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Geriatric Felons Examined at a Forensic Psychiatry Clinic

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ABSTRACT: Descriptive statistics are presented on 25 defendants in the geriatric age range (aged 62 to 78 years old). Demographic variables, criminal charges, medical, neurological and psychiatric illnesses, prior criminal offenses, and final dispositions of the cases are tabulated, and implications for the criminal justice system and social services are discussed.

KEYWORDS: psychiatry, criminalistics, geriatrics, competency

It has become a commonplace observation that as the baby-boom generation of post-World War II infants ages, the proportion of the U.S. population in the geriatric age range will increase. All services for the elderly will be placed under a predictable strain in the foreseeable future, including welfare, health, and criminal justice services. While the social and medical needs of the elderly have received considerable popular attention, relatively little consideration has been given to the impact that "the graying of America" will have on forensic psychiatric services to the criminal justice system. The aim of this paper is to describe the population of geriatric felons examined in a forensic psychiatry clinic, so that some preliminary estimate may be begun of the nature and needs of the geriatric offenders of the future.

The Forensic Psychiatry Clinic for the New York Criminal and Supreme Courts (First Judicial Department) provides psychiatric-legal services for referred defendants in the borough of Manhattan and, to a much lesser degree, Brooklyn and the Bronx. One to two thousand examinations are performed in the course of any given year. The examinations are of two types. In the first type, defendants are evaluated regarding their current competence to stand trial. In the second type, defendants are examined regarding whether or not they suffer from a diagnosable mental disease or mental defect, what the prognosis may be for their condition, and what therapeutic recommendations may be suggested to the court.

Examinations of current competence to stand trial are made by two psychiatrists. If they disagree, a third psychiatrist will examine the defendant and file a supplementary report. Upon request by any of the examining psychiatrists, psychometric testing may be obtained through the services of a staff psychologist.

Diagnostic-dispositional examinations are made by one psychiatrist. At his or her request,

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a supplementary battery of psychometric tests may be obtained. Defendants may be examined at the prepleading, before-sentence, and after-sentence phases of their legal proceedings.

Statement of Purpose

The purpose of this study is to provide data to forensic mental health professionals, attorneys, and criminal justice system personnel about geriatric defendants indicted on felony charges and referred for examination at a forensic psychiatry clinic. This descriptive research will report on such information as the defendants' age, the reason for their referral for examination, the charges against the defendants, the racial/ethnic group to which the defendants belong, the psychiatric diagnoses of the defendants, use of alcohol and illicit drugs, educational level, vocational history, neurological history, medical history, psychiatric history, prior arrest record, marital status, sex, religious affiliation, the size of the sibship in which they were raised, and the disposition that the court made in the legal cases against the defendants.

Method

The files of all defendants examined at the Forensic Psychiatry Clinic between January 1974 and July 1981 were reviewed. The case records of all defendants examined on felony charges in the Supreme Court section of the clinic were selected for consideration. All defendants aged 62 years and older who were examined in the clinic after indictment on felony charges were included in the study. The information in their charts was transferred to data cards that were identified only by code number to protect the anonymity of the specific defendants. The material on the data cards was then reviewed, organized, and tabulated for this report.

The age of 62 years was selected as the entrance criterion because it is at that age that the Social Security program recognizes persons as first qualified for old age/retirement benefits.

Description of the Population

A total of 25 defendants, all aged 62 years or older and all indicted on felony charges, were examined in this Forensic Psychiatry Clinic between January 1974 and July 1981. Fourteen were aged sixty-two to sixty-seven and eleven were sixty-eight or older (Table 1).

In the great majority of instances (17 cases), the defendants were sent for a diagnostic examination. Only eight cases were sent for a determination of competence to stand trial (Table 2).

In 22 cases, the defendants were accused of violent crimes. Six defendants were accused of murder, six were accused of manslaughter, and eight were accused of assault. Only three of the defendants were accused of nonviolent offenses (Table 3). Using age 70 years as a dividing line, there were 12 defendants accused of violent crimes between ages 62 and 69, and there were 10 defendants accused of violent crimes who were over 70 years old (Table 4).

