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DEPARTMENT OF HUMAN SERVICES

Legislative Report

Community Competency Restoration Task Force

Final Legislative Report

Behavioral Health Division and

Direct Care and Treatment

February 2021

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I. Executive summary

In 2019, the Legislature enacted the Community Competency Restoration Task Force to research and develop recommendations to address the rising number of people found incompetent to stand trial. That number has risen year over year since 2013 alongside costs to the state, court system, counties, and the Minnesotans who experience the gaps in this process. The task force published an interim report in February 2020 identifying trends and gaps in Minnesota's competency process and providing context for the recommendations of this report. The work of the task force since the interim report has focused on three areas:

1. Community Competency Restoration
2. Prevention and Diversion
3. Reducing Time in the Criminal Court System

A significant point of emphasis for the task force is that mental health and criminal justice involvement cannot be isolated from the whole experience of a person in their community. As such, many recommendations focus on building the mental health system in Minnesota, addressing systemic racism, and other inequities such as access to housing, affordable healthcare, and other basic needs. Within this holistic framework, the task force developed recommendations and identified three key components necessary to create an equitable and responsive competency process in Minnesota:

1. A state statute to establish standards and processes for competency restoration.
2. A continuum of competency restoration programs including inpatient, community, and jail-based settings.
3. Clarification of roles and financial investments for competency restoration services.

Competency Restoration in State Statute: Currently, no law in Minnesota mandates competency restoration. The only source for this process is Rule 20.01 of the Minnesota Rules of Criminal Procedure, but the Rule does not reflect the needs of today's court or mental health system. The result is a patchwork system that lends itself to confusion with the only path to restoration being through the civil commitment process. A state statute could address three types of cases that Rule 20 does not:

> **Gap Cases:** If a person is found incompetent to stand trial, but they do not meet the criteria for civil commitment, they fall in a "gap" and must seek treatment voluntarily. People in this gap are at a high risk of languishing in jail or being rearrested and entering the "revolving door."
>
> **Unlikely to Attain Competency**: A small subset of people will never attain competency due to the nature of their cognitive impairment or psychiatric condition. These cases often strain resources and leave cases unresolved.
>
> **Misdemeanor Cases**: Upon a finding of incompetency, Rule 20.01 requires misdemeanor charges to be dismissed and referred for civil commitment – this is another gap that contributes to the revolving door.

With a few exceptions, most people found incompetent to stand trial can be restored to competency with adequate psychiatric treatment. A state statute should direct individuals to the most appropriate setting on a continuum of competency restoration services – closing gaps and reserving civil commitment for those with the

highest needs. The needs of individuals in this process are highly variable, and the appropriate setting will depend on the level of care needed, public safety, and available resources. The task force recommends that court examiners be used to recommend the least restrictive setting for restoration, and that a new position of Forensic Navigators be created to support individuals and coordinate placements and services.

The task force recommends that competency restoration continue to be reserved only for felony and gross misdemeanor cases. A new statute should include diversion opportunities for misdemeanor cases and processes for people unlikely to ever attain competency. A new statutory scheme would be a significant undertaking and the task force recommends at least a year be allowed for implementation, training, and building infrastructure.

Continuum of Services: The current competency process assumes that all people found incompetent need the most acute care. This has created severe strain on both ends of the spectrum. State-operated psychiatric beds are virtually inaccessible outside of the court system. Similarly, most community-based services have long waitlists, are not equipped to serve justice-involved individuals with complex needs, and do not formally provide competency education. Without clear directives from the law and adequate services, counties, courts, mental health providers, and Minnesotans with mental illnesses are paying the price. A successful competency system will require infrastructure for inpatient, community, and jail-based competency restoration settings.

> **Inpatient:** Inpatient services must provide a high level of care, access to on demand forensic assessments, and disposition planning by the treating facility in conjunction with a Forensic Navigator. These services should be expanded beyond the current state-operated facilities to include community hospital settings.
>
> **Community:** Community competency restoration services must be standardized, culturally informed, and flexible. Settings should include open and locked Intensive Residential Treatment Services (IRTS) programs as well as home-based services.
>
> **Jail-Based:** In specific circumstances, jail-based services can jumpstart the competency restoration process and reduce or eliminate the need for another setting. Jail based services must have clear time limits and will require robust mental health care in jails.

Roles and Responsibilities: Most of the necessary infrastructure for a multi-faceted, person-centered competency restoration system does not currently exist in Minnesota and will require significant investments to create and operate. Even currently operating services like inpatient competency restoration offered at DHS programs are not funded in a way that could manage significant increases in demand without overwhelming the system. The legislature must provide funding with careful considerations to implement these essential services equitably across the state.

Key Recommendations

A. Community Competency Restoration

- Pass a statute governing competency to stand trial with specific provisions for individuals who do not meet the civil commitment criteria, individuals who are unlikely to ever attain competency, and diversion opportunities for misdemeanor cases.
- Develop a standardized, flexible, statewide competency restoration curriculum.
- Establish and fund a continuum of inpatient, community, and jail-based competency restoration services.
- Establish certified Forensic Navigators to support defendants and expedite the competency process.

B. Prevention and Diversion

- Fund mental health services across a full continuum of care including equitable reimbursement rates, parity enforcement, and funding for psychiatric emergency rooms.
- Fully fund mobile crisis teams, require 911 emergency response services to partner with crisis teams, and establish minimum mental health training requirements for 911 dispatchers.
- Provide funding for counties to pilot voluntary engagement services under Minn. Statute § 253B.041.
- Invest in a full continuum of housing services, affordable housing, and permanent supportive housing.
- Fund programs and address barriers to address black, indigenous, and people of color (BIPOC) and rural mental health workforce shortages.
- Fund diversion programs and mental health and criminal justice collaborations.

C. Reduce Time in the Criminal Court System

- Establish minimum mental health training and continuing education requirements for judicial officials.
- Fund mental health care in jails and incentivize partnerships between jails and community providers.
- Fund pilots to expedite the competency process through pre-screening and same day evaluations.
- Provide resources for the use of video technology for court ordered examinations and hearings.
- Provide funding for expanding mental health courts and creating restorative and competency courts.

II. Legislation

In 2019, the Legislature established the Community Competency Restoration Task Force. *See* Minnesota Laws 2019, 1st Special Session, Chapter 9, Article 6, Section 77, as follows:

Sec. 77. COMMUNITY COMPETENCY RESTORATION TASK FORCE.

Subdivision 1. Establishment; purpose. The Community Competency Restoration Task Force is established to evaluate and study community competency restoration programs and develop recommendations to address the needs of individuals deemed incompetent to stand trial.

Subd. 2. Membership.

(a) The Community Competency Restoration Task Force consists of the following members, appointed as follows:
  (1) a representative appointed by the governor's office;
  (2) the commissioner of human services or designee;
  (3) the commissioner of corrections or designee;
  (4) a representative from direct care and treatment services with experience in competency evaluations, appointed by the commissioner of human services;
  (5) a representative appointed by the designated State Protection and Advocacy system;
  (6) the ombudsman for mental health and developmental disabilities;
  (7) a representative appointed by the Minnesota Hospital Association;
  (8) a representative appointed by the Association of Minnesota Counties;
  (9) two representatives appointed by the Minnesota Association of County Social Service Administrators: one from the seven-county metropolitan area, as defined under Minnesota Statutes, section 473.121, subdivision 2, and one from outside the seven-county metropolitan area;
  (10) a representative appointed by the Minnesota Board of Public Defense;
  (11) a representative appointed by the Minnesota County Attorneys Association;
  (12) a representative appointed by the Minnesota Chiefs of Police Association;
  (13) a representative appointed by the Minnesota Psychiatric Society;
  (14) a representative appointed by the Minnesota Psychological Association;
  (15) a representative appointed by the State Court Administrator;
  (16) a representative appointed by the Minnesota Association of Community Mental Health Programs;
  (17) a representative appointed by the Minnesota Sheriffs' Association;
  (18) a representative appointed by the Minnesota Sentencing Guidelines Commission;
  (19) a jail administrator appointed by the commissioner of corrections;
  (20) a representative from an organization providing reentry services appointed by the commissioner of corrections;
  (21) a representative from a mental health advocacy organization appointed by the commissioner of human services;
  (22) a person with direct experience with competency restoration appointed by the commissioner of human services;
  (23) representatives from organizations representing racial and ethnic groups overrepresented in the justice system appointed by the commissioner of corrections; and
  (24) a crime victim appointed by the commissioner of corrections.

(b) Appointments to the task force must be made no later than July 15, 2019, and members of the task force may be compensated as provided under Minnesota Statutes, section 15.059, subdivision 3.

Subd. 3. Duties. The task force must:

(1) identify current services and resources available for individuals in the criminal justice system who have been found incompetent to stand trial;
(2) analyze current trends of competency referrals by county and the impact of any diversion projects or stepping-up initiatives;
(3) analyze selected case reviews and other data to identify risk levels of those individuals, service usage, housing status, and health insurance status prior to being jailed;
(4) research how other states address this issue, including funding and structure of community competency restoration programs, and jail-based programs; and
(5) develop recommendations to address the growing number of individuals deemed incompetent to stand trial including increasing prevention and diversion efforts, providing a timely process for reducing the amount of time individuals remain in the criminal justice system, determining how to provide and fund competency restoration services in the community, and defining the role of the counties and state in providing competency restoration.

Subd. 4. Officers; meetings.

(a) The commissioner of human services shall convene the first meeting of the task force no later than August 1, 2019.
(b) The task force must elect a chair and vice-chair from among its members and may elect other officers as necessary.
(c) The task force is subject to the Minnesota Open Meeting Law under Minnesota Statutes, chapter 13D.

Subd. 5. Staff.

(a) The commissioner of human services must provide staff assistance to support the task force's work.
(b) The task force may utilize the expertise of the Council of State Governments Justice Center.

Subd. 6. Report required.

(a) By February 1, 2020, the task force shall submit a report on its progress and findings to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health and corrections.
(b) By February 1, 2021, the task force must submit a written report including recommendations to address the growing number of individuals deemed incompetent to stand trial to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health and corrections.

Subd. 7. Expiration. The task force expires upon submission of the report in subdivision 6, paragraph (b), or February 1, 2021, whichever is later.

EFFECTIVE DATE. This section is effective the day following final enactment.

III. Introduction

People who have been charged with crimes have a constitutional and statutory right not to be tried if a judge determines they are incapable of understanding the proceedings or participating in their defense due to a mental illness or cognitive impairment. When a person is found incompetent, the prosecution of the criminal charges must wait until the person becomes competent or the charges are dismissed. Services to restore a person to competency consist primarily of psychiatric treatment, though some defendants also need basic education on the legal process. Unlike most states, Minnesota has no statute regarding the provision of these services – no law requires any state agency or local unit of government to provide treatment for competency restoration, and no law requires defendants found incompetent to participate in or undergo restoration.

