
Assessment of Competency to Stand Trial & Criminal Responsibility

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Criminal attorneys, prosecutors and judges, immersed in their case and court schedules are not always able to identify a mental condition that renders a defendant incompetent to stand trial or legally insane. This article discusses relevant case law and Michigan statutes related to the issues of competency to stand trial and criminal responsibility, and identifies psychological conditions commonly associated with the issue of adjudicative competency. Finally, the basic elements of thorough competency and criminal responsibility evaluations are discussed.

There is a long-standing tradition in American jurisprudence that requires a defendant in a criminal proceeding to be competent to stand trial. The U. S. Supreme Court, in *Dusky v. United States* (1960) stated that competency exists when a defendant "... has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and ... has a rational as well as factual understanding of the proceedings against him" (p. 789). In Michigan, as in most jurisdictions, a criminal defendant is presumed competent unless the court is presented with evidence to the contrary. M.C.L. 330.2020(1) states that a defendant is incompetent to stand trial "... only if he is incapable because of a mental condition of understanding the nature and object of the proceedings against him or of assisting in his defense in a rational manner."

Pretrial competency evaluations are sought in a small proportion of felony cases, typically no more than 8% (Hoge, Bonnie, Poythress, and Monahan, 1992), and approximately one-third of defendants whose competency is legitimately in question are never referred for evaluation (LaFortune and Nicholson, 1995). Constitutional and societal problems arise when incompetent defendants are made to stand trial because they are unable to assist in their own defense (Wulack, 1980). Incompetent defendants may not be able to exercise appropriately their right to due process, including selecting and assisting defense counsel, confronting witnesses and testifying in their own behalf. Finally, no credible social or rehabilitative purpose is achieved by punishing a defendant who cannot understand the nature and purpose of a legal proceeding, and who is unable to understand the reason for which a sentence has been imposed.

The U. S. Supreme Court, in *Pate v. Robinson* (1960), ruled that a trial judge bears responsibility for raising the issue of a criminal defendant's competency if the court has reason to believe that the defendant may not be competent to proceed with adjudication, or if it is presented with evi-

dence by either the prosecution or defense that calls into question this issue. Similarly, case law in Michigan (*People v. Harris*, 1990) holds that a trial judge is obligated to raise the issue of a defendant's competency if "bona fide doubt" exists regarding this issue. These rulings create a duty for trial judges, prosecutors and defense attorneys to be cognizant of a defendant's mental state, and to initiate a referral for evaluation when evidence suggests that a defendant has a mental condition that impairs competency to proceed with adjudication.

Those who are unfamiliar with the area where law and mental health intersect may not readily recognize abnormal psychological conditions that are associated with incompetency. The three clinical populations where the question of competency to stand trial most often arises include defendants with schizophrenic-spectrum, and severe mood disorders, and defendants who possess significantly below average intelligence and can be classified as mentally retarded. Defendants who have schizophrenic-spectrum disorders, who experience fixed and false beliefs typically of a grandiose or persecutory nature, may display superficial capacity for rational and factual understanding of their legal situation and may be capable of limited cooperation with defense counsel. However, because these individuals do not possess stable, enduring contact with external, conventional reality, their delusional beliefs may surface only during extended interview regarding their legal situation or during adjudication proceedings, and they are liable to lack the ability to knowingly and intelligently weigh the defense strategies, and legal options that are available. Defense counsel must remain cognizant of the possibility that a defendant's mental state might deteriorate during the course of a trial because of the stress involved, and that the defendant might not be able to tolerate cross-examination without being overwhelmed.

Defendants whose mental condition is impaired by severely elevated or depressed mood also experience significant problems in thinking rationally and reasoning logically and, consequently, may not be capable of rational and factual understanding of the nature and purpose of adjudication proceedings. Furthermore, such individuals may lack the ability to sustain focused attention and concentration, sufficient to collaborate with defense counsel.

Defendants who are mentally retarded often lack the cognitive skills needed to understand the nature and object of a legal proceeding, yet some research has shown that these individuals are likely not to be referred for compe-

tency evaluations (Bonnie, 1990). The frequency with which mentally retarded defendants are not referred for evaluation is a legitimate social and legal concern, particularly in light of one study that found almost 60% of mentally retarded defendants referred for evaluation were incompetent to stand trial (Everington and Dunn, 1995). Still other research found that mentally retarded defendants with IQs ranging from 50 to 75 frequently did not understand legal terms and concepts, despite reporting familiarity with legal terminology (Ericson and Perlman, 2001).

