Where Two Roads Meet: Restoration of Competence to Stand Trial from a Clinical Perspective

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I. INTRODUCTION

Over thirty years ago, an illiterate, deaf, mute man allegedly stole $9.00 worth of property.[1] After being charged in the criminal court of Marion County, Indiana, Theon Jackson, the defendant in the case, underwent evaluations of his competence to stand trial. The expert psychiatric report at the time concluded that Mr. Jackson's inability to communicate, intellectual deficits, and hearing impairment rendered him unable to work with his lawyer and understand the charges against him. Two testifying experts opined that Mr. Jackson's chance of ever improving to the point where he could competently face his charges was virtually non-existent. After a finding in accordance with these views, the court, based on the existing statute at the time, ordered Mr. Jackson committed to the Indiana Department of Mental Health until he could be certified as "sane."[2]

Defense counsel argued that there was no evidence that Mr. Jackson was insane, that he would never recover functioning to the point of becoming

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1. Jackson v. Indiana, 406 U.S. 715 (1972).

2. *Id.* at 719. At times, courts have used the words 'sanity' and 'competence' interchangeably. Readers must thus be mindful if the word intended relates to criminal responsibility, incompetence to stand trial, or a general state wherein one experiences symptoms of mental illness, because each is a distinct construct. In *Jackson v. Indiana*, defense counsel raised these distinctions in the argument related to the problematic nature of the Indiana statute. *Id.*

competent to stand trial, and that his commitment thus equaled a life sentence despite Mr. Jackson's pre-trial status. Based on Jackson's arguments under the Fourteenth and Eighth Amendments, the United States Supreme Court granted certiorari.

The Court reviewed, among other things, the Indiana statutes related to civil commitment. Ultimately, the Court ruled that holding Jackson to a "more lenient commitment standard and to a more stringent standard of release than those generally applicable to all others not charged with offenses"[3] deprived him of equal protection of the laws. Moreover, the Court ruled that "due process requires that the nature and duration of commitment must bear some reasonable relation to the purpose for which the individual is committed."[4] Thus, the Court held that a defendant found incompetent to stand trial could not be held longer than "the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future."[5] The ruling identified the need to either initiate civil commitment or release a defendant whose competence is not likely to be restored.[6] The decision went on to say that for a defendant who may soon be capable of standing trial, "his continued commitment must be justified by progress toward that goal [i.e., restoration of competence to stand trial.]"[7]

Jackson v. Indiana provided an opening to the notion that commitment of a pretrial defendant must be justified, at least in part, on a goal of restoring the defendant's competence to stand trial, but such commitment cannot be indefinitely based on that rationale. As seen in *Jackson*, mental

3. *Id.* at 730.

4. *Id.* at 738.

5. *Jackson*, 406 U.S. at 738.

6. Competence is a general legal term that can be associated with functional capacities one might assess clinically. One can be competent (or not) to enter a contract, write a will, make treatment decisions, or competent to stand trial, to name a few. For clarity, in this paper, "competence," will refer to competence to stand trial, unless otherwise specified. Forensic assessment of competence to stand trial takes place after a question about a defendant's competence has been raised through parties involved in the legal process. The assessments are conducted by mental health clinicians who evaluate whether there appear to be genuine clinical symptoms that impact on the defendant's capacity to stand trial. In the United States, the precise language used in the standard for competence to stand trial varies across jurisdictions, but is largely based on criteria set forth by Dusky v. United States, 362 U.S. 402, 403 (1960). These criteria state that a defendant is found competent to stand trial if he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding and has a rational as well as factual understanding of the proceedings against him. Restoration in this review will refer to restoration of abilities generally associated with competence to stand trial, following a judicial finding of incompetence.

7. *Jackson*, 406 U.S. at 738.

health clinicians may thus be asked to opine on a defendant's progress toward achieving competence and potential for restorability. Subsequent legal cases regarding restoration or maintenance of competence to stand trial[8] have detailed complex decisions related to circumstances that might allow for mandated interventions to restore defendants' competence over their objection. In cases involving incompetent defendants, medications to treat symptoms of mental illness will generally be a critical component of this treatment. In *Sell v. United States*, the Supreme Court delineated several considerations that a court must take into account, after which a medication-refusing defendant may undergo involuntary medication to restore competence to stand trial.[9] Although medication may be the final path that is effective in ameliorating many psychiatric symptoms, the *Sell* Court stated that the likelihood of restoration through other less restrictive means to restore a defendant's competence to stand trial must also be considered by a court when making decisions regarding forcing medication.[10]

Compared to the administration of medications, legal-type education and treatments comprised of talking with defendants to restore their competence are procedures that might be viewed by courts as being less invasive and posing less risk to incompetent defendants. They aim in large part to expand the legal knowledge base of defendants, and also help them manage anxieties, misperceptions of the legal process, and behavioral disruptions as a result of symptoms of mental disorders. These types of interventions for incompetent defendants, however, have received less rigorous attention, and less is generally known about what they entail, their effectiveness, and the potential issues they may raise for courts and clinicians. Juxtaposed with the clinical literature on the assessment of competence to stand trial,[11] existing literature on this educational type of restoration has been scant, although there has been a slow but steady increase in recent years. Many papers on the subject have been descriptive

8. *See generally* Riggins v. Nevada, 504 U.S. 127 (1992); United States v. Weston, 206 F.3d 9 (D.C. Cir. 2000); United States v. Weston, 36 F. Supp. 2d 7 (D.D.C. 1999); United States v. Weston, No. 9-357, 2001 U.S. Dist. LEXIS 2486 (D.D.C. Mar. 6, 2001); Sell v. United States, 539 U.S. 166 (2003).

9. *See generally Sell*, 539 U.S. 166.

10. *Id.* at 181.

11. *See, e.g.*, Thomas Grisso, *Five-year Research Update (1986-1990): Evaluations for Competence to Stand Trial*, 10 BEHAV. SCI. & L. 353 (1992); Deborah K. Cooper & Thomas Grisso, *Five-year Research Update (1991-1995): Evaluations for Competence to Stand Trial*, 15 BEHAV. SCI. & L. 347 (1997); Denise L. Mumley, et al., *Five-year Research Update (1996-2000): Evaluations for Competence to Stand Trial*, 21 BEHAV. SCI. & L. 329 (2003), each including a comprehensive review of literature pertaining to competence to stand trial.

in nature. Of those outlining specific research, the number of subjects has often been small and poorly described, limiting the generalizability of the findings. Nevertheless, given that this is one arm of treatment utilized for incompetent defendants and one that is referred to in the recent ruling of *Sell*, it behooves criminal attorneys, justices, and mental health clinicians to have some familiarity with the clinical literature on competence restoration. This paper will review the literature on this topic and describe some of the remaining conundrums related to this issue.

II. BACKGROUND: CLINICAL CONSIDERATIONS IN COMPETENCE RESTORATION

Although competence restoration is by no means a simple construct from a legal perspective, treatment providers working with incompetent defendants also face unique challenges. This is equally true whether the defendants are committed for treatment in psychiatric hospital settings, the sites where pretrial defendants are most often committed for restoration,[12] referred for outpatient restoration, or referred for restoration while awaiting trial in jail.

Patients found incompetent to stand trial and committed to treatment or rehabilitation are truly at a place where two roads, legal and clinical, meet. Mental health professionals without forensic training may be unaccustomed to specific competence-related approaches to treatment of patients who have been adjudicated incompetent to stand trial. However, clinicians working with these patients are generally able to focus on symptom improvement, an area they feel more comfortable addressing. This is because common symptoms of mental illness associated with findings of incompetence and leading to hospitalization include delusions (i.e., false, fixed beliefs), disorganized thoughts, and agitation, to name a few. As these symptoms improve, with medication intervention and standard therapies, so naturally do defendants' abilities related to competence to stand trial. Thus, once a patient has improved clinically, the patient can often be adjudicated as competent, eliminating the legal problem.

