



Just and Well:

Rethinking How States
Approach Competency
to Stand Trial

October 2020



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.

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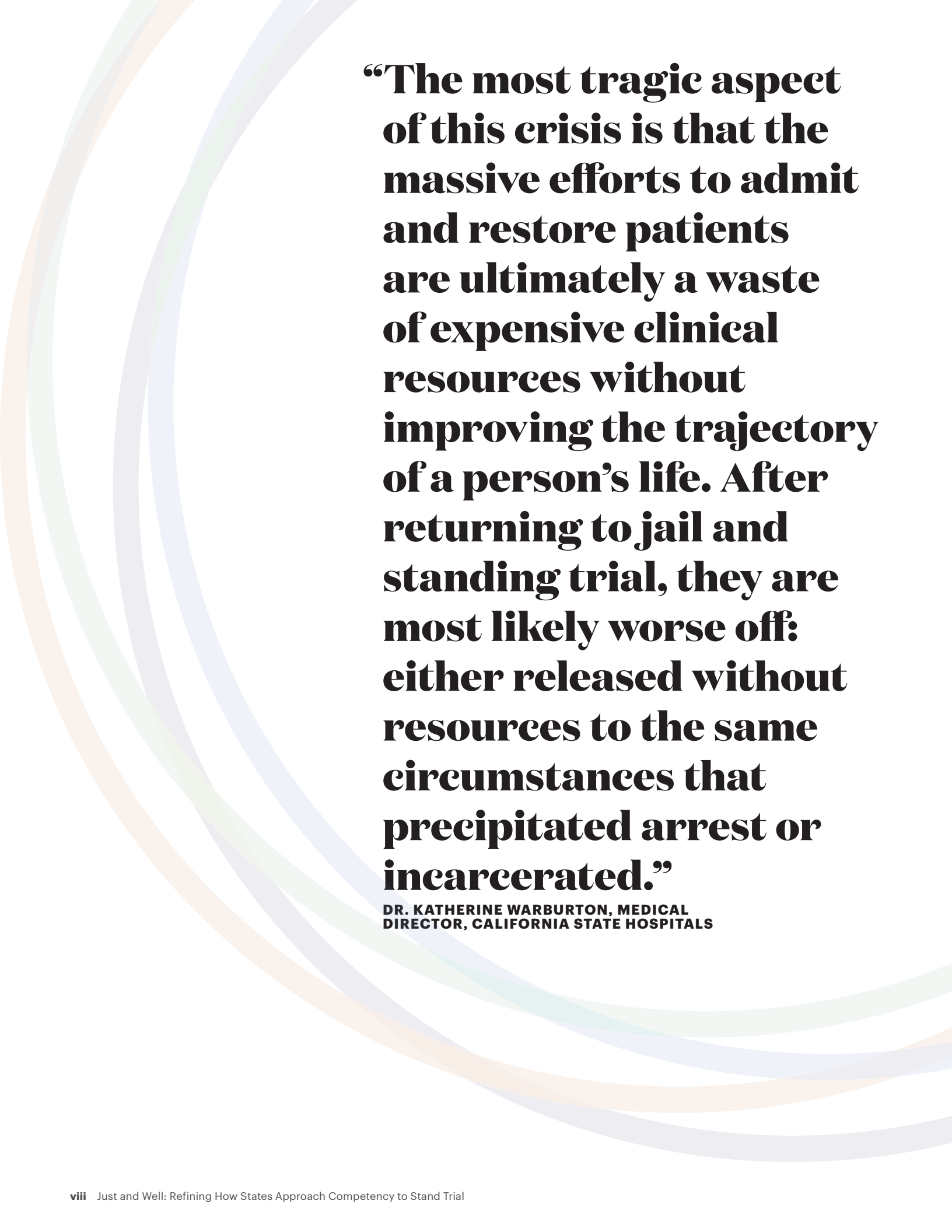
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“The most tragic aspect of this crisis is that the massive efforts to admit and restore patients are ultimately a waste of expensive clinical resources without improving the trajectory of a person’s life. After returning to jail and standing trial,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

**DR. KATHERINE WARBURTON, MEDICAL
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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 academic⁴ 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/nasmhppublisher>.

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 commitment²⁶ 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 costs³⁰ 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, Cassandra 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\(13\)61017-5/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)61017-5/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 CST³⁹ and the American Bar Association's criminal justice and mental health standards.⁴⁰ States should consider how these and other appropriate professional standards and resources⁴¹ 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 psychiatrists 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 Angeles 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://bhwh.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%22colld%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 system⁵⁵ 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://csjjusticecenter.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 Mapping⁶¹ 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 stakeholders⁷¹ 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://csjusticecenter.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. Metzler 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-responsivity/>.

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://csjusticecenter.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.

