THE INTERJUDGE RELIABILITY RATE OF NONHOSPITAL BASED PSYCHIATRISTS' COMPETENCY TO STAND TRIAL AND LEGAL SANITY RECOMMENDATIONS

by

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A Thesis Submitted to the Faculty of the

DEPARTMENT OF PSYCHOLOGY

In Partial Fulfillment of the Requirements
For the Degree of

MASTER OF ARTS

In the Graduate College

THE UNIVERSITY OF ARIZONA

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STATEMENT BY AUTHOR

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ACKNOWLEDGMENTS

This research represents my initial step toward integrating a law and clinical psychology program. My progress in this direction is possible in large part because of the confidence and moral support of Dr. Lawrence Wheeler, Chairman of the Department of Psychology, who encourages inter-displinary study at this University, and Professor David Wexler, mental health law scholar, who helped smooth out the difficulties an inter-disciplinary undertaking creates.

Special thanks to Dr. Marvin Kahn, Professor of Psychology and Chairman of my Masters' Committee, who has guided this research project along, and Dr. Lewis Hertz and Professor Wexler for their comments and suggestions.

This project could not have been completed without help from Dr. Kevin Gilmartin, and the four psychiatrists who allowed me to use their forensic files.

Thanks to the folks at home who kept the lights burning.

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ABSTRACT

This study is an empirical investigation into the interjudge reliability of four court appointed psychiatrists' evaluations of criminal defendant's competency to stand trial and legal sanity in Pima County (Tucson, Arizona, 1976-78.

The psychiatrists agree in their decisions regarding competency 82.90 percent of the time, while agreement as to legal sanity decisions is 64.02 percent. When psychiatrists agree, 88.23 percent of the time they find the defendant competent, and 63.23 percent of the time they find the defendant legally sane.

Several variables are correlated with competency to stand trial and legal sanity decisions. Of special importance is, first, Mexican-Americans and Blacks are found incompetent significantly more often than Anglos; second, the more serious the crime alleged to have been committed by the defendant the more significantly often the defendant is found competent, while the less serious the crime accused, the more significantly often the defendant is found incompetent. Third, those found diagnosed as either psychotic or mentally retarded have a significantly higher probability of being found incompetent and/or insane.

Since so few are found incompetent, it appears there is an overuse of the competency evaluation process by attorneys.

The use of independent "experts" instead of hospital diagnostic assessment of competency is recommended as a more viable, least restrictive, and less costly means of evaluating competency to stand trial.

CHAPTER I

INTRODUCTION

Justice requires that a criminal defendant be mentally competent to stand trial. The competency test originally was devised to protect the individual defendant from decompensating during trial as a result of mental illness. The competency requirement insures that a defendant who does not know what is happening, and therefore cannot take part, will not be tried. However, although the competency test is aimed at protecting the defendant's interests, it has been used to the defendant's detriment.

The legal rule governing competency to stand trial, defined in the U.S. Supreme Court ruling in Dusky v. U.S., 362 U.S. 402 (1960), reads: "A person shall not be tried, convicted, sentenced or punished for a public offense while, as a result of a mental illness or defect, he is unable to understand the proceedings against him or to assist in his own defense." In 1966 the Supreme Court in Pate v. Robinson, 383 U.S. 375, concluded that a trial court must provide a defendant with a hearing on competency, even if a defendant appears alert and rational. In 1975, in Drope v. Missouri, 420 U.S. 170, the Court regarded forcing a person to stand

trial while incompetent as a violation of "due process" rights of the defendant.

The Supreme Court in the above mentioned decisions has defined the competency to stand trial requirement, but has failed as yet to spell out the precise meaning of incompetent. Incompetency, by implication, is taken to mean: (1) a lack of rational understanding of the legal process, (2) a lack of appreciation of the attorney's role and a lack of ability to assist the defense lawyer, and/or (3) a lack of recognition of the consequences of being accused or found guilty of the criminal charges.

If a defendant is found incompetent, rather than proceeding to trial, in most states he is diverted to a State mental hospital in order to be restored to competency. The criminal charges against him remain, and trial will be held when he is deemed competent by the Court based upon mental health professionals' evaluations.

Despite the original intention to safeguard the defendant's "due process" rights, the competency to stand trial requirement created an even more serious problem. Although protecting defendant from going to trial while mentally incompetent, the competency requirement has been used as a pretext to delay trial (a serious "due process" violation). Until recently the prosecutor could rely upon the competency test as a means of diverting for commitment to

mental hospitals for an indefinite period of time (or until competency is restored) persons accused of misdemeanors who if convicted of the alleged crime would be punished by receiving probation. For example, during the anti war era of the 1960s several persons suspected of political activism in St. Louis were charged with criminal trespass, found incompetent before trial, and sent to a state mental hospital for a term lasting two to three years. In every case the time spent in mental hospitals in treatment for incompetency lasted far longer than the maximum criminal punishment for trespass.

The abuse of the competency to stand trial procedure by government officials, i.e., prosecutors, to isolate persons in state mental hospitals before trial remained possible until the U.S. Supreme Court limited the duration of time persons may be committed as incompetent to stand trial (see below). At the time the Supreme Court reviewed the competency procedures several key mental health and law professionals were speaking out against such abuse of competency "safeguards."

Saleem Shah (1974), director of the National Institute of Mental Health Center for Crime and Delinquency Studies, characterized the competency procedures as "idealistic rhetoric and sorry reality," and "as a torrent of idealistic rhetoric to justify coercive interventions."

Professor Stone (1975) commented: "The real tragedy of the incompetency process is that it has, in many places, lost its distinct purpose of protecting defendants and has become merely another element in the array of techniques used by the state to effect the same result: involuntary commitment of worrisome individuals in grossly substandard facilities (p. 205)." The Group for the Advancement of Psychiatry report entitled "Misuse of Psychiatry in the Criminal Courts: Competency to Stand Trial" (1974) investigated the treatment of those deemed incompetent and concluded:

> The majority of persons now held in institutions for the criminally insane are there not because they have been found not guilty by reason of insanity, but rather because they were judged incompetent. In many instances decades have passed since the alleged crime occurred and thus these defendants await a trial which it would no longer be feasible to hold for both legal and practical reasons. As one surveys the demeaning and degrading conditions which exist in hospitals for the criminally insane, the awful hypocrisy of our society and its criminal justice system stands revealed in the harsh light of reality (p. 861).

David Wexler (1976) describes the realities of the competency procedures this way:

> Defendants alleged to be incompetent would be automatically confined, often in a maximum security institution, for a lengthy (30 to 90 day) period of evaluation; ultimately a court hearing would be held, and those persons judicially found incompetent would be automatically committed to a security hospital for an indefinite period of time (until competent), perhaps a lifetime (p. 38).

Much of the misuse by prosecutors of psychiatrists who perform competency evaluations has been corrected by

the highly significant U.S. Supreme Court decision, Jackson v. Indiana, 406 U.S. 715 (1972). Wexler (1977) notes Jackson radically altered the incompetency legal confinement portrait.

The Jackson Court limited the amount of pretrial detention a person could serve as "incompetent to stand trial" to a reasonable time, i.e., the maximum sentence that could be imposed on the individual if he were found guilty of the crime alleged. The Court stated: "At the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual was committed (Jackson v. Indiana, 406 U.S. 738)."

Slovenko (1977) evaluates the Jackson ruling as follows: The U.S. Supreme Court set out a durational limit for the length of confinement for pretrial commitment for incompetency to stand trial, though it did not specify an exact time limit.

The Jackson v. Indiana ruling attacked the most flagrant abuses of the actual practice of competency procedures. The effect has been to (1) decrease the number of persons found in state mental hospitals determined to be incompetent, and (2) drastically shorten the length of time incompetent persons spend in pretrial hospitalized treatment for incompetency.

However, Burt and Morris (1972) who advocate the abolition of the competency to stand trial "safeguard" point out that the Jackson Court did not explicitly limit the length of time persons diverted for competency testing must remain as involuntary diagnostic hospitalized mental patients.

Not only is the Jackson decision silent regarding the period of time a defendant must spend in a mental hospital being evaluated, but the Justices did not specify whether it is necessary that diagnostic assessments of competency be performed in a mental hospital. The Jackson opinion has left to the states the determination of the specific procedures for determining a defendant's competency.

Serious doubt exists as to whether a commitment for competency evaluation in a mental hospital is needed where an outpatient examination is practical. Where a lesser restrictive alternative to hospitalization is possible, a court (at the instigation of the prosecutor) can misuse the competency "safeguard" by making a commitment to a mental hospital. A diagnostic competency commitment lasting three months, for example, has the effect of denying or delaying the right to bail or a speedy trial.

In Arizona, Rule 11.5(b) of the Arizona Statute was drafted to comply with the Jackson decision. No one can be committed as incompetent to stand trial for a period of

time lasting longer than 6 months without a review to insure "due process" rights are not being violated (Shuman, Hegland and Wexler, 1978). In cases where the defendant is judged incompetent and there is a substantial probability that he will be restored to competency, the Arizona law states: "He shall be committed to the supervision of the institution authorized to receive him for a period not to exceed 6 months (Arizona Revised Statutes, Rule 11, 1974)." In Pima County (which includes Tucson) competency to stand trial examinations do take place on an outpatient basis (for there is no large state mental hospital facility convenient to the area).

Since the Jackson decision, the legal focal point is fixed upon the desire to insure that the defendant whose competency is doubted still be guaranteed the constitutional right to bail and speedy trial. Ennis and Emery (1978) encourage the courts to hold the mental health treaters more accountable for their activities so that the defendant will receive appropriate help in being restored to competency. Judicial monitoring of competency treatments can help to identify as quickly as possible those defendants who are not amenable to treatment because of mental retardation. Ennis and Emery recommend that the court deal with persons whose competency cannot be easily restored by either (1) dropping charges and releasing them, (2) civil commitment,

or (3) proceeding to trial in spite of permanent or unchanging incompetency. The final alternative, proceeding to trial, has been recommended with seriously mentally ill persons who are relieved of their condition by the use of psychotropics (Winick, 1977).

Though the abuses of the competency to stand trial requirement have been limited, there remain problems. Three major areas of concern continue to exist which complicate the competency to stand trial process and keep it from guaranteeing competency at trial without sacrificing "due process" rights to bail and speedy trial.

First, mental health professionals, including psychiatrists and clinical psychologists, have not demonstrated their expertise in competency decisions to the satisfaction of the legal community. Mental health professionals have to an extent exploited their position of prestige and respect and sold themselves as experts without much proof. Stone (1975) has written: "The competency procedure has been used by the mental health professionals who too often merely proffer ritualistic and conclusory assertions based on their personal view of the proper disposition of the defendant (p. 205)." In short, mental health people regard themselves as judges, not competency diagnosticians. As a result, competency to stand trial examinations, as lawyers view them, take on a "buy a shrink" supermarket atmosphere which

serves neither justice for the defendant, or mental health professionals ultimately.

Second, incompetency to stand trial has become a catchall by which all kinds of legal purposes are achieved, often at the expense of genuine consideration of the competency questions (Leavy, 1973). There are those, generally in the county attorney's office, who contend that the competency to stand trial process is utilized primarily as a defense shield for the preparation of an insanity defense at the government's expense, or for the purpose of a legal plea bargaining scheme, i.e., to induce the county attorney to accept a plea bargain. On the other hand, defense attorneys counter by suggesting that the competency process still remains an effective prosecutorial sword used to effectively deny bail or delay trial. It is evident that often competency is challenged without real regard for the defendant's mental status but rather as a part of the larger legal tactic or courtroom strategy. Mental health professionals feel caught in the middle of legal shananigans and resent being the guinea pig caught on the witness stand and vulnerable to cross-examination as a result of lawyers' courtroom gaming.

