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MAPPING YOUR COMPETENCE TO STAND TRIAL PROCESS:

Key Questions to Decrease Waitlists and Length of Stay

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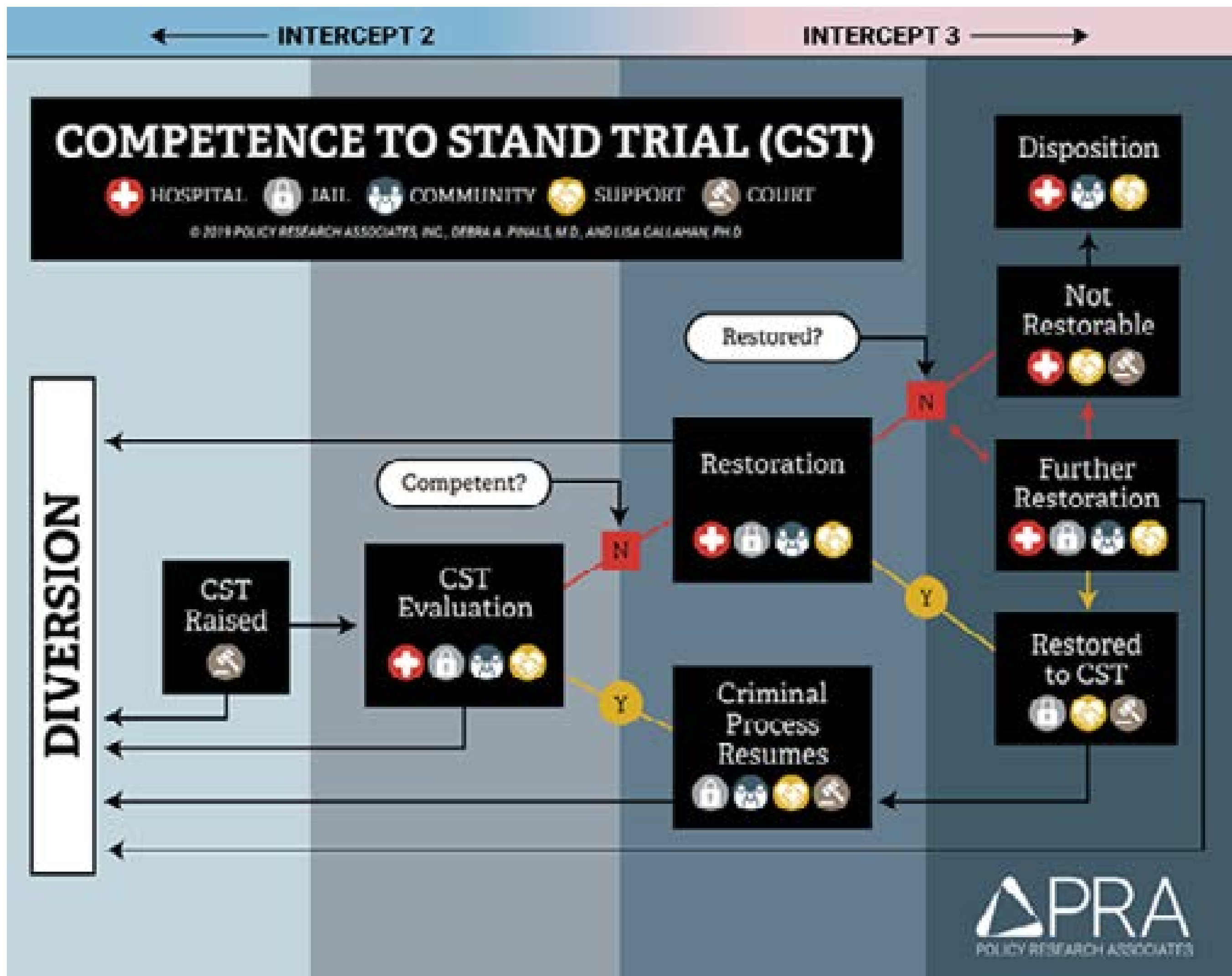
Competence to stand trial (CST) is raised when justice-involved individuals exhibit signs or symptoms of conditions that can impair their ability to competently proceed with their criminal case. When these concerns arise, the court can order a competence examination requiring forensic evaluation and further systems involvement. This process is typically lengthy and expensive. Individuals who are found incompetent to stand trial are often detained for extended periods, potentially leading to harmful outcomes and inefficient use of resources. This misallocation has overburdened the mental health system in many places and has been the subject of class-action lawsuits brought against states.

