

**Incompetent to Stand Trial Solutions Working Group
Work Group 3: Initial County Competency Evaluations
Friday, September 17, 2021 – 2PM to 4PM
Discussion Highlights**

1. Welcome and Introductions

Karen Linkins welcomed all attendees and announced she will be co-facilitating the meeting with John Freeman. She thanked everyone for their dedication to this process and this population. She reminded the group to be solution-oriented and of the urgency of the work, noting the fact that there are currently 1700 people in jail awaiting treatment who have been referred. Karen asked members of the Initial County Competency Evaluations working group to introduce themselves with their name and organization. All members were present except Marni Sager. The members in attendance were:

- Deanna Adams, Judicial Council of California
- Katherine Clark, Department of Finance
- Matthew Greco, Deputy DA of San Diego County
- Stephen Manley, Superior Court Judge of Santa Clara County
- Farrah McDaid Ting, Senior Legislative Representative for the California State Association of Counties
- Danny Offer, NAMI California
- Ira Packer, Forensic Psychologist, UMass Medical School Psychiatry Department, Consultant to State of California
- Dawn Percy, Deputy Director for Department of Developmental Services
- Jonathan Raven, Chief Deputy for Yolo County DA's Office, representing statewide association
- Stephanie Regular, Assistant Public Defender for Contra Costa County, representing statewide association
- Todd Schirmer, Psychologist and Division Director for forensic and criminal justice behavioral health programs for Marin County, representing the county's Behavioral Health Directors Association

Karen Linkins reminded group members that their purpose is to discuss solutions, not provide oversight, and the report with suggestions is due at the end of November. She asked members to be brief and raise their hand on Zoom to speak. She asked that the Zoom chat not be used by workgroup members so their contributions can be heard out loud, but noted the chat is available and encouraged for public comment at the end of the meeting or during audience participation periods at the end of each presentation.

2. Goals of this Working Group

Karen Linkins reviewed the goal of the group, which is “to reduce the number of individuals found incompetent to stand trial by strengthening the quality of the initial competency evaluation.” She also reviewed the foci of the other two working groups and noted that there is potential overlap. One group is focused on early access to treatment and stabilization for felony ISTs and the other is focused on diversion and community-based restoration for felony ISTs. She outlined that the goal for this meeting was to understand the issues with competency evaluations. Karen Linkins introduced Dr. Katherine Warburton, Medical Director, Department of State Hospitals, to address this topic.

3. Overview of Issues to Address and Q+A

Presentation: Dr. Ira Packer

Katherine Warburton introduced the first of two experts in attendance, Dr. Ira Packer, Professor of Psychiatry at UMass Medical School and Director of their Postdoc Fellowship Program. He is also the chair of the MA committee that oversees the training and certification of all forensic psychiatrists and psychologists in the state and the former President of the American Board for Forensic Psychology.

Ira Packer described that his presentation, “Training, Certification and Quality Improvement for Competence to Stand Trial Evaluations,” provides context on this issue outside of California because other states face the same challenges. Presentation highlights included:

- National standards developed by National Judicial College, American Academy of Psychiatry and Law, other resources
- At minimum 19 states have CST evaluation certification programs
- Some states have postdoctoral training for forensic psychologists and psychiatrists
- Many states fail to realize that this is a specialty area that requires specific training
- Many states have seen large increases in IST referrals (75% between 1999 and 2014)

- The demand for evaluations exceeds number of qualified evaluators, leading states to use unqualified evaluators to meet level of need and resulting in poor quality of reports
- Lack of training and low reimbursement rates are widespread problems
- Reports may be poor quality because of insufficient understanding of IST law (falsely equating mental illness with incompetence), reliance on self-reporting (both a problem in terms of people minimizing symptoms and exaggerating them), not accounting for effects of substances, and not connecting final opinions to data
- Elements present in states with certification standards (not all states have all elements):
- Educational classes/training, written exams, written report samples, supervision/mentoring from senior in the field, quality assurance process to review reports and give feedback when necessary
- The Massachusetts model is considered the gold standard:
- Initial workshop, individual mentoring, report review process by someone other than mentor, written exam, ongoing quality improvement process overseen by the state department of mental health
- Report review process is essential and trainings alone are insufficient
- Data from Massachusetts:
- 86% of reports at time of 1998 review met quality standards
- Inpatient evaluators are generally satisfied with the outpatient evaluations that lead to admissions
- Judges surveyed this year are overall satisfied with quality of CST reports
- Investments in this area pay off:
- Average payment for CST evaluations is \$750, which is much less than hospital bed costs spent on inappropriate admissions

