PHILIP B. SCOTT
GOVERNOR

State of Vermont
OFFICE OF THE GOVERNOR

MEMORANDUM

TO: Rep. Martin LaLonde, Chair, House Judiciary Committee
Rep. Theresa Wood, Chair, House Human Services Committee
Rep. Lori Houghton, Chair, House Health Care Committee
Sen. Dick Sears Jr., Chair, Senate Judiciary Committee
Sen. Virginia "Ginny" Lyons, Chair, Senate Health & Welfare Committee

FROM: Jaye Pershing Johnson, Governor's Counsel
Kendal Smith, Director of Policy Development & Legislative Affairs

DATE: December 6, 2023

RE: Public Safety & Competency Restoration

Despite the passage of time, the urgency to address the issue of competency restoration for the protection of the public remains. Governor Scott has repeatedly advocated for changes to our criminal justice system to address the lack of accountability for criminal offenders with which so many of our communities are voicing concern and frustration. We must not forget the series of tragic offenses in recent memory that highlighted gaps in our systems and prompted our work in this area which led to the request from the Legislature on whether a plan for competency restoration should be adopted in Vermont. The short answer is yes, when in the interest of justice for someone to stand trial.

In 2018, Arnaldo Cruz, a serial domestic violence offender with multiple felony convictions, pled guilty by reason of insanity for the brutal and fatal stabbing of Betty Rodrigues inside a Union Street apartment in Springfield. This decision was made simply by agreement of the prosecutor and defense. Cruz's murder case never went to a jury and he was committed to the State psychiatric hospital for 90 days by a judge. Cruz was later released by the Department of Mental Health. A year later Cruz was arraigned on a felony charge that he attempted to stab a man with a knife weeks before the murder. Prosecutors who brought the new assault charges said they didn't know Cruz was no longer being held in the State hospital. In July of 2023 Cruz pled guilty and was sentenced to five to 10 years in prison, all suspended except for three years and 326 days with credit for time served. He is now on probation in the community, according to Vermont Department of Corrections records. He could remain on probation until May 2028.

In 2019 three horrific crimes were dismissed by the Chittenden County State's Attorney for lack of tools to effectively prosecute. These included the attempted murder of Darryl Montague. The offender was subsequently arrested by the Office of the U.S. Attorney and charged with unlawfully possessing a firearm and possessing a stolen firearm, in violation of federal law. She was eventually convicted under state law after it was determined she was competent to stand trial. They include the murder of Yogeswari Khada and attempted murder of Tulasa Rimal. The offender was recharged by the Office of the Attorney General and convicted. They include the murder of Richard Medina who was stabbed multiple times in the neck on a Burlington street corner. The offender was recharged by the Office of the Attorney General

and in April 2023 the Attorney General announced he had been convicted of one count of second degree murder.

Finally, in 2021, Emily Hamann was murdered in broad daylight by a man who confessed to the crime and prior to the time of the murder allegedly made a video bragging about being a murderer and how the state of Vermont couldn't do anything about it because he had paperwork saying he was incompetent. In April 2023 the alleged offender was transferred from the State Psychiatric Hospital to the custody of the Department of Corrections to be held without bail on his original criminal charges. This only occurred because of a groundbreaking stipulation that allowed the offender, after being found incompetent to stand trial by the court, to receive acute care treatment at VPCH for a renewable 90-day period while still maintaining his criminal charges in a dormant-like state until he was discharged.

These tragic examples demonstrate our work in this area is not complete without a system to restore accountability. We also still need a facility for the appropriate placement of those violent offenders who are not competent to stand trial or determined to be not guilty by reason of insanity, yet cannot be returned to the community as a matter of public health and safety. As we continue to create a more balanced and effective criminal justice system, we must remember that justice for victims, safety in our communities, and accountability for offenders must be top priorities.

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Departments of Mental Health & of Disabilities, Aging, and Independent Living **Competency Restoration Program Plan**

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VERMONT

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Executive Summary

After conducting an extensive process, enriched by substantial input from key stakeholders, the Agency of Human Services strongly recommends the adoption of competency restoration as the optimal course of action in Vermont.

Supported by robust research and a review of clinical literature, we have concluded that competency restoration has demonstrated efficacy and has restorative value when implemented well. To optimize the use of limited resources, we recommend a competency restoration program be implemented only for those cases where there exists a compelling interest for the person to be restored to competency so that the criminal case proceeds. The focus would be on more serious crimes and cases where dismissal or diversion is inappropriate.

In light of the consensus derived from a thorough review of clinical literature and the efforts undertaken at the national level by both the Council of State Governments (CSG) and the National Judicial Task Force, this report outlines a set of best practice recommendations. [1] Furthermore, this report will provide recommendations for competency restoration programming in Vermont for individuals within the purview of both the Department of Mental Health (DMH) and the Department of Aging and Independent Living (DAIL) system of care.

Program Design

- Limit competency restoration to serious crimes and for the cases that are inappropriate for dismissal or diversion.
- Conduct evaluations and restoration in the most appropriate site, which may be a health care setting, DOC, or the community.
- Provide high quality and equitable evaluations and restoration services.

[1] Please note that while this report does not specifically relate to diversion for treatment, there are number of references about the importance of diversion. The CSG reviewed Vermont's array of diversion "offramps" for treatment in connection with the 2019-2020 Justice reinvestment study. It is important to note they found programming inconsistent across counties and data collection and outcome reports to be inconsistent and in some cases duplicative. [Justice Reinvestment in Vermont: Second Presentation - CSG Justice Center]. While competency restoration will be critical for addressing more serious offenses through the justice system, some focus on the effectiveness of diversion resources statewide will be necessary for addressing lower-level non-violent offenses in our communities. Further, a study that focused on court diversion participants between 2014 and 2016 found an overall recidivism rate (measured by new conviction) of 17 percent. Participants with no criminal history had a recidivism rate near zero (.68 percent), and participants with criminal histories had a recidivism rate close to 90 percent.

- Develop and impose rational timelines.
- Use data to inform decision making and system improvements.

Clinical Programming

- Offer a mix of clinical and educational programming
- Provide high-quality clinical care in the least restrictive setting possible
- Use involuntary medications when clinically indicated
- Evaluate in a timely manner (including determining when someone is not restorable and providing clinically based timelines for potential restoration)
- Reevaluate when clinically indicated

Reference Legislation

From Act 28 (2023) :

Sec. 7. COMPETENCY RESTORATION PROGRAM PLAN

(a)(1) On or before November 15, 2023, the Department of Mental Health and the Department of Disabilities, Aging, and Independent Living shall report to the Governor, the Senate Committees on Judiciary and on Health and Welfare, and the House Committees on Judiciary, on Health Care, and on Human Services on whether a plan for a competency restoration program should be adopted in Vermont.

(2) For purposes of the report required by the section:

(A) the Department of Mental Health and the Department of Disabilities, Aging, and Independent Living shall consult with:

(i) the Chief Superior Judge or designee;

(ii) the Commissioner of Corrections or designee;

(iii) the Executive Director of the Department of State's Attorneys and Sheriffs or designee;

(iv) the Executive Director of the Vermont Center for Crime Victim Services or designee;

(v) the Vermont Legal Aid Disability Law Project; and

(vi) the Defender General or designee; and

(B) consideration shall be given to providing notification and information to victims of record.

(b) If a competency restoration plan is recommended, the report shall include recommendations for best practices, any changes to law necessary to establish the program, estimated costs, and a proposal for implementing the program.

Competency Restoration Program Plan

Importance of Competency Restoration

Competency to stand trial (CST) is the constitutional requirement that individuals charged with crimes must be able to assist in their own defense, and a criminal case cannot proceed if someone has been found incompetent. The Sixth Amendment guarantees the fundamental right to trial.[2]

While many states have implemented a competency restoration program, no such program exists in Vermont. When someone who has committed a criminal offense is found incompetent in Vermont, the current outcomes are inconsistent -- their charges may or may not be dismissed, they may or may not get treatment and they may or may not ever regain competency. An individual's placement – whether in the custody of DAIL or DMH, whether on an inpatient or outpatient setting – is separate from their competency. Instead the determination of placement is contingent on an individual's clinical presentation, the level of services they need, and the threshold for getting services on an involuntary basis. No restoration services are provided to these individuals at any level of care.

Given the absence of a competency restoration program, many cases in Vermont fail to reach a resolution in the criminal court. Consequently, the lack of a competency program denies an individual the opportunity to present their own defense; this lack of resolution perpetuates stigma as often these individuals are presumed to be guilty but perceived as avoiding accountability. Competency restoration serves the interests of victims, communities, and alleged defendants.

Vermont has the unique opportunity to create a program from the ground up, to learn from others about what is not working, and to look towards research and other publications to design a limited yet successful program. The successes and failures of other states can serve to inform best practices in Vermont.

Existing Competency Restoration Programs

[2] Sixth Amendment of the U.S. Constitution: "In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial, by an impartial jury of the State and district wherein the crime shall have been committed, which district shall have been previously ascertained by law, and to be informed of the nature and cause of the accusation; to be confronted with the witnesses against him; to have compulsory process for obtaining witnesses in his favor, and to have the Assistance of Counsel for his defense."

States, generally, require that defendants who are found incompetent to stand trial begin competency restoration treatment within a certain time period, ranging from 7 to 30 days, after the finding of incompetency.[3]

In a recent review of literature, researchers found that 81% of mentally ill offenders initially found incompetent to stand trial were eventually restored to competency.[4] The median length of stay was 147 days in a treatment program. After removing outliers, the mean length of treatment was 175 days. Individuals who are at particularly high risk of being unrestorable include those with permanent brain damage, severe developmental and intellectual disabilities, and those with treatment-resistant psychosis.

Of the 51 studies on competency restoration programs reviewed by the above referenced researchers, only 29% used competency assessment instruments. There is no standard/best practice for assessment. Traditional psychological tests were also employed rarely (e.g., MMPI-2, WAIS-IV, BPRS). Due to lack of data and gross inconsistencies between studies on reporting practices, the researchers were unable to determine whether there was any relation between scores on these measures and restoration status.[5]

Competency restoration programs, for violent offenders and those cases inappropriate for diversion or dismissal, are typically provided in inpatient settings. While outpatient programs can be an alternative, participants in outpatient programs were typically restricted to individuals charged with misdemeanor offenses or nonviolent felonies, who did not have significant violent criminal histories, and did not present as being at high risk for violence at the time of referral. Understanding our goal of limiting the scope of these programs to the most violent offenders or those determined to be inappropriate for diversion or dismissal, outpatient programs would be inappropriate for implementation at this time.

Some states provide jail-based competency restoration programs as well. These generally are intensive, individualized programs delivered by a multidisciplinary team comprised of forensic psychiatrists, psychologists, social workers, rehabilitation therapists, and nurses.[6] Some states deliver these services out of specialized units, while in other states participants are housed in the general population. Outcome

[3] Heilbrun, K., Giallella, C., Wright, H. J., DeMatteo, D., Griffin, P. A., Locklair, B., & Desai, A. (2019). Treatment for restoration of competence to stand trial: Critical Analysis and policy recommendations. Psychology, Public Policy, and Law, 25(4), 266—283.

[4] Pirelli, G., & Zapf, P.A. (2020). An attempted meta-analysis of the competency restoration research: Important findings for future directions. Journal of Forensic Psychology Research and Practice, 20(2), 134—162.

[5] Id.

[6] Heilbrun et al., 2019.

studies on jail-based programs report a restoration rate ranging from as low as 33% to as high as 86.7%. Treatment periods were as short as 90 days as a standard treatment length to a mean of 82.5 days and seem to roughly correlate with restoration rates.[7]

Regardless of setting, restoration services can be provided by psychiatrists, psychologists, social workers, group therapists, nurses, and case managers.

There is no set standard for how long restoration treatment should be. About 72% of participants in CRT were restored within 6 months, and just under 84% were restored within a year.[8]

Mentally Ill Offenders

There is unfortunately a lack of empirically validated treatment programs. According to a recent review article, "the limited available research on IST restoration means that the field cannot yet establish empirically supported 'best practices' in this area."[9] However, most states do have competency restoration programs. (*But see* "The Council of State Governments and the National Judicial Task Force," and "Important Elements of the Program for Consideration," below.)

Medication is the most common form of treatment for those who are found incompetent to stand trial who experience severe mental illness. Some researchers have noted that, "the use of…medication (primarily 1st and 2nd generation antipsychotics) …is so widely accepted within the field of mental health that it approaches foundational."[10] The same researchers were not able to find any studies on CRT that did not include the use of medications for those with mental health diagnoses. They noted that programs that use involuntary medication treatment report good success across a range of diagnoses including delusional, cognitive, substance use, and psychotic disorders, with rates of restoration from 74% to 77%.

Most programs appear to provide various educational components in addition to medications. (See Appendix A)

Involuntary Medication for Restoration of Competence

[7] Id.

[8] Zapf, P.A., & Roesch, R. Future directions in the restoration of competency to stand trial (2011). Current Directions in Psychological Science, 20(1), 43—47.

[9] Heilbrun et al., at 269.

[10] Id., at 270.

Sell v. United States,[11] is a 2003 decision in which the United States Supreme Court held that four criteria must be met in order to involuntarily medicate a defendant who has who had been determined to be incompetent to stand trial for the sole purpose of restoring competency:

- Are important governmental interests at stake *(i.e.*, did the defendant commit a serious crime?)
- Is there a substantial likelihood that involuntary medication will restore the defendant's competence and do so without causing side effects that will significantly interfere with the defendant's ability to assist counsel?
- Is involuntary medication the least intrusive treatment for restoration of competence (i.e., that alternative, less intrusive treatments are unlikely to achieve substantially the same results), and
- Is the proposed treatment medically appropriate?[12]

In 2020, the Court of Appeals of Maryland heard the *Johnson v. Md. Dep't of Health*[13] case, which held that involuntary medication for competence restoration can be ordered by criminal courts or administrative agencies.

Intellectual Disabilities – The Slater Method

Restoration to competency is possible for persons with intellectual disabilities. One investigator found that people with an IQ of above 63.5 were much more likely to be restored to competency, whereas those with IQs below this cutoff were more likely to be found not restorable.[14] A program called *The Slater Method*, specifically designed for this population, has promising results and appears to be the most common program used.[15]

Services are delivered in structured, one-on-one sessions occurring weekly at minimum, and can be provided by psychologists, social workers, or case managers. A subject's progress is evaluated every 6 months, and training continues until an individual is found competent. If an individual does not appear to make clinically significant progress after

[11] 539 U.S. 166 (2003)

[12] Id, 181.