Over time, there has been a growing refinement in the management of patients who are incompetent to stand trial, which involves recognition of their unique combination of legal and clinical problems. As a consequence, when working with incompetent patients, clinicians face a knotty question as to the primacy of the goals for the patient. Treatment providers may struggle with whether treatment should be aimed solely at improvement of symptoms or competence restoration. The label "patient" vs. "defendant"

12. Robert D. Miller, *Hospitalization of Criminal Defendants for Evaluation of Competence to Stand Trial or for Restoration of Competence: Clinical and Legal Issues*, 21 BEHAV. SCI. & L. 369 (2003).

partially captures this dilemma. It has been noted in the clinical literature that restoration can be a critical form of treatment for those who have entered the mental health system as a result of a finding of incompetence and such treatment should have applicable practice guidelines.[13] This framework for treatment can be important, even though one is in effect "treating" a problem that stems from the criminal justice system. In so doing, one is also assisting courts to help resolve outstanding criminal cases. Whether this process serves the criminal justice system over the needs of the individual patient has been previously raised as a matter of consideration[14] and will be discussed further below. Nevertheless, if restoration is the primary goal of treatment, then a successful outcome could be measured by returning the patient to court and having the patient adjudicated competent. This may occur even when symptoms are not ameliorated to a maximum level. A critical objective for a treatment provider whose focus is on symptomatic improvement, rather than on restoration, is to return a defendant to a prior maximum level of mental stability and health. This could occur regardless of whether the defendant's competence is restored along the way, whether a patient was hospitalized past the point of the patient's competence being restored, or whether the individual entered the institution via a criminal justice or civil route. Indeed, although the *Jackson* case describes "treatment" or "training" for Mr. Jackson, it is unclear if the type of training referred to specific education and therapeutic (non-medication based) interventions aimed at restoring competence to stand trial. However, given that the case unfolded between the late 1960s and the early 1970s, this is not likely, as historically the foundation for treatment with institutions rested on the clinical, rather than the legal, issues at hand.

Another clinical conundrum raised by *Jackson* is one involving ethical concerns. Whether one accepts restoration as a matter of greater, lesser, or equal importance to the general clinical treatment goals for an individual patient, for clinicians working as allies of their patients, ethical tensions arise in the notion that one of their jobs may be to help their patients regain competence to stand trial, which could culminate in an adjudication of guilt and possible incarceration or capital punishment for a particular patient. Treating clinicians working to help their patients may logically eschew the idea of working to send patients back into the criminal justice system. As

13. *See*, *e.g.*, Daniel L. Davis, *Treatment Planning for the Patient Who is Incompetent to Stand Trial*, 36 HOSP. & COMMUNITY PSYCHIATRY 268 (1985); Stephen G. Noffsinger, *Restoration to Competency Practice Guideline*, 45 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 356 (2001).

14. *See generally* Kenneth L. Appelbaum, *Assessment of Criminal-Justice-Related Competencies in Defendants with Mental Retardation*, 22 J. PSYCHIATRY & L. 311 (1994).

alluded to above, Appelbaum[15] made an especially cogent argument in this regard with respect to defendants with mental retardation, who generally are not going to receive the additional beneficial effects of medication that incompetent patients with mental illness will receive. Appelbaum noted that clinicians solely providing specific educational training efforts to defendants with mental retardation may feel they are serving the criminal justice system rather than the patients due to the possibility that an individual defendant may be better off if allowed to avoid facing a criminal charge. Because of this dilemma, Appelbaum suggests the importance of obtaining informed consent from defense attorneys and defendants, or their surrogate decision makers, before embarking on competency training, stating, "[i]n the absence of consent, rehabilitation aimed at enhancing competence to stand trial introduces the risk of further abuse of an already victimized group of people."[16]

Additionally, mental health professionals may not have an in-depth understanding of their patients' legal situations and may not specifically have worked with patients on issues related to competence to stand trial. Before the question can be addressed as to whether restoration should be at the forefront of treatment, clinicians with less familiarity with court processes may feel at a loss for how to manage this patient issue. Although his paper is now almost twenty years old, Davis wrote about the common confusion amongst legal and medical professionals related to the notion that persons with mental illness may or may not be competent to stand trial, and that the mere presence of symptoms of mental illness does not define who is incompetent to stand trial. He noted that clinicians "struggle in nonempirical darkness about what to do when the [incompetent] patient is hospitalized."[17] A lack of knowledge can make clinicians reticent to approach topics related to the law and the criminal process with their patients. Thus, when faced with patients adjudicated as incompetent to stand trial, clinicians who are not familiar with competence and competence restoration may inadvertently ignore a significant issue in their patients' lives. When this occurs, by the time the patient's court case is slated for review, significant periods of time could have passed without any clinician speaking to the patient about the criminal charge.

III. PREVALENCE OF COMPETENCE RESTORATION PROGRAMS

Competence to stand trial has largely been considered one of the most common types of criminal evaluations conducted by mental health

15. *Id.* at 323.

16. *Id.* at 324.

17. Davis, *supra* note 13, at 269.

professionals.[18] Although some have noted that commitments related to these evaluations are used at times to control aberrant behavior[19] and even misused by courts,[20] competence to stand trial continues to be a frequent reason for forensic evaluation and inpatient commitment.[21] In fact, one study found that just over 6,400 defendants were found incompetent and admitted to state forensic hospitals for competence restoration in 1978,[22] leading to an estimation that over 20,000 competence evaluations would have taken place the same year.[23] Subsequent data showed that in 1986, approximately 3,200 incompetent defendants across the United States were utilizing a forensic mental health bed in one day, and that many more were utilizing other psychiatric resources.[24]

In light of the above factors, it is interesting to note that in the early 1990s the general sense was that forensic hospitals treating patients who were incompetent to stand trial were not generally thought to offer specialized competence restoration programs as an adjunct to the use of psychotropic medications.[25] Specific studies examining the prevalence of these programs have been few, although some authors have commented on the types of facilities where restoration might be more successful.[26] In 1987, Siegel and Elwork[27] sent a questionnaire to 128 directors of forensic facilities throughout the United States. Approximately half of the recipients responded. Despite the *Jackson* findings fifteen years earlier emphasizing the importance of restoration, only forty-three percent of the respondents indicated that the patients in their facilities found incompetent to stand trial were provided treatment differing from that offered to general patients in the facility.

18. GARY B. MELTON ET AL., PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS 135 (The Guilford Press, 2d ed. 1997).

19. Jeffrey L. Geller & Eric D. Lister, *The Process of Criminal Commitment for Pre-Trial Psychiatric Examination: An Evaluation*, 135 AM. J. PSYCHIATRY 53 (1978).

20. Alan A. Stone, Comment, 135 AM. J. PSYCHIATRY 61 (1978).

21. Miller, s*upra* note 12.

22. Henry J. Steadman et al., *Mentally Disordered Offenders: A National Survey of Patients and Facilities*, 6 LAW & HUM. BEHAV. 31 (1982).

23. MELTON ET AL., *supra* note 18, at 135.

24. Bruce B. Way et al., *Forensic Psychiatric Inpatients Served in the United States: Regional and System Differences*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 405 (1991).

25. Joyce L. Carbonell et al., *Predicting Who Will Regain Trial Competency: Initial Promise Unfulfilled*, 5 FORENSIC REP. 67 (1992).

