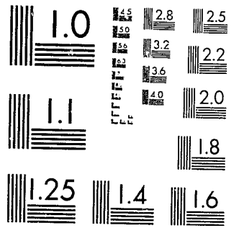

THE MENTALLY ILL AND THE CRIMINAL JUSTICE SYSTEM

A REPORT TO THE HAWAII STATE LEGISLATURE

BY THE
HAWAII CRIME COMMISSION

State Capitol
Honolulu, Hawaii 96813

THOMAS T. OSHIRO
Chairman

APRIL 1982

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George R. Ariyoshi
Governor

Jean S. King
Lieutenant Governor

This report is respectfully submitted to the Legislature, State of Hawaii, pursuant to Act 16, First Special Session, Ninth Legislature, State of Hawaii, 1977 as amended.

THOMAS T. OSHIRO
Chairman
Hawaii Crime Commission

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ACKNOWLEDGMENTS

The staff wishes to acknowledge the invaluable assistance and cooperation received in this study from agencies and individuals both in Hawaii and throughout the nation. Without such cooperation, this work could not have been done.

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EXECUTIVE SUMMARY

Purpose

In the past few years, a few highly publicized cases have focused public attention on the insanity defense in Hawaii.[1] The purpose of this study is to examine the functioning of the insanity defense and make recommendations for its improvement. It considers both the statutes and the implementation of that law.

Methodology

Work on this study was begun in 1981 and completed in 1982. It consisted of extensive research into published materials; the gathering and analysis of primary data from the Hawaii State Hospital, Department of Health, and First Circuit Court; consultation with nationally known experts in the field; interviews with local professionals; and attendance at several conferences and hearings.

Statutory Framework

Insanity is allowed as a complete defense to all crimes in Hawaii. A person who is found to have been affected by mental disease, disorder, or defect which directly influenced the commission of the crime is relieved of responsibility for that crime. Even though the defendant committed the proscribed act, he is not held criminally liable. He is "acquitted on the ground of physical or mental disease, disorder, or defect excluding penal

[1] "Insanity" is not defined under Hawaii law. Similarly, the "insanity defense," "insanity plea," and "not guilty by reason of insanity" (NGRI) do not exist per se. These terms are used popularly and in national literature on the subject and so are employed throughout this report for simplicity and continuity when referring to Hawaii Revised Statutes (HRS) Chapter 704 and "physical or mental disease, disorder, or defect excluding penal responsibility" (Haw. Rev. Stat. §704-400 (1976)).

Proposals for Change

Eight pertinent proposals for change are considered in part III of this study. Each proposal is discussed in detail and a recommendation is made. Taken together, these eight proposals should answer the basic question: "What changes should be made to the insanity defense in Hawaii to improve the protection of the public?" The following proposals are discussed:

A. Eliminate the Insanity Defense;

B. Add a New Plea--Guilty But Mentally Ill;

C. Make the Insanity Defense an Affirmative Defense;

D. Create a Hawaii State Forensic Center;

E. Establish a Time Limit for Raising the Insanity Defense;

F. Certify Sanity Commissioners;

G. Improve Supervision of Conditionally Released Patients;

H. Move the Penal Commitment Facility from Hawaii State Hospital.

Recommendations

On the above eight topics the Commission made the following recommendations:

A. The Insanity Defense. The Commission recommends that the current Not Guilty by Reason of Insanity (NGRI) plea be retained.

B. The Guilty But Mentally Ill Verdict. The Commission recommends that an additional verdict of Guilty But Mentally Ill be added to Hawaii law.

C. Affirmative Defense. The Commission recommends that the insanity defense be made an affirmative defense.

D. Forensic Center. The Commission recommends the creation of a Hawaii State Forensic Center.

responsibility" (HRS 704-411). Such an acquittal is different from a simple not guilty finding, however. A person so acquitted is not simply released, but is usually committed to the state hospital or conditionally released. The decision to commit or conditionally release is based on an assessment of the dangerousness of the individual made by a panel of doctors.

The statutes which create this defense are found in Hawaii Revised Statutes (HRS) Chapter 704. When the defense is raised, proceedings are suspended and three doctors are appointed to independently examine the defendant. The court bases its decisions primarily on these doctors' reports. If a person is acquitted on the basis of the insanity defense and committed to the hospital, he can be released only on a court order.

Data Analysis

In order to provide decision makers with information concerning mental health and the law in Hawaii, the Crime Commission collected data on cases raising questions of insanity over a period of four years. All these cases are from the First Circuit Court. Findings indicate that in 4.1% of all felony cases filed with the court insanity was an issue and 1% of all cases resulted in a disposition of acquittal excluding penal responsibility, about 17 per year. Also, in ten cases where the defendant was convicted the court included mental health treatment (usually residential) as part of the sentence. More importantly, the findings show the insanity defense in Hawaii is not abused or regularly misused just as a defense tactic.

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C. Affirmative Defense. The Commission recommends that the insanity defense be made an affirmative defense.

D. Forensic Center. The Commission recommends the creation of a Hawaii State Forensic Center.

E. Time Limit for Entering the NGRI Plea. The Commission recommends the establishment of a time limit for entering the NGRI plea.

F. Certification of Sanity Commissioners. The Commission recommends the establishment of procedures to train and certify doctors who serve on sanity commissions.

G. Supervision of Conditionally Released Penal Patients. The Commission recommends the establishment of guidelines for monitoring conditionally released penal patients.

H. The Penal Commitment Facility at Hawaii State Hospital. The Commission recommends that the closed intensive supervision unit (CISU) for penal patients remain at the Hawaii State Hospital.

The Commission believes that this set of recommendations would adequately address existing problems and contribute to creating the best possible system for dealing with the criminally insane.

Conclusions

In general, the public is well protected and well served by the existing law and its implementation. The concept of excluding insane defendants from penal responsibility is sound and should be retained. It serves the best interests of a compassionate and fair system of justice. The few changes which seem to be required to improve the system deal mainly with the administration of the law. These changes are contained in the two bills proposed by the Crime Commission.

The insanity defense is not a big problem for our criminal justice system. It is of special concern to the public because of the converging of two fears--the fear of criminals and the fear of the mentally ill. This concern is belied, however, by a close look at the facts. Contrary to the

general public perception, there are few NGRI acquittals each year and they seldom result in outright releases. An NGRI acquittal usually results in confinement in a security ward of the state hospital for a substantial period of time. A patient is released when no longer considered dangerous and only on a court order.

Proposed Legislation

The Crime Commission's recommendations were codified into two bills, proposed to the 1982 legislative session. These bills would 1) institute a guilty but mentally ill verdict; and 2) create a state center for forensic psychiatry. The first is entitled "HB 3022-82: Relating to Penal Responsibility" (SB 2841-82). The second is "HB 2865-82: Relating to the Establishment of a Center for Forensic Psychiatry" (SB 2842-82). Neither bill was passed during the 1982 session.

Summary of Recommendations

A. The Insanity Defense

The Commission recommends that the current Insanity Defense be retained. Philosophically, it satisfies certain basic requirements of the American system of jurisprudence. Constitutionally, there are doubts that the plea could be successfully abolished. Practically, the finding is so seldom returned and the safeguards in the law are so firmly established that the NGRI plea itself cannot be viewed as endangering public safety or causing injustice in any substantial way.

B. The Guilty But Mentally Ill Verdict

The Commission recommends that an additional verdict of Guilty But Mentally Ill be added to Hawaii Law. Such a finding would be used in the case where there is evidence of mental illness, but that illness did not affect the defendant's behavior to the degree necessary to remove responsibility. If still affected by the illness, the defendant would be afforded treatment as part of his sentence. The extra verdict would add one more option for the jury or judge, thereby allowing compassionate treatment of those in needwhile maintaining the strict standard of responsibility and, thus, the integrity of the criminal law.

C. Affirmative Defense

The Commission recommends that the insanity defense be made an affirmative defense. Currently, when mental illness is raised as an issue, the state must prove that the defendant was sane. By placing the burden of proof on the defendant, who is often the sole person in possession of the necessary information to confirm the contention, the

defense would be brought in line with other defenses which admit commission of the act but deny culpability (such as self-defense). Twenty-two states have made insanity an affirmative defense. Constitutional challenges, alleging violation of due process, have been unsuccessful.

D. Forensic Center

The Commission recommends the creation of a Hawaii State Forensic Center. This center would be responsible for the examination and treatment of all persons raising the mental illness issue in a criminal proceeding (HRS Chapter 704). It would also conduct research and educational programs for professionals involved with the insanity plea as well as supervising all those penal patients who are conditionally released. This recommendation was the primary recommendation of the State Commission on Mental Health and Criminal Justice,* which reported in 1980, and the Crime Commission concurs. Such a center would improve the administration of the law by clarifying procedures, centralizing responsibilities, and providing training.

E. Time Limit for Entering the NGRI Plea

The Commission recommends the establishment of a time limit for entering the NGRI plea. Currently, the plea can be raised at anytime up to and including during trial. The difficulty caused by such a liberal procedure is that of determining responsibility long after the incident occurred. The psychiatrists' task becomes increasingly difficult the longer the examination is delayed. It would benefit both the defendant and the prosecution if a time limitation could expedite the convening of a sanity commission and thus improve the quality of the examinations.

*Fukunaga, K., et al. "Final Report: Commission on Criminal Justice and Mental Health." Unpublished, 1980.

F. Certification of Sanity Commissioners

The Commission recommends the establishment of procedures to train and certify doctors who serve on sanity commissions. Currently, there are no experience or requirements for psychologists or psychiatrists who serve on sanity commissions beyond the state licensing requirements. Because the insanity defense is an interface between the legal and mental health fields and because a great burden of responsibility is placed on the sanity commissioners, the functioning of the system would be improved if periodic training and certification were required of doctors who serve on sanity commissions. Should a forensic center be created for Hawaii, this function could be performed by that center.

G. Supervision of Conditionally Released Penal Patients

The Commission recommends the establishment of guidelines for monitoring conditionally released penal patients. Just as with probation and parole, public safety demands the careful monitoring of those who are released from custody with certain conditions. Currently, the division of responsibility and lines of authority are not clear. There should be very clear mechanisms for supervision and procedures for enforcement. Should a forensic center be created for Hawaii, the center could be responsible for monitoring conditional release. In lieu of such a center, the Judiciary should take steps toward improving this situation.

H. The Penal Commitment Facility at Hawaii State Hospital

The Commission recommends that the closed intensive supervision unit for penal patients remain at the Hawaii State Hospital. Any problems with

supervision--the purely custodial aspects of commitment--could be handled administratively, such as with the inter-departmental transfer of employees from DSSH Corrections. Should the Guilty But Mentally Ill finding be added, Corrections may want to add a facility at the Oahu Community Correctional Center for the treatment of those adjudicated GBMI. However, the state hospital should still maintain a penal commitment facility for those found NGRI. Perhaps a prison facility could relieve part of the burden of commitments for examination. Should a forensic center be created for Hawaii, the custodial burden could be shifted to the center, but most likely the existing facilities would continue to be utilized.

I. Introduction

In the past few years, a few highly publicized cases have focused public attention on the insanity defense in Hawaii. Public perception is that the defense is used often, is usually successful, and results in release of the defendant into the community like anyone else found not guilty. Most people believe that it is easy to use the defense in order to "get away with murder" and that, as a result of the defense, dangerous mentally ill people are returned to the community. In order to examine these beliefs and determine the purpose and function of the insanity defense in Hawaii, the Crime Commission undertook this study.

Two other studies focusing on the insanity defense have been done in the recent past. In October, 1977, the Hawaii State Department of Health published a report entitled The Criminally Insane: Who They Are; What Happens To Them; What Can Be Done. It was intended as a master plan for criminally insane in Hawaii and was generated by a grant from the state legislature. In January, 1980, the State Commission on Mental Health and Criminal Justice issued its Final Report. The Commission was appointed by the Governor in 1977 to investigate the relationships between Hawaii's mental health and criminal justice systems and to recommend changes. Both reports are valuable, being carefully done and making substantive recommendations.

The Crime Commission study attempts to do two things. First, it tries to bring up to date the data contained in the two reports mentioned above, and second, to focus informed comment on the important issues identified by those studies. Specifically, it considers only the issues related to

protection of the public-misuse of the insanity defense and the release of dangerous persons into the community. By narrowing the focus of this study to one set of critical issues, the Commission hopes to have directed attention to those concerns most important to the general public and the legislature. In making recommendations in these areas, it hopes to have contributed informed opinion on topics which are often complex and confusing.

Section II of this study describes the current system in Hawaii for dealing with the criminally insane. It describes the statutory framework for the identification and disposition of those who commit crimes but are not responsible due to mental illness. It also details the actual workings of the system in practice. Section II also presents data which describe the functioning of the system during the past four years. These data show the nature and extent of any problems with the insanity defense, as well as give a perspective of the true importance of the insanity defense within the whole criminal justice system. The facts presented in this section are very important for an overall understanding of the insanity defense in Hawaii.

Eight pertinent proposals for change are considered in Section III of this study. Each proposal is discussed in detail and a recommendation is made. Taken together, these eight proposals should answer the basic question: "What changes, if any, should be made to the insanity defense in Hawaii to improve the protection of the public and serve the needs of justice?" The following proposals are discussed:

A. Eliminate the Insanity Defense.

Belief in the misuse and overuse of the insanity defense has led some

to advocate abolishing this defense. What the defense means to the American system of jurisprudence and whether Hawaii can and/or should abolish it are discussed.

B. Add a New Plea--Guilty But Mentally Ill.

Some states have added a criminal plea of "guilty but mentally ill." Some in Hawaii believe that such plea, whether as a replacement for the insanity defense or as an additional finding, would improve justice in Hawaii. The purpose and function of such a plea are discussed.

C. Make the Insanity Defense an Affirmative Defense.

About half of the states in the United States have made the insanity defense an affirmative defense. Hawaii still places the burden of proof on the prosecutor. The desirability and effects of establishing the insanity defense in Hawaii as an affirmative defense are discussed.

D. Create a Hawaii State Forensic Center.

Michigan has established a statewide forensic center for the examination, treatment, and supervision of persons offering the insanity defense. The Governor's Commission on Criminal Justice and Mental Health proposed, as its primary recommendation, to create such a center for Hawaii. The purpose, function, and usefulness of a forensic center are discussed.

E. Establish a Time Limit for Raising the Insanity Defense.

Mental health professionals have stated that ascertaining the defendant's state of mind at the time of the crime becomes increasingly difficult with the passage of time. It has been proposed that a time limit for raising the defense be established which would facilitate more accurate assessment

by requiring the examination at an earlier time. The feasibility of this proposal is discussed.

F. Certify Sanity Commissioners.

Hawaii law states that the doctors appointed to a sanity commission be psychiatrists and psychologists licensed to practice in the state. Questions have been raised about the level of competence attained through such a standard. The suggestion that sanity commissioners be certified in forensic medicine through some education process is discussed.

G. Improve Supervision of Conditionally Released Patients.

Once a person is acquitted of a crime on the basis of the insanity defense, he is usually committed to the state hospital or conditionally released. Persons committed to the hospital usually can later be conditionally released, depending on the progress of their treatment. The adequacy of supervision of such persons, to ensure that the conditions imposed by the court are met, has been questioned. The proposal to improve such supervision is discussed.

H. Move the Penal Commitment Facility from Hawaii State Hospital.

With the rise in number of penal code commitments over the past decade, the Hawaii State Hospital has changed in character and reputation. Some officials fear that the hospital has gained the reputation of something akin to a psychiatric prison, which would lessen its attractiveness and effectiveness to the prospective voluntary admissions. The proposition to relocate the penal commitment facility to another site is examined.

Work on this study was started in 1981 and completed in 1982. It consisted of extensive research into published materials; the gathering and

analysis of primary data from the Hawaii State Hospital, Department of Health, and First Circuit Court; consultation with nationally known experts in the field; interviews with the local professionals; and attendance at several conferences and hearings. It is the sincere hope of the Crime Commission that the information contained herein is of use to the officials concerned with these issues and to the public.

II. Current System in Hawaii

A. Statutory Framework

Insanity is allowed as a complete defense to most crimes in Hawaii. A person who is found to have been affected by mental disease, disorder, or defect which directly influenced the commission of the crime is relieved of responsibility for that crime. Even though the defendant committed the proscribed act, he is not held criminally liable. He is found not guilty by reason of insanity (NGRI). Such a finding is quite different from a simple not guilty finding, however. A person granted an NGRI is not simply released, but is usually committed to the state hospital (similar, in effect, to prison for a guilty finding) or conditionally released (similar in effect, to probation for a guilty finding). The decision to commit or conditionally release is based on an assessment of the dangerousness of the individual made by a panel of doctors.

