Competency to Stand Trial in Connecticut

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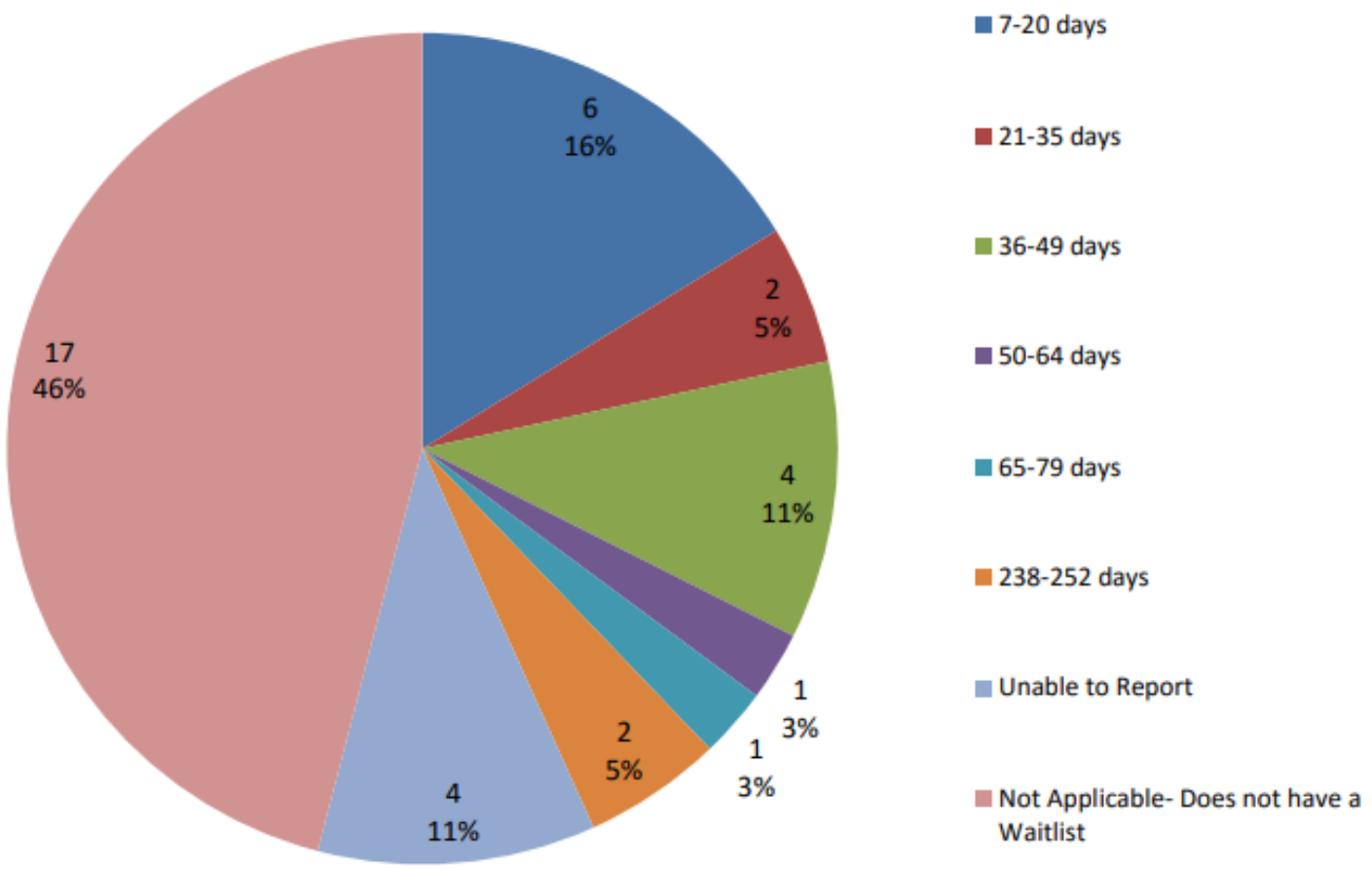
The National Landscape

- Competence questioned in 10-15% of public defense cases, though only half are formally evaluated
- Two decades ago:
  - 60,000 CST evaluations/year
  - 9,000 defendants found IST each year
  - 4,000 IST defendants in state hospital beds at any time
- Since then, >80% of states have reported significant increases in CST evaluations

