

Crisis in the Treatment of Incompetence to Proceed to Trial: Harbinger of a Systemic Illness

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Across the nation, a growing number of defendants judged incompetent to proceed (ITP) to trial are unable to access needed mental health care because of critical shortages of state hospital psychiatric beds and funding. Many of these patients languish in jails and prisons that lack the resources to provide adequate care during their prolonged wait for treatment. The crisis is yielding results that are medically, legally, and ethically unacceptable. The problem is presented as the latest symptom of an overwhelmed mental health system. Deficits across multiple domains are responsible for the current ITP logjam, creating an emergency that has been receiving increasing attention by medical and legal professionals, the media, and the public. Achieving meaningful and long-term solutions will necessitate recognizing the deficiencies in mental health capabilities within jails and prisons, courts of law, and communities, and addressing the dire need for the integration of these sectors.

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The lack of adequate mental health resources across the nation is hardly a recent development. Like most problems left unaddressed, the difficulties related to insufficient psychiatric services continue to mount and to manifest in new and troubling ways. Recently, the latest symptom of this lack of resources has generated front-page news,^{1,2} with increasing attention from medical and legal professionals, the media, and the public. The crisis in treatment of persons judged incompetent to proceed (ITP) to trial is emblematic of an overwhelmed mental health system, representing the downstream logjam resulting from insufficiencies at multiple levels. As a result, hundreds of patients with severe mental illness deemed incompetent to proceed are languishing in jails around the nation, unable to access meaningful psychiatric care

and not moving forward in the legal process as they await admission to grossly undersized and understaffed state hospitals. It is not surprising that the combination of inadequate psychiatric care, the stress of incarceration, and the long waits involved have yielded nightmarish results for many of the individuals, including needless exacerbation of mental illness, bodily harm, and at least two reported deaths.^{3,4} Physicians, advocates for the mentally ill, proponents of constitutional law, legal and correctional authorities, and champions of basic human rights recognize the unacceptable situation that has resulted from the ITP crisis.

The Crisis

The ITP crisis is a national concern. Mossman⁵ reported recent estimates suggesting that 50,000 to 60,000 defendants are evaluated for competency to stand trial each year, and that nearly 20 percent of these defendants are found incompetent by courts. At any given time, defendants hospitalized for restoration to competency occupy nearly 4,000 psychiatric hospital beds in the United States, or more than 10 percent of the nation's state psychiatric hospital beds. The ITP crisis garnered particular attention recently in the states of Colorado and Florida.

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Judges, attorneys, local officials, and state hospital staff faced off in courts of law, mutually frustrated, and struggling to find prompt solutions for the backlog of incompetent defendants languishing in jails, a situation that raises profound constitutional and legal questions.

In the state of Colorado, a lawsuit was filed several years ago by patients of the state mental hospital alleging maltreatment and overcrowding. In a settlement reached in 1999, the hospital agreed to maintain a staff-to-patient ratio of 1.35 to 1.⁶ In the difficult fiscal years that followed, the challenge to provide much-needed services was compounded as budgets for mental health programs in the state were cut. The legislature reduced funding to the state hospitals by \$11 million in 2003 and 2004, and 103 hospital beds were lost in the process. Concurrently, the community mental health centers around the state lost \$30 million from their budgets. Just as the legislature was reducing budgets, the state hospital underwent an increase in referrals for adult competency examinations; referrals rose from 433 in 2003–2004 to 564 in 2005 and totaled 815 in 2006.⁶ Historically, the state hospital in Colorado has been an institution for the care and treatment of the civilly committed mentally ill. Twenty-five years ago, two-thirds of the hospital beds were designated for the civil commitment process. One-third of the hospital beds were designated for forensic use. In 2007, these percentages have reversed with the forensic division of the hospital continuing to grow and the number of beds for civil commitment remaining constant or shrinking.

The problem in Colorado attracted media attention when the case of a mentally ill and homeless man alleged to have stolen a bicycle entered Denver District Court. The defendant was examined by a psychiatrist and was found to be incompetent to proceed, and, on June 13, 2006, the judge ordered him into the custody of the state hospital for restoration to competency. Despite the judge's order, the defendant remained in the county jail for nearly four months, reportedly held in a small cell without medication and permitted out of the cell for only one hour a day. When the defendant was still in the jail three months after the order, the judge ordered the head of the state hospital to appear in court and explain why he should not be held in contempt. The defendant was finally moved to the state hospital in a decision that involved passing over a list of 77 other

inmates around the state who were awaiting admission to the hospital for restoration treatment.^{1,7}

