Treatment Refusal in Arizona's Jail-Based Competency to Stand Trial Restoration Programs

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In 2003, Arizona began a jail-based restoration to competency program for detainees in its largest jail system in Phoenix. Today, jail-based competency programs have become the rule statewide to the degree that very few incompetent detainees are now referred to the Arizona State Hospital for restoration services. This article focuses on the topic of treatment refusal and the use of forced medications for detainees who are in these jail-based restoration programs. We describe Arizona's novel statewide jail-based programs, Arizona's statutory and case law approach to treatment refusal, and the restoration to competency programs in one large county jail that has no legal mechanism outside of civil commitment for the determination of whether forced treatment will be permitted. We conclude with a discussion of specific override procedures that might apply directly to incompetent detainees in a jail-based competency restoration program and whether the use of these procedures is prudent in a jail environment.

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The determination of competency to stand trial for individuals charged with crimes traditionally follows a bifurcated process in which trial competency is first determined by a judge. Following a judicial finding of incompetency, the individual could be committed, if recommended, to a psychiatric hospital or to an outpatient program for a specified period of competency restoration. At any time during this process, the individual might also refuse treatment (most often refusal of medications), and this refusal may be reviewed in legal proceedings. The refusal could be reviewed during the judge's initial determination of incompetency using specific procedures for individuals facing criminal charges.[1,2] Alternatively, the refusal could be reviewed after the individual is admitted to a psychiatric hospital for competency restoration, either by a legally recognized judicial or administrative process as determined in a particular jurisdiction.

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In recent years this traditional approach of hospital transfer has been altered with the establishment of a small number of jail-based competency restoration programs.[2] Treatment refusal, however, may represent a barrier requiring transfer from a jail-based program to a hospital. If for some reason transfer cannot occur, then the jail restoration program must be able to undertake legally acceptable procedures to allow treatment-refusal to be overridden in the jail setting. The question of how to approach treatment refusal in jails is controversial. Can and should involuntary medication administration occur in jail? Are jails prepared to administer override procedures as defined by the Supreme Court in *Washington v. Harper*[3] and *Sell v. United States*[4]? This article focuses on the topic of forced medication administration of defendants undergoing jail-based competency restoration in Arizona, a state where nearly all institutional competency restoration takes place in jail, with few patients ever admitted to a psychiatric hospital.

In 2004, 267 patients were admitted to the Arizona State Hospital (ASH) for competency restoration. This is in stark contrast with ASH data covering the years 2013 to 2017, when ASH had an average daily forensic population census of 118 patients, of which only an average of 10 patients per year were admitted for competency restoration.[5] In Arizona,

most detainees never go to a psychiatric hospital, and most never leave a jail from the time they are arrested to the completion of the trial process. While competency evaluation takes place in each of Arizona's counties, five Arizona county jails now serve as the setting for nearly all of Arizona's in-custody competency restoration programs. This makes Arizona an ideal setting to examine treatment refusal and the use of forced medication in jails, because if forced medications are needed to restore competency administration, it will most likely occur in a county jail.

At the time this article was written, the jail-based competency restoration program in Maricopa County, which is the state's largest county and includes Phoenix and its environs, was operating without a treatment-refusal override process outside of the use of the state's civil commitment law. This article will briefly review the evolution of Arizona's jail-based competency restoration programs, Arizona's statutory approach to treatment refusal, and the consequences of Maricopa County's reliance on its civil commitment statute for determining whether treatment refusal will be overridden.

Competency Evaluation and Restoration

There are statutory processes in Arizona for determining competency to stand trial[6] and for restoration of competency as outlined in the Arizona Rules of Criminal Procedure, Rule 11.[7] Rule 11 was the sole responsibility of state superior courts until 2016, when the legislature passed a statute that allowed municipal courts to conduct the Rule 11 process for persons charged with misdemeanors.[8] Rule 11 is divided into two components, the first being the evaluation of competency. For those found incompetent to stand trial and restorable, a second component addresses the commitment of the detainee to a jail-based or a community-based competency restoration program. This article will focus only on the jail-based restoration to competency (RTC) programs and not on the Rule 11 evaluation phase or on community RTC programs.

