Washington State Institute for Public Policy

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January 2013

STANDARDIZING PROTOCOLS FOR TREATMENT TO RESTORE COMPETENCY TO STAND TRIAL:

INTERVENTIONS AND CLINICALLY APPROPRIATE TIME PERIODS

The Washington State Institute for Public Policy (Institute) was directed by the 2012 Legislature to "*study and report to the legislature the benefit of standardizing treatment protocols used for restoring competency to stand trial in Washington, and during what clinically appropriate time period said treatment might be expected to be effective.*"

To conduct this work, the Institute contracted with a national expert in the field, Dr. Patricia Zapf. The attached report provides background on the types of interventions (treatments) used throughout the United States for the restoration of competency to stand trial, and research regarding the timelines for restoration. In addition, data on length of stay at Eastern State Hospital and Western State Hospital for incompetent defendants remanded for competence restoration are summarized.

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Suggested citation: Zapf, P. (2013). *Standardizing Protocols for Treatment to Restore Competency to Stand Trial: Interventions and Clinically Appropriate Time Periods* (Document No. 13-01-1901). Olympia: Washington State Institute for Public Policy.

Standardizing Protocols for Treatment to Restore Competency to Stand Trial:

Interventions and Clinically Appropriate Time Periods

January 2013

Patricia Zapf, Ph.D.

The Washington State Institute for Public Policy (Institute) was directed by the 2012 Legislature to "*study and report to the legislature the benefit of standardizing treatment protocols used for restoring competency to stand trial in Washington, and during what clinically appropriate time period said treatment might be expected to be effective."*

Data from Western State Hospital and Eastern State Hospital were examined to determine typical length of stay for defendants deemed incompetent and remanded for restoration.

This report then summarizes the literature on treatment protocols used to restore defendants to competency throughout the United States and the literature on the time periods for restoration.

Finally, the report summarizes the 2011-12 recommendations of the National Judicial College's Best Practices Model.

The Washington State Institute for Public Policy (Institute) was directed by the 2012 Legislature to "*study and report to the legislature the benefit of standardizing treatment protocols used for restoring competency to stand trial in Washington, and during what clinically appropriate time period said treatment might be expected to be effective*."[1]

This report provides background on the types of interventions (treatments) used throughout the United States for the restoration of competency to stand trial. In addition, data on length of stay at Eastern State Hospital and Western State Hospital for incompetent defendants remanded for competence restoration are summarized.

Section 1: Background

The constitutional right to a fair trial includes several elements. An accused individual has the right to be present at the trial, must be able to understand the adversarial nature of the proceedings, and must be capable of helping present a defense. If the issue of competency is raised with respect to a particular defendant, the court must order a competency evaluation. The court may assign one or two experts to the evaluation and order the evaluation to take place in a jail, state hospital, or in the community. In Washington, state employees conduct the vast majority of these evaluations and the interviews occur in a jail.[2]

If, after receiving the evaluation report(s), the court finds that the defendant is competent, the case proceeds to trial. If the court concludes that the defendant is incompetent, a period of treatment may be authorized to restore the defendant to competency.

In Washington, most incompetent adult defendants are sent to Western State Hospital (WSH) or Eastern State Hospital (ESH) for competency restoration. The length of the initial treatment period depends upon the type of

[1] SSB 6492, Laws of 2012

[2] R. Lieb & M. Burley. (2011). *Competency to stand trial and conditional release evaluations: Current and potential role of forensic assessment instruments.* Olympia: Washington State Institute for Public Policy, Document Number 11-05-3401.

charge. Defendants charged with violent felony offenses are committed for an initial treatment period of up to 90 days.[3] Non-violent felony offenses qualify for an initial treatment period of 45 days.[4] Defendants charged with non-felony offenses are committed to an initial treatment period of up to 14 days for competency restoration. [5]

Felony defendants may be committed for a second 90-day period of treatment as long as their incompetence is not the result of a developmental disability.[6] In certain circumstances, felony defendants may be committed for a third period of up to six months (180 days).[7]

Defendants who are restored to competence proceed to trial or to the next step of the criminal adjudication process. Defendants who are not restored to competence have their charges dismissed without prejudice and are evaluated for civil commitment proceedings.[8]

Data from Washington's State Hospitals

The author requested data regarding time frames for competency restoration from the Eastern State Hospital (ESH) and the Western State Hospital (WSH). ESH provided 26 years of data, whereas WSH's data covered two recent years. Data from WSH did not include any information on non-felony defendants and was truncated in terms of the timeframe (with data only be provided from January 1, 2010 on). Additionally, the WSH data did not include variables such as admission dates, discharge dates, or legal status at discharge. These limitations call into question the reliability of the data from WSH, an issue noted in a recent JLARC report.[9]

Eastern State Hospital – Competency Restoration

Length of stay (LOS) data for 429 defendants admitted to Eastern State Hospital (ESH) for competency restoration between April 15, 1987 and October 31, 2011 were examined. Of the 429 defendants admitted to ESH for competency restoration, 373 were felony defendants and 40 were non-felony defendants.[10]

Felony defendants who were not restored to competence had longer LOS than those who were restored. Felony defendants who were restored to competency (n = 241) were hospitalized at ESH for an average of 89.2 days (SD = 53.2 days; range = 6 – 551 days).[11] Felony defendants who were not restored to competence (n = 132) spent an overall average of 153.6 days (SD = 568.8 days; range = 22 – 4372 days) at ESH, which included an average of 72.7 days on competency restoration status (SD = 68.0 days; range = 2 – 373 days).[12]

Non-felony defendants restored to competency (n = 23) were hospitalized at ESH for an average of 29.0 days (SD = 17.2 days; range = 16 – 100 days). Non-felony defendants not restored to competency (n = 17) spent an average

[3] RCW 10.77.086
[4] RCW 10.77.086 (1)(b)
[5] In addition to any unused evaluation time as per RCW 10.77.060, see RCW 10.77.088.
[6] Defendants whose incompetence is the result of a developmental disability are not permitted a second or third period of treatment if it appears that competency restoration is not reasonably likely, see RCW 10.77.086.
[7] RCW 10.77.086 stipulates that criminal charges of incompetent felony defendants shall not be dismissed (after a second period of treatment) if "the court or jury finds that: (a) The defendant (i) is a substantial danger to other persons; or (ii) presents a substantial likelihood of committing criminal acts jeopardizing public safety or security; and (b) there us a substantial probability that the defendant will regain competency within a reasonable period of time" at RCW 10.77.086 (4).
[8] RCW 10.77.084 (1) (c)
[9] JLARC report on Competency to Stand Trial: Phase I dated December 5, 2012.
[10] Data for 16 defendants were not included in the overall analyses as determined by the final legal authority on release: 13 defendants were NGRI (Average LOS for competency restoration = 132.1 days, Range = 7 – 365 days; Average total LOS = 2496.5 days, Range = 119 – 5182 days); 2 were voluntary (Average LOS for competency restoration = 192.5 days, Range = 88 – 297; Average total LOS = 249.5 days, Range = 100 – 399 days); and 1 was released on a competency evaluation status (LOS for competency restoration = 91 days; Total LOS = 98 days).
[11] The total LOS at ESH for this group of restored felony defendants was 97.3 days (SD = 56.3 days; Range = 9 – 551 days), which represented an average additional stay of 8.1 days (SD = 16.2 days; Range = 0 – 111 days). It should be noted that 65 (27%) defendants stayed at ESH beyond their competency restoration commitment status.
[12] These defendants spent an additional average of 80.9 days (SD = 43.2 days; Range = 9 - 210 days) at ESH on civil commitment status after the expiration of their competency restoration order.

of 76.2 days at ESH (SD = 21.1 days; range = 32 – 108 days). These defendants spent an average of 29.1 days (SD = 11.1 days; range = 3 – 51 days) on competency restoration status.[13]

Western State Hospital – Competency Restoration

Length of stay (LOS) data for all felony defendants admitted to Western State Hospital (WSH) for competency restoration after January 1, 2010 were examined.

A total of 272 felony defendants were admitted to WSH for competency restoration after January 1, 2010. The average LOS was 80.56 days (range = 1 – 354 days).

For the vast majority of felony defendants, competency restoration took 90 days or less. The breakdown and average LOS is shown below.