Rule 20 of the Minnesota Rules of Criminal Procedure is the sole source for the competency process in Minnesota. In recent years, it has become increasingly clear that the current process is unable to meet the needs of today's court and mental health systems. Since 2013, the number of people found incompetent to stand trial has risen year over year. From 2014-2018 the number of people examined for competency in Minnesota rose 73%. In that same period, Judicial Branch spending rose 40%, topping off at $6 million in 2018 for forensic examinations alone.[1]

In 2019, the Legislature enacted the Community Competency Restoration Task Force to find equitable solutions for addressing the competency process in Minnesota. The task force submitted its interim report to the Legislature in February 2020 detailing barriers throughout the mental health system and criminal justice system that impact the competency process and the Minnesotans who move through it. Building on the research and findings from the interim report, the task force focused on three areas to craft the recommendations in this report:

a. Community Competency Restoration
b. Prevention and Diversion
c. Reducing time in the Criminal Justice System

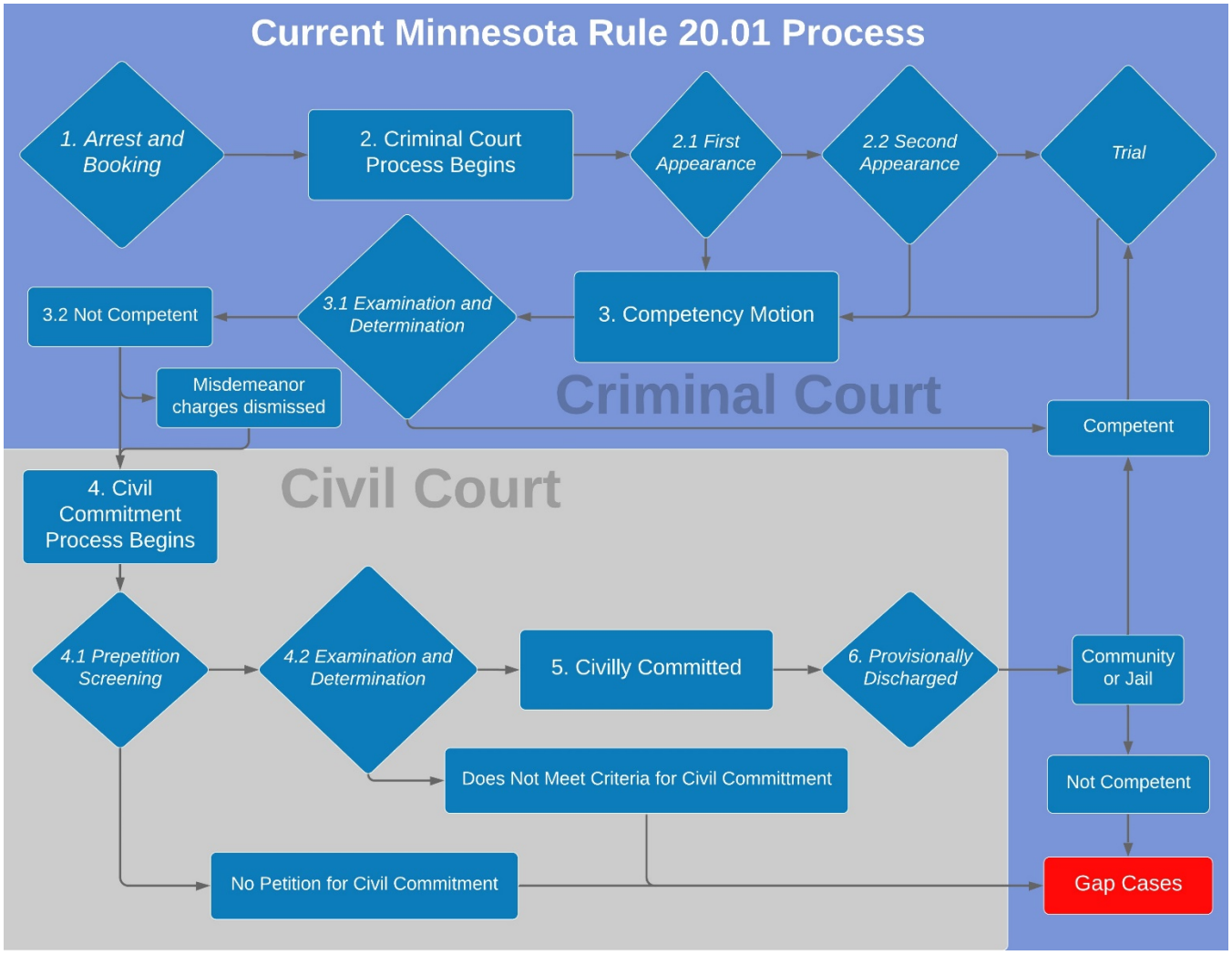
A significant point of emphasis for the task force is that mental health and criminal justice involvement cannot be isolated from the whole experience of a person in their community. As such, many recommendations focus on building the mental health system in Minnesota and addressing systemic racism and other inequities such as access to housing, affordable healthcare, and other basic needs. Within this holistic framework, the task force developed recommendations and identified three key components necessary to create an equitable and responsive competency process:

1. A state statute to establish standards and processes for competency restoration.
2. A continuum of competency restoration programs including inpatient, community, and jail-based settings.
3. Clarification of roles and financial investments for competency restoration services.

[1] Psych Examiner Services Judicial Workgroup Report (2019, December)

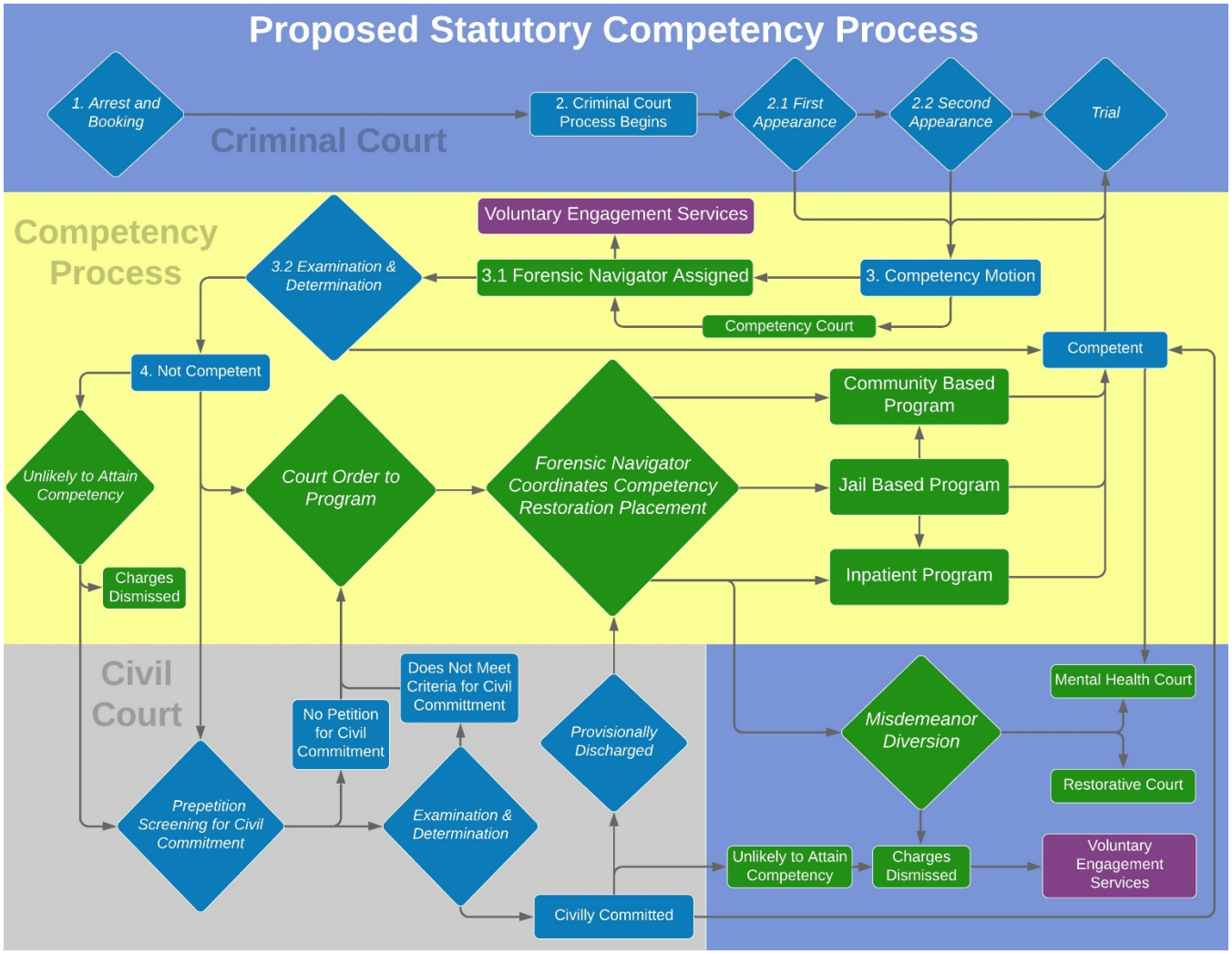
As noted above, Minnesota has no statutory provisions for competency to stand trial. The current process in Rule 20 has only one path for restoration - through civil commitment. Figure 1. shows the current competency process under Rule 20.

Figure 1:



By relying solely on civil commitment, the most acute and expensive level of care, the current process has several gaps. Outside of the civil commitment process there are no legal mechanisms to engage people in treatment unless they seek it voluntarily, and no formal competency restoration programs to provide court education. Notably, Rule 20 does not provide adequate directives for the subset of people who will never attain competency or in misdemeanor cases. Rule 20 requires misdemeanor charges to be dismissed, but it misses an opportunity to engage individuals who often still need mental health treatment and assistance in the community. This gap contributes to the "revolving door" of people with mental illnesses repeatedly returning to the justice system. Figure 2 shows the new statutory process offered in this report to address these issues and provide a more equitable, efficient, and person-centered continuum of competency restoration services.

Figure 2:



Another point of emphasis in the proposed process is the use of Voluntary Engagement Services which provide 90 days of assertive engagement to connect people to treatment before hospitalization, commitment, or incarceration.[2] State investments to pilot engagement services could provide crucial interventions before, during, and after the competency process. Still, most of the necessary infrastructure for the proposed system does not currently exist in Minnesota; for example, Forensic Navigator positions and community and jail-based competency restoration. These services will require significant investments to create and operate. The legislature must provide funding with careful considerations to implement these essential services equitably across the state. The findings and recommendations below reflect over a year and a half of research and earnest engagement with stakeholders across disciplines and across the state of Minnesota.

[2] Minn. Statute § 253B.041 - A new service created in 2020 changes to the Commitment Act.

IV. Findings and Recommendations

A. Community Competency Restoration

State law should establish standards and processes for competency restoration.

Currently, no law in Minnesota requires that any state or local agency provide competency restoration services to a defendant found incompetent to stand trial. Similarly, no law requires such an individual to participate in or undergo competency restoration. Nearly the entirety of existing regulation surrounding competency is found in Minn. R. Crim. P. 20.01. As a criminal court rule, Rule 20.01 applies only to the parties in a criminal case and does not have the force of statutory law. Rule 20.01 itself does not require that competency services be provided to an incompetent defendant, or that the defendant participate in competency restoration when they are found incompetent. Further, Minnesota's current patchwork system requires the involvement of two courts (criminal and civil/mental health), which lends itself to confusion, inefficiencies, and lack of communication. Many other states across the US address competency and competency restoration directly and solely through the criminal court.

The task force recommends a bill governing competency to stand trial be drafted and passed into law. The statute should lay out not only the process for directing defendants to competency restoration services, but also the continuum of where and how such services should be offered and to which populations. It would also be important for a competency statute to address defendants who are not restorable and those who do not meet civil commitment criteria, and to include a competency curriculum which is flexible enough for a variety of users in various settings.

First, a state statute on competency to stand trial should include a provision for those defendants who will never attain competency. There is and will always be a subset of criminal defendants who cannot reach the standard for competency to stand trial, even with extensive competency education and mental health treatment. Individuals with significant cognitive impairments[3] or progressive cognitive illnesses[4] are examples of the population who may not be restorable. It would be both a disservice to these individuals and a poor use of resources to require ongoing competency restoration services for this population. A state statute should allow for a qualified examiner to be able to opine that an individual is likely not able to attain or be restored to competence. Options should then be created for this category of defendants in some cases, such as referral for civil commitment or potentially

[3] Cognitive impairments including fetal alcohol syndrome, intellectual disabilities, traumatic brain injuries, and others.

[4] Examples of such cognitive illness would include dementia, Huntington's disease.

dismissing lower-level charges[5].

