A fundamental principle of constitutional and criminal law is that all people charged with committing an offense must be given an opportunity to defend themselves (see generally, LaFave & Israel, 1985). A number of specific rights emanate from this general principle, including the "right to a speedy and public trial, by an impartial jury," the right to be confronted with the witnesses against him," and the right to have the "assistance of Counsel for his defence" (Amendment VI, United States Constitution).

Beginning with 18th century cases in English common law, courts have recognized that, in order to receive a fair trial, the defendant must be "competent" (Frith's Case, 1790; Ogloff, Wallace, & Otto, 1991). As Ogloff et al. (1991) explain, competence is a legal concept that is defined generally as the "mental capacity or ability required to perform an act" (p. 343). The specific competency questions that arise in legal settings are rather narrowly based on an individual's ability to perform certain tasks and to understand certain concepts. The question of the defendant's competency may arise at several points from the time of arrest to the conclusion of the defendant's sentence (e.g., competency to confess, competency to plead guilty, competency to stand trial, competency to waive counsel, competency to be sentenced, and competency to be executed; Ogloff et al., 1991; Roesch & Golding, 1987).

In order to conduct competency evaluations that are legally valid and useful to the courts in making decisions about competency, it is important that clinicians have a clear understanding of the legal criteria for competency. Indeed, competency is a legal concept that is not defined or operationalized in psychology or psychiatry. This article focuses on three aspects of criminal competency: a) the legal criteria defining competency to stand trial, b) the clinical assessment of competency, and c) the treatment of defendants found incompetent to stand trial.

### The Legal Criteria Defining Competency to Stand Trial

Historically, criminal competency has been defined broadly, to ensure that a criminal defendant received a fair trial, and today, most jurisdictions use the term competency to stand trial to encompass this principle. The competency criteria to stand trial specified in state statutes generally refer to variations of the standard set forth by the United States Supreme Court in *Dusky v. United States* (1960). In *Dusky*, the Court held that for a defendant to be considered competent to stand trial, the defendant must have "sufficient present ability to consult with his attorney with a reasonable degree of rational understanding" and "a rational as well as factual understanding of the proceedings against him" (p. 402).

The *Dusky* criteria reflect general categories of abilities, such as understanding legal proceedings and communicating with an attorney. As the *Dusky* criteria also specify, rationality is a key psychological construct underlying most applications of competency. Incompetent defendants would be considered to lack some or all of these capacities because of their inability to understand, communicate, or make decisions in a rational manner. However, the way in which such judgments about competency in general and rationality of decision making in particular would be assessed is unspecified in the statutory language and in most evaluation procedures. A notable exception is the state of Florida, as its statute (Florida Rules of Criminal Procedure, §3.21(a)(1)) requires evaluators to relate a defendant's mental condition to each of 11 legal factors (e.g., ability to relate to an attorney, capacity to testify relevantly). We regard this type of statute as a model for increased specificity in the statutes governing competency assessments.

In lieu of statutory guidance, the courts, then, have operationalized the concept of competency to stand trial. Given the type of information courts require to satisfy their inquiries into the defendant's competency, we turn next to a discussion of the clinical assessment and treatment of competency.

### The Clinical Assessment of Competency to Stand Trial

The courts have relied upon mental health professionals to conduct evaluations of criminal competency, and provide
the court with reports summarizing the results of these evaluations. Unfortunately, with some exceptions, these evaluations focused on a defendant's mental status with little attention paid to the legal issues involved in a particular case. The recommendations resulting from these evaluations were typically global in nature, usually resulting in statements offering a conclusion about whether or not a defendant was competent to stand trial.

As has been suggested (see Golding & Roesch, 1988; Grisso, 1986; Melton, Petrilia, Poythress, & Slobogin, 1987; Ogloff et al., 1991; Roesch & Golding, 1980), these recommendations were based largely on a finding of psychosis or mental retardation, with virtually no attempt to relate these factors to the specific requirements of the instant criminal case. This is unfortunate since the legal concept of competency to stand trial is quite specific and focuses on questions surrounding a defendant's functional abilities that are directly relevant to the criminal process in the law. Thus, information derived from traditional clinical assessments indicating the defendant's IQ score, personality profile, and mental status generally, is often not relevant to the legal question of the defendant's competence.

