Closing the “Gap” Between Competency and Commitment in Minnesota: Ideas from National Standards and Practices in Other States

A Report by the Robina Institute of Criminal Law and Criminal Justice
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By

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Executive Summary

In Minnesota, a “gap” exists in the justice system for defendants with mental illness. Defendants in criminal cases are found incompetent to stand trial, yet do not meet the higher standard for civil commitment. Commitment is the only way to receive competency restoration treatment, so individuals who do not meet the standard are unable to resolve their criminal cases or to receive treatment. The Robina Institute conducted research to see how other states address incompetency. Below are the key findings from that research:

1. Minnesota’s system, in which a determination of incompetency to stand trial is not a sufficient basis for the court to mandate some form of restoration to competency treatment, is unique. Most states employ a few basic strategies to treat defendants. A finding of incompetency may trigger:
   - Some form of commitment (often based on the incompetency finding and not on a separate commitment standard);
   - Court-ordered inpatient or outpatient treatment; and/or
   - Pre-trial release during which treatment is a condition of release.

2. States that have not found adequate treatment alternatives but require judges to order treatment often experience an overflow of mentally ill defendants waiting in limbo for a bed after treatment is ordered; many await treatment in jails.

3. Defendant rights are an important consideration in writing a law that closes the “gap.” Minnesota’s current system holds the individual rights of mentally ill defendants in high regard and does not simply confine them for being incompetent to stand trial as many other states do.

4. A handful of jurisdictions that have streamlined the commitment process or created other legal mechanisms to close the gap have also taken steps to ensure treatment for defendants in the least-restrictive setting. However, the “least restrictive setting” language loses meaning where no alternatives to inpatient treatment exist (similar to civil commitment in Minnesota, which can only be to a secure hospital setting).

5. In some states, “treatability” is a key consideration in determining the appropriate action upon a finding of incompetency. Untreatable defendants may face civil commitment or release but they are not offered treatment resources.

6. Thirty-one states operate formal and informal outpatient competency restoration treatment programs. Meanwhile, several different states have begun to utilize jail-based treatment to competency. However, such a program may not satisfy Minnesota’s due process requirements.

Solutions to address the “competency gap” in Minnesota should focus on several areas:

- Consider whether to preserve the current legal standard for commitment, lower the standard for this type of commitment, and/or to design an alternative legal mechanism (such as pre-trial conditional release or a court order) for the purposes of competency treatment. Any proposal for change should take into account the capacity of the system and consideration of the state’s commitment to the rights of defendants.
- Work to develop less restrictive forms of treatment than exist in a maximum-security hospital. Community-based outpatient care may meet the needs of many low-to-medium risk defendants.
- Ensure that the treatment delivered is high quality and truly addresses the competency needs of the criminal defendant.
- Work to improve the mental health infrastructure in general to make it easier to access care before a crime can take place and to offer an alternative to defendants whose cases are dismissed but who still need treatment.
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Introduction

In January 2016, the Robina Institute of Criminal Law and Criminal Justice held a conference entitled Criminal Justice and Mental Illness: Creating Alternatives in Minnesota, which addressed the intersection of criminal justice and mental health. Recognizing that increasing numbers of justice-involved individuals suffer from mental illness, the conference aimed to highlight recent creative and intelligent responses to the issue and to provide opportunities for communication and sharing across agencies and among criminal justice practitioners. At the close of the conference, we asked attendees to identify further work that the Robina Institute could undertake to contribute to the development of solutions. One task identified was research on the “competency gap.”

In Minnesota, if the court deems a person incompetent to stand trial, the person must go through a separate civil commitment process to determine whether that person can be placed in treatment intended to restore competency. However, it is much more difficult to meet commitment criteria in the second process, and many incompetent individuals do not qualify for commitment. The court must then determine whether to dismiss the criminal case or whether to place the case on hold in the hopes that the individual will somehow be restored to competency with the passage of time. This is commonly referred to as the “gap” between competency and commitment. In March 2016, Minnesota’s Legislative Auditor published a report entitled Mental Health Services in County Jails that raised several concerns about the inability of the Minnesota system to provide adequate care to individuals found to be incompetent to stand trial.

The competency gap was also poignantly addressed in a July 2015 article titled “The Uncommittables: How Offenders with Mental Illnesses Fall through the Cracks of Minnesota’s Criminal Justice System.” In particular, the article chronicled the struggle of one mentally ill Minnesota defendant, Jack Harvey McClellan. As the reporter wrote, McClellan “doesn’t meet the court’s competency standard to face criminal charges, but he also doesn’t meet the standard for civil commitment: court-ordered, involuntary mental health treatment administered by the state. So he falls through the gap.” Further, the reporter noted, “In Hennepin County, “gap” is a conservative euphemism. Last year, more than half of those deemed incompetent to face charges were also uncommittable.” By falling through the gap, individuals like Mr. McClellan often end up back in the system repeatedly.

Building upon the Criminal Justice and Mental Illness conference and the Legislative Auditor’s report, in June 2016, the Robina Institute hosted a Practitioners’ Roundtable that specifically addressed competency to stand trial. Twenty-two stakeholders met to examine the problems that exist in Minnesota’s current competency system, recommend changes to that system, and discuss the Legislative Auditor’s findings. The group spent much time conversing about the increase in the number of competency evaluations, mental illness in the jail population, and the gap between the criminal incompetency determination and civil commitment. The meeting led to the production of a report entitled Competency in Minnesota: A Practitioner’s Roundtable, which explored potential solutions to address the deficits in the current system. However, attendees were interested in learning more about whether the competency gap exists in other states and if so, how it has been addressed. The Robina Institute therefore committed to research the laws and practices in other states.

As our research revealed, Minnesota is not alone—no state justice system may violate constitutional rights by forcing an incompetent defendant to stand trial. All must cope with the issue of what to do after a court finds a defendant unfit (as well as resolve the many other problems with mental illness in the nation’s justice system that are beyond the scope of this report). However, as this report will show, other states have embraced a number of different strategies to resolve the particular dilemmas raised by a defendant’s lack of fitness. Many states have commitment or conditional release options that make treatment to competency more attainable; however, some of those states may make it too easy to commit an incompetent defendant. Further, some states that have closed the gap between competency and commitment now face new issues stemming from their approach.
This report will examine each phase of the competency and commitment process in the hopes of offering a better understanding of the options available to close the “gap,” provide key services to mentally ill community members, and move forward.

Section I. Background: Competency and Civil Commitment in Minnesota

Step 1: Competency Motion. In Minnesota, the prosecutor, defense counsel, or the court may raise the issue of competency at any time, with or without the defendant’s consent. Competency motions have become much more commonplace in recent years; this alone has exacerbated the effects of problems with the Minnesota system’s design. In 2010, there were 844 criminal cases in which competency was at issue, but the number has steadily increased; in 2015, there were 1,657.

Step 2: Competency Evaluation. After one of the parties makes a motion, the judge must determine whether there is a reason to doubt the defendant’s competency. In a Minnesota felony or gross misdemeanor case, the court must also determine probable cause with regard to the criminal charges; if the court finds probable cause and reason to doubt a defendant’s competency, it must suspend the case and order a mental examination. These evaluations take place at the county’s expense; while Hennepin County uses its own employees to conduct them, other counties must contract for these services.

