Competence to Stand Trial: Restoring Competence in an Inpatient Forensic Hospital Setting

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Abstract

The following is a de-identified case study that describes how competency restoration treatment, psychiatric treatment, and assessments were used to assist Competency to Stand Trial restoration with a patient who has intellectual and psychiatric disabilities, in a state funded and forensic-focused in-patient residential hospital facility. Jack was a 20-year-old White male whose main struggles were with anger and impulsivity. His primary diagnoses were Attention Deficit/Hyperactivity Disorder, and Intellectual Disability. He has a secondary diagnosis of Other Specified Personality Disorder, and a differential diagnosis of Autism Spectrum Disorder. He was recommended by the unit psychologist for individual competency restoration treatment in addition to the group sessions he was assigned to as part of his more comprehensive treatment. Jack was assessed with an initial interview covering psychosocial history and mental status. Formal assessment instruments used included the Emotional Problems Scales (EPS), the Conners' Adult ADHD Rating Scales (CAARS), and the Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST*MR). Individual competency restoration treatment sessions were based on and/or accessed from materials included in the Florida State Hospital CompKit manual (Florida State Hospital, 2011), and supplemented with available Mindfulness materials to increase coping skills and decrease impulsive behaviors. Included in this document is a transcript of a mock competency to stand trial evaluation that was the final session for Jack and designed to demonstrate his overall improvement as a result of the individual competency to stand trial treatment.

Keywords: competence to stand trial (CST), restoration, forensic, inpatient hospital

Competence to Stand Trial: Restoring Competence in an Inpatient Forensic Hospital Setting

Across the United States certain adults who are charged with a crime will be ordered by the court to establish competence to stand trial (CST). For two decades the estimate for national felony competency evaluations was 60,000 per year. However, it is now believed the best estimate is 130,000 each year (Murrie et al., 2023). Unfortunately, there is a gap in the research regarding the number of competencies to stand trial evaluations and treatment orders by state, as well as nationally, per year. Additional gaps include numbers of felony versus misdemeanor CST orders, and that many states do not systematically and reliably track this data.

When the issue of competency is raised, all criminal proceedings must be halted until the defendant can be evaluated to ensure CST. There are a variety of things a defendant can do to trigger a court to order an evaluation for CST, including an inability to understand the trial process, an inability to understand the charges against them, and/or not being able to assist their attorney in their defense. While each state has specific criteria related to CST, in 1960 the U.S. Supreme Court decision in Dusky v. United States (*Dusky v. United States*, 1960) articulated standards that have been adopted by most states, stating the test must be whether [a defendant] has sufficient present ability to consult with their lawyer with a reasonable degree of rational understanding—and whether the defendant has a rational as well as factual understanding of the proceedings against him/her (Morris et al., 2021). If any of these conditions are not met in the State of Kansas, a judge will enter an order for a CST forensic evaluation; or for a CST restoration treatment followed by a competency to stand trial forensic evaluation.

For the sake of the present EST Case Study, the discussion will focus on the statutes relevant to this particular case in order to establish a basic understanding of how the process works. In 1995 Kansas abolished the insanity defense and enacted a *mens rea* approach (Landess

& Holoyda, 2021). As a *mens rea* state, there is no option of an insanity defense when a defendant enters a plea before the court (Bloom & Kirkorsky, 2021). Therefore, the question of CST is often raised in lieu of an insanity defense. According to statutes for the State of Kansas, a person is not competent to stand trial when the individual is charged with a crime, and due to mental disease or defect, does not understand the nature and purpose of the proceedings against him/her, and/or cannot assist in their defense (K.S.A. 22-3301). For individuals whose CST is in question, they can be ordered to the state hospital State Security Program (SSP), or its agent, under two different statutes. Individuals ordered under K.S.A. 22-3302 (3302) are sent to the SSP with orders to participate in a forensic CST evaluation. The K.S.A. 3302 limits their stay in the SSP to a period not to exceed 60 days. Those sent to the SSP under K.S.A. 22-3303 (3303) are ordered to engage in competency to stand trial restoration treatment along with a forensic CST evaluation. Those sent to SSP under 3303 have a time limitation of a period not to exceed 90 days (K.S.A. 22-3303).

While in the SSP, an individual is a patient of the hospital with court processes suspended until the results of the forensic CST evaluation are returned to the court, and the court's response is entered on record. Individuals found competent to stand trial are returned to their respective counties to continue their legal case following the court's response being entered on record. Those found not competent to stand trial and not restorable may be civilly committed by the court, be released to caregivers, or placed in a residential facility after the court drops the charges in their legal case. A meta-analysis by Danzer et al. (2019) summarized research on various levels of criminal charges, psychiatric disorders, CST restoration treatment locations, and whether defendants were found competent to stand trial or not restorable. An individual found not restorable has been determined to be not competent to stand trial within the foreseeable

future by an evaluator during a forensic evaluation. The findings suggested those with less severe or non-violent charges who do not meet criteria for civil commitment by the courts at an inpatient hospital or facility, or have a significant history of substance use, would benefit more from an outpatient-based competency restoration treatment program where they could attend groups or individual sessions weekly while living at home, as they are more likely to have better support, and are more likely to remain medication compliant. Also, those suspected of malingering, as defined in the DSM-5-TR to avoid criminal prosecution, would benefit more from receiving treatment while in jail as they are less likely to cooperate with available programs while hospitalized, and would most likely be more incentivized to participate in treatment and an evaluation while in jail so their case could move forward.

Although the process for accessing CST is clearly articulated in statutes, in practice several potential concerns become apparent. There is often a wait list for beds in the SSP, which can delay a patient's admission, evaluation, and/or treatment. Most individuals are held in their county jail until a bed becomes available, and their county can transport them to the appropriate facility. However, some are released on bail/bond, and are then brought to their facility by family or friends when a bed becomes available. Admission to SSP was complicated by the COVID-19 pandemic, as it limited the number of beds available and greatly increased the waitlist. The longer waitlist resulted in patients being held in jails for longer periods of time, becoming agitated with the circumstance, and mentally destabilizing. Other patients have been able to stabilize while in jail as it allows them access to medication services that are often difficult to find in the community. For patients entering SSP after being released on bail/bond, there is concern about substance use immediately prior to admission, which can result in patients

experiencing withdrawal once admitted. Therefore, each of the aforementioned options holds its own unique advantages and disadvantages.

