Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report

RECOMMENDATIONS FOR CHANGING THE PARADIGM FOR PERSONS WITH MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM

APRIL 2011

ADMINISTRATIVE OFFICE OF THE COURTS

CENTER FOR FAMILIES, CHILDREN & THE COURTS

Competence to Stand Trial

Courts, in collaboration with state hospitals and local mental health treatment facilities, should create and employ methods that prevent prolonged delays in case processing and ensure timely access to restoration programs for defendants found incompetent to stand trial.[70]

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends the following:

28. There should be a dedicated court or calendar where a specially trained judicial officer handles all competency matters. Competency proceedings should be initiated and conducted in accordance with California Rule of Court 4.130 and relevant statutory and case law.[71]

29. Each court should develop its own panel of experts who demonstrate training and expertise in competency evaluations.

30. Mental health professionals should be compensated for competency evaluations in an amount that will encourage in-depth reports.

31. California Rule of Court 4.130(d)(2) should be amended to delineate the information included in the court-appointed expert report in addition to information required by Penal Code section 1369. The report should include the following:[72]

    a. A brief statement of the examiner's training and previous experience as it relates to examining the competence of a criminal defendant to stand trial and preparing a resulting report;
    b. A summary of the examination conducted by the examiner on the defendant, including a current diagnosis, if any, of the defendant's mental disorder and a summary of the defendant's mental status;
    c. A detailed analysis of the competence of the defendant to stand trial using California's current legal standard, including the defendant's ability or inability to understand the nature of the criminal proceedings or assist counsel in the conduct of a defense in a rational manner as a result of a mental disorder;

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[70] The task force examined the difficult problem of the defendant who may not have "a sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding and . . . a rational as well as factual understanding of the proceedings against him" (*Dusky v. U.S.* (1960) 362 U.S. 402), but not as a result of a mental disorder or developmental disability as currently required by Penal Code section 1367. Judges often encounter defendants who seem to lack these abilities as a result of cognitive impairments resulting from organic brain damage, fetal alcohol syndrome, or other causes, which have not been formally diagnosed as developmental disabilities. This is an area that requires further research.

[71] See also Center for Judicial Education and Research (CJER) Benchguide #63 (revised 2010).

[72] A preliminary draft of information that should be included in expert reports originally came from the Council on Mentally Ill Offenders (see glossary).

d. A summary of an assessment conducted for malingering, or feigning symptoms, which may include, but need not be limited to, psychological testing;
e. Pursuant to Penal Code section 1369, a statement on whether treatment with antipsychotic medication is medically appropriate for the defendant, whether the treatment is likely to restore the defendant to mental competence, a list of likely or potential side effects of the medication, the expected efficacy of the medication, possible alternative treatments, whether it is medically appropriate to administer antipsychotic medication in the county jail, and whether the defendant has capacity to make decisions regarding antipsychotic medication;
f. A list of all sources of information considered by the examiner, including, but not limited to, legal, medical, school, military, employment, hospital, and psychiatric records; the evaluations of other experts; the results of psychological testing; and any other collateral sources considered in reaching his or her conclusion;
g. A statement on whether the examiner reviewed the police reports, criminal history, statement of the defendant, and statements of any witness to the alleged crime, as well as a summary of any information from those sources relevant to the examiner's opinion of competency;
h. A statement on whether the examiner reviewed the booking information, including the information from any booking, mental health screening, and mental health records following the alleged crime, as well as a summary of any information from those sources relevant to the examiner's opinion of competency; and
i. A summary of the examiner's consultation with the prosecutor and defendant's attorney, and of their impressions of the defendant's competence-related strengths and weaknesses.

32. An ongoing statewide working group of judicial officers, the Administrative Office of the Courts, Department of Mental Health, CONREP, and other stakeholders should

CONREP has established a pilot program *in collaboration with Napa State Hospital to improve CONREP's ability to accurately identify individuals who can be safely and effectively restored to competence for trial in an outpatient setting rather than the state hospital. San Francisco and Sacramento CONREP program officers will be trained in the use of a preplacement assessment protocol.*

The protocol assesses severity of psychiatric symptoms, the defendant's ability to understand court procedures and charges, and the possibility that the defendant is feigning mental illness (malingering). The protocol also includes an actuarial assessment of risk for violence. It is anticipated that with the successful implementation of these practices, CONREP will be able to place more defendants in the community for competency restoration, identify inmates who might be malingering, and identify inmates who have become almost or fully competent since the initial competency evaluation.

be established to collaborate and resolve issues of mutual concern regarding defendants found incompetent to stand trial.

33. State hospitals and mental health outpatient programs should be adequately funded to ensure effective and timely restoration of competency for defendants found incompetent to stand trial in order to eliminate the need to designate jails as treatment facilities (Pen. Code §1369.1).

34. There should be more options for community placement through CONREP and other community-based programs for felony defendants found incompetent to stand trial on nonviolent charges so that not all such defendants need be committed to a state hospital for competency restoration.

