Neuropsychological Assessment of Competency to Stand Trial Evaluations: A Practical Conceptual Model

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Competency for adjudication is a complex concept that, despite judicial efforts to articulate functional criteria, has presented conscientious clinicians with the need to filter through multiple levels of psychological data to adequately evaluate and describe the germane functional capacities and deficits of a given defendant. Practitioners are confronted with preparing evaluations that are either psychologically inclusive and too broad to be judicially useful or too brief (opinions with inadequate descriptions of how a specific defendant's abilities and impediments affect the legal criteria). The trend toward harsh sentencing guidelines has further increased defendants' incentives either to postpone adjudication or to attempt to establish a foundation for an insanity plea. Therefore, accurate identification of malingered deficits has become a more significant problem in evaluating competency to stand trial than it previously was. When neuropsychological factors are introduced, competency assessment becomes complex. This article presents a methodology for managing these complexities. Strategies for preparing concise competency evaluations for defendants presenting neuropsychological symptoms are provided along with examples that help illustrate the evaluation process.

Despite efforts by the legal community to codify and clarify the criteria for trial competency, the personal mental status capabilities that a defendant must possess to meet the threshold level of competence have not been self-evident. Multiple authors have developed schematic guidelines[1,2] and structured tools[3,4] for addressing what some have erroneously considered to be a straightforward and simple domain. Despite these efforts, each competency evaluation requires both a sophisticated understanding of the evolution and practice of the legal criteria related to trial competency and a firm grounding in clinical pathology and attendant functional deficits. This article focuses on the application of neuropsychological test data to competency to stand trial evaluations.

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Legal Standard

The legal outline for consideration of trial competency was established in the United States Supreme Court decision known as *Dusky v. U.S.*.[5] This case set the prevailing standard and criteria for the determination of competency to stand trial. Two basic elements articulated in *Dusky* are: (1) does the defendant have sufficient present capacity to consult with his lawyer with a reasonable degree of rational understanding; and (2) does the defendant have a "rational as well as factual understanding of the proceedings against him." The Dusky standard for competency has been subsequently adopted in all jurisdictions and codified legal guidelines for competency to stand trial have been established in many states. In California, the standard is codified as follows and outlined in Penal Code Section 1368[6]: (1) to understand the nature and purpose of the proceedings taken against the defendant; (2) to have a rational ability to cooperate with counsel in the development and production of a defense; and (3) to have the ability to prepare and conduct one's own defense in a rational manner without counsel.

The third criterion, parenthetically, does not presuppose that the defendant has the desire or the expertise to represent him or herself. Rather, the defendant must be able to consider the possibility of acting as counsel and exercise a knowing, voluntary, informed choice. The phrase, "by reason of mental disease, defect or disorder" is not specified, although defendants found incompetent to stand trial have been declared so because of mental health deficiencies (either mental illness or developmental disabilities).

Conceptual Models

Grisso[1] developed an excellent conceptual model for the assessment of trial competency. This model examines the functional capacities demonstrated by the individual (i.e., what are the strengths and deficits of specific abilities as defined by legal standards?). Causal explanations are offered for the deficits observed, such as mental disorder, situational state, malingering, and ignorance of legal process for example. If a mental disorder is established, then the next step is the formulation of the link between the symptoms of the illness and the specific competency-related deficits. Prescriptive remedies for alleviating the symptoms and establishing and maintaining competency are then offered on the basis of the deficits observed. The links between the mental illness and the specific functional deficits impairing competency are evaluated for the likelihood that remission can be established and competency restored.

Grisso[1] outlined three elements in his model of trial competency. Functional capacities are the specific mental status characteristics of a defendant, including the strengths and weaknesses as related and defined by the legal standard. Causal explanation includes the detailed causes of a defendant's functional level, including a differentiation among various conditions (mental illness, ignorance or lack of information regarding the legal issues, situational state such as intoxication or malingering). The third element is determination of the prognosis for recovery, or

establishment of trial competency, and the mechanism for facilitating that process. For prescriptive remedies, it is important for evaluators to articulate functional strengths and to use those areas of capacity to elucidate a model for restoring trial competency. This may require multimodal treatment and education as well as specialized circumstances to maintain competency.

