

Leading Reform: Competence to Stand Trial Systems

A Resource for State Courts¹

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THE ISSUE

The majority of state hospitals maintain bed-wait lists of defendants who have been court-ordered for competency to stand trial evaluation or restoration services. A 2017 report found that in some states these waits are around 30 days, but three states reported forensic bed waiting lists of six months to a year. At any given time, there were at least 2,000 defendants waiting in jail for these beds.² During the pandemic these waits have skyrocketed, and in just three states combined, over 3,000 people were reported waiting in jail for a restoration bed. These are pre-trial defendants, sometimes charged only with misdemeanor offenses, all of whom are presumed innocent. And yet, many of them will spend far longer in jail or otherwise confined than they ever would have had they pled to or been convicted of the underlying offense.

BACKGROUND

Of the countless ways in which mental illness and the justice system intersect, one of the most direct is when courts and judges are involved in an order for evaluation and ultimate determination of a defendant's competency to stand trial.³ Any defendant, their counsel, the prosecutor, or the court can raise a concern that the defendant may be incompetent to stand trial in any criminal proceeding, from misdemeanors to capital murder. The United States Supreme Court in *Dusky v. U.S.* (1960) held that in order for a defendant to be found competent to stand trial, 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 raised, 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 an individual is 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 they are 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 risk to the community, or their clinical needs.

In the context of competency to stand trial, due process requires that accused persons understand the charges against them and be able to meaningfully assist in their defense. Due process also requires a limit on the restrictions on the accused's freedom during the evaluation and restoration process. These two seemingly simple propositions of due process are often interpreted and implemented in such inconsistent and ineffective ways that our systems frequently do more harm than good. In this area of the intersection of behavioral health and the justice system, the courts have an integral role and significant responsibility to identify and understand the issues and provide the leadership for change.

One of the first steps undertaken by the Task Force was the selection of eight trial judges from around the country who were asked to focus on

what they thought was working and what was not working relative to the competency processes. That two-day conversation set a solid path for identifying systemic problems and potential solutions to those problems.⁴

In an effort to understand all aspects of these issues, Task Force members and National Center for State Courts (NCSC) staff also engaged with other partner organizations and experts. Shortly after the NCSC focus group met, the Council for State Governments Justice Center (CSG), convened a remarkable group of experts from around the country to have a similar discussion, but from a broader perspective.⁵ A result of that convening is the CSG product [Just and Well: Rethinking How States Approach Competency to Stand Trial](#).⁶

This report builds on both the original interim recommendations to the Task Force and the *Just and Well* strategies to provide specific emphasis and implementation considerations from the perspective of the courts.

Many state courts are currently engaged in competency system and broader behavioral health system reform. Two regional Conference of Chief Justices and Conference of State Court Administrators summits were held in 2019, and the resulting technical assistance initiatives provided thereafter offered additional opportunities for discovery about what is and is not working, and how states are finding ways forward.⁷

Teams from Hawaii, North Dakota, Indiana, and Ohio, among others, identified the competency processes, and specifically the misdemeanor competency process, as area in need of reform.

State courts in each of these states initiated or participated in drafting legislation to reform the competence to stand trial systems in their states during the last year.

There have also 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 focus group of trial judges reconvened in Los Angeles to observe the Los Angeles County misdemeanor and felony diversion program, housing resources,

and same-day competency evaluation process used in the Superior Court in Hollywood. They also recently met remotely to consider the impact of the pandemic on competency issues around the country, and several of these judges now serve as members of the Competency Subcommittee of the Task Force (the Subcommittee).⁸ The Subcommittee examined and refined the original interim recommendations,⁹ and their final recommendations were considered and approved by the Task Force in August, 2021.

