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The Incompetent Defendant: Support Systems Help Avoid Future Legal Problems

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ABSTRACT: Reducing crime and improving efficiency of our criminal justice system should be facilitated by identifying how to treat and manage mental health patients who are prone to committing criminal acts more effectively. A total of 142 competency evaluations were reviewed from cases evaluated by the Galveston County Forensic Psychiatrist from 1984 to 1990. Examination of data from these defendants allowed us to address the psychiatric needs of these defendants in terms of contact with the mental health system, particularly those who had more than one criminal justice system contact. The latter defendants lacked social support systems and consistent mental health system follow-up to provide stabilization of their condition. It was felt that this was a factor in their more frequent contact with the criminal justice system.

KEYWORDS: psychiatry, defendants, competency evaluations, mental health systems, forensic science, criminalistics

Because of the large expenditures required by both the nation's criminal justice and mental health systems, more efficient use of these systems should be continually pursued. Along with the cost of the criminal justice system, the financial and social costs of crime in American society are enormous. Reducing crime and improving efficiency of our criminal justice system may be attainable by discovering how to more effectively treat and manage mental patients who are prone to committing criminal acts. One approach is to explore how both our criminal justice system and mental health system interact to deal with this segment of the population.

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Ideally, our mental health system would be able to stabilize and maintain the patients who, in an otherwise deteriorated mental state, would be more likely to commit legal offenses. However, our present system of dealing with persons deemed mentally incompetent to stand trial does not offer the continuity of care required for the benefit of the individual and society. Rather the system permits only treatment to the extent that they are rendered competent to stand trial [*1*]. According to Article 46.02 [932b] in Vernon's Texas Civil Statutes (supplemented 1994), a person is incompetent to stand trial if he does not have:

(1) sufficient presentability to consult with his lawyer with a reasonable degree of rational understanding; or
(2) a rational as well as factual understanding of the proceedings against him [*2*].

This statute corresponds to the wording used in the United States Supreme Court *Dusky vs U.S.* decision of 1960 [*3*], with the exception that in the *Dusky* decision the word "and" is used instead of "or" as it is between statements (1) and (2).

It is important to realize that the finding of incompetence is supposed to be based on these legally specified functional criteria, rather than the severity of a defendant's mental illness.

However, our society would likely prefer adequate continuity of care beyond restoration of competency. In order to address the present system, we examined the characteristics of persons with a questionable mental state who were repeat offenders of the legal system. Specifically, we looked at individuals subject to legal proceedings who were evaluated for competency because of questions that arose in court as to their mental state. We looked at what happens to a person who is deemed mentally incompetent and remanded to a hospital by the court to address this, but who in the future once again ended up in the criminal justice system and referred for a second competency evaluation. By examining the period between the initial incompetency determination and the next criminal justice system contact, and second competency assessment, we were able to discover possible breakdowns in continuity of care provided by the criminal justice system or mental health system.

Method

A total of 142 competency evaluations were reviewed from cases evaluated by the Galveston County Forensic Psychiatrist from 1984 to 1990. Biographical and demographic data as well as diagnoses and disposition were obtained on each person. Fifteen cases involved individuals who had been determined to be mentally incompetent to stand trial in one evaluation who were later seen in a second competency evaluation (Group A). All of these individuals were committed to a state psychiatric hospital after the first evaluation, having been declared incompetent by a jury. Reviewing the second competency evaluation allowed a retrospective review of what mental health system involvement, if any, these 15 persons had undergone since the first evaluation. It was also determined whether the person was in the mental health system when the second offense was committed. This allowed determination of whether the breakdown more commonly occurred while the person was within or outside the mental health system. We noted competence or incompetence also in the second evaluation, and if competency was assessed by the forensic psychiatrist based on changes in mental status.

Other data from the 15 cases (Group A) were compared with data from the remaining 127 cases examined. These other 127 cases were divided into two groups: one composed of those individuals who were determined incompetent in a single evaluation (Group B) and the other group made of those who were determined competent (Group C). Data from Groups A and B were combined into an A + B group which allowed an analysis of characteristics of all defendants who had been determined incompetent to stand trial at

least once. One individual was not included in the study because in his first evaluation he was determined marginally competent and marginally incompetent in the second. He was placed in the criminal justice system after his first competency evaluation, and a question of breakdown in the mental health system was less relevant.

