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Retrospective Evaluation of Cases Examined to Determine Criminal Responsibilities

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ABSTRACT

Introduction: Even though the assessment of criminal responsibility constitutes an important part of forensic psychiatry practices, it is observed that there is little published data in our country about these cases. In this study, it was aimed to examine the sociodemographic data, characteristics of the alleged crime, their diagnoses and the expert opinions on criminal responsibilities of the forensic cases referred to our hospital.

Method: The medical files and medical board expert reports of 356 cases referred to our hospital by judicial authorities for evaluation of criminal liability, between 1 January 2017 and 31 December 2017, were retrospectively examined. The sociodemographic data of the cases, psychiatric diagnoses made according to DSM-IV diagnostic criteria and the judicial expert decisions made about them were statistically analyzed.

Results: It was reported that 22.2% of the cases (n=79) had no criminal responsibility related to their alleged crime, and 17.7% (n=63) of them had partial criminal responsibility. 47.8% of the cases with partial or no criminal responsibility were diagnosed with schizophrenia or other psychotic disorders, and 30.2% of the cases had mental retardation. "Threat and insult", "theft" or " bodily harm" constituted 53.9% of the 471 criminal acts.

Conclusion: Results of our study are consistent with the results of studies conducted in our country and abroad. Further descriptive studies are needed for a better understanding of the relationship between criminal behavior and mental health and for improving the punishment and the rehabilitation practices in this context.

Keywords: Forensic psychiatry, criminal responsibility, psychotic disorders, mental retardation, schizophrenia

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INTRODUCTION

Any humanitarian act sanctioned within the framework of legal regulations is defined as a crime (1). The sanction applied in cases where these legally defined legal limits are violated called punishment. For a person to be penalized for crimes committed before the law, that person must bear criminal responsibility. Full perception and willpower are the basic requirements of criminal responsibility (2). The qualifications regarding whether a person has criminal responsibility are determined by the Turkish Criminal Code (TCC) No. 5237. Article 32 of this law regulates the relationship between mental illness and criminal responsibility. Under paragraph 1 of article 32, persons who, due to mental illness, cannot perceive the legal meaning and consequences of the act they have committed and whose ability to direct their behavior related to this act is significantly diminished do not have criminal responsibility. In the second paragraph of the same article, it is judged that criminal responsibility is diminished in individuals whose ability to direct their behavior is partially diminished (3).

Judicial bodies may seek the experts' opinions in cases where the solution requires special and technical knowledge (4). Psychiatric expert opinion can be consulted in criminal law, civil law, and administrative law. Evaluating whether a person accused of a crime has a psychiatric disorder that may affect or eliminate criminal responsibility at the time of the crime is among the issues that require expert opinion by the judicial organs.

Although the criminal responsibility assessment constitutes the majority of today's forensic psychiatry practices, there are limited studies on the characteristics of forensic cases in our country. Kalenderoğlu et al., in their study, examined 314 cases referred by the courts over two years, under the headings of criminal law and civil law, in terms of sociodemographic characteristics, clinical diagnoses, and crime-diagnosis relationship (5). There are also similar studies that differ in sample size and time interval (6–8).

This study aims to contribute to the literature in this field by examining the sociodemographic characteristics, crime charging characteristics, clinical diagnoses, and evaluations of individuals referred to a psychiatry clinic to evaluate criminal responsibility by judicial authorities during one year.

METHOD

The researchers retrospectively scanned medical files and expert reports issued to evaluate the sociodemographic characteristics such as age, gender, marital status, total education period, psychiatric diagnoses, and crime charging characteristics of the cases referred to Ankara Numune Training and Research Hospital Psychiatry Outpatient Clinic between January 1, 2017, and December 31, 2017, with the request of the judicial authorities to evaluate their criminal responsibilities. Ethics committee approval for the study was obtained on 26.06.2018 (Ethics committee decision number: 2083/2018).

SPSS version 22.0 program was used for statistical analysis of the data. Descriptive statistics were expressed as numbers and percentages for

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categorical variables and mean ± standard deviation for continuous variables. Categorical variables were compared using the chi-square test. P<0.05 was considered statistically significant.

