Harvey Bluestone,[1] *M.D.; John Melella,*[2] *M.S.W.; and David Baskin,*[3] *Ph.D.*

A Study of Criminal Defendants Referred for Multiple Psychiatric Examinations Regarding Their Competency to Stand Trial

REFERENCE: Bluestone, H., Melella, J., and Baskin, D., **"A Study of Criminal Defendants Referred for Multiple Psychiatric Examinations Regarding Their Competency to Stand Trial,"** *Journal of Forensic Sciences*, JFSCA, Vol. 26, No. 2, April 1981, pp. 416-423.

ABSTRACT: One of the mainstays of forensic psychiatry has been the determination of a defendant's competency to stand trial. Competency to stand trial is based on the U.S. Supreme Court ruling that a defendant must have sufficient ability to understand court proceedings. Regardless of whether or not the defendant was mentally ill at the time a crime was committed or when charged, the court can try someone only if that person has the capacity to understand proceedings in order to defend himself. When there is any question as to the competency of the defendant, he is referred for psychiatric evaluation of competency. Very little research has been undertaken in the past to examine this clinically interesting group of subjects. A study was conducted to explore the characteristics of 137 defendants who had been charged and referred for evaluation at least twice to the Court Clinic of the Bronx-Lebanon Hospital Center Department of Psychiatry. It was expected that these would reflect the consequence of deinstitutionalization in New York State. Data were collected for each evaluation with regard to demographic characteristics, criminal history, and psychiatric history. Results are presented and discussed in light of the issue of deinstitutionalization. Note is made of the fact that only very small percentage of these patients have received outpatient psychiatric care. Suggestions for future research are offered.

KEYWORDS: psychiatry, jurisprudence

In 1967 the Court Clinic of the Bronx-Lebanon Hospital was established to conduct competency examinations for the Bronx Criminal Court; the clinic now also conducts presentencing examinations after conviction and provides outpatient treatment for those defendants convicted of crimes who are mentally ill. The primary thrust of the clinic has remained the determination of the defendants' competency to stand trial.

A previous study [*1*] in which we explored the attributes of 1440 patients referred for testing of their competency to stand trial revealed that there were a number of cases in which patients had been examined at the clinic on more than one occasion, usually on a new charge. To avoid the statistical problems of repeated measures it was necessary to

Received for publication 9 June 1980; revised manuscript received 23 Aug. 1980; accepted for publication 3 Sept. 1980.

[1]Director, Department of Psychiatry, Bronx-Lebanon Hospital Center, and associate professor of psychiatry, Albert Einstein College of Medicine, Bronx, New York.

[2]Chief, Court Psychiatric Clinic, Bronx-Lebanon Hospital Center, Bronx, New York.

[3]Chief, Program Evaluation, Bronx-Lebanon Hospital Department of Psychiatry-Crotona Park Community Mental Health Center, Bronx, New York.

eliminate that group from the original study. It was assumed that those who were repeatedly sent for competency examinations represented a more problematic group for both mental health providers and for the courts.

Although some studies [2–4] have described defendants referred for competency examinations, there is little information available about repeat offenders who have been referred more than once for such examinations. The purpose of this study was to examine the characteristics of those charged and referred to the clinic for competency examinations at least twice and to compare them with our original group.

Method

The population examined consisted of all 137 individuals sent at least twice between 1968 and 1979 by the Bronx criminal courts for a determination of competency to stand trial under Article 730 of the New York State criminal procedure code [5]. For each defendant, data were collected for each evaluation with regard to demographic characteristics, criminal history, and mental illness history. It should be emphasized that most of the data were based on the defendant's self-report.

The demographic data included sex, age, ethnicity, marital status, level of education, estimated intelligence, and living arrangements.

Criminal history included the criminal charge, the name of the judge who ordered the examination, the agent who proposed the examination (court, defense, prosecution), and the disposition of any previous charges.

Mental illness variables included the time since the last psychiatric service rendered, the type of prior psychiatric service obtained, diagnosis of subject, and the competency decision. In cases where further observation was needed to make a determination of competency, defendants were sent to forensic psychiatry wards in municipal hospitals.

Results

The total number of subjects who had been charged and referred for multiple competency evaluations was 137, of whom 116 (84%) were charged and evaluated twice, 16 (12%) three times, 4 (3%) four times, and one (1%) five times. Because of the small sample size, those evaluated more than three times were grouped together in the tables. Of the 137 subjects, 132 (96%) were males.

