Committee on Mental Health and the Justice System

AGENDA

Wednesday, September 26, 2018
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.	**Business Rules/Proxy Procedure**	Mr. Batty
10:20 a.m.	**Committee Member Introductions**	All
11:45 a.m.	**Overview of the Fair Justice Task Force and its Subcommittee on Mental Health and the Criminal Justice System**	Mr. Batty
12:00 p.m.	**LUNCH**	
12:30 p.m.	**Discussion: "*Decriminalizing Mental Illness: Fixing a Broken System*" Conference of State Court Administrators 2016-2017 Policy Paper**	Mr.Batty, All
1:00 p.m.	**Review Charge of the Committee**	Mr. Batty
2:00 p.m.	**Preparation for Next Meeting/Next Steps**	Mr. Batty, All
2:30 p.m.	**Good of the Order/Call to the Public**	Mr. Batty
3:00	**Adjourn**	Mr. Batty

Next Meeting:
TBD

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 Jennifer Albright at (602) 452-3453 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.

IN THE SUPREME COURT OF THE STATE OF ARIZONA

In the Matter of:	)	
	)	
ESTABLISHMENT OF THE	)	Administrative Order
COMMITTEE ON MENTAL HEALTH	)	No. 2018 - 71
AND THE JUSTICE SYSTEM AND	)	
APPOINTMENT OF MEMBERS	)	
	)	

Administrative Order No. 2016-16 established the Task Force on Fair Justice (Task Force), and Administrative Order No. 2017-120 extended the term of the Task Force through June 30, 2018. The Subcommittee on Mental Health and the Criminal Justice System, a subcommittee of the Task Force, presented its final report to the Arizona Judicial Council in June 2018.

The Subcommittee's report recommended that the Court continue the Subcommittee's work by establishing a committee comprised of justice and mental health stakeholders to identify and recommend ways to address the issues and challenges faced by justice system involved individuals with mental and behavioral healthcare needs. The charge of this committee is to develop and recommend comprehensive, evidence-based best practices and cross-agency protocols to improve the administration of civil and criminal justice for persons with mental illness.

The Conference of State Court Administrators published a Policy Paper: "*Decriminalization of Mental Illness: Fixing a Broken System*." In it, the judiciary is described as "the ideal organizing force to convene the entities that must come together to develop better protocols to evaluate the impact of the mental health crisis" on the courts and our communities. The Court recognizes that cases involving individuals with mental health issues have posed challenges to the justice system, as well as to the persons involved and their families. Moreover, the judiciary is in a unique position to bring community stakeholders together to develop solutions to improve the administration of justice for those with mental and behavioral healthcare needs.

Therefore, pursuant to Article VI, Section 3, of the Arizona Constitution,

IT IS ORDERED that the Committee on Mental Health and the Justice System ("Committee") is established as follows:

1. **Purpose**: The Committee shall study and make recommendations as follows:

    a. Continue to identify ways for the courts and other justice system stakeholders to effectively address how the justice system responds to persons in need of behavioral health services.

b. Oversee the development of a model guide to help presiding judges develop protocols to work with justice system involved individuals with mental and behavioral healthcare needs. Coordinate a statewide Summit to share the Guide with judges, court personnel, mental health professionals, and justice system stakeholders.

c. Review Arizona's Mental Health Court Standards to determine whether current performance measures should be adjusted to capture additional data and to examine how that data should be analyzed. Examine how other courts and stakeholders collect data and whether improved communications between behavioral health and justice system stakeholders could result in a more effective delivery of services to those who are mentally ill.

d. 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.

e. Identify ways the court can work collaboratively with other stakeholders to educate the public on the use of advance healthcare directives.

f. Oversee, as necessary, the implementation of recommendations of the Fair Justice Task Force relating to the courts and mental health approved by the Arizona Judicial Council.

g. Identify opportunities to educate the public on court processes involving individuals involved in the justice system who have behavioral health treatment needs.

2. **Membership**: The individuals listed in Appendix A are appointed as members of the Committee beginning upon entry of this Order and ending December 31, 2020. The Chief Justice may appoint additional members as necessary.

3. **Meetings**: The Committee shall meet as necessary, and meetings may be scheduled, cancelled, or moved at the discretion of the Committee chair. All meetings shall comply with the Arizona Code of Judicial Administration § 1-202: Public Meetings.

4. **Administrative Support:** The Administrative Office of the Courts shall provide administrative support and staff for the Committee who may, as feasible, conduct or coordinate research as requested by the Committee.

5. **Reporting**: The Committee shall submit an interim report with findings and recommendations to the Arizona Judicial Council at the October 2019 meeting. The Committee shall submit a final report with findings and recommendations to the Arizona Judicial Council at the October 2020 meeting. Each report shall include any recommendations for necessary statutory changes.

Dated this 8th day of August, 2018.

_____

SCOTT BALES
Chief Justice

Appendix A

Committee on Mental Health and the Justice System
Membership List

Chair

Kent Batty
Pima Superior Court Administrator (Ret.)

Members

The Honorable Elizabeth Finn
Presiding Judge
Glendale City Court

The Honorable Michael Hintze
Judge
Phoenix Municipal Court

The Honorable Cynthia Kuhn
Judge
Superior Court in Pima County

The Honorable Barbara Spencer
Commissioner
Superior Court in Maricopa County

The Honorable Christopher Staring
Judge
Court of Appeals, Division One

Ms. MaryLou Brncik
Director
David's Hope

Mr. Brad Carylon
County Attorney
Navajo County

Ms. Amelia Cramer
Chief Deputy
Office of the Pima County Attorney

Ms. Shelly Curran
Director of Crisis, Prevention & Court Programs
Mercy Maricopa Integrated Care

Mr. Jim Dunn
Executive Director
National Alliance on Mental Illness – Arizona

Chief Kathleen Elliott
Chief of Police
Gila River Indian Community

Ms. Josephine Jones
Deputy Public Advocate
Maricopa County Office of the Public Advocate

Ms. Dianna Kalandros
Director of Treatment Services
Pinal County

Chief Chris Magnus
Chief of Police
City of Tucson

Mr. James McDougall
Attorney
Ryan Frazer Goldberg & Arnold

Dr. Carol Olson
Medical Director
Desert Vista Hospital

Mr. Ron Overholt
Court Administrator
Superior Court in Pima County

Captain David Rhodes
Chief Deputy
Yavapai County Sheriff's Office

Ms. Michal Aimee Rudnick
Project Management Administrator
Arizona Health Care Cost Containment System

Ms. Fanny Steinlage
Deputy Public Defender
Coconino County Public Defender

Dr. Michael Shafer
Professor
Arizona State University

Mr. Paul Thomas
Court Administrator
Mesa Municipal Court

Staff

Ms. Jodi Jerich
Senior Court Policy Analyst
Administrative Office of the Court

Mental Health
And the Justice System

1. Quorum Policy

The minimum number for a quorum of members to conduct the business is fifty percent plus one member. In-person attendance is preferred, but a member, if necessary and if electronic conferencing devices are available, may attend a meeting by telephone or by video.

2. Decision-Making

Committee decisions will be considered upon a motion that is properly seconded and following discussion on the motion. Committee decisions will be made by majority vote of the members attending the meeting. A numerical vote will be recorded unless the decision is unanimous. The chair will vote only to break a tie.

3. Responsibility of Members and Proxy Policy

Members are encouraged to actively participate in Committee meetings, as members are selected for their expertise. However, Committee members may send a proxy to attend meetings on their behalf when necessary. A member should give twenty-four hours' notice to Committee staff concerning the attendance of a proxy.

- A proxy has all the responsibilities of a member, including voting power. A proxy must review the agenda issues, be prepared for a meeting, and brief the member on the meeting within a reasonable time thereafter.
- Another Committee member may not serve as a proxy.
- A proxy is included in the count of members present to determine a quorum.

A proxy form and instructions are on the next page.

4. Call to the Public

Every meeting agenda will include a "Call to the Public" before the meeting is adjourned. The chair will announce the opportunity for public comment regardless of whether a member of the public is attending the meeting or has expressed any desire to comment. The chair may impose reasonable time, place, and manner limitations upon members of the public who respond to the call, including setting time limits, banning repetition, and prohibiting profanity and disruptive behavior.

Proxy Designation Form and Instructions

- Committee members are responsible for briefing their proxy so that the proxy is prepared to conduct Committee business.
- A proxy must similarly communicate with the member after a meeting to inform the member of substantive events that occurred at the meeting.
- A member wishing to appoint a proxy should complete this form and transmit it to Subcommittee staff indicated below at least one day prior to the scheduled Subcommittee meeting. A member who sends a proxy to more than one meeting must use a separate proxy form for each meeting.

Proxy designations should be sent to:

Jodi Jerich, Senior Court Policy Analyst
Administrative Office of the Courts
Phone number: (602) 452-3255
E-mail: jjerich@courts.az.gov

I, (please print your name) _____,
will be absent from the meeting of the Committee on Mental Health and the Justice System scheduled for the _____ day of _____, 201___. Accordingly, I designate the following individual to act as my proxy for this meeting:

Name: _____

Employer/Title: _____

E-mail: _____

Phone: _____

Member's Signature Date

Report and Recommendations of the Fair Justice Task Force's Subcommittee on Mental Health and Criminal Justice System

May 2018

Table of Contents

Fair Justice Task Force's Subcommittee on Mental Health and Criminal Justice

MEMBERS

Mr. Kent Batty, Chair
Consultant, Administrative Office of the Courts

Ms. Susan Alameda
AOC - Adult Probation Division

Professor Tommy K. Begay
University of Arizona College of Medicine

Mr. John L. Belatti
City of Mesa

Ms. Mary Lou Brncik
David's Hope

Detective Kelsey Commisso
Phoenix Police Department

Ms. India Davis
Pima County Behavioral Health

Mr. Jim Dunn
Natl. Alliance on Mental Illness – Arizona

Ms. Vicki Hill
City of Phoenix Prosecutor's Office

Ms. Josephine Jones
Maricopa County Office of the Public Advocate

Honorable Joseph Mikitish
Superior Court in Maricopa County

Dr. Dawn Noggle
Maricopa County Correctional Health Services

Dr. Carol Olson
Maricopa Integrated Health System

Ms. Nancy Rodriguez
Clerk of Superior Court in Maricopa County

Dr. Michael S. Shafer
ASU College of Public Service and Community Solutions

Ms. MaryEllen Sheppard
Maricopa County

Honorable Susan Q. Shetter
Tucson City Court

Honorable Barbara Spencer
Superior Court in Maricopa County

Honorable Christopher Staring
Court of Appeals, Division II

Ms. Lisa Surhio
Pima County Public Defender's Office

Detective Sabrina Taylor
Phoenix Police Department

Mr. Paul Thomas
Mesa Municipal Court

Ms. Juli Warzynski
Maricopa County Attorney's Office

Ms. Danna Whiting
Pima County Office of Medical Services

AOC Staff

Jennifer Albright
Senior Court Policy Analyst
Court Services Division

Theresa Barrett
Manager, Court Programs Unit
Court Services Division

Donald Jacobson
Consultant
Court Service Division

Jodi Jerich
Senior Court Policy Analyst
Court Services Division

Sabrina Nash
Court Programs Specialist
Court Services Division

Angela Pennington
Administrative Assistant
Court Services Division

Kathy Sekardi
Senior Court Policy Analyst
Court Services Division

Report and Recommendations of the Fair Justice Task Force's Subcommittee on Mental Health and Criminal Justice System

May 2018

EXECUTIVE SUMMARY

The Subcommittee submits this report to the Fair Justice for All Task Force (Task Force). Over the course of eight months, the 24 members of the Subcommittee worked diligently to develop a series of recommendations designed to promote a more efficient and effective justice system for those individuals who come to court and are in need of behavioral health services.

Some of these recommendations were approved by the Task Force at its November 2017 meeting. Other recommendations are expected to be considered by the Task Force at its meeting on May 21, 2018. A complete list of all the Subcommittee's recommendations is found in this report.

The justice system, and all the stakeholders who participate in it, must strive to break the cycle of persons with mental illness going in and out of the criminal justice system. To do so, the courts must continue to better address people with mental health care needs by identifying ways to connect people to treatment and to diverting them out of the criminal justice system when appropriate. A 2006 Bureau of Justice Statistics Report revealed that 56% of state prisoners, 45% of federal prisoners and 64% of jail inmates had mental health problems. And nearly a quarter of both state prisoners and inmates who had mental health problems had served

> ***"It has been stated that '[t]he moral test of government is how it treats those who are in the dawn of life, the children; those who are in the twilight of life, the aged; and those who are in the shadows of life, the sick, the needy and the handicapped.'"***
>
> *Arnold v. Arizona Department of Health Services*, 160 Ariz. 593, 609 (1989)

three or more prior incarcerations.[1] With a significant number of persons with mental illness in Arizona's jails and prisons, the Arizona criminal justice system has become a default provider of mental health care services. Jails and prisons are not designed to be mental health care institutions. The courts should play a prominent role in remedying this situation by identifying opportunities, when appropriate, to divert people out of the justice system and into treatment.

When the Task Force terminates in May 2018, so will its Subcommittee, but its work is not yet complete. Therefore, the Subcommittee strongly recommends that the Supreme Court follow the steps taken in other states by creating a longer-lasting committee on the courts and mental health. This new committee should oversee the implementation of the Subcommittee's recommendations. Additionally, the Subcommittee proposes that the Court entrust this new committee with additional charges as discussed later in this report.

CREATION AND CHARGE OF THE SUBCOMMITTEE

The Chairman of the Task Force, Dave Byers, created this Subcommittee to bring together a cross-section of legal and mental health experts. He charged them to find ways to better administer justice for those individuals who suffer from mental illness and are in need of treatment.

"*Justice for all*" embraces the ideal that all people should be treated fairly in the justice system. To achieve this ideal, the Task Force formulated several principles on which the courts should act. One of these principles is that "*special needs offenders should be addressed appropriately*." The Task Force noted that the handling of cases involving individuals with mental health issues is a challenge for the criminal justice system.[2] Other notable organizations have also sounded a clarion call to action. The Conference of State Court Administrators (COSCA) recently issued a policy paper urging courts to take a leadership role to decriminalize mental illness. It stated that the judiciary's "unique vantage point" in the civil commitment process and the criminal justice arena make it the "ideal force" to call community stakeholders together to develop protocols and processes that better address how the courts administer justice for those with behavioral health treatment

[1] See 2006 Bureau of Justice Statistics Special Report https://www.bjs.gov/content/pub/pdf/mhppji.pdf.
[2] "Justice for All: Report and Recommendations of the Task Force on Fair Justice for All: Court-Ordered Fines, Penalties, Fees, and Pretrial Release Policies."

needs.[3] In furtherance of "fair justice for all" for those justice-involved individuals with mental illness, this Subcommittee was created.

The Task Force gave the Subcommittee four charges:

1. Identify rules and procedures to implement legislation that allows limited jurisdiction courts (LJCs) to conduct Rule 11 hearings.

2. Determine if the standard for ordering court ordered treatment should be altered to allow for earlier intervention.

3. Identify ways courts can more effectively address individuals in the justice system who have mental health issues.

4. Develop a model protocol guide for Presiding Judges to use to implement the Task Force's recommendations.

OVERVIEW OF THIS REPORT

This Report begins with an Executive Summary, followed by an account of the Subcommittee's genesis, as well as the charges given to it. Next, the report details the Subcommittee's membership and the processes by which it conducted its meetings. A listing of all its recommendations follows. The report then summarizes each meeting, explaining the underlying discussions which ultimately led to its recommendations. Additional detail of each meeting is available on the Subcommittee's webpage. The report then sets forth the Subcommittee's proposal that the Court create a new committee on behavioral health and the justice system. Finally, the report includes appendices containing reference documents and recommended rule changes.

THE SUBCOMMITTEE MEMBERSHIP AND PROCESS

Members of the Subcommittee were selected to bring together a variety of perspectives to address how the courts can better handle matters involving persons with mental illness. The Subcommittee comprises judicial officers from the appellate,

[3] Conference of State Court Administrators, "Decriminalization of Mental Illness: Fixing a Broken System" 2016-2017 Policy Paper.

superior, and municipal courts; and representatives from court and county administration, the clerk of the court's office, prosecutors, criminal defense attorneys, law enforcement, academics, mental health professionals, and mental health advocates. The Subcommittee also solicited input from other stakeholders interested in this subject matter.

Beginning in September 2017, the Subcommittee met monthly and twice in April 2018 for a total of nine meetings. The members discussed a wide variety of issues. The Subcommittee heard from several speakers who shared both professional and personal accounts of the challenges individuals with mental illness and their families face when navigating the criminal and civil justice systems. The meetings were interactive, and the members were highly engaged. This facilitated input from different perspectives and provided a thoughtful environment for the members to find consensus on a number of issues. The Subcommittee established two workgroups: the Rule 11 Workgroup and the Title 36 Workgroup. Their work will be discussed in greater detail later in this report. Finally, the Subcommittee invited a number of people to address the Subcommittee on a number of topics:

- Recent changes to Rule 11.
- Mesa Municipal Court and Glendale City Court Rule 11 Pilot Programs.
- Superior Court in Pima County's Rule 11 process.
- The COSCA White Paper "Decriminalization of Mental Illness: Fixing a Broken System."
- The standards and processes for conducting Rule 11 competency evaluations and restoration to competency (RTC) programs.
- How Rule 11 cases are transferred from limited jurisdiction courts (LJCs) to superior court and how allowing LJCs to conduct Rule 11 hearings has positively impacted services to the defendants.
- Pre-Trial Release policies and the implementation of the Public Safety Assessment (PSA) tool as a substitute for bond schedules.
- The differences between general jurisdiction (GJ) and LJC mental health courts.
- Legislative updates from AOC staff.
- The Sequential Intercept Model (SIM).
- Crisis Intervention Training (CIT) Officers in Maricopa and Coconino Counties.
- Maricopa County's Crisis Mobile Teams (CMTs) and Criminal Justice Engagement Teams (CJETs).

- Information-sharing datalink between Mercy Maricopa and the Maricopa County jails to identify persons who have been designated as seriously mentally ill (SMI) and in need treatment.
- Personal accounts of persons whose family members suffer from mental illness and have encountered the criminal justice system.
- Review of a "diminished capacity" standard for persons who commit criminal acts but lack a requisite culpable mental state.
- Legislative proposal to amend civil commitment statutes relating to the evaluation and transport of persons who may be in need of mental health treatment but are unable or unwilling to seek such treatment.
- The history and settlement agreement of the *Arnold v. Sarn* class action lawsuit against Maricopa County and the Arizona Department of Health to adequately fund a comprehensive community mental health system.
- Efforts by the Yavapai County Sheriff to develop pre-arrest diversion options when law enforcement encounter mentally distressed persons, to reduce the recidivism rate of defendants with mental illness, to provide mental health treatment while in jail, and to connect these persons to services upon release.

