Characteristics of Criminal Defendants Referred for Psychiatric Evaluation

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This paper describes the socio-demographic and clinical characteristics of a sample of criminal defendants who were referred to the Court Liaison Service for psychiatric screening. Data has been extracted from the records of the Court Liaison Service and the psychiatric reports prepared for the courts. Most defendants were male, Pakeha, and facing serious charges. They had high rates of both previous psychiatric contact and criminal conviction.

Defendants who received the usual correctional sanctions are compared with those who were admitted to a psychiatric hospital as an outcome of their court appearance. More defendants who received correctional sanctions were referred because of concerns about dangerousness and they had high rates of depression. Most defendants who were hospitalised had diagnoses of schizophrenia or bipolar affective disorder.

There are four ways in which criminal defendants can be compulsorily hospitalised due to a mental disorder in New Zealand. Each of these options has distinctly different theoretical justifications, historical origins and developments over time. They functionally lead however to the same outcome for the defendant who becomes compulsorily confined in a psychiatric hospital. The admission criteria do not directly equate with any diagnostic classification. The legal standard for insanity, based on the McNaughten rules, requires the presence of 'natural imbecility or disease of the mind' that impacts on the person's understanding of the nature or quality of the act or that it was morally wrong (section 23(2) Crimes Act, 1961). While there are definitional issues, disability in New Zealand equates with fitness to plead in other jurisdictions. It necessitates mental disorder that interferes with the defendant's ability to plead, to understand the court proceedings or to communicate with counsel (section 108 Criminal Justice Act, 1985). A defendant convicted of a criminal offence can be sentenced to a psychiatric hospital if the court is satisfied that the person is mentally disordered and that detention in a hospital is necessary for the safety of the public or is in the defendant's own interests (section 118 Criminal Justice Act, 1985). When a defendant faces charges that are not serious, there may be negotiation which results in the police prosecutor agreeing to drop charges and proceedings being commenced under the Mental Health (Compulsory Assessment and Treatment) Act, 1992.

International studies of the characteristics of criminal defendants who receive a psychiatric disposition have often employed samples of either insanity acquittees or those found unfit to plea or both. There are differences in legal standards and in the consequences of these findings across jurisdictions which makes comparisons difficult. Approximately 10% of American criminal defendants who receive a psychiatric disposition are female, (Callahan, Steadman, McGreevy, & Robbins, 1991; Zonana, Bartel, Wells, Buchanan, & Getz, 1990). Most studies have found that these defendants are older than other criminal defendants and prison populations (Jeffrey, Pasewark, & Bieber, 1988; Pasewark, Jeffrey, & Bieber, 1987; Rice & Harris, 1990). Generally no association has been found between the race of the defendant and an adjudication of insanity (Callahan et al., 1991; Pasewark et al., 1987); however a meta-analytic review found that members of minority ethnic groups were more likely to be judged incompetent (Nicholson & Kugler, 1991). Marital status does not discriminate between insanity acquittees and comparison groups (Pasewark et al., 1987). Most acquittees are unemployed (Boehnert, 1988; Jeffrey et al., 1988; Pasewark et al., 1987) and employment is less frequent than in comparison groups (Rice & Harris, 1990).

Over 70% of defendants who receive a psychiatric disposition have been previously arrested (Jeffrey et al., 1988; Pasewark et al, 1987). Some researchers have found

that many insanity acquittees faced charges for minor nonviolent and nuisance offences (Boehnert 1988; Golding, Eaves, & Kowaz, 1989). Others have reported that type of offence was not correlated with competency findings (Boehnert, 1988) and that Canadian insanity acquittees face more serious charges (Rice & Harris, 1990).

