CNS Spectrums (2020), **25**, 161–172.
doi:10.1017/S1092852919001597

REVIEW ARTICLE

Competence to stand trial and criminalization: an overview of the research

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Beginning in the 1960s, a steady decline in the number of inpatient psychiatric beds has occurred across the United States, primarily as a result of stricter civil commitment criteria and a societal movement toward deinstitutionalization. Concomitant with this decrease in psychiatric beds has been a steady increase in the number of mentally ill individuals who are arrested and processed through the criminal justice system as defendants. One consequence of this has been an explosion in the number of defendants referred for evaluations of their present mental state—adjudicative competence—and subsequently found incompetent and ordered to complete a period of competency restoration. This has resulted in forensic mental health systems that are overwhelmed by the demand for services and that are unable to meet the needs of these defendants in a timely manner. In many states, lawsuits have been brought by defendants who have had their liberties restricted as a result of lengthy confinements in jail awaiting forensic services. The stress on state-wide forensic systems has become so widespread that this has reached the level of a near-national crisis. Many states and national organizations are currently attempting to study these issues and develop creative strategies for relieving this overburdening of forensic mental health systems nationwide. The purpose of this article is to review the current state of the research on competence to stand trial and to highlight those issues that might be relevant to the issue of criminalization of individuals with mental illness in the United States.

Received 22 July 2019; Accepted 19 September 2019; First published online 20 November 2019

Key words: Competence to stand trial, criminalization, adjudicative competence, mental illness, research.

Competence to Stand Trial and Criminalization: An Overview of the Research

Beginning in the 1960s, a steady decline in the number of inpatient psychiatric beds has occurred across the United States, primarily as a result of stricter civil commitment criteria and a societal movement toward deinstitutionalization. Concomitant with this decrease in psychiatric beds has been a steady increase in the number of mentally ill individuals who are arrested and processed through the criminal justice system as defendants. One consequence of this has been an explosion in the number of defendants who are referred for evaluations of their present mental state—adjudicative competence—and who are subsequently found incompetent and ordered to complete a period of competency restoration. This explosion has resulted in forensic mental health systems that are overwhelmed by the demand for services and that are unable to meet the needs of these defendants in a timely manner. Defendants with mental health concerns are spending an inordinate amount of time incarcerated while waiting for their competency-related services, resulting in what we refer to as criminalization of individuals with mental illness. In many states, lawsuits have been brought by defendants who have had their liberties restricted as a result of lengthy confinements in jail awaiting forensic services. The stress on state-wide forensic systems has become so widespread that we have nearly reached the level of a national crisis. Many states and national organizations are currently attempting to study these issues and develop creative strategies for relieving this near-national overburdening of forensic mental health systems.

The purpose of this article is to review the current state of the research on competence to stand trial and to highlight those issues that might be relevant to the issue of criminalization of individuals with mental illness in the United States. Although there is a large and growing

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literature on issues relevant to adjudicative competence—including its evaluation, the characteristics of competent and incompetent defendants, and restoration services—here, we attempt to focus on those issues that are specifically relevant to the broader issue of criminalization of individuals with mental illness. Space limitations do not permit a comprehensive review, but rather, we present an overview of the competency research as it pertains to criminalization with a focus on recent history and current trends. The interested reader is referred to the other articles in this special issue for more data and detail on related issues, and to other sources.[1–4]

We begin with a brief overview of the competency doctrine and the general procedures used across the United States and then we review the empirical literature on competency to stand trial. We highlight research in 3 areas—system considerations, evaluation considerations, and treatment considerations—relevant to a complete understanding of the current forensic mental health crisis and for discovering new ways to move forward.

Overview of Competency Doctrine and Procedures

The origins of the competency doctrine can be traced to the Babylonian Talmud and early Judeo-Christian texts along with English common law that emerged at some point prior to the 14th century.[5] In English courts of this era, defendants commonly remained mute in lieu of making a plea, which impeded trial proceedings and required English courts to determine whether this muteness was a function of "malice" or "visitation of God."[5] "Mute by visitation of God" encompassed the "deaf and dumb" and expanded to include "lunatics."[6] This distinction provided an opportunity for those suffering from mental illness to avoid the same punishment as those who committed a crime with malicious intent. This was the beginning of the judicial system noting the special needs of the mentally ill in criminal justice proceedings.

