Excluding Personality Disorders from the Insanity Defense—A Follow-up Study

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Examining the effects of Oregon's statutory reform excluding personality disordered individuals from the insanity defense, we previously identified a study sample of insanity acquittees, each of whom was given a primary diagnosis of a personality disorder during subsequent evaluation at the state hospital. In the present study we explore the relationship between that diagnosis and the pretrial psychiatric diagnosis presented to the trial court. By reading the forensic mental health evaluations used at trial we found that 50 percent of our study sample of 34 personality disordered patients were diagnosed with psychotic disorders, affective disorders, retardation, and organic brain disorders. In addition to investigating the diagnosis offered as evidence at trial, we performed assessments of 38 mental health reports using published standards for forensic evaluation reports. We found compliance rates in the various categories ranged from 8 to 84 percent with a mean of 45 percent. We question the value of the mental health input to these trials, and believe that the data tend to validate past aspersions of forensic practice.

In 1983 the Oregon legislature amended the statutes governing the insanity defense to eliminate persons suffering "solely a personality disorder."[1] In excluding personality disordered individuals the legislators were responding to a number of concerns.[2] They felt the insanity defense had a generally bad reputation and that the public perceived the defense as a way to "beat the rap." Also, they believed that prosecutors more commonly contest insanity claims involving personality disordered defendants, and that the juries who heard these cases were confused by the "battle of the experts" likely to be involved. This legislative reform was an attempt to narrow the application of the insanity defense by restricting it to those persons with serious mental illness. Another motivation was to devote scarce state resources to those persons who had the greatest chance of responding favorably to treatment and achieving community placement.

If applied verbatim this would mean that after January 1, 1984, the date the law change became effective, no person with a personality disorder as the only psychiatric diagnosis would be found

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among those newly adjudicated as "guilty except for insanity." (This terminology for Oregon's insanity defense has the same meaning as "not guilty by reason of insanity,"[3] language used in other states. It is clearly distinguished from a finding of "guilty, but mentally ill" that some states have enacted.) In previous work,[4] we studied the effect of this statutory change. Based on diagnoses given at the state forensic hospital following adjudication, we found that courts were still acquitting personality disordered individuals as insane. Although their frequency of acquittal fell after the law change, this decrease was not statistically significant.

Why has the insanity system not responded to the legislative exclusion in this regard? The present study addresses this question by examining the pretrial process for this personality disordered, insanity acquittee population. The study consists of two parts. First, we wanted to find out what diagnostic information the trial court relied on in determining insanity. Presumably, if these defendants had been diagnosed as personality disordered prior to trial, they would not have satisfied the criteria for an insanity verdict. We postulated that either (1) the criminal court heard evidence that the defendant suffered from a mental illness other than, or in addition to, a personality disorder, or (2) the criminal court heard evidence that the person had only a personality disorder, and disregarded the mental health input or acted in apparent conflict with the mandate of the legislature.

For the second part of the study, we were interested in the quality of the pretrial evaluations. In Oregon, private practitioners perform almost all mental health evaluations for criminal responsibility, and there is no known peer review in this system. We therefore took this opportunity to assess the quality of the pretrial reports. A more representative population could perhaps have been examined, but this sample was chosen partly for convenience, since we scored the pretrial evaluation reports for the diagnostic questions above. As such, the assessment portion can be viewed as a preliminary study.

Since 1978 the court trials have placed all insanity acquittees who are both mentally ill and dangerous at the time of their trial under the jurisdiction of the Psychiatric Security Review Board (PSRB), a five-member body similar to a parole board.[3,5] The Board's membership consists of a psychiatrist, a psychologist, a lawyer, a person with experience in the processes of parole and probation, and a member of the general public, each appointed by the governor for four-year terms. The PSRB has the following basic powers over persons the courts place under its jurisdiction: (1) to commit to inpatient treatment at the state hospital, (2) to place on conditional release to community supervision and treatment, (3) to revoke a conditional release and recommit to the state hospital, and (4) to discharge from its own jurisdiction if it makes a finding that the person is either no longer mentally ill or no longer dangerous.

