Reducing the Pennsylvania Incompetency to Stand Trial Restoration Waitlist: More than Just Beds

Henry J. Steadman, Ph.D.
Lisa Callahan, Ph.D.

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Background

On January 27, 2016, the Commonwealth of Pennsylvania Department of Human Services (DHS) entered into a settlement agreement with the American Civil Liberties Union (ACLU) to reduce the jail Waitlists for competency to stand trial restoration. At that time, the Waitlist included 215 defendants. In June 2017, the ACLU petitioned the court that DHS was out of compliance given that the Waitlist on 04/27/17 had increased to 258 defendants. In response, the court approved the ACLU's request for an independent study to offer recommendations to reduce the Waitlists for competency restoration. Policy Research Associates, Inc. of Delmar, New York, was selected to conduct this study. This report is the result. The study's duration was to be July 1 - December 31, 2017.

Methodology

The framework for this study was based on our belief that solving the Waitlist problem involved:

1. Moving defendants who did not need to be there out of forensic restoration beds;
2. Using multiple mechanisms to remove defendants on the Waitlist whose competency could be restored without using Norristown State Hospital (NSH)/Torrance State Hospital (TSH) beds; and
3. Reducing the inappropriate use of IST evaluations and restorations for defendants whose mental health and criminal justice issues could be addressed by appropriate screening, assessment, and treatment in community-based options outside of the criminal justice system.

Data for this report were provided by the Department of Human Services – Office of Mental Health and Substance Abuse Services (DHS-OMHSAS), NSH, TSH, Philadelphia Division of Behavioral Health and Justice Related Services (PDBHJRS), Philadelphia Department of Prisons (PDP), Allegheny County Pre-Trial Services, and public documents. It is not possible to indicate where each data point is from as in many instances, data were incomplete and were complemented by another data source.

To implement this framework we first identified three study groups:

1. All persons residing at NSH/TSH on Incompetent to Stand Trial (IST)/restoration orders on 07/01/17
2. All persons on the NSH/TSH Waitlist on 07/01/17
3. All persons released/discharged from NSH/TSH from 01/26/16 through 06/30/17

Creating complete data sets for these three study groups required data from the sources listed above.

Variables included:

1. Hospital Group (#1 above): name, sex, date of birth (DOB), most serious charge for this case, IST date, diagnoses, county, admission date, and length of stay (LOS)
2. Waitlist Group (#2 above): name, sex, DOB, most serious charge for this case, target arrest date, IST date, county, and length of time on Waitlist
3. Released Group (#3 above): name, sex, DOB, most serious charge for this case, date admitted to state hospital (SH), diagnoses, discharge date, county, and discharged to location

Upon receiving data from the PDP, we determined that there are a number of individuals removed from the Waitlist who never were admitted to the state hospital for this commitment. Consequently, we sought data from both Allegheny County Jail and PDP for the names of individuals committed for restoration who were removed from the Waitlist during our study period. These individuals were added to the Released Group.

Another major objective of this inquiry was to identify the number and location of new community beds created as a result of the settlement and dedicated to the "IST class" of individuals. This task proved to be difficult as there is no central location for these data. We received thorough information about the location of beds in the Southeast Region, primarily in

Philadelphia. Those data were provided to us from a variety of sources, most completely from Philadelphia Department of Behavioral Health and Intellectual Disability Services (DBHIDS) both in documents and during a face-to-face interview. In addition, the research team utilized public documents to identify possible community treatment providers in the remainder of Pennsylvania.

Additional information has been gathered through face-to-face interviews with numerous officials in Pennsylvania as well as through telephone calls and e-mail. Individuals contacted by the research team included:

- David Ayers (Criminal Justice Program Manager, Behavioral Health and Justice-Related Services Division, Philadelphia DBHIDS)
- Frankie Berger (PA-NAMI)
- Gregg Blender (Philadelphia Defender Association)
- Tory Bright (Southeast Regional Mental Health Services Coordinator)
- Katie Brown (Philadelphia District Attorney's Office, Mental Health Unit)
- Jennifer DiGiovani (Allegheny County District Attorney's Office)
- Reed Domer-Shank (Director of Research, Philadelphia Department of Prisons)
- Joel Dvoskin (ACLU Expert)
- Rachel Eisenberg (Office of Criminal Justice, City of Philadelphia)
- Christy Giallella (Clinical Director, Behavioral Health and Justice-Related Services Division, Philadelphia DBHIDS)
- Patricia Griffin (Local Expert)
- Kirk Heilbrun (Drexel University)
- Bruce Herdman (Medical Director, PDP)
- Judge Jeffrey Manning (President Judge, Allegheny County)
- Jessica Keith (Chief of Transition Planning Executive, DHS-NSH)
- Matthew Lang (Psychiatrist, Allegheny County Jail, Torrance State Hospital)
- Philip Mader (Director of Community & Hospital Operations, PA-DHS)
- Thomas McCaffrey (Criminal Court Administrator, Allegheny County)
- Marsha Neifield (President Judge, Philadelphia Municipal Court)
- Luna Pattela (Philadelphia Defender's Association)
- Brinda Penyak (County Commissioners Association of Pennsylvania)
- Michelle Pote (PDP)
- Maryjane Rule (PDP)
- Vic Walczak (ACLU)
- Joy Walters (Philadelphia District Attorney's Office, Mental Health Unit, Clinical)
- Sheila Woods-Skipper (President Judge, Court of Common Pleas of Philadelphia)
- Jean Wright (Director, Behavioral Health and Justice-Related Services Division, Philadelphia DBHIDS)

