

A Comparison of Civil Patients and Incompetent Defendants: Pre and Post Deinstitutionalization

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There has been a great deal of speculation that deinstitutionalization has resulted in the criminalization of the mentally ill. Using two samples of defendants found incompetent to stand trial (IST) and two samples of civil patients randomly selected from five states, pre and post deinstitutionalization, this research compares changes in their mental health and arrest histories. After deinstitutionalization, fewer and less dramatic differences in the arrest and mental health histories were evident between ISTs and civil patients. Both patient samples displayed significant increases in prior hospitalization and arrest histories. Among the civil patients there was a significant increase in the frequency and seriousness of criminal activity. There was no evidence that IST commitments are being expanded to hospitalize the nondangerous mentally ill no longer subject to civil commitment.

In the years since state mental hospital deinstitutionalization there has been increased speculation that it has resulted in the "criminalization of the mentally ill."¹⁻⁶ Deinstitutionalization is a broad term generally used to describe a series of legal, treatment, and economic developments over the past three decades that have resulted in an increased emphasis on community mental health treatment. Landmark cases such as *Lessard v. Schmidt*⁷ and *O'Connor v. Donaldson*⁸ resulted in increased patient rights to resist involuntary hospitalization. Within the past 20 years a total of 48 states have revised their civil commitment statutes to include a determination

of dangerousness and increased procedural safeguards.⁹

An equally important component of deinstitutionalization has been changes in the funding of the mental health system. The number of inpatient beds in state and county hospitals per 100,000 civilian population decreased 62 percent between 1972 and 1981.¹⁰ Teplin⁶ reported that when adjusted for inflation, federal funding for community mental health has actually declined since 1975. Although there is some evidence that the rate of inpatient care episodes remained constant over the past 20 years,¹¹ deinstitutionalization appears to have had a significant impact on the duration and nature of hospitalization. Between 1968 and 1978, the resident population of

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state mental hospitals decreased from 512,500¹² to 147,000.⁹ During the same period, the average length of stay declined from 421 days to 189 days.¹¹ The number of admissions to state and county mental health facilities decreased 23 percent between 1971 and 1979.¹⁰ Inpatient admissions to these facilities continued to decline into the 1980s as well.¹⁰ Clearly, one of the results of deinstitutionalization has been an increased number of mentally ill persons living in the community who previously would have been hospitalized.

The process of responding to the nondangerous mentally ill through the criminal justice system rather than through the mental health system is often described as the "criminalization of the mentally ill." This hypothesis may be based on two very different premises. First, the most common, is the speculation that the nondangerous mentally ill who historically have been civilly committed are now being arrested for minor offenses. It has been suggested that there is a limit to communities' tolerance of "deviant behavior." If commitment statutes or the availability of beds restrict the mental health system from responding to the real or perceived threat presented by the mentally ill, public authorities may increasingly use arrest as a means of institutionalizing them.

There is some evidence that this may be occurring. Several researchers have reported that arrest rates for the mentally ill have increased since deinstitutionalization.^{13,14} Teplin⁶ reports that when controlling for criminal activity, the probability of being arrested was

much greater among mentally disordered offenders than among individuals who did not appear mentally ill. Significant increases in the number of criminal commitments to mental hospitals after arrests for less serious offenses have been reported in earlier studies of the criminalization of the mentally ill.^{2-4,15} These studies are frequently cited as evidence that the criminal justice sphere of coercive control was expanding to include the nondangerous mentally ill, traditionally dealt with through the mental health system.

A second basis for the speculation that deinstitutionalization has resulted in the criminalization of the mentally ill may be grounded on the premise that it has prevented the hospitalization of the nondangerous mentally ill, some of whom, without effective community treatment, will deteriorate to the point where their behavior does, in fact, become criminal. As noted above, inpatient treatment has been limited by available beds, and community treatment is limited by financial resources. As a result, communities have growing numbers of mentally ill who do not meet admission criteria and who may be denied community treatment due to a lack of available programs. If these patients are in fact decompensating to the point of engaging in serious criminal behavior, there should be no change in the seriousness of the crimes for which individuals are arrested or criminally committed. In other words, the criminal commitments would not be "expanding" to include a new type of mentally disordered offender (i.e., a less serious one) but would continue to be

used for those mentally ill engaging in serious crimes.

There are several criminal alternatives to civil commitment: jail, prison, or findings of not guilty by reason of insanity or incompetency to stand trial. The validity of each of the above premises can only be determined by examining *each* type of criminal confinement for changes in the number and types of mentally disordered offenders. It is suggested here that commitment for incompetency to stand trial (IST) represents the best opportunity to test the validity of the two premises.