35. Courts are encouraged to reopen a finding of incompetence to stand trial when new evidence is presented that the person is no longer incompetent. If the defendant is re-evaluated and deemed competent he or she should not be transferred to a state hospital.

36. Existing legislation should be modified or new legislation be created to give judicial officers hearing competency matters access to a variety of alternative procedural and dispositional tools, such as the jurisdiction to conditionally release a defendant found incompetent to stand trial to the community, where appropriate, rather than in a custodial or hospital setting, to receive mental health treatment with supervision until competency is restored.

37. Care and treatment of defendants with mental illness should be continued after restoration of competence. Penal Code section 1372(e) should be expanded, consistent with *Sell v. United States,* to ensure that competence is maintained once restored and that medically appropriate care is provided to defendants until such time that a defendant's incompetent-to-stand-trial status is no longer relevant to the proceedings. In an effort to maintain a defendant's competence once restored, courts, state hospitals, and the California State Sheriff's Association should collaborate to develop common formularies to ensure that medications administered in state hospitals are also available in jails.

Additional Court Resources

Courts are encouraged to provide additional supports to defendants with mental illness.

The Task Force for Criminal Justice Collaboration on Mental Health Issues recommends the following:

38. Forensic Peer Specialist Programs[73] should be utilized within the courts, particularly in mental health courts to assist defendants with mental illness in navigating the criminal justice system.

39. Court Self-Help Centers should provide materials to defendants with mental illness, family members, and mental health advocates about general court processes, mental health courts or other court-based programs and services for defendants with mental illness, and community and legal resources.

[73] See glossary.

CALIFORNIA COURT EVALUATIONS OF NGRI ACQUITTEES
A Research Study Examining 930 NGRI Evaluations
January 9, 2005

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BACKGROUND

The insanity defense is a legal construct that, under some circumstances, excuses mentally ill defendants from legal responsibility for their criminal behavior.

Legal definitions of insanity vary from state to state. In California, Proposition 8, the so-called "Victim's Bill of Rights", went into effect in 1982, abolished the diminished capacity defense, and codified the current definition of insanity used in California.

In California, The insanity defense as defined in California Penal Code Section §25 (b) reads,

> In any criminal proceeding, including any juvenile court proceeding, in which a plea of not guilty by reason of insanity is entered, the defense shall be found by the trier of fact only when the accused person proves by a preponderance of the evidence that he or she was incapable of knowing or understanding the nature and quality of his or her act and [(or)] of distinguishing right from wrong at the time of the commission of the offense.

The finding of insanity is predicated on the presence of a mental illness or defect. The definition of mental disease or defect that qualifies for the insanity defense in California reads as follows,

> "Mental disease" denotes a condition that can improve or deteriorate.
>
> "Mental defect" denotes a condition that cannot improve or deteriorate, and which may be congenital, the result of injury, or the residual effect of a physical or mental illness. (*In re Ramon M.* (1978) 222 Ca. app. 3d 419, 149 Cal.Rptr. 387.)

According to California Penal Code §25.5,

> In any criminal proceeding in which a plea of not guilty by reason of insanity is entered, the defense shall not be found by the trier of fact solely on the basis of a personality or adjustment disorder, a seizure disorder, or

an addiction to, or abuse of intoxicating substances. This section shall apply only to persons who utilize this defense on or after the operative date of the section. (*Added by Stats.1993-4, 1st Ex.Sess., C. 10 (S.B.40), § 1.*)

The California Supreme Court has held that a person may be found legally insane because of long term voluntary intoxication when the intoxication causes a mental disorder which remains after the effects of the intoxicant have worn off. While this mental disorder need not be permanent, it must be of settled nature. (*People v. Kelly (1973) 10 Cal. App. 3d 565, 111 Ca. Rptr. 171*).

However, as noted in California Penal Code §25.5, the defense of insanity cannot be based solely on the basis of an addiction to, or abuse of intoxicating substances.

BRIEF INTRODUCTION TO THE PROBLEM

Individuals who are found Not Guilty by Reason of Insanity (NGRI) are generally involuntarily hospitalized at a forensic psychiatric facility for an indefinite period of time at an estimated cost of approximately $125,000 per year. Hospitalization is appropriate for individuals with a mental illness or defect who meet the legal criteria for insanity. However, persons who are found NGRI and do not have a mental illness or defect or who do not meet the legal criteria for insanity represent a significant challenge when placed in a hospital setting. These challenges include a diversion of mental health resources away from those clients with legitimate mental illness, potential risk of harm to staff or other clients from individuals whose only diagnosis is a personality disorder, and substantial financial costs resulting from an inappropriate commitment. The 10 year financial cost per NGRI commitment exceeds one million dollars.

In 1997, the University of California, Davis began a collaborative relationship with Napa State Hospital to provide forensic education, consultation, and to research forensic issues relevant to this population. Between 1997 and 2002, Charles L. Scott, MD was responsible for providing second opinion consultations for clients found NGRI and hospitalized at NSH. During this five year period, several cases were reviewed where clients did not appear to have a mental disease or defect as defined in the California statute governing insanity. For example, some clients' history indicated that they were actively intoxicated at the time of the offense but had no evidence of a non substance induced mental illness. A review of other clients' police reports on the day of the offense demonstrated clear evidence of a rational non psychotic alternative motive that showed the client knew the nature and quality of their actions and/or could distinguish between right and wrong.

