Arizona Supreme Court
Committee on Mental Health and the Justice System
Final Report | October 2020

> There comes a point where we need to stop just pulling people out of the river. We need to go upstream and find out why they're falling in.
>
> – Desmond Tutu

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*Staff Notes – Items to be added are **Red**; Interim Report Recommendations are **Orange**; New Recommendations are **Blue***

SECTION I: INTRODUCTION

The Committee on Mental Health and the Justice System has convened since September 2018 to develop and recommend comprehensive, evidence-based best practices and cross-agency protocols to improve the administration of justice for persons with mental illness. Combined, the Committee possesses over 500 years of experience in the legal, judicial, behavioral health, and advocacy fields, and many members have dedicated their careers to serving individuals and families who are living with mental health conditions.

The Committee submitted its interim report recommendations in October 2019, and submits this final report to the Arizona Judicial Council, incorporating its work and progress to date, additional findings, and recommendations. Detailed information on each Committee meeting can be found on its website.

The remaining sections of this report include an executive summary, findings and recommendations, a detailed overview of the Committee's work and progress to date, concluding statements, and an Appendix with proposed best practices and statutory changes, along with constructed personal histories that detail the impact of the mental health and justice systems on individuals, to support the Committee's recommendations for change.

The Committee wishes to thank all the subject matter experts and key stakeholders who provided critical input to its work and who had significant impact on its final findings and recommendations.

SECTION II: EXECUTIVE SUMMARY

The Arizona judicial branch is recognized as a leader, nationwide, in addressing individuals' mental health conditions and their impact on communities, the individuals themselves, and families who encounter the behavioral health and justice systems. Administrative Order 2018-71 charged the Committee on Mental Health and the Justice System with studying and making recommendations as follows:

- 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.
- Oversee the development of a model guide to help presiding judges develop protocols to work with the 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.
- 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.
- Review court rules and state statues 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.
- Identify ways the court can work collaboratively with other stakeholders to educate the public on the use of advance healthcare directives.
- 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.
- Identify opportunities to educate the public on court processes involving individuals involved in the justice system who have behavioral health treatment needs.

People living with a mental illness experience disproportionate contact with the criminal justice system – from law enforcement interactions, to arrest, to pre-trial detention, to conviction and incarceration. Research reveals that more than 25 percent of incarcerated inmates have a recent history of mental illness and require ongoing mental health services. As many as 70 percent of youth in the juvenile justice system have been identified as living with at least one mental health condition and 20 percent experience a severe mental illness.[1]

The rationale behind the criminalization of mental illness largely lies in the deinstitutionalization of mental health care decades ago when mental health hospitals were eliminated, which was intended to result in an increase in community-based access to care. However, funding for and access to appropriate care to meet mental health

[1] Arizona Department of Corrections. *Corrections at a Glance*. LINK

needs never ramped up accordingly in communities. Jail bookings of individuals with mental health concerns who committed low-level misdemeanors increased, partly as a way for law enforcement officers to secure treatment for people who needed it. Thus, the abandonment of mental health hospitals simply transferred patients to jails and prisons, making them de facto mental health facilities.

Due to the impact this disproportionality has on individuals, families, communities, and the system itself, there is a growing understanding of the need to stop the too-frequent trajectory of individuals living with mental illness entering the criminal justice system, and to find solutions to improve access to the mental health system where individuals and their families can receive proper treatment, services, and supports.

The mental health of justice-involved individuals has a tremendous impact on public safety, community health and wellness, and both short and long-term costs of the justice system. With the participation of the judicial branch, Arizona remains well-positioned to create a cross-system approach to significantly improve outcomes for people in need of behavioral health services and supports.

Its second year of work corresponded with the COVID-19 worldwide pandemic health crisis and historical events surrounding racism, justice and equality, but Committee members remained connected remotely and committed – perhaps more than ever – to their charge and mission. This time of unprecedented change underscores the Committee's belief in the judiciary's role in addressing access to treatment and justice for individuals living with mental health conditions.

Over the course of its work, the Committee learned the value of individuals' experiences when it comes to understanding the full impact of a disjointed system for helping such individuals and their families. **Appendix B** includes individual, constructed histories created to provide examples of the complexities faced by individuals, the justice system, and its stakeholders when they intersect with someone living with significant trauma or mental health history. These stories reflect the experiences of Committee members, and illuminate the legal, clinical, and practical challenges that accompany the treatment of people with mental illness who become involved with the justice system.

The Committee recommends that a research-based entity such as a university partner use these composites to create a records review process in order to establish true case studies of individuals living with mental illness who encounter the justice system.

Along with the work of this Committee, Arizona's judicial branch has been working for the past two years to develop protocols and resources that cross disciplines and focus on the Sequential Intercept Model – to identify opportunities to intervene as early as possible and prevent justice-involved individuals living with mental illness from entering or further penetrating the system. The Committee strongly believes the Supreme Court can further its leadership role in serving this vulnerable population. To this end, it recommends that the Supreme Court continue the mental health initiatives set forth in the strategic agenda, *Justice for the Future,* and that the Supreme Court should encourage state

leaders to enhance the capacity of the justice and behavioral health systems to work together to implement sound, innovative, and sustainable practices.

One factor has significantly hampered the ability of this Committee to assess impact is a lack of data. Although the Committee is aware from anecdotal testimony provided by families and professionals in the system that people are being denied access to needed involuntary mental health treatment, it was unable to identify any data being collected to support this conclusion. When collected, data should show that continuing current practices has a significant negative impact, in the form of unnecessary costs, on individuals, families, communities, and the justice and mental health systems.

The Committee encourages the Arizona Judicial Council and AOC leadership to review all recommendations in detail (Section III), but emphasizes the following eight recommendations, in no particular order, as immediate action items:

- Evaluate the impact of jurisdictions' implementation of the Sequential Intercept Model and utilize data to make recommendations on how policies, practices and funding can be improved and redirected to areas identified as high need.
- Develop a framework for educating judges and court staff from initial orientation throughout the career span, in the areas of understanding trauma, behavioral health, crisis response, and in existing judicial oversight mechanisms for people with mental health conditions.[2]
- Convene a Task Force to create a set of Mental Health Rules for purposes of improving consistency, clarity and coordination among courts that oversee matters involving individuals and families living with mental illness.
- Support the creation of justice system/behavioral health position(s) in each county for the Superior Court, and in Limited Jurisdiction Courts that serve a high volume of people living with mental illness, to ensure continuity of care for individuals involved in Rule 11, Title 36 and Title 14 processes. This includes elevating, requiring and funding a dedicated clinical liaison (see A.R.S.§13-4501) to ensure oversight and coordination of services and support with AHCCCS and providers.
- Amend the four-decades' old definition of *mental disorder* in A.R.S. §36-50, as described in the "Recommendations" section, by convening a multi-disciplinary team to ensure that persons who are living with a mental disorder co-occurring with dementia, traumatic brain injury or intellectual disability can get needed treatment while ensuring individuals' rights are protected, and that people are not subjected to inappropriate, prolonged and unnecessary inpatient treatment.
- Advocate for statutory change to delineate the court's authority to order the defined enhanced services for individuals identified as not having received consistent, sustained or proper treatment for their mental illness and who continue to cycle in and out of the criminal justice, probate, and civil mental health systems.
- Utilize tele-health for mental health evaluations and restoration to competency processes, provided practices noted by the Committee are in place. The AOC should pursue a statewide contract for providers to deliver specific teleservices.

[2] Note: The first phase of this training development is currently underway for initial roll-out in 2020-21.

- Improve the uniform quality of mental health evaluators in Title 36 processes, in restoration to competency processes, and in Serious Mental Illness determinations. Mechanisms include up-to-date training in best practices; standardized reporting formats; clear expectations; and periodic, regular evaluations.

SECTION III: FINDINGS AND FINAL RECOMMENDATIONS

The recommendations presented here are based on extensive Committee work, research, analysis, discussion and stakeholder input. The Committee's recommendations are grounded in its initial five key findings. It has also considered an additional finding related to children's mental health and wellness that was not included in its 2019 interim report.

Findings

- The civil and criminal justice systems require additional procedures and resources to identify, as early as possible, mental health conditions in those who come into contact with the justice system.
- While options to divert individuals from the civil or criminal justice systems are statutorily authorized, these options are not available or are underutilized across the state, often due to a real or perceived lack of resources.
- People who have been identified as having mental health conditions are more likely to be detained pretrial and to stay longer in detention due to the lack of sufficient inpatient treatment and community-based outpatient treatment options. In some jurisdictions, these individuals are released without a full continuum of treatment care options and, consequently, often return to the justice system.
- Individuals, families and communities are not currently able to access adequate behavioral health services in times of need that would allow for an appropriate level of care along a continuum of services ranging from no justice involvement to diversion, and from the justice system to inpatient, secure care.
- Arizona must address the unique needs and challenges its rural communities face in providing services and treatment for those with mental health conditions who come into contact with the justice system.
- Increased awareness and early identification of mental health conditions are critical to improving the health and well-being of Arizonans. And it starts with our children. We must address court-involved children's mental health through an interdisciplinary lens that emphasizes multi-system partnerships, funding collaboration and accountability to address gaps in service and continuity of care.

Recommendations

The Committee sought to emphasize the importance of the Judiciary's leadership role in driving change forward This can be done by seeking improvements holistically across a system for people, families and communities. When implemented, these recommendations will have a direct impact on Arizonans in need of behavioral health services and their support structures, both within the justice system and in our communities.[3]

1. Evaluate the impact of jurisdictions' implementation of the Sequential Intercept Model and utilize data to make recommendations on how policies, practices and funding can be improved and redirected to areas identified as high need.*
2. Develop a framework for educating judges and court staff from initial orientation throughout the career span, in the areas of understanding trauma, behavioral health, crisis response, and in existing judicial oversight mechanisms for people with mental health conditions.[4]
3. Superior Court Presiding Judges should consider the creation of a Mental Health Division of the Superior Court. If not possible, the Presiding Judge should consider authorizing judicial officers to hear all mental health related matters involving a specific individual.
4. Convene a Task Force to create a set of Mental Health Rules for purposes of improving consistency, clarity and coordination among courts that oversee matters involving individuals and families living with mental illness.
5. Support the creation of justice system/behavioral health position(s) in each county for the Superior Court, and in Limited Jurisdiction Courts that serve a high volume of people living with mental illness, to ensure continuity of care for individuals involved in Rule 11, Title 36 and Title 14 processes. This includes elevating, requiring and funding a dedicated clinical liaison (see A.R.S.§13-4501) to ensure oversight and coordination of services and support with AHCCCS and providers.*
6. Fully explore the use of peer navigators in court, often funded through AHCCCS and ACC/RBHA Health Plans.[5]
7. Implement a cross-disciplinary data repository or locator for courts to access when an individual living with mental health conditions is in multiple courts.
8. Continue to support specialty courts and collaborative groups that have been working together through resources provided by Arizona's Mental Health and Justice System Summits. Jurisdictions creating new specialty or treatment courts are

[3] Additional details on the following recommendations can be found in the Status Update, Section IV of the report. Of note, the eight (8) recommendations noted in the Executive Summary are embedded below and emphasized with a (*) to ensure their inclusion as the Committee's final recommendations.

[4] Note: The first phase of this training development is currently underway for initial roll-out in 2020-21.

[5] Peer navigators, also known as Peer Recovery Support Specialists (PRSS) are individuals with lived experience of behavioral health and/or substance use recovery who have received specialized training on how to use their experience to help others. More information, including AHCCCS' approved PRSS Training Programs: LINK

encouraged to set a well-defined target population; identified goals and outcomes; and tracking measures.

9. Partner with the National Center for State Courts to update the Mental Health Court Standards and data collection requirements and to develop an evaluation framework. Communicate the necessary guidelines and components for developing such courts or coalitions.[6]
10. Amend the four-decades' old definition of *mental disorder* in A.R.S. §36-50, as described in the "Recommendations" section, by convening a multi-disciplinary team to ensure that persons who are living with a mental disorder co-occurring with dementia, traumatic brain injury or intellectual disability can get needed treatment while ensuring individuals' rights are protected, and that people are not subjected to inappropriate, prolonged and unnecessary inpatient treatment.*
11. Advocate for statutory change to delineate the court's authority to order the defined enhanced services for individuals identified as not having received consistent, sustained or proper treatment for their mental illness and who continue to cycle in and out of the criminal justice, probate, and civil mental health systems.*
12. Introduce legislation to amend the definition of persistent or acute disability (PAD) in A.R.S. §36-501 to recognize that causing harm to self or others is one of the possible consequences of not getting treatment for a severe mental disorder that substantially impairs judgment, reason, behavior or capacity to recognize reality.
13. Encourage counties to mandate that SMI evaluations and determinations be made concurrently with the court ordered evaluation process, in accordance with AHCCCS policy. This can be accomplished by including a specific order that the SMI evaluation and determination be made. Education is required to ensure judicial officers are aware of this process.
14. Encourage the review and revision of AHCCCS' schedule of qualifying diagnoses to ensure that it includes the mental disorders which cause significant functional impairment and which are thought to be treatable with psychiatric treatment.
15. Require all persons who conduct SMI evaluations and determinations to receive the most up-to-date education about the process, procedures and protocols developed to make accurate and timely SMI determinations. AHCCCS should be responsible for providing this education on a regular basis.
16. Look for ways for AHCCCS and the Courts to improve for the public the quality of and access to the justice and public and private health care information made available to Crisis Response Network for purposes of making an SMI determination
17. Revisit proposals introduced in the 54th Legislature, Second Regular Legislative Session (2020) that were put on hold due to the COVID-19 health crisis related to changes within the Title 36 system and the justice system overall. Utilize the Committee's research, findings and recommendations as potential avenues for further refinement and improvement.
18. Implement Best Practices in Restoration to Competency.

[6] Mental Health Court Advisory Committee (2014). LINK

19. Utilize tele-health for mental health evaluations and restoration to competency processes, provided practices noted by the Committee are in place. The AOC should pursue a statewide contract for providers to deliver specific teleservices.*
20. Improve the uniform quality of mental health evaluators in Title 36 processes, in restoration to competency processes, and in Serious Mental Illness determinations. Mechanisms include up-to-date training in best practices; standardized reporting formats; clear expectations; and periodic, regular evaluations.*
21. Direct local jurisdictions to evaluate the current pay rates of the mental health experts' contracts, and where needed, to increase them.
22. Support legislation introduced that will improve the implementation of A.R.S. §13-4503 (E) and Rule 11.2 for cases involving misdemeanor defendants in limited jurisdiction court competency proceedings.
23. Adopt protocols in Superior Courts with a corresponding LJC handling competency proceedings to provide an efficient mechanism to move a misdemeanor defendant between criminal and civil court in a timely fashion when the originating case is at the LJC level.[7]
24. Encourage the development of court-based models that provide immediate access to mental health and human services for misdemeanor defendants, including substance use treatment, employment and housing.
25. Confer with university partners about establishing a program and research project among social work, counseling, psychology and criminal justice professionals to: develop future forensic psychological scientists (through a university program); an evidence-based certification process for psychologists that will enhance standards of practice and quality control in forensic mental health services; and a training center to disseminate scientific and evidence-based information relevant to professional judgments in forensic mental health, forensic science, and the law.
26. Pursue and implement curriculum changes identified by the Committee in advance of the next Legal Competency and Restoration Conference, in partnership with a team of subject matter experts, including the university partnership.
27. Encourage advocates to pose the issue of allowing evidence of a mental disorder as an affirmative defense to a defendant's *mens rea* with the legislature.
28. Develop a framework for children, similar to *Stepping Up*, utilizing the concept of the Sequential Intercept Model through a child-focused lens that emphasizes prevention and early involvement in behavioral health services for children and families.
29. Establish a statewide coordinating body with representation from all three branches of government, the community, and people with lived experiences, to focus on improving the delivery of mental health services, data collection and analysis.
30. Create a standing Committee of the Arizona Judicial Council focused on mental health issues across the justice system.

