

ORIGINAL ARTICLE

The utility of treatment orders in the restoration of fitness to stand trial: a Canadian study

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Involuntary treatment orders to restore fitness to stand trial under the Criminal Code of Canada provide an opportunity to explore variables associated with restoration. Charts were reviewed for 199 defendants assessed for fitness to stand trial in a catchment area of 2.3 million people over a three-year period. A treatment order was issued for 26 of these defendants that were admitted to a regional psychiatric program. All had a psychotic disorder, and 92% (n=24) were restored to fitness within the 60-day order period. No specific factors were associated with restoration. Unlike other studies, our study found that psychosis did not militate against restoration of fitness to stand trial.

Key words

Treatment orders, fitness to stand trial, competence restoration, forensic psychiatry

Introduction

Fitness to stand trial (FST) is a complex psychiatric-legal construct that has been interpreted in different ways over time and among jurisdictions. In North America, the definition and evaluation of FST has been framed by the standard set in *Dusky v. United States* (1960) [1], in which the U.S. Supreme Court found that FST involved more than orientation in time and place and recollection of events. Rather, the *Dusky* test for FST indicates that the defendant can consult with his/her legal counsel and has a rational as well as factual understanding of proceedings [2]. Subsequent attempts to develop structured protocols and other aids to evaluate defendants have been only modestly

successful [3], because of difficulties in defining and conceptualizing “fitness to stand trial.” To address these, Bonnie proposed that fitness should be based on a theoretical foundation and reflect two dimensions: fitness to assist counsel and decisional fitness [3]. Fitness to assist counsel includes an understanding of charges, process, system and role of counsel; capacity to understand one’s situation as defendant; and ability to recognize and relate relevant factual information to counsel. Decisional fitness includes the ability to communicate preference about the defense, to understand relevant information, to appreciate the significance of that information, and to weigh the information to reach a decision.

The Criminal Code of Canada (Criminal Code), as amended in 1991, defines “unfit to stand trial” as unable on account of mental disorder to conduct a defense at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so, and, in particular, unable on account of mental disorder to (a) understand the nature or object of the proceedings (b) understand the possible consequences of the proceedings, or (c) communicate with counsel (Sec. 2, 1991) [4]. This is similar to the definition in *Dusky* [1] and reflects only the more operational aspects of Bonnie’s concept, lacking those that capture the defendant’s insight and judgement concerning his or her interests in the proceedings [3].

A subsequent case heard by the Ontario Court of Appeal, *Regina v Taylor* [5], further limited the test of fitness to stand trial [6]. The appeal court opined that the test is “one of limited cognitive capacity” to relate factual details of the offence to counsel. It

held that the accused is entitled to choose his or her own defense, which may not be what others would consider in his or her best interests. This decision has been criticized as lacking an understanding of the effects of mental illness on a defendant's motivation, insight, and volition [6].

Thus, in Canada and the United States, evaluation of FST involves ensuring that the defendant meets limited standards to understand proceedings and their consequences and to communicate with counsel. A wide variety of instruments have been developed in both countries to assist in court-ordered FST evaluations [2]. However, some authors have pointed out that these instruments can assess capacities relevant to fitness, but not fitness itself, as there is no recognized psychometric definition of fitness [7].

As FST remains the most common forensic evaluation requested by the courts [2,6], the role of forensic mental health experts has evolved from simply opining on a defendant's FST to using the Criminal Code to include a process for restoring fitness. Trying a defendant who is incompetent offends moral dignity and undermines the reliability of the criminal justice process, as well as impinges on the defendant's autonomy [3]. Conversely, it can be argued that restoration of fitness supports the dignity and reliability of the legal process and the autonomy of the defendant. Restoration also avoids lengthy hospitalization due to being unfit to stand trial [8], which may be longer than the potential sentence for the crime. As a result of this ethical dilemma, the U.S. Supreme Court ruled in *Jackson v. Indiana* [9] that an incompetent defendant may not be held more than a reasonable amount of time to determine whether fitness will be attainable [10]. Despite the benefits of and legal requirements for restoration of FST, there is limited research on its achievement.