In 1987 another similar model for considering competency was developed by Drob and colleagues.[2] Their model to assist clinicians in addressing competency was similar to those of Roesch and Golding.[4] Collectively, these models focused upon accurately diagnosing the defendant. An accurate description of the defendant's mental status includes the specific symptoms and severity of symptoms for a defendant at the time of the evaluation. The second element is the elucidation of the nexus between the defendant's mental status and the legal criteria. The last element is the determination of the etiology of the incapacity and must include the expected course and duration of the dysfunction. Prescriptive remedies for resolution of the dysfunction should also be outlined.

Neuropsychological assessments can provide critical information in cases in which the mental status deficits are cognitive in nature. Indeed, the competency to stand trial standard can be viewed as a cognitive construct; it encompasses basic cognitive abilities such as a capacity to understand, to exercise rational thought, and to be able to consider specific decisions and their attendant consequences. Additionally, sufficient cognitive ability to *appreciate* retention or dismissal of legal representation is necessary. Trial competency also presupposes certain fundamental abilities:

1. Expressive language skills involve the apparent capacity of the defendant to speak and make his or her thoughts understood, particularly when working with defense counsel.
2. Receptive language skills include the ability to receive and understand what is communicated in the courtroom and with defense counsel.
3. Memory includes the ability to retain information and the ability to recall information that would be useful to defense counsel. Memory also involves the ability to process and remember court proceedings and to be able to make rational decisions with defense counsel in accepting pleas or formulating strategy.
4. Attention involves the ability to sustain alert focus and concentration on court proceedings and to appreciate information discussed with defense counsel.
5. Executive functions include the ability to process information at an abstract level, to be able to engage in cognitively flexible thinking, and to make rational decisions with defense counsel regarding effective trial strategy.

Models for Assessment of Trial Competency with Neuropsychological Data

Neuropsychological data can readily be translated into Grisso's model.[1] When neuropsychological impairment is raised as an issue in trial competency evalua-

tions, the first step is to establish the extent and nature of deficits and whether such deficits are representative of a *bona fide* or malingered neurobehavioral disorder. If the pattern is consistent (i.e., test data, records, and behavioral observations are in accord), then the next step is establishing the link between the observed cognitive deficit and the operational functions fundamental to trial competence. If a link can be established (i.e., the cognitive deficit is such that one or more of the legs of competency to stand trial are impaired), then an opinion of trial incompetence can be rendered. Subsequent to such a determination, the means for establishing cognitive remediation specific to trial competence should be detailed.

Neuropsychological Methods When beginning a competency assessment, it is first important to establish the defendant's global level of functioning and his specific knowledge and understanding about the pending proceedings. Competency assessment instruments are useful for the evaluation of specific content-related trial competency and process issues. It is essential to assess both the concrete elements of judicial process and the elusive interpersonal elements of cooperation between a defendant and defense counsel. Additionally, the stability of a defendant's capacity to remain focused and cooperative in the highly structured, stressful, and demanding situation of court must be evaluated in a manner that will yield reliable and valid opinions.

Mental status examinations, including a brief instrument like the Neurobehavior Cognitive Status Examination,[7] can provide a systematic and efficient manner of screening for the possibility of neuropsychological deficits. Orientation to reality, including time and circumstances, short and long term memory, comprehension of neutral and personal situations, and mental flexibility can be screened with this instrument. If deficits are noted in a general screening, additional assessment will assist in evaluating the extent and limits of the cognitive functional capacity.

A neuropsychological screening battery can be used to establish which essential cognitive capacities fall into an impaired range. Such a battery can also help to determine the extent to which an impairment interferes with specific aspects of trial competence. However, a detailed and lengthy neuropsychological battery is not necessary in most cases. Focused, well-considered neuropsychological assessment can be useful in suggesting prognostic possibilities for recovery of function and restoration of competency. This assessment can also assist in the development of a treatment plan to accomplish appropriate restoration of competency. We recommend a neuropsychological approach that begins with observation of the individual within the context of a clinical interview, followed by a mini-mental status examination and competency assessment instruments.

Cognitive functional capacity can be divided into four broad areas that are essential to trial competence: language skills, memory, auditory attentional skills, and reasoning. Receptive and expressive language can be observed in conversational speech and assessed with brief aphasia screening measures and naming tests. In addition to the aphasia screening

questions of a mental status examination, receptive language can be evaluated by monitoring the accuracy of the defendant's understanding of questions asked and by giving instruction and direction in the course of an interview. Receptive language and comprehension can be evaluated when a question is asked. Appropriate response requires the defendant to maintain focus, accurately interpret the meaning of the question, hold it in short term memory, scan long term memory for an appropriate response, and order the response in a logical and coherent communication. This method of evaluating straightforward questioning can get to the heart of expressive, receptive language, long and short term memory, and attention and concentration.

