Incompetent Misdemeanants—Pseudocivil Commitment

Stephen Rachlin, MD; Cornelis L. J. Stokman, PhD; and Saul Grossman, PhD

Prior to *Jackson v. Indiana*, psychiatric hospitalization of those found to be incompetent to stand trial often led to an inordinately long confinement, a particularly invidious consequence if the patient had been accused only of a misdemeanor. After a highly publicized murder perpetrated by a patient originally in this category, New York State instituted a rather cumbersome set of procedures designed to assure several layers of review, including involvement of the legal system, prior to increasing privileges or discharging someone committed pursuant to a criminal court order. The effect of this new law on patient care is examined by looking at the hospital course of 52 incompetent misdemeanants at one state facility. They are demographically and clinically quite similar to a control group of persons civilly committed, except for an increased length of inpatient stay. When compared with those sent to the county penitentiary after conviction, the study population differs on several important parameters. Looking like a patient, the incompetent misdemeanant is, however, treated more as a criminal with no indication that public safety is thereby increased or that individual therapeutic objectives are enhanced.

Based on observations made relative to a group of patients hospitalized as incompetent to stand trial in 1960, McGarry[1] concluded that indefinite commitment obstructs rehabilitation and is probably unjustified if arising out of a misdemeanor. After a seven-year follow-up, he further recommended that confinement under the criminal admission route be limited to the amount of time to which the individual could have been sentenced if convicted, to be followed by civil commitment if medically necessary.[2] The problem of lengthy pretrial psychiatric admissions came to the attention of the United States Supreme Court in the landmark case of *Jackson v. Indiana*.[3] One of its several holdings was that an individual could not be hospitalized for more than a "reasonable time" to determine the probability that he would attain capacity to proceed in the forseeable future and that he was progressing toward that goal.

Presented at the 15th Annual Meeting of the American Academy of Psychiatry and the Law, Nassau, The Bahamas, October 25–28, 1984.

Dr. Rachlin is chairman, Department of Psychiatry and Psychology, Nassau County Medical Center, East Meadow, NY, and associate professor of clinical psychiatry, School of Medicine, SUNY at Stony Brook, Stony Brook, NY. Dr. Stokman is director of research, Bureau of Forensic Services, New York State Office of Mental Health, and assistant professor of clinical psychology, Department of Psychiatry, College of Physicians and Surgeons of Columbia University, New York, NY. Dr. Grossman is adjunct professor of psychology, Fordham University, Bronx, NY. Address reprint requests to Dr. Rachlin, 2201 Hempstead Turnpike, East Meadow, NY 11554.

Judicial response to *Jackson* has been curiously variable.[4–13] Despite a general shortening of the duration of hospitalization, at least one state has reported a subsequent rise in the use of incompetency proceedings to bring about admission.[14] The first speculation is that this is the new back door to treatment, as deinstitutionalization proceeds apace and criteria for civil commitment tighten. It is, however, unfortunate that it is the misdemeanants, and particularly those charged with disorderly conduct, who are most subjected to traveling this convoluted path.

No greater consistency of approach to the policy determination of how much time is reasonable has been achieved legislatively. According to a 1979 review of state laws, fully half have not really responded to *Jackson's* mandate.[15] The Michigan statute may be cited as one example of a liberal approach: no incompetent defendant may be held for more than 15 months or one-third of the maximum sentence he could have received if convicted, whichever is the lesser.[16]

The New York Situation

New York State traditionally did quite well by its incompetent misdemeanants, with the law providing that these persons are to be hospitalized under a Final Order of Observation, for a period not to exceed 90 days, and that the accusatory instrument must be dismissed. Discharge, as with all other treatment decisions, had been at the sole discretion of the treating facility. Then came one dramatic case that created very significant changes.