■ RECOMMENDATIONS ■

1. Divert cases from the criminal justice system



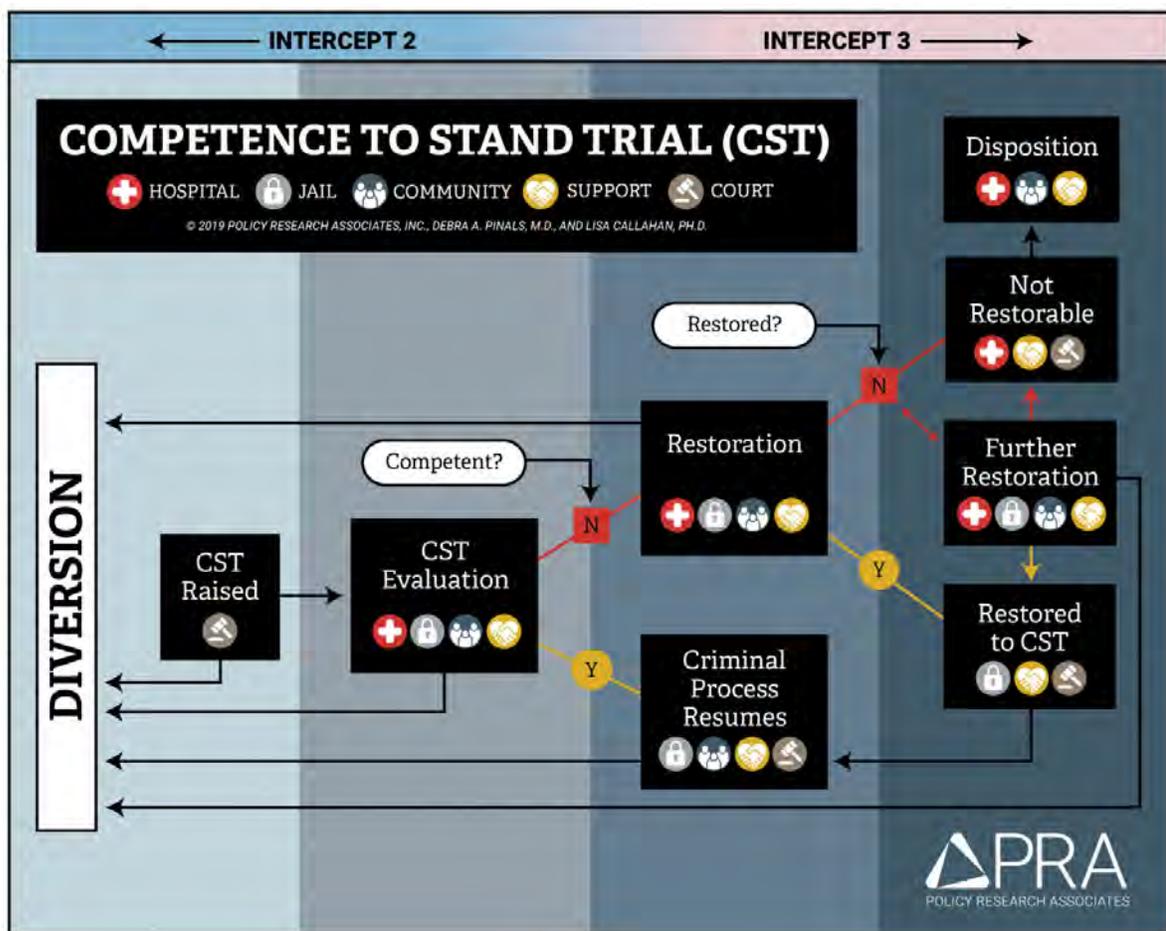
The involvement of the criminal justice system with people with mental illness is all too often a result of “nowhere else to go.” Unlike when someone suffers a physical health emergency, there frequently is no 24/7 emergency mental health response infrastructure. When a mental health emergency happens, 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 who exhibits symptoms of a mental illness, legal competence is a natural issue to be raised, and an array of delays, incarceration, and other problems inevitably follow.

There are, however, alternatives to this scenario, and these alternative approaches often work better for the individual as well as the community and use limited resources and available dollars more wisely. Because jails and courts struggle to effectively address serious mental illness (SMI), moving individuals in and out of these systems can make people with SMI worse. Diverting people who experience mental health symptoms to a system where treatment can be addressed at the right level of need as something more akin to our physical health processes 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 evidence-based, effective, and more humane alternatives.

Looking forward, the recently created mental health crisis line alternative, 988, should also be utilized as a proactive diversion and care coordination opportunity. The greater the availability of these options, the fewer people will be subjected to the criminal justice and competency systems, and the better the outcomes for people with mental illness, courts, and public safety.¹⁰

These diversion opportunities also arise at each point in the competency process, and off-ramps from the criminal justice system to treatment and civil alternatives, including voluntary treatment, the use of Psychiatric Advance Directives, and even involuntary civil commitment when appropriate — such as the use of Assisted Outpatient Treatment (AOT) — should be considered at each of these points. Interventions should be tailored to the needs of the individual and the community at the evaluation stage, prior to restoration, upon return from restoration, and prior to and as a part of sentencing or other case disposition. Even individuals found incompetent to stand trial and unrestorable could take advantage of the right “off-ramp” opportunities for diversion and be linked to appropriate community services to reduce their risk of offending and returning to the competency system.

COMPETENCE PROCESS FLOWCHART



2. Restrict which cases are referred for competency evaluations



Even when the criminal justice system is invoked, there are still ways to divert people with mental illness from the competency road. The first potential point of diversion occurs when someone chooses to raise the issue of competency.