The ethnic distribution of the population was as follows: 63 (46%) were black, 54 (40%) were Hispanic, and 20 (14%) were white. The marital status of the subjects is presented in Table 1. A substantial proportion (77%) had never been married, although there was a slight increase in married subjects in the interval between the first and the second evaluation. A χ^2 test performed to test for statistical significance indicated that a significantly greater number of subjects had never been married.

The household composition of the subjects is presented in Table 2. The largest number of subjects lived alone (49%), 16% lived with at least one parent, and only 5% lived with a spouse.

Intelligence was estimated by the psychiatrists who interviewed the subjects (Table 3). The overall level of intelligence was lower than that of the general population. The educational level of the subjects is presented in Table 4. Only 4% of the subjects had at least some college education, and the modal educational level was about ninth grade. The mean age of the subjects at each evaluation was calculated (Table 5). A comparison between subjects in the first three evaluations indicated that there was no statistically significant difference (F test) in age between the three groups. Subjects at the fourth and fifth evaluation were not included for comparison because of the small sample size.

TABLE 1—*The relationship between marital status of the subjects and competency evaluations (expressed as percentages).*[a]

	Number of Times Subject Was Evaluated			
Marital Status	1	2	3	Total
Never married	38	34	5	77
Married	2	3	1	6
Separated	3	3	0	8
Divorced	1	1	...	1
Widowed	1	1	...	1
Missing data	2	4	1	7
Total	46	46	7	100

[a] Minor differences in percentages are due to rounding off.

TABLE 2—*Household composition of subjects.*

Household	Number	Percentage
Lives alone	67	49
With spouse	7	5
With parent	22	16
Children	3	2
Siblings	1	1
Other relations	2	1
Others	3	2
Institution	1	1
Change in household composition status	23	17
Missing data	8	6
Total	137	100

TABLE 3—*Estimated intelligence.*

Estimated Intelligence	Number	Percentage
Above average	5	4
Average	34	25
Dull to normal	13	9
Retarded	14	10
Missing data	62	45
Change in intelligence between evaluations	9	7
Total	137	100

Analysis of the amount of time since the last psychiatric service was received by the subjects at each evaluation is presented in Table 6. Scrutiny of the findings indicates that the greater the number of evaluations a defendant has received, the more likely that psychiatric service was obtained within a year. A tabulation of the type of prior psychiatric history according to the number of competency evaluations (Table 7) shows that most prevalent

TABLE 4—*Educational level of subjects.*

Level	Number	Percentage
Elementary grades	18	13
Intermediate grades (7-9)	36	26
High school grades (10-12)	36	26
High school graduate	20	15
Some college	4	3
College graduate	2	1
Missing data	21	15
Total	137	100

TABLE 5—*The relationship between mean ages of subjects and competency evaluations.*

Competency Evaluation	Mean	Standard Deviation	Range	Number
1	26.2	9.56	15-71	137
2	27.7	9.56	17-72	137
3	28.6	8.10	20-48	21
Totals	...	...	15-72	295

TABLE 6—*Amount of time since last psychiatric service for the subjects (expressed in percentages).*

Evaluation	Less Than 1 Year	More Than 1 Year	None	Unspecified	Missing	Total
1st	10	12	18	5	1	47
2nd	19	12	8	8	0	47
3rd	4	2	0	1	...	7
Total	33	26	26	14	1	100

TABLE 7—*Type of prior psychiatric service received according to the number of competency evaluations (expressed in percentages).*

Type of Prior Psychiatric Service	Number of Competency Evaluations			Total
	1	2	3	
Inpatient	21	27	5	53
Outpatient	7	7	1	17
None	14	7	0	21
Missing data	4	4	1	10
Total	47	46	7	100

was inpatient care. The more evaluations a defendant received, the more likely the type of psychiatric service obtained was on an inpatient basis.

Additional analyses detailed the specific type of inpatient or outpatient treatment the subjects received (Table 8). Most notably the proportion of subjects who had been in a mental hospital increased as the number of evaluations increased. Moreover, 17 individuals received both inpatient and outpatient treatment and 29 persons received multiple inpatient or outpatient care.

The final diagnosis of the subjects is presented in Table 9. It is quite clear that by far the highest percentage (40%) of subjects was diagnosed as schizophrenic, followed by a relatively high percentage (19%) of personality disorders. Only 2% of the subjects were diagnosed as not having mental illness.