RESULTS

Between January 1, 2017, and December 31, 2017, it was determined that 466 cases applied to the psychiatry health board outpatient clinic for the criminal responsibility assessment. Excluding the cases (n=110) whose medical records could not be accessed with information about the crime charged or the expert report containing the assessment of criminal responsibility, 326 people were included in the study with 356 cases. Among the people included in the study, it was determined that one person with four forensic cases, five with three forensic cases, and 17 with two forensic cases applied to the polyclinic of the psychiatric health board to evaluate their criminal responsibilities in the specified period. It was determined that 10.7% of the evaluated cases were female (n=35), 89.3% were male (n=291), and the age distribution was between 18 and 68 years. The mean age at the time of evaluation was 33.86±11.46 years, 44.8% (n=146) of the cases were young adults (18-30), and 39.0% (n=127) were middle-aged (31-45 years).), 14.7% (n=48) were in the late adult (46 – 64) and 1.5% (n=5) geriatric (65+) age bands. Of the cases examined, whose marital status information could be accessed (n=152), 29.6% (n=45) were married, 61.1% (n=93) were single, and 9.2% (n=14) were divorced. Among those whose educational background information could be reached (n=102), 8.8% were uneducated (n=9), 48% (n=49) were primary school, 34.3% (n=35) were high school, and 8.8% (n=9) of them were educated at the college level. Of those whose occupational status was stated (n=178), 24.1% (n=43) were employed, 71.3% (n=127) were unemployed, 1.1% (n=2) were students, and 3.3% (n=6) were retired (Table 1).

Table 1. Sociodemographic characteristics

Characteristics	N	%
Gender		
M	291	89.3
F	35	10.7
Total	326	100
Age		
Young Adult (18 – 30)	146	44.8
Middle Age (31 – 45)	127	39.0
Late Adult (46 – 64)	48	14.7
Geriatric (65+)	5	1.5
Total	326	100
Marital Status (n=152)		
Married	45	29.6
Single	93	61.1
Divorced	14	9.2
Total	152	100
Education Status (n=102)		
Uneducated	9	8.8
Primary-Secondary	49	48.0
High School	35	34.3
University	9	8.8
Total	102	100
Employment Status (n=178)		
Employed	43	24.1
Unemployed	127	71.3
Student	2	1.1
Retired	6	3.3
Total	178	100

N, number

It was found that 34.9% (n=114) of those evaluated had been examined in terms of criminal responsibility for other crimes before, and 39% (n=139) of the forensic cases evaluated belonged to people who had previously been evaluated for other crimes. It was determined that 28.7% (n=40) of the previously evaluated cases in terms of criminal responsibility for other crimes had a diagnosis of schizophrenia or other psychotic disorder, and 28% did not have any mental illness or weakness. It was determined that there was a significant difference in terms of expert opinions on criminal responsibilities between those with and without a history of forensic psychiatric examination (χ^2=9,046, p=0,003).

It was determined that the criminal responsibility assessments of the cases were made on average 1.59±1.72 years after the date of the crime charged.

Expert opinions on the criminal responsibility of 91.9% (n=327) of the cases referred by the judicial authorities were reported at the first application. Of the cases (n=29), for which a decision could not be made at the first application, an epicrisis, case file, or social examination report was requested from 26 of them regarding their previous medical records, and it was concluded that it would be appropriate to decide whether the criminal responsibility was full or not by hospitalizing 3 of them.

It was stated that 60.1% (n=214) of the evaluated forensic cases had full criminal responsibilities concerning the crime charged. It was stated that 22.2% (n=79) of the cases did not have criminal responsibilities under the 1st paragraph of Article 32 of the TCC and 17.7% (n=63) of the cases had diminished criminal responsibilities within the scope of the 2nd paragraph of the 32nd Article of the TCC (Table 2).

