

Insanity Defenses: Contested or Conceded?

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The authors examined 316 Oregon criminal cases in which the accused successfully pleaded the insanity defense. Prosecutors agreed to the insanity verdict in more than four out of five cases. In most cases all examining experts diagnosed the defendant as psychotic. The smaller number of defendants who were diagnosed by the state hospital staff as displaying only personality disorders accounted for a disproportionately large percentage of the contested trials. Observing that Oregon's insanity defense system is run by consensus, the authors suggest a reorientation of the insanity defense debate.

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My opinion is that we are losing. Insanity defenses seem to be springing up all over. Lawyers have become very familiar with *DSM-II*, and they can usually get the psychiatric expert to admit that the defendant does have a recognizable disease, according to the manual. Whether this is a mild depressive neurosis or an antisocial personality is irrelevant. Once you have admitted that the defendant has a recognizable mental disease, the attorney is off and running. I am amazed at the way words and facts can be distorted on the witness stand. Juries seem to bend considerably to "give someone a break," by finding him mentally ill.

A prominent psychiatrist in Portland wrote these thoughts in a 1975 letter to the head of the security unit at the Oregon State Hospital. He was expressing widely held beliefs. The notorious trial of John Hinckley reinforced the public's perception that the insanity defense is characterized by battles of experts during which defense lawyers and psychiatrists convince juries to acquit defendants who do not have a major mental illness. How accurate is this image of insanity trials?

Pasewark (1) recently reviewed the sparse research literature on the insanity defense. Only a few empirical

studies have considered the nature of the trial proceedings. Examining cases involving the insanity defense in Missouri, Petrila (2) noted the low frequency of contested trials for persons adjudicated insane. Singer (3) discussed 46 insanity trials in New Jersey and observed that most of them were brief proceedings without juries in which the experts agreed on the diagnosis. Fukunaga and associates (4) reported a high degree of interexaminer agreement on insanity and a high congruence between expert opinions and court verdicts in 484 cases in Hawaii. Steadman and associates (5) studied factors associated with successful insanity pleas in New York, focusing on the effect of the forensic evaluation on outcome. They pointed out that a major reason so little is known about court processes involving insanity defenses is that trials usually occur at the county level. Since there is typically no central reporting system, the records of trials are not easily accessible.

Until recently Oregon, like most states, compiled very few data about the actual operation of its insanity defense system. That changed after the Oregon legislature created the Psychiatric Security Review Board (PSRB), which began operation on January 1, 1978 (6). The board has sole jurisdiction over all persons who successfully use the insanity defense, who after the verdict continue to be affected by a mental disease or defect (whether active or in remission), and who present a substantial danger to others. The board decides whether the person should be hospitalized, released into community programs designed specifically for this population, or discharged completely. The board's authority over a person can last as long as the maximum prison sentence that could have been imposed if the person had been convicted.

A collateral advantage of the Oregon system is that the board collects and maintains extensive information about all people under its jurisdiction. Our analysis of that information has led to a series of reports in which we have discussed the creation of the board (7), described its review process in detail (8), looked at characteristics of persons committed to the board (9), discussed the concept of an insanity sentence (10), reviewed applicable legislation (11), and examined conditional release (12).

In this paper we focus on an earlier part of the process: the trial itself. In addition to keeping detailed records of each person's progress, the board compiles substantial background information about each individual, including records of trial proceedings acquired

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from county courts throughout the state. This allows the board to comply with its statutory obligation to review a person's entire criminal and psychiatric history. In most cases, by examining the court records in these files we were able to determine retrospectively the type of trial that resulted in the finding of insanity.

METHOD AND RESULTS

Sample

Our study sample consisted of 316 persons under the jurisdiction of the Psychiatric Security Review Board. We reviewed in detail the board's files on 359 individuals who appeared sequentially before the board during the period from Dec. 8, 1978, to July 10, 1981. From this review we were able to determine whether 316 of those persons had had a jury trial, a court trial, or an uncontested hearing. It was not possible to make this determination for the remaining 43 individuals.

