

Competency to "Cop a Plea"

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The interaction of psychiatry and the law has become more and more complex as the practitioners of law have introduced psychiatric factors into almost every step of criminal legal proceedings. No longer is psychiatric input restricted to issues of responsibility or competency to stand trial. Each significant procedural step is now fought with intensity as the flexible use of public defenders, increasing resources for defense attorneys, and increasing sophistication of participants foster the attack on the validity of statements and confessions on the basis of questioning the defendant's capacity to consent to such "voluntary acts." In the past, one would occasionally encounter a legal curiosity such as capacity to be executed or capacity to give consent to a "voluntary" sexual act which would otherwise be a crime. The psychiatrist who becomes involved in legal proceedings should now be aware of another specific area which has been quiescent in the past: the question of the capacity to plead guilty and especially of the capacity to plead guilty to a lesser charge, or, in the common parlance, the capacity to "cop a plea."

"Copping a plea" involves an agreement between prosecutor and defense attorney wherein the defendant agrees to plead guilty. This action will usually benefit the state by eliminating the trial and the chance of a not-guilty verdict. In return, the defendant may be found guilty of a lesser charge and therefore receive a lesser sentence by such agreement. He may also agree for other motivations—feelings of guilt, protecting a third party, etc.

This paper will present an unusual case in which a defendant copped a plea twice and then attempted to withdraw the guilty plea on each occasion.

The defendant, Mr. A., was arrested in the summer of 1972 on charges of breaking and entering and auto theft. In May 1973, he made a plea of guilty. Subsequent to that plea, he wrote to the governor, claiming that he had been coerced into such a pleading. The judge and the prosecutors then agreed to a retraction of the plea. By this time, the defendant had a different attorney. In June, 1973, the defendant again asked to cop a plea, the benefit to the defendant being that he would be found guilty of two charges of B and E, that other charges would be dismissed, and that the sentences would be concurrent and not to exceed 3 to 5 years. The court procedure required the signature of the defendant on a specific form for this purpose.

The judge, in reviewing the case, stated that he had not had to allow a retraction of the original agreed plea but had done so. He indicated his distress at the possibility that the defendant might again try to withdraw his plea, stating "I never again want to hear that I forced you, that your mother forced you, or that [your lawyers] forced you. . . . Do you understand?"

The judge stressed that the defendant's decision must be voluntary. The defendant responded, "I understand . . . After talking with [my attorney] this morning . . . I do want to plead guilty rather than be tried on so many different offenses." The defendant agreed that he had discussed the matter with his attorney "thoroughly," that he had not been told to plead guilty, and that he understood the various factors as the judge listed

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them. The prosecutor then reviewed the elements of the agreement with the defendant, who indicated his understanding of the agreement and the fact that he had reviewed it with his own attorney. The judge, having the authority to reject a plea bargain, again reviewed the situation with the defendant and indicated that once he, the judge, approved the agreement, there could be no retraction. Again the defendant assented and stated that he was the one who had requested the plea bargain that morning in discussing the situation with his attorney, that he had had adequate time to consult his attorney, and so forth.

Four months later, a third attorney for the plaintiff submitted an affidavit for the vacation of the guilty plea, attaching some prior medical records listing diagnoses of schizophrenia, paranoid type, antisocial personality, and alcoholism. And so it came to pass that yet another hearing was to be held dealing with "competency to cop a plea." At this point I entered the case as consultant to the prosecutor.

In addition to copies of medical records, a report was submitted by a psychiatrist who examined the defendant anew in December, 1973. This report focused on the defendant's hallucinatory experiences, his compulsion to touch the floor with his right hand, and his denial of guilt. Mr. A. complained of headaches, blackouts, and pains in his side, and spoke of his need for treatment. During psychological testing he would stop and stare: he spoke of constant hallucinations. His I.Q. on the Shipley-Hartford Test was 106. "The projectives strongly suggest the presence of schizoid processes and although responses are not clearly bizarre there are reality testing difficulties." The patient was described by the psychiatrist as being quite emotional, with "tears welling up in his eyes." The psychiatrist stated that the defendant had been disturbed for a considerable period of time, and that he had auditory hallucinations which directed his actions and behavior and which increased tension and anxiety that could be relieved only by his complying with the commands given by the "voices." The psychiatrist attributed the plea of guilty to these hallucinatory commands. "It is the opinion of this examiner that this Patient was not Mentally Competent at the time to enter a plea of guilty—that he was actually 'coerced' into doing so by these Hallucinations."

