# Competency to Stand Trial Evaluations: A Study of Actual Practice in Two States

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**A criminal defendant must be competent to stand trial (CST) to safeguard the fundamental right to a fair trial. If there is a question as to a defendant's ability to assist in his or her own defense, a mental health professional is asked to perform a CST evaluation. Forensic assessment is a growing field, and CST is the most frequent evaluation requested. Over the years, forensic examiners' reports to the courts have been criticized for lack of relevance, insufficiency, and invading the province of the judge. If mental health professionals wish to advance the field of forensic assessment and respond to these criticisms, research on current practice with suggestions for advancement are necessary. A total of 66 CST reports conducted within the last five years in two states were compared to a proposed model for CST assessment. Results indicated that although forensic examiners are maintaining legal relevance, some CST reports may lack thoroughness and/or provide information that exceeds their role responsibilities. The findings support the need for the development of a standardized method of conducting and writing CST evaluations that should improve the quality of such reports.**

The issue of whether a criminal defendant is competent to stand trial (CST) is the most frequent type of competency assessed by mental health professionals.[1] Despite its frequent occurrence, CST is still an ambiguous concept, as was recently demonstrated in the Colin Ferguson trial.[2] Colin Ferguson was accused and eventually found guilty of killing 6 people and wounding 19 others on a Long Island Rail Road in December 1993. On August 19, 1994, Mr. Ferguson displayed unusual and bizarre mannerisms in court, "as he told a Nassau County judge in a rambling discourse that he rejected his lawyers' efforts to have him declared mentally unfit to stand trial, and then, moments later, collapsed and had to be dragged from the court."[2] His lawyers stated that his behavior represented only "a glimpse" of the difficulty they were having in working with him to establish a defense. Despite Mr. Ferguson's argument that he was competent, the court-appointed psychologist and psychiatrist believed that he was malingering mental illness. The judge found that Mr. Ferguson was indeed competent and justified his ruling in part by the quality of discus-

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sions he had with Ferguson in the courtroom including Ferguson's concern over the future passing of the death penalty statute.[3] The concept of CST needs further clarification.

The quality of forensic examiners' contributions to the court have been scrutinized for over 30 years.[1,4–11] The criticisms generally include legal irrelevance, insufficient analysis, and exceeding role boundaries. There is no standardized format for conducting and writing CST evaluations that could help forensic experts avoid these issues. Irrelevant reports can result when examiners confuse other legal standards such as "insanity" with CST. Insufficiency can occur when a report provides a clinical diagnosis and description of symptoms without explaining how these characteristics affect CST. In terms of exceeding role boundaries, many argue that forensic examiners go beyond their roles by providing a conclusion on the ultimate issue of CST. However, many states request mental health experts to provide such a conclusion. There is considerable debate over this issue.[12–15]

Research is needed to assess the concurrence between actual CST practices and the criteria of legal relevancy, thoroughness, and restriction of information to the domains of the mental health professional. There are few studies that have investigated actual practice.[16–19] When these three issues are addressed, members of each discipline (law and mental health) can appropriately perform their roles and establish a productive integration of their functions.

Grisso[20] proposed a model to guide assessments of several types of competencies. While this model is not the only one offered for competency assessment,[6,21] we used it in our study based on familiarity. The model consists of six characteristics (functional, contextual, causal, interactive, judgmental, and dispositional) that can conceivably guide the preparation of a competency report toward legal relevance and thoroughness (see Appendix A). This model is not substantive. Rather, it is a template of factors to consider when writing a report.

The present study was designed to assess the quality of common CST report writing practices by examining the content of recent CST reports in Nebraska and New Jersey and comparing them to Grisso's model. While Nebraska's standard is located in case law, *State v. Guatney*, New Jersey's is statutory (see Appendices B and C).[22,23]

## Methods

***Participants*** A total of 50 reports from a New Jersey forensic hospital from the years 1992 to 1995 and 16 reports from a Nebraska public defender's office from 1992 to 1994 were analyzed. Seven psychiatrists performed the 50 CST evaluations in New Jersey, while in Nebraska, a total of three psychologists, five psychiatrists, and one neurologist performed the 16 CST evaluations. Some of the Nebraska examiners were from the forensic division of the county correctional facility, while the others were in private practice.