Competency evaluation can occur in an outpatient setting if a defendant is entitled to release; however, the court may make appearance for the examination a condition of that release. The evaluation process for those who are not released must take place in a “state hospital or other suitable facility,” which can include a jail. Confinement related to competency examination may not exceed 60 days. Sheriffs voiced a concern about how long Minnesota defendants evaluated in jail wait for a competency determination; especially given that “confinement and isolation of jail can be especially challenging for people with mental illness and may sometimes worsen mental health symptoms. Inmates with mental illness may also be vulnerable to victimization in jail.” While Minnesota has an outpatient option that works for some defendants, the remainder stay behind bars during evaluation.

Due to many of these concerns, the National Judicial College has recommended that these evaluations take place in the “least restrictive environment for the level of risk the offender presents.” It also recommends that the examination be swift (generally within 15 days for a misdemeanor or 21-30 days for a felony) to avoid the defendant “languishing in jail” and to protect constitutional rights to a speedy trial. By instituting some outpatient evaluation, it appears that Minnesota has conformed to one of the best practices in this area; however, there may still be room for improvement on the length of the process and the number of defendants released to outpatient evaluation.
Step 3: A Finding of Incompetence

The examiner’s report delivered to the court after a competency evaluation should include:

1) A diagnosis of the defendant’s mental condition.
2) If the defendant is mentally ill, an opinion as to:
   (a) The defendant’s ability to understand the criminal proceedings and participate in their own defense;
   (b) Whether the defendant presents an imminent risk of serious danger to another, is imminently suicidal, or otherwise needs emergency intervention;
   (c) Any treatment required for the defendant to attain or maintain competence and an explanation of appropriate treatment alternatives by order of preference, including the extent to which the defendant can be treated without commitment to an institution and the reasons for rejecting such treatment if institutionalization is recommended;
   (d) Whether a substantial probability exists that the defendant will ever attain competency to proceed;
   (e) The estimated time required to attain competency to proceed; and
   (f) The availability of acceptable treatment programs in the geographic area including the provider and type of treatment.
3) The factual basis for the diagnosis and opinions.12

An individual is incompetent if the court finds that a defendant is unable to “(a) rationally consult with counsel; or (b) understand the proceedings or participate in the defense due to mental illness or deficiency.”13 This finding must be made “by the greater weight of evidence” derived from the examiner’s report and any other source.14 If the court finds a defendant competent, it will resume criminal proceedings; if not, the proceedings will remain suspended.15 However, as will be discussed below, the finding of incompetence is often a dead-end that can result in nothing more than the suspension or dismissal of a case.

The court must dismiss a felony case (that is not murder) within three years after a finding of incompetency to proceed unless the prosecutor files written notice of intent to prosecute when the defendant regains competency. The court must dismiss a gross misdemeanor case 30 days after a finding of incompetency to proceed unless the prosecutor files a similar written notice of intent to prosecute. Even if the prosecutor files a notice, the court must dismiss a gross misdemeanor case when the defendant would be entitled under Minnesota rules of criminal procedure to custody credit of at least one year if convicted.16

In any misdemeanor case, the court also has discretion regardless of probable cause to begin civil commitment proceedings or, alternatively, to dismiss the criminal charges.17 Dismissal may create a second “gap” in the system for misdemeanants; they may never receive evaluation or treatment based on their case. On the other hand, this policy allocates scarce resources towards more serious offenses. It appears that the approach of differentiating between felony and misdemeanor cases at this phase in competency proceedings is rare, if not unique to Minnesota.

Finally, note that part of the initial evaluation process focuses on whether or not professionals can treat a defendant to competency in the first place. However, in Minnesota, nothing prevents civil commitment from occurring in a case where an examiner declares that someone will ultimately be untreatable.
Step 4: Civil Commitment Proceedings and the “Gap”

A finding of incompetence triggers civil commitment proceedings, intended for the purposes of treatment. However, civil commitment can only occur if a defendant either voluntarily enters commitment or meets a much higher standard as a “person who is mentally ill”:

Person who is mentally ill. (a) A “person who is mentally ill” means any person who has an organic disorder of the brain or a substantial psychiatric disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality, or to reason or understand, which is manifested by instances of grossly disturbed behavior or faulty perceptions and poses a substantial likelihood of physical harm to self or others as demonstrated by:

1. A failure to obtain necessary food, clothing, shelter, or medical care as a result of the impairment;
2. An inability for reasons other than indigence to obtain necessary food, clothing, shelter, or medical care as a result of the impairment and it is more probable than not that the person will suffer substantial harm, significant psychiatric deterioration or debilitation, or serious illness, unless appropriate treatment and services are provided;
3. A recent attempt or threat to physically harm self or others; or
4. Recent and volitional conduct involving significant damage to substantial property.18

As mentioned above, incompetency to stand trial means that a defendant, by the greater weight of the evidence, cannot “(a) rationally consult with counsel; or (b) understand the proceedings or participate in the defense due to mental illness or deficiency.”19 Many defendants have difficulty with important aspects of a criminal case, but do not meet the commitment criteria. For example, some defendants who cannot understand the proceedings may be able to care for themselves and are not at risk of self-neglect. Some other defendants, despite having mental barriers to rationally consulting with counsel, may not exhibit signs that they will harm themselves or others; or have not damaged “substantial property” when committing crimes.

The commitment process is also quite complex. As the Legislative Auditor explains, a “simplified version” of the process takes six steps:

1. A request is sent (in this case, by a public official) for prepetition screening;
2. Prepetition screening of the defendant is performed at the county level;
3. A petition for commitment is filed with the district court;
4. A psychiatric evaluation of the defendant is conducted;
5. A commitment hearing is held;
6. Finally, the court makes a commitment decision.20

According to an analysis of 1,545 case files spanning 2010-2014 in which competency of the defendant was raised, no civil commitment petition was filed in 45% of the cases. In 21% of cases, the petition did not succeed. This means that only 34% of the defendants declared incompetent to stand trial were actually civilly committed for treatment.21

Civil commitment is also generally the sole means of restoration to competency in Minnesota. There is currently little else courts can do to resolve a defendant’s mental health concerns for the purposes of trial.22 By creating a much higher standard for commitment of any kind and making civil commitment the only mechanism that triggers treatment to competency, the Minnesota legislature has created a “gap” and foreclosed many opportunities for treatment (inpatient and outpatient) that exist in other states.
A handful of other states have similar gaps in their criminal processes that allow mentally ill defendants to slip through the cracks rather than receive competency treatment. In New Mexico, for example, there is no active outpatient treatment option and only “dangerous” defendants may be committed for treatment. Vermont courts face a similar dilemma: the only option after a finding that a defendant is incompetent is to attempt evaluation and civil commitment of the defendant. However, commitment is only available for “a person in need of treatment,” and the definition of this term requires that the defendant pose a danger to self or others.

Minnesota’s dilemma could potentially be solved by taking a cue from the majority of other states who do not have a gap between competency and commitment; and those that offer various types of restoration to competency treatment.

