



# **INTERIM REPORT AND RECOMMENDATIONS**

**Committee on Mental Health and the Justice System**

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**OCTOBER 2019  
ARIZONA SUPREME COURT**





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## Executive Summary

The Committee on Mental Health and the Justice System (Committee) submits this interim report to the Arizona Judicial Council, as required by [Administrative Order 2018-71](#). Since September 2018, the Committee has worked collaboratively to research and address ways for the courts and other justice system stakeholders to more effectively address how the justice system responds to people with mental health conditions<sup>1</sup> in need of behavioral health services.

The Committee recognizes that its charge extends beyond the courtroom and directly impacts public safety, community health and wellness, and the costs of the justice system. Strategies for addressing mental health and wellness are being studied and implemented across the country and internationally. Utilizing the influence of the judiciary as a convening force, Arizona is well-positioned to create a cross-system approach to significantly improve outcomes for people in need of behavioral health services and supports.

### *Mental Health and Wellness*

Mental health is a universal human experience that includes emotional, psychological, and social well-being, affecting how people think, feel, and act. An individual's mental health and wellness are determinants for handling stress, relating to others, and how choices are made.

In its most recent study, using data reported by 50 states and the District of Columbia to the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control and the Department of Education, Mental Health America reports that over 18 percent of Americans – over 43 million – have a mental health condition, and nearly half have a co-occurring substance abuse disorder. The study found 56 percent of American adults with a mental health condition did not receive treatment, and 1 in 5 report an unmet behavioral health need. In the same study, Arizona was ranked 49th out of 51, using 15 measures that capture prevalence of overall mental health concerns, substance use, and access to insurance and treatment.<sup>2</sup>

For youth, mental health and wellness are worsening and access to care continues to be limited. In the Mental Health America study, Arizona was ranked 50th out of 51 using 7 measures capturing prevalence of mental health conditions and access to care for youth specifically. In order to meet the need for

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<sup>1</sup> According to experts, including the National Alliance on Mental Illness, terminology is very important and can help reduce the stigma of a person's mental illness. The current preferred language is *mental health condition*. Mental illness, or mental health disorders, refer to a wide range of mental health conditions — disorders that affect mood, thinking and behavior. Retrieved from [LINK](#) and [LINK](#).

<sup>2</sup> Nguyen, T., Hellebuyck, M., Halpern, M., (2019). *The State of Mental Health in America 2018*. Retrieved from [LINK](#).

mental health care, the study found that providers in the lower-ranked states would need to treat six times as many people as providers in the highest ranked states.<sup>3</sup>

### *Mental Health and the Justice System*

Today, a person experiencing a mental health crisis is more likely to encounter law enforcement in a time of need than they are to receive medical assistance. Local law enforcement reports across the country reveal approximately one in ten police calls involve mental health situations.<sup>4</sup> Local court users and jail populations reflect this reality. Nationwide, rates of serious mental illness in jails are four to six times higher than in the general population.<sup>5</sup> According to the National Alliance on Mental Illness (NAMI), 2 million people with mental health conditions are booked into jails each year. Nearly 15% of men and 30% of women booked into jails have a serious mental health condition. Further, the majority of these individuals are misdemeanor offenders, or are serving time in jail for non-violent offenses. In fact, most people in jail have not yet gone to trial.<sup>6</sup>

In Arizona, 26 percent (n=12,213) of current Arizona Department of Corrections inmates require ongoing mental health services (July 2019).<sup>7</sup> According to a recent Arizona Town Hall report, 78 percent of Arizona's prisoners have a moderate to intense need for substance abuse treatment.<sup>8</sup> Some attribute the reduction or closure of psychiatric hospitals to the increase in the number of incarcerated people with mental health conditions. In turn, community resources have not been able to adequately keep up with the needs of chronic patients.<sup>9</sup> Without access to adequate inpatient psychiatric treatment, many hospitals and emergency departments are the first option for an individual or first responders to seek treatment for a person experiencing a mental health crisis. However, hospitals are often forced to discharge patients before they have received sufficient treatment.<sup>10</sup>

In the 2016 *Extreme Chronic Offenders* study of individuals booked in the Maricopa County Sheriff's Office (MCSO) jail in calendar year (CY) 2014-2015, MCSO recorded a total of 204,744 bookings which comprised 119,954 unique

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<sup>3</sup> *Id.*

<sup>4</sup> Maciag, Mike, (2016). *The Daily Crisis Cops Aren't Trained to Handle*. Retrieved from [LINK](#).

<sup>5</sup> National Conference of State Legislatures. *The Legislative Primer Series on Front End Justice: Mental Health*. Retrieved from [LINK](#).

<sup>6</sup> National Alliance on Mental Illness. *Jailing People with Mental Illness*. Retrieved from [LINK](#).

<sup>7</sup> Arizona Department of Corrections. *Corrections at a Glance: July 2019*. Retrieved from [LINK](#).

<sup>8</sup> Arizona State University. Morrison Institute for Public Policy. *Arizona Town Hall: Criminal Justice in Arizona 2018*. Retrieved from [LINK](#).

<sup>9</sup> Conference of State Court Administrators, (2016). *Decriminalization of Mental Illness: Fixing a Broken System*. Retrieved from [LINK](#).

<sup>10</sup> Lamb, H. R., & Weinberger, L. E. (2005). Journal of the American Academy of Psychiatry and the Law Online. *The shift of psychiatric inpatient care from hospitals to jails and prisons*.

individuals. Of the 119,954 unique individuals booked in CY2014-2015, 34 percent (n=40,308) were booked more than once and 59 individuals were identified as extreme chronic offenders (booked fifteen or more times for a felony or misdemeanor).

These 59 individuals were responsible for 1,026 bookings, and for most individuals, misdemeanor charges made up over 75 percent of their charges. The average total length of time in jail was 225 days. Over 90 percent of the extreme chronic offenders reported homelessness, and 24 percent had a Serious Mental Illness (SMI) flag – with all individuals with SMI identified as being homeless.<sup>11</sup> Using fiscal year 2019 Maricopa County jail per diem rates, these 59 extreme chronic offenders would cost approximately \$376,039 in booking costs and approximately \$1.4 million in jail “housing” costs.

We are facing significant challenges as a state and a nation in addressing people’s critical behavioral health needs. These challenges are further compounded when an individual with mental health conditions encounters the justice system – not limited to the criminal justice system. Thus, the Committee has focused its work and discussions on multiple decision points that fall under the justice system’s purview – from law enforcement to court, diversion to re-entry, and community-based treatment to more secure treatment options.

### *The Sequential Intercept Model and Developing Mental Health Protocols*

Embedded throughout these recommendations is the Committee’s support for Arizona’s work in implementing the Sequential Intercept Model (SIM) which establishes a framework for identifying individuals with mental health conditions at various intercept points within the justice system and for creating a community-based collaborative support system that allows a person to be rerouted into treatment. The SIM requires proper screening and triage at each intercept point in the justice system (arrest, court, incarceration, supervision after release from incarceration), with goals to produce more therapeutic and desirable results and to decrease further criminal justice involvement. In turn, savings are realized through real economic returns such as reduction in jail populations and emergency department visits, and in ways that are harder to quantify but make a huge impact to communities such as improved quality of life, community safety, and reduced costs to businesses no longer encountering repeat misdemeanor offenders.<sup>12</sup> Clear examples of the SIM in practice in Arizona are Yavapai County’s Reach Out program (Intercept 0-5), the Crisis Response Center – Connections Model in Pima County (Intercept 0-1), and Mesa Municipal Court’s Community Court (Intercept 2), Mental Health Courts around the state

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<sup>11</sup> Cotter, R, PhD. (2016) Maricopa County, Justice System Planning and Information. *Extreme Chronic Offenders*.

<sup>12</sup> Conference of State Court Administrators, (2016). *Decriminalization of Mental Illness: Fixing a Broken System*. Retrieved from [LINK](#).

(Intercept 3), and AHCCCS Co-located Integrated Health Clinics with Probation/Parole (Intercept 5).

Several Committee members participated directly in the 2019 *Developing Mental Health Protocols* Summit. This work is a key piece of the Arizona Supreme Court's ongoing implementation of the Fair Justice for All Task Force recommendations, and the Committee's charge in Administrative Order 2018-71:

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

Through leadership from each Presiding Judge, the Summit and its ongoing work are a collaborative effort for Arizona's courts to improve the justice system's response to persons with mental health issues by mapping resources and community needs in order to fill critical gaps in the system and to establish protocols at each intercept of the SIM.

### **Overview: Committee Recommendations**

The Committee recommends addressing the issues faced by persons with mental health conditions as early as possible, from a cross-systems and cross-judiciary approach. By supporting efforts focused on early identification, intervention and treatment, the state and local communities have opportunities to shift resources to better approaches and make significant improvements in the system.

The Committee's interim report recommendations are based on its charge in [Administrative Order 2018-71](#), as well as research, findings and discussion that has taken place during its first year. Several recommendations focus on the concepts of early intervention and diversion and highlight the significant need for enhanced service delivery and coordination for people with behavioral health needs. They are designed to improve community response and resource application and to halt the current trajectory of jails and prisons being the de facto psychiatric facilities for persons with mental health conditions. Finally, the Committee has been intentional in highlighting recommendations that underscore the need to address the unique challenges and opportunities faced by Arizona's rural courts.

### **Legislation, Policy and Procedure**

- Amend the statutory 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 other 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 the Title 36 civil commitment statutes. See Appendix B.

- Amend A.R.S. §36-540 to permit judges to enter an “enhanced services” order to a mental health treatment agency to provide such service to a person whose history shows that the person cannot or will not adhere to treatment and who poses a substantial risk of harm to themselves or others. See Appendix C.
- Amend A.R.S. §36-501 to clarify the definition of persistent or acute disability (PAD) by reorganizing it and adding that the disability, if untreated, will result in a substantial probability of causing harm to self or others. With these definitional changes to PAD, amend A.R.S. §§36-524 and 36-526 to include PAD or grave disability, allowing screeners and evaluators to immediately hospitalize a person under such circumstances if the emergency standard in the statute is met. See Appendix D.
- Amend statutes in both Title 13 and Title 36 to address the gap between the criminal justice system and the civil mental health treatment system that allows defendants who are mentally ill and dangerous, and who are repeatedly found incompetent and not restorable (INR), to be returned to the community. See Appendix E.
- Provide courts with and encourage use of standardized templates for the Guidelines and Forms used by Mental Health Evaluators in Rule 11 Competency Proceedings in accordance with A.R.S. § 13-4501, et seq., and Rule 11, Ariz.R.Crim.P. See Appendices F-G.
- Continue to address improvements to the implementation of changes to A.R.S. §13-4503 (E) and Rule 11.2, that specifically impact cases involving misdemeanor defendants in limited jurisdiction court competency proceedings.
- Create a workgroup to analyze and make recommendations for improving communication and coordination among the courts handling Title 13, Title 36 and Title 14 proceedings, including a review of Arizona Revised Statutes and Court Rules that impact mental health proceedings to identify possible changes and to clarify and simplify language.

