January 28, 2019

Re: Civil Action No. 11-cv-02285-NYW

The Honorable Judge Nina Wang
United States Magistrate Judge
District of Colorado
Alfred A. Arraj United States Courthouse
901 19th Street
Denver, CO 80294

This report serves as our response to the first duty listed in your court order dated December 28, 2018, appointing us to serve as Special Masters. Specifically, we have reviewed the Colorado Department of Human Services (CDHS) document titled, "Comprehensive Plan for Compliance" (hereafter, "CDHS Plan"),[1] which describes the efforts of CDHS to improve timely performance of competency services, and thereby comply with the timelines delineated in the 2016 Settlement Agreement (hereafter, "Settlement Agreement"). We have prepared feedback and recommendations regarding the Plan, presented below.

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[1] I.e., the plan initially submitted to the federal court (in response to a court order pursuant to case 1:11-cv-02285-NYW) on December 18, 2018, by the Colorado Department of Human Services and then revised and resubmitted on January 4, 2019.

SOURCES OF INFORMATION

In preparing our feedback to the CDHS Plan, we considered a variety of collateral records in addition to the Plan itself. We also conducted interviews with CDHS leadership and staff, staff at Disability Law Colorado (DLC), and many other stakeholders. Specifically, these sources include:

Interviews and Facility Visits

Facility visits:

1. Colorado Mental Health Institute at Pueblo (CMHIP), January 24, 2019
2. Colorado Mental Health Institute at Fort Logan, (CMHIFL), January 25, 2019

Interviews with CDHS leadership and staff:

1. Jill Marshall, Chief Executive Officer for the Colorado Mental Health Institute at Pueblo (CMHIP), telephone interview on January 14, 2019, and meeting on January 24, 2019
2. Robert Werthwein, Ph.D., Director of the Office of Behavioral Health, telephone interview on January 14, 2019, and meeting on January 24, 2019
3. Michael Tessean, Deputy Director for the Office of Behavioral Health, telephone interview on January 16, 2019, and meeting on January 25, 2019
4. Al Singleton, M.D., Chief of Medical Staff at CMHIP, meeting on January 24, 2019
5. Richard Pounds, M.D., Medical Staff President at CMHIP, meeting on January 24, 2019
6. Victoria Gallegos, Chief Operating Officer at CMHIP, meeting on January 24, 2019
7. Bill Martinez, Director of Forensic Community Based Services, meeting on January 24, 2019
8. David Polunas, M.S.W., Chief Executive Officer for the Colorado Mental Health Institute at Fort Logan (CMHI-FL), meeting on January 25, 2019
9. Lisa Lucas, M.D., Psychiatrist at CMHIFL, meeting on January 25, 2019
10. Danielle, Weitenhiller, Psy.D., Chief of Forensics at CMHIFL, meeting on January 25, 2019
11. Rick Martinez, M.D., Director of Forensic Psychiatry for the Office of Behavioral Health, meeting on January 25, 2019
12. Kathryn Davis, Program Director of Outpatient Restoration Forensic Services, telephone interview on January 21, 2019
13. Thomas Gray, Ph.D., Director of Training for the Court Services Department, telephone interview on January 21, 2019

14. Katie McLoughlin, Chief Legal Director for the Colorado Department of Human Services, telephone interview on January 22, 2019

Interviews with other stakeholders:

15. Karen Galin, Ph.D., Vice President of Behavioral Health at Wellpath Recovery Solutions, telephone interview on January 14, 2019
16. Iris Eytan of Eytan Neilsen LLC, telephone interview on January 14, 2019, and meeting on January 23, 2019
17. Doug Wilson, Former Head of the Colorado Public Defenders Office, telephone interview on January 14, 2019
18. Mark Ivandick, Alison Butler, and Jennifer Purrington of Disability Law Colorado, telephone interview on January 16, 2019, and meeting on January 23, 2019
19. Patrick Fox, M.D., Medical Director of Behavioral Health at Colorado Community Health Alliance, telephone interview on January 16, 2019
20. Adrienne Green, Denver District Attorney, telephone interview on January 21, 2019
21. Jennifer Turner, Colorado Supreme Court, telephone interview on January 22, 2019

Collateral Records Reviewed

Colorado documents reviewed:

Documents received in duplicate from more than one source are cited only once

1. Colorado Office of Behavioral Health Needs Analysis – Current Status, Strategic Positioning, and Future Planning, from the Western Interstate Commission for Higher Education (WICHE) Mental Health Program, dated April 2015
2. Colorado Revised Statutes Annotated, Title 27, Article 60 (C.R.S.A. § 27-60-105), effective August 9, 2017
3. Email correspondence from Mark Ivandick of Disability Law Colorado to Tanya Wheeler, First Assistant Attorney General, regarding request for a report on compliance, dated September 13, 2017
4. Internal Working Document by C-Stat for the Office of Behavioral Health, dated December 2018
5. C-Stat Summary Report prepared by Performance Management of the Colorado Department of Human Services, dated October through December 2018

6. Staff Budget Briefing, FY 2019-20, for the Department of Human Services (Office of Behavioral Health), prepared by Carolyn Kampman, dated December 11, 2018
7. Case 1:11-cv-02285-NYW documents & exhibits:
    a. Exhibit A: Plan submitted by Colorado Department of Human Services, filed December 17, 2018
    b. Exhibit A-1 & A-2: Inpatient bed capacity across facilities in Colorado, filed December 17, 2018
    c. Notice of Errata, submitted by defendants Reggie Bicha and Jill Marshall, filed on December 19, 2018
    d. Exhibit A: Corrected plan submitted by Colorado Department of Human Services, filed January 4, 2019 (aka "CDHS Plan")
    e. Exhibit A-1 & A-2: Corrected inpatient bed capacity across facilities in Colorado, amended January 4, 2019
8. Notice of Filing of Defendant's Amended Comprehensive Plan for Compliance, dated January 9, 2019
9. Colorado Mental Health Institute at Pueblo "Huddle": Presentation slides including information about outpatient and inpatient competency restoration waitlists, referral rates, and future strategies, dated January 4, 2019
10. Letter to Phil Weiser, Attorney General for Colorado; Natalie Hanlon Leh, Chief Deputy Attorney General; Tanja Wheeler, First Assistant Attorney General; Libbie McCarthy, Deputy Attorney General; Sarah Richelson, Deputy Attorney General; and Ann Pogue, Deputy Attorney General from Iris Eytan, Caleb Durling, Ellie Lockwood, and Tim Scalo Re: DLC v. DHS Director, et al. 11 CV 02285 – NYW, dated January 8, 2019
11. Transcription of testimony from Robert Werthwein, Ph.D., to the Capital Development Committee (CDC), dated January 8, 2019
12. Transcription of testimony from Robert Werthwein, Ph.D., to the Capital Development Committee (CDC), dated January 10, 2019
13. Community Risk v. Mental Health Need Matrix, received from Patrick Fox, M.D., on January 16, 2019
14. Letter to Phil Weiser, Attorney General for Colorado; Natalie Hanlon Leh, Chief Deputy Attorney General; Tanja Wheeler, First Assistant Attorney General; Libbie McCarthy, Deputy Attorney General; Sarah Richelson, Deputy Attorney General; and Ann Pogue, Deputy Attorney General from Iris Eytan, Caleb Durling, Ellie Lockwood, and Tim Scalo Re: DLC v. DHS Interim Director Jerene Peterson, et al. 11 CV 02285 - NYW, dated January 25, 2019

15. Documents received from Libby McCarthy on January 9, 2019 (comments from Ms. McCarthy are included in the parenthetical clauses for each document):
    a. Settlement Agreement in Case 1:11-cv-02285-NYW, filed July 28, 2016
    b. House Bill 16-1410, regarding where competency evaluations should occur (became law in 2016)
    c. Senate Bill 17-207, ending the use of jails for emergency holds and expanding the crisis response system (became law in 2017)
    d. Senate Bill 18-249, creating the pre-plea diversion pilot project (became law in 2018)
    e. Senate Bill 18-250, creating the Jail Based Behavioral Health Services program (became law in 2018)
    f. Senate Bill 18-251, creating the Behavioral Health Court Liaison Program (became law in 2018)
    g. Senate Bill 18-252, a bill that proposed overhauling the competency restoration process in Colorado (bill failed by filibuster on last day of legislative session)
    h. Information from CDHS regarding the Stakeholder Meeting and Project Smart
    i. Document submitted to Hickenlooper's administration by DLC lobbyist, titled Statewide Strategic Outlook and Plan for Competency Restoration in Colorado
    j. Letter from Mental Health Colorado, dated January 4, 2019
16. Documents received from Katie McLoughlin, Chief Legal Director of Colorado Department of Human Services, on January 22, 2019:
    a. Competency Judicial Outline Draft, undated
    b. Competency Legislation Judicial Draft, dated January 2, 2019
    c. Competency Legislation Prevention Outline, dated January 14, 2019
    d. Competency Prevention Draft, undated
    e. Letter to Governor-elect Polis, Chief Justice Coats, Speaker Becker, and President Garcia, written by Moe Keller, Director of Advocacy at Mental Health Colorado, dated January 4, 2019
17. Documents received from Alison Butler of Disability Law Colorado:
    a. Detailed chart of the competency restoration process in Colorado and suggested solutions, undated
    b. Competency Restoration in Colorado Fact Sheet, undated
    c. Statewide Strategic Outlook and Plan for Competency Restoration in Colorado, undated