The theory behind the insanity defense is that someone who commits a crime because of his mental illness was not in control of his actions and therefore should not be held blameworthy or be punished by society. If someone did not know what he was doing, could not stop what he was doing, or did not know right from wrong, then he should not be treated the same as an offender who knowingly and willfully broke the law. Furthermore, he is bevond the influence of criminal sanctions. Punishment would serve no meaningful purpose to deter him or other mentally ill persons from committing further crimes. Mental health treatment may help him to "rehabilitate" himself but the traditional programs of prison or probation would not.

If that person is felt to be dangerous, however, he is not simply released. For the protection of the public, he is committed to a secure facility at the state hospital. There he is given treatment for his illness while being separated from the community. It is felt that such a disposition serves the interest of both the defendant and society at large, allowing compassionate treatment of those in need while simultaneously ensuring public safety.

The provisions that create this system are located in Chapter 704 of the Hawaii Revised Statutes. Section 704-400, which states the insanity defense, reads:

> §704-400 Physical or mental disease, disorder, or defect excluding penal responsibility. (1) A person is not responsible, under this Code, for conduct if at the time of the conduct as a result of physical or mental disease, disorder, or defect he lacks substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of law.
> (2) As used in this chapter, the terms "physical or mental disease, disorder, or defect" do not include an abnormality manifested only by repeated penal or otherwise anti-social conduct.

A person is not held responsible if, as a direct result of his mental illness, he did not know the act was wrong ("lacked substantial capacity to appreciate the wrongfulness of his conduct") or was unable to stop himself ("lacked substantial capacity to conform his conduct to the requirements of the law"). Part 2 of the section states that a person is not considered mentally ill and not relieved of responsibility simply on the basis that he continually commits crimes.

When a person has indicated that he will rely on the insanity defense, the judge names a sanity commission of three members to examine the defendant. These members are to be psychiatrists and clinical psychologists, one of whom is to be from the state department of health. The doctors file

reports of their findings on the issues of: 1) the defendant's ability to understand the trial proceedings ("fitness to proceed"); and 2) whether or not the defendant was responsible for his actions at the time of the offense. The statute which establishes this examination reads as follows:

> §704-404 Examination of defendant with respect to physical or mental disease, disorder, or defect. (1) Whenever the defendant has filed a notice of intention to rely on the defense of physical or mental disease, disorder, or defect excluding responsibility, or there is reason to doubt his fitness to proceed, or reason to believe that the physical or mental disease, disorder, or defect of the defendant will or has become an issue in the case, the court may immediately suspend all further proceedings in the prosecution. If a trial jury has been empanelled, it shall be discharged or retained at the discretion of the court. The dismissal of the trial jury shall not be a bar to further prosecution.
> (2) Upon suspension of further proceedings in the prosecution, the court shall appoint three qualified examiners to examine and report upon the physical and mental condition of the defendant. In each case the court shall appoint at least one psychiatrist and at least one certified clinical psychologist. The third member may be either a psychiatrist, certified clinical psychologist or qualified physician. One of the three shall be a psychiatrist or certified clinical psychologist designated by the director of health from within the department of health. The court may order the defendant to be committed to a hospital or other suitable facility for the purpose of the examination for a period not exceeding thirty days, or such longer period as the court determines to be necessary for the purpose, and may direct that one or more qualified physicians retained by the defendant be permitted to witness and participate in the examination.
> (3) In such examination any method may be employed which is accepted by the medical profession for the examination of those alleged to be suffering from physical or mental disease, disorder, or defect and the examiners may, upon approval of the court, secure the services of clinical psychologists and other medical or paramedical specialists to assist in the examination and diagnosis.
> (4) The report of the examination shall include the following:
> (a) A description of the nature of the examination;
> (b) A diagnosis of the physical or mental condition of the defendant;
> (c) An opinion as to his capacity to understand the proceedings against him and to assist in his own defense;
> (d) An opinion as to the extent, if any, to which the

capacity of the defendant to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of law was impaired at the time of the conduct alleged; and

(e) When directed by the court, an opinion as to the capacity of the defendant to have a particular state of mind which is required to establish an element of the offense charged.

(5) If the examination cannot be conducted by reason of the unwillingness of the defendant to participate therein, the report shall so state and shall include, if possible, an opinion as to whether such unwillingness of the defendant was the result of physical or mental disease, disorder, or defect.

(6) The report of the examination, including any supporting documents, shall be filed in triplicate with the clerk of the court, who shall cause copies to be delivered to the prosecuting attorney and to counsel for the defendant.

(7) Any examiner shall be permitted to make a separate explanation reasonably serving to clarify his diagnosis or opinion.

(8) There shall be made accessible to the examiners all existing medical, social and other pertinent records in the custody of public agencies notwithstanding any other statutes.

(9) The compensation of persons making or assisting in the examination, other than those retained by the non-indigent defendant, who are not undertaking the examination upon designation by the director of health as part of their normal duties as employees of the State or a county, shall be paid by the State.

The defendant also has the right to be examined by other doctors or experts of his choice (§704-409).

If the defendant is found unfit to proceed with the trial, the proceedings are suspended. The defendant is then either committed to the state hospital or other institution or released with certain conditions attached (conditional release) until such time that he regains his fitness to proceed. If, at the discretion of the Court, it is determined that too much time has elapsed, the charge may be dropped and the defendant committed to the hospital or released on conditional release (§704-409).

If the sanity commission finds the defendant not responsible due to mental illness, the insanity defense is submitted to the jury (or judge if it is a non-jury trial) for a decision. The members of the commission may be called to appear and be cross-examined or the reports can be accepted on their own. Other experts and doctors who have examined the defendant may also be called as witnesses. These witnesses are allowed to testify as experts, as set out in section 704-410:

§704-410 Form of expert testimony regarding physical or mental disease, disorder, or defect. (1) At the hearing pursuant to section 704-405 or upon the trial, the examiners who reported pursuant to section 704-404 may be called as witnesses by the prosecution, the defendant, or the court. If the issue is being tried before a jury, the jury may be informed that the examiners or any of them were designated by the court or by the director of health at the request of the court, as the case may be. If called by the court, the witness shall be subject to cross-examination by the prosecution and the defendant. Both the prosecution and the defendant may summon any other qualified physician or other expert to testify, but no one who has not examined the defendant shall be competent to testify to an expert opinion with respect to the physical or mental condition of the defendant, as distinguished from the validity of the procedure followed by, or the general scientific proposition stated by, another witness.

(2) When an examiner testifies on the issue of the defendant's fitness to proceed, he shall be permitted to make a statement as to the nature of his examination, his diagnosis of the physical or mental condition of the defendant and his opinion of the extent, if any, to which the capacity of the defendant to understand the proceedings against him or to assist in his own defense is impaired as a result of physical or mental disease, disorder, or defect.

(3) When an examiner testifies on the issue of the defendant's responsibility for conduct alleged or the issue of the defendant's capacity to have a particular state of mind which is necessary to establish an element of the offense charged, he shall be permitted to make a statement as to the nature of his examination, his diagnosis of the physical or mental condition of the defendant at the time of the conduct alleged, and his opinion of the extent, if any, to which the capacity of the defendant to appreciate the wrongfulness of his conduct or to conform his conduct

to the requirements of law or to have a particular state of mind which is necessary to establish an element of the offense charged was impaired as a result of physical or mental disease, disorder, or defect at that time.

(4) When an examiner testifies, he shall be permitted to make any explanation reasonably serving to clarify his diagnosis and opinion and may be cross-examined as to any matter bearing on his competency or credibility or the validity of his diagnosis or opinion.

Should the insanity defense not be successful, the defendant is then found either guilty or not guilty on the basis of the facts. If found guilty, he may be placed on probation, with one condition being that he seek mental health treatment, or sentenced to jail or prison, with the possibility of transfer to the state hospital for treatment as necessary. If found not guilty, on the basis of the facts, the defendant is released.

If the defendant is found by the court not to have been responsible because of mental illness, he can be committed to the state hospital, released on certain conditions, or discharged. The determination is based on the defendant's dangerousness "to himself or to the person or property of others." The decision is made by the court, based on the reports of the examining physicians. The statute which authorizes this disposition reads as follows:

§704-411 Legal effect of acquittal on the ground of physical or mental disease, disorder, or defect excluding responsibility; commitment; conditional release; discharge; procedure for separate post-acquittal hearing. (1) When a defendant is acquitted on the ground of physical or mental disease, disorder, or defect excluding responsibility, the court shall, on the basis of the report made pursuant to section 704-404, if uncontested, or the medical evidence given at the trial or at a separate hearing, make an order as follows:

(a) The court shall order him to be committed to the custody of the director of health to be placed in an appropriate institution for custody, care, and treatment if the court finds that the defendant presents a risk of danger to himself or the person or property of others and that he is not a proper subject for conditional release; or

(b) The court shall order the defendant to be released on such conditions as the court deems necessary

if the court finds that the defendant is affected by physical or mental disease, disorder, or defect, and that he presents a danger to himself or the person or property of others, but that can be controlled adequately and given proper care, supervision, and treatment if he is released on condition; or

(c) The court shall order him discharged from custody if the court finds that the defendant is no longer affected by physical or mental disease, disorder, or defect, or, if so affected, that he no longer presents a danger to himself or the person or property of others and is not in need of care, supervision, or treatment.

(2) The court shall, upon its own motion or on the motion of the prosecuting attorney or the defendant, order a separate post-acquittal hearing for the purpose of taking evidence on the issue of the risk of danger which the defendant presents to himself or to the person or property of others.

(3) When ordering such a hearing the court shall appoint three qualified examiners to examine and report upon the physical and mental condition of the defendant. In each case the court shall appoint at least one psychiatrist and at least one certified clinical psychologist. The third member may be either a psychiatrist, certified clinical psychologist or a qualified physician. One of the three shall be a psychiatrist or certified clinical psychologist designated by the director of health from within the department of health. To facilitate such examination and the proceedings thereon, the court may cause the defendant, if not then so confined, to be committed to a hospital or other suitable facility for the purpose of examination and may direct that qualified physicians retained by the defendant be permitted to witness and participate in the examination. The examination and report and the compensation of persons making or assisting in the examination shall be in accord with section 704-404(3), (4)(a) and (b), (6), (7), (8), and (9).

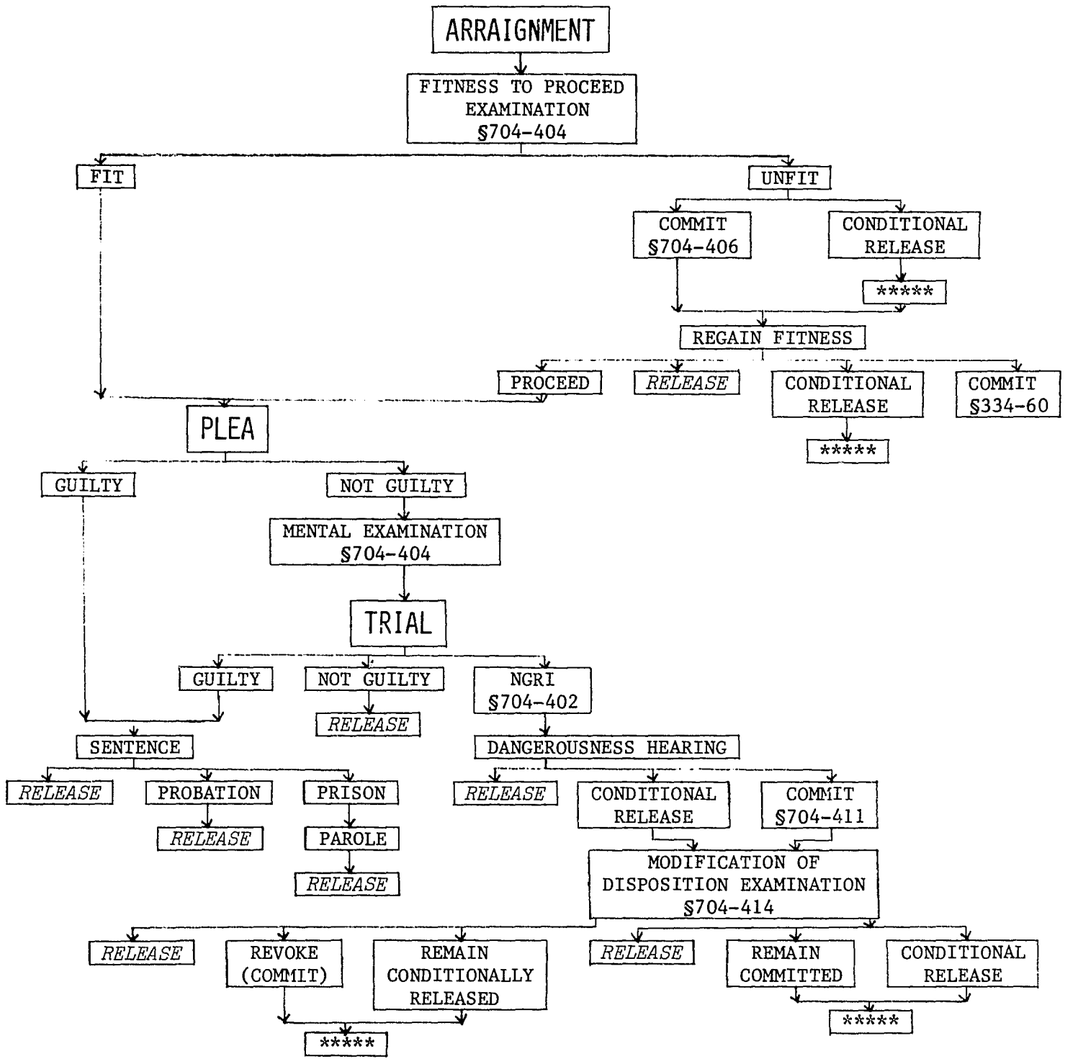
(4) Whether the court's order under subsection (1) is made on the basis of the medical evidence given at the trial or on the basis of the report made pursuant to section 704-404 or the medical evidence given at a separate hearing, the burden shall be upon the State to prove, by a preponderance of the evidence, that the defendant may not safely be discharged and that he should be either committed or conditionally released as provided in subsection (1).

There are provisions for releasing someone from the hospital or modifying the conditions of release. After ninety days, the patient or the Department of Health may apply for such change. If it is denied, the

patient cannot reapply for a minimum of one year, but the department is not so bound. In either case, a court hearing is required and the proceeding is an adversary one. Either change also requires another sanity commission.

If a person is released, then a similar procedure is followed to increase the level of supervision, when necessary. Within five years after the conditional release is granted, if the court determines that the conditions are not being met or that the person has become a danger to himself or others, it may revoke that conditional release. Recommendation is made by the supervising doctor or mental health facility. The person is then either committed to the state hospital or released on modified conditions, as the court deems fit.

INSANITY DEFENSE PROCEEDINGS



*****NOTE: A §704-414 examination can be requested to modify a conditional release or committed disposition.

B. Data Analysis

This section contains specific information relating to the processing of criminal cases in which issues of mental health are raised during the legal process. The data presented are from two state agencies and serve to give the reader an overview of how these mental health issues are treated within the system.

The first part of this chapter is devoted to felony cases of the First Circuit Court reviewed by the Courts and Corrections Mental Health Team for various reasons described below. The second part is a review of the felony cases that have resulted in a defendant being confined for a period of time at Hawaii State Hospital's closed intensive supervision unit.

Courts and Corrections Mental Health Team and the First Circuit Court

In order to establish a data base concerning mental health issues in the adjudication process, the staff of the Hawaii Crime Commission went to John J. Blaylock, Ph.D. chief of the Courts and Corrections Mental Health Team (C & CMHT) to obtain relevant information. The focus of interest was to track felony cases that involve mental health issues through the criminal justice system. Dr. Blaylock explained that although there could be some cases not referred to the team, the great majority of felony cases involving an intent to use insanity as a defense involved a sanity commission. Whenever a panel is assigned, one member must come from the courts and corrections team. Therefore, it was felt that starting at his office and following up with First Circuit Court records would present a fairly complete picture.

