Assessing Competency to Stand Trial: A Case Study of Technology Diffusion in Four States

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During the 1970's, in the wake of major court decisions affirming the due process rights of criminal defendants suspected of incompetency to stand trial, state criminal justice and forensic mental health systems instigated changes both in the organization of systems through which alleged incompetents were processed and in the specific format and objectives of the competency examination itself. The early part of this period (1970-74) coincided with the latter phases of a project sponsored by the National Institute of Mental Health to develop reliable instruments that would translate the essentially legal criteria for competency into terms capable of being assessed by the mental health professionals now charged with competency evaluations in most states.[1] The hope was that these instruments, properly used, would provide a more reliable and consistent basis for competency determination than the unelaborated legal criteria by themselves. Dr. A. Louis McGarry, director of the NIMH project and the man whose name is most frequently associated with the instruments, developed them at the Harvard Laboratory for Community Psychiatry and employed them for a time, with some success, at Bridgewater and Boston State Hospitals in Massachusetts. As other states showed interest, Dr. McGarry also made visits to demonstrate the instruments or to give depositions concerning aspects of the competency determination process.

This paper reports the findings of a project designed to explore the factors influencing four states to use or not use the results of the NIMH-supported research directed by Dr. McGarry. The states are Tennessee, Ohio, North Carolina, and West Virginia. Since the instruments came on the scene at a time of general ferment in the area of psychiatric diversion from the criminal justice system, and since their adoption or non-adoption (and the modes thereof) are heavily influenced by the structure of state forensic service systems and their relationship to criminal justice systems, it was not possible to study the use of the instruments, or the states' encounter with McGarry's work, in isolation. Instead the project sought to explore these issues in the context of on-going developments in forensic service organization in each state. As will be documented later on, these developments, as much as the

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acceptability of the instruments in themselves, or the quality and extent of dissemination activities, are determinants of both the manner and degree of ultimate implementation.

Problem

Although practical solutions to outstanding problems connected with competency to stand trial remain elusive in most jurisdictions of the United States, the major issues are by now familiar. Over the past decade courts and commentators have pointed out that, in the process of encouraging the psychiatric diversion of a segment of the criminal defendant population comprising the mentally disturbed, the retarded, and those merely suspected for various reasons of mental aberration, society has failed to ensure the due process protections to which ordinary criminal defendants are entitled.[2]

It is only in recent years that the legal criteria for competency to stand trial have been made explicit. Stemming from the common law principle that an accused has the right to be present at his own trial, the legal criteria for competency to stand trial were defined by the Supreme Court in *Dusky v. United States.*[3] There the court stated that the "test must be whether [the defendant] 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."[4]

Prior to the *Dusky* decision there existed considerable confusion on the part of both the law and the mental health professions regarding the criteria for criminal responsibility and those for competency to stand trial.[5] The effect of this confusion was to apply a more stringent standard of mental capacity to accused persons than was warranted by the present needs.[6] As a result, far more persons were found incompetent to stand trial than would have been had the appropriate criteria been used. Not only did the two professional groups confuse these issues, but they also applied different criteria based on legal and psychiatric paradigms respectively.

Moreover, while the law made provision for the protection of the due process rights of criminal defendants and, likewise, of the rights of those subjected to involuntary civil commitment proceedings on grounds of mental incompetency, neither the legislature nor the courts in most states had articulated such a provision in the specific case of criminal defendants diverted into the mental health system on suspicion of incompetency to stand trial.[7] "Evaluations" might go on indefinitely, and if they concluded, as they often did, in the finding of incompetency, the accused would usually be left in the state hospital for the criminally insane until he regained competency. In the great majority of cases this amounted to a life sentence.

The net result was that not only were defendants being subjected to incarceration without benefit of trial, often in worse conditions than a prison would have offered, but once interned they most often lacked either legal or administrative means ever to get out. Shah cites Dr. McGarry's findings on these points:

> For example, McGarry (1971) found at Bridgewater State Hospital that prior to 1960 ". . . more of this type of patient (pretrial incompetence) had left Bridgewater by dying than by all other avenues combined"

(page 1181). Among the 148 patients who were found to be still incompetent, there were three who had been hospitalized 40, 36, and 17 years respectively. The average length of hospitalization for 148 incompetents was 14 years and nine months; those who had been returned to court as competent had an average hospital stay of four years and three months. There was a real question whether some of the incompetent patients might during earlier periods of their hospitalization have been competent and then regressed as a function of prolonged confinement.[8]

Following the *Drukens* decision in which the Massachusetts Supreme Judicial Court held that hospitalization before trial constituted civil commitment and thus all the safeguards applying to civil commitments must apply in such cases,[9] attention in Massachusetts became focused on this population. Shah reports,

> A study of the persons affected by this ruling revealed that there were in the State as of May 1, 1970, a total of 496 persons on indeterminate commitment awaiting trial. What the investigators did *not* expect to find, however, was that in over *90 percent* of these cases, the criminal charges against these defendants were no longer outstanding. Even more astounding was the fact that fully 212 of the aforementioned 496 individuals had had their criminal charges dismissed *on the very same day* that they were indeterminately committed to "await trial." Why the courts did not see fit to inform the defendants or the hospitals when the charges were dropped is very difficult to understand (McGarry *et al.*, 1972).[10]

When *Jackson v. Indiana* was decided in 1972 by the U.S. Supreme Court,[11] therefore, the task facing most states was essentially a remedial one: to release or provide, through trial or civil commitment proceedings, for those persons currently institutionalized on the basis of a suspicion or a finding of incompetency, and to devise methods by which the mental health professions, already playing a permanent role *vis-a-vis* state criminal justice systems through divisions of forensic psychiatry or, as individuals, through longterm consulting relationships with particular courts, could apply the articulated legal criteria in terms of the training and skills they possessed.

