



Fair Justice Task Force
Mental Health and Criminal Justice
Subcommittee
December 12, 2017

Fair Justice Subcommittee on Mental Health and the Criminal Justice System

Tuesday, December 12, 2017; 10:00 a.m. – 2:00 p.m.
 Conference Room 119
 State Courts Building, 1501 W. Washington, Phoenix, AZ 85007
[Click Here for Subcommittee Web Page](#)

Time*	Agenda Items	Presenter
10:00 a.m.	Welcome & Discussion of Future Meeting Dates	<i>Kent Batty, Chair</i>
10:10 a.m.	Approval of Minutes from November 13, 2017 meeting <input type="checkbox"/> Formal Action/Request	<i>Kent Batty</i>
10:20 a.m.	Update on Subcommittee’s Recommendations reported to The Fair Justice for All Task Force	<i>Don Jacobson, AOC Sr. Special Consultant</i>
10:30 a.m.	Review Revised Rule 11.5 <input type="checkbox"/> Formal Action/Request	<i>Jennifer Greene, AOC Staff Attorney</i>
11:15 a.m.	Overview of COSCA White Paper “Decriminalization of Mental Illness: Fixing a Broken System”	<i>Kent Batty</i>
Lunch (\$5.00)		
12:00 p.m.	Recommendation regarding centralized locations for court ordered medical evaluations in Rule 11 proceedings <input type="checkbox"/> Formal Action/Request	<i>Kent Batty</i>
12:15 p.m.	Recommendation to create a workgroup to consider legislation to change the definition of “Mental Disorder” in ARS §36-501(25) <input type="checkbox"/> Formal Action/Request	<i>Kathleen Mayer Dep. Pima Cty. Atty.</i>
12:30 p.m.	Discussion of a diminished capacity standard	<i>Mary Lou Brncik Exec. Dir., David’s Hope</i>

*All times are approximate and subject to change. The committee chair reserves the right to set the order of the agenda. For any item on the agenda, the committee may vote to go into executive session as permitted by Arizona Code of Judicial Administration § 1-202. Please contact Jodi Jerich, staff, at (602) 452-3255 with any questions concerning this agenda. Any person with a disability may request a reasonable accommodation, such as auxiliary aids or materials in alternative formats, by contacting Sabrina Nash at (602) 452-3849. Requests should be made as early as possible to allow time to arrange the accommodation.

- 1:00 p.m. **Roundtable discussion of issues raised in past meetings**
1. Encouragement of more inpatient and outpatient treatment options.
 2. Review of pre-trial risk assessment for mentally ill defendants.
 3. Other issues

1:45 p.m. **Good of the Order/Call to the Public**
Adjournment

Kent Batty

Next Meetings:

January 18, 2018

Conference Room 329/330
Arizona State Courts Building

February 12, 2018

Conference Room 119
Arizona State Courts Building

**All times are approximate and subject to change. The committee chair reserves the right to set the order of the agenda. For any item on the agenda, the committee may vote to go into executive session as permitted by Arizona Code of Judicial Administration § 1-202. Please contact Jodi Jerich, staff, at (602) 452-3255 with any questions concerning this agenda. Any person with a disability may request a reasonable accommodation, such as auxiliary aids or materials in alternative formats, by contacting Sabrina Nash at (602) 452-3849. Requests should be made as early as possible to allow time to arrange the accommodation.*

Fair Justice Task Force

Subcommittee on Mental Health and the Criminal Justice System

DRAFT MINUTES

Monday, November 13, 2017

Conference Room 101, Arizona State Courts Building

1501 West Washington Street

Phoenix, AZ 85007

Present: Kent Batty, Chair, Susan Alameda, Dr. Tommy Begay, Mary Lou Brncik Jim Dunn, Vicki Hill, Josephine Jones, Kathleen Mayer, Judge Joe Mikitish, Dr. Dawn Noggle, Dr. Carol Olson, Nancy Rodriguez, Dr. Michael Schafer, Mary Ellen Sheppard, Judge Susan Shetter, Commissioner Barbara Spencer, Judge Christopher Staring, Lisa Surhio, Sabrina Taylor, Paul Thomas, Juli Warzynski

Absent/Excused: Detective Kelsey Commisso, Danna Whiting

Administrative Office of the Courts (AOC) Staff: Theresa Barrett, Jennifer Greene, Don Jacobson, Jodi Jerich, Amy Love, Sabrina Nash, Marcus Reinkensmeyer

Guest Speakers: Ms. Patti Tobias, National Center for State Courts, Sergeant Cory Runge, Flagstaff Police Department

I. Welcome, opening remarks, and approval of minutes

The November 13, 2017 meeting of the Fair Justice Task Force Subcommittee on Mental Health and the Criminal Justice System was called to order at 10:06 a.m. by Kent Batty, chairman. The chairman thanked the members for their attendance and asked each one to introduce themselves.

The draft minutes of the October 24, 2017 meeting were presented for approval.

Motion: To approve the October 24, 2017, meeting minutes, as presented. **Action:** Approve. **Moved by:** Kathleen Mayer. **Seconded by:** Jim Dunn. Motion passed unanimously.