SUMMARY OF SUBCOMMITTEE RECOMMENDATIONS

Through the work of its members, including its workgroups, the Subcommittee developed the following recommendations.

1. Approve a draft administrative order for presiding judges to use if they authorize LJCs in their counties to conduct Rule 11 criminal competency proceedings. This AO provides direction to LJCs on what they should do to ensure the proceedings comply with court rule and state law.

   STATUS: Approved by the Task Force. Distributed to all superior court presiding judges in a statewide memorandum on December 28, 2017. (See Appendix A)

2. Approve a "policies and procedures" document that accompanies the administrative order. This document sets forth the issues LJCs should consider when establishing a Rule 11 court.

   STATUS: Approved by the Task Force. Distributed to all superior court presiding judges in the same statewide memorandum. (See Appendix A)

3. Recommend changes to Rule 11 of the Arizona Rules of Criminal Procedure to permit LJCs to order competency restoration, to clarify that LJCs may not initiate Title 36 civil commitment or guardianship actions, and to align restoration timeframes with applicable criminal sentencing penalties.

STATUS: The Task Force discussed this recommendation at its November 2017 meeting. It asked the Subcommittee to clarify portions of its proposed changes. The Subcommittee adopted clarifying changes. A Rule Petition reflecting the Subcommittee's proposed changes to Rule 11.5 and 11.6 has been filed and will be considered by the Supreme Court in late summer. The Petition is open for public comment through May 21, 2018. (See Appendix B.)

4. Recommend that the Sequential Intercept Model (SIM) be considered a best practice and that judges and staff receive training and implementation assistance on the SIM and other tools to help them recognize the behavioral health needs of persons who come to court and the options available to divert defendants who are mentally ill out of the criminal justice system and, when appropriate, into treatment.

STATUS: Pending Task Force review.

5. Recommend the Task Force create a workgroup to develop options and alternatives for the development of a centralized repository for courts that conduct Rule 11 proceedings, under appropriate circumstances and with appropriate safeguards, to be able to access relevant documents and information from past proceedings in other jurisdictions.

STATUS: Pending Task Force review. (**Note**: Currently, two LJCs have been authorized to conduct Rule 11 proceedings. These courts have established a procedure to access and share documents with each other and Maricopa County through an encrypted mailbox.)

6. Recommend that it be a best practice that courts identify locations that make it easier for defendants to get to court-ordered mental competency evaluations and restoration programs. Access to public transportation is a

key consideration and the courts should consider making space available at the courthouse where doctors can conduct evaluations.

STATUS: Pending Task Force review.

7. Recommend the Task Force direct the AOC to take steps to develop a process for LJCs to report the outcomes of Rule 11 competency proceedings as required by A.R.S. §13-609 to the National Instant Criminal Background Check System (NICS).

STATUS: Pending Task Force review.

8. Recommend that the statutory definition of "mental disorder" found in A.R.S. §36-501(25) be amended to include 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.

STATUS: Pending Task Force review.

9. Recommend the Task Force encourage the AOC to gather experts to examine evidence-based and best practices for competency evaluations and restoration to competency programs and to train accordingly.

STATUS: Pending Task Force review. (**Note:** The AOC has recently provided additional training to mental health experts in legal competency evaluations and restoration programs as discussed later in this report.)

10. Recommend the AOC 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.

STATUS: Pending Task Force review.

11. Recommend that the Supreme Court create a new standing committee that builds on and expands the work already done by the Subcommittee. The committee should look at the entire justice system to identify all possible solutions to break the cycle of persons with mental illness from coming in and out of the justice system. The Subcommittee notes that Supreme Courts in other states have formed similar committees.[4]

STATUS: Pending Task Force review.

Other Work to Address Justice-Involved Persons with Mental Illness

1. The AOC will provide an additional three-day training conference for mental health experts who perform competency evaluations and conduct competency restoration programs in order to expand the pool of qualified experts as required by court rule.

STATUS: The AOC held a three-day training conference in April 2018 to train additional doctors and psychologists in legal competency and restoration programs.

2. The AOC will work with the National Center for State Courts (NCSC) to develop a model protocol guide for presiding judges to improve the justice system's response to those individuals with serious and persistent mental illness.

STATUS: The AOC received a $50,000 grant from the State Justice Institute and is working with the NCSC to develop this guide. NCSC consultants will visit three counties to learn what existing initiatives are underway and how the courts can bring local stakeholders together to develop effective leadership strategies.

[4] Texas Judicial Commission on Mental Health; Supreme Court of Ohio Advisory Committee on Mentally Ill in the Courts.

SUBCOMMITTEE MEETINGS

September 2017 Meeting

The September meeting kicked off the work of the Subcommittee. It began with introductions and a review of the charges to the Subcommittee. The members listened to an overview of the work of the Task Force and the use of the Public Safety Assessment (PSA) tool as a better means of setting appropriate bond amounts. Additionally, the Subcommittee received information on the pilot program authorized by Administrative Order No. 2015-92 that permitted judges from the Mesa Municipal Court and the Glendale City Court to sit as superior court judges pro tempore and conduct Rule 11 proceedings in their courtrooms instead of transferring cases to superior court. These pilot programs demonstrated a marked decrease in the case processing times for Rule 11 proceedings. Members also reviewed recent changes to Rule 11 of the Arizona Rules of Criminal Procedure. In response to these issues, the Subcommittee established the Rule 11 Workgroup.

October 2017 Meeting

Draft administrative order and policies and procedures document

At the October meeting, the members reviewed the draft administrative order and corresponding policies and procedures document developed by the Rule 11 Workgroup. These documents are intended to be a template for presiding judges to use if they authorize LJCs in their counties to conduct Rule 11 proceedings. Members discussed the need for LJCs to access Rule 11 reports and Title 36 court-ordered mental health treatment case history records from other jurisdictions. At present, there is no ability for LJCs to electronically access these records. As other LJCs begin to conduct Rule 11 proceedings, the need for a secure, centralized repository will become more acute. Members discussed the value of holding Rule 11 proceedings at the local level identifying benefits for both the defendant and the municipality. Most notable was the result that more defendants showed up for their scheduled competency evaluations. The Subcommittee concluded this was due in large part to the court scheduling these evaluations at or near the courthouse. Significantly, the Mesa and Glendale courts reported reduced costs and speedier resolutions.

Changes to Rule 11

Members initiated discussions on whether Rule 11 should be amended to allow LJCs, when they find a defendant to be incompetent but whose competency can be restored, to retain jurisdiction and order competency restoration for defendants instead of transferring the case to superior court. Although this would be a substantive change from the version of the rule currently in effect, the members found it appropriate for the LJCs to make this decision. First, the LJC is the court that conducted the Rule 11 hearing and has a full understanding of the case. Second, it is the municipality that pays the costs of restoration services, so it is appropriate for the local court to decide to order restoration and, if so, to monitor its progress.

Sequential Intercept Model

The Subcommittee also heard a presentation of the Sequential Intercept Model (SIM). The SIM is intended to reduce the number of persons with mental illness who are incarcerated, increase the number of people in treatment, and break the cycle of people with mental illness coming in and out of the justice system. The SIM identifies five intercept points in the criminal justice system where a person with mental illness can be diverted out of the justice system and into treatment. Next, the members learned of the efforts of the Maricopa Regional Behavioral Health Authority to create Crisis Mobile Teams (CMTs) and Criminal Justice Engagement Teams (CJETs). These efforts try to divert persons with mental illness out of the criminal justice system at Intercept Points #1 and #2.

Standards for court-ordered treatment

The second charge to the Subcommittee directs it to consider whether changes should be made to the statutory standards for court ordered treatment. Currently, Arizona law provides four standards: (1) danger to self; (2) danger to others; (3) gravely disabled; or (4) persistently or acutely disabled. The Subcommittee reviewed the Conference of State Court Administrators' (COSCA) Policy Paper that called for states to adopt an "incapacity" standard for court-ordered treatment which is the same standard used to appoint a guardian. Most members found the Arizona statutes to be sufficient and that Arizona's standard for court-ordered treatment was not preventing the courts from ordering treatment for those who needed it. Currently a court shall order a person to undergo treatment if it finds by clear and convincing evidence that the person as a result of a "mental disorder":

1. is a danger to self, a danger to others, is gravely disabled, or has a persistent or acute disability;

2. is in need of treatment; and
3. is unable or unwilling to seek treatment.[5]

Members noted that in several other states, a court can only order treatment upon a finding that the person is a danger to themselves or to others. These jurisdictions do not have the persistent or acute disability standard. The Subcommittee noted that Arizona's persistent or acute disability standard is similar, but not identical to, an incapacity standard. Ultimately, members did not find a need to amend the standard for court-ordered treatment at this time.

November 2017 Meeting

The Subcommittee heard from a Crisis Intervention Training (CIT) police officer who described the mental health training police receive. This training teaches officers to identify people who appear to be in mental distress, assess their situation, and divert them, when possible, into treatment.

Members also heard from individuals who recounted their experiences with the justice and behavioral health systems when their family members with a mental illness were charged with a crime or when they sought court-ordered mental health treatment. They shared their frustrations with finding information about the available legal and medical options. Even though both presenters were long-time members of the judicial system, they said they had a very difficult time navigating through it as family members.

Regarding medical treatment, the presenters believed their family members were required to wait too long to receive treatment and that there was insufficient time allotted for inpatient treatment. Members noted that while a court may order treatment, there are not enough resources to meet demand. Members agreed that people need a continuum of care after they are stabilized with intensive inpatient treatment. Without meaningful inpatient stabilization and adequate outpatient treatment, a person will often stop taking medication, become unstable, and end up back in need of emergency mental health treatment or enter into the criminal justice system. Members noted the irony of the desire to have the courts break the cycle of persons with mental illness repeatedly

[5] A.R.S. §36-540

coming into the criminal justice system by diverting them into treatment options that do not adequately meet their needs. Without adequate treatment options, individuals' mental health will deteriorate, and they will become unstable. This increases the likelihood that they will reoffend and enter the criminal justice system once again.

Members revisited their discussion to amend the statutory definition of "mental disorder." There was general agreement that the current interpretation of the statutory definition is unnecessarily narrow. They discussed the merits of making the statute explicitly state that persons with cognitive disabilities due to injuries should meet the definition of "mental disorder" and that people with cognitive disabilities are eligible for services.

Recommendations

Members approved a number of recommendations at this meeting for consideration of the Task Force at its upcoming November meeting including recommendations regarding the SIM and the need for LJCs to report Rule 11 outcomes to NICS. Members also recommended that the AOC develop a central repository where Rule 11 courts can access, under appropriate safeguards, relevant documents from past proceedings in other jurisdictions. Additionally, the members finalized and approved the draft administrative order and the corresponding policies and procedures document for authorizing LJCs to conduct Rule 11 hearings.

Finally, the members approved a recommendation to change Rule 11 in three areas:

1. ***Defendant incompetent <u>but</u> restorable*** - Allow LJCs to retain jurisdiction and provide them with the authority to decide whether to dismiss the case or order competency restoration treatment.
2. ***Defendant incompetent <u>and not</u> restorable*** – Clear up some ambiguity in the rule to make clear that only the superior court, and not the LJC, has the authority to begin Title 36 civil commitment proceedings or appoint a guardian.
3. ***Timeframes*** - Amend timeframes to conform with time limits found in statute.

December 2017 Meeting

The members learned that the Task Force, at its November 2017 meeting, approved the draft administrative order and the policies and procedures document, but asked the Subcommittee to further refine its position on what LJCs may do if they find a defendant to be incompetent and not restorable. The members made final changes that clarified that the LJC could **not** initiate civil commitment proceedings or appoint a guardian.

The members once again reviewed the second charge of the Subcommittee and discussed whether the standard for court-ordered treatment is sufficient. It was noted that Arizona's persistent and acutely disabled standard is broad and allows for flexibility. Again, members were critical of current treatment practices which they considered to provide insufficient inpatient treatment and little regard for a person's capacity to sustain necessary treatment on an outpatient basis. Members noted the lack of funding for mental healthcare programs for persons who are not Title 19 (Medicaid) eligible.

Members reviewed a proposal to amend the statutory definition of "mental disorder." The definition of "mental disorder" is found in A.R.S. §36-501. The proposal amends the definition to include neurological and psychiatric disorders, as well as mental conditions resulting from injury, disease, cognitive disabilities or co-occurring substance use disorders in conjunction with a mental disorder. The Subcommittee recommended that the Task Force establish a workgroup to consider amending the definition of "mental disorder" as follows:

A.R.S. §36-501 Definitions

25) "Mental disorder" means a substantial neurological or psychiatric disorder of the person's emotional processes, thought, cognition, ~~or~~ memory or behavior, including mental conditions resulting from injury or disease, ~~and~~ cognitive disabilities as defined in A.R.S. § 36-551, and substance use disorders which co-occur with a mental disorder. Mental disorder is distinguished from:

> ~~(a) Conditions that are primarily those of drug abuse or alcoholism unless, in addition to one or more of these conditions, the person has a mental disorder.~~
>
> ~~(b)~~ (a) The declining mental abilities that directly accompany impending death.

~~(c)~~ (b) Character and personality disorders characterized by lifelong and deeply ingrained antisocial behavior patterns, including sexual behaviors that are abnormal and prohibited by statute unless the behavior results from a mental disorder.

January 2018 Meeting

The members received a presentation by the Health Systems Alliance of Arizona and other stakeholders of a legislative proposal to amend the screening and evaluation statutes in Title 36, as well as an update on other bills related to criminal justice and mental health care. Members also received information on the mechanics of transferring a Rule 11 case from an LJC to the superior court. Members noted that this practice resulted in delays, higher failure to appear rates, and inefficient use of the municipal prosecutor's time. They agreed that the Rule 11 pilot project yielded a more efficient and streamlined process.

The Subcommittee discussed that the public would benefit from the AOC developing a guide to the Title 36 civil commitment process. The Subcommittee determined there is a need for this information after hearing from individuals in past meetings about how difficult it is to navigate through the various court processes. The Subcommittee agreed to form a workgroup to work with staff to develop this document.

February 2018 Meeting

The Subcommittee identified the need for additional training for judges to identify and, when appropriate, divert persons with mental illness out of the criminal justice system. Effective diversion can happen when the courts become more aware of what mental health care resources are available. This can be achieved by understanding efforts made by local mental health care coalitions like the Stepping Up Initiative adopted by all 15 Arizona counties, and by implementing the protocol guide that the AOC is developing. Members noted that the courts, particularly mental health courts, should collect and report more robust data in order to analyze the impact these problem-solving courts are having on reducing recidivism, increasing community safety, and driving down costs.

The members learned of the Yavapai County Sheriff's efforts to address the disproportionate number of people with mental illness in the county's jails. Working with other local criminal justice and behavioral health stakeholders, the Sheriff's Office developed pre-arrest and post-arrest diversion options. It also created the "Reach Out" program that provides services to people while in jail and links people to treatment services upon leaving the jail. The Subcommittee learned that these programs have resulted in a 40% reduction in recidivism and a 51% reduction in the average length of stay in jail for persons who were in the Reach Out Program.

March 2018 Meeting

The Subcommittee received a presentation on the history of the *Arnold v. Sarn* lawsuit and its 2014 settlement agreement. This action was filed in 1981 and is Arizona's longest standing class action lawsuit. The Court found that Maricopa County and the Arizona Department of Health Services failed to adequately provide a comprehensive community mental health system as required by state law. Members highlighted the powerful impact this lawsuit played in elevating awareness of the need to improve Arizona's behavioral health service delivery system. The members discussed the present need for system oversight and noted the key role the court monitor played during the pendency of the lawsuit. They questioned the wisdom of the 55-bed limit for Maricopa County at the Arizona State Hospital (ASH). The presenter pointed out that this lawsuit was an instance where it took the judiciary to get the executive and legislative branches to work together and resolve this issue

The members received an update on efforts to find consensus on the legislation to amend Title 36 screening and evaluation statutes. Finally, the Subcommittee learned about the competency evaluation programs (CEP) and the restoration to competency (RTC) programs. They opined that although court-appointed psychiatrists and psychologists must attend AOC-sponsored training, there is a need to provide more rigorous and evidence-based training. The Subcommittee recommended that the AOC gather experts to examine evidence-based practices for CEP and RTC program and to train psychiatrists and psychologists on those best practices. The Subcommittee learned that the Task Force was ending in May which meant the work of the Subcommittee was coming to an end as well.

April 2018 Meetings

The Subcommittee met twice in April to review, edit, and approve this report. The Subcommittee also approved a recommendation that AOC staff develop an informational guide on the Title 36 civil commitment process and that this guide be available in both web-based and paper formats. The Workgroup reported that the Arizona Foundation for Legal Services and Education had agreed to partner with the AOC to develop a website that would provide people with information of the Title 36 civil commitment process.

Create a new committee on behavioral health and the justice system

The Subcommittee's work to date has shown to the members that they were just starting to "scratch the surface" of the broad range of issues surrounding the courts and justice-involved individuals with mental illness. As an offshoot of the Task Force, the Subcommittee will terminate when the Task Force convenes for its final meeting in May 2018. For this reason, the Subcommittee recommends that the Supreme Court create a new standing committee to continue and expand on the work. Through the Subcommittee's exploration of the several issues surrounding mental health and the justice system, the members recognized that there are no quick fixes or easy solutions to the challenges courts should address.

The Subcommittee notes that committees such as the one it proposes have been formed by the Texas and Ohio Supreme Courts. In Pennsylvania, court personnel participate in a multi-branch Mental Health and Justice Advisory Committee. In establishing the Judicial Commission on Mental Health, the Texas Supreme Court and the Texas Court of Criminal Appeals stated that, "*improving the lives of Texans who are affected by mental health issues and are involved in the justice system requires judicial leadership at the highest level*." The Supreme Court of Texas directed the Texas Judicial Council to establish a Mental Health Commission charged with examining best practices in the

"Courts and the justice system have a profound impact on mental health services provided to children, adults, and families and the stakes are exceedingly high."

