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Problems Surrounding Release of Persons Found Not Guilty by Reason of Insanity

The concept of not guilty by reason of insanity (NGI) is not simply a philosophical one dealing with courtroom drama [*1,2*]. Despite the attention paid to trial issues and matters of strategy and testimony, there has been a relative neglect in the study of the practical effects of current practices. The labeling process sets in motion a series of events. Generally, in the United States, a person found not guilty by reason of insanity is hospitalized either in a special state institution for the "criminally insane" or in a designated forensic unit at a state hospital. The handling, disposition, and technicalities of release are extremely varied and complex. The vagaries of release and subsequent antisocial behavior by an NGI patient (hereafter referred to as NGI) have resulted in adverse publicity far out of proportion to the numbers of people or problems involved.

In the past, few NGIs came to the attention of the courts in an adversary proceeding so that the lawyers themselves displayed little interest in this aspect of the criminal justice system. Today, with the focus on growing criminality, concern with civil rights, and scrutiny of governmental practices, interest has been directed to the problem of release. A brief review of the varied practices is noted in Brakel and Rock's study [*3*] for the American Bar Association.

New Jersey is a state with both unusual laws [*4*] and concerned judges. Two cases, *State v. Maik* [*5*] and *State v. Carter* [*6*], have taken contrasting views in elaborating on the criteria for release of an NGI.

The Maik Decision

In 1972, Judge Weintraub in the Maik case laid down extremely stringent criteria for release. This judicial attitude is of great importance because, in New Jersey, release of an NGI lies in the hands of the judge of the original court of jurisdiction. Many judges, as did Judge Weintraub, take a most skeptical attitude towards psychiatric evaluation and opinion; for example, "Blame is something [the psychiatrist] leaves to the moral judgment of philosophers, and they draw upon their unverifiable [sic!] view of man and his endownments."

Despite the theory of the law that an NGI has received acquittal, the legitimate question of societal security remains uppermost in the minds of many. Thus the criteria for continuing custody until the patient is "restored to reason" or "is restored to reason and no longer dangerous" are subject to varying interpretations. Weintraub continued, "The point to be stressed is that in drawing a line between the sick and the bad, there is no

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purpose to subject others to harm at the hands of the mentally ill. On the contrary, the aim of the law is to protect the innocent from injury by the sick as well as the bad."

The judicial concern with potential harmfulness remains crucial. Therefore, the judge stated that the legislative intent was that confinement should be continued until there is assurance that the threat of the defect of reason related to the criminal act has been eliminated.

As in many of these cases, Maik suffered from paranoid schizophrenia and had been recommended for discharge because his condition was in remission. The court expressed discontent with the concept of remission, stating:

> But none said defendant no longer suffered from the underlying condition which erupted into a psychotic state in response to a stress defendant could not handle. In short, there was no medical assurance that this latent personality disorder would not be triggered again into violent expression by reason of some stress defendant could reasonably be expected to experience. On the contrary, the tenor of the testimony would suggest there is no medical base for such assurance as a probability.

The judge then postulated psychosis or "psychotic explosion" as being symptomatic of an underlying illness.

> An offender is not "restored to reason" unless he is so freed of the underlying illness that his "reason" can be expected to prevail. Hence the *underlying or latent personality disorder,* and not merely the psychotic episode which emerged from it, is the relevant illness, and the statutory requirement for restoration to reason as a precondition for release from custody is not met so long as that underlying illness continues.

He stressed that the legislature did not speak in terms of remission or freedom from symptoms as criteria for release.

He proceeded further:

> Hence, while a psychotic episode, though temporary in the sense that a defendant may be relieved of its grip and thereupon be in "remission" will be accepted as a state of insanity which may excuse under M'Naghten, insanity continues notwithstanding remission so long as the underlying latent condition remains, and the defendant will not be "restored to reason" within the meaning of the statute unless that condition is removed or effectively neutralized if it can be.

The court did indicate that it was leaving open the question of conditional release.

The Maik decision left chaos in its wake. Psychiatrists did not feel that they could "assure" the court of the nonoccurrence of a potential future event. As a result, patients remained incarcerated at the institution for the criminally insane or at a civil hospital to which they had been transferred. Those judges who read the decision literally could see no ground for consideration for release. Other judges used "common sense" in deciding the issue. Because of the dissatisfaction among the psychiatrists, the New Jersey Psychiatric Association appointed a committee (Drs. Perr, Motley, and Trent) to prepare a position statement criticizing the Supreme Court decision. This statement was adopted and transmitted to the legal profession at large [7].

