An Evaluation of Procedures for Assessing Competency to Stand Trial

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In a field experiment involving 120 defendants at Bridgewater State Hospital in Massachusetts, the authors evaluated three instruments for assessing competency to stand trial: the Competency Screening Test (CST), Competency Assessment Instrument (CAI), and Interdisciplinary Fitness Interview (IFI). The CST (a paper-and-pencil test) was administered by a research assistant and scored by trained graduate students. Lawyers, psychologists, and social workers were recruited and trained in the use of the other instruments, then assigned as individuals (CAI) or teams (IFI) to conduct interviews and assess subjects. The performance of the project interviewers was compared against two yardsticks: (1) actual decisions reached by the regular Bridgewater staff, and (2) a consensus of two nationally respected experts who reviewed the cases and formed independent competency judgments. Both the CAI and IFI performed well under these conditions, indicating that one-time interviews by well-trained persons can lead to accurate competency decisions in the majority of cases. The authors conclude that hospitalization for competency assessment is rarely necessary.

Forensic clinicians are routinely called upon to determine competency to stand trial, yet most statutes fail to specify how they should reach their decision. Among the recommended procedures for assessing competency there has been little basis for choice, because up to now no general evaluation has been conducted. This is a report of such an evaluation, based on interviews held under field conditions with 120 defendants in Massachusetts.

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Background

In the landmark case of *Dusky v. United States*,[1] the Supreme Court stated the criteria for competency to stand trial: "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." This formula has guided forensic psychiatry and psychology in the succeeding quarter century, but it leaves a large area of indeterminacy. It specifies only what qualities are to be found in a defendant who is competent at the time of trial. By contrast, what competency assessors face daily is the more perplexing problem of inferring how an incompetent defendant

may be recognized in advance of the trial.[2]

This problem was made especially acute by the later Supreme Court decision in *Jackson v. Indiana*,[3] which required states to determine within a "reasonable period of time" whether a committed defendant would probably attain competency in the foreseeable future and, if continued incompetency was predicted, to release the defendant or institute civil commitment proceedings. Shortly after that time, McGarry and colleagues[4] at the Harvard Laboratory of Community Psychiatry undertook a project under National Institute of Mental Health sponsorship that resulted in the development of two instruments, the Competency Assessment Instrument (CAI) and the Competency Screening Test (CST).

These instruments were intended as complementary: the CST for use as an initial screening tool in the hands of paraprofessionals and the CAI for use as a full-scale assessment tool in the hands of trained forensic clinicians. The CST, developed by Paul Lipsitt and David Lelos, consists of 22 sentence-stems, which the defendant is to complete using pencil and paper. Examples are:

> If the jury finds me guilty I . . .
> When the evidence in George's case was presented to the jury . . .

The scoring manual gives examples of interpretations and scores. A score of 2 indicates no impairment on an item; 1, possible impairment; and 0, serious impairment. Item scores are summed. A total score below 20 is considered a basis for referral for further examination.

The CAI consists of 13 topic areas, which are listed in Table 1. Apart from Item 2, Unmanageable behavior, all the topics are legally oriented. There are no mental status items. The interviewer is expected to elicit responses from the defendant touching on each of these topics and to indicate degree of impairment on a five-point scale.

While McGarry was director of legal medicine in the Massachusetts Department of Mental Health, he made an attempt to institute the use of these protocols. He also made contact with forensic mental health officials in Tennessee, Ohio, West Virginia, and North Carolina and provided them with information about the instruments.

In 1977, the first author undertook a study sponsored by the National Institute of Mental Health to determine how much use had been made of the instru-

Table 1
Competency Assessment Instrument Items

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, witnesses
6. Understanding of court procedure
7. Appreciation of the charges
8. Appreciation of range and nature of possible penalties
9. Appraisal of likely outcome
10. Capacity to disclose to attorney pertinent facts surrounding the offense
11. Capacity to realistically challenge prosecution witnesses
12. Capacity to testify relevantly
13. Self-defeating versus self-serving motivation (legal sense)

Overall assessment
Rating of confidence in judgment*
Reason for finding*
Other factors that might affect decision*

* Added for purposes of this project.

ments in those four states.[5] The study found that only Tennessee had made extensive use of the CAI and virtually no one was using the CST. Part of the reason was the lack of any evaluation of the instruments' effectiveness, reliability, and validity. To remedy this omission, the authors undertook a full evaluation of the instruments in the context of a general evaluation of procedures for assessing competency to stand trial. The research began in 1980.

A primary purpose of the project was to evaluate the CAI and CST under conditions much like those existing in the field. The CST was designed as a screening instrument and was so evaluated in this study; it was not treated as an instrument that would ever be used alone to arrive at a final assessment of competency. The CAI, on the other hand, might be used for either screening or assessment purposes. In either case it was intended to be used by a single examiner, in the context of an interview generally less than one hour in length.

