Assessment #3

Speaking Different Languages-
Breaking Through the Differences in
the Perspectives of Criminal Justice
and Mental Health Stakeholders on
Competency to Stand Trial Services:
Part 1

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Third in a Series of Ten Briefs Addressing: Bold Approaches for Better
Mental Health Outcomes across the Continuum of Care

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Executive Summary

In 2017, the National Association of State Mental Health Program Directors Research Institute (NRI) found there had been a rise in the number of forensic patients, particularly individuals found incompetent to stand trial (IST), residing at state psychiatric hospitals for inpatient services between 1999 and 2014. This issue has become of increasing importance to criminal justice and mental health stakeholders alike, as states try to implement new programs to divert some of these patients to community based programs. Despite these diversion efforts, states are still continuing to see a rise in the number of IST defendants residing in their state psychiatric hospitals for competency restoration services.

Increasing diversion measures has become a national goal. In December 2017, the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) published its report to Congress. One of the five main goals identified in the ISMICC report was to find additional diversion points and improve mental health care for adults with serious mental illness (SMI) involved with the criminal justice system. This goal is similar to one of the milestones in NASMHPD’s 2018 paper BREAKING THROUGH: Seven Bold Goals for Better Mental Illness Outcomes. The criminal justice/mental health milestone in the report is to achieve “100% diversion from arrest, detention, or incarceration when individuals with mental illness intersect with the justice system and can be appropriately redirected.”

This study was conducted to help criminal justice and mental health stakeholders achieve the goals expressed in the ISMICC report and NASMHPD’s 2018 paper. The study was designed to learn about the perceptions of judges regarding the recent increase in the number of forensic patients residing in state psychiatric hospitals that have been court-ordered to receive inpatient competency to stand trial (CST) restoration services. While the perspectives of judges account for just one of the criminal justice stakeholder viewpoints, their pivotal role within the criminal justice system makes their perspectives important.

The results from this study suggest that judges may have a different perspective than other stakeholders regarding who makes the final determination on whether or not a defendant is competent to stand trial and the types of mental health services that their communities need to provide in order to reduce the number of IST defendants being sent to state psychiatric hospitals. It is important to understand how the viewpoints of mental health and criminal justice stakeholder differ on this topic. Recognizing these different perspectives promotes better communication between stakeholders. This, in turn, can help facilitate collaboration between mental health and criminal justice stakeholders in order to address the goals outlined in the ISMICC report and NASMHPD’s 2018 report.

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1 Diversion points refer to points along the sequential intercept model. The idea behind the sequential intercept model is that a defendant with mental health issues can be removed from the criminal justice system at different stages (e.g. arrest, court, jail/prison, probation) and provided with mental health services (Munetz, & Griffin, 2006).
Introduction

In 1960, the Supreme Court ruled in *Dusky v U.S.* that, to stand trial, a defendant needs “sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding” (p. 402). The Supreme Court held that the defendant needs to have "rational as well as factual understanding of the proceedings against him" (p. 402). The judge, defense attorney, or prosecutor may raise the issue of competency if they believe that a defendant is unable to understand the court proceedings. According to the American Bar Association (2016), a party should not raise the issue of competency unless the party has good faith that the defendant is not competent to stand trial. Judges almost always accept a party’s request for a competency to stand trial (CST) evaluation. The location where the CST evaluation is conducted may vary based on state statutes or, in some cases, the judge’s preference. While it used to be rare for CST evaluations to

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13 (LaFortune & Nicholson, 1995).
be conducted on an outpatient basis, it is now common. Most states allow (some even require) outpatient CST evaluations since most defendants do not require the level of mental health care that is provided at state psychiatric hospitals when their competency is being evaluated. Other benefits of outpatient CST evaluations are that they can be conducted in a shorter timeframe and cost less than inpatient evaluations.

No matter where the evaluation takes place, the evaluator must use the information gathered from the interview of the defendant (and from other sources) to formulate an opinion as to whether the defendant is sufficiently able to understand the court proceedings and assist in his/her defense. Dusky v. U.S. never specified that a defendant must have a mental health disorder or mental condition to be found incompetent to stand trial (IST). Under Dusky, a defendant with other impairments (e.g., hearing or communication) could also be found IST.

Every state has adopted the Dusky standard for determining if a defendant is competent to stand trial. Many states have modified the language of their statutes to require that a defendant must have some type of mental health disorder, mental defect, or mental health condition in order to be found IST. While many states, and even the federal system, require a mental health disorder for a finding of incompetency, the U.S. Supreme Court imposes no such requirement constitutionally.

It should be noted that even though many states require a mental disorder for a defendant to be found IST, the presence of a mental health disorder does not, necessarily, mean that

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15 This refers to evaluations conducted outside of the state psychiatric hospital setting. Typically this term includes evaluations conducted within a community or jail setting.
16 (Miller, 2003; Fitch, 2014).
17 (Miller, 2003; Fitch, 2014).
18 This term refers to evaluations conducted within state psychiatric hospitals.
19 (Miller, 2003).
20 These additional sources can include: the defendant’s health records (medical and psychiatric), court reports on the defendant, interview the defendant’s family/friends, interview criminal justice officials that have been in contact with the defendant, and talking with the defendant’s attorney (Mossman et al., 2007).
25 (Mossman et al, 2007).
26 (Mossman et al, 2007).
27 (Mossman et al., 2007; Roesch & Golding, 1978).
28 (Mossman et al, 2007; Roesch & Golding, 1978).
the defendant is, in fact, IST. According to the American Academy of Psychiatry and Law’s (AAPL) guidelines for CST evaluations, if a defendant is diagnosed with a mental health disorder, the evaluator must carefully assess whether, and to what extent, the defendant’s symptoms impair the defendant’s functioning using the competency standard. The AAPL guideline states that, unless the mental health disorder impedes the defendant’s present ability to understand the court process or assist in his/her defense, the disorder should not be linked to an opinion of incompetence. To illustrate, just because a defendant has had a history of experiencing delusions does not mean he/she is currently experiencing them. Even if the defendant is currently experiencing delusions, it does not mean that the delusions are impacting his/her ability to sufficiently understand the court process or assist his/her attorney; if they are not, the disorder should not be linked to a finding of incompetence.