Position Statement on Maik Decision of

New Jersey Psychiatric Association

> The New Jersey Psychiatric Association and its Psychiatry and Law Committee have prepared the following commentary on certain aspects of the Maik decision (*State v. Maik*, 60 N.J. 203, 1972).
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> While various aspects of that decision merit strong criticism on legal, social and psychiatric grounds, we have been particularly concerned with certain elements of the dicta included in that decision and in this report will focus primarily on the comments dealing with release provisions of those found not guilty by reason of insanity.
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> Parenthetically, at the trial court level the defendant was convicted of murder in the sec-

ond degree. The Appellate Division reversed, holding that the trial court should have directed an acquittal on the ground of insanity at the time of the killing. The Supreme Court emphasized the problems inherent in the relationship of drug intake and criminal acts, reiterating that drugs and liquor, voluntarily taken, may affect intent to a degree that would justify a finding of second degree rather than first degree murder and will not justify an acquittal. The court based the justification for this on the demands of public security. The court pointed out that if a "fixed state of insanity" results and not merely the reflection of the continuing effect of the intoxicant ("after the immediate influence of the intoxicant or drug has spent itself") then the mental condition may justify a valid defense of not quilty by reason of insanity if it otherwise satisfied the M'Naghten rule. The court propounded arguable theses dealing with the nature of psychiatric testimony and etiology of mental disorders. Ultimately the court ruled that the trial court had erred in its instruction that if psychosis was triggered by the voluntary use of LSD or hashish, the defense of insanity could not stand and ordered a retrial on the issue solely of whether the defendant was legally insane at the time of the killing, and if he was, whether such insanity continued.

It might be noted that on retrial of this matter, the defendant was found not guilty by reason of insanity and that such insanity continued, resulting in placement of the defendant at the Vroom Building in Trenton.

The New Jersey Psychiatric Association takes exception to the reasoning in the court's supplemental discussion.

Pertinent keynote comments are as follows:

9. Criminal Law—K.48—In drawing the line between the sick and the bad, there is no purpose to subject others to harm at hands of mentally ill. N.J.S.A. 2A:163-3.

12. Mental health—K.440—Statute requiring confinement of persons acquitted by reason of insanity until such person shall be restored to reason requires confinement until there is assurance that threat of that person's defect of reason has been eliminated. N.J.S.A. 2A:163-3.

13. Mental health—K.440—The underlying or latent personality disorder, and not merely the psychotic episode which emerged from it, is the relevant illness and statutory requirement for restoration to reason as precondition for release from custody is not met so long as that underlying illness continues. N.J.S.A. 2A:163-3.

14. Criminal law—K.48—While psychotic episode, though temporary in sense that a defendant may be relieved of its grip, and thereupon be in "remission" will be accepted as state of insanity which may excuse under M'Naghten, insanity continues notwithstanding remission so long as underlying latent condition remains, and defendant will not be restored to reason within meaning of statute unless that condition is removed or effectively neutralized if it can be. N.J.S.A. 2A:163-3.

15. Mental health—K.440—It is for judiciary, rather than hospital, to determine whether person committed after having been acquitted by reason of insanity should be released. N.J.S.A. 2A:163-3.

The court in elaborating upon its thesis, focuses on protection of society from injury by "the sick as well as the bad" and adds the distinction bears only as to whether the "stigma of criminal" shall be imposed and "upon the measures to guard against further transgressions." If this were so, than perhaps the courts would more appropriately be interested in dangerousness and its scientific assessment.

In many states, release provisions are based upon "restoration to reason" (recovery from the mental illness for which the person is hospitalized) and therefore an absence of dangerousness as a consequence of that illness. If the person is recovered, then release follows, even though he might be "dangerous" because of other personality or social characteristics. This is comparable to the policies followed in a civil commitment where institutionalization is based on the existence of an overt mental illness justifying continued incarceration—a judgment of which is always subject to habeas corpus proceedings.