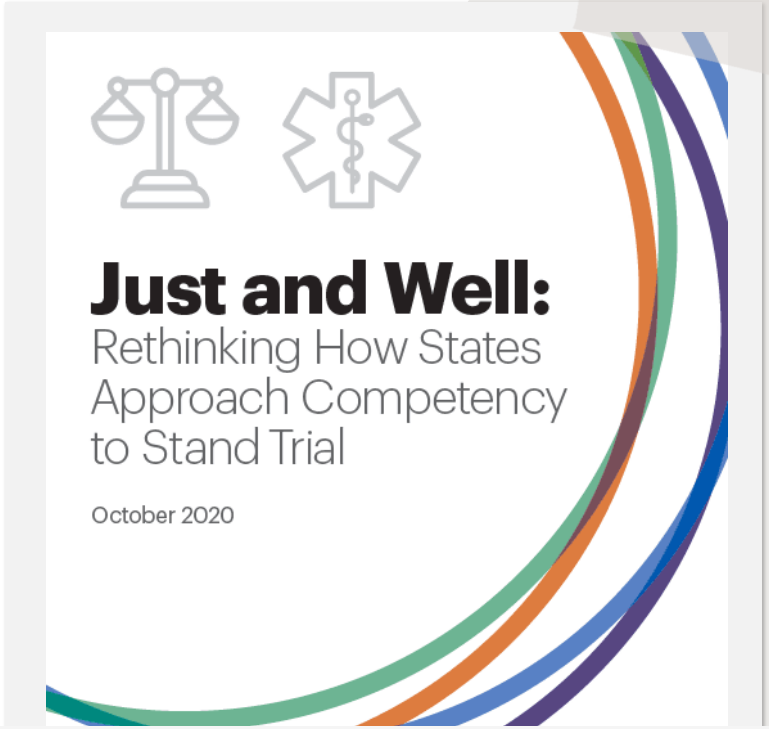
National Wait Times for Restoration Beds

Source: 2017 NRI Inpatient Forensic Services Study



Calls for Reform

- CST admissions make up a larger share of all state inpatient hospitalizations
- At least 12 states are under court-ordered monitoring around restoration wait times, e.g., *Trueblood v. Washington DSHS*
- Major push to reduce CST evaluations by national organizations

