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Assessment #3

Forensic Mental Health Services in the United States: 2014

September 15, 2014

(Updated October 3, 2014)

This work was developed under Task 2.1.1. of NASMHPD's Technical Assistance Coalition contract/task order, HHSS28342001T and funded by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the National Association of State Mental Health Program Directors.

White Paper: Forensic Mental Health Services in the United States (2014)

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September 12, 2014

Introduction

This white paper addresses the organization and operation of forensic mental health services within public mental health systems (PMHS) across the United States. It includes a brief history of forensic services and summarizes the results of a survey of officials responsible for forensic services in all 50 states and the District of Columbia. The survey was conducted under the auspices of the National Association of State Mental Health Program Directors (NASMHPD). The chairs of NASMHPD's forensic and legal divisions provided input on the survey design. NASMHPD Director Bob Glover wrote each state's commissioner, legal division representative, and forensic division representative announcing the survey and encouraging timely responses.

The survey was distributed by email August 7, 2014. By September 7, 43 jurisdictions had responded, 40 states (and DC) with largely complete responses and two states with partial responses. A 44th state promised to respond after their computers were reconnected following a move of their administrative offices. Some respondents included detailed comments on the workings of their systems; others provided supplemental materials describing laws and programs in their states. These comments and materials are appended to the electronic version of this report. The scope of the current study, however, did not permit a thorough review of this additional information.

Background and History

"Forensic" mental health services are services provided by mental health professionals or agencies for use in court or otherwise in connection with a legal matter. They include both evaluations and treatment. Within PMHS's, forensic services traditionally have been provided (i) upon order of a court, (ii) in a criminal case, (iii) in accordance with standards and procedures established by law. Historically, the issues most often addressed have been (i) competency to stand trial (whether a criminal defendant was able to participate meaningfully in the proceedings against him or her), (ii) legal "insanity" (whether a defendant was criminally responsible for his or her behavior or should be found not guilty by reason of insanity), and (iii) sentencing (whether a convicted offender was suitable for treatment in lieu of incarceration).

Unlike services for “civil” patients, forensic services may be commanded by a court. Mental health providers are accustomed to deciding whom to serve. If the staff of an inpatient facility believe a patient is clinically ready for release to the community, ordinarily the decision is theirs. Not necessarily so, however, if the patient is forensic. The courts exercise significant control over the PMHS’s delivery of forensic mental health services.

Before the 1970’s, public sector forensic services were provided almost exclusively on an inpatient basis, typically in secure facilities located in remote settings. Persons committed as incompetent to stand trial or not guilty by reason of insanity often were patients for life. The deinstitutionalization movement of the late 1960’s and early 1970’s was slow to come to forensic services. It did, however, attract the attention of scholars and professional organizations. The American Academy of Psychiatry and the Law (AAPL) was founded in 1969 to promote professionalism in the delivery of services for court-involved persons. Medical schools responded with the establishment of fellowship training programs in law and psychiatry. Some universities developed interdisciplinary programs, drawing together scholars, researchers, and students in psychiatry, psychology, social work, and law. Additional professional organizations emerged, including Division 41 of the American Psychological Association, the National Association of Forensic Social Work, and the International Academy of Law and Mental Health.

In 1984, the American Bar Association published a 532-page volume of standards for the administration of criminal justice in cases involving individuals with mental disabilities (the ABA Criminal Justice/Mental Health Standards). Drawing on the rapidly developing law and reflecting best practices in mental health services delivery, the standards provided a blueprint for legislative reform.

Finally, and importantly, NASMHPD’s forensic division was established in 1982. Meetings of the new division proved immensely popular, attracting not only PMHS officials but also leading scholars, researchers, and practitioners. The division remains active through an electronic Listserv and regular teleconferences.

Forensic services today look far different from 40 years ago. Most states today conduct evaluations in community settings, using specially trained providers who follow standardized procedures reflecting best practices. Persons found incompetent to stand trial today may receive competency “restoration” services in jail or in the community. The large majority continue to be hospitalized, at least initially, but in most states services are targeted to competency restoration and hospital stays are time-limited. Persons found not guilty by reason of insanity may be hospitalized, but court-enforced “conditional release” offers an alternative that many states have embraced.

Some forensic patients, of course, spend lengthy periods in hospital. In many states, however, “forensic review boards” have been established to discipline the review of cases and help clinical staff focus their attention on the particular clinical needs and recidivism risks that impede a patient’s movement through care. Risk assessment

technologies have emerged to more “scientifically” identify patients at risk for violence. Of terrific value in treatment planning (to help staff manage risks), some instruments have been criticized for their disproportionate attention to “static” risk factors, unrelated to a subject’s mental disorder (and thus resistant to change with treatment). Whether a forensic patient, admitted for a crime precipitated by a psychotic episode but now stable (symptoms in remission), should remain in hospital because of unrelated violence risks is controversial.

A significant development in the evolution of forensic services has been the appearance, beginning in the 1990’s, of laws for the special civil commitment of sex offenders. Unlike laws that had existed in the 1940’s-1960’s providing for treatment in lieu of imprisonment for certain sex offenders, these new laws provide for treatment only upon a sentenced offender’s release from penal confinement. Under these laws, now on the books in 20 states and the District of Columbia, any offender with a “mental abnormality” or personality disorder making him or her sexually dangerous may be committed, whether or not in need of treatment. NASMHPD was one of the first professional organizations to question this use of mental health resources. In 1997, it released a position statement cautioning that laws for the special civil commitment of sex offenders threatened to “disrupt the state’s ability to provide services for people with treatable psychiatric illnesses,...undermine the mission and integrity of the public mental health system,...divert scarce resources away from people who both need and desire treatment,...and endanger the safety of others in those facilities who have treatable psychiatric illnesses.” The ABA soon followed (in 1999) with a position statement resoundingly critical of these laws: “[S]exual Predator Commitment Laws represent a serious assault on the integrity of psychiatry...[B]y bending civil commitment to serve essentially non-medical purposes, sexual predator commitment statutes threaten to undermine the legitimacy of the medical model of commitment...[T]his represents an unacceptable misuse of psychiatry” (American Psychiatric Association, 1999, p. 173-174). Other professional organizations have since weighed in, virtually all in opposition. NASMHPD’s bold statement in 1997, however, followed by continued attention within the organization’s forensic division, has been particularly influential in dissuading states from enacting legislation. Indeed, no state in more than a decade has enacted one of these laws—only the federal government has, as part of its Adam Walsh Act. These laws remain in effect in many states, however, and account for a substantial share of forensic services in these states.

Sex offender commitment aside, systems for serving forensic populations have improved immeasurably since the 1970’s. Other forces at work during these decades, however, have presented new challenges. In 1980, there were approximately a half million people incarcerated in state and federal jails and prisons in the United States. By 1990, the number had more than doubled. By 2009, it had doubled again. Only in recent years has the rate of growth slowed—and, very recently, begun to reverse. Much of the growth in incarceration rates can be attributed to the “war on drugs,” which brought about very lengthy (sometimes life)

sentences for drug offenders. A large percentage of these offenders carried substance use diagnoses; many were dually diagnosed with a mental illness.

In 1955, there were nearly 600,000 patients in state psychiatric hospitals. Today there are fewer than 43,000. The forces behind deinstitutionalization are well known: (i) the advent of effective medications (enabling for many patients a first opportunity for treatment outside an institution); (ii) the Community Mental Health Act of 1963 (calling for services and programs in the community); (iii) civil rights reforms (including both lawsuits over poor institutional care and legislation to tighten civil commitment standards); (iv) changes in the funding of services, incentivizing states to use community resources (Medicaid's IMD rule); and (v) most recently, managed care. As the locus of service has shifted from hospitals to the community, the development of community-based services has not always kept pace. Critics charge that deinstitutionalization has had the effect of "transinstitutionalizing" care from the mental health system to the criminal justice system.

