CHAPTER 4

Competency Restoration

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INTRODUCTION

Like many legal concepts, competence to stand trial (CST; see Chapter 1 in this volume) seems reasonably clear in its definition, yet considerably more vague in its application and understanding by the public and by forensic examiners (Gutheil, 1999). As noted by the Supreme Court of the United States in Godinez v. Moran (1993), “while the decision to plead guilty is undeniably a profound one, it is no more complicated than the sum total of decisions that a defendant may be called upon to make during the course of a trial” (p. 398). How, then, when defendants have initially been determined incompetent to stand trial, are they optimally restored to competency?

The answer to this question lies in recognizing and addressing the psychiatric conditions and other personal circumstances underlying this forensic disability. Trial incompetency is strongly associated with psychosis and the presence of more severe psychopathology, including disorientation, hallucinations, impaired memory, and impaired thought and communication (Nicholson & Kugler, 1991). A defendant’s competency may be impaired by other factors, including mental retardation, neurocognitive disorders, the effects of substance abuse, and physical illness. CST is a multidimensional construct, and it varies depending on the content, the person, and the task that is the subject of the evaluation (Freckelton, 2009); defendants
are seldom globally impaired or equally functional across all realms of competence.

Several discrete considerations inform the forensic evaluator’s approach to competency restoration. First, judges typically place a high value on CST assessments. Cruise and Rogers (1998) estimated that the court agreed with clinicians’ conclusions 90% or more of the time. Second, the threshold for competency is low and is constituted of minimal criteria (Wieter v. Settle, 1961). Third, statutory law defines patient competence in terms of an open norm, and the legal, psychological, and ethical literature reveals myriad different, often mutually incompatible definitions, approaches, and criteria. Furthermore, empirical research has shown that in the practice of health care, explicit assessments of patients’ competence are hardly ever made. The meaning of competence to stand trial is generally considered to be contextual; it is often in the eye of the beholder.

Pendleton (1980) concluded that defendants who are committed to psychiatric hospitals for competency restoration after being found incompetent make up the largest group of psychiatric patients who are hospitalized via the criminal justice system. McGarry and Curran (1973) estimated that there were 25,000 to 36,000 such defendants yearly. Winick (1977) concluded that approximately 15,000 criminal defendants were hospitalized at any particular time in the United States after being adjudicated incompetent to stand trial. Steadman, Monahan, Hartstone, Davis, and Robbins (1982) stated that nearly one-third of all admissions of mentally disordered criminal offenders to state and federal mental health facilities are for incompetence to stand trial; this figure translates to approximately 25,000 defendants nationally each year.

Davis (1985) determined that as many as 9,000 inpatient beds were reserved nationwide for individuals who have been adjudicated incompetent to stand trial, with the most common reason for deficits in pretrial competency abilities being psychotic symptoms and mental retardation. Subsequently obtained data showed that in 1986 approximately 3,200 incompetent defendants in the United States were utilizing a forensic mental health bed in one day, and that many more were utilizing other psychiatric resources (Way, Dvoskin, & Steadman, 1991).
Melton, Petrila, Poythress, and Slobogin (2007) describe various research studies indicating that approximately 30% of defendants for a competency evaluation are ultimately deemed incompetent. Of these individuals, psychotic disorders are the most common Axis I diagnosis. Other research indicates that between 45% and 65% of defendants evaluated for competency who have schizophrenia or other psychotic illnesses are found to be incompetent to stand trial (Nicholson & Kugler, 1991; Reich & Wells, 1985; Roesch, Eaves, Sollner, Normandin, & Glackman, 1981; Warren, Fitch, Dietz, & Rosenfeld, 1991).

A MacArthur Foundation Research Network study on Mental Health and the Law (Hoge et al., 1997) concluded that 65% of defendants hospitalized as incompetent to stand trial had a diagnosis of schizophrenia. Goldstein and Burd (1990); Otto et al. (1998); and James, Duffield, Blizard, & Hamilton (2001) likewise concluded that active psychotic symptoms are strongly correlated with impairments in trial-related abilities.