A second purpose of the project was to juxtapose the performance of the CAI with assessments by a well-trained panel consisting of both mental health professionals and lawyers, in order to see whether the dual perspective of such a panel, coupled with a training process stressing the situational nature of the competency construct, could assess competency more accurately over the long term. In our attempt to establish a format for such a panel, we found it necessary to develop a complete interview protocol in order to ensure sufficient uniformity of panel performance for research purposes.

In doing so we tried to redress some balances. We felt that the CAI goes too far in its primary focus on legal issues to the virtual exclusion of mental status questions that may have a bearing on a defendant's ability to participate in a legal process. Indeed, in general we have come to believe that the assessment of competency has been hampered by discipline biases on the part of the decision makers. We concluded that it would be more appropriate to develop a balanced perspective, one that would take both legal and psychological issues into account. In our opinion, an assessment procedure involving both legal and mental health professionals could lead to a more valid definition and assessment of competency and would almost certainly improve communication between the disciplines.

Although the Interdisciplinary Fitness Interview (IFI) as developed by the authors[6] shares its general format with the CAI, it differs from that instrument in a number of ways. First, it contains both legal and mental status questions, designed to elicit information about salient mental, as well as conceptual, obstacles to participation in one's defense. Second, it is designed to be administered jointly by a lawyer and a mental health professional rather than by a single interviewer. Third, it presupposes explicit training of both types of professional in the concepts, legal theory, and clinical issues comprising the competency construct. Finally, the IFI was designed with separate scales for registering the degree of impairment on a particular item and for registering the functional influence of that item on a defendant's compe-

tency. In its research version, the IFI consists of four major sections: (1) legal issues; (2) psychopathological issues; (3) a section for overall assessment of competency by each examiner separately; and (4) a section in which the two examiners could reconcile their findings—both the consensus on competency and the ratings on individual items (Table 2).

Table 2
Interdisciplinary Fitness Interview Items

Section A: Legal items
Capacity to appreciate the nature of the alleged crime and to disclose pertinent facts, events, and motives
Quality of relationship with one's current attorney
Quality of relationship with attorneys in general
Anticipated courtroom demeanor and trial conduct
Appreciating the consequences of various legal options
Section B: Psychopathologic items
Primary disturbance of thought
Primary disturbance of communication
Secondary disturbance of communication
Delusional processes
Hallucinations
Unmanageable or disturbing behavior
Affective disturbances
Disturbances of consciousness/orientation
Disturbances of memory/amnesia
Severe mental retardation
General impairment of judgment/insight
Section C: Overall evaluation
Overall fitness judgment
Rating of confidence in judgment*
Comment on basis for decision about defendant*
Other factors rater might wish to take into account in reaching decision*
Section D: Consensual judgment
Fitness judgment after conferring with partner
Changes in rating of individual items after conferring
Reasons for changes

* These items were added to the CAI as well to create a "research version" for use in the present project.

The instrument asks raters to indicate a defendant's status on five legal issues (e.g., quality of relationship with the [defense] attorney), using a three-point scale ranging from "no or minimal incapacity" to "substantial incapacity." For the 11 mental status items the instrument provides a simple yes/no checklist (e.g., either there are delusional processes or there are not). However, raters must indicate the importance of both the legal and the mental status items in their overall judgment on an adjacent three-point scale, ranging from no bearing to substantial bearing on the competency decision.

Study Design

Testing the CST, the CAI, and the IFI side by side involved creating several paths through which defendants could flow once they had been accepted as subjects in the research project. As shown in Figure 1, any defendant, once referred by a court clinic for a full-scale competency assessment, might be interviewed with the CAI or the IFI format. The CAI was tested both as a "screening" instrument (with subjects to be given a later "assessment" interview using the IFI) and as an assessment instrument in its own right. The IFI was not tested in the screening mode.

When the CAI was used as a screening tool, we wished to send equal numbers of defendants found provisionally fit and unfit by this method for IFI assessment. Because in practice only a small minority of defendants were found unfit by the CAI, virtually all of them were passed on for assessment by the IFI.

