Competence-to-Stand-Trial Evaluations of Geriatric Defendants

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This descriptive study compares geriatric defendants ($n = 57$) found competent to stand trial ($n = 36$) with those found incompetent ($n = 21$). A review of the records of 57 consecutive pretrial geriatric detainees who underwent competence-to-stand-trial evaluation was conducted. The review included comparison of demographic and historical variables, mental status examination (MSE) elements, and trial abilities. Incompetent subjects were older and more frequently had dementia, but did not necessarily have other psychiatric illnesses. Deficits in orientation, memory, abstraction, concentration, calculation, and thought process were associated with incompetence. Deficits in orientation and memory correlated most highly with incompetence. Trial-related deficits associated with incompetence included failure to understand *Miranda* warnings, legal charges, potential penalties, roles of court officers, pleas, and plea-bargaining and inability to consult with an attorney and be self-protective. The ability to maintain appropriate courtroom behavior was not different between groups. The inability to consult with an attorney and understand *Miranda* was most predictive of incompetence-to-stand-trial opinions.

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According to the U.S. Department of Health and Human Services, there were 34.4 million people over the age of 65 living in the United States in 1998. With the aging of the baby-boomer generation, this number is projected to increase to 70.3 million by the year 2030.[1] Although arrested less frequently than their younger counterparts, the elderly are not immune from criminal prosecution. In 1996, there were 72,755 arrests of persons over the age of 65, accounting for approximately 0.7 percent of all arrests in the United States.[2] Twenty-eight percent of these arrests were for violent crimes. If these percentages remain the same, a corresponding increase can be expected in the arrests of elderly persons in the next 30 years. Some have suggested that police may be more reluctant to arrest the elderly, because deterrence and rehabilitation are viewed as less important in this age group.[3] As the number of geriatric arrests increases, service needs for this group will expand to psychiatric and correctional facilities. Consequently, forensic psychiatrists can expect to encounter a larger number of elderly individuals in pretrial and correctional settings.

There are numerous studies examining competence to stand trial (CST). In a review of 30 studies, Nicholson and Kugler[4] reported an average rate of incompetence to stand trial (IST) at 30 percent. Psychotic disorders were the most common diagnoses in incompetent defendants, but defendants in these studies had an average age of 22 years. In addition, IST was linked to demographic as well as diagnostic markers. The authors suggested that future research examine the clinical decision-making process. None of these studies focused on geriatric defendants. In a separate report examining 69 studies of CST from 1992 to 1995, Cooper and Grisso[5] reported that most research was focusing on the development of specific instruments used in conducting CST assessments.

Despite the large number of studies on CST, there are few studies of geriatric defendants in the literature. Heinik *et al.*[6] examined 57 consecutive criminal defendants older than 60 years who were evaluated for CST, finding that 30 percent had dementia, 25 percent had psychosis, and 28 percent had a personality disorder. Fifty percent were deemed incompe-

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tent to stand trial. Because dementia and other organic brain disorders are more prevalent in this age group, evaluation of CST in a geriatric defendant may require a greater attention to cognitive impairment. The types of competency deficits seen in the elderly may differ from those seen in younger defendants, because competency deficits in the younger group may be attributable to functional psychiatric illness rather than organic impairment. Studies comparing competent and incompetent defendants of all ages have shown differences in all trial abilities measured in these groups.[7] However, investigators in these studies have not specifically examined geriatric defendants, nor have they described the specific deficits that lead clinicians to a finding of IST in this age group.

In this study, we compared geriatric defendants found by the examining clinicians to be competent to stand trial with those found incompetent to stand trial. We include a description of the demographic characteristics, mental status findings, and specific trial ability impairments of the group studied and the deficits associated with clinicians' IST opinions.

Methods

This study was approved by the Research Committee of the William S. Hall Psychiatric Institute, South Carolina Department of Mental Health (SCDMH). All subjects (n = 8,250) in this retrospective record review underwent court-ordered pretrial competency and criminal responsibility evaluations at SCDMH between January 1991 and June 1999. All subjects were charged with felony offenses. Geriatric subjects were defined as 65 years of age or older and represented 0.8 percent of the total number of competency and criminal responsibility evaluations conducted at SCDMH during the study period. Sixty-six pretrial geriatric detainees underwent competency and criminal responsibility evaluation. These evaluations consisted of a review of the criminal charges, review of prior mental health records, review of a social history obtained from a family member, and a clinical forensic assessment that included a diagnostic interview, mental status examination (MSE), and a CST interview. Complete psychiatric records were located for 57 of these subjects. These subjects were divided into two groups: those judged by the original pretrial examiner to be competent to stand trial (CST group, n = 36) or incompetent to stand trial (IST group, n = 21). Demographic and historical variables examined included age, race, marital status, legal charge, history of inpatient and outpatient psychiatric treatment, substance abuse history, and diagnosis. Mental status elements included orientation, memory, abstraction, concentration, calculation, hallucinations, delusions, and disturbed thought processes (e.g., looseness of associations, thought blocking). Trial abilities had been assessed using a semistructured clinical forensic interview, the results of which were contained in court reports. Because these defendants underwent court-ordered CST and criminal-responsibility evaluations, *Miranda* warnings were reviewed with all defendants, and defendants were asked to explain the meaning of the warnings, to ascertain whether they understood the right to avoid self-incrimination. Their ability to understand *Miranda* was examined as a trial ability for the purposes of this study. Trial abilities reviewed also included knowledge of their legal charges; knowledge of potential penalties if convicted; understanding the roles of their lawyers, the prosecutor, the judge, and the jury; knowledge of available pleas; understanding the process of plea bargaining; ability to consult with an attorney; ability to maintain appropriate court behavior; and ability to be self-protective within the legal system. These trial abilities were selected because they are commonly assessed during the semistructured clinical interviews used at the evaluating facility.

