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Competency of the Mentally Ill and Intellectually Disabled in the Courts

Haleigh Reisman*

Introduction

Imagine an on-duty public defender entering a crowded courtroom. The clerk assigns her several cases. The attorney looks at the first in the pile: a defendant charged with multiple felony charges. The attorney finds the defendant and determines that something is not quite right about their conversation regarding the crime. The attorney brings this to the attention of the prosecuting attorney and the judge. The judge orders a psychological examination of the client. After the examination and a competency hearing is held, the judge holds the client not competent to stand trial. The case remains open while the defendant goes through a competency restoration program. Once the defendant has been restored to competency, the prosecution resumes. Only a short time later, though, defense counsel notices that the defendant again has trouble understanding so defense attorney raises the issue once more, halting the proceedings.

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1 See e.g., Nick Dutton & Jake Burns, Judge Agrees to Competency Hearing for Man Accused of Shooting Richmond Officer, CBS6, http://wtvr.com/2015/03/13/tamar-x-harris-competency-hearing/ (last updated Mar. 13, 2015, 12:22 PM) (providing real life scenario of hypothetical).

2 Id.

3 Id.

4 Id.


6 See infra notes 125-157 (discussing competency restoration programs).

7 18 U.S.C. § 4241 (e).
and the defendant again goes through a competency restoration program.\(^8\)

This note explores the differences in legal standards to be deemed not competent due to mental illness and to be deemed not competent due to intellectual disability.\(^9\) Part I describes common mental illnesses and intellectual disability.\(^10\) Part II discusses case law and psychological studies influencing competency to stand trial.\(^11\) Part III concludes that competency restoration programs may be an inefficient use of time and money for defendants who suffer from disorders like intellectual disabilities, where the defendant will likely never recover to an adequate level of competency to stand trial, unlike mental illness.\(^12\) Part III concludes that overall, a lack of awareness of the differences between mental illnesses and an intellectual disability pervades the legal system.

I. History

A. Mental Disorders: Schizophrenia, Bipolar Disorder, and Major Depressive Disorder

When determining whether a person has a “mental disorder,” the American Psychiatric Association states that an individual is “diagnosed entirely on the basis of behavioral indicia, broadly defined to include perceptions, thoughts, desires, feelings, moods, and actions.”\(^13\) Currently, the American Psychiatric Association advocates for the proposition that in order for a person to be diagnosed with a mental disorder, certain elements must be met.\(^14\) The diagnosis of such mental disorder should have

\(^8\) 18 U.S.C. § 4241 (a) (noting that each time the issue is raised, it should be addressed).
\(^9\) See generally infra Part II (describing legal landscape of competency law for mentally ill and intellectually disabled).
\(^10\) See infra Part I.
\(^11\) See infra Part II.
\(^12\) See infra Part III.
\(^13\) Stephen J. Morse, Mental Disorder and Criminal Law, 101 J. CRIM. L. & CRIMINOLOGY 885, 889 (2011) (citing AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. 2000)). There remains little understanding of the causes of mental disorders and no physical tests to diagnose mental disorders. Id. “The difficulty of specifying the criteria for behavioral abnormality that qualify it as a disorder is further complicated by understanding the actions that are the signs and symptoms of behavioral disorders are not pure mechanisms.” Id. at 890.
\(^14\) AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 20 (5th ed. 2013) (hereinafter “DSM-5”). DSM-5 states that a person must meet several elements to be diagnosed with a mental disorder:

A mental disorder is a syndrome characterized by clinically significant
"clinical utility," in that the diagnosis should help with prognosis and treatment plans.

While there are many different mental illnesses, the most prevalent ones in the criminal justice system are schizophrenia, bipolar, and major depressive disorder. In 2002, the National Commission on Correctional Health Care issued a report stating that 17.5% of inmates in state prisons had schizophrenia, bipolar disorder, or major depressive disorder. Schizophrenia is a "chronic, severe, and disabling brain disorder" where a person may experience auditory hallucinations. Some schizophrenic disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.

Id.


16 See DSM-5, supra note 14, at 20. A diagnosis of a mental disorder does not signify that an individual must receive treatment, as the determination of the need for treatment is a clinical decision where several factors must be evaluated, like “symptom severity, symptom salience (e.g., the presence of suicidal ideation), the patient’s distress... associated with the symptom(s), disability related to the patient’s symptoms, risks and benefits of available treatments, and other factors...” Id. A person who does not show symptoms after diagnosis need not be limited in access to the appropriate care for the disorder. Id.


18 Id. The inmate percentage for state and federal prisons was 20% by 2003; by 2006, an estimated 24% of state and federal inmates were suffering from a mental disorder. Id.

19 See Schizophrenia, NAT’L INST. OF MENTAL HEALTH, http://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml (last visited Apr. 10, 2015). Auditory hallucinations are typically consuming and may cause those suffering from the illness to sit for hours without moving or speaking. Id. Hallucinations can be seen, heard, or felt only by the person experiencing the hallucination. Id. Voices are the most common form of hallucination. Id. An individual with schizophrenia can also suffer from delusions which “are false beliefs that are not
individuals suffer from a lack of insight or lack of awareness of their disorder.\textsuperscript{20} Hostility and aggression are traits associated with schizophrenia and are most common in young males or individuals with a past history of violence.\textsuperscript{21} Schizophrenia’s prevalence in the United States represents 0.3\% to 0.7\% of the population; onset prior to adolescence is rare.\textsuperscript{22} Treatment for schizophrenia includes the use of antipsychotic medications and psychosocial treatments.\textsuperscript{23}

Bipolar disorder is also a brain disorder, causing a person to have “unusual shifts in mood, energy, [and] activity levels,” and also impacts a person’s ability to carry out normal, everyday tasks.\textsuperscript{24} These mood shifts, known as “mood episodes,” are unusually intense and a person’s mood shifts between manic and depressive.\textsuperscript{25} It is not part of the person’s culture and do not change.” \textit{Id.} Paranoid delusions include believing that someone is out to harm the afflicted individual. \textit{Id.} Other symptoms of schizophrenia include thought disorders, such as “unusual or dysfunctional ways of thinking,” and movement disorders. \textit{Schizophrenia, supra.} Individuals who suffer from schizophrenia may also display inappropriate affect; a dysphoric mood, which may exhibit itself in the form of depression, anxiety or anger; a disturbed sleep pattern and a lack of interest in food. \textit{See DSM-5, supra note 14, at 101.}

\textsuperscript{20} \textit{See DSM-5, supra note 14, at 101.} Lack of insight and awareness can be present throughout the entire illness and is a symptom of the illness, not a coping mechanism. \textit{Id.} Lack of insight and unawareness of the illness is the most common reason for lack of treatment. \textit{Id.}

\textsuperscript{21} \textit{Id.} People who suffer from schizophrenia rarely assault other people spontaneously or randomly. \textit{Id.} Non-adherence with treatment or substance abuse can lead to a higher rate of aggression in persons with schizophrenia. \textit{Id.} “It should be noted that the vast majority of persons with schizophrenia are not aggressive and are more frequently victimized than are individuals in the general population.” \textit{DSM-5, supra note 14, at 101 (emphasis added).}

\textsuperscript{22} \textit{Id.} at 102. Schizophrenia typically manifests itself between the late teens and the mid-thirties, with a peak onset age for a first psychotic episode in the early-to mid-twenties for males and late twenties for females. \textit{Id.} Traditionally, the earlier the onset age, the worse the schizophrenia prognosis is for the person. \textit{Id.}

\textsuperscript{23} \textit{See Schizophrenia, supra note 19.} The course of the schizophrenic illness tends to get better for about 20\% of those diagnosed and some have reportedly been able to recover completely. \textit{DSM-5, supra note 14, at 102.} Many people with schizophrenia require daily assistance and remain chronically ill with symptoms manifesting at varying levels. \textit{Id.} \textit{See also Mental Health Medications, NAT’L INST. OF MENTAL HEALTH, http://www.nimh.nih.gov/health/publications/mental-health-medications/index.shtml (last visited Apr. 10, 2015).} Medications for treating schizophrenics became available during the 1950s and are commonly called conventional “typical” antipsychotics. \textit{Id.} These medications are chlorpromazine, haloperidol, perphenazine, and fluphenazine. \textit{Id.} “Atypical” antipsychotics were developed in the 1990s. \textit{Id.} They include clozapine, risperidone, aripiprazole, and lurasidone. \textit{Id.}


\textsuperscript{25} \textit{Id.} A manic episode occurs when a person is overly joyful or overexcited. \textit{Id.} \textit{See also DSM-5, supra note 14, at 127 (describing manic episode as “euphoric, excessively cheerful, high, or ‘feeling on top of the world’”).} A person suffering from a manic episode can also be extremely
unusual for those with bipolar disorder to encounter substance abuse issues or suffer from other mental disorders. Treatment plans for bipolar disorder include medication and psychotherapy.

A diagnosis of major depressive disorder occurs when an individual exhibits five or more symptoms present during a two-week period which include a depressed mood or loss of interest or pleasure. In addition, a person has “symptoms [that] cause clinically significant distress or impairment in social, occupational, or other important areas of functioning;” no substance abuse or other medical condition to explain the psychological effects; the major depressive episode is not a result of any other psychotic disorder, including schizophrenia; and there has not been a manic or hypomanic episode. Suicidal thoughts, ideations and attempts frequently exist among people with irritable. Id. at 127. Liability occurs when there are rapid shifts in mood in short periods of time, including euphoric, dysphoria, and irritability. Id. at 127-28. A person suffering from a manic episode also has an increased activity or energy level. Id. at 128. These increased activity levels can manifest themselves at unusual hours and tend to cause the person to have a decreased need for sleep. Id. “When the sleep disturbance is severe, the individual may go for days without sleep, yet not feel tired. Often a decreased need for sleep heralds the onset of a manic episode.” Id. A manic episode can lead to poor judgment when it comes to reckless involvement in activities, including driving. DSM-5, supra note 14, at 129. A person suffering from a depressive episode may perpetually be in an extremely sad or hopeless state. See Bipolar Disorder, supra note 24. A person in a depressive episode may suffer from a loss of interest in activities he once enjoyed. Id. A person may also constantly feel tired and have trouble concentrating, remembering or making decisions. Id.

26 See Bipolar Disorder, supra note 24 (detailing bipolar disorder). A person with bipolar disorder may have problems at school or work and within relationships. Id. In addition, it is also common for bipolar disorder to comorbid with Attention Deficit Hyperactivity Disorder (“ADHD”) and other anxiety disorders. Id.

27 Id. Treatment plans vary by individual and even the type of medication can vary. Id. During manic episodes, individuals may not believe they are ill and therefore refuse treatment. See DSM-5, supra note 14, at 129. Some individuals may become hostile or physically assaultive. Id. “Catastrophic consequences of a manic episode such as involuntary hospitalization, difficulties with the law, serious financial difficulties, often result from poor judgment, loss of insight, and hyperactivity.” Id. Mood stabilizers are common medications for people who suffer from bipolar disorder. Mental Health Medications, supra note 23. Lithium, valproic acid, and carbamazepine are examples of mood stabilizing medications. Id. Bipolar disorder can also be treated with atypical antipsychotics (e.g., olanzapine and aripiprazole) and antidepressants (e.g., fluoxetine, paroxetine, and sertraline). Id.