Mr. Batty welcomed the Honorable Christopher Staring, Court of Appeals Division 2, as the newest member of the Subcommittee. He also introduced guest speakers Ms. Patti Tobias and Sergeant Cory Runge. Ms. Tobias is a Principal Consultant with the National Center for State Courts and a former state court administrator. Sergeant Runge is a law enforcement officer with the Flagstaff Police Department and is its Crisis Intervention Team (CIT) Supervisor.

Ms. Tobias, Judge Staring, and Sergeant Runge each gave a presentation to the Subcommittee sharing their first-hand experiences of how the justice system interacts with mentally ill persons.

II. How the justice system can better serve persons with mental illness: Perspectives on court ordered treatment and the incarceration of persons with mental illness.

Guest Speaker Patti Tobias

Ms. Tobias shared her experience as the mother of a mentally ill adult son and detailed her son's cycling in and out of jails and hospitals in three different states. She relayed her opinion that incarceration of her son was the only option for the court because her son refused to participate in mental health court and the criminal court could not order involuntary civil treatment. Jail became the primary mental health care provider for her son.

Ms. Tobias also recounted her son's experience with inpatient treatment. She criticized the practice of short term inpatient stays. She said that the doctors heavily medicated her son in order to stabilize him. Once stabilized, he was released but there was no scheduled follow-up appointment for several weeks. Ms. Tobias stated that this practice of short term inpatient care followed by inadequate outpatient services results in a frustrating and dangerous cycle of precarious mental health. In such circumstances, many mentally ill persons will stop taking their medications and then decompensate to the point where emergency inpatient treatment is again needed to protect the person and the public.

Ms. Tobias expressed frustration that in Colorado a court may order treatment only if the person is a danger to himself or others or is gravely disabled. She urged the Subcommittee members to review Arizona's court-ordered treatment standards to allow for treatment if the person is incapacitated due to a mental illness. Subcommittee members commented that it appears that Colorado does not have a civil commitment standard that is similar to Arizona's "persistent and acutely disabled" (PAD) standard. While PAD is not an emergency-based standard, members opined that Ms. Tobias's son would be eligible for treatment under this standard.

Ultimately, based on her experiences in multiple states, Ms. Tobias believes the criminal justice system can do a better job of administering justice to those who suffer from mental illness. She stated that it was her experience that the civil and criminal justice systems often work in silos. Even as a career court administrator, she still found it extremely difficult to navigate through the justice system and to understand all the options available to her son.

Subcommittee Member Judge Chris Staring

Next, Judge Staring addressed the Subcommittee about the need to destigmatize mental illness. Judge Staring informed members that he is the father of an adult child with a serious mental illness and shared an incident where his adult child made threats to police officers. He stated that it was very fortunate that the officers who responded to the call were veteran law enforcement officers who handled the situation with restraint. The officers called in a Mental Health Support

Team who treated his child with respect. His child was not charged but was taken to Pima County's Crisis Response Center, which is located next to the county's primary mental health treatment hospital. There, the petition process for a mental health evaluation and eventual court-ordered treatment began. During that time, his child had to sleep in a recliner and spent three days untreated while his mental state worsened. Judge Staring recounted that on a different occasion, his child waited 8 days for an inpatient bed to become available.

Judge Staring said that he has seen much suffering during his tenure on the bench. He said that this did little to prepare him for the frustration he experienced in finding help for his child as the family navigated through the criminal justice and mental health systems. Among his observations was that the actual history of events, interviews, evaluations and the like becomes lost over time, as individuals (docs, police officers and others), in their contemporary reports, summarize the previous history, leaving out some of the detail each time. The result is that important details and nuances about a person's condition and behaviors get lost over time.

Guest Speaker Sergeant Cory Runge

Flagstaff police officer, Sergeant Cory Runge, was the final speaker to address the Subcommittee. Sergeant Runge is the supervisor of the Flagstaff Crisis Intervention Team (CIT). CIT officers go out on calls involving a person who has been identified as possibly having mental health issues. Sgt. Runge shared that he also has a family member with a serious mental illness and is personally an advocate for mental health reform.

Sgt. Runge agreed with Ms. Tobias and Judge Staring that the systems are in silos and are often difficult to navigate. Furthermore, he questioned the current practice of using police officers to transport persons to court-ordered evaluations or treatment. Sgt. Runge asserted that having a uniformed officer transport a person to a medical appointment in the back of a squad car does little to destigmatize mental healthcare treatment. (I'm sorry that I can't get the comment feature to work, but I had a different understanding of this last sentence. I heard Cory say that using officers to transport *stigmatizes* the individual, which is a much stronger statement. I also understood him to be speaking of taking individuals to court appearances, not medical appointments.)

He stated that police officers generally are not trained in healthcare matters. They are trained in public safety matters. Sgt. Runge said, without more information, it is difficult for police to know if the person is acting strangely because of a mental health issue or a substance abuse issue. Sgt. Runge suggested that the criminal justice system could benefit if a form were developed that would follow the person from the first encounter with law enforcement all the way through the criminal justice system. At each "intercept" the appropriate person would note on the form their personal observations about their interaction with the person.

