CHAPTER 18

Assessment of Competence to Stand Trial

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INTRODUCTION

Competence to stand trial has long been considered "the most significant mental health inquiry pursued in the system of criminal law" (Stone, 1975, p. 200). Hoge, Bonnie, Poythress, and Monahan (1992) estimated that pretrial competence evaluations are sought in 2% to 8% of all felony cases. LaFortune and Nicholson (1995) reported that judges and attorneys estimate that competency is a legitimate issue in approximately 5% of criminal cases, although only two thirds of these defendants whose competency is questionable are actually referred for competency evaluations.

The frequency of trial competency evaluations in the United States has steadily increased, from the 1978 estimate of 25,000 annually (Steadman, Monahan, Hartstone, Davis, and Robbins, 1982) to more recent estimates of 50,000 to 60,000 defendants evaluated for trial competency (Bonnie & Grisso, 2000; Skeem & Golding, 1998). Approximately 20% to 30% of defendants referred for competency evaluation are adjudicated incompetent to stand trial. Representative studies include the 30% rate of findings of incompetence over a 25-year period reported for the meta-analysis by Nicholson and Kugler (1991); the 18% rate for federal defendants (Cochrane, Grisso, & Frederick, 2001); rates of 13%, 18%, and 29% for defendants evaluated in Virginia, Michigan, and Ohio, respectively (Warren, Rosenfeld, Fitch, & Hawk, 1997); and the overall rate of 19% for statewide samples in Virginia and Alabama (Murrie, Boccaccini, Zapf, Warren, & Henderson, 2008). These findings also indicate that rates of incompetence recommendations vary as a function of examiner, evaluation setting (i.e., inpatient versus outpatient), and the level of impairment of defendants referred.

Cooper and Grisso (1997) noted that referrals for inpatient competence evaluations—as well as incompetence adjudications—may have become a mechanism for hospitalizing persons with mental illness who could not otherwise access inpatient care. This observation is supported by research indicating that defendants who are charged with misdemeanors and are referred for evaluation are more likely to be adjudicated incompetent to proceed than are defendants charged with felonies (e.g., Warren et al., 2006). Similarly, Stafford and Wygant (2005) reported that 78% of defendants referred for competency evaluation by a misdemeanor mental health court were found incompetent and hospitalized for competency restoration—a rate considerably higher than general rates of incompetence adjudication (see immediately above). The growing movement toward specialty courts, including mental health courts (Redlich, Steadman, Griffin, Petrila, & Monahan, 2005), may contribute to an increased number of competence evaluation referrals of defendants who have been identified as having mental disorders, but who lack the capacity to agree to, or to comply with, alternative court proceedings and directives.

This chapter begins with a discussion of the legal framework of competence to stand trial, followed by consideration of the conceptual formulations of the legal standards that guide psychological assessments of trial competence. After the empirical literature on variables relevant to trial competence is reviewed, evaluation issues,

including clinical assessment approaches, use of competence assessment instruments and other assessment tools, and report writing issues are discussed. Issues posed by special populations are reviewed as well. Finally, dispositional issues, such as competency assistance, treatment of incompetent defendants, prediction of restorability, and dispositions in cases of permanently incompetent defendants, are summarized.

Legal Framework

Competency to stand trial is a legal concept rooted in the common law prohibition against trials in absentia. It has evolved over centuries, primarily through case law grounded in values, such as the fairness, accuracy, and dignity of court proceedings. To evaluate a defendant's competency, the psychologist must be guided by the statute in the jurisdiction where the case is being tried. However, understanding case law that considers specific issues that may affect trial competency is also critical.

This section summarizes the legal framework of competency to stand trial, including case law. Issues such as amnesia for the alleged offense, waiver of constitutional rights, decisional capacity, and mandated treatment of conditions that impair the defendant's capacity to proceed with the criminal case against him or her are discussed.

Early History

Trial competency is a legal construct rooted in English common law. Wulach (1980) identified four legal rationales for trying only competent defendants. First, the accuracy of the proceedings demands the assistance of the defendant in acquiring the facts of the case. Second, due process depends on defendants' ability to exercise their rights, including the rights to choose and assist legal counsel, confront their accusers, and testify. Third, the integrity and dignity of the process is undermined by the trial of an incompetent defendant, both in terms of inherent morality and outward appearance. Finally, the goal of punishment is not served by sentencing a defendant who fails to comprehend the sanction and reasons for imposing it. Similarly, Bonnie (1992) noted that concerns about the dignity, reliability, and autonomy of the legal process preclude adjudication of incompetent defendants.

The earliest foundation of the legal construct of competence to stand trial may be the Common Law prohibition against trials in absentia. Just as a criminal defendant has the right to be *physically* present to confront his or her accusers, a defendant must be *mentally* present, or sufficiently aware of the legal situation to meaningfully confront his or her accusers. In tracing the legal roots of trial competency, Melton, Petrila, Poythress, and Slobogin (2007) discussed the practice of 17th-century English courts in determining whether defendants who stood mute and did not enter a plea at trial were "mute of malice" or "mute by visitation of God" (p. 126). The former were subjected to placement of increasingly heavy weights on their chests to force a plea, whereas those considered mute by visitation of God (the deaf, the mute, and later, "lunatics") were not expected to enter a plea. This thinking evolved in the 18th century, as reflected by *Frith's Case* (1790), in which the court delayed trial until the defendant, "by collecting together his intellects, and having them entire, . . . he shall be able so to model his defense and to ward off the punishment of the law" (p. 127).

English Common Law has influenced the development of American criminal law, including the construct of competency. Federal case law linking trial competency to the U.S. Constitution began with the 1899 case of *Youtsey v. United States*. Youtsey had been tried in absentia—due to problems resulting from a seizure disorder—and convicted of embezzlement. The trial court denied his lawyer's motion for a continuance, which was based on expert testimony that his seizure disorder resulted in severe memory impairment that prevented him from providing counsel with information about "many of the vital transactions covered by said indictment which ought to be personally within his knowledge" (p. 939). The Sixth Circuit Court of Appeals overturned the conviction and remanded the case for retrial and a competency hearing, based on evidence that Youtsey's memory and mind were impaired before and during the trial, and that it was "doubtful whether the accused was capable of appreciating his situation, and of intelligently advising his counsel as to his defense, if he had any" (p. 947).

Competence Defined

The U.S. Supreme Court, in *Dusky v. United States* (1960), established what the Constitution minimally requires in order for a prosecution to move forward. In order to be tried, a defendant must have "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and a rational as well as factual understanding of the proceedings against him" (p. 789).

The federal court for the Western District of Missouri attempted to operationalize the Dusky standard in applying the standard to a mentally ill defendant in the 1961 case of *Wieter v. Settle*. This court reasoned that factors

to be considered in finding a defendant competent under the Dusky standard would include

> (1) that he has mental capacity to appreciate his presence in relation to time, place and things; (2) that his elementary mental processes be such that he apprehends (i.e., seizes and grasps with what mind he has) that he is in a Court of Justice, charged with a criminal offense; (3) that there is a Judge on the Bench; (4) a Prosecutor present who will try to convict him of a criminal charge; (5) that he has a lawyer (self-employed or Court appointed) who will undertake to defend him against that charge; (6) that he will be expected to tell his lawyer the circumstances, to the best of his mental ability (whether colored or not by mental aberration) the facts surrounding him at the time and place where the law violation is alleged to have been committed; (7) that there is, or will be, a jury present to pass upon evidence adduced as to his guilt or innocence of such charge; and (8) he has memory sufficient to relate those things in his own personal manner. (pp. 321–322)

The U.S. District Court for the Western District of Louisiana articulated its reasoning in applying the *Dusky* standard to a defendant with mental retardation in *United States v. Duhon* (2000). Although the defendant had a factual understanding of the proceedings (based on rote memorization), the Court ruled that his inability to consult with counsel, otherwise assist in his defense, and rationally understand the proceedings rendered him incompetent to stand trial.

Basis for Raising the Issue of Competence

In *Pate v. Robinson* (1966), the U.S. Supreme Court held that a trial judge must raise the issue of competency if either the court's own evidence or that presented by the prosecution or defense raises a "bona fide doubt" about the defendant's competency. In *Drope v. Missouri* (1975), the Court clarified that evidence of the defendant's irrational behavior, demeanor at trial, and any prior medical opinion on competence to stand trial are relevant to determining whether further inquiry is required.

Amnesia and Competence

The tendency of federal courts to articulate functional criteria pertaining to competence to stand trial continued in the case of *Wilson v. United States* (1968). The U.S. Court of Appeals for the District of Columbia upheld the conviction of a man who had no memory of his behavior at and around the time of the alleged offenses as a result of head injuries he sustained in an accident that occurred during a high-speed chase. However, the court remanded the case for more extensive post-trial findings on the issue of whether the appellant's loss of memory deprived him of a fair trial and effective assistance of counsel. The Court of Appeals articulated six factors that the trial court was to consider before making a judgment whether, under applicable principles of due process, the conviction should stand:

1. The extent to which the amnesia affected the defendant's ability to consult with and assist his lawyer,
2. The extent to which the amnesia affected the defendant's ability to testify in his own behalf,
3. The extent to which the evidence in suit could be extrinsically reconstructed in view of the defendant's amnesia. Such evidence would include evidence relating to the crime itself as well as any reasonably possible alibi,
4. The extent to which the Government assisted the defendant and his counsel in that reconstruction,
5. The strength of the prosecution's case. Most important here will be whether the Government's case is such as to negate all reasonable hypotheses of innocence. If there is any substantial possibility that the accused could, but for his amnesia, establish an alibi or other defense, it should be presumed that he would have been able to do so, and
6. Any other facts and circumstances which would indicate whether or not the defendant had a fair trial. (pp. 463–464)

In addition to illustrating the functional, situation-specific analysis demanded for determinations of competency, the *Wilson* court's reasoning makes clear that adjudication is a legal decision designed to ensure the fairness and accuracy of court proceedings.

Competence to Waive Rights

Implicit in the competency of a defendant to participate in proceedings to resolve criminal charges is the capacity to waive certain rights. Case law makes clear that trial competency includes the capacity to make a number of decisions inherent to resolving a criminal case in a fair, accurate, and just manner.

Competence to Plead Guilty

Over 90% of criminal cases in the United States are resolved by a plea of guilty (Whitebread & Slobogin, 2000), which involves waiver of a number of important rights, including the rights to a jury trial, confront one's accusers, and avoid self-incrimination.

In *Sieling v. Eyman* (1973) the U.S. Court of Appeals for the Ninth Circuit held that competency to stand

trial and competency to plead guilty are not necessarily identical and adopted the following standard: "A defendant is not competent to plead guilty if mental illness has substantially impaired his ability to make a reasoned choice among alternatives presented to him and to understand the nature of the consequences of his plea" (p. 215). In *Allard v. Hedgemoe* (1978), the U.S. Court of Appeals for the First Circuit ruled that the waiver of rights and the plea of guilty need to be closely examined, but suggested that the capacity to make such decisions be considered part of the *Dusky* standard.

In an earlier decision (*North Carolina v. Alford*, 1970), the U.S. Supreme Court had ruled that defendants may waive their right to trial and plead guilty even if they deny their guilt. The court focused on the logic of Mr. Alford's reasoning in choosing to enter a guilty plea to a murder he stated he did not commit. This issue, among others, is further addressed in the case of *Godinez v. Moran* (1993), reviewed further on.

Competence to Waive Counsel

The Supreme Court ruled in *Westbrook v. Arizona* (1966) that a competency-to-stand-trial hearing was not sufficient to determine a defendant's competence to waive his or her constitutional right to the assistance of counsel and to conduct his or her own defense. In *Faretta v. California* (1975), the Supreme Court noted that waiver of counsel must be "knowing and intelligent," but that a defendant's ability to represent himself or herself has no bearing on his or her competence to choose self-representation.