There are a number of factors about the nature and operation of the IST commitment that render it a convenient method of hospitalizing the mentally ill no longer subject to civil commitment. First, IST commitments represent the majority (61%) of all forensic admissions.¹⁷ Second, competency to stand trial refers only to the defendant's ability to understand his/her situation and to assist with his/her defense. Thus, IST commitments do not require a determination of dangerousness, and may be secured after an arrest on a charge as trivial and ambiguous as disorderly conduct or disturbing the peace. Third, although competency is a legal issue, the empirical research clearly demonstrates it is based almost exclusively on psychiatric opinion. Researchers pre and post deinstitutionalization revisions in civil commitment statutes reported that in cases where the psychiatrist determined the defendant was incompetent, judges concurred more than 85 percent of the time.^{18, 19}

Finally, the overwhelming majority of ISTs are committed to maximum security state mental hospitals for treatment to restore competency. Despite the landmark case of *Jackson v. Indiana*²⁰ in which the Supreme Court ruled that ISTs could not be held indefinitely, the most current literature indicates that the length of hospitalization averaged from one to three years.^{19, 21} Thus, if the intent is to hospitalize the mentally ill no longer subject to civil commitment, the IST commitment appears to remain a viable mechanism.

If competency commitments increasingly are being used as an alternative way of hospitalizing the nondangerous mentally ill previously dealt with through civil commitment, this differential processing should be evident in several areas. First, the most simply, there should be increases in the number of IST commitments since deinstitutionalization. Although the total rate of forensic admissions remained relatively stable between 1967 and 1980,¹⁷ the number of IST commitments significantly increased.^{1, 3, 22, 23} More importantly, Arvanites²² reported that the increase in IST admissions was positively related to the rate of deinstitutionalization.

A second indicator of the differential processing of mentally disordered offenders would be changes in the nature of offenses for which ISTs have been arrested. As previously noted, the research on this issue is clearly contradictory. Although earlier studies have reported that ISTs are increasingly arrested for minor criminal offenses,^{1, 3, 17}

more recent studies reported no evidence that IST commitments are being used to hospitalize minor offenders.^{22,24}

One possible explanation for the discrepant findings is that crime overall has increased, and the criminal histories of the ISTs simply *reflect this overall increase*. Data from the Uniform Crime Reports suggest that violent crime has increased 33 percent between 1968 and 1978.^{25,26} *Thus, changes in the arrest histories of ISTs should be compared with other patient groups to determine whether changes paralleled, exceeded, or lagged behind the criminal histories of other patient cohorts.*

To determine whether an increase in the frequency of the IST commitments is occurring because they are increasingly being used to hospitalize the non-dangerous mentally ill, or due to an increase in serious crime by some of the mentally ill whose condition, because of lack of treatment, had deteriorated to the point to which it became violent, changes in the arrest histories of the ISTs should be compared with changes in the histories of civilly committed patients. If ISTs display increases in arrests for minor offenses after revisions in the civil commitment statutes although there is no significant change in the arrest histories of civil patients, this would be supportive of the premise that IST commitments are expanding to include the mentally ill engaging in less serious criminal activity. If, however, ISTs do not reveal increasingly minor arrests, this would suggest that increase in the frequency of ISTs is simply the result of more mentally disordered individuals

engaging in the similar types of serious crimes and not an "expansion" to include more minor offenses.

Currently there is an insufficient understanding at the national level of the impact of deinstitutionalization on commitments for incompetency to stand trial. Roesch and Golding²⁷ noted that much of the current research has little generalizability because it has been conducted on single jurisdictions and is further limited by the scarcity of longitudinal studies. The present research represents the first longitudinal multijurisdictional study to compare the differences in the criminal and psychiatric "careers" of incompetent defendants and patients hospitalized under civil statutes pre- and postrevisions in civil commitment statutes.

Methods

Two samples of defendants found incompetent to stand trial and civil patients were selected from five states: California, Iowa, Massachusetts, New York, and Texas. Subjects were randomly selected from all 1968 and 1978 admissions to state mental health facilities. The earlier year was just prior to the enactment of the "dangerousness standard" for civil commitment in California, variations of which were adopted by 48 other states.⁹ Approximately 16 percent of the nation's state mental patients were hospitalized in these five states during both years.

