Committee on Mental Health and the Justice System
AGENDA

Monday, January 27, 2020
10:00 a.m. – 3:00 p.m.
State Courts Building • 1501 W. Washington St. • Phoenix, Arizona • Conference Room 119 A/B
REGULAR BUSINESS

10:00 a.m.	**Welcoming Remarks**	Mr. Kent Batty, *Chair*
10:10 a.m.	**Approval of November 18, 2019 Minutes** ☐ **Formal Action: Vote to Approve**	Kent Batty
10:15 a.m.	**Follow-up: December AOC Stakeholder Meeting** • Committee Proposals: Appendix B-D	Kent Batty All
11:00 a.m.	**AOC Legislative Update** • HB 2422 and HB 2414 • HB 2581	Liana Garcia Dave Rhodes Amelia Cramer
12:00 p.m.	**LUNCH**	
12:30 p.m.	**National Center on State Courts: National Initiative Update and Discussion**	Patti Tobias Richard Schwermer
1:00 p.m.	**Competency Workgroup: Best Practices in Restoration to Competency** ☐ **Formal Action: Vote to Approve**	Dianna Kalandros
2:00 p.m.	**News & Updates** • Committee Reports	Kent Batty All
2:45 p.m.	**Call to the Public**	Kent Batty
2:50 p.m.	**Adjourn**	Kent Batty

Next Meeting:

February 24, 2020
10:00 am-3:00 pm
State Courts Building
1501 W. Washington
St. Room 345A/B

2020 Meeting Schedule:

March 23	August 24
April 20	September 21
May 18	October 19
June 29	November 16
July 27	December 14

All times are approximate and subject to change. The committee chair reserves the right to set the order of the agenda. For any item on the agenda, the committee may vote to go into executive session as permitted by Arizona Code of Judicial Administration §1-202. Please contact Stacy Reinstein at (602) 452-3255 with any questions. Any person with a disability may request a reasonable accommodation, such as auxiliary aids or materials in alternative formats, by contacting Angela Pennington at (602) 452-3547. Requests should be made as early as possible to allow time to arrange the accommodation.

Committee on Mental Health and the Justice System | DRAFT Minutes

Monday, November 18, 2019

10:00 a.m. – 3:00 p.m.
State Courts Building • 1501 W. Washington St. • Phoenix, Arizona • Conference Room 119 A/B

Present: Kent Batty (Chair), Mary Lou Brncik, Brad Carlyon, Amelia Cramer, Shelley Curran, Asim Dietrich (Proxy for J.J. Rico), Jim Dunn, Hon. Elizabeth Finn, Hon. Michael Hintze, Natalie Jones, Josephine Jones, Dianna Kalandros, James McDougall, Dr. Carol Olson, Ron Overholt, Hon. Barbara Spencer, Beya Thayer (Proxy for David Rhodes), Paul Thomas, Jason Winsky (Proxy for Chief Christopher Magnus), Megan Woods and Susan Podshadley (Proxy for Michal Rudnick)

Telephonic: Hon. Cynthia Kuhn, Kristin McManus, Dr. Michael Shafer

Absent/Excused: Hon. Christopher Staring, Hon. Fanny Steinlage

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Guests/Presenters: Kathy Bashor, Arizona Peer and Family Coalition; Lee Ann Bohn, Maricopa County; Hon. Juan Delgado, Glendale Municipal Court; Andrew Fleming, Banner University Health Plans/Arizona Peer and Family Coalition; Kristina Sabetta, Arizona Peer and Family Coalition

Administrative Office of the Courts (AOC) Staff: Liana Garcia, Don Jacobson, Stacy Reinstein

Regular Business

Welcome and Opening Remarks

Mr. Kent Batty (Chair) asked Committee members and guests to briefly introduce themselves.

Approval of Minutes

Members were asked to approve minutes from October 28, 2019, noting they were in the meeting packet and provided electronically in advance of the meeting. A motion to approve the minutes was made by Jim Dunn and seconded by Paul Thomas. Motion was approved unanimously.

Presentation & Discussion: Arizona Peer and Family Coalition

Kathy Bashor, President of the Arizona Peer and Family Coalition introduced herself and the other presenters, Kristina Sabetta and Andrew (Drew) Fleming. Presentation Slides were made available on the Committee's website in the meeting packet.

Ms. Bashor's work as an advocate began as a dream to create a peer and family system and was involved in spearheading the creation of the Office of Individual and Family Affairs (OIFA) through the Arizona Department of Health Services, which is now housed at AHCCCS. In addition, the OIFA Advisory Council was created to include a powerful community of peer and family-run organizations who provide leadership training, advocacy, and peer and family leads and monitoring within AHCCCS and at each health plan. Ms. Bashor underscored that it is of critical importance for peer and family members to be participants and leaders, and encouraged the Committee and others to tap into the network to support our work moving forward.

Kristina Sabetta presented the Coalition's *Call to Action* based on shared values and the Highlander Statement of Concern and Call to Action:

- We call upon all people committed to human rights to organize and fight against the passage and implementation of legislation making it easier to lock up, shock, and forcibly drug people labeled with psychiatric disorders.
- We call upon all people committed to human rights to work together to build a mental health system that is based upon the principle of self-determination, on a belief in our ability to recover, and on our right to define what recovery is and how best to achieve it.
- We call upon people who have used mental health services to heal each other by telling our stories.
- We call upon elected officials, political candidates, and those with power over our lives to recognize and honor the legitimacy of our concerns through their policy statements, legislative proposals, and their actions.

Ms. Sabetta noted additional threats to the peer and family movement include the two biggest barriers to treatment: stigma and access. One way that stigma is perpetuated is through language, for example the term "frequent fliers" has a negative connotation. Reframing our language and using a "People First" language can help reduce stigma and improve access. An alternative reframing of "frequent fliers" would be to note that people are frequently in and out of our systems because when they enter our system, we did not get them what they needed at the time.

Ms. Sabetta also reviewed the timeline of the mental health and peer and family movements nationally, as well as within Arizona specifically. The "Ladders of Involvement" were presented which include 9 steps to true engagement, participation and initiation, with the attributes of meaningful involvement including access, voice and ownership.

Finally, Ms. Sabetta shared the Coalition's current policy priorities and how those intertwine with the Committee's work.

Andrew (Drew) Fleming currently works as an Adult Member Advocate with Banner University Health Plans where he is able to utilize his experience in the mental health and criminal justice systems to inform policy and decision making, as well as in direct support work with patients.

