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Int J Offender Ther Comp Criminol 2001 45: 356
DOI: 10.1177/0306624X01453007

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What is This?
Restoration to Competency
Practice Guidelines

Stephen G. Noffsinger

Abstract: Courts frequently adjudicate criminal defendants as incompetent to stand trial and order defendants to psychiatric hospitals for treatment and education designed to restore the defendant to competence. However, little information is available on effective restoration to competency techniques. This article summarizes the existing literature on restoration to competency programs, describes a competency restoration program at one Ohio hospital, and offers basic restoration to competency practice guidelines that may be applied to any facility performing competency restoration.

In 1960, the U.S. Supreme Court articulated the legal standard for competence to stand trial in the landmark mental health case Dusky v. United States. The Supreme Court said the proper standard for determining competence to stand trial is “whether the defendant has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding, and whether he (the defendant) has a rational as well as factual understanding of the proceedings against him.”

From 25,000 to 36,000 competence-to-stand-trial evaluations are performed annually in the United States, resulting in approximately 9,000 defendants’ being adjudicated by criminal courts as incompetent to stand trial (McGarry, 1973). The vast majority of those criminal defendants found incompetent are court-ordered into psychiatric hospitals for treatment and education designed to restore them to competence, so that they may proceed to trial at a later date. Approximately 15,000 criminal defendants are hospitalized at any given time in the United States after being adjudicated incompetent to stand trial (Winnick, 1977). Most of these defendants are incompetent due to psychotic disorders and/or mental retardation, with a smaller number incompetent due to mood disorders.

The U.S. Supreme Court ruled in 1972 (12 years after Dusky v. United States) in the case of Jackson v. Indiana that indefinite commitment for competency restoration was a violation of due process and allowed confinement to determine whether the defendant was restorable to competence only for a reasonable period of time. The Jackson v. Indiana ruling put pressure on forensic hospitals to develop efficient and effective programs for competency restoration to be compliant with the limited time frames for restoration to competency.

Restoration to competence to stand trial usually involves two simultaneous processes. First, the underlying mental disorder must be treated. This, in itself, is
no different from treating mental disorders in nonforensic patients and involves accurate assessment, medication treatment of severe mental disorders, and psychosocial rehabilitation. Second, incompetent defendants may need instruction to teach them legal concepts and details of the trial process. This educational process may be problematic in that defendants with mental retardation often have difficulty learning and retaining new information. Persons with schizophrenia may have cognitive impairment accompanying their psychotic symptoms, which may impair the educational component of competency restoration.

LITERATURE REVIEW

There is a large body of literature dealing with the topic of competency in the generic sense as well as procedures for evaluating competence to stand trial. However, there is a striking paucity of information dealing en point with the issue of restoring competence to stand trial. This may be due to the fact that the major clinical issues in competency restoration can be subsumed under other areas. For example, articles dealing with medication treatment of major mental illnesses would apply to all persons with mental illness, not just those who are incompetent to stand trial. Education techniques for teaching persons with mental retardation would apply to all persons with mental retardation, not just those who are incompetent to stand trial.

A Medline search for competency restoration articles published in the past 20 years resulted in four articles for a total of 30 published pages on this topic. However, one article, (Roesch & Golding, 1979), dealt mainly with disposition of charges after the time limits for competency restoration had expired. The remaining three articles consisted of 9 pages published on the topic of competency restoration during the past 20 years. Given the large number of persons hospitalized at any one time for competency restoration, coupled with individual and societal interests in not trying incompetent defendants, more research on competency restoration techniques is called for.

Pendleton (1980) described the competency restoration program at Atascadero State Hospital, California, which in 1978 restored 90% of the 205 criminal defendants admitted that year. Upon admission defendants were administered a structured competency test known as the Competency to Stand Trial Assessment Instrument, developed by Lipsitt and Lelos in 1974, which is similar to the McGarry (1973) criteria for competency assessment. Specific deficits in each defendant’s competency were identified by this instrument, and an individualized treatment plan was developed to address each deficit.

Pendleton reported that at Atascadero State Hospital defendants attended a competency education class and were administered a written competency evaluation. A passing score was 70%. A mock trial was then given to the defendant, using real judges and attorneys. Once the defendant successfully passed the writ-
ten competency test and successfully took part in the mock trial, a formal clinical competency assessment was done by a mental health professional.

Davis (1985) described the competency restoration program at a Columbus, Ohio, maximum security forensic hospital. Davis supported the use of problem-oriented individualized treatment plans for incompetent patients, following the format used for most other psychiatric problems. Davis asserted that the clinical problem of incompetence to stand trial is the first priority of the hospitalization and is more important than other psychosocial problems defendants may be facing, such as lack of job skills, lack of education or housing, or residual psychosis. To that end, Davis supported making incompetence to stand trial the top priority of the individualized treatment plan.

