Commentary: Resistance to *Jackson v. Indiana*—Civil Commitment of Defendants Who Cannot be Restored to Competence

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Levitt and colleagues provide empirical data and qualitative information that indicate that unrestorable, incompetent defendants are treated differently from ordinary patients in the civil commitment process. This report contributes to the literature suggesting that mentally ill defendants' rights under *Jackson v. Indiana* are not being respected. The historic developments that have led to problematic implementation of *Jackson* are reviewed. Increased involvement of the mentally ill in the criminal justice system and civil commitment reform are key factors that have given rise to prosecutors' widespread resistance to implementing *Jackson*. The current approach to unrestorable, incompetent defendants is outmoded and does not serve public safety.

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In this issue of *The Journal*, Levitt and colleagues[1] have provided a valuable and unique report regarding the civil commitment of defendants who cannot be restored to competence. Their article contributes significant empirical data regarding this understudied group of mentally ill individuals and the problems faced by the inpatient services that evaluate and treat them.

As reported in this study, all unrestorable defendants were involuntarily admitted for a court-ordered evaluation. In comparison to patients admitted through ordinary commitment procedures, they were more likely to receive some form of ongoing, court-ordered involuntary treatment (84% compared with 62%) and they had more lengthy hospital stays. Yet, the authors found that most did not meet a single criterion for admission. Unrestorable defendants, having received lengthy treatment directed toward competence restoration before commitment, were at their baseline levels of functioning at the time of hospital admission. This group of patients, the authors concluded, is being treated differently from ordinary civil committees.[1] They raised the question of whether the unrestorable defendants committed in Arizona are accorded the rights that they are due under the U.S. Supreme Court's holding in *Jackson v. Indiana*.[2] As described in their report, ordinary civil commitment standards and procedures appear to have been usurped in the interests of public safety. The use of ordinary civil commitment for this purpose troubled the treatment team and led the authors to question whether the defendants had been treated fairly.

This commentary addresses in greater detail the questions raised by the study authors. First, *Jackson v. Indiana* will be placed in broader historical context. A review of subsequent developments in the criminal justice and mental health systems will reveal why the rights accorded under *Jackson* have been undermined in practice. Second, a closer examination of one of those developments, the reform of civil commitment laws, will explain why the use of ordinary commitment is troubling from an ethics perspective.

Historical Context

A brief review of the U.S. Supreme Court's findings in *Jackson v. Indiana* is necessary. In *Jackson*, the

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Court ruled that a pretrial defendant's constitutional rights to equal protection and due process were violated by indefinite commitment on the sole grounds that he was incompetent to stand trial. Due process, Justice Blackmun wrote,

> . . .requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed. [Therefore,] 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 [Ref. 2, p 406].

States have not embraced implementation of the rights accorded incompetent defendants as articulated in Justice Blackmun's opinion. For decades, many states continued to commit unrestorable, incompetent defendants indefinitely in apparent defiance of *Jackson*. Other states have circumvented the ruling simply by not specifying a duration limit on commitments related to evaluation and restoration of competence.[3–5] As the *Jackson* decision did not require that criminal charges against unrestorable defendants be dropped, in some jurisdictions, prosecutors have petitioned repeatedly for new evaluations of competence, leading to ongoing confinement. In Indiana, the state mental health department has followed a policy of filing for ordinary civil commitment until competence is restored or charges are dropped; reportedly, the courts have routinely found grounds to commit.[6,7] Several reviews of the implementation of *Jackson* rights have concluded that half or more of the states have no effective limit on the length of commitment of unrestorable defendants.[3–5] Taken as a whole, these varied state approaches to detaining mentally ill defendants reflect broad systemic resistance to *Jackson*.

