

# Adjudicative Competence and the Criminalization of Intellectual Disability

Barry W. Wall, MD, and Ruby Lee, MD

Wood and colleagues effectively argue that Title II of the Americans with Disabilities Act applies to securing accommodations for persons with intellectual/disability disorder so that such persons can meaningfully participate in the criminal adjudicative process. This invited commentary further discusses the challenges in identifying, assisting, and fully accommodating persons with intellectual/disability disorder in the criminal justice system. It also highlights ongoing problems with stereotypes within this population, which may affect the outcome of criminal proceedings. This commentary argues that persons with intellectual/disability disorder will likely continue to be treated unequally in the criminal justice system until better supports, treatments, and services are provided in community settings because treatment and placement options are often closely linked with case disposition.

**J Am Acad Psychiatry Law 47:321–24, 2019. DOI:10.29158/JAAPL.003862-19**

In their article “Reasonable Accommodations for Meeting the Unique Needs of Defendants with Intellectual Disability”, Wood and colleagues<sup>1</sup> emphasize many challenges in applying the competence-to-stand-trial paradigm for persons with intellectual/disability disorders (I/DD). They effectively argue that Title II of the Americans with Disabilities Act (ADA)<sup>2</sup> is relevant in providing reasonable accommodations in courtroom settings. Similarly, they argue that Title II of the ADA applies to state-funded competency-restoration efforts when such persons are adjudicated incompetent to stand trial. In addition, they note that, while not covered under the ADA, modifying the competence-assessment process represents ethical professional practice. In linking the ADA with the competency paradigm, Wood *et al.*<sup>1</sup> propose solutions to reach a goal promulgated by disability advocates, which, for persons with I/DD, is to participate fully in the criminal justice system with accommodations. In this commentary, we elaborate

on the challenges the authors have identified and discuss additional topics relevant to the competency paradigm for persons with I/DD, including how stereotypes as well as inadequate funding for treatment and services for this population can affect criminal adjudication and sentencing.

I/DD is the second most frequent cause of adjudicative incompetence.<sup>3</sup> The I/DD population is heterogeneous, persons with I/DD can be arrested for a variety of charges, and the overall approach to the competency paradigm for I/DD varies by jurisdiction. All of these variables can lead to an array of complicated problems.

## Case Illustrations

Consider the following scenarios, which are composites based on experience.

### Case 1

A 20-year-old woman with I/DD lives at home with her parents and walks to her part-time job at a fast food restaurant, as she is unable to drive. She briefly has a boyfriend and becomes pregnant. She uses heroin heavily during pregnancy. No one notices that she is pregnant. Immediately after giving birth, she tells no one, neglects her newborn, and continues to use heroin. After the infant dies, she is charged with murder and is adjudicated incompetent to stand trial. In jurisdiction A, the woman is placed on outpatient commitment to live at home with her

Published online August 12, 2019.

Dr. Wall is Clinical Professor of Psychiatry, Department of Psychiatry and Human Behavior, Alpert Medical School of Brown University, and Director, Forensic Service, Eleanor Slater Hospital, Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals. Dr. Lee is Clinical Assistant Professor of Psychiatry, Department of Psychiatry and Human Behavior, Alpert Medical School of Brown University, and Assistant Director, Forensic Service, Eleanor Slater Hospital, Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals. Address correspondence to: Barry W. Wall, MD, 196 Waterman St., Providence, RI 02906. E-mail: barrywwall@gmail.com.

Disclosures of financial or other potential conflicts of interest: None.

family, where she receives no competency attainment efforts and only meager outpatient services. In jurisdiction B, the woman is transferred to a state hospital for competency attainment (restoration). No family member will accept her for placement.

### Case 2

A 21-year-old male with I/DD is arrested five times in the past six months for physically assaulting his sister at home. His father died seven months ago, so only his sister and mother care for him now. He is repeatedly recommended as competent to stand trial, but the public defender's office will not agree to the recommendation of competent to stand trial, so all five cases remain pending. The juvenile system (from which the young man aged out last year) applied for adult disability services two years ago, but that determination remains pending. If services are ultimately approved, he will receive an approval letter that puts him on a wait list for services. No outpatient services are currently available to meet his needs, however, even if he were to be approved for them.