Today, a defendant's right to a fair trial is one of the core principles of modern law, which strives to provide all defendants with objective and dignified proceedings (of course, the importance of competence to stand trial in the law is primarily in common law nations and does not extend to many civil law nations). Competency to stand trial (adjudicative competence) is a doctrine of jurisprudence that allows for the postponement of criminal proceedings should a defendant be unable to participate in his or her defense on account of mental disorder or intellectual disability. All defendants are required to maintain a basic level of competence to proceed through the adjudication process; therefore, competency is relevant from arrest or initial detention through sentencing.[7] Adjudicative competence is the most commonly referred forensic evaluation,[8,9] with annual competency evaluation referrals increasing over time.[10,11]

The U.S. standard for trial competence was established in *Dusky v. United States*[12] and all states currently use some variant of the *Dusky* standard, with the exact definition varying by jurisdiction. In *Dusky*, the Supreme Court held:

"It is not enough for the district judge to find that 'the defendant is oriented to time and place and has some recollection of events,' but that the test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him." (p. 402)

Thus, the *Dusky* standard established 2 prongs for competency: (a) the sufficient present ability to assist counsel with a reasonable degree of rational understanding and (b) the ability to rationally and factually understand the proceedings against him. As the language in *Dusky* is ambiguous, the typical forensic evaluation is left largely unguided by legal statute, with the courts and legislatures giving mental health professionals a large share of the responsibility for defining and evaluating competency, although various states have made attempts to provide delineated statutes to guide the evaluation process. A vast empirical literature on competency evaluation prompted the publication of guidelines[13,14] and best practices[15] to improve competency evaluation procedures.

Modern competency laws vary from state to state; however, most jurisdictions follow similar procedures. There is a relatively low threshold for ordering a competency evaluation, with all parties to the proceedings responsible for raising the issue of a defendant's competence whenever a *bona fide* doubt exists.[16,17] A written competency evaluation report is typically required for any court-ordered evaluation, with the number of evaluation reports per defendant varying by jurisdiction and ranging between 1 and 3. In most cases, the court readily accepts the opinion of the evaluator (or, of the majority of evaluators when 3 evaluations are conducted, as is the case in Hawaii) and a hearing on the issue becomes unnecessary.[18] In those instances where evaluators are in disagreement about a defendant's competency status, a hearing on the issue is held.

Defendants adjudicated as competent proceed with their cases whereas those found incompetent are ordered to a period of restoration, typically at an inpatient facility but with an increasing number of outpatient restoration programs becoming available in various jurisdictions.[19] Most jurisdictions have time limits for restoration orders and allow for the possibility of extending a restoration order when there is a substantial probability that the defendant will be restored in the foreseeable future. Most defendants (~75%) are restored to competence within a 6-month period and returned to court.[20] A smaller proportion take longer than 6 months but are ultimately

https://doi.org/10.1017/S1092852919001597 Published online by Cambridge University Press

restored within a year. And a very small proportion of defendants—primarily those with intellectual disabilities or treatment-resistant psychosis—will not be restored to competence.[21] The current research on competency restoration is superficial, comparing competent and incompetent defendants and identifying characteristics of individuals involved in restoration procedures, not variables that examine incompetent defendants at various stages of restoration.[20]

We now turn to a review of the research on competence to stand trial and highlight issues relevant to the criminalization of individuals with mental illness in the United States.

Empirical Foundations of Competency to Stand Trial

Prior to the 1980s, there was little research on competency to stand trial but the past few decades have witnessed a surge of research, with more than 5000 publications on this topic since 1980. This vast body of research has explored the characteristics of defendants referred for competency evaluations and those deemed incompetent, the reliability and validity of the evaluation process and of instruments developed for use in competency assessment, predictions regarding the restorability of incompetent defendants, and competency restoration treatment programs.[9] Recently, research has begun to address some of the important system-wide considerations that impact wait lists for evaluations and restoration services.[1–3] We begin by reviewing the empirical literature on competency to stand trial and then highlight various system, evaluation, and treatment considerations important to a complete understanding of the increasing criminalization of individuals with mental illness.