In *Godinez v. Moran* (1993), the Supreme Court considered the issue of waiver of rights in the context of trial competency. The facts of the case are important to consider in view of the significance of this landmark decision. Moran killed two people in a bar and removed the cash register. Several days later, he killed his former wife, shot himself in the abdomen, and attempted to cut his wrists. Two days after the latter incident, Moran summoned police to his hospital bed and confessed to the killings. He was charged with capital murder and adjudicated competent to stand trial. Nearly three months later, Moran appeared in court and stated that he wanted to discharge his attorneys and plead guilty, primarily to prevent the presentation of mitigating evidence at sentencing.

Based on the prior competency evaluations and its inquiry of the defendant on the record, the trial court ruled that Moran understood the consequences of entering a guilty plea and could intelligently and knowingly waive his right to counsel. The competency examiners had noted that Moran's depression affected his motivation to work with defense counsel. Although the court record noted that Moran was taking medication, there was no inquiry regarding the type, dosage, or effects of the medication on the defendant. Moran, who was sentenced to death, later sought postconviction relief based on the claim that he had been incompetent to represent himself. In response, the trial court held an evidentiary hearing, at which testimony indicated that he had been prescribed a number of psychoactive medications at the time of his trial (i.e., phenobarbitol, Inderal, Vistaril, and Dilantin), which had a "numbing" effect on him. The trial court rejected his claim that he lacked the capacity to represent himself.

The Ninth District Court of Appeals reversed the lower court ruling on the grounds that due process required the trial court to determine Moran's competency before granting his request to waive counsel and plead guilty. The court also held that the standards for competency to waive counsel and plead guilty were not the same as the standard for competency to stand trial, but that competency to make these decisions required the capacity for reasoned choice among the available alternatives. On appeal, the Supreme Court held that the standard for pleading guilty or waiving the right to counsel is the same as the *Dusky* standard for competency to stand trial. The Court reasoned that the defendant has to make a number of complicated decisions during a trial and that a separate, more demanding standard is not necessary as a result. The Court acknowledged: "In addition to determining that a defendant who seeks to plead guilty or waive counsel is competent, a trial court must satisfy itself that the waiver of his constitutional rights is knowing and voluntary. . . . In this sense there *is* a heightened standard for pleading guilty and for waiving the right to counsel, but it is not a heightened standard of *competence*" (p. 2687). The concurring opinion suggests that the *Dusky* competence standard should not be viewed too narrowly, as a defendant must be competent throughout the proceedings, from arraignment to pleading, trial, conviction, and sentencing, and whenever the defendant must make a variety of decisions during the course of the proceedings.

Although the court did not articulate a separate standard for competence to waive counsel or plead guilty, Justice Thomas, writing for the majority, acknowledged that "psychiatrists and scholars may find it useful to classify the various kinds and degrees of competence." Felthous (1994) noted that the Court "did not forbid legislatures, courts, attorneys, and mental health witnesses from addressing de facto those abilities that are embodied in decisions about competency to waive counsel and to make one's own defense" (p. 110). Melton et al. (2007)

wrote that *Godinez v. Moran* "should increase the level of competency associated with competency to stand trial, now that judges and evaluators know that the latter finding will also mean a defendant is competent to waive the right to counsel" (p. 177).

In *Indiana v. Edwards* (2008) the U.S. Supreme Court considered the issue of competence to waive counsel. Edwards was a mentally ill defendant who had fired three shots at a department store security guard who observed him shoplifting. Edwards was tried 5 years after the offense, after being adjudicated incompetent to stand trial and hospitalized for treatment designed to restore his competence. Edwards' request to represent himself, on the grounds that he disagreed with his attorney's trial strategy, was denied. He was convicted of criminal recklessness and theft, but the jury could not reach a verdict on the charges of battery with a deadly weapon and attempted murder. When retried on these latter charges, Edwards' request to represent himself was again denied. Although the court considered Edwards to be competent to stand trial, it ruled that he was not competent to defend himself, and appointed counsel to represent him. Edwards was subsequently convicted on these latter charges and sentenced to 30 years in prison.

On appeal, the U.S. Supreme Court ruled that the Constitution does not preclude states from adopting a higher standard for competency to waive counsel than competency to stand trial, nor does it prohibit states from insisting on representation by counsel for defendants who, despite being competent to stand trial, are nonetheless impaired to the extent that they are not competent to conduct trial proceedings by themselves. The Court ruled that to allow such a defendant to represent himself would not affirm the dignity of the defendant and could undermine his right to a fair trial.

Morris and Frierson (2008) noted rational reasons, and potential advantages, for defendants to represent themselves. These include sparing the expense of an attorney (if the defendant does not qualify for court-appointed counsel), the opportunity to present an agenda or unique theory of the case, the belief that one can present one's case better than an attorney, the ability to speak to the jury without undergoing cross-examination and to develop rapport with jurors, and the opportunity to confront and cross-examine accusers directly, and receive potentially greater latitude in behavior and questioning than would a defense attorney. In support of their argument, they cited Miller and Kaplan's (1992) study of 100 defendants consecutively admitted to a Wisconsin forensic hospital for competence evaluation or competence restoration treatment. Twenty-four of these 100 defendants sought to discharge their attorneys; 11 wished to represent themselves, and 13 sought representation by a different attorney. The evaluators considered all 11 of the defendants who wished to discharge their attorneys and represent themselves to be incompetent to stand trial, based on multiple competency-related deficits. However, the 13 defendants who sought to fire their attorneys and have new counsel appointed were largely considered competent to stand trial and as citing rational and self-protective reasons for their requests (e.g., the attorney did not spend enough time with the defendant, the attorney would not listen or verify the defendant's story, the attorney wanted the defendant to plead guilty or not guilty by reason of insanity).

Hashimoto (2007) reported that case outcomes for 208 defendants who represented themselves in state courts were at least as good as those represented by counsel: 50% of *pro se* defendants were convicted of at least one charge, compared to 75% of the represented defendants (descriptions of the weight of the evidence in these cases were not presented). Moreover, felony convictions for *pro se* defendants were less frequent (26%) than for the represented defendants (63%) in state courts. In federal proceedings, acquittal rates for *pro se* and represented defendants were similar: 64% and 61%, respectively. Federal dockets reflected that only 20% of *pro se* defendants were ordered to undergo competency evaluation. More than half of the *pro se* federal defendants had requested new counsel before invoking their rights to self-representation, suggesting that some sought to represent themselves as a result of dissatisfaction with court-appointed counsel. These data indicate that some *pro se* defendants seek to represent themselves for legitimate reasons and may have as good or better case outcomes than represented defendants.

This body of case law implies that the capacity to waive counsel, as well as the capacity to make decisions about trial strategy, must be considered when conducting competency evaluations in cases where waiver of counsel is an issue. Input from defense counsel, always important in conducting competency evaluations, is critical in considering whether the *pro se* defendant's preference for a defense strategy is informed and rational.

The Standard of Proof

In 1996 (*Cooper v. Oklahoma*), the U.S. Supreme Court ruled that Oklahoma's requirement that a defendant prove incompetence by clear and convincing evidence violated due process by allowing "the State to put to trial a

defendant who is more likely than not incompetent" (p. 1382). The Court termed the consequences of an erroneous competency determination in Cooper's case "dire" (p. 1382) and as impinging on his right to a fair trial, whereas the consequence to the state of an erroneous finding of incompetence when a defendant is malingering was "modest" (p. 1382) since it was considered unlikely that even an accomplished malingerer could "feign incompetence successfully for a period of time while under professional care" (p. 1382). The Court affirmed the importance of competence to stand trial, as "the defendant's fundamental right to be tried only while competent outweighs the State's interest in the efficient operation of its criminal justice system" (p. 1383).

Competency to Refuse the Insanity Defense

Federal courts have considered the issue of a defendant's competency to refuse an insanity plea separately from the issue of competency to stand trial. The prevailing view is articulated in *Frendak v. United States* (1979). The federal District Court for the District of Columbia held that a trial judge may not impose a defense of insanity over the defendant's objections if he or she intelligently and voluntarily decides to forgo a defense of insanity. In contrast, in an earlier case, *Whalem v. United States* (1965), the federal Court of Appeals for the District of Columbia Circuit ruled that a trial judge may impose an insanity defense when the defense would be likely to succeed, but this decision was overturned by the case of *United States v. Marble* (1991) and is not followed in most jurisdictions. If it appears that competency to waive an insanity defense may be an issue in a given case, it is prudent for the evaluator to address it during the trial competency evaluation.

Treatment of Incompetent Defendants

The law regarding treatment of incompetent defendants attempts to balance the liberty interests and due process concerns of a defendant who has not been convicted of a crime with the state's interest in a fair and accurate adjudication of criminal cases. Involuntary treatment of incompetent defendants is permissible as long as treatment is likely to restore the defendant to competence and there is no less intrusive means to do so.

Length of Commitment

In *Jackson v. Indiana* (1972), the U.S. Supreme Court reviewed the commitment of a mentally retarded deaf-mute ordered hospitalized until he became competent, even though the hospital did not believe he would ever be able to understand and participate in the legal process. The Court held that "a person charged by a State with a criminal offense who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future. If it is determined that this is not the case, then the State must either institute the customary civil commitment proceeding that would be required to commit any other citizen, or release the defendant. Furthermore, even if it is determined that the defendant probably soon will be able to stand trial, his continued commitment must be justified by progress toward that goal" (p. 1858).

The *Jackson* decision has led many states to limit the length of time defendants can be involuntarily hospitalized for purposes of treating them to restore their competence. However, these limits tend to be arbitrary or are linked to the sentence that could have been imposed had the defendant been convicted as charged. Moreover, most states do not require facilities that treat incompetent defendants provide periodic reports to the court, or that courts hold hearings on the status or progress of defendants committed for competency restoration (Melton et al., 2007). This lack of periodic review of progress toward competency restoration is likely to result in some defendants being hospitalized longer than necessary to restore competency.

Involuntary Medication

The issue of involuntary medication of defendants during trial was addressed by the U.S. Second District Court of Appeals in a case heard twice, *United States v. Charters*. In 1987, the court held that forced administration of psychotropic medication to an incompetent defendant requires a separate judicial decision, using the substituted judgment/best interest standard. In 1988, the U.S. Second District Court of Appeals, sitting *en banc,* endorsed a reasonable professional judgment standard, with the availability of judicial review. The *Charters* case was not appealed to the U.S. Supreme Court in light of its decision in *Washington v. Harper* (1990), in which the Court held that the reasonable professional judgment review of involuntary medication of prison inmates was constitutional.

The U.S. Supreme Court was asked to consider the issue of involuntary administration of psychotropic medication of pretrial detainees in the case of *Riggins v. Nevada* (1992). Riggins had argued to the trial court that continued administration of medication was

an infringement on his freedom, and that the effects of medication during trial would deny him due process by preventing him from showing the jurors his mental state at the time of the offense, in support of his insanity defense. After the trial court found Riggins competent and denied his motion to suspend administration of psychotropic medication during his murder trial, he was convicted and sentenced to death. The U.S. Supreme Court reversed Riggins' conviction and extended the *Washington v. Harper* (1990) ruling on the right of prisoners to refuse medication to pretrial detainees, absent an "overriding justification and a determination of medical appropriateness" (p. 1815). The Court ruled that, once Riggins requested that his medication be discontinued, the state had to establish the "medical appropriateness of the drug" by showing that the medication was essential for the defendant's safety or the safety of others, or that the state could not obtain an adjudication of "guilt or innocence with less intrusive means" (p. 1815).

