Profile of Defendants Seen for Pre-Sentence Psychiatric Examination

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The recent forensic psychiatry literature has focused on such areas as compentency to stand trial and the insanity plea. Very little attention has been given to the pre-sentence psychiatric evaluation particularly from a research point of view. Such information as demographic data on the defendants examined and the role the psychiatric report plays in the sentencing process is both unclear and for the most part unknown. This is ironic in light of the view held by a certain segment of the forensic psychiatry community, that the only legitimate role of the mental health professional in the criminal proceeding should be after the determination of innocence or guilt and in the pre-sentencing phase. Menninger,[1] for example, advocates the elimination of psychiatrists from the criminal courtroom because he considers guilt, competence, and responsibility to be moral questions, not medical ones. In his view, the psychiatrist may function in the post-trial situation as part of a multi-professional treatment tribunal. Also, Halleck[2] suggests that the use of psychiatric testimony is likely to be increased in the sentencing process because of the current determinate sentencing laws and the need by some judges to receive advisement on mitigating circumstances. The recent Estelle v. Smith[3] Supreme Court decision has focused on relevant aspects related to the pre-sentence psychiatric examination.

Simon,[4] in discussing the pre-sentence evaluation, raises some important ethical issues, among them the "ambiguity as to role relationships—doctor, patient, inquisitor, accused" that the psychiatrist finds himself in during the interview. To accurately assess the defendant's mental condition, details about the offense itself may have to be evaluated that, if obtained, could be potentially damaging when the question of guilt in the legal sense is reopened during an appeal. Although Sadoff[5] and other authorities in their writings attempt to sensitize practitioners to basic issues pertaining to forensic psychiatric interviews (for example, identifying oneself and the exact purpose of the examination), ethical uncertainties and role confusion persist.

Review of the Literature

Although there have been numerous studies on pre-sentence reports conducted by probation departments,[6] there are comparatively few such

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studies investigating pre-sentence psychiatric reports. In 1972, Olsson,[7] in a comprehensive study at the Medical Office of the Supreme Bench of Baltimore, evaluated the referral-evaluation-disposition process of defendants sent for psychiatric examination, most of whom were in the pre-sentence context. According to his findings, there was a 54.9 percent complete agreement; 29.5 percent partial agreement; and 15.6 percent disagreement between psychiatric pre-sentence recommendations and judges' dispositions. Bohmer[8] conducted a study of pre-sentence psychiatric reports between the years 1966 and 1970 in Philadelphia on males convicted of sex offenses. One of the main purposes was to understand the use and influence of these reports on judicial sentencing. She found about 40 percent agreement on recommendations of incarceration and a little over 50 percent agreement with recommendations of probation. In canvassing some of the judges, many of them indicated that the most helpful part of the report was the diagnosis. However, there was no discernible correlation between the type of sentence and the diagnosis. In those cases where a decisive recommendation was made, the judge was more often influenced by the report. Bohmer concluded, though, that her research indicated that the psychiatric reports generally had little affect on the judges' sentencing decisions. One function these reports serve, she speculates, is to provide the judges with the psychological support they need to make difficult decisions. It is crucial to state that many of the psychiatrists in the above two research studies saw their function as making specific recommendations to the court such as imprisonment or probation.

The present study is an attempt to look more closely at the kinds of defendants typically referred for evaluation in an inner-city court clinic. It is the contention of the authors that part of the difficulties in the pre-sentence psychiatric evaluation process has to do with the nature of the types of defendants that are characteristically referred. This point will be further developed in the discussion.

Methodology

The authors have conducted a descriptive study of 270 consecutive pre-sentence psychiatric evaluations seen at the Court Psychiatric Clinic of The Bronx-Lebanon Hospital Center between 1978 and 1979. These examinations were part of the overall pre-sentence evaluation under Article 390 of the New York State Criminal Procedure Code.[9] All felony convictions require a pre-sentence investigation and the court may not pronounce sentence until it has received a written report. Also, in cases of misdemeanors, the court requires such a written report before passing a sentence of probation, imprisonment in excess of 90 days, and consecutive sentences of imprisonment aggregating more than 90 days. It is important to note that pre-sentence psychiatric evaluations represent approximately 5 percent of the total number of reports prepared on all defendants by the Probation Department for Bronx County. The vast majority of psychiatric

examinations were directly ordered by the judges, and in only some instances were they requested by the Probation Department as a supplement to its own pre-sentence reports that it provides to the court.