[7] Finalized Protocols and Order templates can be found here: LINK.

SECTION IV: STATUS UPDATE AND ACCOMPLISHMENTS

This section details the Committee's progress on the recommendations from its 2019 interim report, along with the charge to the Committee by Administrative Order 2018-71. Interspersed within this status update are the recommendations detailed in the Recommendations section of the report.

Interim Report Recommendations: Cross-Disciplinary Collaboration and Best Practices

Encourage the Administrative Office of the Courts to partner with a research-based institution to study the impact of implementation of the Sequential Intercept Model as well as the impact of chronic, repeat offenders, particularly as it relates to community-based techniques, recidivism, and a reduction in costs to the judicial system.

Status Update

Approximately twenty (20) general jurisdiction and limited jurisdiction courts have been convening since March 2019 to develop local mental health protocols and collaborations, following the Sequential Intercept Model (SIM) framework. Jurisdictions have been working to map out how an individual with mental health conditions moves through the justice system, and to develop methods, procedures, policy and programs to improve the system's response for individuals and families impacted by mental health conditions. As a result of this focused work, jurisdictions have developed options available for improvement, including staffing models, community collaborations, and enhancing elements within the justice system.

The Committee reinforces its interim report recommendation to evaluate the impact of the Sequential Intercept Model and stresses the importance of utilizing this impact data to make recommendations as to how policies, practices and funding can be revised and redirected to areas identified as high need. In February 2020, the National Center for State Courts and AOC were awarded a technical assistance grant by the State Justice Institute to asses and capture what Arizona has already completed in this area and determine which efforts have had the greatest impact. As a result of COVID-19, the March 2020 Mental Health Summit and NCSC site visits were canceled. It is the Committee's hope that the technical assistance grant will still be carried out, as it is important to study the impact of the work that is being done and to make recommendations for continuous improvement.[8]

[8] In addition to existing partnerships within the state and with the National Center for State Courts, AOC and individual courts can access resources through SAMHSA's Gains Center, including the work detailed in the publication, *Data across the Sequential Intercept Model: Essential Measures* which details essential measures for data and information sharing across the SIM.

Develop comprehensive training for judges and court staff in the areas of behavioral health and crisis response.

Encourage and support the provision of mental health training and information for justice system stakeholders, including:
a. Training on signs and symptoms of mental health conditions, including mental health first aid, as well as eligibility criteria for and availability of mental health services.
b. Mental health training on Title 13, Title 36 and Title 14 statute and case law as it relates to persons with mental health conditions.
c. Use of the orders and standards as provided in A.R.S. §36-540 that allow for assisted court ordered involuntary outpatient treatment or a combined outpatient-inpatient order.
d. Secondary trauma training and comprehensive training on Adverse Childhood Experiences (ACEs) for judicial officers, court staff, law enforcement, probation, and corrections officers and staff.

Status Update

In January 2020, the AOC, in partnership with several Committee members and key stakeholders convened a team of subject matter experts to develop a series of judicial training modules to increase awareness and understanding of mental health and of the experiences of individuals with mental health conditions in the courtroom. The modules include access to specific resources to assist in the delivery of services and improve the administration of justice for these individuals. Judges and court staff must also practice self-care to maintain their own mental health and capacity to serve in high conflict, high stress environments.

Through a partnership between the AOC, this Committee, the Family Court Improvement Committee, the NARBHA Institute, Mental Health First Aid trainers, and Arizona State University – Center for Applied Behavioral Health Policy, Watts College of Public Service and Community Solutions, and School of Social Work, a series of learning modules and resources are being created or delivered, including:

- Online module 1: General mental health, empathy-building, and de-stigmatization.
- Online module 2: Trauma informed courtrooms, to include: hands-on application and specific strategies for judges in trauma informed courtrooms, and secondary trauma impact on judicial officers and court staff.
- Online module 3: Cross-communication within the judicial branch when a person with mental health conditions is involved in multiple courts; to include legal/judicial content, best practices, and community resources.
- Hybrid online and in-person module 4: Leadership, empathy and self-care for judicial officers. Additional support provided to accomplish transfer of learning. Developed in partnership with ASU and the Family Court Improvement Committee.
- "Library of Resources" that will be developed by AOC and subject matter experts as an accompanying piece of the mental health training modules, featuring bench-specific information and resources that can be adjusted as law, policy, and practice changes.

Staff from the AOC have also been working with the National Center for State Courts on the development of national training curricula on mental health and the justice system.

During the team's work with staff, it was determined that judicial officers would most benefit from immediate training on mental health as well as on trauma-informed courtroom and leadership.

In partnership with the Committee, the AOC should develop a program for judges and court staff to receive education at new judge and employee orientation, as well as across all their career spans, in the areas of understanding trauma, behavioral health, crisis response, and developing awareness of existing oversight mechanisms for people with mental health conditions.

The team determined that the judiciary would best be served by creating a library of resources for judicial officers and court staff to better understand the options available to help people with mental health conditions – statewide, locally, and across all divisions of the judiciary. These options and resources may include specific statutes and rules, judicial orders and status reports, deflection and diversion options, treatment resources available, and requirements for treatment providers.

As a result of the training team's work and SIM/Mental Health Protocol development in local jurisdictions, discussions have taken place regarding the need for a separate Mental Health Division in Superior Courts. While this should be determined by each Presiding Judge, the Committee strongly encourages such a division be created to incorporate elements it identifies as high impact opportunities for collaboration and success. In order to accomplish this and other recommendations presented by the Committee, **the Supreme Court should convene a Task Force to create a set of Mental Health Rules.**[9]

Individuals with mental illness often appear in both municipal courts and every superior court division – criminal, civil, probate, family and juvenile. By establishing a "one judge" concept for individuals with mental illness, and utilizing a treatment court, team-based approach, courts and behavioral health providers can more effectively and efficiently serve this population. The Committee has made recommendations to establish this concept and create cross-training opportunities and Mental Health Rules. Several jurisdictions working on mental health protocol development agree that the cross-over within the population lends itself to the "one judge" concept or treatment court model. **Each Superior Court Presiding Judge should consider the creation of a Mental Health Division for purposes of coordination and continuity of care for individuals living with mental illness.**

[9] Please also see the completed work of the Task Force on the Arizona Rules of Probate Procedure for relevant changes to probate and guardianship rules. LINK.

If the individual Superior Court cannot implement a Mental Health Division, it should consider authorizing judicial officers to hear all mental health related matters involving an individual living with mental illness.

Leverage existing resources to create a justice system/behavioral health position available in each court, allowing for coordination of services and supports with AHCCCS and providers for justice-involved individuals with behavioral health needs

Status Update

To help support any newly created Mental Health Division or cross-division efforts**, the Committee recommends the creation of justice system/behavioral health position(s) in each Superior court, and in Limited Jurisdiction Courts that serve a high volume of individuals living with mental illness, for the purpose of ensuring continuity of care for those individuals who encounter the justice system through the Rule 11, Title 36 and Title 14 processes.** This includes elevating, requiring and funding a dedicated clinical liaison (see A.R.S.§13-4501) to oversee and coordinate with AHCCCS and providers services and supports for justice-involved individuals with behavioral health needs.[10] **Further, the Committee recommends that Courts fully explore the use of peer navigators in court, often funded through AHCCCS and ACC/RBHA Health Plans.** The use of peer navigators has been found to be very effective in assisting patients/defendants in their recovery and preventing recidivism.

In order to facilitate information-sharing among courts, the Committee has outlined the necessary elements to be included in a centralized repository to provide judicial officers with access to Rule 11, Title 36 and Title 14 information from other courts on a patient/defendant who is involved in a legal proceeding in their courtroom (See Appendix C). **The Committee maintains its recommendation to encourage the AOC to implement this cross-disciplinary repository.**

Continue to support the development of therapeutic or problem-solving courts which incorporate law enforcement, prosecutors, defense attorneys and community providers to provide access to treatment for individuals with behavioral health and co-occurring disorders.

Status Update

The Committee has continued to learn from jurisdictions across the state that have existing specialty courts or are otherwise working to addresses individual and community behavioral health treatment and service needs. Through the implementation of Mental Health Protocols across the state, courts have proven an ideal force for convening

[10] NOTE: This position currently exists in Pinal County. Other jurisdictions that have recently considered implementing this position, through a redirection of existing funds or positions include City of Phoenix Municipal Court and Maricopa County Superior Court, Probate and Mental Health Division.

community stakeholders to develop protocols and processes that better address how the courts administer justice for those with behavioral health treatment needs.

The Committee encourages the AOC and Arizona Judicial Council to continue their commitment to specialty courts and other collaborative groups that have been working together for several years through resources provided by the National Center for State Courts and through Arizona's Mental Health and Justice System Summits.

Examples of such collaborative courts are identified in Appendix D as models for both limited jurisdiction and general jurisdiction courts to explore for replication and mentoring opportunities. While certainly not an exhaustive list of the work being done statewide, these models highlight collaboration, innovation, and cross-disciplinary opportunities for more effectively serving individuals and families living with mental health conditions in their communities. **The Committee recommends jurisdictions ensure they set a well-defined target population; identified goals and outcomes; and tracking measures to be adjusted accordingly.**

Develop the concept of a tiered approach to the "Mental Health Court" designation, which includes providing support for jurisdictions along a continuum.

Status Update

In addition to the approaches identified directly above, **the Committee recommends that the AOC partner with the National Center for State Courts to evaluate and revise as needed the current Mental Health Court Standards and data collection requirements.** Any jurisdiction or partnership committed to improving the administration of justice for individuals and families living with mental health conditions should be recognized for its value to the community. Therefore, offering a tiered approach or mentorship model, especially for jurisdictions with limited resources, can have a greater impact than requiring courts to adhere to specific standards and data collection requirements in order to be recognized as a program or specialty court. Further, **the Committee recommends that the AOC and NCSC develop the necessary guidelines for developing such courts or coalitions to include an evaluation framework.**

Interim Report Recommendations: Civil (Title 36) and Criminal (Title 13) Statutory and System Improvements

Change the definition of "mental disorder" found in A.R.S. §36-501(25) to include neurological and psychiatric disorders, substance use disorders which co-occur with mental health conditions, along with mental conditions resulting from injury, disease, and cognitive disabilities for the purpose of being eligible to receive mental health services pursuant to Title 36 civil commitment statutes.

Create an "Enhanced Services" program in A.R.S. §36-540 allowing a judge to mandate the provision of specific services for individuals who have shown that they cannot or will

not adhere to treatment and who, as a result, pose a substantial risk of harm to themselves or others, and to require the court to provide hands-on, in-court oversight.

Amend the definition of "persistent or acute disability" (PAD) in A.R.S. §36-501 to identify a substantial probability of causing harm to others as a possible consequence of the condition not being treated. In addition, changes are recommended under A.R.S. §§36-524 and 36-526 to allow screeners and evaluators to immediately hospitalize a person regardless of the category presented if the emergency standard in the statute is met.

Interim Report Recommendations: Title 36 Statutory and System Improvements

Status Update

In its Interim Report, the Committee recommended the above-referenced three specific changes to Title 36.[11] The Arizona Judicial Council directed the AOC and Committee to spend more time during the next year to understand how the three legislative proposals might impact stakeholders in the justice and mental health systems.

In response, the Committee has committed to research, discussion and engagement with several stakeholders from across the judicial, legal, behavioral health, mental health advocacy, peer and family support and disability communities. As a result, it has begun to build partnerships within the justice and mental health communities dedicated to improving the response of the justice and mental health systems to persons with a mental illness. This process has allowed for education between stakeholders and committee members and has fostered critical consensus building on how we can improve the administration of justice for such persons.

One factor has significantly hampered the ability of this Committee to address its charge to assess the impact of its recommendations: a lack of data. It has strived to collect and analyze available data to shows the cost of systemic failures for individuals who routinely interact with the behavioral health and the justice systems. Although anecdotal testimonial evidence provided by families and professionals in the system showed that people are denied access to needed involuntary treatment based on the current language in the definition of mental disorder, the Committee was unable to identify any data to support this conclusion. It is strongly recommended that the AOC, Superior Courts and AHCCCS, along with interested research partners and the state's Health Information Exchange (HIE), Health Current, convene a collective effort to address these data concerns. Doing so will have a lasting impact on our ability to move positive change forward.

Discussion and Details:

Mental Disorder Definition:

The Committee continues to support the recommendation to amend the definition of mental disorder. In its interim report, the Committee proposed language to amend the current statutory definition of "mental disorder."[12] Under that definition, some screeners

[11] See Interim Report, Appendices B-D. LINK.

[12] See Interim Report, Appendix B. LINK.

and evaluators have taken the position that if the person presents as intoxicated, they are screened out of the system because the current definition "distinguishes" mental disorders from substance use disorders. In addition, the mental health treatment system is not meant to be a system for the involuntary treatment of substance use disorders.

Amending the definition of "mental disorder" as proposed will clarify that persons presenting with a substance use disorder are not automatically excluded from consideration of having a mental disorder, which allows mental health intervention to occur at an earlier intercept point and advances our commitment to the Sequential Intercept Model framework.

Although concern regarding increased costs to the system was expressed by some mental health treatment providers and system stakeholders, it was acknowledged that these individuals do end up in the justice system and get passed back to the mental health treatment system; however, they are re-entering the mental health treatment system later, through the "PAD" process.

The current definition of "Mental Disorder" in A.R.S. §36-501 is over 40 years old. **The Committee believes that the Court and its stakeholders must craft a revised definition that will assure that persons living with a mental disorder co-occurring with dementia, traumatic brain injury or intellectual disability can get needed treatment.** But it still must protect individuals' rights, by ensuring people are not subjected to inappropriate, prolonged and unnecessary inpatient treatment. These individuals, when properly evaluated and treated, can respond to psychiatric treatment. Once properly treated, individuals can safely return to their community, which has a positive impact on their lives, their family, and the community overall.

The Committee recommends that, in partnership with members of the legislative and executive branches of the government and staff, a multi-disciplinary team with expertise in psychiatric disorders, neurological conditions, intellectual disabilities, traumatic brain injuries and substance use disorders, be convened to finalize the proposed new definition of mental disorder.

This proposal also seeks to clarify when persons with a mental disorder that co-occurs with a neurological condition, intellectual disability or traumatic brain injury (TBI), should be considered for involuntary mental health treatment. The process for evaluating and treating mental disorders must be thoughtful and inclusive, to ensure that individuals needing evaluation or treatment are provided the opportunity to be evaluated and to receive involuntary mental health treatment where appropriate.

The Committee recognizes the valid concern of the disability advocacy community that including persons with certain co-occurring neurological conditions, such as dementia or TBI, as well as those with an intellectual disability, may result in these persons being inappropriately transferred from or abandoned in the mental health treatment system. In order to alleviate some of the concerns related to court ordered evaluation and treatment (COE/COT), there should be assurances that people have not been court ordered based solely on a neurological, developmental or intellectual disability, and/or a TBI. The fear is that, if the definition of mental disorder is revised as proposed, more

people with these co-occurring conditions will be added to the involuntary mental health treatment system. The result would be significant unreimbursed costs to mental health treatment facilities for inpatient care past the date they can be safely discharged and could subject the person to prolonged unnecessary placement in a facility not equipped to treat the co-occurring condition.