***Materials.*** *Checklist* The authors designed a checklist and operationally defined each characteristic in accordance with Grisso's model for CST assess-

ment.[20] The checklist had a demographic section that contained the following information: the setting where the CST reports were performed (hospital or community); defendant variables (age, race, gender, occupation, marital status, education, criminal history, current criminal charges, history of mental illness, current diagnosis, history of hospitalization); and case variables (violent/nonviolent crime, complexity of upcoming trial, whether there was use of third-party information such as police, family, victim, or witness; past medical history, past psychiatric history, date of evaluation, referral issue, use of interdisciplinary teamwork). Due to small sample sizes, not all of these variables were analyzed in this study. Following the demographic section were five of the six characteristics. The contextual characteristic was not included, since the only competency being studied was "to stand trial." The functional characteristic was operationally defined by dividing it into three subsections: (1) the Competency Assessment Instrument's (CAI)[24] 13 functional abilities (See Table 1); (2) the particular state functional abilities (Appendices B and C); and (3) an "other relevant functional abilities" category. A functional ability that was not part of the CAI, *Guatney*, or the statute was found relevant if deficits in the ability itself could lead to incompetency. The data on functional abilities were categorized accordingly.

**Table 1**
**Functional Abilities from the CAI**

| | |
|---|---|
| 1. | Consider realistically the possible legal defenses |
| 2. | Manage one's own behavior to avoid trial disruption |
| 3. | Relate to attorney |
| 4. | Participate with attorney in planning legal strategy |
| 5. | Understand the roles of various participants in the trial |
| 6. | Understand court procedures |
| 7. | Appreciate the charges |
| 8. | Appreciate the range and nature of possible penalties |
| 9. | Perceive realistically the likely outcome of the trial |
| 10. | Provide attorney with available pertinent facts concerning the offense |
| 11. | Challenge prosecution witnesses |
| 12. | Testify relevantly |
| 13. | Be motivated toward self-defense |

The next section, the causal characteristic, was operationally defined by the following items: whether the report contained a diagnosis from the DSM-III-R or DSM-IV[25,26]; whether the report provided a description of symptoms or psychological characteristics, and if so, whether the examiner discussed or explained the specific role that these symptoms or psychological characteristics played with respect to the defendant's functional abilities; whether there were tests and/or procedures utilized to assess the subject, and if so, whether the examiner explained the relationship between the test results and functional abilities.

The operational definition of the interactive characteristic was: whether the examiner discussed the particular demands of the defendant's trial; whether the examiner described the relationship between functional deficits and the particular demands of the trial; and the types of sources utilized for addressing the complexity of the trial.

The judgmental characteristic section

simply examined whether the examiner provided a conclusion on the ultimate issue of CST and how that conclusion was supported.

The dispositional characteristic section asked whether the examiner provided certain treatment recommendations, and if so, whether the recommendations were related to the defendant's ability to stand trial; whether the report indicated, if the individual was considered to have deficits, whether treatment would provide remediation in a reasonable period of time (*Jackson v. Indiana*);[27] and whether the report indicated, also if deficits existed, the least restrictive setting in which remediation could occur.

At the end of the checklist, space was provided for "notes" on anything in a report that was unexpected or needed additional explanation. Data on irrelevant or improper *statements* made in CST reports as well as evaluation of irrelevant *functional abilities* were recorded in this section. *Statements* considered irrelevant or improper varied from application of an inappropriate legal standard (e.g., insanity, civil commitment) to improper recommendations (e.g., forensic examiner recommending an insanity evaluation or psychotherapy to help the defendant deal with stress). An irrelevant *functional ability* was defined as any ability that, if deficient, could not in itself render incompetency.

*Procedure* A systematic sampling method was used in New Jersey where every third report was pulled from the hospital's computer database. Only males were included. In Nebraska, only CST reports that were part of the public record were used; females were included. The names of the defendants in all reports were deleted.

*Data Collection* The vast amount of information that was provided and collected in both the demographic and characteristic sections required a very detailed list of operational definitions and procedures, which is too long and complicated to include in this article. Specific requests for this document will be honored. However, the procedures used in collecting data on the functional characteristic will be described to clarify the method of dealing with the two different states.

Functional abilities addressed in a report were categorized in one of the three subsections on a hierarchical basis. If the specific ability fit into one of the CAI's 13 functional abilities, it went to the CAI subsection. If a functional ability was particular to the New Jersey statute or *Guatney*, it went under the "State Functional Abilities" subsection. However, if the state's functional ability was also one of the CAI's functions, it was placed in the CAI section. Many of each state's operational definitions of CST were similar to, if not the same as, the CAI's 13 functions. A relevant functional ability written in a report that was neither a CAI function nor a state function was placed in the "Other Relevant Functional Abilities" subsection. As stated previously, irrelevant functional abilities were recorded in "Notes."