In addition, a certain number of sub-

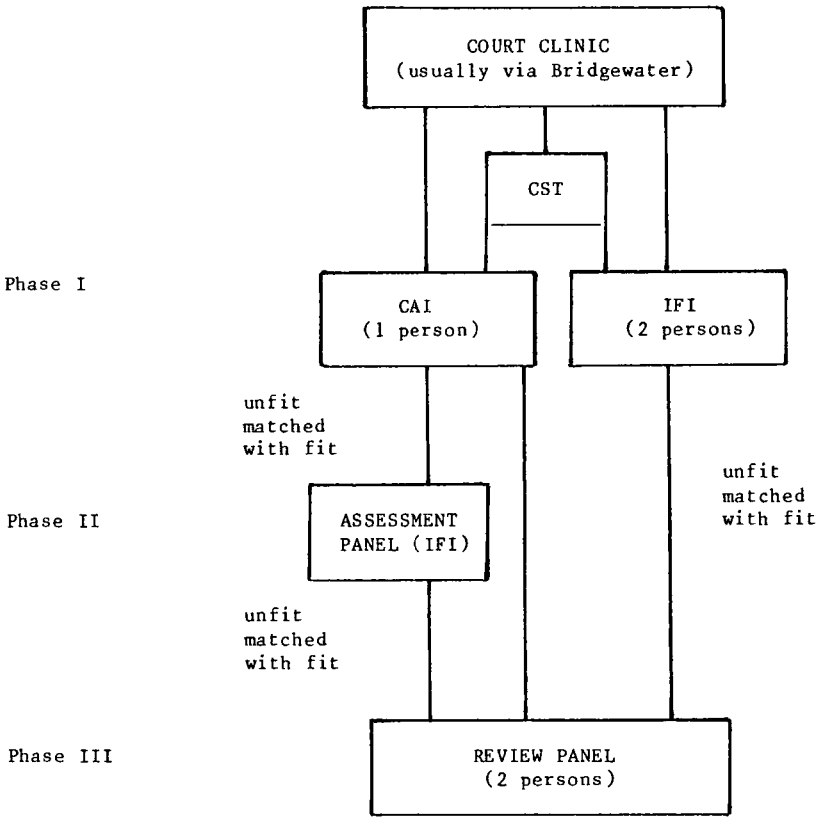

Figure 1. Design of the project.

jects were given the CST examination but were also later interviewed using either the CAI or the IFI format. Finally, records for about half the subjects (i.e., police, hospital, and all project interview records) were sent to a two-person review panel for an independent assessment by experts who were not otherwise affiliated with the project. Ralph Slovenko of Wayne State University Law School served as the legal expert, and Bernard Diamond, professor emeritus at the University of California, Berkeley, served as the expert in psychiatry. Here, too, an attempt was made to match unfit subjects with an equal number of fit ones; however, so few defendants were found unfit that it proved necessary to present to the review panel a disproportionate number of defendants determined fit by one of the previous tests.

The Interview Panelists The project interviewers consisted of 17 lawyers and 15 mental health professionals (psychiatrists, PhD psychologists, and psychiatric social workers; see Table 3). Of these, 14 (seven lawyers and seven mental health professionals) were trained to use the CAI. The rest were trained to use the IFI, and of the IFI panelists, 14 (six mental health professionals and eight lawyers) used it as a single-stage instrument. Two lawyers and two psychologists, all with high levels of experience

Table 3
Professional Affiliation of Interview Panelists

	Instrument			Total
	CAI	IFI (Single Interview)	IFI (Assessment Mode)	
Lawyers	7	8	2	17
Psychologists	3	2	2	7
Social workers	3	4		7
Psychiatrists	1			1
Total	14	14	4	32

and forensic sophistication, were selected to administer the IFI in the assessment mode following the CAI.

Selection criteria required that interviewers have experience in their field at least two years beyond professional school. Mental health professionals serving on the IFI assessment panel (seeing subjects previously screened with the CAI) were required to have additional experience in forensic or law-related activities. Lawyers for all panels were selected on the basis of previous experience in criminal law and forensic mental health issues. In order to maximize the interaction among professional team members, we rotated interviewers, assigning them randomly as far as personal schedules would permit, so that, with one exception, no two persons served together on an IFI panel more than five times.

Subjects The data reported in this project are based on 120 defendants in Massachusetts courts, most of whom had been sent to Bridgewater State Hospital for a competency examination. Most had previously been screened by a court clinic and found in need of further evaluation. The breakdown among assessment modes is shown in Table 4.

Table 4
Competency Measures Used*

CST	26 (24 followed by interview)
CAI	66 (total)
Alone	40
Followed by IFI assessment	26
IFI	78 (total)
Alone	52
Following CAI	26
Review panel	49 (total)
IFI only	19
CAI only	10
Both	20

* N = 120.

Research Environment

This research took place under field conditions within the Massachusetts mental health and criminal justice systems. An understanding of these conditions is necessary to grasp both the extent and the limitations of the inferences we are able to draw from analyzing the study findings.

Chapter 123, Section 15, of the Massachusetts General Laws governs the processes of determining competency to stand trial and criminal responsibility. The two concepts are often treated together in the statute, so that court and mental health personnel have little statutory basis for separating them conceptually. A screening process is built into

the law. Persons charged with a crime (misdemeanor or felony), about whom a question as to competency or criminal responsibility is raised by anyone connected with the case, are to be examined, at the request of the court, by a "physician." No qualifications for the physician are stated, nor is the nature of his or her examination specified. The physician is to submit a report to the court.

Once the report has been received, the court may either order the trial to proceed or order the defendant to be hospitalized for a 20-day period in a state facility while a further examination of competency or criminal responsibility is conducted. The statute does not require that the court's order be based on the screening physician's report or even take it into account, although in fact it is common for a court to follow the recommendations of the screener. The 20-day examination period may be extended for an additional 20 days. After that the hospital must submit a report to the court on the defendant's competency or criminal responsibility. The court is not bound to find competency or incompetency in accordance with the hospital report, although it almost invariably does so.

