Criminal Offense, Psychiatric Diagnosis, and Psycholegal Opinion: An Analysis of 894 Pretrial Referrals

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This article presents the results of a study of 894 criminal defendants referred by Virginia courts for evaluation of competency to stand trial or criminal responsibility. All evaluations were conducted on an outpatient basis by mental health professionals who had received specialized training in forensic evaluation. Findings as to the referral questions posed, the criminal offenses charged, and the clinical diagnoses and psycholegal opinions offered by the evaluators are described. Statistical analyses demonstrate significant relationships between both diagnosis and criminal charge and the psycholegal opinion rendered.

The psychiatric or psychological evaluation of persons charged with or convicted of crime has been the subject of much discussion in the psycholegal literature. Studies have examined the rates of mental illness among criminals,[1] differential treatment of the mentally ill by police,[2] the demographic characteristics of persons who interpose the insanity defense or raise the issue of competency to stand trial,[3-6] factors associated with various legal outcomes in competency and sanity cases,[4,7-12] the length of hospitalization after acquittal by reason of insanity or a finding of incompetency to stand trial,[11,13-16] and recidivism among insanity acquittees and defendants found incompetent.[17-19]

Very little attention, however, has been paid specifically to the relationship between criminal offense, psychiatric diagnosis, and psycholegal opinion on such questions as competency to stand trial and legal insanity. This study represents an effort to fill the void. It reflects an examination of 894 cases in which someone charged with a criminal offense was referred to a psychiatrist or psychologist for evaluation before trial.

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Historical Background/Method

In 1981, the Commonwealth of Virginia embarked on a program to deinstitutionalize its forensic evaluation system.[20] At the direction of the state legislature, the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services arranged for mental health professionals from public sector community mental health centers throughout the state to participate in a 50-hour program of training in forensic evaluation offered by the University of Virginia's Institute of Law, Psychiatry, and Public Policy. As clinicians from different communities were trained, the administrator of the state court system called on judges to make referrals to these clinicians on an experimental basis. The experiment was deemed a success, and in 1982, Virginia's laws were amended to require judges to order forensic evaluations performed on an outpatient basis by these specially trained clinicians, if available. By 1985, clinicians who had completed the training were available to serve every locality in the Commonwealth.

Beginning in July 1985, clinicians working in local mental health centers throughout the state were directed to submit a "forensic information form" with their request for payment for each evaluation performed on court order. This form called for referral information as well as a summary of the evaluator's findings and conclusions. During the following 24 months, July 1, 1985, through June 30, 1987, 1,041 Forensic Information Forms were submitted. The data presented here reflect an analysis of those 894 cases in which competency to stand trial or legal "insanity" was a referral question.

Based on a review of court records, it is estimated that the 1,041 cases included in this study represent approximately two-thirds of all outpatient, court-ordered forensic evaluations conducted in the Commonwealth during the period of the study. Other outpatient evaluations were conducted either at one of Virginia's six state hospitals or by private clinicians. In addition, an estimated 150 to 200 evaluations were conducted on an inpatient basis at the state's maximum security forensic unit.

Description of the Evaluations

Referral Question Data were collected solely for cases referred by criminal courts. Evaluations related to civil commitment, domestic relations, or disability proceedings were not included.

Of the 1,041 evaluations for which information was received, 277 (27%) addressed solely the defendant's competency to stand trial (CST), 121 (12%) addressed solely the defendant's mental state at the time of the offense (MSO), 496 (47%) addressed both CST and MSO, and 109 (10%) addressed sentencing concerns; 38 cases (4%) fell into an "other" category. This article describes the results of the evaluations of competency to stand trial and/or mental state at the time of the offense.

Competency to Stand Trial Under Virginia law, a defendant is incompetent to stand trial if he or she lacks "substantial capacity to understand the proceedings against him or to assist his attorney

in his own defense."[21] Defendants found by the court to be incompetent to stand trial must be admitted to treatment for restoration of competency. If after a period of treatment a defendant is found to be incompetent and "likely to remain incompetent for the foreseeable future," the court must either release the defendant or commit him or her pursuant to civil commitment standards and procedures.[22]

Of the 773 cases in which CST was a referral issue, the defendant's competency was reported to be "significantly impaired" (i.e., the defendant was believed to be incompetent) in 134 (17%). In 21 cases (3% of all cases, 17% of those believed to be incompetent) the evaluator was of the opinion that it was "unlikely" that the defendant could be restored to competence in the foreseeable future. In 17 cases (2% of all cases, 13% of those believed to be incompetent) restorability was deemed "uncertain."

In 112 of the 134 cases (84%) in which an opinion suggesting incompetency was offered, impairment was discerned on both prongs of the competency standard (i.e., (1) the defendant's understanding of the legal proceedings and (2) his or her ability to assist in the defense). In 17 cases (13%) the evaluator suggested that the defendant was able to understand the proceedings but would have significant difficulty assisting in the defense. In only 5 cases (4%) did the clinician opine that the defendant could assist in his defense but would have significant difficulty understanding the proceedings.