The sampling procedure was designed to select 50 incompetent defendants from each state in each year. In states with fewer than 50 ISTs, all incompetent

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defendants were included. Samples of 100 civil patients were selected from Iowa, Massachusetts, and Texas; 400 were selected from California and New York. Larger samples were drawn from the latter states because of their larger general and mental health populations. Because previous researchers have reported that the overwhelming majority (90%+) of incompetent defendants are male, the samples were limited to adult males.^{19,28} The 1968 IST sample consisted of 175 defendants, whereas the 1978 sample consisted of 200 ISTs. A total of 1,089 civil patients was included in the 1968 sample; the 1978 sample consisted of 1,090 civil patients.

For each individual, data were collected for all adult inpatient state mental hospitalizations. Also collected was the psychiatric diagnosis of each patient (DSM II classification) at time of the target admission. Finally, state mental hospital admissions data were collected from the respective states' departments of mental health. Also collected were all *adult* arrests that occurred prior to the target hospitalization. These data were abstracted from "rap" sheets provided by the appropriate state agencies. Differences in averages were tested using a *t* test, and Z scores were computed to test the differences between binominal properties.

Results

As is evident in Table 1, IST commitments, both in raw number and as a percentage of all hospital admissions, increased significantly between 1968 and 1978. During a time when total

Table 1
IST Commitments as a Percentage of All Commitments, by State and Year

State	1968	1978	% Change
New York	2.9	4.7	+62.1*
(IST n)	(716)	(983)	+37.3
(Total N)	(25,131)	(20,740)	+17.5
California	3.0	4.2	+40.0*
(IST n)	(610)	(603)	-1.1
(Total N)	(20,132)	(14,206)	-29.5
Massachusetts	0.5	1.3	+160.0*
(IST n)	(45)	(60)	+33.3
(Total N)	(8,365)	(4,749)	-43.2
Texas	0.3	2.2	+633.3*
(IST n)	(24)	(346)	+1341.7
(Total N)	(8,355)	(15,499)	+85.5
Iowa	0.2	0.1	-50.0
(IST n)	(6)	(6)	0.0
(Total N)	(3,500)	(4,175)	+19.3
Total	2.1	3.4	+61.9*
(Total IST)	(1,401)	(1,999)	(+42.7)
Total Admissions	(65,483)	(59,483)	(-9.3)

* *p* < .01.

admissions declined by 9.3 percent, IST admissions increased by 42.7 percent. This pattern varied across jurisdiction. Increases were evident in Massachusetts, New York, and Texas. California experienced a small decrease (-7), and Iowa remained constant with only six IST commitments.

Table 2 presents the demographics of the two patient cohorts. Before deinstitutionalization, IST and civil patients represented two distinct groups in terms of age and race. ISTs were significantly younger (33 vs. 39 years) and as a cohort were less likely to be white (65.5 vs. 81.4%). After deinstitutionalization, there was no significant difference in age. Although the racial difference remained, each sample was significantly more nonwhite. Between the post deinstitutionalization samples there was virtually no difference in age (31 vs. 33

Table 2
Patient Characteristics by Year and State

1968						
State	IST			Civil		
	n	Age	White (%)	n	Age	White (%)
NY	50	30.7*	55.1*	398	38.9*	70.6*
CA	50	29.8*	60.0*	400	37.9*	85.7*
MA	45	37.7	84.4	92	41.1	95.0
TX	24†	39.6	58.3*	100	40.6	82.0*
IA	6†	28.9	83.3	99	37.8*	95.0*
Total	175	33.4*	65.5*	1,089	38.8*	81.4*

1978						
State	IST			Civil		
	n	Age	White (%)	n	Age	White (%)
NY	50	29.8	42.0*	400	33.8	62.7*
CA	50	32.2	36.0*	399	30.3	58.0*
MA	44	30.3	70.4*	95	32.0	88.4*
TX	50	31.1	50.0	98	35.6	62.2
IA	6†	32.2	71.4*	98	35.8	94.8*
Total	200	30.9	50.3*	1,090	32.7	73.4*

* $p < .05$.

† Represents the state's entire IST population.

years). This similarly is clearly the result of the decrease in age among the civil patients (decreasing from 39 to 33 years) rather than changes in the IST patients (decreasing from 33 to 31 years). Admission diagnosis was not included in Table 2 because the pre and post deinstitutional IST cohorts were virtually identical (e.g., 78 and 79% diagnosed as schizophrenic at admission). Thus, any variance would be the result of changes in civil patients and not, as is commonly attributed, to changes in the type of defendant now being found IST.

The critical question in the criminalization hypothesis is whether the mental health and criminal "careers" of the ISTs have changed. If competency commitments increasingly are being used as an alternative way of hospitalizing the non-

dangerous mentally ill who were previously committed civilly, it is plausible to predict that comparisons between the criminal histories of civil and IST patients before deinstitutionalization should yield more discrepant results than a comparison of post deinstitutionalization cohorts. The proportion of each cohort previously hospitalized or arrested, as well as the average number of times for each, are reported in Table 3. Also reported is the percentage of each cohort *ever* arrested for a violent offense or a crime against a person.