Methods

We maintain a research data base on all insanity acquittees the courts have

assigned to the jurisdiction of the PSRB since its inception in 1978. The subjects for this study are persons whom the courts assigned to the PSRB in the years 1981 to 1986, who spent at least part of their PSRB time committed to the Oregon State Hospital, and who hospital psychiatrists diagnosed as suffering from a personality disorder as the primary diagnosis. In addition, the PSRB maintains files on the persons under its purview. These files contain the legal and clinical information that was available at the time of trial, including the mental health examination reports the criminal court used in making the finding of insanity. We reviewed the PSRB records of these subjects to confirm the diagnosis, to assess the trial process that led to the insanity verdict, and to evaluate the quality of the pretrial reports. We also compared the sample population with the entire PSRB population on the basis of demographic parameters and past history of involvement with the mental health and criminal justice systems.

When the hospital psychiatrists provided multiple diagnoses for a single subject, we chose the one appearing first in the following hierarchy: mental retardation, organic brain disorder, psychosis, affective disorder, personality disorder, all other diagnoses. We produced this ordered list by adapting one used in a previous study of PSRB acquittees and conditional release.[6]

To assess the quality of reports, we constructed a set of standards by which to rate the reports. We derived these standards from suggested report formats found in the psychiatric literature,[7] and those promoted by the American Board of Forensic Psychiatry.[8] The standard format we used was an amalgam of these published recommendations for forensic mental health reports.

We assessed each report for the inclusion of factual material and for professional adequacy. We divided the factual material into two sections, major and minor items. The major items we sought in the reports included: a statement of the purpose of the exam, documentation of consent to examination, use of police reports and medical records, a diagnosis in DSM-III-R terminology, and statements addressing both arms of Oregon's standard for insanity (capacities to appreciate criminality and to conform conduct to the law). The minor items were: the date and place of the alleged crime, a statement of the criminal charge, and place and duration of the examination. In addition we counted the absolute number of clinical identifiers (such as age, sex, race, marital status, place of residence, occupation, etc.).

For each report we also made an assessment based upon professional judgment. We checked this portion of the data collection instrument for reliability with periodic and independent ratings by the two psychiatrist investigators. We rated the adequacy of the history and the mental status, how clear and understandable the answer to the medical-legal question was (even if each arm of the test was not specifically addressed), and how well the data in the report supported the stated diagnosis and the medical-legal conclusion.

Looking at our standards critically,

Table 1
Demographic Data

Sex	Male	30	(88%)
	Female	4	(12%)
Age	Range	17 to 67 years	
	Mean	28.5 years	
	SD	9.4 years	
Race	White	27	(79%)
	Black	3	(9%)
	Hispanic	3	(9%)
	Native American	1	(3%)
Marital Status	Single	22	(65%)
	Divorced	7	(21%)
	Married	3	(9%)
	Separated	2	(6%)
Education	Less than 12 years	15	(52%)
	12 years	10	(34%)
	More than 12 years	4	(14%)

some of the items assessed may be viewed as miscellaneous detail rather than substantive professional output. However, we felt that each report should contain enough information to stand on its own and to be understood with clarity. Even though some individual items may appear unimportant, the impact of each report depends in part on the sum total of its details. Besides, all of the standards used were derived from the professional literature.

Results

Diagnostic Questions In the six years under study, state hospital psychiatrists diagnosed 34 newly admitted acquittees under PSRB jurisdiction as personality disordered. Table 1 shows demographic information about these subjects. Of these variables the study group showed no significant differences when we compared them with the rest of the PSRB population. However, they had significantly more criminal justice contacts prior to assignment to PSRB jurisdiction (5.6 for the personality disorders versus 4.0 for the remainder of the PSRB population; $t = 2.97$, df = 757, $p = .0031$), and more substance abuse diagnoses (62% versus 25%; $\chi^2 = 22.04$, df = 1, $p = .0000$). We found no significant differences in the percentage of felony crimes or in the severity[6] of the crimes leading to assignment to PSRB. The two groups were also similar in their past psychiatric hospital experiences, with no significant differences in total hospital time. The personality disordered group spent 14 percent of the two years prior to PSRB jurisdiction in the hospital, and the whole PSRB group spent 12 percent of that time inhospital. This lack of significant difference remained true when we examined voluntary and involuntary hospital time separately.