[13] 236 A.3d 574 (Md. 2020)

[14] Grabowksi, 2017, cited in Heilbrun et al., 2019.

[15] Wall, B. W., & Christopher, P. P. (2012). A training program for defendants with intellectual disabilities who are found incompetent to stand trial. The Journal of the American Academy of Psychiatry and the Law, 40, 366—373.

2 years, training ceases. In an initial outcome study by Wall and Christopher in 2013, participants who received The Slater Method were restored to competency at a much greater rate (61.1% of participants) than those who did not (16.7%).

Competence to Stand Trial Legal Standards

Dusky v. United States[16] is a 1960 United States Supreme Court case in which the Court affirmed a defendant's right to have a competency evaluation before proceeding to trial. The Court outlined the basic standards for determining competency:

[I]t is not enough for the district judge to find that 'the defendant (is) oriented to time and place and (has) some recollection of events,' but that the 'test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him.[17]

According to some researchers, "[d]efendants found incompetent to stand trial (IST) are most often those with psychotic disorders or acute mood disorders, followed by those with intellectual and developmental disabilities. Other populations include defendants with dementia and traumatic brain injury causing cognitive or behavioral impairments that impede their ability to participate meaningfully in pretrial proceedings."[18]

Jackson v. Indiana[19] is a 1972 decision of the United States Supreme Court that held it violates due process to involuntarily commit a criminal defendant for an indefinite period of time solely on the basis of his permanent incompetency to stand trial.

In this case, the defendant was ordered to be detained in an Indiana facility for competence restoration until his competence was able to be restored. His attorney appealed, arguing that it amounted to an indefinite commitment given that his CST was determined not to be restorable. The court determined that constitutional equal protection and due process rights require that a defendant found incompetent cannot be confined for CST restoration for longer than is necessary to determine whether restoration is possible. After that period, if restoration is not possible, any further

[16] 362 U.S. 402 (1960)

[17] Id., 402.

[18] Pinals, D. A., & Callahan, L. (2020). Evaluation and restoration of competence to stand trial: Intercepting the forensic system using the sequential intercept model. Psychiatric Services, 71(7), 698–705. https://doi.org/10.1176/appi.ps.201900484

[19] 406 U.S. 715 (1972)

involuntary commitment must be justified on other grounds, such as civil commitment for mental illness.

The Council of State Governments & the National Judicial Task Force

The Council of State Governments and the National Judicial Task Force have done significant work on competency restoration and can provide good information on designing a competency restoration program.

In October 2020, the Council of State Governments Justice Center published a report called "Just and Well: Rethinking How States Approach Competency to Stand Trial."[20] Their goal was to re-think the vision:

[T]he CST process would generally be reserved for cases where the criminal justice system had a strong interest in restoring competency so that a person may proceed to face their charges. Advisors noted that the justice system's interest in adjudicating a case tends to rise as the charges become more serious. In other situations, when the state interest in pursuing prosecution is lower, people would have their cases dismissed and/or would enter a diversion program in lieu of typical CST processes. If they were in need of treatment, they would be connected to care in a setting appropriate to their clinical level of need. In this vision, jurisdictions would also focus on preventing criminal justice involvement in the first place through the establishment of robust, community-based treatments and supports, with attention to structural factors—like access to housing and transportation—that may impact access to care. These community-based efforts would also help to reduce the number of people with mental illnesses entering into the criminal justice system and provide viable alternatives to jail-booking for first responders.[21]

To achieve this vision, they articulated ten strategies:

1. Convene diverse stakeholders to develop a shared understanding of the current CST process.

2. Examine system data and information to pinpoint areas for improvement.

3. Provide training for professionals working at the intersection of criminal justice and behavioral health.

[20] https://csgjusticecenter.org/wp-content/uploads/2020/10/Just-and-Well27OCT2020.pdf

[21] Id., at 8.

4. Create and fund a robust system of community-based care and supports that is accessible for all before, during, and after criminal justice contact.

5. Expand opportunities for diversion to treatment at all points in the criminal justice system, including after competency has been raised.

6. Limit the use of CST process to cases that are inappropriate for dismissal or diversion.

7. Promote responsibility and accountability across systems.

8. Improve efficiency at each step of the CST process.

9. Conduct evaluations and restoration in the community, when possible.

10. Provide high-quality and equitable evaluations and restoration services, and ensure continuity of clinical care before, during, and after restoration and upon release.

In July 2021, the National Judicial Task Force to Examine State Courts' Response to Mental Illness published "Leading Reform: Competence to Stand Trial Systems"[22] as a resource to state courts. As with the Council of State Governments, the Task Force saw the benefits in competency restoration but also stressed the importance of being thoughtful and purposeful about how it takes place. To that end, they also made ten recommendations:

1. Divert cases from the criminal justice system

2. Restrict which cases are referred for competency evaluations

3. Develop alternative evaluation sites

4. Develop alternative restoration sites

5. Revise restoration protocols

6. Develop and impose rational timelines

7. Address operational inefficiencies

8. Address training, recruitment, and retention of staff

9. Coordinate and use data

[22] https://www.ncsc.org/__data/assets/pdf_file/0019/66304/Leading_Reform-Competence_to_Stand_Trial.pdf

10. Develop robust community-based treatment and supports for diversion and re-entry

Important Elements of the Program for Consideration

Which Crimes are Eligible:

As the Legislature works with the Executive Branch to implement a competency restoration program, one of the most important elements is to determine which crimes are eligible. As noted above, we are recommending, and both the Council of State Governments and the National Judicial Task Force would recommend, limiting it to those crimes where there is a compelling state interest in restoration (*i.e.*, more serious crimes) as well as those crimes not appropriate for diversion or dismissal.

Diversion:

Another important element to consider, and one which both groups also stress, is the need for strong diversion programs, including once competency has already been raised.

As noted in the feedback from Court Diversion, there seems to be some confusion around when a person could be referred to diversion, especially once competency has been raised, so the Office of the Attorney General recently provided guidance:

Guidance to Court Diversion/Tamarack programs re competency

September 2023

If a case is referred to Court Diversion/Tamarack (CD/T) and the Court has not ordered that a competency evaluation be completed but you think the person is not competent, discuss this with the prosecutor and, if one has been assigned, the defense attorney. As an ethical matter, the person may not be able to understand enough to participate in the program and CD/T staff may not have the necessary skills or resources to work with someone who is not competent.

When a person is referred to CD/T and the Court has ordered that a competency evaluation be completed, meet with the person, and review the Initial Agreement. Just because a Court has ordered a competency evaluation does not mean the person is unable to complete Diversion. They may be competent under the law, or they may be able to understand the Diversion program and its requirements better than the more complex and high-stakes procedures and systems in our Courts. However, if you are concerned that the person does not understand the Diversion program or what you are explaining, inform the prosecutor and defense attorney, and return the case to Court. Indicate on the CD/T status form that the person is not accepted into the program because they are ineligible.

If you think the person understands what you are explaining and is able to participate in the program, proceed as with other program participants. If the participant successfully completes the program, the court order for a competency evaluation will be moot.

If the participant stops engaging or there are other indications that the person is struggling, contact the person's defense attorney and discuss your concerns. Do not consider the person to have failed the program as you might with other participants. The defense attorney can request that the case be returned to Court and the person's court case will be on hold until the competency evaluation is completed. On the CD/T status form, under Program Completion Status, check Requested return to Court.

Role of Evaluators:

One of the key pieces of a competency restoration program will be having qualified evaluators who can provide timely assessments, including determinations around if the evaluator thinks someone can be restored to competency and potential timelines around that restoration. DMH evaluators currently have the capacity to do this work. Under the changes in Act 28 (2023), DMH implemented a new evaluation scheduling process, and evaluations are being scheduled generally within 60 days. Backlogs in competency evaluations have been eliminated.

DMH would propose modifying the existing contract with our evaluators to:

- Conduct an Initial Competency Evaluation
- Provide an opinion on overall restorability which includes:
    - . An estimated restorability timeframe; and Treatment needs for restorability (medication with or without a court order, education, ID-focused education such as the Slater Method, longitudinal evaluation of malingering, etc.)

- Updated evaluations every 90 days.
  - Ideally assigned to same evaluator.
  - If not competent upon re-evaluation, recommend further restoration and either give rough timeline or determine them not competent/not restorable.

Potential Locations:

Best practice would be to have competency restoration programs available throughout the system.

One option might be for the legislature to consider a series of pilot projects in multiple locations – in a hospital (such as VPCH), in a forensic facility, in DOC and in a residential program (such as River Valley).

Further, existing law will need to change to allow someone to be held in a secure facility while undergoing competency restoration for a set period of time tied to restoration timelines.

Cost Estimates:

Recognizing Vermont is still in the preliminary planning stages, the financial advisors have developed cost estimates for two scenarios and two sizes.

Scenario 1: Located at a hospital, forensic facility, in DOC, or a residential program (such as River Valley).

	Scenario 1			
	9 Beds		**16 beds**	
Staffing:	# Staff	Cost	# Staff	Cost
Psychiatrist	0.5	301,600	1	603,200
Psychologist	1	121,200	1	121,200
Registered nurse	4	576,072	4	576,072
Activity Therapist	1	96,815	2	193,630

Social Worker	1	105,466	2	210,932
Mental health specialist	16	1,546,992	24	2,320,488
Subtotal (Staffing)	*23.5*	*2,748,145*	*34*	*4,025,522*
Operating:				
Laptops	4	8,000	4	8,000
Monitors	4	600	4	600
Printer/scanner	1	1,000	1	1,000
Other Supplies		3,000		3,000
Subtotal (Operating)		*12,600*		*12,600*
Final Total		**2,760,745**		**4,038,122**

Scenario 2: Located in DOC, with the assumption that correctional staff would be available (and therefore fewer mental health specialists).

	Scenario 2			
	9 Beds		**16 beds**	
Staffing:	# Staff	Cost	# Staff	Cost
Psychiatrist	0.5	301,600	1	603,200
Psychologist	1	121,200	1	121,200
Registered nurse	4	576,072	4	576,072
Activity Therapist	1	96,815	2	193,630

Social Worker	1	105,466	2	210,932
Mental health specialist	4	386,748	8	773,496
Subtotal (Staffing)	11.5	1,587,901	*18*	*2,478,530*
Operating:				
Laptops		8,000		8,000
Monitors		600		600
Printer/scanner		1,000		1,000
Other Supplies		3,000		3,000
Subtotal (Operating)		12,600		12,600
Final Total		**1,600,501**		**2,491,130**

Unique Vermont Considerations

Medications

As seen from the clinical literature, and from some stakeholder input, medication is a key component in the effectiveness of competency restoration programs. Currently, Vermont does not consider in statute medications to restore competency, leading to a potential gap in adequately serving a person in need.

We request the Legislature consider modifying existing law to allow for a compromise between the current involuntary medication standards in Title 18 and the Sell standard, explained above. One option would be to change the standard just for those in competency restoration programs whereby if someone is in a restoration program, will not take medications voluntarily but does not meet our current statutory standards, that person could be involuntarily medicated pursuant to the Sell standard if:

- It has been 45 days since the competency restoration program has started

- There is expert testimony from the treating physician that the individual could likely be restored with medication and otherwise meets the Sell criteria

The initial medication order could limit the use of medications for 90 days, with a requirement of additional clinical evidence supporting a continued medication order to extend the order – potentially for six-month periods after that.

Short Commitment Timelines

Currently, under Title 13, if someone is found incompetent, there is a very short period of time where the defendant can be held in Department of Corrections facilities before a commitment hearing must be held (it was 15 days, it was expanded to 21 days with Act 28 (2023)).

As discussed above, our existing laws will require further modification for someone to be held while they are restored to competency.

Stakeholder Input

DMH and DAIL reached out to the following to solicit input. Stakeholders were asked to provide input specifically in five areas, in addition to whatever else they would like us to consider. Those five areas were:

- Which crimes should be eligible?
- How can we better divert people from the criminal justice system?
- Timelines for restoring competency
- Use of medications in competency restoration
- Restoration locations

1. Department of Corrections

The Department of Corrections concurs with the recommendations of the Department of Mental Health and Agency of Human Services that competency restoration programming be formalized through legislative action in Vermont.

Several high-profile recent cases have raised questions about current pathways to competency restoration in Vermont. Given DOC continues to play a critical role in housing and serving many of these individuals, the Department strongly endorses further exploration of this topic within the Legislature and encourages lawmakers seek extensive testimony from State officials, subject matter experts and community stakeholders.

DOC further recommends these conversations encompass a wide consideration of clinically appropriate pilot sites and settings for competency evaluation and restoration. While the Department maintains extensive protocol and experience in housing individuals with complex needs, the carceral system is not by nature or design a therapeutic treatment environment. Rather, it is a vehicle of the justice system dedicated to criminal risk reduction.

2. Defender General

No feedback received.

3. State's Attorneys

Timothy Lueders-Dumont provided a memorandum included in its entirety as Appendix B.

4. Vermont Judiciary

Judge Zonay, Chief Superior Judge, provided the following feedback:

"I note that whether to enact legislation for a competency restoration program in Vermont, and what it should look like if enacted, are questions of policy for the Legislature. As such, I am not in a position to offer comment on whether a competency restoration program should be enacted.

Additionally, other states have taken various approaches in their competency restoration enactments in determining eligibility, the timelines which must be met, the use of medication, and the locations where the programs occur. As to these areas, I note that there have been numerous lawsuits, and claims in individual cases where a defendant is required to participate in a program, focusing on these types of issues. That being the case, I do not believe it appropriate for me to offer comment on these questions given that there is the potential, if not likelihood given what has occurred in other jurisdictions, for any enactment in Vermont to be the subject of court proceedings. Notwithstanding this, should a bill be submitted to the Legislature for establishing a program I would be in a position to offer testimony as to the bill's implementation and projected impact on the courts, including the effect potential litigation will have on our courts.

As to better diverting people from the criminal justice system, I assume this is directed at those with mental health needs. I believe that a critical component to better diverting those with mental health needs from the criminal justice system is the availability of mental health programs to assist those in need of treatment.

The one area which I am comfortable weighing in on relates to the question of how we may better divert people from the criminal justice system. As you are aware, Vermont has taken, and is continuing to engage in, significant steps relating to pretrial diversion programs. I will continue to work with the stakeholders regarding such programs."

5. Vermont Care Partners

DMH met with the CRT (Community Rehabilitation Treatment) directors on October 6, 2023, to discuss. Discussion focused around how to best serve individuals, how to better utilize court diversion, and how to meet people where they were at. The importance of housing was emphasized. Having a robust mental health court system was also discussed, similar to Alaska and Texas, as a better option to meet need.

