

# Challenges to Reforming the Competence to Stand Trial and Competence Restoration System

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Many mental health and justice professionals have noted that the system that manages both competence to stand trial (CST) evaluation and competence restoration (CR) processes in criminal cases is in crisis. Public mental health services often are inundated with court referrals and are challenged to address them in a timely manner, resulting in waits for competence-related services for people in jail as well as substantial risks to criminal defendants for whom competence issues are raised. In this review, the authors describe the current CST-CR system and offer preliminary solutions to its challenges. In addition, they examine published works

on the legal foundation of CST to help support the basis for this analysis. The results of this review point to the need to more effectively address the complexities of the CST-CR systems and highlight the importance of collaboration across legal and clinical systems. Guidance to states can be best facilitated by support for empirical research on the individual- and system-level factors that contribute to the waitlists and system paralysis that have a negative impact on people with serious mental illness in the criminal justice system.

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There is little debate among mental health and justice professionals that the system that manages both competence to stand trial (CST) evaluation and competence restoration (CR) processes in criminal cases is in crisis (1–5). To understand the current issues surrounding CST-CR, it is important to understand these constructs. CST is “the legally determined capacity of a criminal defendant to proceed with criminal adjudication.” State statutes and case law establish the criteria for CST. Other terms that are interchangeably used are “adjudicative competence,” “competence to proceed with adjudication,” and “fitness to stand trial” (6). For defendants with intellectual and developmental disabilities, the terms “attainment” and “remediation” are often used because they connote that these individuals might not have had prior competence that would be “restored.” “Incompetent to stand trial” (IST) is the legal determination by a judge that a defendant lacks the capacity to proceed with trial or disposition on the basis of a CST evaluation, which is usually administered by a mental health professional qualified by the local jurisdiction or state to conduct the evaluation on behalf of the court (7).

Restoration to competence is typically applied by the court “to the potential treatment of any defendant who is not competent” (6). According to recent American Academy of Psychiatry and the Law guidelines (6), CR involves treatment of the underlying mental illness (i.e., treatment as usual) as well as instruction in the legal concepts and procedures of the trial process. Restoration focuses solely

on restoring the defendant’s functional capacities to be able to competently serve as a criminal defendant. Therefore, it does not focus on rehabilitation or treatment of mental illness in the broadest sense, which would include investigating what community supports might be needed to help the individual function fully and safely in a less restrictive setting. Consequently, many stakeholders misunderstand the purpose of restoration treatment and how it has evolved, which leads to disappointment when a defendant returns to jail after his or her competence has been restored and then experiences worsened symptoms while awaiting trial in jail.

## SYSTEMIC CHALLENGES RELATED TO CST

Nearly all states report that their CST systems cannot adequately handle the influx of defendants found to be IST with

### HIGHLIGHTS

- The competence to stand trial (CST) and competence restoration system is fraught with challenges for state mental health systems, courts, and others.
- Access to treatment for defendants might best be facilitated by diversion in lieu of CST-related services for individuals for whom criminal prosecution seems unlikely.
- Cross-system collaboration between behavioral health and justice systems could improve the CST system.

current resources (typically state hospital forensic beds) (3, 5, 8, 9). Consequently, other systems, most notably the local jails and state psychiatric hospitals, are significantly affected by barriers within the forensic mental health system (3–5, 8, 9). Individuals who are found to be IST and ordered for restoration ultimately pay the price for the system overload. They typically wait in jails (settings that are equipped to provide only basic mental health treatment, such as medications), most of which are not able to provide CR services, let alone rehabilitative services and sufficient discharge planning to help avoid a repeating cycle of CR, jail detention awaiting trial, clinical deterioration, and return to the “competence system.” Likewise, patients needing psychiatric hospitalization who are in the civil mental health system can be left with limited access to needed hospital beds, delaying their receipt of the most appropriate level of care.