Higher order, complex cognitive operations such as logical sequencing and syntax are also evaluated when questioning the defendant relative to the pending judicial proceedings. Differences can be noted when the defendant is presented with neutral abstraction problems, such as proverb interpretation and similarities. Hypothetical questions related to defense strategy can also be useful in distinguishing between authentic cognitive difficulties and feigned problems. Examples of such questions would include: "What would happen if you were offered 25 years to life?"; "Would you ever consider taking a deal?"; "What would happen if you never went to trial?"; and "What do you think would happen if you went to a state hospital as incompetent to stand trial?" These questions allow the evaluator to address how the individual deals with complex material and whether or not the defendant has considered options, as well as the logic utilized in considering these issues.

Detection of Malingered Cognitive Impairment

Psychogenic and malingered symptoms must be distinguished from neurologically based syndromes. A thoroughly inquired and researched history is imperative to this purpose. Schacter,[8] in a review of studies examining defendants' claim of amnesia for the crime, found that memory loss was claimed in 25 percent to 65 percent of homicide cases. In the case of "fakers," Schacter noted that there appeared to be virtually no memory triggers. Individuals with a genuine memory disorder, however, were much more likely to acknowledge that their memory could be "jogged." Roesch and Golding[4] found that genuine memory loss among individuals undergoing competency to stand trial evaluations was associated with head injury suffered during the offense, severe personality disorder, or alcohol and drug use. Malingered incompetency to stand trial can have the secondary gain of avoiding or delaying prosecution, setting up a foundation for the plea of not guilty by reason of insanity, or reprieve from a custody environment through placement in a hospital setting. A project by Goerss[9] highlighted the increased rate of malingered trial-incompetent patients in a California forensic hospital among "third strike" felons, with claims of amnesia prominently represented. These results underscore the necessity of inquiring and researching the

defendant's history and contrasting that history with assessment and observational data.

Malingered cognitive impairment is a critical issue that must be addressed in forensic neuropsychological evaluations. It is beyond the scope of this article to review the literature on malingered neuropsychological deficits; however, the general consensus is that the best approach utilizes multiple data sources.[9–11] As with any forensic issue, the assessment of malingered cognitive deficits involves a comparison of the consistency among test data, history, and behavioral observations.

Detection strategies for malingered cognitive deficits follow two basic approaches. One approach is a qualitative analysis of test performance to address motivation. The other is the use of specific instruments designed to detect feigned impairment.[12, 13] The qualitative approach involves the analysis of an individual's test performance to patterns of *bona fide* neurologically impaired patients. Inconsistencies within the individual's testing is highly suggestive of purposeful deception. An example of this would be relatively better results on a complex test than on a simple task. For example, impairment on serial learning tasks is a common feature among individuals with true traumatic brain injury. The pattern in those with true traumatic brain injury is that of poorer scores on recall than on recognition. Feigning would be suspected in an individual who obtained the opposite pattern, that is of higher scores on the more difficult recall trial than on the simpler recognition trial.[12, 14, 15] Other qualitative approaches include examining the level of complaints described and their correspondence to observed test behavior and history (e.g., an individual complains of constant confusion, yet is able to drive to doctor's office for his/her appointment without difficulty and is able to read and comprehend material at a high level). The qualitative approach relies heavily on the skill, experience, and judgment of the evaluator. With the adjunct of specifically designed and validated assessment tools, the accuracy of discrimination between *bona fide* and feigned cognitive symptoms can be enhanced. Measures constructed to detect feigned cognitive deficits include instruments such as the Portland Digit Recognition Test,[16] the Rey 15-Item Memory Test, Dot Counting,[17–19] and the Test of Memory Malingering.[12] These instruments have targeted basic memory or attentional skills. Normative data exist on samples of individuals with true brain damage, those asked to feign deficits, or those labeled "at risk" for malingering (e.g., disability evaluations in which there is a clear secondary financial gain). Some of the tests rely upon a "forced choice" approach where the individual must choose between one of two responses. However, it should be noted that malingered neuropsychological deficits cannot be definitively identified on the basis of scores from a single instrument.[20, 21] Scores falling in a malingered range on these measures can be used to raise doubt about the accuracy of the results on the other standardized measures administered as well as raising questions regarding the motivation of the individual. The optimal

assessment approach uses a combination of both the qualitative method and the administration of cognitive tests designed to detect malingering.

