REGULAR ARTICLE

# Expedited Diversion of Criminal Defendants to Court-Ordered Treatment

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The authors propose a formal statutory diversion process for offenders with serious mental disorders: expedited diversion to court-ordered treatment (EDCOT). As a civil commitment proceeding accompanied by dismissal of criminal charges, EDCOT would not entail a waiver of criminal trial rights and could be invoked even if the defendant lacked trial competence. EDCOT would also be available to authorize civil hospitalization of offenders who are not immediately able to function successfully in the community. These provisions, coupled with mandated compliance with outpatient treatment and judicial supervision, would enable diversion of many, perhaps most, offenders with serious mental disorders into a treatment system that could provide acute services, discharge planning, and problem-solving management in the community.

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Over the last 50 years, as the number of public hospital beds has decreased without offsetting increases in community services and supports, individuals with mental disorders increasingly have come to be arrested, jailed, and punished.[1,2] Numerous studies have documented the large numbers of disordered individuals who have entered the criminal justice system. Steadman and colleagues reported a prevalence of 14.5 percent of serious disorders (i.e., bipolar, depressive, and psychotic disorders) among male jail inmates; among female inmates, the prevalence was higher at 31 percent.[3] A Bureau of Justice Statistics survey noted significant mental illness in 16.2 percent of state prisoners, 7.4 percent of federal prisoners, 16.3 percent of jail inmates, and 16.0 percent of those on probation.[4] On the basis of these figures, it has been estimated that more than 800,000 individuals with mental illness are under correctional control at any given time: an estimated 180,000 state prisoners, 8,000 federal prisoners, 97,000 jail inmates, and 547,000 on probation.[5]

Beginning in the 1990s, diversion programs have been implemented to reduce the number of arrestees with serious mental illness who are incarcerated. Across the United States, the most recent estimates have reported 560 diversion programs in operation for arrestees with mental illness who would otherwise be in jail[6] and 350 to 500 mental health courts.[2,7,8] Characteristics of mental health courts have been extensively reviewed.[2,9,10] In summary, they are specialty criminal courts that operate under existing prosecutorial and judicial authority, typically without specific governing statutes. Each local mental health court must be designed, planned, funded, and staffed by the agreement of various stakeholders, including the judiciary, prosecutors, defense bar, and community providers. In addition, the stakeholders must

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agree on defendants' clinical and legal eligibility criteria. Defendants' participation in mental health courts is voluntary. Therefore, defendants must be competent to stand trial and agree to the diversion to mental health court. The legal process either involves a conditional guilty plea or, in some courts, a preadjudication suspension of proceedings for the duration of court-supervised treatment with the expectation that the charges will be dropped upon successful completion. Defendants must be functioning sufficiently well to be placed in the community and receive outpatient services. As the cited figures indicate, diversion programs have not been broadly implemented, and these innovations have had little aggregate national impact on the increasing flow of mentally disordered individuals entering the criminal justice system. Clearly there is room for new approaches.

We propose a new form of diversion designed to expedite the treatment of many offenders with serious mental illness early in the process of criminal justice involvement. This new form of civil commitment is termed expedited diversion to court-ordered treatment (EDCOT). EDCOT differs in fundamental ways from most current diversion efforts that typically are one-off programs designed to fit within the existing framework of the criminal process and typically depend on informal partnerships and locally available resources.[11] EDCOT entails formal termination of the criminal process in favor of a formal civil commitment governed by a specific statute prescribing criteria and procedures, with an accompanying funding appropriation.

EDCOT is designed to be a rapid path into needed treatment for offenders with serious mental disorders, including both inpatient and outpatient services as warranted. In cases involving acutely ill defendants who lack decisional capacity, an EDCOT commitment would not require the defendant's consent, and the delays and costs associated with determination and restoration of competence to stand trial in criminal cases would be avoided. Further, because inpatient treatment options would be available, EDCOT would apply to many defendants with serious disorders who are not eligible for entry into currently available diversion programs and, all too often, become enmeshed in a misshapen process for restoring trial competence.