The Committee believes that these concerns can be alleviated through the work of an inclusive, multi-disciplinary team of experts, as noted in the recommendations.[13]

Persons cannot be compliant with court orders to receive treatment if the network of service providers is inadequate. Therefore, attention should also be given to this need statewide, and especially for individuals and families in rural communities. This may be considered through policy or legislative changes to expand the network of screeners, evaluators, and behavioral health service providers.

The Committee recommends counties and AHCCCS, who are responsible for funding and oversight of the court ordered evaluation and treatment process, be required to do the following:

1. Review and revise the screening and evaluation forms to assure that relevant information is provided for meaningful screening and evaluation and the forms are housed in one place that is accessible to all;
2. AHCCCS and counties collaborate to develop and implement metrics and policy for screeners and evaluators;
3. AHCCCS and counties collaborate to develop a training guide that explains the metrics, policy, evaluation and screening requirements;
4. AHCCCS should enact rules, policy and procedure to ensure that the screening and evaluation forms are consistently applied statewide (AHCCCS has the authority and is required under A.R.S. §36-502 to do so); and
5. Training should be required to be completed every 2 years by any individual and entity administering screening and evaluation, with AHCCCS oversight of the training curriculum and participation.
6. Data collection and analysis should be built into the process in a collaborative manner, to assess current needs, monitor effectiveness, and make recommendations for collaborative change.

Enhanced Services Order:

The Committee continues to support the recommendation for statutory change to identify the court's authority to order defined enhanced services for individuals who are identified as not having received consistent, sustained or proper treatment for their mental illness

[13] Of note, the Committee has carefully considered the U.S. Supreme Court decision, *Olmstead v. LC*, based on the Americans with Disabilities Act (ADA). In this landmark decision, the Court held that people with disabilities have a qualified right to receive state funded supports and services in the community, rather than institutions, when the following three-part test is met: (1) The person's treatment professionals determine that community supports are appropriate; (2) The person does not object to living in the community; and (3) The provision of services in the community would be a reasonable accommodation when balanced with other similarly situated individuals with disabilities.

and who continue to be inadequately served, cycling in and out of the criminal justice, probate, and civil mental health screening, evaluation and treatment systems.[14] While existing statutes allow conditional outpatient treatment pursuant to an outpatient treatment plan, they do not go far enough to authorize the court to play a significant role in holding the treatment system – both providers and payors – and the patient accountable. Current outpatient treatment plans are not utilized as an oversight tool or to ensure consistent treatment and continuity of care.

Most people who come into the involuntary mental health treatment system are evaluated, ordered to comply with treatment from a community treatment provider. After complying with the treatment regime, they stabilize and are able to manage their illnesses without continued contact with the involuntary treatment system. However, there is a small percentage of individuals who are chronically non-compliant with the treatment regime and for whom the providers are unable to either prevent non-compliance or to reengage the patient in treatment. These individuals continue to cycle between the justice and mental health treatment systems with considerable impact on them , their families, and the justice and mental health systems. The result is that both systems fail the individual and incur significant unnecessary cost by continuing to do the same thing over and over again while expecting a different outcome. Constructed composite stories that exemplify the need for this recommendation can be found in Appendix B of this report. Likewise, the potential financial costs of extreme chronic offenders can be seen in the 2016 report, *Extreme Chronic Offenders – Maricopa County*.

A substantial amount of testimony from families and professionals in both the justice and mental health systems clearly demonstrated the impact of system failures for people who continuously cycle through both systems. The lack of accessible, relevant, reliable data hampers the ability to assess how the enactment of the proposal on Enhanced Services might impact stakeholders. However, the Committee believes that, when collected, the data will show that current practices have a significant negative impact on individuals, families, communities, and on the justice and mental health systems in the form of unnecessary costs.

Currently, when an individual qualifies for a Court Order for Treatment, a written outpatient treatment plan is submitted for court approval, after which the court orders a mental health treatment agency to administer and oversee treatment. The information gathered by the Committee, however, indicates that outpatient treatment plans submitted to the court are often not specific enough to clearly identify the treatment needs of the patient or to meet the statutorily mandated contents of such plans set forth in ARS §36-540.01. There is no standardization of plans, content used by the court in each county. And, because there is no person or agency mandated to monitor the actions of the treatment agency after the court order is issued, the delivery of services to address the needs of the patient is often inconsistent, untimely and insufficient to maintain the patient's stability and prevent decompensation.

[14] Committee on Mental Health and the Justice System Interim Report and Recommendations, Appendix C, page 28. LINK.

As a result, such individuals repeatedly enter the system, not receive appropriate available treatment, and fail to comply with treatment specified by the provider. After the provider loses contact with the patient, the court order is terminated or elapses without compliance with the treatment plan. We must figure out a different way to assist and support individuals who are stuck in this revolving door and failed by the current systems.

The goal of the Committee in recommending the Enhanced Services proposal is to accomplish the following:

1. Provide criteria for the identification of individuals who have shown that they cannot or will not adhere to treatment.[15]
2. For those individuals identified, provide clear authority for the Superior Court to oversee the creation of a detailed specific outpatient treatment plan to address the individual's need for treatment and supervision and mandate the provision of appropriate available services to the patient, and,
3. Provide the Superior Court with clear authority to exercise the degree of oversight necessary that will ensure that the outpatient treatment provider addresses the patient's treatment needs in a timely and effective manner and to closely monitor the patient's adherence to the treatment prescribed in the Treatment Plan.

For reasons outlined in detail above, the Committee believes that the Enhanced Services proposal is needed; however, it understands the difficulty in creating new statutes. Consequently, it has explored the court's authority under existing statutes to accomplish some of its goals. Although no existing statutes provide specific criteria for identifying those who continue to cycle in and out of the behavioral health and justice systems, **the** *Persistent or Acute Disability and Emergency Hospitalization Standard*:

Arizona statutes allow for a person to be hospitalized in an emergency without prior court approval pursuant to A.R.S. §36-524. Emergency hospitalization is permitted where the evaluation agency finds that during the time necessary for pre-petition screening the person is "likely without immediate hospitalization to suffer serious physical harm or serious physical harm or serious illness or is likely to inflict serious physical harm upon another person." However, this statute only applies to persons considered to be a danger to self or a danger to others and does not apply to someone determined to have a persistent or acute disability (PAD) or who is Gravely Disabled. As justification for the exclusion of PAD from the emergency hospitalization statute, some point to the fact that the current definition of PAD does not include a potential danger to others as the result of the deteriorating mental health disorder and therefore should not be subject to immediate hospitalization without prior court approval.

Currently, when someone is applying for court ordered evaluation using the definition of PAD, the person's condition is viewed as "non-emergent" even if there is a clear indication in the person's history that they have a severe, persistent mental disorder which is deteriorating and that without immediate treatment, the person is likely to inflict physical harm on oneself or others. Persons identified in the screening process as meeting

[15] The language in the proposed statute was modeled from several states' laws authorizing Assisted Outpatient Treatment Orders. See Appendix H.

this PAD standard are put onto the "non-emergent" track of the system requiring a Petition-and-Pick-up process where a Petition for Involuntary Evaluation, sometimes called a "PAD Petition" is filed with the court and the court issues a Detention Order. This Detention Order is delivered to the sheriff and the sheriff has 14 days to detain the proposed patient and deliver them to an evaluation agency. Because these cases are considered as "non-emergent," the pick-up process is sometimes not given high priority by the Sheriff's Office. It is during this hiatus, between screening and pick up for the court ordered evaluation, that poses the greatest risk of harm to the individual and others.

Family members and friends can identify symptoms of the person's deteriorating persistent illness that, even though they have not yet acted to harm themselves or others, suggests imminent danger if not treated immediately. Yet, statutes do not currently allow partners such as law enforcement, or the screeners and evaluators to react quickly to seek immediate help for a person considered to have a persistent or acute disability.

Committee has identified in Appendix K those laws that do provide the court with some authority to exercise more oversight where needed to ensure proper treatment and compliance.

The Committee recommends seeking legislation to amend the definition of persistent or acute disability (PAD) in A.R.S. §36-501 to recognize that causing harm to self or others is one of the possible consequences of not getting treatment for a severe mental disorder that substantially impairs judgment, reason, behavior or capacity to recognize reality. The proposal would also amend A.R.S. §§36-524 and 36-526 by adding the PAD and grave disability categories to the statutes which authorize emergency hospitalization for psychiatric treatment. That would allow screeners and evaluators to immediately hospitalize a person if the emergency standard for hospitalization set forth in statute is met, regardless of which category for involuntary treatment a person fits into.[16]

The Committee also recommends adequate and consistent training and education of clinicians, including hospital physicians and mental health clinicians regarding application of the standard to ensure that the right people are getting evaluated as emergent vs. non-emergent.

Finally, the issue of a lack of data to assist the Committee must again be raised. After review and discussion with stakeholders, there appears to be little consistency or ease in accessing data regarding individuals turned away at the point of emergency hospitalization because they are considered PAD under the current standard. And yet, when we review the AHCCCS data on the number of people receiving Court Ordered Treatment, persons found to meet the PAD standard are clearly the largest subset of the population under COT. Regardless of the availability of relevant data to support this recommendation, the Committee has been struck by anecdotal evidence that this problem does indeed exist from numerous family members who have experienced first-

[16] Committee on Mental Health and the Justice System Interim Report and Recommendations, Appendix D, page 33. LINK.

hand the inability to get emergency help for a decompensating, potentially dangerous, mentally ill family member because they are considered only PAD and therefore non-emergent.

Additional Civil (Title 36) and Criminal (Title 13) Statutory and System Improvements

Serious Mental Illness Evaluation – Recommended Changes

The Serious Mental Illness (SMI) evaluation process presents an opportunity to improve the care and treatment of individuals in need, along with their families and communities, by improving access to treatment.

The AHCCCS Policy Manual, Section 320-P – Services for People with Special Circumstances emphasizes:

> *A critical component of the AHCCCS delivery system is the effective and efficient identification of individuals who have behavioral health needs due to the severity of their behavioral health disorder. One such group is individuals determined to have an SMI. Without receipt of the appropriate care, these individuals are at high risk for further deterioration of their physical and mental condition, increased hospitalizations and potential homelessness and incarceration.*

SMI is a designation and not a clinical diagnosis. SMI is used to identify individuals based on both a qualifying psychiatric clinical diagnosis and significant functional impairment as a result of a person's psychiatric condition. Individuals may then be determined eligible to receive a variety of services provided through a health plan by an array of community-based agencies, including case management, medication management, supported housing, inpatient and outpatient services.

In general, the process flows as follows:

- A request is made for SMI evaluation by an individual or their health care decision maker, by an entity, or is ordered in the court's Order for Evaluation;
- An evaluation is completed by a qualified professional, entity or provider and submitted to Crisis Response Network (CRN); and
- The determination is made by CRN which holds a contract for making all final SMI determinations, statewide.[17]

The SMI evaluation is paid for through the individual's health plan if the person is enrolled in AHCCCS; and, if not enrolled in AHCCCS, costs are borne by the Regional Behavioral Health Authority (RBHA).

Challenges:

Delays in SMI Evaluation – AHCCCS Policy sets forth specific timelines for SMI determinations to be made. Since 2014, timelines have improved, and CRN reports 100% compliance. For persons involved in the involuntary evaluation and treatment process, the Committee has been advised of county and regional variations in implementation of the SMI evaluation process. For example, in Maricopa County, the SMI evaluation occurs

[17] Crisis Response Network Considerations for Referral for SMI Evaluation LINK.

concurrent with the Title 36 involuntary evaluation process without delay, pursuant to specific authorization in the court's order for evaluation, regardless of whether the individual agrees to the evaluation. This process is allowed for in AHCCCS Policy Section 320-P, III (A), (1)(c). On the other hand, Pima County does not initiate an SMI evaluation unless the person or their healthcare decision maker specifically authorizes it. A delay in the SMI evaluation process can significantly affect the timely delivery of services vital to people who receive a court order for treatment.

The Committee recommends that all county stakeholders be educated and encouraged to follow existing AHCCCS policy which permits the SMI determination to proceed as part of the court order for evaluation process, without the consent of the individual.

The AOC should encourage courts to mandate that SMI evaluations and determinations be made concurrent with the court ordered evaluation process, in accordance with AHCCCS policy. This can be accomplished by including in the Order for Evaluation that the SMI evaluation and determination be made. Education is required to ensure judicial officers are aware of this process.

The process also varies if the individual is incarcerated – anyone can request the SMI determination for a person who is incarcerated, but the person can still decline the evaluation. This may extend the determination period another 20 days, which can inadvertently lead to individuals' penetrating deeper into the justice system, experiencing extended confinement and then delaying timely access to necessary mental health services. For example, a person living with mental illness who has been charged with a crime may be eligible for Mental Health Court, which would allow them to be released to treatment under strict probation conditions. However, a condition of eligibility for Mental Health Court is that the defendant have an SMI designation. The defendant may not clearly understand or fully appreciate the importance of an SMI designation and therefore will sometimes decline or delay the evaluation. During this time lag, the individual's condition may deteriorate, and they may present a safety risk to themselves or others.

Two-Pronged Eligibility Test: Qualifying Diagnosis & Functional Impairment – In accordance with AHCCCS Policy, the final determination of SMI requires a two-pronged test: an individual must have both a qualifying SMI diagnosis and a functional impairment resulting from the qualifying diagnosis. Making these diagnostic and functional determinations can be a daunting task even for the most skilled professionals. And because it is or can be so difficult and is not always clear-cut, some people with co-occurring morbidities may not receive an SMI classification, leaving them without some desperately needed services.

The Committee believes that, for persons who are living with a mental disorder and present with co-morbid conditions, such as developmental or intellectual disability, traumatic brain injury, autism, eating disorder or some personality disorders, this two-

pronged test can present an impediment to the SMI evaluation or its timeliness.[18] The Committee was advised that in these situations, people are often denied the SMI designation because a determination is made that the co-occurring disability causes the impairments.[19]

The Committee recommends that AHCCCS more frequently review and revise its schedule of qualifying diagnoses to ensure that it includes all mental disorders which cause significant functional impairment and which are thought to be treatable with psychiatric treatment. This process should include input from front-line professionals involved in the voluntary and involuntary mental health treatment of individuals before the revisions are put out for public comment. In addition, **all persons who conduct SMI evaluations and determinations should be required to receive from AHCCCS the most up-to-date education about the process, procedures and protocols in order to perform accurate, timely SMI evaluations and determinations.**

Information Sharing – The final eligibility determination by Crisis Review Network (CRN) is only as good as the information it receives about the person's current condition, functionality and past history. While SMI applicants, their guardians or their healthcare decision makers may sign releases for CRN to obtain all of the medical records, CRN can also contact the clinician(s) treating SMI applicants and specifically request information on functional impairments. In addition, important relevant information may be found in prior assessments, such as those conducted as part of a criminal court proceeding and Rule 11 competency evaluation. Records kept during a period of incarceration can be extremely helpful. Of importance are records documenting any treatment provided to the person while incarcerated, any symptoms observed and how their behavior or thought process progresses or changes over time, and what medications are provided and how that affects their thinking or behavior.[20] The committee was advised that there is much room for improvement in both the access to and quality of the records provided to CRN for making the SMI determinations.