28 DSM-5, supra note 14, at 160-61. Symptoms of major depressive disorder include: (1) depressed mood most of the day, nearly every day; (2) loss of interest or pleasure; (3) weight loss or gain, or an increase or decrease in appetite; (4) insomnia or hypersomnia; (5) agitation; (6) fatigue or loss of energy; (7) feelings of worthlessness or unnecessary guilt; (8) inability to think or concentrate or indecisiveness; and (9) recurrent thoughts of death or suicide. Id.

29 Id. See also Major Depression Among Adults, NAT’L INST. OF MENTAL HEALTH, http://www.nimh
major depressive disorder. In the United States, major depressive disorder is one of the most common mental disorders. Medication and psychotherapy are common treatments for major depressive disorder. Electroconvulsive therapy is a form of treatment for major depressive disorder where electrical currents are passed through the brain to trigger brief seizures.

B. Intellectual Disability

Intellectual disability, or intellectual developmental disorder, is a neurodevelopmental disorder that manifests in an individual's developmental period.

30 See DSM-5, supra note 14, at 164. A suicidal person may have “a desire to give up in the face of perceived insurmountable obstacles, an intense wish to end what is perceived as an unending and excruciatingly painful emotional state, an inability to foresee any enjoyment in life, or the wish to not be a burden to others.” Id. While some people may only have suicidal thoughts, others may go through the actions of preparing a will and settling debts. Id.

31 See Major Depression Among Adults, supra note 29. Females are up to three times more likely to suffer from major depressive disorder than males beginning in early adolescence. DSM-5, supra note 14, at 165.

32 See Depression, NAT'L INST. OF MENTAL HEALTH, http://www.nih.gov/health/topics/depression/index.shtml (last visited Apr. 12, 2015) (describing depression and treatment options). The purpose of antidepressants is to balance chemicals in the brain. See Mental Health Medications, supra note 23. Fluoxetine, citalopram, and sertraline are some of the most popularly prescribed antidepressants. Id. See also Depression, NAT'L ALLIANCE FOR MENTAL HEALTH, http://www.nami.org/Learn-More/Mental-Health-Conditions/Depression/Treatment (last visited Apr. 12, 2015) (listing treatment options including various psychotherapy and medication options). Selective serotonin reuptake inhibitors are prescribed most often for depression. Id. Brand names include Prozac, Zoloft, Paxil, Celexa and Lexapro. Id.

33 See Depression, supra note 32 (detailing electroconvulsive therapy). Electroconvulsive therapy (“ECT”) is a treatment option utilized when other treatments do not work. Id. A person undergoing ECT treatment may suffer from memory loss. Id. Patients whose antidepressants do not work and patients with severe depression or depression with psychosis are examples of patients who benefit from ECT. Id.

34 See DSM-5, supra note 14, at 31. Other neurodevelopmental disorders include communication disorders (e.g., language disorder or speech sound disorder), autism spectrum disorder, attention deficit hyperactivity disorder, motor disorders (e.g., tic disorders) and other specific learning disorders. Id. at 31-32. The commonality between these disorders is that they “are characterized by developmental deficits that produce impairments of personal, social, academic, or occupational functioning.” Id. at 31. A person with one neurodevelopmental disorder is likely to have another disorder, as these disorders tend to be comorbid. Id. See also DSM-5 Intellectual Disability Fact Sheet, AM. PSYCHIATRIC PUBLISHING 1 (2013), available at http://www.dsm5.org/documents/intellectual%20disability%20fact%20sheet.pdf. An intellectual disability is considered to be a chronic condition and tends to occur with other mental conditions that may not necessarily be a neurodevelopmental disorder, such as depression. Id. The most common co-
A person with an intellectual disability has intellectual and adaptive functioning deficits in his conceptual, social and practical domains.\(^3\) Approximately one percent of the United States population has an intellectual disability.\(^6\) An intellectual disability is a lifelong disorder and tends to be chronic and non-progressive.\(^37\)

In addition to conceptual, social, and practical deficits, a person with an intellectual disability typically has a low intelligence quotient ("IQ"), but a low IQ is not determinative of an intellectual disability diagnosis.\(^38\) IQ scores "are approximations of occurring mental and neurodevelopmental disorders are attention-deficit/hyperactivity disorder; depressive and bipolar disorders; anxiety disorders; autism spectrum disorder; stereotypic movement disorder . . . ; impulse-control disorders; and major neurocognitive disorders." DSM-5, at 40. The higher likelihood of a person with an intellectual disability to act with an aggressive or disruptive behavior can result in harming others or destroying property. \(\text{Id.}\)

Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.

Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.

Onset of intellectual and adaptive deficits during the developmental period. \(\text{Id.}\) The severity levels of an intellectual disability range from mild to profound. \(\text{Id.}\) The critical components of Criterion A, deficits in intellectual functions, are "verbal comprehension, working memory, perceptual reasoning, quantitative reasoning, abstract thought, and cognitive efficacy." \(\text{Id.}\) at 37. Criterion B, deficits in adaptive functioning, "refer[s] to how well a person meets community standards of personal independence and social responsibility, in comparison to others of similar age and sociocultural background." \(\text{Id.}\) Criterion C identifies that the onset of an intellectual disability must take place during childhood or adolescence. \(\text{Id.}\) at 38.

\(\text{Id.}\) at 37. The impact of gender is reported differently depending on the study, overall, males are more likely to be diagnosed with mild and severe intellectual disabilities than females. \(\text{Id.}\) at 39.

\(\text{Id.}\) at 38-39. Intellectual disabilities do not usually worsen over time; however underlying genetic, medical, or concurring conditions can affect the severity throughout a person's lifetime. \(\text{Id.}\)

\(\text{Id.}\) at 37. "IQ measures are less valid in the lower end of the IQ range." DSM-5, \(\text{ supra}\) note 14, at 37. Individuals with intellectual disabilities typically have an IQ of seventy which is approximately two standard deviations or more below the mean of the population at large. \(\text{Id.}\) The
conceptual functioning but may be insufficient to assess reasoning in real life situations and mastery of practical skills." An intellectually disabled person may also struggle with decisions regarding social judgment and risk assessment, causing him or her to potentially lack communication skills which could make the person more disruptive and aggressive.

C. Competency to Stand Trial

An individual’s competency to stand trial is an area addressed by the courts. Jackson v. Indiana was the first case where the United States Supreme Court made a decision regarding competency to stand trial. The defendant, Theon Jackson ("Jackson"), was illiterate, deaf, and mute and allegedly stole nine dollars’ worth of property. The judge committed Jackson to the Indiana Department of Mental Health until the court could deem him sane. The questions presented to the Supreme Court were: (1) whether Jackson’s commitment violated his Fourteenth Amendment due process and equal protection rights; and (2) whether Jackson’s commitment constituted cruel and unusual punishment under the Eighth Amendment. The Court held that by determination of IQ also should include a measurement of error, approximately five points. Id. Since IQ tests have a margin of error and invalid test scores can occur, a clinical assessment is required in order to determine if an individual actually has an intellectual disability. Id. Other conditions that an individual might have that can co-occur with an intellectual disability can also impact an IQ test and those also need to be considered when determining IQ. Id. A person whose IQ score is seventy could have serious issues in other areas of his or her life such that the person's actual functioning is more comparable to that of an individual with a lower IQ score. DSM-5, supra note 14, at 37. That is another reason a clinical assessment is required to accurately determine a person’s IQ score. Id. People with intellectual disabilities have a tendency to be more vulnerable, naïve and easily influenced by others. Id. “Gullibility and lack of awareness of risk may result in exploitation by others and possible victimization, fraud, unintentional criminal involvement, false confessions, and risk for physical and sexual abuse.” Id. These vulnerabilities are important to consider during criminal cases. See id. See, e.g., Jackson v. Indiana, 406 U.S. 715 (1972) (discussing lenient commitment standard vs. stringent standard of release for mentally ill patients under § 9-1706a). 406 U.S. 715 (1972). See id. at 717. The Court described Jackson as possessing the mental capacity of a pre-school child. Id. At the competency hearing, two psychiatrists and a deaf-school interpreter testified that Jackson was not competent and not likely to ever gain competency. Id. at 718-19. The trial court found that Jackson was not sufficiently competent to understand the charges against him or assist his attorney for his own defense. Id. at 719. See id. While Jackson was never found guilty of any charges, his lawyer argued on appeal that his client was facing a "life sentence" by his commitment to the Department of Mental Health. Jackson, 406 U.S. at 719. See generally U.S. CONST. amend. VIII (banning cruel and unusual punishment); U.S. CONST.
essentially sentencing Jackson to permanent institutionalization, the State of Indiana violated his equal protection and due process rights. The Court held that Jackson could be detained for a reasonable amount of time to determine whether he may be restored to competency, but if determined that he could not be restored, the state must institute civil commitment proceedings to further hold him or release him.

D. Insanity Defense

If adjudicated not competent to stand trial, an individual’s criminal case does not end; the finding simply means that the prosecution of the matter is halted until competency is restored. In contrast, the insanity defense serves as a mitigation to punishment. The insanity defense is distinct from an individual being found not competent to stand trial. The defense of insanity refers to the time at which the crime
was committed, while competency is evaluated at the time of the legal proceedings. While clinical definitions are important for diagnosing and treating mental disorders, the definition of insanity in the legal system represents the “different goals of the criminal law and mental health systems.” When raising insanity as a defense, the defendant must establish that he or she lacks the ability to distinguish between right and wrong and does not know the nature nor consequences of his or her actions at the time of the offense.

II. Facts

A. Assessing Competency

*Jackson v. Indiana* was the first Supreme Court case to address competency to stand trial, but the test for determining competency was established in *Dusky v. United States.* In order for a defendant to be considered competent, he must have the “present sufficient 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.” Competence to stand trial serves four legal purposes: (1)
protecting the accuracy of an individual adjudicated as a criminal; (2) guaranteeing a fair trial, which is protected by the Sixth Amendment to the United States Constitution; (3) "to preserve the dignity and integrity of the legal process;" and (4) to ensure that a defendant understands why he or she is being punished if found guilty.\textsuperscript{56}

Every defendant has the right to have his or her competency to stand trial examined, as long as competency is raised after the commencement of prosecution yet before sentencing.\textsuperscript{57} In addition, a defendant can be found not competent based upon as the "Dusky standard"). The defendant must satisfy a rational understanding and not just the ability to orient to time and place with a recollection of the event to which he is facing charges.\textit{Id.} The \textit{Dusky} standard has two elements, "sufficient present ability to consult with his lawyer" and "rational as well as factual understanding of the proceedings against him," and each element must be established in order for the court to deem a defendant competent once his competency has been questioned. \textit{See} Dillard, supra note 49, at 475. \textit{See also Preliminary Proceedings, 38 GEO. L.J. ANN. REV. CRIM. PROC. 436 (2009)} (discussing competency to stand trial). A defendant must also have the ability to understand the nature of the proceedings and charges he is facing. \textit{Id.} For cases of defendants with intellectual disabilities, it is especially important to focus on a defendant's ability to interact with his or her counsel. \textit{See} United States v. Duhon, 104 F. Supp. 2d 663, 670, 676 (W.D. La. 2000). A defendant appearing to have a rational understanding of the criminal proceedings and his situation as a defendant does not prove that he or she will have the capabilities of assisting his or her counsel in preparing an adequate defense. \textit{Id.} In \textit{Duhon}, a criminal defense expert interviewed the defendant and testified that "[the defendant] would be more or less sitting next to me as a bump on a log. If I were his lawyer and he went to trial, I don't think he would be able to provide any assistance to me." \textit{Id.}

