Competence to Stand Trial

STATE JUSTICE INSTITUTE
IMPROVING THE JUSTICE SYSTEM RESPONSE TO MENTAL ILLNESS

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A PROJECT ON BEHALF OF THE NATIONAL INITIATIVE
TO IMPROVE THE JUSTICE SYSTEM RESPONSE TO MENTAL ILLNESS

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The Issue

Emotionally, the issues are the ones described in this recent article from The Atlantic: *When Mental Illness Becomes a Jail Sentence: Arrestees who are mentally incompetent to stand trial are supposed to be sent for treatment. But thousands are being warehoused in jails for months without a conviction*. It describes the human toll sometimes inflicted by our current competency system, including the story of a young Colorado man spending almost two months in jail waiting for a restoration bed in a private locked "treatment" facility. The whole episode started with an allegedly pilfered hamburger and french fries, which charges were dismissed.

And emotionally, the issue is the California daughter, whose father with a known serious mental health diagnosis and history was left unsupervised and untreated in jail and hanged himself, waiting for a competency restoration bed at the Napa State Hospital.

Intellectually and legally, the issue is that the majority of our state hospitals maintain bed-wait lists of defendants who have been court-ordered for competency evaluation or restoration services. In most states, these waits are around 30 days, but three states report forensic bed waiting lists of six months to a year, and at any given time there are at least 2,000 defendants waiting in jail for these beds.[1] These are pre-trial defendants, sometimes misdemeanants, and all of them enjoy a presumption of innocence. And yet many of them will spend far longer in jail and otherwise confined than they ever would have had they pled to or been convicted of the underlying offense.

Background

There are dozens of ways in which mental illness and the justice system intersect, but one of the most direct ways in which courts and judges are involved is in the determination of a defendant's competency to stand trial.[2] Any defendant or their counsel (and others) can assert incompetence in any criminal proceeding, from misdemeanors to capital murder. *Dusky v. U.S.* (1960) held that a defendant must have "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding" and a "rational as well as factual understanding of the proceedings against him."

If incompetence is asserted, the defendant is evaluated by a mental health professional and based on that evaluation (or evaluations) and other information the court makes a determination of legal competency. If they are found incompetent, a process of restoration to competency generally commences.

During both the evaluation and restoration phases, defendants are often held involuntarily, or committed, either in jail or in a locked treatment facility. In *Jackson v. Indiana* (1972), the U.S. Supreme Court held that the nature and duration of an incompetent defendant's commitment must bear a relationship to the purpose for which he or she was committed. But for a variety of reasons people are often held for periods of time that bear no rational or proportionate relationship to the nature of the offense they are alleged to have committed, their level of dangerousness, or to their clinical needs.

These two seemingly simple propositions of due process - that an accused person should understand the charges and be able to meaningfully assist in their defense, and that as we evaluate those abilities and treat any deficits we limit their freedom only as much as necessary, are interpreted and implemented in

[1] https://www.treatmentadvocacycenter.org/storage/documents/emptying-new-asylums.pdf

[2] Different jurisdictions use different terms for these cases. Some call them Incompetent to Stand Trial (IST), some call them aid and assist cases, others refer to them as fitness to proceed, or by a procedural rule number or statutory reference. For purposes of this paper we refer to them as Competency to Stand Trial (CST) cases.

such inconsistent and often ineffective ways that our systems frequently do more harm than good. And in this area of the intersection of behavioral health and the justice system, the courts have an integral role and significant responsibility.

Because of this direct and frequent intersection with so many courts and judges, the competency process was the first topic slated for examination by the National Initiative Advisory Committee.