Other sources reviewed:

1. Description of "Forensic Support Team" position, specific to the Philadelphia Department of Prisons, undated
2. Description of "Region-IV Jail Team," a collaborative effort between the Community Services Boards (CSBs) in Health Planning Region–IV, Central State Hospital (CSH), and several jails in the region of Virginia, undated
3. Description of "Boundary Spanner" Position, specific to Eastern State Hospital in Virginia, dated January 2016
4. CS/CB/SB 604: Mental Health Services in the Criminal Justice System, 2016 Appropriations; Judiciary; Diaz de la Portilla (Fla. 2016).
5. Miami-Dade County 11th Judicial Circuit Criminal Mental Health Project Criminal Justice/Mental Health Statistics and Project Outcomes, dated June 8, 2016, retrieved from https://www.equitasproject.org/wp-content/uploads/2018/05/CMHP-Data-Criminal-Mental-Health-Project-06082016.pdf
6. "Decriminalizing mental illness – The Miami Model," written by John Iglehart for the *New England Journal of Medicine,* dated May 5, 2016
7. "Criminal mental health program in Miami-Dade seen as a model for the nation," written by D. Chang for the *Miami Herald*, dated May 21, 2016, retrieved from https://www.miamiherald.com/news/health-care/article79004057.html
8. Settlement Agreement in Case 2:15-cv-00645-RJS-BCW between the Utah Department of Human Services and the Disability Law Center, filed June 12, 2017
9. "Forensic Patients in State Psychiatric Hospitals: 1999-2016 (Assessment #10)," report for the National Association of State Mental Health Program Directors Research Institute (NASMHPD), published August 2017
10. "Alternatives to Inpatient Competency Restoration Programs: Jail-based Competency Restoration Programs," report for the National Association of State Mental Health Program Directors Research Institute (NRI), published October 31, 2018
11. "Alternatives to Inpatient Competency Restoration Programs: Community-Based Competency Restoration Programs," report for the National Association of State Mental Health Program Directors Research Institute (NRI), published October 31, 2018
12. Eleventh Judicial Criminal Mental Health Project Program Summary, dated October 2018, retrieved from https://www.equitasproject.org/wp-content/uploads/2019/01/Program-Description-2018_Miami-Model.pdf

Introduction and Orientation

Before providing feedback or recommendations regarding the CHDS Plan, it is important to explicitly acknowledge our perspective, values, and potential biases. First, our goal is to respond to the CDHS Plan in light of empirical research and well-established best practices. When these sources are not available, we rely primarily on our experience—which includes state forensic administration, consultation to other forensic mental health systems, and direct experience providing forensic evaluation, treatment, and consultation—as well as our understanding of emerging best practices. Of course, our perspective will inevitably be shaped by particular value judgments. The most salient of these value judgments, we believe, involve values that are largely shared by all parties involved in this Settlement Agreement (notwithstanding disagreements about how best to honor these values). Specifically, we believe states have some responsibility to provide high quality mental health services even to those who cannot afford them, that these services should be provided in the least restrictive effective setting, that individuals need not incur criminal charges to receive these services, and that these services should be provided in a manner that improves the safety and well-being of clients[2], stewards state financial resources, and respects the dignity of each individual. We believe—and trust all parties involved in the Settlement Agreement believe—that most mental health services are best delivered in a broad system of care, beginning in the community, rather than solely in inpatient psychiatric hospitals.

Second, we read the CDHS Plan with the understanding that the authors designed the plan explicitly to bring Colorado practice into compliance with the Settlement Agreement. As CDHS leadership repeatedly acknowledged to us, a plan to come promptly into compliance with the

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[2] Throughout this report, the term "client" will generally be used to denote a person with mental illness who is eligible for court-ordered, community mental health, and/or CDHS systems of care. "Patient" will generally refer to clients who are admitted to an inpatient hospital. "Class member" will be used to refer specifically to those individuals operationally defined in the 2016 Settlement Agreement. "Defendant" will refer to individuals charged with a crime and (in reference to this report specifically) engaged in pre-trial court-ordered services, such as competency evaluations or competency restoration. At times, given the overlap across these classifications, terms may be used interchangeably.

Settlement Agreement is *not* the same as a comprehensive plan to improve Colorado's civil and forensic mental health services. The former is, of course, more constrained by time and narrower in focus. The latter may require more time and will always require a broader focus. While we are sympathetic to the challenges CDHS faces in pursuing punctual compliance, we also want to explicitly acknowledge one of our primary values that shapes our review of the plan: Consistent, long-term compliance with the Settlement Agreement can only occur by improving the broader system of mental health care. Any steps to attain compliance that undermine a broader system of care—even if they "succeed" in the short term—tend to exacerbate the problem, or create new problems, in the long term. *Our bias in reviewing this plan is to favor strategies that help foster a broader, integrated system of care conducive to long-term compliance and to disfavor strategies that undermine other mental health services*. Why? Because a state mental health system—like a home plumbing system—is necessarily interconnected. Hasty efforts to reduce pressure in one pipe may create more pressure in others, resulting in new breakdowns, and even more difficult and expensive repairs in the future.[3]

Therefore, we review the CDHS Plan recognizing that it is an effort to achieve compliance as promptly as possible. But we provide feedback in the interests of achieving *long-term compliance*, rather than fleeting compliance or compliance that risks creating other crises. Of course, many of the CDHS efforts to promptly attain compliance are also conducive to long-term compliance; however, where hasty efforts at short-term compliance would undermine long-term compliance, we prioritize the long term. With these caveats emphasized, we present our feedback regarding the CHDS Plan.

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[3] Many stakeholders we interviewed used the colloquialism "robbing Peter to pay Paul" when describing their concerns about certain aspects of the CHDS Plan. To be clear, we do not necessarily object to moving resources from one part of the mental health system to another; there are instances when moving resources is necessary to steward limited resources and "triage" services to areas of greatest need. Our concern is proposing apparent "solutions" to the competency crisis that harm other mental health services, because harming other mental health services inevitably exacerbates the competency crisis, and may create other crises, in the long term.

Overview

Overall, the CDHS Plan has many strengths, as well as many opportunities for further improvement. *Our report does not attempt to address every strength and weakness, nor does it respond to every item in the CDHS Plan*. We chose not to address the individual proposals in the CDHS Plan's "Future Plan for Compliance" section in a point-by-point basis, as this approach begets a scattered and reactive approach instead of encouraging a comprehensive, cohesive, proactive reflection. If asked, we can certainly do so. Rather, we present the broad issues we consider most important. Our task at this point is *not* to develop a plan for CDHS, but rather to review their recently-submitted plan and offer feedback. Nevertheless, we have added to each of our broad recommendations some discrete, recommended action items, as well as some examples from others states, for illustrative purposes.

Recommendation 1:
Make the CDHS "Comprehensive Plan" more comprehensive and cohesive

Many experts have compared the public mental health system to a hydraulic system. Pressures on the entrances and exits to the system are felt system-wide. For example, increased referrals for services at the front end inevitably build pressure in the service components of the system. To reduce that pressure, exit points must exist. The reverse is also true—simply closing the front door does not eliminate existing pressure. Instead, it just diverts pressure to other potential entrances. This is why a comprehensive and cohesive plan is crucial. Nothing happens in isolation. Altering discrete components of a system always influences the pressure in other areas. A comprehensive and cohesive plan addresses the entire hydraulic system so that input pressures are well understood and release mechanisms work in concert to avoid unintended pressures in other areas. A primary example is the balance between forensic and civil mental health systems. As civil capacity decreases to make room for forensic referrals, front-end care is likely to suffer for people without criminal charges—likely incentivizing criminal justice pathways to access services.

We expect CDHS leadership is familiar with these principles. But the CDHS Plan must better account for these principles with a more comprehensive and cohesive approach. Many states and jurisdictions have detailed planning documents that guide their public mental health system. These plans provide context for the challenges faced, describe work and initiatives to date (incorporating detailed data and outcomes), analyze the effectiveness of system components, describe interrelation among components, identify existing gaps, estimate future needs, anticipate future gaps, and delineate future plans that flow from the prior sections. These plans typically include a continuum of planning measures, from broad vision and mission statements down to targeted, specific interventions. Effective plans like this are *comprehensive,* and they are *cohesive*. We recognize that the CDHS Plan does not claim to be one of these comprehensive plans that guides the entire public mental health system, but rather a "Comprehensive Plan" to attain compliance with the Settlement Agreement.

Nevertheless, even this relatively narrow goal will be better served in the long run by a more comprehensive and cohesive approach.