The criminal charge at each evaluation is reported in Table 10. Overall, assaults, robbery, and burglary constituted the highest percentages of the charges. There seemed to be proportionate increases of homicides, sex offenses, robbery, and mischief, with concomitant decreases in burglary, arson, and larceny, from the first to the second evaluation.

Table 11 presents the analysis of competency decisions for each evaluation. While 61% of the subjects were found competent at the first evaluation, this percentage decreased as the number of competency evaluations increased.

It was also of interest to determine whether the number of competency evaluations ordered by the courts was evenly distributed among the judges. That is to say, did some judges tend to request competency evaluations more than others? It was found that 19 judges had ordered 65% of the evaluations, whereas an additional 73 judges were responsible for ordering the remaining 35%. One particular judge had ordered 8% of the examinations.

Of particular interest to the authors are cases like that of the individual who was charged and referred for competency examination five times.

This person was first referred from the court on the charge of assault in May 1970. He was a 47-year-old Mexican-American who was married and living with his spouse and

TABLE 8—*The relationship between prior psychiatric service and competency evaluations (percentages in parentheses).*

Type of Service	Number of Competency Evaluations			Total
	1	2	3	
Inpatient				
State mental hospital	54	74	16	144(43)
General municipal hospital	12	11	1	23(7)
Veterans Administration hospital	2	1	...	3(1)
Institution for retarded	1	2	...	3(1)
Other	1	2	...	3(1)
Outpatient				
Mental health center	3	1	...	4(1)
Nursing home	1	...	...	1(0)
Residential treatment center	1	...	...	1(0)
Psychiatric clinic	16	17	3	36(11)
Other psychiatric facility	1	1	...	2(1)
Penal institution	4	7	2	13(4)
None	48	24	1	73(21)
Missing data	15	15	2	32(10)
Total	159	155	25	339(100)

TABLE 9—*Final primary diagnosis of subjects.*

Diagnosis	Number	Percentage
Schizophrenia	55	40
Personality disorders	26	19
Mental retardation	11	8
Alcoholism	10	7
Diagnosis deferred	10	7
Social maladjustment	5	4
Drug dependence	4	3
Unspecified psychosis	4	3
No mental illness	3	2
Neurosis	3	2
Nonpsychotic organic brain syndrome	2	1
Special symptoms	1	1
Sexual deviation	1	1
Manic-depressive	1	1
Paranoid states	1	1
Total	137	100

children. There was a history of more than 20 arrests since 1943 in several states. His highest level of education was sixth grade, and he was estimated as having average intelligence. He had had psychiatric treatment within the year prior to the examination at both a general hospital and a psychiatric clinic. He was known to three New York state hospitals. He was diagnosed as an hysterical personality and was found competent to stand trial. In November 1970 he was charged with burglary and arson. His living arrangements had not changed but he had received psychiatric care both at this facility and in a mental hospital. He was diagnosed as being in a "paranoid state" and sent to Bellevue Hospital for further observation. There he was found to be incompetent and was committed to a state hospital.

One year later (October 1971) he was again charged with arson and referred for a competency examination. He was again found to be in a "paranoid state" but competent. The disposition of this charge is unknown. One month later (November 1971) he was charged with reckless endangerment, harassment, menacing, and resisting arrest. By this time he was separated from his wife and living alone. He was diagnosed as alcoholic and found competent. The charge was dismissed by the court.

In May 1972 the individual was charged with reckless endangerment and criminal mischief. He was again diagnosed as alcoholic but found competent. Finally, after being examined seven or eight times on five different charges, he was diagnosed as schizophrenic and found incompetent to stand trial. He has not been to the clinic since that time. We can only assume that he is in jail or a state hospital or that he left the state.

Discussion

The demographic description of those defendants charged and referred for competency evaluations at least twice has been presented. If one were asked what this typical individual looks like, based on our study the response would be this: he is a male from an ethnic minority (black or Hispanic), unmarried, living alone, of average intelligence, and has had about nine years of education. He has received inpatient psychiatric care within the past year at a state mental hospital. He is being charged with assault, burglary, or robbery and has been diagnosed as schizophrenic. The greater the number of times he has

TABLE 10—*The relationship between most serious crimes and competency evaluations.*