Supreme Court of Texas Docket No. 18-9025 establishing the Texas Judicial Commission on Mental Health

administration of civil and criminal justice for persons with mental illness.[6]

Proposed Committee Membership

The members believe the Subcommittee benefitted from having a membership comprising a broad cross-section of justice system and mental health stakeholders. Members strongly urge the Supreme Court to create the new committee with an expanded membership to broaden its ability to impact the problems that need resolution. The Subcommittee suggests the Court invite representatives from other branches of state government to assist in developing solutions at a larger system level. The Subcommittee believes the Supreme Court should also include representatives from the Department of Health Services (DHS), the Arizona Health Care Cost Containment System (AHCCCS), AHCCCS Complete Care Health Plans ("ACC Plans"), and the behavioral health treatment providers that contract with these ACC Plans.[7] Representation from these health entities should include those providing service in rural Arizona and smaller counties. The expansion of membership also should account for the fact that the vast majority of cases involving persons with mental health problems occur in the limited jurisdiction courts.

Proposed Charge to the Committee

The Subcommittee offers the following six areas be considered by the newly-formed committee:

1. *Continue to identify ways for the courts and other justice system stakeholders to more effectively address how the justice system responds to persons in need of behavioral health services.*

   The new committee should develop an outreach and educational plan that brings together justice, behavioral health, and substance abuse treatment

[6] In the Supreme Court of Texas and the Texas Court of Criminal Appeals; Supreme Court Misc. Docket No. 18-9025, Court of Criminal Appeals Misc. Docket No. 18-004. (See Appendix C)

[7] AHCCCS's redesign of the health delivery system for Medicaid recipients, effective October 1, 2018, requires that all designated health plans provide integrated health services. This change results in behavioral health service providers contracting with the ACC Plans.

stakeholders. Consistent with the six principles of the Stepping Up Initiative[8] and the Substance Abuse and Mental Health Services Administration (SAMHSA) Sequential Intercept Model[9], the committee should develop and maintain collaborative relationships and processes that enhance behavioral health and justice system effectiveness. The committee should grow and facilitate these collaborative relationships and processes for the purpose of improving justice system effectiveness.

2. *Development of a Model Protocol Guide to help judges effectively identify and process cases with persons with behavioral health treatment needs.*

In support of the Subcommittee's original goal to develop a model protocol guide for presiding judges to use in implementing its recommendations for improving the processes for dealing with individuals with mental illness in their jurisdictions, the AOC, working with the National Center for State Courts with funding through a technical assistance grant from the State Justice Institute, will develop model protocols for presiding judges to work with local stakeholders to improve fair treatment of persons with mental health issues. The committee should receive regular progress reports and provide input. Additionally, the committee should develop an outreach effort to share the committee's work with other stakeholders and coalitions, such as the Stepping Up Initiative, who are working toward similar goals.

3. *Review Arizona's Mental Health Court Standards and national best practices.*

Arizona's Mental Health Court Standards were created by the Mental Health Court Advisory Committee and adopted by Administrative Order No. 2015-10. Since then, the operations of these courts have had time to develop and mature. On numerous occasions, the Subcommittee discussed the lack of well-defined data. The new committee should review the standards as well as MHC best practices adopted by other states. It should make recommendations on how the standards may be amended to further improve MHC court operations, reporting of performance measures, and how MHCs can best comply with the

[8] For a review of the six guiding principles of the Stepping Up Initiative, please refer to https://stepuptogether.org/toolkit.

[9] For a review of the five intercept points of the Sequential Intercept Model, please refer to https://www.samhsa.gov/criminal-juvenile-justice/samhsas-efforts.

standards. The committee may wish to seek input from national experts, court administrators, and judges throughout the state.

4. *Oversee implementation of subcommittee recommendations.*

The Subcommittee has made several recommendations for the Fair Justice Task Force to consider. The Task Force will hold its final meeting on May 21, 2018. The committee would oversee these recommendations as they come to fruition.

5. *Identify opportunities to educate the public on court processes involving individuals involved in the justice system who have behavioral health treatment needs.*

The committee should review opportunities to provide the public with information on how to navigate through the justice system in proceedings where a person may have a mental illness. Topics should include at a minimum: guardianship, powers of attorney, advance directives, the civil commitment process, Assisted Outpatient Treatment (AOT), Rule 11 competency proceedings in criminal cases, and the opportunity for eligible defendants to participate in evidence-based problem-solving courts such as mental health courts.

6. *Review statutes and rules for changes that would result in improved court processes in competency, advance directives, and court-ordered treatment hearings.*

Although the Subcommittee did not find a need to amend the standards for court-ordered treatment, it is aware that other stakeholders may wish to revisit this issue. The new committee should maintain open lines of communication with other stakeholders to work collaboratively on any future legislative proposals. The Title 36 standards represent just one of several statutory constructs that impact the lives of persons with mental health challenges. The members believe that an ongoing review of court rules and state laws for potential changes is needed and would result in improved court processes and the better administration of justice.

Conclusion

The Subcommittee respectfully submits this report to the Task Force. Its members have worked diligently to develop recommendations that address the four charges given to it. While its work product is considerable, the members of the Subcommittee believe there is still much work left to do. The courts must take a leadership role in addressing these issues of statewide importance.

Appendix A

Supreme Court of Arizona
Administrative Office of the
Courts Court Services Division
1501 West Washington, Suite 410
Phoenix, AZ. 85007

MEMORANDUM

To: Superior Court Presiding
Judges Superior Court
Administrators Limited
Jurisdiction Court Judges
Limited Jurisdiction Court Administrators

From: Marcus W. Reinkensmeyer, Director, Court Services Division
Date: December 28, 2017
Re: Implementation of Mental Competency Proceedings in Criminal Matters in Limited Jurisdiction Courts

Effective August 9, 2017, legislation amending A.R.S. § 13-4503 grants the Presiding Judge in each county authority to permit a municipal court or justice court to exercise jurisdiction over competency hearings in misdemeanor cases that arise out of the municipal court or justice court. It further provides that the limited jurisdiction court may refer a competency hearing to another limited jurisdiction court in that county with the approval of the Presiding Judge. The Supreme Court amended Rule 11 of the Arizona Rules of Criminal Procedure to conform with the jurisdictional changes the legislature made to A.R.S. § 13-4503.

Attached you will find a model administrative order template, which may be issued by superior court presiding judges, authorizing limited jurisdiction courts to exercise jurisdiction over competency hearings in misdemeanor cases. There is also included an outline of policies and procedures that should be considered when establishing a Rule 11 process in a limited jurisdiction court. The model order was developed by Mental Health Subcommittee of the Fair Justice Task Forces and was supported by the Arizona Judicial Council on December 14 ,2017. The model order and policy and procedure outline address assignment of judicial officers, appointment of counsel, calendaring, record keeping, procurement of expert witnesses and other administrative requirements.

If you have and questions or concerns regarding establishing competency proceedings in limited jurisdiction courts, please contact Don Jacobson at djacobso@courts.az.gov or at 928-853-7351.

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SUPERIOR COURT OF ARIZONA
[XXXXXXXX] COUNTY

IN THE MATTER OF IMPLEMENTATION OF MENTAL COMPETENCY PROCEEDINGS IN CRIMINAL MATTERS IN LIMITED JURISDICTION COURTS	)	ADMINISTRATIVE ORDER No. [year] - ____

On August 9, 2017, legislation amending A.R.S. § 13-4503 became effective granting the Presiding Judge in each county the authority to authorize a municipal court or justice court to exercise jurisdiction over competency hearings in misdemeanor cases that arise out of the municipal court or justice court. It further provides that the limited jurisdiction court may refer a competency hearing to another limited jurisdiction court in that county with the approval of the Presiding Judge. Thereafter, the Supreme Court amended Rule 11 of the Arizona Rules of Criminal Procedure (hereinafter ("Rule 11") to conform to the jurisdictional changes the legislature made to A.R.S. § 13-4503.

Having considered A.R.S. § 13-4503 and Rule 11, this Order addresses how [*insert name of court(s)*] may conduct Rule 11 competency proceedings in [*name of*] County.

IT IS ORDERED [*insert name of court(s)*] shall exercise jurisdiction over competency hearings in misdemeanor cases that arise out of its court in compliance with the policies and procedures set forth below.

IT IS FURTHER ORDERED that beginning on [*insert date*], [*insert name of court(s)*] shall:

1. Conduct Rule 11 proceedings in compliance with the policies and procedures approved by the Presiding Judge and attached to this Order.
2. Ensure an accurate and complete recording of all Rule 11 courtroom proceedings is taken and maintained in accordance with applicable retention schedules. This

includes completion of all automation tasks to ensure the local case management system is properly configured for docketing and retaining case records.

3. Establish a process approved by the Presiding Judge for the issuance, filing, and distribution of minute entries and orders, and for the handling of evaluations and medical reports as required by law and court rule.
4. Appoint mental health experts who meet the requirements set by statute and rule, and who are appointed pursuant to statutory and local procurement requirements.
5. Transmit necessary findings to the Administrative Office of the Courts for the Department of Public Safety for firearm background checks as required by state and federal law.
6. Pay any costs associated with holding Rule 11 competency proceedings as dictated by applicable statute, rule, or local practice at their court.

IT IS FURTHER ORDERED:

7. In accordance with A.R.S. § 13-4508, and Arizona Supreme Court Rule 123, judges shall take all necessary steps to ensure the confidentiality of Rule 11 evaluations and ensure that those records are to be treated as confidential records by all who have access to them, including attorneys. Judges who conduct Rule 11 proceedings shall have the authority to order the unsealing of past Rule 11 evaluations for the limited purposes of the Rule 11 proceedings held in their court.
8. The Superior Court and the Clerk of the Superior Court shall ensure that when [*insert name of court(s)*] conducts Rule 11 competency proceedings, [*insert name of court(s)*] has access to any records necessary to conduct the proceeding, including past Rule 11 evaluations in the Superior Court.
9. [*Name of court(s)*] shall provide to a requesting court access to any records necessary to conduct Rule 11 proceedings in that court if the requesting court is authorized to conduct Rule 11 proceedings.

IT IS FURTHER ORDERED if [*insert name of court(s)*] wishes to refer competency hearings to another court authorized to conduct Rule 11 hearings pursuant to A.R.S. § 13-4503(F), [*insert name of court(s)*] shall submit to the Presiding Judge for approval its policies and procedures regarding referral of these matters.

IT IS FURTHER ORDERED the Presiding Judge may revoke the [*insert name of court(s)*] authorization to conduct or refer Rule 11 competency proceedings if the Presiding Judge determines that the court fails to comply with the conditions of this Order or any subsequent related order.

Dated this_____day of_____, 20___.

_____

[NAME]
Presiding Judge

Document Name:	Rule 11 Proceedings
Effective Date:	Select effective date.
Document Status:	

1.0 Appointment of Counsel

This section should contain language clarifying that counsel should be appointed for all defendants that enter into Rule 11 proceedings and should delineate how that appointment should take place.

2.0 Assignment of Judicial Officer

Courts should decide how they want to assign Rule 11 proceedings to judicial officers, they may wish to consolidate into a single division within the court, move through a rotation, or assign on whatever manner they currently assign criminal cases. Courts should consider expertise and training as part of the assignment matrix.

3.0 Assignment of Judicial Staff

Since limited jurisdiction courts have not managed Rule 11 proceedings in the same manner as this new jurisdiction permits, judicial staff likely will be unfamiliar with various requirements such as sealing or otherwise marking as confidential certain documents, new event codes, and other case management topics. Courts should assign appropriately trained or experienced staff to management of Rule 11 proceedings.

4.0 Rule 11 Calendar and Proceedings

Courts should consider the timing of events in relationship to availability of experts and information as well as judicial workload. Courts may consider discussing these topics with other limited jurisdiction courts that have already begun conducting Rule 11 proceedings for ideas and best practices.

5.0 Access to Prior Rule 11 Mental Health Expert Reports

Procedures for gaining access to previous Rule 11 reports will need to be negotiated with the Superior Court Clerk and other local courts who are authorized to conduct Rule 11 proceedings. A process to have access to reports from other counties should also be considered.

6.0 Access to Rule 11 Reports

The court should establish procedures by which other courts who may perform Rule 11 evaluations may access the expert reports that they have on record.

7.0 Procurement Process of Mental Health Experts for Rule 11

All contracts for services must be obtained through appropriate local, county or state procurement procedures. Should the court use a contract from other agencies it should be sure that procurement policies have been complied with in the process.

8.0 Appointment of Mental Health Experts for Rule 11

Depending on the availability of experts and the volume of Rule 11 cases, the court should establish a process by which Mental Health Experts are appointed to cases. Court should ensure they are familiar the requirements of Rule 11.3 as to who is qualified to be appointed as a mental health expert.

9.0 Mental Health Experts Report Format and Filing

For consistency, courts should provide a template or format for the filing of Rule 11 evaluations. The court should work with other courts within the county that are

performing Rule 11 evaluations and seek to use the same or similar formats to improve readability across jurisdictions.

10.0 Record Keeping

Policies will need to be established regarding the making of the record of Rule 11 events and of the maintenance of those records within appropriate retention schedules. This should include recordings, transcripts, dockets, register of actions, the case record and all other related court records.

11.0 Training

With Rule 11 events being unique within criminal case types, appropriate training and refreshers should be required of all assigned experts, judicial officers and court staff.

12.0 Competing Rule 11 Matters

Should the court become aware that a Rule 11 evaluation is being ordered in another court there is to be a process where a single evaluation or a consolidation or transfer of the case(s) may take place in accordance with A.R.S. § 13-4503(F).

13.0 Restoration

Procedures are to be developed that outline the process by which restoration to competency is to be accomplished. This should include the mechanism for funding of the restoration

Appendix B

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IN THE SUPREME COURT
STATE OF ARIZONA

In the Matter of	)	
	)	
PETITION TO AMEND RULES	)	
11.5 and 11.6 OF THE ARIZONA	)	Supreme Court No. R-18-____
RULES OF CRIMINAL	)	
PROCEDURE	)	
_____	)	

Pursuant to Rule 28 of the Arizona Supreme Court, David K. Byers, Administrative Director, Administrative Office of the Courts, and Chair of the Supreme Court Task Force on Fair Justice for All: Court-Ordered Fines, Penalties, Fees, and Pretrial Release Policies ("the Task Force") respectfully petitions this Court to amend Rules 11.5 and 11.6 of the Rules of Criminal Procedure. The amendments to Rules 11.5 and 11.6 are set forth in Appendix A.

I. Background of the Proposed Rule Amendments. The members of the Task Force's Subcommittee on Mental Health and the Criminal Justice System ("the Subcommittee") recommended these proposed changes to Rules 11.5 and 11.6.

The Subcommittee's membership is comprised of an extensive cross section of professionals from the criminal justice and mental health communities. They include judges, prosecutors, public defenders, court administrators, physicians, academics, and mental health advocates (see Appendix B). The Task Force charged the Subcommittee "to recommend rules and procedures needed to implement new provisions of SB 1157 relating to competency hearings." The Task Force further directed the Subcommittee "to recommend if any current court rule or statutes should be modified to enable the courts to more effectively handle individuals in the justice system who have mental health issues." (See Appendix C). The members of the Subcommittee unanimously support the proposed amendments. The Task Force has reviewed the Subcommittee's proposal and has given it a favorable review.

II. History of 2017 Changes to Rule 11. In 2017, the Court amended Rule 11 on three occasions. First, in R-17-0041, the Court ordered amendments to Rules 11.2, 11.3, 11.5, and 11.7 on an emergency basis, effective August 9, 2017. That Order conformed Rule 11 to the statutory changes made in the 2017 legislative session. In part, the legislative changes allow limited jurisdiction courts, with the permission of the presiding judge, to exercise jurisdiction over competency hearings in misdemeanor cases arising out of that jurisdiction. Second, in R-17-0002, the Court approved the restyling of the Arizona Rules of Criminal Procedures, effective

January 1, 2018. Restyled Rule 11 incorporated the substantive changes from the earlier emergency petition, R-17-0041. Finally, on December 13, 2017, the Court entered an order in R-17-0041 further amending Rules 11.4, 11.5, and 11.7, as restyled in R-17-0002, effective April 2, 2018. This Petition proposes additional changes to Rule 11.5 and 11.6.[1]

III. Purpose and Explanation of the Proposed Rule Amendments. The proposed rule changes follow through on the Task Force's directives and should enable the courts to more effectively handle individuals in the justice system who have mental health issues. The proposed amendments to Rules 11.5 and 11.6 are fall into one of three categories:

(A) substantive changes to permit a limited jurisdiction court to order restoration treatment if the defendant is found <u>incompetent but restorable</u> [Rule 11.5(b)(2)];

(B) clarifying language to delineate the differences between what a limited jurisdiction court and the superior court may do if a defendant is found <u>incompetent but not restorable</u> [Rule 11.5(b)(3)]; and

(C) clarifications to timeframes for the restoration of competency treatment orders.

[1] The proposed amendments are to Rules 11.5 and 11.6 effective April 2, 2018.

A. Substantive changes to permit a limited jurisdiction court to order restoration treatment if the defendant is found incompetent but restorable.

Amendments to Rule 11.5(b)(2) substantively expand the jurisdiction of a limited jurisdiction court to allow it the option to order competency restoration treatment if it finds the defendant incompetent but restorable. Currently under Rule 11.5(b)(2), the limited jurisdiction court has only two options: dismiss the charges on the State's motion or transfer the case to the superior court for further proceedings. The amendment adds a third option: if authorized by the presiding judge of the superior court, the limited jurisdiction court may choose to order competency restoration treatment.

There are several reasons to allow limited jurisdiction courts to order competency restoration treatment. First, allowing a limited jurisdiction court to order treatment and monitor progress is consistent with the policies that supported statutory changes to permit these same courts to conduct Rule 11 hearings. Holding Rule 11 hearings in limited jurisdiction courts provides a defendant easier access to the courts. In 2015, the Supreme Court established a pilot program that authorizes

two municipalities to conduct Rule 11 proceedings.[2] The Task Force's Subcommittee recognized many benefits to this pilot program including a speedier resolution of Rule 11 proceedings with an average time from initial motion to conclusion being 45-50 days (see Appendix D). Furthermore, Glendale and Mesa reported to the Subcommittee other benefits for holding Rule 11 proceedings in their courts. Defendants were more likely to keep their medical appointments because the doctors scheduled the examinations either at the courthouse or close by. Since the municipal courthouse was usually closer to the defendant's home than the superior courthouse, defendants were more likely to appear for their scheduled hearing dates.