PREPARATION

While the focus of this chapter is on restoration of incompetent defendants to stand trial, we understand that for some defendants the issue is not resurrecting something lost but rather achieving something new. We also recognize that the notion of a surgical separation between competent and noncompetent defendants advanced by evaluators and galvanized by a court’s ruling is more a matter of resolving cognitive dissonance than an accurate reflection of clinical realities. In actuality, there is commonly some type of overlap between these conditions; competency, therefore, in our view, is not an absolute condition.

Competency restoration is not a simple construct. Neither is it a process designed to train a criminal defendant to think or act like a lawyer. Restoration refers to restoration of abilities generally associated with competency to stand trial, following a finding of incompetence.

The individuals assigned to the task of restoring competency to incompetent defendants face a number of challenges from scientific, legal, and mental health forums, and potential countertransference reactions that result from having to weigh pride in
one’s clinical efforts against ethical tensions created from knowing that successful treatment may culminate in the individual’s successful prosecution. Consider as well the ethical conflicts faced by the competency restoration staff regarding how, and in what ways, information could be obtained from a defendant that might not be in the defendant’s best interests.

The goal of restoration of incompetent defendants to stand trial in general terms is to expand and correct the legal knowledge base of defendants, to help defendants manage symptoms of their mental disorder and cognitive impairments, and to educate defendants about the courtroom participants and legal process. Appelbaum (1994) noted that clinicians who provide specific educational training efforts to defendants with mental retardation may feel that they are serving the interests of the criminal justice system rather than those of their patients. His solution to this dilemma is to obtain informed consent from defense attorneys and defendants or their surrogate decision makers before beginning competency training, because “in the absence of consent, rehabilitation aimed at enhancing competence to stand trial introduces risk of further abuse of an already victimized group of people” (pp. 232–324).

**RESEARCH WITH PARTICULAR RELEVANCE TO PREPARATION**

The early literature on forensic hospitals that offered restoration of competency programming for incompetent defendants indicates that the programs, with few exceptions nationwide, offered very little specialized training and used medication treatment as the sole intervention. Only a handful of articles, mostly descriptive in nature, discuss psycholegal programming designed to restore competence in defendants in forensic inpatient settings.

Early research studies examining the effects of competency restoration training were descriptive, with small sample sizes assessed within a relatively short study period; very few individuals were described as successfully restored. McGarry (1969) outlined the pertinent issues related to restoration of competency. McGarry (1971) reported a study of 204 defendants deemed incompetent to stand trial who were committed indefinitely to Bridgewater State Hospital in Massachusetts as of 1963. Steadman’s (1979) monograph described his prospective study of 539 incompetent to stand trial
defendants in New York State. Grisso (1992); Cooper and Grisso (1997); and Mumley, Tillbrook, and Grisso (2003) reviewed evolving studies on competence to stand trial for approximately two decades at 5-year intervals.

Pinals’s (2005) review of research-based and descriptive literature represents a significant contribution to developing a perspective on the history and complexities of competency restoration programming, including programming for mentally retarded defendants and juvenile defendants. Her review considers juvenile defendants, restoration rates, and the effectiveness of competency restoration programs, the latter of which “has often been measured in the literature by an ultimate clinical recommendation to the court that the defendant has regained or attained competence, and/or whether the courts have adjudicated the defendants as competent” (p. 97).

Among the studies reviewed by Pinals (2005) were Pendleton’s (1980) frequently cited research on training-based treatment of persons found incompetent to stand trial that was completed at Atascadero State Hospital; Davis’s (1985) clinical treatise describing a multidisciplinary treatment approach, which prioritized competency restoration for patients whose reason for hospitalization was incompetence to stand trial and focused on cognitive facets of competence and treatment that was tailor-made for specific psychiatric complaints; Brown’s (1992) study of didactic programming taking place 5 days a week for 30- to 40-minute periods and focused on improving functioning related to the criminal justice process; and Noffsinger’s (2001) research on a 40-bed competency restoration unit, consisting of 15 hours of weekly contact with staff, mock trials, videotaped role-playing, and individualized treatment programming. While further details are beyond the scope of this chapter, those preparing to provide restoration services are well advised to seek out this review and also the component studies in their original contexts.