As stated previously, the constitutional standard for CST does not require a mental health disorder for a defendant to be found IST (even though many states’ statutes have imposed this requirement). Other limitations (e.g., hearing impairment or language barrier) may impact a defendant’s ability to understand the court process or assist in his/her defense and can lead to a finding of incompetency. The main difference here, in contrast to cases where a mental health disorder is the cause of the defendant’s impairment, is that these issues can be addressed without mental health treatment (e.g., an interpreter could be appointed).

Once the evaluator’s assessment is completed, the evaluator provides the court with his/her opinion. Very few defendants (approximately 25 to 30 percent) referred for a

29 Wolf v. United States, 430 F. 2d 443 (10th Cir. 1970).
30 United States v. Morrison, 153 F. 3d 34 (2d Cir. 1998).
31 Burket v. Angelone, 208 F. 3d 172 (4th Cir. 2000).
33 (Mossman et al., 2007).
34 (Mossman et al., 2007).
35 (Mossman et al., 2007).
36 (Mossman et al., 2007).
37 (Mossman et al., 2007).
38 (Mossman et al., 2007).
competency evaluation ultimately are found incompetent. After the evaluator’s opinion is presented to the court, the court rules on the case. Based on the American Bar Association 2016 standards, the party that raised the issue of competency must prove that the defendant is incompetent to proceed.

Even though the party that raised the issue ordinarily must prove that the defendant is IST, judges tend to adopt the opinion of the evaluators. Previous research has shown that judges rule in accordance with evaluators over 90 percent of the time, there are very few instances where judges decide not to adopt the evaluator’s opinion. If the defendant is found competent to stand trial, the court can proceed with the defendant’s case. If the court finds the defendant is IST, it typically will order competency restoration services, unless the court finds that the defendant is not likely to be restorable in the foreseeable future. Defendants who are not likely to be restorable in the foreseeable future may be handled differently. Based on the Supreme Court’s ruling in Indiana v. Jackson, a defendant who is unlikely to be restored must be released (from any commitment for purposes of competency restoration) or be civilly

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44 The level of proof needed to establish competency (or incompetency) is by a preponderance of the evidence. (American Bar Association, 2016).


46 (Gowensmith, Murrie, & Boccaccini, 2012; Robinson & Acklin, 2010; Zapf, Hubbard, Cooper, Wheeles, & Ronan, 2004).


48 (American Bar Association, 2016; Fitch, 2014; Mossman et al., 2007; Miller, 2003; Pinals, 2005).

In order to be civilly committed, an individual must go through a civil commitment proceeding and (in most states) be found to have a mental health disorder and to be a danger to himself/herself or others.\footnote{In order to be civilly committed, an individual must go through a civil commitment proceeding and (in most states) be found to have a mental health disorder (Fitch, 2014; Nobles & Randall, 2016).} \footnote{Nobles, J. & Randall, J. (2016). \textit{Evaluation report: Mental health services in county jails}. St. Paul, MN: Office of Legislative Auditor. Retrieved from: \url{http://www.auditor.leg.state.mn.us/ped/pedrep/mhjails.pdf}} \footnote{Testa, M., & West, S. G. (2010). Civil commitment in the Unites States. \textit{Psychiatry}, 7(10), 30-40.}

According to the American Bar Association 2016 standards, defendants found IST who are likely to be restored should be ordered to undergo competency restoration services.\footnote{American Bar Association, 2016.} \footnote{Two types of competency restoration services are provided on an outpatient basis: Outpatient competency restoration programs and jail-based competency restoration programs. Outpatient competency restoration programs are provided within a community setting while jail-based competency restoration programs are provided within a jail/custodial setting.} \footnote{(American Bar Association, 2016).} \footnote{GAINS Center. (2007) \textit{Quick fixes for Effectively Dealing with Persons Found IST:} (Mossman et al., 2007; Pinals, 2005).} \footnote{(Fitch, 2014; GAINS Center, 2007; Mossman et al., 2007; Pinals, 2005; Wik, Hollen, & Fisher, 2017).} When possible, these services should be provided on an outpatient basis\footnote{In this paper “outpatient competency restoration” refers to competency restoration services that are provided within the community (in contrast to within a state psychiatric hospital or jail setting).} \footnote{(Gowensmith, Frost, Speelman, & Therson, 2016).} The American Bar Association discourages the involuntary hospitalization of defendants unless there is clear and convincing evidence suggesting that services in less restrictive settings are not available and that hospitalization is the only way to provide these defendants with the level of services they require.\footnote{Defendants found IST who are likely to be restored usually receive court orders for inpatient competency restoration services.} This approach has not changed much over the years.\footnote{Despite the fact that many states allow for outpatient CST restoration services, very few states have formally implemented programs to provide these services. Forty-four states allow for outpatient competency restoration, but only 16 have formal programs that are operational. Even when they are available within a state, outpatient competency restoration programs are not standardized. Each program has its own admission criteria (e.g., some may only accept non-violent misdemeanants), which limits the number of

\textit{\footnote{Commitment, August 2018} 10

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defendants who are eligible to participate. The types of services provided can vary between programs. Another avenue for competency restoration is through jail-based competency restoration programs, but these programs are uncommon.

In the end, most defendants who are found IST are court-ordered to receive inpatient competency restoration services at a state psychiatric hospital. Defendants receiving inpatient CST evaluations and defendants receiving inpatient CST restoration services account for just two of the many types of patients who belong to the “forensic population” within state psychiatric hospitals. State reports and data describing national trends suggest that there has been a recent increase in many states in the number of defendants residing at state psychiatric hospitals for CST services.