The pilot program has shown measurable improvements in case management, improved service to defendants, particularly those suffering from mental illness, and a cost savings realized from fewer missed medical appointments and speedier resolution of cases. Building on the beneficial results of holding Rule 11 proceedings locally, the defendant may continue to benefit if the same court that conducted the defendant's Rule 11 proceeding retains control of the restoration to

[2] Supreme Court Administrative Order No. 2015-092 authorized a limited jurisdiction mental competency proceedings pilot project in the superior court in Maricopa County to allow the Mesa Municipal Court and the Glendale City Court to conduct Rule 11 proceedings for misdemeanor cases originating in their courts. Judges from these municipalities preside over these proceedings as superior court judges pro tempore.

competency process.

Second, municipalities have always been responsible to pay the costs for Rule 11 proceedings and restoration, even when the misdemeanor case is transferred to the superior court (A.R.S. § 13-4512). Therefore, since the local jurisdictions have been responsible for the costs of mental competency evaluations and any subsequent competency restoration treatment, the local court should be the court to decide whether to order the treatment.

Third, the proposed amendment to allow a limited jurisdiction court to order competency restoration treatment is conditioned upon the approval of the presiding judge of that county. A presiding judge would grant authorization only to those courts that have established the proper protocols, procedures, and training. On a final note, the Subcommittee noted when making this proposal that nothing in the language of SB 1157 precludes a limited jurisdiction court from retaining jurisdiction under these circumstances (see Appendix E).

B. Clarifying language delineating the difference between what the limited jurisdiction courts and what the superior court may do if a defendant is found incompetent but not restorable.

The amendment to Rule 11.5(b)(3) clarifies that when a defendant is incompetent and not restorable, a limited jurisdiction court may only dismiss the charges on the State's motion or transfer the case to the superior court for further proceedings. The amendment is intended to resolve any ambiguity regarding the

limits of the limited jurisdiction court's authority. Unlike the superior court, the limited jurisdiction court may not remand the defendant to an evaluating agency approved and licensed under Title 36 to being civil commitment proceedings under A.R.S. § 36-501 et seq., order the appointment of a guardian under A.R.S. § 14-5301 et seq., or retain jurisdiction and enter further orders as specified in A.R.S. § 13-4517 and § 13-4518.

The amendment to Rule 11.5(b)(3) provides clarity. Additionally, it conforms Rule 11.5(b)(3) to the same drafting style of Rule 11.5(b)(2) by breaking out the jurisdiction of the superior court and the limited jurisdiction court into two separate subparts.

C. Clarifying changes to timeframes for the restoration of a defendant to competency.

The amendments make several changes to Rule 11.5 and 11.6 to strike language relating to specific timeframes for court ordered restoration treatment. A treatment order, or combination of orders, shall not be in effect for more than the maximum possible sentence the defendant could have received, excluding sentence enhancements (A.R.S. § 13-4515(A)). In misdemeanor cases, the maximum term of incarceration will be less than the 15-month or 21-month time periods currently cited in the rules. The amendments strike these time periods and clarify that these treatment orders are to be in effect within the timeframes allowed by law. For purposes of internal consistency, the reference to 21 months in 11.5(b)(3) has also

been changed to within the timeframes allowed by law.

II. Preliminary Comments. While the Task Force's Subcommittee on Mental Health and the Criminal Justice System included a very comprehensive cross-section of the criminal justice and mental health communities and the proposed rule amendments were either specifically recommended or promote one or more Task Force's directives to the Subcommittee, the specific language of this petition has not been circulated to other criminal justice system or mental health stakeholders for comment before filing. Therefore, an opportunity for comment as part of the Court's review is recommended.

Wherefore, petitioner respectfully requests that the Court amend the Rules of Criminal Procedure as proposed in Appendix A.

RESPECTFULLY SUBMITTED this 10th day of January, 2018.

By /s/_____
David K. Byers, Administrative Director
Administrative Office of the Courts
1501 W. Washington Street, Suite 411
Phoenix, AZ 85007
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APPENDIX A

(language to be removed is shown in ~~strikethrough~~, new language is underlined)
(amendments are to the Rules in effect on April 2, 2018)

Rule 11.5 Hearing and Orders

(a) [No change]

(b) Orders.

(1) [No change].

(2) *If Incompetent but Restorable.*

~~(A) *Generally*. If a limited jurisdiction court determines that a defendant is incompetent, it must either dismiss the charges on the State's motion, or transfer the case to the superior court for further proceedings. Upon transfer from a limited jurisdiction court, or if a superior court determines that the defendant is incompetent, it must order competency restoration treatment, unless there is clear and convincing evidence that the defendant will not regain competence within 15 months.~~

(A) *Superior Court*. If a superior court determines that the defendant is incompetent, it must either dismiss the charges on the State's motion or order competency restoration treatment, unless there is clear and convincing evidence that the defendant will not regain competence within the timeframes allowed by law.

(B) *Limited Jurisdiction Court.* If a limited jurisdiction court determines that the defendant is incompetent, it must dismiss the charges on the State's motion, transfer the case to the superior court for further proceedings pursuant to A.R.S. §13-4517, or, if authorized by the presiding judge of the superior court, order competency restoration treatment, unless there is clear and convincing evidence that the defendant will not regain competence within the timeframes allowed by law.

(C) *Extended Treatment.* The court may extend treatment ~~for 6 months beyond the 15-month limit~~ as permitted by law if it finds that the defendant is progressing toward competence.

(D) through (F) [No changes]

(3) *If Incompetent and Not Restorable.*

(A) *Superior Court*. If the superior court determines that the defendant is incompetent and that there is no substantial probability that the defendant will become competent

within ~~21 months~~ the timeframes allowed by law, the court may on request of the examined defendant or the State do one or more of the following:

(i) Remand the defendant to an evaluating agency approved and licensed under Title 36 to begin civil commitment proceedings under A.R.S. §§ 36-501 et seq.;

(ii) Order appointment of a guardian under A.R.S. §§ 14-5301 et seq.; or

(iii) Release the defendant from custody and dismiss the charges without prejudice.

(iv) Retain jurisdiction and enter further orders as specified in A.R.S. §§ 13-4517 and 13-4518.

(B) *Limited Jurisdiction Court*. If a limited jurisdiction court determines that the defendant is incompetent and that there is no substantial probability that the defendant will become competent within the timeframes allowed by law, the court must do one of the following:

(i) Dismiss the action on the State's motion; or

(ii) Transfer the case to the superior court for further proceedings pursuant to A.R.S. §13-4517.

(4) [No change]

(c) and (d) [No changes]

Rule 11.6. Later Hearings

(a) [No change]

(b) [No change]

(c) [No change]

(d) Finding of Continuing Incompetence. If the court finds that the defendant is still incompetent, it must proceed in accordance with Rules 11.5(b)(2) or (3). If the court determines that there is a substantial probability that the defendant will regain competence in the foreseeable future, then the court may renew and may modify the treatment order ~~for no more than an additional 180 days~~ as permitted by law.

(e) [No change]

Appendix B

Fair Justice Task Force
Subcommittee on Mental Health and the Criminal Justice System

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CHAIR

Mr. Kent Batty
Court Administrator
Superior Court in Pima County

MEMBERS

Ms. Susan Alameda
Treatment Specialist, Probation
Administrative Office of the Courts

Dr. Tommy K. Begay
Clinical Assistant Professor
U of A, College of Medicine

Ms. Mary Lou Brncik
Director and Founder
David's Hope Services

Ms. Kelsey Commisso
Detective
Phoenix Police Department

Ms. India Davis
Program Manager
Pima County Behavioral Health

Mr. Jim Dunn
Executive Director/CEO
Natl. Alliance on Mental Illness

Ms. Vicki Hill
City Prosecutor
City of Phoenix

Ms. Josephine Jones
Deputy Director
Maricopa Office of the Public Advocate

Ms. Kathleen Mayer
Deputy County Attorney
Pima County Attorney's Office

The Hon. Joseph Mikitish
Judge
Superior Court in Maricopa County

Dr. Dawn Noggle
Mental Health Director
Maricopa County Correctional Health Serv.

Ms. Carol Olson
Director
Desert Vista Hospital

Ms. Nancy Rodriguez
Deputy Director
Maricopa County Clerk of Superior Court

Dr. Michael Schafer
Professor and Director
ASU Center for Applied Behavioral Health

Ms. Mary Ellen Sheppard
Assistant County Manager
Maricopa County

The Hon. Susan Shetter
Judge
Tucson City Mental Health Court

The Hon. Barbara Spencer
Commissioner
Superior Court in Maricopa County

The Hon. Christopher Staring
Judge
Court of Appeals, Division II

Ms. Lisa Surhio
Assistant Public Defender
Pima County Public Defender's Office

Ms. Sabrina Taylor
Detective – Regional CIT Coordinator
Phoenix Police Department

Mr. Paul Thomas
Court Administrator
Mesa Municipal Court

Ms. Juli Warzynski
Deputy County Attorney
Maricopa County Attorney's Office

Ms. Danna Whiting
Administrator
Pima County Office of Behavioral Health

STAFF

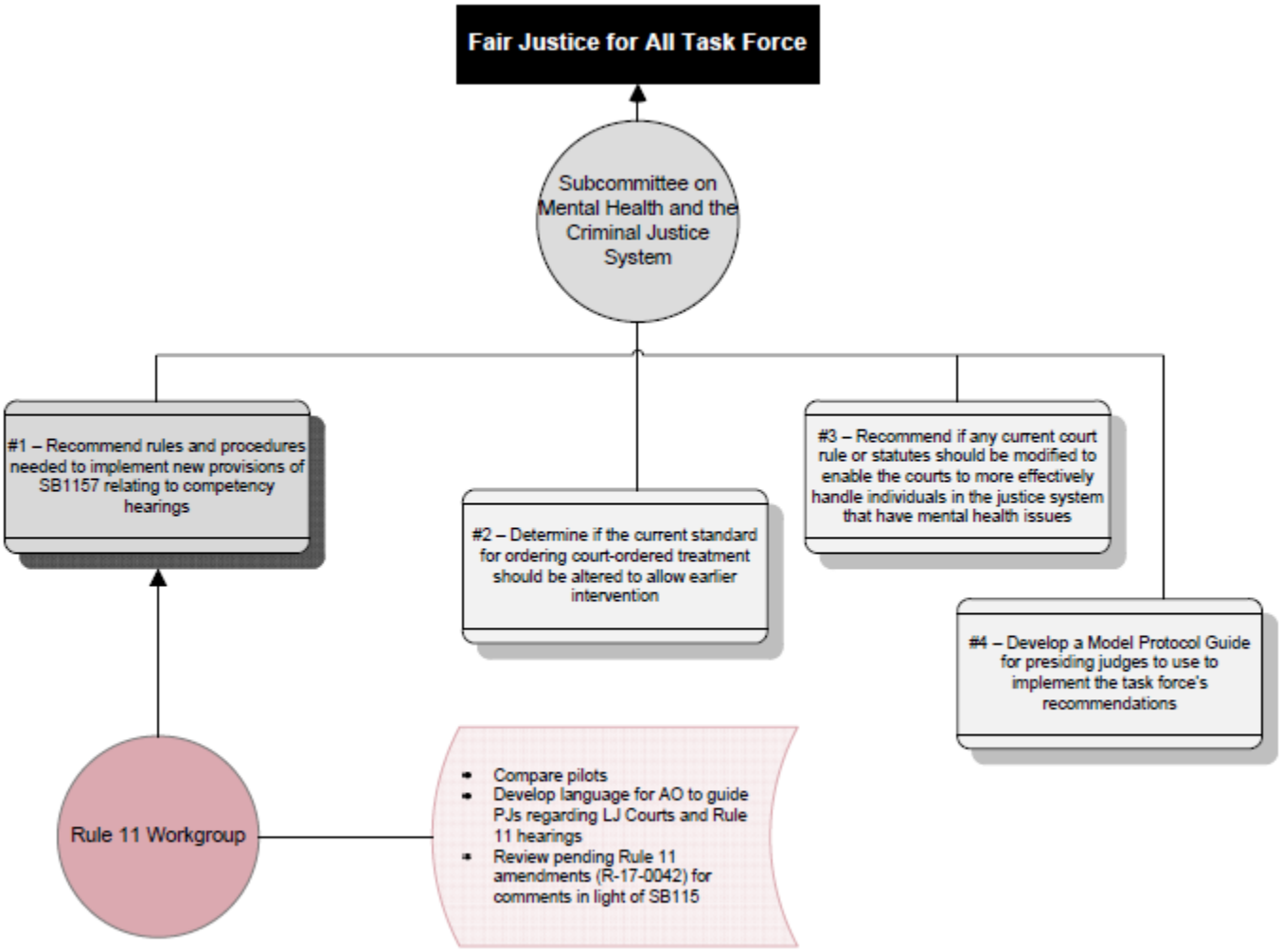
Ms. Theresa Barrett
Court Programs Unit Manager
AOC

Ms. Jennifer Albright
Senior Court Policy Analyst
AOC

Mr. Don Jacobson
Sr. Special Projects Consultant
AOC

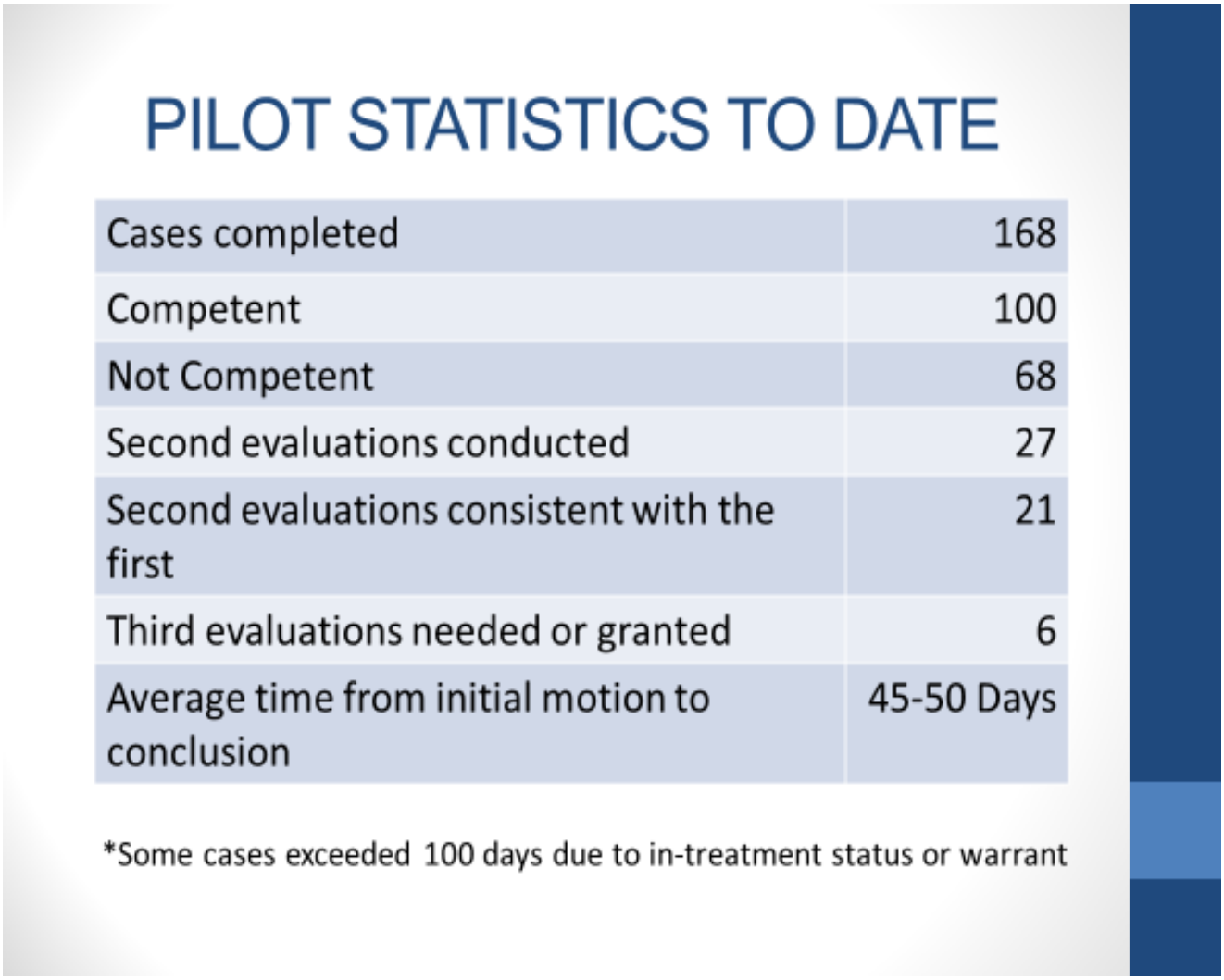
Ms. Jodi Jerich
Sr. Court Policy Analyst
AOC