In working with incompetent defendants, Davis (1985) identified the following problems on the defendants’ individualized treatment plan: (a) knowledge of the charge, (b) knowledge of the possible consequences of the charge, (c) ability to rationally communicate with an attorney, (d) knowledge of courtroom procedures, and (e) capacity to integrate and efficiently use the knowledge and abilities outlined above in either a trial or a plea bargain. With respect to treatment programming for incompetent defendants, Davis placed the patients into one of the following five groups, with specific programming for each group:

1. **Psychotic confused**. Perceptual and/or thought disturbances interfere with the defendant’s understanding of how the legal process works or interfere with communication with the court and the defense attorney. Programming is focused on reality-testing skills and other standard treatment approaches of psychosis.

2. **Low functioning**. Patients who have a low IQ or are organically impaired. These patients require didactic, remedial education techniques on the roles and functions of the courtroom participants, court procedures, and possible legal consequences.

3. **Delusional-irrational**. Patients who have adequate knowledge about their charge and courtroom procedures, but who distort or misinterpret the reality of their situation because of paranoid or other bizarre delusions. Programming focuses upon enhancing nondelusional coping skills.

4. **Disruptive**. Patients who exhibit attention-seeking, hyperactive, impulsive, uncontrollable, or belligerent behavior that impedes learning or the defendant’s presence in the courtroom. Programming is focused on providing structure, reinforcement, and behavior management techniques.

5. **Advanced maintenance**. Patients awaiting discharge to court, clinically believed to be restored to competence. These patients need to maintain their current competence and develop further coping strategies.

Davis reported that defendants’ progress in these groups is monitored, and a mock trial is used at the conclusion of the programming.

Brown (1992) described a competency restoration program at Alton Mental Health and Developmental Center in Illinois. This program consisted of a didactic group that met daily for 30 to 45 minutes per session. The number of participants in each group was from 6 to 14 patients with the group led by a psychologist. The
programming was organized into seven discrete modules, each module lasting several days. The modules addressed (a) the nature of criminal charges and sentences, (b) the elements of specific charges, (c) the roles of participants in trial process, (d) the sequence of events in a trial, and (e) the consequences of pleas, verdicts, and sentences.

Brown reported that each module included written handouts, videotaped vignettes, a mock trial, and videotape trials. Participants were administered a written test at the end of each module.

THE NORTHCOAST EXPERIENCE

Northcoast Behavioral Healthcare System is a 425-bed state-operated behavioral health care organization in northern Ohio that serves a catchment area of 37 counties. At its Cleveland facility, Northcoast operates a 40-bed dedicated restoration-to-competency program, which equals 1 competency restoration bed per every 110,000 persons in the general population. Clinicians perceived that the educational component of the restoration-to-competency program was inefficient and desired to overhaul the curriculum of the program. A more efficient educational program would lead to a shortened length of stay in the hospital for incompetent defendants as well as an increased proportion of incompetent defendants being restored to competency.

Prior to the program renovation, the educational program consisted of 4 to 5 hours of weekly lectures on the court system/legal process, conducted by the program social worker. Perceived criticisms of this program included the fact that the educational component was one-dimensional and did not contain any learning formats other than lectures.

A multidisciplinary committee was formed to study the problem. Out of this process a new restoration-to-competency curriculum was developed. This new curriculum consisted of approximately 15 hours weekly of contact time for each defendant. Multiple members of the clinical staff were responsible for discrete portions of the curriculum. Modules dealing with specific topics in competency restoration were established with an effort to utilize different learning formats for each module. The modules consist of the following:

1. **Educational module.** This module replaced the didactic lecture previously conducted by the program social worker with an enhanced lecture series given by an increased number of clinical staff. A greater number of staff participating in this lecture module could make the lectures more effective in that varied lecturers would make the material more interesting and would result in better learning.

2. **Anxiety Reduction module.** Psychologists met twice weekly for 1 hour with incompetent defendants and focused on developing anxiety management/relaxation techniques that defendants may use in court. Guided imagery and self-hypnotic skills were also taught.
3. **Guest Lecture module.** Court personnel, such as judges, defense attorneys, prosecutors, and probation officers were invited on a weekly basis to speak to the incompetent defendants and answer questions.

4. **Mock Trial module.** A scripted mock trial was carried out, with defendants playing the roles of the various courtroom personnel.

5. **Video module.** Videotape of actual courtroom proceedings was presented to the defendants, followed by a discussion led by clinical staff.

6. **Post-Restoration module.** In a peer-led discussion, defendants who had previously been to court discussed their experiences with incompetent defendants.

