

THE CONTINUED INDEFINITE INCARCERATION OF INDIANA'S INCOMPETENT DEFENDANTS POST-*JACKSON*

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On February 21, 2004, Charlene Davis entered a local Bank One branch.¹ Charlene approached the teller counter and demanded a withdrawal from her savings account.² Certain the account was active, she became enraged when the teller informed her the bank closed the account, and she withdrew a knife from her pocket.³ Panicked employees sounded the silent alarm, and when Charlene refused to drop the knife, police officers released pepper spray and subdued her.⁴ Marion Superior Court charged her “with criminal recklessness as a Class D felony.”⁵ Following questions regarding Charlene’s competency, two psychiatrists opined she was incompetent to stand trial as she suffered from paranoid schizophrenia.⁶ Multiple state psychiatric hospitals attempted to restore Charlene’s competency to no avail.⁷ On December 18, 2008, almost four years after her arrest and commitment for a period exceeding the maximum possible sentence for her charges, the Indiana Supreme Court held it was “a violation of basic notions of fundamental fairness as embodied in the Due Process Clause of the Fourteenth Amendment to hold criminal charges over the head of [Charlene], an incompetent defendant, when it was apparent she will never be able to stand trial.”⁸

In order to be competent to stand trial for a criminal offense, a defendant must be able to understand the proceedings and assist in the preparation of his defense.⁹ The test for determining an individual’s competency is “whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding[,] and whether he has a rational as well as factual understanding of the proceedings against him.”¹⁰ The Indiana Supreme Court’s *State v. Davis* decision came nearly four decades after the United States Supreme Court held in *Jackson v. Indiana* that a criminal defendant incompetent to stand trial may not be involuntarily committed “more than [a] reasonable period of time

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1. *State v. Davis*, 898 N.E.2d 281, 283 (Ind. 2008).
2. *Id.*
3. *Id.*
4. *Id.*
5. *Id.*
6. *Id.*
7. *Id.* at 284.
8. *Id.* at 290.
9. IND. CODE ANN. § 35-36-3-1(a) (West 2020).
10. *Dusky v. United States*, 362 U.S. 402, 402 (1960).

necessary to determine whether there is a substantial probability that he will attain [competency] in the foreseeable future.”¹¹ *Davis* definitively resolved a matter left unsettled by *Jackson* as to “whether states could indefinitely maintain criminal charges against incompetent defendants.”¹² Despite this progress, Indiana statutory law and policy permit incompetent defendants to languish in state hospitals for many years,¹³ compromising substantial liberty interests of the accused. The government has a fundamental interest in ensuring a defendant is held accountable for criminal behavior. Moreover, American citizens expect, and the legal system requires, restraints on the freedom of convicted criminals as a result of their criminality; however, mentally ill and intellectually disabled defendants detained for competency restoration services have not yet been tried for their alleged crimes. Many defendants wait for extensive periods of time for beds to become available for inpatient competency services, subjecting them to abuse, neglect, and decompensation in county jails. Some defendants remain in state hospitals for years when competency restoration efforts are futile, only for probate courts to deny civil commitment, returning them to the jail to repeat the cycle anew, all before their guilt is conclusively determined by the criminal justice system.

This Note advocates for the use of community-based, i.e., outpatient, programs in Indiana for competency restoration services. Pointedly, this Note argues strict adherence to the Indiana Code’s procedures regarding competency determination and restoration of criminal defendants is unworkable, specifically with regard to the Indiana Code’s statutory gap concerning the appropriate course of action for unrestored defendants whose petitions for civil commitment pursuant to Indiana Code section 12-26-7 are denied by Indiana’s probate courts. Additionally, this Note contends the Indiana Supreme Court misinterpreted Indiana Code section 35-36-3-1 as requiring the administration of competency restoration services by the Division of Mental Health and Addiction (“DMHA”),¹⁴ which provides competency restoration services by way of inpatient admission to one of Indiana’s state psychiatric institutions.¹⁵ On the contrary, the Indiana Code expressly permits the use of outpatient programs for competency restoration services,¹⁶ but the DMHA exercises sole discretion in deciding the course of treatment appropriate for competency restoration. As the “statutory gatekeeper” for competency restoration services,¹⁷ the DMHA inevitably selects inpatient treatment over other available, and arguably more beneficial, options for

11. *Jackson v. Indiana*, 406 U.S. 715, 738 (1972).

12. Douglas R. Morris & George F. Parker, *Indiana v. Davis: Revisiting Due Process Rights of Permanently Incompetent Defendants*, 37 J. AM. ACAD. PSYCHIATRY & L. 380, 380 (2009).

13. *Id.* at 383.

14. *Curtis v. State*, 948 N.E.2d 1143, 1153 (Ind. 2011) (“If the trial court finds a defendant incompetent, the trial court must commit the defendant to the DMHA, and the DMHA must provide competency services.” (citing IND. CODE ANN. § 35-36-3-1(b)); see discussion *infra* Section III.A.

15. *Thomas ex rel. Thomas v. Murphy*, 918 N.E.2d 656, 660 (Ind. Ct. App. 2009).

16. IND. CODE ANN. § 35-36-3-1(b).

17. *Thomas*, 918 N.E.2d at 660.

treatment.

Part I of this Note examines Indiana's statutory response to the holding in *Jackson*, as well as "modern" decisions by the Indiana Supreme Court regarding incompetent defendants. Part II analyzes the issues concerning Indiana's current state of affairs with regard to restoring competency and unrestorable defendants. Specifically, Part II discusses the difficulties associated with defining unrestorability, the diminished capacity in state psychiatric institutions to meet the present demand for competency restoration services, the threat of decompensation and associated harms, denials by Indiana probate courts for civil commitment upon unsuccessful attempts to restore defendants' competency, and, lastly, constitutional considerations implicated by the detention of incompetent criminal defendants. Part III of this Note concludes with an analysis of the monetary cost savings and therapeutic benefits of an outpatient model for competency restoration, as well as explicit statutory proposals to the Indiana Code and advocacy for the development of problem-solving courts specifically tasked with monitoring competency restoration efforts.

I. LEGISLATIVE AND JUDICIAL RESPONSES IN A POST-*JACKSON* INDIANA

A. *Indiana's Statutory Framework*

In 1972, the United States Supreme Court condemned Indiana's statutory procedure "for pretrial commitment of incompetent criminal defendants."¹⁸ Theon Jackson was a mute with severely diminished mental capacity charged with the robberies of two women.¹⁹ The total value of Jackson's robberies was nine dollars.²⁰ Following a competency hearing, the court committed Jackson to the Indiana Department of Mental Health until he regained competency for trial.²¹ Jackson's counsel eventually moved for a new trial on the basis that there "was no evidence that Jackson . . . would ever attain a status which the court might regard as 'sane' in the sense of competency to stand trial."²² Under such circumstances, Jackson's counsel "contend[ed] that his commitment was tantamount to a 'life sentence' without" conviction in violation of his due process and equal protection rights under the Fourteenth Amendment.²³

Upon the Supreme Court's review of the matter, the Court held "Indiana's indefinite commitment of a criminal defendant solely on account of his incompetency to stand trial does not square with the Fourteenth Amendment's

18. *Jackson v. Indiana*, 406 U.S. 715, 720 (1972).

19. *Id.* at 717.

20. *Id.*; see also George F. Parker, *An Historical Review of the Legal and Personal Background to Jackson v. Indiana*, 39 J. AM. ACAD. PSYCHIATRY & L. 86 (2011) (providing fascinating insight into the personal history of Mr. Jackson, as well as additional context to the Supreme Court's portrayal of his robbery amounting to "merely" nine dollars).

21. *Jackson*, 406 U.S. at 719.

22. *Id.*

23. *Id.* at 716.

guarantee of due process.”²⁴ Rather, a state may not commit a criminal defendant on account of his incapacity for “more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain [competency] in the foreseeable future.”²⁵ In the absence of such probability, the State must either release the defendant or institute civil proceedings for commitment.²⁶ Furthermore, “by subjecting Jackson to a more lenient commitment standard and to a more stringent standard of release than those generally applicable to all others not charged with offenses,” Indiana divested Jackson “of equal protection of the laws under the Fourteenth Amendment.”²⁷ In order to civilly commit an individual, there must be a finding that he is “mentally ill and either dangerous or gravely disabled.”²⁸ By contrast, the State committed Jackson merely because (1) it charged him with a crime, and (2) the court determined he was incompetent.²⁹

The Supreme Court’s holding in *Jackson* prompted Indiana to immediately amend its statutory framework. Pursuant to the resulting legislation, a defendant must be able to understand the proceedings and assist in the preparation of his defense in order to be adjudicated as competent to stand trial.³⁰ If there are reasonable grounds to believe a defendant is incompetent, the court will set a hearing and appoint two or three psychiatrists, psychologists, or physicians with expertise in competency determination.³¹ The individuals appointed by the court will evaluate the defendant and testify regarding his competency.³²

If the defendant is competent, the trial will proceed; if the defendant is incompetent, the court will continue the proceedings and commit the defendant to the DMHA.³³ Either the DMHA will “provide competency restoration services or enter into a contract for the provision of competency restoration services by a third party in the: (1) location where the defendant currently resides; or (2) least restrictive setting appropriate to the needs of the defendant and the safety of the defendant and others.”³⁴ Indiana Code section 35-36-3-1(b) is particularly significant because it is outpatient permissive on account that the DMHA may either provide competency restoration services at a state hospital *or* “enter into a contract for the provision of competency restoration services by a third-party.”³⁵ In actuality, defendants in Indiana are not provided outpatient treatment for

24. *Id.* at 731.

25. *Id.* at 738.

26. *Id.*

27. *Id.* at 730.

28. IND. CODE ANN. § 12-26-6-1 (West 2020) (providing the standard for temporary civil commitment); *Id.* § 12-26-7-3 (providing the standard for regular civil commitment).

29. *See generally Jackson*, 406 U.S. at 715.