Neurobehavioral Clinical Syndromes Impacting Trial Competency

Some neurobehavioral clinical syndromes that can impact trial competency include dementias that create global cognitive deficits, disorders that result in select cognitive deficits, and disorders that produce mood lability and/or psychotic symptoms. Specific syndromes, which may produce a global dementia, include but are not limited to: Alzheimer's disease, vascular dementias, Parkinson's disease, alcohol-related dementia, AIDS dementia, and traumatic head injury.

Disorders that could result in select cognitive deficits would include, but are not limited to, the following conditions: cerebrovascular accident (CVA), seizure disorder-related memory impairment, postconcussive syndrome, and drug/alcohol/inhalant abuse. Disorders that may produce mood or psychotic symptoms would include the following: head injury-related mood lability, neurotoxic syndromes, infectious diseases, and neoplasms. It should be noted that many syndromes are associated with both focal and global deficits (e.g., CVAs, alcohol-related syndromes, and infectious diseases, to name a few). The following case examples will guide the reader in utilizing these authors' approach to using neuropsychological data to assess competency.

Case Example A The defendant is a 35-year-old male charged with possession and sale of a controlled substance. If found guilty, he could face up to 25 years to life imprisonment, as this is his third felony "strike." His attorney describes the defendant as argumentative, rambling, and often suspicious regarding the motives of counsel. The defendant has no prior psychiatric history of evaluation or treatment, although he does have a history of intravenous heroin, phencyclidine, amphetamine, and crack cocaine abuse. His medical history is positive for evidence of advanced AIDS, confirmed by county hospital diagnosis and computerized tomography (CT) scan documentation of cortical atrophy and enlarged ventricles. Because the incidence of AIDS-related dementia has been shown to occur in only seven percent of AIDS patients, the issue of malingered cognitive deficits needed to be addressed, and some court-appointed evaluators had determined that the defendant was malingering deficits. The secondary gain for such malingered deficits was suggested as reflecting the inmate's desire to prolong or circumvent the pre-sentence process through trial incompetence and also his desire be housed in the comfortable setting of the State Hospital versus county jail. These evaluators noted that the defendant was quick to become abusive when confronted with his lack of knowledge of court proceedings. His lengthy criminal history suggested that the defendant had more than a passing knowledge of criminal trials.

Findings On examination, the defendant is found able to identify the charges against him accurately, although his manner of speech is garbled and notable for word-finding difficulty. His mood and

manner are abrupt and unstable, he frequently shouts and becomes enraged. He repeatedly states that he does not care whether he is convicted because of the terminal nature of his illness. During the course of the interview, the defendant makes numerous references to being "set up by the police." He can identify court personnel and their functions, at a concrete and definitional level. He is dismissive of the abilities of his attorney and berates him for being a "public pretender." He cannot recollect his attorney's name nor can be identify the specifics of even one meeting with his attorney over the three months that his attorney has been on the case.

Neuropsychological Test Findings This individual demonstrated global cognitive deficits on the Folstein Mini-Mental State Examination,[22] with a score of 18 of 30, and poor verbal memory and learning on the Rey Auditory Verbal Learning Test (RAVLT).[23, 24] The Trial 5 score was at the first percentile, and recognition was at the fifth. Wechsler Memory Scale-Revised (WMS-R)[25] Logical Memory was at the 20th percentile. There was also evidence of impaired auditory attention (Wechsler Adult Intelligence Scale Digit Span subtest, 10th percentile)[26] and visual attention (Trails A and B times, both at the first percentile)[27] as well as cognitive rigidity (Wisconsin Card Sorting Test (WCST),[28] Perseverative Responses were 100). The nature of this individual's deficits, the observed mood lability and rage in reaction to his inability to perform cognitive tests, in concert with the CT finding of cortical atrophy, would suggest that there is a definable neurobehavioral disorder at work, specifically AIDS-related dementia. The prognosis for this condition would be poor given the nature of the disease. The consistencies between the medical history and neuropsychological test findings of poor verbal memory, attention and language skills, and extreme cognitive rigidity suggest the deficits are a genuine profile of deficits that would preclude an opinion of trial competency. Despite some relatively preserved functions, such as visual memory (WMS-R Visual Memory was at the 25th percentile), this is an individual who persists in erroneous problem-solving strategy, even in the face of repeated verbal feedback (WCST Perseverative Responses were 100).