Four of the 15 cases in Group A involved a first competency evaluation done by the preceding Galveston County Forensic Psychiatrist, two involved first competency evaluations done at other counties in Texas and one case involved a first competency evaluation done in Florida. The other eight cases had both competency evaluations done by the present Galveston County Forensic Psychiatrist. For all three groups, age groups, racial-ethnic grouping, gender, marital status, employment status, living situation, psychiatric diagnoses, past psychiatric history, past legal history, diagnoses and determination of competence versus incompetence were identified. Additional information for Group A included where the defendants had been since the first evaluation, whether the defendant was in the mental health system at the time of the second offense, and whether the defendant was determined competent or incompetent on the second evaluation. It was possible that between evaluations the person may have been charged with other offenses and underwent other psychiatric evaluations that were unreported.

When applicable, Fisher's Exact Test was used for statistical analysis [*4*].

Results

Of the 142 total cases reviewed, the number of persons determined competent was 109, or 76.8%, while 32, or 22.5%, were determined incompetent (Table 1). This result is comparable to results of eleven other studies [*5–15*] in which it was found that, on the average, 18.6% of defendants were determined incompetent, with only two studies having greater than 50% of the subjects determined incompetent. The percentage for the current study lies near the median of the studies, with five studies having less than 22.5% incompetent and six having more.

As can be seen from the biographical and demographic data in Table 2, clear differences in support systems were evident between Groups A and B versus Group C. In Group C, 56.4% of the defendants were known to be living with someone else, while only 25.0% of A + B were known to be living with some ($P = 0.004$). Of interest, although 15.5% of Group C defendants were known to be married at the time of their evaluation, no one in either Group A or B was married (for A + B versus C, $P = 0.0129$).

TABLE 1—*Percentages of evaluated defendants found incompetent.*

	Total evaluated	Total found incompetent	Percent found incompetent
Bendt, Balcanoff, and Tragellis (1973)	1888	76	4.0
Brown (unpublished) (1993)	142	32	22.5
Fitzgerald, Peszke, and Goodwin (1978)	174	66	38.0
Gold (1973)	455	350	77.0
Goldstein (1973)	1085	276	25.4
Laczko, James, and Alltop (1970)	435	104	23.9
McGarry, et al. [*10*] (1963)	163	36	22.2
McGarry, et al. [*10*] (1971)	501	6	1.2
Pfeiffer, Eisenstein, and Dabbs (1967)	85	30	35.0
Roesch and Golding (1977)	151	11	7.0
Sussman, et al. (1975)	1512	219	14.0
Vann (1965)	83	42	51.0
Totals (excluding Brown)	6532	1216	18.6

TABLE 2—*Demograhic data.*

	Group A (*N*-15)		Group B (*N*-17)		A + B (*N*-32)		Group C (*N*-110)	
	N	%	*N*	%	*N*	%	*N*	%
Gender: M	15	100.0	12	70.6	27	84.4	99	90.0
F	0	0.0	5	29.4	5	15.6	11	10.0
Age: 17–20	3	20.0	0	0.0	3	9.4	14	12.7
21–29	8	53.3	9	52.9	17	53.1	43	39.1
30–39	4	26.7	6	35.3	10	31.3	34	30.9
40–60	0	0.0	2	11.8	2	6.3	19	17.3
Race: Black	5	33.3	12	70.6	17	53.1	50	45.5
White	8	53.3	3	17.6	11	34.4	50	45.5
Hispanic	2	13.3	1	5.9	3	9.4	8	7.3
Other	0	0.0	1	5.9	1	3.1	2	1.8
Marital Status:								
Married	0	0.0	0	0.0	0	0.0	17	15.5
Not Married	15	100.0	16	94.1	31	96.9	90	81.8
Unknown	0	0.0	1	5.9	1	3.1	3	2.7
Employment:								
Employed	0	0.0	1	5.9	1	3.1	41	37.2
Unemployed	14	93.3	13	76.5	27	84.4	59	53.6
Student	0	0.0	0	0.0	0	0.0	3	2.7
Unknown	1	6.7	3	17.6	4	12.6	7	6.4
Living Status:								
Alone	8	53.3	8	47.1	16	50.0	29	26.4
Housemate	5	33.3	3	17.6	8	25.5	62	56.4
Unknown	2	13.3	6	35.3	8	25.5	19	17.3

The workplace can be seen as a potential source of support through interactions with co-workers and employers. While 37.2% of Group C were known to be employed at the time that they were arrested, only one person in A + B (3.1%) was employed ($P = 0.000$) and no one in Group A was known to be employed ($P = 0.0009$). Another remarkable finding was that in Group B, 70.6% of defendants were black, whereas only 33.3% in Group A were black. Conversely, 17.6% of defendants in Group B were white, and 53.3% of Group A were white. For Group A versus Group B, race approached significance ($P = 0.0550$). It would be worthwhile to explore why more whites are subject to recurrent competency evaluations. In comparison to Steadman [*1*], certain demographic data were similar. Steadman found in his sample that 45.6% of defendants were black, 32.8% were white and 19.9% were Hispanic, in comparison to 53.1% black, 34.4% white and 9.4% Hispanic found in our study.