Two obvious questions arose:

1. How frequently are individuals found NGRI that do not meet the legal criteria for insanity?

2. Why are some individuals found NGRI who do not appear to meet legal criteria for insanity?

To answer these questions, Dr. Scott applied for a UC Davis Faculty Alumni Research Development Grant (FARDF) to conduct an archival record review of 500 clients found NGRI and involuntarily committed to NSH. In 2002, Dr. Scott was awarded a $36,000 Faculty Alumni Research Development Grant (FARDF) for his research project titled "An Archival Review of Substance Use in Not Guilty by Reason of Insanity Acquittees." The aims, methodology, results, and implications of this research study are described below.

AIMS OF STUDY

The aims of this research study were to answer the following questions:

1. Determine prevalence of substance intoxication at the time of the instant offense in individuals found NGRI at NSH;

2. Evaluate court reports of those found NGRI to assess strengths and potential weaknesses of mental health evaluations;

3. Examine presence or absence of rational (non psychotic) motive at the time of the offense that would not meet NGRI statutory criteria;

METHODOLOGY AND RESULTS

The researchers applied for and received Human Subjects Approval from Napa State Hospital Institutional Review Board, State of California Board for the Protection of Human Subjects, and the UC Davis Institutional Review Board to conduct an archival record review of all NGRI acquittees hospitalized at NSH.

The research team examined the records of 500 NGRI clients hospitalized at NSH between 7/15/02 and 5/15/03. The records that were required for a subject to be included in the study included the following:

1. Court reports evaluating sanity;
2. Police reports/witness statements;
3. California rap sheet;
4. Hospital records;
5. Probation reports;
6. Drug screens following instant offense when available.

Of the 500 cases reviewed, 458 had sufficient records allowing study inclusion. Of these 458 cases, there were 930 associated court reports. Not all cases had the same number of associated court reports. The breakdown of cases and associated court reports is as follows:

79 cases	x 1 report	=	79 reports
302 cases	x 2 reports	=	604 reports
61 cases	x 3 reports	=	183 reports
16 cases	x 4 reports	=	64 reports
458 cases			930 reports

In regards to the educational background of the court evaluators, 56.6% (n=526) were MDs; 39.2% (n=365) were PhDs; and 2.2% (n=21) did not record any credential on their submitted report.

All 458 cases were reviewed for evidence of intoxication at the time of the offense. 37% of the cases (n=169) had some or definite intoxication at the time of the offense. However, when reviewing the court reports, only 33% of court evaluators noted whether or not substances were used at the time of the offense. This indicates that because the majority of examiners did not mention whether or not substance use was present at the time of the offense, a greater percentage of NGRI acquittees were likely using some substance during the time of the alleged crime.

A scoring system was devised to determine whether five important areas were reviewed in the NGRI court reports. The five areas included:

1. Diagnosis noted;
2. Police reports reviewed;
3. Past substance use history taken (not including week or 24 hour period prior to instant offense);
4. Substance use history at the time of the offense recorded;
5. Correct insanity statute used by examiner.

The review of the 930 reports found the following: 90% of examiners recorded a diagnosis; 66% reviewed the police reports for the instant offense; 76% took a past substance abuse history; but only 33% recorded whether or not they took a substance use history for the day of the instant offense. This means that 66% (two thirds) of evaluators failed to note or consider substance use symptoms/intoxication at the time of the offense.

In examining whether the evaluator used the correct statute, five categories were noted in conducting this analysis. These categories are:

1. Wrong statute used (i.e. completely different statute or made up statute);

2. No statute stated at all (examiner wrote that person was insane but provided no language consistent with the California statute);
3. Statute was significantly altered with incorrect wording;
4. One prong of the statute was mentioned and used correctly;
5. Both prongs of the statute were noted and used correctly.

Because these reports are used for legal purposes with potentially indefinite commitments resulting, the correct statute with an analysis of both prongs was felt critical. Court evaluator's application of the legal statute in this study is noted as follows:

STATUTE ANALYSIS	FREQUENCY
Wrong statute	10%
No statute stated	11%
Statute altered	12%
Only 1 prong correct	7%
Both prongs correct	56%

These results indicate that nearly half (44%) of all court evaluators used either an incorrect statute when conducting their insanity analysis, stated no statute, altered the statute, or only used on part of the statute correctly. In other words, only slightly more than half (56%) of all court examiners correctly applied the legal statute.

In an analysis of the court reports and of police and witness reports at the time of the offense, 41% (188 subjects) had a rational alternative motive rather than a psychotic motive at the time of the offense. In other words, although the person may have had a mental illness, the actual police record and witness reports revealed that there were clear motives for the criminal behavior that did not meet the criteria for insanity. Common motives noted in these cases were robbing to obtain money for drugs, revenge or anger over a personal rejection, or getting into an argument that was based on a real life dispute. For those subjects who were using substances at the time of the offense, 47% were noted to have a criminal motive as compared to 34% of subjects in which there was no evidence of substance intoxication.