Due to the difficulty faced by jurisdictions and states to provide timely CST/competence restoration (CR) services, many jurisdictions are seeking ways to improve this process and identify best practices. Strategies include exploring alternatives to inpatient (hospital-based) restoration alone, such as jail-based and community-based programs, as well as diverting individuals charged with misdemeanors from the competence process entirely. However, each jurisdiction is unique, and it is important to cultivate a clear understanding of local decision points, laws, existing resources, and specific gaps and needs to create the most appropriate and efficient CST process.

Mapping the Local CST Process

One tool that sites can use to develop this understanding is the Sequential Intercept Model (SIM). The SIM framework can be used to potentially "decrease jail stays and maximize community service connections for individuals with some of the most impairing mental health conditions who are involved in the justice system and for whom diversion is a safe option" (Pinals & Callahan, 2020).

The CST/CR process takes place within Intercepts 2 (Initial Detention/Initial Court Hearings) and 3 (Jails/Courts) of the SIM, after arraignment and before case adjudication and sentencing. The CST Flowchart identifies key decision points in the CST/CR process where justice and behavioral health professionals can consider and create diversion opportunities. Intercepts 2 and 3 provide a wide range of options to divert individuals for whom competence is raised, who have been adjudicated incompetent to stand trial with the potential for restoration, or even for those adjudicated but not restorable. Icons for each possible decision point denote possible outcomes and referable services for individuals for whom competence is raised.



CST Flowchart. Available for download in the PRA Resource Library.

Key Questions to Explore

Some communities contract with Policy Research Associates to facilitate a CST Mapping Workshop. This resource provides key questions to help you map your local CST and diversion processes and focuses on alternatives to traditional state hospital-based CR. At every point in the CST process, there is a gatekeeper with the ability to divert an individual to community-based treatment or a less restrictive setting. However, the various parts of the CST, criminal legal, and community behavioral health systems may be poorly connected.

Note: When focusing on this population, a distinction should be made between general deflection and diversion strategies at Intercepts 0 (Community Services) and 1 (Law Enforcement) that prevent entry into the CST system and diversion of individuals with chargeable offenses (Intercepts 2 and 3). Both are integral to the appropriate, efficient, and equitable handling of individuals with competence needs.

AT INTERCEPTS 0 AND 1:

Creating strategies to engage and improve the delivery of care at Intercepts 0 and 1 can help reduce the risk of individuals unnecessarily entering the CST system. Promising strategies include staff cross-training, de-escalation policies and procedures, and increased collaboration among 911 call centers, law enforcement and other first responders, and the community-based continuum of care (Pinals & Callahan, 2020). When creating your local CST map, consider both the current process/structure for deflection and any existing authority (e.g., statutes, municipal codes) that guide decisions around deflection and diversion.

1. What are the current response options for someone experiencing a behavioral health crisis in the community (e.g., crisis hotlines, co-response teams with law enforcement, alternative/mobile crisis teams)?
2. What is the structure of your mental health system (e.g., centralized through the state or decentralized)?
3. Is there routine, cross-system training on competence, the CST process, and the deflection of individuals to care or diversion resources?
4. Has there been any cross-system focus on how to better meet the needs of individuals who frequently contact the local hospital, detox services, housing/homeless systems, or jail (i.e., "familiar faces")?
5. How are any Assertive Community Treatment-based teams (e.g., ACT, FACT, or PACT) integrated into the CST process?
6. How are assisted outpatient treatment (AOT), partial hospitalization, and medication adherence policies and programs integrated into the CST process, if at all?

