The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

APPROPRIATIONS COMMITTEE ON CRIMINAL AND CIVIL JUSTICE
Senator Bradley, Chair
Senator Powell, Vice Chair

MEETING DATE: Thursday, January 11, 2024
TIME: 3:00—4:30 p.m.
PLACE: *Mallory Horne Committee Room,* 37 Senate Building

MEMBERS: Senator Bradley, Chair; Senator Powell, Vice Chair; Senators Baxley, Burgess, Hooper, Martin, Pizzo, Rouson, Torres, and Yarborough

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1		Discussion of Mental Health Issues in the Criminal Justice System	Presented
	Other Related Meeting Documents		

MENTAL HEALTH SERVICES OVERVIEW

SENATE APPROPRIATIONS COMMITTEE ON CRIMINAL AND CIVIL JUSTICE

JANUARY 11, 2024

COMPREHENSIVE HEALTH SERVICES CONTRACT

PREVIOUS CONTRACT	CURRENT CONTRACT
JUNE 2018 – JUNE 2023	JULY 2023 – JUNE 2028
$421 MILLION	$528 MILLION
ADMINISTRATIVE FEE OF 11.5%	ADMINISTRATIVE FEE OF 10%
67 TOTAL PERFORMANCE MEASURES	113 TOTAL PERFORMANCE MEASURES

MENTAL HEALTH SERVICES BY THE NUMBERS

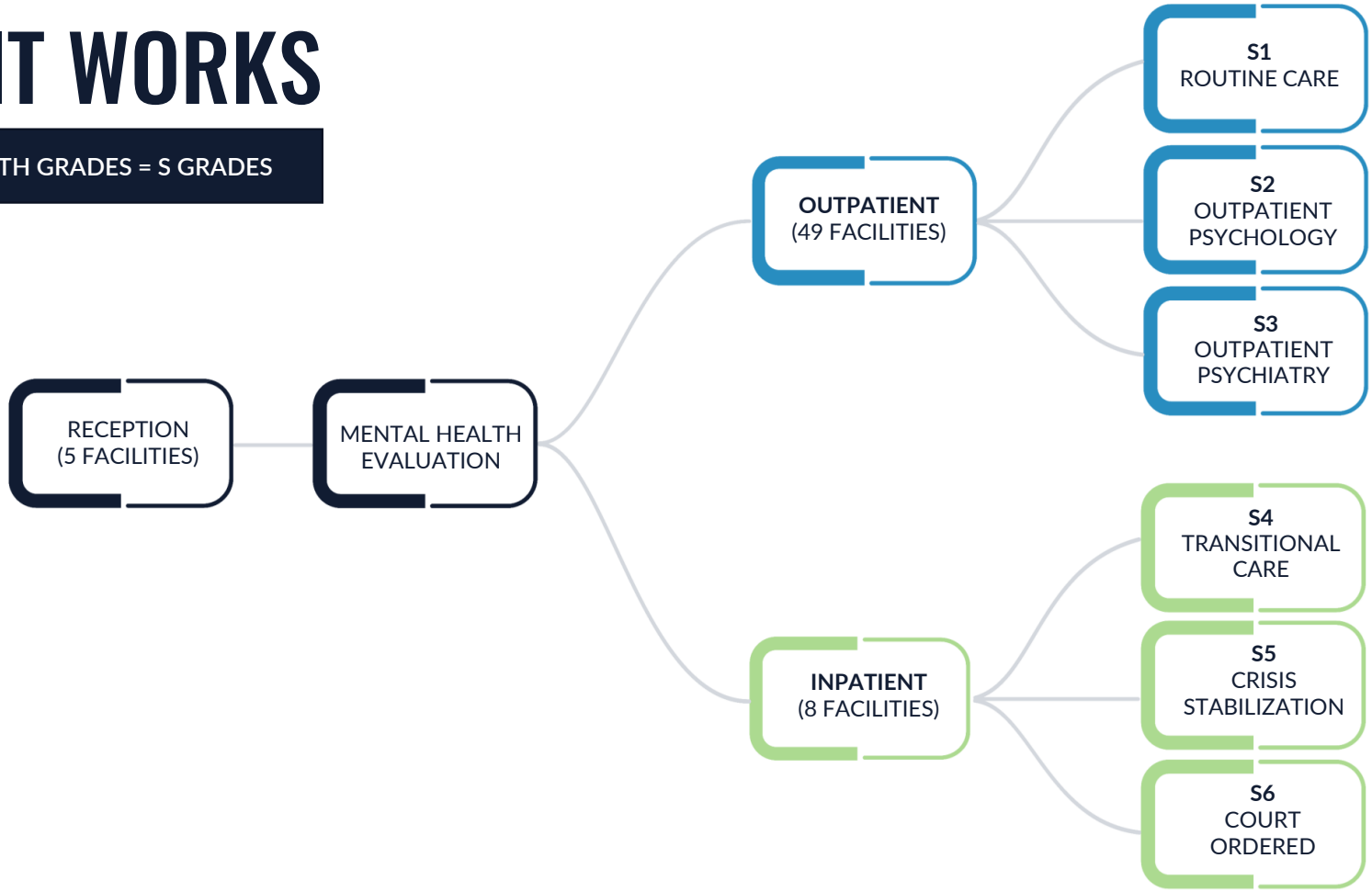
69% RECEIVE MENTAL HEALTH SERVICES

23% HAVE A DIAGNOSED MENTAL ILLNESS

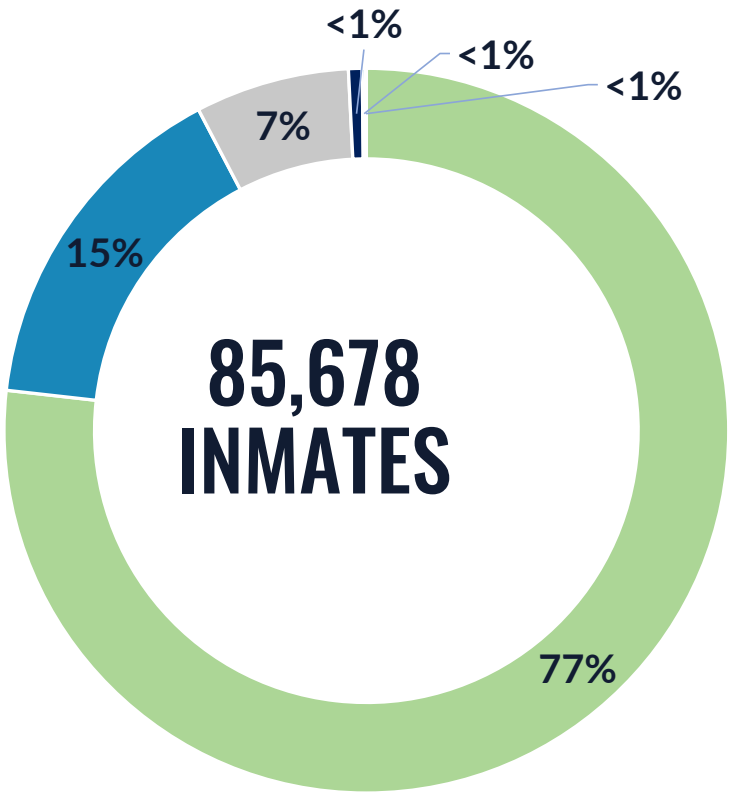
1% RECEIVE INTENSIVE OUTPATIENT OR INPATIENT SERVICES

HOW IT WORKS

MENTAL HEALTH GRADES = S GRADES

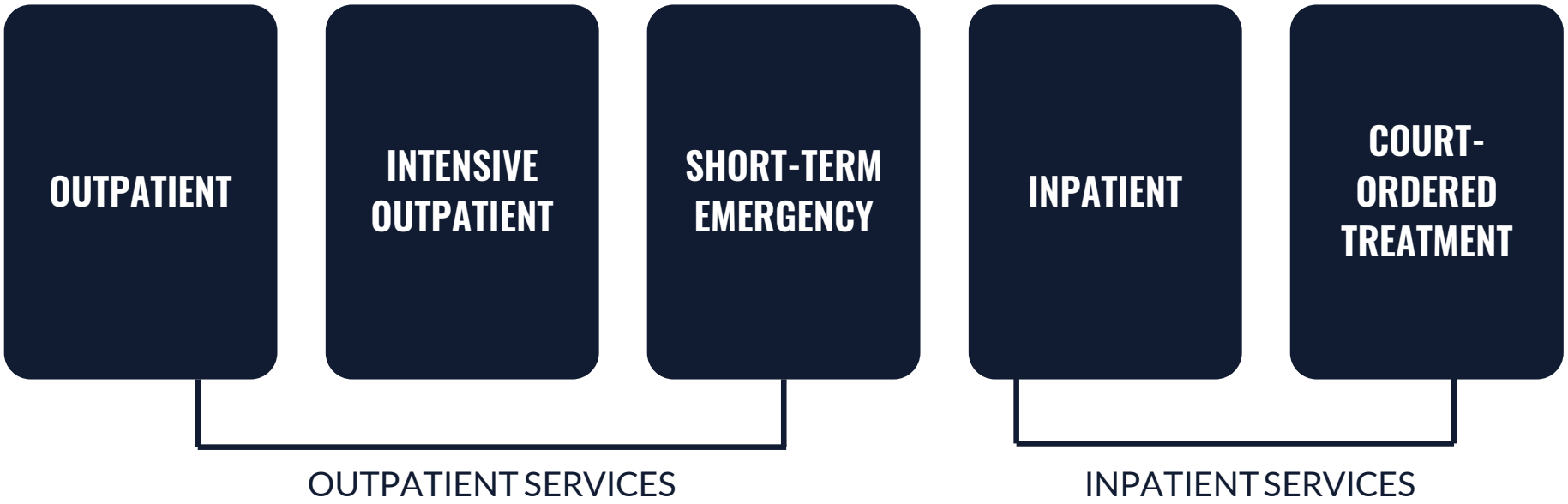


MENTAL HEALTH LEVELS OF CARE



- S1 ROUTINE CARE (77%)
- S2 OUTPATIENT PSYCHOLOGY (15%)
- S3 OUTPATIENT PSYCHIATRY (7%)
- S4 TRANSITIONAL CARE (<1%)
- S5 CRISIS STABILIZATION (<1%)
- S6 COURT ORDERED (<1%)

CONTINUUM OF MENTAL HEALTH CARE



TRADITIONAL OUTPATIENT MENTAL HEALTH | S2 + S3

22% of the current inmate population

Inmate receives care in a general population setting

Case Management and possible medication

Individualized Counseling

Group Counseling

Counseling is facilitated by a licensed mental health professional, or psychologist

FDC'S INTENSIVE OUTPATIENT PROGRAM | S3 ONLY

DIVERSIONARY TREATMENT UNIT (DTU)

COGNITIVE TREATMENT UNIT (CTU)

SECURE TREATMENT UNIT (STU)

INPATIENT MENTAL HEALTH CARE | S4 + S5

TRANSITIONAL CARE UNIT (TCU)

CRISIS STABILIZATION UNIT (CSU)

COURT-ORDERED MENTAL HEALTH TREATMENT | S6

Highest and most intensive level of mental health care available

Admission requires judicial order for involuntary commitment and treatment

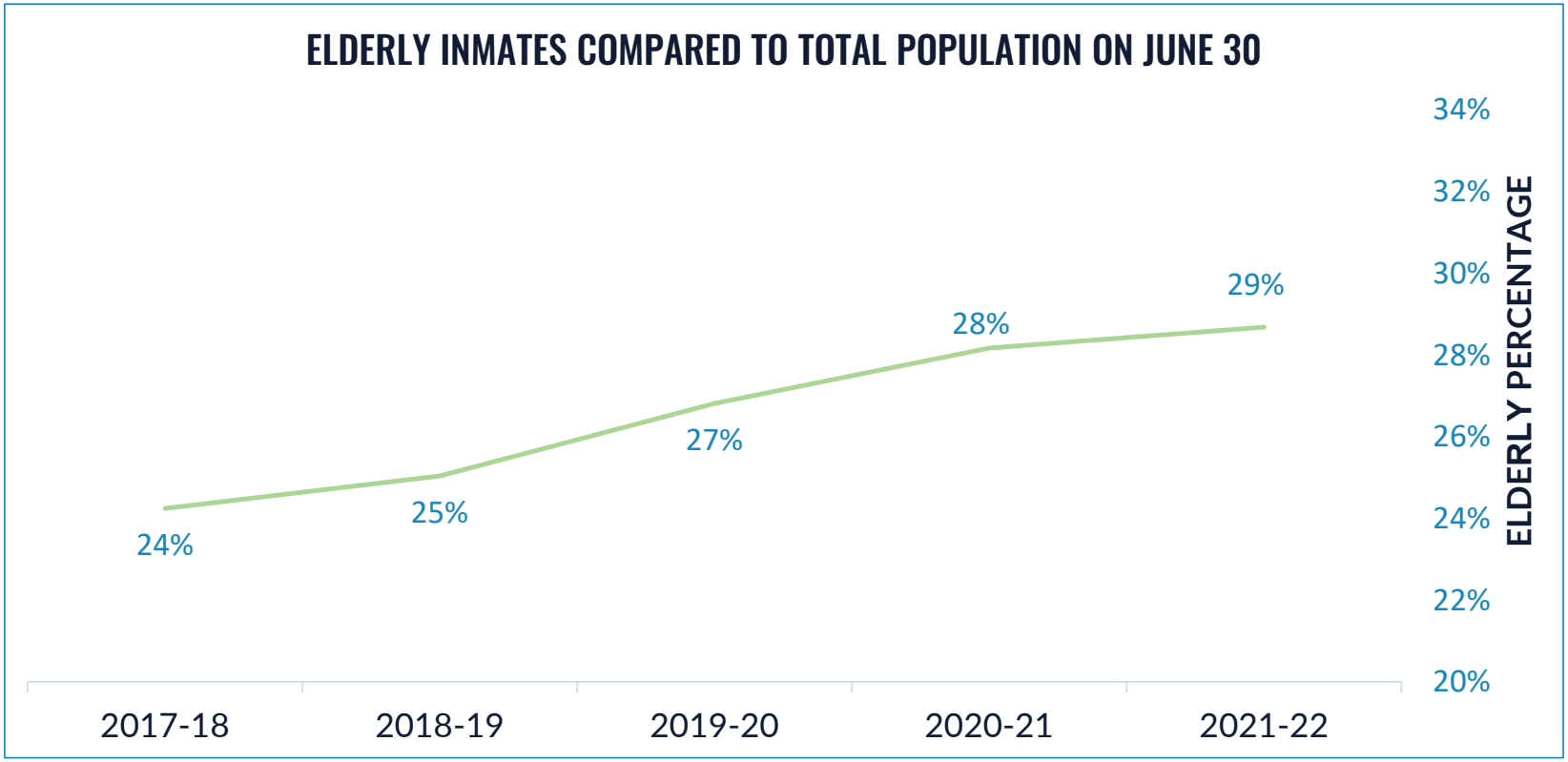
MALES

LAKE CORRECTIONAL INSTITUTION

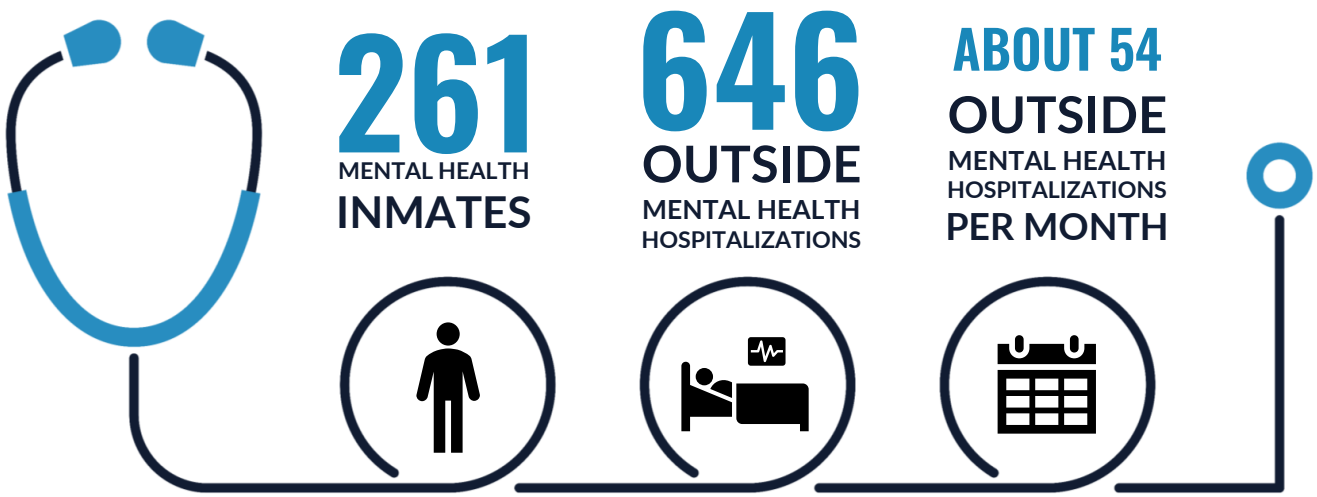
FEMALES

FLORIDA WOMEN'S RECEPTION CENTER

CURRENT CHALLENGES | INCREASING ELDERLY POPULATION



CURRENT CHALLENGES | SERIAL SELF-INJURIOUS BEHAVIOR (SSIB)



261 MENTAL HEALTH INMATES

646 OUTSIDE MENTAL HEALTH HOSPITALIZATIONS

ABOUT 54 OUTSIDE MENTAL HEALTH HOSPITALIZATIONS PER MONTH

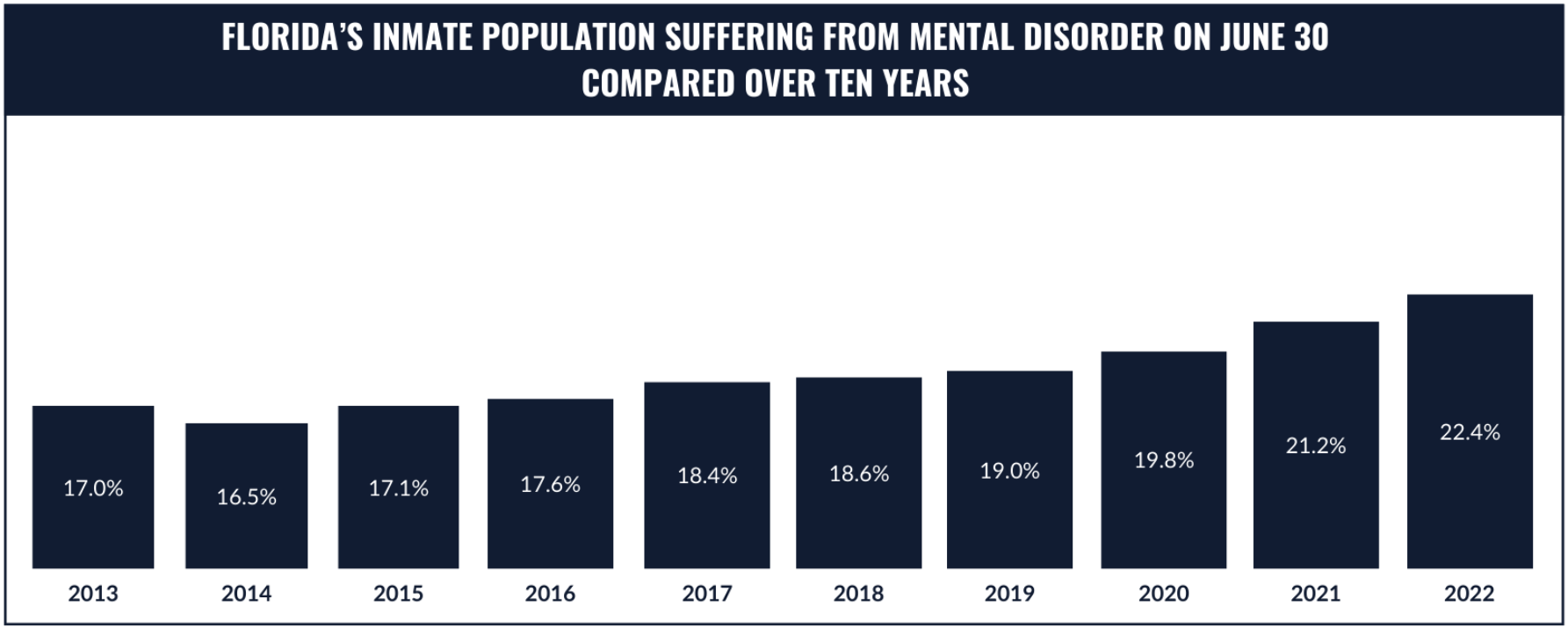
62 MENTAL HEALTH INMATES ACCOUNTED FOR **405** OUTSIDE MENTAL HEALTH HOSPITAL EVENTS

$6M ANNUALLY

OUTSIDE MENTAL HEALTH HOSPITALIZATION COSTS

(FY2022-2023)

CURRENT CHALLENGES | INCREASED MENTAL HEALTH NEED



PROJECTED NEED | 500 ADDITIONAL BEDS

POSSIBLE LONG-TERM SOLUTIONS

ADDITIONAL INPATIENT MENTAL HEALTH BEDS WILL BE NEEDED IN THE FUTURE

- CENTRALIZED FACILITY
- MAXIMIZATION OF STAFFING

EXPANSION OF VARIOUS INTENSIVE OUTPATIENT TREATMENT UNITS

- DEMENTIA AND SSIB UNITS

MORE EFFICIENT JUDICIAL PROCESSES

SB 1284 BY SENATOR MARTIN: HEALTH CARE FOR INMATES

Current processes required to treat inmates are costly for the Department, courts, and inmates

This bill streamlines the process by which the Department can obtain orders to place an inmate with a mental illness in a Mental Health Treatment Facility and treat the inmate as necessary

The bill also creates a process for obtaining a court order to provide emergency surgical or other medical treatment to an inmate that is refusing medical treatment for self-injurious behavior

The bill also develops a process for the appointment of a proxy who can make healthcare decisions on behalf of incapacitated inmates

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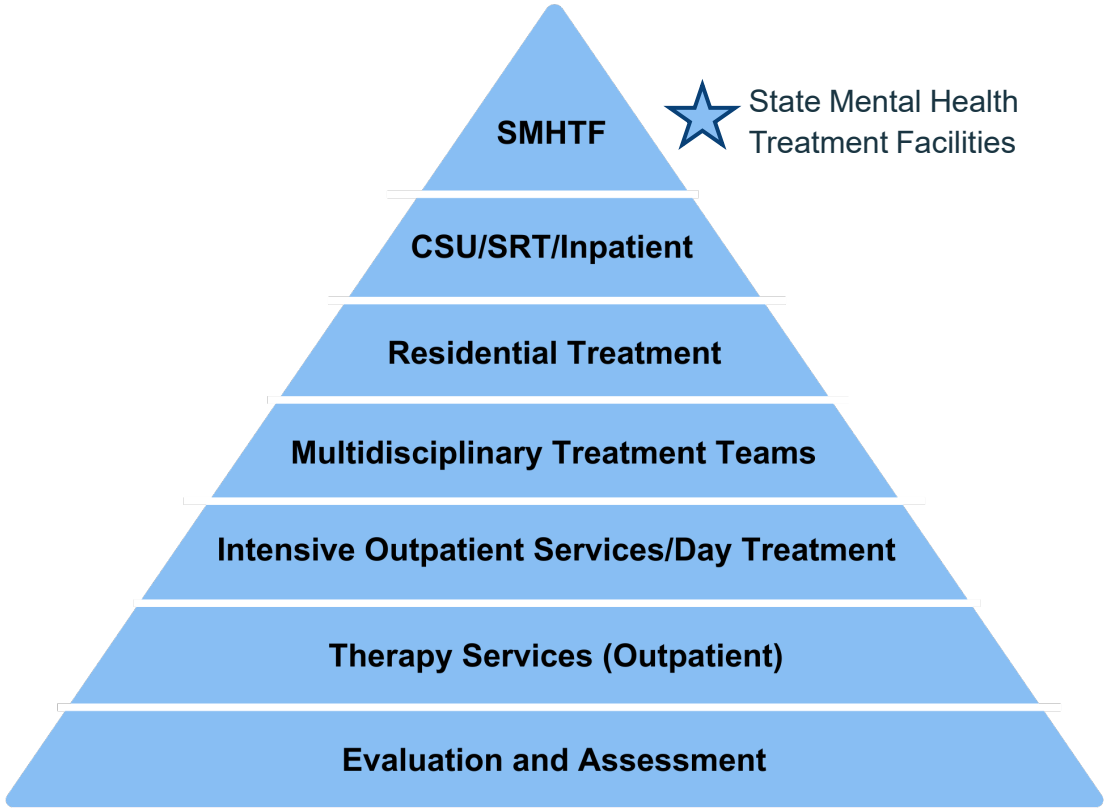
INCOMPETENT TO PROCEED PROCESS

Erica Floyd Thomas
Assistant Secretary for Substance Abuse and Mental Health

January 11, 2024

PURPOSE

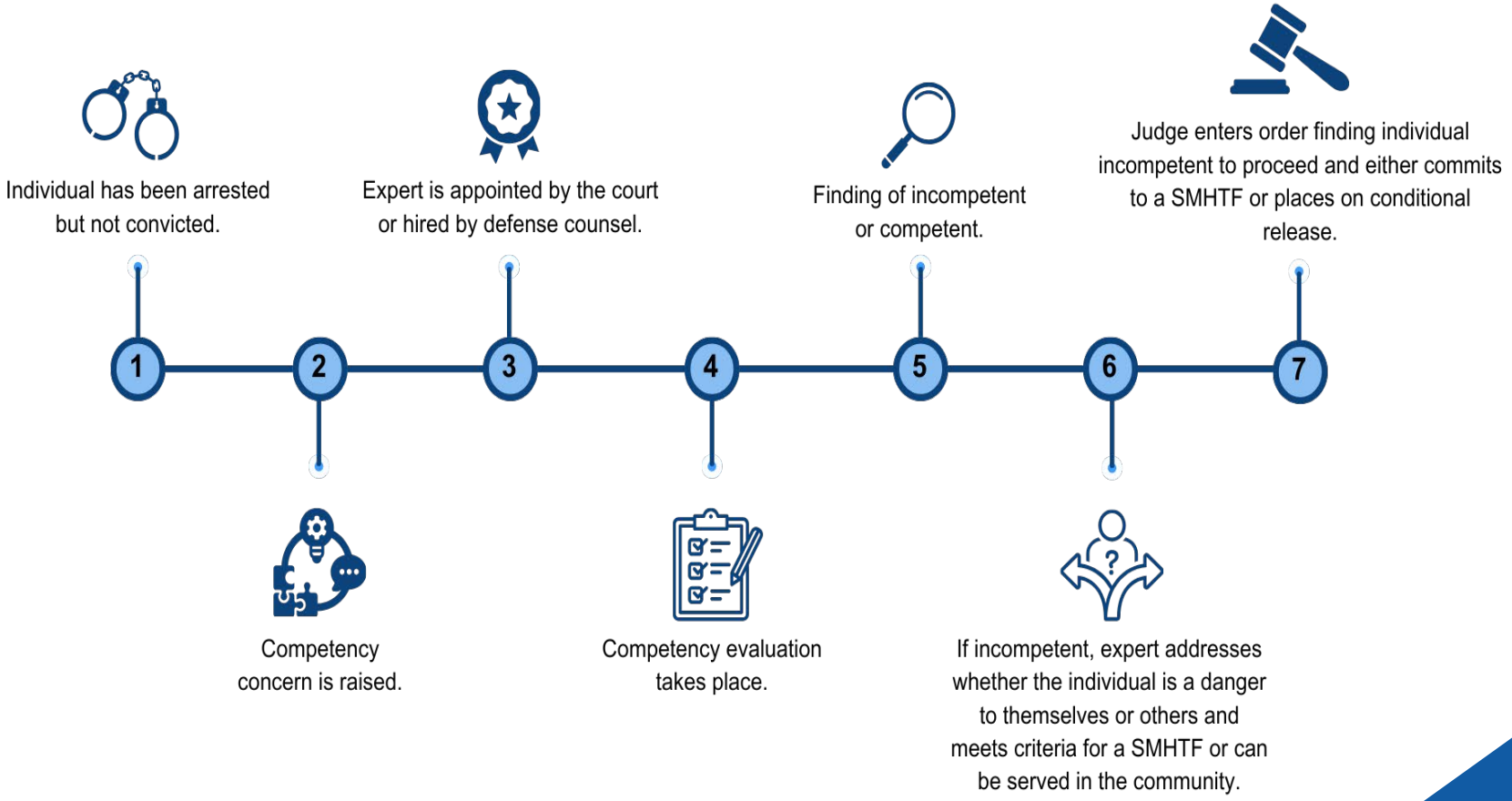


State Mental Health Treatment Facilities (SMHTFs) deliver the highest intensive inpatient behavioral health care to individuals with an array of chronic behavioral health conditions that require long-term stabilizing treatment not available within local communities.

HOW DO INDIVIDUALS RECEIVE SERVICES?

Chapter 394 – Civil Commitment	Chapter 916 – Forensic Commitment
Individuals are referred by one of the 120 designated Baker Act receiving facilities under Chapter 394, Florida Statutes. - Person is a risk to self or others.	Individuals are committed by one of Florida's 20 Circuit Courts under Chapter 916, Florida Statutes. - Competency restoration for ability to stand trial – Competence to Proceed. - Prior to criminal trial/prosecution.

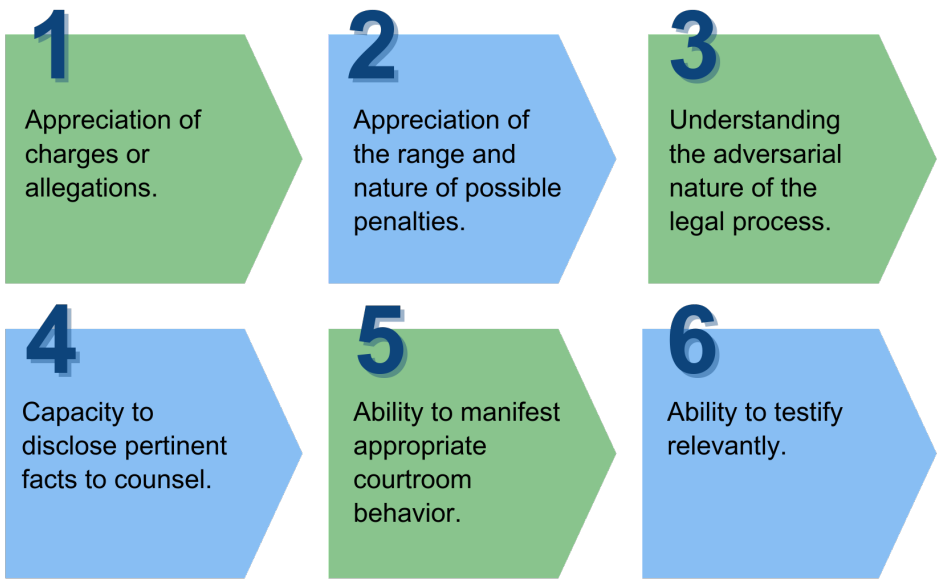
INCOMPETENT TO PROCEED PROCESS



COMPETENCE TO PROCEED

- Refers to an individual's ability to understand and participate meaningfully in legal proceedings.
- Whether or not an individual has sufficient ability to consult with their lawyer with a reasonable degree of rational understanding, or if an individual has a rational understanding of the proceedings against them.

Six Factors of Competency



DIVERSIFIED CLINICAL APPROACH

- Clinical multidisciplinary team works together with individuals to create individualized treatment plans.
- Clinical team includes:
  - Psychiatrists
  - Psychologists
  - Registered Nurses
  - Licensed Mental Health Therapists
  - Licensed Clinical Social Workers
  - Masters' Therapists
  - Health Care Specialists
- Treatment is not limited to judicial education but includes all aspects of an individual's clinical needs.

COMPETENCY RESTORATION SERVICES

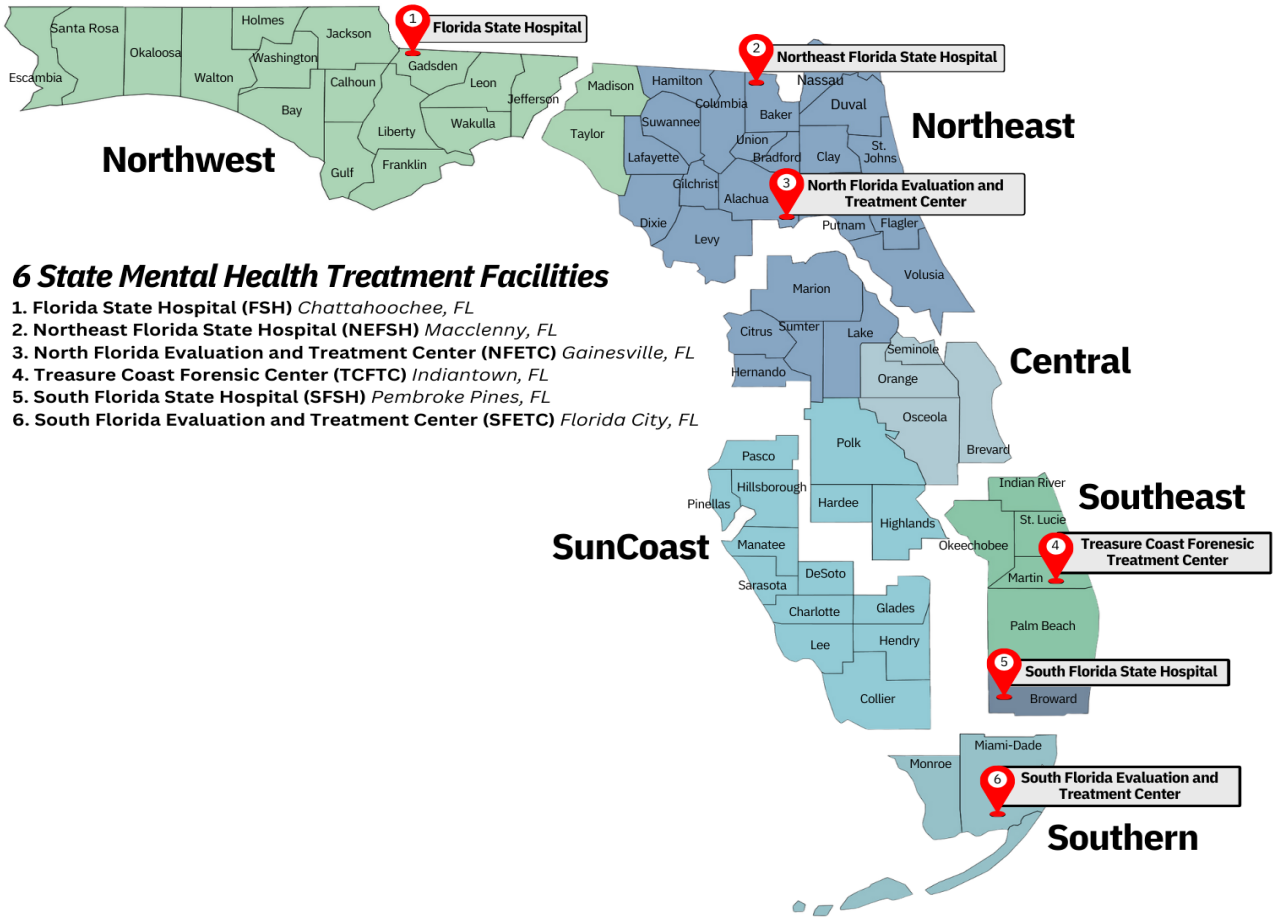
- Psychotropic medication.
- Educational competency restoration groups.
- Psychotherapeutic competency restoration.
- Recovery focused treatment.
- Supportive therapeutic interventions.
- Crisis Management.
- Behavioral programming, if indicated.
- Individual therapy, if indicated.