We examined three subgroups: 1) contested trial involving a jury (jury), 2) contested trial involving a judge (court), and 3) uncontested hearings (uncontested). We defined uncontested cases as those in which the prosecutor agreed with the defense attorney that the defendant should be found not responsible by reason of mental disease or defect. Depending on the particular judge and district attorney involved and on local rules, these cases varied somewhat in actual procedure. For instance, some judges required testimony from an expert witness to complete the record even though there was no disagreement. Others accepted without testimony a prepared written or oral stipulation between the defense and prosecution. However, all cases in this category were characterized by a lack of any contest in court about whether the person should be found not responsible. In effect, the prosecutor conceded an insanity verdict.

The other two categories were characterized by a contest. The prosecutor opposed a finding of not responsible and argued for a guilty verdict. Some of these cases were tried before a jury; in other cases the jury was waived and the case was tried only before a judge.

Of the 316 cases studied, 86% (N=271) were uncontested; of the contested cases, 10% (N=33) were court trials and 4% (N=12) were jury trials. One of the jury trials involved a charge of murder brought when Oregon had a death penalty. Since the Oregon constitution requires a jury trial in capital cases, that case may not reflect true decision making by the attorneys about the type of court proceeding to use.

Diagnosis

We examined the trial subgroups in terms of diagnoses taken from state hospital records. As noted in our earlier reports, we make no claim regarding the

criteria used for these diagnoses or for their reliability. When a person had received a diagnosis of multiple disorders we used the one appearing first in the following hierarchy: mental retardation, organic brain syndrome, psychosis, neurosis, and personality disorder. Twenty-two persons in our sample had not received a final diagnosis by the hospital staff at the time of data collection. A diagnosis of psychosis was given to 70% (N=206) of the remaining sample; 18% (N=53) were judged to have personality disorders; and 12% (N=35) were given a diagnosis of retardation, organic brain syndrome, or neurosis.

We found significant variation in diagnosis within subgroups (see table 1). There was a decreasing percentage of psychoses and an increasing percentage of personality disorders from uncontested to court to jury trials. When jury and court contests were combined, only 57% of all contested cases involved a diagnosis of psychosis, compared with 72% of the uncontested cases. Thirty-six percent of all contested cases, but only 15% of the uncontested cases, involved a diagnosis of personality disorder. The pattern is also evident when one examines the distribution of type of trial proceedings within the two largest diagnostic categories of psychosis and personality disorder. Twenty-eight percent of personality disorder cases were contested, versus 12% of cases involving a diagnosis of psychosis.

We also considered another aspect of diagnosis. As reported earlier (9), we examined the files to determine whether there was agreement or disagreement among the multiple experts who diagnosed each defendant during pretrial and posttrial proceedings, including hospitalization. The files were examined at the time of psychiatric review board hearings, often months after the trial. They contained reports of experts who examined the defendant at various times before trial or after trial. When all the experts' reports in a file concurred on the primary diagnosis, we labeled that case as showing agreement. When any two or more of the experts disagreed on the diagnosis, we labeled that as a case of disagreement. Since we report here the state hospital diagnoses as our point of reference, all cases of disagreement involved at least one diagnosis which differed from that reached by the state hospital staff. Eighty-one files within our sample contained insufficient information to make this retrospective determination.

We emphasize the limitations of these data. Some cases in the disagreement category may reflect changing symptoms over time rather than actual disagreement among examiners as to diagnosis. Our data did not allow us to isolate this factor. Thus, cases of disagreement do not necessarily reflect actual disagreement at the time of trial.

There was agreement on primary diagnosis among all examiners in 81% (N=190) of the cases and disagreement in 19% (N=45). The prosecution contested 31% (N=14) of the cases in which there was disagreement on diagnosis, compared with only 10%

TABLE 1. Primary Diagnoses of 294 Individuals Who Successfully Pleaded the Insanity Defense^a

Diagnosis ^b	Jury Trial (N=11)		Court Trial (N=31)		Uncontested Hearing (N=252)		All Cases	
	N	%	N	%	N	%	N	%
Diagnosis	4	36	20	65	182	72	206	70
Personality disorder	6	55	9	29	38	15	53	18
Mental retardation	0		1	3	14	6	15	5
Organic brain syndrome	1	9	1	3	12	5	14	5
Neurosis	0		0		6	2	6	2

^aThere was a significant variation in diagnoses within subgroups ($\chi^2=15.98$, $df=8$, $p=.04$).

