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Resolution or Resignation: The Role of Forensic Mental Health Professionals Amidst the Competency Services Crisis

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Competency-related services are rising at an unprecedented rate in the United States. Many states are in the midst of lawsuits and legal maneuvering to deal with long wait lists for defendants awaiting competency evaluations and admission to competency restoration services. As a result, many solutions have been proffered and implemented. However, solutions vary in their adherence to existing empirical research and applied experience. Forensic mental health professionals are uniquely qualified to shape the evolution of competency-related services into a humane and effective system. Promising policy implications can be rooted in emerging knowledge about the timing of competency evaluations, certification of evaluators, alternatives to inpatient restoration, and changes to evaluations and the associated reports. However, forensic professionals have typically given minimal attention to these issues, instead giving more focus to narrower issues of optimizing competency evaluations and restoration procedures. In so doing, forensic professionals are at risk of abdicating their expertise regarding competency-related services to other professions, as well as compromising their ethical commitments of beneficence and nonmaleficence in regard to incompetent defendants.

Keywords: competency to stand trial, forensic psychologists, forensic evaluators, forensic mental health professionals, ethics

Mr. Jamycheal Mitchell was a 24-year-old man charged with misdemeanors of petty larceny and trespassing after allegedly stealing a bottle of Mountain Dew, a Snickers bar, and a snack cake from a convenience store in April 2015 (Harki, 2018; Swaine, 2015). He was then booked into a Virginia county jail. After more than 1 month and one transfer to another regional county jail, he was adjudicated as incompetent to stand trial (IST) due to symptoms of psychosis. Mr. Mitchell was ordered to competency restoration in a nearby forensic hospital; however, after more than 2 months he had still not been transferred. At his next court hearing, 71 days after the original competency hearing, the court reinstated the order as he continued to be held in the county jail. Sadly, while awaiting his transfer, Mr. Mitchell's mental status deteriorated significantly. Relatives assert that he refused to take antipsychotic medication, was not coherent enough to contact relatives, and began refusing to eat. On August 19, 2015, Mr. Mitchell was found dead, alone in a cell covered with urine and feces and having lost 46 pounds, still awaiting transfer for competency restoration services. His official cause of death was listed as "wasting disease." Beyond the tragic nature of his death, Mr. Mitchell's incarceration and competency-related judicial processes cost thousands of dollars over the course of nearly four months—certainly longer than he would have spent in jail if he had been found guilty of the $5 theft charges. When asked about the accountability for his transfer to a state hospital, the court clerk on his case gave a troubling but all-too-accurate response: "It's hard to tell who's responsible for it."

Unfortunately, these types of anecdotes are all too frequent across the United States for defendants ordered to competency-related services. In January 2017, a defendant waiting 12 days for his transfer to competency restoration services died in the San Luis Obispo County Jail from complications due to his mental illness (McGuinness, 2017). In 2010, a northern California man previously adjudicated as IST hanged himself in jail awaiting transfer to Napa State Hospital (Shafer, 2015). Across the country in the Philadelphia county jail, a homeless man awaiting inpatient competency restoration services for more than 7 months was beaten to death in his cell by another inmate—while in a separate nearby facility, a different homeless man accused of stealing candy from a Dollar Store remained in jail awaiting competency-related services for nearly 1 year (Moraff, 2015). In Washington state, one woman was eventually deemed "gravely disabled" after waiting in jail for more than 5 months for competency-related services to materialize; she was transferred to a civil hospital as an emergency measure (*Trueblood v. State of Washington Department of Human and Social Services* [*DSHS*], 2015a).

The cases listed above are not meant to besmirch the personnel or agencies in those states listed; unfortunately, these sorts of examples represent a disconcerting and all-too-commonplace reality for people with serious mental health problems across the United States. These types of incidents occur across the country on

Data regarding timing of competency evaluations was presented at the 2016 annual conference of the American Psychology–Law Society in Atlanta, Georgia. It was also disseminated in testimony pursuant to *Trueblood v. State of Washington Department of Human and Social Services (DSHS): Hearing before Judge M. J. Pechman, 2015a*.

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a daily basis. Competency-related cases often occur in underresourced, overtaxed systems of evaluation and care, despite the efforts of dedicated personnel found working in those systems. However, this reality raises the question: how should forensic professionals seek to resolve this challenge, if at all?

To date, forensic mental health has seen great advances in both forensic evaluation and treatment. Prolific research, teaching, mentorship, supervision, and thought have created a sea change in our understanding of competency-related issues, and many policies and statutes have improved as a result. It is indisputable that current forensic professionals, as compared to the latter half of the 20th century, are better equipped to make accurate determinations of competency versus incompetency as well as to restore competency safely, humanely, and effectively. However, the bulk of empirical literature and training sites have been dedicated exclusively to the domains of evaluation and treatment. Very little—often no—time is spent considering the broader implications of our competency-related work and the systems in which we operate. In short, we have emphasized doing "good" work, but not necessarily "just" work. The good work is critically important, yet the consideration of how that good work interfaces with the broader system that surrounds it is also increasingly important.

As a former state forensic mental health director and as the former lead expert witness in the State of Washington's *Trueblood* lawsuit,[1] I firmly consider that delays associated with competency-related services represent a genuine moral crisis for the field of forensic psychology. Forensic psychologists currently often find themselves as unwittingly complicit with a fundamentally flawed and potentially inhumane system of mental health—services related to competency to stand trial (CST)—which places our standing as ethical practitioners at hazard.[2] Forensic psychologists may have difficulty adhering to overarching principles of beneficence and nonmaleficence if their work occurs unabated in the midst of inhumane conditions. These concerns have been raised before (Poythress, Otto, & Heilbrun, 1991; Wortzel, Binswanger, Martinez, Filley, & Anderson, 2007), but few have heeded the alarm; unfortunately, circumstances have only worsened with time.

This article will describe the competency system in greater detail—providing context for its inherent problems, exploring a variety of potential solutions, and considering policy and practice implications that may improve it.

Increasing Demand for CST Evaluations and Restoration

CST evaluations represent the most frequently ordered mental health evaluations by criminal courts (Melton, Petrila, Poythress, & Slobogin, 2007). Courts order an estimated 25,634–51,500 CST evaluations each year nationally, varying from fewer than 50 to approximately 5,000 per year in individual states (Fitch, 2014; Warren, Chauhan, Kois, Dibble, & Knighton, 2013). Moreover, court orders for CST evaluations are growing annually (Johnson & Seaman, 2008). For example, CST evaluations in Wisconsin increased 32.5% from 2010 through 2015 (Wisconsin Department of Health Services, 2015), while evaluations in Washington increased 76.3% from 2001 through 2012 (Joint Legislative and Audit Review Committee [JLARC], 2014). Colorado reported a 206% increase in the number of competence evaluations from 2005 to 2014 (Colorado Department of Human Services, 2015), and Los Angeles county reported a 273% increase from 2010 to 2015 (Sewall, 2016). Roughly 20–40% of those referred for CST evaluations are found incompetent and ordered into competence-restoration services (Murrie & Zelle, 2015; Pirelli, Gottdiener, & Zapf, 2011). Consequently, as the number of CST evaluations increases, so too does the need for restoration services.