Two raters independently coded data from each of the 66 reports. They then assessed the amount of agreement on all reports across all characteristics. The raters agreed an average of 74 percent of the

time on the first five reports. The range was between 56 and 94 percent. After assessing the initial five reports, there was only one report in which agreement fell below 75 percent. Differences in interpretation were able to be reconciled in all cases. There were nine reports (13%) in which 100 percent agreement occurred. The amount of agreement seemed to be related to the complexity of the competency assessment. Agreement was more likely in competency reports that were unequivocal (i.e., a defendant was so clearly psychotic that functional abilities were severely impaired).

## Results

***Demographics*** As can be seen in Table 2, most of the 66 reports provided basic identifying information such as age ($n$ = 59), race ($n$ = 58), occupation ($n$ = 43), marital status ($n$ = 56), and education level achieved ($n$ = 47). New Jersey was more consistent than Nebraska in providing this information (87% compared with 56% of the time). About half of the reports provided information on past criminal behavior, past diagnosis, and whether information from other disciplines was used (e.g., social work, neurology, occupational therapy). In Nebraska, however, past diagnosis and information from other disciplines were provided only 25 percent of the time. Most reports indicated the present criminal charge(s) ($n$ = 60), present diagnoses ($n$ = 62), past hospitalization history ($n$ = 50), sources of third-party information ($n$ = 51), and the referral issue ($n$ = 64). However, the Nebraska sample provided only past hospitalization history 50 percent of the time.

The only demographic variable in which virtually no difference between states existed was the use of third-party information. The sum total of reports containing third-party contacts for Nebraska and New Jersey were 75 percent and 78 percent, respectively. Although only half of all reports provided information on whether interdisciplinary teamwork was used, the New Jersey hospital has traditionally made use of treatment teams to arrive at an opinion. Furthermore, defendants were often provided a legal education course to increase their knowledge about the trial process (personal communication with Clinical Director, April 1995). These procedures, however, were often not cited in the reports.

In addition to the referrals made to conduct CST evaluations, other information was requested for evaluation (e.g., dangerousness to self or others for purposes of civil commitment, dangerousness for purposes of determining the least restrictive environment to hold the defendant until the hearing, and criminal responsibility, i.e., insanity). Three reports had specific referrals for the following: "competency to waive Miranda Rights," "psychiatric examination and evaluation," and "evaluation and treatment." Despite the fact that there was no referral for CST in these reports, the examiner conducted an assessment and provided an opinion on the defendant's competency to stand trial.

For comparison with other studies, our results indicate that the typical defendant referred for a CST evaluation was either a

**Table 2**
**Demographic Characteristics of Defendants and CST Reports**

| Defendant Variables | Nebraska ($n$ = 16) | New Jersey ($n$ = 50) | Total ($n$ = 66) |
|---|---|---|---|
| Age | $\bar{X}$ = 29.7 ($n$ = 9) | $\bar{X}$ = 32 ($n$ = 50) | $\bar{X}$ = 31.7 ($n$ = 59) |
| | $n$ | $n$ | $n$ |
| Race | | | |
| Not mentioned | 7 | 1 | 8 |
| African-American | 2 | 24 | 26 |
| Caucasian | 6 | 17 | 23 |
| Hispanic | 0 | 8 | 8 |
| Multicultural | 1 | 0 | 1 |
| Occupation | | | |
| Not mentioned | 7 | 16 | 23 |
| Blue collar | 2 | 13 | 15 |
| History of blue-collar | 2 | 12 | 14 |
| None/No history of work | 4 | 5 | 9 |
| White collar | 1 | 4 | 5 |
| Marital status | | | |
| Not mentioned | 6 | 4 | 10 |
| Single | 3 | 33 | 36 |
| Divorced | 3 | 10 | 13 |
| Married | 4 | 2 | 6 |
| Widowed | 0 | 1 | 1 |
| Education | | | |
| Not mentioned | 8 | 12 | 20 |
| Special education | 0 | 12 | 12 |
| Grade school | 1 | 5 | 6 |
| Some high school | 1 | 7 | 8 |
| GED | 3 | 2 | 5 |
| High school diploma | 2 | 5 | 7 |
| Some college | 1 | 4 | 5 |
| Technical school | 0 | 2 | 2 |
| College degree | 0 | 1 | 1 |
| Past criminal behavior | | | |
| Not mentioned | 9 | 23 | 32 |
| Violent | 3 | 13 | 16 |
| Non-violent | 4 | 9 | 13 |
| None | 0 | 4 | 4 |
| "Previous incarceration" | 0 | 1 | 1 |
| Present crime | | | |
| Not mentioned | 3 | 3 | 6 |
| Nonsexual | 11 | 35 | 46 |
| Sexual | 2 | 12 | 14 |

