Defendants are clueless — the 30-day psychiatric observation

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Objective. To investigate the understanding and expectations of defendants referred to Valkenberg Hospital for 30-day observation.

Design. Defendants referred for 30 days of psychiatric assessment were surveyed by means of a semi-structured interview within 3 days of admission.

Participants. One hundred consecutive referrals from the Western, Northern and Eastern Cape were considered; 88 were eventually entered into the study.

Results. All defendants were generally ignorant of the reasons for referral, but had a good understanding of court procedure and wrongfulness. Mentally ill subjects differed only in their not being able to distinguish between a guilty/not guilty plea. Most did not have legal representation, did not personally request the assessment and denied guilt of the alleged offence.

Conclusions. Mental illness affects triability but not necessarily criminal responsibility. Disturbingly, most defendants were without legal representation and were unaware of the purpose, implications and possible outcomes of psychiatric observation. It is imperative that the legislation governing these aspects be reviewed.

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Psychiatric participation in the judicial process has become routine despite unresolved philosophical and terminological differences. The current transformation of South African society affords the opportunity to examine and challenge many fondly held assumptions, especially those concerning psychiatric evaluations for the criminal courts. During a trial a defendant can be referred under Section 79(2) of the Criminal Procedure Act (Act 51 of 1977) for 30 days of psychiatric observation to assess whether he or she has a mental illness or defect and consequently is not fit to stand trial (Section 77) and/or is 'incapable of appreciating the wrongfulness of his act; or of acting in accordance with an appreciation of the wrongfulness of his act' (Section 78). Section 79(3) of the Act requires that the evaluating psychiatrist pronounce directly on the above in the report to the court. No clear guidelines exist to direct the assessment.

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Does appreciation of wrongfulness involve mere acknowledgement of the act's unlawfulness, or does it require deeper moral insights? Since the report of the Rumpff Commission there has been little debate in South Africa as to whether psychiatrists should pronounce upon criminal capacity (which ultimately is the court's function), or how competency to stand trial should be assessed.[1] In practice whenever a defendant is assessed as being mentally ill (and certifiable) the psychiatric report almost invariably states that he is unfit to stand trial and was unable to appreciate wrongfulness or act in accordance with such an appreciation during the alleged offence.

Many defendants do not have legal representation and are not given the opportunity to consult a lawyer when their competence to stand trial and criminal responsibility are questioned. In the USA, the insanity defence has to be raised by the defendant and cannot be imposed by the court, and even then the majority withdraw the plea after psychiatric evaluation but before the trial commences.[2] The burden of proof for the insanity defence rests with the accused, yet many defendants in the Western Cape are referred because someone else (in court) has raised the possibility of mental illness. A fundamental aspect of due process is that defendants should be able to understand and participate in the court procedure that results in referral for 30 days of observation. But there has been an enduring impression in this unit that defendants referred for observation appear to have little understanding of why they have been referred, what to expect during hospitalisation, and what the possible outcomes following the psychiatric assessment could be.

A recent study in KwaZulu-Natal concluded that the psychiatric observation process was not cost-effective and that most defendants who attempt to use it are naïve, barely literate and usually charged with serious offences.[3] Most South African criminal law authorities have not considered the possibility that mentally ill individuals may possess criminal capacity and are capable of defending themselves in court.[4] In the USA, there has long been a vigorous debate about the value and place of psychiatric testimony in support of the insanity defence, and the possibility that mentally ill defendants (i.e. psychotic or cognitively impaired individuals) are able to follow court proceedings and brief legal counsel.[5-9]

Psychiatric observation has two possible outcomes. Either the accused is returned to court for trial or the charges are withdrawn, followed by subsequent return to a psychiatric hospital for indefinite admission under Section 28 ('State patient') or Section 9 of the Mental Health Act. The period of hospitalisation for State patients (particularly when a violent charge occasioned the referral) is often longer than they would have been imprisoned for following conviction.

Valkenberg Hospital admits between 25 and 40 male observation patients each month. The drainage area for the hospital includes the Western Cape, Northern Cape and Eastern Cape provinces, which probably have a population of about 12 million.

The aims of this survey were to investigate the understanding and expectations of the observation process by referred defendants, and whether mentally ill defendants differ significantly in respect of their understanding of court procedure and wrongfulness of the alleged offence.