Regarding a comprehensive approach:

The CDHS Plan covers a variety of areas that relate to the Settlement Agreement and the competency restoration process. The CHDS Plan rightly recognizes that there is no single solution or intervention to the problem and that substantial work across multiple areas, settings, and professional jurisdictions is necessary for a sustainable solution. The CDHS Plan touches on many of those areas, albeit with varying detail and emphasis. Some sections of the plan are quite detailed and data-informed; others are far less so. The bulk of the CDHS Plan focuses on two major sections: (a) Department Efforts in 2017 and 2018 and (b) Future Plan for Compliance. The first section is the longest and describes the following efforts:

1. Mental Health Institute bed expansion and reallocation
2. Staffing
3. Expansion of jail-based restoration
4. Contracts with private hospitals
5. Community-based restoration
6. Improved efficiencies at CMHIP
7. Educating judiciary, district attorneys, and public defenders
8. Legislative efforts
9. Partnerships and collaborations

The second section ("Future Plan") is briefer and is organized into the following sections:

1. Short-term solutions not requiring new appropriations
    a. Increasing inpatient bed capacity
    b. Reducing length of stay for inpatient restoration
2. Long-term solutions not requiring further funding
3. Long-term solutions requiring appropriations

In our view, this CDHS Plan clearly reveals substantial efforts to address problems in the competency service system. We affirm those efforts. A comprehensive and coordinated response is not easy, particularly amid additional pressures from litigation, legislative scrutiny,

and media attention. During our interviews, CDHS staff demonstrated clear dedication to serving persons with mental illness and improving the system; our suggestions for improvement should *not* be considered a critique of dedicated CDHS staff.

However, despite these strengths we observed, the current CDHS Plan has several gaps. These will be detailed in later sections of this report, but include the following:

1. A comprehensive, cohesive approach to planning (currently described in this section)
2. A comprehensive vision for increasing capacity that prioritizes community-based resources as highly as inpatient beds
3. A comprehensive approach to community-based outpatient competency restoration
4. A triage system that considers clinical and criminogenic needs to assign individualized services
5. A data-driven system that captures, analyzes, and disseminates data in a reliable and meaningful manner to inform decisions and planning
6. A centralized structure for stakeholders to immediately access detailed information about programs, clients, and settings
7. A plan for prioritizing service quality even amid urgency

Toward a cohesive approach:

An effective, actionable plan must not only be comprehensive, but also integrated and cohesive. As in a good mental health treatment plan, component parts should flow naturally from an overarching vision, moving toward a primary goal and complementing one another as pieces become more detailed. In this way, all stakeholders can easily understand how components are related, and understand the rationale for plans and decisions. Staff in every setting should be able to understand how their roles complement other system components and how they fit into the broader picture.

The CDHS Plan is not cohesive. Generally, the plan comes across as scattershot, with multiple proposals and initiatives (including good ones) listed consecutively, but untethered to a unified, cohesive vision. In this way, the CDHS Plan reads as piecemeal and reactionary rather than cohesive and proactive. The CDHS plan rarely cross-references components, thereby failing to take advantage of many potential opportunities for integrating good services (e.g., how might

the innovative Bridges court liaison program complement outpatient competency restoration?), and failing to address important cross-sectional implications of interventions (e.g., how might a freeze on civil admissions affect other parts of the system?). Again, no piece of the system operates in isolation. Yet the CDHS Plan reads more like a list of isolated interventions than a cohesive network of complementary, interrelated services.

Also indicative of this lack of cohesion, several proposals are listed with substantially different levels of detail. We suspect this reflects the Department's somewhat urgent, disjointed approach to attaining compliance with the Settlement Agreement. There is little uniformity within the written CDHS Plan, leaving one skeptical about the uniformity in planning, implementing, and managing competency-related programs. There is no unifying vision or mission articulated, again making the various sections read as separate and isolated endeavors.

To be clear, the lack of cohesive vision of the CDHS Plan stood in stark contrast to the cohesive vision expressed by most CDHS personnel whom we interviewed. Almost all CDHS personnel were able to describe their vision for an effective system in well-informed, often poignant ways. Staff generally described an ideal system in which Colorado citizens with serious mental illness would have reliable options for effective outpatient and inpatient care, whether forensic or civil. However, most employees also lamented the current state of services and conveyed pessimism about key aspects of the CDHS Plan (as detailed further in subsequent sections). In short, CDHS staff is eager to appreciate and support a comprehensive, cohesive vision for public mental health care. But the CDHS Plan—at least as currently articulated—does not link steps to any broader vision.

Recommendations regarding a comprehensive and cohesive plan:

Once again, we acknowledge the CDHS Plan did not purport to be a comprehensive plan for broad system improvement, but rather a plan for rapid compliance with the Settlement Agreement. Even the CDHS administrators acknowledged ambivalence about the long-term effects of the plan. Most acknowledged the CDHS Plan as less than ideal, emphasizing that they had few options to reach compliance quickly. Nevertheless, the apparent lack of cohesion in

the CDHS Plan is a substantial weakness, and leaves CDHS less likely to attain or maintain meaningful compliance in the long term. *We encourage CDHS to revise the plan in a manner that is truly comprehensive and cohesive*.

Fortunately, CDHS is not the first to struggle with this challenge. Many states and jurisdictions have developed comprehensive and cohesive plans to create meaningful, lasting system change. These effective plans incorporate empirical evidence, best practices from the field, and promising practices from other jurisdictions. They generate meaningful data and use it to refine existing plans. Many states generate proposals for statutory change, integrated with policy changes, quality improvement, and reasonable fiscal notes so that legislative requests can be well-received by lawmakers. Updated roles and expectations with partner agencies are clear and well-integrated with other plan components. The relationships between policy and direct care (and vice versa) are sensible and clearly articulated. Finally, effective plans estimate future needs, addressing sustainability and long-term impact.

The time is ripe for such a comprehensive, cohesive plan in Colorado. The competency crisis is escalating, but Colorado stakeholders have been working on these problems for several years. Momentum remains high. Many pilot programs and recent initiatives are starting to show early promise. In addition, several current drafts of potential legislation are underway. We understand that the pending lawsuit may open new paths for agreed-upon plans, and that the new state administration may provide new opportunities for legislative change and funding. *We encourage leaders at CDHS and DLC to engage in a long-term visioning process that will consolidate disparate pieces of the plan, along with emerging initiatives, into a comprehensive, cohesive omnibus package for courts, administrators, service providers, and legislators to consider.*

There are several examples of effective long-term plans developed in other jurisdictions. None are a “magic pill” that has entirely solved waitlist challenges or all public mental health dilemmas. But all have generated meaningful changes in policy, practice, and statute.

EXAMPLE: Florida

Miami-Dade County has a higher proportion of serious mental illness among residents than other large counties in the United States, but the state of Florida recently ranked 48th in state-funded mental health services nationally. In 2000, Miami-Dade Judge Steve Leifman launched the Eleventh Judicial Circuit Criminal Mental Health Project (CMHP), which included an intensive planning process and ultimately culminated in several sweeping changes for mental health and criminal justice in Florida.[4] For example, the Miami-Dade Forensic Alternative Center (MD-FAC) Program was implemented in 2009 to divert individuals adjudicated as incompetent to proceed or not guilty by reason of insanity away from forensic hospitals to community-based treatment. Coordination among county and state mental health agencies and law enforcement led the county to create a diversion drop-off center to serve as an alternative to jail. Participants receive a range of services, including competency restoration (if indicated), crisis stabilization, community living skills, community monitoring, and assistance with access to entitlement benefits and other means of economic self-sufficiency. For those restored to competency, individuals are not returned to jail but remain in the community, unlike many other hospital-based competency restoration programs.[4,5] By 2016, approximately 400 individuals were diverted from jails and inpatient facilities to community-based services. The average recidivism rate among both misdemeanor and felony participants drastically decreased, as did overall costs and lengths of stays.[4,5] Due to the program's

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[4] "Decriminalizing mental illness – The Miami Model," written by John Iglehart for the *New England Journal of Medicine,* dated May 5, 2016

[5] Eleventh Judicial Criminal Mental Health Project Program Summary, dated October 2018, retrieved from https://www.equitasproject.org/wp-content/uploads/2019/01/Program-Description-2018_Miami-Model.pdf

success, it became a state-wide model in 2016, per Florida Senate Bill 604.[6] The visioning and planning process was key to this coordinated rollout of sweeping changes across Florida.

EXAMPLE: Washington

Washington state long struggled with lengthy waitlists for competency-related services and subsequently faced a federal lawsuit. In 2014-15, Groundswell Services completed a broad forensic systems review and helped prepare a long-term plan for the state. The plan included a process to gather stakeholder input, review inpatient and outpatient data, estimate future trends and service needs, identify systems gaps, and develop interventions based on national best practices and local needs. The process culminated in an actionable plan that led to significant improvements in infrastructure, policies, procedures, and statutes. Changes included creating a central administrative office for forensic mental health, establishing more than a dozen new state forensic evaluator positions, developing satellite offices for forensic evaluation, changing statutes regarding competency to proceed, and obtaining funding for both secure outpatient and community-based competency restoration programs. Although many changes are still ongoing, the master plan has served as the cornerstone for coordinating proposals and initiatives in a unified manner.

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[6] CS/CB/SB 604: Mental Health Services in the Criminal Justice System, 2016 Appropriations; Judiciary; Diaz de la Portilla (Fla. 2016).

Recommendation 2:

Reduce emphasis on inpatient beds and increase emphasis on community services

The CHDS Plan discusses several efforts to secure more inpatient beds for competence restoration services. These include building new beds, reallocating existing beds at the Mental Health Institutes, and contracting with private hospitals.[7] Some of these approaches are reasonable, necessary, and even overdue. There is no doubt that Colorado has far too few inpatient psychiatric hospital beds. Indeed, the 2015 WICHE Report[8] was clear in conveying that Colorado had far too few civil beds for the population in 2014, and that the need for civil beds (let alone forensic beds) would increase with each year. Colorado's general population, including those with psychiatric illness, has certainly continued to increase substantially since 2015.