It is clear that before deinstitutionalization, ISTs and civilly committed patients represented two distinct patient populations. Statistically significant differences were evident in six of the seven characteristics examined. The IST co-

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Table 3
Hospitalization and Arrest Histories

	1968 (%)			1978 (%)		
	IST (n = 175)	Civil (n = 1,089)	Diff.	IST (n = 200)	Civil (n = 1,071)	Diff.
% w/prior hospitalizations	47.7	13.9	243.2**	60.8	29.2	168.0*
Average number	2.1	2.6	23.8	4.1	4.6	12.2
% w/prior arrests	58.6	29.8	96.6**	76.4	45.6	67.5*
Average number	8.9	5.7	56.1*	7.4	7.6	2.7
% arrested for						
Murder	12.1	0.4	2,925.0**	4.0	1.2	233.3
Violent offenses†	37.2	11.6	220.1**	38.5	23.6	63.1*
Crimes vs. persons‡	52.2	17.0	207.0**	53.5	33.7	58.7*

† Murder, rape, attempted murder/rape, assault.

‡ Above plus: robbery, kidnapping, sodomy, sex abuse, and menacing.

* p < .05.

** p < .01.

hort was more likely to have previous hospitalizations (47.7 vs. 13.9%). Among those previously hospitalized however, the average number was not significantly different (2.1 vs. 2.6). In terms of arrest histories, a higher proportion of ISTs were previously arrested (58.6 vs. 29.8%). Further, among those arrested, ISTs averaged more prior arrests than the civil patients (8.9 vs. 5.7). ISTs were also more likely to have been arrested for murder, a violent offense, or a crime against a person.

An examination of the difference between the 1978 ISTs and the 1978 civil patients indicates that they remain distinct patient populations. Statistically significant differences remained in four of the six areas examined. After deinstitutionalization there were no statistically significant differences in the average number of prior arrests or the frequency of arrests for murder. In terms of murder, the lack of significance is the result of a decrease in murder charges against

ISTs. In terms of the average number of prior arrests, however, the disappearance of a statistically significant difference is due to the increase in prior arrests among civil patients.

An examination of the magnitude of the difference between the 1968 patient samples and the 1978 patient samples revealed dramatic decreases. Columns three and six (Table 3) report the percentage differences between patient samples for each year. The difference between the percentage with prior arrests decreased from 56 percent in 1968 to 2.7 percent in 1978. Among crimes versus persons the percentage difference decreased from 207 percent (1968; ISTs vs. civils) to 58.7 percent (1978; ISTs vs. civils). Whether these decreases are the result of changes in the IST samples between 1968 and 1978, or between changes in the civil patients samples can only be determined by examining changes *within* patient groups.

Table 4 presents the same data com-

Table 4
Hospitalization and Arrest Histories

	IST			Civil		
	1968	1978	% Change	1968	1978	% Change
% w/prior hospitalizations	47.7	60.8	+25.7*	13.9	29.2	+110.0*
Average number	2.1	4.1	+95.2*	2.6	4.6	+77.0*
% w/prior arrests	58.6	76.4	+30.2*	29.8	45.6	+53.0*
Average number	8.9	7.4	-16.8	5.7	7.6	+33.3
% arrested for						
Murder	12.1	4.0	-67.0*	0.4	1.2	+200.0
Violent offenses†	37.2	38.5	+3.5	11.6	23.6	+103.4*
Crimes vs. persons‡	52.2	53.5	+2.5	17.0	33.7	+98.2*

† Murder, rape, attempted murder/rape, assault.

‡ Above plus: robbery, kidnapping, sodomy, sex abuse and menacing.

* $p < .05$.

paring the changes *within* patient groups. Although both patient cohorts reveal significant changes between 1968 and 1978, the most dramatic change occurred in the civil patient samples. (See columns three and six). The magnitude of change among the civil patients exceeded the degree of change among the ISTs in all but one area (the average number of previous hospitalizations). Clearly, the decrease in the magnitude of the differences between ISTs and civil patients (between 1968 and 1978) is primarily the result of changes that occurred within the histories of civil patients and not in changes in IST histories.