Referral for a competency evaluation might be initiated for a variety of reasons. A defendant with a history of psychological problems who is currently evidencing serious symptoms or abnormal behavior should be evaluated, as should a defendant who has been diagnosed with below normal intelligence, and a history of significant limitations in adaptive functioning in the areas of school, work, communication, interpersonal relationships, or age-appropriate independence. Defendants reporting amnesia, displaying disturbances in conscious awareness or memory impairment would also be candidates for evaluation. Finally, if it is unusually difficult to communicate with a defendant and there is no apparent reason for this difficulty, a competency evaluation should be undertaken.

A thorough competency evaluation would inquire into several areas including, but not limited to, the defendant's ability to understand the nature of the charges, the relevant facts of the case, the available legal defenses, ability to plan and implement legal strategy, and the plea options that are available and the disposition associated with each one. A defendant's understanding of the roles of judge, prosecutor, defense counsel, and jury should also be determined, as well as defendant's ability to identify and locate witnesses, to appraise their testimony and to communicate this understanding to defense counsel. The defendant's ability to relate to defense counsel is another important area of inquiry, and involves assessing the defendant's "... ability to trust and communicate with the attorney in a relevant and coherent manner" (Shapiro, 1984, p. 5).

Since not all criminal defendants have had previous experience with the legal system, varying levels of understanding of court proceedings are common. For defendants with mental conditions that call into question their competency to stand trial, it is important to assess their capacity to learn and retain new information, and make certain that their mental condition does not impede comprehension. This inquiry assesses the defendant's ability to comprehend and grasp the meaning and significance of relevant legal issues and related matters, once these have been explained, and to retain this information until it is needed.

It is the standard of practice in forensic psychology to conduct evaluations using multiple sources of information, and multiple methods of data collection. Consequently,

when conducting a competency evaluation, in addition to interviewing the defendant, it would be appropriate to gather relevant information about the defendant's behavior and current mental state from defense counsel, from medical and/or mental health records, from police and/or prosecution reports, from direct observation, and from any other relevant source. Comprehensive evaluations are also likely to utilize forensic assessment instruments, such as The MacArthur Competence Assessment Tool - Criminal Adjudication (Otto, et. al., 1998) or The Competence Assessment for Standing Trial for Defendants with Mental Retardation (Everington and Luckasson, 1992). These and other competency instruments are designed to assess knowledge-based competence and provide a means to relate a defendant's mental condition to his/her competency to stand trial (Stafford, 2003). (A thorough review of competency instruments is beyond the scope of this article, but can be found in Stafford (2003).)

Forensic assessment instruments are not designed to answer all questions that might be relevant in a competency evaluation. Clinical assessment instruments can also be employed to address certain other questions, such as whether a defendant is experiencing symptoms consistent with a known abnormal psychological condition or possesses below normal intelligence, and are appropriate to use because that can they provide information that is relevant to a defendant's competency. Examples of clinical assessment instruments that might be utilized in competency evaluations include the Minnesota Multiphasic Personality Inventory-2 (1989) and the Wechsler Adult Intelligence Scale-III (1997). Finally, if a defendant were suspected of malingering, forensically relevant instruments such as the Validity Indicator Profile (Frederick, 1997) the Recognition Memory Test (Warrington, 1984) or the Structured Interview of Reported Symptoms (Rogers, Bagby & Dickens, 1992) could be used to investigate this possibility.

Once a showing has been made that a defendant may be incompetent to stand trial, M.C.L. Section 330.2026(1) provides that the court must order an examination performed by personnel from the Center for Forensic Psychiatry, or other facility certified by the Department of Mental Health to perform competency evaluations. At the present time, the only other facility certified to perform competency to stand trial evaluations is the Third Circuit Criminal Court Psychiatric Clinic in Wayne County. Consequently, the Forensic Center and the Psychiatric Clinic provide the vast majority of first-opinion evaluations regarding the issue of competency. There is no prohibition against the court, prosecuting attorney or defense counsel obtaining a second-opinion evaluation from a private forensic psychologist, and, in fact, M.C.L. Section 330.2030(3) provides that the court or the attorneys may file a motion to present additional evidence relevant to the issue of a defendant's competency. In view

of the duty to pursue all reasonable avenues of defense, defense counsel is most likely to obtain a private examination, particularly in cases where defense counsel wishes to have reviewed the methods and procedures utilized during the first evaluation to make certain they were appropriate and comprehensive, or where there are significant questions regarding the examiner's conclusion. Second-opinions might also be useful if there has been a significant change in a defendant's mental condition after the first evaluation that might render those findings invalid.