### **Training and Education**

- Ensure adequate training for judges and court staff in the areas of behavioral health and crisis response, including an understanding of existing oversight mechanisms available to them in Titles 36, 13 and 14 proceedings for people with mental health conditions.
- Encourage and support comprehensive mental health training for other justice system stakeholders.
- Embed the Committee’s recommendations for standardized Guidelines and Forms in the *Legal Competency & Restoration Conference* – the AOC training required by statute and rule.

- 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.
- In partnership with the Arizona Foundation for Legal Services and Education (Bar Foundation), finalize content to be included on the Arizona Supreme Court and AzCourtHelp.org websites that provides information to the public on Arizona's civil commitment/involuntary treatment law and the use of advanced health care directives.

### **Data Resources and Analysis**

- Encourage the development of data and information gathering regarding individuals facing mental health issues as a means for data driven decision making and as a tool for change.
- Create 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.
- Encourage the Administrative Office of the Courts to partner with a research 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.

### **Court Improvement**

- Review Arizona's Mental Health Court standards to ensure their statewide relevance and currency and develop a continuum of options for courts and local communities that addresses individual and community behavioral health treatment and service needs.
- Support local courts' development and implementation of mental health protocols by providing leadership and expertise, and through resource mapping and training.
- Establish a clear, workable mechanism to transfer a misdemeanor defendant between criminal and civil courts in a timely fashion when the originating case is at the Limited Jurisdiction Court level.
- Partner with AHCCCS to ensure its Justice Liaisons and Court Coordinators are utilized by courts statewide and to explore expanding their capacity to serve the justice system.

### **Community Services and Supports**

- Support ongoing statewide efforts to address and improve mental health care for youth.

- Encourage state and local agencies to address the lack of behavioral health treatment bed space statewide by encouraging increases in the number of: inpatient, secure beds; community-based, secure residential placements; and community-based supportive housing, including group homes.
- Support expanding the use of peer supports and navigators for people with mental health conditions within the crisis response delivery system and throughout an individual's involvement with the justice system.

### **Diversion and Early Intervention Programming and Partnerships**

- Support improvements that strengthen the ability of law enforcement to identify mental health conditions, safely address crisis situations, and understand diversion options, including a process to connect people with mental health services when they are released from jail.
- Explore and expand existing models for courts to support early intervention, crisis response and enhanced treatment for people with behavioral health needs, in partnership with law enforcement, behavioral health and community stakeholders.
- Support expansion of the "Arizona Model" of crisis services statewide particularly in rural communities and for youth, including the availability of community-based, mobile crisis teams and alternative drop-in centers for law enforcement to take individuals who present mental health issues, rather than to jail.<sup>13</sup>

### **Access to Technology**

- Explore opportunities for creating or expanding telehealth services for people with mental health conditions who have contact with the criminal justice system, particularly in rural areas. Telehealth services may include ad hoc crisis consultations with a provider for law enforcement and other first responders, competency evaluations, mental health assessment in jail, probation and jail-based mental health services.

### **Accountability**

- Support creation of an independent, intergovernmental entity to oversee the care of the overall mental health of Arizona's citizens regardless of ability to pay, to cover the full range of their needs from prevention through treatment services and supports.
- Encourage the development of mental health related data collection and reporting at multiple points in the justice system process.

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<sup>13</sup> The Arizona Model is defined by Crisis Now to include four core, common elements: (1) Regional or Statewide Crisis Call Centers; (2) Centrally Deployed 24/7 Mobile Crisis Outreach and Support; (3) Residential Crisis Stabilization Programs; and (4) Essential Crisis Care Principles and Practices. Retrieved from: [LINK](#).

Details on these proposals and recommendations can be found in the Recommendations and Appendix sections.

## Introduction

The [Committee on Mental Health and the Justice System](#) (Committee) was created as a result of the work and recommendations of the Fair Justice Task Force and its Subcommittee on Mental Health and the Criminal Justice System. In his Administrative Order establishing the Committee, Chief Justice Bales (ret.) emphasized:

*The judiciary is in a unique position to bring community stakeholders together to develop solutions to improve the administration of justice for those with mental and behavioral healthcare needs.* – [Administrative Order 2018-71](#)

Further, in the Arizona Supreme Court’s most recent Strategic Agenda set forth by Chief Justice Brutinel, the Court continues to place great significance on this work.

Committee members represent a cross-section of individuals and partner agencies that interact with the justice system and persons with behavioral health needs. The Committee includes members of the judiciary and court administration from both the general jurisdiction and limited jurisdiction courts, as well as the Court of Appeals; representatives from the prosecutorial and civil and criminal defense bars; law enforcement; behavioral health providers; AHCCCS; advocates from NAMI-Arizona and David’s Hope; the Arizona Center for Disability Law; and members from rural and urban communities across the state.

The Committee has met nine (9) times since its establishment and held several workgroup and stakeholder meetings. The Committee’s workgroups include a mix of Committee and non-Committee members, as subject matter experts, and have solicited input from stakeholders and partners.

Over the course of the year since the Committee was established, members have heard from several speakers in Committee, Workgroup and stakeholder meetings which led to its key findings and recommendations.

Detailed information on each Committee meeting can be found on its [website](#).

Topics have included:

- Arizona Health Care Cost Containment System (AHCCCS) overview including Housing Liaisons, Justice Liaisons, and current criminal justice initiatives
- Arizona State Hospital – current and historical perspective
- Assisted Outpatient Treatment<sup>14</sup>

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<sup>14</sup> The Committee is not recommending changes to Arizona’s AOT statutes, as existing statute A.R.S. §36-540 allows an assisted court-ordered involuntary outpatient treatment path through a petition for evaluation and a petition for court ordered treatment using the PAD, DTS/DTO and GD standards. Statute also allows the court to order AOT under an outpatient program or a combined outpatient-inpatient order. Further, the

- Community-based crisis intervention and crisis response
- Court Ordered Evaluation and Court Ordered Treatment
- Developing Mental Health Protocols, specifically the Sequential Intercept Model
- Housing for persons with mental health conditions, including Serious Mental Illness
- Homelessness
- Impact of Committee proposals and discussions on the juvenile justice system, including youth who are adjudicated to the Arizona Department of Juvenile Corrections (ADJC)
- Impact of the justice system on individuals and families via personal accounts from family members who have a loved one with a mental health condition and involvement with the justice system
- Impact of recent changes to Rule 11.5 on Limited Jurisdiction and General Jurisdiction Courts
- Incompetent Not Restorable overview and statutory proposal changes for handling cases involving mentally ill defendants who are determined to be dangerous and found incompetent and not restorable
- Jail-based diversion, specifically Yavapai County's Reach Out program
- Law enforcement response to persons with mental health conditions
- Legislative proposals to improve the court's and community response to persons with behavioral health needs
- Legislative updates from AOC staff
- Mental Health Courts and other problem-solving court models such as Mesa's Community Court
- Variations across the state – by county and community – in both court processes and systems of care for persons with behavioral health needs

Following this introduction, the report includes the Committee's Findings, Recommendations, Conclusion and Next Steps, and an Appendix section with reference documents, including proposed statutory changes.

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proposed *Enhanced Services* statute will provide the court additional options which are found in other states' AOT statutes. The Committee emphasizes there is a need for enhanced judicial education around use of the orders and standards as provided in A.R.S. §36-540.

## Findings

The Committee's exploration into best practices and protocols for improving the administration of justice for people with mental health conditions has resulted in five key findings. These findings inform the Committee's recommendations that follow.

The Committee has found, statewide that:

**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.**

Within Arizona and nationally, attention is turning to the need for a cohesive, collaboration-based mental health crisis response system – one that provides direct support and triage options. The Arizona Health Care Cost Containment System is currently conducting a review of crisis services statewide, as well as the interconnection between crisis services and court-ordered evaluation/court-ordered treatment. Likewise, local Courts are engaged in mapping resources and developing protocols for addressing the needs of people with mental health conditions who interact with the justice system via civil procedure or prior to arrest and once an arrest has been made.

Based on current research, recommendations and models already in place in Arizona, the Committee finds that an integrated model of crisis mental health care is needed, and that it should contain core elements including high-tech crisis call centers, 24/7 mobile crisis, and crisis stabilization programs where hospitalization is not required.<sup>15</sup>

**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.**

Across Arizona, counties and local jurisdictions have embraced the Sequential Intercept Model and established initiatives that aim to reduce the number of people with mental health conditions who are arrested and held in jail or corrections facilities. However, when appropriate options for treatment, housing and levels of care are unavailable, individuals in need of treatment continue to encounter the justice system where their mental health may deteriorate and prospects for success are lessened.

**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**

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<sup>15</sup> National Action Alliance for Suicide Prevention: Crisis Services Task Force. (2016). *Crisis now: Transforming services is within our reach*. Retrieved from: [LINK](#).

**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.**

A whole continuum of care approach necessitates holistic screening and assessment, connections to treatment with daily support, including warm hand-offs, engagement, peer support, housing and a trauma-informed community.

**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.**

For our communities to be safe and healthy, a continuum of mental health and wellness services and supports is needed that requires access to treatment at all levels of care, regardless of geography. In the Arizona court system, a coordinated approach is needed between the civil, criminal and probate judicial divisions handling Title 36, Title 13 and Title 14 proceedings.