Typically two thirds or more of samples of defendants who receive a psychiatric disposition have had prior psychiatric contact (Callahan et al., 1991; Golding, Eaves, & Kowaz, 1989; Jeffrey et al., 1988; Pasewark et al., 1987). About 80% have a diagnosis of schizophrenia or are regarded as psychotic (Bogenberger et al., 1987; Daniel, Beck, Herath, Schmitz, & Menninger 1984; Pasewark et al., 1987). Schizophrenia is more frequent amongst those found not guilty by reason of insanity, than amongst defendants who unsuccessfully raised this defence (Boehnert, 1988; Callahan et al., 1991). However 90% of those who unsuccessfully employed this defence had received a DSM-III diagnosis (Callahan et al., 1991). Affective disorders such as depression are usually diagnosed more frequently in control groups than in samples of insanity acquittees (Pasewark et al.,1987). While about 13% of samples of insanity acquittees have diagnoses of personality disorder (Boehnert 1988; Rice & Harris, 1990), this diagnosis is more frequent amongst defendants who do not receive a psychiatric disposition (Daniel et al., 1984; Pasewark et. al., 1987). Rates of alcohol and/or drug related difficulties are high (Pasewark et al., 1987). Defendants who receive a psychiatric disposition however, less frequently have a history of substance abuse than other defendants (Jeffrey et al., 1988; Pasewark et al., 1987) and are less likely than convicted offenders to have been intoxicated at the time of the index offence (Rice & Harris, 1990).

Most jurisdictions include some method of identifying criminal defendants who may have a mental disorder. The Metropolitan Toronto Forensic Service (METFORS) provides an intensive one day assessment by a multidisciplinary team (Menzies, 1989). In Scotland the procurator fiscal, who is the public prosecutor, identifies potential psychiatric cases (Duff, 1997). Services in England and Wales have focused on the presence of a psychiatric nurse specialist at court (James, 1999; Purchase, McCallum, & Kennedy, 1996; Rowlands, Inch, Rodger, & Soliman, 1997). Studies of pretrial remandees have consistently found high rates of psychiatric disorders (Joseph, 1990; Taylor & Gunn 1984; Teplin, 1990; Teplin, Abram, & McClelland, 1996).

The structure of forensic psychiatric services in New Zealand today is largely a consequence of the Mason Report (Mason, Bennett, & Ryan, 1988) which determined that the responsibility for caring for psychiatrically disturbed people, whether offenders or not, lay with the health service. Part of the new structure that was implemented following the Mason report was the Court Liaison Service which is part of Regional Forensic Psychiatric Services. A psychiatric nurse is made available in major courts throughout New Zealand to screen defendants for psychiatric difficulties. Relevant background information is collected and a semi-structured interview is administered including a mental status examination. On the basis of this screening assessment, recommendations are made to the judge as to whether defendants facing charges for offences punishable by imprisonment, should be remanded for psychiatric evaluation and report (section 121 Criminal Justice Act, 1985).

Spier (1999) reported that 16% of all convictions in New Zealand (except traffic offences) during 1998 involved female offenders. In 65% of cases the offender was under 30. When the ethnicity of the offender was known, 46% were Pakeha and 44% were Maori. Violent offending accounted for 13% of convictions and property offending 43%.

Information with regards to the characteristics of the New Zealand prison population is available from the Ministry of Justice census of prison inmates (Lash, 1998). At the time of the census 4% of sentenced inmates were female. The mean age of both males and females was 31.5 years and the modal age was 20-24. Of the sentenced inmates whose ethnic group was known, 55% of females and 50% of males identified themselves as being Maori. It is likely that the high percentage of people of Maori descent amongst sentenced inmates is at least in part because of the youthfulness of the Maori population. Young people commit most crime (Statistics New Zealand, 1996) and the median age of the Maori ethnic group is 21.6 years, in contrast with 33 years for the New Zealand population in general (Statistics New Zealand, 1998). Lash (1998) reported that the previous conviction rate of sentenced inmates was 81%. Inmates had been most frequently convicted for violent offending (56%) and 21% had offended against property. Psychiatric supervision was provided for 5% of inmates and 9% received psychological supervision.

Simpson, Brinded, Laidlaw, Fairley and Malcolm (1999) using the Comprehensive International Diagnostic Interview-Automated (CIDI-A) and the Personality Diagnostic Questionnaire (PDQ4+), conducted a national study of psychiatric morbidity in New Zealand prisons. In the month prior to the study date, 1.9% of sentenced male inmates and 3.6% of female inmates met the diagnostic criteria for schizophrenia or a related disorder. For sentenced males and remand and sentenced woman combined, respectively, prevalence rates were 1.1% and 1.2% for bipolar affective disorder, 5.9% and 11.1% for major depression and 41% and 46.8% for antisocial personality disorder.