Although the best research suggests little correlation between serious mental illness and violent behavior, all would agree that the prevalence of mental disorder among incarcerated populations is high. Perhaps the most comprehensive national study to date of prevalence rates in jails, published in the June 2009 issue of *Psychiatric Services*, found 16.9% of inmates with a serious mental illness, including 14.5% of male inmates and 31% of female. Other studies have found varying rates, some higher, some lower, but virtually all above NIMH's estimated rate of 6% for the general population. Whether the prevalence rate in jails today is significantly higher than in previous decades is unknown (reliable data becoming available only in recent years). The sheer numbers, however—with the enormous growth in incarcerated populations generally—are undeniable. And they have not gone unnoticed.

In 1998, Russell Weston, a man with a long history of undertreated schizophrenia, traveled to Washington, DC, from his home in Illinois. He attempted to enter the Capitol Building with a gun, and when the police tried to stop him, he fired his weapon, killing two officers and wounding two bystanders. Later he told psychiatrists he needed to stop the country from being devastated by disease and the threat of cannibalism. He said he was searching for "the ruby satellite," which he believed was key to stopping the cannibalism. He believed the satellite was locked in a safe in the Senate. The news accounts of this incident largely focused on the "failure" of the mental health system to provide Mr. Weston the care he needed—this in sharp contrast to most previous coverage of such incidents, which tended to focus (critically) on the insanity defense (reference the case of John Hinckley). Now it was the mental health system in the crosshairs. At about the same time that Mr. Weston's case was headline news, the Department of Justice released a study suggesting that 16% of jail inmates had a serious mental disorder. Although the study was badly flawed (determinations of mental disorder based on inmates' self report), the synergistic effect of its release at the time of the Weston coverage was

immense. Advocates nationally called for reform. The term “transinstitutionalization” entered common parlance.

In 2000, the Council of State Governments (CSG), in partnership with NASMHPD, launched the National Mental Health/Criminal Justice Consensus Project. Two years and much study later, a comprehensive National Consensus Project Report was released. Carefully crafted to address not only mental health officials but also law enforcement agencies, correctional authorities, judges, and lawmakers, the report provided a blueprint for behavioral health services reform. The CSG has continued its work on these issues, establishing the CSG Justice Center, which collects and disseminates information about effective programs and services.

Other organizations have been active as well, notably the GAINS Center. With support from SAMHSA, GAINS has promoted (and, through its active technical assistance arm, helped establish) the development of jail-based diversion programs across the country. The Mentally Ill Offender Treatment and Crime Reduction Act, enacted in 2004 and re-authorized periodically since (although not always fully funded), has supported a variety of efforts to bring services to people involved with or at risk of involvement with the criminal justice system.

In 2006, Munetz and Griffin introduced the “sequential intercept” model of programming services to identify and divert (intercept) people with mental disorders at every (sequential) stage of the criminal justice continuum. SAMHSA, through the GAINS Center, has promoted implementation of the model in states throughout the country. It is not uncommon now for a state to have police departments with specially trained crisis intervention teams, diversion programs within local crisis response centers (as well as in jails), courts with special mental health dockets, and re-entry programs to help link offenders to services upon release from incarceration.

All of these services and programs may be considered part of a state’s forensic services system. The mainstream of forensic services continues to be evaluations and treatment, ordered by a court, relating to psycho-legal questions defined in law. But the action in most states these days is far broader.

The Survey

The survey consisted of 322 questions, focused primarily on traditional forensic services but ranging widely from such mainstream issues as competency to stand trial to such esoteric issues as automatism/lack of *actus reus*. The survey aimed to identify the scope and operation of forensic services, supported by data where available. The sophistication of states’ data systems varies significantly. States unable to produce precise data were encouraged to provide “useful estimates.” Services that fall within the purview of forensic services administrations vary as well. Only a few states were able to provide a complete response to every question. But every question produced useful responses. What emerges is a fairly clear

picture of forensic services activity across the country. Funding issues are addressed, as are critical issues of resources control (the degree to which the courts have *and exercise* control over service delivery). Finally, the survey produces a glimpse at efforts states are making to address the broader concerns of over-representation of mentally disordered persons in the criminal justice system.

The following jurisdictions responded to the survey:

Alabama
Alaska
Arizona
Arkansas
Colorado
Connecticut
Delaware
District of Columbia
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa (partial response)
Kansas
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
Nebraska
Nevada
New Jersey
New York
North Carolina
Ohio
Oklahoma
Oregon
Pennsylvania
South Carolina
South Dakota
Tennessee
Texas

Utah
Virginia
West Virginia (partial response)
Wisconsin
Wyoming

Here's what they had to say.

Competency to Stand Trial in Adult Criminal Court: Evaluations

- Competency to stand trial (CST) is an issue in every state. The U.S. Supreme Court has ruled that it would violate the Constitution to try a criminal defendant who was incompetent to stand trial (IST). To be competent, a defendant must have an adequate (i) understanding of the proceedings against him or her and (ii) ability to consult with counsel and assist in defense against the charges. The trial court determines whether a defendant is competent to stand trial. In virtually every case, however, the court first hears from a mental health professional who has evaluated the defendant's competency.
- In 38 of 43 jurisdictions responding to the survey, the PMHS provides evaluations of CST. In the other 5 jurisdictions, evaluations are provided privately, funded by the courts or by the parties.
- The number of evaluations a state provides annually varies from fewer than 50/yr to "approximately 5,000." There is reason to believe that in some states with large numbers of evaluations, referrals serve not only to help determine triability but also as an avenue to treatment for mentally ill persons in jail. In meetings unrelated to the survey, a mental health court judge from Florida recently told me that competency is rarely his primary concern when he orders an evaluation. If there were another means of obtaining quick treatment, he said, he would use it instead. Responses to the Q, number of PMHS evaluations annually:
 - 1-50: 2 states
 - 51-200: 4 states
 - 201-600: 11 states
 - 601-1,000: 2 states
 - 1,001- 1,500: 6 states
 - 1,501- 2,000: 4 states
 - 2,001+: 5 states

- Forty years ago, virtually all CST evaluations were conducted in inpatient facilities. Even today, respondents in 79% of states report that the court may order defendants admitted for evaluation. Some states report an increasing demand for inpatient evaluation. Oregon reports an 89% increase in inpatient CST evaluation referrals from 2010- 2013. Nonetheless, outpatient evaluations regularly are done in all but 3 states. Of 32 states providing useful responses, 19 reported conducting the majority of evaluations outpatient, mostly by community evaluators, some by facility evaluators on an outpatient basis. Responses to the Q, how many evaluations are conducted annually on an *inpatient* basis:
 - 0-10%: 12 States
 - 11-25%: 7 States
 - 26-50%: 7 States
 - 51-75%: 3 States
 - 76+%: 4 States
 - Range: <2% (9 states)- >95% (3 States)

- Most authorities would agree that the vast majority of CST evaluations can be completed with one or two interviews of the defendant. Yet many defendants admitted for evaluation remain hospitalized for extended periods. In some states, the evaluator may give a defendant time to benefit from (voluntary) treatment during the evaluation period, hoping the defendant will become competent by the time a report must be provided (in order to avoid a finding of incompetency and the potential for an even longer stay for treatment under an order to restore competency). In other states, the court may be less interested in the facility's opinion about the defendant's competency than it is in the defendant remaining for treatment and may discourage submission of a report until the hospital can assure the court that the defendant is doing well. In at least one state (MD), some judges insist that CST reports be accompanied by aftercare plans for services in the community, delaying submission of reports (and the release of defendants).