Third, McGarry (1973) notes competency to stand trial evaluations evolve a great and wasteful expense to the public treasury. The expense of employing psychiatrists and

psychologists to do the competency examinations has grown enormously in the last years. This expenditure is considered wasteful because in large measure money is paid to mental health professionals whose services are to the law-mental health cold war rather than to the advantage of the individual defendant-patient.

What follows is a more complete description of the three critical areas in competency to stand trial activity.

Psychiatrists and the Competency Evaluations

Psychiatrists have eagerly accepted the authority and financial remuneration competency evaluations bring. Yet, they have failed to critically question their expertise. As a consequence, today traditional mental health professionals face a serious challenge from judges and attorneys. Mental health professionals ought to be able to demonstrate and verify their expertise scientifically. This warning has been made to the profession by a few in the past. For example, McGarry (1971) suggested that expertise should be real and not assumed, and specified forensic training or experience is required to responsibly answer court orders. Shah (1975) declared, "It is quite presumptuous, to put it mildly, for mental health and medical professionals to render opinions and recommendations on issues of pretrial competency . . . when the relevant legal issues and criteria

are not properly understood (p. 36)." After all, according to Goldstein and Stone (1977), the psychiatrist's power and influence is all important when he is called upon to advise the court as to who is competent to stand trial and who shall be deprived of personal liberty.

The importance of the competency to stand trial decision is today recognized by the American Psychological Association (A.P.A.). The A.P.A. "Report of the Task Force on the Role of Psychology in the Criminal Justice System" (1978) concludes that the decisions made in the criminal justice system on the basis of psychological reports and testimony are so often fateful for the individuals involved, ignorance of relevant legal concepts and the organizational context in which they operate is particularly distressing. This is especially distressing when judges who have in the past abdicated their authority, delegating it to psychiatrists without much accountability, are beginning to hold forensic experts to closer scrutiny. Morse (1978) reflects this new judicial view of psychological and psychiatric testimony as the psychologist's personal value preferences imposed upon decisions more appropriately left to other decision-makers, i.e., judges themselves.

Previous to this increasingly critical account by judges of mental health expert witness' role, Leifer (1962) described an earlier more compatible era. Leifer concluded

that, "Psychiatry served the purpose of aiding the law in making difficult decisions and the law served psychiatry by underwriting its status as a science (p. 574)."

Perhaps, as Leifer (1962) noted, the scientific imperfections of psychiatry has been overlooked by judges. Though psychiatrists call themselves experts, to achieve the status of an expert it is essential to demonstrate psychiatrists' reliability. The lack of reliability in psychiatric diagnostic decision-making is well known to researchers. Considerable energy has been expended decades ago by researchers who point to the unreliability of psychiatric diagnotic decisions in traditional mental health activities (Ash, 1949; Boisen, 1938; Eysenck, 1952; Roe, 1949; Rotter, 1954, and Scott, 1958). Researchers less willing to condemn psychiatry's lack of scientific reliability, but recognize problems in the evaluation process include Foulds, 1953; Hunt, Wittson, and Hunt, 1953; Schmidt and Fonda, 1956; and Seeman, 1953.

As long as diagnosis in psychiatry is confined to broad diagnostic categories it is reasonably reliable (i.e., approximately 66% of the time psychiatrists will agree with each other on a diagnosis), but the reliability diminishes greatly as one proceeds to more specific class categories such as the type of neurosis (i.e., agreement in 33% of the cases). Among the factors explaining this poor reliability

rate, examiner bias is today attracting the most attention. Ziskin (1970) quotes from Ash (1949), Beck (1962), Dershowitz (1969), Goldberg (1970), Halleck (1967), Loftus (1960), Schmideberg (1962), Spitzer, Cohen, Fleiss and Endicott (1967), Zubin (1967) and others in determining that, "The chances of another expert, similarly qualified, agreeing with the first's findings is barely 50-50. There is about as much chance that a different expert would come to some different conclusion as there is that the other would agree (p. 88)."

Early law-mental health interaction, as described by Leifer, and the psychiatric recommendations regarding competency and sanity decisions has been described by Halleck (1967) as destructive. Psychiatrists, not held strictly accountable to courts, employed a very subjective criteria in determining competency which is intended to help sick people, but too often results only in an arbitrary restriction of freedom for them.

The conclusion of early law-mental health interaction suggested that psychiatrists did not know what they were being asked to do. For example, Hess and Thomas (1963) summarized: "The vast majority of records studied indicated that the psychiatrist confused legal standards of competency with those of responsibility (p. 715)." McGarry (1965) concurred in commenting: "Psychiatrists appear to view

psychotics as uniformly incompetent to stand trial and criminally responsible reflecting an exclusively medical frame of reference (p. 629)." Robey's (1965) study confirmed: "The vast majority of psychiatrists have no awareness of the legal tests or criteria to apply. If they deal with the question at all, many seem to feel that the accused must be free from any symptoms of mental illness before he may be returned to trial (p. 616)." Bukatman, Roy and De Grazia (1971) wrote: "It appears that competency examinations are usually carried out by examiners who are not sure what they are looking for. . . . Reports submitted to the courts are usually of a conclusional nature which Hess and Thomas (1963) characterized as 'empty and meaningless' (p. 1226)." For Goldstein and Stone (1977) the potential abuses and misuses of politicalized psychiatric power is documented sufficiently. They call for a clear and meaningful standard for psychiatric competency examinations to combat the abuse.

Can psychiatric testimony on competency and sanity meet the criteria of admissibility as expert witness testimony? A most outspoken critic of according expertise to mental health professionals is a lawyer-psychologist named Jay Ziskin. Ziskin (1970) concluded that there is no reason to consider such testimony as other than highly speculative. Ziskin, like Szasz (1960), proposes that constructive

law-mental health relationships can best be served by limiting the psychiatrist's role in the courtroom. In refusing to admit expert testimony based upon lie detector tests, courts stress the large potential for error, and the difficulty of jury evaluation of examiner's opinions leading to the tendency of triers of fact to treat the opinions as conclusive on the issue (see Romero v. State, 493 SW 2nd 206, 209-11, Texas, 1973). Ennis and Litwack (1974) assert that there is no distinction between lie detector tests and psychiatric assessments for they both have the same problems associated with them. The research data does not establish satisfactorily the reliability and validity of psychiatric testimony on competency and legal sanity decisions to qualify this information as expert knowledge, say the legal critics of psychiatry. In the face of this harsh treatment of mental health testimony, Karl Menninger and others have suggested that psychiatrists be excluded from the courtroom or limited to post trial matters (Robitscher and Williams, 1977).

Long before the legal attack upon psychiatric testimony began, Slovenko (1964) proposed that lawyers themselves might be considered experts regarding competency to stand trial. Rosenberg (1970) writes: "Any of the three alternative professional disciplines mentioned (i.e., lawyers, psychologists, and social workers) could qualify as experts with adequate training and experience (p. 320)." In the

case of lawyers, it seems only natural that lawyers should judge whether or not a client is able to assist in his own defense. Rosenberg (1970) reiterates the lack of adequate competency to stand trial criteria by saying: "Psychiatrists have poorly understood this legal issue and, out of ignorance, have participated in these proceedings to the detriment of their patients (p. 578)."

The failure of traditional psychological assessment devices, such as the Minnesota Multiphasic Personality Inventory (MMPI), in identifying incompetency encourages lawyers to propose that they can do as well as the psychiatrists in competency evaluation. Maxson and Neuringer (1970) unsuccessfully attempted to demonstrate the MMPI's usefulness as a screening device for the establishment of competency (see also Dahlstrom, Welsh and Dahlstrom, 1960). The authors half-heartedly conclude that the amount of errors made with the MMPI is probably no greater than those associated with the complicated competency status decision-making processes currently used in mental hospitals.

In summary, psychiatrists' evaluation of competency to stand trial defendants is facing criticism from within the mental health profession and increasingly from legal commentators and judges. Psychiatrists' lack of scientific verifiable expertise, i.e., lack of reliability, misconception of competency criteria, subjectivity, etc., is being

frequently challenged by commentators who point out the non-accountability of mental health professionals. Suggestions that laymen, and lawyers themselves, do competency examinations have been offered as alternatives by those who challenge the expertise status accorded psychiatrists.

Legal Purposes Achieved by Competency Procedures

There are many who propose in the research literature (Brakel and Rock, 1971; Cooke, 1969; Hess and Thomas, 1963; Laczko, James and Alltop, 1970; Matthews, 1970; McGarry, 1965, 1971; and Steadman and Braff, 1975) that competency proceedings serve a multitude of purposes other than a genuine concern for the defendant's mental state and ability to stand trial; that it becomes secondary to the other functions served by the diversionary process (Steadman and Cocozza, 1974). It appears that lawyers themselves, while highly critical of psychiatrists' unreliability and scientific expertise, use psychiatric assessments of competency as a means to serve their legal interests.

Matthews (1970) has proposed that competency procedures are frequently initiated when the type of crime is especially serious, violent or atrocious, so as to remove public pressure for severe punishment from the prosecutor and avoid criminal responsibility issues involved in an insanity defense. The implication is that the competency to

stand trial procedures would be used by the defense as a means to delay or avoid trial in cases of serious or violent crimes where bail is likely to be denied anyway.

Eisenstat (1968), on the other hand, defines prosecutor purpose for the competency procedure as acting as a short circuit for the more involved civil commitment procedure, especially for defendants with histories of mental illness. They suggest that charges of a minor nature will occur with greater frequency in competency evaluations because it is easier for the prosecution to deal with these defendants by incompetency calculations rather than by civil commitment alternatives.

No research outside of Matthews (1970) and Eisenstat (1968) has followed up on the relation between accused crime charges and the defendant's competency to stand trial examination.

A. Louis McGarry (1973), a leading researcher of competency procedures whose research the Supreme Court relied heavily upon in forming the Jackson decision, warns against the overuse of the competency procedure by lawyers. He speaks for a group of researchers who have demonstratively shown the overuse of competency as a diversionary legal tactic.

For example, McGarry (1973) cites a Massachusetts Department of Mental Health Study revealing that only 74 of 1806, or 4.1%, of pretrial admissions actually resulted in

findings of incompetency by hospital doctors. Ninety-six percent of persons committed to the hospital as in need of a competency examination were in fact found competent. Is this, as Eisenstat (1968) suggested, a way of putting away (for a short period of time) troublemakers without having to bring them to trial? Szasz (1963) found similarly that 65.5% of the patients at Mattawan State Hospital for the Criminally Insane were competent to stand trial oriented cases. Morris (1968) reviewed the statistics after the hospital had reduced its population by half, and found 78% of the remaining were there for a competency examination.

The overuse of competency to stand trial as a means of detaining persons unnecessarily in state hospitals before trial is documented in a Joint Information Service study (1969) of the American Psychiatric Association which reported that 52% of all admissions to hospitals for the criminally insane are for examination to determine competency to stand trial, while only 4% are persons found not guilty by reason of insanity.

Outpatient nonhospitalized examination of competency to stand trial, proposed by McGarry to avoid the unnecessary hospitalization, is seen as being too superficial by many. However, the problem of falsely hospitalizing competent persons ought to counter the fear of superficiality. A real danger existed for persons whose competency was examined at

the Medical Center for Federal Prisoners at Springfield, Missouri. Stone (1975) cites a Settle and Oppagrad (1964) study in which 66% of the persons committed for a competency examination and spent as much as 6 months in the Medical Center were ultimately determined to be competent.

The overuse of competency to stand trial examinations by lawyers as a legal diversionary tactic is being criticized by researchers who find this practice leads to unnecessary diagnostic evaluations. They fear psychiatrists are wasting their time and energy in competency evaluations which serve neither the mental health nor legal protection of these patient-defendants.

Coping with the Burgeoning Competency to Stand Trial Procedures: Keeping the Cost Down

Investigators whose research identifies the overuse of competency procedures by legal officials for diversionary purposes, and recognize that the scientific expertise of psychiatrists performing competency to stand trial evaluations is under attack recommend limiting competency examinations by (1) aiding these mental health evaluators by developing a valid, reliable screening instrument for determining competency, and (2) employing nonhospitalized examinations by local psychiatrists who are independent of the government and each other.

