Defendants Pleading Insanity: An Analysis of Outcome

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The authors examined the cohort of all defendants pleading not guilty by reason of insanity over a 12-month period in Baltimore City's superior trial court. During that time, 143 of the 11,497 defendants indicted (1.2%) pled not criminally responsible. Fourteen of those defendants (10%) were subsequently found not guilty by reason of insanity. The authors found marked agreement between the prosecution and defense with only two cases leading to full trials where the issue of insanity was argued. The evaluating physician's opinion as to criminal responsibility and Axis I diagnosis, and the most serious underlying charge discriminated between those defendants found not guilty by reason of insanity and those defendants found guilty or not guilty by the court. Other demographic factors such as age, number of dependents, educational level, severity of illness, and criminal background did not discriminate between the two groups.

Much has been written recently regarding the reliability and validity of psychiatrists' assessment of defendants in the criminal justice system. In the past decade several groups of investigators have studied demographic and outcome data for defendants found not guilty by reason of insanity (NGRI). The first such studies described demographic characteristics of cohorts of insanity acquitees from single geopolitical areas.[1-4] Rogers et al.[5] studied the percentage of contested trials among the cohort of insanity acquitees followed in Oregon. A later article[6] compared cohorts of insanity acquitees with cohorts of felony convictees matched by various demographic characteristics. Finally, several groups of researchers[7-10] have taken cohorts of insanity acquitees and looked at actual rehospitalization and rearrest data over time. Thus, the population of patients found not guilty by reason of insanity has been fairly well-characterized.

The cohort of defendants pleading NGRI at trial has not been so well studied, perhaps because of the difficulty in identifying those defendants pleading NGRI at the pretrial level. Steadman et al.[11] were able to identify all defendants

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who entered insanity pleas in Eire County, New York, between 1970 and 1980. Two hundred five cases were reviewed. They found that the only factor associated with the finding of NGRI was the recommendation of the forensic examiner. Sociodemographic characteristics, criminal history, past psychiatric history, and the nature of the current offense did not distinguish between those found NGRI and those found guilty.

Pasewark et al.[12] recently compiled data on 133 defendants pleading NGRI in Colorado in a three-year period. However, the cohort consisted only of those defendants referred to Colorado State Hospital and excluded women. Thus, as the authors point out, the sample is biased. Despite this deficiency, the study found that insanity acquitees were significantly older and better educated than convicted defendants, more likely to be diagnosed as schizophrenic, and less likely to have a history of drug abuse. Other demographic factors were not found to be significantly different between the two groups.

Phillips et al.[13] assessed 951 defendants referred for responsibility assessment in Alaska from 1977 through 1981. They found a high level of interexaminer agreement among forensic psychiatrists. A contradictory psychiatric opinion was presented to the court very infrequently, and in the vast majority of disputed cases, the defendant was, in fact, found guilty. They also found that a "successful" insanity defense leading to either a NGRI finding or a dismissal of charges occurred in less than 0.1 percent of all criminal cases in Alaska.

Our study identified all persons pleading not criminally responsible (Maryland's equivalent of NGRI) in the Circuit Court for Baltimore City from September 5, 1984, through September 5, 1985. Each Maryland county, as well as Baltimore City, has a circuit court which is the superior trial level court in that jurisdiction. The circuit court hears all jury and all felony nonjury criminal cases in its jurisdiction.

During the time studied, all jury and felony nonjury cases in Baltimore City where a plea of not criminally responsible (NCR) was entered by the defense were evaluated by psychiatrists at the medical office of the circuit court. The evaluation consisted of a face to face interview with the defendant and a review of the police records of the current offense, the past arrest record, conviction data, and the psychiatric history. Demographic data was also collected. This screening examination was deliberately designed to minimize false negatives. Thus, if there was any hint that the defendant might not be criminally responsible, he was sent to one of several state psychiatric hospitals for an in-depth inpatient evaluation. In addition, defendants thought to be criminally responsible during the screening process were sent to the state hospital when their attorneys requested such an evaluation.