A county jail prisoner wrote gru somely threatening letters to his wi which formed the basis for an additio charge of aggravated harassment, a m demeanor. He entered the mental hea system when found to be incompet to stand trial and was sent to a secu facility. Eighteen months later, he w felt to be in better control and was tra ferred to a civil psychiatric hospital be prepared for eventual return to t community. However, while overst ing an authorized day pass, he brut murdered his wife, turning himself the next day and never denying the a

In response to the public hue and c generated by this incident, the legislatu enacted Chapter 549 of the Laws 1980, drastically amending the Crimi Procedure Law. A critical modificati is one which requires that patients co mitted to the commissioner as inco petent to stand trial, or "... conti ously thereafter retained in such custo ...," may not be discharged, placed i less secure setting, given passes, and t like without notice to a variety of o cials. The district attorney, upon rece of this notice, may, statutorily, apply a superior court for a hearing to det mine the patient's dangerousness an he is so found, for an order authori further retention.

The State Office of Mental Hea therefore created forensic committees each department facility to make r ommendations to the clinical direct on virtually every privilege requested a patient admitted on a criminal ord The procedures are complicated a time consuming. Those incompet misdemeanants admitted under a Fi

Order of Observation and who might otherwise be released on clinical grounds are now to remain while they go through the forensic committee, the director, required notifications, and possibly a court hearing. At the outset, it was estimated that this would add a minimum of three weeks to the patient's length of stay, at considerable cost.

New York courts have made some interpretations in response to the legislative changes. An appellate panel held that the district attorney was not entitled to a hearing on day 92, since the patient was no longer in custody pursuant to the original court order (which terminated on the 90th day).[17] One judge has suggested further changes in law to allow for a hearing prior to any alteration of status for this group of persons.[18] Another trial court determined that the district attorney lacked standing to challenge the placement of a civil patient subsequent to a "*Jackson* hearing."[19]

How much concern is warranted, given that these are individuals whose misdemeanor charges have been dropped, presumably in the interest of their treatment needs? Steadman and Hartstone[20] point out that there are few empirical studies comparing those found to be incompetent to stand trial with prison or mental hospital populations. What happens to these groups is of clear importance, and our study is a step in this direction.

Method

We intend to examine some effects on the treatment of incompetent misdemeanants as a result of the statutory and regulatory changes described above. This was stimulated by the experiences of one of us (S.G.) as a member of the forensic committee at a state psychiatric center, during which time his anecdotal conclusion was that decision making was unduly delayed by virtue of the need to comply with these involved procedures, to the detriment of the patients.

The facility from which data were gathered serves, as part of its catchment area, a suburb of New York City. It is geographically located about an hour's drive from much of the single county in which the study population originally resided.

In order to achieve relative homogeneity and allow sufficient time between admission and final discharge, our sample consisted of 1981 and 1982 admissions, followed through the end of May, 1984. The incompetent misdemeanant cohort was all 52 males sent by the courts to this hospital during those two years. These patients were compared with a control group composed of all 67 men admitted to the same hospital, during the same time period, from the same county, but under involuntary civil status. Variables studied included the usual demographic data of age, religion, ethnicity, and marital status, plus such clinical material as diagnoses and, where available, prior hospitalizations and relevant criminal history. Critically, we examined length of hospital stay.

For further correlation, we secured information from the relevant county department of corrections for the penitentiary at which those males found to be guilty of misdemeanors and imprisoned

serve their sentences. Approximately 11 percent of the penitentiary admissions were sentenced for felonies. Since their charges could not be separated from the misdemeanors, demographic data were included for comparison to the incompetent misdemeanants. Most of these felonies were among the less serious, such as burglary and possession of burglar's tools (34 percent of felonies), so it seems unlikely that they would invalidate the comparisons. The total number of inmates during the two years surveyed was 3,657.

Because the 1981 and 1982 data within each of the three groups were identical in all major characteristics, they were pooled throughout the study. The statistic employed was the chi-square test of significance. Medians rather than means were used for analysis, as most variables were not normally distributed.