The ethnic/racial background of the defendants was varied (Table 5). Thirteen were black,

TABLE 1—*Age.*

Age Range, years	Number of Subjects
62-64	7
65-67	7
68-70	3
71-73	5
74-78	3

TABLE 2—*Reason for referral of subject.*

Reason for Referral	Number of Subjects
Competence to stand trial	8
Prepleading evaluation	3
Before-sentence evaluation	13
After-sentence evaluation	1

TABLE 3—*Charges.*

Type of Charge	Number of Subjects
Violent charges	**22**
Murder	6
Manslaughter	6
Assault	8
Attempted assault	1
Attempted criminal possession of a dangerous weapon	1
Nonviolent charges	**3**
Criminal contempt	1
Receiving a bribe	1
Conspiracy	1

TABLE 4—*Charges by age group.*

	Number of Subjects by Age Group	
Type of Charge	62-69 Years	70-78 Years
Violent	**12**	**10**
Murder	3	3
Manslaughter	4	2
Assault	5	3
Attempted assault	...	1
Attempted criminal possession of a dangerous weapon	...	1
Nonviolent	**2**	**1**
Criminal contempt	1	...
Receiving a bribe	1	...
Conspiracy	...	1
Total cases	**14**	**11**

TABLE 5—*Ethnic/racial group.*

Classification	Number of Subjects
Black	13
White	5
Hispanic	4
Native American	1
Uncertain	2

five were white, and four were Hispanic (an overlapping noncolor category that included blacks and whites).

In the majority of instances (23 cases), the defendants were male (Table 6). The religious affiliations of the defendants could be reconstructed from our records in twelve cases, of which seven were Protestant and three were Roman Catholic (Table 7). Almost all of the defendants had been married at some time in their lives. Only three were single; seven were legally married, two were in common law marriages, six had separated from spouses, four were widowers or widows, one was divorced, and in two instances our records did not reveal the marital status of the defendants (Table 8).

The size of the sibship in which the defendant was raised could not be determined from our records in nine instances. Two defendants came from a family of eleven siblings, two came from a family of five siblings, two came from a family of four siblings, four came from a family of three siblings, five came from a family of two siblings, and one was an only child (Table 9).

None of the defendants were college graduates, although three had some college-level education. Sixteen had left school before reaching high school and four had dropped out during high school (Table 10).

TABLE 6—*Sex.*

Sex	Number of Subjects
Male	23
Female	2

TABLE 7—*Religion.*

Religion	Number of Subjects
Protestant	7
Roman Catholic	3
"The Tribe"[a]	2
Uncertain	13

[a] "The Tribe" was the name given by these defendants in response to the question, "What religion do you belong to?" It appears to be an idiosyncratic religion that is not affiliated with any of the major faiths.

TABLE 8—*Marital status.*

Status	Number of Subjects
Legally married	7
Common law marriage	2
Separated	6
Single	3
Widowed	4
Divorced	1
Uncertain	2

The range of work cited as the defendants' major employment revealed three tradespersons, three merchant marine workers, two longshoremen, two household domestic workers, two employees of the City of New York, two farm workers, two factory workers, one truck driver, one restaurant owner, one elevator inspector, one alleged undercover investigator for a private detective agency, one pensioner, one person retired on Social Security payments, three persons receiving disability income, and three persons for whom our records revealed no source of income or employment (Table 11).

Ten of the defendants denied any use of alcohol whatsoever. Three admitted that they had life-long drinking problems right up to the time of the interview. Four admitted to having episodic excessive drinking problems. One said he was a former alcoholic who had recovered his sobriety. There were four defendants who described themselves as social drinkers having no problems with alcohol. Two were vague in admitting the extent to which they used alcohol. For one, our records did not reveal data about use or abuse of alcohol (Table 12).

TABLE 9—*Natal sibship size.*

Size of Sibship	Number of Subjects
1	1
2	5
3	4
4	2
5	2
11	2
Uncertain	9

TABLE 10—*Education.*

Educational Level	Number of Subjects
First to eighth grade	16
Ninth to twelfth grade	4
Technical school or college courses	3
Uncertain	2

TABLE 11—*Vocation.*[a]

Vocation	Number of Subjects	Vocation	Number of Subjects
Tradesperson	3	Restaurant worker	1
Merchant marine	3	Elevator inspector	1
Longshoreman	2	"Undercover agent"	1
Domestic	2	Disability income	3
NYC employee	2	Pensioner	1
Farm worker	2	Social Security	1
Factory worker	2	Uncertain	3
Truck driver	1		

[a]There are 28 reported vocations for 25 subjects because some subjects were currently not working at their major jobs due to disability, pensions, or Social Security eligibility.