**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.**

Rural courts in Arizona face unique challenges due to limited resources (even by statute) and a large geographic span. Access to health care and legal resources is a huge barrier to improving mental health and wellness in rural communities. At the same time, rural courts have an opportunity that an urban jurisdiction may not experience with respect to stronger relationships and a willingness to test new initiatives. In partnership with AHCCCS, its health plans and providers, the courts can help rural communities overcome these obstacles by supporting and improving court operations, shared resources, enhanced training, and updated technology.



## Recommendations

Throughout these recommendations, the Committee emphasizes the Judiciary's leadership role in driving change forward by addressing improvements to the supports, services and systems for people, families and communities troubled by adverse mental health conditions. By assuming that role, the Court can uphold its commitment to promoting access to justice and protecting Arizona's children, families and communities.

Each recommendation presents an opportunity for direct impact on Arizonans in need of behavioral health services and supports, both within the justice system and in our communities.

Recommendations fall under the categories of:

- Legislation, Policy and Procedure
- Training and Education
- Data Resources and Analysis
- Court Improvement
- Community Services and Supports
- Diversion and Early Intervention
- Programming and Partnerships
- Access to Technology
- Accountability

The Committee's recommendations are grounded in its five key findings and focus on these important questions:

- What can be done to more effectively **identify early those with mental health conditions** in the justice system to connect them with services and supports in their communities?
- What options can be developed or expanded to **divert more people into community-based mental health services**?
- What can be done to better ensure **access to services and fair justice** for those with mental health conditions in the justice system in order to reduce their likelihood of future involvement?
- Are there opportunities to **shift investments** into less costly and more effective community-based alternatives?
- Are there ways to **increase accountability** in the behavioral health system to enhance the effectiveness of the justice system's response to mental health conditions?

### *Identify Mental Health Issues Early*

1. 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.
2. Encourage and support models that strengthen the ability of law enforcement to identify mental health conditions, safely address crisis situations, and understand diversion options, including:
  - a. Expanded crisis intervention training for all first responders.
  - b. A statewide or regional warm line for first responders to find and access resources, including crisis response teams and mobile crisis centers.
  - c. An option for law enforcement and first responders to utilize telehealth services in the field to contact a provider immediately for screening, and for the provider to partner with law enforcement on a recommendation to address the individual's needs at that moment.
3. Encourage the state and local jurisdictions to fully fund intensive outpatient and crisis stabilization programs, particularly in rural areas that will divert individuals from emergency departments, inpatient facilities and the criminal justice system.
  - a. Core elements of a comprehensive crisis stabilization program include regional or statewide crisis call centers coordinating access to care in real time, centrally deployed mobile crisis units available 24/7, and short-term, sub-acute residential crisis stabilization program.
4. Develop comprehensive training for judges and court staff in the areas of behavioral health and crisis response.
  - a. Training should incorporate the latest models, knowledge and information on identifying signs of mental health conditions in others, de-escalation techniques, trauma, Adverse Childhood Experiences (ACEs), and social determinants of health.
  - b. Integrate training with information on available resources and options for behavioral health supports and services in each county.

### *Expand Opportunities to Divert Individuals with Mental Health Conditions from the Criminal Justice System*

1. 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. Existing models already in place or in development in Arizona include:
  - a. Mental Health Court
  - b. Community Court

- c. Veterans Treatment Court
  - d. Homeless Court
  - e. Drug Court
  - f. Co-Occurring Substance Abuse-Mental Health Court Program
  - g. Wellness Court Program
2. 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. Existing models include:
    - a. Yavapai County's Reach Out Program;
    - b. Maricopa County's Criminal Justice Engagement Team;
    - c. Crisis Response Network in central and northern Arizona;
    - d. Crisis Response Center in Pima County.
  3. Support the expansion and availability of crisis services statewide, particularly in rural areas and for youth, including community-based, mobile crisis teams and drop-in alternative centers for law enforcement to take individuals who present mental health issues, rather than to jail.
    - a. Encourage expansion of the existing AHCCCS Centers of Excellence that provide 24/7 crisis stabilization, specifically for youth and in rural communities.

### *Ensure Access to Appropriate Services and Fair Justice*

1. Develop the concept of a tiered approach to the "Mental Health Court" designation, which includes providing support for jurisdictions along a continuum.
  - a. Work with jurisdictions that have existing specialty courts, or that are interested in developing a specialty court or integrated behavioral health court program that addresses individual and community behavioral health treatment and service needs.
  - b. 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.
  - c. Review requirements for reporting process and outcome measures from courts which are engaged in services to defendants with behavioral health needs.
2. Encourage the development or expansion of processes to connect people with mental health services when they are released from jail.
  - a. Ensure all counties are aware of and utilizing Medicaid suspension while an individual is incarcerated, to provide immediate access to services upon release.

- b. 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.
  - c. Encourage support for the development of a separate “X11” line for people in a mental health crisis and first responders.
  - d. Encourage the expansion of “warm lines” with peer support for faster response to those in crisis.
3. 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.
4. 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.
5. Create 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. Specifically, the workgroup will review the Arizona Revised Statutes and Court Rules that impact mental health proceedings to identify possible changes and to clarify and simplify language.
  - b. Create 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.<sup>16</sup>
  - c. Enhance training for judges and court staff in the areas of behavioral health, crisis response, and understanding existing oversight mechanisms in Titles 13, 36 and 14 for people with mental health conditions.

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<sup>16</sup> At present, there is no way for an attorney or judge to know which court contains records for an individual involved in a Rule 11, Title 36 or Title 14 proceeding. The mechanism to be developed 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. Having a mechanism to locate and request the release of these records is critical to informing the doctors, the attorneys, and the judge in determining the most appropriate response to the case and is most important for defendants with serious mental health issues. The ability to do this is fundamental to the delivery of fairness in these cases.

6. 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. See Appendix B.
7. 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. See Appendix D.
8. 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, including:
  - a. Establish a simple, effective mechanism for transferring a misdemeanor defendant involved in Rule 11 proceedings between criminal and civil court in a timely fashion when the originating case is at the limited jurisdiction court level, as allowed for in 16A A.R.S. [Rules Crim.Proc., Rule 11.5](#).
  - b. Modifications to A.R.S. §13-405(A) – the “two experts” requirement; A.R.S. §13-4503 (B) – the “three working days” requirement; and A.R.S. §13-4514 – progress report timelines.
9. 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.<sup>17</sup> The Committee’s recommended templates for Court Guidelines and Forms can be found in Appendices F-G.
  - a. Changes will need to be made to the AOC training for Mental Health Evaluators, in accordance with the revised Guidelines and forms, including a practice guide that incorporates what the mental health expert should include in their report and findings.
10. Implement additional changes to the AOC training for Mental Health Evaluators including:
  - a. Review of current statute and case law impacting mental health evaluation;

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<sup>17</sup> 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.

- b. Review what is in the records that are included in the Status Report and Final Report to the Court;
  - c. Best practices for restoration to competency programs;
  - d. Specialized training on writing the mental health expert report, including technical and professional terms that can be avoided or explained for non-clinical readers; and
  - e. Consideration for a multi-disciplinary approach to training that includes forensic evaluators, judges and attorneys; and
  - f. 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.
11. 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.
12. Examine changes to allow evidence of a mental disorder as an affirmative defense to a defendant's *mens rea*.

### Cost Shift Opportunities

By creating better responses to persons with mental health conditions through early intervention and diversion from court and jail, there is an opportunity to shift costs toward higher-need individuals who commit more serious, dangerous offenses, and toward those found to be incompetent and not restorable who require a higher level of treatment. The Sequential Intercept Model (SIM) offers such cost shift opportunities through its objectives: preventing initial involvement in the criminal justice system, decreasing admissions to jail, engaging individuals in treatment as soon as possible, minimizing time spent moving through the criminal justice system, linking individuals to community treatment upon release from incarceration, and decreasing the rate of return to the criminal justice system.<sup>18</sup> Jurisdictions across Arizona are already engaged in how to use the SIM as a framework to reduce the number of people with mental health conditions in the criminal justice system while maintaining public safety and efficient use of resources.

Cost shift opportunities are intended to be an ongoing discussion as the Committee and the state make adjustments at the front end of the system to

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<sup>18</sup> Munetz, M.R. & Griffin, P.A. (2006). *Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness*. Retrieved from [LINK](#).

implement diversion and treatment options for individuals experiencing mental health issues.

Current Committee recommendations that may present opportunities for such cost shifts:

1. 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.
2. 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. See Appendix C.
3. 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. See Appendix E.
4. 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.

### ***System Accountability***

1. 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 discrepancy in access to care between rural and urban communities as well as public and private insurance.
2. Support the creation of an independent, intergovernmental entity to oversee the care of the overall mental health of Arizona’s citizens regardless of ability to pay, to cover the full range of their needs from prevention through treatment services and supports.
3. 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.
- 4. 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.
- 5. 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.
    - a. Utilize impact data to recommend funding be redirected to other areas of high need involving people with behavioral health needs.



## Conclusion and Next Steps

Over the past year, the Committee has addressed its purpose and charges in accordance with Administrative Order 2018-71. It encompasses a diverse group of dedicated members, many of whom have put in scores of hours of hard work.

This report presents a number of opportunities for addressing how the justice system might respond more effectively to people with behavioral health needs. While discussions on these topics may lead to some discomfort within the group, as both strengths and gaps in the system are exposed, the Committee must work through those issues and propose solutions that will achieve significant, meaningful change. This is a long-term effort, and there is still much work to be done.

During its second year, the Committee will continue to study and make recommendations in accordance with its charge. It will also continue its emphasis, exploring and understanding the variations in processes and practices among the courts and behavioral health treatment systems. The Committee will use the differing experiences of both rural and urban jurisdictions to find opportunities to improve the administration of justice for people with behavioral health needs.

The Committee will continue to seek improvements to the changes made in 2018 to A.R.S. §13-4503 (E) and Rule 11.2, which allow the presiding judge of each county to authorize a justice or municipal court to exercise jurisdiction over a competency hearing in a misdemeanor case. Further, members believe that attention should be given to the interconnectedness among jurisdictions that persons with mental health conditions encounter, and, consequently, the Committee analyze and make recommendations for improving communication and coordination among the courts handling Title 13, Title 36 and Title 14 proceedings.

The Committee will continue to play an active role in the Supreme Court's focused work and attention on the Sequential Intercept Model and on developing mental health protocols in each jurisdiction, supporting a front-end response, which includes deflection when possible, to an individual's involvement with the justice system. Through this process, the Committee will explore recommendations for technology enhancements, and data collection and analysis to ensure courts and system partners have the tools they need to make decisions.