One of the first steps undertaken to understand these issues from the courts' perspective was to select eight trial judges from around the country and convene them to focus on what they thought was working and what wasn't working relative to competency processes. That two-day conversation set a solid path for identifying systemic problems and potential solutions to those problems.[3]

In an effort to understand all aspects of these issues, Advisory Committee members and NCSC staff also engaged with other partner organizations and experts. Shortly after the NCSC focus group met, the Judges and Psychiatrists Leadership Initiative, supported by the Council for State Governments Justice Center, convened a remarkable group of experts from around the country to have a similar discussion, but from a broader perspective.[4] A summary of that conversation and a proposed blueprint for action regarding competency is being drafted by CSG and will be circulated shortly.

Of course, many state courts themselves are simultaneously engaged in competency system (and broader behavioral health system) reform, and the regional CCJ/COSCA summits and subsequent technical assistance initiatives provided another opportunity for discovery about what is and isn't working, and how states are finding ways forward.

One example is Hawaii, which participated in the first of the regional summits. They identified the competency processes, and specifically the misdemeanor competency process as an area in need of reform. They sought NCSC technical assistance, created a strong state-level steering committee, and in December of 2019 held their own state-level summit. Among other things, out of that summit came a resolve and consensus to redefine the misdemeanor competency standards and process in Hawaii through new legislation in the 2020 legislative session.

There have been other efforts to gather data, identify and research best practices, and collaborate with experts on competency, including webinars, phone conferences, and joint resource development. The original group of focus group trial judges also reconvened in Los Angeles to observe the Los Angeles County misdemeanor and felony diversion program and resources, and the same-day competency evaluation process used in the Superior Court in Hollywood. That same group also recently met remotely to discuss the impact of the pandemic on competency issues around the country.[5]

The result of this research and of the thinking of all of these practitioner experts is summarized in the following list of recommendations.

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[3] A summary of that focus group discussion can be found at https://www.ncsc.org/__data/assets/pdf_file/0013/38020/Competency-Focus-Group-Summary-Final.pdf. This paper should be read in conjunction with that summary.

[4] Participants included forensic psychiatrists, researchers, state mental health directors, prosecutors, defense counsel, advocates for people with mental illness, legislators, judges, and others.

[5] https://www.ncsc.org/__data/assets/pdf_file/0021/38019/Competency-and-MHC-Developments-During-the-Pandemic-Summary.pdf

Recommendations

1. Divert cases from the criminal justice system

The involvement of the criminal justice system with people with mental illness is all too often a result of "nowhere else to go." Unlike when someone suffers a physical health emergency, there frequently is no 24/7 emergency mental health response infrastructure. When a mental health emergency happens, the same 911 call is made, but instead of a ride in the back of an ambulance to the hospital, often the call results in a ride (with handcuffs) in the back of a police cruiser, to jail. From there, the involvement of the courts is almost inevitable. And once the courts are involved with someone with a serious mental illness, legal competence is a natural issue to be raised, and the delays, incarceration, and other problems inevitably follow.

There are alternatives to this scenario, and they usually work better and are cheaper than the criminal justice route. Because jails and courts are not terribly good at addressing serious mental illness, they often make people with SMI worse. Diverting people who experience mental health crises to something more akin to our physical health process and facilities is a better option. Trained 911 dispatchers, mobile crisis units, co-responder models, CIT-trained law enforcement, and well-designed crisis stabilization facilities are all evidence-based, effective, more humane, and cheaper alternatives. The greater the availability of these options, the fewer people will be subjected to the criminal justice and competency machine, and the better the outcomes.

2. Restrict which cases are referred for competency evaluations

When the criminal justice system is invoked, there are still ways to divert from the competency road. First, someone has to choose to raise the issue for the machinery to start.

The constitutional standard for raising competence is quite low. The U.S. Supreme Court found in *Pate v. Robinson* that a hearing is required whenever there is a "*bona fide* doubt" about the defendant's competency. In recent years the trend of raising competence has dropped steadily in some jurisdictions, yet skyrocketed in others, which suggests that local legal cultures, practical circumstances in specific jurisdictions, and individual discretion around legal strategy are driving the numbers rather than principled public policy choices. Certainly, defense counsel has an obligation to explore all possible legal strategies on behalf of their client, but it doesn't follow that competence should be raised every time there is a colorable argument. Newer public defenders, for example, may not have seen how the process really plays out as a practical matter, for their clients.