Much of the information on the defendants was obtained by the authors during their interviews and the remainder was obtained through a systematic review of the charts. For the most part, personal information was of a self-reporting nature. In numerous instances, supplementary personal information was provided by the accompanying Probation Department background material. The data obtained were the following demographic variables: age, sex, race, marital status, education, and employment. Mental health variables included: psychiatric, alcohol, drug and heroin histories, and psychiatric diagnosis. Criminological variables were: history of arrests, current convictions, and judicial dispositions. Estimation of intelligence and psychiatric diagnosis were made by the individual examiners of the defendants using the then criteria of DSM-II.

It is important to state that the position of this clinic is not to make specific recommendations of incarceration or probation to the court. The only opinions and recommendations made were in the context of motivation and need for treatment and the modality deemed as being most suitable.

Results

Of the 270 index cases only two subjects refused to be examined (both of whom were in the 31-40 year age range).

Demographic Variables The breakdown of the subjects by sex was 84 percent male and 16 percent female. Age distribution yields an overwhelming percentage in the 16-30 year range (77 percent). Ethnic distribution shows the majority to be either black (42 percent) or Hispanic (40 percent). Most of the defendants were single (70 percent), with an educational level of some high school study (66 percent). The vast majority (81 percent) had either no employment history or an erratic one.

Mental Health Variables The majority of defendants have had some form of psychiatric history (57 percent). Approximately one-third (31 percent) and one-quarter (25 percent) admit to an alcohol or drug abuse history, respectively. Almost one-fifth (19 percent) report having abused heroin some time in the past. The largest categories of estimated intelligence were dull-normal (40 percent) and average (36 percent). Over half the population's estimated intelligence was dull-normal or below (58 percent). Of particular note in the primary diagnostic breakdown is that 27 percent were diagnosed with what was designated by authors as major (paranoid, schizoid, or borderline) or minor (passive-aggressive, dependant, hysterical, or obsessive-compulsive) personality disorders. Another 5 percent were further delineated into the antisocial personality category. One-third (33 percent) of the total population, therefore, was diagnosed as having character disorders. There were 11 percent diagnosed as schizophrenic, 1 percent as major depression, and 3 percent as sexual perversions. These

results are presented in Table 1. The recommendation often made was for some kind of ambulatory or outpatient treatment (52 percent) followed by no treatment (23 percent), and 2 percent for treatment in a hospital setting, as shown in Table 4.

Table 1. Number and Percentages of Diagnostic Entities

Diagnosis	Number	Percentage
Severe personality disorder	34	14
Minor personality disorder	33	13
Schizophrenia	28	11
Alcohol abuse	25	10
Depressive neurosis	25	10
Adjustment reaction	22	9
Mental retardation	21	9
Adolescent conduct disorder	12	5
Antisocial personality disorder	11	5
No mental disorder	11	4
Sexual perversions	8	3
Drug abuse	7	3
Organic brain syndrome	6	2
Major depression	3	1
Other neuroses	3	1

Total number of subjects in study: 270
Diagnosis deferred: 1
Unobtained (no diagnosis made): 18
Refused: 2
Number of subjects on which statistics based: 249

Criminological Variables The overall proportion of defendants who had an arrest history was 72 percent, of which 24 percent of this total figure represents juvenile arrest histories. As presented in Table 2, the largest category of convictions was for assault (15 percent), robbery (13 percent), possession of a weapon (11 percent), and sexual offenses against adults (9 percent). An interesting finding was the low figure of 1 percent for drug-related offenses. The breakdown of judicial dispositions shown in Table 5 reveals that almost half the defendants (48 percent) were given some form of probation, and approximately one-quarter (26 percent) were given some form of imprisonment.

