Competency To Stand Trial in Connecticut

Presentation to CJPAC

January 28, 2021

Michael Norko MD

Director of Forensic Services, DMHAS

Just and Well:

Rethinking How States Approach Competency to Stand Trial

October 2020

Available at: https://csgjusticecenter.org/publications/just-and-well-rethinking-how-states-approach-competency-to-stand-trial/

Outline

- Definition of competence to stand trial and processes
- Highlights of the report
- Ten strategies recommended in the report
- Connecticut context – data and strategies
- Possible pilot

Competence to Stand Trial (CST)

- **Sec. 54-56d. Competency to stand trial.** (a) **Competency requirement. Definition.** A defendant shall not be tried, convicted or sentenced while the defendant is not competent. For the purposes of this section, a defendant is not competent if the defendant is unable to understand the proceedings against him or her or to assist in his or her own defense.
- b) **Presumption of competency.** A defendant is presumed to be competent. The burden of proving that the defendant is not competent by a preponderance of the evidence and the burden of going forward with the evidence are on the party raising the issue. The burden of going forward with the evidence shall be on the state if the court raises the issue. The court may call its own witnesses and conduct its own inquiry.
- (c) **Request for examination.** If, at any time during a criminal proceeding, it appears that the defendant is not competent, counsel for the defendant or for the state, or the court, on its own motion, may request an examination to determine the defendant's competency.

CST - 2

- Evaluations performed by clinical staff of DMHAS
  - Offices in Hartford, New Haven, Bridgeport, Norwich
  - Psychiatrist or team (psychiatrist, social worker/APRN, psychologist)
  - Examination completed within 15 business days of court order
  - Reported filed with court within 21 business days of court order
  - Performed in DOC, in community, or other location as needed
- Evaluators to opine if competent, not competent but restorable, or not competent and not restorable
  - "Substantial probability" of restoration within maximum period of placement if provided treatment (lower of 18 months or maximum possible sentence)
- Restoration in Whiting Forensic Hospital or community (DMHAS)
  - Or with DDS (community) or DCF (community or hospital) when relevant

Highlights of the Report

- The report primarily focuses on how to improve outcomes for individuals with serious mental illnesses who enter the competency to stand trial (CST) process [p 1]
- From 1999-2014, 72% increase nationally in number of people being restored to CST in state hospitals (based on half of the states reporting) [p 3]
  - Researchers estimate that half of these evaluations are for people charged with misdemeanors
- Race and culture affect CST processes, with disproportionately high percentage of minority defendants sent to secure facilities for restoration [p 4]

Highlights - 2

- States spend significant money from mental health budgets on CST, even though CST processes do not equate to MH treatment or ensure long-term improved outcomes [p 5]
  - In FL, 80% of defendants restored had charges dismissed, got time-served, or were placed on probation – typically without MH follow-up
- Rise in CST restoration admissions may be tied to states' barriers to civil commitment, with legal actors overly relying on CST as a means to get people into the hospital [p 7]

Highlights - 3

- At least 12 states are involved in litigation over excessive wait lists for admission to state hospital for restoration [p 4]
  - Violation of Constitutional right to due process
  - Example: Washington State has paid $85m in fines for failing to meet court-ordered deadlines as part of a consent decree

Vision

- The CST process should generally be “reserved for cases where the criminal justice system had a strong interest in restoring competency so that a person may proceed to face their charges” [p 8]
- When the state interest in prosecution is lower, cases should be dismissed and/or person should enter a diversion program in lieu of CST evaluations and restoration
- Prevention of criminal justice system involvement should also be a strong focus
  - Requires attention to housing, transportation, community-based treatment resources

Action steps

- Prioritize investment in community-based care
- Establish pre- and post-arrest diversion alternatives
- Limit use of CST to cases in which state has strong interest in adjudication

Ten Recommended Strategies

- Strategy 1: Convene diverse stakeholders to develop a shared understanding of the current CST process.
- Strategy 2: Examine system data and information to pinpoint areas for improvement.
- Strategy 3: Provide training for professionals working at the intersection of criminal justice and behavioral health.
- Strategy 4: Create and fund a robust system of community-based care and supports that is accessible for all before, during, and after criminal justice contact.
- Strategy 5: Expand opportunities for diversion to treatment at all points in the criminal justice system, including after competency has been raised.