When these challenges have been overcome and patients are admitted and delivered to their unit, they meet with their unit treatment team which includes the unit psychologist, psychiatrist, leader (nursing), therapist, and social worker. During this initial meeting an unstructured mental status exam is completed, along with a review of medications used and general psychiatric, psychosocial, and medical history.

The first fourteen days of a patient's stay can be most difficult, particularly for patients who have comorbid psychiatric diagnoses and/or intellectual or cognitive disorders as they are often dysregulated due to treatment/medication non-adherence while in the jail or on bond. To address this concern, patients are provided with several introductory guidelines and expectations intended to enhance the utility of their stay and ease their transition into inpatient life. First, they are encouraged not to speak to other patients about their charges. This policy is designed to keep them safe from peers who may be offended by and/or react violently to the crime they allegedly committed. This is especially relevant when the charges involve children and/or are of a sexual nature. Second, patients are asked about anger/agitation issues and ways hospital staff can help them if these issues occur. Third, patients are asked to set a goal for their time on the unit (e.g., "I want to earn the privilege to go off unit to the 'big' library"). Finally, patients are provided with a handbook of rules/expectations, as well as a unit schedule that includes what treatment groups they are assigned to.

Each patient begins the SSP program with a standard treatment schedule based on the type of court order used to justify placement. As a patient is taken through the admission process and meets with the treatment team for the first time, the individual's needs become clearer.

During the first meeting with their treatment team assessments can be requested, diagnoses are added or removed, and an overall case conceptualization is completed. Issues relevant during conceptualization include, but are not limited to, whether patients have an intellectual disorder/disability and how that influenced their behavior in relation to their criminal charges. A 2016 study by McDermott and Langdon found men and women with intellectual disorder/disabilities were much more likely to also have moral reasoning abilities that were developmentally immature. However, a comparison showed non-offenders with intellectual disabilities had a greater degree of immaturity than offenders with intellectual disabilities, were governed more by concrete rules, and were more likely to avoid punishable behaviors. It is important to consider level of intellectual functioning when treatment planning as it can affect how a patient adjusts to the unit rules and schedule, allowing staff to be prepared with interventions to encourage successful adjustment to living on the inpatient unit. Also, the presence of intellectual disability can affect the group a patient is assigned to and alerts the group facilitators to assess a patient's needs more thoroughly and carefully for competency restoration. Through direct observation of behaviors and interactions with others on the unit, rule-out diagnoses may be added to the patient's chart to indicate the need for further interviews or assessments before a new diagnosis is added or a rule-out is removed to ensure the patient receives the most relevant and necessary treatment.

A patient's Forensic CST Evaluation can be conducted at any time during hospitalization, and will vary depending on the patient's perceived abilities. There are times when a patient has been stabilized in the jail and arrives at the SSP ready to participate in intensive treatment. Conversely, there are patients who remain incompetent to stand trial throughout their initial 60 or 90-day stay, and the court will order an extension of their treatment time for another 90 days.

Patients whose time is extended are most often those who receive individual competency restoration treatment sessions, as well as continuing the group competency restoration sessions. The individual competency restoration treatment sessions focus on the same materials as what is covered in the groups. However, the format and approaches used to present the content can be individualized to fit the patient's learning needs and maximize retention and restoration. For example, a patient who is unable to read could receive the materials orally, or sessions can be shortened to accommodate a patient with difficulty sustaining attention.

Patients on a K.S.A. 22-3303 order for treatment and evaluation follow the standard treatment protocol. This treatment includes once weekly group competency restoration treatment sessions that last 30-45 minutes. Most units have two groups a week, with each group session covering the same content, occasionally presented in different ways to accommodate the different groups' learning style. While patients are only assigned to and expected to attend one weekly session, some patients choose to attend both. The material covered is derived from the Florida State Hospital CompKit manual (Florida State Hospital, 2011), and progresses through thirteen modules that have been tailored to follow Kansas statutes/laws. Patients on a second 90-day order are often offered supplemental individual sessions to encourage retention/restoration. These individual sessions cover the same material from the manual and are tailored to a patient's individual learning style based on observation as well as formal assessments. Research has shown that individual sessions, in conjunction with group sessions, allow patients to improve at twice the rate of patients only attending the group sessions (Bertman et al., 2003). Individual sessions are commonly necessitated when a patient is suffering from intellectual or developmental disabilities.

Overview of the Current Case

The current EST Case Study describes how competency restoration treatment, psychiatric treatment, and assessments were used to assist in CST restoration in a forensic state hospital setting with a patient who has intellectual and psychiatric disabilities with a main focus on individual competency restoration treatment. It is important to acknowledge there are various units in the SSP that patients are assigned to based upon their particular needs. The patient who is the focus of this EST Case Study was housed on the men's "vulnerable" unit. This is a unit designed to provide a safe environment for those who are elderly, have sexual charges, or diagnosed with physiological, disabilities, or developmental disabilities which may render placement to other units as unsafe due to the risk of other populations being more aggressive. Specific to CST restoration treatment of patients with intellectual disabilities, Anderson, and Hewitt (2003) found "The results of this study supported the hypothesis that significantly more defendants with MR [mental retardation] would not gain competency than would gain competency…competency training for defendants with MR might not be that effective." (p. 349). The term "mental retardation" or "MR" is the language that was used at the time of the above cited study and is not supported by this writer as it is currently encompassed by the intellectual disability terminology.

Ethical considerations for this case were accounted for on several levels. The facilities Institutional Review Board required oversight and requirements were met before the study was able to begin. This process included ensuring the therapist provided a detailed Informed Consent which was reviewed with and signed by the patient. Taking this process a step farther, assent was obtained from the patient to begin each session. As this is an inpatient hospital where the patient had access to the therapist throughout the workday as she worked with other patients on the unit,

it was important to maintain boundaries. Another consideration was the patients Intellectual Disability. During the study the patient did not have a guardian, allowing him to consent to participate. However, before his discharge from the facility, he was appointed a guardian to aid in his future treatment and placement.