\textsuperscript{56} \textit{See} U.S. \textit{CONST.} amend. VI (articulating right to a fair and speedy trial with an impartial jury); Alan R. Felthous, \textit{Introduction to this Issue: Competence to Stand Trial}, 21 BEHAV. SCI. LAW. 281 (2003) (discussing fitness to plead and guaranteed right to a fair trial). A fundamental aspect of the adversary process is prohibiting courts to try defendants who are incompetent. \textit{See} Stephen J. Morse, \textit{Involuntary Competence}, 21 BEHAV. SCI. LAW. 311, 313 (2003). A fair trial is not possible for a defendant if he or she is not competent. \textit{Id.} A defendant who is not competent lacks the ability to help counsel in his or her own defense, therefore substantially impairing his or her right to a fair trial. \textit{Id.}

\textsuperscript{57} \textit{See} 18 U.S.C. § 4241(a) (2006). A motion to determine competency can be made:

\begin{quote}
[\textit{a}t] any time after the commencement of a prosecution for an offense and prior to the sentencing of the defendant . . . the defendant or the attorney for the Government may file a motion for a hearing to determine the mental competency of the defendant. The court shall grant the motion, or shall order such a hearing on its own motion, if there is reasonable cause to believe that the defendant may presently be suffering from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense.
\end{quote}

\textit{Id.} \textit{See, e.g., MASS. GEN. LAWS ch. 123, § 15(a)} (2001) (stating competency can be raised anytime...
mental illness or intellectual disability. In *Drope v. Missouri*, the Supreme Court held that an evaluation of a defendant must be ordered when the issue of competency is raised. Defendant Drope’s attorney filed a motion for continuance of trial in order to have a competency evaluation of Drope performed. The trial judge denied the motion to continue. Drope failed to appear to court on the second day of trial because he

58 See United States v. Duhon, 104 F. Supp. 2d 663, 671 (W.D. La. 2000) (finding continued hospitalization for restoration of competency to intellectually disabled defendant inappropriate); Claire D. Advokat et al., *Competency Restoration Treatment Differences Between Defendants Declared Competent or Incompetent to Stand Trial*, 40 J. AM. ACAD. PSYCHIATRY L. 89, 90 (2012). Two of the most significant predictors of a defendant’s incompetence to stand trial are a psychotic disorder and an intellectual disability. Id. “Intellectual disability involves impairments of general mental abilities that impact adaptive functioning in three domains, or areas.” See Intellectual Disability, AM. PSYCHIATRIC PUB'G – A DIV. OF AMERICAN PSYCHIATRIC ASS’N 1 (2013), http://www.dsm5.org/documents/intellectual%20disability%20fact%20sheet.pdf. These domains are (i) conceptual domain, meaning “language, reading, writing, math, reasoning, knowledge, and memory;” (ii) social domain, referring to “empathy, social judgment, interpersonal communication skills, the ability to make and retain friendships, and similar capacities;” and (iii) practical domain, which includes “self-management in areas such as personal care, job responsibilities, money management, recreation, and organizing school and work tasks.” Id. Intellectual disabilities are incurable and a person may often have other mental illness such as depression, Attention Deficit Disorder, ADHD or autism. Id. See also Debra A. Pinals, M.D., *Where Two Roads Meet: Restoration of Competence to Stand Trial From a Clinical Perspective*, 31 N.E. J. ON CRIM. & CIV. CON. 81, 94 (Winter 2005) (discussing competency restoration training and programs at hospitals); See IRVING B. WEINER & RANDY K. OTTO, HANDBOOK OF PSYCHOLOGY, VOL. 11: FORENSIC PSYCH. 431 (2d ed. 2012). While anywhere from 2% to 7% of defendants referred for competency evaluations are intellectually disabled, there is still a large number of defendants not referred for competency evaluations even though they have an intellectual disability. Id.

59 See 420 U.S. 162, 181 (1975). Drope was charged with forcible rape of his wife. Id. at 164.

60 Id. at 164. Counsel requested the continuance after a psychiatrist evaluated the defendant at counsel’s request. Id. The psychiatrist suggested that the defendant needed psychiatric treatment. Id.

61 Id. at 162.
attempted to commit suicide by shooting himself.\textsuperscript{62} Drope petitioned that his due process rights were violated with the denial of a psychiatric test to determine his competence to stand trial.\textsuperscript{63} A psychiatrist testifying on behalf of petitioner Drope before the Missouri Supreme Court stated that a person, such as Drope, who gang raped his wife and then attempted to commit suicide during trial was in need of a psychological evaluation.\textsuperscript{64}

If sufficient doubt surrounds the defendant’s competency, the court must conduct a competency hearing.\textsuperscript{65} Prior to the hearing date, the court may order a psychiatric examination of the defendant and a copy of that report is to be filed with the court.\textsuperscript{66} The examination of the defendant is conducted by a licensed or certified psychiatrist or psychologist and the defendant can be committed for a “reasonable period, but not to exceed thirty days” for the examination to take place.\textsuperscript{67} The psychiatrist or psychologist’s report must include the defendant’s history and present symptoms; a description of any test used during the examination; the findings of the

\textsuperscript{62} Drope, 40 U.S. at 162. The trial court allowed the trial to continue without the defendant present, holding that the defendant was not present at court by voluntary choice. \textit{Id.} at 167. The Supreme Court held that if there is any doubt as to a defendant’s competency at the time of the trial, a trial court must consider any and all evidence to warrant an evaluation. \textit{Id.} at 170. \textit{See also} 18 U.S.C. § 4241(a) (2006). “The court shall grant the motion, or shall order such a hearing on its own motion, if there is reasonable cause to believe that the defendant may presently be suffering from a mental disease or defect . . . .” \textit{Id.}

\textsuperscript{63} Drope, 420 U.S. at 163-64.

\textsuperscript{64} \textit{Id.} at 169. In addition to the rape, Drope’s wife testified that Drope and four others subjected her to “other bizarre abuse and indignities.” \textit{Id.} at 165. Two other individuals were also charged with the forcible rape of Drope’s wife. \textit{Id.} at 164. The defendant could not have received a fair trial if the court deemed his due process rights were violated when the trial court failed to address the issue of his competency. \textit{Id.} at 172, 183.

\textsuperscript{65} 18 U.S.C. § 4241(a) (2006). The statute specifically states that “[t]he court shall grant the motion” if the court believes that the “. . . defendant may presently be suffering from a mental disease or defect rendering him mentally incompetent . . . .” \textit{Id.} \textit{See also} Preliminary Proceedings, supra note 55, at 439 (explaining defendant’s due process rights may be violated for failure to hold a competency hearing). The court may grant a motion to allow a competency hearing from either party or \textit{sua sponte}. \textit{Id.} at 440. The standard in a competency hearing is preponderance of the evidence. \textit{Id.}

\textsuperscript{66} 18 U.S.C. § 4241(b); MASS. GEN. LAWS ch. 123, § 15(a) (2014). Upon completion of the competency exam, a court may order a defendant be committed to a hospital for further observation and examination. \textit{Id.} § 15(b). The physician who examined the defendant is required to file a report with the court prior to a competency hearing. \textit{Id.} § 15(c). The report must indicate the physician’s determination bearing on the issue of competency. \textit{Id.}

\textsuperscript{67} 18 U.S.C. § 4247(b) (2014). If more than the initial thirty day commitment is not enough for the facility to conduct the examination, the director of the facility may request an extension of fifteen days with a show of good cause. \textit{Id.}
examiner; and the examiner’s opinions as to diagnosis, prognosis, and whether the defendant is suffering from a mental disease or defect that would render him or her not competent if ordered under 18 U.S.C. section 4241.68 At the hearing, the defendant is represented by counsel and has the ability to testify on his or her own behalf, present any evidence to support the claim of incompetency, have other witnesses testify on his or her behalf, and confront and cross-examine any other witness at the hearing.69

As a result of the Dusky standard, a psychiatrist or psychologist must assist the court in determining that a defendant has a “rational as well as factual understanding of the proceedings against him,” and that he has the “sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding.”70 By statute, the issue of competency can be questioned at any point during criminal proceedings, up until the point of sentencing.71 At the point a defendant is found mentally incompetent, proceedings will halt, with a goal of continuing once the defendant has been restored to the level of competency required to stand trial.72 A defendant’s history of mental illness does not render the defendant mentally incompetent per se but can be a factor in the determination.73 Likewise, intellectually disabled individuals are not necessarily mentally

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68 Id. § 4247(c).
69 Id. § 4247(d).
70 See Dillard, supra note 49, at 475. When a motion is made to determine the competency of a defendant, the court should grant the motion and order an evaluation of the defendant and schedule a competency hearing. 18 U.S.C. § 4241(a). “Prior to the date of the hearing, the court may order that a psychiatric or psychological examination … be conducted, and [ ] a … report be filed with the court.” Id. § 4241(b).
71 See 18 U.S.C. § 4241(a); MASS. GEN. LAWS ch. 123, § 15(a). See also Article: II. Preliminary Proceedings, supra note 55, at 440. A judge has the ability to raise competency sua sponte if it is reasonable to believe that the defendant is suffering from a “mental disease or defect” which would render the defendant not competent. Id.
72 See 18 U.S.C. § 4241(d). A finding of incompetency requires a preponderance of the evidence. Id. If the defendant is found competent to stand trial, the criminal proceedings will continue from the point the trial was left when competency was questioned. Id. Upon a determination of incompetency to stand trial, the court may commit the defendant to the custody of the Attorney General for treatment for a reasonable amount of time in a suitable facility. Id. See also United States v. Shawar, 865 F.2d 856, 860 (7th Cir. 1989). Commitment under § 4241(d) is mandatory, not discretionary. Id. A “reasonable period of time” is not to exceed a period of four months in order to determine whether a defendant can be returned to competency in the foreseeable future. Id. at 859. When enacting § 4241(d), Congress kept in mind the Jackson holding that indefinite commitment is unconstitutional by including in the statute a definite time period defined as “a reasonable period of time.” Id. at 863-64. A defendant will only be held past that four month period if found that competence restoration could take place in the foreseeable future. Id. at 864. See, e.g., MASS. GEN. LAWS ch. 123, § 15(d) (LexisNexis 2015) (citing Massachusetts version of federal law).
73 See McGregor v. Gibson, 248 F.3d 946, 955 (10th Cir. 2001) (holding violation of defendant’s
incompetent. Upon the competency hearing's conclusion, the judge makes the ultimate determination if a defendant is competent, not the licensed mental health professional who performed the examination.

The Supreme Court held in *Pate v. Robinson* that failure to conduct a competency hearing for a defendant whose competency is clearly questionable is a due process violation. Due process requires that a defendant be physically and mentally present and able to defend himself or herself against criminal charges. The state claimed that Robinson had intelligently waived his right to a competency hearing since he failed to request a hearing at the time of his trial. The Supreme Court rejected this argument, due process rights by not providing competency hearing regarding mental illness).

