A Study of Criminal Defendants Referred for Competency to Stand Trial in New York City

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The Court Clinic of the Bronx-Lebanon Hospital was established in 1967 to deal with a combination of certain needs related to the overburdening of the city hospitals designated to furnish psychiatric competency examinations to the Bronx Supreme Court and the Criminal Court.

At that time all such examinations were conducted on an inpatient basis in either the Bellevue or Elmhurst hospital forensic psychiatry units, because there was no appropriate facility in the Bronx.

This procedure presented many serious drawbacks. Hospitalizations tended to be long, usually thirty to sixty days. The forensic units were overburdened, and overcrowded. Delays in submitting competency reports to the Court were commonplace and caused unnecessary delays in court proceedings. The costs of this system both financially and in terms of human suffering had to be corrected.

When court officials expressed the need for a clinic to be organized in the Bronx, we enthusiastically welcomed the suggestion. The clinic was opened in 1967 with the specific purpose of completing as many competency examinations as could be prepared on an outpatient basis.

The first year's history of this enterprise was one of struggle and frustration, of maneuvering within the labyrinth of government agencies to acquire the small amount of money, space and staff to start this program. In 1968 for the first time we had the opportunity to receive our cases systematically.

At the present time we operate an adequately staffed outpatient psychiatric clinic located within the Bronx Criminal Court Building. It is administered by the hospital and supported by New York City and State Mental Health Departments.

In addition to conducting competency examinations, the program has expanded and now conducts "pre-sentencing" examinations after conviction, and also provides outpatient treatment for convicts who are mentally ill. In this study, however, we will confine ourselves to the competency issue.

In New York State, competency to stand trial is a right guaranteed under article 730 of the criminal procedure law. Simply stated, it means that a defendant in a criminal proceeding, who is suspected of being incapacitated

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as a result of "mental disease or defect," must have the capacity to understand the proceedings against him and to assist in his own defense.[1] Historically, competency to stand trial is based on English common law heritage, which held that a person must have the capacity to defend himself against his accusers in a trial. The modern legal precedent, however, was established in 1960 when the United States Supreme Court ruled in *Dusky v. United States* that the "test must be whether he [the defendant] has sufficient present ability to consult with his lawyer with a reasonable degree of understanding – and whether he has a rational as well as a factual understanding of the proceedings against him."[2]

New York State Criminal Procedure Law currently requires that an individual suspected of being incompetent be examined by two qualified psychiatrists, or, if the individual is believed to be mentally defective [mentally retarded], one qualified psychiatrist and one certified psychologist.[3]

Our intention here is not to present a discussion of the controversial issues surrounding competency to stand trial, nor is it to weigh its merits. Such issues have been presented quite comprehensively by Halpern.[4] Our purpose is to present our experiences historically and to present a profile of those individuals whom we have examined since the inception of the clinic.

A 1974 statistical note published by the Department of Health, Education and Welfare[5] reveals that there were 403,924 admissions to state and county medical hospitals throughout the United States in 1973. The Incompetent-to-Stand-Trial category accounted for a total of 9,261 admissions (2.3 per cent), 95% male. In addition, this study of admission rates suggests that the use of competency evaluations has been increasing steadily throughout the country. Despite this finding, very little information about this population has been reported in the literature.

To date, the reliability of psychiatric judgments about competency to stand trial has not been studied.[6] However, the reliability of psychiatric diagnoses in general has been evaluated. Using the *Diagnostic and Statistical Manual* (Second Edition) published by the American Psychiatric Association, investigators have found that trained psychiatrists and psychologists agree with each other 70 per cent of the time when differentiating among the major diagnostic categories (*e.g.*, neurosis, psychosis, schizophrenia, organicity, etc.). Toward this end, the present study endeavors to separate diagnostic labels based on those cases first judged to be competent or incompetent.

Regarding prior psychiatric history as it is related to the issue of competency, Ferster & Weinbogen[7] polled a total of 182 attorneys, psychiatrists, and psychologists to get their opinion of whether or not prior hospitalization for mental illness was tantamount to finding a defendant incompetent to stand trial. Eighty-eight per cent answered "No." A person previously committed to a mental hospital is not automatically presumed incompetent.