The judgment orders with the "guilty except for insanity" verdict specified the trial process leading to the verdict in 26 cases; of these, 23 (88%) were stipulated decisions, two (8%) were contested and

Table 2
Trial Diagnoses

	1981–1983	1984–1986
Retardation	1 (5%)	0 (0%)
Organic	1 (5%)	2 (14%)
Psychosis	5 (25%)	5 (36%)
Affective	2 (10%)	1 (7%)
Personality and other	6 (30%)	5 (36%)
No diagnosis	5 (25%)	1 (7%)
Total	20 (100%)	14 (100%)

tried before a judge, and one (4%) was a contested trial heard by a jury. Subjects came from 12 of 36 Oregon counties. The large, urban counties had the most subjects, although one county had a disproportionately high number of subjects. This county houses the state capital, the largest state penitentiary, and the state forensic hospital. Many local residents believe that a larger share of the state's mentally ill and criminal populations resides in this county. We were unable to identify any patterns regarding the judges and attorneys involved in these cases; most had involvement in only one or two cases. One judge was involved in three cases, and one prosecuting attorney in four; both of these were in the capital county.

The courts assigned to the PSRB 20 subjects diagnosed by state hospital physicians as personality disordered during the three years prior to the statutory reform, and 14 in the subsequent three years. Table 2 shows a summary of the diagnoses presented at trial. The upper four categories (retardation, organicity, psychosis and affective disorders) are more commonly associated with insanity acquittal, as compared with personality disorders and other diagnoses. These four diagnostic categories also constitute major disagreements in diagnosis between the pretrial and the state hospital examiner, since all state hospital diagnoses were personality disorders. Exactly one-half of the 34 study subjects fall above the line on Table 2, and therefore represent this major diagnostic disagreement. The rate of disagreement increases to 61 percent if we exclude those subjects with no diagnosis. (No diagnosis meant either that there was no report in the file, or the report contained no diagnosis.)

In the time period after the legislature eliminated personality disorder as a basis for insanity acquittal, five subjects identified to the trial court as personality disordered successfully raised insanity defenses. Of these five, two subjects had no other diagnosis (and therefore satisfy the literal criterion of having "*solely* a personality disorder") (emphasis added). The other three subjects had additional diagnoses of (1) pedophilia, (2) posttraumatic stress disorder, and (3) pyromania and alcoholism.

To see whether there was a correlation between pretrial diagnosis and the subtype of personality disorder in the same hospital diagnosis, we performed a point by point comparison. For those 10 subjects with psychotic diagnoses, the personality disorder subtypes were: antisocial (4 subjects), borderline (2 subjects), and not otherwise specified (4 subjects). For the three subjects with affective diagnoses the results were: borderline, dependent, and not otherwise specified (one subject each).

Assessments of Forensic Reports

Table 3
Items Assessed (N = 38)

	Compliance Rate
Major items	
Consent to examination	16%
Purpose of exam stated correctly	24%
Police reports used	31%
Past medical and psychiatric history used	36%
Statement of ability to conform conduct	70%
Statement of ability to appreciate criminality	73%
Psychiatric diagnosis	82%
Diagnosis consistent with DSM-III terminology	84%
Minor items	
Place of the criminal charge	8%
Time duration of interviews	21%
Date of the criminal charge	27%
Statement of the criminal charge	63%
Location of evaluation	68%

Among the 34 subjects, the courts assigned three to the PSRB with no record of a written pretrial mental health evaluation report. We reviewed a total of 46 reports for the other 31 subjects. Physicians wrote 28 of the reports (61%), doctorate level psychologists wrote 13 (28%), and an MD-PhD, an RN, an EdD, an EdM, and a counseling supervisor each wrote one report (2% each).