Method

Successive admissions of 100 defendants referred to Valkenberg Hospital were included. All were men. The effective period of the study was January - June 1996. Written informed consent was obtained from each patient. Those who refused to participate or were unable to communicate adequately (e.g. were delirious, demented or grossly psychotic) were excluded. Interviews were conducted within 3 days of admission in order to minimise the possible influence other observandi and patients might have had. Semi-structured interviews were used in which set questions were posed but allowed for the interviewers (MB and FW) to ask follow-up questions to clarify answers.

The following information was elicited: demographics (age, marital status, number of children, origin (rural/urban), level of education, referring court), previous psychiatric contact, and criminal history, including previous violent convictions. Details of the court referral were noted: the charge, who requested the observation, and the reason for referral; and whether the accused agreed with the referral, had legal counsel and was informed about observation procedure. Also recorded were previous referrals for observation (including outcomes), expectations of the observation process (what does the accused believe will happen during the 30 days) and expectations of the outcome following observation, including possible sentence.

Aspects of court procedure were explored, viz. what the accused intended to plead (guilty/not guilty), the difference between guilty/not guilty, the understanding of the wrongfulness of the alleged offence (moral insights as well as acknowledgement of unlawfulness were accepted), and the roles of the magistrate, prosecutor and witnesses.

Cross-tabulations with chi-square statistics were used primarily to compare the responses of those who were eventually declared mentally ill with the general sample. A significance level of $P = 0.05$ (one-tailed) was used. Fisher's exact test was applied when expected frequencies were less than 5.

Results

A total of 88 patients met the study criteria. Twelve patients were excluded because 4 were too psychotic to participate, 1 was moderately mentally handicapped, and 7 were not mentally ill but refused to participate. The average age of the sample was 30.36 years (range 16 - 60; standard deviation 8.75). Most had never married (68.2%), 11.4% were either divorced or widowed and 20.5% were married; 50% had no children and 35.3% had 1 or 2 children. Only 4 (4.5%) were illiterate and, of the remainder, 6 (6.8%) had had 2 years of schooling and 33 (37.5%) primary school education; 23 (26.1%) had achieved Standard 8, 18 (20.5%) Standard 9 or 10, and 2 (2.3%) had a tertiary education. In 2 cases (2.3%) educational status was uncertain. Most were unemployed (56.8%); the rest were labourers (11.4%), semi-skilled (9.1%), skilled (10.2%), self-employed (5.7%), professional (2.3%) or studying (2.3.%). There were 2 (2.3%) policemen. Most referrals were from urban areas (60.2%). The demographics of those ultimately declared mentally ill ($N = 27$ (30.7%)) did not differ significantly from the general sample.

An appreciable number (46.6%) had previously been admitted to a psychiatric hospital, especially if found mentally ill during this observation ($\chi^2 = 12.14$; df = 1; $P = 0.0005$). The charges that occasioned the referrals are listed in Table I. Most were referred following charges for violent offences (71.6%), although fewer of the mentally ill (55.5%) were accused of violent offences. The reasons for the referral are summarised in Table II. In all cases the courts requested that an evaluation of competence and criminal responsibility be conducted.

Table I. The charges

	Found to be mentally ill (N = 27) (%)	Total (N = 88) (%)
Murder	5 (18.5)	29 (33.0)
Attempted murder	1 (3.7)	3 (3.4)
Assault	2 (7.4)	8 (9.1)
Rape	2 (7.4)	10 (11.4)
Malicious damage	5 (18.5)	7 (8.0)
Indecent assault	2 (7.4)	2 (2.3)
Robbery	0	2 (2.3)
Theft	5 (18.5)	15 (17.0)
Housebreaking	3 (11.1)	7 (8.0)
Interdict violation	0	1 (1.1)
Fraud	1 (3.7)	2 (2.3)
Possession of cannabis	1 (3.7)	2 (2.3)

Table II. Reasons for the referral

	Mentally ill (N = 27) (%)	Total (N = 88) (%)
No reason evident/patient did not know	13 (48.1)	28 (31.9)
Defendant had a psychiatric history	5 (18.5)	14 (15.9)
Behaviour in court suggested mental illness	2 (7.4)	8 (9.1)
Defendant complained of 'not being right'	3 (11.1)	14 (15.9)
Defendant's behaviour during the offence seemed disordered	2 (7.4)	5 (5.7)
Epilepsy	1 (3.7)	2 (2.3)
Past head injury	0	5 (5.7)
Claimed amnesia	0	5 (5.7)
Substance abuse	0	2 (2.3)
Was sexually abused in childhood	0	1 (1.1)
Mental retardation	0	1 (1.1)
Lawyer could not understand client	0	1 (1.1)

