Commentary: A Road Map for Research in Restoration of Competency to Stand Trial

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Competency to stand trial (CST) evaluation requests are the most common referrals for criminal forensic examinations.[1,2] Surveys indicate that public defenders have concerns regarding CST in approximately 10 to 15 percent of their clients[3] and that there are nearly 50,000 evaluation requests each year.[4] These assessments are conducted in a variety of settings that include local jails, community mental health facilities, outpatient treatment centers, court clinics, and inpatient psychiatric settings.

Once defendants are adjudicated incompetent to stand trial (IST), they are often involuntarily hospitalized in a psychiatric facility where treatment programs designed to restore competency are offered. A significant amount of mental health resources are allocated for inpatient competency-restoration programs. As many as 9,000 inpatient psychiatric beds are reserved for IST defendants[5] with more than 3,000 of those provided by forensic psychiatric facilities.[6] Although significant literature has been published regarding assessments of CST, more research regarding effective and efficient methods of improving or restoring CST deficits in criminal defendants needs to be undertaken.

In their paper, Dr. Bertman and coauthors[7] make a serious effort to study the effectiveness of three CST restoration treatment approaches. They found that individualized treatment focusing on specific competency deficits did not show a significant improvement on post-test competency scores compared with individualized treatment focusing on general legal rights education. The authors conclude that a focus on individual deficits may not be a particularly useful competency restoration strategy. Of potential importance, the authors comment that the addition of six individual treatment sessions to standard hospital treatment resulted in greater improvement on competency measures than did standard hospital group treatment (four group sessions) alone.

The work of Dr. Bertman *et al*. highlights many difficulties that the forensic mental health researcher faces when conducting a study of criminal defendants. In this commentary, I will discuss the relevant literature regarding CST evaluations as well as research challenges in this field in general and those noted in this particular study.

Overview of CTS Evaluations and Assessment Instruments

The legal standard for assessing a defendant's CST was articulated in *Dusky v. U.S.* In this 1960 landmark case, the U.S. Supreme Court announced, "the test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding and whether he has a rational as well as factual understanding of the proceedings against him" (Ref 8, p 789). More recently, clinical researchers have divided each *Dusky* element into three prongs: (1) factual understanding of the proceedings; (2) rational understanding of the proceedings; and (3) ability to consult with counsel.[9–10]

Although the *Dusky* standard does not specifically state that a mental illness or defect must be present,

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most defendants found IST are diagnosed as having some type of mental disorder. Psychotic disorders are the most common diagnoses among criminal defendants referred for CST evaluations and subsequently found IST. In assessing the frequency of an IST finding with defendants referred for an evaluation, research indicates that between 45 and 65 percent of defendants with schizophrenia or other psychotic illnesses are found incompetent,[2,11–13] between 23 and 37 percent of defendants with affective disorders are found incompetent,[2,14–15] and between 12.5 and 36 percent of individuals with mental retardation (MR) are found incompetent.[2,12,16] In a study published by the MacArthur Foundation Research Network on Mental Health and the Law,[14] 65 percent of defendants hospitalized as IST had a diagnosis of schizophrenia and 28 percent had a diagnosis of an affective disorder. Although the presence of psychosis does not necessarily lead to a finding of IST, research indicates that active psychotic symptoms (such as hallucinations and conceptual disorganization) are strongly correlated with impairments in trial-related abilities.[9,14,17–18]

Various self-report and interview instruments have been developed to assist the evaluator in assessing a defendant's CST. Because these tools may be useful in research protocols examining competency restoration, a brief review of relevant instruments is provided. CST instruments that have not gained wide acceptance in CST evaluations include self-report scales such as the Competency Screening Test[19–20] and the Computer-Assisted Determination of Competency to Proceed (CADCOMP).[21] Interview-based measures include the Competency to Stand Trial Assessment Instrument (CAI)[5] and the Interdisciplinary Fitness Interview (IFI),[22] neither of which has been recently researched.