More recently, there have been compelling arguments calling for more specificity in the conceptualization, evaluation and adjudication of competency (Golding & Roesch, 1988; Grisso, 1986; Melton et al., 1987; Ogloff et al., 1991). The specificity takes two forms. First, the conceptualization of competency and its statutory language need a degree of articulation that reflects more accurately the structure of the domain of the specific competency in question. For example, the commonly used term, competency to stand trial, is not specific enough because it does not reflect the range of abilities that may be required in assisting in the preparation of the defense if the case actually went to trial, testifying on one's own behalf, and so on (Ogloff et al., 1991). Second, this specificity needs to be reflected in the evaluation of competency and in the treatment and disposition of defendants found incompetent. It is inappropriate to evaluate defendants on a unidimensional conceptualization of competency to stand trial (i.e., some delusional defendants might be competent to stand trial, while others may not, depending upon the individual circumstances and the demands of the specific case) or likewise to assume that treatment and disposition issues can be similarly construed.

We have suggested elsewhere (Golding, Roesch, & Schreiber, 1984; Golding & Roesch, 1988; Ogloff et al., 1991; Roesch & Golding, 1980, 1987) that incompetency should be evaluated and treated in a context-dependent manner, taking into account the demands of a defendant's specific legal situation and what is likely to be required of that defendant in a given legal procedure (see also Rogers & Mitchell, 1991). It is quite usual for defendants to be competent for certain types of legal proceedings but not for others, so it is necessary that competency evaluations and the treatment of incompetent defendants consider the specific demands and contextual factors related to a particular case. As Golding and Roesch (1988) commented:

*Mere presence of severe disturbance (a psychopathological criterion) is only a threshold issue--it must be further demonstrated that such severe disturbance in this defendant, facing these charges, in light of existing evidence, anticipating the substantial effort of a particular attorney with a relationship of known characteristics, results in the defendant being unable to rationally assist the attorney or to comprehend the nature of the proceedings and their likely outcome.* (p. 79)

For example, Rogers and Mitchell (1991) comment that:

*An elaborate fraud case likely would require far more cognitive ability than a simple case of vandalism. Similarly, the degree of active participation in a case depends largely on defense strategy. For instance, if there is overwhelming independent evidence of an accused's actions, he/she may only need to understand the charges and be able to discuss rationally options for plea bargaining.* (p. 97)

Thus, clinicians need to be cognizant of the details and level of complexity of the case in which the defendant is involved (see Rogers & Mitchell, 1991 for a table in which they provide criteria to consider depending upon the complexity of the case).

**Guidelines for Evaluators**

Prior to the actual evaluation of a defendant referred for a competency evaluation, it is good clinical practice to speak with both the defense and prosecuting attorneys in order to determine as accurately as possible why the fitness
issue was raised, what evidence was offered, and what sort of trial and dispositional alternatives are being considered by both sides.

There are several methods that have been developed to aid evaluators in assessing competency to stand trial. Obviously, evaluators with little forensic experience or experience with competency assessments will need more specific training on the use of these measures, but we will provide a brief overview of the principle techniques. The interested reader can consult the references for more detail (see also Bagby, Nicholson, Rogers, & Nussbaum, in press; Grisso, 1986; Nicholson & Kugler, 1991; Nicholson, Robertson, Johnson, & Jensen, 1988). We will review three of the principle measures of competency are: a) the Competency Screening Test (Lipsitt, Lelos, & McGarry, 1971); b) the Competency Assessment Instrument (McGarry & Curran, 1973); and c) the Interdisciplinary Fitness Interview (Golding, Roesch, & Schreiber, 1984; McDonald, Nussbaum, & Bagby, 1991). Other methods of assessing competency include The Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR; Everington, 1990) and the Georgia Court Competency Test (GCCT; Wildman, White, & Brandenburg, 1990; see also Nicholson & Johnson, 1991).