NSH/TSH Defendants – Group 1

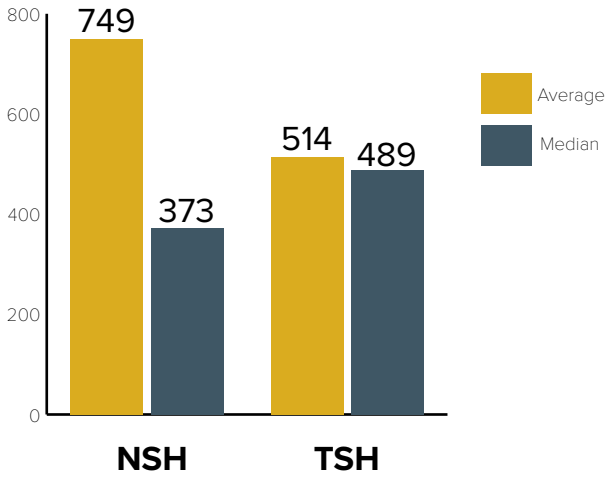
Profile

As of July 1, 2017, there were 179 defendants in NSH and 42 in TSH committed for competency restoration, for a total of 221 across Pennsylvania. Philadelphia comprised the largest portion of individuals committed as IST for restoration (45%, 100). Allegheny (17%, 38), Delaware (13%, 29), and Montgomery (10%, 21) were other counties with the largest number of persons in TSH or NSH for restoration. Overall, 17 counties (of 67) had at least one person residing in

the state hospital for IST restoration.[1] There were 14 people found "not guilty by reason of insanity (NGRI)" occupying state hospital forensic beds and were omitted from the analysis.[2]

The majority of restoration defendants were male (82%), and 65% were persons of color. They ranged in age from 19 to 79 years old with an average age of 43 (median is 44) years old. The lengths of stay (LOS) at NSH ranged from 4 to 4,153 days with an average of 749 days. At TSH, the LOS ranged from 38 to 1,176 days with an average of 514 days. Comparing average LOS can be misleading if there are one or two people with especially long, or short, lengths of stay. The median, or mid-point, for NSH LOS was 373 days, and median LOS at TSH was 489 days. Because all individuals were still in the hospital, their LOS was more correctly stated as "at least" as long as 373 or 489 days.

AVERAGE & MEDIAN LOS IN DAYS BY HOSPITAL



> Based on assessments by the NSH and TSH clinical staff…of the 221 patients in these hospitals on July 1, 2017, 110 (51%) were "non-restorable," and 45 (21%) were recommended as competent to stand trial by clinical staff, leaving only 63 individuals IST and in need of treatment and forensic beds."

Analysis

Based on assessments by the NSH and TSH clinical staff in letters to the committing court, of the 221 patients in these hospitals on July 1, 2017, 110 (51%) were "non-restorable," and 45 (21%) were recommended as competent to stand trial by clinical staff, leaving only 63 individuals IST and in need of treatment and forensic beds. The next question would logically be, "of those 155 individuals who were non-restorable (n=110) or were competent to stand trial (n=45), how many need a bed at TSH or NSH?" Currently, there are few options for the non-restorable patients.

Leaving aside for now potential conflict in opinion between clinical and legal staff as to "competency to stand trial" status, the 45 people recommended to the court by hospital clinical staff as competent to stand trial should be promptly returned to court for disposition of their clinical charges. These two populations – individuals who are "non-restorable" and individuals recommended by the hospital as competent – would be a place for the Commonwealth

1 The following counties had at least one individual on IST restoration orders in either TSH or NSH: Allegheny (38), Berks (1), Bucks (2), Chester (3), Dauphin (3), Delaware (29), Lancaster (4), Lebanon (1), Lehigh (5), Luzerne (5), Montgomery (21), Monroe (2), Northampton (4), Philadelphia (100), Schuylkill (1), Susquehanna (1), and Westmoreland (1).