30. IND. CODE ANN. § 35-36-3-1(a).

31. *Id.*

32. *Id.*

33. *Id.* § 35-36-3-1(b).

34. *Id.*

35. *Id.*

competency restoration services.³⁶ Competency restoration services provided by the DMHA entail commitment to a state institution as defined by Indiana Code section 12-7-2-184. This term includes the following state psychiatric hospitals: Evansville State Hospital, Evansville Psychiatric Children’s Center, Logansport State Hospital, Madison State Hospital, Richmond State Hospital, and the NeuroDiagnostic Institute.³⁷ The majority of criminal defendants are committed to Logansport State Hospital, which has 170 beds available to both forensic, i.e. “court-involved,”³⁸ and civil patients in its Isaac Ray Treatment Center and Larson Treatment Center.³⁹ Seventy-five percent of Logansport State Hospital’s population are forensic patients, including, but not limited to, those deemed incompetent to stand trial, not guilty by reason of insanity, in need of “sexual responsibility programming,” and mentally ill with severely dangerous behaviors.⁴⁰

Within ninety days following the initiation of competency restoration services at a state institution or by a third-party contractor, the superintendent of the state hospital or director or medical director of the third-party contractor will “certify to the . . . court whether the defendant has a substantial probability of attaining” competency in the foreseeable future.⁴¹ If a substantial probability does not exist, the superintendent or director or medical director will initiate civil commitment proceedings pursuant to Indiana Code section 12-26.⁴² If a substantial probability does exist, the state institution or third-party contractor will continue competency restoration services until the defendant attains competency, or for six months

36. Thomas *ex rel.* Thomas v. Murphy, 918 N.E.2d 656, 664 (Ind. Ct. App. 2009) (noting competency restoration services are only offered at six hospitals). At the time this author wrote her Note, the DMHA did not provide outpatient competency restoration services. In November of 2020, the Indiana Family and Social Services Administration “announced a series of pilot programs designed to increase access to mental health care for inmates in Indiana county jails,” including working with “partners to provide [competency restoration] services in . . . the community.” *FSSA Announces Pilot Programs Designed to Treat Hoosiers Involved in the Justice System*, IND. FAM. & SOC. SERVS. ADMIN. (Nov. 6, 2020), <https://www.in.gov/fssa/files/ICST-Press-Release.pdf> [<https://perma.cc/3R75-XP2Z>]. The pilot programs are very encouraging, and this Note provides support for the necessity, and continuous development, of such a program.

37. IND. CODE ANN. § 12-7-2-184(b)(1)-(6); *State Psychiatric Hospitals*, IND. FAM. & SOC. SERVS. ADMIN., <https://www.in.gov/dmha/state-psychiatric-hospitals/> (last visited Aug. 7, 2021) [<https://perma.cc/C2QC-NGQQ>].

38. Mitchell Kirk, *Longstanding Longcliff: Logansport State Hospital Turns 130*, PHAROS TRIB. (June 27, 2018), https://www.pharostribune.com/news/local_news/article_8f145e0d-e0c7-5a85-855c-bd269d2c0207.html [<https://perma.cc/N9XG-AN2Q>].

39. *Population*, IND. FAM. & SOC. SERVS. ADMIN., <https://www.in.gov/fssa/dmha/state-psychiatric-hospitals/logansport-state-hospital/population/> (last visited Aug. 7, 2021) [<https://perma.cc/2VAN-DX3J>].

40. Kirk, *supra* note 38.

41. IND. CODE ANN. § 35-36-3-3(a).

42. *Id.* § 35-36-3-3(b).

from the date restoration services began, whichever occurs first.⁴³ If competency is not restored within six months from the date competency restoration services commenced, the state institution will submit a petition for involuntary commitment pursuant to Indiana Code section 12-26-7.⁴⁴ The petition must include a written statement by a physician that the physician believes the individual to be mentally ill and either dangerous or gravely disabled, and in need of custody, care, or treatment in a facility for a period likely to exceed ninety days.⁴⁵

B. Judicial Clarification

More than thirty years after *Jackson*, it became apparent the Indiana Code complied with the United States Supreme Court's mandates in codification only. Despite progressive reform to Indiana's statutory framework, unrestorable defendants languished in state psychiatric hospitals, committed for periods exceeding the maximum possible sentence that could be imposed if tried for their crimes.⁴⁶ Indiana's "modern" competency cases not only answered questions left unresolved by *Jackson*, but also set forth the Indiana legislature's intent in its adoption of the Indiana Code provisions regarding competency to stand trial, as well as a policy of strict adherence to statutory procedure. Notably, the Indiana Supreme Court's decisions effectively demanded commitment to the DMHA for competency restoration services,⁴⁷ while failing to accord proper recognition to the additional language set forth in the aforementioned statutory procedure that unambiguously provides for an outpatient model for competency restoration services.⁴⁸

In *State v. Davis*, the Indiana Supreme Court ultimately held that commitment of an accused "necessarily entails a finding of probability that the accused can be" restored to competency.⁴⁹ Despite statutory silence regarding a patient's eligibility for release where the confinement was predicated on their incompetency to stand trial, the Indiana Supreme Court granted Davis's motion for dismissal of charges, because Davis's confinement "extended beyond the maximum period of any sentence the trial court [could] impose," and because "it is a violation of basic notions of fundamental fairness as embodied in the Due Process Clause of the Fourteenth Amendment to hold criminal charges over" a defendant that will never attain competency.⁵⁰

In 2011, the Indiana Supreme Court considered the issue of competency once again. Alva Curtis filed a motion to dismiss charges against him for residential

43. *Id.*

44. *See id.* § 12-26-7-1 to -5.

45. *Id.* § 12-26-7-3.

46. *State v. Davis*, 898 N.E.2d 281, 290 (Ind. 2008).

47. *Curtis v. State*, 948 N.E.2d 1143, 1153 (Ind. 2011).

48. IND. CODE ANN. § 35-36-3-3(b).

49. *Davis*, 898 N.E.2d at 289.

50. *Id.* at 289-90.

entry, battery, and criminal mischief.⁵¹ Curtis was fifty-nine years old at the time he presented before the Indiana Supreme Court.⁵² He suffered from a seizure disorder, developmental disability, and dementia, and was unable to “perform simple calculations, go grocery shopping, or read.”⁵³ In order to assess his competency, two psychiatrists evaluated Curtis; one opined Curtis’s competency would never be restored, and the other opined it was unlikely Curtis would attain competency.⁵⁴ However, the court did not commit Curtis to the DMHA.⁵⁵ While the record reflected Curtis had a degenerative,⁵⁶ deteriorating mental condition,⁵⁷ the Indiana Supreme Court reaffirmed the procedures set forth by the legislature in Indiana Code section 35-36-3-1.⁵⁸ The court emphasized the necessity of an appropriate finding that Curtis would never be restored to competency in order for his counsel to successfully assert violation of his client’s right to due process.⁵⁹ Because the two psychiatrists differed in their opinions as to whether Curtis was restorable, the defendant was unable to meet the burden imposed by the Indiana Supreme Court.⁶⁰

The Indiana Supreme Court continued to advocate for strict adherence to the language set forth by Indiana statute when it considered the circumstances of William Coats, a nearly seventy-year-old man diagnosed with Alzheimer’s.⁶¹ Upon a motion for a competency evaluation, psychiatrists diagnosed Coats with dementia.⁶² The psychiatrists concluded Coats “was not competent to stand trial, and predicted he could not be restored to competency.”⁶³ Upon the State’s motion to commit Coats to the DMHA, the trial court denied the motion, determined Coats could not be restored to competency, and concluded “he was not a public safety risk.”⁶⁴ The Indiana Supreme Court stated the plain language of the Indiana Code “does not give trial courts discretion to refuse to commit a defendant once it determines that he or she is not competent to stand trial.”⁶⁵ Furthermore, while “the State’s interest in the restoration of an accused to competency cannot be realized if there is a finding that such restoration is not substantially probable in the foreseeable future,” such a finding is the statutory responsibility of the

51. *Curtis*, 948 N.E.2d at 1146.

52. *Id.*

53. *Id.*

54. *Id.*

55. *Id.*

56. *Id.*

57. *Id.* at 1151.

58. *Id.* at 1153-54.

59. *Id.* at 1154.

60. *Id.* at 1146, 1154.

61. *State v. Coats*, 3 N.E.3d 528 (Ind. 2014).

62. *Id.* at 529.

63. *Id.*

64. *Id.* at 530.

65. *Id.* at 532.

DMHA.⁶⁶

II. UNRESOLVED ISSUES SURROUNDING COMPETENCY DETERMINATIONS AND RESTORATION

A. Distinguishing Between Competency Restoration Services and Mental Health Treatment

At the outset, it is important to note that “competency restoration is not the same as mental health treatment,”⁶⁷ and therefore, it is unlikely that defendants undergoing competency restoration services will receive adequate medical treatment necessary for their underlying mental health conditions. Specifically, competency is a legal term of art, rather than “a medical one.”⁶⁸ The goals of competency restoration and mental health treatment are vastly different: “competency restoration serves the criminal justice system; treatment serves the individual who is ill.”⁶⁹ The principal purpose of competency restoration services “is to help a defendant comprehend his or her charges, understand the hearing process, and assist the attorney in his or her defense.”⁷⁰ An incompetent defendant is taught about the legal system, the roles of its players, and courtroom procedures.⁷¹ In light of the circumstances which lead to a conclusion that the defendant is incompetent to stand trial, this purpose is rationally related to the end goal: to ensure the defendant meets the requirements of competency so that they may answer to the charges pending against them. As a result, restoration services fail to provide “adequate and appropriate mental health treatment to manage illness, provide care, and improve a person’s condition.”⁷² While the services may involve the administration of medications, course of treatment is considerably limited in comparison to what is typically provided in a hospital setting.⁷³

Additionally, competency restoration services “coach defendants to get

66. *Id.* at 534.