Results

Demographic data are presented in Table 1. In terms of age, the two patient groups do not differ from each other, but they are significantly older than the men in the penitentiary ($p < .005$). Incompetent misdemeanants differ significantly from both civil patients ($p < .05$) and from inmates ($p < .005$) in marital status, being more often divorced or separated and less frequently never married. Relative to religion, the incompetent misdemeanants differ significantly from inmates ($p < .05$) but not from other patients in that they are more often Roman Catholic.

Similarly, examination of ethnicity reveals that the incompetent misdemeanants differ significantly from the penitentiary group ($p < .005$), but not from civil committees. Blacks are overrepresented among inmates relative to incom

Table 1
A Comparison of Sociodemographic Characteristics of Incompetent Misdemeanants, Civil Patients, and Penitentiary Inmates

	Incompetent Misdemenants (N = 52)	Civil Patients (N = 67)	Penitentiary Inmates (N = 3657)
Age (years)			
Median	31.5	31.1	26.3
Mean	34.4	34.4	28.9
Ethnicity (%)			
White	53.8	70.1	36.4
Black	40.4	22.4	58.8
Hispanic	5.8	7.5	4.8
Marital status (%)			
Never married	61.2	81.0	78.6
Married (currently)	16.3	9.5	15.9
Separated/divorced	22.5	9.5	5.5
Religion (%)			
Protestant	34.8	37.5	44.7
Catholic	56.5	50.0	35.7
Other	2.2	10.7	4.7
None	6.5	1.8	14.9

petent misdemeanants and civil patients, with a corresponding disproportion of whites. Hispanics appear with approximately equal frequency across all three groups. While the percentage of black incompetent misdemeanants is higher than that of civil patients, this difference did not reach statistical significance. Thus, on the basis of ethnic background, incompetent misdemeanants fall in between the civilly committed patients and the county's incarcerated men, but tend to resemble the psychiatric population more.

Comparison of criminal history is difficult because of different assessment standards. For inmates, information was available only for prior stays at the same local pentitentiary. We used any material known to the hospital forensic committee for the incompetent misdemeanant cohort. Therefore, given that comparisons are only tentative, the Final Order patients are significantly less likely to have a prior criminal history than are the prisoners ($p < .005$). No information is available for civil patients. Incompetent misdemeanants also differ significantly from the penitentiary group in terms of the specific charges ($p < .05$), being more frequently arrested for criminal trespassing and disorderly conduct, yet less often for petit larceny. Again, this comparison is not applicable to those civilly committed (Table 2).

On the major criterion of DSM-III diagnosis, there are no differences between the two hospitalized samples. An impressive majority of each was considered to be schizophrenic, predominantly paranoid or undifferentiated types, with many of the remainder diagnosed as having major affective disorders. Overwhelmingly, the misdemeanants have a history of prior psychiatric hospitalization (83 percent), with the median number of previous admissions being 3.31 (mean, 3.70). Similar data are not available for either of our control groups.

For those who stand convicted and were sent to the county penitentiary, the median sentence was 65 days. Unfortunately, actual duration of imprisonment was not calculated, but was estimated at 15 to 20 days less. The incompetent misdemeanants spent an average of 105 days at the state psychiatric center compared with 88 days for the involuntary committees.

These findings become more meaningful when the distribution of those referred to the hospital was examined. For both groups, there is a clear bimodal curve, with the majority discharged in about two months and very few additional patients released beyond the 120-day point, until such time as close to one year from initial admission is reached. If we use this four-month marker to separate the patients into a short stay and a long stay cohort, we learn that 63 percent of both civil patients and incompetent misdemeanants fall into the former group, suggesting marked similarities between these two classes of patients.