APPENDIX C

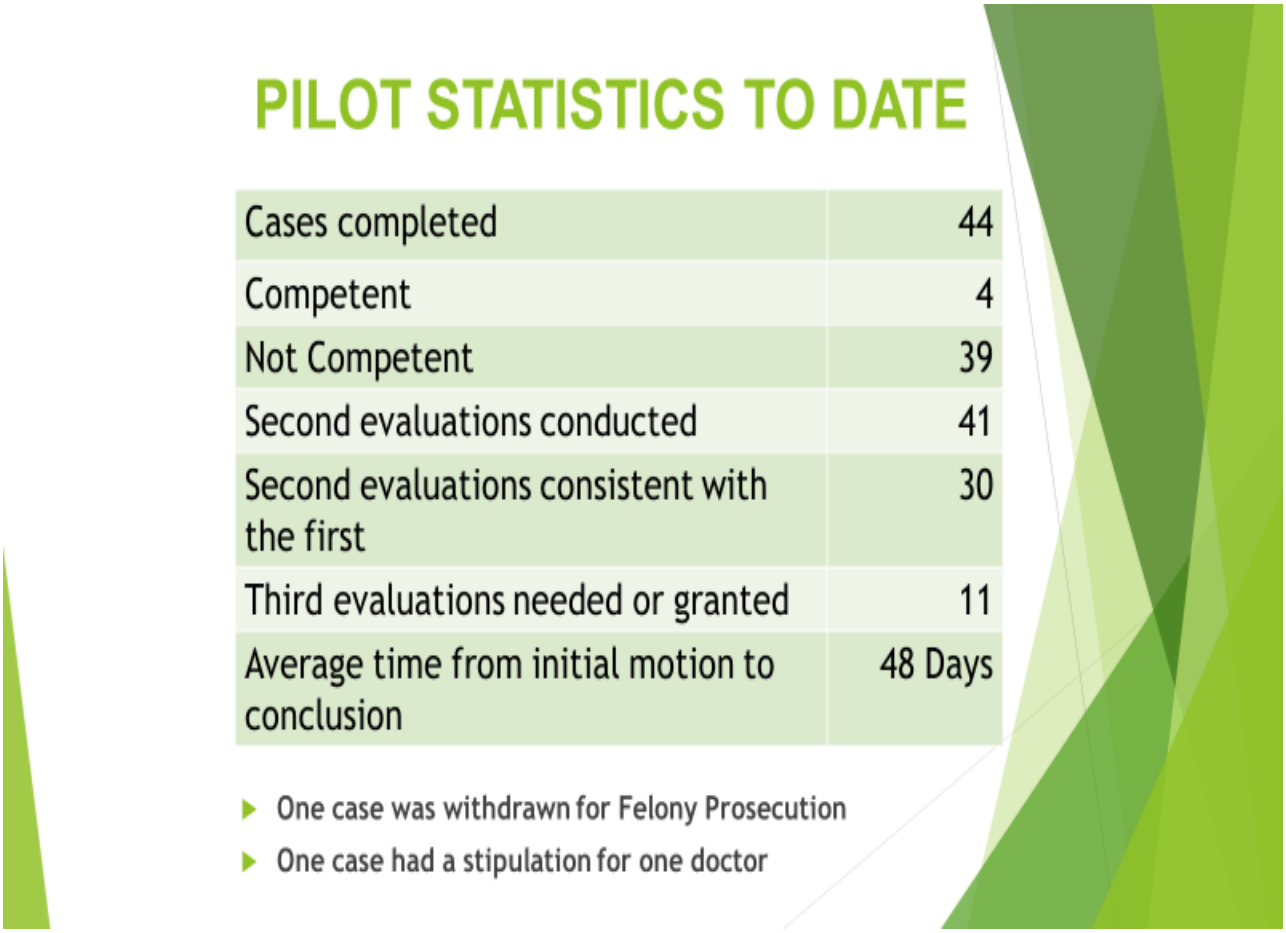

Fair Justice for All Task Force
Subcommittee on Mental Health and the Criminal Justice System
#1 – Recommend rules and procedures needed to implement new provisions of SB1157 relating to competency hearings
#2 – Determine if the current standard for ordering court-ordered treatment should be altered to allow earlier intervention
#3 – Recommend if any current court rule or statutes should be modified to enable the courts to more effectively handle individuals in the justice system that have mental health issues
#4 – Develop a Model Protocol Guide for presiding judges to use to implement the task force's recommendations
Rule 11 Workgroup
Compare pilots
Develop language for AO to guide PJs regarding LJ Courts and Rule 11 hearings
Review pending Rule 11 amendments (R-17-0042) for comments in light of SB115

APPENDIX D

Mesa Municipal Court Rule 11 Proceedings Statistics through 9/2017



Glendale City Court Rule 11 Proceedings Statistics through 9/2017



APPENDIX E

Senate Engrossed

State of Arizona
Senate
Fifty-third Legislature
First Regular Session
2017

CHAPTER 14

SENATE BILL 1157

AN ACT

AMENDING SECTION 13-4503, ARIZONA REVISED STATUTES; RELATING TO COMPETENCY HEARINGS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 13-4503, Arizona Revised Statutes, is amended to read:

13-4503. Request for competency examination; jurisdiction over competency hearings; referral

A. At any time after the prosecutor charges a criminal offense by complaint, information or indictment, any party or the court on its own motion may request in writing that the defendant be examined to determine the defendant's competency to stand trial, to enter a plea or to assist the defendant's attorney. The motion shall state the facts on which the mental examination is sought.

B. Within three working days after a motion is filed pursuant to this section, the parties shall provide all available medical and criminal history records to the court.

C. The court may request that a mental health expert assist the court in determining if reasonable grounds exist for examining a defendant.

D. ~~Once~~ EXCEPT AS PROVIDED IN SUBSECTION E OF THIS SECTION, AFTER any court determines that reasonable grounds exist for further competency proceedings, the superior court shall have exclusive jurisdiction over all competency hearings.

E. THE PRESIDING JUDGE OF THE SUPERIOR COURT IN EACH COUNTY, WITH THE AGREEMENT OF THE JUSTICE OF THE PEACE OR MUNICIPAL COURT JUDGE, MAY AUTHORIZE A JUSTICE COURT OR MUNICIPAL COURT TO EXERCISE JURISDICTION OVER A COMPETENCY HEARING IN A MISDEMEANOR CASE THAT ARISES OUT OF THE JUSTICE COURT OR MUNICIPAL COURT.

F. A JUSTICE OF THE PEACE OR MUNICIPAL COURT JUDGE, WITH THE APPROVAL OF THE PRESIDING JUDGE OF THE SUPERIOR COURT AND THE JUSTICE OR JUDGE OF THE RECEIVING COURT, MAY REFER A COMPETENCY HEARING TO ANOTHER JUSTICE COURT OR MUNICIPAL COURT THAT IS LOCATED IN THE COUNTY.

APPROVED BY THE GOVERNOR MARCH 14, 2017.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MARCH 14, 2017.

Appendix C

IN THE SUPREME COURT OF TEXAS AND THE TEXAS COURT OF CRIMINAL APPEALS

Supreme Court Misc. Docket No. 18-9025
Court of Criminal Appeals Misc. Docket No. 18-004

ORDER ESTABLISHING JUDICIAL COMMISSION ON MENTAL HEALTH

Recognizing that improving the lives of Texans who are affected by mental health issues and are involved in the justice system requires judicial leadership at the highest level, in June 2016 the Supreme Court of Texas directed the Texas Judicial Council to establish a Mental Health Committee. The Court charged the Mental Health Committee with examining best practices in the administration of civil and criminal justice for persons with mental illness.

The Mental Health Committee determined that Texas requires additional resources to ensure that: (1) mental health providers and professionals are able to provide timely and complete mental health assessments; (2) community-based mental health services are available to defendants; (3) outpatient treatment services and education services are available to those providing competency restoration services; (4) inpatient mental health facilities other than those operated by the Department of State Health Services are available for purposes of competency restoration; and (5) jail-based competency restoration programs, either state-funded or county-funded or both, are available.

The Texas Legislature invests heavily each year in behavioral and mental health systems to address mental illness and associated disorders. Yet the criminal justice system still serves as a default provider of mental health services for many Texans. This impact is most often felt at the local level where jail costs related to mental illness exceed $50 million each year in some counties.

Courts and the justice system have a profound impact on mental health services provided to children, adults, and families in this state, and the stakes are exceedingly high. As gatekeepers for families and individuals in crisis, courts must make life-altering decisions that require knowledge of multiple and complex issues such as childhood and adult trauma, abuse, neglect, intellectual and developmental disabilities, substance use, family violence, poverty, racism, and military combat, and how each affects a person's mental health. Too often, courts lack the technology, training, and resources needed to make well-informed decisions.

The Mental Health Committee identified other problems that traditionally exist where complex human service systems intersect with the judicial system, including:

- overcrowded dockets, leaving courts inadequate time to thoughtfully consider the multiple issues that persons with mental illness present and confront;
- a lack of communication, coordination, and collaboration between and among the courts, the state and local mental health providers, attorneys, and mental health advocates;
- a need for specialized, multidisciplinary legal training, and the means to develop and share best practices;
- a lack of technology to efficiently manage dockets and to track and analyze cases and caseloads involving mental health challenges;
- a lack of adequate training and fair compensation for attorneys;
- a need for the children and adults involved in the justice system to have a voice in decisions that affect their lives; and
- a lack of community resources to provide adequate mental health services to children, youth, and families.

The Mental Health Committee also recommended the establishment of a permanent judicial commission on mental health, similar to the Supreme Court's Children's Commission, the Texas Access to Justice Commission, and the Texas Indigent Defense Commission.

Many organizations and individuals throughout the state share a commitment to improving mental health services to Texans, but no single entity is able to coordinate and implement a comprehensive effort aimed at the improvement of the administration of justice in this area.

On January 11, 2018, the Supreme Court and the Court of Criminal Appeals held a historic joint hearing to gather input on what should comprise the priorities of a statewide judicial commission. Mental health experts, state and tribal judges, law enforcement, veterans, juvenile services experts, psychologists, psychiatrists, and persons with lived experience with these systems, provided valuable insight at the hearing and voiced unqualified support for the creation of a statewide judicial commission.

Therefore, the Supreme Court of Texas and the Texas Court of Criminal Appeals ("the two Courts"), having reviewed the report of the Judicial Council's Mental Health Committee, and

understanding the urgency expressed by various community stakeholders and participants in the Texas mental health system, HEREBY ORDER:

> The Judicial Commission on Mental Health ("the Commission") is created to develop, implement, and coordinate policy initiatives designed to improve the courts' interaction with—and the administration of justice for—children, adults, and families with mental health needs.
>
> The Judicial Council's Mental Health Committee, chaired by the Honorable Bill Boyce of Houston, is commended for its examination of best practices and identification and review of innovative approaches to improve the administration of justice in cases involving mental health issues. The Judicial Council's Mental Health Committee will remain intact until it is dissolved by the Judicial Council upon the Commission's recommendation, at which time the Committee's duties will transition to the Commission.

The Commission will:

- develop a strategic plan for strengthening courts and the administration of justice in relation to Texas' mental health system;
- identify and assess current and future needs for the courts to be more effective in achieving positive outcomes for Texans with mental illness;
- promote best practices and programs that are data-driven, evidence-based, and outcome-focused;
- improve collaboration and communication among courts and the mental health system stakeholders;
- endeavor to increase resources and funding and maximize the effective and efficient use of available judicial system resources;
- promote appropriate judicial training regarding mental health needs, systems, and services;
- establish a collaborative model that will continue systemic improvement within the judiciary beyond the tenure of individual Commission members;
- oversee the administration of funds appropriated and granted to the Commission; and
- provide progress reports to the two Courts.

The Commission will consist of no fewer than fourteen (14) Commissioners. The Commission will be co-chaired by a justice of the Supreme Court of Texas and a judge of the Texas Court of Criminal Appeals appointed by their respective Courts. The two Courts shall appoint a justice from the Texas Courts of Appeals to serve as Vice Chair of the Commission. The first collection of Commissioners shall be appointed by a joint order of the two Courts. Thereafter, new Commissioners shall be appointed jointly by the Chief Justice of the Supreme Court and the Presiding Judge of the Court of Criminal Appeals ("the two chiefs"). Each Commissioner shall serve a two-year term and may be renewed by the two chiefs at their discretion. A vacancy on the Commission is created by a Commissioner's three consecutive absences from scheduled Commission meetings, subject to reappointment or the resignation of the Commissioner.

The Commissioners shall include members of the judiciary, members of the juvenile, criminal, and child protection systems and community, representatives of the business and legal communities, representatives of foundations or organizations with a substantial interest in mental health matters, and other state and local leaders who have demonstrated a commitment to mental health matters affecting Texans.

The Governor is invited to designate a person to serve as an ex-officio member of the Commission. The Lieutenant Governor and the Speaker of the House are invited to designate a member from the Texas Senate and the Texas House of Representatives, respectively, to serve as ex-officio members of the Commission. Ex-officio members appointed by the Governor, Lieutenant Governor, and Speaker serve at the pleasure of the appointing officer.

The two Courts recognize that participation by a broad spectrum of persons involved with the mental health, juvenile, criminal, and child welfare systems is critical to the Commission's success. Accordingly, the Commission is empowered to appoint an advisory council as necessary to ensure the Commission is informed by experts in multiple disciplines. Members of the advisory council may attend Commission meetings and may serve on committees as determined by the Commission.

The Commission may adopt rules as necessary for the performance of the Commission's duties and may form new committees or disband existing committees as it deems appropriate.

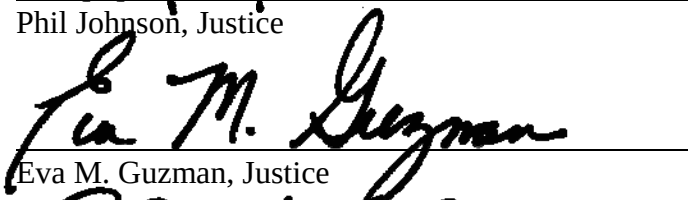
The Honorable Jeff Brown, Justice, Supreme Court of Texas, and the Honorable Barbara Hervey, Judge, Texas Court of Criminal Appeals, shall serve as the initial Co-Chairs of the Commission. The Honorable Bill Boyce, Justice, Fourteenth Court of Appeals, shall serve as the initial Vice Chair.

SIGNED BY THE SUPREME COURT OF TEXAS this 13th day of February, 2018.

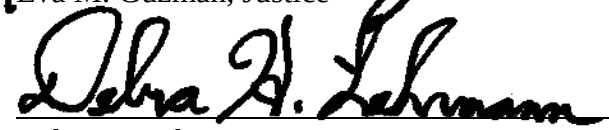
Nathan L. Hecht, Chief Justice

Paul W. Green, Justice

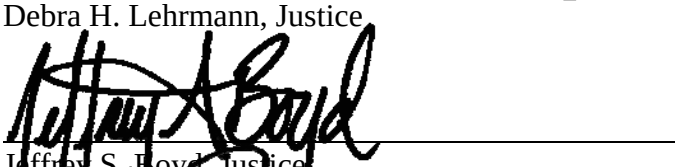
Phil Johnson, Justice



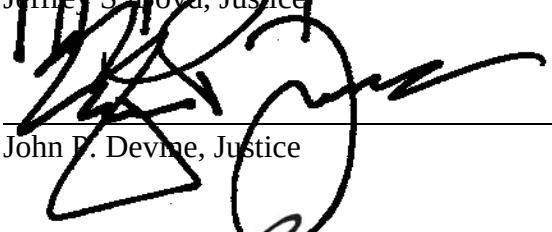
Eva M. Guzman, Justice



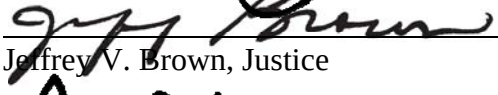
Debra H. Lehrmann, Justice



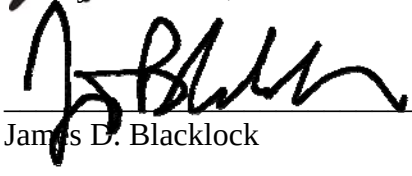
Jeffrey S. Boyd, Justice



John P. Devine, Justice



Jeffrey V. Brown, Justice



James D. Blacklock

SIGNED BY THE TEXAS COURT OF CRIMINAL APPEALS this 13th day of February, 2018.

Sharon Keller, Presiding Judge

Michael Keasler, Judge

Barbara Hervey, Judge

Elsa Alcala, Judge

Bert Richardson, Judge

Kevin P. Yeary, Judge

David Newell, Judge

Mary Lou Keel, Judge

Scott Walker, Judge

2016-2017 Policy Paper

Decriminalization of Mental Illness: Fixing a Broken System

Author

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State Court Administrator, Michigan State Court Administrative Office

Contributors

Steve Canterbury
West Virginia, State Court Administrator (Ret.)

Judge Laura R. Mack
29th District Court, Wayne, Michigan

Table of Contents

I. Introduction

Waiting four months for a state psychiatric hospital bed to become available, Jamycheal Mitchell died of a heart attack after starving himself in a Virginia jail cell. He had been arrested for stealing $5.05 worth of snacks from a 7-Eleven. He had a mental illness and had thought he was in a relative's store. He was arrested, jailed, found incompetent to stand trial, and ordered into a state hospital to restore competency. No bed was available, so he waited in jail until he died. He was 24. [1]

As tragic as Jamycheal Mitchell's story is, it is not uncommon for those suffering from serious mental illnesses to languish in jails or hospital emergency rooms. Jails and prisons have replaced mental health facilities as the primary institutions for housing persons suffering from mental illness. Our criminal justice system has become a revolving door for persons with mental illness, with the same persons cycling through the system again and again at great cost.[2]

With timely and appropriate services and support, most mental illnesses are treatable, and recovery is possible, reducing the likelihood of behavior that can lead to incarceration. However, outdated and untimely responses to mental illness now block treatment and services that can prevent crime and lead to recovery.[3] Rigid legal standards for involuntary treatment and the lack of an adequately funded community-based mental health system have led to a public safety crisis. Instead, the criminal justice system is systematically being used to criminalize mental illness and re-institutionalize persons with mental illnesses into jails and prisons.

For people suffering from serious mental illness, many state court systems are currently unable to order needed treatment as an alternative to incarceration. Judges and court personnel are in a unique position to describe to policymakers what they see in their courtrooms every day – a broken system, leading to compromised public safety, excessive incarceration, and damaged lives.

Policy makers need to provide our courts with better tools to meet this challenge. New legal standards that promote early intervention, combined with easily accessible assisted outpatient community-based treatment, will create the best opportunity to begin to reduce the use of jails and prisons as the *de facto* mental health system.[4]

COSCA advocates (1) An "Intercept 0" capacity based standard for court-ordered treatment as used in court-ordered treatment

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[1] Treatment Advocacy Ctr., Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds 4 (2016), http://www.treatmentadvocacycenter.org/storage/documents/going-going-gone.pdf [http://perma.cc/HFW9-GQUM]; *see also* June W. Jennings, Office of the State Inspector General, Report to Governor Terence R. McAuliffe, Investigation of Critical Incident at Hampton Roads Regional Jail (2016), https://osig.virginia.gov/media/5749/2016-bhds-002-hrrj-death-final-sig-approved.pdf [http://perma.cc/Z946-6PG4].

[2] The Sentencing Project, Mentally Ill Offenders in the Criminal Justice System: An Analysis and Prescription 7 (2002), http://www.sentencingproject.org/wp-content/uploads/2016/01/Mentally-Ill-Offenders-in-the-Criminal-Justice-System.pdf [http://perma.cc/4R6X-NFRE].

[3] Mich. Mental Health Comm'n, Part I: Final Report 16-17 (2004), http://www.michigan.gov/documents/FINAL_MHC_REPORT_PART_1_107061_7.pdf [http://perma.cc/9H47-94XN].

[4] Anasseril E. Daniel, *Care of the Mentally Ill in Prisons: Challenges and Solutions*, 35 J. Am. Acad. Psychiatry & L. 406, 406 (2007).

of other illnesses to replace the dangerousness standard now applied, (2) Assisted Outpatient Treatment (AOT) under a capacity based standard, and (3) robust implementation of Intercepts 1 through 5 of the Sequential Intercept Model. COSCA supports court leadership to convene parties interested in mental health issues to address more effective court involvement with these issues in the three ways advocated in this paper.

