Guilty but Mentally Ill: The South Carolina Experience

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Thirty of the first 45 individuals to receive guilty but mentally ill (GBMI) verdicts in South Carolina were interviewed using a structured interview schedule for diagnosis. The relationship of diagnosis to pretrial evaluation and posttrial conviction treatment are discussed. No person received GBMI in a jury trial. Suggestions to improve the operation of the GBMI verdict are made, as well as a brief review of these data with data from other states.

Society's dilemma concerning the disposition of individuals suffering from mental illness and committing criminal acts is long-standing and has no simple, easily applied solutions. The Anglo-American system requires that individuals possess *mens rea*, a guilty mind, which implies that they have sufficient mental faculties to intend to do wrong. In the past, if the individual's mental illness produced delusions and criminal acts resulted from these delusions, the criminal justice system had sometimes excused the individual from punishment. This conflicted with society's demand for retribution and insistence upon protection from "dangerous individuals," particularly if the crime was highly publicized. Such was the case for the establishment of the first guilty but mentally ill (GBMI) verdict in the United States.

Michigan's Supreme Court decision in *People v. McQuillan*[1] stated that the individuals found not guilty by reason of insanity (NGRI) could not be confined indefinitely in a hospital. If persons found NGRI did not qualify for civil commitment, they were ordered released. As a result, 64 people were released into the community, two of whom committed serious crimes shortly thereafter. Public outcry was tremendous, and the Michigan Legislature responded by passing the first GBMI statute in 1975.

In their review of the application of the GBMI verdict in Michigan, Petrella *et al.*[2] emphasize the political pressures that arose from an increased number of NGRI verdicts as well as publicized crimes committed by released offenders. South Carolina adopted GBMI legislation in April 1984.[3] In part, the passage of the GBMI law in South Carolina was

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influenced by political factors in that both the South Carolina Department of Corrections and the South Carolina Department of Mental Health were and are engaged in US Department of Justice suits. In part, the legislation is a reflection of the national public outcry over John Hinckley's acquittal. It certainly was *not* in response to a too frequent finding of NGRI because, of the approximately 24,000 felony indictments per year, only one or two individuals receive a NGRI verdict.

The South Carolina legislation states that "a defendant is guilty but mentally ill if at the time of the commission of the act constituting the offense he had the capacity to distinguish right from wrong and to recognize his act as being wrong . . . but because of mental disease or defect he lacks sufficient capacity to conform his conduct to the requirements of the law." Thus, in theory, Smith and Hall's[4] concerns that a percentage of GBMI cases would perhaps obtain a NGRI verdict is excluded because in South Carolina defendants are criminally responsible if they knew what they were doing was morally or legally wrong. This is a very strict and cognitively oriented application of the M'Naghten Rule.[5]

Unlike both the Michigan and Georgia statutes for GBMI, which define mental illness as a major disorder of thought and/or mood, the South Carolina GBMI law does not define mental illness. A separate section of South Carolina law defines a mentally ill person as "a person afflicted with mental disease to such extent that for his own welfare or the welfare of others he requires care, treatment, or hospitalization.[6] Thus, although there is a very narrow, rigid rule for criminal responsibility, there is a very broad definition of mental illness that can be used in conjunction with GBMI pleas.

The suggestion of Petrella *et al.*[2] that a control group and comparison of crimes with diagnoses for NGRI and GBMI verdicts is useful. However, in South Carolina there is a system of circuit courts in which the judges move about the 16 judicial districts while the elected solicitors (prosecutors) remain in their several-county district. The actual verdict depends on the solicitor and the defense attorney, as well as on the community's response to the defendant and his crime. Thus, for this preliminary descriptive study we believed there was no way to control the many important variables affecting the verdicts and the sentencing.

Unlike the Michigan GBMI statute, the South Carolina law does not prescribe any form of psychiatric evaluation.

To date, 11 additional states have passed GBMI legislation: Illinois, 1981; Indiana, 1981; Kentucky, 1982; New Mexico, 1982; Georgia, 1982; Delaware, 1982; Alaska, 1982; Pennsylvania, 1982; Utah, 1983; South Dakota, 1983; and South Carolina, 1984. Nine of these appeared to be in response to the sensational trial of John Hinckley and his acquittal by reason of insanity. As South Carolina varies from other states, these statutes vary greatly in their requirements and provisions.

