# The Pre-Trial Examination Process in Missouri: A Descriptive Study

JOHN PETRILA, JD, LLM
JAMES SELLE
PHILLIP C. ROUSE
CRAIG EVANS and
DARRELL MOORE

The procedural and dispositional alternatives available to the mentally disordered offender are much discussed; however, the discussions are generally speculative and are seldom informed by empirical data. Steadman, in reporting on insanity acquittals in New York, noted that "The current paucity of the type of data presented here relegates most debates on the insanity defence to little more than fodder for campus forensic societies."[1]

This characterization may be fairly applied to debate over any of the numerous ways in which criminal justice and mental health systems interact. The "paucity of data" affects not only the debates over these subjects; it has a negative effect upon the ability of administrators to make informed decisions about the systems they are charged with managing.

## Present Study

The principal author was named Director of Forensic Services for the Missouri Department of Mental Health in September, 1979. The position had not existed prior to that time. The Director was given responsibility for developing Department-wide policy for the forensic service system; however, an empirically based description of the system did not exist. The lack of information made difficult informed decision-making concerning policy and budget matters.

The present study was designed to provide the Department with a factually based description of the forensic services system as it was then operating. The information accumulated in the course of this study provides such a description. At the same time, our data adds to the growing body of information necessary for informed debate over the pre-trial examination process, the insanity defence and disposition of the mentally disordered offender.

## Methodology

The subject of the study is the 480 pre-trial examinations performed in calendar year 1978 by six facilities of the Missouri Department of Mental Health and one private community mental health center. This represents all

unduplicated examinations conducted by those facilities in 1978. If an individual was evaluated by more than one facility, only the first examination is reported here. The facilities studied provide more than 90% of the pre-trial examinations conducted in Missouri by DMH facilities and private community mental health centers.[2]

A standard form was developed and used to take certain information from the medical files of the examinees. Information extracted included **demographic,** e.g., sex, age and race of the client; **historical,** e.g., education and previous criminal and psychiatric history; **clinical,** e.g., diagnosis and treatment recommendations and **legal,** e.g., the examiner's response to the questions posed by the referring agency. The information available to the examiner and reviewed by the authors came from a variety of sources, including the client, the court order initiating the examination, family members, police reports and medical records from previous hospitalizations. Sources of information were not the same in every case. In nearly all cases, most of the information was self-reported.

The computerized census file of DMH was then searched to determine how many examinees received mental health services subsequent to the pre-trial examination. The medical files of this group were reviewed again to ascertain the legal route by which the subsequent admission occurred. The possible routes included civil commitment, commitment after acquittal by reason of insanity or adjudication as incompetent to stand trial or commitment as a condition of probation. Length and type (inpatient, outpatient) of the stay were also noted. Court files on individuals who are acquitted, acquitted by reason of insanity or whose charges are dismissed, are closed by Missouri statute. Therefore, these files were unavailable as a source of information.[3]

This paper describes the pre-trial examination process in Missouri in 1978 from the court order initiating the exam to the report filed by the examiner with the court. A subsequent paper will report dispositional information.

## Missouri Forensic System

The traditional site of forensic services in Missouri has been the Biggs Unit, a 225-bed maximum security unit located at Fulton State Hospital in Fulton, MO. The Biggs Unit was designed to accommodate 25 pre-trial examinees at a given time. The remaining beds were devoted to the treatment of those found incompetent to stand trial or acquitted by reason of insanity, transfers from correctional and other mental health facilities and criminal sexual psychopaths (a statutory classification since repealed); however, the demand for examinations outstripped the capacity of the unit. There were frequently more than 50 patients awaiting examination at any one time, with other defendants on waiting lists of three-five months. Because of this, treatment staff were often taken from their assigned duties and were assigned instead to the evaluation ward. Predictably, treatment

suffered.

The Department began limited decentralization of the pre-trial examination process in 1977. A report of the Missouri House of Representatives, issued in early 1978, recounted the problems faced by the Biggs Unit and recommended that decentralization be accelerated.[4] In response, other facilities assumed the responsibility for an increasing number of examinations; however, decentralization occurred without the setting of Department-wide standards or procedures. As a result, each facility operated independently, with individual staff responsible for standards and procedures and for establishing liaison with the local courts.

The goal of decentralization was to have each facility examine individuals from its catchment area. This is the geographic area for which the facility is responsible. An implicit exception existed for individuals accused of serious personal offenses. The Biggs Unit would continue to receive these cases from all areas of the state.

In contrast to the maximum security Biggs Unit, the other facilities included in this study are general psychiatric hospitals and mental health centers. Malcolm Bliss Mental Health Center is a state operated, 180-bed center located in St. Louis City. While Bliss has responsibility for three counties surrounding St. Louis City, it draws nearly all of its forensic cases from the City. It serves a predominantly urban clientele. Western Missouri Mental Health Center (WMMHC) is a State-operated, 200-bed mental health center. It is located in Kansas City, the county seat of Jackson County, and serves an urban area of seven counties. Jackson County is the most populous. St. Joseph State Hospital is a 500-bed general psychiatric hospital. It is located in St. Joseph, MO, a city of 78,000, situated 60 miles north of Kansas City. St. Joseph serves 18 counties in the northwest corner of the state, a mostly rural area. In 1978, it provided a resource for Jackson County when WMMHC developed a backlog of cases. Farmington State Hospital (550 beds) and Nevada State Hospital (160 beds) are general psychiatric hospitals. They serve respectively the southeast and southwest regions of the state. These are also primarily rural areas. Finally, Burrell Mental Health Center is a Federally created mental health center located in Springfield, MO. It serves Springfield, which is the third largest city in Missouri (population — 120,000), and the five surrounding counties.

In 1978, only WMMHC and Burrell evaluated a majority of pre-trial examinations on an outpatient basis. The other facilities hospitalized examinees for periods of time ranging from 14-45 days. A standard evaluation included a physical examination, routine laboratory work, a social history taken from the client or family, psychological testing and one or more psychiatric interviews.

## Missouri Law

Missouri law provides that "No person who as a result of mental disease or defect lacks capacity to understand the proceedings against him or to

assist in his own defense shall be tried, convicted or sentenced for the commission of an offense so long as the incapacity endures."[5] If the court has reasonable cause to believe that the defendant has a mental disease or defect resulting in lack of fitness to proceed, the court, upon its own motion or upon motion filed either by the defence or prosecution, may order the defendant to undergo a psychiatric examination.

The Missouri statutory test for insanity is a slightly modified version of the American Law Institute (ALI) test. The statute provides that

> (A) person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect, he did not know or appreciate the nature, quality or wrongfulness of his conduct or was incapable of conforming his conduct to the requirements of law.[6]

Missouri law differs little in these provisions from that of most states; however, the statute also mandated that the report of the examination include opinions both on the defendant's capacity to stand trial **and** on the defendant's responsibility at the time of the offence. This assured that any defendant referred for examination into fitness to proceed would also be examined on the issue of responsibility. The court had to find "reasonable cause" to believe that incompetency to stand trial existed. The inquiry into responsibility followed automatically. Because of this provision, the issue of responsibility was raised for defendants charged with offenses not normally associated with the insanity defence, e.g., larceny, bad-check writing and driving while intoxicated.

## Examination Site: Location of Examinations

In 1978, the courts had statutory authority to name the examining facility. A subsequent statutory revision requires commitment to the Department, enabling the Department to choose the site of the exam. The Biggs Unit received the largest number of referrals. This is probably attributable in part to habit since Biggs was the sole provider of forensic services in Missouri for nearly 40 years. Judicial concerns over security also undoubtedly played a role. Biggs is the only maximum security unit in the state. Table 1 shows the number of examinations performed by each facility in 1978.

Since 1978, the proportion of examinations performed by Biggs has dropped to approximately 30% of the statewide total. This reflects both an increased willingness on the part of the courts to utilize the nearest mental health facility and implementation of a coordinated policy of decentralized forensic services.

## Appropriateness of Referrals to Maximum Security Unit

In 1978, the DMH had not established standards for the referral process. We speculated that the courts would consider serious offences against

Table 1: Referrals By Facility (N=480)

| Facility | No. of Exams | % of Total |
|---|---|---|
| Fulton (Biggs Unit) | 230 | 47.92 |
| Bliss | 96 | 20.00 |
| Farmington | 64 | 13.33 |
| Western Missouri | 46 | 9.58 |
| St. Joseph | 19 | 3.96 |
| Nevada | 14 | 2.92 |
| Burrell | 11 | 2.29 |
| **Total** | **480** | **100.00** |

another person as evidence that maximum security was required. We anticipated finding that Biggs performed a disproportionate percentage of the examinations in such cases. We also speculated that the Biggs Unit would receive a number of cases where the nature of the offence did not suggest that security was an issue. We assumed this would occur both because Biggs had been the traditional site of examination and because some courts and prosecutors would assume that pre-trial examinations could be conducted only in a maximum security setting.

