Jail Diversion for Misdemeanors Can Be a First Step to Improve the Competency to Stand Trial Process

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The United States is witnessing a slow-moving tsunami disrupting the mental health and criminal justice systems. Bloated correctional mental health systems are overwhelmed by their psychiatric caseloads, publicly funded psychiatric hospitals have shrunk in capacity, increasingly occupied by forensic patients found not competent to stand trial or not guilty by reason of insanity, while under-resourced community mental health services are inaccessible to many people they were intended to serve.[1] The professional literature outlines multiple factors that are postulated to have contributed to the current dilemma. These include deinstitutionalization from formerly large public psychiatric hospitals, inadequate funding of Community Mental Health Centers, prioritization of penal solutions to substance abuse problems during the war on drugs campaigns, tightening of requirements for civil commitment statutes for psychiatric hospitalization, and pressure on inpatient psychiatrists to create room to admit more acutely ill patients by discharging still symptomatic patients before they are fully ready to return to their communities.[1–3]

In settings where social supports are scarce, individuals with mental illnesses are often marginalized from society, disengaged from treatment, and more likely to experience psychiatric symptoms precipitating the intervention of law enforcement. Once called, law enforcement officers, often with little or no mental health training, must decide whether to take the individual to a hospital emergency room (where they may be released within a few hours if not meeting strict dangerousness criteria necessary for hospital admission) or to a jail where safe containment is predictable and needed treatment may or may not be available. Subsequently, jails have filled with detainees with mental illness, whose impairments have generated a sustained surge of referrals for competency to stand trial (CST) evaluations, resulting in an unsustainable demand for state run inpatient forensic psychiatry beds, the typical setting for CST restoration treatment.[4,5] In this issue of The Journal, Morris, McNiel, and Binder estimated that 94,000 CST evaluations are carried out in the United States annually, resulting in annual costs of up to $470 million.[4,6] The accompanying backlog of defendants awaiting CST evaluation or restoration treatment has triggered multiple successful lawsuits challenging the prolonged detentions of defendants found not competent to stand trial.[1,2,4,7] Consequently, states have incrementally re-assigned hospital beds previously used for civil psychiatric commitments to forensic purposes, further limiting state hospital beds available to the community for civil hospitalizations.[1–4]

Inpatient CST restoration treatment, however, differs in many ways from the treatment and outcomes of civil psychiatric hospitalizations. State hospital CST restoration programs have understandably become more specialized to achieve CST restoration as they have grown larger. CST restoration requires that defendants acquire adequate knowledge of legal processes to navigate the criminal justice system. Thus, many CST restoration programs have developed

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curriculum-based group and individual learning activities to teach the necessary information. This focus on CST restoration also means less time and resources are spent during hospitalization to address the underlying social, psychological, substance abuse, and treatment disengagement factors that predispose to repeat arrests or hospitalizations.[2,4,5] On completion of CST restoration treatment, the task of discharge planning from the hospital can be quite challenging and is often incomplete, because many patients who have completed CST restoration may be precipitously discharged from the hospital if charges are dropped or are discharged back to jail to await CST adjudication. Once in jail, these detainees may rapidly decompensate and be re-hospitalized because they refuse medications or are unable to continue their usual medication due to formulary inconsistencies.[2,4,8] Individuals restored to competency are either released from jail for adjudication of their charges or after having their charges summarily dismissed. Unfortunately, there is often little attention paid to reentry into the community, linkage with community mental health services or bridging preexisting family, social, and treatment disengagement problems.[2–5]

In the setting of this highly fragmented and inefficient treatment system, CST restoration programs, while meeting their stated mission, may be discharging many patients with fewer resources to successfully integrate back into society than civilly committed patients. Many individuals with mental illnesses cycle through jail, hospital, and emergency room beds, usually without much communication among these systems about patients' presentation or treatment. The crisis of beds in the CST evaluation and restoration systems has prompted many states across the United States to implement various strategies to deal with the situation, including creating nonhospital-based restoration treatment programs, reducing the time allowed for CST restoration or eliminating CST restoration treatment altogether for certain crimes, and implementing various jail diversion programs. Although each state must craft solutions best suited for its situation, it has become increasingly clear that incorporating jail diversion is an essential component of any interventions.[1,2,4,9–11]