Patients sent to state hospitals were seen by an evaluation team consisting of psychiatrists, social workers, psychologists, and nurses. After a period of behavioral observation, data were pre-

sented in a "psychiatric case conference" and the patient was reinterviewed. The conference board consisted of a minimum of three psychiatrists and Ph.D. psychologists. Board members gave an opinion as to diagnosis, competency to stand trial, and criminal responsibility. Opinions were either unanimous or by a majority. Reports were sent to the court and distributed to the prosecution and defense. Either side had the option to call any conference board member to testify at trial without cost. Additional funding was also available through the public defender's office to provide outside expert evaluation.

At the time of the study, Maryland's test of insanity was a slightly modified, American Law Institute test, which stated:

> A defendant is not criminally responsible for criminal conduct if, at the time of that conduct the defendant, because of a mental disorder or mental retardation, lacks substantial capacity to appreciate the criminality of that conduct or to conform that conduct to the requirements of the law.
> Mental disorder does not include an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct.

In addition, case law in Maryland excludes from the insanity defense mental disorders secondary to voluntary alcohol or illicit drug intoxication.

Methods

The investigators identified the cohort of defendants pleading not criminally responsible during the study period through a log kept at the circuit court medical office. Demographic data, details of past psychiatric and criminal history, medical office diagnoses, and medical office opinions on criminal responsibility were collected through a review of the demographic data sheets completed by the evaluating circuit court medical office psychiatrist. Data missing from the sheet were obtained by reviewing the police report, available past hospital records and court records, and for those patients sent to state hospitals for further evaluation, from the state hospital patient record. Demographic data for patients admitted to state hospitals were verified through a review of the state hospital record. Discrepancies were resolved in favor of the state hospital record. State hospital diagnoses and criminal responsibility opinions were ascertained by a review of the hospital patient record.

Trial outcome data were ascertained through a search of the Circuit Court for Baltimore City's computer system, which listed plea, outcome, and sentence, and identified instances in which experts were called at trial. When computer data was unclear, the original court files and trial transcripts (where available) were reviewed.

Results

Of the 11,497 defendants indicted during the study period, 1.2 percent entered a plea of NCR (see Fig. 1). All cases pleading NCR were evaluated at the medical office of the circuit court. Of this cohort, 11 percent had charges dropped pretrial. One hundred twenty-seven defendants were therefore finally tried. Of these, 38 percent were thought to be possibly not criminally responsible