Background

Over the past 20 years, the over-representation of individuals with mental health disorders involved with the criminal justice system has come to national attention. Research has shown that the prevalence of arrest among persons with mental illness is

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69 (Fitch, 2014).
70 Patients who are typically committed to the state psychiatric hospitals by the criminal courts.
71 (Fisher, Geller, & Pandiani, 2009; Fitch, 2014; Parks, & Radke, 2014).
72 This term refers to both CST evaluations and CST restoration services.
high, and many are at risk of being arrested repeatedly, entering a revolving door of criminal justice involvement.\textsuperscript{76}

For instance, a study published in 2006 found that, out of the 13,816 adults receiving treatment services from Massachusetts’s Department of Mental Health between 1991 and 2000, just slightly less than 30 percent (3,856) had been arrested. Of those, less than two percent accounted for approximately 20 percent of the group’s arrests.\textsuperscript{77} The study also found that relatively few of the individuals (13.6 percent or 1,874 individuals) had been arrested for a violent crime.\textsuperscript{78} This study and others suggest that a higher proportion of offenses conducted by individuals with mental health disorders are petty crimes.\textsuperscript{79,80,81,82} Many jurisdictions have established programs to divert individuals to mental health treatment services.

Diversion programs can help divert individuals with mental health disorders at different points within the criminal justice system. Such programs may have different goals, depending on an individual’s current involvement with the criminal justice system. According to the sequential intercept model, individuals with mental illness can be diverted from further involvement with the criminal justice system at six different points.\textsuperscript{83,84} These points include: Prior to criminal justice involvement (e.g., crisis centers, programs for treating homelessness with mental health disorders), prior to arrest (e.g., Crisis Intervention Training for police officers), after arrest (e.g., mental health liaisons, treatment as an alternative to prosecution or incarceration), jails and courts (e.g., therapeutic courts, outpatient or jail-based CST restoration programs), re-entry (e.g., forensic transitional programs), and probation/parole (e.g., specialized probation/parole

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{77} (Fisher, Roy-Bujnowski, Grudzinskas Jr, Clayfield, f 2006).
\item \textsuperscript{78} (Fisher, Roy-Bujnowski, Grudzinskas Jr, Clayfield, Banks, & Wolff, 2006).
\item \textsuperscript{81} Theriot, M. T. & Segal, S. P. (2005). Involvement with the criminal justice system among new clients at outpatient mental health agencies. \textit{Psychiatric Services}, 56(2), 179-185.
\item \textsuperscript{82} (Fisher, Roy-Bujnowski, Grudzinskas Jr, Clayfield, Banks, & Wolff, 2006).
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caseloads, mental health training for parole and probation officers).\textsuperscript{85} Many states and counties do not have enough diversion programs to meet their current needs.\textsuperscript{86,87}

Additional, or more effective, diversion programs are needed to divert forensic patients\textsuperscript{88} from state psychiatric hospitals.\textsuperscript{89} Despite an overall decline in the nation’s crime rate, many states have seen an increase in the number of forensic patients residing in their state psychiatric hospitals.\textsuperscript{90} Specifically, many (but not all) states are seeing a rise in the number of forensic patients who have been evaluated and found IST.\textsuperscript{91} This increase has led to growth in the number of forensic patients requiring a state hospital bed at a time when public inpatient capacity, generally, has been reduced (with most civil admissions going to private hospitals in many states and the bulk of services, generally, being provided in the community).\textsuperscript{92,93}

Consequently, defendants found IST may experience delays in admission to state psychiatric hospitals. Defendants in some states remain on waitlists for long periods of time. Recently, lawsuits have been filed against states because of these protracted waiting periods.\textsuperscript{94} This has led many states to seek or implement strategies to reduce the number of forensic patients, specifically those found IST, on their waitlists. To respond to this issue, many states have developed diversion programs (e.g., creating additional outpatient forensic services), building additional beds, and hiring additional staff members.\textsuperscript{95} Nevertheless, many of these states continue to experience pressure on admissions, despite these efforts.\textsuperscript{96}

\textsuperscript{85} (Munetz, & Griffin, 2006; Policy Research Associates, 2017).
\textsuperscript{87} (Munetz, & Griffin, 2006; Policy Research Associates, 2017).
\textsuperscript{88} In this paper, the term “forensic patient” will be used to reference defendants who have been court ordered to receive evaluation or treatment services.
\textsuperscript{89} (Pinals et al., 2018; Wik, Hollen, & Fisher, 2018).
\textsuperscript{91} (Wik, Hollen, & Fisher, 2018).
\textsuperscript{95} (Fitch, 2014; Wik, Hollen, & Fisher, 2017)
\textsuperscript{96} (Fitch, 2014; Wik, Hollen, & Fisher, 2017).
This leads to the question: *Why are so many states continuing to see a rise in the number of forensic patients in their state psychiatric hospitals, especially among those found IST?*

Hypotheses as to why this is occurring are numerous. The issue is made more complex by the fact that it involves a variety of different stakeholders, each with a different vantage point, who have their own personal theories as to what explains this increase. Gaining a view of these perspectives was the purpose of the present study. To get at these varied perspectives, we decided to break this question down into smaller parts.

For the initial examination, we sought to get the perspective of a key criminal justice stakeholder by selecting judges who order CST services. To the authors’ knowledge, very few studies have examined the factors that influence whether or not a judge decides to send a defendant for CST services. Those studies that have been conducted are from the late 1900s and early 2000s.\(^97,98,99\) National data collected in 1999, 2002, 2004, 2005, 2006, 2009, and 2011 shows that the number of IST defendants receiving restoration services at state psychiatric hospitals increased over this time period. Data from 2014 and 2016 suggest that this upward trend persists.\(^100\) The continued rise in the number of IST defendants receiving restoration services at state psychiatric hospitals implies that a re-examination of this question is needed.

