Competence to Stand Trial in Connecticut

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In 1974 the Connecticut statute on competence to stand trial was revised to allow the court the option of having competence evaluated by a clinical team consisting of a psychiatrist, a psychologist, and a psychiatric social worker, rather than by a psychiatrist alone.[1] This article traces the history of the Connecticut statute on competence to stand trial and describes the factors leading to the adoption of this interdisciplinary approach. Some advantages and disadvantages of the team approach are noted, and the reaction of the courts is discussed. The interdisciplinary model for competence evaluation is viewed as an efficient and viable alternative to evaluation by an individual psychiatrist and may be applicable to other types of forensic evaluations.

Historical Overview

The evolution of the Connecticut statute on competence can be seen as the history of the state's efforts to deal in an orderly, just, and humane way with "one committed for trial who appears to be insane."[2] Prior to 1887, there was no specific Connecticut statute dealing with the mentally ill accused; each Connecticut court apparently handled these cases under the Act of 1883, Chap. 56, secs. 1 and 2, which called for the transfer to a "suitable place" of any inmate examined by a "reputable physician" and found to be "insane or an idiot."[3] The statute made no distinction between pretrial and convicted inmates. In February 1887, the Connecticut General Assembly passed "An Act concerning Insane Persons committed to Jail for Trial,"[4] the forerunner of today's statute. Since that time, there have been numerous revisions of the law. All versions, however, reflect the legislature's concern with several basic issues:

- Who may raise the issue of the possible mental illness of a person accused of a crime?
- Who shall examine to determine the presence of mental illness?
- What is the goal of the examination?
- Who takes custody of the accused found to be mentally ill?
- Who pays for the cost of examination, confinement and treatment?

The statute of 1887 answered these questions in two concise sentences. It appears the statute was passed to enable the transfer of the mentally ill accused from the jail to the hospital. If, on admission to the jail, the person appeared "to be insane, or thereafter and before trial shall appear to become

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insane," the sheriff could request an examination. If the judge, after a hearing, agreed the person appeared insane, the court appointed "three reputable physicians" to examine as to the "mental condition" of the accused. If the physicians returned a certificate "stating the insanity of said person," the judge ordered the person committed to the Connecticut Hospital for the Insane for "confinement, support, and treatment, until the time of his trial." The expenses of examination, confinement, support, and treatment were paid as a cost of criminal prosecution by the state.

Although this act, as revised over the years, is the forerunner of Connecticut's current competence statute, nothing in this act bears directly on the accused's competence to stand trial. The accused was simply found to be insane and sent to a state hospital "until his trial." On the one hand the statute seemed to assume the accused would eventually go to trial, but under what circumstances was not clear. There was no provision for review or discussion of procedures to dispose of criminal charges. Since the expenses of confinement, support, and treatment were paid by the judiciary, there was no financial pressure on the hospital or the family to limit confinement. Given the limitations of treatment of the mentally ill in 1887, one wonders if, having been found insane, the tacit assumption was that the person committed under the statute would be hospitalized indefinitely.

1931 Version

Not until 1931 was there a substantial revision of this statute.[5] Although the title of the 1931 Act was "Examination of Accused Who Appears to be Insane," for the first time a standard of competence to stand trial, consideration of the accused's ability to understand the proceedings against him or her, was incorporated into the statute. Furthermore, the statute acknowledged a difference between being insane and being "mentally defective" by adding the latter as a basis for raising the issue of competence and allowing the alternative of final commitment to "an institution for the mentally defective."

This version of the statute extended the right to raise the issue of insanity or mental deficiency from the sheriff to "anyone in behalf of the accused person" who felt that the accused was "insane or so mentally defective that he is unable to understand the proceedings against him" and made it mandatory, rather than optional, that the issue be raised. If the judge agreed the accused was "probably so defective that he is unable to understand the proceedings against him," could appoint "not less than two nor more than three reputable, disinterested and qualified physicians" to examine the accused, thus reducing the minimum number of examiners to two, but adding the requirement that the physicians not only be "reputable" but also "disinterested" and "qualified." The judicial standard for commitment was changed substantially from a finding of "insanity" to a judicial decision that "the accused is not able to understand the proceedings because he is insane or mentally defective." The examiners, however, continued to be charged

only with examining as to the accused's "mental condition."

The 1931 statute made provision for the first time for review of the accused's mental state after commitment to a hospital. If the hospital found the accused was "neither insane nor so mentally incapable as to be able to understand such proceedings," a report to the court was required, and a hearing was mandated. At that point if the accused understood the proceedings, he/she went to trial; if he/she still did not understand, he/she was recommitted to either a state hospital or an institution for the mentally defective.