**Step 5: Treatment to Competency**

If an incompetent defendant is deemed treatable and meets the standard for civil commitment, the next step is treatment. Minnesota provides only one option for competency restoration of committed defendants in an inpatient, state hospital setting. There is language in the civil commitment statute that requires courts to find that there is no suitable alternative to commitment (such as appointment of a guardian, voluntary outpatient care, etc.). It also obliges courts to commit patients to the “least restrictive treatment programs or alternative programs that can meet the patient’s treatment needs.” However, while state law asks the court to find the “least restrictive alternative” to commitment, “DHS officials told us that nearly all persons involuntarily committed for competency restoration have been sent to one of two secure inpatient facilities: The Minnesota Security Hospital in St. Peter or The Anoka-Metro Regional Treatment Center.”

According to DHS, as of October 2015, 46% of the individuals receiving inpatient competency treatment at the Anoka-Metro Regional Treatment Center did not require hospitalization. These facilities are an unnecessarily restrictive treatment setting for certain defendants; not all individuals who require commitment also need hospitalization or high-security placement. This treatment is also very expensive. As of July 2015, the Competency Restoration Program cost an average of $694 per patient per day, a total of almost $21,000 a month per defendant. As the Legislative Auditor reports, in 2014, defendants spent a median of 142 days in the program.

Overcrowding problems are exacerbated by the 48-hour law, which requires that any jailed defendant who needs to be evaluated for competency to stand trial or has been committed be given priority placement in a state hospital facility within 48 hours. However, as the legislative auditor mentions, the high population within the facilities has made it impossible for some agencies to remain in exact compliance with the rule because there is often no room for placement in a state hospital facility. Again, another solution may be to expand the number of options available to DHS under the law; especially for individuals committed for treatment to competency, which comprise 83.5% of 48-hour law cases.

According to the agency, the restoration program’s treatment services “include, but are not limited to, assessment, legal education (group and individual), psychosocial groups, rehabilitation services, psychotherapy, and discharge/aftercare planning.” DHS also states that “the ultimate goal of CRP is to optimize each patient’s progress in the restoration process and provide the court with an evaluation that accurately communicates the patient’s rational and factual understanding of the criminal proceedings as well as their ability to consult with counsel.”

One concern for practitioners, especially for defense attorneys, is that the methods used to “restore” a defendant must truly produce competency and at times do not appear to do so. At the Robina Institute’s roundtable discussion in June 2016, participants voiced a concern that treatment too often amounted to rote memorization through workbooks and flash cards. They stressed that a “restored” defendant should be able to truly understand the trial process and participate in their defense.
The treatment institution must report to the court periodically, “not less than once every six months,” on the defendant’s mental condition with an opinion as to competency to proceed. These reports must be given to the prosecutor and defense counsel. The prosecutor, the defense counsel, the defendant, or a person charged with the defendant’s supervision may apply to the court to review the defendant’s competency.35

Section II: Redesigning the System: Competency Restoration Models in Other States

Other states utilize many different approaches to prepare mentally ill defendants to stand trial. Many policy choices go into selecting which approach is best for a given state. This section of the report will outline considerations that policymakers need to make in tailoring an approach and provide illustrative examples from other states.

1. The Basic Design of a Fair System without a “Gap.”
   a. Selecting a Legal Mechanism that Allows Treatment of Defendants

Minnesota is distinct for having a system in which a determination of incompetency to stand trial is not a sufficient basis for the court to mandate some form of restoration to competency treatment. Most states employ a few basic strategies to treat defendants, even if the need for such treatment falls short of the need for civil commitment. A finding of incompetency may trigger:

- Some form of commitment;
- Court-ordered inpatient or outpatient treatment; and/or
- Pre-trial release during which treatment is a condition of release.

Under the American Bar Association standards, when a defendant is found incompetent to stand trial, “a defendant may be ordered to undergo treatment if the court finds that there is a substantial probability the treatment will restore the defendant to competence in the foreseeable future. The court may order treatment to be administered on an outpatient basis (including as a condition of pretrial release), at a custodial facility, or at an inpatient mental health facility.” These standards give state courts many options; they also appear to somewhat reflect the law in a number of states.36

The National Judicial College adds that after a finding of incompetence, “it is best practice for the court to refer a defendant for competency restoration in the least-restrictive setting consistent with public safety and the defendant’s treatment needs - whether in a secure psychiatric hospital, federal medical center, state hospital, jail, community mental health center [...] or other setting.” As will be discussed below, only certain states have adopted the “least-restrictive setting” criteria and many do not have a wide range of treatment options despite closing the “gap.”17

Each state process after a finding of incompetence is slightly different; some allow courts more options than others do. There is no way to make an exhaustive list of the “types” of systems that exist, because there is so much variation. However, to offer some examples of how systems work:

- In California, if a defendant is found incompetent there are two options; outpatient treatment or commitment.38 The court must refer a mentally ill defendant to the county’s mental health director, who makes a recommendation as to whether the defendant should be required to undergo outpatient treatment or should be committed to a treatment facility. The county’s mental health director must recommend
the least restrictive option available. In addition, no person may be admitted to a state hospital unless the director finds that there is no less restrictive appropriate placement available. The defendant’s status must be reviewed at the 90-day mark, and at 6-month intervals thereafter. However, no period of commitment may last longer than one year or the longest term of imprisonment possible for the most serious charge in a misdemeanor case, whichever is less.39

• In Wisconsin, a defendant must be found incompetent and likely to become competent within a specific period (which can be up to 12 months). If that finding is made, the court has one option, in that it must commit40 the defendant to the Department of Health Services. However, DHS then has many different options for treatment. The agency can place the defendant in an inpatient program in one of their facilities, on DHS supervision in a community-based treatment program, or in a jail or locked unit of a facility that has agreed to serve as a location for treatment.41

• In Delaware, the court can act on a finding of incompetence and “may [but is not required to] order the accused person to be confined and treated in the Delaware Psychiatric Center until the accused person is capable of standing trial.”42 No “gap” exists unless the court, in its discretion, decides that the defendant should not be treated. Note that this is a system where confinement is not through “commitment” but rather by court order.

• In Arkansas, if the court determines that a defendant lacks fitness to proceed, there are also two options: the court may commit the defendant to the custody of the Department of Human Services for detention, care, and treatment until restoration of fitness to proceed. However, if the court is satisfied that the defendant may be released without danger to himself or herself or to the person or property of another, the court may order the pre-trial release of the defendant and the release shall continue at the discretion of the court on conditions the court determines necessary.43 Arkansas has an active, formal outpatient competency restoration program that can be part of the pre-trial release conditions.44

One thing that all of these states (and many others) have in common is that there is no separate standard or separate process that the defendant must go through in order to receive treatment through short-term commitment or court order. It is important to note the distinction between states like Wisconsin, however, where the court is compelled by statute to commit a defendant when they are found incompetent and states like Delaware and Arkansas where the court has more discretion.