**Table 2—Continued**
**Demographic Characteristics of Defendants and CST Reports**

| Defendant Variables | Nebraska ($n$ = 16) | New Jersey ($n$ = 50) | Total ($n$ = 66) |
|---|---|---|---|
| Past primary diagnosis | | | |
| Not mentioned | 12 | 25 | 37 |
| Mood disorder | 1 | 9 | 10 |
| Psychosis | 2 | 5 | 7 |
| Mental retardation | 0 | 5 | 5 |
| Personality disorder | 1 | 2 | 3 |
| Substance abuse | 0 | 1 | 1 |
| None | 0 | 2 | 2 |
| Other | 0 | 1 | 1 |
| Present primary diagnosis | | | |
| Not mentioned | 3 | 1 | 4 |
| Psychosis | 4 | 24 | 28 |
| Mood disorder | 1 | 13 | 14 |
| Mental retardation | 1 | 6 | 7 |
| Substance abuse | 1 | 4 | 5 |
| Other | 4 | 0 | 4 |
| Personality disorder | 1 | 1 | 2 |
| None | 1 | 1 | 2 |
| Past hospitalization | | | |
| Not mentioned | 8 | 8 | 16 |
| Yes | 7 | 29 | 36 |
| No | 1 | 13 | 14 |
| Violence of present crime | | | |
| Violent | 9 | 42 | 51 |
| Nonviolent | 5 | 4 | 9 |
| Crime not specified | 2 | 4 | 6 |
| Third party information | | | |
| Not mentioned | 4 | 11 | 15 |
| One source | 5 | 21 | 26 |
| More than one source | 7 | 18 | 25 |
| Referral issue | | | |
| Not mentioned | 0 | 2 | 2 |
| CST | 13 | 28 | 41 |
| CST and civil commitment | 0 | 8 | 8 |
| CST and dangerousness | 0 | 6 | 6 |
| CST and insanity | 2 | 4 | 6 |
| CST and other | 1 | 2 | 3 |
| Interdisciplinary teamwork | | | |
| Not mentioned | 12 | 17 | 29 |
| Treatment teams | 0 | 14 | 14 |
| More than one source from another discipline | 1 | 13 | 14 |
| One source from another discipline | 3 | 0 | 3 |
| Legal education course | 0 | 3 | 3 |

blue-collar worker or had a history of blue-collar employment, had never married, had a diagnosis from the psychotic disorder category of the DSM, and had at least one previous psychiatric hospitalization. The crime with which the typical defendant was charged was violent but nonsexual. The average age was 31.7 years. African Americans (39.4%) and Caucasians (34.8%) were just about evenly represented. Education levels ranged from grade school to a college degree. Many reports ($n = 19$) did not indicate the education level of the defendant, but of those mentioned, most had been in special education classes as children. Half of the reports addressed past criminal behavior. Slightly more of this behavior was violent ($n = 16$) than nonviolent ($n = 13$). The majority of past diagnoses in both states were in the mood disorder category ($n = 10$) as opposed to psychosis ($n = 7$).

***Characteristics of the Report.*** *Functional Characteristic* Reports in both states used CAI functions 3, 5, 7, and 8 most often. The Nebraska sample addressed function 10 twice as often as New Jersey (44% to 22%). In Nebraska, the *Guatney* factors addressed most often were 1, 11 through 13, and 20. In New Jersey, all the statutory functional abilities were addressed about half of the time. Interestingly, half of all reports contained at least one relevant *functional ability* (an ability that deficits in itself could possibly lead to incompetency) that was not part of the CAI, *Guatney*, or the New Jersey statute. Only two reports provided information on irrelevant *functional abilities*. For example, one report stated that the defendant did not know right from wrong (an "insanity" functional ability) and the other stated that the defendant did not know how to read or write.*

*Causal Characteristic* Sixty-two reports discussed whether the defendant had a psychiatric diagnosis. However, with respect to legally relevant information (e.g., how symptoms of a diagnosis affect deficits in functional abilities), only 27.3 percent of the reports provided such information. For the types of tests and procedures used, 11 reports used more than one procedure outside of the interview (e.g., review of past records, administration of psychological tests, and/or neuropsychological tests). The types of psychological tests used included: intelligence tests ($n = 5$), the Rorschach ($n = 1$), figure drawings ($n = 1$), and one mention of a full battery administration. The three remaining reports used forensic instruments. Two of the three forensic instruments used were the Competency Screening Test and the Competency Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR). The third forensic instrument was merely mentioned as a "competency instrument." There were seven administrations of neuropsychological tests, some of which included the Bender-Gestalt test.