If an individual within a community care setting exhibits aggressive or violent behavior, law enforcement is likely to be called, even if the facility serves those experiencing behavioral health crises or other disability needs. These settings include community hospitals, crisis stabilization centers, group homes, nursing care, assisted living, and other care facilities. Mapping this potential intersection point can reveal how the involuntary civil commitment, disability, and criminal legal systems are working with or against each other and whether individuals are unnecessarily being funneled into the criminal legal system.

7. Do local law enforcement agencies have formal policies and procedures regarding the importance of appropriate diversion from the criminal legal system?
8. What relevant community-based services exist across the local continuum of care (e.g., crisis stabilization centers, services for people with intellectual and developmental disabilities (I/DD) or brain injuries, post-crisis follow-up services)?
    - Do relevant programs have eligibility and/or funding restrictions that impact their availability for this population, such as people with pending charges, charges including violence, etc.?
    - What is the information-sharing process and coordination between care facilities, community mental health providers, and the CST process?

- What policies and strategies are in place to support staff working in care settings with individuals who may be at risk of infractions or aggressive behavior (e.g., sufficient staffing levels, training, protocols, security models)?

9. What data are collected and analyzed when law enforcement responds to care settings (e.g., where such calls originate and the nature of alleged offenses)?
   - Does the analysis include details such as the time of day and shift to better identify gaps?
   - Does the analysis include whether individuals have had repeated aggressive behavior?
   - Does the analysis include case outcomes, including if the case was dismissed and what happened to the individual?
   - Does the analysis include any new actions taken to better manage the care setting, staffing, and/or individual?
   - Does the analysis include whether competence was raised while processing the charge(s) and whether the individual was previously involved in the CST process?
10. What policies exist if an individual under a civil commitment court order is charged with aggressive behavior and taken to jail?
    - Are civil orders for medications and placements "dropped" and later must be reinstated?
    - Are they placed in a holding pattern until the criminal case is resolved?

AT INTERCEPTS 2 AND 3:

Before developing specific strategies at Intercepts 2 and 3, consider your most important goal(s) of CST diversion. They may be reducing the number of individuals involved in the overall CST process, reducing wait times for competence restoration beds at the state hospital, stabilizing individuals in the community who may be likely to have competence raised, or a combination of these or other goals.

1. Is there routine, cross-system training on competence, the CST process, and resources and gaps at Intercepts 2 and 3?
   - Is there a team that meets regularly to coordinate resources and processes between the civil and criminal legal systems?
   - What is the relationship between criminal and civil courts regarding civil actions?
2. What state laws and standards guide local CST diversion processes and programs, if any?
   - Are CST processes standardized statewide, or do they vary by judicial district?
   - Are there state laws regarding CST and misdemeanor cases? If so, what are they? Can a local prosecutor and judiciary create CST misdemeanor and/or non-violent charge diversion processes?
   - Do state laws support jail-based or community-based CR programs?
   - Are state CST laws prescriptive or flexible regarding how long an individual must be in a specific CR setting such as a state hospital, when they could be appropriately served in a less restrictive setting?
   - What financial or other relevant resources are available from the state, such as fines from CST settlements, medications, and CST and mental health professionals?

3. What is the current process for raising an individual's potential competence?
    - Is there an opportunity for quick screening (e.g., for attorneys/courts or at the jail) to flag potential behavioral health, I/DD, brain injury, and/or competence needs?
4. What are the current standards around timelines at the various points of the CST process?
    - What size are the waitlists at each point?
5. Is there any "true diversion" (including case dismissal) of individuals who may be incompetent and are charged with misdemeanors and/or whose competence has been raised previously?
6. Is there an existing dedicated CST docket? If not, is there local interest in developing a CST docket or specialty court to focus on this population and increase case efficiency?
7. Are peers/people with lived experience included in the CST process and how?

Evaluator Standards

- What is the current CST evaluation/evaluator process, including any standards, training, report development/review, and supervision/oversight?
- Are evaluators trained to determine the most appropriate setting for an individual (i.e., inpatient, jail-based, or community-based)?
- Are evaluators trained to assess "dangerousness"?
- Are evaluators trained specifically in I/DD, substance use, and brain injury?