Assessment

Presenting Problem and Relevant History

For this study all names, other identifying information, location of crime, and location of treatment have been altered or excluded to protect the patient's privacy. The patient described will be referred to by the pseudonym "Jack". The participating patient in this study was chosen from the inpatient forensic hospital setting and ordered for CST restoration on a KSA 22-3303 court order. Jack is a 20-year-old White, never married male who lived in a small city with his parents and two younger siblings. This was his first admission to the facility, although not his first psychiatric hospitalization. Records indicate he was hospitalized around age 14, but after 12 days was discharged to a residential treatment facility, only to be returned to the hospital on the same day due to "extremely violent" behaviors such as throwing things and being aggressive toward staff and other residents. Following an additional two-week hospitalization, he was discharged to a residential treatment facility, and had two more hospitalizations over the next six years, each followed by a period of time spent in residential treatment facilities. Unfortunately, due to his aggressive and impulsive behaviors he was unable to maintain placement in a residential treatment facility, which led to his return home with his family prior to the current hospitalization.

His current placement in the SSP was the product of being charged with Criminal Threat against his caretakers (parents). This charge is considered to be a severity level 9, person felony,

which is on the lower end of the severity scale according to the Kansas Sentencing Grid (2023) where 1 is the most severe and 10 is the least severe. Designation as a "person felony" is due to the crime being directed at another individual. He was placed on a unit for vulnerable populations due to mental health diagnoses including Autism Spectrum Disorder (ASD); Intellectual Disability, Mild; and Other Specified Personality Disorder with Borderline and Antisocial features. Throughout the 30 weeks of treatment described in this document, Jack was taking Depakote ER, Haldol (as needed), and Ativan (as needed). As reported by the nursing staff he was 100% medication complaint during his stay at this facility. He utilized PRN medications to manage what he called "agitation", generally manifesting as conflict with another patient or when he felt the desire to engage in impulsive and problematic behaviors. The patient was chosen for this study based on his need for individual competency restoration sessions outside the normal course of treatment of group competency restoration sessions.

General History

Jack has a history of special education services during school-aged years with Individualized Educational Plan (IEP) support throughout. He reported being unsure of when he stopped attending formal schooling, recalling it was during high school. He denied any history of substance abuse and reported no prior involvement in romantic or sexual relationships. Jack also denied any history of being the recipient of or perpetrating emotional, physical, or sexual abuse. He endorsed self-harm behaviors stating, "I get mad and hurt myself, hit my head on the wall, or punch things." While he admitted to making comments endorsing suicidal ideation during periods of agitation, he stated, "I would never really do it." When asked about the threats against his caretakers he was arrested for, he responded with remorse, "I was mad, I wouldn't really do it."

Psychiatric/Legal History

Jack has a history of receiving outpatient and inpatient psychiatric services, however, the records available for review by this author date back to only 2017 when he was 14 years old, with previous records being unavailable due to those services being received from non-Kansas facilities. He had multiple psychiatric hospitalizations since 2017 for violence and aggression, mainly aimed at his parents as well as facility, hospital, and law enforcement staff. There is also a history of non-hospital residential treatment provided within a Psychiatric Residential Treatment Facility, with the first admission following his first psychiatric hospitalization in 2017. The patient's parents were unable to care for him at home due to his violent and aggressive tendencies toward them, his siblings, and the family pet. His parents have remained supportive throughout this hospitalization, although they were initially unwilling to allow him back in the home due to the history of violent and aggressive behaviors. His mother has frequently spoken to the unit social worker, attended court via tele video, and he has been able to speak to his parents on the telephone. Despite his charges, Jack expresses feelings of remorse for his behavior, of affection for his family, and a desire to return home. The patient disclosed past encounters with law enforcement, including being charged with four counts of assault against a law enforcement officer when he was 14 years of age. Other encounters with law enforcement officials were also related to violent/aggressive behaviors and threats.

Jack displayed behavior and impulsivity problems, and verbally threatened peers. He was placed on an Individualized Person Management Plan (IPMP), a plan used to modify aggressive behaviors, for a period of approximately 45 days during his first 90-day order. He attended approximately 50% of group competency restoration sessions, which is not uncommon for patients with intellectual disabilities who struggle with self-image, as a group environment can

make them self-conscious. Jack attended 100% of individual competency restoration sessions, as well as routinely attending social support groups, per the unit treatment plan. When his Forensic Evaluation Report (FER) was completed by the unit psychologist, he was found to not be competent to stand trial, and unlikely to be restorable in the foreseeable future due to cognitive impairments related to ASD and intellectual disability. Despite this pessimistic outlook, his competency restoration treatment continued with group and individual sessions to maintain a structured environment as well as encourage learning the CST material during his hospitalization.

Materials

Per hospital treatment standards, the Florida State Hospital CompKit (CompKit) manual (Florida State Hospital, 2011) was used for competency restoration in both group and individual sessions. As noted by Heilburn et al. (2019), this type of competency restoration treatment is most effective in conjunction with a multidisciplinary treatment team to provide psychotropic medication management, case management, medical care, skills development, and assessments, as provided in this facility. The CompKit manual is considered the gold standard as evidenced by its use across many states. One of the most compelling features of this treatment protocol is that it allows for customization to comply with each state's laws and statutes.

Accommodations were made for Jack's poorly developed reading skills, with much of the instruction given orally by this therapist with frequent repetition.

More specifically, the first individual meeting included a clinical interview to obtain psychosocial history from the patient. This interview was then combined with a thorough review of the patient's hospital record, including prior hospitalizations, to establish history and aid in case conceptualization. Due to his apparent challenges in processing emotions, specifically

anger, the decision was made to administer the Emotional Problems Scales (EPS) to assist in determining the best approach to maximize the patient's learning process. This assessment confirmed the patient's tendency to be impulsive, and that he possessed insight into his behaviors. He was provided coping strategies to manage his impulsivity with moderate success as evidenced by his improved behaviors, behavior management, and ability to follow unit expectations.