**Methodology**

The study was designed to examine why there has been an increase in the number of defendants being referred to state psychiatric hospitals for CST services from the viewpoint of the judges who make the final rulings in all cases.\(^101,102\) This role makes them ideal candidates to query regarding what dynamics they believe are causing the influx in the number of forensic patients, specifically those found IST. To assess what factors are currently influencing the decision-making process of judges the following questions were investigated within this study:

1. What factors influence a judge’s decision to send an individual for a competency evaluation or competency restoration services?
2. What factors influence whether or not judges send these individuals to an inpatient or outpatient facility for their competency evaluation or competency restoration services?

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\(^{100}\) (Wik, Hollen, & Fisher, 2017).

\(^{101}\) 5 U.S. Code § 557.

\(^{102}\) 29 CFR 2200.67.
3. What factors, in addition to the evaluator’s report, influence a judge’s decision to deem a patient competent versus IST?

4. To what degree are judges aware of the array of services, besides the services provided at state psychiatric hospitals, available to defendants in their jurisdictions?

5. To what extent do judges interact with officials from local or state mental health authorities to discuss or learn about the availability of mental health services in their jurisdiction?

6. Do judges believe they are referring larger numbers of defendants for trial competency evaluations or restoration services, and, if so, what factors do they believe are affecting the increase?

The first step taken in this project was an examination of data collected for NRI’s 2017 report on forensic patients in state psychiatric hospitals to determine what states should be selected for the study. After examining state trends for IST populations within their state psychiatric hospitals between 1999 and 2014, six states were selected for the study. These six states were selected because, based on the data, three had experienced a large increase in the number of defendants hospitalized as IST and three states had only minimal increases over the observation period. The forensic directors of the state mental health agencies for each of the six states were asked to refer the researchers to the counties within their state that had the largest number of IST defendants in 2017. From there, NRI generated a list of judges presiding in those counties.

The researchers decided to collect the data for this study via telephone interviews with the judges. Several barriers arose that limited the possibility of using electronic or paper-and-pencil surveys methods for data collection. The non-response rates for electronic surveys and paper-and-pencil surveys can be high. Another issue was that not all of the judges presiding in a state/county had accessible email addresses, eliminating electronic surveys as a viable option. While the researchers could have used paper-and-pencil surveys, this type of survey method would have been costly to distribute. A compounding factor that had to be accounted for was that not all judges handle competency-to-stand-trial cases. It would have been difficult to determine which judges should have been sent the surveys and whether a non-response was a result of the judge not wanting to participate or because the judge did not have experience handling these cases.

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104 Note: The study used data on IST patients because the data that was collected on defendants present within the state psychiatric hospital for pre-trial evaluations could not be segregated into types of evaluation (e.g. CST versus sanity evaluations). Nonetheless, the study will still ask judges about what factors influence their decision to refer a defendant for CST evaluations.
106 (Singleton, & Straits, 2010).
cases. The use of phone interviews helped mitigate the non-response issue and an open-ended interview approach allowed the researchers to gain a more detailed, nuanced understanding of the judges’ viewpoints.\textsuperscript{107}

Using the list of judges presiding in each of the counties referred to NRI by the Forensic Directors, NRI contacted all judges on the list (via email or phone) to determine if they would participate. Originally, a total of 12 judges (two from each state) were to be interviewed. One of the states, due to time constraints, was unable to provide NRI with a list of judges who could be contacted. As a result, NRI oversampled one of the other states exhibiting a similar trend that responded to the survey. A total of 13 judges from 10 counties in five states participated in the study.

**Results**

**Demographics**

A majority (seven of the 13) of the judges were male. Nine judges were in a position in their court system that increased their awareness to mental health issues. Out of these nine judges, a majority (six judges) were on a mental health court or had served on a mental health court (or other specialty court) in the past. Four of the nine judges were involved in some type of mental health committee or mental health board within their county. Regardless of the type of court on which a given judge presided (i.e., mental health court or traditional), in order to participate in the study judges were required to have had experience handling criminal cases in which the issue of a defendant’s competency might be raised.

**Competency Evaluations**

The judges identified the defense counsel as the group most frequently responsible for raising the issue of competency (11 of the 13). Not surprisingly, the judges reported that they never denied a request for a competency evaluation.\textsuperscript{108} Almost all of the judges (12 of the 13) reported that they had come across rare instances where other factors influenced their decision to order a CST evaluation. In these instances, it was typically the defendant’s behavior in court that led to the order. Six of the 12 judges ordered evaluations if a defendant was acting in a way that suggested that he/she might not be in a state of mind that would allow him/her to proceed.

Information presented to a judge by a criminal justice official (e.g., bailiff or individual working at a county jail) was also a factor that influenced a judge’s decision to order a CST. Two of the 12 judges indicated that information presented to them by a criminal justice official had impacted their decisions in this area. Their reasoning was that these individuals had more time to observe the defendant’s behaviors and interactions while the defendant awaits a hearing or meeting with his/her defense counsel.

\textsuperscript{107} (Singleton, & Straits, 2010).
\textsuperscript{108} (LaFortune, & Nicholson, 1995; Roesch, & Golding, 1978).
Competency Restoration

Judges unanimously agreed that the most important component of the CST report is the evaluator’s opinion regarding whether or not the defendant is competent to stand trial. This finding concurs with those from previous research studies. Seven of the thirteen judges reported feeling, however, that other components of the evaluator’s report were helpful in guiding their decision making process. These components included: information on previous hospitalizations (3 of the 7), mental health history (3 of the 7), information on the evaluation (e.g., how long it took, what sources were referenced) itself (3 of the 7), and information on the context of the offense (2 of the 7). These judges indicated that the additional pieces of information listed above could be helpful when determining whether or not the defendant required competency restoration services, as well as, if found incompetent, where the defendant should be placed (i.e., in an inpatient or outpatient setting).

