Richard Rosner,[1] M.D.; Melvin Wiederlight,[2] M.D.; Ronnie B. Harmon,[3] M.A.; and David J. Cahn,[4] M.D.

Geriatric Offenders Examined at a Forensic Psychiatry Clinic

REFERENCE: Rosner, R., Wiederlight, M., Harmon, R. B., and Cahn, D. J., **"Geriatric Offenders Examined at a Forensic Psychiatry Clinic,"** *Journal of Forensic Sciences*, JFSCA, Vol. 36, No. 6, Nov. 1991, pp. 1722–1731.

ABSTRACT: This descriptive research paper reports on 52 geriatric defendants accused of criminal offenses and referred for forensic psychiatric evaluation. It addresses demographic and clinical variables in that population. The authors hope that the data will assist in planning for forensic and therapeutic services for geriatric persons in the criminal justice system.

KEYWORDS: psychiatry, geriatrics, jurisprudence, psychiatric evaluations

The dimensions of the problems of serving the geriatric population in the United States have been stated by Lissy F. Jarvik [*1*]:

> Nearly everyone concerned with the elderly in the United States has pointed out that the number of persons 65 years and older is increasing at an accelerating rate. As of 1980, this group reached 25 million members, or 11 percent of the total population in the United States. Barring any major breakthrough which would significantly reduce adult mortality rates, or a major sociopolitical or biologic disaster which would significantly increase them, it is anticipated that there will be approximately 50 million individuals over the age of 65 by the year 2030 and that 25 million of them will be over the age of 75.

Received for publication 4 March 1991; revised manuscript received 11 April 1991; accepted for publication 15 April 1991.

[1]Medical director, Forensic Psychiatry Clinic for the New York Criminal Court and Supreme Court (First Judicial Department), Department of Mental Health, Mental Retardation, and Alcoholism Services of the City of New York, NY, and clinical professor of psychiatry, Department of Psychiatry, New York University School of Medicine, New York, NY.

[2]Senior psychiatrist, Forensic Psychiatry Clinic for the New York Criminal Court and Supreme Court (First Judicial Department), Department of Mental Health, Mental Retardation, and Alcoholism Services of the City of New York, NY, and clinical associate professor of psychiatry, New York University School of Medicine, New York, NY.

[3]Administrative director, Forensic Psychiatry Clinic for the New York Criminal Court and Supreme Court (first Judicial Department), Department of Mental Health, Mental Retardation, and Alcoholism Services of the City of New York, NY.

[4]Research associate, Forensic Psychiatry Clinic for the New York Criminal Court and Supreme Court (First Judicial Department), Department of Mental Health, Mental Retardation, and Alcoholism Services of the City of New York, NY, and resident in urology, Department of Urology, Montefiore Medical Center and Albert Einstein College of Medicine, Yeshiva University, Bronx, NY.

Despite the implications of these projections for the mental health needs of the expanding elderly population, little has been written in the area of geriatric criminal offenders' mental health, at least not with regard to the population to be found in court-based psychiatric clinics [2].

In 1985, in an effort to begin to address this problem, the Forensic Psychiatry Clinic for the New York Criminal and Supreme Courts published a pilot study of 25 geriatric offenders [3]. It is the purpose of this paper to expand that preliminary report by surveying a larger geriatric population of offenders examined at the Forensic Psychiatry Clinic. This paper is the first of two papers covering the period from 1974 through 1990; the present study reviews the period 1974 through 1984, and the subsequent study will review 1985 through 1990. The decision to stop the first study at the end of 1984 was arbitrary; it was determined by the limited period of time in which the assistance of our research associate was available.

The Forensic Psychiatry Clinic is situated in the Criminal Court Building of the County of New York. It receives referrals from judges, attorneys, and probation officers for evaluations regarding defendants' competence to stand trial and for psychiatric assessments in aid of sentencing. Approximately 1000 to 1500 examinations are performed in the course of any single year.

When the issue is a defendant's current competence to stand trial, he or she will be examined by two psychiatrists; a third psychiatric opinion can be obtained if the first two examiners disagree. Staff psychologists may provide supplemental test reports.

In cases that address presentence considerations, usually one psychologist or one psychiatrist performs the evaluation. In some instances, similar evaluations may occur at the prepleading and at the postsentence phase of the criminal justice process.

