Foundation Work for **Exploring Incompetence to Stand Trial Evaluations and Competence Restoration** for People with Serious Mental Illness/Serious Emotional Disturbance

SAMHSA
Substance Abuse and Mental Health Services Administration

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U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

Contents

Introduction

The purpose of this report is to provide an overview of the status of the fields of competence to stand trial (CST), incompetence to stand trial (IST), and competence restoration (CR) for adults and youth in the criminal justice system and youth in the juvenile justice system.

This report consists of four major sections. The **Introduction** includes the foundation for why CST is a key issue in the legal and clinical systems and key definitions. The **Environmental Scan** provides an overview of the legal foundation for CST, including case law and state statutes; definition of the key terminology; and an explanation of waitlists that are integral to the competence process. The environmental scan provides the foundation for examining which issues have risen in priority for the courts, clinicians, and policy makers. Also included in this section is a description of the adult and juvenile competence processes. The **Literature Review** includes a comprehensive review of research on the competence system and national efforts to address the major issues in both the adult and juvenile competence systems. This section also includes a description of key studies on the competence population; examples of inpatient, jail-based, and outpatient restoration programs; and "emerging issues" in the CST/IST/CR area, such as restorability, whether to pursue CST for misdemeanor charges, expedited diversion proposals, and risk assessment. The report concludes with a **Summary** of the national scope of 10 major issues in the CST system. In addition to these major sections to the report, the **Appendices** include references, a state-by-state analysis of laws pertaining to CST for adults and youths, and a list of evidence-based measures utilized in competence evaluations.

An earlier version of this report was developed in 2018. It served as the foundation for the Competence to Stand Trial and Competence Restoration Learning Collaborative hosted by SAMHSA's GAINS Center from 2019-2022. Hereafter, this earlier version is referred to as "the 2018 version of the IST Report." In this 2023 IST Report, the most current information on key trends, emerging issues, and innovations through a review of relevant clinical, legal, research, and policy resources have been identified. The primary focus of these reports is on adults in the competence process due to the national attention focused on the adult waitlists and demand for services. Further, most of the research on competence focuses on adults. However, some information is provided about the process in the juvenile justice system. While the 2018 foundation work provided guidance to SAMHSA's GAINS Center's Learning Collaborative, the information and learning collaborative outcomes are of national importance to the field.

A recent survey by Warburton and colleagues (2020) reports that 82 percent of states claim an increase in referrals for CST evaluations, and 78 percent note an increase in referrals for CR. These reported figures are likely to be underestimates, as many states do not collect systematic data on any of the steps in the CST process, and no system-wide data are published in any state. Reports from the National Association of State Mental Health Program Directors (NASMHPD) notes that there was a 76 percent increase in the number of total forensic patients in state psychiatric hospitals from 1999 to 2014 (n=37 states) (Lutterman, Shaw, Fisher, & Manderscheid, 2017). A larger number of IST/CR forensic patients are being committed

to state psychiatric hospitals (n=51 states/DC), with the median number being 62 in 1999 and 80 in 2014, a 72 percent increase based on a "point in time" census (Wik, Hollen, & Fisher, 2017).

This literature review and environmental scan inform recommendation 4.4 of the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) report (SAMHSA, 2017), revised in 2022 to state:

> **Establish and incentivize best practices for competency to stand trial (CST) that prioritize diversion from arrest or jail/juvenile detention for people with SMI, SED or COD accused of committing low-level and non-violent offenses and that use community-based evaluation and restoration services when CST efforts are necessary.** Develop federal guidelines and work with states to ensure both diversion and reduced wait time in the competency evaluation and restoration processes. When competency evaluation is deemed necessary, use jail/detention diversion options whenever possible instead of holding people in jails or detention to await competency evaluations. Support the use of data-driven strategies to reduce the number of people in need of CST. Set goals to limit the use of the CST process to cases that are inappropriate for dismissal or diversion. Increase opportunities for treatment through diversion. Reduce the need for forensic bed waitlists by increasing restoration in the least restrictive environment where the state has an interest in CST. Give consideration to pre-arrest, post-arrest, and post-competency phases that promote wellness.

The initial objective of this literature review and legal environmental scan was to develop recommendations or guidelines for model policies and practices with the population of adults and youth who are evaluated for CST, found IST, and committed for CR/remediation. The 2018 version of the IST Report concluded that research on these topics falls short of providing evidence on which to base model policies and practices or to make evidence-based recommendations to SAMHSA. In addition, the 2018 review of the research, reports, statutes, and policies did not allow us to articulate the specific impact of the IST process on persons with serious mental illness or related to cognitive issues that might prevent someone from adequately understanding legal proceedings. More systematically collected data were needed. While some states have made incremental progress in collecting more cross-system data necessary for depicting the competence process, the lack of these data is still the norm in 2023.

The CST process is a high priority for many states and for many national organizations, with SAMHSA taking the lead by supporting 4 years of a Competence to Stand Trial Learning Collaborative, engaging 14 jurisdictions in peer-to-peer learning, and engaging with nationally recognized subject-matter experts. The National Council on State Courts (NCSC) convened the National Judicial Task Force (NJTF) to Examine State Courts' Response to Mental Illness, which was composed of judges and other experts who closely examined the CST process and identified recommendations for improving the competence process. The Council of State Governments (CSG) convened a group of experts to discuss broader issues

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related to the competence process and to make recommendations for change. Taken together, these three initiatives underscore the state-level work and progress under way across the country; focus on the role of the courts and judges as leaders in improving the competence process; and focus on the broader issues and challenges in reforming the systems that must address the basic legal right of individuals to be competent to face trial in the United States. All three of these national efforts to reform the competence process are described in more detail in the following sections.

In addition to the groundbreaking work being supported by SAMHSA, NCSC, and CSG, researchers have added to the empirical body of work on CST, IST, and CR. What still is lacking in the empirical literature and the policy reports is evidence of integrated data systems and data collection to inform the national picture on CST. While some states have begun work in collecting intra- and intersystem data, the barriers to data sharing among necessary stakeholders continue to hamper data-driven decision-making to inform systems change.

This report on CST, IST, and CR/remediation includes peer-reviewed articles, reports from state-level work, and an updated analysis of state statutes as of January 2023.

Definitions

Competence to stand trial (CST) is "the legally determined capacity of a criminal defendant to proceed with criminal adjudication. Jurisdictional statutes and case law set out the criteria for competence to stand trial." Other terms that are interchangeably used are 'adjudicative competence,' 'competency to proceed with adjudication,' and 'fitness to stand trial'" (Mossman, Noffsinger, Ash, Frierson et al., 2007).

Incompetent to stand trial (IST) is the legal determination by a judge that a defendant lacks the capacity to proceed with a trial or disposition based on a CST evaluation.

Competence restoration (CR) is typically applied by the court "to the potential treatment of any defendant who is not competent" (Mossman et al., 2007). According to the American Academy of Psychiatry and the Law (AAPL) Guidelines, CR involves treatment of the underlying mental illness and instruction in the legal concepts and procedures of the trial process.

Remediation refers to "efforts to improve youths' abilities when they have been found incompetent" (Kruh & Grisso, 2017). Remediation addresses the fact that youth who are found IST due to intellectual disability or developmental immaturity were likely never competent. Thus, they are not being "restored" to a prior level of intellectual understanding. This would also be more accurate terminology when addressing adults with intellectual disabilities (versus mental illness).

Environmental Scan

The U.S. Supreme Court and CST/IST/CR

The most recent U.S. Supreme Court decision that directly affects people in the competence process was the *Sell v. United States* (2002) decision. It is described below. While firmly rooted in Western law and tradition that a defendant must be competent to stand trial, the U.S. Supreme Court first addressed the question in *Dusky v. United States* (1960). In its decision, the Court stated:

> It is not enough for the district judge to find that "the defendant is oriented to time and place and has some recollection of events," but that the test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him. (*Dusky*, p. 402)

These standards are still in place today and are referred to as "adjudicative competency," as there are many other types of competencies that a court might consider (e.g., to be executed, to be married, to execute a will).

The second major case that affected the due process of defendants found IST and ordered for restoration is *Jackson v. Indiana* (1972). In *Jackson*, the Court held that a defendant committed solely for CR "cannot be held more than the reasonable period of time necessary that he will attain that capacity in the foreseeable future" (*Jackson*, p. 738). As a consequence, some states have statutory requirements that limit the length of time an IST/CR defendant can be committed for restoration. Often, those limitations apply only to persons charged with lower-level offenses that carry a short jail sentence, if any. Not all states provide *Jackson* hearings, and not all judges release someone who has reached the statutory limit of their commitment.

There is a plethora of cases on the involuntary administration of medication for prisoners and psychiatric patients, including defendants found IST and committed for restoration. After many contradictory decisions at the state and federal levels, the U.S. Supreme Court ruled in *Sell* that medications to restore competence could be administered over a patient's/defendant's objections for serious offenses and under certain conditions. The Court held that the government's interest must be compelling and the crimes "serious," and each case must be individually decided. The Court also held that the medication must further the state's interests, be substantially likely to restore competence, and be unlikely to have side effects that would hinder the defense. The Court further held that medication must be the least intrusive, effective treatment and that it is medically appropriate. States are encouraged to find alternative routes for administering involuntary treatment that are well settled in case law, such as when a patient is dangerous, rather than seek the order to restore competence. On the surface, *Sell* may seem to answer the question of

whether and when a state can forcibly medicate someone to restore competence. In practice, however, that is not the case.

Together, these three cases—*Dusky*, *Jackson*, and *Sell*—are the three significant U.S. Supreme Court decisions having the most significant impact on the national scope of defendants found IST and committed for CR.

Over the course of the work completed by SAMHSA's GAINS Center as part of the Learning Collaborative, state teams report that they still struggle with adhering to *Jackson* limitations on the length of time an individual can be in legal limbo in the competence "process." It was regularly reported during discussions with the teams that they knew there were individuals hospitalized for years who were found IST for relatively minor offenses. They expressed frustration that, in most cases, the state mental health department and hospital do not have legal authority to discharge (from an inpatient setting) someone found IST and restored; they must wait for a judicial order. Aside from the unnecessary use of a high-security inpatient bed, this is a clear violation of the spirit and letter of *Jackson* that sought to protect from the unnecessary denial of liberty. The teams also discussed the difficulties of implementing *Sell*, that is, when medications can be "forced" on an individual who is IST and refusing treatment. From a practical matter, in most states jails and community-based programs will not force medication on individuals. Thus, for medications to be compelled on an individual, regardless of whether the presiding judge approves it, an individual must be transferred to a hospital. The concern about growing waitlists is not unique to these states. Most of the federal litigation is based on challenges to waitlists (see for example, *Trueblood v. Washington State DSHS et al.*, 2014).

State IST/CR Statutes

An environmental scan of the statutes and case law of each illuminates the impacts of *Dusky*, *Jackson*, and *Sell* as well as many states' efforts to reduce waitlists and unnecessary confinement for competence examination and restoration treatment. The following six structural commonalities in state CR processes emerged during the initial environmental scan and review of state statutes that was completed in 2018 was updated in 2023 for this report using the same process by the same legal researcher. For this review, the statutes were concluded to have the following structural commonalities:

Days Allotted for Competence Evaluation

States have enacted requirements stipulating the maximum time allowed between a court order for a competence examination and fulfillment of that order. Statutes that give a range of time reflect the extensions that are possible or whether a court stipulates differences on type of charge or whether the exam is inpatient or outpatient. Examples of the range of days from court order to evaluation include Georgia which allows 90 days; in Arkansas the evaluation must occur within 60 days unless a longer

period is necessary; and in Connecticut, the examination must occur within 15 days of the court order and the report filed within 21 days of the order.

Inpatient Confinement Periods for Examination

Many states limit the number of days that a person can be committed for an inpatient examination. Most of these states allow courts to temporarily commit defendants released on bail or recognizance for the purposes of the examination upon the examiner's recommendation or the defendant's noncompliance.

Timeline for Initial Competence Hearing

Competence hearings are not automatically mandatory in many states. If no parties object to or contest the examiner's findings or report, the court is empowered to make its competence determination based on that report. Several states, however, do make hearings mandatory and specify the time frame in which those hearings must occur once the examiner's report is filed or received.

Processes for the Involuntary Administration of Medication

In line with the U.S. Supreme Court's decision in *Sell*, some states commonly have created a process and protections regarding the involuntary administration of medication for the purposes of CR. However, in some states, the courts have had to rule on whether preexisting statutes can be interpreted to include the involuntary administration of medication (see *State v. Sullivan*). A case law review of some states continues to ascertain the permissibility of involuntary medication.

Opportunities for Community-Based Restoration

Where opportunities for community-based restoration are statutorily created, participation in such programs is typically based on a court's finding that the defendant is not a danger to self or others and on the defendant's cooperation with treatment and adherence to other conditions of release.

Sequential Intercept Model Mapping Workshops

A Sequential Intercept Model Mapping Workshop, using the Sequential Intercept Model, is a demonstrated community strategic planning activity that provides a framework for states and communities to closely examine the gaps and opportunities for diverting individuals with mental illness from the justice system when appropriate.

Statutory Maximum Commitment Time Frames

State laws consistently include language based in *Jackson's* prohibition of indefinite CR treatment. Many states have implemented two-tier restoration timing parameters. In the first tier, defendants are held for an initial restoration period in which they receive treatment, and the treating agency/provider continues to assess the probability that the defendant will attain restoration within the state's requisite limitation. Defendants not restored to competence in this time frame may have their charges dismissed (typically for misdemeanor crimes) or may be subject to civil commitment proceedings. Defendants who are not restored during the initial period, but who the treatment provider believes will be restored within the statutory limitation, are then advanced into the second-tier restoration period. If at the end of this period the defendant has not attained restoration, most courts have the option of dismissing the charges, releasing the defendant, and/or ordering civil commitment proceedings. Some states predicate a defendant's release on finding that the defendant does not pose a danger to others and was not charged with an exempted crime (typically murder and crimes of violence against a person). In line with *Jackson*, most states align the maximum term of confinement with the maximum sentence possible for the most serious offense charged. A few states, however, opt to align their maximum term of confinement with two-thirds of the sentence for the most serious offense charged. It is these statutory time frames that often lay the foundation for litigation in states where waitlists persist and grow.

For example, Idaho allows for an initial inpatient restoration period of 90 days with a 180-day extension if restoration is likely. In Illinois and Iowa, the initial order is for only 30 days with possible extensions. Washington's time periods for restoration varies by seriousness of the charges and whether the restoration services are inpatient or outpatient.

The survey of state case law on CR reveals consistent testing for clarification and constitutionality of the states' statutes and their alignment with cases like *Dusky* and *Jackson*. Defendant plaintiffs have launched litigation over states' failures to comply with their own CR processes and time frames.

Changes to State Law

Over the past 5 years, there has been some activity revising state laws on CST and CR. Seven states revised their competence statutes for both adults and juveniles (California, Colorado, Hawaii, North Dakota, South Carolina, Washington, and West Virginia). Six states revised only their adult competence statutes (Florida, Michigan, Nebraska, Ohio, Oregon, and South Dakota). Four states revised only their juvenile competence statutes. In the attached table (Appendix II), changes that states have made since 2018 are highlighted in pink. Information highlighted in green reflects no changes since 2018. The specific information for each change is presented in Appendix II. While the underlying reasons for statutory changes are not revealed by our research, that many of the states with changes to their competence statutes are also involved in recent or ongoing litigation in this area.

Ongoing and Recent Litigation

As of 2023, there is ongoing or recent litigation on CST/IST/CR in at least the following states: Alabama, Arkansas, California, Colorado, Florida, Georgia, Louisiana, Mississippi, Nevada, Oregon, Pennsylvania, Texas, Utah, and Washington. Federal courts continue to step in when states cannot keep up with the increased demand for competence services, including evaluation, treatment, and restoration/remediation. What these cases reveal is a shortage of resources for state mental health departments to provide adequate and timely support and services to meet the needs and rights of individuals. There is no evidence to suggest that state mental health authorities were withholding treatment from this population. Rather, they were woefully underfunded to provide adequate support and treatment services to this growing population that often has complex clinical needs.

System Pressures

As noted previously, there has been national attention directed to the perceived/observed inability of state systems to keep up with the increased demand for competence services from evaluation throughout restoration. These national efforts have grown out of a concern from many stakeholders—judges, clinicians, state mental health officials, jail administrators, and advocates—that the current system is failing individuals caught up in the competence system.

Melton, Petrila, Poythress, and Slobogin (2017) provide a list of possible *justice system* causes of the system overload or failure to meet the basic needs of defendants found IST or in need of CR, including the following: CST can be raised at any time by anyone during the criminal process; the threshold for asking for an examination is low; attorneys confuse IST and insanity; IST is a strategy for both defense attorneys (cooling-off period) and prosecutors (discovery); and judges rarely refuse a request by the defense attorney for an evaluation.

In a more clinical focus, the NASMHPD reports that most states cannot adequately handle the influx of IST defendants with current state forensic bed capacity (Fitch, 2014). Consequently, other systems are significantly affected—most notably the jails—by the barriers and roadblocks along the forensic justice/treatment system.

For change to happen to improve the process and outcomes for people whose CST is raised during the court process, *both the justice and treatment systems* must be at the table. The six-state Peer Learning Community (PLC) report on IST/CR (Pinals et al. 2018) illustrates the value in bringing a wide range of working partners together for the common purpose of closely examining the IST/CR systems. The PLC includes legal and clinical representatives: 9 physicians, 6 doctoral-level psychologists, 2 attorneys, 1 judge, and 11 providers/hospital representatives. The PLC used the Sequential Intercept Model (SIM) framework to "describe opportunities to identify and intercept individuals with mental illness from penetrating into the criminal justice system" (p. 4). The SIM process allows working partners from various jurisdictions

to find common, core concerns of and potential solutions for the issue under discussion—namely the IST/CR system overload.

Pinals and Callahan summarize the challenges and barriers to improving the competence system and to propose potential pathways to reform. In a pair of articles (Callahan & Pinals, 2020; Pinals & Callahan, 2020), they focus on the CST process and how the local systems and services such as community behavioral health providers, jails, and courts are directly affected by state policies and allocation of behavioral health and justice resources. The state behavioral health system does not control the "front door" to the competence process. Instead, it is the decision of local judges to order a competence evaluation, most often to be conducted in a state psychiatric hospital. Individuals wait in a local jail for a bed. This is the crux of the stalemate and the main source of the legally and clinically problematic waitlists (see "Waitlists for Competence Evaluation and Restoration" for more information). Finally, individuals who are found IST and ordered for restoration are the ones ultimately paying the price for the system overload. They languish in jail settings that are typically equipped only to provide minimal mental health treatment (i.e., medications) and are certainly not able to provide CR services.

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Competence Evaluation Process

The *AAPL Practice Guidelines for the Forensic Psychiatric Evaluation of Competence to Stand Trial* provide both legal and ethical "practical guidance to psychiatrists who agree to perform forensic evaluations of adjudicative competence" (Mossman et al., 2007, S3). These are the most up-to-date practice guidelines.

Kruh and Grisso (2017) note that state law provides little guidance on how to proceed with youth whose competence is raised when they have contact with the justice systems. They note that during the 1990s, states trended toward more punitive responses to youth, which led to automatic transfers to the adult system for certain serious offenses. This "has raised a number of issues associated with the criminal code's deficiencies in providing developmentally sensitive evaluation procedures or remedies for incompetence" (p. 2). They continue that the diagnosis and treatment of juveniles with mental illness is more complex than that for adults. For youth, their mental illness is likely emerging along with other typical developmental processes.

Waitlists for Competence Evaluation and Restoration

"IST waitlists" are not a singular legal or clinical entity. Consequently, it is impossible to ascertain how large waitlists are unless they use specific language. Even then, with precise language, most jurisdictions do not compile data on each type of waitlist. However, everyone seems to agree that "waitlists" negatively affect both individuals on the list and the systems responsible for providing custody or care or both without knowing how large the waitlists are and how long people have been on the waitlists.

The *first* waitlist that a person whose CST is questioned may be placed on is the list of competence evaluations. Typically, individuals' criminal proceedings are suspended while a clinical evaluation is conducted to assess CST, the result of which is a recommendation to the court: CST, IST and restorable, or IST and not restorable (in some jurisdictions the "restorability" recommendation is delayed until a more comprehensive evaluation is conducted, usually as an inpatient). While there is an increase in states that allow for CST evaluations to be conducted in the community, most are conducted in jail. There is a measurable time interval from the date a CST order is given by a judge to the date that the CST evaluation is conducted.

The *second* waitlist that a person who was ordered for a CST evaluation may be placed on depends on the outcome of his/her evaluation:

a. For individuals found CST, they are on a waitlist (with most other detainees) for their case to be heard in court for a trial or final disposition. By most estimates, this is the largest group of individuals who have had a CST evaluation.

b. For individuals found IST, they are on a waitlist for a suitable placement for CR services. This period of time waiting for a placement is usually in jail. Depending on the jail services, the individual may regain CST while on this waitlist either due to affirmative jail restoration programs or simply due to regular jail services, such as psychiatric medications, medical care, and shelter/food.

c. If a defendant regains CST, regardless of the setting in which CST occurred, they are removed from the hospital waitlist and placed on the list for case disposition such as a court hearing date. At most stages of the CST/CR process, the courts control the front and back "doors" to this part of the mental health system. One caveat that affects the length and size of the waitlist for this group is if an individual who enters a jail-based competence restoration (JBCR) program remains on the waitlist for an inpatient (or community) bed.