The Georgia Court Competency Test-Mississippi State Hospital (GCCT-MSH) is one of the most commonly used screening tests for CST. The test takes between 15 and 20 minutes to administer and includes three sections. The first section requires a visual identification regarding location of courtroom participants and their corresponding roles in court, and the second section provides eight questions to assess a defendant's ability to assist counsel.[23] The third section consists of the Atypical Presentation Scale (APS), consisting of eight items, and used to screen for possible malingering. In one study, 90 percent of individuals who scored 6 or higher on the APS were correctly classified according to whether they were feigning incompetency.[24] Although a total score of 70 or greater on the GCCT-MSH suggests that the defendant has sufficient understanding of courtroom procedures,[25] this score is not equivalent to legal competency. The GCCT-MSH has been criticized for focusing primarily on a defendant's factual understanding of courtroom proceedings, with less focus on a rational understanding of the legal process and with minimal attention to a defendant's ability to assist counsel.[1]

The MacArthur Competence Assessment Tool-Criminal Adjudication (Mac-CAT-CA) is a commercially available CST evaluation instrument. This tool uses a hypothetical example involving an alleged assault between two men in a pool hall. As with the GCCT-MSH, the Mac-CAT-CA has been criticized for not fully addressing a defendant's ability to consult with counsel.[26] In contrast to the GCCT-MSH, the Mac-CAT-CA explores in greater depth a defendant's rational understanding of the legal process in addition to assessing the defendant's factual understanding of legal procedures.[1]

The Evaluation of Competency to Stand Trial-Revised (ECST-R) measure is a yet to be published instrument developed by Richard Rogers to determine not only a defendant's factual understanding of the proceedings, but also his or her rational understanding and ability to consult with counsel. This instrument appears to be more closely aligned with each element for CST outlined in the *Dusky* standard. In addition, the ECST-R includes a standardized set of 28 questions to evaluate feigned incompetency[1] and helps identify a subset of individuals referred for CST who should undergo a more detailed assessment for malingering.[27]

Finally, the Competency for Standing Trial for Defendants with Mental Retardation (CAST-MR) is a validated screening instrument developed for identifying CST deficits in defendants with MR.[28] This assessment tool consists of 50 items administered in three sections. Two of the sections require a fourth-grade reading level and the third section is administered orally.[29]

Overview of CST Restoration Programs

The literature describing CST restoration programs is scant, and published research examining the effectiveness of such programs is rare. Table 1 summarizes published articles describing individual com-

Table 1 Comparison of Competency-Restoration Treatment Programs

Program	Legal Educational Didactic Groups	CST Assessment Instrument	Written Examination of Patients	Mock Trial Experience	Individualized/Augmented Programming	Average Length of Stay
Atascadero State Hospital[33]	Patients attend a competency education class	Competency to Stand Trial Assessment Instrument	Passing score of 70% required	Used real judges and attorneys	Individualized treatment program developed to address specific deficits	Not described
Forensic Unit Central Ohio Psychiatric Hospital[31]	Patients assigned to groups related to specific deficits; frequency of groups not described	Competency to Stand Trial Assessment Instrument	Not described	Patients role play in mock trials	Patients divided into five groups with specific programming for each group; some patients received individual programming	Not described
Alton Mental Health and Developmental Center[30]	Group led by psychologist (5 days a week); seven discrete modules focusing on legal education with several daily sessions	Not described	Patients given written test at end of each module	Uses mocked trial and videotaped trial training	Meet individually as needed with program manager	Not described
North Coast Behavioral System[32]	Educational module presented by various staff; other modules focusing on legal issues; 15 hours of weekly contact time	Not described	Not described	Defendants role play various courtroom participants	Specific modules to provide anxiety management skills	80 days
FFF Standard Hospital Treatment[7]	Four legal rights education groups presented by social worker	Georgia Court Competency Test	Not described	Not described	Not described	Not described

petency restoration programs at various facilities. The single element common to each of these programs is the use of didactic groups to provide basic legal education on courtroom procedure and trial process. Four of the programs describe the use of some form of mock trial in the training, three use a published competency assessment, and two require the patients to take or pass a written examination.[7,30–33]

