Singapore Med J 1999; Vol 40(7):447-450

Psychiatric Survey of Offenders Under Criminal Commitment in Singapore

H L Yap, L P Sim, L C C Lim

ABSTRACT

Aim of Study: The study examined the demographic characteristics, pattern of psychiatric morbidity in offenders committed by Singapore courts and the effects of psychiatric recommendations on the disposal of these offenders.

Method: A retrospective case-note study was done on all offenders committed by the courts from January 1987 to December 1988 to Woodbridge Hospital. A 23-item questionnaire was used to collect data from the offenders.

Results: There were 187 offenders in the study, 165 males and 22 females. The typical offender was Chinese, male, unemployed and suffered from schizophrenia. 63.1% of the offenders required treatment after commitment. 13.9% had no psychiatric disorder. At the end of commitment, charges were dropped in 25% of cases. Theft was the most common offence and this was followed by sexual offences (molestation, outrage of modesty, exhibitionism). Offenders with schizophrenia were more likely than the others to have committed violent offences.

Conclusion: A large proportion of offenders were unwell at the time of the offence, the majority were suffering from schizophrenia. 13.9% had no psychiatric illness and charges were dropped in 25% indicating that the legal process could be further improved by providing additional psychiatric input to the courts so that offenders who exhibit abnormal or deviant behaviour may be appropriately dealt with.

Keywords: criminal commitment, offenders

Department of Adult Psychiatry III
Woodbridge Hospital
10 Buangkok View
Singapore 539747

H L Yap, MBBS, MMed (Psych), FAMS
Consultant

3 Mt Elizabeth #07-10
Mt Elizabeth Medical Centre
Singapore 228510

L P Sim, MBBS, MRCPsych, FAMS

Department of Psychological Medicine
National University Hospital
5 Lower Kent Ridge Road
Singapore 119074

L C C Lim, MBBS, PhD (Lond), FRCPsych (UK), FAMS
Senior Consultant

Correspondence to:
Dr H L Yap

INTRODUCTION

Psychiatrically disturbed individuals can be found in prisons. In a survey of the English prison services, Gunn[1] estimated that 31% of the convicted prisoners were psychiatrically disturbed. Their diagnoses included psychoses, neuroses, sexual deviations, alcoholism and personality disorders. Taylor and Gunn[2] found that 8.7% of men remanded at Brixton Prison were psychotic, of whom 70% were schizophrenic. Bowden[3] in a study of 634 men remanded at Brixton Prison for medical reports, found that 55% had schizophrenia, 19% had manic depressive psychoses and 15% had personality disorder.

In Singapore, mentally ill individuals who commit felonies or misdemeanours can be arrested by the police and then referred to the psychiatric hospital for voluntary treatment or involuntary commitment under Section 35 of the Mental Disorders and Treatment Act[4] or they may be charged in the courts. The court can, under Section 308 Chapter 68 of the Criminal Procedure Code[5], remand an accused person to a mental hospital for observation for up to one month, if the Judge is not satisfied that the accused is capable of making his defence. Following the trial, the accused can be committed to Woodbridge Hospital under Section 310 of the Criminal Procedure Code if he is found to be of unsound mind and incapable of making his defence. If the accused was acquitted on the grounds of insanity, he can be committed to Woodbridge Hospital under Section 315 of the Criminal Procedure Code.

The pre-trial psychiatric examination examines the person for the presence of mental illness, fitness to plead (competency to stand trial), whether the person was criminally responsible and makes recommendations to the court regarding treatment. A person is deemed competent to stand trial if he is able to understand the charge, the possible consequences, and the difference between a plea of guilty and not guilty, to challenge jurors (not applicable to Singapore since the jury system has been abolished), to instruct counsel, and to follow evidence in court. A person is deemed criminally responsible (to be of sound mind) if he knew the nature or quality of his act and knew that what he did was wrong.

Offenders suspected to be mentally abnormal are remanded either at Changi Prison Hospital or at Woodbridge Hospital for psychiatric assessment. All offenders charged with crimes with mandatory capital punishment such as murder and drug trafficking are remanded at Changi Prison Hospital for security reasons. In addition, offenders are committed to Woodbridge Hospital under the following circumstances:

(1) when the court suspects that the accused is of unsound mind and consequently incapable of making his defence (Section 308 Chapter 68 of the Criminal Procedure Code).
(2) when the accused has been found to be of unsound mind and incapable of making his defence

(Section 310 Chapter 68 of the Criminal Procedure Code).

(3) when the accused has been found not guilty by reason of insanity (Section 315 Chapter 68 of the Criminal Procedure Code).

