First Supplement to Memorandum 2022-04
Competency To Stand Trial and Related Matters
Panelist Materials

Memorandum 2022-04 gave an overview of competency to stand trial and related matters. This supplement presents and summarizes written submissions from panelists scheduled to appear before the Committee on May 17, 2022.

Exhibit

Approaches to Competency to Stand Trial and Related Matters From Other States and Systems

Judge Steven Leifman, Associate Administrative Judge, Miami-Dade County Court ....A

Professor Daniel Murrie, University of Virginia's Institute of Law, Psychiatry, and Public Policy & Neil Gowensmith, Associate Professor, University of Denver's Institute for Research, Service, and Training ....B

Teresa Pasquini, co-author of Housing that Heals...C

Judge Thomas M. Anderson, Nevada County Superior Court............................D

Perspectives on Competency to Stand Trial and Related Matters From California Practitioners

Kim Pederson, Senior Attorney, Disability Rights California.............................E

Stephanie Regular, Chair of California Public Defender Association's Mental Health and Civil Commitment Committee..F

Discussion Panel 1: Approaches to Competency to Stand Trial and Related Matters from Other States and Systems

Judge Steven Leifman, Associate Administrative Judge, Miami-Dade County Court

Judge Leifman's submissions include an overview of the problems with treating behavioral health in the criminal legal system and a status report from the Miami-Dade Alternative Center pilot project. Like California, Florida experienced a crisis in forensic placements in state hospitals with long waitlists. Judge Leifman recommends, among other reforms, limiting competency restoration to serious and violent felonies and increasing opportunities for diversion. Initial results from a pilot community-based competency restoration program in Miami-Dade County demonstrated that participants were restored sooner, at a lower cost, and with a lower recidivism rate than patients sent to the state hospital. (A summary of the study is also here.) Judge Leifman also submitted the 2007 report from the Florida Supreme Court about the need for comprehensive mental health reform in the state.

Professor Daniel Murrie, University of Virginia's Institute of Law, Psychiatry, and Public Policy & Neil Gowensmith, Associate Professor, University of Denver's Institute for Research, Service, and Training

Dr. Murrie and his colleague Dr. Neil Gowensmith are psychologists with extensive experience researching the incompetent to stand trial population and conducting forensic evaluations. They outline both what led California to what they term a "competency crisis" as well as possible solutions. Historically, California has erred by focusing too much on inpatient restoration and by allowing the competency system to become a catchall for all mental health issues. They suggest that the state now focus on early access to diversion, varied types of restoration services (i.e. outpatient, minimal use of JBCT, and a triage system), and better competency evaluation services.

Teresa Pasquini, co-author of Housing that Heals

Ms. Pasquini's submission offers the perspective of a parent of a child with a schizoaffective disorder who was caught up in the competency system for five years. Her son cycled through the competency restoration system several times — from being found incompetent to receiving treatment at a state hospital to being restored as competent and then back through the process again until his case was finally dismissed. Ms. Pasquini was also a member of the Contra Costa County Mental Health Commission for nine years.

Judge Thomas M. Anderson, Nevada County Superior Court
Judge Anderson has presided over Assisted Outpatient Treatment (AOT), also known as Laura's Law in California, in Nevada County since 2008. His submission highlights the process, benefits, and limitations of AOT. While not a panacea for all persons with serious mental illness, when utilized correctly, AOT can provide structured and supervised treatment, reduce arrests, time spent in jail and hospitals, and save money.

Discussion Panel 2: Approaches to Competency to Stand Trial and Related Matters from California Practitioners

Kim Pederson, Senior Attorney, Disability Rights California
Ms. Pederson's submission offers insight from Disability Rights California and her own comprehensive experience representing people living with mental health disabilities in civil legal proceedings. She advocates for policy changes that allow people to access voluntary services offered in the least-restrictive settings and non-carceral and non-institutional alternatives for people found incompetent to stand trial. Specifically, she advocates for expanding access to diversion to community-based services at the earliest opportunity in a criminal case and to a more expansive group of criminal charges and allocating resources that allows for expanded infrastructure of community-based programs.

Stephanie Regular, Chair of California Public Defenders Association's Mental Health and Civil Commitment Committee
Ms. Regular outlines specific statutory reforms the Committee should consider to provide better outcomes for people with serious mental illness that are involved in the criminal legal system. She recommends that the state do the following: (1) increase use of community based treatment, including for those charged with Penal Code section 1170(h) felonies; (2) create an off-ramp for those individuals who clearly cannot be restored due to static or degenerative disorders; (3) create a more detailed definition of what it means to rationally assist counsel; and (4) establish updated timelines, including for the CONREP placement recommendation and reducing the maximum potential time for restoration.

Respectfully submitted,

Joy F. Haviland
Senior Staff Counsel

Exhibit A

Judge Steven Leifman, Associate Administrative Judge,
Miami-Dade County

Testimony before the California Penal Code Committee
May 17, 2022

By Judge Steven Leifman, Associate Administrative Judge for the Eleventh Judicial Circuit in Miami-Dade County, Florida

The United States lacks a cohesive behavioral health system, and most jurisdictions apply an outdated and ineffective model of care. Our laws governing people with serious mental illnesses and substance use disorders in both the civil and criminal justice system are more than fifty years old and do not reflect modern science, medicine, and treatment.

This misguided and ineffectual mental health and substance use system has resulted in mass incarceration in our jails, wholly inappropriately and unsuccessfully, becoming the country's de facto mental health care system. Almost every year, the United States garners the dubious distinction of incarcerating more people per capita than any other nation,[1] at an annual burden of over $1 trillion in direct and indirect costs[2]. Criminal justice interventions including incarceration marginally reduce crime, but they are also linked to a range of harms to individual and community health and wellbeing.[3] In a system focused more on retribution than rehabilitation, instead of re-integrating into communities, individuals have a harder time finding work and housing, and are more likely to suffer from mental and physical health concerns as a result of their incarceration.[4] Recidivism rates reflect those impediments, with over 80% of those exiting jails and prisons becoming rearrested or reincarcerated within 9 years.[5]

Now decades of research and data-gathering provide a clearer picture of who we are incarcerating.[6] Those populations with the lowest incomes[7] and with the greatest share of trauma, are most likely to be incarcerated, yet they are the ones in greatest need of assistance and therapeutic interventions. Over 70% of individuals in jail have at least one mental illness diagnosis, substance use disorder or both and up to one-third of those in jail have serious mental illnesses, much higher than the rate found in the general population.[8] Individuals with a mental illness and substance use disorder in our jails is the norm, not the exception. Surrounded by poorly paid corrections officers untrained in mental illness, and often put in solitary confinement because of their non-compliance due to their ailments, those with mental illnesses often come out of jail in much worse shape than when they came in. And are likely to end up back in jail, or worse, in a disastrous cycle.

While the United States has 4% of the world's population, we have 25% of the world's inmates housed in our jails and prisons. Prior to the pandemic, 1 out of every 115 adults was behind bars

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[1] https://www.prisonstudies.org/highest-to-lowest/prison_population_rate?field_region_taxonomy_tid=All
[2] https://joinnia.com/wp-content/uploads/2017/02/The-Economic-Burden-of-Incarceration-in-the-US-2016.pdf
[3] https://www.americanactionforum.org/research/the-economic-costs-of-the-u-s-criminal-justice-system/
[4] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/incarceration
[5] https://www.bjs.gov/content/pub/pdf/18upr9yfup0514.pdf
[6] See: https://store.samhsa.gov/sites/default/files/d7/priv/pep19-screen-codjs.pdf; pp. 1.
[7] https://www.brookings.edu/research/work-and-opportunity-before-and-after-incarceration/
[8] See: https://store.samhsa.gov/sites/default/files/d7/priv/pep19-screen-codjs.pdf; pp. 1.

and 1 out of every 38 adults was under correctional supervision. Since 1980, the number of people in the nation's prisons and jails has grown by nearly 500%, and length of sentences has increased significantly. A substantial share of these increases is due to untreated mental illnesses, substance use disorders and co-occurring substance use and mental health disorders.

In fact, people with mental illnesses in the United States are 10 times more likely to be incarcerated than hospitalized. Annually, more than 1.7 million people with serious mental illnesses are arrested. On any given day, approximately 380,000 people with mental illnesses are incarcerated in jails and prisons across the United States, and another 574,000 are on probation in the community. And far too many are incarcerated because of encounters with police that escalated when de-escalation would have resolved the encounters without arrest. This is particularly true of people of color with mental illnesses: they are over-represented in the criminal justice system, and they are at a greater risk of dying during an encounter with law enforcement.