Exhibit 1
Length of Stay for Competency Restoration

	% (n)	Average LOS
≤ 90 days	77.57% (211)	60.46 days
91 – 180 days	19.12% (52)	136.06 days
> 180 days	3.31% (9)	231 days

Comparisons between ESH and WSH – Competency Restoration Timelines

The data supplied for ESH do not easily correspond to those from WSH. Thus, it is difficult to meaningfully compare time frames for competency. A comparison of the average length of time to restoration for felony defendants at ESH and WSH is included below. As mentioned earlier, ESH data cover the last 26 years and WSH data, the last two. Both hospitals appear to be restoring felony defendants to competence within the statutorily required time periods.

The data supplied by ESH and WSH indicate that approximately 35% of felony defendants sent to ESH for restoration were considered not restorable after an average of 73 days and were then civilly committed.

Section Summary

Most felony defendants treated for restoration to competency in Washington are restored to competency within 90 days. The available competency restoration research is summarized in the next two sections, with particular attention to treatment protocols and restoration timeframes.

[13] These defendants spent an additional average of 47.1 days (SD = 20.6 days; Range = 10 – 91 days) at ESH on civil commitment status after the expiration of their competency restoration order.

Exhibit 2
Average Days to Restoration

	ESH	WSH
Felony Defendants		
Average Days to Restoration	89.2 (n = 241)	80.6 (n = 272)
Average Days for Those Not Restored	153.6 (n =132)	N/A
Average Days on Restoration Status	72.7 (n = 132)	N/A
Non-Felony Defendants		
Average Days to Restoration	29.0 (n = 23)	N/A
Average Days for Those Not Restored	76.2 (n = 17)	N/A
Average Days on Restoration Status	29.1 (n = 17)	N/A
Time Frame of Data	April 15, 1987 - October 31, 2011	After January 1, 2010

Section II: Treatment Protocols

This section reviews the research literature on treatment protocols for the restoration of competency to stand trial.

The U.S Supreme Court established the current legal standard for determining competency to stand trial in *Dusky v. United States* (1960).[14] Every public jurisdiction in the United States 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),[15] most states allowed the automatic and indefinite confinement of incompetent defendants. Many defendants were 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."[16] 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.

The *Jackson* 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. Still, some states continue to allow long-term, and even indefinite, confinement of incompetent defendants.[17]

Although outpatient treatment is possible, most treatment continues to take place in residential forensic facilities.[18] Most incompetent defendants are returned to court as competent. This review examines treatment protocols developed for competency restoration.

Note: In this review of the literature, the term "incompetent defendants" is primarily used to refer to those defendants whose incompetence is a result of an Axis I mental disorder, as this represents the majority of

[14] Dusky v. United States, 362 U.S. 402 (1960).
[15] Jackson v. Indiana, 406 U. S. 715 (1972).
[16] Ibid at page 738.
[17] Miller, R. D. (2003). Hospitalization of criminal defendants for evaluation of competence to stand trial or for restoration of competence: Clinical and legal issues. *Behavioral Science and Law, 21*, 369 - 391.
[18] Ibid.

incompetent defendants.[19] When cognitively impaired or developmentally disabled defendants are being referred to, this will be explicitly stated.

Summary of Literature

The section below provides a detailed description of each of the studies from the available literature on treatment protocols for competency restoration for the interested reader. A summary table of the studies can be found on page 17 of this report.

The available literature examines five types of treatment protocols:

1) medication;
2) treatments for individuals with developmental disabilities;
3) educational treatment programs;
4) specialized/individualized treatment programs; and
5) cognitive remediation programs.

Treatment Protocols for Competency Restoration

Incompetence is predicated on two components: (1) a mental disorder or cognitive impairment and (2) a deficit in one or more competence-related abilities (i.e., understanding, appreciation, reasoning, assisting counsel) that occur as a result of the mental disorder or cognitive impairment.[20]

Treatment programs for the restoration of competence typically target mental disorder/cognitive impairment and competence-related abilities. Improvement in the underlying mental disorder or cognitive impairment often results in improvement in competence-related deficits. The most common form of treatment for restoration of competence involves the administration of psychotropic medication.

1) Medication

Most incompetent defendants consent to the use of medication. The possibility that an incompetent defendant refuses to consent has been tested in a number of court cases (e.g., *Washington v. Harper*, 1990;[21] *Riggins v. Nevada*, 1992.)[22] The U.S. Supreme Court held in *Sell v. United States* (2003)[23] that antipsychotic drugs could be administered against a 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."[24]

Although medication is the most frequent form of 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).

Some jurisdictions have implemented treatment programs targeted to defendants found incompetent to proceed on the basis of mental retardation or developmental disability.

[19] Common Axis I disorders include depression, anxiety disorders, bipolar disorder, ADHD, autism spectrum disorders, anorexia nervosa, bulimia nervosa, and schizophrenia.
[20] Zapf, P. & Roesch, R.(2009). Best practices in forensic mental health assessment: Evaluating competency to stand trial. New York: Oxford.
[21] Washington v. Harper, 494 U.S. 210 (1990).
[22] Riggins v. Nevada, 504 U. S. 127 (1992).
[23] Sell v. United States, 539 U. S 166 (2003).
[24] Ibid at page 167.

2) Treatment Programs for Individuals with Developmental Disabilities

Two research studies and two commentaries regarding restoration protocols for defendants with developmental disabilities (mental retardation) were reviewed. All four articles underscored the difficulty in restoring developmentally disabled defendants. The two research studies indicated that about 1/3 of developmentally disabled defendants were restored.

Anderson and Hewitt (2002) examined outcomes of a competency restoration program in Missouri for defendants with mental retardation.[25] One-third of the defendants were restored to competency and two-thirds were not. Of those detained in a habilitation facility, 18% were restored, compared with 50% of those who were detained in a psychiatric hospital. The main difference between the two types of facilities was the wider availability of medications in the hospital facility. These researchers concluded, "for the most part, competency training for defendants with MR might not be that effective."[26] Other researchers and commentators have found similar results and have noted the difficulty in treating a chronic condition such as MR.[27,28]

Wall, Krupp, and Guilmette (2003) described a training program developed in Rhode Island for competency restoration for defendants with mental retardation.[29] This treatment program, called the *Slater Method* after the hospital where it was developed, includes five modules:

1. the purpose of the training, review of the charges, pleas, and potential consequences;
2. courtroom personnel;
3. courtroom proceedings, trial, and plea bargain;
4. communicating with the attorney, giving testimony, and assisting in defense; and
5. tolerating the stress of the proceedings.

Each module is presented in sequential order. Trainers meet with the defendants between one and five days a week for up to an hour. Each module is reviewed with the defendant a minimum of three times (the minimum number of times to ensure retention). The training/restoration program lasts for six months, with additional six-month increments provided as necessary. The authors did not present any data on average time to restoration but did indicate that five of 15 defendants had been restored to competency within an eight month to three year period of time.[30] Tables 1 through 4 provide further description regarding these modules.

[25] Anderson, S. D., & Hewitt, J. (2002). The effect of competency restoration training on defendants with mental retardation found not competent to proceed. *Law and Human Behavior, 26*, 343-351.
[26] Ibid at page 349.
[27] Appelbaum, K. L. (1994). Assessment of criminal-justice-related competencies in defendants with mental retardation. *Journal of Psychiatry and Law, 22*, 311-327.
[28] Pinals, D. (2005). Where two roads met: Restoration of competence to stand trial from a clinical perspective. *New England Journal of Civil and Criminal Confinement, 31,* 81-108.
[29] Wall, B. W., Krupp, B. H., Guilmette, T. (2003). Restoration of competency to stand trial: A training program for persons with mental retardation. *The Journal of the American Academy of Psychiatry and Law, 31,* 189-201.
[30] Ibid at pages 194-198.