We also support several of the proposals in the CDHS Plan regarding inpatient hospital development. These include legislative funding requests to expand and/or develop units for competency restoration patients at both CMHIP and CMHIFL. After visiting CMHIP and seeing the double-bunked patient rooms proposed in the Plan, we offer our tentative support for this development (understanding that more analysis may be necessary, and that careful planning for the pairing of "roommates" is essential). This is also crucial at CMHIFL, where multiple patients sharing rooms appears to be the norm; the transition to a forensic population will

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[7] At the time of this report, CHDS has removed from their Plan the proposal to repurpose the Ridgeview facility as an adult facility focused primarily on competency restoration. We therefore do not address this proposal in our review.

[8] "WICHE Report" is the abbreviated title that stakeholders have used to describe the document "Colorado Office of Behavioral Health Needs Analysis—Current Status, Strategic Positions, and Future Planning" prepared by the Western Interstate Commission for Higher Education Mental Health Program (WICHE), in partnership with the National Association of State Mental Health Program Directors Research Institute (NRI) and Advocates for Human Potential (AHP).

require a careful reassessment of this policy to ensure safety and reasonable accommodations. We were struck by the optimism and willingness of CMHIFL leadership to transition to forensic patients, given that their culture and physical campus are both oriented to civil patients. Although we support, in theory, the renovation of some units at CMHIFL to house forensic patients, we urge CDHS leaders to engage in a comprehensive and cohesive planning process before forensic patients are admitted there. Finally, we also support other initiatives described in the CDHS plan, such as identifying improvements to efficiencies and encouraging treatment plans to highlight competency restoration barriers and progress. Clearly inpatient forensic bed space is an essential part of the competency restoration process in Colorado.

While we support some of these efforts to secure more inpatient beds, we emphasize that *securing more inpatient beds is not the primary solution to the competency crisis*. As many stakeholders have quipped, "You can't build your way out of this problem." Bed-building (and even bed-renting)—among the slowest and most expensive strategies—can never keep pace with the increasing need for need for inpatient competence restoration services. Furthermore, such an expensive approach inevitably diverts funding from more efficient and affordable strategies in the community, thereby increasing the number of defendants who require inpatient restoration. Securing some number of additional beds does appear necessary, but securing beds must remain only one step in a viable plan for long-term compliance.

<u>Regarding the plan to "freeze" civil beds:</u>

A key component of the CDHS Plan involves "freezing" civil admissions in order to devote state hospital beds to competence restoration services. Not surprisingly, this has been the most contentious issue among the stakeholders we interviewed and in the public documents we reviewed. Indeed, even CDHS staff and leadership have lamented the "civil bed freeze" as an undesirable, drastic measure to gain prompt compliance with the Settlement Agreement. Virtually all stakeholders we interviewed, as well as third-party reviewers such as WICHE, agreed that Colorado already struggles with a shortage of beds for civil psychiatric patients and

that this shortage already causes significant problems. Decreasing civil inpatient capacity only exacerbates this shortage.

Even amid a desperate need for additional competence restoration beds, *meeting this need with civil beds is not a viable, long-term strategy*. Much like a family in a financial crisis tempted to pay monthly bills with a high-interest credit card, the strategy may seem the only option to meet desperate needs in the short term. But with each month, the short-term "solution" exacerbates the underlying problem and eventually exhausts all resources, creating a more desperate crisis. In our view, sacrificing inpatient civil psychiatric services to meet competence restoration needs is a similarly expensive, short-term "solution" that actually exacerbates the underlying problems.

To be clear, there are also important philosophical and humanitarian reasons to protect the last remaining components of public, inpatient civil psychiatric services in Colorado. Several stakeholders—particularly long-term staff at the CMHI facilities—described these in compelling terms. But even the most utilitarian analysis leads to the same conclusion: Ending civil admissions to expand inpatient competence restoration has the perverse effect of incentivizing criminal charges among those who need psychiatric treatment. When competence restoration is the only route to inpatient psychiatric treatment for people with psychiatric illness and scant resources, those people become much more likely to receive criminal charges. This well-known phenomenon—sometimes labeled "the criminalization of mental illness"—is a primary *cause* of the current competency crisis nationwide, but it will also be an inevitable *consequence* of the Colorado competency crisis if civil beds are "frozen." Eliminating civil psychiatric services only increases the underlying competency crisis.

We strongly encourage CDHS to abandon the "civil bed freeze" and any other strategies that drastically curtail civil psychiatric services. Though these may appear to be some of the only routes to punctual compliance with the Settlement Agreement, we anticipate they will exacerbate the competency crisis and so make long-term, sustained compliance far less likely.

***Regarding efforts to rent beds in private hospitals*:**

The CDHS Plan mentions pursuing contracts with private hospitals to treat "low-risk" defendants or "to receive some of the Department's civil patients, in turn increasing inpatient capacity" at the state hospitals. Private hospital beds may be a perfectly reasonable choice for civil patients, and such a placement may help increase forensic capacity at the CMHI facilities. But private hospitals—particularly several private hospitals with small capacities (3 or 5 beds)—are poor choices for competence restoration. Providing consistent staffing and restoration services to incompetent defendants seems unlikely if the population is scattered across private hospitals. CDHS oversight of their status and progress will be inevitably compromised.

We encourage CDHS to maintain consistent care over those receiving inpatient competence restoration, rather than "spreading them thin" across the private hospital system, where it will inevitably be much harder to maintain quality control and consistent services. Rely on private hospitals for what they do best: providing acute care for civil psychiatric patients.

Recommendations regarding inpatient beds and community resources:

All stakeholders and leaders have acknowledged that CDHS "cannot build its way out" of the competency crisis by building inpatient beds, but rather that CDHS requires a continuum of care, particularly community resources. How, then, does CDHS best utilize beds as well as community resources? The CDHS Plan, in our view, requires a better strategy to direct those (and *only* those) who truly require inpatient care into inpatient restoration, and those suitable for various community-based interventions into those interventions. Such a strategy must be part of a comprehensive, cohesive plan (see Recommendation #1) and requires a thoughtful triage approach (see Recommendation #3). Combining these with strong data collection and data-based planning (see Recommendation #5) would allow CDHS to provide much more rigorous estimates regarding inpatient bed needs and community resource capacity. As CDHS leadership and all stakeholders have acknowledged, the solution is not deciding between

inpatient beds *or* community resources, but providing inpatient beds *and* community resources, while using thoughtful guidelines to determine who requires which.

EXAMPLE: Arizona

Approximately 20 years ago, Maricopa County, Arizona, faced substantial challenges assisting Persons in Crisis (PICs) with mental health concerns. Law enforcement officers were picking up PICs and had nowhere to take them. Their only option was to utilize emergency departments (EDs) in hospitals at a cost of about $2500 per ambulance pickup and evaluation. Then the PIC would either stay in a medical bed for 3-5 days and be released back to the community, or—more often than not—get released back to the community within a few hours of evaluation with no structure for continued care. This inevitably led to a revolving door system of care, because the system was geared to only attend to the crisis event as opposed to the continuing needs of a person with mental illness. Furthermore, when an officer made the transport to the ED, the officer would often have to wait in excess of three hours for the PIC to be evaluated, only to eventually be told that the person was not being admitted. As officers became frustrated with a broken system, it became much easier for the officer to arrest and detain the PIC as opposed to spending hours with the PIC in an ED where they rarely received effective care. Increased criminalization of the mentally ill led to an increased burden on the courts as they were now being overloaded with individuals with severe mental illness who then required evaluations for adjudicative competency and criminal responsibility.

Significant system change began with officers who worked for the Phoenix Police Department but understood larger systems issues. They developed Crisis Intervention Teams (CITs) to train law enforcement officers to interact more effectively with PICs, as well as build collaborative relationships between systems. Through their efforts, ultimately the state assisted in funding stand-alone psychiatric drop-off facilities for law enforcement and other first responders.

Twenty years later, in present-day Maricopa County, the following protocol is in place for assisting a PIC:

1. A PIC (or an individual assisting a PIC, such a law enforcement officer) contacts the 24-7 crisis center hotline for help (the crisis center receives approximately 21,000 calls per month);
2. Approximately 90% of those calls are de-escalated on the phone with no need for additional follow-up;
3. Of the remaining 2000 calls per month, crisis mobile (2-person) teams physically respond to de-escalate in the community;
4. Crisis mobile teams are able to stabilize approximately 72% of PICs in the community;
5. PICs who cannot be stabilized in the community are taken to an Urgent Psychiatric Center stand-alone facility (i.e., not part of a hospital) by crisis mobile teams (approximately 560 people/month);
6. Law enforcement officers can also request the assistance of a mobile crisis team or bring PICs directly to one of the urgent psychiatric stand-alone facilities.

As compared with a multi-hour wait time at an ED, law enforcement officers now enjoy a wait time of between one and seven minutes at three drop-off facilities in Maricopa County.

The urgent psychiatric facilities each have approximately 50 dedicated recliner chairs to assist someone in detox or psychiatric crisis for up to 24 hours. As the 24-hour time limit approaches, PICs are further triaged to determinate if they could be stabilized by a short-term inpatient stay at the urgent care facility (i.e., 7-10 days) or if they need to be transferred to a state psychiatric hospital. Individuals with criminal justice involvement are typically transferred to a state hospital in order to receive forensic evaluation and restoration services.