26. Carol T. Mowbray, *A Study of Patients Treated as Incompetent to Stand Trial*, 14 SOC. PSYCHIATRY 31 (1979).

27. Alex M. Siegel & Amiram Elwork, *Treating Incompetence to Stand Trial*, 14 LAW & HUM. BEHAV. 57 (1990).

A more recent study by Miller[28] surveying forensic mental health program directors found that most restoration takes place within inpatient hospital settings, and the maximum period of time allowed for such restoration is often, but not always, mandated by statute. In fact, according to Miller, eighteen states' statutes require hospitalization of incompetent defendants, while twenty-one states' statutes are permissive regarding hospitalization. One can assume from this data that incompetent defendants continue to be a prominent pool of patients admitted to state forensic mental health hospitals.

Although Miller's data did not detail information regarding the prevalence of specific restoration programming within inpatient or outpatient settings, Mueller et al.[29] recently surveyed 151 "state psychiatric hospitals" listed by the National Association of State Mental Health Program Directors, yielding updated information about incompetent defendants in forensic mental health beds. Seventy-five of ninety-four independent responding hospitals indicated that they work with clients who are incompetent to stand trial, with an average of about 21 percent of all inpatients comprising those found incompetent to stand trial. Furthermore, although most facilities that responded ranked medication as the most prevalent intervention for restoration, sixty-six facilities (88%) indicated they used some type of didactic or psychoeducational group intervention for competence restoration (ranking it as the second most prevalent intervention), and thirty-one facilities (41%) responded that they had competency restoration manuals. Fifty facilities (67%) also indicated that their staff participated in additional training for these types of competence restoration interventions. These findings, which the authors noted they planned on analyzing further, suggest that competence restoration based on educational programs is more commonly encountered now than it was previously. Thus, regardless of the clinical conundrums attached, it appears that clinicians have over the years been learning about and increasingly attending to specific competence restoration interventions for persons committed to their facilities as incompetent to stand trial.

IV. GENERAL COMPETENCE TO STAND TRIAL RESTORATION PROGRAMS: RESEARCH-BASED AND DESCRIPTIVE LITERATURE

Studies reporting on competence restoration programs often do not describe both medication and non-medication aspects of the treatment being given. This is in spite of the fact that, as noted previously, both

28. Miller, *supra* note 12.

29. C. L. Mueller et al., *IST Forensic Mail Survey Results Summary* (2004) (unpublished results obtained from data from the State of Hawaii Dept. of Health, Adult Mental Health Division).

treatments are frequently administered simultaneously. Understanding the factors resulting in improvements in competence is therefore complex. Keeping that in mind, the literature on training-based restoration efforts can shed some light on the utility of these interventions.

One of the early and often cited papers related to the training-based treatment of persons found incompetent to stand trial was by Linda Pendleton, Ph.D.[30] She described a program treating incompetence at Atascadero State Hospital, one of the main state hospitals in California where offenders were sent for inpatient psychiatric treatment. At the time the Atascadero State Hospital received approximately two hundred incompetent to stand trial patients yearly. Patients were sent there on charges ranging from misdemeanors to felony homicides. At the time the paper was written, all the defendants sent there were men, with the most common diagnosis being schizophrenia, paranoid type. Dr. Pendleton noted that patients admitted to the incompetence treatment program were typically psychotic upon admission (having thoughts that were not based in reality). Many harbored delusions specifically related to the trial process.

After an initial evaluation using a standard assessment to ascertain the abilities related to competence to stand trial, patients underwent a multi-disciplinary team conference to outline a plan of treatment with a specific focus related to competence. In addition to the usual treatment approaches available at the time, including psychotropic medication and a variety of therapies, the patients were given specialized individual and group therapy specifically aimed to help the patients understand the legal proceedings against them and to help them cooperate with their lawyers. This treatment was followed by entering the patients into a competency class and, following an examination, having the patients participate in a videotaped mock trial. This technique allowed the staff to assess whether a given patient could withstand the stress of trial. Patients could also be provided feedback regarding the videotaped mock trial.

After achieving a passing score on the examination and passing the mock trial, the patient was reassessed, which included exploring any remaining competence-related deficits and symptoms. At that stage in the process, the patient could be referred directly back to court if it appeared that the patient was competent.

In a subsequent clinical paper, Davis[31] described a method of treatment planning that would prioritize competence restoration for patients where the reason for hospital admission was their incompetence to stand trial. Just like with other treatment plans, Davis stated that a multidisciplinary

30. Linda Pendleton, *Treatment of Persons Found Incompetent to Stand Trial*, 137 AM. J. OF PSYCHIATRY 1098 (1980).

31. *See generally* Davis, *supra* note 13.

treatment approach for incompetent defendants should be identified, placing the legal issue into the clinician's domain. He delineated several areas that needed to be addressed by such treatment plans, based on his experience in the Ohio mental health system. The areas he described for inclusion in the treatment plans included knowledge of the charge and its possible consequences, ability to rationally communicate, knowledge of courtroom procedures, and capacity to integrate and efficiently use the knowledge and abilities in either a trial or a plea bargain scenario.

According to Davis, when the hospital restoration program began, it was framed as general didactic instruction. Later, the program design had the patients divided into groups based on areas of deficits. This allowed the treatment to more specifically address the needs of the participants. Patient groups included advanced-maintenance, psychotic-confused, low functioning, delusional-irrational, disruptive, and those requiring individualized tutoring or counseling. In addition to the specialized groups, patients underwent mock trials with staff from the educational therapy and psychology departments. The program included frequent reassessments of the defendants' competence to stand trial, with written reports sent to the court based on progress toward the goals set forward in the treatment plans. Davis emphasized that this directed approach to incompetence minimized the chance that patient hospital stays would be excessively long, while providing reminders to treatment providers that but for the court's finding of incompetence for individual patients, they would not have been hospitalized. Davis noted that after competence related areas were addressed, clinical staff was available to focus on other needs of the patient to provide comprehensive mental health treatment. One of the aims expressly stated by Davis, however, was developing a means of serving the legal system.

Frequent citations of the papers by Pendleton and Davis are noted in the clinical competence restoration literature, and the papers are recognized largely as the only descriptive works on this topic available through the mid-1980s. Another educational group program for incompetent defendants was subsequently described by Brown.[32] Based in Illinois at the Alton Mental Health and Developmental Center, a didactic program design was utilized after acute psychiatric symptoms were considered at least partly improved following treatment with psychotropic medication. Taking place five days per week for thirty to forty-five minutes per day, educational groups were designed to focus on improved functioning related to the criminal justice process. Interestingly, the program manager for these defendants functioned in a number of roles beyond conducting the didactic

32. D. Ridgley Brown, *A Didactic Group Program for Persons Found Unfit to Stand Trial*, 43 HOSP. & CMTY. PSYCHIATRY 732 (1992).

program. Brown described the program manager as performing individual assessment interviews, writing treatment plans with the treatment team, preparing written reports to the court, accompanying defendants to hearings, and counseling defendants. Periodic written tests were given to the patients to assess their progress.

Observations of the comportment of defendants during groups were utilized to help inform the psychopharmacological treatment. Successful outcome for defendants appeared to be linked to higher education, attention, concentration, and cooperation. Defendants with hostility, suspiciousness, thought disorganization, poor attention, poor concentration, poor comprehension, and delusional ideas specifically surrounding the legal situation were less amenable to successful restoration. These parameters, however, were based on observations rather than a rigorous study.

An expanded competency restoration program based out of Northcoast Behavioral Healthcare System in northern Ohio was described by Noffsinger.[33] Based in a forty bed competence restoration unit, the program was modified from a strict daily lecture series to a full competency restoration curriculum consisting of fifteen hours of weekly contact with staff. Specific module types included educational, anxiety reduction, guest lecture, mock trial, video, post-restoration, and legal current events. Based on the experiences of this expanded program, Noffsinger proposed elements of a model competency restoration program as including: objective competency assessments on admission, individualized treatment programs, multimodal experiential restoration educational experiences, educational components, anxiety reduction components, additional education for defendants with low intelligence, periodic reassessment of competence, medication, and assessments of capacity to make treatment decisions and involuntary medication treatment when indicated.