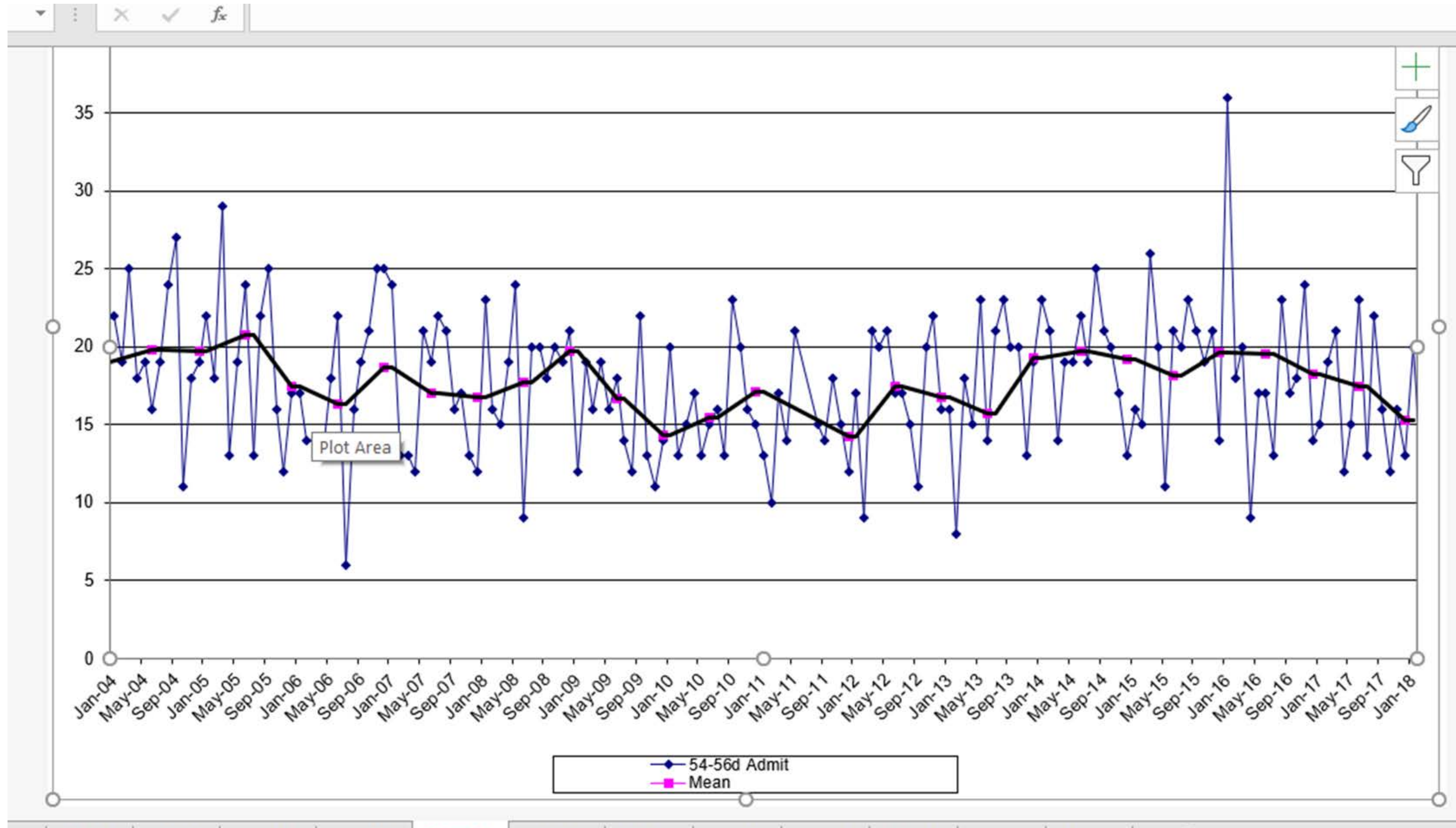
Ten Recommended Strategies

- Strategy 6: Limit the use of the CST process to cases that are inappropriate for dismissal or diversion.
- Strategy 7: Promote responsibility and accountability across systems.
- Strategy 8: Improve efficiency at each step of the CST process.
- Strategy 9: Conduct evaluations and restoration in the community, when possible.
- Strategy 10: Provide high-quality and equitable evaluations and restoration services, and ensure continuity of clinical care before, during, and after restoration and upon release.