Goal: To stabilize and restore competence.

INCOMPETENT TO PROCEED – DISCHARGE PROCESS

- When an individual remains incompetent to proceed but no longer meets criteria for the SMHTF:
  - Case staffing occurs.
  - Conditional release plan is filed with the court.
- Once the individual is restored to competence, a report is written to the court.
  - Individual is transported to the court.
  - The court makes an adjudication.
- Once adjudicated competent to proceed the criminal case resumes.

State Mental Health Treatment Facilities



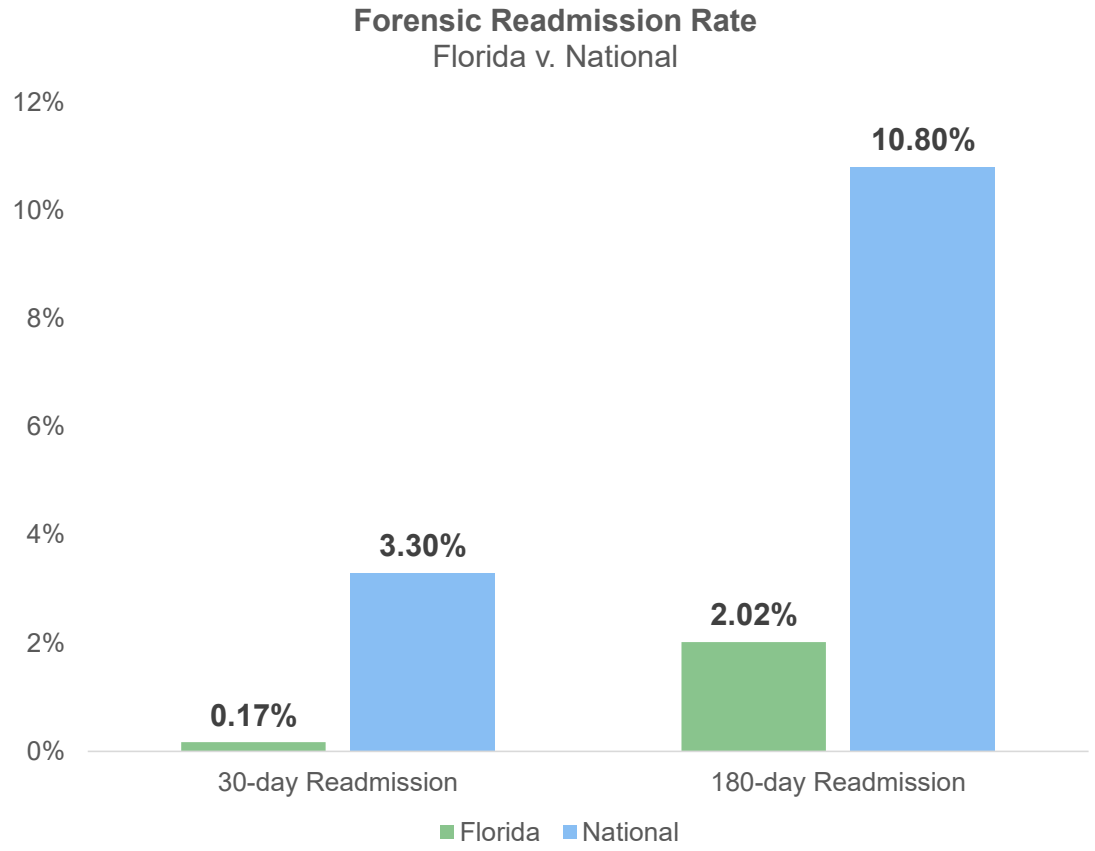
6 State Mental Health Treatment Facilities

1. **Florida State Hospital (FSH)** *Chattahoochee, FL*
2. **Northeast Florida State Hospital (NEFSH)** *Macclenny, FL*
3. **North Florida Evaluation and Treatment Center (NFETC)** *Gainesville, FL*
4. **Treasure Coast Forensic Center (TCFTC)** *Indiantown, FL*
5. **South Florida State Hospital (SFSH)** *Pembroke Pines, FL*
6. **South Florida Evaluation and Treatment Center (SFETC)** *Florida City, FL*

PROGRAM DATA

- On average:
  - SMHTF system provided treatments – **5,696 individuals.**
  - Forensic patients returned to competency – **102 days**.
  - Admissions for forensic patients per month – **227 individuals.**
  - Therapeutic and activity hours provided by the state operated facilities per month – **53,058 hours.**
  - Discharges for forensic patients per month – **168 individuals.**

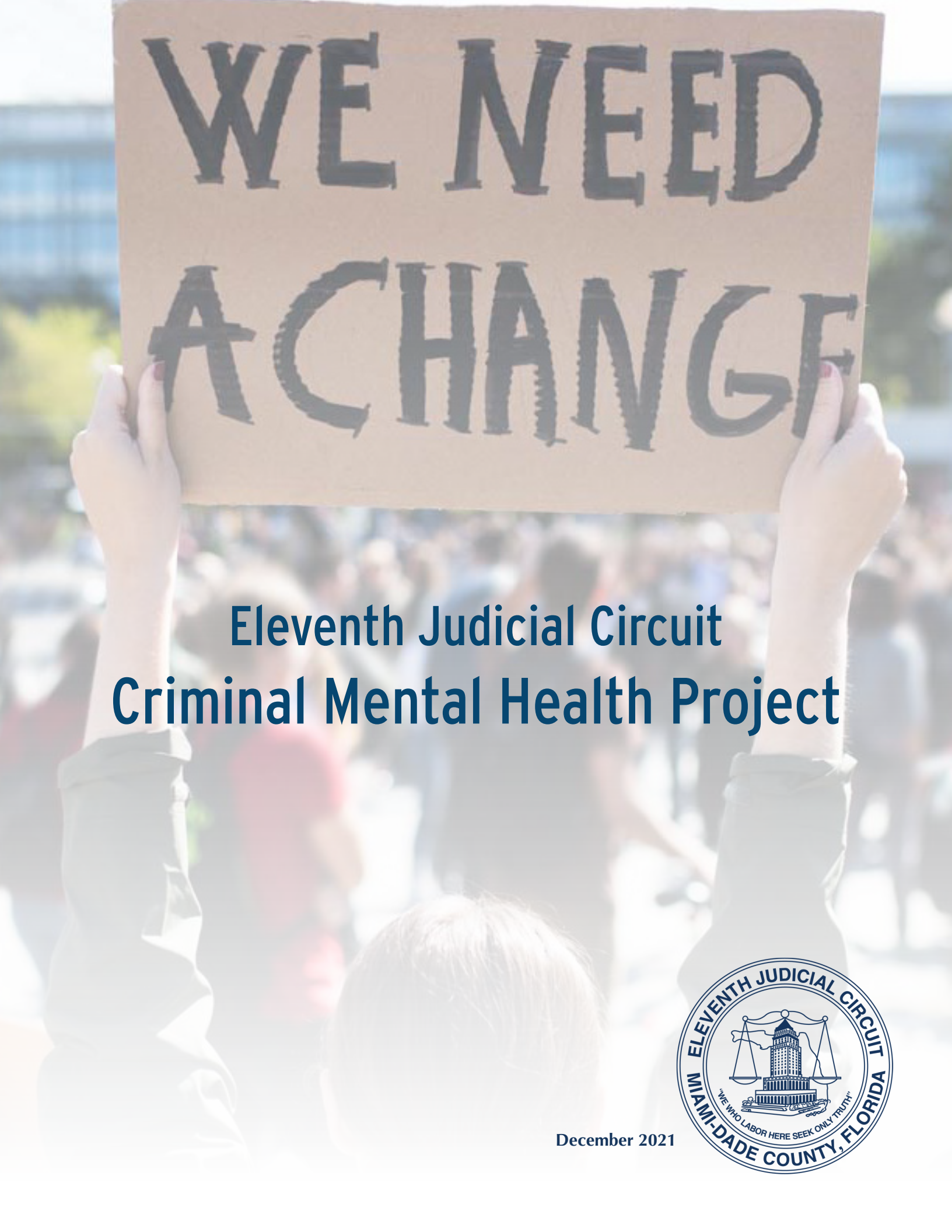
PERFORMANCE – FORENSIC READMISSION



RECENT IMPROVEMENTS

- Since July 2022:
  - Decreased the number of patients waiting in local jails greater than 15 days by 40%.
  - Increased forensic admissions from county jails by 78%.
  - Increased forensic discharges from SMHTFs by 39%.

Questions?



Eleventh Judicial Circuit
Criminal Mental Health Project

December 2021

Making Jail the Last Resort

An analysis was conducted by the Louis de la Parte Florida Mental Health Institute at the University of South Florida examining patterns of arrest and inpatient treatment among 97 "heavy users" of acute care and institutional services in Miami-Dade County. Most individuals were homeless and diagnosed with schizophrenia.

Over the five-year look back period from each individual's most recent jail release date, the **97 individuals** accounted for:

2,200 total county jail bookings,

27,000 total days in county jail, and

13,000 total days in crisis units, hospitals, and emergency rooms.

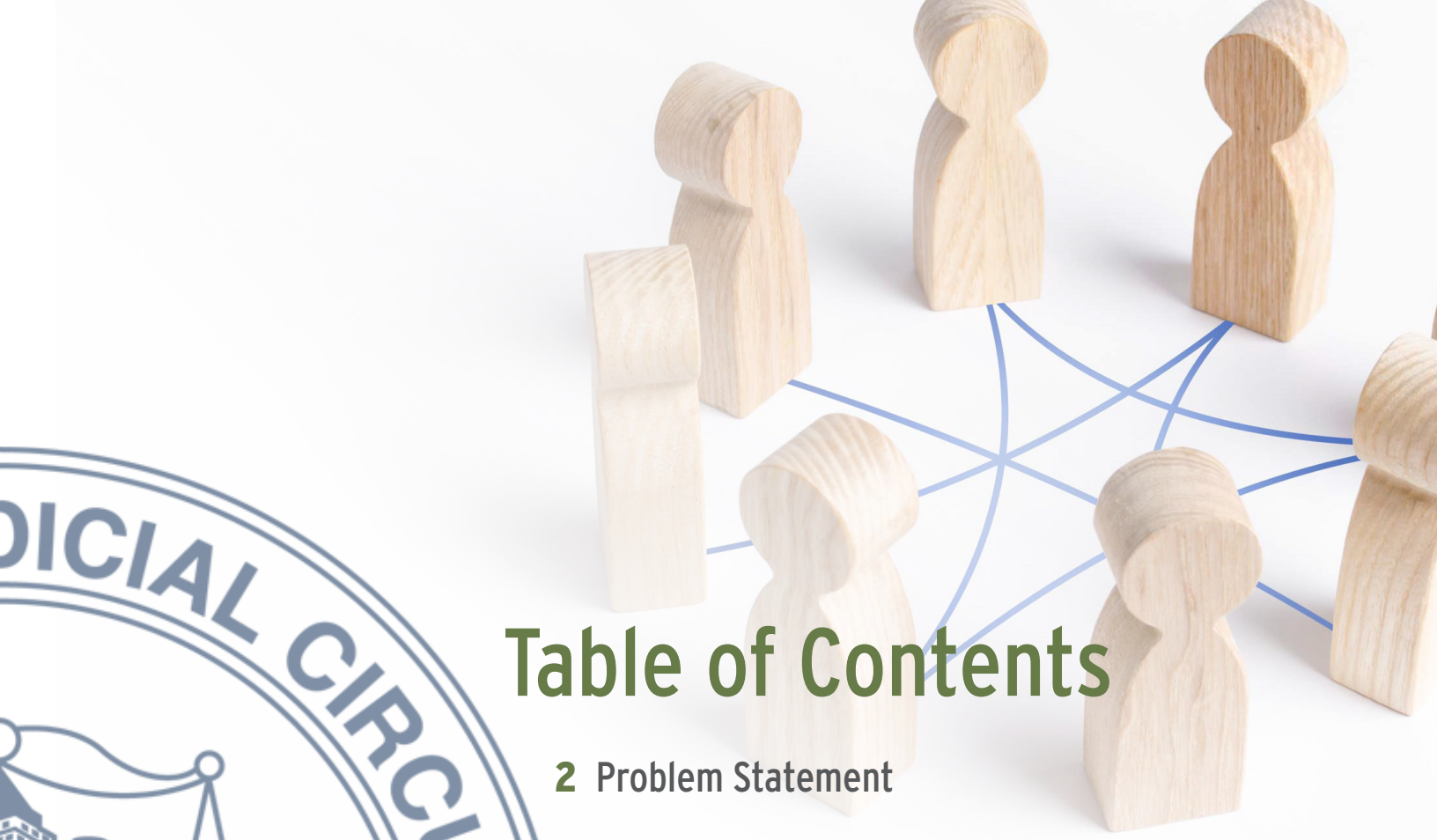
Each "heavy user" was booked into the county jail an average of **4.5 times per year**, and spent nearly a quarter of each year incarcerated or in other institutional settings.

The cost to taxpayers for these services is conservatively estimated at **$17 million in direct costs** with little impact on reducing recidivism and virtually no return on investment.

Miami-Dade County Heavy User Data Analysis

5-yr look back period (97 heavy users, 2002-2009)	Total events over 5 years	Average per individual	Avg cost per event/ per diem	Estimated total cost
Arrests and legal proceedings	2,172	22	$425	$923 thousand
Jail days	26,640	275	$265	$7.1 million
Baker Act initiations	710	8.6	-	-
Inpatient psychiatric days	7,000	72	$291	$2 million
State hospital days	3,200	33	$331	$1 million
Emergency room days	2,600	27	$2,338	$6 million
Total jail, inpatient, hospital, and ER days	**39,440**	**407**	**-**	**$17 million**

Lifetime data for 97 heavy users (1985 to present)	Total (all individuals)	Average (per individual)	Range	
			Low	High
Homeless	89 (92%)	-	-	-
Jail Bookings	4,210	43	5	181
Jail Days	97,438	1,005	110	6,034
Cost	**$25,821,070**	**$266,197**	**$29,150**	**$1,599,010**



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Problem statement

According to the most recent prevalence estimates, 16.9% of all jail detainees (14.5% of men and 31.0% of women) experience serious mental illnesses. Nationwide, it is estimated that 1.8 million people with serious mental illnesses are booked into jails annually; and on any given day, 500,000 people with mental illnesses are incarcerated in jails and prisons. Considering that as of 2016, there were only about 20,000 beds in civil state psychiatric hospitals, this means there are **25 times as many people with mental illnesses in correctional facilities as there are in all civil state treatment facilities combined**.

Although these national statistics are alarming, the problem is even more acute **in Miami-Dade County. Approximately 70% of individuals who live with serious mental illness (SMI) or substance use disorder (SUD) are currently not receiving treatment**. As a result, police officers have increasingly become the first, and often only, responders to people in crisis due to untreated mental illnesses. Too often, these encounters result in the arrest and incarceration of individuals for criminal offenses that are directly related to individuals' psychiatric symptoms or life-health contexts (e.g., homelessness, addiction, poverty).

The **Miami-Dade County jail currently serves as the largest psychiatric institution in Florida** and contains nearly half as many beds serving inmates with mental illnesses as all state civil and forensic mental health treatment facilities combined. Of the roughly 50,000 bookings into the jail each year, approximately 10,000 involve people with mental illnesses requiring intensive psychiatric treatment while incarcerated. On any given day, the jail houses approximately 2,400 individuals receiving psychotherapeutic medications, **and costs taxpayers roughly $232 million annually or $636,000 per day**. Additional costs to the county, the state, and taxpayers result from crime and associated threats to public safety; civil actions brought against the county and state resulting from injuries or deaths involving people with mental illnesses; injuries to law enforcement and correctional officers; ballooning court caseloads involving defendants with mental illnesses; and uncompensated emergency room and medical care.

Criminal Mental Health Project

The Eleventh Judicial Circuit Criminal Mental Health Project (CMHP) was established to divert nonviolent misdemeanant defendants with SMI, or co-occurring SMI and substance use disorders, from the criminal justice system into community-based treatment and support services. Since the inception, the program has expanded to serve defendants that have been arrested for less serious felonies and other charges as determined appropriate. The program operates two components: pre-booking diversion consisting of Crisis Intervention Team (CIT) training for law enforcement officers and post-booking diversion serving individuals booked into the jail and awaiting adjudication. All post-booking participants are provided with individualized transition planning including linkages to community-based treatment and support services.

The CMHP's success and effectiveness depends on the commitment of stakeholders throughout the community. Such cross-system collaboration is essential for the transition from the criminal justice system to the community mental health system. Program operations rely on collaboration among community stakeholders including: the State Attorney's Office, the Public Defender's Office, the Miami-Dade County Department of Corrections and Rehabilitation, the Florida Department of Children and Families, the Social Security Administration, public and private community mental health providers, Jackson Memorial Hospital-Public Health Trust, law enforcement agencies, family members, and mental health consumers.

Pre-booking jail diversion program

CIT PROGRAM The 11th Judicial Circuit Criminal Mental Health Project (CMHP) has embraced and promoted the Crisis Intervention Team (CIT) training model developed in Memphis, Tennessee in the late 1980's. Known as the Memphis Model, the purpose of CIT training is to set a standard of excellence for law enforcement officers with respect to treatment of individuals with mental illnesses. CIT officers perform regular duty assignment as patrol officers but are also trained to respond to calls involving mental health crises. Officers receive 40 hours of specialized training in psychiatric diagnoses, suicide intervention, substance abuse issues, behavioral de-escalation techniques, trauma, the role of the family in the care of people with mental illnesses, mental health and substance abuse laws, and local resources for those in crisis.

The training is designed to educate and prepare officers to recognize the signs and symptoms of mental illnesses, and to respond more effectively and appropriately to individuals in crisis. Because police officers are often first responders to mental health emergencies, it is essential that they know how mental illnesses can impact the behaviors and perceptions of individuals. CIT officers are skilled at conflict resolution by de-escalating crises involving mental illnesses, while bringing an element of understanding and compassion to these difficult situations. When appropriate, individuals in crisis are assisted in accessing treatment facilities in lieu of being arrested and taken to jail.

outcomes

To date, the CMHP has provided CIT training to more than 7,600 law enforcement officers from all 36 local municipalities in Miami-Dade County, as well as Miami-Dade County Public Schools and the Miami-Dade Corrections and Rehabilitation Department. Countywide, CIT officers are estimated to respond to roughly 20,000 mental health crisis calls per year. In 2019, CIT officers from the Miami-Dade Police Department and City of Miami Police Department responded to 13,796 calls, resulting in 1,092 diversions to crisis units and 46 arrests. Since 2010, these two agencies have responded to 105,268 mental health crisis calls resulting in 66,556 diversions to treatment and just 198 arrests, accounting for fewer than 20 jail bookings per year.

105,268 CIT Calls

66,556 Transported to Crisis

18,608 Diverted from Jail

City of Miami and Miami-Dade Police Departments Annual CIT Calls

Miami-Dade PD & City of Miami PD	2010	2011	2012	2013	2014	2015
CIT Calls	7,779	9,399	10,404	10,626	11,042	10,579
Arrests Made	4	45	27	9	24	10
Diverted from Jail	1,940	3,563	2,118	1,215	1,871	1,633
Transported to Crisis	3,307	4,642	5,527	3,946	5,155	7,417
Use of Force	29	75	72	59	79	69
Officer Injuries	-	-	-	11	21	26

Miami-Dade PD & City of Miami PD	2016	2017	2018	2019	Total (2010-2019)	Rate per 1,000 calls
CIT Calls	11,799	11,799	8045*	13,796	105,268	
Arrests Made	19	11	3*	46	198	1.9
Diverted from Jail	1,694	1,860	1622*	1092*	18,608	176.8
Transported to Crisis	8,303	8,818	7898*	11,543	66,556	632.3
Use of Force	58	67	31*	25*	564	5.4
Officer Injuries	12	16	21*	15*	122	1.2

* CIT data was not collected by City of Miami. Information reported reflects calls responded to by Miami-Dade Police Department only. Information for 2020 delayed due to data system change.

fiscal impact

Due in large part to CIT, the average daily census in the county jail system has dropped from 7,200 to 4,400 inmates (39% reduction), and the county has closed one entire jail facility at a cost-savings to taxpayers of $12 million per year. Across all law enforcement agencies in the county, it is estimated that CIT results in approximately 3,757 fewer jail bookings of people with serious mental illnesses annually. With an average length of stay of 39.8 days per booking at a cost of $265 per bed/day, this reduction in jail admissions results in nearly 150,000 fewer inmate jail days (over 400 years) annually and a cost avoidance of over $39 million per year.

39% fewer inmates
in county jail system

County closed one jail facility
saving taxpayers $12 million
per year

Almost **150,000 fewer inmate jail days** (400+ years) annually

Over $39 million savings
from reduced jail admissions

Post-booking jail diversion program

The CMHP was originally established in 2000 to divert nonviolent misdemeanant defendants with SMI and possible co-occurring substance use disorders, from the criminal justice system into community-based treatment and support services. In 2008, the program was expanded to serve defendants that have been arrested for less serious felonies and other charges as determined appropriate. Post-booking jail diversion programs operated by the CMHP currently serve more than 400 individuals with serious mental illnesses annually. Over the past decade, these programs have facilitated roughly 5,000 diversions of defendants with mental illnesses from the county jail into community-based treatment and support services.

Clinical Eligibility

- Must be diagnosed with a primary serious mental illness, i.e., schizophrenia (or other psychotic disorders), schizo-affective disorder, bipolar disorder, major depression or PTSD
- Voluntarily agree to mental health or co-occurring treatment and services

Legal Eligibility

- All misdemeanors (excluding traffic cases)
- Most serious current charge 3rd and some 2nd degree felony (excluding carrying a concealed weapon, child abuse, and aggravated assault with a firearm) with no more than three prior non-violent felony convictions; or
- Individuals with more serious past or present legal involvement may be considered by the SAO for participation on a case-by-case basis
- NOT or NO LONGER adjudicated incompetent to proceed (ITP)

Program Criteria

- Must be identified as High or Moderate Risk/Need as determined by validated screening tool assessment during intake process
- Voluntarily agree to random Drug Screening as requested

To determine the appropriate level of treatment, support services and community supervision, the CMHP assesses each program participant regarding Mental Health, Substance Use and Criminogenic Risks and Needs. A two-page summary is developed that is used to develop an individualized transition plan aimed at reducing criminal justice recidivism and improved psychiatric outcomes, recovery and community integration. The evidence-based screening tools include:

- The Texas Christian University Drug Screen V (TCUDS V)
- Ohio Risk Assessment: Community Supervision Tool (ORAS-CST)

JAIL IN-REACH TEAM The project represents a collaborative effort among community partners that seek to improve the assessment, referral, diversion, and care coordination among individuals with serious mental illness (SMI) and possible co-occurring substance use disorders that are reentering the community from the criminal justice system. The goal is to reduce the cycle of arrests and incarceration for people who need behavioral health treatment and community support that will promote recovery and community integration. The target population includes adults with SMI that are repeat offenders and high utilizers of the acute care treatment systems and are in custody. All project participants are assessed using validated, evidence-based risk and need assessment tools (TCUDS V, and ORAS-CST). Those identified to be at moderate to high risk of future recidivism to the justice and/or acute care treatment systems, and who are eligible for CMHP services, will receive enhanced transition and reentry supports, as well as linkages to and monitoring of evidence-based treatment and support services in the community.

outcomes

Outcomes include increased public safety, decreased demand for services in the criminal justice and acute care treatment systems, and improved access to community-based treatment and recovery support services. The program met its lifetime target (375) within two years of implementation and continued growing to 603 participants over the lifetime of the 3-year grant. Individuals who participate in the program are significantly less likely to be arrested while in the program and upon successfully completing. The program has also secured housing for 88% of the participants over the course of three years. Every participant is assessed for eligibility for Social Security benefits, and if found eligible, assisted in acquiring those benefits.

Misdemeanor jail diversion program

All defendants booked into the jail are screened for signs and symptoms of mental illnesses. Individuals charged with misdemeanors who meet involuntary examination criteria are transferred from the jail to a community-based crisis stabilization unit as soon as possible. Individuals that do not meet involuntary eligibility will be screened, assessed and, if necessary, provided with treatment in jail. Eligible defendants may voluntarily agree to participate in program and legal charges may be dismissed or modified in accordance with treatment engagement. Individuals who agree to services are assisted with linkages to a comprehensive array of community-based treatment, support, and housing services that are essential for successful community re-entry and recovery outcomes. A specialized mental health docket in Domestic Violence Court provides the full range of project services as well. Program participants are monitored by the CMHP for up to one year following community re-entry to ensure ongoing linkage to necessary supports and services. Most participants (75-80%) in the misdemeanor diversion program are homeless at the time of arrest and tend to be among the most severely psychiatrically impaired individuals served by the CMHP.

ASSISTED OUTPATIENT TREATMENT (AOT) Florida Senate Bill 12 went into effect July 1, 2016, and it provided the authority for County Court Criminal Judges to use AOT for individuals charged with misdemeanor offenses. The project serves to identify individuals with histories of repeated admissions to mental health treatment services in the criminal justice and acute care treatment systems that may benefit from court ordered outpatient treatment services. These individuals have histories of treatment noncompliance and/or refusal to engage in treatment and are unlikely to survive safely in the community without supervision. Individuals that complete AOT can be transitioned into misdemeanor jail diversion to resolve misdemeanor cases.

outcomes

The misdemeanor diversion program receives approximately 300 referrals annually. Recidivism rates among program participants has decreased from roughly 75 percent to 20 percent annually.

Felony jail diversion program

Participants in the felony jail diversion program are referred to the CMHP through several sources including Jail In-Reach, the Public Defender's Office, the State Attorney's Office, private attorneys, judges, corrections health services, and family members. All participants must meet diagnostic and legal criteria. At the time a person is accepted into the felony jail diversion program, the state attorney's office informs the court of the plea the defendant will be offered contingent upon successful program completion. Like the misdemeanor program, legal charges may be dismissed or modified based on treatment engagement. All program participants are assisted in accessing community-based services and supports, and their progress is monitored and reported back to the court by CMHP staff.

outcomes Individuals participating in the felony jail diversion program demonstrate reductions in jail bookings and jail days of more than 75 percent, with those who successfully complete the program demonstrating a recidivism rate of just 6 percent. Since 2008, the felony jail program alone is estimated to have saved the county over 31,000 jail days, more than 84 years in jail bed days.

Forensic treatment facility diversion program

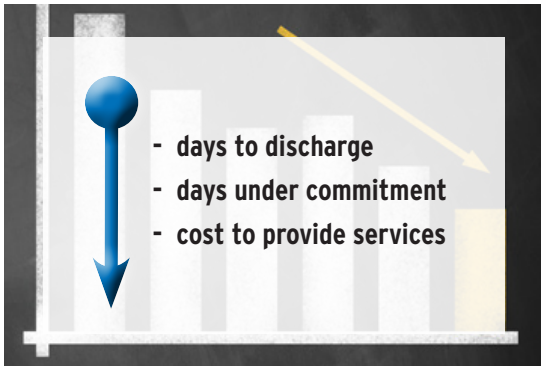
MIAMI-DADE FORENSIC ALTERNATIVE CENTER (MD-FAC) PROGRAM

Since August 2009, the CMHP has overseen the implementation of a state funded pilot project to demonstrate the feasibility of establishing a program to divert individuals with mental illnesses committed to the Florida Department of Children and Families from placement in state forensic facilities to placement in community-based treatment and forensic services. Participants include individuals charged with 2nd and 3rd degree felonies that do not have significant histories of violent felony offenses and are not likely to face incarceration if convicted of their alleged offenses. Participants are adjudicated incompetent to proceed to trial or not guilty by reason of insanity.

The community-based treatment provider operating services for the pilot project is responsible for providing a full array of residential treatment and community re-entry services including crisis stabilization, competency restoration, development of community living skills, assistance with community re-entry, and community monitoring to ensure ongoing treatment following discharge. The treatment provider also assists individuals in accessing entitlement benefits and other means of economic self-sufficiency to ensure ongoing and timely access to services and supports after re-entering the community.

Unlike individuals admitted to state forensic treatment facilities, individuals served by MD-FAC are not returned to jail upon restoration of competency, thereby decreasing burdens on the jail and eliminating the possibility that a person may decompensate while in jail and require readmission to a state facility. To date, the pilot project has demonstrated more cost-effective delivery of forensic mental health services, reduced burdens on the county jail in terms of housing and transporting defendants with forensic mental health needs, and more effective community re-entry and monitoring of individuals who, historically, have been at high risk for recidivism to the justice system and other acute care settings.

outcomes Individuals admitted to the MD-FAC program are identified as ready for discharge from forensic commitment an average of 52 days (35%) sooner than individuals who complete competency restoration services in forensic treatment facilities and spend an average of 31 fewer days (18%) under forensic commitment. The average cost to provide services in the MD-FAC program is roughly 32% less expensive than services provided in state forensic treatment facilities.



ACCESS TO ENTITLEMENT BENEFITS

SOAR entitlement unit program

Stakeholders in the criminal justice and behavioral health communities consistently identify lack of access to public entitlement benefits such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and Medicaid as among the most significant and persistent barriers to successful community re-integration and recovery for individuals who experience serious mental illnesses and co-occurring substance use disorders. Most individuals served by the CMHP are not receiving any entitlement benefits at the time of program entry. As a result, many do not have the necessary resources to access adequate housing, treatment, or support services in the community.

To address this barrier and maximize limited resources, the CMHP developed an innovative plan to improve the ability to transition individuals from the criminal justice system to the community. Toward this goal, all participants in the program who are eligible to apply for Social Security benefits are provided with assistance utilizing a best practice model referred to as SOAR (SSI/SSDI, Outreach, Access and Recovery). This is an approach that was developed as a federal technical assistance initiative to expedite access to social security entitlement benefits for individuals with mental illnesses who are homeless. Access to entitlement benefits is an essential element in successful recovery and community reintegration for many justice system involved individuals with serious mental illnesses. The immediate gains of obtaining SSI and/or SSDI for these people are clear: it provides a steady income and health care coverage which enables individuals to access basic needs including housing, food, medical care, and psychiatric treatment. This significantly reduces recidivism to the criminal justice system, prevents homelessness, and is an essential element in the process of recovery.

outcomes

The CMHP has developed a strong collaborative relationship with the Social Security Administration in order to expedite and ensure approvals for entitlement benefits in the shortest time frame possible. All CMHP participants are screened for eligibility for federal entitlement benefits, with staff initiating applications as early as possible utilizing the SOAR model. Program data demonstrates that 90% of the individuals are approved on the initial application. By contrast, the national average across all disability groups for approval on initial application is 29%. In addition, the average time to approval for CMHP participants is approximately 40 days. This is a remarkable achievement compared to the ordinary approval process which typically takes between 9-12 months.

CMHP Approvals vs. National Average

	CMHP	National Average
Approved on initial application	90%	29%
Average time for approval	~40 days	9-12 months

RECOVERY PEER SPECIALISTS are individuals diagnosed with mental illnesses who work as members of the jail diversion team. Due to their life experience, they are uniquely qualified to perform the functions of the position. The primary function of the Recovery Peer Specialists is to assist jail diversion program participants with community re-entry and engagement in continuing treatment and services. This is accomplished by working with participants, caregivers, family members, and other sources of support to minimize barriers to treatment engagement, and to model and facilitate the development of adaptive coping skills and behaviors. Recovery Peer Specialists also serve as consultants and faculty to the CMHP's Crisis Intervention Team (CIT) training program. There are currently 8 peer specialists on staff.