Contrary to our assumptions, we found that cases involving offences against person were referred to the Biggs Unit in approximately the same proportion as the total share of the state caseload referred to Biggs. Cases involving homicide and escape were the only exceptions.

Biggs performed 230 of the 480 evaluations (47.92%). It evaluated 80.3% of those charged with all categories of homicide. This figure includes 35 of 36 capital murder cases (97.2%). Biggs also evaluated nine of the 10 individuals (90%) charged with escape. Thus, homicide and escape were overrepresented in the Biggs' caseload; however, Biggs evaluated 55.2% of those charged with rape, 39% of those charged with robbery, 44.6% of those charged with assault and 47.1% of those charged with weapons offences. These percentages do not differ significantly from the share of the state caseload referred to Biggs.

It is not surprising that homicide is overrepresented. Courts and the community would want to minimize the chance that those charged with homicide would escape; staff at a general hospital would be reluctant to handle the type of offender perceived as being the most dangerous. It is also not surprising that nearly all of those charged with escape were referred to Biggs. The principle function of a maximum security unit is to provide security. Courts and prosecutors undoubtedly assume that placement in maximum security best denies an individual charged with escape the opportunity to do so again. Those charged with the other offences against person may or may not have needed maximum security; however, contrary to our expectations, we did **not** find these offences to be significantly overrepresented in the maximum security population.

At the same time, the Biggs Unit did evaluate a large number of individuals charged with less serious offences. This was consistent with our expectations. More than one-quarter of the Biggs' cases (64 out of 230, or 27.8%) fell

into the following categories: larceny, stealing, auto theft, burglary, forgery, bad checks, drug possession, tampering with a motor vehicle and failure to return a rented auto. The nature of these offenses does not suggest that the alleged offender represents such a danger to others that he must be confined in maximum security. Barring exceptional circumstances, such defendants should be evaluated in other locations.

## Demographic Information: Age, Sex and Race

The examinees were predominantly young, Caucasian males. There were 447 males (93.13%) and 33 females (6.87%). No facility had fewer than 90% males.

The examinees ranged in age from 16 to 83. The mean age was 28.7, and ranged from a mean of 26.09 at Fulton to 32.53 at Farmington. The mode was 22, and ranged from age 18 at Farmington to 22 at Fulton. The mean age of this population is similar to the age of those studied elsewhere. For example, Bluestone reports a mean age of 29 among defendants referred from Bronx County in New York for competency examinations.[7] Geller and Lister, in studying pre-trial examinations in Massachusetts, report an average age of 30.5.[8] Pfeiffer, in reporting on cases referred for evaluation from the Federal courts, reports an average age of 32.4.[9]

Three hundred twenty (66.67%) of the examinees were Caucasian. There were 158 Blacks (32.92%), one American Indian (.21%), and one Japanese American (.21%). A majority of clients referred to Bliss in St. Louis and WMMHC in Kansas City were Black (54.17% and 56.52%, respectively). Arrest data for the entire state was not available, so it was not possible to compare the racial composition of the examinees with the racial composition of arrestees; however, arrest data were available for St. Louis City.[10] In 1978, 67.5% of all arrestees were Black. Of the 114 arrestees referred for pre-trial examination from St. Louis City, 76 (66.67%) were Black, and the other 38 (33.33%) were Caucasian. The racial composition of those referred for pre-trial examination from St. Louis City corresponds almost exactly to the racial composition of the arrest population.

## Educational Background

Information on school grade completed was available in all but 15 (3.12%) of the cases. More than one-third of the remaining 465 examinees (177, or 38.06%) had either completed high school, received a GED, or had schooling beyond high school. This contrasts with the 14% who had completed high school in Laczko's study of 435 cases referred to a North Carolina institution,[11] the 18.4% reported by Bluestone[12] and the 25% who had completed high school in the Boston State Hospital population studied by McGarry.[13] The mode for grade completed was the 12th grade for the entire sample. This was also the mode for all facilities but Burrell, where the mode was the 13th grade. The mean for the entire sample was 10.26. For

individual facilities, the mean ranged from 9.98 at Farmington to 12.11 at Burrell.

## Psychiatric History

Three hundred seven (307) of the examinees (63.96%) in this study reportedly had at least one admission to a mental health facility. This figure excludes previous referrals for pre-trial examination where the record indicated that the previous admission had been for that purpose; 173 examinees (36.04%) had no reported history. The majority of those with histories had been hospitalized previously as inpatients. Table 2 shows, by facility, the number and percentage of examinees with a psychiatric history. Table 3 shows, by facility, whether the examinees had been hospitalized as inpatients, treated as outpatients or both.

The percentage of this population with a psychiatric history (63.96%) is markedly higher than the figure (13.6%) reported by Laczko.[14] It is comparable to that reported by Bluestone (59.7%).[15]

Bliss had the highest incidence of psychiatric history among the facilities (79.17%). This assumes added importance when the facility response to the issue of responsibility at the time of the offence is considered (see discussion below).

## Previous Criminal History

According to facility files, a majority of those referred (288 or 60.0%) had no reported prior felony convictions. The remaining 192 (40.0%) reportedly had at least one conviction. Table 4 shows, by facility, the number of clients with no prior conviction and the number of clients with convictions.

The 40% with at least one prior conviction is similar to the 36% with previous criminal records reported by Laczko,[16] and the 40% with criminal convictions reported by Rollin.[17] Pasewark reports that 44% of New York insanity acquittees between the years 1971-76 had at least one previous arrest.[18]

## Offenses Charged

Those referred for examination faced a wide variety of charges. When only the most serious charge is considered, assault was most common (38,

Table 2: Psychiatric History

| Facility | No. Cases | History | % | No. History | % |
|---|---|---|---|---|---|
| Fulton (Biggs) | 230 | 139 | 60.43 | 91 | 39.57 |
| Bliss | 96 | 76 | 79.17 | 20 | 20.83 |
| Farmington | 64 | 40 | 62.50 | 24 | 37.50 |
| Western Missouri | 46 | 28 | 60.87 | 18 | 39.13 |
| St. Joseph | 19 | 13 | 68.42 | 6 | 31.58 |
| Burrell | 11 | 3 | 27.27 | 8 | 72.73 |
| Nevada | 14 | 8 | 57.14 | 6 | 42.86 |
| **Total** | **480** | **307** | **63.96** | **173** | **36.04** |

Table 3: Type of Treatment

| Facility | No. of Cases | In-Pt. | % of Facility Caseload | Out-Pt. | % of Facility Caseload | In-Pt. and Out-Pt. | % of Facilities Caseload |
|---|---|---|---|---|---|---|---|
| Fulton (Biggs) | 230 | 110 | 47.83 | 19 | 8.26 | 10 | 4.35 |
| Bliss | 96 | 55 | 57.29 | 6 | 6.25 | 15 | 15.62 |
| Farmington | 64 | 18 | 28.12 | 4 | 6.25 | 18 | 28.12 |
| Western Missouri | 46 | 16 | 34.78 | 7 | 15.22 | 5 | 10.87 |
| St. Joseph | 19 | 10 | 52.63 | 2 | 10.53 | 1 | 5.26 |
| Burrell | 11 | 2 | 18.18 | 1 | 9.09 | 0 | 0 |
| Nevada | 14 | 5 | 35.71 | 1 | 7.14 | 2 | 14.28 |
| **Total** | **480** | **216** | **45.00** | **40** | **8.33** | **51** | **10.62** |

Table 4: Criminal History

N = 480

| Facility | Total | No Convictions | Percent | One Conviction | Percent | Two-Four Convictions | Percent | More Than Four Convictions | Percent |
|---|---|---|---|---|---|---|---|---|---|
| Fulton (Biggs) | 230 | 125 | (54.35) | 43 | (18.70) | 57 | (24.78) | 5 | (2.17) |
| Bliss | 96 | 57 | (59.38) | 23 | (23.96) | 12 | (12.50) | 4 | (4.16) |
| Farmington | 64 | 47 | (73.44) | 7 | (10.94) | 9 | (14.06) | 1 | (1.56) |
| Western Missouri | 46 | 31 | (67.39) | 9 | (19.57) | 5 | (10.87) | 1 | (2.17) |
| St. Joseph | 19 | 13 | (68.42) | 1 | ( 5.26) | 5 | (26.32) | 0 | (0) |
| Burrell | 11 | 10 | (90.91) | 1 | ( 9.09) | 0 | (0) | 0 | (0) |
| Nevada | 14 | 5 | (35.71) | 5 | (35.71) | 3 | (21.43) | 1 | (7.14) |
| **Total** | **480** | **288** | **(60.00)** | **89** | **(18.54)** | **91** | **(18.96)** | **12** | **(2.50)** |

or 17.29% of the total referrals). There were also a large number of referrals for homicide, burglary and robbery. Table 5 shows the distribution of offenses based on the most serious charge against each examinee.