## **APPENDICES**

Appendix A: Committee Membership

Appendix B: Amendments to Mental Disorder Definition

Appendix C: Proposed Enhanced Services Order

Appendix D: Amendments to PAD Definition and Standards for Emergency Hospitalization

Appendix E: Addressing the Population of Incompetent and Not Restorable Dangerous Defendants

Appendix F: Standardized Competency Evaluation Guidelines

Appendix G: Competency Evaluation Forms and Templates

## Appendix A

### ***Committee on Mental Health and the Justice System*** **MEMBERSHIP**

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## Appendix B

### *Committee on Mental Health and the Justice System*

#### **Mental Disorder Definition Proposed Revisions**

The Committee on Mental Health and the Justice System, established by [Administrative Order 2018-71](#), has been tasked with reviewing, and if necessary, refining the definition of Mental Disorder in A.R.S. § 36-501(25).

Specifically the Committee was directed via the recommendations of the [Fair Justice Task Force Subcommittee on Mental Health and the Criminal Justice System](#) to amend the statutory 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 the Title 36 civil commitment statutes.

The Committee has sought input, including from members of the Arizona Judicial Standing Committees on Superior Court and Limited Jurisdiction Courts, as well as by direct solicitation by email to justice system and behavioral health partners and in public meetings. The Committee reviewed and discussed all stakeholder comments in developing its final proposal.

**DEFINITION BEGINS ON NEXT PAGE**

Committee on Mental Health & the Justice System Draft Revision:

36-501. Definitions

25. "Mental Disorder" means a ~~substantial~~-disorder THAT SUBSTANTIALLY IMPAIRS ~~of the~~ A person's emotional processes, thought, cognition, ~~or~~ memory OR BEHAVIOR. THE MENTAL DISORDER MAY BE RELATED TO, CAUSED BY OR ASSOCIATED WITH A PSYCHIATRIC OR NEUROLOGIC CONDITION, OR AN INJURY OR DISEASE, AND MAY CO-OCCUR WITH A SUBSTANCE USE DISORDER.

A. A PERSON WITH AN ANTISOCIAL PERSONALITY DISORDER OR SEXUAL DISORDER SHALL NOT BE CONSIDERED TO HAVE A MENTAL DISORDER UNLESS THAT PERSON ALSO HAS A SUBSTANTIAL IMPAIRMENT OF EMOTIONAL PROCESS, THOUGHT, COGNITION OR MEMORY, AND THE IMPAIRMENT HAS A REASONABLE PROSPECT OF BEING TREATABLE WITH PSYCHIATRIC TREATMENT.

B. A PERSON WITH A FIXED OR PROGRESSIVE DEFICIT IN COGNITION OR MEMORY DUE TO A NEUROLOGIC DISEASE, OR A PERSON WITH EITHER A BRAIN INJURY OR AN INTELLECTUAL OR COGNITIVE DISABILITY, MAY BE CONSIDERED TO HAVE A MENTAL DISORDER IF THE PERSON ALSO HAS A SUBSTANTIAL IMPAIRMENT OF EMOTIONAL PROCESSES, THOUGHT OR BEHAVIOR, AND THE IMPAIRMENT HAS A REASONABLE PROSPECT OF BEING TREATABLE WITH PSYCHIATRIC TREATMENT.

C. MENTAL DISORDER INCLUDES A PERSON PRESENTING WITH IMPAIRMENTS CONSISTENT WITH BOTH A MENTAL DISORDER AND A SUBSTANCE USE DISORDER IF, CONSIDERING THE PERSON'S HISTORY AND AN APPROPRIATE EXAMINATION OF THE PERSON, THE IMPAIRMENTS OF A MENTAL DISORDER PERSIST OR RECUR EVEN AFTER DETOXIFICATION.

~~Mental disorder is distinguished from:~~

~~(a) Conditions that are primarily those of drug abuse, alcoholism or intellectual disability, unless, in addition to one or more of these conditions, the person has a mental disorder.~~

~~(b) The declining mental abilities that directly accompany impending death.~~

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

## Appendix C

### *Committee on Mental Health and the Justice System*

#### **Enhanced Services Order Proposal**

The Committee proposes that a new statute be created that requires the civil court to mandate the provision of specific “enhanced 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 of enhanced services orders to assure that appropriate services are being provided and that the patient is adhering to the specific treatment plan.

#### Background:

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

#### System Challenges:

##### *Criminal Court*

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



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

*Civil Mental Health Treatment System*

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

**PROPOSAL FOR NEW STATUTE BEGINS ON THE NEXT PAGE:**

36-540.03. DETERMINATION AND ORDER FOR ENHANCED SERVICES

A. UPON DETERMINING THAT THE PATIENT SHOULD UNDERGO TREATMENT UNDER PARAGRAPH A OF SECTION 36-540, THE COURT SHALL ORDER THE MENTAL HEALTH TREATMENT AGENCY DESIGNATED TO ADMINISTER AND SUPERVISE THE PATIENT'S TREATMENT PROGRAM TO PROVIDE THE PATIENT WITH ENHANCED SERVICES AS DEFINED IN THIS SUBSECTION IF THE COURT ALSO FINDS THAT:

1. DESPITE HAVING HAD TREATMENT OFFERED, PRESCRIBED, RECOMMENDED OR ORDERED, TO IMPROVE THE PATIENT'S CONDITION OR TO PREVENT A RELAPSE OR HARMFUL DETERIORATION OF THE PATIENT'S CONDITION, THE PATIENT HAS DEMONSTRATED A CONTINUING UNWILLINGNESS OR INABILITY TO PARTICIPATE IN OR ADHERE TO TREATMENT; AND
2. IF THE PATIENT DOES NOT PARTICIPATE IN AND ADHERE TO TREATMENT ORDERED BY THE COURT THERE IS A SUBSTANTIAL RISK THAT THE PATIENT'S PHYSICAL, EMOTIONAL OR MENTAL CONDITION WILL DETERIORATE OR CONTINUE TO DETERIORATE TO THE POINT THAT IT IS LIKELY THAT THE PATIENT WILL, IN THE REASONABLY NEAR FUTURE, INFLICT PHYSICAL HARM ON HIMSELF, HERSELF OR ANOTHER PERSON OR BE IN DANGER OF SUFFERING SERIOUS HARM DUE TO THE PATIENT'S INABILITY TO PROVIDE FOR BASIC PERSONAL NEEDS SUCH AS NOURISHMENT, ESSENTIAL CLOTHING, MEDICAL CARE, SHELTER OR SAFETY.

B. IN DETERMINING WHETHER AN ORDER FOR ENHANCED SERVICES SHOULD BE ENTERED, THE COURT SHALL CONSIDER THE FOLLOWING:

1. EVIDENCE THAT THE PATIENT'S UNDERSTANDING OF THE NEED FOR TREATMENT IS IMPAIRED TO THE POINT THAT HE OR SHE IS UNLIKELY TO VOLUNTARILY PARTICIPATE IN OR ADHERE TO TREATMENT ORDERED.
2. EVIDENCE THAT WITHIN THE 36 MONTHS PRIOR TO THE PETITION, EXCLUDING ANY TIME THE PATIENT WAS HOSPITALIZED OR INCARCERATED DURING THIS PERIOD, THE PATIENT'S NON-PARTICIPATION IN OR NON-ADHERENCE TO TREATMENT OFFERED OR RECOMMENDED TO THE PATIENT HAS BEEN A FACTOR IN:
  - a) THE PATIENT BEING TAKEN TO A HOSPITAL EMERGENCY ROOM, A PSYCHIATRIC HOSPITAL OR A CRISIS CENTER FOR EVALUATION, STABILIZATION OR TREATMENT AT LEAST TWO TIMES; OR
  - b) THE PATIENT BEING ARRESTED, CHARGED WITH A CRIME, DETAINED IN A JAIL OR DETENTION CENTER AT LEAST TWO TIMES; OR

- c) THE PATIENT COMMITTING ONE OR MORE ACTS, ATTEMPTS, OR THREATS OF COMMITTING ACTS OF SERIOUS PHYSICAL HARM ON THE PATIENT OR ON OTHERS; OR
- d) ANY COMBINATION OF THE EVENTS OR ACTS SET FORTH IN A, B, OR C ABOVE AT LEAST TWO TIMES.

3. ANY OTHER EVIDENCE RELEVANT TO THE PATIENT'S WILLINGNESS OR ABILITY TO PARTICIPATE IN AND ADHERE TO TREATMENT.

C. A PETITION FOR COURT ORDERED TREATMENT SHALL CONTAIN AN ALLEGATION THAT THE PROPOSED PATIENT QUALIFIES FOR ENHANCED SERVICES, AS DEFINED IN THIS SECTION. THE BURDEN OF PROVING THE ALLEGATION IS ON THE PETITIONER AND SHALL BE PROVEN BY CLEAR AND CONVINCING EVIDENCE.

D. "ENHANCED SERVICES" ARE DEFINED AS THE FOLLOWING:

- 1. SERVICES IDENTIFIED IN A WRITTEN ENHANCED TREATMENT PLAN APPROVED BY THE COURT THAT INCLUDES:
  - a) ASSIGNMENT OF THE PATIENT TO A TREATMENT TEAM WITH AN INTENSIVE CASE MANAGER FOR ANY OUTPATIENT SERVICES WHO IS REQUIRED, AMONG OTHER DUTIES, TO HAVE IN-PERSON CONTACT WITH THE PATIENT AT SUCH FREQUENCY THAT WILL FACILITATE THE PATIENT'S ADHERENCE TO AND COMPLIANCE WITH THE TREATMENT PLAN AND WILL ALLOW FOR REGULAR FIRST-HAND ASSESSMENT OF THE PATIENT'S PROGRESS AND CONDITION.
  - b) HOUSING OR RESIDENTIAL PLACEMENT THAT PROVIDES THE PATIENT WITH STABLE, SAFE AND, IF NECESSARY, SECURE RESIDENCE TO ENHANCE COMPLIANCE WITH THE TREATMENT PLAN AND PROTECT THE SAFETY OF THE PATIENT AND THE PUBLIC.
  - c) SAFE, RELIABLE, AND ADEQUATE TRANSPORTATION FOR THE PATIENT TO SUCCESSFULLY COMPLY WITH THE TREATMENT PLAN.