Nelson (1989) evaluated the effects of a one-day didactic workshop on levels of competency based on results of the Competency Screening Test. The study found no statistical differences between pretest and post-test data for the experimental and control groups.

Siegel and Elwork (1990) reported that 21 patients determined incompetent to stand trial were assigned to an experimental group or a control group. Each group received 1 hour of training three times
weekly for 3 weeks. Patients in the experimental group received an admixture of education regarding legal concepts, videotape rehearsals, discussions of the roles of courtroom personnel, mental health treatment, and cognitive–behavioral programming that focused on their particular types of incompetence. The control group received mental health treatment only. More from the experimental treatment group than the standard treatment group were ultimately deemed to be competent.

Siegel and Elwork’s (1990) research also included data from a questionnaire they sent to 128 directors of forensic facilities around the United States, asking them to report on the prevalence of their different approaches to treating incompetence to stand trial. Approximately one-half of the recipients responded. The data indicated that only 43% of the facilities reported that patients adjudicated incompetent to stand trial underwent a different form of treatment from other patients; 57% of the respondents stated that they did not treat these individuals differently from other patients. The responding facilities stated that they placed a stronger emphasis on treating the underlying mental illness than on treating the particular symptoms that legally substantiated incompetence to stand trial.

Miller’s (2003) survey of forensic mental health program directors, while not focusing on programming per se, determined that most restoration of competence to stand trial occurs in inpatient hospital settings within the time period allotted for such restoration and is primarily dictated by statute. This study concluded that incompetent defendants are a prominent fixture within the larger pool of patients admitted to state forensic mental health hospitals.

Anderson and Hewitt (2002) investigated the reevaluations of CST of 75 criminal defendants with mental retardation who were originally found incompetent and who were referred for treatment and the effect of competency restoration training. The defendants were administered the CST Education Program (Fritsch & Moseley, 1982), an educational program consisting of a series of seven 1-hour classes composed of 4 to 10 defendants led primarily by social workers; however, the qualifications of the individuals leading the program varied according to the facility. The participants were administered a pretest consisting of 21 true/false questions to assess their knowledge of legal issues. The investigation concluded that, for the most
part, competency training for defendants with mental retardation was questionably effective. The investigation also concluded that higher intelligence quotient (IQ) and being African American rather than Caucasian were predictive of restoration.

Bertsch, Younglove, and Kerr (2002), in response to a California statute, conducted a limited evaluation of the Porterville, California, Developmental Center Court Competency Training program. The participants in the program were developmentally delayed criminal defendants who were not mentally ill.

Results showed that individuals who were adjudged as incompetent to stand trial due to developmental disability and enrolled for 6 months in the training program demonstrated significant gain in Competency Assessment Instrument (CAI) score. The same gain was not evidenced by developmentally delayed Porterville residents who were not criminal defendants and not enrolled in the training program.