Upon release from any of these levels of care, PICs are linked with intensive case management, behavioral health homes, and other services to help manage individuals with severe mental illness in the community.

Of course, the Arizona model is not perfect for every state, but it serves as an illustration of a comprehensive plan to match people with the level of care appropriate to their needs, reserving inpatient admissions for those who most need them, and offering a continuum of community-based services for those who do not.

Recommendation 3:

Further prioritize outpatient competence restoration

A key example of prioritizing community services over inpatient services—and a key strength of the CDHS Plan—is the emphasis on increasing "outpatient" competence restoration, both in the community and in the jail. Nearly every state that has improved competency services has included outpatient restoration as a key component of their plan. As of recent reviews, at least 16 states use some form of outpatient restoration services, and several have comprehensive state-wide outpatient restoration services.[9]

We affirm the CDHS efforts to pilot outpatient competence restoration services (OCR)[10], and expand OCR upon preliminary evidence of success. Indeed, our interviews with Kathryn Davis (Program Director of Outpatient Restoration Services) suggests even broader (or soon-to-be broader) implementation of OCR than is detailed in the CDHS Plan. Similarly, the RISE program is a particular strength of recent CDHS efforts. It appears[11] to provide necessary restoration services in a jail unit while separating the restoration program from general jail population, thereby mitigating many of the common concerns about jail-based restoration. We therefore

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[9] "Lookin' for beds in all the wrong places: Outpatient competency restoration as a promising approach to modern challenges," by Gowensmith, Frost, Speelman, and Therson (2016), *Journal of Psychology, Public Policy, and Law, 22, 293-305*.
This article summarizes results of a nationwide survey of state forensic mental health directors regarding their state's statutory authority for, and implementation of, formal outpatient competence restoration programs.

[10] We recognize that CDHS uses the term "outpatient competence restoration" to include both community-based and jail-based settings. The larger literature generally restricts the term to community-based settings. In this report, the terms "outpatient competence restoration" and "OCR" will be refer only to community-based restoration.

[11] In our role as court monitor, we anticipate site visits in the near future to better learn the details of particular CDHS initiatives. Given the tight timeline to construct this report responding to the CDHS Plan, and our priority on other site visits and interviews (listed earlier in this report), we have not yet visited RISE or community-based competence restoration programs. Our impressions are based on information we have read in the CDHS Plan or heard in collateral interviews.

tentatively support the CDHS Plan's proposal to expand RISE in a new county correctional facility, but only if the same parameters of the current RISE program are kept intact. In our view, these steps toward state-wide OCR services are a crucial step toward better allocation of resources and long-term compliance with the Settlement Agreement, provided they are implemented with strong quality control (see Recommendation #7). Indeed, subsequent to legislative action (SB 17-012), the Department has the responsibility and authority to widely expand these services. *Therefore, we encourage CDHS to go even further in implementing outpatient competence restoration*.

Although CDHS has mentioned some concerns about expanding OCR, these seem largely surmountable. For example, during interviews with the Department, we heard several concerns that judges did not order OCR often enough, that many CMHCs did not want to provide OCR, and so forth. Likewise, the CDHS plan mentions the following:

> While a court's ability to order a defendant inpatient for a competency evaluation is somewhat limited by statute, there is no similar limitation concerning orders for inpatient competency restoration…. And so, an overwhelming majority of defendants ordered to receive competency restoration services are required to do so on an inpatient basis at …CMHIP.

This challenge reveals at least two opportunities for intervention: First, statutory changes are rarely easy, but some states have indeed changed statute to prioritize outpatient restoration. Second, judges' tendency to order inpatient restoration is not immutable. Departments (comparable to CDHS) in other states have initiated state-wide interventions to educate the judiciary, essentially teaching judges to prioritize outpatient restoration as the default option, and order inpatient restoration only when necessary. In short, *most of these perceived barriers to OCR can be addressed with a comprehensive statewide plan*. Wide-scale implementation of OCR works best with a comprehensive "roll out" that not only launches services, but explicitly changes policy, educates judges, and educates evaluators.

Finally, CDHS reported that judges express an understandable wariness about OCR due to the risks (e.g., violence, failure to appear, substance abuse relapse) that some defendants pose

when released to the community. We recommend a triage approach to assessing these risks (Recommendation #4), but we also recommend that CDHS consider making better use of some of their existing resources to manage these risks. For example, CDHS appears to have a well-developed Forensic Community Based Services (FCBS) with well-established procedures for managing not-guilty-by-reason-of-insanity (NGRI) acquittees who are on conditional release in the community. We see no reason that this program—with its ideal staffing ratio, well-established procedures, and established expertise—could not be extended or modified to provide supervision and case management for defendants engaged in outpatient competence restoration. This would be a step towards making OCR more viable for more defendants and more palatable to the courts, and it would also be a step towards making the CDHS services more comprehensive and cohesive (see Recommendation #1). As best we can tell,[12] FCBS represents a "hidden gem:" a good CDHS service that is currently operating in isolation, but could be expanded and better integrated to help address the current competency crisis.

Recommendations regarding outpatient (community-based) competency restoration:

CDHS need not implement OCR exactly the way other states have (each state has unique needs), but they could benefit from a planned, comprehensive, wide-scale "roll out" of interconnected OCR services. This kind of wide-scale implementation certainly does not preclude pilot projects; indeed, pilot projects are often crucial to inform and develop more wide-scale efforts. But, ultimately, the CDHS Plan to attain compliance with the Settlement Agreement should rely on comprehensive and cohesive efforts (see Recommendation #1) to implement wide-scale OCR, in a manner that ensures high-quality services (see

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[12] Again, we could not conduct a comprehensive visit or review of FCBS while we were prioritizing other site visits and interviews in order to complete this report on a tight timeline. Our impressions are therefore based primarily on our interview with FCBS Director Bill Martinez, and favorable comments from other stakeholders. We cannot be sure the FCBS can aid OCR in the way we hypothesize above, but we certainly consider this a promising possibility. It serves as another way CDHS could better integrate (make cohesive) some of the strong resources they already offer.

Recommendation #7). Again, we affirm the CDHS efforts to develop OCR, and *encourage them to forge ahead in thoughtfully implementing wide-scale, high-quality OCR.*

Virginia's approach to launching OCR is a good example of a coordinated, comprehensive, and successful "roll out" of OCR that encouraged statewide implementation and uniform services.

EXAMPLE: Virginia

When Virginia faced waitlists for inpatient competency restoration services, they implemented a comprehensive plan to "roll out" outpatient restoration services for defendants who could be restored to competence outside of a hospital. Of course, doing so required educating all stakeholders as well as changing the longstanding practice of relying solely on inpatient restoration. Among the coordinated steps by the Virginia Department of Behavioral Health and Developmental Services (DBHDS) were the following:

1. Virginia changed statute to specify that OCR was the default restoration approach. Judges were instructed to order outpatient restoration unless there was clinical need for inpatient services.
2. Virginia DBHDS held coordinated trainings for judges, educating them on the new statute and the OCR system.
3. Virginia changed the statute governing competence evaluations to direct evaluators, when they opined a defendant was not competent, to offer a clinical recommendation for inpatient or outpatient restoration.
4. Virginia DBHDS, as part of its training program for evaluators, educated them to offer the recommendation regarding inpatient versus outpatient restoration.
5. Virginia DBHDS developed a series of jail-based restoration programs.
6. Virginia DBHDS contracted with all community mental health centers to include OCR among the community services each clinic provided and to include forensic-savvy staff who were able to provide OCR.
7. Virginia DBHDS contracted with the University of Virginia to develop restoration curriculum and train all restoration providers to provide high-quality restoration services. Identical trainings and curriculum throughout the state ensured that restoration services were uniform across the state.
8. After implementation, Virginia continued to monitor OCR services (including restoration rates, quality measures, etc.).

Recommendation 4:

Prioritize a triage approach over traditional waitlist approach

All defendants have a constitutional right to face their charges and assist counsel with adequate understanding. Stated differently, all defendants have a due process right to be competent, and therefore incompetent defendants have a right to competence restoration services. However, *not all defendants require exactly the same treatment for restoration*. Defendants may be incompetent for different reasons; some require inpatient psychiatric care and some do not.

Modern, best-practice competency services systems function, in some ways, like a hospital emergency room. Those with the most acute treatment needs receive priority access to more intensive interventions, whereas those with less urgent needs may receive less immediate and less intensive services. Likewise, more acutely ill defendants will receive clinical restoration services more quickly than more stable defendants. This service delivery is not equitable in the strictest sense, but it bests allocates limited resources and prioritizes those with greatest needs in a way that best reduces suffering and clinical decompensation.

Compare the modern model above with traditional competency services systems that function more like the Department of Motor Vehicles. Defendants, regardless of need, “take a ticket” and receive service (usually the same service) in the order they appear. This model may have been accepted in an era that prioritized inpatient care and enjoyed ample bed space. But this model is increasingly untenable and undesirable in an era that prioritizes community-based care and has scarce inpatient beds available. The triage model is also inconsistent with more modern approaches to matching level of service with level of need (including both clinical and criminogenic needs).