Miami Center for Mental Health and Recovery

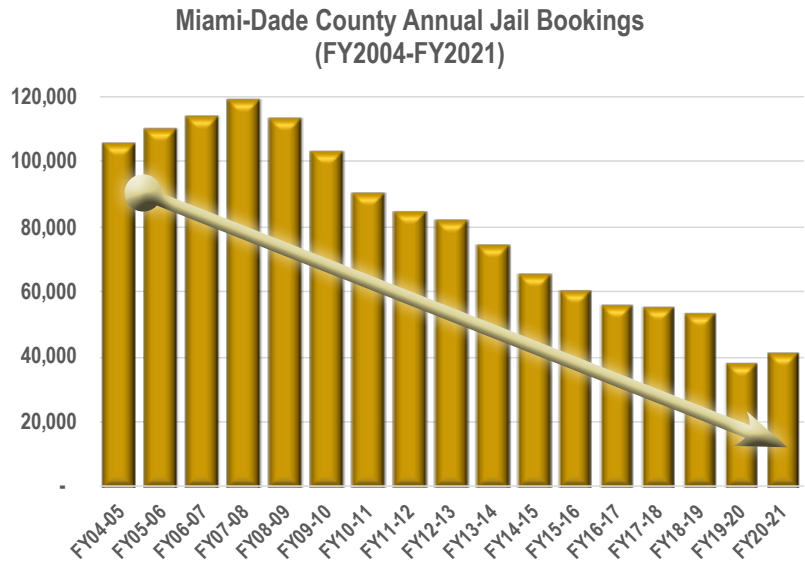
Since 2006, the courts have been working with stakeholders from Miami-Dade County on a capital improvement project to develop a first of its kind mental health diversion and treatment facility, known as the Miami Center for Mental Health and Recovery, which will expand the capacity to divert individuals from the county jail into a seamless continuum of comprehensive community-based treatment programs that leverage local, state, and federal resources. This project, which is funded under the Building Better Communities General Obligation Bond Program, was established to build on the successful work of the CMHP with the goal of creating an effective and cost-efficient alternative treatment setting to which individuals awaiting trial may be diverted.

The Center will be housed in a former state forensic facility which has been leased to Miami-Dade County and is in the process of being renovated to include programs operated by community-based treatment and social services providers. Services offered will include crisis stabilization, short-term residential treatment, day treatment and day activities programs, intensive case management, outpatient behavioral health and primary care treatment services, and vocational rehabilitation/supportive employment services. The proposed plan for the facility includes space for the courts and for social service agencies such housing providers, legal services, and immigration services that will address the comprehensive needs of individuals served.

The vision for the Center and expansion of the CMHP's diversion programs is to **create a centralized, coordinated, and seamless continuum of care for individuals who are diverted from the criminal justice system either pre-booking or post-booking**. By housing a comprehensive array of services and supports in one location, it is anticipated that many of the barriers and obstacles to navigating traditional community mental health and social services will be removed, and individuals who are currently recycling through the criminal justice system will be more likely to engage treatment and recovery services. Creation of this facility will also allow for the movement of individuals currently spending extended amounts of time in the county jail into residential treatment programs and supervised outpatient services supported by more sustainable funding sources. It is anticipated that the facility will begin operations in 2022.

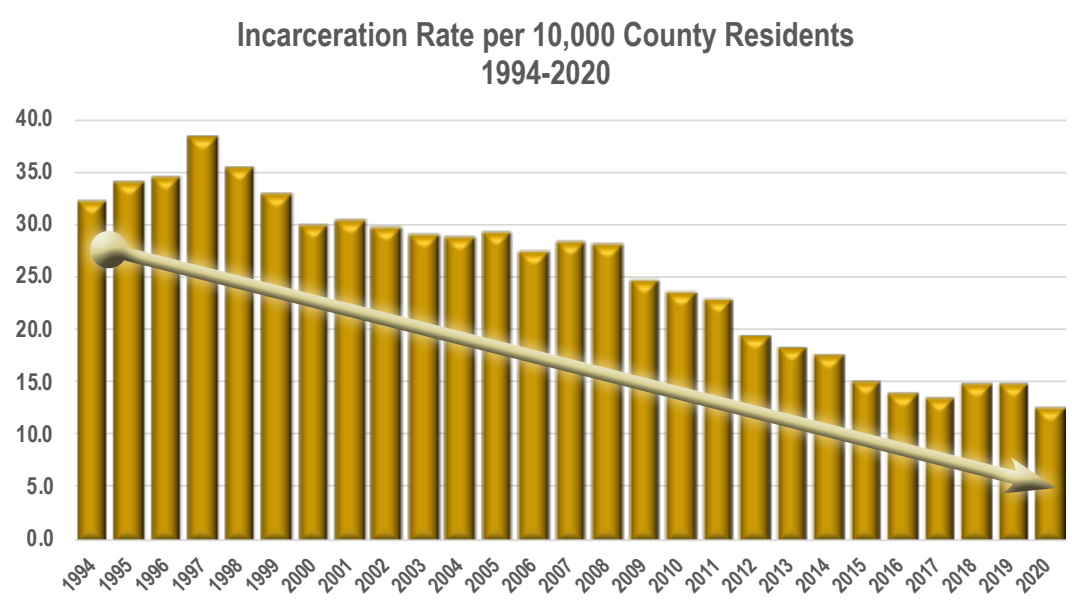
Conclusion

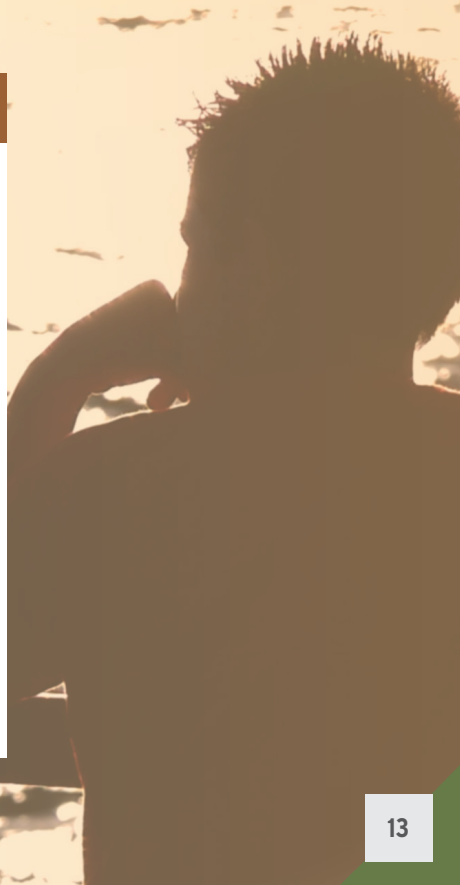
Reduction in annual jail bookings...



The CMHP has demonstrated substantial gains in the effort to reverse the criminalization of people with mental illnesses. The idea was **not to create new services** but to **merge and blend existing services** in a way that was **more efficient and continuous across the system**. The Project works by eliminating gaps in services and by forging productive and innovative relationships among all stakeholders who have an interest in the welfare and safety of one of our community's most vulnerable populations. The CMHP provides an **effective and cost-efficient solution to a community problem**. Program results demonstrate that individualized transition planning to access necessary community-based treatment and services upon release from jail promotes more successful community re-entry and recovery for individuals with mental illnesses, and possible co-occurring substance use disorders that are involved in the criminal justice system.

Reduction in rates of incarceration...



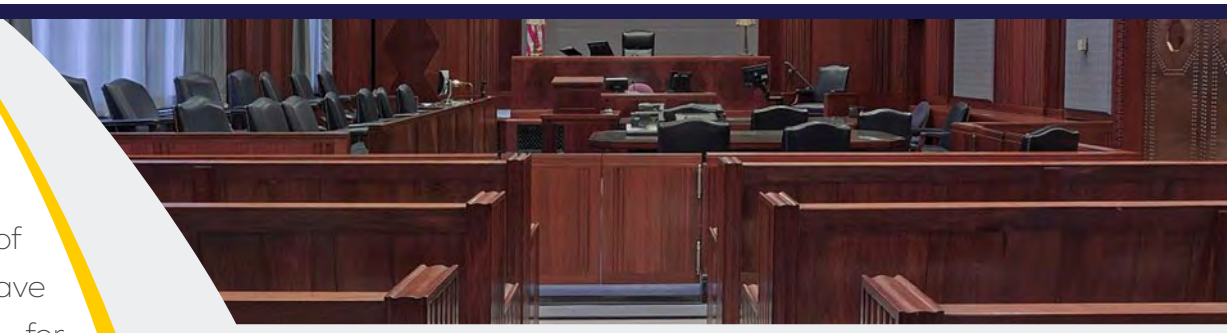


ELEVENTH JUDICIAL CIRCUIT
MIAMI-DADE COUNTY, FLORIDA
"WE WHO LABOR HERE SEEK ONLY TRUTH"

Leading Reform:
Competence to Stand Trial Systems

A Resource for State Courts[1]

August 2021 v2



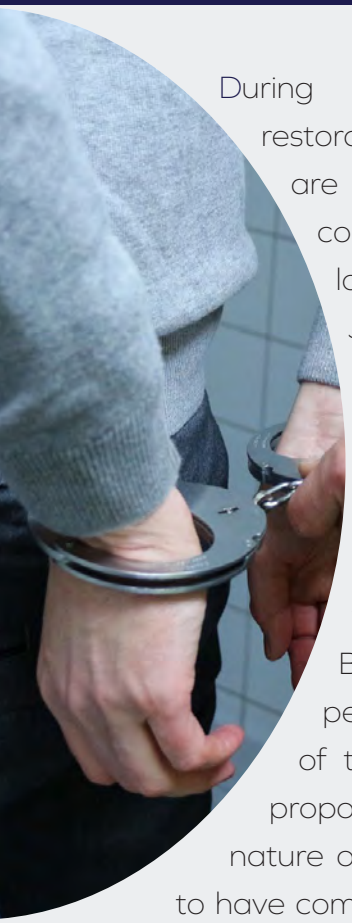
THE ISSUE

The majority of state hospitals maintain bed-wait lists of defendants who have been court-ordered for competency to stand trial evaluation or restoration services. A 2017 report found that in some states these waits are around 30 days, but three states reported forensic bed waiting lists of six months to a year. At any given time, there were at least 2,000 defendants waiting in jail for these beds.[2] During the pandemic these waits have skyrocketed, and in just three states combined, over 3,000 people were reported waiting in jail for a restoration bed. These are pre-trial defendants, sometimes charged only with misdemeanor offenses, all of whom are presumed innocent. And yet, many of them will spend far longer in jail or otherwise confined than they ever would have had they pled to or been convicted of the underlying offense.

BACKGROUND

Of the countless ways in which mental illness and the justice system intersect, one of the most direct is when courts and judges are involved in an order for evaluation and ultimate determination of a defendant's competency to stand trial.[3] Any defendant, their counsel, the prosecutor, or the court can raise a concern that the defendant may be incompetent to stand trial in any criminal proceeding, from misdemeanors to capital murder. The United States Supreme Court in *Dusky v. U.S.* (1960) held that in order for a defendant to be found competent to stand trial, a defendant must have "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding" *and* a "rational as well as factual understanding of the proceedings against him."

If incompetence is raised, the defendant is evaluated by a mental health professional; and based on that evaluation (or evaluations) and other information, the court makes a determination of legal competency. If an individual is found incompetent, a process of restoration to competency generally commences.



During both the evaluation and restoration phases, defendants are often held involuntarily, or committed, either in jail or in a locked treatment facility. In *Jackson v. Indiana* (1972), the U.S. Supreme Court held that the nature and duration of an incompetent defendant's commitment must bear a relationship to the purpose for which they are committed. But for a variety of reasons people are often held for periods of time that bear no rational or proportionate relationship to the nature of the offense they are alleged to have committed, their level of risk to the community, or their clinical needs.

In the context of competency to stand trial, due process requires that accused persons understand the charges against them and be able to meaningfully assist in their defense. Due process also requires a limit on the restrictions on the accused's freedom during the evaluation and restoration process. These two seemingly simple propositions of due process are often interpreted and implemented in such inconsistent and ineffective ways that our systems frequently do more harm than good. In this area of the intersection of behavioral health and the justice system, the courts have an integral role and significant responsibility to identify and understand the issues and provide the leadership for change.

One of the first steps undertaken by the Task Force was the selection of eight trial judges from around the country who were asked to focus on what they thought was working and what was not working relative to the competency processes. That two-day conversation set a solid path for identifying systemic problems and potential solutions to those problems.[4]

In an effort to understand all aspects of these issues, Task Force members and National Center for State Courts (NCSC) staff also engaged with other partner organizations and experts. Shortly after the NCSC focus group met, the Council for State Governments Justice Center (CSG), convened a remarkable group of experts from around the country to have a similar discussion, but from a broader perspective.[5] A result of that convening is the CSG product Just and Well: Rethinking How States Approach Competency to Stand Trial.[6]

This report builds on both the original interim recommendations to the Task Force and the *Just and Well* strategies to provide specific emphasis and implementation considerations from the perspective of the courts.

Many state courts are currently engaged in competency system and broader behavioral health system reform. Two regional Conference of Chief Justices and Conference of State Court Administrators summits were held in 2019, and the resulting technical assistance initiatives provided thereafter offered additional opportunities for discovery about what is and is not working, and how states are finding ways forward.[7]

Teams from Hawaii, North Dakota, Indiana, and Ohio, among others, identified the competency processes, and specifically the misdemeanor competency process, as area in need of reform.

State courts in each of these states initiated or participated in drafting legislation to reform the competence to stand trial systems in their states during the last year.

There have also been other efforts to gather data, identify and research best practices, and collaborate with experts on competency, including webinars, phone conferences, and joint resource development. The original focus group of trial judges reconvened in Los Angeles to observe the Los Angeles County misdemeanor and felony diversion program, housing resources, and same-day competency evaluation process used in the Superior Court in Hollywood. They also recently met remotely to consider the impact of the pandemic on competency issues around the country, and several of these judges now serve as members of the Competency Subcommittee of the Task Force (the Subcommittee).[8] The Subcommittee examined and refined the original interim recommendations,[9] and their final recommendations were considered and approved by the Task Force in August, 2021.

RECOMMENDATIONS

1. Divert cases from the criminal justice system

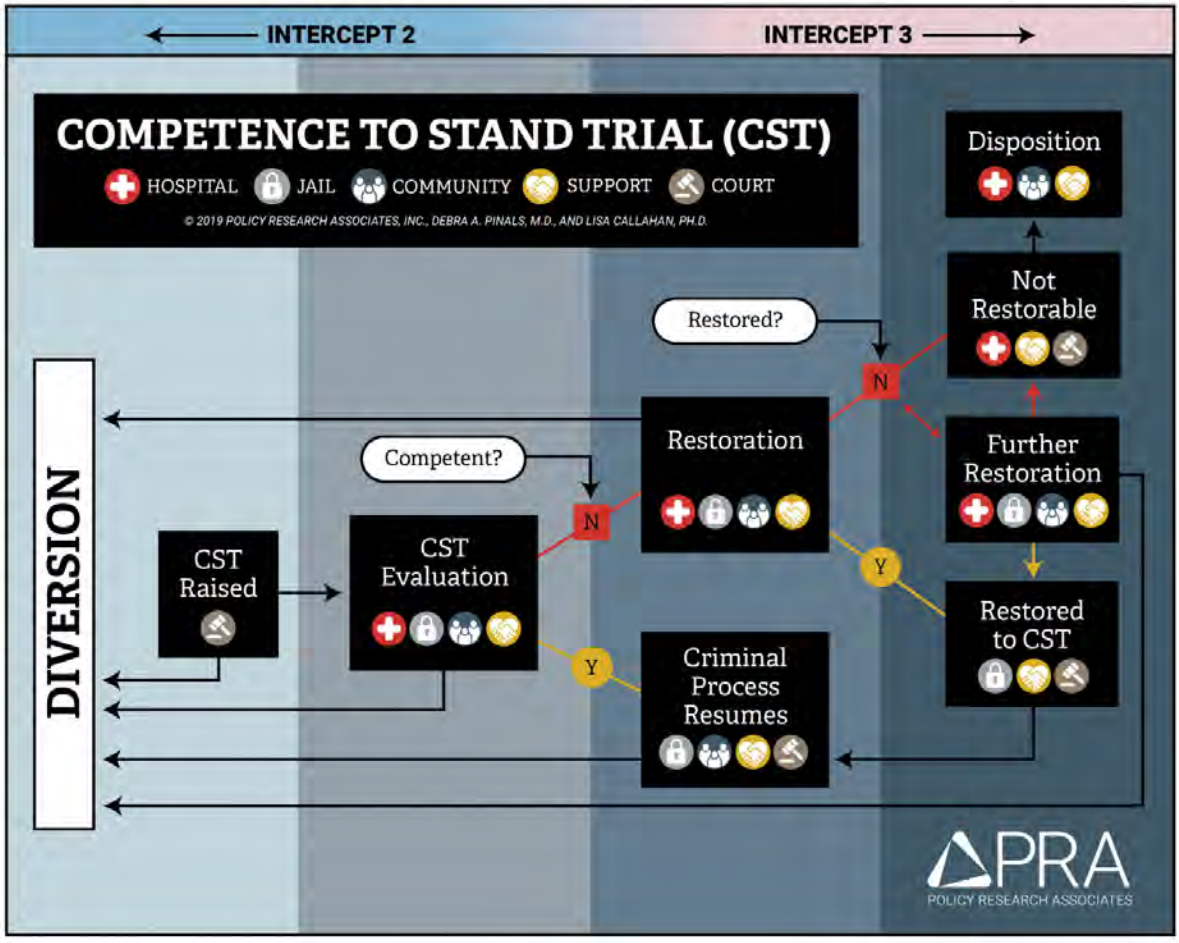
The involvement of the criminal justice system with people with mental illness is all too often a result of "nowhere else to go." Unlike when someone suffers a physical health emergency, there frequently is no 24/7 emergency mental health response infrastructure. When a mental health emergency happens, the same 911 call is made, but instead of a ride in the back of an ambulance to the hospital, often the call results in a ride (with handcuffs) in the back of a police cruiser, to jail. From there, the involvement of the courts is almost inevitable. And once the courts are involved with someone who exhibits symptoms of a mental illness, legal competence is a natural issue to be raised, and an array of delays, incarceration, and other problems inevitably follow.

There are, however, alternatives to this scenario, and these alternative approaches often work better for the individual as well as the community and use limited resources and available dollars more wisely. Because jails and courts struggle to effectively address serious mental illness (SMI), moving individuals in an out of these systems can make people with SMI worse. Diverting people who experience mental health symptoms to a system where treatment can be addressed at the right level of need as something more akin to our physical health processes and facilities is a better option. Trained 911 dispatchers, mobile crisis units, co-responder models, CIT trained law enforcement, and well-designed crisis stabilization facilities are evidence-based, effective, and more humane alternatives.

Looking forward, the recently created mental health crisis line alternative, 988, should also be utilized as a proactive diversion and care coordination opportunity. The greater the availability of these options, the fewer people will be subjected to the criminal justice and competency systems, and the better the outcomes for people with mental illness, courts, and public safety.[10]

These diversion opportunities also arise at each point in the competency process, and off-ramps from the criminal justice system to treatment and civil alternatives, including voluntary treatment, the use of Psychiatric Advance Directives, and even involuntary civil commitment when appropriate — such as the use of Assisted Outpatient Treatment (AOT) — should be considered at each of these points. Interventions should be tailored to the needs of the individual and the community at the evaluation stage, prior to restoration, upon return from restoration, and prior to and as a part of sentencing or other case disposition. Even individuals found incompetent to stand trial and unrestorable could take advantage of the right "off-ramp" opportunities for diversion and be linked to appropriate community services to reduce their risk of offending and returning to the competency system.

COMPETENCE PROCESS FLOWCHART



2. Restrict which cases are referred for competency evaluations

Even when the criminal justice system is invoked, there are still ways to divert people with mental illness from the competency road. The first potential point of diversion occurs when someone chooses to raise the issue of competency.

The constitutional standard for raising competence is quite low. The U.S. Supreme Court found in *Pate v. Robinson* that a hearing is required whenever there is a "*bona fide* doubt" about the defendant's competency. In recent years the trend of raising competence has dropped steadily in some jurisdictions, yet skyrocketed in others, which suggests that local legal cultures, practical circumstances in specific jurisdictions, and individual discretion around legal strategy are driving the numbers rather than principled public policy choices. Legally, all defendants are presumed competent, and judges are under no obligation to order an examination unless there are sufficient grounds to do so.

Certainly, defense counsel have an obligation to explore all possible legal strategies on behalf of their clients, but it does not follow that competence should be raised every time there is a colorable argument. Newer defense lawyers, for example, may not have seen how the process really plays out as a practical matter and may not be aware of better alternatives to pursue for their clients.

In some circumstances, it may be appropriate to take competency off the table as a policy matter, by rule or by statute, and several jurisdictions currently prohibit the use of the restoration process for certain classes of pretrial detainees. There is a growing consensus that individuals charged with misdemeanors, for example, should rarely be subject to the competency process. They often end up incarcerated, waiting for an evaluation, then waiting for the report, then for a hearing, then for a restoration bed to open (most often in a state mental hospital), and then they begin a restoration process that on average takes several months. Next, if restored, they are frequently returned to jail to wait their turn for a final court hearing to formalize that status, and then they are able to restart the criminal trial process. By then, they have been in jail and confinement for far longer than they ever would have been had they been convicted and sentenced on day one. Often the result is that the case is now dismissed or pled to, with a sentence of "time served."

Of course there are exceptions to this scenario, and the fact that someone has been charged with only a misdemeanor tells us little to nothing about their criminogenic risks, needs, or danger to the community. But *Jackson* says and due process requires that the nature and duration of an incompetent defendant's commitment

In some circumstances, it may be appropriate to take competency off the table as a policy matter, by rule or by statute, and several jurisdictions currently prohibit the use of the restoration process for certain classes of pretrial detainees.

must bear a relationship to the purpose for which they are committed. The nature of most competency systems in our country are inherently disproportionately onerous and ponderous when applied to someone charged with a misdemeanor.

Even proposing the "bright line" of misdemeanors versus felonies as a way to presumptively cull cases from the competency system is potentially problematic, however. One risk is that defendants will be charged with felonies, when possible, in order to keep all disposition options on the table for the prosecution and the court. This dynamic is especially pronounced when there are only two options – competency evaluation or traditional prosecution. The better answer is to have a continuum of responses available to the prosecutor and court. A clinical and risk screening and assessment would suggest the appropriate level of treatment intervention and supervision required. This continuum could include:

- A direct handoff to standard community-based treatment;
- Diversion to a treatment program affiliated with the criminal justice system, potentially including some level of community supervision;
- Referral to civil court options, such as civil commitment to a hospital or to Assisted Outpatient Treatment, if the defendant is treatment non-adherent,[11] and is clinically appropriate; and
- Other civil options such as guardianship.

Each of these options would ideally include appropriate supports, such as case management to ensure and coordinate rehabilitative or habilitative resources, such as housing, job training, public benefits, and the like.

If there are other effective options in which system players have confidence, the competency process will be used more sparingly, and more appropriately. By diverting defendants to appropriate targeted interventions and services and reserving the competency to stand trial mechanism for fewer cases and for circumstances for which the process is more proportionate, resources would be better spent and the outcomes for everyone, including the defendants, would be better.

3. Develop alternative evaluation sites

Although some states have shifted competency evaluations to sites outside of state hospitals, they continue to take place in any number of locations — in the community, jails, courthouses, state hospitals, and in other designated secure facilities. Which of those options is used depends largely on what is available in that jurisdiction and what that jurisdiction has chosen to fund, not on what would be the most clinically appropriate. Generally, there is only one option in a jurisdiction.

Judges, when informed by appropriate screen and assessment results and by behavioral health professionals, are in the best position to make the determination

about which setting, among a range of options, is most appropriate for individual defendants. This decision should be in the context of a statute or rule that presumes that evaluations take place in the least restrictive setting appropriate for each individual's demonstrated criminogenic risk and clinical needs.

But judges cannot order evaluations in a setting that does not exist. Courts and judges have a role in advocating for these options, because if more of the less expensive outpatient, community-based options for evaluation existed, there would be less need to wait in jail for the evaluation, fewer transportation and other logistical issues, and perhaps better evaluations. Some of these other options are discussed in Recommendation 7.

4. Develop alternative restoration sites

Similarly, there is usually only one option for restoration services in a jurisdiction, and that remains most commonly the state hospital. This likely leads to delays, jail time, and a loss of liberty that is disproportionate to the purpose for which incompetent defendants are being restored. Some states require, and others permit restoration in a psychiatric hospital. The result is that restoration services are provided only in an in-patient setting in the majority of states. Often this limit on restoration settings means there are a limited number of beds, which creates a bottleneck for the entire process and increases jail time for these defendants as they wait for a restoration bed. These realities point to the better options of diversion from the restoration process and to community treatment alternatives whenever possible.[12]

Treatment should generally be provided in the least restrictive setting that is appropriate, so unless there is a safety to the community concern or other clinical issue, treatment should be in the community. State statutes and rules should clearly presume less restrictive placements, and that presumption should only be overcome when the judge, again informed by objective assessment data and input from forensic professionals, finds that restoration services cannot safely or effectively be provided in the less restrictive community-based setting.

As community settings are developed and emphasized, care must be taken to maintain adherence to best practices and quality care. Decentralizing the provision of restoration services could potentially lead to inconsistent adherence to evidence-based practices, but that should not cause hesitance to move to a presumption in favor of community treatment. Instead, it should inform a system of accountability and appropriate oversight to ensure quality care. Uniform standards of care and consistent reliance on objective determinations of treatment placement eligibility are even more important as the number of restoration sites is increased and decentralized.

The advantages of decentralization outweigh the consistency concerns. The opportunities for integration of long-term community treatment and support with the short-term restoration episode are tremendous. Transitions from large restoration facilities to jail, and from jail to the community are frequently catalysts for a defendant's regression and decompensation. Changes in settings, medications, and therapeutic alliances are often problematic, and those changes can be minimized if appropriate, integrated, community settings are preferred.

Perhaps the most controversial experiment in competency restoration is jail-based restoration. Several states, under pressure to find alternatives to the long waits for restoration beds in state psychiatric facilities, have attempted to provide restoration services in jail. It should be acknowledged that this strategy does usually reduce the overall number of days the defendant is detained.

There are, however, a number of concerns about this approach. First, although jails are required to provide community-based standards of mental health services, often this is not the case. Moreover, the nature of a jail's mission for pretrial populations is to help detain defendants at risk of failing to appear and to protect public safety. As such a jail is not an appropriate setting if there is a significant need for behavioral health treatment. A recent Journal of the American Academy of Psychiatry and the Law review of best practices and recommendations for forensic evaluations in jails[13] agreed with the American Psychological Association's (APA) guidance that that competency *evaluations* should occur in environments that "provide adequate comfort, safety, and privacy" to ensure validity of assessments. Surely the same notion applies to restoration treatment as well.

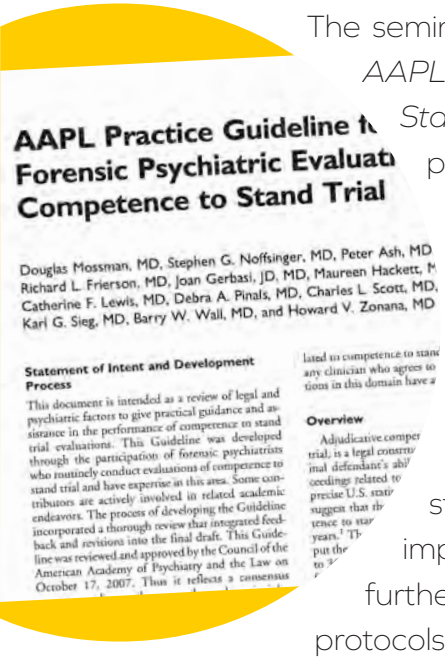
Perhaps the natural result of this incongruity is that jail-based restoration efforts focus more on the other two components of restoration services — legal education, and medication. As discussed below, legal education has not been found to be particularly effective. Medication in jails can be critical, but may also implicate another set of problems when jail medication formularies are limited, especially with respect to certain medications that may have better results in maintaining stability of symptoms, such as long lasting injectable medications. Instead, given the transient populations within jails, they are often set up to prescribe daily dose medications, and there may be limited options of those that are readily available. Daily dosing has its own problems with medication lines, refusals and compliance, but also with medication continuity once a person leaves the jail and hopefully transitions to more sustainable long term injectables.

Transitions from large restoration facilities to jail and from jail to the community are frequently catalysts for regression and decompensation.

Considering each of these factors, the recommendation is that community restoration should be the presumptive placement, and that jail-based restoration should *only* be considered when:

- It is clear that the individual does not have a more acute clinical treatment need;
- The only alternative is a wait of many months for a treatment bed that is not medically necessary;
- The jail program is treatment focused and has appropriate medications available;
- There are clear efforts at continuity between the restoration program and other settings where the person may be sent; and
- Even then, because of the importance of addressing conditions of confinement in jails more broadly, funding separate jail restoration should be only a temporary option while other system reforms are in progress.

5. Revise restoration protocols


AAPL Practice Guideline f
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Competence to Stand Trial

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Richard L. Frierson, MD, Joan Gerbasi, JD, MD, Maureen Hackett, M
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Statement of Intent and Development Process

This document is intended as a review of legal and psychiatric factors to give practical guidance and assistance in the performance of competence to stand trial evaluations. This Guideline was developed through the participation of forensic psychiatrists who routinely conduct evaluations of competence to stand trial and have expertise in this area. Some contributors are actively involved in related academic endeavors. The process of developing the Guideline incorporated a thorough review that integrated feedback and revisions into the final draft. This Guideline was reviewed and approved by the Council of the American Academy of Psychiatry and the Law on October 17, 2007. Thus it reflects a consensus

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Overview

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The seminal guide to best practices in competency evaluation and restoration is the *AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial.*[14] The authors evaluated the available research to determine best practices for, among other things, restoration approaches. While some states focus almost entirely on legal education in an effort to allow the defendant to demonstrate their ability to "consult with his lawyer with a reasonable degree of rational understanding," others prioritize treatment of the underlying mental illness.

This should not be an either/or approach, and there is some consensus that, given that most individuals found incompetent to stand trial have challenges stemming from symptoms of serious mental illness, medication is the most important catalyst for successful restoration. One meta-analyses of the research further concluded that "(t)he benefit of adding educational programs to medication protocols for competency restoration of non- developmentally disabled defendants has not been clearly established."[15] There is an evolving recognition that there is value in all three approaches — medication, individualized treatment, and legal education, to varying degrees depending on the individual defendant's overall needs. As such, given the value of restoration slots or beds, and given the potential for backlogs and delays to ripple through other parts of the system, care must be taken to prioritize getting defendants what they need when they need it rather than making restoration a one-size-fits-all strategy in one state hospital location.

The duration of time individuals spend in restoration programs is another important consideration. The rate of successful restoration for individuals with serious mental illness is relatively consistent across the various systems (80% to 90%), but the length of time defendants spend in restoration programs

around the country varies greatly. Some studies identified mean restoration periods of 60 days, while others documented mean times of a year or more.

One factor in the length of the process is the court's involvement in oversight and monitoring. When court involvement is too passive, the length of the restoration process can be longer, and the *Jackson* requirement for alacrity and proportionality lands at the court's doorstep. Active court oversight of the restoration process and collaborative involvement with treatment professionals is more likely to produce energetic restoration efforts and a more timely, effective, and constitutionally compliant process. Court reviews of the process should occur early and often, and clinical discharge readiness decisions should be met with timely court consideration and authorization. When the courts control the back door of the restoration units, new individuals wait for admittance. Partnership with the treatment providers and trust in them to establish individual readiness for discharge from programs once clinically appropriate should be taken into account by judges.

Active court oversight of the restoration process and collaborative involvement with treatment professionals is more likely to produce energetic restoration efforts and a more timely, effective, and constitutionally compliant process.

While there is evidence that a court review of restoration status at 30 days is too soon, 45 days seems to be a potential sweet spot at which sufficient time has passed to allow medications to work and progress to be made. One of the AAPL reviewed studies found that almost half of the defendants in that sample were restored at the 45-day mark. While there is not sufficient research to recommend setting hard restoration timelines, this dynamic does have implications for case management, and perhaps initial status or review hearings should presumptively be set 45 days from the initiation of restoration services.

6. Develop and impose rational timelines

Beyond the *Jackson* directive to limit the length of pre-trial detention, there is no specific, uniform constitutional timeline for the various stages of the competency process. In *Oregon Advocacy Center v. Mink,*[16] the 9th Circuit, citing *Jackson*, found that Oregon violated a defendant's due process rights if the defendant was not transferred to the Oregon State Hospital within seven days of a court's commitment to the hospital for restoration. This is one of very few times a court has specified a required timeline, and that timeline only speaks to one part of the process. However, to the extent this fixed timeline poses significant logistic and resource challenges, it should serve as a catalyst for proactive collaboration among system partners to themselves develop workable and appropriate timelines rather than leave it to civil rights litigation.[17]

Delays can and do occur: (1) waiting for an evaluation after competence is raised, (2) waiting for the evaluation report and for a hearing on the findings of that report, (3) waiting for a judicial decision after that hearing, (4) waiting for a restoration slot after incompetence is determined, (5) waiting for restoration status reports and hearings on those reports, and finally, (6) waiting for a final legal determination of restoration. A separate issue arises when a defendant is deemed unrestorable. The length of detention and the resolution of those cases is another issue that states should review, including an examination of the processes for potentially transitioning to a civil commitment in those circumstances.

At each of these steps in the process there is an opportunity for delay, and also an opportunity for speed and efficiency. While there is no single time-standard answer for all jurisdictions, it is crucial that individual states address this timeliness issue and establish presumptive timelines through tailored statutes or rules, as applicable. While some of the steps are largely controlled by case management decisions of the court discussed below, others are cross-jurisdictional and cross-branch issues that require the synchronization of several disparate parts. They, therefore, require collaborative consideration of each of the following timing issues:

- The time from when doubt is raised to evaluation should be as brief as possible. Often defendants are incarcerated at this point, and frequently this is at a time shortly after arrest and perhaps a mental health crisis. A clinical response should be prioritized, and that response may inform the timing of an evaluation. In some circumstances it may be appropriate to wait for the defendant to stabilize, such as in the case of stimulant psychosis.
- The time from the administration of the competency evaluation until a judicial determination of competence should also be brief. While largely a judicial scheduling issue, jurisdictions should ensure that evaluators, counsel, and the court all communicate about delays, and that scheduling these hearing be prioritized by each. There are also ways in which report templates and other aspects of evaluator training can facilitate quick turnaround times, and those are discussed in the next section.
- Once a person is found incompetent, the *Jackson* considerations come into play, and the obligation to initiate restoration service promptly begins. While *Mink* finds that taking more than seven days to begin treatment violates the constitution, each jurisdiction (outside of the 9th Circuit) should carefully consider what timeline target makes legal and practical sense for them, while also considering that not all defendants need to go into a state hospital for restoration, and thus timely access should include access to alternative community-based restoration sites and models.
- As discussed above, the first court review of the restoration process should occur quickly, as a significant portion of this population attains competence shortly after clinical stabilization, and often appropriate medication. Subsequent court reviews should also be frequent and meaningful, i.e., the court should ensure that the defendant is transported, that meaningful reports have been prepared and reviewed by all parties, and that treatment progress is maintained. Court liaisons or navigators can be particularly helpful in ensuring that these hearings are meaningful and productive, and that progress is maintained. Their role is discussed further below.