Over half of all the reports did not discuss the types of tests and/or procedures used. Of those reports that men-

*We decided to categorize the ability to read and write as irrelevant for the following reason. Unlike the functional abilities in the CAI, *Guatney*, and the New Jersey statute, the inability to read and write, in and of itself, is not sufficient to render a decision of incompetence. Consideration of a defendant's illiteracy is best left for the dispositional objective, but not to be weighed in the competency decision itself.

tioned the type of tests/procedures used, most of them did not discuss how the results identified any deficits in functional abilities. In comparing the reports of the states for the causal characteristic, no large differences were found except that the New Jersey sample provided information on diagnosis more often (98%) than the Nebraska sample (81%).

*Interactive Characteristic* There were no reports that addressed any part of the interactive characteristic. Two different reports by the same examiner in New Jersey mentioned that the defendant could not handle the stress of a trial. However, the vagueness of this information precluded its inclusion in this section.

*Judgmental Characteristic* Over 25 percent ($n = 17$) of all reports concluded that the defendant was "incompetent" while 65.2 percent ($n = 43$) were evaluated as "competent." Two Nebraska reports (12.5%) and two New Jersey reports (4%) did not make conclusions on the ultimate issue. One Nebraska report and one New Jersey report each provided an improper *statement* for the opinion. For example, one of the reports cited insanity standards as the basis for the defendant's incompetency to stand trial and the other report ambiguously concluded that the defendant was "marginally competent to stand trial."[†]

*Dispositional Characteristic* The New Jersey sample (80%) provided treatment recommendations more often than the Nebraska sample (38%). Most of the forensic examiners provided treatment recommendations regardless of whether the defendant was evaluated as competent or incompetent. Of the 46 treatment recommendations made in the 66 reports, 33 of them were relevant to CST. The Nebraska sample had more CST-related treatment suggestions (94%) than the New Jersey reports (76%) regardless of competency opinion. Some of the recommendations included psychotropic medication to maintain competency, the need for a structured setting or long-term psychiatric treatment to afford competency, the need to explain legal information simply and concretely, and involvement in programs to enhance mental and behavioral status. Some treatment suggestions that were unrelated to CST included recommendations for medical treatment or hospitalization for purposes other than competency, substance abuse treatment, and even recommendations for civil commitment and prompt return from court so as not to interrupt treatment.

Of the 17 opinions that concluded that the defendant was incompetent, only 12 reports provided treatment suggestions to remediate competency. Of these 12, two were made in Nebraska reports (12.5%) and 10 were made in New Jersey reports (20%). Only 4 of the 12 reports provided information on how long it would take for treatment to return the patient to competency. Of these four, three (6%) were from New Jersey and one (6%) was from Nebraska. Eight indicated the least restrictive environment in which competency might be returned. Of these eight, seven (14%) were from New Jersey and one (6%) from Nebraska.

Finally, a total of 27 reports contained

[†]We agreed to find the conclusion of "marginal competence" to be improper, as it goes beyond concluding on the ultimate issue by describing the level of competency.

at least one *statement* that was either improper or irrelevant in relation to the CST standard.

## Discussion

As members of a growing field in forensic assessment, mental health professionals will want to review and improve the manner in which they supply information to the courts. By looking at the discrepancy between what is done and a proposal for what should be done, recommendations for improvement can be made. The following discussion will focus on this discrepancy, indicate instances where good report-writing skills were demonstrated, and provide future research directions. We must consider that Nebraska's sample was quite small and New Jersey reports were limited to inpatient evaluations.

An important consideration when interpreting whether a report fulfills certain qualitative criteria is the relationship between a judge and a forensic examiner. These individuals may have had professional contact with each other for many years and know what each expects or means without asking or reporting on it. An outside researcher, unaware of this relationship, may interpret a report that lacks details and explanations as poor quality when, however, the judge is getting exactly what he/she wants. This issue would appear to become a problem when the judge begins to rely on the forensic examiner's opinion as conclusive.

In terms of providing demographic information, the New Jersey sample was more consistent than the Nebraska sample. This could be due to the fact that more than half of the Nebraska reports were community-based evaluations, whereas the New Jersey hospital followed uniform procedures. These results indicate that where the assessment is performed may affect quality. The fact that most states have modified their forensic assessment systems to an outpatient service raises the concern that although time and money are saved, quality may suffer.

Overall, the objectives of the functional characteristic were met in this study. The CST reports were legally relevant in that they addressed legally relevant functional abilities that pertain to CST. Fifty percent of the reports mentioned at least one relevant ability that did not come from the CAI, *Guatney*, or the New Jersey statute. This suggests that perhaps there may be other abilities that forensic experts can assess that may be helpful to the court that have not been considered before. It can only be speculated as to why both states more frequently utilized factors 3, 5, 7, and 8 of the CAI list of functional abilities. Perhaps forensic examiners routinely focused on them because they appear to be the most fundamental capacities needed of the 13 that are listed. It is unclear why Nebraska focused on factor 10 twice as often as New Jersey did, since both states have similar factors in either *Guatney* or the New Jersey statute. Finally, New Jersey's strength in applying all of their statute's factors about half of the time may reflect the effect of a standardized method for inpatient evaluations as opposed to outpatient.