Method of Data Collection

The population was created by going through the logs of the C & CMHT and taking down names referred by the courts for pre-trial mental health examinations between January 1, 1978 and December 31, 1981. Only those adults who had been indicted for felony charges were selected. The total number of cases is 264 and the actual population is 240. For purposes of comparison, the unit of analysis is "cases" since that is the basis used by the judiciary to analyze its data. Therefore, 24 individuals are in the data set multiple times under multiple indictments. Also, many defendants were charged with multiple crimes under the same indictment. In order to make analysis more manageable, the most serious crime is used to identify what type of a case is involved (violent, property, drug, or other).

Findings

First, general characteristics of the population are described. This is followed by 1) an analysis of the type of cases that raise mental health as a question vis-a-vis criminal responsibility; and 2) factors that contribute to dispositions of acquittal on the ground of physical or mental disease, disorder, or defect excluding responsibility.

Description of population

The average age of this population is 30, with a major portion clustering in the late twenties/early thirties range. (See table 1.)

TABLE 1

AGE OF C & CMHT POPULATION

Age	Number	Percent
17 - 19	5	1.9
20 - 24	58	21.9
25 - 29	64	24.2
30 - 34	60	22.7
35 - 39	31	11.7
40 - 49	19	7.2
50 - 59	12	4.5
60 and over	4	1.5
unknown	11	4.2
	264	100.0

mean - 30 years
median - 29 years
mode - 24 years

This makes the population older than the usual statewide arrest population, which clusters around the late teens/early twenties range. (See table 2.)

TABLE 2

Age	C & CMHT population		1980 statewide arrest population	
	relative frequency (%)	cummulative frequency (%)	relative frequency (%)	cummulative frequency (%)
18 - 19	1.9	1.9	14.8	14.8
20 - 24	21.9	23.8	32.4	47.2
25 - 29	24.2	48.0	19.3	66.5
30 - 34	22.7	70.7	11.2	77.7
35 - 39	11.7	82.4	7.3	85.0
40 - 49	7.2	89.6	7.5	92.5
50 - 59	4.5	94.1	4.8	97.3
60 and over	1.5	95.6	2.7	100.0
unknown	4.2	99.8		

Perhaps this difference could be explained by research that shows that crime heavily tends to be a phenomenon of youth, while mental illness transverses all age groups. If the criminal behavior is a result of a mental or physical problem, age should have little bearing on it.

There is also a little variation between the distribution of the sexes within each population. The statewide arrest data show that 18.3 percent of the arrestees are female, while defendants in those cases that raise issues pertaining to mental health are 10.6 percent female. (See table 3.) It is unknown why there should be a difference.

TABLE 3

Sex	C & CMHT population		1980 statewide arrest population	
	number	percent	number	percent
Male	236	89.4	19,580	81.7
Female	28	10.6	4,384	18.3
	264	100.0	23,964	100.0

Within the C & CMHT population, 47.7 percent are indicted for property crimes and 41.3 percent for violent ones. (See table 4.)

TABLE 4

Crime type	Number	Percent
Violent	109	41.3
Property	126	47.7
Drugs	5	1.9
Other	24	9.1
	264	100.0

This is also a deviation from the usual patterns of crime-type distribution within criminal statistics. At the reporting level, arrest level, indictment level, and conviction level, property crimes always far outnumber the violent crimes. A mere 6.4 percent difference is just not seen. People who suffer from emotional and psychological problems often exhibit their illness at times when they are interacting with others. The interaction puts them under stress and the abnormal behavior is manifested. Therefore, the unusually high rate of crimes against the person being committed by the defendants in the C & CMHT population is not unexpected.

Outcome of the cases

Concern has been expressed in the community that the use of insanity as a defense has been abused by criminal justice practitioners. While this sentiment appears to be based on a few spectacular cases, empirical evidence is needed to see if such concern is warranted. As stated above, 264 cases were referred to the C & CMHT for examinations, but this does not imply that the same number made an actual motion for acquittal. The first time a defendant appears in the study is usually for a mental exam either to decide if a panel exam is warranted or to establish if the defendant is fit and responsible. The results of these exams are often the basis for subsequent action. For example, 15 percent of the cases involved defendants who were determined to have no problems that would exclude penal responsibility so none of them requested further action on that basis (and 71 percent of those eventually were found guilty or plead guilty).

In the same vein, though, being diagnosed as having some sort of problem that could affect behavior does not guarantee a chance for acquittal. Case records show again and again that a diagnosis of physical or mental disease, disorder, or defect does not automatically preclude fitness to proceed or penal responsibility. Table 5 shows the diagnosis, cross-tabulated with the final outcome of the case. Fifty-two percent were diagnosed by the panel to be suffering from some type of mental disorder (most usually paranoid schizophrenia) but only one-third of them were granted acquittals. Of those who had a physical or mental defect (mental retardation most often) only 14.3 percent were granted a motion of acquittal, while 64.3 percent were convicted of their crimes. Reading the evaluations

returned to the court reveals why this happened: the examiners would discover the defendant was mentally retarded, but that the retardation did not interfere with his ability to appreciate the wrongfulness of his actions, therefore rendering him criminally liable.

TABLE 5

DIAGNOSIS BY CASE OUTCOME

Diagnosis	Final outcome						
	guilty plea	found guilty	found not guilty	case dismissed	NGRI	pending	ROW TOTAL
Defect	7 (50.0)	2 (14.3)	0 (0.0)	1 (7.1)	2 (14.3)	2 (14.3)	14 (5.6)
Disease	4 (13.8)	3 (10.3)	2 (6.9)	4 (13.8)	10 (34.5)	6 (20.7)	29 (11.5)
Disorder	30 (23.1)	12 (9.2)	3 (2.3)	8 (6.2)	48 (36.9)	29 (22.3)	130 (51.6)
Substance abuse	17 (41.5)	7 (17.1)	0 (0.0)	2 (4.9)	7 (17.1)	8 (19.5)	41 (16.3)
Not applicable	24 (63.2)	3 (7.9)	1 (2.6)	3 (7.9)	0 (0.0)	7 (18.4)	38 (15.1)
COLUMN TOTAL	82 (32.5)	27 (10.7)	6 (2.4)	18 (7.1)	67 (26.6)	52 (20.6)	252* (100.0)

Of the base population (n=264), 72 cases (27.3 percent) went so far as to put in a motion for acquittal. Of those, 53 (73.6 percent) were granted. Therefore, 53 of the original 264 cases where mental health issues were raised resulted in judgments of acquittal (20.1 percent). In actuality, 14 additional cases were granted acquittals, but there were no defense motions in the record to indicate that such a finding was requested. Reviewing these cases shows that the results of the panel, for the most part, were

*Data missing in 12 cases.

strongly conclusive that the defendant was not responsible for his actions and that the judge appears to have entered the judgment on his own accord. Therefore, the total number of cases that resulted in an acquittal for reasons of "insanity" is 67.

These percentages may seem high--four out of five granted their motion--but the minuteness of the number actually granted becomes strikingly apparent when compared with all criminal cases (Part I and Part II) filed in the First Circuit Court over a four-year period of time. The judiciary bases its annual reports on fiscal years, so the years chosen for comparison were fiscal year 1977-78 through fiscal year 1980-81. During those four years, a total of 6,356 cases involving Part I and Part II offenses were filed. The C & CMHT population is 264 for the four-year period of calendar years 1978-1981, inclusive. Therefore, based on the number of filings in the First Circuit Court (n=6,356), in only 4.1 percent of the cases (n=264) was mental health raised as an issue. Of even greater interest is that in a mere 1.1 percent (n=72) of the cases was an actual motion invoked to request an acquittal and only in 1 percent (n=67) was the final outcome of the cases acquittal excluding penal responsibility.

What happens to those who are acquitted in such a manner--where are they placed after acquittal? It is often assumed these defendants are all placed at the hospital, but actually only 52.2 percent end up in the closed intensive supervision unit (CISU) and another 4.5 percent are sent to less restrictive wards of the hospital. (See table 6.) Another 4.5 percent are placed in other residential treatment centers, such as the Salvation Army, Teen Challenge, and Hina Mauka. Fifteen percent, though, are conditionally released with no mental health treatment

TABLE 6

FOR NGRI POPULATION CRIME TYPE BY PLACEMENT

COUNT ROW PERCENT COLUMN PERCENT	Violent	Property	Other	ROW TOTAL
CISU	16 (45.7) (64.0)	18 (51.4) (50.0)	1 (2.9) (16.7)	35 (52.2)
HSH	0 (0.0) (0.0)	2 (66.7) (5.6)	1 (33.3) (16.7)	3 (4.5)
Residential treatment	1 (33.3) (4.0)	2 (66.7) (5.6)	0 (0.0) (0.0)	3 (4.5)
Release with mental health conditions	6 (40.0) (24.0)	7 (46.6) (19.4)	2 (13.3) (33.3)	15 (22.3)
Release without mental health conditions	1 (11.1) (4.0)	6 (66.6) (16.6)	2 (22.2) (33.3)	9 (13.4)
Not applicable	0 (0.0) (0.0)	1 (100.0) (2.8)	0 (0.0) (0.0)	1 (1.5)
Unknown	1 (100.0) (4.0)	0 (0.0) (0.0)	0 (0.0) (0.0)	1 (1.5)
COLUMN TOTAL	25 (37.3)	36 (53.7)	6 (9.0)	67 (100.0)

requirements attached to their release, or discharged completely. Of the ten defendants so disposed one was under indictment for a bank robbery (robbery, second degree), a class B violent felony. Looking at the case in detail allows us an opportunity to see how such a decision could have been made. The defendant had no prior criminal record and, in an attempt to help some impoverished friends, decided to rob a bank, "who had more money than they needed." No weapon was used. Once outside the bank, she decided it wasn't such a good idea after all and approached a police officer to turn herself in. The officer had not been notified of any recent bank robbery and, even though she showed him the money, he told her to go home. Not knowing what to do, she took the sack of bills and placed it in some nearby bushes. As she did so, a wind stirred up and blew the money around a parking lot. While scrambling to pick it up, the police came, including the policeman she originally approached, to arrest her.

The sanity commissioners all agreed she needed to be supervised and recommended that she receive neuropsychological testing. The neurologist's report stated, "I strongly suspect that her problem is totally emotional in etiology . . . ", and then ended his report with a note of thanks to the court for referring such an interesting case to him.

Once granted the acquittal, her father told the court he would assume custody of his daughter if it would release her to him in Connecticut. Hence, she was strongly advised to seek treatment but not ordered to do so since the treatment would be in a different jurisdiction and therefore such an order would be moot. However, the court did specify that if she does decide to return to Hawaii at a later date, she must report to Adult Probation who will determine if she is in need of further treatment and

whether placement in Hawaii State Hospital is appropriate.

It is apparent that this defendant is not a danger to herself or others, only suffering from an emotional disorder that provoked a criminal incident. On that basis, the court appears to have made an appropriate disposition, even though this defendant was indicted for a violent felony.

Perhaps the most interesting finding in this study is that a few judges in the First Circuit Court already practice a form of the "guilty but mentally ill" disposition. Analysis was done on a variable concerning release conditions or placement of the defendant vis-a-vis mental health needs. This subgroup contained 80 cases, 63 of which were acquittals excluding penal responsibility and 10 which were persons adjudicated guilty (see table 7).

TABLE 7

PLACED POPULATION BY OUTCOME

Category label	Number	Percent
Guilty plea	8	10.0
Found guilty	2	2.5
Found not guilty	1	1.2
Case dismissed	1	1.2
NGRI	63	78.7
Pending	5	6.3
	80	100.0

Seven of the latter were placed on probation with conditions that they participate in specific mental health residential treatment programs until clinically discharged. The remaining three were all sentenced to some time behind bars, but two were able to avoid that if they committed

themselves to the state hospital instead. Both took that option. In the third case, the judge sentenced the defendant to five years at the state prison, but included an unusual request in that judgment:

> " . . . the defendant [is to] be committed to the custody of the Department of Social Services and Housing for incarceration at the Hawaii State Prison for a period of five (5) years. It is further ordered that the Director of the Department of Social Services and Housing consider placement of the defendant at the Closed Intensive Supervision Unit (CISU) of the Hawaii State Hospital."

The Department of Social Services and Housing (DSSH) did move the defendant to CISU at the state hospital. Subsequently, the sentence was changed to five years probation with the following conditions: mental health treatment until clinically discharged; defendant to take medications; place of residence once released from Hawaii State Hospital to be approved by Adult Probation Division. The Hawaii State Hospital recommended a reconsideration of that sentence and that the defendant be placed in a mental health boarding home in Kalihi which could supervise the defendant in taking medications. The prison personnel were happy to see the transfer because they didn't like stocking potent drugs. They testified at the reconsideration hearing that they felt Hawaii State Hospital was a far more appropriate setting for the defendant than Halawa.

This case serves as a clear example of the possibility of the judiciary, the hospital, and corrections working in unison. The judge saw a need to incarcerate this convicted felon, but felt treatment was needed that the prison system might not be able to provide. He requested the Director of DSSH to "consider" hospitalization, which he did. The hospital reviewed the case and also found placement at CISU more appropriate, then considered conditional release into the community. The needs of the defendant were

met and all agencies involved felt the final outcome fulfilled their responsibilities of safeguarding the community.

Time lapse

An important issue from the mental health examiners' point of view is the time lapse between the commission of the crime and the exam to determine the defendant's state of mind at that time. Therefore, it is important that the sanity panel be allowed to examine the defendant as soon as possible. In all but three of the cases reviewed, the motion for examining the defendant was not filed until after indictment. Therefore, the timeliness of the use of the defense must be measured from date of indictment to the date a motion for examination of the defendant is filed.

Of the 264 cases in the data set, a request was submitted in 241 to have a sanity panel examine the defendant for the purpose of determining penal responsibility. The average time lapse between date of indictment and the filing of the motion was 86 days, with the range being 2 to 635 days. In only four cases did the motion for the examination take place more than a year past the indictment date. In three of those cases the defendants had previously been found unfit to proceed and were hospitalized. The last case record does not reflect why the motion was not filed for almost two years and eventually the case was dismissed for "undue delay."

The length of time between indictment and the actual filing of a motion to acquit the defendant is also of interest. The average length of time between indictment and filing in these cases is 6.4 months, just two weeks beyond Hawaii's speedy trial rule. (See table 8.) When broken down by year the motion was filed, 1979 stands out as an unusual year--about

25 percent more motions were filed than any other year and the average time span was merely four months. No information from the records affords us an explanation for this unusual year.

TABLE 8

MOTIONS FOR ACQUITTAL EXCLUDING PENAL RESPONSIBILITY BY YEAR FILED*

	1978	1979	1980	1981	TOTAL
Number filed	18	24	24	20	86
Number granted	15	21	14	17	67
Average time	6.58	4.16	7.24	7.98	6.42

*Only 72 motions were filed, while an additional 14 cases were judgment without motions. Nineteen (26.4 percent) of the 72 motions were denied. Also, two motions from 1981 have not been acted upon because the defendants are currently unfit to proceed.

Hawaii State Hospital

The second part of this section, as stated above, relates to defendants sent to Hawaii State Hospital while under some type of penal code commitment. Initial placement for felons is the closed intensive supervision unit (CISU). Below is a history of the development of CISU and a description of its felon population.

Closed intensive supervision unit (CISU)

In July 1978, the first of three wards comprising the CISU was opened at Hawaii State Hospital. The decision to create this special unit was an internal one made by the administration of the hospital and the Department of Health. The purpose of creating this closed unit was twofold: 1) to meet the needs of the greatly increased number of patients committed for criminal behavior associated with mental illness; and 2) to protect the public from the most dangerous of the hospital population. The three wards within CISU represent three levels of secure supervision which, theoretically, should work thusly:

CISU I : highest security to house class A and B felons (24 beds).

CISU II : moderate security which allows the patients to leave the unit at times to participate in activities in other parts of the hospital (23 beds).

CISU III: minimum security which ideally functions similar to an open ward, with the patients allowed community contact (31 beds).

In reality, while trying to adhere to the above scheme, the problems of overcrowding have forced the hospital to place patients wherever they can. Therefore, a class B felony may be placed in CISU II if CISU I is filled.

All those in the unit are there for penal code commitments or on administrative transfers from a correctional facility (although a rare non-penal code patient who is extremely dangerous could be admitted). Basically, there are two types of penal commitments, pre- and post-adjudication. Pre-adjudication commitments are usually to determine whether the defendant is fit to proceed and to facilitate psychological and neurological evaluations of the defendant (sanity commission examinations). Post-adjudication commitments are for those who are acquitted for lack of penal responsibility (HRS §704-411) or transferred from correctional institutions.