The *third* waitlist that a person who was ordered for a CST evaluation may be placed on is for individuals found IST and not restorable. For those individuals, the location of this competence evaluation and the nature of their charges are key to which waitlist they are placed on. In addition, the court is not bound by the clinical recommendation in most states.

a. If an individual was evaluated in jail and the court accepted the clinical recommendation that s/he is not likely to be restored, it is possible that charges will be dismissed, and the individual will be on a waitlist of community (or hospital) placement or outright discharge. If the judge issues a civil commitment order, the individual is on a waitlist for a civil inpatient bed.

b. If the individual was evaluated in a forensic hospital and the court accepted the clinical recommendation that s/he is not likely to be restored, the individual will remain in the hospital (unless the judge agrees to a discharge) until a suitable community placement is identified and available.

The waitlists described in 2b and 3b contain the group of individuals who have the biggest impact on the perceived forensic bed shortage: individuals found IST and committed for inpatient CR and individuals found IST and not restorable who continue to occupy a forensic inpatient bed while waiting for transfer to a new placement. It is, to some extent, a "front door/back door" problem: if states rely solely, or primarily, on inpatient forensic beds for CST evaluations and CR, there will never be enough beds. The supply chain needs to be disrupted in the form of slowing down the number of CST inpatient commitments through community-based diversion, community-based restoration, and fewer nonviolent defendants being flagged for IST evaluations in the first place. For example, a Colorado report finds that the number of court-ordered restorations increased from 87 in 2001 to 900 in 2017.

When there is an automatic inpatient commitment for competence evaluation and restoration, no attention is paid to whether the individual *needs* that level of custody (i.e., is high risk). Little effort is reported to assess for risk when ordering competence treatment. Consequently, all beds are filled by defendants who may or may not need that level of security, which adds to the bed shortage and the cost of forensic services. There needs to be an awareness among judges, defense attorneys, prosecutors, and treatment providers of how each step in the competence process runs the risk of more deeply embedding an individual with serious mental illness into the criminal justice system. For example, challenging the treating psychiatrist's evaluation that someone has regained competence and is ready to be returned to court for disposition can lead to an extended stay in the hospital. In most states, decisions to move a defendant in or out of the competence process are a judicial one, not a clinical one. Consequently, unless judges—and other legal officials—see the whole system, they may not understand the impact of their decisions on both the individual and the rest of the system.

A commonly cited due process and systems management issue in the area of CR is the forensic bed waitlist. The size of the waitlist and the average time spent waiting for a forensic bed depend on many factors (e.g., the seriousness of charges, statutory provisions, availability of community residential placement, common practice in the jurisdiction).

Despite variability in waitlist lengths, Zapf and Roesch (2011) reported that approximately 75 percent of defendants are restored and returned to court within 6 months. Most CR takes place in state/public hospitals, although there has been a slight increase in the utilization of outpatient restoration in 18 percent of states (n=6) (Wik et al., 2017). Consequently, this means that 82 percent of states have not seen a

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shift from hospital- to community-based restoration. Arkansas is the only state in which a majority of defendants found IST receive CR in the community (Fitch, 2014).

One of the major due process and clinical concerns for defendants who are found IST and ordered for CR is that they wait for sometimes long periods of time in jail for a forensic state hospital bed to become available. A survey by NASMHPD of all 50 states and the District of Columbia (Fitch, 2014) asked whether a given state maintains a forensic bed waitlist, with over half of respondents (n=20; 54 percent) reporting that they do. Among those 20 states, 6 reported that the average wait is between 7–20 days; 2 states reported their wait is 21–35 days; 4 reported that their wait is 36–49 days; 1 reported the wait is 50–64 days; 1 reported the wait is 65–79 days; 2 reported that the wait is 238–252 days; and 4 declined to report their wait time (Lutterman et al., 2017). In a study by Steadman and Callahan (2017), the average wait for a forensic hospital bed was 53 days at one hospital and 429 days at another, with the overall state median being 115 days on the waitlist. Not all defendants were transferred to an inpatient bed. Over half (53 percent) of individuals ordered for CR were restored in the Philadelphia Prison (jail) while awaiting a forensic inpatient bed.

A recent national survey by Warburton and colleagues (2020) reports that 82 percent of states are experiencing an increase in CST evaluation referrals and 78 percent are experiencing an increase in referrals for CR. They identify inadequate community-based resources such as crisis services, psychiatric beds, and assertive community treatment services as among the reasons for the marked uptick in referrals for competence services. The six-state PLC survey finds that individuals placed on the CR bed waitlist usually remain in jail (five states). Only one state places persons awaiting state forensic beds in a community hospital. In those six states, psychiatric acuity is the primary criterion for someone moving off the waitlist and into a forensic inpatient bed. All states maintain a centralized state waitlist for persons found IST and ordered for CR, but it is new in Ohio and inconsistent in Wisconsin. In terms of cross-systems coordination, none of the states reported routine, system-wide, coordinated communication among justice professionals to identify alternative diversion options for the IST population (Pinals et al., 2018). The upward trend in the proportion of state forensic inpatient beds being occupied by defendants found IST was also reported

in the 2014 NASMHPD survey. Consistently across the United States, assessments of trends in state inpatient forensic beds confirm an upward trend in usage by defendants found IST.

What factors contribute to the waitlists are vast and depend on state law, treatment resources, and common practice within jurisdictions. What is somewhat unique about this issue is that the criminal justice system—namely judges—hold the keys to both the front and back doors of the forensic hospitals in 57 percent of states (Fitch, 2014). Judges first determine whether a defendant will be found IST and, second, whether they will be committed to a clinical entity (public hospital, community provider, or private hospital) for assessment and restoration to legal competence. Fitch (2014) reported that in 74 percent of states, a judge has the authority to discharge a defendant found IST, not the state. By far, many IST evaluations are conducted and paid for by the public mental health system. As reported by NASMHPD, some judges are very transparent in using the tools available to them—an IST finding—to assure that the individual will receive treatment while in jail.

Judges also determine whether a defendant who has been "sent back to court" is competent to stand trial. While judges rely on clinical assessments, the decision ultimately is a legal one. The court can accept or reject the recommendations from the treating clinicians. There are few ways for a state forensic hospital bed to become available for someone on the waitlist: the court accepts the clinical recommendation that a defendant who is currently occupying a bed has been restored to competence; the defendant is found "unrestorable" and transferred to another setting; the patient is released from the hospital (in fewer than a quarter of the states); or the patient dies. Typically, the hospital cannot transfer or relocate forensic patients without consent from the court. This reality can cause a bottleneck in forensic hospitals, giving rise to bed waitlists. There is no doubt that serving defendants with serious mental illness is among the greatest challenges to the court as to what is the best outcome for their legal and clinical problems. In fact, this awareness has led many judges to be among the most vocal proponents of early diversion, jail diversion, and treatment courts. When diversion is not an option either due to eligibility restrictions or unavailability of a suitable program, judges might decide to initiate the competence process and hope that treatment is forthcoming. This does allow for an "out of sight, out of mind" scenario, however, usually to the detriment of the defendant. To illustrate the lack of programs available to many defendants (and judges) for persons with serious mental illness, there are mental health courts in only 17 percent of counties in the United States (SAMHSA's GAINS Center, 2022b).

Fitch (2014) queried states as to the practical outcomes of being found "unrestorable" within the constitutional guidelines set in *Jackson*. As with other procedures surrounding defendants found IST, there are state-by-state variations. If someone is charged with a serious felony, and if state law is silent on length of time for CR, the court can require a forensic hospital to hold a patient indefinitely when it has legal authority over release or transfer. Most states allow for civil commitment procedures to commence, but the legal standards for that are more stringent than forensic commitment.

Based on this scan of the published literature, reports, and online searches, no states report data for all their "IST waitlists." Some waitlist data are available, as many states have recent or current litigation on

this issue (see analysis of state statutes, Appendix II). For instance, Texas reported that at the end of 2016, there were nearly 1,000 people on its forensic hospital waitlist; this number has grown to nearly 2,000 people in 2021. Texas reports that nearly 70 percent of state psychiatric hospital beds in the state are used by the forensic population (Texas Health and Human Services, 2021). Due the lack of data, the news media has, at times, picked up on the issues with IST waitlists and forensic bed shortages and reported what they have found to be waitlist populations.

Morris, McNiel, and Binder (2021) report that estimates of the number of annual orders for CST vary widely (19,000–94,000) and emphasize why accurate measures are important to inform policy making, allocation of resources, and training and workforce development. They continue that it is impossible to represent the scope of the competence system without accurate data.

As described by Pinals and Fuller (2017) in "Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care," there is no official count of how many mental health beds there are in the United States. In addition, it is not known how many beds serve which patients and at what level of care. Not knowing this makes it impossible to estimate how many beds are available or needed to dislodge the bottleneck of individuals in the CST/CR system. People ordered for CST and CR are typically ordered by a criminal court into an inpatient psychiatric bed administered by a local or state government. These inpatient beds are "forensic" if set aside for individuals found IST, not guilty by reason of insanity, or another criminal statutory designation. These beds might be in a freestanding forensic hospital, a separate unit within a hospital, or among a few beds scattered across hospitals. However, Pinals and Fuller (2017) note, there are many types of beds that can fill the need, including public and private child/adolescent beds, geriatric beds, acute-care mental health beds, residential treatment beds, group living beds, supported housing beds, and psychiatric emergency room beds with or without a "forensic" designation.

In summary, there is no clear definition of which populations of individuals in the competence determination/restoration process are included in "waitlist" numbers. Second, many states do not publish data on any type of waitlist. Third, some states do not even compile waitlists. And fourth, there is no information about which defendants/patients are most affected by this complex CST/CR legal and clinical process. Until consistent data are collected with similar definitions and measures, it will be impossible to determine to what extent "waitlists" are a problem in states and whether certain populations are more negatively affected by the process than others. It remains a fact, in 2023, that most states do not formally or publicly report the size of their waitlist. And, as noted above, there is not one single waitlist in the competence process.

No research was identified on the waitlist of juveniles who are involved in the CST/IST/CR process in either juvenile or adult courts. Kruh and colleagues (2022) suggest that many factors, such as a shortage of child and adolescent inpatient psychiatric beds, underlying reasons for IST, such as immaturity rather than a severe mental disorder, and overall trends in juvenile justice toward community-based responses all point toward a "least restrictive environment" emphasis for youth being evaluated for CST and being ordered for remediation/restoration if found IST. Consequently, it is logical to infer that these practices would lower waitlists for youths.

Adult Competence Process

Legal Process to Determine Competence to Stand Trial

The legal process to determine CST described in this report is generic in the sense that it reflects requirements found in many, but not all, states. While these main areas of statutory language are derived from a review of the criminal (adult) law. Not all states specify competence procedures for individuals under age 18. When they do have a juvenile competence statute, the legal steps are similar to the adult process. Definitions and measures of an individual adult's or youth's CST vary across states. Most states, however, ground their competence determinations in defendants' abilities to understand the proceedings against them and to assist in their own defense.

Raising the Issue

At any point in the proceedings, the court, defense, or prosecution can raise a doubt regarding a defendant's CST. Judges typically must have a "bona fide doubt" or "reasonable grounds" to believe that the defendant is incapable of understanding the proceedings or assisting with their own defense. All other criminal proceedings are halted until the matter of competence is settled, with the limited exception of some legal matters that a defense attorney could reasonably complete without assistance from the defendant.

Conducting the Examination

Few states rely on just one examination, with most states setting a minimum and maximum number of examinations allowed and the disciplines and licensures examiners must have. Competence examinations may occur in jail, the community, and during confinement in a state mental health facility or other authorized mental health facility. States may authorize examinations for mental illness, medical issues, cognitive disabilities, developmental disabilities, and/or autism. Certain measures are appropriate for certain situations or defendants, such as tools developed for defendants with intellectual disabilities or tools that include an embedded measure of symptom exaggeration. Also, evaluators may need the option to use a different measure if the defendant has been evaluated previously and there is a concern about practice effects falsely improving their performance on the measure. A comprehensive glossary of CST measurements is included in Appendix I without recommending one measure over another.

> *At any point in the proceedings, the court, defense, or prosecution can raise a doubt regarding a defendant's CST.*

Competence Hearing

Upon filing of the examiner(s)' report(s), the court must order a competence hearing or make a decision about the defendant's competence based on the report if neither of the parties object to the examiner(s)' findings. Often, courts must make their findings based on a "preponderance of the evidence" or "probable cause." If the defendant is found CST, the trial proceedings immediately resume. If the defendant is found IST, the defendant may be ordered to the custody or supervision of an inpatient or outpatient service provider for CR treatment and to assess whether there is "substantial probability" that the defendant can be restored to competence within a set framework.

Legal Process to Restore Competence

The term "competence restoration" refers to the process by which a defendant found IST receives court-ordered treatments to remediate medical, mental health, cognitive, or developmental issues and thereby increase the defendant's ability to understand the proceedings against them and to assist in their own defense.

Treatment Options

Depending on the state or jurisdiction, CR services are offered on an inpatient or outpatient basis or both. In many states, courts can order the involuntary medication of defendants if certain criteria are met. These criteria are typically prescribed by statute or case law.

Initial Restoration Period

After a finding of IST is rendered, courts can order the defendant to participate in CR treatment on an inpatient or outpatient basis. Treatment providers often work within an "initial restoration period" (typically 3 to 9 months, depending on the state) in which they are treating the defendant while simultaneously assessing whether there is a "substantial probability" that he or she will regain competence and within what time frame. If the defendant is restored before the completion of the initial restoration period, a report is filed with the court, and upon another competence hearing, the trial proceedings are resumed. If the defendant is not restored within the initial restoration period, the service provider must advise the court as to the possibility of restoration and whether it can be accomplished in an allowed time frame.

Continued Competence Restoration Treatment

In line with Supreme Court case law (see discussion of *Jackson v. Indiana*), many states have statutory maximums for which individuals can be subjected to restoration treatment. Typically, these services cannot extend beyond the maximum period of incarceration for the offense with which the defendant is charged. Most states require periodic status reports and hearings (typically every 90 to 180 days) and

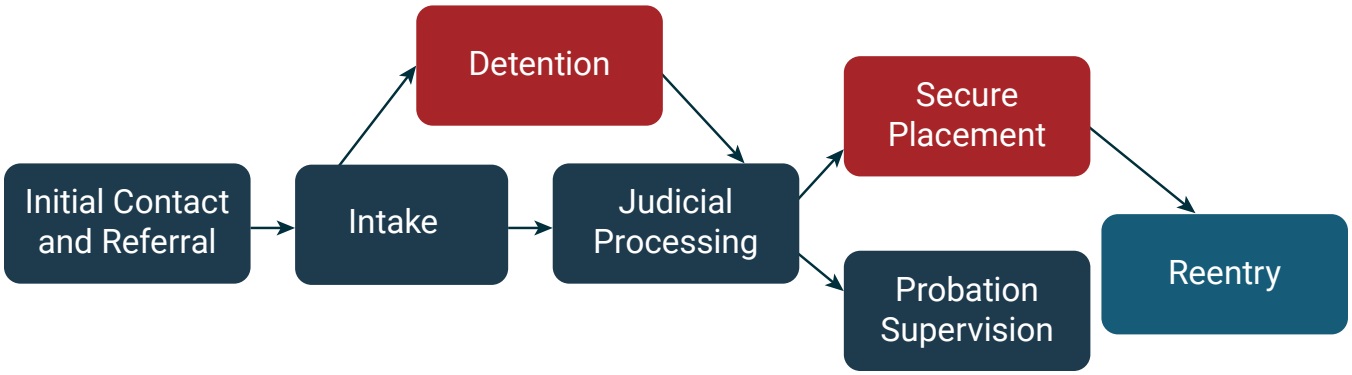
immediate notification if the defendant regains CST. If it is ever concluded that there is a substantial probability that the defendant will not be restored within the allotted time frame, many states have statutory language governing dismissal of charges, release of the defendant, and/or the initiation of civil commitment proceedings.

At each of these steps, there is a disruption in the continuity of treatment for individuals with serious mental illness, cognitive impairment, or intellectual or developmental disability (IDD), including medications, counseling, housing, family supports, substance use services, supported employment, and peer support.

Juvenile Justice Competence Process

Kruh and Grisso's (2017) "Developing Service Delivery Systems for Evaluations of Juveniles' Competency to Stand Trial: A Guide for States and Counties" provides a thorough description and set of recommendations for implementing CST statutes for youth in the juvenile justice system. As in the adult criminal justice system, the question of a juvenile's competence can be raised at any time from arraignment to the end of the adjudicative process but is more often done so by attorneys at or soon after arraignment. Figure 1 depicts the general steps of the juvenile competence process, each of which presents opportunities for critical interventions. A comprehensive glossary of CST measurements is included in Appendix I.

Figure 1. Critical Intervention Points in the Juvenile Justice System



Processing After the Question Has Been Raised

About one-third of juvenile courts in the 100 largest jurisdictions in the United States receive their CST evaluations from clinicians who work in a juvenile court clinic, about half from private practitioners, and the remainder from clinicians in community mental health centers.

Whether youth will await evaluation in the community or in detention and will be evaluated while at home, in detention, or in a child forensic psychiatric inpatient facility usually depends on whether the nature of the offense or the youth's risk level requires detention or whether the youth's psychiatric condition requires inpatient psychiatric care.

Time allowed for the evaluation varies across states, ranging from 20 to 60 days.

Most diversion in juvenile justice is pre-arraignment, so true front-end diversion isn't possible (since all CST evaluation requests occur after arraignment).

CST Judicial Hearing After Evaluation

Dates range from "as soon as practicable" to 45 days following receipt of the evaluator's report. Hearings are not always mandatory; some states allow courts to make determinations unless a hearing is requested.

Judicial Finding

If the defendant is found competent, the trial process proceeds. If the defendant is found not competent, the judge must find whether the youth can be restored. If the youth is found to be restorable, the judge decides where the youth will be during the CST evaluation process: at home, in detention, or at a child forensic psychiatric hospital (if the community has one). Because of limited child forensic beds, delays may occur if hospitalization is required. While waiting for the forensic bed, the youth can be released into the community which might increase the risk of re-offending while waiting for restoration services. The youth might also be held in detention because of waitlists, and that simply isn't acceptable from a psychiatric standard of practice. Increasing the number of child forensic psychiatric hospital beds is extremely expensive.

Restoration Process

The restoration process for juveniles is highly variable across communities and states. A few states have no systematic CST restoration programs for juveniles. Some states have juvenile restoration programs only in child forensic psychiatric inpatient hospitals, and other states have systematic CST restoration programs that can be administered at home, in detention, or when hospitalized. There is no scientific evidence regarding the best CST restoration program for youth. While some programs exist, there are no model CST restoration curricula for juveniles. (There are systematic curricula, but the evidence needed to consider these a "model" does not exist.)

Length of Time for Restoration

States vary in length of time allowed, from 3 months to 2 years.

Re-Evaluations

Most states require the restorative clinicians/hospitals to notify the court as soon as they believe the youth has been restored. In addition, they require reports to the court periodically—often every 90 days. However, it is possible for youth to remain in restoration services longer than they need to, if reevaluation rules are not firm and reasonable. If a youth is found not restorable, most states require that the charges against the youth be dropped. Most states also allow for civil commitment of the youth at that point if the youth is dangerous or in need of care and treatment for their own benefit.

Literature Review

Current National Context of IST/CR

SAMHSA's GAINS Center's Competence to Stand Trial and Competence Restoration Learning Collaborative

The acknowledgment that local and state partners need to be at the table to bring about change in the competence process was the foundation for the SAMHSA GAINS Center's Competence to Stand Trial and Competence Restoration Learning Collaborative for adults. Convened in 2019, the Learning Collaborative focused on improving policies and practices within states selected through a competitive solicitation. The themes identified in the 2018 version of the IST Report guided the foundations for the Learning Collaborative. The Learning Collaborative required that multidisciplinary teams be convened, including local and state officials who had direct engagement with the CST/CR process for adults. States were invited to remain in the Learning Collaborative throughout its duration, 2019–22. States came prepared and motivated to improve their systems. The jurisdictions that participated in the 4 years of the Learning Collaborative are presented in Table 1.