Jail-based RTC programs in Arizona date to 2003 when Maricopa County and ASH began an experimental RTC program in its large jail system.[9] This program focused on individuals in need of competency restoration, with some detainees remaining in jails while those requiring specialized psychiatric treatment due to serious mental illness were admitted to ASH. Arizona statutes were amended in 2005 to allow county boards of supervisors, at their discretion, to administer RTC programs in county jails or in out-of-custody settings.[10] Gradually, over the next 15 years, jail-based RTC programs developed statewide. While county evaluation and RTC programs reserve the ability to transfer their most serious individuals to ASH, such transfers rarely happen.

The use of jails for competency restoration developed because of legislative changes in funding formulas that decreased revenue made available to ASH, which in turn forced the ASH to develop program capacity limits for the number of beds for patients admitted for competency restoration. An agreement between the legislature and ASH established that these limits could not be exceeded. Among other causes, funding limitations led to the development of waiting lists, and individuals experienced lengthy waits in county jails for a hospital bed. Nationally, and in Arizona, the combination of long waits for restoration beds and the comparative lower costs for jail competency programs are the most common reasons given for the development of jail-based RTC programs.[11]

Arizona is a decentralized state, operating primarily through its counties and regional authorities. Except for yearly reports from ASH,[5] we have not been able to find data repositories, at either the state or county levels, regarding forensic mental health services, with any detailed information about Rule 11 evaluations and RTC programs in the jails or in the community.

Arizona's Five Jail-Based RTC Programs

In the spring of 2018, there were five county jail-based RTC programs in Arizona. At that time, we visited two large and long-established programs, which were located in the Yavapai and Pima county jails. In addition, we met with Maricopa County program administrators and discussed various aspects of their RTC program.

There are two other RTC programs in the state. Pinal County has a small jail-based RTC program that began functioning in 2017. In Yuma County, the RTC appeared to be in transition, with a recent request for proposals for reorganization under the Yuma County Sheriff's auspices.[12] The programs in Yavapai and Pinal Counties are administered through subcontracts with Wexford Health Sources, Inc., a for-profit correctional health company located

in Pittsburgh, Pennsylvania. The other three programs are administrated by county government under the direction of the sheriff's offices.

Maricopa County, Pima County, and Yavapai County each have a Corrections Health Services program (CHS) separate from the RTC program. Pima County (Tucson area) and Yavapai County (in northern Arizona) each contract to provide RTC services for other counties that do not operate their own RTC programs. For various programmatic reasons, there is an administrative firewall between the CHS and RTC programs. In Maricopa and Pima Counties, CHS psychiatrists provide medications to RTC clients. The Yavapai county RTC program is the only program that employs its own psychiatrist for the treatment of RTC clients.

None of the three RTC programs has dedicated program space. Each jail has a separate mental health unit with beds to house inmates with the most acute mentally illness, which may include RTC detainees as needed. Detainees in any phase of the Rule 11 program are housed either in the general population or in the CHS mental health unit, depending on their current psychiatric condition. In each program, RTC staff see their clients on a periodic basis for competency education and training.

Pima County began its RTC program in 2007. The RTC program was set up in a manner similar to Maricopa County, with RTC clients seen either in specialized mental health pods or in the jail's general population.[13] In a a statistical overview of the Pima County program, for 2016–2017, the RTC had an average daily census of 26 detainees, with an average total of 143 clients served each year and an average length of stay of 80 days. For this two-year period, an average of 83 percent of clients who completed the program were restored to competency. Since 2008, no RTC detainees had been transferred to ASH.