Second, a state statute on competency should consider and provide for those individuals who are not competent to stand trial but who do not meet the criteria for civil commitment in Minnesota. These are often referred to as "gap cases." Under the current system, incompetency and civil commitment are often thought of as directly tied together. However, the legal criteria for each are markedly different. One set of criteria assesses whether a defendant can participate in their defense and rationally consult with counsel, and the other set of criteria assesses whether an individual's mental illness or developmental disability renders them a danger to self or others, such that they meet criteria for civil commitment (as laid out in detail in Minn. Stat. § 253B.02). A person falls in the "gap" if they do not meet criteria for civil commitment. The lack of competency services offered outside locked state operated facilities usually means that both mental health treatment and competency education are not available to them unless the individual is willing and able to seek such services voluntarily.[6] A state statute should provide an alternative to civil commitment for both the individuals who fall within this gap and those who might otherwise meet civil commitment criteria, but for whom a less restrictive alternative could be identified. For example, allowing courts to direct incompetent defendants to participate in community-based competency programs as a condition of release may be one option for addressing gap cases, although the issue of if and when a defendant can be returned to custody for failure to meet competency related conditions requires nuanced consideration. Creating a system that does not directly tie incompetence to civil commitment would allow for more targeted use of state operated resources for those who require inpatient, involuntary mental health treatment under civil commitment.

A successful competency system must also have a standardized, accessible competency curriculum. Such a curriculum should be developed by stakeholders in a way that ensures the curriculum is consistent and functional in different treatment settings and also culturally responsive and competent. Ultimately, one critical component of competency restoration is educational. Given this, the competency curriculum developed should be one that can be understood, taught by, and utilized by a variety of individuals (social workers, mental health professionals, mental health practitioners, case managers, etc.) in a culturally responsive manner. There are some existing educational resources available for competency restoration materials, including a program currently being used by DHS inpatient facilities. Such materials could be a starting point for a stakeholder group to develop a statewide, standardized curriculum.

A new statutory scheme for addressing incompetency to stand trial would be a significant undertaking and would likely require time for training various stakeholders, building infrastructure, and implementation. The task force recommends at least one year from the passing of the bill and the effective date to allow for implementation efforts. Such a comprehensive system must include adequate support for all stakeholders throughout the

[5] The U.S. Supreme Court has previously ruled that it is unconstitutional to involuntarily commit a criminal defendant for an indefinite period of time based on incompetency to stand trial. See *Jackson v. Indiana*, 406 U.S. 715 (1972). Any system created in Minnesota must therefore align with this decision.

[6] Some counties have utilized the DHS competency restoration education materials in the community, via county case management or group home staff.

continuum of services. This kind of support barely exists in the current system, and while the need is clear, in Minnesota, no party is deemed responsible for providing it.

Forensic Navigators

In several states around the country, this type of support is provided by "forensic navigators." As a relatively new response to competency process issues across the country, forensic navigators vary by locale in job duties and qualifications. Many are housed within the mental health authority of states, but some are coordinated by the judicial branch. This type of support position is partially being modeled in Minnesota by the pilot competency restoration programs in Olmsted County and Crow Wing County.[7]

In the statutory system proposed in this report, forensic navigators would fill an essential role beginning at the initial competency motion. Forensic navigators can assist people out of custody by coordinating assistance for basic needs, especially housing, and ensuring clients are supported to participate in their competency examination. This addresses a significant need the task force identified when defendants are conditionally released, some with high psychiatric needs, and many into homelessness. The time and work to find these individuals is borne mostly by the court system and is a significant contributor to the rising costs of the current competency system. Moreover, failing to address the needs of individuals at this point often results in new charges in the community or issuing warrants and subsequent rearrest.

If a person is found incompetent, they can continue working with the same navigator, building consistency and rapport. At the finding of incompetency, navigators can assist the court in finding the least restrictive available competency program to meet the individual's needs, and further coordinate releases of records to expedite placement. Navigators can also directly provide the educational element of competency restoration services along the full continuum.

The forensic navigator would be responsible for the supervision of the individual in all settings, and could report to the court on progress, or if the defendant is ready to be reexamined for competency sooner than the given timeline in statute. In addition to these critical initial points in the competency process, forensic navigators can help individuals further along, such as coordination at provisional discharge for those who have met the civil commitment criteria, and continued assistance to promote long term success, especially if the individual is a good candidate for a diversion program like a mental health court.

Because of the highly variable needs and circumstances of individuals in the competency process, the task force determined that support positions or forensic navigators in Minnesota should be established with flexibility. The available resources of different regions should be a primary consideration in creating standards and certification. These services could be provided by mental health professionals or practitioners, as well as by bachelors or masters level human service workers and peer support specialists. While the need for flexibility is important, minimum training and ongoing certification requirements should be established across

[7] Community Competency Restoration Task Force Interim Legislative Report (2020, February)

the state, including training on skills like de-escalation and motivational interviewing. The state should fund these positions for administration through community providers, counties, or judicial districts.

Finally, the continued diversion of individuals charged with misdemeanors out of the competency restoration system should be a part of any new statute. Currently Rule 20.01 requires that misdemeanor charges be dismissed when an individual is found incompetent. Sending these individuals back into the competency pipeline under a new system would likely overwhelm both state and county resources quickly and would likely consume significant criminal court resources. Moreover, those charged with misdemeanors would likely spend as much or more time in treatment or regaining competency than they would be sentenced to serve because of their criminal charges. Further, forensic examiner resources would also be taxed if continuing competency evaluations (referring to Rule 20.01, subd. 7) would have to be completed for misdemeanants until they are found competent.

While misdemeanor cases are not appropriate for the competency process, there is subset of people who repeatedly shuffle in and out of the court system with misdemeanor charges. These individuals or "high-utilizers" fall into a similar gap as the one described above; they will not be engaged in services through the competency or civil commitment process. People caught in this revolving door often have needs beyond mental health treatment alone and are ideal candidates for voluntary engagement services under the Commitment Act (described in greater detail in Section B). Engagement services are an early intervention before a person is a danger to themselves or others and require assertive outreach to meet the immediate needs of individuals including access to housing, food, income, disability verification, medications, and treatment for medical conditions. If fully funded, engagement services could be a powerful tool to close the revolving door and prevent future, more serious charges. Forensic navigator positions should also be used to support and assist "high-utilizers." Mental health and restorative courts can also be used for diversion with this population.

The task force would also support the implementation of optional competency courts. These courts would be a new type of specialty courts in Minnesota, similar to a criminal mental health court or veterans' court, intended to divert individuals who have been found incompetent from the mainline criminal courts. Competency courts would have more intensive services, specific expertise, more frequent check-ins, and additional tools to encourage and track competency. Such courts would address several barriers and delays the task force identified by providing more consistency and quality through dedicated court officials and more efficient referrals for supports, services, and interventions than a typical criminal court could provide. With sufficient resources, such courts would be another strong tool for counties and judicial districts to utilize in appropriate cases. To manage varying resources equitably around the state, competency courts could be established regionally with resources given to increase the use the video hearings, where in rural areas, technology and internet access are often disparate to the metro area, particularly considering the lessons learned from the COVID-19 pandemic.

A successful continuum of competency services should include inpatient, community, and jail-based resources and programs.

To maximize resources and successful outcomes for competency restoration programming, there should be a continuum of settings where programming can be provided. The continuum should include more acute settings, like inpatient, along with jail-based programs, as well as less restrictive options like community settings.

The task force recommends that the court examiner be utilized to offer recommendations about which setting is most appropriate for incompetent defendants to receive competency restoration services, be it acute inpatient, community, or jail (full scale or time limited). This competency restoration service placement assessment could be written into Minnesota Rule of Criminal Procedure 20.01 and made a part of the existing competency evaluation process, or it could be created as a standalone function for a court examiner. Court examiners are uniquely qualified to make placement recommendations to the courts, given their clinical and forensic training and expertise. Coordination for actual placement should be done by a forensic navigator to expedite the process.

Acute Inpatient Competency Restoration Services

Competency restoration services should be available in acute, inpatient facilities to serve those individuals whose mental health needs require a more intensive level of care. However, hospitals, state-run facilities, and other acute inpatient settings should not be used as detention or holding facilities for individuals whose mental health needs can be met in a less restrictive setting. There are three key components necessary for successful acute inpatient competency services, laid out below.

The first component for inpatient placement of incompetent individuals is their need for high level, intensive treatment. Individuals with acute mental health needs must have access to inpatient services where the highest levels of treatment can be provided, including necessary medication intervention and management. Beds in such programs should be reserved for the most acute individuals and not utilized for individuals who are incompetent but whose mental health needs could be met in a less restrictive community setting. Acute inpatient programs of this type are currently only operated by the Department of Human Services (DHS), and they accept patients who are civilly committed pursuant to Minnesota Statutes Chapter 253B.

While DHS will remain an important part of inpatient competency restoration services in Minnesota, the current model assumes that all persons served need the most acute care. This lack of continuum of care is inefficient, expensive, occupies inpatient services which are already in high demand by individuals in acute mental health crisis, and does not support the person served in the least restrictive environment and as close to their community as possible. Opportunities should be created for community hospitals to also provide competency services, either directly or via contracted beds with DHS. The availability of such competency services in community hospitals may reduce the number of individuals who are civilly committed to the state hospitals and may better serve individuals whose treatment needs resolve quickly. At present, it does not appear that any community hospitals are providing competency restoration services. It seems likely that incentive programs may be necessary to obtain buy-in from community providers, particularly as it relates to funding or the possibility that competency restoration could become a billable service.

Acute inpatient programs, both state and community operated, are best situated to offer a full-service delivery model of care. They can provide not only competency restoration services, but also a full complement of psychiatric and mental health treatment services, which are person centered and comprehensive. Such programs allow an individual to simultaneously address competency and medical and/or mental health and substance use disorder needs and can provide wrap around services to prepare the individual for a successful transition into a less restrictive environment.

Next, to be successful and operate smoothly, inpatient competency restoration services must include access to forensic assessments, both scheduled and on demand. The courts rely on forensic examiners to assess competency and advise the court on any changes to a defendant's competency status. Such assessments should be available on a regimented schedule that is ordered by the court. However, assessments should also be available on an on demand or as needed basis, to ensure that individuals do not remain in a treatment setting unnecessarily if they attain competency quickly or in advance of a scheduled evaluation.

These on demand or as needed forensic assessments will require the cooperation and training of the treatment team, whose members will provide ongoing clinical assessments of their patients as they have the most frequent interactions with them. Treatment teams should have the ability to request and access forensic assessments as needed and in response to observed changes in patients.

The final key component for successful inpatient competency programming is disposition planning. A successful and timely discharge from inpatient care is vital for transition into the community, prompt resolution of criminal cases, and to ensure that limited inpatient resources are maximized and utilized appropriately. For that reason, the inpatient system must include collaborative disposition planning, which requires the participation of courts, counties, forensic navigators, hospitals, and sheriffs.

Discharge from an inpatient facility serving incompetent individuals must be primarily driven by the treating facility. It should be up to the inpatient treatment team to determine when an individual no longer needs that level of care, and once that determination is made and communicated, the courts and counties must be responsive. Forensic Navigators can also be helpful for smooth and prompt discharge planning. Placing authority for such discharge determinations in the hands of the courts often leads to delays in discharge, which in turn prevents others who need inpatient services from being able to access them promptly.[8]

Community-Based Competency Restoration Services

A continuum of competency restoration services which individualizes the service to the needs of the person (person centered care) and is efficient and cost effective will require the development of community competency restoration services. Competency restoration services should be available in the community through a variety of types of programming to serve individuals who do not require acute inpatient care. A successful system of community-based competency services will require several key components.