Each judge reported instances when one of the parties, in conjunction with the judge or alone, questioned an evaluator’s opinion (12 of the 13). These instances were uncommon, but when they did occur they typically resulted in the judges ordering a second evaluation (rather than using the information provided by the evaluator to make a decision on the question of CST). In regards to another party questioning the evaluator’s opinion, 3 of the 12 judges indicated they normally granted the party’s request for a second evaluation. The other eight judges reported no instances when they denied a request for a second evaluation.

A few judges (4 of the 12) recalled ordering a second evaluation based on their own concerns about the defendant, although they indicated that these instances were extremely rare. The reason that these judges ordered these second opinions typically had to do with how the defendant was behaving in the court room. For instance, if the first evaluator’s opinion suggested that the defendant was competent to stand trial but the defendant was still displaying mental health symptoms and was having apparent difficulty understanding the court proceeding, a second evaluation might be ordered out of concern that the defendant’s condition may have deteriorated since the initial evaluation was completed. Again, instances when a judge, or even another party, questioned the first evaluator’s opinion were rare. Judges, themselves, rarely question the evaluator’s opinion, since they feel they lack the experience and training needed to accurately assess a defendant’s competency. Three of the judges directly stated that this is why they rarely questioned the evaluator’s opinion or ruled contrary to it.

Awareness of Mental Health Services

Most of the judges (10 of the 13) felt there had been an increase in the number of defendants requiring CST services. Half of these judges (5 of the 10) believed that this was a result of population increases. Another four judges felt that a rise in awareness about mental health issues in the criminal justice system may have been responsible for the increase or, at least, responsible for a heightened awareness that a defendant’s mental health disorder may prevent him/her from being competent to stand trial.

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109 (Roesch, & Golding, 1978; Zapf, Hubbard, Cooper, Wheeles, & Ronan, 2004).
Judges reported learning about mental health services available in their communities through a variety of different contexts. Many of the judges (10 of the 13) reported that they learned about the mental health services in their community through their courtroom experiences. More than half (9 of the 13) reported learning about the services available in their community from mental health professionals. Finally, seven judges reported having court staff with experience in the mental health field from whom they learned of services.

Eight judges reported keeping in contact with mental health professionals outside of the courtroom setting. Half (4 of the 8) of the judges said that, while they kept in touch with mental health professionals, their communication with these individuals was infrequent. The other four judges reported speaking to mental health professionals on a weekly basis; however, three of these judges were mental health court judges.

All of the judges (13 of the 13) reported having mental health services available in their communities. Despite these programs being available, few of the judges (2 of the 13) reported having programs in their communities that provided mental health services specifically for defendants found IST. Only two reported currently having operational outpatient competency restoration programs available within their county (or a neighboring county) for defendants found IST. The reason that this number was so small may be due to the fact that most competency restoration programs are still provided at the inpatient level.

None of the judges mentioned having programs available in their communities that could be used to divert defendants from the criminal justice system prior to them becoming involved (e.g., when in a state of crisis). This does not mean that these types of diversion programs are not currently present. Regardless of their presence or absence, all of the judges expressed a need for more mental health services in their community (for defendants who were incompetent and for other defendants with general mental health disorders). When asked about the services available in their community for defendants found IST, 6 out of the 13 judges expressed the need for additional mental health programs/services to help prevent defendants from becoming re-involved with the criminal justice system. Specifically, they expressed a need for more residential treatment programs (4 of the 6), programs that could accept patients who did not have insurance (3 of the 6) programs that specialized in defendants with co-occurring mental health and substance use disorders (2 of the 6), housing arrangements (2 of the 6), and inpatient facilities (1 of the 6) that are separate entities from the state psychiatric hospitals.

**Discussion**

Regarding the information collected from the judges, the results from this study were similar to that of other studies that have been conducted.

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110 (GAINS Center, 2007; Mossman et al., 2007; Pinals, 2005).

111 Note: In many states only state facilities can be used for inpatient CST restoration services.
CST Decision

The judges who participated in this study, like those from other studies, typically adopted the view of the evaluator.\(^\text{112}\) Previous studies have indicated that judges may feel they are unable to determine if the defendant is competent to stand trial because they do not have the expertise or education required to reach that conclusion.\(^\text{113}\) In this study, 3 out of the 13 judges stated they did not feel they had the expertise required to question the evaluator’s opinion.\(^\text{114}\)

Questioning Evaluator’s Opinion

In the rare instance that a judge—or more commonly, one of the parties to the case—questioned the evaluator’s opinion, the judge would typically order a second CST evaluation. The judges recalled that the evaluator’s opinion was typically questioned if the evaluator opined that the defendant was competent to stand trial but the defendant was behaving in a way that made it seem like he/she was not.

Mental Health Services

The rise in the number of defendants receiving inpatient competency restoration services does not appear to be a burden felt only by state psychiatric hospitals\(^\text{115}\) Many of the judges (10 of the 13) felt they were experiencing a rise in the number of defendants that they were referring for CST-related services. The judges believed that a variety of factors were causing this rise, including increases within their county’s population size, as well as increased awareness of mental health disorders in society and, in particular, in the criminal justice system. Unlike previous research studies, very few judges associated this increase with attorneys using CST evaluations as a way to get additional information that could help them obtain a favored adjudication outcome.\(^\text{116,117,118}\)

All of the judges reported that their communities lacked adequate resources for defendants found IST. Even though outpatient competency restoration services were available in some of the communities (or neighboring communities) that these judges presided in, only two judges reported having operational outpatient competency restoration programs in their community. This is not surprising since very few states have

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\(^{112}\) (Gowensmith, Murrie, & Boccaccini, M. T. (2012; Robinson & Acklin, 2010; Roesch & Golding, 1978; Zapf, Hubbard, Cooper, Wheeles, & Ronan, 2004).

\(^{113}\) (Roesch & Golding, 1978; Zapf, Hubbard, Cooper, Wheeles, & Ronan, 2004).

\(^{114}\) (Roesch & Golding, 1978; Zapf, Hubbard, Cooper, Wheeles, & Ronan, 2004).

