CASE REPORT

Assessment of Competency to Stand Trial in Individuals with Mental Retardation

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The basic components of the legal standard for competency to stand trial inherently emphasize the importance of cognitive capacities. However, extant research reflects that forensic evaluators specifically attend to cognitive limitations less frequently than to other factors, such as psychopathology, in their assessments. In addition, individuals with mental retardation are frequently under-identified within the criminal justice system and are more likely to be referred for competency evaluations if they have an accompanying psychiatric illness. However, individuals with mental retardation present with a unique set of characteristics that may impair their competency to stand trial, even without symptoms of mental illness. This case report highlights the specific impairments in individuals with mental retardation and discusses possible implications of those impairments on their competency to stand trial. In addition, this article offers suggestions about how to communicate the impact of those factors in a forensic evaluation.

KEYWORDS competency to stand trial, mental retardation, forensic assessment, cognitive limitations

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The 1960 U. S. Supreme Court decision *Dusky v. United States* established the legal standard that guides the practice of assessing competency to stand trial. The Court held that the test for competency is “whether [the defendant] has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him” (p. 402). Although the wording of the standard is somewhat ambiguous, there are two components to meet the competency threshold: (1) the defendants’ capacity to understand the criminal process both in terms of having a factual and rational understanding of the legal process as it applies to them, and (2) the defendants’ present ability to participate in that process (Melton, Petrila, Poythress, & Slobogin, 2007).

These basic components of the standard inherently emphasize the importance of cognitive functioning. Defendants must possess the cognitive capacities to acquire factual knowledge about the roles of courtroom officials, the plea options and their associated legal proceedings, and the concept of a plea bargain. In addition, arguably more complex cognitive capacities are required to fulfill the second prong of the standard; defendants must demonstrate an ability to decide what information is important to communicate to their attorney and consider their plea options in light of the evidence presented by the prosecution.

Despite the important influence of defendants’ cognitive capacities in determining their competency to stand trial, empirical research suggests that evaluators explicitly attend to these capacities much less frequently than they attend to other factors, such as psychopathology (Anderson & Hewitt, 2002; Martell, 1992). This may be because defendants with significant cognitive limitations typically possess characteristics that do not raise concerns about their competency to stand trial. They are frequently compliant and cooperative with attorneys and judges and often pretend to understand the proceedings (Cooper & Grisso, 1997). This is in sharp contrast to defendants who suffer from psychiatric symptoms, particularly psychosis, and are more likely to display bizarre behavior or disorganized thinking or speech during interactions with the attorney or while in the courtroom, thus triggering a question of their competency.

In a study examining factors that are most commonly assessed in competency to stand trial evaluations, Martell (1992) found that clinicians consistently assess symptoms of psychosis but frequently fail to specifically assess neuropsychological deficits. Furthermore, although individuals with mental retardation have long been recognized as being over-represented and under-identified in the criminal justice system (Anderson & Hewitt, 2002; Bonnie, 1992), articles specifically addressing issues related to mental retardation in competency-to-stand-trial evaluations have only become more prevalent since the 1990s (Cooper & Grisso, 1997). Still, there continues to be a paucity of research on the impact of cognitive factors on competency determinations. A comprehensive review of studies between 1996 and 2000 that investigated correlations between defendant variables and determinations
about competency revealed that numerous studies examined the relationship between competency determinations and demographic variables, such as gender and marital status, classification of charges, and various types of psychopathology (Mumley, Tillbrook, & Grisso, 2003). However, few studies were cited to have examined the role of neuropsychological variables in competency determinations.

The articles that have addressed the specific issues of conducting competency-to-stand-trial evaluations in individuals with mental retardation offer helpful and practical guidance for evaluators to consider in the assessment process. They have outlined several psycho-legal functional abilities that may be especially important to assess in individuals for whom there is a question of cognitive limitations. Specifically, individuals with mental retardation may have increased deficits in capacities for communicating with their attorney and attending to necessary information about their case due to limited expressive abilities and attentional difficulties (Anderson & Hewitt, 2002). In addition, these defendants may have more difficulty with their memory, particularly of personal events such as their involvement in criminal behavior, and understanding and responding appropriately in social situations due to limitations in their self-awareness (Nestor, Daggett, Haycock, & Price, 1999). The implication of these deficits for competency evaluations may be that defendants with mental retardation lack the requisite capacities to determine the appropriate information to convey to their attorney, may not fully and accurately understand the nature and gravity of their charge, and may be at a higher risk for being disruptive in the courtroom due to their attentional difficulties compared to defendants without significant cognitive limitations. To be sure, these deficits are not necessarily applicable to all defendants with mental retardation and are offered only as potential factors to assess.

