THE COMPETENCY *CRISIS:*

A Brief Review of the EVALUATION *and* ASSESSMENT *of* *Competency* *and the* *Restoration Process*

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INTRODUCTION

The competency crisis is a years-long issue observed in jurisdictions across multiple states. This matter tends to be two-pronged in that pretrial defendants experience significant delays in being evaluated as well as receiving treatment, should such be indicated. Though raising concerns about *due process* is legitimate, challenges with maintaining institutional safety, delivering adequate mental health treatment, retaining competent providers and ancillary carceral staff, and providing general case management are equally pressing. I compiled the information contained within this eBook to equip attorneys, judges, and community leaders with a panoramic view of the competency crisis, as different jurisdictions elect to address this issue with varied levels of success. Moreover, I intend to provide a snapshot of my expertise and unique skill set pertaining to the matter at hand.

In my role as a forensic psychologist, I bring nearly 10 years of concentrated experience with the evaluation, assessment, and treatment of justice-involved persons housed in prisons or jails, in forensic state hospitals, or in the community under supervision. The aforementioned gives me unique agency in that I hold practical, real-world understanding of the inner workings of the justice system and carceral environment, in addition to my scholarly work in this area—a notable distinction among consultants, as few have significant or long-term experiences in practice (i.e., providing direct care services in carceral settings across multiple jurisdictions) and in research (i.e., engaging in pertinent research activities). Instead, consultants are often tapped—at least initially—after years of service to a particular jurisdiction, which has its benefits and drawbacks.

In forensic practice, I recently developed a jail-based competency restoration program for a 20-bed unit, during the course of which I directed clinical operations and evaluated the overall effectiveness of treatment activities. *Operating a program of this nature requires a deep understanding of how to balance institutional policies and procedures, general risk management, the requisite standard of care, and the training/development of mental health and correctional staff.* In particular, I supervised mental health professionals in the construction of individualized care plans designed to restore pretrial defendants' competency to stand trial. I also conducted evaluations for psycholegal purposes, including assessments for risk, for diagnostic clarification, for determination of barriers to competency, and for other treatment needs, and ultimately, provided clinical oversight for all jail-based competency restoration services.

In sum, my specialized training and career trajectory thus far has exposed me to nearly every environment in which mental health services are delivered. Such broad exposure affords me a robust understanding of evidence-based treatment in practice, in addition to my research-based knowledge. Observationally, broad exposure promotes operational success and maintains safety—the development of mental health programs in carceral environments cannot be a *one-size-fits-all* approach.

PROFESSIONAL OVERVIEW

Dr. Douglas E. Lewis, Jr.

Dr. Lewis has served as a consultant for court personnel and various industry leaders and has performed court-ordered evaluations for justice-involved adolescents and adults. His approach to evaluation and assessment places special emphasis on case conceptualization from an ecological systems perspective, thereby leading to the procurement of real-world, individual-specific recommendations.

Equally, Dr. Lewis is committed to following the truth wherever it may lead. His foremost research pertains to best practices as well as innovations for the delivery of jail-based competency restoration services. Dr. Lewis is licensed in multiple states and is an expert witness for the Juvenile, State, and Federal Courts.

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IN MEMORIAM TO THOSE WHO *Helped & Inspired*

I curated this *e*Book, which is a brief synopsis of cross-jurisdictional issues pertaining to mental health and the law, to pay homage to the invaluable impact of United States Air Force veteran **Aisha Abdul-Rahim** and Distinguished Professor of Psychology, **Dr. Kaprice R. Thomas**. **Aisha**, my maternal cousin, often gave me glimpses into the unspoken experiences of people forgotten or disregarded--many of whom deserved our gratitude more than judgment. **Kaprice**, my longtime mentor and dear friend, was a licensed attorney and psychologist, whom I frequently leaned on throughout my journey to becoming a forensic psychologist. She recounted her early work at Patton State Hospital, providing treatment to justice-involved persons, and such was my initial exposure to the intersection of long-term mental health treatment and the law. Tragically, I lost both of these trailblazing women on the same day in early 2024. Their work, integrity, wisdom, and fortitude will live on through me and my future works.