Table 1 Summary of Slater Method: Training Tool Rationale

MR Impairment	Phase I Knowledge-Based Training	Phase II Understanding-Based Training
Cognition	The client must learn: • the purpose of training sessions (1)* • the charges (1) • possible pleas (1) • potential consequences (1) • the role of courtroom personnel (2) • the purpose of going to court (3) • the purpose of going to trial (3)	The client must understand that: • this is an adversarial proceeding, and he/she is the accused (1, 3) • he/she cannot be punished just because he/she is accused (1, 3) • a plea is different from a finding (1, 3) • the case may go to trial, but it probably won't (1, 3, 4) • a plea bargain means giving up some rights (1, 3)
Communication	The client must learn: • the importance of speaking with his/her attorney (4) • the importance of listening in court (4) • the importance of not saying "yes" if he/she doesn't understand something (4) • how to testify appropriately (4)	The client must be able to: • understand that the opposing counsel may try to trip him/her up • tell his/her story without self-incrimination • tell all details of his/her story to the attorney • resist leading questions and appreciate and be able to stick to a defense strategy
Emotions and behavior	The client must learn: • to display appropriate behavior (5) • not to display inappropriate behavior (5)	• Role-playing sessions to assess ability to tolerate the stress of courtroom proceedings (1–5)

* Numbers in parentheses denote the main module number(s) where this information is reviewed (see Table 2).

Source: Wall, B. W., Krupp, B. H., Guilmette, T. (2003). Restoration of competency to stand trial: A training program for persons with mental retardation. *The Journal of the American Academy of Psychiatry and Law*, *31*, 189-201.

Table 2 Module Training Topic Summary

Module 1:	Purpose of training: Review of charges, pleas, and potential consequences
Module 2:	Courtroom personnel
Module 3:	Courtroom proceedings, trial, and plea bargain
Module 4:	Communicating with attorney, giving testimony, and assisting in defense
Module 5:	Tolerating stress of proceedings

Source: Wall, B. W., Krupp, B. H., Guilmette, T. (2003). Restoration of competency to stand trial: A training program for persons with mental retardation. *The Journal of the American Academy of Psychiatry and Law*, *31*, 189-201.

Table 3 Sample Questions from Each Module

Column A: Knowledge-Based Questions*	Column B: Understanding-Based Questions
Module 1: Purpose of Training: Review of Charges, Pleas, and Potential Consequences	
What did the police say you did? On what date did this happen? About what time? [*If client does not understand the concept of time, simply teach the date of the offense so it will be memorized for court.*]	**How come you're in trouble?** (Some people say I did something bad. They say I did a crime.)
What is a crime? (It's when you do something bad and break the law.)	**Just because you're in trouble, does that mean you go to jail?** (No) **How come?** (Because I have to tell them I'm guilty or they have to prove I'm guilty before they can punish me. They have to prove it first.)
	Is it a crime to steal a candy bar? (Yes) **Why?** (Because you didn't pay for it. Because it's against the law.) [*Another way to ask this line of questioning at a later time may be:* **Is it a crime to buy a candy bar?** (No) **Why?** (Because you paid for it.)]
Module 2: Review of Courtroom Personnel	
[*Show the photos of the courtroom and ask who sits where. As he/she names the judge, jury, lawyer, ask the following questions*]	**How come the other side's lawyer wants to make you look bad?** (His job is to try to make the judge or jury put me in jail.)
What is the job of the other side's lawyer? (Tries to convince the judge or jury that I did it.)	**Who is on your side in the court?** (My lawyer, my family [*depending on the charge*].)
Can you talk to the other side's lawyer? (Yes.) **When can you talk to the other side's lawyer?** (Only when he asks me a question when I am on the witness stand.)	**Who is not on your side?** (The other lawyer. The judge and the jury are neutral. Some witnesses may not be on my side.)
Module 3: Review of Courtroom Proceedings, Trial, and Plea Bargain	
Having a trial is different from just going to court. There is a trial only if you plead not guilty (innocent). If you plead guilty or *nolo*, there is no trial; instead, the judge just give you the sentence.	**How come you have to go to court?** (Because they say I did something wrong, and when they say you did something wrong, they give you a charge and they take you to court. Because that's how the law works to decide if I'm guilty or not guilty.)
If you say you're guilty, is there a trial? (No)	**Why don't you need a trial if you plead guilty or take a deal?** (Because they already have an answer to the question since I told them I'm guilty or that I did something bad.)
If you say (plead) innocent, is there a trial? (Yes)	
If you say [plead] *nolo*, is there a trial? (No)	
[*Because these are yes/no questions, repeat from a different perspective to make sure the client knows. e.g. What are your possible pleas? (Guilty, innocent and nolo). Which plea would cause the client to have a trial?*]	
Module 4: Review of Working with Attorney/Assisting in Defense	
If you don't understand what is being said about you in court, who can you tell this to? (My lawyer)	**Why is it important to tell your lawyer if you don't understand what is being said?** (Everybody is here in court to talk about me. My job is to make sure that I know what people are saying about my case. I might miss something.)
What do you say to him if you don't understand what is being said? (I say, "I don't know what is going on.")	**Let's talk about what you just told me** (*client's version of what happened*)**. What are the most important things that you told me? Why are these things important?** [*Take the client through several examples of leading questions. Try to get him/her to follow your lead, and then show how he/she is being led so that he/she will recognize the pattern. Then, work with the client to resist answering leading questions, and practice asking for clarification if he/she does not understand a question. The Forensic Service will go over specific examples with you before training.*]
What are the things you need to tell your lawyer? [*Ask the client to tell you his story of what happened. If important parts are left out, help to make it fluent, but don't add new material and don't write down incriminating information. If you don't know what happened, contact the Forensic Service, and we will discuss the police report.*]	
The other side's attorney may try to confuse you on the witness stand. When you are asked a question that you don't understand, what would be the wrong thing to say? (Yes, I understand.) **What will you say instead?** (I don't know what you are saying. Ask me again.)	
Module 5: Tolerating Stress of Proceedings	
How are you supposed to behave in court? (Be nice. Don't yell. Talk to my lawyer.)	**Why is it important to speak up in court?** (Because they are talking about me. Because I have to stand up for myself. Because I have to understand what is going on.)
Can you laugh in court? (No) [*Repeat yes/no questions from a different perspective.*]	**Why is it important to not stand up and move around when court is going on?** (It would make me look bad. I need to look good to help my case.)
Is it good to sit quietly in court? (Yes)	
Does that mean you can never talk in court? (No. I can talk in court sometimes.)	
Can you tell jokes, yell etc., in court? (No) [*Repeat yes/no questions from a different perspective.*] **Why not?** (Because going to court is serious. Because I have to look good.)	
Is it good to talk quietly in court? (Yes)	
Can you get mad in court? (Yes, but I can't yell or scream.)	

* Questions are examples; elaborate on them or add new questions to foster discussion. Samples of acceptable answers are in parentheses.

Source: Wall, B. W., Krupp, B. H., Guilmette, T. (2003). Restoration of competency to stand trial: A training program for persons with mental retardation. *The Journal of the American Academy of Psychiatry and Law, 31*, 189-201.

Table 4 Flow Sheet for Using the Workbook

Step 1:	Phases I and II, Modules 1–5: Ask and record knowledge-based training (Column A) and understanding-based training (Column B) for all modules to obtain a baseline.
	Phase I: Knowledge-Based Training
Step 2:	Phase I, Module 1: Knowledge-based training only (Column A) **Go through this module a minimum of three times. When all answers are fair or good, move to the next step.**
Step 3:	Phase I, Module 2: Knowledge-based training only (Column A) **Go through this module a minimum of three times. When all answers are fair or good, move to the next step.**
Step 4:	Phase I, Module 3: Knowledge-based training only (Column A) **Go through this module a minimum of three times. When all answers are fair or good, move to the next step.**
Step 5:	Phase I, Module 4: Knowledge-based training only (Column A) **Go through this module a minimum of three times. When all answers are fair or good, move to the next step.**
Step 6:	Phase I, Module 5: Knowledge-based training only (Column A) **Go through this module a minimum of three times. When all answers are fair or good, move to the next step.**
Step 7:	Call the Forensic Service to discuss results of Phase I training.
	Phase II: Understanding-Based Training
Step 8:	Phase II, Module 1: Knowledge-based understanding-based training (Columns A and B) **Go through this module a minimum of three times. When all answers are fair or good, move to the next step.**
Step 9:	Phase II, Module 2: Knowledge-based and understanding-based training (Columns A and B) **Go through this module a minimum of three times. When all answers are fair or good, move to the next step.**
Step 10:	Phase II, Module 3: Knowledge-based and understanding-based training (Columns A and B) **Go through this module a minimum of three times. When all answers are fair or good, move to the next step.**
Step 11:	Phase II, Module 4: Knowledge-based and understanding-based training (Columns A and B) **Go through this module a minimum of three times. When all answers are fair or good, move to the next step.**
Step 12:	Phase II, Module 5: Knowledge-based and understanding-based training (Columns A and B) **Go through this module a minimum of three times. When all answers are fair or good, move to the next step.**
Step 13:	Contact the Forensic Service when you believe that your client is ready for a "dress rehearsal" in mock court.