Several studies have reviewed the relationship between type of offense and the determination of competency to stand trial. Steadman and Braff[8] compared the distribution of 541 male felony defendants found incompetent against the distribution of all felony arrests in New York State.

They found that violent crimes represented the highest percentage in the incompetent population. For example, they found that, compared to the base rate for murder in New York State in 1971, which was eight out of 1,000 arrests, there were 144 arrested for murder out of every 1,000 found incompetent. Similar rates of incidence were found for arson and rape arrests, whereas charges of burglary and grand larceny occurred at about the same rate for the incompetent population and total population. In the other direction, the crimes of forgery, drug offenses, and gambling were consistently under-represented in the incompetent population as compared to the total population of arrests.

Henn, Herjanic, and Vanderpearl[9] confirmed this trend in a longitudinal study that covered 22 years and 1,195 cases. They found an increasing referral of violent and youthful defendants to an urban (St. Louis) forensic service. Referral rates were highest for homicide. The prominent diagnoses seen were anti-social personality (27 per cent) followed by schizophrenia (16 per cent).

Cooke, Johnston, and Pogany [10] reported on 326 defendants referred for competency evaluations in Michigan. Most referrals were for homicide and assault. They found that in the population of total arrests in the state, 1 per cent were for homicide, compared to 22 per cent arrested for homicide within the total population referred for competency examinations.

Steadman and Braff explain this trend by asserting that the use of competency evaluations is frequently a defense or prosecution maneuver and conclude that "the use of incompetency as a diversion from the criminal justice system greatly depends on non-medical, dispositional, and procedural machinations."[11]

Halpern[12] suggests that the increase in those referred for competency examinations is not only a procedural tactic, but a gross misuse of psychiatry by the courts to deny bail and incur preventive detention.

In a comprehensive up-to-date analysis of the decision-making process involved in the determination of competency, Roesch[13] provides a demographic, diagnostic, and criminal profile of defendants referred for evaluation in Massachusetts.

Our investigation expands upon and updates this body of descriptive data concerning examination referrals for competency determinations made by the courts in Bronx County, New York.

Methodology

The population studied included all those individuals sent by Supreme and Criminal Courts for a determination of Competency to Stand Trial under Article 730 of the New York State Criminal Procedure Law. These individuals were charged with crimes and arraigned in Bronx County, N.Y. between the years 1968 and 1975. A total number of approximately 2,000 cases came to the clinic for examination during this period. To avoid repeated measures which might skew our statistical findings, those individuals with a history of more than one Competency examination were not included in the study. For this reason the total number of cases studied was 1,440.

In order to collect information, a form which comprised 18 variables was

developed and used in all cases. These 18 variables were divided into three subgroups. The subgroups included: (1) eight variables of demographic data, (2) four variables related to criminal history, and (3) six variables encompassing mental health history.

The demographic items included sex, age, race, marital status, level of education, socio-economic status, veteran and employment status. For employment status, the 12 months preceding the examination were used.

Demographic data were extrapolated from case histories, which were obtained by self-report. It is extremely important to point out that in almost all cases competency examinations were performed with no information about the examinee, not even the fact that the examination was ordered by a judge. The only information available to the psychiatric-examiner was a statement of the crime for which the defendant was currently being charged and a form ("rap sheet") which listed prior criminal record, as provided by the New York State Information Service. Aside from this, all information obtained in this study was from the examinee himself.

Additional variables related to criminal history included a more precise categorization of sex crimes. Two final categories were designed to observe change in types of crime, if any, between an individual's first arrest and the most recent one.

In a case where an individual had no prior arrests, the current arrest was coded as the sole arrest and was deleted for purposes of comparison.

A crucial aspect of this study was the collection of data on the past psychiatric history of the individual. The types of past psychiatric treatment were noted. The time interval since the last psychiatric service was also noted. Further, we separated those who had received inpatient service as a special group to be studied.

Within the sub-group of individuals with past psychiatric histories, the competency determination was noted. The psychiatrist's finding was either competent (fit to stand trial) or incompetent (unfit). In some cases no decision was made, pending further observation. Where no decision was made, the individuals were sent for in-patient observation at either Bellevue Hospital in Manhattan (men) or Elmhurst Hospital in Queens (women). No appropriate in-patient facility exists in Bronx County. For the Bronx defendants requiring in-patient observation, the competency determination is made by examiners at Bellevue and Elmhurst hospitals. The results are unknown to us.