Competency Screening Test

The Competency Screening Test (CST) was created by Lipsitt et al. (1971) as a screening measure that could be administered prior to an institutional evaluation of competency. Thus, it was intended, along with the Competency Assessment Instrument (see review in next section), to facilitate community based screening evaluations of pretrial defendants. The CST is a 22-item measure in sentence completion format. Defendants are asked to complete the sentences on such items as "Jack felt that the judge____", or "If the jury finds me guilty_____." Each item is given a score of 2 (competent response), 1 (questionable competency), or 0 (incompetent response). The CST is designed to allow the calculation of a total score in order to facilitate the use of cutoff scores to identify possibly incompetent defendants (Lipsitt et al. recommend a cutoff score of 20). Low scorers would then be assessed with more traditional methods, including the use of structured interviews such as the Competency Assessment Instrument.

The CST has been used in a number of studies. Nicholson, Robertson, Johnson, and Jensen (1988) collected CST and Georgia Court Competency Test data from 140 defendants referred to a state hospital for competency evaluations. Interscorer reliability for the CST was excellent (r = .94). This is consistent with the .93 figure found by Lipsitt et al. and a similar figure reported by Randolph, Hicks, and Mason (1981). The level of agreement between the CST and staff decisions was 71.2% overall, with a considerable false positive rate (76%) but a low false negative rate (3.5%, only 3 of 86 cases). Overall, the CST misclassified as incompetent approximately 30% of the defendants found to be competent by the hospital evaluation. Thus, the CST overpredicted incompetency but misclassified only a small number of defendants who were found to be incompetent by the hospital evaluators. This outcome is a positive one in the sense that it is more desirable in a screening procedure to err in the direction of false positives but try to minimize the number of false negatives. This is because false positives (screening determination of incompetency but subsequent finding that defendant is competent) will simply be referred for additional evaluation, while false negatives (incorrectly classifying an incompetent defendant as competent) will be missed because there will be no further evaluation. Nicholson et al. also found that a diagnosis of psychosis was not significantly correlated with performance on the CST, but it was correlated with a diagnosis of mental retardation, years of education, and race. They interpret this as suggesting that the CST taps an intellectual component of the competency construct.

Nicholson, Briggs, and Robertson (1988) summarized additional analyses of the same sample. They reported an alpha coefficient of .85 for the CST, and they also looked at its factor structure. They concluded that the factor structure was not clear. In fact, they were unable to interpret factors they did obtain, and they did not replicate the factor structure reported in the original research by McGarry.

The CST requires a level of reading and writing ability that may render it inappropriate for many defendants whose competency has been questioned. For example, Chellsen (1986) used it with a sample of mildly retarded offenders (IQ range of 47 to 77) and found that the CST resulted in a high number of false negatives (44%), and that many individuals had considerable difficulty in responding to the task.

Competency Assessment Instrument
The Competency Assessment Instrument (CAI) contains 13 items focusing on legal issues related to competency. Examples of items include "appraisal of available legal defenses," "quality of relating to attorney," and "capacity to disclose pertinent facts." Each item is scored on a 1 to 5 scale, ranging from "total incapacity" to "no incapacity." The CAI manual contains clinical examples of levels of incapacity as well as suggested interview questions. Grisso (1986) notes that "the method for arriving at the 13 functions ... offers no empirical assurance that the instrument covers the range of potentially relevant functions... Nevertheless, the listing seems adequately complete in its coverage on a rational basis" (p. 81).

The CAI has been used in a number of jurisdictions, although perhaps more as an interview structuring device than in the two stage screening manner (with the Competency Screening Test) as originally intended by McGarry (see Laben, Kashgarian, Nessa, & Spencer, 1977; Schreiber, 1978). A revised and extended version, known as the Fitness Interview Test, has been adopted for use in Canada (Roesch, Webster, & Eaves, 1984). Unfortunately, there are few studies reporting either reliability or validity data. Roesch and Golding (1980) used the CAI in a North Carolina study. Thirty interviews conducted by pairs of interviewers yielded item percent agreement ranging from 68.8% to 96.7%, with a median of 81.2%. The interviewers were in agreement on the competency status of 29 of the 30 defendants (26 competent, 3 incompetent). The interviewers' decisions were in concordance with the more lengthy hospital evaluation decisions in 27 of 30 cases, or 90%.

