Commentary: Restorability of Incompetence to Stand Trial—Implications Beyond Predictive Equations

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Since the United States Supreme Court ruling in *Sell v. U.S.* (539 U.S. 166 (2003)), the prediction of which incompetent criminal defendants are likely to be restored has assumed greater importance. A sophisticated mathematical approach shows promise in achieving this goal. But perhaps more importantly, the data used to construct the predictive equations for restorability yielded findings that may have far-reaching implications involving psychiatry and the community at large.

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In the 2003 case of *Sell v. U.S.*,[1] dealing with the involuntary administration of antipsychotic medication to an incompetent pretrial defendant, the United States Supreme Court promulgated four areas of inquiry (also known as the "*Sell* criteria") for a court to consider before ordering the involuntary restoration of incompetent defendants. The *Sell* criteria include the following: (1) the seriousness of the crime; (2) whether there is a substantial likelihood that involuntary medication will restore the defendant's competence and do so without causing side effects that will significantly interfere with the defendant's ability to assist counsel; (3) whether involuntary medication is the least intrusive treatment for restoration of competence; and (4) whether the proposed treatment is medically appropriate.[1] The first criterion is a purely legal determination. The second, third, and fourth criteria have direct relevance to psychiatric practice. The third and fourth criteria appear to involve matters that are relatively straightforward. The second criterion, however, involving the question of restorability of incompetent pretrial defendants, has received only minimal attention in the literature, despite being raised by the United States Supreme Court in *Jackson v. Indiana*[2] more than three decades ago. Moreover, the published literature through 2006 has not proven to be particularly useful in assisting the psychiatrist in arriving at a determination of the likelihood of restoration (see e.g., Refs. 3–6).

Mossman[7] has undertaken a probing analysis of the restorability of incompetent pretrial defendants that appears to signal a change in forecasting restorability. However, he approached the question using sophisticated statistics, which included the use of receiver operating characteristic analysis. He has already successfully used this technique to study the accuracy of violence predictions.[8] The final product of his exploration was a predictive equation for those in the state hospital system of Ohio who were admitted from 1995 through 1999 for competency restoration. Beyond the sophisticated mathematics of the study were potentially practical findings regarding who was likely or unlikely to be restored. Mossman found that eight variables were associated with a reduced likelihood of restoration: misdemeanor charge, age at admission, mental retardation, having schizophrenia and schizoaffective disorder, number

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of previous admissions to Ohio state hospitals, cumulative previous length of stay of Ohio state hospitals, non-African-American ethnicity, and the presence of a substance use disorder.

Across the Country in Washington

The factors from Mossman's study associated with failure of competency restoration efforts resonates across the country to Washington State. In Washington, before March 1999, only those defendants charged with felonies were eligible for competency restoration. But because of a high-profile homicide of a retired fire department official by a previously incompetent defendant charged with a misdemeanor, the law was modified to allow for the restoration of certain incompetent misdemeanants.[9] Eligibility for competency restoration for those charged with misdemeanors includes one of the following: (1) a history of one or more violent acts; (2) a pending charge of one or more violent acts; (3) previous acquittal by reason of insanity for a crime involving physical harm to another; or (4) a previous finding of incompetence to stand trial for a crime involving physical harm to another.[10] As with Ohio's competency restoration scheme, Washington uses different time frames for incompetent defendants charged with felonies and those charged with misdemeanors. The initial period of competency restoration for an incompetent felony defendant in Washington lasts up to 90 days. The period of competency restoration for eligible incompetent misdemeanor defendants in Washington ranges from 14 to 29 days. However, in practical terms, the amount of time available for competency restoration of incompetent misdemeanants generally ranges from 14 to about 21 days, because any time spent assessing the defendant's competence during the initial 15-day period of evaluation is subtracted from the 29 days.

Prior to the *Sell* decision, Washington trial courts handling the criminal matter ruled on both the matter of competence and involuntary administration of medication for competency restoration, following Washington state case law (see e.g., Ref. 11) mirroring the United States Supreme Court case of *Riggins v. Nevada*.[12] Before the operationalization of competency restoration for incompetent misdemeanants in 1999, the question of whether a defendant could be restored in the available time frame of 90 days for incompetent felony defendants had not generally been a contentious matter. However, beginning in 1999, the limited time frame allotted for the restoration of incompetent misdemeanor defendants became a major focus of court hearings involving competency restoration. In essence, Washington had been conducting *Sell*-type hearings before the *Sell* case. The hearings have continued since the *Sell* decision, and the likelihood of restorability for incompetent misdemeanor defendants has continued to be a key focus in the courtroom.

Before testifying at these *Sell*-type hearings, we (my colleagues Margaret D. Dean, MD, Roman Gleyzer, MD, Sarah E. Leisenring, MD, and I) futilely searched the literature for empirically derived and practical guidelines for testimony concerning the likelihood of restoration in incompetent misdemeanants. We could not locate such forensic literature to guide our testimony. Instead, based on our knowledge of the literature on inpatient psychiatric treatment and our clinical experience (including serving as attending psychiatrists on competency restoration wards), we hypothesized that the following factors appeared to be related to a low likelihood of competency restoration in two to three weeks: lengthy past inpatient admissions; failed prior competency restoration for a misdemeanor charge; prior competency restoration for a felony charge taking longer than the maximum allotted time for incompetent misdemeanants; history of cognitive impairment (whether due to dementia, traumatic brain injury, or substance use); and low intellectual capacity. Mossman's conclusions support our anecdotal findings regarding factors associated with a poorer outcome for competency restoration. In other words, his work appears to have applicability to what has been occurring in Washington state.

Potential Implications of the Ohio and Washington Experiences

From the collective experiences of Ohio and Washington, the restoration of incompetent misdemeanants appears to be a potential area for further debate. In Washington, when the legislature was crafting the statutory modification to allow for restoration of incompetent misdemeanants, clinical input into what constituted a reasonable period of time for treatment to restore an individual's competence went unheeded. Instead, both financial considerations and the myth that those who commit minor crimes (misdemeanants) are less mentally ill than those who commit major crimes (felons) and there-

fore would need less time in treatment appear to have been the driving forces in crafting the statutory modification in Washington. Although a discussion of the financial underpinnings of mental health treatment of mentally disordered offenders lies beyond the scope of this commentary, the myth that defendants charged with misdemeanors are less mentally ill than those charged with felonies appears to merit further consideration. In particular, the low likelihood of restoration for incompetent misdemeanants raises questions as to whether a different pathway should be taken, specifically greater involvement of the civil mental health system at an earlier point in time.

Mossman's study stirs up other potential areas of inquiry beyond the world of misdemeanants just discussed. With state psychiatric facilities shifting toward a forensic population, additional study is needed to describe outcomes of incompetent defendants, especially those charged with misdemeanor crimes. Competency to stand trial is the most frequent issue involving both the mental health and criminal justice systems. Yet, we have more information on what happens to individuals who have successfully raised the far less frequent defense of not guilty by reason of insanity.

In summary, although Mossman's rigorous mathematical approach to prognosticating about competency restoration needs replication in other states, its potential value for psychiatry and the legal system appears substantial. Nonetheless, the legacy of his research may have more far-reaching effects. Namely, his findings, as observed in Ohio and anecdotally in Washington and potentially elsewhere, regarding the restorability of incompetent misdemeanants raise challenging questions for psychiatry and the community at large that should be explored further.

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