Peters and Wade (1996) reviewed 2038 referrals to the Auckland Court Liaison Service over a two year period. Primary referral sources were counsel (43%) and police (24%) and the most frequent reasons for referral were 'unusual or odd behaviour' (26%) and a history of mental illness (23%). In this study 19% of defendants were female, the most frequent age group was 20-29 and 37% of defendants were Maori. Violence (19%) and unlawful taking of property (20%) were the most common offence categories.

The first year of operation of the Wellington Court Liaison Service (1992) has been described by Brinded, Malcolm, Fairley and Doyle (1996). They report that 418 assessments were completed on 359 people. Counsel made 28% of referrals and the police 37% and most referrals were made to determine if the defendant suffered from a psychiatric illness (47%). Of clients assessed, 20% were female and 30% were Maori. The average age was 30 for men and 34 for women. Forty percent were charged with offences against the person and 35% with offences against property. Previous contact with mental health services had occurred for 55% and Court Liaison staff estimated that in 61% of cases substance abuse had significantly contributed to their presentation.

The aim of the current study was to extend the available descriptive information of defendants referred to the Court Liaison Service in New Zealand. This study adds to previous ones by reporting on a Christchurch sample and by providing an analysis of psychiatric diagnoses. An additional aim was to investigate characteristics that discriminate between defendants who were compulsorily hospitalised as an outcome of their court appearance and those who received correctional outcomes.

Method

Retrospective reviews were made of the 'Court Liaison assessment sheets' and available file information of all criminal defendants screened by the Court Liaison Nurse in Christchurch, between 1992 and 1994. Current and previous primary diagnoses were obtained from the section 121 Criminal Justice Act, 1985 reports prepared by psychiatrists. Narrative information was coded and decision rules for the categorisation of variables were established and refined over the first 50 cases. The concordance rate of two independent clinical psychologists using this coding system ranged from 80 to 100%. Cases where information pertaining to a particular variable was not known have been excluded in the calculation of percentages. Comparisons were made between the group who received the usual correctional sanctions, such as imprisonment or periodic detention, who are referred to as the Justice group (J) and the group who were admitted to a psychiatric hospital who are referred to as the Psychiatric group (P). Analysis was by t test for continuous data and chi-square for categorical data.

Results

A total of 575 Court Liaison screenings were completed on 522 people. Of these assessments, 38.3% were completed on an inpatient basis, 36.8% on an outpatient basis and 24.4% in prison. The eventual outcome of the court appearance was known in 561 cases. Of these, 2.0% (N=11) were found to be legally insane at the time of the crime and 0.7% (N=4) were under disability. Orders pursuant to section 118 Criminal Justice Act, 1985 were made in 2.9% (N=16) of cases and charges were withdrawn and proceedings under the Mental Health (Compulsory Assessment and Treatment) Act, 1992 commenced in 5.9% (N=33). Thus 11.4% (N=64) of the total sample of Court Liaison screened defendants were admitted to a psychiatric hospital. There was sufficient data to enable analysis in 81.2% (N=52) of cases.

The police made 36.7% of referrals, legal counsel 40.3%, judges 6.7%, probation officers 6.2% and family members 2.4%. More of the Psychiatric group were referred by the police (J 33.7%, P 58.8%) and more of the Justice group were referred by legal counsel (J 25.5%, P 43.6%) ($\chi^2(6)=15.8$, $p<.05$).

Stated reasons for referral included the defendant having a psychiatric history (19.7%), concerns about his or her mental state (19.1%), the nature of the charge, such as assault on a child (16.5%), the defendant's presentation (12.5%) and dangerousness (11.3%). In the Justice group there was a greater proportion of referrals involving concerns about dangerousness (J 14.0%, P 0%) and more of the Psychiatric group were referred because of the nature of their presentation (J 8.0%, P 28.3%) ($\chi^2(8)=30.5$, $p<.01$).

In the total sample 87.2% were male and 12.8% were female. There were proportionately more males in the Psychiatric group (J 87.0%, P 98.0%) ($\chi^2(1)=5.4$, $p<.05$). The mean age of defendants referred to the Court Liaison Service was 30.3 years (SD 10.5) (males 30.6years, females 28.9 years). Defendants who were hospitalised were older than those who received correctional sanctions ($t(457)=2.3$, $p<.05$). The ethnic background of 81.4% of the total sample of Court Liaison referred defendants was Pakeha, 16.7% were of Maori descent and 1.9% were of Pacific Island origin. Most defendants were single (68.7%) or separated (17.5%). Only 17.4% were employed, with 29.4% on a sickness-related benefit and 41.5% unemployed. Ethnicity ($\chi^2(2)=1.35$, n.s.), relationship status ($\chi^2(3)=0.45$, n.s.) and employment ($\chi^2(3)=7.6$, n.s.) did not discriminate between groups.