Because of them, I have a deeper appreciation for and commitment to serving my community as well as greater society, and I hope that this work sparks the meaningful conversations needed among court stakeholders and community leaders to create innovative and lasting solutions to the mounting competency crisis.

Dr. Lewis

ADVISEMENT

The information contained within this eBook is not exhaustive. Rather, it is intended to provide a breadth of knowledge pertaining to the competency crisis in the United States. Recent studies suggest that legal scholars and mental health experts hold different views concerning the requisite threshold for an individual's competency to stand trial and his or her particular need for services. As such, information about evaluation procedures and treatment was provided in an effort for legal and mental health professionals to acquire a higher level of shared understanding.

*Special thanks to **Julian Victor Mendoza**, without whom this work could not have been produced.

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Competency to Stand Trial (CST): Evaluation & Assessment

What is Competency to Stand Trial?

Competency to Stand Trial (CST) is a legal determination assessing whether a defendant has the mental capacity to understand court proceedings and assist in his or her own defense. This standard, established in Dusky v. United States (1960), ensures that a defendant receives due process and can participate meaningfully in his or her trial.

To be deemed competent, a defendant must:

- Have a **factual understanding** of the legal process.
- Have a **rational understanding** of his or her case.
- Be able to **consult with his or her attorney** and assist in his or her defense.

If a defendant is found **Incompetent to Stand Trial (IST)**, legal proceedings are paused until competency is restored through treatment.

The Problem: The Growing Crisis in CST

A national competency crisis has emerged due to a sharp rise in CST evaluations and competency restoration orders. The system is overwhelmed, leading to:

Dramatic Increase in IST Cases

Driven by the failure of mental health services to meet the community need, more individuals with serious mental illness (SMI) are being criminalized for minor offenses (e.g., trespassing, loitering).

Overburdened Forensic Mental Health Systems

e.g., CST evaluations increased 273% in Los Angeles County (2010–2015), with 50,000–60,000 evaluations annually and 10,000–18,000 defendants found IST.

Severe Delays in Competency Restoration

Limited psychiatric hospital beds and forensic mental health resources result in months-long waitlists for restoration services, leaving IST defendants incarcerated without treatment.

Inhumane Jail Conditions

Many IST defendants are held in jails under harsh conditions, worsening their mental health. Some, like **Jamycheal Mitchell**, died due to prolonged detention and lack of treatment.

Legal Challenges & Violations

Cases like Trueblood v. State of Washington mandate strict timelines for restoration, yet many states fail to comply.

Racial Disparities

Black and Hispanic men are disproportionately referred for competency evaluations and are more likely to be placed in high-security forensic facilities.

COVID-19 Exacerbation

Pandemic-related backlogs worsened delays, leaving many IST defendants in legal limbo while their mental health deteriorated.

Factual vs. Rational Legal Knowledge

To be competent, a defendant must demonstrate **both factual and rational legal understanding**:

Factual Legal Knowledge

The defendant's **basic understanding** of:

- The charges against him or her.
- The roles of the judge, prosecutor, defense attorney, and jury.
- Courtroom procedures and possible legal consequences.

Rational Legal Knowledge

The ability to **apply factual knowledge** meaningfully, including:

- Making informed legal decisions (e.g., whether to accept a plea bargain).
- Understanding legal strategies and potential trial outcomes.
- Communicating effectively with an attorney.
- Engaging in self-advocacy in court.

Functional Capacities for CST

Beyond legal knowledge, **functional abilities** are crucial in CST determinations. A defendant must be able to:

Understand

Comprehend the charges, courtroom procedures, and legal roles.

Appreciate

Recognize how the legal process affects their case.

Reason

Weigh legal options and make informed decisions.

Assist Counsel

Communicate effectively with his or her attorney and contribute to legal strategy.

Make Informed Legal Decisions

Understand plea bargains and the consequences of legal choices.

Demonstrate Courtroom-Appropriate Behavior

Follow proceedings and conduct themselves properly.

If a defendant lacks these capacities due to **mental illness**, **cognitive impairment**, or **intellectual disabilities**, they are deemed **IST** and require competency restoration services. Restoration services aim to **stabilize mental illness**, **improve legal understanding**, and **enhance reasoning skills**.

The Competency Restoration Crisis

What Are Competency Restoration Services?