Typically, when a person is adjudicated as IST, legal proceedings are temporarily halted and the defendant is remanded to competency restoration. Competency restoration usually occurs in state hospitals (Pinals, 2005). As competency evaluations increase, then, so do inpatient populations of defendants ordered to restoration. The overall percentage of forensic admissions for all state hospital patients increased from 7.6% in 1983% to 36% in 2012 to approximately 58% in 2014, with restoration cases comprising the largest proportion of forensic patients (Parks & Radke, 2014; Wik, Hollen, & Fisher, 2017). For example, Wisconsin saw a 34.8% increase between 2011 and 2013 in defendants adjudicated IST and ordered to restoration (Wisconsin Department of Health Services, 2013), Hawaii saw a 35.8% increase from 2005 to 2009 (Gowensmith, 2010), Washington had a 73% increase between 2010 and 2014 (JLARC, 2014), and Los Angeles County reported a 48% increase in the 2014–2015 year alone (Los Angeles County Health Services, 2016). In Oregon, the rate of competence restoration cases increased 129% from 2012 through 2017, with 42% of restoration services provided to misdemeanants (A. Millkey, personal communication, October 16, 2017).

However, many states are struggling to meet the demand caused by the exponential increase in competency-related services. This has often led to long waitlists for the evaluations to be completed. Some states have reported waitlists of more than one year for pretrial evaluations to be conducted, whereas many states remain under some sort of oversight from federal or state agencies to ensure that evaluation wait times are reasonable (Gowensmith, Murrie, & Packer, 2015; Locklair, 2016). For example, Arkansas

[1] *Trueblood v. State of Washington Department of Social and Health Services* (2015b) was a class action lawsuit in which plaintiffs were composed of individuals ordered to competency-related services. Plaintiffs argued that wait times for CST evaluations, as well as transfers of incompetent defendants to restoration settings, were excessive and consistently stretched beyond statutory time limits. The statutory time limit for both categories of plaintiffs had changed over time prior to the lawsuit. At the time of the lawsuit, statute included an aspirational target of seven days for CST evaluations conducted in jails. A 7-day aspirational target was also applied to incompetent defendants awaiting transfer to an inpatient hospital restoration setting. However, actual average timeframes ranged between 19–33 days for CST evaluations, and 15–17 days for transfers for incompetent defendants, both clearly beyond their corresponding aspirational seven-day timeframes. The presiding judge thus ruled in favor of the plaintiffs, essentially reifying the 7-day timeframe for CST evaluations and transfers of IST defendants to restoration settings. The ruling has since been appealed, adjusting the evaluation time frames slightly (now 15 days), and the case is now in a federal monitoring stage. The author's role in the trial was in representing the Department of Social and Health Services to argue against the 7-day evaluation timeframe and against the implementation of fixed, immovable timeframes within which restoration must begin.

[2] The issues discussed in this article are also relevant for other forensic professionals (e.g., forensic psychiatrists, psychiatric nurses performing CST evaluations, etc.). For the sake of readership, "forensic psychology" is used as shorthand for all of the disciplines involved with competency-related services. Domains or issues that are exclusive to forensic psychology will be described where indicated.

was placed under a settlement agreement after a 2002 case found defendants waiting more than eight months for CST evaluations; Louisiana's waitlist for restoration services was more than five months on average, resulting in a 2010 consent decree. Class action lawsuits in the states of Oregon and Washington successfully lobbied for shorter wait times for CST evaluations and access to competency restoration services (*Oregon Advocacy Center v. Mink*, 2003; *Trueblood v. State of Washington Department of Human and Social Services*, 2015b). Other states, like Colorado, Pennsylvania, Nevada, California, and Washington are embroiled in current CST-related legal battles, while several others (e.g., Alabama, Texas, Utah, Washington, DC) are actively attempting to fend them off (Locklair, 2016). Colorado's 2018 legislative session literally ended in a midnight filibuster that killed a controversial bill that would have allowed defendants found IST to receive jail-based restoration in local county jails for up to 150 days before hospitalization would be required (Colorado General Assembly, 2018). In fact, these realities are being encountered in other Western countries as well; the country of South Africa has experienced such massive delays for evaluations that leaders there are proposing sweeping changes across virtually every part of the CST evaluation process (Pillay, 2014).

Causes of Delays for CST Services

No one singular cause has been identified to explain the sharp increase in CST evaluation and restoration cases, and it seems unlikely that one factor will be identified. A constellation of factors is likely responsible. Although empirical evidence is lacking in this area, some potential explanations are briefly offered here.

Ineffective Community Mental Health Service Systems

Competency-related services are ordered, by definition, for people who are charged with criminal behavior and who are suspected of experiencing symptoms of mental illness. A largely ineffectual public mental health system may therefore contribute to the increase in competency-related services. For example, in response to the economic downturn of the late 1990s, the Hawaii Department of Health drastically reduced the number of reimbursed case management hours from three hours per week to three and a half hours per month. This left many persons with serious and persistent mental illness without adequate levels of community treatment, dramatically increasing the size of the forensic population (*Hawaii Disability Rights Center v. State of Hawaii Department of Health*, 2010). Without adequate support services—employment, peer-supported clubhouses, residential housing, substance abuse—many individuals with serious mental illness may fall through the cracks and be at increased risk for engaging in minor, quality-of-life transgressions either to make ends meet or because untreated symptoms override good judgment. This criminalization of the mentally ill has become a widely adopted tenet across mental health and criminal justice settings (Lamb & Weinberger, 2017).

Some data supports this hypothesis. Most CST evaluations are now ordered on misdemeanant defendants (Gowensmith, Murrie, & Boccaccini, 2012; Los Angeles County Health Services, 2016). Further, defendants charged with less serious, often low-level or nuisance offenses, are disproportionately likely to be found incompetent (Cochrane, Grisso, & Frederick, 2001; Gardner, Murrie, Torres, & Agee, 2018; Warren et al., 2006). Data from two jurisdictions, Virginia and Hawaii, reveal that individuals arrested for misdemeanors or nuisance offenses tend to have more severe psychiatric illness than those arrested for felonies (Gowensmith, 2010; Warren et al., 2006). For example, in Hawaii, 65% of misdemeanants referred for CST evaluations had a psychotic disorder, compared to 44% of felony offenders. Furthermore, 30% of misdemeanants had a recent psychiatric hospitalization, compared to 19% of felony offenders. As another example, the City of Denver has compiled a list of its most frequent users of mental health crisis services; this chronically homeless, nuisance-level population is significantly overrepresented in the CST evaluation process as well (Gowensmith, Laub, & Nadkarni, 2015).