- The maximum time a person can be maintained in a competency restoration program varies wildly from state to state. Often the possible duration is tied to maximum potential periods of incarceration, but those periods of time may be wholly incompatible with *Jackson*, and should be reviewed. There is also often confusion about the process to be followed when those time limits are reached — whose responsibility it is to file for a civil commitment, for example. These processes should be clear, and appropriately quick.

As difficult as that synchronization of disparate parts and interests may be, the payoffs could be huge. A recent effort to apply mathematical modeling to delays at each part of the competency process identified some remarkable opportunities:

> The model validates that relatively small changes to specific variables that are determined or influenced by public policy could significantly reduce forensic bed waits. The following examples illustrate the outcomes projected by modeling data from the sample states:
>
> - Diverting two mentally ill offenders per month from the criminal justice system in Florida reduced the average forensic bed wait in the state by 75%. From an average wait of 12 days in early 2016, the average wait fell to three days.
> - Reducing the average length of stay for competency services by less than 2% in Texas — from 189 to 186 days — increased forensic bed capacity sufficiently to reduce bed waits from 61 to 14 days.
> - Increasing the number of forensic beds by 11% in Wisconsin — from 70 beds to 78 beds — reduced IST bed waits from 57 days to 14 days.[18]

These savings and improvements should be a strategic priority for all state courts and for our competency system partners.

7. Address operational inefficiencies

At each step of the process there are opportunities for refinement. Below are examples, but these are only some of the operational opportunities to improve the overall effectiveness of the competency system.

Evaluator training, availability, and speed

In many states, the availability of qualified forensic examiners causes significant delays. One common cause of the lack of availability is funding for positions and compensation rates for the examiners, both of which should be addressed, but there are other operational strategies that have worked in some jurisdictions.

For example, in Massachusetts, every district and superior court has access to same day clinical competency evaluations conducted by state behavioral health staff or contracted providers of the state behavioral health system. Although thousands are done each

year, this allows for "screening" to take place so that only the most ill are referred for further evaluation as inpatients — where they likely clinically belong.

In Los Angeles, a small roster of psychiatrists is paid relatively well for conducting evaluations on a known schedule, for a set number of defendants, for a predetermined number of hours, at the same place each time. This predictability encourages engagement of the psychiatrists and consistency in their evaluations. Once a defendant is referred for evaluation and transported to the Hollywood court, they are evaluated in the morning, the disposition is in the afternoon, and transportation is immediately accomplished. Not every jurisdiction may be able to achieve this level of efficiency, but the principles that underly this success are replicable, and more of those principles are discussed below.

Evaluator availability and efficiency can also be dramatically enhanced by the emerging option of video forensic evaluations.

While in almost all cases the availability, qualifications, compensation, and training of forensic evaluators is not a responsibility of the judiciary, assuming control of all of those factors is an option. This would require strong clinical involvement to ensure clinical quality, but Arizona's court system sets the qualification for evaluators, trains them, and directs payment to them. While this may be a unique circumstance, it should not be completely foreign to court systems, many of which directly employ mediators, custody evaluators, interpreters, and other direct service providers in instances where the performance of those services is integral to the operation of the courts.

Another useful strategy that endeavors to make the most efficient use of evaluator resources is the consolidation of evaluations. In some places this means bringing evaluators to the courthouse to do batched evaluations, in conjunction with a consolidated calendar to ensure sufficient volume to make it worth it. In other cases, it may mean regionalization of competency cases to bring the defendants from a number of smaller jurisdictions to one evaluation site.

Evaluator availability and efficiency can also be dramatically enhanced by the emerging option of video forensic evaluations. As more jurisdictions are using teleservices for more purposes, often behavioral health related, there is more opportunity for assessment and evaluation of those strategies. The research results so far are quite encouraging. An initial randomized control trial conducted pre-pandemic and reported in the Journal of the American Academy of Psychiatry and the Law found that using a telemedicine evaluation produced assessment scores consistent with the in-person evaluations, that patients had no preference for in-person versus remote evaluations, and that the evaluators preferred the in-person option.[19] Given the rapid shift in the use of video technology for evaluations in the COVID-19 context, the preference of clinicians and courts may also evolve as more is learned about the values of more widespread use of this technology.

A 2018 review of that study and others that have followed, and the emerging legal findings, concludes that "[T]he use of (videoconferencing) can be a viable way to meet the demand for timely adjudicative

competence evaluations… [These] evaluations make the most sense when they improve the efficiency of services while maintaining the same standards of quality of traditional evaluations...,"[20] which they seem to have great potential to do.

To the extent that the obstacle to greater use of remote technology for evaluations (and other assessment and treatment) is attitudinal, recent events have likely increased everyone's level of comfort and proficiency with virtual options.

These strategies all support the model of evaluations taking place somewhere other than in a psychiatric hospital, though around the country that is still the most prevalent practice. The other emerging custodial approach is to conduct evaluations in jails, which is an option in at least nine states. While ironically this may in fact reduce the amount of time defendants spend in jail awaiting an evaluation, there are serious questions about the appropriateness of conducting forensic inquiries in jail. An entire 2019 Journal of the American Academy of Psychiatry and the Law article is devoted to the incongruity between the professional guidelines that specify such evaluations "should take place in quiet, private, and distraction-free environments," and the realities of a jail environment.[21] Some states have office space in courthouses devoted for evaluations even if the evaluee is required to be detained in jails. However, in some jurisdictions evaluators navigate space within the jail where issues of privacy and noise can hamper quality of the assessments. More data and research on these options are needed.

Translating behavioral health system processes and requirements to a criminal justice context, and vice versa, has shown to benefit all of the system players by saving resources and more effectively delivering behavioral health services and access to justice.

Evaluation templates

Regardless of how well trained an evaluator may be, different professional backgrounds, experiences, training, and preferences lead to different approaches to evaluation processes and reports. These differences can be helpful, such as the different perspectives of a psychologist and a psychiatrist. But when the reports themselves are dramatically different in content, style, and structure, delays and miscommunication may result. A number of states employ evaluation report templates, so that the readers — judges, lawyers and other clinicians — have a consistent experience in reviewing a report. This can ensure that all required statutory elements are addressed, factual background and detail are consistent, and conclusions and recommendations are legally sufficient. Different approaches and assessment tools can still be accommodated, but the presentation would be consistent. Whether a template is used or not, there should at least be specific drafting guidelines, and adherence to those guidelines ought to be required.[22]

Multiple opinion requirements

The issue of how many evaluations and expert opinions are needed to make an informed decision about competency is largely an issue of local or state legal culture. Many jurisdictions are satisfied with one evaluation. Some allow for a second evaluation if an opponent disagrees with the initial results, and some jurisdictions begin with a requirement for two evaluations, and then an automatic "tie-breaker" if the opinions differ. There are some jurisdictions that allow even more than three forensic evaluations, though to what end is not clear. If more than one evaluation is required, one time-saving measure employed in some jurisdictions is to have the evaluators conduct the evaluation collaboratively, at the same single interview.

Various parties may push for multiple evaluations, including the litigants and the judge, each for various reasons. While legal customs (and the statues and rules that enshrine them) are difficult to change, two things may gradually discourage this resource drain. First, if the timelines discussed above are imposed for the evaluation process for the time from referral to report, multiple evaluations may become impractical.

Second, below is a recommendation that competency teams be deployed — a team would consist of a judge, prosecutor, defense counsel, and a small cadre of neutral, objective evaluators. Some existing programs have found that the secret to efficient and fair processing of competency cases is trust; trust developed over time by frequent interactions, and enduring relationships. If the actors all had more experience with and trust in the evaluators, perhaps there would be less of an inclination to seek redundant evaluations, resources would be saved, and timeliness enhanced.

Case managers and court liaisons

Several states have begun to use court connected or court employed personnel to provide case management-like functions for the court. Colorado calls them court liaisons, Washington calls them forensic navigators, other states refer to them as boundary spanners, but the function is essentially the same: bridge the behavioral health and criminal justice systems to more effectively manage individual defendants' circumstances.

In a competency context, this case management role can facilitate the pairing of defendants and evaluators, identify services that would allow the evaluation and restoration process to occur in the community instead of a custodial facility, ensure appropriate attention is paid to timelines and resource coordination, and generally make sure that cases do not fall through the cracks. Translating behavioral health system processes and requirements to a criminal justice context, and vice versa, has shown to benefit all of the system players by saving resources and more effectively delivering behavioral health services and access to justice.

Court case management – centralized calendars, frequent reviews, and teams

How an individual judge and a court system manage competency cases can make a dramatic difference in the process.

> Centralized calendars

Calendaring practices are another area of longstanding legal culture, and change can be difficult. Depending on the size of the jurisdiction, competency cases may be few and far between, or they may be an everyday occurrence. In either event, combining whatever cases there are and sending them to one judge (or more if the volume requires) will result in a more proficient judge. Law school, and most law practices, do not develop fluency in issues of psychotropic medication, therapeutic alliance, the DSM-5, and the myriad of other terms and issues that are the everyday concerns of competency to stand trial proceedings. But the nuances and context of these and other issues are central to getting it right in these cases. That fluency only develops with repetition and exposure to those issues. Court staff also benefits from repetition with these terms and processes.[23]

Another advantage of consolidation or centralization is that the ancillary resources implicated in competency cases are just that — ancillary, and they (forensic evaluators, treatment providers, hospital staff, community providers, public defender social workers, etc.) are rarely dedicated only to these cases. Bringing them together at a consistent time and place with familiar faces and predictable processes is more efficient for them and for the court.

> Frequent reviews

Because of the huge impact that timeliness can have, frequent reviews at each stage can have an important effect. Cases — and people — can languish if the system players are not held accountable. The delays mentioned earlier, from referral for an evaluation to delivery of the report, from the order of commitment to restoration to transportation to a facility or to release to a community resource, and from status report to status report from a restoration services provider, all benefit from court oversight and accountability. Human nature is to procrastinate, and frequent brief but meaningful and productive court reviews provide deadlines that spur action and progress.

> Teams

Centralized, coordinated calendars and frequent reviews are much easier if there is a competency team — judge, prosecutor, defense counsel, and evaluator(s). This team can also include whatever other resources are involved, such as a forensic navigator or case manager, state hospital representative, local mental health provider, etc. Some of the benefits to a team approach have been alluded to above, but essentially the advantage is proficiency. As with the judge, prosecutors and defense counsel learn about the mental health system and mental illness through experience,

Without abdicating their legal and ethical responsibilities, team members can nonetheless reduce the nonproductive steps in the adversarial process and focus on the operant ones.

and with more experience comes the same more nuanced, contextualized understanding of competency law, psychiatry, and community behavioral health resources. That understanding allows them to be better advocates, and hopefully that leads to more just results.

A team approach also makes scheduling much easier for the court and for the other partners. Continuances and no-shows decrease if everyone has the same calendar and the same regular, predictable schedule.

But the most important benefit of the team approach is the efficiency that comes with predictability and trust among team members. Without abdicating their legal and ethical responsibilities, team members can nonetheless reduce the nonproductive steps in the adversarial process and focus on the operant ones. That predictability and trust can lubricate the otherwise clunky competency machine and make it run more smoothly.

8. Address training, recruitment and retention of staff

Many of the inefficiencies in the competency process have their roots in the lack of a sufficient behavioral health workforce. If there are too few qualified evaluators, for example, jurisdictions either lower the evaluator qualifications or they have waitlists for evaluations, or both. More forensic psychiatrists and psychologists are needed, and some systems have begun to actively incentivize that career track, but progress is slow. Communities have also expanded competency evaluations to other disciplines including social workers, and this can be another consideration. Again, with the use of video technology, more efficient access to an appropriate workforce may be facilitated.

Rural communities are particularly understaffed, and incentives to locate in those communities could be helpful. As noted, technology solutions are part of this issue, but likely cannot be the only answer. Attention to the racial and ethnic makeup of evaluators and others is also necessary, in order to promote trust and confidence in evaluators and the evaluation process.

The solutions are bigger than those that the judiciary alone can implement, but courts do have a stake in the outcome and a role in sounding the siren and focusing attention on the professional resource shortage problem.

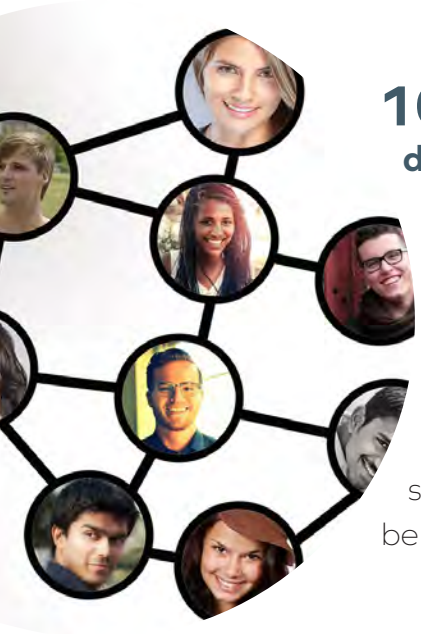
9. Coordinate and use data

Some policymakers and funders respond most acutely to personal stories that illustrate a need, and others gravitate to data. The competency to stand trial problem certainly has no shortage of the former, but more and better data is also needed. The coordination of law enforcement, behavioral health, jail, and court data is difficult. There are disparate data elements, definitions, client identifiers, and technical systems.

Money is one motivator for good data collection and coordination, and some of the best data come from jurisdictions where a managed behavioral health care system demands it. Arizona has such a system, and the crisis care continuum there is gaining notoriety because of those data. They show that early intervention and diversion from the criminal justice system saves money, so investment in those strategies takes priority.

The courts have a significant role in identifying common data elements and coordinating data collection with law enforcement, jail, and treatment partners. SAMHSA developed an *"Essential Measures"* guide for data collection across the SIM,[25] and the National Center for State Courts has a recently retooled behavioral health data elements guide as well.[26] However, it is not clear that there is a consensus about what competency process data should be collected or that there is any urgency about compiling those data.[27] This coordination and compilation can be a bit of a Sisyphean task, but one that state courts should nonetheless pursue to help drive system improvements.

The courts have a significant role in identifying common data elements and coordinating data collection with law enforcement, jail, and treatment partners.



10. Develop robust community-based treatment and supports for diversion and re-entry

The first recommendation above is to divert people with serious behavioral health issues and their cases from the criminal justice system, but a common refrain in the mental health context is, divert to what?[24] The simple answer is to divert to treatment, but the treatment system is often anemic at the pre-arrest community level, at the post-arrest correctional level, at the pre-trial and post-conviction level, and at the point of re-entry to the community. All system partners readily agree that the entire treatment continuum needs to be strengthened.

Concomitantly, there needs to be a continuum of legal avenues to access those services. Criminal court avenues exist, albeit imperfectly, and are often used out of necessity, but a range of civil legal options that can be used to access treatment are also essential. AOT, guardianships, conservatorships, psychiatric advance directives, and other less restrictive options that can be accessed at different stages of a person's diversion and re-entry path are essential to long-term success.

Re-entry to the community from wherever the person exits the competency process needs to be coordinated, seamless, community focused, and with abundant supports, including transitional and supported housing. As much effort needs to be made to ensure a successful community reintegration as was made to intervene in the first place, or all of the resources spent to achieve stabilization and wellness are for naught.

As judges are increasingly expected to assume a problem-solving role rather than a strictly adjudicative one, the need for appropriate treatment options becomes more imperative. It is perhaps unfair to ask judges to manage defendants with mental illness and to hold them accountable for those outcomes without providing the courts the treatment tools and dispositional resources they need. This is one reason that courts and judges have such a substantial interest in leading change in this arena.

Treatment in this context is not just strictly mental health treatment, but also involves aspects of care related to substance use disorder treatment, supports for individuals with intellectual and developmental disabilities, and culturally competent services for veterans, as well as ancillary supports like case management, cognitive behavioral therapy related to criminogenic risks and needs, and wrap around services. Homelessness is also often a companion to mental illness and arrest, and judges and communities are always in need of housing options for defendants with mental illness who are entangled in the competency web — pre-trial, and upon community reentry. Robust treatment, supervision and support options throughout the process are essential if we are to expect better system outcomes and better outcomes for the individuals involved.

Re-entry to the community from wherever the person exits the competency process needs to be coordinated, seamless, community focused, and with abundant supports, including transitional and supported housing.

CONCLUSION

The competency to stand trial process is just one segment of the broader intersection of mental health and the criminal justice system, but it is one that is squarely within the judiciary's ambit. Significant system reform requires strong partnerships with local entities and with state entities in other branches of government.[28] For both institutionally necessary and for altruistic reasons, courts and judges should embrace the issues and actively pursue solutions.[29] **The complexity of the system and the siloed nature of the services cry out for collaboration and for leadership; and the judiciary is in a unique position to not only convene, but to lead.**

APPENDIX A

While the rules, statutes, resources, and processes related to competency to stand trial differ widely from state to state, there are common issues, and there is significant room for improvement in all states. This checklist provides a brief, task-oriented roadmap to assessing and reforming your competency system. It should be read in close conjunction with the companion Task Force product *Leading Reform: Competence to Stand Trial Systems – A Resource for State Courts,* and the resources identified therein..

1. **Convene an interdisciplinary team to examine all aspects of the competency system and to make and advocate for recommended changes** This team should include legislators, executive branch representatives including the state mental health authority, local mental health providers, court administrators, prosecutors, defense counsel, jail administrators, state mental hospital representatives, competency evaluators, judges, and others as appropriate in your system.[30]

2. **Review Leading Reform: Competence to Stand Trial Systems – A Resource for State Courts and the materials referenced therein** Issues specific to statewide court systems are described, and the resources cited provide additional research, context, and insight helpful to court leaders and their partners. This may also be the time to consider the resources you have, and potentially to seek assistance from experts in the field, including technical assistance from the National Center for State Courts.

3. **Identify and gather data related to the competency process** Court filing and disposition information, jail data including screen and assessment results and relevant wait times, evaluation outcome and timeliness data, restoration outcome and timeliness data, and other overall timeliness and wait time or waitlist information.

4. **Review the crisis care and justice system diversion systems for opportunities to divert people with mental illness from the criminal justice system**[31]

5. **Identify opportunities to divert defendants from referral to the competency evaluation mechanism** This includes statutory or rule changes, and prosecutorial initiatives to link defendants directly to treatment rather than to an evaluation, either with a dismissal, a diversion agreement, or a referral to Assisted Outpatient Treatment, if appropriate.[32]

6. **Identify existing competency evaluation protocols, develop outpatient community options, and create a presumption to use those community sites unless unsafe or clinically inappropriate** This may require funding stream changes, and development and training of a new cohort of community-based evaluators.

7. **Identify existing competency restoration locations and processes, develop outpatient community options, and create a presumption to use those community sites unless unsafe or clinically inappropriate** This may require funding stream changes, and development and training of a new cohort of community-based restoration treatment providers.

8. **Revise restoration protocols and timelines** Review best practices for restoration interventions and emphasize clinical treatment resources. Develop consensus about reasonable timelines for referral to and commencement of treatment, and about the reasonable duration of restoration services. Legislative change may be needed for some reforms.

9. **Examine the qualifications, selection, and training of evaluators** Limit the number of automatic evaluations ordered, and then set the qualifications of evaluators as "high" as feasible given a potential reduction in the number of evaluations and set firm timelines for the completion of evaluations. Create a protocol for remote evaluations, particularly for rural areas. Develop a robust evaluator training curriculum, with a requirement for continuing education.

10. **Collaboratively develop an evaluation template and require its use** Seek input from forensic psychiatrists, judges, prosecutors, and defense counsel to create a template that is consistent and meets legal and clinical needs.

11. **Consider the creation (or expansion) of a court-connected case management role** Also called forensic navigators, boundary spanners, and court liaisons.

12. **Centralize or consolidate competency calendars and implement a team approach** Refer cases in which competency is raised to one calendar, with the same judge, counsel, and added case management resources.

13. **Establish a requirement for frequent, meaningful court reviews once a defendant is referred to restoration services**

14. **Identify benchmarks for process improvement using reliable data** Regularly review those data to identify trends, impediments, and progress.

15. **Identify gaps in the continuum of community treatment and supports for those transitioning out of the justice system, and advocate for additional services** Improvements in the rest of the process won't be sustained if defendants cycle back through the system because of a lack of community support, so specific gaps in the continuum of services should be identified and solutions advocated for collaboratively.

ENDNOTES

1 Prepared by Richard Schwermer, National Center for State Courts consultant and retired Utah State Court Administrator under the auspices of the National Judicial Task Force to Examine State Courts' Response to Mental Illness (Task Force), established on March 30, 2020 by the Conference of Chief Justices and Conference of State Court Administrators. This brief summary includes a description of the Task Force membership and charge.

2 https://www.treatmentadvocacycenter.org/storage/documents/emptying-new-asylums.pdf These prevalence numbers have surely only increased as a result of the COVID-19 pandemic.

3 Different jurisdictions use different terms for these cases. Some call them Incompetent to Stand Trial (IST), some call them aid and assist cases, others refer to them as fitness to proceed, or by a procedural rule number or statutory reference. For purposes of this paper, we refer to them as Competency to Stand Trial (CST) cases. This frame recognizes that competency to stand trial relates to competency for criminal defendants and is distinct from competency to make personal or treatment decisions that might be heard in civil courts.

4 A summary of that focus group discussion can be found online here.

5 Participants included forensic psychiatrists, researchers, state mental health directors, prosecutors, defense counsel, advocates for people with mental illness, legislators, judges, and others.

6 CSG drew from an extensive inter-branch and interdisciplinary advisory group to describe competency to stand trial nationally and provide ten strategies for state policymakers. The report reflects a partnership of NCSC, the National Association of State Mental Health Program Directors, and the National Conference of State Legislatures, in addition to the project conveners, the Council of State Governments Justice Center and the American Psychiatric Association Foundation through the work of the Judges and Psychiatrists Leadership Initiative. This group represents the three-branch nature of this issue, of which the courts are a critical component.

7 West and Midwest Region summits, focused on behavioral health issues in the courts, were conducted prior to the formation of the Task Force; the remaining regional summits are scheduled to be held in 2021 and 2022.

8 Subcommittee members include: Judge James Bianco, Judge Matthew D'Emic, Travis Finck, Sim Gill, Dr. Debra Pinals, Walter Thompson, and Judge Nan Waller. Additional liaison members are Lisa Callahan, Hallie-Fader Towe, and Bonnie Hoffman.

9 Competence to Stand Trial was published in 2020 as part of the Interim Report to the Task Force

10 There is also a separate subcommittee of the Task Force focusing on diversion at all stages of the SIM, and those more comprehensive Diversion Subcommittee recommendations should be reviewed and adopted as well.

11 Some jurisdictions also require that the non-adherence to treatment has been demonstrated to contributed to re-hospitalizations and re-arrests.

12 Los Angeles County has an impressive community restoration program that utilizes dozens of neighborhood residential settings as locations for housing, treatment, and case management.

13 Distractions in Forensic Evaluations, http://jaapl.org/content/early/2019/05/16/JAAPL.003842-19

14 American Academy of Psychiatry and the Law, https://www.aapl.org/docs/pdf/Competence%20to%20Stand%20Trial.pdf

15 http://www.wsipp.wa.gov/ReportFile/1121/Wsipp_Standardizing-Protocolsfor-Treatment-to-Restore-Competency-to-Stand-Trial-Interventions-andClinically-Appropriate-Time-Periods_Full-Report.pdf

16 Oregon Advocacy Center v. Mink, 322 F.3d 1101 (9th Cir. 2003)

17 Unreasonable delays in the evaluation and restoration processes have been the impetus for lawsuits in at least a dozen states, and most if not all of them have resulted in findings of unlawful delay.

18 https://www.treatmentadvocacycenter.org/storage/documents/emptying-new-asylums.pdf

19 http://jaapl.org/content/35/4/481

20 Luxton and Lexcen (2018), Professional Psychology: Research and Practice Vol. 49, No. 2, 124-131, accessed at https://www.researchgate.net/publication/324488313_Forensic_competency_evaluations_via_videoconferencing_A_feasibility_review_and_best_practice_recommendations

21 Distractions in Forensic Evaluations, http://jaapl.org/content/early/2019/05/16/JAAPL.003842-19

[22] See e.g., Massachusetts Competency to Stand Trial Report Guidelines

[23] Some courts use existing Mental Health Court teams to manage competency cases.

[24] http://www.bazelon.org/wp-content/uploads/2019/09/Bazelon-Diversion-to-What-Essential-Services-Publication_September-2019.pdf

[25] https://store.samhsa.gov/product/data-collection-across-the-sequential-intercept-model-sim-essential-measures/PEP19-SIM-DATA

[26] https://www.ncsc.org/__data/assets/pdf_file/0019/38026/State_Court_Behavioral_Health_Data_Elements_Interim_Guide_Final.pdf

[27] GAINS/PRA workbook elements

[28] Task Force resources for leading this reform at the state and local levels, respectively, include Leading Change Guide for State Courts and Leading Change: Improving the Court and Community's Response to Mental Health and Co-Occurring Disorders

[29] Appendix A is a checklist for court leaders to use as a framework for beginning that pursuit.

[30] The Task Force resource, Leading Change for State Court Leaders provides an outline for leading broader behavioral health system change, and may be relevant for this narrower purpose as well

[31] Helpful resources include Crisis Services: Meeting Needs, Saving Lives and Roadmap to the Ideal Crisis System

[32] See Implementing Assisted Outpatient Treatment: Essential Elements, Building Blocks and Tips for Maximizing Results

STATE COURTS *LEADING CHANGE*

REPORT AND RECOMMENDATIONS

OCTOBER 2022

REVISED FEB 2023

National Judicial Task Force to Examine State Courts' Response to Mental Illness

Court leaders cannot solve the "chaos and heartbreak of mental health in America." Court leaders can, and must, however, address the impact of the broken mental health system on the nation's courts— especially in partnership with behavioral health systems. The broken system too often negatively impacts court cases involving those with mental illness, especially in competency proceedings, criminal and juvenile cases, civil commitment cases, guardianship proceedings for adults and juveniles, and family law cases. Each state court, as well as CCJ and COSCA, are urged to initiate a thorough examination of the mental health crisis and its impact on fair justice.

From the 2016-17 Policy Paper Adopted by CCJ/COSCA, "*Decriminalization of Mental Illness: Fixing a Broken System*". This work eventually led to the creation of the National Judicial Task Force.

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The Conferences of Chief Justices and State Court Administrators are deeply indebted to the Task Force members for their tireless effort, extraordinary contributions, and commitment to improving the responses of state courts and communities to individuals with serious mental illnesses. The members have each contributed their own special expertise and experience to the examination of our collective systems, the development of recommendations and resources, and provided leadership and guidance for the important work that is now underway.

Chief Justice Loretta A. Rush, President
Conference of Chief Justices

THE TASK FORCE

In March 2020, the Conference of Chief Justices and Conference of State Court Administrators established the National Judicial Task Force to Examine State Courts' Response to Mental Illness to "assist state courts in their efforts to more effectively respond to the needs of court-involved individuals with severe mental illness."

Task Force Co-Chairs

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Judith Harris (MD)
Joseph Homlar (CO)
Hon. Milton Mack (MI)
Hon. Kathleen Quigley (AZ)
Neira Siaperas (UT)
Hon. Sheldon Spotted Elk (CO)
Dr. Linda Teplin (IL)
Dr. Sarah Vinson (GA)

Education and Partnerships Work Group

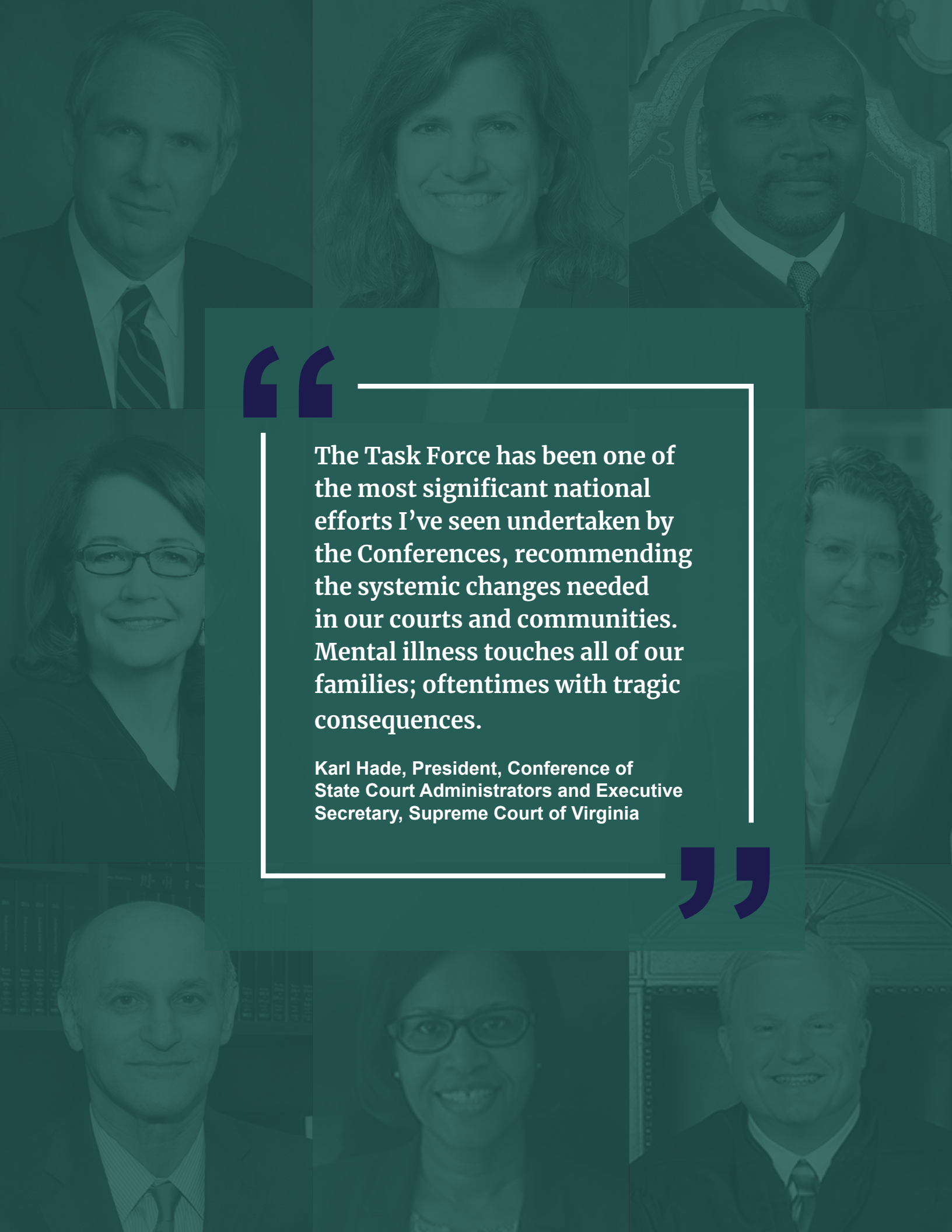
Co-Chairs:

Chief Justice
Loretta H. Rush (IN)

Marcia M. Meis (IL)

Members:

Hon. James Bianco (CA)
Janice Calvi-Ruimerman (CT)
Dr. Michael Champion (HI)
Paul DeLosh (VA)
Russell Deyo (NJ)
Sonja Gaines (TX)
Hon. Christopher Goff (IN)
Hon. Steve Leifman (FL)
Dr. Kenneth Minkoff (AZ)
Gary Raney (ID)
Hon. Kathryn Zenoff (IL)



> The Task Force has been one of the most significant national efforts I've seen undertaken by the Conferences, recommending the systemic changes needed in our courts and communities. Mental illness touches all of our families; oftentimes with tragic consequences.

Karl Hade, President, Conference of State Court Administrators and Executive Secretary, Supreme Court of Virginia

Introduction by the Task Force Co-Chairs

A Letter from Chief Justice Paul L. Reiber and Chief Administrative Judge Lawrence K. Marks

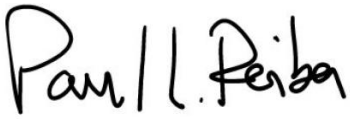
On March 30, 2020, the Conference of Chief Justices (CCJ) and Conference of State Court Administrators (COSCA) established the National Judicial Task Force to Examine State Courts' Responses to Mental Illness (Task Force). We have been honored to serve as the Task Force Co-Chairs. With the support of the National Center for State Courts and funding from the State Justice Institute, the Task Force engaged in research, developed tools and resources, delivered training, education and technical assistance, and developed best practice and policy recommendations for courts and communities.

