Committee on Mental Health and the Justice System
AGENDA

Monday, March 25, 2019
10:00 a.m. – 3:00 p.m.

State Courts Building • 1501 W. Washington St. • Phoenix, Arizona • Conference Room 119A/B

REGULAR BUSINESS

10:00 a.m.	**Welcoming Remarks**	Mr. Kent Batty, *Chair*
10:10 a.m.	**Approval of Minutes** ☐ **Formal Action**	Kent Batty
10:15 a.m.	**Recent News & Updates**	Kent Batty
10:30 a.m.	**Workgroup Report: Education**	Stacy Reinstein Cathleen Cole, Arizona Bar Foundation
11:00 a.m.	**Workgroup Report: Competency Practices**	Dianna Kalandros
11:30	**Key Issues Workgroup Report** Mental Disorder Definition Follow-Up Enhanced Services Proposal Persistent or Acutely Disabled Proposal	James McDougall
12:00 p.m.	**LUNCH**	
12:30 p.m.	**Presentation and Discussion: Incompetent Not Restorable** 1. Overview, Problem Presented and Challenges: Jim McDougall 2. Real Life Examples of the Revolving Door – Amelia Cramer; Hon. Mike Hintze 3. Who and How Many are we talking about? – Dr. Mike Shafer 4. Legal Constitutional Issues to Consider: State v. Williams – McDougall 5. Arizona Legislative History Dealing with this Population – Andy Flagg; Amy Love; Jim McDougall a. Pima County Legislative Proposal – Andy Flagg b. The Legislative Process vis -a-vis any Recommendation by this Committee – Amy Love 6. Next Steps – Jim McDougall	Various
2:30 p.m.	**Future Committee Work**	Kent Batty All Committee
2:55 p.m.	**Call to the Public**	Kent Batty

Committee on Mental Health and the Justice System

March 25, 2019

AGENDA

3:00	**Adjourn**	Kent Batty

Next Meeting:	**Remaining Meetings:**
April 29, 2019	May 20, 2019 June 24, 2019 July 22, 2019

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

Thursday, January 24, 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, Shelley Curran, Jim Dunn, Chief Kathleen Elliott, Judge Elizabeth Finn, Judge Michael Hintze, Josephine Jones, Melissa Knight (PROXY for Dianna Kalandros), Judge Cynthia Kuhn, James McDougall, Carol Olson, Ron Overholt, Chief Deputy David Rhodes, Michal Rudnick, Commissioner Barbara Spencer, Paul Thomas

Telephonic: Amelia Cramer, Chief Chris Magnus, Judge Christopher Staring, Judge Fanny Steinlage

Absent/Excused: Brad Carlyon, Judge Elizabeth Finn, Dianna Kalandros, Dr. Michael Shafer

Guests/Presenters: Chief Justice Scott Bales, Arizona Supreme Court; Dr. Aaron Bowen, Arizona State Hospital; Dr. Steven Dingle, Arizona State Hospital; Erin Cohen, Arizona Attorney General's Office; Louis Caputo, Arizona Attorney General's Office; Amy Love, Administrative Office of the Courts.

Administrative Office of the Courts (AOC) Staff: Jennifer Albright, Stacy Reinstein

Regular Business

Welcome and Opening Remarks
Mr. Kent Batty (Chair), introduced himself and asked Committee members and guests to briefly introduce themselves. Mr. Batty introduced Chief Justice Scott Bales. Chief Justice Bales thanked the Committee for its work, noting the importance of this work and Arizona's leadership in addressing the impact of mental health on our courts.

Approval of Minutes
Members were asked to approve minutes from December 17, 2018, noting they were in the meeting packet and provided electronically in advance of the meeting. No changes to the minutes were noted. A motion to approve the minutes was made by Mr. Dunn and seconded by Mr. Thomas. Motion was approved unanimously.

Discussion: Arizona State Hospital
The Chair, Mr. Batty, introduced guest presenters, Dr. Bowen, CEO – Arizona State Hospital and Dr. Dingle, CMO – Arizona State Hospital. Dr. Bowen and Dr. Dingle noted the questions sent by the Committee prior to the meeting and fielded answers to those and other questions.

The Arizona State Hospital (ASH) is a 93-acre plot of land which provides long-term inpatient psychiatric care to Arizonans with mental illnesses who are under court order for treatment, with 3 separate, licensed facilities including the Arizona Community Protection and Treatment Center

(ACPTC) for civilly committed sexually violent patients (131 beds; 98 individuals – current; length of stay approximately 10.5 years), the "main" civil hospital with individuals under Court-Ordered Treatment (117 licensed beds; 90 individuals – current; length of stay approximately 6 years), and the forensic hospital with restoration to competency patients (census has remained less than 6 patients in recent years due to the jail-based RTC programs) and patients who are found guilty except insane (143 licensed beds; 118 patients – current; length of stay approximately 6.3 years).

Programming and clinical services provided by the hospital include a full range of services – psychiatry, rehabilitation services, dentistry, physical medical care, and dietary and nutrition services. There are a total of 142 full time employees plus contractors, totally approximately 1,000 employees at any one time. Operations are 24/7.

Cost model of $714/day, is set based on AHCCCS bed rates as well as costs of patient care, number of staff needed to maintain 24/7, professional services provided, and census of hospital.

One key statistic raised by the Committee is the 55-bed limitation on individuals from Maricopa County in the civil/main hospital, set through the Arnold v. Sarn litigation exit stipulations. All 55 of those beds are currently filled. There is no allocation for individuals from any other county. A question was raised whether the State Hospital maintains a waiting list, and the answer is that it does not maintain such a list; however, the RBHAs or others may do so.

Committee members posed additional questions to Dr. Bowen and Dr. Dingle:

If an individual meets the criteria for admission to ASH and there are no beds available, where do we put them, and does ASH have a suggestion for what to do? Dr. Dingle noted that the question should be raised with AHCCCS, as the responsibility now lies with them as the administrative agency for behavioral health services.

When asked *if patients can be transferred between the forensic and civil units of the state hospital,* the response was no – under licensure rules individuals cannot be transferred; the patient would need to be discharged and then readmitted. That process has only occurred 5 times in the last three years.

An additional question was posed *if there are criteria or rules for admission to the state hospital and other treatment facilities at ASH*? The State Hospital policy is that it will accept patients whom it can treat. As a licensed facility, ASH is not required to maintain admission criteria. ASH has a utilization management committee comprised of three psychiatrists who receive applications for ASH to consider. The criteria are based on an internal algorithm that consists of two questions – is ASH the least restrictive option for the patient, and can the programs at ASH meet the individual's needs?

The Committee asked the leadership from ASH to have an honest discussion about the 55 bed limit for Maricopa County, including the difference between the initial census and lawsuit requirement and current need. Drs. Bowen and Dingle noted that because the Department of Health Services was the defendant in the case, they would have to ask for that capitation to be lifted, and DHS has not yet asked for lifting the 55-bed requirement after the exit stipulation. It was noted that prior to the signing of the exit stipulation, the DHS Division of Behavioral Health Services at the time did ask for the capitation to be lifted, and the Plaintiffs in the case were clear that the capitation rate of 55 beds could not be changed.

A Committee member noted that this causes a revolving door of individuals who have a need for treatment coming through Maricopa Integrated Health System (MIHS) and Desert Vista, and the setting is not ideal for caring for individuals longer than 3 weeks. A Committee member noted that there is a proportion of patients with treatment resistant symptoms who require long term care in a hospital setting, and with only 55 beds, it does not meet the need of a population of Maricopa's size. Not offering appropriate treatment to those categories of treatment creates a huge stigma for people with mental health issues as a whole and makes others fear the mentally ill;, and the way the situation is being handled is creating other problems and expenses. This Committee could do some good to focus on this area that is impacting this population within the justice system.