In a large meta-analysis of studies of unfit to stand trial rates among defendants referred for evaluation, the base rate of unfit to stand trial was found to be 27.5% [2]. This meta-analysis and many other studies have looked at defendant characteristics associated with being unfit to stand trial, in

order to guide public policy [7] and to better target treatment. Among the characteristics identified are age group (among adolescents) [7]; visible minority, employment, and marital status [2]; and psychiatric and legal antecedents, including diagnosis of psychotic disorder, previous psychiatric hospitalization, and violent criminal charges versus non-violent charges [2].

Similarly, a few studies have looked at whether defendant characteristics affect the restoration of FST. The percentage of those treated who do not achieve restoration of fitness is remarkably similar from study to study, at 20%–25% [8,10,11,12]. Morris & DeYoung found that several factors decreased restoration potential such as: psychotic disorders, intellectual disability, and prior psychiatric hospitalization (which may be a clinical indicator of treatment resistance); diagnosis of personality disorders was associated with successful restoration of fitness [8]. Advokat et al. also found that most patients who did not have their fitness restored after treatment had a diagnosis of psychotic disorder, moderately severe symptoms, and initial low scores on a test of psycho-legal comprehension. However, variables such as employment status, type of offence, IQ and overall symptom severity did not differ between those whose fitness was restored and those who remained unfit to stand trial [10]. Colwell & Gianesini found that defendants deemed unfit and not restorable after treatment had higher rates of previous hospitalizations, incarcerations, and unfit to stand trial findings. In addition, defendants had lower IQ and more medications prescribed, as well as more diagnoses of borderline intellectual functioning, mental deficiency, and psychosis [11].

Many of these authors have also looked at time to restoration of fitness, as they have noted an association between greater length of stay (LOS) in hospital and decreased likelihood of restoration of fitness. For those restored to fitness, LOS averaged 7.7 months [10], and 98.9 days (3.3 months) [11], versus 27.5 months and 173.2 days (5.8 months), respectively, for those not restored. Other studies have also found this association between non-

restorability and LOS [12,13].

Another aspect that may affect outcomes in fitness restoration is whether treatment is voluntary or involuntary. There have been some studies of involuntary treatment, but it is unclear in this literature whether the patient is involuntarily committed but able to accept or refuse treatment, or is being treated involuntarily [14]. The United States and Canada have various mechanisms for mandated involuntary treatment of incompetent defendants in certain situations, both within a limited time period (120 days in the United States and 60 days in Canada). Evidence for these periods is only from the voluntary treatment literature, although patients treated involuntarily may differ substantially from those accepting treatment [14].

In the United States, involuntary treatment of incompetent defendants who pose a danger to themselves or others is mandated under the Penal Code. However, such treatment of “non-dangerous” incompetent defendants has been permitted only since the U.S. Supreme Court decision in *Sell v. United States* (2003) [15]. Under *Sell*, a judge can grant a request to involuntarily treat such defendants. Four criteria must be met to override a defendant’s refusal to accept treatment [14]: the individual is accused of a serious crime in which government interests are at stake; medication is substantially likely to render the defendant FST and substantially unlikely to have side effects that will interfere with the defendant’s ability to assist counsel; less intrusive treatments are unlikely to achieve the same results; and administering the drugs is medically appropriate. A study of all U.S. defendants treated under the *Sell* decision from June 2003 to December 2009 ($n = 132$) found that 78.8% were restored to fitness [14], which is similar to outcomes for restoration of fitness of those voluntarily treated. No predictive relationships were found with type of charge, primary diagnosis, cognitive disorder or substance disorder, although there were slightly better outcomes for first-generation psychotic drugs versus second-generation, and older patients had a shorter LOS. LOS ranged widely, with some defendants restored in

less than one month and some requiring one year or more, and a median time of 120 days — exactly the period mandated.

In Canada since 1985, under the Criminal Code (s.672.58, 1985) [16], courts have the power to order involuntary medication treatment for up to 60 days for defendants who are “unfit to stand trial” in order to restore fitness. As with involuntary treatment under *Sell*, several conditions must be satisfied: a forensic psychiatrist must provide an opinion that psychotropic medication would make a defendant fit to stand trial, the defendant will likely become fit within 60 days, and the risk of harm of taking medication is not disproportionate to the benefit anticipated for the defendant. The psychiatrist needs to specify the type of treatment, which involves medication and cannot include electroconvulsive therapy or psychosurgery. Importantly, the psychiatrist must state that, in the absence of the treatment order, the defendant will remain unfit to stand trial.