Since New York State requires that an alleged offender be examined by two physicians to determine his competency to stand trial, the number of times the psychiatrists agreed or disagreed in each case was compared.

The next consideration was the diagnostic category which was entered in the case record according to the *American Psychiatric Association's Diagnostic and Statistical Manual*, Second Edition. Using cross-tabulations, we proceeded to examine whether or not a finding of competency was related to the type of crime with which a defendant was currently being charged, whether it related to the diagnosis assigned by the examiner, or whether previous psychiatric treatment or the sex of the accused was in any way relevant to the competency finding.

We then cross-tabulated the sex of the offender with psychiatric diagnosis

and prior psychiatric service to see if there were any differences related to the examinee's gender. The most recent arrest was then compared to psychiatric diagnosis to see if certain types of crimes could be associated with particular categories of mental disorders.

Admission dates to the clinic were cross-tabulated with the most recent arrest and with the type of prior psychiatric treatment. The type of prior psychiatric service was weighed against the most recent arrest and psychiatric diagnosis. Finally, admission dates to the clinic were compared with the time since the last psychiatric treatment had been rendered.

The demographic variables are presented below. Nearly 90% of our population were males whose mean age was 29. Racially, 43.1% were Black, 34.4% Hispanic, and 22.4% Caucasian. With regard to marital status, 62.2% were never married, while an additional 15.2% were divorced or separated, and 2.2% were widowed. Only 15.3% of our population were married at the time they were examined. A breakdown of household composition revealed that the largest group of persons examined lived alone (34.6%), the second largest group lived with parents (27.6%), and the third lived with spouses (14.4%). The mean educational level was 9.4 years of schooling, although 18.4% had completed high school and 1.7% had completed college.

Analysis of socio-economic status revealed that 17.8% of our population was on welfare and almost half earned below $10,000 a year. It should be noted, however, that in more than 50% of the cases studied, this information was unavailable or not reported by the examiner. With regard to employment status, 31.5% of those examined reported that they had been employed within the past six months, 32.8% were unemployed during that same period and in 33.2% of the cases the information was unknown. 10.6% of all examined were veterans.

We then looked at the defendants' prior arrest records to see what types of crimes they had been charged with in the past. An analysis of the criminal history by type of crime is presented in Tables 1a and 1b.

TABLE 1a
THE DISTRIBUTION OF FIRST ARRESTS ACCORDING TO TYPE OF OFFENSE FOR THOSE REFERRED FOR COMPETENCY EXAMINATIONS*

Variable	N	Percentage
TYPE OF FIRST ARREST		
Assault	155	10.9
Money Related	244	17.3
Drug Related	77	5.3
Robbery	69	4.8
Sex Offense	52	3.6
Misdemeanor	146	10.1
Not Applicable	681	48.1
TOTAL	1424	100.0

*Figures may differ from total number where data were missing.

TABLE 1b
THE DISTRIBUTION OF ARREST HISTORY ACCORDING TO THE TYPE OF CRIME*

The number of times that each defendant has been previously charged with a particular offense:		0	1	2	3	4	5	6	7	8	9	Total
ROBBERY	N	1145	214	48	16	8	5	0	2	2	0	1440
	%	79.5	14.9	3.3	1.1	0.6	0.3	0.0	0.1	0.1	0.0	100.0