Assessment and interview observations of this individual support the diagnosis of AIDS-related dementia and sufficient functional deficits for a finding of trial incompetence. In this instance the deficits are such that they will interfere in three ways: the defendant's attention is poor and wanes; his mood is unstable; his interpretation of his environment is driven by persecutory thoughts; he is cognitively rigid and unable to manage complex stimuli, and his memory is impaired, rendering his ability to learn poor.

Competency Findings The critical issue is the extent to which neuropsychological findings, consistent with a dementia, impact upon trial competency. Case example A illustrates a situation in which the defendant seemingly knows the first competency criterion (present understanding the nature of the proceedings taken against him). He knows the charges

against him and is aware of the functions of court personnel and the trial process. If the trier of fact were to adopt knowledge as the only standard for competency, then this individual would be considered competent to stand trial. One could argue that this defendant's long criminal history further renders knowledge of court proceedings so familiar to him that it is in the "over-learned" category. This type of knowledge can generally be retrieved even when a patient is suffering from a dementia. The notion of "appreciation" or rational understanding, however, raises the cognitive processes required, to a higher level. Appreciation of the nature of the charges, court proceedings, and sentencing consequences requires cognitive capacity beyond that of an identificational level to one requiring some degree of cognitive integration of the material. In this case, what is required is the recognition that the remainder of his life would likely be spent in prison as the result of the charge having been filed as a third felony "strike." It could be argued that the defendant's poor verbal memory, inattention, cognitive rigidity, and mood lability impact upon his capacity to appreciate the seriousness of the charges against him and the legal consequences attached to the charge. This argument would suggest that the dementia is producing an overarching profile of deficits that impact upon this defendant's appreciation of the first leg of the competency standard. His impaired rational functions, therefore, negate the satisfactory role of his basic understanding of the factual definitions of the court process.

The second leg of the standard—rational cooperation with defense counsel—can also be argued to be greatly limited by the cognitive deficits that emerged on assessment. This is an individual whose memory is impaired, who cannot process and learn new information, and who sticks rigidly with one approach even in the face of feedback that this approach is wrong. He is rageful when confronted with his mistakes. This type of cognitive functioning impacts upon rational communication with his attorney. Additionally, his suspiciousness of others, even those appointed to advocate for him, restricts the potential effectiveness of his relationship with counsel. He may be unable to fully participate in negotiating or understanding plea bargaining agreements or to provide his attorney with information useful to the defense of his case.

General findings for this individual would be that his present level of functioning precludes his rational understanding of the proceedings taken against him and prevents him from rational cooperation with defense counsel. Additionally, understanding the global nature of his current deficits and the deteriorating course of AIDS-related dementia leads the evaluators to suggest a poor prognosis with little likelihood of rehabilitation.

Case Example B The defendant is a 40-year-old male charged with murder for hire. He is alleged to have been paid $10,000 by a disgruntled employee to kill his supervisor. The defendant was arrested after fatally injuring the supervisor who was shot at close range in the employee parking lot. At the time of the arrest, the defendant was "pistol-

whipped" and sustained head injuries. The defendant received medical treatment for his injuries at a county hospital jail ward. The records described the injuries as consisting of superficial contusions with no loss of consciousness. The district attorney is pursuing this as a death penalty case. Competency to stand trial was raised because the defendant claims amnesia for the crime and arrest. Other symptoms observed include impaired speech with what appears to be word-finding difficulties. The defendant, a combat veteran, has received prior psychiatric care for post traumatic stress disorder and compulsive gambling through the Department of Veterans Affairs. He has a history of polydrug use as a young adult but no history of substance abuse since then. His educational history is notable for a master's degree in business administration, and he has owned and operated many small businesses. He lost a successful fast food franchise three years ago through gambling debts. Since then, the defendant has been homeless.

Findings On examination, the defendant indicates that he remembers absolutely nothing about the offense. His responses to questions regarding the charges against him and the court personnel are correct, but reflect a slow response style. He can identify his attorney and can accurately identify his recent court dates and when he has seen his attorney.