67. Elena Schwartz, *Restoring Mental Competency: Who Really Benefits?*, CRIME REP. (Aug. 8, 2018), <https://thecrimereport.org/2018/08/08/restoring-mental-competency-who-really-benefits/> [<https://perma.cc/NKR5-AMUQ>].

68. *Id.*

69. Frankie Berger, *Competency Restoration versus Psychiatric Treatment*, TREATMENT ADVOC. CTR., <https://www.treatmentadvocacycenter.org/fixing-the-system/features-and-news/4126-the-distinction-between-competency-restoration-and-psychiatric-treatment> (last visited Aug. 7, 2021) [<https://perma.cc/L6H7-D8ZE>].

70. *Id.*

71. Eleanor Dearman, *Some Texas Defendants Can Wait Months for State Hospital Beds. What’s Being Done About it?*, CORPUS CHRISTI CALLER TIMES (Aug. 1, 2019, 9:55 AM), <https://www.caller.com/story/news/crime/2019/08/01/accused-criminals-texas-being-held-months-defendants-can-wait-months-state-hospital-beds-whats-being/2748483002/> [<https://perma.cc/X5EQ-4FF3>].

72. Berger, *supra* note 69.

73. *Id.*

through a trial, teaching them about the roles of different court actors, the meaning of various charges, and the potential penalties they will face if convicted.”⁷⁴ This “coaching” raises significant questions regarding the legitimacy of competency determinations. For example, it may be the case that the defendant does not actually understand the nature of the charges pending against him or her or the mechanisms of trial, but rather, in an effort “to escape confinement,” can parrot back the information learned during their lessons at the state psychiatric hospital.⁷⁵ The defendant’s ability to do so may lead to premature and erroneous determinations regarding the efficacy of competency restoration services, meaning that the defendant, who is actually still incompetent, but presents as competent, is returned to jail ahead of trial with substantial likelihood that the issue of competency will be raised once again.⁷⁶

B. Diminished Capacity of Beds Available in State Psychiatric Institutions

A shortage of psychiatric beds in state hospitals also presents significant issues for defendants deemed incompetent to stand trial. Presently, “not enough public psychiatric beds exist to accommodate the defendants referred for competence restoration each year.”⁷⁷ Requests for competency evaluations “are the most common forensic evaluations ordered by the criminal courts.”⁷⁸ Figures estimate “requests for evaluations of competency to stand trial for adult criminal defendants have increased from approximately 25,000 to 36,000 annually to 50,000 to 60,000 in recent years.”⁷⁹ However, as a result of deinstitutionalization, “states continue to decrease the number of state hospital beds they supply per capita.”⁸⁰

The Treatment Advocacy Center, a national nonprofit organization centered upon advocacy for the mentally ill, contends that the “adequate number of psychiatric beds” to accommodate a jurisdiction’s population is “defined as 40

74. Schwartz, *supra* note 67.

75. Graham S. Danzer et al., *Competency Restoration for Adult Defendants in Different Treatment Environments*, 47 J. AM. ACAD. PSYCHIATRY & L. 1, 3 (2019), <http://jaapl.org/content/jaapl/early/2019/02/08/JAAPL.003819-19.full.pdf> [<https://perma.cc/S6GA-RK67>].

76. Margaret Wilkinson Smith, Note, *Restore, Revert, Repeat: Examining the Decomensation Cycle and Due Process Limitations on the Treatment of Incompetent Defendants*, 71 VAND. L. REV. 319, 328 (2018).

77. Susan McMahon, *Reforming Competence Restoration Statutes: An Outpatient Model*, 107 GEO. L.J. 601, 609 (2019).

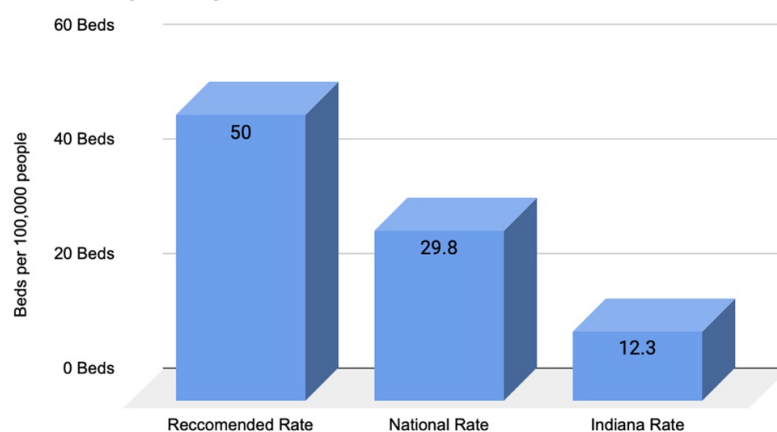
78. W. Neil Gowensmith et al., *Lookin’ for Beds in All the Wrong Places: Outpatient Competency Restoration as a Promising Approach to Modern Challenges*, 22 PSYCH., PUB. POL’Y, & L. 293, 293 (2016) [hereinafter Gowensmith et al., *Competency Restoration*].

79. Danzer et al., *supra* note 75, at 1.

80. *Psychiatric Bed Supply Need Per Capita*, TREATMENT ADVOC. CTR. (Sept. 2016), <https://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3696> [<https://perma.cc/CH9E-ZHW4>]. Deinstitutionalization refers to the closure of “state mental hospitals” and the reduction of available beds for inpatient psychiatric treatment. *Id.*

to 60 beds per 100,000 population, with a consensus of around 50 beds per 100,000 population.”⁸¹ On a national scale, there are “29.8 beds for every 100,000 population.”⁸² As of 2016, Indiana similarly fell well below the acceptable range of psychiatric beds, with its state psychiatric hospitals containing 12.3 beds per 100,000 population.⁸³ Significantly, such figures do not distinguish between beds allocated for the civil population and forensic patients.

Availability of Psychiatric Beds



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With a population of 6,732,219 in 2019,⁸⁵ the current capacity of Indiana’s psychiatric hospitals is insufficient to meet the demand of defendants who require competency restoration services. In recent years, requests for competency evaluations have increased, with estimates ranging between 50,000 to 60,000 annually, and the number of requests continues to swell.⁸⁶ Likewise, as competency evaluations increase, so too does the number of defendants adjudicated as incompetent.⁸⁷ To meet the demand imposed by forensic patients in need of competency restoration services in Indiana, civil beds “are being

81. *State-By-State Guide to Estimating Psychiatric Bed Distribution*, OPEN MINDS at 1 (May 2017), https://www.openminds.com/wp-content/uploads/Psych_Beds_Reference_Guide_051117.pdf [<https://perma.cc/UNB8-M5UE>].

82. *Id.*

83. *Id.* at 3.

84. My express gratitude to my brother-in-law, Philip Shutler, for creating this graphic for me.

85. *QuickFacts: Indiana*, U.S. CENSUS BUREAU, <https://www.census.gov/quickfacts/IN> (last visited Aug. 7, 2021) [<https://perma.cc/WP2A-7AJH>].

86. Gowensmith et al., *Competency Restoration*, *supra* note 78, at 293.

87. *Id.*

repurposed to meet forensic demand.”⁸⁸ Even still, forensic allocations are often exceeded in an attempt, and failure, to meet this demand.⁸⁹ As a result, the bed shortage leads to lengthy periods of time by which the accused sits in jail awaiting competency restoration services, presenting two problems: “(1) defendants found incompetent to stand trial are imprisoned for longer periods of time than competent defendants, and (2) defendants living with mental illness suffer significant harm while in jail.”⁹⁰

1. *Extended Imprisonment for Incompetent Defendants.*—Notably, an incompetent defendant “hospitalized will often spend a longer time imprisoned than a competent defendant accused of the same crime with the same criminal history.”⁹¹ In Indiana, *Davis* requires dismissal of pending criminal charges after a defendant is committed for competency restoration services for a time period in excess of the maximum sentence that could be imposed if the defendant were competent and tried for their crime.⁹² However, *Davis* applies only to the period of time during which the state institutions render competency restoration services, rather than the interim period as an incompetent defendant waits in jail for a bed to become available at a state institution. For a defendant with a pending misdemeanor charge facing a relatively short sentencing penalty, even six months waiting for a bed may constitute a period of time in excess of the penalty possibly imposed if convicted of a crime.⁹³ Nevertheless, *Davis*’ limitation would not apply because the clock does not begin to run at a finding of incompetency, but rather upon commencement of competency restoration services.⁹⁴

2. *Decompensation and Associated Harms.*—Defendants awaiting the availability of a bed for inpatient compensation services are at tremendous risk of decompensation. Decompensation refers to the reversion of a defendant “to a delusional or incompetent state.”⁹⁵ Defendants often decompensate in the interim period waiting for a bed to become available at a state institution after a finding of incompetency,⁹⁶ as well as upon a defendant’s return to jail following

88. Doris A. Fuller et al., *Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds*, 2016, TREATMENT ADVOC. CTR. at 11 (June 2016), <https://www.treatmentadvocacycenter.org/storage/documents/going-going-gone.pdf> [<https://perma.cc/ZK4T-BWEY>].

89. *Id.*

90. McMahon, *supra* note 77, at 610.

91. *Id.*

92. *See generally* State v. Davis, 898 N.E.2d 281 (Ind. 2008).

93. *See* discussion *infra* Section II.E.

94. *Davis*, 898 N.E.2d at 289-90.