In follow up discussions, several things happening in Texas were highlighted as good models. One, in Austin, Texas called the "Downtown Austin Community Court"[23] was referenced as a good example of a mental health court with wrap around services. Texas also has an Office of Forensic Coordination[24] and there is the Texas Behavioral Health and Justice Technical Assistance Center[25], which had online information and resources.

Sequential Intercept Mapping was also highlighted as a great way to think about how to better utilize diversion, at all points in the process.

6. Disability Rights Vermont

Lindsey Owen, Executive Director, provided a statement with related attachments included in its entirety as Appendix C.

7. Court Diversion Programs

Willa Farrell, Court Diversion & Pretrial Services Director, noted that the decision to refer someone to diversion rests with the prosecutors. However, there had been some misunderstanding around when someone could be referred to diversion when competency was at issue, so new guidance went out in September 2023 with the hope

[23] Community Court | AustinTexas.gov

[24] Office of Forensic Coordination | Texas Health and Human Services

[25] Texas Behavioral Health and Justice Technical Assistance Center / Home (txbhjustice.org)

of clarifying any misunderstandings and hopefully leading to more people being diverted. The new below guidance, for Court Diversion staff, was shared with the Judiciary, Dept. of State's Attorneys and Sheriffs, and the Defender General for distribution to their networks.

Guidance to Court Diversion/Tamarack programs re competency

September 2023

If a case is referred to Court Diversion/Tamarack (CD/T) and the Court has not ordered that a competency evaluation be completed but you think the person is not competent, discuss this with the prosecutor and, if one has been assigned, the defense attorney. As an ethical matter, the person may not be able to understand enough to participate in the program and CD/T staff may not have the necessary skills or resources to work with someone who is not competent.

When a person is referred to CD/T and the Court has ordered that a competency evaluation be completed, meet with the person and review the Initial Agreement. Just because a Court has ordered a competency evaluation does not mean the person is unable to complete Diversion. They may be competent under the law, or they may be able to understand the Diversion program and its requirements better than the more complex and high-stakes procedures and systems in our Courts. However, if you are concerned that the person does not understand the Diversion program or what you are explaining, inform the prosecutor and defense attorney, and return the case to Court. Indicate on the CD/T status form that the person is not accepted into the program because they are ineligible.

If you think the person understands what you are explaining and is able to participate in the program, proceed as with other program participants. If the participant successfully completes the program, the court order for a competency evaluation will be moot.

If the participant stops engaging or there are other indications that the person is struggling, contact the person's defense attorney and discuss your concerns. Do not consider the person to have failed the program as you might with other participants. The defense attorney can request that the case be returned to Court and the person's court case will be on hold until the competency evaluation is completed. On the CD/T status form, under Program Completion Status, check Requested return to Court.

8. Mad Freedom

No feedback received.

9. Center for Crime Victims Services

Jennifer Poehlmann, Executive Director of the Vermont Center for Crime Victim Services, provided the following feedback jointly with family members Kelly Carroll and Joanne Kortendick:

"Which crimes should be eligible? We agreed that there should be no absolute bar for consideration of competency restoration for any crime, especially when there is a victim involved. Ideally, cases would be treated individually, with consideration given to a defendant's prior history of charges, compliance history, and risk of harm to self, victim and/or community.

Recognizing that there is likely to be a limitation on available resources to provide competency restoration services in a timely manner, we strongly recommend that at a minimum, **all listed crimes, as defined in 13 VSA 5301(7), are eligible. Additionally, some serious crimes are not within 13 VSA 5301(7)** that we also recommend are included if there is to be a narrowing of crimes – notably:

- Aggravated animal cruelty (13 VSA sec.352(a)
- Countless researchers link animal abuse as a precursor or occurring in conjunction with serious, abusive, and violent crimes against the person.
- Voyeurism 13 VSA sec.2605(j) where the charge is for a second or subsequent offense in violation of 13 VSA sec.2605 (b)(d) or (e)
- Sexual exploitation of children 13 VSA Ch. 64
- Violating an extreme risk protection order 13 VSA sec.4058(b)(1)

How can we better divert people from the CJS?

We agreed that this was not a question addressing the situation in front of us relative to competency restoration. Utilization of our current "pre-charge/pre-trial" programs, such as diversion, restorative justice programming, and Tamarack, would seem to pose a problem if there is a threshold issue concerning competence. If competence is the issue, we are unclear as to how any of our current programming intended to address harm outside of the criminal justice system could provide a viable option until competency is restored. While we agree more resources can and should be provided in order to ideally prevent criminal behavior, once that behavior has occurred and there has been an impact on a victim(s) and communities, in our opinion, competency must be restored in order for the defendant to meaningful engage in any process outside the criminal justice process if meaningful outcomes for all affected parties are to be achieved.

Timelines for restoring competency.

We agreed that the process should start right away/immediately. In this way, we can:

- avoid unnecessary delays for the victim/survivor;
- acknowledge the defendant's constitutional rights to a speedy trial; and
- recognize the statutory rights victims have, which include the right to a speedy trial (13 VSA sec.5312) and the right to be heard.

We agreed that for all listed crimes and for the additional crimes we identified to be included (at a minimum), there should be NO time limit for restoring competency. We would consider supporting a time limit for non-violent misdemeanors and felonies. In our review, other states do have different time frames depending on the offense.

Use of medications in competency restoration.

This is necessary as we do not feel that competency restoration will often be successful without it. As we have referred to many times in testimony, a defense attorney who has participated in these conversations essentially said a defendant would have to be "incompetent" to agree to work toward "restoring" their competency and thereby be subjected to a criminal proceeding. That messages such as these are being sent to clients is deeply concerning to us and provides additional reasons to doubt the success of a competency restoration program where medications cannot be used.

Restoration Locations.

While we support additional locations in the community, it is IMPERATIVE that Vermont establish a forensic facility to address those individuals who cannot be adequately supervised or provided with programming in the community. We have actively participated in countless conversations and workgroups on this issue and continue to believe, even more so after the presentation of evidence and testimony from multiple professionals and experts in the field, that this remains the only feasible option for a VERY small number of individuals who cannot otherwise be safely contained – for their own safety and/or the safety of victims and communities.

Finally, we wish to underscore that the conversation must remain focused on the issue of restoration of competency as a legal standard for purposes of assisting in one's defense; it is not a standard that relates to treatment or larger issues that may be impacting that individual. The restoration that is contemplated is a far narrower standard that is linked to a very specific purpose and intent."

10. Victims/Family Members

See comments from the Center for Crime Victim Services, above.

11. Vermont Association of Hospitals and Health Systems (VAHHS)

Devon Green, Vice President of Government Relations, and Emma Harrigan, Vice President of Policy, provided the following comments:

- Restoration should take place the most appropriate setting for the individual, which is not necessarily the hospital.
- Risk should be taken into account in setting – how do you balance individuals with low treatment needs but high risk with those with high treatment needs and low risk? Especially with our current hospital system?
- While serious crimes should be a focus, often individuals come into the EDs who are committing multiple misdemeanors and their behavior is escalating. How do those individuals fit in?
- There should be a focus on what data we collect and what data we need to collect.

12. Vermont Medical Society

Dr. Simi Ravven helped with a lot of information gathering for this report and has a wealth of information and expertise in this area, so is certainly someone the Legislature may want to hear testimony from. In addition to the assistance she provided to this report, she noted the following:

- Jail-based competency restoration programs are controversial. “The concern is that any such program, in a correctional setting, is by virtue of its frame coercive.”
- As to which crimes should be eligible, “broadly speaking, crimes that pose a significant community safety threat.”
- How can we better divert people, “there are many intercepts it which to do this. The one that comes to mind first is having greater access to mental health courts throughout Vermont. I understand this is only available in Chittenden County currently.”
- Reasonable timelines, “on reviewing the literature, would be six months and then reevaluation. I think it would be reasonable for the evaluators to recommend if an individual has made significant progress and would likely be successfully restored given more time.”

- Medication: “It is difficult to imagine successful restoration without medication for people who experience serious mental illness, specifically psychotic spectrum disorders and bipolar disorders, though it is only one element of a restoration program.”

13. Vermont Legal Aid – both the Mental Health Law Project and Disability Law Project

Jack McCullough, Director of the Mental Health Law Project, provided the following comments:

“We do not support involuntary psychiatric treatment for the purpose of making someone competent to stand trial. Our view is that this kind of proposal would have the effect of keeping people tied up in the involuntary mental health system beyond the point at which it is necessary for the protection of the patient or the public. In addition, as I frequently mentioned in our work group meetings, I believe that forcing someone to undergo involuntary treatment so that they can be prosecuted and incarcerated is inimical to the stated values of medical treatment, which are to benefit the patient.

I should also point out that we are just wondering about what the purpose of this proposal is. Are you hoping to transfer the locus of treatment from the civil to the criminal context? That seems like a real problem.

For defendants charged with serious crimes, it’s been my observation that even without a competency restoration program they tend to be held in the involuntary system for a long time, thereby ensure public safety and keeping open the possibility of competency restoration.

One other thing. Although there aren’t too many cases like this, I suspect that in many of the cases that might be subject to this program, once the defendant is found competent they would still likely have a strong insanity defense, which again raises the question of whether anything has been gained.

14. Developmental Disabilities Counsel

No input provided.

Appendix A: Educational Program Components

Common educational components include:

- "general" psychosocial skills-building in the areas of communication, reasoning, and decision-making
- emotion-regulation training, particularly anxiety-reduction strategies
- group- and individual-based competence education training pertaining to the legal system
- videos and/or model courtrooms designed to demonstrate courtroom procedures
- presentation of common courtroom scenarios designed to facilitate problem-solving
- participation in a mock trial

An educational program used in Florida[26] is comprised of 8 sessions:

- Introduction, Module Objectives, Competency Pre-Test
- Appreciation of Charges
- Appreciation of Possible Penalties
- Understanding the Legal Process
- Understanding the Adversarial nature of the Legal Process
- Description of Courtroom Procedure
- Capacity to Disclose to Attorney
- Ability to Manifest Appropriate Courtroom Behavior.

Each session begins with a brief overview, basic information on the session's topic, and prompts the participant to provide their current understanding of the topic. The participant is routinely provided with short, hypothetical questions on the topic to be able to apply the information learned to possible courtroom scenarios. The facilitator is

[26] Florida Mental Health Law (unknown date). Competency Enhancement Program Manual (http://www.flmhlaw.com/wp-content/uploads/2017/01/CEP-Manual.pdf)

prompted to provide a summary and chance for the participant to ask questions at the end of each session.

A similar training program used in Virginia[27] is comprised of nine content areas:

- Explaining the Purpose of Restoration Services
- Explaining Legal Rights
- Explaining Charges, Penalties, and Evidence
- Explaining Pleas and Plea Bargains
- Explaining Criminal Penalties and Plea Outcomes
- Explaining Courtroom Personnel
- Assisting Your Defense Attorney
- Explaining the Trail Process
- Appropriate Courtroom Behavior.

Each module contains information that is presented to the participant followed by a short quiz to test their understanding of the material. A courtroom diagram is provided as a visual aid. Following completion of all modules, the participant is administered a post-test that includes all required elements for competency.

The Slater Method[28], referenced earlier for those with intellectual disabilities, contains 5 modules:

- purpose of training and review of charges, pleas, and potential consequences
- courtroom personnel
- courtroom proceedings, trail and plea bargaining
- communicating with the attorney, giving testimony, and assisting in the defense

[27] Virginia Department of Behavioral Health and Developmental Services (2018). Adult Outpatient Competency Restoration Manual for Community Services Boards and Behavioral Health Authorities (https://dbhds.virginia.gov/assets/doc/forensic/Adult-Outpatient-Restoration-Manual-for-CSBs-2018.pdf).

[28] Wall, B. W., & Christopher, P. P. (2012). A training program for defendants with intellectual disabilities who are found incompetent to stand trial. The Journal of the American Academy of Psychiatry and the Law, 40, 366—373.

- tolerating the stress of proceedings.

Appendix B: Memo from the State's Attorneys & Sheriffs

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STATE OF VERMONT
OFFICE OF THE EXECUTIVE DIRECTOR
DEPARTMENT OF STATE'S ATTORNEYS & SHERIFFS

TO: Karen Barber, Esq., General Counsel, Department of Mental Health ("DMH")
FROM: Timothy Lueders-Dumont, Esq., Deputy State's Attorney, Legislative & Assistant Appellate Attorney, Department of State's Attorneys and Sheriffs ("SAS")
DATE: October 16, 2023 (*responses collected from the Deputy State's Attorneys and State's Attorneys*)
RE: SAS Response on behalf of State's Attorneys Regarding Act No. 28, 2023 (S.91) Relating to Competency Restoration

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During the 2023 legislative session the legislature passed, and the governor signed, S.91 (Act 28)(2023). Section 7, "COMPETENCY RESTORATION PROGRAM PLAN" directed the Department of Mental Health ("DMH") and the Department of Disabilities, Aging, and Independent Living ("DAIL") to report to the Governor, the Senate Committees on Judiciary and on Health and Welfare, and the House Committees on Judiciary, on Health Care, and on Human Services on whether a plan for a competency restoration program should be adopted in Vermont. For purposes of the report required by Act 28, DMH and DAIL were directed to consult with a number of entities, including the Executive Director of the Department of State's Attorneys ("SAS").