Bertman (2003) utilized a random/matched assessment research design to assign individuals to one of three treatment programs for restoration of competency. Group 1 \((n = 8)\) received weekly 45-minute group legal concept sessions for four weeks. Group 2 \((n = 10)\) received six weekly 45-minute sessions that focused on deficit remediation and legal rights education using a Legal Rights Study Guide Protocol in addition to four weekly 45-minute group sessions. Group 3 \((n = 8)\) received four weekly 45-minute group sessions in addition to six individual sessions that focused on cognitive impairments specific to each group member. Bertman reported that there were no significant baseline differences among the groups, and concluded that all groups differed significantly on competency measures obtained before and after testing, and that the deficit-focused remediation and the legal rights education groups (Groups 2 and 3) demonstrated significantly higher posttreatment scores on competency compared to the standard hospital treatment group (Group 1). The deficit-focused remediation and legal rights group (Group 2) also demonstrated approximately 50% greater improvement on the competency measures than the standard hospital treatment group (Group 1), indicating that education on legal rights issue was a valuable undertaking in this regard. This study did not make clear whether the positive results of Group 3 were due to the nature of the treatment or to the greater number of treatment sessions.
Wall, Krupp, and Guilmette (2003) developed and implemented a formal training tool, the Slater Method, for restoration of competency in clients with mental retardation who were judged to be incompetent to stand trial. The Slater Method was designed to consider the needs of a population otherwise ignored or not explicitly addressed by competency restoration programs, and assesses certain capacities related to competence to stand trial. It was not designed to be a formal competency assessment instrument, but rather a detailed training program using various strategies to improve the organizational and cognitive skills of mentally retarded defendants so that they may return to the criminal justice system and have their charges adjudicated. The Slater Method is based on four areas: the teaching ability of the trainer, the content of the material to be presented to the defendant, the manner in which the material is presented, and the usefulness to legal counsel of restoration methods.

Schouten (2003), in a commentary on the Slater Method, raises the reasonable concern that defendants whose participation in the program may attain the “technical standard for competence to stand trial (CST) without developing the level of understanding necessary to be an informed participant in the trial process” (p. 202). He questioned whether the Slater Method can properly prepare a mentally retarded defendant to withstand a typical prosecutor’s scrutiny, and whether “such training results in technical fulfillment of a legal definition but a failure of justice” (p. 204).

Mueller (2004) surveyed 151 state hospitals listed by the National Association of State Mental Health Program Directors regarding incompetent defendants in forensic mental health beds. Seventy-five out of 94 hospitals reported that they work with clients who are incompetent to stand trial. A majority of the responding programs used medication treatment. However, 88% reported using some type of didactic or psychoeducational group intervention for competency restoration; 41% stated that they utilized competency restoration manuals; and 67% stated that their staff participated in competency training.

Mueller and Wylie (2007) evaluated the effectiveness of the “Fitness Game” (Cuneo & Owen, 1990), a board game used to teach individuals about the legal system according to the eight criteria for competency outlined by Wieter v. Settle (1961). Research participants
consisted of 38 individuals admitted to the Hawaii State Hospital between August 2002 and May 2003 who met a number of criteria, including incompetence to stand trial. The participants were randomly assigned to a competency restoration group \((n = 21)\) and a control group \((n = 17)\). The competency restoration group was exposed to the Fitness Game, while the control group engaged in a different measure that focused on generally healthy behaviors. Results identified that both groups demonstrated significant pretest to posttest improvements, calling the isolated effectiveness of the Fitness Game into question.

Schwalbe and Medalia (2007) identified psychopathology, demographics, and degree of cognitive impairment as the three ways in which competent and incompetent defendants were seen to differ. Hubbard, Zapf, and Ronan (2003) examined the competency evaluation reports of 468 defendants evaluated for CST. Incompetent defendants significantly differed from competent defendants with regard to age, employment status, ethnicity, criminal charges, and psychiatric diagnosis. This study also concluded that few significant differences existed between defendants predicted to be restorable and those predicted not to be restorable by mental health examiners.

After analyzing a sample of 351 inpatient pretrial defendants who underwent competency restoration at a state psychiatric hospital from 1995 to 1999, Mossman et al. (2007) concluded that a reduced probability of restoration was associated with nine variables: misdemeanor charge; longer cumulative length of hospitalization intended to restore competency; number of previous admissions to state hospitals; non–African American ethnicity; substance abuse; mental retardation; schizophrenia and schizoaffective disorder diagnoses; older age; and diagnoses of mental retardation. The research concluded that the overall rate of successful restoration for felony defendants was 75%. The study also concluded that there were two types of incompetent evaluatees who had well below average probabilities of being restored: chronically psychotic defendants with histories of lengthy inpatient hospitalizations, and defendants whose incompetence was the result of mental retardation and other cognitive disorders not subject to remediation.