95. Smith, *supra* note 76, at 328.

96. Justin Jouvenal, *Man Accused of Stealing \$5 in Snacks Died in Jail as He Waited for Space at Mental Hospital*, WASH. POST (Sept. 29, 2015), https://www.washingtonpost.com/local/crime/man-accused-of-stealing-5-in-snacks-died-in-jail-as-he-waited-for-space-at-mental-hospital/2015/09/29/7ceac8a2-5aff-11e5-9757-e49273f05f65_story.html [<https://perma.cc/Y273-BAN7>].

restoration of their competency.⁹⁷

Decompensation can have disastrous or fatal results. In Virginia, Jamycheal Mitchell, an incompetent defendant, died as he waited for a bed at a state hospital.⁹⁸ Officers arrested Jamycheal for stealing “a Mountain Dew, a Snickers bar[,] and a Zebra cake totaling \$5.05.”⁹⁹ After the court determined Jamycheal was incompetent, it ordered his commitment to a state hospital for competency restoration services.¹⁰⁰ Seventy-one days following the determination of his incompetency, Jamycheal still had not been transferred to a state hospital because a bed was unavailable.¹⁰¹ During that period, Jamycheal’s untreated schizophrenia and bipolar disorder caused his “mental status [to deteriorate] significantly.”¹⁰² Tragically, Jamycheal died in his cell, forty-six pounds lighter than he was upon his admission to the jail, “still awaiting transfer for competency restoration services.”¹⁰³

Jamycheal’s family is not alone in experiencing the type of grief caused by this tragic, and avoidable, event.¹⁰⁴ At the San Luis Obispo County Jail, a man died of complications associated with his mental illness as he waited for transfer to a hospital for competency restoration services.¹⁰⁵ Another incompetent defendant in California committed suicide in jail as he awaited a bed at a state hospital.¹⁰⁶ As accused men and women wait for competency restoration services to commence, they languish without adequate treatment, which can cause serious or life-threatening harm.¹⁰⁷ The absence of treatment causes symptoms of mental illness to increase in severity, and “untreated mental illness, particularly untreated psychosis, can lead to irreversible brain atrophy.”¹⁰⁸ Additionally, this sector of the jail population is particularly susceptible to “suicide, self harm, and victimization.”¹⁰⁹ However, these results are avoidable by prompt placement for competency restoration services, which can be accomplished by looking for beds *outside* of state hospitals and adopting an outpatient model for restoration

97. Smith, *supra* note 76, at 328.

98. Jouvenal, *supra* note 96.

99. *Id.*

100. *Id.*

101. W. Neil Gowensmith, *Resolution or Resignation: The Role of Forensic Mental Health Professionals Amidst the Competency Services Crisis*, 25 PSYCH., PUB. POL’Y, & L. 1, 1 (2019) [hereinafter Gowensmith, *Competency Services Crisis*].

102. *Id.*

103. *Id.*

104. *Id.*; see also Jouvenal, *supra* note 96.

105. Chris McGuinness, *No Place to Go: Inmates Declared Mentally Unfit to Stand Trial Languish in Jails*, NEW TIMES (May 31, 2017), <https://www.newtimeslo.com/sanluisobispo/no-place-to-go-inmates-declared-mentally-unfit-to-stand-trial-languish-in-jails/Content?oid=2978784> [https://perma.cc/AN4C-7BME]; Gowensmith, *Competency Services Crisis*, *supra* note 101, at 1.

106. Gowensmith, *Competency Services Crisis*, *supra* note 101, at 1.

107. *Id.* at 4.

108. *Id.*

109. *Id.*

services.¹¹⁰

In addition, defendants “restored” to competency returned to jail to continue trial proceedings typically experience decompensation into an incompetent state.¹¹¹ As a result, questions regarding the accused’s competency are raised once again, and the cycle continues *ad nauseum*.¹¹² Systemic problems associated “with the mental health treatment available in jails and prisons . . . contribute to the decompensation cycle.”¹¹³ Jails and prisons, especially smaller facilities in rural areas, are inadequately prepared to treat mental and psychotic disorders.¹¹⁴ It is tremendously difficult for jails to ensure defendants continue any of the treatment provided to them at the state psychiatric hospitals. Upon returning to the local jails, defendants may refuse to take the medications prescribed at the inpatient facility, or such medication may be unavailable at the jail.¹¹⁵

Moreover, jail conditions are particularly detrimental to mentally ill inmates. Jails in the United States are plagued by overcrowding, which may result in “crowding up to three prisoners per available bed.”¹¹⁶ In addition to spatial limitations, jails, unlike therapeutic institutions, are “[ill-]equipped to manage mental illness or keep those with mental illness from being victimized by the general population of inmates.”¹¹⁷ Deficient mental health services; exposure to a “chaotic, violent environment”; the use of solitary confinement as punishment; and the increased possibility of “abuse and neglect” compared to their mentally sound counterparts contribute to an increased likelihood of decompensation upon a restored defendant’s return to jail.¹¹⁸

C. Forensic Psychology’s Difficulty Determining Unrestorability

While termed “competency restoration services,” inevitably, some defendants committed to the DMHA “never possessed competency to begin with” and “may never be restored to competency.”¹¹⁹ Although approximately eighty to ninety percent of incompetent defendants are restored to competency within six months of treatment, the remaining ten to twenty percent “can consume a

110. *See id.* at 8.

111. McMahon, *supra* note 77, at 611.

112. *Id.*

113. Smith, *supra* note 76, at 332.

114. *Id.* at 332-33.

115. McMahon, *supra* note 77, at 611.

116. Gowensmith, *Competency Services Crisis*, *supra* note 101, at 4.

117. Martha Bellisle, *After Paying \$83 Million in Fines, Washington Settles Jail Mental-Health Lawsuit*, SEATTLE TIMES (Dec. 12, 2018, 4:27 PM), <https://www.seattletimes.com/seattle-news/judge-oks-settlement-in-case-against-washington-state-over-delays-in-mental-competency-services/> [<https://perma.cc/UMM2-EUYY>].

118. McMahon, *supra* note 77, at 613.

119. Thomas *ex rel.* Thomas v. Murphy, 918 N.E.2d 656, 660 (Ind. Ct. App. 2009) (citing the opinion of Dr. George F. Parker, prior Medical Director of the DMHA and forensic psychiatrist, regarding unrestorability).

disproportionate amount of state mental health resources, particularly if they are state hospital patients.”¹²⁰ This remaining portion of incompetent defendants presents additional issues for forensic psychiatrists tasked with assessing an accused’s probability of attaining competency. Referred to as the “quandary of unrestorability,” forensic psychiatry encounters great difficulty predicting whether efforts to restore a defendant’s competency will be successful or not¹²¹; yet the criminal justice system in Indiana requires definitive conclusions as to a defendant’s prospects of restorability. Definitive conclusory statements as to whether a defendant is restorable are complicated, because Indiana, like many other jurisdictions, lacks “established legal guidelines concerning testimony about potential restoration.”¹²²

Unsurprisingly, different states use different approaches for determining competency.¹²³ Some states require a declaration that a defendant is unrestorable after cessation of the time period permitted by statute for competency restoration efforts.¹²⁴ For example, because the Indiana statute limits the period of competency restoration efforts to six months before the court may pursue involuntary civil commitment, pursuant to the foregoing approach, the defendant would be declared unrestorable after the six-month period. Other states, including Indiana, rely on the opinions of psychiatrists or psychologists.¹²⁵ Indiana’s approach requires a finding as to whether there is a substantial probability that the defendant will be restored to competency in the foreseeable future.¹²⁶ However, the term “substantial probability” is undefined, and the forensic psychiatry community lacks complete agreement as to when circumstances and “which disorders might qualify a defendant for this finding.”¹²⁷

Approximately one-third of defendants with intellectual disabilities or mental illness are referred for competency restoration services, with greater chances of restoration for mentally ill defendants compared to intellectually disabled defendants.¹²⁸ Additionally, there are other factors that may impact the likelihood that a defendant’s competency will be restored by restoration efforts.¹²⁹ Generally, competency restoration services are less likely to be successful for men compared

120. George F. Parker, *The Quandary of Unrestorability*, 40 J. AM. ACAD. PSYCHIATRY L. 171, 171 (2012).

121. *Id.*

122. Douglas Mossman, *Predicting Restorability of Incompetent Criminal Defendants*, 35 J. AM. ACAD. PSYCHIATRY & L. 34, 35 (2007).

123. Parker, *Quandary of Unrestorability*, *supra* note 120, at 174.

124. *Id.*

125. *Id.*

126. See IND. CODE ANN. § 35-36-3-3(a) (West 2020).

127. Parker, *Quandary of Unrestorability*, *supra* note 120, at 174.

128. Haleigh Reisman, Note, *Competency of the Mentally Ill and Intellectually Disabled in the Courts*, 11 J. HEALTH & BIOMED. L. 199, 223-24 (2015).

129. See generally Janet I. Warren et al., *Factors Influencing 2,260 Opinions of Defendants’ Restorability to Adjudicative Competency*, 19 PSYCH., PUB. POL’Y, & L. 498 (2013).

to women.¹³⁰ Moreover, competency restoration efforts are less likely to be successful for defendants with dementia over the age of sixty-five.¹³¹ Studies also indicate that clinical characteristics, such as a chronic psychotic illness (e.g., schizophrenia and schizoaffective disorder, intellectual disability, and dementia), may contribute to unrestorability.¹³² Perhaps the most surprising and troubling finding is that the severity of the charge may be determinative regarding the restorability of a defendant's competency. Research suggests restoration efforts are more successful for individuals charged with felonies compared to defendants facing misdemeanor charges.¹³³ Such a finding is especially problematic given felony charges are typically more complex to understand from a legal standpoint,¹³⁴ and penalties for misdemeanor violations are less severe and extensive in duration compared to penalties for felonies.¹³⁵ Take, for example, an incompetent defendant charged with a Class C Misdemeanor. In Indiana, the misdemeanant may not be imprisoned in excess of sixty days, but may wait just as long for a bed to become available at a state hospital.¹³⁶ Once this defendant is transferred to a state hospital, his status as a misdemeanant may indicate that he is at a greater risk of being unrestorable.¹³⁷

Notwithstanding forensic psychology's research concerning factors that may impact the likelihood of restorability, physicians and psychiatrists tasked with assessing competency may nevertheless reach different conclusions regarding a defendant's competency, or express an overall reluctance to state conclusively that a defendant will *never* attain competency. As demonstrated by the *Curtis* decision, even if a defendant *is* unrestorable, differing opinions of forensic psychiatrists regarding the defendant's restorability may result in the defendant's commitment to the DMHA for competency restoration services at a state hospital.¹³⁸ Yet, Indiana courts place significant emphasis on the necessity of finding an incompetent defendant as unrestorable in order to justify dismissal of the charges pending against him.¹³⁹

In *Habibzadah v. State*, Ahmed Habibzadah had "receptive expressive language disorder" as a result of a traumatic brain injury, as well as cognitive deficiencies.¹⁴⁰ The DMHA ultimately concluded Habibzadah was unlikely to

130. *Id.* at 499.