Results

Age and diagnosis differed significantly between groups. The mean age of the CST group was 69 years compared with 72 years in the IST group ($t^{(1,\ n\ =\ 57)} = 4.01, p < .05$). The diagnostic profiles of the two groups were also significantly different. Most notable, the prevalence of dementia was only 19 percent in the CST group, compared with 90 percent in the IST group ($\chi^{2\ (1,\ n\ =\ 57)} = 24.18, p < .0001$). Alcohol-induced persisting dementia was the most common dementia subtype among the defendants in this study. This subtype was diagnosed in 11 of the 19 incompetent defendants (57.9%) who had dementia. The rates of other diagnoses were not significantly different. In an unexpected finding, the history of alcohol abuse or dependence only approached significance, with 42 percent of the CST group having a prior substance use disorder compared with 71 percent in the IST group ($\chi^{2\ (1,\ n\ =\ 57)} = 3.59, p < .06$, not significant [NS]). Demographic characteris-

Table 1 Rates of Mental Illness and Demographic Characteristics of the CST and IST Groups

	CST Group %	IST Group %	*p* Value
Dementia	19.4	90.5	<0.0001
Alcohol or drug use disorder	27.8	57.1	<0.06, NS
History of illicit drug use	3	10	<0.63, NS
Mood disorder	13.9	9.5	<0.95, NS
Psychotic disorder	22.2	9.5	<0.40, NS
Mental retardation/borderline intellectual functioning	5.6	9.5	<0.98, NS
Race (% white)	75	52	<0.15, NS
Marital status (% married)	31	23	<0.38, NS
Crimes against persons	62	55	<0.92, NS
Inpatient psychiatric history	47	43	<0.97, NS
Outpatient psychiatric history	47	38	<0.69, NS

NS, not significant.

tics did not differ significantly between groups (Table 1).

Statistically, analysis of all of the mental status elements showed significantly more impairment in the IST group, except for the presence of hallucinations or delusions (see Table 2). Stepwise multiple regression[8] was performed to determine which mental status variables were most predictive of an IST opinion. Orientation impairment accounted for 72 percent of the variance ($F_{1,38} = 98.8$, $p < .0001$), and memory impairment added an additional 5 percent ($F_{2,37} = 62.1$, $p < .0001$). No other variables entered into the regression equation.

All of the trial abilities were statistically more impaired in the IST group, except the ability to maintain appropriate courtroom behavior (Table 3). A second stepwise multiple regression of trial abilities showed that one variable, ability to consult with an attorney, accounted for 89 percent of the variance in CST decisions ($F_{1,35} = 282.8$, $p < .0001$). Understanding of *Miranda* warnings accounted for an additional 5 percent of the variance ($F_{2,35} = 269.7$, $p <$ .0001). No other variables entered into the regression equation.

Table 2 Rates of Abnormalities on MSE Variables in the CST and IST Groups

	CST Group %	IST Group %	*p* Value
Disorientation	8.3	81.0	<0.0001
Memory impairment	22.2	95.2	<0.0001
Impaired abstraction	25.0	85.7	<0.0001
Impaired concentration	27.8	71.4	<0.0001
Impaired calculation	19.4	61.9	<0.001
Thought process abnormality	5.6	47.6	<0.001
Hallucinations	8.3	14.3	<0.74, NS
Delusions	11.0	14.3	<1.0, NS

NS, not significant.

Table 3 Trial Abilities of the CST and IST Groups

	CST Group %	IST Group %	*p* Value
Understands *Miranda*	97.2	9.5	<0.0001
Understands legal charge(s)	94.4	66.7	<0.01
Awareness of penalty	63.9	0.0	<0.0001
Understands role of attorney	100	52.4	<0.0001
Understands role of prosecutor	97.2	33.3	<0.0001
Understands role of judge	100	66.7	<0.05
Understands role of jury	97.2	33.3	<0.0001
Awareness of pleas	97.2	47.6	<0.0001
Understands plea bargaining	77.8	4.8	<0.0001
Able to consult with attorney	94.4	0.0	<0.0001
Able to maintain appropriate court behavior	86.1	57.1	<0.07, NS
Self-protective behavior	88.9	33.3	<0.0001

NS, not significant.