We hasten to add, however, that EDCOT would also provide an efficient pathway for formal diversion of presumed competent defendants to the civil system when the prosecution and defense agree to do so. We expect that a formal EDCOT commitment, accompanied by dismissal of the criminal charges, would be attractive to both sides in many cases involving defendants with serious mental illness.

Implementation of EDCOT would require enactment of a new civil commitment statute with statewide application. As a result, there would be substantial standardization across court programs, legislative policy affirmation by and support from the state mental health agency, and over time redirection of state resources (e.g., the provision of beds and related treatment funds). In contrast, current diversion programs vary widely with respect to the clinical characteristics and diagnoses eligible, the seriousness of criminal charges targeted, the length and degree of court oversight, the treatment and social services provided, and the goals of diversion.[10,12] As a result of the bottom-up development of diversion programs, they are difficult to implement, may not survive the loss of key personnel or program champions, and may fail due to unstable funding.

It is our hope that EDCOT will be used to channel a large proportion of offenders with serious mental illness into a treatment-oriented system within weeks after arrest. Admittedly, such expedited decision-making will require fundamental changes in the rhythm of the criminal process, but the current practice is rife with inefficiencies, pointless proceedings, and "procedural minuets" (Ref. 13, p 605). Perhaps these frustrations can convince all of the participants and stakeholders that making a definitive decision early in the process is in everyone's interest. The relevant inquiries are if an EDCOT commitment serves the interests of the defendant and if it serves the interests of society better than criminal prosecution.

Our aim is to encourage this conversation. We note that EDCOT, as described in this article, is a preliminary proposal intended to stimulate further discussion; it is not intended to be a finished product.

Implementation of EDCOT will require the allocation of significant resources for the care and management of committed offenders. The costs of these new services would eventually be offset by the elimination of expenditures required for processing

defendants with serious mental illness within the criminal justice and forensic mental health systems. We begin with a review of these systems and their costs. We then present the proposed objectives and procedures for EDCOT, which would reduce these costs and improve the care and management of offenders with serious mental disorders.

## Mentally Disordered Defendants

### *Criminal Courts and the Forensic System*

Following arrest, mentally ill offenders enter a labyrinthine criminal process. Many will enter the forensic mental health system, which leads to long delays in adjudication of cases. These delays add legal costs and substantial expenditures for specialized assessments and, often, hospitalizations.

To proceed to adjudication, all defendants must be competent to stand trial (CST). Bonnie,[14] citing legal authority and precedent,[15–17] summarized it this way:

> The proposition that a defendant's incompetence bars adjudication is deeply rooted in the common law, has been constitutionalized by the U.S. Supreme Court, and is taken as axiomatic in the administration of criminal justice. The Supreme Court has adopted prophylactic procedural requirements to induce trial judges to order mental evaluations, and to hold hearings, whenever significant doubts are raised regarding a defendant's mental competence. In addition, a defense attorney's failure to seek a mental evaluation in doubtful cases is likely to invalidate any resulting conviction. These rules are designed to accomplish the dual purposes of assuring a fair adjudication and of preserving finality by having all doubts regarding the defendant's mental condition raised and resolved as early in the process as possible (Ref. 14, p 291).

The forensic system has evolved in response to these constitutional demands, which are explicitly and fundamentally related to the processing of defendants in the criminal justice system, not to serving the treatment needs of disordered defendants. The forensic system involves initial assessments of CST to identify those who are incompetent to stand trial so they can be ordered to receive treatment designed to restore competence. Published estimates of the annual number of competence evaluations range from 19,000 to 60,000,[18,19] but these estimates have uncertain grounding. The true figure of CST evaluations performed annually is likely much higher. Historically, defendants were committed to state hospitals (often high-security, specialized forensic facilities) for inpatient assessments of CST.[20] The trend in recent decades, however, has been to perform evaluations on an outpatient basis, and 19 states now conduct most of their evaluations in the community, although this usually means in the local jail because the defendants typically remain in custody. Some states have reported an increasing demand for inpatient evaluations.[20]