Increasing Mental Health Expertise in Courtrooms

The judiciary likely plays an important role in the increase of CST evaluation and restoration cases. Mental health advocates, including some judges and attorneys, have attempted to increase the knowledge and sophistication of judiciary personnel regarding mental health issues. In addition, many jurisdictions (e.g., Boston, Chicago, Denver, Honolulu, and Washington, DC) place mental health professionals in high volume courtrooms with high frequencies of mental health cases. It seems likely that the acumen of many judges and attorneys in recognizing legitimate indicators of potential competency-related issues in defendants has subsequently increased. As a result, judges and attorneys may decide to raise competency concerns more often.

Access to Mental Health Services

However, it is also possible that court personnel may at times use competency services to access broader mental health assessments or treatment. To be clear, CST has a constitutional basis as a fundamental protection for defendants.[3] It should be raised without exception when indicated, without influence from mental health or correctional system pressures. However, some defense attorneys may use the CST evaluation as a de facto mental health query, more so to broadly investigate (or raise) the role of mental illness germane to the case than to specifically address competency. In felony cases, they may use the CST evaluation to "fish" for evidence supporting a possible insanity or diminished capacity defense without formally raising the defense. Similarly, judges may use the competency restoration process to mandate treatment for a person who might not otherwise meet criteria for treatment. In short, the rationale for some competency-related services may not simply represent a constitutionally driven due-process protection for persons with mental illness, but instead serve as a potential "back-door" mechanism to test for potential mental illness or to provide treatment services to individuals with mental illness who are not able to access treatment in the community (Appelbaum, Fisher, Nestelbaum, & Bateman, 1992).

[3] A full description of the constitutional basis for competency to stand trial is beyond the scope of this article. Interested readers are directed to the extensive relevant case law or to excellent reviews of the topic for more information (Mossman et al., 2007; Packer, 2009).

Consequences of Long Waitlists

Regardless of how well-intentioned or duplicitous the rationale for the increase in competency-related services may be, the fact remains that demand is outstripping the capacity for most systems to keep up—resulting in serious consequences for systems and individuals alike.

Potential for Harm

In the United States, most CST evaluations are conducted in correctional facilities (Edens, Poythress, Nicholson, & Otto, 1999; Gowensmith, Murrie, & Packer, 2014; JLARC, 2014). Likewise, defendants found IST and ordered to inpatient hospitalization are typically held in the same county correctional facilities until transfer occurs. However, waitlists for admission are often long and the mental health resources in county jails are often inadequate. This combination leads to defendants waiting in jails for long periods of time before competency services begin, often without adequate treatment. As the tragic illustrations at the beginning of this article demonstrate, this can create serious problems. Symptoms of mental illness typically worsen in the absence of treatment; untreated mental illness, particularly untreated psychosis, can lead to irreversible brain atrophy (Altamura, Buoli, & Serati, 2011; Lieberman & Fenton, 2000). Individuals awaiting mental health interventions while in correctional facilities are also at a significantly higher risk for suicide, self harm, and victimization (Hayes, 1995). These problems have provided the foundation for most civil or class action lawsuits regarding competency-related delays.

Limited Resources and Overcrowding

Another downside to long evaluation wait times is the overcrowding of jail and hospital facilities in which defendants are being held. America's incarcerated population is extremely high—more than one out of every 110 U.S. citizens is behind bars (Glaze & Kaeble, 2014), and more than 2.1 million people were incarcerated in 2016 (Kaeble & Cowhig, 2018)—with some jails crowding up to three prisoners per available bed (U.S. Department of Justice, 2015). Moreover, more than 16% of all U.S. prisoners are seriously and persistently mentally ill, including 31% of all female offenders (Steadman, Osher, Robbins, Case, & Samuels, 2009). Accordingly, correctional facilities face significant obstacles when it comes to providing adequate mental health treatment to prisoners. Although state hospitals fare better, many have long waiting lists for entry into the facility (Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010). Moreover, hospitals are increasingly filled with forensic patients rather than civilly admitted patients, creating a pernicious cycle in which a court-order pursuant to a criminal charge is increasingly needed to access an inpatient bed (Parks & Radke, 2014; Torrey et al., 2010; Wik et al., 2017).

Most people who undergo a forensic mental health evaluation are not ultimately found to need court ordered mental health care; in the United States, fewer than 40% of CST evaluations result in findings of incompetence (Gardner et al., 2018; Pirelli et al., 2011). Consequently, most of the people evaluated will ultimately not require intensive, hospital-level services. Long and burdensome competency-related services thus exacerbate the inefficient allocation of mental health resources to those that critically need them.

Financial Costs

Lengthy stays in jails and hospitals while defendants wait for evaluations cost taxpayers a significant amount of money. Although costs vary among facilities, one day in a U.S. jail costs an average of $85.77 (Henrichson & Delaney, 2012). Using conservative estimates, the cost of competency evaluations across the United States totals to approximately $50 million per year.[4] This estimate likely underestimates actual costs, as it does not include the realities that evaluations often take longer than 31 days to be completed, that many defendants wait in jails for weeks to months until competency is raised, that defendants waiting for competency-related services likely incur higher per-inmate costs than other inmates, or that some evaluations are conducted in state hospitals at an average of $1,800 per day (Rappleye, 2015). Nor does this include the even higher costs incurred through competency restoration (typically conducted in state hospitals at an average of 60–120 days per defendant). Although exact figures cannot be calculated, there is little debate that competency-related costs are significant. Delays and inefficiencies in competency-related services only compound taxpayer costs. Frustrations with the slow nature of the judicial system abound in media sources, often focused on the unnecessary expenditure of public taxpayer dollars (Johnson & Seaman, 2008; Sewall, 2016).

The Importance of Informed Decision-Making

It can be argued that the avalanche of referrals for CST evaluations and subsequent orders for CST restoration represents the largest current crisis facing the public forensic mental health system. The confluence of problems associated with competency-related services detailed above has led several states into threatened or actualized class action litigation (Locklair, 2016), forcing these jurisdictions to find solutions. These approaches have been met with varying levels of success, with most still awaiting rigorous empirical investigation to determine effectiveness.

The most common approaches will be reviewed here. Prior to that review, however, is a bit of context. It is important to note that many of these attempted solutions have been proffered largely by judicial and legislative systems, often with varying degrees of input from forensic mental health professionals. Although some states have welcomed input from mental health experts in developing remedies, others have been more skeptical. In some instances, mental health departments and court settlement agreements to improve competency-related services have been antagonistic in nature, with court decrees and requirements from court monitors trumping suggestions from mental health administrators, practitioners, and researchers. In many cases, what may seem like a promising fix can actually represent a tenuous idea without adequate empirical support behind it. Given that, the approaches reviewed here will include any relevant existing empirical support, as well as relevant avenues for future research and implications for public policy.

[4] This total cost was calculated by multiplying the average jail cost of $85.77 per day (Henrichson & Delaney, 2012) times the average national maximum number of days that states allow for competency evaluations to be completed (31 days; Gowensmith et al., 2014). This figure was then multiplied by a conservative estimate of the number of annual competency evaluations (20,000; Fitch, 2014).