Most problems arose in finding data in the reports that met the objectives for the causal, interactive, and dispositional char-

acteristics. In terms of the causal objective, while a significant number of the reports in this study indicated a DSM diagnosis, they did not elaborate on how the symptoms of such a diagnosis affected deficits in functional abilities. For example, many examiners provided the diagnosis of paranoid schizophrenia and described the associated symptoms but did not describe how the symptoms affected legally relevant abilities. The same finding occurred for reporting on the tests and/or procedures used to assess CST. Less than half of the reports indicated the types of tests and/or procedures used in the assessment, and of those that did, almost none of them discussed the relationship between the assessment results and deficits in functional abilities. For example, although objective and projective psychological tests were actually performed, the results of these tests were not discussed let alone related to deficits in legally relevant abilities. Even the results of the most appropriate kinds of testing (e.g., forensic instruments) were neither reported nor connected to legally relevant abilities. The inclusion of logical reasoning used to reach one's opinion in a report is an essential element of the causal characteristic. Without this information, the input of forensic examiners may be of little assistance to the court. Therefore, the causal objective was not fulfilled.

There were no reports that met the objectives of the interactive characteristic. It appears that this objective was beyond the scope of the CST reports in this study. The nature of the interactive characteristic transcends basic objectives of a CST report to describe the defendant and what he/she can and cannot do in relation to the trial process. Grisso[28] himself believes this objective of a CST report is "useful but not essential." We believe that it is very valuable information. The objective provides information relevant to the defendant as an individual whose trial is particular to him/her. As mental health professionals, our primary specialty is understanding individuals as they function in certain situations. Since the law does not recognize any specific degree of incapacity as indicative of incompetency, our ability to enlighten the court on this objective would seem to be imperative.

With respect to the judgmental characteristic, practically all of the reports provided a conclusion on the ultimate issue. For those who believe that providing a conclusion on the ultimate issue is appropriate, the nature of this objective is fulfilled. However, for those who feel that a conclusion on the ultimate issue is never acceptable, may be particularly uneasy about the result. This dissatisfaction would be due to the fact that most reports lacked information to support the ultimate issues frequently provided. For example, the typical report would mention a diagnosis, talk about deficits in several legally relevant functional abilities, and then conclude that "based on reasonable medical certainty"[‡] the defendant was either competent or incompetent to stand trial. Consequently, some forensic examiners are exceeding their role responsibilities in

[‡]The conclusion based on "reasonable medical certainty" was a standard statement in New Jersey. The inappropriateness of this statement lies in the fact that a judgment of CST is not medical, but legal. Ironically, forensic experts use this terminology because it is often found in statutory language.

some areas and not fulfilling them in others. If there is no connection between clinical observations and the final conclusion, the result is an insufficient analysis of CST.

To fulfill the objectives of the dispositional characteristic, the report needs to indicate treatment recommendations that may possibly restore competency, as well as all the associated information such as how long it will take for treatment to restore the subject to competency and the least restrictive environment in which remediation of competency can occur. Treatment recommendations for issues other than CST are irrelevant before the court and do not belong in the CST report. There were 33 reports that suggested treatment for conditions unrelated to CST. This pattern may be due to the examiner's inclination toward clinical work and the treatment process. In the present study, most of the reports contained treatment recommendations regardless of whether the defendant was competent or incompetent. The majority of treatment recommendations were at least relevant to CST in that they provided the manner in which competency could be maintained. However, when the defendant was incompetent, only 12 of the 17 "incompetent" opinions provided treatment recommendations to restore competency. Of these 12 reports, four indicated the projected time it would take for remediation and eight indicated the least restrictive environment in which competency could be returned. Therefore, the dispositional objective was not fulfilled. The decision in *Jackson v. Indiana*[27] that created the need for CST assessments to address restorability was overlooked.

Twenty-seven reports contained at least one irrelevant or improper *statement*. This result leads us to conclude that perhaps forensic examiners could use more training in the law that is relevant to mental health issues. For example, one report in which the only referral issue was CST contained the following conclusion: "The defendant is a potential danger to others, her crime was not prompted by her mental illness, she knows the difference between right and wrong, she understands the nature and consequences of her act and can cooperate in her own defense. Standing trial and serving appropriate punishment will not be deleterious to her physical or mental health." There are several different standards addressed in this report. Only one of them ("can cooperate in her own defense") is relevant to CST. However, rather than lack of training, examiners may include other standards such as "insanity" to avoid repeating examinations in the future or to rule out inappropriate insanity referrals.