The Committee asked *if transitional living or alternative housing funds were available, could the grounds at ASH be used for this type of housing*? The response was, that this would take a significant amount of funding in order to outfit the space for adequate housing, as it is not currently set up or habitable under current conditions. There are also policy questions – which entity is the appropriate entity to provide resources and accept responsibility for those resources? And, is the state hospital location and environment the right place to add residential space, and in the evolving landscape, where does residential programming belong in the continuum of services in the mental health system?

The Committee expressed great appreciation to Dr. Bowen and Dr. Dingle for appearing before the Committee and being willing to engage in this important discussion.

Discussion: Housing, Mental Health and the Justice System

The Chair, Mr. Batty led the Committee in a discussion regarding all of the previous housing conversations that have taken place, including from ASH, DES/Governor's Goal Council, AHCCCS and Mercy Care.

Committee members provided specific ideas for future consideration, including:

- Exploring how to get ASH out of the 55-bed requirement for Maricopa County;
- Definition in legislation for secure treatment to provide this type of housing along the continuum of care, including but not limited to incompetent not restorable defendants who are a danger to community;
- Housing voucher programs that provide safe, high-quality affordable housing options with an oversight function in place to ensure safety and quality.

- Revisiting the Miami-Dade County program for justice-involved individuals, and alternative secure treatment settings, diversion facilities, and giving law enforcement options for residential treatment.
- Oversight or appeal process for intake/application process when individuals are denied services at ASH.
- An effort must be made to treating the whole person, and providing services, not just a place where individuals are housed.

Recent News & Updates

Mr. Batty updated the Committee on the upcoming Developing Mental Health Protocols Summit. Don Jacobson, AOC, reminded the Committee that the teams are made up of individuals identified by the Presiding Judges to represent their County or LJC team, and focus on the response protocols within the Sequential Intercept Model. Future work will take place in the community with key stakeholders. A comment was made by a Committee member to note that each RBHA is required to have collaborative protocols with justice partners in place, and each health plan has a justice liaison.

Mr. Batty noted that some issues were raised with respect to prosecutorial discretion by the Pima County Criminal Justice Advisory Committee in the recent Arizona Town Hall report that was sent to the Committee.

Mr. Batty noted that there will be some new Committee members named representing public defenders, as Committee members Fanny Steinlage and Josephine Jones have taken new positions, and the Arizona Center for Disability Law will also be joining the Committee.

Mr. Batty noted that the Committee and Supreme Court have recently received a request from the Arizona Psychiatric Society interested in data regarding the Rule 11 process.

Key Issues Workgroup Report

Mr. McDougall presented to the Committee the workgroup's proposal for a revised definition of mental disorder and requested the Committee's response to the proposed definition prior to being sent to stakeholders for review. Mr. McDougall also requested the Committee submit additional names for individuals to review the definition which will be sent by staff with comments collected for future Committee review. The Committee noted that this definition change provides an opportunity to recognize the impact that these other disorders have on the first responders, law enforcement and judicial system, and if the definition is changed, there will be a need for further discussion on what screeners and evaluators can do under the law, and under what conditions and timeframes. After review and discussion, the Committee made a motion to vet the proposed Mental Disorder definition to stakeholders "as is" including a language change to match existing statute with "reasonable prospect of being treatable." There is a recognition from the Committee that this language change will likely be met with a good deal of resistance and require further conversation and analysis, should the Committee move this language change forward to the Arizona Judicial Council for consideration.

Additional Committee Workgroups

Mr. Batty reminded the Committee of the additional charges within the Administrative Order, and the formation of two workgroups that will focus specifically on best practices in restoration to competency, and on the development of public education materials through a website and brochure explaining the civil commitment process. Future work may fall under these workgroups including the recent report and recommendations from the Supreme Court Study Committee on Domestic Violence and Mental Illness in Family Court Cases; however, the current resulting workgroup charges and objectives are:

Competency workgroup

- Evaluate and recommend best practices for determining competency by psychological evaluators, to include techniques, methods, tests, etc.
    - Determine whether the subject matter in the current AOC training program matches well to those best practices.
    - Recommend any necessary updates.

- Evaluate and recommend best practices for Restoration to Competency programs.

- Determine and recommend the minimum necessary documents to be placed in a statewide Rule 11 data depository (i.e. What will judges need to know about what happened in another jurisdiction?).
    - Recommend the framework for a system for LJCs to report Rule 11 outcomes, as required under A.R.S. §13-609 and NICS.

- Examine statutes and court rules and recommend changes that would improve court processes around competency.

Education workgroup

- Civil Commitment (website & brochure) Content Review
    - Develop an informational guide explaining the civil commitment process in both web-based and paper formats. Paper guides would be available at courthouse self-service centers and the webpage would be posted on AZCourtHelp.org and on the self-service webpages of the superior courts. (*May 2018 Subcommittee)*
- Identify ways the court can work collaboratively with other stakeholders to educate the public on the use of advance healthcare directives. (*Administrative Order 2018-71*)
- Future Work:
    - Identify opportunities to educate the public on court processes involving individuals involved in the justice system who have behavioral health treatment needs. (*Administrative Order 2018-71;* see also *Domestic Violence & Mental Illness in Family Court Cases: Report and Recommendations*)

Committee members identified themselves, a designee and individuals recommended to participate on these workgroups for staff to follow-up with and meet before the next Committee meeting.

Good of the Order / Call to the Public
Ms. Holly Gieszl spoke to the Committee regarding concerns she sees as a result of taking pro bono cases in criminal cases with people with high needs who have been involved in the public behavioral health system who do not have access to the resources needed to adequately assess competency and treat their needs.

Adjournment
The meeting was adjourned at 2:47 p.m. by order of the Chair.

SJI Funds National Initiative to Address Mental Illness in the State Courts

The state courts are experiencing increasing complexity in handling individuals who have mental illness, and oftentimes a co-occurring substance use issue. System-wide, mental illness has placed a strain on many communities and their resources, and jails are being used to detain those who need mental health treatment. The problem is exacerbated by the lack of a coordinated national, state, and community effort involving all three branches of government. In addition, lack of resources, empirically-based data, and a clearinghouse for state court leaders to learn the practical steps they can take to address the problem in their court systems also contribute to the problem.

To address this issue on a national level, SJI has awarded a major grant to the National Center for State Courts (NCSC), which will work in partnership with the Conference of Chief Justices (CCJ) and the Conference of State Court Administers (COSCA) on a mental illness in the courts initiative that will:

- Develop resources, best practices and recommend standards to address mental illness and the state courts response.
- Expand the NCSC website to create a centralized repository for state courts interested in improving court and community responses.
- Provide resources to improve caseflow management of civil commitment cases as well as felony and misdemeanor cases involving persons with mental illness.
- Provide education by developing national, regional, and statewide training and education opportunities for judges and court practitioners.
- Develop guides and resources on the Sequential Intercept Model, and adapt the SJI-funded Arizona Presiding Judge Guide titled, *Fair Justice for Persons with Mental Illness: Improving the Courts Response* for use nationally.
- Build capacity of state and national court leader to lead and implement reforms.

This national initiative will be based on the 2016-2017 COSCA policy paper, Decriminalization of Mental Illness: Fixing a Broken System. **Additionally,** CCJ/COSCA Court Management Committee working group has identified four areas for further action in addressing mental health:

1) developing resources, best practices, and recommended standards in state court responses to mental health issues;
2) improving caseflow management by examining civil commitment and criminal cases involving persons with mental illness to identify barriers to, and opportunities for, timely and effective case processing;
3) promoting education; and
4) building capacity to implement reforms

This new Initiative will support a resolution passed at the CCJ/COSCA 2018 annual meeting in support of improving the justice system response to mental illness. Promising approaches are currently being explored to address this problem, including the *Sequential Intercept Model*, which identifies where to intercept individuals with mental illness as they move through the criminal justice system, suggests which populations might be targeted at each point of interception, and highlights the decision-makers who can authorize movement away from or through the criminal justice system. Mental health codes require modification to permit timely, appropriately-targeted, court-ordered treatment for persons with mental illness, before and after contact with the justice system. It has also been acknowledged that individuals who are intercepted by the criminal justice system often have co-occurring mental health and substance abuse issues.

