

A Training Program for Defendants With Intellectual Disabilities Who Are Found Incompetent to Stand Trial

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In this study, we examined whether a specialized training program, the Slater Method, affects rates at which persons with intellectual disabilities attain competence to stand trial. We reviewed records of all 30 persons with Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) clinical diagnoses of mental retardation (in this article, intellectual disability) or borderline intellectual functioning whom courts sent to Eleanor Slater Hospital for competency restoration from 2001 through 2006. Significantly more persons exposed to the Slater Method attained clinical trial competence (61.1%) than did persons who received traditional treatment alone (16.7%). Discussion focuses on potential limitations of the study, ethics-related concerns regarding use of the Slater Method, and directions for future research.

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Although persons with intellectual disabilities represent 0.3 to 3.1 percent of the general population,¹ they make up a much larger fraction of individuals encountered in the criminal justice system. Available estimates suggest that such persons constitute 4 to 10 percent of adults who face criminal charges in the United States^{2,3} and 2 to 40 percent of criminal defendants around the world.⁴ Moreover, because correctional institutions often use detainees' self-reports to obtain data on mental illness rates,⁵ these estimates are most likely low.^{6,7}

Individuals with intellectual disabilities pose unique challenges for mental health professionals working in forensic settings. Among these are the care and treatment of persons found incompetent to stand trial. Several studies have identified the presence of intellectual disability as predictive of a clinical finding of incompetent to stand trial.^{8–10} These de-

endants are often committed to state forensic facilities for a period of treatment aimed at establishing or re-establishing trial competence.^{11,12} Until recently, it was not uncommon for the length of hospitalization to exceed the time that would have been spent in prison had the individual been convicted of the alleged crime(s), a fact that has garnered attention in both the academic literature^{13–17} and popular print media.^{18–20}

In response to this concern, as well as to *Jackson v. Indiana*,²¹ states began exploring options specifically aimed at establishing trial competence, not only for persons with normal intellectual functioning, but also for those with intellectual disabilities. In addition to providing traditional psychiatric care, some jurisdictions developed programs designed to educate individuals to attain trial competence (understanding the meaning of their criminal charges, the roles of courtroom personnel, and the nature of legal proceedings, among others). Because such programs, when successful, often provide the first-time acquisition of competency rather than its restoration,¹³ in this article we use the term trial competence attainment rather than competency restoration.

The recommendations of Noffsinger²² that a model competency attainment program incorporate specific provisions for defendants with low intelligence, including additional educational time, in-

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creased one-on-one instruction, and use of simplified terminology, were incorporated into the American Academy of Psychiatry and the Law (AAPL) Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial.²³ However, despite the shared responsibility among jurisdictions to provide trial competence attainment training, apart from a few early descriptions,^{24–26} surprisingly little information is available on what methods are being employed currently,²⁷ particularly with regard to defendants with intellectual disabilities.

Such information may be scarce, in part, because the intellectual disabilities of many individuals are sufficiently severe to make attainment of trial competence impossible.^{13,28,29} Nevertheless, nonattainment is unlikely to be categorically true of all persons with intellectual disabilities, since many are recommended to courts as competent to stand trial at the time of initial screening,^{9,14,28,30–32} and others initially recommended as incompetent to stand trial subsequently attain trial competence.^{13,28,33} We use the term recommended to courts because the clinician makes the competency recommendation, which the judge decides. These data indicate that, despite having decreased capacity and efficiency in learning new material, at least some individuals with intellectual disabilities can acquire the requisite level of understanding of trial-related material and procedures necessary to establish competency.^{34,35}

A review of the available research on competency attainment for persons with intellectual disabilities suggests there is utility in developing trial competence attainment programs further. To our knowledge, there is only one published study regarding the effect of competency attainment training designed for an intellectually disabled adult population.¹³ Among those studied, significantly more defendants meeting Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)³⁶ diagnostic criteria for mental retardation (herein referred to as intellectual disability) did not attain competency than those who did. In that study, hospital staff at one of the study sites were experienced in working with persons with intellectual disabilities; however, the training program and materials were designed for a general educational program provided to all defendants found incompetent to stand trial in Missouri.