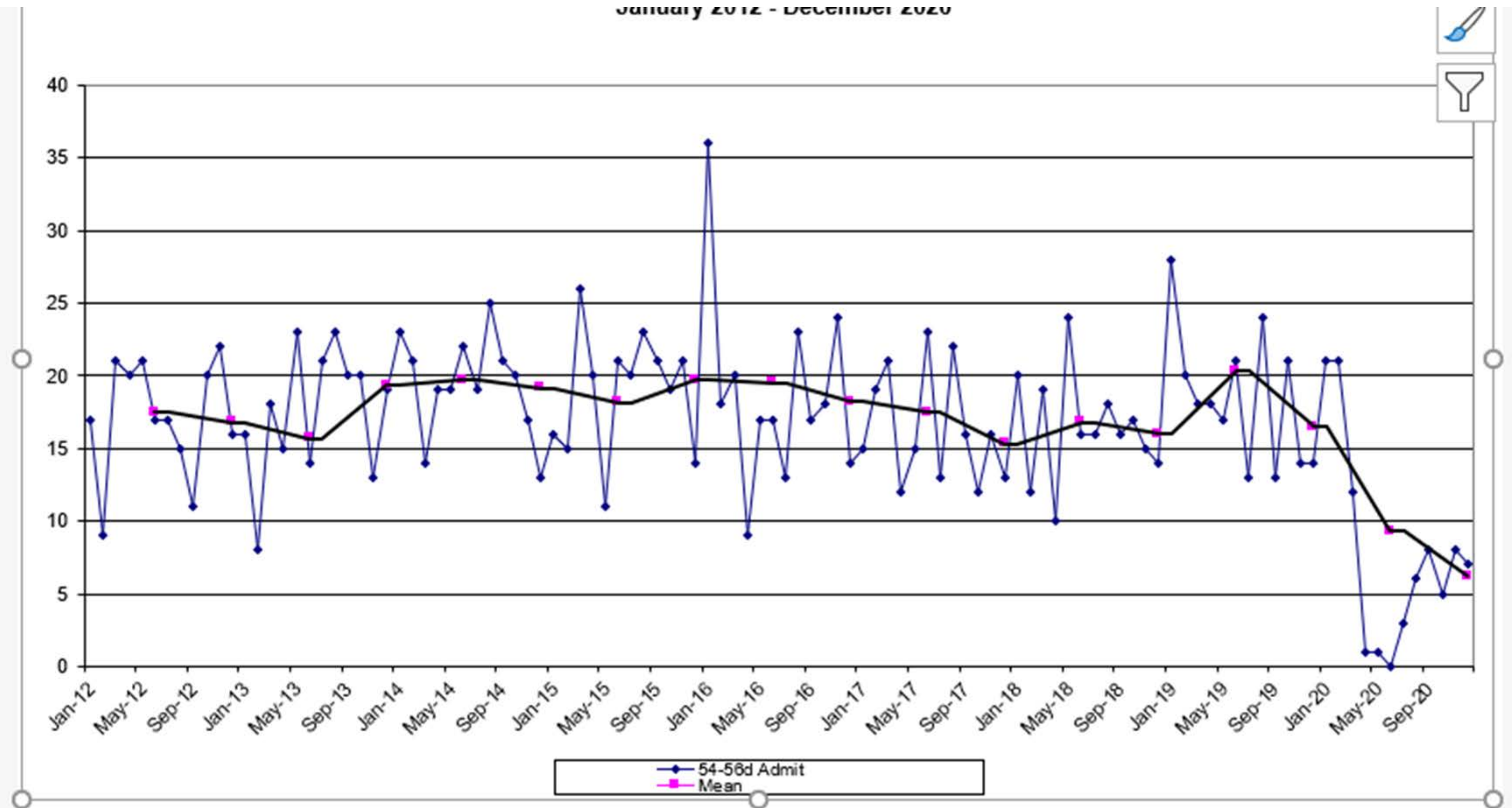
CT Overview

- No one is ever admitted to a state hospital for a CST evaluation
- CT has never had a wait list for admission to the hospital for CST restoration (CSTR)
- Unlike the 72% national increase in CSTR from 1999-2014, CT experienced about a 25% decrease in CSTR from 2004 – 2012
- But then an increase to 2004 levels from 2013-2016
  - Further fluctuations between those ranges from 2017-19
  - Large drop in 2020 secondary to pandemic