Aside from the enormous human cost of using the criminal justice system as the de facto mental health system, the fiscal impact to the government and taxpayers is astronomical, providing few if any measurable positive outcomes. Annually, our counties spend about $26 billion dollars on jails and our states spend another $63.5 billion dollars on prisons. Billions more are spent on trying to restore competency to proceed to trial for a relatively minuscule group of people with mental illnesses in our jails. Miami-Dade County, for example, currently spends $636,000 dollars per day – or $232 million dollars per year – to warehouse approximately 2,400 people with serious mental illnesses in its jail. Comparatively, the state of Florida spends $47.3 million dollars annually to provide mental health services to about 34,000 people in Miami-Dade and Monroe Counties, leaving almost 70,000 people in these two communities without access to any mental health services.

Put another way, taxpayers pay $100,000 a year for each person with a mental illness in jail, with no positive impact but allow only $1,400 a person to treat those with mental illnesses to help them maintain stable lives and contribute to their families and communities and zero for a large number who get nothing. This makes absolutely no sense!

This situation is particularly shameful because treatment works. We have a system problem more than a treatment problem. Most of the money we spend related to mental illnesses is wasted on acute care treatment provided in institutional settings such as jails, hospitals, and competency restoration facilities. In fact, most states spend far more money to incarcerate people with mental illnesses than to treat them. As the Miami-Dade County example so clearly illustrates, the system is backwards.

These costs don't event reflect the exorbitant costs of treating the issues of comorbidity. People with serious mental illnesses also have higher rates of heart disease and cancer than people without serious mental illnesses. They are also more likely to be admitted to hospitals, stay longer and are less likely to have insurance.

Additionally, in a just published study in Denmark, there is a large earning penalty for people with untreated mental illnesses – 34% earning reduction for Depression, 38% earning reduction

for Bi-polar Disorder and a 74% earning reduction for Schizophrenia. Access to treatment eliminates one-third of the earning penalty.

True reform should begin by *treating mental illnesses and substance use disorders as illnesses and not crimes.* Arrests and incarceration should be the very last resort for people with serious behavioral health issues. It should be as uncommon to arrest someone with a mental illness as it is to arrest someone with dementia or cancer. High quality care for mental health and substance use needs should be as easily accessible as treatment for other medical conditions—and if we simply redirect a large share of the money we are wasting on imprisonment, we can do so without a huge increase in spending overall.

A good start would be to develop and fund a model crisis response system for people with mental illnesses and substance use disorders just like we do with emergency rooms for people with a primary health emergency. The National Council for Behavioral Health recently published the "*Roadmap to the Ideal Crisis System*" a 5-year project by the Group for the Advancement of Psychiatry that details the essential elements, measurable standards, and best practices for a behavioral health crisis response. This should receive priority funding.

Next, we need to apply a population health model to the criminal justice system and not a criminal justice model to the mental health and substance use system. This means that we need to develop seamless systems of care that include effective prevention, assessment and diagnosis, crisis care as noted above, case management, medication management, psychotherapy, supportive housing, integrated treatment for co-occurring mental health and substance use disorders, meaningful day activities, and supportive employment. Effective prevention includes identifying and treating youth at-risk of developing mental illnesses and substance use disorders, particularly those with histories of serious trauma—dealing with the problems before they become tragedies.

When an individual with a serious mental illness is arrested, pathways should be developed within the justice system to transfer appropriate individuals to the civil justice system and out of the criminal justice system. (The Equitas Foundation Model Legal Process work group will be publishing model civil and criminal laws and processes pertaining to people with serious mental illnesses later this year.)

When possible, behavioral health treatment and primary care should be available in one location. Medical Homes (primary and psychiatric care) should be promoted around the United States.

Additionally, we should:

- Develop a coordinated criminal justice response with pre- and post-arrest diversion to treatment programs, peer support specialists and programs including Crisis Intervention Team (CIT) police programs with co-responders. For individuals needing court intervention, appropriate cases should be heard in the civil court system and not in the criminal court system. Problem solving treatment courts only handle a small percentage of cases of those with mental illnesses, substance abuse disorders or both. It almost makes more sense to create specialty courts for the 30% without these disorders to treat

them with a traditional criminal justice response and to provide treatment to the remaining 70% justice involved population with these serious illnesses. One way to help fund these treatment programs would be to limit the use of competency restoration to the most serious offenses and take the savings and re-direct them to front-end, community-based prevention and treatment services.

- Limit Competency Restoration.

  a. Reduce the number of eligible cases for competency restoration through robust pre and post arrest diversion programs as described above.

  b. Limit Competency Restoration to individuals charged with serious and violent felonies who are facing long-term prison sentences.

  c. For incompetent individuals charged with less serious and non-violent felonies, divert to locked residential facilities where the emphasis is on community re-integration rather than competency restoration. Upon stabilization, divert individuals to problem-solving courts or to the civil justice system for treatment and case management. (See the Miami-Dade Forensic Alternative Center)

  d. For incompetent individuals charged with misdemeanors, when appropriate, divert to crisis stabilization units for a civil involuntary assessment then to a problem-solving court or to the civil justice system for treatment and case management. No one charged with a misdemeanor should go to a competency restoration facility.

  e. Consider expanding Assisted Outpatient Treatment (AOT) to misdemeanor courts for individuals with serious and persistent mental illnesses who continuously cycle through the acute systems of care.

- Create independent avenues for police officers to get treatment for PTSD and depression. Between 15% and 20% of all law enforcement officers (180,000) nationally suffer from Post-Traumatic Stress Disorder (PTSD) compared to 3.5% of the public. Last year more law enforcement officers died from suicide then in the line of duty. Aside from high suicide rates, law enforcement officers also have high rates of divorce, domestic violence, and substance use disorders. Studies have also shown that police officers who had just come from emotionally distressful situations in the line of duty were more likely to use excessive force in subsequent service calls.

- Develop mobile health care units for rural and under-served communities to provide an array of services, including primary health, mental health, and substance use screenings. Simultaneously, provide access to entitlement benefits and insurance, housing opportunities, educational opportunities, mobile library access, and access to support groups.

- Develop a Center of Excellence in California to deliver best practices more efficiently to the courts and providers of mental health and substance use treatment services, and to

serve as technical advisors to traditional and non-traditional stakeholders of mental health and substance use services.

- Develop applications and information technology solutions to provide immediate access to live telehealth counselors for people in need of crisis care, as well as to promote service coordination and continuity of care across treatment systems.

- Develop regional mental health diversion and treatment facilities for individuals with serious mental illnesses and complex needs involved in or at risk of becoming involved in the criminal justice system, in communities where services are difficult to access or unavailable elsewhere. These comprehensive one-stop diversion and treatment facilities should offer a coordinated system of care for individuals with serious mental illnesses who are frequent and costly recidivists to the criminal justice system, acute care medical and mental health treatment systems, and chronic homelessness.

  These facilities should consist of a central receiving center, an integrated crisis stabilization unit and addiction receiving facility, various levels of residential treatment, day treatment and day activity programs, outpatient behavioral health and primary care, trauma services, dental, optometry and podiatry services, vocational rehabilitation, and employment services, classrooms and educational spaces, transitional housing, and housing assistance, a courtroom, and space for legal and social service agencies.

- Accurately determine the number of behavioral health professionals needed to treat those in need of behavioral health care services and develop an aggressive workforce development and capacity building plan to meet the demand for services—including incentives for getting advanced training and adequate compensation for treating those with chronic serious mental illnesses.

From Policy to Practice

All this may sound overly ambitious. But there are real life examples that show reform can work. The experience of Miami-Dade County, Florida in reforming the way the criminal justice system deals with those with serious mental illnesses shows that reform done right and can create partnerships instead of adversarial relationships, reduce dramatically the number of violent encounters between police and those with mental illness, reduce sharply arrests, incarcerations, police shootings, improve the mental health of police, enable many who have struggled, been homeless or cycled in and out of jail and enabled them to move toward productive lives-- and save money at the same time. And it turns out that training police the right way, convincing them that there are better and safer ways to do their jobs, can change law enforcement culture and reduce police-related deaths overall.

Dealing with all of these issues—training in de-escalation, helping police with their own trauma and stress—reduces all violent encounters with police, not just those involving SMI. Miami-Dade County has over 7,600 police officers trained in Crisis Intervention Team (CIT) policing at all of its 36 police agencies. From 2010 through 2019, the City of Miami and Miami-Dade police CIT officers handled over 105,000 mental health related calls—yet during that period they made

only 198 arrests. In the five years before CIT training, the City of Miami police had a total of 90 police shootings—but only 30 in the first five years following the CIT training. And over the past five years through 2019, as more police have been trained and the culture of the department changed, the number dropped to 16! As a result of the CIT program in Miami-Dade, there have been 109,704 fewer arrests to date or 400 years of fewer jail bed days at an annual cost avoidance of $29 million dollars per year.