In some circumstances it may be appropriate to take competency off the table as a policy matter, by rule or by statute. There is a growing consensus that misdemeanants, for example, should rarely be subject to the competency process. They often end up incarcerated, waiting for an evaluation, then waiting for the report, then for a hearing, then for a restoration bed to open (most often in a state mental hospital), and then they begin a restoration process that on average takes several months. Next, if restored, they wait for a final court hearing to formalize that status, and then they're able to start the criminal trial process. Except by then they've been in jail and confinement for far longer than they ever would have been had they pled guilty on day one, so the case is now dismissed or pled to, with a sentence of time served.

Of course, there are exceptions to this scenario, and the fact that someone has been charged with only a misdemeanor tells us little to nothing about their criminogenic risks, needs, or danger to the community. But the point is that *Jackson* says and due process requires that the nature and duration of an incompetent defendant's commitment must bear a relationship to the purpose for which he or

she was committed. The nature of most competency systems in our country are inherently disproportionately onerous and ponderous when applied to a misdemeanant.

If we were to reserve the competency mechanism for fewer cases, and circumstances for which the process is more proportionate, those resources would be better spent, and the outcomes for everyone, including the defendants, would be better.

3. Develop alternative evaluation sites

Competency evaluations take place in any number of locations – in the community, jails, courthouses, state hospitals, and in other designated secure facilities. Which of those options is used depends largely on what is available in that jurisdiction and what that jurisdiction has chosen to fund, not on what would be the most clinically appropriate. And generally, there is only one option. If more of the less expensive outpatient, community-based options for evaluation existed, there would be less need to wait in jail for the evaluation, fewer transportation and other logistical issues, and perhaps better evaluations. Some of these other options are discussed in recommendation 7, below.

4. Develop alternative restoration sites

Similarly, there is usually only one option for restoration services in a jurisdiction. This also more likely leads to delays, jail time, and a loss of liberty that is disproportionate to the purpose for which they are being restored. Some states require, and others permit restoration in a psychiatric hospital, and the result is that restoration services are provided only in an in-patient setting in the majority of states. Often this limit on restoration settings means there are a limited number of beds, which creates a bottleneck for the entire process and increases jail time for these defendants.

Treatment should generally be provided in the least restrictive setting that is appropriate, so unless there is a safety to the community concern or other clinical issue, that treatment should be in the community.

5. Revise restoration protocols

The seminal guide to best practices in competency evaluation and restoration is the *AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial.*[6] The authors evaluated the available research to determine best practices for, among other things, restoration approaches. While some states focus almost entirely on legal education in an effort to allow the defendant to demonstrate their ability to "consult with his lawyer with a reasonable degree of rational understanding," others prioritize treatment of the underlying mental illness.

Most studies suggest that neither approach is clearly superior, but there is consensus that medication is the most important catalyst for successful restoration, and one meta-analyses of the research conclude that "(t)he benefit of adding educational programs to medication protocols for competency restoration of non- developmentally disabled defendants has not been clearly established."[7]

While there may be value in all three approaches – medication, individualized treatment, and legal education, given the value of restoration slots or beds, and given the potential for backlogs and delays to ripple through other parts of the system, care must be taken to not prolong the restoration process longer than is necessary to achieve competence. The rate of successful restoration is relatively consistent across the various systems (80% to 90%), but the length of time defendants

6 American Academy of Psychiatry and the Law, https://www.aapl.org/docs/pdf/Competence%20to%20Stand%20Trial.pdf
7 http://www.wsipp.wa.gov/ReportFile/1121/Wsipp_Standardizing-Protocolsfor-Treatment-to-Restore-Competency-to-Stand-Trial-Interventions-andClinically-Appropriate-Time-Periods_Full-Report.pdf

spend in restoration programs around the country varies greatly. Some studies identified mean restoration periods of 60 days, while others documented means of a year.