In fact, significant efforts toward this latter goal of devising methods by which legal criteria could be applied easily had begun a few years earlier under the support of the National Institute of Mental Health. Recognizing that "many people, who have been judged to the incompetent for trial, have been unnecessarily and inaccurately committed to our mental hospitals and denied their right to trial,"[12] Dr. McGarry and his research team had sought to develop instruments to "determine more concretely and quantifiably a person's capacity and ability to cope with the task of performing as a defendant in a criminal trial."[13] These instruments were to be "conceptualized and expressed in language with sufficient familiarity to both the law and psychiatry to provide a basis for relevant communication and assessment of the issue."[14] Development and testing of the instruments took

place between September 1, 1966 and December 31, 1970. During the next two years, until the end of 1972, the study team attempted to disseminate the results of the project in the state of Massachusetts.[15]

These efforts led to adoption of the instruments during Dr. McGarry's tenure as Director of the Division of Legal Medicine, Massachusetts Department of Mental Health, though shortly after he left the post, other psychiatrists ceased using them in their evaluations. Their criticisms of the instruments were not well articulated, but one respondent stated they were "too cumbersome and too time consuming to be of practical value."[16] Nevertheless, during the time the instruments were in use, Dr. McGarry claimed a reduction from over 20 percent to around 6 percent of indefinite commitments on the basis of a finding of incompetency.[17]

Dr. McGarry's initial work in Massachusetts was followed by a thirteen month effort (1973-74) to spread information about the project beyond the boundaries of the state. As Dr. McGarry states in his "Final Report" on the phase of effort, "Our goals were to disseminate widely the findings of 'Trial and Mental Illness' to other states in the country. . . . In particular we sought to train mental health professionals throughout the country in the use of the two assessment instruments of competency for trial developed in the earlier research project. These are the *Competency Screening Test* (CST) and the comprehensive *Competency Assessment Instrument* (CAI)."[18]

The Competency Screening Test consists of 22 sentence completion items such as "If the jury finds me guilty, I . . ." and "Jack felt that the judge . . ." Most of the items begin a conditional sentence ("When . . . ," "If . . .") and thus implicitly direct the subject to make a consequential statement about a courtroom situation. Persons administering the test are instructed to give each item a score of 2 if the answer shows high competency, 1 if medium competency, and 0 if no competency. Each of these rating categories is defined mainly by example in the scoring handbook accompanying the instrument. Rating criteria are both "legal" (*e.g.*, understanding and awareness of court process) and "psychological" (*e.g.*, awareness and acceptance of court process). The psychological criteria appear to be blended with political value judgments, as when "Jack felt that the judge was right/was fair" is scored 2 but "Jack felt that the judge was unjust/was wrong" is scored 0.

The Competency Assessment Instrument leaves more discretion to the evaluator. It consists of thirteen topic areas which may be used to structure an interview and each of which can be rated from 1 (total incapacity) to 5 (no incapacity), with a score of 6 used to indicate "unratable." The topic areas are: (1) appraisal of available legal defenses, (2) unmanageable behavior, (3) quality of relating to attorney, (4) planning of legal strategy, (5) appraisal of role of defense counsel, prosecuting attorney, judge, jury, defendant, witness, (6) understanding of court procedure, (7) appreciation of charges, (8) appreciation of range and nature of possible penalties, (9) appraisal of likely outcome, (10) capacity to disclose to attorney pertinent available facts, (11) capacity to challenge realistically prosecution witnesses, (12) capacity to testify relevantly, and (13) self-defeating vs. self-serving motivation.

Almost from the first there was opposition to the McGarry instruments.

Some solid objections to the form and content of the instruments, in particular the Competency Screening Test (CST), were presented by Brakel in 1974.[19] Brakel argued that the CST, particularly with the scoring system employed by McGarry, measured not so much competency to stand trial as an acceptance of the prevailing ideologies (as opposed to practice) of the criminal justice system. He also stated the view of numerous other professionals that a judgment as to competency is of its nature not quantifiable.

The purpose of the project described in this paper was to discern the effect of various factors (including professional objections as described above) on the adoption or non-adoption of the McGarry instruments in each of the study states. The four states chosen by NIMH for the present study – Tennessee, Ohio, North Carolina, and West Virginia – had some degree of contact with Dr. McGarry's project and some internal activity affecting the competency determination process. Further investigations enabled us to discriminate more carefully among Dr. McGarry's efforts in the four study states. In Tennessee and Ohio a number of personal visits were made, and administrators in state forensic divisions were given technical assistance.[20] In North Carolina Dr. McGarry made one Grand Rounds presentation of his work in Chapel Hill, but no administrators of the state forensic services were in attendance. In the case of West Virginia, Dr. McGarry did not actually visit the state, but testified by deposition in the case of *Walker v. Jenkins* regarding the appropriate methods of assessing competency and the amount of time defendants needed to be confined for this purpose. This testimony later became the basis for new legislation passed by the state of West Virginia and modeled on similar provisions in the Massachusetts Code. Thus it was not primarily Dr. McGarry's own activities on which the study focused, but the activities within the four study states which affected the adoption of his instruments.