74 See *Drope v. Missouri*, 420 U.S. 162, 169 (1975) (finding individual attempting suicide during trial created sufficient doubt of competency to stand trial); United States v. Leggett, 162 F.3d 237 (3d Cir. 1998) (finding self-proclamation of incompetency is not sufficient to warrant sua sponte competency hearing); U.S. v. Davis, 93 F.3d 1286 (6th Cir. 1996) (explaining assertion of mental incapacity alone is not enough for competency evaluation); Newfield v. United States, 565 F.2d 203 (2d Cir. 1977) (stating mentally disturbed individual able to understand proceeding is competent to stand trial). See also Morse, supra note 13, at 895 (stating that person is not incompetent just because of mental disorder). The issue of competency to stand trial focuses on the defendant's present state of functioning at the time of trial, not at the time the crime was committed. See *id.* See also *Barry W. Wall et. al., Restoration of Competency to Stand Trial: A Training Program for Persons With Mental Retardation*, 31 J. AM. ACAD. PSYCHIATRY L. 189 (2003) (referencing lack of significant correlation between intellectual disability and competency to stand trial).


76 See *Pate v. Robinson*, 383 U.S. 375, 385 (1966). “Where the evidence raises a 'bona fide doubt' as to a defendant's competence to stand trial, the judge on his own motion must impanel a jury and conduct a sanity hearing” under Illinois state law. *Id.* Robinson had a history of disturbed behavior, he had been previously confined in a psychiatric hospital and previously committed acts of violence, including murdering his infant son and attempting suicide. *Id.* at 381. See also U.S. CONST. amend. XIV, § 1. Due process requires that a state respect all legal rights owed to an individual. *Id.* at § 1.

77 See *Miller*, supra note 57, at 370. The threshold set for raising competency is very low and requests can be made by prosecutors, judges or defense counsel. *Id.* Prior to 1972, the most common party to request a competency evaluation was the prosecution. *Id.* The prosecution's raising of the issue of competency was the only way to guarantee the defendant's incarceration without going to trial. *Id.*

78 See *Pate*, 383 U.S. at 384. Robinson's counsel put four witnesses on the stand during the trial to testify as to the sanity of his client. *Id.* at 378. The trial court rejected medical testimony regarding Robinson's mental sanity because the state had a physician who, if present, would testify that Robinson knew the nature of the charges and could cooperate with counsel when he examined Robinson. *Id.* at 383. During this hearing, the state argued that the state was unsure if
however, reasoning that the defendant could not waive his rights to a competency defense by failing to request a competency hearing during his trial. The decision in Pate cemented the Fourteenth Amendment right for a defendant to avoid trial if found to be mentally incompetent.

B. Competency Under Question

In Riggins v. Nevada, the Supreme Court first addressed the issue of whether a mentally ill person should be forcibly medicated by the state, strictly for the purposes of restoring the defendant to an adequate level of competence to stand trial. The question first arose when Riggins, while held on a murder and robbery charge, admitted to a psychiatrist that he was experiencing auditory hallucinations and trouble sleeping. The Court held that in order to involuntarily medicate a defendant, the state must prove the necessity and appropriateness of continued medication of the defendant.

The Supreme Court considered whether the forced administration of antipsychotic medication to Riggins during his trial was a violation of his Sixth and Robinson was sane or insane and assumed that the physician, at another hearing date, would be able to testify to his opinion, of which the state did not know at that time. The trial court ruled that the physician need not be present, and, based on the information relayed by the State regarding his anticipated testimony, ruled that Robinson was competent to stand trial. The Supreme Court held “it is contradictory to argue that a defendant may be incompetent, and yet knowingly or intelligently ‘waive’ his right to have the court determine his capacity to stand trial.” Pate, 383 U.S. at 384.

79 Id. at 385. The Supreme Court held “it is contradictory to argue that a defendant may be incompetent, and yet knowingly or intelligently ‘waive’ his right to have the court determine his capacity to stand trial.” Pate, 383 U.S. at 384.
80 See Morse, supra note 56, at 313. Through Drope, the Supreme Court held that due process requires a further investigation into competency every time it is raised as an issue. Id.
82 See Riggins v. Nevada, 504 U.S. 127 (1992) (examining whether to induce mentally ill defendant to a competent state for trial); Morse, supra note 13, at 910-16 (discussing different issues surrounding forcing competence to stand trial).
83 See Riggins, 504 U.S. at 129. Riggins informed the prison psychiatrist that he had successfully been treated in the past with Mellaril (thioridazine), an antipsychotic medication, so the doctor prescribed him the same medication. Id. When the dosage proved unsuccessful at relieving Riggins’s symptoms, the doctor increased the dosage. Id. Riggins moved for a determination of his competency to stand trial and was deemed competent by the lower court after a competency hearing. Id. at 130.
84 See id. at 130-31. Riggins moved for his medication to cease, claiming that it was his Constitutional right for the jury to see him in his natural state. Riggins, 504 U.S. at 131. Riggins’ motion was denied, and he was medicated throughout his trial. Id. The jury found Riggins guilty and sentenced him to death. Id. When the Nevada Supreme Court affirmed his sentence, Riggins appealed to the Supreme Court of the United States. Id. at 132.
Fourteenth Amendment rights.\textsuperscript{85} In order to require a defendant to be forcibly medicated, the state must show that the forcible medication of the defendant is the least intrusive means of restoring competence.\textsuperscript{86} The state must also show that the proposed treatment is medically appropriate for the defendant's safety as well as the safety of others.\textsuperscript{87} While the Supreme Court found in favor of petitioner Riggins, the Court held that involuntary medicating is sometimes appropriate if the state can prove an overriding justification and a determination of medical appropriateness for the forced medication.\textsuperscript{88} Since \textit{Riggins}, current medications used to treat mental illnesses, including antipsychotic medications, may be prescribed to assist defendants regain competency to stand trial.\textsuperscript{89}

\textsuperscript{85} See U.S. CONST. amend. VI (articulating right to fair and speedy trial with impartial jury); U.S. CONST. amend. XIV (granting due process and equal protection in context of states); \textit{Riggins}, 504 U.S. at 132-33 (denying Eighth Amendment claim based on inability to present to jury); \textit{Washington v. Harper}, 494 U.S. 210, 229 (1990). In \textit{Washington v. Harper}, the Supreme Court stated that “[t]he forcible injection of medication into a non-consenting person’s body represents a substantial interference with that person's liberty.” \textit{Id.} While the Court found that defendant Harper had the right to be free of unwanted medication under his Due Process Clause rights, the state's legitimate interest in protecting others from the danger of an unmedicated, mentally disordered, violent inmate ranked higher. \textit{Id.} See Morse, \textit{supra} note 80, at 914. “[T]he state’s interest sometimes outweighed the prisoner's liberty interest and antipsychotic medication was found to be a rational means to effectuate the State interest.” \textit{Id.} Harper addresses the involuntary medication of a prisoner, and is therefore distinguishable from \textit{Ruggins}. \textit{Id.} at 317. In the case of \textit{Riggins}, the purpose of forcibly medicating a defendant using antipsychotic medications was a particularly severe interference on a person's liberty. 504 U.S. at 136.

\textsuperscript{86} \textit{Riggins}, 504 U.S. at 136. The state failed to determine whether any other reasonable means could have restored the defendant to competency. \textit{Id.} The state did not show that there was an absolute need for Riggins to remain on Mellaril for the trial. \textit{Id.}

\textsuperscript{87} See \textit{Riggins}, 504 U.S. at 127-28. The state failed to show that the antipsychotic medication was medically appropriate. \textit{Id.} at 135-36. \textit{See also} Douglas Mosssman, \textit{Is Prosecution ‘Medically Appropriate?’} 31 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 15, 37 (2005). Medically appropriate means “whether [Mellaril was the right type of medication for [Riggins'] treatment.” \textit{Id.}

\textsuperscript{88} See \textit{Riggins}, 504 U.S. at 128. In addition, the Court refused to decide whether a competent defendant had the ability to refuse his antipsychotic medications if stopping the medication would render him not competent. \textit{Id.} at 136. See also Morse, \textit{supra} note 80, at 315 (explaining significance of Court's refusal to address issue since it did not arise in case). At the time of the decision, \textit{Riggins} was the most important Supreme Court decision regarding a state's right to involuntarily medicate a criminal defendant in order for the defendant to be competent to stand trial. \textit{Id.} at 314. In his concurring opinion in \textit{Riggins}, Justice Kennedy stated that involuntarily medicating a defendant poses a serious threat to his right to a fair trial. \textit{Riggins}, 504 U.S. at 139 (Kennedy, J. concurring). A state would be required to show in an extraordinary manner that the state's interest in medicating a defendant who was expressing a desire to refuse medication. \textit{Id.} at 139. Justice Kennedy seriously doubted that there would be many instances in which a state would be able to make the requisite showing to involuntarily medicate a defendant in order to make the defendant competent to stand trial. \textit{Id.}

\textsuperscript{89} See Wall, et al., \textit{infra} note 139, at 189. Current medications have improved since the \textit{Riggins}...
In *Gómez v. Moran*, the defendant, Moran, represented himself pro se. The Supreme Court determined that the competency standard to plead guilty or waive the right to counsel is the same level of competency required to stand trial. In order to waive counsel, courts must determine that the waiver was made knowingly and intelligently. Moran requested to represent himself and after pleading guilty to three counts of murder, he was sentenced to death. Post-conviction and post-sentencing, Moran filed a petition asserting his incompetency at the time he declared his intention to represent himself pro se at trial. Until Moran, the Supreme Court had not declared a competency level for defendants to plead guilty or waive the right to counsel. The Due Process clause only requires that states at minimum maintain the competency standard as set out in *Dusky*.

Competency is also a valid inquiry and factor when determining the sentencing decision and have fewer side effects. *Id.*


*Id.* Moran was charged with three counts of first-degree murder after he admitted to police that he had murdered three people. *Id.* Moran shot himself but survived. *Id.* After he was charged, the trial court ordered Moran evaluated by two psychiatrists to determine his competency. *Id.* After Moran was deemed competent by the psychiatrists, the state decided to pursue the death penalty. *Id.* at 391-92.

*See Moran*, 509 U.S. at 392-93. After Moran’s request to represent himself but before the court allowed it, the court explained to Moran the consequences of representing himself. *Id.* at 392. The court was also required to determine that Moran’s plea changes were not due to promises, threats or coercion. *Id.* The court subsequently found that Moran “knowingly and intelligently” waived his right to counsel and “freely and voluntarily” pled guilty to all charges. *Id.* at 393.

*Id.* Moran’s petition was rejected by the court on the grounds that two psychiatrists had found him competent to stand trial. *Moran*, 509 U.S. at 393. The Ninth Circuit Court of Appeals held that the trial court was required to hold a competency hearing so as not to violate Moran’s Due Process rights. *Id.* at 393-94. The Court of Appeals held that the level of competency to waive the right to counsel, a constitutional right, was higher than that required to stand trial. *Id.*

*See id.* at 396. Pleading guilty to charges waives all of a defendant’s criminal justice rights. *See Morse*, supra note 56, at 313. The competency standard to plead guilty and waive the right to assistance of counsel should be no higher than the standard set out in *Dusky*. *Moran*, 509 U.S. at 398. “If the *Dusky* standard is adequate for defendants who plead not guilty, it is necessarily adequate for those who plead guilty.” *Id.* at 399. The Court also held that a defendant who waives his right to counsel does not need to be more competent than a defendant who chooses to utilize counsel. *Id.* “[A] criminal defendant’s ability to represent himself has no bearing upon his competence to choose self-representation.” *Id.* at 400. While the Court of Appeals was not misguided in its belief that a higher standard was required in order to plead guilty and to waive counsel, the higher standard is not one of competence. *Id.* at 401.