We are also aware of the Mentally Retarded Defendant Program at Florida State Hospital, a 124-

bed inpatient facility specifically for those referred for trial competence attainment. While investigating potential racial disparities in competency evaluations, Ho³⁷ found that 21 percent of incompetent intellectually disabled offenders attained competence in the same Florida state hospital program between 1977 and 1991. More recent non-peer-reviewed data indicated that, in one representative year, 56 percent of individuals who completed treatment there were referred to the judicial system as competent.³⁸

In a recent retrospective study of 351 defendants hospitalized for competency attainment in Ohio, Mossman²⁸ found that a lower probability of attainment was associated with intellectual deficiency (among other factors). Although the attainment efforts provided in this jurisdiction were not specifically designed for this population (Mossman D, personal communication, August 31, 2011), many individuals with intellectual disabilities were able to attain competence through this program.

Intuitively, it seems that individuals with milder forms of intellectual disability are most likely to benefit from trial competence training. After all, persons meeting DSM-IV-TR criteria for severe and profound mental disability³⁶ have the greatest cognitive and functional impairments and are more often under relatively constant supervision, thus making them less likely to commit criminal acts. Others meeting DSM-IV-TR criteria for mild and moderate mental disability and for borderline intellectual functioning,³⁶ however, are more often living in the community. Services may have been denied because the level of impairment was deemed insufficient, the person refused services, or the person simply never came to the attention of agencies. Indeed, those with lesser degrees of impairment comprise the majority of individuals with intellectual disabilities in correctional populations.^{4,39}

In this study, we examined whether the Slater Method, a formal competency training tool designed for persons with intellectual disabilities, affects competency attainment rates. This study is the first to examine its use in a forensic state hospital population. We hypothesized that those treated with the Slater Method would have a higher rate of trial competence attainment than individuals in traditional treatment.

Methods

IRB Review and Approval

This study was approved by the Institutional Review Board at Eleanor Slater Hospital, Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH).

Subjects

Eleanor Slater Hospital is Rhode Island's statutorily designated facility for persons found incompetent to stand trial. Individuals may be committed to a forensic unit within the hospital for the purposes of competency attainment, regardless of the presence or absence of psychiatric symptoms; hence, those with intellectual disabilities but without psychiatric symptoms may be committed to a forensic unit initially. As soon as possible, persons without psychiatric symptoms, or those whose psychiatric symptoms have stabilized, are placed on outpatient forensic commitment⁴⁰; hence, persons with intellectual disabilities may be discharged from a forensic unit to outpatient incompetent status for community-based care and treatment with the legal aim of competency attainment. This study included those with intellectual disabilities who were inpatients or outpatients.

Charts for all persons meeting DSM-IV-TR criteria for mental deficiency or borderline intellectual functioning who were committed to BHDDH for attainment of trial competence between 2001 and 2006 were reviewed. At the time of commitment, all underwent a comprehensive clinical assessment at the time of evaluation, including intellectual functioning and IQ testing, when available. DSM-IV-TR diagnoses were made clinically. Demographic, legal, psychiatric, and intellectual functioning data were drawn from these records. Competency assessment scores were based on the Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR).¹⁴ Because some of the subjects were committed multiple times within the study period for different criminal charges, one had three episodes of Slater Method training during the study, another subject had two, and all others had one. Only the earliest episode of Slater Method training was included in the analyses. None of the participants in the traditional method group had received previous Slater Method training.

Intervention

The Slater Method, named after Eleanor Slater, Rhode Island's first female legislator and a long-time advocate for persons with mental and intellectual disabilities, was developed within BHDDH specifically for attainment of trial competence in defendants with intellectual disabilities. A detailed description of the Slater Method is available elsewhere.³² Briefly, it is a five-module training program that provides structured, one-on-one training, in an inpatient or outpatient setting. The five modules are: purpose of training and review of charges, pleas, and potential consequences; courtroom personnel; courtroom proceedings, trial and plea bargaining; communicating with the attorney, giving testimony, and assisting in the defense; and tolerating the stress of proceedings. Training sessions are delivered by clinicians, including psychologists, social workers, and case managers. Modules are presented sequentially over time, with sessions occurring weekly, at a minimum. The subject's progress is evaluated every six months; training can be extended for up to two years if the criminal courts continue the finding of incompetent to stand trial. If an individual does not appear to make clinically significant progress toward competency attainment after two years, training ceases. All Slater Method training supplements standard psychiatric care.