Sgt. Runge said even with all the training in mental health first aid and crisis intervention, a police officer only has three options when the officer has reasonable cause to believe a person has committed a crime: (1) release, (2) arrest, or (3) medical facility. Most times, this is the initial event that results in jails and prisons becoming the primary mental healthcare provider for many persons suffering from mental illness.

Sgt. Runge noted a lack of adequate resources to treat persons with mental illness, particularly in rural Arizona. Sgt. Runge stated that psychiatric centers can treat seriously mentally ill persons, but these facilities are not set up to provide treatment for general mental health issues or for substance abuse problems. He further noted that rural Arizona, due in large part to its geographical expansiveness, has higher treatment costs than in the densely populated metropolitan areas of Phoenix and Tucson.

Sgt. Runge advocated for training in the Sequential Intercept Model (SIM) and in mental health first aid.

Discussion

The members concurred with many of the points raised by the speakers. Members agreed that the criminal, civil, and mental health care systems seem to work in silos and that better communication between them is needed. One member pointed out that the Presiding Judge in Maricopa County issued an administrative order that details how the court may disclose information found in mental health records. Members discussed the benefit of having a clear understanding of what information may and may not be shared. Members also agreed that a mentally ill person often needs a continuum of care after they are stabilized with intensive inpatient treatment. Without meaningful stabilization and adequate outpatient treatment, a person will often stop taking medication, become unstable, and end up back in need of emergency mental health treatment or begin a journey through the criminal justice system.

Members reiterated comments made at the last meeting that there are insufficient inpatient and outpatient resources to adequately meet the needs of persons with mental illnesses. They agreed that additional training for court staff is needed to identify persons with mental health issues and to divert them from the criminal justice system when appropriate to do so. The members discussed that jail and prison are not the best facilities to offer effective mental healthcare. Members noted that limited jurisdiction mental health courts (MHCs) may have more flexibility to offer front-end diversion programs than general jurisdiction MHCs, due to the nature of the charges involved. They suggested that a pre-adjudication program may be an opportunity for the courts to take a leadership role to end the cycle of incarceration and hospitalization for many mentally ill persons. Members suggested that the courts explore diversion options for some felonies.

III. Items for status report to the Fair Justice Task Force

The Chairman noted that the next meeting of the Fair Justice Task Force is November 29, 2017. A representative of the Subcommittee will provide a report at that meeting on its work to date.

The Subcommittee discussed the following items to be included in the report:

1. Draft Administrative Order with policies and procedures.

The Subcommittee members reviewed the draft administrative order with policies and

procedures documents that were provided in the Meeting Packet. With the correction of a typographical error, the members unanimously approved these documents.

2. *Proposed changes to Rule 11.5 to give limited jurisdiction courts the jurisdiction to order competency restoration treatment if the defendant is found incompetent but restorable.*

The members reviewed the draft Rule 11.5 that was provided in the Meeting Packet and proposed two changes. First, members proposed a change to Rule 11.5(b)(3) to address a concern that, as proposed, Rule 11.5(b)(3) could unintentionally permit a superior court to disagree with an LJC's finding that a defendant was incompetent and not restorable. As written, the members agreed that the provision would allow the superior court to disregard the LJC's findings and decide anew whether the defendant is incompetent and not restorable. To eliminate this unintended consequence, the members added the phrase "for proceedings pursuant to A.R.S. §13-4517" at the end of Rule 11.5(b)(3)(A).

The second change to the Rule was to align the restoration timeframes with applicable criminal sentencing penalties. The members noted that restoration treatment cannot last longer than the maximum sentence for the crime charged. Members stated that the current specific timeframes of 15 months and 21 months are not applicable for many crimes. Members proposed to replace these timeframes with the phrase "within the timeframes allowed by law" in order to reflect current practice. As amended, the members unanimously approved the proposed change to Rule 11.5.

3. *Recommendation: "That the Sequential Intercept Model (SIM) be considered a best practice in local jurisdictions and that judges and staff be encouraged to receive training on the SIM and other tools to recognize mental illness in persons who come to court."*

The members urged that all judges and court staff, not just criminal court judges and staff, receive training to identify mentally ill persons and to divert them to appropriate treatment when possible. Members urged that this is an opportunity for the court to become a leader at the local level to introduce the SIM and related training tools to other stakeholders. The members struck the term "mental illness" and inserted "behavioral health needs" in its place. The Subcommittee passed this amended recommendation unanimously.

4. *Recommendation: "That the Fair Justice Task Force create a workgroup to develop options and alternatives for the development of a centralized repository for courts holding Rule 11 proceedings to be able to access prior Rule 11 and Title 36 records from other courts."*

The Subcommittee discussed the scope of this recommendation and whether it conflicts with the restrictions of Rule 123 of the Rules of the Supreme Court. To address this concern, the phrase "under appropriate circumstances and with appropriate safeguards" was added. With a divided voice vote, the recommendation, as amended, passed.