\(^{115}\) (Fitch, 2014; Wik, Hollen, & Fisher, 2017)


\(^{118}\) (American Bar Association, 2016).
operational outpatient competency restoration programs. Furthermore, outpatient competency restoration programs have specific admission criteria, with the criteria varying between programs. This means that, even within the communities where outpatient CST programs are available, not all IST defendants can be admitted to them. For instance, many outpatient programs require that the defendant be non-dangerous or exclude defendants with certain charges (e.g., felonies). As a result, most defendants continue to be referred to the inpatient competency restoration programs provided at the state psychiatric hospitals.

The judges who participated in the study also felt that their communities were lacking in other services that could be used to divert defendants, including those found IST, from both the criminal justice system and state psychiatric hospitals. Six of these judges identified programs that they felt their communities needed for IST defendants, as well as defendants with mental health issues in general. They expressed a need for residential treatment programs (4 of the 6), programs that could accept patients who did not have insurance (3 of the 6) programs that specialized in defendants with co-occurring (mental health and substance use) disorders (2 of the 6), housing arrangements (2 of the 6), and inpatient facilities (1 of the 6) that are separate entities from the state psychiatric hospital. Despite expressing a need for more community-based mental health services, the judges did not report that they saw utilizing court orders for CST services as a method for linking defendants to mental health services. This result was contrary to findings from previous research studies which suggested that courts might order CST services to link defendants with mental health treatment.

Divergence in Perspectives

The viewpoints of the judges may not be the same as those of other criminal justice or mental health stakeholders. This difference can be illustrated by comparing the viewpoints of the judges from our study with those of the forensic mental health experts that developed the American Academy of Psychiatry and Law’s (AAPL’s) 2007 practice guideline for CST evaluations.

One example of this difference is that the judges who were interviewed indicated they typically adopted the opinion of evaluators in regards to whether or not a defendant was competent to stand trial. Yet, according to the AAPL guidelines forensic mental health experts are discouraged (unless required by a state statute) from providing an ultimate issue opinion (i.e., competent or incompetent). Per the AAPL guidelines, the information that the evaluator gives the judge should be used by the judge to determine

122 (GAINS Center, 2007 Mossman et al., 2007; Pinals, 2005)
123 (Applebaum, & Fisher, 1997; Mossman et al., 2007; Owens, Rosner, & Harmon, 1987).
124 (Mossman, et al., 2007).
125 (Glancy, et al., 2015; Mossman et al., 2007).
whether or not the defendant’s level of impairment is critical enough to prevent him/her from being able to understand the court proceedings or assist in his/her defense. This determination serves as a measure of the “fairness” of proceeding with the evaluation, given the defendant’s ability to participate, a question the AAPL guidelines believe must be left to the judge.126 The AAPL guidelines state that forensic mental health experts do not have the expertise required to make this decision, as there are no guidelines in place to help them determine what fairness requires in a particular case.127 The evaluator’s opinion speaks only to the level of the defendant’s impairment (with respect to the competency criteria), not whether, given all of the factors that must be considered (e.g., the seriousness of the charges), that level is so great as to require a finding of incompetency. From both a mental health and a legal perspective, it is the judge who is responsible for making a final decision on the defendant’s CST.128,129,130

Another illustration of the differing perspectives is that judges and forensic mental health experts sometimes disagree about how a defendant’s mental health disorders impacts his/her CST. The judges who participated in this study stated that there were instances where they or another party (typically the defense counsel) questioned an evaluator’s opinion. Typically this occurred when the evaluator’s opinion suggested that the defendant was competent to stand trial but the defendant was still displaying mental health symptoms or behaving in a manner that suggested that he/she may no longer be competent to stand trial. From the mental health perspective, this disagreement should not invalidate the evaluator’s opinion (i.e., should not, by itself, require an additional evaluation); a defendant can meet the legal standard for competency while still displaying mental health symptoms.131 The AAPL guidelines recommend that evaluators assess which symptoms (if any) are impacting the defendant’s cognitive capabilities and to what degree. Using this information, evaluators may specify in their reports whether they believe the defendant’s symptoms are impeding his/her ability to understand the court proceedings and assist his/her defense counsel.132

The views expressed by a majority of the judges in this study, along with the views of forensic mental health experts captured in other studies, suggest that both groups believe there has been an increase in the number of defendants found IST. When it comes to the services that these defendants require, however, their viewpoints diverge. Some of the judges reported feeling that their communities needed residential treatment programs, housing programs, and other community support services to which defendants found incompetent might be diverted.

From a purely forensic mental health perspective these programs are irrelevant to the psycho-legal question at hand: Is the defendant competent to stand trial and, if not, what should be done to restore the defendant to competency to allow the case to proceed?

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126 (Mossman et al., 2007).  
127 (Mossman et al., 2007).  
128 5 U.S. Code § 557.  
129 29 CFR 2200.67.  
130 (American Bar Association, 2016; Fitch, 2014; Mossman et al., 2007).  
131 (Mossman et al., 2007; Pinals, 2005).  
132 (Glancy, et al., 2015; Mossman et al., 2007).
Studies have suggested that courts sometimes order CST evaluations to link defendants with mental health treatment, whether or not related to competency concerns, even though the AAPL 2007 guidelines and the American Bar Association 2016 guidelines agree that CST services should not be used to link defendants with treatment. While the judges may not be intentionally trying to link defendants to non-competency related mental health services, forensic mental health experts may view their responses differently. The AAPL2007 guidelines, as well as the American Bar Association 2016 guidelines, state that to help an incompetent defendant regain his/her competency, restoration services should be provided in the least restrictive setting available, and only until the defendant’s competency is restored. With that said, this does not mean that residential treatment programs, housing programs, and programs designed to treat certain groups of defendants are not important. These programs (ideally) could help reduce the number of defendants found IST in the first place, especially those charged with petty crimes.