In the United States, between 4% and 8% of all felony defendants are referred for a competency evaluation; however, research indicates that attorneys may have concerns about their clients' competence in as many as 15% of all cases.[22] Of those defendants who are referred for formal evaluation, approximately 1 in 4 will be found incompetent, with a meta-analysis of 26 139 defendants indicating a base rate for incompetence of 27.5%.[9]

Symptoms of mental illness, such as the presence of psychosis, play a prominent role in competency determinations.[23] In the past, most evaluators were employed in state psychiatric hospitals and received little formal training in the assessment of competence and matters of law. Therefore, incompetence was equated with psychosis and evaluators rarely considered the specific legal demands of the case.[24] However, empirical research has provided evidence that the presence of psychosis itself is not sufficient for a defendant to be adjudicated incompetent. For example, researchers analyzed data from over 1000 forensic evaluations conducted over a 2-year period and found that only one-half of individuals with a diagnosis of schizophrenia and one-third of those with a diagnosis of intellectual disability were adjudicated incompetent, highlighting that diagnosis alone does not meet the threshold for incompetence.[25] Over the years, researchers sought to identify other variables that are related to competency status.

Comparison studies of competent and incompetent defendants indicate that, relative to competent defendants, incompetent defendants (a) perform poorly on forensic assessment instruments related to legal functional abilities, (b) are more likely to have a psychotic disorder diagnosis, and (c) have psychiatric symptoms that are indicative of severe psychopathology.[23,26,27] Research has consistently demonstrated incompetent defendants to be diagnosed with psychotic disorders at higher rates than their competent counterparts.[28–30] The most robust finding from a meta-analysis of 68 studies published between 1967 and 2008 that compared competent and incompetent defendants was that defendants diagnosed with a psychotic disorder were 8 times more likely to be found incompetent than defendants without a psychotic disorder.[9] Furthermore, unemployed defendants were twice as likely to be incompetent than those who were employed and those with a history of psychiatric hospitalization were twice as likely to be incompetent as those without.[9]

Special populations

Over the last few decades, research has focused on specific vulnerable populations for whom issues of competency are especially important, such as juveniles and individuals diagnosed with intellectual disabilities (formally, mental retardation). More recently, researchers have begun to explore gender and older age in relation to trial competency-related issues.

Individuals with intellectual disabilities

In 1990, Bonnie noted that between 2% and 7% of competency evaluation referrals were defendants with intellectual deficits. Adequate representation and proper identification of intellectually disabled defendants in criminal cases were raised as concerns given that previous research had suggested that approximately 15% of incompetent defendants were intellectually disabled.[31] Throughout the 1990s, research reported that about one-half of intellectually disabled defendants were not identified for competency evaluation[32–34] and suggested that these individuals proceed through the criminal justice system without understanding the process or punishments.

Appelbaum[35] provided guidance for identifying individuals with intellectual disabilities in forensic evaluations, highlighting the importance of assessing functional abilities rather than simply relying on IQ score,

https://doi.org/10.1017/S1092852919001597 Published online by Cambridge University Press

and underscoring the need for evaluators to consider the tendency for these individuals to be compliant and cooperative and to attempt to conceal their difficulties by pretending to understand.[35] A result of this presentation style is that individuals with intellectual disabilities often do not show signs of poor understanding and/or reasoning. In many cases, this "cloak of competence" gives these individuals the appearance of normalcy in the competency context.[36] Legally, significant impairments then become visible only when the individual also has a severe mental illness or acts in a strange or disruptive manner.[37] Smith and Hudson identified a screening device[38] that could be used to identify intellectually disabled defendants and case studies have provided some guidance for assessing[39,40] and restoring[41] this population to competency.

Bonnie[37] postulated that restoration of incompetent intellectually disabled defendants is highly unlikely and research has since provided empirical support for this, reflecting that most intellectually disabled defendants are not restored to competence.[42] Schouten[43] expressed concern that intellectually disabled defendants may be able to provide correct responses to trial-related questions but not understand their significance. Everington et al.[44] used a simulated research design to examine whether defendants with intellectual disabilities were capable of feigning poor performance on the Competence Assessment for Standing Trial for Defendants with Mental Retardation. Results suggested that, in certain circumstances, intellectually disabled defendants may have the ability to feign poor performance and the authors called for additional research to assess whether these defendants truly understand the repercussions of the outcomes in their actual criminal cases.