And importantly, what people in Miami-Dade learned is that changing the way we deal with mental illnesses and substance use disorders also provides a pathway to reform more broadly the way we do policing and manage criminal justice, addressing racial disparities in the criminal justice system and reducing excessive use of force and shootings by police.

If we take these common sense and long overdue steps, we will improve our public health and safety, save critical tax dollars, and return hope, opportunity, and dignity to people with mental illnesses and substance use disorders. To do otherwise and to go back to our pre-pandemic, atrocious response to people with mental illnesses would be immoral, dangerous, irresponsible, and ridiculously expensive.

With the pandemic spotlighting the need for a more deliberate and focused approach to the delivery of mental health and substance use treatment services, and with tragedies every day involving mass shootings, police violence, and more, the call to action has never been more urgent. We know what works. We have lacked the political will and an opportune time to act in the past. The pandemic gives us that once in a lifetime chance to act to create a new vision for mental health and substance use treatment.

Thank you.

Miami-Dade Forensic Alternative Center
Pilot Program Status Report

Background: Individuals with serious mental illnesses ordered into forensic commitment have historically been the fastest growing segment of the publicly funded mental health marketplace in Florida. Between 1999 and 2007, forensic commitments increased by 72 percent, including an unprecedented 16 percent increase between 2005 and 2006. In 2006, Florida experienced a constitutional crisis when demand for state hospital beds among people with mental illnesses involved in the justice system drastically outpaced the number of beds in state treatment facilities. With an average waiting time for admission of nearly three months, the Secretary of the Department of Children and Family Services (DCF) was found in criminal contempt of court and threatened with an $80,000 personal fine and jail time for failing to comply with a court order. This ruling followed months of controversy and high-profile media attention surrounding DCF's inability to place forensically adjudicated individuals in state treatment facilities within 15 days as required by state law. In the wake of this crisis, the Secretary of DCF resigned and the state was forced to allocate $16 million in emergency funding and $48 million in recurring annual funding to create 300 additional forensic treatment beds. Florida currently spends more than $210 million annually – *one third of all adult mental health dollars and two thirds of all state mental health hospital dollars* – on 1,700 beds serving roughly 3,000 individuals under forensic commitment.

In response to the 2006 forensic bed crisis, and at the urging of DCF, the Supreme Court of Florida convened a special committee to address issues relating to the disproportionate representation of people with serious mental illnesses involved in the justice system and to evaluate the role of the forensic treatment system. Consisting of representatives from all three branches of government, as well as top experts from the criminal justice and mental health communities, this body developed a report titled *Transforming Florida's Mental Health System*[1] detailing recommendations for planning, leadership, financing, and service development. The recommendations target effective and sustainable solutions that will help divert people with mental illnesses from the justice system into more appropriate community-based treatment settings. Steps are also outlined to begin shifting investment from costly, deep-end services provided in institutional settings into more effective and cost-efficient front-end services provided in the community.

One of the primary recommendations of the Supreme Court Task Force was to develop safe and cost efficient community-based residential treatment alternatives to serve individuals charged with less serious offenses, who do not pose significant safety risks, and who otherwise would be admitted to state treatment facilities. This recommendation was based on the observation that individuals admitted to state forensic facilities for competency restoration typically receive services focused on resolving legal issues, but not necessarily targeting long-term wellness and recovery from mental illnesses, or eventual community reintegration. As a result, once competency is restored in state treatment facilities, most individuals are discharged from the treatment provider's care and are generally returned to local jails where they are rebooked and incarcerated while waiting for their cases to be resolved. In most cases individuals either have their charges dismissed for lack of prosecution or the defendant takes a plea such as conviction with credit for time served or probation. Individuals are then released to the community, often with limited if any community supports and services in place,

[1] Available at: http://www.floridasupremecourt.org/pub_info/documents/11-14-2007_Mental_Health_Report.pdf

which places individuals at increased risk of reentering the justice system, either as the result of committing a new offense or failing to comply with the terms of probation.

The following report describes outcomes a pilot program implemented to evaluate an alternative approach to forensic service delivery in which services are provided in a locked residential treatment setting by a single treatment provider which is responsible for delivering forensic treatment services, as well as comprehensive recovery and community re-entry services. What is particularly unique about this approach is that participants remain engaged with the service provider following discharge from residential treatment and re-entry into the community to ensure ongoing receipt of services and to respond to treatment and support needs that develop over time.

Concept: In August 2009, the Florida Department of Children and Families (DCF) and the Eleventh Judicial Circuit of Florida implemented a pilot program to demonstrate the feasibility of diverting individuals with mental illnesses adjudicated incompetent to proceed to trial (ITP) from placement in state treatment facilities to placement in community-based treatment and competency restoration services. Program participants have been charged with less serious offenses and are screened to ensure they do not pose public safety risks. They are initially placed in a locked inpatient setting where they receive crisis stabilization, short-term residential treatment, competency restoration services, and community reintegration and living skills. When ready to step-down to a less restrictive placement in the community, participants are provided assistance with re-entry and ongoing service engagement. Unlike individuals admitted to forensic treatment facilities, pilot program participants continue to monitored in the community by the treatment provider following discharge from forensic commitment to ensure ongoing linkage to services and to respond to any emerging treatment and/or support needs.

Program description: The pilot program, known as the Miami-Dade Forensic Alternative Center (MD-FAC), is operated by a community-based treatment provider under contract to DCF's local managing entity, the South Florida Behavioral Health Network. Participants include adults age 18 and older who have been found by the circuit court to be incompetent to proceed on a second or third degree felony(s), who do not have significant histories of violent felony offenses, and are not likely to face incarceration if convicted of their alleged offenses. Admission to MD-FAC is limited to individuals who otherwise would be committed to DCF and admitted to state forensic treatment facilities.

Screening includes review of criminal history for indications of risk of violence or public safety concerns, as well as appropriateness for treatment in an alternative community-based setting. Eligibility criteria exclude admission of any individual who is currently incompetent to proceed, or who has previously been convicted of, found incompetent to proceed on, or found not guilty by reason of insanity of one of the following criminal offenses:

1. Homicide of any kind;
2. Aggravated assault of any kind;
3. Felony battery, as defined in section 784.041, F.S.;
4. Domestic battery by strangulation, as defined in s. 784.041;
5. Aggravated battery of any kind;
6. Kidnapping;
7. Sexual battery of any kind, except as provided in section 794.05, F.S.;
8. Lewd or lascivious battery;
9. Lewd or lascivious molestation;

10. Arson or any offense related to fire bombs or explosive devices;
11. Carjacking;
12. Home invasion robbery;
13. Aggravated child abuse;
14. Aggravated abuse of an elderly person or disabled adult; and
15. Aggravated stalking.

Upon admission to the program, individuals are placed in a locked inpatient crisis unit where crisis stabilization services are provided. Upon stabilization, participants are transferred to a locked, inpatient residential treatment unit where competency restoration and treatment services focusing on illness management and community re-entry are provided. Once competency is restored or the participant no longer meets criteria for continued forensic commitment, the program prepares a treatment summary and recommendations for step-down into community placement. The committing court then holds a hearing to review the recommendations and appropriateness of the recommended community placement. Upon authorization of step-down from inpatient services into community placement by the court, MD-FAC staff provides assistance with re-entry and continues to monitor individuals to ensure efficient and ongoing linkage to necessary treatment and support services.

The MD-FAC program is responsible for providing or assisting participants in accessing a full continuum of care and competency restoration services during both the period of forensic commitment and following community re-entry. The program also provides assistance in accessing entitlement benefits and other means to build economic self-sufficiency, developing effective community supports, and improving living skills. This comprehensive care model contributes to more effective community re-entry and recovery outcomes.

Program Referrals:

Since August 2009, a total of 176 referrals, accounting for 161 unduplicated individuals, have been made to the MD-FAC program. Outcomes of these referrals are as follows:

All referrals:	Total (n=176)
Accepted, admitted to program	111 (63%)
Not eligible for admission to program	57 (32%)
Accepted, not admitted to program	5 (3%)
Referral pending	3 (2%)

Five individuals screened and accepted for placement in the MD-FAC program, were admitted to forensic facilities. The reasons these individuals were not admitted to the MD-FAC program are as follows:

Individuals accepted but not admitted:	Total (n=5)
MD-FAC program at capacity, admitted to forensic treatment facility	4 (80%)
Individual admitted to forensic facility at request of attorney	1 (20%)

Fifty-seven individuals were assessed and found not to meet eligibility criteria for placement in the MD-FAC program. Reasons individuals were not eligible for admission are as follows:

Reason not eligible for admission to MD-FAC:	Total (n=57)
Legal criteria (past/present criminal history)	23 (40%)
Clinical criteria (psychiatric diagnosis)	13 (23%)
Commitment criteria (non-restorable, didn't meet statutory requirement for commitment)	12 (21%)
Defendant refused screening	6 (11%)
Behavioral management/violence concerns	3 (5%)

Program Admissions and Outcomes:
To date, the MD-FAC program has received 111 admissions accounting for 103 unduplicated individuals. Eight individuals were re-admitted to the program following discharge because they were found to be incompetent to proceed and met criteria for forensic commitment following discharge to the community.

