The Insanity Defense in Illinois — A Psychiatric Perspective

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The insanity defense has come under increasingly strong attack by both lawyers[1] and psychiatrists,[2] at least in part, because of its lack of clarity in relating mental illness to criminal responsibility. Recent scholarly publications[3,4] have exhaustively reviewed the pertinent medical-legal, social, and philosophical issues surrounding the contemporary debate regarding retention or abolition of the affirmative defense of insanity. Supporters[5] insist that there is a societal need for the continuation of the insanity defense in order to protect from conviction and punishment the mentally ill offender who is unable to form a criminal intent because of absence of *mens rea.* In contrast, abolitionists attack the psychiatrist's role in court as primarily financially motivated,[6] criticize inadequate follow-up care for defendants acquitted as not guilty by reason of insanity,[7] cite the confusion of insanity defense standards,[8] and deplore the inefficient use of psychiatric time in an adversarial role where physicians are forced into arbitrary discriminations between "mad" and "bad."[9] Some states have already achieved significant modifications in their insanity defense standards.[10] Illinois lawmakers in 1978 introduced the first legislative bill (not passed) which would have totally eliminated the insanity defense replacing it with a "guilty but mentally ill" plea.

While the conceptual issues surrounding the insanity defense have been heatedly debated, there have been few attempts to systematically assess: (1) perceptions of the insanity defense by professionals (attorneys, judges, psychiatrists, etc.) involved in the criminal justice process or, (2) to gather data concerning the demography and treatability of the not guilty by reason of insanity (NGRI) patient. One notable exception is the recent report from the New York Department of Mental Hygiene[11] which systematically details characteristics of insanity defense acquittees under the state's former McNaughton standard and also evaluates perceptions

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of *legal* professionals towards the insanity defense standard in the state. The results of the latter survey showed a wide range of perceptions regarding the functioning of the insanity defense, with approximately 40% of 293 respondents believing it worked poorly. Stated reasons for dissatisfaction included lack of understanding of the statutes on the part of juries or the public; poor statutory definitions of the insanity defense; incompetent or superficial psychiatric testimony; and premature release of the defendants. A majority of the respondents favored some degree of modification of the insanity defense (subsequently accomplished with adoption of the diminished responsibility standard in New York).

Our survey of the legal and psychiatric literatures failed to demonstrate studies analogous to the Carnahan report involving psychiatrists. Though the public image problems of psychiatrists involving themselves in the criminal justice system have been examined,[12] and Dietz[13] has empirically compared forensic and non-forensic psychiatrists, we are unaware of any systematic attempts to assess psychiatric attitudes regarding the insanity defense. An insanity defense questionnaire (IDQ) was developed and sent to a sample of Illinois psychiatrists, asking them to respond to selected psycho-legal issues facing forensic psychiatrists. This survey instrument provided data for a tabulation of psychiatric perceptions of the insanity defense standard in Illinois and possible legal-judicial alternatives. A compilation of respondents' personal and professional development and previous experience in forensic psychiatry was carried out. Finally, the study focused on respondents' perceptions of the need for mandatory court-supervised, outpatient treatment of the mentally ill offender, found NGRI, after discharge from the hospital. This survey is particularly important in Illinois because of increased public and professional concern regarding the insanity defense, as well as recent proposals for legislative change of the insanity defense standard.

Method

The Insanity Defense Questionnaire (IDQ) was developed for the systematic evaluation of the opinions of Illinois psychiatrists on various issues related to the insanity defense standard in Illinois (American Law Institute standard). This instrument consists of two case studies, sixteen more general attitudinal questions, and a demographic summary sheet. It was pre-tested, on a sample of ten university-based psychiatrists, to assess the clarity and coherence of the instrument. The survey sample was randomly drawn from the alphabetized membership list of the Illinois Psychiatric Society (IPS). The survey instrument was sent to 236 members of the IPS, representing approximately 25% of its membership. The initial mailing was followed, after a designated four-week period, by a second mailing to non-respondents. Eleven of the questionnaires received were eliminated because of incompleteness or out of state residency. The data were cross tabulated and analyzed through an SPSS program which provided frequencies and *chi* square values.

Results

One hundred twenty-nine (129) completed, usable responses were obtained from the 236 psychiatrists sampled with the IDQ instrument, representing a 56% response rate. Table I presents sample characteristics of the group of psychiatrists surveyed.

