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Discovery of Mental Illness and Mental Defect Among Offenders

In spite of one psychiatrist's play upon words, infatuation with myth, and diatribes about mental illness, people still get sick in their minds and disturbed in their behavior. They are known to have lost control of their impulses and to have committed dangerous acts causing injury to themselves and to others. Patients have described hallucinatory and delusional experiences, have become disorganized and confused, have lost contact with reality, and have required treatment in specialized hospitals, there to be protected for their own sake as well as for others and to receive help toward halting the disease process, controlling it, curing it.

In contrast there have been many admissions to various penal institutions of people who did not belong there by virtue of their mental illness which rendered them irresponsible for the acts which led to their confinement. To prevent this a system had been developed in the Greater Hartford community which, we believe, allows for a more humane and efficient management of these situations.

As was reported in an earlier publication [*1*], Section 54–40 of the Connecticut Statutes provided for psychiatric examination of an offender to determine his ability to understand the legal proceedings in which he was involved and his ability to assist his attorney in his defense. With the advent of the Family Relations and Adult Probation Divisions of the Circuit Courts, it had become possible to arrange for such examinations and subsequent hearings in a smooth and harmonious manner with dispatch and efficiency.

As soon as it became known that the offender was believed to be suffering from some type of mental illness or defect as noted in the officers' report,[2] or from statements by family or friends, or by his behavior in court, one of the above Divisions notified a consultant psychiatrist to examine the accused and submit a report of his mental condition. When mental illness or appreciable defect was found, a special clerk would be telephoned soon after the examination and advised of the findings. In keeping with Section 54–40, a second psychiatrist would be appointed; and when both physicians agreed that there was incapacitating mental illness or defect, a hearing date would be set. After the facts were presented and proved satisfactory to the Court, the offender would be transferred in most instances to a public mental hospital for observation and care. When there was disagree-

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[2] Actual copy of Officer's Report on a charge of Breach of Peace: "CIRCUMSTANCES OF ARREST: The above accused was causing a disturbance inside of the Washington Pharmacy, 159 Washington Street. When the undersigned officers asked the accused his name and where he lived, he stated that he did not have a home and was not living anywhere. He further stated that he was a government agent. In the undersigned officer's opinion the above accused should have a psychiatric examination for his own protection."

ment between the two examining physicians, a third psychiatrist would be called and his conclusions usually settled the medical issue one way or another.

Discussion

A pre-trial study of 450 mentally disturbed offenders revealed a high percentage who required hospital care. In order to arrange for such treatment, a method had been devised whereby the accused person was given a psychiatric examination soon after his arrest (see Table 1) and initial Court appearance (see Table 2). When he was found unable to stand trial (Connecticut Statutes, Section 54–40) the presiding Judge would order him transferred to a public mental hospital along with a *nolle prosequi* in many instances. The total procedure from the time of the person's apprehension to his commitment was a shared responsibility and included the police department, prosecutor, Family Relations and Adult Probation Divisions, public defender, presiding Judge, and consulting psychiatrists. Years of experience between all these participants have produced a most efficient kind of teamwork. This has been of great benefit both to the sick offender in need of help and to the community at large which was obligated to provide such help.

In his period of service, the author has found the Courts unusually sensitive to the plight of the mentally ill offender. With such support and the coordinated efforts of various arms of the judicial system, the program got off to a good start, was able to build a firm foundation, and has functioned well ever since. Cases have been brought forward

TABLE 1—*Cases ordered by court for psychiatric examination in 1971.*

Nature of Offense at Time of Arrest[a]	Number of Cases
Breach of peace	212
Assault	51
Intoxication	15
Malicious damage to private property	14
Resisting arrest	13
Breaking and entering	11
Larceny	10
Indecent assault	8
Risk of injury to Minors	8
Indecent exposure	7
Attempted Rape, Rape	7
Drug violation	7
False alarm	6
Theft motor vehicle	6
Kindling fire with burning substance	5
Manifest danger, habits of vice	5
Receiving money under false pretenses	4
Shoplifting	4
Vagrancy	4
Carrying dangerous weapon	4
Failure to pay restaurant bill	4
Attempted arson, arson	3
False complaint	3
Assault with intent to commit murder	2

[a] One or two cases each were found in additional categories as trespassing, robbery with violence, non-support, cruelty to person or animal, interference with police, theft from person, manslaughter, possession of stolen goods, loitering, lascivious carriage, throwing fire bomb, throwing objects into street, tampering with motor vehicle, embezzlement, disorderly conduct, reckless driving.