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. Legally, all defendants are presumed competent, and judges are under no obligation to order an examination unless there are sufficient grounds to do so.

Certainly, defense counsel have an obligation to explore all possible legal strategies on behalf of their clients, but it does not follow that competence should be raised every time there is a colorable argument. Newer defense lawyers, for example, may not have seen how the process really plays out as a practical matter and may not be aware of better alternatives to pursue 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, and several jurisdictions currently prohibit the use of the restoration process for certain classes of pretrial detainees. There is a growing consensus that individuals charged with misdemeanors, 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 are frequently returned to jail to wait their turn for a final court hearing to formalize that status, and then they are able to restart the criminal trial process. By then, they have been in jail and confinement for far longer than they ever would have been had they been convicted and sentenced on day one. Often the result is that 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 *Jackson* says and due process requires that the nature and duration of an incompetent defendant’s commitment

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must bear a relationship to the purpose for which they are committed. The nature of most competency systems in our country are inherently disproportionately onerous and ponderous when applied to someone charged with a misdemeanor.

Even proposing the “bright line” of misdemeanors versus felonies as a way to presumptively cull cases from the competency system is potentially problematic, however. One risk is that defendants will be charged with felonies, when possible, in order to keep all disposition options on the table for the prosecution and the court. This dynamic is especially pronounced when there are only two options – competency evaluation or traditional prosecution. The better answer is to have a continuum of responses available to the prosecutor and court. A clinical and risk screening and assessment would suggest the appropriate level of treatment intervention and supervision required. This continuum could include:

- A direct handoff to standard community-based treatment;
- Diversion to a treatment program affiliated with the criminal justice system, potentially including some level of community supervision;
- Referral to civil court options, such as civil commitment to a hospital or to Assisted Outpatient Treatment, if the defendant is treatment non-adherent,¹¹ and is clinically appropriate; and
- Other civil options such as guardianship.

Each of these options would ideally include appropriate supports, such as case management to ensure and coordinate rehabilitative or habilitative resources, such as housing, job training, public benefits, and the like.

If there are other effective options in which system players have confidence, the competency process will be used more sparingly, and more appropriately. By diverting defendants to appropriate targeted interventions and services and reserving the competency to stand trial mechanism for fewer cases and for circumstances for which the process is more proportionate, resources would be better spent and the outcomes for everyone, including the defendants, would be better.

3. Develop alternative evaluation sites

Although some states have shifted competency evaluations to sites outside of state hospitals, they continue to 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. Generally, there is only one option in a jurisdiction.

Judges, when informed by appropriate screen and assessment results and by behavioral health professionals, are in the best position to make the determination



about which setting, among a range of options, is most appropriate for individual defendants. This decision should be in the context of a statute or rule that presumes that evaluations take place in the least restrictive setting appropriate for each individual's demonstrated criminogenic risk and clinical needs.

But judges cannot order evaluations in a setting that does not exist. Courts and judges have a role in advocating for these options, because 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.

4. Develop alternative restoration sites



Similarly, there is usually only one option for restoration services in a jurisdiction, and that remains most commonly the state hospital. This likely leads to delays, jail time, and a loss of liberty that is disproportionate to the purpose for which incompetent defendants are being restored. Some states require, and others permit restoration in a psychiatric hospital. 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 as they wait for a restoration bed. These realities point to the better options of diversion from the restoration process and to community treatment alternatives whenever possible.¹²

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, treatment should be in the community. State statutes and rules should clearly presume less restrictive placements, and that presumption should only be overcome when the judge, again informed by objective assessment data and input from forensic professionals, finds that restoration services cannot safely or effectively be provided in the less restrictive community-based setting.

As community settings are developed and emphasized, care must be taken to maintain adherence to best practices and quality care. Decentralizing the provision of restoration services could potentially lead to inconsistent adherence to evidence-based practices, but that should not cause hesitation to move to a presumption in favor of community treatment. Instead, it should inform a system of accountability and appropriate oversight to ensure quality care. Uniform standards of care and consistent reliance on objective determinations of treatment placement eligibility are even more important as the number of restoration sites is increased and decentralized.

The advantages of decentralization outweigh the consistency concerns. The opportunities for integration of long-term community treatment and support with the short-term restoration episode are tremendous. Transitions from large restoration facilities to jail, and from jail to the community are frequently catalysts for a defendant's regression and decompensation. Changes in settings, medications, and therapeutic alliances are often problematic, and those changes can be minimized if appropriate, integrated, community settings are preferred.

Perhaps the most controversial experiment in competency restoration is jail-based restoration. Several states, under pressure to find alternatives to the long waits for restoration beds in state psychiatric facilities, have attempted to provide restoration services in jail. It should be acknowledged that this strategy does usually reduce the overall number of days the defendant is detained.

