# Effect of an Individualized Treatment Protocol on Restoration of Competency in Pretrial Forensic Inpatients

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In this study, we evaluated the effectiveness of individualized treatment on restoration of competency in patients adjudicated incompetent to stand trial. Treatment groups included deficit-focused remediation (six individual sessions and four group sessions; $n = 8$), legal rights education (control group; six individual sessions and four group sessions; $n = 10$), and standard hospital treatment (control group; four group sessions; $n = 8$). There were no significant baseline differences among groups. All groups differed significantly on competency measures obtained before and after testing. The deficit-focused remediation and the legal rights education groups both demonstrated significantly higher post-treatment scores on competency measures than the standard hospital treatment group. Both groups demonstrated approximately 50 percent more improvement on the competency measures than the standard hospital treatment group. There were no significant differences between the deficit-focused remediation and legal rights education groups on post-test competency scores, suggesting that focus on individual deficits may not be a useful treatment strategy. Results demonstrate, however, that more frequent legal rights education is a worthwhile endeavor in treatment of incompetency.

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As many as 9,000 inpatient beds are reserved nationwide for individuals who have been adjudicated incompetent to stand trial.[1] The most common reasons for deficits in pretrial competency abilities are psychotic symptoms and mental retardation, with the former being the most frequent.[2,3] Mental illness or retardation *per se* do not, however, predict legal incompetency. If a defendant with mental illness is able to understand the nature of the proceedings against him or her and is able to assist counsel in his or her defense, the defendant may proceed to trial.[1,4] However, if a defendant has been declared by the court to be incompetent to stand trial, judicial proceedings are postponed until deficits in competency are remediated. Until 1972, there was no statute of limitation on how long a defendant could be held for treatment. The Supreme Court decision in *Jackson v. Indiana* determined that a "defendant found incompetent to stand trial cannot be held for treatment indefinitely; there must be a prospect for successful treatment within a reasonable period of time" (Ref. 5, p 1855). A "reasonable period of time," however, was not explicitly defined. Thus, the primary goal of the justice system is to remediate the defendant's deficits in competency and to do so in an expeditious manner. Also, in most cases it is in the de-

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fendant's best interest to be restored to competency as quickly as possible to prevent protracted involuntary hospitalization.[1]

Most literature on patients hospitalized before trial has focused on the assessment of competency to stand trial, and until the late 1980s, the treatment of incompetent defendants was a largely neglected area.[6–15] Most forensic hospitals infrequently provide individualized treatment specifically geared toward restoring competency, and most programs typically depend on psychotropic medication for treating patients who are incompetent to stand trial.[16,17]

There are at least four published reports of treatment programs for individuals adjudicated incompetent to stand trial.[1,18–20] However, three of the four studies were not experimentally controlled.[1,18,19] Thus, although each program offers a unique treatment, the nonexperimental nature of their protocols makes it difficult to draw any conclusions about treatment efficacy. In the one published experimentally controlled treatment study on restoration of competency, 41 male defendants adjudicated incompetent to stand trial were included in an experimental-control group design.[20] Group treatment was held three times a week for nine sessions. The experimental subjects ($n = 21$) received psychoeducation about legal proceedings, and a problem-solving approach was used to improve communication with attorneys and understanding of possible outcomes of trials. The control subjects ($n = 20$) experienced the same treatment format, but the focus of these sessions was on basic psychiatric needs. The experimental and control groups showed a statistically significant difference between the pre- and post-treatment mean scores on the Competency Assessment Instrument.[21] This difference was attributed to the experimental condition. In addition, the authors conducted an analysis of hospital staff recommendations to the courts regarding the study patients' competency. Forty-three percent of the experimental group were judged competent to proceed to court at 45 days after treatment, whereas only 15 percent of the control group were deemed competent to stand trial.

The purpose of the current study was to evaluate the effectiveness of an individualized legal rights treatment protocol in restoring competency to stand trial in patients formally adjudicated incompetent to stand trial by various courts in Louisiana. The study compared three treatment conditions with two goals. The first goal was to determine whether patients attending more frequent legal competency education training sessions attain significantly higher scores on measures of competency to stand trial than those attending less frequent sessions. The second goal was to determine whether individual instruction targeting the specific legal competency deficits of the participant (including understanding of the specific legal charges) helps the defendant attain significantly higher scores on competency-to-stand-trial outcome measures than a program in which participants receive only general legal rights education.