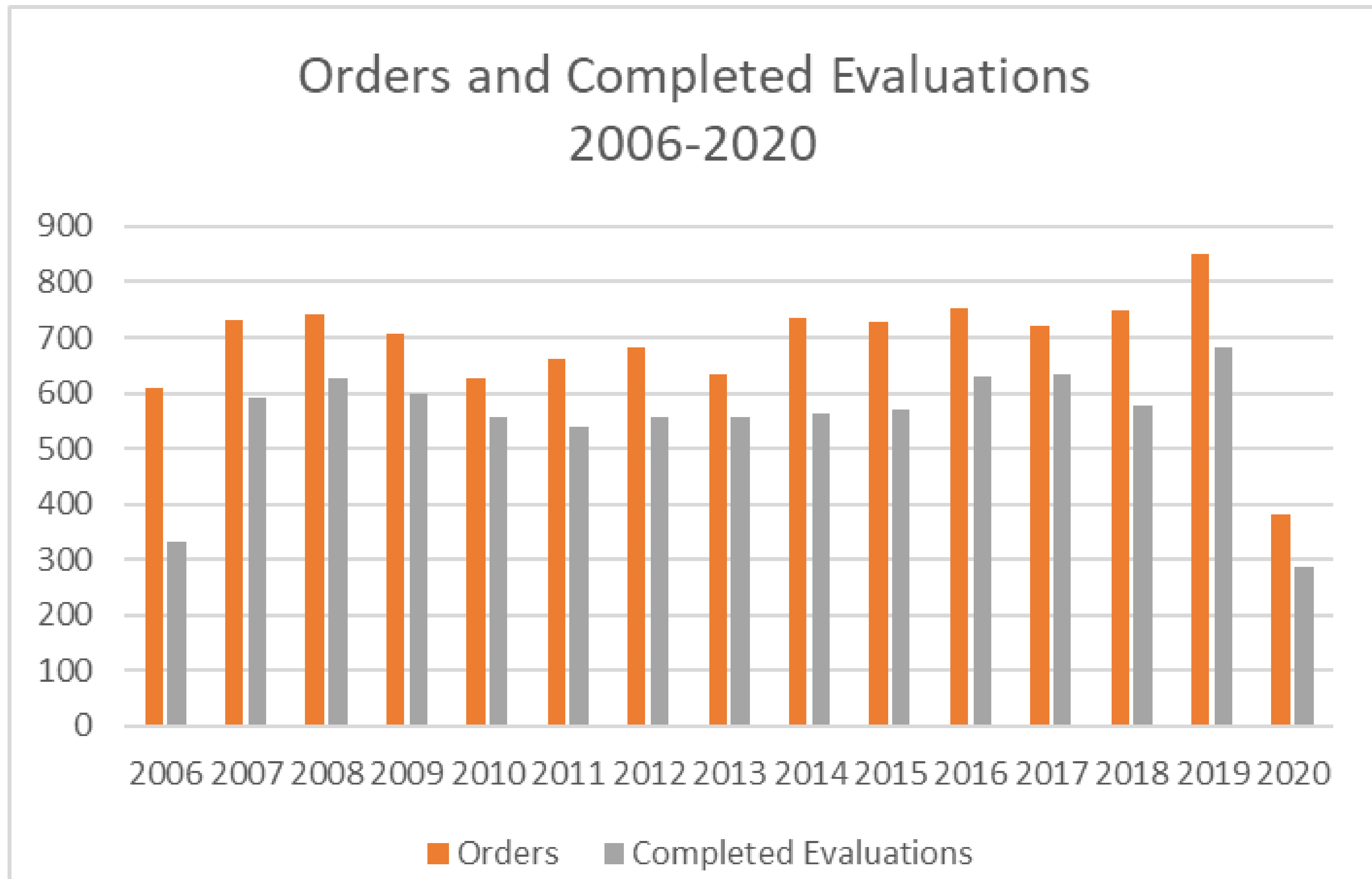
CSTR Admissions in CT 2004-2018



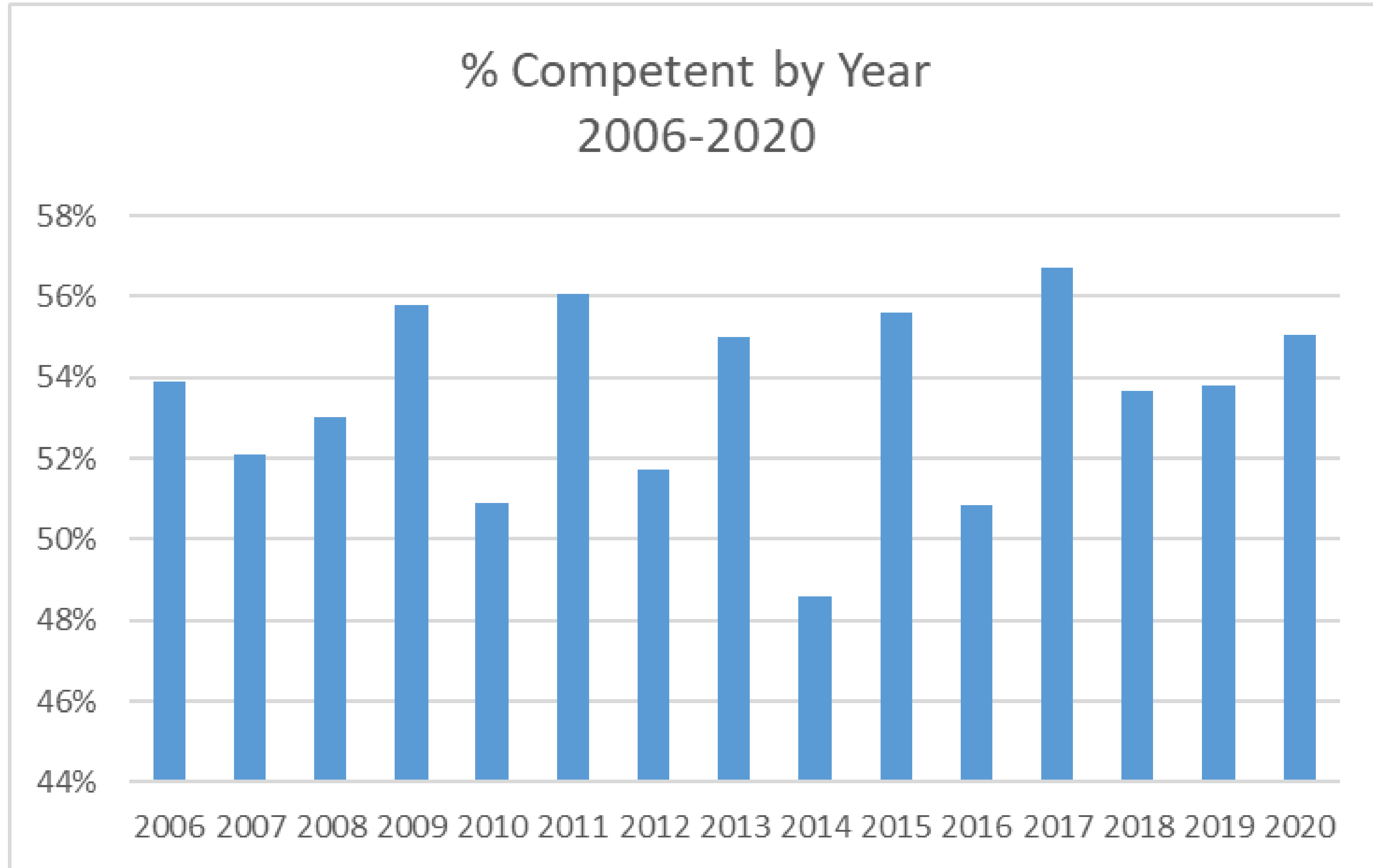
CSTR Admissions in CT 2012-2020



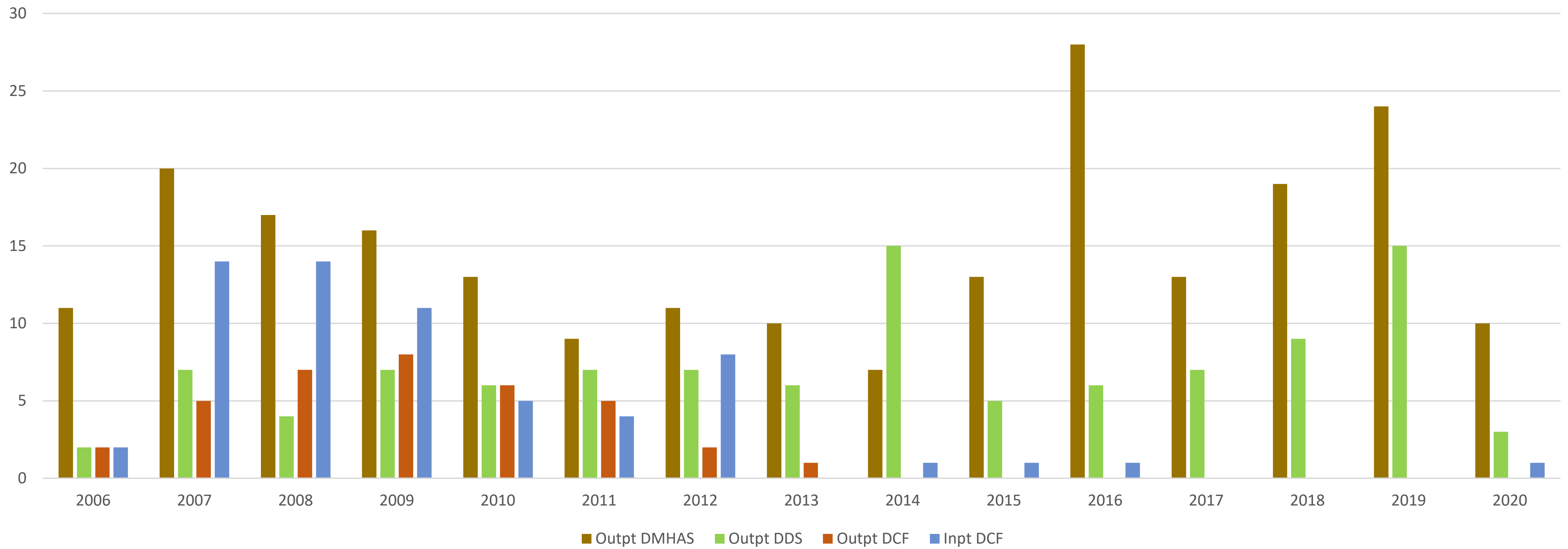
CST Evaluations in CT



Rate of findings/recommendations



Restoration Location



Strategies for CT

- Strategy 1: Convene diverse stakeholders to develop a shared understanding of the current CST process.
  - CJPAC and guests
  - CJPAC work group(s)
- Strategy 2: Examine system data and information to pinpoint areas for improvement.
  - DMHAS data system needs improvement
  - Shared data among DMHAS/Judicial Branch/DOC/others to pinpoint areas for improvement and clients with significant needs
  - Data on charges, housing status, past criminal justice involvement (CJI), health insurance, & employment status to direct interventions and policy development
  - High rates of dismissal or time-served may indicate use of CST in cases with low state interest in adjudication [p 12]