Source: Wall, B. W., Krupp, B. H., Guilmette, T. (2003). Restoration of competency to stand trial: A training program for persons with mental retardation. *The Journal of the American Academy of Psychiatry and Law, 31*, 189-201.

3) Educational Treatment Programs

Five studies on educational treatment programs were reviewed. Educational competency restoration efforts were successful in all five studies but only one study used an experimental design that compared educational programming with no educational programming.

Pendleton (1980) described the treatment program for competency restoration at Atascadero State Hospital, California.[31] Incompetent defendants were administered the Competency to Stand Trial Assessment Instrument (CAI) to determine areas of deficit, which then formed the basis for an individualized treatment plan. Defendants attended a competency education class and were required to obtain a passing score of 70% on a written competency evaluation. Upon successful completion of the written test, defendants were required to participate in a mock trial, using real judges and attorneys. Once the defendant had successfully completed the written exam and the mock trial, a formal competency assessment was then conducted by a mental health professional.

[31] Pendleton, L. (1980). Treatment of persons found incompetent to stand trial. *The American Journal of Psychiatry*, *137*, 1098-1100.

Pendleton reported that 90% of the 205 defendants admitted in 1979 were restored to competency, and 97.5% of that group subsequently completed the trial process. The average length of stay for this group was 104 days.

Davis (1985) described the treatment program at a Columbus, Ohio, maximum-security forensic hospital, which used a problem-oriented individualized treatment plan for the restoration of competence.[32] Defendants were evaluated with respect to the following problems/issues— (a) knowledge of the charge, (b) knowledge of the possible consequences of the charge, (c) ability to rationally communicate with an attorney, (d) knowledge of courtroom procedures, and (e) capacity to integrate and efficiently use the knowledge and abilities outlined above in either a trial or a plea bargain—and then placed into one of five groups, with specific programming for each group:

- *Psychotic confused.* Perceptual and/or thought disturbances interfere with the defendant's understanding of how the legal process works or interfere with communication with the court and the defense attorney. Programming is focused on reality-testing skills and other standard treatment approaches of psychosis.
- *Low functioning.* Patients who have a low IQ or who have brain injury or developmental disability. These patients require didactic, remedial education techniques on the roles and functions of the courtroom participants, court procedures, and possible legal consequences.
- *Delusional-irrational.* Patients who have adequate knowledge about their charge and courtroom procedures, but who distort or misinterpret the reality of their situation because of paranoid or other bizarre delusions. Programming focuses upon enhancing non-delusional coping skills.
- *Disruptive.* Patients who exhibit attention-seeking, hyperactive, impulsive, uncontrollable, or belligerent behavior that impedes learning or the defendant's presence in the courtroom. Programming is focused on providing structure, reinforcement, and behavior management techniques.
- *Advanced maintenance.* Patients awaiting discharge to court; clinically believed to be restored to competence. These patients need to maintain their current competence and develop further coping strategies.

Defendants' progress in the group was monitored and a mock trial was used at the completion of programming. No data regarding restoration rates or length of time to restore competence was presented.

Siegel and Elwork (1990) evaluated the use of an educational program as part of the competency restoration process by comparing randomly assigned control (n = 20) and experimental (n = 21) groups.[33] The experimental group was taught legal concepts using a cognitive, problem-solving approach and psycho-educational components (videotape, courtroom model, and discussion of courtroom personnel/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 competent to stand trial; 45 days after treatment, 43% of the treated group, but only 15% of the controls were considered competent by staff.

Brown (1992) described the competency restoration program at Alton Mental Health and Developmental Center in Illinois.[34] This restoration program was described as didactic in nature and took place in a group format that met daily for 30-45 minutes per session and was organized into seven discrete modules, with each module lasting for several days and including written handouts, videotaped vignettes, a mock trial, video trials, and a written test. The modules addressed the:

[32] Davis D. L. (1985). Treatment planning for the patient who is incompetent to stand trial. *Hospital and Community Psychiatry, 36*, 268-271.

[33] Siegel, A.M., & Elwork, A. (1990). Treating incompetence to stand trial. *Law and Human Behavior, 14,* 57-65.

[34] Brown, D. R. (1992). A didactic group program for person found unfit to stand trial. *Hospital and Community Psychiatry, 43*, 732-733.

(a) nature of criminal charges and sentences,
(b) elements of specific charges,
(c) roles of participants in trial process,
(d) sequence of events in a trial, and
(e) consequences of pleas, verdicts, and sentences. No data was provided regarding restoration rates or the length of time to restoration.

Noffsinger (2001) described an overhauled competency restoration program at the Northcoast Behavioral Healthcare System in Ohio.[35] Prior to the overhaul, the program was educational in nature and consisted of 4 to 5 hours of weekly lectures on the court/legal process provided by the program social worker. The perceived criticisms of this earlier program were that it was one-dimensional and that it did not contain any format other than lectures. A multidisciplinary team was formed to develop a new competency restoration curriculum. The new curriculum consisted of approximately 15 hours weekly of contact time for each defendant and encompassed 7 modules, offered by different members of the multidisciplinary treatment team. The modules consisted of the following:

1. *Educational module.* This module replaced the didactic lecture previously conducted by the program social worker with an enhanced lecture series given by an increased number of clinical staff. A greater number of staff participating in this lecture module could make the lectures more effective in that varied lecturers would make the material more interesting and would result in better learning.
2. *Anxiety Reduction module.* Psychologists met twice weekly for one hour with incompetent defendants and focused on developing anxiety management/relaxation techniques that defendants may use in court. Guided imagery and self-hypnotic skills were also taught.
3. *Guest Lecture module.* Court personnel, such as judges, defense attorneys, prosecutors, and probation officers were invited on a weekly basis to speak to the incompetent defendants and answer questions.
4. *Mock Trial module.* A scripted mock trial was carried out, with defendants playing the roles of the various courtroom personnel.
5. *Video module.* Videotape of actual courtroom proceedings was presented to the defendants, followed by a discussion led by clinical staff.
6. *Post-Restoration module.* In a peer-led discussion, defendants who had previously been to court discussed their experiences with incompetent defendants.
7. *Legal Current Events module.* News stories involving criminal trials that were featured in newspaper articles or the local television news were reviewed and discussed.

Noffsinger reported that the average length of stay in the overhauled competency restoration program was approximately 80 days, which was noted to be shorter than the average length of stay in the earlier one-dimensional treatment program. The Ohio Revised Code provides for maximum competency restoration times, based on the severity of the offense, with defendants charged with misdemeanors and lesser felonies required to be restored within 6 months and those charged with major felonies required to be restored within 1 year. Noffsinger reported that defendants in the new program were restored to competency at the following rates: 81.5% for misdemeanors; 90.9% for lesser felonies; and 85.7% for major felonies. No other data were reported. Noffsinger's recommendations for the components of a competency restoration program are provided in Table 5 (next page).

[35] Noffsinger, S. G. (2001). Restoration to competency practice guidelines. *International Journal of Offender Therapy and Comparative Criminology, 45*, 356-362.

