Future Directions in the Restoration of Competency to Stand Trial

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Abstract
While a vast amount of research has focused on the evaluation of competency to stand trial, there is a relative dearth of research on competency restoration. Only recently have systematic research efforts begun to focus on the issue of restoration. Two primary areas of inquiry regarding restoration have emerged: the prediction of restorability (and the examination of variables related to successful and unsuccessful restoration attempts) and the investigation of various treatment programs for competency restoration. This article will briefly summarize the recent research with respect to these two areas and will highlight deficiencies in our current knowledge with the hope of providing an impetus for future research on competency restoration and related issues.

Keywords
competency to stand trial, competency, restoration, treatment

Incompetency to stand trial is a legal concept of jurisprudence that allows defendants who are unable to participate in their own defense to postpone their trial until competency is regained. The U.S. Supreme Court established the current legal standard for determining competency to stand trial in Dusky v. United States (1960), and every jurisdiction has adopted or adapted this standard into their competency statutes. The issue of how to deal with incompetent defendants, however, was not addressed in Dusky.

Until the landmark case of Jackson v. Indiana (1972), most states allowed the automatic and indefinite confinement of incompetent defendants. This resulted in many defendants being held for lengthy periods of time, often beyond the sentence that might have been imposed had they been convicted. In Jackson, the Supreme Court held that a defendant committed solely on the basis of incompetency “cannot be held more 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” (p. 738). The Court did not specify restrictions to the length of time a defendant could reasonably be held, nor did it indicate how progress toward the goal of regaining competency could be assessed. Nevertheless, this decision resulted in changes to state laws regarding confinement of incompetent defendants. Many states now place limits on the maximum length of time an incompetent defendant can be held and, if a defendant is determined to be unlikely to ever regain competency, the commitment must be terminated. It is worth noting, however, that some states appear to continue to circumvent Jackson by allowing long-term and even indefinite confinement of incompetent defendants (Miller, 2003).

Since 1980, a relatively limited amount of research has begun to accumulate with respect to the issue of competency restoration. Although outpatient treatment is possible, most treatment continues to take place in residential forensic facilities (Miller, 2003). The vast majority—around 75%—of incompetent defendants are returned to court as competent within about 6 months (Bennett & Kish, 1990; Golding, Eaves, & Kowaz, 1989; Morris & Parker, 2008; Nicholson & McNulty, 1992). In general, research has examined two types of questions: (a) whether there are certain variables that can predict who will and will not regain competency and (b) whether certain types of treatment programs are more successful than others. We will review the literature on these two questions in the next two sections.

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Prediction of Restorability

As a result of the Jackson decision, mental health professionals are often required to predict a defendant’s probability of regaining competency. That is, examiners must determine if competency can be restored in a reasonable amount of time. Extrapolating from the work of Mehl (1954), it could be argued that, due to the low base rate of failure to restore competency, evaluators could not predict with any degree of accuracy those defendants who would not regain competency, as those evaluators were likely to automatically assume that competency could be restored. Indeed, in 1980, Roesch and Golding speculated that mental health professionals were limited in their ability to predict which defendants would not be restorable to competency. Research conducted since then has confirmed that the ability of clinicians to predict competency restoration is poor (Carbonell, Heilbrun, & Friedman, 1992; Hubbard, Zapf, & Ronan, 2003; Nicholson, Barnard, Robbins, & Hankins, 1994; Nicholson & McNulty, 1992). An early study conducted by Cuneo and Brelje (1984) illustrates the problems in predicting restoration. These researchers found a 78% accuracy rate for professionals who were asked to predict whether competency would be restored within 1 year. Although at first glance, this rate may seem impressive, it becomes less so when the high base rate for restoration is taken into consideration (i.e., the fact that most defendants are restored within a 6-month period). The false-positive rate (i.e., the proportion of defendants who are predicted to regain competency but do not) is a more appropriate statistic to evaluate the ability to accurately predict responsiveness to treatment. In the Cuneo and Brelje study, the false-positive rate was 23%. Thus, it appears that clinicians have a difficult time identifying the smaller percentage of incompetent defendants who will not respond to treatment.

Hubbard and Zapf (2003) used logistic regression to investigate the variables related to predictions of restorability in a sample of 89 incompetent defendants and found that current violent charge and previous criminal history were the two most significant predictors of restorability decisions. In attempting to explain this finding, the authors interviewed key players in the forensic system who postulated that this might be the result of political pressure to hold accountable and to take to trial those individuals charged with violent crimes and those with criminal histories. When criminal, diagnostic, and sociodemographic variables were considered individually, defendants predicted to not be restorable were more likely to be older and to have impairment in the ability to understand information about the legal process, whereas those predicted to be restorable were more likely to have less serious diagnoses (i.e., nonpsychotic mental disorders) and more serious, violent criminal histories (Hubbard et al., 2003).

