." I understand your frustration but the hospital does not provide pretrial evaluations outside the hospital.

MIKE TIFFIN: Right.

SMITH: The thing that I would say is simply, again, keep in mind that if one of our staff testified initially, it was probably on their own, because our hospital doesn't do that sort of service unless you had sent the person for pre-trial evaluation. When someone comes to us, I guess fundamentally that is our job, is competency restoration. If there is a belief that someone is malingering, that's our legal and ethical responsibility to provide that sort of guidance to the court. And beyond that, I can say I can understand how that would be frustrating, and I'm sorry you folks had to go through that. It sounds like ultimately, in this particular situation, your beliefs, your suspicions about where the person was coming from were validated.

AXELRAD: Any other questions?

GALE GLEIMER (Attorney from Corpus Christi): My name is Gale Gleimer. I'm a prosecutor in Corpus Christi. I have a capital murder defendant that's been in the San Antonio State Hospital for the last number of years. Eight, ten. He's charged with allegedly killing two elderly ladies at that hospital in Corpus Christi. The family of one of the deceased ran into him at Fiesta Texas. And he was on furlough, signed out by his family members. A lot of letters that generated because of that. And of course, they came to me to complain, you have to understand.

What criteria is used when someone is allowed to furlough? I mean, they're held on no bond for a capital case. But what do you use as criteria?

SMITH: Let me see if I can take a stab at that. A couple of things. When I began my remarks, if you'll recall, I talked about the difficult middle ground, and I want to tell you, as a father as a husband and as someone who loves my community, it tears me up when people hurt other innocent people. It really does. As a clinician and a hospital administrator, I have voluntarily accepted an obligation that the law gives to me to administer a treatment program, and sometimes it's a difficult line to walk. I don't know exactly what the furlough criteria is that had been used in this case. It should be fairly individualized and ultimately up to the patient's treatment team. And more specifically, it would be the treating psychiatrist who would be in charge of that patient's treatment. To my knowledge, there's no formula that any of the treatment people have to go by. One thing that I would like you to know though, is that with respect to the Maximum Security environment, there is no such thing as a furlough or a trial community placement or day outing. That's not consistent with our mission.

[APPLAUSE]

AXELRAD: Okay. You can take your questions to an open discussion. Thank you, Jim.

We're now going to move seamlessly into the next part of the program. There are several people who are going to join the panel that have not yet been introduced. And I want to introduce them now as a group. And then after I introduce them as a group, the panelists will come up to the table. There were three names, during our Planning Committee experiences—I think we had two or three, Victor, am I correct, conference calls. And of course, these are representatives of the Defense Attorneys Association and the District and County Attorneys Association of Texas Bar Committee. There were three names that rose to the surface that we should include on this panel discussion. The moderator was a no-brainer. Everybody agreed that Dean Cathy Burnett should serve as the moderator of the panel. Ms. Burnett is a Professor of Law at the South Texas College of Law, and is also an Associate Dean, and has had an interest in criminal law throughout the course of her educational experiences as a law school teacher, and has published some important papers in the area of criminal law in the state of Texas. She will moderate our program.

Lyn McClellan is a Supervising District Attorney in Harris County. He is a very forceful and very knowledgeable speaker on the District Attorney's perspective on the sole issue of insanity and it's administration in criminal justice. He will be representing the prosecutors.

John Niland is a defense attorney. He is currently serving as the Director of the Texas Defenders Service Capital Trial Project, which is really a project that assists all of the defense attorneys in the state in preparation of their case when there's been a capital offense that has been charged. Mr. Niland has had a long experience as a criminal defense attorney, as well as the experience serving as a Direct Public Defender.

They are going to join this panel of persons we've already introduced. And Ms. Burnett, I think we can begin the seamless transition up to the podium now for all the participants.

BURNETT: Good afternoon. And we are kind of seamless. I had assumed, prior to today, that law and psychiatry were involved in a clash of intellectual cultures that could never be reconciled on the issue of insanity. Law, with its focus on moral questions and personal responsibility and culpability; and psychiatry with its preoccupation with root causes, the "why" of behavior. I didn't think we could ever find any kind of common language. The public, it seemed to me, whether it was a criminal defendant or whether it was a jury, were the victims of this intellectual clash of cultures, because they were left trying to find common language and common vocabulary, when we, as two entities, could not. It's been inspiring to see how collaborative we've been, and I hope that will continue with this panel.

The format for this panel discussion is going to be, first, to allow each of the speakers to have five minutes to respond to the papers and presentations made earlier today. I'm sure we're all curious to hear how it is that they respond to one another. That's going to be followed by a question and answer session. I'd developed some questions looking at their written materials that I received prior to this, and then we brainstormed and shared some other questions. I hope that portion of the panel will model for you the kinds of dialogue we're looking for in the last session of questions from the audience. So, Dr. Zonana, you've been waiting the longest. You spoke first, so let's start with you, and everybody please take five minutes to respond to one or more or all of the speakers, or defend a position you feel was unjustly or justly attacked. Doctor?

ZONANA: Let me begin with maybe an easy one. One of the things that's always hard is what you think people will understand or what you think people don't get. We went through in Connecticut the same thing that was discussed about Oregon and some other states about people had a hard time understanding the notion that somebody could have done something and yet be found not guilty. So we had a statute, and I recommended it, that we call "guilty but not criminally responsible." It seemed to me to be reasonably clear. It seemed to me to get at the issues that people were talking about, and somehow would make it not seem as disparate. Well, after about two years, I mean, nobody understood it, is all I can say. And maybe in Connecticut

we're a little thicker or whatever. But most people saw it still as somewhat of a guilty but mentally ill statute. They didn't know where people went. It didn't really end up clarifying anything. And so the Legislature just went back to the other language.

So sometimes what can seem very clear in a room when you have a chance to talk about it and to think it through and think you understand it, doesn't really translate into statutory language that then takes off in the direction that you think it will.

That's part of the issue here. It gets to be a culture. And as you see in each of the states where there's a change made, there is an accommodation in some way to try to deal with the same issues that needs to get dealt with. You know, and if you have a horrible system of treatment, that's going to make a difference, too. And sometimes it really takes either a lawsuit or something like that to change a culture in fashion. I think I share some of the feelings around the most powerful way to change a system's culture, in my view, is to get enough professionals in that they-- Generally, most professionals take pride in what they do and value their work, the long training, and so forth. And if you get it in critical mass, in my view, that then starts to take off into a life of its own. But from the minute you walk in you've got 400 patients or something like that, you're immediately incompetent and sort of have to try and struggle with an impossible system.

There is an irony here, and a couple of people have alluded to it. There's something happening on the civil side that so dwarfs this in a way that it is embarrassing in a lot of ways. You know, I put up these slides and talk about how people are in the hospital for 10 years, 12 years, 20 years. I just saw a guy that's been in for 25 years, and someone that's been in for 20 years after he exposed himself to somebody. I mean, talk about a rigid Review Board. Whereas on the civil side, the average length of stay in our facilities is 10 days, 8 days. The kind of people that we're seeing often and what we-- You know, what rules get put up in one system and what gets in another one are absurd. I mean, we haven't really talked about managed care and the affect of all of that on your systems. But people have alluded to it, that it's opening up the criminal justice system in a way to deal with a lot of our patients. And that's what the staffs are doing. The only way you can get long-term treatment for anybody is to have them found incompetent to stand trial and have them to go a facility where they're likely to be for at least a month or two in contrast to going into a civil facility where they're there for a week. And the revolving door, frequent flyers—I mean, we've got the whole language and lingo for it.

So these are important both moral and practical issues because they affect a significant number of people. Even if you have a state that has somewhere between eight and 15 insanity defenses a year, if people are held for 25 years, you're building up a population that you have to deal with in some way. So somebody has to deal with it. And what is the best way to deal with it?

So I struggle with this. You know, I sit in my office in the mental health center, and I see us struggling with trying to find housing, trying to find some way to get somebody out of a hospital. And you can see it. And then I tell my residents to get long-term treatment experience with the insanity acquitees, because that's the only place you can get it. I mean, there's something a little bit wrong with this picture. And so I do think the perspective has to be-- That doesn't mean we shouldn't try and deal with these other issues which are so important. But I do think our whole system is in great chaos at this moment. We talk about it a lot at most of our major professional organizations. But it's a critical function.

Like we have a volitional thing. I agree with the theoretical view that it could open things up. But by and large it doesn't open things up. At least I haven't seen it. And I don't see the cases. And even when you think "appreciate" might open things open, I mean, it doesn't-- at least if the rest of the system is relatively clean, there's a fair amount of flexibility. So there's room to deal with those issues. There's still a lot of distrust about it. So people are not going to just open it up to anybody who throws up the defense. You've got to see some significant—I mean, to get a prosecutor to agree to something, you have to have some substantial data. This is not a roll-over. I think prosecutors need to have their own evaluated, and to make sure that they're getting credible reports. And they ought to review them. I mean, we get mad when they don't review them. And then people complain that somebody malingered. Well, the prosecutor never got an independent evaluation. That's a mistake. Let me stop there.

BURNETT: Professor Slobogin?

SLOBOGIN: I am going to focus on the insanity defense, because that is the focus of this conference. And since I was forced to defend M'Naghten and the mens rea alternative, and I also chose to defend my own "integrationist" position, I have to disagree with both Brian and Richard. Since Brian is sitting right next to me, I'm not going to disagree very vehemently with him. I think I've already expressed why I think the volitional approach is a bad idea, even though I agree with Howard that a few people are actually acquitted using that approach. As I've said, there are a lot of problems with it, both conceptual and practical.

I do want to respond to some of the things that Richard said. I guess it's all summed up in the question, "Why do we privilege severe mental illness in terms of choosing who should be exculpated and who shouldn't?" Richard is absolutely right, that traditionally that's what these tests are meant to focus on, severe mental illness. And I think that approach is also consistent with the intuitions of many people. But, as he said, we've learned an awful lot about mental illness, and we now know that they are both much more in control of their behavior than intuition would lead us to believe, and that they're a lot less dangerous than most lay people

think. At the same time, we've learned a lot more about other kinds of mental disorders. For instance, take psychopaths. I mentioned during my talk, and Richard also noted that, we know a lot more about them too. I think it's fair to say that their condition is pathological, probably neurological and at least congenital, to use Richard's terms for describing the kind of disorder that should form the predicate for insanity. It's a condition that is not easily within the person's control. In fact, it's less in their control than the condition of a severely mentally ill person, because at least there's treatment for severe mental illness, and there's no treatment for psychopathy. They can't do anything about it.

I think it's also true that they, like psychotic people, are "out of touch with ordinary experience," to use Richard's phrase, although in a different way than psychotic people. One of the studies about psychopaths which has always impressed me was a very simple one that dramatically illustrates their different nature. Psychopaths were hooked up to a device that measures physiological responses, and a control group was hooked up to the same kind of device. Then both groups were read five words. Chair, table, apple, house, murder, or something along those lines. For the control group, the non-psychopathic group, the researchers got a big blip on the screen when the word "murder" was announced. But for the psychopaths, all they got was a flat line. No reaction whatsoever to the word "murder." To me, that's out of touch with every day experience. It seems to me that if you were honestly going to apply the Appreciation Test, then psychopaths have to be excused as well. I don't see why we privilege severe mental illness, outside of weddedness to this myth that they're extremely different than other kinds of people who are involved in abnormal behavior.

One other statement of Richard's that I think needs a response is his suggestion that the Integrationist Approach is arbitrary because it relies on what the Penal Code says is right and wrong. I think that makes it less arbitrary. The Code tells us what society thinks is wrong. On the other hand, the Appreciation Test is extremely arbitrary. Richard states that this test focuses on the extent to which a person's internal reality is connected with the real world. How do you figure that out? It's extremely difficult to discern. At one point Richard stated that a person who doesn't give in to command hallucinations is not out of touch with reality, whereas a person who does give in to command hallucinations is out of touch with reality. But that seems circular. How do we know whether a person who commits a crime based on a command hallucination is out of touch with reality? Maybe they are in control and they just feel like committing the crime. I don't see that inquiry as being less arbitrary, and I think it's probably more arbitrary than imposing the guidelines the Penal Code imposes on everyone.

Just to make that point more specific, I'll use the Andrea Yates case as an example. Andrea Yates, as I suggested, probably should have been acquitted, unless she could have prevented the delusions. But I'd be much more uncomfortable acquitting her if everything was

the same in her case except that, instead of thinking that by killing her children they'd go to heaven and not go to hell, she thought, "Well, if I kill them, they won't become bad kids later on." It would make me much more uncomfortable, even if she otherwise had the same thought process, to acquit her in that situation. To me, that makes her a lot more like, for instance, Susan Smith. I don't see that much difference between the two. At least I'm not sure I can explain what the difference is. And so that's why I take the position I do.

BURNETT: Professor Shannon?

SHANNON: Thanks. It's interesting, first, to comment on one of the earlier reflections. Dr. Zonana is talking about the civil side, and I can relay what we see first-hand at the 30-bed intake public facility that we have in Lubbock. Our average stay is now 10 days. But, at the same time, we're always watching the 30-day, 60-day, and 90-day re-admission rates, that there is a correlation. We also need to see them look at folks who are ending up in the jail and follow them as well. And, then getting back to the insanity defense is that at what point, with the quick treatment or the like, might we drop the ball and the person will end up not only just facing criminal charges but something very serious. I have trouble with the notion of the degree of choice we might be assigning to someone of choosing not to receive treatment because of their lack of insight. Perhaps having seen that symptom with my brother—who happily was never involved in the criminal justice system—I believe the lack of insight to be very real.

I wanted to take just a couple of minutes with the remaining of my five and comment on Richard's concept, that perhaps our court of criminal appeals could just construe "know" in a broad way. And, he commented that he was surprised, perhaps, by the chuckle in the audience. I don't perceive that, at least from my reading of the court, as being something that would be all that likely. This is confirmed by some of the post-hoc legislative analysis. For example, Senator Farabee, who was the bill sponsor in '83 when they narrowed the defense, wrote a post-hoc article commenting about it. And he made some comments in his article that when Texas had first gone to the two-prong ALI test, the legislature intentionally used the word "know," not "appreciate," with the intent to keep it narrower, and of course, that's been carried forward. I agree with Richard, who suggested that "appreciation" ought to be added.

I would certainly support changing the "know" to "appreciate," but I wouldn't stop at that. I think there should also be some greater guidance, whether it be legislative history or direction for the courts with respect to an appropriate instruction to the jury as to what that term means. Otherwise, it's just putting in a word where the jury might still have to guess at its meaning, and whether it has a broader meaning.

I, nonetheless, support the restoration of a volitional prong, at least with respect to the acutely psychotic patient with delusional thinking, because I do think that's the area where we have the risk. And, it may not be that far off from the "integrationist" viewpoint, just in a different kind of approach. In doing that, not just through the instructions the jury would get, but also in making that a part of the test, part of the analysis, it will set up a framework for analysis not only by the experts, but by the defense lawyer working with the client, to the extent that's possible, and for the prosecution. Also, it will assist the defense negotiation with the prosecution in terms of parameters as to when there might be some degree of agreement on the appropriate setting for the individual—long-term hospitalization or in concluding, "No, it's not here. We're going to go for prison," or for death, as perhaps was attempted with Yates.

BURNETT: Mr. Smith?

SMITH: It may be difficult for you to believe, but I'm almost feeling talked out, and that's rather unusual. This has been a terrific experience for me and I'm still doing a lot of digesting, quite frankly. In terms of the perspectives that have been shared regarding our insanity defense in Texas, I wasn't kidding you earlier when I said I feel as though I've gotten to be among giants today. So I don't know that I could add a lot, if anything at all. I'll share a few perspectives, though, in hopes to maybe contribute in some way.

I guess when I reflect on all that I've heard so far, there are two things that have grabbed me up by the short hairs, if you will. One is the remarks following my presentation by the gentleman that is a prosecutor. I'm reflecting on that because I've got a good strong sense of the frustration that was experienced. I have a hunch that there are a lot of good people that are working awfully hard with their limited resources that live day in and day out with frustrations. And it's not so much the challenge that each frustration presents; it's the realization that we could be so much better in so many ways and we have the knowledge and information to do it. What seems to be lacking perhaps is the political will.

On the one hand, I want to be an apologist for all of the frustrations that our system may have caused anyone. And on the other hand, I want to grab you by the lapel and say, "Do you understand what kind of bargain you get for the little amount you invest in this thing?" We have so many people, that are sacrificing so much, to give a level of quality that we shouldn't be able to achieve with the little we get to work with. And it's because there are some people that just decide they'll commit everything they have to this work. It's like a mission. I've seen it for a long while. It's a mission.

I was struck by something that Professor Bonnie said, too, and this was something like an epiphany for me. It was the idea that if nothing else, with all of the discussion that the Yates

case has generated, if nothing else, it's got people talking. In the paper that I wrote, that was an observation that I had made. I think I made reference to the case being played out in the living room courthouses across America. Until Richard said what he did, I don't know that it really dawned on me as to how valuable that is. Because maybe that gets to the fundamental question that we're facing, and that's, "What do we want?" What is it that you want?

From the perspective of an administrator of a psychiatric hospital, I can tell you that had Andrea Yates been found not guilty by reason of insanity, she would have come to my hospital. We've got wonderful clinicians. We're not perfect, but we have wonderful clinicians and we have good programs. But what would you have done? What would this state of ours done? What would the people of America have done, if in a matter of months, at some point, say less than a year we had received Ms. Yates and quickly gotten her to a position that she would have passed the Dangerousness Review Board? Now, had that happened, she would have been transferred to a civil facility. But the point is, I think that's what I'm supposed to do. Our mission is to provide our patients the best psychiatry has to offer, and the best we can do programmatically, with an ultimate aim that somehow they can be a productive member of society. If that's what we're able to do and I think do it fairly quickly, does that offend you? Does that offend the people of this state? Because quite frankly, most of the people that are insanity acquittees who have come to our hospital, are stabilized on medications very quickly. We do a very good assessment of risk for dangerousness, and we help them access some very fine programs at other facilities. But would it have been acceptable if we could have done that for Ms. Yates? And if the answer is no, if at some level you think, "Well, gee, if someone has committed a heinous crime and they go into Maximum Security and they're out in a tenth of the time that they might have spent in prison, can we live with that?" Even if they do good, can you live with that? And if you can't, then maybe we've got more fundamental questions to address than what criteria we need for determining insanity in these matters. Because it speaks to the value of what we're about.

And so for Richard, I appreciate that. Those comments for me were extraordinarily valuable. And if nothing else, it's the conversations that have been started by this case, and all that comes out of it, I think we've gotten some good. To the others of you, I feel like I've been to clinic today, and I appreciate the school.

BURNETT: All right. Professor Bonnie, we're turning it over to you.

BONNIE: I want to address three issues. One is why the appreciation formula is preferable to a narrower approach. I've said a lot about that. I'll just comment briefly on what Chris has said. Second, I want to say something about why it's good not to have the volitional prong in response

to what Brian said. And then finally, I want to make comment about dispositional issues that I haven't addressed.

With regards to why the appreciation formula is preferable to any of the narrower alternatives, the first thing I want to say, and I don't have to go at length about it, is to reiterate the point about why mental illness is different. I think it's different phenomenologically, it's different morally, and it needs to be addressed on its own terms. What one thinks about psychopathy, it seems to me, is an altogether different question. And we can argue about what the courts and commentators referred to as moral insanity a century ago, and the recognition that some people just don't seem to "get it" in terms of their moral sense and conscience. And that deficit may, of course, have some underlying additional biological basis. Whether that should matter is a different question it seems to me. Ultimately one gets into causation and predisposition for criminality. If criminal law gets structured on such a deterministic premise, the law of responsibility would be fundamentally changed. I doubt that our society would ever accept the idea that some people are just not cut out to be accountable for their behavior as a ground for some kind of defense. But as I said, I think that's just a different question.

Now, with regard to the indeterminacy of the appreciation inquiry -- which I think is a legitimate concern -- all of us involved in the criminal justice system have to recognize that mental state inquiries are by their nature indeterminate. We don't know what a person intended or what beliefs they had or what circumstances they were aware of. And yet we have to litigate those questions all the time. Criminal adjudication involves a steady stream of subjective mental state inquiries. And they are, by nature, indeterminate. We just have to do the best that we can to determine whether when somebody says, "I didn't think this," or, "I thought that," or, "I believed this," whether they are telling the truth. We all have to cope with the fact that they often have poor recollections about it, what they thought, particularly in times of emotional arousal. We just have to do the best we can to look at the circumstances and say, "Okay, we think, beyond a reasonable doubt, this is what the person did or did not think." So the fact that the inquiry is indeterminate is not a reason not to make it when we think it's essential for justice. Even Oliver Wendell Holmes acknowledged this. I think justice requires the appreciation inquiry.

On the other extreme, in terms of the debate that we're having here, I do have a great deal of concern about the volitional inquiry, because I don't think we have any tools to be able to make that judgment. The example that I would give is command hallucinations. If we are trying to ask, "Why did this person act on this hallucination?" all we know is that they did it. We also know is that plenty of people have command hallucinations and don't act on them. And we do not know whether the person could have chosen not to follow the command. So I think that is more indeterminacy than we want.

Appreciation I think is somewhere in between. I think we have to ask the appreciation question because if we ask any other question we're not getting it right morally. This is the right question to ask. There might be other ways of formulating it. It seems to me we want a nice, simple, understandable formulation, in asking whether somebody was able to appreciate the wrongfulness, that is to say the moral significance, of their behavior in light of the detachment from reality. I think I got it right about what the moral question is. And we can at least approach that in the same way that we do when we try to get inside somebody's head about what they believe, what their emotional experiences are. If we ask about heat of passion or any other kind of formulation that we use in criminal law, we are asking about what person's emotional and mental experience at the time of the offense. Psychiatrists can help us do that, if we don't get in the way by unfairly obstructing, their efforts to try to help us understand this.

Admittedly, the appreciation inquiry is less determinate than others. But it seems to me we don't really have much of a choice.