The study, reported in this article, will answer the following questions: (1) What

are the psychiatric diagnoses of individuals who have received the GBMI verdict? (2) For what types of crimes is this verdict being granted? (3) What is the correlation between the type and severity of the crime and the person's psychiatric diagnosis? (4) What type of pretrial evaluation did the person receive? (5) What was the individual's understanding of the GBMI plea?

Method

After obtaining approval from the Research Review Committee of the William S. Hall Psychiatric Institute and the South Carolina Department of Corrections, inmates who had received the GBMI verdict were approached by the investigators and requested to consent to being interviewed. Each interview was conducted by two psychiatrists using a semistructured clinical interview and incorporating the Structured Clinical Interview for DSM-III: Patient Version.[7] One examiner (D. W. M.) participated in all interviews. Information concerning the criminal records, the subject's understanding of the plea, and the subject's recollection of his mental state as it related to the offense for which he was convicted was collected.

Records from previous hospitalizations and psychiatric evaluations were also collected and reviewed.

The primary and secondary diagnoses conforming to DSM-III criteria and describing the inmate at the time of the interview were assigned by consensus of these investigators. When available, prior hospital records and pretrial evaluations were reviewed. These provided additional diagnostic impressions and an independent description of the initial charges and events.

Sample

The South Carolina GBMI law was enacted in April 1984. The first individual to receive the verdict was admitted to the penal system on August 17, 1984. From that date to December 31, 1985, 42 men and five women received the GBMI verdict. Of these, 30 were evaluated as part of the study. The 30 were selected because (1) they were still under the control of the South Carolina Department of Corrections; (2) they were confined in a facility in the metropolitan Columbia, South Carolina, area; and (3) they consented to be interviewed. Only one individual approached refused to consent to be interviewed.

Four of the sample were women and 18 were Caucasian. The mean age of the same was 33 years, with a range of 18 to 59. Eighteen individuals were never married, four were currently married, and eight were either separated or divorced. Of the sample, 16 had not completed high school, four had obtained a high school equivalence, 10 had completed high school, and none had completed college.

Results

Using the semistructured clinical interview, the investigators were able to agree upon a primary diagnosis for all individuals at the time of the study. Eleven of the 30 individuals met the criteria for schizophrenia, and six of these had an additional secondary diagnosis of substance abuse. A primary diagnosis of substance abuse was made in

an additional nine individuals, and two of these had a secondary diagnosis of mood disorder. Four individuals were diagnosed as suffering from a paraphilia, and two of these met the specific criteria for pedophilia. Two individuals demonstrated a major depression, and one individual had bipolar disorder, manic phase. One individual had an organic brain syndrome with marked confabulation probably secondary to his chronic alcoholism. No axis I diagnosis but dependent personality disorder was diagnosed for one individual. It was felt that the posttraumatic stress disorder observed in one individual appeared after the crime for which she was incarcerated. Of the 30, 21 could have more than one psychiatric diagnosis established. In some individuals, as many as four separate psychiatric diagnoses were present.

Table 1 presents the crime for which subjects were confined, years of sentence, primary psychiatric diagnosis, type of pretrial evaluation, and length of that evaluation. Only one individual was convicted of murder. Of the five individuals convicted of manslaughter, four suffered from paranoid schizophrenia. These four individuals' paranoid delusional system appeared to be directly related to the crime.

Nine of the 30 were convicted of criminal sexual conduct with minors. None of these was involved in the rape of a minor individual. Four of the nine were convicted of having incestuous relationships with their daughters or stepdaughters. Four were convicted of having sexual relations with adolescent or prepubertal boys.

The length of sentence for the same crime varied greatly. The sentences for manslaughter ranged from five to 40 years. The sentences for criminal sexual conduct with minors ranged from four to 25 years.

The type of pretrial evaluation also varied greatly. Three individuals receiving this verdict had no documented evaluation before the plea being entered. Seven individuals had outpatient evaluations either in jail or in the office or private psychiatrists and or psychologists. These outpatient evaluations varied from an evaluation by a nurse for approximately 30 minutes to 12 separate hour visits to a forensic psychiatrist. The length of the inpatient evaluations in the South Carolina State Hospital also varied markedly from two weeks to six years, with 75 percent of the individuals receiving evaluations of four months or less and 55 percent receiving one month or less. The length and place of evaluation tended to vary with the seriousness of the crime.