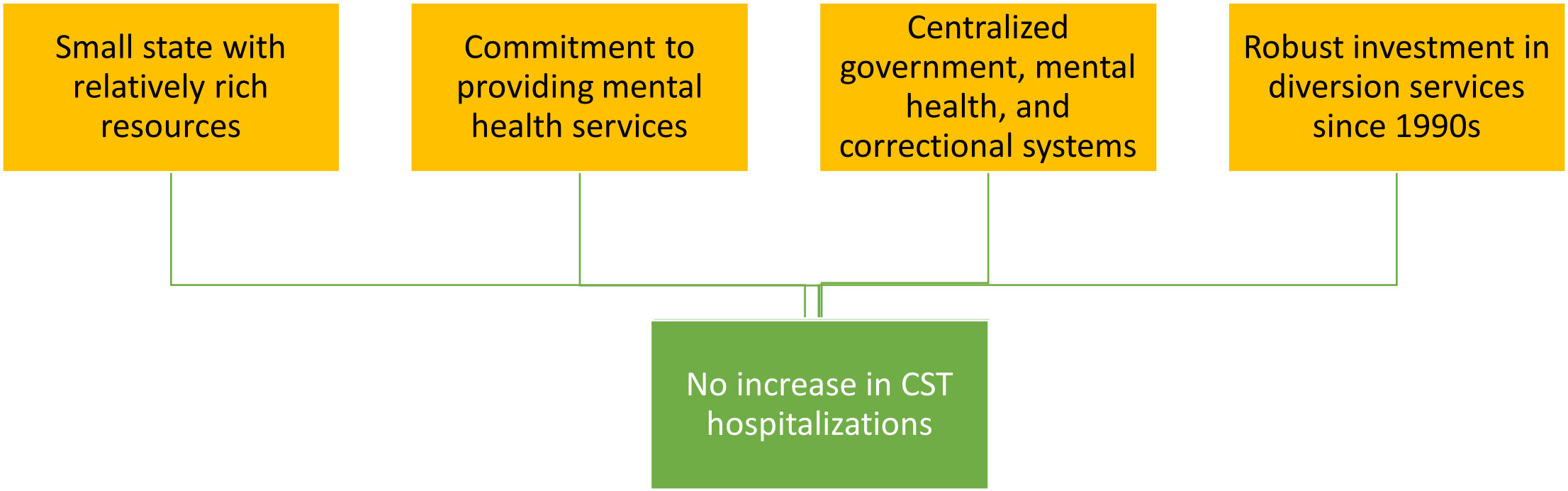


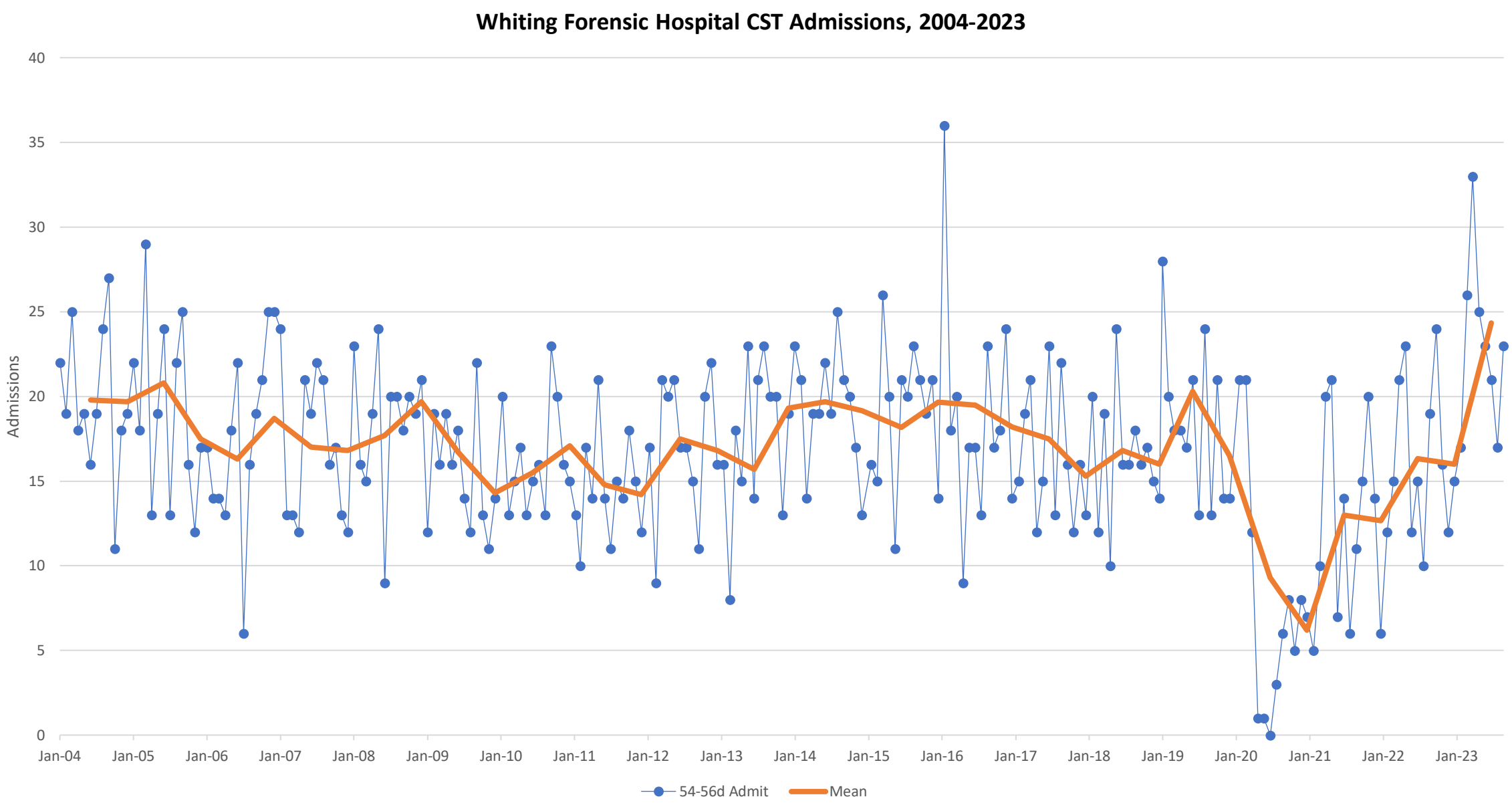
Connecticut in the National Context

Minimal wait time for CST evaluations

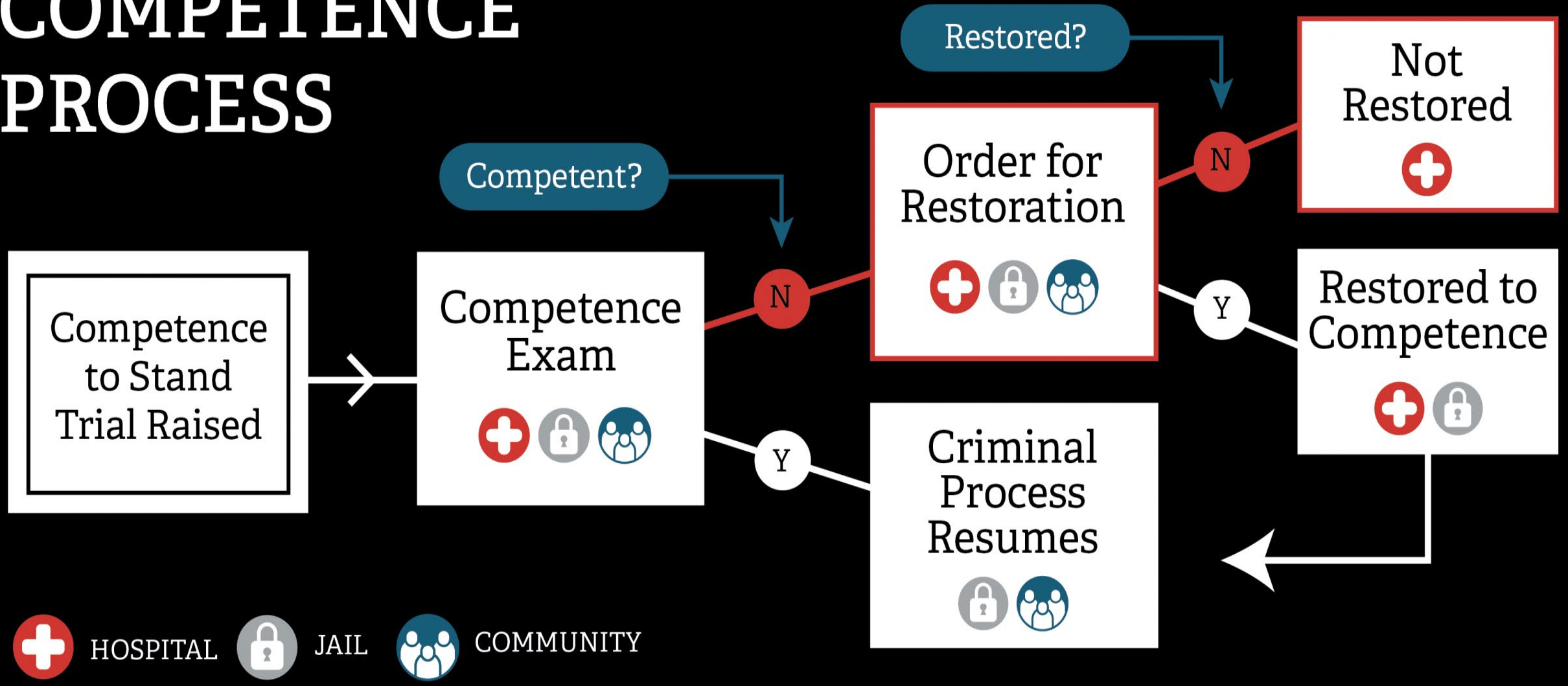
No wait time for inpatient restoration beds

How did we do this?




Whiting Forensic Hospital CST Admissions, 2004-2023
Admissions
40
35
30
25
20
15
10
5
0
Jan-04
Jan-05
Jan-06
Jan-07
Jan-08
Jan-09
Jan-10
Jan-11
Jan-12
Jan-13
Jan-14
Jan-15
Jan-16
Jan-17
Jan-18
Jan-19
Jan-20
Jan-21
Jan-22
Jan-23
54-56d Admit
Mean

COMPETENCE PROCESS



Source: SAMHSA's GAINS Center, Policy Research Associates, prainc.com

How is competency evaluated?

Dusky v. U.S. (1960)
C.G.S. § 54-56d