## Methods

### *Participants*

The participant sample consisted of 26 male patients who were adjudicated incompetent to stand trial by the courts in Louisiana. They had been placed initially on a waiting list to enter the facility and were then admitted based on psychiatric need. This sample was drawn from the individuals who were selected to enter the Feliciana Forensic Facility (FFF) for treatment. The facility is a maximum security hospital for the criminally insane located in Jackson, Louisiana.

This study was approved by the Louisiana State University Institutional Review Board (IRB), the Feliciana Forensic Facility IRB, and the Office of Human Services IRB. There were no amendments to the research protocol during this study.

A consent form offering the opportunity for participation was read to all patients who met inclusion criteria for this study. No patient was included in the present investigation unless prior informed consent was obtained. In addition, participants were required to complete an Informed Consent Validation Questionnaire to ensure their understanding of the purpose of the study, the requirements for participation, and the benefit-risk ratio.

### *Inclusion Criteria*

Participants had to meet the following criteria to be included in the study:

1. Age between 18 and 60 years
2. A score of 60 or more on the four-subtest short-form revised Weschler Adult Intelligence Scale (WAIS-R) full-scale IQ
3. A baseline score on the Georgia Court Competency Test-Mississippi State Hospital (GCCT-

MSH)[22] of less than 70 and/or failure to meet the *Bennett* criteria for competency (the criteria for competency to stand trial in Louisiana)[23]

4. Designated standard-track by a multidisciplinary treatment team. (Patients given a standard-track status are deemed incompetent based on initial evaluation but are likely to be restored to competency within a reasonable period of time. Standard-track patients comprise approximately 90 percent of the Feliciana Forensic Facility pretrial population.)

5. A baseline score on the Brief Psychiatric Rating Scale (BPRS)[24,25] of 5 or less on all Psychoticism subscale items (i.e., hallucinations, unusual thought content, and conceptual disorganization).

6. No suspicion of malingering. (Malingering was suspected if a patient received a score of 6 or more on the Atypical Presentation scale of the GCCT-MSH. In addition, participants were excluded if a malingering evaluation was requested from a psychiatrist independent of the Atypical Presentation scale score.)

7. Not charged with first-degree murder, which could result in the death penalty.

8. An adequate understanding of the purpose of the study, the requirements for participation, and the risk-benefit ratio by being able to answer questions on an informed consent validation questionnaire after the consent form has been read to them. Questions reflect communication of a choice, factual understanding of the issues, appreciation of the situation and its consequences, and rational manipulation of information.

### *Exclusion Criteria*

There were 160 patients who entered FFF on a pretrial status of incompetent to stand trial throughout the duration of this study, which was approximately two years. Twenty-nine (18%) patients were either uncooperative with screening or refused to participate. In many cases, these patients were overtly psychotic and demonstrated minimal if any understanding of the purpose of the study.

Twelve (7.5%) patients withdrew from the study after agreeing to participate. Eight participants had been assigned to a specific group. Three of the remaining four withdrew after they had signed a consent but before they were assigned to a group. The final subject who withdrew was deemed competent to stand trial before the study began. Of the eight who were assigned to a group, five withdrew very early in the study. One was declared to be malingering and was excluded. Another became significantly psychotic during the study (a more than 40-point increase on the BPRS at midtreatment) and was excluded at that time. The final patient was excluded from the study because he experienced a seizure just before post-testing.

Forty-two (26.3%) patients were placed on a fast-track status. Fast-track patients are individuals who are deemed competent to stand trial during the initial evaluation. This evaluation is conducted within 72 hours of arrival at the forensic hospital by a psychiatrist and/or psychologist using the same competency measures administered in this study. These patients are likely to be discharged from the facility within two weeks.

Fifty-one patients were assigned standard-track status, but failed to meet other inclusion criteria: 18 (11.3%) were too psychotic based on BPRS criteria; 15 (9.4%) were either malingering or suspected of malingering based on initial evaluation; 8 (5%) had a WAIS-R four-subtest short-form score of less than 60; 6 (3.8%) were accused of first-degree murder; 2 (1.3%) had a language barrier; 1 (0.6%) did not meet age criteria; and 1 (0.6%) was quarantined.