If a defendant is ordered to undergo a competency evaluation pursuant to M.C.L. Section 330.2026(1), the examiner from the Forensic Center or Psychiatric Clinic is required to consult with defense counsel and defense counsel is required to make him/herself available for consultation, as directed in M.C.L. Section 330.2028(1). In addition, this Section requires that the examiner submit a written report to the court, the prosecuting attorney and defense counsel, within 60 days of the date of the order for the evaluation. Thus, the report must contain: (a) the examiner's clinical findings; (b) the facts, in reasonable detail, upon which the findings are based, and other facts pertinent to the findings, if requested by the court or the attorneys; and (c) the examiner's opinion on the issue of the defendant's competency to stand trial.

If the defendant has been determined incompetent to stand trial, the examiner must also state an opinion regarding the likelihood the defendant would be restored to competency, if provided treatment, within the time limit established by M.C.L. Section 330.2034(1). If the court concludes there is a substantial probability that, with treatment, a defendant can be restored to competency within the time frame provided by statute, the court is required to order the defendant to undergo treatment, pursuant to M.C.L. Section 330.2032(1). Such order involves admitting the defendant to the Forensic Center, where periodic reviews are conducted, until a defendant has been restored to competency.

While a competency to stand trial evaluation involves the assessment of a defendant's current mental state, the assessment of criminal responsibility focuses on a defendant's state of mind at the time the alleged offense was committed. As such, insanity evaluations can occur weeks, months or even years after the alleged offense and, consequently, these assessments are retrospective in nature, and involve consideration of a defendant's state of mind in the weeks, days and hours immediately preceding the criminal act.

In order to establish guilt beyond a reasonable doubt, the prosecution must prove all the elements of the alleged offense, including any mental state elements that might apply. In any given case, a forensic evaluation may provide probative information regarding claims that a defendant's psychological state negated a mental state element of a

crime or if the psychological condition establishes an affirmative defense that provides a legally acceptable excuse for the conduct.

Research indicates that insanity defenses in felony cases occur at varying levels across states, ranging from as low as .1% to as high as 8% (*Melton, Petrila, Poytbress, & Slobogin, 1997*), and are successful no more than 25% of the time (*Golding, Skeem, Roesch, & Zapf, 1999*). A study in British Columbia (*Golding, Eaves, & Kowatz, 1989*) involving NGRI acqutees found that almost 79% of its subjects had at least one psychiatric hospitalization, and that over half had been discharged from a psychiatric hospital within one year prior to committing their crime. These statistics show that the insanity defense is infrequently invoked and more often than not, fails to result in exoneration, and that a majority of NGRI acqutees have a history of psychological problems that have required hospitalization, often close in time to the criminal act. As a practical matter, these studies suggest that, as a group, criminal defendants who have been hospitalized for psychological problems should undergo an evaluation to determine whether there is evidence to support an defense of insanity, and that as a matter of public policy, there is little reason to be concerned that conducting these evaluations will result in defendant's going free who are guilty but not mentally ill.

The legal test of criminal responsibility has a long history, and the case of Daniel M'Naghten has often been cited as the initial dominant legal standard. The "M'Naghten test" fell out of favor because, among other reasons, it was never adequately defined, and it gave way to the "irresistible impulse" rule (*Melton, Petrila, Poytbress, & Slobogin, 1997*). In Michigan, irresistible impulse was defined as "the policeman at the elbow" test because a criminal act was deemed irresistible if the impulse was so overwhelming that a person would commit it even in the presence of a police officer. Today, in Michigan, a defendant is legally insane according to M.C.L. Section 761.21a(1), if, as a result of mental illness or mental retardation as defined in M.C.L. Sections 330.1400-1401, that person lacks substantial capacity either to appreciate the nature and quality or the wrongfulness of his conduct or to conform his conduct to the requirements of the law. Additionally, M.C.L. Section 761.21a(2) provides that a person who was under the influence of voluntarily consumed or injected alcohol or controlled substances at the time of the alleged offense is not considered to have been legally insane solely because of being under the influence of the alcohol or controlled substance. Thus, in its current iteration in Michigan as in many other state jurisdictions, the insanity statute comprises a cognitive component defined as the capacity to appreciate the nature and quality or the wrongfulness of one's conduct, and a volitional component defined as the capacity to conform one's conduct to the requirement of the law.