Attempts were made to analyze the above data according to diagnostic category. Since the absolute numbers were small, the results could not be asserted in statistically significant terms but, rather, as suggestive trends. Even then the groups mentioned are those with relatively large enough numbers to make reasonable generalizations. In Table 3, diagnostic entities were cross-tabulated with the number and percentages of itemized convictions of the total amount recorded. Noteworthy trends indicate that severe personality disorders had the highest percentage of assault convictions (27 percent); antisocial personalities the highest percentage of robberies (31 percent); property related thefts indicate that adolescent conduct disorder

Table 2. Number and Percentages of Type of Convictions

Type of Convictions	Number	Percentage
Assault	43	15
Robbery	36	13
Possession of a weapon	30	11
Petit larceny	17	6
Burglary	17	6
Criminal mischief	16	6
Arson	14	5
Sexual abuse	13	5
Grand larceny	11	4
Endangering welfare of child	11	4
Trespassing	10	4
Criminal possession of stolen property	10	4
Rape	7	2
Manslaughter (6 completed) (1 attempted)	7	2
Reckless endangerment	7	2
Murder 2° (2 completed (3 attempted)	5	2
Sodomy	4	1
Drug related (sale or possession)	4	1
Public lewdness	4	1
Criminal negligent homicide	4	1
Others	15	5

Statistics based on a total of 281 convictions obtained on 262 subjects.
Missing data on 8 subjects.

was the highest (50 percent). Among the weapons convictions, schizophrenics ranked highest (20 percent); the depressive neurosis category had the highest murder-related convictions.

Table 4, "Treatment Recommendations Per Diagnosis," suggests that antisocial personality disorders and "no mental disorder" had the highest "no treatment" recommendations (64 percent and 82 percent, respectively).

Table 3. Number and Percentages of Convictions Per Diagnosis

	Number of Recorded Convictions	Assault	Robbery	Property Related	Sexual Offense	Drug Related	Weapons Conviction	Murder, Manslaughter, Criminal Negligent, Homicide	Arson	Other
Severe personality disorder	43	12 (27%)	5 (12%)	5 (12%)	5 (12%)	2 (5%)	6 (13%)	2 (5%)	2 (5%)	4 (9%)
Minor personality disorder	35	7 (20%)	1 (3%)	5 (14%)	3 (9%)	—	4 (11%)	3 (9%)	3 (9%)	9 (25%)
Schizophrenia	30	4 (13%)	5 (17%)	2 (7%)	1 (3%)	—	6 (20%)	2 (7%)	2 (7%)	8 (26%)
Alcohol abuse	28	6 (21%)	3 (11%)	2 (7%)	—	—	2 (7%)	1 (4%)	1 (4%)	13 (46%)
Depressive neurosis	25	3 (12%)	2 (8%)	6 (24%)	1 (4%)	—	3 (12%)	4 (16%)	1 (4%)	5 (20%)
Adjustment reaction	22	2 (9%)	4 (18%)	4 (18%)	1 (5%)	—	4 (18%)	—	1 (5%)	6 (27%)
Mental retardation	23	1 (4%)	5 (22%)	5 (22%)	3 (13%)	—	1 (4%)	1 (4%)	2 (9%)	5 (22%)
Adolescent conduct disorder	12	1 (8%)	1 (8%)	6 (50%)	—	—	2 (17%)	—	—	2 (17%)
Antisocial personality disorder	13	2 (15%)	4 (31%)	4 (31%)	1 (8%)	—	—	—	—	2 (15%)
No mental disorder	11	1 (9%)	—	2 (18%)	2 (18%)	—	1 (9%)	—	—	5 (46%)
Sexual perversions	7	—	—	2 (29%)	4 (57%)	—	—	—	—	1 (14%)
Drug abuse	10	1 (10%)	1 (10%)	1 (10%)	—	1 (10%)	2 (20%)	—	2 (20%)	2 (20%)
Organic brain syndrome	6	—	1 (17%)	2 (33%)	—	—	1 (17%)	—	—	2 (33%)
Major depression	3	—	1 (33%)	2 (67%)	—	—	—	—	—	—
Other neuroses	4	2 (50%)	—	1 (25%)	—	—	1 (25%)	—	—	—