In an effort to alleviate the problem, the Colorado Department of Human Services requested an emergency \$3.5 million allotment, which was supported by the governor. Without additional funding, the state hospital was simply unable to expand its services and hire the staff necessary to overcome the limitations on the number of patients who could enter treatment that was imposed by the staff-to-patient ratio mandated by the 1999 settlement. The citation issued by the judge ultimately expanded to include the head of the Department of Human Services, and the involved parties entered into mediation under the guidance of a retired judge from Boulder County. Special prosecutors appointed by the judge were poised to file a civil rights lawsuit seeking punitive fines of \$1,000 a day for each day inmates remained on the wait list without a reasonable solution.^{2,8} Fortunately, this outcome was avoided, and the involved parties agreed to a plan that provided that defendants in need of mental health treatment would be admitted to the state hospital in Pueblo within an average of 24 days. This outcome was largely facilitated by the allocation of much-needed funds. The backlog of defendants awaiting admission had been eliminated primarily because the Joint Budget Committee appropriated \$1.6 million on December 15, 2006, enabling the state hospital to open a 20-bed unit for competency evaluations and restoration. With this compromise finally came the realization that the staff at the state hospital are ultimately rich in heart, but poor in the pocket, not willfully denying treatment to defendants, but hamstrung by financial constraints ultimately beyond their control.⁹

A similar version of this crisis has occurred in Florida, described in the opinion filed by Florida's First District Court of Appeals on December 28, 2006, in the case of *Department of Children and Families v. Maurice Soliman and State of Florida*.¹⁰ In this case, the defendant had been found to be ITP and was ordered into commitment with the Department of Children and Families (DCF) on July 17, 2006. When August 29 arrived, the defendant still had not been transferred, and a new motion was filed that included a description of the defendant's condition: refusing medication, refusing meals, experiencing delusions that he was being poisoned, and undergoing confinement to an isolation cell for more than two months. The circuit court entered a new order

demanding that DCF explain why it had failed to comply with the prior order and Florida law. DCF responded on September 11, 2006, explaining that the defendant had been placed on a wait list, one that included 310 names of individuals awaiting transfer and treatment. The involved defendant was number 86 on the list. DCF argued that the court lacked the authority to trump orders for placement from other jurisdictions (by passing over the 61 male defendants higher on the list) and could not hold DCF in contempt for failing to comply with an order for immediate placement that it was incapable of meeting. On September 13, 2006, the circuit court issued a new order, mandating that the defendant be hospitalized within 10 days or be transported by sheriffs to the office of the Secretary of DCF and released into her custody. DCF sought appellate relief from the circuit court's order, and the court of appeals opined,

In this case the trial judge's understandable frustration appears to have led him to issue an order that DCF was incapable of complying with. There is no evidence to demonstrate beds were available. Beds cannot be created without funding. Adequate funding is up to the Legislature. Jumping the defendant over other defendants on the waiting list was not an option. The trial court had inadequate information to judge the conflicting needs of all the parties on the waiting list. The power to weigh these issues lies with the executive branch. . . . Clearly the trial court does not have the power to order the release of respondent to the personal custody of the Secretary of DCF [Ref. 10, p 5].

Numerous newspaper articles from Florida describe the local ITP crisis that has ensued. As alluded to in the case description just presented, the problem involves hundreds of defendants across the state, with judges and attorneys from multiple jurisdictions exasperated as order after order to place defendants into treatment goes unrealized. Individual tragedies illustrate the crisis. One inmate, mentally ill and trapped in legal limbo, awaited treatment while being housed in a suicide wing, where inmates reportedly live without bedding or clothes (they are issued paper garments) and dwell with the lights on 24 hours a day, seven days a week. Court records describe conditions involving overcrowded cells, with inmates sleeping on the floors of cells, drinking out of toilets, and living within walls stained with urine and feces. This particular inmate, when finally hospitalized after more than three months of waiting, rapidly responded to treatment, illustrating the avoidable consequences of the prolonged wait-list ordeal.^{3,11} In the Escambia County Jail in Pensacola, Florida, two mentally ill inmates were reported to have died after

being subdued by correctional officers.⁴ In the Pinellas County Jail, in Clearwater, Florida, a defendant with schizophrenia gouged out his eyes while awaiting hospital admission and treatment.⁴

That inmates have a right to both medical and mental health treatment and can file cases in both state and federal courts to contest the conditions of their incarceration is well established.¹² The case of *Estelle v. Gamble*¹³ recognized inmates' right to medical care, and *Bowring v. Godwin*¹⁴ clarified that this right includes mental health treatment. The case of *Bell v. Wolfish*¹⁵ established a due process requirement for appropriate medical and mental health care and recognized that failure to provide such services to pretrial detainees may cause suffering and death.¹² It is thus not surprising that the situations in Colorado and Florida have already sparked litigation, the financial burden of which can be expected to be substantial and to exacerbate the problems caused by already tight budgets.