This study aims to understand whether the rates of restoration of FST, as a result of judicial treatment orders in Canada, is consistent with the findings of Cochrane et al (2013) for involuntary treatment under *Sell* in the United States [15]. Further, we will explore the association of defendant characteristics with restoration of FST in our study sample. Finally, this study aims to verify whether the 60 day time frame is sufficient for restoration of FST, since this time frame is not based on research evidence.

Methods

A chart review was conducted of all defendants on treatment orders over a three year period at a Forensic Psychiatry Program (FPP) in Ontario, where the standard for fitness to stand trial follows the *Regina v Taylor* decision [5]. The study was conducted in one of the ten FPP in Ontario that provides assessments of fitness to stand trial for defendants in detention centres within a catchment area of 2.3 million. The FPP is a secure facility with inpatient beds designated for defendants requiring inpatient hospitalization for forensic psychiatry assessments, including judicial treatment orders.

In the Canadian legal system, defendants are presumed fit to stand trial. However, if there are concerns about a particular defendant, the issue of fitness to stand trial can be raised by lawyers representing the defense or the Crown (prosecution), or by the court. When this issue is raised, an assessment is requested and is normally conducted by a forensic psychiatrist. It may be conducted in a jail or prison, in a hospital, or in a specialized clinic. If the psychiatrist finds that the defendant is unfit to stand trial, the court then holds a fitness to stand trial hearing during which it hears evidence concerning the defendant's fitness to stand trial from the psychiatrist and any counter-arguments before a decision is made by the court. In cases where there is concern that the defendant will refuse medication (because of prior refusal or continuing untreated psychosis), the Crown may seek a treatment order to render the accused fit to stand trial within 60 days (see explanation in Introduction). In many cases defendants found unfit to stand trial have untreated psychosis and are likely to continue to refuse medication, a court order requiring involuntary medication provision is a useful tool to render the accused fit to stand trial in a relatively short period. To obtain a treatment order, the Crown makes an application for treatment disposition; a hearing is held at which the psychiatrist opines (per Criminal Code requirements) as to whether psychotropic medication would render the defendant fit to stand trial, and whether he/she would remain unfit without such treatment, as well as an opinion on harms and benefits of treatment. The psychiatrist's opinion and recommendation are submitted to the court, where the judge makes a decision and then may issue a treatment order.

Our FPP conducts the assessments of fitness to stand trial within the detention centre. Although there are several instruments available for this purpose, for efficiency, and given the very ill state of most defendants, the assessing psychiatrists use an interview method based on the current legal definition for fitness to stand trial and for involuntary medication in Section 2 of the Criminal Code, and as articulated in *Regina v Taylor*.

Once defendants receive a treatment order and are admitted to the FPP, medication is ordered. All defendants are provided an explanation for the purpose of the hospitalization and the requirement to start medication immediately under a judicial treatment order. The treatment order mandates that medications be provided in the least intrusive and least restrictive fashion. Thus, the least intrusive form of medication is offered first and, if the defendant refuses, treatment may be initiated in an injectable form. Once the defendant is hospitalized and treated, his or her fitness to stand trial is assessed regularly by nurses and a forensic psychiatrist. The opinions of the forensic psychiatrist who performed initial assessments of fitness to stand trial and regular assessments during treatment are recorded in the defendants' medical records.

When the assessing psychiatrist considers a defendant's FST to be restored, a complete FST assessment is completed and the defendant is referred back to the court. If this occurs before the conclusion of the 60-day period, the court is notified and the defendant may be brought back to court early. The forensic psychiatrist provides an opinion on fitness to stand trial upon the defendant's early return to court or, more often, to the court upon the conclusion of the treatment order.

Defendants admitted to the FPP between January 1, 2011, and December 31, 2013, under a judicial treatment order were entered into the study. As this study is retrospective, psychiatrists assessing these patients were not aware that their opinions would be used in this study, but some of the psychiatrists are authors and others have been made aware of the study.