The higher volume courts in Massachusetts make use of court clinics, operated by the Department of Mental Health but responsible to the chief judge in each court, to exercise the screening function mandated by the statute. The screener is often a psychiatrist, although other physicians are employed as well. So are representatives of other professions such as psychology, social work, and law, whose reports, however, must be countersigned by a physician before they reach the judge. Screening by the clinics is conducted on an outpatient basis. In some courts the examiner goes on the day of arraignment to the holding room near the court where defendants are held and conducts the competency interview there. In others the defendants are brought to the court clinic offices for interviews. A few examiners encourage the defendant's lawyer to be present at the examination; most do not.

Assuming the screening examiner finds reason to doubt the defendant's competency (this happens in at least three quarters of the cases in the court clinics we observed), the court makes an order on the same day to have the defendant sent to an inpatient facility for observation and further assessment. Examinations pursuant to this order are conducted in state mental hospitals with locked wards, although security is not high in most of them. (The major exception is Bridgewater State Hospital, which is run by the Department of Correction rather than by the Department of Mental Health. Defendants, who are sent there from all over the state, are legally considered dangerous to themselves or others.) If the defendant is found competent, and this finding is accepted by the court, he or she proceeds to trial; if not, either the charges are dropped and the defendant is released or civil commitment proceedings are initiated, with charges pending and periodic reviews until competency is restored.

Competency examinations at Bridgewater are routinely done by a small staff of about six psychologists and psychiatrists. Their more or less standard report

format includes introductory remarks (usually background on the client, his alleged offense, prior hospitalizations and medications), presenting symptoms and characteristics, findings relative to competency, and final conclusions and recommendations.

Findings

Interviews for this project were completed over a six-month period. In other publications we have discussed the relation between individual item scores and the overall finding rates of each instrument.[7] Here we want to focus on the comparative performance of the assessment procedures and the implications this has for competency determination.

In the present study, 22 defendants completed the CST. Raters were graduate students recruited and specially trained for the project. Each completed instrument was scored by two separate raters, working without knowledge of each other's findings. Thus two CST scores were computed for each subject, one for each rater. The interrater agreement, obtained by correlating the pair of CST total scores, was very high (r = .96). Item reliability was also good.

Using a fitness classification based on the mean total score of the two raters, 14 defendants were classified as fit and the other eight as unfit.

Sixty-six defendants were interviewed by the project evaluators using the CAI. Whenever possible, defendants were interviewed within one week of the court-ordered competency evaluations. Information about a defendant's ability in each area (e.g., quality of relating to attorney; planning of legal strategy) was obtained in response to the 13 topic headings of the CAI (shown in Table 1). The CAI manual contains clinical examples of levels of incapacity corresponding to the ratings.

As the instrument was originally designed, a five on the CAI rating scale denoted no incapacity and a one denoted severe incapacity. In the present study the CAI was modified in two respects. First, in order to match the IFI scoring system, the scale was reversed, so that five denoted total incapacity and one no incapacity. A score of six indicated "unratable." Second, a column was added in which raters were asked, for each item, to indicate any specific concerns they had about the defendant's ability as well as specific behavioral evidence for those concerns. In addition, raters were asked to weigh the importance of each item to their final overall decision. A three-point scale, as used for the IFI, was used here (zero, no importance; one, some importance; two, major importance). Finally, raters were asked to indicate their overall assessment of competency (competent or incompetent), a rating of their confidence in their assessment, reasons for their decision, and a discussion of other factors, if available, that might influence their decision.

The CAI interviewers found 49 defendants (74.2%) fit and 17 (25.8%) unfit.

Seventy-eight subjects received interviews with the IFI, of whom 26 had previously been interviewed with the CAI. In analyzing the rating forms, it was necessary to replace missing data with mean values for the item in seven

cases. Because none of the subjects was found to be mentally retarded, the retardation item was dropped from the analysis. Legal items were collapsed into a two-point scale (by merging "moderate" and "substantial" incapacities) to achieve statistical comparability with the two-point psychopathology scale.

Of the 78 cases, one was dropped because of data irregularities. In two other cases the panelists could not agree on a finding. The interviewers found 58 (77.3%) of the remaining subjects fit for trial and 17 (22.7%) unfit.

Relationships among Measures Because all defendants underwent at least two independent evaluations, the decisions made by each source can be compared to decisions by other sources. A comparison of findings by means of the CST scores with findings of the hospital, the CAI, the IFI, and the review panel is shown in Table 5. In itself, the CST did not show strong correlations with any other competency measure. The apparent statistical agreement with CAI findings should be viewed skeptically in light of the small number of cases examined in common; indeed, the hospital findings, which in general tended to match those of the CAI, may be taken as a better criterion against which to measure performance of the CST. In relation to the CAI there is a slight correlation in fit-unfit findings, mainly because among the cases to which both instruments were applied the CST found only a modest number unfit that were found fit by the CAI. The relations between CST findings and those of the IFI and the review panel were not statistically different from chance. Most important, there was no statistical correlation between CST findings and those of the hospital examiners, the area in which we have the largest amount of data.