Potential Solutions

Shortening the CST Evaluations

Some jurisdictions and practitioners have posited that shorter CST evaluations could alleviate demand by allowing evaluators to conduct more evaluations in a shorter amount of time. Could CST screens or checklists, for example, be utilized in lieu of more comprehensive reports? The initial *Trueblood* decision (2015b) suggested that competency evaluations could be completed more efficiently if a checklist system were used. The checklist idea is appealing in many respects: checklists prioritize speed, simply providing a quick checklist of demographic and diagnostic criteria, with the dichotomous determination of competency reflected in a checkbox. Comprehensive reports are therefore not required—resulting in quicker determinations and adjudications of defendants' competencies.

However, critics have consistently argued that a checklist methodology omits critical psychological information and psycholegal rationale, leading to potentially higher rates of inaccuracy as well as precluding any fallibility or critical analysis of the opinion (Grisso, 2003). Experts must provide the rationale for their opinions, so that their opinions can be challenged—a fundamental due process right afforded defendants in nearly all legal circumstances (*General Electric v. Joiner*, 1997). The checklist approach was more commonly practiced decades ago, when CST evaluations were in their infancy (Nicholson, Robertson, Johnson, & Jensen, 1988; Robey, 1965). More current sources emphasize that the most crucial aspect of a CST evaluation is for an evaluator to transparently detail the specific ways in which symptoms impact psycholegal capacities, rather than stating a dichotomous CST opinion (Melton et al., 2007; Skeem & Golding, 1998; Zapf & Roesch, 2009). However, checklists may be useful in regard to procedural issues; they are commonplace in surgery rooms and airline cockpits to ensure that all necessary procedural steps have been completed. Perhaps checklists could be beneficial as a CST process tool, rather than a content one. Empirical research is needed to identify the benefits and limitations that checklists can play in the competency evaluation.

Competency screens, however, may be more promising. A handful of jurisdictions (Washington, DC, Maryland historically, and some counties in Nevada) use an abbreviated evaluation process in CST cases. In these states, CST evaluations are triaged by the findings of these initial preliminary screeners. Defendants are typically screened within a short period of time (e.g., within 5 days in Washington, DC); those that are identified as likely to be IST are referred for a thorough evaluation. The use of a screening procedure in these contexts seems promising, as they are not used as a proxy for a comprehensive evaluation. Although promising, empirical data as to the quality and reliability of these screens is unfortunately lacking.

Ini addition, using a triage system for CST evaluations could help alleviate long waiting lists for both evaluation and restoration. Several states, such as Colorado, Hawaii, Massachusetts, Ohio, Oregon, and Washington, DC, operate court-based clinics or use court-based clinicians in an attempt to have a mental health expert immediately available at the court's discretion. These clinics and clinicians perform quick screens at arraignment to identify and prioritize the most acutely ill for evaluation and treatment. Of course, other logistical matters have been resolved within such models before implementation (e.g., appointment and access to an attorney, communication of assessment results, accessibility of collateral risk-related and mental health information). In a triage-informed system, selected defendants are given priority for CST evaluation; CST evaluators then use a triage model to identify and prioritize the most acutely ill defendants for hospital-level care for either restoration or further CST evaluation. Restoration services can also use a triage system to "fast track" defendants who are likely to respond quickly to restoration efforts and schedule re-evaluations of CST more nimbly.

Multnomah County (largely represented by the city of Portland, Oregon) has implemented an innovative version of a triage approach (Joplin & Ferguson, 2018). A group forensic psychology practice reserves at minimum two CST evaluation slots for those referred by the local court overseeing most competency-related cases. A team composed of a judge, a mental health district attorney, defense attorneys, and county mental health workers prioritize cases based on urgency of mental health need, duration of time in custody, and the nature of the charge. In this jurisdiction, defendants who are IST and who have nonperson misdemeanors often have their cases dismissed in the interest of justice. Wait times for those evaluations are substantially shorter than those for other cases—they take fewer than 6 days to conduct, compared with the 30+ day average statewide. The evaluations are comprehensive evaluations, rather than checklists or abbreviated evaluations, providing the court with a full complement of information. To date, no empirical investigation has been produced on the evaluations produced in this triage system. It is important to know if the base rates for opinions have changed, if cases opined as IST versus CST are accurately categorized as such, and if any pressures from quick-turnaround requests have affected the evaluations or evaluators. Similar research needs to be conducted on other court-based clinics and clinicians as well, to determine their true viability. Still, the Multnomah approach seems to show promise as a well-coordinated, small-scale triage methodology worthy of investigation and potential expansion.

Expanding the Pool of Qualified CST Evaluators

The *Trueblood* decision also recommended expanding the pool of qualified evaluators beyond psychologists and psychiatrists to include other disciplines, such as social workers or psychiatric nurse practitioners (*Trueblood v State of Washington DSHS*, 2015b). An increasing number of states are using this approach to meet the CST service demand (Gowensmith, Pinals, & Karas, 2015). In 2006, seven states sanctioned disciplines other than psychology and psychiatry to conduct CST evaluations; in 2015, the number was 17 (Frost, de Camara, & Earl, 2006; Gowensmith et al., 2015). South Dakota became the most recent state to allow social workers to conduct competency evaluations (State of South Dakota, Task Force on Community Justice & Early Intervention, 2016).

Allowing more people to conduct CST evaluations seems like a simple solution to managing demand. Historically speaking, the idea has merit. Forensic evaluation was once the exclusive domain of psychiatry. The *Jenkins v. United States* ruling in 1962 fueled the expansion of forensic evaluation to include psychology; consequently, psychologists increasingly became statutorily eligible for forensic evaluation work over the ensuing 50 years (Frost et al.,

2006; Gowensmith et al., 2015). A great deal of skepticism existed about psychologist's ability to conduct high-quality evaluations post-*Jenkins* (Petrella & Poythress, 1983; Perlin, 1977). However, empirical research has consistently shown that little to no differences in CST report reliability or quality exist between those produced by forensic psychiatrists versus forensic psychologists (Gowensmith et al., 2012; Petrella & Poythress, 1983; Robinson & Acklin, 2010; Warren et al., 2006).

How did forensic psychology attain this credibility and validity? The key seems to lie in training. Post-*Jenkins*, psychology developed a specialized forensic training infrastructure patterned after forensic psychiatry training programs. This infrastructure included a consistently expanding array of opportunities for specialized forensic practicum, internship, and fellowship positions. Today, more than 50 predoctoral and postdoctoral sites exist that are dedicated to full-time forensic psychology training (Association of Psychology Postdoctoral & Internship Centers, 2018). This focus on training is critical, because forensic evaluation (including CST evaluation) requires an advanced skill set not covered in nonforensic training programs. Evaluators must be able to use advanced medical or psychological testing, make accurate diagnoses, thoroughly assess for misrepresentation of symptoms, and recognize medical and cognitive disorders. They must also possess a command of complicated psycholegal issues, case law, and courtroom procedures (i.e., defendants proceeding pro se, retrospective competency assessment, juvenile capacities). CST evaluations are also often complicated, requiring evaluators to consider difficult psychological, legal, and cultural nuances (Kois, Pearson, Chauhan, Goni, & Saraydarian, 2013; McCallum, MacLean, & Gowensmith, 2015; Mossman et al., 2007; Pinals, Tillbrook, & Mumley, 2006; Parker, 2016). Focused training in these areas is paramount.