A total of 39 admissions have been discharged to other placements: 7 admissions were transferred to forensic treatment facilities because it was determined that their needs could not be effectively met through the MD-FAC program, and one admission was transferred to a community hospital due to acute medical needs:

Status of admissions to MD-FAC program:	Total (n=111)
Remain in MD-FAC under forensic commitment	10 (9%)
Stepped down to the community from forensic commitment	87 (78%)
Transferred to forensic facility because needs could not be met*	13 (12%)
Transferred to community hospital due to acute medical needs	1 (1%)

*Thirteen individuals were transferred to forensic facilities because they either refused medication and did not meet criteria to petition the court for authorization of involuntary treatment orders, it was determined that the individual was not likely to regain competency within a reasonable amount of time, or because of safety concerns.

Individuals admitted to the MD-FAC program are identified as ready for discharge from forensic commitment an average of 64 days (43%) sooner than individuals who complete competency restoration services in forensic treatment facilities, and spend an average of 32 fewer days (19%) under forensic commitment. This is due, in part, to the fact that not all individuals admitted to the MD-FAC program complete competency restoration training while under forensic commitment. Where possible, the MD-FAC program works to identify individuals who can be safely stepped-down to less restrictive and less costly placements even if they have not yet completed the competency restoration process. In these situations, the individual continues to receive competency restoration services in the community with MD-FAC program staff providing support and linkage to full array of community-based treatment services. This helps to make more efficient use of the limited number of MD-FAC forensic commitment beds.

	Forensic facilities	MD-FAC	Difference
Average time to notify court of discharge readiness	149 days	85 days	-64 days (-43%)
Average length of stay**	170 days	138 days	-32 days (-19%)

** Comparison of length of stay is between individuals who complete competency restoration services in forensic treatment facilities and individuals admitted to MD-FAC program who may or may not complete competency restoration prior to stepping-down from forensic commitment. See narrative for additional

details.

Program costs:
The MD-FAC program operates 16 beds and demonstrates modest savings to the state over services provided in forensic treatment facilities. It should be noted, however, that a substantial proportion of the costs associated with the current program are reflected in minimum staffing standards for licensing short-term residential treatment facilities as well as fixed costs (e.g., utilities, insurance) associated with operations. Because staffing standards allow for additional bed capacity without substantially increasing program staff or fixed costs, operations will become more efficient as program capacity is increased. Based on projections developed by DCF in consultation with treatment providers, increasing pilot program capacity from 10 to 20 beds will result in an average cost of less than $230 per bed/per day, a savings of $107.50 bed/day (32%) over services provided in state forensic treatment facilities. As such, in order to maximize the organizational efficiency of pilot programs such as MD-FAC and to achieve more significant cost savings over state forensic facilities, it is strongly recommended that any such programs be funded to operate at least 20 beds.

Treatment setting	Total bed/days (16 beds x 365 days)	Average bed/day cost	Total cost
Traditional forensic treatment facility	7,300 bed/days	$337.00	$2,460,100
Forensic diversion program	7,300 bed/days	$229.50	$1,675,350
Cost difference		-$107.50	-$784,750 (-32%)

Criminal Justice Outcomes:
While a suitable comparison group for evaluating outcomes of the MD-FAC program has yet to be identified, examination of jail bookings and days in jail among individuals who remain linked to services following community re-entry and those who do not reveal substantial differences.

The vast majority of individuals who remain actively linked to services through the MD-FAC program after stepping down from forensic commitment or complete the program and no longer require monitoring demonstrate no additional involvement in the criminal justice system. In fact, only one such individual has been charged with committing a new offense (misdemeanor, petit theft) since reentering the community. Eight of the 27 individuals (30%) have been rebooked into the jail as the result of sanctions for non-compliance with conditions of release; however all have been successfully re-engaged in treatment services. Overall, individuals who remain linked to services have experienced a total of 11 jail bookings and have spent a total of 85 days in jail since stepping down from forensic commitment.

By contrast, 9 of the 11 individuals (82%) who are no longer linked to MD-FAC services have been re-booked into the jail. This includes a total of 23 bookings resulting from new criminal offenses and 15 bookings resulting from technical violations such as warrants or probation violations. In total, these individuals have spent 1,435 days in jail since stepping down from forensic commitment.

Overall, individuals who remain linked to MD-FAC services demonstrate 68% fewer jail bookings and 94% fewer jail days following step-down from forensic commitment as compared to those who are no longer linked to services.

Criminal justice outcome across all individuals stepped down from forensic commitment (total n=33)	Actively linked to MD-FAC services or completed program (n=27)	No longer linked to MD-FAC services (n=11)
Total individuals re-booked into the jail	8 (30%)	9 (82%)
Number of jail bookings for committing a **new offenses**	1	23
Number of jail bookings for **sanctions, warrants, and/or violations**	11	15
Total days incarcerated	85	1,435

Added Value:

- Unlike most individuals admitted to state forensic treatment facilities, individuals admitted to the MD-FAC program are not rebooked into the jail following restoration of competency. Instead, individuals remain at the treatment program where they are re-evaluated by court appointed experts while the treatment team develops a comprehensive transition plan for step-down into a less restrictive community placement. When court hearings are held to determine competency and/or authorize step-down into community placements, individuals are brought directly to court by MD-FAC staff. This not only reduces burdens on the county jail, but eliminates the possibility that individuals will decompensate while incarcerated and require subsequent readmission to state treatment facilities. It also ensures that individuals remain linked to the service provider through the community re-entry and re-integration process.

- Among individuals discharged from forensic treatment facilities who are restored to competence and can return to court to successfully to take a plea, roughly 80-90 percent have their charges dismissed for lack of prosecution or the defendant takes a plea such as conviction with credit for time served or probation. Most of these individuals are then released to the community, often with limited community supports and services in place. While forensic treatment facilities do provide recommendations regarding continued treatment and placement at the time of discharge, these institutional programs are not designed or equipped to monitor individuals once they leave the hospital or to ensure individuals are linked to services upon community re-entry.

- Because MD-FAC program staff provides ongoing assistance, support, and monitoring following discharge from forensic commitment and community re-entry, individuals remain linked to a continuum of care and are more likely to access necessary services in a timely and efficient manner. This decreases the likelihood of returning to jails, prisons, state treatment facilities, emergency rooms, and other crisis settings.

- Over the course of the individual's inpatient stay, the MD-FAC program provides intensive services targeting competency restoration as well as individualized community-living and re-entry skills.

- MD-FAC provides assistance to all eligible individuals in accessing federal entitlement benefits that pay for treatment and housing services upon discharge. While some forensic treatment

facilities may provide assistance with accessing benefits, it has not yet become standard practice.

Exhibit B

Daniel Murrie, PhD, University of Virginia's Institute of Law, Psychiatry, & Public Policy
&
Neil Gowensmith, PhD, University of Denver's Forensic Institute for Research, Service, & Training

<u>**Addressing California's Competency Crisis**</u>

Daniel Murrie, PhD

University of Virginia's Institute of Law, Psychiatry, & Public Policy

Neil Gowensmith, PhD

University of Denver's Forensic Institute for Research, Service, & Training

When criminal defendants have symptoms of mental illness so severe that they interfere with their participation in criminal justice proceedings, criminal courts may find those criminal defendants incompetent to stand trial and then order *competence restoration* services to provide treatment—traditionally in state psychiatric hospitals—until the defendants can meaningfully understand proceedings, assist counsel, and make decisions necessary for criminal adjudication. This competence restoration is a form of public mental health treatment ordered by the criminal justice system. But in recent history, as more criminal defendants are referred for competence evaluations and found incompetent, the public mental health system, particularly state psychiatric hospitals, are unable to meet increasing demands for competence restoration services. This public health emergency is described as a "competency crisis," common to many states but particularly severe in California.