In a review of the CAI, Grisso (1986) comments that few instructions are available for the administration of the CAI, and that research on the consistency or stability of CAI ratings is not available. Obviously, more studies are needed to address these concerns. Meanwhile, the CAI could be useful to clinicians as a guide for assessing competency to stand trial.

**Interdisciplinary Fitness Interview**

The Interdisciplinary Fitness Interview (IFI) is designed to provide a balance of legal content and psychopathology content in assessments of competency to stand trial. The IFI is organized into four sections: a) legal issues (5 items), b) psychopathological issues (11 items), c) overall evaluation (4 items), and d) consensual judgment (3 items).

Each of the general items represents an organizing scheme for more specific subareas of issues that may be relevant to decisions about a defendant's competency to stand trial. For example, six areas are included under the first item in the legal issues section: 1) appreciating the nature of the alleged crime; 2) ability to provide a reasonable account of one's own behavior prior to, during, and subsequent to the alleged crime; 3) ability to provide an account of the behavior of others during the same time period; 4) ability to provide relevant information about one's own state of mind at the time, including intentions, feelings, and cognitions; 5) ability to provide information about the behavior of the police during the time of apprehension, arrest, and interrogation, and 6) projected ability to provide feedback to an attorney about the veracity of the testimony of witnesses.

The IFI was designed so that evaluators would have to consider both legal and mental status issues, but neither in isolation. The format of the IFI requires evaluators to relate their observations to the specific demands of the legal situations. For each item, evaluators are asked to rate the degree of incapacity of the defendant, as well as indicate the influence that the incapacity might have on the overall decision about competency. Thus, a defendant may receive a score indicating the presence of hallucinations (item 10) but receive a low weight score because the evaluator has determined that the presence of hallucinations would not have much effect on the conduct of the legal case. Another defendant with the same symptom may receive a high weight score because the hallucinations are considered to be more of a potential problem during the legal proceedings.

Golding, Roesch, and Schreiber (1984) used the IFI in a study of pretrial defendants in the Boston area who were referred by court clinics to a state mental hospital for competency evaluations. They were interviewed by teams composed of a lawyer and either a psychologist or a social worker. The interviews lasted approximately 45 minutes. While the interviews were conducted jointly, each evaluator independently completed the rating form of the IFI. The results demonstrated that judgments about competency can be made in a reliable manner by lawyers and mental health evaluators. They were in agreement on 97% of their final determinations of competency. By type of decision, the interviewers found 58 defendants to be competent, 17 incompetent and disagreed on the remaining 2 cases. While overall agreement was excellent, there were some differences between the professions at the item level.

**Concluding Comments About Assessment**
Regardless of the method of evaluation, evaluators should be aware of any aspects of the interview and the resulting report that are covered by statute or are accepted practice within the jurisdiction. As an example of the former, some states require *Miranda* like warnings that inform the defendant of the limitations of confidentiality that may apply. Similarly, other states dictate the form of the report to the court, and an evaluator's report may be excluded if it does not comply with the required format. Evaluators should review the *Specialty Guidelines for Forensic Psychologists* (Committee on Ethical Guidelines for Forensic Psychologists, 1991) for information about procedural and ethical issues related to forensic assessments.

It is likely that the majority of competency evaluations in the United States and Canada are conducted in institutions, but there have been calls to move the site of evaluation from the institution to the community (Golding & Roesch, 1988; Melton, Weithorn, & Slobogin, 1985; Ogloff & Roesch, in press; Winick, 1985). For the vast majority of cases, inpatient evaluation is both unnecessary and costly. This is because the evaluation of most defendants is relatively straightforward, and decisions about competency can be made on the basis of brief screening interviews. A small minority of cases might have to be referred for inpatient evaluations, particularly in cases of suspected malingering, but most cases could be dealt with by conducting the evaluation in the jail or other community location if the defendant has been released on bail. The benefits of a community based system, for both society and defendants, are substantial. The cost of a community evaluation is substantially less than an institutional evaluation (Golding, Roesch, & Schreiber, 1985) and the loss of liberty and delay of trial is minimized for defendants.