SUMMARY AND IMPLICATIONS

The overall caliber of these 930 court evaluations for individuals found NGRI was shockingly poor. Key deficits were:

1. Nearly half (44%) of all evaluators failed to use or mention the relevant legal insanity statute or used/made up a standard that was completely wrong.

2. One third (33%) of evaluators failed to mention, review, or incorporate available police and witness reports. An insanity analysis requires that the examiner review the person's mental state at the time of the offense. Police and witness statements are considered one of the most important collateral sources of information in making this analysis. Failure to do so falls far below the standard expected for a NGRI evaluation.

3. Two thirds (66%) of evaluators failed to note the presence or absence of substance use at the time of the offense. California excludes voluntary intoxication alone as a mental disease for purposes of a NGRI defense. Failure to take a substance use history creates a substantial likelihood that individuals will be found NGRI and indefinitely hospitalized for symptoms related to involuntary intoxication even though this scenario is excluded by statute.

4. 41% of cases were noted to have a rational alternative non psychotic motive at the time of their offense. The police reports and records indicated that the individuals either knew the nature and quality of their actions or were able to distinguish right from wrong. Because nearly half of examiners did not apply the insanity statute correctly, it is not surprising that a substantial number of subjects may have received a NGRI finding based on flawed court reports.

The above findings indicate that a substantial number NSH NGRI acquittees inappropriately received a NGRI finding based on lack of an adequate evaluation and faulty application of the California insanity statute by court examiners. The financial consequences are staggering considering the annual average hospital cost for an NGRI acquittee is approximately $125,000.

Other consequences include: diversion of limited mental health resources from clients with mental illness rather than personality disorders (excluded by statute for a NGRI finding); risk of violence caused by individuals whose only diagnosis is antisocial personality disorder; and decreased morale in treatment providers responsible for managing individuals inappropriately committed.

RECOMMENDATIONS:

Court evaluators should be required to submit reports that meet at least minimal standards for conducting a NGRI evaluation. To assist in this process, strong consideration should be given to mandating guidelines that court evaluators must follow for their report to be accepted. Such mandated guidelines should include the following:

1. List of all sources of information and collateral contacts used in reaching NGRI opinion;
2. Review of police reports, defendant's statement; and witness statements for the alleged crime;
3. Review of jail booking, screening, and mental health records following the alleged crime;
4. Summary of state's version of the current offense (witness or victim account of crime);
5. Summary of defendant's account of the offense reported to court examiner;
6. Summary of defendant's substance abuse history to include alcohol and other substances used in the 24 hours leading up to the instant offense;
7. Summary of defendant's past psychiatric history;
8. Summary of defendant's past legal history;
9. Current mental status examination;
10. Mental disorder at the time of the offense that meets California's statutory definition of a mental disease or defect. Diagnoses should follow the DSM (Diagnostic Statistical Manual) or ICD (International Classification of Disorders) relevant at the time of the offense. If a non DSM or ICD diagnosis is used, citations to the relevant literature should be provided. If there is a differential diagnosis, the reason should be explained. If the diagnosis turns on a fact in dispute (for example, whether or not the defendant's symptoms were induced by intoxication), there should be an explanation as to how the disputed fact affects the differential diagnosis. Diagnoses excluded by California law should not be accepted by the court for purposes of finding a defendant NGRI.
11. Correct legal standard for sanity when conducting insanity analysis;
12. An insanity analysis for each alleged crime;
13. Direct answers to the following questions for each alleged crime:

    a. Did the defendant suffer from a mental disorder at the time of the alleged crime? If yes, what was the diagnosis?
    b. Was the defendant under the influence of alcohol or a substance at the time of the offense?
    c. If the defendant was under the influence of alcohol or a substance at the time of the offense, did they have an additional mental disorder or defect? If yes, what was the diagnosis?
    d. Was there a relationship between the mental disorder (not including intoxication) and the criminal behavior? If yes, describe.
    e. As a result of a mental disease or defect, was the defendant unable to know or understand the quality of their actions? If no, provide supportive evidence and explain connection of mental disorder to inability to know nature and quality of act.
    f. As a result of a mental disease or defect, was the defendant able to distinguish right from wrong? If no, provide supportive evidence and

explain connection of mental disorder to defendant's inability to distinguish right from wrong.

g. Was there a rational alternative motive for the alleged crime? If yes and if you conclude person meets insanity criteria, provide explanation why you conclude the person nevertheless meets criteria for insanity.

Additional information that should be strongly considered when making an insanity analysis includes:

1. Arrest history, rap sheets, and autopsy reports;
2. Psychiatric, substance abuse, and medical records;
3. Psychological testing as appropriate.

Other records to include school records, military records, work records, other expert evaluations and testimony, custodial records, and personal records should be utilized when relevant.

Court personnel to include judges, defense attorneys, and district attorneys should carefully review examiner's reports to ensure that reports that do not adhere to mandated guidelines outlined above are not accepted.

