UNIVERSITY OF MINNESOTA

ROBINA INSTITUTE
OF CRIMINAL LAW AND CRIMINAL JUSTICE

COMPETENCY IN MINNESOTA:

A Practitioners' Roundtable

A Report by the Robina Institute of Criminal Law and Criminal Justice

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By

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Introduction

On January 15, 2016, the Robina Institute of Criminal Law and Criminal Justice brought together nearly 200 people for a day of discussion of what Minnesota is doing to secure better outcomes in criminal cases involving mental illness, and to compare ideas on what still needs to be done. Participants included lawyers, judges, law enforcement, policymakers, mental health service providers, advocates, and members of the public. Numerous ideas were suggested for follow up, including the issue of a defendant's competency to stand trial.[1]

By the spring, issues related to a defendant's competency to stand trial were receiving greater scrutiny in multiple forums. The Legislative Auditor reported in March that orders for competency evaluations increased by 96% from 2010 to 2014.[2] The Legislative Auditor made seven recommendations for policy changes, concerning both the process in the courts, and the resources to be provided for people deemed not competent. In April, the Supreme Court issued an order seeking comment on a number of proposals, one of which was to establish a new group to evaluate the rules that govern the connection between the criminal competency determination and civil commitment.[3] And on a national level, the American Bar Association continued its work to develop new standards in this area.

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Because of the tremendous interest in this area, on June 10, 2016, the Robina Institute of Criminal Law and Criminal Justice convened a group of 22 practitioners, policymakers, and researchers from the mental health and criminal justice communities for a roundtable discussion. The premises for the conversation were, first, that in the near future there are likely to be major discussions among policymakers about changes in this area; and, second, that when those discussions occur, many of the people involved in the Robina conference would be present. Past Robina events yielded the insight that professionals benefit from better understanding the viewpoints of others working in different fields on the same issue. Thus, the purpose of the roundtable was to engage in a multi-agency discussion of how Minnesota handles competency issues, and to develop potential recommendations for improving the system. Participants exchanged ideas on three topics:

- What problems exist in how Minnesota addresses competency to stand trial?
- What changes would the group recommend?
- What are the group's reactions to the Legislative Auditor's recommendations?

This report attempts to summarize many of the ideas discussed and developed through the June roundtable discussion. The Institute agreed not to attribute comments to individual participants in the interest of open discussion. The conversation was complex and free-flowing, and this report does not include everything that was said. The recommendations relating to competency that were identified by the Minnesota Office of the Legislative Auditor are included and discussed in section 3 of this report. The discussion participants are identified on page 9 of this report.

1. What problems exist in how Minnesota addresses competency to stand trial?

Roundtable participants shared their perspectives as to what problems exist in Minnesota's criminal justice system with regard to competency and mental health.

Participants first addressed the great **increase in the number of competency evaluations**, from roughly 800 to 1500, over a five-year period. Participants first noted that the geographic distribution of the increase is unknown. Did the increase primarily occur in a few large counties? Or was it evenly distributed statewide? Participants noted that criminal defense lawyers request evaluations more frequently than in the past, possibly because they have had more training about mental illness than the previous generation of lawyers. It was suggested that lawyers might think that a client will get help in the mental health system, but that the help they are envisioning might not be available. Sometimes a request for an evaluation may be an appeal for the other parties in the case (i.e., judges and prosecutors) to look at the situation in a new light, which raises the question of whether there should be some better way to accomplish that. Some participants also expressed concern that the training for and standards applied by evaluators are inconsistent.

The discussion then turned to a **lack of resources**, a topic that was also covered extensively in the Legislative Auditor's report. One participant commented, "We don't have a broken mental health system; we've never built it." Others noted that there are shortages of hospital beds, but that this fact may be over-emphasized. There is a more important shortfall in community-based services. There is a need for more out-patient programs, but there are not enough psychiatrists and psychologists to staff them. Though rural areas may have difficulty attracting such professionals, in some areas the rural parts of the state are better staffed, on a per capita basis, than the metro area. Participants also questioned why urgent care is not staffed with mental health professionals so that individuals can get help when their symptoms are at an early stage instead of waiting until they hit the crisis point. Finally, the group commented that though law enforcement are often "first responders" to issues related to mental health crises, they need more backup from "second responders," which are jails, social workers, lawyers, courts, and community-based service providers.