Table 5
Noffsinger's (2001) Proposed Elements of a Model Competency Restoration Program[36]

Objective competency assessment upon admission	Specific deficits that result in incompetence to stand trial should be identified upon entry to the competency restoration program. These specific deficits should then be listed individually on the individualized treatment plan and targeted specifically in the course of the defendant's treatment. As mentioned above, various factors can lead to incompetence, such as psychosis, mood symptoms, mental retardation, lack of information, and so forth. Not all defendants are incompetent for the same reason, and therefore, the underlying reason leading to each defendant's incompetence should be identified by an objective competency assessment upon admission to the program.
Individualized treatment program	Each defendant should have a treatment regimen tailored to his or her specific problems. Deficits identified in the competency assessment upon admission to the program should be listed in the individual treatment plan and addressed by specific treatment interventions.
Multimodal, experiential competency restoration educational experience	Defendants learn material best when it is presented in multiple learning formats by multiple staff. For this reason, learning experiences should involve discussion, reading, video, and role-playing. Learning is also enhanced by experiential methods of instruction, such as a mock trial.
Educational component	A mainstay of the competency restoration program should be education regarding the following: various charges; severity of charges; sentencing; pleas; plea bargaining; roles of the courtroom personnel; adversarial nature of trial process; evaluating evidence.
Anxiety reduction component	An anxiety reduction module can be instrumental in providing relaxation techniques to defendants who may become anxious while in court.
Additional education components for defendants with low intelligence	Defendants who are incompetent due to specific knowledge deficits caused by low intelligence can often be restored to competence but may require additional exposure to the educational material. This may be addressed by providing additional learning experiences through increased lecture time as well as individual instruction using simplified terminology.
Periodic reassessment of competency	Defendants should be periodically reassessed for their progress toward restoration to competence. Periodic assessment allows the treatment teams to measure whether their treatment interventions are working, and whether additional treatment elements need to be incorporated into patients' treatment plans.
Medication treatment	Because psychotic and mood disorders are a major cause of incompetence, underlying mood and psychotic disorders must be aggressively treated with biological therapies for restoration to competence to occur.
Capacity assessments / involuntary treatment	Defendants adjudicated as incompetent to stand trial may also lack the capacity to give informed consent for treatment/medication. Because an important component of restoration to competence is medication treatment of underlying mental disorders, it is essential that clinicians address incompetence for treatment decisions per their local hospital policy and state laws. Defendants who refuse medication treatment should be evaluated for competence to make treatment decisions. Defendants who consent to medication treatment but appear incompetent to make such decisions should also be evaluated for competence to make treatment decisions.

[36] Ibid at pages 360-361.

4) Specialized / Individualized Programs

Two studies on specialized or individualized treatment programs were reviewed. Both used an experimental design to examine the effectiveness of a specialized or individualized treatment program. One found no difference between legal and non-legal programming, but both groups engaged in problem-solving activities as part of treatment. The other study found that both deficit-focused remediation and legal rights education impacted competency in comparison with standard hospital treatment, but did not differ from each other in terms of this effect so concluded that legal rights education is a more cost-effective treatment.

Bertman and colleagues (2003) evaluated the effectiveness of individualized treatment for the restoration of competency.[37] Three types of treatment groups were compared: a deficit-focused remediation group (n = 8); a legal rights education group (n = 10); and a standard hospital treatment group (n = 8). The authors indicated that there were no significant baseline differences between the three groups. Each group was administered competency assessment instruments pre- and post-treatment and all three groups performed significantly better on these measures post-treatment. The deficit-focused remediation group and the legal rights education group both demonstrated higher post-treatment scores than did the standard hospital treatment group. The authors found that these two groups demonstrated approximately 50 percent more improvement on competency measures than the standard hospital treatment group. They found no significant differences between the deficit-focused remediation and the legal rights education groups. Thus, they concluded that given no significant differences between the deficit-focused (individualized) remediation and legal rights education groups, deficit-focused remediation may not be necessary when legal rights education appears to work just as well and is less resource-intensive (that is, does not require a different program for each individual). No data regarding restoration or the length of time to restoration were provided.

Mueller and Wylie (2007) examined the effectiveness of the Fitness Game, an intervention created for the restoration of competence to stand trial, in a sample of 38 defendants referred for competency restoration to Hawaii State Hospital to determine whether competency-specific programming would significantly contribute to progress toward competency restoration.[38] The MacArthur Competence Assessment Tool – Criminal Adjudication (MacCAT-CA) was administered to all participants both pre- and post-intervention. Both the experimental (n = 21) and control groups (n = 17) showed significant pretest to posttest improvements on the Understanding and Appreciation subscales of the MacCAT-CA; however, no significant differences were found between the experimental and control groups at posttest on the competency measures. The researchers concluded that the Fitness Game was no more effective at restoring competency than non-legal programming; "in other words, individuals committed to a psychiatric hospital for care and treatment were as likely to improve as those receiving additional specialized competency restoration treatment."[39] The average length of time from admission to posttest in this study was 72.4 days.

5) Cognitive Remediation Programs

One commentary on cognitive remediation programs was relevant to this review. These authors argue for the inclusion of a cognitive remediation component in competency restoration because it focuses on those exact abilities that are deficient in incompetent defendants.

In 2007, Schwalbe and Medalia argued for the use of cognitive remediation as an adjunct to competency restoration programs. They based their conclusion on evidence that cognitive remediation leads to improved cognitive functioning (e.g., improved attention, reasoning, memory, executive function), which not only improves

[37] Bertman, L. J., Thompson, J. W., Jr., Waters, W. F., Estupinan-Kane, L., Martin, J. A., & Russell, L. (2003). Effect of an individualized treatment protocol on restoration of competency in pretrial forensic inpatients. *Journal of the American Academy of Psychiatry and Law, 31*, 27-35.

[38] Mueller, C. & Wylie, A. M. (2007). Examining the effectiveness of an intervention designed for the restoration of competency to stand trial. *Behavioral Sciences and the Law, 25*, 891-900.

[39] Ibid at page 891.

the success of competency training but also improves the individual competence-related abilities required of a defendant (i.e., the specific prongs of the *Dusky* standard).[40,41]

Although they include no data, Schwalbe and Medalia provide a sound, rational argument for the inclusion of a specific treatment component that targets the exact abilities that hospitals attempt to restore in incompetent defendants. A flowchart depicting the way cognitive remediation leads to improved cognitive functioning, which in turn leads to better performance in competence-related abilities, is presented in Figure 1. This model is based on a rationale that is in line with current best practices in the evaluation of competency to stand trial and that attempts to specifically target those areas of deficit in incompetent defendants.

Figure 1
Cognitive Remediation Competency Flow Chart

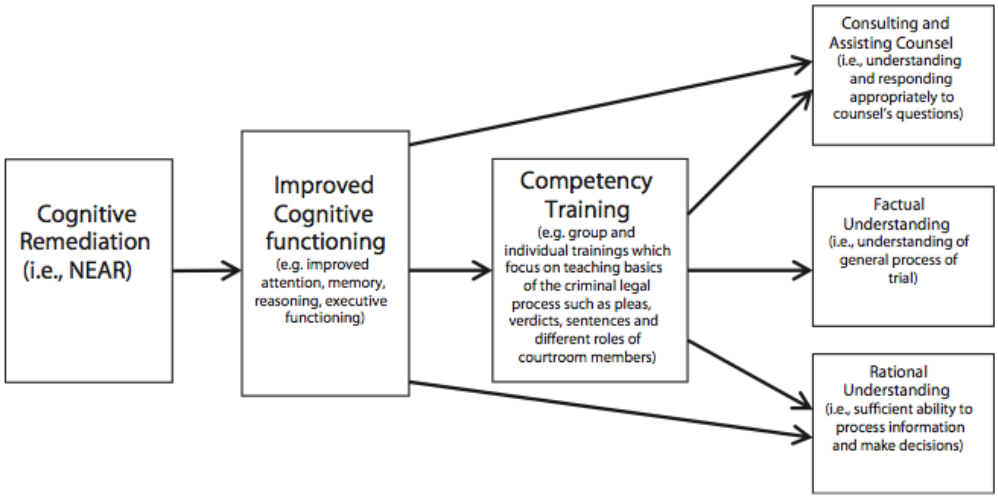

Figure 1. Cognitive remediation competency flow chart.

Source: Wall, B. W., Krupp, B. H., Guilmette, T. (2003). Restoration of competency to stand trial: A training program for persons with mental retardation. *The Journal of the American Academy of Psychiatry and Law, 31*, 189-201.

[40] Schwalbe, E., & Medalia, A. (2007). Cognitive dysfunction and competency restoration: Using cognitive remediation to help restore the unrestorable. *Journal of the American Academy of Psychiatry and Law, 35*, 518-525.

[41] A recent commentary on competency restoration called for further attention, in terms of development and testing, of this type of restoration protocol. Its sound logic and rationale and its focus on remediating cognitive deficits that, in turn, impact competence-related abilities is precisely where we need to be focusing our attention in this arena. See Zapf, P. A., & Roesch, R. (2011). Future directions in the restoration of competency to stand trial. *Current Directions in Psychological Science, 20*, 43-47.