In 43% of states, respondents report that the facility may release the defendant when it completes the evaluation. 57% report that they may not. In many states, defendants who are competent because of the effect of treatment in the hospital may be retained until trial if the staff believe the defendant will decompensate if returned to jail to await trial. Responses to the Q, what is the average length of stay for a CST eval:

- 0- 1 month: 12 States
- 1- 3 months: 11 States
- 3- 6 Months: 6 States
- > 6 Months: 1 State

- Evaluations done in inpatient facilities almost always are at the PMHS's expense. In a few states, however, the court or the county will pay for outpatient evaluations (in jail or in the community). Responses to the Q, who funds CST evals:
 - *Inpatient Evals*
 - PMHS: 84%
 - Court: 5%
 - Other: 11% (e.g., counties, PD)
 - *Outpatients Evals*
 - PMHS: 65%
 - Court: 19%
 - Other: 16% (e.g., counties, PD)
- Compensation provided to community-based evaluators varies from \$300-\$3,000. The responses:
 - \$0- 200: No States
 - \$201- 500: 9 States (many pay \$500)
 - \$501- 750: 5 States
 - \$751- 1,000: 3 States
 - \$1,001- 1,500: 2 States
 - \$1,501- 2,000: 1 State
 - > \$2,000: 1 State

CST in Adult Criminal Court: Restoration Services

- Once an evaluator submits a report concerning a defendant's CST, the court must adjudicate the question. If the court finds the defendant incompetent to stand trial (IST), it may order the PMHS to provide treatment to restore the defendant's competency—except in one state. In Massachusetts, the law makes no provision for court ordered restoration services. That said, MA reports that defendants found IST may be civilly committed, and if they are, facility staff sometimes provide “legal education” to help prepare defendants to participate in their cases when they return to court.

In New York, commitment to restore competency is limited to cases in which the defendant is charged with a felony. Commitment for defendants with lesser charges must follow ordinary civil commitment procedures. In Virginia, commitment for competency restoration must terminate after 45

days unless the charges are serious (felonies or certain serious misdemeanors).

The number of defendants referred for CST restoration varies tremendously, partly reflecting population differences in different states but also reflecting a secondary agenda in some states. As noted earlier, judges in Florida sometimes use CST referrals as a means of accessing treatment for mentally ill defendants in jail. Note below that Florida reported the largest number of IST referrals in the country, 1,540 per year. Here are responses to the Q, how many defendants are referred annually to the PMHS in your state for CST restoration services:

- 0- 50: 5 states
 - 50- 100: 5 states
 - 100- 200: 9 states
 - 200- 300: 7 states
 - 300- 500: 5 states
 - >500: 4 states (1,540 in FL)
- Historically, all defendants referred for CST restoration services were committed to inpatient facilities. Even today, the vast majority are admitted inpatient. But in recent years, several states have developed CST restoration services in the jail or in the community. In one state, Arkansas, the majority of IST defendants receive restoration services in an outpatient setting.

Note that in some states, IST defendants facing minor charges may never stand trial. Once treatment has concluded, the court simply dismisses the charges, often with time served (the defendant having been in treatment for as long as the maximum possible sentence for the crimes charged). Recognizing that IST commitments frequently are used this way (to access treatment rather than prepare defendants for trial), a workgroup meeting to revise and update the ABA Criminal Justice/ Mental Health Standards recently debated language that would allow attorneys for defendants evaluated as IST to negotiate case dispositions, with suspension of the charges and (typically outpatient) treatment in lieu of incarceration, so long as the defendant “assented” to the deal. For states with large numbers of IST referrals, such a diversionary option might prove attractive. Here are responses to the Q, what % of IST referrals are admitted for inpatient CST restoration:

- 0- 50%: 1 state (AR)
 - 51- 75%: 8 states (several report 75%)
 - 76- 90%: 5 states
 - > 90%: 20 states (many report 100%)
- Defendants committed for inpatient CST restoration services historically were placed in dedicated forensic facilities or dedicated forensic wings or

units of larger PMHS facilities. Today, many defendants are served with other, civil patients on ordinary units. A few states even report using private facilities in some cases. Three states report using facilities operated by the jail or prison system, in some cases. Most states use a mix of placements depending on the seriousness of the charges facing the defendant or other security concerns. Here are responses to the Q, where are in-P CST restoration services provided:

- Dedicated Forensic Facility: 25 states
 - Dedicated Forensic Unit in General PMHS Facility: 22 states
 - Ordinary Unit in General PMHS Facility: 17 states
 - Private MH Facility: 4 states
 - MH Facility Operated by Jail/Prison System: 3 states
- Many states report that the largest group of patients they serve in state psychiatric facilities are criminal defendants committed as IST. Here are responses to the Q, what is your average daily census of IST inpatients:
 - 0- 25: 8 states
 - 26- 75: 7 states
 - 76- 150: 9 states
 - 151- 250: 3 states
 - 251- 400: 3 states
 - > 400: 2 states (each with > 1,000)
 - Ordinarily, a person may not be committed to a psychiatric hospital unless found (by clear and convincing evidence) to be dangerous to self or others due to a mental disorder and in need of treatment. In 34 of 39 states responding (87%), however, criminal courts may commit defendants found IST without any additional finding (i.e., no need that the defendant meet other commitment criteria). A few states require that defendants meet criteria approximating ordinary civil commitment criteria. Note that in at least one such state, however, the vast majority of IST defendants (97%) are committed nonetheless (MD). Staff there report that many of these defendants would not be committed in ordinary civil commitment proceedings, suggesting the additional criteria are not always strictly applied.
 - If an involuntary patient in a psychiatric hospital refuses medications, most states' laws provide procedures for medication over objection if certain findings are made (e.g., if the patient is "dangerous" or is unable to make an informed treatment choice). The US Supreme Court, in the case *US v Sell*, has ruled that defendants committed for CST restoration may be medicated over objection for purposes of CST restoration, under limited circumstances, even if otherwise entitled to refuse (e.g., even if not dangerous and not unable to make an informed choice). The survey asked whether states ever use *US v Sell* procedures when an IST patient objects to a medication. Twenty-four

states (63%) reported that they did; 14 states (37%) reported that they did not. A follow-up question asked what the outcome would be if a defendant who required medications to become CST successfully refused. Eighteen states (50%) reported, in effect, that there was no right to refuse—that the court would order treatment in any event. A few simply stated that it had never happened. Fourteen states (39%) reported that the defendant’s right to refuse would be honored, but treatment would continue, without the prescribed medication. Only 4 states (11%) reported that the defendant would be found unrestorable to CST (required by the US Supreme Court’s ruling in *Jackson v Indiana* whenever a defendant is unlikely to be restored in the foreseeable future).

- All states reported that their courts sometimes found defendants unrestorable to CST. In the *Jackson* case, the Supreme Court ruled that defendants found unrestorable must be civilly committed or released—that continued commitment for purposes of CST restoration would violate the Constitution. Several studies over the years have suggested that courts routinely ignore *Jackson* requirements and keep IST defendants hospitalized long after it is apparent that their prospects for restoration are dim—although many (69%, the survey found) do set a cap on length of stay (ranging from as little as 90 days in a few states to the maximum sentence specified by law for the most serious offense charged, in others). Georgia’s representative to NASMHPD’s forensic division, Karen Bailey, will study this question further in the coming months.