*See U.S. CONST. amend. XIV (granting due process and equal protection in context of states); Moran*, 509 U.S. at 402. A state can set a higher standard if the state chooses. 509 U.S. at 402.
of a defendant, especially when considering the death penalty.\textsuperscript{97} There has long been a bar against executing the insane under common law.\textsuperscript{98} In \textit{Ford v. Wainwright}, the Supreme Court upheld the common law rule that execution of the mentally insane is cruel and unusual punishment.\textsuperscript{99} Petitioner Alvin Bernard Ford ("Ford"), who received a death sentence after conviction for murder in 1974, started exhibiting signs of mental illness in 1982.\textsuperscript{100} The Governor of Florida signed a death warrant for Ford's execution in 1984.\textsuperscript{101} After Ford's counsel failed to succeed in requesting a hearing with the state court, a petition for habeas corpus was filed in the United States District Court for the Southern District of Florida.\textsuperscript{102} On a grant for petition of certiorari, the Supreme Court held that the Eighth Amendment prohibits a sentence of death to be carried out when the inmate is found to be insane.\textsuperscript{103}

While \textit{Ford} dealt with the execution of the mentally insane, \textit{Penry v. Lynaugh} addressed the execution of intellectually disabled defendants.\textsuperscript{104} In \textit{Penry}, the Supreme Court sanctioned the death penalty in cases of intellectually disabled defendants.\textsuperscript{105} Petitioner Johnny Paul Penry ("Penry"), twenty-two years old at the time of raping and stabbing a woman to death, had less mental capacity than a seven year old child.\textsuperscript{106}

\textsuperscript{97} See infra notes 98-130 (citing specific cases where Supreme Court made decisions regarding death penalty).

\textsuperscript{98} See, e.g., \textit{Ford v. Wainwright}, 477 U.S. 399, 406-08 (1986). Speculation for the reason for the common law rule against executing the insane include that it offends humanity and the deterrence rationale of punishment is lost on a person who is insane. \textit{Id.} at 407-08. Another explanation includes that "madness is its own punishment." \textit{Id.}

\textsuperscript{99} See \textit{id.} at 418.

\textsuperscript{100} \textit{Id.} at 402. Ford developed an obsession with the Ku Klux Klan. \textit{Id.} He also experienced delusions that led him to believe "one hundred and thirty-five of his friends and family were being held hostage in the prison, and that only he could help them." \textit{Ford}, 477 U.S. at 402.

\textsuperscript{101} \textit{Id.} at 404 (providing facts and procedural posture of case).

\textsuperscript{102} \textit{Id.}

\textsuperscript{103} \textit{Id.} "[T]he Eighth Amendment forbids the execution only of those who are unaware of the punishment they are about to suffer and why they are to suffer it." \textit{Id.} at 422 (Powell, J., concurring). \textit{See also} U.S. Const. amend. VIII (barring excessive bail, fines, and cruel and unusual punishments). Rationales to justify a competency ruling, in order to be support a death penalty sentence include: (1) inability of a not competent person to provide last minute assistance to counsel for information that could vacate a sentence; (2) insanity is punishment in and of itself; (3) the execution of an incompetent person has no deterrent effect on the population; and (4) the retribution or vengeance meant to be realized by execution cannot be exacted from an incompetent person. \textit{See} CHRISTOPHER SLOBOGIN ET AL., LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 1220 (English and English eds., 6th ed. 2013).


\textsuperscript{106} \textit{Id.} at 307. A psychologist testified at a competency hearing that Penry had organic brain
Three psychiatrists testified at the trial, two testified for the state that Penry was legally sane and not suffering from any mental illness or defect at the time of his crime and the third testified that Penry suffered from brain damage and a moderate intellectual disability.\textsuperscript{107} The Court stated that all of a defendant’s mitigating circumstances should be thoroughly and fully communicated to a jury for consideration, particularly when the prosecutor seeks the death penalty as a possible sentence.\textsuperscript{108} The Court found that the death penalty was not cruel and unusual punishment for the intellectually disabled Penry since he was competent to stand trial and therefore not an Eighth Amendment violation.\textsuperscript{109}

In 2002, the Supreme Court again addressed the issue of the intellectually disabled and the death penalty in \textit{Atkins v. Virginia}, this time with different results.\textsuperscript{110} In \textit{Atkins}, the execution of an intellectually disabled individual was deemed cruel and unusual punishment.\textsuperscript{111} Daryl Renard Atkins’s (“Atkins”) counsel provided the court with school records of his client confirming an IQ score of fifty-nine.\textsuperscript{112} Atkins was sentenced to death for abduction, armed robbery and capital murder.\textsuperscript{113} The Supreme Court overturned the case, holding that a person with an intellectual disability does not act with the level of moral culpability that characterizes most serious adult criminal damage. \textit{Id.} Penry was removed from school at the age of twelve, his aunt spent a year trying to teach him how to write his name. \textit{Id.} at 309.

\textsuperscript{107} \textit{Id.} at 309. The two psychiatrists who testified for the state agreed that Penry had limited mental ability. \textit{Id.} at 310. \textit{See also supra} Part I(a) and Part I(b) (distinguishing mental illness and defect from intellectual disability).

\textsuperscript{108} \textit{See Peny}, 492 U.S. at 328. The Supreme Court remanded the case for resentencing because the “jury was not provided with a vehicle for expressing its ‘reasoned moral response’ to that evidence in rendering its sentencing decision.” \textit{Id.} When the death penalty is a sentence to be considered, all factors must be considered in order for a less severe penalty to be considered. \textit{See also} \textit{Eddings v. Oklahoma}, 455 U.S. 104, 119 (1982) (O’Connor, J., concurring); \textit{Lockett v. Ohio}, 438 U.S. 586, 605 (1978).

\textsuperscript{109} \textit{See U.S. CONST. amend. VIII} (banning cruel and unusual punishment); \textit{Peny}, 492 U.S. at 351. Penry argued that the death penalty was cruel and unusual punishment because individuals with an intellectual disability “do not possess the level of moral culpability to justify imposing the death sentence.” \textit{Id.} at 328-29. Penry was found to be competent to stand trial based on the \textit{Dusky} standard, the jury rejected his insanity defense “which reflected their conclusion that Penry knew that his conduct was wrong and was capable of conforming his conduct to the requirements of the law.” \textit{Id.} at 333.


\textsuperscript{111} \textit{See Atkins}, 536 U.S. 304.

\textsuperscript{112} \textit{Id.} at 309. The school records indicated that Atkins had a mild intellectual disability. \textit{Id.}

\textsuperscript{113} \textit{Id.} at 307. Atkins and another man abducted a third man with a handgun and robbed him. \textit{Id.} Atkins and his partner took the victim to a desolate location and shot him. \textit{Id.} Atkins had prior felony convictions, robberies, and assaults on his record. \textit{Id.}
While the Court left the states to formulate states' own definition of intellectual disability, many states determine an individual to be intellectually disabled with an IQ score of seventy or below.115

In *Hall v. Florida*, the Supreme Court narrowed the definition of who was to be considered intellectually disabled in legal proceedings.116 The Court called into question the constitutionality of a Florida’s statute deeming a person with an IQ score of seventy or below to be intellectually disabled.117 The Florida statute defined intellectual disability as “significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the period from conception to 18.”118 Petitioner Freddie Lee Hall (“Hall”) filed a motion to stay his execution due to his intellectual disability, in response to the *Atkins* decision.119 The Court deemed Florida’s rigid determination based on IQ level unconstitutional, as written in the statute.120

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114 *Peng*, 492 U.S. at 307. Persons with intellectual disabilities may exhibit lower skills in reasoning, control of impulses, and judgment. *Id.*

115 See *Atkins*, 536 U.S. at 317; *Intellectual Disability*, *supra* note 58, at 1. An IQ of seventy or below is approximately two standard deviations below the population. *Intellectual Disability*, *supra* note 58, at 1. “Intellectual disability involves impairments of general mental abilities that impact adaptive functioning in three domains.” *Id.* One domain is the conceptual domain which includes language, reading, writing, math, reasoning, knowledge and memory skills. *Id.* The social domain is the second domain which includes empathy, social judgment and interpersonal communication skills. *Id.* The third domain is the practical domain which focuses on “self-management” including care of self, job responsibilities, money management, recreation and organizing school and work tasks. *Id.*


118 *Hall*, 134 S.Ct. at 1990-94. “The term ‘significantly subaverage general intellectual functioning’... means performance that is two or more standard deviations from the mean score on a standardized intelligence test . . . .” *Id.* Since the mean IQ test score is one-hundred and a standard deviation is fifteen, Florida’s statute defines anyone with an intellectual disability as having an IQ lower than seventy. *Id.*

119 *Id.* at 1991-92. Evidence submitted with the motion established Hall’s IQ at seventy-one, even though he had nine IQ evaluations over a span of forty years, the results of which ranged from scores of sixty to eighty. *Id.* For evidentiary reasons, the two tests resulting in an IQ below seventy were not considered for sentencing purposes, therefore, the state argued, and the lower court agreed, that Hall was not intellectually disabled. *Id.* Because of this, Hall’s death sentence was upheld. *Hall*, 134 S. Ct. at 1992.

120 See *id.* at 1990. The Supreme Court found it unacceptable that the trial court rigidly enforced a requirement of an IQ below seventy. *Id.* The Court also found it unacceptable for the trial court not to consider the standard measure of error for IQ tests. *Id.*
Criminal punishment intends to deter people from committing crimes based on a threat of serious punishment.\textsuperscript{121} In Atkins, the Court reasoned that there was no legitimate purpose to execute an individual with an intellectual disability, given that individual’s inability to make calculated judgments which serves as the grounds for the deterrence rationale.\textsuperscript{122} The Court also rejected the narrow interpretation of the insanity standard established in Ford, holding that, in order to be executed, a defendant must have a “rational understanding of the reason for execution.”\textsuperscript{123}

C. Competency Restoration

A court’s goal is to restore competency to any defendant found not
Ordering forced medication is an option of the court to restore a defendant to an adequate level of competency to stand trial. If a court finds, under a preponderance of the evidence standard, that a defendant is medically incompetent, the court may order hospitalization of the defendant. In \textit{Sell v. United States}, the defendant Charles Thomas Sell refused to take antipsychotic medication while committed to a state treatment facility after being found incompetent to stand trial. According to the \textit{Sell} factors, a court must determine that there is a substantial probability that taking antipsychotic medication would enable a defendant to become competent without substantially undermining the fairness of a trial to order forced medication. The medication must also be necessary to restore competency with no other less intrusive methods possible. Based on those two requirements, it is rare for a court to justify forcible antipsychotic medication. The Court also stated that if a defendant chooses to not be medicated voluntarily, he may face a lengthy sentence.