As Brian mentioned, the great concern I have about the volitional inquiry in terms of the daily administration of justice is when it is combined with a broad definition of mental disease. We've talked a lot about what comes after the mental disease requirement in the legal test, and haven't talked enough about the meaning of the mental disease requirement. As I mentioned earlier, in a lot of the states that have the Model Penal Code formulation, the definition of mental disease includes virtually anything that's in DSM. If you have any condition that's in the DSM, and then you ask whether the person was able to conform their behavior to the requirements of the law, in effect, you're just inviting experts to say why the person did what they did, and then link it up in some formulation, psychodynamically or otherwise, with a diagnosed personality disorder or whatever it might be. Juries aren't going to buy it a lot. So I'm not saying that this is a major problem, as everybody has said statistically. But it asks the wrong question, and it slips into a vocabulary of causation, a major conceptual error. And juries do make occasional mistakes on this basis. So that's the problem, the main problem, I think with the volitional inquiry. If we had a "severe mental disease" requirement, and it were limited to essentially psychotic symptoms, as Brian said, and as I have written -- and I will say it again -- I don't think there's that much problem with it.

The final point, though, is that I don't think it adds anything. I don't see how you can ask whether this person could have done other than they did. As the Hinckley testimony shows, for those who have seen my book, it doesn't add anything to the appreciation testimony. So you could add it; it probably wouldn't do any harm. But it isn't going to do any good either. It's just going to say the same thing using the volitional language instead of the appreciation language.

And finally, the dispositional issue, commenting on what Jim said. We aim for a fair dispositional arrangement but it's awfully hard to do. It may be even harder to get that right than

it is to get the insanity test right. A fair system of disposition is one that provides appropriate therapeutic restraint—and I want to emphasize both parts of that. It has to be therapeutic and it has to apply the appropriate restraint. Obviously, the restraint has to tilt more in the direction of protecting society than ordinary civil commitment does, because these are people who have been proven, beyond a reasonable doubt, to have committed serious criminal acts. So we have to err in the direction of restraint, but it has to be fair. And I think the pendulum continues to swing back and forth on our efforts to design a dispositional system that emphasizes treatment, that provides adequate resources for treatment, and that also gives people a fair opportunity to demonstrate that they can behave safely in freedom. And I think that the conditional discharge plan has the structure to do that. It might be that in Connecticut and some other places that they are administered without real attention to how fair they are to the acquittee. But we have to struggle to try to get that right.

The right to treatment case that Jim mentioned (R.A.J. I think) reveals a critically important argument in favor of retaining the insanity defense. The fundamental difference between a GBMI -- guilty but mentally ill -- verdict and an NGRI verdict is that the NGRI verdict entails a constitutionally enforceable right to treatment. The NGRI verdict provides the legal leverage to provide adequate conditions for treatment, where GBMI patients do not have that. And it seems to me, if we care about at least this sub-population of people with severe mental illness, the NGRI verdict is useful. Of course we ought to care about other people with severe mental illness who find their way into the criminal justice system, or even in the civil system. That was only a piece of the problem, but it provides leverage for treatment that abolitionists, in such a case, would not have.

BURNETT: Thank you. Mr. McClellan, your responses and reflections on the conference so far.

MCCLELLAN: Well, I feel like I've listened to five hours of a final argument and now I have five minutes to respond.

BURNETT: Oh, no. There will be questions coming to you.

MCCLELLAN: So I want to express some of the frustrations that prosecutors might have with some of these areas. So maybe the group hug might come to an end, I don't know. As prosecutors, you know, we have problems about how do we ever get to these issues? How do we get to severe mental illness? How is that determination made? And who makes that

determination? We often refer to the fact that these issues are determined by what I refer to as “self reporting.”

There was an example given about this guy who wanted to commit suicide, but it was against his religion, so he shot at the King. He was going to miss, though, because he didn't want to kill the King, or shoot the King. So then he knew he'd be punished by death, he would be put to death and it would not violate his religion by committing suicide. How do we know that? We know that because he must have told us at some point.

The Andrea Yates case seems to be the fair of the day, so if we look at the Andrea Yates case, we can talk about the fact that she had impulses to harm others, to harm her children, that she was controlled by Satan. That he was communicating with her. If she killed the children they were going to go to Heaven and not to Hell, that Satan was influencing her, yet she denied psychotic symptoms, and that she wanted to be executed because then Satan would be destroyed and her children would live. How do we know that? Because that's what she told them. It's self-reporting.

Now, we look at some of the other factors. Now, she committed this crime between 8:00 o'clock and 10:00 o'clock. Now, what's significant about that? Her husband goes to work at 9:00 o'clock. So the mother-in-law comes over to help her with the children at 10:00 o'clock. She had one hour of opportunity. During that one hour of opportunity, she drowns five children. She called 9-1-1. She called her husband. These sound, or seemed to be, somewhat logical legal reactions. Did she sit there and wait and watch TV and cook dinner and wait until he got home? Or wait until the mother-in-law got there to see what had happened? That would to me be more consistent with someone who was doing something as the result of that. Nobody ever looked at the idea that, “Well, what could be her other motivation?” Well, every since she had known Russell Yates—and I didn't try this case. I'm just picking this up from what I understand. Ever since she had been married to Russell Yates, she had been kept barefoot and pregnant, if you will. She's had five kids. Now, Russell Yates-- they also were going to all live in this one little house. In fact, at one point in time they lived in a bus, you know, with these kids. It looked to me like the youngest child was six months of age. So we're talking about they're all going to be home schooled, they're all going to be home “religioned”, if you will, and there's going to be 18 years of incarceration before she ever gets out. Her mother's day out is somebody bringing over lunch to her house, a friend brings food over and eats at her house. Does she go out and go shopping? Does she go out and go to church? Does she leave the children with Russell Yates and then go on about her business when he gets home? No, because Russell Yates is not having it that way. It seems to be a pretty logical reaction that, “I need to get rid of this guy.” Now, there's different ways of doing things like this. What thing could she have done that would have been the worst thing that could happen to Russell Yates? Kill those kids, because Russell Yates

wanted to have more kids. When the psychiatrist or psychologist said, "Don't have any more kids, because of post-partem depression," what did he do? Had more kids. She is nothing more than a conveyor belt to produce kids for him. That's how she felt, I would suggest to you. I have reason to believe that as much as anybody else has to believe that Satan was talking to her through the television. And so she's having these kinds of feelings, and she acted as the result of those. So whom does she call? She calls the police. She calls Russell Yates. "Come home." And that was the "get back," that was the "pay back," that she gave.

Now, everybody seems to have presumed that she is mentally ill. And I'm sure she does have mental illness. But mental illness does not equal insanity. Just because you're mentally ill does not mean you're insane. The law says, "As a result of severe mental disease or defect, you didn't know your conduct was wrong." There is a causation issue there. Can a mentally ill person act out of the same type of emotions that you or I act out? Anger? Happiness? Greed? Seek revenge? All kinds of emotions. And the answer is yes, they can. So how do you determine that Andrea Yates acted out of the result of a mental illness and not acted out of the result of the desire to get back at Russell Yates and put something in his mess kit?

So I don't know that you can get there from here. What you're doing is you're presuming things and their needs to be a causation. Now, people talk about, "Well, the myth is that..." Well, we've talked about different myths about the insanity defense. And we've talked about the fact that everybody does not believe in the insanity defense. Well, let me just tell this myth, or here's what I believe is what most people think. That anybody who would do what Andrea Yates did, or anybody who would do what many other people do who raise the insanity defense, you know, Angel Maturimo Resendiz, the railroad killer, a serial killer in Harris County, "Anybody who would do that has got to be crazy. They have to be mentally ill. No sane person would do that." In fact, in the Resendiz case, the defense wanted to put on all these extraneous offenses on in the guilt/ innocence stage, you know, and it's like we were trying to keep them out. And, "Wait a second, this here has been reversed." Because they wanted to tell all the times he committed murder, and no sane person would have gone on and done all these things. So they just flipped it around. And I think the presumption, when you see a horrible crime is, "This person has got to be crazy to have done this." And so we have to dispel that myth whenever we prosecute somebody.

We've talked about the myth that you can find any expert to say anything. Well, unfortunately, in the prosecution area, we find that not all the time to be a myth. I tried Maria Olivier for the offense of murder of a six- month old child and they used the insanity defense. And a well respected, at least by others other than me, in the Houston area, a psychiatrist, testified that the defendant was insane. Now, he's testified hundreds of times in Harris County, and continues to, to this day. Here is his examination. It lasted 30 minutes, in the bailiff's

office, during trial, on a coffee break. I mean, we started the trial on Monday, and I knew they had two psychiatrists. And they come up with this other person on Wednesday, and I'm thinking, "Well, if they examined her on Tuesday, we were in trial." And I asked him, "When did you examine her?" "Tuesday." "How long?" "30 minutes." "Where?" "In the bailiff's office." That's all the questions I had. Because if that's the kind of analysis you can get, that a person is insane, then I don't need to be talking to you about that. The jury did what I believe to be the right thing in that particular case.

The other myth I believe that exists, and it may occur in other areas, at least in other states. But someone who was found not guilty by reason of insanity by a jury in Texas is not going to spend an inordinate amount of time in a mental health facility. There are numerous cases where a person may be there a year or less if found not guilty by reason of insanity. Dean Shannon was talking about, "Why don't we trust juries?" They should hear about what happens when a person is found not guilty by reason of insanity. And I say, "Bring it on." Because I want to tell them. And I want to tell them, "If you'll allow me to tell them what is the reality of the world, that they may not spend hardly any time in a mental health institution, they may be released and out with you within a year or so, then that's not going to be something the defense is going to want to sign on for, I don't believe." But I have no opposition to telling them what a jury might do. Tell the jury what would happen to a person found not guilty by reason of insanity, because I think they ought to know that a person is not going to be incarcerated for the rest of their life, is not going to be incarcerated for a period of time that would be the period of time for the punishment they could have received had they been found guilty. That's just not going to be the case. But I don't want necessarily somebody just orchestrating, "Here's the language you're going to say." If we use the language of the parole charge, which says, "Nobody can determine...you can't determine how long they're going to be kept or not kept," I don't know that I have a problem with that idea. Just the idea of explaining to the jurors of what life was, or in capital cases life equaling 40 years. A lot of prosecutors used to say, "I don't want to tell them that," or whatever. Now it's widely accepted, I believe. And I always tell them I've never tried a capital murder case where they weren't told that. It had zero effect. I could see, "Well, they know they're going to spend 40 years for this offense so they're going to be less likely to give a person death." And my position was always that the death sentence is given as the result of the facts of the case, not the result of anything else. And the fact that it would be 40 years day for day, is they're not going to say, "I'm not going to give this person the death penalty." I just don't think it has that effect. So I do not know that I oppose just telling the jury, if you tell them truthfully, what might occur if not guilty by reason of insanity and the effects it is going to have.

BURNETT: I feel like I've just been given a final argument.

MCCLELLAN: I feel so much better. [LAUGHTER] [APPLAUSE]

BURNETT: And the group hug continues. Mr. Niland.

NILAND: Before he started, he said, "Now I know what it's like to hear four hours of closing argument and have five minutes to rebut," and I said, "Well, I'm glad you know what it's like to be a defense lawyer." Because I sometimes think the table is reversed. And I'm glad to know that he feels how we feel sometimes. So this has been a good kind of sharing of emotions.

It's really been a great opportunity for me to be here. And I don't know about you all, but my head is spinning with all of these different great ideas as to how Texas Legislation can be changed for the better. And in fact, my head is hurting a little bit trying to keep everything in and analyze it. I'm going to have to go back to the office and draw me a flowchart to keep it all together because there is so much and so many good ideas.

The one thing I would like to say is, and I don't know how many of our policymakers, representatives, are still here with us today; I hope that there are some. But what I would like to suggest to them, and maybe suggest to you all out there, is that we have got to recognize whatever we do with criminal law or the criminal justice system in Texas, we have got to realize the playing field that we have out there. As a criminal defense lawyer, if my client did not have mental illness, mental retardation, drug or alcohol addition, or abuse, there would be very few clients that I would have to represent. Now, we don't like that. And there's many things that hopefully we can do about that. Hopefully we can put that on the downside and reduce it as time goes along. But until we do that, we need to deal with it and we need to recognize it. And I think too often what has happened has been Legislatures have tended to ignore it and gone along with public reaction to particular situations that had gotten a lot of notoriety. The John Hinckley situation for one. Because I think it was that, as we have heard earlier today, that Legislation in Texas will change. I think that the Legislature had kind of gotten drawn up in all of the emotion that accompanied the public's reaction to the acquittal of John Hinckley. I think that our policymakers, though, have got to rise above that and realize that they have got a job to do where they need to deal with the issues that we have and deal with them in a fair way.

Now, those of you all who are out there who are not policymakers or legislators, you're still very important because you know somebody who is a policymaker. I hear from time to time from legislators how important it is, that they get calls from people who make intelligent suggestions about what legislation ought to be and changes that can be made. It does make a difference. Many people feel a particular way, but it's not very many people who go to the

telephone or go to the Capitol Building and talk with their legislators and say, “Look, this is a concern I have, and this is what I think needs to be done.” So I encourage you all to do that.

As far as the particular proposals that we have seen, I think that there has been one thing that has gone throughout, a theme that we have seen throughout our presentations today is, and that is something needs to be changed with the Texas insanity statute—that it needs to be broadened in some respects.

Now, which method you take, there has been disagreement. I think all of the proposals have good things and perhaps bad things. I like Professor Shannon’s idea. I think it addressed the problems that I see in this particular statute. I’m always concerned when I see proposals that focus on choice. And the reason I do that is the more I do this kind of work, and the more I become to understand the clients that we represent, the more I realize that they really don’t have all that much choice in the way their lives turn out. In fact, I find that most of the time our clients are people whose lives are chosen for them by someone else. And I think it’s hard for jurors to understand that, particularly if the focus is made on choice. I do believe that jurors need to be informed as much as they possibly can, because if they don’t, I think it’s unfair to the litigants. I think it’s unfair to the jurors, because these jurors are making decisions that they are going to have to live with for a long period of time.

I think it’s unfortunate in Texas jurisprudence that too often jurors are not completely informed of the consequences of their verdicts. This is just one example in the capital area. In capital murder cases, jurors are told that it takes 10 of them to answer special issues in a particular way that would result in a life sentence. That’s really not what the law is. The law is if they are unable to agree on those special issues, meaning if one of them did not agree, there is no hung jury; there is an automatic life sentence. But the jury is not told that. I think that certainly if we are going to entrust those jurors with that decision making process, we’ve got to trust them enough to-- or we feel the need for them to have as much information as they possibly can.

And I don’t think legislators, or people who fear that this may go too far, have anything to worry about for a number of different reasons. Because as it’s been pointed out, the insanity defense is not raised very often. It’s rarely successful. And to give you an example of some of the ways that jurors will go to nullify what would otherwise be a not guilty by reason of insanity instruction, there was a murder case not too far from here several months ago where the defense raised the issue of insanity, the state psychiatrist agreed that the individual was psychotic. The case went to trial. The jury was instructed that in any event they returned a verdict of not guilty by reason of insanity, outlined what the procedure would be following that verdict. The jury still came back and convicted the individual. And the fact was that the individual killed her sister because her sister had, according to the client in a state of delusion, had said the sister had done

something wrong. Well, the jury said, “Well, because she knew that the sister had done something wrong, then she knew the difference between right and wrong,” and they convicted her. Irrespective of the fact that her whole world was just one big delusion. And so I think, again, those things are going to happen. But I think we can eliminate them possibly if we give jurors the greatest amount of instruction that we possibly can and emphasize what decisions they are there to make.

Lyn had talked about some of the problems that he sees with this area of that law, and that is the self-reporting. And certainly that is something that I think psychiatrists and psychologists deal with. Lawyers deal with that. Our clients tell us versions of the facts; it’s not always the case. But I think an answer to that, and what you see in good defense representation, and I encourage any lawyers who are out there today that any defense of anybody where there is a mental health issue, for any case at all, needs to be being with a good psycho-social history. Because I think that you will find when there are psycho-social issues that are raised at the trial level, that it is not for the first time. If you go back in that client’s life you will see time and time and time again where incidences have indicated that this person has a problem. And I think we as lawyers we need to develop that. Because rather than starting out with a notion of what the psychiatric or emotional problem is, I think we need to start from the very beginning. And if we start from the very beginning, and develop that mental health evidence incrementally, it doesn’t make any difference what statute we have, we will be able to do the best job that we possibly can for our clients. Thank you.

BURNETT: One of the great things about having such a spectacular panel is that I came up with about 10 questions that I wanted to ask them, and they’ve already asked and answered four of them themselves, just in giving their post conference reflections.

The first thing I was going to ask is whether folks in the trenches, that being Lyn and John, actually thought jury nullification did take place. Is there a phenomenon where juries have a perfectly valid law, like the affirmative defense of insanity, but they ignore that law because it seems wrong to them to apply it in a particular case. As a prosecutor earlier today suggested in questions from the attendees, are jurors focusing more on the conduct of the crime that’s been charged, which in their view can never be excused regardless of what the cause is? Well, John and Lyn have already answered the question of jury nullification, which is going to lead to my next series of questions, what might we do with the Texas statute?

But it dawned on me while they were talking that maybe there’s one other preliminary thing we should get out of the way, and that’s the question of ethical norms. As people who are presenting today, some lawyers, some doctors, some both, I realize that we might be getting to issues of insanity using a very different ethical framework. And here I’m talking about not just

ethical restrictions on what we can say, what we can do, what we can ask, but also fundamentally different ethical norms. And so Dr. Zonana, what do lawyers and psychiatrists need to know about the ethics of one another's professions, since you teach both law students and medical students? Particularly, I'm thinking of how it might play out in a couple of pretty common scenarios. A defense lawyer might think there's a legitimate insanity defense in a particular case, but then decides not to raise it because if it doesn't work out at the guilt or innocence stage of the trial, percentage is it's going to make it that much harder for the client at punishment. "Why do I want to even broach these issues?"

And the second one that comes up is a conflict, I think, between treating doctors and attorneys concerning pre-trial forced medications when the issue of sanity is going to be raised at trial. The defense lawyer's ethical view being of course that this is going to present a distorted view of the client. So what do you need to know about each other's ethical morals and ethical restrictions?

ZONANA: A number of psychiatrists that use these evaluations tend to get very wedded to their own opinions, and feel that somehow that they have discerned what is truth, and therefore feel that that could be communicated. When we're working, we're being hired either by defense or by the state or by the court, and we have an obligation, depending on the agency for whom we are working for. So if an attorney says, "Well, thanks, Doc. I appreciate your evaluation. But in the long run I don't think it's in my client's interest to go forward or not," that's really his decision to make. And you should be willing to say, "Well, as long as I can get my bill paid," or something like, "I appreciate the chance to consult."

There are few cases, not so much in this country, where the adversarial system is honed to this sharp degree. But when I was in England, one of the docs decided that when the defense psychiatrist said that, that he wasn't very happy with that. So he wrote a letter to the judge and said he thought the person was mentally ill and needed to have this or that done. And their attitude over there is very different than I think what the attitude here would be. And the judge accepted it and so forth. So cultures vary in this kind of thing. But I think in our culture we are agents and should not intrude our judgments or values in something like that.

The second example?

BURNETT: Pre-trial forced medications when insanity is a contemplated defensive issue.

ZONANA: I got a call from a newspaper reporter two weeks ago who said that an attorney in the western part of Connecticut had filed a motion saying that they needed to stop the medication so the doctor could do an evaluation for insanity. I was really puzzled in some ways. I try to

think back about my own evaluations. I mean, I've been doing this now for some 25 years; I've done, you know, hundreds of evaluations. I've never asked the court or other people to stop medication on somebody in order to do an evaluation. You know, part of your evaluation is not just what people tell you, but you're looking at a whole variety of records and other reports and things like that. I have never found it necessary as part of my evaluations. I'm sure somebody can think of an example where it might be. But boy, that's a rarity. Usually it comes up in the question about whether or not somebody wants to waive their competency, this unanswered question at the moment, and appeal au natural in front of the jury in hopes somehow that will be more convincing. I mean, that's a legal question which the courts have to struggle with. These days I think we've got lots of other ways to generate that same data. Like I say, a lot of us videotape interviews early on. If the attorneys make a mistake, it's often-- and it wasn't in the Yates case because there they had somebody in within days. People wait months before they ask for an evaluation. And so then you're trying to reconstruct stuff. But I have not seen that as an issue for doctors that is necessary to do.

I'd just like to make one other comment. It's nice to hear a good advocate talk. And prosecutors will convince you that there's no such thing as mental illness at all.

BURNETT: And he does it a lot.

ZONANA: I thought his argument is especially important to really keep track on why it's important to narrow. Because the best example of when if you broaden something too broad, for both volition and for mental illness, has been the sexual predator statute. Now, I am sure he will give you an equally impassioned argument about how all of these people deserve to be committed to a mental hospital at the end of their sentences because they are mentally ill and predisposed to do it, in an equally passionate fashion. And so once you open doors in that kind of fashion, you can see the kind of mischief, as I like to call it.

BURNETT: Lyn, I'd like you to pick up on that same question. Are there things about the ethics, the ethical norms or the ethical restrictions, of either lawyers or forensic psychiatrists that you think we need to know about one another? And I'm particularly thinking in light of your comments of myth number two, that you can find an expert to say anything. That almost sounds like that's unethical conduct. Is that where you're headed?

MCCLELLAN: I would not want that to be a broad brush, especially for [inaudible] that one person because I had that particular experience. But I don't believe it really affects the profession. In the Resendiz case, we had a psychiatrist from the University of Virginia. I should

have called you about that. If I had of known you existed, I would have. And he testified for a long period of time on that case. I think the problem is that whenever, you know, you're hired by the defense, it's not like someone in the defense comes up and hires you and says, "Hey, I've got a client that's charged with a criminal offense. Would you go talk to him and come back and tell me what you think." You know, it's not one of these, "I'm not going to tell you what the charge is, I'm not going to tell you what my position is. Just go talk to him and see what you can come back and tell me." You go there with an idea. Because a lot of times when the charge is killing a bunch of people throughout the Unites States, we're going to use the insanity defense. Will you examine him on the issues of sanity?" So you know what you're looking for when you go in, and does that cause you, then, to be more likely to find it, or does that predispose your thought processes of what you do to try to see if you could discover that, as opposed to if you kind of talk to the subject and say, "Tell us what, if any, mental illnesses this person may have." Now, I don't think that's unethical to do that. But, I mean, I think that's something that lends itself to ties and be called into question.