Committee on Mental Health and the Justice System
Synopsis of Stakeholder Input: Proposed Revisions for Mental Disorder Definition
(received February-March 2019)

For:

- The new definition would be more consistent with volume 5 of the Diagnostic and Statistical Manual of Mental Disorders which includes disorders associated with neurological, substance use and cognitive issues.
- The proposed definition changes would significantly expand the ability of law enforcement, crisis workers, health care workers, etc, to help ensure the safety of, and treatment for, individuals experiencing these conditions, as well as to protect the public from the actions of impaired individuals.
- A definition of Mental Illness that allows individuals with substance related-issues, dementia-related issues, cognitive delays, etc. to receive treatment (including psychiatric medications that help ameliorate their emotional and behavioral disturbances), in a safe and structured setting, would be invaluable. Currently, we see these individuals slip through the cracks, have frequent and repeated contact with hospital emergency departments and law enforcement (including arrest and incarceration), as well as be pushed into homelessness, causing harm to themselves, or causing harm to others.
- Request: establish a mechanism and requirement for standardized training for those involved in court ordered psychiatric evaluations so that the statute can be implemented uniformly for all Arizonans in need of such evaluation and treatment.

Against:

- Expanding the definition of Mental Disorder in T36 will overburden our local psychiatric hospitals which do not have room to take on this additional population, nor appropriate staff or equipment to properly diagnose and treat individuals with these types of disorders.
- The proposed new definition would be destructive to the current system by putting more people into the system without providing infrastructure and funding to deal with them. The cost of psychiatric hospitalization is initially paid for by the county and the increased cost to deal with these patients would be an enormous burden for a rural county with a limited tax base.
- The new definition will increase the cost for counties to cover civil commitment proceedings, including screening, inpatient evaluation, inpatient holding prior to hearings and court commitment procedures.
- Properly fund AHCCCS and ALTCS so that they get appropriate treatment in appropriate placements, rather than expanding the T36 population.
- Psychiatric treatment is usually not indicated for individuals who suffer from neurological disorders, traumatic brain injuries, Alzheimer's Disease and intellectual disabilities and psychiatric medicine does not address the underlying conditions.
- This new definition will cause these high need/high cost people to be given a psychiatric diagnosis to remove them from the responsibilities of the health plans and move them into state or county run psychiatric facilities where their freedom will be severely restricted and there is no hope of recovery or release.
- This new definition will have a significant financial impact on the State because there will be an increased demand for substance abuse treatment, which is now covered only by comprehensive substance use disorder benefits under AHCCCS

and Medicaid. Arizona has a shortage of substance use disorder treatment facilities and treating professionals, and there is no State appropriation for substance use disorder treatment.

- Discharge planning and placement for these difficult patients will prove to be difficult and will increase the burden on and cost to the T36 agencies.

[See abbreviated actual feedback attached]

Prosecutor/Law Enforcement
I think this definition is best left to mental health experts with a full understanding of what "mental disorder" entails. However, in reviewing the proposed new language, I think it is a far superior definition to the current definition and provides guidance to practitioners that will more readily assist in determining when such a disorder exists.
Individuals suffering with conditions such as neurological orders, traumatic brain injuries, Alzheimer's disease and intellectual disabilities need proper medical treatment from qualified medical doctors, not psychiatric treatment in a mental hospital. Our local psychiatric hospital is usually close to capacity and simply does not have the appropriate staff nor the appropriate medical equipment to properly diagnose and treat individuals with these conditions. They simply have no room to take on the additional responsibilities of attempting to treat individuals with the types of disorders the proposed statutory amendment would suggest.
Finally, I'd simply note that psychiatric treatment is usually not indicated for individuals who suffer from neurological orders, traumatic brain injuries, Alzheimer's disease and intellectual disabilities. To the extent psychiatric medications may assist in covering symptoms in some of these cases, psychiatric medicine is not capable of addressing the underlying conditions.
It has been my experience over the years that the biggest problem with our system is getting people qualified for either AHCCCS insurance or Arizona long-term care (ALTCS). As to AHCCCS, we presently have a system where the incarcerated are improperly disqualified from receiving insurance during the period of incarceration. This makes it difficult or impossible to get appropriate medical testing or treatment for medical conditions beyond the very basic medical care a jail is required to provide. Over the years, it has become harder and harder to get people qualified for Arizona long-term care, as that system is severely underfunded and they have increased hurdles that need to be overcome to get people into the placements they desperately need. The lack of proper ALTCS funding also makes it impossible for our Public Fiduciary to apply for guardianship or conservatorship in many cases, as we cannot take on the legal responsibility of serving in that capacity for persons who are homeless. Ignoring for a moment the optics involved with attempting to place people with medical conditions and intellectual disabilities into psychiatric hospitals, I will simply tell you that Title 36 is not a place to dump everyone who cannot get able to appropriate medical care. There is an answer to the problem you are seeking to solve. The correct answer is for the state and federal governments to properly fund AHCCCS and ALTCS so that people with the medical conditions you are seeking to address can get

treatment that is actually appropriate for them. We also need people in our county jails to qualify for AHCCCS. I realize that what I suggest is a harder push for the legislature and forces them to face some hard realities and figure out a funding source to deal with the real problems we have.
The proposed revision to the definition of mental disorder is not the way to solve the problem; in fact, it would be destructive to the current system. Putting even more people into the mental health system, without providing infrastructure and funding for it, would sink the system. Over the past several years, the number of Title 36 cases filed has almost doubled. This has put a strain on psychiatric facilities and the personnel to handle them. And in our county, the cost of psychiatric hospitalization is about $1,000/day, initially paid for by the County, which is an enormous burden on a rural county with a very limited tax base.
Legal Advocate/Public Defenders
Given that people can have a psychosis that is caused by drug or alcohol abuse, I would like to see that included in the definition as a cause of a mental disorder and not merely co-occurring with a mental disorder.
State or County Government Agency
Expanding the definition will create controversy. While the statute changes do not imply this, the "grey zone" between a treatable psychiatric condition and a fixed neurological condition is in flux, and can be a distinction or art, not science. We should always seek to ensure that the civil commitment process remains based in the recovery of health which will result in a restoration of the individual's civil liberty. The fact is that individuals with static neurological conditions WILL be given a psychiatric diagnosis to remove them from the responsibilities of health plans. In the world of managing high needs/high costs public sector patients, psychiatric diagnoses will be manufactured to move these individuals into the Arizona State Hospital, or other psychiatric facilities only to find that recovery (and freedom) can not be restored. These changes, while well-intentioned, are not needed, and will pose a threat to the civil liberties of those with chronic neurological or substance abuse issues.
A change of this magnitude will result in an expansion of individuals for whom a civil commitment process could be pursued. While we have not yet developed precise estimates of the impact, we anticipate that the associated court-ordered evaluation costs for all counties will be significant. In addition, we are concerned that the proposed change will have a considerable impact on access to treatment for mental health and substance use disorder (SUD).

