Report on Competency to Stand Trial

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EXECUTIVE SUMMARY

This report presents a comprehensive description of Connecticut's competency to stand trial (CST) process. It is the third report issued by the Connecticut Sentencing Commission in its multi-year study of the intersection of mental health and the criminal legal system in the state.[1] The mental health study began with a request in 2019 from Senator Catherine Osten and has included two earlier reports, published in 2020 and 2023, on the mental health needs of the state's incarcerated population.

The Commission's Mental Health Committee's focus on the CST process began with the findings of its delegation to the "Decriminalizing Mental Illness – The Miami Model" seminar in May of 2023. Returning from that program, members initiated a dialogue about the "Miami Model" and its potential implications for policy and practice change in Connecticut. Guided by the findings of three national task force reports for reform – the Council of State Governments (CSG, 2020), Substance Abuse and Mental Health Services Agency (SAMHSA, 2023a), and National Center for State Courts (NCSC, 2021) – the Commission undertook a systematic review of the CST process in Connecticut.

The Commission worked closely with the Connecticut Department of Mental Health and Addiction Services (DMHAS) in its review. As the main provider of CST evaluation and restoration services in Connecticut, DMHAS tracks and analyzes data on the CST process in the state, along with national trends and task force recommendations, to inform policy and practice changes. As a result, Connecticut has funded, implemented, and supported diversion programs, utilized community-based evaluations, and expanded outpatient restoration. Recently there has been an emphasis on creating additional avenues for diversion from competency and enhancing existing outpatient restoration services, including the piloting of the Enhanced Forensic Respite Bed (EFRB) program, a residential treatment program that provides an alternative to CST evaluation and/or inpatient restoration, in 2021. Limiting the use of the CST process in cases that are appropriate for diversion or dismissal aligns with the recommendations of the 2020 CSG report, "Just and Well: Rethinking How States Approach Competency to Stand Trial." EFRB's rollout was an important step in enhancing Connecticut's CST process.

In 2024, two significant events brought additional attention to the state's CST process: the passage of Public Act 24-137, which made changes to CST restoration for individuals facing only misdemeanor charges, and the Connecticut Supreme Court's oral argument in *State v. Jane Doe*. Public Act 24-137, which went into effect on October 1, 2024, made outpatient restoration the presumptive setting for individuals facing low-level charges. The oral argument in *State v. Jane Doe* on September 25, 2024, underscored the need for such reforms. Although the case was dismissed the following day on procedural grounds, the justices questioned the use of the competency restoration for a woman who was placed in inpatient restoration treatment for eight months, before the state entered a *nolle prosequi* on the misdemeanor charges.

[1] Other current research initiatives under this study include mental health diversionary programs and mental health treatment in reentry and community supervision.

Recognizing the need to continue enhancing Connecticut's CST system, this report is designed to support evidence-based decision making and allow stakeholders to evaluate the performance and chart the future of the state's CST process. The report begins with an introductory section on the legal framework of CST, followed by an overview of the scientific literature on CST practices. After an in-depth review of CST practices in Connecticut, it concludes with a discussion of policy recommendations.

Key findings of this report include:

- In the 10 years between 2013 and 2022, CST evaluations were ordered on 11,334 dockets in state courts, representing an annual average of 3% of criminal dockets processed during that period.
- Approximately 35% of individuals undergoing a CST evaluation were facing only misdemeanor charges.
- Some individuals undergo repeated CST evaluations. In a 10-year period, most defendants (79%) had one CST evaluation, but 14% of defendants had two CST evaluations, 4% had three, and 2% had four or more evaluations.
- Over 500 CST evaluations per year are completed by the DMHAS Office of Forensic Evaluations. This number had been growing slowly prior to the pandemic, though not at the dramatic rate seen in other states. After a dip between 2020 and 2022, evaluations in 2023 and 2024 reached pre-pandemic levels.
- Approximately 54% of defendants are found competent after an initial CST evaluation. 42% are found not competent but restorable (NC-R), and 4% are found non-restorable.
- Between 2013 and 2024, most NC-R defendants, 89%, were referred to DMHAS inpatient programs for restoration. Approximately 11% of NC-R defendants were referred to outpatient restoration programs (~7% to DMHAS, ~3% to Department of Developmental Services).
- Approximately 80% of individuals treated in the inpatient restoration program at Whiting Forensic Hospital are restored to competency, and approximately 20% are determined to be unrestorable.
- Approximately 55% of individuals treated in the outpatient restoration programs are restored to competency, 27% are recommended for inpatient restoration, and 17% are determined to be unrestorable.
- At the time of admission to Whiting for restoration, 68% of individuals were incarcerated and 32% of individuals were in the community. At the conclusion of an inpatient restoration program, more individuals are discharged to the community (56%) than to a correctional facility (31%). Approximately 14% of individuals remain hospitalized or in a skilled nursing facility, mostly after being found not competent and not restorable.
- The average length of stay in Whiting Forensic Hospital's inpatient restoration program is 90 days, with an average cost of over $200,000. In 2023, the state spent at least $40 million on inpatient restoration. The costs for outpatient restoration in Connecticut are not available for this report.

- Between 2018 and 2023, 48 cases were referred to the Department of Developmental Services (DDS) for outpatient competency attainment/restoration, and 10 of those individuals (21%) were deemed to have attained competency as a result.

Nationally, wait times for CST evaluations have been a significant problem; however, in Connecticut most evaluations occur within statutorily outlined time frames. In addition, defendants are almost always admitted to restoration programs on the same day they are found not competent, which is very different from other states, where defendants can wait in jail for months. Once admitted to the state hospital, the average length of stay in Connecticut is shorter than nationally published data, and restoration rates are consistent with nationally published data, indicating good efficacy of the treatment program in restoring individuals to competence. Some individuals that were incarcerated prior to the competency order do not return to a correctional facility after resolving their competency matter, indicating that restoration serves as an additional opportunity for diversion from the criminal justice system for some individuals with mental illness. Furthermore, Connecticut is one of 19 states that operates outpatient restoration programs, providing a pathway for individuals found to be not competent but restorable to receive treatment outside a hospital.

After declines in 2020 and 2021 due to the Covid-19 pandemic, the number of CST evaluations in Connecticut returned to pre-pandemic levels. It will be important for Connecticut to continue to monitor the trends, and to continue to explore alternative strategies to avoid similar increases that other states have experienced.

The Sentencing Commission notes two areas in the competency process that could benefit from additional evaluation. These areas involve individuals who are facing either the most or least serious criminal charges. On one end of the spectrum, 35% of CST evaluations involve individuals who are facing only misdemeanors, which raises questions about civil liberties and whether resources that are currently directed toward inpatient restoration could be better spent on outpatient services to help prevent individuals' involvement with the criminal legal system (e.g., mental health treatment, stable housing, peer supports, jobs, and education). On the other end of the spectrum, the state has no comprehensive system for managing individuals who have been found non-restorable of serious violent offenses.

In this context, the Sentencing Commission makes seven recommendations to improve Connecticut's CST system:

1. Ensure that stakeholders continue to meet regularly and discuss CST improvements, adding the Department of Developmental Services (DDS), the Department of Children and Families (DCF), and the Department of Social Services (DSS) to the discussions that already occur in the Commission's Mental Health Committee and the Office of Policy and Management's Criminal Justice Policy Advisory Committee (CJPAC). Furthermore, the voices of individuals with lived experience of the CST system should be heard in these settings.
2. Institute an annual CST reporting process, supported by a system for collecting and routinely analyzing data, about CST cases across the multiple state agencies involved.

3. Promote the use of all available and appropriate diversionary programs as alternatives to the CST system, to the extent allowed by statute.
4. Enhance outpatient competency restoration programs, as well as the services necessary to support them, such as stable housing, transportation, and treatment for a wide range of mental health and developmental challenges.
5. Create a multi-agency task force to revisit the question of how best to manage individuals who have been found non-restorable and face serious charges.
6. Ensure that the unique needs of individuals with intellectual and developmental disabilities, including, but not limited to, Autism Spectrum Disorder (ASD), are met by the CST system.
7. Expand research and data analysis in the CST system to include individuals with neurocognitive disorders (i.e., dementia) and acquired brain injuries (ABI), about whom little is currently known.

These recommendations are important steps to ensure that Connecticut remains a national leader regarding CST wait times and reduces the direct and indirect costs related to CST cases, especially for defendants who are not facing serious criminal charges.

INTRODUCTION AND BACKGROUND

Adjudicative competence, more commonly referred to as competence to stand trial (CST), is a centuries-old legal construct requiring that defendants be mentally fit (i.e., competent) when subjected to criminal proceedings. A 1960 U.S. Supreme Court case established the current two-pronged legal standard for CST: the defendant must have a rational and factual understanding of the proceedings against them, as well as the ability to assist in their defense (*Dusky v. U.S* (1960)). If a defendant falls short in either of these areas, the court will find them not competent to stand trial and may order a period of restoration. Restoration can occur in a hospital or outpatient setting, with some jurisdictions (not Connecticut) allowing restoration in a carceral setting. If restoration is successful, the court will find a defendant competent and allow the criminal prosecution to resume. If the defendant is not restored, the criminal prosecution is halted.

Competency evaluations are the most common type of mental health evaluation ordered by the courts (Melton et al., 2018; Murrie, 2023; Neal & Grisso, 2014). No national database exists to track the number of CST evaluations annually, but multiple sources indicate that such evaluations have increased dramatically since the 1990s. One study estimated the number of annual CST evaluations in the early 1990s as 60,000 (Bonnie & Grisso, 2000), while more recent estimates range from 94,000 to 130,000 (Owen et al., 2020; Murrie et al., 2023). This increase in demand for CST services has occurred in most areas of the country. In a 2020 survey of state mental health administrators across all 50 states, 82% of states reported an increase in referrals for CST evaluations, and 78% reported an increase in referrals for restoration (Warburton et al., 2020). Outside Connecticut, the increase in demand for CST services has led to long wait times in many jurisdictions, with some defendants waiting over a year before being admitted to an inpatient restoration program (SAMHSA, 2023). Thirty-nine percent of states reported facing litigation from advocacy groups because of these long wait times (Warburton et al., 2020).

Several factors may be contributing to the national increase in CST evaluations. Some scholars have pointed to a deterioration of community mental health services, which shuttles more individuals with serious mental illness into the criminal legal system because of inadequate supports and treatment in the community (Gowensmith, 2019; Murrie et al., 2023). In some cases, courts may be using the CST system as a "back door" to connect individuals with treatment services that are otherwise unavailable to them. Another hypothesis is that increased efforts to educate judges and attorneys about mental health issues have led to greater recognition of legitimate competency-related concerns and referrals for CST evaluation (Gowensmith, 2019).

To date, Connecticut has largely avoided the competency wait-time crisis that has driven national reform efforts. The number of annual CST evaluations and restoration orders has not grown dramatically over the past decade and wait times for evaluation and restoration remain minimal. Contributing factors may include the state's small size and centralized state government structure, allowing for greater ease of collaboration across agencies; concerted efforts at decarceration in the past 10-15 years, leading to fewer criminal prosecutions overall; substantial public and private resources devoted to mental health services; and a long-established network of jail diversion services for individuals with mental illness in the criminal courts.

Many scholars and advocates have described the current national situation as a "competency crisis" (Pinals & Callahan, 2020; Murrie et al., 2023). Responding to the growing issues across states, the Substance Abuse and Mental Health Services Administration (SAMHSA) sponsored a multi-year, national initiative around competency evaluations and restoration called the "Competence to Stand Trial and Competence Restoration Learning Collaborative" that operated from 2019 to 2022. Based on the lessons learned in this intensive program involving representatives of 14 jurisdictions and an extensive environmental scan and literature review, SAMHSA issued an updated version of its earlier 2017 report to inform understanding and improvement of the CST process. Incorporating the findings of two other comprehensive national studies (CSG, 2020; NCSC, 2021), the 2023 SAMHSA report offered a list of ten areas of national importance, while noting that "there is still insufficient evidence to support the creation of evidence-based recommendations or model policies" (p. 41).

SAMHSA's recommendations were remarkably consistent with the Council of State Governments (CSG) Justice Center's 2020 report, "Just and Well: Rethinking How States Approach Competency to Stand Trial" and the National Council on State Court's 2021 "Leading Reform: Competence to Stand Trial Systems." The three reports highlighted the importance of diversion away from the criminal justice system for individuals with serious mental illness and limiting the use of the CST process to only those cases with serious criminal charges and where diversion or dismissal is not appropriate. The reports also shared an emphasis on community-based, outpatient alternatives for evaluation and restoration; improvements in quality and efficiency of care through training and retention of staff; and research-based system improvement. The SAMHSA report also addressed the need for more research to inform CST policy and practice for juveniles and individuals with cognitive deficits.

In 2021, a legislative task force assigned to review practices at Whiting Forensic Hospital, the site of most inpatient competency restoration in Connecticut, made recommendations for CST improvement after its years-long assessment of the hospital (Task Force, 2021). The task force's recommendations were largely consistent with the national studies' findings. Regarding the CST system, the task force recommended to:

1. Expand opportunities for jail diversion at multiple points along the criminal justice process, reserving competency referrals for those cases where jail diversion is not appropriate;
2. Augment the existing structure for conducting competency restoration on an outpatient basis to avoid unnecessary referrals to the hospital; and
3. Promote cross-agency training and collaboration, including:
    a) Ongoing training for all court actors who play a role in requesting, opposing, or ordering competency evaluations (e.g., judges, prosecutorial officials, defense attorneys, public defender social workers, bail commissioners) regarding the non-judicial alternatives available to defendants who present as having an apparent behavioral health issue; and
    b) More regular, formal, and public meetings of the Behavioral Health Subcommittee of the Criminal Justice Policy and Advisory Committee (CJPAC), drawing on outside resources to gather information about the latest trends and issues confronting forensic mental health.

The current report aims to build upon the work of the national and state-specific task forces that have highlighted challenges in the CST system. The report provides an overview of the CST system in Connecticut, describing the state's history with CST legislation and the CST evaluation/restoration process as it exists today. Data about the CST system are included where available. The final section of the report makes state-specific policy recommendations, aiming to translate the national mandates for reform into local actions.

METHODOLOGY

Information regarding current DMHAS practices for CST evaluation and restoration was provided by DMHAS representatives with expertise in the subject matter. In addition, representatives of DDS and DCF involved in the management and implementation of the CST process provided review and input for the sections pertaining to the practices at their respective agencies.

The scientific literature on CST evaluation and restoration is vast, and an exhaustive review is beyond the scope of this report. Therefore, research analysts focused the literature review on national guidelines and practices from other jurisdictions that could help inform Connecticut's policy decisions. Databases including PubMed, Social Science Research Network (SSRN), and PsycINFO were queried for peer-reviewed publications from the past 20 years. In content areas where no current peer-reviewed publications exist, articles older than 20 years were included in the literature review. Research analysts supplemented peer-reviewed articles with relevant reports on CST published by important stakeholder groups in the past 10 years (e.g., National Association of State Mental Health Program Directors, American Bar Association, Center for State Governments, Conference of Chief Justices, The Arc National Center on Criminal Justice and Disability).

All data about CST evaluations or restoration presented in this report were obtained from DMHAS databases, which contained data through December 2024 in most, but not all, areas reviewed in this report. The Judicial Branch provided data regarding all CST orders in Connecticut courts between January 1, 2013, and December 31, 2022. These data included records from 11,334 dockets where a CST evaluation was ordered, including the date of the order, court, defendant's identifying information, charges, verdict, and sentence. To prepare the tables and figures presented in this report, the data were analyzed and matched with DMHAS databases regarding initial CST evaluations and inpatient restoration.

Some limitations to the data collection and analysis are important to note. First, the researchers found significant discrepancies between the CST-related data kept by DMHAS and those kept by the Judicial Branch. For example, of the 5,266 unique CST evaluation orders listed in the Judicial database during the 10-year study period, 419 evaluations did not appear in the statewide DMHAS database of CST evaluations conducted (when matched by name and date of CST order). Conversely, 88 cases that were present in the DMHAS database did not appear in the Judicial database. Thus, for any analyses that involved matching the two data sets, such as CST outcome analyses, the aforementioned 88 cases from the DMHAS database and the 419 evaluation orders from the Judicial Branch database were excluded, resulting in 4,847 total CST evaluations (involving 4,386 individuals, some of whom had multiple evaluations) over 10 years.

Second, it is important to note that most individuals undergoing a CST evaluation are facing multiple charges at once, often across multiple dockets and sometimes in multiple courts. When conducting analyses of the severity of each defendant's charges, each docket listed in the Judicial database was reduced to its most serious charge using the state's crime categorization system (e.g., Misdemeanor A-C, Felony A-E). If multiple dockets were included in one competency evaluation for a given defendant, only the most serious charge across all dockets was included in

the overall analysis of case severity. Violation of probation charges were excluded from the analysis altogether because their severity could not be accurately categorized with the available information. For example, the data provided by the Judicial Branch could not distinguish between a technical Violation of Probation charge, such as not attending a required treatment program, and a more serious violation, such as incurring new criminal charges. To avoid misinterpreting the severity of Violation of Probation charges, they were excluded from the analysis.

Finally, data limitations precluded the Commission from conducting some analyses. Not all data could be analyzed over a 10-year period; some data points were only tracked since 2020 (e.g., length of stay for restoration cases at Whiting Forensic Hospital). Overall, the data presented in this report illustrates the currently available knowledge about state-level CST practices, and it highlights the need for more systematic data collection and analysis, as noted in the *Recommendations* section.