A defendant’s IQ score or diagnosis of mental retardation alone does not automatically equate to a finding of incompetence. Rather, it has been recommended to employ a qualitative approach to assess the defendant’s functional abilities (e.g., evaluate the defendant’s decision-making capacity in considering plea options) as they relate to the legal standard of competency instead of a quantitative approach (i.e., making a determination based on the defendant’s IQ score or diagnosis; Appelbaum, 1994). Similarly, Roesch, Zafp, Golding, and Skeem (1999) recommend conducting a functional evaluation of the defendant’s abilities as they relate to the contextualized demands of the case. Consider a defendant who is charged with a minor crime that the outcome will likely not result in a trial. This individual may not need to have the capacity to consider abstract information necessary to thoroughly grasp the intricacies of a trial to be found competent, as a trial is unlikely for the case.

In the past decade, several measures have been developed to aid in the determination of competence to stand trial. However, only one measure, the Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR; Everington & Dunn, 1995), has been developed
specifically for defendants with mental retardation. This measure is composed of 40 multiple-choice questions that are subdivided into two sections and are directly related to the competency-related abilities, including basic legal concepts and skills to assist defense. The multiple-choice format is designed to assess the defendant’s knowledge without requiring expressive abilities, which are commonly deficient in individuals with mental retardation. In addition, a third section, Understanding Case Events, is composed of 10 open-ended, case-specific questions. This measure was normed using four groups of defendants: a group with no mental retardation, a group with mental retardation not referred for a competency evaluation, a referred group with mental retardation who were judged to be competent, and a referred group with mental retardation who were judged to be incompetent.

A review of the measure revealed that it has adequate psychometric properties, but it also has some limitations. The validation study included a significant number of individuals with dual diagnoses in the group with mental retardation who were judged to be incompetent (Melton et al., 2007). Thus, this group’s significantly lower scores on the measure, compared to the other groups, may not be attributable to differences in cognitive ability alone. In addition, the CAST-MR has been criticized for the multiple-choice format of the first two sections because defendants are typically required to utilize expressive abilities at some point during the legal process (Grisso, 2003). Despite these criticisms, the CAST-MR is the only available measure that has been specifically developed for defendants with mental retardation, and it is viewed as a viable instrument (Melton et al., 2007). As with other psychological assessment measures used in forensic evaluations, and consistent with the principles of forensic mental health assessment (Heilbrun, 2001), the data obtained from the CAST-MR should be integrated with collateral information from multiple sources, such as self-report, third-party interviews, and records.

The following case report is an example of a competency-to-stand-trial evaluation with a defendant who has diagnosed mental retardation. This case illustrates a functional approach to identifying the important cognitive factors that may influence the defendant’s competency to stand trial, and it discusses the defendant’s abilities as they relate to the contextualized demands of the case. Finally, it offers guidance about how to communicate the impairment in functional abilities to the court to aid in its determination of his competence.

**CASE REPORT**

In response to a court order, the evaluator conducted a competency examination of Mr. White on July 10, 2007. Mr. White is an 18-year-old,
African-American male currently facing a felony charge of robbery. According to the court order, Mr. White was referred for the evaluation because he was displaying difficulties in understanding and communicating with his attorney.

This report is based on a 45-minute interview with the defendant. In addition, the following documents were reviewed: the Mental Examination Orders; U.S. Attorney Statement of Charges; the Affidavit in Support of an Arrest Warrant; Forensic Legal Services record; medical records from the jail; urine drug screening test results; and psychoeducational evaluations from May 18, 2000, June 2, 2004, and June 23, 2007. Mr. White was also administered the Brief Symptom Inventory (BSI), a structured inventory of symptoms of mental and emotional disorders, and the CAST-MR, a standardized measure used to assess psycho-legal domains relevant to the standard for competency to stand trial specifically for persons with mental retardation. Finally, a collateral interview was conducted with Mr. White’s attorney on July 6, 2008. Collateral interviews were also attempted with Mr. White’s treating psychiatrist, Dr. Pope, and his social worker at the hospital, Ms. Candid. However, they declined to be interviewed.