The competence restoration programs described above have value for clinicians aiming to develop programs, although a few studies have attempted to go further than program description by testing the utility of various program designs. One such study, published in 1989,[34] attempted to explore empirically the impact of psycho-legal education on incompetent patients' level of motivation and their likelihood of being found competent to stand trial. This was based, in part, on the idea that persons found incompetent to stand trial who were committed as forensic patients often

33. *See generally* Stephen G. Noffsinger, *Restoration to Competency Practice Guidelines*, 45 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 356 (2001).

34. K. Thomas Nelson, *The Patient-Litigant's Knowledge of the Law: Importance in Treatment to Restore Sanity and in Competency Proceedings*, 7 AM. J. FORENSIC PSYCHOL. 29 (1989).

had little knowledge regarding their own legal situation. A small group of thirty-six inpatients was studied. Half were assigned to participate in a two-day workshop related to competency education, which included education about the legal process and how treatment, including medications, may help patients improve their natural functioning. The workshop presentations also included a section on aspects of competency reviewed by staff regarding patients. For example, patients were taught how staff would approach and observe areas such as behavior, attitudes, mental abilities, and knowledge to help restore their competence. Although the number of subjects was small and the study's findings did not rise to the level of statistical significance, in part related to the methodology employed, the authors noted that including a didactic workshop may best help patients whose competence abilities were in the intermediate range, on the margin between competent and incompetent. Law students were utilized to help present a module on the legal and judicial process, but the study authors concluded that these students may have been less adept at answering questions than practicing attorneys would have been.

Siegel and Elwork[35] examined the effects of a competence restoration treatment program on forty-one male defendants who had been adjudged incompetent to stand trial and committed to forensic mental health units. The subjects were divided into experimental and control therapy groups. In the experimental treatment, the group focused on issues specifically related to competence to stand trial, utilizing a videotape, courtroom models, and a competence-related problem-solving approach. In the control group, defendants participated in a group therapy format related to general psychiatric needs. Based on the results of pre- and post-intervention competence assessment scores, there was a significant difference between groups, with the subjects participating in the competence restoration group treatment achieving a greater increase in competence to stand trial scores. Furthermore, within forty-five days, forty-three percent of the experimental group subjects were recommended by hospital staff as competent to stand trial, compared with fifteen percent of subjects in the control group. The authors noted the importance of further examining treatments specific to psycho-legal conditions, and also spoke to the idea that competence to stand trial treatment groups may be useful for all criminal defendants to improve their knowledge of the criminal justice legal process.

Bertman et al.[36] examined twenty-six male incompetent defendants in Louisiana to determine the effectiveness of an individualized legal rights

35. *See generally* Siegel & Elwork, *supra* note 27.

36. *See generally* Lisa Jo Bertman et al., *Effect of an Individualized Treatment Protocol on Restoration of Competency in Pretrial Forensic Inpatients*, 31 J. AM. ACAD. PSYCHIATRY & L. 27 (2003).

treatment protocol as a means of restoring their competence to stand trial. All subjects in the study were treated within a maximum-security state psychiatric hospital. Subjects were considered likely to be restored within a reasonable period of time, had few active psychiatric symptoms, were considered to have genuine (i.e., not malingered) competence deficits, and intelligence scores at least in the mild mental retardation range. The twenty-six defendants who qualified for the study were divided into one of three groups. Subjects in each group participated in four legal rights education group sessions that took place weekly, run by a unit social worker. Two subject groups had additional interventions. Subjects assigned to one group also participated in two instructional deficit-focused one-to-one sessions per week for three weeks. The individual sessions concentrated on the charges against the defendants, the meaning of the charges, and the potential consequences and details related to the alleged offenses. The sessions also specifically focused on unique defendant deficits related to competence to stand trial as determined by baseline competence evaluation assessments. A second subject group received basic legal rights education through two individual sessions per week for three weeks, as well as the four once weekly groups on general legal rights education. The third subject group participated only in the four weekly legal rights education groups on the ward, which was considered the standard hospital treatment at the time.

The results of the Bertman et al. study are based on small numbers of defendants who were willing and able to consent to the research, and are therefore limited and not necessarily generalizable to all incompetent defendants. The study was, nevertheless, a formal effort that exemplified the complexities and importance of research in the area of competence restoration.[37] Furthermore, the findings indicated that subjects who received both the individual and group competence intervention (whether deficit-focused individual treatment or more general legal rights education individual sessions) showed approximately fifty percent more improvement on competency measures and improved on competency measures at twice the rate as those receiving standard hospital treatment for incompetence. The authors concluded that individualized treatment, in addition to group treatment, may be useful for restoration programs. They noted, however, that those defendants receiving additional individual and group treatments received a greater frequency of contacts than the defendants assigned only to standard hospital treatment. This raised the question as to whether the more important variable was the frequency of contacts, rather than whether the contacts were individualized or done through group interventions.

37. Charles L. Scott, *Commentary: A Road Map for Research in Restoration of Competency to Stand Trial*, 31 J. AM. ACAD. PSYCHIATRY & L. 36 (2003).

V. SPECIALIZED COMPETENCE RESTORATION PROGRAMS OF DEFENDANTS WITH MENTAL RETARDATION

Although symptoms of mental illness (such as psychosis) are frequently encountered reasons for findings of incompetence, mental retardation can also be a significant factor in judicial findings of incompetence to stand trial.[38] Mental retardation is manifested by low intellectual abilities and impairment in functioning in major areas of life (such as communication, self care, interpersonal skills, health, and safety). Persons with mental illness may also have mental retardation and vice versa, but they do not always co-exist. Thus, both factors or either factor alone may be at issue for any given incompetent defendant. According to one review, six percent of adult defendants in studies comparing competent and incompetent defendants were diagnosed as mentally retarded.[39] Another study found mental retardation as the clinical factor at hand in sixteen percent of cases involving a clinical opinion that a defendant was incompetent to stand trial.[40]

Competence restoration for defendants with mental retardation presents unique challenges. Several authors have noted that incompetent defendants with mental retardation may never have been competent, and rather than working toward competence *restoration*, these defendants are striving toward *attainment* of competence.[41] Thus, education and competence training may be more appropriate terms to utilize when helping defendants with mental retardation gain the abilities associated with competence to proceed to trial.

The aforementioned restoration literature has generally addressed programs designed for a general pool of incompetent defendants. Papers describing competence education programs specifically designed for defendants with mental retardation are few in number, but such programs raise distinct issues. As seen in *Jackson v. Indiana*, the question as to the

38. Stephen L. Golding, *Studies of Incompetent Defendants: Research and Social Policy Implications*, 5 FORENSIC REP. 77 (1992).

39. Robert A. Nicholson & Karen E. Kugler, *Competent and Incompetent Criminal Defendants: A Quantitative Review of Comparative Research*, 109 PSYCHOL. BULL. 355 (1991).

40. Janet I. Warren et al., *Criminal Offense, Psychiatric Diagnosis, and Psycholegal Opinion: An Analysis of 894 Pretrial Referrals*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 63 (1991).