In terms of employment, 15.3% in Steadman's study were found to be regularly employed, while only 3.1% of the defendants in our study were employed. Interestingly, Steadman found 16.8% of his sample to be married which compares actually with the 15.5% of Group C (found competent), but not with the 0% in Groups A and B combined.

As one might expect, those found incompetent at least once (Groups A and B) tended to have more serious psychiatric disorders (Table 3). Some individuals in both groups were given more than one diagnosis (Table 3). In Groups A and B, 66.7% and 76.5%, respectively, were given thought disorder diagnosis (for example, schizophrenia), while only 8.2% in Group C members were given such a diagnosis. Also, 26.7% of Group A members were diagnosed with organic brain syndrome or dementia, while 11.8% of Group B and only 3.6% of Group C had such a diagnosis. Another notable comparison was that a personality

TABLE 3—*Diagnosis.*

	Group A (*N*-15)		Group B (*N*-17)		A + B (*N*-32)		Group C (*N*-110)	
	N	%	*N*	%	*N*	%	*N*	%
Thought D/O	10	66.7	13	76.9	23	71.9	9	8.2
Substance Abuse	7	46.2	6	35.3	13	40.6	48	43.6
Dementia	4	26.7	2	11.8	6	18.8	4	3.6
Borderline Int./MR[a]	5	33.3	1	5.9	6	18.8	30	27.2
Personality D/O	3	20.0	1	5.9	4	12.6	55	50.0
Affective D/O	1	6.7	1	5.9	2	6.3	12	10.9
Adjustment D/O	0	0.0	0	0.0	0	0.0	4	3.6
Malingering	0	0.0	1	5.9	1	3.1	9	8.2
No Diagnosis	0	0.0	0	0.0	0	0.0	7	6.3
Other	0	0.0	0	0.0	0	0.0	13	11.8

[a]Borderline Intellectual Functioning and Mental Retardation.

disorder was diagnosed in 50% of Group C but in only 20.0% of Group A and 5.9% of Group B. Similar statistics were noted with the diagnosis of substance abuse, with percentages of 46.2%, 35.3% and 43.6% for Groups A, B and C, respectively. All diagnoses of malingering were in Group C except for one member of Group B.

Defendants found incompetent who were referred for a second competency evaluation were more likely to have had a past psychiatric history, a past criminal history, or both (Table 4). In group A, 93.3% had a past psychiatric history, compared to 76.5% of Group B and only 49.1% of Group C (for Group A versus Group B, $P = 0.338$, not significant, for Group A versus Group C, $P = 0.0015$). Group A had a larger percentage with a prior legal history than Groups B and C, 93.3% compared to 64.7% and 60.0%, respectively (for Group A versus Group B, $P = 0.088$, and for Group A versus Group C, $P = 0.0103$). However, Group C had the largest percentage of members with only a legal history, 25.5%, followed by Group B with 17.6% and Group A with only 6.7%.

We looked at dual diagnoses in all three groups, that is, diagnosis of a primary mental disorder comorbid with a substance abuse disorder (Table 5). Analyses included the percentages of Groups A, B or C with a given diagnosis(es) (% *Y*) as well as the percentage of the total number of defendants with a given diagnosis(es) (*X*) in Groups A, B or C (% *X*). The diagnoses of thought disorder, organic brain syndrome or dementia, and personality disorder were examined with respect to this because gross sampling of dual diagnoses with these conditions and substance abuse brought about the largest numbers of defendants. One

TABLE 4—*Past psychiatric and legal histories.*

	Group A (*N*-15)		Group B (*N*-17)		A + B (*N*-32)		Group C (*N*-110)	
	N	%	*N*	%	*N*	%	*N*	%
Legal only	1	6.7	3	17.6	4	12.6	28	25.5
Psychiatric only	1	6.7	5	29.4	6	18.8	16	14.5
Both	13	86.7	8	47.1	21	65.6	38	34.5
Legal (total)	14	93.3	11	64.7	25	78.1	66	60.0
Psychiatric (total)	14	93.3	13	76.5	27	84.4	54	49.1
Neither	0	0.0	1	5.9	1	3.1	29	26.4

NOTE: Table 4 provides quantitative information on the past legal and psychiatric histories of Groups A, B and C, prior to the time that the offense was committed that lead to the first competency evaluation.