None of the individuals actually had a jury trial. It was impossible to state whether the verdict was part of a plea bargain. However, some records indicated that the initial charges were greatly reduced for many individuals who received a GBMI verdict; i.e., a person charged with murder pleaded GBMI to manslaughter and received a sentence of five years.

Seventeen of the sample had had at least one prior conviction and six had four prior convictions. One individual had spent the majority of his adult life in a prison setting.

The investigators attempted to obtain

Table 1
Crime, Sentence, and Diagnosis for Individuals Who Received the Guilty but Mentally Ill Verdict in South Carolina

Sex	Crime	Length of Sentence (yr)	Primary Diagnosis
F	Murder	Life	Posttraumatic stress syndrome
M	Manslaughter	40	Dependent personality
F	Manslaughter	24	Schizophrenia, paranoid
M	Manslaughter	12	Schizophrenia, paranoid
M	Manslaughter	10	Schizophrenia, paranoid
F	Manslaughter	5	Schizophrenia, paranoid
M	Assault and battery*	20	Organic brain syndrome
M	Assault and battery*	20	Alcohol dependence
F	Assault and battery*	8	Schizophrenia, undifferentiated
M	Assault and battery†	10	Mixed substance abuse
M	Assault and battery†	8	Schizophrenia, paranoid
M	Assault and battery†	2	Schizophrenia, undifferentiated
M	Armed robbery	10	Bipolar disorder, manic
M	Armed robbery	6	Schizophrenia, undifferentiated
M	Criminal sexual conduct	25	Pedophilia
M	Criminal sexual conduct	21	Major depression
M	Criminal sexual conduct	20	Atypical paraphilia
M	Criminal sexual conduct	17	Major depression
M	Criminal sexual conduct	15	Alcohol dependence
M	Criminal sexual conduct	15	Pedophilia
M	Criminal sexual conduct	12	Schizophrenia, undifferentiated
M	Criminal sexual conduct	10	Atypical paraphilia
M	Criminal sexual conduct	4	Alcohol dependence
M	Burglary	5	Mixed substance abuse
M	Burglary	3	Mixed substance abuse
M	Housebreaking	5	Alcohol dependence
M	Arson	9	Mixed substance abuse
M	Arson	8	Schizophrenia, undifferentiated
M	Contributing to the delinquency of a minor	2	Schizophrenia, undifferentiated
M	Shoplifting	3	Alcohol dependence

* Assault and battery with intent to kill.
† Assault and battery of a high and aggravated nature.

the individuals' perception of the GBMI verdict. Of the 30 individuals, two were too thought disordered at the time of our interviews to be able to comment upon their understanding. Nine individuals stated that they did not understand the plea but were pleading guilty only on the advice of their lawyers. An additional seven thought that the GBMI plea would be used to reduce their sentences or have them placed on probation. Four thought that they would obtain psychiatric treatment in prison. Three stated that they had no idea concerning the plea but were told by their lawyers to accept this verdict. Two individuals stated that the GBMI plea meant that they were guilty but "unaware" or had "impaired mental faculties." One individual thought that he would go to a hospital instead of a prison. One very angry, disappointed individual stated,

"You get the same sentence with mental illness tacked on." The final individual stated that "it meant a lunatic in search of understanding."

The prisoners' perception of their mental state influencing their behavior at the time of the crime varied greatly. There did not seem to be any correlation between the type of crime and the prisoners' understanding of their mental state. Ten individuals stated that they were under the influence of drugs and/or alcohol at the time of the crime and had either impaired memory of the events or impaired ability to control their actions. An additional six denied any mental disorder at any time. However, all six were judged to be seriously mentally ill by the investigators. Four claimed no mental illness; and the investigators diagnosed either pedophilia, atypical paraphilia, or substance abuse. Three stated that they were depressed and/or angry at the time of the crime and had acted impulsively. These three did not believe that they had any mental disorder. Two individuals were so mentally ill at the time of their interviews that they could not respond adequately to the question. One individual claimed mental illness, stating that "the voices made me do it," but was not judged to be psychotic. The remaining four individuals had been clearly psychotic at the time of the crime but had regained sufficient insight to realize that their mental illness had played a part in their behavior.