Method of data collection

The population for this study was gleaned from Hawaii State Hospital records for penal code commitments. It included adults charged with felonies who were admitted between January 1, 1978 and December 31, 1981 and all current residents of the CISU, five of whom were admitted prior to 1978. The purpose of this analysis is to describe the type of offenders who are diverted to Hawaii State Hospital at one time or another during the adjudication process.

Findings

Between January 1, 1978 and December 31, 1981, 179 defendants were admitted to CISU for a total of 273 commitments. Some were admitted more than once at different points in the legal process (e.g., a defendant is admitted for 30 days for a psychological evaluation, released, and then re-committed when acquitted under HRS §704-411.) Thirty-nine persons were admitted multiple times under different indictments and

criminal charges. The increase in the number of commitments per year is quite noticeable (see table 9.)

TABLE 9

PENAL COMMITMENTS TO CISU

Year	Number	Percent increase
1978	42	
1979	49	14.3
1980	68	28.0
1981	77	11.7
	236	

*Data not available in 37 cases.

During the four-year period covered in this study, 30 percent of those who resided at CISU were eventually acquitted and committed. The bulk of this fluctuating population, though, came to the unit for psychological and neurological examinations. They rarely stayed longer than three months, with 45 percent leaving within 30 days of admittance. The only group that had a shorter average length of stay was the administrative transfers from correctional facilities, with nearly 70 percent leaving within 30 days of the initial transfer.

Comparing crime type (violent, property, and other), admit type (examination or acquit and commit), and length of stay, shows that for commitments for examinations, violent offenders spend less time in the hospital than property offenders. Fifty-six percent of violent offenders spend less than 30 days on a 404, while only 34 percent of the property offenders are released prior to 30 days when being evaluated. If granted

an NGRI, though, those trends reverse, with violent offenders spending more time as residents of the hospital.

In total, there were 218 criminal cases involving the population of 179. One-fourth of those cases resulted in NGRI. The distribution by crime type shows that these 25 percent matched the intake distribution:

TABLE 10

POPULATION BY CRIME TYPE

	Intake crime	Successful NGRI
Violent	122 (56.0)	31 (58.49)
Property	80 (36.7)	17 (32.07)
Other	16 (7.3)	5 (9.43)
	218	53

Therefore, it appears that regardless of crime type, approximately, one-fourth of those cases that enter the Hawaii State Hospital sometime during the adjudication process result in acquit and commit.

Conditional release

Between January 1, 1978 and December 31, 1981, 53 offenders were admitted to Hawaii State Hospital after being granted an acquittal excluding penal responsibility. Of those, 18 applied for conditional release prior to December 31, 1981. (Three in the NGRI subgroup were originally granted conditional release by the courts, had it revoked by not living up to the conditions, and were subsequently sent to the hospital.)

Of those 18 applications, 10 were granted. This does not mean that

the defendant was always released into the community, just that he was released from CISU. Four of the ten were transferred to other wards in the hospital with reduced supervision.

TABLE 11

ANALYSIS FOR THOSE WHO APPLIED FOR CONDITIONAL RELEASE (n=18)*

Crime Type		Outcome			
		Granted			Not granted
		to community	to another ward at HSH	to another residential treatment center	
Violent	A				4 (100.0)
	B	1 (33.3)	1 (33.3)		1 (33.3)
	C	1 (50.0)			1 (50.0)
Property	B		1 (50.0)	1 (50.0)	
	C	3 (42.8)	2 (28.6)		2 (28.6)
Other	B				
	C				

*This table does not include those found unfit to proceed who are in the hospital--only the NGRIs.

Sixty-six percent of the violent felons who applied were not released, while 78 percent of the property felons were. No class A felon was granted release.

Of those violent felons who were released, the class C had spent 271 days in, and the two class Bs averaged 717 days in. Of all 10 granted release, the average was 350 days.

Summary of findings

The following is a summary of findings based on the data collected.

1. In 4.1 percent of all felony cases filed with the First Circuit Court insanity was introduced as an issue, and 1 percent of all cases resulted in a disposition of acquittal excluding penal responsibility, about 17 per year.

2. Fifty-two percent of the defendants were diagnosed as having a mental disorder (usually paranoid schizophrenia) but only one-third of that number were granted an acquittal. A diagnosis of physical or mental disease, disorder, or defect does not automatically preclude penal responsibility.

3. Of those granted an NGRI acquittal, 61 percent were sent to a residential treatment facility and 24 percent granted conditional release with mental health treatment provisions. Fifteen percent were released with no stipulations regarding treatment.

4. Of those subsequently convicted of their crimes, ten were given mental health treatment as conditions of their sentence. This included two who were given a choice between Halawa and the state hospital, both of whom took the latter.

5. Of the population to go through CISU, 75 percent were there for examinations only. The other 25 percent were eventually acquitted and committed.

6. During the four-year period of this study, 18 of those acquitted and committed applied for conditional release. Ten were granted, with five returning to the community and five to less secure facilities than CISU.

7. Of those applying for conditional release, 66 percent of the violent felons were not released while 78 percent of the property felons were. No class A felon was granted release, although four applied.

III. Proposals for Change

A. Abolition of the Insanity Defense

1. Discussion

The insanity defense has recently become the object of widespread criticism. Some people advocate abolishing this defense. The main concern is that the defense is being abused. Other arguments include the lack of a medically-meaningful definition of insanity; the overlapping concept of "lack of mens rea;" divergence of the tenets of the mental health sciences and the law; and conflicting justifications for disposition. Each view will be examined separately to consider the abolition of the insanity defense in Hawaii.

a. Introduction. The Anglo-American system of jurisprudence is founded on the principle of presumption of innocence. It is assumed that a person, acting as a free agent, will choose not to perform a proscribed act. Should he be accused of an offense, the state must prove beyond a reasonable doubt that the person both committed the "actus reus" (criminal act) and possessed a "mens rea" (criminal mind) before the defendant can be held penally responsible.

The notion that a person chose to commit a prohibited act is statutorily defined as "state of mind." The states of mind are "intentionally," "knowingly," "recklessly," and "negligently,"[2] in order of decreasing culpability.[3] It is required to prove that the defendant possessed the required state of mind with respect to each element of the crime--conduct, circumstances, and result.[4] This forms the mental component of criminal responsibility.

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[2]Haw. Rev. Stat. 702-204 (1976).
[3]Haw. Rev. Stat. 702-208 (1976).
[4]Haw. Rev. Stat. 702-205 (1976).

The behavior described above assumes that a person exercises his free will in making a choice. In an expanded concept of responsibility, the law provides special defenses when a person's free will is compromised or the circumstances are justifiable. These defenses include "duress," "entrapment," and "self-protection." Usually, it is sufficient to cast reasonable doubt on the facts to gain an acquittal. Affirmative defenses require that the defendant prove "by a preponderance of evidence" conditions negating penal liability.[5] Where it is not an affirmative defense, the prosecution must disprove certain conditions that the law deems worthy of consideration. In either case, the law defines what those conditions are.

Traditionally, insanity has been a condition which exempted people from criminal responsibility.[6] The acquittal of Daniel M'Naghten in 1843 set the judicial precedent establishing it as a defense. In this English case, the court found that the defendant did not know the nature or wrongfulness of his act.[7] Later tests stressed the loss of "the power to choose right from wrong" and refrain from criminal conduct.[8] Currently, the combination of the loss of cognition and loss of volition are used to define insanity in many jurisdictions, including Hawaii.[9]

A significant step in the development of the insanity defense was marked by dialog on the cause and effect relationship between mental illness and

[5]Haw. Rev. Stat. §701-115 (1976).
[6]Quotations of the various tests and opinions cited in this section are presented in the appendix.
[7]Daniel M'Naghten's Case, 10 Clark & Finnelly 200, 210-211, 8 Eng. Rep. 718, 722-723 (1843).
[8]Parsons v. State, 2 So. 854, 866-867 (Ala. 1887).
[9]American Law Institute, Model Penal Code, Proposed Official Draft, sec. 4.01 (1962) and Haw. Rev. Stat. §704-400 (1976).

criminal behavior. The Durham test was termed the "Product Rule" whereby "such acts stem from and are the product of a mental disease or defect."[10] It goes on to qualify what is meant by a mental disease or defect. A later decision restated what is included in the definition in terms of "mental and emotional processes and . . . behavioral control."[11]

One of the problems with all of the decisions passed down is that the central issue--the lack of free will--has not been sufficiently clarified. The Durham test defined "blameworthy" as "those who [act] of their own free will and with evil intent."[12] The Currens decision related loss of control with not possessing mens rea.[13] Whereas the Brawner decision reasserted that "criminal responsibility is assessed when through 'free will' a man elects to do evil;"[14] the court made no pronouncement as to how to determine when free will was compromised.

There have been two instances when states have tried to remove insanity as a defense under part or the whole of their laws.[15] The state supreme courts in both cases ruled the statutory sections unconstitutional because they denied due process. They reaffirmed the defendant's right to present evidence that may cast doubt on the accusation that he, acting as a free agent, chose to commit a prohibited act. Also, the legislature of the state of Idaho recently passed a bill abolishing the insanity defense. The bill has been signed by the governor. Evaluation of this action must await the bill's implementation.

[10]Durham v. United States, 214 F.2d 862, 874-876, (D.C. Cir. 1954).
[11]McDonald v. United States, 312 F.2d 847 (1962).
[12]Durham, supra.
[13]United States v. Currens, 290 F.2d 751, 774 (3d Cir. 1961).
[14]United States v. Brawner, 471 F.2d 969 (D.C. Cir. 1972).
[15]Sinclair v. State, 132 So. 581 (Miss. 1931); State v. Strasburg, 110 P. 1020 (Wash. 1910).

b. Abuse of the insanity plea.[16] The most popular reason offered why the insanity defense should be abolished is that "the insanity plea is abused." Within that statement are two corollary reasons: "the plea is overused" and "the plea is used unscrupulously." Each statement must be examined for its validity.

The statement that the plea is overused has not been substantiated. There is "an extreme dearth of empirical data relating to the plea," writes one author.[17] Furthermore, inconsistencies between existing studies relating to types of crimes, definitions of insanity and characteristics of those studied--leaves comparison at the level of broad generalizations. Perhaps more important than the actual number of cases when the plea is raised is the public's perception of its use. Numerous studies indicate that the public grossly overestimates the frequency of use and success of the plea.[18]

The statement that the plea is used unscrupulously further reflects public sentiment. The plea is seen as guilt avoidance by a defendant. The fact is that acquittal by reason of insanity is usually followed by confinement or mandatory treatment, not release as with other acquittals.

Belief that the insanity plea is abused seems to be based on misinformation. The sensational media coverage of a few cases distorts the real issues involved. As stated in an earlier section, the data show that the insanity defense is seldom used in Hawaii, successful in 1% of the cases. Of those acquitted NGRI, about half are subsequently committed to a hospital,

[16]It should be noted here that there is no "insanity plea," only an insanity defense. Similarly, there is no finding of "not guilty by reason of insanity (NGRI)" currently used in Hawaii. However, both terms are used on occasion for the purposes of brevity and clarity.

[17]Pasewark, R., "Insanity Plea: A Review of Research Literature," J. Psychiatry and Law (in press).

[18]Id.

especially persons charged with violent offenses. Therefore, claims that the plea is overused or used unscrupulously must be discounted.

c. Mental illness as negating mens rea. In order to find a person guilty of a crime, it must be proved beyond a reasonable doubt that he possessed mens rea. One alternative to a separate defense of insanity is to allow psychiatric evidence only on the issue of state of mind. Such model legislation has been proposed to the United States Congress:

> It is a defense to a prosecution under any Federal criminal statute that the defendant, as a result of a mental disease or defect, lacked the state of mind required as an element of the offense charged. Mental disease or defect does not otherwise constitute a defense.[19]

A variation of this is "diminished capacity," which suggests that a mental illness may negate the particular state of mind of the criminal offense in question but allow conviction of a lesser offense (e.g. manslaughter instead of murder).

Insanity defines a condition that is different from possession or lack of mens rea. To say that we ask whether the person knew what he was doing or was able to control what he was doing is not sufficient to describe insanity. If that were so, insanity would be addressed under "ignorance"[20] or "involuntariness."[21] Instead, it means something more. We question whether the person has an irrational understanding of reality that made his behavior the logical, albeit irrational, result of his beliefs. The issue, then, is not whether he intended to commit the crime but what caused him to choose that behavior as a reasonable means to an end. Did he choose to do it from his own free will, or was he under the duress of an irrational mind?

[19]S. 1400, 93d Cong. 1st Sess. §502 (1973).
[20]Haw. Rev. Stat. §702-218 (1976).
[21]Haw. Rev. Stat. §702-200 (1976).

A defense of mental illness negating mens rea limits our understanding of the defendant's behavior. The testimony would be limited to whether the defendant 1) understood his conduct, 2) knew the circumstances surrounding his action, and 3) sought the results of the conduct. It would no longer matter that his mental condition was so deranged as to alter his perception and personality. Indeed, some argue that Daniel M'Naghten had a full understanding of the import of his actions;[22] nevertheless, the court saw fit to acquit him due to his "defect of reason."[23]

The proposed change would also affect the verdict. With a separate insanity defense, there are three possible verdicts: 1) responsible under the law and guilty of the crime, 2) responsible under the law and innocent of the crime, and 3) not responsible under the law and hence neither guilty nor innocent.[24] The latter verdict is allowed when we assess the totality of a defendant's beliefs and behavior and find that society's laws have no meaning or restriction in his reality. A defense of mental illness negating mens rea would leave only two possible verdicts: guilty and innocent. In the former case, a person who raises the question of his mental condition nevertheless would be held responsible and subject to incarceration. In the case where his mental illness was so severe that he acted without any knowledge or control of his behavior, without any reason--real or imagined, he would be found not guilty and set free.

Eliminating the insanity defense in favor of allowing mental illness specifically negating mens rea would limit the concept of responsibility.

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[22] Stone, A., Mental Health and Law: A System in Transition, Nat'l. Inst. of Mental Health: Md. (1975), p. 224.

[23] M'Naghten, supra.

[24] Fingarette, H., The Meaning of Criminal Insanity, U. Calif. Press: Berkeley, (1972), pp. 134, 127.

Finding that a person is not responsible for his behavior gives the court the authority to dispose him to confinement or treatment for his own good and the good of the community. Limiting the concept of responsibility to merely participation and intention in committing a prohibited act appears to clarify the issue. However, only a reasonable doubt regarding a person's intention is necessary to find him not guilty. The most extreme case of deranged behavior would be found not guilty, yet it is those very individuals who most need treatment and from whom the public demands protection.

d. The insanity defense as part of a larger system. Some people assume that a person acquitted by reason of insanity is then released into the community. In actuality, he is more likely to remain under the supervision of the court than be discharged. Nevertheless, the defendant is not held criminally liable and it is necessary to protect his rights as an individual. Therefore, any discussion of abolishing the insanity defense must view the effects such a change would have on the larger system of mental health/criminal justice.

When an individual relies on the defense of insanity, there is an implicit admission to having committed the crime. The verdict "not guilty by reason of insanity" does not mean that the defendant is found innocent in the same sense that a sane person found "not guilty" may be innocent. The verdict asserts that the defendant did not have the mental capacity to understand or control his behavior. Therefore, the court is justified in maintaining control over the individual--by its dispositional alternatives--until such time as his condition improves and he regains his mental capacity.

The insanity defense also provides for the rights and privileges of the accused individual. It is within these statutes where "fitness to

proceed" is defined.[25] Certain due process rights are protected, including a post-adjudication hearing for release from confinement or conditions.[26] Another area enacted by having an insanity defense is the psychiatric examination.[27] The law creates mechanisms to limit evidence to specific issues, ensure the quality of the examiners, and allow a defendant, unable to retain his own doctor, equal opportunity for examination.

The insanity defense is the cornerstone of a whole system of care and custodial alternatives. Should it be abolished, the protection of the public and the individual's civil rights would be diminished.

e. Mental illness as a cause of criminal behavior. There is a profound philosophical difference between the mental sciences and the law. Psychiatry and psychology are said to be deterministic; this means they are built upon the theory that human behavior is determined by personal traits and external stimuli. The law, on the other hand, is built on the assumption of individual free will. One argument for the abolition of the insanity defense maintains that the court cannot be dominated by the doctrines of a discipline that run contrary to its own.