A recent review of state practices, however, reveals that the majority of evaluations still occur in state hospitals (Miller & Germaine, 1989) and we suspect that few evaluators rely on the available measures of competency that would facilitate community based screening evaluations. Why is this so, given what we have learned about the process of evaluating competency? We believe that this is at least partly explained by the reality that the legal system uses the competency laws and procedures to accomplish a number of aims, only one of which is actually related to a concern about a defendant's competency (Melton et al., 1987; Ogloff, 1991). For example, the changes in civil commitment over the past two decades have resulted in an increase in the number of mentally ill people in the criminal justice system, particularly the local jail (Ogloff, Tien, Roesch, & Eaves, 1991; Roesch & Golding, 1985; Teplin, 1984). Many jails do not have provisions for providing mental health services in the facility (Ogloff & Otto, 1989; Steadman, McCarty, & Morrissey, 1989). While there is little empirical data (but see Dickey, 1980), it is possible that jails and courts may sometimes use competency evaluations as a means of getting certain defendants out of the jail and into a mental health facility. This would account, at least in part, for the consistent finding that only a small percentage of defendants referred for competency evaluations are in fact found to be incompetent (Roesch & Golding, 1987). It would also account for the finding that jurisdictions have been slow to adopt the reforms that have been proposed in the literature, since a community based evaluation would not meet the perceived need to get defendants out of jail and into mental health treatment. Research examining the extent to which this situation occurs in a given jurisdiction is important since we need to have accurate data on the larger needs of the courts and jail in terms of mental health treatment.

One legal issue that may concern evaluators is whether information obtained in a competency evaluation can be used against a defendant during a trial or other legal proceeding. While some concerns have been raised about possible self-incrimination (Berry, 1973; Pizzi, 1977), it is generally agreed that information obtained in an evaluation will be limited to legal hearings on the issue of competency unless the defendant is informed prior to the evaluation of its potential uses and competently consents, as was held in the case of *Estelle v. Smith* (1981). The defendant may object but still be required to attend an evaluation, but may, of course, refuse to cooperate with evaluators. The *Estelle* case, incidentally, raises an important point about the various forms of competency that may enter into a competency evaluation, including competency to consent to an interview, competency to consent to treatment if found incompetent, competency to refuse medication, and so on.

Once a competency evaluation has been completed and the written report submitted (see Petrella & Poythress, 1983 for a discussion of the content of these reports), the court may schedule a hearing. If however, both the defense and the prosecution accept the findings and recommendations in the report, a hearing does not have to take place. It is likely that in the majority of the states, a formal hearing is not held for most cases. If a hearing is held, the evaluators may be asked to testify, but most hearings are quite brief and usually only the written report of an evaluator is used. In fact, the majority of hearings last only a few minutes and are held simply to confirm the findings of evaluators (Steadman, 1979). The ultimate decision about competency rests with the court, which is not bound by the evaluators' recommendations (e.g., *North Dakota v. Heger*, 1982). In most cases, however, the court accepts the
recommendations of the evaluators (Steadman, 1979; Williams & Miller, 1981).

**Treatment of Defendants Found Incompetent to Stand Trial**

Once a defendant is found incompetent to stand trial, judicial proceedings are postponed until competency is restored. In virtually all jurisdictions in the United States, there are time limits on the length of time an individual may be held as incompetent to stand trial, following Jackson v. Indiana (1972). In Jackson, the U.S. Supreme Court held that:

> A person charged by a State with a criminal offense who is committed solely on his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future. If it is determined that this is not the case, then the state must institute the customary civil commitment proceeding that would be required to commit indefinitely any other citizen, or release the defendant. Furthermore, even if it is determined that the defendant probably soon will be able to stand trial, his continued confinement must be justified by that progress toward that goal. (p. 738)

Subsequent to Jackson, a number of proposals were advanced to establish specific limitations on the length of treatment as well guidelines for the disposition of charges should competency not be restored. Roesch and Golding (1980) summarized 12 of these proposals. They found that most of them called for a six-month limitation for the length of time a defendant could be held after being found incompetent to stand trial. Some proposals also provided for a possible six month extension, but there was considerably variability in the proposals. Any specific period can only be arbitrarily determined at this time since very little research has been conducted on treatment responsiveness. The value of these proposals is that they offer alternative suggestions for a reasonable maximum length of confinement.