Review of Scientific Literature on CST Practices

As noted above, an exhaustive review of the CST literature is beyond the scope of this report. The review was focused on areas that can help guide Connecticut's future CST policies and practices.

Professional Standards and Guidelines for CST Evaluation

Evaluation Methods

Detailed guidelines regarding the roles of mental health professionals in the CST process have been developed by the American Bar Association (1984, 2016), the American Academy of Psychiatry and the Law (Mossman et al., 2007a; Wall et al., 2018), and the Group for the Advancement of Psychiatry (1974). These guidelines delineate specific areas that CST evaluators must assess, such as psychiatric symptoms and diagnosis, the relationship between symptoms and psycho-legal abilities, and potential for restoration. The guidelines do not prescribe the use of a particular assessment instrument or specify the qualifications of the examiner.

Several CST evaluation tools have been developed and empirically validated, including the Competency to Stand Trial Screening Test (CST), Competency to Stand Trial Assessment Instrument (CAI), Georgia Court Competency Test (GCCT), Interdisciplinary Fitness Interview (IFI), Fitness Interview Test – Revised (FIT-R), MacArthur Competence Assessment Tool – Criminal Adjudication (MacCAT-CA), and Evaluation of Competency to Stand Trial – Revised (ECST-R). Each instrument has a different structure, method of administration, and scoring system, and each has benefits and drawbacks of its use. For example, the MacCAT-CA is a 22-item semi-structured interview measure that yields quantitative indices of three competency-related capacities aligned with the *Dusky* criteria: understanding, reasoning, and appreciation. The ECST-R is a 47-item semi-structured interview measure that yields four scales also consistent with the *Dusky* criteria: factual understanding, rational understanding, and ability to consult with counsel (the fourth scale being a combination of the latter two). Both instruments provide standardized administration and scoring, have good psychometric properties, and generally align well with one another, as well as with clinicians' judgment. The other instruments listed above follow a similar paradigm of structured interview and scoring.

Despite their strong evidence base and widespread use in CST research, standardized assessment instruments are not often used in clinical practice. More than one-third of forensic mental health evaluators who complete CST evaluations report that they rarely or never use forensic assessment or "forensically relevant" instruments (McLaughlin & Kan, 2014, p. 128). When asked how often they use these tools, 29% indicated "almost always," 13% reported "frequently," 21% endorsed "sometimes," and 37% reported "rarely or never" (McLaughlin & Kan, 2014; Murrie et al., 2020; Neal & Grisso, 2014). In another study, nearly 60% of an international sample of competency evaluators reported using at least one structured tool in their assessments, but these were typically more traditional psychological tests, such as intelligence, personality, or validity measures, rather than structured CST assessment tools. Only three

structured competency tests (MacCAT-CA, ECST-R, and the JACI, a tool for assessing juveniles' competency) made the "top ten" list of commonly used instruments, and, still, these were utilized only 5-6% of the time (Neal & Grisso, 2014; Murrie et al., 2020).

Evaluator Qualifications

In most states, only psychiatrists and psychologists are statutorily eligible to conduct CST evaluations (Mossman, 2007a; Gowensmith et al., 2015). In an effort to expand the pool of examiners and reduce wait times for evaluation, some states have recently changed the qualifications to allow social workers or other masters-level clinicians to perform evaluations (Gowensmith, 2019). Scholars have offered differing opinions on the level of training and licensure necessary for forensic evaluators, with some opining that masters-level clinicians can become proficient (Jackson et al., 2014; Roesch, 2015) and others arguing that only psychiatrists and psychologists should perform CST evaluations (Larson & Grisso, 2011). Several authors have attempted to examine whether there are differences in quality when evaluations are conducted by psychiatrists or psychologists. The studies have consistently demonstrated that there are no major differences in reliability or quality when evaluations are conducted by either psychologists or psychiatrists (Warren et al., 2006; Gowensmith et al., 2012; Petrella & Poythress, 1983; Robinson & Acklin, 2010). No published studies have yet examined the question of quality and reliability of reports when the pool of CST examiners is expanded to include masters-level clinicians.

Several states have implemented formal training and certification programs for CST evaluators, though this is not the norm across the country (Gowensmith et al., 2015). For example, in Massachusetts, psychologists and psychiatrists must attend a five-day "Foundations Training," pass a certification examination, engage in intensive mentoring by a more senior forensic evaluator, and submit at least two CST reports for blind peer review by a committee before becoming certified (Gowensmith et al., 2015). In Virginia, the University of Virginia provides a five-day training for forensic evaluators that culminates in a written exam. Upon completion of the training course and exam, individuals are eligible to perform court-ordered evaluations, though they are not formally certified or licensed (Gowensmith et al., 2015). Most other states do not require specialized training or certification for CST evaluators.

Research indicates that CST evaluations are among the most reliable of forensic mental health evaluations. Evaluators agree about a defendant's competence in 75-80% of cases (Guarnera et al., 2017), though the reliability can be affected by evaluators' training, experience, and biases (Zapf & Beltrani, 2023; Hill, 2022; President's Council of Advisors on Science of Technology, 2016). In the vast majority of cases, 90%, courts agree with the CST evaluator's recommendations about competence and restorability (Zapf & Roesch, 2009).

Initial CST Evaluations

Many studies have examined the characteristics of defendants who undergo CST evaluations, allowing for quantitative, systematic review of the issue (i.e., meta-analysis). A 1991 meta-analysis of peer-reviewed scientific studies (Nicholson & Kugler, 1991), compiling data from 30

studies and over 8,000 defendants evaluated between 1967 and 1989, found that, on average, 31% of defendants who had a CST evaluation ordered were found incompetent to stand trial (Nicholson & Kugler, 1991). Ninety percent of the defendants were male, and they were an average of 30 years old. Thirty-seven percent of defendants belonged to a racial minority group, 57% were never married, and 68% were unemployed. On average, the defendants had 10 years of education. Fifty-five percent had been charged with a violent offense, 50% had been previously arrested, and 39% had been previously hospitalized. Across studies, 39% of defendants were diagnosed with a psychotic illness (e.g., schizophrenia), and 6% had a diagnosis of intellectual disability.

A second meta-analysis was published in 2011 and included 68 quantitative studies and dissertations published from 1967 to 2007, with over 26,000 defendants in total. The rate of defendants who were found incompetent to stand trial (IST) was 28% (Pirelli et al., 2011). The average age of defendants undergoing CST evaluation was 33 years. Eighty-three percent of defendants were male, 53% white, 81% not married, and 65% unemployed. Similar to the 1991 study, defendants had 10 years of education on average. Forty-four percent were diagnosed with a psychotic disorder, and 6% were diagnosed with an intellectual disability. Forty-six percent had previous psychiatric hospitalizations, 62% had been arrested in the past, and 53% were currently charged with a violent crime.

These two meta-analyses also identified characteristics of defendants who were found competent, compared to those who were found incompetent (Nicholson & Kugler, 1991; Pirelli et al., 2011). In the first meta-analysis, the following defendant characteristics were associated with significantly higher IST rates: older age, female, and minority status. The highest correlations between defendant characteristics and IST were observed for (1) diagnosis of psychosis, (2) symptoms indicative of severe psychopathology (i.e., impaired memory and/or communication, disturbed behavior, delusions, hallucinations), and (3) poor performance on forensic psychological tests. Intellectual disability diagnoses and psychiatric symptoms such as disorientation, mood disturbance, and impaired judgment were not significantly associated with being found incompetent.

The second meta-analysis found that a psychotic disorder diagnosis was highly correlated with being found incompetent; defendants with a diagnosed psychotic disorder were eight times more likely to be found incompetent than those without. Furthermore, defendants with previous psychiatric hospitalizations and those who were unemployed were twice as likely to be found IST. Defendants found IST were slightly older (35 years) than competent ones (32 years). Incompetent defendants were more likely to be diagnosed with psychotic disorders and less likely to be diagnosed with substance use disorders or personality disorders than their competent counterparts.

Competency Restoration

Factors Associated with Restorability

Two recent meta-analyses by Pirelli and colleagues (2011, $N = 68$ articles; 2020, $N = 51$ articles) analyzed data from 1977 to 2013 regarding competency restoration times and treatments. The studies both found that 81% of IST defendants were restored to competency, with a median length of stay of 147 days and 175 days, respectively. The restoration methods that achieved these results were not described in detail (Pirelli et al., 2020). Thus, despite a large sample size of over 12,000 defendants, the authors were unable to conclude which of the utilized restoration methods was most effective, instead calling for more research in this area. When analyzing a subset of five articles that included a more rigorous study design (Advokat et al., 2012; Colwell & Gianesini, 2011; Morris & DeYoung, 2012; Tang, 2010; Thomas, 2010; total $N = 871$ defendants), the authors found a lower restoration rate of 57%. Defendants diagnosed with psychotic disorders and intellectual disabilities, as well as those with prior competency evaluations, had lower restoration rates compared to individuals diagnosed with personality disorders, substance use disorders, mood disorders, and those with a history of arrest.

Other scholars have found a number of clinical variables associated with decreased rates of restoration, mostly supporting the findings from Pirelli's meta-analyses. Factors associated with lower restoration rates include psychotic disorders (Colwell & Gianesini, 2011; Morris & Parker, 2008; Mossman, 2007b), intellectual disability (Gay et al., 2017; Mikolajewski et al., 2017; Morris & DeYoung, 2012), neurocognitive disorders (Demakis, 2018; Kivisto et al., 2020; Morris & Parker, 2009), greater number of previous psychiatric hospitalizations (Colwell & Gianesini, 2011; Mossman et al., 2007a; Tang, 2011), and lower scores on forensic global functioning tests (Advokat et al., 2012; Colwell & Gianesini, 2011). Furthermore, demographic and criminogenic variables, such as advanced age (Morris & DeYoung, 2012; Mikolajewski et al., 2017) and lower-level charges (Colwell & Gianesini, 2011) predicted decreased restorability. Recently, Aveson and colleagues (2023) described a neuropsychological framework for CST restoration, finding lower rates of competence in individuals with lower scores on measures of social intelligence/cognition and auditory verbal memory.

Setting of Restoration

Inpatient programs. A 2020 survey of state mental health directors (NRI, 2021) found that state hospitals are the most common location for restoration for both felonies (82%, $n = 41$) and misdemeanors (61%, $n = 30$). The average length of stay in these inpatient programs was 120 days ($SD = 52.2$) for individuals charged with felonies and 94 days ($SD = 39.9$) for individuals charged with misdemeanors. Restoration rates for inpatient programs vary across studies but are generally high, from 80-90% (Danzer et al., 2019).

The programmatic design of inpatient restoration programs generally includes a combination of psychiatric treatment and legal education. A multidisciplinary team provides different aspects of the program, which may include diagnostic assessment, psychotropic medication, psychological

testing, referrals for neurology and neuroimaging, assessment of malingering, and group and individual legal education (Wolber et al., 2011; Danzer et al., 2019). The American Academy of Psychiatry and the Law (Noffsinger et al., 2001) described a model competency restoration at a state hospital that included nine key elements: (1) objective competency assessment upon admission; (2) individualized treatment program; (3) multimodal, experiential educational experiences; (4) education about charges, sentencing, plea bargains, evidence, roles of court personnel, and the adversarial trial process; (5) anxiety reduction; (6) educational components for defendants with low intelligence; (7) periodic reassessments of competency; (8) medication; and (9) capacity assessments/involuntary treatment. Involuntary treatment such as psychotropic medication over a defendant's objection is generally only available in the inpatient setting (Danzer et al., 2019).

Outpatient programs. Outpatient competency restoration (OCR) began in Ohio in 1997, with Connecticut and Florida developing programs in 2001 and 2002, respectively (Heilbrun et al., 2019). As of 2018, although at least 35 states' statutes permitted outpatient restoration, only 19 jurisdictions were operating such programs: Arkansas, California, Colorado, Connecticut, Washington DC, Florida, Georgia, Hawaii, Louisiana, Minnesota, New York, Nevada, Ohio, Oregon, Tennessee, Texas, Virginia, and Wisconsin (Wik, 2018a). Outpatient restoration appears to be growing; in 2025, 32 states had established OCR programs (National Council of State Legislatures, 2025). Seven states prohibit OCR, and eight states do not explicitly address the location of the restoration (Gowensmith et al., 2016).

Research indicates that most OCR programs include elements similar to those described above for inpatient programs, including diagnostic assessment, medication management and adherence monitoring, targeted therapies as needed, and education about the judicial process. In addition, the programs typically include screening for use of drugs and alcohol, which are more readily available in the community than in inpatient restoration programs (Gowensmith et al., 2016). Some OCR programs, such as Hawaii's, occur in a residential setting and include additional supports such as case managers and peer mentors (Wik, 2018a).

Most OCR programs are located in urban settings because most referrals come from urban courts (Gowensmith, et al., 2016). OCR programs primarily serve men who are members of racial/ethnic minority groups, who are young to middle-aged, and who are psychiatrically stable with voluntary adherence to psychotropic medication. Participants presented a low risk of violence to the community, with charges ranging from misdemeanors to nonviolent felonies. Two thirds of participants in OCR programs had a psychiatric illness, with a majority diagnosed with a co-occurring substance use disorder. One third of participants had cognitive or developmental deficits (Gowensmith et al., 2016).

Restoration rates among OCR programs vary widely – from 18% to 95% – depending on the state and treatment protocols (Musgrove et al., 2018; Mikoljewski et al., 2017; Wik, 2018a). The majority of OCR programs have restoration rates that are similar to or lower than inpatient restoration rates, but interpretation of these statistics is difficult because inpatient and outpatient programs often serve different populations (Heilbrun et al., 2019). Gowensmith and colleagues (2016) analyzed outcomes of OCR programs from 13 states, finding an average restoration rate of 70% and a mean length of stay of 149 days. Adverse incidents, defined as criminal activity,

violence, or clinical decompensation resulting in termination from the OCR program, were relatively uncommon, affecting 16.7% of program participants (Gowensmith et al., 2016).

Jail-based programs. In recent years, many states have responded to the competency crisis by developing jail-based competency restoration (JBCR) programs. Virginia was the first state to develop and institute a JBCR program in 1997 (Roberson & Vitacco, 2022). Other states followed suit, including Arizona, Louisiana, California, Georgia, Colorado, New York, Utah, and Texas. According to Wik (2018b), nine states offer full-scale JBCR programs (i.e., as an alternative to inpatient restoration), though typically only in some jails, and three states offer time-limited JBCR services (i.e., until a bed becomes available at an inpatient program). JBCR programs typically admit defendants who do not pose an imminent danger to self or others, who are cooperative with treatment, and who have a likelihood of being restored in two to three months (Roberson & Vitacco, 2022). Some JBCR programs offer services within a separate unit in the jail akin to an inpatient psychiatric unit, including dedicated clinicians and intensive individual and group mental health treatment. Others provide psychoeducation, medication, and infrequent mental health contacts while defendants are housed in the general prison population (Murrie et al., 2023).

Literature addressing the effectiveness of JBCR programs is preliminary, and comparisons of cost and effectiveness are difficult due to substantial variations in program design and implementation (Danzer et al., 2019; Gowensmith & Murrie, 2022; Heilbrun et al., 2019; Murrie et al., 2023; Wik, 2018b). Restoration rates vary widely between the different programs, even between programs with very similar program models: 33% in Louisiana (Wik, 2018b); 40% in Georgia (Ash et al., 2020); 54% in California (Wik, 2018b); 71% in Colorado (Galin et al., 2016; Lewis et al., 2023); and 79% in Arizona (Morenz & Busch, 2011). For those who are not restored in the jail setting, some are diverted from the CST system altogether, while others are transferred to an inpatient program (Ash et al., 2020).

Scholars have noted that JBCR programs offer advantages in that they (1) reduce potential wait lists for defendants who need inpatient hospital restoration treatment, (2) allow defendants to receive restoration services earlier, and (3) save 50-80% of costs in comparison to state hospital restoration services (Kapoor, 2011; Ash et al., 2020). Some have described JBCR programs as part of a continuum of restoration services that also includes community-based and inpatient programs (Heilbrun et al., 2019; Ash et al., 2020; Jennings et al., 2021). Others have raised concerns about defendants being restored in highly restrictive, non-therapeutic correctional settings, which may lack adequate psychiatric expertise or even exacerbate psychiatric symptoms (Gowensmith et al., 2014; Danzer et al., 2019; Kapoor, 2020). Despite these concerns, some states have invested heavily in JBCR programs as an alternative to inpatient treatment. For example, as of 2017, only 10 patients per year in Arizona were being admitted for competency restoration, with the vast majority being restored in jail (Bloom & Kirkorsky, 2019).

Cost of CST Evaluation and Restoration

Scholars and advocates have noted that CST services are an expensive and ineffective method to care for individuals with serious mental illness who are repeatedly involved with the criminal legal system (Zotolla et al., 2023; Fader-Towe & Kelly, 2020; Miami-Dade County, 2016).