Competency restoration services help defendants found Incompetent to Stand Trial (IST) regain the mental capacity to participate in legal proceedings. They provide psychiatric care, legal education, and skill-building to help individuals understand court procedures and defend themselves.

The **General Interventions Used in Competency Restoration** are:

Psychotropic Medication

Used to treat psychiatric disorders (e.g., schizophrenia, bipolar disorder): Most useful for defendants displaying symptoms of psychosis (e.g., auditory hallucinations, delusions, etc.).

Legal Education

Teaches defendants about the legal system, trial process, and courtroom procedures.

Cognitive Remediation

Improves cognitive abilities such as reasoning, memory, and decision-making.

Behavioral & Social Skills Training

Helps defendants develop courtroom-appropriate behavior and communication skills.

Specialized Programs

Tailored for individuals with intellectual disabilities who require structured learning approaches.

Cognitive Remediation Programs

Designed for defendants with cognitive impairments to improve decision-making.

Educational Programs

Group therapy, mock trials, and structured legal education.

Medication-Based Treatment

Often essential for stabilizing mental illness and enabling participation in court

The Problem

Despite available services, long waitlists force IST defendants to remain incarcerated longer than they would if convicted. Some face months or years of pretrial detention awaiting restoration.

Resource Shortages

Many forensic hospitals operate at full capacity, leading to **excessive wait times**.

Lawsuits Against States

Due to **prolonged detentions**, many states face litigation for violating defendants' **due process rights**.

Recurring Defendants

Many IST individuals cycle through the system **due to lack of community mental health support**.

Types of Competency Restoration Services

There are **three main types** of competency restoration services, which differ primarily based on the setting or environment in which services are provided:

- Inpatient (Hospital-Based) Competency Restoration Services
- Jail-Based Competency Restoration Services (JBCR)
- Outpatient (Community-Based) Competency Restoration Services (OCR)

Each method has its **own benefits**, **challenges**, **costs**, and **effectiveness rates** depending on the defendant's mental health condition, legal requirements, and available resources.

Inpatient (Forensic State Hospital-Based) Competency Restoration Services

Overview

- Conducted in **state psychiatric hospitals**, **forensic mental health facilities**, or **secure psychiatric units**.
- Designed for **severe mental illness cases** (e.g., psychosis, significant cognitive impairment).
- Provides **24/7 psychiatric care**, including medication management, therapy, cognitive remediation, and structured legal education.

Effectiveness & Duration

- The **most effective method**, with an 81% success rate on average.
- Average length of stay: **90–120 days**.
- Example:
  - **Ohio's program** reports an 80–90% success rate with an average stay of 80 days.
  - **Median stay** in **New Mexico** is 147 days, but wait times can exceed 500 days.

Cost & Challenges

- The **most expensive** option:
- $603–$1,000 per day, averaging $401–$834/day in hospitals.
- **Limited bed availability** causes **long waitlists**, delaying treatment and trials.
  - **Some defendants do not require this level of care** but are placed in hospitals due to a lack of alternatives.

It is **best suited** for high-risk defendants with **severe psychiatric conditions**, but **extremely costly**, **resource-limited**, and plagued by **long wait times**.

Jail-Based Competency Restoration Services (JBCR)

Overview

- Conducted within **correctional facilities** as an alternative to inpatient care.
- Provides **mental health treatment** and **legal education** while individuals **remain in jail**.
- Used in **at least 9 states**, including Texas, Arizona, Florida, Colorado (RISE Program), Georgia (EMORY University at Fulton County Jail and the RISE Program at Marietta Adult Detention Center), and California (ROC Program).

Effectiveness & Duration

- **Success rates vary widely**, 44%–87% depending on the program.
- Average treatment duration: **57–120 days**.
- Examples:
  - **Virginia ROC program**: 83% success rate, 77-day stay.
  - **Arizona ROC program**: 84–86.7% success rate, 82.5–120 days.
  - **California ROC program**: 55–58% success rate, 57.4-day stay.
  - **Fulton County Jail-Based Program (GA)**: 40% success rate but significant cost savings.