SENATE BILL No. 253

Introduced by Senator Monning
(Principal coauthor: Assembly Member Chiu)

February 18, 2015

An act to amend Section 369.5 of the Welfare and Institutions Code, relating to juveniles.

legislative counsel's digest

SB 253, as introduced, Monning. Dependent children: psychotropic medication.

Existing law establishes the jurisdiction of the juvenile court, which may adjudge children to be dependents of the court under certain circumstances, including when the child suffered or there is a substantial risk that the child will suffer serious physical harm, or a parent fails to provide the child with adequate food, clothing, shelter, or medical treatment. Existing law authorizes only a juvenile court judicial officer to make orders regarding the administration of psychotropic medications for a dependent child who has been removed from the physical custody of his or her parent. Existing law requires the court authorization for the administration of psychotropic medication to be based on a request from a physician, indicating the reasons for the request, a description of the child's diagnosis and behavior, the expected results of the medication, and a description of any side effects of the medication.

This bill would require an order authorizing administration of psychotropic medications to only be granted on clear and convincing evidence of specified matters, and would prohibit the court from authorizing the administration of psychotropic medications for a child unless a 2nd independent medical opinion is obtained from a child psychiatrist or a psychopharmacologist if one or more specified circumstances exist, including if the request is for any class of

psychotropic medication for a child who is 5 years of age or younger. The bill would prohibit the court from authorizing the administration of a psychotropic medication unless the court is provided documentation that appropriate screenings and tests for the child have been completed no more than 30 days prior to submission of the request to the court.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 369.5 of the Welfare and Institutions Code is amended to read:

369.5. (a) If a child is adjudged a dependent child of the court under Section 300 and the child has been removed from the physical custody of the parent under Section 361, only a juvenile court judicial officer shall have authority to make orders regarding the administration of psychotropic medications for that child. The juvenile court may issue a specific order delegating this authority to a parent upon making findings on the record that the parent poses no danger to the child and has the capacity to authorize psychotropic medications. Court authorization for the administration of psychotropic medication shall be based on a request from a physician, indicating the reasons for the request, a description of the child's diagnosis and behavior, the expected results of the medication, and a description of any side effects of the medication. On or before July 1, 2000, the Judicial Council shall adopt rules of court and develop appropriate forms for implementation of this section.

(b) An order authorizing the administration of psychotropic medications pursuant to this section shall only be granted on clear and convincing evidence of all of the following:

(1) The medication is not being used as a chemical restraint.

(2) If the child is 12 years of age or older, the child, after being advised of alternative treatments and informed of the benefits and risks of the medication, has given his or her informed consent.

(3) The prescribing physician submitting the request for psychotropic medication conducted a comprehensive examination of the child in compliance with Section 2242 of the Business and Professions Code that takes into account the child's trauma history.

(4) The prescribed dosage is appropriate for the child's age.

(5) The short- and long-term risks associated with the use of psychotropic medications by the child does not outweigh the reported benefits to the child.

(6) There are no less invasive treatment options available other than the administration of psychotropic medications.

(c) A court shall not issue an order authorizing the administration of psychotropic medications for a child unless a second independent medical opinion is obtained from a child psychiatrist or a psychopharmacologist if one or more of the following circumstances exist:

(1) The request is for any class of psychotropic medication for a child who is five years of age or younger.

(2) The request would result in the child being administered multiple psychotropic medications concurrently.

(3) The request is for the concurrent administration of any two drugs from the same class unless the request is for medication tapering and replacement that is limited to no more than 30 days.

(4) The request is for a dosage that exceeds the amount recommended for children.

(d) The court shall not authorize the administration of the psychotropic medication unless the court is provided documentation all the appropriate lab screenings, measurements, or tests for the child have been completed in accordance with the accepted medical guidelines no more than 30 days prior to submission of the request to the court.

~~(b)~~

(e) (1) In counties in which the county child welfare agency completes the request for authorization for the administration of psychotropic medication, the agency is encouraged to complete the request within three business days of receipt from the physician of the information necessary to fully complete the request.

(2) Nothing in this subdivision is intended to change current local practice or local court rules with respect to the preparation and submission of requests for authorization for the administration of psychotropic medication.

~~(c)~~

(f) Within seven court days from receipt by the court of a completed request, the juvenile court judicial officer shall either approve or deny in writing a request for authorization for the administration of psychotropic medication to the child, or shall,

upon a request by the parent, the legal guardian, or the child's attorney, or upon its own motion, set the matter for hearing.

~~(d)~~

(g) Psychotropic medication or psychotropic drugs are those medications administered for the purpose of affecting the central nervous system to treat psychiatric disorders or illnesses. These medications include, but are not limited to, anxiolytic agents, antidepressants, mood stabilizers, antipsychotic medications, anti-Parkinson agents, hypnotics, medications for dementia, and psychostimulants.

~~(e)~~

(h) Nothing in this section is intended to supersede local court rules regarding a minor's right to participate in mental health decisions.

