Resolution or Resignation: The Role of Forensic Mental Health Professionals Amidst the Competency Services Crisis

Competency-related cases often occur in under-resourced, over-taxied systems of evaluation and care, despite the efforts of dedicated personnel found working in those systems. Forensic psychologists may have difficulty adhering to overarching ethical principles if our work occurs unabated in the midst of the inhumane conditions that often surround competency-related services (e.g., long waits for evaluation and/or restoration, poor jail conditions, limited mental health and crisis services). How should forensic professionals seek to resolve this challenge, if at all?

Despite excellent research on competency-related evaluation and treatment, very little consideration has been given to the broader implications of our competency-related work and the systems in which we operate. In short, we have emphasized doing “good” work, but not necessarily “just” work. The good work is critically important, yet the consideration of how that good work interfaces with the broader system that surrounds it is also increasingly important. These concerns have been raised before (Poythress, Otto, & Heilbrun, 1991; Wortzel, Binswanger, Martinez, Filley, & Anderson, 2007), but few have heeded the alarm; unfortunately, circumstances have only worsened with time.

Increasing Demand for CST Evaluations and Restoration

Courts order an estimated 25,634 to 51,500 competency to stand trial (CST) evaluations each year nationally, varying from fewer than 50 to approximately 5,000 per year in individual states (Warren, Chuahan, Kois, Dibble, & Knighton, 2013; Fitch, 2014). Moreover, most states have reported significant increases in CST evaluation referrals over the past several years, with many states doubling or even tripling recent rates (Colorado Department of Human Services, 2015; State of Washington Joint Legislative and Audit Review Committee (JLARC), 2014; Sewall, 2016). Roughly 20–40% of those referred for CST evaluations are found incompetent and ordered into competence-restoration services (Murrie & Zelle, 2015; Pirelli, Gottdeiner, & Zapf, 2011). Consequently, as the number of CST evaluations increases, so too does the need for restoration services. The overall percentage of forensic admissions for all state hospital patients increased from 7.6% in 1983 to 36% in 2012 to approximately 58% in 2014, with restoration cases comprising the largest proportion of forensic patients (Parks & Radke, 2014; Wik,

*abridged for the AP-LS newsletter*
Hollen & Fisher, 2017). Causes for the increase in these CST-related referrals are multi-faceted but likely stem from some combination of failing community mental health resources, increased identification of mental health cases by the judiciary, and attempts by court personnel to pry open limited resources to individuals presenting with mental health issues.

However, many states are struggling to meet the demand caused by the exponential increase in competency-related services. This has often led to long waitlists for the evaluations to be completed. Some states have reported waitlists of more than one year for pretrial evaluations to be conducted, while many states remain under some sort of oversight from federal or state agencies to ensure that evaluation wait times are reasonable (Gowensmith, Murrie, & Packer, 2015; Locklair, 2016). Various judicial actions have been implemented in many states regarding the reduction of these waitlists, including Arkansas, Louisiana, Colorado, Washington, Alabama, Oregon, Hawaii, and Pennsylvania (among others)—while several others (e.g., Texas, Utah, Washington, D.C., Vermont, Maine) are actively attempting to fend them off (Locklair, 2016). These lawsuits center around the potential for harm experienced by persons awaiting CST services, but these long waitlists have other negative systemic consequences—overcrowded county jails, inadequate staffing ratios, and ballooning financial costs.

It can be argued that the avalanche of referrals for CST evaluations and subsequent orders for CST restoration represents the largest current crisis facing the public forensic mental health system. Attempted solutions have been met with varying levels of success, with most still awaiting rigorous empirical investigation to determine effectiveness. Some of the most popular are critiqued here, followed by brief recommendations for policy and practice.

**Potential Solutions**

**Reducing the time frame for CST evaluations.** One simple solution to waitlists for CST evaluations is to reduce the time it takes to complete them. Several options exist in this framework.