There are, however, a number of concerns about this approach. First, although jails are required to provide community-based standards of mental health services, often this is not the case. Moreover, the nature of a jail's mission for pretrial populations is to help detain defendants at risk of failing to appear and to protect public safety. As such a jail is not an appropriate setting if there is a significant need for behavioral health treatment. A recent *Journal of the American Academy of Psychiatry and the Law* review of best practices and recommendations for forensic evaluations in jails¹³ agreed with the American Psychological Association's (APA) guidance that that competency *evaluations* should occur in environments that "provide adequate comfort, safety, and privacy" to ensure validity of assessments. Surely the same notion applies to restoration treatment as well.

Perhaps the natural result of this incongruity is that jail-based restoration efforts focus more on the other two components of restoration services — legal education, and medication. As discussed below, legal education has not been found to be particularly effective. Medication in jails can be critical, but may also implicate another set of problems when jail medication formularies are limited, especially with respect to certain medications that may have better results in maintaining stability of symptoms, such as long lasting injectable medications. Instead, given the transient populations within jails, they are often set up to prescribe daily dose medications, and there may be limited options of those that are readily available.

Daily dosing has its own problems with medication lines, refusals and compliance, but also with medication continuity once a person leaves the jail and hopefully transitions to more sustainable long term injectables.

Transitions from large restoration facilities to jail and from jail to the community are frequently catalysts for regression and decompensation.

Considering each of these factors, the recommendation is that community restoration should be the presumptive placement, and that jail-based restoration should *only* be considered when:

- > It is clear that the individual does not have a more acute clinical treatment need;
- > The only alternative is a wait of many months for a treatment bed that is not medically necessary;
- > The jail program is treatment focused and has appropriate medications available;
- > There are clear efforts at continuity between the restoration program and other settings where the person may be sent; and
- > Even then, because of the importance of addressing conditions of confinement in jails more broadly, funding separate jail restoration should be only a temporary option while other system reforms are in progress.

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*.¹⁴

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.

This should not be an either/or approach, and there is some consensus that, given that most individuals found incompetent to stand trial have challenges stemming from symptoms of serious mental illness, medication is the most important catalyst for successful restoration. One meta-analysis of the research further concluded that “(t)he benefit of adding educational programs to medication protocols for competency restoration of non-developmentally disabled defendants has not been clearly established.”¹⁵

There is an evolving recognition that there is value in all three approaches — medication, individualized treatment, and legal education, to varying degrees depending on the individual defendant’s overall needs. As such, 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 prioritize getting defendants what they need when they need it rather than making restoration a one-size-fits-all strategy in one state hospital location.

The duration of time individuals spend in restoration programs is another important consideration. The rate of successful restoration for individuals with serious mental illness is relatively consistent across the various systems (80% to 90%), but the length of time defendants spend in restoration programs

AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial

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Statement of Intent and Development Process

This document is intended as a review of legal and psychiatric factors to give practical guidance and assistance in the performance of competence to stand trial evaluations. This Guideline was developed through the participation of forensic psychiatrists who routinely conduct evaluations of competence to stand trial and have expertise in this area. Some contributors are actively involved in related academic endeavors. The process of developing the Guideline incorporated a thorough review that integrated feedback and revisions into the final draft. This Guideline was reviewed and approved by the Council of the American Academy of Psychiatry and the Law on October 17, 2007. Thus it reflects a consensus

related to competence to stand trial. Any clinician who agrees to focus in this domain have a

Overview

Adjudicative competency is a legal construct related to the defendant's ability to understand the proceedings related to precise U.S. state statutes. The process of developing the Guideline incorporated a thorough review that integrated feedback and revisions into the final draft. This Guideline was reviewed and approved by the Council of the American Academy of Psychiatry and the Law on October 17, 2007. Thus it reflects a consensus

around the country varies greatly. Some studies identified mean restoration periods of 60 days, while others documented mean times of a year or more.

One factor in the length of the process is the court's involvement in oversight and monitoring. When court involvement is too passive, the length of the restoration process can be longer, and the *Jackson* requirement for alacrity and proportionality lands at the court's doorstep. Active court oversight of the restoration process and collaborative involvement with treatment professionals is more likely to produce energetic restoration efforts and a more timely, effective, and constitutionally compliant process. Court reviews of the process should occur early and often, and clinical discharge readiness decisions should be met with timely court consideration and authorization. When the courts control the back door of the restoration units, new individuals wait for admittance. Partnership with the treatment providers and trust in them to establish individual readiness for discharge from programs once clinically appropriate should be taken into account by judges.