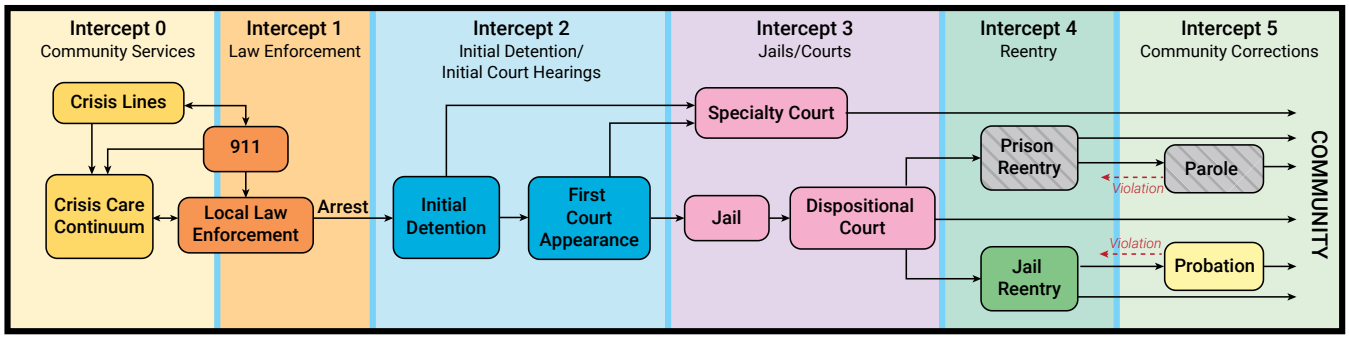
Table 1. Jurisdictions in the GAINS Center's Competence to Stand Trial and Competence Restoration Learning Collaborative

States/Districts	2019	2020	2021	2022
Alabama	-	-	x	-
California	x	x	-	-
District of Columbia	x	x	x	x
Florida	x	x	x	-
Georgia	x	-	-	-
Illinois	x	-	-	-
Nebraska	x	x	x	x
Nashville, Tennessee	-	-	-	x
New Hampshire	-	x	x	x
New York	x	-	-	-
North Carolina	-	x	x	x
Oregon	-	x	x	x
Texas	x	x	x	x
Utah	-	x	-	-

Over the course of the Learning Collaborative, focal topics were based on the needs of the states and the expertise of the subject-matter experts. What is clear from the 4 years' work with the states and districts is that change is possible but requires the vision and dedication of many working partners. While the leadership of an official such as a state forensic director is required to make changes, it requires cooperation and collaboration from state leaders through local officials such as a local judge. (For more details about the changes made by the Learning Collaborative jurisdictions, please see "State Strategies to Address the Crisis in the Competence to Stand Trial and Competence Restoration System," SAMHSA's GAINS Center, 2022a)

Because reforming the competence system requires input from many interested parties, Pinals and Callahan (2020) recommend the Sequential Intercept Model (SIM) as a framework to identify pathways out of the competence system and into treatment (see Figure 2). Using the SIM, communities (and states) can identify opportunities and gaps in diverting individuals with serious mental illness out of the criminal justice system, including the competence system. The authors developed a modified SIM that focuses more closely on Intercepts 2 and 3, where most of the legal system decisions are made on CST (see Figure 3). This abbreviated version of the SIM identifies points where stakeholders can divert individuals away from the system and into treatment. Each of these decision points also provides a point-in-time data element that could be collected to better follow the flow into and out of the competence system.

Figure 2. The Sequential Intercept Model

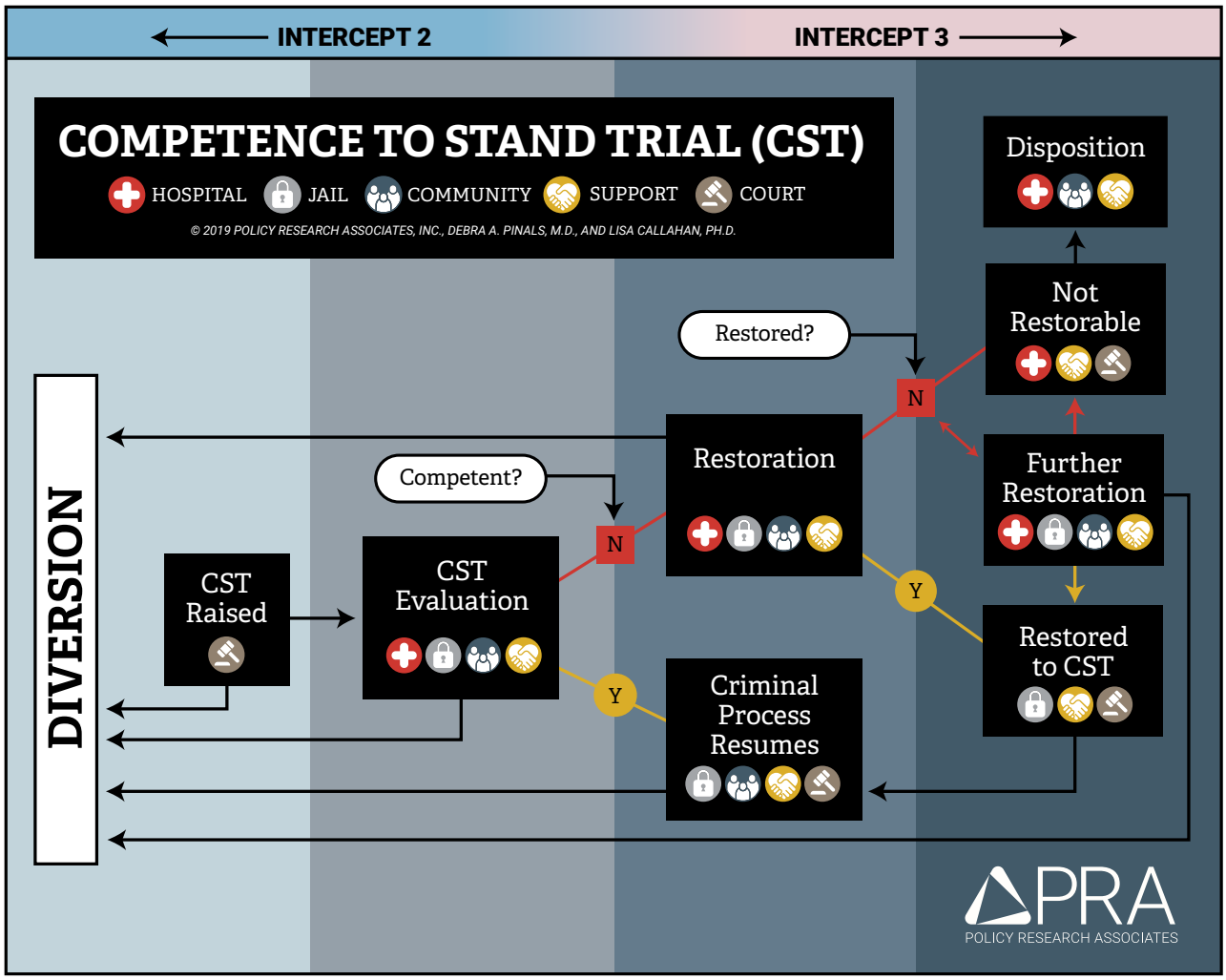


Abreu, D., Parker, T. W., Noether, C. D., Steadman, H. J., & Case, B. (2017). Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0. *Behavioral Sciences & the Law, 35*(5-6), 380-395. https://doi.org/10.1002/bsl.2300

Other National Efforts

Judicial leaders have also recognized that there are many parts of the competence evaluation and restoration process that need their attention. In 2012, with funding from Bureau of Justice Assistance, the National Judicial College convened experts to create the Mental Competency Best Practices Model. According to the National Judicial College (Dressel & Burns, 2012), approximately 60,000 competence evaluations are ordered every year with only 20 percent being found IST. They advise that "not only is the competency evaluation process costly to the jurisdiction, but it may lengthen the time a defendant is involved in the criminal justice system" (p. 1). Their work makes recommendations on issues such as standards for hearings, what evaluations/reports should include, competence treatment plans, CR, court and system-wide practices, establishing a competence court or docket, training and education, and the need for cross-systems collaboration (Dressel & Burns, 2012).

Figure 3. Competence to Stand Trial Flowchart



Recently, the National Center for State Courts created the National Judicial Task Force to Examine State Courts' Response to Mental Illness, which conducted a comprehensive examination of how the judiciary could lead reforms in the competence system. The task force sought to identify reforms already under way in some states, collaborate with experts across the country, and make recommendations for system improvements (see NCSC, 2021). In addition to its task force report, NCSC released a series of fact sheets with practical guidance for judges and courts for responding to the recommendations (see NCSC, 2022a-d). Similarly, CSG convened experts representing a wide range of stakeholders to envision a system that is responsive to the growing population of individuals in the competence system (see Fader-Towe & Kelly, 2020). Both CSG and NCSC suggest strategies for states to begin reform efforts; these recommendations are summarized in Table 2.

> *Gowensmith (2019) refers to the present situation as a "crisis" for forensic mental health professionals in that there are not enough qualified professionals to provide adequate competence services.*

Table 2. Recommendations for Reforming the Legal System and CST/IST/CR

Recommendation	CSG	NCSC-Task Force
Convene diverse stakeholders to understand the CST system	x	x
Move diversion away from the criminal justice system	x	x
Limit CST cases	x	x
Develop alternative evaluation sites	x	x
Develop alternative restoration sites	x	x
Revise restoration protocols–AAPL Practice Guidelines	-	x
Develop and impose rational timelines	-	x
Address operational inefficiencies: • Evaluator training, availability, and speed • Evaluation templates • Multiple opinion requirements • Case managers and court liaisons • Court case management—centralized calendars, frequent reviews, team	x	x
Address training, recruitment, and retention of staff	x	x
Coordinate and use data	x	x
Develop community-based treatment and supports for diversion and reentry	x	x
Establish accountability across systems	x	-

The American Bar Association's (ABA) Criminal Justice Standards on Mental Health (adopted August 8, 2016) addresses competence to proceed (part IV, standard 7-4.1-7-4.16) with details for each step of the competence process and provides a good guide for the steps involved when competence is raised. Its standards are quite detailed and address competence to proceed, raising the issue of competence, orders for evaluations, clinical reports, hearings, the right to undergo and to refuse treatment, periodic review of competence, nonrestorability, and dispositions issues. It emphasizes that competence should be raised under very specific conditions. Were all attorneys and judges to follow the ABA guidelines,

the competence system would likely be used less often as a tactical tool and more for what it is intended to accomplish. The National Judicial College's Mental Competency Best Practices Model and ABA's Standards on Mental Health could serve as templates for issues and considerations that the legal professionals involved in competence procedures must address to fully understand and represent adult defendants with mental illness.

All three national efforts from SAMHSA's GAINS Center, NCSC, and CSG underscore the importance of leadership in identifying and addressing the challenges and solutions to the broken competence system.

Gowensmith (2019) refers to the present situation as a "crisis" for forensic mental health professionals in that there are not enough qualified professionals to provide adequate competence services. He proposes solutions to the crisis, including (1) shortening the CST evaluation process by creating checklists and triaging potential evaluations by using a screen; (2) expanding the pool of qualified evaluators; developing information about what is associated with restoration and developing professionals to deliver that curriculum; (3) developing alternatives to inpatient CR; (4) expanding the timing to allow for sufficient clinical observations for an evaluation; and (5) working across systems to streamline the process while maintaining high standards.

One reported outcome of the increased demand for competence evaluations and other related services is concern about the quality of reports submitted to the courts. Hill and colleagues (2021) reviewed 388 CST reports for individuals from 2012 to 2013. They evaluated the reports for how well they adhered to professional guidelines and research on appropriate evaluation procedures. They found that there was an overall poor quality of the CST reports, with many evaluators not accurately describing underlying mental illness and failing to explain how the mental illness was related to competence. While board-certified evaluators performed better than those not board-certified, their evaluations were still lacking. For example, 31 percent of board-certified evaluators connected mental illness to competence; only 15 percent of non-board-certified examiners made the connection. Additional findings were consistent with the board-certified evaluators outperforming those who were not. They conclude that training matters and all evaluators need additional and ongoing training, especially in scientific developments in neurobiology and mental disorders and how that affects a person's ability to assist in their legal defense. They continue that a formalized forensic training program could provide training and consistency in many areas, including competence examinations.

Juvenile CST

As is evident in this literature review, most of what is written about competence is about adults. Research on juvenile CST, IST, and CR is even more limited than the research on adults. The due process requirements of the U.S. Constitution were extended to juvenile offenders generally starting in the 1960s. It was not until the 1990s that juvenile competence was raised with any frequency (Larson & Grisso, 2011), perhaps in response to the rise in juveniles being transferred—either automatically due to statute or through a

waiver—to adult court, which was perceived as having elevated risks to defendants. As more and younger children were being charged with crimes that both were serious and carried potentially lengthy sentences, questions were raised as to whether youths could truly understand the charges they were facing and participate in their own defense as required by *Dusky*.

By the early 2000s, the juvenile courts had begun to respond to concerns about procedural fairness in the processing of juveniles whose competence was raised. Specialty juvenile court clinics, or clinicians under contract with the court, became more common in larger U.S. jurisdictions (Larson & Grisso, 2005). The researchers found that among the largest juvenile courts in the United States that they surveyed, nearly all clinicians (93 percent) practicing in a court clinic or community mental health center or as a private practitioner conducted CST evaluations for delinquency cases (Larson & Grisso, 2005).

A 2010 study shows that CST was raised in over half (58 percent) of the cases in which a juvenile was transferred to the adult criminal justice system (Viljoen, McLachlan, Wingrove, & Penner, 2010). Larson and Grisso (2011) describe that states either use a "functional abilities" approach, which focuses on what abilities a youth has, or a "cognitive concepts" approach, which is concerned with what the youth should be able to do in assisting counsel. While mental illness is likely the most common reason for an adult's competence to be raised, youth can also be considered developmentally immature or have cognitive impairments.

Research shows that youth in the juvenile (and adult) justice system have elevated rates of at least one mental disorder and much higher rates of comorbidity than their peers (Abram, Teplin, McClelland, & Dulcan, 2003). Kruh and Grisso (2017) cite research that shows for 58 percent of juveniles found IST, it was due to their intellectual deficits, compared with 6 percent of adults (Kruh & Grisso, 2011, citing McGaha et al., 2001). A recent telephone interview with the special project director for a juvenile court in Ohio found that she could not recall any youth with "just a mental illness" ordered for a competence evaluation in the past few years. Instead, she stated that all of their competence evaluations in the juvenile court are for intellectual deficits or immaturity (Callahan, personal correspondence, September 6, 2018). Mental illness, coupled with other deficiencies such as low intelligence (Grisso, Steinberg, Woolard, Cauffman et al., 2003), developmental immaturity, and cognitive impairment hinder youths' CST (c.f. Jackson, 2018, for a thorough review of the factors related to juvenile CST).

Arizona's Juvenile Restoration Program was established in 2009 and serves approximately 100 youths per year. Most program participants (85 percent) are male; half are between the ages of 11–13. The youths in the program are 39 percent Hispanic, 33 percent white, 22 percent African American, and 5 percent Native American. Three-quarters of the youths have been returned to court as competent to proceed (Kruh et al., 2022). This program is described in more detail below.

For the past 65 years, juvenile courts have become increasingly more due-process-oriented, operating similarly to adult courts. One consequence has been an increase in juvenile competence evaluations

(Jackson, 2018). As courts became more punitive in the 1990s, concerns about protecting the rights of juvenile offenders included assuring juveniles were competent to proceed with their criminal charges. Given the well-established prevalence of mental illness among detained juvenile offenders and the link between mental illness and competence in adults, juvenile competence is a serious issue in the justice system (c.f. Jackson, 2018, for a thorough review). It should be of concern that mechanisms for transferring juveniles into the adult criminal justice system could provide an amplified disadvantage to youths whose competence to stand trial might be an issue whether it be due to mental illness or IDD.

According to Kruh and Grisso (2017):

> Between the middle-1990s and about 2010, the demand for evaluations of [juvenile competence to stand trial (JCST)] had increased in some jurisdictions from a handful annually to hundreds. This led appellate courts to consider the special issues raised in JCST cases, because prosecutors in many states challenged the applicability of CST to juvenile court. Between 1978 and 1980, appellate courts in all five states [California, Louisiana, Nevada, Minnesota, and Arizona] in which CST in juvenile court was challenged concluded that it did apply in delinquency proceedings. Continued challenges extending into the 21st century all arrived at the same conclusion, so that today JCST in delinquency cases is recognized in all states. (p. 6)

Santa Clara County, California, implemented a manualized CR program developed by Virginia's Institute of Law, Psychiatry, and Public Policy and found that more youth in California were found to have an intellectual disability than in Virginia (75 percent vs. 38 percent). California youth found incompetent were in the restoration (remediation) program for twice as long as Virginia youth. Both states had similar (5 percent) rates of hospitalization among their youth in the program (Jackson, 2018). Studies have shown that youth who have only a diagnosis of mental disorder are highly likely to be restored, whereas those with both a mental disorder and an intellectual disability or only an intellectual disability are less likely to be restored (or remediated).

As shown in California and Virginia, and based on the 2014 NASMHPD survey, the trend is away from the most punitive approach to juvenile delinquency and criminality, especially where youth with mental disorders or intellectual disabilities are concerned. The 2014 NASMHPD survey asked state mental health directors if juvenile competence was an issue in their state. Nearly all (90 percent) responded that it was an issue in their juvenile courts. In over half of those states (57 percent), the public mental health system provided evaluations; the state's juvenile justice authority or a private entity conducted juvenile competence evaluations in the remainder of the states. Nearly all (90 percent) juvenile competence evaluations were conducted on an outpatient basis. Funding for outpatient evaluations ranged from being paid for by the court to being covered by the county. Sources of funding often influence the frequency of competence

evaluation orders. Tennessee, for instance, observed a drastic reduction in competence evaluation orders once the courts started receiving bills for the evaluations (Fitch, 2014).

Fitch (2014) also reported that juvenile CR is the states' responsibility in only 55 percent of states and is usually provided in an outpatient setting. Restoration may be less likely for juveniles who are found to have developmental delays or are immature. In those cases, the court may accept a finding that a youth is "unrestorable" and move toward alternative outcomes such as releasing the youth with no more juvenile court involvement, civil commitment, or petitions for children in need of supervision. To illustrate the importance of a wide lens of which professionals are involved in the forensic evaluation and treatment system, Grisso and Quinlan (2009) surveyed clinicians who work with justice-involved youth in the nation's 87 largest juvenile courts and report that most (61.8 percent) are funded through county, not state, funds. Consequently, querying only state-level directors will likely miss the full scope of the process.

Heilbrun and colleagues (2019) echo earlier findings that most states' statutes are silent on juvenile competence, and there is little research in the area. Most of what is known is descriptive. Developmental immaturity complicates the competence picture and process with juveniles, as it includes the complexity of adult competence along with immaturity. However, more recently, Kruh and colleagues (2022) found that 36 states and Washington, DC, have specialized juvenile competence statutes or court rules. They found that 10 states extend adult competence statutes to juveniles. Only four states have no formal statutory basis for juvenile CST. They report that community-based remediation services are more common when the program is in a juvenile court rather than an ancillary to the adult system. They identify the following emerging best practices for juvenile CST:

- Delivery of services should be made by experienced and properly trained professionals.
- Instructional services should be individualized.
- Instructional services should be part of the dyadic training relationship and part of an ongoing relationship between the provider and the youth.
- Individualization of clinical services should target mental health symptoms.
- Case management should be available.
- Services should be developmentally appropriate for age and cognitive development.
- Outcomes data should guide services.
- Dosing services should be based on statutory timelines and youth making gains.
- Remediation services should be incorporated into the overall competence process to inform court decisions.

Ohio is one example of a state that has implemented a juvenile competence process. In 2011, Ohio passed a juvenile competence statute that focuses on a hearing and the initial CST evaluation. The presumed age of competence is 14 years old. Once CST is raised, the court can find a youth IST without an evaluation or hearing by agreement of the parties or based on a prior finding. If an evaluation is ordered, the statute articulates who may do the evaluation based on what is known about the youth, such as whether they have a developmental disability. The evaluation must be done in the least restrictive setting and include capacity to understand the charges, understand the adversarial nature of the proceedings, assist in their defense, and comprehend the consequences. If the evaluator finds the youth IST, they must opine on restorability. The court can order attainment services if warranted (Woolson, 2022).

Description of Populations—Who Is Found IST?

It is important to emphasize that there are no national data collected on any step of the competence process, and few states collect, or report, these data. Consequently, studies must rely on access to official statistics, if available, and de-identified data from prior research. This severely limits the ability to understand all aspects of the competence process, including who is referred for an evaluation, who conducts the evaluation, what alternatives are available or recommended, who is found IST, and so on. In addition to providing only a very limited understanding of the population and process, a lack of systematic real-time data hampers efforts at initiating system reforms.

Recent studies shine a light on who is in that jurisdiction's competence population. In Virginia, Murrie Gardner, and Torres (2017) report that the populations evaluated by forensic examiners are typically male, African American, 38 years old, have low education levels, and have a prior criminal record. For those charged only with a misdemeanor, that population is more likely to be female and older and 1.6 times as likely to exhibit psychotic symptoms. In Nashville, researchers found that defendants found IST were over 11 times as likely to exhibit psychotic symptoms (abnormal thoughts) during the evaluation than those found competent. Most individuals found IST had a history of psychiatric treatment, including hospitalization (Tansey, Brown, & Wood, 2021).

Researchers studied the IST population admitted to Napa State Hospital in California from 2009 to 2016 and found an increase over that time in individuals with 15 or more arrests (from 18 percent to 46 percent). At the same time, they found a decrease in individuals with prior inpatient psychiatric hospitalizations (75 percent vs. 50 percent). Individuals with schizophrenia were the least likely to be restored, followed by individuals with cognitive deficits; these two diagnostic groups made up 90 percent of individuals found not restorable (Broderick, Azizian, & Warburton, 2020). They assert that because individuals diagnosed with bipolar disorder are typically responsive to medications, their length of time to restoration is shorter than those with diagnoses of schizophrenia or cognitive disorders.

This same retrospective study at Napa State Hospital in California by Broderick and colleauges (2020) also found that among all IST patients admitted from 2010 to mid-2018, the most important variables associated with a longer length of time in the hospital (from admission as IST to restoration or other discharge) were a diagnosis of schizophrenia or neurocognitive disorder, having committed a violent act while in a hospital, having a prior hospitalization, and older age. While not statistically significant, race appears to play some role in the length of time from IST finding to CR, especially among individuals who identify as Native American; further exploration of this observation is warranted but limited due to the small number of individuals in this group. There were no other effects of race or ethnicity reported in this study, and this population is 36 percent white, 30 percent African American, 28 percent Hispanic, 3 percent Asian, 1.6 percent Pacific Islander, 1.3 percent other, and .7 percent Native American.