Competency Screening

McGarry's (1971) research suggests that psychiatrists can refuse to play into the lawyer's diversionary legal tactic by concentrating their energies on developing a valid and reliable screening method for competency determinations. A screening instrument would have the advantage of taking the heat off psychiatrists who are attacked by legal officials as being unscientific, and lacking expertise in formulating competency decisions.

Bukatman et al. (1971) argues in favor of employing a more objective and law-oriented checklist. He says:

> Our studies persuaded us that if we were to avoid the dangers of confused or misleading competency evaluations, the questions we needed to raise should be in keeping with the legal situations being evaluated; medical questions such as the presence of or absence of psychosis, depression, etc., seemed irrelevant unless they cast useful light on legal questions (p. 1229).

Lipsitt (1970) recommended a checklist measure rather than an interview procedure in determining competency because, "If criteria for competency can be operationally defined and applied in this area, a reduction in the confusion and misunderstanding may be achieved (p. 797)."

Lipsitt, Lelos and McGarry (1971) constructed the "Competency Screening Test" which focused upon courtroom situations and consisted of 22 sentence stems, each included for its relevance to the legal criteria of competency. The advantages, according to Lipsitt et al. were:

". . . in addition to more discriminate focusing on the competency issues during pretrial, include the avoidance of unnecessary hospitalization commitments, with the concomitant economic savings, and the avoidance of loss of liberty of those later found not guilty (p. 108)." Lipsitt's (1970) is the first of several checklists that were devised in the late 1960s since James Robey's (1965) celebrated checklist to determine the ". . . susceptibility to decompensate while awaiting or standing trial (p. 616)."

In the Laboratory of Community Psychiatry, at the Harvard Medical School, McGarry (1973) undertook a six-year research project to develop a Competency Assessment instrument. The results were published in a Crime and Delinquency Series monograph. The staff of the project that developed the assessment instrument achieved a high reliability coefficient of .92, and 216 clinicians in Massachusetts from several disciplines (i.e., social workers, psychologists, psychiatrists) who studied the handbook and used the instrument achieved an overall reliability of .84. McGarry, director of the project, concluded: "This screening test will not predict with complete accuracy the competency recommendations of psychiatrists; the issue is muddied by the confusion as to the criteria that mental health professionals have applied to the determination of competency (p. 91)."

The results are muddied by another issue. Of critical importance, the problem of applying these checklists in cases of malingering, has dissuaded others from taking advantage of these checklists. McGarry (1973) recognizes this problem in stating that: "Inability to function indicated by low scores on this instrument must arise from mental illness and/or mental retardation and not, for example, for ideological motivation (p. 91)." Wexler (1971) early on made the point:

> For low scorers, mental incompetency to stand trial would appear to be but one of many possible conclusions that could be inferred from the test results: a low score could also be attributable to a naivete about the judicial system, or in some cases, to a realistic assessment of its shortcoming, neither of which are appropriate mental grounds for rendering one incompetent (Footnote 85, p. 163).

Weinstein (1977) in a recent review of the "Competency Assessment Instrument" writes: "In cases of malingering, the instruments developed appear to be of little value . . . . Other significant competency problems have to do with depressed and suicidal defendants (p. 135)."

The competency assessment instrument, although achieving a high reliability, has not been widely accepted due to its problems in differentiating malingering, depression, or suicidal patients from truly incompetent ones. As a result, mental health professionals under fire from the courts have turned their attention to setting up a court

related rotating panel of local psychiatrists to make competency determinations.

Independent Psychiatrists and Non-hospitalized Competency Examinations

The obvious attraction of a panel of psychiatrists located in the community in private practice is in avoiding the restrictive alternative of sending defendants to state mental hospitals for inpatient examinations. As a result attorneys, by invoking the competency procedure, would not be able to achieve their diversionary strategy (such as delaying trial) as easily as before. The competency to stand trial examinations could be carried out in a matter of hours rather than 60 to 90 days alloted for hospitalized competency exams. Outpatient evaluation of competency to stand trial would save the expense of maintaining persons within mental hospitals while being examined. Therefore, a local panel of psychiatrists, by performing nonhospitalized examinations, ought to limit the number of competency exams to those when there is a serious doubt as to the competency of the defendant.

However, there is a reluctance to use an independent panel of private practicing psychiatrists to do competency examinations. Psychiatrists fear that the lack of agreement, or interjudge reliability, between nonhospital based experts might further jeopardize the special expert witness status

these professionals have in the courtroom. As a consequence, psychiatrists who do the competency examinations either work in mental hospitals or court clinics (outpatient diagnostic centers in which the psychiatrists are employed by the state to exclusively do forensic examinations for the courts). This has the advantage of insuring high reliability of examiners who work together and can iron out any differences before recommending conclusions to the courts, and offer outpatient exams which are less restrictive. New York State and Michigan represent two examples of the court clinic solution to the problem of restrictive competency examination in mental hospitals.

In a study evaluating the competency agreements of evaluators in a court clinic (i.e., the New York City Criminal Court Forensic Psychiatric Clinic), Goldstein and Stone (1977) found that for a twelve-month period, July 1975-76, a total of 1404 patient defendants were evaluated in each case by two psychiatrists. The disagreement rate among the psychiatrists was only 2.5% or 35 cases of the total case load. Although the reliability rate is very impressive, the examiners were not independent of each other in carrying out the evaluation and assessment. Several researchers, i.e., Thorne and Forgays (1972) and Ellis and Sells (1964), suspect that working in the same organization bias these psychiatrists' judgments on competency and legal sanity.

Thorne and Forgays (1972) in a study into the Dannemore State Hospital (N.Y.) medical staff compared diagnostic classification practices of the regular medical staff with independent psychiatric diagnoses made by a National Institute of Mental Health Hospital Improvement Program group during the period 1967-71. The Hospital Improvement Program (HIP) staff discovered that a number of extraneous administrative factors appeared to influence official staff diagnoses. Patient diagnoses made independently by the regular medical staff and the HIP staff were in agreement only 41% of the time, in partial disagreement 33% of the time, and in total disagreement 26% of the time. Perhaps the Court Clinic psychiatrists, like the Dannemora State Hospital psychiatrists, because of their organizational set-up are influenced by the same administration factors. Ellis and Sells (1964) using a case study approach in military diagnostic evaluations found that in the majority of cases, diagnoses appeared to conform with superior's rating of the patient.

One reason why the reliability of Court Clinic psychiatrists' diagnoses of competency is so high is personal values of the group of psychiatrists who choose to work there are similar. Sullivan (1971) hypothesized that military psychiatrists are in agreement with the stated values of military service, so might not these psychiatrists be

adherents to covert guidelines operating in Court Clinics? Temerlin's (1969) study demonstrates the importance of suggestion on psychiatric diagnosis. He found using an artificial four-group design in which psychiatrists viewed the same recorded interview after having been exposed to different suggestion statements that mental health professionals are extremely suggestible to a presumption of illness in diagnosis.

Several disadvantages exist in utilizing the services of psychiatrists at mental hospitals. Psychiatrists who work in institutions can be influenced by (1) the opinions of other psychiatrists at the facility, (2) the extraneous administrative consequences, such as finding the patient competent in order to get him out of the hospital, and (3) the lack of diversity among psychiatrists' values toward health and sickness.

The advantages of utilizing a group of psychiatrists who receive the bulk of their income from private practice is (1) that they ought to be more independent of each other in formulating their competency decisions thus giving the defendant a real second opinion; (2) that they ought to be free from covert guidelines, or suggestion influences; (3) that their examinations ought to take place quickly (during a one-hour interview in the examiner's office) so as to avoid jeopardizing "due process" rights to bail and a speedy

trial, and cut down on the legal delaying tactics; and (4) that the cost to do the examinations is reduced.

Yet, the use of nonhospital-based psychiatrists has only been employed in communities around the country where the proximity to a mental hospital makes inpatient evaluation not practical. There is a resistance to utilizing nonhospital-based psychiatrists. Mental health professionals fear that independent assessments of competency will cause the reliability of psychiatrists' decisions to drop, and with it will be a decline in the credibility of expertise. Mental health professionals, already under attack as not being true "experts" cannot afford to suffer another blow in the legal arena.

Recent research into the decision-making process employed by psychiatrists continues to cast serious doubt as to whether these "experts" rely on training and scientific knowledge in determining who is competent and who is not. Goldstein and Stone (1977) found that disagreeing examiners weighted the symptoms' importance in what appears to be a distinct expression of their psychiatric philosophies. They characterize the psychiatric styles as split into two camps: the guardians and the greenlighters. The guardians, as described by Goldstein and Stone, were protective of their patients and worried that the worst might

happen unless averted by an incompetency finding. The guardians of the defendant-patient's welfare apply their scientific information and expertise in a solicitious and paternalistic fashion. The greenlighters were found to be laissez-faire, optimistic about patient-defendant's future performance, less concerned about a reversal that might discredit their powers of prediction, and inclined to let the chips fall where they may. These psychiatrists disagreed with the guardians and found their clients competent.

In Tucson, Arizona, psychiatrists are part of a rotating panel of local forensic experts called upon by the court to do competency examinations. The rate of agreement or interjudge reliability of these evaluators (two psychiatrists examine the patient-defendant independently) is expected to be lower then the state mental hospital psychiatrists who are employed in a full-time capacity by the State.

This study is an empirical evaluation of the competency to stand trial and legal sanity examinations made by psychiatrists in Pima County at the direction of the Superior Court. Can these independent experts agree as to their separate competency and sanity recommendations regarding a defendant as reliably as psychiatrists using the competency checklist, or the court clinic psychiatrists, or the hospital based psychiatrists?

Examination of the data will determine the actual competency and sanity decision (when the experts agree) that are recommended to the court. It is expected that the overwhelming majority of recommendations will be for competency suggesting that lawyers do, in fact, overuse the competency examinations when there is no real doubt the defendant is competent.

Finally, factors influencing the psychiatrist's decision-making in determining competent to stand trial and legal sanity will be investigated. It is expected that when the local forensic experts disagree, they disagree according to the Goldstein and Stone (1977) guardian and greenlighter philosophical positions.

CHAPTER II

METHODS

Subjects

The subjects of this study consist of four mental health professionals. These four experts are psychiatrists called upon by the Pima County Superior Court to evaluate the competency to stand and legal sanity of criminally indicted defendants whose competency is questioned by defense or prosecution lawyers.

The procedure for selecting the forensic psychiatric examiners in Pima County is as follows: Two mental health experts, chosen by the judge, perform the competency evaluations. One psychiatrist is appointed from a list of mental health experts provided by the defense attorney. The other expert is selected from a list of experts provided by the county attorney who prosecutes the case.

In Arizona, Rule 11 requires that the court not commit a defendant to a mental health facility for the purposes of a competency examination unless it determines that an examination cannot properly be conducted without commitment. The law in Arizona endorses employment of the least restrictive alternative into the defendant's liberty while he is examined for competency. Therefore, all examinations

for competency take place in Tucson generally at the psychiatrist's office or occasionally in the County Jail where experts separately visit the defendant (if bail is denied).

The mental health experts determining competency are required by Rule 11 to prepare reports on a number of factors bearing on sanity which are in no way relevant to the competency determination. For example, the dangerousness to self or others, restriction recommendation, diagnosis, treatment recommendation, legal sanity, and disposition recommendation are all requested of the examining psychiatrists.

Psychiatrists doing the evaluation know who the other court appointed forensic expert is. They receive this information in advance from the Court subpoena requesting their evaluation. The Arizona Revised Statutes (1974) state:

> Both parties shall make available to the opposite party for examination and reproduction the names of mental health experts who have personally examined a defendant or any evidence in a particular case, together with the results of mental examinations and scientific tests, experiments or comparisons, including all written reports or statements, made by them in connection with the particular case (Rule 11.4b).