5. ***Recommendation: “That the Fair Justice Task Force find that it is a best practice for courts to identify a centralized location where defendants may go for Rule 11 medical evaluations – whether that be in the courthouse itself or in another location. A court should identify a location that is easily accessible by public transportation.”***

While the members were generally supportive of this proposition, there was no consensus on the precise language of the recommendation. The item was tabled.

6. ***Recommendation: “That the Fair Justice Task Force direct the AOC to take steps to develop a method for LJs to report the outcomes of competency hearings as required by A.R.S. §13-609.”***

A.R.S. §13-609 requires that if a defendant is found incompetent, the court must transmit this case information to the Supreme Court. The Supreme Court must then transmit the case information to the Department of Public Safety. DPS then transmits the information to the national instant criminal background check system. Superior courts already have procedures in place to share case information for competency proceedings. However, since LJs have not previously conducted competency hearings, they have no similar procedures in place. For the two LJs that currently conduct Rule 11 competency proceedings on a pilot basis, these municipal court judges are acting as superior court pro tem judges. As pro tem judges, they access case information from the superior court’s court information system and report their findings back through the superior court. Once LJs begin to hold Rule 11 proceedings pursuant to their own authority, each LJ must set up a procedure to comply with A.R.S. §13-609.

The Subcommittee members unanimously passed this recommendation.

IV. Roundtable discussion of issues raised in past meetings

The Subcommittee members discussed the statutory definition of “mental disorder.” Some members opined that this definition is too limited and should be changed. There was discussion whether to create a workgroup of the subcommittee to develop a proposal. There was another suggestion that the Subcommittee urge the Fair Justice Task Force to create a workgroup. Member discussed the need to include other stakeholders to participate in this discussion. The chairman directed member Kathleen Mayer to bring suggested language back to the Subcommittee for discussion at its next meeting.

V. Call to the public

Ms. Tamaria Gammage, speaking for herself, addressed the Subcommittee. Ms. Gammage shared her experience as someone who has been through the court system while suffering from behavioral health and substance abuse issues.

VI. Adjournment

The meeting adjourned at approximately 2:11 p.m.

Status Report of the Subcommittee on Mental Health and the Criminal Justice System

November 27, 2017

1. Draft Administrative Order for Presiding Judges with policies and procedures to implement Rule 11 proceedings.
2. Proposed changes to Arizona Rules of Criminal Procedure Rule 11.5 to give limited jurisdiction courts jurisdiction to order competency restoration treatment if the limited jurisdiction court finds the defendant to be incompetent but restorable.
3. Recommendation that the Sequential Intercept Model (SIM) be considered a best practice in local jurisdictions and that judge and staff be encouraged to receive training on the SIM and other tools to recognize behavioral health needs in person who come to court.
4. Recommendation that the Fair Justice Task Force create a workgroup to develop options and alternatives for the development of a centralized repository for courts holding Rule 11 proceedings under appropriate circumstances and with appropriate safeguards to be able to access prior Rule 11 and Title 36 records from other courts.
5. Recommendation that the Fair Justice Task Force direct the AOC to take steps to develop a method for limited jurisdiction courts to report the outcomes of competency hearings as required by A.R.S. §13-609.

Summary of Changes Proposed by the Fair Justice Task Force to the Mental Health Subcommittee's Proposed Rule 11.5 Amendments

- **Clarify that the LJC may dismiss charges if defendant is found incompetent but restorable.**
 - Add the following to Rule 11.5(b)(2)(A)(i) – “either dismiss the charges on the state’s motion or”. In some cases, it may not make sense to pursue restoration.

- **Make conforming change to strike “within 15 months in all places.**
 - Rule 11.5(b)(2)(A)(ii) & (B) – the phrase “within 15 months” was replaced with “the timeframes allowed by law,” because in some misdemeanor cases, the maximum term of incarceration the defendant is facing will be less than 15 months, and a defendant cannot be held under Rule 11 for a period of time that exceeds the maximum jail sentence for the crime charged (ARS §13-4515).

- **Clarify Subcommittee’s intent on what LJCs may do if defendant is found to be incompetence and not restorable.** The Task Force asked the Subcommittee to consider 3 options:
 - a. LJC **must** transfer the case to the superior court for further proceedings. (This lets the superior court decide whether to dismiss, initiate T36 COT hearings, or appoint a guardian)
 - b. LJC **must** dismiss on State’s motion.
 - c. LJC **may** (1) dismiss **or** (2) refer the transfer the case to the superior court to either dismiss, initiate T36 COT hearing, or appoint a guardian.

Option #1

If a limited jurisdiction court determines that the defendant is incompetent and that there is no substantial probability that the defendant will become competent within the timeframes allowed by law, the limited jurisdiction court must refer the matter to the superior court for proceedings pursuant to A.R.S. §13-4517.

Option #2

If a limited jurisdiction court determines that the defendant is incompetent and that there is no substantial probability that the defendant will become competent within the timeframes allowed by law, the court must dismiss the charges on the State's motion.

Option #3

If a limited jurisdiction court determines that the defendant is incompetent and that there is no substantial probability that the defendant will become competent within the timeframes allowed by law, the court may do one of the following:

- (i) Dismiss the action on the State's motion; or
- (ii) Transfer the case to the superior court for further proceedings pursuant to A.R.S. §13-4517.