Sufficient present ability to consult with an attorney with a reasonable degree of rational understanding ("ability to assist")

Rational as well as factual understanding of the proceedings against him ("rational understanding")

Procedural Matters

- **Who can raise issue**: defense, prosecution, or court. Can be ordered over defendant's objection (*Pate v. Robinson*, 1966)

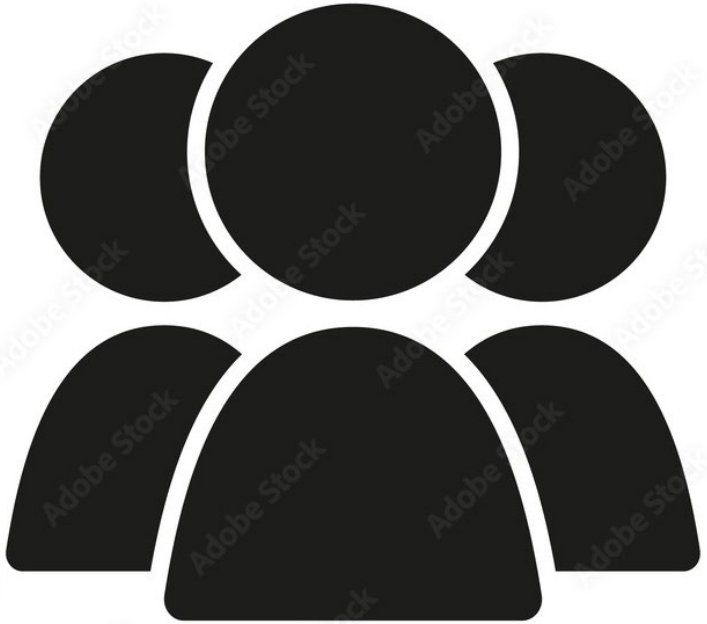
- **Standard for raising issue**: 'bona fide doubt' as to defendant's competence at any point during proceedings (*Drope v. Missouri*, 1975)

- **Burden/standard of proof**: presumption of competence and burden on party raising by preponderance of evidence (*Medina v. California*, 1992; Cooper v. Oklahoma, 1996)