It was observed that 55.3% (n=197) of the evaluated cases had a psychiatric diagnosis. It was reported that 27.9% (n=55) of the cases with a psychiatric diagnosis had full criminal responsibilities, and 72.1% (n=142) had no or partially diminished criminal responsibility. When grouped according to criminal responsibility status, it was determined that all (n=142) of those evaluated within the scope of paragraphs 1 and 2 of Article 32 of the TCC and 25.7% (n=55) of the group with full criminal responsibility had a psychiatric diagnosis. Of the cases with a psychiatric diagnosis (n=55) who were thought to have full criminal responsibilities related to the crime charged, 23.6 (n=13) had mental retardation, 21.8% (n=12) had schizophrenia or other psychotic disorder, 16.3% (n=9) bipolar disorder, 21.8% (n=12) personality disorder, 3.6% (n=2) organic mental disorder and 12%, and 7 (n=7) had diagnoses from other neurotic psychiatric disorder groups (Table 3).

When the medical opinions about the criminal responsibility of the evaluated cases were examined in terms of the diagnosis groups, it was stated that all of the cases (n=159) without any psychiatric diagnosis had full criminal responsibility. Of the 80 cases diagnosed with schizophrenia or other psychotic disorder, 15% (n=12) were stated to have full criminal responsibility, 60% (n=48) did not have criminal responsibility, and 25% (n=20) had diminished criminal responsibility. Of 56 cases with mental retardation, 23.2% (n=13) was stated to have full criminal responsibility, 17.8% (n=10) did not have criminal responsibility, 58.9% (n=33) had diminished criminal responsibility. Of the 39 cases diagnosed with bipolar disorder, 23% (n=9) was stated to have full criminal responsibility, 51.2% (n=20) had no criminal responsibility, 25.6% (n=10) had diminished criminal responsibility. It has been reported that two of the three cases with organic mental disorder diagnoses, had full criminal responsibility, and one of them had no criminal responsibility. It was seen that all of the cases with personality disorder diagnoses (n=12) and other neurotic disorder diagnoses (n=7) had full criminal responsibility (Table 3).

Table 2. Comparison of the opinions reported on the criminal responsibility of the cases according to the presence of a psychiatric diagnosis

	N			
	Psychiatric Diagnosis			
	Yes	No	Total	%
TCC 32/1	79	0	79	22.2
TCC 32/2	63	0	63	17.7
Full Criminal Responsibility	55	159	214	60.1
Total	197	159	356	100

N, number; TCC 32/1, Those evaluated within the scope of Article 32/1 of the TCC; TCC 32/2, Those evaluated within the scope of Article 32/2 of the TCC.

Table 3. Opinions on criminal responsibility according to psychiatric diagnoses

		Decision		
Diagnostic Group	Full Criminal Responsibility	TCC 32/1	TCC 32/2	Total
No Mental Illness or Weakness (NMIW)	159	0	0	159
Mental Retardation (MR)	13	10	33	56
Schizophrenia and Other Psychotic Disorders (SOPD)	12	48	20	80
Bipolar Disorder (BD)	9	20	10	39
Personality Disorder (PD)	12	0	0	12
Organic Mental Disorder (OMD)	2	1	0	3
Other	7	0	0	7
Total	214	79	63	356

TCC 32/1, Those evaluated within the scope of Article 32/1 of the TCC; TCC 32/2, Those evaluated within the scope of Article 32/2 of the TCC.

Table 4. Distribution of crimes by diagnosis groups

Type of Crime	NMIW	MR	SOPD	BD	PD	OMD	Other	Total
Threats/Insults	35	11	31	20	3	0	3	103
Theft	46	13	10	2	3	2	0	76
Injury	29	9	28	7	0	1	1	75
Damage to Property	16	9	10	7	1	0	1	44
Sexual Offenses	7	15	8	0	0	0	1	31
Drugs	11	6	4	0	3	0	0	24
Violation of Immunity of Housing	13	4	5	0	1	0	0	23
Disturbing the Peace and Tranquility	5	2	3	1	0	0	2	13
Smuggling/Counterfeit Product	5	1	1	1	1	0	1	10
Military Offenses	7	1	0	0	1	0	0	9
Absence Without Leave	5	0	1	1	0	0	0	7
Opposition to the Gun Law	3	0	1	1	0	0	0	5
Endangering General Safety	0	0	1	4	0	0	0	5
Fraud	2	0	1	1	0	0	0	4
Terror	4	0	0	0	0	0	0	4
Slander	1	1	2	0	0	0	0	4
Murder	3	0	0	0	0	0	0	3
Attempt to Kill	1	0	0	1	0	0	0	2
Cybercrimes	1	0	1	0	0	0	0	2
Deprivation of Liberty	1	0	0	1	0	0	0	2
Opposition to the Tax Law	1	0	0	0	0	0	0	1
Fire	0	1	0	0	0	0	0	1
Other	12	2	3	6	0	0	0	23
Total	208	75	110	53	13	3	9	471