A history of past criminal offending was known in 81.3% of cases. Defendants referred to the Court Liaison Service most frequently faced a most serious charge of violence (38.7%) or property offending (35.4%). No difference was found between groups in whether defendants had a history of past offending ($\chi^2(1)=3.25$, n.s.) and the type of crime for which they faced charges ($\chi^2(7)=5.95$, n.s.).

Acknowledged alcohol and/or drug related difficulties were recorded for 51.0% of the sample and 28.9% were intoxicated at the time of the crime or were rated as likely to have been so. A similar proportion in both groups had histories of substance abuse ($\chi^2(1)=1.3$, n.s.) and acknowledged or were rated as likely to have been using alcohol and/or drugs at the time of the crime ($\chi^2(1)=0.57$, n.s.).

Previous suicide attempts were recorded for 16.2% of the total sample and 36.0% were rated as being at moderate suicide risk and 11.2% at high risk. More defendants in the Justice group than in the Psychiatric group were recorded as having previously attempted suicide (J 18.1%, P 0%) ($\chi^2(1)=7.4$, $p<.01$)) and more

Table 1. Diagnoses (percentages)

	Defendants who were assessed and received a correctional sanction	Defendants admitted to a psychiatric hospital
Shizophrenia	8.8	43.8
Bipolar affective disorder	6.8	17.5
Psychoses (unspecified)	2.0	14.0
Major depression	12.2	1.8
Substance abuse and/or dependency	27.0	0
Antisocial personality disorder	6.8	0
Other personality disorders	8.1	0
Intellectual disability and organic impairment	7.5	5.3
Other diagnoses	4.1	14.0
None	16.9	3.5

frequent ratings of moderate or high suicide risk were made (J 51.0%, P 15.4%) ($\chi^2(2)=18.1$, $p<.01$).

In total, 70.2% of the sample had had previous contact with mental health services, including 44.7% with a history of inpatient admission. Forensic Psychiatric Services had previously assessed 20.7%. More of the Psychiatric group had histories of inpatient psychiatric care (J 39.3%, P 85.1%) and fewer had no known psychiatric history (J 33.3%, P 4.3%) ($\chi^2(3)=35.0$, $p<.01$).

Table 1 presents diagnostic information. More of the Psychiatric group than the Justice group had diagnoses of schizophrenia (including schizophreniform and schizoaffective disorders) and bipolar affective disorder. Defendants in the Justice group more frequently had diagnoses of major depression, substance abuse or dependency, antisocial personality disorder and no diagnoses ($\chi^2(9)=83.9$, $p<.01$). The percentage in each group who were organically impaired or intellectually disabled was small and did not differ between groups.

Discussion

As in the previous Court Liaison studies (Brinded et al., 1996; Wade & Peters, 1996) police and legal counsel made most referrals. The police referred more of those who were hospitalised, probably because of their early contact with potentially mentally ill offenders and their familiarity with the circumstances of the crime. Legal counsel, who may have been attempting to pursue all potential avenues of defence, referred more of those who received correctional sanctions. More of this group were referred because of issues related to dangerousness. It may be that when referral agents are considering dangerousness, that they refer defendants to the Court Liaison Nurse as a mental health professional who is readily available at court. This finding is consistent with an Australian study of police psychiatric referrals which found that decreased odds for mental illness and hospital admission were associated with threats of self harm and violence (Meadows, Calder, & Van Den Bos, 1996).

The gender ratio in the current study, is similar to that found amongst convicted offenders (Spier, 1999). The emphasis in forensic units on facilities for males may explain the greater proportion of males amongst defendants admitted to a psychiatric hospital. The finding that defendants who were hospitalised were older than those who received the usual correctional sanctions suggests that criminal offending secondary to mental disorder may have an latter age of onset. It may also be that it takes longer to come to the attention of authorities or that there is an interaction with ethnicity.