Table 4. Treatment Recommendations Per Diagnosis

	No Treatment	OPD	In-Patient	Half-way House	Continue Treatment	Vocational Rehabilitation
Severe personality disorder	4 (12%)	23 (68%)	1 (3%)	6 (17%)	—	—
Minor personality disorder	15 (44%)	15 (44%)	—	—	2 (6%)	2 (6%)
Schizophrenia	—	19 (68%)	3 (11%)	—	6 (21%)	—
Alcohol abuse	5 (20%)	12 (48%)	1 (4%)	2 (8%)	5 (20%)	—
Depressive neurosis	2 (8%)	19 (79%)	—	—	3 (13%)	—
Adjustment reaction	4 (19%)	13 (62%)	—	3 (14%)	1 (5%)	—
Mental retardation	4 (19%)	10 (48%)	1 (5%)	—	2 (10%)	4 (19%)
Adolescent conduct disorder	1 (8%)	8 (67%)	—	—	2 (17%)	1 (8%)
Antisocial personality disorder	7 (64%)	3 (27%)	—	—	1 (9%)	—
No mental disorder	9 (82%)	—	—	—	—	2 (18%)
Sexual perversions	2 (29%)	5 (71%)	—	—	—	—
Drug abuse	1 (14%)	5 (72%)	—	—	1 (14%)	—
Organic brain syndrome	—	1 (17%)	—	—	4 (66%)	1 (17%)
Major depression	1 (33%)	2 (67%)	—	—	—	—
Other neuroses	2 (67%)	—	1 (33%)	—	—	—

Table 5, "Judicial Dispositions Per Diagnosis," suggests that antisocial personality and schizophrenia were most likely to receive imprisonment (46 percent and 36 percent, respectively).

Table 5. Judicial Dispositions Per Diagnosis

	Probation	Prison	Grand Jury (Sealed or Unavailable Data)	Conditional Discharge or Dismissed
Severe personality disorder	8 (24%)	10 (29%)	12 (35%)	4 (12%)
Minor personality disorder	18 (53%)	7 (21%)	7 (21%)	2 (5%)
Schizophrenia	10 (36%)	10 (36%)	4 (14%)	4 (14%)
Alcohol abuse	14 (56%)	3 (12%)	6 (24%)	2 (8%)
Depressive neurosis	7 (28%)	7 (28%)	11 (44%)	—
Adjustment reaction	6 (28%)	1 (5%)	12 (57%)	2 (10%)
Mental retardation	11 (52%)	4 (19%)	4 (19%)	2 (10%)
Adolescent conduct disorder	3 (25%)	3 (25%)	6 (50%)	—
Antisocial personality disorder	4 (36%)	5 (46%)	2 (18%)	—
No mental disorder	7 (64%)	1 (9%)	1 (9%)	2 (18%)
Sexual perversions	2 (25%)	2 (25%)	2 (25%)	2 (25%)
Drug abuse	4 (57%)	—	3 (43%)	—
Organic brain syndrome	1 (17%)	1 (17%)	2 (33%)	2 (33%)
Major depression	3 (100%)	—	—	—
Other neuroses	3 (100%)	—	—	—

Table 6. Previous Arrests Per Diagnosis

	% of Offenders in Each Category Previously Arrested	Total Number of Past Recorded Arrests
Severe personality disorder	79	58
Minor personality disorder	58	33
Schizophrenia	61	57
Alcohol abuse	80	49
Depressive neurosis	44	21
Adjustment reaction	45	31
Mental retardation	67	43
Adolescent conduct disorder	75	18
Antisocial personality disorder	100	40
No mental disorder	45	14
Sexual perversions	63	13
Drug abuse	57	13
Organic brain syndrome	83	17
Major depression	33	4
Other neuroses	33	6

Table 6, "Previous Arrests Per Diagnosis," suggests that antisocial personality, alcohol abuse, and severe personality disorders are most likely to have arrest histories (100 percent, 80 percent, 79 percent, respectively). Depressive neurosis and adjustment reaction are least likely to have arrest histories (44 percent and 45 percent, respectively).