Nationally, the number of forensic patients in state psychiatric hospitals increased by 76% from 1999 to 2014 (9), with the highest proportion of those patients being from the CST-CR population (5). The causes of this influx of patients ordered for CST evaluations or CR derive from both the legal and mental health systems. In part because of legal cases prioritizing CST issues, the legal system contributes to the challenges faced by defendants for whom the issue of CST is raised. Other contributing factors include that the issue of CST can be raised at any time by anyone during the criminal process, the threshold for asking for an examination is low, attorneys may confuse IST determinations with insanity, pursuing a finding of IST is a strategy for both defense attorneys (cooling-off period) and prosecutors (discovery), and judges rarely refuse a request by the defense attorney for an evaluation (10).

The treatment system also has a role. Services have shifted outside of state hospitals, and when an individual with mental health challenges or intellectual and developmental disorders is arrested, there is often a gap in treatment services. As a result, more defendants in this legal class are competing for inpatient beds (5) as well as for an unknown number of alternative placement options for CR across a continuum of care (3). A recent six-state learning collaborative to study CST issues found that although all of the states had begun keeping CST waitlists, there was no uniform systematic approach for identifying suitable diversion options or reassessing level of care needed for this population. Consequently, all people ordered for CR were assumed to have the same clinical needs and risks, which resulted most often in placement in state hospitals (11).

## OBJECTIVES

Given that the criminal competence system in the United States is straining from increasing referrals and a shortage of resources to provide effective legal and clinical responses to the population of individuals ordered for a CST evaluation or for CR, it is important to understand contributing factors and

to explore solutions. The aims of this review were to describe the current status of the CST and CR process, providing background information regarding the legal foundation for CST-CR; to delineate the source of current system barriers and roadblocks; and to identify potential avenues for improving the CST-CR system. The key issue facing states that is associated with all contemporary class action lawsuits on behalf of criminal defendants for whom the issue of CST is raised is the management of burgeoning waitlists at every step of the competence process.

The CST process and its challenges are intertwined at the local and state levels. Locally, jails and community mental health providers are directly affected by state practice and overall resources devoted to people with mental illness, intellectual and developmental disabilities, and other conditions as well as those resources specifically directed toward competence-related services. On a state level, behavioral health systems are directly connected to the flow of local competence and treatment practices, whether through the availability of state hospital beds or even access to trained forensic evaluators. Therefore, the response to these challenges must be at both the local and state levels. National guidance and technical assistance may also be helpful in establishing common best practices, examining data, and addressing resource gaps that could be provided through federal funding.

## Legal Background of CST-CR

CST is firmly rooted in Western law and tradition. In 1960, the U.S. Supreme Court first addressed the standard for CST in *Dusky v. United States* (12). Today, after the issue of competence is raised, forensic evaluators examine defendants generally in light of the standards set forth by *Dusky*. In 1972, in *Jackson v. Indiana*, the Supreme Court held that a defendant committed solely for CR “cannot be held more than the reasonable period of time necessary that he will attain that capacity in the foreseeable future” (13). As a consequence, some states have statutory requirements that limit the length of time that a defendant found IST can be committed for restoration, which may or may not apply to people charged with serious offenses, especially murder (6, 14). A 2012 study concluded, however, that most states have not modified their statutes to comply with the principles and procedures outlined in *Jackson*, perhaps because of the lack of specific guidance from the Supreme Court (15).

In addition to the key U.S. Supreme Court case determinations, state statutes addressing competence processes have structural commonalities, highlighting the critical role that CST plays in criminal processes. State statutes generally include the following six frames of reference: days allotted for initial competence evaluations, inpatient confinement periods for examination, timeline for initial CR period, processes for the involuntary administration of medication, location of restoration services, and statutory maximum restoration commitment time frames. State statutes

and case law might further define the contours of these details and their alignment with cases such as *Dusky* and *Jackson* (12, 13).