Highlights changes proposed by AOC Staff

Highlights changes proposed by FJTF.

Proposed Recommendation for Amendments to Rule 11.5 (amendments are to the re-styled rule that goes in effect January 1, 2018)

Rule 11.5 Hearing and Orders

(a) **Hearing.** No later than 30 days after the experts appointed under Rule 11.3 submit their reports to the court, the court must hold a hearing to determine the defendant's competence. The court may grant additional time for good cause. The defendant and the State may introduce other evidence about the defendant's mental condition. If the defendant and the State stipulate in writing or on the record, the court may determine competence based solely on the experts' reports.

(b) Orders.

(1) ***If Competent.*** If the court finds that the defendant is competent, the court must direct that proceedings continue without delay.

(2) ***If Incompetent but Restorable***

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

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

(ii) if a limited jurisdiction court determines that the defendant is incompetent, it must either dismiss the charges on the State's motion, transfer the case to the superior court for further proceedings, or, if authorized by the presiding judge of the superior court, order competency restoration treatment, unless there is clear and convincing evidence that the defendant will not regain competence within the timeframes allowed by law.

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

(C) *Involuntary Treatment.* The court must determine whether the defendant will be subject to treatment without consent.

(D) *Treatment Order.* A treatment order must specify:

- (i) the place where treatment will occur;
- (ii) whether the treatment is inpatient or outpatient under A.R.S. § 13-4512(A);
- (iii) the means of transportation to the treatment site;
- (iv) the length of treatment;
- (v) the means of transporting the defendant after treatment; and
- (vi) that the court is to be notified if the defendant regains competence before the expiration of the treatment order.

(E) *Modification and Limitation.* The court may modify a treatment order at any time. Treatment orders are effective for no longer than 6 months.

(3) *If Incompetent and Not Restorable.*

(a) If the superior court determines that the defendant is incompetent and that there is no substantial probability that the defendant will become competent within 21 months, the court may on request of the examined defendant or the State do one or more of the following:

- (A) Remand the defendant to an evaluating agency approved and licensed under Title 36 to begin civil commitment proceedings under A.R.S. §§ 36-501 et seq.;
- (B) Order appointment of a guardian under A.R.S. §§ 14-5301 et seq.; or
- (C) Release the defendant from custody and dismiss the charges without prejudice.

(b) INSERT OPTION #1, #2, OR #3 HERE

(4) *Additional Actions.* If the court enters an order under (b)(3)(A) or (b)(3)(B), it may retain jurisdiction and enter further orders as specified in A.R.S. §§ 13-4517 and 13-4518.

(c) and (d) [no changes]

Rule 11.6. Later Hearings

(a) Grounds. The court must hold an additional hearing to determine the defendant's competence:

(1) upon receiving a report from an authorized official of the institution in which a defendant is treated under Rule 11.5(b)(2) or (b)(3)(A) stating that, in the official's opinion, the defendant has become competent to stand trial;

(2) upon a defendant's motion supported by the certificate of a mental health expert stating that, in the expert's opinion, the defendant is competent to stand trial;

(3) at the expiration of the maximum period set by the court under Rule 11.5(b)(2);

or

(4) if the court determines that it is appropriate to do so.

(b) Experts. The court may appoint new mental health experts under Rule 11.3.

(c) Finding of Competence. If the court finds that the defendant is competent, regular proceedings must begin again without delay. The defendant is entitled to repeat any proceeding if there are reasonable grounds to believe the defendant was prejudiced by previous incompetence.

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

(e) Dismissal of Charges. At any time after providing notice and a hearing under A.R.S. § 13-4515(C), the court may order the dismissal of the charges against a defendant adjudged incompetent. The defendant must be released from custody upon dismissal of the charges unless the court finds that the defendant's mental condition warrants a civil commitment hearing under A.R.S. §§ 36-501 et seq.

3-4517. Incompetent defendants; disposition

A. If the court finds that a defendant is incompetent to stand trial and that there is no substantial probability that the defendant will regain competency within twenty-one months after the date of the original finding of incompetency, any party may request that the court:

1. Remand the defendant to an evaluating agency for the institution of civil commitment proceedings pursuant to title 36, chapter 5. If the defendant is remanded, the prosecutor shall file a petition for evaluation and provide any known criminal history for the defendant.
2. Appoint a guardian pursuant to title 14, chapter 5.
3. Release the defendant from custody and dismiss the charges against the defendant without prejudice.

B. If the court enters an order pursuant to subsection A, paragraph 1 or 2 of this section, the court may also order an assessment of the defendant's eligibility for private insurance or public benefits that may be applied to the expenses of the defendant's medically necessary maintenance and treatment, including services pursuant to title 36, chapter 29, state-only behavioral health services, title xviii services and medicare part D prescription drug benefits, supplemental security income and supplemental security disability income.

C. The court may retain jurisdiction over the defendant until the defendant is committed for treatment pursuant to title 36, chapter 5 or a guardian is appointed pursuant to title 14, chapter 5.