As to the forced medications, I haven't been involved in the prosecution of Danny G. Thomas how after 17 years of incarceration on Death Row in Texas came back to be tried again, because at the time of trial his wife refused to allow him to go off his medications and required him to be on medications during the trial. And 17 years later we go back and try him again. And at that time, insanity was made an issue. Insanity was an issue at the beginning of the trial 17 years before, but they didn't even raise the issue of insanity 17 years later, partially because he never was insane. But that was, of course, medication required-- I was always worried about if the judge says you can or you can't. Because if he said, "Okay, you can take him off medication," then is the issue going to be, "Well, he was off his medication and we're not able to consult with him rationally about what was going on because he's irrational." It's kind of like an incompetent situation. And incompetency, as you know, can be any point in time along the scale, as opposed to the insanity issue which is the point of reference at the time of trial. So I think you're kind of damned if you, damned if you don't on the issue of forced medications.

BURNETT: Please, jump in.

ZONANA: I wanted to jump in on the ethics issue and what we can learn from each other. I participated on the Task Force on Competency that led to (I'm actually steering from the topic for a moment) a largely agreed bill between prosecutors and defense as well as doctors and psychologists and the like, and urge your support when that gets filed on the second.

But one of the ethical issues that was broached very well by Dr. Scarano and a couple of the other doctors involved was the ethical requirement that says when an expert is hired to do

both the competency evaluation as well as an insanity evaluation, which is pretty typical. I gather that ethics generally should require a halting of the process if the conclusion is that the individual is not competent—that you can't get a good reading about insanity if you're dealing with somebody that you believe at that point is incompetent to stand trial. And so that's led I think to trying to include some language along that lines as part of the statute as well. And I thought that was helpful for me being in the legal field and not in the [inaudible] before.

BURNETT: Dr. Shannon.

SHANNON: I want to make a comment also on the ethical issues that were just discussed. I think you can certainly state that as an ethical matter that professionals ought not to conduct exams in certain ways. 30 minutes isn't long enough, so on and so forth. I also think that judges can have a direct impact on this kind of situation. The Daubert decision that was mentioned a little bit earlier is relevant. The Daubert decision gives the judge discretion to exclude an expert who only does a 30-minute examination. Daubert required that the experts follow reliable procedures when conducting their evaluations. If you're doing a 30-minute evaluation for the court to assess, for instance, competency, insanity, and dangerousness, all on the basis of that one evaluation, that's a problem. If you purport to be able to address all three of those issues in that short evaluation, I think you should never be allowed to get on the stand. Of course, that example suggests that it can be prosecution experts as well as defense experts who might not do an adequate evaluation.

BURNETT: And that's a good lead in to my next question. And I apologize to those of you all from out of state. Let me set a little bit of a stage for you. We have Article 46.03 of the Texas Code of Criminal Procedure, and that authorizes the trial judge to appoint an expert to examine the defendant and within 30 days submit a report back to the court. Copies go to both the prosecution and the defense. So what do you think of this procedure? Professor Shannon, do you think that this portion of the statute should be amended, should be changed?

SHANNON: The task force on 46.02 largely believe that bill's requirements for experts on competency should include some parallel provisions in 46.03, at least in trying to do a couple of things: identifying some qualifications for experts, as well as having some broader identification of the kinds of topics that have to be addressed in a report. The main focus has been competency, but they plan to have some parallel provisions for including in 46.03, as well as in the Family Code.

BURNETT: What would be the point of a judge getting a report on the issue of insanity if insanity is an affirmative defense? It's an adversarial system, it's not an inquisitorial system. Why does the judge get this report at all?

SHANNON: That's a good question. Although this part of 46.03 is at least directed to those experts appointed by the court. It doesn't apply directly to, say, the experts defense might try to bring into their corner. It would not normally apply unless they plan to go forward with the defense.

BURNETT: John.

NILAND: Well, I think it's a real problem because you've got I think 56 amendments interested in this, [inaudible] rights to a defense, and so you're telling them, "Well, if you raise the defense of insanity, you've got to give notice and then you've got to subject yourself to an examination, and then as the result of that, not only does the judge get that report, but the prosecution gets that report. That is an even broader rule and more damaging to the defense than the rule when you waive non-insanity mental health issues. Because the Madrone rule it is called this state, that the defendant raises or gives an intent to offer evidence of mental health. Then the state is entitled to an examination. The state is entitled to an examination limited to the extent of examination which the defense has. A big difference is that the report will go to the judge, but the judge will only release exculpatory material to the attorneys. The report does not go to the state. It doesn't go to the state until the defense expert takes the stand. And then they get the report. So this, which I don't you'll like either, but at the same time this, I think, is a greater assault on the 5th Amendment, and the result of that is greater injury to the system and [inaudible].

BURNETT: Do you have a position, Lyn?

MCCLELLAN: Well, in the defendant's case, obviously you have to give notice in Texas of the intent to use the insanity defense. That's not going to be a secret. But the defendant refused to cooperate with the state. It's not really the state, it's the court...

BURNETT: Let's call it the state psychiatrist.

MCCLELLAN: Okay. The state psychiatrist we pay \$150 to, they pay \$50,000 to the state psychiatrist. And if he didn't agree to let him be examined, then the judge was prepared to rule that they could not put on the testimony of their psychiatrist concerning the issues that he had

talked to him about—he could talk about other things, but he could not talk about those things about the issue of insanity. And I think it takes the state law to support that.

BURNETT: Partisanship issues aside, you know, prosecutor/defender issues put aside, would the rules feel more comfortable or appealing to you if as a prosecutor you had the right to have your own independent exam, the defender had a right to its own independent exam, but the court couldn't order an exam on sanity that was reported to the trial court and then shared with everyone. Do you have a problem with if it were amended just to give you access to your own experts?

MCCLELLAN: No.

BURNETT: Good. Okay. Call your legislator, Bill. Anybody else on this topic?

We've talked a little bit about different alternatives to the Texas Statute. One alternative, is that we are assuming there is jury notification, maybe the statute needs a little refining. Different comments suggested during the day, one earlier comment was that we have an alternative jury verdict, such as guilty but insane, or guilty but mentally ill. I'd like to get to that in a minute. But what I want to ask about first is something we haven't touched on as much. And this is alternative approaches. What if we had bifurcated or even trifurcated proceedings in this state where the issue of sanity is broken out of, totally, the question of guilt/innocence, the question of punishment. And Professor Bonnie, I'd like to turn to you at this point, is this going to do violence to your theory of insanity as an inescapable moral judgment based on commonly shared moral intuitions? Or could you live comfortably with having one jury decide sanity, and if the answer is that they are sane, impaneling yet a different jury to determine guilt/innocence. In other words, not have the two issues mixed up in the same proceeding.

BONNIE: I guess my reaction to this is there are a lot of other problems to solve. And this one seems to me to be really an unnecessary complication. It's obviously going to be very rare situation in which the person who is entering the insanity plea hasn't essentially conceded that they committed the act. And given all the other issues that have to be addressed, including 46.03 and other ways in which we can try to preserve the prerogatives of the defense, I think if you solve those problems, then you don't need to worry about bifurcating to trifurcating the proceedings.

I would like to go back to 46.03, because I think revising this provision is very important. As I understand Texas law, this statute provides the sole way for an indigent defendant to get access to a pre-trial mental health evaluation on the issue of sanity. If this is so, the system is unconstitutional needs to be modified. The defendant should have an opportunity to have an evaluation conducted within the framework of the attorney/client relationship, and the evaluation should be privileged unless and until the decision is made by the defense to put the insanity claim in issue, and then the prosecution is entitled to have its own assessment. The ABA Criminal Justice Mental Health Standards say all this. There are lots of statutory models that say this. And I think that that puts the decision squarely in the hands of the defense, where it should be, to decide whether or not insanity is a matter that should be considered.

BURNETT: Any other questions on a bifurcated or trifurcated system?

UNKNOWN: They've got a system like that in California. Nobody has particularly emulated it or thought it to be a good model as far as I know.

BURNETT: If it had been in any state other than California, do you think-- [LAUGHTER] Okay. So California stands alone and nobody here is particularly in favor of that approach.

UNKNOWN: I have a hard time seeing the value of it as much in the area of insanity for this particular reason. I think that competency is going to necessarily relate to the time of trials, and mental retardation does not necessarily have the same implications for the defense. So, I think from a practical sense that it's kind of difficult to pull one out and say, "We're not going to talk about the circumstances of the offense, but you still have to decide if he was insane at the time of the offense." It's going to be difficult to do.

BURNETT: So the same sort of hearing dilemmas are likely to take place that the system would be designed to correct. Probably so.

Our last question, before we move seamlessly into open questions from the audience, is going to concern the alternative verdict form. And I'd like to open this up to anybody on the panel who wants to address whether we should have guilty but insane, guilty but mentally ill, and I'm going to ask Professor Slobogin to start with, because I think you've written in this area, right? So is this perhaps a SOP for jurors, is this something to make jurors feel good, and does it change what ultimately happens to the persons that are convicted?

SLOBOGIN: I guess I can summarize my thoughts by describing the title of the article that was just referred to: "The Guilty But Mentally Ill Verdict: An Idea Whose Time Should Not Have Come." The GBMI verdict was very popular post-Hinckley. Twelve states adopted it. But virtually no state has adopted it since that time, I think largely because it's a hoax. I think people who first hear the verdict name think that somehow it treats the person found guilty but mentally ill differently from the person who is found straight guilty. But in fact, people found guilty but mentally ill receive exactly the same sentences as a person who is found guilty. In fact, the research suggests they get probably more enhanced sentences than persons found guilty. Apparently mental illness acts as an aggravator, as was suggested a bit earlier. And yet juries don't understand that, and they think, "Oh, a guilty but mentally ill verdict. That's a compromise between insanity on the one hand and guilty on the other, so I'll find them guilty but mentally ill."

Even defense attorneys have been fooled by this verdict. There have been defense attorneys who have pleaded their clients guilty but mentally ill in capital cases, thinking, "This will, at least, prevent the death penalty." Guess what? People found guilty but mentally ill have been sentenced to death and executed. So it's a total hoax.

I could say a lot more about the GBMI verdict. It does not reduce insanity acquittals based on the research. And it does not protect society to any greater extent than the system we already have, and so on and so forth. I think I'll just stop there in case somebody else has some other points.

BURNETT: Anybody else?

SHANNON: I used some of my time this morning and talked about the distinction in Oregon where they just changed the name to "guilty except insane." The person is then directed to the hospital setting. They don't have a so-called "insanity defense" because what they call the insanity defense is "guilty except for insanity." And, so that's different; that's not "guilty but mentally ill," and I think it's far more worthy of something to be looked at. "Guilty but mentally ill" is, for all practical purposes, what we have in Texas. Because, we don't have an insanity defense in Texas. It's been narrowed so as to be completely meaningless for all practical purposes, except when there's an agreement by the prosecution and the defense in a rollover kind of case. So, we send them to prison to the psych division within TCDJ.

BURNETT: Okay. Now, here's the seamless part. They're going to sit here and the good Doctor and I are going to trade places. You all stay there.

AXELRAD: Well, first of all I want to say on behalf of the Planning Committee, we made the right decision in having Dean Burnett come and moderate this panel. And she'll be feel free to respond to any questions or comments from the floor.

This is now the time to open the discussion up from the audience. And you can either ask questions, or if you have a particular point of view that you'd like to express, as long as it's narrowed to the insanity issue, feel free. I need to remind everybody again, we're transcribing these proceedings, so please identify yourself. And the panel is up here and is free to respond to any questions or any comments that they would like. The microphone.

JIM JENKINS (Attorney from Waxahachie): My name is Jim Jenkins. I don't have a question. But I do want to express to the organizers of this whole deal and the participants my great admiration and appreciation for you doing this. I've been practicing law for 30 years, and this is by far one of the most exciting days, and probably the most exciting stimulating events like this I've ever been to. And I want to thank you very much for doing this. [APPLAUSE]

AXELRAD: Now, I know that the recorder got all that, right?

UNKNOWN: I'd like to comment on that. I sure hope that was hyperbole. [LAUGHTER] Because I feel sorry for your practice if that's true.

AXELRAD: Next question or comment. And identify yourself please.

DR. GOFF (Psychiatrist from Victoria): I'm Dr. Goff. I am a psychiatrist practicing in Victoria, Texas. When I got out of my residency, it was in 1965, so that was quite some time ago. And as it would happen, the first night I was on call for the group that I was with, there had been two college university students that had been strangled and raped and left out on Runview Road or something like that, which was wilderness at that time. And I was watching the 10:00 o'clock news and my wife said, "They found the man. They found the murderer." And I looked at her and I said, "They're going to call me at 8:00 o'clock in the morning and want me to do a psychiatric evaluation on this man." And that's truly what happened.

I got a call early in the morning, and I went over to see him. And I actually spent months working with this guy. I was brand new, and at the time I was very curious intellectually as well as through psychiatry as to what in the world this man was up to. What in the world had happened to him? So I tried to get a longitudinal history. I went to his parents, I went to school teachers and so forth, people that had known him for years. And they had absolutely given me no indication of psychopathic behavior in his past, which is quite unusual if you do a

longitudinal history on sociopaths. I wish I had had some of you gentlemen to help me out at that time, but I had no guidance whatsoever. I had just gotten out of medical school, I had just gotten out of my residency. But after working with him a long time, this man had the fantasy of raping and murdering a woman, and had gone around the campus from time to time looking for the opportunity to do so. But, again, had no history of doing anything like this.

After all this evaluation and psychological tests and everything, they were not of much help. Of course, the prosecution was going for capital murder. And I was actually hired by the family to see if that could be avoided. I was flying by the seat of my pants. After working with him a long time, I felt like this man—it was kind of like temporary insanity, except that he had thought about this, he had planned this along the way. But I didn't know how to classify it. I really didn't have a DSM 4 or 3 or 2 at that time. So my testimony was that he had, of course, done what he did. He admitted to that clearly. But that I really did feel that there was a type of insanity involved here that I did not understand, but that I really felt that there was some here that would hopefully later, as we knew more about this, had more time, had more studies, had more research, we would eventually be able to see what was going on. But we couldn't at this time. But we had a real tough prosecutor at that time, and he ate me up pretty good, as you can imagine. And just before the break I said, "This reminds me of the book, *The Mask of Sanity*," and then we recessed.

So when we got back together after lunch, the District Attorney jumped on that very quickly. He said, "Doctor, you mentioned the book, *The Mask of Sanity*." I said, "Yes, sir." He said, "Well, isn't that the book that said that these people are not insane?" And I said, "Well, sir, that's not the way I read it. The book, as I understand it, said that these people look quite sane, when you look at their longitudinal history, there's no sign of insanity there. But there's something self destructive about their behavior. They seem to always trip themselves up. They just keep doing terrible things until finally they get caught and are dealt with in one manner or another." I said, "I felt like there was some type of insanity here." Well, the result was he wasn't given capital punishment. I guess I put enough doubt in there, although it was pretty shaky doubt, that he would be given life in prison. And I was hoping that that was where he would stay for the rest of his life, but he didn't.

About 25 years later, I had this attorney call me again and say that this man is going to be tried again because the jury that had convicted him had also sentenced him, and that that entitled him to a re-trial. And I'm not a lawyer, I didn't know anything about it. but that's just what they told me. And they wanted me to testify again. Well, I had learned enough by then, 25 years later, that I didn't want to testify in this case. I still felt like he needed to be in prison the rest of his life. But he was re-tried and he was released. One of the reasons that he was released, in my opinion, was because, first of all, he had a wonderful history. He was in Huntsville, and he had

worked in the medical department there, and had gotten two or three degrees in all that period of time. Had been a model prisoner in every way. And probably the most distinguishing thing I remember is that his social worker fell in love with him and she worked very hard to get him out, and then they were married. And I remember thinking, "I wonder what she thinks when she goes to bed with him ever night?" If she was worried about what happened during this time.

Listening here, I don't think we've learned that much more. If I had to go there again, I don't know what I'd say. But at least we're all trying to understand this better and give everybody a fair chance. Thank you.

AXELRAD: Thank you.

JOHN BUTLER (Attorney from Austin): I'm John Butler. I'm a defense attorney here in South Austin. I was thinking on the difference in the definition in the Penal Code is a very narrow definition and the much broader ALI definition that's in the Family Code for juveniles. Three questions come to my mind. The first, are there any data or anecdotes on what difference these different definitions have made in jury trials? Secondly, has anybody seen any kind of equal protection problem with having a different standard for juveniles or adults, or juveniles that's certified as an adult? And third, I guess Mr. Smith may know this, what's the disposition for a juvenile that is found insane? What facilities or what treatment for follow-up?

AXELRAD: Good questions. And we'll let the panel take them, whoever would like to respond.

UNKNOWN: I'm not aware of specific data in Texas. But I've wondered the same thing you have with respect to a juvenile being certified in that there's change to substantive intent on how that might fair if a challenge were raised. As far as disposition, Jim?

SMITH: I wish I could be more help than I'm going to be able to. But I'm racking my brain and I cannot recall a case where a young person was so referred.

SLOBOGIN: I think probably one reason that Texas still has the Appreciation Test in the juvenile context is that the dispositional consequences of an acquittal or a conviction in the juvenile context are so different from what happens in the adult context. There's no real consequence to having a broader insanity defense in the juvenile context because the sentence will end at age 21 anyway. If, instead, we started imposing adult sentences on juveniles, you can bet your sweet bippy that the juvenile insanity test would be changed in Texas to a more narrow

one, at least if what's going on in the adult context is an indication of what Texas citizens think about insanity.

With respect to data about the impact of different tests, there really aren't any. There was a study done by Rita Simon which suggested there wasn't a significant consequence to the specific test language used. But she did find a difference between the product test, on the one hand, and some of the other insanity formulations on the other. In a book that I did with three other individuals called *Psychological Evaluations for the Courts*, we did a very rough kind of study where we looked at the acquittal rates in a number of different states that had different types of insanity formulations, and we weren't able to discern any real pattern. It didn't seem to matter whether it was the M'Naghten or the ALI test. But the problem is, there's all sorts of confounds. You often have different burdens of proof and so on and so forth. Finally, there's a study by Hank Steadman and his group which found that perhaps the law does make some difference--not the test language, but the *burden of proof*. But the data are very murky overall so far.

AXELRAD: Anybody else want to comment? Our next question, microphone in the front.

DR. MITCH YOUNG (Psychiatrist from Houston): Since the group hug is over, first a comment and then a question. My understanding is, and correct me if I'm wrong, is that the judge did not remain an expertise in the Yates case, but did in the Resendiz matter, and that the state expert in the Yates case did comment that it might well be appropriate in view of the [inaudible].

And now the question. There is authoritative scientific literature on moral development with various standardized measures of moral development. If penal proportionality requires an assessment of moral versus immoral or blameworthy choice, as was suggested earlier, in the absence of systematic training or measurement, should it be a state case prong to the insanity defense, or psychiatric or jury finding of evil?

MCCLELLAN: I have no earthly idea what you said.

DR. MITCH YOUNG: Let me try to say it plainly.

MCCLELLAN: Put it in my language.

DR. MITCH YOUNG: Yeah. My understanding is that in the real world if the victim dies the insanity defense is nullified. And the rest of this talk is talk by a bunch of people who shouldn't be talking. And maybe I'm wrong about that.

AXELRAD: That's a nice provocative comment. Anybody that would like to take that on?

UNKNOWN: I guess just as an empirical matter, people who have committed homicide are acquitted by reason of insanity. This tends to debunk that last statement.

AXELRAD: Microphone in the back. This is Commissioner Bayles. He is on the Commission of Mental Health and Mental Retardation, the Commissioner.

DR. SPENCER BAYLES (Psychiatrist from Houston): Well, I'm on the Board.

AXELRAD: Oh, you're on the Board of the Commission.

DR. SPENCER BAYLES: The Board that advises the Commissioner.

The question I have for the panel, is there any possibility in the foreseeable future of getting the Law of Moses amended or dropped? The extent of the discussion all day has been the question of how fair is it to punish the person? And the system is based on justice. And according to the rules that Henry Robby and Moses laid down of "a life for a life, an eye for an eye, and a tooth for a tooth." If we would get away from the principal of retaliation to the person who is a miscreant for what he had done, we could ask one jury to determine, "Did the person, in fact, do the foul deed?" And then use our separated trial method of a second trial on the issue of what should be done with the person. The question then should not be, "What is the best punishment, or what is the fair punishment, but what is the treatment of this person that's likely to lead to the safety of the general public?" The person, by having been found guilty of a foul deed, has given the state an authority to decide what should be done with him. And in some instances it will be that there is a treatment that's likely to cause a relief or safety to the public, for maybe even a short period of time. There are other persons where there is no treatment that's known to make a difference, as in pedophiles and psychopaths. But at the moment, or for the foreseeable future, we are hung up on how to make the punishment fair, or as Gilbert and Sullivan said, "My object all sublime, I shall achieve in time, to make the punishment fit the crime." But since that is following Moses's advice, we ought to be able to, in 3000 years, to get a little bit ahead of it.

AXELRAD: Thank you. Any comments on that? Dr. Zonana.

ZONANA: If I understand you correctly, it seems to me what you're arguing for is basically an abolitionistic position. If you're essentially saying *mens rea*, that as long as someone has some

degree of intent, that's all you need to look at for the first part of the trial, which is really then saying that you're not going to consider appreciation or mental state earlier on in the process. And that then transforms it into just the question of litigation or something else.

AXELRAD: Go ahead, Jim.