The overwhelming majority of defendants (22 cases) denied the use of any illicit drugs. Only two defendants acknowledged that they had occasionally used marijuana. In one case, our records were incomplete regarding use or nonuse of drugs (Table 13).

The medical histories of the defendants were often complex. Six defendants denied having any serious medical or surgical problems during their lifetime. In two cases our records did not permit reconstruction of medical histories. However, six instances of hypertension were reported, six instances of heart disease, five instances of arthritis, three instances of venereal disease, two instances of prostatic disease, two instances of hernias, two instances of pneumonia, two instances of abdominal surgery, and two instances of gall bladder disease. In addition, there was one complaint each for hemorrhoids, emphysema, tonsilectomy/adenoidectomy, Webber-Christian disease, nasal surgery, and fracture of the elbow (Table 14).

Questions regarding possible neurological impairment—such as whether or not the defendant had ever been knocked unconscious, had ever required stitches for a scalp wound, had ever had blackouts or seizures or been diagnosed as having epilepsy, had ever had to be evaluated or treated by a neurologist—led to denials of any neurological impairment by 15 defen-

TABLE 12—*Alcohol use.*

Degree of Use	Number of Subjects
Continuous excess up to present time	3
Continuous excess in the past	1
Episodic excess	4
Social drinking	4
Vague on amount	2
Uncertain	1
None at all	10

TABLE 13—*Drugs.*

Degree of Use	Number of Subjects
None at all	22
Uncertain	1
Marijuana	2

TABLE 14—*Medical illness.*

Diagnosis	Number of Subjects	Diagnosis	Number of Subjects
Hypertension	6	Hemorrhoids	1
Heart disease	6	Emphysema	1
Arthritis	5	Webber-Christian	1
Venereal disease	3	Tonsils/adenoids	1
Prostatic disease	2	Nasal surgery	1
Hernias	2	Elbow fracture	1
Pneumonia	2	Uncertain	2
Abdomenal surgery	2	None at all	6
Gall stones	2		

dants. Seven defendants were sufficiently vague in their responses that no clear decision could be made regarding whether they did or did not have a neurological history. One defendant reported having a cerebral vascular accident. One defendant reported having suffered mild dementia secondary to chronic excessive use of alcohol. In one instance, our records did not permit reconstruction of a neurological record (Table 15).

It was difficult to obtain data regarding whether or not other members of the defendants' families had a history of psychiatric disorders. In four instances, we could not reconstruct the data from our records. In six instances, the defendants clearly denied that anyone in their families had emotional illnesses. In one instance, a defendant clearly stated that his daughter had significant mental problems. In 14 instances, the defendants indicated that some person(s) in their families had seen a psychiatrist, been hospitalized, or been regarded as mentally ill, but our records did not permit a reconstruction of exactly what the relationship was between the defendant and the sick family member (Table 16).

The defendants' own psychiatric histories varied. Eleven of the subjects did not report any previous psychiatric evaluation or treatment. Six defendants reported multiple psychiatric hospitalizations, that is, three or more hospitalizations for psychiatric treatment. Three of the subjects had been hospitalized twice. One had been hospitalized once. Three defendants had received outpatient psychiatric care at a clinic and two had received private psychiatric care (Table 17).