The Committee recommends that AHCCCS and the Courts look for ways to improve for the public the quality of and access to the justice and public and private health care information made available to CRN to make the SMI determination. This includes access to the individuals themselves, as well as access to records containing information relevant to the qualifying diagnosis and functional impairment. AHCCCS and the Courts should also look for ways to improve the quality, consistency and completeness of the information in the clinical record that CRN receives and to educate those responsible for

[18] If the person being evaluated for SMI does not have a clearly established diagnosis listed in the qualifying diagnosis section of the AHCCCS Manual, they will not meet the first prong of the SMI test. Meeting the second prong of the SMI test can be even more challenging in the determination process. Even where the person with a co-morbid condition can satisfy the qualifying diagnosis prong of the test, the evaluator, and ultimately Crisis Response Network, must determine that the person also has a functional impairment that results from the qualifying diagnosis and not from the co-morbid condition.

[19] Of note, CRN does flag the cases for those individuals who apply for both SMI and DDD and spends more time on them, coordinating with DDD, to ensure some decision on service delivery.

[20] Records include: the evaluation; clinical records that support treatment outcomes, historical information, diagnostic assessment, engagement in treatment; and jail-based records for those who are incarcerated.

creating and keeping these records regarding their importance to the SMI determination process, and to effective service delivery and enhanced public safety.

2020 Title 36 Legislation – Revisited

There were several key pieces of legislation introduced in the 54th Legislature, Second Regular Legislative Session (2020) that relate to changes within the Title 36 system and the justice system overall. These bills were put on hold due to the COVID-19 health crisis. **The Committee recommends that the AOC revisit these proposals, utilizing the Committee's research, findings and recommendations as potential avenues for further refinement and improvement.** These bills included:

- HB 2070 – Prearrest Diversion program
- HB 2146 – Pretrial intervention; monies authorized uses
- HB 2154 – Recidivism Reduction; evidence-based policies; reports
- HB 2316 – Mental Disorder; considerations; involuntary treatment
- HB 2320 – Psychiatric security review board; hearings
- HB 2422 – Coordinated re-entry planning services program
- HB 2414 – Appropriations; alternative prosecution; diversion programs

Support amendments to statute in both Title 13 and Title 36 to address the gap in appropriate levels of service being provided to defendants who are mentally ill and dangerous, are repeatedly found incompetent and not restorable (INR), and who cycle between the criminal justice system and the civil mental health treatment system.

Status Update

During the 54th Legislature, Second Regular Legislative Session (2020), HB 2581 was introduced, with leadership from the Pima County Attorney's Office to address this population. The House Engrossed version can be found here. This bill was put on hold due to the COVID-19 health crisis, and the Committee recommends that the AOC and its stakeholders in behavioral health and the justice system revisit the proposal once the legislature is back in session.

Interim Report Recommendations: Competency Best Practices

Provide courts with a template for guidelines and standardized forms to be used throughout the competency evaluation process by mental health experts in Criminal Rule 11 competency evaluations.[21] The Committee's recommended templates for Court Guidelines and Forms can be found in its Interim Report, Appendices F-G.

Implement additional changes to the AOC training for Mental Health Evaluators.

[21] Under A.R.S. § 13-4501(3)(c), a "mental health expert" must be certified by the court as meeting court developed guidelines using recognized programs or standards. Similarly, Rule 11.3(b), Ariz.R.Crim.P. states a "mental health expert" must be familiar with this state's competency standards and statutes; familiar with the treatment, training and restoration programs that are available in this state; and approved by the court as meeting court developed guidelines.

Status Update

Guidelines and Forms were completed in October 2019 and embedded as a recommendation for courts to adopt in the May 2020 report, COVID-19 Continuity of Court Operations During a Public Health Emergency Workgroup Best Practice Recommendations, as well as in a statewide memo from the AOC Court Services Division Director in May 2020.

The Committee recommends that the AOC and its planning committee for the Legal Competency and Restoration Conference determine how best to communicate these revised guidelines and forms to mental health experts in advance of the next Conference. In addition, the next conference will need to further enhance training on these areas.

With respect to the training and oversight of mental health evaluators' knowledge base, **the Committee recommends an amendment to Rule 11.3a(5)(C) to include "Trained every 3 years" to be overseen by the Administrative Office of the Courts.**

The Committee has finalized Best Practices in Restoration to Competency (RTC) for implementation statewide. During its development of the Best Practices, the Competency workgroup considered reports, feedback, and suggestions from stakeholders when drafting the best practices guide. It found that there are no known models within the United States regarding best practices in RTC. Currently, all counties implement RTC differently and there are no common guidelines or consistency.

The Committee highlights the role of the clinical liaison in the Best Practices guide, noting that the position is currently underutilized, although required in statute, per A.R.S.§13-4501. There are only three known jurisdictions which currently appoint clinical liaisons, and the process and role are different in each jurisdiction. **The Committee recommends implementation of Best Practices in Restoration to Competency, including requiring each Superior Court to have a dedicated clinical liaison position that ensures continuity of care for individuals who encounter the justice system through the Rule 11 process.**

Explore opportunities for creating or expanding a telehealth infrastructure for the courts and other justice system partners to increase access to services for people with mental health conditions who have contact with the criminal justice system.

Status Update

The Competency Workgroup conducted research and discussed the standards and criteria that need to be established for utilizing telehealth in competency evaluations, including use of appropriate language, development of best practices, and ensuring access to the best options to achieve an equal standard of care and administration of justice, particularly in rural communities. See Appendix E for a detailed summary and recommendations.

Due to the COVID-19 pandemic emergency, Arizona's courts have acted to protect the health and safety of the public and court employees, while ensuring constitutional and statutory obligations are met. The pandemic presents an opportunity for Courts to move some hearings and requirements to a virtual platform. Details can be found in the COVID-19 Continuity of Court Operations During a Public Health Emergency Workgroup Best Practice Recommendations.

One example in Arizona where telehealth is utilized in competency proceedings and is working well is Graham County. As a rural community, the County deems it cost prohibitive to transport defendants to another jurisdiction to receive their competency evaluation and restoration to competency program services, or to set up an in-custody program. To ensure access to justice for defendants in these matters, Graham County contracts with a psychologist who conducts the restoration sessions remotely.

As a result of the COVID-19 pandemic, in order to ensure access to justice, other courts have begun to conduct mental health evaluations and restoration to competency sessions remotely.[22] These practices should continue, and teleconferencing for both evaluations and restoration to competency should be authorized statewide.

While a virtual environment is not always ideal, **the Committee recommends utilizing tele-health for mental health evaluations and restoration to competency efforts, with the following practices in place:**

1. Contract language is aligned with national best practices/standards for competency restorations and mental health evaluations and telehealth use is implemented as an alternative under a defined set of circumstances.
2. Access is assured to standards of care and administration of justice, including: time requirements; geographic differences; and the standards/requirements for the person who may be accompanying the defendant in the room during the evaluation.
3. Timely access to medical records is assured for attorneys and evaluators.

Overall, research concludes that conducting telehealth/video conference evaluations does not produce meaningfully different outcomes compared to in-person evaluations. Utilizing telehealth offers jurisdictions located far from providers a more cost effective and safe option compared to transporting forensic psychiatric patients securely and timely. Researchers indicate that telehealth options also present the opportunity to improve procedural justice by increasing access to mental health evaluators with forensic expertise.

Furthermore, the National Center for State Courts Focus Group on Competency Practices concluded that telehealth for competency proceedings is necessary to ensure fair,

[22] Insert link to statewide memo on competency templates/forms, May 2020

effective administration of justice to individuals who do not have effective, appropriate access to evaluators in their communities.

After hearing from experts in the forensic psychiatry and psychology field, **the Committee recommends that the AOC and individual courts review and increase the current fees in mental health experts' contracts.** Doing so will enhance access to mental health experts who may not currently engage with the courts due to the current low rates.

AOC has been involved in discussions regarding the development of a statewide contract for providers to deliver specific teleservices ranging from assessments to treatment, individual to group, evaluations and screenings, group work and education for services. After the establishment of those contracts, each county/court/department under AOC can create its own accounts with service provider(s). The hope is that the more the teleservice providers are utilized, other jails and agencies will enter into their own contracts for their population's needs. **The Committee recommends that this RFQ and future RFPs incorporate the above-noted considerations, specific to mental health and competency evaluation tele-health services related to proper language use, best practices, access to standards of care, and timely access to records.**

Recommend necessary statute, rule or procedural changes that will improve the implementation of A.R.S. §13-4503 (E) and Rule 11.2 for cases involving misdemeanor defendants in limited jurisdiction court competency proceedings.

Status Update

During the 54th Regular Session of the Arizona legislature, a bill was introduced (HB 2232: Competency examinations; records; appointments) to address improvements to the competency evaluation process. The House Engrossed Version of the bill can be found HERE. Specifically, the bill amends language in A.R.S. §13-4505 to decrease, from two to one, the minimum number of mental health experts the court must appoint when grounds exist for a competency examination if the defendant is charged with a misdemeanor. Language in the bill also removes the requirement for parties to provide all available medical and criminal history records to the court within three working days after a motion for an examination of the defendant's competency is filed. The latter change amends language in A.R.S. §13-4503 to conform with Rule 11.2 (b) language changes made in 2018. Due to the COVID-19 pandemic health crisis, the Arizona legislature adjourned in March 2020 before HB 2232 was enacted and signed by the Governor. **The Committee recommends the AOC continue pursuit of these changes when the legislature is back in regular session.**

In addition, the Committee reviewed 2018 changes to Rule 11.5 Ariz.R.Crim.Proc. allowing Limited Jurisdiction Courts (LJC) to handle competency proceedings for misdemeanor defendants. Under current statute and rule, when the misdemeanor defendant is determined to be incompetent and not restorable, the LJC judge does not have authority to order the city prosecutor to file a Petition for Court Ordered Evaluation (COE) under Title 36. Because these misdemeanor defendants are not currently being linked to

ongoing Title 36 services when charges are dismissed by the LJC, defendants are released back into the community without mental health screening or evaluation.

This process is perpetuating the revolving door of individuals with mental illness entering the justice system, is creating a safety issue for the public and the defendant and is creating a risk that the person's mental illness will become worse without treatment. The Committee determined there is no protocol in place to explain the transfer process, and therefore, developed protocol language and templates for the *Order of Transfer* and *Order Accepting Transfer* (See Appendix G). The adopted protocol and orders can be found here.

The Committee recommends that Maricopa County and any other Superior Court with a limited jurisdiction court handling competency proceedings adopt these protocols to provide an efficient mechanism to move a misdemeanor defendant between courts and court divisions in a timely fashion when the originating case is at the LJC level.

Explore the option of eliminating competency evaluations for misdemeanor defendants and providing immediate access to services through other accountability-based mechanisms, such as the Community Court model.

Status Update

The Committee maintains there are great benefits that can be achieved by having immediate access to services for misdemeanor defendants in need of health care, including mental health and substance abuse, and human services, including employment and housing. Such services are often delayed or interrupted by forcing the individual into the Rule 11 process, which also incurs significant additional costs.

Since the onset of the mapping process of the Sequential Intercept Model (SIM), jurisdictions found that many defendants living with mental illness are arrested and charged for minor offenses and spend a disproportionate amount of time waiting in jail – sometimes for months at a time – solely to go through the competency or restoration to competency process. These individuals rarely benefit from lengthy jail time and are assessed to need mental health services. There is a back and forth cycle that takes place at these intercept points between municipal court, Superior Court, the civil treatment system, providers, and even law enforcement. Examples of this can be seen in the composite stories in Appendix B, including those of MK and AP.

Arizona's courts can improve the administration of justice and realize cost savings by preventing the bottleneck from happening during the Rule 11 process in the first place, and instead offering services and supports for individuals living with mental health and co-occurring disorders and linking them to supports that can prevent re-arrest.

Diverting or deflecting these cases away from the criminal justice system has a positive impact on the overall justice system and our communities, both from a standpoint of reduction in costs, and from reduction or elimination of jail time while awaiting a Rule 11

hearing or placement in treatment, while providing opportunities to redirect funding toward community-based treatment and services.

In addition, the Committee has participated with the National Center for State Courts on its recent work to highlight the competency process as part of its national platform to improve the justice system's response to persons living with mental health conditions. Through a focus group, which includes 8 trial court judges, including one from Arizona, the NCSC has submitted additional recommendations for consideration. Much of this work is also incorporated into these Committee recommendations or is already underway in Arizona.

Explore the development of a university-court partnership to provide continuous training and best practices in competency evaluation and methodology for mental health evaluators, judges and other practitioners. This partnership is intended to increase the pipeline of forensic psychiatrists and psychologists and members of the legal community who are educated in current law, methodology and best practices around competency and forensic mental health services.

Status Update

After research and discussion, including with partners in the university community in Arizona and out of state, **the Committee recommends that the Administrative Office of the Courts (AOC) contract with university partners to establish a program and research project among social work, counseling, psychology and criminal justice professionals to develop: future forensic psychological scientists; an evidence-based certification process that will enhance standards of practice and quality control in forensic mental health services; and a training center to disseminate scientific and evidence-based information relevant to forensic mental health, forensic science, and the law.**

This three-tier, best practices partnership includes:[23]

A. Postdoctoral Fellowship: 2-year postdoctoral training program in Forensic Psychological Science to develop future forensic psychological scientists while satisfying training needs in practice. This fellowship will increase the pool of highly-qualified forensic clinicians in Arizona and will help build Arizona's reputation as a desirable place for skilled and well-trained forensic mental health professionals to work.
B. Certification Process: Forge strategic partnership/contract with the Arizona Supreme Court/AOC to develop and manage a new evidence-based certification process for the state that will enhance standards of practice and quality control in forensic mental health services.
C. Training Center: Disseminate scientific and evidence-based information relevant to professional judgments in forensic mental health, forensic science, and the law.

[23] These three states offer best practice implementation of the model: Massachusetts: www.umassmed.edu/psychiatry/law-psychiatry/training-and-education/; Oregon: www.ohsu.edu/school-of-medicine/psychiatry-education-and-training/forensic-psychiatry-fellowship; Virginia: www.ilppp.virginia.edu/

Much of this training can be made available online, and offer professional education credits for mental health professionals, medical professionals, forensic science professionals, and legal professionals.

Finally, it is recommended that, in advance of the next Legal Competency and Restoration Conference, the following components also be pursued by the AOC either on its own or in partnership with a team of subject matter experts, including the university partnership:

- Develop a practice guide for mental health experts of the guidelines and standardized forms to be used throughout the competency evaluation process.
- Communicate these revised guidelines and forms to mental health experts in advance of next Legal Competency and Restoration Conference.
- Incorporate enhanced training in the next Conference, to include enhancing report writing skills.
- Ensure psychiatrists are included in the Conference.
- Amend Rule 11.3a(5)(C) to include "Trained every 3 years" and specific annual review criteria to be overseen by the AOC, such as the development of a quality control mechanism for mental health evaluators through the training process such as inclusion of a written exam and required annual recertification training.

Interim Report Recommendations: Criminal Justice System

Examine changes to allow evidence of a mental disorder as an affirmative defense to a defendant's *mens rea*.