- **Screens or checklists in lieu of comprehensive initial CST evaluations.** While most scholars maintain that simple competency checklists are at high risk for poor reliability, validity, and admissibility (Grisso, 2003; Melton, Petrila, Poythress, & Slobogin, 2007; Skeem & Golding, 1998; Zapf & Roesch, 2009), the use of competency screens may have more practical application. A handful of jurisdictions utilize an abbreviated CST screening process. In these cases, defendants are typically screened within a short period of time (within 5 days in Washington, D.C., for example); those who are identified as likely to be incompetent to stand trial (IST) are referred for a thorough evaluation. The use of a screening procedure in these contexts has promise, as screens are not used as a proxy for a comprehensive evaluation.
• **Reducing the turnaround time for evaluations.** A handful of preliminary data suggests that the timing of CST evaluations may be critical: conducting evaluations too soon (within 15 days, perhaps) may correlate with artificially inflated IST rates (Bryson et al., 2018; Gowensmith, Metroz, & Bratcher, 2016b; *Trueblood v. Wash. State Dep’t of Soc. & Health Serv.,* 2015). IST rates appear to be highest within 15 days of the court order for evaluation, with those rates falling as time increases. Although more comprehensive data is needed, these early results indicate that more time before the initial CST evaluation may be needed to distinguish genuine incompetence from drug intoxication or temporarily untreated psychosis. Simply requiring evaluators to provide CST opinions within 1–2 weeks may reduce wait times for evaluations, but may come at a cost of lower reliability and validity of the resultant opinions.

• **Use of a triage system or court-based clinicians.** Several states, such as Colorado, Hawaii, Louisiana, Massachusetts, Ohio, Oregon, and Washington, D.C., employ court-based clinicians and/or triage systems to identify and prioritize the most acutely ill for evaluation and treatment. In a triage-informed system, selected defendants are prioritized for CST evaluation; CST evaluators later identify and prioritize the most acutely ill defendants for hospital-level care for restoration. Restoration services can also utilize a triage system to “fast track” defendants who are likely to respond quickly to restoration efforts and schedule re-evaluations of CST more nimbly.

**Expanding the pool of qualified CST evaluators.** An increasing number of states are expanding the pool of qualified CST evaluators to meet rising demands (Gowensmith, Pinals, & Karas, 2015). In 2006, seven states authorized disciplines other than psychology and psychiatry to conduct CST evaluations; in 2015, the number was 17 (Frost, de Camara, & Earl, 2006; Gowensmith et al., 2015). However, most professionals are unequipped to complete CST evaluations without substantial focused training efforts. While psychology and psychiatry have decades’ worth of infrastructure devoted to forensic training and standards, most other mental health disciplines do not. Moreover, only half of the states in the United States have formal forensic training and certification programs. States that simply make other disciplines eligible for competency-related work, without requiring high training and practice standards for those interested, run the risk providing subpar evaluations and restoration services.

**Alternatives to inpatient competency restoration.** A potential “release valve” for state hospital census pressure is community-based competency restoration treatment (CBRT). A recent study (Gowensmith, Frost, Speelman, & Therson, 2016) found that a total of 16 states employed formal CBRT, with most programs originating within the previous ten years. Programs tend to serve adults with serious mental illness facing low-level charges, and services range from standalone competency restoration classes to a broader array of psychosocial services. Programs showed substantial differences among each other in
terms of operations, staffing, structure, and eligibility. Despite the variability across programs, results were promising (Gowensmith et al., 2016). While CBRT data may show lower restoration rates and longer lengths of stay than analogous inpatient outcomes, most jurisdictions understand that CBRT often works with more chronic populations (e.g., intellectually disabled, head injured, demented, intractably mentally ill) than inpatient populations. Given the overall lack of negative incidences (e.g., revocations, terminations, and arrests), the financial gains, and the reduction of inpatient waitlists, most systems are willing to welcome this tradeoff. In addition, jail-based competency treatment is in its infancy but shows some preliminary promise when populations are carefully chosen and programs employ high staff-to-patient ratios; however, more research is needed in this area.

**Other solutions.** Additional attempted solutions have shown success, including increased coordination and collaboration between mental health and criminal justice systems, the proliferation of sound pre-arrest diversion efforts, statutory change to de-incentivize competency-related services (i.e., reducing or eliminating need for CST services for low-level charges), and the re-acquisition of inpatient hospital beds. Each of these seems to play an important systemic role in reducing waitlists for competency services.

**Policy and Practice Recommendations**

A summary of emerging public policy recommendations is provided here. This is neither an exhaustive nor a definitive list; it simply serves as a summary of policy recommendations that have a foundation in empiricism and emerging promising practices. It should also be noted that jurisdictions across the country can vary tremendously. Individual jurisdictions and systems should carefully tailor any policy initiatives to their unique populations and systems of criminal justice and mental health provision.

- **Triage systems** can be useful in the early identification and prioritization of competency evaluations and referrals for restoration to those with the most acute clinical and safety needs. Where adequate judicial infrastructure and collateral information exist, competency screens should be used to prompt comprehensive CST evaluations.