In more recent years, another wave of legal issues pertaining to the competence system has emerged as class action lawsuits have been initiated by plaintiffs over states' failure to comply with their own CR processes and time frames (16–22). Taken together, the case law and statutes emphasize the importance of CST in criminal jurisprudence, but recent litigation points to systemic fixes that are needed.

Many justice professionals recognize the need for improvement in the competence process. In 2012, the National Judicial College convened experts to create a mental competency best practices model and concluded that approximately 60,000 competence evaluations are ordered every year, with only 20% of defendants found to be IST (23). They advised that “not only is the competence evaluation process costly to the jurisdiction, but it may lengthen the time a defendant is involved in the criminal justice system” (23). Their recommendations included standards for hearings, what evaluations and reports should include, competence treatment plans, CR, court and system-wide practices, establishing a competence court or docket, and training and education and addressed the need for cross-systems collaboration (23).

There is no evidence, however, that this best practices model was widely disseminated or adopted. The American Bar Association's “Criminal Justice Standards on Mental Health” (24) attempted to further delineate proper process and offered suggestions that could affect the system, including language that addresses competence to proceed (part IV, standards 7-4.1–7-4.16). These standards include considerations related to raising the issue of competence, orders for evaluations, clinical reports, hearings, right to treatment and to refuse treatment, periodic review of competence, unrestorability, and disposition issues.

### **Waitlists for Competence-Related Services as a Key Issue of Concern**

Competence waitlists for evaluation or restoration are an area of heightened concern among disability rights attorneys, psychiatrists, jail administrators, and mental health administrators and are the subject of litigation, as noted earlier. A report by the Treatment Advocacy Center identified at least 14 states that were or are involved in litigation over waitlists for hospital beds for criminal defendants (2). Factors that contribute to the waitlists are complex and multisystemic and depend on state law, courtroom personnel, treatment resources, and common practice within jurisdictions, among other factors. This issue is unique in that the criminal justice system, namely judges but prosecutors and defense attorneys as well, figuratively holds the keys to both the “front and back doors” of the forensic psychiatric hospitals in most states (8).

In a typical competence process, a judge orders a CST evaluation and whether the evaluation is conducted in a

hospital or elsewhere, without determining bed availability, level of care required, or security needed. Next, a judge determines, typically based on a clinical opinion, whether a defendant is IST and whether the defendant can be released or transferred to another treatment setting or to jail (25). Judges also ultimately decide whether and to where a defendant found to be IST will be committed (public hospital, community provider, or private hospital) for CST restoration, generally after being presented with recommendations from the defense or prosecution. These decision points all reflect the court's legal control over the front door of the competence system, including the treatment settings. Judges might suggest that problems with access to mental health services leave few options after a defendant with behavioral health needs appears in court (26) or that clinical system staff should help them identify these alternatives. Still, Fitch (8) reported that in 74% of states, a judge, not a clinician, has the authority to order release of a defendant found to be IST, illustrating the legal system's control of the back door to the competence system.

As reported by the National Association of State Mental Health Program Directors (5, 8), some judges were transparent that they use the tools available to them to ensure that an individual found IST will receive treatment while in jail. This plan might be well intended on the part of a judge who is seeking a solution for a defendant who might have obvious clinical needs. However, having stakeholders with different goals, vantage points, and levels of authority can cause disjunction in the defendant's processing through the system; a host of political, legal, and clinical complexities; and further bottlenecks in forensic hospitals, giving rise to waitlists for services ranging from evaluation to beds. As such, it is important to examine waitlists for services ranging from competence evaluations to inpatient beds for restoration.

A CST evaluation waitlist is composed of defendants whose criminal proceedings were suspended by a judge because one party raised the question of competence before proceeding in the criminal matter. Although there has been an increase in states that allow for CST evaluations to be conducted in the community, especially if a defendant has been released on bond, most are conducted in jail (8, 11). The next waitlist the defendant is placed on depends on the outcome of his or her evaluation. If found competent to stand trial or restored to competence, a defendant waits for criminal proceedings to commence. If found to be IST, the individual is put on the waitlist for CR services in a suitable setting. Many defendants are on each of these waitlists in the course of just one case in which CST is raised. The longer each of the waitlists are, the longer a defendant's liberty is curtailed and treatment is delayed, just because the issue of CST was raised.