Two Options for CST Evaluations in CT

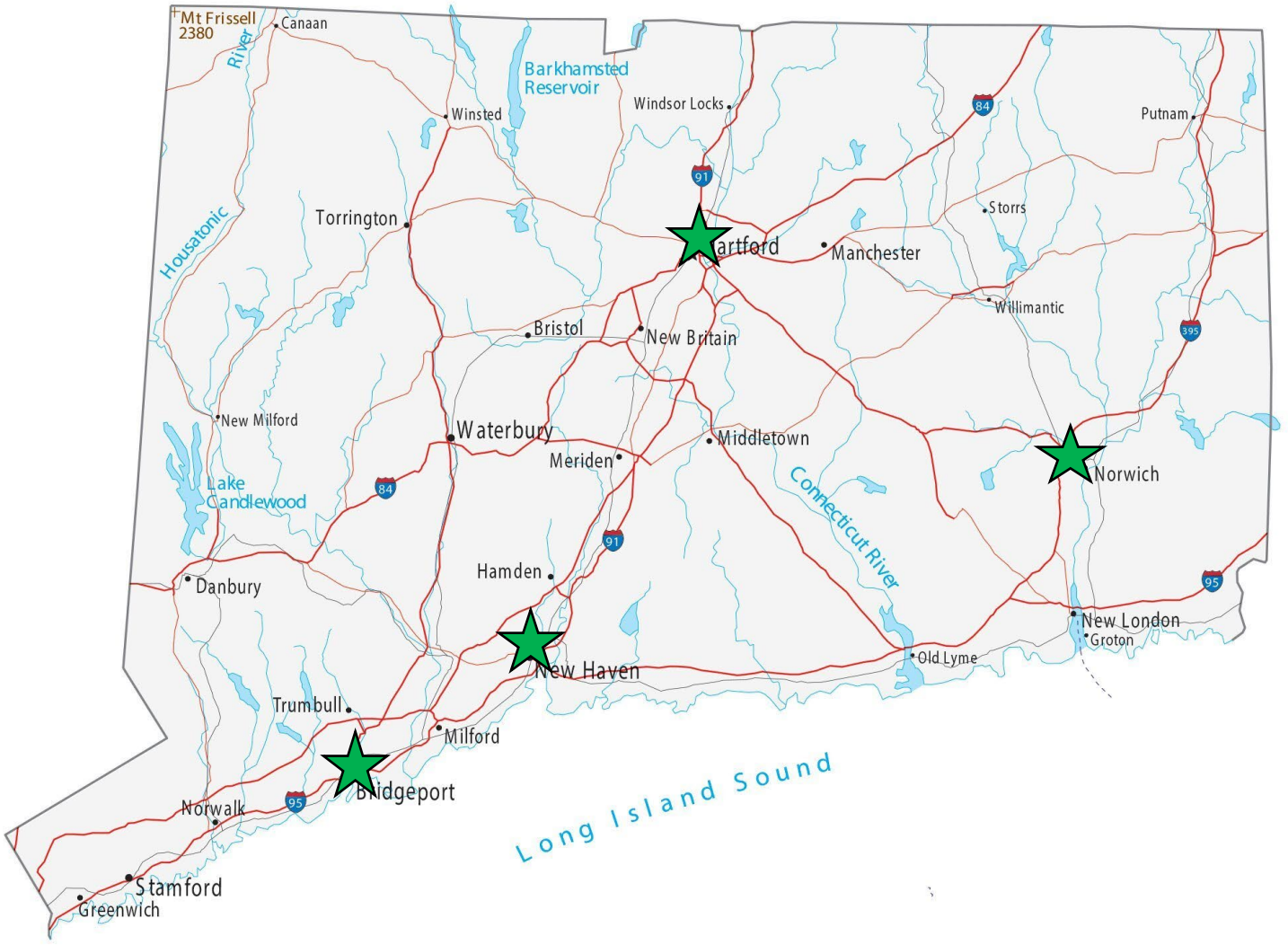
One psychiatrist

Team of psychiatrist, psychologist, and social worker or nurse



DMHAS Offices of Forensic Evaluations

- Bridgeport
- Hartford
- New Haven
- Norwich
- “Float” staff



How many CST evaluations are completed by DMHAS?

Year	Initial CST Evals	% Incompetent
2013	540	45
2014	548	52
2015	567	47
2016	588	49
2017	599	43
2018	543	46
2019	654	46
2020	280	48
2021	422	45
2022	506	47

Misdemeanor vs. Felony CST Evaluations

Competency Restoration

- Defendant can be committed to DMHAS, DDS, or DCF
  - DMHAS and DCF → inpatient or outpatient restoration
  - DDS → outpatient only
  - CT does not have jail-based restoration, which is growing in other states
- Court must order least restrictive alternative
- In practice, most people are committed to DMHAS inpatient facilities, though outpatient can always be recommended

Inpatient or Outpatient Restoration?