The annual cost of jail-based CST evaluations has been estimated to be $50 million.[21] This is likely an underestimate because it is based on only 20,000 evaluations per year, and the projected costs were based solely on jail expenses. This figure does not include payments to evaluators, which have been reported to range from $300 to $3,000 per case in the public sector.[20] If one assumes an average payment of $1,000 per case, this adds $20 million to the aggregate annual costs of jail-based evaluations.

Expenditures on inpatient evaluations are more readily quantified. The Substance Abuse and Mental Health Services Administration's data from 2014 indicated an average census of 3,375 mentally disordered defendants hospitalized for pretrial evaluations in 30 states. Assuming an average hospitalization for CST assessment lasts 30 to 60 days, this would indicate that 20,000 to 40,000 CST evaluations are performed each year in those states on an inpatient basis. On the basis of bed occupancy, the cost of pretrial CST evaluations in state facilities is more than $1 billion per year.[22] These figures for jail-based and state hospital-based evaluations do not include the costs of attorney time, court personnel, clerical staff, or transportation.

Many defendants who are found to be incompetent to stand trial are committed to state hospitals for restoration. The rate of incompetent to stand trial determinations among CST referrals varies, with reported ranges of 7 percent to 70 percent and a mean of 27.5 percent.[23] In 2014, states reported an average census of 4,562 individuals hospitalized for restoration at an annual cost of $1.36 billion.[22] This estimate does not include the federal criminal system.

The CST system has continued to grow at a breathtaking rate. Wisconsin reported an increase of 34.8 percent in restoration commitments between 2011 and 2013; Hawaii, 35.8 percent between 2005 and 2009; Washington, 73 percent between 2010 and 2014; Los Angeles County, 48 percent between 2014 and 2015; and Oregon, 129 percent between 2012 and 2017.[21] In some jurisdictions, waiting

times for a CST evaluation may exceed a year, and adverse clinical outcomes mount as mentally ill inmates languish in jail.[21] Many states have been sued to provide services in a timelier fashion.

### *Treatment Limitations*

Society devotes substantial resources to this forensic scheme to protect the integrity of the adjudication process. The outcomes, however, indicate scant benefits to mentally disordered offenders themselves. Assessments are dedicated to specialized evaluations of defendants' capacities to assist their attorney and to understand the adjudication process. In the event of hospitalization for restoration, treatment is largely limited to pharmacotherapy and to educational programs targeted to address gaps in knowledge about the legal process. The endpoint of forensic treatment and hospitalization is reached once a defendant achieves a minimal level of assessed competence. Practices vary across jurisdictions, but often the goals of typical civil hospitalization (i.e., achieving discharge readiness and arranging services to enable functioning in the community) are not pursued. Because these individuals are forensic patients, they "disappear" from community mental health services.[24]

The bottom line for present purposes is that the resources spent on competence assessment of seriously mentally disordered defendants make very little contribution to their well-being. They are not assessed for their needs with respect to discharge and transition planning for treatment, housing, transportation, or federal entitlements, and no plans are made for successful reentry into the community. This programmatic estrangement from integrated treatment is also physical. In most jurisdictions, forensic patients are cared for in specialized hospitals or on specialized wards where they have no contact with treatment systems (in-reach and out-reach programs) or supportive services that civil patients receive.[24]

The separation of the competence assessment process from the treatment needs of mentally disordered offenders is worsening. As the numbers of defendants with mental disorders have increased, the demand for CST evaluations and restoration services has also increased.[5] Many state forensic systems are in crisis. These systems have long waitlists for inpatient evaluations and restoration. About one-third of states have implemented jail restoration programs, which may help reduce unnecessary hospitalizations but also further attenuate the connection of disordered defendants to the public mental health system and their treatment resources.[21,25]