Studies examining variables that predict successful restoration of competency in IST defendants yield mixed findings. Research indicates that increased impairment in psycholegal ability, aggression toward others after arrest, and greater psychopathology are associated with a negative outcome regarding restoration to competency and length of hospital stay, whereas a history of criminality and substance abuse at the time of the offense is associated with a positive outcome.[34–35] In contrast, other research indicates that the use of psychotropic medications to treat psychotic symptoms is the only reliable correlate of competency restoration.[36]

For MR defendants found IST, treatment is generally focused on gaining competency, rather than on competency restoration.[37] Once MR defendants are adjudicated incompetent, they are not likely to gain competency after competency restoration treatment.[29,38–39] Because disabilities associated with MR may be more resistant to traditional treatments, specialized training or individualized programs may be necessary to maximize opportunities for competency restoration.

Challenges in Conducting CST Restoration Research

Important areas to consider when conducting psychiatric research in criminal defendants include the following: (1) institutional review board (IRB) approval and adherence to federal guidelines relevant to research on forensic subjects; (2) adequacy of informed consent; (3) the use of validated instruments in making assessments and establishing clinical diagnoses; (4) the development of a research protocol designed to minimize confounding variables; and (5) the development of clear outcome measurements to determine success or failure of proposed interventions. The relevance of each of these areas to the study by Bertman *et al.*[7] requires further examination.

The authors overcame a significant hurdle by receiving IRB approval for research involving forensic psychiatric patients with pending legal charges. According to established federal guidelines from the National Institutes of Health (NIH), these subjects are viewed as "prisoners" and as such receive additional protections when enrolled in biomedical or behavioral research. For purposes of research, the NIH guidelines define a prisoner as:

> Any individual involuntarily confined or detained in a penal institution. The term is intended to encompass individuals sentenced to such an institution under a criminal or civil statute, individuals detained in other facilities by virtue of statutes or commitment procedures which provide alternatives to criminal prosecution or incarceration in a penal institution, and individuals detained pending arraignment, trial, or sentencing.[40]

According to these guidelines, researchers must provide additional safeguards to ensure that participation by forensic subjects is truly voluntary and without coercion. Furthermore, any possible advantages afforded the subject through the participation in research cannot be of such magnitude that the subject's ability to weigh the risk of research is diminished.[40] Although the authors mention that the informed-consent process included a risk-benefit ratio discussion with the subjects, they do not provide more detailed specifics regarding considered risks or potential benefits. A significant risk of this study is the possibility that research data could be communicated to the treatment team thereby resulting in a different competency assessment outcome. This article does not specify whether results of the competency testing after the experimental interventions were shared with the treatment team or how the research data were protected from potential discovery during the trial process.

The authors appear to have given consideration to the potential ethics implications of the collected research data, because they excluded any subject who carried a first-degree murder charge that could result in the death penalty. To ensure that research data collected from pretrial defendants remains confidential, investigators working in this field often consider obtaining a Certificate of Confidentiality from the National Institutes of Health. These certificates are issued to protect identifiable research information from forced disclosure. They also allow the investigator and others who have access to research records to refuse to disclose identifying information on research participants in any civil, criminal, administra-

tive, legislative, or other proceeding, whether conducted at the federal, state, or local level.[41]