Finally, the nonrestorable waitlist includes individuals who were ordered for a CST evaluation, found to be IST, and eventually found by clinicians to have unrestorable CST. At this point, criminal proceedings may be dismissed, either fully or with the option to bring them forward at a

later date if the defendant's condition changes. Civil commitment or an alternative disposition is then often pursued. Overall, individuals in the competence system risk spending longer in an institution than they would have versus through civil commitment, despite clinical findings that their condition would not warrant as lengthy a hospitalization (27). These lengthy detentions on one or more waitlists may conflict with *Olmstead v. L.C.* provisions and Americans with Disabilities Act regulations for people with disabilities, including individuals with mental illness (28).

Variability in waitlist lengths aside, Zapf and Roesch (29) reported that approximately 75% of defendants had their CST restored and were returned to court within 6 months with restoration taking place in state and public hospitals, although there has been a slight increase in the utilization of outpatient sites for restoration (5). Individual studies examined time periods to restoration, but no studies have examined time to restoration in comparison with treatment as usual, and thus research on this issue is lacking.

### NEED FOR DATA ON COMPETENCE

There is no official count of how many public or private mental health beds are in the United States nor of how many beds serve which patients in the competence system and at what level of care. Moreover, "bed" in this context is not well-defined (3). Not knowing this information makes it impossible to estimate how many beds are available, or needed, in order to dislodge the bottleneck of individuals in the CST-CR system. State hospital inpatient beds are generally labeled "forensic" if they are set aside for individuals ordered for CST restoration, found to be IST, found to be not guilty by reason of insanity, or assigned another criminal statutory designation. After defendants are restored and committed under civil processes, some systems will count them as civil patients (on the basis of current status), and others will continue to count them as forensic (on the basis of originating legal status), further complicating bed counts. These beds are generally in state hospitals, including free standing forensic hospitals, separate units within a state hospital, or a few beds scattered across state hospitals.

However, as Pinals and Fuller (3) noted, many types of beds can fill the clinical needs of individuals with mental illness, assuming their criminal charges allow for release to the community. For example, some individuals might need only care and treatment in an acute care mental health bed, a geriatric bed, a residential treatment bed, or a bed in a group living environment. Some individuals might require only the level of care found in a supported housing model. For each of these types of arrangements that are typically available for people with serious mental illness without criminal involvement, there is no clear count of how many beds are in a given community nor how many could be available for criminal pretrial defendants, often because it is assumed that these individuals require a level of care and a level of security

that might not be needed, especially for those with lower-level charges.

Two meta-analyses have been completed on competence evaluation research. Nicholson and Kugler (30) analyzed findings of research from 1967 to 1989, whereas more recent efforts by Pirelli et al. (31) analyzed studies published between 1967 and 2008. Overall, the findings from these two meta-analyses were similar. Pirelli and colleagues compared defendants found to be IST with those who were not, drawing on data from 68 studies that met their eligibility criteria. They reported that 27.5% of defendants who raised the use of CST were found to be IST. The most significant variable that separated the two groups of defendants was their diagnosis: 67% of defendants found to be IST had a psychotic disorder diagnosis compared with 22% of the defendants found to be competent.

Other clinical variables, such as lower IQ, also affected outcomes (32), and defendants found to be IST were nearly twice as likely to have a history of psychiatric hospitalization. Research consistently has shown that personal characteristics play little role in whether a defendant is referred (33) for evaluation or found to be IST (31). An examination of all IST patients admitted to a California state psychiatric hospital from 2003 to 2016 showed that a diagnosis of a severe mental disorder, such as schizophrenia, was a strong predictor of length of IST hospitalization. Older age was the only demographic factor associated with length of hospitalization in this study (34).