Another method of returning competency is to enroll defendants in a

\begin{itemize}
\item \textit{See Pinals}, supra note 58, at 86. Clinicians are faced with the dilemma of identifying the defendant committed to the facility as one who needs to restore competency or as a patient who needs treatment for an illness. \textit{Id.} When restoration of competency is the goal, a successful outcome occurs at the point the defendant can be deemed competent. \textit{Id.} This does not mean that the defendant has been treated for and cured of his mental illness or intellectual disability. \textit{Id.}
\item \textit{Id.} at 171. The Court held that while forcible medication for purposes of restoring competency is allowed, it should only be used in the appropriate circumstances. \textit{Id.} at 179-180. The Court made it clear that the Eighth Circuit erred when it approved forced medication solely to render Sell competent to stand trial. \textit{Id.} at 184. The Court vacated the judgment of the Eighth Circuit and remanded the case for further proceedings consistent with its opinion. \textit{Id.} at 186.
\item \textit{Id.} at 179.
\item \textit{Sell}, 539 U.S. at 179.
\item \textit{Id.} at 180. There must be important government interests at stake for a court to consider forcible medication. \textit{Id.} Each case where forcible medication is requested must be determined on a case-by-case basis. \textit{Id.} Forcible medication must significantly and necessarily further those interests. \textit{Id.} at 181. The medication must be medically appropriate. \textit{Id.}
\item \textit{Sell}, 539 U.S. at 180. The risk of a defendant with mental illness being released without punishment is diminished due to lengthy confinement. \textit{Id.} The state’s interest in a speedy trial is negatively impacted if a defendant is not competent for a long period of time. \textit{Id.} If a defendant is found competent after being treated for competency, the defendant may receive credit towards his or her sentence. \textit{Id.} In \textit{Sell}, the lower courts failed to recognize that Sell was at the hospital for a long period of time and that refusal to take the medication may have lengthened his confinement. \textit{Id.} at 186.
\end{itemize}
competency restoration program.\textsuperscript{132} A court should use the least-restrictive setting or facility for competency restoration, determining between inpatient, outpatient or jail-based.\textsuperscript{133} While outpatient restoration is the most cost efficient option, jail-based competency restoration programs charge less than competency restoration programs per diem at a state-run psychiatric hospital.\textsuperscript{134} The length of time that a defendant is in treatment for competency restoration can also depend on the type of program in which the defendant is placed.\textsuperscript{135} Another issue with competency restoration programs is that

\textsuperscript{132} See Colleen Horton, Restoration of Competency to Stand Trial, HOGG FOUND. FOR MENTAL HEALTH (Mar. 2013), http://www.hogg.utexas.edu/uploads/documents/Competency\%20Restoration%20Brief.pdf. “Competency restoration is the process used when an individual charged with a crime is found by a court to be incompetent to stand trial, typically due to an active mental illness or an intellectual disability.” \textit{Id.} at 1.

\textsuperscript{133} See \textit{NAT’L JUDICIAL COLL., supra} note 75, at 25-8. An inpatient hospital or facility would be the best setting for a defendant: who presents an imminent risk of danger to himself or to others due to a mental disorder; is at risk for self-neglect; if the mental disease or defect is difficult to determine and requires close clinical observation; who lacks the ability to consent to necessary psychotropic medications for treatment and may require involuntary administration of such medication; if emergency services are likely to be needed. \textit{Id.} at 25. \textit{See also IRVING, supra} note 58, at 434. Community-based restoration programs on an outpatient basis are likely the least-restrictive option available and should be considered for defendants who have an intellectual disability, cognitive or developmental disorders or a major mental illness. \textit{See NAT’L JUDICIAL COLL., supra} note 75, at 27. When determining if a community-based restoration program is best for certain types of defendants, consideration should also be given to whether: there is a program suitable for the defendant; the program has individual training for the defendant that is specific to his specific case and his personal competency issue; the defendant has a stable living environment with an individual(s) who can assist with getting the defendant to the program as well as support the defendant’s treatment place; the defendant is compliant with the plan. \textit{Id.} Jail-based programs are best for defendants who do not require inpatient treatment but should not be released to the community. \textit{Id.} at 26.

\textsuperscript{134} See Horton, \textit{supra} note 132, at 2. In a state-run psychiatric hospital, the cost per day for a defendant involved in a competency restoration program is $421 and the cost per day for a defendant in a jail-based program is $278. \textit{Id.} The least expensive program on a per diem basis is an outpatient competency restoration program, which averages $106 per day. \textit{Id.} While there are many drawbacks to jail-based competency restoration, there are also certain benefits in addition to cost-effectiveness. \textit{Id.} \textit{See also NAT’L JUDICIAL COLL., supra} note 75 (explaining benefits of jail-based competency restoration programs). Some of the benefits of a jail-based program include: time savings because the defendant will not have to wait for a placement in a hospital and the defendant does not require transport between the treatment center and his or her place of living; potentially keeping a defendant close to his or her family and attorney; and a higher likelihood of continuous care by the same treatment professionals throughout all legal proceedings. \textit{See id.} at 26.

\textsuperscript{135} See \textit{id.} at 27. From the results of a study in Harris County, Texas, the average length of stay at a state hospital was one hundred days. \textit{Id.} In the same study, the average length of time it took for a defendant to be restored to competency in a community-based program was thirty-days. \textit{Id.} Another Texas-based research document resulted in different figures, but reached a similar
these programs may risk violating the ethics of the medical profession by returning patients to an appropriate level of competency simply for the patient to be able to return to trial.\footnote{136}{See Debra A. Pinals, \textit{Where Two Roads Meet: Restoration of Competence to Stand Trial from a Clinical Perspective}, 84-5 (Mar. 9, 2005), http://www.karenfranklin.com/files/CSPP/pinals.pdf. When working with incompetent individuals, "clinicians face a knotty question as to the primary of the goals for the patient. Treatment providers may struggle with whether treatment should be aimed solely at improvement of symptoms or competence restoration. The label 'patient' vs. 'defendant' partially captures this dilemma." \textit{Id.}}

It is necessary for competency restoration programs to be able to specifically diagnose and treat a defendant's mental health issues which result in a lack of competency.\footnote{137}{See \textit{When Treatment is Punishment: The Effects of Maryland's Incompetency to Stand Trial Policies and Practices}, JUST. POL'Y INST., 2-3 (2002), http://www.justicepolicy.org/uploads/justicepolicy/documents/jpi_whentreatment_is_punishment_national_factsheet.pdf (describing various factors, including specific treatment, which impact possibility of restoration of mental competency).} One-third of all defendants with a mental illness or intellectual disability are referred to mental health facilities for competency issues.\footnote{138}{See \textit{Barry W. Wall et al., Restoration of Competence to Stand Trial: A Training Program for Persons with Mental Retardation}, 31 J. AM. ACAD. PSYCHIATRY L. 189, 189 (2003). Of those defendants sent to facilities to be evaluated for competency to stand trial, ninety percent are diagnosed with a mental health disorder and the remaining ten percent are diagnosed with an intellectual disability, either a cognitive or developmental disability. \textit{See Mental Competency Best Practices Model, supra note 75, at 28. See also Wall, at 189 (estimating 2 to 9.5% of those to be evaluated have an intellectual disability). While there has been an increase in research on the impact of competency restoration programs on defendants, there has been little in the area of defendants with intellectual disabilities. \textit{Id.} Many defendants with mental health disorders are able to be assisted in restoring competency through the use of psychotropic medications. \textit{Id. See also Dillard, supra note 49, at 184 (stating psychotropic medications allow for restoration of competency in seriously mentally ill defendants); Pinals, supra note 58, at 83 (finding medication to treat incompetent defendants critical component in competency restoration); Morse, supra note 79, at 316 (characterizing medication as most efficient means of restoring competence, "although not the only means").}} If a defendant in a competency restoration program is a likely candidate for competency restoration, competency will typically be restored within the first six months of treatment.\footnote{139}{See \textit{When Treatment is Punishment, supra note 137, at 2. "Research on competency restoration for people with mental illness shows that 70% or more become competent within six months of starting treatment; nine out of 10 will be restored within a year." \textit{Id} (footnote omitted). See also Pinals, supra note 58, at 104 (explaining competency restored in approximately 80-90% of defendants with mental illness within six months). Defendants who are found not competent are more likely to be diagnosed with a psychotic disorder. \textit{See Michael H. Fogel, et al., Ten Year...}}
intellectually disabled defendants face longer periods of detention because it generally takes longer for competency to be restored for an intellectually disabled defendant than a mentally ill defendant. Studies have also shown that competence is much more likely to be restored to a defendant with a mental illness than one with an intellectual disability. Risks inherent in competency restoration programs treating the

Research Update (2001-2010): Evaluations for Competence to Stand Trial (Adjudicative Competence), 31 BEHAV. SCI. L. 165, 172 (2013). Defendants who are diagnosed with an intellectual disability face more challenges when it comes to being restored to competency. See When Treatment is Punishment, supra note 137, at 2. See also Advokat, supra note 58, at 90 (explaining defendants with most severe intellectual disabilities are less likely to regain competency). Many programs do not consider that restoration programs for the intellectually disabled must cater to their special needs. See When Treatment is Punishment, supra note 137, at 2-3. “[A] study of 75 people with an intellectual disability who were incompetent to stand trial found that two-thirds failed to be restored.” Id. at 3. Of the number of adults who face criminal charges in the United States, four to ten percent of those adults are intellectually disabled. See Barry W. Wall & Paul P. Christopher, A Training Program for Defendants With Intellectual Disabilities Who are Found Incompetent to Stand Trial, 40 J. AM. ACAD. PSYCHIATRY L. 366, 366 (Nov. 3, 2012). The issue with those numbers, though, is that correctional facilities use self-reporting to collect data, leaving the number likely lower than it actually should be. Id. While competence restoration has been successful with some defendants who have an intellectual disability, the treatment time is typically much longer when compared to a defendant who is facing competency restoration based on mental illness. See Pinals, supra note 58, at 104. It could take up to two years in order to determine whether competence of a defendant with an intellectual disability is even possible. Id.

140 See 18 U.S.C. § 4241(d). Federal law requires that a defendant remain hospitalized for a period not to exceed four months in order for the court to determine whether competency can be restored within the foreseeable future. Id. See also supra note 45 and accompanying text (discussing Supreme Court’s holding in Jackson). Defendants with intellectual disabilities pose a challenge for mental health professional whose job it is to restore competency to defendants in order to go to trial. See Wall & Christopher, supra note 139, at 366. These individuals tend to be committed to state hospitals in order to regain competency. Id. In the past it was not uncommon for the amount of time a defendant is in the hospital in order to be restored to competence to surpass the amount of time the defendant would have been sentenced had he or been convicted of the alleged crime. Id. See also Miller, supra note 76, at 379 (stating many defend hospitalized longer than the time committed for the crime). Many courts have ruled that it is a violation of a defendant’s due process rights, though, to be committed for longer than he would have served had he been convicted. Id. at 372. Other courts and legislatures have set maximum time limits on the length of time a defendant can be held while incompetent. Id.