As studies in New York[19] and Michigan[20] have shown, the number of referrals for a given offense is meaningful only when compared with the arrest rate for that offense. Steadman and Braff, in New York, and Cooke, Johnston and Pogany in Michigan, measured the rate of referral per 1,000 arrests for each offense. Each study found that serious offenses against person, e.g., homicide, robbery and rape, were most referred. Less serious offenses like theft, while comprising a significant percentage of total referrals, were referred much less frequently relative to the number of arrests for the offenses.

In Missouri, statewide arrest rates are unavailable; however, arrest rates are available for St. Louis City, the largest metropolitan jurisdiction in Missouri.[21] There were 114 referrals from St. Louis City. This was 23.75% of the total pre-trial caseload. Analysis of the referral rates from St. Louis City relative to the arrest rate for various offenses reveals much the same pattern described above. Table 6 shows the percentage of all arrests represented by each offense, the percentage of all pre-trial referrals represented by each offense, and the referral rate for every 1,000 arrests for the offense. (Five cases are omitted because the offence charged was a driving offence, e.g., driving without a license and the police statistics did not include total arrests for these categories.)

These rankings are similar to those reported by Steadman in his study of New York defendants acquitted by reason of insanity. They are also similar to those reported by Cooke in the study of referrals for pre-trial examinations in Michigan. For example, homicide was referred most frequently in all three studies (87.63 per 1,000 arrests here, 81.8 in Steadman, 134 in Cooke). Rape and "other sex offences" were the second and third ranked offenses here. In Steadman, they were fourth and fifth. In Cooke, "sex crimes," which apparently included rape, were ranked third. The rate of referral for rape was higher here (35.71 per 1,000 arrests for rape versus 11.3 in Steadman); however, the rankings are similar.

"Forgery and counterfeiting" was the most frequently referred property offence in this study (19.61 per 1,000 arrests) and the fourth most referred overall. In the Michigan study, it was the fifth most referred (12 per 1,000). In both studies, it was referred about four times more frequently than assault. In contrast, Steadman found forgery to be among the offenses least frequently referred (.7 referrals per 1,000).

In all three studies, the referral rate for assault relative to the arrest rate is lower than that for any other offence against person. We found 4.6 referrals per 1,000, while Steadman reports seven and Cooke reports three. Cooke speculated that the low rate of referral for assault resulted from the broad range of offences falling within the "assault" category. He implies

**Table 5: Offences Charged**

| Offence | Number of Offenses | Percent of All Offenses |
|---|---|---|
| Murder | 71 | 14.79 |
| (Capital Murder) | (36) | (7.50) |
| (Murder, 1st and 2nd Degree) | (35) | (7.29) |
| Manslaughter | 2 | .42 |
| Rape | 29 | 6.04 |
| Robbery | 41 | 8.54 |
| Assault | 83 | 17.29 |
| Child Molestation | 17 | 3.54 |
| Sodomy | 5 | 1.04 |
| Incest | 1 | .21 |
| Other Sex Offenses | 7 | 1.46 |
| Arson | 12 | 2.50 |
| Kidnap | 6 | 1.25 |
| Burglary/Theft/Larceny | 72 | 15.00 |
| Weapons Offenses | 17 | 3.54 |
| Auto Theft | 25 | 5.21 |
| Other Vehicular Offenses | 8 | 1.67 |
| Possession/Sale Of Drugs | 14 | 2.92 |
| Possession of Stolen Property | 2 | .42 |
| Fraud/Bad Checks | 15 | 3.12 |
| Forgery | 13 | 2.71 |
| Driving While Intoxicated (DWI) | 5 | 1.04 |
| Escape | 10 | 2.08 |
| Parole Violation | 4 | .83 |
| Leaving Scene of an Accident | 4 | .83 |
| Other | 14 | 2.91 |
| Unknown | 3 | .63 |
| **Total** | **480** | **100.00** |

Table 6: Referrals by Arrest Rate for St. Louis City

| Offence | Arrests | Percent Total Arrests | Referrals | Percent Total Referrals | Referrals per 1,000 Arrests |
|---|---|---|---|---|---|
| Homicide | 194 | .7 | 17 | 14.91 | 87.63 |
| Rape | 308 | 1.1 | 11 | 9.65 | 35.71 |
| Other Sex Offenses | 299 | 1.1 | 7 | 6.14 | 23.41 |
| Forgery and Counterfeiting | 102 | .4 | 2 | 1.75 | 19.61 |
| Offenses Against Family and Children | 160 | .59 | 2 | 1.75 | 12.50 |
| Robbery | 1,265 | 4.6 | 14 | 12.28 | 11.06 |
| Auto Theft | 466 | 1.7 | 3 | 2.63 | 6.43 |
| Assault | 5,218 | 19.2 | 24 | 21.05 | 4.60 |
| (Aggravated Assault) | (2,090) | (7.7) | (18) | (15.79) | (8.61) |
| (Other Assault) | (3,128) | (11.5) | (6) | (5.27) | (1.92) |
| Burglary/Theft (except auto) | 5,338 | 19.6 | 16 | 14.03 | 3.0 |
| Vandalism | 425 | 1.56 | 1 | .88 | 2.35 |
| Weapons Offenses | 1,010 | 3.7 | 2 | 1.75 | 1.98 |
| All Other Offenses | 2,212 | 8.12 | 4 | 3.51 | 1.81 |
| Drug Offenses | 1,874 | 6.8 | 2 | 1.75 | 1.06 |
| DWI | 2,331 | 8.6 | 2 | 1.75 | .86 |
| Disorderly Conduct | 2,511 | 9.22 | 2 | 1.75 | .80 |

that the less serious and presumably less frequently referred offences included in the assault category would reduce the rate of referral for the entire category of assault. Our data support this theory. We found that aggravated assaults (assault with intent to maim, to kill, etc.) were referred about four and a half times as frequently as non-aggravated or common assault; however, even with this distinction, the referral rate for aggravated assault is lower than that for the other offenses against person.

It is unfortunate that arrest rates for the entire state of Missouri are unavailable; however, the figures from St. Louis City **do** support the conclusions reached by both Steadman and Cooke that serious offenses against person will be referred most frequently relative to arrest rates. Our findings on clinical conclusions regarding responsibility at the time of the offense, discussed below, also support their conclusion that these high rates of referral result from strategies unrelated to concern over the examinee's mental status.

## Communication Between Criminal Justice and Mental Health Systems

The pre-trial examination process is an attempt at communication between the mental health and criminal justice systems. These are two very different systems. The pre-trial examination process is not used in the case of every criminal defendant. When it **does** occur, it is presumably because there is something about the individual defendant that those in the criminal justice system believe distinguishes him or her from the "usual" defendant. The mental health system is asked to determine whether the defendant is, in fact, sufficiently different to justify the utilization of processes other than conviction and punishment, e.g., treatment after an acquittal on the basis of

insanity. The mental health system is also asked to explain why the defendant is different.

The primary instruments of communication between systems are the court order and the clinician's report. One requests information, the other supplies it. Theoretically, the criminal justice system asks questions relavant to the **individual** defendant whose case is being heard and the clinician's report addresses those questions. Theoretically, other parties to the process, most notably counsel for the defense, will help assure that all possible information is made available to the examiner and that both questions and responses are clear; however, our findings show that the practice diverges sharply from theory.