In the period between October, 1974, and October, 1976, the Pima County Superior Court judges utilized the services of four psychiatrists, under study, almost exclusively. These four psychiatrists examined the competency to

stand trial of 95% of all persons whose competency was questioned during the period under study.

The psychiatrists are all in practice in Tucson, Arizona; all are earning an income sufficient to classify them as upper middle class; all are men; all had been practicing psychiatry for at least ten years; and all engage themselves in forensic diagnostic examinations as a community service. The $50 per case fee that these experts receive from the courts for their evaluations is significantly less than they could be earning for the same type of evaluation done in private practice. However, one psychiatrist has earned nearly $7,500 in evaluations alone from the court appointed competency examinations in two years.

In Tucson (Pima County), if there is a significant discrepancy between the expert opinions contained in the letters they send to the court, then the psychiatrists are called into the pretrial hearing before the judge and are cross-examined by lawyers who attack unfavorable expert opinions. This is considered by all psychiatrists as a "necessary evil" type experience. It has the effect, they say half jokingly, of encouraging agreement among experts in order to avoid the "ordeal" of court testifying despite the fact that there is monetary compensation. If unable to reach a decision based upon the courtroom testimony of the

psychiatrists, the judge has the option to call in a third or fourth mental health expert.

Procedure

In Pima County a budget of over $25,000 is provided for forensic health examiners from the private sector to do evaluations of competency to stand trial (Tucson-Pima County Financial Report, Fiscal Year 1976-77). Each evaluation costs the County at least $100.

Only 4.5% of the criminal defendants are seen for competency evaluations; this amounts to 150 persons per year.

An extensive interdisciplinary-law and psychology-literature search identified a set of factors influencing forensic psychiatric decision-making. Deciding upon a list of factors was important because if there was any significant disagreement between mental health experts, then these factors would be able to explain the reasons for the disagreement in a regression analysis approach.

A review of the Pima County Court Clerk's record of billing receipts regarding forensic examinations of competency to stand trial questioned defendants helped to identify which experts were being called upon to do the examinations. Psychiatrists paid for their services by the Pima County Superior Court are required to list with the Court the Pima County Criminal Case Number of each defendant they examine. Therefore, the Court Case Criminal Numbers found on receipts

investigated between October, 1974 and 1976, defined the total list of competency questioned persons in Pima County. A list was made of all competency questioned individuals by their case numbers.

An attempt to contact the four forensic examiners was successfully made through an official agency of the Pima County Superior Courts. The Director of the Pima County Court Clinic expressed an interest and willingness to support this research project, and officially requested that the four forensic experts used by the courts between 1974 and 1976 participate voluntarily in this research. The Director assured the experts that this research had been screened by the Pima County Superior Court and the University of Arizona Human Subjects Committee and had its approval.

Initial concern over patient-doctor privilege subsided after official approval of this research was received by the Pima County Attorney Mr. Steve Neely, the State of Arizona Attorney General's Office, and the University Human Subjects Committee.

The four psychiatrists approved of this research and provided access to their forensic files. The procedure for the data collection followed this course: (1) the data was collected at the psychiatrists' own offices, (2) an abstract was made from each court report, (3) the variables compiled

from the literature search provided a framework for reading and abstracting the forensic court reports. The factors noted in the abstract included:

age	criminal charge
religion	judge presiding
education	lawyers involved
family history	criminal record
race	psychiatrists
employment	referral source
military status	dress and appearance
income level	pretrial status
mental illness	previous hospitalization
dangerousness	mental status
medical problems	drug/alcohol addiction
recommendations	recent antisocial behavior

All relevant information was typed on 5 by 8 index cards. All data collected was completed by the principal investigator. The domain of data included only the court psychiatric reports of competency; all other information regarding the defendant (including private letters from attorneys providing additional information) was not included in this study. The identification of psychiatrist reports to the court was made through the use of the defendant's criminal court number. Psychiatrists who carried out the examinations were identified by a card color code, i.e., psychiatrist one cases were abstracted on blue cards, psychiatrist two cases were abstracted on yellow, etc.

In order to test whether crimes of a serious nature provoke a larger number of competency to stand trial referrals than minor crimes a separate research survey was undertaken. The Pima County Attorney's Office agreed to

answer a questionnaire in which attorneys were asked to provide a magnitude estimate using a numerical scale to order the crimes according to their harm.

Diagnosis was evaluated in three separate forms: primary, secondary and auxiliary labelling. The primary form was the conclusory diagnosis, while the secondary and auxiliary diagnoses helped the psychiatrist to differentiate illness categories.

The legal competency and sanity determinations were determined by taking the decision of the psychiatrist's report to the court. It is a dichotomous test. However, since competency and sanity decisions do involve variations in language and meaning, competency and sanity decisions were also evaluated by using a 10-point scale. A score of 10 equals absolute competency while a score of 0 is absolute incompetency, based upon the researcher's judgment.

Prognosis and dangerousness determinations were similarly evaluated with absolute certainly of nondangerousness or recovery, while a mark of 3 equals absolute certainty of dangerousness or poor prognosis.

Recommendations regarding treatment and disposition due to open-ended nature of the decision were evaluated on the basis of three criteria: degree of freedom restricted, outlook concerning treatment possibilities, and length of expected recovery.

CHAPTER III

RESULTS

Competency and Sanity Interjudge Reliability among Psychiatrists

As shown in Table 1, the psychiatrist pairs created by the Pima County Superior Court (two psychiatrists are assigned by the Court to evaluate the same defendant) agree in their conclusions as to competency to stand trial 82.98 percent of the time. This competency to stand trial reliability figure appears not to be different from the reliability rate of psychiatrists who used the McGarry competency screening checklist (data does not lend itself to comparison). McGarry (1973) finds that competency reliability percentile of psychiatrists using the checklist is between 84 and 92 percent.

There exists a "moderate" reliability among psychiatrists for their forensic decisions. When psychiatrist pairs are compared, the range of agreement is from a low of 72.72 percent to a high of 90.90 percent, but variance is not significant (chi square = 3.39; df = 5; p = .65). Three sets of psychiatrist pairs (out of six) have reliability percentages at the overall average (Table 1).

Table 2 shows that the overall (interjudge reliability) agreement for psychiatrist pairs' legal sanity decisions

Table 1. Interjudge reliability: Regarding competency to stand trial decisions.

Judges	Disgreements	Agreements	# Cases[a]	% Cases	% Agreement[b]
1 with 2	6	16	22	9.86	72.72
1 with 3	6	28	34	15.25	82.35
1 with 4	4	19	23	10.31	82.60
2 with 3	11	70	81	36.32	86.42
2 with 4	7	34	41	18.38	82.92
3 with 4	2	20	22	9.86	90.90
TOTAL	36	187	223	100.00	82.96

[a] Chi Square = 70.169
df = 5
p = .0001
Cases not randomly distributed

[b] Chi Square = 3.394
df = 5
p = .65
Variance in % agreements

Table 2. Interjudge reliability: Regarding legal sanity decisions.

Judges	Disagreements	Agreements	# Cases[a]	% Cases	% Agreement[b]
1 with 2	5	17	22	10.28	77.27
1 with 3	13	19	32	14.95	59.37
1 with 4	11	10	21	9.81	47.62
2 with 3	31	48	79	36.91	60.75
2 with 4	12	29	41	19.16	70.73
3 with 4	6	13	19	8.88	68.42
TOTAL	78	136	214	100.00	64.02

[a] Chi Square = 72.24
df = 5
p = .0001
Cases not randomly distributed

[b] Chi Square = 8.41
df = 5
p = .12
Variance in % agreements

is 64.02 percent. Psychiatrist pairs vary from 47.62 percent to 77.27 percent, and this variance is also not significant (chi square = 8.41; df = 5; p = .12).

"Moderate" reliability among psychiatrist pairs' competency and legal sanity decisions occurs despite a methodological problem in sampling. Psychiatrist pairs do not receive their assigned cases in a random fashion. For example, the Pima County Superior Courts sent 81 defendants to a psychiatrist pair consisting of psychiatrist 2 and psychiatrist 3, while sending only 22 referrals to psychiatrist pairs which include psychiatrists 1 and 2 and psychiatrists 3 and 4. This distribution of referrals by the courts to psychiatrist pairs is not random (chi square = 70.16; df = 5; p = .0001) with regard to competency nor is it random in regard to legal sanity referrals (chi square = 72.24; df = 5; p = .0001).

When psychiatrists in pairs do disagree as to the legal sanity of a defendant, further investigation into individual psychiatrist decisions shows that disagreements stem from matching a greenlighter (or psychiatrist who tends to find defendants sane) with a guardian (or psychiatrist who tends to find defendants insane). Table 3 shows sanity decisions reflect a significantly consistent rate of disagreement when a greenlighter is matched with a guardian (chi square = 55.5; df = 11; p = .0001).

Table 3. Breakdown of psychiatrist pairs into their individual decisions of competency to stand trial and legal sanity.

	Competency to Stand Trial Decisions[a]			Legal Sanity Decisions[b]		
Judges	Disagree-ments	% Com-petent	Incompe-tence Direction	Disagree-ments	% Sane	Insane Direction
1 with 2	6			5		
1		54.5	5		27.3	5
2		72.7	1		50.0	0
1 with 3	6			13		
1		69.6	4		24.2	13
3		75.7	2		67.7	0
1 with 4	3			11		
1		86.4	2		36.4	11
4		90.9	1		90.5	0
2 with 3	11			31		
2		79.0	11		51.8	28
3		93.9	0		83.9	3
2 with 4	7			12		
2		78.0	4		52.5	7
4		85.3	3		64.1	5
3 with 4	2			6		
3		95.5	0		86.4	0
4		86.4	2		52.6	6

[a]Chi square = 16.80; df = 11; p = .11

[b]Chi square = 55.49; df = 11; p = .0001

In determining the legal sanity of defendants, psychiatrist 1 follows the guardian style when disagreeing with fellow psychiatrists. Psychiatrist 1 finds the defendant insane 100 percent of the time when he disagrees with the other psychiatrist's recommendations. This accounts for 29 disagreements with fellow psychiatrists. On the other hand, psychiatrist 3 takes on a greenlighter style in disagreeing with fellow psychiatrists by finding defendants sane on 47 different occasions. This is nearly 100 percent of the disagreements which psychiatrist 3 is involved in and accounts for over half of all disagreements on sanity decisions.

Psychiatrist 2 adopts a guardian style when coupled with psychiatrist 3. In 28 out of the 31 disagreements between pyschiatrists 2 and 3, psychiatrist 2 finds the defendant to be legally insane, opting for a guardian style ($p = .0001$). Yet, in the few times (5) when psychiatrist 2 was paired with psychiatrist 1, psychiatrist 2 opts for a greenlighter style in finding for sanity all 5 times ($p = .11$).

Similarly, psychiatrist 4 takes on a greenlighter style with psychiatrist 1 ($p = .02$) and a guardian style with psychiatrist 3 ($p = .08$). Finally, when psychiatrists 2 and 4 are paired, no clear style emerges ($p = .66$). Seven times psychiatrist 2 acts as a guardian but 5 times occur in which psychiatrist 4 is the guardian.

Therefore, for legal sanity decisions, psychiatrist 1 takes a guardian orientation, protecting the defendants from standing trial, while psychiatrist 3 takes on a greenlighter position, defining most all defendants which other psychiatrists consider insane as sane. [For support of this look to the comparison between psychiatrist 3 and psychiatrist 1 ($p = .0001$). Psychiatrists 2 and 4 take a greenlighter style with psychiatrist 1, and a guardian style with psychiatrist 3.]

When psychiatrists in pairs disagree as to the competency of a defendant, a significantly consistent rate of disagreement does not occur (chi square = 16.8; df = 11; $p = .11$).