Morris and Parker (2008) reviewed a database of defendants in Indiana State Hospitals who participated in restoration of competence between 1988 and 2005. Analysis of 1,475 restoration of
competence admissions identified that there was an increase in annual admissions over the study period, that the forensic units restored a higher percentage of individuals compared to non-forensic Indiana State Hospitals, and that the percentage of defendants successfully restored to competence decreased over time in all hospitals. The authors concluded that factors associated with an increased likelihood of successful restoration to competence included admission to the forensic hospital, female gender, and mood disorder diagnosis, whereas older age, mental retardation, and psychotic disorder diagnosis were associated with decreased likelihood of restoration.

HOPEs FOR AN EVOLVING STANDARD OF PRACTICE

We would be remiss in failing to acknowledge that one can by no means simply assume the existence a uniformly observed standard of practice in the area of competency restoration. Our own pilot research study may be illustrative in this regard. It is our sincere hope that the standard of practice soon exceeds what we found reflected in the following results.

From 2003 to 2004, we contacted by mail 27 programs from various locations in the United States that were identified by a forensic state hospital database as administering competency restoration programming to criminal defendants. Eleven programs agreed to participate in a telephone interview. The questions we posed were developed by reviewing the literature on competency and competency restoration drawn from a computerized MEDLINE literature search that identified approximately 400 articles under the heading "competency."

Our interviews revealed the following: 78% of the individuals attending competency restoration programming were returned to court as competent within 3 months; 20% were returned as competent from 3 to 12 months; and 2% remained at the hospital for more than 1 year. The programs could not provide an opinion regarding the average number of sessions an individual attended before competency was restored. The respondents were unable to state whether an individual or group treatment format was more productive. The respondents were also unable to conclude which kinds of patients benefited from each type of mental health treatment approach.
The clinicians who administered the competency restoration programming, with two exceptions, did not receive competency restoration training. The two programs that provided training to staff who led the restoration of competency classes did so through workshops and educational handouts. The remaining nine programs used word-of-mouth as the means of educating their staff. Nine of the 11 programs stated that the competency restoration staff’s work was not videotaped, observed, or routinely supervised.

All 11 programs reported that judges agreed with their recommendations 90% of the time. The programs stated that judges appear to rely solely upon their reports. The programs did not have a consensus regarding how best to predict which of their patients could be successfully restored.

We asked the programs to describe specific aspects of their restoration of competency programming. Two programs were described as well-organized with ongoing research, whereas the remaining nine programs characterized themselves as not having a set time for the restoration programming to occur. The two programs that described themselves as “more organized” distributed instructional handouts on a regular basis. Three of the 11 programs utilized a competency evaluation instrument. Three of the 11 programs consulted with their patients’ attorneys; however, all programs stated that it would be of “great importance” for them to talk with their patients’ attorneys.

Nine of the 11 programs indicated that a majority of staff who administer competency restoration training do not do so on an assigned daily basis. This meant that a staff member who leads a group one day would not likely lead the group the next day. Finally, 9 of the 11 programs relied entirely or significantly upon psychological and cognitive testing results as the basis for determining competency status, rather than on the results of competency assessment instruments administered (Borum and Grisso, 1995).

DATA COLLECTION

STANDARDIZED COMPETENCY TESTS

Supplementing appropriately structured clinical and forensic interviews, there are number of standardized competency assessment measures—for additional details, see Chapter 1 in this volume—that
objectively measure a defendant’s potentially restored abilities in this regard. Most of these instruments can be administered within 45 minutes to 1 hour. Of the measures described in detail in Grisso’s (2003) review, we recommend the following for use in restoration evaluations.