The insanity defense attempts to shift liability from the defendant to something called a "mental illness." In most cases, there is a tacit or explicit admission of the criminal act. Therefore, the defendant intends to show that the mental illness caused him to commit the crime.

In Hawaii, the law explicitly acknowledges the deterministic relation: ". . . as a result of . . . mental disease . . . ," the defendant could not

[25]Haw. Rev. Stat. §704-403 (1976).
[26]Haw. Rev. Stat. §§704-412 and -413 (1976).
[27]Haw. Rev. Stat. §704-404 (1976 and Supp. 1981).

meet the test of responsibility.[28] However, the court must weigh other significant factors, besides the mere presence of a mental illness. Here, the question becomes, were it not for his mental illness, does the evidence show that he chose to commit the crime. In this way, the system of law based on free will is upheld.

f. The need for adequate definitions. Mental health experts argue that insanity is a legal term; it has no medical meaning. Ever since M'Naghten, the courts have struggled with how to judge whether a person is responsible. That no definition has been promulgated to keep stride with advances in the mental health sciences has been given as a reason why the insanity defense should be abolished.

At one time or another, different criteria have been used as precluding responsibility. The one central feature of all the tests has been the relation between the defendant's actions and a mental illness. Seldom has the court specified what it meant by ". . . a mental disease or defect . . ."[29] but it has reminded us that:

> [A] 'mental disease or defect' for clinical purposes . . . may or may not be the same as mental disease or defect for the jury's purpose in determining criminal responsibility.[30]

There are problems with the concept of mental illness. There is not always agreement between mental health experts as to what it means. One author divides mental illness into diseases of the brain, which represent deviations from a structural and functional norm, and what he calls "problems of living" manifest in interpersonal and social disharmony.[31] The alternative view is that biological factors operate synergistically with

[28]Haw. Rev. Stat. §704-400 (1976).
[29]Durham v. United States, 214 F 2d 862, 874-875, (D.C. Cir. 1954).
[30]McDonald v. United States, 312 F 2d 847 (1962).
[31]Szasz, T., Law, Liberty, and Psychiatry, p. 281, Macmillan Co., N.Y., (1963).

social and pscyhological factors, each contributing in varying degrees.[32] Current theories of mental illness relate certain behaviors to various defects, chemical reactions, or unconscious maladjustments. A diagnosis of a mental illness is not always a diagnosis of a disease but often of a type of behavior. Thus, an abstraction used to describe a behavior is turned into the cause of that behavior.[33]

Other problems with the concept of mental illness include 1) what qualifies as a mental illness may change from time to time (e.g. homosexuality) and 2) that the same diagnosis used by two examiners may not mean the same thing (e.g. schizophrenia). Depending on a psychiatrist's view of anti-social behavior, it is possible that any criminal could be diagnosed as mentally ill.

Traditionally, the difficulty facing the court has been what to include or not in the definition of insanity. The law is not concerned with what qualifies as a mental illness, but rather how a mental illness bears on a defendant's responsibility. Too narrow of a definition is likely to amount to a denial of due process; too broad of a definition, or no definition at all, would result in unrestricted psychiatric testimony. Changing the wording of the test without addressing the issue of responsibility would be no substantive change at all. The difficulty facing the mental health professionals has been translating the legal concept of insanity into meaningful terms of their fields. The solution is not the abolition of the insanity defense or a change of the definition but an improved understanding, by both sides, of the issues involved.

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[32] Commentary, Haw. Rev. Stat. §704-400 (1976).
[33] Szasz, supra.

g. Expert witness. When a defendant initiates the defense of insanity, psychiatrists and psychologists must examine him for evidence of mental illness. These "expert witnesses" are then asked to determine whether the defendant's mental illness substantially impaired his understanding or control. Implicit in this request is that the psychiatrists must make legal and moral value judgments concerning the scope and limits of the defendant's responsibility. The court may rely on the knowledge of professionals, expert in their fields. However, when too much weight is given to the testimony, the court, in effect, abdicates its authority to determine responsibility to the psychiatrists. Some argue that abolition of the insanity defense would result in less reliance on expert witnesses.

It is questionable whether psychiatrists can ever know the mental state of a defendant at the time of a crime. The examination is usually a considerable time after the initial arrest; it is hard to tell to what degree his behavior may have been affected. The mental health sciences lack the technology of testing and confirmation.

In order to overcome the diagnostic difficulties, the judicial process employs the adversarial setting. Many psychiatrists feel uncomfortable in this situation. In general, they do not have an adequate understanding of the legal concepts involved. Instead, they rely on the abstractions of their own discipline to explain their feelings. The testimony of these expert witnesses can confuse the jury and hide the real issue of the defendant's free will choice behind a cloak of psycho-medico mystique.

Abolishing the insanity defense would not eliminate psychiatric testimony altogether. Professional opinion on the issue of state of mind would still be admissible. Rather than abolish the insanity defense, reforms

such as training for the sanity examiners, expediting the examination, and strengthening the adversarial aspects of professional testimony could be implemented. Such safeguards would ensure the competency and integrity of the witnesses and clarify the issues at hand.

h. "Dangerousness". Another problem often brought up in discussion of the insanity defense is the inability of predicting dangerousness. It is a relevant topic because dangerousness is a criterion used in determining disposition. No one argues that a person with a propensity for violent behavior--directed toward society or himself--should not be restrained from doing harm. However, recognizing who that person is and how he is to be dealt with are not easily achieved.

Dangerousness has no medical meaning. The question it poses is not "was he violent?" but "will he be violent?" Inasmuch as it concerns future events, dangerousness is stated in terms of potential for certain behaviors and probabilities for certain events.[34] Various tests exist to measure dangerousness but none has been proven reliable.[35] Furthermore, there is a presumption that dangerousness is a characteristic of the individual. The violence is more likely to be one alternative reaction to a stressful situation.[36] Whether it is a trait or a stress or a combination of both, dangerousness fluctuates between highs and lows of intensity and duration. Treatment often consists of the use of ameliorating drugs. There is no diagnosis of dangerousness and there is no cure.

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[34] Morris, No., "Psychiatry and the Dangerous Criminal," 41 So. Cal. L. Rev. 514 (1968).

[35] Diamond, B., "The Psychiatric Prediction of Dangerousness," 123 V. Pa. L. Rev. 439 (1974).

[36] Shah, S., "Dangerousness: Conceptual, Prediction, and Public Policy Issues," in Violence and the Violent Individual, p. 151 (1981).

Dangerousness also has no legal definition but it is used at every step of the judicial process. The police, arraigning judge, pre-sentencing report examiners, trial judge, jury, warden, parole board, and psychiatrists all make assessments of a person's dangerousness. The opportunity to observe certain behaviors is different in each case, as is the power to control potential violence.

To prevent a madman from going on a violent spree after having been acquitted NGRI, the tendency is to commit him to a mental hospital for a time sufficient for his dangerousness to abate. Those committed who have little propensity for such behavior are called "false positives." One estimate is that the false positives are ten to one hundred times more than the truly dangerous persons.[37] Some argue that the insanity defense exists for the purpose of sanctioning persons otherwise acquitted.[38] Nevertheless, under the current law, no other alternative is available to ensure the protection of the public.

In Hawaii, dangerousness provides the statutory authority for post-acquittal confinement or conditional release,[39] as well as revocation of release.[40] The public fears that mental illness combined with criminality results in unsuspected, violent outbursts; it prefers a stricter definition of dangerousness that would allow fewer insanity defendants released into the community. Mental health experts insist that no measurement is possible and argue that it be removed from the law. The effect of that

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[37] Diamond, supra.

[38] Goldstein, A. & Katz, J., "Abolish the 'Insanity Defense' - Why Not?", 72 Yale L. J. 853 (1963).

[39] Haw. Rev. Stat. §704-411(1)(a) (1976).

[40] Haw. Rev. Stat. §704-413(2) (1976).

would lessen the court's control over a defendant found not criminally responsible for his behavior. Given the prevalence of implicit determinations of dangerousness throughout the criminal justice system, a significant understanding of it is greatly needed.

i. Acquit and commit. Acquittal by reason of insanity is usually followed by involuntary commitment to a mental hospital or conditional release, with failure to abide by the conditions as cause for commitment. It is essential to any discussion of the abolition of the insanity defense to understand the justification for this restraint and to examine how well the present system works.

There are four reasons that justify incapacitation of a convicted criminal; one must examine whether they apply to a defendant acquitted NGRI and involuntarily committed. It is questionable whether the threat of sanction made to an individual while he is rational will have a deterrent effect when he is insane. Punishment is attached to blameworthiness and so long as we hold that mental incapacity precludes blame, strict punishment is not warranted. Incapacitation provides for the protection of the public and, to a degree, the protection of the individual. Rehabilitation is most easily achieved through treatment; when the individual cannot or will not maintain treatment, restraint provides suitable supervision. Therefore restraint is justified for the protection of the public and the treatment for the individual.

Ideally, the purpose of the mental health system is to treat a patient and return him to normal functioning within society. This can either be achieved on an out-patient basis or through hospitalization. Many mental illnesses are not curable. At times, psychiatrists must content themselves with "stabilizing" a patient. Those persons not capable of caring for

themselves must be gradually brought to that level in a "structured environment." To provide a patient with a non-traumatic transition from the hospital to the community, a spectrum of furloughs and programs are available; furthermore, it is necessary to have a supportive attitude in the community. The goals and methods of the mental health system are quite different from those of the correctional system: the use of restraint by the mental health system facilitates treatment, whereas restraint by a correctional system serves to enforce the law.

Dealing with the criminally insane puts a lot of pressure on the mental health system. During the examination phase, psychiatrists and psychologists are asked to make moralistic and legalistic decisions based upon definitions from outside their fields. They are also asked to determine whether an individual will ever become violent in the future. The admission of a defendant to a mental hospital puts a strain on limited resources and changes the attitudes of both the hospital staff and the patients themselves. Because of the potential for dangerousness, a criminally committed person is likely to spend a longer time in the hospital than a voluntarily committed person. Furthermore, the public implicitly expects that an individual will be "absolutely" rehabilitated, free from any mental illness that will cause him to commit any violent act again; no such test of absoluteness is required of any other social service agency. When a defendant is released into the community, it is questionable whether the mental health system has the authority or the capability for probationary supervision.

Overall, the functioning of mental health/criminal justice system operates in accord with the philosophical aims it espouses. Specific areas

need improvement--including overcrowding of the hospital and inadequate follow-up of persons on conditional release. However, problems that are administrative, financial, or jurisdictional in origin are not sufficient cause to prescribe abolishing the insanity defense.

j. Conclusion. The insanity defense is needed to provide an exculpable condition for persons whose free will choice to avoid prohibited conduct was compromised by a mental illness. The law does not concern itself with what constitutes mental illness. Instead, a substantial impairment of cognition (understanding) or volition (control) is currently accepted as evidence of compromise.

Two objectives of the criminal law are being reinforced by the insanity defense. The first is the protection of the public from dangerous, mentally ill persons who have committed crimes. The second is the need for a just system of law, one that is forgiving of an act committed in a deranged state and willing to provide alleviating treatment. The insanity defense allows for alternatives that a system of law based solely on factual guilt or innocence does not provide.

Significant problems arise at the interface between psychiatry and the law. These problems include misinformation, philosophical differences, technological inadequacies, and conflicting justifications. Yet, no single or composite problem is sufficient to justify the abolition of the insanity defense.

2. Recommendation

The Commission recommends that the current insanity defense be retained. Philosophically, it satisfies certain basic requirements of the American system of jurisprudence. Constitutionally, there are doubts that the

defense could be successfully abolished. Practically, the finding is so seldom returned and the safeguards in the law are so firmly established that the defense itself cannot be viewed as endangering public safety or causing injustice in any substantial way.

B. Add the Guilty But Mentally Ill Verdict

1. Discussion

In Hawaii, when the insanity defense is raised there are three possible verdicts which can result--Guilty, Not Guilty, or Not Guilty by Reason of Insanity (NGRI). In some states (notably Michigan, Indiana, and Illinois) there is a fourth possible verdict--Guilty But Mentally Ill (GBMI). This verdict has been proposed by some in Hawaii as a solution to some of the problems encountered in the functioning of the insanity defense.

The GBMI was passed into law first in Michigan in 1975. It was added as a fourth possible verdict; the NGRI plea was not abolished. It formed part of a comprehensive package of laws intended to "consolidate, codify, and modernize"[41] Michigan's mental health laws. In addition to the GBMI verdict, Michigan added new definitions of "mental illness" and "insanity" as well as new regulations and guidelines for dealing with mentally ill criminals.

In Michigan, the possibility of a GBMI finding is created when the NGRI plea is utilized. A defendant can plead GBMI, but normally it is an alternate verdict, employed when the NGRI is unsuccessful. Three conditions must exist for the GBMI to be returned: 1) the defendant must be found guilty beyond a reasonable doubt; 2) the defendant must be determined to have suffered from mental illness at the time of the offense; and 3) the illness must have been insufficient to have removed criminal responsibility

[41] Mesritz, Comments, Guilty But Mentally Ill: An Historical and Constitutional Analysis, Journal of Urban Law, Vol. 53, 417, 1976 p. 483.

(NGRI and legal insanity). The defendant then is eligible for any sentence normally available for someone found guilty of the same offense.

Upon sentencing, a determination of the defendant's current mental health is made and provision is given in the sentence for any treatment which is necessary. If sentenced to prison, the department of corrections is instructed to supply the appropriate treatment, which can be provided by corrections or by the department of mental health. If the person is transferred to the hospital for treatment, when he is discharged he returns to the department of corrections to serve the balance of his sentence. If the defendant is placed on probation, the judge makes mental health treatment a condition of probation.

These provisions in the Michigan Law were not radically new. The verdict itself was new, but sentencing options were not. The GBMI sought to control disposition to some extent, but in reality it merely duplicated options available to the judge for those found guilty. The consequences to the defendant may be the same whether he is found guilty or GBMI. As one author has noted, "at most, the GBMI verdict may help ensure that convicted defendants who need treatment for mental illness will receive it."[42]

The real differences lie in the determination of verdict. The choice between NGRI and guilty is an all or nothing one which presupposes to a large extent a clear cut division between sane and insane. Most basically, if the defendant is found insane he is treated, if sane he is punished. The problem with this process is two sided. First, modern psychiatric thought does not recognize such a clearcut distinction between sanity and insanity,

[42] Grostic, J.M., "The Constitutionality of Michigan's Guilty But Mentally Ill Verdict," Journal of Law Reform, Vol. 12, No. 1, 1978, p. 191.

but rather distinguishes varying degrees of abnormality. Second, there is no "societal concensus on the definition of mental illness and its relationship to criminal behavior."[43] The GBMI verdict eases the tension in the choice by providing a middle ground, an option for those who are clearly suffering from some form of mental illness but who do not qualify as legally insane. It modifies the all-or-nothing decision, providing flexibility.

While the GBMI does not theoretically provide more than the guilty plea in most states, it does statutorily formalize and clarify the treatment options, with two notable effects. First, it forces the trier of fact, whether jury or judge, to consider degrees of abnormality. Second, it creates a statutory right to treatment.[44] Both of these effects are beneficial.

The conception of degrees of abnormality is an important one to satisfactory reform of the insanity plea. Not only does it agree with modern psychiatric theory which views sanity as part of a continuum, but also it recognizes and offers up for scrutiny the great variety of conditions contained within the term "mental illness." One psychologist has called this term:

> a 'big umbrella' under which are gathered people with organic problems and people with non-organic problems; people with perceptual difficulties and people with behavioral difficulties; people whose brains have been damaged and people who . . . have never learned how to get along in life. Those who are criminal or guilty or lazy have found escape beneath the umbrella together with those who have glandular problems. This is truly a most motley mob.[45]

Focusing on degrees of abnormality forces discrimination among the different types of behavior called "mental illness" and decisions about the particular abnormalities in question and their relationships to criminal behavior. The GBMI serves a useful function in encouraging this discrimination, reducing confusion created by psychiatric jargon, and allowing juries to condemn the behavior yet distinguish the defendant from the ordinary guilty party.

