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ORIGINAL RESEARCH

A survey of national trends in psychiatric patients found incompetent to stand trial: reasons for the reinstitutionalization of people with serious mental illness in the United States

Katherine Warburton[1,2]*, *Barbara E. McDermott*[2], *Anthony Gale and Stephen M. Stahl*[1,3,4]

[1] California Department of State Hospitals, Sacramento, California, USA
[2] University of California Davis, Davis, California, USA
[3] University of California, San Diego, California, USA
[4] University of Cambridge, Cambridge, United Kingdom

Objective. Recent information indicates that the number of forensic patients in state hospitals has been increasing, largely driven by an increase in patients referred to state hospitals as incompetent to stand trial (IST). This survey was intended to broaden the understanding of IST population trends on a national level.

Methods. The authors developed a 30-question survey to gather specific information on IST commitments in each state and the District of Columbia. The survey was administered to all 50 states and the District of Columbia via email. Specific individuals identified as primary administrators responsible for the care and evaluation of IST admissions in each state were contacted.

Results. A total of 50 out of the 51 jurisdictions contacted completed the survey. Fully 82% of states indicated that referrals for competency evaluation were increasing. Additionally, 78% of respondents thought referrals for competency restoration were increasing. When asked to rank factors that led to an increase, the highest ranked response was inadequate general mental health services in the community. Inadequate crisis services were the second ranked reason. Inadequate number of inpatient psychiatric beds in the community was the third highest, with inadequate assertive community treatment services ranking fourth.

Conclusions. Understanding the national trend and causes behind the recent surge in referrals for IST admissions will benefit states searching for ways to remedy this crisis. Our survey indicates most states are facing this issue, and that it is largely related to insufficient services in the community.

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Introduction

Recent information indicates that the number of forensic patients in state hospitals has been increasing, largely driven by an increase in patients referred as incompetent to stand trial (IST).[1,2] The surge in referrals for the evaluation and restoration of patients found IST is taxing state hospital systems, as well as the jails that must care for these patients when state hospitals are unable to accommodate the increased referrals.[3,4] Many state mental health authorities are facing litigation pressure to admit IST patients more quickly, raising concerns about overcrowding and reinstitutionalization. Little is known about these national trends of increasing IST populations, and even less is known about what is driving them. This survey was intended to broaden the understanding of IST population trends on a national level.

In 1960, the United States Supreme Court articulated the standard for competence to stand trial, requiring that

* Address correspondence to: Katherine Warburton, California Department of State Hospitals, Sacramento, California, USA.
(Email: katherine.warburton@dsh.ca.gov)

individuals facing criminal prosecution possess the ability to rationally consult with their attorney and possess a rational and factual understanding of the legal proceedings.[5] Research after this landmark ruling has shown that the majority of defendants deemed IST are suffering from a psychotic disorder.[6–10]

During the same time period, the United States instituted what has been termed "one of the most well-meaning but poorly planned social changes ever carried out in the United States"[11]: the closing of long-term psychiatric hospitals. Since that time, numerous scholars have forecasted that these closures would ultimately lead to the seriously mentally ill receiving services in the criminal justice system.[12,13] Recent reports suggest these predictions were accurate: many individuals with serious mental disorders are now receiving mental health treatment via the criminal justice system, not in the community as originally intended.[11,12,14] A poignant example of this is the commonly cited statistic that Cook County, Los Angeles County, and New York City jails are the largest mental health treatment facilities in the United States.[15] This is supported by recent research that documents that an individual with a serious mental disorder is 3 times more likely to receive psychiatric treatment in the criminal justice system than the mental health system.[11]

More recent data suggest that individuals receiving mental health treatment via forensic hospital systems have been increasing nationally. A 2014 survey of officials responsible for forensic services revealed that 90% of responding states experienced an increased demand for these beds.[1] In 78% of respondents, the increased demand resulted in waitlists to admit patients. Half reported a threat or finding of contempt of court for inability to admit patients in a timely manner. Although this 2014 survey confirmed anecdotal reports and indirect data about increasing forensic admissions, it did not specifically address increases in IST patients within the larger forensic population. Recently, national data have emerged confirming that the number of forensic patients in state hospitals from 1999 to 2016 has increased by 76%, and IST patients are largely responsible for this trend.[2]