It is also very, very important to keep in mind that lowering the bar for commitment of incompetent defendants will automatically increase the number of incompetent defendants in the mental health system. Lowering the bar for commitment may also increase the number of incompetent defendants who proceed through court because they (and their attorneys) are reluctant to introduce mental health issues if commitment will be the likely result. As will be discussed at length below, it will be very important to accommodate that new population that previously did not qualify for commitment or treatment if the “gap” closes.

b. Keeping the System Efficient and Effective

Streamlining the process from finding incompetency to arranging treatment will close the “gap,” but has a potential to create a different set of problems if treatment is still synonymous with hospitalization in one of the state’s dwindling number of psychiatric beds. States that have not found adequate treatment alternatives but require judges to order treatment often experience an overflow of mentally ill defendants waiting in limbo for a bed after treatment is ordered; many await treatment in jails.
In Pennsylvania, the court has discretion to order involuntary treatment of a person found incompetent to stand trial who is not severely disabled. This can only occur if the court is reasonably certain that the involuntary treatment will provide the defendant with the capacity to stand trial. The court may order outpatient treatment, partial hospitalization, or inpatient treatment. However, in practice, outpatient treatment does not currently exist in Pennsylvania; leaving inpatient treatment the only workable option. In 2015, the ACLU sued the state due to the unconstitutional detention of mentally ill defendants awaiting treatment in county jails. According to the ACLU, some defendants waited many months for treatment, often in solitary confinement. The 2016 settlement of this case requires Pennsylvania to create new placement options and supportive housing opportunities for this population.

In Utah, if a defendant is found incompetent to stand trial, the court must order the defendant committed to the custody of the Executive Director of the Department of Human Services or a designee. The court can recommend, but not order, placement; however, the court may order placement in a secure setting. This effectively means that all defendants found incompetent are moved into the treatment system. The Disability Law Center eventually sued the state of Utah. Much like in Pennsylvania, until recently defendants with mental illness were “stuck in this jail limbo” between a finding of incompetence and any form of treatment. This led to “needless suffering, including steadily worsening symptoms, self-mutilation, suicide attempts, and prolonged detention in solitary confinement.”

These systemic crises underscore the need for a well thought-out system that carefully considers the offender population, is prepared to increase capacity if necessary, and can utilize alternative methods of treatment when appropriate. This is important from a purely practical perspective, but this type of planning is also necessary when taking humanitarian considerations into account. When imprisonment is substituted for treatment (or when other individuals with mental health needs cannot receive services) because the mental health system overflows, vulnerable members of society are the worst affected.

c. Finding the Least Restrictive Alternative

Defendant rights are an important consideration in writing a law that closes the “gap.” Right now, there is one advantage to the current system: it holds the individual rights of mentally ill defendants in high regard and does not confine them simply for being incompetent to stand trial as many other states do. Transitioning to a one-size-fits-all process that automatically commits all incompetent defendants for a certain amount of time may close the “gap” in a manner inconsistent with important policy values.

The ABA standards state that “a defendant should not be involuntarily hospitalized to restore or sustain competence unless the court determines by clear and convincing evidence that: (A) treatment appropriate for the defendant to attain or maintain competence is available in the facility; and (B) no appropriate treatment alternative is available that is less restrictive than placement in the facility.”

A handful of jurisdictions that have streamlined the commitment process or created other legal mechanisms to close the gap have also taken steps to ensure treatment for defendants in least-restrictive settings. For example, Connecticut, D.C., Idaho, Indiana, Ohio, and West Virginia all require courts to send defendants to a least restrictive treatment setting. However, the “least-restrictive setting” language loses meaning where no alternatives to inpatient treatment exist. In Indiana and West Virginia, which have no operating outpatient programs, judges can only choose between the existing inpatient options that are available. This makes some type of confinement a certainty (and is similar to what is going on in Minnesota’s civil commitment process, described above).
The chart below shows a range of alternatives that a system could utilize to employ the “least-restrictive alternatives” in a case considering factors such as the severity of the crime, the safety of the community, and the defendant’s psychological needs. Note that Minnesota commonly utilizes one of the least restrictive methods, dismissal (but with no referral to voluntary treatment), and the most restrictive method, commitment to a high security hospital.

In the spirit of “least-restriction” of defendants, the chart shows the options that can be utilized by police and prosecutors, including declining to arrest, dismissal, or continuing a case for dismissal. It is important to remember that members of the criminal justice system trained to identify and respond to mental illness could respond differently to divert some cases that are currently in the system. For example, the police might be able to avoid some arrests if they could use de-escalation tactics to calm an individual rather than trigger anti-social behavior.

<table>
<thead>
<tr>
<th>Least Restrictive</th>
<th>Most Restrictive</th>
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</thead>
<tbody>
<tr>
<td>Decision not to arrest made by police officer</td>
<td>Commitment to high security hospital or jail for restoration to competency</td>
</tr>
<tr>
<td>Decision not to charge made by prosecutor</td>
<td>Commitment to minimum security hospital for restoration to competency</td>
</tr>
<tr>
<td>Continuance for Dismissal (with condition of general treatment)</td>
<td>Commitment (or court ordered release) to a community outpatient restoration to competency program</td>
</tr>
<tr>
<td>Dismissal (access to voluntary treatment)</td>
<td>Commitment (or court ordered release) to a community inpatient restoration to competency program</td>
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<tr>
<td>Commitment (or court ordered release) to a community outpatient restoration to competency program</td>
<td>Commitment to jail-based restoration to competency program</td>
</tr>
</tbody>
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Fig. 1: Example Continuum of Criminal Justice Outcomes for Incompetent Defendant
It is also important to mention the groundbreaking work specialty courts in Minnesota are doing to tackle these issues in a different way. In Hennepin County mental health court, for example, the court diverts defendants diagnosed with serious mental illnesses, traumatic brain injuries, or intellectual development disorders into supervised, community-based treatment. Defendants enter mental health court voluntarily and must agree to the terms and conditions of the court. The court places the defendant on conditional release or probation and they have access to holistic, comprehensive care for the duration of the 12 to 18 month program.53 Note that the defendants in mental health court have not been found incompetent. However, a similar program might be fashioned for incompetent defendants, perhaps envisioned as a form of pre-charge diversion.

However, some criminal cases perhaps ought to move forward and necessitate treatment that is not as voluntary. These might include cases in which the defendant did a great deal of damage to specific victims or a community. In these cases, carefully monitoring the length of treatment (even in the community), the length of confinement, and the release of defendants deemed untreatable are also important facets of a system that respects the liberty interests of incompetent defendants.

2. Making Allowances for Permanent Incompetence

Minnesota examines “treatability” of defendants as part of the competency analysis; however, the fact that a defendant is probably untreatable is not a bar to initiating civil commitment proceedings. The issue of managing treatable versus untreatable defendants is important in states without a gap because it helps to manage capacity and resource allocation. As the ABA standards state, “a defendant may be adjudged permanently incompetent to stand trial if the defendant has previously been adjudged incompetent and there is no substantial probability that the defendant will become mentally competent to stand trial within the foreseeable future.” States handle this issue in various ways. Certain states address the amenability to treatment issue before ordering treatment.54 Alternatively, some jurisdictions (like Minnesota) send incompetent defendants to treatment and afterwards require intermittent reevaluations. These reevaluations may indicate that a defendant is not going to respond to treatment. The ABA standards for treatment recommend that regardless of the initial determination of treatability, courts conduct a “periodic redetermination of incompetence” at 30, 90, and 180-day intervals and every 180 days thereafter. The ABA also advocates, for practicality’s sake, that mental health professionals make a new report on competency whenever a “treating facility or person responsible for treatment” either:55

1) Believes that the defendant has attained competence to stand trial; or
2) Believes that there is not a substantial probability that the defendant will attain competence to stand trial.

