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Competent and Incompetent Defendants Referred to a Court Psychiatric Clinic: A Clinical Comparison

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ABSTRACT: Psychiatric evaluation of a defendant's present state of mind is required by criminal courts whenever the question of competency to proceed in the face of criminal charges is raised. From the examination of court-ordered psychiatric evaluations conducted during a seven-year period, a comparison was made of demographic, clinical, and diagnostic differences between a group of defendants evaluated as incompetent to stand trial and a group evaluated as competent. Findings showed the incompetent defendant to be older, more likely to be female, and more often intellectually impaired. Psychiatric diagnoses revealed more severe symptoms of disabling mental illness and a greater likelihood of psychosis. Because a finding of competency or incompetency dictates different legal dispositions, frequently bringing the legal proceedings to a halt and diverting the defendant into the mental health system, clear behavioral and symptomatic criteria for incompetency to stand trial are needed.

KEYWORDS: psychiatry, competency, jurisprudence

Psychiatric evaluation of a defendant's present state of mind is required by criminal courts whenever the question of competency to proceed is raised. Competency to proceed is a legal determination—not a psychiatric diagnosis. For example, a diagnosis of psychosis or a finding of profound mental retardation is not necessarily equivalent to a court determination of incompetency to proceed in the face of criminal charges.

Although the court must consider clinical findings pertaining to present state of mind, the degree and type of impairment is assessed according to specific legal criteria or guidelines. The legal guidelines for determination of competency to proceed in the face of criminal charges were spelled out by the U.S. Supreme Court in the 1960 Dusky decision [*1*]. Moreover, various authors have devised clinical checklists which have attempted to deal systematically with the clinical assessment of competency [*2,3*].

There has been a tendency on the part of persons inexperienced in forensic science to regard psychosis as tantamount to incompetence, both in criminal and civil matters without specific

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appreciation of the appropriate legal test or standard. Moreover, legal tests differ for various types of competency, which can include competency to proceed, to plead guilty, to contract, to function as a witness, or to write a will. Competency refers to the ability or its lack to perform a certain specific function or functions. While there is some overlap, the legal tests are quite specific. Thus, a court finding that a person is competent to conduct his affairs or to write a will, for example, necessarily does not imply that he is competent to proceed with criminal charges, waive rights, or plead guilty.

For competency to proceed in the face of criminal charges, the Dusky standard states "...the test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him" [*4*].

Competency to proceed pertains to present state of mind, rather than that at the time of the alleged criminal act. This is a court finding rather than a psychiatric diagnosis. While the psychiatric or psychological assessment may provide the determinative material, it is a judicial conclusion that is essential for a finding of incompetence.

The present paper concerns itself specifically with competency to proceed, or so-called present sanity in the face of criminal charges. Steadman [*5*] described various clinical and demographic characteristics of a sample of incompetent defendants, but did not include a comparison group of competent defendants. Because a finding of competency or incompetency dictates different legal dispositions, an examination of the clinical differences between a group of criminal defendants evaluated as incompetent to stand trial and a group evaluated as competent (during the same period of time and in the same court) was undertaken. Roesch and Golding [*6*] have reported a comparison of forensic science patients classified as competent and incompetent, and this paper reports a similar examination of demographic, clinical, and diagnostic differences among defendants referred for competency evaluations.

Setting

The Philadelphia Court of Common Pleas is Pennsylvania's largest crimial court. Since 1966, the Court has obtained pretrial and presentence psychiatric and psychological consultations by contract with Temple University's Department of Psychiatry [*7,8*]. Judicial requests for pretrial examinations follow upon questions of present state of mind raised by the Court, the prosecutor, or defense counsel, anyone or all who may be concerned about the defendant's mental ability to proceed in the face of criminal charges.

Defendants are seen either forthwith or by appointment at the Court Psychiatric Clinic. These defendants include both County Prison detentioners brought to a Court security area by a sheriff's van and bail cases who respond to Court notice of appointment. Defendants are examined individually by psychiatrists in an interview room setting, and psychological testing is administered where indicated. Defense counsel receives notice of the examination and has the option to attend. Since this option is exercised in less than 1% of the cases, the examinations usually involve the psychiatrist and the defendant, unless the defendant refuses to participate after an explanation of the purpose and implications of the examination (less than 0.05%).