Numerous reports have shown that states are struggling to manage the ever-increasing numbers of referrals for competency evaluations and subsequent commitments for restoration. For example, the state of Washington experienced an 82% increase in referrals for competency evaluations between the years 2000 and 2011, and faced litigation because of the increased demand.[16] In Colorado, requests for competency evaluations increased 524% from 2000 to 2017; corresponding requests for restoration increased 931% in the same timeframe.[17] In California, defendants judicially determined to be IST have been increasing at an alarming rate. In Los Angeles alone, the County Health Services Agency reported a 350% increase from 2010 to 2015 in IST cases referred by the criminal courts.[18,19]

The decades-long trend of increasing forensic hospitalization and/or incarceration of individuals with serious mental illness has been well studied, and while often attributed to the unintended impacts of deinstitutionalization,[14,20,21] the more recent surge in referrals has not been fully explained. There are many potential explanations for the observed increases such as decreasing access to treatment for mental illness and substance use in the community[11,20,22] and decreasing access to inpatient psychiatric beds.[11,23] Others have postulated that the increased popularity of specialty courts, such as mental health and drug courts, contributes to an increase in competence referrals for defendants who are unable to comply with the guidelines ordered by these courts due to their serious mental illness.[24] Finally, the Director of Community Health and Integrated Programs at the Los Angeles County Department of Health Services suggested that multiple issues have led to increased competency referrals such as increasing awareness of mental illness in the criminal justice system and the complex relationship between homelessness, methamphetamine use, and psychotic symptoms.[18]

Beyond hypotheses, there is little in the way of consensus or data about the proximal causes of the new IST crisis. Without fully understanding the potential reasons for this increase, the criminalization of individuals with serious mental illness will continue. Although multiple suggestions have been discussed for improving the competency evaluation and restoration system (see for example, Gowensmith's review),[19] the fact remains that in order to address this problem and craft a solution, the underlying cause or causes must be clarified and identified. This survey was designed to achieve two goals. First, we sought to confirm anecdotal reports of recent nationwide increases in competency evaluations and commitments. Second, and more importantly, this survey was designed to gather opinions as to the potential causes of the increases and to ascertain if there were commonalties between jurisdictions. Effective interventions to reverse the criminalization of mental illness depend on a full understanding of the forces that drive this trend.

Methods

The authors developed a survey to gather specific information on the processes for IST commitments in each state and the District of Columbia. We first reviewed the statutes for each jurisdiction. From this review, we determined that offenders found IST for misdemeanor offenses were frequently handled differently than those arrested for felony offenses. For this reason, the survey was designed to gather information about each process separately. Additionally, we found from this review that the

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TABLE 1. Opinions on change in referral rates

	Referrals for evaluations			Referrals for restoration		
	Increasing *n* (%)	Decreasing *n* (%)	No change *N* (%)	Increasing *n* (%)	Decreasing *n* (%)	No change *N* (%)
Misdemeanor	34 (70.8)	1 (2.1)	13 (27.1	33 (68.8)	1 (2.1)	14 (29.2)
Felony	35 (70.0)	–	15 (30.0)	32 (65.3)	–	17 (34.7)
Combined	41 (82.0)	1 (2.0)	8 (16.0)	39 (78.0)	1 (2.0)	10 (20.0)

processes by which individuals are determined to be IST vary between jurisdictions. For example, in some states, defendants are hospitalized to conduct the competence evaluations, whereas in others, community evaluators conduct the assessments while the defendant is in jail. Because of these differences, separate questions were asked about referrals for initial evaluations and referrals for restoration. A 30-question survey was developed to focus on trends in referrals, length of stay, and opinions as to the causes of the IST increases, if applicable. The survey was administered via Survey Monkey to all 50 states and the District of Columbia via email.