Flexibility in design

A community-based competency system will need to be designed with flexibility to serve a broad range of individuals with differing needs and circumstances. Each incompetent individual's case will have a number of factors that must be considered to determine what type of community-based competency

[8] See Appendix B, where the Tennessee state competency statute grants the head of the state treatment facility authority to determine when an individual no longer needs to remain in inpatient care and to return that person to the criminal justice system.

service would be best to serve the individual's needs. Specifically, factors such as the level of services the individual requires, risk to public safety, and the individual's access to social supports (such as housing, transportation, etc.) will influence this determination. Each individual's circumstances should drive the type of community-based services they are directed to.

A community-based competency system will also need to be designed with operational flexibility. Flexibility is necessary so that single counties or groups of counties can make choices about how they want to work with individuals in the community, and in particular individuals who are living in their own homes. Community competency options will likely look very different across the state, given differences in population, resources, and staffing. Thus, the system developed should allow for programming that can be effective in a variety of environments.

Qualifications for competency restoration providers

A set of qualifications for people who provide community-based competency restoration should be created and reflected in statute, though the statute should have sufficient flexibility to allow a variety of people to provide the service. Individuals who are likely to play a role in providing community-based competency restoration include those with professional education, and those with experience in fields like mental health practitioners, mental health professionals, rehabilitation workers, and professional educators. Standard qualifications or training to provide competency education is necessary to ensure that services provided across the state are consistent in content and in quality, and that successful outcomes are achieved. Such providers must also be equipped and trained to provide competency restoration services in a culturally informed and competent manner. When considering what qualifications would be necessary or preferable for individuals providing competency restoration services in the community, it will be important that qualifications are not so restrictive as to be a barrier that limits potential resources.

Settings for competency restoration services

A successful community-based competency restoration system should include a continuum of three types of program settings: locked Intensive Residential Treatment Services (IRTS) programs, open IRTS programs, and home-based competency services.

First, funding should be provided to allow for locked IRTS programs. Such programs would offer a lower level of care than a hospital or acute inpatient setting, while still offering a heightened level of public safety. Individuals who are potential flight risks or whose criminal charges warrant a higher level of security, but who do not require acute inpatient medical or mental health treatment, could be effectively served in a locked IRTS setting. Locked IRTS programs could not only provide competency education, but also other treatment services, and could do so in a community-based environment that would better assist in the transition to a less structured setting.

For maximum program census (population) flexibility in locked IRTS facilities, there should be billing and operation parameters that allow for sustainable operation with fewer than 16 clients. Some individuals will be best served by small programs (6 to 10 beds) based on their unique needs, and some counties or

providers may prefer to operate smaller programs based on their population size and demand for such services in the surrounding area. Resources and reimbursement rates that are flexible enough to sustain lower census programs would allow for services to be more person centered and needs based.

Next, community-based competency services should be offered in traditional or unlocked IRTS programs. Many such programs are currently operating across the state. However, few if any offer competency restoration services. If providers could bill for competency restoration services including education and incorporate that education into existing operations and programming, there is potential to significantly expand competency restoration services available across the state. IRTS programs would be best suited to serve individuals charged with lower-level crimes, those who are considered low risk to public safety, and those who do not need acute inpatient care but who would do well in a residential program setting. Regular IRTS programs would allow individuals to receive competency restoration services while also building skills needed to continue to live in the community and independently. Both unlocked and locked IRTS programs could also serve as step-down placements for individuals being discharged from acute inpatient competency programs.

Finally, community-based competency services should be made available to individuals who are able to reside in their own homes or other similar environments, such as corporate foster homes. Individuals who pose low risk to public safety, who can continue to safely live in the community while their criminal case is pending, would be well served by being allowed to remain in their homes, close to family and social supports. For this option to be successful, such individuals must have assistance to ensure that necessary supports are in place and continue to be in place, so they are enabled to remain in their homes. Necessary supports would include access to transportation, outpatient mental health services, and other components of daily living.

If the community-based competency system is designed to include individuals engaging in competency restoration services at home, the competency restoration curriculum developed must be one that can be adapted for home use. While individuals doing competency work from their homes should have monitoring and assistance from supportive people in their lives, whether it be staff in the home or a case manager who checks in at regular intervals, they must also be able to access and engage in the materials independently for self-study. It will be important for any standardized competency education materials to be able to be utilized in a home environment.

Jail-based Competency Restoration Services

The final environment in which competency restoration services should be provided is in jails or detention facilities. This environment would be appropriate for individuals who require competency restoration services either on a time limited or full-scale basis. Competency services in a jail setting must include several key components discussed below.

Full scale or time limited competency restoration services

First, jail-based competency restoration services must be directed to the appropriate population, which would include individuals found incompetent to stand trial who may not be successful in less restrictive

environments and who do not require acute, inpatient level mental health treatment. Individuals found incompetent to stand trial and who are in jail awaiting admission or transfer to an alternative placement in another program could benefit from time limited competency restoration services to begin immediately while in jail.

For individuals who pose a high risk to public safety and who are not deemed to need acute inpatient medical or mental health treatment, full scale competency restoration services in a jail setting may be the most appropriate option. Some states already utilize this method of competency restoration programming for some portion of incompetent defendants.[9] Individuals who receive full scale competency restoration services in a jail setting must have consistent monitoring and tracking by jail or county staff, who can keep "eyes on" and ensure that individuals who have attained competency are not waiting long periods of time for reassessment and return to criminal court. Of note, in larger county jails, it would be beneficial to house individuals receiving full scale competency restoration services in an area apart from the general population. This would allow easier implementation of competency restoration services for such individuals and better utilize jail and/or competency programming staff. Full scale competency serves in jail would have to be time limited and could not go on for an indefinite amount of time.

The U.S. Supreme Court ruled that it is unconstitutional to involuntarily commit a criminal defendant for an indefinite period of time based on incompetency to stand trial. See *Jackson v. Indiana*, 406 U.S. 715 (1972). Any system created in Minnesota must therefore align with this decision. Additionally, research suggests that individuals who can be restored to competency will typically attain competency within 6 months. Given this, the task force recommends that for individuals receiving full scale competency restoration services in jail that a forensic examiner should opine on restorability (or lack thereof) when the 6-month point is reached. Individuals deemed not restorable should then be diverted to alternative paths (dismissal of charges, civil commitment, etc.).

Individuals who do not pose a high risk to public safety and can either be served in a less restrictive setting (such as an IRTS) or who require acute inpatient treatment, should receive time-limited competency services while in a jail setting. During the time a defendant in this circumstance is awaiting placement at another site, beginning competency restoration services in jail may cut down on the time they remain incompetent, and it may reduce or even eliminate the need for competency restoration services in the next setting. Utilizing this time in jail for competency restoration services, even briefly, can better focus inpatient and residential resources upon the individual's arrival at the next setting. Utilizing this time would also capitalize on an opportunity to provide needed educational services to defendants as soon as possible, rather than losing days or weeks waiting for admission to another site.

[9] For example, see Appendix B describing jail -based competency services as a method utilized in Wisconsin.

Mental health treatment in jail

The primary component for jail-based competency restoration services is mental health treatment. While individuals who require acute mental health treatment should be transferred to inpatient programs, individuals with less acute mental health needs must still have access to meaningful mental health treatment.

The interim report of the task force identified numerous issues in providing adequate mental health care in Minnesota jails. While every jail in Minnesota screens for symptoms of mental illnesses at booking, follow up care varies greatly with few jails providing comprehensive mental health care while a person is incarcerated. If treatment or medication is interrupted at incarceration or an untreated mental illness is not identified at booking, the likelihood of individuals being found incompetent to stand trial will increase. Standards from the American Correctional Association recommend that all people incarcerated in a jail for more than 14 days receive follow up assessment and referral to a qualified mental health professional.[10] Even for those who stay less than 14 days, providing treatment and well-coordinated discharge planning will serve to reduce any negative effects of incarceration on a defendant's mental health.

Mental health care in a jail should include access to effective medications in jail and at release, Medication Assisted Treatment (MAT) for people with substance use disorders, therapy, telehealth care, and health care workers who will administer medications under *Jarvis* orders (court ordered involuntary medication for individuals who lack capacity to consent to such treatment). All jails should also have evidence-based policies, procedures, and ongoing training for suicide prevention and mental health care provisions for people in administrative and disciplinary segregation. The task force's interim report details many of the issues of continuity of care at discharge and the importance of connecting people to social supports, especially medication when possible. Federal regulations suspend Medicaid when a person is incarcerated for less than one year and cut benefits off entirely for people incarcerated over one year. While federal legislation is outside the scope of the task force's recommendations this interruption in coverage highlights the need for adequate discharge planning to assist people when they are released to apply for and receive benefits as soon as possible.

Other treatment modalities, such as assessments, therapy, and telehealth should also be considered for use in jails. Telehealth would allow providers from outside the immediate geographic area to serve individuals in jail in a cost-effective manner. Provision of comprehensive mental health treatment in jails will require coordinated efforts, not only between jail staff and county staff, but also with community mental health providers and the involved courts. This coordination will be particularly necessary to ensure continuity of mental health care as individuals transition out of the jail and into the community or another setting or as their criminal cases continue after competency has been restored.

[10] American Correctional Association, Core Jail Standards (Alexandria, VA, 2010), Standard 1-CORE-4C-11

Disposition planning

Disposition planning will also be a vital element of jail-based competency restoration services. Individuals receiving competency restoration services in jail will require plans and assistance to aid in eventual moves to the community or another setting, either when their criminal case resolves or if they regain competency and are released on conditions or otherwise. County social services must collaborate with jail staff and the court to ensure smooth community transitions in such a way that community supports, such as housing, medical and/or mental health treatment, and other basic needs are accounted for. The courts, parties to the criminal case, and jail staff should also work together to ensure that wait times between competency restoration and competency review hearings are as short as possible. Once an individual is believed to have attained competency, they should be quickly returned to criminal court so their proceedings can resume and be resolved.

Flexibility in providing competency restoration services

The final key component to successful jail-based competency restoration services is flexibility in delivering services. Jail-based competency services must be designed and authorized in statute in such a way that allows for adaptation to county- and jail-level needs. Statute should not dictate a specific agency or organization to provide jail-based competency restoration services, but rather should allow for the choice to be made locally so a variety of options can be utilized based on available resources. These options could include telehealth, local mental health clinics and professionals, county human or social services staff, and jail staff. Including funding for jail-based competency restoration services would also be a vital component in ensuring that jails and local providers are able and willing to step up and provide this service. For larger jails in particular, funding could be specifically tied to a requirement to offer competency restoration services, either through jail staff or contracted community or county staff, as a model or pilot effort. As discussed previously in this report, a competency curriculum should also be developed for statewide, multi-setting use, so the same materials may be directed to individuals in jail as they would to individuals in an IRTS or acute inpatient setting.

Court-Ordered Medication

The issue of voluntary treatment and civil commitment was top of mind for the task force in envisioning a new system. The task force agreed that separating the competency process from civil commitment at the outset is beneficial to address the gaps in the current system, though commitment can still be reserved as a last resort for the highest acuity of cases. However, the issue of ordering defendants to treatment through the competency process is complex. Ultimately any solution must balance the rights of an individual with a mental illness or cognitive impairment to refuse medication with the interest of the state in the defendant attaining competency.

This issue has been addressed in *Sell. v. U.S*. in which the U.S. Supreme Court ruled that the Government may involuntarily administer antipsychotic medications to render an individual competent to stand trial, "but only if the treatment is medically appropriate, is substantially unlikely to have side effects that may undermine the

fairness of the trial and, taking account of less intrusive alternatives, is necessary significantly to further important governmental trial-related interests."[11]

Some states have used this standard in statute to allow court-ordered medication in the competency process. The case law makes clear the high standard that must be used for involuntary medication in this context, yet any creation of statute or implementation of this practice will require consistent attention to preserve the rights of individuals. The task force did not reach consensus on a recommendation for Minnesota. As it is a critical issue, the task force recommends further discussion and engagement with stakeholders through the legislative process.