141 See Pinals, supra note 58, at 94. Competency restoration literature shows that eighty to ninety percent of defendants with a mental illness are restored to competence, generally within six months. Id. Medication plays a large role in restoring competence to individuals who are mentally ill. Id. While intellectually disabled individuals may also have a mental illness, they may not be suitable for medication intervention. Id. There are fewer studies about defendants with intellectual disabilities being restored to competence, but according to what data that is there, not more than half of those defendants are able to regain competency. Id. There are concerns that the competence that intellectually disabled individuals obtain through competency restoration programs is only superficial and may not be long lasting. Id.
intellectually disabled is that competency obtained via restoration programs is only superficial and may not provide permanent benefit.\textsuperscript{142}

In competency restoration programs, there are different treatment protocols that are used by facilities in order to restore a defendant to competency.\textsuperscript{143} Eleanor Slater Hospital in Rhode Island serves as an example of a competency restoration program for individuals with an intellectual disability.\textsuperscript{144} The hospital's program, known as the "Slater Method," uses special structured modules, individualized to the defendant, to assist a defendant in restoring competency and managing through the trial process.\textsuperscript{145} The Slater Method specifically aims to treat defendants incompetent to stand trial due to an intellectual disability.\textsuperscript{146} A study done in Missouri on the ability to restore

\textsuperscript{142} See Pinals, supra note 58, at 94. "Competency restoration of defendants generally requires two levels of intervention: (1) treating the underlying mental condition related to inability to understand the proceedings and/or assist counsel; and (2) targeting the specific details the defendant has in understanding the criminal proceedings he or she faces, and in assisting counsel in his or her defense, through information and training." See IRVING, supra note 58, at 434.

\textsuperscript{143} See Patricia Zapf, Standardizing Protocols for Treatment to Restore Competency to Stand Trial: Interventions and Clinically Appropriate Time Periods, WASH. ST. INST. FOR PUB. POLY 5 (Jan. 2013), http://www.wsipp.wa.gov/ReportFile/1121/Wsipp_Standardizing-Protocols-for-Treatment-to-Restore-Competency-to-Stand-Trial-Interventions-and-Clinically-Appropriate-Time-Periods_Full-Report.pdf. One treatment protocol frequently used in competency restoration is medication. Id. See also supra note 138 and accompanying text (identifying psychotropic medications as essential part of competency restoration). Another type of treatment protocol is educational treatment programs. See Zapf, at 10. At Atascadero State Hospital in California, incompetent defendants were evaluated to determine their individual competency and then a personal treatment plan was developed for each defendant based on his or her mental issues. Id. at 9-10. Many educational treatment plans include requiring the defendant to participate in a mock trial in order for the defendant to understand each person's role in the courtroom. Id. at 10-12. Most important is that a defendant is evaluated and placed into a treatment plan that will best serve that defendant's needs and deficits. See Mental Competency Best Practices Model, supra note 75, at 28. It is the best practice to allow a mental health professional to determine what type of treatment for a defendant is best and for that treatment plan to be the one implemented with the defendant in order to restore his or her competency. Id. While sharing competence-attaining training methods is supposed to occur between jurisdictions, "surprisingly little information is available on what methods are being employed currently, particularly with regard to defendants with intellectual disabilities." Wall & Christopher, supra note 139, at 367 (emphasis added).

\textsuperscript{144} See id. at 368.

\textsuperscript{145} See Wall et al., supra note 74 (providing description of Slater Method). Eleanor Slater Hospital is a "statutorily designated facility for person found incompetent to stand trial." Wall et al., supra note 139, at 368. While there are very few studies regarding competency restoration in defendants with an intellectual disability, there are "[s]everal studies [that] have identified the presence of intellectual disability as predictive of a clinical finding of incompetent to stand trial." Id. at 366-67.

\textsuperscript{146} See id. at 370. Treatment takes place with defendants who are inpatient and outpatient, which
competence to defendants with an intellectual disability found that defendants sent to a state hospital were more likely to regain competence than defendants sent to rehabilitation programs.\textsuperscript{147}

A jail-based competency restoration program was at issue in United States v. Duhon.\textsuperscript{148} Once Keith Joseph Duhon ("Duhon") was deemed incompetent to stand trial, he was sent to the Federal Correctional Institution ("FCI") for competence restoration.\textsuperscript{149} The District Court for the Western District of Louisiana held that mere ability to memorize and retain information did not establish the competency of a...
defendant, as an understanding of the memorized information is also required.\(^{150}\)

Problems exist with competency restoration programs involving defendants who are intellectually disabled.\(^{151}\) Critics argue that the programs fail to restore intellectually disabled defendants to competency but rather assist these defendants in establishing competency for the first time in their lives.\(^{152}\) Information about the success of competency restoration programs specifically for intellectually disabled defendants is scarce.\(^{153}\) One such study, a study of the Slater Method, observed eighteen defendants with intellectual disabilities.\(^{154}\) The results of the study showed the effectiveness of the Slater Method.\(^{155}\) Individuals with milder intellectual disabilities may not be considered for competency restoration program.\(^{156}\)

III. Analysis: A Pathway Forward

Any individual present in the courtroom should have the ability to question a defendant's competency at any point in the legal proceedings in order to ensure that a defendant's constitutional rights are not violated.\(^{157}\) The *Dusky* standard was developed

\(^{150}\) *See Duhon*, 104 F. Supp. 2d at 675. The program in which Duhon participated at FCI focused only on the factual understanding of the criminal proceedings by just memorizing and retaining information. *Id.* at 674. An expert testified that Duhon had been conditioned to say what he was taught, but his words were "hollow" and without any cognitive understanding. *Id.* at 675. While the warden testified that competency restoration programs were widely accepted, another expert disagreed. *Id.* at 676. While some defendants may benefit from competency restoration programs, a defendant with the level of intellectual disability as Duhon's would likely never meet the competency threshold. *Id.* While Duhon may have had a factual understanding of the proceedings, he lacked the ability to consult with his counsel, to assist in his defense and to rationally understand the legal proceedings. *See Irving*, supra note 58, at 414.

\(^{151}\) *See Pinals*, supra note 58, at 94. Different competency restoration programs for defendants who are mentally ill and defendants who are intellectually disabled are necessary since "restoring" competence to a defendant who has an intellectual disability is a different undertaking. *Id.*

\(^{152}\) *See Wall & Christopher*, supra note 139, at 366. Since competence restoration, or as some authors refer to as "competence attainment," for intellectually disabled is different from competence restoration for the mentally ill, special training is needed for the mental health professionals who treat these defendants. *Id.* *See also supra* Part I(A) and Part I(B) (distinguishing characteristics between mental illness and intellectual disability).

\(^{153}\) Wall & Christopher, supra note 139, at 367. Individuals with a lesser severity of intellectual disability are more likely to become competent. *Id.*

\(^{154}\) *Id.* at 370. Of those eighteen defendants, eleven attained competency, five did not, and two were deemed "nonattainable." *Id.*

\(^{155}\) *Id.* Success within competency restoration programs is impacted by many factors including age, severity of intellectual disability and other mental health issues. *Id.* at 371.

\(^{156}\) Wall & Christopher, supra note 139, at 371

\(^{157}\) *See supra* note 56 and accompanying text (identifying Sixth Amendment rights); *supra* notes 45
in order to ensure a defendant's Sixth Amendment rights to a fair trial. While potentially inconvenient for the prosecution, every time a defendant's competency is questioned, competency should be inquired into further. Every defendant should receive at least the examination by a psychiatrist or psychologist in order to determine whether a hearing is necessary. Since a judge determines whether a defendant is competent or not, it is important that the judge be properly informed by the psychologist or psychiatrist ordered to do the examination. While the competency reports require that the medical professional make a recommendation to the judge, the final decision is left to the judge, an individual typically without medical training. The judge then bases his or her decision from the report and any evidence submitted at the competency hearing. The judge may not be able to recognize the difference between mental illness and intellectual disability, especially if the distinction is not raised to the judge. Judges, prosecutors, and defense counsel should receive training on mental illness and intellectual disability in order to properly consider the effectiveness of competency restoration programs for each class of defendants.

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158 See supra note 55 and accompanying text (identifying the Dusky standard). The Dusky standard sets a baseline for lower courts to use when determining whether a defendant is competent. Id. If there are no doubts that the defendant has the ability to consult with his or her attorney in order to adequately defend himself or herself and the defendant has a rational understanding of the whole legal process, then the court will refrain from the competency evaluation or related hearings. Id.

159 See supra note 80 (discussing the holding in Drope). In Drope, the defendant's mental state was obviously questionable on the second day of trial when he shot himself. Drope v. Missouri, 420 U.S. 162, 169 (1975). As held by the Supreme Court, when defense counsel made a motion to continue the trial in order to have his client evaluated, the lower court should have granted the motion. See also supra note 137 (discussing potential impact of delaying case for competency hearings on prosecution); supra note 64 and accompanying text (explaining circumstances in Drope).

160 See supra notes 65-72 and accompanying text (explaining procedural processes once issue of competency is raised).

161 See supra note 67 (stating examination must be done by a licensed psychiatrist or psychologist).

162 See supra note 77 and accompanying text (describing right to be physically and mentally present at trial).

163 See supra notes 66 and 75 (identifying decision maker regarding competency and what must be in the report to the court prior to hearing).

164 See supra Part I (discussing differences between certain mental illnesses and intellectual disability).

165 See supra Part I (discussing the differences between certain mental illnesses and intellectual disability). Id.
Raising the insanity defense is very different from raising competency issues at trial. The insanity defense can be raised only by the defendant and his counsel. The defense is also obligated to notify the prosecution or plaintiff that the defense intends to raise insanity as a defense. For competency, any party can raise the question, which expands the pool of interested parties and does not rely on the defense, who may be unable or unwilling to raise competency issues, particularly if pro se. In addition, the insanity defense focuses on the defendant's mental state at the time of the crime while competency focuses on the defendant's mental state at the time of the trial. The insanity defense also goes before the jury, requiring a special verdict, "not guilty by reason of insanity," to be explained to the jury. When competency is raised, all proceedings come to a halt.

While it is important that the issue of competency can be easily raised, there must be more focus on identifying the distinction between mental illness, like schizophrenia, bipolar disorder, and major depressive disorder, from an intellectual disability. Even distinguishing and properly diagnosing bipolar disorder and major depressive disorder can be difficult due to similar symptoms. While not always curable, schizophrenia, bipolar disorder, and major depressive disorder have treatment plans that can help a person suffering from one of these disorders to return to living life with little to no assistance. In contrast, an intellectual disability is a lifelong condition that is incurable.

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166 See supra notes 50-51 (explaining the insanity defense); supra notes 95 (explaining that defendant cannot waive competency issue on appeal, even if not brought up during trial).
167 See supra note 40 (noting that people with intellectual disabilities have tendency to be more vulnerable and easily influenced).
168 See supra note 40.
169 See supra note 57 (stating competency can be raised by any party, anytime, after indictment or criminal complaint issued).
170 See supra notes 41-43 (noting that criminal responsibility at time of alleged offenses is distinct issue from competency to stand trial).
171 See supra note 50.
172 See supra note 448 (noting that each time this issue is raised, it will be addressed before proceeding).
173 See supra notes 13-38 and accompanying text (identifying the differences in listed mental illnesses and conditions).
174 See supra note 26 (identifying a depressive episode as a part of bipolar disorder); supra notes 28-29 (explaining major depressive disorder)
175 See supra note 23 (discussing treatment for schizophrenia); supra note 27 (identifying treatment for bipolar disorder); supra note 32 (regarding treatment plans for people suffering from major depression).
176 See supra note 37 (discussing lack of treatment for intellectual disabilities).
The courts' use of competency restoration programs for persons with intellectual disabilities are inappropriate since the likelihood of restoration to competency is low. The likelihood of a person with a mental illness to be restored to competency is much greater than a person with an intellectual disability. Another reason the courts' use of competency restoration programs for individuals with intellectual disabilities is unwarranted is because many of these individuals who never had competency will never gain competency.