While there is evidence that a court 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.

Active court oversight of the restoration process and collaborative involvement with treatment professionals is more likely to produce energetic restoration efforts and a more timely, effective, and constitutionally compliant process.



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*,¹⁶ 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. This is one of very few times a court has specified a required timeline, and that timeline only speaks to one part of the process. However, to the extent this fixed timeline poses significant logistic and resource challenges, it should serve as a catalyst for proactive collaboration among system partners to themselves develop workable and appropriate timelines rather than leave it to civil rights litigation.¹⁷

Delays can and do occur: (1) waiting for an evaluation after competence is raised, (2) waiting for the evaluation report and for a hearing on the findings of that report, (3) waiting for a judicial decision after that hearing, (4) waiting for a restoration slot after incompetence is determined, (5) waiting for restoration status reports and hearings on those reports, and finally, (6) waiting for a final legal determination of restoration. A separate issue arises when a defendant is deemed unrestorable. The length of detention and the resolution of those cases is another issue that states should review, 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 speed and efficiency. While there is no single time-standard answer for all jurisdictions, it is crucial that individual states address this timeliness issue and establish presumptive timelines through tailored statutes or rules, as applicable. While some of the steps are largely controlled by case management decisions of the court discussed below, others are cross-jurisdictional and cross-branch issues that require the synchronization of several disparate parts. They, therefore, require collaborative consideration of each of the following timing issues:

- The time from when doubt is raised to evaluation should be as brief as possible. Often defendants are incarcerated at this point, and frequently this is at a time shortly after arrest and perhaps a mental health crisis. A clinical response should be prioritized, and that response may inform the timing of an evaluation. In some circumstances it may be appropriate to wait for the defendant to stabilize, such as in the case of stimulant psychosis.
- The time from the administration of the competency evaluation until a judicial determination of competence should also be brief. While largely a judicial scheduling issue, jurisdictions should ensure that evaluators, counsel, and the court all communicate about delays, and that scheduling these hearing be prioritized by each. There are also ways in which report templates and other aspects of evaluator training can facilitate quick turnaround times, and those are discussed in the next section.
- Once a person is found incompetent, the *Jackson* considerations come into play, and the obligation to initiate restoration service promptly begins. While *Mink* finds that taking more than seven days to begin treatment violates the constitution, each jurisdiction (outside of the 9th Circuit) should carefully consider what timeline target makes legal and practical sense for them, while also considering that not all defendants need to go into a state hospital for restoration, and thus timely access should include access to alternative community-based restoration sites and models.
- As discussed above, the first court review of the restoration process should occur quickly, as a significant portion of this population attains competence shortly after clinical stabilization, and often appropriate medication. Subsequent court reviews should also be frequent and meaningful, i.e., the court should ensure that the defendant is transported, that meaningful reports have been prepared and reviewed by all parties, and that treatment progress is maintained. Court liaisons or navigators can be particularly helpful in ensuring that these hearings are meaningful and productive, and that progress is maintained. Their role is discussed further below.

- > The maximum time a person can be maintained in a competency restoration program varies wildly from state to state. Often the possible duration is tied to maximum potential periods of incarceration, but those periods of time may be wholly incompatible with *Jackson*, and should be reviewed. There is also often confusion about the process to be followed when those time limits are reached — whose responsibility it is to file for a civil commitment, for example. These processes should be clear, and appropriately quick.

As difficult as that synchronization of disparate parts and interests may be, the payoffs could be huge. A recent effort to apply mathematical modeling to delays at each part of the competency process 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:

- > 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.
- > 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.¹⁸

These savings and improvements should be a strategic priority for all state courts and for our competency system partners.



7. Address operational inefficiencies

At each step of the process there are opportunities for refinement. Below are examples, but these are only some of the 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 Massachusetts, every district and superior court has access to same day clinical competency evaluations conducted by state behavioral health staff or contracted providers of the state behavioral health system. Although thousands are done each

year, this allows for “screening” to take place so that only the most ill are referred for further evaluation as inpatients — where they likely clinically belong.

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. Once a defendant is referred for evaluation and transported to the Hollywood court, they are evaluated in the morning, 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 a responsibility of the judiciary, assuming control of all of those factors is an option. This would require strong clinical involvement to ensure clinical quality, but Arizona’s court system sets the qualification for evaluators, trains them, and directs payment to them. While this may be a unique circumstance, it should not 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. In other cases, it may mean regionalization of competency cases to bring the defendants from a number of smaller jurisdictions to one evaluation site.