Today individuals who receive health care services through the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid program, are also eligible for comprehensive substance use disorder benefits but commercial health insurance authorization requirements for substance abuse treatment vary. In addition, there is no comprehensive state appropriation for substance use disorder treatment.[1] Finally, even for individuals with insurance coverage, Arizona experiences a shortage of SUD treatment facilities, SUD professionals (including addiction medicine specialists) and mental health professionals. [1] AHCCCS administers a small amount of state appropriations for non-Medicaid opioid treatment as well as federal grants for substance use disorder. These funds are currently fully expended each year and there is no current excess unspent funding.
The proposed change represents a ***massive*** expansion of the kinds of mental health diagnosis that will qualify an individual for forced confinement, evaluation, and medical treatment under Arizona law. A change of this magnitude will assuredly result in a tremendous increase in the number of individuals for whom a civil commitment process could be pursued. By law, counties must pay the costs of civil commitment proceedings, including the costs of remote screening, inpatient evaluation, inpatient holding pending court hearings, and court commitment procedures. A.R.S. §36-545.04. A preliminary analysis concludes that the counties' costs associated with forced evaluation and court proceedings will expand in direct proportion to the number of new individuals made eligible for involuntary evaluation and treatment by the proposed change. As noted above, that number is likely to be large, and it appears likely the county's existing physical infrastructure will have trouble accommodating the expanded numbers. In addition, the proposed change will have a considerable financial impact on the State of Arizona's access to treatment for mental health and substance use disorder (SUD) programs as well. Today individuals who receive health care services through the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid program, are also eligible for comprehensive substance use disorder benefits. As there is no comprehensive state appropriation for substance use disorder treatment, the changed definition will inevitably lead to the need for additional appropriations for these services. Further, commercial health insurance authorization requirements for substance abuse treatment vary, meaning that private sector funds are not a reliable source to pay for the expanded treatment demand the change will generate. The State of Arizona may be asked to make up the difference.
We agree the civil commitment statutes could stand review and revision. However, this proposal will have an immense impact on the fundamental structure of the civil

commitment process and should not be done in isolation. The statutes, policies and practices governing civil commitment operations are designed to accommodate the relatively narrow group of seriously ill individuals that currently qualify for civil commitment proceedings. Expanding the types of individuals that qualify for civil commitment proceedings without changing the fundamental structure of the process is a recipe for failure.

Behavioral Health Provider Agency

The resulting change would lead to a significant increase in COE admissions.
The subsequent necessary testing (MRI, EEG, etc) for those under section (B) would increase medical care and insurance utilization/costs. Expedited AHCCCS processing would need to occur to enable those uninsured to have these tests completed in a timely manner.

Caring for the proposed populations, such as those with brain injury and an intellectual or cognitive disability would require specialized staff and treatment modalities. Having such a mix of patients on a psychiatric unit will impact the therapeutic aspect of the milieu.

The discharge planning/placement for those admitted, but found not eligible, would place a large burden on the T36 agency.

Crisis Provider Agency

I support the expansion of the definition to specifically include neurological, psychiatric, and substance use disorders as well as mental conditions resulting from injury, disease, and cognitive disabilities as valid conditions to receive mental health services pursuant to the T36 civil commitment statutes.

Firstly, it would bring the state definition of Mental Disorder to closer consistency with the Diagnostic and Statistical Manual of Mental Disorders (DSM 5), which includes disorders associated with neurological, substance use, and cognitive issues. Additionally, the proposed definition changes would significantly expand the ability of law enforcement, crisis workers, health care workers, etc, to help ensure the safety of, and treatment for, individuals experiencing these conditions, as well as to protect the public from the actions of impaired individuals.

Currently, I can directly attest that I frequently see cases where individuals with substance related-issues, dementia-related issues, cognitive delays, etc. "slip through the cracks" and are unable to be kept safe and treated because those issues are judged to disqualify them for eligibility for T36 processes. Often, the outcome instead is that the individual has frequent and repeated contact with hospital emergency departments and law enforcement (including arrest and incarceration), as well as

being pushed into homelessness, causing harm to themselves, or causing harm to others. A definition of Mental Illness that instead allows these individuals to receive treatment (including psychiatric medications that help ameliorate their emotional and behavioral disturbances), in a safe and structured setting, would be invaluable.
I do not believe that I can improve upon this definition.... It opens the door for those dual dx individuals who have a TBI and SMI who have been excluded from T-36 in the past. We can take this as a step and then later deal with the outcome of what to do with folks who [in Rule 11] are determined to be not mentally competent and NOT restorable to competency.
Advocacy Organizations
The definition of a Mental Health Disorder in A.R.S. 36-501(25) is currently in need of revision. Upon review of the proposed revision I recently received as a community stakeholder, I fully support acceptance of the new wording. It is important that, as mental health is quickly growing in understanding, we continue to update definitions to align with that knowledge.
We support fully the aspirations of the language to support individuals affected by neurological and psychiatric disorders, substance use disorders which co-occur with mental illness, along with mental conditions resulting from injury, disease, and cognitive disabilities for the purpose of being eligible to receive mental health services pursuant to the Title 36 civil commitment statutes. In furtherance of that goal, we support the amendment language provided for review.
The statutory provisions in Title 36, Chapters 4 and Chapter 5 can be quite confusing for even experienced mental health professionals, much less attorneys and the general public. In addition, the process is lengthy and often results in unnecessary time in a locked hospital setting when a patient has stabilized sufficiently to be discharged to outpatient treatment. The statute has not had any large-scale revision in many years. The Society believes the statute is in need of broader review and revision to bring the language current with modern mental health terminology, clarify the process of involuntary evaluation and treatment, and improve the efficiency of the process and make it more easily standardized across all areas of the State of Arizona. In addition, the Society would like to ask the Committee to look towards establishing a mechanism and requirement for standardized training for those involved in court ordered psychiatric evaluations, so that the statute can be implemented uniformly for all the citizens of Arizona in need of such evaluation and treatment.

Committee on Mental Health and the Justice System
Enhanced Services Statute Proposal

The Committee on Mental Health and the Justice System, 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, and review court rules and state statutes for changes that can result in improved court processes in competency proceedings and court-ordered treatment hearings and other hearings where a litigant may need mental health treatment. As such, the Committee's Key Issues Workgroup submits the following *Enhanced Services* proposal to the Committee for review.

References:

- Administrative Order Establishing the Committee on Mental Health and the Justice System (August 2018): azcourts.gov/Portals/22/admorder/Orders18/2018-71.pdf
- Arizona Revised Statutes, Title 36: https://www.azleg.gov/arsDetail/?title=36

Background:

Both the Criminal Justice and Civil Mental Health Treatment systems are plagued by "recidivists." On the criminal side these are repeat offenders, people who have a mental illness, defect or deficiency who are repeatedly being arrested, often for low-level crimes which would likely not be repeated if they received proper treatment and other services for their mental illnesses. On the civil side, these are people who have a chronic mental illness and are "stuck" in the revolving door of evaluation, followed by acute crisis and/or short-term treatment services and then released into the community to pursue treatment "voluntarily" or who are referred for involuntary treatment under a Court Order for Treatment (COT). This revolving door has an impact on worsening the underlying mental condition, and consequently makes the patient more dangerous to themselves and others. In turn, repeatedly seeing them cycle through the court system increases the costs to all the agencies involved, at the public's expense.

System Challenges:

Criminal Court

- The criminal justice system can attempt to divert these individuals into treatment before a trial or after trial can put them on a specialized probationary caseload requiring them to engage in treatment; however, both options rely on services available to the defendants by a provider in the civil treatment system.
- If a Judge directs the County Attorney to "institute civil commitment proceedings under Title 36," the person may not meet the criteria for involuntary commitment because there has been no recent behavior to qualify them for involuntary civil commitment.
- Those who do qualify for involuntary treatment in the civil system are ultimately released back into the community under the supervision of providers who are assigned by the civil mental health court to administer an outpatient treatment

program. For a variety of reasons, services designed to closely monitor and prevent the person from destabilizing and cycling back through the criminal and civil system, such as proper, stable and, where necessary, secure housing and intensive case management are not always available or provided.