Clarification of roles and financial investment are needed for Minnesota's competency restoration services.

As previously highlighted in this report, Minnesota law does not currently assign the provision of competency restoration services, whether inpatient, community, or jail-based, to any particular entity, so delineation and clarification is needed. A successful system should provide direction to both state and local/county actors on their roles and responsibilities in competency restoration programming. There must be room in such a system for not only agencies and larger entities, but also attorneys, family and guardians, peer supports, and mental health treatment teams, to maximize success for individuals requiring this service.

One major issue that must be addressed in a new competency statute and structure is that of funding. This task force has recommended development of a multi-faceted system which would allow for person centered competency services to be provided in a variety of settings. Much of this infrastructure does not currently exist (e.g., competency restoration services in community hospitals, jail-based competency restoration programs, locked IRTS programs) and would require significant investment to create and operate. Even those parts of the system that are currently at least partially operational, such as inpatient competency restoration services offered at DHS programs, are not funded in such a way that they could accommodate significant increases in referrals without overwhelming the system.

As the examples from other states found in Appendix B demonstrate, a statutory scheme or system that is not carefully structured and balanced can have disastrous and costly consequences, not only for the entities charged with providing competency restoration services, but also for individual defendants who are found incompetent, and other individuals who need access to state or county mental health services but who are outside the criminal justice system. However, several states listed below have developed functional models for providing competency restoration services, and those models are able to operate without long wait lists, without impacting the services available to patients who are not involved in the criminal justice system, and without significant and costly litigation. A successful Minnesota competency statute and system therefore will have to be accompanied by a significant investment in funding, likely paired with creative new ideas and allowances for program billing options.

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[11] *Sell v. United States*, 539 U.S. 166 (2003).

Final Community Competency Restoration Recommendations

Statute for the Competency to Stand Trial Process

- A statute governing competency to stand trial should include specific provisions for individuals who do not meet the civil commitment criteria, individuals who are unlikely to ever attain competency, and diversion opportunities for misdemeanor cases.
- A standardized, flexible competency restoration curriculum should be developed for use statewide.
- Forensic navigator positions should be established throughout Minnesota with the input of stakeholders from the mental health and court systems.
- Funding should be provided to community providers, counties, Adult Mental Health Initiatives, or judicial districts for forensic navigator positions to provide equitable coverage to the entire state.

Continuum of Competency Restoration Services

- A competency restoration system in Minnesota should include a continuum of services, including acute inpatient, community, and jail-based settings.
- Individuals should be directed to services within the continuum based on their mental health treatment needs, an assessment of public safety risk, and their ability to engage with services.
- Inpatient services should be expanded using reserved or contracted beds in community hospitals.
- Community-based settings should include open and locked IRTS facilities and home-based services.
- Jail-based services should be used with clear time limits for specific cases, and they must be accompanied by robust mental health services in jails.
- Jails should be required to provide referrals for a mental health assessment for all people who screen positive for mental health issues at booking and are incarcerated for more than 14 days.
- Funding should be provided for a full range of mental health care in jails including access to medication while incarcerated and at discharge, Medication Assisted Treatment (MAT), individual or group therapy, telehealth, and administration of court-ordered involuntary medication.
- Partnerships between community healthcare systems, community mental health care providers, and jails should be funded and incentivized.
- The legislature should continue to engage stakeholders to address the issue of court-ordered medication for the purpose of restoring defendants to competency to stand trial.

Clarification of Roles

- The competency system developed in Minnesota should provide clear direction and roles to state and counties as well as to the court systems involved.
- Funding at the state level will be needed to implement a successful, comprehensive continuum of competency restoration services.
- Start-up grants should be used to bolster services across the continuum.
- State and local stakeholders must collaborate to successfully implement a continuum of competency restoration services.

B. Prevention and Diversion

Minnesota's mental health system should be comprehensive, equitable and fully funded.

The interim report of the task force listed several areas for further exploration into barriers in the mental health system. These barriers increase the likelihood of mental health and substance use disorder crises, which in turn increases the chances for criminal justice involvement and subsequently moving through the competency process:

- Access to the continuum of mental health treatment and services
- Disparities in criminal justice responses and accessibility of mental health care in diverse communities
- Workforce and provider shortages in rural and culturally diverse communities
- Parity enforcement to increase access to mental health care
- Access to diversion programs to move people from a criminal justice response to treatment when appropriate.

Recommendations to adequately build the mental health system in the United States have existed for nearly 60 years[12]. Minnesota has a continuum of mental health care services ranging from outpatient services, Adult Rehabilitative Mental Health Services (ARMHS), day treatment, and Assertive Community Treatment (ACT) to crisis response, and inpatient treatment at Intensive Residential Treatment Services (IRTS) and state and community operated hospitals[13]. However, while this continuum of services exists, it also contains numerous barriers and gaps. The system is not readily accessible to meet the demand of mental health treatment in Minnesota, it is unavailable in many parts of rural Minnesota, and it is especially difficult for BIPOC Minnesotans to safely and comfortably access. Integrated and innovative services across the mental health continuum must be fully funded and supported if they are going to meaningfully address the issue of the criminalization of mental illnesses "upstream," before criminal justice involvement is a possibility or necessity.

The historical discrimination against people with mental illnesses in healthcare systems has in part created the overrepresentation of people with mental illnesses in the criminal justice system. One primary way this discrimination has taken form in Minnesota is in the disparity of rate reimbursement for mental health treatments compared to other medical services. The lack of funding parity for mental health treatment is one of the root causes of existing workforce shortages and related inadequate accessibility. Funding for public services cannot meet the need of Minnesotans when reimbursement rates remain so poor that private providers have no incentive to invest in psychiatry and mental health when they cannot even break even for the services.

Another related barrier is the inconsistent enforcement of existing parity laws. Parity laws require that if insurance plans cover mental health and substance use disorder treatment that the plans cover them in the same way they do other types of care. Federal parity laws were passed in the 1990s and have since been clarified and improved

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[12] Action For Mental Health: Final Report of the Joint Commission on Mental Illness and Health, 1961, By Joint Commission on Mental Illness and Health, Boston, MA, US

[13] Appendix C

at both the state and federal level, however, many barriers persist to this day. For example, people seeking care today are largely responsible for raising issues of coverage discrimination. Insurance plans should be responsible for actively providing accurate information on accessing care. Plans should also be proactive in assessing network adequacy and providing complete information on coverage and access for in and out-of-network providers. The emphasis and responsibility for enforcing parity must shift from individuals experiencing discrimination to the insurance plans. Minnesota's Departments of Commerce and Health should continue their work to increase compliance, measure outcomes, and provide education for consumers.

Beyond parity issues, individuals seeking mental health services also face practical barriers in obtaining clinical care. People with mental illnesses are at a higher risk for co-morbid physical conditions, yet mental health care integrated with physical health care remains the exception and not the norm.[14] When people have a medical crisis, they go the emergency room – this should include psychiatric emergencies. Though a traditional emergency room may not be the most therapeutic environment for a person in a mental health crisis, psychiatric emergency rooms can be separate but integrated on a hospital campus to offer the best accessible care. Psychiatric emergency rooms also provide a solution when police are the first responders to a mental health crisis, by offering a well-known, safe, and appropriate place to take a person in crisis. Currently when police take an individual to a traditional emergency room, they may spend hours waiting with them and the person in crisis risks days of boarding while waiting for a psychiatric bed. Increasing the overall number of psychiatric beds throughout the state is essential, however Minnesota should take care to ensure that new beds are appropriately integrated into a full continuum of care.

Despite the above barriers and sparse resources, the available mental health services in Minnesota have demonstrated positive outcomes. However, as long as these existing services lack adequate resourcing, the potential to improve the system and innovate with new services remains unfulfilled. Currently, complex, and often outdated billing and licensure policies limit the larger system from truly providing preventative care and instead maintain a reactive, siloed, and more costly response to mental health care. In truth, many providers are already expanding and integrating care out of necessity and a commitment to their communities, but they do not get reimbursed for many essential tasks such as transportation and time spent on follow up calls and care coordination. These issues are compounded when providers face barriers coordinating across silos from the mental health system to the systems of substance use disorder treatment, physical health care, and social services.

Robust, consistent, and uniform mental health crisis services are needed.

Even with optimal prevention, mental health crises will always occur. A sufficiently resourced mental health system must include a robust crisis response system that can feed into a continuum of care to meet people at the level of their need in the community where they live. However, Minnesota's crisis response teams are woefully underfunded and lack uniformity. Even accounting for the different needs of rural and urban communities, task force stakeholders have identified the need to bring agreed upon standards for their ideal staffing composition,

[14] The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness Firth, Joseph et al. The Lancet Psychiatry, Volume 6, Issue 8, 675 - 712

definitions for the conditions under which they respond, and clarification of the roles and procedures for mobile crisis teams across the state, and to fund these services adequately. Because of the thinness of the current resourcing of crisis response teams, especially after regular business hours, such teams are often staffed by persons at their homes who are operating "on-call," often or usually on a part-time basis when they have primary jobs elsewhere in other parts of the operating agency. This stands in stark contrast to every other type of emergency first responder - EMT, fire, and law enforcement, and thus creates a barrier to providing adequate crisis services to Minnesota communities.

Additionally, crisis response teams are not intentionally or uniformly integrated with the rest of the emergency response system. Models of crisis service continuums exist in other parts of the country that provide clear guidelines on when a mobile crisis response is safe and sufficient, when a "co-response" (trained crisis response staff with law enforcement) is in order, and when law enforcement alone is the proper response. However, unlike fire, EMT, and law enforcement, 911 dispatchers in Minnesota do not send out mobile crisis teams. To access a mobile crisis team a person must know one of the 40 county specific phone numbers, or call **CRISIS from a cell phone; however **CRISIS is not reliable throughout the state yet, and the reality is that in a crisis, people call 911. Without integration and an appropriate decision-making procedure, law enforcement will continue to be seen as the only viable option for mental health crisis response.

To seriously invest in prevention and diversion, mobile crisis teams must operate and be resourced at the same level as all other first responders. Implementing this change would require training and support for 911 dispatchers and collaboration between the mental health system and the emergency response system. While the crisis response system remains under construction, considerable investments are required to bring the level of quality Minnesotans deserve and demand. Increased funding and expansion of mobile crisis teams would not only prevent unnecessary encounters between people in crisis and law enforcement but would save the state money in the long run. In 2016, Minnesota Management and Budget reported a $3.90 benefit for every dollar invested in mobile crisis services. Put another way, each person engaged in mobile crisis response had a $1,280 return by avoiding hospitalization and criminal involvement[15].

Existing supportive services should be fully funded and utilized.

Supportive services for those with ongoing mental health needs must be strengthened and better utilized. Minnesota has existing voluntary engagement services and protected transportation services for people in crisis, but these programs need additional funding to encourage utilization. Further, stronger housing supports and related programs are needed to ensure individuals do not become homeless and thus more likely to fall into the criminal justice system. Each of these is discussed below.

[15] Minnesota Management and Budget, Adult Mental Health Benefit-Cost Analysis, Results First. (2016, December)

Voluntary engagement services

Changes in 2020 to Minnesota Statutes Chapter 253B (the Commitment & Treatment Act) created a new service to promote early intervention by working to engage a person in treatment voluntarily[16]. The goal is to engage someone to accept treatment, services and supports early on, when symptoms are appearing and to prevent someone from being hospitalized, committed, or going to jail. In order to be eligible for engagement services, the person must be at least 18 years old, have a mental illness, and either (1) be exhibiting the signs of a serious mental illness such as hallucinations, mania, delusional thoughts or be unable to care for themselves; or (2) have a history of failing to adhere with treatment for their mental illness that has been a key factor in the past for a hospitalization or incarceration, and the person is now showing the symptoms that may lead to hospitalization, incarceration, or court-ordered treatment.