Method

Subjects and Procedures

Data were obtained from 13 288 consecutive court-ordered psychiatric examinations conducted between 1969 and 1975, exclusively. From each of the seven data base years, a random sample of 300 reports was taken. The seven year total of 2100 sample cases included 410 pretrial competency reports and 1525 presentence evaluations. The remaining 165 reports included miscellaneous issues, such as parole or probation violation examinations.

The 410 case reports of defendants referred for pretrial competency evaluations during the seven-year period constitute the specific sample for this study.[5] The results of the psychiatric examinations indicated that 304 defendants appeared to be competent to proceed and 106 defendants appeared to be incompetent. (The actual determination must be made by the Court following the psychiatric recommendation).

The 410 psychiatric reports involved 386 individuals; 24 defendants were the subject of a reevaluation when they were thought to have regained competency.[6]

The sample of 410 competency reports was coded for content and provided uniform data for a variety of clinical, developmental, and criminal factors. Included for purposes of this study were age, race, sex, criminal charges, measures of intelligence, and clinical findings, including such items as cognitive and sensorial factors, affect, mood, clinical behavior, clinical appearance, and diagnosis.

Results

Age

The mean age of all defendants referred for competency evaluations was 30.1 years. Those evaluated as incompetent tended to be older than those evaluated as competent (mean ages 32.4 and 29.3 years). This difference was statistically significant ($t = 2.58$, degrees of freedom (DF) = 408, $P < 0.01$).

Sex

The total population referred for competency evaluation consisted of 90.0% males and 10.0% females. However, females were more likely to be evaluated as incompetent to proceed than were males (41.5 versus 24.1%), and this difference was statistically significant ($\bar{X}^2 = 4.92$, DF = 1, $P = <0.05$).

Race

The total population referred for competency evaluation consisted of 71.6% black, 24.2% white, and 3.2% "other" races. Overall, there were no significant differences in race between competent and incompetent defendants ($\bar{X}^2 = 0.01$, DF = 1): 25.2% of the white defendants and 25.0% of the black defendants were evaluated as incompetent.

Criminal Charge

The criminal charges for those found competent and incompetent were compared (see Table 1). Overall, there were no differences between the groups, both in terms of specific charge ($\bar{X}^2 = 11.94$, DF = 10), or in violent versus nonviolent crime ($\bar{X}^2 = 1.32$, DF = 1). While it was noted that the persons evaluated as incompetent were less likely to have commit-

[5]The vast majority of defendants who were not referred are presumed to be competent. They would need to be included in a comparison intended to reflect differences between incompetent defendants in general and competent defendants in general. The comparison offered here is limited, of course, to a comparison of groups referred for evaluation.

[6]All 24 defendants were judged competent on reevaluation. However, on statistical analyses, the difference between the competent and incompetent subgroups remain unchanged. The competency population consisted of 26% incompetents and 74% competents. After subtracting the 24 reevaluations, there were 27% incompetents and 73% competents. Statistically, the sample size absorbed the distortion produced by individuals appearing in the sample more than once.

TABLE 1—*Most serious present criminal charge against defendants referred for competency evaluation from 1969 to 1975 and total convicted offenders in 1975.*

Most Serious Charge	Competent Persons, $n = 304$	Incompetent Persons, $n = 106$	Total Convicted Offenders in 1975, $n = 5238$
Violent crimes	226 (74.3%)	72 (67.9%)	46.6%
Homicide/murder	87 (28.6%)	20 (18.9%)	8.0%
Rape	20 (6.6%)	8 (7.5%)	2.1%
Aggravated assault and robbery	8 (2.6%)	5 (4.7%)	no separate figure
Aggravated assault	35 (11.5%)	14 (13.2%)	15.0%
Armed robbery	27 (8.9%)	9 (8.5%)	19.1%
Assault	39 (12.8%)	14 (13.2%)	2.4%
Arson	10 (3.3%)	2 (1.9%)	listed as "other"
Nonviolent crimes	78 (25.7%)	34 (32.1%)	53.4%
Nonviolent property/burglary[a]	33 (10.9%)	21 (19.8%)	35.0%
Weapons	11 (3.6%)	2 (1.9%)	2.0%
Nonviolent sex offenses	20 (6.6%)	4 (3.8%)	listed as "other"
Drug and alcohol	14 (4.6%)	7 (6.6%)	listed as "other"
Other[b]	...	...	16.4%

[a]Includes burglary, theft, auto theft, and receiving stolen property.
[b]Includes arson, sex offenses, and drug and alcohol offenses.

ted homicide and more likely to have committed a property offense, this finding was not statistically significant.