TABLE 1b (Continued)
THE DISTRIBUTION OF ARREST HISTORY ACCORDING TO THE TYPE OF CRIME*

The number of times that each defendant has been previously charged with a particular offense:		0	1	2	3	4	5	6	7	8	9	Total
ASSAULTS	N	1004	288	82	40	15	5	4	1	1	0	1440
	%	69.7	20.0	5.7	2.8	1.0	0.3	0.3	0.1	0.1	0.0	100.0
SEX OFFENSES	N	1219	173	26	11	5	3	2	0		1	1440
	%	84.7	12.0	1.8	0.8	0.3	0.2	0.1	0		0.1	100.0
MONEY RELATED	N	988	216	88	61	26	15	15	12	2	17	1440
	%	68.6	15.0	6.1	4.2	1.8	1.0	1.0	0.8	0.1	1.2	100.0
DRUG RELATED	N	1262	98	41	16	9	5	4	1	1	3	1440
	%	87.2	6.8	2.8	1.1	0.6	0.3	0.3	0.1	0.1	0.2	100.0
MURDERS	N	1267	170	2		1						1440
	%	88.0	11.8	0.1		0.1						100.0
MISDEMEANORS	N	892	389	77	43	13	9	5	3	2	7	1440
	%	61.9	27.9	5.3	3.0	0.9	0.6	0.3	0.2	0.1	0.5	100.0

*For the purpose of this study robbery was defined as a crime where a weapon was used or the threat of bodily harm was implied. Money related crimes were defined as crimes where property was stolen but no threat was made to any person.

Strikingly, 12% of those charged with murder had multiple murder arrests. These constituted 173 individuals. One defendant had four prior murder arrests. Among those charged with sex offenses, 15% had more than one arrest for a sex crime. The most often repeated arrest was for rape.

We were interested in knowing whether these defendants had had prior psychiatric service. If they had, we wanted to know how long it had been since their last service, and what type of service it was. The results turned out to be a matter of extremes, and are presented in Table 2.

TABLE 2
DESCRIPTION OF PAST PSYCHIATRIC HISTORY OF THOSE REFERRED FOR COMPETENCY EXAMINATIONS

Variable	N	Percentage
PRIOR PSYCHIATRIC SERVICE		
None	579	40.3
Inpatient	571	39.7
Res. Drug Treatment	67	4.7
Outpatient	108	7.5
Halfway House	8	0.6
Private Therapist	29	2.0
Unknown	76	5.3
TOTAL	1438	100.0
TIME SINCE LAST PSYCHIATRIC SERVICE		
No Service	575	40.0
Within One Year	364	25.3
Over One Year	413	28.7
Not Applicable	86	6.0
TOTAL	1438	100.0
LAST SERVICE WAS		
Inpatient	571	39.7
Other	211	14.7
Not Applicable	655	45.6
TOTAL	1437	100.0

The largest percentage had had no prior psychiatric service at all. Among the smaller percentage who did have some service, it was likely to be in-patient hospitalization. Among those who had service, about half had had

service within one year of their admission date to the clinic. Among the rest, service had been rendered, but more than a year ago.

Since the major mandate of the clinic is to provide competency examinations, we were interested in finding out, over the period of time studied, how many defendants were found competent, what psychiatric diagnoses were more common, and to what extent our physicians agreed or disagreed on their findings.

On the competency issue, 71.7% of those examined were found to be competent. Only 8.2% were found to be incompetent. There were 19.7% of defendants, however, where doctors could not render a decision, and recommended a period of in-patient longitudinal observation. Where a competency decision was made at the Clinic, there was a 99.7% agreement between the two examiners. A breakdown of diagnostic categories is presented in Table 3.

TABLE 3
PSYCHIATRIC DIAGNOSIS FOR DEFENDANTS EXAMINED FOR COMPETENCY

Variable	N	Percentage
DIAGNOSIS		
Lymphosarcoma and Reticulum-Cell Sarcoma	2	0.1
Senile and Presenile Dementia	1	0.1
Alcoholic Psychoses	13	0.9
Psychosis Associated with other Cerebral Condition	12	0.8
Psychosis Associated with other Physical Condition	7	0.5
Schizophrenia	313	22.1
Major Affective Disorders	11	0.8
Paranoid States	13	0.9
Other Psychoses	22	1.5
Unspecified Psychosis	17	1.2
Neuroses	32	2.2
Personality Disorders	298	21.0
Sexual Deviations	19	1.3
Alcoholism	116	8.1
Drug Dependence	128	8.9
Special Symptoms not Elsewhere Classified	3	0.2
Transient Situational Disturbances	32	2.2
Behavior Disorders of Childhood and Adolescence	44	3.1
Non-Psychotic Organic Brain Syndrome	9	0.6
Borderline Mental Retardation	24	1.7
Mild Mental Retardation	17	1.2
Moderate Mental Retardation	9	0.6
Severe Mental Retardation	5	0.3
Unspecified Mental Retardation	11	0.8
Social Maladjustments without Manifest Psychiatric Disorder	126	8.7
Non-Specific Conditions	18	1.2
No Mental Disorder	33	2.3
Non-Diagnostic Terms for Administrative Use	89	6.2
Epilepsy	6	0.4
Deaf Mutism	1	0.1
TOTAL	1431	100.0