The prevalence of mental illness in the United States has an enormous impact on states and communities and a disproportionate impact on our state and local courts. ***According to the National Institute of Mental Health, nearly one in five U.S. adults live with a mental illness – over 50 million in 2020 – and over 13 million adults live with serious mental illness****. For too many individuals with serious mental illness, substance use disorder, or both, the justice system is the de facto entry point for obtaining treatment and services. There are many causes, not the least of which is the criminalization of mental illness and the lack of alternative approaches and resources to support the diversion of individuals from the courts and into treatment.*

People with mental illnesses in the U.S. are 10 times more likely to be incarcerated than they are to be hospitalized*. Every year, approximately 2 million arrests are made of people with serious mental illnesses.* ***As a result, more than 70 percent of people in American jails and prisons have at least one diagnosed mental illness or substance use disorder, or both****. Up to a third of those incarcerated have serious mental illnesses, a much higher rate than is found at large. On any given day, approximately 380,000 people with mental illnesses are in jail or prison across the U.S., and another 574,000 are under some form of correctional supervision.*

And this is not just a criminal justice issue. The needs of adults, children, and families impacted by serious mental illness touch every aspect of the court system, including civil, probate, domestic relations, guardianship, juvenile, and child welfare cases. While the statistics can be overwhelming and the challenges immense, a national focus on the problems has created great momentum for change. A ***Resolution*** *recently adopted unanimously by CCJ and COSCA states that while "many courts have implemented successful programs, improved court practices and procedures, and initiated significant reform, there is still a need and responsibility for all state and local courts to lead and promote systemic change in the ways that courts and communities respond to individuals with serious mental illness...."*

In July 2022, after almost three years of effort, the Task Force adopted its ***Findings and Recommendations*** *to be used by state and local court leaders in their efforts to examine and address the changes that are needed. These recommendations have now been endorsed by CCJ and COSCA. This report reviews the highlights of the work of the Task Force, provides examples of successful programs from across the nation, and shares the recommendations for change that call for action by all state and local court leaders, behavioral health and other community partners, and other state and federal agencies as we work together and more effectively to meet the needs of justice-involved individuals with serious mental illness.*



Chief Justice Paul L. Reiber
Supreme Court of Vermont
Task Force Co-Chair

Chief Administrative Judge Lawrence K. Marks
New York State Unified Court System
Task Force Co-Chair

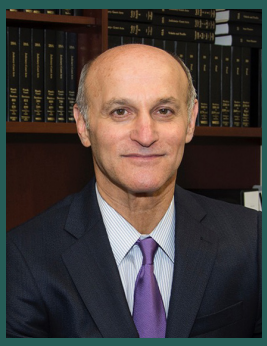
Task Force Executive Committee

Hon. Paul L. Reiber (VT)

Hon. Robert M. Brutinel (AZ)

Hon. Richard A. Robinson (CT)

Hon. Loretta A. Rush (IN)



Hon. Lawrence K. Marks (NY)

Nancy J. Cozine (OR)

Tonnya K. Kohn (SC)

Marcia M. Meis (IL)

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Bev Hanson
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Executive Sponsor

Task Force Highlights

The Task Force Executive Committee, comprised of Chief Justices and State Court Administrators, was appointed and began its work in May 2020. The first meeting of all the members of the Task Force, conducted virtually, took place the following September. Guided by the Executive Committee, members were divided into three Work Groups and, over the next two years, met regularly to collect, examine, and analyze information, discuss and debate the best responses, and develop tools and resources to be used to lead and guide system improvements. It is notable that almost all of this work occurred during a world-wide pandemic. Only one face-to-face meeting of the Task Force occurred, hosted in March 2022 in Miami, Florida. Following are a few of the highlights of Task Force activities.

TASK FORCE HIGHLIGHT

CCJ-COSCA Regional Summits Held to Improve the Court and Community Response to Mental Illness

Of all of the Task Force activities, the sponsorship of five regional summits and subsequent support to state action plans created as a result may be the most far-reaching and impactful.

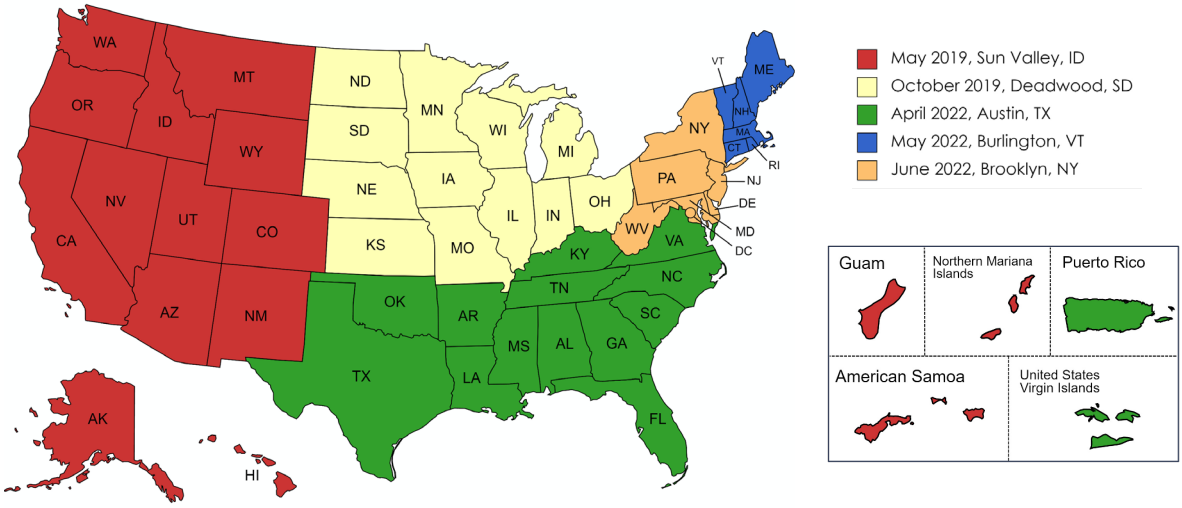
From west to east, five multi-day summits utilizing the framework of CCJ/COSCA Regions were hosted by the Task Force. In 2019, teams from the states in the Western Region met in Sun Valley, Idaho, followed by a meeting of the Midwest Region in Deadwood, South Dakota. After pandemic-related delays, states from the remaining three regions gathered in 2022 in Austin, Texas, Burlington, Vermont, and Brooklyn, New York. Each of the summits featured prestigious national and regional speakers who addressed critical issues found at the intersection of state courts, communities, and behavioral health. Chief Justices and State Court Administrators selected and led the multi-disciplinary team from their state where opportunities for the state teams to meet and identify their state priorities were provided. The State Justice Institute generously provided funds to support the state teams in the implementation of the priorities that they identified.

Miami Judge Steve Leifman, a member of the Task Force, provides opening remarks during the Mid-Atlantic Regional Summit in Brooklyn, New York.

Tonnya Kohn comments about her participation in the Southern Regional Task Force Summit: *"The biggest benefit is communication and collaboration across states and within our states. Many of us have never worked with the state department of mental health or local officials who are involved in the mental health arena."*

In all, teams from 45 states and territories attended the summits, and 36 states requested and are receiving technical assistance from the National Center for State Courts to conduct system assessments, plan state summits, organize mental health commissions or task forces, interview key stakeholders, recruit statewide behavioral health administrators, plan statewide judicial mental health training sessions, conduct sequential intercept and leading change mappings, attend national workshops in Miami, Florida or Tucson, Arizona, or address other priorities identified by summit participants.

Regional Mental Health Summits



45 states and territories attended one of the Summits, and 36 state courts received SJI funding to accomplish their state team priorities.

TASK FORCE HIGHLIGHT

Collaboration and Work with SAMHSA Makes a Difference

The Task Force established a significant and enduring relationship with the Substance Abuse and Mental Health Services Administration (SAMHSA) of the Department of Health and Human Services. In July 2021, SAMHSA and the Task Force released a **Joint Statement of Commitment to Continuing Cooperation | NCSC** that recognized the critical role state courts play in responding to justice-involved individuals living with a serious mental illness (SMI) or a substance use disorder (SUD). SAMHSA, CCJ, and COSCA committed to work in partnership with other state and national leaders to lead systemic change and promote systemic innovation.

During 2020, a series of virtual meetings were hosted in each of the 10 SAMHSA Regions, led by a member of the Task Force and the SAMHSA Regional Administrator. The calls included the Chief Justices, State Court Administrators, and Behavioral Health Directors of each state and were designed to strengthen the connection, communication, and relationship between state judicial and executive branch leaders.

These meetings highlighted the common challenges that face court and behavioral health leaders in every state and confirmed the need for more effective partnerships. They also

> *This partnership presents a unique opportunity to advance transformative work through collaboration between behavioral health and justice leaders. SAMHSA knows that judges and courts can be catalysts in helping to solve this challenge by leveraging their ability to convene broad-based stakeholder groups to influence and drive systems change. And by working together across mental health and criminal justice systems, we can improve the care and experiences of some of society's most vulnerable members and advance the cause of justice.*

CAPT. Jeffrey A. Coady, Psy.D., ABPP, SAMHSA Region 5 Administrator

Remarks during the 2022 Annual Meeting of CCJ/COSCA

demonstrated the importance of joint leadership in addressing the problem with chief justices, state court administrators, SAMHSA and regional and state behavioral health leaders working together to find solutions to a deep and pressing need.

In July 2022, the Assistant Secretary for Mental Health and Substance Use, Dr. Miriam E. Delphin-Rittmon, communicated with all Behavioral Health Authorities nationwide, stressing the importance of working with state courts and local judicial and criminal justice systems to ensure comprehensive coordination of services and outcomes, with a particular focus on health disparities and inequities. SAMHSA proposed questions to be added to the FY 2024-2025 Block Grant application guidance documents to learn more about how state behavioral health authorities are coordinating and partnering with their state courts and justice systems.

Tom Coderre, then Acting Assistant Secretary of SAMHSA, with Task Force Co-Chairs Paul Reiber and Lawrence Marks during the 2021 CCJ-COSCA Annual Meeting in Williamsburg, Virginia, following the announcement of the Joint Statement between SAMHSA and the Task Force.

TASK FORCE HIGHLIGHT

Outreach with Other Agencies and Organizations

A commitment to learn from and collaborate and work with other national organizations and partners also engaged in this common effort was a fundamental principle of the Task Force. A series of convenings was held to build a network of partner organizations and liaisons to identify common goals, available resources, and opportunities for collaboration, all for the purpose of maximizing resources and avoiding duplication of effort. Future implementation of the Task Force recommendations will require the sustained commitment of this extraordinary collaborative effort.

The National Association of Counties (NACo) adopted a resolution at its 2022 annual meeting supporting the Task Force Recommendations found in this report. The Task Force also adopted a resolution in support of several NACo initiatives, including their work to 1) support the Stepping Up Initiative to reduce the number of individuals with behavioral health challenges in jails, 2) increase communication and collaboration between local courts and county officials, 3) support and partner with NACo's Opioid Solutions Center, and 4) foster state court collaboration with state associations of counties to develop coordinated approaches to the use of local opioid settlement funding.

As part of its outreach activities, Task Force members presented information about activities and recommendations to multiple national organizations. Here, Indiana Associate Justice Christopher Goff addresses the National Association of Counties.

Impressive work related to the needs of individuals with serious mental illness is being done by many organizations across the country. A network of partner organizations was created through the Task Force sponsorship of a series of "convenings." Participating organizations included:

ABA Criminal Justice and Mental Health Committee

Center for Court Innovation

Corporation for Supportive Housing

Council of State Governments Justice Center

Council on Criminal Justice

Group for the Advancement of Psychiatry

Judges and Psychiatrists Leadership Initiative

Matthew Ornstein Memorial Foundation

Mental Health Policy Institute

Mental Health Colorado/Equitas Foundation

National Association of Counties

National Association of Drug Court Professionals

National Association of State Mental Health Program Directors

National Conference of State Legislatures

National Governors Association

Pew Foundation

Philanthropy Roundtable

S2i Mental Health Strategic Impact Initiative - New York University Furman Center

Sozosei Foundation

State Justice Institute

American Psychiatric Association Foundation

American Psychological Association

Black Psychiatrists of America

California Judicial Council

Mental Health America

National Alliance on Mental Illness

National Association of Black Social Workers, Inc.

National Council of Behavioral Health

The Association of Black Psychologists, Inc.

Recommendations

TASK FORCE RECOMMENDATION

State and Trial Courts Leading Change

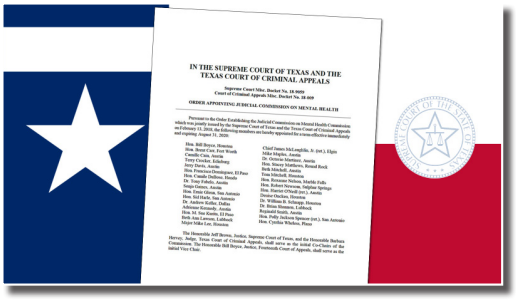
Coordination between the behavioral health and justice systems in states and communities is often lacking and ineffective in providing care that reduces recidivism and improves public safety and treatment outcomes. On state and local levels, behavioral health and justice system stakeholders and community leaders must come together to examine their systems and community resources to determine the best path forward to provide the best care and responses to individuals with mental illness. Judges are in a unique position to lead this change.

Recommendation

State-Level Commissions, Task Forces, and Work Groups provide a solid foundation for systemic change and improving responses to individuals with behavioral health needs. CCJ and COSCA should lead the establishment of state-level, three-branch, multidisciplinary task forces to promote systemic changes necessary to improve the court and community responses to mental illness.

CCJ and COSCA members should utilize the **Leading Change Guide for State Court Leaders** that outlines the steps that each state court should take, community by community, to develop the systemic changes necessary to improve justice system responses to children, youth, and adults with behavioral health disorders.

> *The goal to move from a few local successes to a broader national effort for a more effective justice system response was significantly advanced when the members of CCJ and COSCA adopted Resolution 1 and committed to take specific action in every state and territory. We each agreed to lead the efforts in our state to create a state-level, inter-branch mental health task force, support the creation of local or regional task forces, appoint a behavioral health director and team within the Administrative Office of the Courts to develop and lead improved behavioral health responses, and undertake a comprehensive assessment of our court systems. The CCJ/COSCA Behavioral Health Committee will lead the way as we measure our progress for action in every jurisdiction.*
>
> **Nancy J. Cozine, State Court Administrator, Oregon**



The Supreme Court of Texas and the Texas Court of Criminal Appeals formally created a Judicial Commission on Mental Health.

Kansas Chief Justice Marla Luckert opens the Kansas Mental Health Summit, involving the leadership from all three branches of government. In many states, chief justices and state court administrators hosted a summit as a way to focus on SMI and the development of improved court and community responses.

Shortly after engaging in the work of the National Task Force, it became clear to me that if the state courts were to meet this challenge in a meaningful way, a dedicated voice and primary resource employed within the AOC and committed to furthering behavioral health and justice initiatives would be incredibly advantageous. This realization led to the establishment of statewide behavioral health administrator positions within the AOC in Kentucky, Illinois and other states. In Illinois, this position now serves as the project director for the statewide Illinois Mental Health Task Force, provides behavioral health-related administrative support and technical assistance to the Illinois Supreme Court, Illinois Trial Courts, the AOIC, and acts as liaison to local, state and national behavioral health and justice affiliates and organizations.

Marcia Meis, Director Administrative Office of the Illinois Courts

The Massachusetts Trial Court has developed an innovative project designed to facilitate community collaborations, improve the use and availability of behavioral health services, and reduce the risk of justice involvement. The backbone of the project is the use of the Sequential Intercept Model. The model provides a visual outline that communities can use to analyze each intercept and develop a comprehensive picture of local resources, as well as gaps in processes, programs and services. Judges in our local courts are uniquely positioned to bring all of the important stakeholders to the table.

Former Chief Justice and Task Force member Paula Carey, MA

TASK FORCE RECOMMENDATION

Deflection and Diversion to Treatment

The funding and availability of effective behavioral health treatment accessible to individuals with behavioral health disorders are inadequate in many communities, including insufficient programs, services, and alternatives other than the criminal justice system. All too often, the criminal system is a path of first instead of last resort to access care. A continuum of behavioral health programs, services, and alternatives must be available in the community to prevent individuals with mental illness from entering the criminal justice system, and when appropriate, if criminal justice involvement occurs, deflect and divert to treatment and care as soon as possible.

> *CCJ and COSCA...urge each member to...support state and community efforts to utilize a public health model rather than a criminal justice approach to guide behavioral health policies, practices, and funding...to deflect or divert cases...from the court system and into treatment.*
>
> **CCJ-COSCA Resolution 1, 2022**

Recommendation

Courts should examine the continuum of behavioral health deflection and diversion options available in each community and examine the Task Force **National Diversion Landscape** and other Task Force resources to, where appropriate, promote deflection and diversion to treatment options at the earliest point possible.

All judges should exercise leadership to expand and improve responses to individuals with mental illness across the continuum of behavioral health diversion. While states and communities provide several types of behavioral health resources and services, it is essential that each community strives for and has available a more complete range of programs.

This continuum of care in communities must include a robust set of services and deflection and diversion opportunities that meet the needs of individuals with behavioral health disorders whether through the behavioral health system, the behavioral health crisis system, pre-arrest deflection and diversion, pre-adjudication diversion, or post-adjudication diversion.

The three most important things that courts can do are 1. Divert, 2. Divert, and 3. Divert!

Dr. Kenneth Minkoff, commenting during the meeting of the Task Force in Miami, Florida

'Someone to call, someone to respond, somewhere to go.' The implementation of 988 is a watershed moment in appropriate community responses moving from a criminal justice model to a public health model. And courts need to be at the table.

Indiana Supreme Court Associate Justice Christopher Goff

Reform should begin by tackling mental and substance-use disorders not as criminal behavior but as illnesses. Arrest and incarceration should be the very last resort for people with serious behavioral health issues. We need to apply a public-health model to the criminal justice system, rather than a criminal justice model to the behavioral health system.

Norm Ornstein and Steve Leifman from their article, "Locking People Up Is No Way to Treat Mental Illness"

TASK FORCE RECOMMENDATION

Reforming the Competency to Stand Trial System

Large numbers of defendants, including many who are charged with misdemeanors or non-violent felonies, spend excessive time in jail awaiting mental health evaluations and competency restoration, often staying longer in custody than they would have if they had been convicted of the crime, creating unnecessary cost that could be reinvested in community treatment. Those that then go through a restoration process often emerge legally competent, but remain untreated, and are returned to their communities with a poor prognosis for the future.

Recommendation

Courts and communities should reserve the competency process, including evaluation of competence to stand trial, for defendants who are charged with serious crimes. Others, especially individuals charged with misdemeanors and assessed as low risk to recidivate and whose clinical conditions are not likely to substantially improve (e.g., individuals with dementia) should be diverted to treatment.

Courts should consider the creation of competency dockets that facilitate access to appropriate diversion and outpatient restoration resources for cases involving competency. Courts should actively manage the progress of a competency case to avoid an individual languishing in jail and decompensating. Hearings should be scheduled and held without delay at every juncture.

In 2021, the Task Force published a comprehensive report on the problems with and changes needed in the competency to stand trial system. All courts are urged to use Leading Reform: Competence to Stand Trial Systems and other resources developed by the Task Force to gain a clear understanding of current system gaps, strengths, and weaknesses as measured against these recommendations.


NATIONAL JUDICIAL TASK FORCE TO EXAMINE STATE COURTS' RESPONSE TO MENTAL ILLNESS

Leading Reform:
Competence to Stand Trial Systems
A Resource for State Courts[1]

August 2021 v2

THE ISSUE

BACKGROUND

Use of the Competency Process Should Be Limited and the Restoration Process Should Be Improved

- Encourage development of restoration sites other than institutional settings such as state hospitals and jails;
- Create and promote a presumption of *outpatient* restoration;
- Encourage video evaluations when appropriate;
- Implement specialized competency dockets;
- Ensure timely commencement of restoration services;
- Actively monitor restoration progress, with appropriate timelines;
- Discourage jail restoration;
- Replace legal education with treatment as the primary focus of restoration efforts;
- Create dedicated case management resources.

There is so much work to be done to help improve outcomes for people with mental illness before the courts. To achieve the best results, partnerships are necessary. The Task Force efforts represent a critical national effort demonstrating the convening powers of the courts, while incorporating input of thought leaders across all branches of government, with recommendations that will help shape improved outcomes for years to come.

Dr. Debra Pinals, Medical Director,
Behavioral Health and Forensic Programs,
Michigan Department of Health and Human Services

There are days when it feels like I am presiding over dockets of despair – very mentally ill people in the criminal justice system who too often are met by closed doors at every turn. Their families are worn out by the lack of services available. Community programs reject them as too difficult or risky. The public is frustrated and wants these individuals off the sidewalks, out of sight, and out of mind. Sometimes, the only door open to them is the door to the jail. When that happens the competency system often comes into play. Too often as a judge, I too am met with closed doors in the search for the placement and services that will allow them relief from their mental illness and to be restored to competency. At the end of the day, it is cold comfort when the only thing I have to offer is a moment of compassion.

Task Force Member Judge Nan Waller, Multnomah County, Oregon

The dashboard was developed to provide a way for the Oregon Judicial Department and individual courts to track the status of aid and assist caseloads and work with system partners to identify areas for improvement and change in the competency system at the state and local level.

My son was caged in a rural jail without treatment for 55 days awaiting a bed at a state hospital. What started over a hamburger and french fries resulted in my son being trapped in a barbaric, inhumane and unconstitutional behavioral health and criminal justice system for 25 months, and the journey continues today.

A Mom

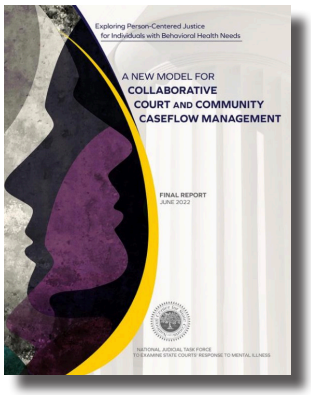
TASK FORCE RECOMMENDATION

Court and Community Collaboration: Person-Centered Justice

Current state court caseflow management practices are not designed to address the behavioral health needs of individuals. Individuals with serious mental illnesses are languishing in jails as a result of case backlogs, exacerbated by the pandemic, and a lack of community-based alternatives and supports.

Recommendation

Courts should establish case management best practices regarding cases with persons with behavioral health issues, including the effective triage of cases. Courts should examine the **New Model for Collaborative Court and Community Caseflow Management**, which explores person-centered justice for individuals with behavioral health needs. This new collaborative approach is necessary to ensure public safety, control costs, and create fair and effective criminal justice and case management systems, tasks made more urgent by the pandemic and the resulting case backlogs.



Traditional criminal case processes are not working to keep our communities safe, or improving outcomes for individuals with behavioral health conditions. The Task Force adopted a new model for person-centered justice, which provides a comprehensive, collaborative approach to reduce recidivism and control costs.

> ***Every day, mental health and substance use conditions experienced by so many Americans can have even harder impacts on those who are involved with the justice system. Collaborating with state courts to help individuals access effective treatments in correctional facilities is an important and timely strategy for helping to address the nation's behavioral health crisis.***
>
> **Miriam E. Delphin-Rittmon, Ph.D., HHS Assistant Secretary for Mental Health and Substance Use and the leader of SAMHSA**

Built on four pillars, the New Model for Collaborative Court and Community Caseflow Management promotes justice, safety and health. Each pillar is strengthened by essential elements and best practices.

> *Moving forward, we need to foster new collaborations among our criminal justice, family justice, and health care systems. Certified Community Behavioral Health Clinics have a critical part in achieving these goals by linking participants with community services and treatment providers.*
>
> **Hon. Lawrence K. Marks, Chief Administrative Judge, New York**

> *Every jail in America is struggling with how to manage mental illness in their population. Jail leaders and judges must step forward, bring stakeholders together, identify options and agree upon solutions that keep our communities safer and promote early intervention and effective management of court cases.*
>
> **Task Force Member and Retired Sheriff Gary Raney, Ada County, Idaho**

The Task Force developed multiple resources to support improvements to caseflow management practices including **diversion pathways**, **civil responses**, **competency dockets**, **specialized behavioral health dockets**, **courtroom practices**, **treatment courts**, and **other pathways and strategies that lead to treatment and recovery**.

TASK FORCE RECOMMENDATION

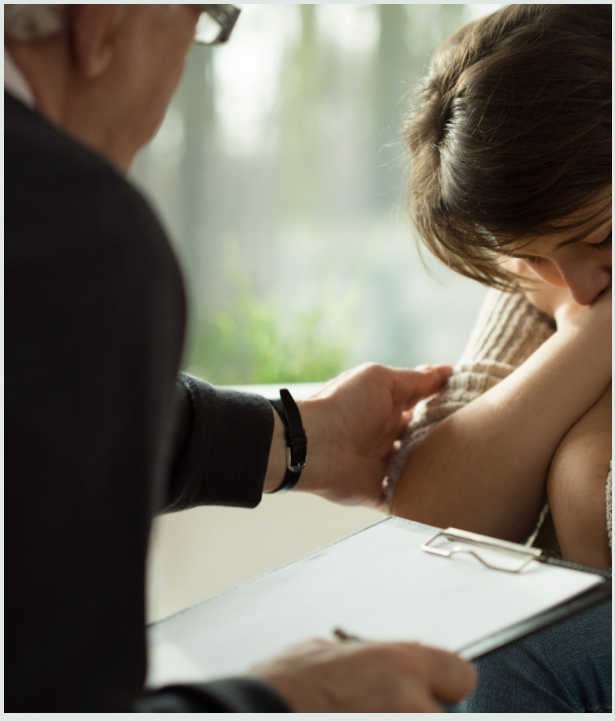
Changing the Law and Process for Civil Commitment

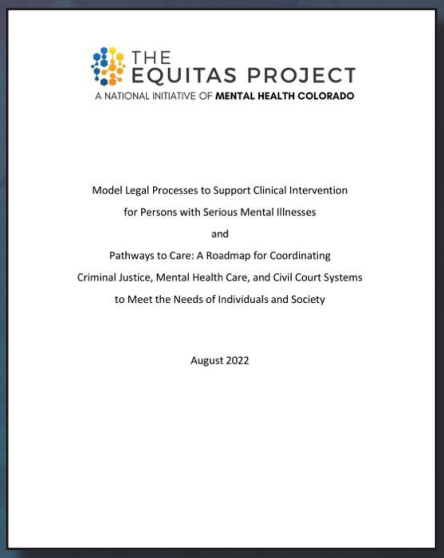
Most state laws for the involuntary commitment of persons with mental illnesses in existence today were adopted in the 1970s. As part of an effort to deinstitutionalize the treatment of mental illness, this generation of statutes favored "dangerousness" standards and individual rights-oriented court processes for involuntary treatment. As a result, in many states today, individuals with mental illnesses who do not clearly present an imminent risk of harm may not be subject to involuntary treatment. If there are no other pathways to treatment, these persons are more likely to experience homelessness, poverty, serious health consequences, and involvement in the criminal justice system.

Recommendation

Courts should develop and provide multiple civil court options that are easily accessible by individuals, families, and behavioral health systems. Courts have a central role in ensuring that these responses appropriately balance individual autonomy and choice in compelled treatment with the state's *parens patriae* interest and public safety.

Hospital stays for serious mental illness are too short and do not provide the time or support to promote recovery. Most mental health treatment is appropriately provided in the community. Courts should order that involuntary treatment be provided in an outpatient setting unless outpatient treatment will not provide reasonable assurances for the safety of the individual or others or would not meet the person's treatment needs.





A blue ribbon workgroup, including several members of the Task Force, was formed in 2019 for the purpose of writing a model civil and criminal mental health law. The group aimed to produce legislative language reflective of cutting-edge brain and behavior research, the civil liberties and patient-rights advocacy of consumers and families, and health provider and public safety innovations and efficiencies. The group included nationally recognized experts in mental health law, psychiatry, and advocacy. Their goal to create a model law that provides for least restrictive involuntary commitment (inpatient and outpatient), and for civil and criminal approaches to optimizing individual health outcomes, defending civil liberties, and preserving public safety, has been endorsed by the Task Force.

> *Arizona's Judicial Branch has already directed that the Equitas Report, endorsed by the National Judicial Task Force, serve as a model for Arizona as we examine our civil court ordered treatment statutes and rules. We are grateful to the many experts who worked tirelessly to craft these recommendations.*
>
> **Task Force Member and Arizona Chief Justice Robert M. Brutinel**

> *The existing legal framework for addressing mental illness is an inpatient model in an outpatient world, because its focus is on hospitalization. By promoting earlier intervention and making outpatient treatment the presumptive course of treatment, we are finally converting our system to an outpatient model in an outpatient world.*
>
> **Task Force Member Hon. Milt Mack,**
> **Michigan State Court Administrator Emeritus**

TASK FORCE RECOMMENDATION

Children, Youth, and Families

It is not just a criminal justice issue. The needs of adults, children, and families impacted by serious mental illness touch every aspect of the court system, including child welfare, juvenile, and domestic relations cases. Courts must examine, educate, and advocate for better ways to meet the needs of individuals who enter the justice system and how better to coordinate multiple courts and responses to make a more person-centered system.

Recommendation

CHILD WELFARE

Courts should examine **Upstream** and other Task Force **resources** to ensure a continuum of behavioral health practices and improve outcomes for children and families with behavioral health needs. State and local courts should use Upstream as a framework to coordinate and align efforts across the child welfare system to promote safe and healthy families and communities and map community resources and opportunities.

> *Courts have long worked with our system partners and the community to find ways to address the mental health needs of children and their parents who touch the court system... We have all seen a dramatic increase in the number of individuals who are experiencing challenges with their mental health, and the complexity of the issues has intensified... I strongly recommend to child welfare courts and their communities the NCSC's Upstream strategy. This preventative, community-based approach coordinates and leverages court and community resources through community mapping to develop more robust intervention and prevention opportunities. The collaboration during the Upstream approach is powerful. When services are identified and the gaps filled, the social determinants of health for individuals and the community will greatly improve.*
>
> **Task Force Member Judge Kathleen Quigley, Arizona**

School Justice Partnerships are perhaps the most critical components in our efforts to reduce youths' contact with the juvenile justice system. We know that exclusionary school discipline often leads to juvenile court referrals and that contact with the juvenile justice system increases the likelihood of recidivism and other negative outcomes for youth. Keeping kids in school and out of the justice system requires relentless and ongoing commitment by community stakeholders involved in School Justice Partnerships.

Task Force Member
Neira Siaperas,
Utah Administrative Office of the Courts

Recommendation

JUVENILE JUSTICE

Courts should lead efforts to divert youth with mental health needs from juvenile justice involvement, when appropriate. Courts should examine **Mental Health Diversion** and Task Force **resources** to support opportunities for youth with mental health diagnoses to be diverted away from deeper involvement with the justice system at multiple points of contact, such as at school when contacted by law enforcement, referral, pre-petition, detention, and pre-adjudication.

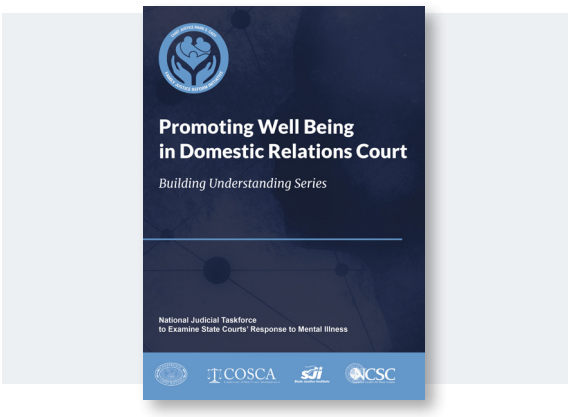
The juvenile mental health guidelines were created to streamline early identification of behavioral health issues. Coupled with a trauma-informed approach, the guidelines help ensure appropriate treatments and assistance are provided on an individual basis. By applying the guidelines, juvenile courts can redirect youth to the appropriate system and reduce youth involvement in the justice system.

Task Force Member
Judge Teresa Dellick, Ohio

Recommendation

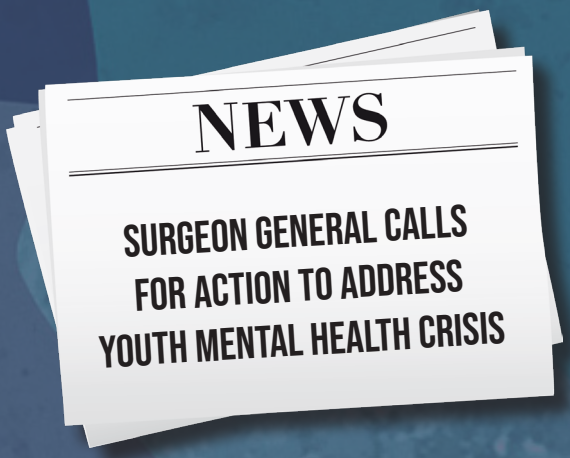
DOMESTIC RELATIONS

Courts must promote the well-being of individuals and families, including implementation of trauma-responsiveness for families, throughout the life of their case and the primary desired outcome, utilizing the Understanding Series and other Task Force **resources**.



Understanding Well-Being – the Understanding Series provides a wonderful foundation for all judges, attorneys, and court personnel when dealing with the well-being of individuals and families in divorce, dissolution or child custody cases.

Task Force Member Dr. Sarah Vinson presents at the Southern Regional Summit about childhood trauma and leads a panel about using social and structural context to understand the mental illness and justice interface.



U.S. Surgeon General Vivek H. Murthy, M.D., M.B.A., issued a rare public health advisory in December 2021, calling on the nation to respond to the growing mental health crisis impacting young people that has worsened with the pandemic.

TASK FORCE RECOMMENDATION

All Judges and Court Professionals Trained, Educated, and Trauma-Informed

There is a lack of education and training for state court judges and court professionals necessary to equip them with the knowledge, data, research, and resources they need to improve the state courts' response to court-involved individuals with mental illness. Judges and court personnel are not trained in mental health conditions, substance use disorders, or co-occurring disorders, nor are they trained in the pervasiveness of trauma and how to be trauma responsive. They lack understanding and knowledge about how behavioral health needs impact all court dockets, ways that judges can improve outcomes for individuals with behavioral health needs while improving public safety, and the unique role of a judge as a leader for positive change.

Recommendation

All judges, court personnel, and justice system partners should be provided collaborative ongoing training and education across all case types utilizing **Task Force Education** resources, including **Trauma and Trauma-Informed Responses**, the **Behavioral Health Resource Hub**, **Behavioral Health Alerts**, and other national educational offerings. A broad array of specific topics, as identified in the CCJ/COSCA **Resolution**, must be included in ongoing training curricula as well as for new judges and new court personnel.

> *The Task Force and the Judges and Psychiatrists Leadership Initiative (JPLI) share a belief in the importance of judicial education to achieve a better understanding of behavioral health needs. Only with that education and specialized knowledge imparted by teams of judges and psychiatrists can we serve as catalysts for meaningful change in our communities and at the state and national levels.*
>
> **Task Force Member Hon. Katherine Zenoff, Illinois Appellate Court, Co-Chair, JPLI**

In Hawaii, Chief Justice Mark E. Recktenwald has supported the use of curriculum developed in partnership between the Task Force and the Judges and Psychiatrists Leadership Initiative. Efforts are underway to train judge-psychiatrist teams in every state to be available for judicial education programs.