The remaining 26 (16.3%) patients entered and completed the study.

### *Participant Assignment to Groups*

Approximately two to four weeks after admission to the facility, baseline measures were administered to all standard-track patients. The rationale for the waiting period was twofold. First, it allowed the participant to adjust to his new environment, and second, it usually takes approximately two weeks for individual doses and titration of medications to be stabilized.

Baseline measures included an evaluation of competency with the GCCT-MSH and the *Bennett* criteria, the four-subtest short form of the WAIS-R, and the BPRS. Competency evaluations were administered by a psychologist or a psychology graduate student who was blind to the treatment condition of the patient. The four-subtest short form of the WAIS-R and the BPRS were administered by an individual who was part of the treatment team (i.e., psychologist, psychology graduate student).

Patients who signed informed consent to participate were assigned to one of three groups: deficit-focused remediation treatment (DFRT), legal rights education (LRE; a control group), or standard hos-

pital treatment (SHT; another control group). Participants were assigned to these groups in a matched-subjects design procedure that was based on whether they had a diagnosis of psychosis and also on their GCCT-MSH scores. First, there were approximately the same number of participants (groups had unequal subject sizes) in both groups who had diagnoses of psychosis—that is, the first patient was randomly assigned to one of these groups. If that patient had a diagnosis of psychosis, the second patient admitted to the study was placed in a different group if he carried a diagnosis of psychosis. Archival data indicated at least 75 percent of pretrial patients would have a diagnosis of psychosis; thus, it was expected that most participants would fall into this category. In this study, 77 percent of subjects carried a diagnosis of psychotic disorder. In addition, subjects were placed into groups based on GCCT-MSH scores, which were divided into two categories to help ensure nonsignificant baseline differences: category one included participants who scored less than 60 on the examination and category two included those who scored 60 or more.

### *Treatment Procedures*

#### *SHT Control Group*

Participants who were assigned to this group were administered the same screening procedures as the other two groups to ensure that an equivalent comparison sample was obtained. Treatment of these patients included four 30- to 45-minute LRE group sessions conducted once weekly by the ward social worker. This was the standard treatment offered by the hospital.

#### *LRE Control Group*

Participants who were assigned to the LRE control group received individual instruction in two sessions a week for three weeks of LRE training (six training sessions). The areas discussed in these sessions followed the Legal Rights Study Guide protocol which includes the possible pleas and verdicts and their meanings; the six legal rights of the defendant; the layout of the courtroom; the roles of different people in the courtroom; ways to assist counsel in the defense; and plea bargains.

During training, each therapist-assistant (these were psychology graduate students who were blind to study rationale and hypotheses) attended at least two of the LRE group treatment sessions conducted weekly on the ward to learn the material necessary for conducting the individual LRE sessions. The individual instruction followed the format of this group, the content of which was described earlier in the article. No specific information related to individual charges was discussed in these sessions. Therefore, specific information regarding each individual was not summarized. The therapist-assistants followed the Legal Rights Study Guide during the sessions.

All of this information was presented to the participant in question form in an attempt to elicit responses that reflected his current knowledge of general legal proceedings. If the participant clearly did not know the material, then it was presented to him. All information in the study guide was presented in each session, which lasted 30 to 45 minutes. In addition, these participants took part in the standard four once-weekly LRE group sessions offered by the ward social worker.

#### *DFRT Group*

Participants who were assigned to the DFRT group took part in two sessions of individual instruction a week for three weeks of treatment (six training sessions). Information presented in this treatment targeted the participant's specific deficits. Thus, the content of each session varied from participant to participant. The sessions focused on two major areas: (1) open discussion of the defendant's specific charges and the meaning of the charges and the possible consequences. Information pertaining to the defendant's history was obtained by conducting a thorough chart review, which summarized data related to the patient's psychiatric and criminal history; existing criminal charge(s); the meaning of the existing charge(s) and the potential consequence(s) (e.g., maximum penalty); all details surrounding the charge(s) including time, date, site of event, and mental status during that time; and, most important, witness and/or police reports; and (2) remediation of the defendant's competency-related deficits observed on the GCCT-MSH and the *Bennett* criteria pretest. Deficits were summarized on a checklist that described to the therapist-assistants the specific areas that were to be targeted during treatment of the specific defendant. The therapist-assistants used this checklist as well as the summary of the chart review as a guide during the sessions. In addition, the raw data from the GCCT-MSH and the *Bennett* criteria were