Juveniles

Prior to the early 1990s, little was known about juvenile trial competencies. Cowden and McKee[45] conducted the first study, over an 8-year period, to explore the characteristics of juveniles referred for competence evaluations. Findings indicated a positive relationship between age and competence. No significant relationships were found between competency status and sex, race, previous mental health history, and frequency or type of criminal charge. Subsequent research replicated and expanded these findings indicating that, compared to youth not evaluated for trial competence, youth who were deemed incompetent were younger, had special education needs, prior mental health treatment, and histories of being in state custody.[46,47] Other research, however, has not found significant differences between age and performance on a competency assessment measure but the truncated nature of the age range in these samples might explain the lack of significant findings.[48–50]

Ensuring the competency of adolescents has become increasingly important as the juvenile justice system has shifted from a rehabilitative model to a more punishment oriented one and as increasing numbers of adolescents are being either waived or transferred to criminal court.[51] Grisso[52,53] reviewed the developmental literature related to capacities of juveniles to participate in their criminal cases. His review underscores the role that developmental immaturity plays in adolescents' limitations in understanding and appreciating the legal process. Bonnie and Grisso[11] proposed future directions for law and policy related to juvenile adjudicative competence and Katner[54] argued for reforms that would provide greater protection from wrongful adjudication of incompetent youth. Subsequent research has indicated that judges do take developmental maturity into consideration when determining adjudicative competence.[55,56]

Current research suggests that there is greater need to tailor evaluations of adjudicative competence for younger adolescents. Definitions and conceptual guidance for forensic evaluators regarding necessary modifications related to assessing juvenile competence have been outlined in other sources.[57–59]

Gender

Most competency research offers limited rigorous examination of the association between gender and competency outcomes. Riley[60] sought to provide seminal baseline data comparing competent and incompetent female defendants with their male counterparts and, while her results did not show an overall pattern of association between gender and competency adjudication, she argued that research on male-only populations could not be applied equally to female defendants. Crocker et al.[61] used a relatively large sample of female defendants and found support for the notion that women are more likely to be found incompetent relative to males. More recently, Kois et al.[62] explored variables that have historically been associated with competency in samples that are predominately male and found that these associations may not transfer across demographic groups. Pirelli et al.'s[9] meta-analysis found that female defendants were equally as likely to be found incompetent as male defendants. It is noteworthy that this may be due to the small proportion of studies employing females in their samples, since only half of the studies analyzed included females.

Elderly defendants

Assessing competence in the geriatric population is particularly challenging, primarily as a result of greater deficits in orientation and memory.[63] Approximately one-third of individuals age 60 years or older who are referred for competency evaluations are deemed incompetent[64] and, compared to younger incompetent defendants, restoration rates for older individuals are much lower.[65] Frierson et al.[66] compared geriatric defendants found

https://doi.org/10.1017/S1092852919001597 Published online by Cambridge University Press

incompetent to stand trial with their competent counterparts and found that the most common variables associated with incompetence were older age, presence of dementia, presence of other memory and concentration impairments, and deficits in orientation. Concerns over individual constitutional rights (eg, *Jackson* time limits) are elevated for competency determinations of elderly defendants as research shows that these defendants are unlikely to benefit from restorative treatment.[65] There is a need for additional research with elderly defendants to further develop our understanding of the implications of age and related impairments on competency evaluation and determination.

We now turn to a discussion of the literature in 3 areas of relevance to criminalization—system considerations, evaluator considerations, and treatment considerations.

System considerations

To curtail mass incarceration of persons with mental illness and to support those who would be better served by treatment than punishment, prearraignment diversion programs, mental health courts, substance use treatment, and postincarceration support services have been established in many jurisdictions. However, these alternatives to incarceration are not a panacea as the frequency of competency evaluations and the number of defendants opined incompetent continue to rise. Issues of specific relevance to criminalization of mentally ill defendants include service delivery/system considerations and misuse of the competency evaluation process, each of which are briefly reviewed here.