Though the Florida District Court of Appeals recognized the impossible nature of the orders issued by lower courts and acknowledged the DCF's budget-imposed limitations, it seems more than likely that judges and juries in future civil cases will be compelled to vilify those perceived to be responsible for the deprivation of these basic rights and to compensate the victims. Long-term solutions not only require legislative appropriations of adequate funds, but also an understanding that the problem represents deficits throughout the mental health system. Attention to mental health services in jails and prisons, in courts of law, and in communities, as well as meaningful integration across these domains, are needed.

Jails and Prisons

The movement toward deinstitutionalization, despite good intentions, appears to have evolved into the criminalization of the mentally ill, with an unfortunate population shift from state hospital beds to jail and prison cells.^{16,17} Conservative estimates offered by Lamb and Weinberger¹⁷ suggest that roughly 310,000 persons with severe mental illness were incarcerated in jails and prisons during 2000, about 113 per 100,000 population. Unfortunately, the literature does not show a commensurate surge in mental health resources behind jail and prison walls. Though some improvements have resulted from legal mandates and various court rulings, the realloca-

tion of resources to meet the shift in population is far from balanced. And these changes, when initiated through court-mandated reform, occur slowly and over several phases described by Metzner¹²: a liability phase involving litigation, a remedial phase involving the development of standards of care and plans to achieve them, and an implementation phase involving the difficult task of overcoming institutional inertia and financial barriers to put the plans into action. One hopes that legislatures will recognize lessons from the past and initiate legislation and funding that might help avoid or minimize the costs in time, money, and human suffering that accumulate during the liability phase.

Clearly, the inadequacy of mental health services in jails plays a major role in the current ITP crisis. Enhanced psychiatric care in jails would presumably help alleviate the problem at three levels: fewer defendants would experience exacerbations of mental illness that result in incompetency, those who decompensated might be restored in jail and not have to wait for a hospital bed, and those requiring hospital-level interventions could receive meaningful treatment while awaiting transfer. While psychiatric services may be a distant or unrealistic goal for smaller or more remote counties across the nation, it seems reasonable to set such targets for larger jurisdictions and facilities, which are very much at the crux of the current ITP crisis. The development of such services in larger jails would help free up state hospital beds for those in smaller jurisdictions without the needed resources and would enable more rapid hospital access for the most severely disabled. Further complicating efforts to provide appropriate treatment to inmates within jail settings are legal obstacles to the implementation of involuntary treatment of the most seriously mentally ill. In Colorado, statutory restrictions make involuntary treatment almost impossible, often causing the most seriously ill jailed patients in dire need of treatment to be abandoned with no treatment or prolonged delay of treatment.

Recognizing that the ITP crisis represents only a fraction of an overwhelmed mental health system and that the former will likely improve with more attention to the latter, jail and prison administrators must address another major mental health service concern that is sorely lacking: discharge planning. Discharge planning is vital to maintaining continuity of care, without which mentally ill patients are likely to fall out of treatment and increase their risk of

bouncing back into the correctional setting. Sufficient discharge services involve the development of an individualized service plan that identifies the inmate's particular needs and appropriate community resources, linking the patient to mental health services in the community, dispensing a sufficient supply of medication to facilitate a smooth transition to community treatment, and providing referrals and/or assistance to establish adequate housing and finances after release.¹² The need for such services is dramatically illustrated by a recent study reporting that inmates in Washington face a risk of suicide after discharge that is 3.4 times greater than that of other state residents.¹⁸ It is difficult to imagine a more stark and obvious indication for urgent attention to meaningful discharge planning to facilitate reintegration into the community.

Courts

Courts around the nation are beginning to respond to the shift in the mentally ill population, recognizing that this segment of society is grossly over-represented in criminal court appearances. Diversion programs seeking to funnel mentally ill defendants away from correctional settings and into treatment have increased across the country, from about 50 to nearly 300 over the past decade, and the number of so-called mental health courts has grown from 2 in 1997 to more than 100 today.¹⁹ Numerous models of the mental health court have been developed, many based on lessons learned from drug-treatment courts. Common attributes of such courts include immediate intervention, a nonadversarial process, actively involved judges, treatment plans involving clear rules and goals, and a collaborative team approach.¹⁶

Participation in court-mandated substance abuse treatment has yielded positive results, with studies demonstrating that patients who get some treatment do better than those who receive none and those who complete treatment experience significant improvement. "Simply put, mandated substance abuse treatment produces improved clinical and social policy outcomes" (Ref. 19, p 298).