Status Update

After dedicated research and discussion on this issue, the Committee determined that current statute and caselaw do not allow consideration of this defense in a criminal matter. Furthermore, recent decisions by the Arizona Supreme Court (State v. Malone) and the United States Supreme Court (Kahler v. Kansas) support the determination that this issue must be taken up by the Arizona Legislature, and cannot be remedied through the judicial branch:

In State v. Malone, the Arizona Supreme Court upheld a Pima County Superior Court decision that a defendant does not have the right to introduce expert evidence of a character trait for impulsivity to challenge premeditation and also introduce evidence of brain damage to corroborate the existence of that trait. This decision also vacated a Court of Appeals, Division II decision in the matter.

In Kahler v. Kansas, the U.S. Supreme Court upheld a Kansas law allowing consideration of mental status only at the sentencing phase of a trial.

In light of these two recent decisions, the Committee concurs that changes must be made to statute – and cannot be done by the court through rule or other procedure – in order to ensure that a defendant's mental capacity is considered as part of the defense of the criminal act and not solely as a consideration at sentencing. **Furthermore, the Committee encourages advocates to pose this issue with the legislature.**

Support ongoing statewide efforts to address mental health conditions and implement trauma-based care and mental health first aid for youth in schools and for youth who encounter both the child protection and juvenile justice systems.

Status Update

During the 54th Regular Session of the Arizona legislature, the Governor signed HB 1523 or "Jason's Law" (link to chaptered bill can be found HERE). This legislation contains specific provisions for children's behavioral health services. Adding a consistent school-based behavioral health component, counseling, and promoting additional mental health services for children is an excellent opportunity to improve services, system capacity and accountability, and eliminate stigmatization of mental illness. This work and legislation are complementary to the Committee's recommendation that Arizona develop the nation's first SIM for children — with an over-emphasis on intercept 0, which includes this type of school-based behavioral health services. In addition, the legislation requires development of a "Mental Health Parity Committee," which is supported by this Committee, in light of21001 the need for oversight and accountability across the behavioral health system. While the Mental Health Parity Committee will initially focus on health insurance and suicidal ideation, its creation is an opportunity to address broader mental health and substance use challenges in terms of service delivery, capacity and accountability.

In addition, the Committee supports the efforts of the juvenile justice system and schools to train both the workforce and youth directly on Mental Health First Aid.

Finally, **the Committee recommends that Arizona develop a framework for children similar to Stepping Up, utilizing the concept of the Sequential Intercept Model that emphasizes prevention and early involvement in behavioral health services for children and families.**

Encourage court leadership to partner with community stakeholders and explore existing models that offer immediate crisis response assessment and screening, peer support, navigators, and transportation to treatment.

Encourage support for the development of a separate "*X11*" line for people in a mental health crisis and first responders.

Encourage the expansion of "warm lines" with peer support for faster response to those in crisis.

Status Update

The Committee heard from several partners in crisis response, crisis care, and peer support regarding their efforts to connect individuals and families with services to improve access to the behavioral health system before engagement with the justice system is needed or providing more immediate access to options such as emergency hospitalization, when warranted.

Examples for jurisdictions and partners such as AHCCCS and Health Plans to consider providing additional supports for expansion include:

- Yavapai Justice and Mental Health Coalition
- Connections Health Solutions – in both Maricopa and Pima Counties; incorporates a peer transition program to assist people with recovery supports prior to leaving the hospital environment.
- Tucson Police Mental Health Support Team

In late 2019, the U.S. Federal Communications Commission (FCC) approved the 3-digit number 9-8-8 as a mental health crisis and suicide prevention lifeline number. While logistics must be worked out at national and state levels, it is anticipated that the line will be activated in 2021. Anyone calling the 9-8-8 number will be directed to the National Suicide Prevention Lifeline, which is operationalized through local crisis centers. This new line provides necessary resources to potentially avoid law enforcement or first responder involvement, along with enhanced crisis intervention training, supports, and de-stigmatization of mental health conditions.

Through a partnership with the Arizona Foundation for Legal Services and Education, the Committee and AOC included a listing of all of Arizona's crisis help lines, by county, on the azcourtcare.org website.

Other "warm lines" are available across the state, including the Family Involvement Center which offers a phone line to talk to someone who can provide emotional support and offer resources to any parent, especially those who need help parenting a child with emotional or behavioral health challenges; and the National Alliance on Mental Illness (NAMI) which offers peer support and a helpline for both calls and texts. Further, in 2020, the Arizona Crisis Response Network received funding supports to reactivate the call-in number for 211, a community information and referral line that provides critical information to Arizonans in need of community-based supports such as housing, food security, healthcare, employment, as well as domestic violence, human trafficking, mental health and substance use disorders. During the COVID-19 crisis, 211 provided much needed information on both the arizona211.org website and the 211 app.

Encourage the development or expansion of processes to connect people with mental health services when they are released from jail.

Ensure all counties are aware of and utilizing Medicaid suspension while an individual is incarcerated, to provide immediate access to services upon release.

Status Update

Through leadership from AHCCCS and its partnerships with AOC Adult Probation Services, county Probation Departments, and state and county health and human services providers, coordination between health care and the justice system upon release from incarceration has much improved in the past few years. Specifically, *Targeted Investments*, an AHCCCS-funded program, integrates services for individuals with significant mental health needs and serves individuals who are on probation and parole

in one center where they can meet with their probation or parole officer and case managers, and receive support services for physical and behavioral health needs, employment, food security, housing, and forensic peer and family support. Currently, there are 13 Targeted Investment Program (TIP) co-located clinics in Phoenix, Mesa, Glendale, Tucson, Case Grande, Kingman, Camp Verde, and Cottonwood. **The Committee supports and recommends expansion of the TIP clinics to ensure that more individuals, families and probation officers have access to these co-located wraparound services and supports.**[24]

Encourage AHCCCS and the RBHAs to continue to engage with judicial partners statewide, particularly in rural communities and communities that have identified issues with their Title 36 treatment system.

Status Update

Committee members and partners have been working to address specific issues identified for rural communities when accessing the Title 36 system for individuals and families in need of evaluation or involuntary treatment and hospitalization. In part, this is a resource and capacity issue; however, systematic and policy implementation challenges were also identified. For example, while improvements have been made in Coconino County with reinvigorated discussions between the provider and Court, along with Yavapai County's creation of a new Title 36 facility onsite with the Superior Court and County Jail, much work remains to better serve Arizonans in rural communities.

Encourage the development of mandated comprehensive case management services with face to face contact in the community to coordinate treatment for mental health and co-occurring substance use disorders, as well as housing, transportation, and other needs.

Encourage state and local agencies to address the lack of behavioral health treatment bed space statewide by increasing the number of: inpatient, secure beds; community based, secure residential placements; and community based supportive housing, including group homes.

Examine opportunities to address the gaps in Arizona's mental health treatment system, including adequate housing, appropriate levels of care, enhanced case management and oversight, increased community treatment and diversion opportunities, and the

[24] In addition, AHCCCS' Reach-In program requires health plans to reach *in* to individuals who are high health risk prior to release from incarceration and to provide coordinated care upon re-entry. AHCCCS utilizes federal approval to suspend instead of terminate incarcerated member enrollment. In SFY 2018, incarcerated member enrollment was suspended approximately 120,000 times. AHCCCS also reports all state prisons and most counties submit pre-release medical assistance applications (approximately 10,711 in SFY 2018 with an approval rate of over 80%). LINK

discrepancy in access to care between rural and urban communities as well as public and private insurance.

Partner with AHCCCS to compile a list to be updated annually and distributed to the courts and law enforcement agencies of services available statewide through the AHCCCS Health Plans and the eligibility criteria for each service.

Status Update

The Committee recommends the AOC spearhead creating a statewide coordinating body with representation from all three branches of government, the community, and people with lived experiences, that will focus on improving both delivery of mental health services and on data collection and analysis. This body would be responsible for overseeing the collection, analysis and reporting of data and information needed to determine how the mental health treatment system is performing and it interfaces with and impacts others in the community. The collection of appropriate data will provide valid, useful information to all stakeholders to not only assess current needs but also to monitor the effectiveness of any changes made. And the Committee believes that the data should be developed and collected by an independent entity or agency, such as a separate collaborative, community oversight or university partnership, not connected to the payor source,. A goal of the proposed Council should be to determine what services are available to persons in need statewide, what new or additional services are needed, how the services or lack of services impact regions or counties, and how the system for providing services can be improved to make individuals with mental illness healthier and our communities safer.

Request to AHCCCS (Michael L, Dana F, Megan W, Alex D) for their wish to include any status update info to tie back to orange recommendations:

- 2020/21 Whole Person Care Initiative, 1115 waiver and RBHA contract revisions
- Other targeted investment and justice transition work

SECTION V: CONCLUSION

Over the last two years, the Committee has met as a team and with numerous stakeholders and subject matter experts to address its purpose and charges in accordance with Administrative Order 2018-71. The Committee Chair and AOC staff wish to thank the membership for their countless hours and dedication to improve the system and lives of people impacted by mental health conditions.

This report provides both immediate and long-term opportunities for the Court and its partners to address how Arizona can more effectively respond to people with behavioral health needs, including those who encounter the justice system.

The Committee's final recommendation is for the AOC and Arizona Supreme Court to formally create a standing Committee of the Arizona Judicial Council focused on mental health issues across the justice system.

The new Committee should be an umbrella entity for all AOC-related mental health work, including implementation of the Sequential Intercept Model and mental health protocols, partnerships with national entities such as the National Center for State Courts, and additional work related to mental health and the justice system, including that focused on children and youth.

This will ensure the continuity required to fully support jurisdictions and partners, to provide cross-learning opportunities, to identify issues, and to embed best practices promptly.

Quoting the Archbishop Desmond Tutu, we need to both help those who find themselves in the river, as well as find out why they fell in to begin with:

There comes a point where we need to stop just pulling people out of the river.
We need to go upstream and find out why they're falling in.
– Desmond Tutu

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SECTION VII: APPENDICES

A. Committee Membership
B. Individuals Living with Mental Illness in the Justice System: Composite Stories
C. Cross-Jurisdiction Mental Health Data Repository
D. Collaborative Court Models
E. Best Practices Restoration to Competency
F. Telehealth in Competency Matters
G. Order of Transfer Protocol
H. AOT Criteria: State Statutory Language Selection
I. Court-Based Interdisciplinary Partnerships & Systems Improvement
J. Discussion – Children's Mental Health
K. Enhanced Services Order

Appendix A
Committee on Mental Health and the Justice System
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Appendix B
Individuals Living with Mental Illness in the Justice System

OVERVIEW

Nationwide, a disproportionate number of individuals living with mental illness come into contact with the justice system. These individuals and their families experience high contact with law enforcement, courts, jails and corrections.

Due to the impact this disproportionality has on individuals, families, communities, and the system itself, there is a growing understanding of the need both to stop the too-frequent trajectory of individuals living with mental illness entering the criminal justice system, and to find solutions to improve access to the mental health system where individuals and their families can receive proper treatment, services, and supports.

Over the course of its work, the Committee learned the value of individuals' experiences when it comes to understanding the full impact of a disjointed system for helping such individuals and their families. Thus, the following are constructed composite stories, created to provide examples of the complexities faced when the justice system and its stakeholders intersect with individuals living with significant trauma or mental health history. These stories reflect the real-life experiences of individuals who Committee members have intersected with during their lives and careers, and illuminate the legal, clinical, and practical challenges that accompany the treatment of people with mental illness who become involved with the justice system. The Committee recommends that a research-based entity such as a university partner use these composites to develop a records review in order to establish true case studies of individuals living with mental illness who encounter the justice system. Such case studies would illustrate both the personal and financial costs borne by the systems and individuals involved.

Following each individual composite are those Committee recommendations that could serve to help and support individuals and families in such situations.

MK

BACKGROUND

Between 1989 and 2016, MK encountered the Arizona adult court system approximately 72 times spanning Mental Health Court (21), Probate Court (3), Superior Court (14) and Municipal Court (34). While information on her Juvenile history is sealed, MK also had history with both the dependency/child welfare system and juvenile justice system. MK called both California and Arizona home for a period, and there are known encounters with the California justice system as well.

Available public records show that MK first encountered Arizona's adult court system in 1989 at 18 years old, where she was in Mental Health Court. MK was involved in Mental Health court in 9 cases between 1989-1996. In 1997, MK first encountered the criminal justice system for charges of aggravated assault. During that case, MK was held in jail for a probation violation in May 1998, and while awaiting a Rule 11 competency proceeding in September 1998 where she was found competent. There was another probation violation in December 1999, which ultimately remanded MK to prison in March 1999. MK was released from prison in 2000. Her 10th Mental Health court case took place that same year. Between 2000 and 2018, when MK ultimately died in transport, there were a total of 20 municipal court and Superior Court cases for trespassing, solicitation and assault, all dismissed for being found incompetent and not restorable, with continuous orders for Court Ordered Treatment throughout.

EVALUATION OF THE CASE

During MK's time with the adult court system, opportunities were identified to help divert her from the criminal justice system through Guardianship, Court Ordered Evaluation, and Court Ordered Treatment.

There were numerous other entities who interacted with MK beyond the Criminal Court for consideration both from cost perspective as well as the personal impact. Like many individuals living with mental illness who continuously cycle through the justice system without proper oversight and treatment, MK encountered prosecutors, defense counsel, law enforcement, EMT/firefighters, jail, medical providers, psychiatrists, psychologists, educators, social workers, behavioral health case managers, hospitals, housing, transportation.

RECOMMENDATIONS

- Enact new statute authorizing court orders for enhanced services
- Create a mental health division of the Superior Court or authorize judicial officers to cross divisions within the branch
- Expand or create a justice system/behavioral health position available in each court, allowing for coordination of services and supports with AHCCCS and providers for justice-involved individuals with behavioral health needs.
- Implement a repository or locator for courts to access when an individual living with mental health conditions is in multiple courts.

AP[25]

BACKGROUND

AP has lived his entire life in a rural community in Arizona. Since the age of 19, he has cycled in and out of the criminal justice, community treatment and involuntary mental health systems. At 34 years old, AP has been in and out of county jail more than 16 times in a 13-year period and has encountered the justice court 7 times for misdemeanors such as public nuisance and shoplifting, and the Superior Court twice for

[25] Adapted from the Arizona Center for Investigative Reporting, *Sick and Alone*, by Terry Greene Sterling. LINK

felonies related to taking a neighbor's car for a joyride and allegedly stealing an auto part. In both felony cases, AP's charges were dismissed due to mental illness and he was admitted to an inpatient behavioral health facility. AP has been diagnosed as living with schizophrenia and psychosis.

EVALUATION OF THE CASE

In 2006, AP presented with mental health conditions and a danger to self, after repeatedly slamming his head against the door and bars in a law enforcement vehicle. AP was apprehended because he had been reported chasing people up and down the street. After being taken to a small county jail and placed in a restraint chair, AP broke an officer's glasses, and was charged with criminal damage and resisting arrest. AP pled guilty, agreed to pay for the damage, and spent three months in jail, largely because he could not pay his bail. AP could not pay the justice court fines either, and failed to appear in court, which mounted additional fines and fees and a warrant for his arrest to appear.

When in Superior Court in 2008 for charges of knowingly taking unauthorized control over a means of transportation and misdemeanor criminal damage, a Judge ordered a Rule 11 for AP, where he was found to be incompetent and sent to the Arizona State Hospital (ASH) for restoration to competency. During this process, AP received his first diagnosis – schizophrenia, undifferentiated type – which qualified him for SMI services through AHCCCS. After six months, it was determined that AP could not be restored to competency. The charges were dismissed, and AP was to receive future services through an AHCCCS health plan and local provider.