California faces a waitlist for inpatient competence restoration services beyond 1500 people, with most waiting many months for inpatient restoration. Because this waitlist comprises criminal defendants with substantial psychiatric symptoms, most are vulnerable and psychiatrically unstable. Long waits for treatment increase the risk of disastrous consequences – increasingly severe symptoms, risk of harm to self or others, and severe human suffering. At least two broad errors—faulty values, assumptions, and default approaches—have contributed to this crisis:

1. *California has historically relied almost entirely on restoration in inpatient psychiatric hospitals*. But not all defendants actually need inpatient restoration. Many (e.g., those with intellectual disability or less severe psychiatric symptoms) are better restored in the community, closer to home and at lower cost, leaving inpatient resources for those who need them most. Strong outpatient and jail-based restoration services could serve many of the defendants waiting for inpatient services.

2. *The competency system has historically served as a single "catchall" solution for most mental health issues that come before the court*. But there are far more efficient and effective approaches to linking detainees with psychiatric illnesses to the services they need. Certainly those facing serious charges will always require a competence restoration system; they must return to court and resolve charges. But that large population who were arrested for misdemeanors or minor charges—many because they lacked the stability of homes or treatment—are much better served by diversion to community treatment (greatly reducing the load on the competency system).

So how might California better approach defendants with mental illness? There is no single solution, but changes at each stage of proceedings will decrease the population waiting for inpatient restoration.

Early Diversion, particularly for those facing misdemeanor charges:

First, *increase early diversion before competence can be raised*: i.e., divert to treatment—immediately before or after arrest—those with misdemeanors or minor charges. Our research reveals that defendants referred for competence evaluations addressing misdemeanor charges were more severely ill and required more resources to restore (despite the minor charges); they also appear more likely to be re-arrested after restoration. Some California jurisdictions have adopted new approaches for misdemeanors, but these must be more widely adopted.

Varied Restoration Services:

Though the default practice around the country has historically been to order incompetent defendants for restoration in the state hospital, *not all defendants require inpatient restoration*. Jurisdictions are increasingly developing outpatient restoration programs, a less restrictive alternative that is far more affordable, and often keeps defendants closer to their communities. Indeed, Virginia and Colorado offer outpatient restoration state-wide and prioritize outpatient as the *default* approach.

Some jurisdictions have also developed jail-based restoration programs, or at least treatment programs to provide medication and "jump start" the restoration process. These must be considered carefully—jails are never the optimal place for treatment—but some programs aim to replicate a hospital-like environment in a jail unit. At a minimum, enhancing psychiatric treatment in jails will reduce suffering and help inpatient restoration proceed at a better pace.

Finally, even for the many defendants who *do* require inpatient restoration, not all need it equally urgently. Historically, restoration services have operated like the local DMV; detainees are transferred to the hospital based on their "place in line." But some need treatment urgently, on an emergency basis, and long waits can be devastating for them. In Colorado, we recommended a triage system to prioritize those defendants who were most acutely ill and admit them sooner (within 7 days) whereas those with less urgent needs are admitted within 28. Of course, they all require careful monitoring and care while they wait, so a program of "forensic navigators" monitors their status.

Better Evaluation Services:

Of course, defendants only enter restoration services if an evaluator opined they should. Currently, California evaluators ("alienists") are procured by counties, which are motivated to cut costs at the evaluation stage. They have little incentive to reduce unnecessary or expensive restoration, because the state (DSH) pays costs at that stage. This means that poorly-paid evaluations, of variable quality, at the county greatly influence whom is ultimately sent for inpatient restoration across the state. A state-wide evaluator training and oversight program (influential in other state systems) could enhance the reliability and accuracy of incompetency findings, better identifying those who actually warrant inpatient restoration

Once evaluators are well-selected and well-trained, they can make other important recommendations at the evaluation stage. For example, in Virginia and Colorado, evaluators may opine that the defendant requires *inpatient* restoration, but inpatient is not necessarily the default. Likewise, evaluators make the triage recommendation in Colorado, regarding whether a defendant needs treatment urgently. In other states, evaluators may identify cases that appear to need a quicker resolution, answer questions about defendants meeting criteria for involuntary medications, discharge placement options, or even re-evaluation of competency capacities. In

short, evaluators may do more than opine whether a defendant is competent or not; they may provide helpful opinions about a greater range of interventions: diversion, emergency treatment, optimal restoration location, etc. But, they may do so only *after rigorous and uniform training, and with ongoing quality control*.

Summary:

The demand for competency restoration services far exceeds what the traditional inpatient restoration model can meet. Indeed, the demand for competency restoration services reflects not simply the needs of a competency system, but rather, a variety of problems such as inadequate housing and inadequate public mental health services. Continuing to use the competency mechanism as a catchall, default strategy to meet these needs will only exacerbate the problem. Instead, California can shift the focus to early diversion and deflection for those with minor charges. Then prioritize strong evaluation services to better identify those who are actually incompetent, and their restoration needs. Prioritize outpatient restoration for all who are suitable, strong psychiatric treatment in jail, and more tailored triage services for those that still require inpatient restoration.

Exhibit C

Teresa Pasquini, co-author of Housing that Heals

Housing That Heals:
A Search for a Place Like Home for Families Like Ours

May 9, 2022

My name is Teresa Pasquini, a lifelong resident of Contra Costa County and a former 9-year member of the Contra Costa County Mental Health Commission. I am also a state and national advocate for families who live with serious mental illnesses that are medical brain disorders, not behavioral issues.

I respectfully submit these comments to the California Penal Code Committee as the proud mom of an adult child who lives heroically with a schizoaffective disorder. He is also a former inmate No. 201202796 in Napa County. But, he is more than a diagnosis or number. His name is Danny and he is a beloved son.

Danny became an inmate upon being arrested while a ***patient*** at Napa State Hospital(NSH). Contra Costa Mental Health had sent him to NSH on an LPS civil, not criminal, commitment. He was placed at NSH when all other LPS facilities declined him access during an acute episode of psychosis. This is typical in the California LPS civil conservatorship system as the research of Dr. Alex Barnard, [Absent Authority, Absent Accountability: Exploring California's Conservatorship Continuum](), demonstrated.

When our son was first placed at NSH he did well and then it turned into a nightmare. It all fell apart due to a lack of coordinating medication history with his county conservator and his mom who knew that the medications he was on at NSH would lead to disaster. Sadly, once the treating psychiatrist started listening to us, it was too late. My son was in deep crisis and was about to be criminalized for his brain illness.

During this crisis, he was placed in seclusion and restraints five times in a handful of days and after being released, he acted out. That resulted in his arrest, his first felony charge and preventable harm to others. The hospital became the potential prison pipeline. He was determined to be Incompetent to Stand Trial and sent back to Napa State Hospital for "competency training" as an inmate. I submit that the California mental health system is incompetent.

I went into warrior mom mentality to save my son from a criminal conviction. Because of luck and heroics, he had all charges dropped after 5 years of trauma and torture in the California Incompetent to Stand Trial human log jam. I speak about the process of how he was transferred from solitary to sanity in this blog, https://www.treatmentadvocacycenter.org/fixing-the-system/features-and-news/3701-my-sons-struggle-for-competent-care-and-psychiatric-bed-personally-speaking.

He is doing very well today at an Adult Residential Facility in Santa Clara County but to understand the depth of California's criminal and civil cruelty towards my son and family, we have to go back 20 years.

My beloved son, Danny, had his first 5150 at the age of 16 in a suicide by cop type event. With the help of a pediatrician and clinician, he was diagnosed early, received intensive therapies, had a job, and graduated from high school. We thought we had managed his care.

But, on his 18th birthday, he was 5150d for the second time and fell into what I call the “black hole” of the California Adult Mental Health System. He was placed on an LPS Conservatorship at the age of 19 during his third involuntary hospitalization that year. We received LPS Conservatorship papers from the Contra Costa County Public Guardian’s office. I called the office to find out what this meant and a public conservator asked me, “Why do you keep bringing him home? He is very sick!”

At the same time, his inpatient psychiatrist told my husband and me that we would be lucky if we could get our son ***into*** the criminal justice system. He said it casually, as though he were being accepted to Cal or Stanford. I was infuriated. But, I eventually realized that he had been giving us fair warning that the criminal justice system is where we “house” the SMI in California. My friend, Mark Gale, says this is because, “Jail is the bed that never says no.”

I learned then that the system required me to make him homeless and gravely disabled in order to get him medically necessary treatment. I learned every nuance of every statute, policy, and regulation. I became an expert on navigating a broken system that demands dangerousness and complete deterioration before one can access the level of care that my son needed. We did everything to prevent danger to our son and others. But the current laws and system require it.

My son’s first LPS Conservatorship was established when he was very sick and suffering from severe anosognosia, a lack of insight. It has been renewed every year upon medical advice and a judge’s approval. During that time he was supposed to be prevented from further grave disability. But, there is no right to treatment in an appropriate setting in California, even when most of your civil rights have been taken away. That should be criminal.