The aim of this survey was to examine the demographic characteristics, pattern of psychiatric morbidity in offenders committed by the courts and the effects of psychiatric recommendations on disposal of these offenders. The results of this study will provide some understanding of how the criminal commitment law operates in Singapore.

METHODS

This is a retrospective case-note study of all offenders committed by the courts to Woodbridge Hospital from January 1987 to December 1988. A 23-item questionnaire was designed to record the offender's demographic information, details of the charge, commitment period, previous offences and past commitments. The diagnosis and treatment before and after the commitment, the psychiatric recommendation and the court outcome were recorded. The outcome of the court proceedings were traced from the subordinate courts. The diagnosis was based on the clinician's diagnosis as stated in the case records. The offences were classified according to the Criminal Procedure Code (Revised Edition, 1985)[5].

RESULTS

The mean age of the offenders was 34.8 years (range 17 – 62 years). Of the 187 offenders surveyed in this study, there were 165 males and 22 females (M:F = 7.5:1). Table I gives the demographic characteristics of the offenders. The majority of offenders were Chinese and single. Indians (9.6%) and Malays (17.6%) were not over-represented in the sample as the numbers are comparable to the racial distribution of the general population (Chinese 75.9%, Malays 15.2%, Indians 6.5% and others 2.4%). Most of the offenders were unemployed and those in employment were mainly unskilled workers. Schizophrenia (45.5%) was the most common diagnosis among the offenders and this was followed by mental retardation (12.8%) and personality disorder (9.1%). Interestingly, a substantial proportion of those committed had no psychiatric illness (13.9%). Although most offenders had no previous forensic record, 36.4% of them had a history of prior arrests. Only a small number of offenders (18.2%) had been committed by the courts in the past.

Although 71.7% of the offenders had a past history of psychiatric disorder, less than one-third (28.9%) were receiving treatment at the time of the offence. A significant number of patients were not on treatment (71.1%) (Table I). This is in contrast to the number (63.1%) of offenders requiring treatment after commitment. The majority were committed for pre-trial psychiatric reports. 70.6% of offenders were committed within one week of the offence. Interestingly, 16% of offenders were committed for more than 10 weeks after the offence was committed. The main reason for the delay was that the offender was not immediately charged in court. For example, there was an illegal hawker who had received summonses dating back several weeks prior to his court appearance.

Table II shows the relationship between psychiatric diagnosis and type of offences committed. Theft and sexual offences were the most common offences. Offenders with schizophrenia were more likely to have committed violent offences or made threats of

Table I – Characteristics of offenders

Offenders	N = 187 (%)
Sex	
Male	165 (88.2)
Female	22 (11.8)
Race	
Chinese	134 (71.7)
Malay	33 (17.6)
Indian	18 (9.6)
Others	2 (1.1)
Marital status	
Single	149 (79.7)
Married	28 (15.0)
Divorced/separated	9 (4.8)
Unknown	1 (0.5)
Employment	
Unemployed	107 (57.2)
Unskilled	64 (34.2)
Skilled	8 (4.3)
Professional	2 (1.1)
Unknown	6 (3.2)
Previous commitment by the court	
None	153 (81.8)
One to two	30 (16.1)
Three to seven	4 (2.1)
Previous offences	
None	117 (62.6)
One	54 (28.9)
Two	6 (3.2)
Three to seven	10 (5.3)
Diagnosis	
No psychiatric illness	26 (13.9)
Schizophrenia	85 (45.5)
Mental retardation	24 (12.8)
Personality disorder	17 (9.1)
Alcoholism	7 (3.7)
Bipolar disorder	5 (2.7)
Paranoid psychosis	5 (2.7)
Major depression	4 (2.1)
Temporal lobe epilepsy	4 (2.1)
Others	10 (5.3)
Past psychiatric disorder	
Yes	134 (71.7)
No	53 (28.3)
Treatment before commitment	
Yes	54 (28.9)
No	133 (71.1)
Treatment during commitment	
Yes	118 (63.1)
No	69 (36.9)
Duration between offence and commitment	
Less than 1 week	132 (70.6)
1 to 5 weeks	16 (8.6)
5 to 10 weeks	9 (4.8)
More than 10 weeks	30 (16.0)

Table II – Diagnosis and nature of offence

Nature of offence	Diagnosis					
	No psychiatric illness	Schizophrenia	Mental retardation	Personality disorder	Others	Total
Theft	3	18	6	7	10	44
Molestation/ Outrage of Modesty/ Exhibitionism	8	11	7	1	7	34
Rash act/killer litter/Vandalism	1	13	6	2	3	25
Voluntarily causing hurt	0	13	0	1	3	17
Possession of weapon/Criminal intimidation	4	10	3	1	7	25
Trespass/ Illegal hawking	7	8	1	2	3	21
Others	3	12	1	3	2	21
Total	26	85	24	17	35	187