Neuropsychological Test Findings The defendant's neuropsychological results were notable. On the Folstein Mini-Mental Status Examination[22] he earned a score of 27 of 30. However, on the Boston Naming Test[29] he scored at the 10th percentile and at the 1st percentile on a Verbal Fluency Task.[27] These results were consistent with the word-finding difficulty he demonstrated in conversational speech. His verbal memory functioning (WMS-R Logical Memory I) was at the 25th percentile; his delayed memory (WMS-R II) was at the 1st percentile. His verbal learning scores (RAVLT Trial 5) were absent and fell at the 1st percentile across repeated trials of the same material. On the Rey 15-Item Memory Test, a measure used to detect feigning, the defendant's score was at the first percentile. This is a measure where even severely brain-impaired individuals can score at the chance 50% level. The Rey 15-Item Memory Test results suggested that the individual was exaggerating his deficits. His auditory attentional score (WAIS-R Digit Span) was at the tenth percentile. In contrast to these very poor scores, WAIS-R subtests in vocabulary, verbal reasoning, and comprehension of general material were at the 75th percentile or above. His score on a measure of a general fund of knowledge was above the 80th percentile. The defendant accurately discussed current and recent news events that occurred around the time of the offense and identified entertainment figures and movies from that time period accurately.

Competency Findings This is an individual who demonstrates neuropsychological test data that are not fully in accord with his complaints of amnesia. This defendant has a verifiable head injury (hospital records) and his cognitive deficits appear legitimate and focal to expressive language manifested as impaired ver-

bal fluency and word-finding problems. There is a discrepancy between his complete amnesia for all events associated with the crime and his capacity to recollect other types of information that would have been learned around the time of the offense (e.g., news events). Other intact functions (a good fund of knowledge, good vocabulary and verbal reasoning) also suggest that this individual's cognitive and memory abilities are greater than he claims. This is an individual who scored in the malingered direction on one measure and showed inconsistencies among the other tests and reported disability. He demonstrated a high level of general knowledge and comprehension, which would be consistent with his premorbid level, yet he was unable to discuss the most basic elements of court proceedings such as the role of a jury when asked questions regarding court proceedings in a direct manner. However, when court issues were raised, in a conversational manner, that did not appear directly related to the assessment of competency, he was able to elaborate upon his irritation regarding delays in the court process, the narrow range of legal options offered to him by his attorney, his displeasure with the plea bargain offered by the prosecutor, and his preferred plea agreement. In this case, the combination of one score in a malingered direction with other test and behavioral inconsistencies suggests that this is an individual who is exaggerating his deficits. Regarding the issue of competency to stand the trial, we do not find that there is sufficient cognitive impairment to support a claim of incompetency.

Conclusions

The neuropsychological approach to assessment of trial competency that we suggest is adapted from the process method[19, 29] and involves evaluating the problem-solving strategy of a subject, not simply the test response outcome. By using interview material and observations as an essential part of the assessment, evaluators may gauge a defendant's capabilities on topics that are neutral or hypothetical but are relevant to the judicial process and personal to the defendant. This process approach is critical to the assessment of trial competency. The ability to acquire new information, and then to be able to utilize it appropriately, is an essential capacity for a finding of trial competency. When deficits are noted in content material early in the interview, teaching the defendant the material with follow-up questions at various intervals during the interview allows for a comparison of the individual's ability to learn and establishes a baseline point for test scores on traditional memory measures such as the RAVLT or the California Verbal Learning Test.[30] For example, an individual who can learn the distinction between a "court trial" and a "jury trial" and can discuss this concept 20 minutes later with accuracy shows a clear capacity to learn and work with relevant material. Regardless of how high or low his results on a standardized learning curve might be, the critical capacity has been demonstrated. In all cases, the practical results bound to the judicial process must be afforded more weight than test results. Formal assessment should be restricted to brief tests

that have significant content or process relevance to judicial procedure generally and to trial competency issues specifically. This type of assessment must be distinguished from a neuropsychological evaluation for clinical purposes. The forensic neuropsychological evaluation is tailored to address the nexus between the cognitive deficits and the forensic issue, in this case competency to stand trial.

Neuropsychological evaluations for a clinical purpose have a broad focus. The purpose of the clinical assessment is to assist in the diagnosis and treatment of that individual. Clinical assessments require a detailed and global analysis of the strengths and weakness of the individual. Forensic evaluations, by contrast, have a specific and narrow purpose. Therefore the information that is inquired about must bear functionally on the statutory criteria and not go beyond the narrow scope of the forensic issue. Neuropsychological data used within this context can offer valuable information in the assessment of trial competence when the impairment appears to have a cognitive component.

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