Redlich *et al.*¹⁹ queried 1,000 patients regarding their experiences with court-mandated or leveraged mental health treatment. Leveraged treatment was not associated with either treatment compliance or satisfaction, nor with perceptions of coercion or mandate efficacy. However, the authors point out

study limitations related to a lack of temporal sequencing and articulate a need for longitudinal studies to assess the effectiveness of court-mandated treatment of mental illness. Another compelling argument lies in the emerging evidence that these programs save money. The Rand Corporation recently released a report comparing the costs associated with sending mentally ill offenders through a mental health court versus a traditional correctional system over two years in Allegheny County, Pennsylvania. During the second year, those sent through the mental health court needed less intensive treatment and were not incarcerated, ultimately resulting in an estimated savings of \$18,000 per individual. Expanded over the nearly 200 defendants serviced by the mental health court per year, this equates to nearly \$3.6 million in savings for the county.²⁰

Of course, the courts' ability to mandate meaningful mental health treatment is dependent on the availability of such resources, which are sorely lacking in correctional settings, and the deficient state of mental health resources in the community creates significant limitations on the ability to divert mentally ill defendants away from jails and prisons, thereby making effective implementation of diversion plans a daunting challenge. It appears that even those courts most inclined to address the particular needs of mentally ill defendants assertively are hamstrung by logjams in either direction. As the ITP crisis illustrates, the power of a court order is only as real as the ability to comply with it. Frustrating as this may be for judges accustomed to having their orders obeyed, it is important that courts recognize the reality of the predicament, utilize their power to facilitate progress through cooperation and productive communication, and avoid escalating adversarial contests that may further alienate the parties that must eventually unite and collaborate to solve this national crisis.

Communities

A variety of community-based interventions have been explored in attempts to fill the vacuum of services created by drastic reductions in state hospital beds since deinstitutionalization. Some of these programs have been investigated and found to help minimize the need for hospitalization as well as reduce involvement with the criminal justice system. Swartz *et al.*²¹ reported that outpatient commitment, when combined with intensive case management, reduced

both hospitalizations and arrests among people with serious mental illness. Trudel and Lesage²² recently examined a population of patients with long-term mental illness residing in a semirural area without a psychiatric hospital. They describe a subgroup of such patients existing in a revolving-door situation with jails and identify a critical role for supervised long-term residential services in maintaining the severely and persistently mentally ill within the community. Parker²³ reports on a five-year study in which assertive community treatment (ACT) applied to 83 acquittees who were judged not guilty by reason of insanity on conditional release successfully yielded low arrest rates, moderate hospitalization rates, and good community tenure.

ACT is a form of community-based treatment in which a multidisciplinary team shares responsibility for all of its patients, directly providing services with expanded availability. Crucial elements involve a low patient-to-staff ratio and the ability to deliver services where the patients live and work, outside traditional clinic settings. The potential for effective incorporation of ACT services into mandated treatment and diversion programs appears to be a worthwhile direction for future investigation. Cuddeback *et al.*²⁴ reported on the level of ACT teams needed to serve a community: enough to provide service to 50 percent of the severely mentally ill population, or roughly 0.6 percent of the adult population. The authors specifically point out that jail detention is not routinely considered in ACT eligibility, despite the increasing trend toward incarceration of this population. Factoring in the considerable costs associated with correctional care should only further strengthen the cost-effectiveness of ACT services.

A vital step in obtaining the funds needed to establish crucial community services is convincing legislatures of the long-term cost effectiveness of providing treatment in the community. In time, the money devoted to solid ACT services should be recouped from hospital and correctional costs. While this prediction may strike some as overly optimistic, similar results have been reported in an analogous form of ACT services aimed at a population that extensively overlaps that of the severely mentally ill: the homeless. The Denver Housing First Collaborative recently reported on the results of a Housing First study involving ACT services for the chronically homeless, combining a place to live with integrated support services including health care, mental health

care, substance abuse treatment, supported employment, and educational opportunities. Results indicated drastically decreased average utilization across multiple costly service modalities: emergency room use declined 34 percent, overnight hospital stays dropped 80 percent, visits to detoxification centers were reduced by 81 percent, and nights in jail decreased by 76 percent. Overall savings per person in Housing First programs amounted to \$4,747 over a two-year period, suggesting savings in the millions across the study population. The U.S. Interagency Council on Homelessness reports that the results in Denver are in keeping with statistics emerging from other cities.^{25,26}

Integration

It is inevitable that there will be movement between systems of patients with severe mental illness. Even the most effective community mental health services will fail periodically to keep patients out of the correctional setting and can unburden jails and prisons only so much. Conversely, inmates will be released from incarceration and need reintegration into the community and guidance regarding the services that exist there. Without collaboration, the efforts of one system might be lost in the other. Clinicians on both sides of the fence have experienced patients who crossed over to the other side and got lost along the way, oftentimes with months to years of diligent mutual efforts between patient and clinician squandered in the transition.