131. *Id.*

132. *Id.* at 499-500.

133. *Id.* at 500.

134. *Id.*

135. Compare IND. CODE ANN. § 35-50-2-7 (West 2020) (setting forth the advisory sentence for the "lowest" level of felony as one and one-half years), with *id.* § 35-50-3-4 (setting forth sixty days as the cap for imprisonment for a violation of the "lowest" level of a misdemeanor).

136. Fuller et al., *supra* note 88, at 23.

137. Warren et al., *supra* note 129, at 500.

138. *Curtis v. State*, 948 N.E.2d 1143, 1154 (Ind. 2011).

139. *Id.*; see *State v. Davis*, 898 N.E.2d 281 (Ind. 2008).

140. *Habibzadah v. State*, 904 N.E.2d 367, 368 (Ind. Ct. App. 2009).

attain competency in the foreseeable future.¹⁴¹ Habibzadah moved the court to dismiss the charges pending against him, but the trial court refused to grant the motion because the DMHA did not present a finding that Habibzadah would never be restored to competency.¹⁴² On appeal, the Indiana Court of Appeals acknowledged that, while “a trial court has inherent authority . . . to dismiss criminal charges where the prosecution would violate a defendant’s constitutional due process rights,”¹⁴³ there was no such violation in Habibzadah’s case, because a determination that he “will *never* be restored to competency” was absent from the record.¹⁴⁴ Despite exemplifying characteristics that increased the likelihood Habibzadah was unrestorable, i.e., his sex and intellectual disability, as well as a subtle concession by the DMHA that he was unlikely to attain competency, the Indiana Court of Appeals required competency restoration services so long as there was a possibility such efforts might prove successful.¹⁴⁵ Absent such a finding, he would have to be confined for the maximum possible sentence for a Class A felony, which was fifty years,¹⁴⁶ before his charges could be dismissed and before any adjudication of his guilt.

Unsettled by the problems presented pertaining to unrestorability, Judge Paul Mathias of the Indiana Court of Appeals offered his critiques in his concurring opinion of *Habibzadah* regarding the inability of Indiana’s criminal justice procedures to “resolve issues presented by defendants suffering from long-term or permanent mental illness.”¹⁴⁷ Judge Mathias called attention to the difficulty in obtaining certainty as to a defendant’s restorability and noted,

The issue left untouched in *Davis* is what happens to charges filed against a defendant who has not yet been civilly committed for the full length of the maximum sentence allowed under the charges against him or her but who is considered mentally incompetent without a chance of recovering competence. Mental health diagnoses are imprecise at best. The difference between indeterminate civil commitment with the underlying charges dismissed and continued pending of charges during that commitment is the word “never,” or words to that effect, in a psychiatrist’s report.¹⁴⁸

Rather than relying on findings that a defendant will never be restored or setting arbitrary percentages of probability as to whether a defendant will regain competency in order to justify dismissing charges against a defendant, Judge

141. *Id.*

142. *Id.*

143. *Id.* at 369 (citing *Davis*, 898 N.E.2d at 285).

144. *Id.* (emphasis in original).

145. *Id.* (“[U]nlike *Davis*, there has not been a determination that Habibzadah will *never* be restored to competency. Although the evidence suggests that such restoration is unlikely, the possibility exists.”).

146. *Id.*

147. *Id.* (Mathias, J., concurring).

148. *Id.* at 370.

Mathias advocated for “an earlier and intervening procedure to determine competency retroactively to the time of the alleged crime” and perhaps consideration of “the concept of a defendant being *unchargeable* because of mental illness under Indiana Code section 35-41-3-6.”¹⁴⁹ Whether Judge Mathias’ proposals are appropriate or not, it logically follows that the issue of deeming a defendant as unrestorable is problematic for both the courts and forensic psychiatry alike. Ultimately, the unrestorable defendant lacking an explicit, or consistent, determination regarding their unrestorability, or deemed “unlikely” to be restored, suffers the most from the quandary of unrestorability.

D. Probate Court Denials of Involuntary Commitment Orders Pursuant to Indiana Code Section 12-26-7

While Indiana Supreme Court decisions mandate compliance with the statutory procedure set forth by Indiana Code section 35-36-3, there is no statutory authority compelling probate courts to grant petitions for civil commitment propounded pursuant to Indiana Code section 12-26-7.¹⁵⁰ As previously explained, Indiana Code section 35-36-3-4 requires the DMHA to institute regular commitment proceedings pursuant to Indiana Code section 12-26 if the defendant is unable to attain competency within six months after the defendant’s admission to the state psychiatric hospital.¹⁵¹ At that point, a hearing is conducted and an accused “found to be mentally ill and either dangerous or gravely disabled” is either ordered by the court to “treatment in an appropriate facility” or “an outpatient therapy program under [Indiana Code section] 12-26-14.”¹⁵² Unlike the procedures for commitment of an incompetent defendant to the DMHA, admission to an outpatient therapy program pursuant to Indiana Code section 12-26-14 requires the court’s approval of the chosen program, as well as a representation made to the court by a representative of the outpatient therapy program “that the individual may enter [the] program immediately.”¹⁵³

Because probate courts utilize a standard requiring a defendant be found mentally ill and either dangerous or gravely disabled,¹⁵⁴ a petition for civil commitment by the DMHA stating an incompetent defendant is unlikely to attain competency within the foreseeable future does not compel the probate courts to grant the DMHA’s request for civil commitment. A probate court’s denial of the DMHA’s petition results in the unrestored defendant returning to jail. The accused is not yet competent, but, absent civil commitment, the DMHA cannot hold the defendant for longer than provided by the Indiana Code.¹⁵⁵ An accused’s

149. *Id.* at 371 (emphasis in original).

150. *See* IND. CODE ANN. § 12-26 (West 2020).

151. *Id.* § 35-36-3-4.

152. *Id.* § 12-26-7-5(a).

153. *Id.* § 12-26-14-2.

154. *Id.* § 12-26-7-5.

155. *Id.* § 35-36-3-4 (“If a defendant . . . has not attained [the ability to understand the proceedings and assist in the preparation of the defendant’s defense] within six (6) months after the

return to jail all but guarantees that they will be susceptible to the risks of decompensation, longer periods in the criminal justice system than their competent counterparts, additional competency hearings, and subsequent recommitment to the DMHA.¹⁵⁶

E. Constitutional Considerations

Unrestorable defendants experience extreme curtailment of rights afforded by the United States Constitution. Indiana's body of case law regarding competency consistently reaffirms the principle that "[i]nvolutionary commitment is a clear deprivation of the defendant's liberty that can be justified only on the basis of legitimate state interests."¹⁵⁷

The State has dual interests in committing an incompetent defendant: (1) to restore the accused to competency due to the "right of the public and the defendant to the prompt disposition of criminal charges pending against him" and (2) to protect the defendant "against being required to answer to charges that she lacks the capacity to understand or assist her attorney in defending against."¹⁵⁸

The State's interests become irrelevant, however, if a defendant's competency is unrestorable; prompt disposition of the criminal charges pending against him cannot occur because his competency can never be restored, and indefinite confinement in an effort to restore competency for a period of time commensurate with the sentence that could be imposed is essentially an adjudication of guilt without a trial. Therefore, commitment of an unrestorable defendant is an unjustified deprivation of an accused's liberty.

Indiana Code section 35-34-1-4 provides a non-exhaustive list of circumstances permitting dismissal of an indictment, including "[a]ny other ground that is a basis for dismissal as a matter of law,"¹⁵⁹ which encompasses violations of an accused's constitutional right to due process.¹⁶⁰ Correspondingly, *Jackson v. Indiana* specified that "due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed."¹⁶¹ Because commitment of an accused "necessarily entails a finding of probability that the accused can be . . . restored" to

date of the . . . defendant's admission to a state institution[,] . . . the state institution . . . [will] institute regular commitment proceedings under IC 12-26."); *id.* § 12-26-7-5(a)(1) (providing that the court may enter an order for the individual's continued custody, care, or treatment in a facility where an individual is found to be mentally ill and either dangerous or gravely disabled).

156. See discussion *supra* Sections II.B.1-2.

157. *Curtis v. State*, 948 N.E.2d 1143, 1153 (Ind. 2011) (citing *State v. Davis*, 898 N.E.2d 281, 288 (Ind. 2008)).

158. *Id.* at 1154 (quoting *Davis*, 898 N.E.2d at 289).

159. IND. CODE ANN. § 35-34-1-4(a)(11).

160. *Habibzadah v. State*, 904 N.E.2d 367, 368 (Ind. Ct. App. 2009).

161. *Jackson v. Indiana*, 406 U.S. 715, 738 (1972).

competency,¹⁶² it is a violation of an accused's due process rights to continue to detain the accused when competency is unlikely to, or cannot, be restored. Rather, the state must pursue civil commitment proceedings or release the accused.¹⁶³

A defendant facing multiple felony charges and considered unable, or unlikely, to be restored as competent presents unique due process considerations that implicate the *Davis* holding. *Davis* prohibits maintaining criminal charges against a defendant unable to be restored to competency, and if restoration services commence for a period greater than the possible sentence imposed had the defendant stood trial for his or her crimes, charges must be dismissed against the defendant.¹⁶⁴ Any act to the contrary violates "basic notions of fundamental fairness as embodied in the Due Process Clause of the Fourteenth Amendment."¹⁶⁵ Applying *Davis* in situations where a defendant is facing multiple felonies, each carrying a substantial sentence, is far more complicated than meets the eye. Consider, as a hypothetical, an accused who is sixty-years old and charged with four Level 3 felonies. In Indiana, the possible sentence for a Level 3 felony is between three and sixteen years, with an advisory sentence of nine years.¹⁶⁶ The accused in this hypothetical also has a degenerative neurological condition and is unlikely to regain competency. Even more concerning, the DMHA petitions for involuntary civil commitment of the accused on more than one occasion, which the probate courts continue to deny, and the accused cycles through the DMHA, back to jail, and back to the DMHA again. If found guilty of his charges, the maximum possible sentence imposed would be sixty-four years. Under the *Davis* ruling, restoration services would have to continue for at least sixty-four years, until he reached the age of 124, before he may be released. His commitment would be tantamount to incarceration without a legal finding of guilt.