Relevant History

Mr. White was born on October 23, 1989, in Canton, Ohio. In his psychoeducational evaluation from June 23, 2007, the evaluating psychologist described Mr. White as a poor historian who was not able to provide an overview of his history. Similarly, during the current evaluation, he was able to provide only basic background information. He reported that he was primarily raised by his grandmother, with whom he was living prior to being detained on the current charge. He commented that he is close with his grandmother because “she has been there all my life.” His mother reportedly lives in North Carolina, and he was unaware of where his father lives. He described having little contact with his parents, stating that he last spoke with his mother “a couple of months ago.” He stated that he is the second oldest of five children but indicated that he has no contact with his siblings. According to the psychoeducational evaluation, Mr. White’s mother used crack cocaine throughout her pregnancy with Mr. White, and he was born prematurely, weighing three pounds, two ounces. Child Protective Services became involved with the family after allegations of neglect. Mr. White was subsequently removed from his mother’s care and placed to live with his grandmother, who is his legal guardian. The psychoeducational evaluation further indicated that, although Mr. White’s grandmother is concerned about his well-being, she has five other grandchildren and limited resources.

Information about Mr. White’s educational history was obtained primarily from his previous psychoeducational evaluations. These evaluations consistently reflect that Mr. White experienced significant difficulties throughout school. He was referred for his first psychoeducational evaluation when he
was 8 years old and in first grade. Results from the evaluation reflect that he performed in the extremely low range of intellectual functioning (WISC-III Full Scale score = 50), and his academic achievement fell in the well-below-average range. Recommendations included that he receive “specialized intervention services to address his cognitive and academic deficits” and be considered for placement in a setting for “Mentally Retarded children.” He was subsequently enrolled in special education classes, and individualized education plans were created for him. However, as noted in his later psychoeducational evaluations, Mr. White’s deficits did not improve. Results from his evaluations in 2004 and 2007 were similar to those in 2000. Mr. White consistently performed in the extremely low range on measures of intellectual functioning (Full Scale score in 2004 = 61, Full Scale score in 2007 = 63) and performed well below average on measures of academic achievement (i.e., reading, written and oral language, and mathematics). Notably, the most recent psychoeducational evaluation reflects that, on measures of oral language, which may be most relevant for the issue of competency to stand trial, his performance was measured to be at the kindergarten level.

Mr. White denied any employment history to date. He expressed interest in working at a “shoe store,” explaining that he likes to interact “with people who buy shoes.” The feasibility of this goal is unclear; however, as Mr. White’s adaptive functioning is comparable to that of a 5½ year old child, according to his most recent psychoeducational evaluation. For example, he is currently unable to use money reliably, cannot tell time, and is unable to read 10 words.

Mr. White reported that he used alcohol and marijuana in the past. He stated that he recently began using these substances “some months ago” and described that he drinks between one and three “small cups” of “Grey Goose” vodka “off and on” and smokes one marijuana blunt “off and on.” Urine drug screening results from March 11, 2007 show “no submit.”

Mr. White denied any significant medical issues or mental health symptoms. He reported experiencing difficulty in sleeping since being detained on his current charges, and he reported feeling depressed and anxious about his current legal situation. However, according to records reviewed for this evaluation, he has no history of receiving psychiatric treatment from the public mental health system, and he was not treated for medical or psychiatric symptoms at the jail.

Mr. White denied any previous involvement with the legal system. Similarly, his attorney reported, and the jail intake assessment reflects, that this was his first incarceration at the jail.

Current Clinical Condition

Mr. White is an 18-year-old, African-American male of slight stature who appeared his stated age. He politely greeted me in the reception area of his
hospital ward, and we walked together to the interview room on the ward. He was casually dressed in a clean t-shirt and jeans.

Mr. White did not appear to be in acute distress. He was fully oriented to person, place, and time, and he was cooperative with the interview. His speech was well enunciated and normal in rate and volume. In addition, he appeared to be engaged during the examination; he made good eye contact and asked for clarification when he did not understand a question. He reported feeling “fine,” and his emotional expression was congruent to matters discussed. For instance, he smiled when he talked about his grandmother, and he became more sullen when discussing the seriousness of his charge. Mr. White’s conversation, although limited, was consistently logical and goal-directed throughout the examination. There was no overt evidence of depression, anxiety, phobias, or bizarre thought content during this examination. He denied hallucinations and suicidal and homicidal ideation. Although I was unable to formally interview any of the hospital staff who work with Mr. White or review his records, Ms. Candid, Mr. White’s Social Worker, mentioned that he was not currently taking any psychiatric medication.

As previously mentioned, the BSI was administered to assess Mr. White’s report of symptoms of mental and emotional disorders that may impair his capacity to have a factual or rational understanding of his legal proceedings or assist his attorney with his defense. He did not report currently being “extremely” distressed on any of the 53 items. He reported being “quite a bit” distressed on one item, which was feeling lonely, and “moderately” distressed on one item, which was feeling lonely even when you are with people. Compared to nonpatient adult males, Mr. White’s scores fell within the normal range on all nine scales. This suggests that, generally, he did not report being significantly distressed by those symptoms that he endorsed.