Ultimately, most disordered defendants will be returned to court for adjudication of charges. If convicted, defendants charged with lesser offenses will often be released for time served, with many defendants spending far more time involved in the forensic system than they would have spent in jail had the question of competency never been raised. As a result, most will be released with inadequate planning for their outpatient treatment needs or the provision of community supports. Florida, for example, spends more than $50 million annually restoring competence to defendants charged with nonviolent crimes who never spend a day in prison; many are released who have no housing, no means of support, and insufficient medication to span the time to an appointment.[26] Current policies governing competence assessment and restoration need reform; resources should be reallocated to the comprehensive care and treatment of offenders with serious mental disorders.

## EDCOT Objectives

Against the backdrop of this disturbing portrait of pretrial competence assessment in the United States, we propose EDCOT, a new form of civil commitment designed to expedite the diversion of many offenders with mental disorders from the criminal process and into a civil pathway of mandated treatment. If the parties are motivated to make decisions promptly, EDCOT orders could be issued within weeks following arrest in many uncomplicated cases. Because the criminal charges would be dropped, EDCOT would not entail the delays and inefficiencies inevitably associated with competence assessment and restoration orders. In an earlier publication,[11] we presented a tentative sketch of EDCOT. We elaborate on these requirements below.

The fundamental goal of EDCOT is therapeutic. The commitment is a variation of ordinary civil commitment governed by the principles enunciated in *O'Connor v. Donaldson*[27] and *Addington v. Texas*[28]. When EDCOT varies from ordinary civil commitment, the difference lies in its role as a formal diversion from the criminal process. The origins of the commitment in criminal prosecution highlight the complementary role of the police power in what is

envisioned primarily as a therapeutic process rooted in the *parens patriae* authority of the state. The commitment criteria, including proof of criminal conduct and the contributory influence of mental illness, specifically take account of the ways in which respondents' behaviors affect public peace and security as well as their own well-being.

The features of contemporary civil commitment that are most germane to EDCOT commitments are those that entail mandatory outpatient treatment designed to reduce the risk of further deterioration, instability, or distress if the respondent remains untreated. One area where EDCOT is meant to be more aggressive and protective than ordinary civil commitment is in authorizing intensive intervention, including confinement, in response to noncompliance or other indicators of instability and possible relapse. Still, EDCOT is not envisioned as a risk-averse, incapacitative form of commitment analogous to commitment of persons acquitted by reason of insanity. For this reason, EDCOT commitment is not intended for use in the typical case involving a person charged with a serious violent offense such as murder or armed robbery.

In sum, EDCOT commitments focus on a subgroup of seriously mentally ill arrestees whose harmful or alarming criminal conduct is found by a court to be sufficiently related to a serious illness that they are likely to continue to offend in the absence of aggressive treatment interventions and social supports addressing criminogenic factors. In some cases, short-term safety risks associated with the individual's mental illness may independently justify ordinary civil commitment in a safe setting, but EDCOT is intended to apply more broadly and to include longer-term risk. Cases suitable for EDCOT are those in which significant criminal behavior associated with the illness justifies an intensive array of mandatory interventions designed to stabilize the individual's functioning and prevent future deterioration and recidivism. In our view, the longer-term risk associated with a deteriorating course of illness fully satisfies the accepted constitutional grounds for preventive intervention under contemporary mandatory outpatient treatment statutes.

EDCOT strikes a somewhat different balance of liberty and restraint than do the two primary civil models. On the one hand, EDCOT treatment and management would place a stronger emphasis on public order and prevention of future deterioration than the traditional civil commitment model. Similarly, EDCOT could feature more intense outpatient monitoring and quicker responses to noncompliance after hospital release than under ordinary civil commitments, thereby placing a greater emphasis on maintaining compliance with treatment. On the other hand, EDCOT would be more therapeutically oriented, and categorically less restrictive, than the typically risk-averse not guilty by reason of insanity management systems that usually err decisively in the direction of confinement and public protection.