## Communication Between Systems: The Court Order

The court order for a pre-trial examination initiates and defines the relationship between the mental health and criminal justice systems. Previous studies have found that court orders vary greatly, from the most general request for an examination to the most detailed and specific types of questions.[22] Several authors have also noted that "There is little relationship between the questions posed by the court and the replies made by psychiatrists."[23]

We also found tremendous variety among the court orders. In 252 of the cases (52.61%), the court ordered simply that the examining facility conduct a "mental" or "psychiatric" examination or a "Chapter 552 examination" (Chapter 552 is the statutory chapter governing the pre-trial examination process.) The other court orders were more specific in that they raised particular issues; however, there was little uniformity from one jurisdiction to another. The orders also varied in the degree of specificity. At one end of the spectrum were orders seeking an opinion only into competency to stand trial. At the other end were orders requesting an opinion on the issues of competency, responsibility, diminished capacity, the need for hospitalization, the existence of mental disease or defect, the presence of psychosis and the presence of mental retardation or brain damage. It appeared that each court had its own "form" order which it used to order all pre-trial examinations. The orders did not appear to be tailored to the individual, asking specific questions about the defendant based on the peculiarities of his or her case. Rather, the orders served only as the mechanical means by which the examination process was initiated. In most cases, they did little to define the issues the mental health system was to address.

For its part, the mental health system largely ignored the court orders. Instead, the clinical report responded to perceived **statutory** requirements. The applicable Missouri statute under which examinations were ordered also stated that "A report of the psychiatric examination shall include:

(1) Detailed findings;
(2) An opinion as to whether the accused has a mental disease or defect, and the duration thereof;

(3) An opinion as to whether the accused, as a result of a mental disease or defect, lacks capacity to understand the proceedings against him or to assist in his own defense;
(4) An opinion as to whether, at the time of the alleged criminal conduct, the accused, as a result of mental disease or defect, did not know or appreciate the nature, quality or wrongfulness of his conduct or as a result of mental disease or defect was incapable of conforming his conduct to the requirements of law;
(5) A recommendation as to whether the accused should be held in custody in a suitable hospital facility for treatment pending determination by the court of the issue of mental fitness to proceed and
(6) A recommendation as to whether the accused, if found by the court mentally fit to proceed, should be detained in such hospital facility pending further proceedings."[24]

•

The statute did not limit the court from raising or the clinician from responding to other relevant issues. In fact, the code also permitted evidence of mental disease or defect to be admitted on the issue of whether the defendant had the requisite mental state for commission of the offense.[25] This enabled the defendant to establish the limited defense known variously as the "partial responsibility" or "diminished capacity" doctrine. Psychiatric evidence was also admissible in determining whether an individual charged with a capital offense should be sentenced to death.[26]

We found that the clinical reports inevitably addressed the six issues that the statute noted explicitly. This was often true even when the courts asked for an opinion on another issue. For example, the courts asked specifically for an opinion on the issue of diminished responsibility in 63 cases. The examiner addressed the issue in only 46 cases (73%). In more than a quarter of the cases in which the issue was raised, the examiner ignored it.

In a number of other cases, the court asked only for an opinion on competency to stand trial; however, the examiner inevitably reported on competency, responsibility and the need for hospitalization. There were two cases (discarded for the purposes of this study) in which the court asked for a presentence evaluation under another chapter of the code. The clinical report addressed competency, responsibility and the need for hospitalization.

## Communication: Defense Counsel

By statute, certain information is to be made available to the examiner. This information includes the police report, a summary of facts surrounding the alleged offense, a description of the client's behavior while under arrest, an opinion as to whether the client has "a violent nature" and the degree of security that seems appropriate.[27] The statute, by its terms, recognizes the need for exchange of information between systems.

The defense attorney most frequently requests pre-trial evaluations.[28] The attorney represents a potentially valuable source of information about the defendant and the circumstances of the alleged offense. The importance of communication between counsel and the examiner would seem to be self-evident. This is true particularly when the charges, and hence the penalties for conviction, are more serious. For example, in capital cases, psychiatric evidence may play a critical role in the penalty giver's decision to assess or withhold the death penalty.[29] In other serious cases, psychiatric evidence may result in a conviction on a lesser offense with a less serious penalty attaching. This may occur either through the diminished responsibility doctrine or through the much more frequent means of plea bargaining. In each of these cases, and on the issue of responsibility at the time of the offense, the clinician must rely in large part on the reconstruction of **factual** material about the defendant, his or her life and the circumstances of the alleged offense. Presumably, the one person nearly as well situated (or, in some cases, better situated) as the defendant to provide this information is the defense attorney.

Despite the potentially valuable source of information represented by counsel, even the identity of the defense attorney could not be determined from DMH files in nearly half of the cases (212 or 44.26%). This figure varied greatly among facilities. Table 7 shows, by facility, the number of cases in which the files revealed the identity of counsel.

In those facilities (Western Missouri, Farmington) where the examiner was more likely to know the identity of defense counsel, the local courts had arrangements for making such information known. This most frequently involved sending a standard form to the facility which contained information about the defendant and his or her case.

In those cases where the attorney was unknown, a source of potentially valuable information went untapped. One can state with reasonable certainty that the lack of communication between counsel and examiner would have an impact on subsequent proceedings. For example, if the clinical report was unclear, it is unlikely that clarifications would be made. If the report did not address the issues of concern to counsel, those issues would simply go unaddressed. The authors of one study noted that "Our own dealings with the various courts were most satisfactory when we were able to have repeated or ongoing contacts, contacts which consisted, moreover, not only of formal written reports and sworn testimony, but of informal phone conversations, pre-trial conferences and in-the-corridor exchanges as well."[30]

In 1978, in Missouri, the contact between criminal justice and mental health systems usually involved only the court order and the clinical report. The orders were "form" orders in the literal sense of the word, either drafted by defense counsel or used as a matter of routine by a jurisdiction in ordering all pre-trial examinations. The clinical reports responded to a statute rather than the order. When issues like diminished responsibility

Table 7: Identity of Defense Counsel Revealed in Files

| Facility | Number of Exams | Attorney Known (%) | Attorney Unknown (%) |
|---|---|---|---|
| Fulton (Biggs Unit) | 230 | 131 (56.96) | 99 (43.04) |
| Bliss | 96 | 21 (21.86) | 75 (78.14) |
| Western Missouri | 46 | 36 (78.26) | 10 (21.74) |
| St. Joseph | 19 | 12 (63.16) | 7 (36.84) |
| Farmington | 64 | 53 (82.81) | 11 (17.19) |
| Burrell | 11 | 10 (90.91) | 1 ( 9.09) |
| Nevada | 14 | 5 (35.71) | 9 (64.29) |
| **Total** | **480** | **268 (55.83)** | **212 (44.17)** |

were raised in the court order, they were often not addressed in the report. A lack of communication between defense counsel and examiner appears to have been very much the rule rather than the exception. It is the perceived ability of the mental health system to individuate between defendants that is its most important contribution to the criminal justice system. This role demands that the process of communication between systems be reflective; in Missouri, it was simply reflexive. Our findings suggest a significant diminution of the individualizing role that is the basis for the mental health professional's involvement in the criminal justice system.

## Clinical Responses: Diagnosis, Competency, Responsibility, Predictions

The next section summarizes the information given to the court in the clinical reports. Two types of information are particularly important. These are the clinical findings concerning the individual and the response of the examiner to the legal questions posed by the referring court. Because of its apparent impact on the response to the legal questions, the diagnosis is the most important piece of clinical information.

### Diagnosis

The diagnosis may be the single most important determinant in the clinician's response to questions of competency and responsibility. Several authors have noted the tendency of examiners to associate psychosis with incompetency and lack of responsibility. Conversely, the absence of psychosis is associated with competency and responsibility.[31] McGarry has noted that the legal questions "Presumably are subsumed, in the eyes of the psychiatrist, under the medical diagnosis and follow uniformly under the psychosis - nonpsychosis criterion."[32]

Table 8 shows, by facility, the distribution of primary diagnoses:

There are several differences among facilities in their use of certain diagnoses. For example, the Biggs Unit diagnosed 31.3% of its caseload as substance abusers, against an overall facility average of 18.54%. Some facilities, e.g., WMMHC, diagnosed a large percentage of cases as "no mental disorder" and very few cases as "antisocial." Others, e.g., Farmington and Bliss, did the opposite; however, it is those diagnoses suggestive

of psychoses that are the most interesting. These are the diagnoses that are most likely to affect the clinical response to the questions of competency and responsibility.