Mr. Fleming highlighted the need for peer and family specialists to be interwoven throughout the Sequential Intercept Model and put in place as a policy of the organizations and entities that interact throughout the SIM – from community to court, in jails and prisons, and upon re-entry and further community support. Mr. Fleming noted that a defendant, particularly one with mental health conditions, can greatly benefit from the court and jail providing additional understanding and assistance through forensic peers, and not just for individuals who are receiving services with a provider. Mr. Fleming provided additional clear examples along intercepts 4 and 5 – for those who are in prison and upon re-entry.

Committee members thanked Ms. Bashor, Ms. Sabetta and Mr. Fleming and discussed additional areas with the presenters related to creating and enhancing the integration of peer support needed for people in crisis and throughout the justice system.

Court Ordered Treatment Data: Feedback & Discussion

Megan Woods presented the data analysis that she and the team at AHCCCS have been working on related to Court Ordered Treatment. The Court Ordered Treatment Data Snapshots were provided on the Committee's website.

Ms. Woods and the Committee discussed what information AHCCCS has available and the Committee gave feedback on additional data analysis that will be helpful in our mutual work. This discussion also raised some gaps in the data and system, as well as discrepancies between the counties and health plans. Committee members again identified the need to understand why there are differences with the court-ordered evaluation and screening decision-making, and how consistency could be useful.

Maricopa County Mental Health Task Force

Lee Ann Bohn, Maricopa County Assistant County Manager presented the Committee with an update and status report on the Maricopa County Mental Health Task Force which was convened by Presiding Judge Welty and Chairman Gates in 2019. The Presentation was made available on the Committee's website.

Ms. Bohn shared an analysis of the Maricopa County jail population which has helped inform the work of the Task Force. This analysis shows that 17 percent of individuals in jail have some type of mental illness identified during the booking process. Further, when looking at an individual with an identified Serious Mental Illness "flag," additional points of interest include being more than twice as likely to have experienced homelessness; 1.5 times more likely to have more than one booking in a year; and 3 times more likely to have a substance use disorder. Of those individuals who have a mental illness, in comparison to those without a mental illness identification, the majority of the offense types are less serious crimes, including property/theft offenses (28%) and public order (33%). And finally, the data analysis showed that those who have a mental illness are more likely to stay in jail longer – at least twice as long as those without a mental illness.

Ms. Bohn reviewed the Task Force structure, including three primary working groups focused on: (1) Data Sharing; (2) SIM Intercepts 1-5 Mapping Update; and (3) SIM Intercept Zero.

Workgroup Report: Competency Practice

Dianna Kalandros updated the Committee on the current status of the workgroup's best practices for Restoration to Competency programs and shared that the workgroup has been vetting its proposal and inviting individuals and groups within the forensic Psychiatric/Psychology community to review and comment on the proposal.

News & Updates

Mr. Batty informed the Committee that there would not be a December meeting, and its next meeting will be January 27, 2020. Mr. Batty noted that the AOC would convene a stakeholder meeting to discuss and further engage them in the Committee's work, and address concerns that some stakeholders have expressed with its specific proposals and recommendations.

In addition, Mr. Batty noted that the Committee will need to review guidelines on meeting attendance and proxies early in the new year.

Mr. Batty noted that other presenters have been requested by Committee members and others and asked for any additional suggestions or input to be provided to staff.

Mr. Batty noted that Chief Deputy Dave Rhodes will be running for Sheriff of Yavapai County and conveyed how much we appreciate his participation, the work that Yavapai County is doing and its value to the Committee's and State's work in this area.

Good of the Order / Call to the Public
No members of the public requested to speak.

Adjournment
The meeting was adjourned at 1:39 p.m. by order of the Chair.

Committee on Mental Health and the Justice System
January 27, 2020
Legislative Update

Current Bills of Interest*

HB2146 – Pretrial intervention; monies; authorized uses

HB2154 – Recidivism Reduction; evidence-based policies; reports

HB2232 – Competency examinations; records; appointments

HB2250 – Grants; behavioral health treatment services

HB2320 – Psychiatric security review board; hearings

HB2414 – Appropriations; alternative prosecution; diversion programs

HB2422 – Coordinated re-entry planning services program

HB2581 – Dangerous; incompetent person; evaluation; commitment

HB2649 – Prisoners; mental health transition program

*as of 1/22/20; please visit azleg.gov for most recent status

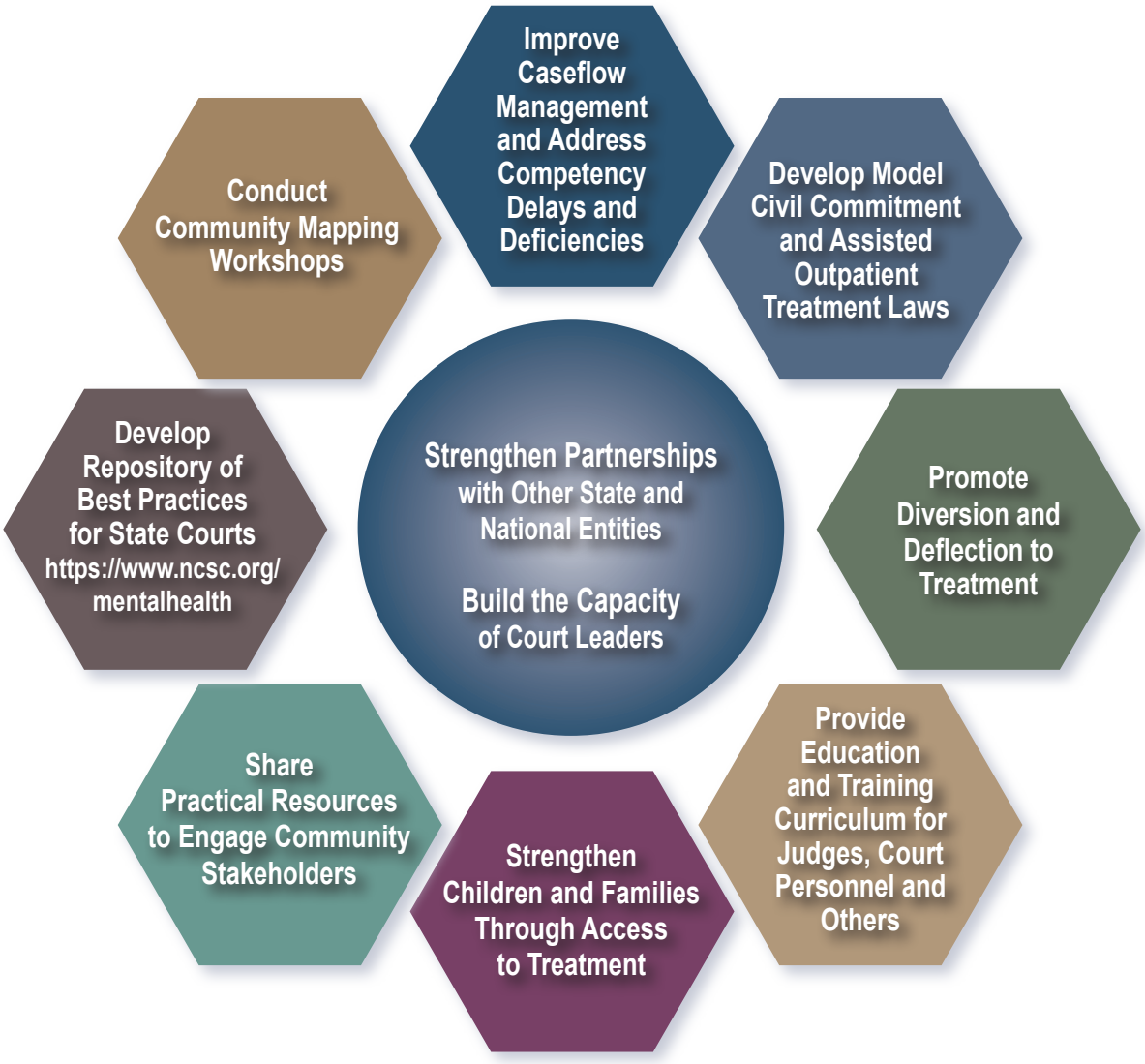
National Initiative funded by the State Justice Institute to Improve the Court and Community Response to Mental Illness