Not all mental health practitioners are provided with the requisite training to address these sorts of complexities. Perhaps with adequate training, professionals in other disciplines such as social work, psychiatric nursing, or master's level psychology can conduct high-quality, reliable CST evaluations as well. The American Bar Association's Criminal Justice Standards for Mental Health supports this conclusion, recommending that the CST evaluation pool include disciplines beyond psychiatry and psychology. However, the Standards also state that "each jurisdiction should strive for the highest possible qualifications" of potential evaluators, requiring that certification standards including requisite training, education, and experience (American Bar Association, 2016).

Overall, history has shown that the discipline of evaluators may be less important than the skills, training, and experience they possess (Petrella & Poythress, 1983; Poythress et al., 1991). However, it seems that some states have reactively expanded the eligible CST evaluator pool to include other disciplines exclusively as a function of meeting demand. This seems unwise from a policy perspective. Opening eligibility to underqualified evaluators, regardless of discipline, will likely exacerbate problems long-term. A more sensible approach might be to ensure that a certain level of expertise be maintained for all evaluators—regardless of their professional disciplines—and to create mandatory training requirements for those who are not yet adequately prepared.

Some states have taken this approach. About half of the states in the United States require CST evaluators to complete a formal certification process prior to being designated as a CST evaluator (Gowensmith et al., 2015). Massachusetts, Michigan, Georgia, Oregon, and Virginia (among others) all maintain certification programs for CST evaluators. Certification and training shows preliminary promise: research on a statewide pool of forensic psychologists and forensic psychiatrists showed improved reliability and quality of CST evaluation reports after attending a mandatory 3-day certification training for competency evaluators (Gowensmith, Sledd, & Sessarego, 2015; Robinson & Acklin, 2010).

However, more research is needed in this area. The true impact of differential training, certification, or statutory requirements is unknown. Although the impact of training and experience in other areas of psychology has been mixed (Garb, 1989; Miller, Spengler, & Spengler, 2015), such research has yet to be broadly conducted with regard to forensic evaluations. A comparison of the quality of CST reports between states with stringent certification standards versus those without such requirements would help determine just how meaningful certification requirements are. Additional research could also help determine what other variables correlate with higher-quality CST evaluations, such as discipline, differential pay, or training (i.e., postdoctoral fellowships, board certification).

This concept also extends to competency restoration. A recent study found that restoration interventions suffer from low quality, with poorly trained staff offering piecemeal approaches that do not have fidelity to the restoration models used in the study (Samuel & Michals, 2011). Still, empirical investigation of the relative effectiveness of various competency restoration modalities is extremely limited. It is disheartening to note the near-complete void in research devoted to competency restoration given the sheer numbers of defendants in restoration and the high stakes at play for involved. Restoration seems to be an afterthought in the empirical competency-related literature. Like evaluators, specialized competency restoration professionals may warrant specialized skills or training to work effectively. Much more empirical research is needed in the area of competency restoration effectiveness—what types of interventions or programs are most effective, what skills are most critical in restoration professionals, what modalities show the best outcomes, and so on. Of particular interest are the varying benefits of the components found in traditional restoration settings, as the extant literature is mixed as to the differential benefits of particular restoration classes or sessions versus psychiatric medication (Bertman et al., 2003; Carbonell, Heilbrun, & Friedman, 1992; Mueller & Wylie, 2007; Scott, 2003). Mandating ineffective clinical components could potentially lengthen lengths of stay in restoration settings unnecessarily. Good research will help restoration settings optimize their restoration efforts, facilitating efficient movement through programs and thereby reducing wait times to access them.

Alternatives to Inpatient Competency Restoration

A potential "release valve" for state hospital census pressure is outpatient competency restoration (OCR). OCR serves as an alternative to inpatient competency restoration, which has served as the traditional default for competency restoration in most states. A recent study (Gowensmith, Frost, Speelman, & Therson, 2016) showed that although most state statutes allow for certain defendants adjudicated as IST to be ordered to an outpatient restoration program, few states operate such programs. At the time of the

study, a total of 16 states used formal OCR, with most programs originating within the previous 10 years. Programs tend to serve adults with serious mental illness facing low-level charges, and services range from standalone competency restoration classes to a broader array of psychosocial services. Programs showed substantial differences among each other in terms of operations, staffing, structure, and eligibility.

Despite the variability across programs, results are promising (Gowensmith et al., 2016). Restoration rates approach those found in state hospital inpatient programs, with lengths of stay slightly longer. Revocations, terminations, and arrests of OCR participants are negligible, likely due to strong oversight and monitoring of participants. Even with this monitoring, however, outpatient programs realize substantial financial savings; at times, savings approached $400 per defendant per day.

Specific program evaluation outcome data is also encouraging. A recent case study of an OCR in New Orleans not only shows good outcomes but also provides the first empirical analysis of predictive factors for success and failure in an OCR (Mikolajewski, Manguno-Mire, Coffman, Deland, & Thompson, 2017). A case study of the OCR in Washington, DC also shows promising rates of restoration, cost savings, and low rates of negative incidents (Johnson & Candilis, 2015; Johnson, Candilis, & Bell, 2018). Emerging research also indicates that OCR success is enhanced when participants receive hospital-level care before being placed in an outpatient program (Musgrove, Gowensmith, Hyde, & Wallerstein, 2018). Still, little consistency exists across OCR operations, staffing, and policies (Gowensmith et al., 2018). Empirical investigation on OCR is in its infancy, and more is needed. These positive preliminary results, however, suggest that expanding the number and scope of OCR programs should be carefully considered as one solution to managing the ever-increasing number of persons ordered to competency restoration (Gowensmith et al., 2016; Miller, 2003).

Some states have also implemented jail-based competency restoration. At least nine states currently use jail-based competency restoration, with others actively considering its viability. Some jail-based programs have shown promise. The RISE (Restoring Individuals Safely and Effectively) program in Colorado reported promising results, with restoration rates and lengths of stay roughly equivalent to inpatient rates (Galin, Weittenhiller, & Gowensmith, 2015). A jail-based program in Georgia also shows encouraging results (Schwenke, Chan, Egan, Roberts, & Ash, 2018), as does the ROC (Restoration of Competency) program in California (Rice & Jennings, 2014). Wisconsin reports that jail-based restoration services in 2017 led to an average 34-day reduction in length of stay for participants later transferred to their state hospital (Wisconsin Department of Health Services, 2017). Virginia's statewide system integrates jail-based restoration across multiple sites, though data to date has been difficult to disentangle from other restoration approaches there.