41. *See generally* Barry W. Wall et al., *Restoration of Competency for Persons with Mental Retardation*, 31 J. AM. ACAD. PSYCHIATRY & L. 189 (2003); Ronald Schouten, *Commentary: Training for Competence — Form or Substance?*, 31 J. AM. ACAD. PSYCHIATRY & L. 202 (2003); Shawn D. Anderson & Jay Hewitt, *The Effect of Competency Restoration Training on Defendants With Mental Retardation Found Not Competent to Proceed*, 26 LAW & HUM. BEHAV. 343 (2002).

appropriate facility for competence to stand trial restoration is often complicated for a defendant with mental retardation. Anderson and Hewitt[42] explored a competence training program specifically for defendants with competence deficits due to mental retardation, comparing restoration services received in state hospitals and those found in habilitation facilities. At the state hospital, competence to stand trial training typically involved weekly ward-based classes or groups, during which staff taught defendants utilizing repetition and visual aides. Apart from these adjunctive interventions, medication was considered a mainstay of treatment for the hospitalized defendants who were incompetent to stand trial. The habilitation facilities more typically employed individualized educational treatment modified depending on the overall capacities of each defendant. Educational efforts included field trips to courthouses, court videos, picture and symbol review, as well as role-playing. Some of the habilitation facilities only pursued such training if it appeared that progress toward attaining competence was being made.

The Mentally Retarded Defendant Program of Florida State Hospital was described in a paper examining racial disparities among incompetent defendants with mental retardation.[43] In this program, incompetent defendants with mental retardation attended competency training for one hour a day, five days per week for five months. Classes included visual and oral presentations, as well as role-playing. Pre-tests and post-tests were utilized to help assess whether the defendants had attained competence.

One of the more detailed published reports of a model program for competence to stand trial for mental retardation came out of Rhode Island's Eleanor Slater Hospital, a hospital run by the State's Department of Mental Health, Retardation and Hospitals, where defendants with mental retardation are frequently sent for competence to stand trial restoration.[44] Although other general competence restoration training programs were available, Wall et al. developed a training program specifically for assisting defendants with mental retardation gain competence. The Slater Method, as it became known, like other restoration programs, consists of an established format for providing units of information to defendants. As described, the program design also included novel features. In addition to the content of the program curriculum, the authors developed mechanisms to help improve the capabilities of trainers to teach the material as well as delineate specialized teaching methods. Finally, the Slater Method was also designed

42. *See generally* Anderson & Hewitt, *supra* note 41.

43. *See generally* Taiping Ho, *Examination of Racial Disparity in Competency to Stand Trial Between White and African American Retarded Defendants*, 29 J. BLACK STUDIES 771 (1999).

44. *See generally* Wall et al., *supra* note 41.

to determine whether the technique would be perceived as useful by attorneys.

The content areas described by Wall et al. included a focus on the ability of defendants to understand information pertaining to the charges and legal proceedings against them, their ability to communicate with their attorneys, and their ability to make competent legal decisions with regard to their specific cases. The training tool consisted of a multi-phase process, whereby defendants first undergo education related to basic information about the criminal process. This was followed by a second phase, during which the trainer worked with defendants individually to help them understand the material presented in the first phase and gain an appreciation of the significance of the criminal charge(s) against them and its potential impact on their lives. Each phase of training referred to specific content areas to assist with typical deficits seen in the mentally retarded population related to cognition, communication, emotions, and behavior.

In order to make the training useful for defense counsel, the Slater Method, as noted by Wall et al., provided reports to the court that contained useful suggestions for attorneys to help their clients overcome remaining competence deficits. The program also offered a representative to assist in the discussions between the defendant and the defendant's attorney to help the attorney determine whether the client understood the decisions being made. The program was formalized with an instructional manual, a workbook, and answer sheets for questions that accompany specific modules. Importantly, the trainer was not the same individual as the one who conducted the competence to stand trial assessments for the court, which the authors noted was designed to maximize the objectivity of the evaluative process.

Training in the Slater Method reviewed by Wall et al. consisted of individualized implementation of a series of modules, wherein role-playing, mock trials, and photographed vignettes of courtroom personnel are utilized. The training site was not restricted to a hospital setting. The authors described that at the time of a defendant's initial competence to stand trial evaluation, a determination is made as to the most appropriate and least restrictive placement for the defendant, including community placement. The time frame for completion of training varied depending on the needs of the defendant, and formal assessments of competence were completed every six months for a period generally of up to two years. Wall et al. pointed out that benefits from the program were generally dependant on the defendant's intellectual functioning and memory.

VI. COMPETENCE RESTORATION LITERATURE REGARDING JUVENILE DEFENDANTS

One clinical paper was recently published specifically reflecting competence restoration programming for juvenile defendants,[45] representing a unique contribution to the literature. Based on a sample of 471 Florida juveniles committed for restoration of their competence to proceed in the delinquency process, approximately fifty-eight percent were diagnosed with mental retardation and approximately twenty percent were diagnosed with a psychotic condition. Once found incompetent to proceed, these juveniles were committed to a program of treatment that included psychoeducational groups about the legal system, as well as routine mental health care, such as psychotropic medications, case management and counseling as needed. Treatment providers were required to notify the court as to the youth's progress with regard to competence on a regular basis. The juveniles in this program were able to be committed to an outpatient setting for restoration.

VII. RESTORATION RATES AND EFFECTIVENESS OF COMPETENCE RESTORATION PROGRAMS

Whether competence restoration programs are successful 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. Other studies have examined the amount of time taken to return defendants to court as a measure of restoration success. In Michigan, for example, an early study by Mowbray[46] examined the efficacy of committing incompetent defendants to state hospitals compared to a specialized forensic hospital, where staff had more knowledge of the legal issues at hand. The study sample included 222 individuals who had received treatment to restore their competence to stand trial at various sites. Treatment at state hospitals was aimed at improving social adjustment, while treatment at the forensic facility had as its objective the attainment of competence related skills, although the specific treatment interventions in this regard were not described. Treatment on a specialized forensic unit resulted in a more rapid return to court, leading the author to recommend separate and specialized treatment for incompetent defendants, although the authors noted that overall management of incompetent defendants needed further public policy attention.

45. *See generally* Annette McGaha et al., *Juveniles Adjudicated Incompetent to Proceed: A Descriptive Study of Florida's Competence Restoration Program*, 29 J. AM. ACAD. PSYCHIATRY & L. 427 (2001).

46. Mowbray, *supra* note 26.

Lamb[47] also reported on a cohort of eighty-five defendants found incompetent to stand trial in Los Angeles in 1983. Lamb's study and that of Mowbray[48] indicated that eighty to ninety percent of incompetent defendants were able to be restored to competence. Among the remaining defendants, however, Mowbray noted that about seven percent were deemed unrestorable.

Pendleton,[49] who described specific restoration techniques utilized at Atascadero State Hospital, measured outcomes of the program's effectiveness and found that virtually all (90%) patients in the program referred back to court were recommended as competent by the treatment providers, and of those, 97.5 percent were able to proceed through the trial process. The remaining ten percent of patients were thought unlikely to be restorable at all or did not improve enough to be recommended as competent within the time frame for restoration specified by the statute. Similarly, approximately eighty to ninety percent of defendants were able to be restored with the new program described by Noffsinger, although data was unavailable as to restoration rates prior to the implementation of the new program.[50]

In the pre-*Jackson v. Indiana* era, the average length of hospitalization for patients found incompetent to stand trial was counted in years. Lamb noted, however, that in his sample the median time from arrest to a court determination of competence after a finding of incompetence was ten months, of which 4.5 months were spent in the hospital.[51] Of those described in the Pendleton report that were able to be restored, the average length of time the process took was approximately three to four months (104 days).[52] This finding is somewhat similar to that of Hoge et al., who reported that successful restoration was achieved on average in about one hundred days for a small cohort of defendants.[53] Nicholson and McNulty[54] also examined the outcome of hospitalization for incompetent defendants. In that study, the length of stay for restoration for the majority of defendants was a matter of months, usually between two and six total

47. H. Richard Lamb, *Incompetency to Stand Trial: Appropriateness and Outcome*, 44 ARCHIVES GEN. PSYCHIATRY 754 (1987).

48. Mowbray, *supra* note 26.

49. Pendleton, *supra* note 30.

50. Noffsinger, *supra* note 33.

51. Lamb, *supra* note 47.

52. Pendleton, *supra* note 30.

53. Steven K. Hoge et al., *Mentally Ill and Non-Mentally Ill Defendants' Abilities to Understand Information Relevant to Adjudication: A Preliminary Study*, 24 BULL. AM. ACAD. PSYCHIATRY & L. 187, 190 (1996).