Evaluator availability and efficiency can also be dramatically enhanced by the emerging option of video forensic evaluations. As more jurisdictions are using teleservices 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 conducted pre-pandemic and 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.¹⁹ Given the rapid shift in the use of video technology for evaluations in the COVID-19 context, the preference of clinicians and courts may also evolve as more is learned about the values of more widespread use of this technology.

A 2018 review of that study and others 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

Evaluator availability and efficiency can also be dramatically enhanced by the emerging option of video forensic evaluations.

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...,²⁰ 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 practice. 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.²¹ Some states have office space in courthouses devoted for evaluations even if the evaluatee is required to be detained in jails. However, in some jurisdictions evaluators navigate space within the jail where issues of privacy and noise can hamper quality of the assessments. More data and research on these options are needed.

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.

Evaluation templates

Regardless of how well trained an evaluator may be, different professional backgrounds, experiences, training, and preferences lead to different approaches to evaluation processes and reports. These differences can be helpful, such as the different perspectives of a psychologist and a psychiatrist. But when the reports themselves are dramatically different in content, style, and structure, delays and miscommunication may result. A number of states employ evaluation report templates, so that the readers — judges, lawyers and other clinicians — have a consistent experience in reviewing a report. This can ensure that all required statutory elements are addressed, factual background and detail are consistent, and conclusions and recommendations are legally sufficient. Different approaches and assessment tools can still be accommodated, but the presentation would be consistent. Whether a template is used or not, there should at least be specific drafting guidelines, and adherence to those guidelines ought to be required.²²

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 is not clear. If more than one evaluation is required, one time-saving measure employed in some jurisdictions is to have the evaluators conduct the evaluation collaboratively, at the same single interview.

Various parties may push for multiple evaluations, including the litigants and the judge, each for various reasons. While legal customs (and the statutes and rules that enshrine them) are difficult to change, two things 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 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 neutral, objective 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.

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 custodial facility, ensure appropriate attention is paid to timelines and resource coordination, and generally make sure that cases do not 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-5, 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.²³

Another advantage 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. 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 are not 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 but meaningful and productive court reviews provide deadlines that spur action and progress.

> **Teams**

Centralized, coordinated 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,

Without abdicating their legal and ethical responsibilities, team members can nonetheless reduce the nonproductive steps in the adversarial process and focus on the operant ones.

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, predictable 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 adversarial 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

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 and psychologists are needed, and some systems have begun to actively incentivize that career track, but progress is slow. Communities have also expanded competency evaluations to other disciplines including social workers, and this can be another consideration. Again, with the use of video technology, more efficient access to an appropriate workforce may be facilitated.

Rural communities are particularly understaffed, and incentives to locate in those communities could be helpful. As noted, technology solutions are part of this issue, but likely cannot be the only answer. Attention to the racial and ethnic makeup of evaluators and others is also necessary, in order to promote trust and confidence in evaluators and the evaluation process.

The solutions are bigger than those that the judiciary alone can implement, but courts do have a stake in the outcome and a role in sounding the siren and focusing attention on the professional resource shortage 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 gaining notoriety because of those data. They show that early intervention and diversion from the criminal justice system saves 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,²⁵ and the National Center for State Courts has a recently retooled behavioral health data elements guide as well.²⁶ However, it is not clear that there is a consensus about what competency process data should be collected or that there is any urgency about compiling those data.²⁷ This coordination and compilation can be a bit of a Sisyphean task, but one that state courts should nonetheless pursue to help drive system improvements.

The courts have a significant role in identifying common data elements and coordinating data collection with law enforcement, jail, and treatment partners.



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

The first recommendation above is to divert people with serious behavioral health issues and their cases from the criminal justice system, but a common refrain in the mental health context is, divert to what?²⁴ 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. All system partners readily agree that the entire treatment continuum needs to be strengthened.

Concomitantly, there needs to be a continuum of legal avenues to access those services. Criminal court avenues exist, albeit imperfectly, and are often used out of necessity, but a range of civil legal options that can be used to access treatment are also essential. AOT, guardianships, conservatorships, psychiatric advance directives, and other less restrictive options that can be accessed at different stages of a person's diversion and re-entry path are essential to long-term success.

Re-entry to the community from wherever the person exits the competency process needs to be coordinated, seamless, community focused, and with abundant supports, including transitional and supported housing. As much effort needs to be made to ensure a successful community reintegration as was made to intervene in the first place, or all of the resources spent to achieve stabilization and wellness are for naught.

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 perhaps unfair to ask judges to manage defendants with mental illness and to hold them accountable for those outcomes without providing the courts 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 involves aspects of care related to substance use disorder treatment, supports for individuals with intellectual and developmental disabilities, and culturally competent services for veterans, as well as ancillary supports like case management, cognitive behavioral therapy related to criminogenic risks and needs, 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 community reentry. Robust treatment, supervision and support options throughout the process are essential if we are to expect better system outcomes and better outcomes for the individuals involved.