With limited access in his rural community to mental health services or the supports needed, AP's family often drove up to 100 miles across Cochise County or to neighboring Graham County for appointments. While AP was in jail and at ASH, he was given antipsychotic medication. But while living at home, AP often ran out of medication and did not have a consistent case manager to offer supports for employment and continuity of his behavioral health care. He was supported primarily by his brother, who sought treatment for substance use disorder in 2018, and AP was placed in a group home. He left the group home, was living on the streets, and did not comply with the Title 36 court ordered treatment. During this time, AP again encountered the criminal justice system and was arrested on 10 misdemeanor charges associated with shoplifting, disorderly conduct, littering, nuisance, and more. He pled guilty in Justice Court and agreed to pay restitution. He was released from jail to a treatment center in Tucson, where he again left, and was soon charged again in Justice Court, back to a treatment center where he left, and back again in Superior Court due to felony theft charges for stealing an auto part.

This was in late 2019, and AP was again found incompetent to stand trial through the Rule 11 process. Due to the process of waiting to hear the criminal case, awaiting the competency decision, and then ruling on the transfer to involuntary treatment, AP remained in jail for over three months – much longer than the average jail stay of 30 days – and was kept in solitary confinement for 23 hours a day due to the finding of risk of harm to himself or others. Nine months passed between AP's original charges and the final dismissal and most recent Title 36 civil commitment order to a secure inpatient behavioral health facility, where he is currently receiving treatment.

RECOMMENDATIONS

- Provide support for rural communities, including expanded use of tele-health services
- Enact new statute authorizing court orders for enhanced services
- Create a mental health division of the Superior Court or authorize judicial officers to cross divisions within the branch
- Expand or create a justice system/behavioral health position available in each court, allowing for coordination of services and supports with AHCCCS and providers for justice-involved individuals with behavioral health needs.

- Implement a repository or locator for courts to access when an individual living with mental health conditions is in multiple courts.
- Support legislation introduced that will improve the implementation of A.R.S. §13-4503 (E) and Rule 11.2 for cases involving misdemeanor defendants in limited jurisdiction court competency proceedings.
- Adopt protocols in Superior Courts with a corresponding LJC handling competency proceedings to provide a clear and workable mechanism to move a misdemeanor defendant between criminal and civil court in a timely fashion when the originating case is at the LJC level.

LM

BACKGROUND

LM's parents both used alcohol in excess during his early childhood and domestic violence was common in the home. By age five, he had been removed from his parents' care and placed in foster care. At age nine, he had his first encounter with the juvenile delinquency system. Prior to turning 18, LM spent time in foster care placements both outside of Arizona and on tribal lands. His initial use of alcohol and marijuana occurred at the age of 10. He was also sexually victimized during his childhood. As an adult, LM has struggled with both alcohol and methamphetamine use disorders. In his mid-twenties, he was diagnosed with schizophrenia.

LM entered the adult felony criminal justice system in Arizona at the age of 20. In total, between 2002 and 2019, he was charged in eight separate felony cases and countless misdemeanor cases. Early into his entry into the adult felony court system, his psychiatric symptoms were still emerging and were not fully recognized by the criminal justice system. For his first three felony offenses, LM participated in probation supervision, including a felony drug court program. Eventually, his probation was revoked, and he was sentenced to the Arizona Department of Corrections (DOC[26]) for a period of 1.5 years.

Following his release from DOC, LM entered the Title 36 system for the first time. In total, between 2009 and 2019, he had seven separate petitions for court ordered evaluation filed. Ultimately, LM was only court ordered to participate in treatment twice. All other involuntary mental health treatment cases were dismissed. Records indicate that these dismissals were the result of LM volunteering to participate in treatment or the evaluating agency finding insufficient evidence to pursue court ordered treatment. Following his release from DOC, LM also quickly reentered the felony criminal justice system.

For several new felony cases following his release from DOC, LM was placed on probation and ordered to participate in felony mental health court. During his participation in felony mental health court, LM struggled to adhere to his medication recommendations, was admitted to the local psychiatric acute care unit on numerous occasions, was homeless for vast periods of time, relapsed with alcohol and methamphetamines, and went through felony probation revocation court three times. Eventually, due to the efforts of a skillful case manager, LM was placed in a behavioral health group home and was administered antipsychotic medication via injection. Although LM's psychiatric symptoms improved due to his placement in the group home and his receipt of medication via injection, he never achieved insight into his alcohol and methamphetamine use disorders or his need for antipsychotic medication. LM never thrived in mental health court. His participation in the program ended when his probationary term expired.

Since the expiration of his felony mental health probationary term, LM has reentered the both the felony criminal justice and Tile 36 systems on several occasions. In 2019, LM was found not competent and not restorable. This was a significant change in LM's legal situation, as through previous Rule 11 evaluations,

[26] In 2020, the name of the Arizona Department of Corrections was changed to Arizona Department of Corrections, Rehabilitation and Reentry.

he had been determined to be competent or not competent but restorable. Currently, LM is court ordered to participate in treatment.

EVALUATION OF THE CASE

Aside from his time in a behavioral health group home and a very brief time during which he had an apartment, LM has been homeless for nearly all his adult life. LM completely lacks any appropriate family support.

During many of the years when LM was entering and quickly leaving the Title 36 system, the local involuntary mental health system was not fully functional. Additionally, Title 14 guardianship has never been pursued, and the more intensive, focused ACT services have never been implemented.

RECOMMENDATIONS

- Develop a Sequential Intercept Model through a child-focused lens that emphasizes prevention and early involvement in behavioral health services for children and families.
- Provide better support for services in rural communities, including expanded use of tele-health services, and fully functioning wraparound services including peer supports, case management.
- Enact new statute authorizing court orders for enhanced services.
- Encourage and support the development of court-based models that provide immediate access to services for misdemeanor defendants in need of health care and human services, including mental health and substance abuse, employment and housing.
- Require and fund each Court to have a dedicated clinical liaison position per A.R.S.§13-4501 to ensure continuity of care for individuals living with mental illness who encounter the justice system through the Rule 11, Title 36 and Title 14 processes.
- Develop a framework for judges and court staff to receive education in new judge or employee orientation, as well as across the career span in the areas of understanding trauma, behavioral health, crisis response, and an awareness of existing judicial oversight mechanisms for people with mental health conditions.

JS

BACKGROUND

JS struggled with addiction for most of his life. After a traumatic childhood experience and death of a caregiver during his teen years, he turned to drugs and alcohol. While functioning as an addict with a job, a marriage and a child, the addiction was ever present, and JS's marriage eventually ended, and he lost custody of his child. Left alone, JS fell deeper into drugs, spending time in and out of police cars and jail when not homeless. Over time, JS began to experience psychosis and it was so intense that suicide felt like the only option. After surviving several suicide attempts, JS eventually was taken into a hospital treatment setting where he received treatment and medication but was not provided with a connection or supports following his release. JS was transported to a homeless shelter without access to treatment, and he again turned to drugs. JS was eventually arrested and booked into jail for drug possession and public nuisance.

During a six-month jail sentence, JS was diagnosed with bi-polar disorder and post-traumatic stress disorder. He was given medication and released at 1am. Upon release, JS faced a new community, and the re-entry process with expectations to meet with a probation officer, navigate treatment and medication, very little money, and no one to call for support.

EVALUATION OF THE CASE

Fortunately, JS's story did not end on the side of the road after being transported from jail to a halfway home. JS's probation officer was stationed at one of Arizona's 13 co-located health/probation clinics (also known as the Targeted Investment Program or TIP), which offers wraparound supports, including a peer support advocate with lived experience in both the behavioral health and criminal justice systems who provided JS with navigation for services, and increased accountability through both the behavioral health provider and probation officer. JS's story illuminates the fact that recovery is possible and points to the capacity of our communities, justice and behavioral health systems to work together to accomplish mutual goals of recovery and preventing recidivism.

RECOMMENDATIONS

- Fully explore the use of peer navigators in court.
- Expand TIP clinics to ensure that more individuals, families and probation officers have access to these co-located wraparound services and supports.

C.

BACKGROUND

C. became involved with the juvenile justice system at age 11, when he was arrested for bringing a knife to school and threatening a teacher. At age 13, he was charged with assaulting his adoptive mother by placing her in a headlock and threatening to slam her head into the wall to kill her.

Shortly after that, DCS took custody of C., based on allegations that his adoptive mother had physically abused him by hitting him and placing him in a choke hold, and that she had failed to protect him from physical abuse by his biological father. C.'s adoptive mother also failed to ensure that C. was engaged in services to address his PTSD and mental health issues, which she said had been ongoing since he was 10 years old. C.'s biological parents' rights had previously been terminated, and his father was sentenced to prison for the attempted murder of C's biological mother.

On the same day that DCS filed a dependency petition, C. was charged with aggravated assault with a deadly weapon for attempting to strangle an employee of his group home with a rope. A few months later, while C. was in a behavioral health hospital, he was charged with aggravated assault on another child.

EVALUATION OF THE CASE

C. was committed to ADJC in 2017. In 2018, he was charged with assault for hitting another ADJC youth in the head and neck with a rock while at Adobe Mountain School. Less than a month later, he was direct filed into adult court, charged with introducing a weapon into a secure facility. He had taken a slat from an air conditioner vent, sharpened it into a shank, and made a plan to use it to stab a correctional officer in the neck. He was sentenced to 3 years of adult probation, scheduled to begin upon release from Adobe Mountain School. However, he never completed the treatment necessary to earn his release. A year later, he was arrested for possessing two metal shanks in his room at Adobe Mountain School. That case was also direct filed into adult court, along with a subsequent charge for aggravated assault of a correctional officer.

The youth, at age 16, accepted a plea offer for 3 years in prison. He is now incarcerated in the minors' unit at the Arizona Department of Corrections. He will age out of foster care while in prison.

D.

BACKGROUND

D. first entered DCS custody at age 8. His biological mother had placed him with a relative when he was 3 days old, and that relative decided to terminate the guardianship. His mother made no effort to resume parenting or find an appropriate placement for him, which led to the need for DCS involvement. D. was placed in foster care.

Approximately 6 months later, D. was arrested for arson of an occupied structure. He had rolled up several papers in a bedroom and lit them on fire with a lighter, telling a peer that he was going to set his bedroom on fire. The case was dismissed because D. was found to be incompetent. A few months later, the youth was charged with assault for attacking a peer in his group home, using a homemade weapon with a thumb tack on the end. This case was also dismissed due to D. being found incompetent. At age 13, D. was charged with sexually assaulting a 4-year-old relative in the family placement where he was staying. He was placed in detention and entered competency restoration proceedings. While in detention, due to his behavior, he had no contact with his peers; only staff. He assaulted a detention officer by punching him in the face. D. remained in restoration proceedings for 7 months. In the meantime, DCS and probation attempted to secure a behavioral health placement for D., but he was denied by all possible placements. He was restored to competency just before his 14th birthday, and a month later, was committed to ADJC.

EVALUATION OF THE CASE

Within a 2-month period of time at ADJC, he had assaulted 10 different correctional officers, resulting in 14 new charges in juvenile court. He was direct filed into adult court after throwing a large rock at an officer's head. The officer raised his arm to protect his face and suffered an injury to his arm.

In adult court, D. entered competency proceedings again and was found incompetent. He entered restoration and was restored to competency. He is currently awaiting a hearing to determine whether the case will be transferred back to juvenile court. Unless D. is sentenced to prison on the adult charge, which is highly unlikely, he will return to Adobe Mountain School to complete his treatment. ADJC, DCS, and the youth's attorney are working to identify possible alternative placements that could better meet his mental health needs and propensity for violence.

RECOMMENDATIONS FOR C. AND D.

- Revisit the Recommendations submitted by the Arizona Supreme Court Task Force on Crossover Youth Data and Information Sharing.
- Develop a framework for judges and court staff to receive education in new judge or employee orientation, as well as across the career span in the areas of understanding trauma, behavioral health, crisis response, and an awareness of existing judicial oversight mechanisms for people with mental health conditions.
- Develop a framework for children, similar to *Stepping Up*, utilizing the concept of the Sequential Intercept Model through a child-focused lens that emphasizes prevention and early involvement in behavioral health services for children and families.
- Establish a statewide coordinating body with representation from all three branches of government, the community, and people with lived experiences, focused on improving the delivery of mental health services, data collection and analysis.

Appendix C
Cross-Jurisdiction Mental Health Data Repository

INTRODUCTION

In its Interim Report and Recommendations (October 2019), the Committee on Mental Health and the Justice System recommended the creation of a workgroup to analyze and make recommendations to improve processes and coordination among courts handling Title 13, Title 36 or Title 14 proceedings involving a single individual. A component of this recommendation is for the Administrative Office of the Courts (AOC) to build a mechanism for judges and attorneys involved in Rule 11, Title 36 or Title 14 proceedings to access remotely the basic information on a defendant's involvement in other mental health proceedings, including current location, findings, or pending proceedings in another court.

Currently, there is no way for an attorney or judge to know which court contains records for an individual involved in a Rule 11 case. The Committee's consensus is that it is very helpful to know when a Rule 11, Title 36 or Title 14 matter exists – both past and current – before another court or entity initiates a new filing or a finding that may be contradictory to other pending matters. This knowledge also impacts a Rule 11 proceeding or a subsequent Petition. It may not be necessary to have the minute entries, but the knowledge of a prior or current Rule 11, Title 36 or 14 would be helpful to: (1) avoid duplication; and (2) coordinate with a current Title 36, 14 or Rule 11 process, assuming court orders are in place already.

The data repository will include the basic information needed for the attorney, having received an order from a court, to properly secure the release of the records from the correct court. This document will provide what information the data repository can display but will not include the technical details of how the requirements will be implemented. The AOC IT Division has engaged in discussions with Committee members and is well positioned to begin implementation of this case repository, in conjunction with subject matter experts identified by the Committee.

REQUIREMENTS

All Arizona courts must be responsible for the supply of the following Rule 11 information for the data repository:

a. The defendant's first middle and last name.
b. The defendant's date of birth.
c. Any Rule 11 Case Numbers associated to the defendant.
d. Court name where the Rule 11 case(s) took place.
e. Charge Description of all charges associated to the Rule 11 case (Optional).
f. All Type of Rule 11 Reports associated to the case (Optional).
g. All Rule 11 Findings for the defendant's evaluation: Competent; Incompetent (Restorable); Incompetent (Non-restorable)
h. Any current or pending Title 14 Guardianships for the defendant.
i. Any current or pending civil commitment orders for evaluation or treatment for the defendant.
j. Date of each Finding.
k. Outcome for the Rule 11 Case (Optional).

This data repository will not include medical reports or other case documents.

The Attorney and/or court will still be responsible for requesting the release of the records.

Appendix D
Collaborative Court Model Examples

MESA MUNICIPAL COURT – COMMUNITY COURT

Mesa Community Court serves chronic justice system offenders who commit low level crimes, fail to comply with court orders, or who fail to appear for Court. These offenders can be more effectively rehabilitated through alternative strategies. The Mesa Community Court is intended to provide a combined response of services needed by the defendant, and a mitigation of sanctions based on the progress of the defendant. The Mesa Community Court has broad based eligibility and is not offense specific. In other words, any recognition by law enforcement, prosecutors, defense attorneys, or judges of underlying social problems as primary contributors to the offense may refer the case to Community Court. The Court will operate a special docket to isolate these cases so the defendant can be connected to appropriate resources. At the time of arraignment, the defendant's first court appearance, the case may be deferred to allow time for evaluating the defendant's circumstances and coordinating appropriate services. As defendants engage in communicating with their services, the prosecutor will consider a possible dismissal based on each case's circumstances and progress.