E. IF AN ORDER FOR ENHANCED SERVICES IS ENTERED, THE JUDGE SHALL ADVISE THE PATIENT ORALLY AND IN WRITING THAT THE ENHANCED TREATMENT PLAN APPROVED BY THE COURT IS PART OF THE COURT ORDER ENFORCEABLE BY THE COURT AND THAT NON-COMPLIANCE WITH THE COURT'S ORDER OR THE TERMS AND CONDITIONS OF THE TREATMENT PLAN MAY RESULT IN THE ISSUANCE OF AN ORDER FOR THE PATIENT TO BE PLACED IN OR RETURN TO INPATIENT TREATMENT AND AN ORDER FOR A PEACE OFFICER TO DETAIN THE PATIENT FOR THAT PURPOSE.

F. THE COURT SHALL ORDER THE MENTAL HEALTH TREATMENT AGENCY DESIGNATED TO ADMINISTER AND SUPERVISE THE PATIENT'S ENHANCED TREATMENT SERVICES PROGRAM TO FILE WRITTEN PROGRESS REPORTS WITH

THE COURT AT LEAST EVERY 60 DAYS. THE COURT MAY REQUIRE THE PATIENT AND A REPRESENTATIVE OF THE TREATMENT TEAM TO APPEAR IN COURT AT TIMES DESIGNATED TO ADDRESS THE PATIENT'S COMPLIANCE AND THE SERVICES PROVIDED. THE PATIENT'S ENHANCED TREATMENT PLAN MAY BE CHANGED OR MODIFIED BY THE COURT AT ANY SUCH APPEARANCE ON MOTION OF ANY PARTY OR ON THE COURT'S OWN MOTION.

G. IN ORDER TO RECEIVE ANY ENHANCED SERVICE ORDERED BY THE COURT, THE PATIENT SHALL NOT BE REQUIRED BY ANY AGENCY OR PROVIDER TO AGREE OR CONSENT.

**Appendix D**  
***Committee on Mental Health and the Justice System***

**Amendments to PAD Definition and Standards for Emergency  
Hospitalization**

The Committee proposes changes to the definition of PAD (*persistent or acute disability*) 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, screeners and evaluators should be able to immediately hospitalize a person under A.R.S. §§36-524 and 36-526 **regardless of the category presented** if the emergency standard in the statute is met, i.e. “*during the time necessary to complete the pre-petition screening procedures set forth in sections 36-520 and 36-521, the person is likely without immediate hospitalization to suffer serious physical harm or serious illness or is likely to inflict serious physical harm upon another person.*”

Background

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

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

**PROPOSED AMENDMENTS BEGIN ON NEXT PAGE**

36-501. Definitions

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

(a) SIGNIFICANTLY IMPAIRS JUDGMENT, REASON, BEHAVIOR OR CAPACITY TO RECOGNIZE REALITY.

~~(a)~~ (b) If not treated has a substantial probability of causing the person to suffer or continue to suffer severe and abnormal mental, emotional or physical harm, OR OF CAUSING THE PERSON TO INFLICT SERIOUS PHYSICAL HARM TO THE PERSON OR OTHERS—~~that significantly impairs judgment, reason, behavior or capacity to recognize reality.~~

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

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

**36-524 Application for emergency admission for evaluation; requirements**

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

1. A statement by the applicant that he believes on the basis of personal observation that the person is, as a result of a mental disorder, a danger to self or others, **OR HAS A PERSISTENT OR ACUTE DISABILITY OR A GRAVE DISABILITY**, and that during the time necessary to complete the prepetition screening procedures set forth in sections 36-520 and 36-521 the person is likely without immediate hospitalization to suffer serious physical harm or serious illness or is likely to inflict serious physical harm upon another person.
2. The specific nature of the danger.
3. A summary of the observations upon which the statement of danger is based.
4. The signature of the applicant.

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

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



**Appendix E**  
***Committee on Mental Health and the Justice System***

**Addressing the Population of Dangerous Incompetent and Not Restorable Defendants**

The Committee requests the Arizona Judicial Council and Administrative Office of the Courts support efforts to address the population of incompetent and not restorable defendants determined to be dangerous through the creation and adoption of a constitutional process, procedure and/or program to provide treatment to the individual and protect the public safety. An example of draft legislation from the Pima County Attorney's Office follows this discussion document.

**Background:**

Members of the Committee on Mental Health and the Justice System agree that it is imperative to address the gap between the criminal justice system and the civil mental health treatment system that allows defendants who are mentally ill and who are repeatedly found incompetent and not restorable (INR) to fall through the crack between the two systems. When a defendant in Arizona is found incompetent and not restorable, A.R.S. §13-4517 allows for only two pathways to assure mental health treatment: 1) for the county attorney to initiate civil commitment proceedings under A.R.S. Title 36, Chapter 5; or 2) the appointment of a guardian under A.R.S. Title 14, Chapter 5. The criminal justice system contemplates that once a guardian is appointed for a defendant found incompetent and not restorable or a civil court order for involuntary treatment is issued, the charges can be dismissed because there is a reasonable expectation that the defendant will get appropriate treatment and criminal behavior will not reoccur.

However, neither of these pathways offer any real assurance that the person will get the services needed to provide them with appropriate treatment and intensive case management to ensure that they remain compliant with an effective treatment program. Likewise, neither of these options provide any assurance that a defendant will cease committing crimes and be found incompetent and not restorable or that the public will be protected while necessary treatment is provided. Because the criminal justice system has seen these defendants repeatedly cycle back and forth between the civil mental health treatment system and the criminal justice system, the criminal justice system is understandably reluctant to simply turn them over to the civil system and dismiss the charges, especially where the defendant has committed a violent act. A different pathway to ensure appropriate treatment and the protection of public safety is needed.

**System Challenges:**

*Title 13*

With the exception of defendants found to fit into statutorily defined categories of Sexually Violent Persons (A.R.S. §36-3701) and Guilty Except Insane (A.R.S. §13-502; 13-3994), the criminal justice system currently has no way to provide services to the mentally ill and must rely on the civil system to provide appropriate services. The criminal justice system can try to divert defendants who are mentally ill into treatment or can put them on specialized probationary caseloads; however, both options rely on services available to the defendant in the civil treatment system. If a defendant is found to be Incompetent and Not Restorable under A.R.S. §13-4517, the county attorney can institute civil proceedings to have the defendant evaluated to determine if the defendant can be put under an order for involuntary treatment.

However, challenges arise if the defendant: does not meet the current definition of “Mental Disorder” required for the issuance of such an order under A.R.S. §36-501; or is determined not to be Seriously Mentally Ill (SMI) under A.R.S. §36-550; or does not meet eligibility for AHCCCS Title XIX services which disqualifies the defendant from receiving some or all involuntary outpatient services. If the county attorney is successful in getting the defendant placed on a Court Order for Treatment (COT), usually after a very short period of inpatient treatment, the defendant is released back into the community for outpatient treatment to providers. Currently, most outpatient treatment providers do not have appropriate programs and services to closely monitor and supervise the defendant to assure their compliance with the treatment plan and to keep them from destabilizing. Services include proper, stable and, where necessary, secure housing and intensive case management. As a consequence, the civil treatment system is not consistently able to stop the incompetent and not restorable defendant from cycling through both the civil and criminal systems.

*Title 36*

A defendant accused of a violent crime and for whom a proceeding for involuntary treatment is commenced, may be found not to qualify for a court order for involuntary treatment because his mental condition may not meet the current definition of “Mental Disorder” under A.R.S. §36-501 which is currently construed as excluding persons who have mental retardation, dementia, traumatic brain injury and personality disorders.

These defendants are typically in treatment for several months to attempt to restore their competency to stand trial. Upon initiation of civil treatment proceedings, the defendant may present as stable without any continuing dangerous behavior and consequently be found by the court not to need

treatment at the time of hearing on the Petition for Court Ordered Treatment (A.R.S. §36-540).

If the defendant is ordered to undergo involuntary treatment under a court order, there is no assurance that the defendant will be placed in a secure setting for treatment for any significant period of time due to a lack of resources in the civil system and an insufficient number of secure inpatient beds or secure community treatment facilities. After a short period of secure treatment, the defendant will be released back into the community where again, because of a lack of funding, there are insufficient services to assure that the defendant will remain compliant with treatment necessary to maintain control of his behavior.

#### *Title 14*

Upon a finding that a defendant is incompetent and not restorable, a county attorney can institute a civil proceeding to have a guardian appointed for the defendant. A defendant found to be an “Incapacitated Adult” as defined by A.R.S. §14-5101 (3) could have a person appointed as a guardian. A guardian has the authority to seek and consent to mental health treatment. In some cases, where the defendant is found to likely need inpatient treatment, the authority of the guardian may include the right to consent to the ward’s inpatient treatment in a mental health facility pursuant to A.R.S. §14-5312.01. However, without sufficient mental health services available, the authority to consent to treatment does not assure that treatment will be provided, and the guardian’s authority to consent to treatment does not assure that the ward actually participates in or complies with the treatment provided.

#### **Proposed Solution:**

The Committee believes that the solution to this problem in Arizona is the creation of a special program administered and overseen by the criminal court to specifically address this difficult population, similar to how Arizona deals with Sexually Violent Persons [A.R.S. §36-3701 et.seq.] and defendants found Guilty Except Insane [A.R.S. §13-3994].