Criminogenic Risk Factors

- Seriousness of alleged offense
- Prior criminal record
- Flight risk
- Dangerousness in community

Clinical Risk Factors

- Substance abuse
- Medication compliance
- Stable living environment
- Severity of symptoms
- Insight into illness

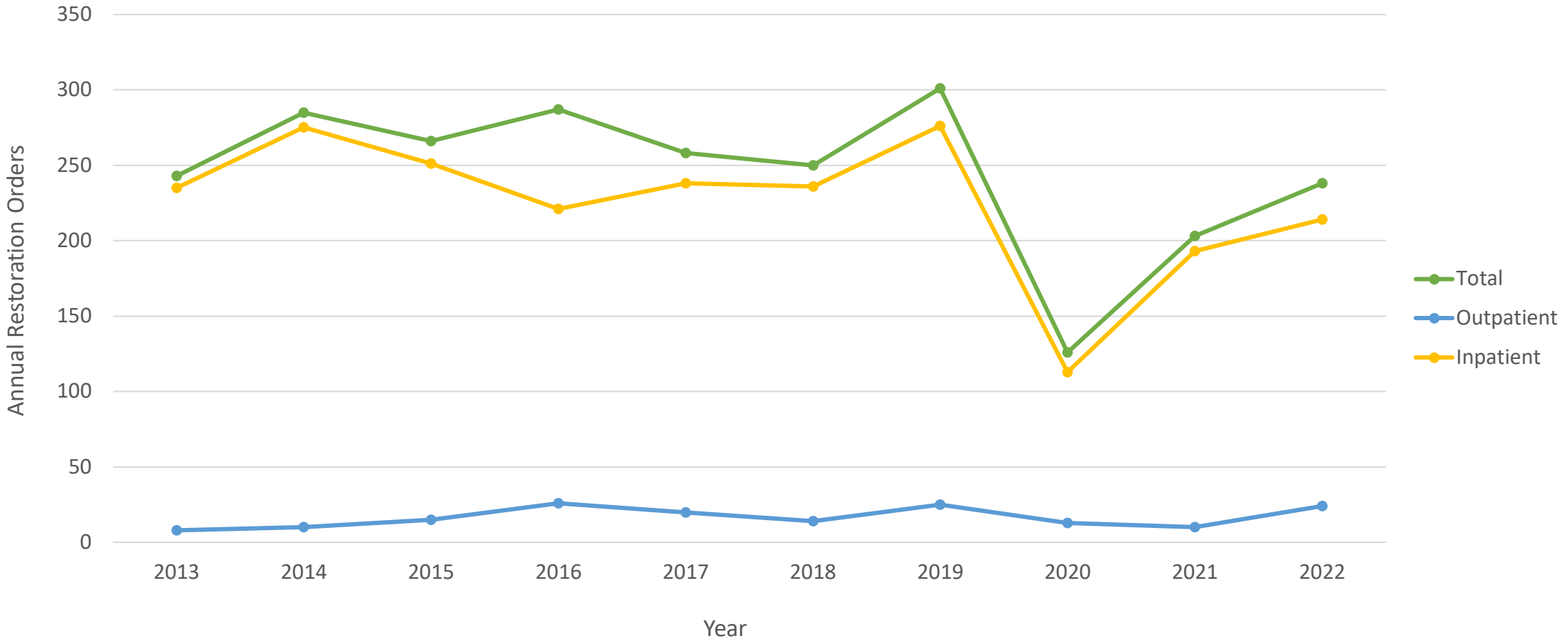
“Ideal” Community Restoration Candidate

- Misdemeanor offense(s)
- Stable living environment
- Access to transportation
- Already in treatment or agreeing to enter treatment
- No substance abuse
- No need for specialty evaluation/referral
- No question of malingering