Given the existence of the competency instruments – the CST and the CAI – and given the obvious need in most states to upgrade and standardize the procedure by which competency was assessed, it is natural to ask what impediments existed to the institutionalization of the CST or the CAI in every state that had official contact with McGarry and his work. That question formed the central research issue of the year-long study reported here, and, with certain qualifications in the light of the project team's field experience, it encapsulates the problem addressed in this paper.

The qualifications stem from the complexity of involvement of technological innovation (the instruments), with the organization of state forensic service systems, and the related procedures by which criminal defendants suspected to be incompetent are processed. It soon became apparent that what was at issue was the simultaneous diffusion of organizational, procedural, and technological change, and accordingly we developed a conceptual framework and a derived data gathering methodology sufficiently broad in focus to take all three levels of activity into account.

Methodology

In effect, a two stage methodology was employed during the conduct of

the change took place and to understand the occurrences at all points along the continuum.[21]

Thus in order to establish the effects of Dr. McGarry's dissemination efforts and, more broadly, to determine the extent to which changes were made in the competency determination procedures of the study states in the direction of any particular set of goals, the study team structured its inquiry according to the following list of tasks:

1. Determine the goals articulated in each state with respect to the competency determination process immediately prior to the onset of Dr. McGarry's dissemination efforts;
2. Determine, for the same point in time, the extent of progress in each state toward those goals;
3. Chart the subsequent changes and the events in each state presumed to have affected the competency determination process, including both Dr. McGarry's activities and other identifiable factors;
4. Determine, to the extent possible, the selective effects of these events on reported change in competency determination procedures;
5. Analyze the information gained during the above steps to determine why initial goals were or were not achieved.

Data Collection

Data collection for this study was divided into three principal phases. In Phase I, literature was reviewed and the background of statute and case law applicable to competency to stand trial investigated for each of the four study states (and for the nation as a whole where laws or court decisions of general application were known to exist). In Phase II, the director of this project visited each of the study states to discuss with the main forensic service figures there the operation of the in-place competency determination systems and to refine and complete the list of prospective respondents. In Phase III, project staff, assisted by consultants, visited each state for approximately one week, conducting semi-structured interviews with respondents according to a pre-arranged schedule.

Those interviews were designed to elicit information as called for in the conceptual framework. As anticipated in the conceptual framework, few respondents were familiar with the entire process, and thus in order to arrive at credible inferences of cause-effect relationships, the study relied rather on the condensation of opinion obtained by interviews with numerous respondents in each of the study states.

The instrument used by the study teams for Phase III data collection actually comprises several instruments since it was designed to be adapted on site by the interviewer for use with either mental health or legal personnel and since it could be expanded or abridged at will depending on the apparent breadth of the respondent's experience as the interview progressed. The instrument is therefore best understood as an interview guide rather than a questionnaire; over the course of some 60 interviews it probably was never used twice in exactly the same way.

Project staff and consultants were organized into site visit teams of from two to five persons depending on the size and complexity of the forensic mental health system and the number of separate locations to be visited in

each state. Site visits lasted from three to five days and involved from five to twenty person days per state. Virtually all interviews were tape recorded. On returning to Boston, the staff member principally responsible for analyzing and presenting the data for each state would play back all tapes for that state. Usually this person had attended a large number of interviews; regarding those he or she had not attended, other staff who had been involved were consulted to ensure that analytic inferences were properly drawn and that known biases were eliminated. All site visit reports were reviewed jointly by project staff (including the project director) and the project consultants before being considered final.

Results

While the study team found that use of the McGarry instruments varied considerably from state to state, one fact emerged as pre-eminent and consistent among all four states. There is no state in which the two McGarry instruments are being used as they were originally intended. Even in Tennessee, where frequent use is made of the CAI, it is never used in tandem with the CST as called for by Dr. McGarry.

The degree of adoption ranked from greatest to least was found to be: Tennessee, Ohio, North Carolina and West Virginia. In Tennessee, which has a decentralized forensics system, the CAI is used for all competency evaluations in keeping with departmental suggestions. In Ohio, the CST and CAI are both well known, most probably as a result of a series of workshops conducted by the state on the competency issue. While use of either one of the instruments was acknowledged by various practitioners, it was not possible to determine precisely the level of usage because the state has not mandated any one method for competency evaluations in its decentralized system. In fact, discretion based on professional judgment is the policy.

North Carolina presents an interesting situation in that at one time the CST was used regularly for competency evaluations and since has fallen into complete disuse. This fact has been linked entirely to the presence and subsequent departure of one practitioner.

In West Virginia respondents had very little knowledge of either the instruments or Dr. McGarry. Use is limited to two practitioners at two of the state's four facilities. The practitioners were introduced to the instruments quite independently of any state-sponsored activities.

Analysis

Three fundamental kinds of change were identified by the study team: changes in the organization of forensic services within a state, changes in the procedures by which courts secure an assessment of a defendant's competency to stand trial, and changes in the specific format of the competency assessment interview. This last area of change was most directly related to the focus of the research project since Louis McGarry's NIMH-supported research on competency, resulting as it did in the development of the Competency Screening Test and the Competency Assessment Instrument, was principally designed to facilitate the conduct of the assessment interview and to standardize the process by which results were achieved. However, since the kinds of professional and paraprofessional

staff who conduct the interviews (and thus may use the instruments) are determined both by statute and by the organization of forensic services within a state, and since the legal mandates under which they operate affect the scope and purpose of the interviews, it is necessary to review all three areas of development in attempting to generalize, on the basis of the present study, about the reasons for the evident disparity among the study states in the use of the CST and the CAI.