The average rate of psychosis is 23.75%, comprised of 16.87% schizophrenia, 4.34% manic-depressive and 2.5% other psychoses. The rate of psychosis among the pre-trial population is consistent with that of all admissions to Department facilities for the mentally ill. In the period July 1, 1977-June 30, 1979, Department facilities diagnosed 27.27% of all admissions as psychotic.[33] The presence of psychosis among the pre-trial population is higher than that reported by Laczko (16.8%).[34] It is comparable to the 27.5% reported as psychotic by Bluestone.[35] The figure is lower than the 47% psychotic reported by Cooke, et al, in their Michigan study.[36]

The facilities differed substantially in the rate at which they found psychosis. Bliss, which had the highest incidence of psychiatric history among its caseload, also had the highest percentage of psychosis (44.79%). WMMHC was at the other end of the spectrum diagnosing only 4.34% of its cases as psychotic.

The rate of psychosis among the Bliss examinees is consistent with the rate of psychosis among all admissions to Bliss in the years 1977-79. The rate among pre-trial examinees was 44.79% psychotic, among all admissions to Bliss, the rate was 47.63%. This was the highest rate of psychosis among Department facilities for those years. It is beyond the scope of this paper to analyze the reasons that Bliss patients had a higher rate of psychosis than patients admitted to other Department facilities; however, as the discussion of responsibility will show, this higher rate did have an impact on the number of individuals found not responsible at the time of the offense.

## Response to Legal Questions: Overview

The clinical reports addressed both competency to stand trial and responsibility at the time of the offense. Table 9 shows, by facility, the opinions given on these two issues.

The opinions on competency and responsibility in individual cases fell into several categories. Table 10 shows these categories by facility:

**Table 8: Diagnosis by Facility**

| Facility | Number of Cases | No Mental Disorder | Anti-social | Substance Abuse | Psychoses | Other Affective Disorders | Personality and Adjustment Disorders | MR | OBS/ Epilepsy | Not Given | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Fulton (Biggs)** | **230** | **9.13** | **10.43** | **31.30** | **21.31** | **1.30** | **8.69** | **5.65** | **5.22** | **6.96** | **100%** |
| Bliss | 96 | 3.12 | 26.04 | 8.33 | 44.79 | 2.08 | 1.04 | 7.29 | 2.08 | 5.22 | 100% |
| Farmington | 64 | 7.81 | 23.44 | 10.95 | 14.06 | 3.12 | 21.87 | 15.62 | 3.13 | 0 | 100% |
| WMMHC | 46 | 39.13 | 6.52 | 2.18 | 4.34 | 0 | 8.69 | 6.52 | 2.18 | 30.43 | 100% |
| St. Joseph | 19 | 20.31 | 21.05 | 0 | 31.58 | 5.26 | 0 | 5.26 | 0 | 10.53 | 100% |
| Burrell | 11 | 0 | 9.09 | 0 | 18.18 | 0 | 0 | 0 | 9.09 | 63.64 | 100% |
| Nevada | 14 | 21.43 | 14.28 | 7.14 | 21.43 | 7.14 | 0 | 7.14 | 21.43 | 0 | 100% |
| **Total** | **480** | **11.46** | **15.42** | **18.54** | **23.74** | **1.88** | **8.12** | **7.29** | **4.37** | **9.18** | **100%** |

## The Question of Competency

All facilities combined reported that 86.25% of the examinees were competent to stand trial. There was little difference on this issue among the four facilities that evaluated the most cases (Biggs, Bliss, Farmington, WMMHC). Other studies report much lower findings of competency. For example, Pfeiffer reports as competent 62% in a sample of 89.[37] Geller and Lister report 64.29% competent in a sample of 84 cases.[38] Laczko reports 72.9% competent in a sample of 435 cases.[39] Other studies report 62% competent in a sample of 174 cases[40] and 65.25% competent in 518 cases.[41]

The percentage of defendants reported as competent is 14-24% higher in this study than in the others; however, all facilities but Nevada (which evaluated only 14 cases) found more individuals competent than responsible. The difference in the findings ranged from 8.26% at Fulton (86.09% competent, 77.83% responsible) to 32.3% at Bliss (84.38% competent, 52.08% responsible). For all facilities, the average difference was 14.17% (86.25% competent, 72.08% responsible). These figures suggest that Missouri's examiners preferred reporting that defendants were not responsible at the time of the offense rather than incompetent to stand trial.

The 72.08% reported as responsible at the time of the offense is similar to the percentage of cases found competent in the other cited studies. In most jurisdictions, a finding of either incompetency to stand trial or lack of responsibility at the time of the offense results in disposition through the mental health rather than criminal justice system. When one compares the figures for **responsibility** in this study to the figures for **competency** in the other studies, Missouri examiners gave findings that could result in dispositions through the mental health system in about the same percentage of cases as did their colleagues elsewhere. The difference is that in Missouri the statute directed the examiner to inquire both into competency and responsibility. The examiners much more frequently chose lack of responsibility as the route by which the potentially exculpating information was reported.

The rationale for this apparent preference may be based upon the difference in dispositions for the incompetent defendant and the defendant acquitted by reason of insanity. An acquittal by reason of insanity disposes completely of the charges against the defendant. Under the statute, the result is commitment for treatment to the Department of Mental Health. The treating facility retains a significant amount of freedom in choosing the site of treatment for the person so committed. He or she may be transferred between facilities or placed in community placement or on conditional release status without prior court approval.

In contrast, if the individual is found incompetent to stand trial, he or she is committed to the Department only until competency is restored. The court retains jurisdiction, and the patient may stand trial later. While the defendant is in Department custody, he or she must remain in the treating facility until the court disposes of the case in some fashion. Geller and

Lister, who report an even wider difference between the percentage of defendants reported as incompetent and the percentage reported as not responsible, speculated that the latter type of disposition may "Reflect, at least in part, the bias of health professionals who spend most of their time caring for the ill."[42] Our data suggest that this hypothesis is correct.

## The Question of Responsibility and Diagnosis

All facilities combined reported that 127 of the examinees (26.46%) were not responsible at the time of the offense. These examinees fell into two major groups: those considered not responsible but competent (67, or 13.96% of all examinees); and those considered not responsible and incom-

**Table 9: Facility Competency and Responsibility Opinions**

| Facility | No. | Competent | Incompetent | Competency Deferred | Responsible | Not Responsible | Responsibility Deferred |
|---|---|---|---|---|---|---|---|
| Fulton (Biggs) | 230 | 198 (86.09) | 32 (13.91) | 0 | 179 (77.83) | 49 (21.30) | 2 ( .87) |
| Bliss | 96 | 81 (84.38) | 15 (15.62) | 0 | 50 (52.08) | 46 (47.92) | 0 |
| Farmington | 64 | 61 (95.31) | 3 ( 4.69) | 0 | 52 (81.25) | 11 (17.19) | 1 ( 1.56) |
| Western Mo. | 46 | 42 (91.30) | 4 ( 8.70) | 0 | 37 (80.43) | 9 (19.57) | 0 |
| St. Joseph | 19 | 16 (84.21) | 2 (10.53) | 1 ( 5.26) | 12 (63.16) | 5 (26.31) | 2 (10.53) |
| Burrell | 11 | 8 (72.73) | 3 (27.27) | 0 | 7 (63.64) | 4 (26.36) | 0 |
| Nevada | 14 | 8 (57.14) | 4 (28.57) | 2 (14.29) | 9 (64.28) | 3 (21.43) | 2 (14.29) |
| **Total** | **480** | **414 (86.25)** | **63 (13.13)** | **3 ( .62)** | **346 (72.08)** | **127 (26.46)** | **7 ( 1.46)** |

**Table 10: Facility Opinions on Legal Issues: All Categories**

| Facility | Number | Competent and Responsible | Competent, but not Responsible | Incompetent; not Responsible | Competent; Responsibility Deferred | Incompetent; Responsibility Deferred | Incompetent; Responsible | Competency Deferred; not Responsible | All Issues Deferred |
|---|---|---|---|---|---|---|---|---|---|
| Fulton (Biggs) | 230 | 177 (76.96) | 19 ( 8.26) | 30 (13.04) | 2 ( .87) | 0 | 2 ( .87) | 0 | 0 |
| Bliss | 96 | 50 (52.08) | 31 (32.29) | 15 (15.63) | 0 | 0 | 0 | 0 | 0 |
| Farmington | 64 | 52 (81.25) | 8 (12.50) | 3 ( 4.69) | 1 (1.56) | 0 | 0 | 0 | 0 |
| Western Mo. | 46 | 37 (80.43) | 5 (10.87) | 4 ( 8.70) | 0 | 0 | 0 | 0 | 0 |
| St. Joseph | 19 | 13 (68.43) | 3 (15.79) | 1 ( 5.26) | 0 | 1 (5.26) | 0 | 1 (5.26) | 0 |
| Burrell | 11 | 7 (63.64) | 1 ( 9.09) | 3 (27.27) | 0 | 0 | 0 | 0 | 0 |
| Nevada | 14 | 8 (57.14) | 0 | 3 (21.43) | 0 | 0 | 1 (7.14) | 0 | 2 (14.29) |
| **Total** | **480** | **344 (71.67)** | **67 (13.96)** | **59 (12.29)** | **3 ( .62)** | **1 ( .21)** | **3 ( .62)** | **1 ( .21)** | **2 ( .42)** |

petent (59, or 12.29% of all examinees). One examinee (.20%) was considered not responsible, with an opinion on competency deferred.