“Ideal” Inpatient Restoration Candidate

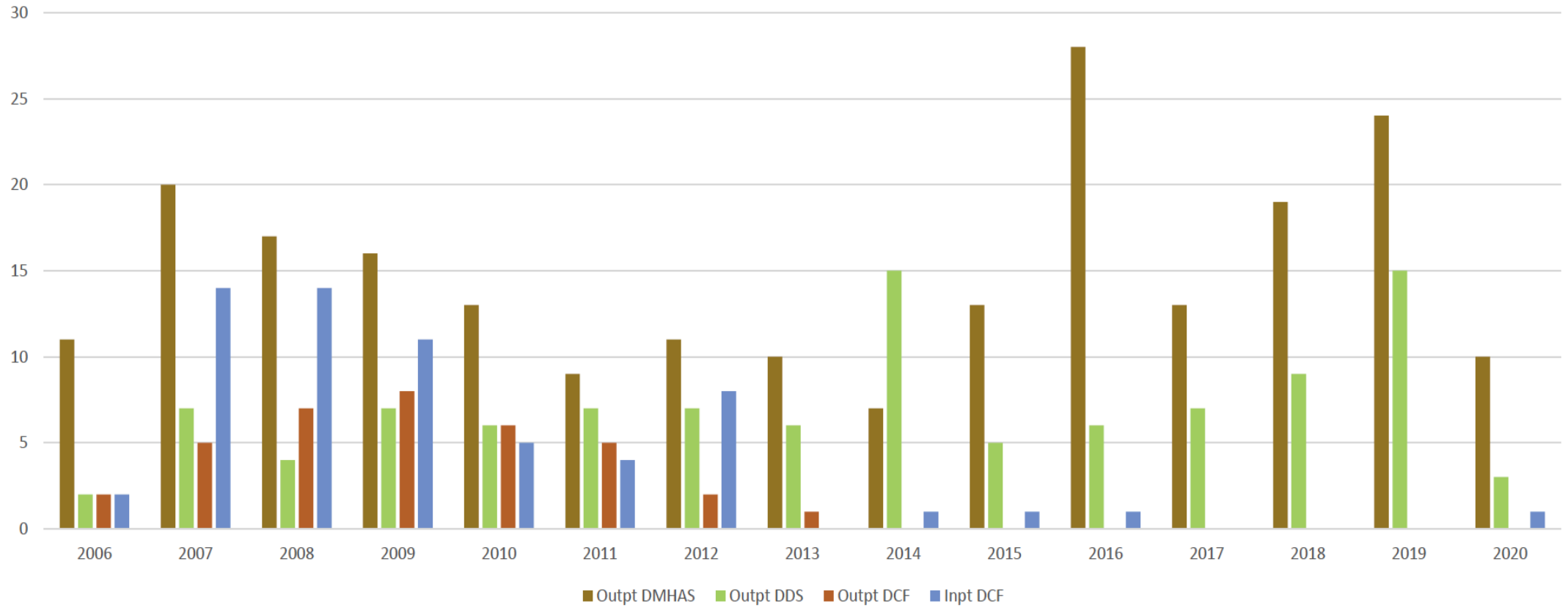
- Severe psychiatric symptoms (danger to self or others)
- Poor insight
- Need for involuntary medication
- Active substance abuse in community
- Homeless
- Question about malingering
- Serious criminal offense

DMHAS Competency Restoration Orders, 2013-2022



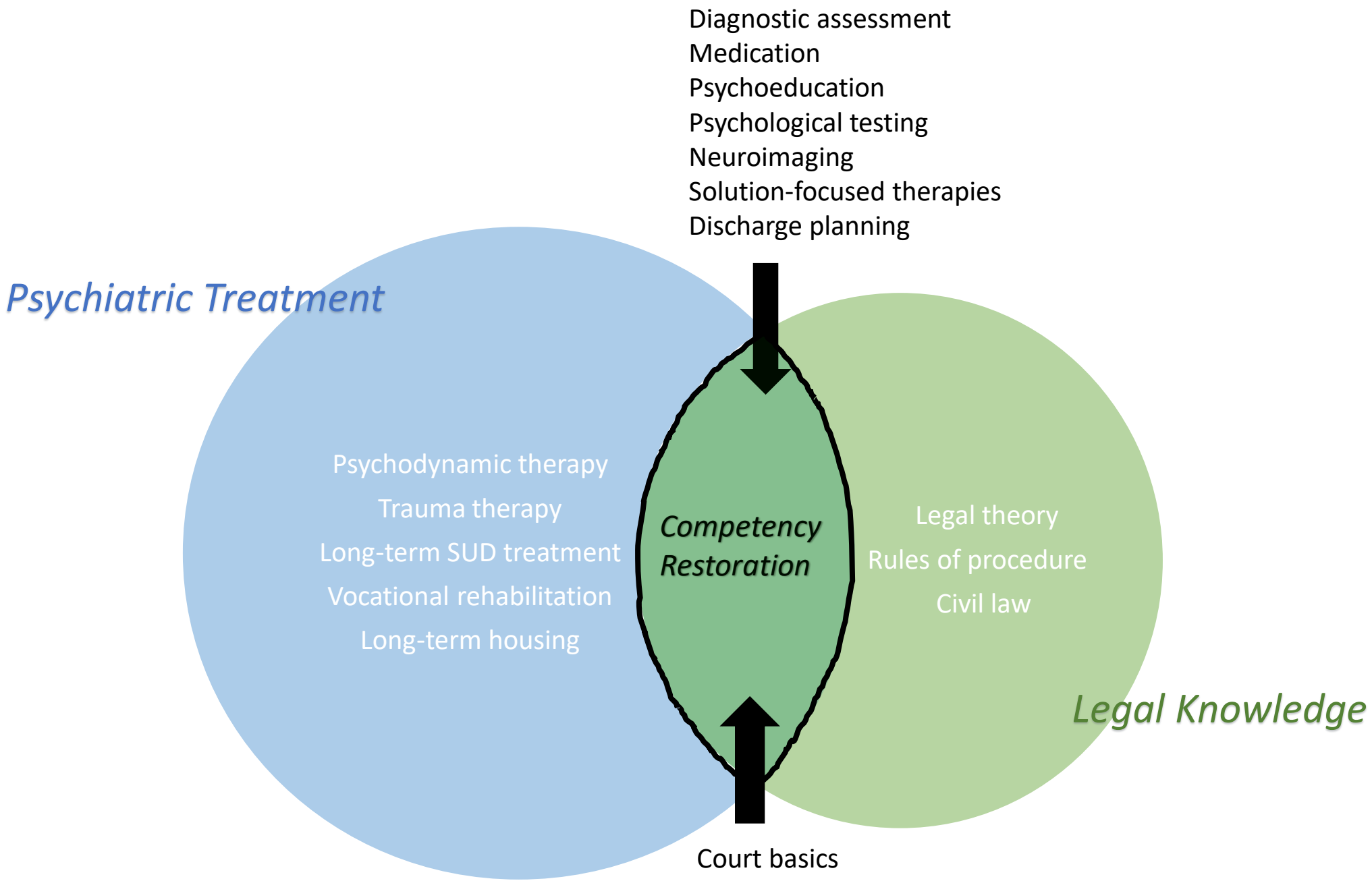
Outpatient Restoration 2006-2020: DMHAS, DDS, DCF