Organizational Change

Because the movement to reform the competency determination process was tied to the deinstitutionalization effort that was well under way in the mental health systems of many states by the early seventies, it is natural that the assertion of defendants' due process rights was coupled with efforts to reorganize the mental health care delivery system. In particular, reformers felt that central hospitals, with their overcrowded conditions and overworked staff, were inappropriate locations for the bulk of competency examinations.

In the narrowest sense decentralization of mental health services means nothing more than the removal of patients from central state mental hospitals to facilities in or near their local communities – whether hospitals, group care settings, or out-patient services provided by community mental health centers. In the widest sense, decentralization connotes a broadening of the corps of persons providing mental health services, often achieved by admitting allied mental health professions to areas of practice previously reserved for psychiatrists and psychologists. Both kinds of decentralization have affected the competency determination process. Initial attempts to get evaluations, and thus the residence time of criminal defendants, out of central facilities and into community settings where the entire process could be shortened often to a matter of hours rather than weeks or months, soon demonstrated to administrators the necessity of training substantial numbers of additional persons in the conduct of competency assessment. Since these persons often lacked a background in psychiatric evaluation techniques, a clear *prima facie* case existed for the introduction of a workable assessment instrument.

Accordingly, changes began to be made in:

- the locations where competency examinations could be performed;
- the persons authorized to perform the examinations;
- the amount of central control exercised over (a) the means of determining competency, (b) the qualifications of the examiners, and (c) the ability of the facility to hold a defendant for observation or until he/she had recovered competency.

Interestingly, while the first two areas of change moved in the direction of decentralization, the last, in two of the study states, saw increasing control being exercised from a central agency level over persons and procedures. We will shortly look at the reasons for this.

In three of the four study states, those changes that were introduced in the competency procedures and in the organization of the mental health system affecting the determination of competency came about largely as a result of the effort of a new person on the scene, occupying a key role in the

state bureaucracy related to forensic services. In Tennessee, Commissioner Treadway, himself new to his position in 1972, appointed Joyce Laben director of his newly created Forensic Services Section within the Department of Mental Health and Mental Retardation. The creation of this section was itself a response to the concerns of numerous individuals who had made their opinions known to the Commissioner. Ms. Laben was from the start given a relatively free hand to develop a program for reforming the competency determination process in Tennessee. She had, in addition to the necessary skills and energy to carry her self-defined task through to completion, an outsider's perspective on the needs of the state bureaucracy.

In Ohio a series of exposes in the *Cleveland Plain Dealer,* coupled with the court's decision in *Davis v. Watkins,* prepared the way for a reform effort that began following the appointment in 1973 of Carolyn Shahan as Chief of Community and Institutional Programs for the Division of Forensic Psychiatry. Her superior, John Vermuelen, assumed his post in 1974, though he had been active as a consultant to the Department of Mental Health and Mental Retardation some years earlier. Ms. Shahan also has had a fairly free hand in the efforts to reorganize her state's forensic service system to change its procedures for determining competency.

In North Carolina both William Hales and Robert Rollins assumed their positions with the Division of Forensic Services in 1973 and were able to guide the reform efforts called for by the Governor's Study Commission (Forensic Services Task Force) and the Criminal Procedures Act of 1973.

In West Virginia, Robert Kerns had been Assistant Director of Professional Services, Department of Mental Health, for some years when in 1973 he became concerned with the status of defendants referred or committed for indefinite periods to the state mental hospitals while undergoing "observation" or "treatment" in connection with alleged incompetency to stand trial. His actions to reform competency procedures, while not as dramatic in their results as others we have examined, seem to have been assisted by national publicity focused on conditions (not necessarily in West Virginia) that had existed for some time but were now repugnant to reformers and those courts in which tests cases were being brought.

In two of the study states – Tennessee and Ohio – the result of the activities of the new forensic service directors was a clear movement toward decentralization, with community mental health centers or regional forensic centers assuming responsibility for competency examinations previously administered in state mental hospitals. This in turn had the following consequences:

- Examinations were now usually performed on an out-patient rather than an in-patient basis, with a resultant shortening of evaluation time.
- Local center staff, often including paraprofessionals at the master's level, performed the competency examination, supplemented, where required by law, by a psychiatrist or clinical psychologist.
- The introduction of new staff to the competency examination procedure created a need to teach relatively uninformed people the operational criteria for competency to stand trial and the means of structuring an interview to learn, in a relatively short time, whether those criteria were met.

Thus, the most fertile ground for the dissemination of a new and systematic approach to the determination of competency would appear to lie in those states which, by administrative action, have created a large class of persons, both psychiatrists and others, who need to learn the new skill of competency evaluation quickly and in a uniform fashion. It seems no coincidence, therefore, that the states which made the widest investigation and use of Dr. McGarry's instruments were those in which the process of decentralization was farthest advanced. These states simply had the greatest need for what Dr. McGarry had to offer.

That is only part of the picture, however. In order that a particular approach to competency determination be adopted on a wide scale, it is a necessary but not sufficient condition that there be widespread need. What is much more likely to secure uniformity of approach is a mandate that the same techniques be used statewide in determining competency. A less certain method of dissemination is the simple provision of information services from a central state office to those community mental health centers that are or will be engaged in competency examinations. In either case it is paradoxical that successful "decentralization" of competency procedures requires the retention of central authority in the state forensic services unit to ensure that reasonable consistency is applied throughout the competency determination process.