EDCOT is designed to embody a problem-solving approach to management with the goal of supporting committed individuals so that they can function appropriately in the community. A strong emphasis would be placed on identifying stressors and triggers of problematic community behavior. Discharge planning, supervised treatment, and ongoing problem-solving are important features of EDCOT.

Unlike most diversion programs currently in place, this new pathway would represent a formal diversion from the criminal process. If it works as we intend, it will involve the formal termination of criminal proceedings, not a conditional disposition under which the charges could be resurrected as a result of noncompliance. Therefore, in the event of noncompliance, the consequences would involve problem-solving interventions, including short-term detention (including hospitalization if clinically indicated), but not criminal sanctions or punitive restraint.

## EDCOT Process

EDCOT would be available procedurally upon a petition by the prosecution, although we expect that it would be a consensual disposition in most cases involving less serious offenses. Unless the necessary findings are stipulated, a formal hearing would be held at which the prosecution would be required to prove the commitment criteria summarized below. Upon commitment, criminal charges would be dropped. The prosecution would be entitled to file new criminal charges, however, in the event of reoffending by the patient during the period of the EDCOT commitment order.

Unlike current forms of diversion, EDCOT would provide inpatient and outpatient treatment options, applied on an individualized basis according to clinical criteria. The availability of inpatient commitment will facilitate expedited transfer of seriously

disordered inmates out of the jail setting. Outpatient treatment would have similarities with mandatory outpatient treatment currently available in many states. As indicated above, in the event of deterioration or a violation of specific terms of the commitment order, the individual would be subject to a detention order (and possible hospitalization) to allow for reassessment and treatment planning.

Our expectation is that, under EDCOT, many of the seriously mentally offenders now in jail would be diverted from the criminal process and into treatment rather than continuing in the criminal justice system to adjudication and incarceration.

In cases involving defendants whose competence to stand trial is in doubt, the decision to invoke this pathway ideally would be made early in the criminal proceedings, so that most mentally ill offenders would not enter the costly CST system and, therefore, would not be found incompetent to stand trial and committed for restoration. Instead, an EDCOT commitment hearing would be held without delay or negotiation and (as with an ordinary commitment hearing) without the need for the respondent's consent. (We anticipate that defense attorneys would support or accede to commitment in such cases, although the question requires further study.) Upon proof of the commitment criteria by clear and convincing evidence, the respondent would be committed, and the criminal charges would be dismissed.

We also envision a separate consensual process involving defendants whose competence to stand trial is not in doubt. For example, the prosecution and defense could stipulate that the EDCOT civil commitment criteria are met in an agreement analogous to those negotiated in traditional diversion programs. Upon issuance of the order, the criminal charges would be dismissed. Alternatively, the court could hold a hearing *sua sponte* on the matter and enter the order after making the necessary findings. Either way, we anticipate that consensual EDCOT orders would displace leveraged mental health court guilty pleas in many cases.

### *Initiating a Commitment*

A request for an assessment of a detainee's eligibility for EDCOT commitment may be made by the prosecutor or by the court. A request for a CST evaluation (by either party or the court) would ordinarily be expected to trigger judicial consideration of the appropriateness of an assessment for eligibility for EDCOT commitment as an alternative course.

The mental health assessment required for commitment would be performed by the state department of mental health or its designee. These evaluations may be performed on an outpatient basis, including in jails and other detention facilities, or may be done at an appropriate designated inpatient facility. The length of commitment for evaluation should be short (e.g., no more than 30 days).

The initial mental health assessment would include determination of the presence of a mental disorder as well as a summary of past problematic behavior, including offending. In addition, the evaluator would provide an individualized assessment of risks and triggers for criminal behavior and other factors likely to affect the defendant's social adjustment. The treatment plan would address how the identified triggers and precipitants to problematic behavior would be addressed. The assessment would be based on mental health records and historical information provided by the court, the prosecutor, and the defense attorney.