SMITH: I very much appreciate the question and comment. It seems to me that, again, it goes back in some respects to what we expect, what we want from the various systems. For instance, when someone comes to us at the hospital after having been determined not guilty by reason of insanity, there is absolutely nothing that suggests that the hospital in any way should be a party to punishing or incarcerating. I know that's not what you're suggesting. It's just to make the point that throughout the afternoon I've heard comments like, "Should we be able to tell the jury that if there's a finding of NGRI, here's the dispositional issues that if they go to the mental health system." There seems to be a concern that if they go to the mental health system, we may not keep them long enough. And that may be true. I mean, people will have different opinions. Where I'm coming from is that it's not the job of the mental health system or the hospital to keep someone for any period of time beyond what is necessary to accomplish whatever treatment mission has been assigned to the hospital. I know that must be terribly frustrating for some folks, particularly in the public, to think that, "Golly, these people are found NGRI, they go to hospitals, and they don't stay long enough." But quite frankly, there are loads and loads of examples where short-term treatment is extraordinarily effective and it gets the desired results.

When I received a joint appointment as Superintendent of the Wichita Falls State Hospital, I remember a woman patient we had pushing three decades at that facility. She had been tried on every anti-psychotic medication that was routinely available. And someone put this woman on Clozapine. Within three weeks we were making discharge plans, because that's what it took. She was resistant to every other kind of medication, but a new generation anti-psychotic, it was like the silver bullet. And I'm not saying that it's like the silver bullet for everyone. But for this person it was. To have kept that person in that hospital a day longer than was necessary to make effective discharge and after-care arrangements, I think would have violated her rights. I don't think her rights were violated for all of those decades that she was there, because that was the best place under the circumstances then.

I think with insanity acquitees, sometimes what we find is that they come to the hospital and if they get appropriate care and treatment, they're ready to move out of the hospital sometimes faster than anyone would like, because there's this sense that we should keep them longer. But I'm just suggesting to you incarcerating or keeping people confined is not our mission—treating is. Where we get into horrible problems in this state is that we can do the best

job that anyone could ever expect in an institutional setting, but if they get to a community program and the supports are inadequate, or it's difficult or impossible for them to have access to the kinds of services they need, there are going to be consequences. And if that happens, there's a darn good chance they're going to be dangerous if they were dangerous before, because I think we all know that a history of violence is probably the best predictor of future violence. And that's what we bump up against.

AXELRAD: Professor Bonnie.

BONNIE: As the person who asked the question may know, there were actually proposals made along this line for a long period of time, at least over the past century, quite often. And one particular one that I'm aware of because it's in all the criminal law casebooks, a proposal that was made by a woman in Great Britain named Lady Wooten. And it's actually set forth in exactly the way that the questioner posed it, which is, "Why don't we just use the criminal trial to determine whether the person committed the bad act, and then, instead of the premise at that point being punishment, we should just select the disposition that will minimize the likelihood of repetition of the offense." Her proposal is used to raise the question about whether we should radically overhaul the system that we now have, by erasing the issue of punishment and substituting a rehabilitative foundation. However, it has never been done and under the system we now have, one of its purposes, and maybe the dominant one, is punishment.

You might also recall that rehabilitation was the premise of the juvenile court when it was created a century ago. "Well, why not do that now?" you might ask. However, the recent history of the juvenile court shows us that the dominant thinking about the purposes of the criminal law, including juvenile delinquency adjudication, is moving in exactly the opposite direction. Some of the European countries actually have something that is a little bit more along that line, called basically a "social defense" view of the criminal law. But that's surely not ours. Our assumption throughout this symposium has been that the underlying premise is responsibility and punishment, and we have to act within that framework.

AXELRAD: Anybody else on the panel that would like to address this question? All right. The front microphone. Identify yourself, please.

DR. MITCH DUNN (Psychiatrist from Terrell State Hospital): It's Mitch Dunn. I guess this question is for Dr. Axelrad and other members of the TSPP. You had a variety of panelists make numerous very articulate presentations about their suggestions about how we might change the insanity statute here in Texas. But they were different presentations—they had different ideas.

As citizens of Texas and members of the TSPP, where do we go now? Are we going to present a coherent or articulate plan to the Texas Legislature? Are we going to throw out or are we going to hand them the different syllabi from the speakers and say, "Here's a variety of things that we might think"? What next?

AXELRAD: Well, I don't want to presume to speak for the Executive Council of the Texas Society of Psychiatric Physicians of such policies. But I'll share with you that the perspectives and the philosophy of this whole program is going to be carried forward in this context. We as a psychiatric society have an obligation to the citizens of Texas: to provide relevant information that can be useful to the Representatives representing the people of this state as to where we go from here regarding insanity in Texas. We took upon ourselves the responsibility of inviting all of the relevant legal organizations in the state who have joined with us, from the Texas Bar and the relevant committees to two major state associations of attorneys involved in this matter. And we essentially had determined that by providing this kind of program, we are providing the kind of information that our Legislature is going to need to arrive at a just and proper bill to address this question of insanity. And, of course, there are a variety of perspectives here. And we felt that this would be a way of getting it to the Legislature. And we also have another policymaking organization in this state, which is the judiciary, that sometimes sets rule and procedures involving insanity.

Now, as Executive Council, we'll be willing to provide spokespersons for the TSPP at the appropriate time to address these various questions if a bill comes before you, Legislature, but I can't speak for what position might be articulated by the Association until the Association makes a decision as to how to proceed. But right now we are providing this information as a way of discharging our views. I think if any TSPP member has a difference of opinion here, the President of the TSPP is here, Sandy Kiser, who might be able to say something more enlightening than I have. But I think it's an important question.

DR. SANFORD KISER (Psychiatrist from Dallas): Yes, David. This is Sandy Kiser from Dallas. I think you stated the position of the TSPP very clearly. There is a group of very complex issues that are before us. As physicians and psychiatrists, we have a certain area of expertise. In the legal arena, lawyers, judges, have another set of expertise. And where those boundaries meet is very difficult and challenging. As we started out today, we're talking about how difficult it is to determine where those meet. And we're trying to, today, present these issues for open discussion and open debate. We don't have any specific positions as a state psychiatric organization on this. But I will say that it's been a wonderful presentation. It has given so much food for thought for all of us.

On the psychiatric side of things, I will say that I think you have presented a challenge by organizations in that how can we best provide the standards, to provide the data, to the legal system to make the best decisions? You've wonderfully presented the cognitive, volitional, punishment/treatment issues. But ultimately you and all of us depend upon the clinical data that comes forth from the evaluations. What's the quality of that data? It may be good for our society to establish a practice guidelines for what is a quality evaluation of quality data.

So rather than there being a definite position, I think we will be spurred into action.

AXELRAD: Thank you, Dr. Kiser. Before the end of the day, I will give you the phone number and address of the American Academy for Psychiatry and Law where you can make contact with the organization that has published this practice guideline that Dr. Zonana has so eloquently addressed today.

At the back microphone is Ms. Genevieve Hearon, who is one of the founders of NAMI-Texas, and she also is the founder of an organization in Texas called the Capacity for Justice. Your question or comment, Genevieve.

GENEVIEVE HEARON (Advocate from Austin): Yes. Thank you. And again, I would like to express appreciation for the day and the work of the TSPP to make it happen. In the array of the alternatives that have been presented today on the way to treat the insanity issue, we heard mention of guilty except insane. In my view, there's not much difference between that and guilty but insane. There's one word in there. And I heard some mention about it being dealt with in a hospital. But I wish the panel would clarify that alternative in relation to the other alternatives that have been presented today. I really appreciate the data that Professor Slobogin brought up about guilty but insane, because I know in Texas there was an effort to make that happen, and it didn't happen.

SLOBOGIN: I think earlier when I was talking about the guilty but mentally ill verdict I may have been a little confusing, so let me clarify something. The guilty but mentally ill verdict is meant to be an alternative verdict to the insanity defense. In a guilty but mentally ill state, jurors are told they can find the person not guilty, guilty, insane, or guilty but mentally ill. They have all four verdict options. The idea behind the guilty but mentally ill verdict, at least as traditionally proposed, is to give the jury this compromise verdict so they will be tempted to avoid an insanity verdict. That's what I was explaining in my earlier comments, and that was why I said the verdict was a hoax.

GENEVIEVE HEARON: Right. I hear you.

SLOBOGIN: In fact, you receive the same sentence as if you're found straight guilty. It doesn't guarantee treatment, it doesn't protect the public to any greater extent. Then there's the "guilty except insane" or "guilty but insane" verdict form, which is totally different. It's not an alternative verdict. It's another way of describing the insanity acquittal. And I'm going to hand this over to Brian and let him talk about that.

SHANNON: And, Genevieve, that "guilty but mentally ill" approach that Chris talked about is another form of guilty. The "guilty except for insane" that Oregon adopted, and to a lesser extent Arizona, that is their NGRI. Instead of telling the jury that their third choice after "guilty" or "not guilty" is not guilty by reason of insanity, instead, this is their third choice in Oregon. It's the ALI test. The result is different in that the result is equivalent to an NGRI finding in that the direction is whatever state process that they have for hospitalization. The Psychiatric Security Review Board, etc.

GENEVIEVE HEARON: So it goes that way.

SHANNON: Well, it's essentially like an NGRI finding. And, the theory is that jurors might feel better about making such a finding if they say "guilty."

GENEVIEVE HEARON: Is there data on that practice?

SHANNON: I assume there is out of Oregon and Arizona, but I have not seen any.

AXELRAD: Are you saying that it will increase the number of insanity acquittals or decrease the number of insanity acquittals?

SHANNON: I don't think there's any data on that.

AXELRAD: All right. Any other comments on that point? Okay, the front microphone, please.

DR. BRIAN EARTHMAN (Psychiatry resident in San Antonio): I just wanted your thoughts on system where judges are elected versus a system where judges are appointed. And if you're going to make statutory changes like we're talking about today, how much of an equivalent shift in public opinion do you need to help make real world changes when you're going to make the statutory changes?

AXELRAD: Good question. Who would like to take that first? Brian?

SHANNON: I'm not entirely sure of the premise, but I think one concern that has been voiced in the past with respect to an elected judiciary relates to the amount of time that somebody who has been found NGRI might continue to receive, once a year, long-term commitments orders, that there could well be some bearing with respect to a judge who might be appointed versus a judge who has to come back before the populous. But, that's entirely anecdotal. I've heard some stories on that. There are far more and different reasons why, I think, a number of Legislative leaders have looked at the possibility of pursuing some kind of Missouri plan or the like for selecting judiciary. I've never heard the insanity defense as being one of the reasons that they've talked about for judicial reform.

AXELRAD: Any other comments from the panel? Mr. Niland?

NILAND: [Inaudible] the issue of [inaudible] Texas Supreme Court just kind of made these issues. And his conclusion, after working on it for some time, was that nobody cares. So unless somebody cares, nothing is going to happen. And so there's got to be a ground swell coming from somewhere. But, you know, I think if you go to somebody on the street and ask them about members of the judiciary, they're not going to know anything. And if you ask them, "Does it make any difference to them whether they're elected or appointed," they're not going to say, it's probably not going to make any difference. So I have practiced in two jurisdictions where judges were elected, and I'm amazed at the difference of the attitude of those judges that are elected. You would think that they would be the same, but they can be completely different. I think that appointed judges, I think that system has a lot to offer, but I think we are a long way away from doing that. And I think there's going to have to be a ground swell coming from somewhere, and where it's going to come from, I don't know.

AXELRAD: Front microphone.

DR. JOEL KUTNICK (Psychiatrist from Corpus Christi): My fondest hope is that this today leads to perhaps a panel that will begin to advise our State Legislature that we need some changes in the interface between psychiatry and the law and all those issues. I would also suggest that if that comes about, we expand it into also looking at-- I consult at the State School for the Retarded, and we have a number of retarded people that have been declared incompetent to stand trial when their crime was breaking out a window. And essentially they have a life sentence because of course they're never going to gain competency, which seems to not be just.

So to look at that issue. And the other issue that I think the public is very concerned about, I agree the hospital's goal should be to get these people well. But the public also wants protection, and we know a lot of the mentally ill people, once they leave the hospital setting, stop taking their medications, get psychotic again, and violence and the crime is repeated. We need to have some plan how we keep these people that have done a crime and they were ill, but how we keep them in treatment so it doesn't repeat. Because right now we lose a lot of them, and the public is very upset about that.

SMITH: There are a number of states that have conditional release programs. And there was a program out in California, I really don't know the status of it now, but I would presume that over the years it's kind of fallen victim to some of their budgetary woes. But a friend of mine used to be administratively responsible for what they call CONREP, for Conditional Release Program. I think a lot of it was oriented to violent sexual offenders. But the principle was really interesting, and that is that if someone transitioned out of an in-patient setting into the community, with the potential for violence, then there was a risk for dangerousness management plan. Community based treatment was an ongoing condition for release and continued stay in the community.

It's my understanding that in some of the conditional release programs what you'll have are ways for the out-patient providers to intervene when any of a series of conditions that have been set for that out-patient placement are violated. I know in California, at least in the initial part of this CONREP Project, for instance that if someone was a pedophile, and they were at a supported group home and one of their conditions for release was urine screens for drug abuse, and attending so many therapy sessions in a given period of time, or not being within a certain proximity to a child, that violation of any of those conditions would allow that person to be taken into custody and returned to the state hospital. Now as I recall, there was a hearing process that would follow later. But the thing is, there was an opportunity to intervene very quickly, get that person out of that environment, into a setting where essentially it became an issue of treatment. So it's like a pre-emptive strike before someone committed a crime based on a series of conditions that were set to manage the risk that had been identified.

We don't have that in Texas. The thing is, even with out-patient commitments in Texas, my experience has been that more times than not there's a major event before the person again comes to the attention of the court. There's a failure. And it's not simply a failure to meet their particular conditions for outpatient commitment. So I think there's some things that we could do to avoid keeping people in hospitals any longer than they need to be. And aside from moral issues, hospitals are very expensive places. We don't have, in my opinion, adequate mechanisms to do that, and I'm not convinced that we have the adequate resources available

right now in community settings to really honor the terms of what I would consider viable management planning. Dr. Mitch Dunn deals with this day in and day out in Dallas and that metropolitan area, and might be a good resource.

AXELRAD: Thank you, Jim. Any other questions or comments? We're about ready to have the highlight of the proceedings today, Dr. Scarano's summary. In order for this to be seamless, I would like to have the panel stay up just for a moment, if you don't mind. I want a captive audience.

Dr. Scarano is the Director of Forensic Psychiatry Training at Baylor College of Medicine. He is on the faculty at Baylor, and he also is a Board Certified Pediatric Surgeon, a Board Certified Thoracic Surgeon, he has practiced Thoracic Pediatric Surgery, he also is a JD, and he is an attorney who actually trained at the University of Florida, I think, at the same time that you were there, Chris. And he is currently involved very actively—in fact, he was very actively involved in the task force that just recently concluded the competency reform in the State of Texas. Dr. Scarano has been asked to summarize all of these proceedings in 10 minutes, and I know he can do it. [APPLAUSE]

SCARANO: First we heard from Dr. Zonana, who gave us a clear and concise history of the insanity plea and its origins in English Jurisprudence, including the M'Naghten cognitive test, the Durham Product of Mental Illness Test and the ALI Penal Code Test, which was a combination of both the cognitive and the volitional prongs. In the ALI Test, of course, we use the words such as "substantial capacity" and "appreciates," which provides a more reasonable opportunity to find a defendant insane at the time of the alleged crime. Many of the psychiatrists in the State of Texas are grateful that the Texas Legislature has used the word "appreciates" in the Texas Medical Consent Act. It was placed in that Act to allow the physician to have a broad discretion in assisting mentally ill individuals or other individuals who do not possess the capacity to make medical decisions, to obtain a surrogate decision maker. On a number of occasions, we are confronted with identical words used in one section of the law that may not be understood as meaning the same in another section of the law.

Dr. Zonana reviewed the Connecticut statute. I was very interested in the Psychiatric Security Review Board. One of the primary concerns had to do with public safety. The discharge burden was on the NGRI acquittee. Dr. Zonana provided us with a very useful list of the state laws pertaining to insanity. In Texas, we have a Dangerousness Review Board, but it is not constructed, in my understanding, similar to the Connecticut Psychiatric Security Review Board. In Connecticut, Dr. Zonana said, and I believe it is also true here in Texas, that the insanity plea is usually used in serious cases rather than in misdemeanors.

Now, an important thing to understand, as Dr. Zonana pointed out, is the fact NGRI acquittees often spend more time in an incarcerated situation than if they were found guilty in the criminal system and sent to prison. I think this is an extremely important point for defense attorneys in our state to understand, because I have visited the psychiatric hospitals in the Texas Department of Corrections, which are very good. Many of these individuals, when they are found guilty and go into the TDCJ system go to one of these hospitals. For instance, Andrea Yates is at Skyview. We have Montford over in the West area, we have Skyview over in the east area. So it would be something to be very seriously considered by a defense attorney, to have their client determined to be guilty and be sent to one of these hospitals and treated for their mental illness, and most likely may well serve less time than they would if they were found not guilty by reason of insanity.

Professor Slobogin talked about the M’Naghten Test and its variations. In his comments regarding the volitional arm of the ALI test, Professor Slobogin pointed out the difficulty in distinguishing between an *irresistible impulse* from an *impulse not resisted*. Professor Slobogin told us that the Appreciation Test, as far as it is formulated, is too broad. A serious concern about using the volitional arm of the ALI insanity test has to do with the repercussions if it does not work. The psychiatric expert testimony regarding the defendant’s inability to control his/her impulses can then be used to enhance punishment. Thus, the inability to control one’s conduct even as a strategy to mitigate the defendant’s culpability must be fully and seriously considered by the defense attorney in the light of its possible repercussions..

Professor Slobogin then introduced us to the Integrationist Test. Now, as I listened to Professor Slobogin’s presentation, it came to my mind that we should consider that the defendant’s deranged thought process and thought content, which resulted in the perpetration of a criminal act really includes both “knowing” and “volition.” Professor Bonnie laid out for our consideration a broader understanding of “appreciation,” which would include both “knowing” and “volition.” The affirmative defense of insanity in the Federal Courts uses the word “appreciate.” However, it is up to the defendant to prove his/her defense by clear and convincing evidence rather than by a preponderance of evidence.

Dean Shannon spoke on the value of expanding the current Texas insanity defense to include a volitional arm. Dean Shannon understanding the difficulty in determining whether an impulse is controllable or not controllable suggested that it would be best to narrow the volitional definition by using it with defendants suffering with major psychotic disorders. A position which was supported by Professor Bonnie, since a defendant in the throes of a serious psychosis at the time of the alleged crime would not appreciate the wrongfulness of his/her act and would not be in control of his/her behavior.

What about the question of informing the jury as to what happens to a defendant found NGRI. Assistant District Attorney McClellan's remarks must be seriously considered. Though Article 46.03 of the Texas Criminal Procedure 46.03, provides for the commitment of an NGRI acquittee to a state mental institution, Mr. McClellan is absolutely right when he told us that Article 46.03 says nothing about how long the NGRI acquittee will remain there. So if Texas is going to formulate a law in which would be of value in apprising the jury as to what will happen to the defendant if he/she is found NGRI, we would have to have some system similar to what Dr. Zonana told us exists in Connecticut.

Dean Shannon cited comments by jurors in the Yates case indicating it was clear to them that Mrs. Yates knew what she did was wrong. My comment is, and I think others have commented to this too, would a volitional prong have changed the juror's opinion in that case?

Professor Bonnie laid out his case for the following. There should be an insanity defense. We have a long history of this defense coming through English jurisprudence to ours. It should be narrow, because it is an exception to individual responsibility. Individual responsibility is something I think our country is struggling with at the present time, especially in the civil system. One wonders whether anybody is responsible for anything anymore. Professor Bonnie commented that the insanity defense should not be quite as narrow as it is if you're in Texas.

Professor Bonnie argued that a Cognitive Test inquires whether the mentally ill defendant appreciated the wrongfulness of the conduct is a necessary and sufficient formula in regards to determining insanity. The term "appreciates" is meant to signal deeper understanding of the significance of the conduct than simply recognizing that one will be punished for doing it. I agree with that concept. The problem lies in how do you get that across to the jury?

Professor Bonnie rejected the volitional arm. He said he would reject it because it really does not add much. Professor Bonnie suggested that it would not cause too much mischief, if it was focused on severe psychotic disorders.

I am privileged to say to Dr. Smith, as far as I'm concerned, you are as much a giant as anyone speaking at this conference. Dr. Smith provided an excellent overview of the historical situation here in Texas—the creation and development of the Texas State Hospital System. Dr. Smith talked to us about the Dangerousness Risk Review Board, how this Board decides who is and who is not manifestly dangerous. If the NGRI acquittee is found not to be manifestly dangerous, he/she is sent to a lesser institution for continued observation and treatment.

I have visited the Vernon Campus of the North Texas State Hospital, and I will tell you that Dr. Smith certainly deserves to be very proud of the accomplishments of that institution.

In regards to the panel, Mr. McClellan talked about an important concept. Mr. McClellan noted that there is a world of people with mental illness and in that world of mental illness, some people commit crimes and some don't. Of those who commit crimes, some of the crimes are related to the defendant's mental illness and some are not. Of those crimes that are committed by defendant's with mentally ill commit that are related to their mental illness, some knew what they were doing was wrong, and some of them didn't know that they were doing wrong. Thus, in the world of defendant's with mental illness only a small portion were insane at the time of the commission of the criminal act.

Mr. Niland spoke about the psychiatric expert's responsibility to the criminal justice system. That responsibility is to perform a very complete and fair evaluation while striving for objectivity. Though we don't ever reach total objectivity, ladies and gentlemen, we must continually strive for objectivity. Those of us who perform as experts in the criminal justice system have an obligation to continually strive for objectivity. It is disappointing when Mr. McClellan brings up the fact that some experts do not do their work properly.

The ethical norms. I think there is an important concept that psychiatrists need to understand about the ethical principals that guide the legal profession. An attorney must zealously advocate for their client's benefit or position within the limits of the law. The ethical duty of the examining psychiatrist is to perform a complete evaluation while striving for objectivity. A tension exists between these ethical duties. As a psychiatrist, I am not going to take umbrage at any attorney who is doing their job zealously, but I'm going to do my job according to my ethical principals.