2. Evaluation of Competency to Stand Trial—Revised (ECST-R; Rogers, Tillbrook, & Sewell, 2004).
3. Fitness Interview Test—Revised (FIT-R; Roesch, Zapf, Eaves, & Webster, 1998).
5. Competency Screening Test (CST; Laboratory of Community Psychiatry, 1973).
6. Georgia Court Competency Test (GCCT; Wildman et al., 1978).
7. Competency Assessment to Stand Trial for Defendants With Mental Retardation (CAST-MR; Everington & Luckasson, 1992).

DATA INTERPRETATION

RESEARCH-BASED CONSIDERATIONS

A review of core literature concerning competency restoration (Anderson & Hewitt, 2002; Bertman 2003; Davis, 1985; Hubbard et al., 2003; Morris, 2009; Mueller & Wylie, 2007; Pendleton, 1980; Rogers, Gillis, McMain, & Dickens, 1988; Siegel & Elwork, 1990; Wall, Krupp, & Guilmette, 2003) identifies the following findings with relevance to interpreting—particularly in regard to prognosis—data collected in this context.

1. Overall, 80% to 90% of defendants with mental illness can be restored to competence, typically within a period of less than 6 months.
2. Across the nation, competency restoration programs apply a plethora of competency restoration training techniques. It appears that most do not utilize standardized competency
assessment instruments to evaluate pre- and postlearning status; nor do they educate hospital staff using standardized protocols.

3. Sample sizes evaluated for competency restoration research are typically small, and their results are not easily generalized.

4. Few studies specifically focus on CST in elderly and demented defendants. There are fewer still studies on juveniles (Viljoen and Grisso, 2007; Grisso, 1998; Grisso, 2003).

5. Studies describing competency restoration programs frequently neglect to describe both medication and nonmedication aspects of treatment, despite their often simultaneous utilization.

6. The success rates of competency restoration for defendants with mental retardation are low, with only one-third to one-half being able to attain competency, and when competency is achieved, this takes longer to realize than for other individuals.

7. There are as yet no clearly established means to predict with accuracy which competency restoration candidates are restorable and which are not.

8. Defendants with psychotic disorders and nonpsychotic major disorders are more likely to be judged incompetent, while incompetent defendants with a diagnosis of nonpsychotic minor disorders are more likely to be predicted restorable.

9. Incompetent defendants are less likely to be diagnosed with a personality disorder than are competent defendants.

**COMMUNICATION**

**Conveying Appropriate Procedures**

When communicating the results of attempts to restore pretrial defendants to competency, it is worthwhile to (1) reflect on the following notions; (2) determine the extent to which the notions are reflected in the reports and testimony that resulted in an initial adjudication of incompetency; and (3) be prepared to describe how these notions informed one’s own forensic work product.

- *Assessment.* Were standardized, objective assessment of competency instruments administered to all participants prior to and at the conclusion of restoration of competency programming?
• **Programming.** Was restoration of competency programming multimodal, including a combination of group and individual mental health treatment, medication treatment when indicated, legal concept education, cognitive rehabilitation, role playing, and participation in mock courtroom competency proceedings?

• **Staffing.** Were specific staff assigned, educated, and supervised in providing restoration of competency programming?

• **Ethics.** Were ethical issues related to restoration of competency a component of staff training?

• **Remediation.** Neuropsychological deficits inherent to major psychiatric disorders compromise an individual’s ability to understand and recall information necessary to be found competent. Studies have identified a relationship between cognitive deficits and incompetency and nonrestorability (Schwalbe & Medalia, 2007). There is a body of research literature supporting the conclusion that cognitive deficits of psychotic patients, a group most likely to be refractive to restoration of competency, can be treated with cognitive remediation. Was this type of intervention utilized?

**REFERENCES**


Wildman, R. W., Batchelor, E. S., Thompson, L., Nelson, F. R., Moore, J. T., Patterson, M. E., & deLaosa, M. (1978). The Georgia Court Competency Test: An attempt to develop a rapid, quantitative measure of fitness for trial. Unpublished manuscript, Forensic Services Division, Central State Hospital, Milledgeville, GA.