Source: CJPAC Presentation by Michael Norko, MD, 1/28/21



What happens during restoration?

- **Court Education**
  - Groups
  - Individual competency monitor/tutor
  - Periodic reassessment
- **Psychiatric Assessment & Treatment**
  - Medication (involuntary if needed)
  - Psychological testing, including validity measures
  - Neuroimaging
  - Specialty referrals
  - Psycho-education
  - Solution-focused therapies
  - Discharge planning


Diagnostic assessment
Medication
Psychoeducation
Psychological testing
Neuroimaging
Solution-focused therapies
Discharge planning
Psychiatric Treatment
Psychodynamic therapy
Trauma therapy
Long-term SUD treatment
Vocational rehabilitation
Long-term housing
Competency Restoration
Legal theory
Rules of procedure
Civil law
Legal Knowledge
Court basics

Services Available in Each Restoration Setting

	Inpatient	Community	Jail
Individual Court Education	X	X	X
Group Court Education	X	sometimes	rarely
Voluntary Medication	X	X	X
Involuntary Medication	X		
Neuroimaging	X	X	
Psychological Testing	X	sometimes	
Specialty Referrals	X	X	

Two Pathways for Involuntary Medication

C.G.S. 17a-543a

- Special Limited Conservator through Probate Court
- Reason: Defendant is incapable of giving informed consent for medication
- Time frame: typically 1-3 weeks

C.G.S. 54-56d (k)

- Health Care Guardian through Superior Court
- Reason: Defendant will not attain competency without medication
- Time frame: typically several months

How Often is Competency Status Reviewed?

- *Jackson v. Indiana* (1972): cannot hold a defendant indefinitely for restoration, only a "reasonable period of time"
- In Connecticut:
  - 18 months total restoration time for each CST order *(State v. Jenkins, 2008)*
  - must review case every 60-90 days
- Published studies from other states indicate about half of defendants are restored by 45 days, diminishing returns after 6 months of restoration

Restoration Length of Stay and Outcomes

- 191 restoration admissions to WFH in FY 2023
- Average length of stay = 99 days (range = 30-297 days)
- Outcomes
  - Competent = 76%
  - Not competent, not restorable = 22.5%
  - Converted to outpatient restoration = 0.5%

- Outpatient restoration → most are resolved outpatient, with small number referred for inpatient

Cost of Inpatient Restoration

Direct costs:

- $2634 for CVH bed (WFH cost likely higher)
- Average length of stay = 99 days in FY 2023
- **At least $260,766 per restoration**

Indirect costs:

- Using scarce state hospital beds for criminal rather than civil patients
- Separating defendants from family and supports
- Prolonging criminal-legal involvement for non-serious offenses

What happens after restoration?

- WFH arranges a discharge plan for all patients with a reasonable likelihood of being released to the community
- Not clear how many defendants return to jail (vs. release to community)
- Not clear how many cases are resolved at time of CST resolution

Non-Restorable Defendants

- 54-56d (m) → “Sub m” population
- Court can release to community or order DMHAS to apply for civil commitment in probate court
  - Court can be notified upon discharge from hospital
  - All other conditions (e.g., bond) should be vacated
- Periodic reviews for crimes that “resulted in the death or serious physical injury”
  - First review at 6 months
  - Then every 18 months until statute of limitations

Factors Associated with Non-Restorability

intellectual or communication limitations

brain injury (though can improve in first 18-24 months

Treatment-refractory psychosis

Major neurocognitive disorders (i.e., dementia)

Current State of CST Affairs

- Connecticut does not have the same CST crisis as other states, where long wait times and scarce resources are the norm

- But we can always improve!
  - Reduce the number of misdemeanor CST evaluations and restorations?
  - Enhance outpatient restoration services?
  - Improve the management of non-restorable defendants?

Thank you!