Service delivery

LaFortune and Nicholson[67] surveyed judges and attorneys about the competency referral and evaluation process and found that referral for evaluation does not occur for approximately one-third of defendants whose competency is a concern. These researchers and Winick[68] raised concern about the ethical dilemma faced by attorneys when dealing with a client whose competency is in question but the prolonged legal case, involuntary hospitalization involved in the competency process, and the related infringement on the defendant's autonomy may not be seen as being in the best interests of their client.

Various scholars have provided reconceptualizations of competence to stand trial that take into consideration the fiduciary nature of the relationship between defense attorney and defendant. Winick[32] argued that, in some circumstances, it might be in the best interest of the defendant to proceed with a trial even if he or she is incompetent. He postulated that this could take the form of a "provisional trial" where the defense attorney would ensure protection of the defendant, allowing the defendant to proceed with his or her case, with appropriate courtroom behavior. Bonnie[37] proposed 2 levels of competence—foundational competence to assist counsel and higher-order decisional competence. He argued that defendants found incompetent to assist counsel should be barred from proceeding until they were restored to foundational competence, whereas defendants found decisionally incompetent could proceed by having their defense attorney make decisions on their behalf. Despite the logic presented for these reconceptualizations of competence, provisional trials have not been adopted in any jurisdiction and the decision of the Supreme Court in *Godinez v. Moran*[69] made clear that decision-making is an important component of a defendant's competence-related abilities.

Throughout the 1980s, various states began making changes to the process by which court-ordered competency evaluations were delivered. Systems evolved from conducting all evaluations at centralized inpatient facilities only to the use of jails and mental health centers as well. Nicholson and Kugler's[26] meta-analysis explored the function of evaluation site (inpatient vs outpatient) on various defendant variables and found that most of the descriptive characteristics that were associated with findings of incompetence did not differ as a result of evaluation setting.

Grisso et al. conducted a national survey to determine the organization of pretrial forensic evaluation services in the United States.[70] They concluded, "the traditional use of centrally located, inpatient facilities for obtaining pretrial evaluations survives in only a minority of states, having been replaced by other models that employ various types of outpatient approaches" (p. 388). One compelling reason for this shift is cost. Winick[6] estimated that $185 million was spent annually on competency evaluations. By 2012, a conservative estimate of $700 million in annual costs for evaluation and restoration services in the United States was reported.[71]

A more recent national survey was conducted by the National Association of State Mental Health Program Directors and, of the 37 states that responded, only 12 indicated that their state handled competency evaluations solely outside of the psychiatric hospital.[4] Outpatient services varied by state, with various options including, jails, outpatient locations, use of community evaluators, and private agencies. The remaining 25 states indicated that some (or most) competency evaluations are conducted at their state psychiatric hospital.[4]

The number of evaluations is growing annually[19] and state reports have documented an increase in the number of forensic patients admitted to state psychiatric in-patient hospitals.[1,2,4] Various states have indicated they are implementing a variety of methods in response to increasing numbers of forensic patients in state hospitals and growing wait lists, including, but not limited to, adding more beds, adapting the admission process, modifying prioritization

https://doi.org/10.1017/S1092852919001597 Published online by Cambridge University Press

of waitlists, and developing community- or jail-based programs.[4] Christy et al.[72] noted that defendants in Florida waited an average of 81 days to be admitted to hospital after the court ordered restoration; this research provided the impetus for Florida to reallocate finances to provide additional forensic services.

Few empirical studies have documented the process of the increase in referrals, assessed the scope of the problem, or have identified factors may be driving it, but these issues are becoming the focus of national attention.[73] Currently, between 10 000 and 18 000 defendants are adjudicated incompetent to stand trial each year and remanded to competency restoration services,[74] with commensurate annual increases as the number of competency evaluations increase. This is an area in need of research and focused attention.