Counties may, but are not required, to offer engagement in treatment services. For those who do choose to offer these services, families and others can contact pre-petition screening at the county and ask for help. Engagement services include assertive attempts to engage the individual in mental health treatment, engaging the person's support network (family) including educating them on means restriction and suicide prevention, and meeting the person's immediate needs for food, housing, medication, income, disability verification and treatment for medical conditions. Engagement services must consider a person's personal preferences and can last for up to 90 days. Engagement services must be person-centered and can be provided even if someone is in jail.

Services end if the person meets the criteria for civil commitment or if the person agrees to voluntary treatment. When an individual agrees to voluntary treatment, the engagement team must facilitate the referral to an appropriate mental health provider and assist the individual in obtaining insurance. Engagement staff can be county staff or hired through a contracted agency. They can include but are not limited to members of a mobile crisis teams, certified peer specialists, and homeless outreach workers. Mobile crisis team staff could perform assertive outreach under this service during the times they are not responding to calls. Paying crisis teams for this service creates a more sustainable infrastructure of crisis response and promotes prevention of unnecessary criminal justice involvement.

Transportation services

Often the best response to a mental health crisis is to take the person to the hospital. However, for a person who poses no public safety threat, transportation by law enforcement or an ambulance can be at the least invasive and embarrassing, and at worst the lights and sirens could serve as an escalation to the crisis. Additionally, transporting people to the hospital can take time away from law enforcement that could be spent on more pressing public safety issues.

In 2015, a new mode of transportation was created under the Non-Emergency Medical Transportation Medicaid service. This new mode is called protected transport and is designed for someone who is

[16] Minnesota Session Laws – 2020, 1st Special Session, Chapter 2, Article 6.

experiencing a mental health crisis. The vehicle cannot be an ambulance or police car, but must have safety locks, a video recorder, a transparent thermoplastic partition, and drivers/aides who have received specialized training. The mobile crisis team can determine that this mode is appropriate for an individual. This is a more dignified and less invasive way to transport people with mental illnesses in crisis. Unfortunately, it is rarely used due to liability insurers not being willing to cover the vehicle and the authorization and billing required for use under Medicaid has proven to be a barrier. If a city or county funded such a vehicle during peak times of the day it would provide more dignity to the individual, keep police and EMTs from unnecessarily transporting people and provide more timely connection to mental health resources.

Housing services

The lack of access to affordable housing, emergency shelters, and transitional and supportive housing directly impacts the people who are most likely to be found incompetent to stand trial. A 2019 report from the National Law Center on Homelessness and Poverty showed a person experiencing homelessness is 11 times more likely to be arrested than a housed person[17]. Additionally, a 2015 study by the U.S. Department of Housing and Urban Development reported that 25% of homeless people on a given night had a serious mental illness and 45% had any mental illness. These intersections create a revolving door of criminalizing homelessness and mental illnesses and exacerbate costly and avoidable competency processes. The task force also identified housing as a key element in providing competency restoration later in the process. Housing is essential to provide the necessary support for a person with a mental illness to recover and as a preventative measure against entering the justice system. Minnesota must continue to build a full continuum of services to prevent homelessness and increase access to affordable and supportive housing.

Mental health workforce shortages and racial disparities must be addressed.

One of the biggest barriers to accessing the mental health system in Minnesota is a shortage of providers, particularly in rural areas and for BIPOC people. Poor reimbursement rates for mental health services make it difficult for providers to retain staff and create long waitlists to access services, increasing the risk of a crisis or criminal justice involvement for untreated mental illnesses, particularly in diverse communities.

If diversion and prevention are to be prioritized for all Minnesotans, systemic racism in our healthcare systems must be addressed. Conversations with the BIPOC community reveal a long and deep distrust of health care systems in the United States. Currently, providers representative of the communities they serve are not readily accessible and there are no general requirements in statute for all providers to meet a standard of cultural competency or continuing education hours on cultural responsiveness. The shortage of BIPOC and culturally competent mental health and substance use disorder providers often leads to over-diagnoses of serious mental

[17] National Law Center on Homelessness and Poverty, Housing Not Handcuffs 2019, Ending the Criminalization of Homelessness in U.S. Cities. (2019, December

illnesses in people of color and under-diagnoses of PTSD, failing to acknowledge the historical and systemic racial trauma experienced by these communities[18].

To overcome these disparities, opportunities for culturally specific treatment should be increased with outcomes and goals informed by the directly impacted communities. Additionally, providers in the mental health system and in all health care systems should develop standards for cultural competency and establish metrics for evaluating the experience people of color have when accessing care. In addition to education and training, workforce shortages are compounded by a gap between the number of BIPOC people who pursue higher education in mental health fields and those who go on to obtain a license. Many national licensing examinations for mental health professionals are not culturally competent. For many potential BIPOC professionals, supervisory hours are inaccessible and unaffordable when the burden falls on the student to cover the costs. Additionally, pathways for BIPOC people to become supervisors and provide culturally specific supervision are inaccessible and expensive. Alternative pathways to licensure and increased loan forgiveness programs could help more BIPOC people enter the workforce and address racial disparities in healthcare.

These efforts to uproot systemic racism must also be matched in the criminal justice system. Research from the Robina Institute for Criminal Law and Criminal Justice at the University of Minnesota is clear and consistent with national statistics – BIPOC communities are disproportionately, arrested, charged, detained, sentenced, and incarcerated[19]. Trauma-informed anti-racist education and training should be required for law enforcement, attorneys, judges, corrections officers, and health care and social service professionals, both in higher education and in continuing professional education. Alternative and non-punitive pathways should also be considered such as restorative, transformative and community justice programs. Programs like *Common Justice* in New York City offer alternatives to incarceration specifically for people with violent offenses. *Common Justice's* model works with court officials to offer victim-centered accountability and restorative justice circles with an explicit focus on racial justice.[20]

Diversion programs should be developed through cooperation between community providers and the criminal justice system.

The interim report of the task force listed many existing programs and partnerships between the criminal justice system and mental health system in Minnesota which can safely divert people with mental illnesses away from

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[18] Ethnicity and Diagnosis in Patients With Affective Disorders, *Stephen M. Strakowski, Paul E. Keck, Jr., Lesley M. Arnold, Jacqueline Collins, Rodgers M. Wilson, David E. Fleck, Kimberly B. Corey and Victor R. Adebimpe* J Clin Psychiatry 2003;64(7):747-754; A Naturalistic Study of Racial Disparities in Diagnoses at an Outpatient Behavioral Health Clinic, *Michael A. Gara, Shula Minsky, Steven M Silverstein, Theresa Miskimen, and Stephen M. Strakowski* Psychiatric Services 2019 70:2, 130-134

[19] Robina Institute of Criminal Law and Criminal Justice, *In Conversation*, "Racial Disparities in the Criminal Justice System," *Richard Frase, Kedar Hickman, Perry L. Moriearty, and Myron Orfield*. (2016, June)

[20] Danielle Sered. Accounting for Violence: How to Increase Safety and Break Our Failed Reliance on Mass Incarceration. New York: Vera Institute of Justice, 2017

criminalization and into treatment. These partnerships are a key element to prevention and early intervention. The task force has identified several key components in building sustainable and effective diversion programs.

Diversion programs and certified Crisis Intervention Team (CIT) programs should be expanded in Minnesota and incentives given to programs that follow best practices and community collaboration. Whenever possible, law enforcement and county jails should partner with community mental health providers. This provides a continuity of care and clarifies appropriate roles around things like confidential health data and medical decisions.

Additionally, many programs and law enforcement departments throughout Minnesota train their officers in CIT training. CIT training was started in Memphis, Tennessee in the 1980s and has since grown to include an international organization. CIT International released a best practice guide in 2019 and released a certification program in 2020 to ensure fidelity to the best practices[21]. A true CIT program should not only be training for officers but should also prominently involve providers and community members.

Final Prevention and Diversion Recommendations

Minnesota's mental health system should be comprehensive, equitable and fully funded.

- Fund mental health services across a full continuum of care, and update rate methodologies so that reimbursement covers the cost of services provided and rates grow over time consistent with costs.
- Enforce parity with insurance plans to increase access to mental health care.
- Provide funding for psychiatric emergency rooms integrated into hospital systems.

Crisis Response

- Update the statute governing Minnesota mobile crisis teams for uniformity and fully fund them to provide an adequate and full range of services, such as Voluntary Engagement discussed below.
- Establish minimum training requirements for 911 dispatchers including trauma-informed, antiracist education on how to identify a mental health or substance use disorder crisis, community mental health resources, and scenario-based de-escalation and crisis intervention training.
- Require emergency dispatch services to partner with mobile crisis teams and create risks assessment and decision-making procedures for integrating crisis teams into the emergency response system.
- Fund pilot projects to provide tablets and telehealth technology to law enforcement departments to quickly connect with mobile crisis teams when time and distance prevent the crisis team from responding first.

Supportive Services

- Provide funding for counties to pilot voluntary engagement services under Minn. Statute § 253B.041, including funding for data collection and analysis of measures, outcomes, and possible cost savings.

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[21] Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises. (2019, August)

- Provide funding for protected transport services certified under Non-Emergency Medical Transport including grant funds for county mobile crisis teams, community providers, and coverage from insurance plans.
- Encourage self-insured entities such as local or county government and health systems to operate protected transport vehicles.
- Increase and expand access to a continuum of housing services integrated with treatment and other social supports that prioritize justice-involved individuals with mental illnesses and substance use disorders.
- Invest in rental assistance programs and increase affordable housing.
- Increase funding and expand permanent supportive housing and assistance programs for people with mental illnesses like the Bridges grant.
- Invest in landlord risk mitigation funds to decrease the perception of risk about renting to people with mental illnesses or criminal records.
- Convene stakeholders to examine local ordinances and eviction policies and make recommendations to reduce housing discrimination against justice-involved people and people with mental illnesses or substance use disorders.

Workforce and Racial Disparities

- Require private insurance plans to cover treatment from a clinical trainee, a practice that is already allowed under Medical Assistance.
- Provide additional funding and expand the use of DHS grants to pay for supervision of BIPOC trainees and traditional healers in American Indian Communities.
- Provide funding to pay for continuing education credits for BIPOC mental health professionals to become supervisors.
- Expand the definition of a mental health practitioner so that providers who utilize students completing a practicum or internship can bill for services and support both the provider and student.
- Increase funding for loan forgiveness programs for BIPOC mental health professionals and professionals serving rural and other underserved communities and expand programs to include Licensed Alcohol and Drug Counselors.
- Require mental health licensing boards to have representation from rural, BIPOC, and underrepresented communities.
- Convene higher education stakeholders to examine requirements and barriers to recruiting people from BIPOC communities to mental health fields.
- Convene a task force on culturally informed and responsive mental health to create a more diverse workforce and meet the needs of all Minnesotans.
- Require at least six hours of training and continuing education on culturally informed practice for all mental health professionals and practitioners including cultural competence and humility.[22]
- Convene mental health licensing boards to discuss and make recommendations on alternative pathways to licensure for students, without sacrificing quality.

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[22] The National Institute of Health defines cultural humility as "a process of reflection and lifelong inquiry, (which) involves self-awareness of personal and cultural biases as well as awareness and sensitivity to significant cultural issues of others." Yeager KA, Bauer-Wu S. Cultural humility: Essential foundation for clinical researchers. Applied Nursing Research. 2013;26(4):251–6. 10.1016/j.apnr.2013.06.008

- Create minimum requirements for trauma-informed anti-racist education and training for all health care providers, 911 dispatchers, law enforcement, court officials, and corrections officers.

Diversion programs should be developed through cooperation between community providers and the criminal justice system.

- Provide funding for diversion programs and create incentives for community partnerships, for example local law enforcement contracting with the county crisis team to co-respond to crises; embedding community social workers in county jails to improve screening, care coordination, and discharge planning; partnerships with community mental health centers to provide care in jails; Certified Crisis Intervention Team implementation.