The advantage of the CST is that it can be administered rapidly by someone with minimal training and scored quickly by a professional or paraprofessional trained according to the developer's method, thus purportedly providing a quick, "first-line" view of competency. The disadvantage, however, is that the method does not appear to call either competency or incompetency with any reliability. In general it appears to find few subjects fit whom other techniques find unfit; thus it might be defended as a screening technique to make sure, at the expense of a high false-posi-

Table 5
Overall Agreement between All Judgment Sources and the CST

Source		CST Judgment				
		Fit	Unfit	N	χ^2	*p*
Hospital	Fit	56.5	26.1	23	.49	NS
	Unfit	8.7	8.7			
CAI	Fit	61.5	15.4	13	6.24	0.05
	Unfit	0.0	23.1			
IFI	Fit	46.2	38.5	13	.014	NS
	Unfit	7.7	7.7			
Review panel	Fit	14.3	57.1	7	.63	NS
	Unfit	14.3	14.3			

tive rate, that few truly incompetent people escape later, more thorough examination. But it does so with no demonstrably greater precision than would be achieved by randomly selecting candidates for further examination, with a bias toward overcalling incompetency. Any screening device, of course, uses a "coarse mesh" and should overselect for the condition to be examined (in this case, incompetency). The degree of overselection is a policy decision. However, in view of the severe consequence of heavy overselection and of the availability of more finely tuned instruments that can be readily applied, there is no research justification for use of the CST as a screening test.

In theory such a test could be used in conjunction with others, to arrive at a multiperspective determination. Thus the CST might be defended as part of a battery of tests. However, its lack of acceptable performance statistics argues against this policy, especially because tests are available that are not appreciably more time consuming and that correlate significantly with other measures of competency. These tests can be used as effective screening tools; the CST adds no useful information.

The relationship of judgments based on the CAI with judgments from all other sources is shown in Table 6. It should be noted that the number of defendants in each comparison varies, from 13 cases shared in common with the CST to 61 cases with hospital evaluation data.

The CAI decisions show the best accord with hospital and court decisions, disagreeing with each in slightly less than one fifth of the cases. If decisions were based solely on the CAI, about 10 percent of the defendants found unfit by the hospital or court would be considered fit. However, compared with the IFI and the review panel, the CAI still finds a greater proportion of defendants unfit.

Table 6
Overall Agreement between All Judgment Sources and the CAI

Source		CAI Judgment				
		Fit	Unfit	N	χ^2	*p*
Court clinic	Fit	0.0	5.3	19	0.38	NS
	Unfit	26.3	68.4			
Hospital	Fit	65.0	10.0	60	16.36	.001
	Unfit	8.3	16.7			
Court	Fit	64.0	8.0	50	14.81	.001
	Unfit	10.0	18.0			
IFI	Fit	42.3	19.2	26	5.85	.05
	Unfit	7.7	30.8			
CST	Fit	61.5	0.0	13	6.24	.05
	Unfit	15.4	23.1			
Review panel	Fit	39.3	17.9	28	10.22	.01
	Unfit	3.6	39.3			
Hospital diagnosis	Psychotic	26.2	26.2	61	19.65	.001
	Nonpsychotic	18.0	0.0			
	No diagnosis	29.5	0.0			

The CAI evaluators appear not to base their decisions solely on a finding that psychosis is present or absent, because approximately 50 percent of the defendants considered by the hospital to be psychotic were found fit by the CAI evaluators. Given that the orientation of the CAI is toward legal issues rather than those of psychopathology, such a finding is not surprising. This result is supported by an analysis of hospital decisions by hospital diagnosis for all defendants seen by the hospital. Psychosis appears to be a necessary but not sufficient basis for a hospital or CAI determination of unfitness. All but one of the 25 clients found unfit by the hospital were considered psychotic, but so were 41 percent of the fit defendants.

The outcome of IFI decisions cross-tabulated with various other decisions about the defendants is shown in Table 7. Several aspects of the results deserve special attention. In the first place, our best measure of the defendant's mental state—hospital diagnosis—is related to IFI decision making in an important sense. Although the chi-square is significant, inspection of the cross-tabulation makes it clear that presence of psychosis is unrelated to decision making, whereas absence of psychosis is highly related. Secondly, the IFI panelists are in highest agreement with the review panel (overall agreement, 90.6%), with most of the disagreement with the remaining sources of judgment being in a consistent direction of conservatism on the part of the IFI in calling unfitness. Thus, with the CAI, most of the disagreement is with the CAI calling unfit and the IFI calling fit. This cannot be simply explained as time sampling, because the IFIs used in one-time interviews were on average administered at the same point in relation to hospital admission and treatment as the CAIs, and their rate of calling competency does not differ significantly from that of all IFIs combined. Notice that the time sampling

Table 7
Overall Agreement between All Judgment Sources and the IFI

Source		IFI Judgment				
		Fit	Unfit	N	χ^2	*p*
Court clinic	Fit	13.0	0.0	23	3.16	.10
	Unfit	39.1	47.8			
Hospital	Fit	59.4	7.2	69	14.09	.001
	Unfit	15.9	17.4			
Court	Fit	57.6	8.5	59	11.90	.001
	Unfit	10.0	18.0			
CAI	Fit	42.3	7.7	26	5.85	.05
	Unfit	19.2	30.8			
CST	Fit	46.2	7.7	13	.014	NS
	Unfit	38.5	7.7			
Review panel	Fit	50.0	9.4	32	21.9	.001
	Unfit	0.0	40.6			
Hospital diagnosis	Psychotic	37.5	22.2	72	11.1	.01
	Nonpsychotic	18.1	0.0			
	No diagnosis	20.8	1.4			

explanation could not account for the similar pattern of court judgments that occur after the IFI judgments and considerable treatment.