Civil Mental Health Treatment System

- While the civil system has the processes and procedures to serve people who are in an acute mental health crisis, there are inconsistencies in effectively serving people who have a chronic mental illness, mental defect or deficiency and who are non-compliant with treatment and unable to control their behavior. Many of these people are seen repeatedly in Arizona's crisis centers, treated as an acute patient and released back into the community only to stop the treatment recommended, destabilize and return through the revolving door. Often these are the same people who recidivate in the criminal system.
- Currently, resources vary and are inconsistent for providing intensive case management to closely monitor and assure compliance with treatment plans.
- The level of treatment provided to a patient depends on the patient qualifying as SMI and/or Title 19. Even then, the system allows a patient under a court order to decline to "consent" to a service offered, most notably assignment to an ACT team or placement in a structured residence.
- Once a Court Order is entered, the court does not currently provide ongoing oversight over the services provided or the patient's compliance. The court does not get involved unless the matter is brought back to court by the provider, and then usually only to grant an "amendment," without hearing, to allow a short period of inpatient treatment.

The Key Issues Workgroup proposes that a new statute be created that requires the civil court to mandate the provision of specific "Enhanced Services" for patients identified as individuals who have shown that they cannot or will not adhere to treatment and who, as a result, pose a substantial risk of harm to themselves or others, and to require the court to provide hands-on, in-court oversight of Enhanced Services Orders to assure that appropriate services are being provided and that the patient is adhering to the specific treatment plan.

Proposal for new statute on following page:

36-540.03 **Determination and order for enhanced services**

A. Upon determining that the patient should undergo treatment under paragraph A of Section 36-540, the court shall order the mental health treatment agency designated to administer and supervise the patient's treatment program to provide the patient with enhanced services as defined in this subsection if the court also finds that:

1. Despite having had treatment offered, prescribed, recommended or ordered, to improve the patient's condition or to prevent a relapse or harmful deterioration of the patient's condition, the patient has demonstrated a continuing unwillingness or inability to participate in or adhere to treatment; and

2. If the patient does not participate in and adhere to treatment ordered by the court there is a substantial risk that the patient's physical, emotional or mental condition will deteriorate or continue to deteriorate to the point that it is likely that the patient will, in the reasonably near future, inflict physical harm on himself, herself or another person or be in danger of suffering serious harm due to the patient's inability to provide for basic personal needs such as nourishment, essential clothing, medical care, shelter or safety.

B. In determining whether an order for enhanced services should be entered, the court shall consider the following:

1. Evidence that the patient's understanding of the need for treatment is impaired to the point that he or she is unlikely to voluntarily participate in or adhere to treatment ordered.
2. Evidence that within the 36 months prior to the petition, excluding any time the patient was hospitalized or incarcerated during this period, the patient's non-participation in or non-adherence to treatment offered or recommended to the patient has been a factor in:
   a) the patient being taken to a hospital emergency room, a psychiatric hospital or a crisis center for evaluation, stabilization or treatment at least two times; or
   b) the patient being arrested, charged with a crime, detained in a jail or detention center at least two times; or
   c) the patient committing one or more acts, attempts, or threats of committing acts of serious physical harm on the patient or on others; or
   d) any combination of the events or acts set forth in a, b, or c above at least two times.

3. Any other evidence relevant to the patient's willingness or ability to participate in and adhere to treatment.

C. A petition for court ordered treatment shall contain an allegation that the proposed patient qualifies for enhanced services, as defined in this section. The burden of proving the allegation is on the petitioner and shall be proven by clear and convincing evidence.

D. "Enhanced Services" are defined as the following:

1. Services identified in a written Enhanced Treatment Plan approved by the court that includes:

a) Assignment of the patient to a Treatment Team with an Intensive Case Manager for any outpatient services who is required, among other duties, to have in-person contact with the patient at such frequency that will facilitate the patient's adherence to and compliance with the treatment plan and will allow for regular first-hand assessment of the patient's progress and condition.
b) Housing or residential placement that provides the patient with stable, safe and, if necessary, secure residence to enhance compliance with the treatment plan and protect the safety of the patient and the public.
c) Safe, reliable, and adequate transportation for the patient to successfully comply with the treatment plan.

E. If an order for enhanced services is entered, the judge shall advise the patient orally and in writing that the Enhanced Treatment Plan approved by the court is part of the court order enforceable by the court and that non-compliance with the court's order or the terms and conditions of the treatment plan may result in the issuance of an order for the patient to be placed in or return to inpatient treatment and an order for a peace officer to detain the patient for that purpose.

F. The court shall order the mental health treatment agency designated to administer and supervise the patient's enhanced treatment services program to file written progress reports with the court at least every 60 days. The court may require the patient and a representative of the treatment team to appear in court at times designated to address the patient's compliance and the services provided. The patient's Enhanced Treatment Plan may be changed or modified by the court at any such appearance on motion of any party or on the court's own motion.

G. In order to receive any enhanced service ordered by the court, the patient shall not be required by any agency or provider to agree or consent.

Committee on Mental Health and the Justice System
Amendments to PAD Definition and Standards for Emergency Hospitalization

The Committee on Mental Health and the Justice System, 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, and review court rules and state statutes for changes that can result in improved court processes in competency proceedings and court-ordered treatment hearings and other hearings where a litigant may need mental health treatment. As such, the Committee's Key Issues Workgroup submits the following amending the PAD (*persistent or acute disability*) definition and standards for emergency hospitalization to the Committee for review.

References:

- Administrative Order Establishing the Committee on Mental Health and the Justice System (August 2018): azcourts.gov/Portals/22/admorder/Orders18/2018-71.pdf
- Arizona Revised Statutes, Title 36: https://www.azleg.gov/arsDetail/?title=36

Background

Arizona's current statutory definition of *persistent or acute disability (*PAD) does not identify a likely danger to others as a possible consequence of not getting needed treatment. Therefore, in Arizona, the PAD standard has historically been identified as being a "non-emergent" standard not eligible for immediate hospitalization.

Attorneys have argued that because the PAD standard does not identify danger to others in the definition, the person cannot be detained for immediate emergency hospitalization on this standard without a Petition for Involuntary Evaluation being filed and a Detention Order issued by a court. Historically, Arizona's screening agencies have identified and moved those not clearly meeting the standard of DTS or DTO into the Petition and Pick-up process requiring a Petition for Involuntary Evaluation to be filed with the court and the court issuing a Detention Order which is delivered to the sheriff. The sheriff has 14 days to detain the proposed patient and deliver them to an evaluation agency. Because these cases are considered as "non-emergent," the pick-up process is sometimes not given high priority. These "PAD Petitions" are viewed as "non-emergent" even if there is a clear indication by history that the proposed patient has a mental disorder and when s/he deteriorates (usually due to being non-compliant with medication) the person is likely, without treatment, to inflict physical harm on himself or others without immediate help.

The Key Issues Workgroup proposes that the definition of PAD should identify a substantial probability of causing harm to others as a possible consequence of the condition not being treated. In addition, screeners and evaluators should be able to immediately hospitalize a person under ARS §§36-524 and 36-526 **regardless of the category presented** if the emergency standard in the statute is met, i.e. *"during the time necessary to complete the pre-petition screening procedures set forth in sections 36-520 and 36-521, the person is likely without immediate hospitalization to suffer serious physical harm or serious illness or is likely to inflict serious physical harm upon another person."*

Proposed Amendments

36-501. Definitions

32. "Persistent or acute disability" means a severe mental disorder that meets all the following criteria:

(a) Significantly impairs judgment, reason, behavior or capacity to recognize reality.