The prevalence of mental illness and co-occurring disorders has greatly impacted the community and the justice system. State court leaders require resources, education and training, data, research, best practices and other tools to devise solutions to the growing number of ways state courts are impacted by cases involving individuals with mental and behavioral disorders.

BACKGROUND

In December 2017, the Conference of State Court Administrators (COSCA) adopted the policy paper, *Decriminalization of Mental Illness: Fixing a Broken System*, endorsed by the Conference of Chief Justices (CCJ) in February 2018. This work culminated in *Resolution 6, In Support of Improving the Justice System Response to Mental Illness*, adopted by CCJ/COSCA at the 2018 Annual Meeting. In early 2019, the State Justice Institute (SJI) awarded a three-year strategic initiative grant to the National Center for State Courts (NCSC) to support CCJ and COSCA in its commitment to improve the court and community response to those with mental illness and co-occurring disorders.

NATIONAL PRIORITIES



LEADING CHANGE: THE NATIONAL INITIATIVE'S STRATEGIC DIRECTION

LEADERSHIP

The CCJ/COSCA Advisory Committee, along with NCSC, are providing leadership to improve court and community responses to mental illness and co-occurring disorders. The Advisory Committee includes:

Co-Chairs

Hon. Paul Reiber, Chief Justice, Vermont Supreme Court (CCJ)

Hon. Milton Mack, Jr., State Court Administrator, Michigan State Court Administrative Office (COSCA)

Members

Hon. Mary Ellen Barbera, Chief Judge, Maryland Court of Appeals (CCJ)
Hon. Nathan Hecht, Chief Justice, Supreme Court of Texas (CCJ)
Nancy Cozine, State Court Administrator, Oregon Office of the State Court Administrator (COSCA)
Hon. Lawrence Marks, Chief Administrative Judge, New York Office of Court Administration (COSCA)
Hon. Steven Leifman, Judge, Miami Dade County, Florida
Hon. Paula Carey, Chief Justice, Massachusetts Trial Court (President, NAPCO)
Paul DeLosh, Department of Judicial Services, Supreme Court of Virginia (Past President, NACM)
Ex Officio Member – Hon. David Brewer, Retired Justice, Oregon Supreme Court
Ex Officio Member – Jonathan Mattiello, Executive Director, SJI

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Conference of Chief Justices 1949 · COSCA Conference of State Court Administrators · SJI State Justice Institute · NCSC National Center for State Courts

STATE JUSTICE INSTITUTE
IMPROVING THE JUSTICE SYSTEM RESPONSE TO MENTAL ILLNESS

NCSC Competency Focus Group

Discussion Summary

As both a constitutional principle and one of fundamental fairness, the government cannot prosecute a defendant who does not understand the nature of the charges against him and cannot participate in his defense. While *Dusky* articulates this standard in broad terms, states have operationalized it in a multitude of ways. There is no clear consensus among the states about how, when, or where competency should be measured.

The process of legally restoring a presumptively incompetent defendant is likewise inconsistent. Where it is done, by whom, for how long, and even what elements such a process consists of are different from state to state.

On October 4, 2019 eight trial judges from around the country were convened by the National Center for State Courts to discuss their experiences, observations, and needs relative to the forensic competency process. They were asked to identify promising practices, gaps in resources or knowledge, and changes they thought would improve that system. The following are the actions they identified as needing the most immediate attention from policymakers, though as one judge put it, all of these issues are important, and we can't afford to address them one at a time, they all require urgent and immediate attention.

The most urgent issues relate to the fundamentals of the process – liberty interests and effective treatment:

Expedite and make uniform timing at all points of the process. Screening, assessment, and evaluation delays have particular implications for the liberty interests of defendants. Oregon rapid evaluation process once competency is raised seems promising, usually within 5 days, and California often does competency evaluations for both in and out of custody defendants within one day. Research shows that the sooner one is engaged with treatment, the better the outcomes, and there are obvious deleterious effects of staying in jail while these processes play out.

Later in the process there are also significant concerns about timely placement upon a finding of a defendant's incompetency and additionally for prompt return to court with a sufficiently resourced plan to maintain a restored defendant's competency.

Legal standards and processes vary from state to state, but model time standards should be developed for each stage of the process, based on relevant efficacy research and a respect for the liberty interests of the defendants.

Improve treatment options throughout the process (meaning treatment in the broad sense, i.e. including housing and other supports). Treatment needs to begin before the legal consideration of competency, and an appropriate continuum of effective treatment resources must be available throughout the evaluation, competency determination, and restoration processes.

Without meaningful treatment options, case management, wrap around services, housing and the like, a trial court in the process of adjudicating competency issues often is unable to set meaningful and realistic conditions for a defendant's release. A trial court should not be placed in the position of effectively ordering illusory conditions of release or conversely of detaining persons for want of clinicians to provide evidently necessary treatment in a least restrictive setting.