Another valuable assessment tool based on his history and presentation was the Conners' Adult ADHD Rating Scales (CAARS). Many of Jack's behaviors were dismissed as being attributable to his current mental health diagnoses. However, further assessment to delineate and clarify how his symptoms constellate proved to be extremely pertinent. During the assessment Jack endorsed six of the nine symptoms of the Inattentive presentation of ADHD as described in DSM-5-TR, six of the nine symptoms of the Hyperactive/Impulsive presentation of ADHD, as well as met criterion C, D, and E. While medication to treat ADHD was not an option due to his current medication regimen, possessing accurate diagnoses greatly assisted current and future case conceptualization.

A Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST*MR) was completed to establish general CST knowledge that could be compared with results from a "mock" forensic evaluation at the conclusion of individual treatment to assess if any learning had been achieved. The CAST*MR is an assessment tool used to help determine CST in patients with intellectual disabilities. A "mock" forensic evaluation can be done to determine if a patient is ready for their actual evaluation or to help them practice for their evaluation. It asks the same categorical questions as a forensic evaluation, making it an accurate indicator of future performance.

Florida CompKit Competency to Stand Trial Training Resources (CompKit).

Originally introduced at the 2007 meeting of the Forensic Division of the National Association of State Mental Health Program Directors in San Antonio, Texas, the CompKit is now used in CST restoration kits across the United States. Based upon comprehensive knowledge of individuals and programs from across the nation, the CompKit was compiled by the Florida State Hospital Strategic Plan Workgroup for Trial Competency Education (Florida State Hospital, 2011). Prior to the current Compkit's development, a study at Florida State Hospital found that medication compliance and patient motivation were the main predictors of a patient's outcome with CST training (Florida State Hospital, 2011). The kit consists of materials that simplify legal jargon, present the material at a suitable learning level for the learner, and are appropriate for individual or group learning. As psychotropic medications and CST training are the principal treatment options for those in a forensic, or jail setting, the material can be customized for the learner.

The Comp-Kit includes materials to cover everything a defendant needs to know to pass a CST forensic evaluation. These include the topics of what competency is, important people in the courtroom and their jobs, legal terms and definitions, legal rights, pleas, plea bargains, managing courtroom behaviors, working with an attorney, pre-trial and trial process, sentencing/sentencing options from the Kansas sentencing grid, and understanding charges and possible penalties if the defendant is found guilty. All of these topics are covered in group sessions, and when appropriate, individual sessions, with the exception of charges and possible penalties. For privacy and safety reasons, a patient's charges are not discussed in group sessions or around/with others on the unit. Patients are allowed to discuss their specific charges with staff only in private settings.

There are a wide variety of methods employed to maximize retention for patients of varying learning styles. These include oral presentation with white board emphasis, short quizzes, and worksheets (often reviewed orally for patients unable to read), handouts with terms and definitions that are also discussed in classes, flashcards, and games such as Competency Bingo. Materials from the Comp-Kit were used for instruction with Jack in group sessions, as well as individual sessions, and modified to best fit his learning style. Modifications used for this patient included oral repetition of terms and definitions, use of picture cues for terms and definitions, and shortened sessions to accommodate for patients' difficulty focusing.

Emotional Problems Scales (EPS). The EPS was developed to identify emotional problems and maladaptive behavior of adolescents and adults with mild intellectual disabilities or borderline mental abilities (Strohmer, 1994). It is comprised of two components, the Behavior Rating Scales (BRS) and the Self-Report Inventory (SRI). The BRS is completed by an informant and consists of 135 item statements to be rated from 0 to 3 (almost never, rarely, occasionally, often). Items cluster to provide scores on twelve clinical subscales of: thought/behavior disorder, verbal aggression, physical aggression, sexual maladjustment, noncompliance, distractibility, hyperactivity, somatic concerns, anxiety, depression, withdrawal, and low self-esteem. These responses are then assigned for scoring into fourteen clinical scales (thought/behavior disorder, verbal aggression, physical aggression, sexual maladjustment, noncompliance, hyperactivity, distractibility, anxiety, somatic concerns, withdrawal, depression, low self-esteem, externalizing behavior problems, and internalizing behavior problems) using standardized templates.

Administration of the SRI is accomplished by having the items read aloud by the examiner, answered verbally by the examinee, and recorded by the examiner. The SRI consists

of 147 statements that are answered either “yes” or “no”. Clusters of items are used to calculate the validity indicators, the positive impression scale, and the six clinical scales (thought/behavior disorder, impulse control, anxiety, depression, low self-esteem, and total pathology) using standardized templates.

The EPS BRS has internal consistency reliability across the BRS clinical scales, with reported Cronbach’s alpha of *a* = .91 for thought/behavior disorder, *a* = .93 for verbal aggression, *a* = .91 for anxiety, *a* = .91 for depression, *a* = .94 for low self-esteem, *a* = .94 for physical aggression, *a* = .96 for noncompliance, *a* = .90 for hyperactivity, *a* = .94 for distractibility, *a* = .96 for somatic concerns, *a* = .95 for withdrawal, *a* = ..97 for externalizing behavior problems, *a* = .96 for internalizing behavior problems, and *a* = .90 for sexual maladjustment (Strohmer & Prout, 1989).

The EPS SRI has internal consistency reliability across the clinical scales, the positive impression scale, and the total pathology scale with reported Cronbach’s alpha of *a* = .84 for thought/behavior disorder, *a* = .89 for impulse control, *a* = .86 for anxiety, *a* = .87 for depression, *a* = .81 for low self-esteem, *a* = .77 for positive impression, and *a* = .96 for total pathology (Strohmer et al., 1994). In addition, two studies of test-retest reliability were conducted. In the first study, *r* = .83 was found to be the average test-retest correlation across the clinical scales across a time gap of four to six weeks. For the second study, *r* = .80 was the average test-retest correlation for the clinical scales across a timeframe of two weeks.

On the BRS, completed by this writer, Jack had a statistically elevated score on the hyperactivity scale (*T* score of 76, equals or exceeds the scores of 99% of the standardized sample). This indicates he could engage in behavior that appears impatient, impulsive, easily excitable, and that these behaviors could disturb others. He also had statistically elevated scores

indicating distractibility (*T* 66, 95%), and overall externalizing behavior problems (*T* 65, 93%), along with less pronounced elevations on scales of behavioral difficulty in verbal aggression (*T* 63, 90%), and physical aggression (*T* 63, 90%).