Here in that netherworld between that of the criminal and that of the "insane," the court applies a different concept of both mental illness and law. A psychosis is no longer the significant condition but rather it focuses on an entity delineated as the fixed illness, underlying condition or latent illness. The court insists upon "assurance" that the threat of defect of reason has been eliminated. The court seeks medical assurance that a "latent personality disorder" will not be triggered by some future stress.

"It would depart from the justification for the recognition of insanity as a defense to view the psychotic explosion in isolation from the underlying illness. To do so would fail to protect the citizens from further acute episodes. The protection must be equal to the risk of further violence. An offender is not "restored" to "reason" unless he is so freed of the underlying illness that his "reason" can be expected to prevail. Hence the underlying or latent per-

sonality disorder, and not merely the psychotic episode which emerged from it, is the relevant illness and the statutory requirement for restoration to reason as a precondition for release from custody is not met so long as that underlying illness continues."

Psychiatrists would argue that this conceptualization of human behavior is not reasonable; such a thesis would be much more appropriate to the personality disorders (which have a much different meaning to psychiatrists) and socially maladaptive individuals whose character structure is such that recidivism is likely—in other words, those usually found guilty of criminal acts. How would the legal profession react to a rule which stated that no criminal shall be released from prison unless the prison authorities can assure a judge that the individual would not in the future engage in antisocial activities? In view of the extreme recidivistic results of the penal system, the consequence would be a cessation of release and the use of preventive detention unheard of in world history. Yet this is the criterion that would be applied to those "acquitted" by reason of insanity, whose numbers are relatively few and whose recidivistic proclivities, in terms of antisocial acts, are not remarkable. This, of course, raises constitutional legal issues which are not in our province.

The vast majority of psychiatrists in the world would agree that there is no "cure" for most cases of schizophrenia. As with other chronic conditions, "cure" is measured by remission of symptoms or absence of disability. In some diseases, this is measured by an arbitrary time period—for example, the five-year "cure rate" for cancer. Although schizophrenic illnesses can fluctuate, have relapses or remissions, and may be subjected to modification by various forms of drug, psychological and environmental treatments, we recognize that many patients demonstrate evidences of some continuing defect in their psychological function which may not be completely alterable. Many patients with such continuing underlying defect may function at this level indefinitely. Other patients may show no evidence of residual defect and may at some future time have a subsequent episode. The current interpretation of the standards for discharge, requiring the eradication of an underlying or latent personality disorder, results, if followed literally, in no one ever being found suitable for discharge after having once been found not guilty by reason of insanity. The very concept does not allow for reasonable psychiatric participation. The Maik decision is unworkable in terms of application by those who are asked to function under its directive.

It is within our professional realm to question the psychiatric base of the court's thesis. If a person's mental illness (which is the prime and relevant issue to psychiatrists) is in remission, then by definition the individual either shows no signs and symptoms of a definable disorder or minimal signs and symptoms which allow for different management. The question of "latency" involves different semantic concepts, but as referable to this issue, a latent condition is one that is not present, observable, or apparent and is therefore unmeasurable.

Secondly, the phraseology of the court assumes a rather monolithic conceptualization of mental illness. What previously had been considered to be "mental illness" is now just a symptom that emerges from an underlying hidden condition. Since the psychiatrist cannot offer an opinion as to the absence of something that he cannot observe or measure, the seeming result would be that a determination of not guilty by reason of insanity is a special form of guilt finding that merits permanent incarceration, not in a prison, but in a hospital.

In the State of New Jersey, such individuals are being held in state civil hospitals to which they have been transferred (for varying reasons), have been treated and are now recovered or in a state of remission, no longer under active hospital treatment, and for whom discharge has been recommended by hospital authorities. Stripped of semantics, they are therefore not "patients" but are "prisoners" by order of the sentencing court in a system not designed for that purpose.

The causes of this dilemma and the resultant social and professional turmoil are many. The psychiatric profession did not create a distinction between the "sick and the bad." An Anglo-Saxon legal system reared in a world of witches and devils did. If in fact the concern is the security of society, then studies of criminal acts by individuals with different types of mental disorders can provide guidelines to a rational system.

If a person is to be considered for release from institutionalization after finding of not guilty by reason of insanity, then the psychiatrists should be asked certain relevant questions:

1. For what type of mental illness was the person institutionalized?
2. What is his mental status now?
3. Is his mental illness observably present and to what degree?
4. Is he currently under any treatment regimen in order to maintain stability?
5. What would be the probable effects if this regimen were to be stopped?
6. Can this treatment regimen be given in other than an institutional setting?
7. What is the likelihood of recurrence of his mental disease?