Subjects were assigned to receive Slater Method training based on whether they were receiving services through the Rhode Island BHDDH before the initial finding of incompetent to stand trial, because funding for Slater Method training was made available only for individuals who had been recognized previously by BHDDH as meeting criteria for services because of intellectual disability. We operationally defined the control group as all individuals who were committed for competency restoration within the study period, after being adjudicated incompetent due to an intellectual disability, and who were not receiving BHDDH services for their disability at that time. This group received standard care without the addition of Slater Method training. Standard psychiatric care was also provided to Slater Method subjects. For inpatients, care included medication, psychotherapy, and social treatments plus a standard competency restoration group for non-intellectually disabled persons, led by a social worker. Therefore, persons in the traditional group received group competency restoration training during the inpatient

phase of commitment. Outpatients received medication management, psychotherapy, and social treatments. Standard care was provided until individuals were adjudicated competent to stand trial.

Outcome Measures

Our primary outcome measure was clinical restoration of competence to stand trial, as determined by a forensic psychiatrist during forensic assessments. We also collected data on trial outcomes for all subjects with the understanding that a dismissal of charges could occur during the period of treatment, thereby affecting our primary outcome measure.

Subjects in three episodes from the Slater Method group and one from the traditional group were deemed unable to attain trial competence within the maximum allowed detainment period. One subject in the traditional group died, and data from this person were excluded from the analyses.

Regarding pretrial detention, charges were dismissed for four persons who were treated by the Slater Method. We included these cases in the competence-not-attained group, which reflects the real-world practice in legal settings. This approach was the more conservative one, with fewer Slater Method participants coded as having attained competence.

Statistical Analyses

Alpha was set at .05, and two-tailed tests were used for all analyses. Before conducting primary analyses, we considered potential confounding variables (confounders). To examine confounders, independent *t*-tests, chi-square tests, and (where cell sizes were less than 5) Fisher's exact test was used to compare baseline demographic and legal characteristics and CAST-MR scores between the two groups, as well as association between these variables and the primary outcome measure of competency restoration.

To examine the primary hypothesis, a chi-square analysis was conducted to compare restoration rates for the Slater group with those of the traditional group. Then, a logistic regression analysis was used to determine whether Slater Method training had an independent effect on competency restoration rates after adjustment for potential confounding variables.

Results

Subject Characteristics

Thirty participants were included. Baseline demographic, legal, and clinical variables in the two groups

are shown in Table 1. The mean age of those in the Slater group was significantly younger than that of those in the traditional group ($t = -3.09$, $df = 28$, $p < .005$). The groups did not differ in the other characteristics.

Analysis of Potential Confounders: Factors Influencing Competence Attainment

The following variables were independently associated with attainment of competence to stand trial: age (28.1 ± 8.3 years for competency attained versus 36 ± 10.1 years for not attained; $t = 2.44$, $df = 30$, $p = .021$) and having a substance abuse disorder (13/18 (72.2%) for competency attained versus 1/12 (8.3%) not attained; $\chi^2 = 11.81$, $df = 1$, Fisher's exact $p = .002$). IQ data were available for 17 Slater Method subjects and 6 in traditional treatment. The mean IQ for individuals who attained trial competence was roughly equal to that for those who did not attain competency (60.17 ± 8.89 versus 59.44 ± 9.41 ; $t = .18$, $df = 19$, $p = .86$). Competency attainment was not significantly associated with any category of psychiatric disorder (other than substance abuse disorder) or other legal or demographic variable.

As described by Baron and Kenny,⁴¹ only variables that are related to both the intervention and the outcome should be considered potential explanations of treatment effects. Therefore, we then considered whether persons who were or were not in the Slater Method group differed in age and substance abuse. Although those in the Slater group were younger (mean = 28.56 years) than those who did not have the intervention (mean = 38.45 years; $t = -2.84$, $df = 25$, $p < .05$), the Slater and traditional groups did not differ in substance abuse ($\chi^2 = 2.89$, $df = 1$, nonsignificant). Therefore, only age was regarded as a potential confounder in further analyses.