Although not as well demonstrated, competency to stand trial decisions still tend to follow the guardian and greenlighter styles. This is especially the case with psychiatrists 1 and 3 respectively (see Table 3). Psychiatrist 1 finds for incompetency when disagreeing with other psychiatrists. This occurs less often than with psychiatrist 1's insanity decisions. For competency decisions, psychiatrist 1 disagrees with the other psychiatrists and finds the defendant incompetent 70 percent of the time.

Psychiatrist 3 continues to be a greenlighter finding for competency when disagreeing with the other psychiatrists nearly 100 percent of the time. Finally, as with

sanity decisions, psychiatrists 2 and 4 adopt a guardian style with psychiatrist 3 and a greenlighter style with psychiatrist 1.

The analysis of psychiatrists' individual competency and sanity decisions (Table 4) bears out the guardian and greenlighter styles of psychiatrists 1 and 3. Psychiatrist 1 finds 70.13 precent of the defendants he evaluates to be competent to stand trial, while psychiatrist 3 recommends 90.44 percent of the defendants he sees as competent. The differentiation between a guardian and a greenlighter perspective is more clearly demonstrated with the legal sanity recommendations. For sanity decisions, psychiatrist 1 finds as little as 28.57 percent of persons he examines to be legally sane, while psychiatrist 3 determines that 80.60 percent of the defendants he examines are legally sane. The variance between psychiatrists for their competency to stand trial decisions is not significant (chi square = 3.01; df = 3; p = .38), but it is significant for psychiatrists' legal sanity decisions (chi square = 26.54; df = 3; p = .0001).

It is highly possible that the population of persons psychiatrist 1 examines is different from (perhaps more insane) those seen by psychiatrist 3. This is because the distribution of referrals by the courts to these individual

Table 4. Individual psychiatrist decisions: Regarding competency to stand trial and legal sanity.

	Competency to Stand Trial Decisions				Legal Sanity Decisions			
Judges	Competent	Incompetent	Total[a]	% Competent[b]	Sane[c]	Insane	Total	% Sane
1	54	23	77	70.13	22	55	77	28.57
2	112	31	143	78.32	74	69	143	51.75
3	123	13	136	90.44	108	26	134	80.60
4	74	11	85	87.06	54	25	79	68.35

[a] Chi Square = 31.6
df = 3
p = .0001
Variance in distribution of cases

[b] Chi Square = 3.01
df = 3
p = .38
Variance in % competent

[c] Chi Square = 26.54
df = 3
p = .0001
Variance in % sane

psychiatrists is not random (chi square = 31.6; df = 3; p = .0001).

Psychiatrists 2 and 4 determine that 78.32 percent and 87.06 percent of their populations are competent, and 51.75 percent and 68.35 percent are sane, respectively. Individual psychiatrist statistics reinforce the tendency to view psychiatrists 2 and 4 as switching from the green-lighter to the guardian styles in relation to psychiatrists 1 and 3.

Actual Competency and Sanity Decision Outcomes

When psychiatrist pairs agree, 88.23 percent of the time they find the defendant competent to stand trial and only 11.77 percent of the time are defendants labelled incompetent. According to Table 5, the range of psychiatrist pairs as to competency to stand trial decisions is not significant (chi square = 6.60; df = 5; p = .25).

When psychiatrist pairs agree, 63.23 percent of the time they find the defendant legally sane, and 36.77 percent of the time they find the defendant legally insane. Psychiatrists do not agree among themselves in their sanity decisions overall (chi square = 23.80; df = 5; p = .0001). Data are not conclusive as to whether this significant variance is a reflection of a lack of random assignment of referrals to psychiatrist pairs. The referrals are distributed

Table 5. Psychiatrists' decisions: Regarding competency to stand trial and legal sanity (when in agreement).

	Competency to Stand Trial Decisions				Legal Sanity Decisions			
Judges	Compe-tent	Incom-petent	Total[a]	% Compe-tent[b]	Sane	Insane	Total[c]	% Sane[d]
1 with 2	11	5	16	68.75	6	11	17	35.29
1 with 3	22	6	28	78.57	9	10	19	47.36
1 with 4	18	1	19	94.74	6	4	10	60.00
2 with 3	65	5	70	92.86	38	10	48	79.16
2 with 4	30	4	34	88.23	17	12	29	58.62
3 with 4	19	1	20	95.00	10	3	13	76.92
TOTAL	165	22	187	88.23	86	50	136	63.23

[a] Chi Square = 65.4
df = 5
p = .0001
Variance in distribution of cases

[b] Chi Square = 6.60
df = 5
p = .25
Variance in % competent

[c] Chi Square = 42.59
df = 5
p = .001
Variance in distribution of cases

[d] Chi Square = 23.80
df = 5
p = .0001
Variance in % sane

among psychiatrists in a non-randomized manner (chi square = 65.4; df = 5; p = .0001) for competency to stand trial referrals, and (chi square = 42.59; df = 5; p = .001) for sanity referrals.

Selected Variables Impact upon Competency and Sanity Decisions

Empirical evaluation of competency to stand trial and legal sanity recommendations involves looking at several variables which might be correlated with competency and sanity decisions. These variables are the following: defendant's psychosis, crime accused, mental retardation, sex, military affiliation, drug or alcohol intoxication, race, education, age, and dangerousness.

Table 6 summarizes the variables correlated with the competency to stand trial or legal sanity decisions. Those variables correlated with the psychiatrists' decisions at the p = .01 or better level of significance are the race of the defendant, the crime defendant is accused of committing, the age of the defendant, the educational level of the defendant, the defendant's psychiatric diagnosis if it is psychosis, the effect of the psychiatrists' decision of incompetency upon the legal sanity decision (Table 7), the effect of the psychiatrists' decision of insanity upon the competency evaluation (Table 8), the psychiatrist pairs

Table 6. Breakdown by selected variables for competency to stand trial and legal sanity recommendations to Pima County courts.

	Compentency to Stand Trial			Legal Sanity		
	Incompetence	Competence	Disagreement	Insane	Sane	Disagreement
Race:						
Mexican-American	20.6	64.7	14.7	32.5	17.6	50.0
Anglo	7.8	74.7	17.5	21.4	42.9	35.7
Black	12.5	75.0	12.5	25.0	45.0	29.2
	(Chi Square = 15.75; p = .005)			(Chi Square = 24.2; p = .0001)		
Psychosis:						
Psychotic	72.7	9.1	18.6	63.6	0.0	36.6
Non-psychotic	7.1	77.4	15.6	21.7	40.6	37.7
	(Chi Square = 462.35; p = .0001)			(Chi Square = 108.87; p=.0001)		
Military:						
Military	6.1	78.8	15.2	21.2	40.9	37.9
Non-military	12.1	72.0	15.9	24.8	37.6	37.6
	(Chi Square = 2.638; p = .01)			(Chi Square = .694; p = .001)		
Sex:						
Male	10.0	73.5	18.5	22.5	40.0	37.5
Female	13.3	73.3	13.3	40.0	20.0	40.0
	(Chi Square = 2.178; p = .51)			(Chi Square = 22.4; p = .001)		
Dangerous:						
Dangerous	10.0	70.0	20.0	30.0	30.0	40.0
Non-dangerous	10.3	74.2	15.5	23.5	39.0	37.6
	(Chi Square = .816; p = .85)			(Chi Square = 5.02; p = .25)		

Table 6--Continued

	Competency to Stand Trial			Legal Sanity		
	Incompetence	Competence	Disagreement	Insane	Sane	Disagreement
Drug Intoxication:						
Drug	0.0	100.0	0.0	20.0	48.3	31.7
Non-Drug	11.6	70.7	17.7	24.3	37.4	38.4
	(Chi Square = 37.01; p = .0001)			(Chi Square = 3.03; p = .05)		
Alcoholic:						
Alcoholic	3.8	80.8	15.4	11.5	46.2	42.3
Non-alcoholic	11.2	73.1	15.7	25.4	37.6	37.1
	(Chi Square = 4.87; p = .07)			(Chi Square = 8.43; p = .02)		
Mentally Retarded:						
Mentally Retard.	77.8	0.0	22.2	100.0	0.0	0.0
Non-ment. retard.	7.5	77.1	15.4	20.6	40.2	39.3
	(Chi Square = 549.46; p = .0001)			(Chi Square = 660.0; p = .0001)		
Psychiatrist Pairs:						
1 and 2	22.7	50.0	27.3	50.0	27.3	22.7
1 and 3	17.6	64.7	17.6	35.3	26.5	38.2
1 and 4	4.5	81.8	13.6	18.2	27.3	52.5
2 and 3	7.3	79.3	18.4	13.4	46.3	40.2
2 and 4	9.8	73.2	17.1	29.3	41.5	29.3
3 and 4	4.5	86.4	9.1	13.6	45.5	40.9
	(Chi Square = 52.66; p = .001)			(Chi Square = 75.9; p = .001		

Table 6--Continued

	Competency to Stand Trial			Legal Sanity		
	Incompetence	Competence	Disagreement	Insane	Sane	Disagreement
Crime:						
0-200	20.7	51.7	27.6	37.9	27.6	34.5
201-480	26.0	65.6	9.4	34.4	37.5	28.1
481-510	8.8	73.5	17.6	25.0	33.3	41.7
511-750	2.8	80.6	16.7	25.0	33.3	46.7
751-850	6.5	80.4	13.0	17.4	45.9	37.0
851-950	8.0	76.0	16.0	12.0	48.0	40.0
951-999	0.0	90.5	9.5	4.8	61.9	33.3
	(Chi Square = 83.62; p = .0001)			(Chi Square = 62.96; p = .0001)		
Education:						
0-6	16.9	65.2	18.0	25.8	34.8	39.3
7-9	7.3	82.9	9.8	22.6	39.0	39.0
10-11	0.0	81.6	18.4	23.7	42.1	34.2
12	10.0	75.0	15.0	22.5	45.0	32.5
12+	6.7	80.0	15.5	20.0	33.3	46.7
	(Chi Square = 22.17; p = .05)			(Chi Square = 7.972; p = .30)		
Age:						
0-16	0.0	91.7	8.5	8.3	41.7	50.0
17-21	6.7	83.7	11.6	16.3	58.1	25.6
22-25	10.0	77.5	12.5	25.0	47.5	27.5
26-30	18.4	63.3	18.4	22.4	30.6	46.9
31-35	12.9	67.7	19.4	38.7	22.0	38.7
36-50	7.4	74.1	18.5	29.6	25.9	44.4
50+	9.5	71.4	19.0	19.0	38.1	40.9
	(Chi Square = 37.03; p = .001)			(Chi Square = 70.22; p = .0001)		

Table 7. The impact of competency decisions upon legal sanity decisions by psychiatrists.

Judges	Agreement for Incompetence		
	Sanity	Insanity	Disagree
1 with 2	0.0%	100.0%	0.0%
1 with 3	0.0%	100.0%	0.0%
1 with 4	0.0%	100.0%	0.0%
2 with 3	0.0%	83.3%	16.7%
2 with 4	0.0%	75.0%	25.0%
3 with 4	0.0%	100.0%	0.0%
OVERALL	0.0%	91.3%	8.7%

Judges	Agreement for Competence		
	Sanity	Insanity	Disagree
1 with 2	54.5%	27.3%	18.2%
1 with 3	40.9%	13.6%	45.5%
1 with 4	33.3%	11.1%	55.6%
2 with 3	58.5%	7.7%	33.8%
2 with 4	53.3%	20.0%	26.7%
3 with 4	52.6%	5.3%	42.1%
OVERALL	51.6%	12.2%	36.2%

Judges	Disagreement for Incompetence		
	Sanity	Insanity	Disagree
1 with 2	0.0%	50.0%	50.0%
1 with 3	0.0%	50.0%	50.0%
1 with 4	0.0%	33.3%	66.6%
2 with 3	0.0%	9.1%	90.9%
2 with 4	14.3%	42.9%	42.9%
3 with 4	0.0%	50.0%	50.0%
OVERALL	3.9%	34.3%	61.8%

Table 8. The impact of sanity decisions upon competency decisions made by psychiatrists.