While there is evidence that a review of restoration status at 30 days is too soon, 45 days seems to be a potential sweet spot at which sufficient time has passed to allow medications to work and progress to be made. One of the AAPL reviewed studies found that almost half of the defendants in that sample were restored at the 45-day mark. While there is not sufficient research to recommend setting hard restoration timelines, this dynamic does have implications for case management, and perhaps initial status or review hearings should presumptively be set 45 days from the initiation of restoration services.

6. Develop and impose rational timelines

Beyond the *Jackson* directive to limit the length of pre-trial detention, there is no specific, uniform constitutional timeline for the various stages of the competency process. In *Oregon Advocacy Center v. Mink*,[8] the 9th Circuit citing *Jackson*, found that Oregon violated a defendant's due process rights if the defendant was not transferred to the Oregon State Hospital within seven days of a court's commitment to the hospital for restoration. But that is one of very few times a court has specified a required timeline, and that timeline only speaks to one part of the process.

Delays can and do occur waiting for an evaluation after competence is raised, waiting for the evaluation report and for a hearing on the findings of that report, waiting for a judicial decision after that hearing, waiting for a restoration slot after incompetence is determined, waiting for restoration status reports and hearings on those reports, and finally, waiting for a final legal determination of restoration. A separate issue arises when a defendant is deemed unrestorable, and the length of detention and the resolution of those cases is another issue that needs attention, including an examination of the processes for potentially transitioning to a civil commitment in those circumstances.

At each of these steps in the process there is an opportunity for delay, and also an opportunity for alacrity and efficiency. An important item left for further Task Force exploration is the development of at least a proposed slate of presumptive best practice timelines for each of these steps in the process. Some of the steps are largely controlled by case management decisions of the court, discussed below, but others are cross-jurisdictional and cross-branch issues that require the synchronization of many disparate parts.

As difficult as that synchronization may be, the payoffs could be huge. A recent effort to apply mathematical modeling to delays at each part of the competency process[9] identified some remarkable opportunities:

> The model validates that relatively small changes to specific variables that are determined or influenced by public policy could significantly reduce forensic bed waits. The following examples illustrate the outcomes projected by modeling data from the sample states:
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> - Diverting two mentally ill offenders per month from the criminal justice system in Florida reduced the average forensic bed wait in the state by 75%. From an average wait of 12 days in early 2016, the average wait fell to three days.

[8] *Oregon Advocacy Center v. Mink*, 322 F.3d 1101 (9th Cir. 2003)
[9] https://www.treatmentadvocacycenter.org/storage/documents/emptying-new-asylums.pdf

- Reducing the average length of stay for competency services by less than 2% in Texas — from 189 to 186 days — increased forensic bed capacity sufficiently to reduce bed waits from 61 to 14 days.
- Increasing the number of forensic beds by 11% in Wisconsin — from 70 beds to 78 beds — reduced IST bed waits from 57 days to 14 days.

These savings and improvements are well worth the time and attention of the Task Force and of our competency system partners.

7. Address operational inefficiencies

At each step of the process, there are opportunities for refinement. These are only some of those operational opportunities to improve the overall effectiveness of the competency system.

- *Evaluator training, availability, and speed*

  In many states the availability of qualified forensic examiners causes significant delays. One common cause of the lack of availability is funding for positions and compensation rates for the examiners, both of which should be addressed, but there are other operational strategies that have worked in some jurisdictions.