D. If the court remands the defendant for the institution of civil commitment proceedings pursuant to title 36, chapter 5 and the court is notified that the defendant has not had a civil commitment evaluation, the court, if it has retained jurisdiction, may order the sheriff to take the defendant into custody so that the court may explore options pursuant to subsection A, paragraph 2 or 3 of this section.

E. If the court is notified that the defendant has not been ordered into treatment pursuant to title 36, chapter 5 and the court has retained jurisdiction, the court may order the sheriff to take the defendant into custody so that the court may explore options pursuant to subsection A, paragraph 2 or 3 of this section.

2016-2017 Policy Paper

Decriminalization of Mental Illness: Fixing a Broken System



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I. Introduction

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

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

With timely and appropriate services and support, most mental illnesses are treatable, and recovery is possible, reducing the likelihood of behavior that can lead to incarceration. However, outdated and untimely responses to mental illness now

block treatment and services that can prevent crime and lead to recovery.³ Rigid legal standards for involuntary treatment and the lack of an adequately funded community-based mental health system have led to a public safety crisis. Instead, the criminal justice system is systematically being used to criminalize mental illness and re-institutionalize persons with mental illnesses into jails and prisons.

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

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

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

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

² The Sentencing Project, *Mentally Ill Offenders in the Criminal Justice System: An Analysis and Prescription*

7 (2002), <http://www.sentencingproject.org/wp-content/uploads/2016/01/Mentally-Ill-Offenders-in-the-Criminal-Justice-System.pdf> [<http://perma.cc/4R6X-NFRE>].

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

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

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

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

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

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

Over the course of the year, approximately two million adults suffering from serious mental illnesses will spend time in our

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

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

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

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

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

⁸ See Anasseril, *supra* note 4; see also Beatrice Coulter, *My Turn: The Trouble with New Hampshire’s Secure Psychiatric Unit*, *The Concord Monitor* (Feb. 28, 2016),

<http://www.concordmonitor.com/Archive/2016/02/myturncoulter-cmforum-022716> [<http://perma.cc/L5L6-PJS4>].

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

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

¹¹ See Manon S. Parry, *Dorothea Dix (1802-1887)*, 96 *Am. J. Pub. Health* 624, 624-25 (2006); see also Dorothea L. Dix, *Memorial to the Legislature of Massachusetts*, 1843, <http://www.archive.org/stream/memorialtolegisl00dix/d#page/n3/mode/2up> [<http://perma.cc/Z733-L2P2>].

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

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

\$5,741 annually on unincarcerated adults with mental illness.¹⁷

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

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

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

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

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

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

¹⁶ Michael Gerstein & Jonathan Oosting, *Growth of Mentally Ill Inmates Raises Concern in Mich.*, The Detroit News (Dec. 28, 2016, 12:03 AM), <http://www.detroitnews.com/story/news/local/michigan/2016/12/28/growth-mentally-inmates-raises->

[concern-mich/95897544/ \[http://perma.cc/V7GH-U77G\]](http://perma.cc/V7GH-U77G) (referencing a Michigan Department of Corrections report).

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

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

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

²⁰ *Id.* at 11-12.

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

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

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

III. The Forces that Shaped this Outcome

The Community Mental Health Act (CMHA) of 1963 created a financial incentive for states to close state-funded

mental hospitals while promising to fund community-based outpatient treatment and community mental health centers to replace the services provided by hospitals. However, the community mental health centers that were to be the backbone of the promised community treatment system failed to materialize.²⁵ The absence of the promised community treatment system, the lack of adequate funding, and the inability to intervene except in the event of a crisis have led to the dramatic increase in the incarceration of persons with mental illness.²⁶

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

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

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

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

²³ *Id.*

²⁴ *Id.* at 3-4.

²⁵ Michelle R. Smith, *50 Years Later, Kennedy’s Vision for Mental Health Not Realized*, *The Seattle*

Times (October 21, 2013, 8:28 PM), <http://www.seattletimes.com/nation-world/50-years-later-kennedys-vision-for-mental-health-not-realized/> [<http://perma.cc/ART8-JF5Y>].

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

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

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

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

The codes were designed to make it very difficult to order hospitalization, thereby helping to facilitate the deinstitutionalization³¹ of persons with mental illness and the closing of psychiatric hospitals.³² “The purported effectiveness of deinstitutionalization was predicated both on the availability of effective treatment in the community and on the willingness of patients to accept treatment voluntarily.”³³ While most people who suffer from mental illness who would have been institutionalized in the past are able to live independently, for far too many, the system is inadequate to prevent homelessness, incarceration, and impoverishment.

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

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

²⁹ O’Connor v. Donaldson, 422 U.S. 563, 575 (1975).

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

³¹ “Deinstitutionalization” is moving psychiatric patients from hospital settings into less restrictive settings in the community.