Effective treatment must also include an emphasis on diversion and deflection The best way to avoid the inefficiency of the competency process, and the above list of problems that come with it may be to avoid the competency process altogether. For appropriate cases, treatment and diversion from the criminal system entirely seems the most effective, cost-efficient, and humane course. For example, several judges described ways in which the systems in their states presumptively removed misdemeanants from the competency process altogether, even post-charging. This approach reserves competency and restoration resources for those who are more likely to need that level of intervention.

- The judiciary should play a role in Intercept 0 opportunities, including judicial outreach (compassion, stigma reduction, also focus on diversity/inclusion)
- Intercept 1 diversion opportunities should be emphasized, and resources to which defendants can be diverted expanded
- Consider opportunities for court involved or court directed treatment, aside from competence consideration, perhaps akin to AOT, but pre-plea and pre-competency determination
- The need for housing resources cannot be overstated. Treatment is much less likely to be effective if this need is not addressed early in the process.

Develop the behavioral health treatment workforce Related to the overall issue of supporting an effective treatment continuum, this is a pervasive issue, and is most acute in rural areas. More and perhaps different resources are needed in rural jurisdictions. Tele-health services seem promising for some functions. Urban jurisdictions are also affected by this deficiency though. In both settings the issue of what qualifications a competency evaluator should have is important to address.

This lack of a sufficiently robust behavioral health workforce not only effects the treatment required for restoration and maintenance of competency but also significantly impedes efforts to stem the larger behavioral health crisis.

The next broad issue relates to the restoration process:

Assess the appropriate use of jail-based restoration There is some sense that it should be prohibited, unless clearly required. While everyone believes that community-based restoration appears to be preferable, the issue becomes what the alternative is. Other alternatives may not have the ability to provide medication monitoring and other short-term compliance monitoring. Which setting is

appropriate should be based on the offenders clinically determined needs. Community safety considerations and victim perspectives are also relevant. More research may be needed to help inform this decision, but clearly there should be a continuum of settings that can be matched to the defendant's therapeutic and safety needs.

The added complication of private for-profit jails, some of which provide restoration services, makes the practice even more concerning. Several state's statutes (e.g. Maryland) simply prohibit restoration in any jail. Where custodial settings *are* appropriate, they should be as therapeutic as possible.

Better Define Restoration Services There are different definitions of what the restoration process is – it can be legal education, treatment, or both. The legal education alone approach seems insufficient, if not inappropriate.

Promote effective post-restoration services Best practices need development and dissemination. After we put all the time, effort and resources into community restoration (or even in a more structured setting), we should make sure the person is transitioned onto a path of sustainable treatment and housing.

Improve the transition to civil commitment Options for transitioning to a civil process should occur early in the process, whether as an alternative to the criminal process entirely, or as an adjunct to the criminal process, akin to an AOT format.

At the post-restoration stage, we need best practices re who files or has the responsibility to initiate a civil commitment, and what the specific timing and trigger is. The Oregon statute directs the judge to look at transition options, including civil commitment. California judges can order an investigation into danger to self or others by the conservatorship investigator, who would then direct the civil process. But the protocol for this stage in the proceedings varies widely from state to state, and the principles for how this should work need to be clearly articulated.

The remaining issues relate to important system efficiencies and best practices

Maximize technology to:

- Have better, more complete, timely information about participants;
- Provide less threatening (for some) court interfaces to defendants via video or virtual technologies;
- Allow for better access to resources and resource inventories;
- Promote more accurate descriptions of resources and eligibility requirements;
- Enhance timeliness of evaluations;
- Increase rural treatment services;
- Enhance uniformity of pleadings and practices.

Improve treatment efficacy We need research on what treatment modalities work, when, and where. How does a judge know if the treatment to which a defendant is ordered is "good" treatment? We also need support for effective and appropriate peer support programs, as they seem promising.

Assess the role of the judge Especially when there is no appropriate continuum of treatment options and when executive branch players are unable or unwilling to meet court-ordered or statutory timelines or other responsibilities, judges are put in the position of having to compel compliance with those orders or statutes. The adversarial system doesn't seem to work as well in the competency context, which puts judges in the uncomfortable position of having to be more of an advocate when they see systemic failures that impact individual defendants. Judges are a sometimes uncomfortable when they try to lead out in that individual capacity.

Assess the federal role The federal role would, optimally, include allocating funds, allowing flexibility in use of those funds, support for research, and perhaps an IMD exclusion repeal, but obviously without going back to gross institutionalization. Clear federal policies and funding structures favoring continuity of care for this severely ill revolving door population of competency defendants and similarly situated individuals would also be of enormous benefit.

Resolve data-sharing and privacy Best practices on universal releases and unique identifiers would be helpful. It appears that HIPPA and 42 CFR are read more broadly than intended sometimes, but because of their complexity and opacity, judges sometimes lack the nuanced understanding of the regulations, and a lack of appropriate information sharing can occur.

Improve process efficacy data Leverage the cost-savings aspects of early treatment and evidence-based practices. We need to collect the data though, so outcome evaluation and measurement of particular practices and programs is important. The judiciary can play a role in articulating these savings and advocating for effective practices.

Enhance coordination A boundary-spanner type role is especially important with this population – resolving, consolidating, and coordinating multiple cases in multiple jurisdictions. Some person, whether in the judicial branch or the executive branch, should have the responsibility to facilitate this communication as well as legal and treatment coordination. The resource savings should quickly outweigh the cost. We should explore and the potential placement in the courts of liaisons, navigators, facilitators, and the like. The ability to link the treatment and legal systems, and to translate the needs of each to one another seems to benefit all stakeholders.

Improve court case management Consolidated calendars breeds consistency and competence. Perhaps also include Mental Health Court, civil commitments, temporary holds or interventions, guardianship/conservatorship proceedings, GAMI, NGRI, etc. in those calendars. Broad education about mental health issues of all judges is also important, as well as education about procedural fairness/procedural justice concepts – those are particularly important considerations when working with people with behavioral health needs. Consistent assignment of counsel is also a promising practice, for the rapport of the "team," for awareness or resources, and for implementation of best practices.

Support J**udicial well-being efforts**. Several states are following-up on the ABA's recent lawyer well-being effort with judicial well-being programs, and judges (and staff) involved in the spectrum of issues surrounding competency may be particularly vulnerable to vicarious trauma.