In a statistically well-controlled study on prediction of competency restoration, Mossman (2007) examined the records of 351 inpatient pretrial defendants who underwent competency restoration at a state psychiatric facility in Ohio, to determine whether there were certain variables available to forensic examiners that could predict restoration outcome. The variables of interest included demographic characteristics, diagnoses, symptom patterns, criminal charges, number of prior psychiatric hospitalizations, and cumulative prior length of stay. Mossman found that there were two typical instances in which a defendant might be considered to have a low probability of restoration: first, if the basis for the defendant’s incompetence was a long-standing psychotic disorder that had resulted in lengthy periods of hospitalization, and second, if the basis for the defendant’s incompetence was an irremediable cognitive disorder, such as mental retardation, that resulted in a limited grasp of the information that an examiner attempted to convey during an evaluation. Each of these scenarios appears to result in a well-below-average chance of successful restoration.

In a similar study, Morris and Parker (2008) examined data from 1,475 admissions for competency restoration in Indiana between 1988 and 2005 to determine the factors associated with successful restoration to competence. These authors reported that 72.3% of the admissions over this time period were restored to competence within 6 months and 83.9% within 1 year. In addition, those with mood disorders were most likely to be restored to competence and were significantly more likely to be restored than those diagnosed with psychotic disorders. Defendants with mental retardation (either alone or in conjunction with a mental illness) were significantly less likely to be restored than were defendants with any other psychiatric disorder, and those diagnosed with both mental retardation and a mental illness were significantly less likely to be restored than were defendants with mental retardation alone. Regression analyses indicated that females and those with affective disorders were most likely to be successfully restored, whereas older age, mental retardation, and a psychotic diagnosis were significantly related to a decreased chance of restoration.

The available research has provided two important insights for clinicians who are required to make predictions regarding restorability and for lawmakers charged with developing or refining competency statutes. First, the vast majority of defendants are restored to competency within a 6-month period (and even more within 1 year). Second, certain characteristics have been consistently suggestive of a reduced chance of successful restoration: older age, a diagnosis of mental retardation, and a diagnosis of psychotic disorder (especially if it has resulted in lengthy periods of hospitalization). This is important information for evaluators to consider when opining about the chances of a defendant’s successful restoration.

The weaknesses in the available research, however, are its primary focus on diagnosis as a psychiatric indicator of successful or unsuccessful restoration and its reduction of competence to a single construct. Information regarding the specific symptoms associated with unsuccessful and successful restoration attempts and the specific competency-related abilities that are impaired and/or remediable would be more useful in this regard. To date, research on competency (and other psycho-legal issues) has focused almost solely on diagnosis as a psychiatric indicator; however, diagnosis per se is far less informative than is information regarding the extent to which specific psychiatric symptoms
are associated with competency-related deficits and successful and/or unsuccessful restoration attempts.

Only relatively recently have some investigators begun to focus more on the specific competency-related abilities than on competency as a singular construct (see Jacobs, Ryba, & Zapf, 2008; Viljoen, Zapf, & Roesch, 2003). Moving forward, research that examines both symptom-level impairments and competency-specific deficits will provide a more detailed illustration of the ways in which specific symptoms (regardless of diagnosis) impact various competency-related abilities. This information could provide key insights regarding the types of symptoms and competency-related deficits that have the most significant implications for competency status and successful remediation. Competency restoration programs could then be developed and tailored to individual defendants and their specific symptoms and deficits.

Treatment Programs for Competency Restoration

Incompetence is predicated on two components: a mental disorder or cognitive impairment and a deficit in one or more competency-related abilities that occurs as a result of the mental disorder or cognitive impairment. Thus, treatment programs for the restoration of competency have typically targeted both mental disorder/cognitive impairment and competency-related abilities. It is often the case that improvement in the underlying mental disorder or cognitive impairment results in improvement in competency-related deficits. The most common form of treatment for the restoration of competency involves the administration of psychotropic medication.

The majority of incompetent defendants consent to the use of medication. The issue of an incompetent defendant refusing to consent has been tested in a number of court cases (e.g., Washington v. Harper, 1990; Riggins v. Nevada, 1992). The U.S. Supreme Court held, in Sell v. United States (2003), that antipsychotic drugs could be administered against the defendant’s wishes for the purpose of restoring competency, but only in rare, limited circumstances. Writing for the majority, Justice Breyer noted that a court “must find that medication is substantially likely to render the defendant competent to stand trial and substantially unlikely to have side effects that will interfere significantly with the defendant’s ability to assist counsel in conducting a defense” (p. 167).