Bertman *et al.*[7] took measures to ensure adequacy of the subject's informed consent. First, subjects who received the two highest possible scores (6 or 7) on three BPRS scales measuring "psychoticism" were excluded from the study. Although the reasoning for this exclusion was not described, one possible explanation is that the authors intended to exclude severely impaired subjects who might be unable to give adequate informed consent. Second, to enter the study, subjects were required to communicate a choice regarding participation in the research, to possess a factual understanding of the topics involved in the research, to demonstrate an appreciation of the consequences, and to be able to manipulate the information rationally. Although I recognize that competency to consent to research involves a very different standard from CST, I find it interesting that subjects with the ability to demonstrate appreciation of potential consequences regarding participation in research and with the ability to manipulate this information rationally were at the same time so impaired that they failed to pass basic CST screening measures. A discussion by the authors of those deficits rendering individuals incompetent to stand trial yet competent to consent to research would have been illuminating and helpful to future researchers in this area.

Research in forensic mental health can be advanced by the use of validated diagnostic and assessment instruments. The authors incorporated three validated instruments (the GCCT-MSH, the four-subtest short-form WAIS-R full-scale IQ, and the BPRS) as measurements of trial-related abilities, cognitive functioning, and psychotic symptoms, respectively. In addition, the authors attempted to exclude potential malingerers by removing from the study subjects who scored 6 or higher on the APS scale of the GCCT-MSH.

The authors also used a nonvalidated CST instrument that they developed based on 16 criteria articulated by the Louisiana Supreme Court in the case of *State v. Bennett*.[42] A coding system was developed for these 16 criteria that examined a defendant's awareness of the nature of the proceedings and his or her ability to assist in the defense. A score of 1 was given for each item on which the individual was determined to meet successfully the individual *Bennett* criteria, with a possible total score ranging between 0 and 16. According to Bertman *et al.*,[7] a final determination was made whether a person was deemed CST according to the subject's performance on the *Bennett* criteria. However, no final scoring system, mean scores, or cutoff scores were provided for the reader to understand how CST decisions were made.

The authors acknowledged that reliability and validity data for their *Bennett* criteria measure are nonexistent, which obviously limits utility of the *Bennett* criteria for accurately assessing a defendant's CST for research purposes. However, the authors elected to include subjects in the study who may have passed the GCCT-MSH but failed the untested *Bennett* assessment tool. I would like to have known what proportion of their total sample size of 26 were included as IST based on failure to meet *Bennett* criteria, failure to score 70 or more on the GCCT-MSH, or failure on both tests.

The authors chose not to use a validated clinical diagnostic assessment instrument, such as the Structured Clinical Interview for DSM-IV (SCID)[43] or the Structured Interview for DSM-IV Personality (SIDP)[44] for subjects enrolled in their study. Although the use of a structured research instrument such as the SCID is generally not practical in standard CST evaluations, the incorporation of a structured clinical interview in research studies is valuable when studying the effects of various treatment interventions on psychiatric inpatients as this study strives to do.

Improved diagnostic clarity is particularly relevant in this study, as the article provides conflicting data regarding the prevalence of psychiatric diagnosis in their sample. For example, in the section describing assignment of participants to groups, the authors noted that, "77 percent of subjects carried a diagnosis of psychotic disorder." They subsequently noted that "77 percent of subjects in this study carried a diagnosis of a psychotic disorder or Bipolar Disorder."[7] Perhaps those subjects with bipolar disorder also had a current or past history of psychosis, although this was not clear from the information provided to the reader. This distinction may be important, because one study found that low scores on CST as measured by the MacArthur Structured Assessment of the Competencies of Criminal Defendants (MacSAC-CD) were more closely associated with psychotic symptoms related to affective disorders than with schizophrenia.[14]

Owing to the inclusion criteria that required subjects to score 60 or more on the four-subtest short-form WAIS-R full-scale IQ, some of the subjects in the sample may also have had a diagnosis of mild MR. The importance of recognizing and accurately diagnosing MR in this population cannot be underestimated; research indicates that the disabilities associated with MR may be unaffected by treatment or education.[39] The authors did not report the frequency of subjects who achieved scores suggesting possible mild MR nor was any formal assessment of MR described. As the authors noted that there were no significant differences between the three study groups on the WAIS-R four-subtest short-form scores, the impact of the effect of subjects with potential mild MR on competency assessment outcome scores appears to have been neutralized.