### Case 3

A young man with I/DD lives with his mother near a school. The man is known to habitually approach elementary age girls at or near the school. He has received multiple misdemeanor charges for approaching young girls, and he is currently on probation for trespassing at the school. When he attempts to fondle an eight-year-old girl walking to school, he is then charged with sexual assault. The judge orders an evaluation to determine competence to stand trial, and the young man scores 44/50 on the Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR).<sup>4</sup> He is recommended as competent to stand trial. In his past criminal cases, the public defender's office has never requested a competency hearing, but it does so now.

As these cases demonstrate, the competence-to-stand trial paradigm for persons with I/DD consists of multiple interfaces: identifying/diagnosing I/DD; assessing competence to stand trial; providing competency restoration in different settings; and providing long-term support services (LTSS) generally. This commentary relies on our experiences with the competence-to-stand trial paradigm in our jurisdiction, continued use of the Slater Method in Rhode Island, correspondence with forensic professions

who use the Slater Method in other jurisdictions, and forensic consultative work in other jurisdictions.<sup>5,6</sup>

### Working with Courts

We emphasize the importance of avoiding I/DD severity specifiers delineated by the DSM-5, such as mild or moderate, when describing the diagnosis in a forensic setting.<sup>7</sup> Doing so may result in the court inadvertently minimizing an individual's degree of impairment if the severity specifier is mild. In addition, persons with I/DD with past experience in the criminal justice system may have more adaptive functioning in the courtroom setting compared with persons with I/DD with no prior arrests, even if the severity specifier is moderate.

In our view, using the Slater Method aligns with research that persons with I/DD can benefit from education to foster improvements in comprehension, performance, and working memory.<sup>5,6</sup> In our jurisdiction, using the Slater Method helps us demonstrate to the courts that we are working toward competency restoration in a systematic fashion, regardless of whether the individual who is adjudicated incompetent to stand trial is ultimately recommended to the court as having attained competency or as being nonrestorable. Because providing one-on-one competence training is resource-intensive, it would be useful if additional research could assess whether specific variables to predict nonrestorability as early as possible can be identified, such as degree of abstract reasoning or full IQ score. Accurately identifying persons with I/DD as nonrestorable as early into the court case as possible would help maximize the use of limited resources for competency restoration and attainment. Although competency attainment may never be achieved in Case 1 in jurisdiction A because there are no restoration services, it may be attainable in jurisdiction B even though placement in a state hospital setting is not ideal.

Persons with I/DD are not typically incompetent across all domains, but rather have a range of abilities. This reality can challenge lay stereotypes about the limitations of people with I/DD. Judges and attorneys may hold such stereotypes, which can also continue to affect competency determinations as the case progresses. This means that courts can continue to have bias toward identifying persons with I/DD as incompetent, based on stereotypes as well as on *bona fide* impairments. After all, the deficits cited in *Atkins v. Virginia* relate not only to capital sentencing but

also to competency: “[b]ecause of their impairments . . . by definition they have diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others . . . . They typically make poor witnesses, being more prone to suggestion and willing to ‘confess’ to placate or please their questioner . . .” (Ref. 8, p 305).

We find that the competency paradigm can be used to commit persons with I/DD into a more appropriate level of outpatient treatment, or off the streets into a state hospital setting when a safe outpatient setting is not available. Case 2 highlights the problem in transitioning persons with I/DD from the juvenile setting to the adult setting: sometimes approval for services is delayed by years, and sometimes the provision of outpatient services is wait-listed. In our experience, judges want care systems to provide meaningful LTSS. For better or for worse, the competency paradigm can be used to achieve that aim. Diversion to a state hospital to await development of LTSS, a lengthy process, is often preferred to placement in a correctional setting or return to the community without appropriate supports. Case 3 exemplifies the difficulty of continuing to place an individual in a community setting without LTSS.