~~(f)~~

(i) This section shall not apply to nonminor dependents, as defined in subdivision (v) of Section 11400.

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Juvenile Law: Competency Issues

Annual Agenda Item:

To enrich recommendations to the council and avoid duplication of effort, members of the committee will collaborate with members of the Collaborative Justice Courts Advisory Committee, and former members of the Mental Health Task Force serving on other advisory bodies, to consider developing recommendations to the Judicial Council to: (1) revise rule 5.645 to define appropriate evaluation tools for use with juveniles, (2) amend legislative language to clarify the presumption of competency, (3) suggest other legislative changes necessary to improve the handling of cases where competency issues are raised, and (4) identify effective practices developed by local courts to address juvenile cases in which competency is a factor.

Background:

Effective January 1, 2012, the council at the recommendation of the committee amended rule 5.645(d) of the California Rules of Court to specify the qualifications of experts evaluating children's competency to participate in juvenile proceedings as required by changes to WIC 709 enacted in 2010. At that time the committee also considered drafting proposed legislation to more comprehensibly address this issue but decided that the complexity of the issues coupled with the need to address core issues during the economic downturn warranted posting discussion.

The Task Force for Criminal Justice Collaboration on Mental Health Issues examined metal health issues in juvenile court and while no recommendations in the April 2011 report specifically dealt with the issue of expert qualifications, the task force noted that procedures to determine competency should be clarified and improved. The Implementation Task force was scheduled to sunset on June 30, 2014. In order to help meet the ongoing and emerging needs of the courts, the Mental Health Issues Implementation Task Force was extended to December 31, 2015. This extension will allow the Implementation Task Force to (1) support the projects that are currently in progress and (2) complete the process of reassigning the work while providing a single body with mental health expertise to guide the transition.

Update:

In 2014, the Family and Juvenile Law Advisory Committee decided to continue working with the Collaborative Justice Courts Advisory Committee and Mental Health Issues Implementation Task Force on the drafting of proposed legislation. A Joint Juvenile Competency Issues Working Group was formed with members from all three bodies. The working group sought informal comment from court stakeholders in the juvenile justice community on the draft legislation and has incorporated that input into the current proposed legislation. The chart addressing the stakeholder comments and the current draft of the legislation are attached. The working group is presenting the current draft to the advisory bodies in the winter and spring of 2015. The hope is for the Judicial Council to take action on the proposal at their December 11, 2015 meeting.

Welfare and Institutions Code §709

709.

(a) ~~A minor cannot be tried or adjudged a ward while that minor is mentally incompetent~~. Whenever the court believes that a minor who is subject to any juvenile proceedings is mentally incompetent, the court must suspend all proceeding and proceed pursuant to this section. A minor is mentally incompetent for purposes of this section if, as a result of mental illness, mental disorder, developmental disability, or developmental immaturity, the minor is unable to understand the nature of the delinquency proceedings or to assist counsel in the conduct of a defense in a rational manner. Except as a specifically provided otherwise, this section applies to a minor who is alleged to come within the jurisdiction of the court pursuant to §601 or §602.

(~~b~~) (1) ~~During the pendency of any juvenile proceeding~~, the minor's counsel, or any party, participant, ~~or~~ the court may express a doubt as to the minor's competency. Doubt expressed by a party or participant does not automatically require suspension of the proceedings, but is information that must be considered by the court. A minor is incompetent to proceed if he or she lacks sufficient present ability to consult with counsel and assist in preparing his or her defense with a reasonable degree of rational understanding, or lacks a rational as well as factual understanding, of the nature of the charges or proceedings against him or her. Incompetency to stand trial may result from the presence of any condition or conditions that result in an inability to assist counsel or understand the nature of the proceedings, including but not limited to mental illness or mental disorder, developmental disability, or developmental immaturity If the court finds substantial evidence that raises a reasonable doubt as to the minor's competency, the proceedings shall be suspended.

(~~c~~b) Upon suspension of proceedings, the court shall order that the question of the minor's competence be determined at an evidentiary hearing, unless a stipulation or submission by the parties is made to the court. At an evidentiary hearing, ~~minor's counsel~~ the minor has the burden of establishing by a preponderance of the evidence that ~~the~~

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~~minor~~ he or she is incompetent to proceed. The court shall appoint an expert to evaluate whether the minor suffers from a mental illness or mental disorder, developmental disability, developmental immaturity, or other condition affecting competence and, if so, whether the condition or conditions impair the minor's present capacity to assist counsel or understand the nature of the proceedings.

(1) The expert shall have expertise in child and adolescent development~~, training in~~ and forensic evaluation of juveniles, and shall be familiar with competency standards and accepted criteria used in evaluating competence.