Misuse of competency evaluations

As a result of broad deinstitutionalization and legislation changes imposing stricter criteria for involuntary civil commitment, inpatient admissions to psychiatric hospitals declined; however, this was accompanied by a concomitant increase in admissions for forensic services, such as evaluations for competency.[75] Throughout the late 1980s and 1990s various studies explored questions related to whether the competency evaluation process was being used by the courts to obtain inpatient treatment for nondangerous mentally ill individuals.[76–78] Warren et al.[79] examined data from 3 states and found that defendants charged with public order offenses were more likely to be opined incompetent by forensic evaluators than those charged with more serious offenses. In addition, defendants in Ohio were more likely to be found incompetent than defendants in Michigan and Virginia. These researchers postulated that this difference might be a result of fewer community mental health services in Ohio, leading the courts to use competency referrals as an avenue to obtaining mental health treatment. These data suggest that some portion of inpatient evaluations may be ordered for the primary purpose of securing mental health treatment for the defendant. This "criminalization of the mentally ill" highlights that mental health services are often most accessible through court-ordered services.[80]

The increasing rate of competency referrals and the subsequent increase in incompetent defendants have raised concerns regarding the quality and timeliness of forensic mental health services.[80] Many states are dealing with the challenge of balancing the demands of the legal system, with public safety concerns and limited mental health resources. As of 2015, 37 states had identified specific time requirements for completion of competency evaluations and delineated various settings in which evaluations can be conducted. Gowensmith et al. noted that states with a centralized administration with authority specific to forensic services are in a better position to address delays in competence restoration and inefficiencies in the evaluation and restoration process.[80]

Evaluation considerations

Several factors regarding the evaluation of competence to stand trial are relevant to a complete understanding of those factors that might play a role in criminalizing individuals with mental illness, including the research on quality of evaluations and reports, evaluator differences, and bias in forensic evaluation. We briefly address each of these here.

Quality of evaluations and reports

No published research has examined forensic evaluations but there have been some studies examining the quality of forensic reports, which can, arguably, serve as a proxy for the forensic evaluation. Skeem et al.[81] examined competency evaluation reports in Utah and found that evaluators failed to delineate the rationale or reasoning for their psycholegal opinions and also failed to address some of the specific capacities involved in adjudicative competence. Zapf et al.[18] examined competency evaluation reports in Alabama and found that many evaluators failed to address important, statutorily required, elements. Nicholson and Norwood[82] summarized the research on forensic evaluation reports and testimony and concluded that, "the practice of forensic psychological assessment falls short of its promise" (p. 40).

Several competency assessment tools have been developed to assist in structuring the competency evaluation process.[5,15,83] The benefits of using competence assessment tools include that they provide structure the evaluation, help to standardize the assessment procedures, improve reliability between evaluators, promote meaningful comparisons across time or between evaluators, facilitate research, improve communication in legal settings, and facilitate deficit-focused restoration efforts.[15,83] Research examining inter-rater reliability for various competency assessment tools indicates higher rates of agreement for overall determinations of competency status, moderate rates of agreement for individual scales, and lower agreement for specific abilities encompassed within each scale.[84–86]

Evaluator differences

Murrie et al.[87] examined more than 7000 evaluations, conducted by 60 clinicians, to explore the degree to which individual clinicians varied in terms of their opinions of incompetence. Rates of incompetence opinions varied considerably across evaluators, suggesting that evaluators might differ in terms of how they define,

https://doi.org/10.1017/S1092852919001597 Published online by Cambridge University Press

conceptualize, and arrive at opinions regarding incompetence. Although there is greater variability in opinions regarding specific components of competence, there is generally good agreement between evaluators regarding a defendant's overall competency status (ie, competent or incompetent).[88,90] In a study of competency evaluation reports in Utah where 2 reports were completed on each of 50 defendants, Skeem et al.[81] found 82% agreement between evaluators regarding overall competency status, but this dropped to an average rate of about 25% when examining agreement between evaluators on whether a particular psycholegal ability was impaired, with agreement on many of the psycholegal abilities examined at less than 10%. In a large field reliability study, Gowensmith et al.[91] examined 216 competency cases in Hawaii, where statute requires 3 separate evaluations be conducted by independent clinicians for each felony defendant referred for competency evaluation. Results indicated that all 3 evaluators arrived at the same opinion regarding competence in 71% of cases. Rates of agreement fell to 61% for opinions of competency status for defendants who received restoration services subsequent to being adjudicated incompetent. These results reflect moderate agreement among independent evaluators regarding overarching opinions of competency status but decreasing agreement between evaluators regarding the specific domains and abilities encompassed within competency status. Similarly, these data also indicate that various evaluators may be more or less inclined to opine in a particular direction regarding overall competency status. More research and information is needed regarding the impact of evaluator differences on both the competency evaluation process as well as evaluator decisions and opinions regarding competency status. In addition to evaluator differences, more research on the impact of evaluation context on reliability rates is required.[92]