As devastating symptoms erupt in the absence of support or treatment, potentially inordinate costs to both the individual and society in human suffering and finances accumulate. Societal costs include potential lapses in public safety, particularly when patients with comorbid severe mental illness and substance abuse are released into the community without resources or meaningful follow-up. In a consensus statement on the neurobehavioral aspects of unwarranted physical aggression, a panel of experts point to powerful evidence linking mental illness and violence.

Recent evidence has therefore clearly supported the link between mental illness and violence and has forced a paradigm shift among clinicians, who now acknowledge what the public has long suspected. Violence seems to be more likely among those with severe mental illness, particularly psychosis, and is exacerbated by alcohol and other psychoactive substance use [Ref. 27, p 10].

Ensuring the safety of both patients and the public at large necessitates recognizing the reality of the situation and the need for integrated services that seal the existing gaps between systems. Grudzinskas and Clayfield noted, "Only by taking a holistic approach and integrating services in all domains in which this very vulnerable population functions can we begin to offer hope that treatment will have any lasting effect" (Ref. 16, p 226).

Recent evidence suggests that, beyond relapses and suffering, the lack of integration across these systems may result in death. Binswanger *et al.*¹⁸ reported that inmates released from Washington prisons faced death after discharge at a rate 3.5 times higher than that of other state residents over a mean of 1.9 years. This disturbing statistic grows even more appalling during the first two weeks following discharge, during which time the increased risk of death relative to other state residents skyrockets to 12.7. Leading causes of death among released inmates included drug overdose, cardiovascular disease, homicide, and suicide. Clearly, this indicates a need for integration between prisons and community resources (mental health among others) and illustrates the consequences of systems' failure to operate in concert to sustain needed care and resources during periods of transition.

Cooperative efforts in Denver County are targeting this problem, with collaboration involving the Denver sheriff's department, the mayor's office, both the major inpatient and outpatient mental health providers for the county, the police department, the Denver County courts, the city attorney, county probation office, the public defender's office, and others. These group efforts have helped to establish various programs to address the complex problems facing both the criminal justice system and the mental health system. A special pod has been established within the county jail to house and treat the mentally ill, the diversion program has been modified and made more efficient, a court-to-community program has been established to remove from the county jails those nonviolent mentally ill defendants awaiting adjudication, and case management and other services have been developed to work closely on disposition planning with newly developed ACT teams in the community.

Prompt resolution of the current ITP crisis, as well as the larger mental health calamity that it represents, will necessitate close collaboration among jail,

prison, court, and mental health officials. Achieving solutions will necessitate recognizing that the ITP crisis is the result of deficits across all these domains and that the responsibility for rectifying the problem is a shared one. Only by invoking the strengths of the parallel systems and mutually supporting and respecting the others' efforts will each agency be able to achieve meaningful progress toward sustained benefits in this unfortunate population and to move toward the integrated system that the situation desperately calls for. Absent such efforts, the ITP crisis, with the tragedies it engenders, will persist, and the larger problems of inadequate mental health resources will continue to manifest in new and increasingly costly ways.

Conclusion

The legal, personal, medical, and ethics-related ramifications of the ITP crisis have become unacceptable, and mounting attention and outraged responses in our court rooms and in the media to the needless and potentially dangerous exacerbations of mental illness precipitated by the current situation demand action. Meaningful efforts to remedy the situation will require stepping back from the immediate problem, viewing our overall mental health system, and recognizing the deficiencies that exist throughout. Work is needed at multiple levels. Creating and/or expanding mental health services in jails and prisons is essential, and discharge planning must be a feature if mental health benefits are to be maintained. Our judiciary must continue developing mental health courts, to wield their legal powers to promote coordinated care and avoid pitting against one another in escalating battles the very agencies that must cooperate. Communities simply need more service availability, particularly ACT teams, and legislatures must proactively fund such programs, given the benefits to society in cost and safety. And the various systems involved in delivering these different aspects of service must integrate, recognizing their mutual goals and obligations, taking advantage of one other's respective strengths and abilities to maximize patient care, and avoiding oppositional showdowns that patients and society can ill afford.

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