#### *Supporting Case Law*

The U.S. Supreme Court in Kansas v. Hendricks upholding the constitutionality of the Kansas statute for the commitment of Sexually Violent Predators states:

*Kansas argues that the Act's definition of "mental abnormality" satisfies "substantive" due process requirements. We agree. Although freedom from physical restraint "has always been at the core of the liberty protected by the Due Process Clause from arbitrary governmental action," Foucha v. Louisiana, 504 U.S. 71, 80, 112 S.Ct. 1780, 1785, 118 L.Ed.2d 437 (1992), that liberty interest is not*

*absolute. The Court has recognized that an individual's constitutionally protected interest in avoiding physical restraint may be overridden even in the civil context:*

*"[T]he liberty secured by the Constitution of the United States to every person within its jurisdiction does not import an absolute right in each person to be, at all times and in all circumstances, wholly free from restraint. There are manifold restraints to which every person is necessarily subject for the common good. On any other basis organized society could not exist with safety to its members." Jacobson v. Massachusetts, 197 U.S. 11, 26, 25 S.Ct. 358, 361, 49 L.Ed. 643 (1905).*

*Accordingly, **States have in certain narrow circumstances provided for the forcible civil detainment of people who are unable to control their behavior and who thereby pose a danger to the public health and safety.** See, e.g., 1788 N.Y. Laws, ch. 31 (Feb. 9, 1788) (permitting confinement of the "furiously mad"); see also A. Deutsch, *The Mentally Ill in America* (1949) (tracing history of civil commitment in the 18th and 19th centuries); G. Grob, *Mental Institutions in America: Social Policy to 1875* (1973) (discussing colonial and early American civil commitment statutes). **We have consistently upheld such involuntary commitment statutes provided the confinement takes place pursuant to proper procedures and evidentiary standards.** See *Foucha, supra*, at 80, 112 S.Ct., at 1785-1786; *Addington v. Texas*, 441 U.S. 418, 426-427, 99 S.Ct. 1804, 1809-1810, 60 L.Ed.2d 323 (1979). It thus cannot be said that the involuntary civil confinement of a limited subclass of dangerous persons is contrary to our understanding of ordered liberty. Cf. *id.*, at 426, 99 S.Ct., at 1809-1810. **[emphasis added]***

*Standards that must be met:*

In trying to design a system to deal with this population, US Supreme Court cases upholding as constitutional statutory schemes to deal with Sexually Violent Predators are instructive. See Kansas v. Hendricks, 521 U.S. 346, 117 S. Ct 2072, 138 L. Ed 2d 501, (1997) Kansas v. Crane, 534 U.S. 407, 122 S. Ct 867, 151 L.Ed. 2d 856 (2002) and, in Arizona, In Re Leon G., 204 Ariz. 15, 59 P. 3d 779, (Ariz. 2002). Also instructive are the decisions of the Supreme Courts of states that have upheld the constitutionality of state statutes permitting the criminal commitment of defendants found incompetent and not restorable. See the Ohio Supreme Court case of State v. Williams, 126 Ohio St.3d 65, 930 N.E. 2d 770, 2010 Ohio 2453 (Ohio, 2010) and the New Mexico Supreme Court case of State v. Rotherham, 122 N.M.246, 923 P.2d 1131, (N.M., 1996).

The statute must be narrowly drafted to target a limited subclass of dangerous persons. There needs to be some reason that the civil commitment system and the criminal justice system are inadequate to deal with the risk posed by this

subclass of individuals. A finding of “dangerousness” alone is not sufficient. It must be coupled with proof of an additional factor, such as mental health condition or mental abnormality. It requires more than a predisposition to violence. It requires proof of volitional impairment rendering the person dangerous beyond their control which is generally recognized as proof of previous dangerous behavior resulting from some mental condition or disorder that makes it difficult, if not impossible for the person to control his dangerous behavior.

Commitment to the program can be through the criminal justice system and the criminal justice system can retain jurisdiction to oversee the agency administering the program. The court should be required to make an evidentiary finding that the defendant committed the dangerous acts charged, not for the purpose of finding the defendant guilty of a criminal offense, but solely for the purpose of demonstrating the presence of a mental condition or abnormality and to support a finding of future dangerousness. A finding of scienter is irrelevant and is not required.

The purpose for commitment to the program must be treatment and protection of the community, and not retribution or punishment. Therefore, the standard of least restrictive placement must be used. The duration of any confinement must be linked to the stated purpose of the confinement, i.e. to hold the person until his mental condition or abnormality no longer exists or no longer causes him to be a threat to others, or until he is deemed competent to stand trial. The program must provide for an opportunity for the defendant to prove that he or she can be released into a less restrictive treatment setting subject to continued treatment and close control and supervision if it is shown that without such restrictions the person is likely to again engage in dangerous behavior. The state should be required to re-examine the defendant at least yearly to determine whether continued commitment is necessary, and the defendant should have the right to petition for discharge or conditional release at reasonable intervals.

Both substantive and procedural due process standards must be met. The defendant should have the right to a trial, the right to have an attorney without charge if indigent, the right to have an independent evaluation by a qualified professional, the right to present evidence and cross examine witnesses and the right to appeal. The state should have the burden of proving that the criteria for commitment to the program has been met by a standard of clear and convincing evidence.

#### *Past Arizona efforts:*

Over the past 10 years many bills have been introduced in Arizona to deal with this relatively small population of defendants who are found incompetent to stand trial and who are dangerous. There have been times when the legislature seemed close to approving a program to deal with this issue, but each time the

legislation failed because no department or agency could be identified to administer the program, and without good data on the scope of the program it was always seen as too expensive.

The issue of what to do with these individuals has been the subject of an Arizona Legislative Study Committee on Incompetent Non-Restorable Dangerous Defendants from 2016 to 2018. An official Report on the subject containing research conducted by Arizona State University Professor Dr. Michael Shafer, dated September 20, 2018 is attached which helps in estimating the small number of individuals believed to encompass this population.

*Conclusion:*

During the work of the current Committee on Mental Health and the Justice System, various stakeholders including judges, prosecutors, defense counsel, law enforcement and policy makers have spoken, and the Committee reviewed two legislative proposals. One of the proposals was drafted by the Yavapai County Attorney's office and filed as HB 2356. This proposal would have allowed the county attorney to request the appointment of a "public safety guardian" who could then place the incompetent not restorable defendant into a treatment program. This legislative proposal was held by the sponsor and did not receive consideration in this legislative session. (2019 – 54<sup>th</sup> Legislature, First Regular Session). The Committee also considered a draft proposal by the Pima County Attorney's Office which was not filed this legislative session. The Committee received testimony about the proposal and worked with the proponents of the proposal to revise provisions seen as problematic.

Although the Committee members are aware that the Pima County proposal will still be widely vetted to key stakeholders and may need further refinement, the Committee agreed that the Pima County proposal provides a program and procedure to provide treatment to this difficult population of mentally ill defendants while protecting the public and recommends that the Administrative Office of the Courts support efforts to move this proposal forward. A copy of this proposed legislation is attached.

The Committee understands that creating a law that identifies the narrow class of individuals who qualify for placement and the processes needed to get them into the program is the easy part. The hard part is creating a program which is properly funded and administered to meet the needs of those committed to it.

**DRAFT LEGISLATION BY THE PIMA COUNTY ATTORNEY'S OFFICE CAN  
BE ACCESSED BY CLICKING [HERE](#)**

## Appendix F

### *Committee on Mental Health and the Justice System*

#### **Proposed Guidelines for Mental Health Evaluation in Rule 11 Proceedings<sup>19</sup>**

The following provide a template for Courts to adopt as required guidelines as listed in Rule 11.3 (a)(5), Ariz.R.Crim.P.

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### **Superior Court of (Name) County**

### **Guidelines for Mental Health Experts**

#### *Overview*

Court appointments of mental health experts for criminal competency evaluations in adult court proceedings are made pursuant to A.R.S. § 13-4501, et seq., and Rule 11, Ariz.R.Crim.P.

A.R.S. § 13-4501(3) defines a “mental health expert” as a physician who is licensed pursuant to title 32, chapter 13 or 17 or a psychologist who is licensed pursuant to title 32, chapter 19.1 and who is:

- (a) Familiar with this state's competency standards and statutes and criminal and involuntary commitment statutes.
- (b) Familiar with the treatment, training and restoration programs that are available in this state.
- (c) Certified by the court as meeting court developed guidelines using recognized programs or standards.

Similarly, Rule 11.3, Ariz.R.Crim.P. defines a “mental health expert” as a physician licensed under A.R.S. §§ 32-1421 to -1437 or 32-1721 to -1730; or a psychologist licensed under A.R.S. §§ 32-2071 to --2076. Further, Rule 11.3 states a mental health expert must be:

- (a) familiar with Arizona's standards and statutes for competence and criminal and involuntary commitment statutes;
- (b) familiar with the treatment, training, and restoration programs that are available in Arizona; and
- (c) approved by the court as meeting court-developed guidelines, including demonstrated experience in forensics matters, required attendance at a court-approved training program of not less than 16 hours and any court-required continuing forensic education programs, and annual review criteria.

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<sup>19</sup> NOTE: These guidelines and templates will be created as fillable forms upon approval by the AJC of the Committee on Mental Health and the Justice System Interim Report and Recommendations (October 2019)

**A. Qualifications for Physicians:**

A physician wishing to qualify as a “mental health expert” defined under A.R.S. § 13-4501 and appointed pursuant to A.R.S. § 13-4505(A) shall:

1. Be a Medical Doctor or Osteopathic Physician currently licensed by the State of Arizona under Title 32, Chapters 13 or 17; and
2. Be a graduate of a residency program in psychiatry accredited by the American College of Graduate Medical Education or foreign equivalent; and
3. Submit to the court evidence of forensic experience and/or training in forensic psychiatry, as evidenced by either a, b, c or d below:
  - a. Completion of one or more years of a Forensic Psychiatry fellowship and three references familiar with the work product, at least one of whom is a superior court judge or commissioner, concerning the vendor’s practice of forensic psychiatry; or
  - b. Certification by the American Board of Forensic Psychiatry or added qualifications in forensic psychiatry by the American Board of Psychiatry and Neurology and three references familiar with the work product, at least one of whom is a superior court judge or commissioner, concerning the vendor’s practice of forensic psychiatry; or
  - c. Three years of post-residency experience, including 500 hours in forensic psychiatry, substantiated by submission of at least five written reports concerning competency to stand trial and three references familiar with the work product, at least one of whom is a superior court judge, commissioner or hearing officer concerning the vendor’s practice of forensic psychiatry; or
  - d. Two years of post-residency experience, with documentation of at least 1) 30 cumulative hours of forensic CME, or 2) residency training in forensic psychiatry within the previous three years and completion of the court-approved clinical preceptorship, and three references concerning the vendor’s practice of psychiatry who are familiar with the work product.