In eight of these 46 reports the writers did not address the issue of insanity at all. Some of these reports were directed at the question of trial competency, some were for civil commitment hearings, and others were for other clinical purposes. In most of these reports, the writers made no reference to the incident which led to the arrest.

We regarded the remaining 38 reports as mental health input to the legal process of determining insanity, and we used them in the assessment phase of the study. Among these, 23 (60%) offered an opinion that the defendant was insane, nine (23%) said he or she was sane, and one (3%) gave no opinion because the examiner felt an inpatient evaluation was necessary to reach a conclusion. In five (13%) the writer either gave no opinion, or stated the opinion with such obscure language that it could not be distinguished as sane or insane.

Table 3 lists the items assessed in the mental health reports, along with the "compliance rate," the percentage of reports that included that item. Compliance rates range from 8 percent for Place of Criminal Charge to 84 percent for Diagnosis Consistent with DSM-III. The mean of these rates is 45 percent.

We counted the number of clinical identifiers (statements of sex, age, race, marital status, occupation, etc.) in each report. For all reports assessed, we found a mean of 3.1 (SD 1.4) clinical identifiers. Finally, Table 4 contains the results of judgment ratings. Those scoring in the medium-to-high range (3–5) have roughly a "passing" score, and we give the rates of these in the rightmost column. The range is 34 percent for "Adequacy of support for conclusion", to 79 percent for "Wording and clarity of medical-legal conclusion."

Discussion

A significant portion of the national debate[9, 10] concerning the insanity defense focuses on the types of patients highlighted in this study, those individuals with a diagnosis of personality disorder without an overriding organic,

Table 4
Judgment Issues

	Mean Judgment Score (1 = Poor, 5 = Excellent)	Percent of Reports Scoring Between 3 and 5
Adequacy of support for conclusion	2.1 (SD = 1.3)	34%
Adequacy of clinical history	2.4 (SD = 1.3)	44%
Adequacy of mental status exam	2.7 (SD = 1.3)	45%
Adequacy of support for diagnosis	2.7 (SD = 1.3)	61%
Wording and clarity of medical-legal conclusion	3.8 (SD = 1.4)	79%

psychotic, or affective disorder. It was this population that the Oregon legislature explicitly determined should not be acquitted by reason of insanity. Our subjects all had state hospital diagnoses of personality disorders, but for at least 50 percent of the 34 subjects studied the pretrial and state hospital evaluators disagreed on the primary diagnosis. Interrater differences, rather than diagnostic "accuracy," are being addressed in this study. Although these diagnoses were given in a forensic setting, this result is consistent with the general psychiatric interrater reliability studies in DSM-III, which showed that Axis II disorders were diagnosed less reliably than Axis I disorders.[11] This population is generally considered difficult to diagnose, and we did not reinterview these patients with research standards. Some diagnostic assumptions did not hold, such as the intuitive notion that psychotics, when alternatively diagnosed as personality disordered, will carry the "odd" subtypes of paranoid, schizoid, or schizotypal personalities.

The subjects in this study are a subset of the entire PSRB population, but they differ little or not at all from the larger population in terms of demographics, seriousness of criminal charge, or in the high percentage of stipulated decisions[12] leading to adjudication. It is likely that the mental health input to these stipulated trials, embodied in the evaluation report, was influential in the result. In many cases a single evaluation is sufficient for an insanity verdict. We previously demonstrated that the legislative reform eliminating personality disordered individuals from the insanity defense did not result in a statistically significant drop in such adjudications.[4] We now find that for at least half of these patients, pretrial reports informed the trial court that they had retardation, organicity, psychosis, or affective disorder. This disagreement of diagnosis appears to be the most significant factor accounting for the continued admission of patients to the state forensic hospital who are later diagnosed as personality disordered.