> *The National Association for Court Management's (NACM) support of the National Judicial Task Force emphasized the need for court leaders to address the impact of mental health system challenges on the judicial system through coordinated efforts among behavioral health systems and the greater community. The NACM Behavioral Health Guide, Court Leaders Advantage 5-part Podcast series, and conference educational programming underscore the importance of developing statewide multi-branch commissions, committees, or task forces focused on this issue while encouraging all state and local courts to lead and promote systemic change in the ways courts and communities respond to individuals with serious mental illness.*
>
> **Task Force Member and Past NACM President, Paul Delosh, Virginia**

The Task Force website **www.ncsc.org/behavioralhealth** includes an array of training modules and podcasts on behavioral health and the courts. Efforts are also underway to provide adolescent brain development training for juvenile judges through the **ECHO model**.

TASK FORCE RECOMMENDATION

Behavioral Health and Equity

Ample evidence points to the inequities that exist in access to treatment, misdiagnoses for marginalized populations, an over-representation of minority communities in the justice system, and a lack of behavioral health providers of color. Treatment rates are the lowest for Black, Indigenous, and people of color (BIPOC).

Recommendation

Courts should develop and adopt a Behavioral Health and Equity statement as it relates to children, youth, and adults with behavioral health conditions and identify and implement evidence-based practices to ensure diversity, equity, and inclusion across all programs and processes.

Courts should examine the disproportionate impact of behavioral health conditions and associated demographics such as race on the over-representation of individuals who enter the justice system and ensure that interventions, diversion systems, specialized dockets, and other programming are equitably applied.

Courts should actively collect and review **race and ethnicity data** in order to identify inequitable practices and to monitor progress in achieving equity. This analysis should extend to diversion to treatment placements.

> *It is imperative that court systems actively engage in all of the issues surrounding behavioral health equity with a focus on person centered justice and cultural humility. It is not only more humane but will make behavioral health and court systems more effective and efficient.*
>
> **Task Force Members Dr. Michael Champion and Chief Justice Paula Carey**

At the Mid-Atlantic Regional Task Force Summit, Norm Ornstein interviews Miami Heat player Udonis Haslem about his organization and its mission to address the mental health crisis that exists in poor and underserved communities.

The Task Force heard, in one of its many **convenings**, about the pervasive impact of racism that contributes to the over-representation of black and brown people in the justice system, the impact of having only a small number of mental health professionals of color, the importance of infusing cultural values into community systems, and the reliance on psychological tests that may not have been validated for use with persons of color.

TASK FORCE RECOMMENDATION

Peers, Individuals with Lived Experience, and Families

Too often the voices of families and individuals with lived experience are left out of implementation and improvement efforts, and our responses suffer as a result.

Recommendation

Courts should create opportunities to listen to and gather input from individuals with lived experience and their families in all efforts to improve court and community responses.

A choir of voices and perspectives is needed in every effort to improve court and community responses to individuals with serious mental illnesses.

Courts should examine **Peers in Courts** to learn about strategies for the use of peers in court settings and other SAMHSA resources available to support these efforts. Courts should encourage the integration of trained peers at all appropriate points in the treatment, case management, and justice processes including hiring trained peers in their programs, services, and operations to improve the responses for individuals with behavioral health needs. Courts should promote and support the certification and education of peers.

> ***Every court participant has different situations and circumstances, but they all have to be treated with love and kindness. This starts their recovery.***
>
> **Task Force Member**
> **Walter Thompson, Peer Support Specialist, Florida Criminal Mental Health Project, the Eleventh Judicial Circuit Miami-Dade County**

Nothing about us, without us!

When our son was 23 years old he was diagnosed with schizoaffective disorder… He ended up getting arrested. That could have been the beginning of a horrible story for all of us but, in the end, it was one of the best things that ever happened. That's because his contact with the criminal justice system was overseen by a superior court judge who had incredible foresight. Through the efforts of this judge we were able to get our son into treatment programs and he was able, not only to survive, but to thrive… I imagine what could have happened. My son was lucky. *But it shouldn't be luck that the justice system helps rather than destroys your life*… Our goal should be to direct all of these cases, like my son's, away from the criminal justice system and toward the mental health treatment that they need.

Connecticut Supreme Court Chief Justice, Richard A. Robinson, remarks shared during the 2022 Annual Meeting of CCJ/COSCA

TASK FORCE RECOMMENDATION

Well-Being of Judges and Court Personnel

Sixty-three percent of judges have at least one symptom of secondary or vicarious trauma and 50% of court child protection staff experience high or very high levels of compassion fatigue. Daily interactions with individuals, children, and families who are reliving trauma takes an emotional toll on justice system practitioners and places them at high risk for experiencing secondary trauma.

Recommendation

Courts should examine **Task Force resources** on the well-being of judges and court personnel that provide guidance, best practices, tips, and support for mental health. Courts should engage in an **organizational assessment** to gauge the strengths and gaps across areas of workplace mental health including leadership, access, culture, and awareness. Courts should promote best practices in the workplace including communicating effectively about employee assistance programs (EAP), lawyer assistance programs (LAP), and educational resources.

Courts should implement secondary trauma prevention and intervention strategies, including adopting policies that promote self-care, ensuring a safe work environment, providing secondary trauma education, establishing peer-mentoring programs, offering supportive services, and setting manageable work and caseload expectations.

Pilot efforts are underway with courts in four states- Arizona, Illinois, Indiana, and Massachusetts – working with One Mind at Work to develop mentally healthy court workplaces.

The Institute for Well-Being in the Law (I-WIL) is testing a self-assessment for judges on depression, anxiety, burnout, and secondary trauma and another instrument for state court leadership to administer on behalf of the judicial branch to assess the mental health and well-being needs of the judiciary overall. Both instruments are intended to provide strategies that might address the recommended responses.

> *Judges and court personnel need mental health and well-being support because of the high stress and trauma-inducing critical public service they provide. A valuable collateral benefit of such self-care is a deeper understanding of and greater empathy for the many individuals with mental illness served by them in our court systems.*
>
> **Task Force Member Russell Deyo, New Jersey**

TASK FORCE RECOMMENDATION

Key Questions All Courts Must Ask – Data and Information Sharing

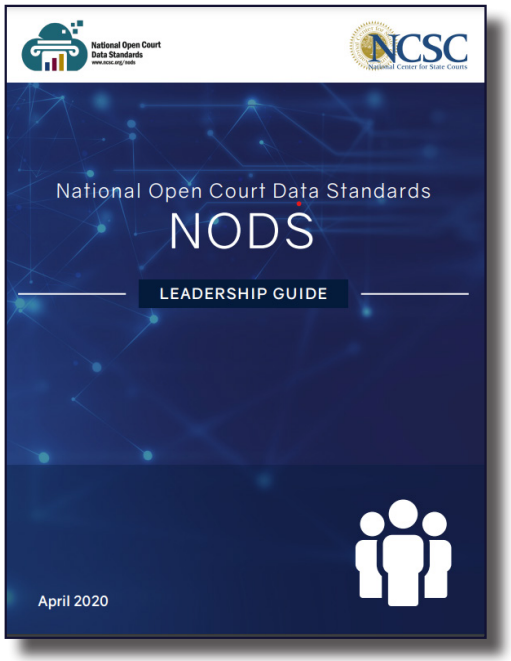
Information sharing within and across systems utilized by courts and behavioral health agencies is inadequate, undermining opportunities to identify issues, target resources, and improve system responses.

Recommendation

Courts should lead and support the identification of appropriate data, as well as data collection and information-sharing opportunities across the community, behavioral health, and justice systems as a critical part of developing a comprehensive and collaborative continuum of behavioral health services.

Courts should review data about the **prevalence of people in the United States living with serious mental illness (SMI) and substance use disorders (SUD)** and ensure that comparable state and local prevalence data is being compiled. Courts should also collect data specified in the **Behavioral Health Data Guides** and Task Force resources. Courts should assess the current state of data sharing between the court, jails, other justice partners, and community providers to identify gaps in needed data and assess whether there is a place to capture these data in the current court case management systems.

Through the National Open Court Data Standards (NODS), COSCA and the NCSC are working toward a solution of how to confidently collect, analyze, and share court data based upon creating national data standards. In a 2019 policy paper, "Open Data - the New Frontier for Court Records," COSCA endorsed making "court case data open and accessible to the maximum practical degree when balanced with legal restrictions."



As a researcher, I am often asked how often court cases involve individuals with mental illness. I can't answer this question. The case type alone is not a clear indicator and characteristics about the litigants or defendants are rarely captured by court case management systems. What we do know is that individuals with mental illness come into the justice system from many avenues. However, if we are committed to identifying individuals early and reliably so we can best address their needs, courts must identify data elements critical to understanding who is in the justice system and work with justice partners to establish robust data sharing protocols. Serving this population takes a community and systemwide commitment to using data to drive critical policy decisions and better understand what works. Without such data, we are all flying blind.

Dr. Nicole Waters, NCSC Director of Research Services

CCJ-COSCA Resolution and Call to Action

CCJ-COSCA Resolution

CONFERENCE OF CHIEF JUSTICES
CONFERENCE OF STATE COURT ADMINISTRATORS

RESOLUTION 1

In Support of the Recommendations of the National Judicial Task Force to Examine State Courts' Response to Mental Illness

WHEREAS, the Conference of Chief Justices (CCJ) and the Conference of State Court Administrators (COSCA) established the National Judicial Task Force to Examine State Courts' Response to Mental Illness (Task Force) to "assist state courts in their efforts to more effectively respond to the needs of court-involved individuals with serious mental illness"; and

WHEREAS, multiple Resolutions adopted by CCJ and COSCA over the last twenty years have recognized that mental illness is a far-reaching problem and have identified the enormous impacts that it has on all aspects of the judicial system; and

WHEREAS, many courts have implemented successful programs, improved court practices and procedures, and initiated significant reform, but there is still a need and responsibility for all state and local courts to lead and promote systemic change in the ways that courts and communities respond to individuals with serious mental illness; and

WHEREAS, the Task Force has benefited greatly in its work from a strong collaboration with Substance Abuse and Mental Health Services Administration (SAMHSA) leadership and Regional Administrators and building upon this collaboration with SAMHSA and with other federal agencies will be critical in addressing the needs of justice-involved individuals with serious mental illness or substance use disorder; and

WHEREAS, members of CCJ and COSCA are uniquely positioned to assume a leadership role to address the impacts of serious mental illness on the court system in every state and territory; and

WHEREAS, the Task Force has comprehensively examined all aspects of the impacts of serious mental illness on state courts and now offers its findings and recommendations;

NOW, THEREFORE, BE IT RESOLVED, that CCJ and COSCA support the Findings and Recommendations of the Task Force and urge each member of the Conferences to take the following action in his or her state or territory to improve the state courts' response to mental illness:

• **LEAD**. Create and support a state-level, inter-branch mental health task force and encourage and support local judges and courts in the creation of local or regional mental health task forces. Consider the appointment of a behavioral health director/administrator and a team within the Administrative Office of the Courts to develop and implement improved court responses for court-involved individuals with serious mental illness;

• **EXAMINE**. Utilizing the recommended models and best practice and policy recommendations of the Task Force undertake an assessment of the court system including state laws, court rules, policies, practices, and procedures across all case types involving individuals with serious mental illness. Recommend and encourage judges to exercise their "power to convene" and support courts and communities in the use of the Leading Change Guides and Sequential Intercept Model to map resources, opportunities, and gaps, and develop plans to improve court and community responses to serious mental illness;

• **EDUCATE.** Provide and support opportunities for the education and training of judges and court professionals on all aspects of serious mental illness and effective court responses. Distribute and make available the tools, resources, and recommendations developed by the Task Force to all state and local judges and court professionals; and

• **ADVOCATE**. Support state efforts to utilize a public health model rather than a criminal justice approach to guide behavioral health policies, practices, and funding, including efforts to, when appropriate, deflect or divert cases involving individuals with mental illness from the court system and into treatment. Advocate for funding and resources needed to implement a continuum of diversion programs, treatment, and related services to improve public safety as a more humane and cost-effective approach.

BE IT FURTHER RESOLVED, that CCJ and COSCA renew their commitment to work closely with SAMHSA and other federal agencies to increase the capacity of state courts to respond to the needs of justice-involved individuals with serious mental illness or substance use disorder; and

BE IT FURTHER RESOLVED, that following the termination of the Task Force, CCJ and COSCA support future efforts, with the leadership of the CCJ/COSCA Behavioral Health Committee and supported by the National Center for State Courts, to implement the recommendations of the Task Force, develop performance measures for state courts and communities, and monitor and report progress and success.

Adopted as proposed by the CCJ/COSCA Behavioral Health Committee at the CCJ/COSCA 2022 Annual Meeting on July 27, 2022.

APPENDIX

Task Force Publications and Resources

APPENDIX

Task Force Publications and Resources

Click here for the latest list of publications and resources.

ONLINE RESOURCES
Behavioral Health and the Courts Website
Behavioral Health Resource Hub
Behavioral Health Alerts Newsletter (published 2x/month, Jan 2020 – present)
State Innovations and Resources
Webinars and Podcasts
Behavioral Health eLearning Series & Resources
PUBLICATIONS
TASK FORCE BACKGROUND AND REPORTS
Conference of Chief Justices Conference of State Court Administrators Final Resolution 1 (Aug 2022)
Findings and Recommendations of the Task Force (Aug 2022)
Conference of Chief Justices Conference of State Court Administrators 2021 Annual Conference Report (Jul 2021)
National Judicial Task Force to Examine State Courts' Response to Mental Illness Overview (Jul 2021)
2020-2021 National Convenings Summary (Jun 2021)
State Courts' Responsibility to Convene, Collaborate, and Identify Individuals Across Systems (Jun 2020)
The Future Is Now: Decriminalization of Mental Illness (May 2020)
STATE AND TRIAL COURTS LEADING CHANGE
Violence and Mental Illness Myths and Reality (Nov 2022)
Implementation of the 988 Suicide and Crisis Line Lifeline: What Court Leaders Need to Know (July 2022)
Leading Change Guide for Trial Court Leaders: Improving the Court and Community's Response to Mental Health and Co-Occurring Disorders (Jun 2022)
Leading Change Guide for State Court Leaders: Improving the Court and Community's Response to Mental Health and Co-Occurring Disorders (Jun 2022)
Fostering a State Court Informed Behavioral Health Continuum of Care (May 2022)
External Funding Support to Lead Change (May 2022)
Measuring Your Progress (Feb 2022)
Building Relationships to Lead Change (Feb 2022)
Strategic Planning Through Sequential Intercept Mapping (Feb 2022)

State Court Commission or Task Force Composition (Feb 2022)

What State Court Leaders Need to Know About State Behavioral Health Systems (Jun 2022)

Statewide, Regional, and Trial Court Behavioral Health Positions Are Recommended (Dec 2021)

Certified Community Behavioral Health Clinics (CCBHCs) and the State Courts (Dec 2021)

Statewide Behavioral Health Leadership Positions Are Recommended (Nov 2021)

Behavioral Health Commissions and Task Forces (Nov 2021)

What We Have Learned and What We Must Do! (Jul 2021)

Mental Health Facts in Brief (Feb 2022)

Social Determinants of Health and Mental Health (Dec 2021)

Co-Occurring Mental Illness and Substance Use Disorders (CODs) (Mar 2020)

The Psychiatric Care Continuum (Jan 2020)

Medicaid and Improved Court Practices (In development)

DEFLECTION AND DIVERSION TO TREATMENT

Judges' Guide to Mental Health Diversion (Nov 2022)

National Diversion Landscape: Continuum of Behavioral Health Diversions Survey Report (May 2022)

National Diversion Landscape Survey Summary (May 2022)

Collaborative Court and Community Diversion for Individuals with Behavioral Health Needs (Jun 2021)

Juvenile Justice Mental Health Diversion Guidelines and Principles (Mar 2022)

Improving Outcomes for People with Behavioral Health Needs: Diversion and Case Processing Considerations During a Pandemic (Mar 2021)

Listening to the Field: Observation and Recommendations to Reduce Jail Population During a Pandemic (Jan 2021)

REFORMING THE COMPETENCY TO STAND TRIAL SYSTEM

Competency to Stand Trial System Assessment Tool (Oct 2022)

Leading Reform: Competence to Stand Trial Systems — Questions State Court Leaders Should Ask First (May 2022)

Leading Reform: Competence to Stand Trial Systems (Aug 2021)

Oregon's Aid & Assist Dashboard (Dec 2021)

Just and Well: Rethinking How States Approach Competency to Stand Trial (Oct 2020)

COURT AND COMMUNITY COLLABORATION: PERSON-CENTERED JUSTICE

Exploring Person-Centered Justice for Individuals with Behavioral Health Needs: A New Model for Collaborative Court and Community Caseflow Management (Jun 2022)

STRENGTHEN COMMUNITY RESPONSES AND MINIMIZE CRIMINAL JUSTICE SYSTEM:

Comprehensive Behavioral Health Crisis Systems | **Deflection** | **Stop the "Revolving Door" into the Justice System** | **Prosecution Alternatives**

PROMOTE EARLY INTERVENTION AND EFFECTIVE MANAGEMENT OF COURT CASES:

Screening and Assessment | **Behavioral Health Triage** | **Jail Practices** | **First Appearance and Pretrial Practices** | **Prosecution Practices** | **Effective Defense Representation** | **Effective Caseflow Management**

INSTITUTIONALIZE ALTERNATIVE PATHWAYS TO TREATMENT AND RECOVERY:
Diversion – A Pathways Approach | **Civil Responses** | **Competency Dockets** | **Specialized Behavioral Health Dockets** | **Courtroom Practices** | **Treatment Courts** | **Other Pathways and Strategies to Treatment and Recovery**

MANAGE POST-ADJUDICATION EVENTS AND TRANSITIONS EFFECTIVELY:
Community Supervision and Violations | **Transition and Aftercare Plans** | **Reentry Practices**

Behavioral Health Data Elements Guide: Key Questions About Criminal Cases (Oct 2022)

Key Questions at Appearances for Individuals with Serious Mental Illness Bench Card (Sep 2022)

Pathways to Care: A Roadmap for Coordinating Criminal Justice, Mental Health Care, and Civil Court Systems to Meet the Needs of Individuals and Society (Equitas, Sep 2022)

A New Model for Court and Community Collaborative Caseflow Management (Jul 2022)

Connecting Community Health Centers & Courts to Improve Behavioral Health of People & Communities (July 2022)

Using Collaborative Court Case Processing to Help People with Behavioral Health Needs: Q&A with Former Chief Justice Paula M. Carey (Mar 2022)

Connecticut Jail & Court Diversion (Feb 2022)

Certified Community Behavioral Health Clinics (CCBHCs) and the State Courts (Dec 2021)

Certified Community Behavioral Health Clinics and the Justice Systems (Sep 2021)

Connecting Care for Better Outcomes (Nov 2021)

Treatment Considerations in Correctional Settings (Nov 2021)

The Crisis Care Continuum: Resources for Courts During and After the COVID-19 Pandemic (Dec 2020)

Providing Court-Connected Behavioral Health Services During the Pandemic: Remote Technology Solutions (Jul 2020)

CHANGING THE LAW AND PROCESS FOR CIVIL COMMITMENT

Behavioral Health Data Elements Guide: Key Questions about Court-Ordered Evaluation and Treatment (Oct 2022)

Model Legal Processes to Support Clinical Intervention for Persons with Serious Mental Illnesses (Equitas, Sep 2022)

Improved Civil Court-Ordered Treatment Responses (Jul 2022)

Psychiatric Advance Directives (Jun 2022)

Supporting Vulnerable Populations: Civil Interventions and Diversion for Those with Mental Illness (Jul 2020)

Assisted Outpatient Treatment (AOT) Community-Based Civil Commitment (Jan 2020)

CHILDREN, YOUTH, AND FAMILIES

Behavioral Health Data Elements Guide: Key Questions About Juvenile Justice (Oct 2022)

Youth Mental Health Crisis (Sep 2022)

Oversight of Psychotropic Medications Prescribed to Children in Foster Care (Sep 2022)

Dependency Alternative Program, Pima AZ (Jul 2022)

I-Matter Program-Colorado (Jul 2022)

Upstream – Strengthening Children and Families through Prevention and Intervention Strategies: A Court and Community-Based Approach (Jul 2022)

Title IV-E Reimbursement for Lawyers Representing Children, Parents, & Pre-Petition Prevention Opportunities (Jul 2022)

Well-Being in Domestic Relations Court (Jun 2022)
Social Determinants of Health (Jun 2022)
The Benefits of Upstream for Courts (Jun 2022)
The Benefits of Upstream for Child Welfare Agencies (Jun 2022)
Access to Treatment for Adolescents (Jun 2022)
Excerpts from Helping Children Impacted by Parental Substance Use Disorder (Jun 2022)
Juvenile Justice Mental Health Diversion Guidelines and Principles (Mar 2022)
ADDRESSING BEHAVIORAL HEALTH AND EQUITY
Behavioral Health and Equity (Nov 2022)
TRAINING AND EDUCATION
Understanding the Impact of Stigma (Jul 2022)
Secondary Trauma and the Courts (Jun 2022)
Trauma and Trauma-Informed Responses (Jun 2022)
Comprehensive Overview: State and Trial Court Leadership Guides and Behavioral Health Resources (Jun 2022)
Mental/Behavioral Health Educational Resources (Jun 2021)
Trauma and Its Implication for Justice Systems (Mar 2020)
Co-Occurring Mental Illness and Substance Use Disorders (CODs) (Mar 2020)
Jargon Guides (in development)
VOICES OF PEERS, INDIVIDUALS WITH LIVED EXPERIENCE, AND FAMILIES
Peers in Courts (Jun 2022)
Peers 101 (Feb 2022)
WELL-BEING OF JUDGES AND COURT PERSONNEL
Judicial Wellness (Jul 2022)
Trauma-Informed Practices and Jurors (Jun 2022)
Addressing the Mental Health and Well-Being of Judges and Court Employees (Jan 2021)
Addressing Court Workplace Mental Health and Well-Being in Tense Times – Webinar (Jun 2020)
KEY QUESTIONS COURTS MUST ASK: DATA AND INFORMATION SHARING
Behavioral Health Data Elements Guide for the State Courts (Oct 2022)
Behavioral Health Data Guides by Case Type: Criminal | **Juvenile** | **Civil** (Oct 2022)
Prevalence of Serious Mental Illness and Substance Use Disorders (Jun 2022)

With the publication of this Final Report, the work of the National Judicial Task Force to Examine State Courts' Response to Mental Illness comes to an end. Pursuant to the Resolution adopted by CCJ and COSCA, the situs for the future work to implement the recommendations of the Task Force shifts to the CCJ/COCSA Behavioral Health Committee. For further information or to participate in these efforts, please contact the National Center for State Courts.

This document was developed under the Mental Health Initiative: Phase II Grant #SJI-20-P-054 from the State Justice Institute and approved by the Task Force Executive Committee. The points of view expressed do not necessarily represent the official position or policies of the State Justice Institute.

ncsc.org/behavioralhealth

Just and Well:

Rethinking How States Approach Competency to Stand Trial

October 2020

CSG Justice Center

American Psychiatric Association Foundation

Judges Psychiatrists Leadership Initiative

NASMHPD

NCSC National Center for State Courts

NCSL National Conference of State Legislatures

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Program Director, Behavioral Health

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Senior Policy Analyst, Behavioral Health

The Council of State Governments (CSG) Justice Center prepared this report in partnership with the American Psychiatric Association Foundation (APAF), the National Association of State Mental Health Program Directors (NASMHPD), the National Center for State Courts (NCSC), and the National Conference of State Legislatures (NCSL) as a project of the Judges and Psychiatrists Leadership Initiative (JPLI). The opinions and findings in this document are those of the authors and do not necessarily represent the official position or policies of the members of The Council of State Governments.

Websites, examples, and resources referenced in this publication provided useful information at the time of this writing. The authors do not, however, necessarily endorse the information or sources.

About the CSG Justice Center
The CSG Justice Center is a national nonprofit, nonpartisan organization that combines the power of a membership association, representing state officials in all three branches of government, with policy and research expertise to develop strategies that increase public safety and strengthen communities. For more information about the CSG Justice Center, visit www.CSGJusticeCenter.org.

About the APA Foundation
As the charitable arm of the American Psychiatric Association, APA Foundation programs focus on raising awareness and overcoming barriers; investing in the future leaders of psychiatry; supporting research and training to improve mental health care; and leading partnerships to address public challenges in mental health. All APA Foundation initiatives focus on one goal: *A mentally healthy nation for all*. To learn more, visit apafdn.org.

About JPLI
JPLI is a partnership between the CSG Justice Center and the APA Foundation; it aims to stimulate, support, and enhance efforts by judges and psychiatrists to improve judicial, community, and systemic responses to people with behavioral health needs involved in the justice system.

About NASMHPD
Founded in 1959, NASMHPD represents the public mental health service delivery system in all 50 states, 4 territories, and the District of Columbia. NASMHPD serves as the national representative and advocate for state mental health agencies and their directors and supports effective stewardship of state mental health systems. NASMHPD informs its members on current and emerging public policy issues, educates on research findings and best practices, provides consultation and technical assistance, collaborates with key stakeholders, and facilitates state-to-state sharing. For more information, see www.nasmhpd.org.

About NCSC
NCSC promotes the rule of law and improves the administration of justice in state courts and courts around the world. Trusted Leadership. Proven Solutions. Better Courts. See www.ncsc.org for additional information.

About NCSL
NCSL is the bipartisan organization dedicated to serving the lawmakers and staffs of the nation's 50 states, its commonwealths and territories. It provides research, technical assistance, and opportunities for policymakers to exchange ideas on the most pressing state issues, and is an effective and respected advocate for the interests of the states in the American federal system. Its objectives are: improve the quality and effectiveness of state legislatures; promote policy innovation and communication among state legislatures; and ensure state legislatures a strong, cohesive voice in the federal system. For more information, see www.ncsl.org.

The Council of State Governments Justice Center, New York, 10007

Cover and interior design by Michael Bierman.

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Table of Contents

Acknowledgments

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Additionally, we extend our appreciation to the three organizational partners on this effort: The National Association of State Mental Health Program Directors, the National Center for State Courts, and the National Conference of State Legislatures, each of whose members play a critical role in the development and implementation of competency to stand trial (CST) in the states. These organizations were integral in defining the national problem addressed in the report and identifying viable, practical solutions.

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Note: Title and agency affiliations reflect those at the time of project participation.

"The most tragic aspect of this crisis is that the massive efforts to admit and restore patients are ultimately a waste of expensive clinical resources without improving the trajectory of a person's life. After returning to jail and standing trial, they are most likely worse off: either released without resources to the same circumstances that precipitated arrest or incarcerated."

DR. KATHERINE WARBURTON, MEDICAL DIRECTOR, CALIFORNIA STATE HOSPITALS

Competency to Stand Trial At a Glance

Competency to stand trial (CST), also known as "fitness," refers to the constitutional requirement that people facing criminal charges must be able to assist in their own defense. A criminal case cannot be adjudicated unless this requirement is met. The U.S. Supreme Court considers someone competent to stand trial if that person is rationally able to consult with an attorney and holds a clear understanding of the charges against him or her.[1]

How does the CST process work?

The process varies depending on state law and availability of services and facilities. Generally, the judge or either party in a criminal case may raise a concern about a person's ability to understand and participate in the court's proceedings. Once this occurs, an evaluation of the person's competency must be conducted, and if needed, restoration services may be provided either in the community or at an inpatient competency restoration facility. These restoration services are designed to prepare people to participate in a courtroom process, generally focusing on symptom management or legal education. However, they are not the equivalent to, nor should they be a substitute for, treatment of mental illnesses and substance use disorders ("behavioral health" conditions). If a person's competency is restored, their case may proceed.

Who enters the process?

People who enter the CST process often have complex needs, which may include behavioral health conditions, cognitive and neurodevelopmental impairments, and an often-undiagnosed history of traumatic experiences. These health needs are also usually exacerbated by a lack of social and financial supports. For example, a study of CST patients in California's Napa State Hospital's Incompetent to Stand Trial program showed about 80 percent had a psychotic condition, 15 percent had mood disorders, and just under 10 percent had a substance use disorder as the primary diagnosis. Nearly half of these patients had also been homeless in the previous year, and 45 percent had 15 or more prior arrests.[2]

Because many people who enter the competency process have serious mental illnesses, this report primarily focuses on how to improve outcomes for those individuals. But it is important to remember that not everyone who enters the CST process has behavioral health needs; nor should everyone with such needs be ordered to undergo evaluation and restoration. As they consider reforms, communities may also find it helpful to examine the needs of people with other primary conditions (e.g., organic brain disorders, intellectual and developmental disabilities) who also become involved the CST process.

1. This standard was established by the U.S. Supreme Court in Dusky v. United States (1960). It describes the test for competency as whether a defendant has "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him." See Dusky v. United States, 362 U.S. 402 (1960).

2. California Department of State Hospitals, "Incompetent to Stand Trial Diversion Program" (PowerPoint presentation, Program Implementation Partners Meeting, California, September 26, 2018), https://www.dsh.ca.gov/Treatment/docs/IST_Diversion_Slides.pdf.

"He had an evaluation each time after he was declared incompetent, but there were always issues, [and] he would go back to the county jail. He never came home . . . never sent to the hospital for treatment. Just continually, court date set, declared incompetent, see a counselor or doctor, go back to court, he's still incompetent, and just repeatedly over and over, over a period of three years."

ANONYMOUS, FATHER OF A MAN WHO EXPERIENCED THE COMPETENCY PROCESS FIRSTHAND

Introduction

Across the U.S., states and localities are reporting significant increases in the number of people entering the process to have their competency evaluated and restored in order to stand trial.

Increasing use of CST processes is leading to delays in getting people evaluated and restored, resulting in significant costs to the people involved in the process and the general public. The overwhelmed system is causing scarce state hospital beds to be used for evaluation and restoration, instead of providing inpatient treatment to those who need it. And as hospitals and restoration facilities reach capacity, others are left to wait in jail, sometimes indefinitely, for a restoration bed to become available. These delays often result in litigation against the states.

Numerous states have undertaken efforts to rethink the CST process in light of these challenges,[3] and there are rich academic[4] and professional discussions about the importance of reform.[5] But policymakers eager to improve their own state systems largely lack guidance for how to do so.

3. Through funding from the Substance Abuse and Mental Health Services Administration, 11 states have participated in a pair of learning collaboratives on CST in an approach that builds on earlier successes from a regional effort involving 6 states in the Midwest led by the Michigan Department of Health and Human Services. See Lisa Callahan, email message to authors, July 15, 2020; Debra A. Pinals et. al, *Multi-State Peer Learning Collaborative focused on Individuals found Incompetent to Stand Trial: March 1, 2017-March 1, 2018, Report on Proceedings, Follow-up, and Findings* (Saline, MI: Michigan Department of Health and Human Services, 2018).

4. See, for example, Amanda Beltrani and Patricia A. Zapf, "Competence to Stand Trial and Criminalization: An Overview of the Research," *CNS Spectrums* 25 (2020): 161–172; and Lisa Callahan and Debra A. Pinals, "Challenges to Reforming the Competence to Stand Trial and Competence Restoration System," *Psychiatric Services* 71, no. 7 (2020): 691–697.

5. For example, NCSC has included competency to stand trial as a key policy area in its national project, *Improving the Justice System Response to Mental Illness*. See Richard Schwermer, *Competence to Stand Trial: Interim Report* (Williamsburg, VA: NCSC, 2020), https://www.ncsc.org/__data/assets/pdf_file/0025/38680/Competence_to_Stand_Trial_Interim_Final.pdf. NASMHPD has also developed numerous reports and resources on this topic. See "NASMHPD Publications," NASMHPD, accessed July 21, 2020, https://www.nasmhpd.org/nasmhppulisher.

To help policymakers navigate these complexities, the CSG Justice Center and the APA Foundation convened an advisory group of experts to agree upon strategies and best practices policymakers can use to improve their CST processes—including strengthening connections to community-based treatment so that the process can be avoided altogether when appropriate. This report provides examples that demonstrate how these changes can be achieved in communities across the country. It also calls on local and state leaders to adopt strategies that will improve current practices in their own communities—improving health, saving money, protecting public safety, and making the legal process more just. This report reflects a consensus about the problems states face, as well as a shared vision of how an ideal CST process would look.

A National Tragedy

The failings of the current approach to CST have gained increased national attention in recent years. A feature in the fall 2019 issue of *The Atlantic*, for example, discussed current CST processes in several states and highlighted the story of a 26-year-old who spent 55 days in jail, in part, because he was awaiting a spot for restoration at the state hospital. His alleged crime was stealing a hamburger and fries.[6] Another article explored a case in New York where a man was evaluated at least 31 times and spent more than 30 years cycling between the jail and state hospitals without a trial.[7]

Stories like these are striking, but not isolated.[8] Indeed, they are part of trends affecting states across the country as the number of people being evaluated and going through restoration grow. NASMHPD surveyed its members and reported an average 72-percent overall increase in the number of people receiving competency restoration services in state hospitals from 1999 to 2014, with approximately half of all states responding.[9] And recent research estimates that more than 91,000 competency evaluations were conducted in 2019; researchers also estimate that about half of these evaluations were for people charged with misdemeanors.[10]

As the news stories highlight, people are spending long periods of time in the CST process. Whether they are waiting after a doubt of competency is raised, waiting to be declared competent for trial, waiting to be found "unrestorable," or waiting to see if their charges are dismissed, these delays cause hardship for individuals, their families, and state and county budgets. Now, as some states place additional restrictions on movement and admissions between jails and hospitals to contain the spread of COVID-19, these backlogs have grown in some places.[11] This is particularly troubling because people with serious mental illnesses, who are often among those referred for competency evaluations, are at increased risk to complications from COVID-19 due to chronic medical conditions.[12]

6. Paul Tullis, "When Mental Illness Becomes a Jail Sentence," *The Atlantic*, December 6, 2019, accessed February 25, 2020, https://www.theatlantic.com/politics/archive/2019/12/when-mental-illness-becomes-jail-sentence/603154/.