	Agreement for Insanity		
Judges	Competency	Incompetency	Disagree
1 with 2	27.3%	45.5%	27.3%
1 with 3	25.0%	50.0%	25.0%
1 with 4	50.0%	25.0%	25.0%
2 with 3	45.5%	45.5%	9.1%
2 with 4	50.0%	25.0%	25.0%
3 with 4	33.3%	33.3%	33.3%
OVERALL	35.9%	37.7%	26.4%
	Agreement for Sanity		
Judges	Competency	Incompetency	Disagree
All Pairs	100.0%	0.0%	0.0%
1 with 3	94.1%	0.0%	5.9%
	Disagreement for Insanity		
Judges	Competency	Incompetency	Disagree
1 with 2	40.0%	0.0%	60.0%
1 with 3	76.9%	0.0%	23.1%
1 with 4	83.3%	0.0%	16.7%
2 with 3	66.7%	3.0%	30.3%
2 with 4	66.7%	8.3%	25.0%
3 with 4	88.9%	0.0%	11.1%
OVERALL	71.4%	2.4%	26.2%

themselves, and the diagnosis of mental retardation (Tables 6 and 9).

Race

One extremely important conclusion is that the Mexican-American and Black populations are found to be incompetent significantly more often ($p = .001$) than the Anglo population. The correlation between race and competency decisions (chi square = 15.75; df = 2; $p = .001$) is similar for legal sanity decisions (chi square = 24.2; df = 2; $p = .0001$). Only 7 percent of the persons seen by two psychiatrists as being both competent and sane were Mexican-Americans; whereas nearly 40 percent of persons found by psychiatrists as being incompetent and insane were Mexican-Americans. Similarly, only 12.9 percent of all persons seen and found to be both competent and sane were Black; whereas 16.6 percent of persons found to be insane and incompetent were Black. Together the Mexican-Americans and Blacks made up 56.6 percent of the incompetent and insane population.

This is in stark contrast to the fact that of persons recommended by the courts to undergo competency and sanity examinations 71.3 percent were Anglos, 15.7 percent are Mexican-Americans, 11.1 percent are Black, and 1.4 percent are other than the above.

An average of 7.8 percent of the persons found incompetent were Anglos, while nearly 20.6 percent were

Table 9. Competency to stand trial, legal sanity, and mental retardation findings: Interjudge reliability and the impact of mental retardation upon decisions.

	Competency To Stand Trial Decisions Mentally Retarded and						Legal Sanity Decisions Mentally Retarded and					
	Incompetent		Competent		Disagree		Incompetent		Competent		Disagree	
Judges	Both	v. One	Both	v. One	Both	v. One	Both	v. One	Both	v. One	Both	v. One
1 with 2	2	1	0	1	0	1	4	1	0	0	0	1
1 with 3	3	1	0	1	1	2	5	1	0	0	0	1
2 with 3	1	0	0	0	0	1	1	1	0	0	0	1
2 with 4	1	0	0	0	1	0	2	0	0	0	0	0
1 with 4	7	2	0	2	2	5	12	3	0	0	0	3

7 of 36 found in disagreement by the judges were considered mentally retarded, or 19.44%.
9 of 22 who are found incompetent by both judges were considered mentally retarded, or 40.91%.
15 of 50 who are found insane by both judges were considered mentally retarded, or 30.00%.
9 or 18 cases in which mental retardation reliably agreed upon by both judges, or 50.00%.

Mexican-Americans, and 12.5 percent Blacks. This means that although 15.7 percent of the population is Mexican-American, over 20 percent of them were found to be incompetent.

The same result is evident in legal sanity decisions with Anglos being lower in insanity recommendations (21.4 percent) and Mexican-Americans (32.5 percent) and Blacks (21.4 percent) being found insane in higher proportions than their representation in the population. In making legal sanity decisions, psychiatrists had a great deal of difficulty agreeing for Mexican-Americans (they disagreed 50 percent of the time) and generally had more trouble agreeing here than they did with competency decisions.

Crime

The relationship between seriousness of crime charged with and competency or sanity decisions is also significant (chi square = 83.62; df = 11; p = .0001) for competency decisions and for sanity decisions (chi square = 62.96; df = 11; p = .0001). There are no persons found incompetent for extremely "serious" crimes such as murder, rape, or murder 2; while over 20 percent of the persons charged with "minor" crimes such as bigamy, indecent exposure, trespassing, disorderly conduct, malicious mischief, etc., are found incompetent; over 25 percent are found incompetent when charged with crimes such as grand theft, battery, conspiracy,

obstruction of justice, burglary 2, etc., which are considered to be "intermediate." See Tables 10 and 11 for a description of the various crimes defendants were accused of as broken down into their seriousness by the Pima County attorneys who prosecute the defendants.

Interestingly, the rate of agreement became higher as the crimes defendants were accused of were more serious in nature. Overall, for competency evaluations the more serious the nature of the charge against the defendant, the higher the probability the defendant will be found competent to stand trial; the lower the rate of seriousness of crime the lower the probability that the defendant will be found competent to stand trial.

A similar correlational relationship exists between the evaluation of legal sanity and the nature of the crime alleged. Nearly 37 percent of persons charged with very minor charges such as bigamy, throwing objects at a vehicle, malicious mischief, indecent exposure, etc., are found insane, while only 4.8 percent of those charged with murder are found legally insane. As with competency, the correlation between legal sanity and the nature of the crime is such that when a person is accused of a major felony the probability that he will be found sane increases; while on the other hand, when an individual is accused of a minor crime he is

Table 10. Magnitude or seriousness of crime alleged.

Category	Crime	Magnitude Estimate
I	Murder, first degree	999
II	Murder, second degree	902
	Kidnapping, w/serious bodily harm	899
	Armed rape	897
	Rape, first degree	890
	Armed kidnapping	858
	Kidnapping for robbery, or rape	853
III	Assault w/intent to murder or rape	850
	Armed voluntary manslaughter	845
	Sex assault	840
	Child molestation	800
	Armed robbery	797
IV	Assault w/a deadly weapon (AWDW)	703
	Armed burglary	697
	Arson, first degree	688
	Heroin sales	644
	Possession of heroin, large amount	635
	Armed aggravated assault/battery	608
	Sodomy	603
	Involuntary manslaughter	513
V	Robbery	508
	Lewd and lascivious behavior	501
	Narcotic/syn-narcotic sales	500
	Burglary I	494
	Selling/possessing cocaine	493
	Vehicular manslaughter	492
VI	Possession of a deadly weapon, w/intent to harm	381
	Selling marijuana to a minor	360
	Selling/possessing marijuana, large amount	350
	Extortion	309
	Arson, second to fourth degree	308
	Rape, second degree	306
	Conspiracy I	300
	Possession of a weapon by a criminal	290
	Burglary II	280

Table 10--Continued

Category	Crime	Magnitude Estimate
VI	Possession heroin, cocaine; small amount	257
	Grand theft	250
	Aggravated assault/battery	250
	Obstruction of justice, contempt of court	220
	Committing a felony while on bond	217
	Mask crime	210
	Unlawful use of deadly weapon	204
	Exhibiting a deadly weapon not in defense	202
	Conspiracy II	200
	Fraud	192
	Possession of a lost/mislaid credit card	190
	Perjury	180
	Unlawful use of telephone	150
	Concealing or receiving stolen property	110
	Forgery of a credit card	105
	Forgery	103
	Driving while under the influence of alcohol (DWI)	103
	Possession of forged checks	101
	Theft of a motor vehicle	100
	Possession of stolen vehicle (joy riding)	99
VII	Larceny	95
	Drawing checks on insufficient funds	93
	Disorderly conduct	90
	Leaving the scene of accident w/damage	80
	Maliscious mischief	70
	Throwing objects at vehicles	70
	Indecent exposure	60
	Trespassing	50
	Possession small amounts of dangerous drugs	50
	Prostitution	10
	Bigamy	5

Table 11. Codes for categories.

Category Label	Frequency	Category Definition
Education:		
1	89	0-6th grade
2	41	7-9th grade
3	38	10-11th grade
4	40	12th grade
5	15	above 12th grade
Age:		
1	12	0-16 years
2	43	17-21 years
3	40	22-25 years
4	49	26-30 years
5	31	31-35 years
6	27	36-50 years
7	21	51+ years
Crime:		
1	29	0-200
2	32	201-480
3	34	481-510
4	36	511-750
5	46	751-850
6	25	851-950
7	21	951-999
Psychiatrist Pairs:		
0	19	Psych. 3 and 4
1	41	Psych. 2 and 4
2	79	Psych. 2 and 3
3	21	Psych. 1 and 4
4	32	Psych. 1 and 3
5	22	Psych. 1 and 2

more likely to be found insane. The rate of disagreement drops off when the charge is extremely serious.

Psychiatrist Pairs

The impact of psychiatrist pairs upon the competency and sanity decisions demonstrates with significance for competency (chi square = 52.06; df = 10; p = .0001) and for sanity (chi square = 75.9; df = 10; p = .0001) that a correlation exists between those psychiatrists performing the evaluation and the evaluation outcome (Table 6). If psychiatrists 1 and 2 are evaluating a defendant, the probability is that 50 percent of the time the defendant will be found competent, while 27 percent of the time the defendant will be found sane. This is the lowest probability among the psychiatrist pairs.

On the other hand, if psychiatrists 3 and 4 evaluate a defendant, the probability is that 86.4 percent of the time he will be found competent, and 45.5 percent of the time he will be found sane. These are the highest probabilities among the psychiatrist pairs. Again, these results are subject to contamination by sampling error.

Sex

The sex of the defendant appears to have little or no influence upon the competency to stand trial decisions

(chi square = 2.17; df = 1; p = .51). While 10 percent of the males examined for competency are found incompetent, 13.3 percent of the females are found incompetent. However, for sanity decisions, there is a divergence of significance (chi square = 22.4; df = 1; p = .001), suggesting that sex of the defendant does influence the psychiatrists in their sanity recommendations (Table 6). Whereas 22.5 percent of the males are found insane, nearly 40 percent of the females are determined to be insane. Also, while only 4.7 percent of the persons found competent and sane are females; nearly 17 percent of persons found competent and insane are females. Results regarding sex and psychiatrist decisions involve a population in which 92.6 percent are females.

Impact of Competency upon Sanity Decisions

Table 7 provides information about the impact of competency decisions upon the sanity decisions. For example, if psychiatrists 1 and 2 are evaluating a defendant and they conclude that the person is incompetent, then they will decide for insanity 100 percent of the time. If they find the person is competent, then 54.5 percent of the time they will find for sanity, 27.3 percent of the time they will conclude the person is insane, and 18.2 percent of the time psychiatrists 1 and 2 will not agree on sanity.

Overall, psychiatrists, if determining a defendant is incompetent, will also find a defendant insane 91.3

percent of the time and disagree 8.7 percent of the time; while if they determine the defendant is competent, they find for insanity 12.2 percent of the time, sanity 51.6 percent, and disagree 36.2 percent. Finally, if psychiatrists are unable to agree as to competency, they will find for sanity only 3.9 percent of the time, insanity 34.3 percent of the time, and disagree 61.8 percent of the time regarding sanity.

Mental Retardation Diagnosis and Competency and Sanity Decisions

In Table 6 the correlation between a diagnosis of mentally retarded and incompetence to stand trial is highly significant (chi square = 647; df = 5; p = .0001). No defendants found to be mentally retarded by the psychiatrists are also found as competent to stand trial. Of those defendants found to be incompetent to stand trial, 40.91 percent are diagnosed as mentally retarded. Psychiatrists have difficulty in agreeing on a diagnosis of mental retardation, and in 22.2 percent of the cases psychiatrists did disagree (e.g., where one psychiatrist diagnosed as mentally retarded and the other did not). This figure is higher than the disagreement rate for the non-mentally retarded population (15.4 percent). There exist 9 cases of mentally retarded and incompetent to stand trial defendants in the population under study (Table 9).

