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Assessment of Competence Restoration: Determining the Threshold

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Assessment of Competence Restoration: Determining the Threshold

Andrea Dinsmore, PsyD

Disclosure

- I have no actual or potential conflict of interest in relation to this program/presentation.

Objectives

- Legal Precedent
- Research Basis
- Case Presentation
- Discussion

Legal Precedent

- In courts of the Commonwealth of Massachusetts, a defendant is found competent to stand trial if he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding, and if he has a rational as well as factual understanding of the proceedings against him (Commonwealth v. Vailes, 1971)

Problematic Results

- Thousands of indeterminate hospitalizations
- Surplus of patients requiring services that state hospitals and forensic mental health centers were not capable of providing
- Drain on financial resources

United States Supreme Court Ruling

- *Jackson v. Indiana* (1972)
 - Violation of due process and equal protection
 - No commitment solely for incompetence
 - Reasonable period of time
 - If no probability exists:
 - Civil commitment
 - Release
- Massachusetts Application
 - M.G.L. Ch. 123 S. 16(f) states that the period of confinement shall be one half of the potential maximum sentence for the charge(s).

Importance of Competence Restoration Opinion

- Financially taxing
- Potential conflict
- Due Process
- Equal protection

Competence Restoration Research

- Predicted Restorable to Competent
 - No prior mental health history
 - Violent crime
 - Serious, violent criminal history
 - Non-psychotic Disorder
 - Charge of Murder
- Predicted Not Restorable to Competent
 - Extensive, complicated psychiatric histories
 - Older age (mean of 42 vs. 33)
 - Understanding of criminal justice process
 - Less prior convictions
 - More organic/intellectual disorders

Hubbard, Zapf, and Ronan (2003)

Warren, Fitch, Dietz, and Rosenfeld (1991)

Competence Restoration Research

- Variables of Defendants Restored to Competent
 - No diagnosis of Schizophrenia
 - No prior history of incarceration
 - History of criminality
 - History of substance abuse
 - Personality Disorders
 - Female Gender
 - Mood Disorder

Rhodenhauser & Khamis (1988)

Nicolson, Barnard, Robbins, and Hankins (1994)

Mossman (2007)

Morris and Parker (2008)

Colwell and Gianesini (2011)

Competence Restoration Research

- Variables of Defendants Not Restored to Competent
 - Greater impairment in psycholegal ability
 - Severe psychopathology
 - Presence of psychotic disorder
 - Mental Retardation
 - Comorbid Mental Retardation and Mental Illness
 - Prior state hospitalization
 - Treatment resistant Schizophrenia
 - Prior findings of Incompetent to Stand Trial
 - Prescribed more medications
 - Low GAF

Rhodenhauser & Khamis (1988)

Nicolson, Barnard, Robbins, and Hankins (1994)

Mossman (2007)

Morris and Parker (2008)

Colwell and Gianesini (2011)

Programs for Competence Restoration

- Focus of treatment is symptom reduction and education
- Medication
 - The U.S. Supreme Court held in *Sell v. United States (2003)* that antipsychotic drugs could be administered against a defendant's wishes for the purpose of restoring competency, but only in rare, limited circumstances.
- Many programs (CompKit, Slater Method)
 - Psychoeducational and legal curriculum
 - Physical courtroom maps
 - Demonstrative videos
 - Role-playing
 - Mock trials

Mr. Jones

- 38-year-old African American Male
- Homeless prior to admission
- Third admission to Bridgewater State Hospital
 - 1993 - 18(a) from Suffolk County HOC for assaultive behavior in the context of paranoia and hallucinations
 - 2002- 18(a) from Suffolk County Jail for paranoia, assaultiveness, and bizarre behavior
- Charged with Open and Gross Lewdness
 - Exposed genitals to two young boys

Relevant History

- Early development unremarkable
- Limited employment
- Difficulties in school, completed 10th grade
- One head injury from fight in jail, no LOC
- Substance Use
 - Prior use of marijuana and alcohol
- Cognitive Deficits
 - IQ assessed as Mild Mental Retardation
 - Neurological workup revealed brain damage
 - Neuropsychological assessment revealed significant deficits in memory, verbal fluidity, and processing speed
 - Unable to read or write

Psychiatric History

- Symptomatic since 1993, Rogers in 1994
- Diagnosed with Schizophrenia, Paranoid Type
- Over 30 hospitalizations in over 20 years
- Treatment with many antipsychotic and mood stabilizing medications; Typically noncompliant
- Found Incompetent to Stand Trial in 1994 and 2008
- Symptoms Include:
 - Delusional beliefs, magical thinking, pressure speech, in appropriate laughter, auditory and visual hallucinations, inappropriate affect, bizarre behavior, paranoia regarding conspiracies against him, men making homosexual advances toward him, people trying to infect him with diseases, people stealing from him

Criminal History

- Twelve charges since 1993
 - Possession of a Firearm, Discharging a Firearm
 - Assault with a Dangerous Weapon
 - Assault & Battery
 - Trespassing
 - Disorderly Conduct
 - Open & Gross Lewdness
- Served several 1 - 3 year sentences
- MIPSB Evaluation inconclusive - unclear how psychotic symptoms impacted sexually inappropriate behavior
- Approximately 25 assaults at nearly every hospital or group home due to paranoia

Clinical Presentation

- Somewhat Cooperative
- Agitated, Easily angered
- Loud, mumbling at times
- Tangential, rapid, unfocused
- Disorganized speech, Neologisms, Echolalia
- Responding to internal stimuli
- Denied suicidal and homicidal ideation
- Transferred to Max Unit following assault on peer who he believed had broken into his room at night and stolen from him
- Compliant with medications since admission
 - Valproic Acid, 500mg
 - Haloperidol Lactate, Intramuscular 10mg PRN

Competence Deficits

- Basic understanding of charges, court process, and roles of participants in court, but not adequate
- Able to converse minimally with attorney
- Unable to understand circumstances of evaluation, potential plea options, defense strategies, and sentencing possibilities
- Did not benefit from education or repetition
- Reported he could not work with attorney due to belief that attorney “works for DMH” and was not trustworthy
- Difficulty participating in mutual conversation

Restorable	Not Restorable
No charge of murder	History of psychiatric treatment
History of violent crime	Current charge non-violent*
Many prior convictions	Psychotic disorder diagnosis
History of criminality	Complicated history of treatment
History of substance abuse	Poor understanding of system
	Brain damage/impairment
	Intellectual deficit
	Male
	Co-morbid MR and MI
	Prior state hospitalizations
	Treatment resistant
	Prior findings of IST
	Low GAF (20s)
	*Not operationally defined

Discussion

- Did I have enough data to opine that he was not restorable?
- What other information could have aided the decision?
- Is it possible to feel completely confident with a restoration opinion?
- Factual understanding can be learned, but is it reasonable to teach rational understanding?
- What are the benefits (state interest, clinical interest, etc) in stating in a report whether or not a person is restorable?
- Given the dearth of research on competence restoration prediction, are we able to provide a competent, well-supported opinion?
- Should the court be tasked with the final decision on restoration or should the evaluator deliver the ultimate opinion?