TABLE 15—*Neurological illness.*

Diagnosis	Number of Subjects
None at all	15
Uncertain	7
Cerebrovascular accident	1
Dementia, mild	1
No data	1

TABLE 16—*Family history of mental disorder.*

History Reported	Number of Subjects
None at all	6
No data	4
Someone in family	14
Daughter	1

TABLE 17—*Psychiatric history.*

History Reported	Number of Subjects
In-hospital, once	1
In-hospital, twice	3
In-hospital, multiple	6
Outpatient, clinic	3
Outpatient, private	2
None at all	11

Because of the time period under consideration (1974 to 1981), the great majority of the psychiatric diagnoses were made according to the second edition of the *Diagnostic and Statistical Manual* [*1*] of the American Psychiatric Association (DSM-2). In terms of the major diagnostic categories, six defendants were diagnosed with schizophrenia, seven with personality disorders, seven with organic mental syndrome, three with chronic alcoholism, two with a major affective disorder, one with acute anxiety reaction, and one with atypical paranoid disorder. Two defendants had no mental disorder. In four instances the diagnosis was deferred (Table 18).

It is difficult to categorize properly the materials regarding the subtypes of the major illnesses noted above, partially because of the problems related to interrater low reliability with DSM-2 diagnostic subtypes [*2*]. However, it should be noted that the issue of paranoid ideation was considered in five of the defendants diagnosed as schizophrenic and five of the defendants diagnosed as personality disorders; was of major concern in the one atypical paranoid disorder; and was noted as a significant feature in two of the defendants whose diagnoses were deferred. Thus in 13 defendants, regardless of their major diagnostic category, paranoid ideation was a salient feature in their clinical symptomatology.

Eleven of the defendants had no prior history of arrests. Four defendants had been arrested once previously. One defendant had been arrested twice before the current offense. Four of the defendants had multiple (three or more) previous arrests. In five instances, our records did not permit reconstruction of the defendants' prior arrest records (Table 19).

The courts' disposition of the cases varied. One defendant died between the time of arrest and the date set for the trial. In two instances, the charges against the defendants were dismissed. In one case, the defendant was given a conditional discharge. In eleven of the cases, the defendants were sentenced to probation supervision. One of the defendants was committed to the custody of the commissioner of mental hygiene—that is, was involuntarily hospitalized for psychiatric care and treatment. Six of the defendants were sentenced to a period of incar-

TABLE 18—*Psychiatric diagnosis.*

Diagnosis	Number of Subjects
Organic mental syndrome	7
Personality disorders	7
Schizophrenia	6
Alcoholism, chronic	3
Affective disorders	2
Acute anxiety reaction	1
Atypical paranoid disorder	1
Deferred diagnosis	4
No mental disorder	2

TABLE 19—*Prior arrests.*

Arrest History	Number of Subjects
None at all	11
One arrest	4
Two arrests	1
Three or more	4
No data	5

ceration in prison. In three cases, the court had not yet determined a disposition as of the time of the writing of this study (Table 20).

Limitations of the Study

There are several significant limitations on this study. While we are unable to alter them, we feel obliged to indicate that we are aware of them.

The sample of geriatric felons referred for examination at the Forensic Psychiatry Clinic is a biased sample. Not all indicted persons over age 62 are referred for psychiatric evaluation. Not all of the geriatric persons who are presented to a grand jury on felony level charges are indicted, regardless of the likelihood that they committed the alleged offense. Not all of the geriatric offenders are prosecuted by the Office of the District Attorney. Not all of the geriatric felons are apprehended and arrested by the police. Therefore, our study population cannot be generalized to the population of geriatric felons as a whole.

Further, the population of geriatric offenders in the borough of Manhattan of the City of New York is not representative of geriatric offenders as a whole. The unique conditions in New York City make it impossible to generalize from our local population to the general mass of U.S. citizens.

As regards the geriatric population of the United States, it is also impossible to generalize from a description of current needs to a projection of future needs. When the geriatric population has reached its future peak, the social conditions that now prevail may be so altered that no plan based on current data will be valid at that time.

Discussion

In our sample, the court was primarily interested in obtaining diagnostic, therapeutic, and dispositional data. In only about one third of the cases was the issue of competence to stand trial of primary concern.

In the great majority of cases, violent criminal acts were at issue. Only about one case in eight entailed charges of a nonviolent nature. Persons over 70 years of age were as likely to engage in violent offenses (10 cases) as those under 70 (12 cases). Society's fond wish that the elderly be as harmless as they are helpless is not consistent with our experience.

A large majority of our sample was male and most came from ethnic/racial minority groups. Almost all of them had been married at some time in their lives. None of them had graduated from college. Most had been blue collar workers.