**Table 1** Summary of Treatment Procedures

| Deficit-Focused Remediation Treatment Group ($n = 8$) | Legal Rights Education Control Group ($n = 10$) | Standard Hospital Treatment Group ($n = 8$) |
|---|---|---|
| Four legal rights education group sessions<br>+<br>Six individual sessions highlighting specific competency deficits of the participant | Four legal rights education group sessions<br>+<br>Six individual sessions highlighting general legal rights education | Four legal rights education group sessions |

accessible to the therapist-assistants during each session if they wanted to use the actual answers given by the participants as a reference.

All of this information was presented to the participant in question form in an attempt to elicit responses that reflected his current knowledge of the specific charge(s) and the legal procedures as they related to his deficits. If the participant clearly did not know the material, then it was presented to him. All deficits were addressed in each session. If all information was presented before 30 to 45 minutes had elapsed, the presentation was repeated. No legal advice or specific legal decisions were discussed during the treatment. Participants in the DFRT group also part in the four once-weekly LRE group sessions offered by the ward social worker. Table 1 summarizes all treatment procedures.

Individual sessions for the DFRT group and the LRE control group were conducted by therapist-assistants who were blind to the study rationale and hypotheses. Each therapist-assistant conducted three treatment sessions per patient for these groups, therefore controlling for the effect of any intertherapist variables.

Therapist-assistants were formally trained in conducting treatment of the two groups. In the LRE control group training, therapist-assistants began training by sitting in on a weekly legal rights education group session with the ward social worker, which was followed by a one-time formal training session in which the protocol format and procedure were described. In the DFRT training, the principal investigator conducted an in-depth chart review and generated a list of competency-related deficits for each participant. The principal investigator summarized, presented, and discussed the information with each therapist-assistant before treatment began with each participant. The therapist-assistants used the checklist and summary of the chart review as a guide during the sessions.

### *Outcome Measures*

The GCCT-MSH and the BPRS were readministered and the *Bennett* criteria re-evaluated after treatment, or three weeks after baseline. The GCCT-MSH is a 21-item measure designed to assess an individual's level of competency to stand trial.[22] The total score ranges from 0 to 100, and different score weights are applied to each question. A score of 70 or more is recommended for classifying defendants as competent, a score between 60 and 70 is considered marginal competence, and below 60 indicates incompetence.[22] The GCCT-MSH has demonstrated a stable factor structure across two samples.[10,23] It has also demonstrated good internal consistency ($\alpha$ coefficient = .88) and item homogeneity.[11,10] Excellent interscorer reliability ($r = .95$) and criterion validity have also been established with this measure,[13] as well as low false-positive rates and objective scoring when compared with other measures.[11]

The psychologist or psychology graduate student made a qualitative judgment regarding the participant's competency to stand trial based on specific *Bennett* criteria. The *Bennett* criteria are derived from *State v. Bennett*,[24] which outlines areas the judge should consider while evaluating a defendant's ability to stand trial. These criteria are organized into two broad classes: the individual's overall ability to understand and appreciate the nature of the charges; and the defendant's ability to assist counsel in his or her defense. The *Bennett* criteria consist of 16 items representing these broad classes. The items are scored "yes" or "no", where "yes" represents adequate competency in a particular area and "no" reflects incompetency. A score of 1 is given for each item scored "yes." Thus, a participant can have a total score between 0 and 16, with a lower score representing more deficiencies in competency. The *Bennett* criteria are given in conjunction with the GCCT-MSH and assist the examiner in forming a clinical impression about whether the patient is competent to stand trial. The final *Bennett* criteria judgment will be either yes,

