Legal Process

There are five main stages in the procedure for determining and disposing of competence cases:

- Requesting a competence determination (often called "raising the question");
- The competence evaluation stage;
- The judicial determination of competence or incompetence; and in some cases;

- Disposition and provision of treatment; and
- Rehearings on competence.

REQUESTING A COMPETENCE DETERMINATION. In most jurisdictions, the question of a defendant's competence to stand trial may be raised by the defense, the prosecution, or the judge at any stage in the criminal court proceeding. Judges are allowed considerable discretion in determining whether there is a "*bona fide* doubt" of competence.

Forensic examiners should be aware that courts and attorneys sometimes have raised the question of pretrial competence for purposes other than those for which the competence doctrine exists. These inappropriate referrals for competence evaluation have been said to occur for several reasons. Some courts or defense attorneys apparently have sought competence evaluations primarily in order to obtain immediate treatment of a defendant's behavioral disorder, especially when other methods for obtaining treatment are either more difficult or unavailable (Bonovitz & Bonovitz, 1981; Gudeman, 1981; Warren et al., 1991). In addition, Roesch and Golding (1980) observed that the competence question is raised in some cases merely as a legal maneuver. Prosecutors might seek extra time to prepare the state's case, and defense attorneys sometimes call for competence evaluations in order to obtain information not about competence, but about the potential for a later insanity plea.

THE COMPETENCE EVALUATION STAGE. The present section focuses only on where, when, and by whom competence evaluations are performed; the actual substance of competence evaluations will be reviewed later.

Some states have developed a system for providing competence screening evaluations (Grisso, Steadman, Cocozza, Fisher, & Greer, 1994). Screening typically involves a brief evaluation, often at the time of arraignment, designed simply to determine if there is reason to believe that further evaluation is necessary. In this way a large number of the "easy" cases for which the competence question is raised (persons who are very clearly competent or very obviously incompetent) can be returned to court without requiring relatively lengthy, full competence evaluations.

Courts obtain their full competence evaluations in various ways across the 50 states (Grisso et al., 1994; Melton et al., 1997; Poythress, Otto, & Heilbrun, 1991). During the past two decades, courts have greatly reduced their reliance on inpatient evaluations for competence to stand trial, most states having moved to much greater use of evaluations performed while defendants are outpatients (that is, are awaiting trial in jail

or in the community). Often these evaluations are performed by forensic examiners in community mental health clinics or by special arrangements between the courts and examiners in private practice in the community. Grisso et al. (1994) found that state systems for providing competence evaluations tend more often to employ clinical psychologists than psychiatrists, although the latter are still substantially involved.

Many statutes limit the length of evaluation commitments and the time within which an evaluation report must be made. Often they specify 30 days with possible extensions to 60 days. The CJMH standards (Standard 7-4.4, ABA, 1984) recommended 7 days when a defendant is in custody, 14 days when the defendant is at liberty (e.g., has been placed on pretrial release), and possible extension to 30 days for "good cause." These time limits underscore the fact that pretrial competence evaluation commitments are not intended to be a means for obtaining prolonged treatment of disordered defendants. The trend in recent years in state statutes controlling competence evaluations has been to shorten considerably the evaluation time allowed, requiring clinicians to become more efficient if they are to continue to provide evaluations of quality to the courts in competence cases.

The legal purpose of an assessment for competence to stand trial often requires attention to procedures that are not typical for other clinical assessments. For example, laws in many states, as well as general ethical guidelines for forensic evaluations (Committee on Ethical Guidelines for Forensic Psychologists, 1991; Heilbrun, 2001), require that defendants be informed about (a) the purpose of the evaluation, (b) potential uses of disclosures made during evaluation, (c) conditions under which the prosecutor will have access to information from the evaluation, and (d) consequences of defendant's refusal to cooperate in the evaluation. Defense counsel usually has the option to observe the evaluation. Audiotaped or videotaped recording of the evaluation is not legally required but is often recommended (e.g., Committee on Ethical Guidelines for Forensic Psychologists, 1991) in order to produce an evidentiary record.

JUDICIAL DETERMINATION OF THE COMPETENCE QUESTION. Judicial practice does not always require a formal hearing on the question of a defendant's pretrial competence after the evaluation. In fact, the CJMH standards (Standard 7-4.7, ABA, 1984) recommended that a court hearing on the issue may not be necessary if all parties have stipulated that they are in agreement on the defendant's competence or incompetence, and if the court concurs after considering the forensic evaluation results. Otherwise, a formal hearing generally will be required, offering opportunity for

examinations of the forensic assessment results and challenges by either party during the hearing.

DISPOSITION AND PROVISION OF TREATMENT. Trial proceedings resume if the defendant is found competent to stand trial. If the defendant is found incompetent, however, the competence hearing turns to inquiry concerning the likelihood that treatment can render the defendant competent to stand trial.

This stage of the proceeding has been greatly influenced by the U.S. Supreme Court ruling in *Jackson v. Indiana* (1972). Prior to *Jackson*, many incompetent defendants who were involuntarily hospitalized for treatment did not improve, resulting in indefinite hospitalization. Their lack of improvement with treatment sometimes was a consequence of disabilities that were not likely ever to respond to treatment (e.g., severe mental retardation or brain damage). Thus they might spend years in involuntary confinement (often longer than if they had been tried, convicted, and served the usual sentence for their crime), with little likelihood of ever being brought to trial. Prior to the *Jackson* decision, researchers at one hospital (McGarry, Curran, & Kenefick, 1968) reported that the number of patients being treated for pretrial incompetence who were discharged as restored and returned to court was exceeded by the number whose hospitalization was terminated due to their natural death!

The court in *Jackson* ruled that incompetent defendants could not be held for treatment longer than the nature of their disorders warranted. Therefore, courts must determine whether the potential treatment of an incompetent defendant's disorder offers a reasonable prospect for bringing the defendant to competence. When the disorder cannot be treated, the incompetent defendant can neither be committed nor tried on the criminal charges. The state must either drop the charges and release the defendant or initiate commitment proceedings under the state's civil commitment criteria. Therefore, a forensic examiner's testimony about the defendant's mental disability and potential for treatment plays an important role in this stage of the legal inquiry.

If it appears that the defendant's incompetence can be treated, commitment to a state mental hospital or forensic treatment facility for that purpose is the most common disposition. Some statutes require that the defendant must be treated in the least restrictive setting that provides a reasonable opportunity for gaining pretrial competence. In general, courts have ruled that defendants have no right to refuse treatment (e.g., psychoactive medication) to restore their competence (Melton et al., 1997). The U.S. Supreme Court in *Riggins v. Nevada* (1992) required that courts consider whether medication, even if it reduced patients' symptoms,

might also interfere with their ability to perform certain functions such as interaction with counsel or the provision of testimony at their trials.

REHEARINGS ON COMPETENCE. The need for forensic evaluations of competence to stand trial will occur periodically in the course of a defendant's treatment. Most states require reevaluation and court review of incompetent defendants at least once every six months during their treatment. At the review, typically a court must: (a) make a ruling on the question of competence if the forensic examiner and treating professional believe that competence has been restored; or (b) extend the commitment (e.g., another six months) if it appears that competence can be restored "in the foreseeable future"; or (c) terminate commitment if at any point pretrial competence appears not to be attainable (see also CJMH Standard 7-4.11, ABA, 1984). The cumulative results of several reports suggest that most defendants found incompetent to stand trial and provided treatment are found competent within 4 to 6 months (for reviews of these studies, see Cooper & Grisso, 1997; Grisso, 1992; Melton et al., 1997).