Although there are practice guidelines (6) and published studies of promising practices (35), there are no evidence-based established practices regarding CR (1) applicable to all defendants across multiple jurisdictions. Especially lacking are studies that distinguish restoration into component parts that include the location of restoration (i.e., hospital, jail, community) and associated services that considerably vary across programs. Reports in the literature, with some exceptions, primarily analyze CR that occurs in state forensic hospitals (35–38). Zapf (39) identified the most common restoration practices within forensic hospitals, including use of medication, legal education (e.g., information on charges, description of the trial process, consequences if convicted), specific programming for individuals with developmental disabilities, individualized treatment programming, and cognitive remediation. On the basis of this review, Zapf concluded that use of psychotropic medication in forensic hospitals appeared to provide some benefit in terms of CR, a finding consistent with a review of the literature by Pinals (38) more than a decade ago.

Similarly, utilizing a legal education program also seemed to have provided some benefit to IST defendants, although less information is available on these programs. Individualized programming did not seem to have an added benefit in terms of restoration, and generally, programs reported worse outcomes for IST defendants with developmental disabilities versus mental illness. Pirelli and Zapf (40) recently conducted a meta-analysis examining the effectiveness of CR

programs and reported that, in general, little information was available regarding specific restoration practices. The base rate for CR was 81%, with a median length of stay of 147 days. The authors noted that virtually no published data identify specific restoration practices that directly result in successful restoration.

To reduce the amount of time defendants have to wait for a hospital bed in order to be restored, several states are considering or have implemented alternative settings for restoration, including jails and community outpatient programs. Several states offer jail-based restoration programs and have reported successful outcomes (41, 42). The practice of jail-based restoration is controversial because several authors have argued that defendants with a mental illness serious enough to render them incompetent do not belong in jail for their restoration (43, 44) or that such programs should be cautiously considered (45). Given long waitlists for hospital restoration and controversy surrounding the use of jail-based restoration, several states have developed community-based restoration programs. A 2016 review of outpatient restoration programs reported that across 13 outpatient restoration programs with outcomes data available, rates of CR averaged 70%, with an average time to restoration of 149 days (1). Each of these data points has its own limitations but comprise the available literature.

## **DISCUSSION AND REVIEW OF KEY CST SYSTEM CHALLENGES**

States that report their data to national organizations have revealed that the competence system cannot meet the demand for CST-related services (8). Furthermore, plaintiffs have prevailed in class action claims about access to timely evaluation and restoration services, most notably in Washington (18), in which the state has been fined more than \$80 million for failure to adhere to the federal court order in a timely manner. Scarce resources include overall funding for mental health treatment, community and hospital residential beds and options for outpatient restoration services, available community-based treatment for diversion or to avoid involvement with the justice system in the first place, and a robust workforce of trained professionals adept at working with behavioral health patients in the justice system.

### **Systemic Data Needs**

A key challenge for the mental health and criminal justice systems to effectively address the widespread problems in the competence process is the lack of empirical data to drive policy and standards. There is a need for such system-based, multistate empirical data to provide evidence-based guidance on improving the CST legal and clinical systems, recognizing that it is a challenge to coordinate local, state, and national data. Current practice often results in a disruption in continuity of care for individuals ordered for competence evaluation and restoration who are moving between systems

(46), but it is unknown for whom and for how long these interruptions in treatment last. Although well-meaning attorneys and judges likely flag competence for the right legal reasons, raising the issue of CST has profound implications for individuals and the criminal justice and mental health systems, including both forensic and civil patients.

### **Access to Care at the Right Level**

CST restoration services often do not yield the access to long-term supports being sought, because individuals who are restored are shifted back into the criminal case process as pretrial defendants. It is not the role of the CST-CR system to be the primary route to mental health access for individuals with mental illness in the justice system. Also, as noted previously, raising the issue of CST for defendants may not yield access to the right level of psychiatric care that they need, and can risk placement in a higher level of security, even for those whose underlying offense would otherwise carry little or no risk of incarceration.