Issues related to **mentally ill individuals in jail** were also raised. As one participant said, "The problem is that many [individuals] never should have ended up in jail to begin with, if we had other places to be able to treat or manage their mental illness." Yet, it was noted that people with mental illnesses make up 30 to 70% of the jail populations in the state. A recurrent, related question is whether jails should be able to "treat" or just to "manage" an individual's mental condition. Though the average jail stay is short, some inmates are in jail for months, raising serious questions about the long-term impact of these stays on their mental health and wellbeing.

Among other issues at the jail is medication. Some individuals booked into jail have prescriptions related to mental health diagnoses, but are not taking them. The jail cannot forcibly medicate these individuals; and their prescription pills may be seen as contraband within the confines of the jail. The formulas dispensed in jail may also differ from previous, effective medications. This raises issues of whether or not jails should be responsible for making new prescriptions available and what quantity of medication should be dispensed, especially at discharge. Counties currently have varying policies on how medication is provided.

"The problem is that many [individuals] never should have ended up in jail to begin with, if we had other places to be able to treat or manage their mental illness."

The group discussed the fact that individuals with mental illness who get arrested may have **multiple, complex issues**. There may be little correlation between the seriousness of the alleged crime and the seriousness of their mental illness. A given individual may have a psychosis, AND an anti-social personality disorder AND a severe chemical dependency problem. Professionals who work with these clients tend to see the individual through the lens of their expertise (e.g., a chemical health assessor may say the substance abuse disorder is primary whereas the psychiatrist may see the psychosis as primary), and so there may be disagreement about what the individual needs. Some also have anosognosia, a condition which renders an individual unaware of or unable to accurately perceive their own mental health condition. This group does not follow medication regimens and often fails to comply with treatment in general, not because they are oppositional, but because they genuinely believe that they do not have a problem. Some cases are further complicated by developmental disability.

The group next talked about the **gap between the criminal incompetency determination and civil commitment**. Competency to stand trial in a criminal case is governed by Rule 20.01 of the Minnesota Rules of Criminal Procedure. Rule 20.01 subd. 6, provides that an individual is incompetent if the court finds the individual to be mentally ill or mentally deficient "so as to be incapable of understanding the proceedings or participating in the defense." When an individual is found incompetent in a misdemeanor case, the charge must be dismissed. In felony and gross misdemeanor cases the criminal proceedings must be suspended and, "if the defendant is not under commitment, the court must commence a civil commitment proceeding."[4] In contrast, civil commitment requires a finding that the individual is a mentally ill person, which is a complex definition including things such as having an organic disorder of the brain that impairs judgment and the ability to recognize reality or exhibiting a substantial likelihood to harm oneself or others.[5] The Legislative Auditor found that of the individuals deemed to be incompetent only 34% are actually committed. In the other cases, either no petition is filed (45%), or the legal standard for commitment is not met (21%).[6]

The discussion group was acutely aware of the difference between the "incompetency" standard and the "commitment" standard.[7] One speaker said, "They don't fit the definition of commitment, they don't fit our rules, and all of a sudden we go from a very structured [criminal justice] system to nothing, and no one knows what to do." Other options need to be available for "some of those folks who aren't committed, and just keep cycling through the system." Some individuals will not be committed AND they will not become competent. Timeliness of the steps is also a problem. Competency and commitment evaluations can be done together if all parties agree, but in an adversarial system, it is hard to reach this agreement.

For individuals deemed incompetent, one potential solution is **"competency restoration treatment,"** but this has created a new generation of issues. In Minnesota, the Department of Human Services (DHS) operates two programs, totaling 80 beds, in secure hospital settings. DHS is not obligated to operate these programs, but they do to make this alternative available. DHS was not prepared at this meeting to detail how the program works, but some in the group described the treatment as consisting of teaching the individuals the roles of the parties in the courtroom, using flash cards and a work book. Defense lawyers commented that they think of competency more in the terms of the requirement in Rule 20.01 that the defendant be able to rationally consult with counsel, understand the proceedings, and participate in the defense. One lawyer put it like this:

> *"Practitioners have been reliant on the idea that if [the individuals] can memorize, they are competent. Defense attorneys need to speak up and say that clients aren't working enough with them. And a lot of times when we do, the answer is, well, you need to spend more time with them, you need to talk slower, you need to repeat yourself more often. There is a lack of understanding of how a trial works on the part of evaluators. I can't stop every three seconds during a trial to explain to him or her what happened."*

Another participant questioned how our practices with regard to competency fit into the bigger picture.