8. What is the likelihood of recurrence of unacceptable or antisocial behavior in the event of recurrence of his mental disease (a very different question from number 7)?
9. What is the likelihood of antisocial behavior even if he does not have a relapse of his mental disease?
10. Is he dangerous now?
11. What are the probabilities of future dangerousness?

Psychiatrists recognize that behavioral scientists have limited ability to foretell the future. A physician who treats diabetes, heart disease, and strokes has only limited ability to tell what will happen to a given individual at some future time. He may be able to give a statistical prognosis based on a large number of cases. He may also know from experience that certain factors indicate a good prognosis or a bad prognosis (control of blood, stabilization of blood pressure, results on electrocardiogram, functional capacity, age, sex, etc.).

The same is true in psychiatry. Those who are found not guilty by reason of insanity may have a variety of psychiatric conditions—acute schizophrenia under stress, chronic paranoid schizophrenia, post-partum depression, involutional melancholia, epilepsy, psychotic depressive reaction in association with a variety of physical diseases, organic brain illness,—brain tumor, vascular, degeneration, trauma, chemical intoxication, etc. There is a body of knowledge dealing with these matters upon which skilled opinions may be offered. Age, sex, onset of behavior are all relevant as is particularly a history of past antisocial acts.

These are matters upon which medical men may testify and which reflect their skills. If indeed, psychiatrists depend "upon their unverifiable view of man and his endowments" then the presence of psychiatrists in the courtroom or as advisers to the court has no merit.

We psychiatrists offer these comments to our brothers in the law to express our concern as to what we see as defects in our sociolegal system as it attempts to deal with what we all recognize as a very difficult problem that hopefully is ameliorable to conscientious, intelligent consideration. We have in particular devoted our attention to specific problems which have arisen as a result of some of the holdings of the Maik case.

The Carter Decision

In the interim, the stringencies of the court's decision were considerably loosened in the *State v. Carter* case, decided in March 1974. This excellent opinion as written by Judge Pashman for the majority and Judge Clifford (concurring and dissenting in part) is a thorough review of the issues which have been well-referenced.

Carter was a young man who shot and wounded a police officer. He was both mentally retarded and schizophrenic with some difference of opinion as to the significance or degree of the latter. He was inadvertently released and later placed under guardianship. The prosecutor asked for a review and he was returned to the state hospital as he was deemed not "restored to reason." There was some indication of periodic homicidal or suicidal preoccupation as well as an indication of the relationship of use of alcohol and psychotic episodes. However, it was felt that he could function with proper supervision. One dissenting judge at the appellate level felt that Carter had been restored to that degree of reason which he was capable of reaching, that courts have a responsibility to take calculated risks, and that to do otherwise would be to condemn the 25-year-old Carter to life institutionalization.

The Court stated that the concern for public safety is not a carte blanche justification for lifetime commitment where the underlying mental condition is incurable and then proceeded to delineate criteria for other alternatives. Though not spelled out in law, the court indicated that the judiciary has an inherent power to establish rules for conditional release as it does to suspend sentences or order probation in criminal cases. The court acknowledged a right to treatment and consideration for release when opportunity for treatment has been exhausted or treatment is otherwise inappropriate [*8*].

The court then confronted the issue of the case where the patient's underlying or latent personality disorder is incurable but in a state of remission. Interestingly, the court took a positive stance towards conditional release as a therapeutic measure in accord with the legislature's intent to provide "humane care and treatment," pointing out the

potential harmfulness of continued institutionalization where it was no longer therapeutic and the benefit of contact with the outside environment.

The court acknowledged the testimony of the various psychiatrists, particularly one who found that the personality organization which may produce an illness continued, that under stress the patient's stability might disintegrate but that with proper treatment and regulation, reintegration was possible. He could not predict that future psychotic episodes would not occur.

The court recognized a need for balance between protection of the public and the medical rationales for release, stating that denial of the possibility of conditional release is "tantamount to an elaborate mask for preventive detention."

"Neutralization" was defined as something less than a cure but something more than remission. Mere abatement of symptoms is not enough. Neutralization implies some degree of permanence but allows for the possibility of relapses. Neutralization means coping with the world as it is, without supervision and guidance.