Precise costs are difficult to determine, but some scholars have attempted to compare different restoration settings. A 2023 report estimated that, in Texas, the average total cost of competency restoration per individual, accounting for cost associated with incarceration prior to and during treatment, was approximately $361,000 for placement in a non-maximum security hospital, $248,000 in a maximum security hospital, $55,000 for jail-based restoration, and $17,000 for outpatient programs (Texas Behavioral Health and Justice Technical Assistance Center & Texas Health and Human Services, 2023). The report also emphasized that the costs associated with inpatient restoration rise significantly when factoring in the time between arrest and hospital admission, as well as the period following discharge and before case disposition.

Other studies have examined the relative costs of jail-based and outpatient competency restoration compared to inpatient treatment. Ash et al. (2020) estimated inpatient restoration at approximately $750 per day and jail-based programs costing less than $250, even after including the costs of running a county jail. However, they cautioned that these savings may be offset when restoration fails in the less intensive jail setting and delays eventual transfer to inpatient care. Similarly, Taylor (2012) reported inpatient costs of $450 per day versus $278 for jail-based services. In Washington, D.C., outpatient restoration was estimated at $2,006 per week, substantially lower than the $6,307 weekly cost of inpatient treatment (Johnson & Candilis, 2015). Gowensmith and colleagues (2016) found that OCR programs save an average of $388 per participant per day when compared with inpatient restoration programs. However, Wik (2018a) cautioned that cost estimates of OCR programs do not always include all costs of sustaining an individual in the community, such as food and housing, so precise comparisons between inpatient and outpatient services are difficult.

Special Populations

Individuals with Intellectual Disabilities

As described above, Pirelli and Zapf's 2020 meta-analysis found that defendants with intellectual disabilities (ID) were found non-restorable, on average, in 27% of the cases across studies. Individual studies report a wide range of restoration rates, from 17% (Wall & Christopher, 2012) to 56% (Kleinginna, 2002). Appelbaum and Appelbaum (1994) emphasized the importance of assessing each defendant's functional abilities instead of just relying on intelligence test scores. While acknowledging that IQ scores are not the sole determinant of restorability, Grabowski and colleagues (2023) determined an IQ score cut-off of 63, above which participants were of greater likelihood to be restored.

In 2002, Anderson and Hewitt questioned the efficacy of specialized restoration programs for defendants with ID, finding low restoration rates in habilitation centers (as opposed to state hospitals designed for patients with mental illness). Ten years later, Wall and Christopher (2012) developed a unique restoration program using methods tailored specifically to defendants with ID—the Slater Method—at a public psychiatric hospital in Rhode Island. The program addresses three deficit areas commonly seen in individual with ID: cognitive, communication, and emotional/behavioral. It provides explicit guidance to clinicians regarding how to interview and educate such defendants to enhance comprehension and ensure a valid assessment. Specific

recommendations include using simple, concrete language; presenting information slowly, clearly, and repetitively; using open-ended questions and repeating questions from different perspectives; avoiding giving nonverbal cues that may inadvertently aid the defendant in responding; conducting more frequent, shorter sessions and minimizing distractions; and giving immediate, clear feedback (Wall et al., 2003; Wall & Christopher, 2012). In one study, use of the Slater Method resulted in 61% of defendants with ID attaining competency, in comparison to 17% of defendants attaining competency when treated in the usual competency restoration program (Wall & Christopher, 2012).

In 2017, the Arc's National Center on Criminal Justice & Disability (NCCJD) published a comprehensive report, "Competency of Individuals with Intellectual and Developmental Disabilities in the Criminal Justice System: A Call to Action for the Criminal Justice Community." According to the studies included in the report:

- 4 to 10 percent of adults charged with criminal offenses in the U.S. have an intellectual disability (self-reported);
- 6 to 16 percent of adult defendants deemed to be incompetent to stand trial have an intellectual disability diagnosis (data from the 1990s);
- 13 to 36 percent of individuals with an intellectual disability are found incompetent to stand trial after evaluation, as compared to 45 to 65 percent of individuals with schizophrenia or other psychotic diagnoses who undergo evaluation; and
- it is more likely for defendants with both an intellectual disability and mental illness or physical disabilities to be found incompetent than for those with intellectual disability alone.

Summarizing the available information, the NCJJD presented these key findings related to the experience and outcomes for individuals with intellectual and developmental disabilities in the competency process:

- Defendants with an intellectual disability are less likely than those with mental illness to attain competence.
- Defendants with intellectual disabilities without symptoms of mental illness, however, may not be suitable for medication interventions.
- Unlike their counterparts with mental illness, many defendants with an intellectual disability may never have been competent.
- Only about one-third to one-half of defendants with ID achieve competence, even when favorable conditions for placement and treatment are available.
- Treatment time is typically much longer for individuals with ID compared to a defendant who has a mental illness.
- There are concerns that individuals with intellectual disabilities obtain only a superficial level of competency that may not be long-lasting.

Juveniles

Juvenile Competency to Stand Trial (JCST) evaluations involve some unique considerations. While questions of competency in cases involving adults are concerned with underlying factors

related to mental illness and intellectual disability, juvenile competency also involves the natural maturation or developmental process. In comparison to adult CST evaluations, juvenile evaluations must factor in the defendant's responses to authority figures and susceptibility to undue influence by peers (Cunningham, 2020). Larson and Grisso (2011) recommended ten assessment categories specific to JCST evaluations, including responsibility (i.e., autonomy and self-reliance), temperance (i.e., ability to delay action and seek advice), perspective (i.e., ability to acknowledge complexity), developmental stage, judgment, future orientation, risk perception, peer influences, parent influences, and suggestibility. Several authors have noted that the Juvenile Adjudicative Competence Interview (JACI), a structured interview method, is a best practice for juvenile CST evaluations (Stepanyan et al., 2016; Wall et al., 2018; Cunningham, 2020), though its actual use in practice remains limited.

In the first compilation of state statutes and case law related to JCST, Redding and Frost (2001) identified 22 states with formal JCST laws and four that mentioned juveniles in some way in the adult statute. The authors found case law highlighting the importance of JCST assessment in nine additional states, as well as one state, Oklahoma, which indicated that competency was irrelevant in juvenile court. In the subsequent two decades, studies on various aspects of JCST statutes across states were undertaken, adding to the knowledge base (Bath & Gerring, 2014; National Center for Juvenile Justice, 2015; National Conference of State Legislatures, 2015; National District Attorneys Association, 2012; O'Donnell & Gross, 2012; Sanborn, 2009). Panza and colleagues (2020) conducted a comprehensive study of JCST using Larson and Grisso's framework (2011). The study aimed to produce an accurate and up-to-date compilation of all JCST statutes, to assess how frequently each aspect of Larson and Grisso's (2011) framework and best practice recommendations were addressed, and to identify areas for improvement. The authors found 27 states with JCST statutes and an additional 10 with reference to juveniles in existing adult statutes. In addition, two states (Alaska and Rhode Island) were silent on the issue, and another two (Montana and North Dakota) referred to the topic in case law (Panza et al., 2020).

A review of CST studies from 2010 to 2019 found that defendants aged 15 or younger were more likely to be found incompetent and less likely to be restored, as were those (juveniles) with intellectual disabilities and psychiatric diagnoses (Cunningham, 2020). Chien and colleagues (2016) reported similar findings, with IQ as the most robust predictor of restorability. A 2019 study found that restoration was successful in 66% of defendants aged 8–10 years, 80% of those aged 11–13 years, 76% of those aged 14–16 years, and 72% of those aged 17–18 years (Warren, 2019). In the same study, 62% of defendants completed restoration in three months or less, and 92% completed restoration in six months or less.

Connecticut-Specific Studies

Adults

Relatively little has been published about CST in Connecticut to date. Colwell and Gianesini (2011) reviewed the records of 71 male patients who had been court-ordered for competency restoration in Connecticut. Consistent with national averages, 75% of patients in the study were

restored to competency following a period of treatment. Compared to their restored counterparts, individuals ultimately determined to be non-restorable had slightly lower-level charges, twice as many prior hospitalizations, twice as many prior incarcerations, and 50% more prior episodes of incompetence. Likewise, these individuals had lower IQs and were more likely to be diagnosed with a cognitive or psychotic disorder, whereas those restored to competency were more likely to be diagnosed with a personality disorder. Non-restorable individuals were hospitalized nearly twice as long (M = 173 days) as those eventually deemed to be competent (M = 99 days). The results were consistent with prior (and subsequent) research indicating that non-restorability is related to "treatment-refractory illnesses, untreated or untreatable cognitive disorders, and generally poorer overall functioning" (p. 304).

In 2016, Gowensmith and colleagues conducted a survey of outpatient restoration programs in 16 jurisdictions, including Connecticut. Using data from 2014, the authors found that Connecticut's outpatient restoration rate of 75% was slightly above the average of 70% across all programs in the study.[2] The average length of stay in the program was 180 days, higher than the study's average of 149 days. Ten percent of program participants were involved in an adverse event (e.g., criminal activity, violence, or clinical decompensation requiring removal from the program), lower than the global average of 16.7%. The authors estimated that $388 per defendant per day was saved by utilizing outpatient restoration instead of inpatient hospitalization.

Norko and colleagues (2020) examined all admissions to the state forensic hospital for competency restoration from 2005 to 2011 to compare Connecticut's two mechanisms for involuntary medication (see *Competency Restoration* section below for a more detailed discussion of involuntary medication). Petitions for involuntary medication were filed and ruled upon in five cases in criminal court (0.3%) and in 177 cases (12.2%) in probate court. One hundred sixty (90%) of the 177 petitions filed in probate court were granted, and of those granted, 118 (74%) ultimately were restored to competency after receiving medication interventions. Three of the five petitions filed in superior court were granted (60%), and of those granted, two (67%) were restored and one was not. In sum, both mechanisms were effective in treating patients' psychiatric illnesses and restoring them to competency, though the petitions filed in the probate court resulted in a significantly shorter time to restoration (an average of 140 days) than did those filed in the superior court (an average of 300 days).

Juveniles

In an analysis of juvenile CST statutes and processes across the country, Panza et al. (2020) found that Connecticut's system aligned with 13 of 17 best practice recommendations (Larson and Grisso, 2011) for CST restoration/remediation programs, as well as five of 14 best practice recommendations for CST statutes. The authors ranked Connecticut in the middle of the 37 states responding to the survey, and they did not delineate which statutory or programmatic components were missing.

[2] The data in Gowensmith's article differ from the OFE's internal data (collected in 2023), which show that 11 cases were referred for outpatient restoration in 2014, with a 45% restoration rate. It is unclear what accounts for the discrepancy.

Chien and colleagues (2016) conducted a study of all juvenile defendants referred for inpatient competency restoration in Connecticut between January 1, 2005, and December 31, 2012. This group of sixty-one juveniles under the age of 18 had been found IST and were remanded for inpatient restoration at the Albert J. Solnit Center. The age range for the group was 12-17, with a mean age of 15. The study examined demographic and clinical factors associated with likelihood of restoration. The findings were somewhat surprising, as only IQ was found to correlate with successful competency restoration, in contrast to variables such as psychiatric diagnosis, age, race/ethnicity, and type of crime. Juveniles with a higher IQ were significantly more likely than counterparts with a lower IQ to be restored.

CST Practices in Connecticut

Legislative History of C.G.S. § 54-56d

Connecticut General Statutes (C.G.S.), Section (§) 54-56d, states that "a defendant is not competent if the defendant is unable to understand the proceedings against him or her or to assist in his or her own defense." Originally enacted in 1949, C.G.S. § 54-56d has been amended over the years in accordance with state and federal case law. In 1967, the "ability to assist" prong was added to the initial "understanding of the proceedings" prong, aligning the statute with the holdings from *Dusky v. U.S.* (1960) and recognizing that more process-related elements (e.g., attending to and following the proceedings, communicating effectively with counsel, and making rational, informed decisions about one's case) are as important as having a simple understanding of the proceedings. In addition, verbiage specifying the maximum period of commitment for restoration (that is, eighteen months or the maximum exposure for the pending charges, whichever is less) was added in 1969, while *Jackson v. Indiana* (1972) was making its way through the federal appellate system to the U.S. Supreme Court. Throughout the 1970s and 1980s, several revisions were made to clarify or update the statutory language or to change various procedural elements of CST (e.g., time frames for evaluations, qualifications of the evaluators, when a hearing must be held. See, for example Public Act 81-365). In 1996, the clear and convincing standard of proof was amended to a preponderance of evidence standard in accordance with *Cooper v. Oklahoma* (1996).

Beginning in 1998, the statutory procedures allowing involuntary treatment of individuals found not competent to stand trial were revised several times. First, C.G.S. § 54-56d(k) was amended to codify the holding in *State v. Garcia* (1995), allowing a judge to appoint a healthcare guardian to oversee the healthcare interests of an incompetent defendant. Upon advisement by the healthcare guardian, the judge could authorize the administration of medications after finding by clear and convincing evidence that the medications would be effective in restoring competency, that adjudication could not be attained using less intrusive means, that the proposed medication plan was narrowly tailored to minimize intrusion on a defendant's liberty and privacy interest, that the medication would not cause unreasonable risk to the defendant's health, and that the seriousness of the case was such that the state's interest in prosecuting superseded the defendant's self-determination interests (loosely modeled after *Riggins v. Nevada* (1992)). In 2004, in response to the dicta in *Sell v. United States* (2003), Public Act (PA) 04-160 created a second pathway to involuntary medication for defendants found incompetent to stand trial (C.G.S. § 17a-543a). Under this law, a Special Limited Conservator (SLC) could be appointed by the probate court after a finding that the defendant was incapable of providing informed consent to medication and that such medication was necessary for the treatment of a psychiatric condition. This pathway was intended to parallel the process for involuntary medication of civil patients. Under the SLC statute, the SLC rather than the judge could authorize the administration of medications.

In between the two major changes to the involuntary medication statutes in 1998 and 2004, "Track II" (C.G.S. § 543-46d(h)) was created in PA 03-3, June Special Session, §§ 13-17. This statutory amendment created a mechanism to admit a defendant who is not competent to the hospital as a civil patient rather than for competency restoration. The change was prompted by the fact that, at the time, there was a process for involuntary medication of civil patients but not

for competency restoration patients who had less serious charges. If a patient with less serious charges refused to accept needed medication voluntarily, they could more effectively be treated under Track II (i.e., under civil commitment) than under competency restoration. A Track II admission, if successful, also had the benefit of leading to a *nolle prosequi* or dismissal of charges. After the 2004 statutory change that created the SLC process for involuntary medication of CST patients, Track II has been used sparingly, though it remains part of the statute.

Several statutory changes also were made regarding individuals found not competent and not restorable over the years. The first change, in 1998, allowed for periodic re-examination of a defendant's competency after being found not competent and not restorable for charges that resulted in death or serious physical injury; the first such review may occur six months after the initial finding of non-restorability. Following a state supreme court case in 2008, *Connecticut v. Jenkins*, it was determined that "placements for treatment must be treated cumulatively for purposes of applying the eighteen month time limitation;" that is, eighteen months is the maximum period for a particular set of charges and does not start over with each new restoration period. In 2018, PA 18-134 lengthened the interval between periodic examinations to every 18 months if an individual was determined to be not competent and not restorable after the first periodic review.

Two other significant changes related to non-restorable defendants were made to the statute in 2007 and 2010. First, PA 07-153 created a process whereby a person found non-restorable could be referred to an appropriate and available outpatient treatment setting as an alternative to being referred for civil commitment to a hospital. This change was made so that individuals who were living in a stable community setting at the time of their non-restorable finding would not be unnecessarily uprooted from their supports. Subsequently, in PA 10-28, courts were entitled to request notification from DMHAS when an individual who was found non-restorable and subsequently civilly committed was released from DMHAS' custody, as long as the statute of limitations had not expired. In PA 11-15, language was added to allow transfer of a patient from a hospital to an outpatient setting for continued restoration treatment if a hospital level of care was no longer required, thus more explicitly encouraging a shift to outpatient restoration where appropriate.

In October 2012, pursuant to PA 12-1, June 12, 2012 Special Session § 268, changes were made regarding the evaluation of juvenile defendants, stipulating timelines for competency reports and restoration and mandating that juvenile CST evaluations be conducted by clinicians familiar with child and adolescent psychology and psychiatry. PA 12-1 also allowed for restoration in the Department of Correction (DOC) of defendants who presented significant security, safety, or medical risks such that they could not be maintained in a psychiatric hospital (C.G.S. § 54-56d(p)). It also allowed for the appointment of a health care guardian for such defendants while in the DOC, allowing involuntary medication for competency restoration to be continued in jail.

Between 2013 and 2015, a special working group was convened to review the system for managing defendants found non-restorable of serious charges, with the goal of making recommendations to the legislature of revising subsection (m) of C.G.S. § 54-56d. The work group met for approximately two years and considered strategies such as committing non-restorable defendants charged with serious offenses to the jurisdiction of the Psychiatric Security

Review Board (PSRB) or of the probate court, or to special oversight by the superior court. However, the stakeholders were unable to agree on recommendations. For example, there was concern from the Office of the Chief Public Defender about the ethics of representing a client who is not competent at any hearing that might have substantial consequences for the defendant. Additionally, there was no support at the time for referring these defendants to the PSRB or to the probate court, and there were concerns about mechanisms for review of treatment services by the superior court. As a result, no report for the legislature was generated.