MARICOPA COUNTY HOMELESS COURT

The Maricopa County Regional Homeless Court (MCRHC) helps homeless individuals resolve outstanding minor misdemeanor, victimless offenses and warrants in order to remove barriers to ending their homelessness. MCRHC has the ability to take cases from any limited jurisdiction court within Maricopa County, where cases are essentially transferred to MCRHC from other courts. The MCRHC is designed to help individuals address underlying issues that may keep them from getting a driver's license, getting and keeping a job and living without homelessness. The individual works with the Court and community providers, and actively commits to ending their own experience living with homelessness, while resolving outstanding fines and fees through community restitution or other agreed-upon programs.

PAYSON MAGISTRATE RESTORATIVE COURT

In 2018, a collaborative effort of the Town of Payson, Payson Magistrate Court, and Payson Police Department began a restorative court to serve individuals living with a serious mental illness and or substance abuse condition who have accessed the crisis or mental health system and are pending criminal charges. The model utilizes a multi-disciplinary team to staff current mental health cases on a court calendar once per week or as determined by the counseling agency. Collectively, the team decides on a treatment plan that provides wrap-around services, treatment, and interventions to stabilize, monitor, and engage individuals in the program. The ultimate goals are to reduce recidivism and police contact, and provide resources to prevent barriers to recovery, including housing, clothing, food, and integrated care. The program has had a positive impact, with nearly all experiencing stability with their treatment programs and no new law enforcement contact.

PIMA COUNTY CONSOLIDATED JUSTICE COURT

Request for information from PCCJC

YAVAPAI COUNTY JUSTICE AND MENTAL HEALTH COALITION

Through a highly collaborative community partnership, the Yavapai County Sheriff's Office leads the coalition that focuses on early identification of individuals with mental and substance use disorders allows proper coordination of care and treatment. Its premiere program, the Reach Out Initiative, includes a team

of stakeholders that cross over multiple systems, including mental health, substance use, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, family members and many others. The goal is to improve cross-system collaborations to reduce involvement in the justice system by people with mental and substance use disorders. The Sequential Intercept Model is an evidence-based tool used to achieve this goal.

PHOENIX MUNICIPAL COURT VETERANS COURT

The Municipal Court, Prosecutor's Office, Public Defender's Office, and Phoenix Veterans Administration (VA) partner together on cases involving veterans who served in the United States Armed Forces who are experiencing treatable behavioral issues such as post-traumatic stress (PTS), traumatic brain injury (TBI), anger management, domestic violence, or substance and alcohol abuse. All veterans are eligible to participate, unless the Veterans Court Team determines that the case is not appropriate due to the seriousness of offense, or prior criminal history that would negatively impact public history. Through multiple system partners and services, the Court works to address substance abuse treatment, assess and engage an individual for unmet mental health needs, medical concerns, benefits, housing and other psychosocial factors. Participants who do not qualify for VA or Medicaid benefits, or are financially unable to obtain treatment/service on their own receives services through La Frontera/EMPACT via a grant from SAMHSA (Substance Abuse and Mental Health Services).

Mohave Veterans Court? Graham Wellness Court? Yuma MHC?

Appendix E

Developing Best Practices in Restoration to Competency Programs

OVERVIEW

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

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

Arizona is one of the first states in the country to develop such a Best Practices Guide. The workgroup has invited many subject matter experts to review its proposal including practitioners, mental health experts, and treatment and correctional health staff professionals from the psychology and psychiatry community. As our knowledge and awareness of these practices improves and changes, this Guide will be reviewed for needed updates.

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

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

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

Please click HERE for the full Best Practices content:
(1) RTC Flowchart
(2) Qualifications
(3) Duties
(4) RTC Program Instructions
(5) Sub-Appendices with Additional Resources

Appendix F
Telehealth Infrastructure for Rule 11-Competency Proceedings

In its 2019 interim report and recommendations, the Committee on Mental Health and the Justice System recommended that the AOC and individual Courts "Explore opportunities for creating or expanding a telehealth infrastructure for the courts and other justice system partners to increase access to services for people with mental health conditions who have contact with the criminal justice system, including:

a. Provide a telehealth option for competency evaluations.
b. Evaluate the feasibility of the use of telehealth for mental health assessments in jails; crisis consultations for law enforcement; crisis response for people who have encounters with law enforcement; probation mental health services; and, jail mental health services.

The Committee's Competency workgroup has conducted research and discussed the standards and criteria that need to be established for these specific evaluations, including language, development of best practices, and how to ensure access to the best options to achieve an equal standard of care and administration of justice, particularly in rural communities.

Overall, the research concludes that conducting videoconference evaluations does not produce meaningful different outcomes compared to in-person evaluations. Furthermore, utilizing video conferencing offers jurisdictions who are located far from providers a more cost effective and safe option compared to transporting forensic psychiatric patients securely and timely. Researchers indicate that the telehealth options also present the opportunity to improve the procedural justice of examinations by increasing access to mental health evaluators with forensic expertise.

Furthermore, the National Center for State Courts formed a Focus Group this year centered around Competency Practices. This work has also concluded that telehealth for competency proceedings is necessary to ensure administration of justice to individuals, particularly in rural areas that do not have access to evaluators in their communities, as well as for larger jurisdictions with a high number of defendants/patients but a low number of evaluators.

Due to the COVID-19 pandemic emergency, Arizona's courts have acted to protect the health and safety of the public and court employees, while ensuring constitutional and statutory obligations are met. The pandemic presents an opportunity for Courts to move some hearings and requirements to a virtual platform. While a virtual environment is not always ideal in all mental health related court proceedings, the Competency workgroup maintains that utilizing tele-health for mental health evaluations and restoration to competency education are a recommended practice for the Courts, provided the defendant is given access to technology and the following practices are in place:

- Language is aligned with national best practices/standards for competency and mental health evaluations and implemented as an alternative to in-person examinations under a defined set of circumstances.
- Access to standards of care and administration of justice, including: time requirements; geographic differences; and the standards/requirements for the person who may be accompanying the defendant in the room during the evaluation.
- Timely access to medical records for attorneys and evaluators.

One example in Arizona where this is already in place and working well is Graham County. As a rural community, it is cost prohibitive for the County to transport defendants to another jurisdiction – out of

County – to receive their competency evaluation and restoration to competency education, or to set up an in-custody program. To ensure access to justice for defendants in these matters, Graham County contracts with a psychologist who conducts the restoration sessions remotely.

As a result of the COVID-19 pandemic, in order to ensure access to justice, other courts have begun to conduct mental health evaluations remotely. The workgroup recommends that these practices continue, and that teleconferencing for both mental health evaluations and restoration to competency be authorized as a statewide practice.

In order to implement these practices, the workgroup strongly encourages the AOC and courts take action on the following:

- Embed the revised guidelines and templates/forms for mental health evaluators into practice;
- Adopt the recommended best practices for restoration to competency into practice;
- Communicate the revised guidelines, templates/forms and best practices to all current practitioners/mental health evaluators; and
- Create an intermediary, required training for practitioners in advance of the next Legal Competency and Restoration Conference.[27]

After hearing from experts in the forensic psychiatry and psychology field who are currently practicing today, the workgroup also recommends that the AOC and courts reconsider the current rates of the mental health experts' contracts. Doing so will enhance access to mental health experts who may not currently engage with the courts due to the current low rates.

In addition, Workgroup members and AOC staff have been involved in discussions with the AOC Adult and Juvenile Probation Services Division regarding the development of a Teleservice Request for Quotation (RFQ) for providers contracted with the AOC to deliver specific teleservices ranging from assessments to treatment, individual to group, evaluations and screenings, group work and education for services particular to mental health, family counseling, DUI/SUD, sex offender counseling, crisis intervention, and more. After the establishment of those contracts, each county/court/department under AOC can create their own accounts with the chosen service provider(s) for payment. The hope is that the more the teleservice providers are utilized, other jails and agencies will enter into their own contracts for their population's needs. The Competency workgroup recommends that this RFQ and future RFP incorporate the above noted considerations, specific to mental health and competency evaluation tele-health services related to language, best practices, access to standards of care, and timely access to records.

[27] Please see Recommendations on Practice Improvement: University Partnership for further enhancements to the training and education for mental health evaluators.

Resources:

- American Psychological Association:
  - Medicare and Medicaid's expanded telehealth coverage and more. Link: www.apaservices.org/practice/reimbursement/government/medicare-updates-covid-19
  - Neuropsychology via telehealth: Guidance on CPT codes, technical requirements and more. Link: www.apaservices.org/practice/reimbursement/health-codes/testing/teleneuropsychology-resources
  - New APA COVID-19 tele-assessment principles. Link: www.apaservices.org/practice/reimbursement/health-codes/testing/tele-assessment-covid-19
- Epstein Becker Green. 50 State Survey of Telemental/Telebehavioral Health (2017). Link: www.ebglaw.com/content/uploads/2017/10/EPSTEIN-BECKER-GREEN-2017-APPENDIX-50-STATE-TELEMENTAL-HEALTH-SURVEY.pdf
- National Center for State Courts:
  - *Lights, Camera, Motion! - A timely primer on how to implement remote judicial hearings*. Webinar, April 7, 2020.
  - *State Court Judges Embrace Virtual Hearings as Part of the New Normal*. Link: ncsc.org/Newsroom/Public-health-emergency/Stories/Videoconferencing.aspx
- Professional Psychology Research and Practices. Luxton and Lexcen. *Forensic Competency Evaluations via Videoconferencing: A Feasibility Review and Best Practice* Recommendations. 2018.
- Psychiatric Services. Luxton et al. *Use of video conferencing for psychiatric and forensic evaluations*. 2006.
- Psychology, Crime and Law. Batastini, Pike, Thoen, Jones, Davis and Escalera. *Perceptions and use of videoconferencing in forensic mental health assessments: A survey of evaluators and legal personnel*. 2019. Link: doi.org/10.1080/1068316X.2019.1708355.
- Telemedicine and E-health. *Implementation and Evaluation of Videoconferencing for Forensic Competency Evaluation*. Link: www.liebertpub.com/doi/abs/10.1089/tmj.2019.0150.
- The Telemedicine and Teleconsultation System Application in Clinical Medicine. Link: ieeexplore.ieee.org/document/1403953.

Appendix G
Order of Transfer Protocol

The Committee on Mental Health and the Justice System was tasked to develop protocol for Limited Jurisdiction Court (LJC) judges to transfer a case where the defendant has been found incompetent and not restorable to Superior Court, as allowed under A.R.S. §13-4517 (Rule 11.5). This protocol was developed in partnership with the Maricopa County Superior Court, Maricopa County Attorney's Office, judicial officers and court administrators from municipal courts with expertise in handling Rule 11 matters – Phoenix Municipal Court, Glendale City Court and Mesa Municipal Court, as well as the Maricopa County AHCCCS Complete Care (ACC)/Regional Behavioral Health Authority (RBHA) provider, Mercy Care.

This team of local and statewide experts has developed a clear, workable mechanism to move a misdemeanor defendant between criminal and civil court in a timely fashion when the originating case is at the LJC level, including:

(1) Transfer Protocol
(2) Order of Transfer from LJ to Superior Court and Order Accepting Transfer

Maricopa County Superior Court has taken the lead to implement this protocol and process as an extension of being the only current Superior court with municipal courts conducting Rule 11 proceedings. It is further recommended that other Superior Courts adopt this protocol and process, so it is in place when municipal courts within the county begin to handle Rule 11 matters. The adopted protocol and orders can be found here.

Appendix H
AOT Criteria: State Statutory Language Selection

California:* *Available only in counties that have "opted in" by Board of Supervisors action; otherwise outpatient commitment only permitted via conservatorship process.*

Criteria:
CALIF. WELF. & INST. CODE § 5346(a). In any county in which services are available …, a court may order a person who is the subject of a petition filed pursuant to this section to obtain assisted outpatient treatment if the court finds, by clear and convincing evidence, that the facts stated in the verified petition filed in accordance with this section are true and establish that all of the requisite criteria set forth in this section are met, including, but not limited to, each of the following:
(1) The person is 18 years of age or older.
(2) The person is suffering from a mental illness[.]
(3) There has been a clinical determination that the person is unlikely to survive safely in the community without supervision.
(4) The person has a history of lack of compliance with treatment for his or her mental illness, in that at least one of the following is true:
(A) The person's mental illness has, at least twice within the last 36 months, been a substantial factor in necessitating hospitalization, or receipt of services in a forensic or other mental health unit of a state correctional facility or local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition.
(B) The person's mental illness has resulted in one or more acts of serious and violent behavior toward himself or herself or another, or threats, or attempts to cause serious physical harm to himself or herself or another within the last 48 months, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition.
(5) The person has been offered an opportunity to participate in a treatment plan by the director of the local mental health department, or his or her designee, provided the treatment plan includes [comprehensive services], and the person continues to fail to engage in treatment.
(6) The person's condition is substantially deteriorating.
(7) Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure the person's recovery and stability.
(8) In view of the person's treatment history and current behavior, the person is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to himself or herself, or to others[.]
(9) It is likely that the person will benefit from assisted outpatient treatment.

Louisiana:

LA. REV. STAT. ANN. § 28:66 (A) A patient may be ordered to obtain civil involuntary outpatient treatment if the court finds that all of the following conditions apply:
(1) The patient is 18 years of age or older.
(2) The patient is suffering from a mental illness.
(3) The patient is unlikely to survive safely in the community without supervision, based on a clinical determination.
(4) The patient has a history of lack of compliance with treatment for mental illness that has resulted in either of the following:
(a) At least twice within the last thirty-six months, the lack of compliance with treatment for mental illness has been a significant factor resulting in an emergency certificate for

hospitalization, or receipt of services in a forensic or other mental health unit of a correctional facility or a local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition.
(b) One or more acts of serious violent behavior toward self or others or threats of, or attempts of, serious physical harm to self or others within the last thirty-six months as a result of mental illness, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition.
(5) The patient is, as a result of his mental illness, unlikely to voluntarily participate in the recommended treatment pursuant to the treatment plan.
(6) In view of the treatment history and current behavior of the patient, the patient is in need of involuntary outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in the patient becoming dangerous to self or others or gravely disabled as defined in R.S. 28:2.
(7) It is likely that the patient will benefit from involuntary outpatient treatment.

Michigan:

MICH. COMP. LAWS § 330.1401(1).

(d) An individual who has mental illness, whose understanding of the need for treatment is impaired to the point that he or she is unlikely to voluntarily participate in or adhere to treatment that has been determined necessary to prevent a relapse or harmful deterioration of his or her condition, and whose noncompliance with treatment has been a factor in the individual's placement in a psychiatric hospital, prison, or jail at least 2 times within the last 48 months or whose noncompliance with treatment has been a factor in the individual's committing 1 or more acts, attempts, or threats of serious violent behavior within the last 48 months. An individual under this subdivision is only eligible to receive assisted outpatient treatment.