Cost & Challenges

- **More cost-effective** than inpatient care:
  - $42–$222 per day vs. $401–$834 per day in hospitals.
- **Jails are not therapeutic environments**, often worsening psychiatric conditions.
- **Lack of adequate mental health resources** in many correctional settings.
- **Raises ethical concerns** about treating mental illness in punitive environments.

Outpatient (Community-Based) Competency Restoration Services (OCR)

Overview

- Defendants receive treatment **while living in the community**, **at home**, or **in supervised housing**.
- Includes **therapy**, **medication management**, **legal education**, and **case management**.
- Used in **at least 16 states** (as of 2016), including California, Texas, Florida, Ohio, and Wisconsin.
- Preferred for **low-risk defendants with mild to moderate mental illness or intellectual disabilities**.

Effectiveness & Duration

- **Comparable restoration rates** to inpatient care.
- Average treatment duration: about **280 days** (longer than inpatient or jail-based programs).
- Examples:
  - **Texas OCRPs**: 62–94% success rate.
  - **Louisiana**: 54% success rate.
  - **Hawaii** (structured community support model): 95% success rate.
  - **Tennessee** prioritizes outpatient restoration due to **cost and resource limitations**.

Cost & Challenges

- The **most cost-effective** option:
  - $215 per day vs. $603 per day for inpatient care.
  - Savings of up to $400 per day per defendant.
- **Reduces pressure** on forensic hospitals and jails.
- Requires **strong community mental health infrastructure**, **stable housing**, and **consistent access to treatment**.
- Effectiveness depends on **defendant compliance** and **strict supervision**.

Key Takeaways

- **Inpatient restoration** is the most intensive and effective, but high costs and bed shortages create severe waitlist issues.
- **Jail-based restoration** helps reduce hospital demand but raises ethical concerns due to inadequate mental health environments.
- **Outpatient restoration** is the most cost-effective and humane, but requires strong infrastructure and is less effective for severe cases.

Each model plays a **crucial role** in addressing the **backlog of IST defendants**, but **systemic challenges**—limited resources, high costs, and ethical concerns—**continue to impact** overall effectiveness. The choice of method depends on the **severity of the defendant's condition**, **available resources**, and **legal considerations**.

Conclusion: The Urgent Need for Reform

The **CST system is overwhelmed**, with rising IST cases, severe delays, and insufficient mental health resources. Without major reforms, the **cycle of re-arrest**, **hospitalization**, and **prolonged detention** will continue.

Key Reforms Needed

- ☑ **Expand community-based mental health services** to reduce IST cases.
- ☑ **Reduce unnecessary CST referrals** by improving mental health diversion programs.
- ☑ **Increase forensic hospital capacity** and **fund outpatient restoration programs**.
- ☑ **Implement standardized competency assessments** to ensure consistency in evaluations.
- ☑ **Improve legal-mental health collaboration** to ensure fair, efficient, and humane CST determinations.

Failure to address these issues will continue to **violate due process rights**, **exacerbate mass incarceration**, and **deny justice** to both defendants and victims.

Court stakeholders, to include attorneys, judges, and lawmakers, are urged to **seek consultation** from **forensic experts** like Dr. Lewis to **develop real-world, practical solutions** for issues pertaining to mental health and the law.

Model for Diversion – Using the Sequential Intercept Model as a Framework

Current Challenges in CST Evaluation and Restoration

- There is a **high demand for CST evaluations and restoration services**, which has led to significant backlogs in many states.
- **State hospitals** are the primary providers of these services, causing long waitlists and delays.
- Many defendants, even those charged with low-level offenses (such as Theon Jackson in Jackson v. Indiana, 1972), become **stuck in this system**.
- The **Jackson v. Indiana ruling** states that defendants cannot be confined indefinitely if they are **unlikely to be restored**, yet many states vary in their compliance with this standard.
- Individuals found **incompetent to stand trial (IST)** are often **sent to state hospitals** for restoration, making this a major function of forensic psychiatric facilities.

Fragmented Systems and Misconceptions

Local courts are typically responsible for initiating CST evaluations, while **state mental health systems** control the necessary treatment resources, resulting in a fragmented process.

Restoration is often **misunderstood** as a **form of mental health treatment**, when in reality, it focuses narrowly on **restoring legal competence** rather than addressing broader psychological or social needs.