One post-script, just so that it isn't lost:

A thread that resurfaced several times during the day was the extent to which the legal concept of "competency" is a useful framework for addressing these problems. Thinking of this as a competency issue is perhaps too narrow, and that may constrain the conversation and limit the scope of the solutions. However, it was also noted that legal competency can give the court a lever that can be used to compel treatment. It also constitutes an entitlement to treatment, and a way that some well-meaning system actors seek to access services that otherwise would not be available. Again, this speaks to a lack of appropriate treatment options across the continuum.

As Judge Lipman stated: "Many court -involved seriously mentally ill defendants in Maryland never touch the competency process. Competency is perceived as a high standard. The majority of seriously ill individuals who are in contact with the criminal justice system are diverted, placed on therapeutic pretrial conditions of release, given clinically meaningful conditions of probation, apart from competency evaluation, adjudication or restoration."

Appendix:

To better understand the perspective of our participant judges, they were asked to generally describe the issues, challenges, and innovations in their states relative to the competency process.

Judge Nan Waller (Multnomah County Circuit Court, Portland, Oregon)

- State Hospital resources dictated a need for change, and one solution was to perhaps divert misdemeanants.
- "Rapid evaluation process" gets a competency evaluation done quickly, within days. This process gets incompetent folks out of jail and into treatment quicker.
- A 2019 law now requires a dangerousness determination in order to be eligible for the State Hospital setting. There is also a 7-day reevaluation clause in the bill may have constitutional issues (because they would continue to hold people in custody after an incompetency determination), and that may be revisited in the next legislative session.
- The good news is that this is forcing the creation of temporary therapeutic settings, as alternatives to jail.
- There is also an issue on the back end – after restoration time periods time out, we release them to nothing.

Judge James Bianco (Superior Court of Los Angeles County, California)

- There has been a large increase in competency proceedings lately, mostly because defense counsel, on misdemeanants, has recently decided it is a better practice to raise competency, whereas before they didn't. But misdemeanor treatment, the responsibility of counties in California, was only in jails. Now there are community resources (200+ in LA County in the new resource), but there is a similar number of people getting treatment/restoration services in jails.

- On the felony side, the state is responsible, and the State Hospital backlog is 2-5 months. Judges have begun to impose day fines on the State for these delays past statutory timelines.
- Office of Diversion and Reentry allows felony restoration in the community. Note the downside risk, one person released to this program killed his mother while in the program.
- One can, in some circumstances, keep restored folks in the therapeutic setting rather than jail before and during trials.
- USC and UCLA have forensic psychiatry fellowships, and they work in the courthouses, and then sometimes become the permanent providers afterwards.

Judge Jonathan Shamis (Lake County Court, Fifth Judicial District, Leadville, Colorado)

- Colorado's recent progress is largely because of a recent lawsuit and consent decree and the fallout therefrom. And while the consent decree and plan going forward is a good one, there are insufficient safeguards and oversight measures to ensure compliance. So even a lawsuit and consent decree don't necessarily create sustainable and effective change.
- If we place people with significant needs in a community resource that is insufficient to meet their needs, and they fail, we've done them no favors – we've made them worse.
- Incarceration makes defendants ineligible for Medicaid, so their ability to get timely and appropriate community services and to transition successfully diminishes.
- Colorado is engaged in an extremely promising endeavor to place court liaisons in each jurisdiction. These court employees serve as behavioral health "translators" and case managers, bridging the gap between the treatment and criminal justice systems.

Judge George Lipman (First District Court, Baltimore, Maryland)

- Their recent experience is unusual in that their competency volume has not increased dramatically. It is relatively flat.
- Maryland has dedicated competency judges.
- The biggest structural issue is services silos, and there are no wraparound services or supportive services.
- A class action lawsuit filed, but no real change came about.
- New legislation: no restoration services in jail, they must be by the Health Department, in the community or in a treatment facility.
- Two Sessions ago the Maryland General Assembly amended the competency statute to not only prohibit restoration of competency in detention centers but also to require the State Health Department to place a defendant found incompetent and dangerous in a state hospital or state designate health facility within 10 working days of the trail court's commitment order. The statue also permits the trial court to impose reasonable sanctions upon the Health Department, including the defendant's jail costs, if the Department fails to place within the time frame. The statute also requires the trial court to hold a hearing within 10 working days of the Health Departments notice or their opinion that a defendant has been restored to competency.

Judge Mark Stoner (Marion Superior Court, Criminal Division, Indianapolis, Indiana)

- Resources are an issue; his involvement came from frustration with a lack of compliance with constitutional and statutory restoration responsibilities and timelines.
- Mental health issues aren't particularly sexy, and there is little public attention on the issue. Unlike the opioid crisis, for example.
- Recently there were 80 incompetency commitments in Indiana, languishing in county jails, awaiting treatment. This led to contempt proceedings against the Department of Mental Health.

Judge Brian Grearson (Chief Superior Judge for the Trial Courts, Vermont)

- There are only 25 secure mental health beds in Vermont.
- Orders for hospitalization kick in when incompetence is determined, then it becomes a civil process.
- Misdemeanors are dismissed, as a practical matter, 95% of the time when incompetence is determined. But it is a civil context, so they still get treatment.
- For felonies and misdemeanors once it is civil the proceedings become confidential, so the prosecutors are out of the picture, and they are starting to object to that blindspot.
- Mental health screens are done in court, often within 2 hours. That determines whether they need inpatient treatment. To some extent this is the result of the extraordinarily rare bail hold process.

Judge Matthew D'Emic (Presiding Judge of the mental health court in the New York State Supreme Court in Brooklyn, New York.)

- There are significant differences between the city and the rest of the state.
- In New York, restoration is not treatment. It is more of a legal education model.
- Judge D'Emic frequently sees people who are found competent after restoration services were successful, then they go back to jail (Rikers), decompensate, and start all over again. One successful response is that when competency is restored, they are assigned to mental health court dockets/judges.
- In New York, misdemeanors result in a 90 day treatment opportunity, but there is no restoration process option.

Judge Michael Hintze (Phoenix Municipal Court, Phoenix, Arizona)

- Restoration is often in jail, at least in Maricopa and Pima counties; outpatient is available, but there aren't enough community evaluators and providers. Pre-screens occur in the municipal courts, and doctors turn those around in a day or two. They are coordinated to be at the courthouse on mental health calendar days.
- They do a pre-screen (triage) to determine if a full competency evaluation is necessary.
- Arizona is working now to adopt best practice standards for the competency and restoration process.
- The Arizona Supreme Court certifies and trains competency evaluators.