Court Orders for Competency Evaluations

All criminal defendants are presumed to be competent (*Medina v. California*, 1992). Any party (defense attorney, prosecutor, or the court *sua sponte*) may request a competency evaluation at any time during the proceedings if they have a "bona fide doubt" about the defendant's competence (*Drope v. Missouri,* 1975). In most cases, defense counsel requests a CST evaluation, but the court or prosecutor may do so, even over the defendant's objections (*Pate v. Robinson,* 1966). The burden of proving a defendant not competent lies on the party raising the issue by a preponderance of evidence (*Medina v. California*, 1992; *Cooper v. Oklahoma*, 1996).

Data obtained from the Connecticut Judicial Branch indicate that CST evaluations were ordered in 11,334 of the total dockets processed by the criminal courts between 2013 and 2022, or approximately 3% of cases. Many defendants faced charges on multiple dockets at the time of the CST order, so the 11,334 dockets equate to 5,266 unique CST orders between 2013 and 2022.

Data from the DMHAS Office of Forensic Evaluations indicate that, over the twelve-year period between 2013 and 2024, 6,257 CST evaluations were conducted, stemming from orders in every Geographical Area (GA, or the lower court) and Judicial District (JD, or the higher court), as illustrated in Table 1.

Table 1. Competency Orders, 2013-2024 (*N* = 6,257 cases)

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	Total
Geographical Area Courts													
GA01 Stamford	23	26	40	59	41	39	51	17	31	41	57	82	**507**
GA02 Bridgeport	36	50	58	84	61	74	68	37	53	72	89	54	**736**
GA03 Danbury	9	16	22	15	19	17	21	6	10	17	16	17	**185**
GA04 Waterbury	29	32	38	26	26	23	34	9	24	16	37	31	**325**
GA05 Derby	7	14	10	8	8	10	11	5	9	9	6	4	**101**
GA07 Meriden	28	35	24	32	28	34	29	15	19	16	29	23	**312**
GA09 Middletown	9	7	7	11	10	11	16	9	14	7	20	13	**134**
GA10 New London	22	33	28	30	35	21	38	18	36	52	56	51	**420**
GA11 Danielson	15	17	11	14	14	18	21	10	19	23	26	23	**211**

GA12 Manchester	30	18	23	23	21	25	51	14	11	23	18	16	**273**
GA13 Enfield	8	14	12	7	6	7	8	0	1	4	1	0	**68**
GA14 Hartford	51	52	52	48	38	36	41	30	22	38	35	38	**481**
GA15 New Britain	35	38	52	35	69	50	37	21	23	19	50	52	**481**
GA17 Bristol	10	5	6	8	11	13	11	0	0	0	0	0	**64**
GA18 Torrington	21	13	12	16	11	10	6	3	3	10	3	11	**119**
GA19 Rockville	11	20	14	13	17	13	20	6	13	20	10	10	**167**
GA20 Norwalk	14	11	16	16	25	21	16	4	3	13	0	0	**139**
GA21 Norwich	11	27	19	26	15	10	20	9	18	19	27	15	**216**
GA22 Milford	18	18	8	13	21	20	22	11	15	13	13	9	**181**
GA23 New Haven	30	39	44	35	29	26	41	13	27	25	20	39	**368**
Hartford Community Court	2	5	0	3	2	1	2	0	0	1	0	3	**19**
Judicial District Courts													
JD Ansonia/Milford	8	5	1	4	1	2	2	6	5	2	8	1	**45**
JD Bridgeport	6	2	12	8	13	6	7	5	7	5	8	10	**89**
JD Danbury	5	0	6	10	9	2	13	1	6	6	4	2	**64**
JD Hartford	15	18	11	9	16	8	14	4	9	19	11	13	**147**
JD Middlesex	0	1	2	0	0	1	3	0	4	3	2	1	**17**
JD New Britain	1	2	0	2	2	3	8	2	5	3	6	4	**38**
JD New Haven	5	11	12	7	6	8	9	3	9	6	5	8	**89**
JD New London	6	4	5	5	11	9	8	1	5	4	7	6	**71**
JD Stamford-Norwich	1	3	4	3	8	5	7	3	5	4	6	6	**55**
JD Rockville	0	0	0	0	0	0	0	0	0	0	0	3	**3**
JD Torrington	3	0	4	3	3	3	3	4	8	1	3	5	**40**
JD Waterbury	6	7	8	5	5	6	3	7	1	4	3	2	**57**
JD Windham	1	2	4	4	7	5	2	2	1	3	1	2	**34**
JUV New Britain	0	0	0	0	0	0	0	1	0	0	0	0	**1**
Total	**476**	**545**	**565**	**582**	**588**	**537**	**643**	**276**	**416**	**498**	**577**	**554**	**6257**

Source: Connecticut Department of Mental Health and Addiction Services.
Note: The yearly counts of CST evaluations do not match the yearly totals reported in Table 2 due to differences in reporting between the Judicial Branch and the DHMAS. Data received from the Judicial Branch uses the date the CST evaluation was ordered. Data from DHMAS reports the date the CST evaluation was completed. Also, as noted in the methods section above, there are some evaluations that appear in DMHAS data that do not appear in the Judicial data and vice-versa.

Notably, 1,243 of the total CST orders (~20%) stem from just two GA courts: Stamford and Bridgeport. It is not clear what accounts for this finding, but the number of CST orders appears disproportionate to the volume of criminal cases processed in those jurisdictions.

A substantial number of competency evaluations were ordered in cases where the defendant's most serious charge was a misdemeanor. Between 2013 and 2022, 35% of court orders fell into this category, as noted in Table 2.

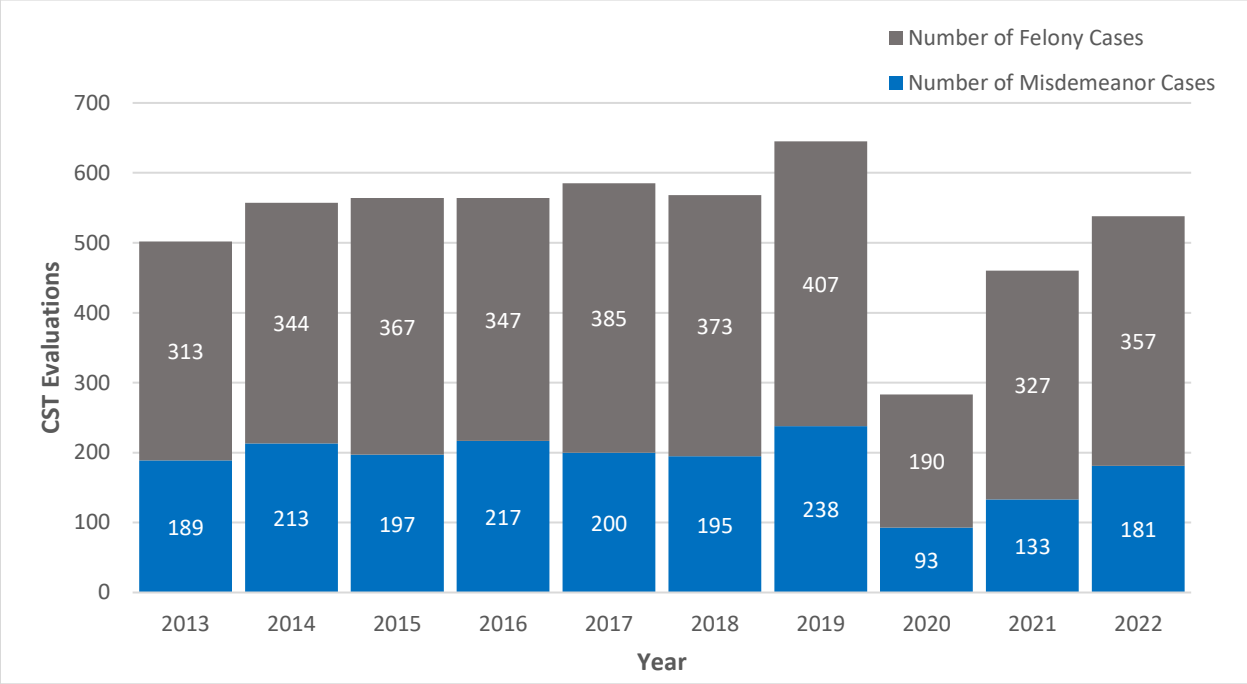
Table 2. Seriousness of Charges in CST Evaluation Cases, 2013-2022 (*N* = 5,266)

Year	Number of Misdemeanor Cases (%)	Number of Felony Cases (%)	Total (%)
2013	189 37.6%	313 62.4%	**502** **100.0%**
2014	213 38.2%	344 61.8%	**557** **100.0%**
2015	197 34.9%	367 65.1%	**564** **100.0%**
2016	217 38.5%	347 61.5%	**564** **100.0%**
2017	200 34.2%	385 65.8%	**585** **100.0%**
2018	195 34.3%	373 65.7%	**568** **100.0%**
2019	238 36.9%	407 63.1%	**645** **100.0%**
2020	93 32.9%	190 67.1%	**283** **100.0%**
2021	133 28.9%	327 71.1%	**460** **100.0%**
2022	181 33.6%	357 66.4%	**538** **100.0%**
TOTAL	**1856** **35.2%**	**3410** **64.8%**	**5266** **100.0%**

Source: Connecticut Judicial Branch.
Note: The yearly counts of CST evaluations do not match the yearly totals reported in Table 1 due to differences in reporting between the Judicial Branch and the DHMAS. Data received from the Judicial Branch uses the date the CST evaluation was ordered. Data from DHMAS reports the date the CST evaluation was completed. Also, as noted in the methods section above, there are some evaluations that appear in DMHAS data that do not appear in the Judicial data and vice-versa.

The same data from Table 2 are depicted graphically in Figure 1. The percentage of cases where defendants are facing only misdemeanor charges was relatively stable over the ten-year period between 2013 and 2022, even when the total number of evaluations dropped dramatically in the COVID-19 pandemic.

Figure 1. CST Evaluations by Offense Type, 2013-2022



No data are available regarding gender, race/ethnicity, or other important demographic characteristics of CST evaluees in Connecticut because neither DMHAS nor the Judicial Branch systematically tracks this information. Thus, it is not possible to compare Connecticut's CST population with the published scientific literature in these areas. Data from the Judicial Branch is available regarding defendants' age at the time of CST order. These data (N = 5,266) indicate that, on average, defendants were 39 years old (SD = 14.11; Range = 76.74, [15.18, 91.92]).

Initial Competency Evaluations

Once an evaluation has been ordered by the court, the DMHAS Office of Forensic Evaluations (OFE) conducts the initial evaluation of competency. There are four OFEs in Connecticut, located in Hartford, New Haven, Bridgeport, and Norwich, and each is responsible for conducting CST evaluations for several GA and JD courts within their region. Each OFE is affiliated with one of DMHAS' Local Mental Health Authorities, with central administration for OFEs located within DMHAS' Forensic Services Division in Middletown (OLR report, 2017).

Table 3 details the number of CST evaluations annually from 2013 to 2024, as well as the OFE's recommended findings regarding competency.[3] On average, 54% of defendants were

recommended as competent by the OFE. Of the remaining cases, most were recommended as restorable (41.7%), while a small number were recommended as non-restorable (4.3%).

Table 3. Annual CST Evaluations, 2013-2024

YEAR	Total Evaluations[4]	Competent (%)	Not Competent but Restorable (%)	Not Competent and Not Restorable (%)
2013	**476**	262 (55.3%)	192 (40.5%)	20 (4.2%)
2014	**545**	270 (49.5%)	248 (45.5%)	27 (5.0%)
2015	**565**	309 (54.7%)	236 (41.8%)	20 (3.5%)
2016	**582**	310 (53.3%)	247 (42.4%)	25 (4.3%)
2017	**588**	347 (59.0%)	216 (36.7%)	25 (4.3%)
2018	**537**	300 (55.9%)	211 (39.3%)	26 (4.8%)
2019	**643**	355 (55.2%)	260 (40.4%)	28 (4.4%)
2020	**276**	160 (58.0%)	99 (35.9%)	17 (6.2%)
2021	**416**	227 (54.7%)	167 (40.2%)	21 (5.1%)
2022	**498**	267 (53.6%)	218 (43.8%)	13 (2.6%)
2023	**577**	303 (52.5%)	252 (43.7%)	22 (3.8%)
2024	**554**	265 (47.8%)	261 (47.1%)	28 5.1%)
TOTAL	**6257**	**3375**	**2607**	**272**
AVERAGE	**521(100.0)**	**281 (54.0%)**	**217 (41.7%)**	**23 (4.3%)**

Figure 2 illustrates the trends in CST evaluations between 2013 and 2024. Prior to the COVID-19 pandemic in 2020, CST evaluations were relatively stable, with perhaps a slight upward trend. Evaluations fell dramatically in 2020 and 2021, when courts were operating on limited schedules. By the end of 2023, however, they had reached pre-pandemic levels, and this held steady in 2024. Overall, Connecticut has not seen the dramatic uptick in CST evaluation requests that other states have reported over the past decade, but firm conclusions are difficult to draw because of pandemic-related disruptions to the usual flow of courts and CST cases.

[4] In a small number of cases each year (<1%), the OFE cannot make a recommendation about competency because of the defendant's lack of cooperation. Thus, in some years, the total number of evaluations conducted exceeds the number of evaluations with a finding (Competent, NC-R, or NC-NR).

Figure 2. CST Evaluations, 2013-2024

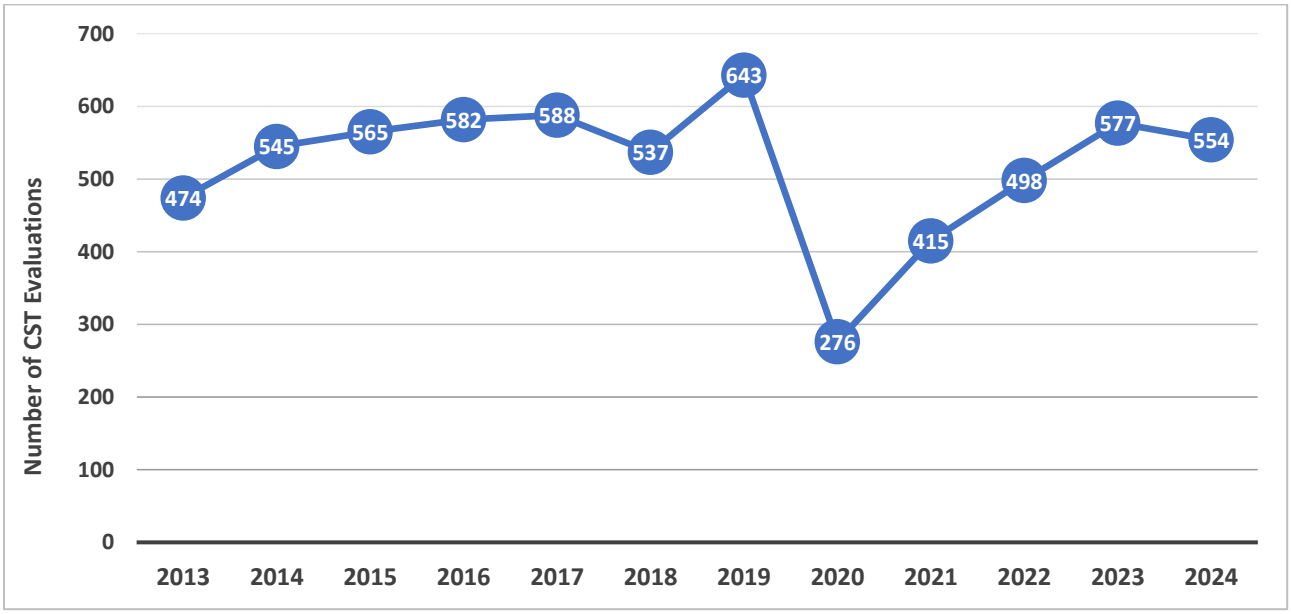


Table 4 illustrates the number of defendants who have undergone multiple CST evaluations. The majority of defendants (79%) had only one CST evaluation completed in a twelve-year period (2013-2024), whereas 14% and 4% of defendants had two and three evaluations, respectively. Two percent of defendants had four or more CST evaluations completed in this period.

Table 4. Number of CST Evaluations per Defendant, 2013-2024

Number of CST Orders per Defendant	Number of Defendants	Percent
1	3833	79.1%
2	694	14.3%
3	208	4.3%
4	75	1.5%
5 or more	35	0.7%
Total	**4845**	**100.0%**

Connecticut's competency statute allows initial CST evaluations to be conducted by either a psychiatrist or a three-person team consisting of a psychiatrist, psychologist, and either a clinical social worker or an advance practice registered nurse. When a CST evaluation is ordered by the court, the responsible OFE assigns the evaluation to be conducted by an individual or a team. The CST examination must be completed by the OFE within 15 business days of the court's order and a report filed with the court within 21 business days of the order. The court also may, at

the request of counsel or at its own discretion, order an independent CST evaluation by a private psychiatrist/psychologist to provide a second opinion to that offered by the OFE.

If the defendant is incarcerated, the initial CST evaluation occurs either in person at the correctional facility or virtually using video-conferencing software. If the defendant has been released on bond or a promise to appear, the evaluation typically occurs at the OFE office. Occasionally, evaluations are conducted in hospitals, nursing homes, or residential placements, depending on where the defendant is located when the CST order is issued by the court.

The evaluating professional(s) engage in an evaluation with three component parts: (1) an interview of the defendant; (2) a review of relevant records (e.g., police reports, court documents, medical records); and (3) communication with relevant collateral informants (e.g., the defendant's attorney, treatment providers, family members).