Re-entry to the community from wherever the person exits the competency process needs to be coordinated, seamless, community focused, and with abundant supports, including transitional and supported housing.

■ 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. Significant system reform requires strong partnerships with local entities and with state entities in other branches of government.²⁸ For both institutionally necessary and for altruistic reasons, courts and judges should embrace the issues and actively pursue solutions.²⁹ **The complexity of the system and the siloed nature of the services cry out for collaboration and for leadership; and the judiciary is in a unique position to not only convene, but to lead.**

While the rules, statutes, resources, and processes related to competency to stand trial differ widely from state to state, there are common issues, and there is significant room for improvement in all states. This checklist provides a brief, task-oriented roadmap to assessing and reforming your competency system. It should be read in close conjunction with the companion Task Force product *Leading Reform: Competence to Stand Trial Systems – A Resource for State Courts*, and the resources identified therein..

- 1. Convene an interdisciplinary team to examine all aspects of the competency system and to make and advocate for recommended changes** This team should include legislators, executive branch representatives including the state mental health authority, local mental health providers, court administrators, prosecutors, defense counsel, jail administrators, state mental hospital representatives, competency evaluators, judges, and others as appropriate in your system.³⁰
- 2. Review *Leading Reform: Competence to Stand Trial Systems – A Resource for State Courts* and the materials referenced therein** Issues specific to statewide court systems are described, and the resources cited provide additional research, context, and insight helpful to court leaders and their partners. This may also be the time to consider the resources you have, and potentially to seek assistance from experts in the field, including technical assistance from the National Center for State Courts.
- 3. Identify and gather data related to the competency process** Court filing and disposition information, jail data including screen and assessment results and relevant wait times, evaluation outcome and timeliness data, restoration outcome and timeliness data, and other overall timeliness and wait time or waitlist information.
- 4. Review the crisis care and justice system diversion systems for opportunities to divert people with mental illness from the criminal justice system**³¹
- 5. Identify opportunities to divert defendants from referral to the competency evaluation mechanism** This includes statutory or rule changes, and prosecutorial initiatives to link defendants directly to treatment rather than to an evaluation, either with a dismissal, a diversion agreement, or a referral to Assisted Outpatient Treatment, if appropriate.³²
- 6. Identify existing competency evaluation protocols, develop outpatient community options, and create a presumption to use those community sites unless unsafe or clinically inappropriate** This may require funding stream changes, and development and training of a new cohort of community-based evaluators.

- 7. Identify existing competency restoration locations and processes, develop outpatient community options, and create a presumption to use those community sites unless unsafe or clinically inappropriate** This may require funding stream changes, and development and training of a new cohort of community-based restoration treatment providers.
- 8. Revise restoration protocols and timelines** Review best practices for restoration interventions and emphasize clinical treatment resources. Develop consensus about reasonable timelines for referral to and commencement of treatment, and about the reasonable duration of restoration services. Legislative change may be needed for some reforms.
- 9. Examine the qualifications, selection, and training of evaluators** Limit the number of automatic evaluations ordered, and then set the qualifications of evaluators as “high” as feasible given a potential reduction in the number of evaluations and set firm timelines for the completion of evaluations. Create a protocol for remote evaluations, particularly for rural areas. Develop a robust evaluator training curriculum, with a requirement for continuing education.
- 10. Collaboratively develop an evaluation template and require its use** Seek input from forensic psychiatrists, judges, prosecutors, and defense counsel to create a template that is consistent and meets legal and clinical needs.
- 11. Consider the creation (or expansion) of a court-connected case management role** Also called forensic navigators, boundary spanners, and court liaisons.
- 12. Centralize or consolidate competency calendars and implement a team approach** Refer cases in which competency is raised to one calendar, with the same judge, counsel, and added case management resources.
- 13. Establish a requirement for frequent, meaningful court reviews once a defendant is referred to restoration services**
- 14. Identify benchmarks for process improvement using reliable data** Regularly review those data to identify trends, impediments, and progress.
- 15. Identify gaps in the continuum of community treatment and supports for those transitioning out of the justice system, and advocate for additional services** Improvements in the rest of the process won’t be sustained if defendants cycle back through the system because of a lack of community support, so specific gaps in the continuum of services should be identified and solutions advocated for collaboratively.