Discussion

Our sample, when compared with South Carolina's current prison population, is overrepresented by Caucasians and women. Only 40 percent of the prison population is Caucasian, whereas Caucasians represent 60 percent of the GBMI group. Less than four percent of the prison population is female, while our sample was made up of 17 percent females. These results may be due to the small numbers in our sample. However, the age of our sample is representative of the age of the prison population.

Because of the very small sample size of this study, the greatly differing concepts of legislation in the various states, and the legal interpretation and judicial implementation of the GBMI verdict among the states, it is difficult to directly compare our results with those present in the literature.

This GBMI sample has a very wide range of diagnoses. If the South Carolina statute defined mental illness as the Georgia GBMI statute,[8] i.e., a major disorder of thought or mood, 50 percent of the sample would *not* be eligible for the verdict. That four of the five individuals convicted of manslaughter maintained a paranoid delusional system that was directly related to the crime yet received a GBMI verdict rather than NGRI probably reflects the very strict interpretations of the M'Naghten Rule within South Carolina. Of 22,000 to 24,000 felons indicted each year, only one or two obtain a NGRI verdict. Given the long period of pretrial evaluation for three of these individuals, it seems possible that the GBMI verdict was used to dispose of cases in which the accused could not be restored to competency for full trial. Clearly, the GBMI verdict can have little impact on NGRI verdicts be-

cause NGRI verdicts are already negligible. The miniscule number of NGRI verdicts has remained similar before and after GBMI. Undoubtedly, many people in South Carolina are found GBMI or guilty who in other states might be found NGRI.

The fact that three of the 30 individuals had no psychiatric or mental health professional evaluation before obtaining a GBMI verdict was an unexpected finding. The great variety of evaluations for the remaining 27 might argue for the inclusion of a specified type of evaluation as is present in the Michigan statute.

The South Carolina statute requires treatment until such time as the individual can be released into the general prison population. GBMI does not require treatment for the specific mental illness leading to the verdict. Male offenders who receive the GBMI verdict are admitted to the Gilliam Psychiatric Center, a 100-bed, all-male inpatient unit housed within a maximum security facility. They are then evaluated. Once they are judged capable of managing in the general prison population, they are transferred to an appropriate prison facility. The female offenders have no similar evaluation as no inpatient beds are provided. There is very limited psychiatric care provided by the Department of Corrections in its various prisons. The GBMI law does not require treatment for the disorder that is associated with the crime. Therefore, those with substance abuse and/or paraphilias could be evaluated briefly and placed in the general prison population. For these individuals, the GBMI verdict is no different from a guilty verdict unless the judge used the presence of a mental disorder as mitigation when determining the length of sentence. Given that many of our sample were confused about the GBMI verdict and that none of them had a jury trial, it is possible that the verdict was used to expedite cases by promising the accused treatment and dispensing with a full trial. Because none of our sample received a jury trial, it is impossible to assess the effect that this new verdict has upon the behavior of lay jurors. We were also unable to assess the impact of this verdict upon the judges' sentencing decisions. In any event, if the GBMI verdict includes a wide range of mental disorders, it would seem that treatment programs for these disorders should be required. If resources within the correctional system are sufficient to treat only the severely mentally ill, then perhaps only severe mental illness should be included in the GBMI verdict. The number of individuals who felt that they were to obtain treatment in exchange for entering the plea and who then were angry that no treatment was offered would be reduced.

The reason the defendants' failed to understand the implications of a GBMI plea may be that we examined the operation of the GBMI verdict in its infancy, and our results may reflect a lack of familiarity on the part of the legal profession about the concept and statute. Clearly, closer cooperation between the psychiatric and legal professions when laws are drafted and in monitoring their operation may resolve this issue as would the development of appropriate treatment programs within the Department of Corrections.

Recommendations

Based on our review of statutes from other states and this limited study, the investigators believe that the following should be included in future GBMI legislation: (1) specified mandatory pretrial psychiatric evaluations, (2) documentation that the accused does not meet the standard for NGRI, (3) specific mental disorders for which the verdict is appropriate, and (4) the mandating of treatment for these disorders whenever the individual is confined.

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