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REGULAR ARTICLE

Competency Restoration for Adult Defendants in Different Treatment Environments

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The optimization of trial competency restoration is a topic of growing interest and controversy in the fields of forensics, psychology, criminal law, and public policy. Research has established that adult defendants who have severe psychotic disorders and cognitive impairments are more likely than defendants without these conditions to be found incompetent to stand trial and are less likely to be restored to competency thereafter. Research has also identified some of the benefits of attempting restoration in hospitals, jails, or outpatient settings for defendants with different diagnoses or levels of cognitive functioning. Rates of restoration, length of stay necessary to achieve restoration, and, in some cases, how quickly defendants are found non-restorable are primary indicators of positive outcome. We sought to review the extant literature on competency restoration, with the goals of identifying implications for current practice and generating inquiries for future research. We found that there are significant advantages and disadvantages of attempting restoration in a hospital, jail, or outpatient setting on rates of restoration, length of stay necessary to achieve restoration, or length of time necessary to determine non-restorability, while controlling for several relevant factors (e.g., diagnosis, cognitive limitations).

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Does Competence restoration work?

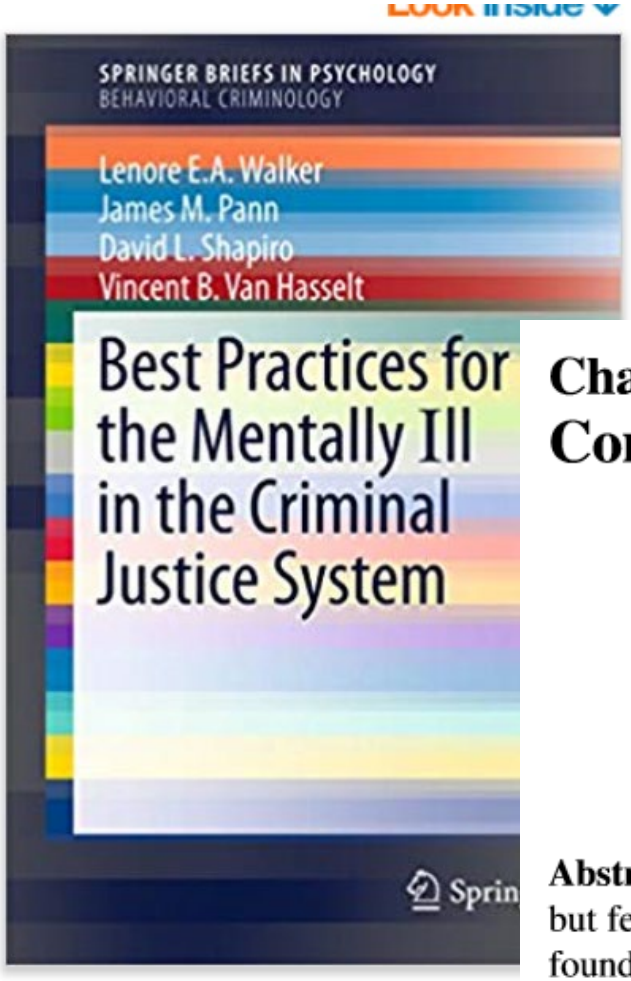
Competency Restoration for Adult Defendants

Table 1 Attributes of State Hospital, Jail and Outpatient Restoration Programs

Treatment Setting	State Hospitals*	Jails†	Outpatient‡
Costs	$300–$1,000 per day	$42–$222 per day	$100–$500 per day
Rates of restoration	80–90%	55–86%	54–70%
Mean LOSR (per research)	73 days	57.4 days, usually followed by transfer to state hospitals	149–207 days
Patients served	High % of defendants with psychotic disorders	Moderate % of defendants with psychotic disorders	Moderate to low % of defendants with psychotic disorders
Crime type/risk	Moderate to high level of dangerousness	Moderate to high level of dangerousness	Moderate to low level of dangerousness
Medication considerations	High % of adherence, largely due to greater resources to administer involuntary medications	Limited resources for involuntary medication administration	High % of adherence, largely based on screening
Malingering considerations	May teach defendants how to malinger more convincingly	Theoretically ideal for malingerers	Setting less likely to affect malingering either way

* Data on hospital-based restoration obtained from References 2, 3, 5, 8, 13, 16, 19, 23, 29.
† Data on jail-based restoration obtained from References 1, 16, 17, 36, 37, 38.
‡ Data on outpatient-based restoration obtained from References 2, 8, 16, 17, 29, 39, 40.
LOSR = length of stay necessary to achieve restoration.

Competence Restoration



Chapter 4
Competency Restoration Programs

Abstract Competency restoration programs have had various features in common but few are comprehensive in trying to restore or build competency in those people found incompetent to proceed to trial. A model program outline is proposed here.

Competence Restoration

1. *Systematic Competence Assessment*—Defendants, upon admission, will undergo a comprehensive assessment to determine the specific reasons for the incompetence, be they psychotic and confused thinking, limited intelligence, mood fluctuations, or brain impairment.
2. *Individualized Treatment Program*—Each defendant will have treatment program tailored to her or his specific needs. Deficits identified in the initial assessment will be addressed by specific treatment modalities.
3. *Education*—This will be the didactic component consisting of education surrounding charges, sentencing, plea bargaining, roles of courtroom personnel, the trial process, and understanding evidence.

Competence Restoration

4. *Anxiety Reduction*—Defendants will be taught anxiety reducing techniques to help them deal with the stress of court proceedings.
5. *Additional Education for Defendants with Limited Intelligence*—If incompetence stems from intellectual deficits, a specific intervention based on the results of an intellectual assessment at the outset will be used here. Didactic material may be reviewed a number of subsequent times in individual sessions to address aspects of the group program that were not well understood by the defendant.
6. *Periodic Reassessment*—Each defendant will be reassessed on at least two occasions, focusing on the individualized treatment modules to see whether progress is being made.
7. *Medication*—For those defendants whose incompetence is based on psychosis or mood disorders, appropriate medications will be prescribed and regularly monitored. Medication reassessment will coincide with the periodic reassessment of competence to see if the pharmacotherapy needs to be altered.
8. *Assessments of Capacity*—A procedure needs to be set in place for the assessment of competency to make treatment decisions, especially when medication is involved. This may vary by depending on relevant statutes and case law.
9. *Risk Assessment*—Considering the fact that some defendants who are unrestorable need to be evaluated for involuntary commitment, there needs to be a standard protocol for assessing risk of future violence using empirically based instruments.

Oversight for Persons found Not Guilty by Reason of Insanity

- Oversight body that is distinct from clinical treaters
- Specialized expertise for risk assessment and clinical needs for those with SMI and criminal justice involvement

Dedicated forensic hospital beds

- persons found NGRI
- competence to stand trial assessment and restoration
- complex risk assessment.
- Other clinical assessments
- Funded by general fund support
- These areas not typically supported by insurance funded hospitalizations.