NMIW, No Mental Illness or Weakness; MR, Mental Retardation; SOPD Schizophrenia and Other Psychotic Disorders; BD, Bipolar Disorder; PD, Personality Disorder; OMD, Organic Mental Disorder

Table 5. Distribution of crime types according to criminal responsibilities of the cases

Type of Crime	Criminal Responsibility	TCC 32/1	TCC 32/2	Total
Threats/Insults	54	33	16	103
Theft	57	2	17	76
Injury	35	25	15	75
Damage to Property	22	11	11	44
Sexual Offenses	15	7	9	31
Drugs	19	1	4	24
Violation of Immunity of Housing	16	3	4	23
Disturbing the Peace and Tranquility	8	2	3	13
Smuggling/Counterfeit Product	7	0	3	10
Military Offenses	8	0	1	9
Absence Without Leave	5	2	0	7
Opposition to the Gun Law	4	0	1	5
Endangering General Safety	0	3	2	5
Fraud	3	1	0	4
Terror	4	0	0	4
Slander	1	3	0	4
Murder	3	0	0	3
Attempt to Kill	1	0	1	2
Cybercrimes	1	1	0	2
Deprivation of Liberty	1	1	0	2
Opposition to the Tax Law	1	0	0	1
Fire	0	0	1	1
Other	14	7	2	23
Total	279	102	90	471

TCC 32/1, Those evaluated within the scope of Article 32/1 of the TCC; TCC 32/2, Those evaluated within the scope of Article 32/2 of the TCC.

It was determined that the crimes charged to 30.3% (n=108) of the evaluated cases were violent crimes, and 62.9% (n=68) of these cases had a psychiatric disorder.

For 74.4% (n=265) of the cases referred by the judicial authorities, only criminal responsibility assessment was requested for a criminal act, and it was determined that 25.6% (n=91) had a request for evaluation with more than one criminal charge. The distribution of crime types evaluated within the framework of the psychiatric diagnoses of the cases is shown in Table 4. Cases evaluated in terms of more than one type of crime are included in the table separately for each crime. A psychiatric evaluation was requested in terms of criminal responsibility for a total of 471 criminal acts of persons referred by the judicial authorities, and it was determined that threats and insults (n=103), theft (n=76), and injury (n=75) crimes constitute 53.9% (n=254) of the criminal acts evaluated. Comparisons of the medical opinions about whether the evaluated cases have criminal responsibility or not with the types of crimes charged by the judicial authorities are shown in Table 5. It was concluded that 52.4% (n=54) of the cases (n=103) evaluated with the crime of "threat and insult", which is the most charged crime in the sample, had full criminal responsibility. For other crime types that follow this in terms of frequency, 75% (n=57) of the cases evaluated with the crime of "theft" (n=76), 46% (n=35) of the cases evaluated with the crime of injury (n=75), and 50% (n=11) of those evaluated with damage to property (n=22) and property damage had full criminal responsibility.

It was stated that 12 of the cases examined were directed to be evaluated for the criminal responsibility in terms of crimes against the child, and 11 of these cases were charged with the crime of sexual abuse of the child and one with the crime of persecution against the child. It was determined that the case charged with the crime of persecution of the child was female, the other 11 cases charged with the crime of sexual abuse were all men, 50% of the cases (n=6) did not have any psychiatric disorder, and it was determined that their criminal responsibilities were full. It was determined that 66.7% (n=4) of the cases evaluated in terms of crimes against children were diagnosed with mental retardation and 33.3% (n=2) with schizophrenia or other psychotic disorders. It was reported that 33.3% (n=2) of these cases did not have criminal responsibility, and 66.7% (n=4) of them had diminished criminal responsibility.