In *Sell v. United States* (2003), the U.S. Supreme Court addressed whether psychotropic medication can be forced on a defendant who is not considered dangerous while institutionalized, for the sole purpose of rendering him competent to stand trial. Sell, a dentist, was charged in 1997 with submitting false insurance claims. After being adjudicated incompetent to stand trial and committed for treatment, he refused psychotropic medication and appealed orders for forced medication. Although the Eighth District United States Court of Appeals affirmed the district court's order authorizing forced medication, it also ruled that Sell was not dangerous while institutionalized. On appeal, the Supreme Court ruled that, before ordering forced medication to restore a criminal defendant to competence, trial courts should consider other grounds for ordering involuntary medication, such as medical need, prevention of dangerous behavior, or avoidance of serious harm to the person himself or herself. The Court articulated a standard permitting involuntary administration of drugs solely for trial competence purposes in certain instances, based on consideration of whether:

1. the government has an interest in prosecuting the defendant by addressing: the seriousness of the charges; how long the defendant has been confined relative to the potential sentence; and whether the defendant, if not treated, might be committed to a psychiatric hospital for a lengthy period that "would diminish the risks that ordinarily attach to freeing without punishment one who has committed a serious crime";
2. the proposed medication would be "substantially likely" to render the defendant competent without causing side effects that would interfere with his ability to work with his attorney;
3. there is less intrusive treatment that would restore the defendant's competence; and
4. the proposed involuntary medication would be "medically appropriate, i.e., in the patient's best medical interest in light of his medical condition." (p. 182)

The Court ruled that the orders for forced medication of Sell could not stand because lower courts had not adequately considered trial-related side effects, the impact on the sentence of Sell's pretrial confinement, and any potential future confinement that might lessen the importance of prosecuting him. The case was remanded for further proceedings in accordance with the Court's decision.

THE CONCEPTUALIZATION OF COMPETENCE TO STAND TRIAL

The legal doctrine of competence to stand trial has been the subject of conceptual analysis regarding its meaning and its application to psychological assessment and legal decision making. For example, Roesch and Golding (1980), in discussing the assessment of competence to stand trial, structured the inquiry as "whether or not *this* defendant, facing *these* charges, *in light of the existing evidence,* will be able to assist his attorney in a rational manner" (pp. 18–19). They further noted: "Testimony about mental and physical illnesses is relevant, but only insofar as it speaks to the functional ability of a defendant to *reasonably understand and assist in his/her own defense.* Defendants are not expected to be amateur lawyers, nor paragons of mental health, nor admirers of and true believers in the criminal justice system" (p. 23).

Grisso (2003) reiterated that a defendant's competence depends on the seriousness and complexity of the charges, what is expected of the defendant in the given case, the defendant's relationship with his or her attorney, the attorney's skill, and other interactive factors. This focus on the functional, individual, and situation-specific nature of competence to stand trial is a natural extension of the case law.

Bonnie (1992) proposed a two-pronged model of competence to stand trial. The first dimension, *foundational competence,* or competence to assist counsel, consists of the capacity to (a) understand the charges, the purpose of the criminal process, and the adversary system, particularly the role of the defense attorney; (b) appreciate one's situation as a defendant in a criminal prosecution; and (c) recognize and relate pertinent information to counsel

concerning the facts of the case. This dimension meets the societal need to maintain the dignity of the proceedings and the reliability of the outcome.

The second component proposed by Bonnie is *decisional competence,* the capacity to make whatever decisions a defendant is required to make to defend himself or herself, and/or resolve the case without a trial. These decisions may include waiver of constitutional rights, such as the right to confront one's accusers at trial, the right to counsel, and the right to a trial by jury. Bonnie noted that the capacity to make decisions may require reassessment at decision points throughout the proceedings, and that assessment of competence at any one point is in this respect provisional.

Bonnie also referred to the literature on competencies in other legal contexts as relevant to assessing decisional competence. For example, Grisso and Appelbaum (1995) identified four components of competency to consent to treatment: the abilities to (1) communicate a preference, (2) understand relevant information about a particular decision, (3) appreciate the significance of that information to one's own case, and (4) rationally manipulate or weigh information in reaching a decision. Understanding information does not necessarily enable individuals to apply that information to their situations in a rational manner to make intelligent decisions.

EMPIRICAL LITERATURE

Research has explored attorneys' views of competence and their practices in representing defendants when they have doubts about their competence to proceed. There is also a body of research describing demographic, legal, and clinical variables associated with examiner opinions of competence or incompetence to stand trial. Surveys of system differences in the prevalence of findings of incompetence have shed light on the impact of variables such as jurisdiction, and the setting in which the evaluation takes place (e.g., inpatient versus outpatient), on examiners' opinions. Finally, the possible role of arrest and subsequent competency evaluation as a means of securing emergency mental health treatment or psychiatric hospitalization of mentally disordered individuals has been investigated.

Attorney Opinions and Decision Making

Because competency to stand trial is a legal concept, it is useful to start with the literature on attorneys' views and practices regarding potentially incompetent defendants. For example, Berman and Osborne (1987), in a survey of 20 attorneys who had concerns about their clients' competence, found that attorneys reported a broader range of problematic behaviors in terms of competence than did the clinicians conducting the competency evaluations.

Hoge, Bonnie, Poythress, and Monahan (1992) interviewed public defenders regarding 122 randomly selected felony cases resolved during a 6-month period. Whereas the attorneys reported that they had doubts about their clients' competence in 15% of these cases, they indicated that they requested competence evaluations only half the time. The attorneys identified three basic reasons why they did not refer for evaluation clients whose competence they doubted: (1) The client was unlikely to be considered incompetent due to the low threshold for competency findings; (2) there were limited resources for such evaluations; or (3) a finding of incompetence might not be in the client's best interests. Attorneys also reported that they were more likely to doubt their clients' competence when they rejected their advice or were unusually passive in making decisions about their defense.

In a series of three studies, Poythress, Bonnie, Hoge, Monahan, and Oberlander (1994) reviewed 200 felony and misdemeanor cases, 92.5% of which were resolved by plea, and 200 felony and misdemeanor cases resolved by trial, and then interviewed attorneys and clients in 35 recently closed felony cases. Although attorneys reported doubting the competence of 8% to 15% of their clients charged with felonies and 3% to 8% of their clients facing misdemeanors, they referred only between 20% and 45% of these defendants for evaluation. Attorneys' doubts about their clients' competence were based on the degree of the client's helpfulness in developing the facts of the case, particularly when lack of helpfulness was perceived to be due to impaired ability rather than intentional unwillingness. Attorneys also reported being more likely to express doubts about the competence of clients who faced serious charges, who were unusually passive, or who rejected their advice. Attorneys reported spending significantly more time on the case in total, and directly with the client, when they had concerns about the client's competence. They also tended to consult with other attorneys and with clients' relatives or significant others in cases of doubted competence. These studies highlight the interactive, situation-specific nature of competence to stand trial, and the importance of involving attorneys in the process of competency assessment.

Clinician Opinions and Decision Making

A number of investigators have examined variables that differentiate defendants who have been recommended by examiners as competent from those recommended as incompetent. Nicholson and Kugler (1991) conducted a meta-analysis of studies of competent and incompetent criminal defendants published between 1967 and 1989. Incompetent defendants were more likely to be diagnosed with a psychotic disorder, although only half of the defendants with such diagnoses were recommended as incompetent. Symptoms of severe psychopathology, including delusions, hallucinations, impaired memory, impaired thought or communication, and disturbed behavior, significantly differentiated defendants recommended as incompetent from competent defendants. Older defendants, those with a history of psychiatric hospitalization, and defendants without an arrest history were more apt to be considered incompetent by the examiners, as well. The severity of the offense was more strongly related to the decision to refer defendants for competency evaluations, than to the clinician's opinion of incompetence.

Pirelli, Gottdiener, and Zapf (2011) conducted an updated meta-analysis based on 68 studies published between 1967 and 2008 that compared competent and incompetent defendants on demographic, psychiatric, and criminological variables. They found the base rate of recommended incompetency across 59 nonmatched samples to be 27.5%. The most robust findings were: (1) Defendants diagnosed with a psychotic disorder were 8 times more likely to be recommended by examiners as incompetent to stand trial than those who were not; (2) unemployed defendants were twice as likely to be recommended by examiners as incompetent as employed defendants; and (3) defendants with a history of psychiatric hospitalizations were twice as likely to be recommended as incompetent by examiners as those without such histories. With respect to demographic variables, non-White defendants who were evaluated were approximately one-and-a-half times more likely to be recommended as incompetent than Whites.

Cochrane, Grisso, and Frederick (2001) reported that, in a sample of 1,436 defendants referred for competency evaluation to a federal medical center, forensic examiners considered 19% to be incompetent to stand trial. When diagnosis was controlled, there was no significant difference in rates of recommended incompetence adjudications among categories of offense. Consistent with the existing literature, diagnoses of psychotic disorders, affective disorders, and mental retardation were most closely associated with the examiners' opinions of incompetence to stand trial.

Similarly, Hubbard, Zapf, and Ronan (2003) found that 19% of 468 defendants evaluated in Alabama were recommended by examiners as incompetent to stand trial. These defendants were more likely to be male, single, and African American, and to receive disability benefits. They were less likely to be charged with a violent offense and less likely to be diagnosed with substance abuse disorders, but more likely to be diagnosed with major mental disorder.

Competence Evaluation Systems

Grisso, Cocozza, Steadman, Fisher, and Greer (1994) surveyed the 50 states and the District of Columbia regarding systems of service delivery for pretrial forensic evaluations and developed a typology. Ten states were classified as having in place a *traditional* model whereby pretrial evaluations were primarily conducted in inpatient settings, using public mental health funds and multidisciplinary staff, with secondary reliance on outpatient evaluations. Nine states utilized a *private practitioner* model in which outpatient evaluations were conducted by community practitioners on a case-by-case basis, and were financed by court or criminal justice funds. Eleven states used a *community-based* system of local outpatient mental health facilities or court clinics funded primarily by public mental health funds. In five states, classified as *modified traditional,* most evaluations were conducted at centralized mental health facilities, but on an outpatient basis, and eight states employed a *mixed* model, with a balance of outpatient evaluations funded by either court or public mental health funds, and inpatient evaluations funded by public mental health funds.

Nicholson and Kugler (1991), in their review, found a slightly greater rate of clinician opinions of incompetence for evaluations conducted in inpatient (32.2%) versus outpatient (25.8%) settings. Correlations between clinician competency opinions and defendant characteristics were similar across both settings, suggesting that the larger proportion of incompetence opinions in inpatient settings may reflect greater psychopathology in defendants who are hospitalized for competency evaluation. However, Warren, Rosenfeld, Fitch, and Hawk (1997) reported contrary findings, based on data from Virginia. It is likely that defendants evaluated as inpatients in Virginia also received treatment while hospitalized, so that their mental conditions may have improved over the course of the

evaluation period, resulting in a lower rate of incompetence opinions in the inpatient setting.

Warren et al. (1997) reported rates of clinician recommendations of incompetence of 29%, 18%, and 13%, for competency evaluations conducted in Ohio, Michigan, and Virginia, respectively. They attributed the greater rate of incompetence opinions in Ohio to the regional, outpatient system of providing competence evaluations, leading to a greater percentage of defendants charged with minor misdemeanor offenses, such as disorderly conduct, and/or diagnosed with schizophrenia, referred for competency evaluations. In fact, in all three states defendants charged with misdemeanor offenses and defendants diagnosed with major mental disorders (psychotic, organic, and affective disorders) were more likely to be considered incompetent to stand trial by forensic examiners. These findings were subsequently cited in the 5-year review of research by Mumley, Tillbrook, and Grisso (2003) as support for the possibility of competence evaluation as the "back door" to the hospital for mentally ill persons who were not being involuntarily hospitalized as the result of strict interpretation of the dangerousness criterion for civil commitment.