TABLE 5—*Diagnoses with or without comorbid substance abuse problem.*

	Group A (Y = 15)			Group B (Y = 17)			A + B (Y = 32)			Group C (Y = 110)		
	N	$\%Y$	$\%X$	N	$\%Y$	$\%X$	N	$\%Y$	$\%X$	N	$\%Y$	$\%X$
Thought D/O Without Substance Abuse (X = 21)	6	40.0	28.6	10	58.8	47.6	16	50.0	76.2	5	4.5	23.8
Thought D/O With Substance Abuse (X = 11)	4	26.7	36.4	3	17.6	27.3	7	21.9	63.6	4	3.6	36.4
Dementia Without Substance Abuse (X = 3)	0	0.0	0.0	2	11.8	66.7	2	6.3	66.7	1	0.9	33.3
Dementia With Substance Abuse (X = 7)	4	26.7	57.1	0	0.0	0.0	4	12.6	57.1	3	2.7	42.9
Personality D/O Without Substance Abuse (X = 36)	3	20.0	8.3	1	5.9	2.8	4	12.6	11.1	32	29.1	88.9
Personality D/O With Substance Abuse (X–23)	0	0.0	0.0	0	0.0	0.0	0	0.0	0.0	23	20.9	100.0

observation is that higher percentages of defendants with thought disorder and organic brian syndrome (or dementia) with substance abuse were in Group A than those percentages of individuals with thought disorder and organic brain syndrome (or dementia) alone. However, another interesting finding is that for Group C (the defendants found competent in their one evaluation), each diagnosis with substance abuse actually had a higher percentage of X than the same diagnosis without substance abuse.

Figure 1 illustrates the sequence of being in the mental health or criminal justice systems or being "lost" between the first and second evaluation of all fifteen subjects in Group A. The term "lost" denotes that the person was not in the mental health system at that time. All defendants in Group A were first committed to a psychiatric hospital; from there, the sequence for each varied until commission of the second offense. At least five persons were in the legal system (without reported psychiatric evaluations) between the first and second evaluations. Different sequences occurred. For example, a trend of moving in and out of the psychiatric hospital is seen with defendants 2, 5, and 6, while defendants 1 and 3 were found to move in and out of jail. Also, nine of the fifteen subjects were not in any mental health system at the time that they committed the offense that led to the second evaluation.

Discussion

The demographic data clearly demonstrated differences between the defendants who were determined incompetent at last once, Groups A and B, versus the defendants who were determined competent, Group C. The latter defendants more often lived with someone else, were more often married, and were more often employed. All these features are elements consistent with a supportive environment. A housemate can monitor a mentally ill person's functioning and provide assistance and support to maintain the individual's

		First Evaluation									Second Evaluation
	1	H	O	J	O	J	O	L			-Competent
	2	H	O	H	L	H	L				-Competent
	3	H	O	L	J	L	J	L	H	L	-Competent
S	4	H	O	L							-Incompetent
U											
B	5	H	O	H	O	H	O	H	O		-Competent
J											
E	6	H	L	H	H	L	H	O			-Incompetent
C											
T	7	H	O	L							-Incompetent
S											
	8	H	O	L							-Incompetent
	9	H	H	O							-Competent
	10	H	H	O	L						-Competent
	11	H	O								-Incompetent
	12	H	J	O	L						-Competent
	13	H	O	L	J	H	O				-Incompetent
	14	H	H	O	L						-Incompetent
	15	H	J	H	H	O					-Incompetent

SEQUENCE OF BEING IN DIFFERENT SYSTEMS

Legend:

H	Hospital	Subject was hospitalized for psychiatric illness.
O	Outpatient	Subject was in an outpatient mental health system.
L	"Lost"	Subject was neither in the mental health nor the penal system.
J	Jail	Subject was held in the penal system.