**Table 2** *Bennett* Criteria

| | |
|---|---|
| In regard to the defendant's awareness of the nature of the proceedings, I have considered the following during my evaluation with him/her: | |
| Yes/No | 1. Does he/she understand the nature of the charge(s)? |
| Yes/No | 2. Can he/she appreciate its seriousness? |
| Yes/No | 3. Can he/she understand the defense(s) available to him/her? |
| Yes/No | 4. Can he/she distinguish between a guilty plea and not guilty plea? |
| Yes/No | 5. Can he/she understand the consequences of either plea? |
| Yes/No | 6. Does he/she understand the role of the: |
| | A. Defense Counsel |
| | B. Prosecuting attorney |
| | C. Judge |
| | D. Jury |
| | E. Defendant |
| | F. Witnesses |
| Yes/No | 7. Can he/she understand his/her "legal rights"? |
| | A. Right to choose between trial by jury or trial by judge. |
| | B. Right to remain silent. |
| | C. Right to have an attorney present. |
| | D. Right to have an attorney appointed. |
| | E. Right to call witnesses. |
| | F. Right to a fair and speedy trial. |
| Yes/No | 8. Can he/she understand the possible verdicts that a judge or jury may return per the existing charge or charges? |
| Yes/No | 9. Can he/she understand the consequences of a conviction? |
| Regarding his/her ability to assist in his/her defense, I considered the following during the interview: | |
| Yes/No | 1. Whether he/she is able to recall and relate facts pertaining to his/her actions and whereabouts at certain times? |
| Yes/No | 2. Whether he/she is able to assist counsel in locating and examining relevant witnesses? |
| Yes/No | 3. Whether he/she is able to maintain a consistent defense? |
| Yes/No | 4. Whether he/she is able to listen to the testimony of witnesses and inform his/her lawyer of any distortions or misstatements? |
| Yes/No | 5. Whether he/she has the ability to make simple decisions in response to well-explained alternatives? |
| Yes/No | 6. Whether he/she is capable of testifying in his/her own defense? |
| Yes/No | 7. What extent, if any, would his/her mental condition be apt to deteriorate under the stress of trial? |

Based on the *Bennett* criteria, a final determination of "yes," patient is competent to proceed, or "no," further treatment is needed.

the individual is competent to stand trial, or no, the individual is not competent to stand trial. There are no reliability and validity data on this measure, which is strictly a clinical impression about an individual's competency status. The *Bennett* criteria are illustrated in Table 2.

The BPRS is a widely used standardized assessment tool for the description, measurement, and classification of psychiatric symptom severity.[25,26] The BPRS was administered to patients in the middle of and after treatment, for better tracking of improvement or lack of improvement in the severity of psychiatric symptoms. This allowed more accurate determination of the role of psychotic symptomatology in restoration of competency. All outcome measures were again administered by a psychologist or psychology graduate student who was blind to the treatment condition of the participant. Subjects in all groups were given $6.00 for their participation in the study. Payment was offered incrementally and was contingent on full participation during each week. After completion of the tests, the participant was read the debriefing statement.

## Results

Because of the small and unequal sample sizes ($n = 8$ for the DFRT group; $n = 10$ for the LRE control group; and $n = 8$ for the SHT group) and potential violations of assumptions of normality, nonparametric statistics were used in the data analysis.

The mean age of subjects was 37 years; 73 percent were African American and 27 percent were white. Average years of education were 9.5. Eighty-eight percent were not married. Seventy-one percent had more than five previous criminal charges, and 29 percent had fewer than five. This was the first criminal charge for only one subject. Only 15 percent of subjects were employed at the time of the arrest. Forty-four percent were using drugs and/or alcohol at the time of the arrest. Finally, 77 percent of participants carried a diagnosis of a psychotic disorder or Bipolar Disorder, 54 percent had a diagnosis of a substance abuse or dependence disorder, and 11.5 percent had a diagnosis of personality disorder.

There were no significant differences among the three groups in baseline scores on the GCCT-MSH, the *Bennett* criteria, the WAIS-R four-subtest short form, the BPRS, or demographic variables considered (age, education, race, marital status, employment, diagnosis, substance use at time of arrest, previous charges).