C. Reducing Time in the Criminal Court System

In addition to the gaps identified in the Rule 20 process, certain steps are unnecessarily prolonged and increase costly time that individuals stay in the system, often while their charges go unresolved and their mental health needs go unmet. The task force identified process improvements for reducing the amount of time individuals remain in the criminal justice system, namely: further education and training for court officials, better mental health care in jails, consistent and quality competency evaluations, and more effective coordination of services.

Education and Training

The task force identified inadequate training and education on mental illnesses and substance use disorders (SUD) for court officials as one of the primary causes of delays in moving the competency process forward in a timely manner. Minnesota Judicial Branch policy requires 45 hours of continuing education for judicial officers, but there are no requirements specifically relating to mental illness or SUD education[23]. Minnesota Statute section 480.30 is one example of legislative oversight into judicial education and requires the Supreme Court's education program to include ongoing training on specific topics such as child abuse, sexual violence, and impartial bail evaluations. A similar education requirement related to mental health and substance use disorders should be included in this statute.

When judicial officers do not have a working understanding of the symptoms of a mental illness or SUDs, defendants may be inappropriately ordered into conditional release without support or held in custody to the detriment of their mental health, furthering the likelihood of incompetency to stand trial. Additionally, the interim report of the task force documented the costly and inappropriate judicial practice of ordering Rule 20.01 and 20.02 evaluations simultaneously. Such process issues should be a part of education and training, including the appropriate use of Rule 20.04 to order to competency and civil commitment exams at the same time. Further education and understanding between the criminal court and civil courts during the Rule 20.01 process is also necessary for defendants to have optimal outcomes and save time and resources for the courts.

[23] Minnesota Judicial Council Policy Number 400. Revised September, 2020.

Quality and Timeliness of Competency Evaluations

The interim report of the task force identified the availability, quality, and timeliness of competency evaluations as a primary reason for delays in the process. In addition to these issues, the task force identified the need for racially and regionally equitable access to timely evaluations and a standardized approach to qualifying court examiners to conduct such evaluations. Any implementation of improvements to the competency evaluation process must account for the prevalent racial disparities noted above and the disparate access to resources that rural Minnesotans experience. A system-wide culturally competent certification process for all forensic court examiners performing competency evaluations would help to ensure equity across regions and culturally specific communities, which necessarily includes growing the BIPOC workforce of forensic examiners. To overcome regional disparities and maximize efficiency, hubs could be created where examiners cover sections of the state and courts coordinate to schedule examinations in a timely and equitable fashion.

Judges and examiners should also explore the viability of increased video examinations and hearings. The processes and standards for deciding the appropriateness of hearings should be agreed to by all stakeholders including prosecutors, public defenders, judges, and the mental health and substance use disorder community. For forensic examinations, in-person exams are preferred. The decision should ultimately be left to examiners who have important ethical and professional considerations to maintain the quality of their practice – though there are many cases where video exams can be effectively used. Another important consideration for the use of video in court proceedings is accessibility of technology. If uniform standards are made around video use in courts, they must account for people with little to no access to video technology, either by providing technology or making in-person examinations and hearings as accessible as possible.

Final Recommendations to Reduce Time in the Criminal Court System

Education and Training

- Establish minimum training and continuing education requirements for court officials on understanding mental illnesses and substance use disorders.
- Require training and continuing education on understanding the mental health and substance use disorder systems and the availability or barriers to treatment options in local jurisdictions.
- Require trauma-informed, culturally informed education addressing racial disparities in the past and present within the U.S. justice system.
- Promote and support education on the competency process either in Rule or statute including the appropriate use of Rule 20.04 and collaboration and understanding between civil and criminal courts.

Quality and Timeliness of Competency Evaluations

- Provide funding to implement a certification program for forensic examiners specializing in competency examinations, including measures and outcomes for program evaluation and possible expansion.
- Create and incentivize tracks for BIPOC people to become court examiners and improve training and education for cultural competency in the workforce.

- Provide funding to establish regional evaluation hubs to maximize resources and provide consistency in competency examinations throughout different regions in Minnesota, especially in rural areas.
- Provide funding to expand the use of video technology for court ordered examinations and proceedings and create standards and policies to determine when the use of video is appropriate.
- Expand same-day competency screening and/or evaluation programs throughout the state with policies and procedures to determine qualifications for defendants and best practices for adversarial cases.
- Pilot competency screening programs to increase efficiency in competency referrals – programs should have clear criteria and be designed with flexibility for local differences with consensus from the Minnesota Judicial Branch, the Minnesota County Attorneys Association, and the Minnesota Board of Public Defense.
- Provide funding to increase availability and access to mental health courts across Minnesota as well as restorative courts for defendants with low level offenses.

V. Final Recommendations

A. Community Competency Restoration

Statute for the Competency to Stand Trial Process

- A statute governing competency to stand trial should include specific provisions for individuals who do not meet the civil commitment criteria, individuals who are unlikely to ever attain competency, and diversion opportunities for misdemeanor cases.
- A standardized, flexible competency restoration curriculum should be developed for use statewide.
- Forensic navigator positions should be established throughout Minnesota with the input of stakeholders from the mental health and court systems.
- Funding should be provided to community providers, counties, Adult Mental Health Initiatives, or judicial districts for forensic navigator positions to provide equitable coverage to the entire state.

Continuum of Competency Restoration Services

- A competency restoration system in Minnesota should include a continuum of services, including acute inpatient, community, and jail-based settings.
- Individuals should be directed to services within the continuum based on their mental health treatment needs, an assessment of public safety risk, and their ability to engage with services.
- Inpatient services should be expanded through contracted beds in community hospitals.
- Community-based settings should include open and locked IRTS facilities and home-based services.
- Jail-based services should be used with clear time limits for specific cases, and they must be accompanied by robust mental health services in jails.
- Jails should be required to provide referrals for a mental health assessment for all people who screen positive for mental health issues at booking and are incarcerated for more than 14 days.
- Funding should be provided for a full range of mental health care in jails including access to medication while incarcerated and at discharge, Medication Assisted Treatment (MAT), individual or group therapy, telehealth, and administration of court-ordered involuntary medication.
- Partnerships between community healthcare systems, community mental health care providers, and jails should be funded and incentivized.
- The legislature should continue to engage stakeholders to address the issue of court-ordered medication for the purpose of restoring defendants to competency to stand trial.

Clarification of Roles

- The competency system developed in Minnesota should provide clear direction and roles to state and counties as well as to the court systems involved.
- Funding at the state level will be needed to implement a successful, comprehensive continuum of competency restoration services.
- Start-up grants should be used to bolster services across the continuum.

- State and local stakeholders must collaborate to successfully implement a continuum of competency restoration services.

B. Prevention and Diversion

Minnesota's mental health system should be comprehensive, equitable and fully funded.

- Fund mental health services across a full continuum of care, and update rate methodologies so that reimbursement covers the cost of services provided and rates grow over time consistent with costs.
- Enforce parity with insurance plans to increase access to mental health care.
- Provide funding for psychiatric emergency rooms integrated into hospital systems.

Crisis Response

- Update the statute governing Minnesota mobile crisis teams for uniformity and fully fund them to provide an adequate and full range of services, such as Voluntary Engagement discussed below.
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- Require at least six hours of training and continuing education on culturally informed practice for all mental health professionals and practitioners including cultural competence and humility.[24]
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D. Reducing Time in the Criminal Court System

Education and Training

- Establish minimum training and continuing education requirements for court officials on understanding mental illnesses and substance use disorders.

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- Require training and continuing education on understanding the mental health and substance use disorder systems and the availability or barriers to treatment options in local jurisdictions.
- Require trauma-informed, culturally informed education addressing racial disparities in the past and present within the U.S. justice system.
- Promote and support education on the competency process either in Rule or statute including the appropriate use of Rule 20.04 and collaboration and understanding between civil and criminal courts.

Quality and Timeliness of Competency Evaluations

- Provide funding to implement a certification program for forensic examiners specializing in competency examinations, including measures and outcomes for program evaluation and possible expansion.
- Create and incentivize tracks for BIPOC people to become court examiners and improve training and education for cultural competency in the workforce.
- Provide funding to establish regional evaluation hubs to maximize resources and provide consistency in competency examinations throughout different regions in Minnesota, especially in rural areas.
- Provide funding to expand the use of video technology for court ordered examinations and proceedings and create standards and policies to determine when the use of video is appropriate.
- Expand same-day competency screening and/or evaluation programs throughout the state with policies and procedures to determine qualifications for defendants and best practices for adversarial cases.
- Pilot competency screening programs to increase efficiency in competency referrals – programs should have clear criteria and be designed with flexibility for local differences with consensus from the Minnesota Judicial Branch, the Minnesota County Attorneys Association, and the Minnesota Board of Public Defense.
- Provide funding to increase availability and access to mental health courts across Minnesota as well as restorative courts for defendants with low level offenses.

VI. Appendix

A. Task Force Membership

The Community Competency Restoration Task Force is comprised of 25 members:

Chair: Sue Abderholden: a mental health organization representative

Vice-chair: William Ward: the Minnesota Board of Public Defense representative

Monette J. Berkevich: Jail Administrator representative

Mark Bliven: designated by the Commissioner of the Department of Corrections Paul Schnell

Timothy Carey: Minnesota County Attorney Association representative

Tarryl Clark: The Association of Minnesota Counties representative

Dr. Katheryn Cranbrook: State Court Administrator representative

Harlan James Gilbertson: Minnesota Psychological Association representative

Becky Graves: a reentry representative

Dr. Ian Heath: Minnesota Hospital Association representative

Molly Hicken: governor appointed member

David Hutchinson: Minnesota Sheriff's Association representative

Leah Kaiser: Minnesota Association of County Social Service Administration representative

Dr. Richard Lee: Minnesota Association of Community Mental Health Programs representative

Tami Lueck: Minnesota Association of County Social Service Administration representative

Gertrude Matemba-Mutasa: The Commissioner of Human Services representative

Cathryn Middlebrook: Minnesota Sentencing Guidelines Commission representative

Catherine Moore: a person with direct competency experience representative

Sheila Novak: a crime victim representative

Dr. Raj Sethuraju: organizations representing racial and ethnic groups overrepresented in the justice system representative

Andy Skoogman: Minnesota Chiefs of Police Association representative

Dr. KyleeAnn Stevens: DHS Direct Care and Treatment Services representative

Eren Sutherland: Protection and Advocacy Organization representative, Minnesota Disability Law Center

Dr. Michael Trangle: Minnesota Psychiatric Society representative

Michael Woods: Ombudsman for Mental Health and Developmental Disabilities representative

B. Examples of Competency Programming in Other States

In developing a comprehensive competency restoration structure in Minnesota, the systems and experiences of other states may be instructive. A number of examples of other state systems for competency restoration are discussed below, some of which have been successful and others of which have faced repeated challenges and strain.

Tennessee

Tennessee has developed a system that has operated smoothly and seemingly not resulted in major bed shortages or protracted litigation against the state or other involved entities. The basic structure of Tennessee's competency practice is laid out below.

When a defendant in Tennessee is believed to be incompetent, the court may, upon its own motion or the motion of any party, order the defendant to be evaluated on an outpatient basis. Tenn. Code Ann. § 33-7-13. The evaluation shall be completed by a private practitioner or by the state hospital or state supported hospital. Id. Only if the evaluator concludes further evaluation and treatment are necessary, may the court order the defendant hospitalized. Id. If the defendant is hospitalized in a state facility, it shall be for not more than 30 days for further evaluation and treatment. Id.