An analysis of state law subsequent to the Jackson decision showed that many states revised their state statutes (Roesch & Golding, 1980), setting limits of varying length. Since, as a result of Jackson, incompetent defendants would be released if they are not likely to regain competency or if the established time limit has been exceeded, the treatment of incompetent defendants has assumed greater priority in recent years. In this section, we will review treatment programs for incompetent defendants.

There are three major issues that need to be addressed. First, the expected level of competency must be delineated in a specific manner so that the treatment can be directed at the appropriate behaviors or capacities as they relate to a restoration of competency. Second, given the state of knowledge about treatment responsiveness, is it possible to make predictions about the treatment responsiveness of incompetent defendants? Third, is it possible to provide treatment in the community rather than in institutions?

Before one can specify treatments, it is necessary to have a clear understanding of the expected level of knowledge and ability a criminal defendant needs to be considered competent. Unfortunately, little is known about how the average criminal defendant functions in terms of the usual criteria against which defendants evaluated for competency are compared. Many of the treatment programs focus on knowledge of courtroom personnel and procedures (e.g., Pendleton, 1980). Does this mean that an incompetent defendant simply lacks knowledge about the legal system? Obviously, it must be more than that, but this is not adequately addressed in most treatment programs.

A notable exception is a recent study by Siegel and Elwork (1990). In their evaluation of a treatment program for incompetent defendants, they compared an experimental group with a control group, assigning subjects randomly to the conditions (a rank order procedure was used, based on pretest scores on the CAI). The treatment included the use of a videotape that described the roles of courtroom personnel and court procedure as well as group problem solving sessions in which problems arising from a subject's actual legal case were presented and discussed. Results showed greater improvement on CAI scores for the experimental group and a greater number of staff recommendations of competency to stand trial (45 days after treatment, 43% of the treated group, but only 15% of the controls were considered competent by staff).

We are aware, of course, that medication is the most common form of treatment and that considerable controversy surrounds this issue. Questions have been raised about the relation of competency to stand trial and competency to
refuse psychotropic medications, the potential disadvantages a heavily medicated defendant may experience at trial, the side-effects of medications, and the difficulties in establishing mental state at the time of the offense for defendants declared incompetent who wish to raise a mental state defense. We need to understand empirically the decisional abilities relevant to competency restoration of those adjudicated incompetent to proceed and the direct effects of medication on those decisional abilities relevant to the original finding of incompetence. It is also important to recognize that medication alone may only temporarily restore competency.

Beckham, Annis, and Bein (1986) examined data collected from hospital records of two samples of competent defendants to evaluate group differences between those who maintain competency to stand trial (nonrecidivists) and those who do not maintain competency (recidivists). They found that medication change and severity of charges were the primary predictors of recidivism. Decreases in medication after being determined competent, which may frequently occur after the defendant leaves the institutional setting, and a maximum possible penalty of greater than 40 years, were significant factors in predicting recidivism.

Predicting response to treatment

The Jackson based criteria for commitment of incompetent defendants requires a prediction of responsiveness to treatment within a specified, time limited period. How accurately are clinicians able to predict responsiveness to treatment? There has been little research in this area. Cuneo and Brelje (1984) found a 78% accuracy rate for professionals who were asked to predict whether competency would be restored within one year. But this figure is not impressive when one looks at the base rates; most defendants are restored to competency within six months (Golding, Eaves, & Kowaz, 1989). A more appropriate figure to evaluate the ability to accurately predict responsiveness to treatment is the false positive rate (i.e., defendants who are predicted to regain competency who do not). In the Cuneo and Brelje study, the false positive rate was 23%. Obviously, clinicians may have difficulty identifying the smaller percentage of incompetent defendants who do not respond to treatment.