The National Judicial College's Best Practices Model – Competency Restoration

Recently, the National Judicial College assembled a panel of experts[42] to develop a Mental Competency—Best Practices Model that would present "a body of practices deemed to be most effective and efficient for handling mental incompetency issues in the criminal justice and mental health systems."[43] The Best Practices Model with respect to restoration is summarized in the box below.[44]

National Judicial College's Best Practices Model: Competency Restoration

Best Practice: It is a best practice for the treating physician or primary treatment provider to determine the treatment regimen necessary for the defendant to be restored to, and maintain, competency. If the defendant is in need of psychoeducational training to gain competency to stand trial or plead, it is a best practice to provide psychoeducational training as part of the competency restoration. It is a best practice to rely on the opinion of the evaluating mental health professional as to what competency restoration interventions should be initially provided to the defendant.

Discussion: There is a debate as to whether psychoeducational training is effective in helping to restore competency to defendants who are not cognitively challenged. Many practitioners currently utilize some type of psychoeducational group training for competency restoration. However, to date, there does not appear to be scientific evidence to demonstrate that this type of training is essential to restore competency in persons who suffer from a mental illness; nor is there is evidence that these individuals will be restored faster with psychoeducational training.

Statistics show that approximately 90 percent of defendants referred for competency restoration are diagnosed with a mental health disorder, and approximately 10 percent are diagnosed with a cognitive disorder or developmental disability (these numbers may vary slightly from state to state). Of the roughly 10 percent of defendants who are diagnosed with a cognitive disorder or developmental disability, roughly 18-30 percent are rendered competent. For this group, psychoeducational training may be the only method available to render them competent.

Section Summary

The available research and commentary suggests that successful restoration is related to how well the defendant responds to psychotropic medications administered to alleviate symptoms of mental disorders. The addition of an educational component (either general or individualized) appears to offer some benefit for increasing a defendant's general legal knowledge and for increasing the level of competency in the defendant.

Research examining the efficacy of various educational treatment programs for defendants with mental retardation (developmental disability) was also reviewed. The converging conclusion across each of the studies reviewed was that competency training for these individuals does not appear to be very effective.

The Slater Method, described by Wall and colleagues, is a resource-intensive training program that resulted in one-third of the defendants restored to competency in a time frame of eight months to three years. Consideration must be given to balancing the benefit of the program and the amount of resources (i.e., time, staff) involved in offering such a program. As a general statement, it takes many more resources to restore a defendant with a developmental or cognitive disability to competence than it does to restore a mentally ill defendant, and fewer defendants with cognitive or developmental disabilities are ultimately restored.

[42] The panel includes judges, lawyers, policy makers, court managers, psychiatrists and psychologists, from academic, research, clinical and practice positions—all expert on various aspects of competency to stand trial. The authors this report, Patricia Zapf, was a panel member.

[43] More information about the panel or the Best Practices Model, as well as a copy of the complete Best Practices Model document and other helpful resources are available from the website www.mentalcompetency.org.

[44] Best Practices Model Section VI (B) available at http://www.mentalcompetency.org/model/model-sec-VI.html#VI

The available research on the efficacy of including an educational component to competency restoration for defendants with mental illness. provides some evidence for including an educational component with competency restoration. Siegel and Elwork (1990)[45] demonstrated that the use of an educational component that incorporated legal concepts using a cognitive, problem-solving approach and psycho-educational components (videotape, courtroom model, and discussion of courtroom personnel/procedure as well as group problem solving sessions in which problems arising from a defendant's actual legal case were presented and discussed) increased competency restoration rates. In addition, Noffsinger (2001)[46] presented a comprehensive model for competency restoration, that encompasses the same type of educational components as described by Siegel and Elwork, but that also includes additional aspects such as an anxiety reduction component. Noffsinger's model was included as a Table in this report as it might provide useful information for the State of Washington in this regard.

Additional studies that examined the specialized or individualized components in competency restoration concluded that the additional resources involved in individualized treatment plans might not be justified.

Finally, recent commentary[47] has indicated the potential utility of a competency restoration program focuses on improving the cognitive skills of incompetent defendants. This approach could provide some additional benefit to incompetent defendants in terms of both improving cognitive skills and functioning in general as well as with respect to the specific competence-related abilities required to proceed. More research in this area is needed.

Conclusions about Treatment Protocols

The available literature on treatment protocols for the restoration of competence in defendants who are not cognitively or developmental disabled does not provide strong scientific evidence for a preferred method for competency restoration, aside from pharmaceutical treatment. According to the National Judicial College's Best Practices Model, pharmaceutical treatment should be tailored to the specific needs and symptoms of each defendant.

The benefit of adding educational programs to medication protocols for competency restoration of non-developmentally disabled defendants has not been clearly established. There does appear to be some support for the inclusion of a general legal educational component and an opportunity for defendants to engage in problem solving about their own cases in a group format.

Cognitive remediation programs for competency restoration may hold some promise but scientific evidence is needed. This is certainly an area worthy of further investigation.

For defendants with developmental disabilities, educational treatment programs may be one of the only means for increasing the level of competence; however, there is limited scientific evidence for the overall efficacy of implementing these resource-intensive training programs.

The table below provides a brief description of each of the research studies reviewed.

[45] See note 32.
[46] See note 34.
[47] See notes 39 and 40.

Authors/Study	State/N	Study Population/ Success of Restoration Efforts	Timeframe for Restoration	Summary
		Treatment Protocols for Defendants with Developmental Disabilities		
Anderson & Hewitt (2002)	Missouri (N = 75)	1/3 were restored; 2/3 were not	No data on timeframes	Concluded that competency training for those with MR might not be that effective
Wall, Krupp, & Guilmette (2003)	Rhode Island (N = 15)	1/3 of defendants were restored	Restoration took between 8-months and 3-years	Full description of the Slater Method program for developmentally disabled; resource-intensive
Appelbaum (1994)	Commentary underscoring difficulty in restoring those with MR			
Pinals (2005)	Commentary underscoring difficulty in restoring those with MR			
		Educational Treatment Programs		
Pendleton (1980)	California (N= 205)	90% were restored	104 days	Most defendants were restored within 4 months
Davis (1985)	Ohio (N not provided)	No data provided	No data provided	Provided detailed description of program
Siegel & Elwork (1990)	No information provided (n = 20 controls; n = 21 experimental)	43% of those who received educational program were restored compared to 15% of controls	45 days	Educational, problem-solving approach was effective in restoring competency
Brown (1992)	Illinois (N not provided)	No data provided	No data provided	Described their didactic, educational approach and seven modules
Noffsinger (2001)	Ohio (N not provided; 40-bed facility)	81.5% of misdemeanants restored within 6 months; 90.9% of lesser felony D's restored within 6 months; 85.7% of major felony D's restored within 1 year	6 months or 1 year as defined by statute	Provided a detailed description of this restoration program
		Specialized/Individualized Treatment Programs		
Bertman et al. (2003)	Louisiana (n = 8 controls; n = 8 deficit-focused; n = 10 legal rights)	No data provided	No data provided	Compared deficit-focused remediation, legal rights education, and standard hospital treatment and found an effect for both deficit-focused remediation and legal rights education but no differences between the two types of treatments.
Mueller & Wylie (2007)	Hawaii (n = 17 controls; n = 21 experimental)	No data provided	72.4 days	Compared legal and non-legal programming and found no differences
		Cognitive Remediation Programs		
Schwalbe & Medalia (2007)	Commentary regarding the inclusion of a cognitive remediation component, which targets competence-related abilities (attention, memory, reasoning, executive functioning)			

Section III: Restoration Time Periods

The available research from 15 studies on timelines for restoration is reviewed in this section.

Summary of Literature

Research exploring the rates of competency restoration consistently indicates that the vast majority of defendants (80 – 90%) are eventually restored to competency.[48,49,50,51,52] Most defendants are restored to competency within 180 days and an even greater number are restored within one year.

Restoration Time Periods

Methodological issues with some of the earlier research in this area makes it difficult to determine the exact timelines for restoration. Some recent research has used more sound methodology, which allows for more specific information regarding how long it takes to restore certain types of defendants.

Pendleton (described in more detail in Section II above) reported that 90% of the 205 defendants admitted to the competency restoration program at Atascadero State Hospital in California in 1979 were restored to competency.[53] This group had a mean length of stay of 104 days and 97.5% of them subsequently completed the trial process.