Decentralization of the competency determination procedures in the four study states depended on the ease with which the functions of central facilities could be transferred to local facilities. Allowing for some admitted over-simplification, it seems clear that this transfer process was easiest in the case of Tennessee, where a system of community mental health centers already existed. In the other states the legal and financial force behind the effort to create CMHCs or expand their number varied, and with it the ease with which decentralization could be achieved. In Ohio, the *Davis v. Watkins* case mandated the gradual closing of the Lima State Hospital and the provision of a "least restrictive alternative" for defendants whose competency was questioned. Executive Order G-22, created in response to the court order, gave responsibility to the Department of Mental Health for the management of the competency determination process. The Department was thus able to make use of the regional forensic centers established in the previous year, and it has done so, reducing the proportion of competency evaluations conducted in the central facility from nearly 100 percent in 1973 to about 10 percent in recent years. Nevertheless, because the Department has lacked either the statutory or the financial authority to impose a uniform method of conducting evaluations, the methods in use vary across the state. This state of affairs contrasts with that in Tennessee, where the funding of the CMHCs is largely controlled by the Forensic Services Section of the Department of Mental Health and Mental Retardation, and where training programs offered by the Department have resulted in a much higher degree of uniformity in competency evaluation procedures than is found throughout the Ohio system.

In North Carolina, the Forensic Services Task Force of the Governor's Study Commission on the Efficiency of State Government has recommended decentralization but has lacked the funding to secure the practical

consequences of the move (local out-patient and in-patient competency examinations) in the preponderance of cases. Training efforts which aim at achieving some uniformity of evaluative technique have been hampered by lack of adequate funding and resistance at the local level. The consequence is that while decentralization is still espoused as a goal, most competency examinations are still conducted at Dorothea Dix Hospital on an in-patient basis.[22] Thus, some uniformity of procedure exists in North Carolina, not because it has been retained in the face of decentralization but because decentralization has not yet proceeded far enough to make uniformity an issue.

By contrast, West Virginia has not yet felt much impetus toward decentralization, in large part because the number of competency cases coming to the attention of the courts in any one year is small and places no undue burden on the existing facilities. All evaluations are conducted on an in-patient basis in one of the state's four mental hospitals, using either staff or consulting psychiatrists. These psychiatrists have retained virtually complete discretion over the procedures by which the examinations and observations are made and the conclusions drawn. Thus, neither the question of decentralization nor the issue of uniformity has been of importance in the state.

It is worth noting that in none of the study states do the courts ordinarily require the examiner to state his reasons for an assessment as to competency, and this fact has undoubtedly made it possible for greater variation in evaluative technique to exist than might otherwise be the case.

Procedural Change

By "procedures" we mean the manner in which the question of a defendant's competency is raised in court, the process of referring the defendant to an appropriate agency or person for evaluation, the structure of that evaluation, and the practices governing disposition in cases where the evaluator concludes that the defendant is in fact incompetent.

One of the most striking findings of this study was that even though competency to stand trial is in principle a legal rather than psychiatric concept, mental health professionals in the study states understood the criteria for competency much better, on the average, than did lawyers and judges. Notwithstanding the distinctions made in most recent statutes and in case law since 1970 between the question of competency and the insanity defense, practicing attorneys in every state, and many judges, saw the two issues as fused and often assumed that a defendant might be found incompetent to stand trial on the basis of demonstrable mental confusion at the time the offense was committed. In some instances this view resulted in a reluctance to raise the issue of competency to stand trial at all, since the attorney feared that offering the insanity defense (which he perceived to be the same thing) was tantamount to admitting that the defendant had committed the act in question. More often raising the issue of competency was considered a necessary step in the practice of defensive law – proving that the attorney had "touched all the bases" in defending his client.

Since the mental health profession has had the responsibility of determining competency, psychiatrists and psychologists have been the ones

to face the task of first understanding the legal criteria for competency and then translating those criteria into terms comprehensible within the paradigm of their profession. Since it is still uncommon for judges to require the examining agency or person to state the reasons behind a finding of competency or incompetency, most judges still have not become familiar with particular tests or examination procedures. And since lawyers, though they may raise the issue in the first instance, are even less closely associated with the actual examination process, they remain as a group unfamiliar with both the procedures involved and the specific criteria applied.

Since about 1973 the most notable changes have occurred in the study states not in the way the issue is raised but in the competency evaluation process itself and in the subsequent disposition of cases. These changes appear to have been brought about principally by two forces: (a) changes in case law and statute requiring that timely determinations of competency be made in the "least restrictive environment" and (b) a general trend in the nation at large toward the deinstitutionalization of mental patients. Both forces have created an impetus toward decentralization and the development of out-patient services, in impetus that has met with various responses in the various study states.

Clearly the most successful effort in that direction has been mounted in Tennessee. There the decentralization effort has directly affected the competency assessment procedure simply by requiring the training of personnel outside the original institutions. Had the training been less systematic, as it was in Ohio, some professionals doubtless would have resisted performing competency evaluations at all, and others would have used idiosyncratic methods that would fail to assure equal treatment in what is still essentially a legal process. Thus, the Tennessee formula for decentralization of the forensic mental health system, while assuring reasonable consistency of approach to the assessment of competency, could be summed up in these words: *Make use of staff persons other than psychiatrists and clinical psychologists for competency evaluations if this is permitted by law; train these persons (and retrain psychiatrists and psychologists as necessary) in a consistent approach to the evaluation of competency grounded in the legal criteria for making such a determination. Central control over the funding of regional facilities will assure their acceptance of a centrally devised training program.*

In one sense the most significant changes in the area of competency have come in the disposition of cases once the evaluation is made. Defendants in all four study states now are assured the right to a civil involuntary commitment hearing if found incompetent to stand trial, and those who are believed to be restorable to competency must have their status periodically reviewed to ensure that they are being treated and not merely warehoused. These changes are not necessarily related to particular competency evaluation instruments but stem from ideas about the right to treatment and the right to periodic review enunciated by early court decisions and disseminated by various means, including the work of Louis McGarry. (The most clear-cut instance of this influence is in West Virginia where Dr. McGarry's deposition was used as a basis for the new mental health legislation passed in 1973.)