There were no time limits specified in this statute for review of the accused's condition by the hospital or by the court, and after the second hearing, provision for review was exhausted. In a significant change, this version of the statute shifted the burden of "confinement, support, and treatment" to the state hospital. The statute allowed only the expense of the examination to be considered as a cost of prosecution. It was not until 1959[6] that the statute was amended to require payment for the cost of hospitalization by the accused or his/her family on the same basis as people committed by the probate court.

The next substantive amendment to the statute, in 1967,[7] further defined the qualifications of the examiner. The title of the act, "An Act Concerning Psychiatric Examination of Defendant with Respect to Mental Disease or Defect," gave recognition to the psychiatric nature of the examination, and the examiners were now required to be "reputable, disinterested, and qualified physicians specializing in the practice of psychiatry." The examiners continued to be charged with examining as to the accused's mental condition, while the court, in order to commit, was charged with considering not only the accused's ability to understand the proceedings, but also the added factor of whether the accused was able to "assist in his own defense." Thus, seven years after the Supreme Court decision, Connecticut incorporated into the statute the standard articulated in Dusky v. U.S.[8] For the first time both elements of the competence standard were spelled out in the statutory language.

In another major change, the judge was empowered to order the accused to be committed to a state hospital for mental illness prior to examination. Not only was the judge empowered to order the accused into a hospital for examination before there was any finding of insanity or mental deficiency, but also the accused could be committed "for such period as such judge determines to be necessary" for the purpose of examination.

According to information provided in an interview on 5/5/81 with M.J. Rockmore, Director of Psychiatric Social Work, Connecticut Department of Mental Health, 1954 to 1977, this provision resulted in an increase in commitments of criminal defendants to the state mental hospitals. The Department of Mental Health, overwhelmed by the number of patients hospitalized for competence evaluations, initiated the process that led to the statutory revision of 1974 providing for examination on an outpatient basis by an intradisciplinary clinical team.

1974 Revision

The 1974 revision of the statute, "An Act Concerning Custody, Treatment and Referral of Accused Persons Who Appear to be Insane or Mentally Ill," was the result of approximately two years of informal meetings between representatives of the Judicial, Mental Health and Corrections Departments. Joseph Shortall, currently Connecticut's Chief Public Defender, was the Judicial Department's representative to the interdepartmental committee on competence. In an interview on 4/30/81 he recalled clearly the Judicial Department's concern with the cost of examination and testimony by psychiatrist.

A hearing on the bill brought to light other concerns and points of view.[9] Superintendents of the state mental hospitals were concerned that the time of staff psychiatrists, already in short supply, was being taken up in examination and in testimony on behalf of court-committed patients. According to Rockmore, staff psychiatrists at state mental hospitals were demanding extra pay, claiming that performing court-ordered evaluations and testifying were outside the scope of their responsibilities. The Commissioner of Mental Health, testifying in support of the statute, stated that over two thousand court-referred cases had passed through the state hospitals during that year and that "the largest number of people" were those referred for competence evaluations. He testified further that evaluating competence outside the hospital could reduce admissions "by as great as 35 percent to 40 percent." There were a number of favorable comments on — and no objections to — the new provision establishing a clinical team composed of a psychiatrist, clinical psychologist, and a social worker, who would perform on-site competence evaluations. The bill specified that the evaluation was to be completed within 15 days, during which time the accused was to remain in the custody of the Commissioner of Corrections.

During the hearing on the bill and in subsequent proceedings in the General Assembly, no one mentioned that prior to 1967 the court did not have the power to commit an accused to a state mental hospital unless there had been a prior examination of his or her "mental condition"; presumably these examinations were done by a psychiatrist at the local jail. There was no suggestion that the task of examining simply be returned exclusively to the psychiatrist; instead, remarks emphasized the flexibility and mobility of the proposed clinical team that could "make a diagnostic evaluation right at the point where the person may be before they have been hospitalized."

Testimony from legislators, the Connecticut Mental Health Association and private citizens living near state hospitals warned that public safety was being jeopardized by placing dangerous individuals in mental hospitals rather than more secure institutions. The Commissioner of Mental Health and the superintendent of one of the state mental hospitals testified that court-referred patients presented no greater security risk or risk of assault to staff than other patients. However, a doctor who claimed to have treated staff members on a ward housing numerous criminal defendants testified

that staff on this ward sustained a disproportionate number of injuries due to patient assaults. In light of this well-orchestrated expression of public concern, the bill passed easily in both houses of the General Assembly.