The pattern of scores Jack produced on the EPS is consistent with findings from a 2007 study by Hogue et al. which reported offenders with mild to borderline intellectual disability were more likely to be physically aggressive when held in a higher security environment, such as a secure forensic state security facility. On the SRI, Jack's responses produced a statistically elevated score on only one subscale, the impulse control scale (*T* score of 71, equals or exceeds the scores of 98% of the standardized sample). This indicates he may have trouble listening to others, paying attention, and manifests unpredictable, and disorganized behaviors. However, it is also indicative of insight into how his behaviors get him into trouble along with acknowledgement that he has few friends. Experiencing a lack of impulse control has led to many of Jack's maladaptive behaviors. His self-awareness of the link between this and his relationships, has created a desire for him to not act as impulsively.

Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR). The CAST-MR was developed for use by forensic evaluators to determine if an adult defendant with an intellectual disability is Competent to Stand Trial (Everington, 1990). However, its admissibility in legal proceedings has been questioned due to the limited sample size of scale validation studies. A 2022 article by Wood et. al. advised against allowing the CAST-MR results to stand alone in forensic evaluations, arguing this measure is strengthened when used in combination with other tools. The CAST-MR is divided into three sections. In Section 1, 25 questions about Basic Legal Concepts are asked to assess the defendant's knowledge of the criminal justice process. The questions are simply worded, such as "What is a

crime," with three possible correct answers provided, and they are then scored 1 for a correct answer or 0 for an incorrect answer. In Section 2, 15 questions about Skills to Assist Defense are asked to assess the defendant's understanding of the attorney-client relationship. These questions are of a "Let's pretend…" or "What if…" nature requiring the patient to be able to imagine a scenario. The answers are given the same as in section 1, with three possibilities, and then scored 1 for a correct answer and 0 for an incorrect answer. In Section 3, Understanding Case Events, an assessment is made of the defendant's ability to discuss the facts concerning the alleged offense in a coherent manner, and to understand the relationship between the alleged facts in the case that led to the defendant's subsequent arrest and legal charges. These questions are of an open format in direct relation to the crime they are charged with based on the information provided in the affidavit, such as "What were you doing that caused you to be arrested?". Scoring for these is based on the amount of *correct* information provided by the patient, and can result in either 0, 0.5, or 1 scoring point per the manual.

Internal consistency reliability of the CAST-MR was determined through three pilot tests which produced Cronbach's alphas of .91, .90, and .87, respectively (Everington, 1990). Two groups from pilot test 3 provided estimates of test-retest reliability. The first group produced a correlation coefficient of $r = .90$ across a span of two weeks; with a very comparable $r = .89$ produced by the second group.

Prior to commencing individual competency restoration sessions, on Section 1, Basic Legal Concepts, Jack's responses produced a raw score of 15, for a total of 60% correct. On Section 2, Skills to Assist Defense, he had a raw score of 7, for a total of 47% correct. For Section 3, Understanding Case Events, he had a raw score of 1, for a total of 10% correct. Finally, this amounted to a total score raw score of 23, for a total of 46% correct. This was below

the norm of 25.6 for defendants found to be incompetent. Overall, based on his responses to the CAST*MR, Jack's pre-individual competency restoration session scores suggest he has a limited understanding of basic legal concepts, is lacking the skills needed to assist in his defense, and that he has little to no understanding of case events, including the ability to provide sufficient details related to his case.

Conners' Adult ADHD Rating Scales (CAARS). The CAARS was designed to assess symptoms and behaviors related to ADHD in adults (Macey, 2003). A 2019 study by Harrison et al. questioned the validity of the CAARS as a self-report measure but concluded it can serve as an adequate initial screener when supplemented by follow-up questions from the examiner to determine whether DSM-V-TR criteria were met and verified. For this case the assessment was comprised of two components, the first was the CAARS-Self-Report: Long Version (CAARS-S:L). The CAARS-S:L consists of 66 statements, which were read aloud by the examiner, answered by the examinee, and recorded by the examiner, using a scale where 0 = not at all/never; 1 = just a little/once in a while; 2 = pretty much/often; and 3 = very much/very frequently. Item responses are then transferred to a scoring grid and placed in one of eight clinical scales (inattention/memory problems, hyperactivity/restlessness, impulsivity/emotional liability, problems with self-concept, DSM-IV inattentive symptoms, DSM-IV hyperactive-impulsive symptoms, DSM-IV ADHD symptoms total, and ADHD index).

The second component is the CAARS-Observer: Long Version (CAARS-O: L). The CAARS-O: L consists of 66 statements, which the observer rates for the examinee using a 4-point scale where 0 = not at all/never; 1 = just a little/once in a while; 2 = pretty much/often; and 3 = very much/very frequently. Items are then transferred to a scoring grid and placed in one of eight clinical scales (inattention/memory problems, hyperactivity/restlessness,

impulsivity/emotional liability, problems with self-concept, DSM-IV inattentive symptoms, DSM-IV hyperactive-impulsive symptoms, DSM-IV ADHD symptoms total, ADHD index). The scoring sheet for both the CAARS-S: L and the CAARS-O: L includes an Inconsistency Index that compares answers to predetermined questions to check for inconsistent reporting.

Test-retest reliability of the CAARS-S: L was established in a study with 61 participants (28 women, 33 men) seen at an adult ADHD clinic (Conners et al., 1999). Participants completed the measure twice, one month apart, and produced correlation coefficients that ranged from p = .88 to p = .91. Test-retest reliability of the CAARS-O: L was established through administration to 50 non-clinical participants (26 women, 24 men). Participants completed the measure twice, one month apart, and produced correlation coefficients that ranged from p = .85 to p = .95.

During the initial intake, on the CAARS-S: L Jack scored in the Very Much Above Average range (above T = 70, above 98% percentile) in seven of the eight clinical scales with markedly elevated t-scores of T = 90 on the three scales of Inattentive symptoms, Hyperactive-Impulsive symptoms, and ADHD symptoms total. A slightly lower t-score of T = 82 was obtained on the ADHD index, with less pronounced elevations of T = 72, T = 72, T = *76*, respectively, on the Inattention/Memory Problems, Hyperactivity/Restlessness, and Impulsivity/Emotional Liability scales. A score of 7 on the Inconsistency Index was below the cut-off of 8required to suggest the presence of significant inconsistencies in Jack's response style. This set of scores on the CAARS indicates a moderate to high probability of Jack meeting DSM-V-TR criteria for ADHD.