Presentation: Dr. Charles Scott

Katherine Warburton said they would now shift to talk specifically about California and DSH. She introduced Dr. Charles Scott, Chief of Psychiatry and the Law, Forensic Psychiatry and Training Director, and Professor of Psychiatry at UC Davis. He is also the former President of the American Academy of Psychiatry and the Law and of the Association of Forensic Fellowship Directors. Dr. Charles Scott acknowledged his presentation featured a study done by UC Davis in collaboration with DSH. Presentation highlights included:

- The study was published recently in the journal *Psychiatric Services* (2021)
- Reviewed the quality of 388 CST reports of people found incompetent to stand trial
- 138 experts involved in the study
- 72% of reports were by psychologists, 28% by psychiatrists

- Number of ISTs has close to doubled in recent years and judge's decision usually follows evaluator's recommendation

Researchers evaluated reports for adherence to guidelines and best practices in the literature, including if evaluators reviewed the description of the charges and collateral data (police records, attorney contact), if they conducted a mental status exam, provided a DSM diagnosis, discussed impairment, and if they addressed California's standards

Influence of education/training (board certification) on the quality of reports:

- A majority, regardless of board certification, correctly identified charges and reviewed some collateral data, though board certified evaluators had higher rates of reviewing collateral data
- 71% of non-certified evaluators included a mental status exam compared with 93% of certified evaluators
- More than double the amount of certified than non-certified evaluators did structured assessments for feigning and competence and considered feigning
- Only a third of non-certified evaluators provided a DSM diagnosis compared with over 85% of certified ones
- Majority of both groups provided an opinion about competency but there was a difference in quality/depth
- Fewer than half of both groups linked diagnosis and competency impairment, though rates differed (around 15% non-certified, around 30% certified)
- More certified evaluators considered questions about medication
- Overall, the number of key factors non-certified evaluators considered was 4 compared to certified evaluators who considered 8
- Study found that many reports are not meeting standards and most lacked a DSM diagnosis
- There was low utilization of structured assessments by evaluators
- Concluded that training is crucial for quality improvement, particularly to increase thoroughness, adherence to standards, and use of scientific methods

Presentation: Dr. Katherine Warburton

Katherine Warburton thanked Charles Scott and shared a slide on report quality milestones and noted that:

When she was a forensic psychiatrist at Napa State Hospital she saw many concerning CST reports

- With the UC Davis Research team, they found that 25% of IST referrals entering the hospital were likely competent
- This statistic of 25% competency holds true with the current IST waitlist as well
- She presented this information to a Judicial Council/DMH workgroup 2009 and the TJC published guidance in 2018 in the form of rules of the court.
- AB-1962 passed in 2016 instructing DSH to hold a workgroup to come up with guidelines for evaluators, which was completed in 2019:

- Required board certification or minimum hours of training
- However, if courts cannot find an evaluator that meets criteria, another can be used

Q+A

Karen Linkins thanked all three presenters for laying an important foundation. She welcomed questions from group members:

- Farrah McDaid Ting asked who is doing the evaluations at local jails in California and asked if nationally there is a correlation between the quality of evaluations and the number of people found IST. Charles Scott replied that the majority of CA evaluators are psychologists and the remainder are psychiatrists. In Sacramento County, there are evaluation panels that a Judge and attorneys sit on as well. While all evaluators have these advanced degrees, they do not all have the training required to be effective evaluators. Farrah McDaid Ting asked if courts hire evaluators and Charles Scott said that in some cases yes and in some cases DAs and defense attorneys obtain additional evaluations. Ira Packer added that there are not sufficient data to conclude that untrained evaluators are more likely to deem people incompetent, but anecdotal data from Massachusetts supports that when the responsibility of hiring and overseeing evaluators was transferred from the courts to the Department of Mental Health, a decreased number of people were referred to hospitals.
- Deanna Adams asked Katherine Warburton if the impacts of the state regulations are measurable. Katherine Warburton said she thinks that if evaluations are improving, the number of competent people found IST would decrease, which has not happened as the 25% statistic remains stagnant.
- Judge Manley referenced Ira Packer's slide on costs and observed that in the current court system, each trial court individually determines how much of their budget will be spent on FIST evaluations. He has been advocating that this become an official budget line item with additional funding because there are vast variations between counties. Rural counties struggle to find evaluators. Currently, there are an insufficient number of evaluators overall and they are not paid enough to achieve the goals being discussed. He suggested that the system could be overseen by DSH rather than the judicial council. He said that increasing the budget for evaluations may effectively reduce the number of people in jail awaiting evaluations.
- Karen Linkins read a question from the chat by William Oglesby. He asked Charles Scott if there were differences found in evaluation quality between evaluators trained and not trained in CST, separate from board certification. Charles Scott said that board certification (psychology and psychiatry) provides extensive training on this, which is why they looked at that variable for the study.

- Matthew Greco asked Ira Parker, given that quality reports depend on speedy admission to hospital settings because long wait times in jail for evaluations are costly, what the wait times are in MA compared to CA, which in San Diego are 2-8 months. Ira Packer said that there is no wait time in MA—it happens same day and there are no jail-based evaluations, rather they are court-based. This results in an insufficient number of beds for civil patients. He discussed that wait times pose many issues and even misdemeanor cases (not in MA) are sitting in jail awaiting competency evaluations. Matthew Greco asked for clarification that ISTs are indeed evaluated immediately and referred to the hospital that same day for restoration. Ira Packer said that technically they are referred for further evaluation, not restoration, but indeed they are not waiting in jail for either evaluation or an available hospital bed.
- Stephanie Regular asserted that there is not agreement on the DSH finding that 25% of referrals are competent and the courts have often contested these determinations of competency. She asked Charles Scott about short form vs. long form reports (referenced LA county which has increased speed through short form reports) and if short term reports were part of their study. Charles Scott said that they looked at reports from Napa State Hospital, which he believed did not contain any short form reports. Stephanie Regular asked if there have been any studies looking at quick reports done in court like the ones LA County conducts. Charles Scott said he has not seen research on this but has seen data that say structured reports that look at feigning and other factors are useful. Ira Packer agreed there is not data because it is not a common practice but has anecdotally seen in MA that longer form evaluations in hospitals find the same results as court evaluations, with the exception of cases of effective malingering.
- Todd Schirmer said that based on his experience at Napa State Hospital, he has seen the negative impacts of poor evaluations. He raised concern about the focus on training and credentials because he agrees with Judge Manley that the primary problem is a shortage of evaluators. He said it is important to incentivize training and he would support the state taking this on as well as increasing standards but the bar should not be set too high because of the overall shortage.
- William Oglesby clarified his previous question in the chat and asked if there were differences found between untrained evaluators and evaluators with sufficient training but without board certification. Charles Scott said that their study did not look at differences in training between uncertified evaluators but there was a significant enough difference between them and the certified evaluators that looking at training differences would likely not have changed that ultimate finding.
- Ira Packer agreed with Todd Schirmer that board certification should not be a requirement, at least for psychologists, because of how few certified psychologists there are and the fact that those people still need to be trained. He added that multiple types of forensic training are sufficient. Charles Scott agreed and said the study was looking at the amount of difference that training makes through looking specifically at

board certification, but it was not meant to imply board certification must be the requirement. Katherine Warburton said that in the previous stakeholder workgroup, they looked to other states who do internal certifications and recognized that it was not feasible to expect board certification.