Even though we were willing to maintain private insurance for our gravely disabled son and provide as much care as the law allowed, we were forced to make decisions that are illogical and cruel. Or the “mental health” system made them for us.. I have shared our family story publicly in order to teach how we are designing health and safety systems that actually provide no choice or compassionate care all under the guise of civil liberties. The results are scattered across our streets, in jails, graveyards or in the back bedrooms of aging parent’s homes.

Here is a recent article that describes the insanity faced by families like mine and the fiscal waste of chasing justice within the current IST system in California. This family deserved a right to treatment, not a right to deteriorate in jail. Now they are in the “divert to where and what” scenario that will only lead to more worry, waiting and waste. https://www.sanluisobispo.com/news/health-and-medicine/article260241945.html?%20fbclid=IwAR2ExL-AT6JeMv6MApjpEdni0RFVdSSARgVm9wdZ4G84bAlr3K8SOiDNRno.

This article provides a snapshot of data that should make all lawmakers and policy makers pause regarding the effectiveness of the diversion laws and programs that are being created. There is a lack of performance-based accountability. And, there is a disregard for the impact on communities and families like mine. We must stop making laws about this vulnerable, marginalized population based on ideology and misinformation. Reliable data should be driving health and justice policy and it should always include “data of the soul” which is what the mom in this article is publicly providing.

There is a huge gap of knowledge among judges, District Attorneys, Public Defenders and even health systems about how difficult it is for someone with a serious mental illness to access any treatment before tragedy. The amount of money and time wasted for the IST population should be calculated and that funding should be diverted to pay for a right to treatment and appropriate housing that heals for the most gravely disabled seriously mentally ill population.

You can't divert someone into appropriate care without creating a complete continuum of care that includes Housing That Heals. That is why I traveled over 3000 miles across the state in 2019, with another mom, visiting over 22 facilities and we co wrote this white paper, released in May 2020, https://namica.org/community-voices/team-nami-spotlight-housing-that-heals-project-report/
I co wrote the Housing That Heals paper to demonstrate that there are solutions and alternatives to state hospitals, jails, and prisons for families like mine. I will spend the rest of my life fighting for a system of solutions that will prevent the suffering and solitary that my son and family survived.

For the past 3 years, my son remains on an LPS conservatorship while living in the community at Psynergy, an unlocked ARF in Santa Clara County paid with MHSA funding. This is the first successful community transition in 20 years. He does not need a state hospital or an IMD anymore but he will likely not be able to live independently. He needs Housing That Heals to prevent a return to the more restrictive level of care. The Psynergy model is unique and must be studied, spread and scaled.

Most Board and Care facilities are underfunded and do not provide the appropriate level of clinical and recovery support provided at Psynergy. This paper reflects the board and care crisis, " No Time to Waste: An Imminent Housing Crisis for People with Serious Mental Illness Living in Adult Residential Facilities" https://www.chhs.ca.gov/wp-content/uploads/2021/11/Housing-That-Heals-11-05-21.pdf. I have joined local, state and national advocates on a call to action that will incentivize creating a continuum of community and clinical care in order to avoid continuous crisis and criminalization.

The recent DSH Stakeholder Workgroup was an attempt to respond to a law suit against the state of California. I joined almost every meeting as a mom and member of the public. There were the best intentions made by state and local stakeholders, each representing a different piece of the puzzle. But, there was a lack of authentic partnership with moms like me or sons like mine who have lived through and survived California's criminalization cruelty. They just don't know what we know. I fear their solutions will be inadequate to end the chaos of care in California without establishing clear measures of accountability.

Thank you for giving me this opportunity to share my family's lived experience. And, please know my commitment to seeing our beloved state put a stop to this humanity crisis. The one size fits all system approach, fails too many families like mine in California. My son has been on an 20 year cycle that has stolen his life, liberty and forced him into a 'fail first, housing last" circle of suffering, homelessness, institutionalization and incarceration. This deliberate discrimination and criminalization must end. Together, we must **all** make the choice to do better.

It is time to cure the system insanity and focus on funding a right to treatment along a full continuum of care that includes all levels of Housing That Heals. I have seen it work. I know it is possible. And, it should not have taken 20 years of being failed, jailed, shunned and shamed.

Respectfully submitted,

Teresa Pasquini, Danny's mom

Mom on a Mission for Housing that Heals

Exhibit D

Judge Thomas M. Anderson,
Nevada County Superior Court

SUBMISSION STATEMENT
Penal Code Committee Hearing May 17, 2022

FROM: THOMAS M. ANDERSON
JUDGE OF THE SUPERIOR COURT, COUNTY OF NEVADA (2007-present)

RELEVENT HISTORY: Presiding over Laura's Law/Assisted Outpatient Treatment (LL/AOT) Court since 2008. Prior to going on the bench, served as the Public Defender for Lassen County 1996-2000 and Nevada County 2000-2007. Was in private practice focusing on criminal law and general practice. During that time served as a pro tem judge for San Francisco Court and as an Administrative Law Judge pro tem for the Office of Administrative Hearings.

This is to provide some background on some of the programs that interface with the Penal Code.

ISSUES: The interaction between the Penal Code with the variety of mental health statutes:

- Laura's Law/ Assisted Outpatient Treatment
- Conservatorships / W&IC 5150 (danger to self or others)
- Penal Code section 1368, incompetent to stand trial (felony v misdemeanor)
- Criminal Court Diversion
- Mental Health Court
- Drug Courts
- NGI, not guilty by reason of insanity
- Proposed "CARE COURT"

ASSISTED OUTPATIENT TREATMEN (AOT)
AOT is designed for a specific group of persons with severe mental illness (SMI). AOT is a civil program, separate from criminal courts. AOT was created to avoid tragedies, such as the one that occurred in Nevada County in January 2001, where Pearlie May Feldman, Mike Markle and Laura Wilcox were shot and killed by an under-served man with SMI. AOT intervention and treatments focus on persons with SMI that are decompensating and without treatment will likely be jailed, hospitalized against their will, killed or harm their self or others. When the AOT program is designed with fidelity to the purpose of AOT, it has shown to be exceptionally successful and saves money for the county!

How AOT works:

1. A person calls the county behavioral health department with a referral.
2. The department sends a mental health professional to intervene and assess the referred person
3. After that interview the person is offered to accept voluntary services. If the person accepts voluntary service — no further action is required. Typically, approximately 50 to 60 percent of the persons assessed accept voluntary treatment.
4. If, after the interview, the person refused treatment and the person appears to likely meet the statutory criteria, County Counsel is informed and prepares a Petition for an AOT Order.
5. The person is brought before the Court and a formal hearing is conducted to determine if the person meets criteria. The person is provided an attorney and apprised of their Due Process rights. (In Practice the person has an opportunity to discuss their situation with their attorney. Then the Court usually has an informal discussion with the person, reviewing the proposed treatment plan. The Court, the person and the treatment provided may attempt to negotiate the proposed treatment plan to engage the person.)
6. After the hearing, if the person meets criteria or prior to the hearing agrees to submit to an Order, the Court issues the AOT Order After hearing that includes that the treatment prover and the person are to abide by the terms of the treatment plan.
7. Following the issuance of an Order, the Court sets a status review hearing to assess the person's and the treatment provider's adherence to the order. The first status review hearing is usually held with one or two weeks. Then the status reviews are conducted as need, usually every two to three weeks for the duration of the Order.

Benefits of AOT:

- Provides structured and supervised treatment for the person.
- Efficient court process.
- Reduces arrests, jail days, ER visits, hospitalization costs and reoffending.
- High rate of success for the person.
- Saves money. (A study of Nevada County's program showed that for every $1.00 spent — the County got a return of $1.81.)

Limitations of AOT:

- AOT is not a panacea for the underserved persons with SMI or any person with a diagnosable Psychiatric condition.
- AOT is not mandated for all counties
- Limited to the statutory criteria

DIVERSION AND MENTAL HEALTH DIVERSION:
Diversion programs are typically used to remove a case from the criminal docket with little or no focus on treatment. It is discretionary disposition. Terms vary, usually six months to 12 months. There is little information on whether these programs reduce recidivism and rehabilitation. The structure of these programs vary for county to county.

MENTAL HEALTH COURT:
The structure of these court programs vary among counties. Most are structured like other treatment courts and allow incarceration as a consequence for not following the assigned treatment plan.

CARE COURT:
The proposed CARE Court is an effort to create an AOT type program that would appear to be more accessible than AOT and broaden the criteria.

It is still being reviewed and redrafted.

The current plans require more administrative processes and are more costly than AOT.

THOUGHTS:
When editing or drafting new Penal Codes that involve mental health treatment concerns, each proposals needs to be reviewed by mental health professionals and administrators.

Brevity 'is the soul of wit" and I believe brevity to be the path to a clearer and effective Penal Code.