The authors took several steps to minimize potentially confounding variables, and their efforts in this area can serve in part as a model for future studies. First, they implemented measures to exclude subjects with severe psychosis, MR (other than mild retardation), and possible malingering. Second, evaluators assessing competency outcomes were blinded to the treatment intervention. Third, BPRS scores were assessed at baseline, at midtreatment, and after treatment to track impact of severity of psychiatric symptoms on CST. Fourth, the authors rotated treatment providers in the experimental treatment groups to minimize the chance that improved outcomes were related to a particular clinician. However, the authors elected not to rotate clinicians in the standard hospital treatment (SHT) group. This raises the question of whether the improved outcome found in the two experimental groups was related to increased frequency (as suggested by the authors) or was associated with the presentation of information by different providers. Fifth, all subjects in this study received standard hospital treatment (SHT), although the authors did not clarify whether this treatment was concurrent with the experimental group or whether it occurred in subsequent weeks after the experimental treatment was provided. This is an important distinction, because it is unclear whether the improvement associated with the more frequent training was related to more frequent interventions during a three- to four-week period or was associated more simply with additional treatment provided over an extended seven-week period. From the information provided, the reader cannot easily determine whether intensity of treatment versus length of time of treatment played the primary role in improving competency outcome scores.

The authors noted that there was no significant relationship between the degree of change on BPRS scores and competency outcome measures or between baseline BPRS scores and competency outcome measures. By design, this study excluded individuals with the most severe psychotic symptoms, as measured by the BPRS, by requiring that all individuals enrolled in the study have a score of 5 or less on all psychoticism subscale items (range is 0 to 7, where 0 is "symptom not present" and 7 is "symptom extremely severe").[45]

Although the authors did not explain their reasons for excluding those with higher scores on the psychoticism subscale of the BPRS, the probable result is a study sample that represents a more clinically stable group of defendants at the onset of the study. This may help account for the researchers' surprising finding that there was no significant relationship between the degree of change on BPRS scores and competency outcomes or between baseline BRPS scores and competency outcome measures.

As previously described, the GCCT-MSH is not considered a strong measure of the ability-to-consult-with-counsel prong of the *Dusky* test. Furthermore, the *Bennett* criteria regarding a defendant's ability to assist in his or her defense consists of six questions that may be difficult to answer without the researcher's speaking with the defendant's attorney. Unfortunately, this study does not describe whether decisions were made regarding a subject's CST on interview data alone or whether collateral information was obtained from the defendant's attorney.

The finding that more frequent competency restoration treatment yields improved scores on assessment of CST makes common sense. Bertman *et al.*[7] also found that treatment focusing on a defendant's individual CST deficits did not show an advantage to more general legal rights training as assessed by the GCCT-MSH and the *Bennett* criteria. One possible explanation for this finding is the likelihood that the education provided in the legal rights education treatment group also sought to overcome similar individual deficits identified in those defendants in the deficit-focused remedial treatment group.

Summary

Dr. Bertman and coauthors should be recognized and complimented for their tremendous effort in completing a research protocol in a hard-to-study population. Strengths of this research include the use of a validated CST assessment instrument, ongoing measurements of psychiatric status with the BPRS, and the attempt to exclude malingerers through the use of the APS scale of the GCCT-MSH. Future researchers in this area should consider the use of structured diagnostic instruments, a careful assessment of possible mild MR, usefulness of obtaining a Certificate of Confidentiality from NIH, description of legal charges facing the defendant, and the use of additional CST instruments for evaluating not only the defendant's factual understanding of the charges, but also his or her rational understanding and ability to consult with counsel. The challenges of conducting research in pretrial defendants are substantial. Bertman *et al*. offer a beginning road map for CST research that highlights useful directions and the inherent difficulty of such work.

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