Mr. A., 29 years old, had undergone a number of brief hospitalizations since age 20, when he was sent to a state hospital from a county workhouse. At that time he spoke of his dislike of confinement, his marital problems, and his feeling of being different. He had "threatened self-destruction half-heartedly." Earlier his marriage of one year had broken up with the discovery that his wife's pregnancy was not his doing. He was described as being free of psychosis but was felt to be unstable and immature, although his behavior in the hospital was quite appropriate and not remarkable.

In 1971 he underwent a brief hospitalization of three days at a private psychiatric hospital. He was noted to have been an extremely heavy drinker and drug abuser. He also claimed that he had been hallucinating while in prison earlier that year. Hospitalization resulted after he did much damage at his parents' home and bruised his mother. He was coherent, without abnormal mood or thought disorder. Tentative diagnosis or impression was schizophrenia, paranoid type. His agitation quickly subsided and he eloped after three days. (Parenthetically, one might raise a question as to diagnosis under these circumstances, particularly in terms of diagnosis and insurance coverage. This comment is purely speculative, but in general should be considered in the review of hospital records.)

In July, 1972, he was again hospitalized for two days—he spoke of a touching compulsion, being on thiorazine. Again too, there was reference to heavy drinking and threatening behavior, with coherent and organized behavior in the hospital. In April, 1972, he was seen because of auditory hallucinations and excessive alcoholic intake, acted bizarre and agitated but walked out without admission. The July admission followed three days of drinking after which he shot at his girl friend because of her attention to other men. After one day, he requested discharge. He was not felt to be com-

mittable. Diagnosis was paranoid schizophrenia, antisocial personality, and alcoholism. He again eloped, this time with a decision by the hospital not to readmit him.

He was hospitalized at a state hospital in 1971 for 18 days, with a diagnosis of alcoholism, habitual excessive drinking and behavior disorder, and unsocialized aggressive reaction to adult life. Again he acted threatening and excited on admission but showed no abnormal behavior or psychotic thinking in the hospital. At a second hospitalization in the summer of 1973 (during the proceedings described above), he was diagnosed as having chronic, undifferentiated schizophrenia.

In the mother's affidavit she spoke of his having an organic brain condition. He told a physician at the hospital that he had a benign brain cyst discovered at the private hospital. Skull X-rays were negative. He also had had an E.E.G. in the past (results not described in the hospital summary). The mother also stated that he had cancer. None of these statements was substantiated by medical records.

The family background, early life, and other details will not be elaborated upon here. During his three-hour interview, he did provide a most adequate history without apparent defect in memory. He had been a musician. Initially in the interview he spoke of hallucinations and the compulsion to touch things, but he went on to discuss other matters without seeming interference. He had recently returned from the state hospital, where he had spent four more visits of 1 to 3 weeks each and was probably on mellaril 200 mg. a day. He had eloped twice from the state hospital. Thus he was travelling back and forth between the state hospital and the county jail; he would be agitated at the jail and would be hospitalized for brief periods, then would be promptly returned by the hospital. To my knowledge, the jail had no psychiatrist. Since age 22, Mr. A. had been incarcerated in three state prisons for 14 months, 7 months, and 16 months. In the original charges in the pending case, there were four counts of B and E; he admitted to an "uncomfortable urge to steal. . . . It's so embarrassing." The voices told him to steal. At one point, he dated auditory hallucinations to age 13; at another to age 17, when he stole a car. The hallucinations are not reflected in prior records. He stated that in June, his attorney told him to plead guilty but the voices told him not to. He now wanted to withdraw his plea because he was innocent. He was rather vague in describing his experience with "voices." Asked why he had never mentioned "voices" in his earlier correctional institutionalizations, he stated that he was afraid. He also indicated that he had been physically and sexually assaulted in prison but would not give any details. In essence, he denied both drug and significant alcohol intake, in contrast to the material in the records.

I might add that a matter of great and appropriate concern was his history of prior cooperation with police on a number of matters—behavior which was generally known and was particularly appropriate to his fear of returning to one of the prisons. This situation raises other questions as to his motivation in delaying trial and staying in a mental hospital or county jail.