The Yavapai County Program began in 2010.[14] The program included RTC detainees from nine counties with relatively small populations. The RTC had a 20-bed limit. The evaluation portion of Rule 11 was done in each home county. Once adjudicated incompetent to stand trial, detainees were admitted immediately to the RTC program as beds were available. RTC program staff see their clients on a periodic basis for evaluation and competency training. Psychiatric medication is prescribed by the RTC staff psychiatrist. Data for the seven-year period from 2010 to 2016 revealed that the Yavapai County Jail had an average daily population of 521 inmates, and the RTC program had an average population of 14 detainees. During this seven-year period, the program admitted a total of 306 detainees and discharged 285, with 226 (79%) discharged as restored, 37 (13%) as not restorable, 15 (5.3%) diagnosed as malingering and returned to the court, and a remaining few discharged from the RTC program for medical or court-related reasons. Schizophrenia was the most common diagnosis. During this period, no RTC participants were referred to ASH for hospital level care.

Treatment Refusal in Arizona

As background to the discussion of treatment refusal in Maricopa County, we first provide an overview of Arizona statutes that have a treatment-refusal provision and review a recent Arizona Court of Appeals decision that has direct relevance to the issue of forced medication for individuals found incompetent to stand trial.

Statutory Approaches to Forced Medication

The Rule 11 process had a provision for the use of forced medication: "If the court finds that a defendant is incompetent to stand trial, the court shall determine, (1) if the defendant is incompetent to refuse treatment, including medication, and be subject to involuntary treatment."[15] If the court makes this finding, it will be entered into the Treatment Order for the detainee.[16] Recently, these provisions were deemed insufficient in favor of *Sell* criteria (see below).

A broad treatment-refusal provision is found in Arizona's civil commitment statute, which allows commitment "if the court finds by clear and convincing evidence that the proposed patient, as a result of mental disorder, is a danger to self, is a danger to others, has a persistent or acute disability (PAD) or a grave disability and is in need of treatment, and is either unwilling or unable to accept voluntary treatment."[17] Arizona's definition of PAD is:

> A severe mental disorder that meets all the following criteria: (a) If not treated has a substantial probability of causing the person to suffer or continue to suffer severe and abnormal mental, emotional, or physical harm that significantly impairs judgment, reason, behavior, or capacity to recognize reality. (b) Substantially impairs the person's capacity to make an informed decision regarding treatment, and this impairment causes the person to be incapable of understanding and expressing an understanding of the advantages and disadvantages of accepting treatment and understanding and expressing an understanding of the alternatives to the treatment

offered after the advantages, disadvantages, and alternatives are explained to that person. (c) Has a reasonable prospect of being treatable by outpatient, inpatient, or combined inpatient and outpatient treatment. [Ref. 18]

Cotner v. Liwski (2017)

Amy Cotner challenged an order regarding her medications by Pima County Superior Court Judge Danelle Liwski in a Special Action Proceeding in the Arizona Court of Appeals.[19] Ms. Cotner based her request for relief on the judge's *Sell* order for involuntary medication in the Rule 11 treatment order. The court of appeals found that, in conducting a *Sell* hearing, the judge "abused her discretion by entering findings that do not comply with *Sell*" (Ref. 19, p 5). The error was that the judge did not engage in a specific inquiry about this patient and how she did, or did not, specifically meet each of the *Sell* criteria. The court of appeals granted relief to Ms. Cotner and directed the judge "to reevaluate Cotner's objection in compliance with *Sell* and this opinion" (Ref. 19, p 5). This case is important because the court of appeals, by its decision, had endorsed *Sell* as providing the appropriate criteria that a judge should use when applying the Arizona involuntary medication statutes for individuals being restored to competence to stand trial.[15,16]

This court of appeals decision also emphasized that *Sell* requires "an individualized, fact-based examination of each case and each defendant" (Ref. 19, p 3). Judge Liwski's application of the first *Sell* criteria regarding governmental interest was particularly problematic in this regard. As cited in the court of appeals decision, Judge Liwski's opinion read, "I believe there is an important government interest [in] proceed[ing] as timely as possible with criminal cases, to hold people accountable for criminal actions if they did complete them, if they are responsible for them, and to prosecute the cases" (Ref. 19, p 3). Judge Liwski subsequently added that the fact this case involves victims, who "have a constitutional right to have a speedy trial in Arizona, also compels a government interest in this case," and is "a valid reason for requiring medications" (Ref. 19, p 3).