And that concludes my interpretation of what our faculty and panel told us today about the affirmative defense of insanity in Texas. [APPLAUSE]

AXELRAD: I want to first of all thank all of you who have stayed until the last hour, the last moment of this conference. The bitter end, as Professor Bonnie would say. I want to also share with you that we will be preparing a transcript of these proceedings. If you'd like to have that transcript, or make it available to somebody else, the form is in your packet.

On behalf of the American Journal of Criminal Law, the State Bar of Texas Committee on Legal Services for the Poor in Criminal Matters and the Committee on Disability Issues, the Texas Criminal Defense Bars Association, the Texas District and County Attorneys Association, and the Texas Society of Psychiatric Physicians, and with deep gratitude to the Texas Foundation for Psychiatric Education and Research, who sponsored this program, I want to extend my appreciation and the appreciation of the citizens of Texas, to Richard J. Bonnie, Cathy Burnett, Lyn McClellan, John Niland, Victor Scarano, Brian Shannon, Christopher Slobogin, Jim Smith, and Howard V. Zonana, for your participation in this program. Dr. Zonana and

everybody at AAPL has told me that we ought to take this show on the road and take it to AAPL.
So I guess now you've got to go back to AAPL and bring it there.

Thank you very much. Goodnight.

[APPLAUSE]

APPENDIX

EXPANDING THE CURRENT TEXAS INSANITY DEFENSE TO INCLUDE A VOLITIONAL STANDARD: GOING BACK TO THE FUTURE

An Essay

Brian D. Shannon*

I. INTRODUCTION	2
II. THE TEXAS INSANITY DEFENSE	2
III. RESTORING A VOLITIONAL COMPONENT	6
IV. OTHER ALTERNATIVES	12
<i>A. Fully Informing the Jury</i>	12
<i>B. Allocation of the Burden of Proof</i>	14
<i>C. The Oregon Approach</i>	16
V. CONCLUSION	18

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I. INTRODUCTION

I am very delighted to have the opportunity to participate in today's conference. It was a great honor to have been asked to join such a strong array of true experts. In fact, as I learned about the conference in the Fall, my students and I were using books co-authored by Professors Bonnie and Slobogin, and Dr. Zonana's expert testimony was an integral part of one of the significant court decisions we studied. It is my great privilege to join them and the other excellent members of today's conference faculty.

We are all aware that we are assembled here today to discuss this important topic because of the Andrea Yates case. Ms. Yates was convicted of capital murder in March 2002 in connection with having systematically killed her five children by drowning in June 2001. In finding Ms. Yates guilty, the jury implicitly rejected her plea of insanity. As part of the closing arguments in that case, defense lawyer Wendell Odom summarized that "a number of the medical experts who testified said Yates was the sickest patient they had ever seen."¹ Fellow defense attorney George Parnham argued to the jury, "If this woman doesn't meet the test of insanity in this state, then nobody does. We might as well wipe it from the books."²

Mr. Parnham may well be correct. Other than the rare and occasional acquittal, often in matters uncontested by the prosecution, the current Texas insanity defense is seldom raised and rarely successful. Because the scope of the current Texas defense is in my view unduly narrow, to the point of being largely a nullity, my focus today will be to urge consideration of restoring a volitional component to the Texas test – at least for certain classes of defendants. I will also broach other possible alternatives to the current Texas statute.

II. THE TEXAS INSANITY DEFENSE

The Texas insanity defense for adult offenders is set forth in Section 8.01 of the Texas Penal Code. It provides the following:

Sec. 8.01. Insanity. (a) It is an affirmative defense to prosecution that, at the time of the conduct charged, the actor, as a result of severe mental disease or defect, did not know that his conduct was wrong.

¹ *Case of Texas mother goes to jury*, CNN.com (March 12, 2002), available at http://www.courttv.com/trials/yates/031202_cnn.html.

² *Id.*

(b) The term “mental disease or defect” does not include an abnormality manifested by repeated criminal or otherwise antisocial conduct.³

The Texas insanity defense is, in essence, a slight variation on the old M’Naghten test, first promulgated in England in 1843.⁴ Because Professor Slobogin has already discussed the M’Naghten test and its variations, I will limit my discussion here. It is necessary, however, to know something of the history of the M’Naghten test to appreciate its inadequacy, and to better understand why the present Texas insanity defense provided for in Section 8.01 of the Penal Code is inadequate and should be changed.

The name of the test comes, of course, from *M’Naghten’s Case*,⁵ in which a defendant named Daniel M’Naghten was prosecuted for the murder of the private secretary of Sir Robert Peel, the Prime Minister of England. M’Naghten had apparently intended to kill Peel, but by mistake shot Peel’s private secretary instead. At trial, “[t]he thrust of the medical testimony was that M’Naghten was suffering from what today would be described as delusions of persecution symptomatic of paranoid schizophrenia.”⁶ M’Naghten was acquitted on grounds of insanity, and the acquittal caused widespread public outrage. Queen Victoria was also concerned, particularly given that she and other members of the English royal family had been the targets of previous assassination attempts. Accordingly, she summoned the House of Lords to “take the opinion of the Judges on the law governing such cases.”⁷

Responding to the Queen’s summons, the House of Lords conducted a general inquiry into the matter of the insanity defense, and asked the judges of the Queen’s Bench a series of questions regarding the standards that should be employed. In responding to the questions put to them by the House of Lords, the English judges in effect reversed the approach that had been used in M’Naghten’s trial for ensuing cases. “Combined answers to two of those questions have come to be known as the *M’Naghten* rules [or test]: ... ‘at the time of committing the act, the party accused was labouring 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

³ TEX. PEN. CODE ANN. § 8.01 (Vernon 1994).

⁴ M’Naghten’s Case, 8 Eng. Rep. 718 (1843).

⁵ *Id.*

⁶ RICHARD J. BONNIE ET AL., A CASE STUDY IN THE INSANITY DEFENSE: THE TRIAL OF JOHN W. HINCKLEY 10 (2d ed. 2000).

⁷ United States v. Freeman, 357 F.2d 606, 617 (2d Cir. 1966).

was doing wrong.”⁸ The M’Naghten test is often referred to as the “right-wrong” test, because of its exclusive focus on whether the accused person knew the difference between right and wrong at the time of his or her alleged offense. American jurisdictions, including Texas, picked up the M’Naghten test from English law, although for a brief period from 1973 to 1983 Texas used a different, more adequate, insanity test, as I will discuss.

The Texas Legislature departed from the narrow M’Naghten standard in 1973 when it adopted an insanity defense based largely on the American Law Institute’s (ALI’s) 1962 Model Penal Code.⁹ Accordingly, the 1973 Texas enactment added a “volitional” prong to the Texas insanity defense consistent with the ALI recommendation. “Thus, in addition to the narrow *M’Naghten* inquiry of whether the defendant knew that his conduct was wrong, the test was expanded to ascertain whether the defendant was capable of conforming his conduct to the requirements of the law.”¹⁰ The volitional prong of the ALI test derived from courts’ dissatisfaction with the narrow inquiry under the M’Naghten standard and some states’ having developed and tinkered with the so-called “irresistible impulse” test.¹¹ The ALI test has been styled “an amalgam of *M’Naghten* and ‘irresistible impulse.’”¹² Professor Bonnie and his colleagues have described the underlying theory supporting the volitional prong as follows:

It rests on the notion ... that the conviction of crime expresses a moral judgment about the defendant’s behavior. Moral judgments about people, the argument goes, are premised on the concept of free will. In general, behavior is the product

⁸ RICHARD J. BONNIE ET AL., *supra* note 6, at 11.

⁹ Texas Penal Code, ch. 399, § 8.01, 1973 Tex. Gen. Laws 883, 896, *amended by* Act of Aug. 29, 1983, ch. 454, § 1, 1983 Tex. Gen. Laws 2640. *See* MODEL PENAL CODE § 4.01 (Proposed Official Draft 1962) (which recommended that states adopt the following test: “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 either to appreciate the criminality [wrongfulness] of his conduct or conform his conduct to the requirements of the law.”).

¹⁰ Ray Farabee & James L. Spearly, *The New Insanity Law in Texas: Reliable Testimony and Judicial Review of Release*, 24 S. TEX. L. REV. 671, 673 (1983).

¹¹ RICHARD J. BONNIE ET AL., *supra* note 6, at 14-16. As one court put it, “The vast absurdity of the application of the M’Naghten Rules in order to determine the sanity or insanity, the mental health or lack of it, of the defendant by securing the answer to a single question: Did the defendant know the difference between right and wrong, appears clearly when one surveys the array of symptomatology which the skilled psychiatrist employs in determining the mental condition of an individual.” *United States v. Currens*, 290 F.2d 751, 766-67 (3d Cir. 1961). A later court observed that to ask merely whether a person knows right from wrong “is to ask a question irrelevant to the nature of his [or her] mental illness or to the degree of his [or her] criminal responsibility.” *People v. Drew*, 583 P.2d 1318, 1322 (Cal. 1978). For a thoughtful and succinct collection of some of the many criticisms of the M’Naghten standard, see MICHAEL L. PERLIN, *LAW & MENTAL DISABILITY* 566-67 (1994).

¹² RICHARD J. BONNIE ET AL., *supra* note 6, at 19.

of choice, and people who make bad choices are subject to moral condemnation. In cases where mental disease or defect robs people of the capacity to choose not to engage in criminal behavior, the argument concludes, it is inappropriate to condemn them morally and therefore inappropriate to convict them of a crime.¹³

Although the 1973 Texas insanity defense revisions were based largely on the ALI test, they differed in one significant respect. The short-lived Texas standard retained the narrow “did not know” language for the M’Naghten prong of the test, as opposed to the ALI’s recommended use of “appreciate the wrongfulness” verbiage. As former Senator Farabee observed, “The use of the term “know” in reference to whether conduct was wrong was ... more restrictive.”¹⁴ Thus, even while including a volitional component in 1973, the Texas Legislature opted not to use the term “appreciate” for the cognitive prong of the test, which could more broadly allow consideration of emotional and affective aspects of serious mental illnesses, as opposed to a more limited focus on cognitive or intellectual mental functioning.¹⁵

The use of a variation of the ALI test was short-lived in Texas, however. After the public outrage relating to the result in the trial of John Hinckley, the Texas Legislature in 1983 rushed to narrow the scope of the insanity defense to its present restrictive M’Naghten formulation. Moreover, not only was the volitional component excised, the revised statute retained its employment of the word, “know,” rather than “appreciate,” for the amended, “right-wrong” standard. The legislative sponsor of the 1983 Texas revisions, former Senator Ray Farabee, later wrote that over ninety percent of the residents in his senatorial district favored a restriction on the insanity defense in responding to polling following the Hinckley verdict.¹⁶ Ironically, another contemporaneous case that had arisen in Senator Farabee’s district had also influenced the powerful legislator. A woman who had been diagnosed “as having experienced a post-partem [sic] psychosis” had “cut out her young daughter’s heart in an effort to exorcise a devil which she thought possessed her child.”¹⁷ Following an insanity acquittal, the state hospital released the woman after less than two years of treatment without further required supervision.¹⁸ Senator

¹³ *Id.* at 16.

¹⁴ Ray Farabee & James L. Spearly, *supra* note 10, at 674.

¹⁵ *Id.*

¹⁶ *Id.* at 671.

¹⁷ *Id.* at 671-72.

¹⁸ *Id.* at 671.

Farabee had acknowledged during the legislative session that “his primary interest in the insanity defense centered on increased court supervision of those acquitted,”¹⁹ which was a major component of the 1983 legislation. Moreover, given the 1983 enactment, Texas jettisoned the volitional component of the 1973 reforms and has employed the limited “right-wrong” test for the last two decades.

III. RESTORING A VOLITIONAL COMPONENT

Roughly two decades after John Hinckley’s insanity acquittal following his attempt to assassinate President Reagan, another high-profile case – that of Andrea Yates – is causing us to re-examine the moral underpinning of the insanity defense. What is the impact of limiting the insanity test to a purely cognitive approach? Andrea Yates, who had a long family history of serious mental illness, had twice previously attempted suicide and had been treated intermittently for her own mental illness. One psychiatrist identified her as “grossly psychotic” and another as one of the most ill individuals that she had ever treated.²⁰ Through the symptoms and manifestations of her psychosis, Ms. Yates apparently felt compelled to kill her children to “save” them from some delusional belief of overwhelming evil.²¹ Of course, the legal test for insanity in Texas is very different from and much narrower than a medical diagnosis of serious mental illness coupled with conduct stemming from delusional beliefs.

Not surprisingly, the fact of Yates’ serious mental illness was of no consequence to the operative “right-wrong” insanity defense. As one juror later observed, “Andrea Yates, herself in her interviews, said she knew it was wrong in the eyes of society She knew it was wrong in the eyes of God, and she knew it was illegal. And, . . . I don’t know what wrong means if all those three things aren’t factored in.”²² Another juror commented, “She was able to describe what she did I felt like she knew exactly what she was doing, and she knew it was wrong, or she would not have called the police.”²³ A third juror summed up this sentiment by stating, “I

¹⁹ TEX. H.R. HOUSE STUDY GROUP SPECIAL LEGIS. REPORT, *Reshaping the Insanity Defense*, at 12 (Jan. 23, 1984).

²⁰ Charles Krauthammer, *Not Guilty, Insane*, WASHINGTON POST, Mar. 15, 2002, at A23, available at <http://www.washingtonpost.com/ac2/wp-dyn/A29958-2002Mar14>.

²¹ *Id.*

²² *Jurors: Yates’ drowning of her children seemed premeditated*, March 18, 2002, available at http://www.courtTV.com/trials/yates/031802-b_ap.html.

²³ *Id.*

think she should be punished for what she did considering she did know right from wrong and I think prison's the way to go.”²⁴

By way of contrast, however, the columnist, Charles Krauthammer – himself a former psychiatrist – has argued differently: “She clearly knew that what she did was illegal. And prohibited. And would cause her to be punished. But in the grip of a fantastic psychosis, she actually thought it was right. She thought she was saving her children from a worse fate, in this world and the next.”²⁵ Krauthammer summarized his opinion as follows, “This is not a matter of sympathy. I have infinitely more sympathy for the five innocents who died so terribly. This is a matter of justice. Guilt presupposes free will. Did Andrea Yates really have it?”²⁶

This question is significant. The Yates case should serve as a catalyst for a re-examination of the continued reliance solely on a narrow M’Naghten standard. In my view, the Texas law’s exclusive focus on an accused person’s cognitive capacity should be reconsidered and revised. Acute symptoms of an untreated serious mental illness may leave an individual’s intellectual understanding and cognitive capacity relatively unimpaired, but can still affect the person’s emotions and reason to such a degree that the individual cannot completely or willfully control his or her behavior. Moreover, because the confines of the M’Naghten test can also restrict psychiatric testimony to the narrow area of a defendant’s cognitive capacity, the limited “right-wrong” test frequently makes it impossible for expert witnesses to place before the jury a complete picture of a defendant’s mental illness. Hence, the M’Naghten test fails to aid the criminal justice system in identifying many defendants who may suffer from acute symptoms of serious mental illness, and it provides a defense only for those mentally diseased persons who have cognitive impairment.

Of course, in the political rush to narrow the insanity defense following the Hinckley verdict, Texas and other jurisdictions discarded the volitional prong of the ALI standard. Professor Bonnie substantially impacted the debate through his critical assessment of the volitional prong: “Psychiatric concepts of mental abnormality remain fluid and imprecise, and most academic commentary within the last ten years continues to question the scientific basis for assessment of volitional incapacity.”²⁷ Similarly, the American Psychiatric Association declared:

²⁴ *Yates family members decry husband*, March 18, 2002, available at http://www.courttv.com/trials/yates/031802_ap.html.

²⁵ Charles Krauthammer, *supra* note 20.

²⁶ *Id.*

²⁷ Richard J. Bonnie, *The Moral Basis of the Insanity Defense*, 69 A.B.A. J. 194, 196 (1983).

“The concept of volition is the subject of some disagreement among psychiatrists. Many psychiatrists therefore believe that psychiatric testimony (particularly that of a conclusory nature) about volition is more likely to produce confusion for jurors than is psychiatric testimony relevant to a defendant’s appreciation or understanding.”²⁸ The American Bar Association (ABA) recommended a narrower test “based in large part on the observation that there are occasional mistakes, most likely to be associated with the volitional criterion.”²⁹

Despite the rush to abandon the volitional prong, some concerns were raised along the way. The ABA, for example, acknowledged that its position was not based on empirical investigation, but “on the informed observation of forensic practitioners and scholars, such as those in the American Psychiatric Association.”³⁰ Moreover, the ABA emphasized that its preference for a narrow insanity test was not based on any findings that there had been any systematic abuse of the ALI standard.³¹ Indeed, Professor Perlin has asserted that the volitional prong was abandoned “without any consideration of the empirical studies then widely available as to the impact or wisdom of such a change,” and that the elimination of the volitional prong would most likely exclude defendants with treatable, mental illnesses of biologic origin.³² Professor Perlin has further contended that there is “significant doubt that ‘morally correct’ answers are more likely to be achieved under the narrower test than had been achieved under the ALI construction.”³³

The time has come to restore a volitional prong to the Texas insanity defense for adult offenders. Please make note of that last phrase: “adult offenders.” Ironically, although the Texas Legislature rushed to abandon the ALI insanity test for a return to a limited variation of M’Naghten in 1983, there has never been a corresponding narrowing of the test for juveniles. Indeed, the insanity defense for juveniles in Texas is not designated as an “insanity defense” in the Family Code. Instead, Section 55.51, which delineates the provisions for the defense, is

²⁸ American Psychiatric Association, *The Insanity Defense Position Statement*, at 5 (Dec. 1982), available at <http://www.psychorg/archives/820002.pdf>.

²⁹ AMERICAN BAR ASSOCIATION CRIMINAL JUSTICE MENTAL HEALTH STANDARDS § 7-6.1 cmt. at 342 (1989) [hereinafter ABA STANDARDS].

³⁰ *Id.*

³¹ *See id.* (observing further that the empirical evidence was to the contrary).

³² MICHAEL L. PERLIN, *supra* note 11, at 574.

³³ *Id.*

entitled “Lack of Responsibility for Conduct as a Result of Mental Illness or Mental Retardation,” and provides the following standard in subsection (a):

(a) A child alleged by petition to have engaged in delinquent conduct or conduct indicating a need for supervision is not responsible for the conduct if at the time of the conduct, as a result of mental illness or mental retardation, the child lacks substantial capacity either to appreciate the wrongfulness of the child’s conduct or to conform the child’s conduct to the requirements of law.³⁴

Several aspects of Section 55.51 are worthy of comment. First, the statute makes available to juveniles the kind of insanity defense Texas formerly provided for adults for the decade between 1973 and 1983 (before the insanity test was “reformed” by being changed back to the old nineteenth century M’Naghten “right-wrong” test that focuses solely on a defendant’s cognitive capacity). Basically, the Texas formulation of the juvenile insanity defense tracks the 1962 ALI standard, as slightly modified. Not only does the juvenile standard include a volitional component relating to the child’s ability to conform his or her conduct to the requirements of the law, it also uses the somewhat broader term “appreciate” rather than “know” for the cognitive prong of the test. Moreover, the statute uses the specific language “mental illness or mental retardation” rather than the more arcane and vague “mental disease or defect” that is contained in the adult standard.³⁵ This contrast between the Texas Family Code and Texas Penal Code results in an anomalous situation in our state – a juvenile defendant will have the benefit of an appropriate, modern insanity test, while an adult defendant has available only the old nineteenth century M’Naghten “right-wrong” test with all of its short-comings.

The time has come to restore a volitional component for adult offenders. I am not alone in raising this call. Advocacy groups that support appropriate treatment for persons with mental illness have called for restoration of a two-prong insanity standard to include a volitional component. For example, NAMI “supports the retention of the insanity defense and favors the two-prong test that includes volitional as well as the cognitive standard.”³⁶ Similarly, the Mental Health Association in Texas has also urged that changes be made in Texas law so that “[d]eterminations of a defendant’s sanity should not rest solely on whether the defendant knew

³⁴ TEX. FAM. CODE ANN. § 55.51(a) (Vernon 2002).

³⁵ TEX. PEN. CODE ANN. § 8.01 (Vernon 1994).

³⁶ NAMI, *The Criminalization of People with Mental Illness*, available at <http://www.nami.org/update/unitedcriminal.html>. NAMI was formerly known as the National Alliance for the Mentally Ill.

right from wrong in the legal sense.”³⁷ That organization has further commented “that Texas’ insanity defense should be revised to reflect more accurately the impact and effect of serious mental illnesses.”³⁸

Even Professor Bonnie in his influential articulation of grounds for eliminating the volitional prong, observed that “[t]he volitional inquiry probably would be manageable if the insanity defense were permitted only in cases involving psychotic disorders.”³⁹ The situation in Yates underscores that sentiment. It is time to make the Texas insanity defense more consistent with modern medicine. Psychiatric diagnostics have improved dramatically since the time of the Hinckley trial. Today we know far more about the medical aspects and neurobiological bases of serious mental illnesses and their symptoms and treatment than two decades ago. And, diagnostics are only going to improve. Future assessments and diagnoses will likely incorporate biological findings for many of the serious mental illnesses and major psychoses, and functional brain imaging will play an increasingly important role.⁴⁰

Admittedly, whether the result in the Yates case would have been any different had the insanity defense included a volitional component is entirely a matter of conjecture. The jury could well have still returned a guilty verdict, particularly given the lack of any jury instruction about the repercussions of an insanity finding. Moreover, as defense attorney George Parnham later commented,

We can talk all day long about mental health, medications, delusions and psychosis, but by golly when you take a picture of a 7-year-old boy who is lying face down in the tub, rigor mortis has set in, and you flip him over and you see the agony on his poor face, that’s a toughie.⁴¹

Moreover, even prior to the 1983 abandonment of the volitional prong of the Texas insanity defense, the defense was rarely invoked and rarely successful. There were only sixteen persons committed to state hospitals following insanity acquittals in 1980, and merely eight such

³⁷ *Legislative Platform Adopted by the Mental Health Association in Texas*, THE MENTAL HEALTH ADVOCATE (Mental Health Assoc. in Texas), Winter 2002, at 6 [hereinafter *Legislative Platform*].