TABLE 2—*Results of psychiatric examinations completed and reported to the court in 1971.*

Major Category[a]	Committed by Emergency Certificate	Committed Following Court Hearing	Able to Stand Trial	Referred to Outside Agency
Schizophrenia	17	99	5	3
Alcoholism	4	21	20	31
Mental Defect	...	22	12	7
Paranoid Psychosis	2	21	1 (remission)	...
Chronic Brain Syndrome	2	15	...	2

[a] The Chronic Brain category included mostly persons with a chronic alcohol history. The Mental Defect group had a mixture of schizophrenia, epilepsy, alcoholism, drug addiction. Many were in difficulty soon after release from the hospital. The above table includes some unavoidable overlap such as alcoholism and schizophrenia, paranoid psychosis with alcoholism.

to an early hearing, families contacted when possible, social agencies referred to when indicated. Throughout the process it was quite clear to all concerned that we were dealing with people who were ill. The same serious consideration was accorded the offender during his pre-trial stay at the Correction Center where the attendants have gained considerable awareness of the significance of mental symptoms. Guards have said, "Doc, half the guys here could use your help."

By now most of us are familiar with certain arguments directed against commitment, against psychiatrists testifying in court, against the concept of mental illness as a medical model. It has been suggested that we abolish the psychiatric hospital, quit giving shock therapy, and no longer use psychotropic drugs. Perhaps one might coin a new term, "opposition complex," and recruit into this category all those individuals who are compelled to be against something. Such noblesse oblige is not realistic or practical, neither are these outcries to be found in sensible and logical alignment with the true issues and facts. When a mentally disabled person, particularly one of the paranoid category, has committed a crime (and some have been horrendous), the paramount consideration is to recognize and treat his condition; and the best place to do this is in a hospital. Obviously, he should be prevented from doing harm, and he should have the benefit of a protective environment where he will hopefully feel reasonably safe.

The original paper [*1*] on mental illness among offenders published in 1969 described 100 psychiatric examinations and associated findings (Table 2A). The present report (Table 2B) was based on 450 subsequent examinations. The first study showed the Schizophrenia percentage to be 34 while in the latter group which was over 4 times as large the Schizophrenia percentage was 29.6. With the addition of Paranoid Psychosis to both series, the 1969 and 1971 percentages are almost equal (38 and 37.5 respectively). There appeared to be a remarkable consistency in the incidence of these disorders among the mentally ill offenders. It has been accepted quite universally that persons with this type of psychosis can be dangerous. They need close attention and society requires protection. To allow these offenders to circulate freely in an open community is a matter of deep public concern. The judicial system has played a very important role in providing the means for adequate management of this serious problem, and the presiding Judges by their liberal and humane understanding have helped to make the life of the mentally ill offender a little bit easier.

TABLE 2A—*Disorders diagnosed in 100 Court-Appointed psychiatric examinations in 1969.*

Classification	Number of Cases and % of Total
Without Psychosis[a]	10
Schizophrenia	34
Alcoholism[b]	13
Mental Defect[b]	9
Schizo-Affective	5
Paranoid Psychosis	4
Depressive States	4
Chronic Brain Syndrome	5
Personality Disorders	6
Sociopathic Personality	3
Neutrotic Reaction	3
All Other	4
Number of Hospital Commitments[c]	57

[a] In these there was no obvious psychiatric diagnosis.
[b] Includes psychotic illness.
[c] In some instances other arrangements were made for care of psychotic patients.

TABLE 2B—*Classification of disorders in 450 offenders after psychiatric examination in 1971. These are provisional diagnoses; and in some cases more than one category of disorder has been cited.*

Schizophrenia	133
Paranoid Psychosis	36
Alcoholism (plus/minus Psychosis)	96
Mental Defect	39
Chronic Brain Syndrome	21
Convulsive Disorder	7
Sociopathic Personality	9
Schizoid Personality	5
Schizo-Affective Type	5
Depressive Reaction	14
Conversion Hysteria	1
Manic Depressive Illness	3
Drug Dependence	8
Psychosis, unclassified	1
Adjustment Problem of Adolescence	2
Cerebral Palsy	1
Without Psychosis	97
Behavior Disorder	5
Confusional State	1
Anxiety Reaction	2
Personality Disorders	19

TABLE 3—*The general disposition of the psychiatric examinations completed and reported to the court in 1971.*

Emergency commitment	29
Court commitment	196
Psychiatric clinic referral	65
Court trails on charges	105
Social agency referral	60

Summary

Two successive studies of offenders recommended by the Circuit Courts for psychiatric examination confirmed the importance and value of this service. Looked upon negatively one might ask what would have happened to these people if this service was not available? Now, enough years have passed in the experience of our Circuit Courts to warrant continuation of this function; however, once such persons have left the psychiatric hospital, a good number often get into difficulty again. It is hoped that some means will be developed in the near future to provide special types of shelter, therapy, and rehabilitation for these unfortunate individuals. This plan will be the subject of a forthcoming paper.

Reference

[1] Gold, L. H., "*A Statistical Review of Court-Appointed Psychiatric Examinations*," *Journal of Forensic Sciences*, Vol. 14, No. 3, July 1969, pp. 294–301.