Why has there been such resistance? Insight may be gained by an examination of the historical context in which the decision was made. In the decades before 1972, the year of the decision, society had relied on psychiatry, and psychiatric institutions, to manage the problematic behavior of mentally ill individuals. In this era of large state hospitals, loose commitment standards, lax procedural protections, and intolerance of social deviance, mentally ill individuals whose behavior created problems in the community were likely to be involuntarily committed to psychiatric institutions. It is not unreasonable to believe that the *Jackson* Court took these practices as a given and envisioned ordinary civil commitment as routine following a finding of unrestorable incompetence. The Court at the time of the decision had not heard a case involving ordinary civil commitment and would not decide *O'Connor v. Donaldson*[8] until 1975. At the time of the *Jackson* decision, deinstitutionalization was under way, but it had been fueled largely by the introduction of antipsychotic medications, the community psychiatry movement's emphasis on maintaining patients as outpatients, and the advent of government entitlement programs that opened access to other forms of institutional care. In 1972, nearly 250,000 patients filled public hospital beds.

Dramatic changes were soon to come. The U.S. District Court decision in *Lessard v. Schmidt*,[9] which required a stringent dangerousness standard and instituted strict procedural safeguards, would be handed down later in 1972, after *Jackson*. Civil commitment reform gained momentum and would lead to widespread adoption of more restrictive standards for involuntary hospitalization based on current evidence of dangerousness. Coupled with new procedural safeguards, these laws reduced psychiatrists' discretion to hospitalize mentally ill individuals involuntarily and greatly reduced the average length of hospital stays.

The *Jackson* Court was not only unaware of the impending revolution in the laws regarding civil commitment, it could not foresee a related development: the criminalization of the mentally ill. Indeed, 1972 proved to be a pivotal year in the process of criminalization. California fully implemented civil commitment reform under the Lanterman-Petris-Short Act in July of that year, which instituted strict dangerousness criteria and new procedural safeguards for civil commitment.[10] As a result, many disordered individuals who would have been hospitalized in the past were arrested and incarcerated. The first report that mentally ill offenders were flooding jails in California was published in 1972.[11] As civil commitment reform swept across the nation, states accelerated the process of deinstitutionalization.[12] At present, there are approximately 44,000 public sector beds available for the mentally ill, about one-third of which are forensic beds (Gillece J, personal communication, 2009).[13]

Substantial changes in penal policy also closely followed the *Jackson* decision and contributed to criminalization of the mentally ill. In 1972, the rate of incarceration in the United States was about 100 per 100,000 adults, a rate that had been stable for nearly a century. Beginning in the mid-1970s through to the present, the rate of incarceration rose steadily and now stands at more than 750 per 100,000 adults, the highest rate in the world.[14] This increase has been the result of an increasing societal reliance on punishment to solve social problems. Perhaps most significantly, in the 1970s, treatment strategies were perceived as having failed in the "war on drugs" and penal solutions were implemented. In the wake of these changes, reports documented the rising population of mentally ill inmates in jails and prisons.[15–17]

Since that time, there has been mounting concern about the number of mentally ill individuals in our jails and prisons. It has been estimated that 10 to 15 percent of incarcerated populations have some form of mental illness requiring treatment. This translates to more than 800,000 mentally disordered offenders in jails and prisons or on parole. Approximately 1 million mentally ill offenders are arrested each year.[18] Research indicates that mentally ill individuals who are involved in the criminal justice system are likely to have comorbid conditions, such as substance abuse, that render them difficult to treat. Many are homeless and estranged from care; most will not receive any form of treatment following release from incarceration. Not surprisingly, mentally ill offenders have high rates of recidivism, higher than nonmentally ill offenders.[18]

At the time of the *Jackson* decision, relatively few mentally ill offenders found their way into the criminal justice system. For the small number of defendants who could not be tried because they could not be restored to competence, the ordinary civil commitment process provided an easy path to involuntary hospitalization, involving relatively vague standards and lax procedures. However, immediately after the decision, broad historical forces transformed the mental health and criminal justice landscape. The criminal justice system was flooded with mentally ill offenders, including those who would be identified as *Jackson* defendants. Mentally ill offenders were difficult to maintain in treatment and demonstrated high rates of recidivism. Prosecutors and courts, operating in an era in which social policy has emphasized public safety, have found it difficult to allow mentally ill offenders to be governed by ordinary civil commitment laws, which would lead to immediate release for many, at least as routinely applied.