Table III – Diagnosis, court outcome and psychiatrist's recommendations

	Psychiatrist's recommendations			
	Fit to plead Sound mind	Fit to plead Unsound mind	Unfit to plead Unsound mind	Total
Diagnosis:				
No psychiatric illness	26	0	0	26
Shizophrenia	71	3	11	85
Mental retardation	19	0	5	24
Personality disorder	17	0	0	17
Others	35	0	0	35
Total	168	3	16	187
Court outcome*:				
Imprisonment	52	0	0	52
Charges dropped	43	1	2	46
Fine	34	1	1	36
Further remand/ hospital treatment	5	1	12	18
Parole/supervision	7	0	0	7
Others	5	0	1	6
Total	146	3	16	165

* outcome unknown in 22 cases

violence – voluntarily causing hurt, rash act/killer litter and vandalism, criminal intimidation, possession of offensive weapon, than other mentally ill offenders. Similarly for the non-violent offences, offenders with schizophrenia were also more likely to have committed them. Sexual offences (molestation/outrage of modesty, exhibitionism) were committed more frequently by offenders with schizophrenia and mental retardation.

Table III shows that the majority of offenders were assessed to be fit to plead and not of unsound mind at the time of the offence. Of these, only 52 received custodial sentences from the court while 34 were fined for their offences. Interestingly, charges were dropped in 43 offenders. Offenders found to be of unsound mind suffered from schizophrenia or mental retardation. Although 19 offenders were of unsound mind at the time of the offences, 3 were assessed to be fit to plead while the remaining 16 were unfit to plead. Those offenders who were unfit to plead and to be of unsound mind were usually further remanded or given hospital treatment orders by the court.

DISCUSSION

The most striking finding in our study is the large proportion of offenders who received treatment after their commitment. This indicates that they were unwell at the time. Whether their illness contributed directly or indirectly to their offences is uncertain in the majority. Our study did show that for at least 19 offenders, their illness contributed to the offence as they were found to be of unsound mind at that time.

The typical offender was Chinese, single, male, unemployed with schizophrenia. Theft was the most common offence while sexual offences were the second largest group of offences. Affective psychosis, alcoholism and substance abuse were not prominent diagnoses. 13.9% of the offenders were found to have no psychiatric illness and 25% of offenders had their charges dropped. A subgroup of repeat offenders were also found. This is a retrospective study of the casenotes and has its drawbacks. The outcome information of 22 cases could not be traced.

Schizophrenia[7-11], mental retardation[10,12], alcoholism[2,9], substance abuse[2,10], personality disorder[2,3,10] and affective psychosis[7,8,11] were prominent diagnoses in offenders with psychiatric disorders in other studies. Schizophrenia, mental retardation and personality disorder figured prominently in our study but not affective psychosis, alcoholism and substance abuse. The rate of alcohol drinking[13] is lower in Singapore than in the US or UK and substance abusers are usually sent to Drug Rehabilitation Centres. These reasons may account for the lower rates in our sample. It is unclear why affective psychosis does not figure prominently in our offenders. This is probably because the courts find it easier to identify the floridly psychotic schizophrenic than an offender who is depressed or hypomanic.

Studies[3,6,14] have shown that 8% to 17% of offenders are assessed as having no mental illness or are not given a psychiatric diagnosis after assessment. Our study found that 13.9% of the subjects had no psychiatric disorder. We postulate that the court is more likely to commit offenders who exhibit bizarre behaviour or who are socially deviant for psychiatric evaluation. However, not all bizarre and socially deviant behaviour result from mental disorder which could have accounted for the offenders without a psychiatric diagnosis. Although our findings are comparable to other studies, the dilemma here is whether this figure is still unacceptably high and if it can be reduced further by establishing court liaison clinics. Appelbaum et al[17] have shown that establishing court clinics can help reduce the number of inappropriate commitments under criminal law.

The staff in this clinic have a gate-keeping function by conducting mental health evaluations in courts, forestalling many court-ordered inpatient forensic evaluations.

There are few studies that report on court disposition following psychiatric assessment. In two studies[3,6] 3% and 72% of offenders had their charges dropped. In our study, charges were dropped in 25% of offenders. The court could have taken into consideration the fact that the offender was unwell at the time of the offence and dropped the charge if the offence was minor.