## Conclusions

In sum, the CST reports were legally relevant in that they addressed functional abilities that pertain to CST. Almost all reports provided a conclusion on the ultimate issue, and thus, depending on the side of the debate one falls, the fulfillment of the judgmental characteristic may or may not be commendable. There were frequent deficiencies in fulfilling the objectives for the causal, interactive, and dispositional characteristics.

This study has shown that there is a

discrepancy between actual practice and a proposal for quality CST reports. This difference may be largely due to the fact that there is presently no standardized format for conducting and writing CST evaluations. As a result, many of the reports had irrelevant or improper discussion or did not provide a sufficient and thorough analysis to support their opinions.

It is clear that a national sample is needed to assess actual practices in conducting CST evaluations for the courts. Although this sample is restricted to data from two state sources, the results indicate that current CST reports leave room for improvement. Since forensic assessment systems vary by state, there could be differences in actual practices across the nation. Valuable information could be provided if research were conducted on the variation of quality in CST evaluations across the United States. In particular, a study of differences in quality between settings (hospital versus community) would be worthwhile.

The manner in which a criminal defendant is referred for a CST evaluation is also relevant for future research. For example, forensic examiners may not perform the interactive objective of the evaluation because the referral packet does not have information on the nature of the trial which would facilitate a sufficient analysis. Research on the contents of CST referral packets and its relationship to report quality may uncover certain restrictions in the CST assessment process and lead to other suggestions for improvement.

In a time when managed care is shaping private practice, many mental health professionals conceivably will move into forensic assessment, an area in which insurance reimbursement is not an issue. If a standardized method of competency assessment is in place, variations in quality among private practitioners can be kept to a minimum. Research on the benefits of using a standardized versus nonstandardized approach could determine whether such a control would benefit the courts and mental health professionals.

A standardized method of conceptualizing and writing CST evaluations for the courts can ensure forensic mental health professionals a marketplace in the legal forum. The result would be relevant and thorough reports in which forensic examiners remain within their scope of expertise.

## Appendix A

### The Six Characteristics

### (Adapted from T. Grisso, 1988)[28]

1. Functional Characteristic: Describes the defendant's strengths and deficits in the specific abilities defined by the legal standard for pretrial competency.
2. Contextual Characteristic: This is the type of competency being assessed. In the case of "competency to stand trial," an examiner will maintain relevance if he/she focuses only on those functional abilities related to this context.
3. Causal Characteristic: Provides information that suggests the cause of any deficits in competency abilities that have been observed. By linking the diagnostic symptoms to deficits in relevant functional abilities, the examiner is steered toward relevance.
4. Interactive Characteristic: Considering what is known about the demands of a defendant's future trial process and the significance or implications

of the defendant's particular deficits in that light.
5. Judgmental Characteristic: The opinion concerning whether the defendant is competent or incompetent to stand trial.
6. Dispositional Characteristic: Provides information with which the court can decide matters of remediation or other dispositional options relevant to regaining competency.

## Appendix B

Twenty factors to be considered in whether a defendant is competent to stand trial[22]:

1. That the defendant has sufficient mental capacity to appreciate his presence in relation to time, place, and things;
2. That his elementary mental processes are such that he understands that he is in a court of law charged with a criminal offense;
3. That he realizes there is a judge on the bench;
4. That he understands that there is a prosecutor present who will try to convict him of a criminal charge;
5. That he has a lawyer who will undertake to defend him against the charge;
6. That he knows that he will be expected to tell his lawyer all he knows or remembers about the events involved in the alleged crime;
7. That he understands that there will be a jury present to pass upon evidence in determining his guilt or innocence;
8. That he has sufficient memory to relate answers to questions posed to him;
9. That he has established rapport with his lawyer;
10. That he can follow the testimony reasonably well;
11. That he has the ability to meet stresses without his rationality or judgment breaking down;
12. That he has at least minimal contact with reality;
13. That he has the minimum intelligence necessary to grasp the events taking place;
14. That he can confer coherently with some appreciation of proceedings;
15. That he can both give and receive advice from his attorneys;
16. That he can divulge facts without paranoid distress;
17. That he can decide upon a plea;
18. That he can testify, if necessary;
19. That he can make simple decisions; and
20. That he has a desire for justice rather than underserved punishment.