- Ms. Byrne asked in the chat if the number of 25% competency results from medication in the hospital or if they were not IST to begin with. Katherine Warburton answered that it is some of both, as well as drugs in people's systems wearing off.

4. Discussion of Short-Term Strategies

Karen Linkins moved the group into a discussion about strategies and asked the group to think about short term solutions today that could be implemented by April 1, 2022. She asked that any other questions and comments on the previous presentations be emailed. Work group members shared ideas:

- Farrah McDaid Ting said that what has been discussed today mirrors what she has heard from counties and from the Behavioral Health Directors Association. She raised an idea brought up previously that the state should play a role in hiring and training evaluators and providing oversight. She acknowledged that this would not be feasible by April but large steps could be taken, with oversight and reporting being especially important.
- Jonathan Raven asked if DSH could supplement the evaluation budgets if the reason that there is an insufficient number of evaluators is indeed because of a lack of funding. He also asked about the possibility of TeleHealth for evaluations and if DSH could fund that. Katherine Warburton responded that she cannot speak to what DSH will and won't fund but they want to partner with counties on TeleHealth. She said the money question will be put on the list.
- Karen Linkins said that cost implications should be considered for all proposed solutions.
- Judge Manley repeated the need for funding as an immediate issue because otherwise nothing can happen quickly. He emphasized the diversity of CA counties in regards to needs and budgets. He stated that they cannot reduce waitlist times without more evaluators and more money to pay them, as their number of evaluators currently is declining due to insufficient pay.
- Stephanie Regular agreed with Judge Manley and added that in CA, court evaluators get paid between \$350 and \$500 compared to \$750 in MA. This results in a loss of the best evaluators who are offered more money in private contracts.

- Matthew Greco said he does not have a solution, but he has seen that even with a team of 8 well trained evaluators in San Diego, initial evaluations take 40 days, so training alone is not sufficient. He disagreed with the idea that with better training, more people will be found competent. He suggested instead that there is an argument that competence is being declared more than it should be. He said that funding is an issue even in large counties. Charles Scott responded that the study's concerning finding was an overall insufficient number of diagnoses, which could include incompetent people being missed.
- Deanna Adams brought up a chat message that discussed expanding forensic programs in medical schools and suggested that USC provides a strong example. Chris Scott discussed that the number of these programs has steadily increased and it remains a goal to increase that number further, but it will not be enough to meet the level of need.
- Stephanie Regular agreed that fellows in forensic programs are a strong resource but not enough. She raised concerns about TeleHealth in relation to the quality of an evaluation that is not done in person and the idea that this would be overseen by DSH whose evaluators do not speak with defense attorneys, which is necessary.

Karen Linkins said that the group could also raise mid-term solutions to be implemented by January 2023. Group discussion continues:

- Todd Schirmer asked if DSH could provide ongoing training to current evaluators to increase the overall quality of reports. This could be a short-term or mid-term goal.
- Katherine Warburton said that linking eligible diversion candidates to county diversion programs could be a mid-term solution.
- Matthew Greco proposed that a mid-term solution could be that during jail wait times, jail psychiatric or medical staff evaluate people who have been medicated (referenced Penal Code Section 1370) to see if they have been restored to competency, which kicks the case back to the court. He clarified that this is different than jail-based competence.
- Ira Packer raised that the core issue is that mentally ill people should not be in jail. Currently, the competency system is a backdoor to get people to hospitals when they should be able to go directly to hospitals.
- Brian Bloom suggested in the chat that a mid-term solution could be treating 1170 felonies ("county jail felonies") as misdemeanors. Stephanie Regular said this is a great idea and those individuals could then be diverted to different programs, including AOT or conservatorships if necessary.

Karen Linkins asked the group to show up to the next meeting with two solutions in mind. She requested that the group members not discuss these with each other ahead of time as that would be a Bagley-Keene violation. She encouraged people to email their questions and comments.