Statement of Purpose

The aim of this study is to make available to forensic mental health professionals and criminal justice system personnel data about the population of geriatric offenders referred for psychiatric examination at a forensic psychiatric clinic in a major urban center. The authors hope that this descriptive research report will assist those persons charged with long-term planning to begin the process of preparing their agencies and facilities for the geriatric offender population that may be anticipated in the future.

Methodology

The files of all defendants examined at the Criminal Court section of the Forensic Psychiatry Clinic between January 1974 and December 1984 were reviewed. All defendants over 62 years of age were included in the study. That age was selected because it is the youngest age at which a person might be eligible for Social Security retirement benefits, and therefore we chose it as an arbitrary marker of entrance into the geriatric population in this country. The information in the case files was transferred to index cards identified only by code number. This coded procedure was used to insure the anonymity of the defendants, and thus to protect their right to privacy. The material on the index cards was subsequently tabulated for this report.

Because the defendants included in this report were evaluated during a time in which both the second edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-II) of the American Psychiatric Association and the third edition (DSM-III) were in use, all the charts with DSM-II diagnoses were reviewed by two psychiatrists and reevaluated to convert the DSM-II diagnoses into DSM-III diagnoses, using the DSM-III criteria.

Description of the Population

A total of 52 defendants, between the ages of 62 and 88, were examined in the Criminal Court section of the Forensic Psychiatry Clinic between 1974 and 1984. Twenty-three were under age 64, and 29 were age 65 or older (Table 1).

In the great majority of instances, the referrals were made for assessment of the defendant's competence to stand trial (32 out of 52) (Table 2).

Eighty-three percent of the defendants were facing charges related to violent criminal offenses (Table 3).

Using age 70 as a dividing line, 40 defendants were under age 70 and 12 were age 70 or older. The percentage of violent criminal charges was essentially the same for both age groups; that is, 82.5% for those age 62 through 69 and 83% for those age 70 or older (Table 4).

There were 21 black defendants, 16 white defendants, and 12 Hispanic defendants (Table 5).

The overwhelming majority of the defendants were male (Table 6).

Because of a lack of adequate information, we can make no meaningful comments regarding the religious affiliation of the defendants. In 42 out 52 instances, it was not possible to learn the defendants' religious preferences from our case records (Table 7).

The great majority of the defendants, 40 out of 52, had been married at some time in the course of their lives (Table 8). It should be noted, however, that 35 of the 52 were not still living with their spouses at the time of the offense that brought them to the attention of the criminal justice system.

In 12 instances, the size of the sibship from which the defendant came could not be reliably determined. However, 7 defendants were only children; 5 had just 1 sibling; 5 had 2 siblings; 6 had 4 siblings; and 4 had 5 siblings. The number of defendants from very large sibships, that is, 6 or more in addition to the defendant, was relatively few.

TABLE 1—*Age of the subject.*

Age Range, years	Number of Subjects
62 to 64	23
65 to 67	10
68 to 70	10
71 to 73	1
74 to 76	2
77 to 79	4
80 to 82	1
83 to 85	0
86 to 88	1
Total	52

TABLE 2—*Reason for referral of the subject.*

Reason	Number of Subjects
Competence to stand trial	32
Prepleading evaluation	0
Before sentence evaluation	19
After sentence evaluation	1
Total	52

TABLE 3—*Charges against the subject.*

Type of Charge	Number of Subjects (%)
Violent	
Aggravated harassment	2
Assault	13
Arson	1
Attempted arson	1
Criminal mischief	3
Attempted criminal mischief	1
Criminal possession of a weapon	8
Criminal use of a firearm	1
Endangering the welfare of a child	2
Attempted endangering the welfare of a child	1
Menacing	1
Manslaughter	1
Public lewdness	2
Reckless endangerment	1
Sexual abuse	2
Unlawful imprisonment	1
Robbery	1
Attempted rape	
Nonviolent	
Bail jumping	1
Criminal possession of property	4
Driving while intoxicated	2
Petty larceny	1
Trespassing	1
Total	52 (100)
Violent	43 (83)
Nonviolent	9 (17)

Twenty-eight defendants had a grade school education or less (Table 9). Fifteen defendants had some high school education. Six had attended some post-high-school vocational training program or college.

The range of jobs held by the defendants was too wide to be easily categorized. The most common job was that of unskilled laborer (8 defendants); 4 were porters; 4 worked as carpenters in construction work; 4 were house painters; and 4 were housewives.

Only 3 defendants out of the 9 accused of nonviolent crimes admitted to using alcohol, whereas 32 of the 43 defendants accused of violent crimes admitted using alcohol (Table 10).