Specifically, DMH requested that SAS provide responses to the five questions below:

- ***Question #1: Which crimes should be eligible?***
- ***Question #2: How can we better divert people from the criminal justice system?***
- ***Question #3: Timelines for restoring competency?***
- ***Question #4: Use of medications in competency restoration?***
- ***Question #5: Restoration locations?***

In response to questions posed by DMH, State's Attorneys provided feedback, compiled below:[1]

- ***Question #1: Which crimes should be eligible?***[2]
  - Many prosecutors believe that all crimes, on a case-by-case basis, should be eligible for competency restoration but if narrowing is needed then crimes involving violence to persons or destruction of property (both misdemeanors and felonies), all listed crimes, "Big-12" offenses (both now and in the future), crimes where there is danger to the community, or to the defendant, and, as a rule, any crime with a victim. Prosecutors also emphasized the importance of access to restoration for all felonies and all violent-related misdemeanors and stressed emphasis for repeat offenders where is an ongoing issue risk to community or victim safety.
  - Likewise, all responses emphasized the need to prioritize cases and individuals with ongoing risk to community safety. Prosecutors broadly agree that crimes involving victims should weigh heavily in the analysis concerning eligibility for competency restoration.
  - In sum, if there is to be a list, while all listed offenses and "Big-12" offenses should be included, the current enumerated "Big-12" and listed offenses are non-exhaustive. Thus, in addition to those offenses noted above, any list concerning eligibility for competency restoration should include the following serious crimes:
    - *Conspiracy to commit a listed offense. 13 V.S.A. 1404.*
    - *Accessory to a listed offense. 13 V.S.A. §§ 3-5.*
    - *Criminal use of anesthetics. 13 V.S.A. § 12.*
    - *Any Crime with a Hate Crime Enhancement / Hate-motivated crimes. 13 V.S.A. § 1455.*
      Animal cruelty (if another's animal). 13 V.S.A. § 352.
    - *Aggravated animal cruelty (if another's animal). 13 V.S.A. § 352a.*
    - *Interference with or cruelty to a guide dog (if another's service animal). 13 V.S.A. § 355.*
    - *First degree arson (burning someone's house). 13 V.S.A. § 502.*
    - *Second degree arson (burning someone's business). 13 V.S.A. § 503.*
    - *Law enforcement use of prohibited restraint. 13 V.S.A. § 1032.*
    - *Assault of protected professional; assault with bodily fluids (but not restricted to that form of assault). 13 V.S.A. § 1028.*
    - *Assault of correctional officer; assault with bodily fluids. 13 V.S.A. § 1028a.*

[1] Comments are provided here as compiled from responsive State's Attorneys and Deputy State's Attorneys and summarized in the interest of providing consultation pursuant to Act 28, 2023.

[2] There are policy concerns related to enumerating crimes eligible for restoration. Enumeration may leave out important contextual considerations that may be at issue, underneath the surface of a case (*e.g., How many pending cases? Victims and victim perspective? Bail status/HWB? Is Def currently being held? How many counties are involved? In-state vs. out-of-state record? Prior record? Prior record with ONH or OH? Housing access status? Substance use disorder? Violations of conditions of release? Dangerousness and violence considerations relating to public safety?*). Enumerating crimes could result in arbitrary exclusion for individuals that may well benefit from restoration programming.

- *Aggravated stalking. 13 V.S.A. §§ 1063(1) (violated court order), (2) (previous convictions), and (5) (deadly weapon).*
- *Abandonment or exposure of baby (if it is another's baby). 13 V.S.A. § 1303.*
- *Cruelty to a child. 13 V.S.A. § 1304.*
- *Cruelty by person having custody of another. 13 V.S.A. § 1305.*
- *Mistreatment of person with impaired cognitive function. 13 V.S.A. § 1306.*
- *Unlawful sheltering; aiding a runaway child. 13 V.S.A. § 1311.*
- *Abuse, neglect, and exploitation of vulnerable adults. 13 V.S.A. §§ 1376 (abuse), 1377 (unlawful restraint and confinement), 1378 (neglect), 1379 (sexual abuse), 1380 (financial exploitation), and 1381.*
- *Willful and malicious injuries caused by explosives (blowing up a house; setting a bomb). 13 V.S.A. § 1601.*
- *Injuries caused by destructive devices. 13 V.S.A. § 1605.*
- *Injuries caused by explosives. 13 V.S.A. § 1608.*
- *Definition and penalty (extorsion; could include sextortion). 13 V.S.A. § 1701.*
- *False alarms to agencies of public safety (death or bodily injury resulting). 13 V.S.A. § 1751(b).*
- *Employers without workers' compensation insurance; criminal sanction. 13 V.S.A. § 2025.*
- *Installation of object in lieu of air bag. 13 V.S.A. § 2026.*
- *Sale or trade of motor vehicle with an inoperable air bag. 13 V.S.A. § 2027.*
- *Identity theft. 13 V.S.A. § 2030.*
- *Poisoning food, drink, medicine, or water. 13 V.S.A. § 2306.*
- *Grand larceny. 13 V.S.A. § 2501.*
- *Larceny from the person. 13 V.S.A. § 2503.*
- *Embezzlement (at least when committed by a public/school employee). 13 V.S.A. §§ 2531, 2532, 2533, 2534, 2535, 2537, and 1538.*
- *Voyeurism. 13 V.S.A. § 2605.*
- *Disclosure of sexually explicit images without consent. 13 V.S.A. § 2606.*
- *Slave traffic (relating to prostitution). 13 V.S.A. § 2635.*
- *Disseminating indecent material to a minor in the presence of the minor (not the offense where a minor disseminates it). 13 V.S.A. § 2802.*
- *Disseminating indecent material to a minor outside the presence of the minor (not the offense where a minor disseminates it). 13 V.S.A. § 2802a.*
- *Sexual Exploitation of Children. 13 V.S.A. Ch. 64.*
- *Female genital mutilation or cutting. 13 V.S.A. § 3151.*
- *Sexual exploitation of an inmate. 13 V.S.A. 3257.*
- *Sexual exploitation of a minor. (e.g., school personnel). 13 V.S.A. § 3258.*
- *Sexual exploitation of a person in the custody of a law enforcement officer. 13 V.S.A. § 3259.*
- *Unlawful trespass of a dwelling. 13 V.S.A. § 3705(d).*
- *Unauthorized removal of human remains. 13 V.S.A. § 3761.*
- *Violating an extreme risk protection order. 13 V.S.A. § 4058(b)(1).*
- *Sexual intercourse when infected with venereal disease. 18 V.S.A. § 1106.*
- *Selling or dispensing a regulated drug with death resulting. 18 V.S.A. § 4250.*
- *Eluding a police officer with serious bodily injury or death resulting. 23 V.S.A. § 1133(b).*
- *Custodial Interference. 13 V.S.A. § 2451.*
- *Weapons of Mass Destruction. 13 V.S.A. §§ 3502, 3503.*
- *Domestic Terrorism. 13 V.S.A. § 1703.*
- *Any Crime with a Habitual Offender Enhancement.*

- ***Question #2: How can we better divert people from the criminal justice system?***
  - Expanded community-based intensive services and supportive housing.
  - More beds for higher-level residential care.
  - As needed and determined by proper analysis, increased use of long-acting, injectable anti-psychotics.
  - More in-home support for families.
  - Mental-health problem-solving courts.
  - More effective enforcement and staffing of ONHs.
  - More voluntary inpatient access.
  - More effective utilization of community organizations: police, DOC, local community organizations, and social workers to assist individuals in accessing services and voluntary admissions. Likewise, better resourced community partners to provide comprehensive services to those who are criminal justice involved.
  - Some noted that this inquiry/premise may be misguided as there are issues with sending incompetent people to Diversion or Tamarack. To engage with Diversion and Tamarack, restoration is still important. That said, if there is adequate staffing and resources, perhaps *misdemeanor-non-victim-cases* could be eligible for *diversion-esque* programming with a governmental entity monitoring for treatment and engagement

- ***Question #3: Timelines for restoring competency?***
  - Six months-1 year, depending on the context of a particular individual.
  - Six months for violent misdemeanors, one year for felonies.
  - No time limit for "Big-12" and listed offenses and those other serious offenses noted above (*e.g., those serious offenses not currently accounted for in the "Big-12" or "listed" offenses*).
  - A rubric whereby there is no time limit for serious offenses and a time limit for minor offenses (other states have this).

- ***Question #4: Use of medications in competency restoration?***
  - Yes, as needed, but how will it be enforced?
  - Yes, this is necessary – otherwise competency restoration will be unsuccessful in many cases.

- **Question #5: Restoration locations?**
  - Should be options for both community-based restoration and inpatient, depending on the needs and circumstances of the individual.
  - Inpatient setting run by the DMH or DAIL: should be inpatient or outpatient, depending on needs and circumstances. Setting must ensure security and safety.
  - For those that cannot remain in the community, a forensic facility and/or DOC facility (*if circumstances are such that someone is in a DOC facility then there should be access to restoration and other programming*).
  - Anything outside of jail or a forensic facility must be accompanied with housing support; we cannot have an outpatient program where people are living on the streets and self-medicating, being taken advantage of, and returning to behaviors

that brought them into contact with law enforcement in the first place (*this is what we have now, and it is not working*).
    - If outpatient, it must be structured with frequent check-ins and waivers for ability to check on compliance with medication and substance use or therapy and ability to issue AW if patient does not engage. Whether inpatient or outpatient, both settings must have case management to address complex life circumstances that contribute to incompetence (*poverty, substance use, housing instability*).
    - If inpatient, the facility should be run by the State, not private contractors.

- ***Other SAS Comments:***
    - State's Attorneys are in favor of Vermont establishing a competency restoration program as well as a forensic facility. Likewise, State's Attorneys believe that the Agency of Human Services ("AHS") should have a public safety mission that complements the existing duties of AHS departments.
    - Restitution is not available for cases when the case is dismissed for lack of competence. If the statute could provide a fix to assist in accessing restitution to non-business victims, it could go a long way in helping some victims with significant financial losses.

Appendix C: Disability Rights Vermont and Companion Materials

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To: The Vermont Department of Mental Health

c/o Karen Barber

Re: Competency Restoration Input

Date: October 19, 2023

Thank you for requesting input on the proposed inclusion of a competency restoration process for Vermont. As the Department of Mental Health is aware, Disability Rights Vermont is the Protection and Advocacy agency for the State of Vermont. Protection and Advocacy agencies across the country are tasked and funded to investigate abuse, neglect, and rights violations impacting individuals with disabilities, and seek remedies for those individuals. Where possible, Protection and Advocacy agencies also advocate for systemic changes to prevent future harm to disabled members of our communities.

Given our federal mandate, DRVT maintains that the question exists, as to whether competency restoration is even an appropriate process to address alleged criminal conduct in our communities by persons who are presumed to lack capacity or be able to be restored to capacity. We maintain that community-based supports for people experiencing mental illness would be far more effective in preventing or limiting their engagement with the criminal justice system, altogether. Considering the State's trajectory of proceeding with a Competency Restoration Treatment (CRT) process, DRVT's recommendations remain rooted in that obvious need for a more proactive and preventative approach to our system of care that would reduce the number of individuals impacted by CRT. We support the incorporation of diversion efforts and systems wherever possible. Furthermore, we would advocate that any CRT process incorporated into our system should be conducted in the least restrictive setting, using outpatient therapies and evaluations. Below are some brief responses to the Department's questions and some additional feedback. Thank you again for reaching out to DRVT.

1. What Crimes should be eligible for CRT:

DRVT believes anyone charged with a crime should be equally eligible for CRT, should we adopt a CRT process. However, the nature or severity of the crime may be a factor in what the process looks like in terms of placement, timing, etc. DRVT is including with these responses several settlement agreements from across the country that shed light on how some states have landed on these issues.

2. How can we better divert people from the criminal justice system?

As alluded to above, DRVT would recommend that DMH, in coordination with the other State Departments, and community partners, invest in preventative and proactive measures addressing the social determinants of health that inevitably impact and influence whether someone will find themselves in the criminal justice system. Extreme and intentional efforts to increase access to affordable and accessible housing; affordable and accessible healthcare- to include all types of care, physical and mental; affordable/livable and accessible employment; affordable and accessible childcare, would make an enormous positive difference for reducing individuals' involvement with the criminal justice system. Standing up a new system in an already resource depleted environment is financially irresponsible without simultaneously, or firstly, trying to address the need for such a system through less costly measures. A few years ago, DRVT published a report entitled Wrongly Confined. Within that report exists the costs of treating people across a variety of settings compiled by Vermont Care Partners in a 2018 report. The cost of living in a state-run inpatient psychiatric facility was $2,537/day and the cost of living with some services in a person's home was only $64/day. https://disabilityrightsvt.org/wp-content/uploads/2020/06/DRVT-Olmstead-Report.pdf. DRVT believes that these costs have increased significantly over the last five years, and that it would be fiscally irresponsible to create another system geared towards confining more individuals with disabilities instead of trying to address the basic needs of Vermonters to prevent the problem from occurring in the first place. DRVT does acknowledge that working towards these preventative and proactive measures will not stop all crimes from occurring and that there will continue to be questions around some people's competency, but for the focus and the resources to be on that small population when so many more could be served with those same resources in the community, that is where DRVT asserts the resources are best spent.

3. Timelines for restoring competency?

DRVT does not have any medical or psychiatric expertise to opine on this with any sort of specificity. However, some of the settlement agreements included with this statement demonstrate some reasonable ideas on this matter. For example, Oregon makes it clear that the restoration process cannot exceed the minimum sentence that the crime itself carries. DRVT acknowledges the efforts DMH has made to do some research into this, and we would defer to those experts and the settlement agreements attached hereto.

4. Use of medications in competency restoration.

Despite the Sell v. United States decision that found states *could* use involuntary medication for competency restoration, it certainly did not make involuntary medication a mandatory treatment option for CRT and DRVT strongly opposes the use of involuntary

medication for CRT in the state of Vermont, and DMH should as well. Currently, involuntary medication is only permissible as a last resort if someone is an imminent risk of serious bodily harm to themselves or others, or if it is court ordered for purposes of psychiatric treatment. DRVT does not believe that Vermont, a state that has declared a "policy of the General Assembly to work toward a mental health system that does not require coercion or the use of involuntary medication," should expand the opportunities to involuntarily medicate its residents. 18 V.S.A. 7629(c).

5. Restoration locations:

DRVT believes, and the Americans with Disabilities Act requires, that all people should reside in the least restrictive setting possible. Individuals in need of, or involved with, CRT services should not be treated any differently. Also, DRVT would refer to its earlier citation to the Wrongly Confined Report it authored regarding the costs associated with different living arrangements. There are also many due process concerns with confining individuals who have not been convicted of a crime, so DMH should be mindful of that, too.

Finally, after receiving the request for input, DRVT reached out to its national partners and engaged in brief research and derived the following general themes to keep in mind when creating a CRT process in Vermont.

1) Current State laws *re* competency to stand trial prevent people from receiving effective treatment and psychological care, and require only psychological evaluation.

2) CRT laws disproportionately delay due process for people with mental illness, and disenfranchises them from their right to a speedy resolution.

3) CRT prolongs detention in jails, prisons, and psychiatric facilities, for even minor offenses, amounting to cruel and unusual punishment, or incarceration without due process and conviction.

4) CRT adds additional strain to an already underfunded mental health system.

5) Current State Laws require that individuals receive treatment for indefinite periods of time, until competency is restored (potential Olmstead issues)

6) No current State outpatient system for individuals found to be incompetent to stand trial.

7) Inpatient and jail-based restoration models do not provide options for defendants to post bail, while awaiting evaluation and restoration, amounting to unequal treatment of people with disabilities.