During the interview, the evaluator(s) strive to obtain the following information to inform their evaluation, either from the defendant directly or from the relevant records when available:

1. Current legal charges
2. Background information
    a. Developmental history
    b. Social/relationship history
    c. Educational history
    d. Employment history
    e. Military history
    f. Family history
3. Legal history
4. Medical history
5. Psychiatric history
6. Substance use history

The evaluator(s) also conduct a mental status examination. This includes an assessment of the defendant's awareness, alertness, orientation, basic cognitive function, general fund of knowledge, and capacity for abstract reasoning. The evaluator(s) then assess the individual's factual and rational understanding of the court proceedings. This includes an evaluation of the individual's knowledge of courtroom personnel (e.g., relevant courtroom terminology) and procedures (e.g., understanding the course of a trial or the plea-bargaining process) and whether symptoms of a mental illness or cognitive disorder are interfering with their capacity to have a rational understanding of the proceedings. The evaluator(s) finally assess the defendant's ability to assist in their own defense, which may entail an assessment of the defendant's past experiences working with attorneys, view of their relationship with their current attorney, ability to bring forward relevant information and identify contradictions, and capacity to align their behavior with the expectations of the court.

In their report, in addition to making a recommendation to the court regarding the defendant's competence, the evaluator(s) are asked by the court to determine whether there is a substantial probability that the defendant can be restored to competency within the time allowed by law if

provided a course of treatment. The maximum period allowed for restoration is eighteen months or the maximum exposure for the defendant's charges, whichever is less. If there is not a substantial probability of restoration, the evaluator(s) must then recommend to the court whether the defendant is eligible for civil commitment (OLR, 2017).

After the evaluation, the court holds a hearing within 10 days of receiving the evaluators' report. At the hearing, either the defendant or the state's attorney may introduce evidence pertaining to the defendant's competency, including the evaluators' report. If the report is introduced as evidence, then at least one of the examiners must be available to testify regarding its findings. If the examiners' report recommends that the defendant is competent, then the defendant has the right to waive the hearing if they so choose (C.G.S. § 54-56d(e)). During the hearing, the evaluator will provide testimony regarding their (or the evaluation team's) opinion regarding the defendant's competence, likelihood of being restored within the maximum allowable timeframe, and the least restrictive setting for restoration that is appropriate and available (i.e., inpatient vs. outpatient).

If the court, after the hearing, finds by a preponderance of the evidence that the defendant is competent, the criminal proceedings continue. If the court finds that the defendant is not competent, it must also determine whether there is a substantial probability that the defendant, with a course of treatment, will regain competency within the time allowed by law.

If it is determined that a substantial probability of restoration exists, the court must then determine the least restrictive setting necessary for treatment. In practice, the court relies heavily upon the recommendation of the OFE evaluator(s) to inform this decision. From the court's perspective, certain criminogenic risk factors influence the decision, such as the defendant's criminal history, flight risk, or danger to public safety, as well as the seriousness of the alleged offense itself. With the passage of PA 24-137, these factors were codified in C.G.S. § 54-56d(i). From the evaluating clinician's perspective, several clinical factors play a role in determining whether an inpatient treatment setting is necessary, including the severity of the defendant's symptoms, insight into their illness, the likelihood of treatment cooperation, co-occurring substance use, and other factors related to their overall stability in the community environment. These factors are also codified in C.G.S. § 54-56d(i).

The passage of PA 24-137 also codified that if the defendant is charged only with a misdemeanor(s) the court shall presume that outpatient treatment is the least restrictive placement appropriate, unless the court has good cause to find otherwise (C.G.S § 54-56d(i)).

The intensity and breadth of treatment services vary between inpatient and outpatient settings, and so this also may play a role in the clinician's recommendation of the least restrictive setting appropriate for restoration. Table 5 outlines the different services available through different competency restoration mechanisms available in Connecticut. As of early 2025, the major differences between inpatient and outpatient restoration are (1) availability of involuntary medication, and (2) intensity of group-based legal education, which occurs several times per week in the inpatient setting.

Table 5. Services Typically Available in Competency Restoration Settings

Services Available	Inpatient	Outpatient
Individual court education	X	X
Group court education	X	Sometimes
Voluntary medications	X	X
Involuntary medications	X	
Neuroimaging	X	X
Psychological testing	X	X
Specialty referrals	X	X

If the court determines that an inpatient level of care is the least restrictive setting appropriate and available for restoration, then the court must order the defendant into the custody of the DMHAS Commissioner for placement at either Whiting Forensic Hospital (WFH) or Connecticut Valley Hospital (CVH). The vast majority of defendants are admitted to WFH.[5] Because DMHAS inpatient facilities do not admit individuals under 18 years of age, juvenile defendants are placed in the custody of DCF for inpatient restoration at the Albert J. Solnit Center.

If an outpatient level of care is determined to be the least restrictive setting necessary for restoration, the court may order the defendant into the custody of either the DMHAS, DDS, or DCF Commissioner, depending on age and whether the individual has a mental illness or an intellectual disability. The respective agency will then arrange for competency restoration on an outpatient basis.

Competency Restoration

Most individuals who are found not competent are ordered to undergo a period of restoration. In Connecticut, as noted above, the vast majority of competency restoration occurs in DMHAS programs, either inpatient or outpatient, with a small number of cases referred to DDS (individuals with ID) or DCF (individuals under age 18). As shown in Table 6, between 2013 and 2024, an annual average 10.8% of restoration cases were handled as outpatients, including 7.1% in DMHAS programs and 3.4% in DDS programs. The remaining cases were referred to the inpatient restoration program at WFH.

[5] If a client is hospitalized at CVH at the time of the order, and DMHAS believes the patient will be more clinically stable by remaining at CVH and does not require the intensive restoration services available at WFH, they can remain at CVH upon agreement of the two hospitals.

Table 6. CST Restoration Settings, 2013-2024

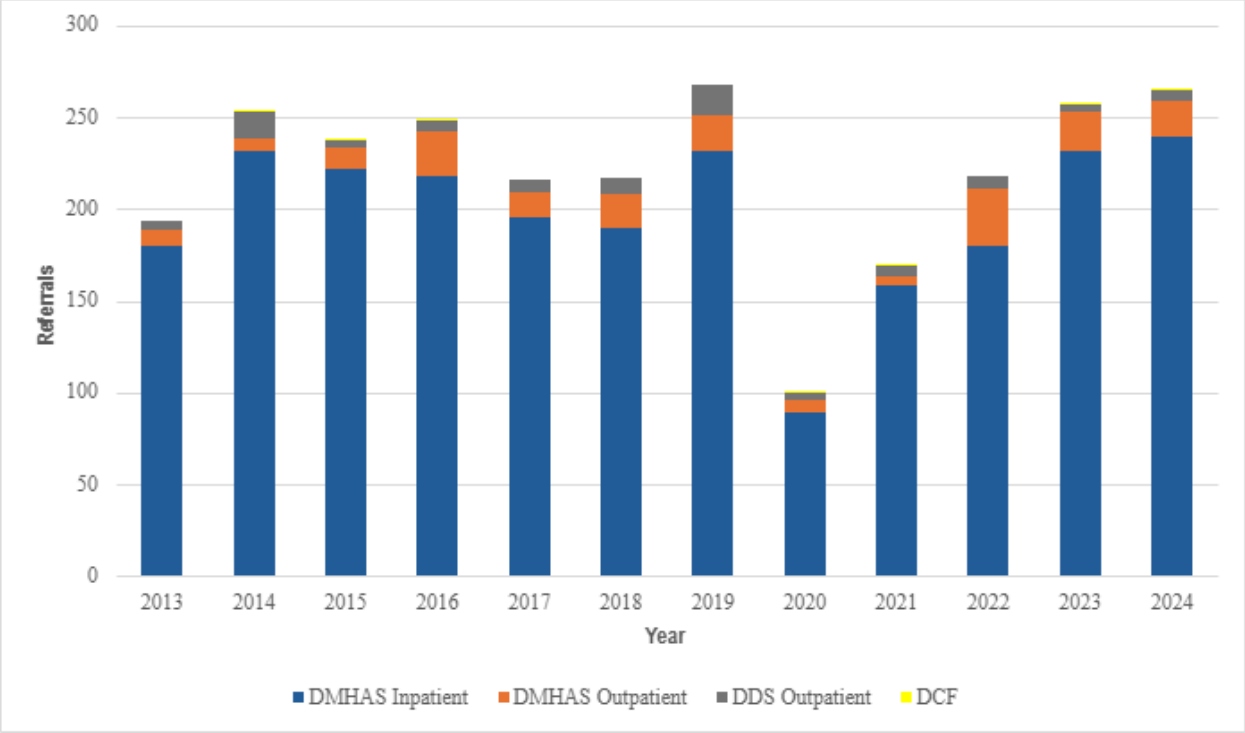
YEAR	Total Referrals for Restoration	DMHAS Inpatient[6]	DMHAS Outpatient	DDS Outpatient	DCF[7]
2013	193	180	9	4	0
2014	254	231	7	15	1
2015	238	222	11	4	1
2016	249	218	24	6	1
2017	216	195	14	7	0
2018	217	190	18	9	0
2019	268	231	20	17	0
2020	101	89	7	4	1
2021	170	158	5	6	1
2022	218	180	31	7	0
2023	258	231	22	4	1
2024	266	239	20	6	1
TOTAL	**2648**	**2364**	**188**	**89**	**7**
AVERAGE per Year	**221 (100%)**	**197 (89.3%)**	**16 (7.1%)**	**7 (3.4)**	**1 (0.3%)**

Figure 3 presents the same data as Table 6 but highlights the recovery of CST referrals from pandemic-era lows, mirroring the trends observed in evaluations. Inpatient referrals reached a decade high in 2024; DMHAS outpatient referrals peaked in 2022, and DDS outpatient referrals saw their highest point in 2019.

[6] The number of defendants referred to DMHAS inpatient may include individuals found NC/NR who are Whiting for civil commitment.

[7] It is not known whether the DCF restoration cases were inpatient or outpatient.

Figure 3. CST Restoration Referrals by Setting, 2013-2024

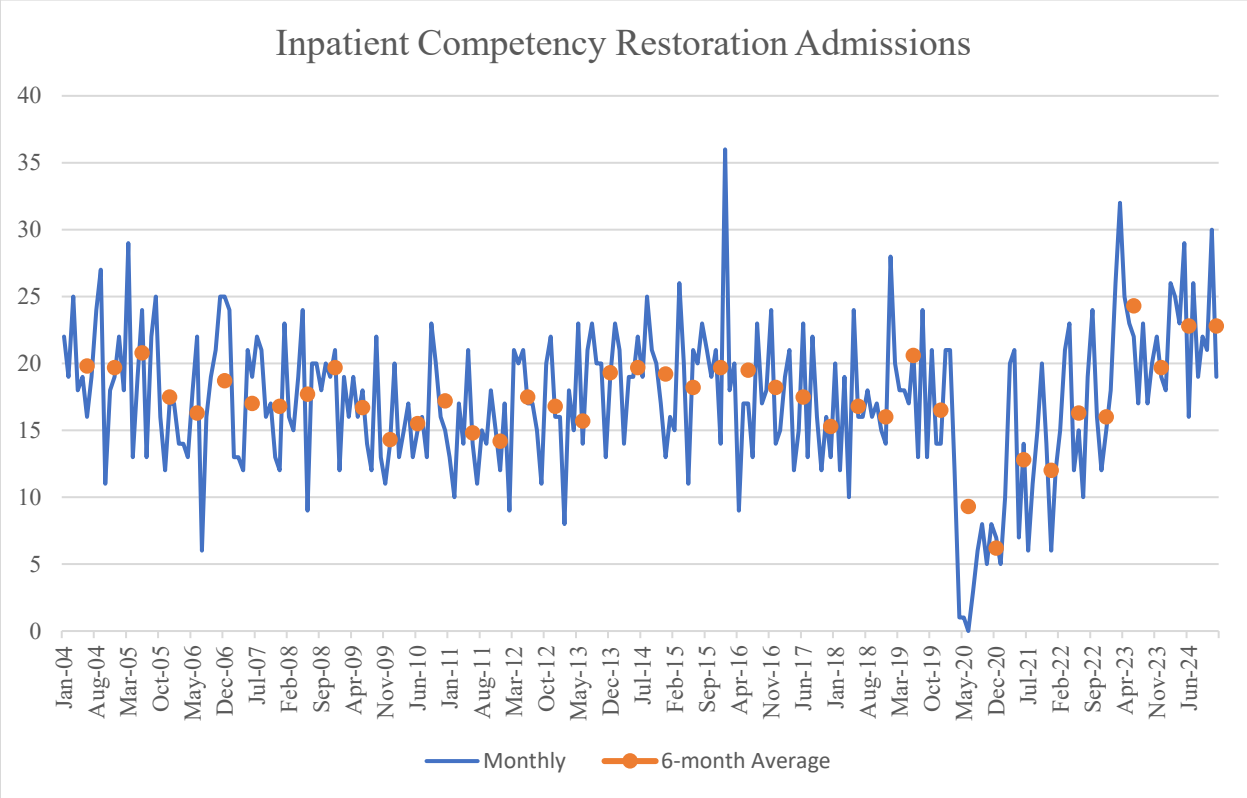


Whether inpatient or outpatient, the purpose of any competency restoration program is to identify the clinical barriers that are interfering with specific psycho-legal abilities, and then to remove those barriers so that the defendant can resolve their legal matters with sound mind and full participation. In this sense, assessment (identifying the barriers) and treatment (removing the barriers) are intertwined. Every interaction and intervention with an individual provide an opportunity not only to move the needle forward toward the goal of restoration, but also to assess how close the individual is to that goal and what specific obstacles stand in the way. If the individual has not yet been restored, the program must consider whether (1) there are other treatment interventions that could be employed, (2) the case conceptualization needs to be adjusted, or (3) all viable treatment options have been attempted without success, leaving little probability of restoration.

Inpatient Restoration

In practice, inpatient restoration occurs almost exclusively at WFH. In an average month, the hospital admits between 15 and 20 patients for competency restoration ($M = 17.3$, $SD = 5.3$). Prior to the COVID-19 pandemic, this number had been relatively stable since DMHAS began tracking data in 2004, as shown in Figure 4. An increase in admissions in 2023 and 2024 returned admission numbers to pre-pandemic levels.

Figure 4. Inpatient Competency Restoration Admissions, 2004-2024



The process of CST restoration begins upon admission to the hospital, with the completion of assessments by the various disciplines that comprise the treatment team; psychiatry, psychology, nursing, social work, and rehabilitation therapists all conduct their own assessments. These assessments are meant to gather information that will aid in diagnostic formulation, identify specific competency-related barriers, and determine the need for specialized treatment planning (for instance, related to communication/language barriers, intellectual/learning deficits, or other issues). Throughout the hospitalization, more in-depth assessments, such as a comprehensive psychological/neuropsychological evaluation, neuroimaging, referral to medical specialists, and occupational therapy assessments may be indicated to further inform the conceptualization of the individual and/or appropriate discharge options.

In the early days of the admission, individuals are oriented to the unit routine and the nature and expectations of the competency program by the unit nursing staff and treatment team. As noted above, programming is designed to remove the identified barriers for each individual and, thus, is patient-specific. However, treatment typically consists of medication management, a variety of therapeutic and psychoeducational treatment groups, and individualized competency education sessions facilitated by "forensic monitors" (typically masters-level clinicians).

Involuntary medication. Involuntary medication options are available if an individual undergoing inpatient restoration is unable to provide informed consent (C.G.S. § 17a-543a) and/or if medication is necessary to restore competency (C.G.S. § 54-56d(k)). As noted above, C.G.S. § 17a-543a was crafted in the aftermath of *Sell v. United States* (2003), drawing largely on the

dicta of that decision that involuntary medication decisions should rest upon more clinical, *Harper*-type grounds (referring to the U.S. Supreme Court case *Washington v. Harper*, 1990), rather than solely to restore competency to stand trial. Under this statute, if two qualified physicians and the head of the hospital determine that a patient hospitalized for competency restoration "is incapable of giving informed consent to medication for the treatment of the patient's psychiatric disabilities and such medication is deemed to be necessary for the patient's treatment," the hospital may petition the probate court for the "appointment of a special limited conservator with specific authority to consent to the administration of medications" (C.G.S. § 17a-543a). If appointed, the special limited conservator meets with the patient, consults with the treatment team, and reviews available records in order to make a determination regarding whether medications should be authorized. In addition, in consideration of the treating psychiatrist's recommendations, the SLC then outlines specifically what medications, doses, and administration methods they approve. In other words, the SLC acts as the patient's substituted decision-maker to approve or disapprove of medications.