DISCUSSION

Ankara Numune Training and Research Hospital, where our study was conducted, has continued its services in health, especially in Ankara and Central Anatolia region, since its establishment in 1881 under the name of Gureba Hospital. Since 2019, it has continued its education, research, and health service delivery activities within the newly established Ankara City Hospital. A significant portion of the criminal responsibility or civil competence assessments requested by the judicial authorities of Ankara and surrounding provinces during service was made by the health board of Ankara Numune Training and Research Hospital. In our study, cases referred by judicial authorities and evaluated in terms of criminal responsibility in our clinic during one year were examined.

Our study observed that 89.3% (n=291) of all cases sent for criminal responsibility assessment and 91.3% (n=21) of cases consulted for more than one lawsuit were male. During the evaluation, it was determined that 83.3% of the cases were between the ages of 18 and 45, 61.1% were single, 56.8% had primary education or were uneducated, and 71.3% were not working. Similar to previous studies, male gender, young age, low education level, and unemployment were the demographic characteristics observed in most of the sample (5–7, 9–11).

It was observed that 48.7% (n=159) of the cases were evaluated as not having any mental illness or weakness. This finding is consistent with

previous studies. In the study of Görgülü et al., it was reported that 54.5% (n=181) of 332 individuals evaluated in terms of criminal responsibility did not have a mental illness or weakness (9). In the study of Çubuk et al., which evaluated 1087 cases, it was reported that 37.3% (n=406) of the cases did not have a mental illness or weakness (6). These studies show that in cases consulted by judicial authorities regarding criminal responsibility, the largest diagnostic group is people who do not have a mental illness or weakness. There are approximately 25 years between the date of the study of Kapakür et al. and the time of both our study and the study of Görgülü et al. The percentages of people without a mental illness or disability were significantly higher in both studies compared to the study by Çöpür et al. (6, 9). With the increase in awareness about psychiatric diseases, the fact that judicial authorities resort to experts more frequently in evaluating criminal responsibility may be one of the possible reasons for this situation. Another possible reason is that the defense may demand evaluation in terms of criminal responsibility to reduce the sentence.

Among the cases with a psychiatric diagnosis, it was determined that the patients diagnosed with schizophrenia or other psychotic disorder were consulted for forensic psychiatric evaluation, and the patients with mental retardation were the second most frequent. The finding of our study that schizophrenia or other psychotic disorder is the most common psychiatric disorder consulted by judicial authorities is consistent with previous studies. In the study of Türkcan et al., 32.8% of the forensic cases they evaluated were diagnosed with schizophrenia, 14.3% with delusional disorder, and 9.9% with atypical psychosis (11). In the study of Çöpür et al., in which they evaluated 1087 cases, it was reported that 22% (n=240) were evaluated with the diagnosis of schizophrenia or other psychotic disorder (6). Unlike previous studies, our study determined that patients diagnosed with mental retardation were consulted with the second frequency by judicial authorities. As discussed before, the fact that judicial authorities apply to experts more frequently in terms of criminal responsibility may be one of the possible reasons for this increase.

Among the cases examined in our study, 60.7% of the cases in which the opinion that there is no criminal responsibility were reported were diagnosed with schizophrenia or other psychotic disorder (n=48), and it was observed that 85% (n=68) of the cases diagnosed with schizophrenia or other psychotic disorder were stated that they had diminished or no criminal responsibility. Although these findings suggest that crime-related behavior is more prevalent in those with schizophrenia or other psychotic disorders than other psychiatric disorders, they need to be carefully evaluated. Swanson et al. reported that violent behavior increased five times in those with psychiatric disorders such as schizophrenia and mood disorders than in the normal population (12). On the other hand, although there are certain risk factors between psychiatric disorders and crime-related behaviors, there are also studies reporting that crime-related behavior in psychiatric disorders is less than in the general population (13). In our study and similar studies, the inclusion of only cases directed by judicial authorities to be evaluated regarding criminal responsibility is one of the critical points to be considered while evaluating the findings. Considering that the cases referred with the request for criminal responsibility assessment are selected among all investigations and prosecutions conducted by the judicial authorities, it can be thought that the crime-related behavior rates of individuals with psychiatric disorders in the general population are much lower than in our study.