This survey addressed a separate but related question: what is the usual outcome when a court makes a finding of unrestorability. Here are the responses:

- Release or ordinary civil commitment, with no further criminal court involvement: 18 states (49%)
- As above, but with continuing criminal court involvement (including a requirement that the court approve release): 9 states (24%)
- As above or, in some cases, special commitment by different standards and procedures, with continuing criminal court oversight (may be preceded by a “finding of factual guilt”): 6 states (16%)
- Continued treatment to restore (despite the finding of unrestorability): 1 state (3%)

Note that option 3, above, although seemingly in violation of *Jackson v Indiana*, has been approved by appellate courts in 2 states (Ohio and New Mexico) and is the disposition recommended by the ABA Criminal Justice/Mental Health Standards for use in cases where the defendant is charged with a felony “causing or seriously threatening serious bodily harm” (Standard 7-4.13).

- The length of stay for defendants committed as IST has always been long. A MA study from the early 1970's found that more defendants committed to that state's maximum security hospital for CST restoration remained for life (i.e., left by reason of death) than returned to court for trial. In more recent years, lengths of stay have fallen, but they remain high in many states. Asked to provide the average length of stay for defendants committed as IST, the states responded as follows:
 - 0- 60 Days: 5 states
 - 60- 120 days: 13 states
 - 120- 180 days: 7 states
 - 180- 360 days: 3 states
 - > 360 days: 2 states
- Although the courts have the authority to order defendants committed for inpatient CST restoration (in every state except MA), 10 states (26%) report that they may discharge a patient committed as IST, without court authorization, when they believe the defendant has become CST or no longer requires an inpatient level of care. Twenty-nine states (74%) do not have this authority, but 5 of these states report that the courts "almost never" deny their requests to release, and 17 report that their requests are denied only "sometimes." Five states report that that the courts "frequently" deny their requests to release.
- Historically, the cost of CST restoration has fallen on the PMHS. That remains largely true today, although 1 state reports that the courts will pay for *outpatient* restoration services, and 7 say such (outpatient) services are funded by "other" sources, including the counties. Only 1 of 30 states reporting collects Medicaid for outpatient CST restoration services. In comments, however, another state said Medicaid was collected "when services are related to primary MH issues."

CST in Juvenile Court: Evaluations

- Juvenile courts were established at the turn of the 20th century to provide an alternative to criminal prosecution for youth in trouble with the law. The courts' purpose was beneficent—to serve the "best interests" of the child. Procedures were relaxed. There was no need for the rigorous due process accorded defendants in adult, criminal court, because punishment was not an option. CST thus had no place in the early juvenile court. By the 1960's, however, it had become apparent that the "services" juvenile courts were ordering—including extended confinement in locked facilities—were not always beneficent. In a series of cases, the US Supreme Court found that youth facing delinquency proceedings in juvenile court (i.e., those charged with offenses that would be criminal in adult court) *were* entitled to due

process, essentially equivalent to that provided adult criminal defendants (all but the right to trial by jury). Following the Supreme Court's lead, many states in recent years have recognized the right of these youth not to be adjudicated (for a delinquency offense) if incompetent to stand trial.

Of 41 states responding, 37 (90%) said CST was an issue in their state's juvenile court. In 21 of these states (57% of the 37), the PMHS provides evaluations. In the other 16 states (43%), evaluations are provided either privately or by the state's juvenile justice authority.

- States providing juvenile court CST evaluations within their PMHS's report referrals in the following numbers:
 - 0- 30: 5 States
 - 31- 60: 4 States
 - 61- 100: 3 States
 - > 100: 6 States (1 with 450)

- Although 67% of states report that the juvenile court has the authority to order CST evaluations on an inpatient basis, inpatient evaluations are rare in most states. Of 18 states reporting, 14 conduct more than 90% of these evaluations outpatient. An additional 2 states conduct at least 75% outpatient. Only 2 states reported doing more than 25% of evaluations on an inpatient basis.

- For youth admitted for evaluation, the average length of stay was as follows:
 - 0-30 days: 4 states
 - 31-60 days: 1 state
 - 61-90 days: 3 states
 - > 90 days: 0 states

- Inpatient evaluations are nearly always funded by the PMHS (13 of 14 states responding to this question). Outpatient evaluations, on the other hand, are funded by the courts in several states (7 states, or 39% of the 18 states responding to this question). In Tennessee, the courts routinely ordered evaluations on an inpatient basis until an appellate court ruled that the cost of evaluations was the counties' responsibility. When the courts began to receive bills for these services, Tennessee reports, the inpatient referral rate "plummeted."

- Outpatient juvenile court CST evaluations are compensated at the following rates:
 - \$0- 250: 0 States
 - \$251- 500: 5 States
 - \$501- 750: 3 States
 - > \$750: 4 States

CST in Juvenile Court: Restoration Services

- Although CST is an issue in juvenile court in all but a few states, PMHS's have responsibility for CST restoration services in only 17 states (55% of 31 states responding, all states in which CST is an issue in juvenile court). Referral numbers (annually) are as follows:
 - < 6 referrals: 7 states
 - 20- 50 referrals: 3 states
 - > 100 referrals: 2 states
- Of 13 states providing useful responses, 9 report that all or nearly all juvenile court CST restoration services are provided on an outpatient basis. Interestingly, the remaining 4 states report that all or nearly all such services are provided on an inpatient basis.
- Asked whether they collect Medicaid or CHIP for juvenile court CST restoration services, 2 states (of 9 responding) reported collecting for inpatient services, while 1 state (of 12 responding) reported collecting for outpatient services. It is widely known that juveniles who are IST are less likely than adults to be IST for reasons of serious mental illness. Thus, juvenile court CST restoration services are less likely to take the form of ordinary mental health treatment (and therefore are less likely to be considered "medically necessary").
- Because the numbers of inpatient cases for juvenile court CST restoration are so small, no analysis of inpatient management issues (e.g., procedures for medication over objection) is presented here. The states' responses, however, appear in Appendix A.
- For many children found IST, immaturity or developmental delay may hamper efforts at restoration to CST. Although the US Supreme Court has never ruled that *Jackson v Indiana* applies in juvenile court cases (requiring the release or civil commitment of youth found unrestorable), 14 of 16 states report that the courts do on occasion make findings of unrestorability. When such a finding is made, states report the following outcomes:
 - Release or ordinary civil commitment, with no further juvenile court involvement: 4 states (31%)
 - As above, but with continuing court oversight (including requirement that court approve release): 2 states (15%)
 - As above, but with option for special commitment by different standards and procedures: 0 states
 - Initiation of other non-delinquency juvenile court proceedings (e.g., CHINS, where the CST requirement is not applicable): 4 states (31%)

The Insanity Defense in Adult Criminal Court: Evaluations

- The US Supreme Court has never ruled that a state must provide an insanity defense. Nonetheless, the defense exists in the laws of all but 4 states: Montana, Idaho, Utah, and Kansas. The courts in these states have approved the defense's abolition on the condition that the law provide some other grounds for defendants to introduce evidence of a mental disorder on the question of their guilt (e.g., "diminished capacity," or lack of mens rea).

When asked if the insanity defense is recognized in their state, 41 of 42 respondents said "yes," including respondents from 3 of the states in which the defense formally has been abolished. Although the matter bears further study, this reviewer surmises that the practices followed in these states for developing and presenting mental health evidence (on diminished capacity or similar issues) are so similar to the practices historically followed in insanity defense cases as to be practically indistinguishable. Another possibility, frankly more consistent with the survey results, is that the insanity defense actually is used in these states despite laws saying it need not be.