2 The 14 individuals found NGRI and residing in either state hospital were from the following counties: Allegheny (1), Bucks (1), Chester (2), Dauphin (1), Delaware (3), Montgomery (4), and Westmoreland (1).

and the committing counties to start to open up beds for defendants who truly demand competency restoration in a secure hospital setting.

It is clear that there is some disagreement between the NSH clinical staff and the court professionals as to whether or not some defendants are in fact ready to face and understand criminal court proceedings. However, one-quarter of the beds at NSH were currently occupied by these individuals, whereas only one person at TSH deemed competent by clinical staff occupied a bed. Courts are not picking up defendants who have been recommended as competent for return to court and the appropriate hearing unless they are from TSH.

Recommendations

1. **All defendants in NSH/TSH who have been there 12 months or more should have *Jackson*-type independent reviews to determine if they have a reasonable probability of attaining competency in the foreseeable future.**

   This review should be an independent review not done by the current treatment team or the most recent clinical evaluator.

   Jackson[3] is very clear: "...a person charged by a state with a criminal offense and who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future. If it is determined that this is not the case, then the State must either institute the customary civil commitment proceedings that would be required to commit indefinitely any other citizen, or release the defendant."

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2. **If defendants are not likely to be restored and do not need secure hospital levels, they should be eligible for community beds being developed.[4]**
3. **Court and hospital clinical staff should develop shared definitions and procedures for individuals to be restored to competency to stand trial to facilitate the timely discharge of individuals to the court of commitment for criminal disposition.**

   Currently, there appears to be inconsistency or disagreement between the hospital clinicians' opinions when a defendant is restored to competency and when the court professionals

3 *Jackson v. Indiana*, 406 US 715 (1972)

4 A study concluded that in 2007, 28% of states specify 1 year or less for restoration, 20% specify 1-10 years, 22% link time to maximum criminal penalty, and 30% set no limit. This study clearly indicates that many states were, at that time, out of compliance with Jackson. "Forty Years After Jackson v. Indiana: States' Compliance With 'Reasonable Period of Time"' Ruling," *J Am Acad Psychiatry Law*, 40, 261-265, 2012. Kaufman, Way, & Suardi

(e.g., public defender) believes they are restored. This discrepancy leads to individuals being maintained at NSH when appropriate for return to court and could be lessened if court and clinical staff created common language, standards, and information that is required to be considered legally competent.