Ms. Cotner's crimes involved causing minor injuries to police officers called to the scene because of her psychotic behavior on a public bus. When the officers attempted to restrain her, she began "kicking them and inflicting minor cuts on one officer's hands" (Ref. 19, p 3).

Treatment Refusal in Maricopa County

In 2017, Maricopa County had an estimated population of 4,307,333, and in 2015 there was a reported average jail population of 8,000 inmates divided among six jails.[20,21] At the time this article was written, Maricopa County, like Pima and Yavapai Counties, no longer used the Rule 11 statutory provision allowing a judge to order involuntary treatment for detainees found incompetent to stand trial and incompetent to refuse treatment, including medication. Unlike Pima and Yavapai Counties, however, Maricopa County did not plan to institute *Sell* hearings.

The only time involuntary treatment would be initiated was if jail staff determined that the detainee was so mentally ill that a court hearing was necessary to order conditional release to the county psychiatric hospital or to find the detainee not competent and not restorable (NCNR). In either case, the detainee could then immediately be entered into the Arizona civil commitment process and transferred to the county psychiatric hospital for evaluation, treatment, and stabilization. If civilly committed, the individual could be treated involuntarily at the county hospital. Once psychiatrically stable, those who were conditionally released were transferred back to the jail, where the RTC process would proceed.

We have not been able to access any data from Maricopa County jails for either the Rule 11 evaluation or its RTC programs, or for the frequency of hospital transfer for either conditionally released or NCNR individuals.

Graves v. Penzone (formerly Arpaio) (2017)

The Maricopa County jail's approach to treatment refusal is highlighted in an ongoing class action law suit currently in the Federal District Court in Arizona. *Graves v. Penzone* (2017)[22], which was originally filed in 1977 as *Graves v. Arpaio*, 2-77-cv-00479 (D. Ariz), now focuses on mental health services in Maricopa County jails. The defendants in the case were originally the long-time sheriff, Joe Arpaio, and the Maricopa County Board of County Supervisors. The case has been ongoing for more than 40 years, with Arpaio being replaced by the current sheriff, Paul Penzone. The case is complicated but was recently summarized in a section of an order by Judge Neil Wake.[22] Although all elements of this longstanding lawsuit are relevant to jail health programs, we focus only on those elements relat-

ing to the jail-based RTC program and the issue of treatment refusal.

In 2016, the *Graves* plaintiffs filed a motion entitled Plaintiff's Motion to Enforce Fourth Amended Judgment and for Additional Relief.[23] In this document, the plaintiffs focus on detainees with serious mental illness who:

> languish in Maricopa jail because their criminal cases are at a standstill, their severe mental health problems having forced the courts to deem them incompetent to stand trial. Unlike Maricopa, most counties in the country send detainees who have been deemed incompetent to a hospital to be restored to competency. Defendants have chosen to keep their restoration program at the jail [Ref. 23, pp 1–2].

The motion focuses on these detainees based on an evaluation by the plaintiff's forensic psychiatric consultant, Dr. Pablo Stewart. In his report, Stewart[24] notes that, from March to August 2015, there were 235 prisoners enrolled in the jail RTC program. The report focuses in part on the failure of the jail to provide ready access to hospitalization when the mental health needs of jail detainees exceeds the ability of the jail to render appropriate care. Stewart stated, "Prisoners in the Jail's Restoration to Competency Program are often the most severely impacted by lack of timely hospitalization. These are the most seriously mentally ill prisoners in the Jail's population" (Ref. 24, p 125). Summaries of many cases are found in Stewart's report.