Two meta-analyses have been completed on competence evaluation research and are among the most highly-cited works on this topic. The first, by Nicholson and Kugler (1991), analyzed the findings of research from 1967 to 1989, whereas more recent efforts by Pirelli, Gottdiener, and Zapf (2011) analyzed published studies between 1967 and 2008. Overall, the findings from both meta-analyses were similar. Given that the more recent analysis includes the years examined by the 1991 effort, the summary statistics are reported here for the more recent research.

Pirelli and colleagues compared defendants found IST with those who were not, drawing on data from 68 studies that met their eligibility criteria (cf. Pirelli et al., 2011, for detailed description of methodology and included/excluded studies). Pirelli et al. (2011) reported that 27.5 percent of defendants who raised (on their behalf) competence were found IST. The most significant variable that separated the two groups of defendants was their diagnosis—67 percent of defendants found IST had a psychotic disorder diagnosis, compared with 22 percent of the defendants found competent to stand trial. Other clinical variables also affected outcomes. For example, defendants found IST were nearly twice as likely to have a history of psychiatric hospitalization.

Meta-analysis studies face many limitations, among the most relevant being how prior studies measured factors, such as personal characteristics. For example, Pirelli et al. (2011) found a near-neutral effect of a defendant's race, gender, or marital status on being found IST. Because of prior study measurements, their findings are limited to "% white," "% female," "% married," or "% unemployed." More specificity is not feasible when combining multiple studies. Pirelli et al. (2011) also found being charged with a violent crime had no impact as to whether a defendant was found IST. A 2017 study of the IST/CR waitlist in Pennsylvania shows that 80 percent (n=200) of IST defendants are male, 61 percent are persons of color, and they are on average aged 40 years old. As with the meta-analyses described above, most (90 percent) have a diagnosis of a psychotic disorder, and 20 percent have a substance use disorder (Steadman & Callahan, 2017).

Examples of CR or Remediation Programs

Research on evaluation of IST has steadily increased over the last 25 years, especially in the adult system; however, little work has been done to examine CR practices for adults or juveniles found IST. Consequently, there are *still* no established "best practices" regarding CR (Gowensmith, Frost, Speelman, & Therson, 2016) for adults or juveniles. Restoration and remediation practices, including the location of restoration (i.e., hospital, jail, community), vary considerably across states. Before best practices or models can be identified, more research is needed on each phase of this process for both adults and juveniles.

Findings from recent studies are presented in the following sections; however, there continues to be a lack of systematic research on CR. One major barrier to conducting the much-needed research is the challenge in data sharing across the systems that (might) retain the needed data. For example, to study CR, a study would need access to both legal data (such as court documents) and clinical data. The GAINS Center's CST/CR Learning Collaborative observed continued difficulty in brokering data sharing across the necessary systems. Pirelli and Zapf (2020) conducted a meta-analysis to examine the effectiveness of CR programs (note that most of the studies included in the meta-analysis were hospital-based programs; two studies used a mixed inpatient/outpatient model, and one study utilized an outpatient model).

Given inconsistencies across program practices and available data, a several planned analyses could not be conducted. Nonetheless, the authors reported that, in general, little information is available regarding specific restoration practices, and the base rate for CR is 81 percent with a median length of stay of 147 days. The authors note that there exist "virtually no" published data identifying specific restoration practices that result in successful restoration.

Hospital-Based Restoration

Pinals reported in 2005 that most restoration to competence occurs in a state forensic hospital. No research to date disputes that finding. Although restoration practices vary across states, there are a few common practices that have been documented. Zapf (2013) reviewed the most common restoration practices within forensic hospitals, including use of medication, legal education (e.g., information on charges, description of the trial process, consequences if convicted), specific programming for individuals with developmental disabilities, individualized treatment programming, and cognitive remediation.

> *One major barrier to conducting the much-needed research is the challenge in data sharing across the systems that (might) retain the needed data.*

Based on this review, Zapf (2013) concluded that use of psychotropic medication in forensic hospitals appears to provide some benefit in terms of CR. Similarly, although less information is available about this approach, utilizing a legal education program also seems to provide some benefit to IST defendants. Individualized programming does not seem to provide an added benefit in terms of restoration, and generally programs report worse outcomes for IST defendants with developmental disabilities versus mental illness.

Noffsinger (2001) offered several recommendations for CR curricula, based on programming from an Ohio hospital system. The following modules were recommended for inclusion in a model restoration program: legal education, anxiety reduction strategies to utilize in court, guest lectures from court personnel (e.g., judge, attorney), mock trials, video viewings of actual trial footage, conversations with defendants who had been successfully restored about their experiences, and reviews of current events relevant to the legal system. This program structure reportedly decreased average time to restoration to 80 days within this Ohio hospital (although prior time to restoration was not included) and resulted in most defendants being successfully restored (between 81.5 percent and 90.5 percent, depending on severity of charges).

Many states have adopted/adapted a curriculum developed by Florida State Hospital, the Florida State Hospital CompKit, although little outcomes data are available (see Gowensmith et al., 2016). The Florida State Hospital CompKit includes curriculum for legal education, including information on the court, the defendant, the role of the defense attorney, the plea process, the role of the prosecutor, the role of the jury, witness testimony, the bailiff, the clerk, sentencing and possible outcomes, and appropriate courtroom behavior. In addition to information modules, the CompKit requires that patients complete quizzes after each module to demonstrate competence in that area.

Danzer, Wheeler, Alexander, and Wasser (2019) assert that state-hospital-based restoration has many advantages if beds are available, including the suitability of the setting being a treatment environment and the availability of multiple types of services and treatments including psychiatric, medical, and social work. The disadvantage, aside from the low availability, is cost.

Jail-Based Competence Restoration

In an effort to reduce the amount of time defendants have to wait for a hospital bed to be restored, several states are considering alternative settings for restoration, including jails. The practice of jail-based competence restoration (JBCR) is controversial, as some have argued that defendants with mental illness do not belong in jail settings (e.g., Kapoor, 2011). Nonetheless, several states offer jail-based restoration programs and have reported successful outcomes. During the GAINS Center's Learning Collaborative, JBCR was increasingly discussed by the teams as an alternative to hospital-based restoration.

Wik (2018) identifies two general categories of JBCR: full-scale and time-limited programs. Full-scale programs usually include a dedicated housing unit (or pod) in a jail for day treatment, including individual

and group activities that focus on competence education. Time-limited programs include services provided to individuals as they wait for a hospital bed.

There are three models of JBCR: (1) Restoration of Competence, developed in Virginia in the late 1990s; (2) the Fulton County, Georgia, JBCR Program; and (3) Restoring Individuals Safely and Effectively (RISE), developed in Colorado.

Restoration of Competence was based in a separate psychiatric unit within the Prince George County, Virginia, jail and was in operation from 1997 to 2002. It reported an 83 percent restoration rate in an average of 77 days (Jennings & Bell, 2011). The program focused on up to 5 hours/day of groups on CR, mental illness and medication management, and mental/social/physical stimulation. California briefly adopted the Restoration of Competence program and reported a 55 percent restoration rate in an average of 57 days (Jennings & Bell, 2011). The Restoration of Competence program did not administer involuntary medications and, instead, focused on engagement to gain compliance.

The *Fulton County, Georigia, JBCR program* was designed to specifically reduce waitlists and wait times. This program partners with a university forensic training program and includes a separate 16-bed unit in the jail. The individuals engage in specialized day programming such as legal education, conflict resolution, values clarification, basic reading skills, and medication management. There is a strong focus on cognitive remediation to enhance problem-solving skills, attention, and memory. No involuntary medications are administered (Roberson & Vitacco, 2023).

With the onset of the COVID-19 pandemic, the Fulton County JBCR program needed to change to be provided via teleservices. The program took advantage of this "natural" experiment, identifying a matched comparison group of pre-pandemic defendants who received in-person services compared to the pandemic group of defendants who received only teleservices. The length of stay for defendants remained constant, but the restoration rate for the teleservices group increased significantly from pre-pandemic levels (Lewis et al., 2023).

The *Restoring Individuals Safely and Effectively* (*RISE)* program in Colorado reported that patients are restored in fewer days than in hospital-based programs in the state (an average of 52 days; Arapahoe County Board Summary Report, 2017) and that the program is "cost-saving" (Galin, Wallerstein & Miller, 2016). The RISE program is available to IST defendants who are treatment compliant, motivated, medically stable, considered likely to be restored in 60 days or less, and not an imminent threat to themselves or others (Galin et al., 2016). The RISE program utilizes a multidisciplinary treatment team (e.g., psychiatrist, psychologist, psychiatric nurse, social worker). Individuals in the RISE program participate in a combination of legal education groups (Florida CompKit curriculum), psychotherapy groups (social skills, anger management, cognitive behavioral therapy, dialectical behavioral therapy), individual sessions, and behavioral incentive plans. Patients engage in programming for 8 hours a day, 5 days a week, with mental health providers

on call on the weekends. The program opened in 2016. As of 2017, the RISE program has had 371 total admissions and has restored 226 defendants to competence (61 percent).

Temporary JBCR programs have been identified. Utah implemented a time-limited jail restoration program in 2014 in which state hospital staff members went to local jails to provide CR services for defendants waiting for state hospital beds. Wisconsin and Texas provide JBCR with the goal of restoring individuals before they are admitted to the state hospital (Roberson & Vitacco, 2023).

Among the CR models, jail-based restoration is the most controversial. In his declaration for a class-action suit brought on behalf of defendants found IST and ordered for restoration in Alabama, Dr. Joel Dvoskin identifies seven problems with providing restoration in a jail setting: (1) most jails lack adequate treatment staff to ensure appropriate prescribing and dispensing of therapeutic medications; (2) few jails have a therapeutic environment; (3) jails do not individualize treatment; (4) detainees fear being vulnerable if they are medicated; (5) jail staff and other inmates often demean and insult detainees receiving mental health treatments; (6) detainees with mental illness often have difficulty following rules and are consequently punished by jail staff for minor infractions; and (7) jail detainees with mental illness are detained before trial 6.5 times as long as inmates without mental illness, even when their charges are less serious. These same concerns are raised in additional declarations in ongoing litigation in Mississippi and Louisiana.

JBCR programs are growing in number, or at least are being more frequently acknowledged. For example, California has at least 15 county-based JBCR units, with over 425 beds (Jennings & Rice, 2022). At least 13 states have at least one JBCR program. As community mental health services continue to be underfunded in most states, people with severe mental illness are often driven into the criminal justice system. JBCR has some advantages, according to Danzer et al. (2019), including cost, reduced time to initiate restoration, increased supervision and monitoring, and the discomfort of the setting potentially motivating increased treatment adherence. Tansey et al. (2021) found that in Nashville, Tennessee, people whose CST evaluations were conducted in jail versus in the community had a shorter time between arrest and evaluation.

Community-Based Restoration

Given long waitlists for hospital restoration and controversy surrounding the use of jail-based restoration, several states have developed community-based restoration programs. In a 2016 review of outpatient restoration programs, Gowensmith and colleagues reported that across 13 programs with outcomes data available, rates of CR averaged 70 percent, with the average time to restoration being 149 days. All states included in the survey reported that community-based restoration saved money when compared to inpatient restoration.

Colorado developed the Denver FIRST outpatient CR program with the Denver Graduate School of Professional Psychology. Services include individual and group sessions, all of which are provided by

psychology doctoral students. Recent outcomes data suggest that the Denver FIRST program produced a restoration rate of 18 percent in an average of 226.4 days (Musgrove, Gowensmith, Hyde, & Wallerstein, 2018; note that this is a much lower rate than in other state programs, though data were only presented for the first 50 participants).

The Miami-Dade Forensic Unit in Florida offers community-based restoration for individuals with nonviolent felonies facing a second or third felony charge. Individuals are first placed in an inpatient crisis unit to ensure they are stabilized prior to community placement. Restoration then occurs in a residential treatment center, and services focus on illness management and community reentry. Recommendations for additional community services are made once competence is restored. Outcome data shows that patients are restored within 85 days (which is 43 percent faster than in inpatient CR in Florida) and that this program is 32 percent less expensive than inpatient options. Approximately 78 percent of patients successfully reintegrated to the community post-restoration. Moreover, individuals who stayed engaged in programming post-restoration were less likely to reoffend or experience hospitalization (Miami-Dade Forensic Alternative Center, n.d.).

Hawaii's outpatient restoration program is coordinated by the Department of Health Services and occurs in a community mental health center. All patients are placed in a group home without security restrictions while being restored. Services available include case management, psychiatry, and peer support (clubhouse services). Additional services, including substance use treatment, are provided as needed by a privately contracted provider. The program utilizes the same restoration materials and processes as the state hospital in Hawaii. Gowensmith et al. (2016) reported that the program was cost-efficient and restored more patients than the hospital program, approximately 95 percent.

Johnson and Candilis (2015) summarized the outcomes from a potential model outpatient competence restoration (OPCR) program operating in Washington, DC. Although the overall rate of restoration that was reported (32 percent) was lower than in other states, 76 percent of individuals who were able to be restored were restored within 45 days, a much shorter time period than other states have reported. The authors suggest that 45 days may be an optimal time to restoration in community settings. The Washington, DC, program is held in an outpatient clinic. Individuals with violent charges are not eligible. Sessions are held twice a week for 1.25 hours at a time, and all are in a group format. A 42-item survey "loosely based on the Florida State hospital CompKit" is used as a primary tool to educate patients about legal issues. Information is taught through several modalities, such as case vignettes, visual aids, role plays, word associations, and videos. The authors specifically note that group members view the movie *My Cousin Vinny* to illustrate courtroom proceedings. Restoration groups are run by licensed mental health providers. Although mental health services are not provided within the context of this restoration program, many of the patients involved in restoration receive mental health services in the community.

Following the 2015 study, the Washington, DC, OPCR program was revised; it now includes defendants with both minor and major offenses, many international defendants due to their location, an increased level of cultural responsivity via interpreters, a standard curriculum, group and individual programming,

counseling, and alliance strategies over 4 days/week. Participants continue to meet in an outpatient clinic. The authors report that from 2013 to 2017, the program had a 28 percent restoration rate for the initial referral, lower than in their earlier report. Over time, some participants, in particular those with IDD, regained competence after many referrals for CR. The program was modified for an increase in younger defendants, including juveniles (Bell, Candilis, & Johnson, 2021).

Wisconsin offers outpatient CR through a private contractor, Behavioral Consultants, Inc. IST defendants are eligible for this program if they have no imminent risk concerns, are able to remain sober, have stable mental health, and have some community supports in place (e.g., reliable transportation, housing). Individuals referred to this program complete an intake assessment to determine whether they are a good fit for the program. Once enrolled in the program, individuals are assigned a behavioral specialist and case manager. Depending on need, patients also meet with a psychiatrist. Patients typically meet with the behavioral specialist twice a week for 1 hour and meet with the case manager once a week for 1 hour. The Wisconsin outpatient restoration program is less expensive than inpatient options and results in 75 percent of patients being successfully restored (Wisconsin Department of Health Services, 2013).

Juvenile Competence Restoration, Attainment, or Remediation Programs

Utah's Juvenile Competence Attainment Services was established in 2012. The program takes approximately 35 hours to complete; takes place in the least restrictive environment, such as the youth's home or a library; is 6 months in duration but can be extended; requires progress reports to be submitted to the court; includes an attainment curriculum; and is connected to other services. From 2017 to 2019, 69 youths were ordered for remediation services, with most having both IDD and mental illness, with IDD being primary for 54 percent. Remediation was less successful for youths with IDD. By the end of the program evaluation period, the remediation rate had increased from 28 percent to 85 percent (Kruh et al., 2022).

Arizona's Superior Court in Maricopa County has a juvenile restoration program that was begun in 2009. It is overseen by the court to assure accountability. Each youth is assigned a provider and a post-remediation evaluator. Usually, the provider and youth meet weekly. An individualized plan is developed with input from many sources, including parents and schools. The evaluator receives monthly reports from the provider and submits those reports to the court. The program reports that 77 percent of youth were returned to the court as remediated (Kruh et al., 2022).

A 2020 study by Berryessa and Reeves focused on juvenile judges' perception of adolescent development and juvenile competence. Most judges reported that they connect adolescent development information to offending, not competence. While they acknowledge that age, awareness, and mental capacity are factors in competence, judges are more likely to connect peer pressure, irrational behavior, immaturity, and a lack of value system to juvenile offending than competence. Interestingly, while most judges knew that the brain develops around age 24, most did not think that was related to competence. For the minority of judges who do see a link between competence and development, they stated that the brain decidedly affects capacity to make decisions and should be considered.

Current and Emerging Issues With CST/IST/CR

As noted previously, *Sell v. United States* provides some guidance on the *involuntary administration of antipsychotic medications* for persons found IST. The four elements of *Sell* must be met, and the legal argument now is whether long-acting injectable medications can be court-ordered and whether they are as intrusive as oral medications. Courts have provided inconsistent guidance on this issue (Wang, Lanzillotta, & Weiss, 2022). Cochrane, Laxton, and Mulay (2021) observe that because restoration rates vary by diagnosis and duration of a person's illness, clinicians should conduct a deep inquiry prior to asking for an involuntary treatment order.

Restorability is an additional key complex issue in improving the competence process, as most states report difficulty identifying a pathway out of the criminal justice system for individuals found "not restorable to competence to stand trial." While they comprise a small percentage of individuals in the competence process, people found unrestorable contribute to the growing waitlists for competence services. Heilbrun and colleagues (2021) state that while most people are restorable, there is no research on those who are not. They argue that when courts or statutes impose tight timelines for a finding of restorability, clinicians are opining based on predictions, not observations. This sets up a paradox: to meet the constitutional timelines established in *Jackson* (time to restoration proportionate to underlying offense), clinicians often do not have enough time to make an evidence-based prediction on restorability. While most state statutes indicate that individuals found "unrestorable" should be considered for civil commitment and moved to the least restrictive alternative, no studies examine whether that happens. Kivisto, Staats, and Connel (2020) found that for most defendants, the likelihood of restoration is quite high, between 83 percent and 100 percent. However, they found that older adults with neurocognitive disorders who are admitted to an inpatient hospital for CR are at high risk for being found unrestorable. They conclude that in an inpatient setting, 180 days is the threshold for likelihood of CR.

As Heilbrun et al. (2021) note, most people are restored within a year, but two questions remain: (1) How long should someone be in competence services before being found unrestorable? and (2) Does the state have a compelling reason to prosecute every case? These questions prompt discussions about the types of cases or charges involved in raising questions of competence and implications for defendants.

Misdemeanors and violations carry short sentences (less than a year) and/or fines in every state for persons found guilty. This fact raises the question of whether the state should deflect some individuals whose competence is questioned out of the criminal justice system altogether and into treatment. Some states such as New York and Florida do not prosecute misdemeanor cases involving CST. Obikova (2021) asserts that people charged with misdemeanors in the competence process are more likely to be found IST, take longer to restore, and are more likely to be found "unrestorable" than people with more serious

charges. In other words, people with less serious charges end up with the most intensive, most expensive treatment services, for the longest period of time. It is worth noting here that the state mental health authority is responsible for providing treatment to whomever the courts send to them and for as long as the court mandates they provide treatment.

Murrie, Gardner, and Torres (2020) studied the impact of misdemeanor arrests on Virginia's forensic system by systematically analyzing 1,126 CST evaluations. In comparing people charged with misdemeanors versus felonies, they report that 29 percent of the reports were for people charged with misdemeanors, 45 percent for felonies, and 22 percent for a combination of charges. They found that defendants facing misdemeanor charges were more likely to be determined by the forensic evaluator as IST than those facing felony charges (44 percent vs. 31 percent). People charged with misdemeanors were twice as likely to have psychotic symptoms (35 percent vs. 16 percent), which likely explains why they were more likely to be found IST. While only 7.5 percent were viewed as unrestorable, those were 84 people who needed a long-term treatment/support plan. The authors found that people charged with misdemeanors need longer to be restored, and they are more costly to the state treatment system.

A little-discussed concern in forensic conversations is the *impact on civil mental health systems* of the growing use of precious state inpatient psychiatric beds for forensic patients. Linking the extensive use of state mental health resources for forensic patients, especially those who need competence services, Bloom, Hansen, and Blekic (2022) note that in Oregon there was a near-perfect inverse relationship between competence admissions and civil commitments at the state's only state psychiatric hospital. The *Oregon Advocacy Center v. Mink* (2003) decision requires that all persons ordered for a competence evaluation be admitted to the state hospital within 7 days or be held in contempt. In other words, beds were increasingly being occupied by forensic patients, resulting in fewer and fewer beds for people who needed that level of care but were in the civil mental health system.

The role of the *Americans with Disabilities Act (ADA)* in mitigating the impact of the competence process on persons with mental illness and other cognitive challenges is an emerging issue with the increase in long waitlists for all steps in the competence process, including once an individual is found to be "unrestorable." The prolonged detainment waiting for services, discharge, or a new residential placement raises challenges to *Olmstead v. L.C.* and provisions in the ADA regulations (Callahan & Pinals, 2020).