Yearly Revisions

With the exception of 1979, the competence statute was revised yearly from 1974 to 1981.[10] In 1974 definite time limits were specified within which the examination must be completed and the accused returned to court if he/she became competent. In addition, the court was ordered to set a maximum period of commitment upon the initial finding of incompetence. In response to the Jackson v. Indiana[11] decision by the Supreme Court, procedures to be used on a second finding of incompetence, as well as other time limits, were spelled out in the amendments of 1975, 1976, and 1977.

The 1974 revision provided that an examination ordered through the Commissioner of Mental Health would be paid for by the Department of Mental Health and would be done exclusively by a clinical team; on the other hand, examinations done by individual psychiatrists were charged to the Judicial Department. This provided a powerful financial incentive for the court to order the examination through the Commissioner of Mental Health. The 1975 revision gave the Commissioner of Mental Health the additional option of using a psychiatrist or the clinical team, and in a further refinement of criteria for examiners, "physicians specializing in the practice of psychiatry" was changed to "physicians specializing in psychiatry," a change that unambiguously enabled psychiatric residents to do competence evaluations and testify.

During this period questions of custody still received attention. Although persons awaiting examination were remanded to the custody of the Commissioner of Corrections, provision was added to allow the court to transfer violent defendants to a secure facility, as well as to allow the court to release a defendant to the community to await an examination if the court believed this was appropriate. If, by some chance, a dangerous person was placed in an insecure facility, the statute since 1974 has provided for a state policeman to stand guard over the accused.

The 1975 amendment formally acknowledged that the statute dealt with competence to stand trial. The act, "An Act Concerning Commitment of Accused Who Appears to be Incompetent to Stand Trial," specified that the psychiatrist or clinical team examine the accused as to "ability to understand the proceedings against him and to assist in his own defense," rather than as to "mental condition" as in the past. It was not until 1977, however, that the language throughout the statute was made consistent, and it was clear that the focus of the entire process — examination, hearing, and judicial decision — was whether the accused was able to understand the proceedings and assist in his/her defense.

The Connecticut statute dealing with "one committed for trial appearing to be insane" has now been on the books for almost 100 years. During that

period there have been major shifts in thinking about the mentally ill defendant. We have gone full circle from examining in the local jail to examining in the state hospital and back again to examining in the local jail. Nonetheless, custody of the accused remains a major issue and there continue to be transfers from the jail to the state hospitals.

We have seen the qualifications of examining personnel specifically defined and upgraded and qualified non-medical examiners accepted under limited conditions. The costs of examination, confinement, and treatment, once charged exclusively to the judiciary, are now borne mainly by the Department of Mental Health and by the accused or his or her family. Finally, the purpose of the proceeding has been limited and clarified, and the nature of the examination by the mental health professional has been defined in a manner consistent with the goals of the proceeding.

With this historical perspective, we move to discussion of the operation of the clinical team.

The Clinical Team

The concept of a mobile clinical team consisting of a psychiatrist, clinical psychologist, and a psychiatric social worker was suggested by Rockmore. During World War II Rockmore helped establish a similar team at Fort Monmouth, NJ, to do brief, focused evaluations for the military.[12] An application to the Law Enforcement Assistance Administration for initial funding for the clinical team,[13] prepared by Rockmore, stated:

> The classic team of psychiatrist, clinical psychologist, and psychiatric social worker has been adapted to serve a variety of administrative settings including the Judicial setting. A key note is its leadership and understanding of its specific functions as subordinate to and serving the Judicial system. Therefore, more important than the technical expertise of the professionals is the grasp and conception of the leadership and administratively responsible person for the team. Thus, it can be either one of the three professional disciplines aforementioned who can essentially carry the administrative responsibilities for the service. In all likelihood, a full-time psychiatrist or psychologist of the quality needed would be fiscally prohibitive. Thus, it would be proposed that a mature, experienced administrative psychiatric social worker be designated as the administrative full-time head of the project. The other members of the clinic, the psychiatrist and the clinical psychologist, who have the specific technical skill clinically required to perform the individual examinations and/or evaluations, would probably be most available on a contractual part-time basis.

With passage of the bill establishing the clinical team, the Department of Mental Health set about to implement the statute essentially in the manner outlined above. A three-year demonstration grant of approximately $55,000 to $60,000 per year from the Law Enforcement Assistance Administration was supplemented with approximately $40,000 from the Department of Mental Health to get the project off the ground the first year.[14] Eventually the clinical team was made available to courts in Bridgeport, Hartford, and New Haven, three of Connecticut's largest cities. Examinations ordered by courts outside these areas continue to be done by a psychiatrist from the

closest state mental hospital.