Ultimately, due to the foregoing constitutional concerns, the DMHA, as well as other State officials, may inevitably find themselves subject to lawsuits, as exemplified in other jurisdictions,¹⁶⁷ for failing to provide competency restoration services in the "least restrictive setting appropriate to the needs of the defendant and the safety of the defendant and others."¹⁶⁸ Several states have been subject to class action suits due to "delays in competency restoration treatment."¹⁶⁹ Modest resolutions of these lawsuits include promises to provide prompt competency restoration services or consent decrees requiring the implementation of specified

162. *Davis*, 898 N.E.2d at 289.

163. *Jackson*, 406 U.S. at 738.

164. *Davis*, 898 N.E.2d at 290.

165. *Id.*

166. IND. CODE ANN. § 35-50-2-5(b) (West 2020).

167. See Gowensmith et al., *Competency Restoration*, *supra* note 78, at 293.

168. IND. CODE ANN. § 35-36-3-1(b)(2); Kirk Heilbrun et al., *Treatment for Restoration of Competence to Stand Trial: Critical Analysis and Policy Recommendations*, 25 PSYCH., PUB. POL'Y, & L. 266, 266 (2019).

169. Heilbrun et al., *supra* note 168, at 267.

procedural alterations.¹⁷⁰ Noncompliance with court orders, on the other hand, can result in significant fines and fees levied against the state.¹⁷¹ In 2015, the Disability Law Center, a non-profit advocacy group for Massachusetts residents with disabilities,¹⁷² filed a federal class-action lawsuit under 42 U.S.C. § 1983, “alleg[ing] the state failed to provide timely and proper mental health competency evaluations and treatment to pre-trial detainees” in violation of Utah’s Constitution and the Fourteenth Amendment.¹⁷³ Utah officials eventually consented to a settlement after incidents in which individuals adjudged incompetent waited more than six months for a bed to become available at a state hospital.¹⁷⁴

Violation of such settlements may result in the imposition of hefty fines. In the state of Washington, the Department of Social and Health Services reached a settlement with Disability Rights Washington, a non-profit advocacy organization for people with disabilities, to require compliance on the part of the state “to provide timely competency evaluations and treatment for mentally ill people charged with crimes.”¹⁷⁵ Prior to the agreement reached with Washington officials, contempt fines of approximately \$83.4 million were assessed against the state for failing to provide competency restoration services.¹⁷⁶ Washington’s Department of Social and Health Services eventually announced its intention to invest in developing “state run community-based facilities.”¹⁷⁷ Kimberly Mosolf, a representative of Disability Rights Washington, believes the settlement agreement “will also bring about long term reforms to . . . bolster community mental health services.”¹⁷⁸

The diminished capacity of beds available for competency restoration, coupled with extended periods of time spent in jail awaiting a bed, exposes Indiana to liability for resulting constitutional violations. Moreover, allowing

170. *Department of Health Agrees to End Lengthy Waitlist for Admission of Prisoners with Mental Illness to State Mental Hospital*, ADVOC. CTR. LA. (Sept. 6, 2016), <http://advocacyla.org/component/content/article/11-news/163-department-of-health-agrees-to-end-lengthy-waitlist-for-admission-of-prisoners-with-mental-illness-to-state-mental-hospital> [<https://perma.cc/SKQ2-P222>]; Paul Tullis, *When Mental Illness Becomes a Jail Sentence*, ATLANTIC (Dec. 6, 2019, 6:00 PM), <https://www.theatlantic.com/politics/archive/2019/12/when-mental-illness-becomes-jail-sentence/603154/> [<https://perma.cc/M47X-Y8GP>].

171. Tullis, *supra* note 170.

172. *Home*, DISABILITY L. CTR., <https://www.dlc-ma.org> (last visited Mar. 14, 2020) [<https://perma.cc/3NDV-TC6T>].

173. Derek Gilna, *Utah Settles Federal Suit Alleging Delays in Competency Treatment for Pre-Trial Detainees*, PRISON LEGAL NEWS (Jan. 8, 2018), <https://www.prisonlegalnews.org/news/2018/jan/8/utah-settles-federal-suit-alleging-delays-competency-treatment-pre-trial-detainees/> [<https://perma.cc/LX3Y-DE4A>].

174. *Id.*

175. Bellisle, *supra* note 117.

176. *Id.*

177. *Id.*

178. *Id.*

incompetent defendants to decompensate and endure extended periods of incarceration prior to determining guilt “implicates many individual rights protected by the Constitution,” including the freedom from detention before a judgment of guilt in a criminal trial, the right to adequate medical treatment, and the right to a speedy trial.¹⁷⁹ By refusing to seek additional beds outside of the inpatient psychiatric system and beneficial treatment options available through community-based outpatient programs, Indiana may find itself subject to similar lawsuits, like Utah, Washington, and other states, and inevitably forced to invest in community-based outpatient treatment.

III. PROPOSED SOLUTIONS

A. Setting the Record Straight: Reconsidering the Judiciary’s Interpretation of Indiana Code Section 35-36-3-1 and Holding the DMHA Accountable

The Indiana Supreme Court’s decisions on the topic of competency to stand trial exemplify the court’s reliance on Indiana Code section 35-36-3-1(b) as mandating inpatient commitment of the defendant to one of the six state psychiatric hospitals for competency restoration services. As expressed in the *Curtis* opinion:

Statutes control the appropriate way to determine a defendant’s competency and, if necessary, to commit the defendant and provide restoration services. Indiana Code section 35-36-3-1 (Supp. 2010) establishes the procedures to determine a defendant’s competency to stand trial. . . . If the trial court finds a defendant incompetent, the trial court must commit the defendant to the DMHA, and the DMHA must provide competency services.¹⁸⁰

Perhaps the Indiana Supreme Court intended to implicitly acknowledge the possibility of the DMHA contracting with a third party for competency restoration in its statement that the DMHA must provide competency restoration services. If one were to rely on the language in *Curtis*, and its failure to note the option to contract with a third-party, they might be susceptible to a misunderstanding of the statute. Nevertheless, the ambiguity of the opinion’s language leaves far too much to interpretation.

Moreover, the language in the *Curtis* opinion fails to comport with the statutory language. Indiana Code section 35-36-3-1(b) states, “[T]he division of mental health and addiction shall provide competency restoration services *or* enter into a contract for the provision of competency restoration services by a third party”¹⁸¹ The foregoing provision’s language is unambiguous and permits the DMHA to contract with a community-based third party for such services. Furthermore, the language requires competency restoration efforts in the

179. Smith, *supra* note 76, at 332, 339, 343.

180. *Curtis v. State*, 948 N.E.2d 1143, 1153 (Ind. 2011).

181. IND. CODE ANN. § 35-36-3-1(b) (West 2020) (emphasis added).

“least restrictive setting appropriate to the needs of the defendant and the safety of the defendant and others.”¹⁸² Notably, in light of the foregoing, “[m]any individuals do not require an inpatient setting to be restored to competency”¹⁸³; thus, requiring inpatient treatment for such incompetent defendants “may constitute an unnecessary infringement on their civil liberties”¹⁸⁴ and violates the plainly-stated “least restrictive” requirement of Indiana Code section 35-36-3-1(b)(2).¹⁸⁵

Use of outpatient programs for certain defendants “who do not require inpatient level of care and can be treated within the community”¹⁸⁶ is not only permissible, according to the Indiana legislature, but would alleviate burdens placed on state psychiatric institutions so that they may focus their efforts on providing mental health services to those with the most debilitating and serious mental health conditions. To reap the benefits provided by an outpatient competency restoration model, Indiana Code section 35-36-3-1(b) should be revised to require the DMHA to promulgate an outpatient treatment program. Furthermore, revisions to Indiana Code section 35-36-3-1(b) should mandate that the DMHA consider the appropriateness of competency restoration on an outpatient basis before committing incompetent defendants for inpatient treatment at one of Indiana’s six psychiatric hospitals.

The monetary and therapeutic benefits associated with an outpatient model for competency restoration services prove compelling. The use of an outpatient model “can lower the amount states spend on treating [incompetent] defendants and reduce the number of state psychiatric hospital beds occupied by [incompetent] defendants.”¹⁸⁷ By prioritizing outpatient programs over inpatient commitment, Indiana’s state psychiatric hospitals will be relieved of some of the burden caused by accommodating forensic patients referred for competency restoration services¹⁸⁸ and will notice decreased state hospital waitlists.¹⁸⁹ In addition, use of an outpatient treatment model is less costly than inpatient treatment at a state hospital.¹⁹⁰ As of July 1, 2020, the daily rate for treatment at Logansport State Hospital, one of Indiana’s six psychiatric hospitals and the hospital responsible for housing the majority of Indiana’s incompetent defendants

182. *Id.*

183. Gowensmith et al., *Competency Restoration*, *supra* note 78, at 295.

184. *Id.*

185. *See* IND. CODE ANN. 35-36-3-1(b)(2).

186. Amanda Wik, *Alternatives to Inpatient Competency Restoration Programs: Community-Based Competency Restoration Programs*, NRI, INC. 1, 16 (Oct. 31, 2018), https://www.nri-inc.org/media/1508/ocr_website-format_oct2018.pdf [<https://perma.cc/9Z4G-ERGH>].

187. *Id.* at 2.

188. *Id.*

189. *Id.* at 4.