> *"Are we seeking to make people competent for criminal prosecution, or are we seeking to give people mental health treatment that they might otherwise need regardless of whether they have been charged with a crime?"*

Participants also discussed the unforeseen consequence of the **"48-Hour Rule,"** which requires individuals who have been ordered confined for a competency evaluation or who have been found incompetent and committed to the Department of Human Services for competency treatment, to be moved out of the jail and admitted to a DHS facility within 48 hours.[8] This is a rational, humane requirement, but DHS lacks appropriate facilities to carry out the requirements of the law. As one participant put it, "We have people sitting in the back of a squad car waiting to be transferred because we have got to get them transferred, but they are literally waiting for where to go."

The Anoka State Hospital is the main metro-area placement, but most of those sent to Anoka do not need that level of care. As one participant said, "Fifty percent of the people in Anoka are now there because of this rule even though they don't need that level of care; but they can't get out because they are in under a commitment and the community-based organizations won't take them." This means that people who DO need hospital care, but aren't coming from jails, cannot be placed. This led one participant to comment, "There is a spillover into the community behavioral health hospitals that has essentially destroyed the system." And noting that the spillover often extends to rural placements, another said, "The unmet need from the Metro Area has a serious impact on the rural areas."

*The **"48-Hour Rule,"** requires individuals who have been ordered confined for a competency evaluation or who have been found incompetent and committed to the Department of Human Services (DHS) for competency treatment, to be moved out of the jail and admitted to a DHS facility within 48 hours.*

2. What changes would the group recommend? Key Issues

Participants in the roundtable next turned to the difficult task of suggesting solutions to address the issues that had been raised. These ideas are the products of brainstorming; they are not universally supported by the whole group, and some of them are not compatible with each other. They are worth consideration as products of a rich discussion among people with decades of professional experience in criminal justice and mental health.

A) Increase in the number of competency evaluations.

In recent years professionals in criminal justice have become much more aware of the prevalence of mental illness among people who are arrested. And the standard for commencing a competency evaluation is that the prosecutor, defense counsel, or court "doubts the defendant's competency."[9] This is an appropriate and well-established standard, but it is a very low bar. It seems that the need for evaluations will only increase. Participants did not have suggestions for decreasing the number or need for evaluations, but they did suggest some ways that the evaluation process might be improved:

- Develop uniform standards and continuing education for evaluators.
- Create opportunities for evaluation by multiple evaluators.
- Remove mandatory dismissal for misdemeanors (this was suggested as a means to stop low-level offenders from repeatedly cycling through the system or to reach them early before their behavior escalates to the gross misdemeanor or felony level).

B) Lack of resources; mentally ill individuals in jail.

Many suggestions arose regarding resources that are needed in the field. Most were for alternatives to the present path that cases tend to take toward commitment in a secure hospital. Many intertwined with the issues that had been raised about mentally ill individuals being held in jail, and were aimed at reducing or eliminating that time. Suggested solutions were:

- Evaluate the current system with regard to the effectiveness of its programs. "Do they provide a quality product worth the public investment? We don't know what we have."
- Expand Urgent Care to cover mental illness.
- Provide all police officers and deputy sheriffs with Crisis Intervention Training (CIT) (acknowledging that small jurisdictions have logistical problems taking officers out of the rotation for 40 hours of CIT) so that mental health crises can be de-escalated and the mentally ill can be appropriately directed to the help that they need.
- Establish programs that divert individuals who are mentally ill from jail (e.g., "a walk-in 24-hour assessment center with the ability to hold someone overnight").
- Establish more programs like the Hennepin County Behavioral Health Initiative, which helps jail and workhouse inmates connect with health insurance, housing, and employment.
- Utilize the law that allows competency and commitment evaluations to be done contemporaneously if all the parties agree; this would require trust and less adversarial behavior.
- Amend the rules of criminal procedure to impose expedited timelines (e.g., require the competency hearing to be held within 14 days; shorten the deadline for the report). Currently the individual often sits in jail for six weeks waiting for a report.
- Establish more criminal mental health courts. Minnesota currently has three, but also many drug courts which consider options for co-occurring mental health disorders.