7. **Legal Current Events module.** News stories involving criminal trials that were featured in newspaper articles or the local television news were reviewed and discussed.

Outcomes of the new competency restoration curriculum were difficult to measure in that data on the number of defendants restored and length of stay were not routinely tabulated prior to the program overhaul. In addition, the efficacy of individual modules in the new curriculum was difficult to measure as there was no way to assess the impact of any single module. However, once the revised program was in place, the average length of stay in the Northcoast competency restoration program was approximately 80 days, which was anecdotally noted to be less than the length of stay prior to the program revision.

Following the program revision, defendants were restored to competency at the following rates: (a) misdemeanors (81.5%), (b) lesser felonies (90.9%), and (c) major felonies (85.7%). (The Ohio Revised Code provides for maximum competency restoration times, based on the severity of the offense. Misdemeanants must be restored within 60 days or the defendant is found *incompetent to stand trial*, unrestorable. Defendants charged with lesser felonies must be restored within 6 months, and defendants charged with major felonies must be restored within 1 year.)

**PROPOSED ELEMENTS OF A MODEL COMPETENCY RESTORATION PROGRAM**

Based on a review of the literature, discussion with clinicians at both a state and national level as well as the Northcoast experience, the following elements are suggested for a model competency restoration program:

1. **Objective competency assessment upon admission.** Specific deficits that result in incompetence to stand trial should be identified upon entry to the competency restoration program. These specific deficits should then be listed individually on the individualized treatment plan and targeted specifically in the course of the defendant’s treatment. As mentioned above, various factors can lead to incompetence, such as psychosis, mood symptoms, mental retardation, lack of information, and so forth. Not all defendants are incompetent for the same reason, and therefore, the
underlying reason leading to each defendant’s incompetence should be identified by an objective competency assessment upon admission to the program.

2. **Individualized treatment program.** Each defendant should have a treatment regimen tailored to his or her specific problems. Deficits identified in the competency assessment upon admission to the program should be listed in the individual treatment plan and addressed by specific treatment interventions.

3. **Multimodal, experiential competency restoration educational experience.** Defendants learn material best when it is presented in multiple learning formats by multiple staff. For this reason, learning experiences should involve discussion, reading, video, and role-playing. Learning is also enhanced by experiential methods of instruction, such as a mock trial.

4. **Educational component.** A mainstay of the competency restoration program should be education regarding the following:
   - various charges
   - severity of charges
   - sentencing
   - pleas
   - plea bargaining
   - roles of the courtroom personnel
   - adversarial nature of trial process
   - evaluating evidence

5. **Anxiety reduction component.** An anxiety reduction module can be instrumental in providing relaxation techniques to defendants who may become anxious while in court.

6. **Additional education components for defendants with low intelligence.** Defendants who are incompetent due to specific knowledge deficits caused by low intelligence can often be restored to competence but may require additional exposure to the educational material. This may be addressed by providing additional learning experiences through increased lecture time as well as individual instruction using simplified terminology.

7. **Periodic reassessment of competency.** Defendants should be periodically reassessed for their progress toward restoration to competence. Periodic assessment allows the treatment teams to measure whether their treatment interventions are working, and whether additional treatment elements need to be incorporated into patients’ treatment plans.

8. **Medication treatment.** Because psychotic and mood disorders are a major cause of incompetence, underlying mood and psychotic disorders must be aggressively treated with biological therapies for restoration to competence to occur.

9. **Capacity assessments/involuntary treatment.** Defendants adjudicated as incompetent to stand trial may also lack the capacity to give informed consent for treatment/medication. Because an important component of restoration to competence is medication treatment of underlying mental disorders, it is essential that clinicians address incompetence for treatment decisions per their local hospital policy and state laws. Defendants who refuse medication treatment should be evaluated for competence to make treatment decisions. Defendants who consent to medication treatment but appear incompetent to make such decisions should also be evaluated for competence to make treatment decisions.
The elements listed above are not intended to be an exhaustive list of the components of a good competency restoration program. Rather, they represent the bare essentials of a good program, and clinicians should feel free to use whatever individual resources are available to them to develop their program further.

Other issues that may be addressed, but are beyond the scope of this article, include the following:

1. What is the role of competency screening instruments, such as the MacArthur Competency Assessment Tool (MacCAT-CA) and the Competence Assessment for Standing Trial for Defendants With Mental Retardation (CAST-MR)?
2. Should defendants adjudicated incompetent to stand trial receive competency restoration on dedicated, specialized competency restoration units, or be mixed in with the general inpatient psychiatric population?
3. Are treating clinicians able to perform accurate, unbiased competency assessments, or should a mental health professional not involved in the incompetent patient’s treatment perform this evaluation?

REFERENCES


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