Regarding the current CDHS competency services system:

The current CDHS competency services system is not entirely a traditional, "take a ticket" system. Admirably, CDHS now manages a greater variety of competence restoration settings and resources, ranging from inpatient hospitals to jail-based placements to community-based settings. This places Colorado among the more modern, best-practice states that support a continuum of restoration options. Again, we affirm the options for outpatient restorations in the CDHS Plan.

However, there is still considerable delay in Colorado for many defendants to access any of those restoration options. One reason for the delay is that courts receive little case-specific information when ordering competence restoration. Currently, CDHS does not routinely provide courts with clinical information that could influence court-ordered restoration placement decisions. Indeed, it appears that the only current way for incompetent defendants with acute treatment needs to "jump the line" is with a show-cause order from the court. However, it is not clear to us whether all defendants with a show-cause order are indeed in need of urgent treatment, or whether all defendants in urgent need of treatment receive such an order. In short, the show-cause orders are not necessarily a reliable means for prioritizing admissions. CDHS requires a better, more consistent strategy for identifying which defendants warrant which restoration services.

Moreover, CDHS leaders have been clear for several years that not all court-ordered admissions to CMHIP warrant inpatient hospitalization. Criteria for inpatient admission can vary and may not always equate to the strictest "imminent danger" criterion. However, current CDHS administrators have, they reported, very recently identified a preliminary set of clinical hospital-level criteria with which to compare to the clinical acuity of incoming patients (see Recommendation #5). Although preliminary, administrators recently estimated that approximately 10-20% of people adjudicated incompetent and ordered to inpatient restoration

do *not* meet hospital-level clinical criteria (that is, they do not warrant hospitalization).[13] Of course, sending defendants to hospital-level care when unwarranted reduces inpatient space available to those who truly need it. Even a 10% difference (i.e., admitting 10% more for inpatient restoration than truly warrant inpatient care) can result in significant delays for those who legitimately require inpatient hospitalization.

Regarding clinical eligibility versus legal suitability:

Typically, two main variables are at play when determining restoration placement: clinical eligibility and legal suitability. These two concepts operate largely independently of one another. First, incompetent defendants have a continuum of clinical needs, ranging from those who are reasonably stable to those who are acutely, severely psychotic and warrant immediate inpatient treatment. These needs determine "clinical eligibility," in that different clinical needs require different levels of clinical care. Second, defendants vary according to their criminal charges and risk management needs, ranging from misdemeanants and non-violent defendants to the most serious of violent felony offenders. Courts must also therefore determine the "legal suitability" of placements; the defense, prosecution, and judges must weigh various placement options from a risk management / public safety perspective.

Some defendants may be clinically appropriate for community restoration but not legally suitable. Conversely, some may be legally suitable for the community, but clinically require inpatient care. But there are many times both variables align for the same placement.

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[13] We encourage CDHS to develop more formal criteria for determining which incompetent defendants truly warrant inpatient care, and then use these criteria to analyze admissions. The clinical criteria used for these estimates were not shared with us, so we cannot comment on the accuracy of the 10-20% estimate that CDHS recently offered. Furthermore, of the few CDHS representatives that had attempted any formal estimates of this issue, they provided different figures (and those asked to provide informal estimates provided even more divergent figures). However, identifying and sharing the criteria for inpatient treatment is an important quality-management procedure that can help inform decision-making and related priorities (e.g., educating courts, prioritizing earlier assessment and triage, etc.). We discuss this issue further in Recommendation #5.

Assessment of *both* clinical eligibility and legal suitability are essential to adequately inform optimal restoration placement.

Regarding the role of triage:

The CDHS Plan is largely silent on the issue of triage. Monthly reports and other data sources do not appear to address clinical needs or underlying basis for incompetence (e.g., acute psychosis, intellectual disabilities, etc.). The CDHS Plan could do much more to incorporate a triage approach to competence restoration services, tailoring the right service to the right defendant. Many states and jurisdictions employ a triage system to quickly assess clinical eligibility and legal suitability to nimbly and rapidly provide placement decisions for incompetent defendants.

Whereas a strength of the CDHS Plan is that it includes a continuum of services, a weakness of the CDHS Plan is that there is no mechanism to provide the court with a timely assessment of clinical and criminogenic needs that will help the court make placement decisions. Historically, there has been no mechanism for providing such information in a timely manner. However, recent initiatives—such as the 29 “Bridges court liaison” positions recently created across all 22 jurisdictions through SB 018-251—now make a triage approach more viable than ever. Additional CDHS positions could supplement these liaison positions by tying clinicians to various courts to provide quick competence screening or clinical screening, advising the court on placement options.

For example, imagine a model with the following components:

1. Each court has a neutral liaison (see SB 018-251) who can assess a defendant’s criminogenic needs. This liaison has access to risk-related information such as criminal histories, criminogenic factors (e.g., housing placements, employment, education), and previous failures on community release. The liaison provides this information to the court at the time of the competency hearing.

2. Forensic evaluators, in addition to assessing competence, also assess each defendant on specific clinical criteria for inpatient care. Evaluators provide an opinion on competence and, for those defendants they opine are incompetent, a recommendation regarding level of clinical care.
3. When the court adjudicates a defendant incompetent, the court considers both risk (and criminogenic needs) and clinical suitability.
4. Courts coordinate with a court liaison and/or forensic coordinator (see Recommendation #6) to determine if outpatient restoration is an immediately viable option. If so, the defendant is ordered to outpatient restoration immediately.
5. For those not clinically eligible or legally suitable for outpatient restoration, the court sends both sets of recommendations to CDHS OBH administration upon finding the defendant incompetent.
6. OBH administration prioritizes inpatient admissions for those that meet applicable clinical and risk management criteria.
7. For those defendants not suitable for outpatient restoration, but also not meeting the highest levels of clinical acuity, mental health personnel provide assertive assessment and treatment in the jail until inpatient admission occurs (still adhering to appropriate maximum timeframes still in place).

<u>Caveat:</u>

We consider a triage model like this ideal, but it cannot be implemented hastily (see Recommendation #7 regarding quality control). Currently, there is no statutory guidance or CDHS guidance for forensic evaluators offering opinions about clinical criteria (indeed, no such criteria appear to currently exist). Well-informed opinions require collateral information review that is not routinely accessible to the evaluator in a timely fashion. Lastly, formulating risk-related opinions take time, both at the assessment and writing stages, which runs counter to the current pressure to complete competence evaluations in a timely manner. Finally, we do not advocate for court services evaluators to opine on criminogenic risk or related placement

decisions; the above issues are only more pronounced in such circumstances. Any changes to evaluator duties (and delineating duties for new court liaisons) will take careful, thoughtful planning.

Recommendations regarding a triage approach:

We strongly encourage CDHS to develop a triage system to provide the court with clinical eligibility and legal suitability information at the time of the competency hearing. Within such a triage system, clinicians must still assess and treat the individuals assertively. Those who do not receive immediate inpatient treatment still require treatment and monitoring. If a defendant appears to become competent while awaiting transfer to an inpatient facility, a process for quickly providing that information to the court is critical. More importantly, if defendants show signs of increasing clinical acuity, they must be prioritized for inpatient transfer. Of course, reasonable maximum timeframes must still apply to all defendants waiting in jail who have been ordered to competence restoration, regardless of their levels of clinical stability.

EXAMPLE: Virginia

The Region-IV Jail Team:
The Region-IV Jail Team in Virginia employs a comprehensive approach that involves identification, treatment, and management of persons with mental illness in a jail setting. The jail team is unique because it partners with multiple agencies, including a maximum-security state hospital, several local jails, and community mental health centers within a particular region of central Virginia. The team is designed to divert offenders (when clinically appropriate) from inpatient competence restoration and is comprised of a forensic psychologist, restoration counselors, a jail diversion coordinator, and an administrative assistant. The team works collaboratively with Central State Hospital (CSH) to identify defendants who are on the forensic waitlist and assess if they are appropriate for restoration services in the jail. Conversely, defendants who are more acutely ill and in need of inpatient restoration are identified early and scheduled for rapid admission to the state facility. The courts in the region can also order jail-based restoration directly. For individuals returning to the jail following inpatient restoration services, the jail team provides a critical role in maintaining competence while the defendant awaits a disposition in their case, and, if needed, will advocate for earlier court dates to reduce

the likelihood of decompensation in the jail. The jail diversion coordinator's main function is to close the gaps for persons with mental illness who are reentering the community. The coordinator will follow the individual for 30-60 days post-release to aid in continuity of care from the jail back to the community, a critical time for those needing service linkage to multiple agencies to address multiple needs. The Region-IV Jail Team is unique in that it closes the gaps between the state facility, the jails, the courts, and the community, following the defendant at all points across these interwoven systems.

Eastern State Hospital:
Forensic and civil orders for treatment in eastern Virginia rose steadily over the last several years, leading to at-census or over-census bed use at Eastern State Hospital (ESH), with no plan to allocate additional beds. This catchment area has the largest number of forensic admissions of any in the state, serving 67 different court jurisdictions (six of which have mental health dockets and/or courts), all of which create additional layers of complexity to coordinate services across all of these systems. Further, Hampton Roads Regional Jail, coined by the *Daily Press* "by default, Virginia's largest mental hospital" is in this catchment area.