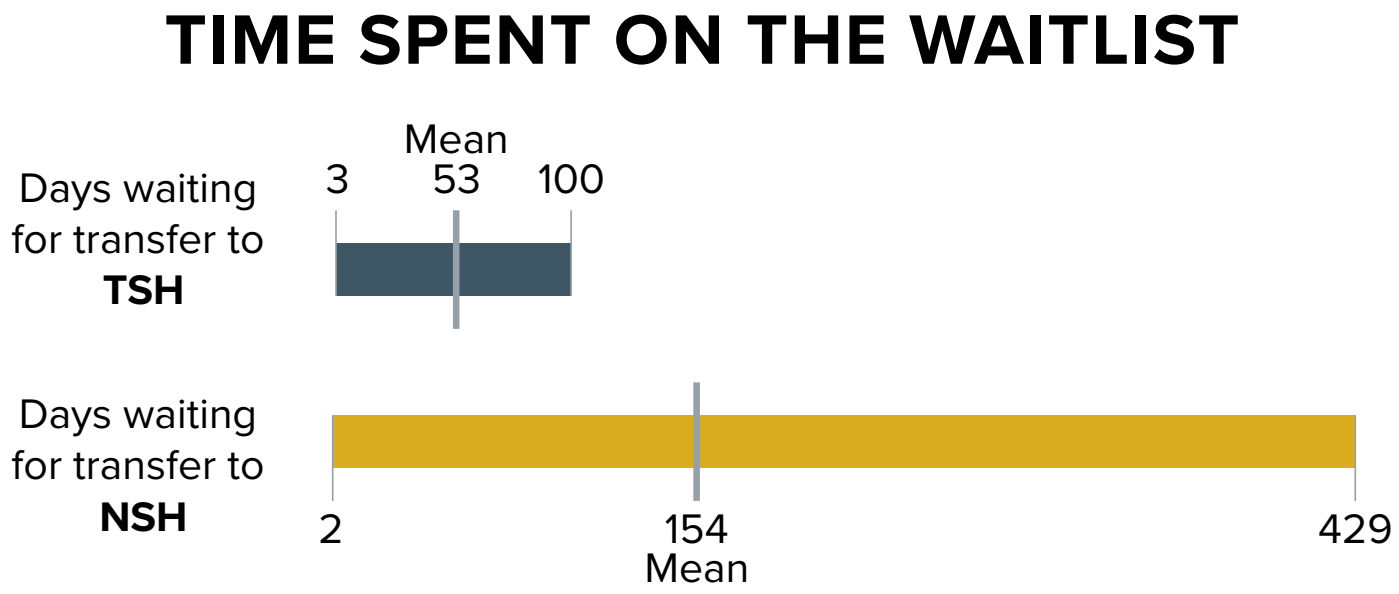
Waitlist Defendants – Groups 2 and 3

Profile

As of July 1, 2017, there were 251 defendants on the IST-Restoration Waitlist. Philadelphia County accounted for 136 (54%) defendants, Delaware 24 (9%), Allegheny 17 (7%), and Bucks 17 (7%).

Of the Waitlist defendants, 200 (80%) were male. Of those for whom race was known to us, 61% were persons of color. Their ages ranged from 19 to 79 with an average age of 40 years old. Most (90%) were diagnosed with a psychotic disorder and 20% had a substance use disorder. A potentially important diagnosis that might lead to "non-restorablility" under *Jackson* is having a neurological or "organic" diagnosis, such as TBI, cognitive impairment, or dementia; 12% of the Waitlist had such a diagnosis. These diagnostic categories are not mutually exclusive. For example, a defendant could have both a psychotic disorder and a neurological disorder. Their criminal charges widely varied with crimes against persons accounting for 59% of those with valid data, lesser charges (42%), and violations (4%) making up the balance. Overall time on the Waitlist ranged from 2 days to 429 days, with an average of 138 days on the IST-restoration Waitlist. These overall results of time on the Waitlist masks some big differences between those awaiting transfer to NSH or to TSH. For those defendants awaiting transfer to TSH, the number of days waiting ranged from 3 to 100 days with an average of 53 days. For NSH, the days on the Waitlist was substantially longer than TSH, ranging from 2 to 429 days with an average of 154 days. As with length of stay, time on the Waitlist is more accurately stated as "at least" 53 or 154 days.

Individuals on the Waitlist who were removed between 01/26/16 and 06/30/17 comprise Group 3 of this report. There were 432 individuals removed from the Waitlists of TSH (16%, 68) and NSH (85%, 364) in the time period from the settlement to the start of data collection for this report. As expected, the majority of "removals" were of individuals from Philadelphia (63%, 270). Delaware removed 53 people and Allegheny removed 44 people. There were 21 additional counties that removed defendants from the statewide IST Waitlist during this period. This group



of defendants varied little from the people in the state hospital for competency restoration in that 79% were male and 62% persons of color. Their time on the Waitlist (usually while in jail, as only 17% were out of custody) ranged from 4 to 487 days with an average of 140 days and a median of 115 days on the Waitlist before removal.

Among the differences observed in the group removed from the Waitlist is the proportion diagnosed with a psychotic disorder (80%) compared with 90% in the hospitalized group. One-third had a substance abuse diagnosis, and 9% had a neurological disorder diagnosis. Similarly with the defendants still on the Waitlist, 20% of the persons removed from the Waitlist had one of the seven most serious charges noted earlier, compared with more than double that proportion (46%) of the defendants in the hospital.

Analysis

One dynamic of the Waitlists for which our study design did not account was Waitlist removals with competency restored directly from the jails to the courts. In a Philadelphia DBHIDS 12/06/17 report (Appendix A), they noted that of 425 Philadelphia defendants removed from the Waitlist 01/27/16 – 12/04/17 only 85 (18%) went to NSH. A majority (53%) of defendants ordered for restoration were, in fact, restored to competency in PDP; 99 (22%) were placed out of custody (e.g., bail); and 30 (7%) were discharged to community placements. This dynamic heavily influenced our focus group and individual interviews in Philadelphia and Pittsburgh

Of the 425 Philadelphia defendants removed from the Waitlist 01/27/16 – 12/04/17 only 85 (18%) went to NSH. A majority (53%) of defendants ordered for restoration were, in fact, restored to competency in PDP.

Of the 230 defendants on the Waitlist on 12/01/17, approximately 74 (32%) of the individuals were currently likely to be competent to stand trial.

in late November 2017. In retrospect, we should have anticipated this phenomenon. Given the long times on the Waitlist, often a year or more, the medications and other services administered in the jails often stabilize symptoms and allow competency to be restored prior to being transferred to a state hospital.