Models used in other locations:

Conditional Release to Community-Based restoration program. Non-hospitalization. Preferred by DRVT

Inpatient Competency Restoration Program. Limited to serious felonies and threats of harm to self or others. Not for persons accused of misdemeanors, and lower level and non-violent felonies.

Jail-Based Competency Restoration Program. Not recommended by DRVT.

Alternative Models-

a) Mental Health Court-SAMHSA model. Expand the judiciary's Treatment and Specialty Courts by creating a specific Mental Health Court.
b) Sequential Intercept Model to divert people with Mental Health Disabilities away from the justice system. DRVT Advocates for more funding to be allocated to restorative justice service providers, statewide.

Sources:

https://rockefeller.dartmouth.edu/sites/rockefeller.prod/files/2122-12_forensic_mental_health_final.pdf

https://www.samhsa.gov/criminal-juvenile-justice/sim-overview

Thank you for your consideration of DRVT's input.

Respectfully,

Lindsey Owen, Esq., Executive Director

Laura Cushman, Esq., Legal Director

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

BRANDON COOPER, *et al.*,	*	
Plaintiffs	*	**CIVIL ACTION NO. 3:14-00507-SDD-RLB**
v.	*	**JUDGE DICK**
REBEKAH GEE, *et al.*,	*	**MAGISTRATE JUDGE BOURGEOIS**
Defendants	*	
Consolidated with	*	
ADVOCACY CENTER and MONICA JACKSON,	*	
Plaintiffs	*	**CIVIL ACTION NO. 3:15-00751-SDD-RLB**
v.	*	**JUDGE DICK**
REBEKAH GEE, *et al.*,	*	**MAGISTRATE JUDGE BOURGEOIS**
Defendants.	*	

SETTLEMENT AGREEMENT

I. Introduction:

In these consolidated actions, Plaintiffs, Brandon Cooper, Louis Davenport, Ron Gatlin, Kenny Swatt, Stephen Zeringue, William Pitzer, Tyrin Perkins, Dominick Perniciaro III, Scott Frye, and Ryan Kazemi are individuals who have been diagnosed with mental illness and found Not Guilty by Reason of Insanity (NGRI) of a criminal offense. Plaintiff Monica Jackson has been diagnosed with mental illness and was found incompetent to stand trial and ordered committed to Feliciana Forensic Facility, but was incarcerated in correctional facilities in Louisiana following that order. Plaintiff Advocacy Center is a private, federally-funded, non-

profit corporation, designated by Louisiana to serve as the State's protection and advocacy system for persons with disabilities and is a party in the instant consolidated cases as an associational plaintiff. Plaintiffs allege that Defendants have refused, and are continuing to refuse, to promptly accept physical custody of individuals found NGRI and Incompetent to Stand Trial who have been ordered to be admitted to an inpatient psychiatric facility for care and treatment. Plaintiffs allege that Defendants' refusal to accept physical custody has resulted and is resulting in prolonged and unconstitutional confinement in parish jails, in violation of Plaintiffs' rights to due process under the United States Constitution, Title II of the Americans with Disabilities Act of 1990, and Section 504 of the Rehabilitation Act of 1973.

The parties mutually desire to settle all of the claims asserted by the Plaintiffs in these consolidated cases without the need for further litigation and have therefore agreed to enter into this Settlement Agreement.

It is, therefore, ORDERED, ADJUDGED, AND DECREED:

1. This Court has jurisdiction over Plaintiffs' claims against the Defendants set forth in the Complaint.

2. This Settlement Agreement applies to the individuals defined as follows:

> All individuals who, after having been found Not Guilty by Reason of Insanity or Incompetent to Stand Trial are remanded by a court to a mental health facility for treatment pursuant to Louisiana law.

II. Definitions:

3. For the purposes of this Settlement Agreement, the following definitions shall apply unless a contrary meaning is indicated by the text:

a. Incompetent Individual: a person who has been found to lack the mental capacity to proceed to trial, is being held in jail, and has been ordered committed to Feliciana Forensic Facility (a.k.a. ELMHS) or other mental health facility pursuant to La. Code Crim. P. art. 648.

b. NGRI : a person who has been found Not Guilty by Reason of Insanity ("NGRI") and has been ordered by a court to be committed to a mental health facility pursuant to La. Code Crim. P. art. 654.

c. NGRI Order: an order entered by a criminal court subsequent to a finding of NGRI, committing an individual to a mental health facility pursuant to La. Code Crim. P. art. 654.

d. Order for Competency Restoration: an order committing an Incompetent Individual to a mental health facility issued pursuant to La. Code Crim P. art. 648(A)(2)(a).

e. Mental health facility: The Feliciana forensic facility at ELMHS designated by La. R.S. 28:25.1 and any other facility to which NGRI or Incompetent Individual may be committed by an NGRI Order or an Order for Competency Restoration.

f. Jail: A parish or municipal detention facility in which NGRI and Incompetent Individuals are held, or may be held, pending admission to a mental health facility pursuant to an Order of Commitment or an Order

for Inpatient Treatment. This may include DOC facilities or facilities owned or operated by third-party contractors who have contracted with Parish Sheriffs to house pretrial detainees.

g. Waiting list: the list of individuals described in paragraph 4 below.

h. Diversion from the waiting list: Release from jail to a placement in the community.

i. Sanity Commission: a commission appointed by a State court pursuant to La. Code Crim. P. art. 644 to examine a criminal defendant whose mental capacity to proceed to trial is in question, and to make findings concerning his competency to proceed to trial; or pursuant to Art. 650 in cases in which a defendant enters a combined plea of "not guilty and not guilty by reason of insanity" in order to make an examination as to the defendant's mental condition at the time of the offense.

j. Sanity Commission Report: A report prepared by the Sanity Commission and submitted to the Court.

k. District Forensic Coordinator (DFC): a mental health professional employed by the Louisiana Department of Health with at least a master's degree in social work, psychology or related field, such as counseling or nursing, and who has been trained by and is under the active supervision of the Medical Director of Defendant's Forensic Program or other Board-certified forensic psychiatrist.

l. Brief Psychiatric Rating Scale (BPRS): a standardized 24-item psychiatric rating scale used to rate psychiatric symptoms and behaviors. The BPRS comprises 24 items that can be rated from not present (1) to extremely severe (7).

o. CAGE-AID questionnaire: a brief standardized questionnaire that is a widely used method of screening for alcoholism, adapted to include other types of substance abuse.

p. Behavioral Health Assessment: a face-to-face assessment by a psychiatrist, licensed psychologist, or District Forensic Coordinator for mental illness and addiction problems, using the Brief Psychiatric Rating Scale (BPRS) for mental health symptoms and the CAGE-AID for substance abuse issues. Also included in the term "Behavioral Health Assessment" is a review of any sanity commission report; medical and mental health history, if available; jail medical and mental health records; and assessment of other factors bearing on the acuity of the NGRI or Incompetent Individual's need for mental health and substance abuse treatment, including whether the NGRI or Incompetent Individual is receiving medication, whether the NGRI or Incompetent Individual is compliant with his or her medication, efficacy and side effects of medication, physical health needs, and extent to which he or she has received jail-based competency restoration services. The Behavioral Health Assessment will result in a determination as to whether an NGRI or Incompetent Individual has an Emergency Mental Health Need, as defined below.

q. Incompetent or NGRI Individual with Emergency Mental Health Needs: an Incompetent Individual or NGRI who has a BPRS total score that is 50 or greater; who is determined by a psychiatrist designated by the ELMHS Chief of Staff to need immediate hospital treatment; or who has engaged, or is likely to engage, in acts of serious self-harm, acts of violence toward others, or significant acts of violence toward property. These individuals shall be admitted pursuant to Paragraph 8 of this Agreement.

III. Actions Required of Defendants:

4. Defendants shall maintain an updated cumulative list of all NGRI and Incompetent Individuals who are or have been housed in parish jails in Louisiana awaiting transfer to the forensic unit at ELMHS or other mental health facility or placement, on or after the date of the entry of this Settlement Agreement. The summary or list shall include, for each NGRI and Incompetent Individual:

   a. The NGRI or Incompetent Individual's name and docket number.

   b. Whether the person is an NGRI or Incompetent Individual.

   c. The court that entered the NGRI Order or Order for Competency Restoration.

   d. The date of the Order.

   e. The date that LDH was notified of the Order.

   f. The dates and results of the Behavioral Assessment and whether the person was classified as an NGRI or Incompetent Individual with Emergency Mental Health Needs.

   g. The jail or other facility in which the NGRI or Incompetent Individual is being held, if known.

   h. The status of any paperwork that must be completed, pursuant to Louisiana Code of Criminal Procedure 648.1 and Louisiana Code of Criminal Procedure 654.1 prior to admission of the NGRI or Incompetent Individual to a mental health facility or community placement.

   i. The date of admission of the NGRI or Incompetent Individual to the forensic unit at ELMHS or other mental health facility or placement.

   j. Date of any NGRI or Incompetent Individual's removal from the list due to diversion or other reasons.

k. The reasons for the NGRI or Incompetent Individual's removal from the list, including identification of the facility or other setting to which the NGRI or Incompetent Individual was transferred.

5. Defendants shall maintain their current system for receiving Orders from criminal courts. Defendants previously notified all criminal courts in Louisiana that Orders should be sent promptly to ensure individuals can be quickly assessed. If any court sends an Order more than two days after it is signed, Defendants follow up with that court via letter to reinforce the importance of the timeliness of transmission.

6. Defendants shall provide all NGRI Incompetent Individuals a Behavioral Health Assessment, as defined above, within five (5) calendar days of notification of an order for inpatient treatment or order of commitment. If the Behavioral Health Assessment is conducted by a DFC, as opposed to a psychiatrist or psychologist, the DFC must send the BPRS and CAGE-AID test results and documentation, and all other documentation described above that has been obtained, to the Forensic Aftercare Clinic (FAC) Medical Director, or another psychiatrist on staff designated by the Eastern Louisiana Mental Health System's (ELMHS) Chief of Staff, to interpret the results of the Behavioral Health Assessment in order to determine if the client needs emergency services.

7. No later than two hundred forty-five days (245) from the date of this Order, Defendants shall have admitted all NGRI and Incompetent Individuals who are on the waiting list to ELMHS, another mental health facility, or community residential program, as of the date of this Order.

8. Following the signing of this Order, Defendants shall admit all new NGRI or Incompetent Individuals with Emergency Mental Health Needs to a Mental Health

Facility within two (2) business days following completion of a Behavioral Health Assessment.

9. No later than two hundred forty-five days (245) from the date of this Order, Defendants shall admit all NGRI or Incompetent Individuals to the forensic unit at ELMHS or other mental health facility, or to an appropriate community based program within fifteen (15) calendar days following receipt of an Order, except that if Defendants demonstrate that unusual and exigent circumstances make it is impossible for them to admit an NGRI or Incompetent Individual within fifteen (15) calendar days, Defendants may have up to thirty (30) calendar days to admit the NGRI or Incompetent Individual. If the monthly reporting provisions below demonstrate admission times regularly exceeding 15 calendar days, the Plaintiffs may, at their option, call a meeting with Defendants to devise a remedial action plan to bring admission times within the 15-day threshold. Such a meeting shall not limit Plaintiffs' enforcement rights under paragraph 23.

10. Within ninety (90) days of this Order, Defendants shall implement procedures to help provide NGRI or Incompetent Individuals who are incarcerated in parish jails with expedited admission in the event of emergent mental health needs. Such procedures shall include, at a minimum, the following:

a. Defendants shall establish and publicize to each sheriff or other personnel responsible for parish jails the name, telephone number, and email address of DHH personnel to contact in the cases concerning an Incompetent Individual or NGRI with Emergency Mental Health Needs. This publication shall further instruct each sheriff or other personnel responsible for parish jails of how to report an emergency to DHH

personnel and shall include a description of the factors that substantiate the emergency.

b. Within forty-eight (48) hours of the report of an emergency to LDH, the ELMHS Chief of Staff or his Designee shall make the determination as to whether there is an actual emergency, and whether to admit the NGRI or Incompetent Individual to a Mental Health Facility on an expedited basis or take other action except when such reports occur between the close of business on Friday and 12:00 a.m. Sunday in which case determinations shall be made within seventy-two (72) hours.

11. Defendants will continue their current intake assessment procedures as well as their post-admission assessment procedures to ensure appropriate placement for each individual. In the event of a discrepancy between Defendants' recommendation for an individual's placement and the court's order regarding that individual's placement, Defendants will provide the Plaintiffs with the individual's name and the information listed in Paragraph 4 of this agreement.

12. Within one hundred and eighty (180) days of this Order, Defendants shall confer and meet to develop a plan for providing less restrictive placement options in which NGRI and Incompetent Individuals can, with the appropriate permission of the criminal court, receive clinically appropriate competency restoration or mental treatment placement options. The parties will discuss potential legislative proposals to address needs or issues brought forth in this meeting. The implementation of any such plan shall be subject to concurrence of LDH executive management and budgetary appropriation by the legislature.

13. In developing the plan described in paragraph 12, Defendants shall coordinate

a meeting of Defendants, Plaintiffs' counsel, Plaintiffs' expert, Dr. Joel Dvoskin, and any stakeholders Defendants deem necessary to discuss (a) needed research and analysis beyond that identified in the preceding paragraph, and (b) necessary elements of the strategic plan. Defendants shall consider, in addition to the funding of new placements identified in paragraph 18, opportunities to divert NGRI and Incompetency Individuals from the criminal justice system and to improve efficiencies in existing operations. To facilitate that meeting, Defendants, in addition to the information contained in paragraph 4 of this agreement, will provide to Plaintiffs' counsel relevant data in Defendants' possession regarding patient wait times and recidivism rates for persons placed on conditional release or returned to jail to stand trial after a determination that his or her competency has been restored.

14. Plaintiffs shall seek alternate methods of funding Dr. Dvoskin's consultation, including but not limited to searching and applying for any grants. In the event alternate funding cannot be found, Defendants agree to pay Dr. Dvoskin his standard hourly rate of four hundred dollars ($400) per hour as well as travel expenses for a total of up to thirty-thousand dollars ($30,000). Dr. Dvoskin will not bill Defendants for any travel time.