³⁸ *Id.*

³⁹ Richard J. Bonnie, *supra* note 27, at 196.

⁴⁰ My thanks to Dr. George Trapp of the University of Texas Southwestern Medical Center at Dallas for his helpful comments about the future of psychiatric diagnostics.

⁴¹ Michael J. Grinfeld, *Mother’s Murder Conviction Turns Insanity Defense Suspect*, PSYCHIATRIC TIMES, June 2002, available at <http://www.psychiatrictimes.com/p020601.html>.

acquittals and commitments in 1981.⁴² Nonetheless, the lack of a volitional component, particularly in situations in which the defendant was experiencing acute symptoms of a serious neurobiological mental illness, is inconsistent with and anathema to the moral foundation of an insanity defense as it pertains to criminal responsibility.

What approach should the Texas Legislature adopt? One possibility is simply to amend the Penal Code to track the language of the current insanity defense for juveniles set forth in the Family Code. That would result in a restoration of an ALI standard to include both a cognitive test and a volitional prong. It would also serve to use more modern terms like “mental illness or mental retardation” as opposed to the current employment of the antiquated and stigmatizing language, “mental disease or defect.” A less sweeping alternative would be to enact an approach that adds a volitional alternative, but only for persons with diagnosable serious mental illnesses. The following sets forth a possible amendment of the current Texas insanity defense for adult offenders to add a narrowly cabined volitional prong:

Sec. 8.01. Insanity. (a) It is an affirmative defense to prosecution that, at the time of the conduct charged, the actor,

(1) as a result of severe mental disease or defect, did not know that his conduct was wrong, or

(2) lacked substantial capacity to conform the actor’s conduct with the requirements of the law because the actor was experiencing symptoms of a serious mental illness such as schizophrenia, bi-polar disorder, schizoaffective disorder, or other major psychotic disorder diagnosed through accepted scientific criteria.

(b) The term “mental disease or defect” does not include an abnormality manifested by repeated criminal or otherwise antisocial conduct.

Of course, it takes political will to make a change to the insanity defense. The public overwhelmingly supported the narrowing of the insanity defense following the Hinckley verdict. There is certainly not the same sense of wide-scale public interest in making changes in light of the Yates situation. Moreover, for representatives elected on a “law and order” platform, making changes also implicates issues involving political will. Nonetheless, the criminal code should reflect moral judgments about criminal culpability. Additionally, even if there is a public need for separation of a person such as Andrea Yates from society, a long-term hospital setting appears far more appropriate than incarceration or execution.

⁴² Ray Farabee & James L. Searly, *supra* note 10, at 672 & 672 n.8.

IV. OTHER ALTERNATIVES

In addition to adding a volitional component to the Texas insanity defense, other revisions merit consideration. In this Section, I will first discuss the need to amend Texas law to authorize the court to provide a dispositional instruction to jurors regarding the consequences of an insanity verdict. Then, I will discuss possible modifications of the burden of proof in certain cases. Finally, I will address the prospect of considering a very different alternative, which is currently followed by the criminal justice system in Oregon.

A. Fully Informing the Jury

Under Texas law, the jury is not informed of the potential consequences of a finding of not guilty by reason of insanity. Specifically, Subsection 1(e) of Article 46.03 of the Texas Code of Criminal Procedure provides the following:

The court, the attorney for the state, or the attorney for the defendant may not inform a juror or a prospective juror of the consequences to the defendant if a verdict of not guilty by reason of insanity is returned.⁴³

Thus, Subsection 1(e) prohibits the court and the attorneys from informing a juror or prospective juror of the consequences to the defendant if a verdict of not guilty by reason of insanity is returned. The ostensible purpose of this provision is to prevent the jurors, if possible, from being influenced in their deliberations by the consequences to the defendant of their decision. Although it has been held that this provision does not deny fundamental fairness to the defendant,⁴⁴ this provision is extremely troubling. If we trust juries sufficiently to make determinations as serious as imposing death, why not trust them with knowledge regarding likely hospitalization of a person found not guilty by reason of insanity?

Apparently, the “only real floor debate” during the 1983 legislative overhaul of the Texas insanity defense centered on the question of informing jurors of the consequences of an insanity acquittal.⁴⁵ “The author of the bill [Senator Farabee] supported the prohibition of such comment

⁴³ TEX. CODE CRIM PROC. ANN. Art. 46.03 § 1(e) (Vernon Supp. 2003).

⁴⁴ See, e.g., *Zwack v. State*, 757 S.W.2d 66, 69 (Tex. App.—Houston [14th Dist.] 1988, pet. ref’d) (holding same); *Shannon v. United States*, 512 U.S. 573 (1994) (federal insanity law does not require trial court to instruct the jury on the consequences of an insanity determination).

⁴⁵ Ray Farabee & James L. Spearly, *supra* note 10, at 683.

to the jury as being irrelevant to the determination of the mental condition at the time of the offense.”⁴⁶

Even though such information is irrelevant to the central question of a person’s mental state at the time of the offense in question, the information is necessary for a jury to make a knowledgeable and informed decision about the insanity defense. The typical juror is likely acting under the impression that a person who is acquitted on the basis of insanity will immediately walk free from the courtroom, as would a person who is otherwise acquitted. No doubt there is lack of awareness that lengthy hospitalization is a likely result in Texas and elsewhere in most cases in which the insanity defense has been invoked. Moreover, despite a tremendous growth in knowledge and awareness over the last ten to fifteen years regarding serious mental illnesses, the range and depth of psychoses, new varieties of successful treatments, and the dangers of non-treatment, there are still many myths and a substantial amount of stigma.

Advocacy groups have urged that the law should be changed to allow jurors to be better informed. For example, as part of calling for a “sweeping reexamination of the legal standards for insanity and how such cases are handled,” NAMI leaders urged the following:

At the very least, judges should be required to instruct juries ... as to what will happen to a defendant found not guilty by reason of insanity: that they will be hospitalized in secure facilities for treatment, and if they ever recover sufficiently to return to the community, they will be subject to continued monitoring.⁴⁷

Similarly, the Mental Health Association in Texas has urged that our legislation be revised so that jurors in insanity defense cases will “be told what the implications of a verdict of not guilty by reason of insanity are.”⁴⁸

The ABA has concluded that a “court should instruct the jury as to the dispositional consequences of a verdict of not guilty by reason of mental nonresponsibility [insanity].”⁴⁹ Although recognizing the arguments previously made in Texas and other jurisdictions asserting that to inform juries about the consequences of an insanity verdict “may distort the

⁴⁶ *Id.*

⁴⁷ Statement of Richard Birkel, NAMI Nat’l Director, & Mark Hardwick, President, NAMI Texas, Don’t Kill Andrea Yates: Change the Law Instead (March 14, 2002), available at <http://www.nami.org/pressroom/20020314.html>.

⁴⁸ *Legislative Platform*, *supra* note 37, at 6.

⁴⁹ ABA STANDARDS, *supra* note 29, § 7-6.8.

decisionmaking process” and potentially lead to compromise verdicts, the ABA has taken a contrary view.⁵⁰ The ABA expressed concern that “jurors who are not informed about dispositional consequences will speculate about the practical results of a nonresponsibility verdict and, in ignorance of reality, will convict persons who are not criminally responsible in order to protect society.”⁵¹ The ABA concluded that an instruction was “the most sensible approach given the potential for prejudice otherwise,” and observed the following:

Particularly in cases in which defendants are charged with violent crimes (which is usually the case if the nonresponsibility issue is tried to a jury, as opposed to a judge), juries need to be told about the effect of a finding of mental nonresponsibility [insanity] if the possibility of a serious injustice is to be avoided. The fear of compromise verdicts is misplaced. Jurors frequently are given instructions about lesser-included offenses which theoretically could as easily soften jury decisions but do not seem to do so in practice.⁵²

As described earlier, Texas has one of the narrowest formulations of the M’Naghten standard – so narrow that our insanity defense is largely meaningless in a contested case. To then keep the jurors totally in the dark about the consequences of an insanity finding is morally repugnant. Regardless of whether the legislature is willing to expand the standard for insanity, there should be an amendment to allow the jurors to have an instruction about the follow-up process delineated in the Code of Criminal Procedure. Accordingly, I recommend that Subsection 1(e) of Texas Code of Criminal Procedure Article 46.03 be amended as follows:

~~The court, the attorney for the state, or the attorney for the defendant may not inform a juror or a prospective juror of~~ shall instruct the jury regarding the consequences to the defendant if a verdict of not guilty by reason of insanity is returned.

B. Allocation of the Burden of Proof

Another potential reform to the Texas insanity defense for adult offenders relates to the allocation of the burden of proof. The Texas insanity defense is an affirmative defense. Accordingly, the defendant has the burden of proving the legal test for insanity by a

⁵⁰ *Id.* § 7-6.8 cmt. at 380-81.

⁵¹ *Id.* at 381.

⁵² *Id.*

preponderance of the evidence. Thus, the burden of persuasion rests with the defendant. Even prior to the 1983 narrowing of the Texas insanity defense to the narrow M’Naghten approach, Texas law treated the defense in a like manner – as an affirmative defense.⁵³ Interestingly, the ABA has taken the view that in jurisdictions utilizing the ALI Model Penal Code approach (which includes a volitional prong), the defendant should bear the burden of persuasion by a preponderance of the evidence; however, in those jurisdictions which employ a test that is limited to a “right-wrong” inquiry, “the prosecution should have the burden of disproving the defendant’s claim ... beyond a reasonable doubt.”⁵⁴ The ABA opined that because the volitional criterion is more likely “to produce expert speculation and jury confusion,” then there exists “ample moral public policy justification for placing the burden” on a defendant if the state employs the two-pronged test.⁵⁵ In contrast, the ABA asserted that if “exculpation is morally required when a significant cognitive-affective dysfunction existed at the time of the offense, then the argument is strong that the prosecution should be required to negate the existence of this fact beyond a reasonable doubt.”⁵⁶ When the Texas Legislature narrowed the insanity defense to our variation of the M’Naghten test, the affirmative defense structure was retained.

One possible reform of the Texas insanity defense is to enact revisions to the burden of persuasion. Like any broadening of the insanity defense, however, the political will to enact such a revision is perhaps questionable – particularly for representatives who were elected on a “law and order” platform. On the other hand, as a matter of moral focus, a case in which the defendant suffers from a serious mental illness and was acutely psychotic and delusional at the time of the offense, is arguably the most compelling type of situation for invoking the insanity defense. Correspondingly, as suggested by the ABA, the burden of persuasion should rest with the prosecution to negate mental nonresponsibility – particularly in that type of case. If the legislature is unwilling to contemplate altering the burden of persuasion for all cases in which the defense is invoked, then an in-between position would be to shift the burden for the class of cases in which delusional thinking is a significant aspect of the defendant’s mental disease. One

⁵³ Ray Farabee & James L. Searly, *supra* note 10, at 674.

⁵⁴ ABA STANDARDS, *supra* note 29, § 7-6.9(b)(i)-(ii).

⁵⁵ *Id.* § 7-6.9 cmt. at 387.

⁵⁶ *Id.* at 386.

prospect would be to revise Section 8.01 of the Texas Penal Code in the following manner:

(a) It is an affirmative defense to prosecution that, at the time of the conduct charged, the actor, as a result of severe mental disease or defect, did not know that his conduct was wrong. However, in cases in which the defense is invoked and evidence is introduced that the actor at the time of the conduct charged was experiencing delusions or hallucinations which were symptomatic of a serious mental illness such as schizophrenia, bi-polar disorder, schizoaffective disorder, or other major psychotic disorder diagnosed through accepted scientific criteria, the prosecution has the burden of disproving the defendant's claim of mental nonresponsibility.⁵⁷–

C. The Oregon Approach

Another formulation of the insanity defense that merits study with respect to possible enactment is the approach that has been codified in Oregon. The Oregon insanity defense is essentially the ALI two-pronged model, with both cognitive and volitional tests, but with a significant twist. Instead of identifying the prospective verdict as “not guilty by reason of insanity,” the Oregon law styles the defense and potential jury verdict as “guilty except for insanity.”⁵⁸ Specifically, the Oregon statute provides: “A person is guilty except for insanity if, as a result of mental disease or defect at the time of engaging in criminal conduct, the person lacks substantial capacity either to appreciate the criminality of the conduct or to conform the conduct to the requirements of law.”⁵⁹ Moreover, the Oregon statute is not a “guilty but mentally ill” law, which requires incarceration like other criminal convictions. Instead, persons who are found “guilty except for insanity” under Oregon law are placed under the jurisdiction of that state’s Psychiatric Security Review Board, and generally are placed at the Oregon State Hospital for treatment and later supervised, conditional release.⁶⁰ This is not substantially dissimilar to the

⁵⁷ Corresponding changes would need to be enacted to TEX. CODE CRIM. PROC. ANN. Art. 46.03 § 1(c) (Vernon Supp. 2003). I would like to thank Keith Hampton of the Texas Criminal Defense Lawyers Association and Dr. George Trapp for their suggestions in this regard.

⁵⁸ OR. REV. STAT. § 161.295 (2001).

⁵⁹ *Id.* § 161.295(a). The statute also excludes repeated criminal or antisocial conduct and personality disorders. *Id.* § 161.295(b).

⁶⁰ *Id.* § 161.327. See also *Mental Health Law in Oregon: A Guide for Consumers and Families – Guilty Except for Insanity (GEI) and Psychiatric Security Review Board (PSRB) Jurisdiction Under Oregon State Law* (Oregon Advocacy Center, Portland, Or.), available at http://www.oradvocacy.org/mh_ch3.htm.

subsequent commitment, treatment, and conditional release procedures followed in Texas for those few persons who are found not guilty by reason of insanity.

Given that treatment and hospitalization (generally within a secure hospital setting), not incarceration, follow a jury finding of “guilty except for insanity,” the chief distinction between Oregon’s insanity defense and a “not guilty by reason of insanity” defense is one of nomenclature. There may be some appeal in considering a similar name change in Texas. Given the common misperceptions regarding the insanity defense, and particularly in light of the inability under current Texas law to provide accurate information to a jury about the consequences of an insanity verdict, “[m]any potential jurors believe that the defense of insanity is simply an excuse or trick used by defense attorneys to get their clients ‘off the hook.’”⁶¹ Accordingly, one possible change to Texas law would be to employ the phrase, “guilty except for insanity,” as opposed to “not guilty by reason of insanity,” without altering the substantive effect of such a determination.⁶² Given the long history of misinformation and ignorance about both the insanity defense and serious mental illness, there may be a greater willingness on the part of jurors (and legislators) to embrace a defense that includes the word “guilty” in contrast to “not guilty.” At the very least, the premise is worthy of further study.

⁶¹ TEXAS APPLESEED, MENTAL ILLNESS, YOUR CLIENT, AND THE CRIMINAL LAW: A HANDBOOK FOR ATTORNEYS WHO REPRESENT PERSONS WITH MENTAL ILLNESS 28 (2002), available at <http://appleseeds.net/tx/ACF167B.pdf>.

⁶² In this regard I am *not* advocating a “guilty but mentally ill” approach with its follow-on incarceration. On a cynical note, however, it could be argued that Texas essentially has a “guilty but mentally ill” statute for all practical purposes at present given the extremely narrow – perhaps even meaningless – scope of our limited M’Naghten test.

V. CONCLUSION

In summary, it is time for Texas to go back to the future with regard to our insanity defense; that is, the Texas Legislature should amend the insanity defense for adult offenders to restore a volitional component, as was once the law for adults and has remained the law for juveniles. At the very least, the volitional component should be included for defendants with diagnosable serious mental illnesses. Moreover, the current requirement that jurors must be kept in the dark about the consequences of an insanity verdict should be discarded. I have also addressed alternatives relating to the allocation of the burden of proof and the prospect of studying a name change such as the approach in Oregon.

Our law should not be morally bankrupt. Revisions should be considered to better comport our law with the medical understanding of the typical symptoms of untreated serious mental illness. I am not advocating a “get out of jail free” approach, but rather the use of secure hospitalization and treatment alternatives for such defendants following a criminal proceeding that involves appropriate and modern legal standards.

Separate and apart from the issues surrounding the criminal justice aspects of the insanity defense, we must continue to focus on improving our mental health treatment system. Think of the tragedies, including the horrific Yates case, in which serious human consequences might well have been avoided had there been proper, timely, and adequate treatment. Indeed, we now know that serious mental illnesses are generally treatable, particularly with the array of modern and newer generation medications that are available. We should be striving to make available appropriate and modern treatments for such neurobiological diseases. If we as a society continue to neglect and under-fund the needs of our at-risk citizens with serious mental illnesses, however, the criminal justice system will continue to be overburdened with persons who might have been successfully treated in the community prior to any overlap with criminality. Although the insanity defense can be and should be improved, the need for its employment can be lessened with early diagnoses and appropriate treatments for persons with serious mental illnesses.

Disposition: The Insanity Defendant Found NGRI.
Overview of Methods of Intervention
and
Management for Defendants Found NGRI; What Happens After NGRI

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Disposition: The Insanity Defendant Found NGRI.

Overview of Methods of Intervention

and

Management for Defendants Found NGRI; What Happens After NGRI

Some years ago I was asked near the last minute to be the keynote speaker at a forensic conference after planners of the event learned the intended speaker could not participate. Hurriedly and with considerable anxiety I put together an address titled, “The Evolution of Forensic Mental Health or From Gladiators to Good Ole Boys and Girls”. The presentation was aimed at reminding those in attendance that the roots of our work in forensic mental health run deep and connect us to others in ways we sometimes forget; that in fact, we stand on the shoulders of giants. To my surprise and continuing amazement, the audience responded with a standing ovation. On reflection I have come to believe that this positive response had less to do with the quality of my address and more to do with the need of those who heard it to feel affirmed for the good work they do and the values that serve as its underpinning.

It is in this same spirit of wanting to affirm the value of our work that I offer the following discussion regarding the disposition, management and treatment of insanity acquittees in Texas. The information is presented in a historical context in hopes that it will be more interesting than a litany of policies, procedures and clinical considerations that both govern our work and seek to conform it to the letter and spirit of prevailing state statutes. I believe this history is a story worth telling and it is one I have in some measure lived.

Those of us who have committed substantial parts of our lives to forensic mental health work often find ourselves in the middle ground that exists between society’s need to control inappropriate and injurious behavior by the determination of responsibility for the behavior, and the requirement of commitment of those who are injurious to themselves or to others and whose rights require protection from arbitrary and unconstitutional restrictions against freedom of behavior. In both emotional and intellectual terms, it can be difficult ground to occupy. One can hardly argue with society’s need for peace and stability nor the criminal law it has evolved. With the conviction and sentencing of those guilty of injurious conduct against others as well as against society at large, criminal law attempts to prevent such conduct from happening in the future, extract retribution for the harm done to others; and, rehabilitate the offenders so that they might be returned to later useful and productive lives. However, to accomplish these goals the offender must be seen as morally blameworthy for his conduct. A conflict arises when for a

variety of reasons the offender lacks the capacity for free choice because then the purpose of deterrence and retribution arguably are not served by holding such a person responsible (Tancredi, Lieb, & Slaby, 1975) For those of us in this work, management of this conflict is a daily business and in the larger scheme of things a fairly circumscribed one. However, on occasion events occur that seem to focus the world's attention on what we do and why we do it. The Andrea Yates' case serves as a recent and powerful example.

Within hours of the breaking news of the tragic deaths of the Yates children, speculation regarding the ultimate disposition of the case was widespread and rampant. Inevitably, the question of insanity would be raised and addressed in tens of millions of living room courthouses across America and in the one that mattered most, the 230th Criminal District Court, Harris County. As administrator of North Texas State Hospital (site of the Texas public mental health system's only Maximum Security forensic psychiatric facility), I knew without a doubt that should she be found Not Guilty by Reason of Insanity (NGRI), Andrea Yates would be committed to our facility. Obviously, many people knew this as well in that it seemed my staff and I were constantly asked by media representatives and others what we would do if we got "her". At the very least the Yates case afforded us some opportunity to discuss the disposition of insanity acquittees and the quality of care afforded them. Fundamentally, the answer to the questions was consistently the same, "should she come to our hospital we will treat her as we do any person similarly committed...". As time went on and the case resolved, questions regarding quality of care gave way to questions regarding quality of caring. Our state's history, even with its inglorious periods as regards care of the mentally ill, is filled with many examples attesting to a high quality of caring. Clearly, the decisions that will be made in the coming months by the people of Texas and their leaders will determine how future generations judge the quality of our caring.

A Brief Historical Perspective

Among the first statutory considerations pertaining to the disposition of the mentally ill in Texas was a law enacted in 1840 by the 4th Congress of the Republic of Texas. It provided for the appointment of guardians for "idiots, lunatics and persons non compos mentis (of unsound mind)" on proof of their idiocy, madness or incompetency. While not specifically addressing criminal insanity, it set the stage for such laws that would be adopted when statehood was achieved.

In 1848, a law enacted by the first Legislature of the State of Texas organized probate courts and in so doing articulated the powers and duties of probate court judges. Among the powers granted to these judges was that of ordering an "inquisition to be made by a jury, of

idiocy, lunacy, and persons of. unsound mind” (Gamel, 1848, p. 302). Like the law enacted in 1840 by the Congress of the Republic of Texas, this statute provided for the appointment of guardians for this group and made no mention of criminal insanity. It would be almost a decade before the state addressed this particular issue.

Early in 1857, the Texas Penal Code and The Texas Code of Criminal Procedure were promulgated and were significant in that they established the foundation of state law regarding the disposition of the criminally insane. Three articles in the Penal Code dealt with the issue of insanity. Article 34 stated:

No act done in a state of insanity can be punished as an offence. No person who becomes insane after he committed an offence shall be tried for the same while in such a condition. No person who became insane after he is found guilty shall be punished for the offence while in such a condition.