As expected, the incidence of psychosis is much higher among those considered not responsible than those considered responsible. The tendency of clinicians and attorneys to view psychosis as indicative of a lack of responsibility has been noted.[43] Table 11 shows the major diagnostic categories and their distribution among the reports of "competent and responsible," "competent and not responsible" and "incompetent and not responsible."

71.14% of the "competent and not responsible" and 72.88% of the "incompetent and not responsible" were diagnosed as psychotic. In contrast, less than 5% of those considered competent and responsible received such a diagnosis. Other studies report a comparable percentage of psychosis among those whom the examiners considered incompetent. For example, Roesch reports that 69% of the incompetent among his cohorts were considered psychotic.[44] Pasewark and Steadman report that 69% of those acquitted by reason of insanity in New York in the years 1971-76 were psychotic.[45] These figures suggest that Missouri clinicians, like their colleagues, equated psychosis with lack of responsibility and/or lack of competency. Also, like their colleagues, they equated an absence of psychosis with competency and responsibility.

The use of the diagnosis "substance abuse" is also noteworthy. Five of the 67 examinees considered "competent but not responsible" (7.46% of this category) received this as their primary diagnosis. The Missouri statute, in defining "mental disease or defect" (the prerequisite for a defense of nonresponsibility) excludes by its terms "alcoholism without psychosis or drug abuse without psychosis."[46] There was evidence in the clinical reports that the defendants diagnosed as "substance abusers" were reported as not responsible because they were intoxicated at the time of the offense. The presence of psychosis was generally not noted. The simple loosening of inhibitions as a result of alcohol consumption was equated with the "irresistible impulse" prong of the test for criminal responsibility.

The use of the diagnosis "mental retardation" is also interesting. Five of the competent but not responsible (7.46%) and six of the incompetent and not responsible (10.17%) were diagnosed "mentally retarded." In all but one of these cases, the retardation was characterized as "mild." These cases suggest a tendency to equate mental retardation with lack of responsibility and incompetency. Roesch also found that the incompetent in his study were most frequently diagnosed either as psychotic or mentally retarded.[47] 13.84% of his sample were in the latter category. Such a connection between medical diagnosis and the legal questions, particularly in the case of the "mildly" retarded, suggests that the desire of mental health professionals for disposition involving treatment may control their response to the questions of competency and responsibility.

Table 11: Diagnoses and Opinions on Legal Issues

| Diagnoses | Competent and Responsible No. | % | Competent and not Responsible No. | % | Incompetent and not Responsible No. | % | Total No. | % |
|---|---|---|---|---|---|---|---|---|
| No Mental Disorder | 54 | ( 15.70) | 1 | ( 1.49) | 0 | ( 0 ) | **55** | **( 11.46)** |
| Antisocial | 73 | ( 21.22) | 0 | ( 0 ) | 0 | ( 0 ) | **74**[1] | **( 15.42)** |
| Substance Abuse | 83 | ( 24.13) | 5 | ( 7.46) | 0 | ( 0 ) | **89**[2] | **( 18.54)** |
| Psychosis | 17 | ( 4.94) | 48 | ( 71.64) | 43 | ( 72.88) | **114**[3] | **( 23.75)** |
| Other Affective Disorders | 7 | ( 2.03) | 2 | ( 2.99) | 0 | ( 0 ) | **9** | **( 1.88)** |
| Personality and Adjustment Disorders | 38 | ( 11.05) | 0 | ( 0 ) | 1 | ( 1.69) | **39** | **( 8.12)** |
| MR | 24 | ( 6.98) | 5 | ( 7.46) | 6 | ( 10.17) | **35** | **( 7.29)** |
| OBS/Epilepsy | 7 | ( 2.03) | 3 | ( 4.48) | 9 | ( 15.25) | **21**[4] | **( 4.37)** |
| Not Given | 41 | ( 11.92) | 3 | ( 4.48) | 0 | ( 0 ) | **44** | **( 9.17)** |
| **Total** | **344** | **(100.00)** | **67** | **(100.00)** | **59** | **(100.00)** | **480** | **(100.00)** |

[1]This includes one client deemed competent, with responsibility deferred.
[2]This includes one case where opinion was deferred on all issues.
[3]This includes two cases deemed competent, with responsibility deferred, and two deemed incompetent, but responsible; one deemed not responsible with competency deferred and one deemed incompetent with responsibility deferred.
[4]This includes one case deferred on all issues and one case deemed responsible, but incompetent.

## Individual Facility Response to Responsibility Question and Diagnosis

Individual facilities responded to the issue of responsibility in the following way: Farmington (17.19% not responsible), WMMHC (19.57%), Biggs Unit (21.3%), Nevada (21.43%), St. Joseph (26.31%), Burrell (27.36%), Malcolm Bliss (47.92%).

There is no established norm for the percentage of pre-trial examinees that can be expected to be found responsible at the time of the offense; however, the figure for Malcolm Bliss (47.92%, or nearly one-half of its cases found not responsible) is much higher than the figures for the other facilities. The primary reason for this difference appears to be the fact that Bliss found clients to be psychotic in a much higher percentage of its cases than did the other facilities. A secondary reason is that the existence of a psychiatric history appears to have had a greater impact on findings regarding responsibility at Bliss than at the other facilities.

The percentage of examinees found psychotic by Bliss (44.79%) was about twice the percentage receiving that label at the Biggs Unit (21.31%), about three times the percentage at Farmington (14.06%) and more than 10 times the percentage at WMMHC (4.34%). Most of those diagnosed as psychotic were also found not responsible. For example, Bliss found 81.39% of its psychotics to be not responsible; Fulton, 79.59% and Farmington, 89.88%. Those considered not responsible tended to be psychotic;

as noted, more than 70% of the "not responsible" received such a diagnosis. Given these facts, one could anticipate that the facility with the highest percentage of psychosis among its caseload would also have the highest percentage of "not responsible" findings. This, in fact, was the case with Bliss. This does not address the issue of whether the diagnosis came before or after the finding of lack of responsibility. Nor does it address the issue of whether the connection between psychosis and non-responsibility should be made as easily as it apparently is. It does suggest that the diagnostic tendencies of a facility or examiner may have a great impact on the fate of criminal defendants. For example, in this study, clients referred to Bliss had a much higher chance of being labeled psychotic and, therefore, not responsible as did those referred to other facilities.

The existence of a psychiatric history also apparently had more impact on the question of responsibility at Bliss than at the other facilities. As noted earlier, 79.17% of the Bliss population reportedly had a psychiatric history. The average for all facilities was 63.96%. Table 12 shows, by facility, the response to the questions of competency and responsibility in the case of those with psychiatric histories. (Ten cases are omitted from this table because opinions on the legal issues did not fall into the categories of "competent but responsible," "competent but not responsible" or "incompetent and not responsible.")

Of the four facilities with the largest caseloads, Fulton found 74.81% of those with histories to be competent and responsible; Farmington, 79.49%; WMMHC, 75.00% and Bliss 46.05%. The importance of psychiatric history as an outcome-indicator cannot be completely measured without more detailed analysis of the content of each individual history; however, the figures do suggest that it was more of a factor at Bliss than elsewhere.

## Responsibility and the Criminal Offense

Findings that the defendant was not responsible at the time of the offense were distributed unevenly by offense. Table 13 shows the number of referrals for each offense, and the number and percentages of defendants within each offense category found competent and responsible, competent but not responsible and incompetent and not responsible.