~~(a)~~ (b) If not treated has a substantial probability of causing the person to suffer or continue to suffer severe and abnormal mental, emotional or physical harm, or of causing the person to inflict serious physical harm to the person or others ~~that significantly impairs judgment, reason, behavior or capacity to recognize reality~~.

~~(b)~~ (c) Substantially impairs the person's capacity to make an informed decision regarding treatment, and this impairment causes the person to be incapable of understanding and expressing an understanding of the advantages and disadvantages of accepting treatment and understanding and expressing an understanding of the alternatives to the particular treatment offered after the advantages, disadvantages and alternatives are explained to that person.

~~(c)~~ (d) Has a reasonable prospect of being treatable by outpatient, inpatient or combined inpatient and outpatient treatment.

36-524 Application for emergency admission for evaluation; requirements

C. The application shall be upon a prescribed form and shall include the following:

1. A statement by the applicant that he believes on the basis of personal observation that the person is, as a result of a mental disorder, a danger to self or others, OR has a persistent or acute disability or a grave disability, and that during the time necessary to complete the prepetition screening procedures set forth in sections 36-520 and 36-521 the person is likely without immediate hospitalization to suffer serious physical harm or serious illness or is likely to inflict serious physical harm upon another person.

2. The specific nature of the danger.

3. A summary of the observations upon which the statement of danger is based.

4. The signature of the applicant.

36-526. Emergency admission; examination; petition for court-ordered evaluation

A. On presentation of the person for emergency admission, an admitting officer of an evaluation agency shall perform an examination of the person's psychiatric and physical condition and may admit the person to the agency as an emergency patient if the admitting officer finds, as a result of the examination and investigation of the application for emergency admission, that there is reasonable cause to believe that the person, as a result of a mental disorder, is a danger to self or others, OR has a persistent or acute disability or a grave disability, and that during the time necessary to complete the prepetition screening procedures set forth in sections 36-520 and 36-521 the person is likely without immediate hospitalization to suffer serious physical harm or serious illness or to inflict serious physical harm on another person. If a person is hospitalized pursuant to this section, the admitting officer may notify a screening agency and seek its assistance or guidance in developing alternatives to involuntary confinement and in counseling the person and his family.

A Report to the Arizona Legislative Study Committee of Incompetent Non-restorable, Dangerous Defendents

September 20, 2018

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Background and Policy Context

Competency to stand trial is a jurisprudential principle founded in English common law. The standard for competency is set forth in the U.S. Supreme Court case Dusky V. United States (1960) which requires that a defendant have "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."

In Arizona, the determination of and outcomes for findings of competency are incorporated in the Arizona Rules of Criminal Procedure and Chapter 41 of Title 13, Arizona Revised Statutes. Options for a court that has found no substantial probability of the defendant regaining competency are found in ARS Sec. 13-4517. The legislature has considered, but not acted on any, bills to expand programs and treatments related to defendents found to be incompetent, nonrestorable, and considered dangerous. Among the considerations before the legislature has been the authorization for the commitment of nonrestorable dangerous defendants to a secure mental health facility and the retention of criminal court jurisdiction over INDDs committed to such facilities.

The Legislative Study Committee of Incompetent Non-restorable, Dangerous Defendents was authorized in 2016 and issued a report on December 15, 2016 and was extended by one year in Laws 2017, Chapter 103).

Arizona State University Professor Dr. Michael S. Shafer has been conducting research in support of the INDD study committee This work has consisted of two elements. First, a survey of all 15 county attorney offices was conducted to estimate the number and type of individuals found to be non-restorable who are considered dangerous. ASU issued a formal report and presentation to the INDD study committee on these findings in December 2016. While the findings provided some factual basis of the relative prevalence and dimensions of individuals processing through the competency process, the report fell short of projecting the number of individuals charged with crimes involving violent or dangerous behavior who have been found incompetent and nonrestorable (pursuant to title 13, chapter 41, Arizona Revised Statutes). This year's report provides estimates on the number of individuals that may meet an INDD crtierai each year who could be a target for ongoing justice supervision and/or treatment.

The second area of research conducted by ASU was an environmental scan of other states' policies, procedures, and funding mechanisms for managing incompetenmt amd dangerous defendants Ten states were selected with web-page searches, document reviews, and key informant interviews conducted to identify innovative approaches other states are approaching to address these issues before the INDD Committee. This year's report summarizes major trends and highlights some innovative practices in forensic mental health services.

I. Estimating the Number of Incomptent, Non-Restorable, Dangerous Defendents

In the 2016 report issued to this study committee, we describe the methodology and key findings of a survey conducted of all 15 Arizona counties regarding pipeline estimates and key characteristics of incompetency processing in their courts (see Appendix A). As noted in that report, significant variation in the capacity of county-level record keeping and documentation limited county by county comparisons. However, this information does provide an accurate portrayal of the general size and charactreristics of the population of individuals engaged in the Arizona justice system, and their criminogenic and clinical characteristics, who have been found incompetent, non-restorable, and dangerous. We re-analyzed data reported in the 2016 report to provide an estimate of the number of people who may be in need of ongoing psychiatric treatment and supervision.

Utilizying data from Maricopa County exclusively (they had the most complete and comprehensive data available on non-restorable incompetents), we were able to identify individuals who had been found non-restoprable, had been released from custody, and had re-offended. Three justice subject matter experts indepdently identified the re-offense charges that met the dangerous standard, consistent with ARS 13-4517. See Appendix A: Technical Note for estimation details.

Based upon these analyses, we estimate that statewide there may be upwards of 19-41 new individuals per year who are found to be incompetent and non-restorable and represent a continuing threat to public safety. We estimate that this is the approximate annual size of a group of individuals who may benefit from ongoing justice supervision and access to forensic psychiatric treatment and support services.

II. Environmental Scan of Other State's Programs for Incompetent, Nonrestorable and Dangerous Defendants

Methods. A convenience sample of 10 states were selected after consultation with subject matter experts and based upon ASU researchers' working knowledge of state-level initiatives in the area of forensic behavioral health services. A state by state profile was created first by reviewing publically available websites, accessing and reviewing publicly available documents, and conducting brief, semi-structured telephone interviews with available and willing state agency representatives. As reflected by the accompanying table, ASU researchers reviewed websites and relevant documents for all 10 states and conducted interviews with representatives of four states (FL,OR,PA,VA).

State	Relevant State Agency	Website Review	Document Retrieval and Review	State Agency Representative Interview
California		✓	✓	
Colorado	Department of Human Services Department of Health Care Policy & Financing	✓	✓	
Connecticut	Department of Mental Health and Addiction Services	✓	✓	
Florida	Department of Children and Families	✓	✓	✓
Illinois	Department of Human Services	✓	✓	
Ohio	Department of Mental Health	✓	✓	
Oregon	Oregon Health Authority	✓	✓	✓
Pennsylvania	Department of Public Welfare	✓	✓	✓
Washington	Department of Social and Health Services	✓	✓	
Virginia	Department of Behavioral Health and Disability Services	✓	✓	✓

Innovations in Fornesic Programs Across States

Well-established policy and programmatic dimensions of forensic services, service capacity and service innovations were evidenced across the survey states. These innovations involve intervention at a number of points in the criminal justice process: pretrial diversion, utilization of uniform standards of determining competency, utilization of post-finding institutional commitment, and utilization of community-based programs. Among the key highlights from some of the surveyed states include:

Ohio. This state has enacted legislation that allows for individuals who are found to be non-restorable who had been accused of a violent felony to be involuntary committed for a duration equivalent to the maximum prison sentence had the defendant been convicted or until the individual is deemed no longer mentally ill and subject to hospitalization.

New Jersey. This state recently released Requests for Proposals targetting supportive housing and other community support services for forensic involved individuals discharged from state psychiatric hospitals.