Other scales from the CAARS indicated difficulties in verbal aggression (T = 63, 90%), physical aggression (T = 63, 90%), distractibility (T = 66, 95%), and overall externalizing behaviors (T = 65, 93%). This set of scores from CAARS subscales is consistent with findings

from the SRI of the EPS previously described. More specifically, the statistically elevated score on the impulse control scale (T =71) from the SRI equals or exceeds the scores of 98% of the standardized sample. These converging scores indicate he may have trouble listening to others and paying attention, as well as unpredictable and disorganized behaviors.

However, it is noteworthy that as seen in the EPS, his scores on the CAARS are also indicative of insight into his behaviors getting him into trouble as well as having few friends. Overall, based on responses to the CAARS-S:L combined with the responses of the informant (this writer) on the CAARS-O:L, the scores suggest he has difficulty with hyperactivity, impulsivity, and overall externalizing behavior problems. The scoring profile also indicates the patient may struggle with verbal aggression, physical aggression, and distractibility.

Treatment Goals and Plan

Jack's competence to stand trial (CST) treatment was multifaceted in approach and tools. His treatment plan focused on learning competency material and coping strategies that work for him, developing healthy relationships, respecting others' boundaries as well as maintaining his own, and completing assessments to aid in informing the best way to accomplish treatment goals. The treatment plan included participating in one, 15-30-minute individual competency restoration session weekly and completing necessary assessments, including the CAST-MR (pre individual sessions), CAARS, EPS, and a "mock" FER at the completion of individual sessions, over twelve weeks. Jack also was court-ordered to attend one, 45-minute group session per week, which, combined with aforementioned individual sessions, provided the opportunity to expand his understanding of the charges, court personnel, and processes as well as empower him to aid in his own defense and understand appropriate courtroom behavior.

Time during individual sessions was shared between teaching and reviewing competency materials, providing psychoeducation and practice on how to implement various coping and impulse control strategies to improve overall psychosocial quality of life. Following completion of individual sessions, Jack maintained gains as demonstrated through tri-weekly "check-ins" with support personnel and review of records. These "check-ins" were conducted by this writer as well as other support personnel in a non-formal manner to assess whether more support was needed beyond the weekly group session throughout the duration of his stay in SSP. The interventions applied to Jack ultimately culminated in him being discharged from the facility after 211 days of treatment.

Results

Diagnosis

314.01 (F90.2) Attention Deficit/Hyperactivity Disorder, combined presentation, mild.

317 (F70) Intellectual Disability, Mild

301.89 (F60.89) Other Specified Personality Disorder, with Borderline and Antisocial Features

Differential Diagnosis

299.00 (F84.0) Autism Spectrum Disorder, Social Communication, requiring support, Restricted, repetitive behaviors, requiring support, with accompanying intellectual impairment

The Autism Spectrum Disorder (ASD) is a part of Jack's medical record and endorsed by clinical staff in the facility. However, throughout this course of treatment there appeared to be more clinical level distress related to ADHD, leading this writer to assess and focus treatment based on that combined with his Intellectual Disability. During completion of the CAARS with this writer, Jack endorsed six of the nine symptoms of the Inattentive presentation of ADHD as described in DSM-5-TR (APA, 2022) that, included: 1) an inability to sustain attention in any

construct; 2) an inability to follow through on tasks occupational and recreational; 3) difficulty organizing tasks occupational and recreational; 4) avoiding tasks occupational or recreational that require sustained mental effort; 5) often losing things that are needed; and 6) being easily distracted by extraneous stimuli. He also endorsed six of the nine symptoms of the Hyperactive/Impulsive presentation of ADHD, including: 1) often leaves seat in situations where remaining seated is expected; 2) often feel restless; 3) is often "on the go" or acting as if "driven by a motor"; 4) often talks excessively; 5) often blurts out or completes people's sentences; and 6) often interrupts people/conversations. Additional DSM-5-TR criteria for the Combined Presentation of ADHD were also met as these sets of symptoms are present in two or more settings (i.e., class and leisure, thereby fulfilling criterion C); and symptoms interfere with functioning socially, and academically (thereby fulfilling criterion D). Finally, while it is difficult to separate symptoms when dealing with a patient who has a diagnosis of ASD and an intellectual disability (criterion E), there is enough evidence to support the ADHD Combined presentation diagnosis as evidenced above. While pharmacological intervention is not currently possible (because stimulant medication is not allowed within the treatment setting), having the diagnoses included on the patient's chart can aid in case conceptualization and future treatment protocols for this patient.

Course of Treatment Tied to Treatment Plan

Jack attended eight individual in-person competency sessions over the course of twelve weeks, with one session being conducted with a worksheet taken to his room and explained via intercom between his room and the nurses' station, due to his positive COVID-19 status. The sessions consisted of a mental status exam, employment of learning materials based on the

CompKit and adapted to the patient's learning style, as well as psychoeducation, practice in session, encouragement, and troubleshooting obstacles of coping and impulse control strategies.

Mental Status Exam

Each session began with a mental status exam to determine patients' current state of mind. Components included subjective observations on physical appearance, including state of clothing, hygiene, and any physical abnormalities such as a tremor or abnormal gait. Questions regarding current symptoms, such as suicidal or homicidal ideation and hallucinations or delusions, were also reviewed. Finally, questions regarding what the patient had for breakfast, their mood, and the current date were asked to assess orientation. Patient was consistently cooperative with this portion of the session.