This back-door possibility was supported by findings from a study of 363 defendants evaluated at a five-county court clinic in Ohio (Rohrer, Stafford, & Ben-Porath, 2002). Although the overall rate of clinician opinions of incompetence in this sample was 23%, the rate varied, based on severity of offense. Of the 79 misdemeanor defendants, forensic clinicians opined that 53% were incompetent to stand trial, whereas only 14% of the 284 felony defendants were recommended as incompetent to stand trial. Defendants considered incompetent were less likely to have antisocial traits and substance abuse histories than were defendants evaluated as competent. Defendants opined to be incompetent were significantly more likely to have delusional thinking or impaired thought processes, to be diagnosed with schizophrenia, and to have been prescribed antipsychotic medication at the time of the evaluation than were defendants recommend as competent. Incompetent defendants were less likely to have ever been prescribed antidepressants or to have been employed at the time of the offense. The defendants opined to be incompetent were significantly older, and had significantly lower intellectual functioning than defendants opined to be competent. The two groups did not differ on demographic variables, such as gender, race, marital status, or education.

In the same Ohio jurisdiction, a study of competency evaluations conducted for a misdemeanor mental health court found an even greater rate of recommended incompetence: 77.5% of the 80 defendants referred for competency evaluation (Stafford & Wygant, 2005). Defendants recommended as incompetent to proceed were significantly more likely to be diagnosed with a psychotic disorder, and less likely to be diagnosed with a personality disorder, than were defendants opined to be competent. They did not significantly differ on rate of substance abuse diagnosis, or on a number of variables related to history of major mental disorder (e.g., number of hospitalizations, prescribed psychotropic medications, suicide attempts). However, the incompetent defendants had significantly fewer indicators of antisocial behavior, such as history of juvenile court referrals and number of felony convictions, than did the competent defendants.

Both competent and incompetent defendants had a high prevalence of prior violent behavior, 89% and 79%, respectively, and 58% were facing charges indicative of recent harm to others (domestic violence, menacing, or assault). These data suggest that the incompetent defendants, in addition to having acute symptoms of major mental illness, were likely to have met the civil commitment criterion for dangerousness. In fact, over the 6 months preceding arrest, 6 of the 18 competent defendants, and 13 of the 62 incompetent defendants, had undergone screening for emergency psychiatric hospitalization. However, only 6 of the 19 defendants who had been screened were transferred to community hospitals, and none had been transferred to the state hospital for extended treatment.

In contrast, the 62 defendants subsequently found incompetent were committed for competency restoration and remained in the hospital, on average, 49 days. After 60 days, over half of these defendants remained incompetent, and their charges were dismissed. Nearly all of the unrestored defendants then remained in the hospital for further treatment as civil patients.

EVALUATION OF TRIAL COMPETENCE

Grisso (1988) published a practice manual outlining five objectives for competence evaluations. On a *functional* level, the defendant's strengths and weaknesses in terms of specific legal abilities should be assessed. A *causal* analysis focuses on the most plausible explanation for any observed deficits, based on clinical observations and data. The *interactive* objective of a competency evaluation is concerned with assessment of the significance of deficits in light of the case-specific demands. The opinion about the ultimate legal issue of competency to stand trial is

the *conclusory* objective, although Grisso acknowledged that jurisdictions vary on whether opinions on the issue of competency are permitted or required. For the defendant who is likely to be found incompetent, assessment of the potential for remediation of deficits and recommendations for treatment constitutes the *prescriptive* objective of the evaluation.

Although apparent deficits in knowledge and reasoning about one's legal situation trigger concerns about competence, the issue of competence is not only a *functional,* but also a *capacity* issue. Therefore, evaluation of competence to stand trial requires two levels of assessment. First, the psychologist assesses the defendant's understanding of his or her legal situation and appraisal of his options through interview, use of competency assessment instruments, review of prosecutor's information, and input from defense counsel about doubts regarding competence. Second, the psychologist assesses for the presence or absence of symptoms of mental disorder, and for signs of cognitive impairment and malingering, to evaluate whether apparent difficulties are due to impaired capacity to proceed with the case.

More recent guides to trial competence evaluation (Stafford & Sadoff, 2011; Zapf & Roesch, 2009) provide updated, specific recommendations regarding legal, empirical, clinical, ethical, and communication issues in the evaluation of trial competence. Zapf and Roesch included forms developed for structuring the evaluation, and for eliciting input from the defense attorney, particularly regarding the defendant's ability to assist counsel.

Forensic Assessment Instruments (FAIs) for Competence to Stand Trial

Nicholson and Kugler (1991) concluded that use of structured interviews or standardized competence assessment instruments increase the reliability of examiners' judgments of defendants' abilities to understand and participate in the legal process. Their meta-analysis included validation studies of competence assessment instruments, in which examiners had reached opinions of defendants' competency without access to the results of the FAIs. They found that defendants evaluated as incompetent to stand trial had been rated as having significantly more limited abilities using FAIs than those who had been recommended as competent. The magnitude of the relationship between the ratings on FAIs and clinician opinions of competence far exceeded the correlations found between traditional psychological tests and clinician opinions of competence. The following correlations between clinicians' opinions of recommendations of incompetence, and defendants' performance on FAI's, were reported: Competency Screening Test (Lipsitt, Lelos, & McGarry, 1971), –.37, Georgia Court Competency Test (Wildman et al., 1978), –.42, Competency Assessment Instrument (Laboratory of Community Psychiatry, 1974), –.52, and Interdisciplinary Fitness Interview (Golding, Roesch, & Schreiber, 1984), –42. Of the studies reviewed, only two incorporated criteria in addition to clinician opinions: Lipsitt et al., who used court decisions and attorney ratings, in addition to forensic staff decisions, for the Competency Screening Test, and Schreiber et al., who used findings from a blue-ribbon panel of experts and court decision criteria, in addition to forensic staff, for the Interdisciplinary Fitness Interview.

Pirelli, Gottdiener, and Zapf (2011) conducted a meta-analysis of trial competence research, including eight studies from which sufficient data comparing performance of competent and incompetent defendants on FAIs were available. These included the Competency Screening Test, Fitness Interview Test (Roesch, Webster, & Eaves, 1984), Georgia Court Competency Test–Mississippi State Hospital (Wildman, White, & Brandenburg, 1990), Metropolitan Toronto Forensic Service Fitness Questionnaire (Nussbaum, Mamak, Tremblay, Wright, & Callaghan, 1998), and the Mosley Forensic Competency Scale (Mosley, Thyer, & Larrison, 2001). They found a relatively large combined effect size associated with the pooled data for competency assessment instruments overall. They noted that data on FAIs are limited, and that additional research is required before empirically supported conclusions can be made. Commonly used FAIs for the evaluation of competency to stand trial are reviewed in the following.

Competency to Stand Trial Assessment Instrument and Competency Screening Test

Lipsitt, Lelos, and McGarry (1971; Laboratory of Community Psychiatry, 1974) developed the Competency to Stand Trial Assessment Instrument, a semistructured interview for considering 13 functions related to the ability of a criminal defendant to proceed. The functions were derived from review of appellate cases and the legal literature, and the clinical and courtroom experience of the multidisciplinary team that developed the instrument. The handbook provides illustrative questions and examples to use in rating the degree of incapacity on functions such as appraisal of legal defenses and quality of relating to attorney. However, there is no standardized administration, or well-defined rules for translating ratings to an overall judgment of the defendant's competence. Two

studies included in the meta-analysis by Nicholson and Kugler (1991) reported high levels of interrater reliability for clinician ratings (.87 to .90) on the CAI, and significant correlations between competence opinions of mental health professionals and overall CAI ratings. In practice, the CAI has been used as an interview guide or structured professional judgment tool, rather than as a test (Schreiber, 1978). The major contribution of the CAI was probably its early impact on educating clinicians about the concept of competence to stand trial and guiding assessments along legally relevant lines.

The Competency Screening Test (CST) is a sentence-completion screening tool involving case scenarios. The defendant's written responses are rated on a 0–2 scale, based on defined criteria. However, the cutoff score was not derived empirically, but rather set arbitrarily, based on qualitative impressions by the research staff as an indicator of the need for further evaluation with a more specific measure. Interscorer reliability ranging from .88 to .95 and classification accuracy rates of 71% to 84% have been reported (Nicholson, Robertson, Johnson, & Jensen, 1988). These same investigators found a high false-positive rate (76%), but a low (3.5%) false-negative rate using this cutoff. Therefore, in this sample, with the relatively low base rate of 10% incompetent, the CST appeared to function well in its intended role as screening measure in that few defendants who were actually incompetent were screened out from a full competence assessment.

Nicholson and Kugler (1991) reviewed 11 studies of the CST and reported a significant mean weighted correlation (–.37) between CST scores and examiner opinions of competence. However, Bagby, Nicholson, Rogers, and Nussbaum (1992) found there was little stability in factor structure across studies for the CST, making it difficult to determine just what aspects of competency this instrument measures. Moreover, Grisso (2003) noted high interscorer reliability for total CST scores, but no studies of interscorer reliability for individual items, and factor analyses that vary across samples studied. He raised concerns about the utility of the CST as a screening measure and noted that, in jurisdictions where greater than 20% of defendants are adjudicated incompetent, 10% of the defendants who met the CST cutoff score of 20 or above would be wrongly found competent and tried. In jurisdictions with very low base rates of pretrial incompetence (less than 15%), the CST as a screening device would have a lower hit rate than simply concluding that all defendants are competent. Pirelli et al. (2011) reported that competent defendants scored approximately 10 points higher on the CST than incompetent defendants in the two studies that presented data sufficient to calculate effect sizes in their meta-analysis.

The Interdisciplinary Fitness Interview

Golding, Roesch, and Schreiber (1984) developed the Interdisciplinary Fitness Interview (IFI) to assess symptoms of psychopathology and to assess understanding of legal concepts and functions through a joint interview by a psychologist and a lawyer. Each legal item is rated in terms of the defendant's capacity, and for relevance or importance. Symptoms of psychopathology are rated as present or absent, and for significance. Overall ratings of fit or unfit, and of confidence in that judgment, are made. The potential strength of the instrument lies in its attempt to structure the examiner's assessment of the defendant's functioning in the context of the anticipated demands of his or her legal situation, determined in part through attorney input. The authors reported 95% agreement among the IFI interviewers on opinions regarding competence, substantial interrater reliability on most of the psychopathology items, and correlation of .41 between performance on the IFI and competency opinions of mental health professionals.

Golding (1993) developed the Interdisciplinary Fitness Interview–Revised (IFI-R) in the context of a large-scale study of competency reports (Skeem, Golding, Cohn, & Berge, 1998), but empirical studies of the instrument itself have not been published. The IFI-R may be a promising interview guide or structured professional judgment tool that tailors the assessment to the individual case, ensures lawyer input, and highlights the connection between psychopathology and psycholegal impairment.

The MacArthur Competence Assessment Tool–Criminal Adjudication

Otto and colleagues (1998) developed this CAI from a more extensive research instrument, the MacArthur Structured Assessment of the Competencies of Criminal Defendants (MacSAC-CD). The MacSAC-CD was designed to investigate Bonnie's (1992) two-factor theory of competence, consisting of competence to assist counsel, and decisional competence; to assess capacity rather than merely current knowledge; and to provide quantitative measures of distinct competence-related abilities, such as reasoning (Hoge et al., 1997). The MacSAC-CD distinguished between competent and incompetent defendants and reflected changes in competence status. It correlated positively with clinical judgments of competence abilities, and negatively with measures of psychopathology

and impaired cognitive functioning. On the MacSAC-CD, significant impairments in competence-related abilities were found in about half of defendants with schizophrenia, but there was substantial overlap in scores obtained by defendants with schizophrenia and those without mental illness. Hallucinations and delusions were associated with impairment in defendants with affective disorders. Conceptual disorganization was associated with competency impairment both in defendants with affective disorders and in those with schizophrenia.