The report by Levitt and colleagues[1] in this issue of *The Journal* describes a system in which the prosecutor, rather than a clinician, initiates civil commitment and the evaluation and documentation of the basis for commitment is absent at the time of the admission. The authors conclude that over half of the committed unrestorable defendants met no criteria for admission and, had they gone through the routine process, would not have been admitted. The treatment team and the research group were troubled by this practice. The next section explores the basis for ethics-related and clinical concerns regarding the use of civil commitment for detention of unrestorable defendants.

Civil Commitment

Ordinary civil commitment is grounded in the doctor-patient relationship and underlying medical ethics that require physicians to act in patients' interests. Historically, psychiatrists have initiated civil commitment to hospitalize seriously mentally disordered individuals who fail to recognize the need for care so that they may be provided treatment. The basis for civil commitment has been, and is, avowedly paternalistic.

Although firmly rooted in the paternalistic ethics of medicine, the professional standards for the application of civil commitment have not been static. Psychiatrists are influenced by social mores, legal developments, and evolving notions of ethics and human rights. Over the last generation, professional standards for commitment have changed dramatically.

During the era of institutionalization, psychiatrists interpreted their paternalistic mission broadly. In times predating the introduction of effective pharmacological agents, psychiatrists relied on long-term psychotherapeutic treatment and respite from day-to-day stresses to treat patients. The provision of asylum to mentally ill individuals who might otherwise have been incarcerated was accepted as an appropriate and paternalistic intervention. As the decline of institutions, characterized by underfunding, overcrowding, and, often, abuse of patients, provided fuel to reformers, it also altered psychiatrists' attitudes toward commitment. Over time, psychiatrists recog-

nized that the paternalistic promise of civil commitment during this period was often empty, as treatment was unavailable and hospital conditions were substandard. The future course of professional standards would reflect a rejection of this period of "warehousing" of the mentally ill and the broad, unfettered application of civil commitment that had facilitated institutionalization.

Civil commitment reform ushered in our current era of dangerousness-oriented criteria for hospitalization. These criteria require that a person by reason of mental illness pose a danger: a likelihood of causing harm to self, to others, or both; a grave disability; or an inability to care for self. These criteria function to limit the scope of paternalistic intervention. In 1982, the American Psychiatric Association adopted a model civil commitment law that substantially embraced the new libertarian reform; the model law reflected the change in professional practices that had occurred in the aftermath of reform.[19] A brief review of prevailing practices pertaining to involuntary civil commitment follows.

In modern, post-reform practice, ordinary civil commitment addresses the current treatment needs of the individual and, consequently, the predicate behavior justifying hospitalization must be recent. Some commitment laws embody this principle in a requirement that a recent, overt act serve as the basis for commitment. According to Levitt and colleagues,[1] in Arizona, this behavior must occur within 72 hours of commitment; other states have specified longer periods. Regardless of the legal period specified, professional standards recognize that psychiatrists must base their decisions on recent behavior.[19]

Similarly, because the purpose of ordinary commitment is to address an individual's current treatment needs, professional standards envision a short-term time horizon for the threatened danger. The APA model requires that the dangerous behavior be likely to occur in the near future. This focus on the near term also reflects the profession's position that psychiatrists cannot make long-term predictions of violent behavior. Moreover, the emerging practice of long-term risk assessment is not in the scope of general psychiatric practice, but rather is in the domain of specialized forensic practitioners.

Ordinary civil commitment is in the province of psychiatric practice. Psychiatrists either initiate the involuntary hospital process or collaborate with family, friends, or others in doing so. Regardless, the commitment process is best conceptualized as an aspect of psychiatric practice.

In retrospect, the psychiatric profession's widespread adoption of the principles of libertarian reform provided a critical blow to the routine commitment of unrestorable, incompetent defendants envisioned by the *Jackson* Court. At the time of the *Jackson* ruling, psychiatrists were inclined to view hospitalization on paternalistic grounds, broadly and uncritically. In an era in which outpatient resources were scant, communities intolerant of the mentally ill, and hospital beds relatively plentiful, justifying the commitment of a mentally disordered person who had significant ongoing cognitive impairments and recent criminal charges was not problematic.