A data collection form was developed and used to standardize data collection. Two co-authors reviewed defendants' medical records and documentation of the initial FST assessments that were carried out in the FST clinic. All data in the medical records that we hypothesized could affect restorability or LOS was collected, such as: age (continuous), gender (M/F), DSM-IV primary diagnosis [17], offences (all offen-

ces, scored according to the Cormier-Lang system of quantification of criminal history [18]), medication treatment (start date, oral versus injectable, drug class), and fitness restoration (LOS) were collected. All data collected and coded was reviewed against the medical records by a forensic psychiatrist.

Results

Referrals for Judicial Treatment Orders

Between January 1, 2011, and December 31, 2013, a total of 199 defendants were referred for fitness to stand trial assessments from our catchment area. Subsequently, 43 (22%) were found unfit to stand trial. Of those unfit to stand trial, 17 (40%) were not subsequently admitted to our facility under judicial treatment orders for the following reasons: 10 (59%) were found FST when re-assessed in court at a later date, 3 (18%) were assessed as unlikely to become fit by both the psychiatrist and court, 2 (12%) were admitted for a further 30-day inpatient fitness assessment, the outcomes of which are not available and due to violence risk concerns, 2 (12%) were admitted to a maximum secure forensic facility in Ontario under a judicial treatment order.

Of those defendants unlikely to become fit, one had a diagnosis of severe mental retardation and two had cognitive impairments that would not benefit from psychotropic medication. These defendants were not admitted to a forensic facility under a judicial treatment order, but rather were placed in a hospital or long-term care facility that was more appropriate to their needs. Finally, 26 (60%) of those unfit to stand trial were hospitalized under a 60-day judicial treatment order and entered into the study. See Figure 1.

Gender and Diagnosis

Eighty-five percent of the sample was male, with mean age 35.0 years (range 19–54 years; SD 10.46). Eighty-eight percent (n=23) of the sample had a DSM-IV [17] diagnostic category of Schizophrenia and other psychotic disorders, with one defendant each having a primary diagnosis of bipolar affective disorder, dementia, and traumatic brain injury. However, all

defendants had a primary or secondary diagnosis of Schizophrenia and other psychotic disorders, and two had a secondary diagnosis of intellectual disability.

Offences

A total of 100 offences were committed by the 26 defendants admitted under a judicial treatment order. Offences for each defendant were categorized as violent or non-violent, using the Cormier-Lang system for quantifying criminal history [18]: 32 of the offences were violent, and 29 of the offences were considered non-violent. While the Cormier-Lang system does not categorize offences such as breaches or failure to comply, these made up 39 of the offences. By defendant, the most serious offence for each defendant was violent in 58% (n=15) of defendants, non-violent in 23% (n=6) and consisted of a breach or failure in 19% (n=5).

Medications

Psychotropic medication was started on the day of admission to the FPP for 92% (n=24) of defendants and on the second day of admission for the remaining 8% (n=2). All defendants had some form of psychosis and were given antipsychotics. During the 60-day judicial treatment order, 27% (n=7) of the sample received oral antipsychotic medication only and 73% (n=19) received a combination of oral and injectable antipsychotic medication. Other medications used in addition to antipsychotic medication during the 60-day judicial treatment order were mood stabilizers in 31% of patients (n=8), benzodiazepines in 88% of patients (n=23) and antidepressants in 12% of patients (n=3).

Fitness Restoration

All defendants' fitness to stand trial was eventually restored (Figure 1). While 92% (n=24) of defendants were found fit to stand trial by the end of the order period (60 days), 8% (n=2) were not. Both defendants found unfit to stand trial after 60 days agreed to continue with treatment and eventually one was deemed FST at 69 days and the other at 95 days. For defendants whose fitness was restored within the 60 day period, the mean number of days to

fitness restoration was 50 days (range 26–95 days; SD 13.9).