5. Call for Public Comment

Karen Linkins opened the floor to public comment through either raising hands in Zoom, commenting in the chat, or emailing:

- Douglas Dunn emphasized that TeleHealth is an insufficient solution and does not work to do evaluations. He also said that in Contra Costa County they are looking for misdemeanor alternatives including AOT and that Contra Costa County needs additional funding to care for this population.

Meeting Wrap Up and Next Steps

Katherine Warburton thanked the presenters and work group members for their contributions. She reminded the group to come to the next meeting with two concrete, short-term solutions.

Jonathan Raven said that he thinks some conversations between group members is appropriate and complies with Bagley-Keene as long as it is not a meeting of the majority. Karen Linkins agreed and said she was coming from a place of wanting to be cautious and inclusive.

The next group meeting will be September 24th from 2-4pm and the one after that will be October 15th from 2-4pm. Karen Linkins reminded the group that the minutes and agenda will be posted on the website.

Appendix 1: Chat Transcript

From John Freeman to Everyone:

We have now enabled chat for all participants. Working group members, please raise your hands and provide questions verbally.

From John Freeman to Everyone:

Participants Please enter any questions here and we will work through them as possible.

From John Freeman to Everyone:

You may also always email them to ISTolutionsWorkgroup@dsh.ca.gov

From John Freeman to Everyone:

Materials will be posted to the working group Web Site:
<https://www.chhs.ca.gov/home/committees/ist-solutions-workgroup>

From William Oglesby to Everyone:

In FL, CST evaluators, who must to complete state-required training, contract individually with each judicial circuit.

From William Oglesby to Everyone:

Dr. Scott, the study results demonstrated differences between board-certified versus non-board certified evaluators -- were there differences identified between those who had received specific CST training (i.e., in another jurisdiction) regardless of board-certification?

From Michelle Cabrera to Everyone:

Agree with the point here that we're paying too low. We've heard that the \$750 average is much lower in some places, to Judge Manley's point. We need to look at the fully loaded costs here. Inappropriate determinations now resulting in: longer wait list (i.e. longer wait time for those who really need treatment at DSH, cost of reevaluations, and jail and state hospital costs, inappropriate time in jail, not to mention any penalties the state may be on the hook for). When/if we pay more, need to also look for improvement in quality per the UC Davis research.

From Scott, Charles to Hosts and panelists:

Both forensic psychology training and forensic psychiatry training require extensive training in trial competency....

From Scott, Charles to Hosts and panelists:

general psychiatry and psychology training do not require competency to stand trial as part of national standards...but forensic training does to meet national standards

From Raven, Jonathan to Hosts and panelists:

Well said, Judge!

From Julie Enea to Everyone:

I understand that most inmates referred to DSH arrive with a medication order by the referring court. How is that possible if most CA courts use a psychologist rather than a psychiatrist as the alienist? Our court cannot afford a psychiatrist and few are qualified for this purpose.

From Linda Mimms to Hosts and panelists:

Yes Judge, sitting months in jail, often years, with no medical treatment for their brain deterioration, getting worse and reducing their chance of a meaningful recovery.

From William Oglesby to Everyone:

For those who are not board-certified but who have nonetheless received appropriate training, were there found differences?

From Mark Gale to Everyone:

Also to add to Judge Manley's point, not only are people waiting for the evaluation, but after that is done they sit for many months waiting for a bed at DSH. And if 25% of those are not IST, what are we doing to people? Thank you to everyone on this workgroup so we can finally fix this broken system of laws and protocols. If Massachusetts can improve upon their system, so can we!

From Michelle Cabrera to Everyone:

About the same size as Imperial county in square miles

From Michelle Cabrera to Everyone:

Sorry Inyo!

From Byrne to Hosts and panelists:

Are the 25% of people who come to the hospital that are not IST-- is that because they have access to meds? or were not IST in the first place?

From William Oglesby to Everyone:

Gotcha thanks

From Raven, Jonathan to Hosts and panelists:

To Byrne - I understand both. Some were never IST. Some were, but regained competence prior transport to the state hospital.