All were referred for assessment of their competence to stand trial and criminal capacity. Many had legal counsel (40.9%), but those eventually declared mentally ill were less likely to have legal representation (25.9%; $\chi^2 = 3.62$; $P = 0.05$). Only 16 (18.2%) were informed about the process and implications of the observation referral during the court case. Legal representation did not result in greater awareness or knowledge on the part of defendants. A variety of participants requested the referral. Most referrals originated with the presiding magistrate (21.6%), but the next most common finding was that the patient under observation did not know which had requested the referral (17.0%). Defence counsel requests accounted for 18.2%, family 14.8%, the prosecutor 8.0%, the police officer 6.8% and the spouse 3.4%. In only 5 cases (5.7%) did the defendant himself ask for the assessment. Other petitioners were the Attorney-General, probation officer and friends (4.2%). Yet 59 (67.0%) agreed with the need for referral, with no differences between the groups.

Only 12 (13.6%) had been referred for psychiatric assessment in the past (and all but 3 had been found fit to stand trial). Three had been declared State patients in the past, of whom 2 were again found to be mentally ill.

Past convictions were confirmed in 48 (54.5%), and past convictions for violent offences were found in 22 (25.0%); again, no differences between mentally ill and others were detected.

Only 22 (25.0%) knew that they were to be psychiatrically examined during the 30-day period. The rest had no idea what to expect (63.6%). Either they believed they had been sent for treatment (5.7%), were being incarcerated (3.4%) or had been sent for a rest (2.3%). Observandi also generally did not know what was to happen to them after the completion of the observation period; 39 (44.3%) did not know, 27 (30.7%) believed that they would be released to go home and only 2 (2.3%) assumed that they would be returned to the hospital. The remainder expected to return to court where they would either be found not guilty (11.4%) or found guilty and sentenced (8.0%). Only 1 expected the psychiatric assessment to support a plea for mitigation. Despite their ignorance of their fate following the observation period, most observandi had a definite expectation of the eventual outcome of their court case. They expected sentencing and incarceration (28.4%), to be acquitted (20.5%), correctional service (9.1%), or a suspended sentence (3.4%). However, 34 (38.6%) did not know what their ultimate fate might be.

Although 46 (52.3%) admitted during interviews that they had actually committed the offence, 31 (35.2%) intended to plead guilty. Mentally ill observandi were not more likely to admit culpability. However, 59.3% claimed that their actions (at the time of the alleged offence) were not their fault. The reasons advanced for this included intoxication (11.4%), psychotic symptoms (6.8%), trance (5.7%), stress (4.5%), amnesia (3.4%), and anger (3.4%). Two (2.3%) claimed that a combination of anger and intoxication explained their behaviour.

Most (79.5%) were able to distinguish, with good reasoning, the difference between a guilty and not guilty plea. But mentally ill obervandi were significantly less able to do so ($\chi^2 = 6.58$; $P = 0.01$). However, 75% were able to give good explanations of the conceptual wrongfulness of the alleged offence, and no significant differences between the groups were found.

There was generally an adequate knowledge about court procedure. They correctly explained the role of the magistrate (72.7%) and witnesses (65.9%), but did not really seem to know what the prosecutor's role was (42.0%). Again, the mentally ill were not significantly less able to accomplish these explanations.

Most were sent back to court with no recommendations (61.4%). Only 9.1% were returned to court with a finding of 'not mentally ill' but with specific recommendations for future management. Of the 27 (30.7%) mentally ill

observandi it was recommended that 16 (18.2%) be returned to the hospital under Section 9 of the Mental Health Act, and 11 (12.5%) under Section 28 ('State patients').