Another way to view this process is the conflict between two models. "Mental illness" is a medical label but it is applied to what is actually "a deviation from society's norms of behavior."[46] Thus, the term and the host of attributes and types of behavior it connotes in reality is a junction between two models, two ways of viewing the proscribed behavior--the medical model and the ethical model. The medical model deals with causation and symptomology; it is by definition amoral. The ethical model, on the other hand, is concerned with the victim and the outcome of behavior and it is supremely moral. The GBMI recognizes the tension between these two models and, by allowing the flexibility of holding some mentally ill defendants responsible, eases that tension. Doing so provides more public satisfaction with the insanity defense in general.

By creating a statutory right to treatment, the GBMI also increases satisfaction with the insanity defense. Although in theory the corrections department can and should provide mental health treatment as needed, in

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[43] Watkins, C.M., "Guilty But Mentally Ill: A Reasonable Compromise for Pennsylvania," Dickenson Law Review, Vol. 85, Winter '81, p. 291

[44] Amarilio, J.D., "Insanity-Guilty But Mentally Ill-Diminished Capacity: An Aggregate Approach to Madness," The John Marshall Journal of Practice and Procedure, Vol. 12, No. 351, 1979, p. 354, Note 17.

[45] Watkins, supra at 291.

[46] Watkins, supra at 309.

reality sufficient treatment is not always available. The public conception of prison as mainly punishment is too often borne out in fact. As such, the GBMI verdict satisfies the judge or jury that such a finding will indeed result in appropriate mental health treatment. Furthermore, as studies show that many jury verdicts are the result of compromise, the statutory right to treatment can favorably influence the jury to be honest about the responsibility issue. The extra option eases the dilemma between the desire for accountability and the wish for compassionate treatment.

These effects seem to have resulted from the enactment of the GBMI verdict in Michigan. The first year after the new law, the number of NGRI verdicts dropped from approximately eighty per year to about thirty-five per year. Since that time, 1975, the number has crept back up to approximately seventy per year. The number of GBMI verdicts has remained less than the number of NGRI verdicts, but approximately making up the difference. It can be said that about half of those who previously would have received the NGRI now will receive the GBMI instead.

Even more revealing is what the Director of the Michigan Center for Forensic Psychiatry calls the "appropriateness rate." In the center's opinion, before the GBMI verdict, only approximately fifty per cent of the NGRI findings were appropriate. Since the new law, that rate has risen drastically to about ninety-five per cent. This means that currently in Michigan, with the GBMI verdict, almost all of those found NGRI truly deserves that finding, in the opinion of the trained staff at the state forensic center. The GBMI has sorted out the borderline or questionable cases, making the whole system which deals with the insanity defense more honest.

It should be noted that the addition of the GBMI in 1975 was not the only change made in the system. An important factor was the creation of a centralized, state forensic center which conducts all the court ordered sanity examinations. The existence of such a program has standardized the examination and gone a long way toward ensuring high quality, consistent evaluations. The 1975 law also made such examinations free to any defendant, thus increasing the availability of the defense. Each year the center conducts approximately one thousand examinations to determine criminal responsibility. As previously noted, approximately seventy defendants are granted an NGRI annually, for a success rate of approximately seven per cent.

Some arguments have been advanced against the appropriateness of a GBMI verdict. The most common criticism is that injustice will result because of jury confusion. The argument states that the definitions of "mental illness" and "insanity" are so close that juries will not be able to discriminate the two, which will result in some defendants deserving of the NGRI being found GBMI. It also claims that jury confusion over the difference between NGRI and GBMI in terms of criminal responsibility will also result in inappropriate GBMI verdicts. Another argument states that the GBMI is simply a way to circumvent the insanity defense because the defense cannot constitutionally be eliminated entirely.

Critics also claim that the GBMI is no different than existing guilty verdicts in meaning or sentencing options. They insist that this duplication of options merely masks circumvention of the NGRI and a desire to reduce the number of successful insanity defenses. They see the verdict as a dishonest attempt either to gain political popularity or to persecute mentally ill offenders. The result for defendants found GBMI, they argue, is to be doubly

branded--both as "felon" and "lunatic," both "bad" and "mad."

Finally, some have argued that for various reasons, the Michigan GBMI statute should be held unconstitutional. Despite numerous challenges over the past six years, however, the statute to date has withstood the constitutional test.

2. Recommendation

The Commission recommends that an additional verdict of "Guilty but Mentally Ill" be added to Hawaii law. The experience in Michigan and other states seem to show that the GBMI is appropriate and effective. It has successfully addressed problems in those states which also exist in Hawaii. The worth of the extra option seems to far outweigh the potential dangers cited by critics of the verdict. The Commission believes that the GBMI verdict will go far in improving the administration of justice with regard to the insanity defense. Enabling legislation, found in section V of this report, is proposed to the 1982 session of the legislature to effect the addition of this verdict.

C. Make Not Guilty by Reason of Insanity an Affirmative Defense

1. Discussion

In Hawaii, as in all the states, there is a presumption of sanity in criminal cases. Unless the defendant places his sanity at issue, the prosecution is not required to prove the defendant sane. Once the defendant has introduced sufficient evidence to meet the burden of going forward, however, the prosecution must then assume the burden of providing the defendant sane beyond a reasonable doubt. If the prosecution cannot, then the defendant is adjudicated not guilty by reason of insanity.

The underlying reason for this requirement is that due process requires the state to prove every element of the crime. A defendant is presumed innocent until proven guilty. Insanity, in so far as it negates the essential element "intent" (mens rea, or "criminal mind"), negates guilt. Therefore, to prove the defendant guilty, the prosecution must prove that he was sane. Under Hawaii law, this means that the prosecution must prove that the defendant did not "lack substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of the law" (HRS §704-404).

The Federal law and twenty-seven other states also place the burden of proof on the prosecution. Twenty-two states have made insanity an affirmative defense, which places the burden of proof on the defendant. Traditional affirmative defenses include self-defense, entrapment, and duress. In asserting an affirmative defense, the defendant implicitly or explicitly admits commission of the act, but relies on a "distinctive

substantive matter to exempt him from punishment."[47] Insanity is an affirmative defense when the defendant must prove, by a preponderance of the evidence, that he was insane at the time of the crime.

The basis for making insanity an affirmative defense is the philosophical position that the existence of insanity does not preclude the showing of criminal intent. This belief holds that because insanity is not necessarily inconsistent with mens rea, due process is not offended by requiring the defendant to prove insanity. The defendant is not required to prove his innocence, under this theory, because sanity is not an aspect of culpability. Insanity should mitigate punishment, the argument goes, but not negate the defendant's guilt. It should excuse the conduct, not remove the guilt.

Some have proposed that insanity be made an affirmative defense in Hawaii. One justification put forward for the change is that it would reduce the number of NGRI acquittals. Such a view presumes that there are currently too many NGRI dispositions and that some of them are inappropriate. The affirmative defense would increase the burden on the defendant, which would supposedly curb abuses (those faking) and thereby reduce the number of successful NGRI attempts. To implement the affirmative defense, they hold, would not be an attempt to circumvent constitutional restrictions on abolishing the insanity defense or reduce its availability, but a needed reform to restore the integrity of the defense.

The adoption of insanity as an affirmative defense in Hawaii is probably constitutionally permissible. As mentioned above, some twenty-two states have made insanity an affirmative defense. Constitutional challenges have

[47]Am. Jr., 2d Evidence §156 (1967).

failed to overturn these statutes.[48] Should such a change be instituted in Hawaii, very carefully worded jury instructions would be required to clearly spell out the difference between the prosecutor's burden (evidence of sanity as it bears on an element of the crime) and the defendant's burden (evidence of insanity sufficient to meet the test of "lacked substantial capacity...."). Under no circumstances should the defense be required to prove an essential element of the crime itself.

Those who advocate the affirmative defense believe it will improve the implementation of the law and restore confidence in the insanity defense. They feel it would help reduce unnecessary delay and stalling techniques which sometimes cause hardships for the victims and other prosecution witnesses. It would also solve the problem caused when the defendant is unwilling to cooperate with the examining doctors. Finally, they hold, it would bring the insanity defense in line with other defense in which the defendant admits committing the act but denies culpability (such as self-defense).

Insanity as a complete defense, not affirmative defense, is in conformance with previous Hawaii law,[49] the Model Penal Code, Federal law, and a majority of states' laws. Those who oppose the affirmative defense claim that the current law protects the defendant's right to due process, avoids confusion over burden of proof, and maintains the integrity of the law by

[48]See Hill v. Lockhart, 516 F. 2d 910 (8th Cir. 1975); United States v. Greene, 489 F. 2d 1145 (D.C. Cir. 1973), cert. denied, 419 U.S. 977 (1974); Phillips v. Hocker, 473 F. 2d 395 (9th Cir.), cert. denied, 411 U.S. 939 (1973); State v. Mytycg, 292 Minn. 248, 194 N.W. 2d 276 (1972) (following Leland without discussing the impact of Winship); Phillips v. State, 86 Nev. 720, 475 F. 2d 617 (1970), cert. denied, 403 U.S. 940 (1971); Nilsson v. State, 477 S.W. 2d 592 (Tex. Ct. Crim. App. 1972).

[49]Commentary, Haw. Rev. Stat. §704-402 (1976).

clearly affirming the basic precept "innocent until proven guilty." It recognizes that insanity is a special kind of defense, different in nature and quality from self-defense, or entrapment. The issues of rationality, choice, and free will, which are all raised by the defense, necessarily bear on the concept of volition and the constitutional requirement of a showing of mens rea. Opponents of the affirmative defense hold that although it seems possible to differentiate evidence of insanity as it bears on an element of the crime (prosecutor's burden) and evidence of insanity which only bears on the test for insanity (defendant's burden under affirmative defense) it is improbable that in reality the sanctity of such a differentiation would be maintained and confusion avoided. It seems more in the interest of justice, they argue, to maintain the status quo of insanity as a complete defense, which appears to be the direction in which many jurisdictions are heading. One author made this point well:

> Recently, there has been a trend to shift the burden of persuasion regarding affirmative defenses to the prosecution. Thus, once the defendant has raised sufficient evidence to put the matter in issue, the prosecution is required to prove the absence of the defense beyond a reasonable doubt. The rationale for this shift in the burden of persuasion is that the truth of affirmative defenses ultimately bears on the issue of guilt, and to permit the jury to convict in spite of their reasonable doubt about the defendant's excuse would be inconsistent with prohibiting his conviction when they reasonably doubt that the defendant did the act or that he had the required mens rea.[50]

2. Recommendation

The Crime Commission recommends that the insanity defense be made an

[50] Watkins, C.M., "Guilty But Mentally Ill: A Reasonable Compromise for Pennsylvania," Dickenson Law Review, Vol. 85, Winter '81, p. 298.

affirmative defense. Although there are good arguments on both sides, it seems that the advantages of the affirmative defense outweigh any potential disadvantages. The constitutionality of the affirmative defense has been upheld in the many jurisdictions in which it is law, which dispels the criticism that due process would be compromised. The prosecutorial burden can be lightened without sacrificing defendant's rights. The administration of justice can thus be improved for the betterment of the general good while still maintaining high standards of fairness.

D. Create A Hawaii Forensic Center

1. Discussion

The primary recommendation of the State Commission on Mental Health and Justice, which reported in 1980, was the creation of a Hawaii State Forensic Center. Such a center would centralize responsibility for the examination, treatment, and custody of those who raise the mental health issue in a criminal proceeding (HRS Chapter 704). The forensic center would also maintain data, conduct research on those it examined, educate and train mental health professionals, and monitor those released on conditional release. The Governor's commission felt that creating a forensic center in Hawaii was the major change needed to improve the administration of the mental health law.

A primary responsibility of the forensic center would be the examination of all those claiming mental disease, disorder, or defect as an issue in a criminal case. This would cover all examinations under HRS Chapter 704, including fitness to proceed (704-404), responsibility (704-404), disposition (704-411), dangerousness (704-411), conditional release (704-413). It is argued that centralizing these functions in one administrative unit would improve consistency and, thus, the quality of justice. A more uniform application of the law should help prevent abuse.

Another important responsibility delegated to the forensic center would be the custody, care, and treatment of those found unfit to proceed, criminally irresponsible, and guilty but mentally ill. Mentally ill offenders assigned to DSSH Corrections or Adult Probation would also be treated at

the forensic center. The center would administer the maximum security hospital unit now at the Hawaii State Hospital.

Another function of a forensic center would be to educate and train mental health professionals in the administration of examinations under Chapter 704. Currently, there is no training provided the psychologists and psychiatrists who make determinations related to legal issues such as fitness to proceed and criminal responsibility. As noted elsewhere in this report, the need exists for such training to improve the administration of the law. A forensic center would be the ideal vehicle to supply this training on a regular, continuing basis. The Commission on Criminal Justice and Mental Health made this point well:

> The education function is particularly important for those mental health professionals whose practice may involve clients under criminal charges but who may be untrained in the complex area of criminal responsibility.
>
> We believe that the establishment of a central administrative unit, under the auspices of the Department of Health, would be best suited to regularize and standardize knowledge in the field of criminal responsibility.[51]

Another responsibility of the forensic center would be to monitor those acquitted by reason of mental illness and released on conditional release. Currently, those released are assigned to Adult Probation for supervision. As noted in another section of this report, there are problems with this procedure. There is a need for improved supervision and the establishment of guidelines for monitoring conditional release. This need could be met by centralizing this responsibility in the forensic center.

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[51] Commission on Criminal Justice and Mental Health, Final Report to the Governor, January 1980, p. 10.

The final function of a forensic center would be to conduct ongoing research and maintain data on mental illness and the law. Such research and data would provide a base for analyzing the functioning of the system and modifying the system as appropriate. The Governor's Commission described this function as:

> an important priority function in not only keeping up with ever-changing legal and mental health advances, but also in analyzing the on-going functioning of the mental health-criminal justice systems in Hawaii.[52]

It seems that the existence of a state forensic center in Hawaii would improve the administration of the law in several important aspects. First, it would help stem abuses of the insanity defense by improving the process of determining responsibility. It would create guidelines, educate and train the professionals conducting the examinations, and standardize examinations. Second, it would foster improved public safety by closely monitoring those released into the community on conditional release. Third, it would provide a mechanism for adjustments in the system as conditions change with the need for such adjustments detected through continuous research and data collection. Fourth, it should improve the reputation and, thus, effectiveness of the Hawaii State Hospital by assuming the task of custody of the penal code patients. All of these improvements would address shortcomings in the existing system.

Although most people in the system would welcome the creation of a forensic center, some have expressed reservations with the idea. The main criticism of a centralized forensic center is that evaluation and treatment should be kept separate. The decision of whether or not to commit a person,

[52] Dr. Aron Wolf, Letter of May 18, 1977 in Fukunaga Report, Appendix H.

they argue, should be entirely separate from considerations of crowding or other conditions at the facility. The only way to keep the two distinct is to have independent sanity commissions. As one psychiatrist commented, "mixing treatment and evaluation confuses many issues."[53]

The forensic center proposal is modeled after the successful program in Michigan. Started in 1967, the Michigan Center for Forensic Medicine currently conducts approximately one thousand responsibility examinations per year. In the opinion of the Center Director, the existence of a centralized program, complete with training and research, has gone a long way toward making the whole system more honest.

2. Recommendation

The Commission recommends the creation of a Hawaii State Forensic Center. This center would be responsible for the examination and treatment of all persons raising the mental illness issue in a criminal proceeding; research and educational programs; and supervision of all those penal patients who are conditionally released. The creation of a forensic center was the primary recommendation of the State Commission on Mental Health and Criminal Justice, which reported in 1980, and the Crime Commission concurs. Such a center would improve the administration of the law by clarifying procedures, centralizing responsibilities, and providing training. Enabling legislation to create a forensic center in Hawaii was submitted to the 1982 session of the legislature. A copy of the bill is included in section V of this report.

[53] Id.

E. Establish a Time Limit for Entering NGRI Plea

1. Discussion

Currently in Hawaii, a motion for a mental examination to determine the defendant's fitness to proceed (Section 704-404) or responsibility (Section 704-408) may be entered at any time during the criminal proceedings. Neither Hawaii's statutes nor court rules specify any time limitation on the performance of the examination. When the motion is granted, all proceedings are suspended until the examinations are completed and the reports presented to the court. This liberal procedure has produced two stumbling blocks: 1) the difficulty of assessing the defendant's state of mind at the time of the incident when a considerable amount of time has elapsed before the examination; and 2) a disruption of judicial proceedings when motions for examinations are filed after the trial has begun.