54. Robert A. Nicholson & John L. McNulty, *Outcome of Hospitalization for Defendants Found Incompetent to Stand Trial*, 10 BEHAV. SCI. & L. 371 (1992).

months. In conjunction, significant improvement in psychiatric symptoms, allowing improved functioning, were noted. Noffsinger reported an average length of stay of eighty days for restoration patients following instatement of the expanded restoration program, which was anecdotally thought to be less than the length of stay before the program was revised.[55]

Data regarding success for restoration among the mentally retarded have not yielded such high rates. For example, despite the sophisticated nature of the competence training program in the Slater Method described above, at the time of their report, Wall et al. noted that of fifteen defendants who had participated in the restoration program, six were recommended to be found competent to stand trial (and five of those were so adjudicated), four had been recommended as unrestorable, and five were still undergoing training.[56] The authors commented that defendants who do not evidence some learning after the first several attempts of reviewing the material were ultimately less likely to attain competence.

In an effort to examine the effect of the location (i.e., state hospital vs. habilitation facilities) on helping defendants with mental retardation gain competence to stand trial abilities, Anderson and Hewitt[57] collected data for seventy-five defendants classified as having mental retardation and who were deemed incompetent by Missouri courts during a five-year time frame. The defendants had been placed into either a habilitation facility or a state hospital. The specific restoration techniques they received at each facility are described above. As expected, only a small minority of the defendants deemed incompetent to stand trial as a result of mental retardation were able to attain competence, and those with lower IQs were less likely to do so than those with higher IQs. The authors commented that defendants with mental retardation may not have skills that are easily learned, such as abstract reasoning and decision-making abilities. Nevertheless, defendants in the Anderson and Hewitt study who were at the state hospital were restored to competence more often than those who were sent to the habilitation facilities. Anderson and Hewitt noted that over three quarters of the defendants sent to the psychiatric hospitals had a co-existing disorder such as schizophrenia, or drug or alcohol dependence. Thus, despite adjunctive restoration training, psychiatric medication to treat underlying symptoms of mental illness, or a period of sobriety, rather than the hospital site itself or type of restoration training alone, more likely assisted these defendants regain competence to stand trial. Of note, however, even within this population, only fifty percent of the defendants were restored to competence to stand trial. Although not stated by the

55. Noffsinger, *supra* note 33.

56. Wall et al., *supra* note 41.

57. Anderson & Hewitt, *supra* note 41.

authors, this percentage is lower than that reported in other studies examining rates of restoration among defendants with mental illness who have been found incompetent to stand trial. Again, the additive difficulty of restoring a defendant with multiple deficits (i.e., mental retardation in addition to co-existing conditions), may have been the reason for the lower rates of restoration reported by Anderson and Hewitt.

With regard to the ability of juveniles to attain or be restored to competence, there is again limited data available in the literature. In the study by McGaha et al., most of the juveniles (71%) were returned to court and considered competent after engaging in the restoration program.[58] The authors speculated that this restoration rate may have been lower than that seen in adult incompetent defendants in part because of the higher proportion of juveniles with a mental retardation diagnosis. When examined separately, there was a notable distinction in the percentages of juveniles with mental illness who were restored (92%), compared with the percentage of youth whose incompetence was related to a mental retardation diagnosis (44%) and were thought to be unrestorable. When mental retardation and mental illness were both at issue in the incompetence finding, approximately one third of the youth were identified as unrestorable. Interestingly, age as a distinguishing factor in this study of juvenile offenders did not yield any significant findings. The authors noted that the ages of the youth did not appear related to clinical opinions regarding restoration or restorability of the subjects. They hypothesized that this finding may have been due to staff utilizing competence standards that shifted with age.

Defendants who are ultimately found unrestorable present complex issues for the courts and the mental health professionals who treat them. Nevertheless, creative jurisprudence or a lapsed time clock may come into play for these individuals, for whom legal outcomes have been described as including dismissal of the charges, release without provision for treatment, released with provisions for treatment, further time in the hospital awaiting restoration of competence, and even ultimate adjudication of not guilty by reason of insanity, to name a few.[59]

VIII. PREDICTIONS OF ABILITIES OF DEFENDANTS TO BE RESTORED TO COMPETENCE TO STAND TRIAL

Many statutes require a clinician's opinion regarding the likelihood that a given defendant will be able to be restored to competence. Legal cases, including *Jackson v. Indiana*, often also address this issue. Thus, as pointed

58. McGaha et al., *supra* note 45.

59. *See, e.g.*, Ho, *supra* note 43; McGaha et al., *supra* note 45; Lamb, *supra* note 47; Nicholson & McNulty, *supra* note 54.

out by the early work of Cuneo and Brelje,[60] there is merit to increasing the understanding of how such clinical predictions of restorability are made and whether these predictions are made accurately. In their study, Cuneo and Brelje examined clinicians' abilities to accurately predict that a given defendant would be restored to competence within a year, as required by the existing Illinois statute at the time. The study's findings are based on a restrospective review of seventy-eight cases in which the authors compared court records with probability statements recorded in the patients' Master Treatment Plans, which were provided to the court early in the patients' hospital stay. Interestingly, although a predictive accuracy of seventy-eight percent was found, all errors were due to over predicting defendants' abilities to be restored to competence. Only three of the seventy-eight patients were predicted to be unrestorable, while seventy-five were predicted restorable. Although only fifty-eight of those seventy-five predictions were accurate, the authors concluded that this rate of successful predictions likely satisfied the statute's requirement for a clinical opinion as to whether there was a "substantial probability" that a given defendant could be restored. Cuneo and Brelje noted that the risks inherent to predicting that a defendant could not be restored would be potentially greater than making an inaccurate prediction that a defendant could be restored, in part because defendants predicted as unrestorable may never receive the treatment needed to make them competent, and thus may "never have [their] day in court."[61] The authors commented on the importance of learning more about how restoration predictions may be impacted by factors including chronicity of illness, intelligence level, and levels of organic impairment.

Carbonell et al.[62] attempted to identify variables that might assist in the prediction of restorability. The authors determined that variables such as education, demographic data, criminal history, psychopathology, and intelligence level yielded little promise for forming accurate predictions of restorability. The inherent difficulties with identifying the few defendants who will be unrestorable were also noted by Nicholson and McNulty, who also concluded that clinicians will tend toward over predicting restorability.[63] Nicholson and McNulty cautioned that often the clinician performing the initial competence evaluation is in a position to predict a defendant's potential for restorability, yet the same clinician may not have access to data related to a history of social functioning and response to

60. *See generally* Daniel J. Cuneo & Terry B. Brelje, *Predicting Probability of Attaining Fitness to Stand Trial*, 55 PSYCHOL. REP. 35 (1984).

61. *Id.* at 38.

62. Carbonell et al., *supra* note 25.

63. Nicholson & McNutly, *supra* note 54.

treatment. Other than the finding that increased severity of deficits at admission predicted severity of impairment at discharge, the authors' findings did not identify specific factors by which clinicians could make more accurate predications. Because the Oklahoma statute relevant to Nicholson's and McNulty's study required a prediction of a defendant's restorability, the authors cautioned forensic evaluators to note to the court that although most defendants are able to be restored, predictions could best be done after there had been an opportunity to observe the effects of treatment interventions in the hospital.