Analysis of Data

In terms of our descriptive study, a composite figure may be drawn: The person is likely to be a male in his early twenties, from an ethnic minority (black or Hispanic), of low average intelligence, and with some high school education. He is likely to be single with an unsteady employment record and to have had some form of psychiatric history. Almost 3 out of every 4 defendants have been arrested before, and there is a 2 out of 3 chance that he is currently convicted of a crime that can be considered violent or potentially violent against people as opposed to crimes against property. These violent offenses include assault, robbery, weapons, arson, sex abuse, endangerment of a child, manslaughter, reckless endangerment, and murder. Specifically, the most likely convictions would be for assault and robbery.

Approximately 1 out of 3 would be diagnosed as having some kind of character disorder and a little more than 10 percent would be considered schizophrenic. In the majority of cases he is recommended for outpatient treatment. There is 50 percent chance that he will be sentenced to probation, although those defendants diagnosed as antisocial or schizophrenic appear to have a higher likelihood of going to prison.

From our data we can infer that the judges and the Probation Department

are referring to the Court Psychiatric Clinic for pre-sentence examination defendants convicted of violent acts against people. It is instructive to compare the top five types of convictions seen for psychiatric examination in our study to the conviction rate in the general population of Bronx County.[10] As is evident in Table 7, our population is skewed toward assaultive convictions. We also speculate that the relatively lower rate of robbery (13 percent) in our study compared to that in the general population (36 percent) might be due to the seemingly "non-psychopathological" nature of robbery where motivation is understandable versus the less clear motivational context of assaultive acts that often involve victims known to the assailant. The implied question of dangerousness might account for the relatively high referral to the Court Clinic for examination of these defendants convicted of weapons possession (11 percent). Conspicuously lacking are referrals of drug-related offenders for psychiatric examination, suggesting that the judges either do not see any particular need for such evaluations and/or are using alternate referral sources.

Table 7. Comparison of Types of Convictions Seen in Pre-sentence Study Versus Types of Convictions in Bronx County, 1978-1979

Types of Convictions in our study, between 1978-79	Percent	Felony Convictions only, in Bronx County, from 1/1/79—12/31/79*	Percent
(1) Assault	15	(1) Robbery	36
(2) Robbery	13	(2) Burglary	15
(3) Weapons possession	11	(3) Murder related	10
(4) Petit larceny	6	(4) Drug related	9.5
(5) Murder related	5	(5) Assault	7

*Information obtained from the Division of Criminal Justice Services, Albany, NY.

A contributing factor in the statistical relationship between diagnosis and crime has to do with the nature of the diagnosing process itself in the court setting. For example, severe personality disorders were found to have the highest percentage of assaults. The definition of some severe personality disorders such as a paranoid and borderline includes impulsiveness, aggressiveness, acting out, and transient disorganization. A history of this kind of behavior in addition to the present mental status contributes to the overall diagnostic appraisal. Hence, it is interesting, but not very surprising, that severe personality disorders have the highest assault rate and among the highest percentages of previous arrests. Depressive neurosis not associated with aggressive behavior understandably has among the lowest past arrest rates.

It also is not surprising that every single defendant diagnosed as antisocial personality disorder had been previously arrested. Also, these antisocials have a fairly high assault rate and among the highest robbery and

property related convictions. These findings are consistent with the assumption that such diagnoses as antisocial personality are usually based on known historical behavior, for example, unlawful acts, recidivism, remorselessness, and so on.

Other relationships between diagnoses and convictions are less obvious. Adolescent conduct disorders have the highest property related offenses. Those defendants diagnosed as depressive neurosis had the highest rate of convictions involving loss of life. One could speculate that the prospective sentencing as well as the severity of the crime had an effect on their depression-laden mental status. Another interesting but unexplainable finding is the relatively high rate of weapons convictions among schizophrenics.