The constant flow of pretrial and emergency admissions prompted a careful examination of their inpatient restoration system. In January 2016, the Department of Behavioral Health and Developmental Services (DBHDS), Eastern State Hospital (ESH), and Central State Hospital (CSH) developed a position to screen and assess persons in Hampton Roads Regional Jail (HRRJ) ordered to inpatient restoration. The position triaged clinically fragile inmates for rapid admission to the state facilities, advocated for their medical needs in the jails, and aided in coordinated reentry planning with our local community mental health centers. Management and oversight flows through the pretrial forensic coordinator at ESH. The approach is that of a boundary spanner communicating directly with the jails, medical staff, local community services boards, and the state facilities to provide a continuum of care for vulnerable individuals that crosses institutional boundaries.

Recommendation 5:

Make better use of data

The CDHS Plan lacks adequate, specific data on which to base its projections and recommendations. The Plan rarely mentions source material or calculations for projecting service needs, raising doubts about the accuracy of some of those projections. The same is true for calculations of inpatient bed space, CMHC capacity, financial estimates, and other key considerations. Several areas of the plan include no data whatsoever. Moreover, little is written about the need for data, leaving us to wonder what role data plays in planning. Of course, in a period of crisis, CDHS may rightly prioritize service delivery over data collection. But data collection and management are crucial to planning and delivering services.

As alluded to previously, an ideal CDHS Plan would have included well-researched estimates of the proportion of CMHIP patients who *actually met admission criteria* and warranted inpatient treatment versus the proportion of patients ordered to receive inpatient restoration even though they did not truly require inpatient treatment. These data are a starting point to inform basic planning questions (e.g., How many inpatient beds do we truly need? How many individuals would be appropriate for outpatient restoration?). But when we asked CDHS personnel about such data or estimates, we received widely discrepant estimates. Fortunately, one CDHS staff appeared to track such data (Dr. Victoria Gallegos of CMHIP).[14] Separately, CDHS leadership reported that they had also, very recently (within the last month), begun considering similar questions and offered a somewhat different estimate. Unfortunately, these efforts did not appear to be coordinated, and the estimate from leadership appeared to reflect a very recent exercise. These empirical questions should have been part of the problem-solving

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[14] Dr. Victoria Gallegos of CMHIP seemed to maintain important hospital data, and was the only CDHS leader we interviewed who was able to consistently answer questions with specific data. She was able to understand, share, and explain that data well during our brief interview. Our impression is that CDHS could go much further in making use of her data collection, management, and expertise.

process for years. Such basic data are crucial to an effective plan, and it is necessary to inform questions about inpatient bed needs, community resource capacity, and the best strategies to serve the population of incompetent defendants across the continuum of care.

Currently, the potential for a truly data-informed system at CDHS remains unrealized. During some interviews with CDHS staff and other stakeholders, we were encouraged to hear that programs were collecting some form of data. During other interviews, we were concerned that CDHS staff or leadership could not provide basic (even estimated) data, such as census estimates or estimated patient populations in various settings. On the one hand, many people we interviewed seemed to recognize, at least in principle, the importance of tracking data. On the other hand, many people we interviewed seemed to lack a fluency with CDHS data or understand how such data could be useful to inform decisions and services. This underscored our concern that data was not meaningfully incorporated into the important work of CDHS employees, such that staff and units may be operating in ignorance about key elements of their work.

Given the minimal data in the CDHS Plan and the relatively few data-specific answers during our interviews, we continue to have many unanswered questions about the role and use of data in CDHS. The origins of most CDHS data are unclear. The process of data collection is also unclear. Beyond the data from Dr. Gallegos at CMHIP, we cannot determine, for example, how particular data come into the CDHS office, who manages them, or who analyzes them. It is critical to have clear processes for data collection, identified channels for data transmission, clearly reported data, and dedicated personnel for data management in order to develop and maintain a data-driven system.

Regarding the accuracy of CDHS data:

Beyond the concerns about gaps in data, there are some credible concerns about the accuracy of some CDHS data that *does* exist. Disability Law Colorado (DLC) staff reported that much of the data they received from CDHS in 2015 were revealed as inaccurate when they called jails,

hospitals, or families or otherwise checked on the status of individuals. That inaccuracy led to the reopening of the previous settlement agreement and has continued to be a divisive issue since. It led to a great deal of lingering mistrust between DLC and CDHS. Improving accuracy in future data reports will be essential to repair trust and to accurately informing policy and service delivery.

Recommendations regarding a data-informed system:

Beyond specific concerns about data gaps and data accuracy, our primary recommendation is for CDHS to better prioritize the role of data in their routine operations and planning. Some areas for better data collection and data-driven recommendations include the following:

- Court services (e.g., referral sources, defendant demographics, evaluation information, base rates of opinions, time frames or causes for delays)
- Short-term and long-term bed projections (based on population, age, service needs, the 2015 WICHE study, and other sources)
- Financial costs of each outpatient and inpatient program
- Operational variables and outcomes of Bridges court liaison program
- Restoration time frames across different types of patients and settings

The above are just some examples, and many other areas need data-driven and data-informed policies. The need for effective data collection, management, and dissemination appeared pervasive across CDHS.[15] Fortunately, the inception of several new programs (e.g., outpatient restoration, Bridges, etc.) provides an excellent opportunity to begin data collection with each. Effective data-driven systems help employees experience data as critically important, easy to use, and directly meaningful to their work. *We recommend stronger efforts from CDHS to create*

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[15] Again, an important exception was Dr. Gallegos's data collection at CMHIP. However, it was not clear to us whether CDHS leadership or CMHIP operational staff was benefitting from these data.

meaningful, effective, and transparent data collection, management, and dissemination policies, procedures, and infrastructure.

Though a thorough recommendation for data management and data-based planning is far beyond the scope of this report, we provide a case example below. Our perspective is that the CDHS Plan could be greatly enhanced with more detailed data, and that ongoing compliance efforts will require better data tracking and greater transparency with that data.

EXAMPLE: Hawaii

One example of data-driven planning comes from the state of Hawaii's Adult Mental Health Division. The Courts and Corrections branch is responsible for court-ordered evaluations of competence, sanity, and need for hospitalization. The state of Hawaii has experienced the same dramatic rise in competence evaluations from 2008 to present that Colorado and most other states have experienced. In 2010, the branch created a data system to collect information regarding referral sources, demographic data, and forensic opinions. The data were intended to better inform administrators about trends in referrals and outcomes. Branch clerical staff maintained a database of referral information, evaluators completed brief data sheets for each evaluation, and administrators created a system to analyze data across a variety of variables.

These data were useful in many ways. Courtrooms and counties with high rates of referrals but low rates of incompetence findings were targeted for judicial training and education. Base rates of competence and sanity opinions were collected to compare departmental rates against national norms, as well as to identify and educate evaluators that strayed significantly from expected ranges of base rate findings. Finally, comparisons of opinions on multiple-evaluator cases as well as the creation of a peer-reviewed report quality improvement system allowed for a better understanding of variables that lowered evaluation reliability, validity, and quality—setting the stage for specific training emphases at annual evaluator trainings. Implementing this data-focused procedure was fairly simple for evaluators and clerical staff alike; in the modern age, handheld technology and portable computers make it even easier to code brief fields of data almost immediately.

Again, this example is meant to be illustrative, not prescriptive. Some pieces may fit for CDSH, some may not. The intention is to encourage CDHS leadership to consider how a richer data system can impact and improve efficiency, planning, and client outcomes.

Recommendation 6:

Create a central system of easily-accessible information for stakeholders

Many stakeholders described practical difficulties that arise because CDHS lacks a centralized point of contact to provide immediate information about specific individuals and programs. Stakeholders conveyed that they do not know whom to contact (or how to contact) the appropriate CDHS personnel with emergent questions that could inform decision making and treatment planning. Likewise, our understanding of the CDHS Plan is that it lacks any central mechanism to obtain data on a particular defendant receiving restoration services.

Several states and jurisdictions employ these types of centralized positions or provide an accessible access point for obtaining this information. At times, the access point is a specialized department or office in the forensic services branch. In other systems, specific positions are used for this function; they are often called forensic coordinators, boundary spanners, forensic liaisons, or forensic network specialists. Regardless of the name of the office or personnel, the goal is essentially the same: *provide an easy and consistent access point for approved stakeholders to obtain current information about forensic clients and programs*.

In our interviews, stakeholders were often frustrated by the lack of current information about forensic clients and programs. For example, attorneys reported difficulty knowing about their client's progress through competence restoration, the status of competence evaluations, current competence restoration placements, or the possibility of openings in specific community-based forensic programs. Likewise, clinical workers and CDHS line staff reported difficulty understanding treatment and placement options, accessing legal documents, or knowing dates of upcoming court hearings. This lack of information slows the forensic process unnecessarily—court hearings are delayed or reset, patients stay in unnecessarily restrictive placements (or county jails) when alternative placements may be available, and so on.

Forensic coordinators (to use one of the many position titles mentioned above) alleviate this inefficiency. They know where each client is at all times—which housing placement, which

clinical program, which jail, which hospital, and so on. They have contact information for the relevant professionals surrounding the client's care—psychiatrist, case manager, housing provider, court clerk, restoration provider, etc. They have copies of relevant court orders and treatment plans. At times they provide limited treatment services (such as psycho-education or some components of competence restoration). And they retain permanent assignment to these cases as long as any forensic involvement continues, regardless of housing placement, rehospitalization, or rearrest.