This provision in the penal code remained essentially the same for another eighty years. A person who was considered sane at the time of trial but insane at the time of commission of the crime could be permanently free from punishment. A person considered insane at the time of trial could be placed in an asylum although it would be several years before the first such asylum would actually open its doors (establishment of the State Lunatic Asylum in Austin was by act of the Sixth Legislature in 1856). If the individual later became sane he could be tried for the offense. A companion to Article 34, Article 35 addressed the rule of evidence to be used in such matters and referenced the M'Naughten Rule. Article 36 addressed the concept of “temporary insanity” as the result of use of alcohol and other drugs and specified that evidence of such insanity could only be introduced for the purpose of mitigating the penalty.

There were numerous provisions in the 1857 Code of Criminal Procedure related to the issue of criminal insanity and in large measure spoke to the role and responsibilities of the jury in cases involving the consideration of criminal insanity. It is of particular interest that the Code placed responsibility on the county court to provide for safekeeping and proper treatment of the individual declared insane as has been pointed out, the state had no asylums at the time.

Though two years earlier the legislature appropriated fifty thousand dollars for the erection and support of the first asylum to be located in Austin, it was in 1858 that the Legislature passed an act entitled, “An Act to Provide for the Organization of the State Lunatic Asylum, and for the Care and Maintenance of the Insane.” Section II of this Act allowed for any person charged with or convicted of any criminal offense who was found to be insane by the court in

which he was so charged or convicted to be conveyed to and retained by the asylum on order of the court and removed only by order of the same court. The state asylum opened its doors in 1861. Prior to that time individuals determined insane were kept at home, sent out of state for treatment or custodial care, or confined in almshouses or jails. During the Civil War and Reconstruction the asylum was neglected (Creson, 2002). Nevertheless, the Legislature saw fit to amend Section II in 1863 clarifying that a person so committed to the asylum could be removed to the custody of the sheriff of the county in which he was charged or convicted by order of a judge authorized to issue a writ of habeas corpus.

The last major statutory change of the 1800's specifically affecting this population occurred in 1879 with the amendment of the Texas Code of Criminal Procedure. While provisions in the Code which allowed for the inquiry into the sanity or insanity of the accused after conviction remained virtually the same as the Code of 1857, there were significant procedural changes. Under this code, the court rather than the sheriff was responsible for obtaining jurors to try the case. The establishment of an asylum meant that individuals found to be insane under the provisions of the Code of 1879 would be sent to the facility, there to remain until the Superintendent of the facility notified the court in writing that the individual had become sane. It was the court's responsibility to see to the return of the individual and impanel a jury to determine his sanity or insanity. If the individual was found sane his conviction was carried out. If not, he was returned to the asylum. It is interesting to note that before the turn of the century two more such asylums would be established, the North Texas Lunatic Asylum in Terrell (1883) and the Southwestern Lunatic Asylum in San Antonio (1892). At best these institutions offered humane custodial care emphasizing detention, economic efficiency and behavior management. At their worst, patients were mismanaged and mistreated to a degree eliciting public attention and censure (Creson, 2002)

The 1900's

The first half of the twentieth century was a particularly important time in the evolution of Texas law pertaining to persons considered criminally insane. This period set the stage for the later establishment of a designated maximum security unit in the Texas state hospital system.

In 1913, during the Regular Session of the 33rd Legislature a measure was passed calling for the appointment of a commission, by county judges, of six individuals whose responsibility it was to determine the mental condition of persons brought before it. The commission was to have a number of physician members, in proportion to the total number of physicians to the county's population. Such commissions were intended to assume the role previously played by juries as required in the state constitution. In 1917, the Texas Supreme Court voided the entire 1913

measure in deciding the case of White vs. White affirming Mrs. Lillie White's assertion of a right to a jury trial after she had been adjudged a lunatic by a county judge upon the report of the six member commission. 1917 was also the year that legislation was passed mandating the creation of a hospital for the "Negro insane" in Rusk, Texas and another hospital (the Northwest Texas Insane Asylum) to be located some seven miles outside Wichita Falls, Texas. When it actually opened in 1919 the name of the Rusk facility was changed to East Texas State Hospital and its doors opened to all races (Creson, 2002).

By 1923 the legislature had become concerned with conditions existing at the various state "eleemosynaries" (institutions supported by charity) and established a commission to make a "careful study" and subsequent report of conditions (Gamel, 1848). Among the issues specifically cited was the "care and custody of the criminally insane" as well as the laws dealing with commitment, parole, discharge, care and custody of inmates of State eleemosynary institutions. One of the recommendations made some two years later by the commission was to change commitment laws so that jury trials would only be used to determine insanity when demanded. The clear intent of the recommendation was to spare individuals and their loved ones the stigma of a legal determination of insanity. The recommendation was adopted by the 39th Legislature and enacted into law in 1925 (the law was later declared unconstitutional in 1927). The 39th Legislature enacted further reforms in dropping the words "lunatic" and "insane" from the names of state institutions, substituting instead the words, "State Hospital" and a locality name. Other reform oriented legislation considered superficial by some, included provision for two "psychopathic hospitals" to be located in Galveston and Dallas. Of the two, only the Galveston hospital was built, opening in 1931. it closed after a 1943

hurricane and was later reopened under the auspices of the University of Texas Medical Branch at Galveston (Creson, 2002).

Other legislation relevant to this discussion and adopted in the 1930's was enacted against the backdrop of a deteriorating state system in which the warehousing of patients increased.

In 1931 the Code of Criminal Procedure was amended as follows:

Information to the Judge of the Court as provided in Article 921 of the Code of Criminal Procedure of the State of Texas as to the insanity of a defendant, shall consist of an affidavit of the Superintendent of some State institution for the treatment of the insane, or the affidavit of not less than two licensed and regularly practicing physicians of the State of Texas, or the affidavit of the prison physician or warden of the Penal Institution wherein the defendant is in prison, or the

County Health Officer of the County where the defendant was finally convicted, which affidavits, if made, shall state that after a personal examination of the defendant it is the opinion of the affiant that the defendant is insane, and said affidavits shall, in addition thereto set forth the reasons and the cause or causes which have justified the opinion.

This amendment, which provided for an affidavit from a credible person in insanity cases, wasn't the only change made in 1931. Statutes were enacted to allow for the transfer of penitentiary prisoners adjudged to be insane subsequent to conviction, to a state hospital. Another law was enacted to allow for the creation of a State Prison Psychopathic Hospital to be operated as part of the Texas Prison System to serve persons who had been adjudged insane both at the time of the offense and at the time of trial, as well as those adjudged insane subsequent to conviction. When funds were appropriated two years later to build the hospital within the prison walls at Huntsville, Texas, prison officials apparently interpreted the appropriation bill to mean a general medical hospital with facilities for mental patients. This being the case, the new facility was designed as a general hospital with a relatively small capacity (45 patients) for serving the persons envisioned by the legislature.

In 1937, the 45th Legislature enacted legislation that spoke specifically to issues regarding the commitment of the criminally insane in terms and language that were arguably more direct, if not substantially different than established practice. By the end of the decade, the problem of overcrowding at state facilities loomed large on the horizon in spite of the opening of Big Spring State Hospital in 1939.

During the 1940's overcrowding became a major problem at state facilities and was exacerbated by public pressure to reduce the lengthy waiting lists for admission and to remove mentally ill persons from local jails. Further deterioration occurred during World War II. It was a period during which there seemed to be some confusion regarding disposition of the criminally insane.

In 1946, the General Manager of the Texas Prison System wrote the Texas Attorney General regarding the State Prison Psychopathic Hospital. At issue was the fact that the hospital for the criminally insane previously authorized by the legislature was not appropriately staffed nor functionally was it the hospital contemplated by the enabling legislation. In 1947, the Attorney General noted in essence that the prison-based facility would be staffed to accomplish its intended mission. Nevertheless, during the remainder of the decade and early into the next one, many persons who were determined insane subsequent to conviction of a crime were in State

Hospitals. Either they had been placed there prior to the Attorney General's ruling in 1947 or courts, unaware of or in disagreement with the ruling, continued to commit such persons to state hospitals (Dudley, 1980).

Soon after it was established by the 51st Legislature in 1949, the Board for Texas State Hospitals and Special Schools authorized a study of state institutions. The study directed by Ernst and Ernst Management Firm confirmed among other things that the institutions were overcrowded, and understaffed by poorly trained workers. In 1951, in an effort to reduce overcrowding, the Kerrville State Home was opened as a branch of the San Antonio State Hospital and the Vernon State Home opened as a branch of the Wichita Falls State Hospital. Both were intended to serve aged mentally ill patients and both ultimately became free standing state hospitals that ironically are now forensic psychiatric facilities.

In 1952, the Board for Texas State Hospitals and Special Schools decided to establish a maximum security unit at Rusk State Hospital in which persons considered to be criminally insane and at that point in time residing in the other facilities, could be placed. Over the next two years three existing buildings at the Rusk facility were converted accordingly and in 1954 opened as the system's maximum security unit (Dudley, 1980). A law enacted in 1955 by the 54th Legislature recognized persons adjudged insane both at the time of the offense and at the time of trial to be appropriate for state hospital commitment but not those adjudged insane subsequent to conviction. The 54th Legislature also tasked The Texas Legislature Council to study the need for additional facilities for the care and treatment of the criminally insane. After appreciable work, the Council in 1956 recommended that the Legislature consider formulation of a new policy wherein care and treatment of the criminally insane would be made wholly the responsibility of the Board for Hospitals and Special Schools and consider revision of state laws pertaining to the criminally insane in such a way as to make them clearer and less subject to differing interpretations.

These recommendations in part led the 55th Legislature in 1957 to amend the 1937 statute as pertained to the criminally insane to require the court to order the commitment of a person adjudged insane to a state mental hospital to remain until became sane. It also authorized the head of a mental hospital to which such persons were committed to transfer, furlough, discharge and treat them as any other patient committed for an indefinite period. The 55th Legislature also amended Article 34 of the Penal Code, adding a provision specifying that the time of confinement in a state mental hospital for treatment may be considered time served and may be credited to the term of a person's sentence. In addition, this legislature also amended provision of the Code of Criminal Procedure adopted in 1937 and spoke to procedures involved

in transferring individuals who had become insane from the penitentiary or county jail to a state mental hospital. This statute remained unchanged until 1965.

In 1965, the 59th Texas Legislature enacted changes to the Code of Criminal Procedure which functionally reinstated the 1937 statute. It instructed the court to order commitment of a person judged to be insane by a jury, where the person was to remain until the head of the facility notified the committing court that the person had regained sanity. Once the judge of the committing court received such notice, he was to impanel a jury to determine the issue of sanity. In cases where the jury found the person to be sane the person was released. If the jury found the person to be insane, the court was statutorily required to order the person returned to the state hospital until a time he was subsequently adjudged to be sane by a jury from the committing county. Absent was the kind of language that appeared in the 1957 statute that arguably required the receiving facility to treat criminally insane patients as they would any other patients committed and not considered criminally insane.

Action taken by the House of Representatives of the 60th Legislature in 1967 set the stage for what would become a very interesting study of state mental health facilities. Resolution H.S.R. 427 directed an interim committee to study facilities for the care and treatment of the criminally insane and required that the study be made in depth to include legal, medical, rehabilitative and preventative aspects of mental illness with criminal tendencies. A report to the 61st Legislature entitled, "This May Make You Mad", by the Interim Committee in May 1969, made specific recommendations concerning the care and treatment of the criminally insane at Rusk State Hospital (Dudley, 1980). Among the recommendations made were:

- Abolition of the segregation of the criminally insane with the specification that security precautions should be taken to protect both the public and other patients from high risk patients without respect to the cause of their commitment.
- Division of high-risk patients into two categories: treatable and non-treatable. It was thought that the number of long term non-treatables was a growing though relatively small proportion of the total annual commitments and should be left at the Rusk facility and managed. Persons considered high risk but treatable were recommended for transfer from the Rusk facility to a high security environment near a medical school in hopes that training and research initiatives could be undertaken in hopes of ushering in a new era that would lead to progress in the treatment of such persons. The recommendation also envisioned the creation of a new unit, a maximum security ward to be located in Houston, Lubbock, Dallas or San Antonio which would in turn contract with medical schools for needed services.

- The report recommended that “retardates” with organic etiologies should be left at the Rusk facility. The report did go on to suggest that a unit be developed near a medical school complex for purposes similar to the aforementioned. The report acknowledged that there were some members of this particular patient population who exhibited violent and aggressive behavior and it suggested that special security provisions should be made and that as the aggressive behavior diminished that work should be designed to suit the skill level of this population.
- The report recommended that the department design meaningful work programs for the criminally insane.
- That community based outpatient facilities be specifically funded to enable them to provide post discharge follow-up services for patients who had previously been discharged from institutions responsible for treating high risk patients. The report went on to suggest that not only would such an approach reflect the ideas of humaneness and compassion, it would make good economic sense as well.

From 1967 until the Legislative Session in 1973, there were a number of revisions to the Texas Code of Criminal Procedure. However, most of these changes were minor and of no major significance (Dudley, 1980). The Texas Penal Code was amended in 1973 by the 63rd Legislature which acknowledged insanity as an affirmative defense to prosecution insofar as the person charged did not know that his conduct was wrong or was incapable of conforming his conduct to the requirements of the law he allegedly violated; and clarifying language was included stating that an abnormality manifested only by repeated criminal or otherwise anti-social conduct was not to be included in the meaning of the term “mental disease or defect”.

By 1974, the class action lawsuit, R.A.J. v TDMHMR Commissioner was filed in federal court and intended to reform the state’s eight psychiatric hospitals. In a retrospective description of hospital life, former TDMHMR Commissioner Don Gilbert wrote:

We were certainly aware of the crowding, the lack of privacy, and the chaotic environment, but within those constraints, staff worked with considerable caring to provide for men and women with mental illnesses. That caring was expressed in a paternalistic way with staff taking care of patients as a parent might take care of a child in need. The fact that the great majority of the staff were unskilled or at least untrained workers with very little in the way of professional supervision allowed well-intended but misguided approaches to care and treatment to abound.

We didn't consider patient rights because, as a practical matter, state hospital patients at that time were guaranteed very little in the way of rights. The staff was in charge and the staff knew best. Psychiatric patients were not expected to participate in treatment decisions; that was the role of the staff. The role of the patient was to be compliant. While this approach to the care and treatment of mental illness is primitive by today's standard, it represented the paradigm for state hospital work in 1974. (1998).

The conditions described by Commissioner Gilbert would prove to be the subject of a legal action that would surpass two decades in length and profoundly, if not intentionally, impact services to insanity acquittees.

By 1975, certain provisions of Article 46.02 of the Texas Code of Criminal Procedure had been successfully challenged as unconstitutional with respect to treatment and release standards and procedures pertaining to the criminally insane. This, along with the desire of the leadership of TDMHMR to see the emergence of an enlightened and progressive set of legal statutes designed to protect and enhance the conditions of the persons it served led the department and other interested individuals to invest considerable work for statutory change in the areas of equal protection, least restrictive alternatives, right to treatment and due process as they affected the criminally insane. The revisions made to Article 46.02 and the addition of Article 46.03 to the Texas Code of Criminal Procedure in 1975 by the 64th Legislature have been described as among the most extensive and far reaching ever attempted in the state of Texas as regards this population. Of particular note were the statutory provisions related to pretrial evaluations and competency/incompetency dispositions. The statute also provided that when a defendant was found Not Guilty by Reason of Insanity in the trial of a criminal offense, and in the opinion of the court, the defendant required observation and/or treatment in a mental health or mental retardation facility for his own welfare and protection or the protection of others, the court was to transfer the defendant to the appropriate court for civil commitment proceedings.

In 1977, at the request of the Texas Department of Mental Health and Mental Retardation, the 65th Texas Legislature revised Articles 46.02 and 46.03 of the Texas Code of Criminal Procedure. Whereas previously insanity acquittees were civilly committed to the maximum security unit at Rusk State Hospital and transferred to a non-security unit within 30-days unless he was determined to be manifestly dangerous, a revision to the code allowed such a person to remain in maximum security an additional 30-days (for a total of 60-days) after admission in order for staff to have more time to make observations and gather information before the hearing of the Dangerousness Review Board. If the Board determined the person no

longer Manifestly Dangerous then he was to be moved to a less restrictive environment. In the two years previous, the “Review Board for Manifest Dangerousness” was an interdisciplinary team(s) that met once a month to determine as to whether the civilly committed patients at the maximum security unit were Manifestly Dangerous or not. Changes made by the 65th Legislature and made effective September 1, 1977 changed the membership of the Review Board(s) to include only three psychiatrists licensed to practice medicine in the state of Texas. The law was also amended to specify that if the superintendent of the facility at which the maximum security unit was located disagreed with the determination of the Review Board, the matter would be referred directly to the Commissioner of TDMHMR for resolution, whereas previously the appeal process was directed to the Deputy Commissioner for Mental Health Services. As history would soon prove, the stage was set for more significant changes in the near future.

Article 46.03 of the code of Criminal Procedure was amended extensively by the 68th Legislature in 1983. Language in the statute was changed to read, “it is an affirmative defense to prosecution that, at the time of the conduct charged, the actor, as a result of severe mental disease or defect did not know that his conduct was wrong.” The word “severe” was added and the words “incapable of conforming his conduct to the requirements of the law. . .” were stricken, narrowing parameters for acquittal by insanity. Language was also added to the effect that a verdict of not guilty by reason of insanity could only be returned if the prosecution established by a “preponderance of the evidence that the defendant was insane at the time of the alleged conduct” Words prohibiting the court, attorney for the state, or the attorney for the defendant from informing a juror or prospective juror of the consequences to the defendant if a verdict of not guilty by reason of insanity was returned were also added.

It was also at this time that the code was amended to require a determination by the court as to whether “the conduct committed by the defendant involved an act, attempt or threat of serious bodily injury to another person” following a finding of not guilty by reason of insanity in a criminal offense. If there was no such conduct and the person was determined mentally ill or mentally retarded the statute required the transfer of the defendant to the appropriate civil court for civil commitment proceedings, and possible subsequent commitment to a mental health or mental retardation facility. Otherwise, if the offense involved such conduct, language in the statute required that the trial court retain jurisdiction over the person who was to be committed to the maximum security unit of Rusk State Hospital or other maximum security unit of another TDMHMR facility (no other unit was so designated). This amendment addressed the issue of outpatient commitment and supervision and while not speaking to “conditional release” as such, did envision the appropriateness of court mandated outpatient services in lieu of hospitalization for some insanity acquittees as well as its potential usefulness for post discharge insanity acquittees. It should be noted that no new or specific funds were appropriated for this purpose.

It is fair to say that up until this time statutory change was the most significant influencing factor as regards the disposition of insanity acquittees in Texas. This is not to say that this population didn't benefit from other changes in the public mental health system that occurred over time, clearly they did. It's simply an acknowledgement that services and programming for insanity acquittees emphasized security, containment and custodial care. Ironically, it was the "perfect storm" created by a severe down turn in the Texas economy, relentless pressure to deinstitutionalize the Texas state hospital system and the ever increasing weariness of officials, consumers and the public with a classaction lawsuit (R.A.J vs. Miller) well into its second decade, that would drive unprecedented improvement in the care and treatment of Texas' insanity acquittees.

Early in 1987, it was clear that the 70th Legislature would require the Texas Department of Mental Health and Mental Retardation to close one of its state hospital facilities. The decision, primarily driven by economic factors, was also seen by some as a way to prove the Department's commitment to a community based approach to the delivery of public mental health services. Before the close of the session, it was announced that the Vernon State hospital was targeted for closure. At that time the hospital, located in the small rural North Texas community of Vernon, was the newest of all state facilities having been opened in 1969. Last hour negotiations between elected officials and agency leaders brought about at the urging of hospital staff and local citizens resulted in an alternate plan. With the consent and support of the legislature, Vernon State Hospital would become the mental health system's designated maximum security unit, assuming a role that had been played by the Rusk facility for over three decades (the Rusk State Hospital retained its civil psychiatric hospital mission).

By the fall of 1987, work was well underway to convert the physical plant of what had been a comparatively small, civil psychiatric facility to a maximum security forensic hospital complete with perimeter fencing, electronic surveillance equipment, security observation towers and "hardened" patient buildings. A security force was employed and trained and a number of employees from the Rusk facility transferred to Vernon. Thus prepared, on April 5, 1988, the new maximum security unit of TDMHMR received its first patients. The process of transferring insanity acquittees and other "forensic" patients on that bright spring day in April spoke volumes about how they were regarded in the public mental health system. Patients made the 309-mile journey from Rusk to Vernon shackled and handcuffed in buses with police escort. It was later learned that there were no stops for breaks in the five-hour long ride and that a rumor had circulated among some patients that they were actually being transported to gas chambers for execution. From the start, male and female patients were segregated and the females were confined to a small separate area on campus where attempts were made to replicate all aspects of

programming then available to male patients throughout the grounds. Such was the emphasis on containment and its effects on patients that one administrator bemoaned the purchase of new style security fencing that was supposedly “escape proof”, saying that patients need to have “hope” that it is possible to escape and taking that hope away could provoke violent behavior. While persons committed as incompetent to stand trial were at least initially housed together and engaged in activities aimed at competency restoration, insanity acquittees were housed and programmed for with little regard to individualized treatment. In many respects the facility was more akin to a correctional institution than a hospital. The administrator, fearful of being taken hostage, would not go among patients without a security escort. Patients were often described in terms of being “good” or “bad” depending on “how much a problem” they were for staff.