Misalignment Between the Competence System and the Treatment System

Restoration most often takes place in **locked hospital units** and **emphasizes legal readiness over comprehensive or long-term care**.

Many legal and clinical professionals assume that CST restoration provides sufficient care and safety, but it often **disconnects individuals from broader community treatment networks**.

Prosecutors may **pursue CST restoration to justify detention** for treatment or public safety reasons, while defense attorneys may support it to **preserve the defendant's legal rights** during trial proceedings.

Systemic Gaps, Legal Risks, and a Strategic Framework for Reform

- CST restoration services often **overlook critical clinical and social needs** such as housing, substance use treatment, and employment support.
- **Many defendants miss diversion opportunities** and are **returned to jail post-restoration without reentry planning**, increasing the risk of recidivism and repeated CST involvement.
- Community-based restoration programs exist in some states but **remain rare**, **unstandardized**, and **not legally required**.
- **Rising CST demand** has led to **litigation over excessive wait times** and **inhumane conditions**, including preventable deaths in custody.
- **Some legal settlements** have prompted **reduced delays** and **expanded service access**.
- Advocates argue that **ADA protections should offer accommodations as alternatives to CST**, though this **remains largely untested**.

The Sequential Intercept Model (SIM)

- **The Sequential Intercept Model (SIM)** is proposed as a tool to **identify diversion points** within the legal process.
- **SIM encourages limiting CST restoration** to those likely to face trial and creating alternatives for low-risk or minor cases.
- This approach aims to **reduce jail time**, **ensure timely treatment**, and **minimize unnecessary forensic involvement**.
- The CST system often **prioritizes legal process over individual needs**, particularly for people with serious mental illness or cognitive disabilities.
- SIM offers a **pathway** toward more **clinically appropriate, rights-based responses**.

The Sequential Intercept Model (SIM) outlines **various points** in the criminal justice process where individuals can be diverted from the traditional forensic system to more appropriate treatments:

- **Intercepts 0 & 1**: Community and Law Enforcement Contact
- **Intercepts 2 & 3**: Court and Jail Entry
- **Intercepts 4 & 5**: Reentry and Community Supervision

Intercept Breakdown Summary

Intercepts 0 & 1: Community and Law Enforcement Contact

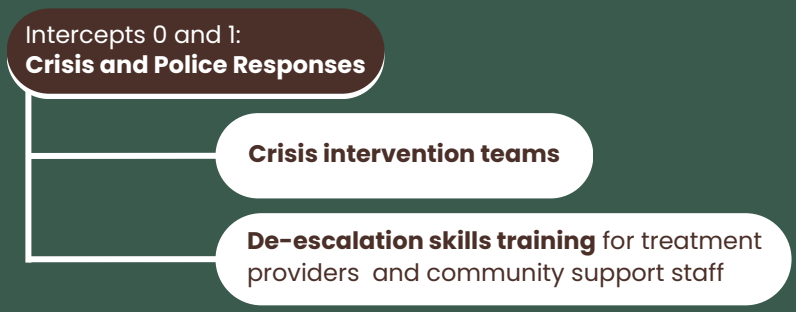
- **Early intervention** and **crisis response** are **critical** at this stage.
- Strategies should include **cross-agency collaboration** (e.g., between 911 operators, crisis response teams, and law enforcement), **increased availability of alternatives to arrest**, and **expanded access to mobile crisis units and stabilization centers**.

Intercepts 2 & 3: Court and Jail Entry

- This is often where **CST concerns are first formally raised**.
- Courts should promote **pretrial release with appropriate support**, ensure **rapid access to competency evaluations**, and strengthen **connections to community-based mental health services**.
- Specialized CST courts, training for legal professionals, and a shift in focus from legal trivia to functional capacity and holistic support are all encouraged.