Implications

One of the goals of NASMHPD’s 2018 paper BREAKING THROUGH: Seven Bold Goals for Better Mental Illness Outcomes, is to achieve “100 percent diversion from arrest, detention, or incarceration when individuals with mental illness intersect with the justice system and can be appropriately redirected.” This goal is akin to the over-arching criminal justice/mental health goal expressed in SAMHSA’s 2017 Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) report of diverting patients with serious mental illness from the criminal justice system. State representatives and policy-makers should take several steps in order to help their states, and the counties within them, achieve these goals.

In regards to defendants found IST, it may be beneficial if more outpatient competency restoration programs were developed. As noted above, the American Bar Association 2016 standards indicate that defendants should be ordered to receive care in the least restrictive setting possible. Defendants should not be involuntarily hospitalized unless there is clear evidence that inpatient competency restoration services are the only ones available that meet the restoration needs of these defendants. Only 2 of the 13 judges in our survey reported currently having a formal outpatient competency restoration program in their community. As stated previously, many states allow for the development of

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133 (Applebaum & Fisher, 2007; Mossman et al., 2007; Owens, Rosner & Harmon, 1987).
134 (American Bar Association, 2016; Mossman et al., 2007).
136 (Constantine, et al., 2010; Fither et al, 2002; Theriot & Segal, 2005).
139 (Pinals, 2005).
States that have statutes allowing for the development of outpatient competency restoration programs should examine whether developing these programs would be effective for their communities, considering the volume of cases and the resources available in their counties. States should also look into developing jail-based competency restoration programs. While not always ideal, jail–based competency restoration programs would allow for defendants who do not require hospital level care to be restored without wasting the state’s inpatient resources. The development of outpatient and jail-based competency restoration programs aligns with one of the ISMICC report goals.

Another potential step that should be taken is the standardization of outpatient competency restoration programs. Outpatient competency restoration programs, like inpatient programs, are designed to provide treatment and educational services to help defendants regain their competency. Location aside, competency restoration services are not standardized. To illustrate, some outpatient company restoration programs (but not all) provide housing services to defendants. Judges and forensic mental health experts should work together to develop best practice guidelines for inpatient and outpatient competency restoration programs. Developing these guidelines would also allow states to accomplish SAMHSA’s 2017 ISMICC goal of: “Establish[ing] and incentivize[ing] best practices for competency restoration that use community based evaluation and services”.

Other measures can be taken to help prevent both defendants who are found to be IST and defendants whose competency is not questioned but who have mental health disorders from becoming involved in the criminal justice system in the first place. For instance, state legislatures and policy-makers should consider funding and developing more pre-arrest diversion programs (e.g., crisis centers, treatment programs for the homeless, assisted-outpatient treatment, or Crisis Intervention Team (CIT) Training for police officers). As several of the participating judges suggested, developing housing programs and residential treatment centers could be beneficial.

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140 (Gowensmith, Frost, Speelman, & Therson, 2016).
142 (Fitch, 2014; Gowensmith, Frost, Speelman, & Therson, 2016; Gowensmith, Murrie, Packer, 2014).
143 ISMICC recommendation 4.1: Support interventions to correspond to all strategies of justice involvement.
144 (Substance Abuse and Mental Health Services Administration, 2017).
145 (Gowensmith, Frost, Speelman, & Therson, 2016; Gowensmith, Murrie, Packer, 2014; Pinals, 2005).
146 (Gowensmith, Frost, Speelman, & Therson, 2016; Gowensmith, Murrie, Packer, 2014; Pinals, 2005).
147 (Gowensmith, Frost, Speelman, & Therson, 2016).
148 (Substance Abuse and Mental Health Services Administration, 2017, p. 7).
The development of these types of programs to help divert individuals with mental health disorders from being arrested aligns with two of SAMHSA’s ISMICC report goals.\textsuperscript{151,152} To meet some of the ISMICC goals, state representatives and policy-makers should also consider having their courts hire mental health system liaisons. Research, as well as responses from some of the judges who participated in this study, suggest that mental health liaisons can facilitate communication between the judicial system and the mental health system, which in turn can help the judicial system learn about what service options are available for defendants, and whether to address concerns about a defendant’s CST or offer alternatives to incarceration.\textsuperscript{153}

Limitations

The results of this study may be influenced by both selection and response bias. Six forensic directors were asked to refer the researchers to the counties within their state that had the largest number of IST defendants in 2017. Some of the forensic directors provided the researchers with a list of judges who they believed would be interested in participating in the study or could provide assistance in locating other judges within the county who handle IST cases. Therefore, the judges who were referred to us by the forensic directors may have been ones who are known for their involvement in working with behavioral health agents and behavioral health care organizations. This increased the possibility that selection bias was present within the study. It may have also played a role in why the judges who were interviewed had different levels of involvement in CST cases.

While the researchers were occasionally provided with a list of potential judges to contact, the main method used to locate potential participants involved searching each county’s court website. In general, the judges who responded to the request to participate may have done so because of their increased knowledge about, interest in, or awareness regarding mental health issues.

As the demographic section illustrates, many of the judges who participated in the study were in positions, or had been in positions, that increased their awareness of mental health issues. A majority of the judges were part of mental health committees/workgroups/boards within their county or had experience on mental health courts. While this information could be seen as a limitation of the study, it may also be a benefit. These judges may have had experiences that increased their eagerness to participate in the study, but this may mean that they also are more willing to learn about the programs available in their communities. In order to learn about the programs the judges feel should be available in the communities, talking to judges who are passionate about mental health issues and knowledgeable about the mental health programs in their

\textsuperscript{151} ISMICC recommendation 4.1: Support interventions to correspond to all strategies of justice involvement
ISMICC recommendation 4.2: Develop an integrated crisis response system to divert people with SMI and SED from the justice system
\textsuperscript{152} (Substance Abuse and Mental Health Services Administration, 2017).
\textsuperscript{153} (Munetz, & Griffin, 2006; Pinals, 2005).
communities is vital. Regardless, this limitation should still be considered when analyzing the results of this study since it is possible that judges who have had less experience handling mental health cases may have different views and experiences regarding the availability or accessibility of mental health services in their county, which may influence how they handle their CST cases.