In a second pathway, C.G.S. § 54-56d(k) allows the superior court to authorize medications on an involuntary basis solely for the purpose of competency restoration (more closely aligned with the actual holding of *Sell*). That is, the question of whether the patient has the capacity for informed consent does not enter into the determination; rather, the purpose is to restore them to competency to be adjudicated for their pending charges. In this case, if the hospital determines that a patient will not attain competency absent the administration of medications, the superior court judge may appoint a healthcare guardian (HCG, a licensed mental health professional) to oversee the healthcare interests of the defendant before the court. Much like an SLC, the HCG evaluates the patient, consults with the treatment team, and reviews available records to determine whether medications would be effective in restoring the patient to competency without creating undue health risks. However, unlike an SLC, the HCG does not authorize the medications directly, instead reporting back to the superior court regarding their evaluation. If the court then finds by clear and convincing evidence that the medications would be effective in restoring competency, that adjudication cannot be attained using less intrusive means, that the proposed medication plan is narrowly tailored to minimize intrusion on a defendant's liberty and privacy interest, that the medication would not cause unreasonable risk to the defendant's health, and that the seriousness of the case is such that the state's interest in prosecuting supersedes the defendant's self-determination interests, the court may authorize medications to be administered in accordance with the proposed plan. The other important difference from C.G.S. § 17a-543a is that, under C.G.S. § 54-56d(k), the authority to medicate continues through adjudication of the case rather than ending upon restoration of the patient (as with C.G.S. § 17a-543a). This helps to maintain the defendant's competency until the case is disposed rather than to risk decompensation if the defendant declines medication interventions after leaving the hospital. Table 7 summarizes the key differences between these statutes.

Table 7. Involuntary Medication Pathways for Competency Restoration Patients in Connecticut

	C.G.S. § 17a-543a	C.G.S. § 54-56d(k)
Court	Probate	Superior
Evaluator	Special limited conservator	Healthcare guardian (to "represent the healthcare interests of the defendant before the court")
Medication decision authority	Special limited conservator (acting as the patient's substituted judgment)	Judge
Reason	Patient "is incapable of giving informed consent to medication for the treatment of such patient's psychiatric disabilities and such medication is deemed to be necessary for such patient's treatment."	Defendant "will not attain competency within the remainder of the period covered by the placement order absent administration of psychiatric medication for which the defendant is unwilling or unable to give consent."
Review period	120 days	180 days
Duration	Authority ends when court finds that patient is restored to competency	Authority continues through adjudication of case

Group programming. Group programming may consist of some or all of the following: psychoeducation regarding court terminology/procedures; discussion of case vignettes/other topic areas; cognitive remediation/exercise; emotion regulation/coping skills; social/interpersonal skills; and leisure/recreational groups. Different formats and content bases of groups are offered in an effort to capture different psycho-legal abilities. For instance, some groups employ a lecture-style, psychoeducational presentation of information to teach patients pertinent information that they need to know about court procedures. These groups also cover- topics related to decision-making capacities (for example, plea bargaining vs. trial, bench vs. jury trial, testifying vs. not, having an attorney vs. proceeding *pro se*) to help patients to appreciate the advantages and disadvantages of these different legal options. Other groups offer discussion of actual court cases or hypothetical vignettes to enable patients to apply the information they learn to real-world scenarios. Cognitive-based groups are designed to encourage patients to examine things from different perspectives, and therapeutic/coping skills groups help to teach important skills such as distress tolerance, emotion regulation, anger management, and appropriate verbal expression. Finally, leisure and recreational activities provide opportunities for patients to engage with staff and peers in a different context and capture elements of social relatedness, collaboration, and adherence to structured parameters. Table 8 summarizes the features of various psychoeducational, therapeutic, and recreational groups offered, as well as the data that each provides in determining patients' psycho-legal capacities.

Table 8. Group Therapies Offered and Psycho-Legal Capacities Assessed in the Inpatient Restoration Setting

Group Type	Description	Capacities Assessed
Court knowledge	These groups use a combination of lecture-style presentation of information, question-and-answer of patients, and some group discussion covering topics such as courtroom personnel, pleas, procedures, and sentences/dispositions, as well as various decisional capacities. Competency-based games are used to provide alternative ways of engaging patients in the learning process, and mock trials are conducted to enable patients to observe and participate in the court process in real time.	attention, concentration, information processing, comprehension, learning, retention/recall of information, overall court knowledge
Case discussion	These groups employ a discussion-based format using vignettes of actual court cases for analysis and discussion. After each vignette is presented to the group, patients are asked to recap the story, to identify the relevant evidence and arguments on each side, and to engage in discussion/debate regarding the outcome (akin to the elements of attorney arguments and/or jury deliberation during the trial process).	attention, concentration, auditory verbal recall, verbal expression, identification of relevant information, reasoning capacity, social awareness/relatedness
Cognitive	These groups use puzzles, riddles, and brain teasers to encourage patients to think outside the box and to examine things from different perspectives.	attention, concentration, information processing, comprehension, abstract reasoning, cognitive flexibility, induction/ deduction skills, decision making
Therapeutic/ coping skills	These groups use a skills-based approach to build such skills as: distress tolerance, self-soothing, emotion regulation/expression, anger management, and assertiveness.	tolerance for unpleasant emotions, ability to cope with stressful events, expression of emotions/wants in healthy ways, maintenance of behavior in a social/group setting, comporting oneself in accordance with established expectations/parameters
Leisure/ recreational	These groups provide opportunities for patients to engage with staff and peers in various sports, games, movies, etc.	social awareness/relatedness, ability to comport oneself in accordance with established expectations and parameters, planning/strategy, recall of information/events

Individual competency education. Individuals are assigned a forensic monitor during their hospital stay whose job it is to meet with them on an individual basis to provide education regarding court terminology/procedures and to review their specific legal situation. Regarding the latter, the purpose here is to ensure that the individual develops a solid understanding of their legal situation (e.g., the charges, allegations, evidence) and their options before the court, not to advise them regarding potential resolutions or defense strategies as an attorney would. Many times, the operative part of this intervention is to afford individuals an opportunity to consider their case and become less emotionally reactive while developing a better grasp of their realistic options for its resolution, such that they can assist counsel toward that end. The monitor serves as

a neutral, non-judgmental educator with whom the individual can collaborate toward the goal of restoration.

Milieu interventions. In addition to these more formalized educational and therapeutic engagements, daily observations and interactions with the patients by numerous staff and treatment providers create opportunities to advance and subsequently assess competency-related capacities, particularly related to aspects of the ability to assist that are sometimes hard to operationalize. As Hauser (2023) noted, in an inpatient setting, patients' ability to learn unit routines and protocols, utilize these to get their needs met, and demonstrate that they can adhere to expectations provides evidence for their ability to navigate a social environment, as expected of them in a court setting. Additionally, patients' capacity to navigate interpersonal dynamics may be evident through their ability to communicate their needs or preferences effectively (relevantly, logically, succinctly) and, in turn, respond appropriately to feedback. Having an appreciation of others' perspectives and intentions is an important aspect of social intelligence/cognition and may be revealed in the inpatient setting through patients' ability to consider others' views or perspectives during group discussions, as well as their ability to consider feedback from others regarding their behavior or stated plans. Finally, the inpatient setting affords numerous opportunities to build, reinforce, and later assess patients' auditory verbal memory skills, that is, their ability to learn, consolidate, and later recall information. Just like in a courtroom, much of the information in this setting is relayed through spoken channels and either in an instructional/command format or a narrative one, thus providing various occasions and contexts to strengthen these skills in patients in the hope that such skills will translate to the court setting.

Treatment teams meet in conjunction with clinical supervisors on a weekly basis to discuss all patients on the unit with respect to their progress toward competency, unmet treatment needs, and discharge planning. This not only enables all who work with the patients to provide input regarding the competency question but also unifies the plan of care to restore them through ongoing communication and alignment of interventions.

Re-Evaluation. The restoration programming is punctuated by a formal evaluation of the patient's competency conducted by the forensic monitor in advance of the patient's next scheduled court appearance. C.G.S. § 54-56d(k) requires that whenever the court issues or extends a restoration order, it must schedule a competency-reassessment hearing to occur within 90 days. This evaluation assesses the patient's understanding of general court terminology and procedures and their own legal situation, as well as the patient's ability to apply their legal knowledge to their judicial matters in a rational manner. After discussing the results of the evaluation with the treatment team and supervisory channels, the forensic monitor authors a report that includes the patient's progress throughout the course of hospitalization, outlines their capacities with respect to the psycho-legal abilities, and offers an opinion regarding the patient's competency. If the recommendation is that the restoration efforts should conclude (i.e., competent, or not competent and not restorable), recommendations for discharge, if applicable, are outlined for the court's consideration. The report is submitted to the court (by statute, seven days prior to the hearing), and a hearing takes place either in person or remotely via videoconference. If the recommendation involves the opinion that the patient is not competent,

the monitor must provide testimony at the hearing; alternatively, the parties can stipulate to a competent opinion.

Discharge planning. From the first day of hospitalization, the treatment team, led largely by the social worker, explores potential discharge options for patients in the restoration program. In some cases, a high bond or imposition of bonds across multiple jurisdictions indicates that a patient is likely to return to the DOC after discharge from the hospital. However, in many cases, and increasingly so in recent years, courts are willing to entertain a release to the community on a promise to appear for defendants following a period of treatment for competency restoration. As such, discharge planning is a key aspect of inpatient restoration programming. Typical discharge options include independent living arrangements (apartment or residence), family or friends, and respite programs (temporary, staff-supported residential settings that provide structure and oversight while working with residents to secure more permanent housing), in conjunction with outpatient treatment provided by a local mental health agency (e.g., medication management, case management, therapies). Prioritizing continuity of care in this way helps to ensure that patients remain stable psychiatrically and increases the likelihood of their release from a carceral environment following a period of restoration.

Defendants who cannot safely be managed in a hospital setting. C.G.S. § 54-54d(p) states that DMHAS is not obligated to "place any defendant who presents a significant security, safety or medical risk in a hospital for psychiatric disabilities which does not have the trained staff, facilities or security to accommodate such a person," as determined by the DMHAS Commissioner in consultation with the DOC Commissioner. This statutory provision is utilized rarely, typically in cases where all reasonable clinical interventions to mitigate the risks posed by an individual have been unsuccessful. In such cases, DOC may agree to house the individual during their period of restoration and to provide any necessary mental health treatment. By agreement between the two agencies, DMHAS clinicians provide other appropriate services, which generally include 1:1 legal education, psychological testing if necessary, consultation with the DOC treatment providers, formal assessment of competency in advance of the defendant's court date, and the court report/testimony.

Outpatient Restoration

Defendants can be ordered by the court to engage in outpatient restoration through two mechanisms: (1) after the initial CST evaluation by the OFE, or (2) after a period of inpatient restoration at WFH. In either case, DMHAS staff (OFE or WFH) will coordinate outpatient restoration services with the Local Mental Health Authority (LMHA) affiliated with the court where the defendant's case is being heard. In situations where the defendant lives in a different area from the court, outpatient restoration may be referred to the LMHA in the area where the defendant resides. As noted above, outpatient restoration is generally recommended in cases where the defendant is facing lower-level charges, has agreed to participate in treatment, is reasonably clinically stable, is not actively using substances that will interfere with restoration efforts, and can regularly attend outpatient appointments. Outpatient restoration is typically ordered in 90-day increments by the court.

After receiving relevant clinical information from the OFE or WFH about the outpatient restoration, a clinician from the LMHA begins meeting with the patient for 1:1 education sessions and assesses the patient's needs. Generally, these sessions occur at the LMHA or courthouse, though they can occur at a residential treatment program if needed. At a minimum, clinicians attempt to meet with patients once a week for 1:1 sessions. Sessions include reviewing the same court-related subjects described in the *Inpatient Restoration* section above, including the patient's legal situation, the roles of court personnel, trial proceedings, plea bargaining, and working with an attorney.

In addition to providing legal education, the outpatient restoration provider considers whether the patient needs psychiatric evaluation for diagnosis or medication treatment, referral for additional testing, medical evaluation, and/or case management services. If needed, the clinician makes referrals for these services, typically at the LMHA. The outpatient restoration clinician also keeps in close contact with the OFE, ensuring that the OFE knows whether the patient has been attending appointments, cooperating with assessment/treatment, and making progress in restoration.

In advance of the individual's next scheduled court hearing, generally 90 days after the outpatient restoration order, the social worker from the OFE is responsible for re-evaluating the defendant and providing a report to the court about the defendant's progress. Toward that end, the social worker meets with the defendant to conduct a formal assessment of their competency. In their report to the court, the OFE social worker can:

1. Opine that the defendant has been restored to competency;
2. Request additional outpatient restoration time if the defendant has demonstrated progress;
3. Recommend that the defendant may never reach competency within the statutory time frame; or,
4. Recommend that the defendant needs more intensive services such as an inpatient setting.

Upon receiving the OFE's report, the court schedules a hearing to review the status of restoration efforts within 10 days. As with initial CST evaluations, the OFE report may be entered into evidence, and the clinician may testify as to their opinion. The court can order an additional period of outpatient restoration, order a period of inpatient restoration at WFH, find the defendant competent, or find the defendant NC-NR.

Individuals with Intellectual Disability

The Forensic Services Division within DDS is responsible for ensuring compliance with C.G.S. § 54-56d relating to the CST process for individuals served by DDS who are involved with the criminal justice system. DDS Forensic Services develops policies and procedures to meet the levels of need and supervision for individuals served by DDS who are court-involved.

As noted above, one of the options under C.G.S. § 54-56d for restoration placement is under the Commissioner of Developmental Services. While the statute mentions placement in a "facility for persons with intellectual disability" as an option, services through DDS function solely on an outpatient basis for the competency process. It is also important to note that "restoration" is a

misnomer in the context of intellectual/developmental disability, so the term "competency attainment" is often used instead.

Individuals are assigned to DDS for competency attainment after they are evaluated by the OFE and a court determines that they are not competent but restorable. Various groups within DDS meet to discuss such cases (among other policy issues), including regional Forensic Committees, which convene monthly, and a Statewide Forensic Committee, which convenes every other month.

According to DDS Forensics records, 48 cases for competency restoration were assigned to DDS across the three regions from 2018 to 2023, and 10 of those individuals (20.8%) were deemed to have attained competency as a result. The department does not have data on the eventual outcomes of those cases.

According to DDS training materials, individuals found non-restorable under C.G.S. § 54-56d(m) can be placed under the custody of the DDS Commissioner for the purpose of applying for a civil commitment. After the superior court makes such an order, DDS must, within a reasonable period of time, file an application for involuntary placement with the appropriate probate court. In these situations, DDS takes the individual into its care and custody from the moment the order is issued, typically as an outpatient. The risk management aspect of the care is reviewed by the Regional Forensic Committees periodically, and the probate court ultimately determines whether the individual will be civilly committed.

Juveniles

As noted above, October 2012 marked a change in judicial procedures for JCST in Connecticut. Prior to this date, there was no separate juvenile CST statute, and questions of juvenile competency were governed by C.G.S. § 54-56d, which did not specify any minimum age. Under this statute, juvenile defendants found not competent but restorable were to have a period of restoration no longer than the maximum sentence if convicted of their charges, or 18 months, in the custody of the Commissioner of DCF. Restoration was to occur in the least restrictive appropriate placement on an inpatient or outpatient basis (Chien et al., 2016).

In October 2012, C.G.S. § 46b-128a took effect, establishing new standards and processes for CST examinations in the Superior Court for Juvenile Matters, in recognition of the unique needs and developing maturity of children. Responsibility for arranging all competency examinations ordered by the Superior Court of Juvenile Matters was assigned to the Chief Court Administrator, and the Court Support Services Division (CSSD) contracted with Charter Oak Forensic Consultants beginning in February 2013 to complete all initial examinations and restoration re-examinations. This applies only to juveniles facing charges in juvenile court; those facing charges in adult court are evaluated by DMHAS OFEs.

Like the adult CST system, the juvenile CST statute provides for an exam to be conducted by a three-person clinical team (a clinical psychologist with experience in child and adolescent psychology, and two of the following: licensed clinical social worker, child and adolescent psychiatric nurse clinical specialist holding a master's degree in nursing, or a physician specializing in psychiatry), except when all parties agree to substituting a sole physician

specializing in psychiatry who has experience in conducting forensic interviews in place of the team approach.

The timeline for the process is the same as for adults:

- The examination is to be completed not later than 15 business days after it was ordered, unless an extension is granted for good cause.
- The clinical team or examining physician's written report is due within 21 business days after it was ordered.
- The court shall hold a competency hearing not later than 10 business days after receipt of the report.

If there is a finding of not competent, but with a substantial probability of attaining competency within 90 days, DCF is notified by the court's clinical coordinator and has five business days to present a restoration plan to the court. The restoration plan is based on the findings from the Charter Oak CST report and any other information available. It is the joint responsibility of the DCF Area Office and the DCF Chiefs of Psychiatry (Solnit and Community Services). If a youth above age 18 is still involved in juvenile court, DCF will make arrangements with DMHAS or DDS for restoration.

Until 2006, the restoration process for juveniles was completed on an inpatient basis only, at Riverview Hospital. Since 2006, outpatient restoration has also been possible through DCF. At the time of this report, all inpatient restoration for juveniles takes place at Solnit Children's Center (formerly Riverview Hospital), a state-administered psychiatric facility that is part of DCF and located in Middletown, Connecticut.

If there is a finding of non-restorability at any point in the process, one of three things happens: (1) the petition is dismissed if it is a delinquency or family with service needs petition; (2) temporary custody of the child or youth is vested in the DCF Commissioner, and the Office of the Chief Public Defender is notified to assign an attorney to serve as guardian *ad litem* for the child or youth and investigate whether a petition should be filed under C.G.S. § 46b-129; or (3) DCF or some other person, agency, mental health facility or treatment program, or such child's or youth's probation officer, is ordered to conduct or obtain an appropriate assessment and, where appropriate, propose a plan for services that can appropriately address the child's or youth's needs in the least restrictive setting available and appropriate. Any plan for services may include interagency collaboration for the provision of appropriate services after the child or youth attains the age of 18.