Change in Instruments

In Tennessee, the primary factor responsible for effecting change and promulgating the CAI was the strength of the Department of Mental Health and Mental Retardation in a state possessing a pre-existing network of community mental health centers. Passage of the Forensic Services Act enabled the Department, through the Forensic Services Section, to stipulate training and certification requirements for CMHCs and to require CMHCs to perform competency examinations. In this way, the process of decentralizing competency examinations was attended by the development of a uniform, *centrally controlled* procedure for conducting competency examinations throughout the state CMHC network. The CAI did not revolutionize this procedure but simply facilitated its widespread adoption.

Active forces in Ohio have worked hard to promote use of the McGarry instruments with, however, only indifferent success. Lack of centralized state control over the funding and training of community mental health centers and personnel has left considerable autonomy in the hands of local directors, and their resistance to adoption of the CST in particular has been marked. In fact, in spite of court orders to close Lima State Hospital by 1980, few competency evaluations are performed as yet outside the central facility. Where they are performed, and where the McGarry instruments are used, it is often as a structuring device rather than a definitive determiner of competency: the instruments are frequently not scored but are used rather to articulate the standards for competency and the areas of psychology and behavior in which observations should be made.

Decentralization of forensic mental health service delivery is proceeding slowly in North Carolina, and it involved the McGarry instruments only to the extent that the CST is included in training packages, together with the recommendation that it not be scored but used only as a structuring device. Curiously, the CAI, which might serve much better as a structuring device, has never been considered seriously. It is clear that North Carolina, like Tennessee and Ohio, has drawn back from the concept of a quantitative approach to competency, assessed by scorable instruments and allowing relatively little judgmental scope for the examiner, and prefers simply to articulate the standards and appropriate areas of behavior to be observed in a competency assessment, leaving in the hands of professional observers the finer judgments as to whether those standards are met.

In West Virginia only four sites for competency examination – the four state hospitals – are of concern, since only there are competency examinations performed on a regular basis. The McGarry instruments are used in two of these sites because psychiatrists there believe they are effective. They are not used in the other locations because they are not favored by the clinical directors there. As far as the study team was able to tell, the instruments, where used, are used quite literally – *i.e.*, they are scored as intended and not merely used to structure the competency interview. This is noteworthy, since the individuals who use them would appear quite capable of employing independent judgment in conducting an assessment. The extent to which such judgment ordinarily is combined with the numerical score from the instrument in reaching a final decision as to competency could not be determined within the scope of the present study.

The Competency Assessment Instrument is, in effect, an interview format. It is by no means exclusive but allows the clinician to employ any other diagnostic instruments he or she may find advisable. It is used regularly and almost universally in Tennessee because it has been made available to staff at just the time when their need for it was greatest – *i.e.*, when they found themselves mandated to perform competency examinations and without prior guidance in the proper technique for doing so. It is used here and there in Ohio, though by no means universally, because the training program there has been less systematic than in Tennessee, and regional forensic centers often developed their own procedures before being exposed to the McGarry instruments. North Carolina's encounter with Dr. McGarry's work appears not to have included the CAI; as a result, those who perform competency examinations, after trial and rejection of the CST as an interview tool, have preferred to develop their own interview formats, relying on their own clinical judgment and interpretation of the legal criteria for competency. West Virginia uses the CAI in two hospitals whose directors have become familiar with Dr. McGarry's work and relies on personal judgment to structure the interview format in the other two (and in those cases where consulting psychiatrists are brought in to perform examinations).

To sum up, regarding the CAI the opinion of respondents in the four states ranges from the view that the CAI is a virtually indispensable instrument (or, better, structuring device) for the competency interview without which many interviewers would be at a loss, to the view that any reasonably intelligent professional who understands the legal criteria for competency would of his own accord develop an interview format resembling in most details that offered by the CAI.

Regarding the CST, our investigations in the four study states, and further inquiries regarding the use of the instrument in Massachusetts, indicate that it has failed to find general acceptance in the forensic community. These negative conclusions have not been reached by professionals only on the basis of a cursory examination. The instrument has been tried extensively in Massachusetts, North Carolina, Ohio, and West Virginia. It is still being used with consistency only in West Virginia where the number of competency cases annually is very small. The principal reasons given for failing to adopt it, or for discontinuing its use, are that it is cumbersome, that it has a built-in bias toward those who accept the most favorable interpretation of the criminal justice system, that it is not easy to use with defendants who are illiterate or semi-literate, and that a scorable instrument does not provide the best means of assessing competency in an area where considerable clinical judgment is called for. It is felt widely that assigning scores to the responses to instrument items is an insufficiently sensitive way of examining a personality faced with an experience of such potentially decisive impact on his or her future life. Moreover, many prospective instrument users are aware that their own view of the criminal justice system might not be nearly so favorable as that which the CST rewards with high competency scores. Like their lower class clients, but with less personally at stake, they recognize that courtroom procedures may abridge due process and that attorneys may be less than wholeheartedly devoted to conducting the best possible defense. And they doubt the relevance of questions on these subjects to the real issue

at hand: the defendant's ability to understand the charges against him and to assist in his own defense. Beyond making these points, relatively few of our respondents addressed the question whether the CST accurately and adequately translates the legal criteria for competency into psychological terms.