Incidentally, 20.2% of our total population admitted alcohol abuse, and 20.8% admitted narcotics abuse, although this fact had no specific relationship to their current charges.

One of the questions we wanted to explore was whether or not a finding of competency or incompetency was related to a variety of variables, including the type of crime that the individual was charged with, the

psychiatric diagnosis, and prior psychiatric treatment.

We wondered whether there was a higher percentage of people found incompetent for a particular crime. Table 4 shows that a higher percentage were found incompetent for robbery, assault, money related crimes, and misdemeanors than for any other crimes.

TABLE 4
COMPARISON OF COMPETENCY FINDING WITH MOST RECENT ARREST

	Assault	Money Related	Drug Related	Robbery	Sex Offense	Murder	Misde-meanor	Total
COMPETENT	191	239	34	133	131	122	165	1015
INCOMPETENT	26	31	2	17	11	9	17	113
NO DECISION	57	84	3	39	24	31	42	280
TOTAL	274	354	39	189	166	162	224	1408

Level of Significance = $p < .05$

Interestingly the lowest percentages of "no-decisions" by our doctors were for drug related crimes.

Extremely important to us was the relationship between the type of prior psychiatric service and the doctor's recommendation with regard to competency to stand trial. We found that the highest percentage of those considered incompetent had received prior in-patient psychiatric treatment. It seems noteworthy that the second highest percentage found incompetent had received no prior treatment at all. Conversely, for those who were found to be competent, the highest percentage had received no prior treatment. The second highest percentage of those found competent had received in-patient treatment. For those individuals where no decision was made, the highest percentage had received in-patient treatment, and again the second highest had received none at all.

We then wanted to know if the diagnosis offered by the examiners was associated with particular types of crimes. We found that the highest proportion of those with a diagnosis of schizophrenia were more often charged with assault and money-related crimes. Personality disorders, alcoholism, and social maladjustment were also associated with assault and money-related crimes. Drug addiction was associated with money-related crimes and robbery, and was least likely to be associated with assault. See Table 5.

TABLE 5
COMPARISON OF DIAGNOSIS WITH MOST RECENT ARREST

	Assault	Money Related	Drug Related	Robbery	Sex Offense	Murder	Misde-meanor	Total
Lymphosarcoma and reticulum-cell sarcoma	0	1	0	1	0	0	0	2
Senile and presenile dementia	0	1	0	0	0	0	0	1
Alcoholic psychosis	1	2	0	2	2	2	4	13
Psychosis associated with other cerebral condition	4	2	0	1	2	0	2	11
Psychosis associated with other physical condition	2	1	0	1	1	0	1	6
Schizophrenia	77	81	2	39	20	39	47	305

TABLE 5 (Continued)
COMPARISON OF DIAGNOSIS WITH MOST RECENT ARREST

	Assault	Money Related	Drug Related	Robbery	Sex Offense	Murder	Misdemeanor	Total
Affective psychoses	2	3	0	1	1	0	4	11
Paranoid states	4	6	0	1	0	1	1	13
Other psychoses	3	4	2	2	4	4	3	22
Unspecified psychosis	3	5	0	2	2	4	1	17
Neuroses	4	12	0	7	6	1	2	32
Personality disorders	57	71	6	41	25	44	49	293
Sexual deviation	3	0	1	0	12	0	2	18
Alcoholism	29	36	1	4	17	9	19	115
Drug dependence	18	30	21	27	4	10	17	127
Specialty symptoms not elsewhere classified	0	1	0	0	0	0	2	3
Transient situational disturbances	3	8	0	2	5	7	6	31
Behavior disorders of childhood	3	14	1	9	3	2	10	42
Mental disorders not specified as psychotic associated with physical conditions	2	1	0	0	2	1	3	9
Borderline mental retardation	5	2	0	8	4	3	2	24
Mild mental retardation	1	6	0	1	3	1	5	17
Moderate mental retardation	1	3	0	1	0	1	2	8
Severe mental retardation	0	1	0	0	3	0	1	5
Unspecified mental retardation	2	4	0	2	2	0	1	11
Social maladjustments without manifest psychiatric disorder	27	26	3	15	24	7	23	125
Non-specific conditions	6	2	0	1	3	5	1	18
No mental disorder	6	10	1	3	6	3	3	32
Non-diagnostic terms for administrative use	8	19	1	16	14	17	12	87
Epilepsy	2	1	0	1	0	1	1	6
Deaf mutism	0	0	0	0	1	0	0	1
TOTAL	273	353	39	189	166	162	224	1405