This preliminary jail-based restoration data seems promising. Based on these studies, it seems that high staff-to-patient ratios, collaboration between program and jail administrators, and targeting defendants who are likely to restore to competency quickly for inclusion into the jail-based programs seem to hold special promise. Jails may actually provide some differential benefits over hospitals in some cases, such as closer proximity and better accessibility to community support systems, attorneys, and courts. They may also provide some measure of continuity of care, if defendants will otherwise be shuttled between hospital and correctional facilities with differing levels of care, medication formularies, and therapeutic alliances with personnel. However, outcome research and program evaluations are currently a major gap in the scholarly understanding of the potential beneficial role jail-based restoration can play; they are important areas for future research.

In addition, the added benefits of formal restoration components in jail, over and above those provided by good psychiatric care, should be studied. A correlate approach to both jail-based restoration and triage systems is to use clinicians to reassess incompetent defendants in jail who are awaiting transfer to a restoration setting. Some proportion of defendants may indeed restore to competency exclusively due to consistent adherence to psychiatric medication, even in the absence of other restoration components. Some jurisdictions in Texas, as well as the county of Los Angeles, use clinicians to provide quick screens of competency for this reason. If a defendant is believed to have been restored while awaiting transfer, a brief interim report is written and submitted to the court. At times, judges, prosecutors, and defense counsel rely on these screens outright to adjudicate a defendant as restored; at other times, the screen prompts a formal CST evaluation to be conducted.

Regardless of outcomes, a jail can never be confused with an inpatient hospital setting. The American Bar Association explicitly excludes jails from the definition of "mental health facilities" in their nationally adopted criminal justice standards on mental health (American Bar Association, 2016). Critical and undeniable differences exist. The preliminary data above suggest that jail may be an appropriate restoration setting for some incompetent defendants, but likely not the majority. States must be especially careful when considering jails as an option for restoration; if so chosen, a great deal of planning and resources must be allocated to the program for it to be successful. The multiple tragedies and subsequent class action lawsuits detailed earlier demonstrate the lack of many traditional county jails to adequately serve as de facto settings for competency restoration.

Timing of Competency Evaluations

A total of 37 states currently identify specific time frames to complete CST evaluations; nationally, the average statutory deadline for competency evaluations is 31 days, according to a recent review (Gowensmith et al., 2015).[5] However, in reality many evaluations take longer than the 3 to 4 weeks generally allowed.

To avoid such delays, one tempting solution might be to shorten allowable time frames for evaluations to be completed. In Maryland, many evaluations must be completed within 7 days of the initial court order. The initial *Trueblood* decision in Washington State mandated a similar 7-day timeframe for CST evaluations (*Trueblood v State of Washington DSHS*, 2015b).[6] However, some caution should be exercised when considering these aggressive timeframes for competency evaluations, as emerging data has

[5] To be clear, this figure reflects an overall, crude average and does not account for differing time frames based on evaluation locations, charges, settlement agreements, or other factors.

[6] Subsequently appealed and currently set at a 15-day timeframe.

shown that rates of IST opinions increase substantially when evaluations are conducted within a very short time frame.

Data from Hawaii indicates that a short turnaround time for CST evaluations seems to artificially increase the rate of findings of incompetence (Gowensmith, Metroz, & Bratcher, 2016). Overall, a total of 28.9% were found IST in this sample ($n = 501$), which approximates the national base rate of 27.5% (Pirelli et al., 2011). However, for the sample of evaluation reports submitted within 15 days of the court order ($n = 12$), the IST rate was 41.70%. As time increased, the rate fell steadily.

These findings are largely consistent with 50% IST rates found in a sample in Washington State in which CST evaluations were conducted within seven days (*Trueblood v State of Washington DSHS*, 2015b). The state of Maryland's Department of Health and Mental Hygiene also reported a 50% rate of IST opinions for the same 7-day timeframe (E. Roskes, personal communication, December 12, 2014). This trend seems to be especially true for defendants with psychotic diagnoses; preliminary data from a large dataset in Texas shows that the rate of IST opinions in defendants with a schizophrenia-spectrum diagnosis rose nearly 25% when evaluations were completed within 10 days of the court order (Bryson et al., 2018). Analyses of the diagnoses of the defendants in Hawaii indicated higher rates of substance use and psychotic spectrum diagnoses in evaluation reports conducted within 15 days.

Although early, this constellation of independent studies suggests that the timing of CST evaluations may be critical—conducting evaluations too soon (within 15 days, perhaps) may correlate with artificially inflated IST rates. More time may be needed to distinguish genuine incompetence from drug intoxication or temporarily untreated psychosis. More research is clearly needed in this area. What is the shortest amount of time postarrest at which competency evaluation opinions match standard base rates? What variables influence CST evaluation base rates at various time frames (e.g., substance use, developmental or cognitive issues, etc.)? Meeting the demands of the competency crisis will require a balance of speed and accuracy in CST evaluations—finding the "sweet spot" where evaluations can be completed in the shortest amount of time after arrest without compromising accuracy. Empiricism is just beginning to provide clues to these parameters.

Likewise, this data has clear public policy implications. The American Bar Association (2016) recommends that CST evaluations receive a maximum time frame of 28 days for completion. Although they recommend a default time frame of 14 days, the Standard (Standard 7–4.4[d]) explicitly states that good cause should extend these time frames out to 28 days. The National Judicial College recommends that CST evaluations be conducted within 15 to 30 days of the initial court order (National Judicial College, 2011–2012). Their rationale is as follows:

> Performing a competency evaluation within the best practices timeframes [15-30 days, author note] prevents the person from languishing in jail and protects his or her constitutional right to a speedy trial relative to the charges. *Jackson v. Indiana*, 406 US 715 (1972). However, if the evaluation is performed too close in time to when the defendant is taken into custody, it may pose a difficulty for the examiner to rule out the possibility that the defendant's mental state is impaired due to the effects of any potential substance use or abuse. Depending upon the circumstances, it is a best practice to allow enough time for the defendant to withdraw or recover from the effects of any substance use or abuse; or, if the defendant has a history of major mental illness, to be stabilized on a regimen of psychotropic medications before performing the competency evaluation—both may affect a determination as to whether the defendant is competent.

In summary, some states have recently adopted 15-day or shorter timeframes for CST evaluations. However, emerging research and other policy recommendations suggest that evaluation validity may be compromised within that timeframe. Caution should therefore be exercised when ordering or conducting CST evaluations within 15 days of the initial court order until more definitive research is available. Research as to the effect of timing on validity of opinions, as well as outcome research on jurisdictions with short timeframes, must be conducted to better pinpoint the ideal window within which CST evaluations should be conducted.

Other Approaches

There are several longer-standing ideas that continue to have merit, although their true impact has not yet been realized. First, coordination and collaboration between mental health and criminal justice systems is essential. Joint trainings and workshops can be held to identify exemplar CST cases and minimize inappropriate referrals for CST evaluation. Competency calendars or specialized mental health calendars can be created at local courts to organize CST-related cases more efficiently and to maximize the expertise in the courtroom; a centralized docket for competency cases has been critical to the success of the Multnomah system (Joplin & Ferguson, 2018). Cross-agency data collection can identify trends and patterns for appropriate (and inappropriate) CST referrals and restoration cases. Using partnerships among judicial and treatment agencies for outpatient restoration will be critical in relieving pressure on inpatient restoration bed space.