His medical complaints were quite vague and not typical of organic disorder. For example, his "blackouts" caused him to sit down when he heard a swirling noise.

Mr. A. was a nice-looking man with no deviation in appearance, pleasant, affable, cooperative. Initially tense, he soon spoke in a relaxed and appropriate fashion. When he was evasive, the topic was such that evasion was reasonable. He was not unduly anxious or depressed. Mr. A. made much of his voices initially but without blunting of affect or agitation. He related quite well, was coherent, logical, and pertinent. No deviation in thought processes otherwise was noted. He did well on interpretation of proverbs, but did show some tendency towards impulsivity on the fire in the theatre inquiry. Projective testing was well within normal limits, with some expression of somatic concern, mild anxiety, and self-doubts, but with good reality contact. His drawings did show deviant responses with a grossly distorted body image as is sometimes seen in schizophrenia. The angry-looking females were reflective of his relationships with

women. His I.Q. on the Ammons Picture Vocabulary Test was 102, which was in keeping with past tests; no organicity was reflected on the Graham-Kendall Test.

He was felt to have a complex picture of longstanding maladjustment, antisocial behavior, explosive destructive acts, periods of heavy drinking, and occasional transitory symptoms of schizophrenia. Alcohol was a probable precipitant to his behavioral and questionable hallucinatory episodes.

He was keenly aware of his predicament and legal situation. Despite the constant reference to voices, there was little substantiation of a thought process abnormality clinically or in testing. The extremely rapid subsidence of schizophrenia-like symptoms in a day or two of hospitalization raised a question of drug and alcohol as precipitants, rather than a basic schizophrenic process. His anxiety about imprisonment seemed most appropriate. Note was made of his 'street awareness.' Despite all his hospitalizations, no continuing psychosis had been described in the hospital records other than the continuation of the labeling process once it had begun.

Specific commentary was directed to the hearing of June, 1973, where he was noted to have handled himself in a reasonable manner, responding appropriately with verbal content that indicated an understanding of what was happening.

Acknowledging the fact that he was currently on some medication, the opinion was offered that the past episodes seemed to have been acute stress reactions with episodic alcoholism, aggravating antisocial and explosive personality traits. The symptoms of chronic undifferentiated schizophrenia were felt to be borderline (no further specific mention was made of possible reasonable motivation for the expression of some of the symptomatology, although, of course, concurrent malingering must always be considered).

After court review, he was found to have been competent to cop a plea, and a retraction based on incompetency was denied.

My role in this case was to act as consultant to the prosecutor as to the merits of a claim of mental illness at the time of the copping of the plea—a rather narrow issue, but one which could determine immediate disposition and transfer to a stringent penal setting. Further discussion of the "strategy" in this particular case is unnecessary, but reasonable speculation is left to the reader as it is to the writer.

Communication to the private hospital (with authorization by the defendant) did result in receipt of an additional psychological report dated July, 1972. Impression was "antisocial or psychopathic pattern of behavior" with problems in impulse control and frustration tolerance. He exhibited a "personality disorder marked by uncontrolled aggressive impulses and increased energy level." No indications of psychosis were reflected in the testing at that time.

The prosecutor's search for applicable law uncovered two earlier cases whose findings were relevant to the issue of competency to cop a plea.

In *New Jersey v. Fischer*,¹ the defendant had confessed to a murder in December, 1953. The defendant entered a plea of guilty; the attorney for the defendant had some question as to the defendant's sanity, with the result that three psychiatrists filed reports. Psychiatrist No. 1 made a diagnosis of multiple psychopathic traits and a schizophrenic form of psychosis, but he felt that the defendant was responsible within the M'Naghten rules and competent to stand trial. Psychiatrist No. 2 felt the defendant had a psychopathic personality with schizoid trends and aggressive episodes. He felt the defendant to be responsible, competent to stand trial, and "capable of entering a plea." Psychiatrist No. 3 felt that the defendant was definitely psychotic, "unable to cooperate with his legal defense." He felt that the defendant did not show an awareness of the seriousness of his crime and went on to state, "This man is definitely what is classically referred to as 'a mad dog killer.' Though many would say that he would be better off dead than alive, this would not fit into our humanitarian concepts."