Recently, the Intake Service Center has instituted a misdemeanor diversion program which has somewhat eased these problems. On a daily basis, Center personnel visit the police cellblock and assess any detainees who show any signs of mental illness. If they find any people who need further examinations, a court order is obtained and the persons are taken directly to the Hawaii State Hospital. The examinations are thus done quite early in the process. The Intake Service Center feels this program has been successful and intends to extend it to include felony arrests. While not a cure-all for the problem of timeliness, the diversion program should help considerably.

Another diversion process operates at the police level. When the police arrest someone who is obviously in need of mental health care or who seems

to be an imminent danger to himself, they immediately take that person to a mental health facility for observation and treatment. The person is admitted on an emergency basis, which allows forty-eight hours observation. After that time, the treatment facility communicates with the court concerning the patient's mental health.

This procedure only applies to those who are currently and obviously in need of care. Most of those arrested who eventually utilize the insanity defense are not so diverted at an early stage. Many examinations take place after a considerable period of time. The average lapse of time, as discussed in the data section, is approximately three months from date of indictment to date of performance of the examination pursuant to HRS §704-404.

It would seem beneficial to place some time constraint on the performance of mental examinations; such as three months from the date of indictment. The longer the time span between the two, inevitably the harder it is for the defendant to remember the events of the offense which puts a greater burden on the examiner to determine "state of mind" and responsibility at the time of the incident. With a time constraint, defendants would be able to describe the events of the incident while they were still fresh in their minds. Another advantage would be that the examinations would be completed before trial was started and proceedings would not be interrupted.

Michigan has placed a time limit on the performance of mental examinations. The examination is to be completed not later than thirty days after an intent to assert the insanity defense has been filed (which should be filed not less than 30 days before the date set for trial). While this time limit would not directly solve the problem of delayed examinations, as the

trial could be scheduled several years after indictment, it at least does set some limitation and prevents the disruption of trial.

The constitutionality of such a timeliness requirement has apparently not been established. Certainly, the defendant's right to assert the insanity defense is compromised to a certain degree, but whether this consideration is significant is not presently known. Tying the limit to the trial date and not the indictment date, as Michigan has done, seems to class this requirement with certain other pretrial motions which cannot be filed after the start of trial. In so doing, Michigan seems to have avoided any possible constitutional problems.

2. Recommendation

The Commission recommends the establishment of a time limit for entering the NGRI plea. Currently, the plea can be raised at anytime up to and including during trial. Data show that, currently, examinations are being performed within a reasonable time after indictment (within three months). The long delay seems to be between the incident and the subsequent indictment, which would not be affected by changes in the law. What can be done is to prevent the disruption of the trial by mandating that the examination be requested and completed before the start of the trial. Included in the Commission's proposal to establish a forensic center in Hawaii is the establishment of a time limit commensurate with that imposed in Michigan--that the examination must be completed before the start of trial.

F. Certify Sanity Commissioners

1. Discussion

Currently in Hawaii, when mental illness has become an issue in a criminal case, the proceedings are suspended and a three--person sanity commission is appointed to examine the defendant. Three independent examinations are conducted and three separate reports are filed with the court. This examination process is critical to the insanity defense because the doctors testify as experts and the reports often are the sole basis for the court's decisions. Recommendations have been made in several reports and by numerous individuals to improve this process by requiring certification of the psychiatrists and psychologists who serve as examiners.

Hawaii's statutes are specific about who shall be appointed as examiners. HRS §704-404 states:

> (2) Upon suspension of further proceedings in the prosecution, the court shall appoint three qualified examiners to examine and report upon the physical and mental condition of the defendant. In each case the court shall appoint at least one psychiatrist and at least one certified clinical psychologist. The third member may be either a psychiatrist, certified clinical psychologist or qualified physician. One of the three shall be a psychiatrist or certified clinical psychologist designated by the director of health from within the department of health. The court...may direct that one or more qualified physician retained by the defendant be permitted to witness and participate in the examination.
>
> (3) In such examination, ...the examiners may, upon approval of the court, secure the services of clinical psychologists and other medical or paramedical specialists to assist in the examination and diagnosis.

The only qualifications specified in the statute are "qualified" and "certified." "Certified" means licensed by the state, but "qualified" is not further explained. In theory, the court could take it upon itself to

determine which psychologists and psychiatrists are "qualified" to conduct sanity examinations, but in practice it does not. The court appoints from a list of those willing to participate. Doctors volunteer to be included on the list. There are no education, training, or experience requirements and there is no procedure for removing anyone from the list. It is this appointment procedure which has drawn criticism.

Attention is focused on the education and experience of sanity examiners because the court orders them to give opinions on legal issues. They are not only asked to describe the diagnosis of the defendant's mental condition and how his mental disease, disorder, or defect may have affected his behavior, but also required to state opinions on the issues of criminal responsibility and state of mind. Both of these are <u>legal</u> issues, not mental health questions, and ones which medical training does not normally prepare someone to address. The statute specifying the report (HRS §704-404) reads as follows:

> (4) The report of the examination shall include the following:
> (a) A description of the nature of the examination;
> (b) A diagnosis of the physical or mental condition of the defendant;
> (c) An opinion as to his capacity to understand the proceedings against him and to assist in his own defense;
> (d) <u>An opinion as to the extent, if any, to which the capacity of the defendant to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of law was impaired at the time of the conduct alleged; and</u>
> (e) <u>When directed by the court, an opinion as to the capacity of the defendant to have a particular state of mind which is required to establish an element of the offense charged</u>. [Emphasis added]

It is because of this interface between medicine and law, requiring substantial understanding of both, that the issue of certification of sanity examiners has arisen. Critics claim that misunderstanding of the law,

inexperience, prejudice, or simply incompetence has led, in some cases, to biased and inconsistent reports. They point to the inherent contradiction in requiring opinions on legal issues but not requiring any demonstration of competence to give such opinions. Furthermore, doctors can be appointed sanity examiners over and over despite a demonstrated inability to fulfill the role.

Reformers have proposed two alternatives for correcting these problems. One group would like to remove the "expert" status from sanity examiners and require not that they give an opinion on criminal responsibility but that they only describe the defendant's mental condition. The legal question of responsbility would be left up to the trier of fact--either judge or jury--who would decide based on all the evidence. The other group would like to improve the current system by requiring certification of examiners, based on education and experience criteria. Anyone not meeting the criteria would be ineligible for appointment as a sanity examiner. Those now on the list who did not qualify would be removed from the list.

The critics of the current system generally agree that the insanity defense is necessary and that abuses of the defense can mostly be prevented with improved administration of the law. They hold that certification of sanity examiners can go a long way in improving the administration of justice, leading to fairer treatment of defendants, better public protection, and more public confidence. Some argue that the development of guidelines and the certification of sanity commissioners are two important functions which can best be served by creating a forensic center in Hawaii. Certainly, should a forensic center be created, the implementation of a certification process would be greatly facilitated.

2. Recommendation

The Crime Commission recommends the establishment of procedures to train and certify doctors who serve on sanity commissions. It agrees with experts in the field who hold that lack of certification is a major weakness in the system. Because a great burden of responsibility is placed on the sanity commissioners, this issue is important. Should a forensic center be created for Hawaii, as recommended elsewhere in this report, this function could be performed by that center. Otherwise, the Judiciary should publish guidelines requiring training and certification.

G. Improve Supervision of Conditional Release

1. Discussion

Conditional release is a court disposition of a case that is sometimes used when a person accused of committing a crime is found not guilty by reason of insanity (NGRI). The person is then released into the community on condition that he can be adequately controlled with proper care, supervision, and treatment.

There are two types of conditional release cases. The first is based on unfitness to proceed. In this case, the defendant is mentally ill and unable to understand the proceedings against him. Since he is unable to assist in his own defense, the court has the defendant committed to the custody of the Director of Health. The Director then places him in an appropriate institution for as long as he remains unfit. If it is determined that he is no longer in need of hospitalization, he may be released under conditions specified by the court.

The second type of conditional release is based on a finding of NGRI. After the person is acquitted, it is up to the court to decide whether to have the person committed to an institution, or released into the community. The main concern of the court in making this decision is the factor of dangerousness. If the defendant is considered dangerous to himself, others, or the property of others, in order to protect the public, the court could commit him to the Director of Health for institutionalization. Upon improvement, he may be granted conditional release by the court. On the other hand, if he is considered not dangerous or dangerous only to a moderate degree (whereby he can be adequately controlled with outpatient

treatment), the court could release him under the condition that he receive proper treatment and supervision.

Until recently, persons granted conditional release were placed in the custody of a mental health facility or doctor. Presently, the court assigns the responsibility of supervision and reporting to the Adult Probation Division (APD).[54] The APD has emphasized that having NGRI conditional release cases placed under it is not a statutory authorization. In effect, it is a practical approach since the acquitted person that is granted conditional release is still under the jurisdiction of the court and APD is a highly visible unit of the judiciary.

APD is reported to have 59 NGRI conditional release cases under its supervision at the present time. These cases are assigned to the senior probation officers on a rotating basis. While these officers are responsible for the supervision of their cases, it is not a close supervision as with probation. This is primarily due to the fact that conditional release clients, unlike probation, have not been convicted of anything. As a result, they are often resistant to being under the supervision of a probation officer. For this reason, APD refers to the handling of conditional release cases as a monitoring process.

In monitoring a conditional release case, a probation officer is assigned to:

1) Ensure that the conditions of release are maintained at all times. The following are 6 general terms of conditional release that apply

[54]APD assumed the responsibility for the supervision of conditional release in 1976 upon the request of Administrative Judge Masato Doi.

to all cases: (a) be placed under the supervision (monitoring) of a probation officer; (b) undergo psychiatric treatment until clinically discharged (this involves keeping all appointments for treatment and taking all medications prescribed); (c) submit quarterly reports from the doctor regarding progress; (d) report any change of address within 2 days; (e) obtain permission before leaving this island; (f) probation officer has right to ask the doctor for a progress report from time to time. The 7th general term (g) involves special conditions that differ from case to case. These conditions are determined by the court and they are specifically tailored to the individual. Some examples are go to the mainland, enter a residential treatment program, or stay away from someone.

2) Periodically review and evaluate progress of the case.
3) Follow-up and investigate possible violations.
4) Initiate revocation proceedings (if necessary) by preparing an affidavit citing the violation(s).
5) Initiate all appropriate actions for discharges or modification of conditional release.

A probation officer is in contact with the defense counsel, treating doctor, and prosecutor, each of whom has certain responsibilities. The defense counsel is required to provide APD with his client's background information in printed form at the time conditional release is granted. The counsel should also assist the probation officer by encouraging his client to comply with the conditions of his release. The treating doctor has the responsibility of informing the probation officer when appointments are not

being kept and submitting the following to the probation officer: (1) quarterly written reports on the progress of the person; (2) a special written report when discharge or revocation is recommended; and (3) supporting affidavit when recommending discharge. The responsibility of the prosecutor is to provide consultation to the probation officer when needed, prepare motions for modification or revocation of conditional release, and represent the state in hearings.

Some examples of conditional release violations would be leaving this island without permission, failing to see a treating doctor, or not reporting a change of address. Adult Probation highly recommends that the commission of a new crime be classified as a violation of conditional release and be included as ground for revocation.

If a person should violate his conditional release, the consequence would be one of the following: (a) he may be arrested on a bench warrant and kept in custody in jail pending disposition of the case; (b) the court may revoke his conditional release and have the person committed or re-committed to the State Hospital; or (c) the Court may modify the conditions of his release.

According to the law, within 5 years the court may revoke a person's conditional release if the conditions of his release have not been fulfilled or the person presents a danger to himself, others, or the property of others. It is a probation officer's responsibility to initiate all actions concerning the revocation of conditional release. Since this process is both difficult and time-consuming, APD has encountered problems in this area. One of the problems is determining when a probation officer should start revocation proceedings--after the first, second, or third violation. Another

is the factor of undue delay between the time of the violation and subsequent hearing. In addition, there is the inability to quickly place a person under custody due to legal requirements. Also, since the prosecutor's office has the burden of conviction, the handling of conditional release cases is of low priority. A final problem is lack of coordination between the District Courts, the Circuit Courts, and the Prosecutor's Office.

Adult Probation has stated that conditional release has been revoked in only 3 or 4 cases since it was put in charge of the supervision. While APD is doing the best it can under the circumstances, there are inherent contradictions in having APD responsible for the supervision of conditional release cases. The law does provide adquate safeguards, but perhaps the administration of the law could be improved. If a Forensic Center were created and made responsible for the supervision, it would alleviate some of these problems.

2. Recommendation

The Commission recommends the establishment of guidelines for monitoring conditionally released penal patients. Just as with probation and parole, public safety demands the careful monitoring of those who are released from custody with certain conditions. Currently, the division of responsibility and lines of authority are not clear. There should be very clear mechanisms for supervision and procedures for enforcement. Should a forensic center be created for Hawaii, the center could be responsible for monitoring conditional release. In lieu of such a center, the Judiciary should take steps toward improving this situation. Guidelines should be standardized and shared among the agencies dealing with conditional release revocation to allow for quick action in emergency situations.

CONTINUED

1 OF 2

H. Move the Penal Commitment Facility from Hawaii State Hospital

1. Discussion

When a defendant is adjudicated not guilty by reason of insanity, under HRS §704-411 the judge can order him committed to "an appropriate institution," can release him on certain conditions, or can discharge him from custody entirely. The decision is made on the basis of medical evidence presented at the trial or at a special hearing for disposition. The main criteria used are current mental illness and dangerousness "to himself or the person or property of others." If the person is found dangerous, he is then"committed to the custody of the director of health to be placed in an appropriate institution for custody, care, and treatment."

The "appropriate institution" usually means the Hawaii State Hospital. However, HRS §704-417 allows the director of health to place the individual in any appropriate institution in Hawaii or out-of-state. The section reads:

> §704-417 Use of out-of-state institutions. The term "appropriate institution" includes any institution within or without this State to which the defendant may be eligible for admission and treatment for physical or mental disease, disorder, or defect.

At the Hawaii State Hospital, those adjudicated NGRI are placed in the Closed Intensive Supervision Unit (CISU). This is a secure facility, reserved for penal code commitments. Patients can be transferred from CISU to an open ward, depending on their progress, and are usually so transferred prior to furlough and conditional release. Those considered still dangerous, regardless of the state of their illness, remain in CISU.

The use of the CISU at Hawaii State Hospital is consistent with the intent of the statutes which call for custody of the criminally insane. The commentary to HRS §704-411 calls for:

> "a flexible mode of disposition of defendants thus acquitted, which depends on (1) The restraint necessary to protect other members of society and the defendant from consequences of a recurrence of the prohibited conduct, and (2) the conditions necessary to afford the defendant proper care and supervision."

Maintaining the facility at the Hawaii State Hospital allows for proper treatment of the mentally ill, while the secure nature of the CISU provides for protection of the public. Patients are not released from CISU or the hospital itself until they are determined to be no longer dangerous. Reliance on the criterion of dangerousness is intended to "protect other members of society."

The existence of a secure facility for the criminally insane at the state hospital has caused several problems. Foremost among these is concern that custody of dangerous persons is not a medical, hospital function. Some believe that such detention for the protection of the society is a police function and should be handled by those specially trained for that function. They see the CISU as a small prison within the hospital, run not by prison guards but by doctors and paramedics. They believe that the CISU either should be moved to the prison or should be run as a separate facility at the hospital, staffed by DSSH Corrections personnel. As such, it would be at the hospital but not part of the hospital.

A related problem is that of the reputation of the Hawaii State Hospital. It has been remarked that during the last decade the hospital has come to be regarded as something of a psychiatric prison. The large number of penal admissions has served to exclude some people who desired to voluntarily commit themselves and discourage others from doing so. This has somewhat eroded the hospital's effectiveness as a public mental health institution.

The large increase in penal admissions (for short term testing, for unfit to proceed, and for acquit and commit) has also taxed the hospital's resources. Not only is the hospital unable to admit as many voluntary patients as before, but also it has been forced to discourage transfers from correctional centers. Such transfers require the consent of both the prison officials and the Department of Health. This restriction has limited the system's ability to deal effectively with certain situations, such as the disturbed inmate who could benefit by the hospital treatment before an explosive incident occurs.