Originally the CST and the CAI were developed for quite different purposes. The expectations of the developers were that a two-stage competency determination process would be the norm: a triage stage in which those who were clearly competent and those clearly incompetent would be singled out, and a second stage in which the remaining group – those whose competency remained in doubt – would be subjected to more individualized analysis. The Competency Screening Test was designed to assist in the first stage, the Competency Assessment Instrument in the second. But, in fact, of the states investigated by the study team, only North Carolina regularly conducts competency examinations in this manner. Perhaps for reasons of cost or because recent legislation limits the length of time during which a defendant can be held for examination, a single examination usually serves as the basis for final determination in the other three states. As a consequence, the initial purpose of the CST – as a screening test that would weed out those clearly competent or clearly incompetent and send the others for further examination – seems to have been forgotten in many places where the instrument is known. In general those familiar with both McGarry instruments consider it an alternate and inferior method of assessing competency.

Conclusion

In the preceding section we examined the three basic kinds of changes identified in the four study states and their relation to the adoption or non-adoption of the McGarry instruments. What began as a clearly and narrowly focused project effort became an analysis of a more complex form. While implicit in the early conceptual framework was the assumption that, given the right set of conditions, the McGarry instruments would be seen as offering substantial benefits to the competency determination process and would be adopted on a statewide basis, it soon became apparent that a more complex situation existed in every study state. Since about 1972, changes in the competency determination process and in the forensic mental health system had been occurring in response to a variety of forces among which the NIMH-sponsored research was by no means the most significant. In order to understand the activities of the study states regarding the CST and the CAI, it was clearly necessary to see these changes in their full scope – that is, as they affected the reorganization of state forensic service systems, the procedures by which defendants were "processed" by these systems, and, finally, the specific format of the competency interview or observation period.

By approaching our study in this way we were able to discover important connections between macro-level changes – *i.e.*, those affecting the reorganization of service systems – and micro-level changes in the instruments or other clinical tools used in performing an assessment of competency. A statewide decentralization effort affecting the mental health

delivery system creates the most thorough-going climate for change by spreading the responsibility for competency determination throughout the state system, though it was previously concentrated only in central mental hospitals. A need is thus created for instructional programs to turn professionals and paraprofessionals throughout the system into examiners of competency capable of meeting the standards of the legal process. If, as in the case of Tennessee, the requirement that examiners be trained is supported by centrally controlled funding restrictions, and if concurrently the examiners' training program is centrally operated, then conditions are favorable for the adoption of an appropriate interview technique. What is "appropriate," however, is a matter of judgment, both by the central forensic service agency and by the local facility conducting the examinations. Clearly if the central office decides not to promulgate a particular instrument, it is unlikely to be adopted at the local level. If, on the other hand, an instrument is promulgated that local users decide is unsatisfactory, our inquiries indicate they will abandon it in favor of other self-chosen and sometimes *ad hoc* methods of conducting the assessment interview.

In places where decentralization has not proceeded nearly so far, such as North Carolina and West Virginia, conditions for change in a competency instrument are much more likely to depend on the need or enthusiasm of particular individuals. While change may thus occur more rapidly – for example when a central mental hospital adopts the CST because of its director's prefernece – it also is less firmly entrenched, since a change in directors, or a particular director's change of mind, can terminate use virtually overnight. Recognizing, however, that many more states will be taking steps to deinstitutionalize their forensic services in the near future as part of the overall deinstitutionalization of the mental health system, the study team is convinced of the importance of a carefully controlled evaluation of both the Competency Screening Test and the Competency Assessment Instrument against the standards they were designed to achieve: the best judgment of acknowledged clinical and legal experts on the basis of a detailed interview with the defendant. Beyond that, because this study has thrown considerable light on implementation methods that work well and those that are less effective, we suggest that a more concentrated study should be performed in the state of Tennessee, to examine the history of the Forensic Services Section of the Department of Mental Health and Mental Retardation and its role in the process of decentralizing forensic services, and to determine the most efficient way of incorporating any validated competency instrument (whether a scored test or simply an interview guide) in a decentralized service delivery system.

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2. See, *e.g.*, Lewin T: Incompetency to stand trial: Legal and ethical aspects of an absurd doctrine, Law and Social Order, 19 (1969), 233; Morris G: The confusion of confinement syndrome extended: The treatment of mentally ill 'noncriminal criminals' in New York, Buffalo Law Rev, 18 (1968) 393: Acher JP, Guzman R and Lewin TH: Psychiatric Evaluation in Criminal Cases (Ann Arbor: Michigan Department of Mental Health, 1967); Hess JH and Thomas HE: Incompetency to