In order to obtain the most accurate information possible, potential sources were identified by reviewing rosters available on the National Association of State Mental Health Program Directors website. Individual emails were sent to these individuals. In most cases, the initial contact either agreed to take the survey or provided an alternative contact who they determined would be more appropriate and provide more accurate information. Occasionally, either the email address was invalid or the individual did not respond. In those instances, either the state hospitals or largest correctional institutions in those jurisdictions were contacted directly to determine who would be most appropriate to complete the survey. Each individual identified was sent a link to the survey. Nonresponders were sent repeat requests via email. When this was not successful, identified individuals were contacted by phone and asked to complete the survey.

Results

Characteristics of respondents

A total of 50 out of the 51 jurisdictions contacted completed the survey. In most jurisdictions, the survey was completed by an individual in an administrative role. Forty-eight percent (24/50) of individuals identified themselves as a Central Office Administrator (state office position) and 30% (15/50) identified themselves as a State Hospital Administrator (eg, Executive Director, Medical Director). The remaining 22% (11/50) identified themselves as "Other." Specific roles included: Chief Psychologist, Chief of Forensic Psychology Department, County Behavioral Health Director, Statewide Forensic Mental Health Program Director, Director of Forensic Services, Psychological Services Director, Area Forensic Director for the Department of Mental Health, Assistant Attorney General, Program Director for Competency Restoration, Chief Forensic Psychologist, and State Forensic Service Director.

IST rates and processes

As is shown in Table 1, approximately 70% of the respondents indicated referrals for competency evaluations for both misdemeanor and felony offenses were increasing. Only 2% of respondents felt misdemeanor competency evaluation requests were decreasing; no respondent indicated felony requests were decreasing. When combined, fully 82% of states indicated that referrals for competency evaluations for either misdemeanor or felony offenses were increasing. Not surprisingly, states reported that referrals for restoration were increasing as well; 68.8% for offenders with misdemeanor charges and 65.3% for offenders with felony charges. When combined, 78% of respondents thought referrals for restoration of offenders with either felony or misdemeanor offenses were increasing.

In addition to ascertaining if rates of referrals for evaluation and restoration services were changing, we also requested information about the processes for restoration services. When asked where restoration services occur in their jurisdiction, the majority indicated that state hospitals were the primary location for both misdemeanor (n = 30, 61.2%) and felony offenders (n = 41, 82%). Four states (8.2%) reported that misdemeanant offenders were not restored and charges were dropped, whereas only 1 state (2%) indicated felony offenders were not restored. Some states used both in- and out-patient restoration; more for misdemeanant offenders (n = 7, 14.3%) than for felony offenders (n = 5, 10%). One state restores both misdemeanant and felony offenders in jail. Of those jurisdictions that reported state hospital as the primary site for restoration of misdemeanants, the average length of stay was 93.58 days (SD 39.9), with a range from 33 days to 180 days. In contrast, felony offenders' length of stay ranged from 33 days to 281 days, with an average of 120.7 days (SD 52.2). Fully 70.8% of jurisdictions reported

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TABLE 2. Ranking of factors leading to increase

Factor	Number of respondents	Average rank	Modal rank	Median rank	SD
Inadequate general mental health services in the community	38	3.45	1	2.5	2.46
Inadequate crisis services in the community	38	3.71	3	3.0	1.80
Inadequate number of inpatient psychiatric beds in the community	36	3.78	1	3.0	2.50
Inadequate ACT services in the community	37	4.22	4	4.0	1.92
Other	17	4.24	1	3.0	3.35
More awareness of mental illness by the courts/officers of the court	38	4.58	2, 6	5.0	2.45
Homelessness	36	4.92	6	5.0	1.98
Bar for involuntary medication is too high	32	5.56	6	6.0	1.92
Bar for involuntary hospitalization is too high	28	5.75	7	5.5	2.20

having a waitlist to admit IST patient and 38.8% reported having faced litigation due to length of time on the waitlist.