Discussion

The authors have attempted to gain some understanding of their role in conducting pre-sentence psychiatric examinations from the vantage of studying the kinds of subjects seen. The dominant impression had been one of uncertainty and ambiguity concerning the evaluations. This is particularly so in the context of the last decade when forensic psychiatry has undergone a civil libertarian transformation. As forensic psychiatry has become more sensitive to central ethical-philosophical issues, as well as to its own limitations, our role often becomes more uncertain and ambiguous. This issue perhaps is no more better exemplified than in the sphere of the pre-sentence psychiatric evaluation. If we are not able to make definitive statements about such issues as dangerousness, then what precisely is our role?

Although very seldom articulated, there is often the implication in the judges' requests for psychiatric examination that some kind of relationship might exist between criminality and psychiatric disturbance. Our job becomes "easier" (and less ambiguous) when the psychiatric disorder falls at the end of the continuum, that is, a major psychiatric disorder such as schizophrenia, or when, in good conscience, we can diagnose no discernible mental disorder. Although even when diagnosing schizophrenia we do not purport there is necessarily a causal connection between the diagnosis and the criminal act, we can at least clearly offer the court a reasonable alternative of involvement in the mental health system. For example, in the hypothetical case of a man who attacks his neighbor because of command hallucinations and paranoid delusions, specific statements can be made about his mental condition and how it may relate to his crime. What, however, about our composite man who has a middle-range character disorder with impulsive and acting-out tendencies and is quite likely to have committed an assaultive-type act? Our task then becomes more difficult in that it is less clear what we can offer the court.

The designation of character disorder as a psychiatric disturbance is problematic in the present context. Essentially, our composite character is a crystallization of socioeconomic, familial, and cultural factors with a variety of behaviors labeled as "problems," but which may be syntonic to the

patient's environment. Although this may be true to some degree with the more severe pathologies, that is schizophrenia, in these cases the psychiatric factors appear to be more prominent, central to the condition, and influential of behavior. Hence, they fall more clearly in the domain of mental health concerns.

Implied notions of responsibility are made with respect to the character disordered defendant. Unlike the severe pathologies, we do not generally "excuse" an unlawful act in this kind of offender. In the pre-sentence report we are thus less likely to offer mitigating psychological circumstances to the judge. In summary, we do not necessarily see these kinds of defendants' problems as primarily psychological; we hold them responsible for their acts and, consequently, as candidates for the legal and not the mental health system.

Case Illustration

It is instructive to focus on an example of a productive referral made to the Court Clinic for a pre-sentence psychiatric evaluation.

The patient was a 35-year-old male arrested on over 50 occasions for stealing a car from a parking lot, with accompanying acts of masturbation. The method of theft was such as to almost guarantee that he would get caught, yet he repeatedly carried out this crime in the same almost ritualistic fashion. Under statutes of the habitual offender it was possible for this person to be imprisoned for many years.

In this unusual case the judge, frankly perplexed as to what course of action he should take, requested a conference with the examiner. Specifically, the judge wanted to know whether there was some kind of relationship between the criminal activity and mental disturbance. The psychiatric examination revealed—and this was explained to the judge—that the criminal act was indeed demonstrably related to psychological factors. There were clear historical links to earlier traumatic events in his life, and his illegal actions were associated with significantly compelling and ego-alien type impulses, thoughts, and affects. It should also be noted that this defendant had a moderate degree of insight into his mental condition and verbalized a willingness to obtain psychiatric help. The judge then wanted to know whether the examiner believed psychotherapy could be of help to this man and if it could prevent a repetition of the behavior. The examiner believed that psychotherapy could be of benefit to the defendant but could not predict with any degree of certainty the patient's future criminal behavior. Acknowledging this risk limitation, the judge persisted and, in essence, asked whether it was "worth a shot" for the patient to receive psychiatric treatment versus another round of imprisonment. The examiner explained to the judge that psychiatric treatment would be the only intervention that could reasonably address this man's psychopathology. Taking this exchange under consideration, the judge sentenced the defendant to closely supervised probation with outpatient psychiatric treatment.