Today, the circumstances are very different. As illustrated by the report in this issue of *The Journal*, psychiatrists involved in the ordinary civil commitment of unrestorable defendants predictably face problems of ethics and standard of practice. For example, Levitt and colleagues[1] expressed concern that the routine use of civil commitment in Arizona included many who did not qualify for hospital admission on any grounds. As many were at baseline, they were not going to benefit from further hospitalization and, therefore, it was not in their interests. Moreover, there was no basis for a finding of dangerousness and no immediate risk of harm in the near future. In sum, many of the defendants were not committable on the basis of modern psychiatric standards. In light of these findings, the authors felt that civil commitment may have been used as a back-door method to protect the community. They also take note of the plight of the inpatient assessment team in having to balance concerns about the safety of the community and the liability of doctors, hospitals, and courts. The practice in most cases, according to the authors, is to allow the commitment to continue and to allow the court to determine the outcome of the court-ordered evaluation process. It is evident that the treatment team was uncomfortable, as it should have been, that their patients' best interests had been relegated to the background. There is no facile solution to the problems currently faced by this treatment team.

Conclusions

Prosecutors and other representatives of the criminal justice system have demonstrated sustained resistance to *Jackson v. Indiana* because the ordinary

civil commitment system, as a result of the historical developments described earlier, no longer provides for the long-term management of problematic mentally ill individuals. Charged with protection of public safety, these officials cannot rely on ordinary civil commitment procedures. Yet, they cannot prosecute incompetent defendants.

The current approaches to unrestorable, incompetent defendants are dysfunctional. In some jurisdictions, defendants are committed for long periods in forensic systems. The costs of secure hospitalization are substantial and the lengthy commitments of these defendants often entail expensive evaluations, court appearances, and related costs of legal representation. The jurisdictions that follow this approach have dedicated substantial resources toward confinement, although many of these individuals could be managed in the community, and the investment in repeated assessments of competence and court proceedings does not appear to be warranted. In Arizona, the defendants are channeled into ordinary commitment and a service system designed for short-term hospitalization. This approach places a burden on a civil system and does not appear to have any advantages in promoting public safety.

While ordinary civil commitment has been rendered unsuitable for management of unrestorable defendants, other methods have improved over the years and have been underutilized in this population. Modern risk assessment tools have been applied to mentally ill offender populations and provide useful guidance for decision-making regarding management. Many states have implemented centralized insanity management programs that have developed methods for transitioning patients with violent histories to less restrictive settings and, ultimately, to the community. These methodologies seem to fit the needs of unrestorable defendants better than the ones currently employed.

It is time to reform our laws on the management of unrestorable, incompetent defendants and to implement sensible policies to protect the public. As should be apparent, the unrestorable, incompetent defendants share many characteristics with insanity acquittees. The American Bar Association Criminal Justice Mental Health Standards recognized these similarities in a 1986 proposal for reform.[20] The proposal pertained to permanently incompetent defendants who had been charged with "a felony causing or seriously threatening serious bodily harm." For these defendants, a hearing on factual guilt would be held. With the exception of the requirement of competence, the defendant would have the same rights as at a criminal trial. If the prosecution proved the elements of the offense beyond a reasonable doubt, then the defendant would be subject to the same special commitment procedures as an insanity acquittee. Although long ignored, the ABA Criminal Justice Mental Health Standards proposal is an innovative approach to a longstanding problem in forensic mental health. The proposal would provide a scheme that takes into account the public's interest in safety, while allowing sufficient flexibility to manage committees in the least restrictive setting under supervised monitoring; and, the professional evaluations would be conducted based on accepted principles of ethics in forensic practice, eliminating conflicts that might arise in the ordinary treatment settings.

The management of unrestorable, incompetent defendants is just one piece to a much larger, and growing, puzzle. The public sector has largely failed to meet the needs of mentally ill offenders. More than a million psychiatrically ill individuals are incarcerated in any given year, yet most fail to get services upon release and repeat the dismal cycle of arrest and imprisonment.[18] We require more innovation in the treatment of mentally ill offenders, including laws, policies, and programs to prevent their involvement in the criminal justice system, to maintain them in treatment following release, and to intervene early to avert arrest or to divert them to treatment-oriented dispositions.

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