II. Jails and Prisons: The New Institutions for Persons with Mental Illness

"[W]hen mental illness is a factor in lawlessness and that fact is ignored, the result can be an unproductive recycling of the perpetrator through the criminal justice system, with dire consequences to us all."[5]
Chief Judge Judith S. Kaye

In nearly every state, jails and prisons are now the primary institutions for housing persons with mental illness.[6]

Over the course of the year, approximately two million adults suffering from serious mental illnesses will spend time in our nation's jails.[7] While many thousands receive mental health treatment in custody, many do not. Even if treatment is available, jails and prisons are not therapeutic environments, leading to increased symptoms and diminished quality of life following release.[8] For persons who enter the jail on a regimen of psychotropic medications, this regimen often cannot be sustained because of inadequate access in the jail to prescription medication. Often, inmates experience a delay between entry to the jail and provision of medication (which may not be their regularly prescribed medication, but a substitution based on availability or cost). Interruptions in the continuity of a medication regimen are detrimental to establishing stability.[9]

Current estimates are that over 383,000 people with serious mental illnesses are residing in our nation's jails and prisons while fewer than 40,000 people with mental illnesses are being treated in state-funded hospitals.[10] Ironically, the movement to provide state psychiatric hospitals, also known as "mental institutions", was a reform movement that began over 150 years ago to end inhumane conditions of incarceration.[11]

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[5] Matthew J. D'Emic, *The Promise of Mental Health Courts: Brooklyn Criminal Justice System Experiments with Treatment as an Alternative to Prison*, 22 Crim. Just. 24, 28 (2007) (quoting a November 25, 2002 press release from the New York State Office of Mental Health).

[6] Treatment Advocacy Ctr., More Mentally Ill Persons Are in Jails and Prisons than Hospitals: A Survey of the States (2010), http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf [http://perma.cc/XV5L-9YD6].

[7] Henry Steadman et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 Psychiatric Servs. 761, 764 (2009).

[8] *See* Anasseril, *supra* note 4; *see also* Beatrice Coulter, *My Turn: The Trouble with New Hampshire's Secure Psychiatric Unit*, The Concord Monitor (Feb. 28, 2016), http://www.concordmonitor.com/Archive/2016/02/myturncoulter-cmforum-022716 [http://perma.cc/L5L6-PJS4].

[9] Kavita Patel et al., *Integrating Correctional and Community Health for Formerly Incarcerated People Who Are Eligible for Medicaid*, 33 Health Aff. 468 (2014).

[10] *Fast Facts*, Treatment Advocacy Ctr., http://www.treatmentadvocacycenter.org/evidence-and-research/fast-facts (last visited Jan. 31, 2017) [http://perma.cc/ED22-KNDS].

[11] *See* Manon S. Parry, *Dorothea Dix (1802-1887)*, 96 Am. J. Pub. Health 624, 624-25 (2006); *see also* Dorothea L. Dix, Memorial to the Legislature of Massachusetts, 1843, http://www.archive.org/stream/memorialtolegisl00dixd#page/n3/mode/2up [http://perma.cc/Z733-L2P2].

In 44 states, a jail or prison holds more prisoners with mental illness than the largest state psychiatric hospital.[12] In a 2009 study, nearly two-thirds of all prisoners with mental illness were off their medications at the time of arrest.[13] Estimates are that 25% to 40% of individuals with serious mental illness have been in jail or prison at some time in their lives.[14]

Incarceration of persons with mental illness has been a growing problem for several years and shows no signs of abating. A 2002 report warned of the growing population shift of persons with mental illness from psychiatric hospitals to prisons.[15] Fifteen years later, that trend continues to grow. For example, in Michigan, although the total number of prisoners is declining, the number of prisoners with serious mental illness has increased 14% since 2012 and now comprises 23% of the total prison population while those with the most severe mental illnesses annually cost $95,233 per inmate to house and treat compared with an average cost of $35,253 for other inmates.[16] On the other hand, Michigan spends an average of $5,741 annually on unincarcerated adults with mental illness.[17]

Virginia has had a similar experience. The closure of state hospitals was not accompanied by an adequate increase in community-based services, resulting in an increase in the number of people with mental illness in Virginia's jails. Between 2005 and 2012, Virginia's share of inmates with mental illness went from 16% to 23.7%.[18]

Prisoners with mental illness are also more likely to have experienced homelessness and prior incarceration, and they are known to have other criminogenic risk factors, including substance use disorders.[19] Studies of prisoners with mental illness in Texas, Utah, Maryland, Illinois, and Ohio found that the likelihood of returning to prison dramatically increased for inmates with major psychiatric disorders.[20] Prisoners with mental illness in the criminal justice system serve longer sentences, receive more

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[12] *Criminalization of Mental Illness*, Treatment Advocacy Ctr., http://www.treatmentadvocacycenter.org/key-issues/criminalization-of-mental-illness (last visited Jan. 31, 2017) [http://perma.cc/V4EM-9GV3].

[13] Andrew P. Wilper et al., *The Health and Health Care of U.S. Prisoners: Results of a Nationwide Survey*, 99 Am. J. Pub. Health 666, 666 (2009).

[14] *See* Jeffrey W. Swanson et al., *Costs of Criminal Justice Involvement Among Persons with Serious Mental Illness in Connecticut*, 64 Psychiatric Servs. 630 (2013); More Mentally Ill Persons are in Jails and Prisons than Hospitals, *supra* note 6, at 1.

[15] Mentally Ill Offenders in the Criminal Justice System, *supra* note 2, at 3.

[16] Michael Gerstein & Jonathan Oosting, *Growth of Mentally Ill Inmates Raises Concern in Mich.*, The Detroit News (Dec. 28, 2016, 12:03 AM), http://www.detroitnews.com/story/news/local/michigan/2016/12/28/growth-mentally-inmates-raises-concern-mich/95897544/ [http://perma.cc/V7GH-U77G] (referencing a Michigan Department of Corrections report).

[17] Mich. Dep't of Health & Human Servs., Report on CMHSPs, PIHPs, Regional Entities, at 904(2)(b), p. 1 (2016), http://www.michigan.gov/documents/mdhhs/Section_904_2015_530673_7.pdf [http://perma.cc/RRD8-KJSM].

[18] Mira E. Signer, *Virginia's Mental Health System: How It Has Evolved and What Remains To Be Improved*, 90 Va News Letter 1, 10 (2014).

[19] KiDeuk Kim et al., Urban Inst., The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System 9-10 (2015), http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000173-The-Processing-and-Treatment-of-Mentally-Ill-Persons-in-the-Criminal-Justice-System.pdf [http://perma.cc/KYN2-5KRV].

[20] *Id.* at 11-12.

probation and parole violations, and have higher rates of recidivism.[21]

Prisoners with mental illness remain incarcerated much longer than other inmates largely because many find it difficult to follow and understand jail and prison rules.[22] For example, in Washington State, prisoners with mental illness accounted for 41% of prison rule infractions but only 19% of the prison population.[23] Prisoners with mental illness are more likely to be placed in solitary confinement and commit suicide.[24] All of this is at great expense to taxpayers and great human cost to affected inmates and their families.

The cost for psychiatric services spent in correctional environments, combined with the increased rate of recidivism for those with mental illness who are not appropriately supported means that these societal fiscal and human expenditures must be made again and again with no measurable benefit.

III. The Forces that Shaped this Outcome

The Community Mental Health Act (CMHA) of 1963 created a financial incentive for states to close state-funded mental hospitals while promising to fund community-based outpatient treatment and community mental health centers to replace the services provided by hospitals. However, the community mental health centers that were to be the backbone of the promised community treatment system failed to materialize.[25] The absence of the promised community treatment system, the lack of adequate funding, and the inability to intervene except in the event of a crisis have led to the dramatic increase in the incarceration of persons with mental illness.[26]

Under the CMHA, the federal government agreed to help states pay for the treatment of indigent persons with mental illness. In 1965, Congress excluded the use of federal funds for hospitalization in state hospitals. This restriction, known as the Institution for Mental Diseases (IMD) exclusion was the "stick" used by the federal government to disincentivize the treatment of persons with mental illness in large institutions.[27] This created a strong impetus for states to close hospitals.[28]

In 1975, the United States Supreme Court ruled in *O'Connor v. Donaldson* that persons could not be held in mental hospitals solely due to mental illness if they

[21] Doris J. James & Lauren E. Glaze, U.S. Dep't of Justice, Bureau of Justice Statistics Special Report, Mental Health Problems of Prison and Jail Inmates (2006), https://www.bjs.gov/content/pub/pdf/mhppji.pdf [http://perma.cc/G7K9-2UTK].

[22] Treatment Advocacy Ctr., Serious Mental Illness (SMI) Prevalence in Jails and Prisons 2 (2016), http://www.treatmentadvocacycenter.org/storage/documents/backgrounders/smi-in-jails-and-prisons.pdf [http://perma.cc/YBF4-3CFJ].

[23] *Id.*

[24] *Id.* at 3-4.

[25] Michelle R. Smith, *50 Years Later, Kennedy's Vision for Mental Health Not Realized*, The Seattle Times (October 21, 2013, 8:28 PM), http://www.seattletimes.com/nation-world/50-years-later-kennedyrsquos-vision-for-mental-health-not-realized/ [http://perma.cc/ART8-JF5Y].

[26] More Mentally Ill Persons are in Jails and Prisons than Hospitals, *supra* note 6.

[27] Treatment Advocacy Ctr., The Medicaid IMD Exclusion and Mental Illness Discrimination 2 (2016), http://www.treatmentadvocacycenter.org/storage/documents/backgrounders/imd-exclusion-and-discrimination.pdf [http://perma.cc/E376-KTDK].

[28] Part I: Final Report, *supra* note 3, at 9.

were capable of living safely outside the hospital.[29] In reaction to this decision and the financial incentives in the CMHA, state legislatures adopted mental health codes that severely restricted the ability of courts to order inpatient treatment without the consent of the person with mental illness.[30]

The codes were designed to make it very difficult to order hospitalization, thereby helping to facilitate the deinstitutionalization[31] of persons with mental illness and the closing of psychiatric hospitals.[32] "The purported effectiveness of deinstitutionalization was predicated both on the availability of effective treatment in the community and on the willingness of patients to accept treatment voluntarily."[33] While most people who suffer from mental illness who would have been institutionalized in the past are able to live independently, for far too many, the system is inadequate to prevent homelessness, incarceration, and impoverishment.

The mental health codes of the 1970s established important due process rights in involuntary mental health proceedings. Those safeguards, such as the right to counsel at state expense, the right to a trial by jury, and the right to an independent medical examination at state expense, were important reforms that should continue.

In addition to due process protections, these laws limited the basis upon which mental health treatment could be ordered. Over the years, there have been some modifications to these laws, but generally, three standards for involuntary mental health treatment are in use by all of the states. They include: (1) dangerousness, (2) gravely disabled, and (3) need-for-treatment.[34] However, all of the standards require a substantial probability of harm or dangerousness. The result is that civil courts can only intervene when an individual is in crisis and poses a clear risk of harm.[35] For example, Wisconsin, in its need-for-treatment standard, requires that an individual's lack of capacity be accompanied by a substantial probability of severe mental, physical, or emotional harm based on a history of actions by that individual that supports that expectation. Even then, if there is a substantial probability that the individual may be provided protective placement or services, involuntary treatment cannot be ordered.[36] These codes also created complex processes to secure treatment. A request for treatment is initiated by petition. In most states, a family member can initiate the proceeding, but in some states, only a professional can initiate proceedings. Most states require that multiple physicians participate in the process to secure treatment. For many

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[29] O'Connor v. Donaldson, 422 U.S. 563, 575 (1975).

[30] Treatment Advocacy Ctr., Mental Health Commitment Laws: A Survey of the States 5-6 (2014), http://www.treatmentadvocacycenter.org/storage/documents/2014-state-survey-abridged.pdf [http://perma.cc/U9CB-C9HU].

[31] "Deinstitutionalization" is moving psychiatric patients from hospital settings into less restrictive settings in the community.

[32] Am. Psychiatric Ass'n, Mandatory Outpatient Treatment Resource Document 2 (1999), https://www.psychiatry.org/File%20Library/Psychiatrists/Directories/Library-and-Archive/resource_documents/rd1999_MandatoryOutpatient.pdf [http://perma.cc/GLE6-SHFS]. *See also* Richard D. Lyons, *How Release of Mental Patients Began*, N.Y. Times (Oct. 30, 1984), http://www.nytimes.com/1984/10/30/science/how-release-of-mental-patients-began.html?pagewanted=all [http://perma.cc/K9RP-VLJD].

[33] See Mandatory Outpatient Treatment Resource Document, *supra* note 32, at 2.

[34] Mental Health Commitment Laws, *supra* note 30, at 7-8.

[35] *Id.* at 4-8.

[36] Wis. Stat. § 51.20(1)(a)2(e) (2016).

family members, the process is too complicated and too late.

States should be given greater flexibility to use federal funds to address the mental health needs of the general population. Today, with less than 38,000 psychiatric beds available in the United States, the goal of the IMD to reduce the use of hospitalization for treatment has long been met. The IMD exclusion has greatly contributed to the nation's shortage of psychiatric hospital beds and should be eliminated.

The risk of unnecessary or inappropriate hospitalization has vanished. While hospitalization is sometimes necessary, mental health systems, like medical systems in general, will remain financially incentivized to use hospitalization as a last resort, even without the IMD exclusion, in order to maximize the allocation of scarce resources. "In fact, longer hospital stay[s] may nowadays imply poor mental health care and support in the community."[37] Funding decisions have also contributed to the crisis by converting state mental health systems that once served the general public into systems that primarily serve only those who qualify for Medicaid. Following adoption of the CMHA, states began reducing funding for mental health.[38]

Therefore, for those not eligible for Medicaid, safety net resources are hard to find,[39] resulting in delays in treatment and increasing the risk of adverse consequences. More recently, during the 2007-2009 recession, state funding for mental health dropped by $4.35 billion.[40] Many states also cut back services for uninsured people who were not Medicaid-eligible, leaving them without access to care.[41]

A study of state spending on mental health systems for fiscal year 2002 established a very strong correlation between those states having more persons with mental illness in jails and prisons and those states spending less on mental health services. The states spending more on mental health services were less reliant on jails and prisons while those spending less on mental health tended to rely more heavily on jails and prisons.[42]

Compounding this problem, the promised comprehensive community-based treatment services that were to replace hospitalization did not materialize. "Unfortunately, community resources have not been adequate to serve the needs of many chronic patients, and large numbers of patients have failed to become engaged with the community treatment system."[43]

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[37] Athanassios Douzenis et al., *Factors Affecting Hospital Stay in Psychiatric Patients: The Role of Active Comorbidity*, 12:166 BMC Health Servs. Res. 1, 3 (2012), http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-12-166 [http://perma.cc/GTB9-KFJP].

[38] Judge David L. Bazelon Ctr. for Mental Health Law, Funding for Mental Health Services and Programs 1-2 (2011), http://www.bazelon.org/LinkClick.aspx?fileticket=GzmAbAweikQ%3D&tabid=436 [http://perma.cc/ESC6-VURZ].

[39] Part 1: Final Report, *supra* note 3, at 9.

[40] Nat'l All. on Mental Illness, State Mental Health Legislation 2015: Trends, Themes & Effective Practices 1 (2015), https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/State-Mental-Health-Legislation-2015/NAMI-StateMentalHealthLegislation2015.pdf [http://perma.cc/6KY8-87BJ].

[41] Funding for Mental Health Services and Programs, *supra* note 38, at 2-3.

[42] More Mentally Ill Persons Are in Jail and Prisons than Hospitals, *supra* note 6, at 8.

[43] Mandatory Outpatient Treatment Resource Document, *supra* note 31, at 2 (citations omitted).

The closure of most psychiatric hospitals in response to the CMHA and the enactment of laws limiting involuntary treatment have resulted in an apparent shortage of psychiatric hospital beds.[44] This shortage, along with insurance limits, has created an incentive to release patients as quickly as possible to create more bed capacity without adding more beds. There is also a shortage of psychiatrists for adults[45] and an even greater shortage for children.[46] As a result of these shortages and changing practices, length of stay (LOS) in the hospital has been steadily shrinking. The median LOS for an acute episode of schizophrenia went from 42 days in 1980 to 7 days by 2013.[47]

The shortage of hospital beds and psychiatrists is also affecting the criminal justice system. Forensic centers that house and treat persons found not guilty by reason of insanity and those found incompetent to stand trial are full, and these persons are now filling state psychiatric hospital beds.[48] In Maryland, 80% of those admitted to state facilities are arriving via the criminal justice system.[49]

The shortage of space is causing long delays in conducting competency evaluations and placement for those ultimately found incompetent to stand trial. These prisoners languish in jail awaiting their evaluation or placement, too often with tragic results, like the senseless death of Jamycheal Mitchell.

The shortage of hospital beds has also led to the practice of "psychiatric boarding." People experiencing mental health crises often appear in hospital emergency rooms, where they face prolonged waits for admission or placement. Psychiatric patients are boarded in hospital emergency departments longer than any other type of patient and experience poorer outcomes.[50] In West Virginia, "psychiatric boarding" may mean the back of a police cruiser; a person picked up on a mental hygiene order could potentially spend as many as eighteen hours in the back of the car waiting for a mental hygiene commissioner.[51]

Today, when a law enforcement officer encounters a person with mental illness who is creating a disturbance, the officer must

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[44] The shortage has continued to grow. Bed capacity has declined from 70,000 in 2002 to less than 40,000 in 2017. Mentally Ill Offenders in the Criminal Justice System, *supra* note 2, at 3; E. Fuller Torrey, *A Dearth of Psychiatric Beds*, Psychiatric Times (Feb. 25, 2016), http://www.psychiatrictimes.com/psychiatric-emergencies/dearth-psychiatric-beds [http://perma.cc/SX9B-XFVN].

[45] Jonathan Block, *Shortage of Psychiatrists Only Getting Worse*, Psychiatry Advisor (Sept. 8, 2015), http://www.psychiatryadvisor.com/practice-management/psychiatrist-psychiatry-shortage-few-stigma/article/437233 [http://perma.cc/PF39-DQ3N].

[46] *Workforce Maps by State: Practicing Child and Adolescent Psychiatrists by State 2015*, Am. Acad. Child & Adolescent Psychiatry, https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx (last visited Jan. 31, 2017) [http://perma.cc/4WKW-Y8ZR].

[47] Treatment Advocacy Ctr., Released, Relapsed, Rehospitalized: Length of Stay and Readmission Rates in State Hospitals 1 (2016), http://www.treatmentadvocacycenter.org/storage/documents/released-relapsed-rehospitalized.pdf [http://perma.cc/T2U7-73FQ].