The Wilcoxon signed ranks tests (for dependent means) yielded significant within-group pretest/post-test differences for all three conditions on the GCCT-MSH and *Bennett* criteria, respectively:

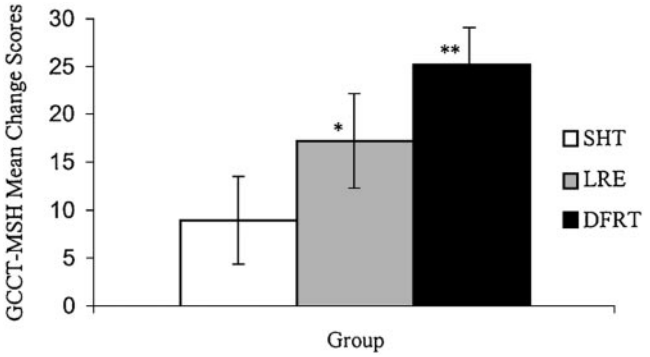


**Figure 1.** Mean changes in GCCT-MSH scores (post-treatment minus baseline) for the three groups. *Significantly greater than SHT group at $p < .05$; **significantly greater than SHT group at $p < .01$.

DFRT group (GCCT-MSH: $z = -2.5$; $p = .012$; *Bennett* criteria: $z = -2.5$; $p = .012$); LRE group (GCCT-MSH: $z = -2.7$; $p = .007$; *Bennett* criteria: $z = -2.8$; $p = .005$); SHT group (GCCT-MSH: $z = -2.2$; $p = .025$; *Bennett* criteria: $z = -2.2$; $p = .027$).

Kruskal-Wallis ANOVAs were conducted to detect whether significant differences existed among the three conditions on each competency measure. This was significant for both the GCCT-MSH chi-square = 10.3; $df = 2$; $p = .006$) and the *Bennett* criteria (chi-square = 10.3; $df = 2$; $p = .006$). Mann-Whitney tests (independent sample *t*-test) were then conducted to determine between which pairs of groups there were significant differences. On the GCCT-MSH, the DFRT group obtained significantly higher post-treatment scores than the SHT group (Mann-Whitney = 2.5; $p = .001$) as did the LRE group (Mann-Whitney = 16.5; $p = .034$). On the Bennett criteria, the DFRT group obtained significantly higher post-treatment scores than the SHT group (Mann-Whitney = 4.5; $p = .002$) as did the LRE group (Mann-Whitney = 15.5; $p = .027$). Mann-Whitney tests showed no significant differences between the LRE and DFRT groups on either the GCCT-MSH (Mann-Whitney = 26; $p = .237$) or the Bennett criteria (Mann-Whitney = 23.5; $p = .146$). GCCT-MSH data are summarized in Figure 1 and the *Bennett* criteria data in Figure 2.

To rule out potential confounding variables, analyses were conducted to determine whether level of psychosis, therapist ratings, and defendant characteristics significantly affected treatment outcome. Regarding psychosis, there was no significant relation between degree of change on BPRS scores and competency outcome measures or between baseline BPRS scores and competency outcome measures. There were also no significant differences in therapist variables (friendliness, comfort level, trustworthiness, helpfulness of therapist, level of interest in patient treatment success, and therapist attitude toward the patient) between the treatment and control groups. Regarding the defendant's characteristics, there were significant differences between groups on only one demographic variable. Mann-Whitney tests showed significant differences in GCCT-MSH residual scores for individuals who had more than five previous criminal charges versus those who had fewer than five (Mann-Whitney = 3.0; $p = .013$). Subjects with more than five previous criminal charges showed more change. Mann-Whitney tests showed significant differences in *Bennett* criteria residual scores for individuals who had more than five previous criminal charges versus those who had fewer than five (Mann-Whitney = 7; $p = .05$); subjects with more than five previous criminal charges had greater changes in scores.

Intraclass correlations (ICCs) were determined to ascertain reliability among raters on the BPRS. The average correlation among raters was .85.

The $\kappa$ statistic agreement was determined for both the GCCT-MSH and *Bennett* criteria during the study. The average correlation of the two raters' judgments with the expert rater was .88 for the GCCT-MSH and .90 for the *Bennett* criteria.