The situation, then, is that the CAI judgments agree best with the court and hospital findings, the IFI judgments agree best with the review panel determinations, and the judgments of the two instruments, although showing a clear direction of difference, do not disagree with each other in a statistically significant way. Given the limitations of sample size in this study, it is reasonable to say that interviewers using the CAI, carefully trained by an authority familiar with the principles of its development, perform at about the same level as professional practitioners in a field setting. Those using the IFI, trained in a parallel fashion, are slightly less likely to find a subject incompetent, but they, too, mirror field practice.

Discussion of Comparative Data

Typically, competency evaluations are conducted by mental health professionals according to individualized practice and without lawyers present. Our data indicate that the legal and mental health perspectives can be joined in productive ways. We are, of course, in no position to argue on empirical grounds that the panels composed of lawyers and mental health professionals reached "better" decisions. Although their findings tended to agree most consistently with those of the review panel, we have no hard criterion against which to evaluate this procedure rather than some other.[8] Nevertheless, our analysis of the basis for decisions by panelists of various professional backgrounds stresses the interaction between legal and psychopathology items and highlights the importance of legally trained and psychotherapeutically trained assessors working in tandem.

As a general comment, it is clear from our analysis that the minority of cases in which one or more raters found a subject unfit presented the greatest decision-making difficulties. The training program accompanying the IFI was deliberately designed to foster conservatism in calling incompetency, and it was apparently successful to the extent that raters trained for the IFI agreed with the conservative review panel more consistently than with either the hospital teams or the CAI interviewers. (The presence of a mental health professional on every IFI panel may also have helped to ensure that aberrant speech or behavior would not in itself be taken as evidence of unfitness.) As we move along the spectrum of trial competency from most to least competent, we find first the CAI and hospital interviewers willing to say a subject is incompetent, then the IFI and review panelists (Table 8). The nature of the competency construct is such that no one can say confidently who is right. One can decide *a priori* that a conservative approach best reflects the competency construct as it has evolved in theory, but this decision carries with it a preference for a lower rate of finding incompetency than is the norm, at least in Massachusetts. Furthermore, there is some circularity in choosing this or any other criterion in that the competency construct evolves largely through the interaction of court decisions and schol-

Table 8
Overall Agreement between All Judgment Sources and the Review Panel

Source		Review Panel Judgment				
		Fit	Unfit	N	χ^2	p
Hospital	Fit	39.5	7.0	43	11.08	.001
	Unfit	18.6	34.9			
Court	Fit	41.7	2.8	36	14.86	.001
	Unfit	16.7	38.9			
CAI	Fit	39.3	3.6	28	10.22	.01
	Unfit	17.9	39.3			
CST	Fit	14.3	14.3	7	.63	NS
	Unfit	57.1	14.3			
IFI	Fit	50.0	0.0	32	21.9	.001
	Unfit	9.4	40.6			

arly thinking; thus neither is an independent reference point.

Competency examiners, traditionally physicians, are charged by law to report on fitness as assessed through their professional expertise. Courts, on the other hand, in determining whether a defendant of questionable competency could receive a fair trial, may consider issues of justice in weighing the testimony of mental health experts. Regardless of scholarly consensus, court findings are likely to vary with time and region. Although we do not argue here that standards of justice are less well defined than are standards of competency, it seems clear that the two need not necessarily be coextensive. If, in fact, standards of justice at times admit more latitude, depending on circumstances, that is simply a further indication that issues other than mental condition alone, such as the nature of the charge and the planned defense strategy, may (indeed, should) enter the competency construct to affect the decision in particular cases.

In Massachusetts, technically defendants at the stage of court clinic referral for hospital examination are only questionably competent, because the court has not made a determination. However, because the effect of the recommendation of the clinic is usually to confine them involuntarily in a state facility for a period of three to six weeks, the referral amounts to a judicially ordered temporary commitment.

A follow-up inquiry, conducted one year after the interviews in this project took place, discovered that only one of the 120 original defendants had been explicitly found incompetent by the court. Twenty-nine cases were continued; the defendants in these cases may have been considered provisionally incompetent or the continuance may have been for other reasons; the records are not explicit, but judging by the hospital findings about half were deemed unfit. Seventeen cases were dropped. Two defendants were found not guilty by reason of insanity. Thirty-nine were convicted, three were acquitted at trial, and four were bound over to a higher court; in these 46 cases there is a clear de facto finding of competent. Information on 25 defendants was unobtainable.