^bDiagnoses were taken from state hospital records.

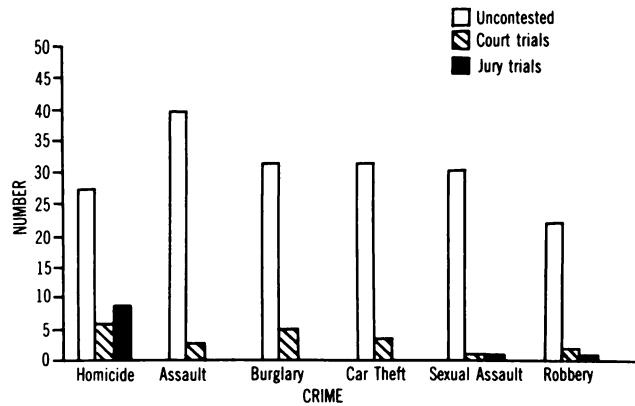
(N=19) of those in which there was agreement ($\chi^2=11.74$, $df=1$, $p=.0006$).

To examine further the disagreement on diagnosis, which related to the increased likelihood of a contested trial, we looked to see if agreement/disagreement varied within diagnostic categories. The findings are dramatic. Of the persons who received final diagnoses, there was agreement on the diagnosis of 97% (N=154) of those who were psychotic. By contrast, there was agreement by all examiners on only 28% (N=11) of the defendants considered to display primarily personality disorders. In addition, there was agreement on the diagnosis of all of the defendants considered mentally retarded (N=12), on 82% (N=9) of those diagnosed as having organic brain syndrome, and on 25% (N=1) of those diagnosed as neurotic. Overall, there was agreement in 83% (N=187) of the cases ($\chi^2=123.41$, $df=4$, $p<.001$). The other dimension of the same cross-tabulation showed that those diagnosed as having personality disorders accounted for 76% (N=29) of the cases in which there was disagreement on diagnosis. Those considered psychotic accounted for only 11% (N=4) of the disagreement.

Crimes

We also examined the trial subgroups in terms of various measures of crime. The crimes are those which the judge determined the individual had committed but was not responsible for because of mental disease or defect. For persons with multiple crimes we chose the most serious as the crime designated for that individual. We grouped crime designations by types of behavior, e.g., homicide, assault. Attempted crimes were included in the corresponding substantive crime category, e.g., attempted murder in the homicide category. The 83 different kinds of crimes committed by those in our sample were ranked, with murder as the most serious and false fire alarm as the least serious. We ranked crimes according to statutory degrees of seriousness and by the degree of danger to other persons.

FIGURE 1. Distribution of Types of Court Proceedings Within the Six Largest Categories of Felonies^a



^a $\chi^2=33.63$, $df=10$, $p=.0002$.

After this ranking was developed, each person was assigned a crime seriousness score from 1 to 83 (1=the most serious). We lacked information on one person in our study group.

Eighty-four percent (N=266) were felons, and 16% (N=49) were misdemeanants. This pattern did not vary significantly among the subgroups. However, significant variation was apparent when data were analyzed by types of felony criminal behavior ($\chi^2=45.66$, $df=18$, $p=.0003$). Particularly notable was the fact that although only 16% (N=43) of the felonies were homicides, 82% (N=9) of the felony jury trials involved homicides. The high percentage of contested trials involving homicides was also evident in the other axis of the cross-tabulation. Figure 1 shows the distribution of types of proceedings within the six largest categories of felonies. Thirty-five percent (N=15) of the trials involving homicides were contested; a smaller percentage (6% to 14%) of the trials involving other types of felonies were contested. The mean (\pm SD) crime seriousness score for the jury trial subgroup was 10.3 ± 16.64 , compared with the significantly less serious mean scores of 26.8 ± 20.56 for the court trial subgroup and 25.9 ± 20.70 for the uncontested subgroup ($F=3.38$, $df=2$, $p=.035$).