[48] Forensic patients now occupy almost half of state hospital beds nationwide. Going, Going, Gone, *supra* note 1, at 1-2.

[49] Michael Dresser, *With Psychiatric Beds Full, Mentally Ill in Maryland are Stuck in Jails*, The Balt. Sun (June 8, 2016, 8:43 PM), http://www.baltimoresun.com/health/bs-md-mental-health-beds-20160608-story.html [http://perma.cc/GP7C-DWJT].

[50] John E. Oliver, *Mental Health Crises and Hospital Emergency Departments*, 34 U. Va. Inst. L., Psychiatry & Pub. Pol'y 6, 6 (2015).

[51] E-mail from Steve Canterbury, State Court Administrator (Ret), West Virginia, to author (Jan. 27, 2017, 1:49 AM).

decide between arrest and referral to a psychiatric facility for mental health treatment. In practice, officers know that access to care is limited, so the default option to resolve the immediate problem is often arrest or no action at all.[52]

IV. More Effective Tools Exist for Courts to Address Mental Illness and its Impact on the Court System and the Community

What should courts do to address this complex issue? The overuse of jails and prisons to house persons with serious mental illnesses has broad impact and should be addressed systematically.[53]

A. Overview of the Sequential Intercept Model

A promising approach is the Sequential Intercept Model. The model provides a conceptual framework for states and communities to use when constructing the interface between the criminal justice and mental health communities to use as they address the criminalization of people with mental illness.

"The Sequential Intercept Model … can help communities understand the big picture of interactions between the criminal justice and mental health systems, identify where to intercept individuals with mental illness as they move through the criminal justice system, suggest which populations might be targeted at each point of interception, highlight the likely decision-makers who can authorize movement from the criminal justice system, and identify who needs to be at the table to develop interventions at each point of interception. By addressing the problem at the level of each sequential intercept, a community can develop targeted strategies to enhance effectiveness that can evolve over time."[54]

The model contemplates diversion programs to keep people with serious mental illness in the community and not in the criminal justice system, providing constitutionally adequate institutional services in correctional facilities and the establishment of reentry transition programs to link those inmates with serious mental illness to community-based services when they are released.

The CMHS National GAINS Center[55] has developed a comprehensive sequential model for people with serious mental illness caught up in the criminal justice system. It provides for five intercept points: Intercept 1—contact with law enforcement, Intercept 2—initial detention and court hearing, Intercept 3—after incarceration, including mental health court and jail-based services; Intercept 4—reentry, and Intercept 5—parole or probation.

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[52] Mentally Ill Offenders in the Criminal Justice System, *supra* note 2, at 14.

[53] Adults with a serious mental illness (SMI) are defined by the Substance Abuse and Mental Health Services Administration as persons age 18 or over with a diagnosable mental illness of sufficient duration to meet diagnostic criteria with the DSM-IV, resulting in functional impairment which substantially interferes with or limits one or more major life activities. *See* Substance Abuse & Mental Health Admin. Ctr., Definitions and Terms Relating to Co-Occurring Disorders*:* COCE Overview Paper 1, at 2 (2006), https://store.samhsa.gov/shin/content/PHD1130/PHD1130.pdf [http://perma.cc/GA9J-EEQY].

[54] Mark R. Munetz & Patricia A. Griffin, *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*, 57 Psychiatric Servs. 544, 547-48 (2006).

[55] The Gains Center is a part of the Substance Abuse and Mental Health Services Administration (SAMHSA) and is focused on expanding access to services for people with mental illness who come into contact with the criminal justice system.

COSCA supports the sequential intercept model and encourages its adoption. COSCA also supports the addition of an Intercept 0 that addresses what can be done prior to contact with law enforcement. The new Intercept 0 should enable the civil justice system to help persons with mental illness secure earlier treatment in order to avoid behavior that may lead to contact with the criminal justice system.

Accomplishing this requires modifying mental health codes to permit timely, court-ordered treatment for persons with mental illness, before and after contact with law enforcement. This requires the conversion of mental health codes from current "inpatient" models to "outpatient" models focused on delivering timely treatment in the community.

If we are to be successful in reducing our reliance on jails and prisons, the courts would do best if they could address the needs of individuals with mental illness prior to their involvement with the criminal justice system. Modern mental health codes that will permit earlier intervention and promote the use of assisted outpatient treatment (AOT) will help persons with serious mental illness recover, exercise meaningful self-determination and avoid contact with law enforcement.

1. Capacity-Based Standard for Intervention

State mental health codes adopted in the 1970s in response to the Supreme Court's decision in *O'Connor* were modeled to only address involuntary hospitalization. Court-ordered community-based treatment did not exist and therefore was not addressed.

The late 1990s saw the emergence of the "recovery model" in guiding mental health policy and practice. The emphasis of this model was on the ability of a person with severe mental illness to develop a sense of identity and regain control over his or her life.[56] This model offered the hope of restoring the capacity to exercise self-determination. The recovery model recognizes that early intervention is preferred to secure the likelihood of a successful recovery. However, the recovery model is not reflected in the old mental health codes, which are "inpatient" models in an "outpatient" world.[57] The old codes focus on preventing hospitalization unless an individual is in crisis.

Modern brain research and the development of effective treatment have demonstrated the value of early intervention in recovery and resiliency.[58] What is needed are mental health codes based on the current outpatient model of treatment. That begins with changing the standard for intervention in the course of a person's mental illness. Since O'Connor was decided, most mental health treatment is now provided on an outpatient basis. Recognizing this fact, states have begun using court-ordered Assisted Outpatient Treatment (AOT) instead of hospitalization for those who do not recognize their need for treatment. AOT is court-supervised treatment within the community. A treatment plan is developed that is highly individualized. These plans typically include case management, personal therapy, medication, and other services

[56] The President's New Freedom Comm'n on Mental Health, Final Report 4-5, 57, 60 (2003), http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/FinalReport.pdf [http://perma.cc/TEV5-BVVF].

[57] Part I: Final Report, *supra* note 3, at 30.

[58] *Id.* at 12, 14.

designed to promote recovery. Noncompliance with the plan can lead to immediate hospitalization.[59]

The Agency for Healthcare Research and Quality and the Substance Abuse and Mental Health Services Administration have both recognized AOT as an effective treatment option that has now been added to the National Registry of Evidence-Based Programs and Practices.[60]

AOT enables people with mental illness to recover from their symptoms and lead productive lives. *AOT is not confinement*. It is most useful when used before an individual with mental illness is in crisis. AOT reduces hospitalization, arrests, incarceration, poverty, and homelessness. It would be difficult to imagine a more significant array of legitimate state interests that would justify ordering outpatient treatment. There is nothing in *O'Connor* that requires a showing of dangerousness before ordering AOT for a person suffering from mental illness in order to alleviate the symptoms of mental illness.

Currently, the standards for court-ordered treatment focus on a person's *future conduct* (the likelihood of causing harm), not *capacity*. This requires predictive ability as opposed to a present assessment. Assessing a person's present capacity is far less problematic than predicting future conduct. The person may be incapacitated and unable to make informed decisions about his or her mental illness, but, unless the person can be predicted to be currently dangerous enough to be expected to seriously injure someone, nothing can be done. The *lack of capacity to make an informed decision* alone is not sufficient to secure court-ordered treatment for mental illness in any state.

Even in those states[61] that appear to have a capacity-oriented standard, also known as the "need-for-treatment standard," the law still requires that there also be a substantial probability of severe mental, emotional, or physical harm without the treatment.[62] A person that lacks the capacity to make an informed decision about his/her illness is simply not enough. The law requires waiting for crisis before acting.

Comparing the evolution of the law with respect to adult guardianship proceedings is helpful. Years ago, most states moved from a conduct-based standard to a capacity-based standard when deciding whether to appoint a guardian for an incapacitated adult. The old standard focused on whether the person was making responsible decisions.[63] The modern standard for appointing a guardian focuses on whether the person lacks the capacity to make or communicate informed decisions about him/herself. Unlike a petition seeking

[59] Treatment Advocacy Ctr., A Guide for Implementing Assisted Outpatient Treatment 9 (2012), http://www.treatmentadvocacycenter.org/storage/documents/aot-implementation-guide.pdf [http://perma.cc/N2GC-UL53].

[60] *Assisted Outpatient Treatment (AOT)*, Substance Abuse & Mental Health Servs. Admin., Nat'l Registry of Evidence-Based Programs & Practices, http://legacy.nreppadmin.net/ViewIntervention.aspx?id=401 (last visited Jan. 31, 2017) [http://perma.cc/A923-S8BM].

[61] Alabama, Arizona, Colorado, Kansas, Mississippi, Texas, Utah and Wisconsin.

[62] Mental Health Commitment Laws, *supra* note 30, at 7.

[63] *See* Mich. State Representative Perry Bullard, Chair, House Judiciary Comm., Michigan Guardianship Reform Act Handbook (1991).

involuntary mental health treatment, there is no requirement of a threat of imminent harm or danger before a guardian can be appointed for someone who is incapacitated.

The same standard should be used when deciding whether to order mental health treatment. Mental illness should be treated the same as any other illness. For someone incapacitated by mental illness, current law makes it more difficult to secure involuntary mental health treatment than for almost any other illness.

For example, if a person has a guardian due to mental illness, the guardian could, over the ward's objection, consent to treatment of a leg infection that could include amputation. However, unless danger is imminent (i.e., the person was threatening to harm himself or others), the guardian would be unable to secure court-ordered mental health treatment for that same person, even though that treatment may restore the person's capacity to make his/her own decisions.

In most states, the same court that can appoint a guardian for a person with mental illness if that person lacks the capacity to make informed decisions cannot grant authority to the guardian to consent to mental health treatment that would restore that person's capacity and terminate the guardianship. To rectify this issue, at least four states have implemented some statutory authority to permit guardians to consent to mental health treatment over the ward's objection. North Dakota made that change this year.[64]

Waiting to intervene until a crisis exists damages a person's resiliency, the ability to recover from a psychotic episode.[65] There is often adequate time between the onset of incapacity and crisis to secure the treatment necessary to prevent the crisis and avoid the consequences of untreated mental illness. For too long, family members of persons with mental illness have endured the frustration of attempting to secure treatment for family members unable to help themselves only to be turned away because the person was not yet in crisis.[66]

Complicating the problem is the fact that many individuals with serious mental illness, like schizophrenia, lack insight into their illness due to anosognosia, a functional and structural abnormality of the brain. In these cases, poor insight is a function of the illness rather than a coping mechanism.[67]

A more appropriate standard for ordering involuntary mental health treatment would be: *When a person's judgment is so impaired by mental illness that he or she is unable to make informed decisions about that mental illness.* This is the standard used for all other illnesses. This is the standard generally used to appoint a guardian to consent to treatment for all other ailments. Such a standard would permit earlier intervention—intervention before a crisis occurs. This intervention would also present a better opportunity for an earlier recovery that would preserve that person's ability to

[64] H.B. 1365, 65th Legis. Assemb., Reg. Sess. (N.D. 2017), http://www.legis.nd.gov/assembly/65-2017/documents/17-0901-04000.pdf [http://perma.cc/TH7S-X2TX]. Wisconsin, Florida and Massachusetts have taken similar action.

[65] Am. Psychiatric Ass'n, Practice Guidelines for the Treatment of Psychiatric Disorders 256-61 (2004).

[66] *See generally* Pete Earley, Crazy: A Father's Search Through America's Mental Health Madness (2006).

[67] *See generally* Xavier Amador, I Am Not Sick I Don't Need Help!: How to Help Someone with Mental Illness Accept Treatment (2012).

bounce back from a future episode and avoid permanent incapacity. Most significantly, it would create the opportunity to restore the person's capacity and liberty to make his or her own choices.

2. Expanded Use of Assisted Outpatient Treatment

New York State has led the way in implementing AOT. A study of New York State's AOT program found that court-ordered AOT was effective at increasing medication adherence, reducing hospital readmission, and promoting recovery. AOT patients had a substantially higher level of personal engagement in their treatment, and they were no more likely to feel coerced by the mental health system than voluntary patients. The best predictor of perceived coercion or stigma was the patient's perception of being treated with dignity and respect by mental health professionals. The study found that increased services available under AOT clearly improved recipient outcomes. The court order itself, and its monitoring, appeared to offer additional benefits in improving outcomes.[68] Other states, including California, Florida, and Ohio have also found that the use of AOT reduces hospitalization, incarceration, and cost.

However, despite its effectiveness, in many states, the standard that must be used to order AOT is often stricter than the standard for ordering hospitalization. States often require that a person have a history of recent involuntary hospitalization, serious violent behavior, or incarceration before AOT can be ordered. AOT is not used to prevent crisis; it is used only after the adverse consequences of a crisis have occurred.[69] Recently, Michigan joined Arizona and modified its law to permit courts to order AOT in all proceedings seeking involuntary mental health treatment.[70] Michigan no longer requires a history of recent involuntary hospitalization, serious violent behavior, or incarceration to order AOT. This policy change will permit the use of AOT whenever treatment is ordered.

AOT has been referred to as "outpatient commitment." This term reflects the ethical tension in the psychiatric community between principles of self-determination and promotion of the patient's medical best interest.[71] However, AOT is less likely to impair self-determination than detention in a prison or psychiatric hospital and is an opportunity to restore the person's meaningful exercise of self-determination.

Dr. Alexander Simpson, Chief of Forensic Psychiatry at the Center for Addiction and Mental Health in Toronto, Ontario, Canada, wrote that the international evidence of the effectiveness of AOT supports the conclusion that it provides treatment in a deinstitutionalized environment for those who would otherwise refuse it and for whom

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[68] Sharon E. Carpinello, N.Y. State Office of Mental Health, Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment 20-21 (2005), https://www.omh.ny.gov/omhweb/Kendra_web/finalreport/AOTFinal2005.pdf [http://perma.cc/JF3K-JB33].

[69] Mental Health Commitment Laws, *supra* note 30, at 14-18.

[70] Mich. Comp. Laws 330.1468(2)(e), as enacted by 2016 PA 320 (effective Feb. 14, 2017).

[71] Am. Psychiatric Ass'n, Position Statement on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment 1 (2015), https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2015-Involuntary-Outpatient-Commitment.pdf [http://perma.cc/CKS6-NQZY].

adverse events would otherwise occur.[72] He added that limiting the use of compulsory treatment increases the likelihood that treatment will occur late in the course of a relapse, too late to be used as a risk management tool.[73] He observed that these compulsory treatment laws require that the risk be manifested, not anticipated, which results in intervention that is too late.[74] It means that people suffering from serious mental illness will be at risk of living in the community with more acute symptoms and functional impairment, leading to homelessness, self-harm, criminalization, and incarceration. He added that too many limits on intervention make it harder for families to cope with major ongoing symptoms.[75]

Where AOT has been used, it has been effective in reducing homelessness, psychiatric hospitalization, violent behavior, arrest, and incarceration.[76] Unfortunately, AOT has not been widely used in most states. Just as courts can order hospitalization without a history of violence or incarceration, courts should be able to order AOT before people are in crisis rather than require that they suffer the consequences of untreated mental illness before receiving help.
AOT, rather than being a rarely used special sort of relief, should be the cornerstone of the community treatment program promised by the CMHA. Some states use AOT as a discharge planning tool following treatment in a hospital.[77] AOT should be used as a discharge planning tool from jails and prisons as well as hospitals for those who fail to recognize their need for ongoing treatment.

The current model of hospitalization until stabilization is expensive. Short stays mean that release, relapse, and then rehospitalization occur far too often.[78] AOT, on the other hand, is a less restrictive, evidence-based practice that improves self-care, reduces harmful behavior, and offers results that are sustainable. Persons who have been the subject of AOT orders report high levels of satisfaction, including gaining control over their lives, getting well and staying well, and being more likely to keep appointments and take medication.[79]

Instead of wasting scarce resources by repeatedly incarcerating or hospitalizing people with mental illness, it would be much better policy, at far less cost, to provide AOT early in the course of a person's mental illness. This would promote recovery and avoid criminal behavior that could result in incarceration as well as creating avoidable victims of criminal behavior. This is particularly evident when the crime is a minor one, such as shoplifting snacks worth $5.05.[80] If Jamycheal Mitchell had received outpatient treatment through an AOT, he might be alive today.

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[72] Alexander Simpson, *Mental Health Law in Ontario: Challenges for Reform*, 31 Health L. in Can. 65, 69 (2011).

[73] *Id.*

[74] *Id.*

[75] *Id.*

[76] Marvin S. Swartz et al., Duke Univ. Sch. of Med., New York State Assisted Outpatient Treatment Program Evaluation (2009), https://www.omh.ny.gov/omhweb/resources/publications/aot_program_evaluation/report.pdf [http://perma.cc/K84P-DZ8M].

[77] *See id.*

[78] *See* Released, Relapsed, Rehospitalization, *supra* note 47.

[79] Sharon E. Carpinello, N.Y. State Office of Mental Health, Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment 20-21 (2005), https://www.omh.ny.gov/omhweb/Kendra_web/finalreport/AOTFinal2005.pdf [http://perma.cc/JF3K-JB33].

[80] *See supra* text accompanying note 1.

There are significant up-front costs in establishing AOT programs.[81] However, states that use AOT have found that the cost of mental health services for those being served has been reduced, primarily due to the effectiveness of AOT in reducing rehospitalization rates,[82] reduced length of stay, and less expenditures of tax dollars per person.[83]

More access to care as well as earlier intervention would increase the number of people being served. This could result in a short-term increase in cost. However, the cost over time, and the burden on other entities like jails, prisons, and hospitals would decrease; and the quality of the lives of persons with mental illness would improve.[84]

Modifying mental health codes to permit ordering treatment, including AOT, when a person's mental illness robs them of the capacity to make informed decisions would be an effective addition that would reduce contact with law enforcement and reliance on jails and prisons. It would also permit the civil justice system to intervene earlier and order a mental health evaluation and either AOT or hospitalization.

B. Use of the Sequential Intercept Model

The Sequential Intercept Model, as described below, should be implemented throughout the country.

1. Intercept "0"

Intercept 0 is prior to contact with law enforcement. This contact should permit the civil justice system to intervene early in the course of a person's mental illness in order to treat the illness and avoid contact with law enforcement. Changing the standard for court-ordered treatment to permit earlier intervention and providing assisted outpatient treatment as described in earlier sections of this paper will create the best opportunity to help someone recover in the course of their mental illness and avoid behavior that might lead to contact with the criminal justice system and other consequences of untreated mental illness.

2. Intercept 1

Intercept 1 is the first contact with law enforcement. Action steps in Intercept 1 include training police officers and 911 operators to recognize mental illness and providing a police-friendly drop-off at local hospitals or crisis centers.