### *Commitment Hearing*

The commitment would be under the authority of the court with jurisdiction over the criminal case. EDCOT proceedings would follow current commitment requirements: right to notice, right to counsel, right to a hearing, proof by clear and convincing evidence, and the right to appeal, for example.

### *Commitment Criteria*

The predicates for commitment would be a serious mental disorder as defined by state law for traditional civil commitment as well as proof by clear and convincing evidence that the person engaged in criminal conduct; the conduct was clinically related to a serious mental illness; there is a significant likelihood of future offending in the absence of treatment interventions; and there is a reasonable likelihood, based on expert evidence, that mental health treatment and accompanying community interventions and services will reduce the risk of reoffending.

This set of clinically grounded criteria should not be confused with the legal criteria associated with the insanity defense (e.g., substantially impaired capacity to appreciate the wrongfulness of the conduct or to conform the conduct to the requirements of the law).

Case example: Mr. Jones is a 25-year-old homeless man with a long history of chronic mental illness. He was arrested after he confronted an elderly couple on the street, yelled racial epithets, and punched a passerby who intervened. He is well known to the police and has been arrested more than two dozen times for disruptive and assaultive behavior. In some instances, charges have been dropped. When they have not, he has cycled through the CST and restoration system and been released for time served after restoration. Released from court, he has never had discharge plans other than being given a list of local public clinics where he might seek treatment. Outside jail and the forensic system, he has not received any mental health treatment or services. EDCOT provides a legal mechanism for the extended period of assertive outpatient treatment, social support, and oversight that he needs.

While extended discussion of the criteria would exceed the scope and ambition of this article, two points should be noted in passing. First, the criteria refer to occurrence of "criminal conduct." Technically, it is possible that the defendant who committed the *actus reus* of the offense lacked the *mens rea* because of mental illness or was not criminally responsible. Our present inclination is to say that the EDCOT statute should make it clear that such a person is committable under EDCOT. Second, a finding of dangerousness is not required under EDCOT; instead, the formal therapeutic intervention is warranted by any criminal behavior that breaches the peace or arouses public alarm, including (but not limited to) threatening or assaultive behavior.

### Commitment Order

The EDCOT commitment order would identify the required services as well as designated providers and would specify classes of medication needed, as identified in the mental health assessment. The order would include clinically indicated inpatient and outpatient treatment and, as necessary, assertive community treatment, residential services, day treatment, and other community services or supports. The order would include estimates of the anticipated length of mandated treatment. The order also would indicate the treatment and service needs likely to be required following the termination of the commitment.

### Judicial Monitoring

The court would review and approve the treatment plan, would monitor the implementation of mandated services specified in the order, and, if necessary, take steps to assure compliance and continuity of court-ordered care. We expect the EDCOT statute to authorize short-term custodial orders in the event of material noncompliance to provide an opportunity for assessment and intervention (as well as a deterrent to noncompliance). An appropriate person in the public mental health system would be designated to make periodic reports to the court regarding compliance with the order and any problems that may arise that jeopardize continuity of care or public safety.

In some jurisdictions, commitment to established mandatory outpatient treatment programs may be appropriate for individuals facing misdemeanor charges, if they are clinically indicated and provide sufficient oversight. A status hearing would be held periodically, but no less than once every six months, and the care and progress of the committed person would be thoroughly reviewed.

### Length of Commitment

The order would be indeterminate in length up to a statutory ceiling (i.e., the typical arrangement for mandatory outpatient treatment orders under traditional civil commitment), although the ceiling on EDCOT commitment would be tied to the seriousness of the offense. Ideally, courts should make individualized judgments about the length of commitment on the basis of the committed person's therapeutic progress, the degree of their stability in the community, and other evidence of successful transition. There is evidence that mandatory outpatient treatment is most likely to be successful when sustained over periods of 18 months.[29,30] Of course, individuals may have differing needs; those with comorbid illnesses or other complicating social factors may need to be committed for a more extended period of mandatory care.