The diagnosis assigned by evaluators was significantly related to the determination of incompetency ($p < 0.001$; see Table 1). The diagnostic categories most often associated with opinions suggesting incompetency were schizophrenia (34% of cases in which an opinion suggesting incompetency was reported), mental retardation (16%), affective disorder (9%), and organic brain disorder (9%). In those cases in which restorability was deemed "unlikely," mental retardation (55%) and organic brain disorder (27%) comprised the majority of cases, whereas in those cases where restorability was deemed "uncertain," schizophrenia (24%) was the most frequent diagnostic category.

Opinion regarding competency to stand trial also was significantly related to charge ($p < 0.001$; see Table 2). Opinions suggesting incompetency were offered for only five of 60 defendants charged with homicide (8%), eight of 89 defendants charged with sex offenses (9%), and three of 32 defendants charged

Table 1
Clinical Findings of Incompetency by Diagnosis

Diagnosis	Competent N (%)	Incompetent N (%)
Schizophrenia	47 (51)	45 (49)
Affective disorders	41 (77)	12 (23)
*Paranoid/psychotic disorders	16 (64)	9 (36)
Mental retardation	38 (64)	21 (36)
Organic disorders	45 (79)	12 (21)
Personality disorders	52 (96)	2 (4)
Dissociative disorders	3 (100)	0 (0)
Other disorders	148 (97)	5 (3)
** Missing	249 (90)	28 (10)
Total	639 (83)	134 (17)

Chi-square (8 *df*) = 92.56, $p < 0.0001$.
* Includes delusional (paranoid) disorder and brief reactive psychosis.
** Data not available as to whether diagnosis was not made or was simply unavailable.

Table 2
Clinical Findings of Incompetency by Offense Charged

Offense Category	Competent N (%)	Incompetent N (%)
Homicide	55 (92)	5 (8)
Crimes against people	96 (81)	23 (19)
Sex offenses	81 (91)	8 (9)
Robbery	29 (91)	3 (9)
Property crimes	198 (82)	44 (18)
*Public order offenses	30 (52)	28 (48)
Drug offenses	21 (87)	3 (13)
Other offenses	82 (88)	11 (12)
** Missing	47 (84)	9 (16)
Total	639 (83)	134 (17)

Chi-square (8 *df*) = 50.47, $p < 0.0001$.
* Includes tresspassing and disorderly conduct.
** Data not reported by evaluating clinician.

with robbery (9%), as compared with 28 of 58 defendants charged with public order and trespassing offenses (48%).

Mental State at the Time of the Offense Under Virginia law, a defendant is not guilty by reason of insanity if at the time of the offense, because of a "mental disease or defect," he or she did not understand the nature, character, and consequences of the act, was unable to distinguish right from wrong, or was driven by an irresistible impulse to commit the act.[23,24] "Mental disease or defect" is defined as a disorder that "substantially impairs the defendant's capacity to understand or appreciate his conduct."[25] The Virginia courts have held that expert testimony is not admissible on the issue of "diminished capacity," or *mens rea* (i.e., whether the defendant's capacity to form the mental state that constituted an element of the offense was impaired).[26] Accordingly, MSO evaluations in Virginia focus on the question of legal insanity as defined by the *Price* and *Thompson* cases.

Of the 617 defendants for whom MSO was a referral issue, 196 (32%) were viewed as suffering from a "mental disease or defect." In only 47 of these 196 cases (24%), or eight percent of all MSO referrals, was an opinion offered supporting an insanity claim (i.e., presenting a finding of "significant impairment" on one of the functional prongs). Of these 47 defendants, 20 (43%) were considered "significantly impaired" on all three prongs of the insanity standard: (1) ability to understand the nature, character, and consequences of the act; (2) ability to distinguish right from wrong; and (3) ability to resist the impulse to commit the act. In 16 of the cases (34%), the defendant was deemed significantly impaired on two of the three prongs (typically the two "cognitive" prongs: (1) ability to understand the nature, character, and consequences of the act and (2) ability to distinguish right from wrong). In 11 cases (23%) the defendant's impairment was believed to be limited to one prong, five of which were categorized as an inability to resist the impulse to commit the act.

Various diagnoses were associated with a finding of significant impairment on one of the functional prongs of the insanity defense. As with competency, schizophrenia was the most frequently cited diagnostic category (28% of defendants for whom a relevant functional impairment was identified), followed by organic brain disorder (17%). Other diagnoses associated with a determination of significant impairment included affective disorder (15%) and mental retardation (11%).

The diagnosis ascribed to the defend-

ant was significantly associated with an opinion supporting legal insanity ($p < .0001$; see Table 3). Opinions supporting an insanity defense occurred in 13 of 50 cases in which the defendant was diagnosed as schizophrenic (26%), eight of 44 cases in which an organic impairment was found (18%), and seven of 47 cases in which the diagnosis was affective disorder (15%). Diagnoses most likely to be associated with an opinion that the defendant was sane included the personality disorders (1 of 63 defendants, or 2%) and those classified as "other," such as substance abuse disorders (2 of 152, or 1%).