Regarding the diagnostic change, we only identified change in one direction, from a higher diagnosis in our hierarchy to personality disorder. Our method would not identify a subject with the converse situation, that is, a personality disordered defendant who achieves an insanity acquittal and is later diagnosed

as psychotic. (We consider this a less likely scenario.) With that caveat, we found that in the three post-reform years studied, only two defendants with "solely a personality disorder" raised successful insanity defenses, and three other defendants with personality disorders plus other psychiatric diagnoses raised successful insanity defenses. These results do not support a conclusion that the courts are ignoring the legislative reform. In fact, the courts assigned few personality disordered individuals to the PSRB during our entire study period, both before and after the statutory reform. Therefore, postulate 1 above appears to be the primary factor in the acquittal of personality disordered subjects: trial evidence generally included a diagnosis other than personality disorder.

We are left with the fact that judges are dependent on the quality of the mental health reports used at trial. Seventeen percent of the reports the courts used were not even written for the purpose of evaluating criminal responsibility. Of those that were, 13 percent either omitted a medical-legal opinion on the issue, or had opinions stated in such vague terms that they could not be deciphered. In Oregon, an opinion on the "ultimate issue" is an allowable inclusion, and most court orders specifically request such an opinion.

Some of the assessment results were discouraging. On average, reports contained only slightly more than three clinical identifiers. The modal report stated, as an example, "38-year-old, white male" and left out all other orienting information, such as marital status, occupation, or place of residence. Over one-third of reports omitted the nature of the criminal charge. Almost two-thirds omitted the medical-legal question being addressed. Almost one-third did not speak specifically to the two major elements of the insanity standard in Oregon, appreciation of criminality and conforming of conduct. In the professional judgment of the authors, only one-third of the reports gave sufficient information to adequately support the medical-legal conclusion.

This study has limitations common to naturalistic investigations. There was no control group, or comparisons made with other subpopulations. There is no attempt to compare reports according to the professional credentials of the authors. Although we hope that a means of professional improvement can be found, we have not experimented with alternative systems as part of this project. Furthermore, we cannot state with scientific confidence that specialized forensic training makes a difference. As noted earlier, the sample of subjects upon which these assessments were based is unique within the insanity acquittee population, and this may affect the generalizability of our conclusions.

Nonetheless, these results raise a number of concerns. The consequences of professional evaluations in the legal system cannot be overstated. Steadman *et al.*[13] showed that in New York the factor most commonly associated with a successful insanity plea is the opinion of the forensic examiner. In Oregon, Rogers *et al.*[12] showed that the majority of insanity

verdicts are not the result of trials where there is a public airing of conflicting clinical points of view. Rather, verdicts are predominantly determined upon agreement between prosecution and defense. In some cases a single mental health opinion favoring an insanity verdict is both necessary and sufficient to result in acquittal. This study indicates not only that the quality of the mental health reports may be lacking, but also that courts have at times utilized reports that were for entirely different purposes. Reports of this type may have indicated the presence of a psychiatric disorder, but they clearly did not address the statutory test for criminal nonresponsibility.

This study raises questions about the quality of the mental health information available to the Oregon courts in the area of criminal responsibility. Dietz[14] had similar concerns when he called forensic reports and court testimony, "unintelligible, unscientific, misinformed, and irrelevant." He cited the low exposure to forensic issues during general psychiatric training as one reason. Other authors[15] have described the need for special training to engage in forensic practice. Ciccone[16] suggests ways to enhance forensic psychiatry education in residency and gives specific arenas of practice. A comprehensive plan to demonstrate such an advance in residency programming has been proposed by Harry.[17]

There is no mechanism to assure that mental health information used by the criminal courts conforms to recommended standards of professional quality. Quality assurance monitoring in general psychiatry[18] has become a direction not to be overlooked for a number of reasons, among them being the public perception of the profession, and maintenance of favorable reimbursement policies. Perhaps it is time to extend quality assurance concepts to pretrial forensic evaluations. There are many potential avenues for addressing the quality of forensic reports, including certification of evaluators, centralized evaluations in university, state hospital or court clinics, standardization of report formats, greater attention to forensic issues in psychiatric training, peer review, and evaluation boards. In systems that rely heavily on stipulated verdicts, adopting one or several of these methods to improve quality appears to be imperative. Proper evaluation is central to appropriate placement of defendants into mental health or criminal justice systems, and this has material implications both for the individual and for society.

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