DISCUSSION

Our findings contrast sharply with the common perception of the insanity trial noted in the first part of this article. More than four of five successful insanity defenses in our study were agreed to by the prosecution, resulting in no contested trial before either a judge or jury. The typical defendant in those cases was affected by a major mental illness, usually a psychosis, and that diagnosis was agreed to by all the experts who examined the defendant. These findings are consistent with the few previously reported observations mentioned earlier in this article.

What can we conclude about the fewer than one in five insanity verdicts that were contested by the prosecution? As a group, defendants in those cases displayed significantly more personality disorders than did defendants in the uncontested cases. However, even among contested cases a majority of the defendants were psychotic. This suggests that there are cases in which the prosecution is advised that the defendant is severely mentally ill but argues that he or she nonetheless should be held responsible for criminal actions. This is logical, since the legal test of insanity requires not only a mental disease or defect but also a resulting lack of substantial capacity to appreciate criminality or to conform one's conduct to the law.

Not surprisingly, there was greater disagreement between experts about diagnosis in the contested group than in the uncontested group. However, even among contested cases there was diagnostic agreement about two-thirds of the defendants. Presumably the argument at trial concerned whether the mental disorder resulted in lack of legal responsibility. Most of the disagreement on diagnosis concerned those defendants diagnosed by the state hospital staff as having personality disorders. Both our data and anecdotal observations suggest the typical disagreement is that experts testifying for the prosecution diagnose personality disorders, whereas experts testifying for the defense diagnose psychoses.

From our findings we can conclude that the prosecutor is most likely to contest cases in which there is a diagnosis of personality disorder or a major disagreement over diagnosis. Furthermore, cases involving insanity defenses for serious crimes, particularly homicides, are more likely to be tried by juries than are cases involving minor crimes. Since homicide trials are frequently publicized, they may erroneously be perceived by the public as typical insanity defense cases.

We emphasize that our study group consisted of individuals who were successful with their insanity defense. Cases in which the defense failed might present a very different picture and lead to different conclusions. Our data also did not include the apparently very small number of persons who are found insane but are not placed under the jurisdiction of the Psychiatric Security Review Board.

The central message of our findings is clear. Successful insanity defenses in Oregon are characterized by cases in which the medical experts, defense attorney, prosecutor, and judge all agree that the defendant displays major mental illness and was not responsible for his crime. The insanity defense system is run by consensus. Further research is needed to determine if Oregon is typical. In any jurisdiction with similar findings, the insanity defense debate should be recast. We should abandon the myth that successful insanity defenses are characterized by defense psychiatrists convincing juries over the prosecutor's objections to acquit defendants with only minor mental disorders.

Instead, all should recognize that disputed cases may constitute less than 20% of successful defenses. Although we question how much this percentage can be reduced, it might be advisable to explore mechanisms to decrease still further the already small number of controversial insanity verdicts. For example, legislatures could enact statutes to disqualify those displaying only personality disorders from successfully pleading the insanity defense, since those defendants create the most disagreement about diagnosis and legal insanity.

Currently, those proposing reform of the insanity defense are concentrating on aspects highlighted by the Hinckley case. These include the burden of proof, the legal standard of insanity, and the opinions that psychiatrists should be permitted to express to the jury. These issues have most relevance to those few cases which include a battle of the experts fought before a jury.

It would be more productive to focus the insanity defense debate on the issues presented by the less controversial but far more numerous undisputed cases. One thing is certain: No change in the laws will make severely mentally ill offenders disappear; they will be somewhere in the criminal justice or mental health system. We might wisely devote less energy to debating nuances of trial procedure and more to ensuring that we have effective follow-up mechanisms for treating mentally ill offenders while simultaneously protecting the community.

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