In a study examining the potential of defendants to be restored to competence, Hubbard et al.[64] examined 468 reports on competence to stand trial from Alabama, but found only a few significant differences between defendants predicted to be restorable and those predicted as unrestorable out of the nineteen percent of defendants recommended as incompetent to stand trial. Of these incompetent defendants, thirty-four percent had psychotic disorders and sixty-five percent had non-psychotic major mental disorders. Despite a statutory requirement to provide a predictive statement about restorability to the court, only fifty-eight percent of the reports had a clear prediction and twenty-seven percent of reports included no prediction at all. Forensic evaluators gave definitive statements about restorability more often when defendants did not have significant mental health histories and when they were charged with more violent offenses. In contrast to literature suggesting several clinical variables that would be likely predictive of restorability,[65] defendants in the Hubbard et al. study thought to be unrestorable were distinguished from those thought to be restorable by essentially non-clinical variables such as older age and a poor understanding of the criminal justice proceedings. Defendants predicted to be restorable more likely had minor nonpsychotic mental health difficulties and more seriously violent criminal charges against them. The study's findings are limited because of the small number of defendants for whom clear predictions of restorability were made. Furthermore, without any follow-up data related to actual restoration results, the accuracy of the predictions cannot be tested. Similar to the comments above, Hubbard et al., also cautioned that predictions can carry tremendous weight, given the potential for treatment to be limited for those defendants predicted to be unrestorable.[66]

With regard to defendants with mental retardation, not surprisingly,

64. *See generally* Karen L. Hubbard et al., *Competency Restoration: An Examination of the Differences Between Defendants Predicted Restorable and Not Restorable to Competency*, 27 LAW & HUM. BEHAV. 127 (2003).

65. Golding, *supra* note 38.

66. Hubbard, *supra* note 64.

intelligence levels were found to predict restorability. That is, persons with less severe intellectual deficits were more likely to be restored.[67] However, experience with the Slater Method indicated that the spectrum of deficits among defendants with mental retardation and the variables for each defendant made prediction of restorability and prediction of time for restoration difficult.[68]

IX. COMMENTARY

In the United States Supreme Court decision of *Sell*, the Court ruled that forced medication for incompetent defendants to restore their competence could be permitted, but only in limited circumstances.[69] The numerous clinical and legal issues raised by involuntary medication of pre-trial defendants are important, but they are beyond the scope of this paper.[70] One cannot, however, comment on education-based restoration programs without acknowledging the critical salience of medications for restoration for defendants with symptoms of mental illness. Leong and Silva went so far as to say, "[that] without taking prescribed antipsychotic medications, it is doubtful that many mentally ill defendants could have a change in mental status that would lead to a forensic opinion supportive of restoration of competency to stand trial."[71] Although medications are clearly considered a key component of restoration, courts have been concerned about the impact of forced medication on the legal best interests of individual defendants. This is despite findings such as those in a study by Ladds, et al., which demonstrated involuntary medication did not limit the potential for plea bargaining, nor did involuntary medication prevent successful insanity

67. Anderson & Hewitt, *supra* note 41.

68. Wall et al., *supra* note 41.

69. *See generally Sell*, 539 U.S. 166.

70. The issue of the forced medication of a pretrial defendant is one where taking action to meet an individual's legal best interests may not always correspond with the action needed to meet that individual's medical best interests. The dilemmas raised by this topic, including some of the issues regarding newer psychotropic medications, have been thoroughly reviewed elsewhere. *See, e.g.*, Douglas Mossman, *Unbuckling the "Chemical Straightjacket": The Legal Significance of Recent Advances in the Pharmacological Treatment of Psychosis*, 39 SAN DIEGO L. REV. 1033 (2002); David M. Siegel et al., *Old Law Meets New Medicine: Revisiting Involuntary Psychotropic Medication of the Criminal Defendant*, 2001 WIS. L. REV. 307; Jeffrey L. Geller & Paul S. Appelbaum, *Competency to Stand Trial: Neuroleptic Medication and Demeanor in Court*, 36 HOSP. & CMTY. PSYCHIATRY 6 (1985); Briefs of the American Psychiatric Association and American Psychological Association as Amici Curiae, Sell v. United States, 539 U.S. 166 (2003) (No. 02-5664).

71. Gregory B. Leong & J. Arturo Silva, *The Right to Refuse Treatment: An Uncertain Future*, 59 PSYCHIATRIC Q. 284, 288 (1988).

pleas.[72]

Medication issues aside, over the years, clinicians have become increasingly sophisticated about clinical approaches to competence restoration programming. However, as reviewed here, there are only a handful of studies where actual research has been conducted to examine aspects of competence restoration. Many of the papers on the subject are descriptive in nature. The studies that do exist have often been based on small numbers or retrospective analysis with several methodological limitations. Nevertheless, from the literature described above, there are several points worth noting. To begin with, medications when indicated in combination with adjunctive restoration programming, or in some jurisdictions, restoration programming alone for defendants not in need of medication, could now be considered mainstream treatments for incompetent defendants. Also, not all incompetent defendants are alike. Defendants with mental retardation, serious and persistent mental illness, other mental disorders, and youthful offenders comprise unique defendant groups, although mental disorders may overlap in any given individual. Further, functional impairments are distinct among these individuals, and a diagnosis itself does not equal a finding of incompetence.[73] As such, amenability to restoration or education will vary among defendants.

Overall, the competence restoration literature supports that between eighty and ninety percent of defendants with mental illness will be able to be restored to competence, and generally this restoration has been achieved in a period of less than six months. Defendants with mental retardation in the absence of symptoms of mental illness, however, may not be suitable for medication interventions. When educational efforts are undertaken to help them attain competence, the success rates have generally not been as high, with some studies showing only about one third to one half of defendants being able attain competence, and other studies pointing out that defendants with more severe cognitive impairments may not be able to attain competence at all. Even when competence training has been successful for defendants with mental retardation, the time to achieve attainment of competence has been significantly longer, with some studies alluding to two-year time frames to ascertain whether competence is likely to be achieved.

Despite potential successes of competence restoration interventions, ethical issues for clinicians related to these programs are also important to consider. For example, just as the issue of capacity of pretrial defendants to

72. *See generally* Brian Ladds et al., *The Disposition of Criminal Charges After Involuntary Medication to Restore Competency to Stand Trial*, 38 J. FORENSIC SCI. 1442 (1993).

73. Golding, *supra* note 38.

make informed medication decisions has been raised,[74] so has the issue of obtaining defendants' informed consent to participate in competence education and training programs.[75] The competence restoration literature has not addressed the informed consent process for participation in programming, the management of situations where defendants might raise incriminating information during an educational group, or the ramifications of refusal of a defendant to participate in restoration programming. These details could provide useful information for clinicians involved in restoration programming and for attorneys whose clients may be participants in these programs. Further review and discussion of these nuances would contribute to our understanding of the restoration process.

An additional concern was raised by Schouten[76] who posited that competence training for defendants with mental retardation may lead only to a superficial achievement rather than the defendants' acquisition of the complex skills needed to assist in their own defense. Competence restoration for youthful offenders raise similar concerns, despite the McGaha et al. study[77] showing that almost three quarters of the juveniles were able to be restored. It has been noted that among youthful offenders, although competence to stand trial may be affected by the same mental health factors as with adults, developmental issues (such as the capacity to appreciate long-term consequences of decisions) likely also play a role in functional abilities related to competence.[78] There is a burgeoning interest in these issues, and further research is needed to learn more about the nuances of competence to stand trial, its assessment, and the meaning of restoration in these special populations.