Discussion

Most were between the ages of 22 and 38 years, single, literate, urban and unemployed men, which probably approximates the general male population of those who appear in the courts. Of the 12 excluded subjects, 5 were obviously incompetent to stand trial because of psychosis or severe mental handicap. Only 8 (of whom 2 were eventually found to be mentally ill) were referred for observation because their behaviour in court seemed disordered, and 5 (of whom 2 were mentally ill) were thought to have been disordered at the time of the alleged offence. Almost 32% professed not to know why they had been referred (or no reason was offered by the court), and 16% were referred simply because of past psychiatric contacts. The most disturbing set of findings indicated that almost 60% had no legal representation, only 18.2% had been given information about the purpose and consequences of psychiatric evaluation before arrival at Valkenberg Hospital, and only 5 had personally requested a psychiatric evaluation; even after admission only 25% realised that they would be undergoing a psychiatric evaluation during the following 30 days. It seems that court officials, especially the presiding magistrate, are most likely to consider that psychiatric assessment is needed, and then fail adequately to explain the procedure and its implications to the accused. However, following admission most seemed to accept the observation process. Considering that just over half (54.5%) had previous convictions, this was probably in the hope that a psychiatric report could somehow assist them, even though 63.6% did not quite know how. Interestingly, only 2 believed that they would be returned to hospital for treatment. Obviously, most intended to continue with their cases, but armed with psychiatric testimony. Only 13.6% had previously undergone observation. Considering the high rate of recidivism in this group it is likely that previously assessed defendants know that observation ultimately offers little but carries the risk of indefinite hospitalisation.

Mentally ill defendants differed significantly only in their competence to stand trial. They were less likely to know the difference between a guilty or not guilty plea, and 5 were too disordered to participate in this study, which was indication enough that they would not have been able to participate in their own defence. Nevertheless, their knowledge of the roles of court officials and general court procedure seemed as good as that of the others. Interestingly there was general ignorance of the role of the prosecutor. A worrying finding was that 30 - 60% of the sample displayed inadequate knowledge of the roles of the various court officials. This is probably an indication that most defendants, especially if without legal representation, have difficulties following court procedure.

The assumption that mentally ill defendants are generally unable to appreciate wrongfulness was not supported. Neither were they more likely to admit culpability for the alleged offence. Although almost 60% of all subjects claimed that they were not responsible for their actions at the time of alleged offence, only 6.8% provided pathological reasons, i.e. psychosis. The reasons advanced were mostly non-pathological (and therefore not included in definitions of mental illness) such as anger, intoxication and stress, and really should not have been accepted as valid reasons for referral (as stipulated in the Criminal Procedure Act).

All were referred for evaluation of competence and criminal capacity. In no case was a distinction made between these. It was our impression that most referrals were considered before any facts of the case had been presented to the court, which begs the question of what grounds were used to raise the insanity defence on behalf of the defendant. All those declared unfit to stand trial were also deemed not to have been criminally responsible at the time of the alleged offence. Competence to stand trial refers to the defendant's mental state at time of trial, whereas assessment of criminal responsibility is retrospective. Clearly, in most cases mentally ill individuals are disordered in both contexts. In South African practice the presence of mental illness is almost always assumed to negate competence and criminal responsibility. There is no overt requirement that a cause-effect relationship between alleged offence and mental state be established. Many psychotic individuals steal, rob and murder for reasons similar to those that motivate so-called normal people. Mental illness should not be used to escape justice but should certainly be important in deciding on disposal, i.e. treatment. It is perhaps a fiction that mentally ill defendants cannot be competent to stand trial and possess culpability.[10,11] There has been an ongoing debate in the USA, which has resulted either in increased emphasis on competence assessments or the use of 'guilty but mentally ill verdicts'.[8,12-15]

A proposal that has been widely accepted is that legislative provisions that require psychiatrists to pronounce on juridical tests should be scrapped. Psychiatrists are able to assess an accused's mental state at the time of trial and during the alleged offence, but should not be asked to comment on criminal responsibility, which remains the function of the court. Legislation might confer on the courts greater discretion and flexibility to request psychiatric and psychological assessments on any issue that may possibly help them in their deliberations. Almost half of the sample denied guilt, yet the insanity defence relies on acceptance by the defendant of the facts of the case, further indication that the defence is being misapplied.

Most of those found to be mentally ill were returned to court with recommendations that they be civilly committed under Section 9 of the Mental Health Act, which is surely an indication that many of these subjects need not have been brought to trial with the subsequent expensive (and time-consuming) referral for 30 days of observation. A small minority of defendants are eventually declared State patients (12.5%). Most of those found not to be mentally ill are returned without any recommendation.

A formal revision of court referrals for psychiatric observation should be considered. A disturbing non-psychiatric finding was the high degree of ignorance all defendants have about court procedure and their lack of legal representation. Transformation should target these issues.

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