In April, 1954, the defendant pleaded *non vult*. At that time, psychiatrist No. 1 examined him again and stated that Fischer was aware of the proceedings, that he knew

exactly what was going on, that he in essence had put himself at the mercy of the court, realizing that by doing so he might escape capital punishment, and that he also recognized that he was trying to avoid placement in a mental institution.

The defendant was specifically interrogated in court about his plea. A life sentence was imposed. In 1961, the defendant sought to withdraw his plea, claiming that he was now for the first time able to assess his situation and that his mental condition had precluded appropriate legal steps previously. His motion was denied, and the appeal went to the Supreme Court. The rule of law in New Jersey is that *to correct manifest injustice*, the court, after sentence, may set aside the judgment of conviction and permit the defendant to withdraw the plea. The court noted that the defendant did not deny the homicide and did not claim a lack of mental responsibility under M'Naghten. Rather he claimed that his motivation for a plea was his fear of commitment to the state institution for the criminally insane. The court noted that the three psychiatrists' reports precluded a defense of insanity, that two said specifically that he could stand trial, and that two examined him further at the time of the plea. The court concluded that not only was there no manifest injustice but that the defendant's action was voluntary and calculated, and that he knew and understood what he was doing.

In the appellate case of *New Jersey v. Pugh*,² the defendant similarly pleaded *non vult* and was sentenced to a life sentence in 1967. In 1971 he appealed on the basis that the court had failed to hold a hearing on competence to stand trial and competence to enter a guilty plea. Here the defendant was charged with two murders and an atrocious assault and battery on a third party. At the first hearing, a mistrial was declared on the basis of a claim of chronic brain syndrome with psychotic reaction at that time. At the second trial, after the defendant entered a guilty plea to one charge, the other two charges were dismissed. When the defendant was questioned about his understanding he indicated some confusion, and when the questions were put in simpler form, he said that he understood the situation. Before the second trial, the professional experts had indicated that the defendant was competent to stand trial.

At the entering of the plea, the attorney for the defendant indicated that he had explained the sentence possibilities and probabilities. The lawyer went over each question with the defendant at that time.

The defendant was mildly retarded, with an I.Q. of 71, and had suffered a head injury while in military service. At various times, he claimed amnesia for what had occurred.

The court concluded that there was nothing to indicate that the defendant could not reasonably comprehend his position and consult with his lawyer, noting further the reports of the various doctors as well as a hospital entry to the effect that the patient knew the details of his offense, had knowledge of his legal rights, and was capable of assisting his attorney and following his advice.

The court pointed out that the court may refuse a plea and shall not accept it without personally determining that such a plea was voluntarily made and that there was a factual basis for the guilty plea. Further, on an application to withdraw a plea, the execution of the plea itself weighs heavily against a contention that the plea was not entered voluntarily and understandably. The court similarly denied coercion where there were multiple hearings and assertions by defendant and counsel as to their understanding.

Thus, psychiatrists performing evaluations for forensic purposes in criminal cases should be aware that the question of competency to "cop a plea" is not a theoretical possibility but one which may arise on appeal years after the event. One is likelier to encounter such an issue where the issue of competency to stand trial has been resolved and where the claim of not guilty by reason of insanity lacks adequate substantiation on which to base a defense. Such a claim may be a desperate attempt after conviction by the defendant to negate the prior process, or it may be a delaying tactic for whatever reason. The psychiatrist must also keep in mind the possibility of a genuine contention where

the defendant's state at the time precludes adequate understanding of the meaning of copping a plea. Such an occurrence would indeed be rare, considering the limited mental functioning required to understand the implications of a guilty plea.

As with other issues in legal psychiatry, the forensic psychiatrist should first diagnose or appraise the patient's mental condition in terms of traditional psychiatric concepts and then respond to the legally meaningful issue: Is the patient's aberrant mental condition such that he cannot meet the legal standard for competency or sanity?

An unusual case in which a defendant twice attempted to withdraw a guilty plea is here presented. Forensic psychiatrists should be aware of the issues presented in such a rare situation, keeping in mind that the courts have considered such situations and are most cautious in accepting a retraction on psychiatric grounds in a legal situation where the capacity to comprehend the meaning of the legal act is specifically scrutinized at the time of that act.

References

1. *New Jersey v. Fischer*, 38 N.J. 40 (Sup. Ct., 1962)
2. *New Jersey v. Pugh*, 117 N.J. Super. 26 (Superior Ct., App. Div., 1971)