Session Topics

The first session was focused on important people in the courtroom and their roles; this was taught through oral instruction and a matching worksheet. Session two was not conducted due to the patient being COVID-19 positive; however, a similar matching worksheet in reference to important courtroom personnel and their roles was provided to the patient with the expectation that he would study this on his own and review with therapist in session three. The third session reviewed important courtroom personnel and their roles, as well as discussion and introduction of coping skills that could be employed in different environments. Session four focused on commonly used legal terms and was taught using a handout and a blank courtroom diagram as well as review of coping strategies. The fifth session focused on the three pleas available in Kansas, guilty, not guilty, no contest, review, and in-session practice of previously described coping strategies. The pleas were discussed using a handout from the CompKit tailored to Kansas law. Coping strategies were reviewed using a six-sided breathing handout as well as an

"anger thermometer" to teach the patient when to use coping strategies. Session six reviewed the plea options in Kansas, introduced plea bargains, and working with an attorney. The seventh session reviewed plea options in Kansas and plea bargains, as well as review of coping strategies to manage courtroom behaviors. The final individual session was a mock evaluation that simulated the format and key content of a Forensic Evaluation which included reviewing all previously learned material.

Evaluation of Treatment Outcomes and Disposition

Over the course of treatment, Jack learned and retained various aspects of the covered material. This is notable for him due to his intellectual disability, which combined with ADHD, make learning quite difficult for him. His ability to retain and *understand* information such as the concept of self-incrimination was actually quite impressive given his intellectual limitations and history of behavioral functioning. Jack also learned and understood the role of the bailiff in the courtroom using his own past experience as a cue. Too often individuals will "learn" the information by simply parroting it back in a manner they believe is desired. However, for competency to stand trial, it is also necessary for them to demonstrate they understand the information. Although he was found incompetent to stand trial, and unlikely to be restorable in the foreseeable future, he showed progress in learning as mentioned above.

Additionally, he learned some coping and impulse control skills, which helped him manage his behavior on the unit and during sessions. This is especially notable due to the severe lack of impulse control he exhibited when this writer first met with him, combined with the difficulty of being in a maximum-security environment that houses others with severe behavioral complications. By using the tools provided during sessions, he achieved a heightened privilege level on the unit, which afforded him additional privileges. Patients begin at a red band (e.g., unit

snacks at designated time, last choice for unit television time) level that affords basic unit privileges and can advance to advanced green band (e.g. commissary bought snacks, television in room). Patients earn points by completing daily tasks associated with unit expectations (e.g. make bed, perform daily hygiene, attend groups). Although he was unable to maintain the higher level, having achieved it provided an incentive for better behaviors.

More specifically, Jack repeatedly employed coping strategies such as walking away and using the 6-sided breathing handout to remove himself from situations and restore a calmer state that previously would have escalated. For example, when he was in his room and another patient was exhibiting loud disruptive behaviors, he would use breathing to prevent him from engaging in responsive aggressive behaviors. A simple rule of counting to ten before responding to situations allowed him to be less impulsive when reacting to external or internal stimuli. For example, when another patient on the unit would engage in behaviors that "agitated" him he would walk away and count to 10, rather than aggressively engage as he had previously. He reported his overall self-confidence and insight also improved as evidenced by his ability to remain calm for longer periods of time and feeling that others interacted better with him. Unfortunately, he required another Individualized Person Management Plan (IPMP) during his time in the facility due to maladaptive behavior. However, he was able to progress through this easier than he had during his initial IPMP.

Transcript: Self Evaluation

This case study includes a transcript of one mock evaluation session that is in Appendix A. Some information, denoted by asterisks, has been redacted to protect the patient's privacy.

What I did Well

When reviewing the transcribed session, I reflected on the course of Jack's mock evaluation and recognized where my therapeutic skills worked well in this forensic environment. When he became distracted by his thoughts and lost focus, I could redirect him while allowing him to keep his autonomy. I gently reminded him that what he had asked was not our focus and instead reoriented him to what we were covering during this session, and asked permission to continue. At another point in the session, he used a swear word, which is something we had previously worked on monitoring and eliminating, with notable improvement. With a gentle reminder, he corrected the behavior and apologized for the verbal slip-up. Another strength I noticed across the transcript was the praise I included at random intervals. Jack struggles with self-image and doubts related to his impulsive behaviors; therefore, this pattern of providing intentional positive reinforcement fostered confidence and has been beneficial throughout his treatment. Overall, this experience has allowed me to expand my clinical skills by working with a population I previously did not have access to. Learning to use clinical skills outside of a typical therapeutic environment challenged me daily. However, I grew more confident in my new skills allowing me to better serve the patients.

What Needs Improvement

While reviewing the transcribed session, I reflected on areas where I can continue to develop as a clinician. For instance, some of my questions could have been more clearly phrased. As I am still becoming familiar with forensic language, I need to develop my skills in formatting questions clearly and concisely. Developing this vocabulary will benefit future patients in individual and group sessions, as they need to know and understand a wide range of information. Additionally, I should have found a quieter environment to conduct the individual sessions with

this patient. I chose the unit conference room in a main corridor where patients come to line up for activities. The presence of a speaker that pipes in anything staff put over the paging system in this setting was very distracting to the patient. Overall, this experience was challenging, as it was a new population, environment, and even language. I felt I struggled to learn the terms associated with the new role, the legal precedents, and statutes in a timely manner. Making adjustments as needed for the things I need to improve and continuing to build on the things that went well will allow me to continue to grow as a clinician in a forensic environment.

Conclusion

Competence to stand trial is often raised with those who encounter law enforcement while possessing intellectual or developmental disabilities. Unfortunately, only limited research exists regarding how to work with these patients. Zapf and Roesch (2011) pointed out that much of the extant research supported the notion that patients who are the most successful in competency restoration respond well to psychotropic medication. These authors also recommend future research into cognitive remediation in a forensic setting, as evidence suggests improving the quality of the interventions used not only enhances a patient's ability to have CST restored, but also produces improvements in overall cognitive functioning. A meta-analysis done by Pirelli et al. (2011) found that patients with previous psychiatric hospitalizations, psychotic disorders, and/or are unemployed are most likely to be non-restorable. Unfortunately, what often happens is a revolving door of admissions with no viable solutions to interrupt this pattern. Due to staffing shortages, many facilities do not possess the capacity for doing extra individual or group competency sessions with patients with intellectual disabilities, autistic features, and related externalizing behaviors. Although Jack was ultimately found not competent to stand trial, and not likely to be restorable in the foreseeable future, he made progress during treatment. His

understanding of the legal process improved along with increased behavioral impulse control via implementation of coping skills discussed and practiced during individual and group sessions.