With regard to identifying variables that will routinely help clinicians accurately predict who will be successfully restored to competence, there have been few reliable findings. Overall, the literature suggests that because most defendants can be restored, clinicians will over-predict restorability. However, there are no clearly established means of accurately

74. *See generally* David M. Siegel et al., *supra* note 70. ; Jeffrey L. Geller & Paul S. Appelbaum, *Competency to Stand Trial: Neuroleptic Medication and Demeanor in Court*, 36 HOSP. & CMTY. PSYCHIATRY 6 (1985); Brian Ladds & Antonio Convit, *Involuntary Medication of Patients Who Are Incompetent to Stand Trial: A Review of Empirical Studies*, 22 BULL. AM. ACAD. PSYCHIATRY & L. 519, 527 (1994).

75. Appelbaum, *supra* note 14.

76. *See generally* Schouten, *supra* note 41.

77. McGaha et al., *supra* note 45.

78. *See generally* YOUTH ON TRIAL: A DEVELOPMENTAL PERSPECTIVE ON JUVENILE JUSTICE (Thomas Grisso & Robert G. Schwartz eds., University of Chicago Press 2000); *see also* Laurence Steinberg & Robert G. Schwartz, *Developmental Psychology Goes to Court*, *in* YOUTH ON TRIAL: A DEVELOPMENTAL PERSPECTIVE ON JUVENILE JUSTICE 19 (Thomas Grisso & Robert G. Schwartz eds., University of Chicago Press 2000).

predicting who among defendants are restorable and who are not. This, too, is an area where more research may be helpful.

As discussed above, legislators have often included a requirement for forensic evaluators to opine on restorability.[79] *Sell* requires that there be a substantial likelihood that administration of medication will lead to the defendants becoming competent, a statement that requires an ability to predict more than just a probability of restorability, and speaks also to response to psychotropic medications. The *Sell* case also requires a determination as to whether "any alternative, less intrusive treatments are unlikely to achieve substantially the same results" as involuntary medication.[80] This suggests that there should be some mechanism to predict the comparative efficacy of non-medication related restoration treatment alone (such as in individual and group education) and restoration solely via medications, or a period of time to try one form of restoration before the other. Allowing time to resolve whether non-medication efforts at restoration would be effective in a given defendant might create significant delays in providing appropriate medical treatments for a given defendant's symptoms. Additionally, the restoration literature has not compared the two treatments side by side, as studies involving defendants with mental illness have utilized education-based restoration as an adjunct to medication. This type of comparison would raise considerable clinical, ethical and practical concerns, if persons in need of medications were treated with only education-related programming to test the relative value of this intervention alone. Thus, at this time, it would seem that courts must continue to rely on appropriate expert testimony to help sort out the potential efficacy of these interventions for a given defendant.

Returning to the issue of predictions, a message to be gleaned from the data available is that predictions should be cautious and limited when less is known about the defendant's history of restoration and current progress toward restoration. A further clinical concern, however, is that by predicting non-restorability the clinician might inadvertently limit the defendant's access to treatment. Taken together, court decisions and legislative requirements for predictions of restorability will continue to present challenges for clinicians and legal professionals.

Another issue of note is that the restoration programs described in the literature primarily are housed in state inpatient facilities. Some of the programs allowed for a least restrictive alternative analysis to determine the most appropriate placement of a defendant during the period of restoration. This analysis is critical, but complicated because what constitutes

79. *See, e.g.*, Nicholson & McNulty, *supra* note 54; Cuneo & Brelje, *supra* note 60; Hubbard et al., *supra* note 64.

80. *Sell*, 539 U.S. at 181.

restrictive treatment may vary based on the needs of society and individuals.[81] However, individual jurisdictions may be able to define levels of restrictiveness of available programs appropriate for given defendants. Given the scarcity of resources for inpatient and rehabilitative housing, this trend will likely continue and grow across multiple jurisdictions, and further exploration of alternative placements for restoration programs is warranted.[82]

Although restoration programs are largely staffed by clinicians, one study noted that a legal professional, who would likely know more about the criminal justice system than a mental health professional, might be well-positioned to help defendants achieve competence,[83] and several others described the use of legal professionals to help with the educational program. If utilized in restoration programs, these individuals would likely need to be neutral legal professionals, as defense attorneys, acting as zealous advocates, may not want their clients to be restored in order to eschew an undesired verdict. Outside educators, however, besides being costly, may not be adept at communicating with mentally disordered individuals. The Slater Method described utilizing a mechanism to train staff to work with mentally retarded defendants in areas relevant to restoration,[84] which may be a useful consideration for other programs. Related to mental health staffing, despite one paper described multiple agency responsibilities of an individual clinician,[85] when clinicians are the mainstay of restoration interventions, the validity of the assessment process and the objectivity of the information presented to the courts can be maximized by a separation of treatment and competence assessment roles.[86]

Restoration programs that include an educational component appear to have evolved over the last twenty years from time-limited lecture presentations, to multi-modal interactive training programs. Many include videotape vignettes, visual cues, and mock trials, along with periodic written examinations to measure progress. These programs reflect rigorous rehabilitative type efforts with a clear goal of moving individuals from the

81. *See generally* Chih-Yuan Lin, *Ethical Exploration of the Least Restrictive Alternative*, 54 PSYCHIATRIC SERVICES 866 (2003).

82. Miller, *supra* note 12.

83. Nelson, *supra* note 34.

84. Wall et al., *supra* note 41.

85. Brown, *supra* note 32.

86. *See, e.g.*, Wall et al., *supra* note 41, at 195, 198-99 (the design of the Slater Method describes having competence assessments completed by clinicians other than those persons designated as trainers those conducting the restoration programming); Larry H. Strasburger et al., *On Wearing Two Hats: Role Conflict in Serving as Both Psychotherapist and Expert Witness*, 154 AM. J. PSYCHIATRY 448 (1997).

mental health system to the criminal justice arena to resolve the outstanding criminal matters at hand. Therefore, where restoration programs exist, despite the ethical tensions noted earlier, clinicians have likely adopted the notion that restoration achieves some greater good either for the individual and/or for society.

There are several ways in which clinicians might view restoration as helpful in a larger context. Specifically, once charges are resolved, individuals in need of further treatment can be diverted to appropriate mental health care wherever they are sent. Resolution of the criminal charge may allow for treatment via a civil, rather than criminal, route. Additionally, restoration for an individual defendant can assist the defendant in achieving maximal functional autonomy, which is a goal of general psychiatric treatment aimed toward recovery for persons with serious mental disorders. Although this improved functional autonomy might result in a defendant being returned to the criminal justice system, defendants would be best equipped to deal with legal and personal choices if able to more adeptly understand their situation and the proceedings they face. With an eye toward improving the ability of incompetent defendants to cope with challenges that life brings, treating clinicians may view their work as assisting these individuals defendants attain the tools needed to help themselves. Without treatment, these same defendants might languish in institutions in legal and clinical limbo, with no resolution to the criminal matter or to the clinical symptoms that contributed to the need for institutionalization.

From a policy standpoint, without restoration efforts for mentally disordered offenders, the question of warehousing untreated individuals would become a significant concern. Inadvertently increased stigma might also attach to these defendants if they are sequestered from the rest of criminal defendants who are obliged to face trial. If excessive numbers of mentally disordered defendants were permitted to avoid trial by virtue of having an unaddressed mental disability, society would have failed in integrating them into the social requirements of other citizens. Ongoing efforts to conduct functional analysis of defendants' capacities, rather than a presumption of incompetence based on the presence of a mental disorder, and a focus on competence restoration can assist in avoiding these negative outcomes.

Regardless of the evolution of restoration efforts, the themes raised in *Jackson v. Indiana* remain relevant. There will presumably always be incompetent defendants, including those unable to be restored. As jurisdictions continue to develop mechanisms for managing these defendants, clinicians and legal professionals would do well to consider long-term treatment needs of the defendants and informed, practical approaches to problem solving.