The median hospitalization for the short stay combined sample was 55 days, while the longer stay patient remained for 232.5 days, indicating two very different categories in terms of treatment needs. Further breakdown of the brief hospitalization group reveals that the incompetent misdemeanants ($n = 33$) had

Table 2
A Comparison of Mental Health and Criminal Data of Incompetent Misdemeanants, Civil Patients, and Penitentiary Inmates

	Incompetent Misdemeanants (N = 52)	Civil Patients (N = 67)	Penitentiary Inmates (N = 3657)
Admission diagnosis			
Schizophrenia			
Paranoid	34.6	41.5	
Other	32.7	35.4	
Affective disorder			
Bipolar	9.6	9.2	
Other	23.1	13.9	
Length of stay (days)			
All			
Median	105	88	65*
Mean	146	125	97
Patients (%)	100	100	
Short stay			
Median	71.0	50.5	
Mean	70.0	55.9	
Patients (%)	63.5	62.7	
Long stay			
Median	236	204	
Mean	277.1	239.8	
Patients (%)	36.5	37.3	
Criminal Charges (%)			
Trespassing	14.0		4.1
Disorderly conduct	16.0		9.7
Petit larceny	10.0		20.8
Other	60.0		65.4

* Length of sentence. Actual length of incarceration is unknown, but estimated to be approximately 15 to 20 days less.

a median length of stay of 71 days compared with 50.5 days for their civilly committed counterparts (n = 42), the addition of 20.5 days representing a 40 percent extension of hospitalization. For those patients requiring long-term inpatient care, the length of stay for the 19 incompetent misdemeanants was 236 days and for the 25 controls was 204. While there obviously is a 32-day gap, it accounts for a greater course of treatment of only 16 percent.

Because of the small sample size and its distribution, our length of stay data analysis fails to reach significance in a statistical sense. However, in terms of resources and impact, these differences are very important.

Discussion

There are limitations to the material we have presented. This study was performed retrospectively, using available records which were collected for purposes other than research and might therefore have some inaccuracies. More worthy of mention is the fact that the information recorded by the correctional and mental health systems are not always directly comparable. As an example, each is not overly interested in recording the extent of past history of in-

volvement with the other. Diagnoses are not reported from jails, nor are prior convictions from hospitals. Since we consider this an initial investigation, we did not search individual medical records for treatment-related indices.

Nonetheless, there are rather striking observations that can be made. The incompetent misdemeanants are older, more likely separated or divorced, white, and Catholic when compared with the prisoners. In short, they bear a marked demographic resemblance to civil committees. In extremely impressive numbers, they have previous psychiatric hospitalizations and carry psychotic diagnoses that are very similar to those of other involuntary patients. They are less likely to have a prior criminal history, but are more commonly arrested for such relatively minor offenses as disorderly conduct and trespassing. It is easy to hypothesize that these behaviors were manifestations of mental illness in the first place. The critical variable is, of course, length of stay. Here, we found that 37 percent of both hospitalized groups require an average of almost eight months of inpatient treatment, suggesting a very ill subpopulation. However, when we focus only on those patients in the short-term group, we observed a three-week increase of hospital stay for the incompetent misdemeanant when compared with his civilly committed counterpart.

Extended hospitalization could be warranted for several reasons, prominent among which is a greater propensity for institutional violence (which we recognize is not predictive of community behavior[21]). The present study did not evaluate this variable at all. An earlier project by Stokman and Heiber,[22] conducted at a specialized forensic psychiatric hospital geared to treat those found to be incompetent to stand trial and insanity acquittees, demonstrated that their few civil patients (9 percent of the admissions) accounted for a startling proportion of the incidents (52 percent). They were the only group more likely to be judged dangerous by staff than not. However, these patients were referred to the forensic facility because of their unmanageability at civil state hospitals. Of particular importance is the fact that patients hospitalized as incompetent to stand trial had a comparatively low rate of incidents. More recently, Beran and Hotz[23] reported on mentally ill offenders treated at civil hospitals. Bearing directly on our thesis, they found that their forensic cohort did not constitute a unique class clearly more dangerous and, in fact, had more similarities to, rather than differences from, ordinary patients vis-à-vis incidents. Their civil group actually manifested overt violence to others and property destruction with greater frequency than did the criminals. In light of these empirical findings and in the absence of any evidence that our study group is sicker than the controls, we postulate that the increased length of stay is a result of the additional procedural requirements now imposed. The importance of the incompetent misdemeanant is perhaps highlighted by the observational study of Teplin[24] confirming a trend toward criminalization of the mentally disordered, which suggests that

the numbers of "offenders" found to be incompetent to stand trial may increase.