One strategy adopted by many states to address the backlog of defendants awaiting CST restoration has been enacting legislation permitting outpatient CST restoration. But only 16 jurisdictions (Arkansas, California, Colorado, Connecticut, DC, Florida, Georgia, Hawaii, Louisiana, Nevada, Ohio, Oregon, Tennessee, Texas, Virginia, and Wisconsin) have formal outpatient CST restoration programs.[11–13] These programs are more cost-effective than inpatient CST restoration, have favorable CST restoration rates, allow the quicker return of defendants found not competent to stand trial to the community, enable treatment engagement with community mental health services, and appear to have favorable psychiatric outcomes.[11–14] A second strategy adopted by some states (including California, Colorado, Florida, Georgia, Louisiana, Pennsylvania, Tennessee, Texas, Wisconsin, and Virginia) has been to create jail-based competency restoration (JBCR) treatment programs as an alternative to hospital-based treatment.[11,13,15] JBCR programs have been successful in lowering costs compared with inpatient CST restoration, reducing the pressure on inpatient forensic hospital beds, cutting jail wait times for defendants found not competent to stand trial, and thereby reducing time to CST restoration in many cases.[11,13,14]

The reported cost effectiveness of outpatient and JBCR treatment programs compared with inpatient CST restoration may not reflect an accurate comparison because the former programs have eligibility criteria that exclude the most severely ill defendants. Excluded defendants include those with serious or felony charges, those who require inpatient psychiatric treatment due to aggression or suicidality, and those with serious medical problems and serious neurocognitive disorders (e.g., traumatic brain injuries and dementia). Defendants who refuse medication and those who abuse substances are also frequently excluded from these programs.[11,13,14] JBCR treatment can conversely delay attaining CST restoration if treatment in jail is unsuccessful and defendants must then be transferred to the hospital.[11] Also, while JBCR programs offer the possibility of starting treatment earlier, defendants and attorneys often prefer the more accessible, comfortable, and therapeutic hospital milieu. In addition, punitive jail environments, which tend to encourage maladaptive behaviors in individuals with mental illness, are poorly suited to the task and often ill-equipped to handle complex clinical and behavioral problems and tend to have poorer treatment outcomes compared with psychiatric hospitals.[5,16,17]

Overall, alternative nonhospital-based CST restoration treatment programs are solutions that build on existing structures and reflect concerns about

public safety because most individuals remain ensconced within or under the supervision of the criminal justice system. This approach on its own, however, perpetuates a system where CST restoration remains the primary treatment focus, with inadequate intervention to address co-occurring factors that predispose to poor functioning in society and recidivism. Without additional strategic interventions promoting access to community-based and recovery-focused treatment, these programs could entrench the criminalization of mental illness, further expand an already bloated criminal justice system, and support continued diversion of resources from community mental health services where most people are best served.

A third strategy some states have attempted has been to statutorily reduce the length of time allowed for CST restoration services for minor crimes (e.g., Hawaii, North Carolina, Ohio, and Washington).[1] Other states have eliminated CST restoration treatment for minor crimes altogether (e.g., Florida and New York).[1,18] Although these interventions can offer a rapid reduction in jail wait times and the number of defendants awaiting CST restoration treatment, long-term effectiveness can only be attained if they are accompanied by adequate resources and connection to community mental health services on community reentry, including substance abuse treatment and social services.[2,9,18] Tansey *et al.* illustrated the value of adequate connection to mental health services in their findings that better outcomes were achieved when programs connected defendants to community mental health and social resources following dismissal of charges and jail release.[18] Failure to provide adequate linkage to community mental health and social services can create a revolving door of defendants with mental illnesses who rapidly decompensate on release from jail and end up repeatedly cycling from jails to hospitals. Any short-term cost savings will be lost by the long-term cost and the attendant negative outcomes of repeated institutionalization. Leifman and Coffey found that in a five-year span, 97 individuals with serious mental illnesses in Miami-Dade County accounted for nearly 2,200 arrests, 27,000 days in jail, 13,000 days in emergency rooms, crisis centers and state hospitals and approximately $16 million in costs to Florida taxpayers.[9]

A fourth stragey (and probably the most effective and efficient compared with others) has been to implement jail diversion programs. Jail diversion programs aim to move eligible individuals with mental illness from criminal processes to civil mental health treatment services. Proponents of jail diversion programs recognize that not all offenders are appropriate for diversion; it is important to select individuals whose behavior is not driven primarily by criminality, that diverted individuals do not pose a safety threat in society, and that victims' rights are protected.[2,19] The eligibility criteria for jail diversion programs typically reflect these concerns, and programs often include a provision for approval from the prosecutor's office for cases to be diverted.[2,19] Jail diversion programs often operate through problem solving specialty courts such as mental health, family violence, and drug courts but can occur at earlier stages of interaction with the criminal justice system, including during the initial interaction of individuals with police, crisis teams, or other first responders. In the Sequential Intercept Model, Munetz and Griffin described numerous intercept points at which individuals can be moved toward treatment instead of into the criminal justice system.[20] Pinals and Callahan have proposed applying the Sequential Intercept Model to identify and direct eligible individuals into civil mental health treatment pathways at various levels of the CST evaluation and restoration system.[21]