Another problem which the Hawaii State Hospital faces is the penal code patients who are dangerous but not mentally ill. HRS §704-411 requires the judge to commit those defendants who are adjudicated NGRI and are determined to be dangerous. The code reads:

> (a) The court shall order him to be committed to the custody of the director of health to be placed in an appropriate institution for custody, care, and treatment if the court finds that the defendant presents risk of danger to himself or the person or property of others and that he is not a proper subject for conditional release;

Mental illness is not a requirement, only dangerousness. The case has arisen whereby patients either are successfully treated for their illness or are diagnosed originally as not suffering from any mental illness, yet the hospital must retain custody of them because they are still potentially dangerous. They are not being treated yet they must stay in CISU at the hospital. Some believe that the state hospital should not be responsible for long-term custody of those who do not need and are not receiving treatment.

2. Recommendation

The Commission recommends that the closed intensive supervision unit for penal code patients remain at the Hawaii State Hospital. Any problems with supervision--the purely custodial aspects of commitment--could be handled administratively, such as with the training and employment of specific security personnel. Should the Guilty But Mentally Ill finding be added, Corrections may want to add a facility at the Oahu Community Correctional Center for the treatment of those adjudicated GBMI. Perhaps a prison facility could relieve part of the burden of commitments for examination, but the state hospital should still maintain a commitment facility for those found NGRI. Should a forensic center be created for Hawaii, the custodial burden could be shifted to the center, but most likely the existing facilities would continue to be utilized. All in all, such a facility for those acquitted of crimes by reason of mental illness is necessary for Hawaii and any improvements can be made working within the existing setup.

IV. CONCLUSIONS

This study attempted to answer the question, "What changes, if any, should be made to the insanity defense in Hawaii to improve the protection of the public and serve the needs of justice?" In so doing, it addressed the adequacy of both the insanity defense law and its implementation. A basic finding is that, in general, the public is well protected and well served by the existing law and its implementation. The few changes which seem to be required to improve the system deal mainly with the administration of the law. These changes are codified in the proposed legislation appended hereto.

The insanity defense is not a big problem for our criminal justice system. It is of special concern to the public because of the special fear of the criminally insane. This concern is belied, however, by a close look at the facts. Contrary to the general public perception, there are few NGRI acquittals each year and they do not result in outright releases. An NGRI acquittal usually results in confinement in a security ward of the state hospital for a considerable period of time. A patient is only released when considered no longer dangerous and only then on a court order.

The concept of excluding insane defendants from penal responsibility is sound and should be retained. It serves the best interests of a compassionate and fair system of justice. The several improvements to the system which seem to be needed, which are contained in the two bills proposed by the Crime Commission and other bills before the legislature, include:

* the need for training and certification of sanity commission examiners;

* the need for making insanity an affirmative defense;

* the need for the creation of a state forensic center;

* the need for greater choice of verdicts for mentally ill offenders (to be met by the Guilty But Mentally Ill Verdict);

* the need for a better system of monitoring those released on conditional release (along with faster revocation procedures); and

* the need for a time limitation on the performance of examinations.

The Crime Commission believes that effecting these improvements, through passage of proposed legislation and implementation of certain administrative changes, would adequately address existing problems and contribute to creating the best possible system for dealing with the criminally insane.

It is hoped that this study will serve many purposes in identifying and clarifying the problems of handling persons who might be mentally ill and, because of this mental illness, commit criminal offenses. This study presents facts, not rumors, and expert information gathered from many well-qualified individuals and studies. The better the general public understands the problems faced by the persons responsible to carry out the mandates of the system, the better the system will operate.

V. PROPOSED LEGISLATION

The Crime Commission's recommendations were codified into two bills proposed to the 1982 legislative session. These bills would 1) institute a guilty but mentally ill verdict; and 2) create a state center for forensic psychiatry. The first is entitled "HB 3022-82; Relating to Penal Responsibility" (SB 2841-82). The second is HB 2865-82; Relating to the Establishment of a Center for Forensic Psychiatry" (SB 2842-82). These bills are attached as an appendix to this report.

The recommended legislation was not passed during the 1982 session but was considered with other bills that addressed the same problem. The Commission hopes that these bills will encourage future legislatures to propose legislation that it believes is needed. It should also be pointed out that administrative change without change in laws is a better method of reform and should be used whenever possible. Operational procedures may be changed to meet new conditions when needed, without waiting for legislative action.

(To be made one and twelve copies)
THE SENATE
ELEVENTH LEGISLATURE, 19 82
STATE OF HAWAII

S.B. NO. 3022-82

A BILL FOR AN ACT

RELATING TO PENAL RESPONSIBILITY.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. Chapter 704, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"§704- Guilty but mentally ill; plea of guilty but mentally ill; sentence. (1) If the defendant asserts a defense of physical or mental disease, disorder, or defect excluding responsibility pursuant to section 704-402, the defendant may be found "guilty but mentally ill" if, after trial, the trier of fact finds all of the following beyond a reasonable doubt:

(a) That the defendant is guilty of an offense;

(b) That the defendant suffered from a physical or mental disease, disorder, or defect at the time of the commission of the offense; and

(c) That the defendant's capacity to appreciate the wrongfulness of his conduct or to conform his

conduct to the requirements of law was not substantially impaired at the time of the commission of the offense.

(2) If the defendant asserts a defense of physical or mental disease, disorder, or defect excluding responsibility pursuant to section 704-402 and the defendant waives his right to trial, by jury or judge, the trial judge, with the approval of the prosecuting attorney, may accept a plea of guilty but mentally ill in lieu of a plea of guilty or a plea of nolo contendere. The judge may not accept a plea of guilty but mentally ill until, with the defendant's consent, he has examined the report or reports prepared pursuant to section 704-404, has held a hearing on the issue of whether the defendant suffered from a physical or mental disease, disorder, or defect at the time of the commission of the offense at which either party may present evidence, and is satisfied that the defendant was suffering from a physical or mental disease, disorder, or defect at the time of the offense to which the plea is entered. The reports shall be made a part of the record of the case.

(3) If a defendant is found guilty but mentally ill or enters a plea to that effect which is accepted by the court, the court shall impose any sentence which could be imposed

pursuant to law upon a defendant who is convicted of the same offense. If the defendant is committed to the custody of the department of social services and housing, he shall undergo further evaluation and be given such treatment as is psychiatrically indicated for his physical or mental disease, disorder, or defect. Treatment may be provided by the department of health after his transfer pursuant to section 334-74. Section 334-74 shall apply to the discharge of such a defendant and shall apply to the return of such a defendant to the department of social services and housing for the balance of the defendant's sentence. In the event the treating facility of the department of health discharges the defendant prior to the expiration of his sentence, the treating facility shall transmit to the Hawaii paroling authority a report on the condition of the defendant which contains the clinical facts, the diagnosis, the course of treatment, and the prognosis for the remission of symptoms, the potential for recidivism and for the danger to himself or the public, and recommendations for future treatment. In the event the Hawaii paroling authority should consider him for parole, the authority shall consult with the treating facility at which the defendant is being treated or from which he has been discharged and a comparable report on the condition of the defendant shall be filed with the authority.

If he is placed on parole by the authority, his treatment shall, upon recommendation of the treating facility, be made a condition of parole, and failure to continue treatment except by agreement with the designated facility and the paroling authority shall be a basis for the institution of parole violation hearings.

(4) If a defendant who is found guilty but mentally ill is placed on probation, the sentencing judge may make treatment a condition of probation. Failure to continue treatment, except by agreement with the treating agency and the sentencing court, shall be a basis for the institution of probation violation hearings. Treatment shall be provided by the department of health, or with the approval of the sentencing court and at individual expense, by private agencies, private physicians, or other mental health personnel. A psychiatric report shall be filed with the probation officer and the sentencing court every 3 months during the period of probation."

SECTION 2. Section 704-402, Hawaii Revised Statutes, is amended to read as follows:

"§704-402 Physical or mental disease, disorder, or defect excluding responsibility is a defense; form of verdict and judgment when finding of irresponsibility or guilty but mentally ill is made. (1) Physical or mental disease, disorder, or

defect excluding responsibility is a defense[.]; provided that the defendant in a prosecution for a felony shall file and serve upon the court and the prosecuting attorney a notice in writing of his intention to assert the defense not less than 30 days before the date set for trial or at such other time as the court directs.

(2) When the defense provided for by subsection (1) is submitted to a jury, the court shall, if requested by the defendant, instruct the jury as to the consequences to the defendant of an acquittal on the ground of physical or mental disease, disorder, or defect excluding responsibility.

(3) When the defendant is acquitted on the ground of physical or mental disease, disorder, or defect excluding responsibility, or is found guilty but mentally ill, the verdict and the judgment shall so state."

SECTION 3. Statutory material to be repealed is bracketed. New material is underscored.

SECTION 4. This Act shall take effect upon its approval.

INTRODUCED BY: _____

(To be made one and twelve copies)
THE SENATE
ELEVENTH LEGISLATURE, 1982
STATE OF HAWAII

S.B. NO. 2865-82

A BILL FOR AN ACT

RELATING TO THE ESTABLISHMENT OF A CENTER FOR FORENSIC PSYCHIATRY.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The Hawaii Revised Statutes is amended by adding a new chapter to be appropriately designated and to read as follows:

"CHAPTER

CENTER FOR FORENSIC PSYCHIATRY

§ -1 Center for forensic psychiatry. There is hereby established in the department of health, a center for forensic psychiatry.

§ -2 Duties of the center. The center shall:

(1) be responsible for the administration of all criminal responsibility examinations and all fitness to proceed examinations as provided under chapter 704;

(2) provide for the care and treatment of those found unfit to proceed, those found criminally irresponsible at the time of the alleged crime, and mentally disordered prisoners;

(3) administer a maximum security hospital unit which may have as patients those acquitted under section 704-408, those found unfit to proceed under section 704-403, those being examined under chapter 704, and those transferred pursuant to section 334-74;

(4) conduct research on persons examined and committed under the provisions of chapter 704;

(5) educate and train individuals in the administration of examinations under chapter 704;

(6) establish the minimum qualifications of education, training and experience for physicians and psychologists to be eligible for appointment as examiners under chapter 704;

(7) certify that the physicians or psychologists eligible for appointment as examiners under chapter 704 meet or possess the minimum qualifications of education, training, and experience;

(8) monitor all persons released under sections 704-406(1), 704-407(3), and 704-411(1)(b);

(9) report to the director of the department of health in January of each year on its activities and findings and recommendations with respect to those it has examined and treated under the provisions of chapter 704.

For purposes of this section, the director of the department of health may transfer any unit of the Hawaii state hospital to the administrative control of the center.

§ -3 Staff. The director of the department of health may hire such additional necessary staff to carry out the duties of the center subject to chapters 76 and 77. In addition, the director of health may transfer to the center, without loss of seniority or salary, personnel of any existing division, branch, or section of the department to effectuate the purpose of the center."

SECTION 2. This Act shall take effect upon its approval.

INTRODUCED BY: _____

APPENDIX

A PRE-M'NAGHTEN OPINION, 1724.

". . . [G]uilt arises from the mind, and the wicked will and intention of the man. If a man be deprived of his reason, and consequently of his intention, he cannot be guilty. . . . [I]t is not every frantic and idle humor of a man, that will exempt him from justice. . . [I]t must be a man that is totally deprived of his understanding and memory, and doth not know what he is doing, no more than an infant. . . such a one is never the object of punishment."

16 State Trial of Edward Arnold, 596, 764 (1724) in Goldstein J. and Katz, J., "Abolish the 'Insanity Defense' - Why Not?," 72 Yale L. J. p. 863 f. 35 (1963).

THE M'NAGHTEN TEST, 1843.

"Every man is to be presumed to be sane, and. . . to establish a defense on the ground of insanity, it must be clearly proved that, at the time of the committing of 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 was doing what was wrong."

Daniel M'Naghten's Case, 10 Clark & Finnelly 200, 210-211, 8 Eng. Rep. 718, 722-723 (1843), in Stone, A. Mental Health and Law: A System in Transition, p. 228 Nat'l. Inst. of Mental Health: Md. (1975).

THE IRRESISTIBLE IMPULSE TESTS, 1887 & 1897.

"Did he know right from wrong, as applied to the particular act in question?. . . . If he did have such knowledge, he may nevertheless not be legally responsible if the two following conditions concur: (1) If, by reason of the duress of such mental disease, he had so far lost the power to choose between the right and wrong, and to avoid doing the act in question, as that his free agency was at the time destroyed; (2) and if, at the same time, the alleged crime was so connected with such mental disease, in the relation of cause and effect, as to have been the product of it solely."

Parsons v. State, 2 So. 854, 866-67 (Ala. 1887) in Stone ibid., p. 229.

"(The accused is to be classed as insane if) though conscious of (the nature of his act) and able to distinguish right from wrong,. . . yet his will, by which I mean the governing power of his mind, has been otherwise than voluntarily so completely destroyed that his actions are not subject to it, but are beyond his control."

Davis v. United States, 165 US 373, 378 (1897) in Stone ibid., p. 229.

THE DURHAM TEST, 1954.

". . . [T]hose who, of their own free will and with evil intent (sometimes called mens rea), commit acts which violate the law, shall be criminally responsible for those acts. [W]here such acts stem from and are the product of a mental disease or defect. . . moral blame shall not attach, and hence there will not be criminal responsibility. . . ."[1]

". . . 'disease' in the sense of a condition which is considered capable of either improving or deteriorating [and] 'defect' in the sense of a condition which is not considered capable of either improving or deteriorating and which may be either congenital, or the result of injury, or the residual effect of a physical or mental disease."[2]

Durham v. United States, 94 US App DC 228, 214 F2d 862, 45 ALR 2d 1430 (1954) in

[1] Goldstein and Katz op. cit. p. 860 f. 25,

[2] Stone op. cit. p. 229.

THE CURRENS DECISION, 1961.

". . . [A]n 'insane' defendant commits the crime not because his mental illness causes him to do a certain prohibited act but because the totality of his personality is such, because of mental illness, that he has lost the capacity to control his acts in the way that the normal individual can and does control them. If this effect has taken place he must be found not to possess the guilty mind, the mens rea, necessary to constitute his prohibited act a crime."

United States v. Currens, 290 F2d 751, 774 (3d Cir. 1961) in Goldstein and Katz op. cit. p. 862 f. 32.

THE MC DONALD DECISION, 1962.

"[A] 'mental disease or defect' for clinical purposes. . . may or may not be the same as mental disease or defect for the jury's purpose in determining criminal responsibility. . . ."

". . . a mental disease or defect includes any abnormal condition of the mind which substantially affects mental or emotional processes and substantially impairs behavioral control."

McDonald v. United States, 312 F2d 847 (1962) in Fingarette, H., The Meaning of Criminal Insanity, pps. 33-34, U. Cal. Press: Berkeley (1972).

THE BRAWNER DECISION, 1972.

"The concept of belief in freedom of the human will and a consequent ability and duty of the normal individual to choose between good and evil' is a core concept that is 'universal and persistent in mature systems of law.' Criminal responsibility is assessed when through 'free will' a man elects to do evil."

United States v. Brawner, 471 F2d 985 (D.C. Cir. 1972) in Stone op. cit. p. 222 f. 48.

HAWAII ADAPTATION OF AMERCAN LAW INSTITUTE (ALI) TEST, 1972.

PHYSICAL OR MENTAL DISEASE, DISORDER, OR DEFECT EXCLUDING PENAL RESPONSIBILITY.

(1) A person is not responsible, under this Code, for conduct if at the time of the conduct as a result of physical or mental disease, disorder, or defect he lacks substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of law.

(2) As used in this chapter, the terms "physical or mental disease, disorder, or defect" do not include an abnormality manifested only by repeated penal or otherwise anti-social conduct.

Hawaii Revised Statutes §704-400 (1972).

TWO ATTEMPTS TO ABOLISH THE INSANITY DEFENSE, 1931 & 1910.

". . . [T]he insanity of the defendant at the time of commission of the crime shall not be a defense against indictments for murder and the courts shall so instruct the jury in trials for murder."

Sinclair v. State, 132 So. 581 (Miss. 1931) in Fukunaga, K., The Criminally Insane: Who Are They, What Happens To Them, What Can Be Done, p. 14, State Hawaii: Honolulu, (1977).

"[I]t shall be no defense to a person charged with the commission of a crime that at the time of its commission he was unable, by reason of his insanity, idiocy or imbecility, to comprehend the nature and quality of the act committed, or to understand that it was wrong; or that he was afflicted with a morbid propensity to commit prohibited acts; nor shall any testimony or other proof thereof be admitted in evidence."

State v. Strasburg, 110 P. 1020 (Wash. 1910) in Fukunaga, ibid.

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