Rodenhauser and Khamis (1988) examined restorability and length of stay in a sample of 376 patients who were court ordered to a maximum-security forensic hospital for competency restoration over a four-year period. Although these authors did not report overall rates of restoration, they did examine rates by factors such as medication refusal and diagnosis. The overall average length of stay was 153 days (SD = 164 days), with longer length of stay associated with a diagnosis of schizophrenia, lack of personality disorder, felony charges, medication refusal, involuntarily receiving medication, and requiring physical restraint[54].

Siegel and Elwork (described in more detail in Section II above) conducted a controlled study of a competency restoration program in the Philadelphia area and reported that 43% of the intervention group (versus only 15% of the control group) was restored to competency within 45 days.[55]

Bennett and Kish (1990) examined the relationship between length of treatment and demographic characteristics for 1090 incompetent defendants remanded to the North Florida Evaluation and Treatment Center between 1978-1984 for competency restoration to determine whether demographic characteristics influence length of time to

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[48] Cuneo, D. J., & Brelje, T. B. (1984). Predicting probability of attaining fitness to stand trial. *Psychological Reports, 55*, 35-39. (Found that 74.4% were restored within one year, 25.6% were not restored after one year.)
[49] Lamb, H. R. (1987). Incompetency to stand trial. *Archives of General Psychiatry, 44*, 754-758. (Found that 83.5% were restored after a median hospital stay of 4.5 months; did not describe the percent who were not restored.)
[50] Mowbray, C. T. (1979). A study of patients treated as incompetent to stand trial. *Social Psychiatry, 14*, 31-39. (Reported an 88.7% restoration rate, 7.2% not restored.)
[51] Nicholson, R., Barnard, G., Robbins, L., & Hankins, G. (1994). Predicting treatment outcome for incompetent defendants. *Bulletin of the American Academy of Psychiatry and the Law, 22*, 367-377. (Reported that 89.5% were restored, 10.5% not restored within 1 year.)
[52] Nicholson, R., & McNulty, J. (1992). Outcome of hospitalization for defendants found incompetent to stand trial. *Behavioral Sciences and the Law, 10, 371*-383. (Found 94.7% were restored, 5.3% not restorable.)
[53] See note 27.
[54] Rodenhauser, P., & Khamis, H. J. (1988). Predictors of improvement in maximum-security forensic hospital patients. *Behavioral Sciences and the Law, 6*, 531-542.
[55] See note 29.

restoration. These researchers concluded that length of treatment was not influenced by race, education, and marital status. The overall mean length of time to restoration was 174.96 days.[56]

Nicholson and McNulty (1992) reported on the restoration rates for 150 randomly selected incompetent defendants who had undergone restoration efforts in Oklahoma. These researchers reported successful restoration for 94.7% of these defendants; the an average length of stay for those restored was 63.7 days versus 234 days for those who were not restored. The average length of stay for the entire sample was 68.6 days and less than 6% had a length of stay greater than 6 months.[57]

Nicholson, Barnard, Robbins, and Hankins (1994) examined length of stay and restoration rates for 133 male defendants ordered to the North Florida Evaluation and Treatment Center as incompetent to stand trial. These researchers found that 89.5% of the defendants were restored to competency (10.5% were not restored) by the cutoff date for the study. On average, defendants were hospitalized for more than nine months (M = 283 days, SD = 272.2 days); however, the median length of stay was only 169 days. The proportion of defendants hospitalized for more than 3 months was 87.2%; 45.9% were hospitalized for more than 6 months, 30.8% for more than 9 months, and 24.1% for more than 1 year. Defendants considered not restorable remained in hospital significantly longer (M = 825.9 days, SD = 280.9 days) than those who were restored to competency (M = 219.2 days, SD = 187.4 days).[58]

Hoge and colleagues (1996) compared incompetent (n = 42) and competent (n = 42) defendants on a variety of measures of capacity to understand legally relevant information. The authors found that incompetent defendants were impaired in their ability to understand information relevant to assisting counsel, pleading guilty, and waiving a jury. The authors also reported an average timeframe for restoration of 97.9 days (SD = 50.5 days) for the 28 incompetent defendants who were restored to competency during the study period.[59]

Noffsinger (2001) reported on a competency restoration program consisting of seven modules delivered by a multidisciplinary treatment team (see Section II for more detail). The average length of stay in this treatment program was approximately 80 days. Noffsinger reported that 81.5% of defendants charged with misdemeanors were restored to competence within the required six-month timeframe; 90.9% of defendants charged with lesser felonies were restored within the required six-month timeframe; and 85.7% of defendants charged with major felonies were restored within the required one-year timeframe.[60]

Stafford and Wygant (2005) examined the outcomes of 80 competency evaluations conducted with defendants who were referred from a mental health court. Of the 80 defendants evaluated, 62 defendants (77.5%) were found incompetent and ordered to a competency restoration program. The incompetent defendants were given an average of 49 days of competency restoration treatment (SD = 23.8 days) in the state hospital and 47% were restored to competency during this timeframe.[61] It is important to note that this was a select group of referrals from a mental health court; thus, the lower rate of restoration is likely due to more severe psychiatric symptomatology.

Mueller and Wylie (2007) reported on the effectiveness of an intervention created for the restoration of competence to stand trial in a sample of 38 incompetent defendants (see Section II for more detail). They reported

[56] Bennett, G., & Kish, G. (1990). Incompetency to stand trial: Treatment unaffected by demographic variables. *Journal of Forensic Sciences, 35*, 403-412. (Note: n = 1019; SD = 137.07).
[57] See note 49.
[58] See note 48.
[59] Hoge, S. K., Poythress, N., Bonnie, R., Eisenberg, M., Monahan, J., Feucht-Haviar, T., & Oberlander, L. (1996). Mentally ill and non-mentally ill defendants' abilities to understand information relevant to adjudication: A preliminary study. *Bulletin of the American Academy of Psychiatry and Law, 24*, 187-197.
[60] See note 31.
[61] Stafford, K. P., & Wygant, D. B. (2005). The role of competency to stand trial in mental health courts. *Behavioral Sciences and the Law, 23*, 245-258.

an average of 72.4 days from admission to posttest but did not break this out by experimental and control groups, as there were no differences between the two groups at posttest on any competency measures.[62]

Herbel and Stelmach (2007) reviewed the cases of all incompetent defendants with the principal diagnosis of delusional disorder who underwent involuntary medication for competency restoration during a 13-year period at the Federal Medical Center in Butner, North Carolina (n = 22). The majority of these defendants (77%) were restored to competency within five months.[63]

Mossman (2007) examined the records of 351 inpatient pretrial defendants who underwent competence restoration at a state psychiatric facility in Ohio to determine whether certain variables available to forensic examiners could predict restoration outcome.[64] The variables of interest included demographic characteristics, diagnoses, symptom patterns, criminal charges, number of prior psychiatric hospitalizations, and cumulative prior length of stay. The overall rate of successful restoration reported by Mossman was 75% for felony defendants and 48% for misdemeanants. Length of restoration data were not presented but Mossman noted that Ohio statute requires that maximum restoration periods for felony defendants were 4–12 months (depending upon the specific charge) and 30–60 days for misdemeanants (again, depending upon the specific charge). Mossman found that "lower probability of restoration was associated with having a misdemeanor charge, longer cumulative length of stay, older age, and diagnoses of mental retardation, schizophrenia, and schizoaffective disorder."[65]

Mossman delineated 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 longstanding psychotic disorder that resulted in lengthy periods of hospitalization. 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 attempts to convey during an evaluation. Each scenario appears to result in a well-below-average chance of successful restoration.

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 were restored to competence within six months and 83.9% within one year.[66] In addition, those with mood disorders were significantly more likely to be restored to competence 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 defendants with any other psychiatric disorder. Those diagnosed with both mental retardation and a mental illness were significantly less likely to be restored than 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.