About half the defendants reported having had no problems with abuse of alcohol. The vast majority indicated they had no problems with abuse of illicit drugs. This suggests that alcoholism counseling services should be available to this population, but that narcotics counseling may not have to be developed as a separate resource.

The range of medical illness reported indicates that careful medical examination should be

TABLE 20—*Disposition of case.*

Disposition	Number of Subjects
Died	1
Dismissed	2
Conditional discharge	1
Probation	11
Prison	6
Department of Mental Hygiene	1
Case not yet concluded	3

part of the routine services provided to this population. Further, chronic illnesses, such as hypertension, heart disease, and arthritis, rather than acute illnesses, mark this group of offenders, so that ongoing medical supervision and reevaluation must be available for these offenders. Since the preponderance of offenders in the criminal justice system are youthful and medical services are aimed at the needs of that primary population, it is quite possible that geriatric offenders will not find ready access to adequate medical services within the existing system. As the geriatric population and, presumably, the population of geriatric offenders grows, medical care programs in jails, prisons, and probation consultation services will require reconsideration.

Although only two defendants spontaneously reported having any neurological illnesses, it is noteworthy that seven were diagnosed as suffering from organic mental syndrome. The problem appears to be one of unreliable medical histories and lack of sufficient self-awareness. As much medical screening depends on reliable medical histories, providing detailed physical evaluations only to those persons who offer present complaints or have positive past histories, many elderly defendants will slip through the traditional screening system. It may be important to include a cognitive capacity screening test in any routine examinations of the elderly in order to cope with this problem.

More than half the defendants said that a member of their family had a history of mental illness. This suggests that probation or parole authorities should consider that the defendant's family network may include emotionally unstable people and that family supportive resources may be compromised. Perhaps family counseling might be used to supplement traditional individual supervision.

More than half the defendants had previously received psychiatric treatment, six of them having been hospitalized on three or more occasions. Only two defendants were found to have no mental disorder at the time of examination. The most common diagnoses—organic mental syndrome, personality disorders, and schizophrenia—were chronic conditions. Only one defendant was thought to have an acute and transient problem. This finding suggests that it is highly likely that elderly defendants referred for psychiatric evaluation will be found to have mental illness and will be in need of psychiatric care and treatment. Further, it seems likely that short-term crisis intervention techniques will not be consistent with the needs of this population. Rather, long-term supervision and therapy will be required for these chronically disturbed defendants.

As noted earlier, paranoid ideation was a major symptom in the study sample. To the extent that paranoid traits tend to impair and distort interpersonal relations, this symptomatology may have predisposed these defendants to legal entanglements. However, it should be noted that these paranoid tendencies did not necessarily render the defendants incompetent to stand trial nor substantially impair their culpability. However, the combination of chronic emotional illness and paranoid symptomatology makes the prognosis for this group of offenders a guarded one.

Almost half of the defendants had no prior criminal record, even though the great majority of the cases involved violent offenses. Perhaps the lack of past criminality helps account for the relatively mild sentences that were imposed: eleven defendants were granted probation, two had charges dismissed, and one was given a conditional discharge. The implication is that over half of these geriatric offenders were returned to the community and its mental health resources. Attention should thus be devoted to devising and implementing a means of linking these defendants to therapeutic resources and ensuring that they receive the care they require. In our experience, defendants often do not follow through with referrals to community mental health services. We have developed a referral assistance service, staffed by paraprofessional mental health workers, that is able to provide transition services to the defendants, such as escorting them to the initial interview at the community mental health center, assisting them to complete intake application forms, finding the community resource best suited to their needs and financial ability, making sure that the clinic's psychiatric evaluation is conveyed to

the community treatment center, and encouraging them to persist in the face of discouraging bureaucratic delays.

Conclusion

As the U.S. population comes to include an increasingly large geriatric proportion, it is likely that more elderly persons will come to the attention of the criminal justice system. A review of the current geriatric offender population in an urban forensic psychiatric clinic indicates that elderly offenders will have chronic mental and physical illnesses, that they will have committed violent offenses, and that the existing medical service support network within the criminal justice system will require modifications to meet their needs. It is hoped that our observations will permit initial planning for anticipated future needs of the elderly offenders.

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