- Judge Hintze's court uses some many problem-solving court principles, so e.g. the judge, prosecutor and defense attorney operate as a team in competency proceedings. This consistency makes for much quicker and more effective processes and decisions.
- Arizona is working on uniform database and information sharing system. They are currently trying to arrive at a consensus single identifier for defendants, across systems.
- Peer support in the jails has been very successful.
- Misdemeanor restoration isn't done, largely because there are 30, 120 and 180 days for the various misdemeanor offense levels. That's generally too quick to restore, except for the severe 180-day-level offenses.

Committee on Mental Health and the Justice System
Developing Best Practices in Restoration to Competency Programs

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OVERVIEW

The Committee on Mental Health and the Justice System (Committee), established by Administrative Order 2018-71, has been tasked with studying, and if necessary, making recommendations to effectively address how the justice system responds to persons in need of behavioral health services. The Committee is also charged with reviewing court rules and state statutes for changes that can result in improved court processes in competency proceedings, court-ordered treatment hearings and other hearings where a litigant may need mental health treatment.

The Committee's Competency Practices Workgroup has been charged with examining evidence-based and best practices for competency evaluations and restoration to competency programs and making recommendations for Restoration to Competency (RTC) programs statewide.

Arizona is one of the first states in the country to develop such a Best Practices Guide. The workgroup has invited many subject matter experts to review its proposal including practitioners, mental health experts, and treatment and correctional health staff professionals from the psychology and psychiatry community.

In addition, Arizona is currently participating on a working team with the National Center on State Courts and Council of State Governments. This national team is focused on developing recommendations for states' competency programs, including immediately addressing delays that cause people to languish in jail without treatment; limiting competency proceedings to only the most serious offenses; emphasize diversion and a continuum approach to treatment; and assessing the appropriate use of jail-based restoration.

The workgroup believes that it is well-positioned to make these recommendations for Best Practices and recognizes that implementation of these guidelines will require an intentional approach by the Court and local jurisdictions, as well as the behavioral health provider community.

The workgroup also strongly recommends the creation of a university-based partnership, focused on forensic psychology and the law, to further improve the training, education, and career development pipeline for those who work in the fields of forensic psychology, psychiatry, nursing, social work, and the medical and legal fields. Finally, the compensation and contracts for individuals and providers must be reviewed in order to ensure implementation of these best practices.

The content that follows this Best Practice Guide includes:
(1) Qualifications
(2) Duties
(3) RTC Program Instructions
(4) Appendices with Additional Resources

Section 1: Qualifications

This section details the recommended qualifications for the primary staff involved in a Restoration to Competency program.

CLINICAL LIAISON

Minimum Qualifications:

- Must meet the Statutory Definition found in A.R.S.§13-4501:
  - A mental health expert or any other individual who has experience and training in mental health or developmental disabilities.
  - Who is qualified and appointed by the court to aid in coordinating the treatment or training of individuals who are found incompetent to stand trial.
  - If intellectual disability is an issue, the clinical liaison shall be an expert in intellectual and developmental disabilities.

Preferred Qualifications:

- Experience and knowledge of the Arizona Behavioral Health System
- Experience and knowledge of the Arizona Division of Developmental Disabilities
- Experience and knowledge of the Arizona Long Term Care System

RESTORATION SPECIALIST

Minimum Qualifications:

- Bachelor's degree with minimum of 5 years' experience working in a field of Social Work, Counseling, Education, Legal, Behavioral Health, or with vulnerable populations (i.e. – aging/adult, developmental disabilities, homeless, etc.).
- Demonstrated knowledge of working legal terminology and court processes specific to criminal proceedings.
- Able to demonstrate knowledge of Arizona's competency standards and statutes.
- Restoration Specialist must be proficient in the defendant's primary language or in order of preference:
  - Request the Court provide an interpreter through the Arizona Court Interpreter Credentialing Program;
  - Utilize a Court approved language line.
- Experience and/or education related to at-risk learners and will utilize that knowledge to create an individualized Restoration Education Program for each referred defendant.

Preferred Qualifications:

- Master's degree in Education or in a Human Services field.
- Experience teaching persons with special needs and/or at-risk learners.
- Experience and knowledge of the Arizona Behavioral Health System.
- Experience and knowledge of the Arizona Division of Developmental Disabilities.

- Experience and knowledge of the Arizona Long Term Care System.

MENTAL HEALTH EXPERT (MHE)

Minimum Qualifications:

- Must meet the Statutory Definition in A.R.S.§13-4501:
  - A physician who is licensed pursuant to title 32, chapter 13 or 17 or a psychologist who is licensed pursuant to title 32, chapter 19.1 and who is:
    - Familiar with this state's competency standards and statutes and criminal and involuntary commitment statutes.
    - Familiar with the treatment, training and restoration programs that are available in this state.
    - Certified by the court as meeting court developed guidelines using recognized programs or standards.
- MHE must be proficient in the defendant's primary language or in order of preference:
  - Request the Court provide an interpreter through the Arizona Court Interpreter Credentialing Program;
  - Utilize a Court approved language line.

Preferred Qualifications:

- Experience teaching persons with special needs and/or at-risk learners
- Experience and knowledge of the Arizona Behavioral Health System
- Experience and knowledge of the Arizona Division of Developmental Disabilities
- Experience and knowledge of the Arizona Long Term Care System.
- Experience and knowledge of other special populations with unique needs, including individuals with traumatic brain injury.

RESTORATION TO COMPETENCY PSYCHIATRIST:

Minimum Qualifications:

- Must meet the Statutory Definition in A.R.S.§13-4501.
  - A physician who is licensed pursuant to title 32, chapter 13 or 17 and who is:
  - Familiar with this state's competency standards and statutes and criminal and involuntary commitment statutes.
  - Familiar with the treatment, training and restoration programs that are available in this state.
  - Certified by the court as meeting court developed guidelines using recognized programs or standards.
- The Psychiatrist must be proficient in the defendant's primary language, or in order of preference:
  - Request the Court provide an interpreter through the Arizona Court Interpreter Credentialing Program;
  - Utilize a Court approved language line.

Preferred Qualifications:

- Experience teaching persons with special needs and/or at-risk learners
- Experience and knowledge of the Arizona Behavioral Health System
- Experience and knowledge of the Arizona Division of Developmental Disabilities
- Experience and knowledge of the Arizona Long Term Care System.
- Experience and knowledge of other special populations with unique needs, including individuals with traumatic brain injury.

Section 2: Duties

This section details the recommended duties to be included for each of the primary staff involved in a Restoration to Competency program.