Primary Analyses: Comparison of Competency Attainment Rates

Subjects receiving the Slater Method were more likely to be clinically recommended to the court as having attained competency than those in the traditional group (Table 2, 61.1% versus 16.7%, respectively; $\chi^2 = 6.68$, $df = 1$, Fisher's exact $p = .018$). Because groups differed in mean age, further analyses were conducted to examine whether age was a potential confounder in this effect. A hierarchical logistic regression analysis was conducted, in which age was controlled in the first block and the Slater Method

Competency Training for ICT Defendants

Table 1 Demographic, Legal, and Psychiatric Characteristics by Treatment Group

	Slater Method Mean (SD or %)	<i>n</i>	Traditional Method Mean (SD or %)	<i>n</i>
Age*	30.17 (9.65)	18	38.58 (8.38)	12
Highest grade completed	9.38 (2.69)	13	7.83 (3.66)	6
Intelligence quotient (total)	57.47 (8.52)	15	63.83 (4.66)	6
Number of previous charges	0.86 (1.17)	14	.40 (0.52)	10
Baseline CAST-MR total score	50.13 (10.30)	8	38.50 (6.36)	2
Female	3 (16.7%)	18	3 (25.0%)	12
Single	15 (83.3%)		10 (83.3%)	
Race/ethnicity		18		12
Caucasian	10 (52.9%)		8 (66.7%)	
Hispanic	5 (29.4%)		2 (16.7%)	
African American	3 (17.6%)		1 (8.3%)	
Asian	0 (0%)		1 (8.3%)	
Employed	4 (23.52%)	17	2 (18.2%)	11
Prior special education	11 (61.1%)	18	7 (57.1%)	7
Language barrier	4 (22.2%)	18	2 (16.7%)	12
DDD eligibility	15 (83.3%)	12	8 (62.5%)	8
DDD refusal	2 (12.5%)	10	2 (16.7%)	9
Primary psychiatric diagnosis		18		12
Depressive disorder	0 (0%)		1 (8.3%)	
Bipolar	1 (5.6%)		0 (0%)	
Schizophrenia or other psychotic disorder	5 (27.8%)		2 (16.7%)	
Age, <i>y</i>	30.17 (9.65)	18	38.58 (8.38)	12
Impulse control disorder	1 (5.6%)		2 (16.7%)	
Adjustment	1 (5.6%)		2 (16.7%)	
None	8 (44.4%)		4 (33.3%)	
Substance abuse history	9 (52.9%)	18	2 (18.2%)	12

DDD, Division of Developmental Disabilities.

* $p < .005$.

was examined in the second block as a predictor of competency restoration. After adjustment for age (Wald = .73, $df = 1$, $p = .39$), Slater Method training remained related to significantly higher competency attainment rates (Wald = 4.58, $df = 1$, $p = .03$).

Discussion

Findings in this small, retrospective chart review study indicate that, compared with traditional treatment, the Slater Method may improve attainment rates of competence to stand trial in persons with intellectual disabilities. The difference in compe-

tence attainment rates between individuals who had training with the Slater Method and those in traditional treatment remained significant after adjustment for age.

These data are consistent with previous research findings that some persons with intellectual disabilities can attain trial competence.^{13,28,37,38} Unlike other research examining trial competence attainment in persons with intellectual disabilities, the training offered in this study was designed specifically to address the difficulties encountered by persons with intellectual impairments.

The forensic commitment of incompetent defendants with intellectual disabilities, their rising arrest and incarceration rates, and the trend in community-based mental health services present an occasion for state mental health agencies to examine appropriate competency restoration attainment methods for this population. To the best of our knowledge, this is the first published study of outcomes from a competency training program designed for persons with intellectual disabilities who have been found incompetent to stand trial. In reporting these data, we recognize sev-

Table 2 Trial Competence Attainment Rates by Group

	Slater Method (<i>n</i> = 18)	Traditional Method (<i>n</i> = 12)
Attained	11 (61.1%)	2 (16.7%)
Not attained	5 (27.8%)	9 (75%)
Deemed nonattainable	2 (11.1%)	1 (8.3%)

Original number of episodes of care, 36.

Episodes excluded due to repeat episodes, 5.

Other episodes excluded (one individual died during training), 1.