Place and Type of Treatment

Schutte, Malouff, Lucore, and Shern (1988) obtained questionnaire responses from 288 community mental health center and state hospital administrators and treatment staff members. They expressed their belief that given enhanced community evaluation and treatment programs for forensic clients, approximately one-third of the clients found incompetent could be treated in local communities. We agree that many incompetent defendants could be treated in the community, and the actual figure might be considerably higher than that found by Schutte et al. In practice, however, very little treatment occurs in the community. To our knowledge, most incompetent defendants are committed to mental health or forensic institutions for treatment. In most treatment facilities, the nature of the treatment is not clearly specified, but there have been a few programs that have developed treatment programs that focus directly on competency related issues.

Davis (1985) developed a treatment program in which priority is placed on the restoration of competency and not on other problem areas. A treatment plan is developed for each defendant that addresses the following areas: knowledge of charges and possible consequences, ability to communicate rationally with an attorney, knowledge of courtroom procedures, and the capacity to apply knowledge and abilities to the actual demands of a defendant's specific legal situation. Most of the treatment takes place in a group setting, but there is individual treatment as well. The potential strength of this program is that treatment is individualized. Each defendant is assessed to determine the specific deficits or problems that hinder going forward with the legal proceedings, and then assigned to one of several different types of treatment groups. For example, there is a "psychotic-confused" group that includes defendants who are "unable to adequately understand or communicate information because of perceptual or thought disturbances"; there is also a "disruptive" group for defendants who are "attention-seeking, hyperactive, impulsive, uncontrollable, or belligerent" (p. 270). Other groups focus on defendants with delusions or irrational thought processes. An important aspect of the program is the mock trials in which all defendants participate and play actual trial roles. Unfortunately, no data are available on the effectiveness of this program.

As mentioned previously, defendants need a rational understanding of legal proceedings to be found competent (Dusky v. U.S., 1960). Thus, it is not enough that defendants merely gain a factual understanding of the legal system in order to be considered competent. The Siegel and Elwork (1990) program goes beyond simple knowledge building to facilitating problem solving skills.
One alternative to treatment, especially when it appears that treatment is likely to be lengthy, is to allow possibly incompetent defendants to proceed with their criminal cases (Burt & Morris, 1972; Roesch & Golding, 1980). This may, at first blush, appear to be contradictory, since the competency laws are designed to protect the rights of incompetent defendants to a fair trial. But it is important to recognize that lengthy delays may not be in the best interest of defendants. The effect of a finding of incompetency is to postpone all legal proceedings until competency is restored (or charges are dismissed following Jackson guidelines). Allowing a trial would provide an opportunity to advance a defense to any criminal charges and force the state to show that it had sufficient evidence for a conviction. Such a provisional trial could allow evaluators and others a more direct assessment of the defendant's capacities in the actual criterion situation. This assessment could provide useful validity data on the assessment process. At present, evaluators have no data on the validity of decisions about incompetent defendants, since a finding of incompetency results in a suspension of the criminal case. The provisional trial could, in effect, provide a direct test of the validity of the initial assessment, assuming that evaluators could continue to observe and assess the defendant during the legal proceedings. If a defendant was acquitted, the issue of competency would be moot. If convicted, the verdict could be accepted or set aside if evidence was presented that the defendant's competency was an issue.

Summary and Conclusions

As we emphasized in this article, competency to stand trial evaluations must focus on the defendant's functional understanding of the legal proceedings in which he or she is engaged. Further, the assessment must include an evaluation of the defendant's ability (capacity) to make rational decisions regarding the case. In conducting competency assessments, the clinician should consider the context of the case. For example, it would seem that a greater level of understanding is necessary if the defendant's case is a particularly complex one. Whenever possible, clinicians should use one of the competency evaluation instruments as a screening tool to reduce the likelihood of misidentifying a defendant as incompetent when, in fact, the defendant is competent. In addition, evaluations should be conducted in the least restrictive environment possible.

When treating defendants found incompetent to stand trial, clinicians should focus their efforts on the individual needs of the specific defendant. Just as with evaluations, treatment should take place in the least restrictive environment possible. Finally, if treatment efforts are not effective after a reasonable period of time, clinicians need to consult with the prosecution and the court to find an alternative option for the defendant (e.g., dismissal of charges and release, or civil commitment if appropriate).

References