The clinical team meets weekly for approximately four hours during which three to five examinations are completed. The few defendants who are not in jail are given an appointment to meet with the team at the clinic. Interviews at the jail are done in a small room in the hospital section. Prior to the interview, the social worker goes to the jail and interviews the defendant to obtain background information and to have release-of-information forms signed. The social worker reviews the defendant's criminal history, the account of his/her current arrest and may review prior treatment records and talk to family or friends. This information, which is shared with team members, helps to focus the team's thinking about the case and often clarifies questions about malingering.

The clinic uses only two or three consulting psychologists and psychiatrists, with the result that team members have learned to work together and to limit the examination to significant issues. Team members take turns "leading off" in the questioning. The other team members join in as the interview develops. Following the interview, which includes a mental status examination, the impressions of the interviewers are recorded jointly on a form prepared by the clinic. The specific items on the form relating directly to competence were adopted from Bukatmen *et al.*'s criteria for competence.[15] The use of a standarized format for noting impressions helps to focus the thinking of the team. This method of recording also highlights areas of uncertainty and disagreement. Disagreement among team members on substantive issues is rare. When team members do disagree on a specific point, this is noted in the final report to the court.

The report is prepared bearing in mind the standard articulated by McGarry that findings in matters of competence be "delivered in a form and language which are appropriate to the needs of the court."[16] The social worker writes the report that carries the notarized signature of each team member. The report contains background information about the defendant, describes the defendant's mental status at the time of the interview, and reviews the defendant's understanding of his/her current legal situation. If the defendant is currently under psychiatric treatment and on medication, this fact is noted. The reports generally do not assign a diagnosis; if the defendant is mentally ill, the prognosis is not considered unless it appears that the court will find the defendant incompetent. In such cases the team attempts to assess whether the defendant can be restored to competence in the foreseeable future and recommends the least restrictive setting in which the defendant can be restored to competence. The report avoids use of psychiatric jargon and excludes any information that might be prejudicial to the defendant in future proceedings. Both in the report and in subsequent testimony, the team attempts to confine its comments to the issue of whether, by reason of mental illness or mental defect, the accused is able to understand the proceedings against him/her and to assist in his/her defense.

If testimony is required, the social worker testifies as to the contents of the report, unless the nature of the case is such that testimony from the

psychologist or psychiatrist would be more appropriate. For example, the psychiatrist testified in the case of a middle-aged man who was showing signs of organic brain damage due to cirrhosis of the liver. Similarly, the psychologist testified in the case of a woman in her 80s with senile dementia whom the team believed would never become competent. On rare occasions the entire team has been subpoenaed, usually by the defendant's attorney who disagrees with the team's findings.

Fitzgerald *et al.* have outlined some benefits and reviewed some criticisms of the team approach.[17] They note the team is composed exclusively of mental health professionals who are asked to make judgments on legal matters. For this reason, several writers have suggested the client's attorney or another officer of the court be assigned as an examiner.[18] Team members are, however, familiar with the courtroom and the demands of the attorney-client relationship. If a team member has never testified, he or she is encouraged to do so. Furthermore, the social worker is in court on a regular basis either to testify or to carry out administrative responsibilities. In most cases clients are represented by a member of the public defender's staff, who work closely with the social worker. If the client is represented by a private attorney, it is the clinic's policy to call the attorney to discuss the request for evaluation and to maintain contact as needed.

Questions are frequently raised about disagreement among team members. In practice, perhaps because the interview is structured and highly focused, there is generally little substantive disagreement among team members and, as noted above, if there is disagreement, the fact is noted on the report to the court.

Questions also arise about the cost of using three professionals to do an examination that can be done by one person. A 1977 evaluation of the Courts Diagnostic Clinic in Hartford[19] found that the clinical team provided the examination at a cost lower than that of a private psychiatrist and higher than that of the psychiatrist working in a state hospital. However, cost factors associated with loss of patient services and hospitalization of defendants were not considered in the latter estimate. It is clear that overall costs to the state have been reduced by performing the examination outside the state hospital system.

Volume of Evaluations

Currently over 600 evaluations of competence are performed each year in Connecticut.[20] Whether it would be possible to find qualified private psychiatrists or other mental health professionals willing to handle this volume is difficult to assess. If examiners could be found, a careful assessment of costs, taking into account all factors, would have to be made over a given period to determine the cost effectiveness of the individual versus the clinical team approach. What appears to be professional overkill may, in fact, be the most cost-efficient way of completing these evaluations.