Table 2 provides the descriptive statistics for the factors respondents considered to be the most important cause of increases in IST referrals. Respondents were asked to rank 9 factors (including one where they could provide a response other than the 8 contained in the survey). Rankings ranged from a 1 (most important) to a 9 (least important). The factors are presented in order from the smallest mean score (suggesting it was ranked as more important by many respondents) to the largest (ranked as less important by many respondents). The modal and median scores also are included in the table to provide a comparison between factors. Thirty-eight participants ranked these 9 factors, although not all 38 ranked all 9.

The highest ranked response was inadequate general mental health services with an average score of 3.45 (lower numbers indicate a higher ranking). Inadequate crisis services in the community was ranked second, inadequate number of inpatient psychiatric beds in the community was the third highest, with inadequate Assertive Community Treatment (ACT) services in the community ranked fourth. Fifth highest was respondent's opinions on factors not mentioned. Those factors included: the bar for finding defendants incompetent was too low, inadequate jail mental health, increasing rate of substance abuse, inefficiency of the court with involuntary medication orders, and lack of compliance with outpatient treatment. As seen in Table 2, homelessness and the bar being too high for involuntary medication or hospitalization were ranked lowest, with each having a modal ranking of 6 or 7, suggesting states believed lack of mental health services in the community were more important to the competency problem. Interestingly, rankings on increased awareness by the courts regarding mental illness were bimodal. With some states, believing this was highly relevant, with others thinking it was less relevant than other factors.

Respondents were asked to provide what, if any methods they have used to address the problem of increased demand for services to restore offenders. The most cited method was implementing diversion programs with 54% of respondents indicating they were developing or had already implemented diversion programs. Forty-two percentage tried either increasing the numbers of beds or decreasing length of stay. Ten states (20%) indicated that they have used double-bedding to address the problem. When asked to provide other methods used, some states indicated they were providing restoration services in the community, contracting with private hospitals for restoration, and implementing jail-based restoration services. States were evenly split on whether these methods improved the problem, with 10 (35.7%) saying yes and the same number saying no. Six (21.4%) said it was too soon to tell if their methods addressed the problem, with only 2 (7.1%) indicating the efficacy was equivocal.

Discussion

The results of our survey indicate that requests for competency evaluations and restoration services are indeed rising. Many of the respondents ranked a lack of community mental health services as a primary reason for the rising numbers of IST commitments, be it community hospital beds, crisis services, ACT teams, or general mental health services. One potential explanation for the perceived lack of services is the economic downturn in 2008. Advocacy groups at that time warned that "massive" cuts to mental health spending in the wake of the great recession would "simply shift financial responsibility to emergency rooms, community hospitals, law enforcement agencies, correctional facilities, and homeless shelters."[25] Moreover, IST defendants charged with violent offenses have been shown to have a higher degree of marginalization from society, particularly manifested as homelessness and unemployment.[26-28] Cuts in services following the recession could account for the recent sustained increase in IST referrals via a mechanism of patient decompensation, downward drift, and subsequent criminal justice contact.

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The opinion that the IST crisis is driven by a lack of community mental health beds is intriguing. Much has been written about what an appropriate number of hospital beds per capita is, and the appropriate location for those beds.[11,29,30] The Treatment Advocacy Center expert consensus guidelines recommend 50 inpatient psychiatric beds per 100 000 population. Recent literature points out that the average in the United States is 22 beds per 100 000, and in California that number is 17 per 100 000.[29–31] There is a suggestion that increasing suicide rates also are related to the decline in beds over time.[29] As such, it is feasible that arrest, incarceration, and forensic hospitalization are also negative outcomes of the decline in community inpatient beds. A compelling explanation is the decision an officer makes about whether to bring a psychiatric patient to a hospital or charge them with a crime and book them into jail. Research suggests that this decision depends on whether the arresting officer thinks the patient will be admitted to a hospital bed.[32] Therefore, a lack of community hospital and/or crisis beds could be a strong driver of an increase in arrests of individuals living with serious mental illness. The combination of these factors may drive both the IST crisis and increasing numbers of psychiatric patients in jails and prisons.