For subjects numbered 1 through 15, each system is delineated by a letter placed in the order of occurrence. The sequence for each individual starts at the left of the column, and progresses toward the second evaluation. At the end of the sequence, the person has been arrested. Letters do not indicate length of time in a system. Additionally, this figure shows if the person was determined to be competent or incompetent in the second evaluation.

FIG. 1—*The sequence of being in different systems.*

emotional stability. A housemate can also contact the agency or professionals who provide care for the mentally ill person.

Overall, only a small number of the defendants in all three groups were married. Steadman's [*1*] findings were consistent with this. Yet our data indicate that defendants found to be competent also were much less likely to be married. The lack of spousal support likely does not help any of these defendants cope with society and its rules any better.

The workplace can also be a source of social support for a mentally ill person in much the same way that marriage and living with a housemate can be. Coworkers can also monitor how mentally ill persons are functioning, provide some emotional support and contact health care facilities that treat the person. Coworkers can also be valuable information

sources to the treating facilities. A stable job can also improve a patient's self-esteem, lending stability to the person's emotional condition.

Along with examining the demographic data from the standpoint of systems support, it is important to consider the mentally ill person's own characteristics that render the person less likely to effectively use such support systems. The lack of housemates and spouses for persons in Groups A and B could be due to their difficulties with social interactions and intimacy. The high rates of unemployment may also be a function of greater social impairment of the defendants in Groups A and B. Their lack of employment demonstrates problems with self-sufficiency. Again, Steadman's data on incompetent defendants were consistent with this [*1*].

With regard to ethnicity, our data indicated that blacks were determined incompetent somewhat more often than whites. While the numbers of blacks and whites in Group C were equal, the percentages of blacks in Groups A and B combined were higher than the percentage of whites in those groups. Steadman's data were also consistent with this [*1*]. This might be secondary to failure of agencies and systems to provide consistent follow-up care for their mental conditions in comparison with whites. On the other hand, individuals from black ethnic backgrounds may be less able and motivated to seek out and use the help of mental health agencies. The higher representation of blacks in the incompetent groups could as well be due to both factors.

It is, however, interesting to note that a higher percentage of whites underwent repeated competency evaluations. Reasons for this are not clear. Perhaps white defendants received favorable treatment because lawyers and judges were more willing to provide them with an alternative path to avoid direct contact with the penal system, and this took the form of a competency evaluation. Another reason may be that these same legal professionals make a greater effort to understand why a white subject has broken the law, and to identify their vulnerabilities. In contrast, a black defendant may be regarded as a "hardened" criminal.

Looking at the data on diagnoses, persons in Groups A and B much more often had a diagnosis involving thought disorder than Group C, with the percentages being comparable between Groups A and B. Individuals with a thought disorder typically function marginally outside of an institution, with limited coping abilities and resources; yet, the similarities between the percentages of these individuals in Groups A and B might indicate that many of these defendants can be stabilized, as evidenced by Group B members, who to our knowledge required only one competency evaluation. Possibly some of the Group B members were never again subject to the criminal justice system; or, if they were, they might have been sufficiently mentally stable as to not require another competency evaluation.

The percentages of organic brain syndrome (or dementia) cases diagnosed in each group were compared. Group A had a larger percentage of defendants with this diagnosis compared to both Groups B and C. This probably reflects that these defendants have such a lower baseline level of functioning and treatments for these defendants are limited in number and effectiveness. Persons with dementia, on the whole, usually have less potential for improvement in their level of functioning.

Regarding the legal and psychiatric histories of defendants in each group, a greater percentage of defendants in Group A had been in contact with mental health systems before their competency evaluations than persons in Groups B and C (Table 4). This indicates that these defendants had more often at least been in contact with mental health systems, so their problems may have been recognized before they went to court and subsequently received a competency evaluation. The question still remains as to whether they had the benefit of consistent follow-up within the mental health systems.

Group A defendants also have had more contacts with the legal system than defendants in Groups B and C. It is possible that their poor functioning state made them more susceptible to committing repeated criminal offenses. Consistent psychiatric treatment and follow-up may have conceivably broken this pattern. Yet one could also conclude that defendants in

Group A, with their preponderance of thought disorders and dementia, may have been more subject to entry into the criminal justice system because they were more easily identified and apprehended than other offenders. The data indicate that although more defendants in Group A had prior involvement with the criminal justice system than those in the other two groups, fewer defendants in this group had been exposed *only* to the criminal justice system. With Group C having the largest percentage of defendants with only a legal history, these defendants being determined competent may indicate less need of psychiatric treatment to avoid further criminal justice system contact in the future. This is in contrast to the indications that the mental states of Group A defendants would benefit from more intense psychiatric follow-up to render them less susceptible to being subject to the criminal justice system.