Intercepts 4 & 5: Reentry and Community Supervision

- **Reentry** should prioritize **continuity of care** and **prevention of re-involvement** in the CST system.
- Tools such as **specialized probation programs**, **coordinated care plans across jail**, **hospital, and community providers**, and **consistent access to medication and support services** are essential.
- For those deemed permanently IST, options like **civil commitment** or **case dismissal** should be available



Intercepts 2 and 3:
First Court Appearance, Jail Stays, and Specialty Courts

- **Training for forensic evaluators** on alternatives to inpatient restoration
- Pathways to **acute psychiatric units**
- Linkage to **specialized pretrial services**
- Linkage to **services for unique populations** (such as those with intellectual and developmental disabilities, traumatic brain injury, neuro-cognitive challenges)
- **Competence to stand trial dockets**
- **Expansion of community-based restoration options**
- **Cross-system training** to shift from automatic responses based on older systems
- Reexamination of **restorability predictions**
- **Collaborations for improved continuity of care and treatment of mental illness** across settings

Intercepts 4 and 5:
Jails, Re-entry, and Community Services

- Enhanced **community release planning**
- Attention to **improving conditions of confinement**
- **Boundary spanner outreach**
- Linkage to **wrap around supports through outreach to state hospitals and jails**
- Provision of **aftercare case management** and coordination with **treatment system**

Conceptual Shift Encouraged

- The CST process **should not be treated as a simple pass/fail assessment**.
- Instead, it should be viewed as an **opportunity to evaluate an individual's broader functional needs** and the **kinds of support that could improve long-term outcomes**.
- The goal of restoration should not be limited to enabling trial participation—it should also **aim to contribute to lasting health and community integration**.

Legal and Ethical Considerations

- The **current CST framework** must **uphold constitutional protections**, such as those established in **Jackson v. Indiana**, while also **addressing inequities** in how IST individuals are treated compared to others with similar conditions.
- The article by Pinals & Callahan (2020) **encourages new legal strategies**, including those grounded in the ADA, and broader policy reforms to better protect the rights and needs of vulnerable populations.

Implementation Strategies

- **SIM Mapping** is presented as a practical tool to **identify weaknesses in the current CST system**.
- This approach can **promote better cross-agency collaboration** and **support the development of actionable, locally informed diversion plans** that prioritize care, equity, and efficiency.

Expert Commentary

In large part, the competency crisis can be linked to *deinstitutionalization*. Deinstitutionalization began around the late 1950s as a movement to shutter large psychiatric hospitals and shift mental health care to community-based settings. While arguably well-intentioned, the lack of adequate funding and support services left many individuals with serious mental illnesses without access to proper care. Consequently, a subset of those individuals ended up unhoused or justice involved due to untreated psychiatric symptoms. Jails and prisons, still unequipped to provide comprehensive mental health treatment, became de facto psychiatric institutions. This shift has contributed to the overrepresentation of mentally ill persons in correctional facilities across the United States.

The *sequential intercept model*, albeit a fine paradigm for case management and diversion for justice-involved persons with serious mental illness, may be viewed as aspirational for many jurisdictions. Notwithstanding, it is vital that case management, diversion, and multiple modes for competency restoration treatment are available. The institution of such intervention methods will require educating legal professionals and other stakeholders about jurisdiction-specific problems, conducting a jurisdiction-specific needs assessment, and reimagining jurisdictional practices with the assistance of a consultant.

On a smaller scale, existing services within a particular jurisdiction may be improved with comprehensive staff/professional development. Often case expeditors, mitigation specialists, and other stakeholders do not fully grasp the totality of the issues at hand—the respective roles tend to view case details through their own lens or fail to weigh the factors of the case in a way that brings about a comprehensive yet swift resolution. As an example, I have conducted meetings with court personnel who managed cases involving justice-involved juveniles opined incompetent to stand trial (IST) and were unaware of the potential difference in treatment needs for IST juveniles with status offense(s) versus those with delinquent (or criminal) offense(s). Why does the failure of understanding that distinction present a problem? If resources are already limited, should a juvenile undergo competency remediation for truancy? The aforementioned professionals, who collaborate frequently with attorneys and judges, tend to aid in dispositional planning, and increasing their knowledge could improve efficiency. Similar challenges may be observed in the criminal justice system.

Should a person with a known (well documented) history of serious mental illness and housing instability undergo competency restoration for an offense like criminal trespassing or other low-level misdemeanors? Could diversion (and case management) or a mental health court better serve that individual? ***To address the myriad of problems emerging from the competency crisis, jurisdictions must be open to change and growth, and ongoing consultancy with a forensic (mental health) expert will be necessary to bring about productive changes.***

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