Further, we observe that the goal of full participation of persons with I/DD in court settings with accommodations is not always desired by some. Modifying the forensic assessment and restoration process may not decrease inappropriate findings of incompetence to stand trial, and it may not increase proper findings of competent to stand trial with accommodations, when the process is used to garner LTSS in lieu of adjudication. Sometimes cases remain pending until LTSS is delivered, and only then will charges be dismissed in less serious matters. We have learned that arranging for LTSS may be the best way to circumvent contested competence cases instead of proceeding to a competency hearing. Forging a beneficial outcome by linking a person with I/DD to LTSS will continue to be the driving aim of some courts.

Our experience is that persons with I/DD who are initially adjudicated competent to stand trial or ultimately attain competence can also receive leniency at sentencing. Again, excerpts from *Atkins* are relevant: “There is no evidence that they are more likely to engage in criminal conduct than others, but there is abundant evidence that they often act on impulse

rather than pursuant to a premeditated plan, and that in group settings they are followers rather than leaders. Their deficiencies do not warrant an exemption from criminal sanctions, but they do diminish their personal culpability . . .” (Ref. 8, p 305).

Persons with I/DD, particularly those with behavioral disturbances that result in arrest, have complex needs that usually require intensive and comprehensive treatment over an extended period of time. Unfortunately, the current forensic management of high-risk individuals often involves many systems of care, many treatment modalities, high staff-to-client ratios, use of forensic mental health facilities, and incarceration. Although persons with I/DD will always come to the attention of criminal courts, their overrepresentation in the current era reflects the larger problem of accessing services. A joint position statement by the American Association on Intellectual and Developmental Disabilities and The Arc states, “The lack of a comprehensive community long-term supports and services system is a national crisis requiring immediate national solutions. The patchwork of limited private LTSS options and the current [Medicaid] program are not designed to address or capable of meeting the demand for community-based LTSS for people of all ages.”<sup>9</sup> This holds especially true for the forensic I/DD population.

We, too, believe that persons with I/DD should be able to fully participate in the criminal justice system with accommodations. The challenge of their full participation comes about in large part due to the closure of many I/DD public facilities, the lack of sufficient LTSS, and underfunding of I/DD systems, all of which can drive some of those in need of care into the criminal justice system.<sup>10,11</sup> The criminalization of intellectual disability is a complex public health problem that requires many solutions. Providing reasonable accommodations for persons with I/DD at court is only one part of that solution.

## References

1. Wood ME, Lawson KM, Anderson JL, *et al*: Reasonable accommodations for meeting the unique needs of defendants with intellectual disability. *J Am Acad Psychiatry Law* 47:310–20, 2019
2. Americans With Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 328 (1990)
3. Wall, BW, Ash P, Keram E, *et al*: Practice resource for the forensic psychiatric evaluation of competence to stand trial: Update 2018. *J Am Acad Psychiatry Law* 46:S4–S79, 2018
4. Everington C, Luckasson R: *The Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR)*. Worthington, OH: IDS, 1992

## Commentary

5. Wall BW, Krupp B, Guilmette T: Restoration of competency to stand trial: a training program for persons with mental retardation. *J Am Acad Psychiatry Law* 31:189–201, 2003
6. Wall BW, Christopher P: A training program for defendants with intellectual disabilities who are found incompetent to stand trial. *J Amer Acad Psychiatry Law* 40:366–73, 2012
7. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Washington, DC: American Psychiatric Association, 2013
8. *Atkins v. Virginia*, 536 U.S. 304 (2002)
9. American Association on Intellectual and Developmental Disabilities, The Arc: Joint position statement on long-term supports and services. Available at: <https://aaid.org/news-policy/policy/position-statements/long-term-supports-and-services>. Accessed May 30, 2019
10. Hemp R, Braddock D, King M: Community-based Medicaid funding for people with intellectual and developmental disabilities. National Conference of State Legislatures. Available at: <http://www.ncsl.org/research/health/community-based-medicaid-funding-for-people-with-intellectual-and-developmental-disabilities.aspx>. Accessed June 1, 2019
11. Medicaid. Long-term services and supports. Available at: <https://www.medicaid.gov/medicaid/ltss/index.html>. Accessed May 27, 2019