Although medication is the most frequent treatment, some jurisdictions have established educational treatment programs designed to increase a defendant’s understanding of the legal process or individualized treatment programs that confront the problems that hinder a defendant’s ability to participate in his or her defense (competence-related deficits). In addition, some jurisdictions have implemented treatment programs specifically targeted toward those defendants found incompetent to proceed on the basis of mental retardation.

The success of treatment programs for the restoration of competence is variable and dependent upon the type of treatment program and the type of defendant targeted. Anderson and Hewitt (2002) examined treatment programs designed to restore competency in defendants with mental retardation and found that only 18% of their sample was restored. These researchers concluded that “for the most part, competency training for defendants with [mental retardation] might not be that effective” (p. 349). Other researchers and commentators have found similar results and have noted the difficulty in treating a chronic condition such as mental retardation (Appelbaum, 1994; Pinals, 2005; Wall, Krupp, & Guilmette, 2003).

Treatment programs that target defendants with various other types of mental disorders have met with more success, in that larger proportions of the defendants are restored to competency. Siegel and Elwork (1990) evaluated the use of an educational program as part of the competency restoration process by comparing randomly assigned control and experimental groups. The experimental condition included the use of a videotape that described the roles of courtroom personnel and court procedure, as well as group problem-solving sessions in which problems arising from a defendant’s actual legal case were presented and discussed. Results showed greater improvement on Competency Assessment Instrument scores for the experimental group and a greater number of staff recommendations of competency to stand trial (45 days after treatment, 43% of the treated group, but only 15% of the controls were considered competent by staff).

Bertman and colleagues (2003) examined the effectiveness of three types of treatment programs for the restoration of competence: standard hospital treatment, legal rights education, and deficit-focused (competency-related, not psychiatric, deficits) remediation. While the individualized treatment programs (both legal rights education and deficit-focused remediation) led to higher scores on posttreatment competency measures than did standard hospital treatment, the authors were unable to tease apart whether this was a result of the individualized attention or simply a result of the greater number of treatment sessions that those in the individualized treatment groups received. Thus, it is not clear that individualized treatment programs that target specific underlying deficits for each defendant are any more effective than educational programs that teach defendants about their legal rights.

What the available research appears to indicate is that successful restoration is related to how well the defendant responds to psychotropic medications administered to alleviate the symptoms of the mental disorder. The addition of an educational component (either general or individualized) appears to offer some benefit for increasing a defendant’s legal knowledge; however, to date, there has not been any published research that specifically examines how either the improved symptoms of mental disorder or improved legal knowledge might impact a defendant’s specific competency-related abilities or deficits. Once again, it becomes clear that more information regarding the interplay between psychiatric symptoms and competency-related abilities or deficits could provide better direction for the development and personalization of competency restoration programs.
Call for Research

Recently, Schwalbe and Medalia (2007) have argued for the use of cognitive remediation as an adjunct to competency restoration programs on the basis that there is evidence to suggest that it leads to improved cognitive functioning (e.g., improved attention, reasoning, memory, executive function), which not only improves the success of competency training but also improves the individual competency-related abilities required of a defendant (i.e., the specific prongs of the Dusky standard). Although they provide no data, Schwalbe and Medalia make a sound, rational argument for the inclusion of a specific treatment component that targets the exact abilities to be restored. This is precisely the type of rationale upon which treatment programs for competency restoration should be developed and tested.

Future research on competency restoration is necessary to further develop and refine effective competency restoration programs for various types of defendants. Focusing on specific cognitive deficits and symptoms of mental disorder and the interplay between these and various competency-related abilities and deficits will provide critical information to increase our understanding of both the construct of competence (and all that it entails) and how we can develop and refine effective interventions for the successful restoration of competency.

Notes

1. Our discussion of treatment focuses on adults found incompetent. As Viljoen and Grisso comment (2007), adolescent competence concerns are due infrequently to mental illness but more often to deficits stemming from developmental immaturity and/or mental retardation. As a consequence, neither psychotropic medication nor psychoeducational programs are likely to be effective.

Declaration of Conflicting Interests

The authors declared that they had no conflicts of interest with respect to their authorship or the publication of this article.

Recommended Reading

Mossman, D. (2007). (See References). Examines the characteristics of incompetent defendants and concludes that two types of defendants appear to be unrestorable.


References