In addition to the problems mentioned, our experience has yielded

several minor difficulties with the team approach. The attorney who is not familiar with the clinic's services may object to the team on the basis that he or she will be asked to carry on a dialogue about the case with three people. This objection evaporates when attorneys discover that although the psychologist and psychiatrist are available for consultation in complex cases involving specific areas of expertise, routine questions and contacts can be handled by the social worker.

Another problem can be the sheer number of interviewers, particularly with a paranoid defendant who has trouble talking to even one person. The social worker, in the preinterview screening, often refers these people to an individual psychiatrist for evaluation. On the other hand, the defendant's inability to tolerate dealing with more than one person is often an important clue as to ability to handle himself or herself in court.

In general the response of the courts to the evaluation of competence by the clinical team has been favorable. The 1977 evaluation of the first year of operation of the Courts Diagnostic Clinic in Hartford found that of 18 judges responding who used the Clinic, 72.2 percent agreed with the statement "The clinical team is expert in its ability to render competency opinions." These judges also agreed overwhelmingly that the reports of the team were "complete with respect to the information they provide me for rendering a finding" and believed that the clinical team should be available to all the courts in the state.

In regard to testimony, half the judges who had used the clinic's services disagreed with the statement, "I prefer to have an individual psychiatrist testify at a competency hearing"; 27.8 percent agreed with this statement, and 16.7 percent had no opinion. The study further showed that the percentage found competent by the team (62 percent) was consistent with the percentage found competent by individual psychiatrists.[21]

In an unpublished 1976 study, a student at the University of Connecticut Law School, C. Forzani, compared evaluations done by the clinical team to those done by a chief forensic psychiatrist at a state mental institution and an evaluation conducted by a private psychiatrist. The writer found some of the reports of the team to be conclusory and all of the reports written by the state psychiatrist and the report written by the private psychiatrist to be conclusory. Furthermore, the state psychiatrist and individual psychiatrist sometimes confused the issues of competence and criminal responsibility and often included irrelevant and highly prejudicial information in their reports. The writer concluded that "the team's use of specific criteria in a structured interview schedule is highly successful in keeping the evaluations within the scope of a competency examination and eliciting responses probative of the issues before the court."

Fitzgerald has noted the benefits of uniformity and error or bias reduction in the team approach to evaluation of competence.[22] We have discovered several other advantages. In our experience team members not only learn from each other but also provide mutual support in those difficult situations when the defendant is hostile and/or intimidating. If a defendant

becomes angry at an interviewer's probing questions, another team member may salvage the interview by stepping in and re-establishing rapport. At times hostile defendants demonstrate their anger by spurning two members of the team and talking exclusively to only one team member — but the interview still goes on.

Each examination is, in a sense, a mini-teaching case, and team members learn from each other as they discuss the defendant and note conclusions. For this reason, the team is also a fertile training ground for psychiatric residents. Residents who work with the team are initiated into the mysteries of the jail and the trial courts in the company of experienced colleagues. Furthermore, rotation of the members of the team, diffusion of the interview stress over three people, and the stimulation of working with knowledgeable colleagues prevents burnout of examiners. The competency evaluation is limited in scope, and the individual psychiatrist who conducts as many as two or three evaluations a week may, over time, find the process repetitious and lacking in challenge. In contrast, the give-and-take of the team evaluation provides stimulation to all concerned.

Also, the outcome of the evaluations as a matter of judgment and accuracy is enhanced by multiple evaluators having first-hand contact with the data. Traditionally when a single doctor is the evaluator and one party, prosecutor or defense attorney, disagrees with the findings, the disgruntled party requests a further examination. The team approach provides a check on the judgmental character of the evaluation and often obviates the need for a second or third opinion.

Overall, the experience of the State of Connecticut with interdisciplinary evaluations of competence has been positive. The primary reason the concept works in Connecticut is that the limits of the examination are well-defined and the examination is geared to meet the needs of the court. The clinical team has been accepted by most judges and officers of the court, whose main concern seems to be that the evaluations are completed in a timely and efficient manner.

The interdisciplinary approach has been used in child custody cases and might profitably be extended to insanity defense evaluations and other types of forensic evaluations. As long as the ground rules are clear, professionals of different disciplines can do collaborative evaluations, each contributing significantly from a particular body of expertise, with the resulting evaluation being enriched in the process.

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