Expedited diversion has been proposed by Hoge and Bonnie (2021) in response to growing waitlists and burgeoning forensic treatment systems. They argue this intervention should occur very early in the process to reduce further involvement in the CST system. Specifically, they assert that individuals with serious mental illness who encounter law enforcement or crisis services should be given a commitment hearing along with a formal dismissal of the associated criminal charges. The commitment hearing would include a diagnosis consistent with the state's definition of serious mental illness, clear and convincing evidence that the individual committed the underlying crime, a clear nexus between the behavior and mental illness, significant risk of reoffending if untreated, and evidence that treatment would reduce the risk of reoffending. They continue that the length of commitment should mirror the seriousness of the

> *Murrie, Gardner, and Torres (2020) . . . found that defendants facing misdemeanor charges were more likely to be determined by the forensic evaluator as IST than those facing felony charges.*

crime, that there should be a statutory ceiling for length of commitment, and that the judge can terminate the commitment if the individual is no longer in need of treatment. Simpson (2021) asserts that this process would reduce reliance on the CST system and avoid deeper justice system involvement.

Risk Assessment and CST

During the final year of the GAINS Center's CST/CR Learning Collaborative, the focus was on risk assessment in the competence processes. This topic emerged from the prior years' discussions and the updated literature. Judges (are supposed to) rely on evaluators' reports to the court and make the decision on where an individual will reside during competence evaluation and restoration: in custody, in a hospital, or in the community. While there remain academic and practical discussions on the content bias of some risk-assessment tools, there is emerging knowledge that evidence-based risk-assessment tools could be incorporated into the competence process throughout the inflection points that allow consideration for diversion.

Only one study focuses on the severity of charges and aggression during the inpatient CR process that then raises the question of risk assessment. Morris (2022) studied 655 men during their first 90 days of inpatient CR. Relying on many sources of information, the author found, consistent with other studies, that the individuals with the least serious charges had the highest level of impairment. Nonetheless, individuals with the most serious charges are often ineligible for appropriate diversion programs such as treatment courts.

Desmarais, Monahan, and Austin (2021) address concerns with bias in risk-assessment instruments. They state that for pretrial risk assessment to be just and fair, instruments should be subjected to robust scrutiny as to their validity; that due process and transparency be present; and there should be a pretrial presumption of release. They argue that the advantages of using validated risk-assessment tools is that judgments of risk are going to happen anyway through application of procedures and judges' opinions. They assert that validated risk-assessment tools are better than simple human judgment and should be part of the decision-making process, not the sole criterion. Because the population who are in the competence system are all pre-trial, careful use of risk assessment tools to assist in a range of judicial decisions should be considered.

Lowder and colleagues (2021) found that when judges use the results of pretrial risk assessment, rates of pretrial release increase. Redcross and colleagues (2019) studied the use of pretrial risk assessment in one North Carolina County that started using the Laura and John Arnold Foundation's Public Safety Assessment (PSA) in 2014. Their findings show that when the PSA was implemented, there was less use of cash bail and a higher rate of unsecured bonds. Following implementation of the PSA, fewer cases resulted in a guilty plea and conviction. Further, the researchers found no evidence related to the likelihood of appearing in court or involvement in new crimes while in the community. Their study showed no evidence of racial disparities in how the PSA information was used by judges. Monahan, Metz, and Garret (2018) concluded that if there were robust alternatives to detention, judges would likely rely more on risk-assessment tools.

> *Because the population who are in the competence system are all pre-trial, careful use of risk assessment tools to assist in a range of judicial decisions should be considered.*

Summary

While research and the development of promising practices have expanded, albeit slowly, since the 2018 version of the IST Report, there is still insufficient evidence to support the creation of evidence-based recommendations or model policies. The following sections summarize the national scope of issues in the areas of CST/IST/CR with a 2023 update added to each to reflect the latest information available in the field:

1. Across the CST and CR processes, there is widespread lack of empirical data to drive policy and practice, and cross-jurisdictional comparisons are challenging. Nonetheless, research is needed at each stage of the CST/IST/CR system. Despite some progress in data collection efforts, systematic national data is lacking aside from surveys that continue to confirm that nearly every state is experiencing an upward trend in persons receiving competence services from evaluation to restoration. However, small steps forward have been taken to identify critical data across systems to better understand the competence process and how to improve services to this disadvantaged population.
2. The goal of the competence system has been to address criminal justic issues, and as a result the lack of cross-systems collaboration results in a disruption in continuity of care for individuals ordered for competence evaluation and subsequent commitment for CR (or remediation). Evaluation services typically address only evaluation issues related to one's functional abilities as a criminal defendant. Restoration services typically encompass several component parts, but many services fall outside of the restoration system, hence the discontinuity. A full continuum of care for chronic mental illness necessitates access to effective and appropriate medication; mental health treatments such as psycho-social counseling; regular medical care; case management; and appropriate services and supports such as housing, substance use treatment, supportive employment, vocational support, educational support, peer support, and family counseling. A cross-system CR program would include all these areas of treatment and, when the criminal charges warrant, further efforts at the education necessary to attain legal competence. There is no agreed-upon definition of CR and what constitutes an effective education curriculum. There also continues to be a short supply of alternatives to inpatient CR. While more states now have outpatient restoration programs, they are underutilized by judges who express concerns about public safety.

3. The current standard of clinical practice for persons with serious mental illness is to provide the services and supports necessary for the individual to live in their community in the least restrictive setting possible. Because of the differential mandates of the criminal justice system to address bail/bond (e.g., failure to appear, public safety issues), and because of a traditional reliance upon state hospitals to provide a locked setting, CR services have largely not applied the least restrictive alternatives for treatment mandates for individuals ordered for CST and CR. Future models should aim to balance these principles to best serve the public safety needs of society and the individual's pretrial rights. One area of growth in knowledge and programs is the increase in JBCR programs. Evaluations of single programs show that restoration can be accomplished for some offenders when partnering with strong academic programs. Relying on carceral institutions to provide a supportive treatment environment is not without controversy. Judges seem more at ease with JBCR. Clinicians are often vocally opposed to JBCR or are resigned to the fact that JBCR is one of the locations for CR to take place. The continued long waitlists in many states reveal that individuals referred for competence services are often spending lengthy periods of time in jail anyway. While far from optimal, some jurisdictions are going forward in developing JBCR so that individuals can receive services while waiting for an inpatient bed (when ordered by the judge) rather than waiting without services. An outcome of JBCR is that individuals gain competence and can avoid transferring to the state hospital and continue with their disposition, often for a shorter period.

4. It is optimal for persons with serious mental illness to be diverted from the criminal justice system and into a treatment system and level of care that is consistent with their public safety risk and psychiatric symptoms or neurological challenges. CR services should be reserved for offenders with the most serious criminal charges where the legal issues are most relevant and when public safety is a high concern; services should occur in a treatment rather than a criminal justice setting. Diverting or deflecting individuals from the criminal justice system remains a goal of some working partners in the competence process. In some jurisdictions, there continues to be a move for prosecutors and judges to ask, "Is this case worth prosecuting?" when individuals with serious mental illness have been arrested for a misdemeanor or violation. Failing to divert people away from a legal system intervention rather than a treatment intervention inevitably leads to the likelihood that the state will continue to toe the constitutional line established in *Jackson v. Indiana* over 50 years ago. In addition, research continues to demonstrate that people charged with the least serious crimes have the most serious mental disorders, requiring longer periods of time for resource-intensive interventions such as inpatient forensic hospitalization. After all that intensive treatment, people charged with misdemeanors are more likely to be rendered "unrestorable."

5. It is not the role of the CST/IST/CR system to be the primary route for accessing mental health services or to be used as the primary vehicle to receive mental health treatment for justice-involved individuals with mental illness. Recognizing that individuals with serious mental illness are often challenging cases for judges to effectively resolve, guidance for judges to appropriately use the competence system should be developed. The National Judicial Task Force's "Leading Reform: Competence to Stand Trial Systems" (2021) provides ample information for state judiciaries to

> *The Learning Collaborative demonstrated that making change in such a complex system takes vision, time, patience, trust, and respect.*

educate judges and other court professionals in their jurisdiction. The fact that the chief justices from across the United States endorsed the recommendations is evidence enough that some judicial leaders believe that they have a role in improving the competence process in their state. It is hoped that this report will be shared with all court professionals and considered an important document to guide education and training for judges to do their part in reforming the system.

6. Raising CST has profound implications on individuals and the criminal justice and mental health systems. Individuals referred for competence evaluation become more deeply embedded in the criminal justice system at each step described in this report. The competence system is overwhelmed by inappropriate referrals for CST and CR. All partners must work to ensure that only individuals who are legally and clinically appropriate should enter the competence system. All stakeholders need to be aware of their role and responsibilities to protect due process and provide access to mental health treatment for defendants with serious mental illness or cognitive/intellectual disability. In addition to judges doing their part to reform their court system, the clinical professions are obligated to do their share of the work. Two main conclusions can be made from the SAMHSA GAINS Center's Learning Collaborative, literature, and reports. First, there is a severe shortage, or crisis, in the professions that provide competence services to the court. Recommendations include revising the evaluation process and requirements to reduce the time required to evaluate an individual and issue a report to the judge. Second, and related to the first, is that many evaluations are poorly done. There are several factors that are associated with poor reports—low pay, lack of training, lack of time, and lack of accountability, to name a few. State licensing boards, legislatures, and national professional organizations need to address both the shortage of professionals and the quality of their work.

7. States vary in the statutory length of time required to initiate competence services. Therefore, specific federal guidelines, beyond outlining principles, may not be feasible as standards consider state statutory and case law variations. These differences are a contributing factor to the barriers in developing national guidelines aside from aspirational goals such as those issued by CSG in its 2021 report "Just and Well: Rethinking How States Approach Competency to Stand Trial." This is not to suggest that research examining how statutory timelines affect outcomes is not feasible. As noted by the new literature, too short a period for evaluations can lead to clinicians guessing about competence and restorability. Too long a time can result in constitutional violations. A national study comparing statutory and actual lengths of time for evaluations and restoration could be done, regardless of the differences among jurisdictions.

8. When competence abilities are impaired due to cognitive or other challenges with or without serious mental illness, policies and procedures aimed at "restoring" (regaining, attaining) competence by relieving mental health symptoms that are impairing may not be the primary target. For both adults and juveniles with cognitive or other challenges and who are found IST because of these challenges, different policies and procedures may be required than for persons found IST due primarily to mental illness. Focusing specifically on cognitive or other challenges and competence is not the focus of this report and is unaddressed in the research. Cognitive or other challenges are mentioned when coupled with a person's co-occurring mental illness. Research consistently demonstrates, however, that people with neurocognitive disorders are among the least likely candidates for restoration. Given the purpose of a forensic psychiatric hospital is treatment with a goal of recovery, many forensic programs are not designed to work toward attainment of competence for adults with cognitive or other challenges. For youth with cognitive or other challenges , a similar consideration must be made as to the suitability of existing youth competence restoration programs. Recommendations for attainment programs should be considered for the most evidence based comprehensive plan for the youth.

9. Although overall juvenile IST restoration systems have advanced no more than adult systems, some juvenile system models have arisen (e.g., in Virginia, Utah, Arizona) for outpatient restoration that may offer guidance for further adult IST restoration systems, as well as juvenile systems. The trend toward community-based, least-restrictive alternative settings for youths involved in competence evaluation or remediation identified in 2018 continues in 2023. Aside from an occasional case that results in national attention, juvenile competence is not a focus of attention. One study found that juvenile court judges do not necessarily equate development with competence, leading one to suggest that juvenile court judges may need additional education as part of a national judicial initiative on competence.

10. SAMHSA's GAINS Center's CST/CR Learning Collaborative provided an excellent opportunity for local and state stakeholders to engage in a cross-system examination of the CST/IST/CR system. Bringing national leaders on CST/IST/CR into the effort as subject-matter experts for 14 jurisdictions to learn from is a major step in the direction of translating evidence into practice. As noted in *State Strategies to Address the Crisis in the Competence to Stand Trial and Competence Restoration System* (SAMHSA's GAINS Center, 2022a), each jurisdiction made noteworthy progress in identifying goals to reform its competence process. Their teams included many stakeholders representing both legal and clinical professionals at the local and state levels. They collaborated with the same goal: improving their competence process. The Learning Collaborative demonstrated that making change in such a complex system takes vision, time, patience, trust, and respect.

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Appendix I: Glossary of Assessment Instruments

Forensic Assessment Instruments (FAIs) are designed specifically to assess the psycho-legal ability. Listed are the FAIs for competency to stand trial evaluations:

CADCOMP: Computer Assisted Determination of Competency to Stand Trial

RCAI: Revised Competency to Stand Trial Assessment Instrument

CAST*ID: Competence Assessment for Standing Trial for Defendants with Intellectual Disabilities

CST: Competency to Stand Trial Screening Test

ECST-R: Evaluation of Competency to Stand Trial—Revised

FIT-R: Fitness Interview Test-Revised

GCCT: Georgia Court Competency Test

IFI-R: Interdisciplinary Fitness Interview-Revised

ILK: Inventory of Legal Knowledge

JACI: Juvenile Adjudicative Competence Interview

Mac-CAT-CA: MacArthur Competence Assessment Tool-Criminal Adjudication

METFORS: Metropolitan Toronto Forensic Service Fitness Questionnaire

Forensically Relevant Instruments (FRIs) assess clinical constructs that are relevant to a legal question but are not specific to a certain type of assessment. These are FRIs commonly used in competency to stand trial evaluations:

APS: Atypical Presentation Scale

SIRS-II: Structured Interview of Reported Symptoms, 2nd Edition

M-FAST: Miller Forensic Assessment of Symptoms Test

DCT: Dot Counting Test

FIT: Fifteen Item Test

TOMM: Test of Memory Malingering

VIP: Validity Indicator Profile

TOMI: Test of Malingered Incompetence

Clinical Assessment Instruments (CAIs) are standard psychological assessments used for diagnosis and treatment planning but can be informative for forensic evaluations. Listed are CAIs occasionally needed during competency to stand trial evaluations:

MMSE-2: Mini-Mental Status Exam, 2nd Edition

MoCA: Montreal Cognitive Assessment

MMPI-2-RF: Minnesota Multiphasic Personality Inventory-2 Restructured Form

MMPI-A: Minnesota Multiphasic Personality Inventory- Adolescent

WASI-II: Wechsler Abbreviated Scale of Intelligence, 2nd Edition

WAIS-IV: Wechsler Adult Intelligence Scale, 4th Edition

WISC: Wechsler Intelligence Scale for Children, 5th Edition

ABAS-3: Adaptive Behavior Assessment System, 3rd Edition

WRAT-5: Wide Range Achievement Test, 5th Edition

Bender-Gestalt

Vineland Adaptive Behavior Scales

Appendix II: Competence Standards by State

Adult Standards

State	Days Allotted for Competence Evaluation (CE)	Inpatient Confinement Periods (CPs) for Examination	Timeline for Initial Competence Hearing (CH)	Outpatient Treatment Services	Restoration to Competence Time Frames	Maximum Commitment Time Frames	Notes	Source
Alabama	N/S	"Reasonable period of time necessary to conduct the examination" §11.3	42 days after report(s) received §11.6	Yes §11.3	6 months or earlier restoration, whichever is first; subsequent renewal may not exceed 1 year §11.6	6 months or earlier restoration, whichever is first; subsequent renewal may not exceed 1 year §11.6	N/S	AL Rules of Criminal Procedure Rule 11
Alaska	N/S	60 days §12.47.070	N/S	Unclear	90-day initial restoration period with additional 90-day extension possible; An additional 6-month extension is possible if defendant is charged with a crime involving force against a person, the court finds a substantial danger of physical injury to other persons, and there is a substantial probability that restoration will happen within a reasonable period of time §12.47.110	N/S	Proposed Legislation	AK Title 12 Code of Criminal Procedure §12.47.070 et seq
Arizona	N/S	30 days, with 15- day extension possible A.R.S. § 13-4507	30 days after report(s) received, additional time possible for good cause" §11.5	Yes §11.5	15 months with possible 6 months extension if defendant is making progress §11.5	21 months or within maximum sentence, whichever is less §11.5	N/S	Rule of Criminal Procedure Rule 11 Criminal Code 13-4510
Arkansas	60 days, unless longer period necessary §5-2-327	N/S	N/S	Yes, if no danger to person or property of another §5-2-310	10-month initial restoration period, court must make a determination within 1 year of commitment §5-2-310	N/S	N/S	Criminal Offenses Ch. 2 Sch 3 §5-2-302 et seq

N/S = NOT SUPPLIED STATUTE IS UNCHANGED STATUTE HAS CHANGED

State	Days Alloted for CE	Inpatient CPs for Ex.	Timeline for Initial CH	Outpatient Tx Services	Restoration to Competence Time Frames	Maximum Commitment Time Frames	Notes	Source
California	N/S	N/S	N/S	Yes Penal Code §1370 New language in effect 7/1//2023 – D shall first be first considered for placement in an outpatient or community program or diversion program	Initial 90-day restoration period; Report required in 6-month intervals thereafter; Penal Code §1370 ~~Superior Court may dismiss misdemeanor charges; 6 month limitation for restoration treatment services in jail treatment facilities~~	2 years from commitment date, or period equal to maximum term, defendant who has not been restored shall be returned to committing court and custody of committing county Effective 1/1/2023 court can, for misdemeanor charges, over up to 1 year of diversion, and upon success dismiss charges; if ineligible for diversion can be referred to outpatient treatment, conservatorship, or CARE program. §1370 ~~3 years or the maximum term of imprisonment for the most serious offense charged~~	N/S	California rules of Court Rule 4.130 Penal Code §1368 et seq
Colorado	Court can make a preliminary finding, which shall be final if neither party objects within 7 days. If there is an objection, court shall order an evaluation §16-8.5-103 ~~Court can make a preliminary finding, which shall be final if neither party objects. If there is an objection, or court has insufficient information, court shall order an evaluation which is due in 63 days.~~	21-days for inpatient evaluation 42-days for outpatient evaluation §16-8.5-105	Hearing not mandatory unless timely request made by either party, hearing should be held within 35 days of request or filing of second evaluation report §16-8.5-103	N/S	Restoration hearing ordered by court at any time on its own motion, or a motion of the parties. Court can continue order and commit or recommit defendant as necessary §16-8.5-114	Maximum term of confinement for single most serious offense charged, less 30 percent for misdemeanor, less 50 percent for felony offense, then court shall dismiss the chargers For outpatient restoration, after initial 90 days, four more reviews may take place at 90-day intervals, if competency has not been restored, court can dismiss charges. §16-8.5-116 ~~Maximum term of confinement not in excess of maximum term of confinement for offense charged, less any earned time.~~	N/S	Code of Criminal Procedure §16-85-103

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State	Days Alloted for CE	Inpatient CPs for Ex.	Timeline for Initial CH	Outpatient Tx Services	Restoration to Competence Time Frames	Maximum Commitment Time Frames	Notes	Source
Connecticut	15 days from court order, report filed within 21 days of court order §54-56d	N/S §54-56d	10 days after report(s) received, defense can waive hearing if examiners determine without qualification that the defendant is competent §54-56d	Yes §54-56d	Initial 90-day review period §54-56dw	Maximum sentence for charge or 18 months, whichever is lesser; does not apply to Class A felony charges and certain Class B felonies, person charged with motor vehicle violation that causes the death, or any class C felony §54-56d ~~If court orders release or placement of defendant charged with a crime that resulted in death or serious physical injury (or other named crimes) and finds that there is a substantial probability that defendant will never regain competency, subsequent examinations of competency shall be "at intervals of not less than 18 months."~~	N/S	Criminal Procedure §54-56d
Delaware	Prescribed by Court of Jurisdiction §402	Prescribed by Court of Jurisdiction §402	Prescribed by Court of Jurisdiction §402	No §404	N/S	N/S	N/S	Criminal Procedure Code 402 and 404
Florida	N/S	N/S	Within 20 days of filing of motion raising the issue Rule 3.210	Yes Rule 3.212	Initial 6-month restoration period, with possible court-ordered extensions in 1-year increments Rule 3.212 ~~Felony: initial 6-month restoration period~~	Dismissal after 1 year for misdemeanor charge Dismissal after no later than 2 years if due to intellectual disability or autism Dismissal after 3 years unless a charge listed under Florida Statutes S 916.145	N/S	Fla. R. Crim. P. Rule 3.210 et seq

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State	Days Alloted for CE	Inpatient CPs for Ex.	Timeline for Initial CH	Outpatient Tx Services	Restoration to Competence Time Frames	Maximum Commitment Time Frames	Notes	Source
Florida (cont.)	See previous page	See previous page	See previous page	See previous page	See previous page	Dismissal is defendant has remained incompetent for 5 continuous and uninterrupted years Rule 3.213 ~~If incompetent for 5 continuous, uninterrupted years due to mental illness, charges shall be dismissed unless court believes defendant will become competent in foreseeable future and specifies a timeframe. Charges can be dismissed after 3 years with certain excluded charges and circumstances~~	See previous page	See previous page
Georgia	90 days for inpatient and outpatient evaluations §17-7-130	90 days §17-7-130	Within 45 days of receiving the department's evaluation, or if demanded, a special jury trial within 6 months §17-7-130	Yes §17-7-130	90-day initial restoration period; Outpatient treatment not to exceed 9 months §17-7-130	If defendant's charge is a misdemeanor and there is not a substantial probability of restoration, civil commitment, or release in 45 days; If the charge is a felony, after 45 days the court shall begin proceedings for release or civil commitment. For a non-violent offense the maximum commitment is 5 years or the maximum sentence for the most serious offense charged; For violent offenses, civil commitment can be ordered for the maximum sentence of the most serious violent offense charged §17-7-130	Unconstitutional as applied by McGouirk v. State – June 18, 2018 Proposed Legislation	Criminal Procedure §17-7-130