Just how significant these removals are is highlighted by the August 22, 2017 *Competency Screening Summary Report* of the Philadelphia Behavioral Health and Justice Related Services Division (DBH) in collaboration with Drexel University, led by Dr. Kirk Heilbrun (Appendix B). Between April 2016 and April 2017, the Drexel team interviewed 97 defendants on the Waitlist from Philadelphia. Using a variety of standardized instruments on symptoms, self-harm, and competency, they concluded that of all 97 Waitlist defendants, only 36% appeared as IST and required hospital-level care; 32% appeared IST but could function safely in the community; and 32% appeared competent to stand trial.

We believe these were reasonable screenings and that there is no evidence that this sample was biased in any significant way from the entire Waitlist. Accordingly, we estimate that of the 230 defendants on the Waitlist on 12/01/17, approximately 74 (32%) of the individuals were currently likely to be competent to stand trial and could return to court for disposition. Approximately a third (32%) continued to be IST, but this group would not require hospital-level (forensic state hospital) care and could be restored to competency with sufficient resources in jail or community settings. Only 82 individuals (36%) should remain on the Waitlist for an inpatient, secure forensic bed at NSH/TSH.

Recommendations

4. **Commonwealth-wide standards and policies for jail-based competency restoration should be developed and implemented.**

   There are at least one-third of the defendants on the Waitlist who could more quickly and more inexpensively regain competency with high-quality restoration at the local jail. The target group for this program would be defendants who, with medication and housing, are likely to regain competency within 7-21 days. Either as a result of initial assessment or after failed restoration efforts after 21 days, defendants would be put on the Waitlist. An example of this type of restoration program is the Restoring Individuals Safely and Effectively (RISE) program at the Arapahoe County (Colorado) Detention Center. The 21-day proposed limit is based on conversations with various clinicians during and after our recent site visits.

5. **Commonwealth-wide standards, policies, and targeted funding for community-based outpatient competency restoration should be developed by PA-DHS.**

   Among the estimated third of the Waitlist who are IST and do not require a hospitalization-level of care are an unknown number who could safely reside in the community while receiving medication and supports to regain competency. These defendants could be supervised by Pretrial Services or by behavioral health specialists with appropriate requirements to report at Community Mental Health Centers (CMHCs) or Federally Qualified Health Centers (FQHC).

6. **For the estimated one-third of defendants on the Waitlist who are recommended as no longer incompetent to stand trial, these individuals should be returned to the court for a competency hearing. If they are found competent to stand trial, there should be a disposition of criminal charges. The county behavioral health providers should develop or expand "boundary spanner" positions to facilitate linkages to community-based behavioral health for defendants released from the jail.**

   "Boundary spanners" are positions that link two or more systems whose goals and expectations are likely to be at least partially conflicting.[5]

   In this instance, these positions could do jail in-reach for community providers to establish treatment plans and insure direct connection to services and housing upon jail release. The incumbents of these positions, as described by Steadman, "…are some very savvy people…who have been around a number of years and know the nuts and bolts of both systems [behavioral health and criminal justice] and their interface points…they know both the informal and formal norms of the relevant organizations, as well as their internal operations and politics" (1992:84).

7. **Create a fund with Commonwealth dollars to support the development and operation of the jail and community restoration programs and the boundary spanner positions for community releases from the Waitlist.**

   The Commonwealth should work with stakeholders to examine the Mental Health Procedures Act (MHPA) for changes that are needed to support these efforts, including building forensic guidelines and policies that cross over all counties to make these efforts possible.

5 "Boundary Spanners: A Key Component for the Effective Interactions of the Justice and Mental Health Systems." *Law and Human Behavior*, 16, 75-87, 1992, Henry J. Steadman

Reduce Waitlist Inputs

Analysis

From our focus group in Philadelphia and interviews in Philadelphia and Pittsburgh, it appears to us that some judges are using IST as a procedure to access what they see as needed mental health assessment and treatment which are in short supply. Because there are few court-based options to screen, assess, and divert defendants with low and medium-level charges, IST evaluations orders are used to incarcerate defendants who exhibit signs and symptoms of mental illness and who are seen as incapable of making it in the community, many of whom have been seen many times previously by the courts. By creating and expanding new boundary spanner positions for the courts, substantial reduction in the flow of new cases on the Waitlist could be achieved. Also, some expansion of some community supervision options could further reduce this flow.

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Recommendations

8. **Develop court-based behavioral health boundary spanners.**

   We presented a description of boundary spanners above. Their niche here would be modeled on the Allegheny County Behavioral Health Clinic and other efforts currently underway in Philadelphia. In addition, the New York City Misdemeanor Arraignment Diversion Project (MAP) of the Legal Aid Society offers a model that could fit into all Pennsylvania courts and build on work already being initiated in both Allegheny and Philadelphia Counties (Policy Research Associates, January 2013) (Appendix C).