Washington. The Community Protection Program is a voluntary program for persons with developmental disabilities with forensic involvement that includes housing and constant staff supervision, on-going therapy and support to learn daily living skills.

Connecticut. Clinicians of the state's Department of Mental Health and Addiction Services Department review arraignment lists and referrals from judges, prosecutors and defending attorneys to suggest options to the judge.

Virginia. The Commonwealth of Virginia offers a robust virtual repository of referral forms, court reporting forms, and other templates to facilitate forensic referral and communication processes, consistent with state judicial and health policy standards.

A directory of the websites and documents reviewed in each state is contained in Appendix B.

Common Trends and Experiences Across States

A number of common trends and experiences were reported by the contacted key informants, or gleaned from the web- and document review process.

- ✓ **States Are Experiencing Surges in Incompetent to Stand Trial (IST)Referrals.** All 10 of the states whose materials were reviewed reported significant growth in the number of individuals being referred to competency restoration programs and the resulting strain on treatment resources. California State Hospitals, for example, report a 50% increase in Incompetent to Stand Trial (IST) admissions, climbing to 2,991 in SFY 2016.

- ✓ **Growth in IST Referrals Strain Limited Available Inpatient Beds.** States note that managing the surge in referrals for competency treatment has ripple effects on the already limited inpatient bed availability. The State of Connecticut, for example, note: "..forensic patients that are referred for competency evaluations do compete for beds that may be reserved for civil patients. This occurs when a patient is found to be incompetent and non-restorable. These patients may be evaluated in a community setting but then require hospitalization, ultimately becoming civil patients. These patients then compete for available beds within the state system. " (DMHAS Psychiatric Services Study Report, 2016, pp 7).

- ✓ **States Have Utilized Jail Diversion to Reduce IST Referrals**. A number of states have reported their development and deployment of jail diversionary programming, in an effort to avoid unnecessary and costly competency evaluations.

- ✓ **Use of Jail-Based Competency Treatment Programs is Gaining Ground.** In lieu of, or in addition to, hospital and outpatient-based competency treatment, many states are expanding use of jail-based competency programs. California, for example, has established and expanded jail-based IST programming in a number of counties.

- ✓ **Use of Competency-based Approaches to Determining Competency Appear Promising**. Research published by Pirelli and colleagues (Pirelli, Gottdiener, & Zapf, 2001), report the results of a meta-analytic review of competency to stand trial research. Their research suggests that use of competency-based, standardized assessments hold promise in IST programming, in lieu of traditional, trait-based psychological assessments of personality and intelligence.

Appendix A: Technical Note on Incidence Estimates

Qualifying Offenses	Non-Qualifying Offenses	
Aggravated assault	Assault	Marijuana violation
Aggravated domestic violence	Burglary second degree	Narcotic drug violation
Aggravated robbery	Burglary third degree	Promoting prison contraband
Armed robbery	Burglary tools possession	Public sexual indecency
Arson of occupied structure	Criminal damage	Resisting arrest
Arson of structure/property	Criminal trespass first degree	Robbery
Dang/deadly aslt by prisoner	Criminal trespass third degree	Shoplifting
Kidnap	Disorderly conduct	Theft
Misconduct involving weapons	Drug paraphernalia violation	Theft means of transportation
Sexual assault	Fail register as sex offender	Unknown
	Indecent exposure	Unlaw use of means of transp
	Interfer with judicial proceeding	Unlawful imprisonment

Pipeline Estimates

507 # people determined non-restorable 2012-2016 (Maricopa County only; partial year 2016)	
157 (31%) #/% non-restorables that had been charged with least one new crime 2012-2016	
71 (45%) # of 'dangerous[1]' re-offense charges/% of re-offenders w/ at least one dangerous charge	**141 (89%)** # of 'dangerous' re-offense charges/% of re-offenders w/ No dangerous charge
Aggravated Assault **(25%)**	Dangerous Drug Violation **(9.9%)**
Aggravated DV**(1.89%)**	Resisting Arrest **(5.2%)**
Armed Robbery **(1.89%)**	Burglary, 3rd Degree **(4.25%)**
15 -25 *Estimated # of non-restorable, dangerous defendents, per year. Maricopa County only.* **19-41** *Statewide estimate of non-restorable dangerous defendents, per year*	

[1] Dangerousness definition based upon I. A defendant determined to be nonrestorable pursuant to 13-4517 may be considered for Civil Commitment to Dangerous Nonrestorable Program ("DNP") if:

A. The defendant is charged with a crime or crimes as follows:
   1. **A crime involving the discharge, use or threatening exhibition of a deadly weapon or dangerous instrument**;
   2. The infliction, attempted infliction or the threat of infliction of **serious physical injury on another person;**
   3. **A dangerous crime against children** pursuant to section 13-705

Appendix B. Relevant Links of Surveyed States

State	Primary Page	Relevant Documents
California	http://www.dhcs.ca.gov/services/Pages/MentalHealthPrograms-Svcs.aspx	http://www.dsh.ca.gov/Publications/docs/2016_Annual_Report.pdf http://www.lao.ca.gov/reports/2012/hlth/ist/incompetent-stand-trial-010312.pdf http://www.courts.ca.gov/documents/LA-Competency-Protocol.pdf http://www.dhcs.ca.gov/services/MH/Documents/10-DayLimit_Leg_Rpt.pdf http://www.dhcs.ca.gov/services/MH/Documents/MHBG_FedMonitorRpt7-2010.pdf http://www.dhcs.ca.gov/services/MH/Documents/CMHPcPRCJan2015.pdf http://www.scscourt.org/court_divisions/criminal/forensic_evaluators.shtml http://www.scscourt.org/documents/ForensicEvaluatorManual.pdf
Colorado	https://www.colorado.gov/cdhs https://www.colorado.gov/pacific/cdhs/behavioral-health	https://www.colorado.gov/pacific/cdhs/alcohol-drug-emergency-commitmentalcohol-drug-involuntary-commitment https://www.colorado.gov/pacific/cdhs/colorado-mental-health-institute-pueblo
Conneticut	http://www.ct.gov/dmhas/cwp/view.asp?q=334712	
Florida	http://www.myflfamilies.com/service-programs/mental-health/about-adult-forensic-mental-health	
Illinois	http://www.dhs.state.il.us/page.aspx?item=29763	http://www.dhs.state.il.us/OneNetLibrary/27896/documents/By_Division/MentalHealth/ForensicHandBook.pdf http://www.dhs.state.il.us/OneNetLibrary/27897/documents/Mental%20Health/andersonFreeman/DHS4111withCovers.pdf
Oregon	http://www.oregon.gov/oha/HSD/AMH/Pages/Mental-Health.aspx	http://www.oregon.gov/oha/OSH/LEGAL/Pages/Aid-Assist-Orders.aspx
Pennsylvania	http://www.dhs.pa.gov/index.htm	http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/d_005973.pdf

	http://www.dhs.pa.gov/citizens/statehospitals/index.htm	https://www.aclupa.org/news/2017/06/15/pa-agrees-expand-treatment-people-severe-mental-illness-held
Washington	http://www.dbhds.virginia.gov/forensic-services	http://www.dbhds.virginia.gov/professionals-and-service-providers/forensic-services http://www.dbhds.virginia.gov/library/forensics/ofo%20-%20mental%20health%20docket%20report%20final.pdf