N/S = NOT SUPPLIED STATUTE IS UNCHANGED STATUTE HAS CHANGED

State	Days Alloted for CE	Inpatient CPs for Ex.	Timeline for Initial CH	Outpatient Tx Services	Restoration to Competence Time Frames	Maximum Commitment Time Frames	Notes	Source
Hawaii	If petty misdemeanor not involving violence or attempted violence charge, within 2 days of examiner's appointment or as soon as practicable thereafter §704-404 ~~N/S~~	30 days, or longer "as the court determines to be necessary for the purpose." §704-404	Hearing not mandatory, shall be ordered if a party contests the court's finding §704-405	Yes §704-406	For petty misdemeanor chargers not involving violence or attempted violence, defendant shall be diverted from criminal justice system For misdemeanor charges not involving violence, 120 days from courts finding of lack of fitness to proceed §704-406 ~~For non-violent petty misdemeanors: 60 days from the date court finds the defendant incompetent; for non-violent misdemeanors: 120 days~~	For charges of murder in the 1st or 2nd degree, or a class A felony, if defendant is committed and ultimately restored, and court finds that so much time has lapsed as to render it unjust to resume the proceedings the court may dismiss the charge and discharge, require involuntary hospitalization, or assign community-based treatment. If the charge is 1st or 2nd degree murder or a class A felony, and restoration is not substantially probable, court may dismiss the charge and release the defendant, and require involuntary hospitalization §704-406	N/S	Hawaii Penal Code §704-403 et. seq
Idaho	Location for the examination should be established within 3 days of examiner's appointment, if practical, should be conducted locally on an outpatient basis §18-211	30 days §18-211	Hearing not mandatory, shall be ordered upon the court's own motion or any party's motion §18-212	No §18-212	90-day initial restoration period with the Department of Health and Welfare or Department of Corrections (the latter placement is reserved for defendants found to be dangerously mentally ill). If there is a substantial probability of restoration, 180-day extension possible §18-212	If defendant is not fit to proceed after additional 180-day period, court can begin involuntary commitment proceedings §18-212	N/S	Crimes and Punishments §18-211 §18-212

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State	Days Alloted for CE	Inpatient CPs for Ex.	Timeline for Initial CH	Outpatient Tx Services	Restoration to Competence Time Frames	Maximum Commitment Time Frames	Notes	Source
Illinois	Report due in 30 days, ~~with 15-day extension possible~~ §5/104-15	7 days, with 7-day extension possible §5/104-13	Within 45 days of receipt of examiner(s)' report §5/104-16	Yes §5/104-13 §5/104/17	30-day initial restorability assessment period, 90-day review hearing §5/104-17 §5/104-20	For misdemeanor charges, restoration treatment shall not exceed the maximum term of imprisonment for the most serious offense; For a felony charge, 1 year commitment allowed for restoration §5/104-15 §5/104-17	Proposed Legislation	Criminal Procedure 725 5/104-10 et seq
Indiana	N/S	N/S	N/S	Least restrictive setting §35-36-3-1	90-day initial restoration period; If substantial probability of restoration does exist, 6 months of treatment allowed from date of admission to state institution or initiation of competency restoration services by third party contractor §35-36-3-3	N/S	Proposed Legislation	Criminal Law and Procedure §35-36-3-1 et seq
Iowa	N/S	N/S	Within 14 days of defendant's arrival at a psychiatric facility for the examination. If defendant has had a psychiatric evaluation within the previous 30 days, then hearing within 5 days of court's motion or the filing of an application §812.4	Yes, If no danger to public peace or safety §812.6	Initial status report within 30 days, progress reports 60 days thereafter §812.7	Placement shall not exceed the maximum term of confinement for the charged offense or 18 months from the date of incompetence adjudication, whichever occurs first §812.9	N/S	Criminal Law and Procedure §812.3 et seq
Kansas	N/S	60 days §22-3302	N/S	Yes §22-3303	90-day initial restoration period; If substantial probability of restoration does exist, additional 6 months of treatment allowed §22-3303	90-day initial restoration period; If substantial probability of restoration does exist, additional 6 months of treatment allowed §22-3303	N/S	Criminal Procedure § 22-3302 et seq

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State	Days Alloted for CE	Inpatient CPs for Ex.	Timeline for Initial CH	Outpatient Tx Services	Restoration to Competence Time Frames	Maximum Commitment Time Frames	Notes	Source
Kentucky	N/S	60 days §504.110	10 days after restoration or 60-day time limit §504.110	No	Earlier of 60 days or until examiner finds defendant competent (does not apply to felony charges). If the charge is a felony, defendant is committed to a forensic psychiatric facility unless other facility designated. Within 10 days of treatment completion, the court shall hold another hearing on the defendant's competency to stand trial §504.110	At post-treatment hearing, if there is no substantial probability that the defendant will attain competency, the court shall conduct involuntary hospitalization proceedings. §504.110	N/S	Penal Code § 504.090 et seq
Louisiana	Sanity commission appointed within 7 days of court's order for examination Art 644	N/S	N/S	Yes Art 648	90-day initial restoration period inpatient or outpatient, if defendant has a felony, or violent misdemeanor, or is likely to commit violence court can order jail-based treatment by the Department of Health. If defendant is committed to Feliciana Forensic Facility and remains in a parish jail for 180 days, court shall order a status conference, if defendant still in jail 180 days after initial status conference court shall order hearing to determine whether to release defendant to the appropriate authorities or to begin civil commitment proceedings Art 648	Custody, care, and treatment time shall not exceed the maximum sentence for the crime charged Art 648	N/S	Louisiana Code of Criminal Procedure Art 641 et. seq

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State	Days Alloted for CE	Inpatient CPs for Ex.	Timeline for Initial CH	Outpatient Tx Services	Restoration to Competence Time Frames	Maximum Commitment Time Frames	Notes	Source
Maine	Prompt examination required	If defendant is incarcerated, examination required within 21 days of court, if second required, 60 days allowed § 101-D	N/S	Yes	Reports due at to court at 30, 60, and 180 days § 101-D ~~Commitment cannot exceed 60 days, can be extended for up to an additional 90 days~~	N/S	N/S	Court Procedure – Criminal §15 M.R.S.A. § 101-D
Maryland	Court determined Report due 7 days after the court orders the examination §3-105	Court determined §3-105	N/S	Yes §3-105	Hearings required every year from date of commitment §3-106	For felony charge, 5 years or maximum sentence of charge. For non-felony charge, 3 years or maximum sentence of charge §3-107	Kimble v. State of Maryland 242 Md.App 73, court clarifies that dismissal clock starts from time of incompetence finding	Criminal Procedure §3-104
Massachusetts	N/S	20 days, with potential 20-day extension for good cause shown 123 § 15	N/S	No	Civil commitment proceedings can begin after 60 days of incompetence finding, order of commitment valid for 6 months 123 § 16	Should not exceed time of imprisonment for most serious crime charged 123 § 16	Proposed Legislation Portions of § 123-16 found unconstitutional by Garcia v. Commonwealth 3.22. 2021 pertaining to temporary confinement of individual found not criminally responsible due to mental illness violated substantive due process.	Public Welfare Title 123 § 15 et seq

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State	Days Alloted for CE	Inpatient CPs for Ex.	Timeline for Initial CH	Outpatient Tx Services	Restoration to Competence Time Frames	Maximum Commitment Time Frames	Notes	Source
Michigan	Evaluation performed and written report submitted within 60 days §330.2028	N/S	Required within 5 days of receipt of evaluation report §330.2030	Yes §330.2032	Reports due every 90 days from date order issues §330.2038 N/S	Total period of 15 months or 1/3 of the maximum sentence of charges, whichever is lesser §330.2034	N/S	Mental Health Code §330.2020 et seq
Minnesota	N/S	Not to exceed 60 days §20.01	In felony or gross misdemeanor cases, 60 days from date of court order Hearing not mandatory, shall be ordered upon filing of motion by either party within 10 days of report's receipt §20.01	Yes §20.01	Reports must be submitted to court not less than once every six monthsw §20.01	For felonies, dismissal after 3 years, unless prosecutor files notice of intent to prosecute when defendant regains competency. For gross misdemeanors, dismissal after 30 days, unless prosecutor files notice of intent. For misdemeanor, charge dismissed. §20.01	N/S	Rules of Criminal Procedure § 20.01
Mississippi	N/S	For no longer than reasonably necessary to conduct the evaluation §12.3	Upon its own motion, or a party's, the court "shall promptly hold a hearing" after submission of the examiner's reports §12.5	Yes §12.5	Examinations and reports required every four calendar months §12.5	Reasonable time after commitment order §12.5	N/S	Mississippi Rules of Criminal Procedure Rule 12.1 et seq
Missouri	Evaluation performed and written report submitted within 60 days §552.020	N/S	Hearing not mandatory, shall be ordered upon the court's own motion or any party's motion. Court may impanel a jury of 6 for assistance §552.020	Vague, but seems like available option if defendant is released on bail or other otherwise eligible for release §552.020	Initial commitment may be for 6 months, court can continue it for an additional 6 months §552.020	N/S	Proposed Legislation	Criminal Procedure 552.020

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State	Days Alloted for CE	Inpatient CPs for Ex.	Timeline for Initial CH	Outpatient Tx Services	Restoration to Competence Time Frames	Maximum Commitment Time Frames	Notes	Source
Montana	60 days §46-14-202	60 days or a court determined longer period §46-14-202	Hearing not mandatory, shall be ordered upon the court's own motion or any party's motion §46-14-221	No §46-14-221	Review required in 90 days. If restoration not likely in the reasonably foreseeable future, proceedings must be dismissed §46-14-221	Defendant can be committed as long as the unfitness endures or until a disposition is made, whichever occurs first §46-14-221	N/S	Criminal Procedure §46-14-103
Nebraska	N/S ~~N/S, at discretion of district court. State v. Lassek (2006)~~	N/S ~~N/S, at discretion of district court, State v. Lassek (2006)~~	21 days after filing of report §29-1823 ~~Hearing required, timeframe N/S, at discretion of district court, State v. Lassek (2006)~~	Unclear §29-1823 ~~N/S, at discretion of district court, State v. Lassek (2006)~~	Initial report within 60 days of commitment order, and every sixty days thereafter until disability is removed or other disposition made §29-1823 ~~Initial commitment for 6 months, review every 6 months thereafter until the defendance is restored or a disposition is made~~	N/S	N/S	Criminal Procedure §29-1823
Nevada	N/S	N/S	N/S	Yes, if defendant found not dangerous to self or society §178.425	3-month initial restoration period for misdemeanors followed by monthly reports thereafter; for all other cases, initial restoration period of 6 months followed thereafter by reports at 6-month intervals §178.450	Maximum term of confinement is the longest period of incarceration provided for the charged crime(s), or 10 years, whichever is shorter If person is within 6 months of maximum length of confinement for sexual assault or murder and was committed, Administrator may request extended commitment not to exceed 5 years §178.461	N/S	Procedure in Criminal Cases §178.405 et seq
New Hampshire	45 days if defendant is held at a county correctional facility, otherwise 90 days after the court order §135:17	45 days §135:17	N/S	Yes §135:17-a	If defendant is danger to others or themselves, can remain in custody not to exceed 90 days §135:17-a	12 months §135:17-a	N/S	Public Health §135:17 et seq

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State	Days Alloted for CE	Inpatient CPs for Ex.	Timeline for Initial CH	Outpatient Tx Services	Restoration to Competence Time Frames	Maximum Commitment Time Frames	Notes	Source
New Jersey	N/S	30 days §2C:4-5	Hearing not mandatory, shall be ordered upon the court's own motion or any party's motion §2C:4-6	Yes, if not dangerous to self or others §2C:4-6	3 months initial restoration period, treatment can be continued and reviewed at 6-month intervals until defendant is restored or charges are dismissed §2C:4-6	N/S	N/S	Code of Criminal Justice 2C:4-4 et seq
New Mexico	N/S	N/S	30 days after court notified that the diagnostic evaluation is completed; unless defendant is not charged with a felony, then hearing shall be held within 10 days of notification of completion of diagnostic evaluation §31-9-1.1	N/S	If court finds by clear and convincing evidence that the defendant committed a crime, but is not dangerous, court can dismiss the case after the competency hearing in the interests of justice; if charge is a felony and defendant found to be dangerous, can be committed to a secure facility for restoration for maximum of 9 months, initial 90-day hearing required §31-9-1.2	If court finds by clear and convincing evidence that defendant committed a felony that involved great bodily harm, use of a firearm, aggravated arson, criminal sexual penetration, or criminal sexual contact with a minor, and remains dangerous and incompetent, defendant can be held in a secure facility for the maximum sentence possible if convicted in a criminal proceeding, shall be reviewed every two years §39-1-1.5	N/S	Criminal Procedure §31-9-1
New York	N/S	30 days, possible extension of additional 30 days §730.20	Hearing not mandatory, shall be ordered upon the court's own motion or any party's motion. If examiners are not unanimous, court must conduct a hearing. §730.30	Yes §730.20	3 months for non-felony charges; for felony charges one year §730.40 (local criminal court) §730.50 (superior court)	Court can issue an initial order of retention for 1 year, and subsequent orders of retention for two years each; the cumulative retention orders cannot exceed 2/3s of the maximum term for the highest class felony charged §730.5	Proposed Legislation	Criminal Procedure §730.10 et seq

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State	Days Alloted for CE	Inpatient CPs for Ex.	Timeline for Initial CH	Outpatient Tx Services	Restoration to Competence Time Frames	Maximum Commitment Time Frames	Notes	Source
North Carolina	N/S	60 days §15A-1002	N/S	Unclear	N/S	Defendant should not be confined or committed in excess of the maximum term for Level VI felonies or Level 3 misdemeanors, 5 years from the determination of incompetence for misdemeanor charges or 10 years if felony charges §15A-1008	N/S	Criminal Procedure Act §15A-1001 et seq
North Dakota	15 days of order served upon mental health professional, 7 day extension possible for good cause §12.1-04-07 ~~N/S~~	30 days~~, possible extension of additional 30 days~~ §12.1-04-06	N/S ~~Hearing and competency determination only mandated if evaluator's findings are contested~~	Least restrictive form of treatment §12.1-04-08	Initial 180-day period, 365-day extension possible §12.1-04-08 ~~N/S~~	For misdemeanor charge, proceedings suspended for not longer than maximum term of imprisonment for most serious offense charged §12.1-04-08 ~~Maximum period for which defendant could be sentenced~~	N/S	Criminal Code §12.1-04-04 N.D.R.Crim.P., Rule 12.2
Ohio	Report due 30 days after court order for evaluation §2945.371	20 days; If defendant previously released on bail or recognizance, may be involuntarily confined for up to 20 days §2945.371	30 days after issue raised, or 10 days after filing of evaluator's report §2945.37 ~~N/S~~	Yes 2945.38	One year standard at initial hearing, court can hold second hearing to correlate to charges §2945.38	One year for certain "serious" felonies Six months, other felonies 60 days for 1st and 2nd degree misdemeanors 30 days for other misdemeanors §2945.38	Proposed Legislation	Crimes—Procedure §2945.37 et seq
Oklahoma	N/S	Court determined §1175.3	Within 30 days of receipt of competency evaluation §1175.4	Yes §1175.7	Reasonable period of time, as determined by the court; periodic reports due 1175.2	Maximum sentence specified for most serious offense charged or two years §1175.1	N/S	Criminal Procedure §1175.1 et seq

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State	Days Alloted for CE	Inpatient CPs for Ex.	Timeline for Initial CH	Outpatient Tx Services	Restoration to Competence Time Frames	Maximum Commitment Time Frames	Notes	Source
Oregon	60 days §161.371	30 days §161.365	Hearing not mandatory, shall be ordered upon the court's own motion or any party's contesting the evaluation report §161.370	Yes §161.370	Initial 90-day report, additional reports due every 180 days §161.371 ~~If defendant is committed for restoration services the time frame is described as "a period of time that is reasonable for making a determination concerning whether or not, and when, the defendant may gain or regain capacity."~~	Three years (from date of initial commitment) or period of time equal to the maximum sentence if defendant had been convicted §161.371	Proposed Legislation	Crimes and Punishments §161.360
Pennsylvania	N/S	Involuntary treatment can be ordered for 60 days §7402	Determination rendered within 20 days of receipt of examination report unless hearing continued at defendant's request §7402	Yes §7402	Psychiatric examination every 12 months to determine if defendant has become competent §7403	Except for 1st and 2nd degree murder charges, proceedings shall not be stayed in excess of the maximum sentence of confinement or ten years, whichever is less. If the charge is 1st or 2nd degree murder, there is no time limitation §7403	N/S	Mental Health §7402 et seq
Rhode Island	If defendant confined, 5 days §40.1-5.3-3	5 days confinement, 10 days to file report §40.1-5.3-3	Timeframe N/S Court must hold hearing unless reports find defendant competent, and both parties' assent to the findings on the record §40.1-5.3-3	Yes, if doing so does not imperil the peace or safety of defendant or others §40.1-5.3-3	Periodic 6-month reviews §40.1-5.3-3	Commitment not to exceed 2/3s for the maximum term of imprisonment for the most serious offense charged. If the maximum sentence would be life imprisonment or death, the maximum term shall be 30 years §40.1-5.3-3	N/S	Behavioral Healthcare, Developmental Disabilities, and Hospitals §40.1-5.3-3 et seq
South Carolina	30 days §44-23-410	15 days with possible 15-day extension §44-23-410	N/S	Yes §44-23-410	180 days §44-23-410	Maximum possible period of imprisonment if defendant had been convicted as charged §44-23-410	N/S	Health §44-23-410

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State	Days Alloted for CE	Inpatient CPs for Ex.	Timeline for Initial CH	Outpatient Tx Services	Restoration to Competence Time Frames	Maximum Commitment Time Frames	Notes	Source
South Dakota	21 days §23A-10A-3	N/S	N/S	Yes §23A-10A-4 §23A-10A-13.1 ~~unclear, definition of approved facility includes "community support provider"~~	4 month initial restoration hearing, facility must report on substantial probability that defendant will become competent within 1 year §23A-10A-4 §23A-10A-14	For Class A and B felony, court's order of detention may not exceed maximum penalty for most serious charge, 12-month reviews required §23A-10A-15	Proposed Legislation	Criminal Procedure §23A-10A-3
Tennessee	N/S	30 days §33-7-301	N/S	Unclear	6 months initial restoration hearing, followed by 6 month reports thereafter §33-7-301	Misdemeanor charges "retired" no later than 11 months and 29 days after arrest date §33-7-301	N/S	Mental Health and Substance Abuse and Intellectual and Developmental Disabilities §33-7-301
Texas	Report due within 30 days of court's order of examination §46B.026	N/S	Hearing not mandatory, shall be ordered upon the court's own motion or any party's motion §46B.005	Yes §46B.0095	For defendants released on bail, outpatient restoration services not to exceed 120 days; For defendants not released on bail, initial restoration period for misdemeanor 60 days, 120 days for a felony; court can extend by an additional 60 days §46B.071 §46B.079	Commitment or participation in restoration treatment not to exceed maximum term for offense defendant was to be charged, except if charge is a misdemeanor and defendant ordered to outpatient treatment, then the maximum period of restoration is 2 years §46B.0095	Proposed Legislation	Code of Criminal Procedure §46B.004 et seq §46B.071
Utah	Report due within 30 days of receipt of court's order, possible 30-day extension §77-15-5	N/S	Not more than 15 days after receipt of evaluator(s)' report(s) §77-15-5	No §77-15-6	For class B misdemeanor or less - 60 days Initial Progress Report after 90 days, 3-month extension possible	Time reasonable necessary to determine probability of restoration; or maximum period of incarceration received if convicted of most severe offense charged §77-15-6	Proposed Legislation	Code of Criminal Procedure §77-15-3 et seq

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State	Days Alloted for CE	Inpatient CPs for Ex.	Timeline for Initial CH	Outpatient Tx Services	Restoration to Competence Time Frames	Maximum Commitment Time Frames	Notes	Source
Utah (cont)	See previous page	See previous page	See previous page	See previous page	If defendant charged with aggravated murder, murder, attempted murder, manslaughter, or a 1st degree felony court may extend commitment for up to 9 months (if making reasonable progress), subsequently, for murder and aggravated murder charges, can be extended for 24 months (if making reasonable progress). §77-15-3 §77-15-6	See previous page	See previous page	See previous page
Vermont	N/S	30 days with 15-day extension possible §4815	N/S	No §4822	Indeterminate Period §4822	N/S	N/S	Crimes and Criminal Procedure §4814 et seq
Virginia	N/S	N/S	Hearing not mandatory, shall be ordered by motion of the parties or by the court if it has reasonable cause to believe the defendant will be hospitalized for restorative treatment §19.2-169.1	Yes §19.2-169.1 §19.2-169.2	For certain misdemeanors, initial restoration period is 45 days For other charges, the initial restoration period is 6 months, with subsequent 6 months extensions possible §19.2-169.3	For all chargers except aggravated murder, charges should be dismissed upon expiration of sentence had defendant been convicted and received the maximum sentence or 5 years from the date of arrest, whichever is sooner. For aggravated murder charges, no limitation on extensions if regular hearings, defendant remains incompetent, continued medical treatment is appropriate, with hearings held yearly for 5 years and at biennial intervals thereafter §19.2-169.3	N/S	Criminal Procedure §19.2-169.1