ENDNOTES

- ¹ Prepared by Richard Schwermer, National Center for State Courts consultant and retired Utah State Court Administrator under the auspices of the National Judicial Task Force to Examine State Courts' Response to Mental Illness (Task Force), established on March 30, 2020 by the Conference of Chief Justices and Conference of State Court Administrators. [This brief summary](#) includes a description of the Task Force membership and charge.
- ² <https://www.treatmentadvocacycenter.org/storage/documents/emptying-new-asylums.pdf> These prevalence numbers have surely only increased as a result of the COVID-19 pandemic.
- ³ 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. This frame recognizes that competency to stand trial relates to competency for criminal defendants and is distinct from competency to make personal or treatment decisions that might be heard in civil courts.
- ⁴ A summary of that focus group discussion can be found online [here](#).
- ⁵ Participants included forensic psychiatrists, researchers, state mental health directors, prosecutors, defense counsel, advocates for people with mental illness, legislators, judges, and others.
- ⁶ CSG drew from an extensive inter-branch and interdisciplinary advisory group to describe competency to stand trial nationally and provide ten strategies for state policymakers. The report reflects a partnership of NCSC, the National Association of State Mental Health Program Directors, and the National Conference of State Legislatures, in addition to the project conveners, the Council of State Governments Justice Center and the American Psychiatric Association Foundation through the work of the Judges and Psychiatrists Leadership Initiative. This group represents the three-branch nature of this issue, of which the courts are a critical component.
- ⁷ West and Midwest Region summits, focused on behavioral health issues in the courts, were conducted prior to the formation of the Task Force; the remaining regional summits are scheduled to be held in 2021 and 2022.
- ⁸ Subcommittee members include: Judge James Bianco, Judge Matthew D'Emic, Travis Finck, Sim Gill, Dr. Debra Pinals, Walter Thompson, and Judge Nan Waller. Additional liaison members are Lisa Callahan, Hallie-Fader Towe, and Bonnie Hoffman.
- ⁹ [Competence to Stand Trial](#) was published in 2020 as part of the Interim Report to the Task Force
- ¹⁰ There is also a separate subcommittee of the Task Force focusing on diversion at all stages of the SIM, and those more comprehensive Diversion Subcommittee recommendations should be reviewed and adopted as well.
- ¹¹ Some jurisdictions also require that the non-adherence to treatment has been demonstrated to contributed to re-hospitalizations and re-arrests.
- ¹² Los Angeles County has an impressive community restoration program that utilizes dozens of neighborhood residential settings as locations for housing, treatment, and case management.
- ¹³ Distractions in Forensic Evaluations, <http://jaapl.org/content/early/2019/05/16/JAAPL.003842-19>
- ¹⁴ American Academy of Psychiatry and the Law, <https://www.aapl.org/docs/pdf/Competence%20to%20Stand%20Trial.pdf>
- ¹⁵ 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
- ¹⁶ Oregon Advocacy Center v. Mink, 322 F.3d 1101 (9th Cir. 2003)
- ¹⁷ Unreasonable delays in the evaluation and restoration processes have been the impetus for lawsuits in at least a dozen states, and most if not all of them have resulted in findings of unlawful delay.
- ¹⁸ <https://www.treatmentadvocacycenter.org/storage/documents/emptying-new-asylums.pdf>
- ¹⁹ <http://jaapl.org/content/35/4/481>
- ²⁰ 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
- ²¹ Distractions in Forensic Evaluations, <http://jaapl.org/content/early/2019/05/16/JAAPL.003842-19>

- 22 See e.g., [Massachusetts Competency to Stand Trial Report Guidelines](#)
- 23 Some courts use existing Mental Health Court teams to manage competency cases.
- 24 <http://www.bazelon.org/wp-content/uploads/2019/09/Bazelon-Diversion-to-What-Essential-Services-Publication-September-2019.pdf>
- 25 <https://store.samhsa.gov/product/data-collection-across-the-sequential-intercept-model-sim-essential-measures/PEP19-SIM-DATA>
- 26 https://www.ncsc.org/_data/assets/pdf_file/0019/38026/State_Court_Behavioral_Health_Data_Elements_Interim_Guide_Final.pdf
- 27 GAINS/PRA workbook elements
- 28 Task Force resources for leading this reform at the state and local levels, respectively, include Leading Change Guide for State Courts and [Leading Change: Improving the Court and Community's Response to Mental Health and Co-Occurring Disorders](#)
- 29 Appendix A is a checklist for court leaders to use as a framework for beginning that pursuit.
- 30 The Task Force resource, Leading Change for State Court Leaders provides an outline for leading broader behavioral health system change, and may be relevant for this narrower purpose as well
- 31 Helpful resources include [Crisis Services: Meeting Needs, Saving Lives](#) and [Roadmap to the Ideal Crisis System](#)
- 32 See [Implementing Assisted Outpatient Treatment: Essential Elements, Building Blocks and Tips for Maximizing Results](#)

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