**Table 12: Individuals with Psychiatric History and Response to Legal Questions**

| Facility | No. with History | Competent but Responsible (%) | Competent but not Responsible (%) | Incompetent and not Responsible (%) |
|---|---|---|---|---|
| Fulton (Biggs) | 135 | 101 ( 74.81%) | 11 ( 8.15%) | 23 (17.04%) |
| Bliss | 76 | 35 ( 46.05%) | 26 (34.21%) | 15 (19.74%) |
| Farmington | 39 | 31 ( 79.49%) | 6 (15.38%) | 2 ( 5.13%) |
| WMMHC | 28 | 21 ( 75.00%) | 4 (14.29%) | 3 (10.71%) |
| St. Joseph | 11 | 7 ( 63.64%) | 3 (27.27%) | 1 ( 9.09%) |
| Nevada | 6 | 4 ( 66.67%) | 0 ( 0 ) | 2 (33.33%) |
| Burrell | 3 | 3 (100.00%) | 0 ( 0 ) | 0 ( 0 ) |
| **Total** | **298** | **202 ( 67.78%)** | **50 (16.78%)** | **46 (15.44%)** |

The difference in the examiners' response to the various offenses against person is striking. For example, 91.67% of those charged with capital murder and 93.10% of those charged with rape were found competent and responsible. In contrast, 71.43% of those charged with first and second degree homicide and 57.83% of those charged with assault fell into this category.

Again, the role of the diagnosis of psychosis appears to be largely responsible. Only 5.5% of those charged with capital murder and 10.34% of those charged with rape were diagnosed as psychotic. This compares to 25.71% of those charged with first and second degree murder and 32.53% of those charged with assault. Those found psychotic tended to be found not responsible. As the incidence of psychosis within a given offense category rises, one can expect to find a correspondingly higher percentage of findings of lack of responsibility at the time of the offense.

**Table 13: Legal Opinions Within Each Offense Category**

| Offense | No. | Competent and Responsible | Competent but not Responsible | Incompetent and not Responsible | Incompetent; Responsible |
|---|---|---|---|---|---|
| Capital Murder | 36 | 33 ( 91.67) | 1 ( 2.78) | 2 ( 5.55) | 0 |
| Murder | 35 | 25 ( 71.43) | 6 (17.14)[1] | 2 ( 5.71) | 0 |
| Manslaughter | 2 | 2 (100.00) | 0 | 0 | 0 |
| Rape | 29 | 27 ( 93.10) | 0 | 2 ( 6.90) | 0 |
| Robbery | 41 | 29 ( 70.73) | 5 (12.20) | 6 (14.63) | 1 (2.44) |
| Assault | 83 | 48 ( 57.83) | 20 (24.10)[2] | 13 (15.66) | 0 |
| Child Molestation | 17 | 14 ( 82.35) | 0 | 3 (17.65) | 0 |
| Sodomy | 5 | 4 ( 80.00) | 0 | 1 (20.00) | 0 |
| Incest | 1 | 1 (100.00) | 0 | 0 | 0 |
| Other Sex Offenses | 7 | 4 ( 57.14) | 1 (14.29) | 2 (28.57) | 0 |
| Arson | 12 | 8 ( 66.67) | 2 (16.67) | 1 ( 8.33) | 1 (8.33) |
| Kidnap | 6 | 5 ( 83.33) | 1 (16.67) | 0 | 0 |
| Burglary/Theft/Larceny | 72 | 48 ( 66.67) | 7 ( 9.72)[3] | 15 (20.83) | 1 (1.39) |
| Weapons Offenses | 17 | 8 ( 47.06) | 5 (29.41)[4] | 3 (17.65) | 0 |
| Auto Theft | 25 | 18 ( 72.00) | 7 (28.00) | 0 | 0 |
| Other Vehicles Offenses | 8 | 7 ( 87.50) | 1 (12.50) | 0 | 0 |
| Possession/Sale of Drugs | 14 | 11 ( 78.57) | 1 ( 7.14) | 2 (14.29) | 0 |
| Possession of Stolen Property | 2 | 2 (100.00) | 0 | 0 | 0 |
| Fraud/Bad Checks | 15 | 11 ( 73.33) | 2 (13.33) | 2 (13.33) | 0 |
| Forgery | 13 | 12 ( 92.31) | 0 | 1 ( 7.69) | 0 |
| Driving While Intoxicated (DWI) | 5 | 3 ( 60.00) | 1 (20.00) | 1 (20.00) | 0 |
| Escape | 10 | 10 (100.00) | 0 | 0 | 0 |
| Parole Violation | 4 | 2 ( 50.00) | 2 (50.00) | 0 | 0 |
| Leaving Scene of an Accident | 4 | 1 ( 25.00) | 3 (75.00) | 0 | 0 |
| Other | 14 | 8 ( 57.14) | 2 (14.28)[5] | 3 (21.43) | 0 |
| Unknown | 3 | 3 (100.00) | 0 | 0 | 0 |

[1]In two cases (5.71%), the individuals were competent, with responsibility deferred.
[2]In two cases (2.41%), opinions were deferred on all issues.
[3]In one case (1.39%), the individual was competent, with responsibility deferred.
[4]In one case (5.88%), the individual was incompetent, with responsibility deferred.
[5]In one case (7.14%), the individual was not responsible, with competency deferred.

As noted above, homicide, rape and other offenses against person are referred relative to arrest rate much more frequently than most other offenses. At the same time, examiners make very few findings either of incompetency or lack of responsibility. This led Cooke to conclude that referrals of these offenses were based on strategies unrelated to concern over the defendant's mental status. He concurred with Mathews' conclusions that these strategies involved attempts to remove public pressure for punishment, to avoid a jury trial on the issue of responsibility or to lay the groundwork for an insanity plea in cases where conviction would result in a lengthy sentence.[48] Steadman drew similar conclusions in his study of New York defendants found incompetent to stand trial.[49]

Our data also support these conclusions. Capital murder and rape, in particular, are often referred; the referrals seldom result in a report either of incompetency or lack of responsibility. We would add a fourth reason in explaining why the process works in this fashion. In many of these cases, it is likely that defense counsel simply has no viable defense to a charge carrying a very serious penalty. Psychiatric evidence, whether used in plea bargaining, at trial or at sentencing, offers the only hope for mitigating the degree of guilt or alleviating the sentence. The defendant literally has nothing to lose; he seldom pays for the cost of examination. The only surprise is that defendants charged with serious offenses are not referred more frequently.

## Predictions of Behavior

The pre-trial examination focuses on the issues of competency to stand trial and responsibility at the time of the offense. An inquiry into responsibility is entirely retrospective, as the examiner attempts to reconstruct a defendant's state of mind during the commission of an offense that occurred weeks or months in the past. The inquiry into competency focuses on the defendant's current mental state. It is predictive only in the sense that the clinician must assess the defendant's ability to withstand the stress of a trial that may occur some months in the future; however, such a prediction has nothing to do with the client's potential for future **criminal** behavior.

Though speculation about the client's future behavior is irrelevant, at least one study found that clinicians frequently made such predictions in reports on competency and responsibility.[50] The predictive ability of clinicians is under increasing attack, with legal commentators in particular arguing that such predictions should be accorded no weight in legal proceedings.[51] We looked for two types of predictions in this study. First, did the examiner predict that the client would engage again in the behavior which formed the underlying basis for the criminal charge? Second, did the examiner make any other prediction or statement concerning future behavior by the client?

In each case, only a handful of predictions were made. With respect to future criminal behavior, in 15 (3.12%) cases, the examiner made a state-

ment that could be construed as a prediction that the defendant might recidivate. In 454 cases (94.58%), the examiner made no prediction concerning future criminal acts. In 11 cases, (2.29%) information on this issue was not available.

With respect to the client's future, non-criminal behavior, the examiner made no prediction in 458 cases (95.42%). In 11 cases (2.29%), the examiner commented on future behavior. In most of these cases, this consisted of a warning that the client presented a serious risk of suicide and that precautionary measures should be taken by his or her custodian. In 11 cases, (2.29%) the information was not available.

This low rate of prediction is probably attributable in large measure to the rigid adherence to the statutory requirements for clinical reports noted earlier in this paper. The statute did not direct the examiner to inquire into the future behavior of the defendant. Therefore, the issue was largely ignored.

## Summary

This study enabled us to reach several conclusions about the pre-trial examination process in Missouri.

First, despite the absence of standards governing the referral process, courts did not rely wholly on the maximum security Biggs Unit to provide examinations in cases involving offenses against another person. Except in the case of homicide, the percentage of such cases referred to Biggs did not differ significantly from the percentage of all cases referred to Biggs. This was contrary to our expectations. At the same time, more than one quarter of the defendants referred to Biggs had been charged with property offenses. If the criminal charge is used as an indicator of the degree of security required, these referrals represent an inappropriate use of maximum security.

Second, the study resulted in a description of the population referred for examination in Missouri. This population is predominantly young (mean age 28.7), Caucasian (66.67%) and male (93.13%). A majority (63.96%) had a psychiatric history; 40% had at least one prior criminal conviction. As a whole, the population is not dissimilar to populations described in other studies.