  For example, in Los Angeles, a small roster of psychiatrists is paid relatively well for conducting evaluations on a known schedule, for a set number of defendants, for a predetermined number of hours, at the same place each time. This predictability encourages engagement of the psychiatrists and consistency in their evaluations. This also happens to be one of the few same-day evaluation schemes in the country. Once a defendant is referred for evaluation and transported to the Hollywood court, they are evaluated in the morning and the disposition is in the afternoon, and transportation is immediately accomplished. Not every jurisdiction may be able to achieve this level of efficiency, but the principles that underly this success are replicable, and more of those principles are discussed below.

  While in almost all cases the availability, qualifications, compensation, and training of forensic evaluators is not on the judiciary's side of the fence, assuming control of all of those factors is an option. Arizona sets the qualification for evaluators, trains them, and directs payment to them. While this may be a unique circumstance, it shouldn't be completely foreign to court systems, many of which directly employ mediators, custody evaluators, interpreters, and other direct service providers in instances where the performance of those services is integral to the operation of the courts.

  Another useful strategy that endeavors to make the most efficient use of evaluator resources is the consolidation of evaluations. In some places this means bringing evaluators to the courthouse to do batched evaluations, in conjunction with a consolidated calendar to ensure sufficient volume to make it worth it, and in other cases it may mean regionalization of competency cases to bring the defendants from a number of smaller jurisdictions to one evaluation site.

  An emerging option involves telehealth. As more jurisdictions are using tele-services for more purposes, often behavioral health related, there is more opportunity for assessment and evaluation of those strategies. The research results so far are quite encouraging. An initial randomized control trial reported in the Journal of the American Academy of Psychiatry and the Law found that using a telemedicine evaluation produced assessment scores consistent

with the in-person evaluations, that patients had no preference for in-person versus remote evaluations, and that the evaluators preferred the in person option.[10]

A 2018 review of that study, those that have followed, and the emerging legal findings concludes that "[T]he use of (videoconferencing) can be a viable way to meet the demand for timely adjudicative competence evaluations… [These] evaluations make the most sense when they improve the efficiency of services while maintaining the same standards of quality of traditional evaluations."[11] Which they seem to have great potential to do.

To the extent that the obstacle to greater use of remote technology for evaluations (and other assessment and treatment) is attitudinal, recent events have likely increased everyone's level of comfort and proficiency with virtual options.

These strategies all support the model of evaluations taking place somewhere other than in a psychiatric hospital, though around the country that is still the most prevalent model. The other emerging custodial approach is to conduct evaluations in jails, which is an option in at least nine states. While ironically this may in fact reduce the amount of time defendants spend in jail awaiting an evaluation, there are serious questions about the appropriateness of conducting forensic inquiries in jail. An entire 2019 Journal of the American Academy of Psychiatry and the Law article is devoted to the incongruity between the professional guidelines that specify such evaluations "should take place in quiet, private, and distraction-free environments," and the realities of a jail environment.[12] More data and research on this option are needed.

- *Multiple opinion requirements*

  The issue of how many evaluations and expert opinions are needed to make an informed decision about competency is largely an issue of local or state legal culture. Many jurisdictions are satisfied with one evaluation. Some allow for a second evaluation if an opponent disagrees with the initial results, and some jurisdictions begin with a requirement for two evaluations, and then an automatic "tie-breaker" if the opinions differ. There are some jurisdictions that allow even more than three forensic evaluations, though to what end isn't clear.

  In fairness, it is not always the litigants that push for multiple evaluations, sometimes it is the judge. While legal customs (and the statues and rules that enshrine them) are difficult to change, two changes may gradually discourage this resource drain. First, if the timelines discussed above are imposed for the evaluation process for the time from referral to report, multiple evaluations may simply become impractical.

  Second, below is a recommendation that competency teams be deployed – a team would consist of a judge, prosecutor, defense counsel, and a small cadre of evaluators. Some existing programs have found that the secret to efficient and fair processing of competency cases is trust; trust developed over time by frequent interactions, and enduring relationships. If the actors all had more experience with and trust in the evaluators, perhaps there would be less of an inclination to seek redundant evaluations, resources would be saved, and timeliness enhanced.