A comparison of most serious charge for the competency population with total convicted offenders in the sample year 1975 suggests that the seriousness of the charge is an important factor in competency referral (see Table 1). Defendants charged with murder/homicide and rape were referred for competency evaluation at more than three times the rate expected by chance alone.

While defendants charged with simple assault were also more likely to be referred for competency evaluation, defendants charged with nonviolent crimes against property (such as burglary, theft, auto theft, and receiving stolen property) were less than half as likely to be referred for competency evaluation.

Intelligence

Slightly less than half (or 47.8%) of the population referred for competency evaluation required formal intelligence testing in addition to their clinical evaluation. Routine tests were not given to illiterates who were unable to complete the pen and paper test, to an additional group who were too disturbed to undergo testing at the time, nor to a smaller group (generally diagnosed as personality disorders) who did not wish to cooperate.

The intelligence test data of those formally tested indicated that 11.7% had intellectual impairment of borderline or retarded degree (see Table 2). The incompetent group contained approximately four times as many persons with either borderline or retarded levels of intellectual impairment (32.5 versus 6.4%), while the population of competents were more likely to have average intelligence (69.3 versus 42.5%). These differences were found to be statistically significant ($\bar{X}^2 = 8.67$, DF = 2, $P = < 0.02$).

The intelligence scores of the competent group followed a normal pattern of distribution, with the greatest percentage falling within an average range of scores and smaller percentages with considerably lower or higher scores. However, this was not the case for those judged incompetent. The incompetent group presented a bimodal distribution of scores, with peaks in the average and borderline regions.

TABLE 2—*Distribution of intelligence quotients of 410 defendants referred for a pretrial competency evaluation.*[a]

Intelligence Test Score[b]	Incompetent Persons, $n = 106$	Competent Persons, $n = 304$	Total, $n = 410$
Superior (above 120)	1 (2.5%)	1 (0.6%)	2 (1.0%)
High average (110-120)	4 (10.0%)	15 (9.6%)	19 (9.7%)
Average (90-110)	17 (42.5%)	108 (69.3%)	125 (63.8%)
Low average (80-90)	5 (12.5%)	22 (14.1%)	27 (13.8%)
Borderline (70-80)	9 (22.5%)	9 (5.8%)	18 (9.2%)
Retarded (below 70)	4 (10.0%)	1 (0.6%)	5 (2.5%)
Total completed test	40 (100.0%)	156 (100.0%)	196 (100.0%)
Did not complete test	66 (62.3%)	148 (48.7%)	214 (52.2%)

[a]On a Kolmogorov-Smirnov test for those tested, $\bar{X}^2 = 8.67$, DF = 2, $P < 0.02$.
[b]66 (62.3%) of the incompetent defendants and 148 (48.7%) of the competent defendants were not formally tested.

Cognitive and Sensorial Differences

As expected, persons evaluated as incompetent were found more often to be disoriented, and to present evidence of both recent and remote memory impairment (see Table 3). There was also a greater likelihood for the incompetent group to present grossly impaired thought processes as well as hallucinations and delusions.

Affective Differences

Among symptoms presented by defendants referred for competency evaluations, inappropriate affect (38.7 versus 14.8%) and flattened affect (30.2 versus 17.8%) were present more often in the incompetent population than in the competent group (see Table 3).

Behavioral Differences

Behavioral differences were also in evidence (see Table 3). These involved a greater frequency of agitation, bizarreness, and incoherence among the incompetents. In addition, speech and thought patterns among the incompetent group were more frequently described in such terms as "irrelevant" and "tangential."

Additional Clinical Differences

During the evaluation itself, the behavioral and physical appearance of defendants found incompetent were more often described in terms such as "inappropriate," "bizarre," "markedly unkempt."

Defendants may have the option of refusing a court-ordered examination. For the present sample of defendants, 8% of persons subsequently found to be competent did not wish a formal psychiatric examination. As a result, the quality of their interview was considered inadequate. This is in contrast to the group of defendants found to be incompetent to proceed, of whom 28% were either unwilling or unable to undergo a formal psychiatric examination. In many instances, grossly psychotic defendants whose behavior precluded a formal examination were quickly diagnosed as psychotic on the basis of grossly delusional thought content and apparent hallucinations. These observations appeared sufficient to warrant a recommendation of an incompetency finding to the Court.