Bias in forensic evaluation

The extent to which bias impacts forensic evaluations is unknown, although consideration of the issue of potential bias and inquiry into ways in which potential bias might be mitigated have become the focus of research and commentary over the past few years.[93–95] Specific issues, such as hindsight bias,[96] and bias awareness[97] have been studied with respect to forensic evaluations. A survey of 1099 forensic evaluators indicated that most evaluators expressed concern over cognitive bias but held the incorrect view that bias can be reduced by sheer willpower.[98] In addition, evidence for a bias blind spot[99] was found, with evaluators indicating more bias in their peers' judgments than in their own.[98]

Mossman[100] used computer simulation of 20 000 pairs of competency evaluations to test whether bias might account for differences in evaluator opinions regarding competency status. His results indicated that between-examiner disagreements might be attributable to random error rather than examiner biases that imply different thresholds for conceptualizing a defendant's competency status. Murrie et al. have conducted several studies examining the issue of adversarial allegiance—the idea that an evaluator might be more sympathetic to the retaining side—and provided the first empirical support for this allegiance using an experimental research design.[87,101,102]

Although experimental research designs have not been used to address the issue of potential bias in competency evaluations, some research has indicated that certain groups, such as felony defendants and non-White defendants, are more likely to be found incompetent. Further exploration of issues of potential bias are relevant to a complete understanding of criminalization and mental illness.

Treatment considerations

In 1997, Cooper and Grisso noted that a majority of forensic patients in the United States were receiving competency restoration services but there existed little research on treatment for competency restoration.[34] Two decades later, we remain in dire need of systematic research on competency restoration. Pirelli and Zapf[20] conducted a systematic review of restoration services for 12 781 defendants across 51 studies and found that 81% of individuals were restored to competency, after an average of 175 days. Additional planned analyses could not be conducted because of the limited number of studies using a research design allowing for comparison of defendants at prerestoration and postrestoration, prompting Pirelli and Zapf to call out the grave state of the competency restoration literature over the last half century.

Although the specific statutes vary by state, restoration services are most typically ordered when treatment is likely to restore competency and no less intrusive alternative exists. In addition, the majority of defendants who are assessed for competency consent to prescribed medication[103]; whereas those who deny their mental illness, or have delusions related to their medications, generally refuse psychotropic treatment.[104] Ladds and Convit noted that most decisions to forcibly medicate defendants are made for clinical reasons rather than legal ones.[104] The United States Supreme Court decision in *Sell v. United States*[105] gave courts legal authority to mandate the involuntary administration of medications to restore competency under certain limited circumstances: *important* governmental interests are at stake; the forced medication will *significantly further* those state interests; involuntary medication is *necessary* to further those interests; and administering the medication is *medically appropriate* and will not significantly interfere with the defense or have adverse side effects.

https://doi.org/10.1017/S1092852919001597 Published online by Cambridge University Press

Although psychotropic medication is the most frequent treatment modality utilized for competency restoration, various jurisdictions have established an educational component for competency restoration. Most typically, these educational programs are structured in nature and focus on the goal of providing factual information and decision making skills to defendants with the goal of restoring the defendant to competence. Siegel and Elwork[106] developed, and empirically tested, a structured psychoeducational program for competence restoration. Scores on a competency assessment instrument were compared for matched groups of incompetent defendants, with one group receiving the psychoeducational competency program and the other serving as a control group. Upon completion of the treatment period, higher ratings of competency were found for the competence restoration group (45%) than for the control group (15%), providing support for the notion that educating incompetent defendants regarding legal aspects specific to trial competence may improve outcomes. Several other researchers have explored educational programs for competency restoration and have provided recommendations for improving the efficacy of competence restoration.[107–109]