- In 31 of the 41 states recognizing an insanity defense, the PMHS provides evaluations. In 10 states, these evaluations are done in the private sector.
- In states where the PMHS provides evaluations, the evaluation referral rate ranges widely:
 - 0-25 (referrals annually): 4 States
 - 26-100: 5 States
 - 101- 600: 3 States
 - 601- 1,000: 4 States
 - 1,001- 1,500: 3 States
 - > 1,500: 4 States
- The locus of these evaluations varies substantially as well. Although most states provide the bulk of their evaluations on an outpatient basis, several states continue to do the large majority inpatient. The following represents percentages of evaluations conducted on an *inpatient* basis:
 - 0- 10%: 9 States
 - 11- 25%: 3 States
 - 26- 50%: 4 States
 - 51- 75%: 2 States
 - > 75%: 6 States

- In most states, only the defendant may raise the insanity defense and request an evaluation. Thus, these evaluations are less likely to be used by courts and others to serve secondary agenda (e.g., diversion from jail to hospital), and average lengths of stay typically are shorter than they are for CST evaluations (with a few notable exceptions):
 - 0-30 Days: 12 States
 - 31- 60 days: 4 States
 - 60- 90 Days: 1 State
 - 90- 120 Days: 0 State
 - > 120 days: 4 States

- As with CST evaluations, the PMHS generally has responsibility for funding insanity defense evaluations. The courts, however, do fund inpatient evaluations in 2 states (7% of responding states) and outpatient evaluations in 8 states (28%). The cost of an outpatient evaluation ranges from \$240-\$2,500:
 - \$0-250: 1 State
 - \$250- 500: 6 States
 - \$500- 1,000: 7 States
 - \$1,000- 1,500: 1 State
 - > \$1,500: 1 State (\$2,500)

Services for Persons Found Not Guilty by Reason of Insanity (NGRI) in Adult Criminal Court

- Although found “not guilty” (in most states), insanity “acquittees” may be subject to involuntary commitment by procedures substantially different from those applicable to ordinary civil commitment. The US Supreme Court has sanctioned this differential treatment in two cases, *US v Jones* and *Foucha v Louisiana*. Ordinarily the court in which the person was found NGRI decides the commitment question (and retains jurisdiction post-commitment)—although in two states, Oregon and Connecticut, this authority rests with an interagency review board.

The courts have said a defendant must have a mental illness to be eligible for commitment (*Foucha*), and most require a finding of dangerousness as well, as in ordinary civil commitment law. Nonetheless, because of procedural differences, outcomes for persons committed as NGRI bear little resemblance to outcomes in civil cases. While the average length of stay for persons civilly committed in most states ranges from a week to 10 days, average lengths of stay for NGRI’s tend to range from months to years.

- In response to the Q, does your state have a special commitment procedure for NGRI acquittees, all but 2 of 39 states responding (95%) said “yes.” In all

37 states (saying yes), the PMHS provides inpatient services for this population. Inpatient services are provided in an array of PMHS facilities:

- Dedicated PMHS forensic facility: 24 states (65%)
- Dedicated forensic unit in gen'l PMHS facility: 18 states (49%)
- Ordinary unit in gen'l PMHS facility: 18 states (49%)
- Private facility: 0 states
- Facility operated by jail/prison system: 0 states

Note that only PMHS facilities are used.

- Sometimes an individual is serving a criminal sentence at the time he or she is found NGRI for some other offense. Other times, an individual is hospitalized following an NGRI acquittal when he or she is convicted and sentenced for another offense (e.g., the NGRI acquittee convicted of assaulting a patient in the hospital). The question arises, how do the states handle such competing commitments? Some PMHS officials complain that courts are reluctant to imprison any forensic patient, assuming their behaviors were to be expected (“behaviors the prediction of which provided the basis for their commitment”). Others complain that sentenced offenders found NGRI too quickly are admitted, without regard for the availability of adequate treatment services in corrections. Asked what happens in practice, here’s how the states responded:
 - **Person serving sentence for 1 crime when found NGRI of another**
 - Committed to NGRI facility in all cases: 9 states (26%)
 - Remains in jail/prison to complete sentence: 10 states (29%)
 - Depends– remains in jail/prison if necessary services avail there, otherwise goes to NGRI facility: 10 states (29%)
 - **Person in NGRI facility when sentenced for another crime**
 - Remains in NGRI facility in all cases: 1 state (3%)
 - Remains in NGRI facility unless conditionally released to jail/prison: 5 states (15%)
 - Goes to jail/prison to serve sentence in all cases: 15 states (44%)
 - Depends– goes to jail/prison if necessary services avail there, otherwise remains in NGRI facility: 11 states (32%)
- The insanity defense is used much less frequently than most people imagine. Acquittes, however, tend to spend extended periods in hospital, resulting in large acquittee censuses in some states. Here are the states’ responses to the Q, how many NGRI inpatient commitments annually:
 - 0-10: 14 states
 - 11-30: 9 states
 - 31-60: 6 states
 - 61- 90: 3 states
 - > 90: 1 state

Here are responses to the Q, what's the average length of stay for NGRI inpatients:

- 0- 1 yr: 2 states
- 1- 3 yrs: 9 states (several report 3 yrs)
- 3- 5 yrs: 3 states
- 5- 7 yrs: 5 states
- 7- 10 yrs: 6 states (several report 10 yrs)
- > 10 yrs: 2 states

Here are responses to the Q, what's the average daily NGRI inpatient census:

- 1- 20: 8 states
- 21- 50: 7 states
- 51- 100: 2 states
- 101- 200: 5 states
- 201- 400: 8 states
- > 400: 2 states

- In most states, patients committed as NGRI remain hospitalized until released by the court. Four states responding to the survey (11% of respondents), however, report that their PMHS may release without court authorization. For most states, though, a variety of obstacles impede release. Asked to rank 5 obstacles commonly encountered, the states responded as follows (the greater the number, the greater an obstacle):
 - Opposition from court or prosecutor: 3.62 (of 5)
 - Unavailability of housing: 3.34 (of 5)
 - Risk assessment scores: 2.88 (of 5)
 - Unavailability of treatment resources: 2.65 (of 5)
 - Opposition from the community: 2.44 (of 5)
- Historically, NGRI acquittees (in most states) were hospitalized for many years—substantially longer than today. If they were released, they were released unconditionally. Beginning in the late 1970's and early 1980's, 3 states (OR, CT, and MD) introduced programs for conditional release (CR). Acquittees who were conditionally released remained under the jurisdiction of authorities (the court in MD, the interagency review board in OR and CT). These authorities established the conditions of release (typically including housing, treatment, and supervision) and exercised authority to terminate CR (and rehospitalize the acquittee, if appropriate) upon proof of a violation. With the option of CR, these states reasoned, it should be possible to move more patients from a hospital level of care, at little or no increased risk to public safety.