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3. 362 U.S. (1960). See also Silten PR and Tullis R: Mental competency in criminal proceedings, Hasting L J, 28 (1977), 1053 for a discussion of this case and related issues.
4. 362 U.S. (1960) at 402. Note that these criteria had been articulated half a century earlier in *United States v. Chisolm* (1906) in the judge's charge to the jury: "The question the court submits to you is whether the prisoner at this time is possessed of sufficient mental power, and has such understanding of his situation, such coherency of ideas, control of his mental faculties, and the requisite power of memory, as will enable him to testify in his own behalf, if he so desires, and otherwise to properly and intelligently aid his counsel in making a rational defense." 149 F. 284 (S.D. Ala. 1906), at 285-86. Cited by Shah, p. 17. See also *Youtsey v. United States*, 97 F. 937 (6th Cir. 1899) for a still earlier ruling.
5. Both the criteria elaborated under the M'Naghten Rule and those contained in the more recent ALI guidelines require psychiatric testimony on the question of the defendant's mental state *at the time of the alleged commission of the offense*. By contrast, the criteria for incompetency do not take into account the defendant's general mental state, either during commission of the crime or at the time of the trial. As the transcripts of the Dusky case (reproduced in the GAP publication cited in note 6, pp. 868 ff.) make clear, a defendant could technically be suffering from a variety of diagnosable mental disturbances and still be considered competent to stand trial.
6. Note, however, the concern of the Group for the Advancement of Psychiatry, in *Misuse of Psychiatry in the Criminal Courts* (GAP Publication No. 89, New York, 1974, page 893), with variable standards for competency: "It may be that a given mentally ill defendant would be competent with one attorney but incompetent with another. It also is true that the complexity of the case . . . requires very different levels of functioning on the part of the defendant. Finally, it is clear that similar mental pathology may have a differing impact on the competency of different defendants. All these variables suggest that the competency test is more related to the particulars of the anticipated trial than most psychiatrists have recognized."
7. "It should be noted that under the commitment laws of most states a person charged with a crime cannot be civilly committed. The purpose of this rule seems to be to prevent friends or relatives of the accused from forestalling a criminal conviction by instituting civil commitment proceedings. Weihoffen: Mental Disorder as a Criminal Defense (1954), 450-51. Therefore under present law the state could not civilly commit incompetent defendants without dropping the criminal charges and forgoing the possibility of future prosecution. In addition, persons found incompetent to stand trial are usually committed to an institution for the criminally insane rather than to an ordinary mental hospital." Incompetency to stand trial, note 53 at p. 463
8. Shah SA: Law and mental health interactions: Some recent trends and policy implications. Paper presented to the Third Annual Institute on Law, Psychiatry, and the Mentally Disordered Offender, Southern Illinois University, Carbondale, Illinois, November 14-16, 1972
9. *Commonwealth v. Drukens*, 254 N.E. 2d 779 (1970).
10. Shah SA: Law and mental health interactions, p. 27. Emphasis in original
11. 406 U.S. 715, 717-19 (1972)
12. Competency to Stand Trial and Mental Illness, p. 2
13. *Ibid.*, p. 3
14. *Ibid.*, p. 3
15. See Walker OW: Mental health law reform in Massachusetts, Boston U Law Rev, 53 (1973) 986
16. McGarry AL: Final report – December 30, 1974, re Contract No. 278-77-0068 (OP), submitted to NIMH, p. 5
17. Figures from Competency to Stand Trial and Mental Illness cited in NIMH memo, Significant research findings in crime and delinquency, March 16, 1972
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20. See Laben JK *et al.*: Reform from the inside: Mental health center evaluations of competency to stand trial, J Commun Psycho, 5 (1977), 52, for a detailed description of this approach in Tennessee. See also Caulfield JM: Ohio commitments of the mentally ill offender, Capital U Law Rev, 4 (1975), 1, and Carlson EW: Forensic psychiatric examinations in the community and the institution: An analysis of differential costs and client characteristics in Ohio, Ohio State University Program for the Study of Crime and Delinquency, April 1977
21. For the studies of innovation on which these remarks are based, see Rogers EM: Diffusion and Innovation, (New York, 1962); Havelock RG: Planning for Innovation (Ann Arbor, Center for Research in Utilization of Scientific Knowledge, University of Michigan, 1975); Zaltman G *et al.*:

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22. See, however, recommendations for decentralization and uniform screening procedures in Roesch R and Golding S: A Systems Analysis of Competency to Stand Trial Procedure (Urbana, 1977)

Editorial Note

Pre-trial psychiatric examinations represent one of the greatest areas of "defensive law" and unnecessary over-utilization of forensic psychiatric services in the United States and Canada. If we are unable to halt this waste of hospital services and beds, we must face the continued necessity for additional funding for the care of these patients in hospitals thereby making less funds available for community programs.

Should not every state have a diversified outpatient pre-trial screening program? Then, only those cases that absolutely require hospitalization for their evaluations will need to be hospitalized. Many jurisdictions have reported false positives or "no indication of incompetency or lack of responsibility" for between 70 and 80 per cent of all those for whom incompetency or insanity pleas are made. Such a high level of negative findings clearly indicates the necessity for the development of screening programs in order to save services that are in short supply.

It is interesting to see that the two major procedures that have been developed in the area of competency evaluation, the McGarry Instruments, as discussed in this paper, have not been effectively utilized except in one of the four jurisdictions that were exposed to them. Does this mean that the instruments are not satisfactory, or does this mean that we are so established in our ways that we cannot make changes and adopt modern techniques? Does this mean that we are such strong individuals that we must all do it our own way, or does this mean that we don't want to change anything? At the very least, one would have hoped that the establishment of these two instruments would have caused a flurry of excitement with several research projects testing their validity, etc. Apparently numerous individuals have been using the instruments, yet, to my knowledge, there has been no new research with them; and this paper seems to indicate that there has been very little utilization throughout a "system."

It is hoped that with the requirement that community mental health centers become more involved with services to the courts these instruments will be utilized. In fact, I would predict that if they are not, the level of competency evaluations will be so variable and inconsistent from community mental health center to community mental health center that psychiatry's public image will be further tarnished.

Those conducting competency examinations certainly should give a new look at the McGarry Instruments as well as the development of decentralized pre-trial screening programs in their jurisdictions. The two can go hand-in-hand as Tennessee has shown.

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