The MacArthur Competence Assessment Tool–Criminal Adjudication (MacCAT-CA) is an abbreviated clinical version of the MacSAC-CD that assesses the defendant's ability to *understand* information related to law and adjudicatory proceedings, and *reason* about specific choices that defendants must make. The Understanding and the Reasoning scales are based on a hypothetical legal scenario, whereas the Appreciation scale taps the ability to *appreciate* the meaning and consequences of the proceedings in the defendant's own case, through items that refer to the defendant's specific legal situation.

The initial validation study of the MacCAT-CA (Otto et al., 1998) was based on the responses of 729 felony defendants between 18 and 65 years of age in eight states, who spoke English and had a prorated WAIS-R IQ of at least 60. Three groups were tested: untreated defendants in jail, defendants in jail receiving mental health treatment but not referred for competency evaluations, and defendants admitted to forensic psychiatric units after having been adjudicated incompetent to stand trial. Otto et al. reported good internal consistency for the three measures, and very good–to–excellent interrater reliability. The MacCAT-CA correlated negatively with measures of psychopathology, including the Brief Psychiatric Rating Scale and the MMPI-2 Psychoticism scale, and correlated positively with the measure of cognitive functioning, the WAIS-R prorated IQ. Differences between competent and incompetent defendants on the MacCAT-CA were comparable to those obtained on the CST and the GCCT-MSH. The effect sizes for the Reasoning and Appreciation scales were more robust than those for the Understanding scale. The strength of the Reasoning and Appreciation scales lies in the assessment of different aspects of competence, relevant to decisional competence, that are not tapped by the Understanding scale or by most other competency assessment instruments. However, the unique contribution of the Reasoning Scale may be somewhat limited by the hypothetical rather than case-specific nature of the items on which it is based. The authors noted that the MacCAT-CA does not include measures of response style, and that the possibility of feigning needs to be assessed through other methods. They advocate for the clinical use of the MacCAT-CA in the context of a comprehensive competency evaluation.

Zapf, Skeem, and Golding (2005) conducted a confirmatory factor analysis of the MacCAT-CA that yielded a modified, three-factor model representing both method and construct variance. They found moderate correlations for the MacCAT-CA with intelligence ($r = .42$), and psychopathology ($r = -.36$). They noted that the MacCAT-CA contributes to the assessment of competence by providing normative data, but that the assessment of competency also requires an idiographic, case-specific approach.

Fitness Interview Test

Roesch, Webster, and Eaves (1984) developed the Fitness Interview Test (FIT), a Canadian interview schedule similar to the CAI and the IFI. It contains items focused on legal issues and on assessment of psychopathology. McDonald, Nussbaum, and Bagby (1991) reported a high degree of correspondence between FIT ratings and legal decisions about competence, but the legal decisions were not independent of the FIT ratings. Bagby et al. (1992) found that factor analyses of the FIT legal items failed to yield a stable factor structure across samples, most likely due to the uniformity of item content. The FIT legal items appear to be fairly one-dimensional and may not assess multiple aspects of competence. Moreover, the lack of concrete definitions for rating the items may lead to generalization of ratings across items.

The revised version of this instrument, the FIT-R (Roesch, Zapf, & Eaves, 2006; Zapf & Roesch, 1997), reportedly demonstrated perfect sensitivity and negative predictive power as a screening instrument in a study of 57 male defendants. Based on the FIT-R, 82% of the defendants who were clearly fit to stand trial would have been screened out before being remanded for a lengthy inpatient competence evaluation. Whittemore, Ogloff, and Roesch (1997) analyzed responses of a similar sample to the FIT-R, and to FIT-R items that address ability to make a guilty plea. They suggested the need for a stage-specific approach to forensic competency assessment, with specialized instruments designed to assess the legal issues of competency at various stages of the proceedings.

Zapf (1999) reported a common underlying construct, termed *cognitive organization*, measured by the FIT-R, the MacArthur Competency Assessment Tool–Criminal Adjudication (MacCAT-CA), and the MacArthur Competency Assessment Tool–Treatment. Zapf and Roesch

(2001) found reasonably high agreement between the FIT-R and MacCAT-CA scores.

Viljoen, Roesch, and Zapf (2002) compared FIT-R measures of legal abilities of defendants with psychotic disorders, affective disorders, substance abuse disorders, and no major mental illness. They found that 60% of psychotic defendants were not rated as impaired on the sections of the FIT-R. However, defendants with schizophrenia demonstrated considerably more impairment on legal abilities than did those with delusions. IQ scores significantly predicted understanding of the nature and objective of the proceedings, but not of the possible consequences of the proceedings or ability to consult with counsel. Depression appeared to have a relatively weak relationship with legal impairment, in contrast to bipolar disorder, which was more highly correlated. The authors reported that average interrater reliability for overall determination of fitness on the FIT-R is .98, although reliability for individual sections ranged from .54 to .70.

Computer-Assisted Determination of Competency to Proceed

The CADCOMP is a computer-administered interview, with over 200 questions pertaining to history, demographics, the day of the crime, behavior since arrest, psycholegal ability, and psychopathology (Barnard et al., 1991, 1992). The initial study found a correlation of .55 between competency judgments based on the CADCOMP and competency judgments based on interview by a forensic examiner. This is consistent with the level of predictive validity reported for other competency assessment instruments in the literature. The second study analyzed 18 conceptually developed scales from the CADCOMP using the data obtained from incompetent defendants treated in the same inpatient setting who were either restored to competency or remained incompetent. The scales most predictive of competency opinions reflect lack of knowledge of the adversarial process, lack of appreciation of appropriate courtroom behavior, prominent psychotic features, and cognitive impairment.

The two scales developed to measure the defendant's relationship with counsel did not significantly correlate with examiners' competency opinions, perhaps because the defendants in this hospitalized sample did not have active relationships with their attorneys. Examiners' opinions of incompetence were negatively correlated with criminal history and positively correlated with history of childhood/educational problems. The defendants restored to competency endorsed more items related to substance abuse and antisocial features, whereas defendants who remained incompetent were more likely to have a history of educational problems and/or persisting impairment in thinking, perception, and legal ability.

Although the CADCOMP provides a standardized database for assessing competence, there is insufficient data on competent defendants to calculate effect sizes. Further research would be required to demonstrate utility for clinical/forensic use.

Georgia Court Competency Test

The Georgia Court Competency Test (GCCT; Wildman, Batchelor, Thompson, Nelson, Moore, & Patterson, 1978) uses a courtroom drawing as a reference point for questions about the physical positions and functional roles of court participants in a trial. Additional questions about the defendant's charge(s) and defense are included. Initial findings indicated reliability of .79 across two examiners and scorers on two different administrations, and classification accuracy of 68% to 78%.

Nicholson, Robertson, Johnson, and Jensen (1988) revised the GCCT to create the Mississippi State Hospital version (GCCT-MSH). They added four questions about the defendant's knowledge of courtroom proceedings, changed the weights of some items, and clarified scoring, but they did not change the total or cutoff score. Nicholson et al. reported excellent interscorer reliability ($r = -.95$). Classification accuracy, based on the criterion of independent opinions by experienced forensic clinicians, was 81.8%, with a false-positive rate of 67.7% but a false-negative rate of only 3.8%. Classification and false-positive rates improved when the interval between testing and examiner assessment was less than the average time of 2 weeks. This initial study found that the GCCT-MSH compared favorably to the Competency Screening Test in this setting, even though the base rate of incompetence findings was only 10%.

Nicholson and Johnson (1991) found that the GCCT or GCCT-MSH was the strongest predictor of competency decisions on an inpatient unit, and that the GCCT did not correlate highly with diagnosis. However, all of the variables combined accounted for a relatively small proportion of the variance in competency findings.

A factor-analytic study of the CST, the FIT, and the GCCT-MSH found that only the GCCT-MSH yielded stable, independent factors: general legal knowledge, courtroom layout, and specific legal knowledge (Bagby, Nicholson, Rogers, & Bussbaum, 1992). The investigators noted, however, that the GCCT-MSH does not appear to address ability to consult counsel and assist in one's defense in a comprehensive or conceptually reliable way.

Competency assessment instruments have not been designed to measure response set and generally possess face validity, making them vulnerable to malingering. In an attempt to overcome this problem, Gothard, Rogers, and Sewell (1995) developed the Atypical Presentation Scale (APS): eight yes/no questions related to general courtroom process that varied in terms of bizarre quality, to screen for feigned incompetency on the GCCT-MSH. The initial study produced a 90% classification rate among five groups administered the GCCT-MSH with the APS. These included pretrial defendants identified as suspected malingerers, as competent, or as incompetent, and individuals from a detention center, either instructed to malinger or given standard instructions. The simulators and suspected malingerers scored significantly below the control, competent, and incompetent groups on the GCCT, and significantly above these groups on the Atypical Presentation Scale. Classification accuracy for the Atypical Presentation Scale was 90% overall and 82.6% in distinguishing malingerers from the incompetent group, but this result requires cross-validation.

The Competence Assessment for Standing Trial for Defendants With Mental Retardation

The CAST-MR (Everington & Luckasson, 1992) consists of three scales developed to assist in evaluation of competency to stand trial of mentally retarded defendants. Two are comprised of multiple-choice items—Basic Legal Concepts, and Skills to Assist Defense—based on hypothetical situations the defendant may face in working with his or her attorney. The third scale, Understanding Case Events, consists of open-ended questions tapping understanding of aspects of case events in the defendant's own court case.

Initial studies of reliability and validity were conducted on group home residents with mental retardation; "normal" defendants; defendants with mental retardation who were not referred for competence evaluation; defendants with mental retardation evaluated as competent to stand trial; and defendants with mental retardation evaluated as incompetent to stand trial. These initial studies produced high levels of internal consistency for the three sections of the test, comparable to those obtained with the CST and the GCCT-MSH (Everington, 1990).

Everington and Dunn (1995) found a 70% to 80% agreement rate between examiners' opinions regarding trial competency and scores from blind administration of the CAST-MR. The defendants considered competent had significantly higher scores on the Wechsler Adult Intelligence Scale–Revised (WAIS-R) (mean IQ 66) than those considered incompetent (mean IQ 57). The "competent" defendants scored significantly higher on all CAST-MR scales than the "incompetent" defendants. All CAST-MR scores were significantly correlated with IQ, but the discriminant function yielded a stepwise function for IQ, and for the case-specific, open-ended scale, Understanding Case Events, suggesting that this section of the test contributes to assessment of competence, independent of intelligence.

Everington, Notario-Smull, and Horton (2007) found that adjudicated criminal defendants with mental retardation, instructed to pretend that they did not know the answers to the CAST-MR, scored significantly lower than individuals with mental retardation who completed the examination under standard instructions. These results demonstrate that persons with mental retardation can lower their scores on the CAST-MR when instructed to do so. However, the authors cautioned that individuals with mental retardation are generally acquiescent, and that these results do not establish that they would malinger under standard test instructions.

The Evaluation of Competency to Stand Trial–Revised

Rogers, Tillbrook, and Sewell (2004) developed the Evaluation of Competency to Stand Trial–Revised (ECST-R) to assess aspects of the *Dusky* standard in the defendant's own case, and to screen for feigned incompetency in a standardized manner. The ECST-R contains scales tapping Factual Understanding of the Courtroom Proceedings, and Overall Rational Ability (combined measures of Rational Understanding of the Courtroom Proceedings, and Consult with Counsel). Rogers, Jackson, Sewell, Tillbrook, and Martin (2003) presented evidence of this discrete abilities model of competency to stand trial, based on combined data from six forensic and correctional samples, indicating that assessment of competency to stand trial should consider separately each defendant's factual understanding of the proceedings, rational understanding of the proceedings, and ability to consult with counsel. This study reported evidence of high internal consistency (alphas of .83 to .89) and interrater reliabilities (.97 to .98).