State legislatures will make different judgments regarding the proper balance of public safety and the liberty interests of offenders when setting the statutory limits for EDCOT commitments. The seriousness of the criminal conduct on which the order is predicated should play a role in determining the involuntary treatment period. We believe that the correct approach is to establish upper limits on the maximum period of EDCOT commitment on the basis of the underlying predicate offense. For misdemeanor offenses, the maximum period of mandated treatment should be one year. For those with

an underlying nonviolent felony charge, a period of three years should be appropriate in most circumstances and should be sufficient to bring prosecutors on board. For more serious felonies, a ceiling of five years may strike an acceptable balance. In any case, the length of commitment should not extend beyond the period of the maximum sentence the committed person would have received if convicted of the charged criminal behavior.

The commitment period would be terminated if there were a judicial determination that the individual is no longer in need of supervision for public safety reasons or is no longer in need of treatment. Conversely, the three traditional commitment pathways (ordinary civil commitment, CST commitment, and not guilty by reason of insanity commitment) would remain available if the intermediate pathway outlined in this article is not a good fit for a particular case.

### *Summary of EDCOT*

The proposed EDCOT commitment law borrows familiar elements from contemporary civil commitment models, particularly those that concentrate on mandatory outpatient treatment. Although it is expected to be somewhat more restrictive than ordinary commitment laws, EDCOT commitment is driven primarily by therapeutic considerations and bears no resemblance to not guilty by reason of insanity commitment statutes and sex offender commitment laws that prioritize incapacitative considerations.

Adoption of this model does not preclude continued use of other local programmatic innovations, such as mental health courts and other diversion programs. Nonetheless, EDCOT commitment, as we have envisioned it in this article, differs in important ways from those valuable initiatives. As a commitment law, it provides a new path to involuntary treatment and would be applicable state-wide. State mental health agencies would, by necessity, be involved in making public inpatient beds available, likely those redeployed from CST restoration use. In addition, state agencies' resources would be needed to designate qualified examiners, provide training, and implement policies and procedures.

EDCOT would not be restricted to higher-functioning offenders who are capable of decision-making regarding adjudication and are ready for community placement. EDCOT can be applied to offenders with serious, current mental disorders with significant, active symptoms of mental illness, as well as those in need of drug or alcohol detoxification prior to treatment of primary psychiatric disorders.

## Conclusion

It is time for the criminal justice system and public mental health agencies to rationalize the nation's approach to the care and management of individuals with serious mental illnesses who become involved in the criminal justice system. Under our proposal, a substantial proportion of such defendants would be diverted formally to a new form of civil commitment early in the criminal process and would thereafter receive care and be managed in treatment systems operated by state and community mental health authorities. These individuals would not be relegated to jails or prisons with uncertain prospects for care and the risks of victimization.

Our state and local mental health agencies would be able to reduce their outsized resource allocations to nonclinical responsibilities related to the CST system. Beds currently allocated to restoration of CST could be repurposed to core treatment functions. In addition, the costs of the new pathway of commitment would be offset by the elimination of criminal justice and forensic mental health expenditures. Assuming half of seriously mentally ill offenders were to follow this new pathway, the savings to the criminal justice system alone would be about $15 billion.[31] The new pathway would also save the public mental health system substantial sums. State forensic mental health divisions have become unsustainably enlarged to serve the interests of criminal adjudication. In 2014, the states spent nearly $9 billion for all inpatient services, of which $4.1 billion was spent for inpatient forensic services, 43.7 percent of the total.[22] This percentage has steadily grown over the years, increasing from 25.7 percent in fiscal year 2001 to 36.4 percent in fiscal year 2008.[22] Substantial reduction in the costs devoted to the CST process would free billions of dollars a year that could be targeted for treatment.

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