**B. Qualifications for Psychologists:** A psychologist wishing to qualify as a “mental health expert” defined under A.R.S. § 13-4501 and appointed pursuant to A.R.S. § 13-4505(A) shall:

1. Be licensed pursuant to Title 32, Chapter 19.1; and
2. Have completed training and/or gained experience in one of the following ways:
  - a. Diplomate status by the American Board of Forensic Psychology (American Board of Professional Psychology) and submission of three references familiar with the work product, at least one of whom is a superior court judge or commissioner, concerning the vendor’s practice of forensic psychology; or
  - b. Three years of post-doctoral (although not necessarily post-licensure) experience in the practice of psychology including either: 1) one year (500 hours) of pre-doctoral forensic training with appropriate supervision as defined in A.R.S. § 32-2071(D); or 2) one year (1500 hours) of post-doctoral forensic training, fellowship, or verifiable work experience in a forensic setting, and submission of three references familiar with the work product,



at least one of whom is a superior court judge or commissioner, concerning the vendor's practice of forensic psychology. If this training or experience is undertaken prior to licensure, it shall be appropriately supervised as defined in A.R.S. § 32-2071(E); or

- c. Five years of post-licensure practice of psychology as defined in A.R.S. § 32-2061(7). In addition, 500 hours of documented experience in forensic psychology, plus 30 hours of continuing education in forensic psychology, and submission of three references familiar with the work product, at least one of whom is a superior court judge or commissioner, concerning the vendor's practice of forensic psychology; or
- d. Five years of post-licensure practice of psychology as defined in A.R.S. § 32-2601(7) plus willingness to attend court-approved clinical preceptorship and submission of three references concerning the applicant's practice of psychology who are familiar with the work product.

**C. Standing:** In addition to the qualifications as stated in A and B, the Psychiatrist or Psychologist wishing to qualify as a "mental health expert" defined under A.R.S. § 13-4501 and appointed pursuant to A.R.S. § 13-4505(A) must:

1. Be currently licensed as a Psychiatrist or Psychologist with the State of Arizona and be in good standing with their respective licensing boards.
2. Within three business days, inform the Court of complaints or disciplinary actions for any matter related to mental health services by their respective oversight State Board. This notification must be in writing and copied to the (Name) County Health and Human Services Contract Specialist and the (Name) County Superior Court Director of Treatment Services.
3. Within 24 hours, notify the Court of any arrest, or of any pending criminal charge in any jurisdiction.

**D. Training:** In addition to the foregoing qualifications, mental health experts appointed by the Court must also participate in periodic forensic education training sessions pursuant to Rule 11.3, including the 16-hour court-approved training program, and any court-required continuing forensic education programs, and annual review criteria. The mental health expert must submit such requirements to the Court accordingly.

**E. Mental Health Expert Report:** As part of the completion of the required training, mental health experts will be provided with materials and information for using standard templates for the mental health expert report to be submitted to the Court.

1. *See Competency Evaluation Templates:*
  - a. Pre-Screen – Rule 11 Competency Evaluation;
  - b. Rule 11 Competency Evaluation;
  - c. Status Competency Report – RTC Program; and
  - d. Final Competency Report – RTC Program.
2. When submitting the mental health expert report to the Court, unexplained jargon is to be avoided whenever possible. Professional or technical terms are often confusing or unfamiliar

to the Court. Sometimes technical terms are necessary to anchor a statement in recognized clinical terms (e.g., providing a diagnosis). However, one should be aware that even words such as “agitated,” “somatic,” “hallucinations,” and “labile” may not necessarily be understood by others in the same way that they are consensually understood by mental health professionals.

3. When it seems necessary to use a technical term in a report, the term should be defined in common language in parentheses. For example: “The defendant currently is prescribed Haldol (an antipsychotic medication) and Cogentin (a medication to reduce side effects of the Haldol).” “Nurses described his emotions as labile (shifting rapidly, frequently, and/or to different extremes).” At other times, however, clinical terminology that may be meaningful in a clinical context is simply unhelpful when writing for non-clinical readers. For example, even if it takes more words, “Recognized who she was, where she was, and the date” is better than “Oriented x3.”

In light of the authorities and mental health expert qualifications set forth above, the Court adopts the following guidelines for the appointment of mental health experts within the meaning of A.R.S. § 13-4501(3)(c), and Rule 11.3(b) as follows:

1. That the mental health expert is qualified, approved and in good standing as an independent contract provider with their professional licensing boards and any terms and conditions established through contract or County court administrative order.
2. That the mental health expert is qualified and meets the terms and conditions of employment as a psychologist or psychiatrist for their respective County Competency Evaluation Program.
3. That the mental health expert agrees to be compliant with any and all additional court-approved forensic education training sessions or programs while employed or while providing services as a mental health expert, as required by the Arizona Supreme Court or the Presiding Judge of the Superior Court in conformance with Rule 11.3(b). Each County Superior Court will designate the appropriate entity within the Court to conduct an annual review to determine whether current mental health experts are in compliance with court-required forensic training and education sessions or programs, and whether any have been the subject of professional disciplinary proceedings.
4. In Counties where services are rendered to juveniles, the mental health expert must submit proof of attendance at the Arizona Administrative Office of the Courts (AOC) four (4) hour training course provided by the AOC. If the four (4) hours of specialized juvenile training is not provided by the AOC, the mental health expert shall provide a certificate of completion signed by the sponsoring agency. If services are to be rendered to juveniles, a fingerprint clearance card must be submitted to the County Superior Court.

\_\_\_\_\_ (Signature of authority enacting the Guidelines) \_\_\_\_\_ (Date)

**Appendix G**  
***Committee on Mental Health and the Justice System***

**Proposed Standardized Templates for Mental Health Evaluation in Rule 11 Proceedings<sup>20</sup>**

**TEMPLATES BEGIN ON THE NEXT PAGE:**

Pre-Screen – Rule 11 Competency Evaluation

Rule 11 Competency Evaluation

Status Competency Report – RTC Program

Final Competency Report – RTC Program

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<sup>20</sup> NOTE: These guidelines and templates will be created as fillable forms upon approval by the AJC of the Committee on Mental Health and the Justice System Interim Report and Recommendations (October 2019)

## **PSYCHOLOGICAL PRE-EVALUATION**

**Pursuant to Rule 11.2 and A.R.S. §13-4503**

**Defendant:**

**Case number:**

**Court:**

**Name of Evaluator:**

Referred By: Honorable (Name), (Name of Court, County/City), Arizona

1. Can the defendant adequately relate the following information:

yes/no - Identifying data (i.e. Name, Age, DOB, Marital Status, etc.)

yes/no - Family history, education, medical (including psychiatric and substance abuse) history

yes/no - Date and location of evaluation

2. Does the defendant understand the following:

yes/no - Reason for his/her arrest (the nature of the charges or allegations)

yes/no - Seriousness of the offense and potential penalties

yes/no - The adversarial nature of the legal process

yes/no - The roles of the pertinent parties (i.e. Judge, Defense Counsel, Prosecutor)

3. Does the defendant have the capacity to:

yes/no - Disclose relevant or pertinent facts to defense counsel? (Assist counsel with effective communication).

yes/no - Manifest appropriate courtroom behavior?

yes/no - Testify relevantly about the case?

4. Is the defendant currently prescribed any medications? ☐ yes/no/unknown

Is the defendant currently taking any medications? ☐ yes/no/unknown

If so, describe:

5. Examiner's Impressions:

☐ yes/no/unknown - The defendant is capable of understanding the nature of the proceedings against him/her.

☐ yes/no/unknown - The defendant is capable of assisting in his/her own defense.

☐ yes/no/unknown - Further evaluation of the defendant is warranted.

☐ yes/no/unknown - Further evaluation of the defendant is unwarranted

☐ yes/no/unknown - The defendant may be malingering symptoms of mental illness.

[Defendant Name]

[Date of birth of defendant]

[Case Number]

[Evaluator Name]

Pre-Screen Competency Evaluation Page 2 of 2 Pages

Diagnostic Hypothesis:

**Comments**

*Please elaborate in paragraph form: an explanation of the defendant's competency or lack thereof, if malingering is present, and if there is a need for further evaluation*

Respectfully submitted,

[Evaluator signature/electronic signature]

---

[Evaluator Name]

[Evaluator Credentials]

[Evaluator Address]

[Date]

---

*This report was generated for use by forensic professionals for purposes of a Court proceeding and Court order, pursuant to A.R.S. §13-4508 and Ariz.R.Crim.P. Rule 11.7[c]. The opinions and recommendations stated in this report are based on information available at the time this evaluation was conducted. If further information becomes available relative to the issues cited above, I reserve the right to alter these opinions and recommendations*

## COMPETENCY EVALUATION

Honorable [name]  
Court – [County/City]  
[Address Line 1]  
[Address Line 2]  
[Address Line 3]

[Evaluator Name: \_\_\_\_\_]  
[Date of Report Submission = MM/DD/YYYY]  
[Date of Evaluation = MM/DD/YYYY]

Re: [Defendant's Name]  
[Defendant's DOB = MM/DD/YYYY]  
[Defendant Location – i.e. <In-Custody>, <Out-of-Custody> <location>]  
[Defendant's Booking #] (if applicable)  
[Case Number]

### RULE 11 COMPETENCY EVALUATION

Dear Honorable [Name]

This is a report opining on the competency of the above-named defendant pursuant to A.R.S. §§ 13-4507 and 13-4509 and Rule 11.3 Ariz.R.Crim.Proc. This report shall reproduce in bold type the relevant provisions of A.R.S. § 13-4509. The response appears in regular type below each provision.

#### Opinion as to Competency of Defendant

Defendant is:

- ☐ Competent to Stand Trial
- ☐ Competency is Medication Dependent [Defendant is currently competent by virtue of ongoing treatment with psychotropic medication]
- ☐ Not Competent but Restorable within statutory timeline
- ☐ Not Competent and Not Restorable within statutory time frame

If Not Competent and Not Restorable, select from the following options:

- ☐ **Yes/no** Defendant **is/may be** DTS, DTO, GD or PAD as a result of a mental disorder as defined in A.R.S. § 36-501 and Court Ordered Evaluation/Civil Commitment is recommended pursuant to Title 36, Chapter 5, Articles 4 and 5, A.R.S. §§ 36-520 -544.
- ☐ **Yes/no** Defendant **is/ may be** an “incapacitated person” as defined in A.R.S. § 14-5101 and appointment of a guardian should be considered pursuant to Title 14, Chapter 5, Article 3, A.R.S. 14-5301 et. seq.