C) The gap between the criminal incompetency determination and civil commitment; competency restoration treatment.

Here, the roundtable participants recognized that two groups of rights have to be balanced: the individual rights of the accused and the community's interest in public safety. But participants also acknowledged that there are a lack of options for the individuals who do not meet the civil commitment standard and will never attain competency. Suggestions included:

- Develop options for individuals who are found to be incompetent to stand trial but do not meet the standard for civil commitment.
- Address restoration to competency in ways that do not require commitment (which demands that "danger to self or others" be proven by clear and convincing evidence).[10]
- Establish competency restoration treatment outside the state's two secure hospitals. This could include outpatient competency restoration treatment, for which the National Judicial College has developed best practices. This could also include some form of less restrictive community care.
- Develop a more holistic treatment program than memorization of courtroom roles.
- Authorize entities and programs other than DHS to take responsibility for individuals under commitment solely for the purpose of competency restoration treatment; there is no requirement that commitment must be to DHS.
- Enact laws to govern competency restoration treatment.

D) The "48-Hour Rule":

As this discussion developed, it seemed that the issues raised were not about the law itself, but about resource shortages which became more apparent when the law made it necessary to move people out of jail in 48 hours. Suggestions included:

- It may be necessary to repeal or revise the 48-hour rule.
- Perhaps the law should be revised so someone who has been found in need of competency restoration treatment is referred to a program, but NOT the Anoka Regional Treatment Center.

3. What are the group's reactions to the Legislative Auditor's recommendations?

The roundtable participants also discussed the specific recommendations regarding competency contained in the Legislative Auditor's report.[11] Generally the group was sympathetic to the Auditor's approaches to the issues, but by looking at the big picture from multiple angles was able to suggest many considerations that would arise in the implementation of these and other necessary improvements to Minnesota's competency standards and competency restoration strategies. This section details reactions to a few recommendations in particular.

LEGISLATIVE AUDITOR RECOMMENDATION

The Legislature should amend Minnesota Statutes 2015, Chapter 253B, to:

- ***Create a commitment category specifically for competency restoration. Courts would be authorized in law to commit an individual to competency treatment based solely on a court finding of incompetency, without having to go through a separate commitment process.***
- ***Require that individuals deemed incompetent but no longer facing criminal charges be referred to their county human services agency for follow-up.***[12]

The roundtable participants had mixed reactions to this recommendation. Some commented that it failed to address the fact that some individuals cannot be treated to competency, and that there is no separate process to decide whether someone ever will be competent. Others noted that the Legislative Auditor's recommendation is something that several other states do. One participant said, "This recommendation is changing the way the criminal court can retain jurisdiction over individuals." Another further elaborated, "This might be a bad idea on constitutional due process grounds" because it could be used to retain court jurisdiction over an individual at a point when the individual is still presumed innocent of the crime but yet does not meet the commitment standard of danger to self or others. Participants also discussed the possibility that commitment to competency restoration treatment could be a condition of pretrial release; however, it was noted that there are many counties that have no pretrial release supervision capabilities.

LEGISLATIVE AUDITOR RECOMMENDATION

For persons committed to the commissioner of human services for competency restoration, DHS should have a continuum of placement options that it can choose from, rather than just high-security settings.[13]

The roundtable participants endorsed the need for a "continuum of options" throughout the discussion, but still had some caveats in regard to this recommendation. First, participants noted that evaluators need to know what placement and treatment options are available. Second, participants noted that the options within the continuum must be adequately funded. Especially if some of the options are developed within the community, it would be difficult to have individuals committed at the county level without any source of funding for their care. Even with that caveat, participants suggested that perhaps the effort to develop such a continuum of options should not be solely the responsibility of DHS.