190. *See* Danzer et al., *supra* note 75, at 6.

for competency restoration services,¹⁹¹ is as high as \$1,230.¹⁹² Assuming a defendant is committed to Logansport State Hospital for competency restoration services for no longer than ninety days, the total cost of their restoration services would amount to approximately \$110,700.

Additional data regarding the costs associated with inpatient competency restoration suggests Indiana's daily rates, though on the higher end of the scale, are not necessarily atypical of an inpatient treatment model. The average cost for inpatient competency restoration services varies between \$300 to \$1,000 per day, with an estimated average of \$603 per day.¹⁹³ Implementing an outpatient treatment model will alleviate the financial burdens caused by Indiana's current inpatient treatment dominated system. A survey of sixteen states and the District of Columbia that implemented an outpatient treatment model reported "significant financial savings."¹⁹⁴ For formal outpatient restoration programs, "[f]orensic administrators reported daily costs . . . between \$101 to \$500 per day."¹⁹⁵ Outpatient restoration services supplied by private providers cost "between \$40 to \$75 per hour for restoration," but costs attributed to other state resources for the defendant supplemented costs paid to these third party contractors.¹⁹⁶ Nevertheless, "total daily costs for [outpatient] restoration averaged approximately \$215 per defendant."¹⁹⁷ Assuming an outpatient program in Indiana would land on the higher end of the reported daily rates, i.e., \$500 per day, treatment for ninety days would amount to \$45,000—\$65,700 less than the cost of treatment for a comparable time period spent at Logansport State Hospital for competency restoration.

In addition to monetary cost savings, preliminary data suggests the adoption of an outpatient model may result in "promising outcomes in terms of high restoration rates [and] low program failure rates,"¹⁹⁸ as well as "increased inpatient bed capacity [and] maintenance of public safety."¹⁹⁹ A study of current outpatient competence restoration programs ("OCRPs") in operation in the United

191. *Population, supra* note 39; *Thomas ex rel. Thomas v. Murphy*, 918 N.E.2d 656, 660 (Ind. Ct. App. 2009).

192. *State Psychiatric Hospital's Daily Rates*, IND. FAM. & SOC. SERVS. ADMIN., <https://www.in.gov/fssa/dmha/state-psychiatric-hospitals/state-psychiatric-hospitals-daily-rates/> (last visited Aug. 7, 2021) [<https://perma.cc/X2AG-GC5P>].

193. Gowensmith et al., *Competency Restoration, supra* note 78, at 299 (These figures stemmed from a multistep study with the purpose of receiving information regarding outpatient competency restoration programs. The researchers requested information from representatives of the Forensic Division of the National Association of State Mental Health Program Directors. The researchers received responses from forty-seven states and the District of Columbia. The administrators provided the average daily rates for inpatient competency restoration services).

194. *Id.*

195. *Id.*

196. *Id.*

197. *Id.*

198. *Id.* at 293.

199. *Id.* at 300.

States²⁰⁰ reported that “rates of competency restoration for outpatient programs were found to be slightly lower than reported rates for inpatient restoration programs (70.0% compared to inpatient restoration rates of 70% to 80%).”²⁰¹ However, a higher rate of success in an inpatient context may be attributed to the fact that the surveyed “OCRPs anecdotally reported higher proportions of participants with head injuries and developmental disabilities as compared to corresponding inpatient units.”²⁰² Additionally, some “programs reported that many of the cases for OCRP participants were dismissed after a demonstrated period of adhering to treatment and obeying the law,” which ultimately led to court dismissal of charges, rather than determinations that the defendants were competent to stand trial.²⁰³ Notably, states surveyed with OCRPs did not “report[] any incidences of serious recidivism or violence.”²⁰⁴ The foregoing, coupled with an increase in the supply of hospital beds and financial savings, exemplify just a few of the potential benefits of implementing an OCRP.²⁰⁵

Indiana’s reluctance to permit outpatient competency restoration likely stems from the fact that Indiana lacks a state-run outpatient program.²⁰⁶ Notwithstanding this, the Indiana Code defers authority to the DMHA as the “statutory gatekeeper” for an incompetent defendant to select an outpatient model by way of contracting with a third-party contractor; yet the DMHA refuses to consider the use of outpatient or community-based programs for competency restoration services.²⁰⁷ In *Thomas ex rel. Thomas v. Murphy*, the Indiana Court of Appeals explicitly acknowledged that the DMHA has neither contracted with third-parties for competency restoration services, nor permits such services on an outpatient or community-based basis.²⁰⁸ The DMHA refuses to approve community-based restoration services because, from its perspective, such services do “not provide the requisite level of supervision and monitoring for those charged with crimes.”²⁰⁹ Yet, the fact that an Indiana citizen is charged with a crime *and* found incompetent does not necessitate a finding that supervision rising to the level of inpatient commitment is absolutely necessary.

Consider the example of a defendant who is charged with a low-level, non-violent felony, but, due to his socioeconomic status, he cannot afford bail.

200. *Id.* at 296. At the time of the study, Arkansas, California, Colorado, Connecticut, Washington, D.C., Florida, Georgia, Hawaii, Louisiana, Nevada, Ohio, Oregon, Tennessee, Virginia, and Wisconsin had formal OCRPs. California, Colorado, Hawaii, Idaho, Illinois, Maryland, Michigan, Nevada, New Hampshire, New York, Ohio, Rhode Island, Virginia, Washington, and Wyoming operated informal OCRPs. *Id.* tbl.2.

201. *Id.* at 301 (citation omitted).

202. *Id.*

203. *Id.*

204. *Id.* at 302.

205. *Id.* at 301.

206. McMahan, *supra* note 77, at 630.

207. *Thomas ex rel. Thomas v. Murphy*, 918 N.E.2d 656, 660 (Ind. Ct. App. 2009).

208. *Id.*

209. *Id.* at 661.

Additionally, he is diagnosed with schizophrenia and dementia—questions regarding his competency immediately follow his arrest. The court determines he is incompetent and commits the defendant to the DMHA, but it is nearly undisputed by the parties that if he had the money to afford bail, he would be released. There are no extenuating circumstances that warrant supervision of the defendant; although, because of his legal status as incompetent, the DMHA determines he *must* be supervised in a state psychiatric hospital. The DMHA's justification for inpatient treatment is fundamentally flawed because an incompetency determination is based merely on the defendant's ability to understand the charges pending against him and to assist in his defense.²¹⁰ It does not take into account the severity or the circumstances surrounding the alleged criminal conduct, and it has no bearing on what level of supervision is required for the defendant. On the contrary, the level of supervision required, as noted by the DMHA, should be considered when determining whether competency restoration services should be administered on an inpatient or outpatient basis.

It is in Indiana's best interest to invest in an outpatient competency restoration program. The present infrastructure, and its associated disadvantages, necessitate reform to Indiana's procedures regarding competency. As previously explained, Indiana Code section 35-36-3-1(b) permits outpatient treatment for competency restoration services, and Indiana, and its citizens, would derive many benefits from an outpatient model, including, but not limited to, increased availability of beds in the state psychiatric hospitals,²¹¹ reduced financial costs for competency restoration,²¹² and greater constitutional protections for defendants.²¹³

B. Statutory Reform to Indiana Code sections 35-36-3 and 12-26-7

As a result of the foregoing, Indiana Code section 35-36-3-1(b) ought to be amended to state the following language provided in bold:

At the hearing, other evidence relevant to whether the defendant has the ability to understand the proceedings and assist in the preparation of the defendant's defense may be introduced. If the court finds that the defendant has the ability to understand the proceedings and assist in the preparation of the defendant's defense, the trial shall proceed. If the court finds that the defendant lacks this ability, it shall delay or continue the trial and order the defendant committed to the division of mental health and addiction. The division of mental health and addiction shall **first consider whether competency restoration services for the defendant are most appropriate in an outpatient, community-based program. If so, the division of mental health and addiction will enter into a contract for the provision of competency restoration services by a third party in the:**

210. IND. CODE ANN. § 35-36-3-1(a) (West 2018).

211. Wik, *supra* note 186, at 2.

212. Gowensmith et al., *Competency Restoration*, *supra* note 78, at 299.

213. *See* discussion *supra* Section II.E.

- (1) location closest in proximity to where the defendant or his or her family contacts currently resides; or
- (2) least restrictive setting appropriate to the needs of the defendant and the safety of the defendant and others.

In the event the division of mental health and addiction determines an outpatient, community-based program is an inappropriate provider for competency restoration services for a particular defendant, it must submit a report to the court, specifying:

- (1) the reasons for its finding;
- (2) whether additional supervision necessitates competency restoration services in a state institution;
- (3) the state institution to provide competency restoration services; and
- (4) the availability of immediate commitment to the state institution.

If the court finds that the defendant is unlikely to be restored to competency in the foreseeable future, it may exercise its discretion and dismiss the charges pending against the defendant, or seek involuntary civil commitment of the defendant to an outpatient program in the:

- (1) location closest in proximity to where the defendant or his or her family currently resides; or
- (2) least restrictive setting appropriate to the needs of the defendant and the safety of the defendant and others.

The amendments proposed to Indiana Code section 35-36-3-1(b) require the DMHA to first consider the appropriateness of outpatient treatment with a third party for competency restoration services. Additionally, in the event the DMHA believes outpatient treatment is an inappropriate course of action for a particular defendant, the DMHA must submit a report to the court substantiating its position. The foregoing requirements are critical to ensure outpatient competency restoration services are utilized by the DMHA. Without appropriate oversight of the DMHA's decision-making authority, the current state of affairs will likely continue without any change.