NASMHPD's forensic division, since its inception, has heralded the virtues of CR. Today, 31 states (84% of the 37 states responding) have programs for CR. Although designed primarily for the transition of patients from hospital to community, CR is used in some states, for some acquittees, at the time of

the NGRI verdict. The following shows the % of NGRI acquittees placed on CR at the time of verdict:

- 0- 5%: 18 states (most report 0%)
 - 6- 10%: 6 state
 - 11- 20%: 1 state
 - 21- 30%: 1 state
 - 31- 39%: 0 states
 - > 39%: 2 states
- The number of acquittees on CR ranges widely from state to state:
 - 0- 10 (on CR): 5 states
 - 11- 50: 3 states
 - 51- 150: 5 states
 - 151- 300: 3 states
 - 301- 500: 7 states
 - > 500: 1 state (>700 in MD)
 - Acquittees on CR tend to be supervised very closely. At the first sign of trouble—a violation of conditions or a return of symptoms—rehospitalization proceedings may be initiated. In most states, acquittees on CR may be rehospitalized without revocation of the CR order. Such “voluntary” returns are encouraged, to nip problems in the bud. Voluntary returns also obviate the need for revocation in some cases. If an acquittee returns voluntarily, the PMHS usually may return the acquittee to the community without court authorization. If CR is revoked, however, it may be necessary to secure a new CR order, delaying the acquittee’s placement back in the community.
 - Here are the states’ responses to the Q, what % of acquittees on CR are readmitted annually:
 - 0- 10% re-admitted: 16 states
 - 11- 20%: 6 states
 - 21- 50%: 2 states
 - > 50%: 2 states
 - Here are the states’ responses to the Q, what % of acquittees who are re-admitted from CR are revoked from CR:
 - 0- 10%: 12 states
 - 11- 25%: 4 states
 - 26- 40%: 1 state
 - 41- 60%: 2 states
 - > 60%: 3 states (one state explaining—unfortunately—that its forensic hospital refuses to accept voluntary patients, necessitating revocation before re-admission in every case)

- The responses appearing in Appendix A provide additional details about the workings of CR. A few highlights:
 - Only 9 of 31 states place a specific limit on how long an acquittee may remain on CR.
 - In 24 of 32 states, responsibility for developing the CR plan rests with staff of the facility in which the acquittee is a patient; the entity that monitors CR has responsibility in 3 states; in 2 states the local mental health authority has responsibility.
 - In 26 of 32 states, acquittees on CR receive services from ordinary community health providers; in 15 states, specialty providers sometimes are used; hospital staff provide services (on an outpatient basis) in 2 states.
 - 20 of 28 states responding collect Medicaid for the services they provide (parenthetically, the consequence of a NASMHPD delegation 19 years ago that successfully challenged a Social Security Administration regulation denying federal entitlements to persons on CR).
 - In 21 of 28 states, the PMHS has responsibility for monitoring acquittees' compliance with CR.
 - Monitoring compliance entails receiving reports from providers and arranging re-admission when necessary (23 of 24 states), receiving reports from providers and notifying legal authorities of non-compliance (20 of 24 states), and meeting periodically with acquittees on CR (18 of 24 states)
 - The ratio of monitors to acquittees on CR ranges widely from 1:1 to 1:75, with several states in the range of 1:15 to 1:20

The Insanity Defense in Juvenile Court: Evaluations

- If CST was slow to come to the juvenile justice system, the insanity defense has been even slower. While it is true that dispositions in juvenile court are not always beneficent, such (non-beneficent) dispositions may be unlikely in cases involving youth so disabled by the symptoms of a mental disorder as to qualify for an insanity defense. Juvenile courts have extraordinary latitude at disposition. If a youth shows symptoms of a major mental disorder and it appears that the youth's misbehavior was a consequence of those symptoms, the defense should not require an insanity defense to make its case for an appropriate disposition.
- That said, laws in a number of states recognize the insanity defense in juvenile delinquency cases (16 of 36 states, or 44%). Of these 16 states, PMHS's have responsibility for evaluations in 9 (or 56%). Referrals are

relatively rare however: fewer than 25 annually in 3 states and between 26 and 50 in 2 others. The other 4 states had insufficient data.

- The large majority of evaluations are conducted on an outpatient basis: 100% in 5 of the 7 states reporting, 30% in the 6th, and 25% in the 7th. The PMHS funds 78% of inpatient and 56% of outpatient evaluations. The courts fund 22% of inpatient evaluations and 33% of outpatient. The costs of an outpatient evaluation range from \$365 to \$1,600.

Services for Youth Found NGRI in Juvenile Court

- Eleven states (of 16 recognizing the insanity defense in juvenile court) report special commitment procedures for youth found NGRI. In 8 of these states, the PMHS reports providing inpatient services in some cases. The annual number of referrals, however, is very small. Of the 4 states with useful data, 1 reported an average of 0 referrals, 1 reported an average of 1, 1 reported an average of 2-3, and 1 reported an average of 3. The average daily census is small in each state as well: 0 in one state; 1 in one state; 9 in one state; and “small” in a fourth state. Only 2 states were able to provide data on the average length of stay: 6 months in one state; 2 years in the other. The PMHS fully funds inpatient services for this population. Two states report collecting Medicaid or CHIP for inpatient services.
- Four states report that their laws provide for conditional release (CR) of youth found NGRI in juvenile court. Two states reported CR census data: 1 in one state; 9 in the other. Two of 4 states reported collecting Medicaid or CHIP for services provided youth on CR.
- Additional data—but not much—is available in Appendix A.

Guilty but Mentally Ill (GBMI)

- After John Hinckley was found NGRI of shooting President Reagan, many states re-visited their insanity defense laws. Wishing to provide juries with an alternative to the insanity defense that recognized the role of a defendant’s mental disorder at the time of an offense but denied defendants the relief of acquittal, several states amended their laws to include the special verdict of GBMI. The verdict does not supplant the insanity defense. Rather, it offers jurors in insanity cases an alternative to acquittal.
- The special verdict has been roundly criticized as offering defendants nothing. Defendants found GBMI may be sentenced the same as if they had

been found straight guilty. Indeed, defendants found GBMI have been sentenced to death and executed. Whether defendants found GBMI receive special consideration for treatment as part of sentencing is one of the questions posed by this survey. Everyone sentenced to jail or prison has a right to treatment for his or her serious medical or mental health needs. Anecdotal reports suggest defendants found GBMI get no special consideration.

- Fifteen states report that their laws recognize the verdict of GBMI. Respondents in 6 states report that the PMHS provides evaluations addressing GBMI that are separate and distinct from evaluations of a defendant's legal insanity (NGRI). (In other states, NGRI evaluations may be used as evidence that a defendant was mentally ill at the time of an offense and should be found GBMI.) The 6 states reported annual evaluation rates of: 55, 25-30, 20, 4, 4, and 5. One state reported doing all of its evaluations on an inpatient basis, 1 does 50% inpatient, 1 does 37% inpatient, 1 does less than 5% inpatient, and 1 does none inpatient. States report outpatient evaluation costs ranging from \$350 to \$800 per evaluation.
- One state reported that GBMI evaluations were done in "only very specific circumstances: when the trial court intends to find a defendant GBMI, intends to place him/her on probation, and intends to make treatment a condition of probation, then the court may order an evaluation for the purpose of obtaining treatment recommendations." One state reported that the GBMI plea was rarely used because "it has been documented that defendants are more likely to be paroled if they just plead guilty."
- States were asked whether the most common outcome in cases involving a GBMI verdict was (i) commitment for inpatient MH services (plus a criminal sentence) or (ii) ordinary criminal sentencing and placement, including a possibility of probation with a condition of MH treatment. 14% reported the former; 71% reported the latter. 14% reported "other," including stabilization in hospital if indicated, followed by placement in prison. One state reported that defendants found GBMI were eligible for parole "after 25% of unsuspended portion of the sentence, and either they or the DPHHS director can also petition the court for review of sentence at any time, generally to suspend the remaining time with probation supervision in the community."
- Six states report receiving inpatient GBMI commitments, none more than 15 commitments per year. Five states provided census data: "approximately 4" GBMI committees in 1 state, 8 in 1 state, 9 in 1 state, 100 in 1 state, and "150 in prison" in 1 state. Four states reported average lengths of stay for GBMI committees: 2 months in 1 state; 6-8 months in 1 state; "1767" (days?) in 1 state; and "2 months to 20 years" in 1 state. Only 3 of 8 states responding

(38%) report that they have the authority to release a GBMI committee when the committee no longer needs inpatient treatment.