New Mexico:

Available only in jurisdictions that have "opted in" with a memorandum of understanding between the jurisdiction and the local district court.
N.M. STAT. ANN. § 43-1B-3. A person may be ordered to participate in assisted outpatient treatment if the court finds by clear and convincing evidence that the person:
A. is eighteen years of age or older and is a resident of a participating municipality or county;
B. has a primary diagnosis of a mental disorder;
C. has demonstrated a history of lack of compliance with treatment for a mental disorder that has:
(1) at least twice within the last forty-eight months, been a significant factor in necessitating hospitalization or necessitating receipt of services in a forensic or other mental health unit or a jail, prison or detention center; provided that the forty-eight-month period shall be extended by the length of any hospitalization, incarceration or detention of the person that occurred within the forty-eight-month period;
(2) resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last forty-eight months; provided that the forty-eight-month period shall be extended by the length of any hospitalization, incarceration or detention of the person that occurred within the fortyeight-month period; or
(3) resulted in the person being hospitalized, incarcerated or detained for six months or more and the person is to be discharged or released within the next thirty days or was discharged or released within the past sixty days;
D. is unwilling or unlikely, as a result of a mental disorder, to participate voluntarily in outpatient

treatment that would enable the person to live safely in the community without court supervision;
E. is in need of assisted outpatient treatment as the least restrictive appropriate alternative to prevent a relapse or deterioration likely to result in serious harm to self or likely to result in serious harm to others; and
F. will likely benefit from, and the person's best interests will be served by, receiving assisted outpatient treatment.

New York:

N.Y. MENTAL HYG. LAW § 9.60(c). A person may be ordered to receive assisted outpatient treatment if the court finds that such person:
(1) is eighteen years of age or older; and
(2) is suffering from a mental illness; and
(3) is unlikely to survive safely in the community without supervision, based on a clinical determination; and
(4) has a history of lack of compliance with treatment for mental illness that has:
(i) prior to the filing of the petition, at least twice within the last thirty-six months been a significant factor in necessitating hospitalization in a hospital, or receipt of services in a forensic or other mental health unit of a correctional facility, not including any current period, or period ending within the last six months, in which the person was or is hospitalized or incarcerated; or
(ii) prior to the filing of the petition, resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last forty-eight months, not including any period, or period ending within the last six months, in which the person was or is hospitalized or incarcerated; and
(5) is, as a result of his or her mental illness, unlikely to voluntarily participate in the outpatient treatment that would enable him or her to live safely in the community; and
(6) in view of his or her treatment history and current behavior, is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the person or others as defined in section 9.01 of this article; and
(7) is likely to benefit from assisted outpatient treatment.

Ohio:

OHIO REV. CODE ANN. § 5122.01(B).
(5) (a) Would benefit from treatment as manifested by evidence of behavior that indicates all of the following:
(i) The person is unlikely to survive safely in the community without supervision, based on a clinical determination.
(ii) The person has a history of lack of compliance with treatment for mental illness and one of the following applies:
(I) At least twice within the thirty-six months prior to the filing of an affidavit seeking court-ordered treatment of the person… he lack of compliance has been a significant factor in necessitating hospitalization in a hospital or receipt of services in a forensic or other mental health unit of a correctional facility, provided that the thirty-six-month period shall be extended by the length of any hospitalization or incarceration of the person that occurred within the thirty-six-month period.
(II) Within the forty-eight months prior to the filing of an affidavit seeking court-ordered treatment of the person …, the lack of compliance resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others,

provided that the forty-eight-month period shall be extended by the length of any hospitalization or incarceration of the person that occurred within the forty-eight-month period.
(iii) The person, as a result of the person's mental illness, is unlikely to voluntarily participate in necessary treatment.
(iv) In view of the person's treatment history and current behavior, the person is in need of treatment in order to prevent a relapse or deterioration that would be likely to result in substantial risk of serious harm to the person or others.
(b) An individual who meets only the criteria described in division (B)(5)(a) of this section is not subject to hospitalization.

Oklahoma:

43A OKL. ST. § 1-103(20). "Assisted outpatient" means a person who:
(a) is eighteen (18) years of age or older,
(b) is either currently under the care of a facility certified by the Department of Mental Health and Substance Abuse Services as a Community Mental Health Center, or is being discharged from the custody of the Oklahoma Department of Corrections,
(c) is suffering from a mental illness,
(d) is unlikely to survive safely in the community without supervision, based on a clinical determination,
(e) has a history of lack of compliance with treatment for mental illness that has:
(1) prior to the filing of a petition, at least twice within the last thirty-six (36) months been a significant factor in necessitating hospitalization or treatment in a hospital or residential facility, or receipt of services in a forensic or other mental health unit of a correctional facility, or
(2) prior to the filing of the petition, resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last twenty-four (24) months,
(f) is, as a result of his or her mental illness, unlikely to voluntarily participate in outpatient treatment that would enable him or her to live safely in the community,
(g) in view of his or her treatment history and current behavior, is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the person or persons as defined in this section, and
(h) is likely to benefit from assisted outpatient treatment.

Appendix I
Court-Based Interdisciplinary Partnerships and Systems Improvement

The Committee and AOC have enhanced and established new partnerships related to mental health and the justice system. The following milestones were achieved because of this leadership and collaborative efforts:

- A key charge to the Committee in its Administrative Order was to identify opportunities to educate the public on court processes involving individuals in the justice system with behavioral health treatment needs. In collaboration with the Arizona Foundation for Legal Services and Education, the Committee developed a website and hard copy brochure for individuals who may be experiencing a crisis and find themselves in need of information related to Arizona's involuntary treatment system. In a user-friendly website, azcourtcare.org offers information on how to locate crisis response providers, health care providers, and what takes place in Arizona's Court Ordered Evaluation and Court Ordered Treatment process. The website has been placed on individual court websites, as well as partner sites such as the Yavapai Criminal Justice and Mental Health Coalition and NAMI-Arizona. During the COVID-19 pandemic crisis, individual courts and partners reported using the printable "Help For Your Loved Ones" brochure as a helpful resource for families experiencing crisis who otherwise may come to court in person for questions.
- Committee members engaged with the Arizona Health Plan Association and its members to discuss improvements to the Court Ordered Evaluation and Court Ordered Treatment system. In addition to the discussion, the Committee engaged directly with AHCCCS and the Association to link providers with individual courts and support further enhancement of both the justice liaison role and the data sharing needs between providers and the court for COE/COT hearings.
- A partnership was established with Health Current, Arizona's Health Information Exchange entity. Through that partnership, the AOC, Pinal County Superior Court and Maricopa County Adult Probation participated in an engaging presentation on privacy of health information and the judicial system – focused on HIPAA, 42 CFR Part 2, and Arizona law. This presentation is being converted by the AOC into an e-learning module for court staff and others to access.
- The AOC submitted a response to the AHCCCS call for comments on its Whole Person Care Initiative, detailing options to incorporate justice-involved populations into the AHCCCS 1115 waiver application. Specifically, the AOC recommended expanding services to improve outcomes and potentially reduce costs for a subset of the probation and misdemeanor offender populations who are identified as high risk to reoffend, experience Serious Mental Illness and homelessness, and who are seen repetitively in the lower jurisdiction courts as misdemeanor offenders with substance abuse or mental health needs.

Appendix J
Discussion – Children's Mental Health

According to the National Alliance on Mental Illness, nearly 75 percent of serious mental illness symptoms first appear before the age of 25; however, mental illness in children is difficult to diagnose and treat, making children and adolescents even more vulnerable, particularly when early symptoms go untreated.[28]

Nearly 550,000 children under age 6 live in Arizona – more than the population of Tucson and enough to fill almost 9 Cardinals' football stadiums. The number is expected to increase by 19 percent by the year 2030.

Across the nation and in Arizona, youth mental health is worsening and access to care continues to be limited. In just a five-year period, rates of severe youth depression have increased from 5.9 percent to 8.2 percent, and over 1.7 million American youth with major depressive episodes did not receive treatment. In the Mental Health America study, Arizona was ranked 50th out of 51 using 7 measures capturing prevalence of mental illness and access to care for youth.[29]

Arizona has consistently been ranked near the bottom nationwide for outcomes collected around Adverse Childhood Experiences (ACEs) which may include early exposure to family violence, abusive treatment, neglect, alcohol and drug abuse, or separated/divorced parents. A recent report by United Health Foundation found 30.6 percent of children in Arizona experienced two or more adversities in 2018, whereas the national average was 22.6 percent.[30] Childhood trauma and ACEs greatly increase a person's risk of long-term health problems as well as depression, anxiety, suicide and post-traumatic stress disorder.

In addition, young people living with mental health conditions are considerably over-represented in the juvenile justice system, in comparison to the general youth population.[31] A 2008 meta-analysis crystallizes this point: at some juvenile justice contact points, as many as 70 percent of youth experience a diagnosable mental health condition, and prevalence increases the further that youth are processed in the juvenile justice system.

Specific to mental health and the justice system, a systematic approach and interventions are needed for children to be identified early on – either through the school system or once they enter the justice system – for children who require more intensive, acute mental health services due to their extreme high risk for violence and victimizing others. These children require a different type of treatment and placement than is currently available or offered in Arizona. The stories of C. and D. in the composite section (Appendix B) exemplify the needs of these children and their caregivers, along with the system's inability to proactively provide services to mitigate future violent acts and serve and protect children and the public adequately.

Each of these findings and stories illustrates an opportunity to ensure public safety, connect families with consistent and adequate resources and supports, and evaluate and improve children's physical, mental, social and emotional well-being.

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[28] National Alliance on Mental Illness. *Mental Health by the Numbers.* LINK.
[29] Nguyen, T., Hellebuyck, M., Halpern, M., (2019) *The State of Mental Health in America 2018.* LINK.
[30] United Health Foundation. *America's Health Rankings.* LINK.
[31] Office of Juvenile Justice and Delinquency Prevention. LINK.

The Committee's concept and recommendation is to build on the work happening nationally and develop a home-grown version of the Sequential Intercept Model that is specifically geared toward children's behavioral health. This model will allow for the identification of gaps in services to develop a comprehensive approach for prevention and intervention both before and after formal court involvement.

Appendix K
Enhanced Services Order

Committee has identified in an appendix those laws that do provide the court with some authority to exercise more oversight where needed to ensure proper treatment and compliance, and recommends the following:

A. Enforce A.R.S. §36-540 (C) (2) which requires the court to approve a written treatment plan that conforms to the requirements of 36-540.01 (B) and is approved by the medical director of the agency that will supervise the treatment. This statute requires staff familiar with the patient's case history to prepare a written treatment plan and specifies what should be included in the plan. Current treatment plans reviewed by the Committee appear to address the requirements of this statute only on a superficial level. **The Committee recommends that, regardless of the approval of its proposal that the courts and AHCCCS work together to revise and standardize Outpatient Treatment Plans to be used in all counties pursuant to Title 36.**

B. A.R.S. §36-540 (E) (4) states: "The court may order the medical director to provide notice to the court of any noncompliance with the terms of a treatment order." In cases where an individual's case history identifies them as a person needing enhanced scrutiny, **the order for treatment should include an order to provide the court with notice of non-compliance with the terms of treatment**. With notice of non-compliance the court can take action under ARS §36-540 (E)(5) to set a hearing orissue an amended order for treatment based upon the record and recommendations of medical professionals familiar with the treatment of the patient.

C. **The court should advise the patient in open court and state specifically in its order for treatment that: the Treatment Plan approved by the court is part of the Order and is enforceable by the court; that the Plan may be amended by the court; and, that non-compliance with the order or the terms and conditions of the Plan may result in an order for the patient to be placed in or return to inpatient treatment and an order for a peace officer to detain the patient for that purpose pursuant to A.R.S. §36-540 E (5) or (6).** If the court amends a Treatment Plan, an Amended Treatment Plan should be placed in the patient's medical file and filed with the court. A copy should be given to and discussed with the patient by the agency assigned to administer and supervise the Plan and the court should order the treatment agency to file with the court an affidavit which verifies that such has been done.

D. Many patients who desperately need certain benefits, treatment or services do not receive them because they refuse to agree to the services when offered. For example, if the treatment plan identifies that the patient needs residential placement to assist in the delivery of treatment services and to assure compliance, if the patient refuses, the placement does not occur. The committee believes that this is antithetical to a system that allows the court to issue an or order for treatment and, as a condition for its issuance, the court must find that because of their mental disorder the patient is either unwilling or unable to accept voluntary treatment. **Therefore, the committee believes that it is essential that the court orders for treatment in Arizona contain the following:**

> *"Based on the evidence presented, the court has determined that this patient's mental disorder substantially impairs their ability to make an informed decision regarding treatment, to understand the advantages and disadvantages or the alternatives to a particular treatment and therefore, until further order of the court, the patient shall not be allowed to refuse or be required to agree or consent to any particular treatment or service set forth in the Treatment Plan."*

E. It is axiomatic that a court that has the power to issue an order mandating mental health treatment and appointing an agency to oversee such treatment pursuant to a treatment plan has the power to demand that the agency report to the court about the progress of treatment ordered and the patient's compliance. In Maricopa County, this has been done in the past through an Administrative Order requiring reports to the court 60 days after the order is entered and 60 days prior to expiration of the term of COT. Arizona law does not prevent the Superior Court from requiring in the COT Order that periodic reports be filed with the court and to set status hearings requiring attendance of parties. In fact, during the period of outpatient treatment A.R.S. §36-540(E)(5) allows the court *on its own motion* to determine that a patient is not complying with the terms of the order or that the treatment plan is no longer appropriate and to change the treatment plan. A.R.S. §36-540(E)(5) states (*emphasis added*):

> "During any period of outpatient treatment under subsection A, paragraph 2 of this section, *if the court, on its own motion* or on motion by the medical director of the patient's outpatient mental health treatment facility, *determines that the patient is not complying with the terms of the order or that the outpatient treatment plan is no longer appropriate* and the patient needs inpatient treatment, the court, *without a hearing and based on the court record, the patient's medical record, the affidavits and recommendations of the medical director, and the advice of staff and physicians or the psychiatric and mental health nurse practitioner familiar with the treatment of the patient, may enter an order amending its original order*. The amended order may alter the outpatient treatment plan or order the patient to inpatient treatment pursuant to subsection A, paragraph 3 of this section. The amended order shall not increase the total period of commitment originally ordered by the court or, when added to the period of inpatient treatment provided by the original order and any other amended orders, exceed the maximum period allowed for an order for inpatient treatment pursuant to subsection F of this section. *If the patient refuses to comply with an amended order for inpatient treatment, the court, on its own motion* or on the request of the medical director, *may authorize and direct a peace officer to take the patient into protective custody and transport the patient to the agency for inpatient treatment.* Any authorization, directive or order issued to a peace officer to take the patient into protective custody shall include the patient's criminal history and the name and telephone numbers of the patient's case manager, guardian, spouse, next of kin or significant other, as applicable. When reporting to or being returned to a treatment agency for inpatient treatment pursuant to an amended order, the patient shall be informed of the patient's right to judicial review and the patient's right to consult with counsel pursuant to section A.R.S. §36-546.

Accordingly, in cases needing enhanced scrutiny, the Superior Court should consider doing the following:

a. Direct the medical director of the outpatient treatment agency to review the condition of the patient and to report to the court about the patient's progress in treatment and any non-compliance with the treatment plan, identifying any real or perceived obstacles to needed treatment and requiring the medical director and the treatment team to consider all reports and information relevant to the patient's treatment or compliance received from any source, including family and friends of the patient.
b. In cases where the patient has a history of chronic non-compliance with treatment, consider requiring in the Order for Treatment the medical director of the outpatient treatment agency, or designee, and the patient to participate in an "in-court" case review, periodically, to review the progress or lack of progress in treatment and the need to amend the Treatment Plan or Court Order. This "in-court" review should allow for the parties to appear through an audio/video conferencing tool from a remote location where needed.

F. Training on this authority should be incorporated into statewide judicial training.