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State	Days Alloted for CE	Inpatient CPs for Ex.	Timeline for Initial CH	Outpatient Tx Services	Restoration to Competence Time Frames	Maximum Commitment Time Frames	Notes	Source
Washington, DC	Hearing required with 30 days of in-patient exam and 45 days of out-patient exam; 15-day extension available §24-531.04	30 days, with 15-day extension possible §24-531.03	N/S	Yes, least restrictive setting §24.531-05	One or more periods to treatment not exceeding 180 days §24.531-05	Inpatient treatment may not last longer than maximum possible sentence if convicted of pending charges If charge is violent crime (except murder, first degree sexual abuse, or first-degree child sexual abuse) and defendant hasn't attained competence in 5 years, charges dismissed and can be reinstated within statute of limitations in competency regained §24-531.08	N/S	Criminal Law and Procedure and Prisoners §24-531.01 et seq
Washington	21 days for evaluation in the community	Performance target of 7-days or fewer for offer of inpatient evaluation for, 14 days maximum 15 days to complete the exam once admitted §10.77.060	N/S	Yes §10.77.074 §10.77.088	Offer of admission for treatment, target 7 days, 14 days maximum; for Class C felonies or lower, or non- violent Class B the initial restoration period is 45 days for in-patient and 90 days for outpatient, additional 90-day extensions possible For non-felony charges that are serious offenses, 29 days for in-patient, 90 days for outpatient For other felonies there is a 90-day initial restoration period, No additional restoration periods if the incompetence is solely related to a developmental disability that is unlikely to be resolved during an extension;	Commitment or treatment cannot exceed the maximum possible penal systems for any offense charged §10.77.025	Proposed Legislation	Criminal Procedure §10.77.060 et seq

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State	Days Alloted for CE	Inpatient CPs for Ex.	Timeline for Initial CH	Outpatient Tx Services	Restoration to Competence Time Frames	Maximum Commitment Time Frames	Notes	Source
Washington (cont)	See previous page	See previous page	See previous page	See previous page	At the end of the 2nd restoration period, charges must be dismissed unless the defendant is a substantial danger to others, substantial likelihood of additional criminal acts jeopardizing public safety or security, substantial probability that defendant will regain additional competence within 6 months. Then the court may extent for an additional 6 months. §10.77.086 §10.77.088	See previous page	See previous page	See previous page
West Virginia	10 days, 10-day extension possible, should not exceed 30 days §27-6A-2 ~~N/S~~	15 days §27-6-2	Hearing not mandatory, shall be ordered upon the court's own motion or any party's motion. Court's preliminary finding required within 5 days of receipt of evaluation State or defense counsel can make a motion for a hearing within 20 days of receipt of court's preliminary finding, hearing shall be held within 15 days of motion §27-6A-3	Yes §27-6a-2 §27-6A-3	90-day initial in-patient restoration, defendant may not be held in mental health facility of state hospital for a period longer than 240 days §27-6A-3	Substantially likely to attain competency and is charged with a misdemeanor or non-violent felony, restoration services for 180 days or maximum sentence served if convicted of charge the criminal charges shall be dismissed For violent misdemeanors and violent felonies, defendant shall remain under court's jurisdiction until the expiration of the maximum sentence had conviction occurred, unless the defendant attains competency, or the court dismisses the indictment or charge §27-6A-3	N/S	Mentally Ill Persons §27-6A-1 et seq

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State	Days Alloted for CE	Inpatient CPs for Ex.	Timeline for Initial CH	Outpatient Tx Services	Restoration to Competence Time Frames	Maximum Commitment Time Frames	Notes	Source
Wisconsin	Outpatient exams completed and report filed within 30 days of order for examination §971.14	15 days, with possible 15-day extension §971.14	Hearing not mandatory, shall be ordered upon the court's own motion or any party's motion §971.14	Yes §971.14	Written reports required 3, 6, and 9 months after commitment and within 30 days prior to expiration of commitment §971.14	12 months or the maximum sentence specified for the most serious offense charged, whichever is less §971.14	Portions of statute concerning involuntary medication held unconstitutional in Matter of Commitment of C.S. (2020) and State V. Fitzgerald (2019)	Criminal Procedure §971.13
Wyoming	N/S	30 days §7-11-303	Hearing not mandatory, shall be ordered upon the court's own motion or any party's motion §7-11-303	Unclear	90-day initial restoration period with additional 90-day extension possible §7-11-303	Can be held at designated facility until head of facility determines that defendant is fit to proceed, with reports due at least once every 3 months §7-11-303	Proposed Legislation	Criminal Procedure §7-11-303

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Juvenile Standards

State	Any Juvenile Competence Statute	Competence Requirements	Days Allotted for Competence Evaluation (CE)	Inpatient Confinement Periods for Examination	Timeline for Initial Competence Hearing (CH)	Outpatient Treatment Services	Restoration to Competence Time Frames	Maximum Commitment Time Frames	Notes	Source
Alabama	Yes	"Sufficient present ability to assist in his or defense . .." §12-15-130	N/S	N/S	N/S	"Examinations made prior to a hearing . . . shall be conducted on an outpatient basis unless the juvenile court finds that placement in a hospital or other facility is necessary" §12-15-130	N/S	N/S	N/S	Alabama 12-15-130
Alaska	No, some language on commitment to psychiatric settings but not tied directly into competency in juvenile delinquency proceedings. Adult statutes apply to juveniles tried as adults in adult court	N/S	N/S	N/S	N/S	N/S	N/S	N/S	N/S	N/S

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State	Competence Statute?	Competence Requirements	Days Allotted for CE	Inpatient Confinement Periods for CE	Timeline for Initial CH	Outpatient Treatment Services	Restoration to Competence Time Frames	Maximum Commitment Time Frames	Notes	Source
Arizona	Yes	"Sufficient present ability to consult with the juvenile's lawyer with a reasonable degree of rational understanding or who does not have a rational and factual understanding of the proceedings against the juvenile" §8-291	N/S	30 days with possible 15-day extension §8-291.04	Within 30 days of filing of examiner's report §8-291.08	Yes, least restrictive alternative §8-291.09	Initial 6-month restoration period; if child adjudicated incompetent in past year, court may dismiss misdemeanor charges and begin civil commitment proceedings §8-291.09	240 days, matter dismissed and civil commitment proceedings began, if appropriate §8-291.08	N/S	Child Safety Juvenile Competency. §8-291 et seq
Arkansas (Track 1—Typical juvenile delinquency proceedings or extended juvenile jurisdiction proceedings)	By statute, adult competency statutes apply in juvenile delinquency proceedings	Capacity to understand the proceedings against him or to assist in his own defense §5-2-302	60 days, unless longer period necessary §5-2-327	N/S	N/S	Yes, if no danger to person or property of another §5-2-310	10-month initial restoration period, court must make a determination within 1 year of commitment §5-2-310	N/S	N/S	Title 9: Family Law §5-2-302 et seq

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State	Competence Statute?	Competence Requirements	Days Allotted for CE	Inpatient Confinement Periods for CE	Timeline for Initial CH	Outpatient Treatment Services	Restoration to Competence Time Frames	Maximum Commitment Time Frames	Notes	Source
Arkansas (Track 2—Competency proceedings for juvenile under the age of 13 charged with capital or 1st degree murder)	Yes	Ability to understand the charges, roles of parties in court, ability to work with his attorney, weigh the consequences of options, provide attorney description of facts, and articulate motives; Under 13, rebuttable presumption that child is incompetent in cases of capital or first-degree murder charges §9-27-502	Evaluations filed with court within 90 days of court order §9-27-502	N/S	Within 30 days of receipt of evaluation report §9-27-502	N/S Custody of Dept. of Human Services or RTF §9-27-502 ~~No~~	Treatment not to exceed 9 months, with reports due every 30 days; if child is not restored in 9 months, delinquency petition converted to a family in need of services petition 9§-27-502	N/S	N/S	Title 9: Family Law §9-27-502
California	Yes, there is also a 2015 competency to stand trial protocol for Los Angeles County	"Sufficient present ability to consult with counsel and assist in preparing his or her defense with a reasonable degree of rational understanding, or lacks a rational as well as factual understanding, of the nature of the charges or proceedings against them"	N/S ~~Parties can stipulate to a finding that minor lacks competency, 3 days from court order, if the minor is detained~~	N/S, ~~Certain categories of youth can be committed to the CYA for a diagnostic examination for no more than 90 days~~	Evidentiary hearing required, unless parties stipulate on the finds of the expert that the minor is incompetent. For minors under 14 years of age, court can make determination of capacity unless there is clear proof that at the time of the act "they knew its wrongfulness"	Yes—Least restrictive environment consistent with public safety	6-month initial restoration period, with additional 6 months allowable	Remediation period not to exceed 1-year, secure confinement shall not exceed 6 months from incompetence finding with exceptions	N/S	Welfare and Institutions Code 709 California Rules of Court – Rules 5.642 and 5.645

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State	Competence Statute?	Competence Requirements	Days Allotted for CE	Inpatient Confinement Periods for CE	Timeline for Initial CH	Outpatient Treatment Services	Restoration to Competence Time Frames	Maximum Commitment Time Frames	Notes	Source
Colorado	Yes	Juvenile has sufficient present ability to consult with the juvenile's attorney with a reasonable degree of rational understanding in order to assist in the defense and that the juvenile has a rational as well as factual understanding of the proceedings 19-2.5-102 ~~Age alone is not a determinant, evaluation must include developmental and mental disabilities, and mental capacity~~	35 days after court order, if juvenile is in secure detention 49 days after court order, if juvenile is not in secure detention 19-2.5-704 ~~30 days after court order if child is held in secure detention, otherwise 45 days after court order~~	N/S	Court can make preliminary finding, if court needs more information can order a competency examination. If court makes a preliminary finding, parties can request a hearing on that finding 19-2.5-705 ~~N/S~~	Least restrictive environment – including home or community placement, if appropriate, taking into account the public safety and the best interests of the juvenile 19-2.5-703	Court shall review at least every 91 days, if juvenile is in custody, court shall review ever 35-days 19.25-704 ~~Competency reviews every 90 days, unless the child is in custody - then reviews every 30 days~~	Court cannot maintain jurisdiction beyond the maximum possible sentence for the charged offense unless specific finds for good cause to retain jurisdiction. Juvenile court's jurisdiction shall not extend beyond the child's 21st birthday 19-2.5-704	N/S	Colorado Children's Code – 19-2.5-102 19-2.5-703 et seq
Connecticut	Yes	Age is not a per se determinant of incompetence; evaluation of child's ability to understand the proceedings and ability to assist in defense §46b-128a	15 days, extension available §46b-128a	N/S	within 10 days of receipt of examiner(s)'s report §46b-128a	Least restrictive setting	90-day initial restoration period, 90-day extension possible §46b-128a	If child has not regained competency court can dismiss the petition, give temporary custody to the Dept of Children and Families, or order the development of a plan of services in the least restrictive setting §46b-128a	N/S	Family Law §46b-128a

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Delaware	Yes	Age alone not a basis for finding of incompetence "Not competent" shall mean a child who is unable to understand the nature of the proceedings against the child, or to give evidence in the child's own defense or to instruct counsel on the child's own behalf Underlying basis may be mental disorder or incapacity, significant developmental delay, significant cognitive impairment, and/or chronological immaturity §1007A	30 days if child is in secure or nonsecure detention; 60 days if the child is not detained §1007A	N/S	N/S	Yes §1007A	Competency review hearings scheduled every 6 months §1007A	If child is found incompetent and unlikely to timely restored, the court shall dismiss nonviolent misdemeanor charges within 6 to 12 months; dismiss violent misdemeanor or non-violent felony charges within 12 to 24 months, dismiss violent felony charges at age 18, unless child was under 14 at time of arrest for violent felonies then court shall dismiss within 18 to 36 months §1007A	N/S	Courts and Judicial Procedure §1007A

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Florida	Yes	Child is competent if they have sufficient present ability to consult with counsel with a reasonable degree of rational understanding and the child has a rational and factual understanding of the present proceedings; evaluations on mental illness, intellectual disability, and/or autism	N/S	N/S	N/S	Yes; children adjudicated incompetent and charged with felony offense must be committed to DCF; a child found incompetent because of age or immaturity, or for any reason other than MI, ID, or Autism can NOT be committed to DCF; a child charged with a misdemeanor can NOT be committed to DCF	Treatment plan must be prepared within first 30 days of child's placement in treatment setting	Court can retain jurisdiction for 2 years, with 6-month reviews required. If court determines at any time that child will never become competent, it may dismiss the delinquency petition. If after 2 years there is no evidence that child will not attain competency within a year, court must dismiss the delinquency petition	N/S	Criminal Procedure and Corrections 985.19
Georgia	Yes	"Sufficient present ability to understand the nature and object of the proceedings, to comprehend his or her own situation in relation to the proceedings, and to assist his or her attorney in the preparation and presentation of his or her case in all	Evaluation not mandatory, parties may stipulate to the child's incompetency; if evaluation ordered, report due within 30 days of court order, extension possible	N/S	Within 60 days of initial court order for evaluation §15-11-655	Yes §15-11-653	6-month initial restoration period; competency reviews required at least every 6 months thereafter §15-11-656	For felony offenses, 2 years with review hearings every 6 months; for misdemeanor offenses, up to 120 days; If misdemeanor charge and remediation not likely before child's 18th birthday – petition dismissed with prejudice	N/S	Courts Juvenile Code §15-11-651 et. seq

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Georgia (cont)	See previous page	adjudication, disposition, or transfer hearings. Such term shall include consideration of a child's age or immaturity" §15-11-651	§15-11-652 §15-11-653	See previous page	See previous page	See previous page	See previous page	Once child reaches 18 court can refer for appropriate adult services §15-11-656 §15-11-658 §15-11-660	See previous page	See previous page
Hawaii	Statute says "no person;" courts use adult standard and statutes	Physical or mental disease, disorder, or defect; and lacks the capacity to understand the proceedings or assist in their own defense §704-403	If petty misdemeanor not involving violence or attempted violence charge, within 2 days of examiner's appointment or as soon as practicable thereafter. §704-404 N/S	30 days, or longer "as the court determines to be necessary for the purpose." §704-404	Hearing not mandatory, shall be ordered if party contests the court's finding §704-405	Yes § 704-406	For petty misdemeanor chargers not involving violence or attempted violence, defendant shall be diverted from criminal justice system For misdemeanor charges not involving violence, 120 days from courts finding of lack of fitness to proceed §704-406 ~~For non-violent petty misdemeanors: 60 days from the date court finds the defendant incompetent; for non-violent misdemeanors: 120 days.~~	For charges of murder in the 1st or 2nd degree, or a class A felony, if defendant is committed and ultimately restored, and court finds that so much time has elapsed as to render it unjust to resume the proceedings the court may dismiss the charge and discharge, require involuntary hospitalization or assign community-based treatment. If the charge is 1st or 2nd degree murder or a class A felony, and restoration is not substantially probable, court may dismiss the charge and release the defendant, and require involuntary hospitalization §704-406	N/S	Hawaii Penal Code §704-403 et. seq

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Idaho	Yes	To be competent: (a) A sufficient present ability to consult with his or her lawyer with a reasonable degree of rational understanding; (b) A rational and factual understanding of the proceedings against him or her; and (c) The capacity to assist in preparing his or her defense §20-519A	Examiner(s)' report due within 30 days of receipt of appointment §20-519A	10 days §20-519A	Hearing within 30 days of report filing; not mandatory court can make a finding based on the report, unless a party contests the examiner's findings §20-519B	Yes, least restrictive alternative requirement §20-519B	6-month initial restoration period; reports required every 90 days §20-519B	Court can extend restoration beyond 6 months upon showing of good cause; can extend until treatment provider states there is no substantial probability that the juvenile will regain competency within stipulated timeframe, charges are dismissed, or child reaches 21 years of age §20-519B	N/S	§20-519A et seq
Illinois	No, adult code of criminal procedure applies "the procedural rights of a minor shall be those of an adult unless precluded by laws which enhance the protection of minors. In the Interest of T.D.W., 109 Ill.App.3d 852	"A defendant is unfit if, because of his mental or physical condition, he is unable to understand the nature and purpose of the proceedings against him or to assist in his defense" §5/104-10	Report due in 30 day, §5/104-13 ~~with 15-day extension possible~~	7 days, with 7-day extension possible §5/104-13	Within 45 days of receipt of examiner(s)' report §4/104-6	Yes §5/104-13 §5/104-17	30-day initial restorability assessment period, period, 90-day review hearing §5/104-17 §5/104-20	For misdemeanor charges, restoration treatment shall not exceed the maximum term of imprisonment for the most serious offense; For a felony charge, 1 year commitment allowed for restoration §5/104-15 §5/104-17	N/S	Criminal Procedure 725 5/104-10 et. seq

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Indiana	Yes §31-27-26-1 ~~No, there is a statute authorizing mental and physical examinations for children alleged delinquent or in need of services. In re K.G ., 808 N.E.2d 631, 635 (Ind. 2004), the Supreme Court of Indiana ruled that this specific statute was sufficient for finding a child incompetent and ordering treatment services~~	". . . the present ability of a child to: (A) understand the nature and objectives of a proceeding against the child; and (B) assist in the child's defense" §31-37-26-2	N/S	N/S	"As soon as practicable after receiving the written competency evaluation, the court shall determine whether the child is competent for adjudication or disposition . . ." Court shall conduct a hearing upon a party's motion §31-37-26-5	Yes, least restrictive setting 31-37-26-6	180 days for a felony act if committed by an adult; 90 days for non-felony act if, 30-day progress reports required §31-37-26-6	In a non-residential setting, 180 days for a felony act; 90 days for non-felony act In a residential setting operated solely or in part for the purposes of competency attainment services, 45 days for a non-felony act, 90 days for a Level 4, 5, or 6 felony, and 180 days for an act that would be murder or a Level 1, 2, or 3 felony In residential, detention, or other secured setting where child placed for reasons other than competency attainment, but where child is ordered to participate in competency attainment services, 90 days if felony act, 180 days for murder or felony act 31-37-26-6	N/S	§31-37-26-1 et seq
Iowa	No, applicability of adult statute confirmed in case law see In re A.B., 2006 715 N.W.2d 767	As established in case law "juvenile's inability to appreciate the charge, understand the proceedings, or assist effectively	N/S	N/S	Within 14 days of defendant's arrival at a psychiatric facility for the examination. If defendant has had a psychiatric evaluation within the	Yes, if no danger to public peace or safety §812.6	Initial status report within 30 days, progress reports 60 days thereafter §812.7	Placement shall not exceed the maximum term of confinement for the charged offense or 18 months from the date of incompetence adjudication, whichever occurs first	N/S	Criminal Law and Procedure §812.3 et seq

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Iowa (cont)	See previous page	in the defense may be the result of immaturity, lack of intellectual capacity, or both §812.3	See previous page	See previous page	previous 30 days, then hearing within 5 days of court's motion or the filing of an application §812.4	See previous page	See previous page	§812.9	See previous page	See previous page
Kansas	Yes	Child is incompetent if, because of a mental illness or defect, they are unable to "understand the nature and purpose of the proceedings; or make or assist in making a defense" §38-2348	N/S	60 days §38-2348	N/S	N/S	90-day initial restoration period §38-2349	If competency not attained within 6 months of start of original commitment, court shall order civil commitment proceedings §38-2349	N/S	§38-2348 et seq
Kentucky	No, adult statutes govern See Kentucky v. Stincer 482 U.S. 730 (1987)	" . . . as a result of a mental condition, lack of capacity to appreciate the nature and consequences of the proceedings against one or to participate rationally in one's own defense" §504.110	N/S	60 days §504.110	N/S	No	Earlier of 60 days or until examiner finds defendant competent (does not apply to felony charges). If the charge is a felony, defendant is committed to a forensic psychiatric facility unless other facility designated. Within 10 days of treatment completion, the court shall hold another hearing on the defendant's competency §504.110	At post-treatment hearing, if there is no substantial probability that the defendant will attain competency, the court shall conduct involuntary hospitalization proceedings §504.110	N/S	Penal Code §504.110

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Louisiana	Yes	"Whether as a result of mental illness or developmental disability a child presently lacks the capacity to understand the nature of proceedings against him or to assist in his defense" §804	Competency commission appointed and date for hearing set within 7 days of court order for examination § 834	N/S	If child is in secure detention, hearing set for within 45 days of appointment of competency commission; for children outside of secure detention time frame is 60 days from the commission's appointment. 15-day extension possible for either timeframe § 836	Yes	90-day initial restoration period, with hearings every 90 days thereafter; there is a 2-year evaluation hearing, followed by a 1 year evaluation hearing; then court must either dismiss, FINS, place child with family or suitable person or institution, or begin civil commitment proceedings § 837.2-5	No commitment or placement shall exceed the time of the maximum disposition the child could have received if adjudicated delinquent. § 837	N/S	Louisiana Children's Code Art 832 et. seq
Maine	Yes	Rational and factual understanding of the proceedings; and a sufficient present ability to consult with legal counsel with a reasonable degree of understanding; examiner also evaluating for mental illness, mental retardation, or chronological immaturity §3318-A	21 days from court's order §3318-A	N/S	N/S	N/S	Repeat examinations at the 60-day, 180 day, and 1 year marks following referral. After 1 year, if court finds there is not substantial probability of restoration, court shall either order HHS to provide services or take custody of the child; court shall dismiss the petition or vacate the adjudication order and dismiss the petition	N/S	Proposed Legislation	Court Procedure – Criminal §3318-A et seq