Data in Table 5 demonstrate a higher percentage of defendants with thought disorder and organic brain syndrome (or dementia) with substance abuse (versus without substance abuse) being in Group A, a notable observation. This raises the question of whether the substance abuse causes defendants with these conditions to be further and repeatedly mentally compromised, and, therefore, subject to repeated competency evaluations. Mental health systems should be funded for substance abuse programs in addition to the funding for treatment programs for mental disorders unrelated to substance abuse.

Yet another finding to consider is in the Group C data, where there was a higher percentage of *X* with comorbid substance abuse than without substance abuse. Since thought disorders and dementia were less common in Group C, the evaluator could obtain a more complete history during the interview, permitting more frequent diagnoses of both personality disorders and substance abuse disorders.

The frequency of being in either the mental health or criminal justice system did not appear related to being judged competent or incompetent on the second evaluation. However, a determination of competency on the second evaluation did not mean that the subjects' emotional states were not compromised, as evidenced by the question of competency coming up a second time in court. Sixty percent of these defendants were in no mental health system at the time of their second competency evaluation. This may indicate that deterioration in their mental state led to this second competency evaluation with this occurring because of a lack of mental health system follow-up.

Conclusions

In this study those who were determined incompetent in an initial evaluation and were referred later for a second competency assessment (Group A) suffered from more serious disorders and impairments and were more likely to have had prior psychiatric and criminal histories.

Defendants in Group A have a history of being in the criminal justice system more often than those in Groups B and C. This is supported by noting the percentage of those in Group A with a legal history, prior to even the first evaluation, was much larger than that of Groups B and C. The defendants in Group A appear to lack social support systems where interaction and monitoring of their mental condition could take place. They were without essential components of support for maintaining mental stability from the standpoint of their illnesses. They were deprived of a system for monitoring their mental health as an outpatient. Mental health agencies can also provide a place for day activities with monitoring and support. This could be provided to a person living alone and/or without a job, among others who have less than optimal support systems.

In comparison to Groups B and C, the defendants in Group A had more chronic mental illnesses with a much larger percentage of thought disorders and organic brain syndrome/dementia than those in Group A. The defendants with these conditions, having limited coping abilities and resources, would be expected to function marginally without institutional

support. Other demographic statistics of Group A reflected the limited social functioning of defendants in this group; for example, the lack of employment demonstrates problems in self-sufficiency. One could also conclude that individuals who have thought disorders and organic brain syndromes/dementias are more subject to entry into the criminal justice system by being more easily apprehended than other offenders.

The combination of marginal functioning and few support systems seen with the defendants in Group A is typical of problems of many patients who are in the state mental health system. However, the data on subjects in Group A suggest that mental health patients, because of this, might be subject to the criminal justice system on more than one occasion. A solution to this problem might be longer and more intense follow-up in the mental health system to ensure better treatment as well as support. Additional support could be provided with regularly assigned case workers and more frequently scheduled group activities to allow closer monitoring of their mental health status. This could actually be beneficial to many patients in the state mental health system, in general. However, for mental health patients who are prone to violate social norms and laws, there probably is justification to devote greater resources toward their problems.

Further emphasis should be placed on coordinating substance abuse treatment for individuals who risk decompensation of their mental states because of substance abuse, such as those defendants who were in Group A. Also, mental health systems need to make stronger efforts to allow minorities access to consistent mental health care. This may require exploration and elimination of biases that hinder full access. Cross-cultural studies may provide some insights on how to address this. Emphasis on hiring more minorities may make mental health systems more receptive to the population of individuals who shy away because of biases on both sides. Discouragement of cultural discriminations within the mental health system's present personnel is essential too.

In further research, it would be important to obtain information regarding the length of time that patients are in a certain system, be it inpatient or outpatient treatment, the legal system or no system at all. This could lead to better understanding of the duration of treatment that is best indicated to keep people out of the criminal justice system. More could also be learned about specific outpatient psychiatric treatments to see what types and frequencies of treatment are most beneficial. It would also be useful to ascertain, through follow-up interviews, what happened to individuals who were determined mentally incompetent in court process many years ago, and who since have not reentered the criminal justice system.

Note

Aside from references cited in this article, additional relevant literature resources are listed in the references section as References *16* to *35*.

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