Only 2 of the 52 defendants admitted to having ever used illicit drugs (Table 11).

The defendants reported a wide range of medical illnesses for which they had been treated in the past, some of which continued to need medical attention. Eight reported having heart disease; 6 reported having arthritis; 5 reported having high blood pressure; 4 reported having diabetes; and 4 reported having lung disease. Twenty-three reported no medical illnesses.

When questioned about a history of past neurologic illness, 39 defendants denied any positive neurologic history. Four reported blackouts associated with alcoholism, and 3 reported have been knocked unconscious by head trauma.

In the vast majority of instances, our case files did not contain data about past psychiatric illness in the families of the defendants.

Twenty-nine defendants had no prior history of any psychiatric treatment (Table 12).

TABLE 4—*Charges by age, in number of charges.*

Charge	Age 62 to 69, No. (%)	Age 70 and Over, No. (%)
Violent		
Aggravated harassment	2	0
Assault	11	2
Arson	0	1
Attempted arson	1	0
Criminal mischief	2	1
Attempted criminal mischief	1	0
Criminal possession of a weapon	6	2
Criminal use of a firearm	0	1
Endangering the welfare of a child	2	0
Attempted endangering the welfare of a child	0	1
Menacing	1	0
Manslaughter	0	1
Public lewdness	2	0
Reckless endangerment	1	0
Sexual abuse	2	0
Unlawful imprisonment	1	0
Robbery	1	0
Attempted rape	0	1
Nonviolent		
Bail jumping	0	1
Criminal possession of property	4	0
Driving while intoxicated	1	1
Petty larceny	1	0
Trespassing	1	0
Total	40 (100.0)	12 (100)
Violent	33 (82.5)	10 (83)
Nonviolent	7 (17.5)	2 (17)

TABLE 5—*Ethnic/racial group of the subject.*

Group	Number of Subjects
Black	21
White	16
Hispanic	12
Indian	1
Gypsy	1
Oriental	1
Total	52

TABLE 6—*Sex of the subject.*

Sex	Number of Subjects
Male	45
Female	7
Total	52

TABLE 7—*Religion of the subject.*

Religious Group	Number of Subjects
Protestant	3
Catholic	4
Jewish	3
Uncertain	42
Total	52

TABLE 8—*Marital status of the subject.*

Status	Number of Subjects
Legally married	14
Common-law	1
Separated	13
Single	10
Widowed	7
Divorced	5
Unknown	2
Total	52

TABLE 9—*Education of the subject.*

Highest Level of Schooling	Number of Subjects
1st through 8th grade	28
9th through 12th grade	15
Technical school or college	6
Uncertain	0
None	3
Total	52

TABLE 10—*Alcoholism of the subject, in number of subjects.*

Degree of Alcoholism	Nonviolent	Violent	Total
Continuous excess up to present	1	9	10
Continuous excess in past	0	3	3
Episodic excess	1	5	6
Social drinking	1	15	16
None at all	5	12	17

TABLE 11—*Drug dependence of the subject.*

Degree of Dependence	Number of Subjects
None at all	49
Marijuana	1
Marijuana and other drugs	1
Uncertain	1

TABLE 12—*Psychiatric history of the subject.*

History	Number of Subjects
In hospital	
Once	5
Twice	4
Multiple	7
Outpatient	
Clinic	6
Private	0
Unspecified	2
No history	29

TABLE 13—*Diagnosis of the subject.*

Disorder	Number of Subjects
Organic mental disorders, dementia	10
Substance use disorder, alcoholism	11
Schizophrenic disorders	
Schizophrenia, paranoid	8
Schizophrenia, undifferentiated	3
Paranoid disorders, atypical paranoid disorder	1
Psychotic disorders (not classified elsewhere), atypical psychosis	4
Psychosexual disorders, atypical paraphilia	1
Disorders of impulse control (not classified elsewhere) (intermittent or isolated) explosive disorder	1
Adjustment disorder, adjustment disorder	7
Personality disorders	
Paranoid	2
Schizoid	3
Schizotypal	2
Dependent	1
Passive-aggressive	2
No mental disorder	1
Deferred	8

TABLE 14—*Prior arrests of the subject.*

Arrest Record	Number of Subjects
None at all	17
One arrest	16
Two arrests	6
Three or more arrests	11
No data	2
Total	52

Sixteen had had at least one psychiatric in-patient period of treatment. Eight had had some outpatient psychotherapy.