- **Court-based clinicians or clinics** can help court personnel discriminate legitimate competency-related issues from those defendants with confounding issues (substance abuse, malingering, etc.). These clinicians and clinics can also serve as liaisons between courtrooms, inpatient settings, and community mental health services to streamline placements and facilitate inter-agency communication.

- **Competency dockets or calendars** in judicial districts can serve as an important mechanism to consolidate competency-related cases into one courtroom. This allows for competency cases to be heard by knowledgeable and consistently-present court personnel, and it allows for cases to be heard more quickly and responsively.
• **Training, certification, and ongoing maintenance** of CST evaluation expertise should be implemented in states where it does not currently exist. High standards should be delineated and required for all evaluators, regardless of discipline. Additionally, forensic professionals should seek opportunities for dedicated, specialized training in forensic evaluation and/or treatment.

• **Community-based restoration treatment** (CBRT) should receive consideration as one component of states’ array of competency restoration alternatives. CBRT programs that include enhanced psychosocial resources seem to show the most optimal outcomes. Until more research is conducted, jail-based restoration should be primarily considered as a specialized adjunctive service, not as a default or primary setting for restoration.

• **Aside from exceptional cases, competency evaluations should not be completed within 15 days from the court order until more empirical research is available.** Emerging research indicates that this short period of time produces an artificially high number of IST opinions, especially in defendants with psychotic and substance-related disorders. Additionally, restoration personnel should carefully monitor defendants adjudicated as IST within the first 15 days of the court order to identify and fast-track defendants who may have erroneously been opined as IST.

• **Early diversion efforts**, such as pre- and post-booking diversion, should be assertively enhanced as a primary mechanism for addressing the competency crisis. Also, local laws and state statutes can be amended to restrict competency services (e.g., competency restoration) to particular populations of offenders (felony offenders, violent offenders, etc.).

• **Professional organizations** (e.g., American Psychology-Law Society, American Academy of Psychiatry and Law) should create and support task forces to spearhead research and policy development related to competency services. Dedicated funding for applied and policy-level research could encourage empirical attention. Position papers and/or white papers should be considered, and outreach with partner organizations (e.g., American Bar Association, National Judicial College) could help promote uniform creation and dissemination of sound, sensible policy proposals.

• **Differential pay** may improve recruitment and retention of high-quality evaluators and restoration providers, which may in turn lessen avoidable financial costs associated with low-quality evaluations, poorly-formed CST opinions, or ineffective restoration interventions.

• **Forensic evaluators and restoration professionals should maintain a database of their evaluation opinions, restoration outcomes, and related demographic variables.** Some demographic variables have been shown to influence IST opinion rates (Gowensmith, Smith, Yeager, & Meyer, 2018; Kois, Pearson, Chauhan, Goni, & Saraydarian, 2013; McCallum,
• MacLean, & Gowensmith, 2015; Parker, 2016). It could be informative to one’s practice to compare one’s own base rates to those found in the literature. Significant discrepancies could highlight areas for further investigation.

• **Forensic professionals should consider advocating for policy change** where relevant and appropriate. However, advocacy should be firewalled from professional duties. Evaluation reports, forensic opinions, and forensic treatment should not be influenced by one’s advocacy efforts.

**Moving Forward**

The United States is facing a “competency crisis.” Referrals for CST evaluations, and subsequent orders for CST restoration, are far outpacing capacity. This has led to untold numbers of defendants with mental illnesses languishing in jail cells, waiting for either delayed evaluations or—even worse—delayed transfers to mental health settings. Consequently, competency-related lawsuits are increasingly common in the United States (Locklair, 2016).

Forensic professionals should be at the forefront of recommendations for change. The ethical code and guidelines of both the American Psychological Association (APA; 2017) and the American Psychology-Law Society (APA, 2013) emphasize the concept of non-maleficence: in short, to avoid harm to the people and agencies with whom we work. Forensic professionals must therefore be both wary and vocal about legislative changes that promise short-term fixes at the expense of quality and accuracy. CST evaluations have serious consequences on a defendant’s life course—his or her access to mental health care, ability to adequately exercise constitutional rights of defendants in the courtroom, and access to basic civil liberties. We must lead these discussions by actively addressing unjust systems of care, long waitlists, and poor short-term solutions with empirically-based information and solutions rooted in best practices. Forensic professionals play a critical role in ensuring that the entire CST process operates justly and humanely. Further exploration of the ideas summarized in this column are contained in Gowensmith (2019).
References


Locklair, B. (March, 2016). *Due process problems with civil commitment of incompetent defendants: The current round of litigation and the next.* Paper presented at the meeting of the American Psychology–Law Society Annual, Atlanta, GA.