The primary goal of these diversion programs is to prevent the deep enmeshment or even the entry of individuals with mental illnesses into the criminal justice system. Jail diversion programs can also rapidly reduce the overwhelming number of individuals involved in the CST evaluation and restoration process, while still ensuring access to necessary treatment within community mental health services. Local jurisdictions with jail diversion programs have reported positive results. In Miami-Dade County, Florida, the creation of prebooking and postbooking diversion programs resulted in remarkable cost savings, jail population reduction, and positive outcomes for diverted individuals.[9,22] In Bexar County, Texas, where diversion programs were set up at different intercept points, all diversion programs saved costs overall, although prebooking diversion programs had significantly greater cost savings than postbooking programs.[10] Nonetheless, disparities can occur in access to the jail diversion programs because of eligibility criteria that tend to skew toward selecting female, white, older individuals charged with nonviolent, nonfelony charges compared with the average defendant.[10] Both

programs stressed the importance of collaboration in planning and implementation with all relevant stakeholders, including state and local government agencies, law enforcement, courts, mental health care and substance abuse treatment providers, consumers of mental health and substance abuse treatment programs, family members, mental health advocacy, and social welfare organizations.[10,22]

In summary, jail diversion programs offer the possibility of reducing cost and improving outcomes by enabling community-based, recovery-focused treatment so individuals can retain connections with their families and social support systems, while preventing prolonged incarceration in the costly jail environment awaiting the CST restoration process. Although jail diversion programs appear to offer enormous promise, programs must be adequately funded, implementation must be coordinated with local stakeholders, and monitoring of outcomes must be consistent for the most favorable outcomes.

In the search for solutions, it is illuminating to examine the outcomes of jail diversion in the subset of individuals with mental illness arrested for less serious, "nuisance" crimes (Ref. 1, p 3) who tend to be more likely to be found not competent to stand trial, and have more severe mental illness, particularly psychotic illnesses compared with those on felony charges.[1] Misdemeanor defendants make up a substantial portion of the increasing number of referrals for CST evaluations and treatment.[4,23–25] They are also more likely to take longer to regain competency, need inpatient CST restoration and be found not restorable following CST restoration treatment.[24–26] In dealing with this population, many states have already indicated an interest in providing treatment instead of incarceration and tend to dismiss charges in misdemeanor offenses once CST restoration treatment has been completed.[2,4,7,24] This is a good place to start and should occur in combination with other interventions that would be best suited for each state or jurisdiction. The Miami-Dade model has demonstrated the success of this graduated implementation approach, first instituting diversion programs for misdemeanor offenders with serious mental illnesses. Subsequent phases included expanding jail diversion eligibility criteria to include those with qualifying felony charges, diverting individuals found not competent to stand trial and not guilty by reason of insanity to community-based residential and reentry services. The final phase consists of creating a center to provide crisis stabilization and residential treatment beds, with additional resources for transitional housing, primary care, vocational training, and legal resources. These interventions have so far created an estimated annual cost savings of $12,000,000 from reducing the jail population by 45 percent, and achieving 18 percent fewer days in community based residential treatment beds and 32 percent cost savings compared with admissions in criminal commitment inpatient beds.[9,22,27]

Other proposed solutions would require systemic changes to increase the training of jail and courtroom personnel to quickly identify those appropriate for jail diversion, improve the quality of CST assessments by increasing the remuneration for and standardizing credentials of an expanded cadre of forensic mental health professionals performing CST evaluations, and increase inpatient hospital bed capacity if necessary.[1] Similarly, in October 2020, the Council of State Governments Justice Center (a national nonprofit, nonpartisan organization comprising officers from all three branches of government, and policy and research experts that aim to formulate strategies to improve public safety and strengthen communities), released a report describing 10 strategies that jurisdictions can adopt to improve the CST process.[4] Hoge and Bonnie have drafted a proposal to statutorily create a new commitment pathway for court ordered outpatient or inpatient treatment for detainees with serious mental illnesses who are most likely to have high rates of repeated criminal behavior in relation to their mental illness.[5,16]

Policy makers must deal with the fragmentation of services that has contributed to the current situation and avoid mistakes of the past, such as inadequately funding programs, not consulting with relevant stakeholders, and neglecting to prevent disparities in program access for racial or social minorities, those with the most severe mental illnesses or substance abuse and medical co-morbidities that have limited the benefits of previous programs. Forensic mental health professionals are uniquely positioned with their training and experience to contribute to the formulation and impact assessment of interventions and must actively engage in the process of advocating for policy changes that are patient-centered and recovery-focused. Forensic mental health professionals should continue to develop the knowledge base by directing research to identify the most effective methods of addressing these critical problems. Any

solutions must be accompanied by a robust data gathering component and oversight to ensure programs achieve their goals and improve the lives of individuals with mental illnesses and society at large.

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