## Appendix C

N.J. Stat. Ann. 2C:4-4 (West 1997): mental incompetence excluding fitness to proceed

a. No person who lacks capacity to understand the proceedings against him or to assist in his own defense shall be tried, convicted or sentenced for the commission of an offense so long as such incapacity endures.

b. A person shall be considered mentally competent to stand trial on criminal charges if the proofs shall establish:

(1) That the defendant has the mental capacity to appreciate his presence in relation to time, place and things; and
(2) That his elementary mental processes are such that he comprehends:
(a) That he is in a court of justice charged with a criminal offense;
(b) That there is a judge on the bench;
(c) That there is a prosecutor present who will try to convict him of a criminal charge;
(d) That he has a lawyer who will undertake to defend him against that charge;
(e) That he will be expected to tell to the best of his mental ability the facts surrounding him at the time and place where the alleged violation was committed if he chooses to testify and understands the right not to testify;
(f) That there is or may be a jury present to pass upon evidence adduced as to guilt or innocence of such charge or, that if he should choose to enter into plea negotiations or to plead guilty, that he comprehend the consequences of a guilty plea and that he be able to knowingly, intelligently, and voluntarily waive those rights which are waived upon such entry of a guilty plea; and
(g) That he has the ability to participate in an adequate presentation of his defense.

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## References

1. Melton G, Petrila J, Poythress N, Slobogin C: Psychological evaluations for the courts: a handbook for mental health professionals and lawyers. New York: Guilford Press, 1987
2. Ferguson collapses in court after scorning insanity plea: rail-shooting suspect defies his lawyers. New York Times. August 20, 1994, p 28
3. Suspect in L.I.R.R. killings ruled competent for trial. New York Times. December 10, 1994
4. Grisso T: The economic and scientific future of forensic psychological assessment. Am Psychol 42:831–9, 1987
5. Barnum R: An agenda for quality improvement in forensic mental health consultation. Bull Am Acad Psychiatry Law 21:5–21, 1993
6. Drob SL, Berger RH, Weinstein HC: Competency to stand trial: a conceptual model for its proper assessment. Bull Am Acad Psychiatry Law 15:85–94, 1987
7. Faust D, Ziskin J: The expert witness in psychology and psychiatry. Science 241:31–5, 1988
8. Hess J, Thomas H: Incompetency to stand trial: procedures, results, and problems. Am J Psychiatry 119:713-20, 1963
9. Larkin EP, Collins PJ: Fitness to plead and psychiatric reports. Med Sci Law 29:26–32, 1989
10. Miller GH: Competency to stand trial. Contemp Psychiatry 18:660–64, 1988
11. Owens, H, Rosner R, Harmon R: The judge's view of competency evaluations. Part II. Bull Am Acad Psychiatry Law 15:381–9, 1987
12. Rogers R, Ewing C: Ultimate opinion proscriptions: a cosmetic fix and a plea for empiricism. Law Hum Behav 13:357–74, 1989
13. Slobogin C: The "ultimate issue" issue. Behav Sci Law 7:259–66, 1989
14. Insanity Defense Work Group: American Psychiatric Association statement on the insanity defense. Am J Psychiatry 140:681–8, 1983
15. Morse S: Crazy behavior, morals, and science: an analysis of mental health law. 51 S Cal L Rev 527–654 (1978)
16. Petrella RC, Poythress NG: The quality of forensic evaluations: an interdisciplinary study. J Consult Clin Psychol 51:76–85, 1983
17. Heilbrun K, Rosenfeld B, Warren J, Collins S: The use of third party information in forensic assessments. Bull Am Acad Psychiatry Law 22:399–406, 1994
18. Heilbrun K, Collins S: Evaluations of trial competency and mental state at the time of the offense: report characteristics. Prof Psychol Res Pract 26:61–7, 1995
19. Borum R, Grisso T: Establishing standards in criminal forensic reports: an empirical analysis. Bull Am Acad Psychiatry Law 24:297–317, 1996
20. Grisso T: Evaluating competencies: forensic assessments and instruments. New York: Plenum, 1986
21. Golding S, Roesch R, Schreiber J: Assessment and conceptualization of competency to stand trial: preliminary data on the Interdisciplinary Fitness Interview. Law Hum Behav 8:321–34, 1984
22. State v. Guatney, 207 Neb. 501, 509–13, 299 N.W.2d 538, 543 (Neb. 1980) (Krivosha, C.J., concurring)
23. N.J. Stat. Ann. 2C:4-4 (West 1997)
24. McGarry A: Competency to Stand Trial and Mental Illness (Department of Health, Education, and Welfare Publication No. ADM 77-103; out of print). Rockville, MD: DHEW,1973
25. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders (ed 3 rev). Washington, DC: APA,1987
26. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders (ed 4). Washington, DC: APA, 1994
27. The relevant case on this issue is Jackson v. Indiana, 406 U.S.715, 1972
28. Grisso T: Competency to Stand Trial Evaluations: A Manual for Practice. Sarasota, FL: Professional Resource Exchange, Inc., 1988