As the National Judicial College states, “if an individual adjudicated unfit to stand trial for a felony remains unfit at the end of a one-year period (or longer, depending upon the severity of the crime), it is a best practice for the court to conduct a discharge or civil commitment hearing.”56 In most states, if the court determines that a defendant is permanently incapacitated before, during, or after treatment, this determination may trigger civil commitment proceedings. Civil commitment’s role in competency proceedings in those states is not to restore competency, but to provide general mental health treatment for those who meet the civil commitment standard.57
The policies described above stem from *Jackson v. Indiana*, which disallowed indefinite commitment of criminal defendants without significant due process protections. The court held that “a person charged by a State with a criminal offense who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future. If it is determined that this is not the case, then the State must either institute the customary civil commitment proceeding that would be required to commit indefinitely any other citizen, or release the defendant.”

If mental health professionals cannot restore competency and an individual does not qualify for civil commitment, a “gap” exists in most states; courts must often dismiss these cases. Arizona has closed this gap by essentially lowering or distorting the civil commitment criteria for incompetent, non-restorable defendants; however, researchers have suggested that this may be an inappropriate use of the mental health system. One option here is to offer services to these individuals that they may voluntarily accept; securing stable, affordable housing and community based care is often key in reducing recidivism and may reduce costs associated with hospitalization or incarceration.

**Note: The Length of Competency Treatment**

In *Jackson v. Indiana*, the Supreme Court held that a defendant committed due to incompetency “cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future.” Yet, even after *Jackson v. Indiana*, the length of treatment varies considerably between states. At the same time, according to multiple studies, “for the majority of people who are likely to be restored, it usually happens within the first six months of starting treatment to restore competency.”

A survey of state laws found that several states such as Alabama, Montana, Nebraska and North Dakota do not have a formal limit on the length of treatment. Some other states tie the maximum length of treatment to the length of the maximum sentence for the crime charged or otherwise vary the length depending on the severity of the crime. Finally, many states have set maximum treatment lengths that range from fairly short (i.e. 60 days for any type of crime in North Carolina) to much longer (i.e. the lesser of five years or maximum sentence for Virginia felonies). Minnesota’s treatment limit for felonies is three years; this is well beyond the typical amount of time that is required to restore competence but much shorter than in some states where treatment could correspond to the maximum length of a felony sentence.

### 3. Designing a System with Outcomes in Mind

The goal of competency restoration treatment should be to make it possible for a defendant to understand and participate in their own case. The landmark Supreme Court case on the subject, *Dusky v. U.S.*, set out a general standard for competence to stand trial that states follow. Under this standard, the defendant must have sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding, and must have a rational as well as factual understanding of the proceedings against him.

The *Dusky* requirements of “sufficient present ability” and a rational as well as factual understanding” are unclear. In Minnesota, the legislature has stated that a defendant is incompetent to stand trial if they cannot: “(a) rationally consult with counsel; or (b) understand the proceedings or participate in the defense due to mental illness or deficiency.” This standard is no less ambiguous. Some other states have developed similar legal standards.
Adding to this is that in most states, statutory law and regulations do not give forensic evaluators a great deal of guidance as to what specific outcomes treatment to competency ought to produce. There are also very high levels of examiner-judge agreement on competency issues; in other words, most of the time judges will follow the recommendations of the mental health professionals who evaluate defendants. Therefore, the legal standard is in reality muddled with much more complex criteria and tools used by forensic mental health professionals.66 In addition, for many defendants, responsivity to medication is one of the more important variables in whether competency measures will work; this clinical outcome is larger in scope than any of the legal requirements for fitness to stand trial. As one author explains:

“Patients found incompetent to stand trial and committed to treatment or rehabilitation are truly at a place where two roads, legal and clinical, meet. Mental health professionals without forensic training may be unaccustomed to specific competence-related approaches to treatment of patients who have been adjudicated incompetent to stand trial. However, clinicians working with these patients are generally able to focus on symptom improvement, an area they feel more comfortable addressing. This is because common symptoms of mental illness associated with findings of incompetence and leading to hospitalization include delusions (i.e., false, fixed beliefs), disorganized thoughts, and agitation, to name a few. As these symptoms improve, with medication intervention and standard therapies, so naturally do defendants’ abilities related to competence to stand trial. Thus, once a patient has improved clinically, the patient can often be adjudicated as competent, eliminating the legal problem.”67

When closing the “gap,” it is important to develop a treatment system that ensures that defendants who the court finds “competent” are truly able to both understand what is happening in court and to communicate effectively with their attorney and assist in their own defense. This may involve refining the state level standard for competence in Minnesota and making sure that professionals involved in the examination and treatment of defendants are aware of the legal dimensions of their work.

To summarize, an ideal system should:

- Have a fair but efficient legal mechanism to require treatment to competency for some mentally ill defendants;
- Draft laws and budgets with an eye towards the overall capacity of the system;
- Offer various alternatives for treatment that are appropriate to the defendant’s needs and liberty interests and to the safety of the community;
- Reflect the fact that not all defendants can be treated to competency or treated in a reasonable amount of time;
- Provide treatment that genuinely allows defendants to understand the criminal process and to work with their attorneys to resolve the case at hand in a meaningful way.
Section III: Evaluating Two Models for “Alternative” Competency Restoration Treatment

Many other states have experienced budget and capacity issues around treatment to competency in the state hospital setting. Two of the more popular solutions to the problem have been outpatient treatment and jail-based treatment. While this paper does not strongly favor jail-based competency treatment, it is included due to its apparent rise in popularity among state-level policymakers.

1. Outpatient Treatment

Outpatient treatment is a potentially useful alternative, especially for low-risk offenders who will likely gain competency. It is a way to gain treatment for defendants while avoiding hospital capacity issues. As a 2016 article stated, “the combination of burgeoning [mental health treatment] populations, lean state mental health budgets, and [in some states] successful lawsuits arguing for placement in “least restrictive settings” for forensic patients has led many states to develop community forensic programs as alternatives to correctional confinement and inpatient hospitalization.”

In Minnesota, outpatient treatment programs could serve several functions. Counties could design some mental health care programs for defendants who voluntarily accept treatment or who negotiate for a continuance for dismissal with the condition of accessing treatment. However, outpatient programs may also allow judges to commit (or otherwise order) defendants to treatment to competency that is not as disruptive of daily life and is much less expensive. This type of program helps reserve facilities like Anoka for individuals who need greater security and care.