Exhibit E

Kim Pederson, Senior Attorney
Disability Rights California

Written Submission of Kim Pederson, Disability Rights California for Committee on Revision of the Penal Code May 12, 2022

Background: I am an attorney in the Mental Health Practice Group of Disability Rights California. One of the main focuses of our work is advocating for policy changes to strengthen systems of community-based behavioral health services that allow people to access voluntary services offered in the least-restrictive settings. Along these lines, we advocate for non-carceral and non-institutional alternatives for defendants found incompetent to stand trial on misdemeanor and felony charges.

Personally, I have over 17 years' experience representing people living with mental health disabilities in civil legal proceedings related to civil commitment, housing, and public benefits. I have never represented clients in criminal legal proceedings. My experience can help inform the committee about the community-based systems that are necessary to effectively divert people from the criminal legal system.

Below, I list several areas in which California can improve access to community-based services for people found incompetent to stand trial ("IST").

Expand diversion opportunities that meaningfully exit people from the cycle of homelessness, incarceration, and hospitalization. When DRC talks about diversion, we mean diversion to community-based services whenever possible, not diversion to locked psychiatric facilities via Lanterman-Petris-Short Act conservatorships. In addition, whenever possible, felony defendants should be diverted via Penal Code sections 1001.35 *et seq.* ("Penal Code Diversion"), rather than via collaborative courts that require a plea in exchange for diversion. Upon successful completion of Penal Code Diversion, charges are dismissed and the record of the case is sealed. The promise of not having a criminal conviction on their record makes it easier for a person to secure housing, employment, and benefits that allow for easier re-entry following involvement in the criminal legal system.

Diversion should be offered at the earliest possible opportunity in a criminal legal proceeding. While the funds that the Department of State Hospitals seeks to allocate for felony mental health diversion would be a significant commitment by the State, these funds would only be available to serve defendants who have *already been deemed* IST on felony charges. A finding of IST may come after several months or years of

incarceration, meaning that a person ultimately eligible for diversion may languish in jail for a long period of time because resources are not available to divert them. In addition, limiting state-subsidized diversion to people already found IST limits diversion opportunities in counties that have not funded diversion programs sufficiently to meet need.

Expanding diversion opportunities could also mean changing the Penal Code to require consideration of Penal Code Diversion for all defendants charged with non-violent, lower-level felonies who meet certain criteria. The changes to misdemeanor diversion enacted through SB 317 (Stern) last year could serve as a model for this.

Provide resources necessary to allow counties and community-based organizations to build out programming, workforce, and infrastructure for effective diversion programs for all eligible defendants. Expanding opportunities for diversion goes beyond making changes to the Penal Code. In addition, resources must be allocated to build out resources for housing and intensive community-based behavioral health services necessary to ensure successful diversion and beyond. DSH's proposed Trailer Bill Language provides a roadmap forward on this point, but if it is passed as drafted, it will only provide diversion funding for people already found IST on felony charges. The State must make similar commitments that allow diversion of felony defendants with behavioral health disabilities earlier in their proceedings.

Effective diversion relies on several factors that must be resourced:

- **Safe and stable housing for all people granted diversion.** Housing is the most critical element for achieving behavioral health stability, regardless of involvement in the criminal legal system. Housing for diversion participants should be provided in the least-restrictive setting that meets a person's needs. Ideally, successful completion of diversion would lead to permanent housing with voluntary services, to ensure long-term stability. Given California's current real estate market, significant state investment may be necessary to overcome barriers to creating housing for diversion participants.
- **Intensive behavioral health services that are recovery-oriented and consumer-driven.** Behavioral health services include services for mental health and substance use disorders. These services should be provided whenever and wherever a person needs them. Assertive Community Treatment (ACT) is an evidence-based practice proven to effectively engage people with serious mental illness in services, and there is a forensic variation that can be used to serve

people involved in the criminal legal system. From what I have observed, too few counties offer ACT-level services to all people who would benefit from them. In addition, services provided to diversion participants should include Peer Support and should include Community-Defined Evidence Practices to meet the needs of California's diverse cultural populations.

- **Workforce that reflects California's diversity.** The State is currently in the midst of a historic behavioral health workforce shortage. Any efforts to scale up diversion will depend upon the ability to invest in a workforce that reflects the racial, cultural, and linguistic diversity of our State.

Exhibit F

Stephanie Regular, Chair of California Public Defender Association's Mental Health and Civil Commitment Committee

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CPDA

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Alameda County

Chapter 6 of the Penal Code – California's Competency to Stand Trial Provisions

Stephanie Regular, Chair CPDA Mental Health/Civil Commitment Committee

Thank you to the Committee for inviting me to comment and answer questions regarding California's Competency to Stand Trial provisions. On behalf of the California Public Defenders Association, a statewide organization of criminal defense practitioners, I propose the following reforms to Chapter 6 of the Penal Code.

Shifting Demographics and a Lack of Capacity in California's State Hospitals

The State has made incremental improvements to its competency provisions in the past three years with the enactment of SB 1187 (reducing the maximum commitment for felony ISTs from three years to two years) and SB 317 (eliminating competency restoration for misdemeanor ISTs). Otherwise, Chapter 6 of the Penal Code remains largely unchanged since 1974.

Since the 1970's, however, patient demographics at state hospitals have shifted dramatically. In 1971 the state hospitals housed 6,075 LPS patients and 2,123 forensic patients.[1] In 2017, the state hospitals housed 7,199 forensic patients and 706 LPS patients.[2] In other words, in 2017, more individuals entered our state hospital systems through arrest and criminal charges than civil intervention.[3]

Currently, the Department of State Hospitals' (DSH) waitlist for forensic patients awaiting competency restoration exceeds 1700 persons.[4] After waiting anywhere from five-months to a year for treatment, some of these individuals receive targeted restoration services in a hospital, many are allocated to jail-based-services, and few are placed in the community. At the end of their commitment and conclusion of their criminal cases, most are released to the same conditions that lead to their incarceration – managing symptoms of serious mental illness without housing, treatment, or support.

Although this committee cannot possibly overhaul California's fragmented and under-resourced behavioral health systems, it can reform this State's competency

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[1] *Major Milestones: 43 Years of Care and Treatment of the Mentally Ill,* Legislative Analyst's Office (March 2000) *available at* Major Milestones: 43 Years of Care and Treatment of the Mentally Ill
[2] https://data.chhs.ca.gov/dataset/department-of-state-hospitals-forensic-vs-civil-commitment-population
[3] Notably, the patient census was higher in 1971 than it was in 2017 by 293 people.
[4] Incompetent to Stand Trial Solutions Workgroup Report of Recommended Solutions, p.13 (November 2021) *available at* https://www.chhs.ca.gov/wp-content/uploads/2021/12/IST_Solutions_Report_Final_v2.pdf

provisions to create off-ramps to community-based treatment or other more appropriate civil commitment schemes, establish updated timelines, and clarify outdated definitions to provide better outcomes for the vulnerable men and women who become system-involved as a result of serious mental illness.

Expanding SB 317 to Include Penal Code section 1170 (h) Offenses will Increase Opportunities for Community-Based Treatment

In 2018, the Council of State Governments Justice Center (CSG) convened an advisory group of experts from around the state to identify system improvements to competency to stand trial procedures. The group generated ten evidence-based strategies to decrease referrals to state hospitals, increase opportunities for diversion and other community-based treatment options, and streamline processes. Among its strategies, the workgroup recommended that states limit the use of competency restoration for cases too serious to warrant dismissal or diversion.[5]

In 2021, in line with advisory group recommendations, this State enacted legislation reforming California's competency provisions for individuals charged with misdemeanors. SB 317 eliminated competency restoration for these individuals and requires courts to consider mental health diversion instead. For those not suitable for diversion, the statute allows the court to refer the individual for Assisted Outpatient Treatment (AOT) or a conservatorship. Referrals to treatment-centered approaches occur at the beginning of proceedings rather than after a year of incarceration or multiple failed attempts at restoration.

Unfortunately, SB 317 applies to only a segment of system-involved individuals, with other low-level offenders still among the hundreds of individuals on DSH's 1700-person waitlist. By the time these men and women are "restored" to competency, they, like their misdemeanor counterparts prior to SB 317, have reached their maximum sentence, or have far surpassed the amount of time they would have served if not for their mental illness.

As noted by the CSG advisory group, high rates of dismissal or time served following restoration may be indicative of the over-utilization of competency restoration for cases where the state's interest in adjudication was relatively low. For these low-level offenders, including those charged with Penal Code section 1170 (h) felonies, the State should expand SB 317 to reduce the number of individuals committed to state hospital beds and increase opportunities of diversion to community-based services.