8. If an individual's CST status changes (e.g., they regain competence while in jail awaiting CR), who notifies key players such as the court, state forensic director, etc.?
9. If someone is found incompetent, is inpatient CR the only option, or are there any jail-based or community-based CR programs to enhance earlier access to treatment?
    - If an individual must wait in jail for CR, is there a process for revisiting their competence in the meantime?
    - If jail-based and/or community-based CR programs do not exist, is there local interest in exploring pilot programs?
10. Upon return to jail from inpatient CR, are individuals able to stay on the same medication prescribed at the hospital to prevent potential decompensation?
11. How quickly is a court appearance scheduled upon return from inpatient CR?
12. What are current policies regarding individuals who are deemed non-restorable (e.g., release to the community with no services, release with services and care coordination, coordination with the civil commitment process, detained in the hospital or jail)?
    - Related to *Jackson v. Indiana*, what is the maximum time limit for CR to be attempted?
13. What relevant auxiliary services, such as a housing continuum, are available in your community for this population?

Jail-Based CR Programs

- Describe any dedicated mental health units within the correctional facility.
- Are community-based providers able to perform in-reach to individuals who are incarcerated?
- If a jail-based CR program exists, describe the overall staffing and management.
- Are individuals awaiting CR or whose competence has been restored eligible for any jail-based behavioral health services or programming?
- How are best practices like peer support, motivational interviewing, and ensuring a safe environment used to help individuals maintain prescribed medications?
- Describe how medications are used within jail facilities (cost, formulary, medication over objection, and medication management).
  - How are *Sell v. United States* requirements implemented around medication over objection, if at all?
- What metrics does the CR program collect and evaluate in addition to restoration rates?

Community-Based CR Programs

- If a community-based CR program exists, describe the overall staffing, management, setting(s), any associated housing, and location(s).
- Is there an oversight mechanism for community-based CR in your state/county, including but not limited to:
  - Standardized operations (e.g., training and certification for CR instructors, compensation for services, curriculum and training materials, delivery methods, student materials, cultural competency, access to medications, housing, treatment, and supports)
  - Standardized process (e.g., referrals and eligibility, determination of outcomes, supports, and settings)
- What metrics does the CR program collect and evaluate in addition to restoration rates?

Additional strategies to decrease waitlists and shorten individuals' length of stay in a hospital or jail setting include increased collaboration between forensic evaluators and local mental health services, formal communication flows between community programs and courts, linkage to specialized services based on individual needs, and additional training for all parties to "foster simultaneous pursuit of competence evaluation and restoration, when needed, and diversion strategies when appropriate" (Pinals & Callahan, 2020).

AT INTERCEPT 4:

In addition to specific deflection and diversion strategies at Intercepts 0-3, robust transition planning across CST and CR settings is essential to increase patient well-being and reduce new instances of competence being raised. Several key questions will help you map your discharge planning and reentry processes.

1. Is there standardized and comprehensive transition planning from all inpatient, jail, and community-based CR settings? Describe the process, including any gaps.
2. What information does correctional health receive from inpatient CR settings, and when?
    - How do they receive information regarding medications and patient status (not just restoration status)?
3. What information do the courts receive from inpatient and jail-based (if applicable) CR settings?
    - When and how do they receive the information?
4. What information do crisis stabilization centers, co-responders (mental health clinicians), and other crisis responders have regarding people who have returned to the community from the CST process, toward the goal of continuity of care?

Going Deeper: Gathering Cross-Intercept Data

Once you have a clear map of your current CST process, you may wish to collect additional cross-intercept data. Data collected and analyzed across CST deflection, diversion, and restoration settings should have common and clear definitions. Metrics should include age, race/ethnicity, gender, and any prior instances of raised competence to better identify disparities.

It can also be helpful to determine who currently pays for CST services at each step: initial evaluation, any subsequent evaluations in custody, CR treatment in any available setting (including inpatient), and post-restoration services. Identifying the pay sources may provide leverage for obtaining buy in to better meet the needs of this population.

Citation

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Acknowledgments

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