Episodes assessed for trial competence attainment, 30.

eral ethics-related concerns that have been articulated about the practice of providing competency training to individuals with intellectual impairment.^{29,42} The first is that competency training programs may prolong the detention and incarceration of persons with intellectual disabilities. However, we did not find evidence to support this concern among subjects in this study. Although the law mandates a maximum period of detention for trial competence attainment, judges dropped charges for four persons enrolled in the Slater Method after several weeks or months. Not surprisingly, this occurred most often when the charge was a misdemeanor. As noted before, individuals were also frequently released to the community during their treatment for trial incompetence. Nor is there evidence from this study to justify the concern that competence training necessarily increases incarceration. All but one subject who attained trial competence with the Slater Method pleaded to their charges and did not serve prison time, reflecting the relatively minor nature of charges faced by this group. One served a four-month sentence on a conviction of manufacture and delivery of a controlled substance. Therefore, these data do not support the assertion that trial competence training leads to periods of detention that exceed what would be considered appropriate for the relevant charges.

Another objection to trial competence training is on the grounds that these programs violate the ethics that guide medical practice by encouraging criminal processing of persons with intellectual disabilities, at times against their will. This argument places the individual interests of the defendant (to avoid prosecution and possible punishment by remaining incompetent) above the state's interest in serving justice. However, as Mossman⁴³ pointed out, from a Kantian perspective, acceding to a defendant's (expressed or presumed) desire to avoid prosecution by remaining incompetent invalidates his moral worth or fails to treat him as an end unto himself. Treatment aimed at establishing trial competence then, even when coercive, serves to support the equal standing of defendants in a moral society.

A third objection is that trial competence training gives the illusion that defendants have attained competence when they in fact have not or that they merely obtain the minimal skills associated with trial competence but not the full abilities needed in an adversarial trial.²⁹ These concerns, while important, are certainly not unique to individuals with intellec-

tual disabilities. Various trial-related impairments associated with serious mental illness may sufficiently improve (through medication, therapy, and education) so that defendants attain a reasonable level of trial competence without requiring that every defendant approach an ideal, or normal, state before the criminal proceedings. The same is true of individuals with intellectual disability. The extent to which any competency attainment efforts will succeed depends on a variety of factors, including the severity and type of a defendant's disability, the seriousness of the criminal charges, and any comorbid psychiatric disorders that may affect trial competence. As the data from this study suggest, for some defendants, no amount of Slater Method training or other restoration attainment efforts will provide attainment of trial competence. For others, however, such training succeeds because these defendants have the ability to acquire and use new information, albeit with reduced efficiency. So long as the forensic assessment of competence to stand trial accurately describes the specific capacities and remaining incapacities of the defendant, justifying and specifying one's opinion helps the fact finder in the final determination of competence.⁴⁴

This study had several limitations. First, our sample size was limited by the relatively few referrals to the Rhode Island BHDDH for competency attainment of defendants with intellectual disabilities, and some cases were missing full data on potential confounding factors. As noted, we suspect that many individuals with milder intellectual impairments are not being referred for trial competence assessments at all. Broader screening measures, if utilized, could better identify defendants with borderline or mild intellectual impairment whose competence is in question. We suspect that for those individuals who ultimately are adjudicated incompetent, trial competence training with the Slater Method would be applicable and useful.

Second, as described in the Methods section, whether a person received Slater Method training depended on several factors beyond our control. Funding for the Slater Method training instructors was provided only for persons who received services through the Rhode Island BHDDH. The assessment of who warrants services, the distribution of finite resources, and whether individuals and their family members accepted services when offered all influenced group assignment.

Third, some confounding variables are important to consider. As mentioned, groups differed in mean age, and age was independently related to trial competence attainment. Substance abuse history, while not significantly different between the two groups, also predicted competence attainment. Data on other variables of particular interest (IQ, education level, and CAST-MR scores) were not available for several subjects in the records we had access to during the study period. IQ scores were available for only about one-half of the traditional group, and the mean CAST-MR score for the traditional group at baseline was lower than that of the Slater Method group. Finally, it is possible that positive effects of the Slater Method represent additional attention, such as increased stimulation and social interaction effects. Unfortunately, our sample size was too small to control adequately for these potential confounders in multivariate models.

In sum, although these results suggest that use of the Slater Method significantly improves trial competence attainment rates above traditional treatment means, further research with a larger subject cohort is needed. Given the practical and moral justifications for trial competence training programs, we hope that this study will encourage further development and study of their use in persons with intellectual disabilities.

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