   Both Allegheny County and Philadelphia are piloting programs to divert people with mental illness away from the justice system. These initiatives can be supported and expanded to assist in reducing the flow of individuals into the jails for competency restoration and being added to the Waitlist.

   The Allegheny County Behavioral Health Court Clinic is working with providers to establish a program for community-based competency restoration. Clearly, this program is intended to target the IST/restoration cohort of defendants. In Philadelphia, the city is piloting a pre-arrest diversion for persons with substance use disorders and co-occurring substance use and mental health disorders. They have plans to expand the pre-arrest diversion to include persons with mental illness. In addition, another pilot program in Philadelphia targets individuals who violate their terms of specialty probation, working to quickly re-connect them to treatment in lieu of a violation/incarceration. While the Philadelphia programs are not designed to target persons found IST and ordered for restoration, it is completely plausible that the programs will include some people who would have otherwise been arrested and found IST. These “front-end” programs could help to reduce the pipeline that leads to the Waitlist.

   The Misdemeanor Arraignment Project (MAP) model is an interdisciplinary team that includes the defense attorney and paralegal assigned to the case and a licensed clinical social worker. The attorney provides legal advocacy and directs how the screening and assessment information will be used at initial arraignment. The social worker is responsible for identifying and assessing defendants awaiting arraignment

for treatment planning and referrals to community providers. The MAP team is present for the arraignment to advise the judge about possible diversion. Outcome data showed 52% of MAP clients diverted had no arrest in the first year after diversion compared to 24% of non-diverted comparison group.

During one interview, we were told that the real Waitlist is much higher as the smaller, more rural counties have "just given up" trying to get anyone into either TSH or NSH. The interviewee also stated that the counties are "clearly on board to solve this problem with the Commonwealth as partners." The interviewer stated that leadership is required to identify the problems and bring together local, regional, and state officials to address the complex problems and inadequate resources for persons with mental illness in the justice system.

9. **Implement targeted Assisted Outpatient Treatment for diversion.**

   Under Section 304(f) of the Mental Health Procedure Act, Pennsylvania statutorily allows for Involuntary Outpatient Treatment, but there is no infrastructure to support it, and it is not used. We believe that a model that would include civil court supervisions with funded community wrap-around services could keep people off the Waitlist.

   In a White Paper adopted by the Pennsylvania Association of County Administrators of Mental Health and Developmental Services (PACA MH/DS) Board in 2016, they stated their support for the DHS' policy of "serving people in the community" in an effective and efficient manner. They cite as an example of how changes to the MHPA could enhance that goal by allowing outpatient commitment as "an alternative pathway to the traditional involuntary commitment process." Many states, such as Ohio, have changed their civil commitment standards to allow for outpatient commitment, often referred to as "Assisted Outpatient Commitment or AOT," within their overall commitment statutes. Typically, AOT provides an avenue for court-ordered treatment for individuals who may or may not meet inpatient commitment standards but who can be safely and effectively treated in the community. Two AOT laws were introduced into the 2017 General Assembly of Pennsylvania – House Bill 1233 and Senate Bill 599 – that would amend the MHPA to expand outpatient commitment.

   The most widely-studied AOT implementation is New York's "Kendra's Law," which was enacted in 1999. The New York legislature attached $23 million for wrap-around community services specifically for AOT patients. This is, obviously, a larger-scale reform than our other recommendations, but it is one worth considering for longer-term impact of reducing the inappropriate use of IST. This program area could target persons with non-violent charges with civil court oversight by specialized case managers in the least restrictive alternative while protecting public safety. The evidence from New York demonstrates that it works to reduce unnecessary hospitalization, reduces arrests, keeps people in community-based treatment, and improves quality of life for persons with serious mental illness (Appendix D). Estimates for how many current individuals in the targeted population (IST/restoration) would be suitable for outpatient commitment would depend on the extent to which recommendations included in this report are adopted.

Beds

Identifying all community-based beds created as a result of the January 27, 2016 settlement class proved to be an elusive endeavor. There is no central accounting of beds created by county in the Commonwealth. There are no "real-time" methods for identifying available, or soon-to-be-available beds to

house the settlement population (or others). If either of these resources exist, we were not provided them despite multiple requests to multiple individuals. Consequently, it is impossible to affirmatively identify what beds were created as a result of the settlement and if they are being occupied by the settlement class of individuals – people found IST and ordered for restoration who do not need to be housed at NSH or TSH. Thus, we were left with a piecemeal approach to responding to the questions: "Are there sufficient beds in Pennsylvania to meet the needs of the IST/ restoration population?" and "If there are insufficient beds, how many new beds need to be developed?"