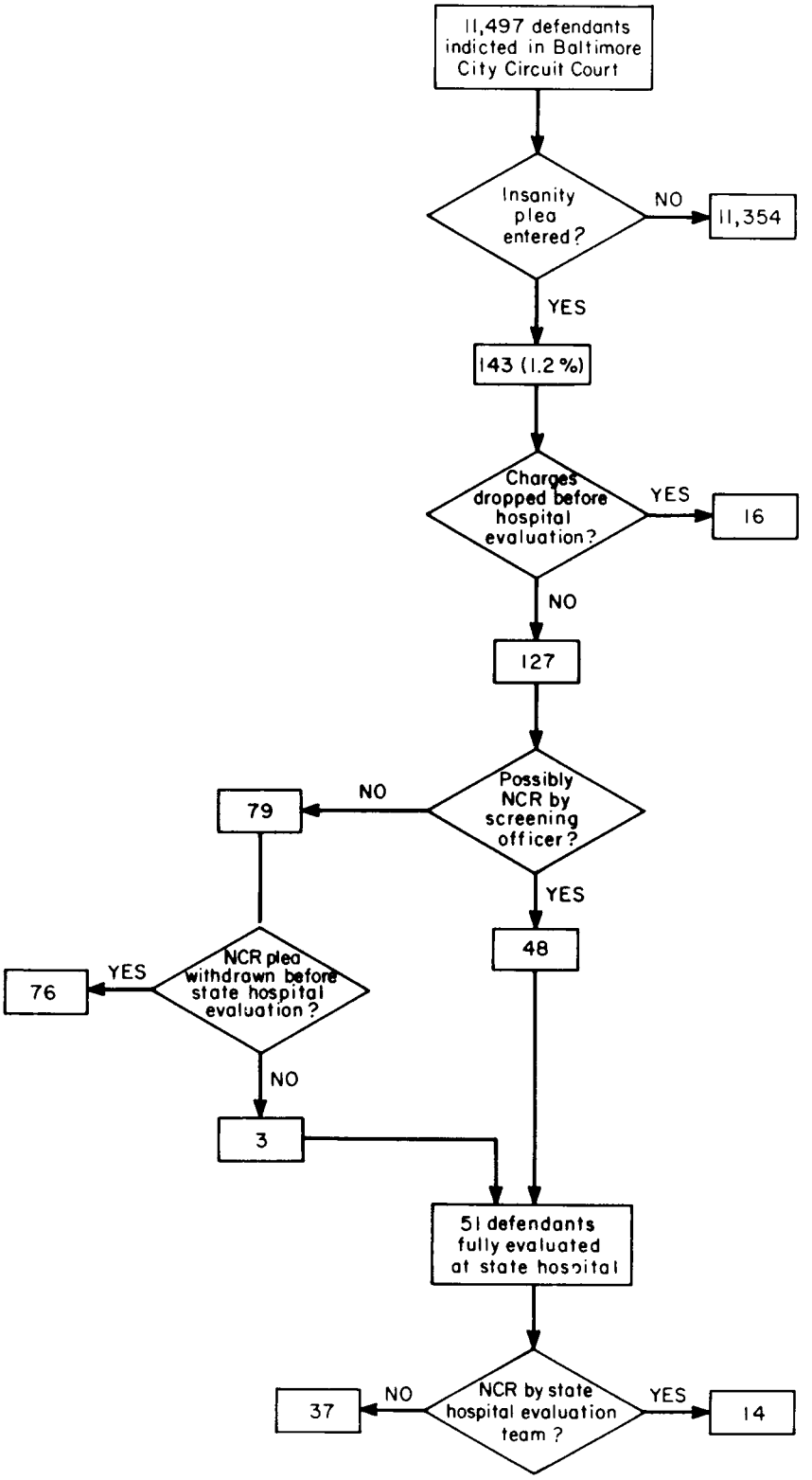

Figure 1. Outcome for defendants pleading insanity September 5, 1984, to September 5, 1985.

by the medical office of the circuit court and were referred to the state hospital for further in-depth evaluation. Three additional defendants screened as criminally responsible by the circuit court medical office were sent to state hospitals at their attorneys' request. The remaining 76 defendants withdrew their insanity pleas before trial.

After evaluation at the state hospital the forensic conference board evaluated 28 percent of the referred defendants as not criminally responsible. State hospital opinion versus actual outcome is presented in Table 1. The hospital evaluation team was unanimous in its opinion about criminal responsibility 96 percent of the time.

The insanity defense was dropped by the defense before trial in all but 16 instances. Both the state and the defense agreed that the defendant should be found not criminally responsible in 13 of those cases, and at trial the finding of NCR was uncontested. In one remaining case, the insanity defense was dropped at trial because of a technical legal issue. Only two cases led to full-blown insanity trials with opposing experts being called in to testify before a jury. One of these defendants was found guilty, and the other was found not criminally responsible.

Table 1
State Hospital Opinion versus Outcome

Opinion of Forensic Conference Board	Trial Outcome	
	Guilty	NGRI
Responsible	36	1
Not Responsible	1	13

$p < 0.0001$ by Fisher's exact test.

Of the remaining 111 defendants who dropped the insanity defense pretrial, 80 (72%) pled guilty in a plea bargain arrangement, 27 (24%) were found guilty after full trials, three (2.7%) were found not guilty, and one (0.9%) defendant's trial ended in a mistrial.