The chart below shows the geographical spread of outpatient competency treatment in 2014:

<table>
<thead>
<tr>
<th>States with Statutes Prohibiting Outpatient Competency Restoration</th>
<th>States Operating Formal Outpatient Restoration Programs</th>
<th>States Operating Informal Outpatient Restoration Programs</th>
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<tr>
<td>Alaska</td>
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| Wisconsin | }
The study notes that as of 2014, Florida, Texas, Virginia, and Wisconsin operate the largest formal outpatient programs (with between 50 and 100+ participants per year). New Hampshire operates the largest informal outpatient program, also with over 100 participants per year.\(^{71}\) In some states, these were state operated programs, while other states (around 31.2% with formal programs) “tended to rely more heavily on privately contracted providers.” However, “ultimately, funding was always provided through government mental health agencies.”\(^{72}\) In addition, these programs provided a large cost savings per patient day: total daily costs for outpatient treatment was around $215 per defendant per day as opposed to $603 on average for inpatient treatment.\(^{73}\)

The National Judicial Council’s 2012 recommendations support community restoration for defendants with major mental illness, but only if all of the following apply:

(a) The community has a program to restore competency that is suitable for the treatment needs of the defendant;
(b) The program provides intensive, individualized competency training tailored to the demands of the case and the defendant’s particular competency deficits;
(c) The defendant has a stable living arrangement with individuals who can assist with compliance with appointments and with treatment; and
(d) The defendant is compliant with treatment, and not abusing alcohol or other chemical substances.\(^{74}\)

Outpatient treatment programs may save money and time.\(^{75}\) They also reserve space in inpatient treatment programs for those who need them the most. Especially in states where defendants are routinely made to undergo treatment if they have been found incompetent, outpatient treatment may be a potential safety valve to avoid overcrowding in state hospitals and other mental health facilities. Finally, outpatient treatment programs may reduce life disruption by allowing for care without drastic changes in daily routine or severing contact with friends and family.\(^{76}\)

However, outpatient treatment programs vary in effectiveness. For example, one outpatient program in Summit County, Ohio reportedly “required a longer period of time and led to greater case delays because the community-based treatment was less intensive and more prone to treatment noncompliance.” The county further reported that the program worked best with those with cognitive impairments rather than mental illness because it required having a “stable, supportive living arrangement.”\(^{77}\)

**Case Study: Wisconsin.** As mentioned above, incompetent felony or misdemeanor level defendants in Wisconsin are automatically committed to the state’s Department of Health Services, which can choose to offer them supervised release along with outpatient treatment. Defendants can be committed for up to 9 months for a misdemeanor or one year for a felony.\(^{78}\) Wisconsin’s Outpatient Competency Restoration Program began in 2008, after a change in the commitment statute was included in the 2007 budget bill. Behavioral Consultants, Inc. (BCI), a private contractor, runs the program. BCI has also been performing outpatient competency to proceed evaluations since 2001.\(^{80}\)

The Department of Health Services reported that in 2015, BCI served 66 individuals in the outpatient program and their treatment lasted an average of 115 days. Of those individuals, 14, or around 20% of the total participants, were removed during treatment and presumably sent to receive a more secure form of treatment. Thirteen of the participants were still completing the program at the time of the report. Of the 39 that completed the program, 25 were found competent to proceed, while 14 were still incompetent after treatment (and had their cases dismissed or were referred to inpatient care). This represents a successful treatment rate of 64% among those completing the program.\(^{81}\)
Not all defendants qualify for the outpatient program. According to a brochure, the “Optimal Participant” in the BCI program:

- Refrains from alcohol and/or other drug use or abuse;
- Presents no immediate danger to community or self;
- Has stable mental health;
- Has reliable transportation;
- Has stable housing; and
- Is motivated with a good attitude.82

Based on these criteria, outpatient treatment does not appear to be an option for individuals with co-occurring mental health and substance abuse disorders. In addition, it is hard to know what “has stable mental health” means in this context, but it sounds as if they are looking for candidates that have competency issues but are also low-risk.

Inpatient treatment in a Wisconsin state hospital costs $1,025 per patient per day.83 According to BCI, their program runs at a “significant cost savings” to taxpayers.84

Case Study: Texas. In Texas, anyone charged with a felony or misdemeanor punishable by confinement who is found incompetent, and is not found unlikely to be restored to competency may be committed to a facility or released on bail. If released on bail, the court must order the defendant to participate in outpatient treatment. Outpatient treatment may not exceed 120 days. The court may order outpatient treatment only after it receives and approves a comprehensive plan that provides for the treatment of the defendant for purposes of competency restoration and identifies the person who will be responsible for providing that treatment.85 One interesting note about the Texas program is that this state also makes involuntary medication is available in an outpatient setting for some defendants.86

Outpatient Competency Restoration Programs in Texas began with pilot projects in 2008, and quickly grew. There are now 12 programs throughout the state, which run through contracts with private companies or Local Mental Health Authorities. While there is not a great deal of very recent information about the programs, Texas reports that between the spring of 2008 and August 2013, the OCR programs served over 1,061 individuals and restored 42% to competency. In fiscal year 2013, the average cost of treatment per day in a state hospital was $415, compared to an average of $229 per day in an outpatient program.87

Case Study: Washington D.C. Prior to treatment in D.C., the court must find a felony or misdemeanor defendant incompetent. The court must also find that the defendant is either likely to obtain competence in the foreseeable future or that additional time is necessary to assess whether the defendant is likely to obtain competence.88 The court may order the defendant to participate in either an inpatient or an outpatient treatment program; it must order treatment in the least restrictive setting consistent with the goal of restoration of competence. In fact, the court may order inpatient treatment only if it finds that placement in an inpatient treatment facility setting is necessary in order to provide appropriate treatment or that the defendant is unlikely to comply with the conditions of outpatient treatment. Outpatient competency treatment may last for up to 180 days.89
In D.C., competency restoration takes place in a group setting. The group meets twice a week for an hour and 15 minutes. Between 2009 and 2013, the program has had 170 participants, with an average referral rate of 35 per year. It was able to restore 55 of those participants (around 32%) to competency. In 2014, it cost $2,006 per week (or around $287 per day) to run the outpatient restoration program, compared with inpatient restoration at $6,307 per week (or $901 per day).90 While $2,006 per week is still expensive, it is under 1/3 of the cost of inpatient restoration; however, the percentage of individuals restored to competency in the program is low.91

Note: Public Programs or Public-Private Partnerships?

One consideration to make is whether to design and staff a new program or to contract with a private entity to do that. Some of the outpatient competency restoration programs in Texas are privately run, and so is the entire Wisconsin outpatient system. Both of the jail-based treatment programs described below are also administered through private contracts. Whether or not this is ideal is a matter of opinion; but it is important to note that these options exist and that they each have their own costs and benefits.

2. Allowing for Jail-Based Treatment

Several different states have begun to utilize jail-based treatment to competency as a new way to streamline the process. Among these states, some have improvised this solution due to a backlog of mentally ill defendants awaiting treatment who would currently be stuck in jail in any event. Other states have found this to be a useful solution when outpatient treatment is undesirable in a particular case or simply not available. As the National Judicial College’s best practices state:

“When circumstances requiring hospitalization are not present, and either the defendant needs to be detained or community restoration is not available, it is a best practice to provide restoration treatment in a jail setting. It is also a best practice for the jail to create a mental health pod in which to hold, treat, and restore defendants to competency. It is further a best practice for the jail to employ the services of a mental health care nurse practitioner to staff the mental health pod.”93

According to a recent presentation at the annual conference of the National Alliance on Mental Illness, jail based treatment now exists in Arizona, California, Colorado, Florida, Georgia, Louisiana, Tennessee, Texas, and Virginia.94

Advantages to jail-based treatment may include saved time (the defendant does not need to wait for a hospital bed or for transportation), proximity to family and to counsel, “greater likelihood that the defendant will receive continuity of care” (if treated to competency and held in custody during judicial proceedings), and finally cost savings.95