10 http://jaapl.org/content/35/4/481

11 Luxton and Lexcen (2018), Professional Psychology: Research and Practice Vol. 49, No. 2, 124-131, accessed at https://www.researchgate.net/publication/324488313_Forensic_competency_evaluations_via_videoconferencing_A_feasibility_review_and_best_practice_recommendations

12 Distractions in Forensic Evaluations, http://jaapl.org/content/early/2019/05/16/JAAPL.003842-19

- *Case managers and court liaisons*
  Several states have begun to use court connected or court employed personnel to provide case management-like functions for the court. Colorado calls them court liaisons, Washington calls them forensic navigators, other states refer to them as boundary spanners, but the function is essentially the same: bridge the behavioral health and criminal justice systems to more effectively manage individual defendants' circumstances.

  In a competency context this case management role can facilitate the pairing of defendants and evaluators, identify services that would allow the evaluation and restoration process to occur in the community instead of a facility, and generally make sure that cases don't fall through the cracks. Translating behavioral health system processes and requirements to a criminal justice context, and vice versa, has shown to benefit all of the system players by saving resources and more effectively delivering behavioral health services and access to justice.

- *Court case management – centralized calendars, frequent reviews, and teams*
  How an individual judge and a court system manage competency cases can make a dramatic difference in the process.

  - *Centralized calendars*
    Calendaring practices are another area of longstanding legal culture, and change can be difficult. Depending on the size of the jurisdiction, competency cases may be few and far between, or they may be an everyday occurrence. In either event, combining whatever cases there are and sending them to one judge (or more if the volume requires) will result in a more proficient judge. Law school, and most law practices, do not develop fluency in issues of psychotropic medication, therapeutic alliance, the DSM-V, and the myriad of other terms and issues that are the everyday concerns of competency to stand trial proceedings. But the nuances and context of these and other issues are central to getting it right in these cases. That fluency only develops with repetition and exposure to those issues. Court staff also benefits from repetition with these terms and processes.

    Another benefit of consolidation or centralization is that the ancillary resources implicated in competency cases are just that – ancillary, and they (forensic evaluators, treatment providers, hospital staff, community providers, public defender social workers, etc.) are rarely dedicated only to these cases, so bringing them together at a consistent time and place, with familiar faces and predictable processes is more efficient for them and for the court.

  - *Frequent reviews*
    Because of the huge impact that timeliness can have, frequent reviews at each stage can have an important effect. Cases – and people – can languish if the system players aren't held accountable. The delays mentioned earlier, from referral for an evaluation to delivery of the report, from the order of commitment to restoration to transportation to a facility or to release to a community resource, and from status report to status report from a restoration services provider, all benefit from court oversight and accountability. Human nature is to procrastinate, and frequent brief court reviews provide deadlines that spur action and progress.

  - *Teams*
    Centralized calendars and frequent reviews are much easier if there is a competency team – judge, prosecutor, defense counsel, and evaluator(s). This team can also include whatever other resources are involved, such as a forensic navigator or case manager,

state hospital representative, local mental health provider, etc. Some of the benefits to a team approach have been alluded to above, but essentially the advantage is proficiency. As with the judge, prosecutors and defense counsel learn about the mental health system and mental illness through experience, and with more experience comes the same more nuanced, contextualized understanding of competency law, psychiatry, and community behavioral health resources. That understanding allows them to be better advocates, and hopefully that leads to more just results.

A team approach also makes scheduling much easier for the court and for the other partners. Continuances and no-shows decrease if everyone has the same calendar and the same regular schedule.

But the most important benefit of the team approach is the efficiency that comes with predictability and trust among team members. Without abdicating their legal and ethical responsibilities, team members can nonetheless reduce the nonproductive steps in the process and focus on the operant ones. That predictability and trust can lubricate the otherwise clunky competency machine and make it run more smoothly.