## Discussion

A review of the results suggests that subjects in the DFRT and LRE groups improved on competency measures at twice the rate of subjects in the SHT

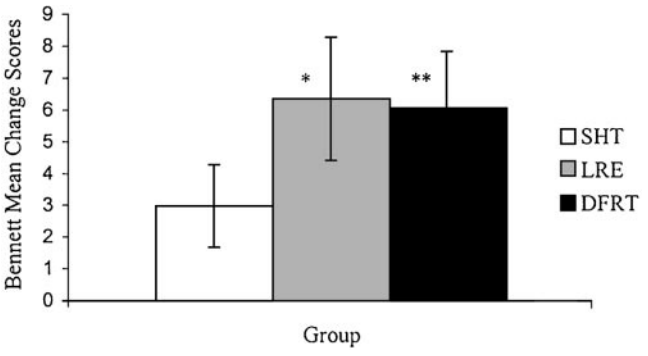


**Figure 2.** Mean changes in *Bennett* criteria scores (post-treatment minus baseline) for the three groups. *Significantly greater than SHT group at $p < .05$; **significantly greater than SHT group at $p < .01$.

control group. More specifically, individuals in the DFRT group demonstrated a mean increase of 25.3 percent on the GCCT-MSH and 38.3 percent on the *Bennett* criteria, the LRE group exhibited a mean change of 17.4 percent on the GCCT-MSH and 40 percent on the *Bennett* criteria, and the SHT control group, although attaining scores that were significantly different from baseline, demonstrated a mean change of only 9 percent on the GCCT-MSH and 19.6 percent on the *Bennett* criteria. Thus, both the DFRT and LRE groups demonstrated approximately 50 percent more improvement on the competency outcome measures than the SHT control group.

Results of this study demonstrate that more frequent individualized LRE is a worthwhile endeavor in treatment of incompetency. However, it remains unclear whether the individualized (individual attention) component of the training was a key variable in positive treatment outcome or whether more intensive (more frequent sessions) training could be conducted as effectively in a group setting. The key variable remains unclear because both the DFRT and LRE groups participated in individualized treatment that was more frequent, and the SHT group participated in group treatment that was less frequent. It was clear, however, that in this study the deficit focused attention was not identified as being more advantageous than the LRE, because these groups did not differ on competency assessment scores. Thus, focus on individual deficits did not stand out as a significantly more efficacious treatment, suggesting that the specific type of treatment may not be critical. Because individualized treatment is time consuming, the next practical step in research would be to determine whether more frequent group training would be as effective.

The primary limitation of the current study is the small sample size for each treatment group, because it restricts the generalizability of results. The small sample size is the product of failure of a large proportion of patients to meet the inclusion criteria. A change in state policy partially accounted for this problem. During the initial phase of data collection, there was a statewide effort to increase legal rights training in parish jails while the patients awaited admission to FFF. In addition, a full-time employee was hired at approximately the same time, exclusively to offer this type of training in the parish jails in the New Orleans area, which is where most patients at FFF originate. Thus, more patients arriving at FFF were placed on a fast track because it was the clinical impression that they would be restored to competency within two weeks. In addition, in an effort to exclude individuals who were clearly incompetent to participate in this study, we erred on the side of caution in imposing the exclusion criteria. As a result, some individuals who could have participated in general research studies may have been excluded.

The second limitation is of more concern and also limits the generalizability of the study. The subjects self-selected for the study and represent a group able and willing to give consent. Because they represented a minority of the persons committed for restoration, the generalizability of these results is limited. However, the findings are relevant to a subset of incompetent individuals. One challenge for further research is defining the characteristics of persons who will respond to different restoration approaches. The process of restoration is complex and complicated. No one method will be applicable for all subtypes.

In summary, the present study is limited by many of the very real problems that exist in treatment outcome research, which thus excludes many potential subjects. Although sample size was small in the current study, results suggest the need for more frequent individualized education and competency training in this population, as well as a need for more research about the best process by which to accomplish competency training. There are still many critical questions that should be examined, including whether more frequent group treatment or individualized treatment is the most important variable in improving competency training outcomes. Answering these questions will help guide the process by which treating staff proceed with competency restoration and could promote beneficial outcomes for the hospitals, courts, and the patient-defendant.

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