In 1989, the 71st Legislature amended the Code of Criminal Procedure, changing provisions regarding composition of the dangerousness review board to require the appointment of five members, “including one psychiatrist licensed to practice medicine in this state and two persons who work directly with mental health patients or mentally retarded clients”. This was the last major amendment that would be made to this statute for years to come. Although it was possible for an insanity acquittee to transition from maximum security to a less restrictive civil hospital (and vice versa) via the review board process, the process itself was fraught with problems that were to last for years to come. In the late 1980’s, comparatively little was known about violence risk assessment and TDMHMR Dangerousness Review Boards made determinations based largely on whether or not the patient was stabilized on medication, and had an extended period of “good” behavior. One review board member from that era was commonly heard to say that he would never “pass” patients who did not sincerely express remorse for their actions. It was not uncommon for boards to review as many as sixty cases a day with some reviews taking only minutes to complete. By the end of the decade the situation at the hospital had become critical. A burgeoning census had previously resulted in a change in practice wherein the hospital only accepted persons with felony level charges/offenses (except for persons with mental retardation) as there was no longer sufficient space to serve misdemeanants. For many patients maximum security must have seemed their final stop.

A Decade of Change

At the time of my appointment as Superintendent of the hospital in June 1990, things were near turmoil. A review of the hospital by the RAJ Monitor and consultants in December 1990, concluded that the hospital was “seriously out of compliance with the terms of the settlement agreement”. The hospital’s average daily census was 414 and the entire medical staff was comprised of six full-time physicians, two of which were engaged in general medical roles. Of the remaining four physicians, only two were psychiatrically trained and none were board

certified in psychiatry. Widely regarded as the worst of the state facilities in the Texas system, it is accurate to say that safe containment of insanity acquittees and other patients was the order of the day. Predictably, staff who were in large measure ill prepared and poorly trained at times resorted to abusive behavior themselves in an attempt to exert some control in the environment and increase their personal feelings of safety.

Disrupting cycles of staff to patient, patient to staff and patient to patient violence was difficult but absolutely essential as a first step to shifting emphasis from confinement to real and meaningful treatment. More than any other of the hospital's patients, insanity acquittees were well acquainted with "correctional culture". As a result of having the experience of being in jail, some for considerable periods, many came to the hospital with needs and expectations appreciably different than those of patients without experience in correctional settings. As had been observed before, many of those persons acquired repertoires of attitude, beliefs and behaviors that while adaptive in jail, get in the way of their succeeding in treatment settings. Staff who are unaware of the different patterns can miss or misread early warning signs of difficult adjustment to place, program and treatment, therein losing the chance for early and empathic engagement (Rotter & Stein bacher, 2001).

The first order of business was to adopt and enforce a policy of no tolerance for patient abuse and neglect. While unquestionably necessary, this admittedly left those staff with no training and inherently poor people skills at risk of harm themselves. Relying on the large cadre of staff who desperately wanted to establish meaningful treatment programs, we adopted and "preached" the principle that the most effective way to create a safe and secure hospital environment was through the development of good quality treatment programs. In espousing this principle, one that had inherent payoffs for staff as well as patients, the groundwork was laid for the organizational culture change that had to occur.

To accomplish this change, mission, vision and values statements were adopted which reflected an uncompromising commitment to quality patient care. Every manager and department head at the hospital was required to appear before the hospital's Executive Committee and justify the continued existence of their operation in terms of how same furthered the clinical care mission of the hospital in a way that honored the expressed values of the hospital. Those who could not do this were sent away and asked to try again. When they got it right there were tasked to teach it to their staff. These efforts were supported by an unprecedented professional staff recruitment initiative and a massive commitment to staff training. To this day, new staff are taught that every job counts and is important only to the extent it serves the patient care mission of the hospital. Every year since, hundreds of professional clinical staff and direct care workers are afforded training at the Texas Forensic Conference hosted by the hospital and held in Vernon.

Over the next several years the hospital made significant progress. With the greater sense of organizational stability afforded by previous organizational restructuring, successful recruitment of well trained and competent psychiatrists and other professional staff, and a commitment to the principles of psychiatric rehabilitation, the quality of treatment for insanity acquirers and other patients improved to the point where staff had begun to envision an organized and methodical approach to patient programming that specifically targeted those factors which prevented patients quicker transition from the maximum security unit.

In 1993, a multi-year initiative was launched called “The Program Integrity Project”. Its focus was to define treatment tracks based on identified clinical characteristics of patients (as opposed to commitment type, diagnoses, etc.) that figure most prominently in the patient’s hospitalization/continued hospitalization in the maximum security unit, so that these factors become the locus of treatment. In so doing, we believed that we could more appropriately assign new admissions, expedite treatment and transition patients out of maximum security and to the appropriate civil facility or state school more quickly and safely.

Four basic categories of recurrent behavior and likely accompanying underlying processes were identified by the Medical Staff and Clinical Leadership through the multi-year Program Integrity Project. These categories provide a basis for grouping patients and providing programming appropriate to their clinical needs. The focus of treatment for these groups is to identify the overall patterns of behavior and illness that are evident in the individual’s lifetime so as to interrupt the cycle of exacerbation, re-arrest, rehospitalization, and recidivism, in addition to alleviating symptoms immediately evident in the hospital. The four subsets of the Maximum Security Unit populations organized into treatment tracks are as follows:

Track I: Patients with habitual or chronic aggressive behaviors that are either severe or frequent in nature, who are initiators of violence. Diagnoses in this group frequently are, but are not limited to, bi-polar disorder and other mood disorders, major affective disorder with agitation, organic personality syndrome, borderline personality disorder, schizoaffective disorder with manic features, etc. These patients would primarily benefit from a highly structured and individualized treatment program designed to contain, manage, decrease, and redirect the overtly aggressive, assaultive, and self-mutilate behaviors and encourage and teach more adaptive functioning. These patients are usually stimulus seeking and active in engaging others. They usually have poorly developed skills at independent self-care and sustained multi-step planning and action toward longer-term goals. They often have fear or anxiety related to being alone.

Track II: Patients with a history of episodic or situational violent behaviors who are generally otherwise passive or even withdrawn individuals. These patients are usually stimulus avoidant and are characterized by reacting violently either to internal stimuli or intrusions by others into their very rigidly defined and narrowly circumscribed set of rules and explanations of the world around them. They are often delusional, very narcissistic, or referential. Diagnoses frequently associated with this group are paranoid personality, chronic paranoid schizophrenia, dissociative disorder, and delusional disorder, although other diagnoses may be found. Individualized treatment is directed at the likely underlying causes of the patient's violence, such as: delusions and/or hallucinations often accentuated by addictions and intoxicated states, severe family and inter personal conflicts with frequent early history of sadistic or abusive primary relationships, noncompliance with medications, anxiety, trauma, homosexual fears, etc. These patients have to learn new skills to assess more accurately the perceptions and feelings of others and use this to plan their own actions to better support their own needs.

Track III: Patients currently charged with a felony who have impairments or deficits in reality testing, neuro-cognitive functioning, factual knowledge, or communication skills and hence are unable or unwilling to form a collaborative and cooperative relationship with their attorneys. This population includes malingerers and manipulative patients who are attempting to avoid facing their charges. These patients generally require short-term care (less than three months), psychiatric treatment, education regarding their charges, and court²⁸ ordered psychiatric or psychological reports. The goal of their treatment is to return to court for adjudication of their charges. Treatment is directed at the underlying causes of their lack of cooperation with their attorneys and their deficits in knowledge and reality testing.

Track IV: Persons with mental retardation who are committed to the hospital. Persons with mental retardation meet the following criteria, as established by law and as defined by the DSM-IV: Significantly sub-average general intellectual functioning (an I.Q. of 70 or below on an individually administered I.Q. test) concurrent deficits or impairments in adaptive functioning, i.e., the person's effectiveness in meeting the standards expected for his or her age by his/her cultural group in areas such as social skills and responsibility, communications, daily living skills, personal independence and self-sufficiency; and onset before the age of 18.

In addition to the above primary focus of treatment, there are certain behaviors that, when recurring repeatedly or impulsively, present needs for a special focus of treatment and caution. Sexual crimes and crimes of arson are two of these that warrant special identification for treatment planning.

All of the above populations have a high incidence (65-75%) of substance abuse or dependency that both heightens and accentuates their maladaptive behavior patterns and lowers the threshold for impulsive or violent action. Substance abuse/dependency assessment, education and counseling will be an identified ongoing need in the majority of these patients.

Following the initial identification and description of treatment tracks, every patient in the hospital was reassessed and appropriately assigned. Insanity acquittees will be found in all these tracks with the obvious exception of Track III.

By 1994, this approach to patient programming in the maximum security environment yielded results consistent with our initial expectations and provided the foundation on which programming still rests today.

Although all our state mental hospitals are surveyed, audited and monitored to a degree beyond what most people imagine, I have always told staff that the best way for them to evaluate their work is to ask, “Is this hospital good enough for someone I love?” If the answer is “yes”, then I believe we’re likely doing a fine job. Nevertheless, one of the most significant validations of the improvements made came in February 1995, when the Vernon State Hospital became the first facility in the system to be excused from the more than two decades old R.A.J. lawsuit. Another validation, the following letter in the book State Hospital Reform, Why Was It So Hard To Accomplish?, captures in simple but eloquent language just how much was accomplished in so short a time:

Vernon State Hospital, 1995, Anonymous

The employees we have come in contact with at Vernon State Hospital are not only efficient in their fields, but are also courteous and caring people, dedicated, and willing to readily help us in our needs. With our lives stressed from recent occurring events, their “caring” has truly been a “godsend” to us and needless to write we are appreciative, and are also appreciative of the care of our son. We realize now why Vernon State Hospital was apparently the first hospital to pass the monitoring regulations in regards to the R.A.J. lawsuit.

Our son was admitted to the psychiatric unit at Vernon State Hospital during August 1995, and after a medical crisis was transferred to a general hospital. We have been kept informed by phone calls on all issues affecting him. When we came to the general hospital to be with our son during the crisis of his illness a staff member met us there. Talking to her on the phone was always

helpful to us and then meeting her, she reached out to offer more help. She even arranged for us to speak with the physician regarding our son's illness. The physician was kind enough to take time out of his busy schedule to speak with us.

The social worker has been most helpful, giving us information on phone numbers and just being there to assist us with answers to our questions, and always willing to take the time to do this.

The state hospital chaplain was very compassionate and kind, taking the time to come to the local hospital and offer encouragement and prayers; truly a spiritual uplift!

We were very much impressed by the security guards from the state hospital who alternated shifts at the general hospital. We expected these men to be very stern authoritarians but to our grateful surprise, they were caring individuals, doing their assigned jobs, but human enough to be understanding and kind (Bell, Cheyney, Dees, Medlin & Anonymous, 1995).

As treatment improved for insanity acquittees and others in the hospital, pressure increased to both improve the dangerousness review process and to develop specialized programming at the state's civil facilities to which patients were transferred after being determined "not manifestly dangerous". In spite of a fairly stable maximum security unit average daily census, during the period from Fiscal Year (FY) 1991 to FY 1993, the number of persons presented to the TDMHMR Dangerousness Review Board increased by 33.6% from 291 to 440. The number who passed increased by 35.6% from 130 to 175. The average length of stay during this period changed from 256 days in FY 1991 to 203 days in FY 1993. During this same period the numbers of female patients who "passed" the DRB increased by 100% and the number of persons with mental retardation likewise passing increased by 62.5%. In response, a plan for the establishment of forensic step down programs was developed in December 1994 under the auspices of the then Deputy Commissioner for Mental Health Services. Though never officially adopted, the need it addressed was the impetus for the development of specialized inpatient programs at Terrell State Hospital, and other TDMHMR facilities. Unfortunately, the need for a systems oriented, more organized continuum of care for persons transitioning from maximum security not only remains, but is arguably greater. Efforts made during this period to improve the dangerousness review process were operational in nature, affecting efficiency and economy, but not targeted to the long-standing problems of inconsistent and idiosyncratic decision making of some review boards. Nevertheless, the early 1990's marked the beginning of real hope for insanity acquittees in the Texas State Hospital system. Finally, the right of acquittees to receive real treatment in the most

appropriate least restrictive setting was no longer viewed in terms mutually exclusive of the safety and security interests of others.

The mid-1990's was a period of continuing change, during which the leadership of TDMHMR gave increasing attention to forensic mental health issues. In 1995, professional staff from a number of TDMHMR state facilities and central office were tasked to rewrite the rules regarding manifest dangerousness determination. Their work ultimately led to the adoption of a change to the Texas Administrative Code regarding the rules for determination of manifest dangerousness ("Determination of Manifest Dangerousness", 1996). This new rule of the Texas Department of Mental Health and Mental Retardation was important to the disposition of insanity acquittees in that it:

- placed a greater emphasis on continuity of care for individuals found to be manifestly dangerous
 - exhibited clinical guidelines for identifying factors relating to an individual's dangerousness
 - focused treatment on those factors
 - required that treatment continue upon an individual's transfer from maximum security to a less secure facility
 - defined new membership requirements for facility review boards and the TDMHMR Review Board
 - identified specific procedures for transferring an individual to a less secure facility outside their county of residence
 - articulated due process protections for the individual being reviewed
- Adoption of this rule was important to all persons who became the subject of a dangerousness review but it was particularly important for insanity acquittees whose initial commitment was to maximum security, the most restrictive treatment setting in the TDMHMR system. It served to focus increased attention at the state's civil facilities on the needs of this population and on the need for meaningful violence risk assessments as opposed to predictions regarding violence potential that still occurred in spite of a significant body of literature challenging their worth (Kramer & Heilbrun, 2002).

In 1995, the 74th Legislature appropriated funds for the construction of a new state of the art, residential building on the grounds of Vernon State Hospital. Later that year and well before construction was complete, I was asked by the Commissioner to create a shared administration for the Vernon and Wichita Falls State Hospitals that would eventually result in their consolidation as North Texas State Hospital. This is worth mentioning in that out of necessity the newly emerging organization's attention shifted to this endeavor.

In the latter part of the decade TDMHMR commissioned a group of staff to craft a multi-year strategic plan for forensic services. Submitted in 1998, "The State Facilities Forensic Strategic Plan, Fiscal Years 1999-2001" ("State Facilities Forensics", 1998) proposed sweeping changes clustered under the following broad goals:

Goal I: To establish an MHMR facility-based continuum of forensic services and programs that result in demonstrated improvement in the consumer's ability to function effectively and safely.

Goal II: To increase public security and community safety through the assurance that consumer movement along the continuum of campus-based forensic services is clinically appropriate, based on an accurate assessment of risk with corresponding strategies for managing same, and governed by a dangerousness review board process that is fair, consistent and clinically sound.

Goal III: To develop a comprehensive forensic training and education capacity for all stakeholders (e.g., providers, members of the judiciary, law enforcement officials, etc.) in support of their acquisition of skills, knowledge and abilities so as to foster the development, maintenance and ongoing improvement of a continuum of forensic services.

Goal IV: Redefine/design a contemporary and effective forensic information management system to meet current and anticipated demands.

The plan, though thematically consistent with another planning effort of that era that addressed the establishment of a community based continuum of forensic services, was never officially adopted. Nonetheless, improvements continued to occur.

In 1999, the Executive Committee of North Texas State Hospital committed the hospital and its resources to a multi-year phase in of a Social Learning and Diagnostic Program that was first piloted on the maximum security unit.

Social Learning is now considered the treatment modality of choice at the hospital and is one that is central to the Maximum Security Unit's treatment philosophy. This approach offers the following advantages:

1. Emphasis on positive reinforcement as a means of teaching and maintaining healthy, adaptive behaviors with resulting de-emphasis on more negative means of control.
2. Facilitation of providing each patient with the least restrictive environment necessary for the patient's safety and progress by clearly defining minimal requirements for earning increased independence and privileges and by shaping growth toward these goals.
3. Emphasis on a very active and structured program focused on specific goals and objectives.
4. Provision of a mechanism (behavioral data collection) for relatively easy, accurate evaluation of patient progress and of the effectiveness of treatment techniques.
5. For patients, the provision of consistent, clear, concrete messages of the consequences and rewards they may expect for their behavior; for staff provision of guidelines for consistent and therapeutic responses in a variety of patient behaviors.

In the Maximum Security Unit, a social learning milieu which emphasizes positive reinforcement through a Point Economy and Privilege Level System provides the foundation for almost all therapeutic services. The major thrust of the program is the use of positive reinforcement through contingent points, differentiated privilege levels, and social reinforcement to shape and maintain adaptive prosocial behaviors. It should also be noted that the availability of new generation anti-psychotic medication has been nothing short of a Godsend for the forensic patient population in Texas and absolutely essential in the treatment armamentarium.

In 1999, the Kerrville State Hospital took on a forensic psychiatric mission for reasons akin to those that prompted the early transformation of the Vernon facility. The quality of care offered at the hospital was a resource the Department couldn't afford to lose and its value as an economic asset to its host community was undeniable. Nevertheless, a comparatively low rate of use made per diem rates untenable for the long term. For these reasons, among others, the facility

took on a minimum security mission in addition to its existing role as a civil facility with a regional catchment area. Patients are now directly referred to Kerrville State Hospital from the Maximum Security Unit after being determined not manifestly dangerous if they are considered likely to need long term inpatient care in a specialized environment. The initial concerns of some who feared the program would become a warehouse have not been realized. As with the Vernon facility, the vast majority of patients at Kerrville are persons remaining incompetent to stand trial. A good number of these persons ultimately attain trial competency or transition back to the community, as is the case with insanity acquittees.

The Next Decade: Now and Later

By the year 2001, Kerrville State Hospital's forensic mission was firmly established with approximately 74% of its capacity devoted to the forensic patient population. Terrell State Hospital's specialized forensic unit had by this time established itself as a critical player in the effort to develop a continuum of forensic mental health services in the Dallas metropolitan and neighboring areas. The program's highly motivated professional staff have worked effectively to partner with area district attorneys and judges to improve opportunities for patient transition to community based care. In varying degrees, by 2001 the system's other state facilities had made strides in the development of services for insanity acquittees and persons remaining incompetent to stand trial.

Meeting in 2001, the 77th Legislature amended the Code of Criminal Procedure specifying provisions under which the trial court "may" transfer a defendant found NGRI to an appropriate court for civil commitment proceedings, following a determination that the defendant committed an act, attempt, or threat of serious bodily harm to another person. The previous code stated that the trial court under similar circumstances had to retain jurisdiction and commit the person to the Maximum Security Unit.

In July 2002, new rules governing determination of manifest dangerousness were adopted by the TDMHMR Board. The new rule is significantly different from the repealed rule in that it:

- provides for the appointment of a pool of sixteen members to the TDMHMR Dangerousness Review Board, from which five are to be empanelled to conduct hearings
- expands the duties of the TDMHMR Dangerousness Review Board Chair

- strengthens due process protections for persons subject to review board hearing
- provides procedures wherein adolescents may be the subject of review board hearings to determine manifest dangerousness
- requires the Commissioner to designate a facility based Secure Adolescent Unit (SAU) to treat adolescents determined manifestly dangerous

Following adoption of the new rule, a Forensic sub-committee of the Department's Clinical Oversight Committee was appointed and charged "to utilize a performance improvement model to ensure that the needs of the forensic mental health population in the State Mental Health Facility (SMHF) system are regularly reviewed, assessed and presented for consideration in the development and implementation of the SMHF Management Plan." Comprised of representatives from each of the state mental health facilities, TDMHMR Central Office, the State Mental Retardation Facilities division and the Chair of the TDMHMR Dangerousness Review Board, this sub-committee has been assigned the following functions:

- Implementation and ongoing monitoring of the Department's Manifest Dangerousness Rule
- Establishment of relevant forensic data bases
- Development of specialty forensic training for professionals and other staff
- Endorsement of standardized processes and evaluation protocols where indicated
- Identification of forensic treatment issues for inclusion in the SMHF Annual Management Plan and/or the Department's Strategic Plan
- Identification of needs and assisting in planning related to development of the Department's legislative agenda

Unlike most other large state mental health systems, TDMHMR has never maintained a forensic mental health division or employed a full-time director of forensic mental health services. In light of this, the creation of a sub-committee, specifically tasked with responsibility

for functions typically performed by central office level staff in other systems, is a milestone. What is to be made of this opportunity remains to be seen.

Conclusion

With some degree of justified indignation we can assert that history has shown that our failures and shortcomings in serving those entrusted to our care, owe less to our lack of skill and professional know how, than to a consistent lack of political will necessary to do the right thing. I freely admit that oftentimes I find myself wanting to claim the moral high ground and there, safely contemplate what good we have done and might yet have done if only our leaders and fellow citizens understood the importance of our work. It is during these times that I remind myself that while much of the good we have accomplished on behalf of insanity acquittees is due to the work of a committed few, more has been accomplished as the result of the work of the many seeking to improve conditions for all those whom we serve. Our story has been one of continually trying to reconcile the unique needs of the forensic patient population with the prevailing political, social and economic winds of the time.

Texas is facing a grave fiscal crisis. Our state hospitals are consistently filled to capacity, over 22,000 of our fellow citizens are on waiting lists to receive services at the state's Community MHMR Centers and the TDMHMR Commissioner has as of this writing been asked by the Governor to cut the agency's current annual budget by seven percent with scarcely more than six months left in the fiscal year. This is one reality. Another reality is that on any given day there are likely to be fewer than 70 insanity acquittees among the other 2300 patients in Texas state mental hospitals. Of these 70, approximately one-third will be in the maximum security unit and the others, having been determined not manifestly dangerous, will be in the state's civil facilities. Last fiscal year (FY 2002) 90 persons were committed to the Vernon facility as Not Guilty by Reason of Insanity while there were 17,680 admissions to all the state's psychiatric hospitals during the same period.

Consideration of insanity defense reforms consumes enormous time and effort for legislative committees, state mental health agency staff and special committees of various professional associations, and as such may result in a disproportionate investment of scarce resources not only in the reform process itself, but also in the creation of institutional arrangements that will draw limited and critically needed resources away from the larger system (Steadman, McGreery, Morrissey, Callahan, Robbins & Cirincione, 1993). As much as I desire insanity defense reform in Texas, I can't help but think we are like sailors consumed with charting tomorrow's voyage when the ship on which we stand is now fast sinking.

I believe history teaches us that in order to make improvements in the care, treatment and compassionate disposition of insanity acquittees, we must be willing to confront the obstacles to such ends facing all persons with severe and persistent mental illness. I am convinced that the quality of our caring will ultimately be judged by the whole of our efforts on behalf of every citizen who struggles with mental illness.

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