According to his attorney, Mr. White has been working with a psychologist since he was transferred to the hospital to improve his understanding of the legal proceedings against him. Attempts were made to contact the psychologist, but he was not reached, so no information about Mr. White’s progress in understanding the competency-related information was available. To aid in assessing his current factual and rational understanding of the legal proceedings against him and his ability to assist his attorney with his defense, Mr. White was administered the CAST-MR. As Mr. White is unable to read, all of the questions and answer choices were read to him. He then verbally indicated his response choice. Mr. White answered the first five questions on the measure incorrectly, demonstrating that he was unable to answer even the most basic of the competency-related questions. Consequently, the evaluator ended the administration of the measure and discussed the competency material with Mr. White. After lengthy discussion about court proceedings and roles of the officials, Mr. White was again administered the
CAST-MR. After instruction, his performance on the measure was much improved, suggesting he was able to learn the information and recall it within a discrete amount of time.

On the Basic Legal Concepts scale, or factual understanding, Mr. White answered 84% of the questions correctly and performed similarly to other criminal defendants with mental retardation found competent to stand trial (raw score = 21; mean score for MR-competent = 18.3; mean score for MR-incompetent = 12.3). Specifically, he was able to choose the correct response from three answer choices about the roles of the judge, defense attorney, and prosecutor. He understood the meaning of a sentence, the definition of a crime, the difference between a misdemeanor and a felony, the meaning of the guilty plea, the concept of a plea bargain, and the purpose of a trial. He also correctly answered questions about the possible sentences, including the meaning of time served and probation. Mr. White had difficulty in choosing the correct response for questions asking about the meaning of a hearing, the role of the jury, what it means to be innocent, and what it means to be acquitted.

On the Skills to Assist Defense scale, Mr. White answered 60% of the questions correctly, and his score was more similar to that of individuals with mental retardation found incompetent to stand trial (raw score = 9; mean score for MR-incompetent = 8.2; mean score for MR-competent = 10.7). Questions on this scale provide hypothetical scenarios in which the examinee is asked to choose the best response. A sample question reads, “Let’s pretend that you took something from a store and you got arrested for it. You didn’t mean to do it, and you felt really bad about it. When your lawyer asks you if you did it, what would you say?” Mr. White’s responses suggest that he has some understanding of appropriate courtroom behavior, but he displayed deficits in his ability to communicate effectively with his attorney. He correctly stated that if his lawyer objects to the prosecutor’s question, he would wait for the judge to tell him what to do. However, he stated that if he heard his lawyer and the judge talking about him but did not understand, he would pretend that he understood rather than asking for clarification. In addition, he stated that if he and his lawyer agree on his testimony and he changes his mind, he would say what he wants on the stand despite his earlier agreement with his lawyer.

Finally, on the Understanding Case Events scale, Mr. White correctly answered 55% of the questions, performing comparably to individuals with mental retardation who have been found incompetent to stand trial (raw score = 5.5; mean score for MR-incompetent = 5.2; mean score for MR-competent = 8.0). This scale asks open-ended questions about his specific case. Although he correctly stated that he was charged with “armed robbery,” which was “serious,” he was unable to identify why he had that specific charge (i.e., he allegedly had a weapon when he robbed someone). Rather, he stated that he did not know why he was charged with armed
robbery instead of another charge. When asked to describe the circumstances surrounding the incident, Mr. White did not correctly recall the date of the incident or where he was arrested. According to the police report, he was arrested at a friend’s house 5 days after the instant offense occurred. However, Mr. White stated that he was arrested immediately after the incident.

Summary and Conclusions

On the basis of this evaluation, Mr. White’s cognitive limitations associated with mild mental retardation substantially impair his capacity to have a rational understanding of the proceedings against him and to properly assist counsel with the preparation of his defense. After considerable instruction, Mr. White appears to have gained a basic factual understanding of his charge and the legal proceedings against him. He correctly identified the roles of courtroom officials, the legal process associated with the plea options, the sentencing options, and the concept of a plea bargain.