In light of the *Curtis* and *Habibzadah* decisions, amendments to the Indiana Code proposed in this Note contemplate the amount of discretion that ought to be afforded to the trial courts. In exercising its discretion, the court should conduct a close examination of the facts specific to a particular criminal case and circumstances of a defendant's incompetency. If the court concludes, with the advisement of forensic psychiatrists or psychologists, that a defendant is unlikely to be restored, the trial court should be able to dismiss the charges pending against the defendant. Although, the court's discretion is not without limits. As proposed above, the trial court may either dismiss the charges against the accused, or seek involuntary civil commitment to an outpatient program. In order for the trial court to seek involuntary civil commitment of a defendant to an outpatient program, the defendant must be "found to be mentally ill and either dangerous or gravely disabled," as required by Indiana Code section 12-26-7-

5(a).

As true for anyone else, a judge's "personal values and standards"²¹⁴ may be implicated while considering the appropriate course of action with regard to an incompetent defendant with severe mental illness, especially in light of the stigmatization of mental health.²¹⁵ In order to restrain a judge from exercising his authority according to his own personal biases, or relenting to the court of public scrutiny, proposed amendments to Indiana Code section 35-36-3-1(b) protect the rights of the accused, the conscience of the judge, and prevents "the overcommitment of defendants to inpatient facilities."²¹⁶ Lastly, because of the inherent difficulties associated with determining unrestorability, it is imperative that the courts abandon the practice of requiring a finding that a defendant's competency will never be restored in order to dismiss criminal charges against a defendant. Rather, a finding that a defendant is "unlikely" to be restored is sufficient.

Two or three psychiatrists, psychologists, or physicians with expertise in competency evaluations and the mental or physical conditions pertinent to that specific defendant should be responsible for assessments of competency. Emphasis is placed on the expertise of medical professionals so that the defendant is evaluated by someone with substantial knowledge and experience regarding the precise details of the defendant's condition, future prognosis, and the implications, and appropriateness, of commitment to either a state psychiatric hospital or outpatient facility. If the court agrees with the appointed medical professionals' opinion that restorability is unlikely, or impossible, it may act in accord with the amended form of Indiana Code section 35-36-3-1(b). The decision as to whether competency restoration services will be provided on an outpatient or inpatient basis should be guided by the accused's circumstances, including, but not limited to, the nature of the criminal charges, the possible danger to the defendant or public, the availability of guardianship by a close relative, and the severity of the defendant's mental health conditions.

Additional revisions to the Indiana Code are necessary to provide adequate resolution in the event defendants return to the criminal courts following denial of petitions for civil commitment by the probate courts. As revised, the Indiana Code permits the criminal court to either dismiss the criminal charges pending against the defendant, or seek involuntary civil commitment of the defendant to an outpatient program. The underlying rationale for this proposal is that the probate court, in denying the petition, effectively disputes whether the defendant is mentally ill and gravely disabled or dangerous, as required by the statute for temporary civil commitment following an inability to restore a defendant's competency.²¹⁷ The appropriate course of action should be guided by consideration of the charges pending against the defendant, the maximum sentence that may be imposed if the defendant stood trial for his crimes, and the

214. McMahon, *supra* note 77, at 636.

215. *Id.* at 637.

216. *Id.* at 636.

217. IND. CODE ANN. § 12-26-7-5 (West 2020).

period of time the defendant has been subjected to competency restoration efforts.

*C. Establishing Problem-Solving Courts for Defendants Found
Incompetent to Stand Trial*

In addition to the statutory reform proposed above, it may be advantageous to create problem-solving courts tasked specifically with conducting competency hearings and monitoring the efficacy of competency restoration services for its participants. Upon application for certification, the Indiana Judicial Center permits city and county courts to create specific court systems tasked with the responsibility of responding to issues plaguing the community.²¹⁸ The Indiana Code recognizes the following types of problem-solving courts: drug court, mental health court, family dependency drug court, community court, reentry court, domestic violence court, veterans' court, or any other court certified by the Office of Judicial Administration as a problem-solving court.²¹⁹ Problem-solving courts provide “a process for immediate and highly structured judicial intervention for eligible individuals” and integrate principles designed to promote “[e]nhanced information to improve decision making,” community engagement, “[c]ollaboration with social service providers and other stakeholders,” connections between “participants with community services based on risk and needs,” and a court-system to evaluate “the effectiveness of operations continuously.”²²⁰

As Indiana courts continue to deliver decisions in pursuit of a more “perfect” system for competency restoration services, perhaps the solution lies in creating a separate court system, particularly in counties most overwhelmed by requests for competency evaluations and incompetency determinations. The proposed courts are narrow in scope: the primary operations of the courts should focus on administering competency restoration services, overseeing efforts to restore competency, and assisting when restorability of competency seems unlikely. While it is not practical, and may not be necessary, to develop a competency restoration problem-solving court in every county, the Indiana Problem-Solving Court Rules and Indiana law permit transfers of cases from referring courts within the same county and across county lines.²²¹ The ability to refer cases to competency restoration problem-solving courts may be particularly beneficial to rural counties or areas of the state with limited resources to provide adequate outpatient competency restoration services.

There are certain aspects of problem-solving courts that make them a particularly desirable solution to the problems associated with competency restoration efforts. Problem-solving courts are marked by their use of

218. *See id.* § 33-23-16-11; *see also id.* § 33-23-16-17.

219. *Id.* § 33-23-16-11.

220. *Id.* § 33-23-16-8.

221. Jonathan Cleary, *Indiana Problem-Solving Courts: On the Frontline of a Drug Epidemic*, IND. CT. TIMES (Dec. 4, 2018), indianacourts.us/times/2018/12/indiana-problem-solving-courts/ [https://perma.cc/8B8T-JBMX].

collaborative, interdisciplinary approaches offering innovative solutions to specific problems faced by the community.²²² The criminal justice system certainly has persisting issues regarding its competency procedures that require frequent communication and collaboration between the legal and forensic psychology disciplines. Problem-solving courts focused on competency restoration services would provide a productive environment to facilitate an innovative and cooperative approach from the two disciplines while providing appropriate oversight of its actors and participants.

The collaborative working group created by the problem-solving courts described above may also be replicated in the context of a state task force to advise problem-solving courts established in the state, as well as monitor legislative, legal, and medical developments related to competency. This task force would ideally consist of legal professionals, including lawyers, judges, and academics, as well as forensic psychology and mental health experts, and DMHA administrators. This collaborative group should, as practicable, mirror the interdisciplinary approach utilized by the problem-solving courts tasked with monitoring competency restoration efforts. A primary responsibility of the task force would be to assist in clarifying the meaning of the phrases “substantial probability of attaining competency in the foreseeable future”²²³ and “unrestorability.”²²⁴ Members of this group should oversee the implementation and efficacy of any proposed reform to the Indiana Code and assist cities and counties that choose to develop problem-solving courts specific to competency. As a collaborative group of experts, and other stakeholders, the task force should provide valuable insight regarding any developments concerning mental health and degenerative physical and neurological conditions in relation to competency issues.

CONCLUSION

Immediately following *Jackson*, Indiana revised its statutory provisions to comply with the mandates of the United States Supreme Court. Nonetheless, the “modern” Indiana Supreme Court decisions concerning competency demonstrate codification of statutory procedure was insufficient to ensure compliance with *Jackson*.²²⁵ The reality surrounding issues regarding competency restoration in Indiana, and across the country, calls into question whether the Indiana Code’s contemporary statutory procedure is a workable solution to the questions left unresolved by *Jackson*. The current infrastructure for competency restoration services places significant burdens on state psychiatric hospitals to accommodate the influx of forensic patients deemed incompetent to stand trial and results in

222. *Problem Solving Courts in Indiana*, IND. CT. TIMES (May 5, 2010), indianacourts.us/times/2010/05/problem-solving-courts/ [https://perma.cc/B2AM-L6RC].

223. See IND. CODE ANN. § 35-36-3-3(a) (West 2020).

224. See generally Parker, *Quandary of Unrestorability*, *supra* note 120.

225. See *State v. Davis*, 898 N.E.2d 281 (Ind. 2008).

excessive state hospital waitlists for civilians and forensic patients alike,²²⁶ as well as the loss of cost savings due to the expensive nature of inpatient treatment compared to outpatient competency restoration services.²²⁷

Most importantly, Indiana's sole use of inpatient treatment for competency restoration services infringes upon the constitutional rights of the accused not yet found guilty of the charges levied against them. Indiana's current infrastructure not only deprives citizens of their liberty, but may even deprive them of their lives.²²⁸ The present system causes defendants to languish in jail for extensive periods of time as they wait for beds to become available. During this period, they are at risk of decompensation. Some accused remain in state hospitals for years when competency restoration efforts are futile, only for probate courts to deny civil commitment, returning them to the jail to repeat the cycle anew, all before their guilt is conclusively determined by a judge or jury.

In order to protect Indiana's incompetent defendants from future violations of their Fourteenth Amendment rights, this Note argued that Indiana Code section 35-36-3 should be amended to prioritize the use of outpatient competency restoration programs. Furthermore, greater deference should be granted to trial courts to dismiss charges in the event restorability of a defendant's competency is unlikely. In the event probate courts deny petitions for civil commitment, it may be appropriate to dismiss the charges pending against defendants unable to be restored within the six-month period mandated by the Indiana Code. In the alternative, the trial court may seek civil commitment to an outpatient program for a defendant's continued treatment and care. Lastly, this Note advocated for the development of problem-solving courts premised on competency restoration, and that any statutory reform to Indiana Code sections 35-36-3 and 12-26-7 should occur with the input and assistance of a collaborative working group consisting of legal, mental health, and forensic psychology experts. Adoption of the foregoing proposals not only protects the liberty interests of the accused and integrity of the criminal justice system as a whole, but also ensures prompt placement of incompetent defendants for competency restoration services, thereby reducing the risk of decompensation and other associated harms. Moreover, an outpatient model for competency restoration services will increase the supply of beds in psychiatric hospitals for civil patients and defendants requiring inpatient treatment; provide financial savings, positive restoration rates, and beneficial program outcomes; and divert criminal defendants who might otherwise benefit from outpatient treatment as opposed to inpatient treatment from the criminal justice system.

226. Wik, *supra* note 186, at 2.

227. Danzer et al., *supra* note 75, at 6.

228. See Jouvenal, *supra* note 96.