Restoration Outcomes

Inpatient Setting

It is difficult to describe with precision the outcome data for inpatient restoration in a specified year, as cases admitted during that year are not necessarily completed by its end. However, Whiting followed 191 inpatient competency admissions in 2023, and of those, 152 (80%) individuals were restored following a period of treatment. For those restored to competency, the average length of stay for restoration was 90 days (*SD* = 44.5).

For a subset of this dataset ($N = 137$), data from WFH are available regarding the discharge outcome for patients following their stays in the hospital for competency restoration. Overall, 56% of patients ($N = 76$) were discharged from the hospital to a community setting (e.g., private home, group home, rooming house, respite program) upon resolution of their competency matter. Among individuals who were restored to competency ($N = 104$), 60 individuals (58%) were released to the community. In contrast, 42 (40%) were admitted to DOC custody, and 2 (2%) remained in a hospital, skilled nursing facility, or similar setting. Among those who were not restored to competency ($N = 33$), 16 (49%) were released to the community following their stay, while 17 (52%) remained in a hospital, skilled nursing facility, or similar setting. Thus, it appears that individuals found competent are slightly more likely to be released to the community upon resolution of their competency matter than those who are found non-restorable (58% vs. 49%), though the absolute numbers are small and should be interpreted with caution.

Data indicate that a small number of people have been admitted to WFH repeatedly for CST restoration. Between 2020 and 2023, 23 of the 607 admissions (4%) were individuals who had been previously hospitalized at WFH for competency restoration. Of these 23 individuals, eight were ordered to undergo restoration for the same pending charges as before, whereas 12 had incurred new charges; three had faced both new charges and their original charges concurrently.

Outpatient Setting

Since 2013, the OFE has averaged 521 evaluations annually,[8] with an average of 221 (42%) being deemed not competent but restorable. Of those, an annual average of 11% were recommended for outpatient restoration with DMHAS (7%) or DDS (3%).

For individuals ordered to DMHAS outpatient restoration, DMHAS tracks the OFE's recommendations in subsequent CST evaluations. Table 9 shows the outcomes of outpatient restorations between 2013 and 2024.

[8] This figure includes 2020 and 2021, when CST evaluations substantially decreased because of the COVID-19 pandemic. Excluding those two years, the average number of annual CST evaluations is 556

Table 9. CST Re-Evaluations for Outpatient Restoration Cases

Year	Number of Outpatient CST restorations	Deemed competent after Outpatient Restoration	Deemed NCR after Outpatient Restoration and Referred to Inpatient Restoration	Deemed NCNR after Outpatient Restoration
2013	**11**	6 (54.5%)	2 (18.2%)	3 (27.3%)
2014	**7**	4 (57.1%)	3 (42.9%)	0 (0.0%)
2015	**18**	11 (61.1%)	2 (11.1%)	5 (27.8%)
2016	**26**	13 (50.0%)	7 (26.9%)	6 (23.1%)
2017	**14**	9 (64.3%)	4 (28.6%)	1 (7.1%)
2018	**16**	9 (56.3%)	3 (18.8%)	4 (25.0%)
2019	**20**	11 (55.0%)	4 (20.0%)	5 (25.0%)
2020	**7**	3 (42.9 %)	3 (42.9%)	1 (14.3%)
2021	**14**	7 (50.0%)	3 (21.4%)	4 (28.6%)
2022	**27**	19 (70.4%)	6 (22.2%)	2 (7.4%)
2023	**25**	11 (44.0%)	13 (52.0%)	1 (4.0%)
2024	**16**	8 (50.0%)	5 (31.3%)	3 (18.8%)
TOTAL	**201**	**111** (55.2%)	**55** (27.4%)	**35** (17.4%)
AVERAGE per Year	**16.8**	**9.3**	**4.6**	**2.9**

On average, in 55% of cases the defendant was recommended as competent after a period of outpatient restoration. This figure is lower than that for inpatient restoration in Connecticut (approximately 80%). Approximately 27% were referred for inpatient restoration, likely indicating the need for more intensive restoration services than was available in the community. Approximately 17% of defendants were found not competent and not restorable after a period of outpatient restoration without ever undergoing inpatient treatment.

Non-Restorable Defendants

As noted above, defendants can be found not competent and not restorable (NC-NR) after an initial CST evaluation or after a period of attempted restoration. DMHAS data indicate that 4.3 of individuals are found NC-NR after an initial evaluation, and approximately 20% of those referred for restoration (inpatient or outpatient) are eventually found NC-NR. DDS data indicate much lower rates of CST restoration/attainment, with 79% of those referred for restoration found NC-NR.

Once the court has found an individual NC-NR, the court has three options: (1) release the individual to the community, removing them from the state's custody; (2) place the individual in the DMHAS or DDS Commissioner's custody for application to the probate court for civil commitment; or (3) place the individual in the DMHAS or DDS Commissioner's custody for placement in a less restrictive environment. The latter option is rarely utilized, typically for purposes of WFH's discharge planning, when a community bed is not yet available at the time of the competency hearing but is anticipated to be available within a short period of time. This option is also occasionally used for individuals already placed in a community/residential placement or a nursing home who would otherwise be recommended for civil commitment, so as not to uproot them unnecessarily at the time of the NC-NR finding.

Regarding the defendant's charges, the court may *nolle,* dismiss outright the charges, or allow the charges to remain open in accordance with the statute of limitations. In cases involving serious bodily injury, the court may order periodic reexamination of the defendant's competence. As noted above, the first of these evaluations can occur six months after the initial finding of non-restorability, and subsequent reviews can be conducted no more frequently than every 18 months. The court may continue ordering such periodic reviews until the statute of limitations for the defendant's charge(s) has expired.

The OFE conducts periodic reviews in accordance with the same procedures and standards outlined above for initial CST evaluations. If the defendant was placed in the custody of DDS or DHMAS for restoration, periodic review evaluations are conducted by the DMHAS OFE. If the defendant was placed in DCF custody, periodic reviews are completed by DCF under C.G.S. § 46b-128a. As with initial CST evaluations, either the prosecution or defense may request an independent evaluation of the defendant. If, after evaluation by the OFE and/or an independent evaluator, the court finds that the defendant has regained competence, the court can choose to proceed with prosecution of the charges. If the court finds that the defendant is not competent but restorable, the court can order an additional period of inpatient or outpatient restoration, provided that the maximum time for restoration (18 months or the maximum penalty for the charges, whichever is less) has not been exhausted. If the court finds that the defendant is NC-NR, the court may order another periodic examination in 18 months. Table 10 shows the number of such periodic exams conducted by the OFEs since 2013.

Table 10. Periodic Reviews of Non-Restorable Defendants, 2013-2024

Year	# of Periodic Exams	Evaluation Outcome			Recommended Restoration Setting		
		Competent	***NC-NR***	***NC-R***	***Inpatient***	***Outpatient DMHAS***	***Outpatient DDS***
2013	12	0	10	2	2	0	0
2014	10	0	9	1	1	0	0
2015	18	0	18	0	0	0	0
2016	20	0	20	0	0	0	0
2017	18	0	18	0	0	0	0
2018	19	0	19	0	0	0	0
2019	13	1	10	2	2	0	0
2020	8	0	8	0	0	0	0
2021	8	0	8	0	0	0	0
2022	11	0	10	1	1	0	0
2023	10	1	8	1	1	0	0
2024	12	0	11	1	0	1	0
TOTAL	**159**	**2**	**149**	**8**	**7**	**1**	**0**
AVERAGE	**13.3 (100.0)**	**0.2 (1.3)**	**12.4 (93.7)**	**0.7 (5.0)**	**0.6 (4.4)**	**0.1 (0.6)**	**0 (0.0)**

Most defendants, 94%, are found to be non-restorable at their periodic reviews. “Spontaneous restoration” of NC-NR defendants (i.e., that they are found competent after a periodic review evaluation) has occurred just two times since 2013.

In 5% of periodic review evaluations, the OFE recommended that the defendant is not competent but restorable. In 70% of those cases since 2013, inpatient restoration was recommended. In 20% of cases, outpatient restoration was recommended. The outcomes of the subsequent restoration attempts are not tracked systematically.

Court Outcomes of CST Cases

No state agency systematically tracks how CST cases are ultimately resolved. The Judicial Branch tracks verdicts and sentences for all criminal charges, of which CST cases are a subset. However, no analysis of the CST cases is routinely performed. This data would be vital to making informed recommendations regarding the Competency Process.

RECENT DEVELOPMENTS

Several recent developments could have significant impacts on the CST system in Connecticut. The first is the passage of Public Act 24-137, which codified factors for judges to consider before ordering competency restoration and created a presumption of outpatient restoration for individuals whose most serious charge is a misdemeanor. The second is the state supreme court case *State of Connecticut v. Jane Doe*. Although the Court did not issue a ruling because the case was deemed moot, the justices raised concerns during the oral argument about the extended inpatient competency restoration for non-violent, misdemeanor defendants. Third, DMHAS expanded its Enhanced Forensic Respite Bed program in 2024, with the aim of diverting individuals from the CST evaluation and inpatient restoration pathways.

Public Act 24-137

The Sentencing Commission submitted two proposals in 2024 to the legislature, recommending amendments to 54-56(d). After discussion with impacted agencies, final language contained in Public Act 24-137, which amended C.G.S. § 54-56d(i), required that a defendant must be placed in the "least restrictive placement appropriate and available" for competency restoration. PA 24-137 § 6 added two new subsections to the statute: subsection (i)(2), which delineated factors for courts to consider when determining the least restrictive placement; and (i)(3), which established a presumption of outpatient competency restoration for misdemeanor defendants. These new provisions went into effect on October 1, 2024.

Under PA 24-137, when determining the least restrictive placement to restore competency, the court must consider the following factors:

> (A) The nature and circumstances of the alleged crime;
> (B) such defendant's record of criminal convictions;
> (C) such defendant's record of appearance in court;
> (D) such defendant's family and community ties;
> (E) such defendant's willingness and ability to engage with treatment ordered under this section;
> (F) whether such defendant's use of substances would interfere with such defendant's ability to be successful in such placement;
> (G) any psychiatric symptoms experienced by such defendant and the nature and severity of the symptoms; and
> (H) any other relevant factors specific to the defendant and such defendant's circumstances.

Further, if the defendant is charged only with misdemeanor offenses, "the court shall presume that outpatient treatment is the least restrictive placement appropriate and available to restore competency unless the court has good cause to find otherwise" based on the factors above.

It is too soon to tell whether the statutory changes implemented in PA 24-137 will substantially decrease inpatient restoration admissions and/or increase outpatient restoration orders. In preparation, DMHAS took action following the law's passage to enhance its capacity for outpatient restoration and to state more clearly in CST reports and testimony its rationale for recommending restoration settings.

State of Connecticut v. Jane Doe

The facts of this case were taken from court documents, authored by both the defense counsel and state prosecutors. They are provided here to illustrate the complex procedural, legal, and personal challenges faced by defendants and court actors in cases involving low-level charges and the CST system.

On November 24, 2023, Jane Doe attempted to check into a hotel in Uncasville, Connecticut.[9] The hotel declined to give her a room after she failed to produce acceptable identification, suggesting that she try a different hotel.[10] Ms. Doe asked to use the hotel shuttle but was informed that she needed to locate transportation on her own.[11] A hotel employee called the police, notifying them of her presence in the hotel lobby.[12]

After arriving at the hotel, the police officer discussed Ms. Doe's presence with the hotel employee, asking whether they wanted Ms. Doe to remain on premises.[13] The employee stated that they wanted her to leave if she was not a guest or if she did not know any of the guests.[14] However, the employee "made no request that Jane be 'trespassed' or otherwise arrested."[15] According to the police report, the employee also reported that Ms. Doe had claimed that she was the "queen of Hyatt," she had been in the hotel lobby for about one hour, and that he had asked the defendant to leave the property twice.[16]

The police officers then approached Ms. Doe, asking her if she needed assistance getting a hotel room.[17] When approached, Ms. Doe answered the questions from the police officers and began walking into the parking lot.[18] The interaction escalated after Ms. Doe declined to provide the officers with the identification she was attempting to use to get the hotel room.[19] As the police

[9] Brief for the Defendant-Appellant at 8, State of Connecticut v. Jane Doe, SC 21029 (Conn. 2024), available at https://appellateinquiry.jud.ct.gov/DocumentDisplayer.aspx?AppId=2&DocId=f2j4w8JdhuffCeCjog8uUA%3d%3d
[10] *Id.* at 8-9.
[11] *Id. at 9.*
[12] *Id.*
[13] *Id.*
[14] *Id.*
[15] *Id.*
[16] Brief for the Commissioner of Correction–Appellee at 96-98, State of Connecticut v. Jane Doe, SC 21029 (Conn. 2024), available at https://appellateinquiry.jud.ct.gov/DocumentDisplayer.aspx?AppId=2&DocId=2iIWVWY1rY4X%2bPE0vs09XQ%3d%3d
[17] Def.-Appellant Br. at 9.
[18] *Id.*
[19] *Id.* at 10.

told her she had to stop and talk to them, Ms. Doe continued to walk away.[20] In response, the officers physically restrained her and told her, "It doesn't work like that."[21] At this point, she was informed that she must share her identity before she would be allowed to leave.[22] She reiterated that she would not do so and that the officers' actions were illegal.[23]

Ms. Doe was handcuffed and transported to the Montville Police Department, where she was questioned without receiving a *Miranda* warning.[24] While being processed at the police department, the police found a hospital a bracelet that read "18 year old unidentified" and "a paper from Virginia" that indicated a dismissed charge for failing to provide fingerprints.[25] Pursuant to C.G.S. § 53a-167a, Ms. Doe was arrested on the charge of Interfering with an Officer, a misdemeanor punishable by up to one year in jail and a fine of up to $2,000.[26] The police also advised that she would face an additional charge of failing to provide fingerprints if she continued to refuse to provide her identity, pursuant to C.G.S. § 29-12.[27] This charge, a violation with up to a $100 fine, was later added. Ms. Doe was unable to post her $500 bond and was subsequently detained at the police department.

At her first criminal proceeding on November 27, 2023, Ms. Doe's appointed public defender agreed to a competency evaluation.[28] At this initial proceeding, the state asked that Ms. Doe be held without bond until her identity was revealed, while the defense counsel argued for her release on a promise to appear.[29] The defense counsel indicated that the defendant maintained the hotel staff had never directly asked her to leave and that she believed that she was arrested illegally.[30] The court asked if counsel believed a competency evaluation was warranted, and counsel replied that an evaluation might address certain issues, stating that the defendant had made some odd statements.[31] However, counsel noted that she understood the defendant's refusal to talk to the police.[32] At the hearing, the bail commissioner reported that he was unable to obtain any information about the defendant and that a mental health screening likewise yielded no information.[33] The court proceeded to find that probable cause existed, set her bond at $30,000 cash or surety, and order a competency examination pursuant to 54-56d.[34] At a December 28, 2023 hearing, while the competency evaluation was still ongoing, the presiding judge again inquired about the defendant's refusal to identify herself and argued that the court needed to assess if there was an outstanding warrant. Ms. Doe maintained that she was under a "false arrest."[35]

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[20] Comm'r-Appellee Br. at 10.
[21] Def.-Appellant Br. at 10.
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] Comm'r-Appellee Br. at 12.
[26] *Id.*
[27] *Id.*
[28] Def.-Appellant Br. at 11.
[29] *Id.* at 11-12.
[30] Comm'r-Appellee Br. at 13.
[31] *Id.* 13-14.
[32] *Id.*
[33] *Id.* at 14.
[34] *Id.*
[35] Def.-Appellant Br. at 13.

On January 30, 2024, an evaluator from the DMHAS OFE testified that it was the "unanimous opinion of the team that Ms. Doe was unable to understand the proceedings and was unable to assist in her own defense."[36] The team determined that the least restrictive means for restoration was treatment at WFH.[37] The OFE, however, did not provide information that Ms. Doe had been violent or was a danger to herself or others.[38] The evaluators did report that Ms. Doe "presented with disorganized and tangential thinking."[39] Ms. Doe's counsel requested that the defendant be found not competent but restorable and that the court adopt the team's recommendations.[40] The court asked Ms. Doe if she was prepared to provide her identity to the court, but she again declined and indicated that she would like to represent herself.[41] The court adopted the recommendations from the Office of Forensic Evaluations and increased the defendant's bond from $30,000 to $50,000.[42] At the end of the hearing, Ms. Doe asked about the basis for which she was being held but was not answered.[43]

During her hospitalization at WFH, Ms. Doe exhibited signs of mental illness and was diagnosed with schizophrenia, a diagnosis she disagreed with.[44] After she declined to take medication voluntarily, the hospital applied to the Middletown Probate Court for permission to administer involuntary medication under G.G.S. 17a-543a.[45] The hospital's petition was granted, and a Special Limited Conservator subsequently consented to the administration of antipsychotic medication.[46] Antipsychotic medication was administered in accordance with the court order.[47]

On March 28, 2024, Ms. Doe was again found not competent but restorable, and restoration efforts at WFH continued.[48] At the March 28 meeting Ms. Doe's counsel argued that the lack of progress after receiving medication supported a finding that the defendant was not restorable.[49] On June 18, 2024, the staff at WFH again recommended the finding that the defendant was not competent to stand trial.[50] While Ms. Doe's new counsel contested the recommendation, the court found Ms. Doe not competent but restorable.[51] On July 3, 2024, the defendant filed an application for a public interest appeal, which the Connecticut Supreme Court granted on July 7, 2024.[52]

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[36] *Id.* at 14.
[37] *Id.*
[38] *Id.*
[39] *Id.*
[40] *Id.*
[41] *Id.* at 13-14.
[42] *Id* at 15.
[43] *Id.*
[44] *Id.* at 16.
[45] *Id.* at 15-16.
[46] *Id.*
[47] *Id.*
[48] *Id.* 16-18.
[49] *Id.* at 17.
[50] *Id.* at 18.
[51] *Id.*
[52] Comm'r-Appellee Br. at 20.