Although this case is somewhat dramatic, it exemplifies some of the

conditions under which mental health intervention in the court can be most helpful. Present in this case was a clearly identifiable psychological factor that operated so as to diminish the defendant's sense of control of and responsibility for the problematic and antisocial act.

The authors wonder whether the disposition would have been the same if the above had been accompanied by acts of repetitive violence. Obviously, the issue of public safety would be of paramount concern and, in all likelihood, he would not have been considered for probation. As our study indicates, most of our clients sent for pre-sentence psychiatric evaluation are, in fact, referred for violence-related crimes and are recidivistic. It is very questionable whether psychiatric treatment, even in the best circumstances (and often the circumstances are the worst), can have any certain predictable effect on this kind of violent behavior. The conflict and role confusion at this point surfaces for the examiner who, after all, is himself a member of society.

The question can then be posed: Who is the client and on whose behalf do we make a strong case—the client's mental health as he sits before us or society's public safety? The answer is obviously that the psychiatric report should be made on an individual case basis and, perhaps more importantly, we believe the decision of freedom versus the restriction of freedom is and should remain a judicial decision. Hence, in our psychiatric pre-sentence report we always qualify our recommendations with the following statement: "If the defendant remains in the community, the following is recommended: . . . ."

Conclusion

The implication of our study is that the pre-sentence psychiatric evaluation in its present form is of limited value. Based on our experience, and illustrated by the case above, we recommend: (a) more discriminating selection in referring psychiatrically relevant defendants for pre-sentence psychiatric evaluation; (b) greater attempts at collaborating with the judges and probation officers to educate them concerning the scope of the psychiatric report; (c) encouragement of specific and explicit questions to which we can reasonably respond; and (d) more judicious recommendations of outpatient treatment and more consideration of non-psychiatric rehabilitative efforts.

This paper has focused on the kind of patients seen in an inner-city multi-service court clinic, highlighting some of the problems inherent in the pre-sentence examination. Further research obviously is needed to investigate the involvement in the pre-sentence examination by other components of the court system, namely the judicial and probation departments.

Rappeport and associates[11] presently are undertaking a large-scale study on the Utilization of Psychiatric and Psychological Assessments by Criminal Court Judges that appears likely to be a major step in the demystification of the psychiatric report provided to the criminal justice system.

The authors of the present study intend to follow up those patients sentenced to probation to include the conditions of probation and the kinds of treatment they actually received.

References

1. Menninger KA: The Crime of Punishment. New York, Viking, 1968
2. Halleck SL: Law In The Practice Of Psychiatry. A Handbook For Clinicians. New York, New York, Plenum, 1980, p. 221
3. Estelle v. Smith, _____ US _____, 101 S. Ct. 1866, (1981)
4. Simon JL: Guilt and innocence in the pre-sentence psychiatric examination: Some ethical considerations. Bull Am Acad Psychiat Law, VI(4):41-44, 1978
5. Sadoff RL: Forensic Psychiatry. Springfield, Illinois, Charles C. Thomas, 1975, pp. 25-31
6. Carter RM: The pre-sentence report and the decisionmaking process. Research in Crime and Delinquency, IX:203-211, 1967
7. Olsson JE: An evaluation of the medical service of the Supreme Bench of Baltimore, 1972
8. Bohmer CER: Bad or mad: the psychiatrist in the sentencing process. J. Psychiatry Law, 4:23-48, 1976
9. Criminal Law, New York Penal Law Criminal Procedure Law, New York, New York, Bender, 1978-79, p. 227
10. Dispositions of Felony Indictments, 01/01/79 through 12/31/79, Bronx County. Division of Criminal Justice Services, Albany, New York
11. Utilization of Psychiatric and Psychological Assessments by Criminal Court Judges. LEAA Grant #79NI-AX-0103. □