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

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

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

³⁵ *Id.* at 4-8.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The closure of most psychiatric hospitals in response to the CMHA and the enactment of laws limiting involuntary treatment have resulted in an apparent shortage of psychiatric hospital beds.⁴⁴ This shortage, along with insurance limits, has created an incentive to release patients as quickly as possible to create more bed capacity without adding more beds. There is also a shortage of psychiatrists for adults⁴⁵ and an even greater shortage for children.⁴⁶ As a result of these shortages and changing practices, length of stay (LOS) in the hospital has been steadily shrinking. The median LOS for an acute episode of schizophrenia went from 42 days in 1980 to 7 days by 2013.⁴⁷

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

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

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

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

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

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

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

⁴⁷ Treatment Advocacy Ctr., *Released, Relapsed, Rehospitalized: Length of Stay and Readmission Rates*

in *State Hospitals 1* (2016), <http://www.treatmentadvocacycenter.org/storage/documents/released-relapsed-rehospitalized.pdf> [<http://perma.cc/T2U7-73FQ>].

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

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

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

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

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

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

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

A. Overview of the Sequential Intercept Model

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

“The Sequential Intercept Model ... can help communities understand the big picture of interactions between the criminal justice and mental health systems, identify where to intercept individuals with mental illness as

they move through the criminal justice system, suggest which populations might be targeted at each point of interception, highlight the likely decision-makers who can authorize movement from the criminal justice system, and identify who needs to be at the table to develop interventions at each point of interception. By addressing the problem at the level of each sequential intercept, a community can develop targeted strategies to enhance effectiveness that can evolve over time.”⁵⁴

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

The CMHS National GAINS Center⁵⁵ has developed a comprehensive sequential model for people with serious mental illness caught up in the criminal justice system. It provides for five intercept points: Intercept 1—contact with law enforcement, Intercept 2—initial detention and court hearing, Intercept 3—after incarceration, including mental health court and jail-based services; Intercept 4—reentry, and Intercept 5—parole or probation.

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

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

<https://store.samhsa.gov/shin/content/PHD1130/PHD1130.pdf> [<http://perma.cc/GA9J-EEQY>].

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

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

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

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

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

1. Capacity-Based Standard for Intervention

State mental health codes adopted in the 1970s in response to the Supreme Court’s decision in *O’Connor* were modeled to only address involuntary hospitalization. Court-

ordered community-based treatment did not exist and therefore was not addressed.

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

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

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

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

⁵⁸ *Id.* at 12, 14.

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

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

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

Currently, the standards for court-ordered treatment focus on a person's *future conduct* (the likelihood of causing harm), not *capacity*. This requires predictive ability as opposed to a present assessment. Assessing

a person's present capacity is far less problematic than predicting future conduct. The person may be incapacitated and unable to make informed decisions about his or her mental illness, but, unless the person can be predicted to be currently dangerous enough to be expected to seriously injure someone, nothing can be done. The *lack of capacity to make an informed decision* alone is not sufficient to secure court-ordered treatment for mental illness in any state.

Even in those states⁶¹ that appear to have a capacity-oriented standard, also known as the "need-for-treatment standard," the law still requires that there also be a substantial probability of severe mental, emotional, or physical harm without the treatment.⁶² A person that lacks the capacity to make an informed decision about his/her illness is simply not enough. The law requires waiting for crisis before acting.

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

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

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

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

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

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

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

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

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

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

objection. North Dakota made that change this year.⁶⁴

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

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

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

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

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

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

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

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

2. Expanded Use of Assisted Outpatient Treatment

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

However, despite its effectiveness, in many states, the standard that must be used to order AOT is often stricter than the standard for ordering hospitalization. States often

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

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

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

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

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

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

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

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

Where AOT has been used, it has been effective in reducing homelessness, psychiatric hospitalization, violent behavior, arrest, and incarceration.⁷⁶ Unfortunately, AOT has not been widely used in most states. Just as courts can order hospitalization without a history of violence or incarceration, courts should be able to order AOT before people are in crisis rather than require that they suffer the consequences of untreated mental illness before receiving help.

AOT, rather than being a rarely used special sort of relief, should be the cornerstone of the community treatment program promised by the CMHA. Some states use AOT as a

discharge planning tool following treatment in a hospital.⁷⁷ AOT should be used as a discharge planning tool from jails and prisons as well as hospitals for those who fail to recognize their need for ongoing treatment.

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

Instead of wasting scarce resources by repeatedly incarcerating or hospitalizing people with mental illness, it would be much better policy, at far less cost, to provide AOT early in the course of a person's mental illness. This would promote recovery and avoid criminal behavior that could result in incarceration as well as creating avoidable victims of criminal behavior. This is particularly evident when the crime is a minor one, such as shoplifting snacks worth \$5.05.⁸⁰ If Jamycheal Mitchell had received outpatient treatment through an AOT, he might be alive today.

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

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ Marvin S. Swartz et al., Duke Univ. Sch. of Med., New York State Assisted Outpatient Treatment Program Evaluation (2009), <https://www.omh.ny.gov/omhweb/resources/publicati>

[ons/aot_program_evaluation/report.pdf](https://www.omh.ny.gov/omhweb/resources/publications/aot_program_evaluation/report.pdf) [<http://perma.cc/K84P-DZ8M>].

⁷⁷ *See id.*

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

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

⁸⁰ *See supra* text accompanying note 1.

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

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

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

B. Use of the Sequential Intercept Model

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

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

⁸² *Id.* at 1430.