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[5] *Just and Well: Rethinking How States Approach Competency to Stand Trial*, The Council of State Governments (October 2020) *available at* https://csgjusticecenter.org/wp-content/uploads/2020/10/Just-and-Well27OCT2020.pdf

An Early Off-Ramp for those who are Unlikely to be Restored to Competency will Promote Early Access to Appropriate Levels of Care.

Many individuals who are found incompetent to stand trial do not suffer from a mental illness that can be treated with medication. These individuals are committed to state hospitals or developmental centers due to static or degenerative disorders that include dementia, traumatic brain injury, neurocognitive disorders, and developmental disabilities. Under the existing statutory scheme, the court has no authority to find the individual unlikely to be restored to competency at the beginning of proceedings and must delay referrals to more appropriate levels of care until the end of a lengthy, costly, and futile competency restoration process.[6]

Rather than delaying the determination of whether an individual is unlikely to be restored until after commitment, section 1369 should require court-appointed experts to provide an opinion to the court as to whether the person is likely to be restored to competency in the foreseeable future prior to commitment. For those who will not be restored, section 1370 should require the court to initiate conservatorship proceedings or release the individual.

Statutory Definition of Competency to Stand Trial

In California, an individual is incompetent to stand trial if, as a result of a mental health disorder or developmental disability, the defendant is unable to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a rational manner.[7] What it means to rationally assist counsel is not codified by statute and remains largely undefined in California's case law. Absent clear guidance, court-appointed doctors, attorneys, courts and juries, fill in the gaps, leading to variable results across cases and jurisdiction in this State.[8]

Florida and Utah's competency statutes list information that experts must consider and include in their reports. In Florida, the expert must consider the defendant's capacity to: 1) appreciate the charges; 2) appreciate the range of penalties; 3) understand the adversarial nature of the process; 4) disclose to counsel facts pertinent to the proceedings at issue; 5) manifest appropriate courtroom behavior; 6) testify relevantly.[9]

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[6] Welfare and Institution Code section 4335.2 permits the Department of State Hospitals to evaluate an individual 60-days after commitment to determine whether the individual is competent, unlikely to be restored, or potentially eligible for mental health diversion. Although this section provides an off-ramp prior to admission, this State can amend provision to provide an off-ramp prior to commitment.

[7] Penal Code section 1367

[8] Bagby, R.M., Nicholson, R.A., Rogers, R., & Nussbaum, D., *Domains of competency to stand trial: A factor analytic study,* Law and Human Behavior, 16. (1992).

[9] Fla.R.Crim.P 916.12 *available at* http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0900-0999/0916/Sections/0916.12.html

Although both Florida and Utah's statutes under-represent the capacities that a court-appointed expert should consider when assessing competency,[10] these statutes provide a framework for court-appointed experts and an example of the direction that California's competency statute should take.

Current Statutory Timeframes Exacerbate Delays to Appropriate Systems of Care Before and After Competency Restoration

1. *CONREP Placement Recommendation*

Once an individual is found incompetent to stand trial, the court refers that individual to the community program director (CONREP) to make a recommendation as to whether the individual should undergo inpatient or outpatient treatment.[11] The statute provides that CONREP shall submit its recommendation within 15 court days of the referral. In practice, the matter is continued three to four weeks for the recommendation.

The California Public Defender Association recently held a roundtable for mental health practitioners from across the state. Representatives attended from approximately 20 counties, including Sacramento, Los Angeles, San Diego, Santa Clara, San Francisco and Orange County. When asked for a show of hands whether anyone had received a recommendation for outpatient treatment in the last five years from CONREP, no one raised their hand.

Individuals should be committed to the state hospital upon a finding that they are incompetent to stand trial, not four weeks later. For the rare circumstances where CONREP provides a recommendation of outpatient treatment after referral, the court can modify its order accordingly.

2. *Maximum Commitment for Felony Offenses*

In 2018, SB 1187 modified California's maximum commitment for felony offenses from three years to two years. However, the State should consider reducing this time period even further.

Research indicates that the vast majority of people are restored to competency within six months of starting treatment and nine out of 10 individuals are restored within one year.[12] The chances that an individual will attain trial competency sharply declines after a year of treatment.

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[10] Melton, G.B., Petrila, J., Pythress, N.G., & Slobogin, C., *Psychological evaluations for the courts: A handbook for mental health professionals and lawyers,* New York: Guilford. (1987) [Melton, et al. provide 21 capacities that a court-appointed expert should consider.]
[11] Penal Code section 1370 subd. (a)(2)(A).
[12] Morris, D. and DeYoung, N., *Long-Term Competence Restoration*, Journal of the American Academy of Psychiatry and the Law, 42(1) 81-90 (March 2014) *available at*

At least 24 other States, including South Carolina, Texas, Missouri, Kentucky, Kansas, and Massachusetts have maximum commitments shorter than California's current two-year commitment period, with many States codifying timeframes of one-year or less.[13] While an 18-month or one year commitment may not seem feasible in California given current admission delays of over six months, this Committee should consider whether notions of due process and basic human dignity are served by existing statutory timeframes.

The State Should Bear the Burden of Proof in Cases where the Court-Appointed Expert Opines that the Defendant is Incompetent to Stand Trial

In California a defendant is presumed to be competent even after the the court is presented with substantial evidence of incompetency, suspends criminal proceedings, and a court-appointed expert determines that defendant is *not* presently competent to stand trial. Competency proceedings are the only California civil commitment proceedings where the person subject to involuntary commitment must prove that they are mentally ill in order to receive necessary treatment.

Consistent with procedures in 15 other states,[14] California should require the state to prove that the defendant is competent where one or more court-appointed experts conclude that they are not. If all experts opine that the defendant is competent to stand trial, then the presumption of competency should remain in place, and the defendant would still bear the burden of overcoming it.[15]

Commitment under a Murphy Conservatorship Should not be a Means to Compel Lifetime Competency Restoration

In *Jackson v. Indiana* (1972) 406 U.S. 715, the United States Supreme Court held that an incompetent defendant may not be committed indefinitely on the sole ground of incompetency. In 1974, in accordance with *Jackson,* the Legislature amended section 1370 to provide a limit on involuntary commitments.[16] After the amendments, a defendant who had not regained mental competency at the end of

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http://jaapl.org/content/42/1/81#:~:text=Fortunately%2C%20rates%20of%20competence%20restoration,months%20of%20inpatient%20restoration%20efforts.

[13] *When Treatment is Punishment,* Justice Policy Institute (October 2011) *available at* https://justicepolicy.org/wp-content/uploads/justicepolicy/documents/jpi_when_treatment_is_punishment_national_factsheet.pdf

[14] Delaware, Illinois, Maryland, Massachusetts, Minnesota, Nebraska, New Hampshire, New Jersey, New York, North Dakota, South Dakota, Vermont, Wisconsin, and Wyoming apply a presumption of incompetency when the court-appointed expert opines that the defendant is mentally incompetent.

[15] AB 1630, The Vulnerable Defendant's Right to a Fair Trial Act, is currently on suspense in Appropriations. If passed, the bill would amend section 1369 to shift the presumption of competency to the State when any court-appointed expert opines that the defendant is not competent to stand trial.

[16] *In re Mille* (2010) 182 Cal.App.4th 635, 643.

three years had to be returned to court and either released or recommitted under alternative commitment procedures.[17]

An individual who is not restored to competency and recommitted pursuant to Welfare and Institutions Code section 5008 subd. (h)(1)(B) (Murphy conservatorship), must be: 1) incompetent to stand trial; 2) charged by complaint, indictment, or information with a felony involving death, great bodily harm, or serious threat of physical harm to another person that has not been dismissed and; 3) represent a substantial danger of physical harm to others as the result of a mental disease, defect, or disorder.

Consequently, an individual charged with a violation of Penal Code section 245 (a)(1) (Assault with a Deadly Weapon), who is committed on a Murphy conservatorship may be subject to lifetime commitment and competency restoration with no opportunity for resolution or dismissal of pending criminal charges. If convicted of the same charge, the individual would face a maximum penalty of four years state prison.

Current law does not comport with *Jackson's* prohibition against indefinite confinement nor provide an equal opportunity for those who are not restored to competency to have their charges dismissed. If an individual charged with the same offense is never restored to competency, represents a substantial danger of physical harm, but suffers from a developmental disability, that individual is not subject to continued competency restoration and may have charges dismissed.[18]

When an individual is not restored to competency within statutory timeframes, this State should not compel continued restoration under the guise of another statutory scheme.

Respectfully submitted,

/s/ Stephanie Regular

Stephanie Regular
Chair CPDA Mental Health and Civil Commitment Committee

[17] *In re Davis* (1973) 8 Cal.3d 798, 801.
[18] Welfare and Institution Code section 6500.