### **Expanding Diversion Options for Individuals Found to Be IST**

The number of CST inpatient commitments needs to be reduced through community-based diversion, community-based restoration, and fewer nonviolent defendants being flagged for CST evaluations in the first place. For example, a recent report from Colorado found that the number of court-ordered restorations increased from 87 in 2001 to 900 in 2017 (41). When there was an automatic inpatient commitment for competence evaluation and restoration, no attention was paid to whether the individual needed that level of care. Moreover, when defendants were detained in jail awaiting competence evaluation or restoration, they often would not otherwise need that high risk level of criminal custody.

This finding illustrates that little effort is expended to assess for criminal risk or consideration of bail and bond release when ordering competence treatment. Consequently, many psychiatric inpatient beds are filled by defendants who may or may not need that level of care or level of security, adding to the bed shortage and the cost of forensic services. When the beds are full, defendants usually wait in jail, and, similar to state hospitals, the jail beds might not be needed either to enhance public safety nor to guarantee a defendant will appear in court. Bail reform that includes all pretrial defendants, including those for whom the issue of CST is raised, could alleviate some of the pressures on the forensic and civil mental health systems as well as the local jails by diverting individuals who pose no substantial risk to the community and who could receive appropriate services in the community.

### **Expanded Education of Stakeholders**

Increased awareness is needed among judges, defense attorneys, prosecutors, administrators, policy makers, and treatment providers about how each step in the competence

process runs the risk of more deeply embedding an individual with serious mental illness or intellectual and developmental disabilities into the criminal justice system. Further training may be needed to help the workforce in these systems understand and meet the clinical and legal needs of this population. In most states, decisions to move a defendant in or out of the competence process are judicial judgments, even if informed by clinicians. Consequently, although judges are in a role to adjudicate a single issue before them, an examination of the entire system with assistance from and awareness of other legal officials is warranted. This systemic examination is beginning to more broadly occur among legal stakeholders (47). A companion piece to this review articulates the potential for a systematic examination of diversion and alternative pathways for defendants found to be IST (25).

## CONCLUSIONS

Whether addressing the competence process at a local, state, or national level, data are needed to identify possible challenges and solutions. One recommendation is that national reporting guidelines be developed with input from the wide range of stakeholders who participate in the competence process. Standards from the American Academy of Psychiatry and the Law (6) and the American Bar Association (24) will be common foundations for this effort. A national picture will also identify states that have made significant progress in improving the competence system. At the very least, states that maintain accurate and real-time data on who are in their competence system, where they are, and the time frame for their case to conclude either through diversion, dismissal, or disposition will have a better chance of helping resolve some of the issues at stake.

There is no doubt that defendants with serious mental illness and neurocognitive and neurodevelopmental symptoms present great challenges to the court, and most want the best outcome for their legal and clinical problems and for society as a whole. When diversion is not an option either because of eligibility restrictions or unavailability of a suitable program, judges might decide to initiate the competence process and hope that treatment is forthcoming. However, this decision allows for an “out of sight, out of mind” scenario that could be to the detriment of the defendant. If all attorneys and judges were to follow the American Bar Association’s guidelines (24) that consider diversion for lower-level offenses, the competence system would be less likely to be used as a tactical tool for defendants facing these types of charges who may never be prosecuted anyway.

Gowensmith (48) has challenged the forensic mental health field to be active in proposing and implementing solutions to the growing demand for competence services, such as shortening the CST evaluation, expanding the pool of qualified evaluators, developing alternatives to inpatient restoration, and developing specific time frames for evaluations. In this vein, the community mental health system

and other stakeholders should equally challenge themselves for improvements. A multistate learning collaborative on competence concluded that “juxtaposing legal rights and treatment needs. . . is a complex endeavor” (11) but one that can succeed when leadership from both systems work collaboratively and communicate.

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