Crime	Number of Competency Evaluations			Total
	1	2	3	
Assaults	32	33	7	72
Homicide	6	12	2	20
Sex offenses	11	15	2	28
Kidnapping	1	1	...	2
Firearms	1	4	1	6
Burglary	23	10	1	34
Trespassing	...	1	...	1
Mischief and tampering	6	9	...	15
Arson	12	10	2	24
Unauthorized use of vehicles	1	...	...	1
Robbery	16	22	3	41
Larceny	13	5	2	20
Possession of stolen property	7	6	...	13
Impersonation	...	...	...	0
Escape	...	...	1	1
Violating probation	...	1	...	1
Public lewdness	...	1	...	1
Drugs and narcotics violations	3	3	...	6
Harassment	2	4	...	6
Loitering	1	...	...	1
False report	2	...	...	2
Total	137	137	21	295

TABLE 11—*The relationship between competency decisions and competency evaluations (expressed in percentages).*

Competency Decision	Number of Competency Evaluations			Total
	1	2	3	
Competent	29	27	3	59
Incompetent	9	13	2	24
Further observation needed	8	7	1	17
Total	46	47	7	100

been charged and evaluated, the more likely he is to be found incompetent. This finding is consistent with our expectations. One reason may be that doctors seeing individuals as "sick" and in need of treatment interpret and structure their reports in such a way as to allow the individual to receive proper treatment. This would be especially true for a defendant who was diagnosed as having a serious psychotic condition and whose crimes are not considered by the doctor to be serious. The doctors involved may simply find the defendant incompetent to allow him to get treatment for the illness. Many judges welcome

such decisions since it absolves them of legal responsibility when they themselves think the person needs treatment.

While the defendants in our subpopulation may not differ from the defendant population as a whole in many respects, they do appear to have a history of much greater psychiatric institutionalization.

It should be stressed that a decision of competence can be made even though a person may be found mentally ill. Nonetheless, a finding that there are individuals who have extensive involvement in both criminal justice and mental health systems suggests that our society and its systems are not adequately dealing with the problem. The very fact that there was a 100% increase in the number of homicides and a 40% increase in sex offenses from the first to the second evaluation indicates the need for appropriate care or monitoring of these individuals.

The finding that certain judges refer defendants more frequently than others underscores the need for study of the reasons why judges refer defendants for evaluations. A paper presented by Halpern [*6*] suggested that defense attorneys occasionally request evaluations to avoid trial for charges, and the prosecution requests examinations to prevent the release of defendants on bail. These requests also present a prime area for future inquiry.

Our previous study [*1*] reported that most of the defendants who had been charged and evaluated once had received either no psychiatric care or had obtained such care in an inpatient setting; very few individuals received outpatient care. Our findings in this study corroborated this information. It is not certain why these individuals have not received outpatient care. It may be because they avoid psychiatric treatment and are treated only when they are forced to do so or when they are in acute crisis. On the other hand, it is possible that psychiatric clinics are not sensitive to their needs, are reluctant to treat criminal offenders, or are disillusioned about treatment for such individuals. Further research on this matter is clearly necessary. The "volleying" of mentally ill people between the criminal justice system and the mental health system not only does not protect citizens from people who do not or cannot control their behavior, but it also does not offer these patients an opportunity to receive the type of care they so sorely need. Additional investigations would shed light on the relationships between the complex variables that affect this subpopulation.

References

[*1*] Bluestone, H. and Melella, J., "A Study of Criminal Defendants Referred for Competency to Stand Trial in New York City," *Bulletin of the American Academy of Psychiatry and the Law,* 1980, in press.

[*2*] Henn, F. A., Herjanic, M., and Vanderpearl, R. H., "Forensic Psychiatry: Anatomy of a Service," *Comprehensive Psychiatry,* Vol. 18, 1977, pp. 337-345.

[*3*] Cook, G., Johnston, N., and Pogeny, E., "Factors Affecting Referral to Determine Competency to Stand Trial," *American Journal of Psychiatry,* Vol. 130, 1978, p. 870.

[*4*] Roesch, R. M., "Competency to Stand Trial: An Analysis of Legal Mental Health Issues and Procedures and a Proposal for Change," dissertation, available from University Microfilm International, Ann Arbor, Mich., 1977.

[*5*] New York Criminal Procedure Law § 470 (McKinney 1971).

[*6*] Halpern, A. L., "Use of Misuse of Psychiatry in Competency Examinations of Criminal Defendants," *Psychiatry Annals,* Vol. 5, 1965, pp. 9-73.

Address requests for reprints or additional information to
Harvey Bluestone, M.D.
Bronx-Lebanon Hospital Center
1285 Fulton Ave.
Bronx, New York, N.Y. 10456