Factors which discriminated between those defendants found not criminally responsible and those found guilty or not guilty included the most serious charge originally brought, medical office and state hospital Axis I diagnosis, and final hospital physician recommendation as to criminal responsibility (see Table 2). Because of the low base-rate for NGRI outcomes, data groups were combined to give statistically meaningful results. Factors such as defendant's age, number of previous arrests, educational attainment, number of months spent in and number of hospitalizations in mental hospitals, race, occupational history, marital status, current living situation, family background, and degree or history of alcohol and drug use did not differentiate between the two groups when appropriate statistical tests were applied.

To further assess the level of agreement between psychiatrists, we identified those defendants evaluated by independent psychiatric experts. Nine defendants had such evaluations (see Fig. 2). Two defendants screened as criminally responsible by the circuit court medical office were also thought to be responsible by the independent expert. Their insanity plea was dropped before a full state hospital evaluation, and they were found guilty and sentenced to

Table 2
Significant Discriminators versus Trial Outcome

		Guilty	NGRI
Most Serious Charges*	Personal Crimes		
	Homicide	17	0
	Rape	8	0
	Other Sex Offense	9	2
	Robbery	19	0
	Assault	36	5
	Child abuse	2	0
	Other	0	0
	Total	91	7
	Property Crimes		
	Larceny-Theft	10	1
	MV Theft	1	0
	Arson	5	6
	Breaking and Entering	3	0
	Other	3	0
	Total	22	7
Medical Office Axis I Diagnosis†	Psychotic		
	Bipolar Manic or Mixed	1	1
	Bipolar or Unipolar Major Depression	2	0
	Schizophrenia	14	7
	Substance induced organic mental disorder	5	0
	Other	1	1
	Total	23	9
	Nonpsychotic		
	Substance Abuse/Dependency	23	0
	Alcohol Abuse/Dependency	23	0
	Paraphilia	4	0
	Mental Retardation	6	1
	Other	4	1
	Total	60	2
	No Axis I Dx	25	1
	Diagnosis Deferred	5	2
State Hospital Axis I Diagnosis‡	Psychotic		
	Bipolar Manic or Mixed	1	3
	Bipolar or Unipolar Major Depression	0	0
	Schizophrenia	6	7
	Substance Induced Organic Mental Disorder	1	1
	Other	1	0
	Total	9	11
	Nonpsychotic		
	Substance Abuse/Dependency	13	0
	Alcohol Abuse/Dependency	9	1
	Paraphilia	0	0
	MR	2	1
	Other	1	1
	Total	25	3
	No Axis I Diagnosis	3	0
Final Physician's Opinion as to Criminal Responsibility§	Responsible	112	1
	Not Responsible	1	13

* $p < 0.02$ by Fisher's exact test for personal versus property crimes.
† $p < 0.001$ by Fisher's exact test for psychotic versus non-psychotic.
‡ $p < 0.002$ by Fisher's exact test for psychotic versus non-psychotic.
§ $p < 0.001$ by Fisher's exact test.