Sex Offender Civil Commitment (SVP)

As discussed in the background and history section earlier, 20 states have laws for the special civil commitment of sex offenders completing a criminal sentence (or otherwise about to be released from court-ordered confinement). Many states refer to these offenders as sexually violent predators, or “SVP’s,” the abbreviation used here.

- Fifteen (of 40 states responding) report that their laws provide for SVP commitment. In 7 of these states, the PMHS provides evaluations to assess an offender’s committability. The number of evaluation referrals in these states ranges from 20- 40 annually. Three states report that they do nearly all of their evaluations on an outpatient basis. The other 4 report doing nearly all of their evaluations inpatient. The costs of an outpatient evaluation range from \$2,000- \$4,000.
- Twelve states (of the 15) report that their PMHS provides services for committed SVP’s. Ten use a dedicated PMHS facility; 1 uses a dedicated unit in a PMHS facility; and 2 use dedicated facilities operated by the prison system. Services are funded by the PMHS in 8 states and by the prison system in 2 states. The annual per-resident cost to the PMHS for inpatient SVP services was reported as follows:
 - 0- \$50,000: 1 state (\$40K)
 - \$50,000- \$80,000: 1 state
 - \$80,000- \$110,000: 3 states
 - \$110,000- \$145,000: 0 states
 - > \$145,000: 2 states (\$150K and \$175K)
- States report annual commitments of:
 - 0- 10: in 2 states
 - 11- 30: in 4 states
 - 31- 60: in 4 states
- States report an average daily census of:
 - 0- 50: in 1 state
 - 51- 200: in 3 states
 - 201- 300: in 2 states
 - 301- 400: in 2 states

- 401- 500: in 1 state
- > 500: in 2 states
- States report average annual discharges of:
 - 0- 10: 6 states
 - 11- 20: 3 states
 - 21- 30: 3 states
 - > 30: 0 states
- States report an average length of stay (for SVP's who have been released) of:
 - 0- 3 yrs: 1 state
 - 3- 6 yrs: 4 states
 - 6- 9 yrs: 2 states
 - > 9 yrs: 2 states

Note that in some states, very few SVP's ever have been released.

- Nine states report that their laws provide for conditional release of SVP's. In 2 states, CR is not an option. The 9 states with CR report an average daily census of SVP's on CR of:
 - 0- 5: 4 states
 - 6- 25: 0 states
 - 26- 60: 2 states
 - 61- 90: 2 states
 - > 90: 1 state
- Four states reported an average annual cost to their PMHS for serving an SVP on CR:
 - \$24,000
 - \$80,000
 - \$85,000
 - \$116,000
- Additional information about the management of SVP's may be found among the individual state responses, in Appendix A.

Presentence Evaluations in Capital Cases

- Twenty-six of 40 states responding (65%) indicated that the death penalty was available in their state. In 10 of these states, the PMHS reports it provides presentence evaluations to help guide the judge or jury at sentencing. The evaluation numbers are generally small: 0- 13 annually, except in 1 state that reports doing 60 evaluations each year.

- In every state where the PMHS does these evaluations, the court may order an evaluation conducted on an inpatient basis. Nonetheless, more than half of the states responding (5 of 9) say they do no or almost no evaluations inpatient. The other 4 report doing all or nearly all of their evaluations inpatient. The cost of an outpatient evaluation ranges from \$365 to “~\$10,000. “

Presentence Evaluations in Non-Capital Cases

- Traditionally, in non-capital cases, the courts have looked to the mental health community for evaluations to aid in sentencing. In many states, these evaluations are provided adjunct to presentence investigations prepared by probation offices. A state’s PMHS may or may not have involvement in these evaluations.
- Sixteen of 40 states responding (40%) report that the PMHS provides presentence evaluations in non-capital cases. The number of evaluations provided ranges widely:
 - 0- 50: 6 states
 - 51-100: 2 states
 - 101- 200: 2 states
 - > 200: 1 state (375 evals)
- The % of defendants evaluated on an inpatient basis ranges widely as well:
 - 0% evaluated inpatient (i.e., all outpatient): 4 states
 - 35%- 50% inpatient: 3 states
 - 80% inpatient: 1 state
 - 99%- 100% inpatient: 3 states
- Ten states (83%) report that outpatient evaluations are funded by the PMHS. In two states (17%), the court provides funding. Most states report a per-evaluation cost between \$250 and \$400. One state, however, pays \$1,600 for these evaluations.

Services for Sentenced Offenders

- Twenty of 41 states responding (49%) indicate that their PMHS provides inpatient services for sentenced offenders: 10 states in facilities used for other PMHS patients; 7 in facilities or units dedicated for sentenced offenders; and 3 in correctional facilities.

- Only 5 states authorize courts to sentence offenders to inpatient facilities. But facilities in many states accept offenders who have been civilly committed from prison. The vast majority of states allow facilities to discharge offenders (back to jail or prison) when stable.
- Twenty of 35 states responding (57%) indicate that their PMHS provides community-based services for offenders on probation or parole (P&P).
- States report that community-based services are funded by:
 - PMHS: in 15 states (63%)
 - Court: in 1 state (4%)
 - P&P: in 5 states (21%)
 - The individual: in 7 states (29%)

Note: 16 states (84% of respondents) collect Medicaid for services provided in the community.

Pre-disposition Evaluations in Juvenile Court Delinquency Cases

- The juvenile courts rely on mental health professionals to provide assessments for consideration at disposition. The purpose of disposition, after all, is to address the needs of the child. In only 10 states, however—28% of the 36 states responding—does the PMHS provide these evaluations. In most states, it seems, evaluations are provided by the state’s juvenile justice system.
- States that do provide these evaluations report widely ranging numbers: 50-60 evaluations annually in 2 states; 260- 270 evaluations annually in 2 states; and 1,000 evaluations annually in 1 state.
- Almost all evaluations are conducted on an outpatient basis. Only 1 state reports doing more than 5% of its evaluations inpatient (MD, where 80% are done inpatient).
- Evaluations generally are funded by the PMHS, although 1 state reports funding from the court for outpatient evaluations.
- The cost of outpatient evaluations ranges from \$300- \$400 in 2 of the 4 states with useful data to \$1,200- \$1,600 in the other 2 states.

Services for Juveniles Adjudicated Delinquent

- Ten states (31% of states responding) report providing inpatient services for youth adjudicated delinquent: 8 states in facilities used for other PMHS patients; 1 state in a facility or unit dedicated for adjudicated delinquents; and 1 state in a facility operated by the juvenile justice system. Eight states (80%) report collecting Medicaid or CHIP reimbursement for these services. 20 states (62%) report providing no inpatient services for adjudicated delinquents.
- 17 states (50% of states responding) report providing community-based services for adjudicated delinquents on probation. 13 of these states (76%) report Medicaid or CHIP collections by community providers.