The Plaintiff's Enforcement motion along with Stewart's report were considered by the Court, and on March 3, 2017, Judge Wake issued his order in response to the Plaintiff's motion.[22] In this section of the Order, Judge Wake denied the Plaintiff's Motion for Additional Relief regarding patients who refuse treatment in the jail's RTC program. The Order states:

> Because delay in treatment risks serious harm, Dr. Stewart opined that Defendants should seek court orders for involuntary treatment more quickly—that is, before a patient is found incompetent and non-restorable, before criminal charges are dismissed. But Dr. Stewart did not explain what "higher level of care" a psychiatric hospital would provide detainees if a court will not order involuntary treatment for an RTC pretrial detainee and the detainee continues to refuse treatment. Dr. Stewart opined that pretrial detainees were subjected to additional and needless suffering during completion of the RTC process, but he did not explain how their suffering would be reduced by psychiatric hospitalization [Ref. 22, p 10].

The judge's response to Stewart's opinion suggests a misunderstanding of the role of psychiatric hospitalization for jail-based RTC detainees. Psychiatric hospitals can provide necessary treatment for detainees with the most serious mental illness and are very familiar with the necessary steps to take if a patient admitted for competency restoration refuses psychiatric treatment. It appears from review of this court record that RTC clients in the Maricopa RTC program were not being referred in a timely manner to a court to consider involuntary treatment. It was only after the detainee was found NCNR that civil commitment proceedings were initiated, and involuntary treatment could be initiated. *Graves v. Penzone* continues today, apparently without a specific focus on the pretrial detainees in the RTC program.

Discussion

The situation in the Maricopa County jails is complicated by the involvement of its mental health programs in a long-term lawsuit, which raises serious questions about the care and treatment of detainees with severe mental illness in the jail, particularly those who fall under Rule 11. We do not know the extent of this problem because data regarding such detainees in the jail are not available to us. The treatment refusal situation, as described here, derives from discussions with several county administrators, defense attorneys, and mental health professionals familiar with the county RTC program, and from a review of the material presented from the *Graves* case. On the basis of interviews that we conducted and the written record from the *Graves* case, we conclude that the Rule 11 program in Maricopa County, at this time, does not have a specific mechanism to override treatment refusal outside of the mechanism found in the Arizona civil commitment process. This situation does not exist in Pima or Yavapai Counties, where program administrators reported the adoption of *Sell* hearings for treatment refusal situations.

That leaves Maricopa County, the largest jail in the state, with its reliance on civil commitment. This situation is untenable in the long run because any program dealing with the evaluation of competency to stand trial and competency restoration cannot operate effectively and humanely without treatment-refusal override procedures that meet current procedural standards. Today, there are two treatment-refusal procedures that might apply in this situation, namely those derived from the Supreme Court decisions in *Washington v. Harper*[3] and *Sell*.[4]

There is controversy about whether the *Harper* procedures can be applied to jails because that deci-

sion focused on treatment refusal in a prison psychiatric program in the state of Washington, which was more like a psychiatric program in a hospital than any program likely encountered in a jail.[25,26] Those who make an argument that a jail is similar enough to a prison hospital that *Harper* should apply, however, should look carefully at the due process required in *Harper*, especially the layers of careful review necessary to force medications in a well-staffed prison psychiatric unit. A review of the 2015 update of the State of Washington Department of Corrections policy for involuntary antipsychotic administration from the Prison Offender Manual should give pause to any jail administration as to their ability to meet these standards.[27] The *Harper* criteria themselves, however, are reasonable and familiar to psychiatrists, as they represent the use of what amounts to civil commitment criteria (mental disorder coupled with grave disablity and danger to self and others) along with due process provided by administrative procedures criteria recognized as far back as *Rennie v. Klein.*[28]