Using the 2015 and 2016 SAMHSA National Directory of Mental Health Facilities, we created a data base to track which facilities on these lists served clients referred from the court/judicial system. We further narrowed these directories down by using the following terms, which we chose based on the assumption that these would most likely be the terms that would apply to the IST population: Persons with Serious Mental Illness (SMI), Persons with Alzheimer's or Dementia (ALZ), Persons with Co-Occurring Mental and Substance Abuse Disorders (CO). We also tracked the service setting type, including the following: Hospital Inpatient (HI), Partial Hospitalization/Day Treatment (PHDT), Residential (RES), and Outpatient (OP). For further analysis, we eliminated facilities that only indicated that they were an outpatient facility, as they would not technically have "beds," although they may have offered Court-Ordered Outpatient Treatment (COOT) or Assertive Community Treatment (ACT). The final classification we tracked was what type of funding was accepted by the facility, including the following: County of Local Government Funds (CLF), Medicaid (MD), State Corrections or Juvenile Justice Funds (SCJJ), and State Mental Health Agency Funds (SMHA).

To further identify "new" beds across the Commonwealth, we compared separately the 2015 and 2016 SAMHSA Directories as mentioned above and tracked any changes between the 2015 and 2016 directories. This included determining which facilities remained on the 2016 list, which facilities were not listed on the 2016 list, any new facilities that were added to the 2016 list, and any facilities that were still on the list but no longer served court-ordered patientsby county and city. We found that by using this public data base (https://www.samhsa.gov/data/mental-health-facilities-data-nmhss/reports), there were 12 new facilities listed on the 2016 SAMHSA registry that were residential/inpatient/ partial hospitalization and indicated that they serve court-ordered clients. However, we also found that 21 facilities removed "court-ordered" clients from their populations served. Also from 2015 to 2016, six facilities indicated that they now had Assertive Community Treatment (ACT) teams.

The Pennsylvania Department of Human Services (DHS) Provider Directory was also identified as a potential source for identifying new beds statewide (http://www.dhs.pa.gov/dhsassets/pchdirectory/index.htm). Using the service code "Residential Treatment Facility for Adults" and the program office "Office of Mental Health and Substance Abuse Services" as search terms, this directory provided a list of current facilities that may serve IST patients. Some of these overlapped with facilities listed in the SAMHSA directory and some did not, although it is important to note that this directory is current as of 11/28/2017, which is far past the settlement date.

Without a statewide tracking system for community beds for this "class" of defendants – those who are incompetent to stand trial and ordered for restoration – an estimate of the number of beds needed to reduce the Waitlist for state hospital beds is just that, an estimate. Based on the analysis above and on records provided to us during our data gathering efforts, the only sound accounting of new beds that opened in response to the settlement is for Philadelphia.

Analysis

The most fundamental idea for understanding the number and type of beds needed for defendants found IST is that as long as the courts continue to increase the number of IST defendants, there will never be enough beds. The analysis that follows assumes that with the other recommendations above, the flow will decrease substantially and the number of beds will catch up with competency restoration referrals.

NSH/TSH Forensic Beds

As of July 1, 2017, based on data provided to us by DHS, there were 179 IST defendants at NSH, where 137 were in forensic beds and 42 were in civil beds. At TSH there are 100 forensic beds, 42 of which were occupied by IST defendants.[6] Based on clinical recommendations provided to the courts by NSH/TSH clinical staff, 110 patients could be removed as not being restorable.

In addition, 45 patients were recommended to the court as competent to stand trial and who do not require additional treatment in their forensic beds.

Waitlist Beds Needed

Using the clinical screenings from the DBH/Drexel University study, of the 230 defendants on the 12/01/17 Waitlist, 74 (32%) would be competent, 74 (32%) would be IST, but would not require secure forensic beds, and 82 (36%) Waitlist defendants would need NSH/TSH forensic beds.

Since the Waitlist is not static (i.e., defendants are regularly added), even with the turnover in the new beds with those currently on the Waitlist, some additional community IST beds would be needed. These would not be Community Hospital Integration Projects Program (CHIPP) beds since those are intended for people leaving state hospitals, and the newly added Waitlist defendants would be being released from jails to community beds.

We cannot accurately estimate how many beds this would represent without knowing which of our recommendations for reducing the Waitlist flow will be implemented and what their actual impacts will be. Because people are removed from the Waitlist without state hospitalization, or following restoration and NSH/TSH, communities do have residential services available. We could not locate any data to determine how many and where those beds are outside of the eastern region of the state and in Allegheny County.