Several additional recommendations from the Legislative Auditor pertained to the "48-Hour Rule." These are addressed above. The Legislative Auditor's Report on *Mental Health Services in County Jails* can be found at http://www.auditor.leg.state.mn.us/ped/pedrep/mhjails.pdf.

Conclusion

Overall, participants' experience at this roundtable confirms that more work needs to be done with regard to the evaluation and determination of competency to stand trial in criminal cases, subsequent civil commitment proceedings, and treatment. As professionals in the criminal justice system continue to become more familiar with the challenges faced by persons with mental illness in the criminal justice system, the volume of civil commitment referrals will continue to increase. The result will be that the already overtaxed resources—particularly those in community-based settings—will be supplemented and perhaps redesigned. The perspectives of many different entities and agencies in the criminal justice and mental health systems should be taken into account when developing legislative solutions. The Robina Institute will continue to serve as a resource and contributor to this effort.

End Notes

[1] *See* Minn. Stat. § 611.026 (2016) ("No person having a mental illness or cognitive impairment so as to be incapable of understanding the proceedings or making a defense shall be tried, sentenced, or punished for any crime."). Competency proceedings are governed by Minn. R. Crim. P. 20.01 (2016).

[2] Minn. Office of the Legislative Auditor, *Mental Health Services in County Jails* 21 (Mar. 2016), available at: http://www.auditor.leg.state.mn.us/ped/pedrep/mhjails.pdf.

[3] Order Regarding Proposed Amendments to the Rules of Crim. Procedure Governing Proceedings Under the Minnesota Commitment and Treatment Act, ADM10-8046 at 10 (Minn. April 22, 2016), http://www.mncourts.gov/mncourtsgov/media/CIOMediaLibrary/News%20and%20Public%20Notices/Administrative-Order-Comment-Period-(002).pdf.

[4] Minn. R. Crim. P. 201.01, subd. 6.

[5] Minn. Stat. § 253B.02, subd. 13 (2015).

[6] Minn. Office of the Legislative Auditor, *Mental Health Services in County Jails* 83 (Mar. 2016).

[7] *See id.* at 78 ("The commitment criteria focus on the individuals' mental illness and dangerousness to self or others; the competency criteria focus on the impact of mental illness on the defendants' ability to understand court proceedings or participate in their own defense.").

[8] *See* Minn. Stat. § 253B.10, subd. 1 (2016).

[9] Minn. R. Crim. P. 20.01, subd. 3.

[10] Minn. Stat. § 253B.09, subd. 1 (2016).

[11] Minn. Office of the Legislative Auditor, *Mental Health Services in County Jails* ch. 4, pgs. 75-95 (Mar. 2016).

[12] *Id.*at 86.

[13] *Id.* at 87.

Competency Roundtable Participants:

Sue Abderholden, Executive Director, NAMI Minnesota
Glenn Anderson, Northern Pines Mental Health
Linda Berglin, Hennepin County Intergovernmental Relations
John Choi, Ramsey County Attorney
Dr. Mary Kenning, Forensic Psychologist
Kirstin Kopp, Commitment Defense Attorney
Kelli Lassig, MN Department of Human Services
Ryan Magnus, Commitment Defense Attorney
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Virginia Murphrey, 10th District Chief Public Defender
Roberta Opheim, Ombudsman for Mental Health and Developmental Disabilities
Sen. Julianne Ortman (R-Chanhassen)
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Hon. George Stephenson, Judge of Ramsey County District Court
Beth Sullivan, Minnesota Department of Human Services
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About the Robina Institute of Criminal Law and Criminal Justice

The Robina Institute brings legal education, theory, policy and practice together to achieve transformative change in punishment policies and practices. The Institute is focused nationally on sentencing guidelines, probation revocations, and parole release and revocations, and locally on the Minnesota criminal justice system.

The Robina Institute was established in 2011 at the University of Minnesota Law School thanks to a generous gift from the Robina Foundation. Created by James H. Binger ('41), the Robina Foundation provides funding to major institutions that generate transformative ideas and promising approaches to addressing critical social issues.

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