15. Defendants agree as follows to allocate necessary resources to create new placement options, in addition to and not in lieu of current placement opportunities, at clinically and legally suitable locations. Said locations will include community-based settings. Defendants agree to allocate resources to provide less restrictive placement alternatives to NGRI or Incompetent Individuals currently housed at ELMHS or incarcerated in parish jails and to prevent future NGRI or

Incompetent Individuals from being unnecessarily confined in a Mental Health Facility or jail, or detained in jail beyond the time periods provided for in this agreement. To this end:

a. Within two hundred forty-five (245) days from the date of this Order, Defendants shall increase the number of available beds at ELMHS by an amount necessary to accommodate the placement of individuals within the time frame established in Paragraph 9 of this Agreement;

b. Within two hundred forty-five (245) days from the date of this agreement, Defendants shall develop a plan to create supportive housing opportunities with appropriate mental health services for NGRI and Incompetent Individuals in locations throughout the Louisiana, which shall include, but not be limited to, New Orleans, Baton Rouge, Lafayette, Lake Charles, and Shreveport, including the possibility of an increase in community based beds.

16. Jail-based competency restoration and mental health treatment provided in jails do not constitute new placement options required by the preceding paragraph.

IV. Reporting provisions:

17. Defendants shall submit a report to Plaintiffs' counsel on the first working day of each month beginning November 1, 2016. The report shall contain the information set forth in Paragraph 4 above, as well as the number of NGRI and Incompetent Individuals disaggregated by category of detention, gender, and the facility to which each Individual was admitted, and a description of any unusual and exigent circumstances that resulted in a delay in placement in excess of 15 days as

established in Paragraph 9. Such report shall also contain the name of any NGRI or Incompetent Individual for whom Defendants have received a report of a mental health emergency pursuant to paragraph 12 above, the facility in which the NGRI or Incompetent Individual was held at the time of the report, a description of the factors that were provided as substantiating the emergency, the identity of the ELMHS Chief of Staff or his Designee who made the determination as to whether there is an actual emergency, the time and date of such determination, and a description of any action taken by Defendants with regard to the claimed emergency.

18. Any current or future individual(s), as defined in Paragraph 2, shall have the right to seek enforcement of this Settlement Agreement in accordance with the procedures set forth herein, regardless of whether he or she was a named Plaintiff in this action. In the event that NGRI or Incompetent Individuals seek to enforce this settlement based on the belief that Defendants have failed to discharge any obligations under this settlement, they will give written notice of such failure to Defendants' counsel, specifying the grounds that demonstrate such failure, and the Defendants will have thirty (30) days from receipt of such notice to come into or establish compliance with this settlement. If an individual believes that the alleged failure has not been cured within the thirty (30) day period, they may seek in this Court specific performance of this settlement, together with attorneys' fees and/or costs recoverable under 42 U.S.C. §1988, but not contempt of court. The sole exception to the obligation of NGRI or Incompetent Individuals to provide the written notice required by this paragraph is a circumstance in which an alleged failure to comply with a term of this agreement warrants immediate injunctive relief. in which case defendants will receive the appropriate notice required when such

relief is sought.

19. The reporting provisions in this agreement shall terminate after four (4) continuous years of Defendants' substantial compliance with the terms of this agreement.

V. ATTORNEYS' FEES AND COSTS

20. Plaintiffs are a prevailing party. In full and final settlement of this matter, and within 90 days of the execution of this Settlement Agreement, Defendants will issue Plaintiff a settlement payment in the amount of $466,000 that will be inclusive of all attorneys' fees and costs incurred in connection with this action, up to and including the date of the entry of this Settlement Agreement.

21. The parties agree that Plaintiffs may recover attorneys' fees under §1988 after final approval of this Settlement Agreement and satisfaction of the initial claim for attorneys' fees referred to in Paragraph 20 above, subject to the provisions of Section V of this Agreement.

22. Such "future" claims for fees are limited to fees and costs for work performed in obtaining Defendants' compliance with the Settlement Agreement; obtaining attorney's fees merited under the Agreement; seeking a modification of the Settlement Agreement over Defendants' objection (if the Court modifies the Settlement Agreement at Plaintiff's Request), and/or opposing a modification requested by Defendants if the Court denies (or denies, in part) Defendants' request for a modification. If the Court denies Defendants' request for modification in part, Plaintiffs are only entitled to fees for the part(s) denied.

23. In the absence of a filing for judicial enforcement or modification of the Settlement Agreement, Plaintiffs may not recover attorneys' fees. In the event that such a

motion is filed and Plaintiffs are the prevailing party, Plaintiffs' reserve the right to seek a reasonable award of fees for all work done in connection with the particular motion. Defendants reserve the right to oppose any such request.

24. The Parties agree that Plaintiffs are entitled to reasonable attorneys' fees if Defendants are found out of compliance by the Court after Plaintiffs file a motion for judicial enforcement or modification of the Settlement Agreement, provided that Plaintiffs' have given Defendants' notice and an opportunity to come into compliance pursuant to Paragraph 18 of this Settlement Agreement prior to filing their motion.

25. Reasonable attorneys' fees shall be awarded only to counsel of record and/or to any paralegals employed by counsel of record, the Advocacy Center, and/or the MacArthur Justice Center. (The person(s) claiming reimbursement of attorneys' fees shall hereinafter be referred to as "Claimant(s).")

26. In accordance with precedent of the U.S. Fifth Circuit Court of Appeals, §1988 attorneys' fees and costs can only be awarded for the work of a legal assistant or paralegal if that work is legal, as opposed to clerical. Work that is legal in nature includes, for example, factual investigation, locating and interviewing witnesses, assistance with depositions, interrogatories and document production, compilation of statistical and financial data, checking legal citations and drafting correspondence. Activities that are purely clerical in nature include, for example, typing, copying, filing, or delivering pleadings. Pure clerical or secretarial work may not be billed at an attorney's or paralegal's rate.

27. The cost of services performed by paralegals or other persons supervised by counsel of record and/or the Advocacy Center are to be included in the assessment and award

of attorneys' fees if the following criteria are met:

a. The services performed must be legal in nature;

b. The performance of such services must be supervised by an attorney;

c. The qualifications of the person performing the services must be specified in the application or motion requesting an award of fees in order to demonstrate that the person is qualified by virtue of education, training, or work experience to perform substantive work;

d. The nature of the services performed by the person must be specified in the application/motion requesting an award of fees in order to permit a determination that the services performed were legal rather than clerical in nature;

e. The amount of time expended by the person in performing the services must be reasonable and must be set out in the motion; and

f. The amount charged for the time spent by the person must reflect reasonable community standards of remuneration.

28. Costs available under 28 U.S.C. §1920 will be reimbursed whenever Plaintiffs are entitled to recover attorneys' fees and costs as described above.

29. Other costs will only be reimbursed if the evidence accompanying the claim shows that they are of the type of costs that would normally be reimbursed by a fee-paying client and that the costs were necessarily incurred in the litigation.

30. Mileage for necessary travel will be reimbursed at the rate established annually (on a fiscal calendar) by the State Division of Administration and will be reimbursed at the rate in effect at the time of travel.

31. Attorneys' fees for travel time will be paid at 50% of the claimant's billable rate.

32. Counsel of record for the Plaintiffs, at the time the instant Settlement Agreement is entered, bill at the following rates (which are fixed for the calendar year 2016): Ronald Lospennato, $375/hour; Ellen Hahn, $375/hour; Katie Schwartzmann, $350/hour; Eric Foley, $240/hour; Kathryn Fernandez, $240/hour; Laura Thornton, $200/hour.

33. The billable rates of the above-named counsel may increase annually (beginning January 1, 2017) in accordance with commensurate increase in the relevant legal market (Baton Rouge, Louisiana).

34. However, counsels' billable rates (for purposes of claims in this case under §1988) shall not increase more than $25.00 in a calendar year.

35. Billable rates for any legal personnel other than current counsel of record, as listed above in paragraph 37, must comport with the prevailing rates in the relevant legal market (Baton Rouge, Louisiana), and may increase annually (beginning January 1, 2017) in accordance with commensurate increases in the relevant legal market, but not to exceed $25.00 in a calendar year.

36. Any annual increases by attorneys other than current of record, as listed above in paragraph 37, shall not exceed $25.00 in a calendar year.

37. Any annual increases by non-lawyers shall not exceed $12.50 in a calendar year.

38. Any future claims for attorneys' fees and costs and appropriate documentation supporting the claim shall be presented to counsel for defendants within thirty (30) days of entry of the applicable Judgment or Order, unless the parties agree on, or the Court by order permits, a longer period of time.

39. The evidence accompanying any and all claims for attorneys' fees and costs must expressly show and, if requested by defendants, certify under penalty of perjury, that all costs and hours claimed were incurred in this case and that no cost or hour claimed has been

previously reimbursed in this litigation or any other litigation against the State of Louisiana, any of its agencies, officials, and/or employees.

40. If the parties cannot amicably agree on a future claim of attorneys' fees and costs pursuant to paragraph 38 above, it shall be the responsibility to the Plaintiffs to document, via time and date stamped e-mail to defense counsel, the official end to the negotiation.

41. In the event that the parties cannot amicably resolve a future claim for attorneys' fees and costs, Plaintiffs must file a Motion for Attorneys' Fees and Costs within thirty (30) days of the end of the negotiation, as described in paragraph 40 above.

42. Defendants have and reserve their right to question and/or challenge the hours billed by any claimant, exercise of billing judgment by any claimant, and necessity of costs requested by any claimant.

43. Defendants have and reserve their rights to question and/or challenge the reasonableness of the billable hourly rates of any claimant.

CAP ON ATTORNEYS' FEES AND COSTS

44. In light of the four (4) year limit on this Settlement Agreement and so the State may budget accurately, the parties have agreed to a maximum amount of attorneys' fees and costs that may be awarded during the course of this litigation.

45. The total amount of attorneys' fees that may be awarded in this case after final approval of this Settlement Agreement and satisfaction of the initial claim for attorneys' fees referred to in Paragraph 20 above shall not exceed $300,000.

46. Counsel for Defendants shall include in each Receipt, Release, and Indemnity Agreement signed by Plaintiffs' counsel as described above, an accounting of how much has been paid in attorneys' fees and costs up to and including the sum received on that date and the remaining balance on the cap.

VI. Miscellaneous

47. This Settlement Agreement represents the entire agreement between the parties.

48. This Settlement Agreement is a settlement of disputed claims and shall not be considered to be an admission of liability by any party.

49. Each party to this Settlement Agreement was assisted by counsel, understands the meaning and consequences of the Settlement Agreement, and executes the Settlement Agreement of his, her, its, or their own free will.

50. This Court shall retain jurisdiction to enforce this Settlement Agreement until this matter is dismissed after four (4) continuous years of Defendants' substantial compliance with this Settlement Agreement.

51. Each party to this Settlement Agreement has cooperated in the preparation and drafting of this Settlement Agreement. Accordingly, the Settlement Agreement shall not be construed more strictly against any party than it is against any other party.

52. The claims compromised, settled, and resolved by this Settlement Agreement include all claims that were raised in the Original or Amended Complaints filed in this action, as well as all claims precluded by governing law, on behalf of the Plaintiffs defined in Section I above. This agreement does not compromise, settle or resolve, and shall in no way impair, any claims that may arise after the end of this Settlement Agreement.

53. In consideration of the commitment contained herein, and the benefits provided or to be provided hereunder, this Settlement Agreement shall fully resolve, extinguish, and finally and forever bar, and the Plaintiffs' hereby release, all claims described in paragraph 51 above. Upon final approval by the court, this Settlement Agreement

shall be fully binding on, and fully extinguish and release the claims of, all Plaintiffs, and may be plead as a full and complete defense to any subsequent action or other proceeding that arises out of the claims released and discharged by this Settlement Agreement.

54. Nothing in this Settlement Agreement is intended to affect any rights of any party or non-party other than to the extent specifically addressed by the terms of this Settlement Agreement.

SO ORDERED this 16th day of November, 2016, in Baton Rouge, Louisiana.

SHELLY D. DICK
UNITED STATES DISTRICT JUDGE

Approved:

s/ Ronald K. Lospennato

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Dated: September 1, 2016

Approved:

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Dated: September 1, 2016

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Attorneys for Plaintiffs

IN THE UNITED STATES DISTRICT COURT IN AND FOR

THE DISTRICT OF UTAH, CENTRAL DIVISION

DISABILITY LAW CENTER, a Utah nonprofit corporation; S.B., an individual, by and through his next friend Margaret Goodman; A.U., by and through his next friend Mary Eka; and S.W., an individual, Plaintiffs, vs. STATE OF UTAH; UTAH DEPARTMENT OF HUMAN SERVICES; ANN WILLIAMSON, in her official capacity as Executive Director of the Utah Department of	**JOINT MOTION FOR (1) APPROVAL OF SETTLEMENT AGREEMENT AND CLASS NOTICES, (2) APPOINTMENT OF MONITOR, AND (3) STAY OF PROCEEDINGS** Case No. 2:15-CV-00645-RJS-BCW Judge Robert J. Shelby

Human Services; UTAH DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH; DOUGLAS THOMAS, in his official capacity as Director of the Utah Division of Substance Abuse and Mental Health; UTAH STATE HOSPITAL; DALLAS EARNSHAW, in his official capacity as Superintendent of Utah State Hospital, Defendants.	

Pursuant to Rule 23(e)(3), Federal Rules of Civil Procedure, Plaintiffs S.B., A.U., S.W., and Disability Law Center ("DLC") (collectively "Plaintiffs") and Defendants State of Utah, the Utah Department of Human Services, Ann Williamson, the Utah Division of Substance Abuse and Mental Health, Douglas Thomas, the Utah State Hospital ("USH"), and Dallas Earnshaw (collectively "Defendants") jointly move the Court for an order: (1) approving the proposed Settlement Agreement and the joint proposals for notice and comment attached to this motion as Exhibits 1, 2, and 3; (2) appointing Patrick K. Fox, M.D., as Monitor under the Settlement Agreement; and (3) staying all proceedings in this action during the five-year term of the proposed Settlement Agreement, with the Court retaining enforcement jurisdiction during that period.

Background

1. On September 8, 2015, Plaintiffs initiated this class action against Defendants for allegedly failing to admit mentally incompetent pretrial detainees to USH's Forensic Unit for competency restoration treatment in a reasonably timely manner. (Docket No. 1).

2. On October 3, 2015, Defendants moved to dismiss the complaint, arguing that it failed to state a plausible claim for relief under the Fourteenth Amendment's Due Process Claim and Article I, section 7 of the Utah Constitution. (Docket No. 37). The Court denied Defendants' motion to dismiss on April 7, 2016. (Docket No. 51).