The *Sell* decision speaks directly to the question of competency to stand trial in criminal matters and, as such, was the procedure favored by the Arizona Court of Appeals in *Cotner*. *Sell* represents the combining of government interests in a particular case with strong psychiatric criteria, while at the same time taking into consideration the cautions that were raised in *Riggins v. Nevada* about the danger of psychiatric interventions injuring the defendant at trial.[29] The psychiatric criteria of *Sell* were meant to be taken very seriously, and one can imagine that the Supreme Court never intended to have these criteria used, perhaps hastily, by a variety of evaluating psychiatrists in busy jail settings. It appeared that the Court was talking directly about the psychiatrist treating a patient in a psychiatric hospital unit.

Whether *Harper* or *Sell* can be properly administered in a jail environment awaits future judicial clarification. There is little literature on jail-based RTC programs and little mention of the use of forced medication treatment in these jail programs. Kapoor suggested that jail programs might avoid this issue by referring individuals to hospitals where the staff has the knowledge and ability to provide recognized procedures and treatment to refusing patients.[11] This is what we found in a review of the scant literature regarding jail programs. The RTC program in place in San Bernardino, California,[30] and the pilot project in Atlanta Georgia[31] do not accept treatment refusers or transfer treatment refusers to a state hospital. This is certainly a safe and prudent approach.

The *Sell* decision recognized the importance of civil commitment, but not as a total solution to treatment refusal by pretrial detainees by stating, "We do not mean that civil commitment is a substitute for a criminal trial. The Government has a substantial interest in timely prosecution" (Ref. 4, p 180). So does the defendant.

By relying on civil commitment as its only approach to involuntary treatment, Maricopa County introduces delay into the treatment of refusing detainees. Delays and detainee deterioration are clearly illustrated in the record in *Graves v. Penzone*[23,24] and echo the Supreme Court's cautions in *Sell* about the use of civil commitment as a substitute for a criminal trial. Civil commitment can certainly be an acceptable mechanism for those detainees diverted early out of jail or for those who are truly not restorable and meet civil commitment criteria.

In Maricopa County, the jail-based RTC program currently has no functioning involuntary treatment override procedures other than eventual civil commitment. This means that treatment refusers who may well be restorable are deprived of their criminal trial and subsequently are entered into civil commitment, where there is now enhanced involvement of state prosecutors because of recent legislation.[32] These new statutory provisions allow prosecutors oversight of the results of these civil commitment hearings, with the rumored effect in some cases of charges immediately being refiled against individuals, which results in starting the Rule 11 process again in the jail. Currently, in Maricopa County, there appears to be no mechanism for separating the nontreated from the truly non-restorable.

In conclusion, the situation in Maricopa County, as described in this commentary, summons a view of the national context of people with severe mental illness in the nation's jails. Here the perspective rapidly broadens into a stark picture of people potentially detained and not treated. We know that in some states it takes an inordinately long time to complete an evaluation of competency to stand trial. We believe from observation that this is true in Arizona and hope to study this evaluation component of Rule 11 soon. We know that in many states there is also a significant period between an adjudication of incompetency to stand trial and the transfer of the detainee to a psychiatric hospital bed. We do not know how treat-

ment refusal further complicates these potentially long waits either for evaluation or hospital transfer.

We have been told repeatedly that the nation's jails are the country's new mental institutions, but we know very little about these jails and about the population of individuals with mental illness who are incarcerated in these jails. We do not have research endeavors designed to describe exactly what is taking place in our jails based on data more finely tuned to delineate the characteristics of these pretrial detainees or of the sentenced inmates along lines recently proposed for state hospitals.[33] If these jails are a new form of mental institution, then as a profession we should pay much more attention to them, both in terms of increased research endeavors and advocacy for improvement in what appears to be extremely deleterious situations.

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