Conditional release is an alternative allowing for return to custody if signs of an oncoming illness should appear.

The standards of other jurisdictions, on review, fit into several categories. About two thirds of the states use statutory standards. Some of the criteria are (1) public safety, (2) best interests of the patient or his recovery, (3) restoration to reason, (4) no longer dangerous, or (5) whenever the court deems it appropriate.

Now in New Jersey cogent considerations are the availability of psychiatric outpatient care and the social and environmental conditions. Supervisory control requires psychiatric follow-up and mandatory supervision over a period of time. The patient must be a fit subject for such a program. The compulsion of a court order without the willing cooperation of a patient would be counterproductive, a point with which psychiatrists will agree strongly. Dangerousness to self and others continues to be a factor. However, a patient may be retained if further progress can be made in rehabilitation.

The judge is to seek additional expert opinion if he is not satisfied with the evidence presented. The burden of proof in a review hearing for conditional release is again something less than beyond a reasonable doubt but something more than preponderance of the evidence. The standard in New Jersey is "clear and convincing evidence."

The court may require periodic reports to a probation officer from the psychiatrist and patient and maintains jurisdiction so that immediate hospitalization may be effected if necessary. Territorial restriction on the right to travel is implied.

Judge Clifford, in his partial dissent, focused, unlike the majority, on constitutional issues. He criticized those procedures which do not allow for equal protection as was spelled out in *Jackson v. Indiana* [*9*] and *Baxstrom v. Herold* [*10*]. Clifford felt that the facts of the Carter case closely approximated those of Jackson and that the standards should be those of civil commitment.

The dissenting opinion questioned the wisdom and constitutionality of the Maik holding, both as to due process and equal protection. Equal protection dictates the same standard as civil commitment—namely, dangerousness to self or others. The judge also favors application of the least restrictive alternative doctrine as laid down by Bazelon in *Lake v. Cameron* [*11*]. He would insist on a preponderance of the evidence standard and would allow a release where the defendant is no longer dangerous to himself or others as long as he complies with the terms and conditions imposed on him by his conditional release. The clear and convincing standard is a higher standard than that in civil commitment and therefore violates the equal protection clause.

Summary

The problem of release from institutionalization of those not guilty by reason of insanity is a most troublesome one. Psychiatric criteria for release are to be balanced by

what judges see as the needs and protection of society. In 1972, New Jersey in the Maik decision adopted an extremely stringent rule which, if strictly followed, would condemn most NGIs to life imprisonment. Judge Weintraub's demand for assurance that the underlying or latent condition was no longer present put psychiatric examiners in an untenable position. The psychiatrists of the state took the unusual step of preparing a critique of the Supreme Court decision and distributing it to the legal profession through a law periodical.

In the interim, the inequities of the Maik rule were recognized and an evolutionary set of standards laid down in the Carter case which provided some flexibility and set standards for conditional release. This clarification will undoubtedly be of great assistance to both courts and psychiatrists in dealing with a complex issue which can never have simple guidelines.

References

[1] Perr, I. N., "Psychiatry and Preventive Detention," *Forensic Science,* Vol. 4, 1974, pp. 1-6.
[2] Perr, I. N., "Is the Insanity Defense "Unconscionable"?," *Journal of Forensic Sciences,* Vol. 20, No. 1, Jan. 1975, pp. 169-174.
[3] Brakel, S. J. and Rock, R. S., *The Mentally Disabled and the Law,* rev. ed., University of Chicago Press, Chicago, 1971.
[4] N.J.S.A. 2A:163-3.
[5] *State v. Maik,* 60 N.J. 203, 287 A.2d 715 (1972).
[6] *State v. Carter,* 64 N.J. 382, 316 A.2d 449 (1974).
[7] Position Statement on Maik Decision of New Jersey Psychiatric Association, *New Jersey Law Journal,* Vol. 97, 2 May 1974, p. 15.
[8] *Rouse v. Cameron,* 373 F.2d 451 (D.C. Cir., 1966).
[9] *Jackson v. Indiana,* 406 U.S. 715, 32 L. Ed. 2d 435 (1972).
[10] *Baxstrom v. Herold,* 383 U.S. 107, 15 L. Ed. 2d 620 (1966).
[11] *Lake v. Cameron,* 364 F.2d 657 (D.C. Cir., 1966).

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