Because having the ability to consult with an attorney was found to be so important in determining competency, a third regression analysis was performed to determine which mental status elements were most predictive of this trial ability. Again, orientation impairment surfaced as the most important variable, accounting for 71 percent of the variance in consultation ability ($F_{1,25} = 60.5$, $p < .0001$). No other variables entered into the stepwise equation.

Discussion

Considering that dementia is associated with age, it is not surprising that IST is also associated with age in this study. However, although clinically significant, the actual mean ages of these two groups were relatively close (69 and 72). The only diagnosis that distinguished between the CST and IST groups was dementia. Unlike the general population, in which other subtypes of dementia are more common, our findings indicate a large predominance of alcohol-induced persisting dementia. In these cases, the examining psychiatrist opined that a history of alcohol dependence was etiologically related to the onset of dementia. All of these defendants had a long-standing history of alcohol use. This finding reflects the high rate of alcohol abuse and dependence seen in forensic populations and underscores the need for adequate interventions for alcohol abuse. Intervention and treatment in the younger forensic population may decrease the future prevalence of alcohol-induced persisting dementia. Although alcohol

appears to be the drug of choice in the geriatric age group, the relationship between other substance abuse and IST approached significance. This may have long-term implications when the baby-boomer generation enters the geriatric years, because illicit substance use is higher in that group.

The incompetent defendants did not have a higher incidence of prior psychiatric inpatient or outpatient treatment. However, this is probably best explained by the diagnosis of dementia. Families may be tolerant of dementia in their older relatives, and these individuals may not come to the attention of mental health clinicians.

The presence of hallucinations and delusions did not distinguish between groups, reflecting the fact that psychotic disorders were no more frequent in the IST group than in the CST group. Our data indicate that CST in the geriatric population is more often related to cognitive impairment than to impairment by psychotic symptoms. This is in contrast to younger patients who are more likely to be found incompetent to stand trial due to psychotic symptoms. Psychotic symptoms, as seen in younger incompetent defendants, may have less impact on the factual prong, as outlined in *Dusky.*[9] Cognitive deficits, which are more likely to occur with advancing age and the onset of dementias, impair both the rational and factual prongs of the *Dusky* standard. Thus, cognitive deficits can impact attorney-client communication differently from hallucinations and delusions.

All of the cognitive skills measured on MSE were significantly impaired in the IST group, consistent with the high rate of dementia found in this group. Disorientation was the most important predictor of a clinician's opinion that a defendant was incompetent to stand trial, followed by memory impairment. If a defendant lacks basic understanding of person, place, time, or situation, he or she cannot be expected to provide rational assistance to an attorney at trial or to participate meaningfully in the trial process.

All of the trial abilities examined, except the ability to behave appropriately in court, differentiated between the CST and IST groups. All of these abilities are probably sensitive to cognitive impairments. Our data indicate that the ability to consult with an attorney is the single most important trial ability correlated with a CST or an IST opinion. The second most important trial ability is the capacity to understand *Miranda* warnings. The geriatric defendant may be less self-protective and may not fully apply the right against self-incrimination or the right to legal representation. This ability requires a significant degree of abstraction, a cognitive skill that may be more sensitive to impairment in early dementia and is frequently seen as an early prefrontal sign. Finally, it appears that courtroom behavior may be less impaired in the geriatric population. The quietly demented patient is less likely to engage in acting-out behavior in the courtroom, compared with younger mentally ill defendants. Thus, cognitive and trial abilities must be examined carefully in the compliant elderly person.

Among defendants more than 65 years of age in South Carolina, the rate of IST was 37 percent. This compares with the prior study by Heinik *et al.*,[6] who found a 50 percent incompetence rate in an Israeli sample of geriatric defendants. The actual difference in the rate of incompetence may be related to differences between these studies in the standard for CST used in the two studies, an artifact of who is referred for evaluation, cultural differences, or the different prevalence of specific mental illnesses, including the rate of alcoholism. This rate is also double the rate of IST in all evaluations conducted at this facility. For example, in 1998, 13.8 percent of all competency evaluations conducted at SCDMH resulted in a finding of IST. A functional psychotic illness (schizophrenia, schizoaffective disorder, delusional disorder) or mood disorder (bipolar disorder, major depression) was present in 81 percent of incompetent younger defendants, whereas dementia was present in only 9 percent of incompetent defendants less than 65 years of age.

This relatively high rate of incompetence among those over 65 has implications for the future in forensic mental health systems, especially as the geriatric population increases. Because the U.S. population is aging, the number of incompetent geriatric defendants can also be expected to increase. This growing population will present unique challenges to health care delivery systems. Nursing homes may be reluctant to accept individuals who have a history of serious legal charges. Psychiatric hospitals may not be the ideal treatment setting for geriatric patients with organic brain impairments. Boarding homes may not be able to provide adequate supervision and security that the community demands. The inability to dispose of their legal charges by trial leaves these defendants in a precarious situation regarding placement,

and pressure from the community may force secure placement, regardless of clinical indication.

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