TABLE I
DEMOGRAPHIC AND TRAINING/EXPERIENCE PROFILES

DEMOGRAPHIC

Variables		Percentages		
Residency Training	V.A. Hospital	11.8%	Military Hospital	1.6%
	State Hospital	29.1%	Private Hospital	15.7%
	University Medical Center	37.9%	No Response	4.6%
Board Certification	Yes	64.4%	No	35.4%
Professional Orientation	Psychoanalytic	24.4%	Behavioral	0%
	Eclectic	63.8%	Other	6.3%
	Pharmacologic	5.5%		
Sex	Male	85.8%	Female	14.2%

TRAINING/EXPERIENCE

Variables		Percentages		
Special Training in Psychiatry and Law	Yes	15.7%	No	84.3%
Contact with Violent, Aggressive Patients	Never	4.7%	Often	19.8%
	Seldom	31.7%	Almost Always	2.5%
	Sometimes	41.3%		
Total Experience as Expert Witness	Never	51.2%	20 + Times	8.7%
	1–19 Times	40.1%		
Recent Expert Witness (Last 12 Months)	0 Times	78.0%	3 Times	3.9%
	1 Time	11.8%	4 Times	.8%
	2 Times	3.9%	>5 Times	1.6%

Examining the modal distribution in Table I, the prototypic respondent was a male, board-certified psychiatrist, trained in a university-based residency program, who avows a professionally eclectic orientation. Few respondents had received specialized training in law and psychiatry, most had no experience as an expert witness in criminal court, but close to half had at least some on-going professional contact with violent or aggressive patients.

TABLE II
RESPONSE PERCENTAGES REGARDING INSANITY DEFENSE AND ITS ALTERNATIVES

Psychiatrist Perceptions	Responses				
	Strongly Disagree	Disagree	Agree	Strongly Agree	No Opinion
Present A.L.I. Standard	48.0%	20.3%	7.6%	8.4%	15.6%
Guilty But Mentally Ill	4.7%	3.1%	20.3%	66.4%	5.5%
Diminished Responsibility	27.6%	13.4%	29.1%	22.8%	7.1%
Temporary Insanity	38.3%	14.1%	21.9%	18.0%	7.8%
Mandatory Outpatient Treatment of NGRI	12.1%	4.7%	17.2%	60.2%	5.8%

Table II reports the response percentages from Illinois psychiatrists regarding the insanity defense and its alternatives. Significant *chi* square values were established for all variables ($p=.001$), indicating significant variability of response percentages from the expected. Approximately seven of ten psychiatrists questioned, believed either that the present insanity defense standard should be abolished or that the insanity defense is greatly abused. Eighty-seven percent (87%) of the respondents favored the "guilty but mentally ill" standard, whereas less than half of the respondents supported either a diminished responsibility or temporary insanity standard. On other issues, sixty-eight percent (68%) of the psychiatrists responding failed to see a *direct* relationship between mental illness and criminal behavior (*chi* square = 58.72, df=2, $p=.001$) and approximately two-thirds of the respondents (65) were of the opinion that the quality of psychiatric testimony presently being given in trials involving the insanity defense is ineffective (*chi* square = 46.3, df=2, $p=.001$). An unexpected finding was the strong support of psychiatrists who favored mandatory outpatient treatment for patients found NGRI (77.4%). It was also found by use of an analysis of variance that psychiatrists with greater experience with aggressive and violent patients were significantly more in favor of mandatory outpatient treatment than those psychiatrists who had no such experience ($t=-2.82$, df=68, $p=.001$).

Discussion

Results from the present study remarkably parallel those obtained in a recent New York study of legal professionals' perceptions of the then operative McNaughton standard.[14] A significant majority of respondents in that study (293 subscribers of the *Criminal Law Review*) did not wish to see a total elimination of the insanity defense but would prefer a change to "guilty but mentally ill." Only 14 of the 293 respondents in that study felt that the insanity defense worked well statewide. Similarly, our study showed only 16% of the respondents supporting the current Illinois insanity defense standard (A.L.I.).

Further, our study expands upon the results of the Carnahan report[11] in that, for the first time, psychiatric opinions are included in evaluations of the present functioning of the insanity defense standard within a state's criminal justice system. Over-utilization of the insanity defense, and abuses in determinations of lack of criminal responsibility were frequently mentioned by respondents in our study. In the same light, psychiatrists in our study expressed opinions similar to those of the public[15] and professionals[16] that mental illness and criminal behavior are not necessarily etiologically related. In our study, sixty-eight percent (68%) of the respondents surveyed see no direct relationship between mental illness and criminal behavior.

An important finding of our study is the strong support of respondents for the special treatment needs of the mentally disabled offender.

Criticism of the premature release from inpatient hospitalization or failure to provide adequate outpatient follow-up care of individuals who are found not guilty by reason of insanity is extensive.[17] Psychiatrists in Illinois (eight of ten) support court-supervised, long-term outpatient treatment of NGRI patients, apparently recognizing the special treatment needs and problems of this difficult population. Though constitutional questions can be raised by court-ordered treatment in individuals adjudicated not guilty,[18] the clinicians surveyed apparently found treatment needs more important than legal-judicial consideration. No studies were found evaluating mandatory treatment and outcome of mentally ill offenders. Currently underway in Chicago, in collaboration with the Illinois Department of Mental Health and Developmental Disabilities and the Rush Medical College, is the state's first university-based ambulatory psychiatric clinic for the evaluation and treatment of mentally ill offenders — the Isaac Ray Center.[19] Preliminary data[20] presently available re-emphasize the importance of court-mandated treatment in designing outpatient clinical services for NGRI patients after release from the hospital.

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