Level of Significance = $p < .01$

We next cross-tabulated admission dates with the psychiatric diagnoses to see if the types of disorders as a whole had changed over time. We found that the percentages of the two largest diagnostic categories had not changed over time. Next, we looked to see if more people were being found incompetent over time. Significantly, there was an increase in the number of people found incompetent, and a decrease in those sent for further observation where no decisions were formally rendered. Were the crimes changing over time? The only consistent trend was a decrease in drug-related crimes, and increases in those charged with robbery and murder.

Our experience told us that certain diagnoses would be associated with a finding of incompetency. 52.5% of those diagnosed as schizophrenia were found to be incompetent, and 52.9% diagnosed with some degree of mental retardation were found to be incompetent.

An important part of our study was an attempt to determine the kind of past experiences our population had with psychiatric treatment. We cross-tabulated admission dates and prior psychiatric service in an attempt to determine how many had recently been discharged from in-patient psychiatric settings. There did not seem to be a changing trend over time. In order to see how recently people had received treatment, we compared the examination date with the last psychiatric service. The results are shown in Table 6. There was a decrease in individuals who had received service within one year, and an increase in those whose last treatment was over one year from the time admitted to the clinic.

TABLE 6
COMPARISON OF ADMISSION YEAR WITH TIME SINCE LAST PSYCHIATRIC SERVICE

	No Prior Service	Within 1 Year	Over 1 Year	Total
1969	68	58	37	163
1971	141	87	72	300
1972	38	18	35	91
1973	69	55	58	182
1974	135	80	103	318
1975	121	63	108	292
TOTAL	572	361	413	1346

Level of Significance = $p < .01$

Next we explored the relationship between the current charge and the type of past psychiatric service. As shown in Table 7, those charged with assault, robbery, and misdemeanor were most likely to have had either in-patient treatment or no treatment at all. Conversely, for money-related crimes these defendants were likely to have received no treatment at all, or they were hospitalized. The same was true for drug related crimes, sex offenses and murder.

TABLE 7
COMPARISON OF TYPE OF PRIOR PSYCHIATRIC SERVICE WITH THE MOST RECENT ARREST ATEGORY

	Assault	Money Related	Drug Related	Robbery	Sex Offense	Murder	Other	Total
None	102	158	13	56	79	78	86	572
In-Patient	114	121	13	97	55	59	95	554
Res. Drug Treatment	9	18	8	12	5	8	7	67
Out-Patient	27	28	4	12	14	5	17	107
Halfway House	4	1	0	0	1	0	2	8
Private Therapist	7	9	0	2	4	4	3	29
Unknown	11	20	1	13	8	8	14	75
TOTAL	274	355	39	192	166	162	224	1412

Level of Significance = $p < .001$

Since 90% of our population was male, we were curious to see if there were any differences in the competency finding in relationship to the subject's gender. We found none. There was also no relationship between gender and diagnosis. Comparisons of gender with time since last psychiatric service, admission date to our Clinic, and type of prior psychiatric service also showed no significant differences.

Discussion

This study reports data on a population in order to give some idea of defendants referred for competency examination in a large urban court system. We have tried to present a comprehensive picture of the characteristics of this population.