About one in ten police calls across the nation now involve mental health situations.[85] People with mental illness are 16 times more likely to be killed than any other civilians approached or stopped by law enforcement.[86]

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[81] Jeffrey W. Swanson et al., *The Cost of Assisted Outpatient Treatment: Can It Save States Money?*, 170 Am. J. Psychiatry 1423, 1423 (2013).

[82] *Id.* at 1430.

[83] *Id.* at 1426.

[84] Caroline M. Sallee & Erin M. Agemy, Anderson Econ. Grp., Costs and Benefits of Investing in Mental Health Services in Michigan 4-6 (2011), http://www.andersoneconomicgroup.com/Portals/0/upload/AEG_MACMHB_Final%20Full%20Report.pdf [http://perma.cc/6BAK-UQDA].

[85] Mike Maciag, *The Daily Crisis Cops Aren't Trained to Handle*, Governing, May 2016, at 55, http://www.governing.com/topics/public-justice-safety/gov-mental-health-crisis-training-police.html [http://perma.cc/Z6XM-FBFB].

[86] Treatment Advocacy Ctr., Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters 1 (2015),

Crisis Intervention Training (CIT) for law enforcement is effective in reducing violent incidents involving police and persons with mental illness. This program originated in Memphis, Tennessee, and is now promoted by a national CIT training curriculum developed through a partnership between the National Alliance on Mental Illness, the University of Memphis CIT Center, CIT International, and the International Association of Chiefs of Police. The curriculum is designed to give officers more tools to do their jobs safely and effectively and help people with mental illness stay out of jail and get on the road to recovery.[87]

In a recent study, officers who received CIT training believed that the training not only increased their knowledge and understanding of mental illness, but also gave them the skills to identify possible mental illness, de-escalate the situation, listen actively, and build trust. Following training, there was a significant and constant increase in drop offs at the mental health crisis center as opposed to jail.[88] More CIT training would improve law enforcement's response to mental health situations and help divert people from the criminal justice system. CIT training would also help probation officers who work closely with the courts, emergency room personnel unfamiliar with mental health issues, jail personnel, and others called upon to intervene in crisis situations.

As an example, Oakland County, Michigan, in partnership with its community mental health agency began CIT training of officers from across the county in 2015. In the previous five years, 51 individuals had been diverted to treatment in lieu of incarceration. Since then, over 300 persons per year have been diverted to treatment. The de-escalation skills learned by officers have improved the handling of other potentially hazardous situations such as domestic disputes.[89]

Even with a civil justice intervention system that has the tools to handle mental health cases effectively and efficiently, there will still be a need for the criminal justice system to be able to effectively respond. This includes not only law enforcement, but all the participants in the criminal justice system. This means using effective screening tools to divert persons with mental illness into treatment, training judges and staff, and expanding the use of mental health courts and diversion programs.

There is evidence that well planned diversion programs that include jail-based interventions and CIT training can substantially reduce the rate of incarceration of people with serious mental illness. Aggregate findings for eight counties in Michigan with diversion programs found a 25% reduction in the number of inmates with serious mental illness between 2015 and 2016.[90]

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http://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf [http://perma.cc/SR7S-WPEM].

[87] *What is CIT?*, Nat'l All. on Mental Health, http://www.nami.org/Law-Enforcement-and-Mental-Health/What-Is-CIT (last visited Feb. 1, 2017) [http://perma.cc/6ZNK-YPRF].

[88] Sheryl Kubiak et al., Mich. State Univ., Statewide Jail Diversion Pilot Program Implementation Process Report, at I-G4 and I-G5 (2015), http://www.michigan.gov/documents/snyder/MSU_Implementation_Process_Report_FINAL_033016_526665_7.pdf [http://perma.cc/DS7H-838E].

[89] Testimony of Lieutenant Steven Schneider to the Michigan House Law and Justice Committee on May 23, 2017.

[90] Sheryl Kubiak et al., Mich. State Univ., Diversion Pilots: Planning for the Future with Baseline Data 5 (2017), http://www.michigan.gov/documents/mentalhealth/Aggregate_Report_NO_Appendices_1.5.17_568762_7.pdf [http://perma.cc/2PYN-A723].

Miami-Dade County in Florida has developed a remarkably successful pre-booking jail diversion program under the leadership of Judge Steven Leifman. Over the past seven years law enforcement has responded to 71,628 mental health crisis calls resulting in almost 16,000 diversions to crisis units and only 138 arrests. The daily census in the county jail system has dropped from well over 7,000 to 4,000 inmates and the county has closed an entire jail facility representing cost-savings of $12 million per year.[91]

3. Intercept 2

Intercept 2 is the initial detention and initial court hearing. Action steps at Intercept 2 include screening, assessments, pretrial diversion, and service linkage.

The courts should use their convening power to set up an interagency commission to study expediting time to disposition for cases where mental illness has been identified as a factor in the alleged crime. The courts should also provide education and training to court personnel in pretrial services to help them work effectively with defendants who have been identified as having a serious mental illness as well as education on community resources and how to link defendants with them.

Assessments should be used to determine appropriateness for diversion decisions, such as bond release programs, pretrial services, and by prosecutors in pre- or post-plea diversion programs. Identifying criminogenic risk is one critical component, but the assessment should also include mental health screening. Mental health screens and assessments identify an individual's needs for services and provide the best placement and treatment plan for providing support, services, and stability.

In a typical pre-adjudication diversion program, a person with mental illness who has committed a crime would be offered the opportunity to have potential charges dismissed if he or she submits to mental health treatment and other conditions. There is usually some type of supervision similar to probation to ensure the conditions are met. Once conditions are met, the prosecutor or judge dismisses the charges.[92]

4. Intercept 3

Intercept 3 usually occurs after incarceration and includes problem solving courts designed to divert persons with mental illness. The action steps include screening, referral to a mental health court and jail-based services.

Mental health courts are a type of problem solving court. They represent a dynamic partnership between the criminal justice system and community mental health providers. Mental health court is usually a form of intensive probation after a criminal charge is made and the defendant pleads guilty or is found guilty by a judge or jury. Nationally, the majority (73%) of mental health courts allow participants to enter post-plea, but there are also a significant number who also accept participants post-sentence (41%). The trend is that more

[91] Judge Steven Leifman. Decriminalizing Mental Illness - Applying Lessons Learned in Miami-Dade County, paper delivered at the Arizona Court Leadership Conference in Flagstaff, Arizona, on October 13, 2017

[92] Ctr. for Health & Justice at TASC, No Entry: A National Survey of Criminal Justice Diversion Programs and Initiatives 20 (2013), http://www2.centerforhealthandjustice.org/sites/www2.centerforhealthandjustice.org/files/publications/CHJ%20Diversion%20Report_web.pdf [http://perma.cc/8V76-DBHT].

mental health courts are trying to divert individuals sooner in the adjudicative process.[93]

Potential participants must meet certain eligibility requirements and agree to participate and comply with their treatment plans. Once admitted into the program, they appear regularly at status hearings before the judge, where their accomplishments and setbacks from the date of the last status hearing are discussed. Accomplishments are rewarded with incentives, and setbacks are punished by sanctions.[94] Typically, mental health courts adopt the Ten Essential Elements of Mental Health Courts. Some also apply case management through the Assertive Community Treatment (ACT) model, which provides wraparound services to meet an array of treatment and social service needs.

Nationally, mental health courts have become an effective way to address individuals with mental illness who face criminal charges. They have increased in number by 36% between 2009 and 2014.[95]

Several research findings have supported positive outcomes with regard to reductions in recidivism and less time in custody and have found lasting results for at least two years after discharge; results extend beyond just the provision of treatment and services.[96]

A statewide comparison of Michigan mental health courts found a significant difference in recidivism based on the structure of the program. Mental health courts with higher levels of integration performed better, meaning that, the case manager and the clinician participate on the treatment team and attend status conferences.[97]

There is evidence that it is difficult to sustain reductions in recidivism over time for those who participate in these programs. For example, in one statewide study, recidivism rates for mental health court participants four years after graduation rose to 23%, only slightly better than the comparison group recidivism rate of 26% after two years, although still better than the nonparticipants after four years.[98] It may be

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[93] Suzanne M. Strong, Ramona R. Rantala & Tracey Kyckelhahn, U.S. Dep't of Justice, Census of Problem-Solving Courts, 2012 (2016), https://www.bjs.gov/content/pub/pdf/cpsc12.pdf [http://perma.cc/A3N8-MK8M].

[94] Sheryl Kubiak et al., Mich. State Univ., Statewide Mental Health Court Outcome Evaluation Aggregate Report (2012), https://www.michigan.gov/documents/mdch/Statewide_MHC_Evaluation_-_Aggregate_Report_Final_103112_w_seal_407300_7.pdf [http://perma.cc/RT2S-52BR].

[95] Douglas B. Marlowe, Carolyn D. Hardin & Carson L. Fox, Nat'l Drug Court Inst., Painting the Current Picture: A National Report on Drug Courts and Other Problem-Solving Courts in the United States (2016), http://www.nadcp.org/sites/default/files/2014/Painting%20the%20Current%20Picture%202016.pdf [http://perma.cc/J6M3-DE3L].

[96] Christine M. Sarteschi, Michael G. Vaugh & Kevin Kim, *Assessing the Effectiveness of Mental Health Courts: A Quantitative Review*, 39 J. Crim. Just. 12 (2011); H.J. Steadman et al., *Effect of Mental Health Courts on Arrests and Jail Days: A Multisite Study*, 68 Archives of Gen. Psychiatry 167 (2011); Virginia Aldigé Hiday, Bradley Ray & Heathcote W. Wales, *Predictors of Mental Health Court Graduation*, 20 Psychol., Pub. Pol'y & Law 191 (2014); Shelli B. Rossman et al., U.S. Dep't of Justice, Criminal Justice Interventions for Offenders with Mental Illness: Evaluation of Mental Health Courts in Bronx and Brooklyn, New York, Final Report (2012), https://www.ncjrs.gov/pdffiles1/nij/grants/238264.pdf [http://perma.cc/6VVW-AHNB]; Virginia Aldigé Hiday, Bradley Ray & Heathcote W. Wales, *Longer-Term Impacts of Mental Health Courts: Recidivism Two Years After Exit*, 67 Psychiatric Servs. 378 (2016).

[97] Kubiak et al., *supra* note 94, at 60-62.

[98] Mich. Supreme Court, State Court Admin. Office, Michigan's Problem-Solving Courts: Solving Problems Saving Lives 42 (2015), http://courts.mi.gov/administration/admin/op/problem-

that participation in the program only defers recidivism.

Recidivism for participants may increase over time due to a lack of adequate community treatment and support. Once a person completes the program, he or she may lack access to continuing treatment and may decompensate. Unless the person poses an immediate danger to self or others, involuntary treatment cannot be ordered, and it is necessary to wait until the recurrence of the behavior that led to arrest in the first place. Linking the person to continuing community treatment may be necessary to achieve sustainable, long-term improvement in recidivism and mental health. More research is needed to measure the impact of different mental health court practices in reducing recidivism.[99] Research should include whether mental health courts have an impact on involuntary treatment orders and on why rates of recidivism increase over time. For example: What intervening variables might be influencing this and can they be addressed while the defendant is still subject to the jurisdiction of the mental health court?

In addition, mental health courts often have constraints that limit their use. Participation is usually voluntary, so those who do not understand their need for treatment are less likely to participate. This excludes the highest need defendants. And these courts usually require a guilty plea before the defendant can participate. This results in a criminal record and the negative consequences that flow from a conviction, including social stigma and its effect on a person's well-being.[100]

Many diversion programs and mental health courts exclude those who have been charged with a violent crime, although inclusion could very well help avoid future violence. Since almost half of all state prisoners had a violent offense as their most serious offense, this exclusion can also be a significant limitation on the scope and usefulness of these programs.[101] Federal grant programs have exacerbated the problem by restricting the use of those funds for nonviolent offenses. COSCA has previously recommended that federal law automatic exclusion of certain categories of persons and other state law or practice automatic exclusions be eliminated.[102]

The level of supervision needed for mental health courts is time intensive and costly. With prosecutor and court budgets strained, sustainability is a significant challenge. For all of these reasons, diversion programs and mental health courts reach only a small percentage of the severely mentally ill defendants in the criminal justice system.

Expanding the continuum of criminal justice alternatives, including diversion programs and mental health courts, coupled with ensuring community-based treatment and support for each participant after completion of diversion or probation, would likely be most effective at securing long-term

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solving-courts/documents/psc%202015%20report%20final_4-7-16.pdf [http://perma.cc/PMM5-8648].

[99] Kim et al., *supra* note 19, at 40.

[100] *Id.*

[101] *Id.* at 9.

[102] Conf. of State Court Adm'rs, 2014-2015 Policy Paper: Problem-Solving Courts in the 21st Century (2015), http://cosca.ncsc.org/~/media/Microsites/Files/COSCA/Policy%20Papers/Problem-Solving-Courts-in-the-21st-Century-Final.ashx [http://perma.cc/MC44-6X97].

recovery for participants and achieving long-term reductions in recidivism.

5. Intercept 4

Intercept 4 occurs at reentry to society following discharge from incarceration and should include a plan for treatment and services and coordination with community programs to avoid gaps in service. It has been demonstrated that people with medical care and health insurance at reentry experience reduced rates of recidivism.[103]

The Substance Abuse and Mental Health Services Administration (SAMHSA) has noted that transition planning is the least developed jail-based service and has developed a comprehensive implementation guide to help transition persons with mental illness or substance use disorders from institutional correctional settings into the community.[104]

SAMHSA found that upon release from jail or prison, persons with mental illness or substance use disorders often lack access to services while at a time of heightened vulnerability. A formalized continuity of services from institution to community settings offers better outcomes and reduced recidivism. This is necessary to ensure adherence to treatment plans and avoid gaps in care. Coordination between corrections departments, mental health agencies, and the courts, could result in the use of court-ordered AOT to encourage compliance and improve treatment outcomes.

6. Intercept 5

Intercept 5 occurs at parole or probation and includes screening and maintaining a community of care. It also includes connecting individuals to employment and housing. Courts should adopt specialized dockets to provide supervision after release. This could be accomplished with AOT orders.

Housing is the number one critical resource lacking for persons with mental illness. A meta-analysis of controlled outcome evaluations on effectiveness of housing and support interventions and assertive community treatment found support for such programs.[105]

V. State Court Judges as Conveners

Because of the unique vantage point of the judiciary at the front and back doors of the civil commitment and criminal justice systems, state courts judges, particularly presiding judges or those that hold administrative leadership positions in the courts, are the ideal organizing force to convene the entities that must come together to develop better protocols to evaluate the impact of the mental health crisis on our criminal justice system and devise solutions. The courts are found at nearly every step of the Sequential Intercept Model. In order to integrate that model, it is necessary that all the stakeholders are brought together, and state court judges are in the best position to make that happen.

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[103] *See supra* note 100 and accompanying text.

[104] Substance Abuse & Mental Health Servs. Admin., Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide 4 (2017), https://store.samhsa.gov/shin/content/SMA16-4998/SMA16-4998.pdf [http://perma.cc/YFW2-7344].

[105] *See* Geoffrey Neslon, Tim Aubry & Adele Lafrance, *A Review of the Literature on the Effectiveness of Housing and Support, Assertive Community Treatment, and Intensive Case Management Interventions for Persons with Mental Illness Who Have Been Homeless*, 77 Am. J. Orthopsychiatry 350 (2007).

Juvenile, criminal, civil, and family courts all face this crisis as well as all the various parties interested in the outcome of these proceedings. They include the mental health system, National Alliance on Mental Illness (NAMI), law enforcement, prosecutors, public defenders, public health agencies, healthcare providers such as doctors, emergency room physicians, therapists, and case workers, as well as correction agencies and state and local government. State courts are in the best position to convene these groups, because they have frequent and collegial contact with many officials from the executive branch. They are in the best position to convene the relevant interested parties and design a comprehensive, collaborative approach to provide treatment instead of incarceration for persons with mental illness.

Judge Leifman is the perfect example of the effectiveness of the judge as a convening force. Prior to becoming a judge, he was in charge of the public defender office. He attempted but was unsuccessful in convening the necessary parties to address jail conditions for persons with mental illness. Once he became a judge and sent the same invitation out on judicial stationary, he had no trouble convening the necessary parties.

A series of public policy decisions has caused a shift in addressing mental health issues from the civil justice side of the judiciary to the criminal justice side. This has come at great human and monetary cost. Institutions were developed in the mid-nineteenth century as a reform effort to stop warehousing people with mental illness in jails. One hundred fifty years later, we are once again confronted with the same dilemma.

Court leaders cannot solve the "chaos and heartbreak of mental health in America."[106] Court leaders can, and must, however, address the impact of the broken mental health system on the nation's courts—especially in partnership with behavioral health systems. The broken system too often negatively impacts court cases involving those with mental illness, especially in competency proceedings, criminal and juvenile cases, civil commitment cases, guardianship proceedings for adults and juveniles, and oftentimes family law cases. Each state court, as well as CCJ and COSCA, are urged to initiate a thorough examination of the mental health crisis and its impact on fair justice.

VI. Conclusion

The tools currently available to the judiciary fail to meet the challenge of dealing with persons with mental illness. The public safety of our citizens is as much at stake with the improper handling of such cases as is the fair treatment of individuals who have mental illness.

State courts should encourage policy makers to make changes in the court-ordered treatment standard and to use their convening power to bring stakeholders to the table to work on correcting problems and developing better tools for addressing mental health issues. COSCA advocates for judges to convene all parties interested in mental health issues to support these actions:

[106] Ron Powers, No One Cares About Crazy People: The Chaos and Heartbreak of Mental Health in America (2017).

1. Encourage policy makers to modify mental health codes to adopt a standard based on *capacity* and not *conduct* for ordering involuntary mental health treatment similar to the standard for court-ordered treatment of other illnesses.

2. Expand the use of Assisted Outpatient Treatment (AOT).

3. Encourage law enforcement agencies to train their officers in the use of CIT.

4. Support the adoption of the Sequential Intercept Model.

5. Chief Justices and State Court Administrators should encourage and assist local judges to convene stakeholders to develop plans and protocols for their local jurisdiction.

6. Provide information to policymakers that demonstrates how increased funding for mental health treatment can reduce jail and prison cost as has been demonstrated in Miami Dade County.

These recommendations, if implemented, will enable the courts to do a better job of effectively managing mental health cases. Courts can help forge a path toward policies and practices that treat those with mental illness more effectively and justly.