3. The Court later certified the plaintiff class ("the Class") to include all individuals who are now, or will be in the future, (i) charged with a crime in Utah, (ii) determined by the court in which they are charged to be mentally incompetent to stand trial, and (iii) ordered to the custody of the executive director of DHS or a designee for the purpose of treatment intended to restore the defendant to competency, but who remain housed in a Utah county jail. (Docket No. 71). On November 7, 2016, the United States Court of Appeals for the Tenth Circuit denied Defendants' petition for interlocutory review of the Court's certification of the Class. (Docket No. 75).

4. Since May 2016, the parties have been engaged in settlement discussions aimed at resolving all of the constitutional and remedial issues in this case. In their discussions, the parties have been assisted by two experts in the field, Dr. Patrick Fox of Colorado and Dr. Andrew Phillips of Washington. On June 9, 2017, the parties reached an agreement to resolve all claims, subject to this Court's approval of the terms of settlement.

The Proposed Settlement Agreement and Strategic Plan

5. If approved, the proposed Settlement Agreement will be enforceable in this Court for a period of five years from the date of its approval. *Settlement Agr.* ¶ 30. The Settlement Agreement will establish a maximum allowable wait time – measured from the date on which USH receives the custody order to the date on which the Class member begins restoration

treatment – for all Class members. Under the terms of the proposed Settlement Agreement, Defendants will adopt and implement a series of measures reflected in a Strategic Plan, a copy of which is annexed as Exhibit 1 to the Settlement Agreement, in order to reduce the time during which Class members must wait to receive competency restoration treatment, taking into consideration likely future increases in the number of pretrial detainees requiring treatment. Plaintiffs believe that the proposed Settlement Agreement and Strategic Plan will, if fully implemented, resolve all claims asserted by Plaintiffs, subject to the monitoring of Defendants' compliance for the next five years.

6. The next seven paragraphs highlight the most critical features of the proposed Settlement Agreement and the Strategic Plan.

7. The proposed Settlement Agreement will establish a 72-hour screening deadline for all pretrial detainees who have been determined by a Utah state court to be mentally incompetent to stand trial. *Settlement Agr*. ¶ 19(a). It will also provide specific screening standards for the USH professionals who make treatment decisions so that Class members will be directed to the Utah State Hospital's Forensic Unit or to one of several other defined treatment options, based on uniform diagnostic criteria. *Id*. *See also Strat. Plan* at p. 10.

8. One of the treatment options designated in the proposed Settlement Agreement is treatment in an "Offsite Forensic Facility," one of which USH is now in the process of establishing in space to be leased from the Salt Lake County Metro Jail. *Settlement Agr*. ¶¶ 19(a) and 24. USH will build and operate this new facility with an appropriation of $3 million from the 2017 Utah Legislature. The facility will have capacity to treat 22 or more patients and will be operated by a multidisciplinary team consisting of a psychiatrist and other full-time

professionals. *Strat. Plan* at pp. 6-7, 13-14. "[T]he anticipated staffing and training of the offsite forensic facility will be commensurate with their counterparts at the USH." *Id*. at p. 6. Class members assigned to the facility will be segregated from the general jail population. *Settlement Agr*. ¶ 24(a). Under the Settlement Agreement, "Defendants shall establish and operate one or more Offsite Forensic Facilities with sufficient capacity to meet, in combination with other improvements, the Maximum Allowable Wait Time deadlines in paragraph 21." *Id*. ¶ 24(c).

9. Another treatment option designated in the proposed Settlement Agreement will be in-jail treatment through USH's "Outreach Program." *Settlement Agr*. ¶¶ 19(a) and 25. Under the proposed Settlement Agreement, Class members may be provided treatment under this option only if a qualified USH professional concludes, at the time of screening, that the Class member "is likely to show meaningful progress toward restoration of competency within 30 days, [that the Class member's] symptoms are stabilizing, and [that the Class member is] likely to be referred for re-evaluation and restored to competency within 60 days." *Id*. ¶ 25(a); *see also Strat. Plan* at pp. 12-13. Class members may be disqualified from the Outreach Program based on specific diagnostic criteria and will instead be directed to USH, an Offsite Forensic Facility, or an Alternative Therapeutic Facility. *Id*.

10. DLC has previously raised questions concerning the efficacy of the Outreach Program. For this reason, the program's performance will be watched carefully and re-evaluated by the Monitor (discussed below) at the end of the first year of the term of the proposed Settlement Agreement. If, after one year, the Monitor determines that the Outreach Program has not been effective, it will be terminated as a treatment option unless "the Monitor prescribes

additional steps to improve [its] efficacy and USH complies with and implements those steps." *Id*. ¶ 26.

11. Looking into the future, the Settlement Agreement and the Strategic Plan require the study of additional treatment options to address the needs of female members of the Class, and likely increases in general Class membership over time. *See, e.g., Settlement Agr*. ¶¶ 1 and 24(e).

12. The central requirement of the Settlement Agreement is that the maximum number of days during which Class members must wait to begin treatment must be dramatically reduced in several stages. When this case was filed in September 2015, wait time for Class members, as measured from the date of the custody order to the date on which treatment at USH or elsewhere begins, was about six months. Compl. ¶ 4. Under the proposed Settlement Agreement, the maximum wait time for all Class members will be reduced to 60 days within six months of the Court's approval of the Settlement Agreement, to 30 days within twelve months of approval, and to 14 days within eighteen months of approval. *Settlement Agr*. ¶ 21.

13. Defendants' compliance with these and all other requirements of settlement will be overseen by the Monitor, who will report quarterly to the parties. *Settlement Agr*. ¶ 20. The Monitor will base his reports on detailed monthly compliance reports from Defendants' Designated Representative, together with any additional information brought to his attention. *Id*. ¶¶ 4 and 18.

14. Subject to the Court's approval, the parties have named Patrick K. Fox, M.D. as Monitor. *Settlement Agr*. ¶ 8. Dr. Fox's credentials are summarized in Exhibit 4. Dr. Fox is a trained psychiatrist with extensive experience in competency restoration and correctional

psychiatry in the States of Connecticut and Colorado. He is the Chief Medical Officer of the Colorado Department of Human Services and one of the two professionals selected by the parties to advise them during negotiation of the Settlement Agreement.

15. The Settlement Agreement will provide a mechanism for dispute resolution and enforcement before this Court during its five-year term. *Settlement Agr*. ¶ 28. Thereafter, any party may move for dismissal of this case. *Id.* at ¶ 27. The present motion is brought pursuant to paragraph 27, which requires the parties jointly to move the Court for an order staying this case pending implementation of the Plan and compliance with the Settlement Agreement.

Compliance with Rule 23(a)

16. Rule 23(e) provides that "claims, issues, or defenses of a certified class may be settled, voluntarily dismissed, or compromised only with the court's approval." The Court must "direct notice in a reasonable manner to all class members who would be bound by the proposal" and "[i]f the proposal would bind class members, the court may approve it only after a hearing and on finding that it is fair, reasonable, and adequate." Fed. R. Civ. P. 23(e)(1) and (2). Finally, because settlement of this case requires court approval, class members must be given the opportunity to object to the proposal. *Id.* 23(e)(5).

17. The parties jointly propose that the forms of notice attached to this motion as Exhibits 2 and 3 be used to give Class members notice of the proposed settlement under the following terms:

a. To provide notice of the proposed settlement agreement to existing Class members, the parties will rely on the waiting list for admission to the Utah State Hospital in effect at the time the Court grants the present motion.

b. The parties will send, by first-class U.S. mail, a copy of the proposed "Notice of Proposed Class Action Settlement" attached to this motion as Exhibit 2 as well as a copy of the proposed Settlement Agreement attached to this motion as Exhibit 1 to all class members on the waitlist. The proposed "Notice of Proposed Class Action Settlement" allows class members affected by the proposed Settlement Agreement to make objections to the proposed Settlement Agreement, submit comments concerning the proposed Settlement Agreement, and indicate whether they intend to appear at the final settlement approval hearing. The parties will include a self-addressed stamped envelope for class members to submit written objections or comments to the Disability Law Center.

c. The parties will mail a copy of the proposed "Notice of Proposed Class Action Settlement" attached to this motion as Exhibit 3 and a copy of the proposed Settlement Agreement to counsel of record for each class member. The parties will use Utah Courts' Xchange Case Search to identify counsel of record for each class member at the time the "Notice of Proposed Class Action Settlement" is mailed. The proposed "Notice of Proposed Class Action Settlement" attached to this motion as Exhibit 3 allows defense counsel for class members to make objections to the proposed Settlement Agreement, submit comments concerning the proposed Settlement Agreement, and indicate whether they intend to appear at the final settlement approval hearing. The "Notice of Proposed Class Action Settlement" attached to this motion as Exhibit 3 expressly requests that defense counsel share the Notice and proposed Settlement Agreement with known family

members and any known legal guardian of the class member and to encourage those individuals to submit any objections or comments to the proposed Settlement Agreement.

d. All comments or objections to the proposed Settlement Agreement received by the Disability Law Center will be consolidated and saved in a separate file until the end of the comment period. Copies of the comments will be provided to counsel for Plaintiffs and counsel for Defendants. The original comments and objections regarding the proposed Settlement Agreement will be submitted in a single, hard copy filing with the Clerk of Court for the United States District Court for the District of Utah no later than two weeks before the fairness hearing.

18. After notice has been given, the parties respectfully request the Court to schedule a hearing regarding the fairness, reasonableness, and adequacy of the proposed Settlement Agreement.

Based on the above, the parties request that this Court enter an order: (1) making a preliminary determination to ensure that the proposed Settlement Agreement attached to this motion as Exhibit 1 is fair, reasonable, and adequate; (2) approving the "Notice of Proposed Class Action Settlement" to class members, attached as Exhibit 2 to this motion; (3) approving the "Notice of Proposed Class Action Settlement" to defense counsel for class members, attached as Exhibit 3 to this motion; (4) scheduling a fairness hearing under Federal Rule of Civil Procedure 23(e), and thereafter (5) approving the Settlement Agreement, appointing Dr. Fox as Monitor, and staying all proceedings in this action during the five-year term of the proposed Settlement Agreement.

Dated: June 12, 2017

SNELL & WILMER L.L.P.

/s/ Alan L. Sullivan
Alan L. Sullivan
Bret R. Evans
Attorneys for Plaintiff

DISABILITY LAW CENTER

/s/ Erin B. Sullivan
Aaron M. Kinikini
Erin B. Sullivan
Attorneys for Plaintiff

UTAH ATTORNEY GENERAL

/s/ Laura K. Thompson
Laura K. Thompson
David N. Wolf
Parker Douglas
Assistant Attorneys General for Defendants

Exhibits to Joint Motion for Approval of Settlement Agreement

1. Settlement Agreement (June 9, 2017)

2. Notice of Proposed Class Action Settlement (to Class members)

3. Notice of Proposed Class Action Settlement (to counsel for Class members)

4. Curriculum Vitae of Patrick K. Fox, M.D.

EXHIBIT
1

Return

SETTLEMENT AGREEMENT

This Settlement Agreement is entered into by and between the Disability Law Center (hereinafter "DLC"), an individual identified as S.B., an individual identified as A.U., and an individual identified as S.W. (hereinafter collectively the "Named Plaintiffs"), on the one hand, and the Utah Department of Human Services (hereinafter "DHS"), Ann Williamson in her official capacity as Executive Director of DHS, the Utah Division of Substance Abuse and Mental Health (hereinafter the "Division"), Douglas Thomas in his official capacity as Director of the Division, the Utah State Hospital (hereinafter "USH"), and Dallas Earnshaw in his official capacity as Superintendent of USH (hereinafter collectively "Defendants"). Each of the foregoing parties is sometimes referred to as a "party" and collectively as "the parties."

Recitals

The parties jointly acknowledge the following undisputed facts, which form the background for this Settlement Agreement:

A. DHS has the statutory obligation under Title 77, Chapter 15 of the Utah Code to provide competency evaluations for persons charged with criminal offenses, and to provide Restoration Treatment (as defined below) for persons found incompetent to proceed.

B. On behalf of the class of plaintiffs described below, DLC and the other Named Plaintiffs filed a civil action against the Defendants in the United States District Court for the District of Utah (hereinafter the "Court") Disability Law Center, a Utah nonprofit corporation, et al., vs. State of Utah, et al., Case No. 2:15-CV-00645-RJS-BCW (hereinafter the "Litigation"), to challenge the length of time pretrial detainees in Utah's county jails must wait to receive Restoration Treatment.

C. The purposes of this Settlement Agreement are: (i) for the parties jointly to adopt and implement a strategic plan that will significantly reduce the wait time for Class members (as defined below) to be admitted to Restoration Treatment; (ii) to resolve all claims asserted by the Named Plaintiffs on behalf of the Class in the Litigation; (iii) to provide a mechanism for monitoring Defendants' compliance with this Settlement Agreement and the Plan; and (iv) to provide a mechanism for enforcement of this Settlement Agreement and the Plan.

D. As discussed below, the Named Plaintiffs claim on behalf of the Class that Defendants violate the rights of criminal defendants who have been found incompetent to stand trial under the Fourteenth Amendment to the United States Constitution and Article I, § 7 of the Utah Constitution, by infringing their liberty interests in being free from incarceration absent a criminal conviction. Defendants deny Plaintiffs' claims.

E. DLC is a federally authorized and funded nonprofit corporation established under the Protection and Advocacy for Individuals with Mental Illness Act of 1986, 42 U.S.C. § 10801 *et. seq*. Plaintiffs S. B., A. U., and S. W. were, at the time the complaint in the Litigation was filed, pretrial detainees who had been declared incompetent to stand trial in a criminal proceeding and committed to the custody of the executive director of DHS for the purpose of treatment intended to restore them to competency.

F. DHS is the agency of the State of Utah with responsibility to administer or supervise the administration of competency Restoration Treatment under Utah Code Ann. § 77-15-6(1). The Division is the division of the State of Utah charged with responsibility to ensure the availability of services for people with mental health disorders and substance abuse issues. USH, which operates under the direction of DHS and the Division, is the Utah state psychiatric hospital. Currently, USH is the only state facility providing Restoration Treatment to Class

members, although Restoration Treatment is also provided to Class members through the State's Outreach Program designed to restore competency to individuals housed in Utah county jails.

G. In entering into this Settlement Agreement, Defendants do not admit any wrongdoing or constitutional violation as to any Named Plaintiff or Class member. Defendants do not admit that their conduct, whether actual or alleged, constitutes a legitimate ground for liability against the State or any Defendant.