Another limitation of the study is that only 13 judges from 10 counties in five states were interviewed. States, and the counties within them, vary in terms of population size, funding for behavioral health services, and the availability and accessibility of their mental health resources. Caution should be used when generalizing the results from this study to other counties. Our study examined the views and practices of only a handful of judges. Nonetheless, we feel the information gained from these interviews is significant, and that it could pave the way for future research in this area. The counties that were selected for this study had different resources (e.g., funding, mental health service availability, substance use programs, or diversion programs), yet the judges who were interviewed expressed many of the same concerns and that they were experiencing similar issues. These commonalities imply that these issues are widespread. It is unlikely that these views are exclusive to the responding judges’ counties that were selected for this study.

While the commonalities among the responses of the judges may suggest that other judges feel the same way, the perspectives of the judges who were interviewed in this study cannot be generalized to other criminal justice stakeholders. Multiple factors (including state/county specific factors) may be working together to perpetuate the rise in the number of IST patients residing at state psychiatric hospitals. Other criminal justice stakeholders may have different views based on their job experiences. A larger study should be undertaken in the future to review the perspectives of other stakeholders (e.g., those who provide services or those who administer services systems).

Future studies should also consider interviewing mental health experts. The AAPL 2007 guidelines for CST evaluations were referenced in this paper to illustrate how the viewpoints of the judges in this survey may be different from those of other stakeholders. While helpful, the guidelines were written for CST evaluations, and, therefore, do not fully capture the perspectives of forensic mental health experts. In addition, forensic mental health experts have a different role than traditional mental health providers.154 Their interaction with the court system prevents them from having a therapeutic relationship with the defendants.155 As a result, the mental health professionals who provide treatment or restoration services to defendants found to be IST have a different perspective on the issue.

Lastly, the main purpose of this study was to conduct a preliminary examination into what factors judges believe are causing the rise in the number of defendants being served in state psychiatric hospitals for CST services. While speaking with judges a second issue emerged: Concerns about insufficient community mental health services. While these issues can be related, they are not one in the same; competency restoration programs may

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154 (Glancy, et al., 2015; Mossman et al., 2007; Pinals, 2005).
155 (Glancy, et al., 2015; Mossman et al., 2007; Pinals, 2005).
not need to include comprehensive mental health services. While some outpatient competency restoration programs provide additional services, the main goal of competency restoration programs is to treat the defendant’s symptoms and help him/her regain competency.\textsuperscript{156}

The development of additional community mental health services/programs, like the ones suggested by the judges in this study, could help prevent people who would have been found incompetent from entering the criminal justice system. However, their main goal would be to prevent criminal justice involvement of individuals with mental health disorders (in general). In order to effectively divert individuals with mental health disorders from the criminal justice system, community mental health programs should work together, as well as with other stakeholders, not only to treat their underlying mental health disorders, but also to address the criminogenic risk factors (e.g. poverty, homelessness, unemployment) that increase the likelihood that these individuals will become involved with the criminal justice system. Studies have shown that very few individuals commit crimes because of their mental health disorders.\textsuperscript{157,158} It is the interaction between the criminogenic risk factors and mental health disorders that increase an individual’s likelihood to become involved with the criminal justice system.\textsuperscript{159}

The issue of there potentially being an insufficient number of community mental health services is outside of the scope of this paper. Future studies should examine whether or not other stakeholders feel the same way about these services.

\section*{Conclusion}

The issues discussed in this paper have broad implications for multiple systems--criminal courts, corrections, and mental health and substance abuse services--for individuals with behavioral health disorders who come into contact with the criminal justice system, and, ultimately, for taxpayers. The information gleaned from this study could be used to help determine what factors influence a judge’s decision-making process in cases where a defendant’s CST is raised. This can help mental health experts, state administrators, and policy makers identify the factors that judges perceive to be important when ruling on the matter.

\textsuperscript{156} (Fitch, 2014; Gowensmith, Frost, Speelman, & Therson, 2016; Gowensmith, Murrie, & Packer, 2014; Noffsinger, 2001; Mossman et al., 2007; Pinals, 2005; Wik, Hollen, & Fisher, 2017; Zapf, 2013).
\textsuperscript{159} (Fisher, Silver, & Wolff 2006; Skeem, Winter, Kennealy, P. J., Louden, & Tatar II, 2013).
This study also allows the audience to see how judges view the mental health system and gain their perspective on how accessible they perceive community mental health services to be to defendants found IST and others. Forensic mental health experts, judges, state administrators, and policy makers could use this information to work together in determining what services are really needed within the community to divert defendants with mental health disorders from the criminal justice system and to reduce the number of IST defendants being court ordered to state psychiatric hospitals for CST restoration services. This type of collaboration could help forensic mental health experts, judges, state administrators, and policy makers meet several of the goals expressed in the 2017 ISMICC report,\textsuperscript{160} as well as help meet NASMHPD’s 100 percent diversion goal.\textsuperscript{161}

In the end, the major take-away from this study is that different stakeholders may have different perspectives on how CST services should be provided. In order to develop effective policies for CST services, other stakeholders’ perspectives should be surveyed.

\textsuperscript{160} ISMICC recommendation 4.1: Support interventions to correspond to all strategies of justice involvement
ISMICC recommendation 4.2: Develop an integrated crisis response system to divert people with SMI and SED from the justice system
ISMICC recommendation 4.4: Establish and incentivize best practices for competency restoration that use community based evaluation and services;
ISMICC recommendation 4.5: Develop and sustain therapeutic justice dockets in Federal, state and local courts for any person with SMI or SED who becomes involved in the justice system

\textsuperscript{161} (Substance Abuse and Mental Health Services Administration, 2017).