TABLE 3—*Clinical signs and symptoms in 410 defendants referred for competency examinations.*[a]

	Incompetent, $n = 106$	Competent, $n = 304$	$\bar{X}^2$	$P<$
	COGNITIVE AND SENSORIAL FACTORS			
Sensorium disorientation	28 (26.4%)	6 (2.0%)	58.57	0.001*
Memory impairment, recent	29 (27.4%)	39 (12.5%)	11.63	0.001*
Memory impairment, remote	26 (24.5%)	14 (4.6%)	33.21	0.001*
Grossly impaired thought process	40 (43.4%)	25 (8.2%)	49.13	0.001*
Hallucinations, by history	22 (20.8%)	30 (9.9%)	7.46	0.01*
Hallucinations, present	19 (17.9%)	8 (2.6%)	27.45	0.001*
Delusions, by history	15 (14.2%)	23 (7.6%)	3.31	ns
Delusions, present	19 (17.9%)	15 (4.9%)	15.77	0.001*
	AFFECTIVE FINDINGS			
Inappropriate	41 (38.7%)	45 (14.8%)	25.61	0.001*
Constricted	11 (10.4%)	55 (18.1%)	2.92	ns
Flattened	32 (30.2%)	54 (17.8%)	6.69	0.02*
Emotionally labile	6 (5.7%)	8 (2.6%)	1.36	ns
	MOST FREQUENTLY NOTED BEHAVIORS			
Agitation	18 (17.0%)	26 (8.6%)	4.98	0.05*
Overt hostility/anger	18 (17.0%)	30 (9.9%)	3.19	ns
Bizarreness	12 (11.3%)	7 (2.3%)	12.49	0.001*
Blocking	8 (7.5%)	15 (4.9%)	0.58	ns
Evasiveness	6 (5.7%)	15 (4.9%)	0.00	ns
Grandiosity	10 (9.4%)	18 (5.9%)	1.02	ns
Guarded	13 (12.2%)	51 (16.8%)	0.90	ns
Incoherence	13 (12.3%)	4 (1.3%)	21.03	0.001*
Irrelevance	12 (11.3%)	7 (2.3%)	12.49	0.001*
Tangential responses	16 (15.1%)	8 (2.6%)	19.95	0.001*
Anxiety	18 (17.0%)	62 (20.4%)	0.39	ns
Depression	19 (17.9%)	58 (19.1%)	0.01	ns

[a]ns = not significant and * = significant.

Clinical Diagnosis

Each defendant examined was given a primary psychiatric diagnosis of present state of mind at the time of the examination[7] (see Table 4). Incompetent defendants were significantly more likely (69.7 versus 25.9%) to be diagnosed as psychotic ($\bar{X}^2 = 62.7$, DF = 1, $P = <0.001$), whereas the most common diagnosis for those defendants evaluated as competent was a Personality Disorder.[8] Among schizophrenic defendants, incompetent defendants were less likely to be found "in remission" ($\bar{X}^2 = 44.5$, DF = 1, $P = <0.001$). Thus there appeared to be a clear association between the psychiatrist's diagnosis of an active functional psychosis and a finding of competency.

[7]Each clinician is required to give a primary diagnosis if more than one psychiatric syndrome is present. Inservice discussions provide a measure of uniformity of diagnostic criteria.

[8]The most frequent clinical diagnosis accompanying a recommendation that the Court find the defendant incompetent was schizophrenia (57.5%). It is noteworthy that 8.2% of the group found to be competent were suffering from manifest schizophrenic symptoms which did not, however, substantially interfere with their understanding of the nature of the charges against them nor preclude their assisting counsel in a rational defense.