Perhaps the biggest disadvantage of these programs is the difference in setting. As one expert writes, “the unique characteristics of jails are almost all therapy-inhibiting; it is difficult to identify features of the correctional environment that could enhance competency restoration treatment. For example, would routine contact with competent, non-mentally ill inmates and their legal problems serve as an adjunct to formal courtroom education groups? It seems unlikely. What seems more likely is that incompetent defendants would be targeted and victimized by other inmates.”96
As a study done by Disability Rights California points out, “inmates with mental illness find it difficult to abide by the formal and informal rules that govern prison life. Staff neglects them, accuse them of malingering, and treat them as disciplinary problems. Other prisoners exploit and victimize them. Prisoners who break the rules because of their illnesses are punished. Even self-mutilation and attempted suicide are dealt with as disciplinary matters.” Many of these defendants also end up in solitary confinement or other high security settings.97

In Minnesota, there are other specific disadvantages to jail-based competency restoration. The state already leaves some defendants in jail pending competency evaluation, and complying with the legal requirement that treatment to competency be in the least restrictive appropriate setting. It seems unhelpful to add another setting that is at least equally, if not more, restrictive.98 Many smaller jail facilities in the state may be unable to provide a mental health “pod” or some other form of separation between vulnerable mentally ill defendants and the general jail population; this raises humanitarian concerns. Finally, other states skirt the constitutional issue of confining a person in a jail without a speedy trial by stopping the clock on the case and “committing” defendants to jail for the purposes of treatment. It is unclear whether this would be acceptable under Minnesota jurisprudence.

In summary, jail-based treatment offers another set of potentially time and cost-effective alternatives but needs to be considered with the best outcomes for the defendant in mind. Forcing mentally ill defendants who are ill-equipped to deal with the nuances of jail life may be too traumatizing to be called “treatment.” There are currently successful programs that more or less follow best practices and are solving the treatment bed crisis in some states, but these may be unworkable in many Minnesota counties. Finally, jail-based treatment may fail to meet the state Constitution’s due process requirements.

Case Study: Arizona’s Camp Verde Jail Program

As noted above, in Arizona, after a finding of incompetence, the court must order competency restoration treatment through commitment unless there is clear and convincing evidence that the defendant will not regain competency within 15 months. The 15-month period may be extended to up to 21 months if the defendant is making progress towards restoration of competency.99

Yavapai County developed a jail-based restoration to competency (RTC) program in response to the high cost of hospitalization-based treatment. It is also faster because there is often a 60- to 90-day wait for hospitalization. According to program advocates, it is also a closer to “local treatment, where friends and family could visit and be a part of it, rather than ship them [to Phoenix].” The program is run through a partnership between the County and Wexford Health Sources, a private national-level corporation that provides behavioral health services.100 According to the County, in the three years after it opened in April 2010, the program saved taxpayers $6.75 million dollars. Wexford Health Sources’ Program received the 2014 “Innovation in Corrections Award” from the American Correctional Association.101 As of May 2014, the program had served 136 defendants with a restoration rate of 85%.102

Potential drawbacks to the Yavapai program include the setting. One of the jail’s health administrators conceded that “while there are so many merits to a jail-based restoration program, being jail-based is also its own enemy. This environment makes people not stay together well. We can put the meds in them, but the lack of social interaction with their families, the lack of being able to drive and go out and have fresh air, to be able to go to a movie” all contribute to “decompensating” or losing the benefits of RTC treatment.” This means that the window of competency is short and that it is important “to catch them while they’re competent and can assist in their own defense.” In other words, jail-based restoration to competency may be fleeting since it is done in such a non-therapeutic location.103
In addition, a “frequently asked questions” document from Wexford Health implies that restoration to competency defendants are housed “according to their detention classification.” In other words, there is likely no dedicated space for RTC inmates. In addition, acceptance to the program is made on a case-by-case basis and “violent history does not necessarily preclude acceptance to the program.” There does not appear to be a publicly available list of acceptance criteria available as there is for the Colorado program discussed below.104

Case Study: Colorado’s RISE Program
Restoring Individuals Safely and Effectively (RISE) has operated since November 2013. It operates in Arapahoe County and is a partnership between that county and Correct Care, an international private health care provider.105 The program serves many Colorado counties. Suitable candidates for the program include those that are:106

- Not an imminent danger to self/others;
- Likely to be restored in 60 days or less;
- Medication and treatment compliant;
- Motivated;
- Medically stable; and
- Not at significant risk for self-neglect.

According to the program’s staff, RISE places defendants in treatment units within a jail and offers a day treatment program to those defendants Monday through Friday during business hours. It offers individual counselling daily, as well as group therapy and many other programs. A unique program offered by RISE is peer support, which allows inmates to work together towards competency and other important goals such as education and finding community resources. Since 2013, it has served 256 individuals and has restored 76% of patients to competence within 60 days and 90% within 90 days. The average time to restoration is 51 days.107 While it is difficult to find the total cost of the program, the contract with Correct Care is currently at $91.08 per day per inmate, with a minimum of 18 inmates per day.108
Conclusion

In closing the “gap” between competency and commitment, many considerations must be made to ensure an efficient, effective, and humane system going forward. We must also look to other states who have taken innovative steps to make restoration to competency better. There can be no standard solution that addresses the needs of every defendant; rather, careful planning should lead to a continuum of potential solutions that can make the process better and more just for those involved.

There is more than one potential path ahead. However, it is clear that Minnesota defendants and judges need more options. Currently, the state is operating between two extremes: dismissal and no treatment at all, or commitment (with difficulty) to an overcrowded maximum security hospital. The two options include one that may be too lenient and the other that is fairly draconian unless a defendant presents true public safety concerns.

To solve this issue in the future, researchers and policymakers should address several areas:

- Consider whether to preserve the current legal standard for commitment, lower the standard for this type of commitment, and/or to design an alternative legal mechanism (such as pre-trial conditional release or a court order) for the purposes of competency treatment. Any proposal for change should take into account the capacity of the system and consideration of the state’s commitment to the rights of defendants;
- Work to develop less restrictive forms of treatment than exist in a maximum-security hospital. Community-based outpatient care may meet the needs of many low-to-medium risk defendants;
- Ensure that the treatment delivered is high quality and truly addresses the competency needs of the criminal defendant; and
- Work to improve the mental health infrastructure in general to make it easier to access care before a crime can take place and to offer an alternative to defendants whose cases are dismissed but who still need treatment.

Policymakers should also weigh the relative advantages and disadvantages of the current system. For example, in the system as it is, courts sometimes dismiss cases involving misdemeanants who are incompetent to stand trial; this preserves a defendant’s liberty and lessens the resources spent. Certain “gaps” can remain in a legal system and the system can still function in general. Any solution to the problem, if it is a problem, should consist of something much less restrictive than placement in a high-security state hospital.

On the other hand, those concerned about public safety and safety of defendants themselves may wish to find a way to end the cycle of arrest, attempted prosecution, and release. In addition, there may be something gained by holding a restored, competent defendant accountable for a crime in certain cases. Access to more forms of mental health treatment in general, and to more forms of competency restoration treatment in particular, may solve these problems.

About the Robina Institute of Criminal Law and Criminal Justice

The Robina Institute brings legal education, theory, policy and practice together to achieve transformative change in punishment policies and practices. The Institute is focused nationally on sentencing guidelines, probation revocations, and parole release and revocations, and locally on the Minnesota criminal justice system.