However, as evidenced by his poorer performance on the Skills to Assist Defense and Understanding Case Events scale, Mr. White appears to have significant difficulty in his ability to apply the factual understanding of the legal proceedings to his own case, make informed decisions about his plea options, and communicate those decisions to his attorney. Specifically, he did not understand why he was charged with armed robbery or recall the events surrounding the incident, both of which are necessary to consider in deciding how to plead. In addition, although he appeared to understand that his attorney’s role was to help him, he stated that he would say what he wants on the stand despite his earlier agreement with his lawyer. Notably, these deficits in his reasoning and decision making about his legal proceedings remained despite both the individual instruction that he has been receiving since he was transferred to the hospital, according to his attorney, and the instruction provided by the evaluator just prior to completing the CAST-MR. In light of his documented cognitive impairments generally and oral communication skills specifically, Mr. White appears able to learn the factual information, at least for a discrete amount of time, but he does not appear able to integrate that information and apply it in a reasoned manner to assist his attorney in developing his defense.

DISCUSSION AND PRACTICE RECOMMENDATIONS

This case illustrates the importance of (1) assessing specific neuropsychological capacities specific to individuals with mental retardation (e.g., communication, memory, and behavior in legal situations) and (2) relating
specific deficits in functional abilities to the legal standard for competency
determinations. As the assessment of cognitive capacities is inherently impor-
tant in competency to stand trial evaluations, the following practice recom-
mendations are offered to assist clinicians to identify the necessary functional
abilities that specifically apply to individuals with mental retardation and
effectively communicate those recommendations to the court.

Consistent with the functional approach to forensic assessment recom-
mended by Appelbaum (1994) and Roesch et al. (1999) and outlined by
Heilbrun (2001), this case provided an example of conducting a forensic
assessment in a systematic way. First, the evaluator should identify the rele-
vant functional capacities that pertain to the legal referral question. In this
case, the reason for the referral was relatively vague, stating only that Mr. White
displayed difficulties in understanding and communicating with his attorney.
However, on the basis of other sources of information obtained during the
evaluation, an initial hypothesis as to why Mr. White was not effectively
communicating with his attorney was his limited expressive abilities resulting
from deficits in cognitive capacities. In addition, at the time of the referral, it
was unclear whether Mr. White was experiencing psychiatric symptoms that
may impair his ability to communicate with his attorney. Consequently, the
evaluator included an assessment of symptoms of mental and emotional dis-
orders to rule out impairment due to psychiatric symptoms.

Second, it is recommended that the clinician conduct a comprehensive
clinical interview with the defendant and administer standardized measures
with appropriate norms to gather additional information about the func-
tional abilities as they relate to the question of competency. These include a
measure of mental and emotional symptoms (e.g., the BSI) and a measure
of his factual and rational understanding of the proceedings against him and
his ability to assist his attorney specifically developed for individuals with
mental retardation (i.e., CAST-MR). Measures of Mr. White's intellectual, aca-
demic, and adaptive functioning were not included in this evaluation
because he was administered these measures less than 1 month prior to the
evaluation and those results were reviewed for the current evaluation. How-
ever, had the prior psychoeducational assessment not been conducted,
measures of intellectual, academic, and adaptive functioning would have been
included to provide an accurate picture of Mr. White's present functioning
in these areas.

Third, the evaluator should collect collateral information from third par-
ties and review applicable records to corroborate or disconfirm self-report
information. Although recommended in the principles of forensic mental
health assessment (Heilbrun, 2001), it may be especially important in indi-
viduals with mental retardation, given their deficits in memory. Mr. White
proved to be a poor historian and displayed little recollection of the circum-
stances surrounding the charges. If the evaluator asked only about Mr. White's
knowledge of the nature and gravity of the charge, he may not appear to
have the same level of deficits in his understanding. Consequently, it is critical for the evaluator to be thorough in the clinical interview, comparing the self-report information obtained with the records and other collateral information to determine the presence of specific deficits displayed in individuals with mental retardation.

Finally, it is recommended that all of the information obtained be integrated and the findings about the defendant’s functional capacities as they related to the legal question be communicated clearly and concisely. This final section of the report provides the evaluator with an opportunity to provide a rationale for his or her psycho-legal conclusions to assist the court in its final determination of competency to stand trial. Notably, the debate about whether to answer the ultimate legal question of a defendant’s competence is beyond the scope of this article. However, the principles of forensic mental health assessment caution against answering the ultimate question of competence, as that is a legal question to be left up to the court (Heilbrun, 2001). It is unequivocally recommended, however, that the relationship between the functional abilities (e.g., memory for the circumstances of the events, expressive abilities to communicate one’s ideas about the case with one’s attorney) and the aspects of the legal standard (e.g., rational understanding of the possible sentencing ranges for one’s specific charges, decision-making ability about plea options) be spelled out (Skeem, Golding, Cohn, & Berge, 1998).

REFERENCES