8. Address training, recruitment and retention of staff

This issue was one particularly highlighted by the trial judge focus group. Many of the inefficiencies in the competency process have their roots in the lack of a sufficient behavioral health workforce. If there are too few qualified evaluators, for example, jurisdictions either lower the evaluator qualifications or they have waitlists for evaluations, or both. More forensic psychiatrists are needed, and some systems have begun to actively incentivize that career track, but progress is slow. The solutions are bigger than those that the judiciary alone can implement, but courts do have a role in sounding the siren and focusing attention on the problem.

9. Coordinate and use data

Some policymakers and funders respond most acutely to personal stories that illustrate a need, and others gravitate to data. The competency to stand trial problem certainly has no shortage of the former, but more and better data is also needed. The coordination of law enforcement, behavioral health, jail, and court data is difficult. There are disparate data elements, definitions, client identifiers, and technical systems.

Money is one motivator for good data collection and coordination, and some of the best data come from jurisdictions where a managed behavioral health care system demands it. Arizona has such a system, and the crisis care continuum there is one of the best in the country because of those data. Early intervention and diversion from the criminal justice system are consistently shown to save money, so investment in those strategies takes priority.

The courts have a significant role in identifying common data elements and coordinating data collection with law enforcement, jail, and treatment partners. SAMHSA developed an “Essential Measures” guide for data collection across the SIM,[13] and the National Center for State Courts has a recently retooled behavioral health data elements guide as well,[14] but it isn’t clear that there is a consensus about what competency process data should be collected or that there is any urgency

[13] https://store.samhsa.gov/product/data-collection-across-the-sequential-intercept-model-sim-essential-measures/PEP19-SIM-DATA

[14] https://www.ncsc.org/__data/assets/pdf_file/0019/38026/State_Court_Behavioral_Health_Data_Elements_Interim_Guide_Final.pdf

about compiling those data. This coordination and compilation can be a bit of a Sisyphean task, but one that state courts should nonetheless pursue.

10. Develop robust community-based treatment and supports for diversion and for re-entry

The first recommendation above is to divert these people and these cases from the criminal justice system, but a common refrain in the mental health context is, divert to what?[15] The simple answer is to divert to treatment, but the treatment system is often anemic at the pre-arrest community level, at the post-arrest correctional level, at the pre-trial and post-conviction level, and at the point of re-entry to the community. The recommendation about which there was the most consensus among the trial judge focus group (and others) is that the entire treatment continuum needs to be strengthened.

As judges are increasingly expected to assume a problem-solving role rather than a strictly adjudicative one, the need for appropriate treatment options becomes more imperative. It is unfair to judges to ask them to manage defendants with mental illness and to hold them accountable for those outcomes without giving those judges the treatment tools and dispositional resources they need. This is one reason that courts and judges have such a substantial interest in leading change in this arena.

Treatment in this context is not just strictly mental health treatment, but also case management, cognitive behavioral therapy, substance use disorder treatment, and wrap around services. Homelessness is also often a companion to mental illness and arrest, and judges and communities are always in need of housing options for defendants with mental illness who are entangled in the competency web – pre-trial, and upon re-entry. Robust treatment, supervision and support options throughout the process are essential if we are to expect better system outcomes.

Conclusion

The competency to stand trial process is just one segment of the broader intersection of mental health and the criminal justice system, but it is one that is squarely within the judiciary's ambit. For both institutionally selfish and for altruistic reasons, courts and judges should embrace the issues and actively pursue solutions. The complexity of the system and the siloed nature of the services cries out for collaboration and for leadership, and the judiciary is in a unique position to not only convene, but to lead.

The young Colorado man, the daughter in California, and many more to come deserve no less.

[15] http://www.bazelon.org/wp-content/uploads/2019/09/Bazelon-Diversion-to-What-Essential-Services-Publication_September-2019.pdf