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Maryland	Yes	Child's ability to understand the allegations, range and nature of allowable dispositions; roles of the participants and adversary nature, assist counsel, behave appropriately in court and testify relevantly; can be examined for mental illness, mental retardations, developmental immaturity, or other developmental disability §3-8A-17.3	Report filed within 45 days of court order for examination, 15-day extension possible §3-8A-17.3	N/S	Hearing within 15 days of receipt of report, 15-day extension possible §11-416	Yes, least restrictive environment §3-8A-17.6	90-day initial restoration period, Services may be continued in increments of not more than 6 months §§3-8A-17.6 and 3-8A-17.8	Court shall dismiss delinquency petition or probation violation petition after 18months if child is alleged to have committed certain acts that would be felonies if committed by an adult, or 6 months for alleged acts that would be a misdemeanor if committed by an adult §3-18-17,9	N/S	Maryland Rules §11-416 Code, Courts Article §3-8A-17.2 et seq
Massachusetts	Subsection of adult statute gives authority of court to order psychological and psychiatric for children alleged delinquent	N/S	N/S	40 days 123 § 15	N/S	No	Order of commitment valid for 6 months 123 § 15	N/S	Proposed Legislation	Administration of the Government, Public Welfare 123 § 15(f)

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Michigan	Yes	a juvenile, based on age-appropriate norms, lacks a reasonable degree of rational and factual understanding of the proceeding or is unable to . . . a) consult with and assist his or her attorney in preparing his or defense in a meaningful manner, b) sufficiently understand the charges against him or her §330.2060a	30 days from receipt of court order §330.2066	N/S	30 days from filing of examination report §330.2068	Least restrictive environment requirement §330.2074	Initial 60-day restoration order, 60-day extension possible, not to exceed 120 days, report required at least every 30 days §330.2074	Juvenile reaches 18 years of age, restoration order and renewal order not to exceed 120 days total § 330.2074	N/S	Mental Health Code §330.2062
Minnesota	Yes	Sufficient ability to consult with a reasonable degree of rational understanding; or understand the proceedings or participate in the defense due to mental illness or mental deficiency §20.01	Report due within 60 days §20.01	60 days §20.01	Hearing to review within 10 days of receipt of examiner(s)'s report; if any party contests report's findings, competency hearing required in 10 days §20.01	Yes	If child is incompetent and offense is misdemeanor, juvenile petty offense, or juvenile traffic offense, court shall dismiss; if offense is gross misdemeanor court can dismiss or suspend; if felony offense, court can only suspend proceedings. Child can be civilly committed, or CHIPS; reviews at 6-month intervals §20.01	Dismissal upon child's 19th or 21st birthday (in case of extended jurisdiction); for all cases except murder, upon 1 year from date of incompetency finding unless prosecutor files intent to prosecute upon restoration; for all cases except murder, case dismissed 3 years from finding of incompetency, no incompetence	N/S	Court Rules, Juvenile Delinquency Procedure Rule 20.01

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Minnesota (cont)	See previous page	See previous page	See previous page	See previous page	See previous page	See previous page	See previous page	dismissal for murder charges §20.01	See previous page	See previous page
Mississippi	No, adult statutes apply indirectly	N/S	For no longer than reasonably necessary to conduct the evaluation §12.3	N/S	Upon its own motion, or a party's, the court "shall promptly hold a hearing: after submission of the examiner's report §12.5	Yes §12.5	Examinations and reports required every four calendar months §12.5	Reasonable time after commitment order §12.5	N/S	Mississippi Rules of Criminal Procedure Rule 12.1 et seq
Missouri	Yes, statute gives power to the court to examine children for competency, then process determined by applying same statute to adults and juveniles	"No person who as a result of mental disease or defect lacks capacity to understand the proceedings against him or her or to assist in his or her own defense shall be tried." Examinations for intellectual and developmental disabilities, and mental illness §552.020	Evaluation performed and written report submitted within 60 days §552.020	N/S	Hearing not mandatory, shall be ordered upon the court's own motion or any party's motion. Court may impanel a jury of 6 for assistance §552.020	Vague, but seems like available option if defendant is released on bail or other otherwise eligible for release §552.020	Initial commitment may be for 6 months, court can continue it for an additional 6 months §552.020	N/S	N/S	Criminal Procedure §552.020
Montana	No, see In re G.T.M., Supreme Court of Montana distinguishes protections needed by	N/S	N/S	N/S	N/S	N/S	N/S	N/S	N/S	N/S

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Montana (cont)	adults and children as those for children in need of supervision do not result in detention and incarceration	See previous page	See previous page	See previous page	See previous page	See previous page	See previous page	See previous page	See previous page	See previous page
Nebraska	Yes	N/S	30 days if placed with DHHS on residential or non-residential basis, 30-day extension possible §43-258	N/S	Hearing within 10 days of court's receipt of evaluation §43-258	N/S	N/S	N/S	N/S	Infants and Juveniles §43-258
Nevada	Yes	Incompetency means child does not have the ability to understand the allegations of delinquency; the nature and purpose of the court proceedings; aid and assist counsel in the defense with a reasonable degree of rational understanding §62D.140	14 days after appointment order §62D.155	N/S	N/S, expedited hearing upon receipt of the required written repots §62D.170	Yes 62D.180	1st periodic review within 6 months of commitment to an institution for persons with intellectual disabilities or mental illness 62D.185	N/S	N/S	Juvenile Justice 62D.140 et seq.

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New Hampshire	Yes	Child is competent if they have a rational and factual understanding of the proceedings, and a sufficient ability to consult with their lawyer with a "reasonable degree of rational understanding." Examinations for mental illness, developmental disability 169-B:20	21 days if detained, 30 days if in out-of-home placement, and 60 days if at home §169-B:20	21 days §169-B:20	N/S	N/S	N/S	N/S	N/S	Public Safety and Welfare §169-B:20
New Jersey	Yes, via caselaw adult statues apply in juvenile delinquency cases. See In Re. N.C., 182 A.3d 419	Capacity to understand the proceedings against him or to assist in his own defense §2C:4-4	N/S	30 days § 2C:4-4	Hearing not mandatory, shall be ordered upon the court's own motion or any party's motion § 2C:4-5	Yes, if not dangerous to self or others § 2C:4-5	3 months initial restoration period, treatment can be continued and reviewed at 6- month intervals until defendant is restored or charges are dismissed § 2C:4-5	N/S	N/S	Code of Criminal Justice § 2C:4-4 et seq.
New Mexico	Yes	Examination for mental disorder or developmental disability §32A-2-21	N/S	N/S	N/S	N/S	If the offense would be a misdemeanor matter shall be dismissed with prejudice; Petition shall not be stayed for more than one year, pending competency restoration treatment. Review required every 90 days §32A-2-21	N/S	N/S	Children's Code §32A-2-21 Children's Mental Health and Developmental Disabilities Act §32A-6A-5

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New York	Yes	N/S	Reports due within 10 days of court order, extension possible §322.1	N/S	Timeline of hearing N/S; probable cause hearing for crime within 3 days if initial appearance or 4 days of petition filing §325.1	Yes §322.2	If committed initial review within 45 days, then again at 90 days §322.2	If probable cause that misdemeanor was committed, 90-day commitment; if felony commitment up to 1 year, with possible extensions; Commitments terminate upon child's 18th birthday; unless child was 16+ when at committed, then commitment terminates at 21st birthday §322.2	Proposed Legislation	Family Court Act §322.1 et seq
North Carolina	Yes, by statutory declaration, adult statutes apply to juvenile delinquency cases §7B-2401	When by reason of mental illness or defect he is unable to understand the nature and object of the proceedings against him, to comprehend his own situation in reference to the proceedings, or to assist in his defense in a rational or reasonable manner §15A-1001	N/S	60 days §15A-1002	N/S	Unclear	N/S	Defendant should not be confined or committed in excess of the maximum term for Level VI felonies or Level 3 misdemeanors, 5 years from the determination of incompetence for misdemeanor charges or 10 years if felony charges §15A-1008	N/S	Juvenile Code §7B-2401 Criminal Procedure Act §15A-1001 et seq

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North Dakota	Yes, individual under age of ten is incapable of commission of an offense, individual ten or older may be assess under Criminal Code §12.1-04-04 et seq.	"sufficient present ability to consult with the individual's counsel with a reasonable degree of rational understanding and a rational as well as factual understanding of the proceedings against the individual" §12.1-04-04	15 days of order served upon mental health professional, 7-day extension possible for good cause §12.1-04-07 ~~N/S~~	30 days, ~~possible extension of additional 30 days~~ §12.1-04-06	N/S ~~Hearing and competency determination only mandated if evaluator's findings are contested~~	Least restrictive form of treatment §12.1-04-08	Initial 180-day period, 365 day extension possible §12.1-04-08 N/S	For misdemeanor charge, proceedings suspended for not longer than maximum term of imprisonment for most serious offense charged §12.1-04-08 ~~Maximum period for which defendant could be sentenced.~~	A version called into doubt by Graham v. Florida	Criminal Code N.D.R.Crim.P., Rule 12.2
Ohio	Yes	Ability to understand the nature and objectives of a proceeding against the child and to assist in the child's defense." Bases for incompetence include mental illness, developmental disability, or lack of mental capacity; children 14 and older presumed to have the appropriate mental capacity if they do not have a mental illness	Court can forego an evaluation if all parties and a parent agree to the determination; or the court relies on a prior court determination that the child was unrestorably incompetent; within 15 business days of motion raising issue, court must either make a determination on competency, determine the need for evaluation without a hearing, or	N/S	Within 15 to 30 days of filing of evaluation report §2152.58	Yes, least restrictive setting §2152.56	Initial restoration plan after 30 days, 30-day progress reports thereafter §2152.59	Outside of residential settings: 3 months for a misdemeanor; 6 months if a 3rd, 4th, or 5th degree felony, 1 year if a 1st or 2nd degree felony, aggravated murder, or murder. In residential settings, 45 days for misdemeanor, 3 months for 3rd, 4th, murder. In residential settings, 45 days for misdemeanor, 3 months for 3rd, 4th, or 5th degree felony, and 6 months for a 1st or 2nd degree felony, aggravated murder, or murder §2152.59	N/S	Juvenile Courts-Criminal Provisions §2152.52

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Ohio (cont)	See previous page	or developmental disability §2152.56 §2152.52	hold a hearing to determine whether to order an evaluation; Evaluation report due within 45 days of court order §2152.52 §2152.53	See previous page	See previous page	See previous page	See previous page	See previous page	See previous page	See previous page
Oklahoma	Yes	"If, due to developmental disability, developmental immaturity, intellectual disability, or mental illness, the child is presently incapable of understanding the nature and objective of proceedings against the child or assisting in the child's defense." If child is 13 years or older and with disability, rebuttable presumption that child is competent §2-2-401.1 §2-2-401.2	Court may find child incompetent without evaluation or hearing if the parties and at least one of the child's parents agree to the determination; Within five days of raising of issue court must either 1) find the child incompetent; 2) without conducting a hearing order a competency evaluation; or 3) schedule a hearing to determine whether a reasonable basis for a competency evaluation exists	N/S	Hearing required within 15 days of receipt of evaluator's report §2-2-401.6	Yes, least restrictive environment §2-2-401.5	Reports due every 90 days §2-2-401.7	If charge is misdemeanor, services for 6 months or 19th birthday; if charge is a felony services for 12 months or until 19th birthday §2-2-401.7	N/S	Children and Juvenile Code §2-2-401.1 et seq

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Oklahoma (cont)	See previous page	See previous page	Evaluation due within 30 days of court order, with possible 30-day extension §2-2-401.2, §2-2-401.3, §2-2-401.5	See previous page	See previous page	See previous page	See previous page	See previous page	See previous page	See previous page
Oregon	Yes	If by "qualifying mental disorder or another condition, the youth is unable to understand the nature of the proceedings against the youth, to assist and cooperate with counsel for the youth; or to participate in the defense of the youth" §419C.378	Within 30 days of court order, with possible 30-day extension §419C.386	N/S	If party objects to the evaluation report, court must hold a hearing within 21 days of objection §419C.388	N/S	90-day initial report; 90-day continuation allowed §419C.396	3 years or the maximum commitment possible if the petition had been adjudicated §419C.396	Proposed Legislation	Human Services, Juvenile Code, Corrections §419C.378 et seq.
Pennsylvania	No, adult standard applied to juvenile delinquency case by PA Superior Court; see In re R.D., 2012, 44 A.3d 657 See also §7401(c)	"Substantially unable to understand the nature or object of the proceedings against him or to participate in his defense" §7402	N/S	Involuntary treatment can be ordered for 60 days §7402	Determination rendered within 20 days of receipt of examination report unless hearing continued at defendant's request §7402	Yes §7402	Psychiatric examination every 12 months to determine if defendant has become competent §7403	Except for 1st and 2nd degree murder charges, proceedings shall not be stayed in excess of the maximum sentence of confinement or ten years, whichever is less. If the charge is 1st or 2nd degree murder, there is no time limitation §7403	N/S	Mental Health §7401 et seq

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Rhode Island	No	N/S	N/S	N/S	N/S	N/S	N/S	N/S	N/S	N/S
South Carolina	Yes, juvenile and adult statutes are the same; see In Interest of Antonio H., 1995, 461 S.E.2d 825	"Lacks capacity to understand the proceedings against him or assist in his own defense as a result of a lack of mental capacity" §44-23-410	30 days §44-23-410	15 days with possible 15-day extension §44-23-410	N/S	Yes §44-23-410	180 days §44-23-410	Maximum possible period of imprisonment if defendant had been convicted as charged §44-23-410	N/S	Health §44-23-410
South Dakota	Yes	"A person who is suffering from a mental disease, developmental disability, or psychological, physiological, or etiological condition rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense" §23A-10A-1	Within 30 days of court order §26-7A-32.4	N/S	N/S	Least restrictive environment §23-7A-32.11	60-day initial restoration period, report due then and at 180 days and end of one year; if child turns 18 during suspension of proceedings, court can evaluate appropriateness of transferring to adult placement for continued services §26-7A-32.11	N/S	N/S	Minors §26-7A-32.1

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Tennessee	Yes	N/S	N/S	N/S	N/S	Yes	N/S	N/S	N/S	Rules of Juvenile Practice and Procedure §Rule 207
Texas	Yes	" . . . as a result of mental illness or an intellectual disability lacks capacity to understand the proceedings in juvenile court or to assist in the child's own defense is unfit" §55.31	N/S	N/S	N/S	Yes §55.33	90-day initial restoration period; if restoration treatment unsuccessful court can initiate civil commitment proceedings §55.33 §55.35	Proceedings transferred to criminal court on child's 18th birthday §55.44	Proposed Legislation	Family Code Juvenile Justice §51.20 §55.31 et seq
Utah	Yes	". . . minor has i) a present ability to consult with counsel with a reasonable degree of rational understanding; and ii) a rational as well as factual understanding of the proceedings" §80=6-401 ~~Evaluation of impact of mental disorder or intellectual disability on minor's ability~~	Report due within 30 days of receipt of order, 15-day extension possible §80-6-402 ~~Initial report due within 30 to 60 days of court order~~	N/S	Within 5 to 15 days of receipt of examiner's report §80-6-402	Yes, least restrictive setting requirement §80-6-403	30-day period for development of attainment plan; report due at 3 months, if reasonable progress being made, 3-month extension possible §80-6-403 ~~Initial 30 day to 6 month competency attainment plan developed; 6 month extension possible; reports due every 90 days~~	If most severe charge is class B misdemeanor, and more than 60 days have passed and minor not competent to proceed, order of detention terminated If minor not competent within 6 months, court shall terminate proceedings and dismiss petition unless substantial likelihood that competency attained within one year of initial finding of incompetence	N/S	Utah Juvenile Code §80-6-401 et seq.

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Utah (cont)	See previous page	~~to understand the charges, assist counsel, understand the possible penalties, engage in reasoned choice of legal strategies, understand the adversarial nature of the proceedings, behave appropriately in court, and testify if relevant~~	See previous page	See previous page	See previous page	See previous page	See previous page	§80-6-403 ~~If child has not attained competency within 1 year, court shall dismiss delinquency proceedings without prejudice.~~	See previous page	See previous page
Vermont	Adult statute applies, see In re J.M. , 2001, 769 A.2d 656 Affirmed, People in Interest of A.C.E-D 2018 COA 157	"due to a mental disease or mental defect" §4817	N/S	30 days with 15-day extension possible §4815	N/S	No §4822	Indeterminate Period §4822	N/S	N/S	Crimes and Criminal Procedure §4814 et seq
Virginia	Yes	Juvenile's ability to understand the proceedings and assist in his defense §16.1-356	Evaluation competed within 10 days of admission to hospital, evaluations filed court within 14 days of evaluator receiving all required information §16.1.356	10 days §16-1.356	Hearing not mandatory, only required upon motion of one of the parties §16.1-356	Unclear, nonsecure community settings allowed §16.1-357	Initial 3-month restoration period, with extensions possible in 3-month intervals §16.1-357	If child is unlikely to be restored, misdemeanor charges dismissed within 1 year of date of arrest, and within 3 years of date of arrest for felonies §16.1-358	Proposed Legislation	Courts Not of Record §16.1-356

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Washington, DC	Yes	The child's ability to understand the proceedings, nature and range of possible dispositions, and ability to assist attorney §16-2315	21 days if hospitalized §16-2315	21 days, extensions possible aggregated up to 21 days total §16-2315	N/S	Yes §16-2315	Reports due every 2 months §16-2315	Restoration treatment for 180 days with possible 180-day extension §16-2315	N/S	Judiciary and Juvenile Procedure §16-2315
Washington	Adult statute applies, see State v. P.E.T., 2015, 344, P.689	"A person lacks the capacity to understand the nature of the proceedings against him or her or to assist in his or her own defense as a result of mental disease or defect" §10.77.010	21 days for evaluation in the community §10.77.068	Performance target of 7-days or fewer for offer of inpatient evaluation for, 14 days maximum 15 days to complete the exam once admitted §10.77.060	N/S	Yes §10.77.074 §10.77.088	Offer of admission for treatment, target 7 days, 14 days maximum; for Class C felonies or lower, or non-violent Class B the initial restoration period is 45 days for in-patient and 90 days for outpatient, additional 90-day extensions possible For non-felony charges that are serious offenses, 29 days for in-patient, 90 days for outpatient Other felonies there is a 90-day initial restoration period, No additional restoration periods if the incompetence is solely related to a developmental disability that is unlikely to be resolved during an extension; At the end of the 2nd restoration period, charges must be dismissed unless the defendant is a substantial danger to others substantial likelihood of additional criminal acts	Commitment or treatment cannot exceed the maximum possible penal systems for any offense charged §10.77.025	Proposed Legislation	Criminal Procedure §10.77.060 et seq.

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Washington (cont)	See previous page	See previous page	See previous page	See previous page	See previous page	See previous page	jeopardizing public safety or security, substantial probability that defendant will regain additional competence within 6 months. Then the court may extent for an additional 6 months. §10.77.086 §10.77.088	See previous page	See previous page	See previous page
West Virginia	By statute, adult competency statutes apply in juvenile delinquency proceedings	". . . the ability of a criminal defendant to consult with his or her attorney with a reasonable degree of rational understanding, including a rational and factual understanding of the procedure and charges against him or her" §27-6A-1	10 days, 10-day extension possible, should not exceed 30 days §27-6A-2 ~~N/S~~	15 days maximum for period of observation in mental health facility §27-6A-9	Hearing not mandatory, shall be ordered upon the court's own motion or any party's motion. Court's preliminary finding required within 5 days of receipt of evaluation State or defense counsel can make a motion for a hearing within 20 days of receipt of court's preliminary finding, hearing shall be held within 15 days of motion §27-6A-3	Yes §27-6a-2 §27-6A-3	90-day initial in-patient restoration, defendant may not be held in mental health facility of state hospital for a period longer than 240 days §27-6A-3	If defendant is found not substantially likely to attain competency and is charged with a misdemeanor or non-violent felony, restoration services for 180 days or maximum sentence served if convicted of charge the criminal charges shall be dismissed For violent misdemeanors and violent felonies, defendant shall remain under court's jurisdiction until the expiration of the maximum sentence had conviction occurred, unless the defendant attains competency, or the court dismisses the indictment or charge §27-6A-3	N/S	Mentally Ill Persons §27-6A-9 §27-6A-2 §27-6A-4

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Wisconsin	Yes	Juvenile's present mental capacity to understand the proceedings and assist in his or her defense §938.295	N/S	"In a specified period that is no longer than necessary" §938.295	No more than 10 days after plea hearing if in secure custody and no more than 30 days if not in secure custody §938.30	N/S	Competency reports every 3 months and within 30 days of expiration of competency order §938.30	Within 12 months or within the time period of the maximum sentence that may be imposed on an adult for the most serious delinquent act with which the juvenile is charged, whichever is less §938.30	N/S	Juvenile Justice Code §938.295 §938.30
Wyoming	Yes	Incompetency evaluated on basis of mental illness or intellectual disability §14-6-219	N/S	15 days §14-6-219	N/S	N/S	N/S	N/S	N/S	Children §14-6-219

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