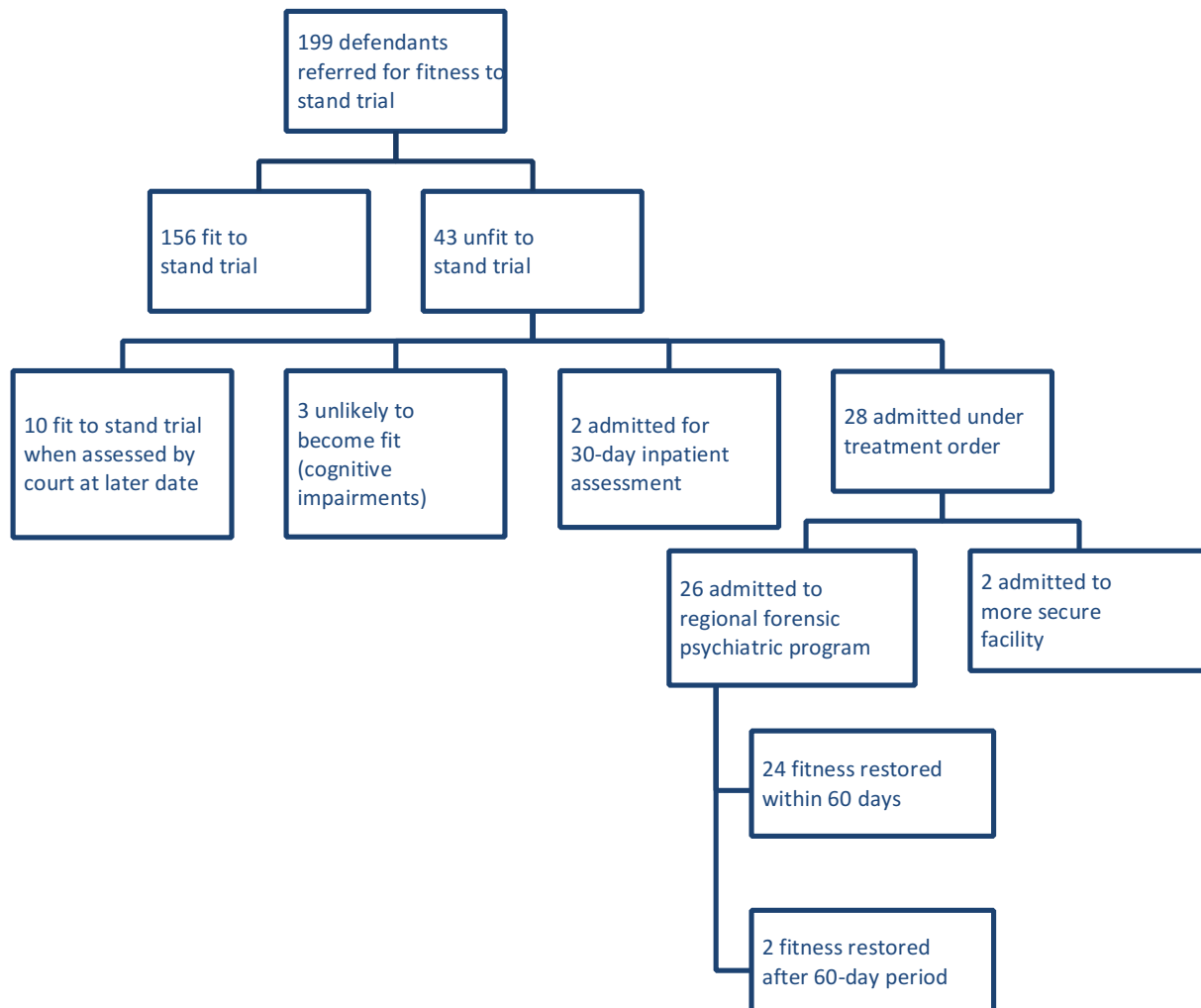


Figure 1: Disposition of defendants referred for assessment of fitness to stand trial in the catchment area of the regional forensic psychiatric program during the three-year study period.

Discussion

One of the aims of the study was to determine whether the rates of restoration of FST as a result of judicial treatment orders in Canada was consistent with the findings of the Cochrane et al. (2013) study whose findings showed that involuntary treatment resulted in restoration of FST in 78.8% of defendants retrospectively reviewed in the United States [14]. In our study, 92% (n=24) of defendants were restored to fitness within a 60-day timeframe with the remaining 8% (n=2) restored at 69 and 95

days after admission to the FPP for involuntary treatment. One strength of this study, as with the Cochrane et al. (2013) study is that it represents the entire population in the catchment area, not a sample.