Thus the clearly competent cases are matched by an almost equal number of continued and dropped cases, roughly half of which probably represented defendants considered incompetent, for the time being, by the courts. It appears, then, that the clinics referred about four times as many people for inpatient examination as were ultimately found unfit. The others were returned for trial. Spontaneous remissions, the effects of medication, and the structured environment of the hospital account for some of the differences between the clinic and the hospital assessments, but the fact remains that screening clinicians refer numerous clients for observation as involuntary inpatients who would probably not be judged incompetent by a qualified observer familiar with the accepted standards. The effect is to transfer a disturbed population temporarily out of the criminal justice system, with its built-in due process protections, into the mental health system, without triggering commitment or psychiatric transfer criteria, the ordinary safeguards against arbitrary enforced hospitalization.[9]

Further research is needed on the psychiatric and social system needs that cause the competency process to be invoked for large numbers of defendants. Judges associated with this project, and others convened later by the Social Science Research Institute and the Massachusetts Bar Association to discuss the issues it raised,[10] freely acknowledged that the mechanism is often used in Massachusetts because it is the easiest and fastest way to remove from the streets individuals who seem unable to care for themselves or who may pose problems for people near to them. They recognized that trial competency in the technical sense is not really at issue much of the time. This fact explains why it is difficult, in a field setting, to find a large enough pool of incompetent defendants to evaluate assessment procedures adequately. It also raises a host of ancillary issues ranging from civil liberties to the adequacy of basic mechanisms in the mental health and criminal justice systems, among others, to meet (or even catalogue) the needs of individuals functioning at the margins of society.[11]

We can briefly summarize the salient conclusions of this study:

1. A brief, one-time interview can lead to a reliable competency decision in the vast majority of cases. Therefore, it is rarely necessary for a defendant to be hospitalized solely for the determination of competency to stand trial. Whereas confinement may be in order for demonstrably dangerous or severely decompensating individuals and should be provided for, in our view this procedure, when invoked, should be justified on grounds other than the need for a competency examination.

2. Psychologists, lawyers, and psychiatric social workers, suitably trained, appear to be as effective as psychiatrists (i.e., Bridgewater staff) in determining competency.

3. Our preferred format for a competency interview is one in which a lawyer and a mental health professional, both specially trained, question the defendant, thus allowing each to exercise judgment in the area of strongest background and providing a useful check on individual impressions. However, CAI

interviews conducted by individuals rather than by teams were as effective with our study population. Whether this equivalence would hold true with a large population of problematic or "gray area" defendants is a subject for further research.

4. In general, a written, semistructured interview format is preferred, because it assures courts of a standard basis for competency judgments. A carefully designed format also serves as a checklist for the interviewers, prompts them to record supporting observations, and guides them in cuing subjects to elicit their responses in specific areas.

5. Like the review panel, the IFI panelists were conservative in calling incompetency. This agreement between the two panels was particularly striking in the area of the fitness judgment by the instrument; no one found fit by IFI panelists was called unfit by the review panel, and only 9.4 percent of subjects were found unfit by the IFI and fit by the review panel. This is the lowest net disagreement of any combination of ratings examined in this project.[12]

6. In considering interview panel accuracy, it is not possible, given the project research design, to separate the contribution of the instruments *per se* from the contribution of the training session all panelists were required to undergo. In practical terms, of course, there is no need to make such a separation, because the training is seen as an integral part of the use of either instrument. Although a rigid training format is not prescribed, we recommend that any training session last at least eight hours and be preceded by reading of current literature on competency as prescribed by the trainer, including the work of the present authors.[13] In addition, one or more videotaped competency interviews (using the format of the training instrument) are extremely important. They should be presented so that trainees can score them and arrive at their own fitness determinations, then discuss this process and the results with the instructor, who should offer a critique of the entire process. Needless to say, the instructor should be highly experienced in conducting competency interviews and familiar with the construct of competency as elaborated in the literature cited above.

We do not maintain that a one-time interview, even with an interdisciplinary team, is sufficient for a final determination of competency in every case. In fact, we would argue strongly that more research is needed on the "grey area" cases that are underrepresented in our sample. Nevertheless, it is clear that a majority of competency cases can be decided quickly on the basis of a single comprehensive interview, and that such an interview, at an early stage in the proceedings, could obviate the need for hospitalization in the bulk of cases.

Other cases—in which clients are initially found incompetent—undoubtedly call for further examination. Whether hospitalization is required should be a clinical (not *pro forma*) decision in each such case. Here the interview format (protocol) serves simply to alert the examiner and the court that the individual might not be competent and that more intensive examination is advisable. A defendant who is competent to stand

trial may still, of course, require hospitalization for other reasons.

This approach is in line with the recommendations of the American Bar Association.[14] The ABA committee sets out the following criteria as constituting a first level of competency:

1. Understanding of the nature of the trial process, without undue perceptual distortion;
2. Capacity to maintain the attorney-client relationship;
3. Ability to recall and relate factual information;
4. Capacity to testify relevantly; and
5. The above abilities in light of the particular charge, extent of defendant's participation, and complexity of the case.

