Understanding Montana Mental Disease and Disorder

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Mental State at the time of the alleged offense

MSO

Not Guilty by reason of Mental Disease or Disorder

Or

Guilty but Mentally Ill

How often is the Insanity Plea made?

- Studies conducted in 70's and 80's suggested only raised .1-.5% of the time
- California has gone from 1% in 1979 to .3% in 1984; Georgia went from 1.5% in 1976 to 2.5% in 1985
- Favorable opinion in only 12% of 1,710
- Mostly due to Mental Health Professionals not supporting the data

How often is the plea successful?

- Nationally about 1 out of every 4 times it is posed
- Nationally only 8.1% of the 1,971 in 1978 were found NGRI (.3%)
- 70% of these did not face a jury and went through a plea or quasi – plea
- 60-90% of those acquitted continued to be diagnosed as "psychotic after acquittal"

Montana's MDD

- Montana abolished the insanity defense in 1979
- We now have A Knowledge and Purpose standard (NGRMDD)
- As well as a Guilty but Mentally Ill sentencing option (GBMI)
- We do not have Forensic Aftercare
- We do not have checks and balances through court as we lack conditional release

Consequences of Abolishing

- Henry Steadman 1993 compared data from the periods pre (1976-1979) and post (1980-1985)
- Found the number of defendants adjudicated as Incompetent to Stand Trial increased significantly after Abolition

Policy

- Several implications

1. Standards to contain and release from forensic treatment programs (whether contained in statute or administrative code) should be structured according to the legal status of the patient. This establishes a precedent for the structuring of a forensic treatment program within the larger forensic system and reflects the importance of relevant legal considerations in setting goals.

Continued

- It is Important to clarify the legal requirements and associated policy in relevant areas for treatment agents and programs.

1. First, assessment, treatment and decision making associated with the risk of patients' violence toward others should be primary elements of a treatment program
2. Second, the failure to anticipate the possibility that a discharged patient may, despite all efforts to the contrary, be involved in an incident in which someone is seriously hurt- is to increase the prospect that a forensic program or system will be dismantled in the event of such a disaster.
3. Third, Forensic treatment programs should be leaders in development and implementation of sound risk management procedures through the use of administrative review boards, conditional release, and the proactive awareness of and compliance with professional risk management standards.