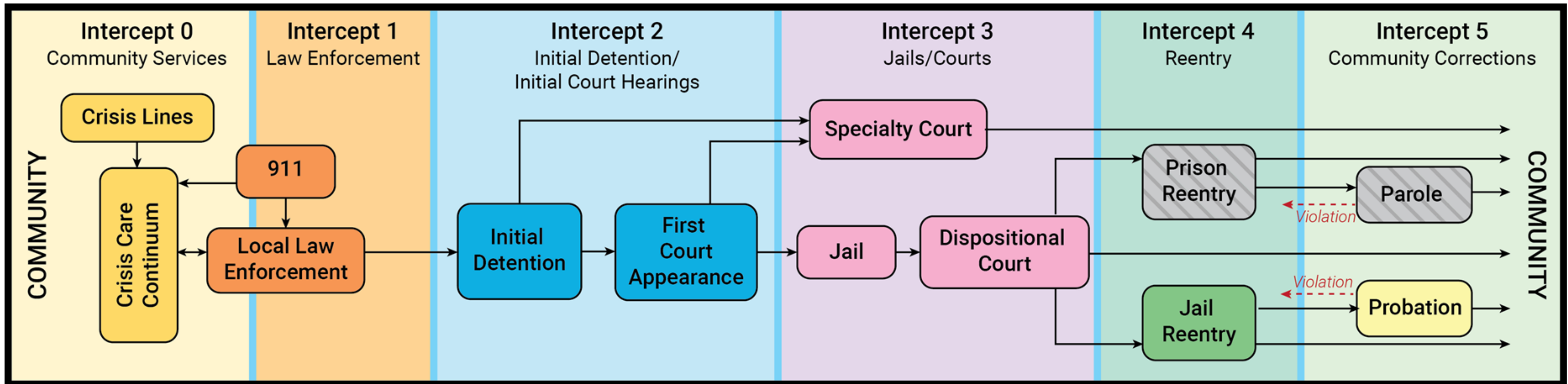
Strategies for CT

- Strategy 3: Provide training for professionals working at the intersection of criminal justice and behavioral health.
  - Inter-agency training re: jail diversion, CST, community resources, etc.
  - Improved understanding of diversion decreases use of CST as gateway to treatment [p 13]
- Strategy 4: Create and fund a robust system of community-based care and supports that is accessible for all before, during, and after criminal justice contact.
  - Enhance current diversion (DMHAS, Judicial, State's Attorneys)
  - Expand training of MH clinicians to better identify clients at risk for CJI and respond with broader range of interventions
  - Investments in housing reduces CJI and lowers overall costs [p 14]

Strategies for CT

- Strategy 5: Expand opportunities for diversion to treatment at all points in the criminal justice system, including after competency has been raised.
  - We have programs at all phases of the Sequential Intercept Model
  - Room to expand and improve these
  - CSG report emphasizes early interventions through non-mandated care and appropriate supports [p 15]
  - Example: Miami-Dade stopped ordering CST evaluations for misdemeanor cases, and diverted those individuals to treatment [p 16]

Sequential Intercept in CT



© 2016 Policy Research Associates, Inc.

0-1: Crisis Intervention Team (CIT); Law Enforcement Assisted Diversion (LEAD)
2: Pretrial Alcohol and Drug Intervention Program
2-3: Jail Diversion Programs
2-5: Transitional Housing; Permanent Supportive Housing; SSI/SSDI Income expedited applications; Day Reporting Program
4: Mental Health Re-entry Services and Supports; Substance Use Re-entry Services and Supports

Strategies for CT

- Strategy 6: Limit the use of the CST process to cases that are inappropriate for dismissal or diversion.
  - There should be a compelling interest in restoring CST [p17]
  - For certain charges, restoring CST may not be worth the costs [p 17]
- Strategy 7: Promote responsibility and accountability across systems.
  - Utilizing clinical liaison and care coordinators [p 18]
  - Other supports. Example: AZ employing forensic peer support navigators to help defendants in their recovery

Strategies for CT

- Strategy 8: Improve efficiency at each step of the CST process.
  - Prior to COVID, this was not a particular challenge for CT
- Strategy 9: Conduct evaluations and restoration in the community, when possible.
  - Already permitted in CT statutes
  - DMHAS conducts 15 outpatient restorations per year, on average
    - Compared to about 200 inpatient restorations per year
  - Resources and further training could improve the outpatient numbers
  - Challenges include: homelessness/housing insecurity; lack of adherence to needed medication and other clinical services; active substance use

Strategies for CT

- Strategy 10: Provide high-quality and equitable evaluations and restoration services, and ensure continuity of clinical care before, during, and after restoration and upon release.
  - Critical to have clinical care plans that go beyond restoration and toward recovery [p 21]
    - Especially warm hand-offs [p 22]
  - Whiting works hard to ensure such plans are in place, especially for defendants likely to be released by the court upon restoration
    - Illustrates how the CST processes are a costly interjection/interruption of clinical processes

Possible Pilot Project

- Refer defendants with only misdemeanor charges to diversion
- Create/enhance forensic respite bed capacity in community to receive defendants as needed. This would include:
  - Clinical stabilization
  - Case management
  - Restoration or initiation of entitlements
  - Engagement with forensic peer support specialists
  - Housing outflow tracks (e.g., forensic rental assistance programs)
  - Employment services in follow-up care
- Enhance data systems to enable relevant analyses and assessment of intervention outcomes