CLINICAL LIAISON

The Clinical Liaison is responsible for the coordination of care for individuals who encounter the Restoration to Competency process. The Clinical Liaison shall ensure continuity of care and is responsible for release coordination.

If the defendant is found not competent and unable to be restored, the Clinical Liaison will assist in the defendant's coordination of care through the Title 36 (civil commitment) process or the Title 14 (guardianship) process with the Superior Court.

RESTORATION SPECIALIST

The Restoration Specialist is designated to provide the Education Program for the defendant, and to consult with the assigned Mental Health Expert in the provision of those services, with the goal of achieving or restoring the defendant's mental competency.

The Restoration Specialist is required to meet and participate in an initial consultation with the Competency Mental Health Expert (MHE) to develop the restoration plan and then to continue to engage in consultation during the entirety of the restoration process.

Meetings between the Restoration Specialist and the MHE will include:

- Review of the most recent Rule 11 reports, and prior Rule 11 reports, if available.

- Development of a Restoration Plan (within 10 business days), to include:
  - Identify areas where the defendant is already competent, if any.
  - Evaluate the specific deficits or problems that are barriers to competence (i.e. lack of knowledge, psychosis, developmental delay, etc.).
  - Obtain additional information from the Court/Attorneys to assist in developing the Restoration Plan.
  - Incorporate recommendations from the Rule 11 reports.
  - List recommendations by the MHE.
  - Describe individualized methods of instruction appropriate for the defendant, including the multimodal formats in which instruction will be delivered.
  - Signed by the Restoration Specialist and the MHE.

- Revising the Restoration Plan every 60 days and submitting the Plan with the required status report to the Court.

- Telehealth or other video conferencing instruction is acceptable as long as an in-person visit is completed every fourteen (14) days.

MENTAL HEALTH EXPERT (MHE)

- The Mental Health Expert meets face-to-face with each Restoration Participant a minimum of every 30 days.
- Engage in ongoing consultation with the Restoration Specialist and Psychiatrist (if any) throughout the restoration services.

- The MHE and the Restoration Specialist will develop a Restoration Plan within ten (10) business days and revise the Restoration Plan every 60 days.

- The Restoration Plan will:
  - Identify areas where the defendant is already competent, if any.
  - Evaluate the specific deficits or problems that are barriers to competence (i.e. lack of knowledge, psychosis, developmental delay, etc.).
  - Obtain additional information from the Court/Attorneys to assist in developing the Restoration Plan.
  - Incorporate recommendations from the Rule 11 reports.
  - List recommendations by the MHE.
  - Describe individualized methods of instruction appropriate for the defendant, including the multimodal formats in which instruction will be delivered.
  - Signed by the Restoration Specialist and the MHE.

- The Restoration Plan should have goals in these areas:
  - The defendant will evidence a sufficient level of factual understanding of court related issues as to be found competent to stand trial, including:
    - Knowledge of the charge(s);
    - Knowledge of the possible consequences of the charge(s);
    - Pleas and plea bargaining;
    - Roles of the courtroom personnel;
    - Adversarial nature of the process;
    - Understanding and evaluating evidence; and
    - Knowledge of courtroom procedures.
  - The defendant will evidence a sufficient level of rational understanding of court related issues so as to be found competent to stand trial.
  - The defendant shall evidence sufficient ability to assist counsel in developing a defense so as to be found competent to stand trial.
    - Including ability to communicate rationally with defense counsel.
    - Including the capacity to integrate and efficiently use the knowledge and abilities outlined in either a trial or a plea bargain situation.
  - Stress-reduction techniques related to the court proceedings, if necessary.
    - This may include providing specific accommodations related to the defendant's mental health/developmental diagnosis, such as: slowing the process down for defendants who have auditory processing issues; allowing for breaks for defendants who are overwhelmed with anxiety or have another condition such as IBS; etc.

- For each Goal of the plan, the MHE will need to list interventions such as:

- The defendant will meet with the Restoration Specialist 2 to 3 times per week to receive education about the legal system to improve factual understanding of court processes.
- The defendant will meet with the Restoration Specialist 2 to 3 times per week to discuss court processes in order to improve rational understanding.
- The defendant agrees to a referral to a psychiatric evaluation of presenting symptoms which contribute to the on-going questions regarding the defendant's legal competency to stand trial.
- The defendant will receive supportive education to encourage full engagement with the restoration process to develop legal competency.
- The defendant will sign releases of information to allow the Restoration Specialist and Mental Health Expert to acquire prior treatment records for restoration education purposes.

- If at any time the MHE is unable to meet the requirement of submitting the report ten (10) working days prior to the competency hearing, the MHE shall contact the appointed Clinical Liaison.

- Clinical interview, analysis, interpretations, report writing, and recommendations may be conducted only by the licensed psychologist or psychiatrist.

- If the defendant is not able to be restored, the MHE must identify if Title 14 and/or Title 36 recommendations to the Court will be made in the final report.

- Telehealth or other video conferencing services are acceptable, but not exclusively. An in-person assessment is required every thirty (30) days.

RESTORATION SPECIALIST AND MENTAL HEALTH EXPERT MUST:

- Engage in ongoing consultation throughout the restoration services.

- Review case progress at least once every fourteen (14) calendar days throughout the service provision period, or more often as needed.

- Consultation may occur in person or telephonically, and may be accompanied or confirmed by email, but the consultation cannot be completed solely via email correspondence.

- Discussion shall include the defendant's progress, barriers to progress, and the ongoing determination of whether there is a substantial probability that the defendant will regain/achieve competency and if not, if recommendations for Title 14 and/or Title 36 will be made.

- Modify the training material and instruction methods as necessary to meet the individualized needs for the defendant, and to consider all cultural, educational, developmental, behavioral and mental health needs.

- Modify the frequency and content of instruction after consideration of the defendant's individual needs.

- Identify stress-reduction techniques related to the court proceedings, if necessary. This may include providing specific accommodations related to the defendant's mental health/developmental diagnosis, such as: slowing the process down for defendants who have auditory processing issues; allowing for breaks for defendants who are overwhelmed with anxiety or have another condition such as IBS; etc.

- It is the responsibility of the Restoration Specialist and MHE to translate legal terminology into a level of language that is appropriate for the individual defendant and his/her needs.

RESTORATION TO COMPETENCY PSYCHIATRIST MUST:

- Engage in ongoing consultation with the MHE throughout the restoration services.

- Review case progress with the MHE at least once every 45 calendar days, throughout the service provision period, or more often as needed.

- Such consultation may occur in person or telephonically, and may be accompanied or confirmed by email, but the consultation cannot be completed solely via email correspondence.