About one month later, on August 7, 2024, the hospital issued a report recommending that Ms. Doe was competent to stand trial, and on August 12, 2024, the court concurred with the recommendation.[53] The state dropped both of Ms. Doe's charges shortly thereafter, and she was released from custody.[54]

The Connecticut Supreme Court considered whether Ms. Doe's placement at WFH and the $50,000 bond had been the least restrictive placement when there had been no indication that she was a danger to herself or others. On September 25, 2024, the Court heard oral argument.[55] The justices questioned the state and the appellant on whether inpatient competency restoration was appropriate or lawful in this case.[56] Specifically, the justices expressly questioned the frequency of competency orders for individuals only charged with misdemeanors, the duration of her hospitalization, and if Jane Doe's case served the state's goals of justice and fairness.[57] Ultimately, no decision on the substantive matter was reached, as the case was determined to be moot since the charges had been dismissed and the defendant released from custody.[58] Nonetheless, the case brought attention to the CST process in Connecticut.[59]

Enhanced Forensic Respite Bed Program

In October of 2021, DMHAS opened the Enhanced Forensic Respite Bed (EFRB) pilot program, a three-bed residential program in Bridgeport whose aim was to divert individuals with low-level charges from the CST system. Bridgeport was chosen as the pilot site because of the high number of CST evaluations originating from that court, and referrals were initially accepted only from the Bridgeport court. The EFRB program provides comprehensive mental health services, including medication, therapy, and linkage to aftercare services, in an unlocked residential setting for 30 to 90 days. The program excludes those charged with high-level felonies (class A and B), certain sex offenses, defendants with a history of arson, and clients with intellectual disabilities.

DMHAS partnered with UConn researchers to evaluate the pilot program's outcomes. By December of 2023, EFRB had admitted 28 clients, 26 of whom had been discharged (two remained active clients in the program). Twenty-one clients (81%) successfully completed their legal requirements (i.e., court mandate for treatment), and 24 clients (93%) met the goals of their mental health treatment. Just two individuals (7%) were terminated from the program.

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[53] *Id.* at 21.
[54] *Id.*
[55] Oral Argument, State of Connecticut v. Jane Doe, SC 21029 (CT Sept. 25, 2025), available at https://www.jud.ct.gov/supremecourt/Audio/PlayAudio.aspx?ID=1920&secondsToWait=5
[56] *Id.*
[57] *Id.*
[58] Order On Motion to Dismiss, State of Connecticut v. Jane Doe, SC 21029 (Conn. Sept. 26, 2025), available at http://appellateinquiry.jud.ct.gov/DocumentDisplayer.aspx?AppId=2&DocId=CdkPcrdxg0kEDRTgQacu4A%3d%3d
[59] Edmund Mahony, A CT Woman Was Arrested and Committed to a Mental Hospital After Refusing to Give a Hotel Clerk ID, Hartford Courant (Sep. 26, 2024), https://www.courant.com/2024/09/26/a-ct-woman-was-arrested-and-committed-to-a-mental-hospital-after-refusing-to-give-a-hotel-clerk-id/

Because of these promising data, DMHAS expanded the EFRB program in 2024 to 16 beds across two sites, 12 co-ed beds in Bridgeport and four male beds in New Haven. The expanded EFRB program accepted referrals from all courts statewide and all court personnel. Initially, utilization of the program was limited, but it increased modestly over time. After the passage of PA 24-137, DMHAS also began accepting referrals for outpatient restoration to the EFRB program.

In February 2025, DHMAS provided an update to the Commission's Mental Health Committee on EFRB. At this time, the expanded, statewide program had admitted 84 clients, 68 of whom had been discharged. From May 2024 to February 2025, most referrals (83.85%) came from the Public Defender's Office, DHMAS Jail Diversion staff, and CSSD bail staff. Additionally, completion rates continued to remain promising; fifty clients (73.5%) completed the program, while eighteen (26.5%) clients were discharged before completion. Of these 18, four were referred to a higher level of care, eight left against staff advice, and six were discharged due to non-compliance with rules or a violation of supervision conditions.

This data also showed that the mean length of stay was 1.5 months, with 57.4% percent of clients staying less than one month. Most clients (75%) exited the program with community living arraignments (either in the shelter system, a community residence, or a treatment facility). A minority of clients (17.6%) were discharged either unsheltered or to a correctional facility.

Overall, the goal of EFRB is to enhance Connecticut’s alternatives to inpatient competency restoration, providing a residential treatment setting that can help individuals without stable housing, transportation, or social supports who might otherwise find themselves involved in the CST system for lengthy periods. Outcomes data show promising results that mirror or exceed competency restoration rates.

DISCUSSION

Further discussion and evaluation should be undertaken regarding the impact of the CST process on individuals, especially those who are facing low-level charges, and the expense of inpatient restoration. At an average cost of over $200,000 per defendant, the state spent at least $40 million on 201 inpatient restoration admissions in 2023. Further, this amount represents direct costs only. Indirect costs of inpatient restoration include limitations on defendants' liberty, longer involvement with the criminal justice system for lower-level offenses, and the allocation of limited state hospital resources to forensic rather than civil populations. With approximately 35% of defendants undergoing restoration facing misdemeanor-only charges, this raises important questions regarding the extent to which the current CST system aligns with the stated objectives of the judicial system.

Yet, there are also secondary gains of competency restoration for individuals with low-level charges. Recent studies have shown that individuals charged with misdemeanors suffer disproportionately from serious mental illness (Murrie, Gardner, & Torres, 2022; Compton et al., 2023) and are more likely than those facing felonies to be found incompetent to stand trial (Wik, Hallen, & Fisher, 2020; Murrie, Gardner, & Torres, 2022). In states like New York and Minnesota (Kelley et al., 2024), where competency restoration is not utilized for misdemeanor cases, there is an increased chance that individuals will not be connected to appropriate and necessary treatment, increasing the risk of adverse outcomes including homelessness, substance use, self-harm, and further criminal charges. Thus, it is important to acknowledge that, for those who need intensive psychiatric treatment, competency restoration can serve an important therapeutic purpose. The question is whether less restrictive, more cost-effective ways can be found to accomplish the objectives of providing necessary treatment and resolving criminal charges.

Other states have already been investigating possible alternatives. While New York and Minnesota have moved away from misdemeanor restoration altogether (Kelley et al., 2024), some states have restricted restoration to the outpatient setting for misdemeanor cases (Murrie et al., 2023). Ohio and Hawaii have shortened their time limits for defendants charged with misdemeanors, allowing only 60 and 120 days, respectively, for restoration (McCormick et al., 2024). New Mexico limits inpatient CST restoration to cases where the court finds that the defendant is dangerous (Kelley et al., 2024), while Texas, Ohio, and Virginia shorten the time until mandated re-evaluation for lower-level charges (McCormick et al., 2024). Finally, other states, such as California, Colorado, Texas, and Washington, have prioritized diversion of misdemeanor cases out of the competency system altogether, finding that this strategy helped to decrease wait times and backlogs for inpatient restoration (Obikoya, 2021). Stakeholders may wish to further analyze these practices implemented in other states and explore efforts, such as, but not limited to, revising maximum allowable lengths of stay, modifying timelines for required re-evaluations, enhancing and further encouraging the use of mental health diversionary programs, and expanding outpatient restoration options.

Currently, Connecticut has several initiatives underway that can have a positive impact on the CST system. Jail diversion programs, which have existed in the state since the 1990s, have continued to expand in scope and eligibility. In addition to having DMHAS jail diversion clinicians present in every arraignment courthouse, diversion programs are operated by the Court Support Services Division (CSSD), the Department of Veterans Affairs, and the Office of the Chief State's Attorney. In addition, the Commission has been working to expand eligibility for the court's Supervised Diversionary Program (SDP) to individuals with intellectual disabilities and autism spectrum disorders. The Commission's proposed legislation did not pass in 2024 but remains an area of interest for the Commission and relevant stakeholders. These measures, together with the legislative, judicial, and programmatic changes described in the *Recent Developments* section above, help to reduce the likelihood that Connecticut will see a substantial increase in CST referrals in the coming years.

Additionally, discussion and evaluation of the C.G.S. § 54-56(m) process is encouraged, specifically for those defendants charged with serious, violent crimes who cannot be restored to competency. Currently, these individuals are typically transferred to the civil psychiatric system upon resolution of their competency matters. The differing missions of the criminal and probate court systems can conflict in these cases; criminal courts are interested in protecting public safety after a serious event has occurred, while probate courts are obligated to authorize psychiatric treatment in the least restrictive setting.

This problem is not unique to Connecticut, and several states and legal scholars have proposed different options for managing defendants who are permanently non-restorable. Massachusetts, for instance, allows an individual that has been found not competent and not restorable to request a court proceeding if they believe they can establish a defense of not guilty. This allows the court to review the evidence and release the defendant if there is insufficient evidence to support a conviction. In other words, it allows an argument to be made that the defendant is not guilty of the charges, in order to clear the case out of the criminal justice venue altogether (Melton, 2018). Ohio, as another example, has adopted a practice (formerly, the official position of the American Bar Association) to try the non-competent defendant and, if found guilty, subject them to a special commitment procedure akin to those used for insanity acquittees, typically involving more secure facilities and longer periods of confinement than those seen with civilly committed individuals. This hybrid option was meant to satisfy multiple components of these oft-competing mindsets and missions: recognizing the non-competent defendant's right to obtain a judgment of acquittal when evidence is insufficient to prove guilt while also protecting society from dangerous individuals by providing greater supervision and oversight than is afforded in the civil system (Melton et al., 2018). When a legislative work group was created to address this matter in 2013, Connecticut was unable to reach consensus about solutions for this population. These models from other states may prove helpful if the question is reconsidered.

POLICY RECOMMENDATIONS

Convening Diverse Stakeholders

Connecticut now has two groups that convene stakeholders relevant to CST: the Behavioral Health Subcommittee of CJPAC and the Mental Health Committee of the Sentencing Commission. These meetings are attended by defense attorneys, prosecutors, judges, representatives from DMHAS and the DOC, and members of nonprofit organizations such as the National Alliance on Mental Illness (NAMI-CT) and the Connecticut Legal Rights Project (CLRP). Both groups have demonstrated a history of collegiality and collaborative problem-solving. These groups should continue to remain actively involved in conversation regarding the CST process. Additionally, it is important to include stakeholders from across the system, including representatives from DDS, DSS, and DCF, given their active role in the CST process, and individuals with lived experience.

Enhancing Data Collection and Sharing

Individual agencies involved in the CST process keep data about judicial orders, CST evaluations, and restoration outcomes, but these data are not shared with other agencies on a routine basis. The Commission could serve as a clearinghouse for this information and work to establish a more systematic, inter-agency data sharing system for CST cases that would allow the state to track annual data more easily, including the following:

Table 11. Recommendations for CST Inter-agency Data Collection

Data to be collected	*Why?*
Number of CST evaluations being ordered	To help identify whether Connecticut is facing the same upward trend of CST orders that led to long wait times in other states
Number of unique individuals for whom CST evaluations are ordered	To identify repeat/frequent utilizers of the CST system and investigate alternative resolutions to their criminal cases
Demographics of CST evaluees, such as age, gender, race, and ethnicity	To identify disparities in the CST system and their underlying reasons
Number of CST evaluations ordered by each court, compared with the volume of total cases processed in that court	To identify disproportionate use of the CST system in certain jurisdictions
Number of CST evaluations ordered for cases where the defendant is facing only misdemeanor charges	To determine how many low-level defendants are in the CST system
Wait times for CST evaluations and restoration	To track trends and allocate resources accordingly
Outcomes of CST evaluations (e.g., competent, NC-R, NC-NR)	To track trends and understand how Connecticut compares with other states
Number of restoration cases referred to DMHAS, DDS, and DCF, further divided into inpatient and outpatient	To understand the demand for services for each agency's unique population
Restoration length of stay and outcomes, further divided by agency and inpatient/outpatient	To track trends and, if possible, compare the efficacy of different restoration settings
Resolution of criminal charges in cases involving CST restoration	To understand the relationship between competency restoration and case outcomes
Annual average costs of outpatient and inpatient restoration treatment	To enable a comparative analysis of fiscal efficiency and efficacy across restoration settings and time

Ideally, a shared, inter-agency electronic database could be created so that CST cases could be followed from start to finish (i.e., from CST evaluation order to resolution of criminal charges). However, privacy considerations, particularly about individuals' diagnoses and treatment history, may present challenges.

Furthermore, relevant stakeholders, including the Commission, DHMAS, and DDS, should create a process where metrics, such as CST outcomes, lengths of stay, wait times, and demographics, are reported and tracked annually to examine trends, costs, challenges, and any gaps in information that would be useful for the continued monitoring and improvement of the process. The database described above would facilitate the generation of these reports.

Increasing Diversion from the Competency Evaluation/Restoration Pathway

As recommended in all three national task force reports, alternative pathways such as jail diversion programs should be considered before ordering a CST evaluation. This consideration of alternatives should become routine practice in courtrooms, particularly in misdemeanor cases. It is important to acknowledge, however, that diversion will not be possible or appropriate in all cases, including those where a defendant does not agree to participate in a diversion program or

cannot make a knowing and/or voluntary choice. Further, a central purpose of the CST system is to ensure that a defendant has the capacity to make sound decisions about the resolution of their criminal matter, respecting their autonomy in the process. Thus, although we recommend exploring alternative dispositions to cases and not resorting to a CST evaluation at the first sign of mental health issues, we recognize that CST evaluation and restoration will continue to play an important role in ensuring a just resolution to criminal charges for some defendants.

The Commission's 2024 proposed language for amending C.G.S. § 54-56d called for the court to order a competency exam except for when the most serious crime charged against the defendant is a misdemeanor, in which case "the court may order a competency examination only after considering, based on all available information, whether participation by the defendant in a jail diversion program is not appropriate." This proposal did not pass in 2024. There should be continued dialogue with stakeholders, guided by national task force recommendations and informed by state data, to develop new language around this objective of increasing diversion from the CST system.

Enhancing Outpatient and Community Residential CST Restoration Services

PA 24-137 mandated the presumption in misdemeanor cases that outpatient treatment is the least restrictive placement appropriate for competency restoration unless there is good cause to find otherwise. Although systematic data are lacking, anecdotal reports from mental health and justice professionals across the state indicate that the use of outpatient restoration is currently limited by a lack of stable, supportive housing and wraparound treatment services for defendants. Therefore, there should be additional funding to further develop residential and outpatient treatment services to support defendants who are engaged in competency restoration. These services could involve expansion of existing jail diversion programs or continued support for residential placements devoted primarily to competency restoration, such as EFRB.

Despite the growing trend of jail-based competency restoration across the country, this strategy may not be advisable at this time. JBCR initially arose in states with long wait times for hospital beds out of a desire to treat incompetent defendants while they were awaiting placement in a more therapeutic setting. The strategy makes sense in the context of bed shortages, but it does not apply to Connecticut currently, where defendants typically are admitted to a restoration program on the same day as they are found incompetent.

Improving Oversight of Individuals Found Non-Restorable of Serious Charges

The CSG, SAMHSA, and NCSC task force reports do not identify the oversight of individuals found non-restorable of serious charges as a priority for national change, but it is a problem that has challenged Connecticut for decades and should be addressed. Currently, the state does not have a dedicated oversight system for non-restorable individuals. We recommend gathering relevant stakeholders to reconsider the development of such an oversight system.

Investigating Best Practices for Individuals with Intellectual and Developmental Disabilities, Including Autism Spectrum Disorder

Section 15 of Public Act 23-137 requires the Commission to study the experience of people with intellectual disability or other developmental disabilities, including, but not limited to, autism spectrum disorder, who are involved in the criminal justice system. The results of the study and recommendations are to be presented to the Human Services, Judiciary, and Public Health Committees by December 31, 2025. The CST system will be included in this study.

The Commission was not able to obtain much information as it pertains to CST restoration services provided to individuals with ID in Connecticut, such as what services are provided, what assessment tools are used, and what factors are associated with successful attainment of competency. This data should be collected systematically to inform further discussion and evaluation.

Enhancing Knowledge of Individuals with Dementia and Acquired Brain Injuries in the CST System

Although individuals with neurocognitive disorders (i.e., dementia) and brain injuries undergo CST evaluation and restoration in Connecticut with some regularity, systematic data about these populations are lacking. Anecdotally, CST evaluations of individuals with dementia have been increasing as the population ages. Similarly, as recognition of acquired brain injuries (ABI) has increased in recent years, its interface with the CST and criminal justice system warrants further attention. It is important that data collected about the CST system include diagnostic information so that best practices for CST evaluation and restoration of individuals with dementia and ABI can be developed.

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