M.C.L. Section 761.21a(1) can be further conceptualized as consisting of two broad required elements. The first element is that a defendant must have a statutorily defined mental illness, (see M.C.L. Sections 330.1400-1401) which is defined as a “substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.” That a disorder must be “substantial” and must “significantly impair” indicates that not all psychological problems are equal and, therefore, some will meet this threshold test while others will fall short. Also, Michigan’s criminal statutes have not defined the terms “substantial” or “significantly impairs” and, consequently, these determinations result in subjective judgments that, depending on the circumstance, might be open to dispute. This point notwithstanding, severe affective disturbances and severe psychotic-spectrum disorders marked by fixed and false grandiose or persecutory beliefs or false auditory sensations, are more likely than not to meet the statute’s language without generating controversy. In contrast, symptoms such as mild anxiety and moderate depression are unlikely to meet this threshold requirement and are more vulnerable to successful challenge, as are situations where a defendant with a history of psychological problems was not manifesting acute symptoms of disturbance at the time of the alleged offense.

If the initial threshold question is answered affirmatively, the second element involves whether there is a connection between a defendant’s psychological problems and the capacity to either to appreciate the nature and quality or the wrongfulness of their conduct, or to conform their conduct to the requirements of the law. In some cases, the relationship may be obvious, while in others the connection may be less certain or open to dispute like, for example, in the case of the mother in Dallas who killed her five children. Since criminal responsibility evaluations are retrospective inquiries, how does a forensic psychologist determine whether there is a connection between the defendant’s mental state and behavior at the time of the instant offense?

As previously mentioned, it is the standard of practice in forensic psychology to conduct multi-source, multi-method assessments. When conducting a criminal responsibility evaluation it is important to review all the police and prosecution records, and statements from any witnesses who saw what transpired and observed the defendant’s behavior. This information can provide understanding of the nature of the defendant’s behavior at the time of the offense. In addition, if the defendant gave a statement, this should be reviewed for the same reason. Given the particular circumstances of a case, it might be useful to interview family members, friends and associates of the defendant’s, as well as other individuals who had direct contact with the defendant immediately preceding the instant offense for the

information they can provide regarding the nature of his thought processes and behavior.

Jail records should be reviewed for all incarcerated defendants. For inmates treated in the jail’s mental health unit, psychiatric intake assessments, medication logs and written observations can provide important documentation concerning a defendant’s behavior and mental state. While these data do not address the defendant’s mental state at the time of the offense, they can be used to corroborate the defendant’s self-report. For example, when a defendant reports that he was hearing voices that contributed to the alleged act, one would expect notation of this behavior included in the initial police narrative or at the time of incarceration. Furthermore, because this symptom would typically occur until treated with medication, one would expect that the defendant’s behavior brought him to the attention of the jail’s mental health personnel, and that appropriate medical treatment was instituted. In legitimate claims of disturbance, these factors should be in evidence and documented, and their existence would substantiate the defendant’s report, and support an insanity defense.

Some inmates are hospitalized at the time of or subsequent to incarceration, and these records should be reviewed for information that would corroborate claims of psychological impairment. Hospital staff closely monitor and document every patient’s clinical status, and this information can be extremely valuable for deciding whether or not a defendant’s behavior is consistent with the known phenomenology of a particular psychological disorder. Similarly, an examiner’s direct observations of a defendant can be utilized to corroborate a defendant’s self-report.

An evaluation must also include the defendant’s account of the instant event and the circumstances immediately preceding it. If a statement has already been given to police or a previous examiner, it can be compared to the current one for consistencies and inconsistencies. Furthermore, attempt should be made to corroborate the defendant’s self-report with each of the above sources of information. Generally speaking, the most important aspect of a defendant’s self-report is the reason given for his actions. This means that specific attention should be devoted to the defendant’s thoughts, feelings and perceptions immediately preceding the offense, and any attempts made to refrain from the criminal act.

Psychological testing may also play a vital role in evaluation, and instruments designed to assess malingering and intellectual functioning are the most common ones used to assess claims of cognitive impairment, mental retardation and memory disturbances. Malingering falls on a continuum from purely feigned symptoms to exaggeration of real symptoms, and malingering and the presence of actual psychological disturbance are not mutually exclusive and should not be conceptualized as an either-or phenomenon.

Some defendants with bona fide psychological problems may exaggerate their symptoms to avoid or lessen criminal responsibility, and this possibility should not be overlooked.

The data derived from clinical interview, direct observation, history taking, psychological testing, and review of records provide individual means that are used to form hypotheses about a defendant's state of mind at the time of the offense. Hypotheses supported by multiple data sources should serve as the basis for a final opinion. Finally, if there are important discrepancies between the defendant's present behavior and behavior reported at the time of the instant offense, this should be reported and explained.

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