Third, the process of communication between criminal justice and mental health systems in Missouri is very formalistic. Courts rely on "form" orders to initiate examinations. The orders are seldom tailored to the individual case. The examiners respond to issues cited in Missouri statutes rather than in the court orders. The rigid adherence to statutory language impedes consideration of pertinent issues raised occasionally by the courts. The issue of diminished responsibility provides the most striking example—in more than a quarter of the cases in which the courts raised it, the clinical report did not address it. Defense counsel appears to be largely uninvolved in the examination process, despite the source of information

represented by counsel. In nearly one-half of the cases, the **identity** of defense counsel could not be ascertained from facility files. These findings suggest that the critical role of the mental health system in individualizing defendants is diminished.

Fourth, examiners preferred reporting that a defendant was not responsible at the time of the offense rather than incompetent to stand trial. The reason for this preference appears to lie in the disposition which results from an acquittal by reason of insanity. Such a finding disposes of the criminal charges. The defendant is committed to DMH for treatment. The treating facility largely controls the type and site of treatment. In contrast, charges often remain pending against the incompetent defendant. The treating facility enjoys little freedom in determining where treatment will occur; the facility must provide treatment within its confines.

Fifth, the examiners tend to associate psychosis with a lack of responsibility. This association has been noted in other studies. The fact that one facility (Bliss) found 47.92% of its population "not responsible," a figure nearly twice that of any other facility, is explicable in light of the fact that Bliss also found a much higher percentage of its caseload to be psychotic. The presence of "psychotic" findings within offense categories also appears to explain the differences in the percentage of "not responsible" findings within those categories.

Sixth, our findings support the conclusions of Mathews, Cooke and Steadman that referrals for examination of defendants charged with serious offenses against person reflect strategies unrelated to concern over the mental status of the defendant. In addition to the reasons advanced in their reports, the referrals presumably also reflect the unavailability of any factual defense to the charges. The defendants face serious charges with serious penalties attaching upon conviction. Lacking a factual defense, counsel seeks clinical evidence that would assist in mitigating guilt or punishment in plea bargaining, at trial or at sentencing.

Data like these are indispensable in the development and management of a forensic services program. It is difficult to manage a system without an empirically based understanding of the manner in which that system operates. At the same time, additional studies are needed, both in Missouri and in other jurisdictions. The information base developed to date is not yet firm enough to enable policy makers to speak with absolute certainty about the workings of the processes they debate.

### References


1. Steadman, H.: Insanity Acquittals in New York State, 1965-78. Am. J. Psychiat., 137:321-326, 1980, at 325.
2. Petrila, J.: A Proposal for Missouri Forensic Services in the Eighties. Missouri Department of Mental Health, 1980.
3. Section 610.105, Revised Statutes of Missouri, 1978.
4. Mental Health Care in Missouri's Criminal Justice System: A Report of the Committee on State Institutions and Property of the Missouri House of Representatives. General Assembly of Missouri, 1978.

5. Section 552.020, Revised Statutes of Missouri, 1978.
6. Section 552.030, Revised Statutes of Missouri, 1978.
7. Bluestone, H. and Melella, J.: A Study of Criminal Defendants Referred for Competency to Stand Trial in New York City. Bull. Amer. Acad. Psychiat. Law. 7(4), 166-178, 1979.
8. Geller, J. and Lister, E.: The Process of Criminal Commitment for Pre-Trial Psychiatric Examination: An Evaluation. Am. J. Psychiat. 135:53-63, 1978.
9. Pfeiffer, E.; Eisenstein, R. and Dabbs, E.G.: Mental Competency Evaluation for the Federal Courts: I. Methods and Results. J. of Nerv. and Mental Disease 144:320-328, 1967.
10. 1978-79 Annual Report. St. Louis Metropolitan Police Department, 1979.
11. Laczko, J.; James, J.F. and Alltop, L.: A Study of 435 Court-Referred Cases. J. of Forensic Sciences 15:311-323, 1970.
12. Bluestone, H. and Melella, J.: op. cit., n. 7.
13. McGarry, A.L.: A Review of Court Observation Cases at Boston State Hospital in 1960. Boston Med. Quart. 16:59-63, 1965.
14. Laczko, J.; James, J.F. and Alltop, L.: op. cit., n. 11.
15. Bluestone, H. and Melella, J.: op. cit., n. 7.
16. Laczko, J.; James, J.F. and Alltop, L.: op. cit., n. 11.
17. Rollin, H.R.: Unprosecuted Mentally Abnormal Offenders. Brit. Med. J. 1:831-835, 1965.
18. Pasewark, R.; Pantle, M. and Steadman, H.: Characteristics and Disposition of Persons Found Not Guilty by Reason of Insanity in New York State. Am. J. Psychiat. 136:655-660, 1979.
19. Steadman, H. and Braff, J.: Crimes of Violence and Incompetency Diversion. J. of Criminal Law and Criminology 66:73-78, 1975.
20. Cooke, G.; Johnston, N. and Pogany, E.: Factors Affecting Referral to Determine Competency to Stand Trial. Am. J. Psychiat. 130:870-875, 1973.
21. 1978-79 Annual Report: op. cit., n. 10.
22. Pfeiffer, E.; Eisenstein, R. and Dabbs, E.G.: Mental Competency Evaluation for the Federal Courts: II. Appraisal and Implications. J. of Nerv. and Mental Disease 145:18-24, 1967.
23. Geller, J and Lister, E.: op. cit., n. 8, at 58.
24. Section 552.020.3, Revised Statutes of Missouri, 1978.
25. Section 552.030.3(1), Revised Statutes of Missouri, 1978.
26. Section 552.030.3(2), Revised Statutes of Missouri, 1978.
27. Section 552.045, Revised Statutes of Missouri, 1978.
28. Mathews, A.: Mental Disability and the Criminal Law: A Field Study. American Bar Foundation, 1970.
29. See, e.g., Estelle v. Smith, 445 F. Supp. 647 (N.D. TX 1978), aff'd. 602 F.2d 694 (5th Cir. 1979), cert. granted, 48 USLW 3602 (1980).
30. Pfeiffer, E.; Eisenstein, R. and Dabbs, E.G.: op. cit., n. 22.
31. McGarry, A.L.: Competency to Stand Trial and Due Process Through the State Hospital. Am. J. Psychiat. 122:623-631, 1965; Mathews, A.: op. cit., n. 28; Roesch, R.: Determining Competency to Stand Trial: An Examination of Evaluation Procedures in an Institutional Setting. J. of Consulting and Clinical Psychology 47:542-550, 1979.
32. McGarry, A.L.: op. cit., n. 31, at 625.
33. Annual Report Summary. Missouri Department of Mental Health, 1978, 1979.
34. Laczko, J.; James, J.F. and Alltop, L.: op. cit., n. 11.
35. Bluestone, H. and Melella, J.: op. cit., n. 7.
36. Cooke, G.; Johnston, N. and Pogany E.: op. cit., n. 20.
37. Pfeiffer, E.; Eisenstein, R. and Dabbs, E.G.: op. cit., n. 22.
38. Geller, J. and Lister, E.: op. cit., n. 8.
39. Laczko, J.; James, J.F. and Alltop, L.: op. cit., n. 11.
40. Fitzgerald, J.; Peszke, M. and Goodwin, R.: Competency Evaluations in Connecticut. Hosp. and Community Psychiat. 29:450-453, 1978.
41. Arboleda-Florez, J.; Gupta, K and Alcock, A.: Two-Year Review of Court Examinations. Can. Psychiat. Assn. J. 20:469-475, 1975.
42. Geller, J. and Lister, E.: op. cit., n. 8, at 58.
43. See n. 31 and acompanying text.
44. Roesch, R.: op. cit., n. 31.
45. Pasewark, R.; Pantle, M. and Steadman, H.: op. cit., n. 18.
46. Section 552.010, Revised Statutes of Missouri, 1978.
47. Roesch, R.: op. cit., n. 31.
48. Cooke, G.; Johnston, N. and Pogany, E.: op. cit., n. 20.
49. Steadman, H. and Brass J.: op. cit., n. 19.
50. Geller, J. and Lister, E.: op. cit., n. 8.
51. Ennis, B and Litwack, T.: Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom. CA L. Rev. 62:693-752, 1974.

## Acknowledgment

The authors thank Paul Ahr, PhD, MPA, Director of the Missouri Department of Mental Health, who made available the financial resources that made this research possible. □