(2) The expert shall personally interview and review all the available records provided, including but not limited to medical, education, special education, child welfare, mental health, regional center and court records. The expert shall consult with the minor's defense attorney and whoever raised a doubt of competency, if that person is different from the minor's attorney, to ascertain ~~their~~ his or her reasons for doubting competency. The expert shall gather a developmental history of the minor. When standardized testing is used, the expert shall administer age- appropriate testing specific to the issue of competency, unless the facts of the particular case render testing unnecessary or inappropriate. ~~This expert shall state~~ In the written report, the expert shall opine whether the minor has the sufficient present ability to consult with his or her attorney with a reasonable degree of rational understanding and whether he or she has a rational as well as factual understanding of the proceedings against him or her. The expert shall also state ~~the reasons for making~~ the basis for these ~~the~~ conclusions, as well as address the ~~what~~ type of treatment that would be effective in restoring the minor to competency, and ~~whether~~ the likelihood that the the minor can attain competency within a reasonable period of time.

(3) The Judicial Council shall develop a rule of court outlining the training and experience needed for an expert to be competent in forensic evaluations of juveniles and shall develop and adopt rules for the implementation of other requirements related to subdivision.

(~~d~~c) Statements made to the appointed expert during the ~~examination~~ minor's competency evaluation ~~examination~~ ~~by the minor to appointed experts, statementmade to~~

~~experts which are submitted to the court on the issue of~~ the minor's ~~competence, and~~ any statements made ~~at trial~~ by the appointed expert on the issue of the minor's competency, and any fruits of the minor's competency evaluation ~~examination~~, shall not be used in any other delinquency, dependency, or criminal adjudication against the minor in either juvenile or adult court.

(~~e~~d) At any time after the court determines that there is a likelihood the minor is incompetent to stand trial, the court may, with consent of minor's counsel and the District Attorney's Office, and notice to the Probation Department, and in consideration of public safety, continue hearing on the pending ~~an a P~~petition for up to twelve months without an adjudication, ~~with~~conducting periodic review hearings, to facilitate the provision of services to address the issues that brought the minor to the attention of the court, services consistent with public safety, as directed by the probation officer. Probation shall make referrals and assist the family in accessing appropriate services to address the issues that brought the minor before the court. ~~This occurs without an admission and without adjudging the minor a ward of the court~~. Upon successful completion of the voluntary service program, the Court shall dismiss the proceeding.

(~~f~~e) The District Attorney or minor may retain or seek the appointment of additional qualified experts, who may testify during the competency hearing. In the event ~~of~~ that a party seeking to obtain an additional report anticipates presenting the expert's testimony and/or report, the report and the expert's qualifications shall be disclosed to the opposing party within a reasonable time prior to the hearing, and not later than five court days prior to the hearing. If, after disclosure of the report, the opposing party ~~may~~ requests a continuance in order to prepare further for the hearing and shows good cause for the continuance, the court shall grant a continuance for a reasonable period of time ~~upon showing of a good cause~~.

(~~g~~f) If the expert believes the minor is developmentally disabled, the court shall appoint the director of a regional center for developmentally disabled individuals

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described in Article 1 (commencing with Section 4620) of Chapter 5 of Division 4.5, or his or her designee, to evaluate the minor. The director of the regional center, or his or her designee, shall determine whether the minor is eligible for services under the Lanterman Developmental Disabilities Services Act (Division 4.5 (commencing with Section 4500)), and shall provide the court with a written report informing the court of his or her determination. The court's appointment of the director of the regional center for determination of eligibility for services shall not delay the court's proceedings for determination of competency.

(~~h~~g) An expert's opinion that a minor is developmentally disabled does not supersede an independent determination by the regional center regarding the minor's eligibility for services under the Lanterman Developmental Disabilities Services Act (Division 4.5 (commencing with Section 4500)).

(~~i~~h) Nothing in this section shall be interpreted to authorize or require the following:

(1) Placement of a minor who is incompetent in a developmental center or community facility operated by the State Department of Developmental Services without a determination by a regional center director, or his or her designee, that the minor has a developmental disability and is eligible for services under the Lanterman Developmental Disabilities Services Act (Division 4.5 (commencing with Section 4500)).

(2) Determinations regarding the competency of a minor <u>by the director of the regional center, or his or designee.</u>

(~~j~~i) If the court finds by a preponderance of evidence, that the minor is incompetent, all proceedings shall remain suspended for a period of time that is no longer than reasonably necessary to determine whether there is a substantial probability that the minor will attain competency in the foreseeable future, or the court no longer retains jurisdiction. During this time, the court may make orders that it deems appropriate for services, subject to subdivision (d). Further, the court may rule on motions that do not require the participation of the minor in the preparation of the motions. These motions include, but are not limited to, the following:

(1) Motions to dismiss.

(2) Motions ~~by the defense~~ regarding a change in the placement of the minor.

(3) Detention hearings.

(4) Demurrers.

(~~k~~ j) ~~If the minor is found to be competent~~, The court ~~may~~ shall reinstate proceedings and proceed commensurate with the court's jurisdiction.

(~~l~~ k) The Presiding Judge of the Juvenile Court, the County Probation Department, the County Mental Health Department, and any other participants the Presiding Judge shall designate, shall develop a written protocol and program to ensure that minors who are found incompetent receive appropriate services for the remediation of competency.