- Monitor the defendant during the restoration process for increased or decreased symptoms requiring a medication adjustment.

- Medication adjustments must be communicated to the MHE and Restoration Specialist.

- Discussion shall include the defendant's progress, barriers to progress, and the ongoing determination of whether there is a substantial probability that the defendant will regain/achieve competency and if not, if Title 14 and/or Title 36 recommendations will be made in the Final RTC report to the Court.

- An in-person evaluation is required every thirty (30) days. Telehealth or other video conferencing services are acceptable, but not exclusively.

Section 3: Restoration to Competency Instruction

- Initial session may be scheduled through the Defense Attorney or Clinical Liaison.
- Instruction will occur a minimum of 2 times per week.
- Restoration sessions should last a minimum of 45 to 60 minutes unless otherwise indicated due to disability.
- For Defendants with cognitive impairments, the sessions should occur more frequently but with a shorter duration.
- Sessions should be scheduled quickly and frequently.
- Groups are the preferred method of restoration education delivery.
- Group and individual sessions should be no less than 30 minutes, and:
  - Group sessions should be no more than 8 defendants.
  - Group sessions can be divided by learning styles and information deficits.
- Refusals or absences will be documented in the report to the Court.
- Non-attendance after 3 groups/sessions will be reported to the appointed Clinical Liaison.
- Individual sessions are acceptable when group sessions are not feasible, as determined by the Mental Health Expert's evaluation.
- Instruction methods should take into consideration the defendant's most effective learning style, and utilize a mixture of visual, auditory, and kinesthetic learning approaches to reinforce concepts.
- The Mental Health Expert may also provide insight and recommendations as to approaches suitable for the individual defendant.
- All adjunct training materials and instruction methods must be designed by the Restoration Specialist and/or MHE and modified as necessary to meet the individualized needs for defendant, considering all cultural, educational, behavioral and mental health needs.
- Documentation of initial and all ongoing consultation is the responsibility of the MHE and Restoration Specialist and shall be retained for 6 years, in accordance with Arizona Administrative Code for Psychologists R4-26-106.
- The MHE will be notified by the Superior Court/Clinical Liaison of all dates of hearings and reviews, and of any changes in hearing dates or reviews.
- Assessment methods must be appropriate to the defendant's language preference and proficiency at this language, unless the use of an alternative language is relevant to the assessment issues.
- Must describe the strengths and limitations of any tests used.[1]
- Must explain how examination results can be affected by factors unique to, or differentially present in, forensic contexts including response style, voluntariness of participation, and situational stress associated with involvement in forensic or legal matters.

[1] NOTE: Jurisdictions may use additional testing methods, including psychometry. The RTC program shall determine whether additional testing methods will be used in the competency proceeding or not. However, psychometry is not available in all jurisdictions, nor is it currently defined in AZ Statute. Therefore, the Committee is not choosing to recognize this as a statewide best practice.

- Identify any significant strengths and limitations of procedures and interpretations used for RTC education.
- Must make language accommodations as possible and consider such when interpreting and communicating the results of the assessment.
- Telehealth or other video conferencing services are acceptable and encouraged if travelling to the Restoration Specialist is geographically problematic.
- Restoration Specialist is required to complete an in person visit every fourteen (14) days. It would be required that there is a person available to ask questions to regarding the physical presentation of the defendant for Telehealth or other video conferencing instruction.
- The MHE may provide Telehealth or other video conferencing evaluations as long as an in-person assessment is completed every thirty (30) days.
- The Psychiatrist (if appointed) may provide Telehealth or other video conferencing evaluations as long as an in-person evaluation is completed every thirty (30) days.
- If the defendant is experiencing adverse effects with the use of telehealth or videoconferencing, the practice must be suspended and revisited. This may require notification to the Superior Court/Court Liaison that RTC is interrupted until alternative arrangements are made.

Section 4: Appendices

Appendix A: Arizona Legal Criteria Overview

The following provide a short summary of Arizona's legal criteria for competency evaluation. Hyperlinks are included, where available:

In Arizona, upon motion of any party or *sua sponte*, the court may order an examination to determine if a defendant is competent to stand trial. See:
Ariz. R. Crim. P. 11.2 (a)(1), (a)(2), (3), (4); and A.R.S. §13-4503

Rules 11.2 (c) and 11.3, Ariz. R. Crim. P. provide for preliminary examination to assist the court in determining if reasonable grounds exist to order a defendant's further examination and appointment of mental health experts.

Restoration to Competency developed from the Supreme Court of the United States Dusky Decision which says that a person who is not mentally competent may not be tried in a court of law.

Appendix B: Restoration Plan

The Restoration Plan will include the following components:

- Identify areas where the defendant is already competent, if any.
- Evaluate the specific deficits or problems that are barriers to competence (i.e. lack of knowledge, psychosis, developmental delay, etc.).
- Obtain additional information from the Court/Attorneys to assist in developing the Restoration Plan.
- Incorporate recommendations from the Rule 11 reports.
- Describe individualized methods of instruction appropriate for the defendant, including the multimodal formats in which instruction will be delivered.
- Signed by the Restoration Specialist and the Mental Health Expert.

The Restoration Plan will incorporate the following goals:

- The defendant will evidence a sufficient level of factual understanding of court related issues as to be found competent to stand trial, including:
    - Knowledge of the charge(s);
    - Knowledge of the possible consequences of the charge(s);
    - Pleas and plea bargaining;
    - Roles of the courtroom personnel;
    - Adversarial nature of the process;
    - Understanding and evaluating evidence; and
    - Knowledge of courtroom procedures.
- The defendant will evidence a sufficient level of rational understanding of court related issues so as to be found competent to stand trial.
- The defendant shall evidence sufficient ability to assist counsel in developing a defense so as to be found competent to stand trial.
    - Including ability to communicate rationally with defense counsel.
    - Including the capacity to integrate and efficiently use the knowledge and abilities outlined in either a trial or a plea bargain situation.
    - Stress-reduction techniques related to the court proceedings, if necessary.
        - This may include providing specific accommodations related to the defendant's mental health/developmental diagnosis, such as: slowing the process down for defendants who have auditory processing issues; allowing for breaks for defendants who are overwhelmed with anxiety or have another condition such as IBS; etc.

Appendix C: Sources

The following resources were used in the development of this Guide. Hyperlinks are included, where available and known.

American Academy of Psychiatry and the Law. LINK 1; LINK 2.

American Bar Association. Criminal Justice Standards on Mental Health. LINK.

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RESTORATION TO COMPETENCY FLOW CHART