In terms of the seriousness of the offenses for which ISTs are arrested, there is not much support for the premise that IST commitments are increasingly confining minor offenders. Although the frequency of murder decreased (12 to 4.0%), the overall proportion of ISTs charged with violent offenses (approximately 38%) or crimes against persons (approximately 53%) remained rela-

tively constant. A somewhat surprising finding was the dramatic increase in the seriousness of offenses for which civil patients had been arrested. After deinstitutionalization, the percentage of civil patients with an arrest for a violent offense increased twofold (11.6 to 23.6%) and the percentage arrested for a crime against a person almost doubled (17.0 to 33.7%).

Discussion

The longitudinal data presented here are clearly supportive of the criminalization hypothesis. First, and foremost, there was a significant increase in the number of individuals hospitalized after a determination of incompetency to stand trial. The critical question this research addresses, however, is why has this increase occurred. Much of the speculation on the criminalization of the mentally ill suggests that criminal alternatives are expanding to include the mentally ill who are either not dangerous enough to meet the current civil commitment statutes, and/or for whom

bed space is not available in many state and county mental health hospitals due to decreasing fiscal resources. Across the five states studied here, there was no significant change in the percentage of ISTs, pre and post deinstitutionalization, charged with violent offenses. Thus, these data provide little support for the speculation that commitments for incompetency to stand trial are expanding to confine the nondangerous mentally ill.

As noted previously, there are a number of ways in which the criminalization of the mentally ill may occur. The validity of such speculation can only be determined through a systematic study of *each* possible mechanism for evidence that it is expanding to include the mentally ill for whom civil commitment is not available. The research presented here has focused on only one such mechanism: commitments for *incompetency* to stand trial. Although these data do not support the premise that the IST commitment is expanding, it is plausible that commitments for *evaluation* of competency to stand trial are being used to hospitalize the nondangerous mentally ill.

An alternative explanation for the increased numbers of incompetency commitments is that the more restrictive civil commitment standards combined with the economic constraints of the mental health system have resulted in reduced psychiatric services to the mentally ill, some of whom ultimately deteriorate to the point where they engage in serious crime. An examination of the trends in civil patients reveals that this

may be occurring. After deinstitutionalization, a higher percentage of civil patients have previous arrests (45.6 vs. 29.8%) and on average were arrested more often (7.6 vs. 5.7). More importantly, there has been a significant increase in the seriousness of the offenses for which some are being arrested. As noted above, there was a twofold increase in arrests for violent offenses. These data are clearly supportive of the premise that without an effective community treatment network, an increasing number of mentally ill are becoming violent.

The increase in the proportion of civil patients with prior arrests is consistent with the "criminalization" hypothesis. It supports the premise that the mentally ill are increasingly being arrested rather than (re)hospitalized under civil commitment statutes. The increase in the seriousness of criminal activity for which they have been arrested suggests that the number of mentally ill in the community prone to violence has increased after the revisions in the civil commitment statutes. This does not suggest that it is solely the mental illness that renders them more likely to engage in violent behavior. As reported previously, there was a significant increase in the level of serious crime in the U.S. during the time span of this study. Although the increase in serious crime among mental patients reported here exceeded U.S. trends, some of the increase probably reflects the increase of violence in our society.

Another possible factor contributing to the increase in the criminal activity of the civil patients was that the post

deinstitutionalization sample was significantly younger than the pre-deinstitutional cohort (33 vs. 39). Because age is inversely related to criminal activity, this increase in crime may simply be the result of a younger cohort. Determining the exact causes of the increase in serious crime by the civil patients is beyond the scope of this article.

The data from these five states clearly document the significant increase in serious crime committed by the mentally ill hospitalized through the civil commitment process. As a result, there are several implications to this study. First, this increase in serious crime suggests that the public and law enforcement officers are now at an increased risk of being victimized. Further, the deteriorating conditions of the mentally ill may increase their risk of victimization as well.

Secondly, because the arrest rates of the mentally ill are increasing, the criminal justice system can expect to process and confine more mentally ill. Increased numbers of mentally ill offenders affect the mental health system as well as the criminal justice system. Increases in the number of criminal commitments to mental hospitals (such as the increase in ISTs cited here) are likely. Criminal commitments to mental hospitals have their own set of consequences for mental health professionals. They are usually more restrictive, which may interfere with treatment plans, and in some jurisdictions certain privileges and/or release must be reviewed by the criminal court.

Finally, the increase in the seriousness of crime for which the mentally ill are

being arrested suggests that the more restrictive civil commitment standards have prevented the hospitalization of some of the mentally ill, who ultimately deteriorate to the point where they become violent. This would support the view that the post deinstitutionalization admission standards are too restrictive and should be relaxed to permit hospitalization and treatment before they become dangerous. A few states have recently removed the dangerousness standard from their civil commitment process, and the data presented here would support such a reform.

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