(~~m~~ l) Upon finding of incompetency the court shall refer the minor to the county's remediation program, as described in (m). Remediation counselors and evaluators shall adhere to the standards set forth in this statute and the ~~in subsection (c) and~~ California Rules of Court~~, Rule 5. 645~~. The program shall provide services in the least restrictive environment consistent with public safety. Priority shall be given to minors in custody. The Remediation counselor(s) shall promptly determine ~~whether~~ the likelihood that the minor can attain competency within a reasonable amount of time, and if the opinion is that the minor will not, the minor shall be returned to court at the earliest possible time. The Court shall review remediation services at least every 30 calendar days for minors in custody and every 45 calendar days for minors out of custody.

(~~n~~ m) Upon presentation of the recommendation, the court shall hold an evidentiary hearing on whether the child is remediated or is able to be remediated, unless a stipulation or submission by the parties is made to the court. If the recommendation is that the minor's competency has been remediated, the burden is on the minor to ~~show~~ prove, by a preponderance of evidence, ~~incompetence~~ that the minor is incompetent. If the recommendation is that the minor is not able to be remediated, the ~~people~~ District

Attorney must ~~demonstrate~~ prove by a preponderance of evidence that the minor is remediable. The provisions of subsection (~~f~~ e) shall apply at this stage of the proceedings.

(1) If the court finds the minor has been remediated, the court shall reinstate the delinquency proceedings.

(2)If the court finds the minor is not yet remediated, but is able to be remediated, the court shall order the minor returned to the remediation program.

(3) If it appears that the minor will not achieve remediation, the court may set a hearing to determine ~~what services are necessary~~ if there are services that would be beneficial and available after dismissal of the petition. All persons and agencies with information about the minor or about such services ~~which may be available to the minor~~ shall be invited to this hearing or a meeting. Such persons and agencies may include, but not be limited to, the minor and his or her attorney; parents, guardians, or relative caregiver; mental health treatment professionals; public guardian educational rights holder; education provider and social service agency. If appropriate, the Court shall refer the minor for evaluation pursuant to Welfare and Institutions Code §6550, et seq. or §5300, et seq.

(~~o~~) ~~Except as a specifically provided otherwise, this section applies to a minor who is alleged to come within the jurisdiction of the court pursuant to §601 or §602~~.

(~~o~~n) An expert's opinion that a minor is developmentally disabled does not supersede an independent determination by the regional center whether the minor is eligible for services under the Lanterman Developmental Disabilities Services Act (Division 4.5 (commencing with Section 4500)).

JUDICIAL COUNCIL
OF CALIFORNIA

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MENTAL HEALTH ISSUES IMPLEMENTATION TASK FORCE

MINUTES OF OPEN MEETING

October 20, 2014
10:00 – 3:30 p.m.
Judicial Council Conference Center

Advisory Body Members Present:	Hon. Richard Loftus, Jr., Chair; Hon. Susan Gill, Hon. Suzanne Kingsbury, Hon. Stephen Manley, Mr. Michael Planet , Mr. Michael Roddy, Judge Jaime Román , Hon. Garrett Wong
Advisory Body Members Absent:	Hon. Hilary Chittick, Hon. Rogelio Flores, Hon. Clifford Klein, Hon. Maria Stratton, Hon. Michael Tynan,
Others Present:	Hon. James Bianco (Los Angeles Superior Court); Ms. Francie Cordova, Ms. Pamela Ahlin, Mr. Michael Wilkening, Mr. Kristopher Kent (Department of State Hospitals); Mr. Daniel Pone, Ms. Sharon Reilly (by telephone); Francine Byrne, Ms. Audrey Fancy, Ms. Karen Moen, Ms. Danielle McCurry, Ms. Angelica Souza, Nancy Taylor, Ms. Charina Zalzos.

OPEN MEETING

Call to Order and Roll Call

The chair called the meeting to order at 10:00 a.m., and took roll call.

Approval of Minutes

The advisory body reviewed and approved the minutes of the September 10, 2014, Mental Health Issues Implementation Task Force meeting.

DISCUSSION AND ACTION ITEMS (ITEM 1)

Item 1

Department of State Hospitals and the Courts

Description of Item Discussed

A discussion of issues related to the state hospitals and Incompetent to Stand Trial (IST) commitments including issues related to state mental hospitals operating at or near capacity levels and complications arising out the delay in admittance of persons deemed IST and in need of competency restoration services. Other issues discussed included the apparent increase in persons being evaluated and found incompetent to stand trial, limited options for local restoration to competency services, incomplete admissions packets forwarded to the state hospitals (state hospital concern), and inconsistencies in admission procedures and requirements among the various state hospitals (court concern). It was also

noted that these issues will require a multi-partner approach and active involvement of partners and stakeholders, including district attorneys, public defenders, sheriffs, county mental/behavioral health, courts, state hospitals, CONREP, and Disabilities Rights, to develop an effective, systemic response to IST restoration service issues in California.

Action:

Judge Loftus will continue to consult with the Department of State Hospitals and the Health and Human Services Agency IST commitment issues.

ADJOURNMENT

There being no further business, the meeting was adjourned at 1:40 p.m.

Approved by the advisory body on enter date.