In 8 instances, diagnoses were deferred (Table 13). In 1 instance, the defendant had no mental disorder. Because some defendants had more than one Axis I diagnosis and some defendants had an Axis II diagnosis as well as an Axis I diagnosis, the number of diagnoses listed does not correspond to the 52 that might be expected for 52 defendants. There were 11 defendants with schizophrenia, 11 with alcoholism, 10 with dementia, and 10 with personality disorders.

For 17 of the defendants, this was the first criminal arrest in their lives (Table 14). Sixteen defendants had been arrested on only one prior occasion. Only 11 defendants reported a history of three or more prior arrests for criminal acts.

Limitations of the Study

It should be understood that a biased sample of defendants is sent to the Forensic Psychiatry Clinic. Not all geriatric offenders are caught; not all of those who are caught are formally arraigned (some may be dismissed with a warning); and not all of those who are arraigned are referred for psychiatric evaluation. Our data are not meant to be representative of the overall population of geriatric offenders. Rather, this is merely a report on that group of formally charged geriatric offenders who were referred to our agency for mental health assessment. Furthermore, we have not been able to determine whether or not all of those persons examined were eventually found guilty of the charges against them, so it is more correct to refer to this population as a group of "alleged" geriatric criminal offenders. Of course, the conditions that exist in a huge urban center, such as New York County, cannot be generalized to other communities elsewhere in the United States. Thus, we believe that our findings can only be generalized with caution to other populations of "alleged" geriatric offenders.

Discussion

Our data indicate that 83% of the geriatric defendants we examined between 1974 and 1984 were accused of violent crimes. Although the number of offenses committed by persons over age 70 was less than the number committed by persons between 62 and 69 years of age, the percentage of violent crimes was essentially identical. Thus, the geriatric offender population should not be viewed as harmless.

Almost three fourths of those geriatric offenders who were accused of violent crimes admitted to using alcohol, whereas only one third of those accused of nonviolent crimes admitted using alcohol. This suggests that alcoholism treatment programs should be considered as an adjunct to whatever criminal justice system penalties may be imposed on violent geriatric offenders.

Barry J. Gurland and Peter S. Cross [*4*] have reviewed the prevalence of mental disorders in old age. Their figures for the United States indicate a 24% prevalence of severe senile and arteriosclerotic dementias in American acute care outpatient psychiatric services, whereas our figure is 10 out of 52 defendants, about 19%, which is slightly lower than their figures. Amazingly, we found no defendants to be suffering from depression, in contrast to Gurland and Cross, who found a prevalence of 47% in acute care private mental hospital admissions in the United States. We can only speculate that severely depressed geriatric persons may not be *able* to commit criminal offenses because of the debilitating nature of the depressive illness itself. Gurland and Cross note that the prevalence of schizophrenia in the general population is estimated at 0.3 to 1.1% for the geriatric population; we found that 11 out of 52 defendants had schizophrenia, or 21% of our sample. Similarly, Gurland and Cross report that 2.8 to 11.0% of the geriatric population in the general population of the United States has a personality disorder, whereas we found 10 out of 52 defendants with such a diagnosis, or about 19%.

Gurland and Cross cite the prevalence of alcoholism in the general geriatric population in the United States as 0.5 to 1.0%, but we had 11 out of 52 defendants with alcoholism, about 21%. The population of geriatric criminal offenders seen in our agency is different in their diagnoses from the general American geriatric population. Whether or not the increased prevalence of schizophrenia, personality disorder, and alcoholism has a cause-and-effect relationship to the criminal behavior of the subjects in our survey is beyond our ability to determine, but it is important that the issue be raised for other researchers to consider.

Our data suggest that the criminal justice system should begin planning now for the geriatric offender population that is likely to evolve with the "greying of America." Special medical and psychiatric treatment facilities will be needed to cope with the range of physical illnesses this geriatric population will present and to cope with the mental conditions that are likely to be more prevalent in the geriatric offender population than in the general American geriatric population.

The authors hope that this survey will encourage further research and planning to prepare for the anticipated increase in the geriatric criminal offender population in the future.

Acknowledgment

The authors wish to express their appreciation to M. Bernice Rosner, M.S.N., chief executive officer, Visiting Nurse Association, Brooklyn, N.Y., who provided the initial suggestion to study the population of geriatric offenders examined at our agency.

APPENDIX

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Address requests for reprints or additional information to
Richard Rosner, M.D.
Medical Director
Forensic Psychiatry Clinic
DMHMR & AS
100 Centre Street, Suite 124
New York, NY 10013