This type of structure provides several benefits. Primarily, it serves as an important liaison for the forensic client's network. The coordinator receives and provides updates with all of the client's stakeholders, allowing updated information to flow to everyone invested in that client's success. The coordinator can also provide updated information to the court regarding community-based placement options or program availability. Also, if problems emerge with a client, the coordinator can work among systems to arrange for adjustments to placement or supervision. Finally, by being permanently assigned to specific clients, the coordinator can provide historical clinical and risk information to the ever-changing cast of providers, officers, attorneys, and other stakeholders that surround that client.

The information must of course be governed by privacy and confidentiality laws, and policies and procedures must be clear about *who* can obtain *what* information. It is also important to note the difference between these types of positions or offices versus the newly-created court liaisons through the Bridges program (the two types of positions may appear similar at first glance). The court liaisons are employed by the judiciary and appear to be primarily focused on providing courts preliminary information about criminogenic risks and readiness for placement on bond. They provide criminogenic, non-clinical screening for courts to manage early decision making. While clearly important, these positions are not clinical; as such, they are unlikely to have up-to-the-minute information related to clients' clinical services and programs. However, the forensic coordinator can provide an analogous service in the mental health system. As the court liaison is to the judicial system, the forensic coordinator is to the mental health system.

In addition, the court liaisons are unlikely to follow cases or clients after initial decisions are made. Coordinators, on the other hand, will follow cases throughout their journey through the forensic mental health system. For these reasons, these types of positions are best housed within the jurisdiction of CDHS.

Recommendations regarding access to a central repository for forensic information:

There is no single "right" model for this type of infrastructure. Some jurisdictions use boundary spanners in administrative roles only, while others use them to provide specific clinical services. Some house this information in a central office, while some utilize a network of coordinators. Finally, some coordinate with law enforcement and jails to provide additional options for liaison and coordination. We offer these ideas not to prescribe a specific approach, but rather to (a) enhance the early promise and potential impact of the Bridges court liaison program and (b) to respond to several requests from stakeholders for such a system. *We recommend that CDHS consider how such an initiative could complement the Bridges liaison program in providing immediate and current information to stakeholders across the clinical service provision spectrum.*

EXAMPLE: Pennsylvania

The Forensic Support Team (FST) was established to work within the Philadelphia Department of Prisons (PDP) and support individuals who have been found incompetent to stand trial, are in jail, and await care at Norristown State Hospital (NSH). The goal of the FST is to increase the movement of individuals from PDP to NSH or a community service provider. In order to do so, the FST engages, evaluates, provides recommendations about, and supports individuals deemed incompetent to stand trial. To achieve this goal, FST works closely with the PDP, NSH, the Philadelphia District Attorney's Office, the Defender Association of Philadelphia, the City's Department of Behavioral Health and Intellectual Disabilities, and various community behavioral health providers. The FST is a six-person team comprised of one supervisor, one data and research assistant, one certified peer specialist, and three navigators.

EXAMPLE: Hawaii

In 2005, a network of community forensic psychologists was created to provide resources to community mental health centers and the courts. These statewide positions are called forensic coordinators. Forensic coordinators' responsibilities include the following:

- Monitoring individuals on post-insanity acquittal conditional release,
- Facilitating access to community-based competence restoration,
- Updating and gathering information from mental health professionals and any supervisory officers from the court,
- Providing trainings to CMHC staff,
- Facilitating inpatient discharges,
- Adjusting community treatment plans as necessary to maintain clients' community tenure,
- Maintaining databases of their interactions and outcomes, and
- Maintaining up-to-date information about all forensic clients statewide (e.g., contact information for housing, treatment, supervision, etc.).

Forensic coordinators follow their caseloads for as long as their clients maintain any forensic encumbrance (i.e., inpatient, outpatient, jail). This system allows for all stakeholders to have immediate access to experts who know and understand court-ordered mandates, clinical criteria, current status, and histories for all forensically-encumbered individuals statewide.

Recommendation 7:

Prioritize *quality*, even amid quantity and time pressures

Lawsuits and settlement agreements are intended to spur rapid action. But rapid action sometimes prioritizes speed over quality. We affirm that the CDHS Plan reflects an effort to increase speed of service and meet goals within prescribed timeframes. We also affirm particular quality control efforts that were implied in the Plan. For example, the Plan mentions CDHS efforts to offer training to new competence restoration providers.

However, during collateral interviews, we also heard concerns that efforts to initiate or accelerate services sometimes led to hasty service and poor quality. For example, some interviewees mentioned a decrease in the quality of competence evaluations prepared under new quotas and "bonus" procedures. Others mentioned a lapse in various clinical services due to increased pressures. One of us was contacted by a newly contracted competence restoration provider who reported *no* knowledge or expertise in providing restoration services. The CDHS Plan proposes that court service evaluators should include more specific information about barriers to competence, and to utilize a dictation service to increase the speed of their report writing; we affirm both initiatives but only so far as the requisite time and training is allotted for both to occur competently. The competency services described throughout the CDHS Plan and our review are highly specialized services, which require hiring expert staff and/or training staff to a level of expertise. Implementing state-wide services requires state-wide, shared standards and training to ensure uniform services. The CDHS Plan provides little detail regarding whether and how new or expanding services will be accompanied by efforts to ensure those services are of high quality.

Relevant to service quality, of course, is sufficiency of staffing. The CDHS Plan does emphasize efforts to increase staff and salaries, particularly at CMHIP, which we affirm as a crucial step. During our visit to CMHIP, it was clear that hiring, retention, and salary increase efforts were appreciated. But it was also clear that facilities remained short-staffed and morale remained

quite low. Interviewees described many concerns about the quality of hiring processes, such as lengthy delays causing them to lose qualified candidates. At times this has resulted in other disciplines "filling in" for vacant positions (the lack of psychiatrists and psychologists in both hospitals is a vivid example, forcing nurse practitioners, social workers, and licensed counselors to perform duties assigned to other disciplines).

CDHS leadership has emphasized many of the barriers to hiring and staffing. For example, they need to hire specialized clinicians (e.g., forensic evaluators), psychiatrists can earn more in the private sector, Pueblo is not the most desirable urban location, and so forth. In our view, many of these barriers are surmountable. After all, all states have similar needs, and many states staff facilities in locations far less desirable than Denver or Pueblo. Salary increases are an important step, but there are other important strategies as well. Psychiatrist Dr. Martinez, who directs the forensic psychiatry fellowship affiliated with OBH, described his disappointment that graduating forensic psychiatry fellows opt not to work for CDHS in lieu of other employment opportunities. He described several inexpensive strategies—particularly establishing formal academic affiliation for CMHI-based psychiatrists with the University of Colorado—that could help recruit and retain the most competent and desirable candidates.

Other quality improvement efforts not only attract desirable, conscientious candidates, but also improve the work force already present. For example, several states include rigorous trainings for forensic evaluators and restoration providers – even when their parent mental health departments are in the midst of lengthy litigation, escalating referrals, and media pressures.

EXAMPLES: Virginia, Massachusetts, Florida, Oregon, and others

- Decades ago, Virginia developed a partnership with the University of Virginia to provide rigorous training in forensic evaluation. Even today, newly hired evaluators must complete a one-week training that addresses competence, sanity, report writing, expert testimony, and other skills crucial for forensic clinicians. Over the years, these collaborations have expanded and the state/university partnership has offered training

to restoration counselors. The state now also maintains an oversight program, such that every court-ordered evaluation is reviewed by a state administrator who monitors quality and helps support or remediate evaluators whose work quality does not meet expectations.

- Massachusetts developed a similar training program. Massachusetts training and oversight program went even further in that new evaluators are mentored for one year and must submit repeated work samples for review. Ultimately, they are certified as a "Designated Forensic Psychologist." Florida also provides evaluator training through a state/university partnership.

- More recently, Oregon established a forensic certification system in 2012 by House Bill 3100. The system not only educated new evaluators, but was designed to have a strong auditing function, so that certified evaluators would have their work reviewed, be provided corrective feedback, and—if necessary—have their certification withdrawn. Evaluators attain conditional, temporary, or full certification over time but are also required to attend a multi-day training every two years to maintain their certification status. It should be noted that this process was created even in the shadow of *Oregon Advocacy Center v. Mink*, a class action lawsuit predicated on competence-related waitlists and challenges identical to those that Colorado is facing.

In short, many states provide rigorous training and oversight to address the quality of evaluations and related services. These training and monitoring programs tend to be inexpensive and far more affordable than the costs that follow poor evaluations or other poor forensic services.

Recommendations regarding quality improvement and maintenance:

Even when facing significant pressure to initiate or accelerate services, we recommend that CDHS maintain a focus on quality. Interventions that enlist new staff or new collaborators should include a mechanism to ensure they are well-trained and well-qualified. New types of services should include quality control plans.

Conclusions

As detailed above, we affirm many strengths in the CDHS Plan, the services CDHS provides, and (in particular) the strengths among the CDHS staff we interviewed. However, we also encourage CDHS to make better use of some of their resources, better integrate their services, and thoughtfully implement some additional services. Even amid their significant pressures, these services should be implemented with strict quality control, cohesively, and in the service of a broader comprehensive mission.

We welcome all parties involved in the Settlement Agreement to contact us with questions about our review and recommendations. We thank you for the opportunity to assist the court in this manner.

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