Other Forensic Evaluations

- This report has addressed the issues that most often precipitate court orders for evaluation. There are a number of other issues that arise on occasion, however. Most fall outside the purview of states' PMHS's; if evaluations are to be done on these issues, they often must be arranged privately by the parties (defense or prosecution). An example is "competency to confess"—whether a defendant's incriminating statements to the police should be considered inadmissible because they were made "involuntarily" or without a knowing and intelligent waiver of Miranda rights. Other issues may be considered covered by evaluations the PMHS already does. Competency to plead guilty, for example, may be seen as part and parcel of competency to stand trial. In the interest of completeness, however, the survey asked whether states' PMHS's provided evaluations (independent of other evaluations) on these and other issues. Here's how the states responded:
 - Competency to Confess: 21% Yes
 - Competency to Plead Guilty: 21% Yes
 - Competency to Waive Counsel: 15% Yes
 - Competency to Waive the Insanity Defense: 11% Yes
 - Competency of a Witness to Testify: 13% Yes
 - "Diminished Capacity" (*mens rea*): 31% Yes
 - "Automatism" (*actus reus*): 16% Yes
 - Competency of a Death Row Inmate to be Executed: 19% Yes
 - Transfer of a Juvenile from Juvenile to Adult Criminal Court: 21% Yes

Miscellaneous Issues

- Many states complain that their facility staff must provide off-grounds transportation for dangerous forensic patients requiring high security. Some

- believe the transportation of these patients should be the responsibility of law enforcement, at least when the transportation is in connection with the patient's appearance in court. In response to the Q, who provides off-grounds transportation of forensic patients, states responded as follows:
- The facility/ PMHS in all cases: 9 states (23%)
 - Justice system in all cases: 1 state (3%)
 - Justice system in connection with the court case; facility/PMHS otherwise: 17 states (43%)
 - Justice system in connection with the court case but only for patients admitted for evaluation; facility/PMHS otherwise: 3 states (8%)
- A controversial question in many states is when to pursue criminal charges against a patient who has broken the law. When asked about their practices, here's how the states responded:
 - Never or almost never prosecute unless crime very serious: 9 states (23%)
 - Always or almost always prosecute unless crime very minor: 2 states (5%)
 - Prosecute only if victim insists, crime very serious, or PMHS determines conduct not manifestation of SMI: 23 states (58%)
 - Many states report that the demand for forensic services has increased substantially in recent years, requiring additional resources for services and programs. Here's what the states said when asked:
 - Yes, demand has increased a lot: 21 states (54%)
 - Yes, demand has increased moderately: 8 states (21%)
 - Yes, demand has increased a little: 6 states (15%)
 - No, demand is about the same: 4 states (10%)
 - No, demand has decreased: 0 states (although CT reports reduced demand for inpatient services)
 - 31 states (78% of the 40 states responding) report that increasing demand for inpatient forensic services has required that they maintain waiting lists for admission. Wait times are in the 30-day range in most states, but 3 states report wait times ranging from 6 months to a year.
 - States were asked what measures they have taken to reduce the wait times for admission. Here's what they reported:
 - Increased outpatient forensic services: 19 states (61%)
 - Added beds: 14 states (45%)
 - Added facility staff: 11 states (35%)
 - Nineteen states (half of the 38 states responding) report that they have been threatened with or found in contempt of court for failing to admit court-ordered patients in a timely matter. In most states threatened with

contempt, officials were able to avoid contempt findings by juggling admissions to accommodate demand. A few states, however, operate under consent decrees to reduce wait times. In one state (LA), PMHS officials, working with the courts, spearheaded legislation that gave them the authority to discharge inpatient CST evaluatees back to jail when their evaluations were done, reducing these patients' lengths of stay by approximately 1 month and freeing up beds for new admissions (reducing wait times).

- As discussed in the background and history section of this report, public officials, advocates, and others throughout the country bemoan the very large presence of people with mental disorders in the nation's jails and prisons. To gauge the level of concern in the various states, the survey asked how strongly people in their states felt about the problem. Here's what they had to say:
 - Very Strong Concerns: 26 states (65%)
 - Somewhat Strong Concerns: 12 states (30%)
 - Not Very Strong Concerns: 1 state (3%)
 - Not Concerned at all: 1 state (3%)

- Asked what measures their states had taken to address concerns about the over-representation of people with mental disorders in the criminal justice system, respondents replied as follows:
 - Meetings of MH and criminal justice leaders: 37 states (97%)
 - PMHS staff hired/ tasked to develop new initiatives: 18 states (47%)
 - Pursued grants to support new initiatives: 16 states (42%)
 - Increased law enforcement training: 33 states (87%)
 - Established CIT Programs: 31 states (82%)
 - Established/expanded PMHS crisis response teams: 27 states (71%)
 - Established pre-booking diversion programs: 17 states (45%)
 - Established jail-based diversion programs: 16 states (42%)
 - Established MH Courts (or similar): 31 states (82%)
 - Additional PMHS resources for services in jails: 9 states (24%)
 - Established re-entry programs: 22 states (58%)
 - Enacted legislation re the above: 14 states (37%)

- Finally, the survey asked about staffing for the administration of forensic services within PMHS's. Respondents reported that primary administrative responsibility rested with:
 - A forensic services director with exclusive responsibility for forensic services, in 20 states (53%)
 - A facility director, in 4 states (11%)
 - A PMHS administrative staff person with other responsibilities, in 9 states (24%)

- The total number of staff dedicated to the administration of forensic services was reported to be:
 - 0- 5: 13 states
 - 6-10: 3 states
 - 11- 20: 6 states
 - > 20: 6 states (one state reporting 2,700, accompanied by the comment, “Define administration!”)

Going Forward

Although the issues calling for PMHS services in criminal and juvenile justice settings are largely the same from state to state, the demand for services and the manner in which services are delivered vary substantially. Forensic services systems share many commonalities, to be sure, some resulting from the close collaborations NASMHPD has fostered over the years through its forensic and legal divisions. But there are striking differences.

The law in most states gives the courts authority to order PMHS’s to provide mental health evaluations, to require that these evaluations be done in inpatient facilities, and to insist that evaluatees (and others the courts commit) remain inpatient until the courts say they may leave—all at the PMHS’s expense. Yet in most states today, evaluations and other forensic services regularly are provided in outpatient settings. If a court-ordered individual *is* admitted, it is the PMHS in some states, not the court, that decides when the individual may leave. And, in a growing number of states, the courts share in the funding of services. These and other changes are seen in the states’ responses to this survey.

Some of the survey findings are surprising and will require further study to fully comprehend. Following a webinar presentation of the survey results on September 12, 2014, staff from the forensic office in one state wrote asking (1) which were the 10 states that reported that they could discharge patients committed as IST without court order, and (2) by what authority were they able to do this. The identity of the states was easy to ascertain, but nothing in the survey addressed the second question. That any state has this authority comes as a surprise. That 10 states have it is big news, worth exploring further.

Deinstitutionalization is relatively new to forensic services. How is it that some states have been so successful at it? In a few states, it’s clear. Virginia years ago demonstrated the cost savings that could be achieved by moving to a community-based system of pretrial evaluation, and the state’s General Assembly responded with legislation *requiring* that evaluations be done outpatient. Louisiana changed its law to give the PMHS authority to discharge inpatient CST evaluatees after their evaluations were done, freeing up beds for needier patients. New York changed its laws to exempt lower-level defendants found IST from court-ordered competency

restoration commitment, again freeing up resources. In Tennessee, an appellate court ruled that the counties in the state (in effect the trial courts) bore responsibility for the cost of inpatient evaluations in juvenile court cases, not the PMHS; inpatient referrals dropped precipitously. In most states, however, changes have come about not by legal mandate but, rather, as a result of interagency cooperation. Learning more about this should help in those states where change has been slow in coming.

A few states are feeling increasing pressure to use inpatient resources for justice-involved persons, reflecting heightened public concern about the prevalence of mental disorder in jails and prisons. One state, however, reports *decreasing* demand for inpatient forensic services, it believes because of the many successful diversion programs that state has put in place in recent years.

The survey touches on initiatives many states have undertaken to “intercept” and divert (to treatment) individuals involved with or at risk of involvement with the criminal justice system. The extent of these initiatives, their cost, and how they have affected service configuration are not fully addressed, however. These and other questions await further research.