The Atypical Presentation scales of the ECST are comprised of atypical items with obvious psychotic content, atypical items with an affective component, and items tapping realistic, common concerns facing criminal defendants. These items yield scores on five scales. The scales are reported to have high internal consistency and interrater reliability. Most subsequent research on the ECST-R has evaluated feigning on the instrument and the utility

of the Atypical Presentation Scale (discussed ahead in the section on malingering) in detecting such feigning (Rogers, Jackson, Sewell, & Harrison, 2004; Vitacco, Rogers, Gabel, & Munizza, 2007).

Summary

In general, the interview-based instruments, such as the CAI, the IFI and IFI-R, and the FIT and FIT-R, appear to be useful in structuring competence evaluations to include assessment of specific aspects of knowledge-based competence. The IFI/ IFI-R introduce lawyer input and emphasize the relationship between psychopathology and psycholegal impairment. Other instruments, such as the CST, the GCCT-MSH, the CAST-MR, and the MacCAT-CA, yield scores with norms and psychometric properties important for research and for more standardized assessment. The MacCAT-CA shows some promise in contributing incremental validity to a competency evaluation by measuring the understanding and reasoning underlying decisional capacity, an aspect of competence not comprehensively tapped by instruments that assess primarily knowledge-based competence. The ECST-R attempts to differentiate factual and rational aspects of competency, in addition to introducing scales to assess feigning of incompetence. All of these instruments are designed to be used as part of a comprehensive competence assessment that considers multiple sources of data.

Value of Psychological Testing

Although competency assessment instruments focus on functional aspects of competency to stand trial, they do not measure capacity, or whether there is an underlying condition that contributes to a defendant's poor functioning in resolving a criminal case. Psychological testing is particularly helpful in objectively assessing whether displayed deficits are genuine or malingered; the product of mental retardation; associated with cognitive deficits due to traumatic brain injury, brain disease, or dementia; or caused by mood or psychotic disorders. Whereas competency assessment instruments identify possible impairments in competency-related functions, traditional psychological tests may clarify the cause of these potential impairments.

Malingering

Malingering, the exaggeration or fabrication of deficits or symptoms in the context of an external incentive, is typically reflected in three broad domains: psychopathology, cognitive impairment, and physical or medical illness (Rogers, 2008). The differential manifestation of malingering across these three domains has required the development of a variety of techniques for detecting it. Wygant, Sellbom, Ben-Porath, Stafford, Freeman, and Heilbronner (2007) found that individuals' particular response styles are likely dictated by the type of forensic setting in which they are evaluated, in that those in criminal settings tend to present with a more broad-based exaggeration or fabrication of psychological problems, whereas those in civil forensic settings tend to more specifically portray themselves as physically injured or cognitively impaired.

Psychological testing can objectively evaluate the probability of malingering of cognitive deficits motivated by the goal of being found incompetent to avoid prosecution. A number of measures have been developed to assess the malingering of cognitive difficulties, including the Validity Indicator Profile (Frederick, 1997), Word Memory Test (Green, 2003), and the Computerized Assessment of Response Bias. The Test of Memory Malingering has reported levels of sensitivity of 96% to 98% and specificity of 100% (Rees, Tombaugh, Gansler, & Moczynski, 1998). However, others have questioned this sensitivity statistic for the TOMM and recommend other measures, such as the Word Memory Test, in civil forensic settings (e.g., Gervais, Rohling, Green, & Ford, 2004).

In terms of evaluating malingered psychopathology in competency evaluations, a number of omnibus measures are available. The *Structured Interview of Reported Symptoms* (SIRS; Rogers, Bagby, & Dickens, 1992), now with a revised scoring algorithm (SIRS-2; Rogers, Sewell, & Gillard, 2010), performs quite well in differentiating malingerers from non-malingerers in criminal forensic settings, but not with the extremely low false-positive error rate the manual professes (Green & Rosenfeld, 2011).

Personality inventories, such as the Minnesota Multiphasic Personality Inventory–2 (MMPI-2; Butcher, Graham, Ben-Porath, Tellegen, Dahlstrom, & Kaemmer, 2001), and the more recent alternative, the MMPI-2 Restructured Form (MMPI-2-RF; Ben-Porath & Tellegen, 2008), as well as the Personality Assessment Inventory (PAI; Morey, 1991, 2007) and the Millon Clinical Multiaxial Inventory–III (MCMI-III; Millon, Davis, & Millon, 1997), have validity scales designed to measure response bias. These scales tend to work quite well in detecting overreported psychopathology in criminal forensic settings (e.g., Hawes & Boccaccini, 2009; Rogers et al., 2003; Sellbom & Bagby, 2008; Sellbom et al., 2010), with the possible exception of the MCMI-III validity scales (see Sellbom & Bagby, 2008, for a review). Most of this research has only examined the utility of the

malingering measures in the context of pretrial forensic evaluations, such as evaluations of competency to stand trial. However, Miller (2004) examined 50 patients found incompetent to stand trial due to mental illness. Results indicated that the MMPI-2 validity scales were strongly correlated with SIRS scores, lending good convergent evidence for the two instruments in this setting.

Instruments designed to assess competency have generally not been designed to measure response bias and possess face validity, making them vulnerable to dissimulation. In an attempt to overcome this problem, Gothard, Rogers, and Sewell (1995) developed an Atypical Presentation Scale for the GCCT, consisting of eight questions varying in level of bizarreness. Pretrial defendants evaluated as competent, incompetent, or suspected malingerers were administered the test. A control group of sentenced inmates and a group of sentenced inmates instructed to feign incompetence, both without histories of psychiatric treatment or findings of incompetence, were also tested. The simulators and suspected malingerers scored significantly below the control, competent, and incompetent groups on the GCCT, and significantly above these groups on the Atypical Presentation Scale. These results confirm that individuals with experience in the criminal justice system can modify their responses to a face-valid competency assessment instrument such as the GCCT. However, the specificity and sensitivity of cutoff scores in differentiating malingerers from incompetent defendants on the GCCT was low. Classification accuracy for the Atypical Presentation Scale was 90% overall and 82.6% in distinguishing malingerers from the incompetent group, but this result requires cross-validation.

Gothard, Viglione, Meloy, and Sherman (1995) elaborated on these results using the SIRS as a criterion for malingering. The investigators suggested that a total GCCT score of less than 60, endorsement of items on the Atypical Presentation Scale (ATP), and an unexpected pattern of correct and incorrect responses based on item difficulty are promising approaches to assessment of malingering of incompetence. However, they cautioned that the assessment of malingering requires a comprehensive, multimethod assessment, including the SIRS, the MMPI-2, and measures of malingering of cognitive deficits when appropriate. Rogers, Grandjean, Tillbrook, Vitacco, and Sewell (2001) recommend the clinical use of the GCCT, without cut scores, as a screening instrument to identify potential competency deficits and potential feigning for further evaluation.

Rogers and his colleagues have since extended the use of the ATP to the Evaluation of Competency to Stand Trial–Revised (ECST-R), a standardized interview designed to assess dimensions of CST and to screen for feigned CST. The ATP was expanded into three subscales: ATP-Psychotic, ATP-Nonpsychotic, and ATP-Realistic, as well as an ATP-Impairment index that focuses on the overall ATP-P and ATP-N score. Rogers et al. (2004) examined the effectiveness of the ATP scales in detecting feigned incompetency. Comparisons of ATP scales yielded very large effect sizes when differentiating patients asked to feign incompetency from jail inmate controls (mean $d = 2.50$), and from defendants found incompetent to stand trial and hospitalized for competency restoration treatment (mean $d = 1.83$). Vitacco, Rogers, Gable, and Munizza (2007) also reported promising results for the ATP scales. However, the Miller Forensic Assessment of Symptoms Test (M-FAST; Miller, 2001), a general malingering screen, performed better as a screen for malingering with 100 forensic defendants involved in competency evaluations who had been divided into malingering and non-malingering groups based on the SIRS.

Finally, the Inventory of Legal Knowledge (ILK; Otto, Musick, & Sherrod, 2010) is a 61-item, true–false measure that was designed to measure dissimulation associated with deficits in specific legal knowledge. Guenther and Otto (2010) found that the ILK demonstrated promising utility in differentiating 76 college students asked to feign legal deficits in the context of a competency evaluation from 100 genuine psychiatric patients. Otto, Musick, and Sherrod (2011) found that the ILK exhibited moderate correlations with other response bias measures in a sample of criminal defendants.

Cognitive Functioning

Two meta-analyses have examined the associations between intelligence and competency. Nicholson and Kugler (1991) reported a small, but statistically significant, negative relationship between findings of incompetency and intelligence test scores (–0.16). Two decades later, Pirelli et al. (2011) extended these analyses with three studies of Full Scale IQ score differences between competent and incompetent defendants that produced a small-to-medium effect size of approximately six Full Scale IQ points. They found similar results in studies using Performance IQ or Verbal IQ on Wechsler measures, and for Verbal Cognitive Functioning (Vocabulary, Similarities, and Digit Span from the WAIS-R) with medium effect sizes ($r = 0.32$–0.38).

One study (Otto et al., 1998) examined the associations between the MacCAT-CA and Full Scale IQ

scores derived from the Wechsler Adult Intelligence Scale–Revised. The results indicated that intelligence was moderately correlated with the MacCAT-CA Reasoning and Understanding scores, but uncorrelated with the Appreciation score. A second study (Nestor, Daggett, Haycock, & Price, 1999) was based on the WAIS-R administered as part of a comprehensive neuropsychological battery to defendants being evaluated for trial competency. The authors found significant differences on tests of verbal reasoning, episodic memory, and social judgment between competent and incompetent defendants. Grandjean (2004) reported that competent defendants differed from incompetent defendants on measures of verbal memory, verbal comprehension, social judgment, and executive functioning, but not on visual memory or skills, nor attention. In a sample of mentally retarded defendants, Everington and Dunn (1995) found a high correlation between WAIS-R IQ and performance on the knowledge-based scales of the CAST-MR.

Most recently, Ryba and Zapf (2011) examined the association between cognitive functioning and competency-related abilities in a sample of 77 male forensic patients who had been administered the MacCAT-CA. Cognitive abilities accounted for a substantial amount of variance in all three competency abilities (Understanding, Reasoning, and Appreciation), even more so than did psychopathology factors. Psychosis moderated the association between cognition and reasoning abilities in that this relationship was stronger when a patient was also psychotic. Such data establish a causal link between observed deficits in competence functions and underlying cognitive disorders.

Personality/Psychopathology Functioning

Personality assessment instruments can aid in assessing psychopathology and/or personality functioning potentially relevant to evaluation of competency to stand trial. In particular, symptoms of disordered thinking may impact reasoning ability, including the capacity to understand the criminal proceedings and to plan a rational defense strategy in consultation with counsel. Beyond the validity scales studies cited earlier, neither the PAI nor the MCMI-III has been directly examined within the context of competency-to-stand-trial evaluations.

The MMPI-2 is the psychological test most widely used in forensic cases as a measure of symptoms and traits associated with psychopathology and other behavioral and/or personality factors that may relate to trial competency (Archer, Buffington-Vollum, Stredney, & Handel, 2006; Lally, 2003; Pope, Butcher, & Seelen, 2000). The MMPI-2 and the most recent version, the MMPI-2-RF, have sets of scales that are designed to assess response set to the evaluation, as well as aspects of personality and psychopathology potentially relevant to competency to stand trial. In addition to measures of lack of cooperation, symptom exaggeration, and defensiveness, these instruments provide considerable information about psychotic and manic symptoms that might impair a defendant's capacity for rational reasoning about his or her case (Sellbom & Ben-Porath, 2006), and various antisocial and psychopathic personality proclivities that might increase the risk for malingering of psychotic symptomatology (Sellbom, Ben-Porath, & Stafford, 2007).