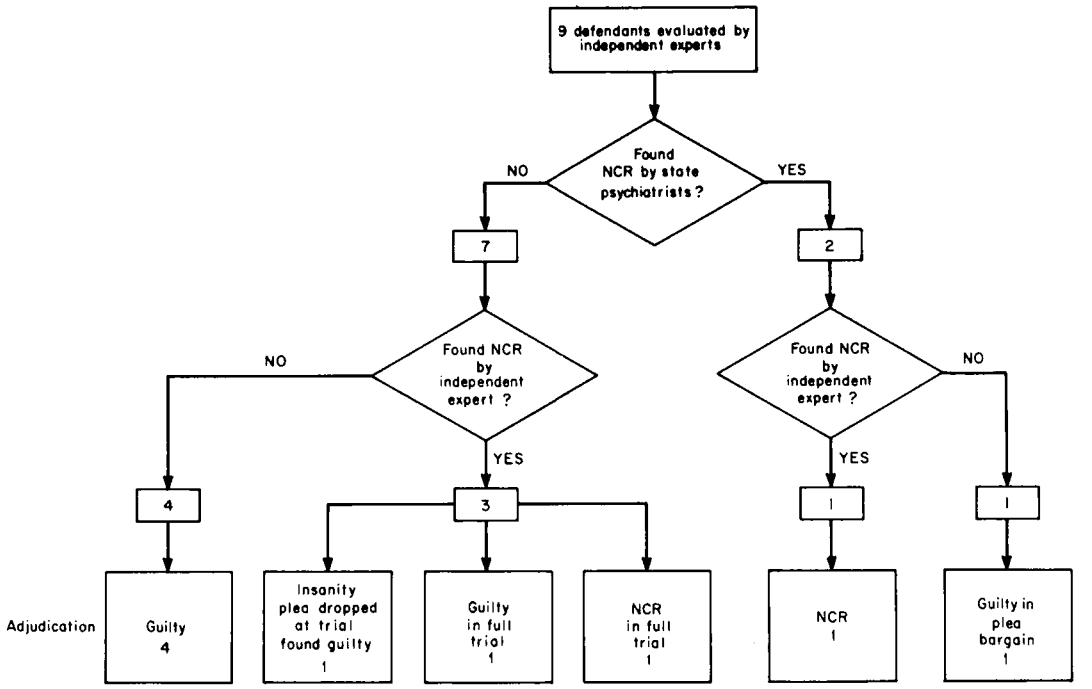

Figure 2. Agreement between independent experts' opinions and outcome.

prison at trial. Two other defendants screened as possibly not criminally responsible were evaluated as criminally responsible in both a full state hospital evaluation and by independent experts. Both defendants dropped their insanity plea and were found guilty.

Two other defendants assessed as not criminally responsible in full state hospital evaluations were evaluated by independent experts. In one case the expert agreed with the state hospital opinion. That defendant was adjudicated NCR. In the other case the defendant was thought to be criminally responsible by the independent expert. That defendant plead guilty in a plea bargain arrangement and received probation. Three defendants were thought to be criminally responsible by the state hospital team and not criminally responsible by independent experts. One of those defendants dropped the insanity plea for a technical legal reason and was sentenced to prison after a full trial. Both of the two remaining cases went to full trial with one defendant adjudicated NCR and one found guilty and sentenced to prison.

Discussion

We found that trial outcome for the finding of insanity was highly correlated with the opinions of the evaluating psychiatric expert. This confirms the finding of previous researchers.[11-13] Additionally, the vast majority of cases in our study were noncontested regarding the findings of criminal responsibility. This correlation and lack of contested cases can be viewed from two antithetical viewpoints. Perhaps courts and attor-

neys rely too heavily on the opinions of experts, and psychiatrists have usurped the role of the fact finder in the adversarial process. Alternatively, perhaps this agreement represents the "real world," with both the legal system and the medical system viewing the same data and coming to the same conclusions. Obviously, there is no correct answer, as no "gold standard" test of criminal responsibility exists. Although the insanity defense is frequently portrayed as a war between hired guns, in Baltimore City, at least, there is remarkable agreement between both sides. Only two cases (1.4% of those pleading NCR and 0.02% of all those indicted in Baltimore City during the same time period) had full-blown insanity trials. With respect to the remaining defendants, they either dropped their insanity pleas, or else all sides agreed as to the defendant's insanity.

Besides the experts' opinion, both diagnosis and the most serious underlying charge discriminated between those eventually found guilty and those found not guilty by reason of insanity. Again, in contrast to popular perception, no defendants charged with rape or murder were found not guilty by reason of insanity. That psychotic versus nonpsychotic Axis I diagnoses can discriminate between the two groups becomes even more striking when defendants' diagnosed as suffering from a psychotic illness are compared with those only suffering from substance or alcohol abuse. This is as it should be, given Maryland's test of insanity.

In Baltimore City insanity is pled only infrequently. When pled, it is successful less than 10 percent of the time. There seems to be little controversy in the courtroom over these cases. The public debate instead seems to be fed by the media's portrayal of the insanity defense. The occasional contested case raises the specter that a finding of not guilty by reason of insanity is overused, is frequently successful, and can be bought by the highest bidder. A careful review of real data shows that this is incorrect.

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