If the defendant is determined to be incompetent to stand trial because of mental illness, the defendant may be judicially committed to involuntary care and treatment. Tenn. Code Ann. § 33-6-502. When such an admitted defendant has been hospitalized for six months, and at six-month intervals thereafter, the chief officer of the hospital shall file a written report regarding the defendant's prospects for recovery, present condition, the time required for recovery, and whether there is substantial probability that the defendant will become competent to stand trial in the foreseeable future. Tenn. Code Ann. § 33-7-301(c).

When the chief officer of a state hospital or treatment resource determines that a defendant who is charged with a crime is restored to competence, the chief officer shall provide notice to the court and deliver the defendant to the sheriff of the county from which the defendant was admitted. Tenn. Code Ann. § 33-7-302.

Unlike many other states[25], Tennessee has not faced recent litigation pertaining to delays in the administration of competency restoration services.

Wisconsin

Wisconsin is another state where the competency system appears to operate smoothly and where protracted litigation against the state or other involved entities on the issue of accessibility to competency restoration has

[25] In addition to the states discussed below, the authorities responsible for competency restoration services in the following states have all faced repeated or protracted litigation in response to their inability to meet the demands for competency services: Alabama, Arkansas, California, Louisiana, Maryland, Oregon, Texas, Utah, Washington.

not occurred. A portion of the statute addressing involuntary administration of medication in competency proceedings, however, has been found unconstitutional by the Supreme Court of Wisconsin in as far as it conflicted with *Sell v. United States*, 539 U.S. 166 (2003) standard[26]. Competency restoration services in Wisconsin are offered in state operated facilities, community-based programs, and in jails or locked facilities.

In Wisconsin, the court is permitted to appoint an examiner whenever there is a reason to doubt a defendant's competency to proceed. Wis. Stat. Ann. § 971.14(1r). If the examination is to be conducted by the Wisconsin Department of Health Services ("WDHS"), the Department shall determine where the initial evaluation will be conducted, who will conduct the examination, and whether the examination will be conducted on an inpatient or out-patient basis. Wis. Stat. Ann. § 971.14(2) (am). If the examiner determines that the defendant lacks competency, the examiner must provide an opinion regarding the likelihood that the defendant, if provided treatment, may be restored to competency within 12 months or the maximum sentence specified for the most serious offense with which the defendant is charged, whichever is less. Wis. Stat. Ann. § 971.14(3) (d).

If the court determines the defendant is not competent but is likely to become competent within 12 months or the maximum sentence specified by the most serious offense with which the defendant is charged, the court shall suspend the proceedings and commit the defendant to the custody of WDHS for treatment for a period not to exceed the lesser of the two periods. Wis. Stat. Ann. § 971.14(5) (a). WDHS shall determine whether the defendant will receive treatment in an appropriate institution designated by the department, while under the supervision of the department in a community-based treatment program under contract with the department, or in a jail or a locked unit of a facility that has entered into a voluntary agreement with the state to serve as a location for treatment. Id.

The defendant shall be periodically reexamined by WDHS examiners. Wis. Stat. Ann. § 971.14(5) (b). Written reports of examination shall be furnished to the court three months after commitment, six months after commitment, nine months after commitment and within 30 days prior to the expiration of commitment. Id. Upon receiving a report indicating the defendant has regained competency or is not competent and unlikely to become competent in the remaining commitment period, the court shall hold a hearing within 14 days of receipt of the report. Wis. Stat. Ann. § 971.14(5) (c). If the court determines that the defendant has become competent, the defendant shall be discharged from commitment and the criminal proceeding shall be resumed. Id. If the court determines that the defendant is making sufficient progress toward becoming competent, the commitment shall continue. Id. If the court determines that it is unlikely that the defendant will become competent in the remaining commitment period, the court may either discharge the defendant or order that the defendant remain detained in a facility pursuant to statutes authorizing emergency and temporary protective placement, treatment for alcoholism and drug dependence, or emergency treatment for individuals experiencing mental illness, drug dependence, or who are developmentally disabled. Wis. Stat. Ann. § 971.14 (6) (b). If discharged, the court may require the defendant to appear at specific intervals for a competency redetermination. Id.

[26] *State v. Fitzgerald*, 387 Wis.2d 384 (2019).

Pennsylvania

Pennsylvania's competency system appears to be heavily dependent on placement of incompetent individuals in state operated forensic facilities. As a result, such facilities have consistently had significant wait lists for admission and the state has faced ongoing litigation over its ability to meet its obligations under law.

In Pennsylvania, whenever a person is charged with a crime, competency examination and treatment under civil proceedings may be instituted in the same manner as for those who are not charged with crimes. 50 Pa. Stat. Ann. § 7401(a). However, Pennsylvania statutes allow the court to order involuntary treatment of a person who has been found incompetent to stand trial but who is not severely mentally disabled only when the court is reasonably certain that the involuntary treatment will provide the defendant with the capacity to stand trial. 50 Pa. Stat. Ann. § 7402. The court may order outpatient treatment, inpatient treatment, or partial hospitalization, and the proceedings may be stayed only for so long as the defendant remains restorable. Id. The stay may not exceed the period which the defendant is deemed to be restorable or the maximum sentence of confinement that may be imposed for the crime(s) for which the defendant is charged or ten years, whichever is less, except in cases of first and second-degree murder, where there is no maximum period so long as the defendant remains restorable. 50 Pa. Stat. Ann. § 7403(f).

If the court finds that the defendant is incompetent but substantially likely to become competent in the foreseeable future, the court should order further evaluation and treatment, which may include involuntary treatment, for the defendant for the purposes of restoring his competency for a period not to exceed 60 days. 50 Pa. Stat. Ann. § 7402(b). Involuntary administration of antipsychotic medications to a criminal defendant must comport with the constitutional requirements of *Sell v. United States*. See *Com v. Watson*, 597 Pa. 483 (2008). Such additional evaluation and treatment should occur on an outpatient basis unless the court determines that public safety and treatment needs require an inpatient setting.

In the event that the court finds the defendant incompetent and not substantially likely to become competent in the foreseeable future, the court shall discharge the person from the detention pursuant to the criminal case and release the defendant, unless involuntary civil commitment is authorized. 50 Pa. Stat. Ann. § 7403(d).

Pennsylvania has faced substantial, protracted, ongoing litigation regarding delays in competency restoration. For example, *J.H. v. Miller*, 1:15-CV-02057 (Middle D. PA Oct. 22, 2015), is a class action lawsuit brought by individuals in punitive settings waiting for admission into forensic hospitals and individuals confined to forensic hospitals whose clinicians have opined that they are not likely to regain competency yet nevertheless remain confined to maximally restrictive settings. The plaintiffs alleged Pennsylvania's actions violated the Fourteenth Amendment, Title II of the ADA, and Section 504 of the Rehabilitation Act. Pennsylvania entered into a settlement agreement with the plaintiffs in 2016. As part of the agreement, the court retained jurisdiction over the matter for a period of three years. Plaintiffs renewed the action in May 2017 and again in March 2019 due to Pennsylvania's alleged failure to reduce wait times to constitutionally acceptable levels. Pennsylvania has committed to reducing wait times for commencement of substantive services to restore a defendant to competency to no longer than 21 days. As of April 2019, the average wait time was 29 days. Plaintiffs seek to reduce the wait time to a period of seven days. Docket activity indicates this matter is stayed and settlement negotiations are ongoing.

Colorado

The State of Colorado has been engaged in litigation regarding its competency services for nearly a decade. In 2011, a complaint in the matter entitled *Center for Legal Advocacy v. Bicha and Bernal*, alleged Colorado violated the Due Process Clause of the Fourteenth Amendment when it failed to timely conduct competency evaluations and admit individuals found to be incompetent into state hospitals. Complaint, *Center for Legal Advocacy v. Bicha and Bernal*, 1:11-cv-02285-NYW (D. Colo. Aug. 11, 2011). The parties entered into a settlement agreement in 2012.

Plaintiffs have twice filed motions to reopen the case, including as recently as 2018 when the court appointed a special master following allegations by plaintiffs that CDHS was failing to meet admission deadlines and abusing its right to invoke special circumstances. *Ctr. for Legal Advocacy v. Bicha*, 2018 WL 6834597 (D. Colo. Dec. 28, 2018). In February of 2019, CDHS announced that it would no longer accept any civil admissions to either of its state operated psychiatric hospitals. Instead, in order to try to meet the demands of the forensic population, CDHS announced it would serve only those individuals from criminal cases who require initial competency evaluations and/or restoration services.[27] In May of 2019, the Colorado Legislature passed SB19-233, an act amending and improving the competency system.

The decision on inpatient versus outpatient competency restoration services is first considered by the competency evaluator at the time of the evaluation. Statute mandates evaluators to opine as to whether inpatient or outpatient services are more appropriate. Most evaluations, about 60%, occur in jails. About 35% occur in the community, leaving only a small amount conducted in the hospital. Statute now mandates that outpatient restoration be the default setting for restoration for all persons evaluated while in the community, unless inpatient criteria are met. Courts have final discretion on placement for restoration, but as expected those decisions typically follow the opinions of the evaluator.

Evaluators are also required to provide an opinion on admission urgency (triage) for anyone they opine as incompetent and in need of inpatient restoration. Colorado has a two-tier system for inpatient restoration admissions. Tier 1 individuals must be admitted to the state hospital within 7 days of the adjudication of incompetency, whereas Tier 2 individuals have until the maximum time currently set by the Consent Decree to be admitted (which will be 28 days in January 2022). The tiered system is essentially a triage system that allows evaluators to prioritize the most acute defendants for more urgent admission. About 20-30% of all persons opined as incompetent are categorized as Tier 1 admissions, which comprises about 12% of all competency evaluations conducted. Prior to COVID, the state had a track record of getting Tier 1 defendants into the hospital within the 7-day time frame but has had more difficulty getting the Tier 2 defendants in by the relevant time frames.

[27] "Officials to Halt Admissions to State-Run Mental Health Hospitals Except for Those in Jail." High Plains Public Radio News. Feb. 7, 2019. https://www.hppr.org/post/officials-halt-admissions-state-run-mental-health-hospitals-except-those-jail.

Inpatient services are located primarily at one of two state hospitals as well as a handful of longer-term contracted inpatient beds at local hospitals. The state will be opening competency restoration units at the second state hospital in late 2021. Overall, the state will have nearly 200 beds for inpatient restoration at that point. Jail-based services are located in two jails in major metropolitan areas (Denver and Boulder, titled “RISE"). They are subcontracted to a private provider, Wellpath. There are approximately 100 jail-based beds across the two programs. The jail-based programs are standalone units in the jails and operate theoretically like external units for the state hospital. Statutorily they are considered inpatient beds, and are an extension of the state hospital. This means that the state receives an order for inpatient restoration and then has the discretion as to where the person will receive restoration — hospital or jail-based program. There is no requirement for the defendant to have a case in the jurisdiction in which the RISE program operates; they provide services to defendants from all over the state. The state has an office that determines placement, integrity of the jail-based services, discharges, communication with hospital and court, and other services.

Outpatient services are located in every jurisdiction in Colorado. Initially, the state contracted with private providers through an RFP process and paid as a fee-for-service model. They have recently switched to contracting with the 17 Community Mental Health Centers across Colorado to take the bulk of cases going forward, retaining some specialty services (juvenile, ID/DD, rural) here and there. The outpatient competency restoration program in Colorado is very successful and serves around 300 people at any one point in time. There is no waitlist for anyone seeking outpatient competency restoration program services.

Finally, the state operates a safety net service called the Forensic Support Team (FST) that monitors each person on the waitlist (defendants in jail awaiting inpatient restoration) weekly. They monitor clinical stability and progress to restoration. This allows for a more nimble adjustment of the admission waitlist — if a Tier 2 person decompensates, the FST Navigator can alert the hospital that more urgent admission is warranted. Similarly, if a Tier 2 defendant stabilizes significantly, the FST Navigator can alert stakeholders that discharge to the outpatient competency restoration program is indicated.

C. Continuum of Mental Health Services in Minnesota