The possibility that a lack of community psychiatric hospital beds is indeed behind the recent surge sheds an ironic cast on the controversy over a call to bring back asylums.[33] The data confirm that people with serious mental illness are growing populations in forensic institutions and the problem of overrepresentation of persons with Serious Mental Illness (SMI) in prisons is well documented.[34–36] California alone has added over 400 state hospital beds and approximately 300 treatment beds in local jails in response to the crisis in the last 5 years. The effort to avoid the stigma of psychiatric hospitalization may in fact be exacerbating the trend of long-term institutionalization.

Understanding the causes behind the recent surge in referrals for IST evaluations and restoration services will benefit states vulnerable to increased scrutiny and federal lawsuits. For example, in the state of Washington, the outcome of a recent lawsuit resulted in mandates for admission of defendants found IST within a very narrow time range.[16] Fines in that case have topped 80 million dollars as the state struggles to comply in the face of increasing referrals.[37] Failure to comply with mandatory timelines is likely related to the fact that many state mental health authorities have limited or no influence over forensic referrals from the community. Because the entity being sued (State Mental Health Authority) has limited influence on the source of the crisis (increasing referrals from the community), the consequence of judicially mandated admission timelines is increased pressure on an already taxed system in the form of overcrowding and reinstitutionalization of individuals living with serious mental illness. A more logical solution is to find ways of reversing the increased referral trends by addressing the root causes driving them.

Our survey supports the notion that timeline to admission mandates have the potential to dramatically increase state hospital populations, creating a dangerous precedent for over-crowding. That 20% of states responded that they are "double-bedding" to comply with the increased demand indicates a potentially counterintuitive result of legal actions intended to preserve civil liberties.

In addition to creating a situation of reinstitutionalization and over-crowding, the current response to the IST crisis does nothing to address the complex long-term biopsychosocial needs of individuals living with serious mental illness. Once a patient admitted for competency restoration demonstrates the abilities to understand the criminal proceedings and assist counsel, the law mandates a return to court. Once the proceedings have concluded, the patient is released to the same circumstances that precipitated the arrest, institutionalized, or incarcerated, no better off for the state hospital stay.

The opinion data indicate that expanding state hospital capacity is not a remedy to the problem. What then, is? Jail diversion, based on sequential intercept mapping, is a well-studied systemic intervention that provides short, medium, and long-term alternatives. As our survey reflected, 54% of states are implementing diversion programs in an effort to reduce the influx of IST commitments. Funding may also provide an answer. In many states, local jurisdictions fund many community mental health programs, while the state authority tends to pay for the state hospital and prison mental health services. This provides a perverse fiscal incentive that supports downward drift to the point of arrest. In short, policy related to services for the SMI population need to shift funding incentives away from costly state hospital beds and prison mental health services. Instead, these public mental health dollars should focus on robust long-term continuums in the community that include adequate wrap around services, housing, crisis services, and community hospital beds. Finally, to ensure that communities have adequate services to deal with most mentally ill patients, consistent measuring of outcomes is needed. Arrest, incarceration, and institutionalization rates need to be considered metrics by which to measure service delivery.

Conclusion

Whatever the cause, increased demand for competency services is overwhelming state hospital capacity, resulting in a backlog of patients into local jails. Although some states are compelled via litigation to comply with challenging timelines for admitting IST patients, this approach does little to solve the problem of the increasing

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demand. The data from our survey support a disturbing trend of forensically driven reinstitutionalization of patients living with serious mental illness. Jail diversion and funding incentives are two potential solutions.

Disclaimer

The findings and conclusions in this article are those of the authors and do not necessarily represent the views or opinions of the California Department of State Hospitals or the California Health and Human Services Agency.

Disclosures

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Supplementary Materials

To view supplementary material for this article, please visit http://dx.doi.org/10.1017/S1092852919001585.

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