To estimate how long a defendant resides in the hospital prior to being determined to be competent, the process would require that the defendants are promptly returned to the county of commitment for disposition of their charges. Because so many of the individuals in either TSH or NSH were found, by clinicians, to be competent but not returned to the county, the length of time required for hospital-based competency cannot be determined by these data. They include unnecessarily long delays, especially in NSH, in returning defendants to court.

One approach would be to use data from the DBHIDS October 2017 Monthly Report, showing 449 Waitlist additions since 01/27/16, the original settlement date. This produces a monthly average of 21. Since Philadelphia had 136 of the 241 defendants on the Waitlist (56%), extrapolating the 21 additions a month would mean statewide about 37 additions a month. Using the DBHIDS/Drexel University findings of 32% of Waitlist Defendants needing IST non-secure residential placements, about 12 community beds would be needed for Waitlist additions each month.

Recommendations

For the 221 IST defendants on 07/01/17 in NSH and TSH, we have subtracted 110 who were not restorable and would require civil hospitalization or community residential placements. At least 45 defendants were recommended as clinically competent and did not need secure restoration treatment. This leaves 66 of

6 Other individuals who can occupy forensic beds at TSH and NSH include persons found "not guilty by reason of insanity (NGRI), persons in local jails who are in need of hospitalization, persons found "guilty but mentally ill (GBMI)," and some state inmates.

the current NSH/TSH IST patients who need a secure forensic bed.

For the 230 defendants on the 12/01/17 Waitlist, we estimate 36% (82) are IST and require a secure forensic bed. Assuming the removal of the non-restorable and clinically competent defendants, 155 beds become available, raising the question of whether any new beds are needed.

Since the 50 beds at NSH are already scheduled to come on line, care needs to be taken that they are used for defendants that really need them and that it does not result in the overuse of these forensic beds or that they are built and remain empty.

10. **Assuming a 6 month length of stay and staggered admissions and discharges, a grand total of about 60 community beds would be needed for community restoration.**[7]
11. **An additional 50 forensic beds at NSH are scheduled to become available by January 5, 2018, meaning 0 additional forensic beds are needed.**

Conclusion

We purposefully left our discussion of beds until the end. We have done this because we believed that beds are only one piece of needed IST systemic reform.

1. **There are too many people in TSH and NSH who should not be there.**
2. **There are too many people on the Waitlist who should not be.**

The IST system in Pennsylvania is broken. We know how to fix it. It needs leadership. It needs dollars for innovative community staff positions we have called "boundary spanners." It needs linkages to effective treatment services to pair with quality supervision to insure public safety. Just building more beds is little more than a band aid for a body that is mortally wounded. The body can be saved. It is a question of political will. We were struck by the number of people we met who work in the system that were trying to do the right thing in the absence of state-level leadership and creative commitment. There is room for optimism that the IST system, not just the Waitlist, can be fixed and fixed soon through immediate collaboration across the Commonwealth among all state, county, and local officials.

7 Community restoration programs exist throughout the United States and are being implemented at an increasing rate as an alternative to hospital-based restoration. "Looking for Beds in All the Wrong Places," Psychology, Public Policy, & Law, 22, 293-305, 2016, Gowensmith, Frost, Speelman, and Therson

Recommendations

1. All defendants in NSH/TSH who have been there 12 months or more should have *Jackson*-type independent reviews to determine if they have a reasonable probability of attaining competency in the foreseeable future.
2. If defendants are not likely to be restored and do not need secure hospital levels, they should be eligible for community beds being developed.
3. Court and hospital clinical staff should develop shared definitions and procedures for individuals to be restored to competency to stand trial to facilitate the timely discharge of individuals to the court of commitment for criminal disposition.
4. Commonwealth-wide standards and policies for jail-based competency restoration should be developed and implemented.
5. Commonwealth-wide standards, policies, and targeted funding for community-based outpatient competency restoration should be developed by PA-DHS.
6. For the estimated one-third of defendants on the Waitlist who are recommended as no longer incompetent to stand trial, these individuals should be returned to the court for a competency hearing. If they are found competent to stand trial, there should be a disposition of criminal charges. The county behavioral health providers should develop or expand "boundary spanner" positions to facilitate linkages to community-based behavioral health for defendants released from the jail.
7. Create a fund with Commonwealth dollars to support the development and operation of the jail and community restoration programs and the boundary spanner positions for community releases from the Waitlist.
8. Develop court-based behavioral health boundary spanners.
9. Implement targeted Assisted Outpatient Treatment for diversion.
10. Assuming a 6-month length of stay and staggered admissions and discharges, a grand total of about 60 community beds would be needed for community restoration.
11. An additional 50 forensic beds at NSH are scheduled to become available by January 5, 2018, meaning 0 additional forensic beds are needed.

PRA

POLICY RESEARCH ASSOCIATES

Delmar, New York