The Robina Institute was established in 2011 at the University of Minnesota Law School thanks to a generous gift from the Robina Foundation. Created by James H. Binger (’41), the Robina Foundation provides funding to major institutions that generate transformative ideas and promising approaches to addressing critical social issues.

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End Notes


4 Minn. R. Crim. P. 20.01 subd. 3.

5 Legislative Auditor’s Report, supra note 1 at 21. Note that Minnesota is not the only state that has seen an increase in competency cases. See, e.g., Ruth Brown, Messenger Index, Mental Health Commitments on the Rise in Idaho (Oct. 25, 2016), http://www.messenger-index.com/news/mental-health-commitments-on-the-rise-in-idaho/article_b1fc197f-30c1-5935-83f8-8956059aad7c.html.

6 Minn. R. Crim. P. 20.01 subd. 3.

7 Legislative Auditor’s Report, supra note 1 at 77 (fn. 6).

8 Minn. R. Crim. P. 20.01 subd. 4.

9 Legislative Auditor’s Report, supra note 1 at 81.


11 This process is also important to consider in the context of overall system design; numerous states have had serious issues with the timing and execution of evaluation that have led to crises. See, e.g., Linda Freeman et al., N.M. Sentencing Comm’n, Effect of Competency and Diagnostic Evaluation on Length of Stay in a Sample of New Mexico Detention Facilities (2013), http://nmcs.unm.edu/reports/2013/effect-of-competency-and-diagnostic-evaluation-on-length-of-stay-in-a-sample-of-new-mexico-detention-facilities.pdf. (The study found that arrestees who had a competency proceeding and were found competent had jail stay that was on average 2.3 times longer than arrestees who had no competency proceeding. It also found that arrestees who had a competency proceeding and were found incompetent had a jail stay that was on average 3.8 times longer than arrestees who had no competency proceeding.); Jakob Rodgers, The Gazette, Colorado to Hire Consultant to Ensure Speedy Competency Evaluations for Inmates (Aug. 2, 2016) http://gazette.com/colorado-to-hire-consultant-to-ensure-speedy-competency-evaluations-for-inmates/article/1581807.

12 Minn. R. Crim. P. 20.01 subd. 4(b).

13 Id. at subd. 2.

14 Id. at subd. 5(f).

15 Id. at subd. 6.

16 Id. at subd. 8.

17 Minn. R. Crim. P. 20.01 subd. 3.

18 Minn. Stat. § 253B.02.

19 Minn. R. Crim. P. 20.01 subd. 2.

20 Legislative Auditor’s Report, supra note 1 at 79.

21 Id. at 83.

22 While Hennepin County has recently begun to offer voluntary competency restoration treatment for defendants who are jailed when declared incompetent, this program can only serve a limited number of individuals who both qualify and are willing to voluntarily submit to treatment. Id. at 80 (fn. 20).
Closing the “Gap” Between Competency and Commitment in Minnesota: Ideas from National Standards and Practices in Other States

26 Minn. Stat. § 253B.09 subd. 1.
27 Legislative Auditor’s Report, supra note 1 at 85.
28 Id. at 85.
29 Id. at 85-87.
31 Legislative Auditor’s Report, supra note 1 at 87.
32 Id. at 92.
33 Minn. Dep’t of Human Svcs. Psychology Department Postdoctoral Fellowship in Forensic Psychology 2017-2018 at 4-5 (2016), https://edocs.dhs.state.mn.us/ilserver/Public/DHS-6311-ENG.
35 Minn. R. Crim. P. 20.01 subd. 7.
36 American Bar Ass’n, Criminal Justice Section Mental Health Standards 7-4.10, http://www.americanbar.org/content/dam/aba/publications/criminal_justice_standards/mental_health_standards_2016.authcheckdam.pdf (adopted Aug. 8, 2016) [Hereinafter “ABA Mental Health Standards”].
37 NJC Best Practices, supra note 10 at 23.
38 Cal. Penal Code § 1370.01. This type of commitment is under court order and its only legal prerequisites appear to be that a defendant be incompetent and that the county mental health director recommends commitment as the least restrictive appropriate form of treatment. Compare Cal. Welf. & Inst. Code § 5150 et. seq. (“Detention of Mentally Disordered Persons for Evaluation and Treatment”).
39 Cal. Penal Code § 1370.01.
40 Wis. Stat. § 971.14. Commitment under this statute is by court order after a court finds that the defendant is not competent but is likely to become competent through treatment within the period specified (which can be up to 12 months).
44 Gowensmith & Frost, supra note 30 at 293.
46 Gowensmith & Frost, supra note 30 at 293.
50 ABA Mental Health Standards, supra note 37, 7-4.10(a)(iii).
52 Gowensmith & Frost, supra note 30 at 293.
Closing the “Gap” Between Competency and Commitment in Minnesota: Ideas from National Standards and Practices in Other States


55 ABA Mental Health Standards, supra note 37, 7-4.12(a).

56 NJC Best Practices, supra note 10 at 39. See also ABA Mental Health Standards, supra note 37, 7-4.13(c) (“If the defendant has been found unrestorable then the defendant should be released from any detention or commitment for treatment to attain or restore competence. If the defendant meets the criteria for involuntary civil commitment, the court may order such commitment and may direct that initial commitment take place in a forensic facility.”).


61 406 U.S. at 738.


63 Id.


65 Minn. R. Crim. P. 20.01 subd. 2.


68 Gowensmith & Frost, supra note 30 at 293.

69 Id.

70 Informal here denotes the reality that “[i]n several states, the lack of a formal OCRP did not preclude individuals from being ordered to the community for outpatient restoration. These 15 states utilized a variety of informal or ad hoc restoration services. […] Some states (California, Colorado, Hawaii, Nevada, Ohio, and Virginia) had two concurrent populations of incompetent individuals in the community; those who received restoration from their state’s formal OCRP, and those who were not participating in the formal OCRP but nonetheless received restoration from alternative restoration services (often from private providers.” Id. at 296

71 Id. at 296-297.

72 Id. at 298.

73 Id. at 299.

74 NJC Best Practices, supra note 10 at 27.

75 Id.


Closing the “Gap” Between Competency and Commitment in Minnesota: Ideas from National Standards and Practices in Other States


D.C. Code § 24-531.04.

D.C. Code § 24-531.05.

Johnson & Candilis, supra note 87.

A caveat to this statement is that there is no data in the report about the relative success rate of inpatient mental health care in D.C.

In Louisiana, “the wait time for hospitalization is currently over 100 days […] while in jail, all [incompetent] defendants receive services from the District Forensic Coordinator in that region. Traditionally, approximately 30 percent of [incompetent defendants] have been restored in jail.” Reena Kapoor, Commentary: Jail-Based Competency Restoration, 39 J. American Academy of Psychiatry and the Law, 311, 312 (2011), citing State of Louisiana Department of Health and Hospitals: Request for Information for Provision of Forensic Services (Oct. 2010), http://new.dhh.louisiana.gov/assets/docs/RFIs/RFI%20209-27-102.pdf.


Minn. Stat. § 253B.09(a).

Ariz. R. Crim. P. 11.5.


Id.


Galin et al., supra note 94.

Id.