If all defendants found unfit to stand trial before and during involuntary treatment are considered, high rates of restoration of fitness continue to hold. Three defendants were considered unlikely to become FST

with psychotropic medication as a result of cognitive impairment or severe mental retardation in the absence of psychosis. One of the predictors of fitness restoration found in other studies is the degree of cognitive impairment [11]. However, two of the defendants restored to fitness in this study had some degree of intellectual disability in addition to psychosis. For 10 of the defendants who were found unfit, fitness to stand trial was found to be restored when re-assessed the day of their court proceedings. One factor that may have accounted for this was that these defendants voluntarily started psychotropic medication while detained and awaiting their fitness hearing. Information was not available on the outcome for the two patients admitted for a further 30-day inpatient assessment or the two referred to a more secure facility. Thus, of 43 defendants, 36 had fitness restored, for a restoration rate of 84%, which is still higher than the findings of other studies [8,10,11,12]. The outcome was unknown for four defendants.

The high rate of restoration of FST was not related to triage of defendants before issuing the treatment order. However, it may have been related to a concerted effort within the FPP to treat and educate defendants. All of the defendants admitted to the FPP under a judicial treatment order had refused medication when it was offered at the detention centre. However, their assessment by the forensic psychiatrist showed they would benefit from psychotropic medication. Upon admission, defendants were provided with an explanation of the purpose of the judicial treatment order and offered options to receive medication orally or by injection. Most started medication upon admission, although two defendants started medication the following day. There is no indication clinically or from the data that indicates this brief delay affected outcomes. Therefore, all defendants admitted under a judicial treatment order to

the FPP received continuous psychotropic medication.

A judicial treatment order only mandates psychotropic medication. However, as standard practice in the FPP, defendants also are educated about courtroom proceedings. This combination may help restore fitness over medication alone, but this study did not compare medication alone with medication plus education. As well, it should be noted that medication alone may have restored fitness for 10 defendants at the detention centre.

The high rate of restoration may also be partially explained by the relatively low standard for fitness, the limited cognitive capacity test, that prevails in Canada under the *Regina v Taylor* [5] decision. This was the standard used in assessments in the FPP. A standard with added criteria, such as the Dusky [1] criteria, might have resulted in fewer defendants achieving FST.

A statistical analysis of patient or medication characteristics that may be associated with fitness to stand trial was not conducted because of the small number of defendants and the fact that all were eventually restored to fitness. However, some observations indicated that the sample was fairly homogeneous, with almost all having a diagnosis of psychotic disorder and 85% being male. These characteristics may suggest some risk factors for the status of unfit to stand trial. Yet all were successfully restored to fitness. Previous studies have shown psychotic disorder as a risk factor mitigating against restorability [2,8,10,11], although the study did not indicate this.

As there was no comparison group, conclusions could not be reached about the relative effectiveness of treatment orders. However, the study confirmed the findings of Cochrane et al [14], and demonstrated that fitness to stand trial within 60 days is achievable utilizing a judicial treatment order as available in Canada.

Conclusion

This was a retrospective study at a single regional forensic psychiatric program. Clearly, much more research is needed in order to determine factors affecting restorability and time to restoration of fitness to stand trial in the setting of involuntary medication treatment. Future research should involve multiple programs as well as comparisons of voluntary with involuntary treatment, and of different standards for fitness.

Such research would support decisions to continue to use judicial treatment orders in Canadian jurisdictions, where there has been some reluctance to use these orders due to ethical concerns about involuntary treatment. These concerns must be weighed against the value of restoring not only the defendant's fitness to stand trial but also his or her autonomy, and allowing justice to be served in a timely manner. This study provides support for imbedding similar provisions in to the Criminal Code in other jurisdictions.

The Canadian judicial treatment order provides a unique opportunity to treat a defendant with a mental illness quickly and decrease pre-trial detention. This study lends support for the Criminal Code measure in Canada and involuntary treatment measures in other jurisdictions.

Conflict of Interest: none

Ethical Approval: This study received approval from the local research ethics board before starting data collection.

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