7. George Joseph and Simon Davis-Cohen, "Locked up for Three Decades Without a Trial: A New York City Man Has Been Shuffled between Rikers Island and Mental Hospitals for 32 Years," *The Appeal*, June 21, 2018, accessed June 4, 2020, https://theappeal.org/locked-up-for-three-decades-without-a-trial/.

8. For example, in another case, a man was arrested for stealing snacks worth 5 dollars. While a judge found him "incompetent" to stand trial, he died in his jail cell, 40 pounds lighter than he was at the time of his arrest, waiting to be transferred to a state mental health facility. See, Susan MacMahon, "Reforming Competence Restoration Statutes: An Outpatient Model," *The Georgetown Law Review* 107 (2019): 601–603. For more examples, see Elena Schwartz, "Restoring Mental Competency: Who Really Benefits?" *The Crime Report*, August 8, 2018, accessed September 4, 2019, https://thecrimereport.org/2018/08/08/restoring-mental-competency-who-really-benefits/.

9. Amanda Wik, Vera Hollen, and William Fisher, *Forensic Patients in State Psychiatric Hospitals: 1999–2016* (Alexandria, VA: National Association of State Mental Health Directors Research Institute, Inc., 2017), 40, https://www.nri-inc.org/our-work/nri-reports/forensic-patients-in-state-psychiatric-hospitals-1999-2016/.

10. Lauren E. Kois et al., "Updating the 'Magic Number:' Contemporary Competence to Proceed Metrics Reported by U.S. Judiciaries" (paper presented at the annual meeting of the American Psychology-Law Society, March 6, 2020).

11. For example, see Sam Stites, "State Hospital Curtails Admissions as Concerns over COVID-19 Grow," *Portland Tribune*, March 31, 2020, accessed May 6, 2020, https://pamplinmedia.com/pt/9-news/460144-374371-state-hospital-curtails-admissions-as-concerns-over-covid-19-grow-pwoff.

12. "Mental Disorders and Medical Comorbidity," Robert Wood Johnson Foundation, February 1, 2011, accessed July 27, 2020, https://www.rwjf.org/en/library/research/2011/02/mental-disorders-and-medical-comorbidity.html; Benjamin G. Druss, "Addressing the COVID-19 Pandemic in Populations with Serious Mental Illness," *Journal of the American Academy of Psychiatry and the Law* (2020), doi:10.1001/jamapsychiatry.2020.0894.

The available evidence also suggests that the impacts of CST's challenges are not evenly distributed. When people have their competency raised, data show that race and cultural differences can impact the way evaluations are conducted. In Massachusetts, a study found that a greater percentage of Hispanic and Black men were sent for inpatient evaluation in a strict-security facility (compared to less secure settings) regardless of diagnosis and the level of severity of the criminal charges,[13] with similar results reported in Florida.[14]

Delays Found Unconstitutional

Delays in getting people evaluated and restored can lead to legal problems for states. While the law requires that the CST process be conducted within a "reasonable period of time,"[15] at least a dozen states are involved in litigation alleging that they have failed to meet this standard.

In one of the most well-known cases, Trueblood v. Washington State Department of Social and Health Services, a federal court found that Washington's CST process was taking too long, violating people's constitutional right to due process. In its 2015 ruling, the court spoke in stark terms of the human costs of those delays for people who have mental illnesses, stating: "Our jails are not suitable places for the mentally ill to be warehoused while they wait for services. Jails are not hospitals, they are not designed as therapeutic environments, and they are not equipped to manage mental illness or keep those with mental illness from being victimized by the general population of inmates. Punitive settings and isolation for twenty-three hours each day exacerbate mental illness and increase the likelihood that the individual will never recover." It ordered the state to provide competency evaluations within 14 days, and restoration services within 7 days of the court ordering them.

Washington has worked—and struggled—to comply with the court's order, and has thus far been required to pay $85 million in fines for failing to reach full compliance.[16] The state is challenged by high demand and a lack of adequate services and is still working to reach compliance through a range of policy and practice changes.[17] Included among these are changes that aim to reduce the number of people with mental illness who enter the criminal justice system in the first place.

13. Debra Pinals et al., "Relationship between Race and Ethnicity and Forensic Clinical Triage Dispositions," *Psychiatric Services* 55, no. 8 (2004): 873-878, https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.55.8.873.

14. A report by the Treatment Advocacy Center notes a similar trend of higher hospitalization rates for African American clients in Florida. See Doris A. Fuller, Elizabeth Sinclair, and John Snook, *A Crisis in Search of Date: The Revolving Door of Serious Mental Illness in Super Utilization* (Arlington, VA: Treatment Advocacy Center, 2017), 17, https://www.treatmentadvocacycenter.org/storage/documents/smi-super-utilizers.pdf.

15. The U.S. Supreme Court ruling stated, "At the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed. We hold, consequently, that a person charged by a State with a criminal offense who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future." See Jackson v. Indiana 406 U.S. 715 (1972).

16. In Trueblood et al. v. Washington State Department of Social and Health Services, 101 F. Supp. 3d 1010 (W.D. Wash. 2015), the court found that Washington State's delays in evaluation and restoration of CST were unconstitutional. The state was also required to make fundamental changes to improve the availability of community-based treatment and CST evaluation and restoration. See Mark Wilson, "Oregon Faces State and Federal Contempt Proceedings over Delayed Competency Services for Mentally Ill Defendants—Again," *Prison Legal News*, September 9, 2019, accessed June 11, 2020, https://www.prisonlegalnews.org/news/2019/sep/9/oregon-faces-state-and-federal-contempt-proceedings-over-delayed-competency-services-mentally-ill-defendants-again/.

17. "Trueblood et al v. Washington State DSHS," Washington State Department of Social and Health Services, accessed July 21, 2020, https://www.dshs.wa.gov/bha/trueblood-et-al-v-washington-state-dshs.

An Expensive Approach

"It has cost us more than $300,000 to try to restore competency to a young woman on my docket. And yet, when her charges are dismissed, she will have no housing and no community supports or services. The community and this young woman would have been far better off if we diverted her out of the criminal justice system at the beginning and invested the money spent on restoration on services and housing that would support her for the long run."

HONORABLE NAN WALLER, CIRCUIT COURT JUDGE, MULTNOMAH COUNTY, OREGON

Nationwide, states report the same thing: they are spending a significant amount of money (particularly from state mental health budgets) on CST, despite the fact that restoration services are not the equivalent of mental health treatment and do not ensure long-term improved outcomes for people with mental health needs.

For example, Florida's three-branch task force, formed in response to a lawsuit, found that the state was spending 25 percent of its entire mental health services budget—approximately $212 million dollars annually—for 1,652 forensic beds in state mental health treatment facilities serving approximately 4,000 individuals.[18] Eighty percent of the individuals who were restored either had their charges dismissed, received credit for the time they spent in the facility and jail, or were put on probation. Under all 3 scenarios, however, they typically left the courthouse without access to the mental health treatment many of them needed.[19]

Another example from Cook County, Illinois, showed how one man was arrested over 150 times and went through the CST process 4 times. When looking at only his fourth CST process, jail costs plus costs associated with competency evaluation and restoration totaled almost $150,000. This money was spent simply to position him to face his misdemeanor charges, without addressing the chronic nature of his mental health condition or the other factors driving his criminal justice involvement.[20]

Too many communities have stories like these. The result is more taxpayer money spent without seeing positive health outcomes and the CST process becoming a revolving door. The growth in this problem is real. Colorado found that 500 CST referrals in FY2016–17 involved people who had previously received competency-related services. What's worse is that number had more than doubled over the previous 6 years.[21] This trend frustrates law enforcement officers, judges, and others who report seeing the same people struggling with the same challenges and not being able to provide them with the help they need. People who go through the process, especially those who do so multiple times, also have their natural support system and professional treatment relationships disrupted.

18 Steve Leifman, associate administrative judge for the Eleventh Judicial Circuit Court of Florida (Presentation at the Florida House Judiciary Committee Workshop on Mental Health and the Criminal Justice System, Tallahassee, FL, December 10, 2019).

19 Supreme Court of the State of Florida, *Mental Health: Transforming Florida's Mental Health System* (Florida: Supreme Court of the State of Florida, 2007), https://www.floridasupremecourt.org/content/download/243049/2143136/11-14-2007_Mental_Health_Report.pdf.

20 Judge Sharon Sullivan, "Cook County Fitness Diversion Pilot Project 2020" (PowerPoint presentation, Chicago Bar Association, Chicago, IL, November 12, 2019, and MacArthur Foundation Safety and Justice Challenge Network Meeting, Houston, TX, October 3, 2019).

21 Colorado Department of Human Services, *Department of Human Services Office of Behavioral Health, Services for People with Disabilities, County Administration, Office of Self-Sufficiency, Adult Assistance Programs, Office of Early Childhood FY 2019-20 Joint Budget Committee Hearing Agenda* (Denver: Colorado Department of Human Services, 2018), 24.

Costs to Individual Health

Some advisors suggested that increased orders for CST evaluations may, at least in part, be attributable to a misunderstanding of the purpose of the CST process. A defense attorney, prosecutor, or judge may suggest a competency evaluation, believing that raising doubt about someone's competency is the best or only way to get them needed mental health care. While this approach may be well-intentioned, forensic psychiatrists clarified that this reflects a misunderstanding of the purpose of competency restoration services.[22] These services are generally narrowly focused on stabilization, symptom management, and legal education and are not the same as providing access to a fully developed treatment plan and services with the goal of long-term recovery and a positive place in the community.

Instead of receiving needed behavioral health treatment while awaiting evaluation, restoration, or trial, many people are left in jail, where treatment for their mental illnesses may be disrupted and their risk of symptom recurrence is increased.[23] Jails are a profoundly destabilizing setting for people with behavioral health needs; they are isolated, separated from community-based supports and treatment providers, and exposed to trauma. Adding to the challenges, people's medication regimens are often changed during incarceration due to availability and cost, and other non-pharmaceutical mental health care is limited, if it is available at all.[24]

Advisors also highlighted that even when a person makes it through this lengthy process and competency restoration is achieved, the person is ultimately sent back to jail as their case is adjudicated, opening up a new opportunity to decompensate and bring competency back into question. The result is that people can cycle from jail to court to hospital and back with no long-term benefit to their health or to public safety.

Pressures on State Hospitals

The problems with the CST process extend beyond the people facing criminal cases. Some advisors stressed that the misuse of the CST process is making the limited space within state hospitals even more scarce. So-called "civil" beds, which are used by people who require inpatient behavioral health treatment, are being converted into "forensic" beds, as states work to meet the constitutional mandate of providing timely restoration services to those who require them. As a result, access to civil inpatient beds is limited, creating a shortage of beds and a cascade of patients into inappropriate levels of care.[25]

Delays, legal woes, hospital bed shortages, and long waits in jail add up to a CST process that is not delivering positive outcomes for anyone involved. State and local officials are looking for a different way.

22. The CSG Justice Center advisor meeting on competency to stand trial, October 28, 2019. See also "Restoration to competency so one may face criminal charges is not the same as adequate and appropriate mental health treatment to manage illness, provide care, and improve a person's condition. The goals are fundamentally different: competency restoration serves the criminal justice system; treatment serves the individual who is ill." Frankie Berger, "Competency Restoration versus Psychiatric Treatment," *Treatment Advocacy Center*, accessed June 24, 2020, https://www.treatmentadvocacycenter.org/fixing-the-system/features-and-news/4126-the-distinction-between-competency-restoration-and-psychiatric-treatment.

23. It is also worth noting that research has indicated that pretrial detention, particularly for those at a low risk of pretrial failure, can increase the risk of pretrial failure. This research is not focused on people with behavioral health needs but suggests another important consequence of pretrial detention. See Christopher T. Lowenkamp, Marie VanNostrand, and Alexander Holsinger, *The Hidden Costs of Pre-Trial Detention* (Houston, TX: Laura and John Arnold Foundation, 2013), https://craftmediabucket.s3.amazonaws.com/uploads/PDFs/LJAF_Report_hidden-costs_FNL.pdf.

24. The U.S. Court of Appeals for the Ninth Circuit recognized that "we are also mindful of the undisputed harms that incapacitated criminal defendants suffer when they spend weeks or months in jail waiting for transfer to [Oregon State Hospital]." See Oregon Advocacy Center v. Mink, 322 F.3d 1101, 1120 (2003).

25. When patients, whether forensic or not, cannot access the appropriate level of care, their health suffers. See Debra A. Pinals and Doris A. Fuller, *Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care* (Alexandria, VA: National Association of State Mental Health Program Directors, 2017), https://www.nasmhpd.org/sites/default/files/TAC.Paper_.1Beyond_Beds.pdf.

The Relationship Between Competency and the Civil System

Civil commitment[26] is a non-criminal legal process, distinct from CST, in which a person is required to undergo involuntary mental health treatment. When court-ordered, involuntary treatment occurs in an outpatient setting, it is sometimes referred to as Assisted Outpatient Treatment (AOT).[27]

Some advisors raised the possibility that, in communities where it is more challenging to civilly commit an individual, legal actors may come to overly rely on CST. Some policymakers have even explored whether barriers to civil commitment are driving an increase in requests for competency evaluations.[28] Between 2009 and 2018, for instance, Oregon saw its civil commitment numbers fall while use of CST increased,[29] leading to speculation that the inability to access treatment through civil commitment was one reason driving judges and attorneys to explore CST as a way to get people needed care. This led some advisors to suggest increasing the use of civil commitment—particularly AOT. However, this proposal prompted strong opinions among both proponents and detractors.

Proponents note that some studies indicate that when adequately funded and carefully implemented, AOT can reduce system treatment costs[30] and improve participants' quality of life.[31] They argue that AOT provides an opportunity to help prevent episodes of deterioration and negative outcomes, such as arrest or violence.[32] Opponents counter that the benefits do not outweigh the restrictions on patients' liberties.[33] Detractors specifically raise clinical and ethical concerns about AOT, including that it may not always place people in the least restrictive setting that is clinically appropriate.

An additional layer to this discussion comes from New York State, where researchers have tried to understand disproportionate rates of outpatient commitment for Black people relative to White people. Their discussion concludes against "bias" by decision-makers, but also highlights the role of structural factors—such as high use of the public mental health system by Black New Yorkers—in these disproportionate outcomes.[34] Jurisdictions should discuss these issues and arrive at their own judgments about whether AOT has a place in their continuum of care, and if it should be used as an alternative to the CST process.

26. Civil commitment is defined as "involuntary outpatient commitment in a civil court procedure wherein a judge orders a person with severe mental illness to adhere to an outpatient treatment plan designed to prevent relapse and dangerous deterioration. Persons appropriate for this intervention are those who need ongoing psychiatric care owing to severe illness but who are unable or unwilling to engage in ongoing, voluntary, outpatient care." See APA Assembly and Board of Trustees, *Position Statement on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment* (Washington, DC: APA Operations Manual, 2015).

27. According to the Treatment Advocacy Center, "Assisted Outpatient Treatment (AOT) is the practice of providing community-based mental health treatment under civil court commitment, as a means of: (1) motivating an adult with mental illness who struggles with voluntary treatment adherence to engage fully with their treatment plan; and (2) focusing the attention of treatment providers on the need to work diligently to keep the person engaged in effective treatment." See Treatment Advocacy Center, *Implementing Assisted Outpatient Treatment: Essential Elements, Building Blocks and Tips for Maximizing Results* (Arlington, VA: Treatment Advocacy Center, 2019), https://www.treatmentadvocacycenter.org/storage/documents/White_Paper_FINAL_1.pdf.

28. Milton L. Mack, Jr., *Decriminalization of Mental Illness: Fixing a Broken System* (Williamsburg, VA: Conference of State Court Administrators, 2017), https://cosca.ncsc.org/__data/assets/pdf_file/0018/23643/2016-2017-decriminalization-of-mental-illness-fixing-a-broken-system.pdf; John Stewart, Alexis Lee Watts, and Kelly Lyn Mitchell, *Competency in Minnesota: A Practitioners' Roundtable Report* (Minneapolis, MN: Robina Institute of Criminal Law and Criminal Justice, 2016), https://robinainstitute.umn.edu/publications/competency-minnesota-practitioners-roundtable-report.

29. Steve Allen, Cassondra Warney, and Andy Barbee, "Behavioral Health Justice Reinvestment in Oregon," (PowerPoint Presentation, Steering Committee meeting, October 31, 2019, https://csgjusticecenter.org/wp-content/uploads/2020/01/OR-Launch-Presentation.pdf.

30. Health Management Associates, *State and Community Considerations for Demonstrating the Cost of AOT Services, Final Report* (Washington, DC: Health Management Associates, 2015), https://www.treatmentadvocacycenter.org/storage/documents/aot-cost-study.pdf.

31. Marvin Swartz et al., *New York State Assisted Outpatient Treatment Program Evaluation* (Durham, NC: Duke University School of Medicine, 2009), https://omh.ny.gov/omhweb/resources/publications/aot_program_evaluation/.

32. Jeffrey Draine, "Conceptualizing Services Research on Outpatient Commitment," *Journal of Mental Health Administration* 24 (1997): 306–15.

33. Tom Burns et al., "Community Treatment Orders for Patients with Psychosis (OCTET): A Randomised Controlled Trial," *The Lancet* 381, no. 9878 (2013): 1627–1633, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60107-5/fulltext.

34. See Jeffrey Swanson et. al., "Racial Disparities in Involuntary Outpatient Commitment: Are They Real?," *Health Affairs* 28, no. 3 (2009).

"He got locked up June 11 or 12, 2018. He just got sent to the hospital October 2019, so that's how long he's been dealing with it. He probably went in front of the judge maybe twice . . . [but] there has to be some kind of proper training, and it all starts from the top . . . It's not about getting a conviction; it's about helping these individuals."

ANONYMOUS, MOTHER OF A MAN WHO EXPERIENCED THE CST PROCESS FIRSTHAND

Rethinking Competency to Stand Trial: The Vision

In light of the challenges faced by state and local governments, the national advisory group worked together and established a shared vision of an ideal CST process that plays a discrete role in our behavioral health and criminal justice systems—one that makes for more just systems that also help individuals become well.

In this vision, the CST process would generally be reserved for cases where the criminal justice system had a strong interest in restoring competency so that a person may proceed to face their charges. Advisors noted that the justice system's interest in adjudicating a case tends to rise as the charges become more serious. In other situations, when the state interest in pursuing prosecution is lower, people would have their cases dismissed and/or would enter a diversion program in lieu of typical CST processes. If they were in need of treatment, they would be connected to care in a setting appropriate to their clinical level of need. In this vision, jurisdictions would also focus on preventing criminal justice involvement in the first place through the establishment of robust, community-based treatments and supports, with attention to structural factors—like access to housing and transportation—that may impact access to care. These community-based efforts would also help to reduce the number of people with mental illnesses entering into the criminal justice system and provide viable alternatives to jail-booking for first responders.

For people whose cases appropriately proceed for competency evaluation and, where needed, restoration—or for judges and prosecutors who elect to proceed with the CST process despite the availability of alternatives—the streamlined CST process they encounter would place them in the least restrictive environment possible from a

range of available settings. This process would also include centrally qualified evaluators and clear accountability for systematic quality, efficiency, and equity. And evaluation and restoration would always be paired with a robust treatment plan that follows the person through the process.

Realizing this vision will require strong collaboration and commitment across all three branches of state and local government to implement solutions based on research and local data. Jurisdictions will need to prioritize investments in community-based care; establish pre- and post-arrest diversion alternatives; limit the use of CST to cases in which the state has a strong interest in adjudication; and assign clear accountability for quality, speed, and equity throughout CST processes. In the pages that follow, this report outlines 10 specific, tested strategies that jurisdictions can deploy as they pursue change. It includes examples from around the country that prove positive change is possible.

Collaborative Leadership in Action: Texas

Responding to increasing demand for competency restoration services, Texas established several state-level leadership groups to develop initiatives focused on improving the quality and availability of competency restoration services provided in both inpatient and outpatient settings. These groups include the Judicial Commission on Mental Health, Statewide Behavioral Health Coordinating Council, Joint Committee on Access and Forensic Services, and the Texas Forensic Implementation Team. With leadership from all three branches of government, they have been able to pursue legislative changes to the CST process and changes to relevant court rules, improve coordination of care across different state agencies and regions of the state, and develop new trainings and programmatic initiatives as well as educational materials about jail diversion for judicial officials, jail staff, local mental health authorities, people who may experience CST firsthand, and members of the public.[35]

35. Jim LaRue, email message to authors, May 8, 2020.

"We have a responsibility to work across systems to make competency work for the purpose for which it was intended. Otherwise, we fail in guaranteeing the constitutional rights in our legal system and the people whose complex health needs warrant seamless continuity of care."

DR. DEBRA A. PINALS, MEDICAL DIRECTOR, BEHAVIORAL HEALTH AND FORENSIC PROGRAMS, MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Rethinking Competency to Stand Trial: The Strategies

Many of the strategies identified by the national advisors to improve CST processes are built from approaches policymakers and practitioners are already using in states across the country. These strategies should serve as a model for jurisdictions that are preparing to confront the issue and need guidance. Jurisdictions that pursue these strategies can do so in the order that fits their unique circumstances.

Strategy 1: Convene diverse stakeholders to develop a shared understanding of the current CST process.

In order to successfully address the challenges with the CST process, states will need to leverage the expertise, authority, and resources of all three branches of state and local government, as well as associated community partners. Typically, this will mean involving court leaders, state and local mental health administrators, and legislators, as well as judges, attorneys, sheriffs/jail administrators, law enforcement, medical professionals, and local treatment providers. States that have made improvements in their competency policies and practices have also included the critical perspectives from people with firsthand experience of CST and their advocates. A statewide effort also should include people from various regions throughout the state and reflect the racial, cultural, gender, ethnic, and linguistic makeup of residents. Each stakeholder has perspectives that will help

position the initiative for success, and many will also have resources that are needed to implement changes.

A joint partnership between state and local governments is vital to properly coordinating the varying responsibilities within the CST process, which can span different components of both levels of government. Once the stakeholders are gathered, they will need to establish a clear understanding of how individuals move through a jurisdiction's courts, jails, hospitals, and community-based programs for evaluation and restoration. Because each state's—and, sometimes, each judicial circuit's—CST process is unique and potentially complex, developing a common understanding can be achieved by bringing different stakeholders together to jointly develop process flows or maps of individuals' potential paths through the CST process. All key stakeholders should be involved in creating this process flow, as each perspective provides additional information (like varied terminology) that makes it possible to determine the decision points, policies, timelines, and other practical considerations driving the volume and pace of CST cases in a state.

It is also essential for the stakeholders to bluntly discuss the costs associated with the current CST process and understand who bears these expenses. Given that many states and counties share the price tag of evaluation and restoration, attention must be paid to cost shifts that result from policy changes. Clear understanding of these costs and the incentives they create can position policymakers to ensure that incentives are correctly aligned with the policy goals.

Strategy 2: Examine system data and information to pinpoint areas for improvement.

States can begin to understand the full scope of challenges facing their CST process by analyzing the data they currently have. Relevant data are often being collected across various state and local agencies involved in the CST process, but rarely are the data examined together to identify overall system trends and key areas for improvement.[36] By working together, partners can set shared goals to address the challenges they uncover, continue to collect data to track progress, and provide ongoing quality assurance for any policies and practices implemented. Policymakers in Oregon, for example, paired their analysis of jail data with Oregon State Hospital data, allowing them to identify people who had frequent contact with both systems and target that population for a new grant program for counties, tribal nations, and regional consortiums.[37]

As leaders coalesce around data analysis, key stakeholder input, and a better understanding of existing policies and procedures, they should document their findings and prioritize changes to make immediately, while also memorializing improvements that require more preparation and a longer timeline. Florida developed an expansive report in 2007 that outlined the state's problems at the intersection of mental health and criminal justice and established recommendations for change. This led to the development of local and state collaborations; the addition of training for all new judges on mental health and substance use; and the expansion of the state Criminal Justice, Mental Health, Substance Abuse Reinvestment Grant, among other changes.[38]

36. Additional data collection may be needed to answer some of these questions. As data collection procedures are developed, securing individual authorization to share health information for operational improvement, as well as treatment, can facilitate these and future information exchanges.

37. The CSG Justice Center, *Justice Reinvestment in Oregon Policy Framework* (New York: the CSG Justice Center, 2020), https://csgjusticecenter.org/wp-content/uploads/2020/04/JR-OR-Policy-Framework.pdf.

38. Supreme Court of the State of Florida, *Mental Health: Transforming Florida's Mental Health System* (Tallahassee, FL: Supreme Court of the State of Florida, 2007), https://www.floridasupremecourt.org/content/download/243049/2143136/11-14-2007_Mental_Health_Report.pdf; Steve Leifman, email to authors, July 24, 2020.

Key Data to Inform CST Policy

Accurate, accessible data is critical for policymakers to make informed decisions about what is working well and where changes are needed in the CST process. At a minimum, state policymakers should collect and analyze the following data to identify areas for further inquiry, including local or regional variations worthy of exploration. Better data collection can also lay the groundwork for more research, a priority noted by the advisory group.

Individual demographics: Data from the courts and forensic systems can help determine the age, gender, race, and ethnicity of the people cycling through the CST process. This can help identify potential inequities in how CST is being used. Data on health insurance and housing status may also reveal opportunities to implement strategies that could prevent criminal justice involvement. Current charges and prior criminal justice involvement, including prior CST findings, can also help identify diversion opportunities and any need for additional community-based treatment resources. Charges with high rates of referral for CST may be worth additional inquiry to determine whether specific statutory language is driving arrests that lead to CST requests. For instance, if people with mental illnesses are arrested and charged (and then referred for CST) at high rates because of the way the crime is defined or because it is described as a felony, a statutory change could prioritize connection to crisis services rather than arrest or make the same crime a misdemeanor instead of a felony.

Duration of the process: There should be a reasonable relationship between the time a person is in the CST process and the most likely length of incarceration they would face for the alleged offense (e.g., a person should not spend 6 months being restored to competency when the maximum sentence for the alleged offense is 30 days). In order to make this kind of determination, jurisdictions must first know and track the amount of time their CST process takes. Some key timeframes to consider: time taken from arraignment to the start of the competency process; from when competency is first raised through the evaluation; from evaluation to restoration, including potential wait time for admission to an inpatient facility; and from restoration to the resumption of case proceedings.

Outcomes: Measures like the percentage of cases referred for competency evaluations and the final disposition of these cases can show policymakers the overall demand for CST and whether it contributes to effective prosecution. High rates of “dismissal” or “time served” following restoration may indicate that CST processes are being used in cases in which the state’s interest in adjudication is relatively low. Overall costs from relevant systems (e.g., courts, jail, state hospital, community-based care) are another key measure to ensure that resources across systems are being used wisely.

Strategy 3: Provide training for professionals working at the intersection of criminal justice and behavioral health.

Criminal justice and behavioral health stakeholders need profession-specific training regarding CST. Attorneys and judges who understand the difference between the services to restore competency and those offered in a diversion program will be less likely to view CST as a gateway to treatment. A number of profession-specific standards and curricula exist nationally, such as the American Academy of Psychiatry and the Law's guidelines on evaluation for CST[39] and the American Bar Association's criminal justice and mental health standards.[40] States should consider how these and other appropriate professional standards and resources[41] are incorporated into state training requirements, as well as how compliance can be encouraged through continuing education credits or even state professional practice standards. The Judges and Psychiatrists Leadership Initiative has worked with teams of judges and pyschiatrists to provide training for judges on addressing people with behavioral health needs in the criminal justice system.[42] Engagement with community-based groups or people with firsthand experiences can also help stakeholders understand practical and structural factors impacting how people with behavioral health needs access services, such as the availability of transportation, costs, and wait times.

Cross-training (i.e., training that includes both criminal justice and behavioral health stakeholders) is also critical for effective collaboration. This kind of training can help professionals in both systems better understand how to make connections to community-based care, improve proceedings in a competency case, achieve the best possible health outcome for the person, and ensure dispositions include appropriate care and supports. Training and review of guiding documents on responding to people with mental health needs in the criminal justice system also provide helpful touchstones for professionals working on improving care for those whose competency has been raised. Examples include mental health training for court personnel and training on court processes for mental health professionals; Collaborative Comprehensive Case Planning training;[43] and training on criminogenic risk and the Risk-Needs-Responsivity model.[44]

39. Douglas Mossman et al., "AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial," *Journal of the American Academy of Psychiatry and the Law* 35, Suppl. 4 (2007): S3–S72, https://www.aapl.org/docs/pdf/Competence%20to%20Stand%20Trial.pdf.

40. American Bar Association, *Criminal Justice Mental Health Standards* (Chicago: American Bar Association, 2016), 7–9, https://www.americanbar.org/content/dam/aba/publications/criminal_justice_standards/mental_health_standards_2016.authcheckdam.pdf.

41. Additional resources from national organizations are available as background for these topics, such as from the Bureau of Justice Assistance and the SAMHSA GAINS Center at https://www/bja/gov and http://samhsa.gov/gains-center, respectively. NCSC also has resources specifically to help state courts. See "National Judicial Task Force to Examine State Courts' Response to Mental Illness," NCSC, accessed July 22, 2020, https://www.ncsc.org/mentalhealth. And NCSL has developed similar resources for legislatures at https://www.ncsl.org.

42. The Judges and Psychiatrists Leadership Initiative (JPLI) has worked with judicial educators in 23 states to deliver training for judges hearing criminal cases. They also regularly host webinars covering relevant and pressing topics in criminal justice and behavioral health. For example, in 2019, JPLI held a webinar on ways to improve cultural competency while working with people in the criminal justice system. JPLI, "Improving Cultural Competency: Working with People in the Criminal Justice System Who Have Mental Illnesses" (webinar, the CSG Justice Center, New York, May 16, 2019), https://csgjusticecenter.org/wp-content/uploads/2019/12/Improving-Cultural-Competency_Working-with-People-in-the-Criminal-Justice-System-Who-Have-Mental-Illnesses.pdf.

43. "Collaborative Comprehensive Case Plans," the CSG Justice Center, accessed April 23, 2020, https://csgjusticecenter.org/publications/collaborative-comprehensive-case-plans/.

44. D.A. Andrews, James Bonta, and Robert D. Hoge, "Classification for Effective Rehabilitation: Rediscovering Psychology," *Criminal Justice and Behavior* 17, no. 1 (1990): 19–52. https://doi.org/10.1177/0093854890017001004.

Strategy 4: Create and fund a robust system of community-based care and supports that is accessible for all before, during, and after criminal justice contact.

Robust community-based care and supports can help prevent criminal justice contact for people with behavioral health conditions. Such programs also provide opportunities for diversion once a person is involved in the criminal justice system. Because people with behavioral health needs are often those who become involved in the CST process, providing services in the community can limit the number of people entering the CST process in the first place.

The availability of community-based behavioral health care should also counter any perception that raising competency is an appropriate or necessary strategy for getting a person the treatment they need. To build up these services and supports, policymakers must take stock of what is currently available in their community, understand the needs of that community, and be aware of their ability to redirect resources to bolster services that are evidence based and most effective. Services that policymakers establish or enhance may include mental health or substance use disorder treatment, including crisis services;[45] educational and vocational programs; and/or prosocial activities that support recovery. Housing and transportation, as well as access to technology that facilitates support from care providers and loved ones, are also critical to recovery. Investments in affordable, supportive housing have also been shown to reduce criminal justice involvement and overall justice and health system costs,[46] particularly for people who have frequent arrests, hospitalizations, and episodes of homelessness.[47]

> **"Where possible, focus resources on prevention, recovery, and reintegration back into the community."**
>
> **DR. MICHAEL CHAMPION, MEDICAL DIRECTOR, ADULT MENTAL HEALTH DIVISION, BEHAVIORAL HEALTH ADMINISTRATION, STATE OF HAWAII DEPARTMENT OF HEALTH**

Many communities are already facing a shortage of behavioral health professionals across a range of disciplines, from psychiatrists to community health workers.[48] According to the most recent national data, 120 million Americans live in mental health Professional Shortage Areas.[49] Experts are anticipating expanded need for mental health services as a result of the COVID-19 pandemic, increasing the urgency for accessible, responsive care.[50] Meeting this need will require both short-term strategies and longer-term development

45. Substance Abuse and Mental Health Services Administration (SAMHSA), *National Guidelines for Behavioral Health Crisis Care–A Best Practice Toolkit* (Rockville, MD: SAMHSA, 2020), https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf.

46. A RAND Corporation essay recently summarized how supportive housing in Los Angles is reducing criminal justice involvement and saving health and housing costs as part of that county's efforts to divert people with mental illnesses from jail, including some who might otherwise be sent to the state hospital for competency restoration. See Doug Irving, "Supportive Housing Can Help Keep People with Mental Illness Out of Jail," *The RAND Review*, February 27, 2020, accessed May 11, 2020, https://www.rand.org/blog/rand-review/2020/02/supportive-housing-can-help-keep-people-with-mental.html.

47. One initiative that focuses on supportive housing is the Frequent Users System Engagement (FUSE) model. For further information, see "FUSE," Corporation for Supportive Housing, accessed June 3, 2020, https://www.csh.org/fuse/.

48. The Health Resources & Services Administration conducts surveys and forecasts for the behavioral health workforce. See "Behavioral Health Workforce Projections," Health Resources & Services Administration, accessed June 2, 2020, https://bhw.hrsa.gov/health-workforce-analysis/research/projections/behavioral-health-workforce-projections. Additional state-specific information on the mental health workforce can be found through the Kaiser Family Foundation, see "Mental Health Care Health Professional Shortage Areas (HPSAs)," Kaiser Family Foundation, accessed June 2, 2020, https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

49. "Shortage Areas," Health Resources & Services Administration, accessed June 2, 2020, https://data.hrsa.gov/topics/health-workforce/shortage-areas.

50. Sandro Galea, Raina M. Merchant, and Nicole Lurie, "The Mental Health Consequences of COVID-19 and Physical Distancing: The Need for Prevention and Early Intervention," *JAMA Internal Medicine* 180, no. 6 (2020): 817–818, https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2764404.

of a robust, adequately paid, and diverse behavioral health workforce to provide a wide range of services at different levels of care.[51]

Once an adequate behavioral health workforce is in place, communities will require training that equips them to deliver care for people in the justice system that is trauma informed,[52] accessible, effective with all patients, and inclusive of people with diverse racial, cultural, ethnic, linguistic, and socioeconomic backgrounds.[53] One way to gain more of this understanding is continued engagement with people who have firsthand experiences with CST and their advocates.