Second, early diversion efforts and statutory change can lessen the demand for competency-related services. Most CST evaluations are now conducted pursuant to misdemeanor charges (Gowensmith et al., 2012; Los Angeles County Health Services, 2016). Many of these evaluations could likely be avoided with the presence of strong, robust diversion and preventative programs. Miami-Dade County continues to serve as a national leader in this respect, through the use of detention, diversion, and holding facilities that prioritize mental health and psychosocial needs over competency services (Leifman, 2017). Bexar County in Texas also provides an innovative approach, whereby police officers are provided with a dedicated short-term treatment facility for alleged low-level offenders with mental illness; outcomes are promising in that numbers of successful diversions have increased annually (Cowell, Aldridge, Broner, & Hinde, 2008; Evans, 2017). In addition, statutory reform, such as aggressive time limits on competency restoration for low-level charges (e.g., Hawaii, North Carolina, Ohio, and Washington) or even the elimination of competency restoration for certain misdemeanor charges (e.g., Florida, New York), can be a powerful tool in decreasing the volume of competency-related services. Statutes that disincentivize the use of CST services to address mental health needs in misdemeanants play a role in rerouting mental health provision away from courts and jails and into mental health agencies. They are also critical in decreasing the criminalization of persons with mental illness. Of course, budgetary appropriations must accompany these statutory

and policy changes to develop and maintain adequate levels of community mental health resources.

Finally, it should also be noted that diversion is not appropriate for every person under consideration for competency-related services. Although some are appropriate for community or county jail placements, many are acutely ill and in need of intensive hospital-level care. However, as has been noted, capacity for these individuals has dwindled substantially throughout the past several decades. State mental health hospital capacity has shrunk from about 600,000 beds in the 1950s to approximately 40,000 currently (Fitch, 2014; Parks & Radke, 2014; Torrey et al., 2010; Wik et al., 2017), ultimately leading to the waitlists that serve as the foundation for the class action lawsuits referenced previously. This capacity decrease affects restoration services more than evaluation services. During the past several decades, CST evaluations have been increasingly conducted in county jails rather than state hospitals (Edens et al., 1999; Poythress et al., 1991; Robinson & Acklin, 2010; Zapf & Roesch, 2006). However, as discussed previously, the majority of competency restoration services still rests within state hospitals; restoration cases create the bulk of the long wait times for defendants awaiting competency-related services (Locklair, 2016; *Trueblood v. State of Washington Department of Human & Social Services*, 2015b). States may ultimately need to reexamine their numbers of beds and adjust accordingly if truly adequate capacity for competency-related services can be made available.

Policy Recommendations

This article has summarized some of the proposals and attempted solutions to address the "competency crisis" in the United States, providing empirical support and recommendations for research where possible. This research, combined with existing policies, emerging practices, and the ever-increasing demand for competency services, should inform thoughtful public policy recommendations. A summary of emerging public policy recommendations is provided here. This is neither an exhaustive nor a definitive list; it simply serves as a summary of policy recommendations that have a foundation in empiricism and emerging promising practices. It should also be noted that jurisdictions across the country can vary tremendously. Individual jurisdictions and systems should carefully tailor any policy initiatives to their unique populations and systems of criminal justice and mental health provision.

- Triage systems can be useful in the early identification and prioritization of competency evaluations and referrals for restoration to those with the most acute clinical and safety needs. Where adequate judicial infrastructure and collateral information exist, competency screens should be used to prompt comprehensive CST evaluations. The use of checklists that serve as de facto CST evaluations should be discouraged, although procedural checklists may be useful to ensure quality control.
- Court-based clinicians or clinics can help court personnel discriminate legitimate competency-related issues from those defendants with confounding issues (e.g., substance abuse, malingering, etc.). These clinicians and clinics can also serve as liaisons between courtrooms, inpatient settings, and community mental health services to streamline placements and facilitate interagency communication.
- Certification of competency evaluators appears to improve report reliability and quality, and it satisfies standards outlined by the American Bar Association. Training, certification, and ongoing maintenance of CST evaluation expertise should be implemented in states where it does not currently exist. Expanding the pool of evaluators to disciplines other than psychiatry and psychology has merit, but only in systems whereby skill development and demonstrated expertise is required of all evaluators and in which infrastructure exists to promote high-quality forensic training.
- Differential pay may improve recruitment and retention of high-quality evaluators and restoration providers, which may in turn lessen avoidable financial costs associated with low-quality evaluations, poorly formed CST opinions, or ineffective restoration interventions.
- Emerging research on OCR shows good early outcomes. OCR should receive consideration as one component of states' array of competency restoration alternatives. States whose statutes currently prohibit outpatient restoration should be amended to allow for it. Programs can be developed for specific populations and systems; OCR programs that include enhanced psychosocial resources seem to show the most optimal outcomes.
- Jail-based competency restoration can serve as an effective component of the restoration array of services, but careful thought must be given to ensure that programs target only specific populations (typically those likely to restore to competency quickly), maintain adequate facilities, provide well-trained staff (including dedicated correctional officers with mental health training), and include adequate oversight and monitoring by outside agencies. Jail-based restoration should serve as a specialized adjunctive service, not as a default or primary setting for restoration.
- Aside from exceptional cases, competency evaluations should not be completed within 15 days from the court order until more empirical research is available. Emerging research indicates that this short period of time produces an artificially high number of IST opinions, especially in defendants with psychotic and substance-related disorders.
- Early diversion efforts, such as pre- and postbooking diversion, should be assertively enhanced as a primary mechanism for addressing the competency crisis. Diverting people with mental illness away from arrest and into mental health care sidesteps the competency process for those individuals. Also, local laws and state statutes can be amended to restrict competency services (e.g., competency restoration) to particular populations of offenders (e.g., felony offenders, violent offenders, etc.).
- Professional organizations (e.g., American Psychology–Law Society, American Academy of Psychiatry and Law) should create and support task forces to spearhead research and policy development related to competency services. Dedicated funding for applied and policy-level research could encourage empirical attention. Position papers and/or white papers should be considered, and out-

reach with partner organizations (e.g., American Bar Association, National Judicial College) could help promote uniform creation and dissemination of sound, sensible policy proposals.
- State legislators and mental health administrators must review population trends to determine adequate inpatient hospital bed capacity for their states.

Recommendations for Practice

There are also several areas of intervention for forensic practitioners and professionals, including those working in applied practice domains related to competency. Some recommendations are listed here, though again this list is not exhaustive nor can it be applied to all jurisdictions or scopes of practice.