Among the cases evaluated in our study, it was observed that the most accused crime was "threat" and "insult", followed by "theft" and "injury" crimes. Consistent with previous studies, when individuals without a mental illness or weakness are excluded, the group most frequently assessed for criminal responsibility for "threatening" and "insulting" and "injuring" is people with a diagnosis of schizophrenia or other psychotic disorder (9, 14). For the crime of theft, it was observed that those with mental retardation were the most frequently evaluated patient group after those who did not have any psychiatric disease. One of the possible explanations of this finding may be that mentally retarded patients are easily incited to crime due to their susceptibility to suggestion and limited reasoning abilities (15, 16).

In our study, all of the cases evaluated within the framework of sexual crimes (n=31) were male, 48.3% (n=15) were diagnosed with mental retardation, and 35.4% were evaluated for sexual abuse of the child (n=11). It was observed that 48.3% (n=15) of the cases were decided to have full criminal responsibility. Cantürk and Koç, in their study evaluating sexual crime suspects, reported that full criminal responsibility was evaluated in 51.4% of the cases. It has been reported that 25% to 36% of sexual crime cases have a diagnosis of mental retardation (17).

In 91.9% of the cases evaluated in our study, it was determined that the medical opinion about criminal responsibility was reported to the courts at the first application. To the best of our knowledge, no data evaluating decision time was found in previous studies. In addition, it has been observed that criminal responsibility assessments are made approximately 1.5 years after the crime date. Criminal responsibility assessment is almost always made in terms of the past and the time the crime was committed. As the time between the crime and the evaluation increases in this retrospective evaluation, the psychiatric evaluation becomes difficult and sometimes cannot be done (18).

For this reason, a psychiatric evaluation to be made as early as possible will both increase the reliability of the medical opinion and be of critical importance in terms of facilitating the forensic processes. It was determined that in 89.6% (n=23) of the cases where a decision could not be made at their first application, additional documents such as the applicant's previous medical records, case file, or social examination report were requested. The decision process will be carried out more quickly and reliably in the referrals to be made by the judicial authorities together with the available records of the persons whose criminal responsibility is requested to be evaluated.

The most important limitation of our study is that patients with alcohol-substance use disorder were not included in the study since the health committee of the AMATEM unit was different from the health committee that we selected the sample of our study. The AMATEM unit health committee reported the evaluations of these patients regarding their criminal responsibility, which limited the generalizability of the results of the study. Another limitation of our study is the insufficient data on which judicial authorities sent the cases. Individuals may be referred by courts or prosecutors' offices to assess their criminal responsibility. Evaluating which judicial authorities refer the cases will provide information on which stage of the judicial process a psychiatric expert institution is mainly applied. In addition, the retrospective nature of our study and the fact that the information was obtained from health committee reports and medical records can be stated as other limitations of the study.

Criminal responsibility examination constitutes an important part of forensic psychiatry practices. The legal framework of the expert opinion reported by forensic psychiatric evaluation and its place in implementing laws may differ from country to country. Therefore, although there is a need for descriptive studies that will help to understand the relationship between criminal behavior and mental health better, and in this context, improve punishment and rehabilitation practices, it can be said that there is a limited number of studies in this area in our country. One of the strengths of our study is that it was conducted with a relatively large sample size in Ankara, the second-largest city and capital of Turkey. The results of our study, together with the previous studies conducted in our country, guide future studies in this field.

Ethics Committee Approval: Approval of ethics committee for this study was received from SBU Ankara Numune Health Practices and Research Center Clinical Research Ethics Committee. (2083/2018).

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