The MMPI-2 has been specifically examined with individuals adjudicated competent or incompetent to stand trial, though the literature has been somewhat sparse in this regard. An early study by Cooke (1969) found that 93 individuals adjudicated incompetent scored significantly higher on the F validity scale as well as Clinical Scales 2, 3, 4, 6, 7, and 8, relative to 122 patients who had been found competent to stand trial. Maxson and Neuringer (1970) replicated these findings in a larger sample ($n = 594$) but found only differences on the F scale and Clinical Scale 6. In a similar design at a Canadian inpatient unit, Rogers et al. (1988) found negligible differences only on Clinical Scale 9. Most recently, Otto et al. (1998) reported moderate negative correlations between the MMPI-2 Psychoticism scale and the Reasoning and Understanding domains of the MacCAT-CA in a large sample of individuals evaluated for competency.

These results have been summarized in two meta-analyses. Nicholson and Kugler (1991) found small but significant correlations for scales F, 6, and 8 of the MMPI/MMPI-2 with findings of incompetence. Pirelli et al. (2011), using many of the same studies, reported that the effect sizes for MMPI scales F, 6, and 8 were in the small-to-moderate range (0.33, 0.39, and 0.33, respectively), as incompetent defendants produced higher-than-average scores on these scales that assess symptoms of psychopathology. They noted that traditional assessment instruments can be useful in competency evaluations for specific reasons.

Many of these studies have significant limitations, particularly in terms of criterion contamination, in that the MMPI/MMPI-2 results were most likely considered in reaching the opinion about trial competency. Future research with meaningful external criterion measures would be helpful in evaluating the role of the MMPI-2, PAI, and other traditional assessment instruments in competency evaluations.

Competence Evaluation Reports

There are a number of published studies on competence evaluation reports. The authors of many of these studies report a high level of agreement between clinician opinions of individual defendants' competence to stand trial. For example, Poythress and Stock (1980) found 100% agreement between pairs of clinical psychologists who interviewed 44 defendants and then independently reached opinions regarding competence. Other investigators have focused on the statistical relationship between opinions regarding competence and variables rationally expected to be associated with findings of competence or incompetence (e.g., Nicholson & Kugler, 1991, and Pirelli et al., 2011).

Skeem, Golding, Cohn, and Berge (1998) analyzed 100 competence reports completed on 50 defendants, each evaluated independently by two examiners. The reports were coded for documentation of statutory criteria, the demands of the defendant's specific legal situation, substantiation of diagnosis, medication issues, possible malingering, use of psychological testing, and disclosure regarding the purpose and confidentiality of the evaluation.

In 53% of the reports, the examiners had opined that the defendant was incompetent to stand trial. Most reports addressed the defendant's appreciation of the charges and proceedings, but decisional abilities were addressed relatively infrequently. For example, only 12% of reports addressed the implications of a guilty plea, even though all of the defendants who returned to court engaged in plea bargaining. Most reports provided data supporting clinical opinions, but only 10% provided data or reasoning regarding the relationship between symptoms of psychopathology and psycholegal deficits. Although examiners agreed in 82% of the cases on the defendant's global competence, they agreed only 25% of the time about the particular psycholegal impairments on which their opinions were based. Competency assessment instruments were rarely used, and the results of psychological testing were linked to opinions about competence in fewer than half of the cases in which testing was employed. Few examiners contacted the defendant's attorney or reviewed treatment records for the evaluation.

Based on their research, the authors recommended that examiners address key psycholegal abilities and consider the demands of the case, particularly in terms of the decisions the defendant would be expected to make. These decisions include choosing a plea, and waiver of constitutional rights, such as the right to counsel, the right to trial, the right to a jury trial, and the right to testify.

The authors further recommended gathering data from a variety of sources. These include third-party information from legal and mental health records; input from defense counsel regarding concerns about the defendant's competence, the likely demands of the case and defense strategy, and the attorney–client relationship; competency assessment instruments; and targeted psychological testing.

Skeem et al. (1998) further recommended that competence reports include reasoning to support conclusions about the defendant's psychopathology, specific psycholegal abilities and impairments, and the relationship, if any, between psychopathology and deficits in competence. They recommended explaining the results of psychological testing by addressing their relevance to any psychological conditions that could account for observed impairments in the defendant's psycholegal functioning. For defendants on psychotropic medication at the time of the evaluation, they recommended explaining the effect of the medication on the defendant's current mental state, and explaining possible changes in mental state since the time of the offense attributable to current medication.

Zapf and Roesch (2009), in their volume on evaluation of competence to stand trial, provide a comprehensive guide to conducting competence evaluations and communicating the results through reports and testimony. There are other sources of specific information regarding the process of competence evaluation and communication of results (e.g., Melton, Petrila, Poythress, & Slobogin, 2007; Stafford & Sadoff, 2011.)

TRIAL COMPETENCE IN SPECIAL POPULATIONS

Potential causes of impairment severe enough to potentially affect a defendant's competency to stand trial are considered in this section.

Psychotic disorders, mental retardation, and speech and hearing impairments each present challenges to the adjudication of criminal cases.

Psychosis

Nicholson and Kugler (1991) reported significant correlations between symptoms of psychosis and findings of incompetence as a result of their meta-analysis. The correlations between incompetence and factors related to mental illness, such as psychosis, delusions, hallucinations, and disturbed behavior, ranged from 0.25 to 0.45.

In a more recent meta-analysis, Pirelli et al. (2011) reported that defendants diagnosed with a psychotic

disorder were 8 times more likely to be found incompetent than defendants without such a diagnosis. The likelihood of being found incompetent was also double for individuals with a previous psychiatric hospitalization, compared to those never hospitalized. The third most robust finding, a rate of unemployment twice as high for incompetent than competent defendants, is likely to reflect the higher rate of unemployment among the severely mentally ill.

Goldstein and Burd (1990) published a review of the case law on the role of delusions in trial competency and the clinical implications of this body of law for competency evaluation. They reported that delusional defendants may appear to have a rational and factual understanding of the proceedings against them, and they may appear to demonstrate the ability to consult rationally with their attorneys, during a cursory, structured interview. However, a thorough assessment is often required before delusional thinking surfaces, and the impact of such thinking on trial competency needs to be explored fully. Delusions may directly interfere with the defendant's perception of the nature and objectives of the proceedings and with the ability to assist in his or her own defense. For example, the New Hampshire Supreme Court in *State v. Champagne* (1985) noted that the defendant could accurately answer simple yes/no questions about the proceedings, but if "the questioning proceeded at any length . . . the defendant's delusions and loosening of association took over, so that his first answer would not be a reliable indicator of his thinking" (p. 1247). The court ruled that, although the defendant understood the roles of various court personnel, the role of the jury in determining guilt or innocence, and the charges against him, he was incompetent to stand trial. His paranoid delusions impaired his "ability to communicate meaningfully with his lawyer so as to make informed choices regarding trial strategy" (p. 1245) and "so imbued the defendant's thought processes that he could not rationally understand the nature of the proceedings against him" (p. 1246). This case and others emphasize the importance of a comprehensive evaluation to assess the impact of delusions on trial competency, competency to waive counsel, and competency to waive the insanity defense. Goldstein and Burd (1990) further noted that competency assessment of psychotic defendants requires consideration of the likelihood of deterioration in the defendant's mental state prior to the resolution of the case, factors likely to precipitate deterioration, and possible signs of such deterioration. Other cases cited by the authors (e.g., *State v. Hahn,* 1985; *Pride v. Estelle,* 1981) have reinforced the need for inquiry into the defendant's education, literacy, background, prior court experience, and psychiatric treatment history, and for the use of psychological testing, in competency assessment.

Psychotic symptoms, although not synonymous with incompetence, contribute significantly to consideration of the capacity of the defendant to proceed to trial. They also have implications for recommendations for competency restoration, including psychiatric hospitalization, treatment with psychotropic medications, and potential need to explore involuntary administration of medication (Brinkley & DeMier, 2009).

Mental Retardation

The development of the CAST-MR by Everington and Luckasson (1992) illustrates the particular challenge of determining whether defendants with mental retardation are competent to proceed with their criminal cases. Bonnie (1990) reported that mentally retarded defendants constitute 2% to 7% of competence evaluation referrals, but that as many as half of mentally retarded defendants are not referred for competence evaluation. Everington and Dunn (1995) found that 57% of 35 mentally retarded defendants referred for competency evaluations to outpatient forensic centers in Ohio were considered incompetent to stand trial.

Cochrane, Grisso, and Frederick (2001) reviewed literature reporting a 12% to 36% rate of incompetence among mentally retarded defendants referred for competency evaluation. Their own study of 1,436 defendants referred for competency evaluation to a federal medical center found that of the 33 mentally retarded defendants evaluated, 30% were considered incompetent, comparable to the rate of mentally ill defendants evaluated as incompetent to stand trial.

In a Canadian study, Ericson and Perlman (2001) compared adults with IQ scores in the borderline-to-mentally retarded range (50–75) with adults of average intelligence on knowledge of 34 legal terms. The mentally retarded adults scored significantly lower on conceptual understanding of almost all the terms, and 45% did not understand the concept of *guilty.* Only 8 of the 34 terms were reasonably understood by at least 75% of the mentally retarded adults. In addition, there were discrepancies of approximately 20% between subjects' report of familiarity with concepts and their actual understanding of the concepts. Mentally retarded subjects frequently reported familiarity with a term when they clearly did not understand what it meant. The investigators noted that this result is consistent with other findings indicating that mentally retarded individuals are likely to acquiesce rather

than report they do not know information, particularly to authority figures. The authors recommend the use of open-ended rather than yes/no questions, in assessing the competency of defendants with below-average intelligence, and the use of language appropriate to their level of understanding, to facilitate participation in court proceedings.

Speech and Hearing Impairment

The special case of the deaf defendant is epitomized by Theon Jackson, the defendant in *Jackson v. Indiana* (1972), who was indefinitely committed as incompetent to stand trial with virtually no likelihood of becoming competent. Vernon, Steinberg, and Montoya (1999) presented data on 28 deaf defendants charged with murder and referred for evaluations to assist in trial or treatment planning. Twenty-eight percent had been psychiatrically hospitalized in the past, and an additional 32% had been treated as outpatients. Fifty percent of the defendants were diagnosed with antisocial personality disorder and had criminal histories, and 64% had a history of substance abuse. The mean IQ of the group was 100, but more than half had indications of neurological impairment associated with the underlying etiology of deafness and of violent behavior. Fewer than half were proficient in American Sign Language (ASL). Of these 28 defendants, 18 pled guilty or were convicted; three were found incompetent to stand trial due to mental illness. Five of these defendants were released because of linguistic incompetence or because they had not been administered the *Miranda* warning in a manner that they could comprehend. The evaluators reported that 13 of the defendants were sufficiently limited linguistically that a strong case could have been made for their incompetence.

The authors discussed particular conceptual difficulties with trial competence for deaf defendants, who may be illiterate, have a poor understanding of sign language, have considerable information gaps, or may never have developed a formal language system. They recommended that practitioners not competent in sign language use interpreters, preferably those with legal interpreting certificates, in conducting competency evaluations of deaf defendants. They noted that there are few formal signs for most legal concepts and terms used in court proceedings. Therefore, a team of interpreters is often necessary in court, so that one interpreter can translate from English to ASL, and a second from ASL to the defendant's own idiosyncratic "language" of gestures, signs, and mime.

Wood (1984) reviewed case law relevant to the efforts of courts to protect the rights of deaf suspects to understand criminal proceedings, with a particular emphasis on sign language interpreting, and including a model statute. The National Center for Law and Deafness (1992) has published a guide to legal rights for deaf and hard-of-hearing people.

Interventions for Competence Deficits

After a defendant is found incompetent to stand trial, the next step varies. Depending on the extent and likely cause of the difficulties, and the demands of the case, the defendant may be provided special assistance, or the proceedings themselves may be modified, to allow for resolution of the case. If the defendant is considered unlikely to become competent, criminal proceedings may be dismissed and civil commitment could be considered. If the defendant is predicted to be likely to become competent with treatment, he or she may be committed to a hospital or ordered to comply with recommended treatment in another setting. Further discussion of these options follows.