The decision of the United States Supreme Court in *Jackson v. Indiana*[110] underscores that incompetent defendants cannot be held indefinitely and, if restoration is unlikely, must either be released or civilly committed. The *Jackson* ruling set the foundation for revisions to state statutes to provide alternatives to commitment as well as limits on the length of commitment.[24] In 1992, Golding[111] speculated that the best predictor of restorability may be a defendant's initial responsiveness to treatment and noted that restoration is unlikely to occur in some cases as a result of the chronic nature of a defendant's psychological or psychiatric issues. Subsequent research sought to gain insight on those defendants who are not likely to be restored to competence. Findings suggested that intellectual disabilities,[42,112,113] and more severe pathology (eg, schizophrenia spectrum disorder)[114–116] were related to poor restoration outcomes. Hubbard and Zapf[117] explored variables related to clinicians' opinions regarding restorability and found no particular set of variables that produced a high classification rate or that served as reliable predictors of restorability. Warren et al.[116] also explored variables related to restorability and found that defendants considered not restorable were more likely to have intellectual deficits or learning disorders. Mossman[13] also noted that significant cognitive deficits, as well as chronic psychosis, were associated with a low probability of restoration.

Pirelli and Zapf[20] found that when comparing defendants who had been restored to competency with those who had not, non-white defendants and unmarried defendants were less likely to be restored. In addition, defendants with psychotic disorders were 2 to 3 times more likely than those without to be incompetent/not restored and defendants who had previously been evaluated for competency were 3 to 5 times more likely to be incompetent/not restored than those who had not.

Outpatient restoration

The high costs and resource demands of treatment for restoration has led some states to examine alternative competency restoration models. In 2003, Miller noted that outpatient restoration treatment was rare, with over 30% of states not legally allowing for such treatment. In 2011, Kapoor reported that 35 states' (70%) statutes allowed for outpatient competency restoration programs, with 16 states having active outpatient programs.[118] Almost half of these 16 states—Florida, Pennsylvania, Virginia, Tennessee, Arizona, Texas, and Louisiana—have attempted jail-based restoration programs, with initial estimates of cost savings from these jail-based programs appearing promising. Yet the lack of mental health staff in jails and the limited number of incompetent defendants a jail has at any given time has caused pushback within several jurisdictions, making jail-based restoration programs difficult to maintain.[118] By 2016, Gowensmith et al. reported that 44 states (86.3%) allowed for outpatient restoration programs and noted that between 2003 and 2016, there was growth in the number of states that allowed for outpatient restoration programs, but that from 2011 to 2016, the number of states that actually utilized such programs remained static at 16.[19] Gowensmith et al. highlighted preliminary but promising results for states using outpatient competency restoration programs.[19] At present, jail-based competency restoration programs require further research to identify the as-of-yet undetermined efficacy and viability of these programs.

Future research on competency restoration is dire to the further development and enhancement of effective competency restoration programs for defendants. Focusing on specific cognitive deficits and symptoms of mental disorder as well as the nexus between these clinical issues/symptoms and the various competency-related abilities and deficits is critical to increasing our understanding of effective interventions for the successful restoration of competency.

Summary and Conclusions

Although there is a large body of research on competence to stand trial, this has primarily focused on the characteristics of defendants referred for competency evaluations and those deemed incompetent, the reliability and validity of the evaluation process and the use of instruments developed for competency assessment, predictions

https://doi.org/10.1017/S1092852919001597 Published online by Cambridge University Press

regarding the restorability of incompetent defendants, and competency restoration treatment programs. Larger issues—such as the best methods and procedures for competency restoration and the ways in which the systemic burdens placed on state forensic mental health systems by current standards, statutes, and procedures pertaining to adjudicative competence can be remedied—have not received nearly as much attention. Indeed, Gowensmith[119] argued, "promising policy implications can be rooted in emerging knowledge about the timing of competency evaluations, certification of evaluators, alternatives to inpatient restoration, and changes to evaluations and the associated reports" (p. 1). This brief overview provides a summary of research on competency to stand trial that might be relevant to working through broader issues related to the criminalization of individuals with mental illness. It appears to be time to turn our attention to the wider systemic issues involved in our overburdened forensic systems nationwide in an attempt to understand the contributing factors and how these might be changed to improve service provision and outcomes. The issue of criminalization of individuals with mental illness and how this impacts the competency evaluation and restoration process, as well as the wider systemic demands this places on the state forensic mental health system, are important considerations that are the focus of this special issue.

Disclosure

Amanda Beltrani and Patricia Zapf do not have anything to disclose.

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