The correlation between diagnosis of mentally retarded and legal insanity is also high significant (chi square = 480; df = 5; p = .0001). There is no disagreement. All persons considered to be mentally retarded are found legally insane. These terms are considered synonomous by the psychiatrists. This is in contrast to the nearly 40 percent usual disagreement rate for insanity decisions by psychiatrists for non-mentally retarded persons under study (Table 6).

CHAPTER IV

DISCUSSION

Reliability of Psychiatrists' Forensic Decisions

Since no studies exist that have investigated inter-clinician agreement on determination of competency and sanity recommendations, the results of 30 years of intensive research (see page 12) into the reliability of psychiatric diagnosis can serve as a context in which to understand these results. Using the Diagnostic and Statistical Manual of Mental Illnesses (1968), trained psychiatrists and psychologists will agree with each other on a diagnosis approximately 66 percent of the time when diagnosing broad, unrefined categories such as neurosis vs. psychosis vs. personality disorders. Reliability diminishes to a rate of 33 percent, however, as one proceeds to more specific class categories such as the types of neurosis (Ziskin, 1970). Placed in this context, the reliability of psychiatrists' competency decisions is relatively high at 83 percent. Psychiatrists' legal sanity decisions reflect a reliability rate (64 percent) typical of psychiatrists' diagnosing broad categories of mental illness.

For competency decisions it appears that psychiatrists have come a long way from the time they were first

criticized by Hess and Thomas (1963) for failure to recognize the court-defined criteria for competency. Psychiatrists' unreliability for competency evaluations could be due to court matching of a greenlighter with a guardian, but the four sources of legal sanity disagreement (given below) are also applicable here.

The issue of legal sanity refers to the defendant's mental state at the time of the alleged crime he is accused of committing. The courts are asking psychiatrists to go back in time to the moment of the alleged offense and decide whether the defendant was at that moment in a position to know legally what he was doing. This is nearly impossible (Ennis and Litwack, 1974). Information about legal sanity is utilized by the defendant's attorney as a trial defense maneuver to reduce the charges, or obtain a not guilty by reason of insanity disposition.

For legal sanity recommendations, the major sources of disagreement found in this study are probably due to (1) a lack of actual concrete criteria for determining legal sanity in defendants, (2) an ambiguity among psychiatrists in interpreting the criteria, (3) a lack of available information concerning defendants, or (4) a possible sampling error (see below). It is entirely understandable that the criteria for legal insanity remains unclear, and personal orientations or psychiatrists prevail creating unreliability

in their decisions. Still, this unreliability might well be explained by methodological errors.

Methodological Sampling Error

This research represents an attempt to determine how well the appraisals of independent clinicians agree. In carrying out this research it is necessary to give up a certain amount of experimental control. As a consequence, the reliability rates of psychiatrists doing evaluations for the Pima County Superior Courts must be analyzed by taking into consideration the fact that psychiatrists (or psychiatrist pairs) do not receive their assigned cases in a random fashion from the Courts.

One possible explanation for the lack of random assignment of court referred defendants is that judges prefer certain psychiatrists over others. Since psychiatrists are chosen by a judge using two lists of recommendations supplied by the attorneys, it is this researcher's view that the lack of randomization is due to the attorney's attempt to cause a judge to choose the psychiatrist most sympathetic to his defendant's interests. It is possible that lawyers seeking to have certain types of individual defendants referred to special psychiatrists will create a situation in which each psychiatrist pair evaluates a different type of defendant. For example, certain psychiatrists whom lawyers view as greenlighter could receive the most severely retarded

defendants because both the prosecutor and defense lawyer recognize these persons are incompetent, whereas those defendants seen as borderline incompetent could be sent to a psychiatrist pair representing a greenlighter and a guardian. The danger then exists that the population of persons examined by each psychiatrist pair is different from that population examined by every other psychiatrist pair.

In this study, psychiatrist 2, who seems to switch from a greenlighter to a guardian style and vice versa, receives the most court referrals (143), while psychiatrist 3, considered a greenlighter in both competency and sanity decisions, receives the next highest number of referrals (136). Psychiatrist 1, on the other hand, receives the lowest number of referrals (77) and acts as a guardian in both competency and sanity decisions, and psychiatrist 4 (who received 85 referrals) acts as a guardian with competency decisions and a greenlighter regarding sanity decisions (see Table 4).

This study is not able to determine whether disagreements in the rates of reliability between psychiatrist pairs, or differences in the percentages of those found competent between psychiatrist pairs is due to a variation in the type of defendants referred to each psychiatrist pair. For example, a defendant characterized as being "neurotic" may be more often sent to psychiatrist pair 1 and 2, while a more

psychotic, or mentally retarded defendant may be sent to psychiatrist pair 2 and 3.

It is not clear whether the attorneys are aware of the psychiatrists' sympathies. This is especially true with the defense lawyers who, unlike the county attorneys, are not in a position to call for competency or sanity examinations as often since they do not handle as many cases, and are therefore less familiar with the psychiatrists' past records. The data do show that psychiatrist 3, a greenlighter or friend of the prosecutor most of the time, is called upon more often than psychiatrist 1, or guardian (in sympathy with the defense lawyer). However, defense attorneys are often from the public defender's office and, therefore, in handling many competency motions would soon become aware of which psychiatrists are their "friends."

A second methodological sampling error concerns the psychiatrists themselves rather than the defendants they examine. A way to avoid the problems of randomization is to create more categories in order to equalize the distribution of subjects. In this study there are only four psychiatrists. This is because in Pima County these four psychiatrists handled 95 percent of the court referrals for competency and sanity evaluations. These four psychiatrists make up six psychiatric pairings. The fact that only six

psychiatric pairs exist makes it difficult to generalize these results with certainty.

Competency and Sanity Decisions: Overuse by Courts

The overuse of competency to stand trial examinations by courts is supported by the data which confirm that only 11.77 percent of the time a defendant referred for competency evaluation will be labelled incompetent. Fears that psychiatrists are wasting their time and energy in competency evaluations which do not serve the mental health of these defendants are warranted. The use of competency evaluations has been steadily increasing throughout this country and represents a substantial cost in terms of professional time.

A review of studies by Roesch and Golding (1977) reporting base rates of incompetence determinations for hospitalized diagnostic assessments of competency suggest that Pima County's non-hospitalized diagnostic assessment of competency attracts a higher rate of frivolous competency referrals by the Courts. For example, whereas Pima County competency assessment procedure determines only 11.7 percent of persons referred to be incompetent, McGarry (1973) reported that at Bridgewater Hospital in Massachusetts in 1963, 22.2 percent were found incompetent. Vann (1965) reports a higher rate of incompetency in New York State where

a total of 41 incompetent determinations resulted from 83 referrals. In a study at the Dix Hospital in North Carolina, Laczko, James and Alltop (1970) report that 23.9 percent of evaluations for competency resulted in determinations for incompetency. The Gold study (1973) of competency evaluations conducted in Connecticut determined that 50 percent of the competency referrals were committed as incompetent, after evaluation at the hospital. Finally, Roesch and Golding (1977) report that Pfeiffer, Eisenstein and Dabbs (1967) completed a study of federal competency evaluations at the U. S. Public Health Service Hospital in Lexington, Kentucky, and found that 38 percent of the defendants were considered to be incompetent.

Although the number of defendants found incompetent will vary from location to location, depending upon admission practices, legal guidelines, etc., it appears that one conclusion can be made. The greatest danger in employing an outpatient oriented competency assessment is the risk that courts will overuse this procedure because it is quicker and less intrusive into the lives of the defendants. The ease in which competency evaluation procedures are overused by legal officials for diversionary purposes ought to be identified and limited, without returning to the in-hospital based competency examination. The burden is on both the mental health community to create more effective and valid

screening instruments to screen out the obviously competent, and the legal community to build in punishments for wasteful and costly competency referrals.

Selected Variables' Impact upon Competency and Sanity Decisions

Psychiatrist Pairs

Assuming that the sampling error, e.g., the lack of randomization, is due purely to chance factors, and that psychiatrists are aware of who the other examiner is, it is possible to speculate that psychiatrists are influenced in their forensic decisions by knowledge of the psychiatrist they are paired with. For example, if psychiatrist 1 is paired with psychiatrist 3, and if psychiatrist 3 knows that psychiatrist 1 has a reputation for being a guardian, this information could have an effect upon psychiatrist 3 so that he lowers his overall ocm competency recommendation criteria and finds nearly 15 percent fewer people incompetent than he normally does (see Table 12). Data are far from conclusive as to whether it is the knowledge of the paired psychiatrist which causes the competency percentage to drop or whether it is a reflection of the lack of randomization of subjects to psychiatrist pairs. Yet, it is understandable that psychiatrists familiar with each other's reputations might adjust their own criteria to insure a higher reliability rate. No psychiatrist likes to have to appear in court to defend a

Table 12. Probability of individual psychiatrists finding for competency and sanity: Overall and in relation to fellow psychiatrists.

Judges	Competency to Stand Trial Percentages[a]					Legal Sanity Percentages[b]				
	Overall	1	2	3	4	Overall	1	2	3	4
1 with	70.13		54.5	69.3	86.4	28.57		27.3	24.2	36.4
2 with	78.32	72.7		79.0	78.0	51.75	50.0		51.8	52.5
3 with	90.44	75.7	93.9		95.5	80.60	67.7	83.9		86.4
4 with	87.06	90.9	85.3	86.4		68.35	90.5	64.1	52.6	

[a] 1 Chi Square = 7.65; p = .03
2 Chi Square = .41; p = .84
3 Chi Square = 2.81; p = .25
4 Chi Square = .22; p = .88

[b] 1 Chi Square = 2.87; p = .25
2 Chi Square = .07; p = .96
3 Chi Square = 2.62; p = .27
4 Chi Square = 1.11; p = .0001

competency decision when it is in disagreement with another psychiatrist.

If there is some basis to conclude that the variance in competency percentages between psychiatrists (from 70.13 to 90.44) and sanity percentages (from 28.57 to 80.60) is due to the effects of knowing the other psychiatrist, then being paired with psychiatrist 1 has a significant effect (Table 12). For example, in relation to psychiatrists 2 and 4, psychiatrist 3 maintains his competency percentages at his overall overage. However, in relation to psychiatrist 1, psychiatrist 3 seems to bend his criteria to lower the percentage of defendants found incompetent by him nearly 15 points.

Except when psychiatrist 1 is paired with psychiatrist 4, psychiatrist 1 appears to modify his strong stance, adjusting his criteria for competency to allow 86.4 percent of his cases with psychiatrist 4 to be defined as competent while his overall competency percentage is 70.13, nearly 17 points lower. Psychiatrist 4, when paired with psychiatrist 1, modifies his competency percentage in the opposite direction, finding more competent in spite of the reputation of psychiatrist 1 for being a guardian.

Actually, psychiatrists 2 and 4 vary little relative to fellow psychiatrists 1 and 3. It is possible that

psychiatrists 2 and 4 do not look at the informating citing the other psychiatrist, or perhaps they do not care.

The legal sanity decisions cause problems in agreement between psychiatrists far more often than do competency decisions. Only psychiatrist 2 is uninfluenced by the other psychiatrists. Psychiatrist 4, again, modifies his criteria in the opposite direction from that of psychiatrist 1 who himself modifies his decisions on the sanity issue toward the greenlighter view.

Psychiatrist 3, when paired with psychiatrist 1, changes his criteria for sanity decisions in the direction of psychiatrist 1, a guardian view. Finally, psychiatrist 4 when opposite psychiatrist 3 softens his tough greenlighter stance to accommodate.

Crime

In determining the competency and sanity of a defendant, psychiatrists appear to be influenced by the type of crime and its magnitude. The data results suggest that persons found to be incompetent have a higher probability of being charged with more minor, less serious crimes, while persons judged to be competent are charged with more serious crimes. As with competency, those judged insane appear to be accused of committing less serious crimes, while the sane are accused of committing crimes of violence and other crimes of greater magnitude. Disagreements as to competency

and sanity seem to follow a random pattern with regard to the seriousness of the crime accused.