State v. Williams
2010 Ohio Supreme Court
126 Ohio St.3d 65
930 N.E.2d 770

Ohio INR Civil Commitment statute:

a. D charged with 1st or 2nd degree violent felony, found incompetent and remains incompetent after 1 year of treatment = CA has two options:
   1- seek civil commitment in probate court, or
   2- request the criminal court to retain jurisdiction over D
b. To retain jurisdiction the criminal court must hold a hearing and find by clear and convincing evidence that both:
   1 – D committed the offense charged [without the required finding of scienter], and
   2 – D is a "mentally Ill person subject to hospitalization by court order" [a person who, because of a mental illness, represents a substantial risk of physical harm to others as manifested by evidence of recent violent behavior or present dangerousness].
c. If the court does not make both findings, the indictment must be dismissed [without prejudice] and the D discharged unless the CA files a petition of civil commitment in probate court.
d. If the court makes both findings;
   1 – D is committed to a hospital or other appropriate facility in the least restrictive placement alternative available consistent with public safety and Ds welfare, "giving preference to protecting public safety".
   2 – During commitment periodic clinical reports and recommendations concerning D's competence, degree of confinement and termination of commitment are required to be given to the court and further proceedings are available to consider placement in a non-secured setting, possible conditional release to the community and termination of commitment.
e. Commitment of D terminates upon the earlier of:
   1 – Criminal court's determination that D is no longer a mentally ill person subject to hospitalization by court order, or
   2 – expiration of the maximum prison term D could have received if convicted for the most serious offense charged, or
   3 – Criminal court finds that D is competent to stand trial and is no longer a mentally ill person subject to hospitalization by court order.
   [Note: if commitment terminates because of #2, the court or CA can seek civil commitment in probate court]

State v. Williams
2010 Ohio Supreme Court
126 Ohio St.3d 65
930 N.E.2d 770

Constitutional attack:

A. Criminal v. Civil: The statute is Criminal in nature and as such denies defendants constitutional rights because procedural safeguards for criminal prosecution are not present:

The Appellate court below (overturned here) found that the overriding intent of the statute was to confine incompetent defendants who have been charged with serious felonies as if they had been convicted or until they can be tried and therefore was criminal in nature.

Ohio court using the "intents/effects test" applied by U.S. Supreme Court in Kansas v. Hendricks (1997) 521 U.S. 346 [an SVP case] overruled the Appellate Court and held the statute to be remedial and therefore civil, rather than penal and therefore criminal.

Facts used to attempt to prove the statute is criminal:

- The statute is in the criminal code not the probate code
- The criminal indictment remains pending after commitment
- That the D has to remain incompetent throughout commitment
- That the length of detention is linked to a possible maximum prison sentence

Ohio Supreme Court held the statute is remedial or civil in nature and is designed primarily for the purpose of protecting the public citing the following:

- Statute specifically states that the least restrictive commitment alternative must be ordered consistent with the welfare of the patient and public safety and the court shall give preference to protecting public safety
- Seriousness of the offense is merely an indicator of the level of dangerousness in determination of whether to commit [a factor previously approved in Kansas v. Hendricks]
- As in Kansas v. Hendricks, this statute does not affix culpability for criminal conduct and in determining that the offense was committed does not require a finding of scienter
- The statute does not implicate retribution or deterrence, both primary objectives in a criminal statute
- As stated in the dissent in the appellate court, this statute contained in the criminal code functions merely as a "transfer of commitment authority to a criminal court from a probate court for

mentally ill persons subject to hospitalization by court order, whose present dangerousness is demonstrated by the commission of a serious felony"

- D can be released when found no longer a mentally ill person subject to hospitalization by court order
- The release provisions of the statute emphasize that the primary purpose of the statute is to provide stricter confinement for mentally ill persons who are particularly dangerous which conforms to the statement in Kansas v. Hendricks that confinement of the dangerously mentally ill has been historically regarded as a legitimate nonpunitive governmental objective

A. The statute is a violation of the Equal Protection Clause:

Ohio Supreme Court reviewed the statute under the "Rational Basis Test" to determine whether the classifications and the procedures found in the statute are related to and are justified by a legitimate governmental interest and held that there was no violation of Equal Protection.

Facts used to argue equal protection violation are that although both the criminal and civil statutes use many of the same standards and procedures:

- The commitment under the criminal statute is more restrictive than a civil commitment in probate court
- The procedures for terminating a commitment under the criminal statute are more onerous than under a probate court civil commitment.
- Cases used to bolster argument: Jackson v. Indiana and Baxstrom v. Herold.

The Ohio Supreme Court held that the procedures used in the criminal statute which are more restrictive or more onerous are rationally related to a legitimate public interest and therefore do not violate equal protection, stating:

- The statutory differences are justified by the contexts of the two commitments. The fact that in the criminal commitment the defendant has been found to be a danger to others and ***also*** found to have committed a violent felony, fundamentally distinguishes it from a commitment under the civil statute. Public safety concerns reasonably justify assigning to the criminal court an important role in the possible reduction of the committed person's reduction ion

restrictions in determining whether the commitment should be terminated.

- This statute here is distinguished from the statutes in Jackson and Baxstrom because the D here, unlike in Indiana, has the opportunity for release and unlike in New York, D was committed only after a judicial hearing to determine dangerousness.
- The legislature could rationally conclude that an individual's present involvement in the criminal justice system (those under indictment) indicates a greater degree of dangerousness than those facing a civil commitment.
- Society has a substantial interest in ensuring that those individuals who have been deemed particularly dangerous truly are no longer mentally ill persons subject to hospitalization by court order prior to being released from commitment.

B. The Ohio statute violates Due-Process:

The Ohio court reviewed the statute under the "Rational Basis Test" and found that the commitment under this criminal statute does not violate principles of due process.

Arguments used to show violation of due-process:

- A defendant committed solely for incompetency cannot be held more than a reasonable period of time to determine if he will be able to again attain competency and cannot be required to undergo treatment for a set period of time without the right to be released if determined that competency cannot be restored.
- Due process requires that an indictment be dismissed upon a finding the defendant cannot be restored to competency because it is fundamentally unfair to have charges pending indefinitely when there is little hope the defendant will be brought to trial and exonerated.
- The use of the clear and convincing standard of proof rather than the beyond a reasonable doubt standard to determine whether the defendant committed the charged offense violates due process.

The Ohio Supreme Court found that the Ohio statute is civil in nature with the primary purpose of protecting the public and does not violate due process, citing the following significant factors:

- The statute requires commitment to the least restrictive alternative consistent with public safety and the defendant's welfare.

- Although possible restoration to competency remains an issue, the person is not committed solely on incapacity to proceed to trial and is committed only after being found by clear and convincing evidence that they are mentally ill and subject to hospitalization by court order and being a danger to the public because he has committed the serious offense with which he was charged.
- The Ohio statute has similar features to the statute found constitutional in Kansas v. Hendricks.
- The court's finding that the defendant committed the offense is used only to determine the defendant's degree of dangerousness.
- Although a defendant may be committed until the expiration of the term of maximum imprisonment, due process is satisfied because the defendant may be released if it is proven that he is no longer a mentally ill person subject to hospitalization by court order.
- If restored to competency during commitment and while the person remains mentally ill, he can be tried on the offense while remaining committed for his mental illness.
- The Ohio Supreme Court cited with approval the following statement from Kansas v. Hendricks:

  > A civil commitment for any purpose is a significant deprivation of liberty and due-process protections must be afforded to a person facing involuntary commitment.*(citations omitted)* However, the right to be free from physical restraint is not absolute; the United States Supreme Court has consistently upheld statutes authorizing the forceable civil commitment of persons who are unable to c0ntrol their behavior and who pose a danger to the safety of the public, provided the confinement takes place pursuant to proper procedures and evidentiary standards.

- The court found the overriding purpose of the Ohio statute is to protect the public from a person who is dangerously mentally ill, has perpetrated felonious conduct, and cannot be tried because of his mental incompetency, and found that the process, standards and procedures in the statute bear a reasonable relation to this purpose. Even though there is a way to civilly commit a person who has committed an serious offense of violence, this does not prevent the legislature from creating an alternative procedure in the criminal court for persons who pose an especially high degree of risk to safety of the public.