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Appendix A

Session Transcript

T: Good Morning. How is your morning going?
P: Not good at all.
T: What's wrong?
(*This response could have been articulated better by being more specific, such as saying "Did something happen this morning?" or "Tell me more about why it's not a good morning.")*
P: [laughs] I'm just kidding, it's good.
T: Good. Have you been using your coping skills?
(*I did laugh at the patient's "joke" here to show support and encouragement.)*
P: Yes. I just walk away when ***** is pissing me off.
T: I'm glad. You've been doing much better. Are you ready to do the mock evaluation?
P: No [laughs]. Let's do it anyway.
T: What county are your charges located in?
P: ***** County.
T: Good job. What are your charges?
(*The use of positive reinforcement to intentionally acknowledge patients correct response by saying "Good job" provides a solid foundation early in the session by establishing a "positive" and encouraging environment*)
P: The name of it?
T: Yes.
P: I don't know.
T: Ok. It was criminal threat.
P: Oh! I remember that.
(*Rather than immediately providing patient with the correct answer when he said, "I don't know", I could have paused and offered encouragement to express my confidence that patient could provide the correct response on his own*)
T: What does it mean when someone is charged with criminal threat?
P: I wouldn't have really done it, I was just mad.
T: Ok. What are the police accusing you of doing?
P: I don't know. Only one officer that night showed up to get me.
(*Here I could have asked, "Why did the officer show up that night?" rather than just providing the answer.)*
T: The police are saying that on ***** **, 2022 you allegedly threatened to kill your parents with a knife while they slept after they asked you to stop kicking the dog. This placed them in fear for their lives.
P: Yeah, but I didn't actually do it and wasn't going to do it.
T: What evidence is there that could prove you committed the crime?
P: I don't know. Just saying it?
T: What evidence is there that could prove you did not commit the crime?
P: Who said I couldn't go home to my parents?
T: That's not our focus right now, remember? One more question on your charges and then we'll be done with this section. Is that ok?

(*Gently reminding the patient of our focus, letting him know where we were in the questions, and asking him if it was ok to move forward, showed my support as well as allowed him to make the decision to move forward.)*
P: Yeah.
T: Ok. What are the possible penalties you could receive if you were convicted of your charge?
P: What does convicted mean?
T: If you are found guilty.
P: I have no idea to be honest.
T: That's ok. What is your attorney's name?
P: I don't know.
T: How many times have you met with your attorney?
P: I don't remember.
T: Do you like your attorney?
P: Yeah.
T: Do you trust your attorney?
P: Yeah.
T: How do you know when you can trust someone?
P: Cause I know they're not going to lie.
(*Here I could have asked, "How do you know they're not going to lie?" to expand on the concept of trust.)*
T: How can you help your attorney with your case?
P: I honestly don't remember. I'm not just trying to get past what you're saying.
T: It's ok, just answer to the best of your ability. If you disagreed with how your attorney was handling your case, what would you do?
P: I usually wouldn't. Plus, I don't get along with my parents. So nothing, I'd try not to.
T: Is what you and your attorney talk about private, just between the two of you?
P: Yeah.
T: Is what you and your evaluator talk about private or confidential?
P: Yeah, as long as you don't go telling everybody.
(*Instead of just moving on here I could have gently cued to get the correct response, and reminded him of the correct response if he was unable to produce it.)*
T: If the prosecutor were to try to talk to you about your case and your attorney was not present, what would you do?
P: Don't talk to them. How come you don't talk to them by themselves?
T: Because…
(*With this encouraging pause I allowed the patient to come up with the correct response, which re-energized him and gave him confidence for the rest of the interview.)*
P: [interrupting] Oh yeah! Self-incrimination!
T: Yes! Very good. Now we're going to talk about the important people in the courtroom and what they do. What is the purpose or reason for a trial?
P: I know…I know this…
T: What does the jury do?
P: If you're guilty or not!
T: Good job! Do you think you can get a fair trial?
P: Yeah.
T: Who are the important people in the courtroom during a trial?

P: Judge, jury, district attorney, defense attorney, steno-whatever they're called, and the cop.
T: Good. The last two are the stenographer and the bailiff. There's two more. What's your role?
P: Defendant.
T: Good! And who testifies about something they saw?
P: Witness! Did I get them all?
T: Yes! Great job. What's the judge's role in the courtroom?
P: Sentencing.
T: What does the jury do?
P: Damn.
T: Language please.
P: Sorry. Can you tell me? Wait! They decide if you're guilty or not!
T: There you go! And how many people are on the jury?
P: Twelve.
T: What does the district attorney do?
P: I don't remember.
T: What does the defense attorney do?
P: Appointed to you.
T: What are they trying to do?
P: Wait, I remember! The DA wants you to look guilty and the defense wants you to be innocent.
T: What about the stenographer? What do they do?
P: They write up the report so they can use it later on. Transcript, whatever you call it.
T: Good. What does the bailiff do?
P: They give things to the judge or take people out who are disrupting the court.
T: If a witness were telling lies about you during a trial, what would you do?
P: Not talk to them, cause you're not supposed to. Right?
T: Yes. Good job. How should you behave in court?
P: Quiet. Sit in chair still.
T: Do you have to testify in your case?
P: Yeah. No!
T: What legal right protects you from having to testify?
P: The Fifth Amendment protects you from self-incrimination.
T: Great job! One more section on how you can plead in your case. What are the different ways a defendant can plead in their case?
P: Not guilty, guilty…. I don't remember the other one.
T: That's ok. It is no contest. What does it mean when you plead not guilty?
P: You didn't do the crime.
T: What about when you plead guilty?
P: Then you did do the crime.
T: What does a no contest plea mean?
P: You're not saying guilty or not guilty.
T: What is a plea bargain?
P: Where you want the best for your outcome.
T: Why would a defendant agree to a plea bargain?
P: Less time. Fast.
T: Why would a district attorney agree to a plea bargain?
P: No.

T: That's all the questions. Thank you for meeting with me, I really appreciate it. Do you have any questions?
P: Are we still gonna meet?
T: Yes, I'll still be doing groups and I'll be checking in with you.
P: Ok. Bye.