[Defendant Name]  
[Date of birth of defendant]  
[Case Number]  
[Evaluator Name]

Competency Evaluation Page 2 of 3 Pages

**§ 13-4509. Expert's report**

**A. An expert's report shall include the examiner's findings and the information required under A.R.S. § 13-4509:**

**1. Name of each Mental Health Expert who examined the defendant**

*Name of each Mental Health Expert who examined the defendant*

**2. A description of the nature, content, extent and results of the examination and any test conducted.**

The Defendant is charged with the crime(s) of: Count 1: *Name of charge, Class of felony or misdemeanor*, committed on or about *Date*

Sources of Information:

*Please list the sources of information used for this report here*

*Defendant's Name* was evaluated on *date* in *location of interview*. I explained to the defendant, the nature and purpose of the present evaluation, that I was not a representative of either prosecution nor defense, and limitations of confidentiality. The defendant was advised that I would be taking notes and issuing a subsequent report back to the court.

☐ Yes/no/unknown The defendant indicated understanding of these warnings

☐ Yes/no/unknown The defendant agreed to speak with me.

*Doctor to elaborate if necessary:*

**3. The facts on which the findings are based.**

**4. An opinion as to the competency of the defendant.**

[Defendant Name]  
[Date of birth of defendant]  
[Case Number]  
[Evaluator Name]

Competency Evaluation Page 3 of 3 Pages

**B. If the mental health expert determines that the defendant is incompetent to stand trial, the report shall also include the following information:**

1. **The nature of the mental disease, defect or disability that is the cause of the incompetency.**

*Explanation or N/A*

2. **The defendant's prognosis.**

*Explanation of prognosis or N/A.*

3. **The most appropriate form and place of treatment in this state, based on the defendant's therapeutic needs and potential threat to public safety.**

*Explanation of treatment form and place or N/A*

4. **Whether the defendant is incompetent to refuse treatment and should be subject to involuntary treatment.**

*If incompetent to refuse treatment or N/A*

**C. If the mental health examiner determines that the defendant is currently competent by virtue of ongoing treatment with psychotropic medication, the report shall address: (1) the necessity of continuing that treatment; and (2) shall include a description of any of the limitations that medication may have on competency.**

*Medication dependent or N/A*

Respectfully submitted,

[Evaluator signature/electronic signature]

---

[Evaluator Name]

[Evaluator Credentials]

[Date]

---

FOOTER

*This report was generated for use by forensic professionals for purposes of a Court proceeding and Court order, pursuant to A.R.S. §13-4508 and Ariz.R.Crim.P. Rule 11.7[c]. The opinions and recommendations stated in this report are based on information available at the time this evaluation was conducted. If further information becomes available relative to the issues cited above, I reserve the right to alter these opinions and recommendations*





[Defendant Name]  
[Date of Birth of Defendant]  
[Case Number]  
[Evaluator Name]

Status Competency Report Page 2 of 3 Pages

*A description of the nature, content, extent and results of the examination and any test conducted.*

The Defendant is charged with the crime(s) of: Count 1: *Name of charge, Class of felony or misdemeanor*, committed on or about *Date*

Sources of Information:

*Please list the sources of information used for this report here*

The opinions in this report were based on a review of records, competency evaluation on *[Date of evaluation]*, and consultation with RTC staff members, *Name of each Mental Health Expert who examined the defendant*, including psychological testing results described below.

The defendant was evaluated on *[Date of Evaluation]* in *location of interview*. I explained to the defendant the nature and purpose of the present evaluation, that I was not a representative of either prosecution or defense, and limitations of confidentiality. The defendant was advised that I would be taking notes and issuing a subsequent report back to the court.

- ☐ The defendant indicated understanding of these warnings and agreed to speak with me.  
☐ The defendant was unable/refused to indicate understanding

*Doctor to elaborate if necessary:*

*[Additional Text if Necessary]*

**3. Facts on which the treatment supervisor's findings are based:**

*[Facts on which the findings are based]*

**4. Treatment supervisor's opinion as to defendant's capacity to understand the nature of the court proceeding and assist in his or her defense.**

*[Opinion on capacity to understand]*

**If the treatment supervisor finds the defendant remains incompetent, the report must also include:**

**5. Nature of the mental disease, defect or disability that is the cause of the incompetency:**

*[Explanation or N/A]*

[Defendant Name]  
[Date of Birth of Defendant]  
[Case Number]  
[Evaluator Name]

Status Competency Report Page 3 of 3 Pages

**6. Prognosis as to defendant's restoration to competency and estimated time period for restoration to competence:**

[Prognosis for restoration and estimated time]

**7. Recommendations for treatment modifications.**

[Recommendations for treatment modifications]

I respectfully request an additional [ ] 30 days [ ] 45 days [ ] 60 days to assess and educate the defendant.

Thank you for your consideration in this matter.

Respectfully submitted,

[Evaluator signature/electronic signature]

---

[Evaluator Name]

[Evaluator Credentials]

[Evaluator Address]

[Date]

---

*This report was generated for use by forensic professionals for purposes of a Court proceeding and Court order, pursuant to A.R.S. §13-4508 and Ariz.R.Crim.P. Rule 11.7[c]. The opinions and recommendations stated in this report are based on information available at the time this evaluation was conducted. If further information becomes available relative to the issues cited above, I reserve the right to alter these opinions and recommendations*

## FINAL COMPETENCY REPORT – RESTORATION TO COMPETENCY PROGRAM

Honorable [name]  
Court – [County/City]  
[Address Line 1]  
[Address Line 2]  
[Address Line 3]

[Evaluator Name: \_\_\_\_\_]  
[Date of Report Submission = MM/DD/YYYY]  
[Date of Evaluation = MM/DD/YYYY]

Re: [Defendant's Name]  
 [Defendant's DOB = MM/DD/YYYY]  
 [Defendant Location – i.e. <In-Custody>, <Out-of-Custody> <location>]  
 [Defendant's Booking #] (if applicable)  
 [Case Number]

## FINAL COMPETENCY REPORT – RESTORATION TO COMPETENCY PROGRAM

Dear Honorable [Name]:

This is a final report on the above defendant's competency to stand trial, pursuant to A.R.S. §§ 13-4514 (B) and 13-4509 and Rule 11.5 Ariz.R.Crim.Proc. On Date of RTC admission Defendant's Name, the defendant was found incompetent to stand trial pursuant to A.R.S § 13-4510 (C) and placed into the Location of Defendant Restoration to Competency Program (RTC). This report shall reproduce in bold type the relevant provisions of A.R.S. § 13-4509. The response appears below each provision.

### Opinion as to Competency of Defendant

Defendant is:

- ☐ Competent to Stand Trial
- ☐ Competency is Medication Dependent [Defendant is currently competent by virtue of ongoing treatment with psychotropic medication]
- ☐ Not Competent and Not Restorable within statutory time frame

If Not Competent and Not Restorable, select from the following options:

- ☐ Yes/no Defendant is/may be DTS, DTO, GD or PAD as a result of a mental disorder as defined in A.R.S. § 36-501 and Court Ordered Evaluation/Civil Commitment is recommended pursuant to Title 36, Chapter 5, Articles 4 and 5, A.R.S. §§ 36-520 -544.

[Defendant Name]

[Date of Birth of Defendant]

[Case Number]

[Evaluator Name]

Final Competency Report Page 2 of 3 Pages

☐ Yes/no Defendant is/ may be an “incapacitated person” as defined in A.R.S. § 14-5101 and appointment of a guardian should be considered pursuant to Title 14, Chapter 5, Article 3, A.R.S. 14-5301 et. seq

### § 13-4509. Expert's report

**A. An expert’s report shall include the examiner’s findings and the information required under A.R.S. § 13-4509:**

**1. Name of each Mental Health Expert who examined the defendant**

*Name of each Mental Health Expert who examined the defendant*

**2. A description of the nature, content, extent and results of the examination and any test conducted.**

*A description of the nature, content, extent and results of the examination and any test conducted.*

The Defendant is charged with the crime(s) of: Count 1: *Name of charge Class of felony or misdemeanor*, committed on or about *Date*

Sources of Information:

*Please list the sources of information used for this report here*

*Defendant’s Name* was evaluated on *date* in *location of interview*. I explained to the defendant the nature and purpose of the present evaluation, that I was not a representative of either prosecution nor defense, and limitations of confidentiality. The defendant was advised that I would be taking notes and issuing a subsequent report back to the court.

*Doctor to elaborate if necessary:*

**3. The facts on which the findings are based.**

**4. An opinion as to the competency of the defendant.**

[Defendant Name]  
[Date of Birth of Defendant]  
[Case Number]  
[Evaluator Name]

Final Competency Report Page 3 of 3 Pages

**B. If the mental health expert determines that the defendant is incompetent to stand trial, the report shall also include the following information:**

**1. The nature of the mental disease, defect or disability that is the cause of the incompetency.**

*Explanation or N/A*

**2. The defendant's prognosis.**

*Explanation of prognosis or N/A*

**3. The most appropriate form and place of treatment in this state, based on the defendant's therapeutic needs and potential threat to public safety.**

*Explanation of treatment form and place or N/A*

**4. Whether the defendant is incompetent to refuse treatment and should be subject to involuntary treatment.**

*If incompetent to refuse treatment or N/A*

**C. If the mental health examiner determines that the defendant is currently competent by virtue of ongoing treatment with psychotropic medication, the report shall address (1) the necessity of continuing that treatment and (2) shall include a description of any of the limitations that medication may have on competency.**

*Medication dependent or N/A*

Respectfully submitted,

[Evaluator signature/electronic signature]

\_\_\_\_\_  
[Evaluator Name]

[Evaluator Credentials]

[Evaluator Address]

[Date]

\_\_\_\_\_  
*This report was generated for use by forensic professionals for purposes of a Court proceeding and Court order, pursuant to A.R.S. §13-4508 and Ariz.R.Crim.P. Rule 11.7[c]. The opinions and recommendations stated in this report are based on information available at the time this evaluation was conducted. If further information becomes available relative to the issues cited above, I reserve the right to alter these opinions and recommendations*





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**INTERIM REPORT AND RECOMMENDATIONS OF  
THE COMMITTEE ON MENTAL HEALTH AND THE JUSTICE SYSTEM  
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