Strategy 5: Expand opportunities for diversion to treatment at all points in the criminal justice system, including after competency has been raised.

States and localities are able to address people's underlying behavioral health needs outside of the criminal justice system when diversion opportunities exist at each point within the system—particularly opportunities that prioritize early intervention through non-mandated care and appropriate supports.[54] This, in turn, helps to reduce people's long-term contact with the criminal justice system[55] and can help reduce the strain on a community's CST process.

State leaders should review existing statutes, rules, and practices to understand current diversion opportunities and identify additional policy opportunities for promoting diversion. About half of the states in the U.S. have statutory provisions for diversion for people with mental health needs.[56] These can range from broad policies encouraging diversion, such as in Texas,[57] to defined diversion program types.[58] An example of this is the Bridges Program in Colorado, a legislative initiative that places behavioral health professionals in each state judicial district to act as court liaisons and facilitate assessments and connections to needed care.[59] Additionally, in Michigan, the Mental Health Diversion Council convened by the governor seeded pilot diversion programs throughout the state and facilitated training and ongoing evaluation of these efforts to inform local and state diversion policies.[60]

51. The Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) model is one example of a model for balancing quality care and wise use of resources. See Wesley Sowers and Robert Benacci, *LOCUS Training Manual: Level of Care Utilization System for Psychiatric and Addiction Services Adult Version* 2000 (Erie, PA: Deerfield Behavioral Health, Inc., 2003), https://redecomposition.files.wordpress.com/2012/12/csplocustrainingmanual.pdf.

52. SAMHSA recommends 10 domains for organizations, agencies, and facilities to evaluate and incorporate trauma-informed principles into practice. See Substance Abuse and Mental Health Services Administration Trauma and Justice Strategic Initiative, *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach* (Rockville, MD: SAMHSA, 2014), https://store.samhsa.gov/system/files/sma14-4884.pdf.

53. SAMHSA, *A Treatment Improvement Protocol: Improving Cultural Competence TIP 59* (Rockville, MD: SAMHSA, 2014). Additional specifics can be found in "National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care," U.S. Department of Health & Human Services, accessed June 3, 2020, https://thinkculturalhealth.hhs.gov/clas/standards.

54. The CSG Justice Center, *Behavioral Health Diversion Interventions: Moving from Individual Programs to a Systems-Wide Strategy* (New York: the CSG Justice Center, 2019), https://csgjusticecenter.org/publications/behavioral-health-diversion-interventions-moving-from-individual-programs-to-a-systems-wide-strategy/.

55. Madeline M. Carter, *Diversion 101: Using the "What Works" Research to Determine Who Should Be Considered for Diversion* (Kensington, MD: Center for Effective Public Policy, 2019), https://cepp.com/diversion-101-using-the-what-works-research-to-determine-who-should-be-considered-for-diversion/.

56. "Pretrial Diversion," National Conference of State Legislatures, accessed June 4, 2020, https://www.ncsl.org/research/civil-and-criminal-justice/pretrial-diversion.aspx.

57. Texas Code of Criminal Procedure section 16.23 requires that "each law enforcement agency shall make a good faith effort to divert a person suffering a mental health crisis or suffering from the effects of substance abuse to a proper treatment center" within reason. Tex. Code Crim. Proc. § 16.23 (2017).

58. For example, Nevada explicitly authorizes a post-plea diversion opportunity for people convicted of nonviolent misdemeanors who have a mental illness. See NV Rev Stat § 176A.250 (2017).

59. Colorado State Court Administrator's Office, "Connecting Colorado's Criminal Justice and Mental Health Systems," (PowerPoint presentation, Colorado Commission on Criminal and Juvenile Justice meeting, June 14, 2019), https://cdpsdocs.state.co.us/ccjj/meetings/2019/2019-06-14_MHJTF_SB18-251_LiaisonBridges_Turner_PPT.pdf.

60. State of Michigan Mental Health Diversion Council, *Mental Health Diversion Council Progress Report* (Lansing, MI: State of Michigan Mental Health Diversion Council, 2018), https://www.michigan.gov/documents/mentalhealth/Diversion_Council_Progress_Report_Jan_2018_611673_7.pdf.

At the local level, Sequential Intercept Mapping[61] and other process mapping approaches can help identify existing diversion efforts, as well as additional opportunities for diversion.[62] Stakeholders from crisis services, law enforcement, jail, courts, pretrial services, community supervision, homeless services, community-based organizations, peer support programs, and housing and community-based treatment providers, as well as people with firsthand experiences and their loved ones, can help illustrate how people with behavioral health needs move through the criminal justice system and where opportunities for diversion currently exist or could be developed. In Illinois, state officials worked with leaders in Cook County to analyze data and develop a range of new strategies for people with mental illnesses, including a misdemeanor diversion program.[63]

Change in Action: Miami-Dade, FL

For more than 20 years, Miami-Dade County, Florida, has engaged a cross-section of leaders to understand their systems and identify strategies to reduce the number of people with mental illnesses in the criminal justice system. Because of this ongoing commitment, they have developed training and protocols for police responding to mental health calls, numerous post- arrest diversion programs, and robust relationships with researchers to help understand the impact of changes. They also stopped initially ordering competency evaluations for misdemeanor cases, and instead began diverting these individuals to treatment.

One particularly innovative way these leaders worked together was developing the Miami-Dade Forensic Alternative Center Program, which diverts people charged with second- and third-degree felonies from the state restoration facility to a local inpatient hospital that includes not only competency restoration services, but also crisis stabilization, development of community living skills, assistance with community reentry (including benefits enrollment), and community monitoring to ensure ongoing treatment following discharge. A 2015 study found that people admitted to the program were discharged from inpatient forensic commitment at an average of 73 days (33 percent) sooner than people who complete competency restoration services in traditional forensic treatment facilities. Upon discharge, most people were enrolled in a post- arrest diversion program where the court monitored their progress for at least 1 year and, in most cases, dismissed the charges upon successful completion. During the year following community reentry, people admitted to the program were half as likely to return to jail and spent an average of 41 fewer days in jail compared to people who received services in state forensic treatment facilities. According to the study, the cost per admission to the program was half that of admission to a state forensic facility.[64]

Ideally, diversion will begin at a person's first interaction with the criminal justice system. Jurisdictions are increasingly developing law enforcement responses for people who have mental health needs, including

- Providing officers with training on mental illness, crisis intervention, and de-escalation;
- Developing specialized teams of officers who respond to calls involving mental illness;

61. "The Sequential Intercept Model," Policy Research Associates, accessed July 21, 2020, https://www.prainc.com/sim/.

62. Stepping Up Initiative, *In Focus: Conducting a Comprehensive Process Analysis* (New York: Stepping Up Initiative, 2019), https://stepuptogether.org/wp-content/uploads/JC_Stepping-Up-In-Focus_Conducting-a-Comprehensive-Process-Analysis.pdf.

63. Meeting with Presiding Judge Sharon Sullivan, Dr. Sharon Coleman, Dr. Lorrie Rickman Jones, and authors, July 8, 2020.

64. Sana Qureshi et al., *Outcomes of the Miami-Dade County Forensic Alternative Center: A Diversion Program for Mentally Ill Offenders* (Miami, FL: University of Miami Miller School of Medicine, 2015).

- Creating co-responder teams, which pair officers with representatives from the behavioral health field; and
- Establishing mobile crisis units, which are generally staffed by social workers, behavioral health professionals, or peers.

While there are many iterations of each of these models and approaches, they all share a common goal: keep people out of the criminal justice system wherever possible and connect them with needed treatment.

Overlaying existing CST processes on local system maps can help identify additional opportunities to divert people to community-based care even once competency has been raised.[65] When standing up such programs, policymakers should ensure that there is a clear mechanism to allow for dismissal of charges and appropriate record clearance, potential transfer of the case to the civil system (if appropriate), and procedures for releasing people from custody, including connections to community-based care. Los Angeles, for example, has developed approaches to divert people facing misdemeanor and felony charges into community-based care with provisions to drop charges upon completion of the diversion intervention.[66] Diversion statutes and program materials should underscore the importance of providing treatment and supports that will be accessible to diverse participants and support regular evaluation to identify any unequal outcomes based on race, socioeconomic status, and sexual orientation.

Any plans for returning people to the community should also include appropriate notification to key individuals, including the person's family members or other loved ones and victims of crime. Prosecutors, with their authority to dismiss charges and their connections with victims of crime, can be particularly helpful in ensuring that these steps function well.

Strategy 6: Limit the use of the CST process to cases that are inappropriate for dismissal or diversion.

The CST process should generally be used only when there is a compelling interest in ensuring that a person is restored to competency so that a criminal case can proceed. Members of the national advisory group noted that for many low-level cases, the CST process may take longer than the maximum potential incarceration for the charged offense. Those scenarios appear to violate the U.S. Supreme Court's ruling in Jackson v. Indiana, which states that "due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed."[67] State policymakers can play an important role in limiting CST to those cases in which the state has a strong interest in adjudication and that clear "off ramps" are in place to divert people to needed community-based care. Of course, a person who chooses to reject an opportunity to participate in a diversion program and proceed with adjudication of their case should always have the right to do so and to proceed through the CST process as needed.

With their state's statutory approach and these considerations in mind, jurisdictions may determine that, for certain charges, the benefit of restoring a person's competency to face that charge in court is not worth the costs. This might be because the person committed a nonviolent offense and would be better served if

65. Debra A. Pinals and Lisa Callahan, "Evaluation and Restoration of Competence to Stand Trial: Intercepting the Forensic System Using the Sequential Intercept Model," *Psychiatric Services* 71, no. 4 (2020): 698–705, https://doi.org/10.1176/appi.ps.201900484.

66. Irving, "Supportive Housing."

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

diverted to non-mandated treatment with a dismissal of charges, or because the time they might spend in jail while awaiting an evaluation and potential restoration is significantly larger than the jail time they would face if convicted of the crime. State task forces can provide helpful information to judges and attorneys through continuing education about the state CST process, statewide outcome data for similar charges, and available alternative case dispositions.

Strategy 7: Promote responsibility and accountability across systems.

States should designate a specific person, a multi-disciplinary team, or an agency to be responsible for ensuring that the CST process proceeds efficiently and effectively at each step. A designated person or agency can closely track each case to ensure that needed steps are taken and linkages across systems happen, whether in the form of paperwork or the physical transportation of people. This individual or agency is also best equipped to track trends and problem-solve any challenges that arise.

Transitions across systems (e.g., from a court to a hospital) present particular risk for delay or confusion, so policies should delineate the responsible party to ensure that cases do not get backlogged at key transition points. Those include

- Getting an evaluation completed after CST is raised in court;
- Returning evaluation results to the court promptly after completion;
- Establishing the beginning of restoration services following an order for restoration;
- Returning a person to court and, potentially, jail after restoration, and making sure the jail can continue the person's medications; and
- Supporting a person's return to the community (from the state hospital or jail).

A number of communities are using designated liaisons to follow each case through those very steps, managing coordination across agencies to advance the case to the next phase of the process. Arizona is establishing standardized descriptions and qualifications for "clinical liaisons," who coordinate care,[68] and is providing additional support in some communities in the form of "peer/forensic navigators"—often people who have experienced the CST process firsthand and help defendants navigate their court cases and path toward recovery.[69]

County jails and state hospitals should also assign clear responsibility for transporting people between jail and the location for their evaluation or restoration, as well as a timeframe for doing so, and support costs accordingly. In Washington, jails must transport a person to the competency restoration site within one day of an offer of admission and must provide their medical clearance to the state hospital admissions staff. The state's Department of Social and Health Services also asks jails to collaborate with hospital admissions staff in screening people for placement to reduce the chances of prolonged delays in the process.[70]

68. Committee on Mental Health and the Justice System, *Developing Best Practices in Restoration to Competency Programs* (Phoenix, Arizona: Committee on Mental Health and the Justice System, 2020), https://www.azcourts.gov/Portals/74/MHJS/Resources/CompetencyRTCBPs2420.pdf?ver=2020-04-27-090342-170; State of Arizona Supreme Court, *COVID-19 Continuity of Court Operations during a Public Health Emergency Workgroup Best Practice Recommendations* (Phoenix: State of Arizona Supreme Court, 2020), https://www.azcourts.gov/Portals/216/Pandemic/050120CV19COOPRecommendations.pdf?ver=2020-05-06-150156-047.

69. Stacy Reinstein, email message to authors, March 3, 2020.

70. "Competency Restoration Facilities," Washington State Department of Social and Health Services, accessed June 3, 2020, https://www.dshs.wa.gov/bha/office-service-integration/competency-restoration-facilities.

Strategy 8: Improve efficiency at each step of the CST process.

For both CST evaluation and restoration, it is critical that people move through the process in a timely manner. While the differences in state systems make national standards challenging to define, some states and stakeholders[71] have established specific timeframes within the CST process to help improve efficiency. States that have statutory timeframes in place should work to understand and address any challenges they may have in meeting these timeframes. To develop new timeframes, stakeholders involved in the various aspects of the CST process should use the process flow developed above (in Strategy 1) to identify critical steps in the CST process that would be amenable to time limits. Stakeholders should also keep in mind the need for timeframes to fit the local structures and capacities, as well as encourage efficiency without creating perverse incentives.[72]

Several communities have also streamlined the flow of CST information within their courts so that they can centralize mental health expertise and reduce the time it takes to complete a CST process. Mechanisms such as "competency dockets" with dedicated calendars allow judges, attorneys, and treatment professionals to develop a deeper understanding of this area of law and related court processes. They also create opportunities to build relationships with behavioral health partners and each other and can potentially improve their ability to share information needed to make timely and appropriate decisions.[73]

Dueling Evaluators

In some communities, defense attorneys and prosecutors spend a significant amount of time and money hiring what are sometimes known as "dueling evaluators"— competing forensic evaluators representing the prosecution and defense. The goal is usually to ensure the quality of the forensic evaluation. But not only does this increase the costs of the case, it also often creates doubt for the court, leading to an order for an expensive evaluation from the state hospital to break the tie. States can reduce this concern and improve efficiency by developing standards for competency evaluators and ensuring qualification using these accepted standards of practice. Evaluators in Michigan are trained through the Michigan Center for Forensic Psychiatry using a method that combines didactics and supervised case work, as well as experience with mock trial testimony.[74] The Maryland Department of Health's Behavioral Health Administration also supervises a core group of evaluators who are deployed locally as needed.[75] And in Tennessee, the Department of Mental Health and Substance Abuse Services contracts with nine agencies across the state to cover all jurisdictions; each court has an assigned outpatient forensic mental health evaluation provider.[76]

71. For example, The National Judicial College provided recommended timeframes for aspects of the CST process. See National Judicial College, *Mental Competency—Best Practices Model* (Reno, NV: National Judicial College, 2012).

72. While time limits may be helpful for guiding behavior, care should be taken to ensure that any time limits are meaningful locally and appropriately resourced. Arbitrary time requirements do not always achieve the goal of getting people into the most appropriate services in a timely manner, and policymakers should be mindful of this consequence, lest people follow the letter but not the intention of the law. For example, stakeholders in Minnesota reported that a requirement to transfer people from jail to a competency restoration program within 48 hours resulted in some individuals being placed in inappropriate levels of care, simply because the programs were more readily accessible. See Stewart, Watts, and Mitchell, *Competency in Minnesota*.

73. This approach has been tried in urban jurisdictions such as Los Angeles, CA, and Multnomah County, OR, as well as on a smaller scale in rural jurisdictions, such as Dougherty County, GA.

74. Debra A. Pinals, email message to authors, July 15, 2020.

75. George Lipman, email message to authors, April 1, 2020.

76. The department's Office of Forensic and Juvenile Court Services also provides training, certification, and ongoing technical assistance to professionals designated at each provider to conduct forensic mental health evaluations and associated services. See Tennessee Department of Mental Health and Substance Abuse Services, *Forensic and Juvenile Court Services Annual Report July 1, 2018–June 30, 2019 (FY 19)* (Tennessee: Department of Mental Health and Substance Abuse Services, 2019), https://www.tn.gov/content/dam/tn/mentalhealth/documents/TDMHSAS_Forensic_Report-FY19.pdf.

Strategy 9: Conduct evaluations and restoration in the community, when possible.

While detention may be required in certain cases, jurisdictions should consider conducting evaluations and restoration in the community to keep people close to home and in the least restrictive environment possible. Decisions about location should be made based on the clinical level of care needed. However, community-based evaluation and restoration options are an important tool to help address competency in a setting that is less expensive than a state hospital or inpatient forensic facility and likely closer to the individual, even in remote areas. As of 2019, almost all states allow restoration services to occur in an outpatient setting (sometimes called "community-based restoration"),[77] and most states have some form of outpatient competency restoration in practice, whether as part of a state-led program or on an *ad hoc* basis.[78] Some states, like Tennessee, use it as the primary approach for handling competency restoration. Others, like Texas, are looking to expand this capacity because these programs show "promising outcomes in terms of high restoration rates, low program failure rates, and substantial cost savings," according to a national survey of the practice.[79] They also have the benefit of taking people out of institutional settings and potentially starting connections with community-based treatment providers and services.

States are also increasingly leveraging technology to overcome geographic challenges and facilitate connections between behavioral health care providers and their patients, an option being used more commonly in light of COVID-19 restrictions on in-person activities.[80] The pandemic has resulted in a sea change in approaches, with many states adapting their forensic services to provide competency evaluations remotely. Michigan, for instance, launched full "Video Conference Forensic Evaluation" services and has conducted hundreds of video evaluations since the services began.[81] Testimony has also been permitted by video and telephone across many jurisdictions.

77. Susan MacMahon, *Reforming Competence Restoration Statutes: An Outpatient Model*.

78. For a list of existing community-based competency restoration programs as of 2016, see W. Neil Gowensmith et al., "Lookin' for Beds in All the Wrong Places: Outpatient Competency Restoration as a Promising Approach to Modern Challenges," *Psychology, Public Policy, and Law* 22, no. 3 (2016): 296–297. MacMahon also includes a list of state statutes as of 2019 in her article. See Susan MacMahon, *Reforming Competence Restoration Statutes: An Outpatient Model*, 627.

79. W. Neil Gowensmith et al., "Lookin' for Beds in All the Wrong Places: Outpatient Competency Restoration as a Promising Approach to Modern Challenges," 293.

80. As courts closed during the coronavirus pandemic, NCSC developed an overview of telehealth resources and options for courts. See NCSC, *Providing Court-Connected Behavioral Health Services During the Pandemic: Remote Technology Solutions* (Williamsburg, VA:NCSC, 2020), https://www.ncsc.org/__data/assets/pdf_file/0014/42314/Behavioral-Health-Resources.pdf.

81. Debra A. Pinals, email message to authors, July 23, 2020.

Jail-Based Restoration Services

A handful of states have explored jail-based competency restoration as a way to keep a defendant in a consistent, secure setting throughout the CST process.[82] For example, Fulton County, Georgia, developed a jail-based restoration program through a collaborative partnership between jail administrators and Emory University School of Medicine, which aimed to create a therapeutic environment, even in the jail setting. The county launched a 16-bed pilot program for jail-based restoration in 2011 that reduced long wait times for those who needed hospitalization while costing significantly less than hospital services.[83] However, jail-based restoration is controversial, as many people do not believe a jail can ever achieve a therapeutic environment. Indeed, several states prohibit jail-based restoration categorically.[84] Whether or not states determine that jail-based restoration is part of their "continuum of services,"[85] policymakers should ensure any policies they approve allow people to be served in the least restrictive setting possible based on their clinical need.[86]

Strategy 10: Provide high-quality and equitable evaluations and restoration services, and ensure continuity of clinical care before, during, and after restoration and upon release.

When it is determined that evaluation and restoration are the appropriate course, these services should be available in a variety of settings and provided consistently with the highest professional standards, including ensuring that services are performed in a manner appropriate for diverse subpopulations. It is also critical that attention is paid to developing clinical care plans that go beyond restoration and toward recovery. Clinical care plans need to be part of the CST process to ensure that whether a person is in jail, in a community-based program, or a hospital or forensic facility, their clinical needs are also addressed.

Conducting universal mental health and substance use screening and assessments at the earliest point possible in the criminal justice system to determine the person's level of behavioral health needs is important to ensure that appropriate clinical care plans are developed and implemented.[87] As with community-based behavioral health supports, care plans also should be designed in a culturally competent manner for the people they are intended to serve.[88] Recent research suggests they should also aim to be "structurally

82. "Alternatives to Inpatient Restoration Programs," NRI Inc., accessed May 15, 2020, https://www.nri-inc.org/media/1500/jbcr_website-format_oct2018.pdf.

83. It's important to note that Fulton County's program includes the following staff members: a psychologist director, a social worker, a masters-level mental health clinician, a part-time diversion specialist, and psychiatry fellows under the supervision of faculty forensic psychiatrists. Many jail-restoration programs across the country do not have this level of mental health expertise on their staff. See Peter Ash et al., "A Jail-Based Competency Restoration Unit as a Component of a Continuum of Restoration Services," *Journal of the American Academy of Psychiatry and the Law Online* 48, no. 1 (2020), 43–51, http://jaapl.org/content/48/1/43.

84. For example, Maryland Code of Criminal Procedure explicitly excludes correctional or detention facilities, as well as units within these facilities, from the list of designated health care facilities that can provide restoration services. Md. Code, Crim. Proc. § 3-106.

85. Peter Ash et al., "A Jail-Based Competency Restoration Unit as a Component of a Continuum of Restoration Services," 43–51, 46.

86. For example, the American Bar Association standard states that "A defendant should be evaluated in jail only when the defendant is ineligible for release to the community." See American Bar Association, *Criminal Justice Mental Health Standards*.

87. "Collaborative Comprehensive Case Plans," the CSG Justice Center, accessed April 23, 2020, https://csgjusticecenter.org/publications/collaborative-comprehensive-case-plans/.

88. For example, the American Academy on Psychiatry and the Law has developed practice guidelines for forensic psychiatric evaluations that include the importance of cultural competence. See Douglas Mossman et al., "AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial," S30. Similarly,

competent,"[89] meaning they should consider structural factors that may impact people's ability to benefit from services, such as geography or socioeconomic status.

While a limited, well-functioning CST process is vital, it is just as important to consider what happens once a person's competency has been restored and they return to jail, or the case ends, and the person returns to the community. Quality treatment upon return to jail and linkage to quality treatment in the community is needed to ensure continued stabilization while supporting next steps in the person's recovery process. "Warm hand-offs" should be made to community-based treatments and supports upon reentry.[90]

One way to ensure that people are connected to care upon release is by establishing methods for collaborative case management to link people to services within and outside of the jail. Collaborative Comprehensive Case Plans draw from information gathered in behavioral health, criminogenic risk, and psychosocial assessments. They can help facilitate efforts to get people to the programs and services that meet their needs and bring together the appropriate professionals and supports to assist them with reintegration and recovery.[91]

"[The judge] felt I needed care, and she was right. I did . . . They developed these programs for us, and we had therapy, and the food was excellent, and we had some recreation, some occupational therapy . . . all of these things were useful."

ANONYMOUS, PERSON WITH A MENTAL ILLNESS DESCRIBING HIS POSITIVE EXPERIENCE RECEIVING CLINICAL CARE IN A STATE HOSPITAL

An important component of successful case planning involves identifying how people will pay for available community services. States may also need to determine whether their laws and policies make it harder or easier for people to access some form of medical insurance to pay for their continued care upon release. This might involve reviewing provisions for Medicaid and other federal and state benefits in their state,[92] as well as the impact these have on people getting medical and behavioral health care when released from incarceration.[93]

Leaders should also pursue strategies to streamline continuity of care. For example, efforts to standardize formularies (i.e., the lists of available, approved medications) used for medication purchases across different treatment settings, including the jail, can help people stay on medications that have been found to work. Putting appropriate processes in place to facilitate sharing health records for treatment purposes can also save time and expense in developing clinical care plans.

the American Bar Association's Criminal Justice Standards for Mental Health include consideration of "the possible impact of culture, race, ethnicity, and language on mental health" in responding to people with mental health needs in the criminal justice system. See American Bar Association, *Criminal Justice Mental Health Standards* (Chicago: American Bar Association, 2016), Standard 7-1.2(b)(iii).

89. "Structural competency" is a term in medical literature to describe the necessity of understanding the impact of social, economic, and political conditions on individual health, including mental health. See Jonathan M. Metzl and Helena Hansen, "Structural Competency and Psychiatry," *JAMA Psychiatry* 75, no. 2 (2018): 115–116.

90. As people with behavioral health needs reenter communities from incarceration, unmet basic or health needs impede their progress toward stability. Some non-criminogenic needs, such as homelessness or severe mental illness, are also likely to interfere with a participant's response to correctional rehabilitation efforts and must be stabilized early before other interventions can proceed. See Dr Douglas B. Marlowe, *The Most Carefully Studied, Yet Least Understood, Terms in the Criminal Justice Lexicon: Risk, Need, and Responsivity* (Alexandria, VA: National Association of Drug Court Professionals, 2018), https://www.prainc.com/risk-need-responsitivity/.

91. "Collaborative Comprehensive Case Plans," the CSG Justice Center.

92. The CSG Justice Center, *Critical Connections: Getting People Leaving Prison and Jail the Mental Health Care and Substance Use Treatment They Need* (New York: the CSG Justice Center, 2017), https://csgjusticecenter.org/publications/critical-connections/.

93. Medicaid and CHIP Learning Collaboratives, "Medicaid Eligibility and Enrollment for Justice-Involved Populations" (PowerPoint presentation, Coverage Learning Collaborative, Washington, DC, February 19, 2015).

"We can better serve some populations by connecting them to appropriate treatment in the community, instead of filling precious state hospital beds with people facing low-level offenses undergoing competency restoration. We need to be smarter about the process and better utilize our resources."

THERESA GAVARONE, STATE SENATOR, OHIO

A Call to Action

Now is the moment to rethink our approach to CST. States are facing significant budget pressures due to increased costs associated with COVID-19. Experts are warning of a wave of increased need for mental health services associated with the pandemic. And renewed calls for criminal justice reform are echoing louder than ever in communities across the country. Using strategies other states have pioneered, jurisdictions can save taxpayer money and improve individual health while ensuring public safety and a better justice system.

Taking action on this report's strategies can have real impact. People who might previously have languished in jail will be moved into more therapeutic settings. Families and friends will have the opportunity to be closer to their loved ones. State and local budgets will be spared wasteful spending. And communities that have historically been both underserved by mental health services and over-represented in the criminal justice system are likely to benefit disproportionately from this change.

Advisory group members who were consulted during the drafting of this report agreed that, despite the budgetary pressures brought on by the COVID-19 pandemic, it is vital to protect investments in mental health, substance use treatment, and associated supportive services, such as affordable housing and case management. Without community-based treatment and supports, people wind up in hospitals and jails, both of which are more expensive and less likely to achieve optimal health and safety outcomes.

Leadership and commitment from policymakers will be critical to overcoming inefficiencies and breakdowns across the criminal justice and behavioral health systems. Policymakers should come together in their states to identify opportunities to apply the principles and strategies articulated in this report and evaluate the best practices identified to see what may work locally.

Some changes, such as increased use of telemedicine and reliance on community-based services, may already be in place as temporary responses to decrease institutional populations in jails and state hospitals due to COVID-19. States should review these approaches and determine if they are successful and can be made permanent. Other changes, such as statutory changes allowing for community-based evaluation and restoration or enhanced community-based treatments, may take more time and planning.

The organizational partners for this report stand committed to supporting states and localities in these efforts, even during the tough times on the immediate horizon. Continued research into current and best practices in this area also can elevate new successful approaches and help provide a clearer picture of how CST operates across the country as the pandemic plays out.

Grounding state efforts in the vision of this report can help states and local practitioners thoughtfully determine a strategy for reducing their CST referrals, improving efficiency within them, and ensuring evaluations and restoration services are provided with equity and quality to protect people's constitutional right to assist in their own defense. By doing this, leaders across the country can work together to develop solutions that improve outcomes for their state and local systems, as well as individual lives, and create just and well CST processes.

The Florida Senate

APPEARANCE RECORD

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1/11/24
Meeting Date

Crim Approps
Committee

ITP presentation
Bill Number or Topic

Amendment Barcode (if applicable)

Name Erica Floyd Thomas

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Speaking: ☐ For ☐ Against ☒ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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S-001 (08/10/2021)

The Florida Senate

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1/11/24
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CCJ Approps
Committee

FDC Mental Health
Bill Number or Topic

Amendment Barcode (if applicable)

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Speaking: ☐ For ☐ Against ☑ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

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Florida Dep of Corrections

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January 11. 2024
Meeting Date

Appropriations Committee on Criminal and Civil Justice
Committee

Discussion of Mental Health Issues in the Criminal Justice System
Bill Number or Topic

Amendment Barcode (if applicable)

Name Judge Steve Leifman

Phone

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Street

Email

Miami Florida 33125
City *State* *Zip*

Speaking: ☐ For ☐ Against ☑ Information **OR** Waive Speaking: ☐ In Support ☐ Against

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S-001 (08/10/2021)

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Jan 11, 2024
Meeting Date

Mental Health
Bill Number or Topic

Amendment Barcode (if applicable)

Appropriations Criminal + Civil Justice
Committee

Name Cynthia Murphy (Cindee) Phone 941-875-4129

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PLEASE CHECK ONE OF THE FOLLOWING:

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S-001 (08/10/2021)

The Florida Senate

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1/11/23
Meeting Date

Senate Appropriations
Committee

Dental Health
Bill Number or Topic

Amendment Barcode (if applicable)

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PLEASE CHECK ONE OF THE FOLLOWING:

☒ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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S-001 (08/10/2021)

THE FLORIDA SENATE

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SENATOR VICTOR M. TORRES, JR.
25th District

January 10, 2024

Jennifer Bradley, Chair
Appropriations Committee on Criminal & Civil Justice
404 S Monroe Street
Tallahassee

Please accept this letter of excusal from myself for the January 11th Appropriations Committee on Criminal and Civil Justice due to an illness. Please accept this letter as a formal request for excusal of this absence. Please let me know if you have any questions or need any additional information.

Respectfully Submitted,

Victor M. Torres, Jr.
Florida State Senator
District 25

REPLY TO:
❒ 101 Church Street, Suite 305, Kissimmee, Florida 34741 (407) 846-5187 FAX: (850) 410-4817
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KATHLEEN PASSIDOMO
President of the Senate

DENNIS BAXLEY
President Pro Tempore

CourtSmart Tag Report

Room: SB 37 **Case No.:** **Type:**
Caption: Senate Appropriations Committee on Criminal and Civil Justice **Judge:**

Started: 1/11/2024 3:02:06 PM
Ends: 1/11/2024 4:31:39 PM **Length: 01:29:34**

3:03:20 PM Sen. Bradley (Chair)
3:04:04 PM TAB 1 - Discussion of Mental Health Issues in the Criminal Justice System
3:04:58 PM Erica Floyd Thomas, Assistant Secretary for Substance Abuse and Mental Health, Department of Children and Families
3:17:07 PM Sen. Martin
3:17:25 PM E. Floyd Thomas
3:17:50 PM Sen. Martin
3:17:56 PM E. Floyd Thomas
3:18:00 PM Sen. Martin
3:18:05 PM E. Floyd Thomas
3:18:42 PM Sen. Martin
3:18:53 PM Sen. Pizzo
3:19:06 PM E. Floyd Thomas
3:19:12 PM Sen. Pizzo
3:19:18 PM E. Floyd Thomas
3:19:22 PM Sen. Pizzo
3:19:31 PM E. Floyd Thomas
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3:20:18 PM Sen. Pizzo
3:20:22 PM E. Floyd Thomas
3:20:27 PM Sen. Pizzo
3:20:41 PM E. Floyd Thomas
3:21:48 PM Sen. Pizzo
3:22:01 PM E. Floyd Thomas
3:22:33 PM Sen. Pizzo
3:22:55 PM E. Floyd Thomas
3:23:28 PM Sen. Pizzo
3:23:57 PM E. Floyd Thomas
3:24:04 PM Sen. Pizzo
3:24:44 PM E. Floyd Thomas
3:25:15 PM Sen. Bradley
3:26:11 PM E. Floyd Thomas
3:27:03 PM Sen. Rouson
3:27:26 PM E. Floyd Thomas
3:28:03 PM Sen. Rouson
3:28:14 PM E. Floyd Thomas
3:28:17 PM Sen. Rouson
3:28:25 PM E. Floyd Thomas
3:28:31 PM Sen. Rouson
3:28:54 PM E. Floyd Thomas
3:29:09 PM Sen. Rouson
3:29:12 PM Sen. Martin
3:29:49 PM E. Floyd Thomas
3:29:52 PM Sen. Martin
3:30:00 PM E. Floyd Thomas
3:30:02 PM Sen. Martin
3:30:11 PM E. Floyd Thomas

3:30:43 PM Sen. Martin
3:32:25 PM E. Floyd Thomas
3:33:24 PM Sen. Martin
3:34:15 PM E. Floyd Thomas
3:35:22 PM Sen. Bradley
3:35:50 PM Dr. Suzonne Kline, Bureau Chief of Mental Health Services, Florida Department of Corrections
3:50:36 PM Sen. Bradley
3:50:40 PM Sen. Pizzo
3:51:03 PM Sen. Bradley
3:51:17 PM S. Kline
3:51:44 PM Sen. Bradley
3:51:48 PM S. Kline
3:52:14 PM Sen. Pizzo
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3:54:19 PM S. Kline
3:54:22 PM Sen. Pizzo
3:54:37 PM S. Kline
3:55:10 PM Sen. Pizzo
3:55:44 PM S. Kline
3:56:59 PM Sen. Pizzo
3:57:56 PM S. Kline
3:58:50 PM Sen. Bradley
3:59:00 PM The honorable Steve Leifman, Associate Administrative Judge, 11th Judicial Circuit of Florida
4:16:18 PM Sen. Bradley
4:16:53 PM Sen. Martin
4:17:59 PM S. Leifman
4:20:38 PM Sen. Bradley
4:20:52 PM Cynthia Murphy
4:28:33 PM Sen. Bradley
4:29:02 PM C. Murphy
4:29:16 PM *