- Forensic evaluators could maintain a database of their evaluation opinions and related demographic variables. Base rates of CST opinions are well established (Pirelli et al., 2011). However, some demographic variables have been shown to influence IST opinion rates (Gowensmith, Smith, Yeager, & Meyer, 2018; Kois et al., 2013; McCallum et al., 2015; Parker, 2016). It could be informative to one's practice to compare one's own base rates to those found in the literature. Significant discrepancies could highlight areas for further investigation.
- The above methodology could also be used by practitioners working in competency restoration. Rates of restoration are readily available, some with differential categorical rates highlighted (Zapf & Roesch, 2009; Zapf & Roesch, 2011).
- Forensic professionals should seek opportunities for dedicated, specialized training in forensic evaluation and/or treatment. Although relevant to even the most veteran professional, this is especially important for professionals working in jurisdictions where such training is not mandatory to retain forensic qualifications or certifications.
- Competency evaluators should be cautious about making definitive opinions of incompetency within 15 days of court orders until an adequate body of empirical data is gathered about the impact of timing on IST opinion validity. When statutes allow, evaluators may opt to conduct CST evaluations between 15 and 30 days. This timeframe is in line with most state statutes and recommended judicial standards, and it provides a competency opinion closer in time to the subsequent competency hearing (should the subsequent hearing be set beyond 15 days of the date ordering the evaluation).
- Restoration personnel should carefully monitor defendants adjudicated as IST within the first 15 days of the court order. Defendants with previously untreated psychotic disorders may restore quickly with appropriate medication adherence, and defendants with substance-related symptoms may resolve quickly as defendants become clean and sober. Return to court dates should be set soon for these defendants as well.
- Competency evaluators should resist using simple checklists as substitutes for comprehensive CST evaluations but may wish to incorporate process-level checklists as part of their routine practice.
- Forensic professionals should consider advocating for policy change where relevant and appropriate. However, advocacy should be firewalled from professional duties. Evaluation reports, forensic opinions, and forensic treatment should not be influenced by one's advocacy efforts.
- Practicing professionals should find avenues for empirical data collection and analysis, even as part of their routine work duties. Collecting base rates of opinions versus the timing of the evaluation (i.e., how many days have elapsed between the court order and the evaluation date) is an especially important area for field-based research.

Moving Forward

The United States is facing a "competency crisis." Referrals for CST evaluations, and subsequent orders for CST restoration, are far outpacing capacity. The problem has been raised for several decades (Poythress et al., 1991; Wortzel et al., 2007), but circumstances continue to worsen. This has led to untold numbers of defendants with mental illnesses languishing in jail cells, waiting for either delayed evaluations or—even worse—delayed transfers to mental health settings. Class action lawsuits and subsequent settlement agreements, consent decrees, and court-ordered monitoring have led to policy changes in a number of state competency service systems.

Washington's *Trueblood* class action case provides an interesting experimental crucible of policy change, and it may well serve as a bellwether for similar competency-related class action lawsuits in the future (*Trueblood v. State of Washington DHHS*, 2015b). On the one hand, the settlement and monitoring agreements mandate the development of high-quality restoration services; for example, jail-based restoration (although found to be effective in certain circumstances in other jurisdictions) is a nonstarter for Washington. On the other hand, statutory changes and settlement expectations drastically reduced allowable time frames for competency evaluations; research suggests that the validity of reports and opinions will likely be artificially compromised by this change. Research on the outcomes of this naturalistic study will be important in order to determine the impact that these policies will have on defendants with mental illness.

Competency-related class action lawsuits, like *Trueblood*, are increasingly common in the United States (Locklair, 2016). Class members urge courts to mandate system change in order to correct the long delays faced by persons ordered to competency services. Courts are spurred to action to address these demands. However, courts, administrators, legislators, and other decision-makers are at times forced to operate without a full complement of empirical data and information when developing policy and statutory changes. Some changes which seem benign and helpful (e.g., mandating evaluations be completed within 15 days, expanding the pool of evaluators to nonforensic professionals) may unintentionally worsen the problem.

Forensic professionals should be at the forefront of these conversations. Where research exists, it should be disseminated and promoted to decision-makers and stakeholders. Where gaps remain, researchers should redouble efforts to investigate systems-level issues. Moreover, this research, combined with our clinical and administrative expertise, should serve as the bedrock for legislative and policy change regarding competency-related poli-

cies. Unfortunately, however, forensic psychology and psychiatry have often been silent on these macro issues. The bulk of competency-related research is focused on improving competency evaluations (and restoration methods, to a lesser extent). Although certainly important, an exclusive focus on such research is reminiscent of "rearranging deck chairs on the Titanic." In addition, professionals in forensic psychiatry and psychology have been largely silent regarding proactive policy changes in the competency arena.

Of course, exceptions exist. The sequential intercept model, for example, provides an ideal opportunity to combine policy and research regarding early diversion efforts (Griffin, Munetz, Bonfine, & Kemp, 2015; Munetz & Griffin, 2006). Research on the timing of CST evaluations and the efficacy of outpatient and jail-based restoration programs is emerging. In addition, some promising competency-related programs and proposals have been partially abandoned due to lack of consistent funding. It is important not to dismiss these types of incomplete programs as ineffectual before outcomes on fully resourced programs are reviewed.

The ethical code and guidelines of both the American Psychological Association (APA, 2017) and the American Psychology–Law Society (APA, 2013) emphasized the concept of nonmaleficence: in short, to avoid harm to the people and agencies with whom we work. The forensic psychiatrist and ethicist Martinez (2018) recommended that these concepts may require forensic professionals to bear witness and narrate the suffering that accompanies mental illness and the inadequate systems in which forensic work is conducted, given our unique access to these systems. In other words, perhaps nonmaleficence in forensic evaluation should not be limited to the interactions between evaluator and defendant, or even the court; perhaps it should recognize the potentially damaging role that evaluators engage in by simply being complicit with a competency system beset by long wait times, racial disparities, and poor treatment of persons with mental health problems. These issues should not formatively alter specific evaluation reports or restoration work, but they warrant reflection, discussion, and advocacy in other contexts both from individual professionals and the professional member organizations to which they belong.

Forensic professionals must therefore be both wary and vocal about legislative changes that promise short-term fixes at the expense of quality and accuracy. CST evaluations have serious consequences on a defendant's life course—his or her access to mental health care, the defendant's ability to adequately exercise their constitutional rights to self-defense in the courtroom, his or her access to basic civil liberties. We must lead these discussions by actively addressing unjust systems of care, long waitlists, and poor short-term solutions with empirically based information and solutions rooted in best practices. We should advocate strongly for sensible statutory and policy change that emphasizes access and provision of mental health services over bloated competency-related services for lower-level offenders. We should emphasize triage, outpatient options, inpatient accessibility, and cross-systems coordination when competency services are necessary. We should elevate standards of practice so that our work in each of these spheres is as reliable and valid as possible. Finally, we should conduct empirical research across multiple competency-related areas to inform both practice and policy. Courts, jails, hospitals, taxpayers, and the defendants themselves deserve more than second-rate services. Forensic professionals play a critical role in ensuring the entire CST process operates justly and humanely.

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