Collwell and Gianesini (2011) reviewed the records of 71 incompetent male patients ordered for competency restoration and subsequently discharged from a maximum-security forensic hospital. The majority of defendants (75.7%) were restored to competency.[67] The mean length of stay for restored defendants was 98.92 days (SD = 54.54 days), which was significantly shorter than the mean length of stay for non-restored defendants (173.18 days; SD = 106.79 days). Non-restorable patients had more prior incarcerations, hospitalizations, and episodes of

[62] See note 34.
[63] Herbel, B. L., & Stelmach, H. (2007). Involuntary medication treatment for competency restoration of 22 defendants with delusional disorder. *Journal of the American Academy of Psychiatry and the Law, 35*, 47-59.
[64] Mossman, D. (2007). Predicting restorability of incompetent criminal defendants. *The Journal of the American Academy of Psychiatry and the Law, 35*, 34-43.
[65] Ibid at page 34.
[66] Morris, D. R., & Parker, G. F. (2008). Jackson's Indiana: State hospital competence restoration in Indiana. *Journal of the American Academy of Psychiatry and Law, 36*, 522-534.
[67] Colwell, L. H., & Gianesini, J. (2011). Demographic, criminogenic, and psychiatric factors that predict competency restoration. *Journal of the American Academy of Psychiatry and Law, 39*, 297-306.

incompetence as well as lower level charges, diagnoses of psychotic and cognitive disorders, lower global assessment of functioning (GAF) scores, and were prescribed more medications.

Advokat and colleagues (2012) examined archival data to determine the differences between incompetent defendants who were restored to competence (n = 43) and those who were not (n = 15).[68] No differences were found between the restored and unrestored groups with respect to demographic variables, intellectual capacity, offense type, diagnoses, substance abuse, or psychotic symptomatology. The restored group performed significantly better on the Georgia Court Competency Test (GCCT) and on the Global Assessment of Functioning scale (GAF), both at the initial evaluation period as well as at the final evaluation period. Severity of psychotic symptoms decreased significantly for the restored group, but not for the unrestored group, and the restored group was discharged significantly sooner (mean = 7.7 months; SD = 8.6 months) than the unrestored group (mean = 17.9 months; SD = 7.0 months).

Summary of Data

A summary table of the available research that provided time frames to restoration for incompetent defendant is provided below.

Exhibit 4
Time Frames to Restoration from the Research Literature

Study	N	Average time to Restoration
Pendleton (‘80)	205	104 days
Rodenhauser & Khamis (‘88)	375	153 days
Bennett & Kish (‘90)	1090	175 days
Nicholson & McNulty (‘92)	150	64 days
Nicholson et al. (‘94)	133	219 days
Hoge et al. (‘96)	28	98 days
Noffsinger (‘01)	n.r.	80 days
Stafford & Wygant (‘05)	38	72 days
Morris & Parker (‘08)	1475	72.3% within 6 mo 83.9% within 1 year
Collwell & Gianesini (‘11)	71	99 days
Average		153 days

Note: Reviewed studies that provided data on the average time to restoration are included in this table.

[68] Advokat, C. D., Guidry, D., Burnett, D. M. R., Manguno-Mire, G., & Thompson, J. W. Jr. (2012). Competency restoration treatment: Differences between defendants declared competency or incompetent to stand trial. *Journal of the American Academy of Psychiatry and Law, 40,* 89-97.

The National Judicial College's Best Practices Model – Length of Time for Competency Restoration

With respect to the issue of time frames for competency restoration, the 2011-12 National Judicial College's Best Practices Model is summarized in the box below.[69]

National Judicial College's Best Practices Model: Length of Time for Competency Restoration

Best Practice: For a person charged with a misdemeanor, it is a best practice for the initial competency restoration to be no more than 120 days, unless that period of time is longer than the maximum amount of time the defendant would have served if incarcerated for the pending charge(s). It is a best practice for the mental health professional to notify the court as soon as he or she believes the defendant is rendered competent, which may be less than the 120-day period. It is a best practice for the court to not criminally commit a defendant to be restored to competency (including pre-treatment detention) for a period that is longer than the maximum amount of time that he or she would have served if incarcerated for the pending charge(s).

For a person charged with a felony, it is a best practice for the initial competency restoration to be no more than 120 days. By or before the end of the 120-day period, it is also a best practice for the treating mental health professional to file a report with the court stating his or her opinion as to whether he or she believes there is a substantial probability that the defendant can be restored to competency in the foreseeable future, or no longer than by an additional 245 days. If the mental health professional believes there is a substantial probability that the defendant can be restored to competency in the foreseeable future, it is further a best practice for him or her to opine as to what additional time is needed to restore the defendant to competency; for the court to grant 60-day extensions up to the additional 245 days; and for the treating mental health professional to file additional progress reports at the end of each additional 60-day period. It is also a best practice for the mental health professional to notify the court as soon as he or she believes the defendant is restored, which may be less than the initial 120-day period. Finally, it is a best practice for the court to not criminally commit a defendant for restoration for a period that is longer than the maximum amount of time that he or she would have served if incarcerated for the pending charge(s) (including pre-treatment detention).

Discussion: The Supreme Court made clear in *Jackson v. Indiana*, 406 U.S. 715 (1972), that a person may not be criminally committed for purposes of rendering him or her competent to stand trial "more than the reasonable period of time necessary to determine whether there is a substantial probability that he [or she] will attain that capacity in the foreseeable future." *Id.* at 738. Further, if a physician determines that the defendant "probably soon will be able to stand trial," the defendant must be making progress toward that goal to justify his or her continued commitment.

[69] Best Practices Model Section VI (C) available at http://www.mentalcompetency.org/model/model-sec-VI.html#VI

Section Summary

The available literature on time frames to successful competency restoration indicates that the majority of incompetent defendants (80 – 90%) are restored to competency within six months.

Defendants that take the longest to restore to competence appear to be those with: (a) developmental disabilities, and (b) those with longstanding psychotic disorders that have resulted in lengthy periods of hospitalization. The available research indicates that these two categories of defendants also have the lowest probability of being restored.

In terms of the characteristics that are common to defendants who are ultimately not restored, these defendants tend to:

- be older;
- have more extensive histories of mental illness (as indicated by longer cumulative length of stay for inpatient admissions as well as more prior incidents of incompetence);
- have diagnoses of psychotic disorders (especially schizophrenia or schizoaffective disorder), mental retardation, or both mental retardation and a psychiatric disorder (putting these dually diagnosed individuals at the lowest probability for restoration); and
- have lower level charges (misdemeanors; although this might be an artifact of shorter statutory timelines for treatment).

Clinically, one would not expect to find a significant difference in the time it takes to restore felony and misdemeanor defendants. In recognition of the variation in sentence lengths, however, many jurisdictions have implemented different time frames for competency restoration by category of offense (felony v. non-felony). The National Judicial College's Best Practices Model's recommendations regarding time frames for restoration also take offense category into consideration.

Conclusions

This literature review concerns the clinically appropriate time periods for effective competency restoration.

The average time to restoration for incompetent felony defendants in the state of Washington, treated at either WSH or ESH, is less than 3 months (90 days), which is well within the allotted statutory time frames for the state (up to 360 days) and less than the initial period for restoration recommended by the National Judicial College (120 days).

Incompetent felony defendants who are not restored to competency spend an average of 154 days at ESH, including 76 days on competency restoration status before being civilly committed. The overall average length of time to restoration supplied by the available national research data was 153 days. Thus, it appears that 76 days (or even the statutorily required 90 days) might not be enough time to conclude that a defendant is not restorable. Data regarding the clinical characteristics of this group of defendants was not available. Similarly, it is not known whether any of these defendants went on to become competent. More information regarding these defendants would be helpful in ascertaining whether a longer initial statutory time frame for competency restoration would be beneficial.

With respect to the time frames for restoration of incompetent felony defendants, Washington State's statutes allow for a total time frame of up to 1 year (360 days) for restoration. This appears to be an adequate and clinically appropriate time frame for restoration to competency as indicated by the data reviewed in this report as well as the recommendations of the National Judicial College's Best Practice Model.

In terms of non-felony defendants, the available data for ESH indicate that this population is restored to competency within one month (30 days), presumably within the allotted statutory time frames for non-felony defendants in Washington (14 days plus any unused evaluation time) but well below the initial period for restoration recommended by the National Judicial College (120 days).

In addition, the data from ESH indicate that non-felony defendants who are found to be non-restorable are hospitalized for an average of 76 days, including an average of 29 days on restoration status before being civilly committed. Thus, it appears that the statutorily required initial 30-day period is not enough time to make a determination regarding whether these non-felony defendants are ultimately restorable. The available data on time to restoration appear to indicate that a lengthier initial time period might allow for more of these non-felony defendants to be ultimately restored and would reduce the number of non-felony defendants who become civilly committed.

Finally, given that one should not expect to find any differences—clinically—between incompetent felony and non-felony defendants, it appears reasonable to allow both types of defendants the same initial treatment period for restoration of competency.