As with incompetency to stand trial, opinion supporting legal insanity was significantly related to charge ($p < .05$; see Table 4). Such opinions were offered in only two of 57 cases involving defendants charged with murder (4%), one of the 78 defendants charged with sex offenses (1%), and none of the 27 defendants charged with robbery, in contrast to 20 of 196 of those defendants charged with property crimes (10%) and two of 20 defendants charged with public order and trespass offenses (10%).

Table 3
Clinical Findings of Legal Insanity by Diagnosis

Diagnosis	Not Insane N (%)	Insane N (%)
Schizophrenia	37 (74)	13 (26)
Affective disorders	40 (85)	7 (15)
*Paranoid/psychotic disorders	14 (78)	4 (22)
Mental retardation	34 (87)	5 (13)
Organic disorders	36 (82)	8 (18)
Personality disorders	62 (98)	1 (2)
Dissociative disorders	3 (100)	0 (0)
Other disorders	150 (99)	2 (1)
* Missing	194 (96)	7 (4)
Total	570 (92)	47 (8)

Chi-square (8 *df*) = 41.46, p < 0.0001.
* See Table 1.

Table 4
Clinical Findings of Legal Insanity by Offense Charged

Offense Category	Competent N (%)	Incompetent N (%)
Homicide	55 (96)	2 (4)
Crimes against people	93 (92)	8 (8)
Sex offenses	77 (99)	1 (1)
Robbery	27 (100)	0 (0)
Property crimes	176 (90)	20 (10)
*Public order offenses	18 (90)	2 (10)
Drug offenses	13 (100)	0 (0)
Other offenses	55 (85)	10 (15)
* Missing	56 (93)	4 (7)
Total	570 (92)	47 (8)

Chi-square (8 *df*) = 16.42, $p < 0.05$.
* See Table 2.

Discussion

It is important to recognize that the findings presented in this article reflect opinions reached by mental health professionals, not legal outcome. Many defendants for whom an opinion supportive of legal insanity was offered reached a disposition other than acquittal by reason of insanity, perhaps influenced by the clinician's findings. It is widely acknowledged that evaluation reports supporting insanity routinely are used in plea bargaining and that, faced with the prospect of a contested insanity trial, prosecutors often prefer to reduce the charge or perhaps recommend a desirable treatment disposition in exchange for a plea of guilty.[27] Moreover, given the consequences of an insanity acquittal in Virginia—an indefinite and often extended period of hospitalization—defendants charged with less serious offenses may prefer conviction to acquittal on this ground. Accordingly, it is likely that significantly fewer than the

eight percent of individuals referred for an insanity evaluation and found by the evaluator to have been "significantly impaired" were, in fact, acquitted by reason of insanity.

The finding that evaluators presented an opinion supporting legal insanity in only 24% of cases in which the defendant was believed to suffer from a "mental disease or defect" and only eight percent of all MSO evaluations suggests that insanity criteria were applied with some rigor. Of course, the evaluators whose opinions are reflected in this study all had received specialized training in forensic evaluation before accepting referrals.* Thus, these findings may not generalize to other states in which such training has not been conducted.

It should not be surprising that relatively few defendants were deemed incompetent to stand trial or insane. Attorneys frequently request evaluations even though they have little doubt about a client's competency or sanity. To begin with, many defendants, although not incompetent or insane, have mental, emotional, or substance abuse problems that require attention, and requesting a forensic evaluation may be the easiest way for the attorney to insure that this attention is given. In addition, attorneys sometimes view evaluations as an opportunity to gather information for use in plea negotiation or at sentencing, to argue for leniency or for a treatment alternative to prison, or to insure that they have adequately represented their client rather than foreclosing a psychiatric defense without the benefit of expert consultation.

The relatively high rate at which defendants charged with public order offenses were believed to be incompetent (48%) provides some support for the much heralded theory that the mentally ill have become "criminalized" in American society in recent years: that mentally ill persons increasingly are coming into contact with the criminal justice system, charged, typically, with minor offenses such as trespass and disorderly conduct. Of course, without data regarding the rate of trial incompetency among public order offenders before deinstitutionalization, these findings are inconclusive. Other explanations for these findings include the possibility that among those defendants charged with minor crimes, only those for whom trial competency (or legal insanity) was *clearly* at issue were referred for evaluation. This could reflect an awareness among attorneys that defendants found incompetent to stand trial or insane for a minor offense frequently spend more time hospitalized than defendants convicted of such offenses spend in jail. Alternatively, these findings may be explained by the practice of many attorneys routinely to request an evaluation where the defendant is charged with a very serious crime, as a means of guarding against a subsequent claim that the attorney provided "ineffective assistance of counsel." Of course, this practice would result in relatively fewer defendants charged with serious offenses manifesting signs of serious psychopathol-

* The *post-hoc* nature of this analysis, however, prevents any interpretation as to the effect of this training on the findings presented here.

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Currently, data are being collected on subsequent legal processing of cases in which mental health evaluations were conducted. This research will show the correlation, if any, between clinical findings and legal outcome.

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