The percentage of defendants of Maori descent was lower than that found in the other New Zealand Court Liaison studies (Brinded et al., 1996; Peters & Wade, 1996) and that of sentenced male inmates (Lash, 1998). This is likely because more people of Maori descent are found in the Northern regions (Statistics New Zealand, 1998). It may also be that people of Maori descent may be more reluctant to seek or accept psychiatric referral or to view it as potentially useful. Psychiatric explanations for criminal offending may also be sought less often for Maori defendants. The community prevalence rates of mental disorder amongst Maori are unknown, however Horwood and Fergusson (1998) report higher rates amongst Maori than Pakeha young people and while total psychiatric admissions have decreased over recent years, admission rates for Maori have increased (Disley, 1997). A review of referrals to the Psychological Services of the Justice Department found that while inmates of Maori descent were less frequently referred, they appeared to benefit from treatment to the same extent as other inmates (Bakker & Riley, 1994). Direct comparison between these studies is difficult because of the various ways in which ethnicity has been identified and classified.

The severity of the offending of the sample, as measured by the percentage of defendants facing violent charges, fell between that of prison inmates and the percentage found amongst all New Zealand convictions. It is similar to the percentage charged with offences against the person reported by Brinded et al (1996) but greater than that reported by Peters and Wade (1996) who utilised a larger number of crime categories.

While over half the defendants acknowledged substance abuse difficulties, this is likely to be an underestimate. In a Christchurch study of prisoners, 81% had a lifetime alcohol disorder and 30% a lifetime drug use disorder (Bushnell & Bakker, 1997). The finding that intoxication at the time of the crime was more frequent amongst those who were not hospitalised may have occurred because of effective screening of the often disorganised behaviour related to substance abuse which can mimic signs of mental disorder. Alternatively there may be a failure to detect mental disorder in defendants who were comorbidly intoxicated.

In comparison with defendants who were hospitalised, more of those who received correctional sanctions had a history of prior suicide attempt and more were rated as being of high to moderate risk of suicide. Suicide risk is a component in the compulsory admission criterion to the

mental health system only when it is accompanied by severe psychiatric disorder, excluding substance abuse and intellectual disability (Mental Health (Compulsory Assessment and Treatment) Act, 1992)

Most defendants who were admitted to a psychiatric hospital had diagnoses of schizophrenia, bipolar affective disorder or unspecified psychoses. These disorders were also present amongst the group of defendants who were assessed but received the usual correctional outcomes and rates were more frequent than those found amongst prison inmates. When schizophrenia was diagnosed there was a higher likelihood that psychiatric admission would eventuate, than if bipolar affective disorder or major depression were present. These disorders may occur without the individual necessarily meeting the threshold for insanity, disability or compulsory treatment. For example, depression in its most severe form is accompanied by psychotic processes which could well impact on a person's legally functional abilities, however on most occasions when major depression is evident, the person would not meet these criteria. Alternatively these disorders may have been in remission.

Standardisation of the information collected and the classification systems utilised by Court Liaison Services throughout New Zealand, including consideration of reliability, would improve comparisons between regions. A more accurate picture of offending and diagnoses could be obtained by including secondary information in addition to most serious categories. In the current study results have been compared with the prison population, however the severity of offending suggests that some defendants would have received community sentences if they were not diverted. Comparisons with non-offenders in psychiatric hospitals may yield useful information about crime committed as a manifestation of mental disorder.

Conclusions

This study indicates that there is a uniform picture in New Zealand and internationally, of criminal defendants referred to Court Liaison Services. They are most frequently male, Pakeha and tend to be older than sentenced inmates. Usually these defendants have offended in the past and they have had prior contact with mental health services. They are infrequently employed or married. Examination of the socio-demographic correlates indicates that they are much like other defendants. It is predicted that since the time of data collection, there are higher percentages of young people, Maori and females amongst defendants referred to the Court Liaison Service.

While some defendants who were screened but not hospitalised have major mental disorders, most have diagnoses of moderate or low severity or do not meet DSM criteria. This group often has mental health problems, most frequently depression and substance abuse difficulties that require intervention. A considerable number are at risk of harming themselves or others. These issues may well have had an etiological role in their offending and they may be addressed by psychological or psychiatric intervention either in the community or in prison. Defendants who were hospitalised were proportionately small in number and most were psychotic.

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