From Michelle Cabrera to Everyone:

Can you say more about oversight/secondary review?

From Raven, Jonathan to Hosts and panelists:

i had some questions i emailed.

From John Freeman to Everyone:

Thanks, Jonathan. For reference and to keep these in one place, here is what came through in the email:

1. Why do we have a hard time finding evaluators?

2. I assume it's money. You get what you pay for. Our bench tells us the funding comes from the judicial council and this funding is not enough. Can DSH supplement this?

3. What about more telehealth? I'm sure there's not data out there yet, but do we are we comfortable with the accuracy of telehealth evaluations?

4. Could DSH use the funding to do more telehealth evaluations at the initial IST evaluation?

From Raven, Jonathan to Hosts and panelists:

I'm talking telehealth initial evaluations not after an individual has been declared IST.

From Lindsay Schachinger to Hosts and panelists:

Ms. Regular has her hand up

From Byrne to Hosts and panelists:

USC medical school has med school residents do the evaluations. Is/Could this be replicated in other psychiatric residency programs?

From Douglas Dunn to Everyone:

I agree with Judge Manley. Up front funding quickly, by line item, from the state though the DSH is "mission critical."

From Raven, Jonathan to Hosts and panelists:

I agree also.

From William Oglesby to Everyone:

Agreed. Increase the pool of evaluators beyond a core few. This is a function of payment solely.

From Teresa Pasquini to Hosts and panelists:

Judge Manley speaks for families like mine. It is impossible to have any discussion about this population without focusing on the fiscal discrimination that is driving the disparities.

From Michelle Cabrera to Everyone:

We are also experiencing extremely high demand for our behavioral health workforce, so pay will need to increase no matter what, but it must come with additional oversight/quality controls.

From Douglas Dunn to Everyone:

From live experience with our loved one, tele-health evaluations for persons considered or "at risk" of IST are highly suspect.

From Lindsay Schachinger to Hosts and panelists:

I agree. I don't think it follows that more training will lead to fewer findings of incompetency.

From Raven, Jonathan to Hosts and panelists:

Right Douglas - one of my questions was how accurate are telehealth evals.

From Teresa Pasquini to Hosts and panelists:

agree.

From Linda Mimms to Hosts and panelists:

Agree Mr. Greco. I think a mission of finding fewer people determined incompetent has the danger of not catching and treating very sick people who have been criminalized solely for their no-fault brain diseases.

From Byrne to Hosts and panelists:

Thanks Deanna. My mic doesn't work?

From Linda Mimms to Hosts and panelists:

The problems with increasing IST people, back ups in the jail to DSH beds, etc., are due to our state's much greater problem of lack of access to entry into care, a strong continuum of care, strong AOT programs across our state, and a lower bar for compassionate involuntary care for our sickest.

From Linda Mimms to Hosts and panelists:

Exactly Dr. Packer—nail on the head!

From Brian Bloom to Hosts and panelists:

One mid-term solution for reducing the number of folks on the waiting list for a competency restoration bed is a legislative solution. Why not treat 1170(h) felonies (so-called "county jail felonies") like misdemeanors per 1370.01?

From Linda Mimms to Hosts and panelists:

Plus the treatment for restoring competency is not the same as the kind of treatment needed for a solid road to recovery—it is a band aid to get folks back into the courtroom.

From Mark Gale to Everyone:

Thank you for your comments, Dr. Packer. We should be restoring people in the community unless they are such a public safety issue they need to go to a state hospital. I realize my comment is outside evaluators, but we really need to examine the purpose of our state hospitals.

From Lindsay Schachinger to Hosts and panelists:

When is the next meeting?

From Mark Gale to Everyone:

Are we really using our state hospitals for the purpose that was originally intended?

From John Freeman to Everyone:

Email: ISTSolutionsWorkgroup@dsh.ca.gov

Web Site: <https://www.chhs.ca.gov/home/committees/ist-solutions-workgroup>

From Douglas Dunn to Everyone:

I have a public comment, if allowed.