A defendant showing deficiencies in one or more of these areas should be further examined to determine the need for treatment, the nature of the treatment, and the likelihood of regaining competency. However, those defendants not showing significant liabilities in respect to the first set of criteria need not be examined further, in the view of the ABA drafting committee.

The CAI and, even more completely, the IFI, measure the extent to which defendants meet the above criteria. There is thus good agreement between the ABA recommendations and our own findings, with the addition that we can offer empirical evidence for the effectiveness of two interview formats in determining the need for further, possibly inpatient, examination.

Although a national legal standard of competency exists and is widely recognized, there has been little uniformity in the local determination of competency, even among jurisdictions that have been brought into contact with earlier research findings.[15] However, it seems plain that a sound basis now exists for policy making—or remaking—in courts and legislatures across the country. There is also a basis for determining, in general terms, when competency questions are used inappropriately to confine without their consent defendants who might otherwise not legally be detained. This is a foundation on which to build a more uniform, and more rational, nationwide approach to competency determination in the next few years.

References

1. *Dusky v. United States*, 362 U.S. 402 (1960)
2. The state of Florida offers an exception. There the new statute incorporates most of the fitness criteria from the Competency Assessment Instrument. The examiner must relate the following legal factors to the defendant's mental condition:
   a. Defendant's appreciation of the charges;
   b. Defendant's appreciation of range and nature of possible penalties;
   c. Defendant's understanding of the adversary nature of the legal process;
   d. Defendant's capacity to disclose to attorney pertinent facts surrounding the alleged offense;
   e. Defendant's ability to relate to attorney;
   f. Defendant's ability to assist attorney in planning defense;
   g. Defendant's capacity to realistically challenge prosecution witness;
   h. Defendant's ability to manifest appropriate courtroom behavior;
   i. Defendant's capacity to testify relevantly;
   j. Defendant's motivation to help himself in the legal process;
   k. Defendant's capacity to cope with the stress of incarceration before trial.

   (Florida Rule of Criminal Procedure 3.21(a)(1))
3. *Jackson v, Indiana*, 406 U.S. 715 (1972)
4. McGarry AL, Lipsitt PD, Lelos D: Competency to stand trial and mental illness: final

report (DHEW Pub. No. (HSM) 73-9105). Rockville, MD: National Institute of Mental Health, 1973

5. Schreiber J: Assessing competency to stand trial: a case study of technology diffusion in four states. Bull Am Acad Psychiatry Law 6:439–57, 1978
6. See Golding S, Roesch R, Schreiber J: Assessment and conceptualization of competency to stand trial: preliminary data on the interdisciplinary fitness interview. Law Hum Behav 8:321, 1984 (A copy of the Interdisciplinary Fitness Interview may be obtained from Dr. Roesch, Department of Psychology, Simon Fraser University, Burnaby, B.C. V5A 1S6, Canada)
7. Golding S, Roesch R, Schreiber J: op. cit. (1984); Schreiber J, Roesch R, Golding S: Evaluation of procedures for assessing competency to stand trial (Report to the National Institute of Mental Health, Project No. MH 33669). Boston, Social Science Research Institute, 1984
8. See Goldstein R, Stone M: When doctors disagree: differing views on competency. Bull Am Acad Psychiatry Law 5:90–7, 1977
9. See Geller J, Lister E: The process of criminal commitment for pre-trial psychiatric examination: an evaluation. Am J Psychiatry 135:53–63, 1978; Bangstron W, *et al*: Social structural contingencies in the decision of criminal courts to commit defendants as incompetent or criminally insane. Criminal Justice Rev 2, 1977; Dickey W: Incompetence and the nondangerous mentally ill client. Criminal Law Bull 16:22, 1982
10. Bench/Bar Conference on Competency to Stand Trial. Cambridge, MA, Social Science Research Institute and Massachusetts Bar Association, April 1982
11. Bloom J, Shore J, Arvidson B: Local variations in arrests of psychiatric patients. Bull Am Acad Psychiatry Law 9:203–9, 1981.
12. It could be argued that the Bridgewater team has the most accurate view of competency as construed by the courts in Massachusetts and thus best reflects the competency construct being applied in "real life" situations. However, because courts tend to accept the Bridgewater findings rather than the other way around, court feedback regarding hospital decisions is relatively uncommon. Which standard one finally accepts will no doubt partly depend on whether one seeks to promote an "academic" or a "practical" climate for development of the fitness construct. Which standard is the more just cannot be addressed from the present research evidence.
13. Roesch R, Golding S: Competency to Stand Trial. Urbana, IL, University of Illinois Press, 1980; Golding S, Roesch R, Schreiber J: op. cit., 1984
14. American Bar Association: Criminal justice mental health standards. New York, 1984, pp. 152–154
15. Schreiber J: Assessing competency to stand trial, op. cit., 1978