Competency Assistance

The concept of competency assistance (Keilitz, Monahan, Keilitz, & Dillon, 1987) is based on alternatives that are used to enhance defendants' ability to understand the proceedings and to assist in their defense. For example, interpreters for defendants who are deaf or hearing impaired or not facile in English are broadly mandated. Psychotropic medication to establish or maintain competence is allowed by law, with some safeguards (e.g., *Sell v. United States,* 2003).

Keilitz et al. (1987) reported that some courts permit counsel to proceed with defenses that do not require the assistance of incompetent defendants, such as insufficiency of the indictment, statute of limitations, and double jeopardy. In some states, defense counsel may request "innocence-only trials," in which the court hears evidence. Keilitz et al. reported, based on the results of their mail survey of trial judges, that most of the judges estimated that fewer than 10% of criminal defendants in their courts presented with suspected "trial disabilities" (sensory and communication problems, mental illness, mental retardation, learning disabilities, or epilepsy). The judges reported making a number of accommodations to assist such defendants. They might appoint defense lawyers with experience working with trial-disabled defendants and/or a *guardian ad litem*. A "support person" might be permitted to sit at the defense table. Judges were willing to schedule hearings at less hectic times of the day, to take a more tolerant approach to aberrant behavior in the courtroom, and to conduct the

proceedings with simpler language and at a slower pace. Judges also reported that they would allow testimony about the defendant's difficulties at trial, if relevant.

This notion of competency assistance is also consistent with the recommendations of the court in *Wilson v. United States* (1968). For amnestic defendants, the court suggested that providing additional discovery information to the defense might assist in the reconstruction of events at the time of the offense and increase the likelihood that the defendant could proceed with the case.

Research by Poythress et al. (1994) indicates that attorneys who doubt their clients' competence but do not seek competency evaluations use compensatory strategies to facilitate their clients' participation in the proceedings. These accommodations include spending more time with the client, involving family members in decision making, modifying their approaches to consulting with clients to minimize impairments, and consulting other attorneys for advice.

Similarly, if defendants referred for competency evaluation appear marginal in their capacity to proceed with the case, the evaluator can recommend specific accommodations to assist them in moving forward with the case. For example, when defendants with paranoia have difficulty working with a particular attorney, the possibility of a change in court-appointed counsel could be raised. A recommendation for supportive counseling for an overly anxious defendant awaiting trial would be likely to improve his or her ability to work actively with counsel. The competency report could include the option of referral for an updated competency evaluation if a defendant with a history of deteriorating under stress or discontinuing treatment appears to deteriorate before the case is resolved, or if there is an unforeseen complication in the proceedings (such as a defendant's attempt to waive the right to counsel, a supplementary indictment, or a more serious or complex charge). This is consistent with the notion raised by Whittemore et al. (1997) about a "stage-specific" approach to competency assessment.

Predicting Competency Restoration

In some jurisdictions, the prediction of a defendant's restorability to competence is mandated at the time of evaluation; other jurisdictions allow for a trial of treatment to determine whether the defendant is likely to become competent to stand trial. As described earlier, in *Jackson v. Indiana* (1972), the U.S. Supreme Court ruled that an incompetent defendant cannot be committed longer than "a reasonable period of time necessary to determine whether there is a substantial probability that he will attain the capacity in the foreseeable future" (pp. 737–738).

The literature on competency restoration indicates that most defendants are restored to competency. Cuneo and Brejle (1984) reported a restoration rate of 74% within 1 year. Restoration rates of 95% after an average of 2 months were reported by Nicholson and McNulty (1992), and of 90% after a mean hospital stay of over 280 days (Nicholson, Barnard, Robbins, & Hankins, 1994). Carbonell, Heilbrun, and Friedman (1992) reported that approximately two thirds of incompetent inpatients were restored after 3 months of treatment. None of these investigators were able to develop prediction models that improved on predictions that all incompetent defendants would be restored to competence.

Other research suggests that the use of medications to treat psychotic symptoms is the only reliable correlate of competence restoration (Carbonell et al., 1992). Golding (1992) noted that, because psychosis correlates highly with findings of incompetence, examiners do not carefully distinguish between psychotic symptoms and psycholegal impairments, and competency treatment programs rely primarily on treatment with psychotropic medication. As a result, predicting restorability often becomes a matter of predicting response to antipsychotic medication.

Studies examining the variables associated with successful restoration have yielded mixed findings. Some studies have suggested that factors associated with failure of efforts at competence restoration and greater lengths of hospital stay include severe impairment in psycholegal ability, aggression toward others after arrest, and more severe psychopathology. A history of criminality and substance abuse at the time of the offense are associated with successful restoration (Cuneo & Brejle, 1984; Nicholson et al., 1994; Scott, 2003).

Anderson and Hewitt (2002) reported rates of competency restoration for defendants with mental retardation of 22% to 33%. Wall, Krupp, and Guilmette (2003) noted that this rate also applies to restoration programs specifically designed for defendants with mental retardation.

Warren et al. (2006) reviewed 8,416 competency evaluations conducted in Virginia over a 12-year period. They reported that 19% of the defendants were considered incompetent to stand trial by the examiners. Of these incompetent defendants, the examiners predicted that 51.5% were likely to be restored to competency, and that 23.0% were not likely to become competent. Examiners were uncertain about the restorability of the remaining 25.5% of the incompetent defendants. Defendants considered likely to become competent were more likely to have

had prior convictions and to be diagnosed with psychotic or affective disorders, and less likely to be diagnosed with organic or intellectual/learning deficit disorders. However, outcome data regarding actual restoration were not reported.

Mossman (2007) analyzed data from records of all 351 defendants treated for competency restoration at a state psychiatric hospital between 1995 and 1999. Most defendants were either committed for competency restoration with an order for involuntary medication, or such an order was readily obtained if the defendant refused prescribed psychotropic medications. Defendants who were identified as not restorable were more likely to be older, to be facing misdemeanor charges, to have longer hospital stays, and/or to be diagnosed with mental retardation, schizophrenia, or schizoaffective disorder. Although the overall rate of restoration for felony defendants was 75%, logistic equations allowed selection of subgroups with high (>90%) and low (<35%) predicted probabilities of restoration. Two types of incompetent defendants had well-below-average probabilities of being restored: chronically psychotic defendants with histories of lengthy inpatient hospitalizations, and defendants whose incompetence stemmed from irremediable cognitive disorders. However, Mossman noted that, "even when an evaluator identifies a defendant with a well-below-average probability of restoration, that defendant's likelihood of becoming competent with treatment may still be 'substantial' enough for a court to order time-limited attempts at restoration" (p. 41).

Similarly, Wolber (2008) reported results of a survey of 48 states indicating that defendants with significant cognitive impairment (developmental disability, brain injury, or dementia) were generally considered to be incompetent to stand trial and not restorable after a period of 1 to 3 months of attempted treatment. However, defendants with psychosis that was unresponsive to medications could be provided treatment for a period of a year or more before they were determined to be not restorable to competency.

Given the low base rate associated with failure to be restored to competence, it is probably most accurate to predict that all psychotic defendants will be restored to competence. Carbonell et al. (1992) recommended a "demonstration model" with a period of varied treatment for all incompetent defendants until competency appears to have been restored, or until it seems reasonably clear that competency will *not* be restored in the foreseeable future. However, there are a small number of incompetent defendants with major, irreversible cognitive disorders, such as dementia, autism, or moderate mental retardation, for whom it may be reasonable to predict that they will not become competent without an attempt at treatment designed for competency restoration.

Treatment of Defendants Adjudicated Incompetent

Based on estimates of 60,000 competence evaluations per year (Bonnie & Grisso, 2000) and up to a 30% rate of findings of incompetence (Nicholson & Kugler, 1991), approximately 18,000 defendants are found incompetent to stand trial each year. On any given date, it has been estimated that defendants hospitalized for competence restoration occupy approximately 4,000 psychiatric beds in the United States, or about one ninth of the nation's state psychiatric hospital beds (Mossman, 2007).

Major mental illness, mental retardation, or other cognitive limitations are the most frequent causes of adjudicative incompetence. Competency restoration of defendants generally requires two levels of intervention: (1) treating the underlying mental condition related to inability to understand the proceedings and/or assist counsel; and (2) targeting the specific deficits the defendant has in understanding the criminal proceedings he or she faces, and in assisting counsel in his or her defense, through information and training. Consultation with defense counsel to understand counsel's concerns about competency, and to clarify what the defendant needs to understand and be able to do in resolving the case he or she faces, is helpful in individualizing competency restoration treatment. Competency restoration is usually provided in inpatient mental health facilities operated by the state or federal government in the vicinity of the jurisdiction where the defendant is charged. Hospital-based competency restoration is indicated when the defendant poses an imminent risk of harm to self or others due to severe mental disorder, when there is a question about diagnosis or malingering that requires close observation to assess or treat, or when the defendant lacks the capacity to consent to psychotropic medications and is likely to require the involuntary administration of medication for restoration to competence.

Outpatient competency restoration of defendants on bond is occasionally ordered. However, outpatient restoration is generally limited to defendants charged with nonviolent offenses who have sufficient community support to keep appointments and who are able to cooperate with treatment. This option is most likely to be effective in communities with outpatient competency restoration programs suitable for the needs of the defendant, and for defendants with mental retardation, cognitive or

developmental disorders, or major mental illness who do not pose a risk to self or others in the community, and have a stable, safe residence.

Descriptions of competency treatment programs in the literature primarily describe hospital-based treatment consisting primarily of psychotropic medication and didactic programming focused on knowledge-based competence (e.g., Brown, 1992; Davis, 1985; Mueller & Wylie, 2007; Samuel & Michals, 2011; Siegel & Elwork, 1990; Wall, Krupp, & Guilmette, 2003). Mossman et al. (2007) proposed nine elements of a model competence restoration program that has been endorsed by the American Academy of Psychiatry and the Law: (1) systematic competence assessment; (2) individualized treatment program; (3) multimodal experiential competence restoration educational experiences; (4) education regarding court proceedings; (5) anxiety reduction; (6) additional educational components for defendants with low intelligence; (7) periodic reassessment of incompetence; (8) medication; and (9) capacity assessments and involuntary treatment.

Permanently Incompetent Defendants

Morris and Meloy (1993) summarized data on California defendants hospitalized for as long as 3 years in failed attempts to restore them to competence, and then held under conservatorship for up to 4 additional years. They concluded that the Supreme Court's holding in *Jackson v. Indiana* (1972) has been circumvented in many jurisdictions by statutory provisions that permit civil commitment of permanently incompetent defendants using criteria different from those applied to other civil patients.

Samuel and Michals (2011) concluded, based on their review of this literature on competency restoration, that 80% to 90% of defendants with mental illness can be restored to competence, typically within less than 6 months. They reported that only a third to a half of mentally retarded defendants attain competency, and then generally following a longer period of time and treatment.

CONCLUSION

Competence to stand trial is a constitutional prerequisite to adjudication of criminal cases, and essential to preserving the fairness, accuracy, and dignity of criminal proceedings. Psychologists are called on to address the issue of competence more often than any other issue in criminal law. Increasingly, case law developments and psychological formulations of the concept of trial competence have focused on not only the knowledge-based or foundational aspects of competence, but the decisional aspects as well. Competency assessment instruments, multiple sources of data, the relationship between psycholegal impairments and symptoms of psychopathology, and the fluid nature of competency across time and across specific case demands are all aspects of the evaluation of trial competence. Prediction of restorability, treatment, including the use of involuntary medication, for competency restoration, the needs of special populations, competency assistance strategies, and the problem of the permanently incompetent defendant highlight the complexity of the issue. Psychology makes a significant contribution to the understanding of trial competence through the development of measures, theoretical and empirical research, assessment and treatment, and consultation with courts and attorneys.

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