The first question answered was whether, in fact, the court clinic actually reduced the number of referrals for in-patient competency determinations. Excess use of hospitalization would essentially invalidate the intended purpose of the clinic. From the study the efficacy of performing competency examinations on an out-patient basis is clear. There is an obvious impact in cost effectiveness and reduction of human suffering by greatly decreasing the need for in-patient observation and thereby expediting legal proceedings. In our clinic most examinations can be completed within five days of the time the court orders the examination.

We stated earlier in this report that competency based on diagnosis is spurious. Our study demonstrates that when competency is derived strictly from the legal criteria the decision among doctors as to competency is almost unanimous. Helping to account for this fact is that in our clinic in most cases the doctors interview simultaneously.

The nature of some disorders is known to be cyclical, characterized by periods of remission. Since competency addresses itself to the defendant's mental status at the time of trial, simultaneous interviewing has the advantage of eliminating these fluctuations. A competency recommendation is made knowing that the condition can change at any time.

If no agreement is reached on the competency decision, a third doctor examines the defendant. If there is still doubt after a re-examination, the defendant is then sent to the hospital for a period of longitudinal observation.

Although we observed an increase in those found to be incompetent over the period encompassed by the study, we do not feel that people sent for these later examinations are in fact more disturbed. The change can be attributed to administrative clarification of the criterion for requesting further observation. We found that doctors were, with increasing frequency, hospitalizing patients for 30 to 60 days because to do so was easier than making decisions in more difficult cases. Another major but inappropriate reason for hospitalization was to obtain treatment for the accused. As a result of this change, more were found to be incompetent over time.

Even using the legal definition as a criterion, one can predict that if found incompetent the defendant will be diagnosed as schizophrenic, mentally retarded, or suffering from chronic brain syndrome. As can be seen from the results, the converse is not true. Those diagnosed as having these disorders will be found incompetent only about half the time.

Since all of our information, except for a statement of the current charges and the criminal history, was gathered from the defendants themselves, the reliability of our data must be viewed in this light. At the time of examination we did not even know the reason why it had been ordered by the court. We were forced to make the assumption (1) that the defendant had a prior psychiatric history; (2) that his behavior in the court setting was bizarre; or (3) that the crime itself was. If none of these criteria was

appropriate, then we attributed the order to court procedural machinations. Knowing why competency examinations are ordered by judges is an area that needs to be investigated.

As others cited earlier have found an increase in referrals for violent crimes such as murder and assault, we also found an increase in referrals for murder. However, they were not related to a finding of incompetence. In fact the highest number of people found incompetent had been charged with money-related crimes. Although assault was second, the percentage of assault referrals had not increased over time.

One of the results anticipated in our study but not found concerned recently released state hospital patients. It was expected that with more people being released from hospitals every year, there would be more filtered through the Criminal Justice System *via* the competency procedure. Instead, to our surprise, we found a relatively steady rate of previously hospitalized patients over the seven-year period. One reason for this is likely to be related to our statistical design. Since we wanted to avoid repeated measures in our frequencies, we eliminated over 600 cases because they had been examined more than once. It is in this population that we are more likely to find the classical "revolving door" as a result of "deinstitutionalization."

We did, however, identify a peculiar pattern of psychiatric care. Patients with diagnosable mental disorders, whether competent or incompetent, were either hospitalized or received no care at all. There was a distinct absence of out-patient treatment provided to this group. There is no evidence of out-patient follow-up care to previously hospitalized patients. How can this fact be explained? Probably by several factors:

(1) The patient seeks care only at a time of acute crises.
(2) There is no care available, or if there is, this population is not being reached.
(3) Mental health care providers are reluctant to treat criminal offenders.

For this population our clinic has long recognized the need for out-patient and support services beyond the state hospital. For several years we have been providing out-patient psychiatric care routinely to patients who are on probation.

Treatment of mentally ill defendants in a court-related facility might be construed by some to involve conflict of interest. In fact, no patient is accepted for treatment until his case has been adjudicated. Only those who have been found guilty and placed on probation are accepted for treatment. For the most part these individuals are chronically mentally ill and cannot find adequate treatment in traditional mental health agencies, except in acute emergencies. Our clinic is able to provide them with ongoing treatment, medication, and community support systems, without which many of them would be forced to spend their lives in the back wards of the state mental hospitals.

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