It appears that the judicial-legislative pendulum is continuing to swing in the direction of perceived public safety considerations rather than *parens patriae* approaches to treatment. However, this posture may not be supported by the evidence in terms of the clearly mentally ill incompetent misdemeanant. He is, in most all respects, a patient and, ideally from the standpoints both of fairness to the individual and cost effectiveness of the system, further actions should flow from and conform to that basic conclusion. Despite this, he is presently subjected to a system of what we call pseudocivil commitment, which incorrectly assumes, with all of the checks and balances required, that mental health professionals are able to assess dangerousness and predict violence accurately. Therefore, the New York legislation may give the public no more than a false sense of safety. Prospective replication of our data is indicated and, if confirmatory, will provide additional support for the contention that duration of hospitalization be based on clinical determinations about illness, and release likewise be in accord with improvement and rehabilitation, as is the case for other involuntarily hospitalized persons.

References

1. McGarry AL: Competency for trial and due process via the state hospital. Am J Psychiatry 122:623–30, 1965
2. McGarry AL, Bendt RH: Criminal vs. civil commitment of psychotic offenders: A seven year follow-up. Am J Psychiatry 125:1387–94, 1969
3. *Jackson v. Indiana*, 406 U.S. 715, 92 S.Ct. 1845, 32 L.Ed.2d 435 (1972)
4. *People v. Byrnes*, 7 Ill. App.3d 735, 288 N.E.2d 690 (1972)
5. *Commonwealth v. McQuaid*, 347 A.2d 465 (Pa. 1975)
6. *Commonwealth v. McBurse*, 348 A.2d 423 (Pa. 1975)
7. *People v. Arendes*, 92 Misc.2d 372, 400 N.Y.S.2d 273 (1977)
8. *Garrett v. State*, 390 So.2d 95 (Fla. App. 1980)
9. *State v. Raitz*, 621 P.2d 352 (Hawaii 1980)
10. *State v. Mayer*, 423 A.2d 492 (Vt. 1980)
11. *State ex rel Matalik v. Schubert*, 57 Wis.2d 315, 204 N.W.2d 13 (1973)
12. *State ex rel Haskins v. County Court of Dodge County*, 62 Wis.2d 250, 214 N.W.2d 575 (1974)
13. *State ex rel Deisinger v. Treffert*, 85 Wis.2d 257, 270 N.W.2d 402 (1978)
14. Dickey W: Incompetency and the nondangerous mentally ill. Crim Law Bull 16:22–40, 1980
15. Roesch R, Golding SL: Treatment and disposition of defendants found incompetent to stand trial: A review and a proposal. Int J Law Psychiatry 2:349–70, 1979
16. Michigan Mental Health Code Secs. 330.2032 and 330.2034. Michigan Compiled Laws Annotated, Vol. 16A, West, 1980
17. *People v. Helfman*, 458 N.Y.S.2d 628 (App.Div. 1983)
18. *People v. Anonymous A.*, 460 N.Y.S.2d 864 (Sup.Ct. 1983)
19. *People v. McArthur*, 461 N.Y.S.2d 173 (Sup.Ct. 1983)
20. Steadman HJ, Hartstone E: Defendants incompetent to stand trial, in Mentally Disordered Offenders: Perspectives from Law and Social Science. Edited by Monahan J, Steadman HJ. New York, Plenum, 1982
21. Stokman CLJ: Dangerousness and violence in hospitalized mentally ill offenders. Psychiatr Q 56:138–43, 1984
22. Stokman CLJ, Heiber P: Incidents in hospitalized forensic patients. Victimology 5:175–92, 1980
23. Beran NJ, Hotz AM: The behavior of mentally disordered criminals in civil mental hospitals. Hosp Community Psychiatry 35:585–9, 1984
24. Teplin LA: Criminalizing mental disorder: The comparative arrest rate of the mentally ill. Am Psychologist 39:794–803, 1984