The results of this study are contradictory to those of Steadman and Braff (1975) who found that violent crimes against persons were highly overrepresented in the incompetent population, whereas crimes such as forgery, drug offenses, and gambling were consistently underrepresented. The conclusion of this study is that psychiatrists view competency-questioned defendants with skepticism. In taking the alleged crime into consideration when deciding upon competency or sanity, psychiatrists may feel that competency and/or sanity referrals are a maneuver by the defense attorney either to delay the trial or lay the foundation for the introduction of mitigating circumstances. As a result, psychiatrists tend to find persons competent and/or sane who they feel stand the most to gain by being found incompetent in order to avoid the legal process, or use mental health as a means to mitigate an expected harsh outcome. Perhaps this is a reaction of the role of psychiatrists as being exploited by defense attorneys seeking to get their client "off" by using mental health professions to defeat the state's interests. Perhaps, too, psychiatrists, by and large, represent in their political and social attitudes the position represented by the prosecutors rather than the defense attorneys.

There is a second issue in the literature regarding the relationship between the charges pending against a defendant and the competency or sanity evaluation. Eisenstat (1968) concludes that the prosecutors misuse the motion for a competency evaluation to circumvent pretrial release or to avoid the more lengthy and difficult trial resulting from an insanity defense, while Cooke, Johnston, and Pogany (1973) report that competency referrals were for the more serious crimes such as homicide, assault, and battery. (Homicide accounted for only 1 percent of the general population arrests, but almost 22 percent of the competency referrals were charged with homicide.) As a result, Cooke et al. (1974) conclude that it is the defense attorneys who overuse the competency examination procedures. Balcanoff and McGarry (1969) using data collected in Massachusetts, concur with the results of Cooke et al. (1974) in showing that most referrals were charged with serious property crimes, murder, and armed robbery. Laczko et al. (1970) also agree with these findings.

This research finds, contrary to the above studies (Table 6), that competency referrals are made irrespective of the nature or seriousness of the crime charged (chi square = 12.34, df = 6, p = .055). These results suggest that there is a difference in the manner of referrals by the courts for competency evaluation when the evaluation facility

is an in-hospital diagnostic assessment, as opposed to an outpatient assessment by independent examiners. Whereas there is dispute in the literature as to whether defense or prosecuting attorneys call for the competency examination if the diagnostic assessment is done in an in-hospital setting, with outpatient evaluation both defense and prosecuting attorneys seek competency referrals equally as often.

Psychosis and Mental Retardation

In both competency and legal sanity evaluations, psychiatrists continue to equate psychosis and/or mental retardation with insanity, and/or incompetency, in spite of the fact that this is not in accord with the legal criteria. According to the results, McGarry's (1965) conclusion that "psychiatrists uniformly viewed psychotics as incompetent to stand trial and criminally irresponsible, reflecting an exclusively medical frame of reference (p. 269)," continues to exist. Part of this confusion has to do with the troublesome possible lack of criteria in defining legal sanity, and the fact that legal sanity and competency evaluations are done at the same time in Arizona.

Race, Education, Age and Sex

The fact that a significant relationship exists between the determination of competency and sanity and such demographic factors as race, sex, age and education reflects

the lack of validity in psychiatric evaluations of forensic issues. Courts must become more wary of psychiatric expertise in these matters and begin to hold psychiatrists more accountable by providing them with a clear statement of the criteria involved to make these decisions.

Summary

In sum, this research is an empirical demonstration that a group of independently practicing psychiatrists can reliably evaluate the competency of defendants to stand trial. Although there exist the research problems of lack of randomization of referrals to psychiatrists, and an extremely small sample of psychiatrists, this researcher concludes that independent examinations undertaken in local communities, outside the institutional setting, should be encouraged. These examinations are reliable without jeopardizing the defendant's due process right to bail and a speedy trial. However, the ease in which competency evaluation procedures creates overuse by their legal officials for diversionary purposes should be limited. Variables such as the crime accused, diagnosis of psychotic, or mentally retarded, and race of the defendant are correlated with psychiatric decisions.

CHAPTER V

RECOMMENDATIONS

The competency to stand trial requirement, initiated to protect the defendant from standing trial while mentally incapacitated, is a part of the "due process" rights afforded to a defendant. Still, a defendant's rights are not safeguarded by a competency to stand trial examination that fails to successfully identify those persons who are incompetent from those who are not. To be effective, the competency examiners must demonstrate that they can validly and reliably predict whether a person can stand trial. Since it is extremely difficult to scientifically prove the validity of competency examiners, researchers have inferred validity by demonstrating the reliability of psychiatrists' decisions.

This research is an empirical demonstration that a group of independent practicing psychiatrists can evaluate the competency to stand trial with "moderate" reliability. It is this researcher's conclusion that independent examinations of competency to stand trial be undertaken rather than in-hospital teamwork decisions. This is because independent evaluations are less costly, a lesser restrictive alternative for the defendant, and achieve "moderate" reliability in competency decisions. The in-hospital psychiatrists'

reliability rate is an artificial indicator, since psychiatrists are able to iron out their disagreements beforehand, and does not provide the defendant with an all-important second opinion.

Independent psychiatrist examiners insure that a defendant will receive a second opinion on this critical matter, without jeopardizing the "due process" rights to bail and speedy trial. Independent private practicing psychiatrists can perform the competency and sanity decisions with the least restrictive intrusion into the life of the defendant. However, according to the data, the use of these examiners does not limit the extent to which competency evaluations are used as a legal tactic by attorneys nor does it lower the cost of examinations for the court.

In fiscal year 1972-73 the Pima County general ledger account number 213 showed that $10,000 had been appropriated to pay psychiatrists for their competency recommendations. Nearly all of the money appropriated $9,565) was spent. In fiscal year 1976-77 Pima County budgeted $17,000 for competency examinations, but as much as $25,674 was spent. In human terms, the fiscal year 1976-77 cost the taxpayers over $25,000 to find that 22 persons were incompetent out of 223 and the rest disagreed as to competence. Further, Pima County's share of the cost of rehabilitating these 22 persons for fiscal year 1976-77

to the state mental hospital was $153,235. Therefore, the County paid out in one year over $175,000 to insure that 22 persons or .06 percent of the entire criminal defendant population of the year were competent to stand trial. Clearly, this is a lot of money for a very small part of the population.

The use of competency examinations by lawyers to serve purposes other than the legitimate interests in competency is a costly problem. Since it is not possible to determine whether it is the prosecutors or the defense attorneys who initiate the competency proceedings, further research is suggested to find out whether the competency to stand trial examination will ultimately help or hurt a criminal defendant. It is expected that being examined for competency to stand trial will have a beneficial impact upon the judge if the defendant is found guilty of the crime. Due to concern as to mental competency, the judge might tend to refer the convicted defendant to an alternative or diversion project rather than send him to jail. On the other hand, with some judges, being examined for competency to stand trial might have the effect of influencing the judge to sentence the convicted defendant to a longer period of time in prison that he might otherwise for fear that a defendant is dangerous. If the research demonstrates that generally it is in the interest of defense lawyers to call for competency

examinations (because the judge most likely will "go easy" on the defendant because there is some doubt as to whether he should have gone to trial), then this could explain the interest in competency exams by defense attorneys. On the other hand, if prosecutors can gain more severe sentencing of defendants who were earlier examined regarding competency, then this could provide some explanation as to their behavior in calling for these exams. In any event, knowledge as to who benefits from the overuse of competency to stand trial examinations will aid social programmers of the criminal justice system to build in incentives or disincentives to limit the abuse of the competency exam in the future.

A second course of action recommended to combat the overuse of competency to stand trial exams by lawyers is to split off the insanity examinations from the competency evaluations. In Arizona, Wexler (1971) recommends such a measure.

> The apparent rationale for requiring these various findings [such as diagnosis, dangerousness, commitability, sanity, competency, etc.] is expediency--giving the defendant a full psychiatric workup on various issues so long as he must be examined for competency. But the problem with this sort of economizing is that factors not at all relevant to the defendant's ability to stand trial may enter into confusion and prejudice the ruling on competency (164-5).

This would have the effect of deterring lawyers from calling for competency examinations if their purpose is really to prepare a legal sanity defense.

A third means of limiting the competency to stand trial examination use is to change the method of selecting psychiatrists to do the exams. Presently psychiatrists are chosen by the judge from two lists of recommended names provided by the defense and prosecutor. Lawyers are extremely familiar with the empirical evidence regarding greenlighter and guardian styles. The use of psychiatrists known to lawyers as greenlighters or guardians is rampant and troublesome. A comment by an assistant county attorney reflects the problem: "Let's face it, what is going on is a shrink supermarket, with each lawyer buying a shrink--they are prostitutes, that's all." A simple solution to this problem would be to randomly select psychiatrists rather than choose them from lists provided by lawyers.

Research following upon the guardian and greenlighter hypothesis, supported by the data, ought to be undertaken on a national or regional scale. In this way, with the use of a larger number of psychiatrists (this data was drawn from only 4 psychiatrists), a more definitive empirical picture will form regarding psychiatrist subjectivity in approaching the task of deciding competency and sanity of the defendant. In fact, a larger sampling of competency examiners should include in addition to psychiatrists experimental use of nonpsychiatrists as examiners. For example, lawyers, social workers and clinical psychologists most

probably will demonstrate equal reliability and validity in these examinations if given the chance. Research into the individual psychiatrist decision-making criteria will be fruitless unless done on a more complex and larger scale, with the use of experimental groups of examiners (i.e., attorneys, clinical psychologists) as experts, too.

Since so many of the defendants recommended for competency examinations are found to be competent to stand trial, a fourth course of action to limit these frivolous requests is to require a full competency examination to be made only after an initial competency screening test. The competency checklist can be administered to screen out those obviously competent from those doubtful. This would have a two-fold effect of cutting down on the use of competency exams by lawyers, and saving the court's money, too.

Ultimately, it would be nice if a competency checklist could be devised which could successfully distinguish competents from incompetents. Further research is recommended to explore the correlations between competency-incompetency decisions and mental retardation, psychosis, race, educational level, and alcoholism. In addition, an incompetency profile, similar to the psychological profiles used to identify skyjackers or shoplifters could be developed for incompetency to stand trial persons, and for those recommended for competency examination. The data

suggest that persons recommended as possibly incompetent and in need of examination are generally young white males, poorly educated charged with all kinds of crimes.

It is recommended that the mental health community, including both researchers and practitioners, work together with legal officials to develop a definite, overt, and clearly operationalized criteria for evaluating competency to stand trial and legal sanity. Perhaps, as Roesch and Golding (1977) suggest, defendants considered to be incompetent under traditional competency examination procedures should be allowed to stand trial while a screening panel continues to monitor their behavior during the trial. This in situ evaluation provides an ideal opportunity to determine just what it is in fact that causes a person to decompensate during the adversarial process. Practically, however, there is serious doubt as to whether the courts would allow such experimental situations to occur in the actual trial itself.

Nevertheless, research can be carried out to determine the extent to which the nature of the criminal charge has an effect upon psychiatrists. Legal information, such as the crime alleged, ought to be withheld from psychiatrists who perform competency examinations. If the criteria for determining mental incompetency involves the defendant's ability to relate to his lawyer, and to understand the

position he is in, and the consequences of being found guilty, then the psychiatrists ought not be influenced by the type of crime the defendant is charged with. After all, the defendant is innocent until proven guilty. On the other hand, information regarding the nature of crime might provide the evaluator with psychiatric insight into the defendant, i.e., when unusual crime is committed.

The legal community could do its part in bringing about a more just and fair competency examination process by defining in behavioral terms why the defendant is not competent to stand trial, or is legally insane. This information would provide mental health examiners, and their screening agents, a clear specific question for evaluation, rather than leaving it entirely to the mental health people to decide.

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