Due to an intellectual disability, a person is also at higher risk to give a false confession than a person without an intellectual disability. An intellectually disabled person may be more willing to listen to someone else who could potentially influence the intellectually disabled person to commit a crime. In addition, deterrence serves little to no purpose to a person who is intellectually disabled, making competency restoration programs of little value. An individual with a severe enough intellectual disability may be unable to consider the resulting punishment before committing the crime. Competency standards also serve as a safeguard for defendants who may be unable to make a rational decision, especially when it comes to important aspects of legal proceedings like pleading guilty and waiving counsel.

177 See supra notes 148 and 150 (identifying case where lack of knowledge of person in charge of competency restoration program was problematic). In United States v. Duhon, the warden of the correctional facility where the defendant was sent for competence restoration was untrained in his duties and responsibilities. United States v. Duhon, 104 F. Supp. 2d. 663, 668 (W.D. La. 2000). The warden deemed the defendant competent after only two months. Id. at 667. The court sent the defendant to FCI knowing that it was likely impossible for him to be rendered competent. Id.

178 See supra note 141 (explaining high level of defendants with mental illness who are restored to competency).

179 See supra note 152 and accompanying text (explaining most defendants with intellectual disabilities were never competent). Instead of using the term “competence restoration,” authors Wall and Christopher use the term “competence attainment.” See Wall & Christopher, supra note 139, at 366. The term competency restoration simply implies that the defendant was competent at one time and, though not currently competent, will be able to be restored to the defendant’s prior self when he or she was competent. Id. at 367.

180 See supra note 40 and accompanying text (explaining why people with an intellectual disability are more likely to falsely confess).

181 See supra note 40.

182 See supra note 53 (explaining punishment only serves purpose to person who rationally choses to commit crime).

183 See also supra note 53.

184 See supra notes 90-95 and accompanying text (identifying case where defendant wanted to represent himself and pled guilty to first-degree murder).
The likelihood of a person with an intellectual disability to be restored to the level of competency required to stand trial is minimal when compared to the likelihood of a person with a mental illness’s restoration.\textsuperscript{185} For those with an intellectual disability, competency restoration is much more difficult and clinicians face more obstacles, such as treatment in programs not specifically designed for the intellectually disabled.\textsuperscript{186} These obstacles include trying to restore competency to a person who has never been competent.\textsuperscript{187} Another obstacle is that many individuals with an intellectual disability also suffer from a mental illness.\textsuperscript{188} Due to these difficulties, people with intellectual disabilities may face longer commitments to competency restoration programs than persons suffering from mental illnesses.\textsuperscript{189}

Longer commitments in competency restoration programs means more money spent on these programs.\textsuperscript{190} While community based restoration programs are the least expensive option, enrollment in these programs also means that the individual is out in the community, perhaps posing a danger to the general public’s safety.\textsuperscript{191} Though the defendant is out in the community, these programs are also the most efficient.\textsuperscript{192} Defendants who are unlikely to be restored to competency should still be placed in outpatient programs and attempts should still be made to restore competency, yet in the least expensive environment.\textsuperscript{193} Outpatient competency restoration programs are considered best for individuals who have a strong support system at home, and therefore are less likely to commit a crime again.\textsuperscript{194}

If an individual is found to have an intellectual disability, and that because of this disability he or she will never be restored to competency, the case should be considered dismissed, depending on the charges, and other mental health treatments imposed.\textsuperscript{195} Since deterrence does not typically work for individuals with an intellectual

\textsuperscript{185} See supra note 139 and accompanying text (showing skepticism on ability for intellectually disabled defendant to be restored to competency).
\textsuperscript{186} See Wall, supra note 138 (identifying differences in enrollment in competency restoration programs between mentally ill and intellectually disabled).
\textsuperscript{187} See supra note 152.
\textsuperscript{188} See supra notes 26 and 34-36 (discussing incidence of comorbidity).
\textsuperscript{189} See supra notes 139 and 141 (describing length of time typically necessary to determine competence of defendant with intellectual disability).
\textsuperscript{190} See supra note 134 and accompanying text (explaining cost of different types of restoration programs).
\textsuperscript{191} See supra note 134.
\textsuperscript{192} See supra note 135 (referring to efficiency of the different competency restoration programs).
\textsuperscript{193} See supra note 133-134 (stating for whom community programs work best).
\textsuperscript{194} See supra notes 133-134.
\textsuperscript{195} See supra notes 42-47 (using comparison to Jackson, who stole nine dollars’ worth of property
disability, jail-based programs could also be a good option. Then, the individual receives constant supervision as well as serving some time incarcerated for his or her actions. While jail-based competency restoration programs may take longer and cost more than outpatient programs, the defendant receives more continuous care and constant supervision. The individuals who are going through competency restoration programs will not escape punishment; many of them may be hospitalized in lieu of imprisonment and receive credit for time served at the ultimate sentencing.

Information about competency restoration programs for intellectual disabilities is scarce due in part because the small number of defendants with an intellectual disability are referred to competency restoration programs. Very few studies and information exist regarding competency restoration of intellectually disabled defendants. This lack of information only adds to the need for knowledge regarding the handling of intellectually disabled defendants. The courts struggle with understanding the difference between mental illness and intellectual disability. This struggle is obvious, since the death penalty for those deemed mentally insane was deemed cruel and unusual punishment in 1986, while the death penalty for individuals suffering from intellectual disabilities was not similarly deemed cruel and unusual punishment until sixteen years later in Atkins v. Virginia.

and was held “indefinitely”).

196 See supra note 53 (explaining that rational thinking is required for criminal punishment).

197 See supra note 138.

198 See supra notes 134-135.

199 See supra note 131.

200 See supra note 143 and accompanying text (showing lack of knowledge about programs); supra note 156 (identifying mild intellectually disabled persons as less likely to be referred to competency restoration programs).

201 See supra note 145 and accompanying text (finding only one other study about intellectually disabled defendants was known to authors).

202 See Pinals, supra note 58 (noting many defendants do not receive competency evaluations despite being intellectually disabled).

203 See Pinals, supra note 58. It is much less likely for an intellectually disabled person to benefit from hospitalization to restore competency than a mentally ill person. Id. at 99. It is difficult to restore competency to a person who has never been competent. Id. at 94. See also Jackson v. Indiana, 406 U.S. 715 (1972). Jackson was committed to the Department of Mental Health by the trial court, yet there was testimony that he would never be competent, much less in the foreseeable future. Id. at 718-19. Jackson's intellectual disabilities were far too great to overcome. Id. at 719.

204 See supra note 99 and accompanying text (explaining death penalty is cruel and unusual punishment for the insane); supra note 109 and accompanying text. In Penny v. Lynaugh, in 1989, it was not cruel and unusual punishment for an intellectually disabled person to receive death penalty. See supra notes 110-111 and accompanying text (identifying when Supreme Court finally
Individuals enrolled in competency restoration programs are subjected to review by facility personnel under a statutorily prescribed number of days, as well as other deadlines set by statute and overseen by the courts which contributes added stress. While a licensed medical professional may believe competency can be restored to an individual, medical professionals are under time constraints and scrutiny by the legal system to ensure competency has been restored- pressures which do not typically exist in mental health treatment. Mental health professionals who treat individuals in competency restoration programs also require additional training to treat those with intellectual disabilities.

While it may be allowable under an individual's Sixth Amendment right to decide whether to take medication or not, a state has the responsibility to protect everyone in a state facility. Forcible medication may not be appropriate in all circumstances, but it serves as an option if it is the least intrusive manner in which to restore competency to a defendant and protect the public safety. While inpatient treatment for competency restoration is lengthy and expensive, if forced medication is required, the defendant should be committed to an inpatient facility in order to receive constant supervision and dispensing of the medication. Some early concerns raised regarding forcing medication have lessened, since psychiatric medications have improved substantially, including an improvement in side effects, since these medications were originally forcibly administered in competency restoration programs.

Deemed death penalty cruel and unusual punishment for intellectually disabled). Ironically, Penry argued that, as an intellectually disabled person, he could not develop the "moral culpability to justify imposing the death sentence." See Penry v. Lynaugh, 492 U.S. 302, 328-29 (1989). When deciding Atkins, the Supreme Court held that a person with an intellectual disability does not "act with the level of moral culpability that characterizes the most serious adult criminal conduct." 536 U.S. 304, 306 (2002).

See 18 U.S.C. § 4241(d) (2012). Federal laws require a determination about whether a defendant can be restored to competency within four months. Id. As set by Jackson, a defendant cannot be indefinitely held for competency restoration, especially if no progress is made towards competency. See 406 U.S. at 738-39 (identifying Jackson holding). See also Miller, supra note 57, at 379 (stating many defendants are hospitalized longer than the time committed for the crime).

See supra note 140 (noting difficulties encountered by mental health professionals).

See supra note 152 (explaining need for special training).

See supra note 85 and accompanying text (referring to Washington v. Harper, court held that inmate could be involuntarily medicated). While Harper was distinguishable from Riggins v. Nevada, the Court stated in both cases that involuntary medication may be considered by the court, especially when the defendant is a danger to himself or herself or to others. See supra note 85.

See supra note 127 and accompanying text (stating that forcible medication is not always appropriate).

See supra notes 133-134.
making requiring these medications a more palatable option.\textsuperscript{211}

\textbf{IV. Conclusion}

While public understanding about mental illness and intellectual disabilities have increased, the criminal justice system lags behind in understanding. Courts still struggle to grasp the distinction between mental illness and intellectual disabilities, which require different treatment in the courts. A defendant with schizophrenia and a defendant with an intellectual disability should not be ordered to the same competency restoration program under the assumption that they will both return to court in the same amount of time, fully competent and ready to face the consequences of their actions. Special training is required for treatment of each class of defendants.

Courts fail to fully understand that a person with an intellectual disability cannot simply be required to take medication to restore competency. Yet judges and court personnel are not the only parties to struggle, but also attorneys. Not every attorney is equipped to handle the variety of defendants faced in the course of work. It is important for everyone involved in the courtroom to pursue further training in the areas of mental illness and intellectual disabilities to be better equipped to enforce justice.

\textsuperscript{211} See supra note 138 and accompanying text (identifying sources that argue medication is essential for restoring competency). Many of the current medications prescribed are essential in assisting defendants becoming competent to stand trial. See Wall et al., supra note 138, at 189. Of the defendants who are found not competent to stand trial, almost all of them are found incompetent because of a mental illness. Id. See Best Practices Model, supra note 75, at 28. Medications have evolved since Riggins v. Nevada when the dosage of medication Riggins received put him in a state that made it obvious that he was suffering from an illness. See supra notes 82-84 and accompanying text (explaining the forcible medication in Riggins).