⁸³ *Id.* at 1426.

⁸⁴ Caroline M. Sallee & Erin M. Agemy, Anderson Econ. Grp., *Costs and Benefits of Investing in Mental Health Services in Michigan* 4-6 (2011), <http://www.andersoneconomicgroup.com/Portals/0/upl>

1. Intercept “0”

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

2. Intercept 1

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

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

oad/AEG_MACMHB_Final%20Full%20Report.pdf [<http://perma.cc/6BAK-UQDA>].

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

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

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

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

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

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

⁸⁸ Sheryl Kubiak et al., Mich. State Univ., *Statewide Jail Diversion Pilot Program Implementation Process Report*, at I-G4 and I-G5 (2015), http://www.michigan.gov/documents/snyder/MSU_Im

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

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

There is evidence that well planned diversion programs that include jail-based interventions and CIT training can substantially reduce the rate of incarceration of people with serious mental illness. Aggregate findings for eight counties in Michigan with diversion programs found a 25% reduction in the number of inmates with serious mental illness between 2015 and 2016.⁹⁰

plementation_Process_Report_FINAL_033016_526665_7.pdf [<http://perma.cc/DS7H-838E>].

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

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

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

3. Intercept 2

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

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

Assessments should be used to determine appropriateness for diversion decisions, such as bond release programs, pretrial services, and by prosecutors in pre- or post-plea diversion programs. Identifying criminogenic risk is one critical component,

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

⁹² Ctr. for Health & Justice at TASC, No Entry: A National Survey of Criminal Justice Diversion

but the assessment should also include mental health screening. Mental health screens and assessments identify an individual's needs for services and provide the best placement and treatment plan for providing support, services, and stability.

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

4. Intercept 3

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

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

Programs and Initiatives 20 (2013), http://www2.centerforhealthandjustice.org/sites/www2.centerforhealthandjustice.org/files/publications/CHJ%20Diversion%20Report_web.pdf [<http://perma.cc/8V76-DBHT>].

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

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

Nationally, mental health courts have become an effective way to address individuals with mental illness who face criminal charges. They have increased in number by 36% between 2009 and 2014.⁹⁵

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

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

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

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

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

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

⁹⁶ Christine M. Sarteschi, Michael G. Vaughn & Kevin Kim, *Assessing the Effectiveness of Mental Health*

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

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

⁹⁸ Mich. Supreme Court, State Court Admin. Office, *Michigan's Problem-Solving Courts: Solving Problems Saving Lives* 42 (2015), [17](http://courts.mi.gov/administration/admin/op/problem-</p></div><div data-bbox=)

that participation in the program only defers recidivism.

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

In addition, mental health courts often have constraints that limit their use. Participation is usually voluntary, so those who do not understand their need for treatment are less likely to participate. This excludes the highest need defendants. And these courts usually require a guilty plea before the defendant can participate. This results in a criminal record and the negative

consequences that flow from a conviction, including social stigma and its effect on a person's well-being.¹⁰⁰

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

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

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

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

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

¹⁰⁰ *Id.*

¹⁰¹ *Id.* at 9.

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

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

5. Intercept 4

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

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

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

¹⁰³ See *supra* note 100 and accompanying text.

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

6. Intercept 5

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

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

V. State Court Judges as Conveners

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

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

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

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

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

once again confronted with the same dilemma.

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

VI. Conclusion

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

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

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

1. Encourage policy makers to modify mental health codes to adopt a standard based on *capacity* and not *conduct* for ordering involuntary mental health treatment similar to the standard for court-ordered treatment of other illnesses.
2. Expand the use of Assisted Outpatient Treatment (AOT).
3. Encourage law enforcement agencies to train their officers in the use of CIT.
4. Support the adoption of the Sequential Intercept Model.
5. Chief Justices and State Court Administrators should encourage and assist local judges to convene stakeholders to develop plans and protocols for their local jurisdiction.
6. Provide information to policymakers that demonstrates how increased funding for mental health treatment can reduce jail and prison cost as has been demonstrated in Miami Dade County.

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

Proposed Language for Motion to recommend courts identify centralized locations for Rule 11 medical evaluations

Recommendation that the Fair Justice Task Force find that it is a best practice for courts to identify a centralized location or locations where defendants may go for Rule 11 competency evaluations – whether that be at the courthouse itself or at another location. A court should identify locations that are easily accessible by public transportation.

Proposed language to amend the definition of “Mental Disorder”

36-501. [Definitions](#)

Current definition

25. "Mental disorder" means a substantial disorder of the person's emotional processes, thought, cognition or memory. 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.

Proposed definition

25) “Mental Disorder” means a substantial neurological or psychiatric disorder of the person's emotional processes, thought, cognition, ~~or~~ memory or behavior, including congenital mental conditions resulting from injury or disease, and cognitive disabilities as defined in §36-551. Mental disorder is distinguished from:

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

36-551. [Definitions](#)

14. "Cognitive disability" means a condition that involves subaverage general intellectual functioning, that exists concurrently with deficits in adaptive behavior manifested before the age of eighteen and that is sometimes referred to as intellectual disability.