A study[16] found that there is a revolving door phenomenon for a subgroup of offenders sent by the courts for psychiatric evaluation. A 33% recidivism rate (defined as at least one readmission to the psychiatric forensic unit within two years of the index admission) was found in their study and the recidivists were characterised by being older, were severely mentally ill, were charged for minor offences and had more psychiatric hospitalisations. Our study found that about 18% had a history of previous commitment for psychiatric evaluation. Further study of this subgroup of offenders is important because if they turn out to be suffering from severe mental illness then provision of better aftercare services may help to reduce recidivism.

There are few studies[12] on the relationship between the pattern of offence and different psychiatric diagnosis. The relationship between schizophrenia and offence is the most widely studied[14,15]. Our study showed that offenders with schizophrenia committed more of both violent and non-violent crimes when compared to offenders with other psychiatric diagnosis. Taylor[15] reviewed the association between schizophrenia and violent offences and found that active psychopathology was related to the offence. Our data do not allow us to make such an analysis. However it can be deduced that a proportion of them must have been unwell as a substantial number of our subjects required treatment after commitment. The number of offenders in the other diagnostic categories are small and no identifiable pattern of offence is obvious for them. A drawback of attempting to identify a pattern of offence in this study is that there is a selection bias. Offenders are sent here for evaluation precisely because they have not committed a serious offence. Otherwise they would have been evaluated by the prison forensic service.

Studies[6,18] of pre-trial psychiatric reports show that not all psychiatrists give opinions on fitness to plead and competency to stand trial, and that this was due to a lack of understanding the issues. In our study, it was mentioned in all psychiatric court reports about the accused's competency to stand trial and about his criminal responsibility. Eighty-nine of the offenders were judged competent to stand trial and were criminally responsible. Interestingly, 3 offenders were found to be fit to stand trial even though they were of unsound mind at the time of the offence. This is because fitness to plead can be modified by treatment.

CONCLUSION

This study found that a large proportion of offenders were mentally unwell at the time of the offence, with the majority suffering from schizophrenia. 13.9% had no psychiatric illness and charges were dropped in a quarter of offenders. The study indicates that legal process can be further improved by providing additional psychiatric input to the courts so that offenders who exhibit abnormal or deviant behaviour may be more appropriately dealt with. Further study needs to be done on the reasons for recidivism.

REFERENCES

1. Gunn J. Criminal Behaviour and Mental Disorder. Br J Psychiatry 1977; 130:317-29.
2. Taylor PJ, Gunn J. Violence and psychosis I - Risk of violence among psychotic men. Br Med J 1984; 288: 1945-9.
3. Bowden P. Men Remanded into Custody for Medical Reports - The Outcome of the Treatment Recommendations. Br J Psychiatry 1978; 132:332-8.
4. Mental Disorders and Treatment Act (chapter 178). Revised Edition 1985.
5. The Statutes of the Republic of Singapore. Criminal Procedure Code (Chapter 68). Revised Edition 1985.
6. Geller JL, Lister ED. The Process of Criminal Commitment for Pretrial Psychiatric Examination: An Evaluation. Am J Psychiatry 1978; 135:53-60.
7. Lamb RH, Grant RW. The Mentally Ill in an Urban County Jail. Arch Gen Psychiatry 1982; 39:17-22.
8. Lamb RH, Grant RW. Mentally Ill. Women in a County Jail. Arch Gen Psychiatry 1983; 40:363-8.
9. Bowden P. Men Remanded into Custody for Medical Reports: The Selection for Treatment. Br J Psychiatry 1978; 132:320-31.
10. Coid JW. Mentally abnormal prisoners on remand: I-Rejected or accepted by the NHS. Br Med Journal 1988; 96:1779-82.
11. Joseph PLA, Potter M. Diversion from Custody. II: Effects on Hospital and Prison Resources. Br J Psychiatry 1993; 162:330-4.
12. Hodgkins S. Mental Disorder, Intellectual Deficiency, and Crime. Arch Gen Psychiatry 1992; 49:476-83.
13. Straits Times, 8 March 1993.
14. Smith J, Grant F, Brinded P. Schizophrenics Remanded to the Forensic Psychiatric Institute of British Columbia, 1975-1990. Med Sci Law 1994; 34:221-6.
15. Taylor PJ. Motives for offending among Violent and Psychotic Men. Br J Psychiatry 1985; 147:491-8.
16. Greenberg WM, Shah PJ, Seide M. Recidivism on an Acute Psychiatric Forensic Service. Hosp and Community Psychiatry 1993; 44:583-5.
17. Appelbaum KL, Fisher WH, Nestlebaum Z, Batemen A. Are Pre-trial Commitments for Forensic Evaluation Used to Control Nuisance Behaviour? Hosp and Community Psychiatry 1992; 43:603-7.
18. Larkin EP, Collins PJ. Fitness to Plead and Psychiatric Reports. Med Sci Law 1989; 29:29-32.