TABLE 4—*Major diagnostic categories of 410 defendants referred for competency examination.*

Mental Disorder	Incompetent, $n = 106$	Competent, $n = 304$
Mental retardation (I.Q. below 70)	1 (0.9%)	4 (1.3%)
Organic brain syndrome		
Nonpsychotic	2 (1.9%)	7 (2.3%)
Psychotic	3 (2.8%)	2 (0.7%)
Psychosis—total	74 (69.7%)	79 (25.9%)
Schizophrenia-active	61 (57.5%)	25 (8.2%)
Schizophrenia (in remission)	5 (4.7%)	45 (14.7%)
Affective psychosis-depression	3 (2.8%)	0 (0.0%)
Borderline	5 (4.7%)	9 (3.0%)
Personality disorder, various	18 (17.0%)	176 (57.9%)
Substance abuse—drugs and alcohol	1 (0.9%)	3 (1.0%)
Sexual deviation	1 (0.9%)	0 (0.0%)
Symptom neurosis	0 (0.0%)	2 (0.7%)
Adolescent adjustment reaction	0 (0.0%)	1 (0.3%)
No mental disorder	0 (0.0%)	3 (1.0%)
Diagnosis deferred	6 (5.8%)	27 (8.9%)
Total	106 (100.0%)	304 (100.0%)

Discussion

Steadman [5] presented a profile of the institutionalized incompetent defendant in New York State. The median age was 28 years, 46% were black, 55% had never married, 16% had regular employment, 42% had a history of drug abuse, 38% had a history of alcohol abuse, 21% had previous psychiatric hospitalizations, and the median grade attained was the 9th grade.

The present study provided comparable data for some of these variables for this sample of pretrial (rather than institutionalized) Pennsylvania incompetent defendants. The incompetent defendants in Pennsylvania had a mean age of 32.4 years, 72% were black, 63% were never married, 22% had regular employment, and 45% had a history of alcohol abuse. The median grade level attained was 10th to 12th.

Steadman focused mainly on sociological variables. The present study employed a wider selection of variables, including psychiatric variables not available to Steadman. In the present sample of Pennsylvania defendants evaluated as incompetent, 68% had committed violent crime, 18% were judged to be currently hallucinating, 18% to have delusions, 39% with inappropriate affect, and 43% to have greatly impaired thought processes. In addition, 42% tested within the average range of intelligence and 32% had an intellegence quotient (I.Q.) below 80.

The present study also provided a comparison of the characteristics of competent and incompetent defendants, a task not attempted by Steadman. As compared to the competent defendant, the incompetent defendant was slightly but significantly older, more likely to be female, more often intellectually impaired (that is, with an I.Q. below 80) and more likely to be charged with a nonviolent property crime than with homicide or murder. The incompetent defendant's psychiatric evaluation revealed more impaired cognitive and sensorial processes (such as disorientation, impairment of memory and thought processes, hallucinations, and delusions) and more inappropriate mood and behavior symptoms (including agitated, bizarre,

and incoherent behavior and irrelevant and tangential thought processes). On examination, the incompetent defendant's behavior and physical appearance was more often described as inappropriate, bizarre, unkempt, and he or she was less often able or willing to provide sufficient or adequate information for the evaluation.

The incompetent defendant was more likely to be diagnosed as psychotic rather than a personality disorder, and, if schizophrenic, more likely to be diagnosed as an active schizophrenic and less often judged to be in remission. Overall, it appears that the incompetent offender was suffering from more severe symptoms of disabling mental illness.

These results are consistent with those reported by Roesch and Golding [*6*]. Their samples of competent and incompetent defendants did not differ in sex, race, or marital status. As in our study, the incompetent defendants were older than the competent defendants. Both studies report an excess of incompetent defendants with a diagnosis of psychosis, and a greater incidence of such psychiatric symptoms as delusions, inappropriate behavior, and deficits in cognitive functioning in the incompetent defendants. However, the two samples differ in the kinds of crimes with which the defendants had been charged. Our study found an excess of murders and other violent crimes for those judged to be competent, whereas Roesch and Golding found an excess of property crimes and other nonviolent crimes.

Because a finding of incompetence to stand trial brings at least a temporary halt to the legal proceedings and a diversion of the defendant into the mental health system, there is a continuing need to explore and define the kinds of symptoms and behaviors associated with a finding of incompetency.

While mental health professionals have, in the past, regarded mentally ill defendants as persons in need of treatment, they have sometimes failed to recognize their need for, or right to, a trial. Whereas hospitalization, voluntary or involuntary, might seem more humane than a trial and potential imprisonment, the result has been the indeterminate custodial hospitalization of some defendants who, had they been tried, might have been found not guilty. In addition, of those who might have been found guilty, substantial numbers of such defendants have been kept involuntarily in custodial hospitals for far longer periods of confinement than they would have experienced had they been found guilty and served a maximum sentence.

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