H. On September 27, 2016, the Court in the Litigation certified the following plaintiff class (the "Class"): all individuals who are now, or will be in the future, (i) charged with a crime in Utah, (ii) determined by the court in which they are charged to be incompetent to stand trial, and (iii) ordered to the custody of the executive director of DHS or a designee for the purpose of treatment intended to restore the defendant to competency, but who remain housed in a Utah county jail. On November 7, 2016, the United States Court of Appeals for the Tenth Circuit denied Defendants' petition for interlocutory review of the Court's certification of the Class.

I. Under Utah Code Ann. § 77-15-3(1), whenever a person charged with a public offense is, or becomes, mentally incompetent to proceed, a petition for inquiry may be filed in the state district court in which the charge is pending for the determination of the person's mental competency. If the court determines that the person is incompetent to stand trial, the court must order him or her committed to the custody of the executive director of DHS or a designee for competency restoration treatment.

J. As the result of limitations on space at USH and limitations on DHS's resources, some Class members have historically waited months after the state court orders restorative competency treatment to be admitted to USH for treatment. During this waiting period, Class

members were incarcerated in county jails, where they received little or no treatment to restore competency from professionals employed by the jail. As a general matter, Utah's county jails are not specifically designed to provide competency restoration treatment, and jail staff do not administer such treatment. Accordingly, since July 2014, the State has administered an Outreach Program designed to restore competency to individuals housed in Utah county jails.

K. With DLC's concurrence, Defendants have formulated and adopted a plan entitled "A Strategic Plan for Providing Utah Adult Mental Health Competency Restoration Services" (June 9, 2017) (the "Plan") to reduce the time during which Class members must wait to receive Restoration Treatment. A copy of the Plan is attached as Exhibit 1. The Plan consists of the following elements:

i. A process for promptly screening and identifying: (a) those Class members who, because of the acuity and nature of their mental illness, should be transferred from jail to the USH Forensic Unit for Restoration Treatment; (b) those Class members whose mental illness is less severe and should be transferred to an Alternative Therapeutic Unit, as defined below, which may be established by USH; (c) those Class members who may likely be restored to competency in a suitable Offsite Forensic Facility, as defined below, operated by USH or under contract with DHS; (d) those Class members who are likely to be restored to competency through the Outreach Program, as defined below, subject to the limits in paragraphs 25(a) and 26, below; (e) those Class members with intellectual or developmental disabilities who should be directed to the Division of Services for People with Disabilities for Restoration Treatment ("DSPD"); (f) those Class members whose mental

condition has stabilized since initial evaluation, with the result that a further evaluation should be made to determine if these Class members are now competent; and (g) those Class members who are unlikely to be restored to mental competence and should be released from DHS custody so that civil commitment, dismissal of charges, or other resolution can occur.

ii. USH's continued operation and further development of the Outreach Program, as defined below, to screen, treat, assess, and monitor Class members.

iii. USH's development of one or more Offsite Forensic Facilities for Restoration Treatment of Class members for whom such programs are likely to be a suitable means to restore competency.

iv. USH's development of one or more Alternative Therapeutic Units for Restoration Treatment of Class members for whom such programs are likely to be a suitable means to restore competency.

v. Measures to assure that all Class members begin receiving the timely provision of appropriate Restoration Treatment after the state court orders treatment for them.

vi. Measures to increase the efficient use of the USH Forensic Unit so as to maximize its existing capacity.

vii. Measures to manage the anticipated growth in the number of people who are likely to become Class members in years to come.

L. The Court has jurisdiction over the Litigation under 42 U.S.C. §§ 1331 and 1343. The parties agree that venue is proper under 28 U.S.C. § 1391(b)(2). The parties will

jointly submit this Settlement Agreement to the Court for approval, and its terms will not be effective until the Court approves it.

NOW, THEREFORE, in consideration of the mutual promises set forth below, the parties agree as follows:

Definitions

Return 1. "**Alternative Therapeutic Unit** " means any treatment unit established and operated by USH or under contract with DHS for Restoration Treatment on or off of the USH Campus for Class members who, in USH's professional judgment, do not require hospitalization level of care, but are not appropriate for an Offsite Forensic Facility or the Outreach Program.

2. The "**Class**" means all individuals who are now or will in the future be:

   a. Charged with a crime in Utah state courts,

   b. Determined by the court in which they are charged to be mentally incompetent to stand trial,

   c. Ordered or committed by the court to the custody of the DHS executive director or a designee for the purpose of treatment intended to restore the individuals to competency, but who remain incarcerated in a county jail in Utah, and

   d. Waiting to begin Restoration Treatment.

3. "**Custody** or **Commitment Order**" means a written order, issued by a court and signed by a judge, which orders a Class member committed to the custody of the executive director of DHS or a designee for the purpose of treatment intended to restore the defendant to competency, as described in Utah Code Ann. § 77-15-6(1).

Return 4. "**Defendants' Designated Representative**" is Dallas Earnshaw, who has been appointed by Defendants to perform the duties set forth in paragraph 18, below.

5. **"Forensic Evaluator"** means a licensed independent mental health professional qualified to conduct court-ordered mental illness evaluations of adults in the criminal justice system, who is familiar with and complies with the requirements of Utah Code Ann. § 77-15-1 et. seq., and who is not involved in the treatment of the Class member.

6. "**Incompetent to proceed**" has the same meaning as set forth in Utah Code Ann. § 77-15-2.

7. "**Maximum Allowable Wait Time**" means the largest number of days that any Class member is permitted to wait under paragraph 21 to be admitted into Restoration Treatment, as measured from the date on which USH received the Custody Order until the date on which the Class member began receiving Restoration Treatment at USH, at an Alternative Therapeutic Unit, at an Offsite Forensic Facility, through the Outreach Program, or from DSPD. For purposes of this Settlement Agreement, the wait times for class members who are already incarcerated when the Plan is implemented, or September 30, 2017, whichever is later, will be tracked, but the wait times associated with those current Class members will not count towards compliance with the deadlines established in paragraph 21, below.

Return 8. The "**Monitor**" is Patrick K. Fox, M.D., who has been appointed by the Court based on the parties' stipulation to perform the duties set forth in paragraphs 20, 26 and 28 below. Defendants and the Monitor shall promptly negotiate and enter into a retention agreement pursuant to which Defendants shall pay the Monitor a reasonable hourly rate and all necessary expenses incurred in performing those duties, with the exception of the duties set forth

in paragraph 28, as the costs associated with Monitor-led mediation shall be shared by the parties equally.

9. The "**Monitoring Period**" means five (5) years from the date on which the Court approves this Settlement Agreement.

10. "**Offsite Forensic Facility**" means a program of Restoration Treatment administered by USH forensic personnel, or by similarly qualified professionals employed by DHS's contractor, at a location other than the USH Campus. Every Offsite Forensic Facility established by Defendants pursuant to this Settlement Agreement must comply with the requirements of paragraph 24 below.

11. "**Outreach Program**" means USH's program of screening, treating, assessing and monitoring Class members while they remain residents in county jails and are not residents in any Offsite Forensic Facility. Outreach Program professionals will screen Class members for the appropriate level of Restoration Treatment; treat Class members whose screening indicates that they are likely to show meaningful progress towards restoration of competency within 30 days, whose symptoms are stabilizing, and who are likely to be referred for re-evaluation and restored to competency within 60 days; assess Outreach Program patients' progress; and monitor Class members who have been restored to competency, wherever they are located, and assist them in remaining competent to stand trial. Subject to the terms of paragraph 26, below, USH may utilize the Outreach Program as an approved method of Restoration Treatment for a period of one year from the date on which the court approves this Settlement Agreement

12. "**Restoration Treatment**" in this Settlement Agreement means competency restoration treatment provided by USH forensic personnel or by similarly qualified professionals

employed by DHS's contractor, to Class members in an effort to restore them to competency, in accordance with Utah Code Ann. § 77-15-6(1), regardless of location or level of need.

13. "**Status Report**" means the written report issued by the Defendants' Designated Representative on a monthly basis during the Monitoring Period, pursuant to paragraph 18, below.

14. "**USH Forensic Unit**" has the same meaning as set forth in Utah Code Ann. § 62A-15-901.

15. "**Waitlist**" means the list of individuals committed to the custody of the executive director of DHS and waiting in jail for Restoration Treatment.

Objectives, Plan Implementation and Measures of Compliance

16. **Timely Restoration Treatment** – Defendants shall take all necessary steps to meet the objective of providing all Class members with timely and appropriate Restoration Treatment. Pursuant to the screening procedures referenced in paragraph 19, below, and without any unnecessary delay, Defendants shall transport or direct transportation consistent with Utah Code Ann. Sect. 77-15 et seq., of Class members to the appropriate program or location for Restoration Treatment.

17. **Implementation of the Plan** – Subject to the Court's approval of this Settlement Agreement, Defendants shall implement the Plan annexed hereto as Exhibit 1 no later than September 30, 2017, and shall take all steps necessary to diligently follow the Plan during the term of this Settlement Agreement.

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18. **Duties of Defendants' Designated Representative** – No later than the tenth day of the month following the end of every month during the Monitoring Period, the Defendants' Designated Representative shall transmit to the Monitor and DLC a Status Report accurately

reporting the status of all Class members then waiting for Restoration Treatment. Each report must include the following information for each Class member:

a. The Class member's name and criminal case number;

b. The name of the court that entered the Class member's Custody Order;

c. The date of the court's Custody Order;

d. The date USH received the Custody Order;

e. The name of the jail where the Class member is being held;

f. The dates on which the Outreach Program screened the Class member and the results of the screenings, including the current disposition of the Class member for Restoration Treatment;

g. The date on which the Class member began receiving Restoration Treatment and the location of the Class member's Restoration Treatment;

h. The date, if any, on which the Class member was terminated from DHS custody for any reason;

i. The reasons for the Class member's termination from DHS custody, including the name and location of the facility or other setting to which the Class member was transferred, if that information is known to DHS; and,

j. The number of days the Class member has spent on the Waitlist.

The report shall also state: (1) the longest wait time as among all Class members then on the Waitlist; (2) whether the Defendants have complied with the requirements of paragraph 21, below, during the month; and, if applicable, (3) the reasons for Defendants' inability to comply with the requirements of paragraph 21.

Defendants' Designated Representative shall, on request, cooperate with the Monitor in gathering any additional information necessary for the Monitor's reports, which are required in paragraph 20, below.

19. **Screening deadlines and disposition of Class members** –

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a. Within seventy-two (72) hours, excluding weekends and holidays, of DHS's receipt of the Custody Order with respect to a Class member, a qualified USH Forensic Unit professional shall screen the Class member using a screening tool approved by, and subject to modification and replacement as determined appropriate by, Defendant's Designated Representative and the Monitor. On the basis of the screening, the USH Forensic Unit professional shall determine whether the Class member: (i) should be transferred from jail to the USH Forensic Unit for Restoration Treatment due to the acuity and nature of the Class member's mental illness; (ii) should be transferred to an Alternative Therapeutic Unit; (iii) should be transferred to an Offsite Forensic Facility for Restoration Treatment; (iv) subject to the limits in paragraph 26, below, should be treated by the Outreach Program based on the standards set forth in subparagraph 25(a), below; (v) should be directed to DSPD for Restoration Treatment because of the Class member's intellectual or developmental disabilities; (vi) should be reevaluated by a Forensic Evaluator to determine if the Class member is now competent; or (vii) should be released from DHS custody because it is unlikely that Restoration Treatment would be effective.

b. As soon as the foregoing determination is made, Defendants shall take all steps necessary to promptly effectuate the appropriate disposition of the Class member.

c. If the qualified USH Forensic Unit professional determines that the Class member should be directed to DSPD for Restoration Treatment because of the Class member's intellectual or developmental disabilities, USH shall make the referral within 72 hours, excluding weekends and holidays, of the screening determination. DSPD shall make a determination about whether it is the agency best suited to provide Restoration Treatment to the Class member within 72 hours, excluding weekends and holidays, of the referral from USH. If DSPD does not accept the referral, USH shall place the Class member back on the Waitlist consistent with the date of the court's Custody Order and comply with the Maximum Allowable Wait Time deadlines in paragraph 21. The time spent towards the Class member's referral and assessment will not count in computing the Maximum Allowable Wait Time.

d. If the qualified USH Forensic Unit professional determines that the Class member should be reevaluated by a Forensic Evaluator to determine if the Class member is now competent, a referral to a Forensic Evaluator shall be made within 72 hours, excluding weekends and holidays, of the determination. If the reevaluation cannot be conducted within 72 hours, excluding weekends and holidays, of the referral, or if the Forensic Evaluator recommends that the Class member is still not competent to

proceed but there is a substantial likelihood that the Class member can be restored to competency in the foreseeable future, USH shall continue administering competency restoration services appropriate for the patient's level of need and shall have complied with the Maximum Allowable Wait Time deadlines in paragraph 21. The time spent towards the Class member's referral and assessment will not count in computing the Maximum Allowable Wait Time.

e. If, at any time, the qualified USH Forensic Unit professional identifies an emergent mental health need, the Defendant's Designated Representative shall expeditiously report the circumstances to DLC and the Monitor, describe any action taken by USH, and keep DLC and the Monitor apprised of any subsequent disposition of the Class member.

Return 20. **Monitor's quarterly reports** – No later than the fifteenth day of the month after the end of each calendar quarter during the Monitoring Period, the Monitor shall report in writing to the Defendants and DLC on Defendants' progress during the preceding quarter in implementing each specific provision of the Plan and in complying with each specific term of this Settlement Agreement.

Return 21. **Deadlines for reduction in Maximum Allowable Wait Time –**

a. By March 31, 2018, Defendants shall reduce the Maximum Allowable Wait Time to sixty (60) days.

b. By September 30, 2018, Defendants shall reduce the Maximum Allowable Wait Time to thirty (30) days.

c. By March 31, 2019, Defendants shall reduce the Maximum Allowable Wait Time to fourteen (14) days.

22. **Modification to the Plan** – If Defendants believe that to achieve compliance with the screening deadlines in paragraph 19 or the Maximum Allowable Wait Time deadlines in paragraph 21, above, they will require a modification of the Plan, the Defendants' Designated Representative shall provide the Monitor and DLC with a detailed written explanation of the necessary modification. If DLC objects to any proposed Plan modification, it will notify Defendants' Designated Representative of the objection in writing within fourteen (14) days of its receipt of the notice of modification. DLC and Defendants' Designated Representative shall thereafter confer in good faith to resolve their differences. If they are unable to resolve their differences in this manner, the parties will submit their differences to the Monitor for possible dispute resolution. If they are unable to resolve their differences in consultation with the Monitor, the Monitor will make a written report and recommendation to the parties. If, after conferring with the Monitor, the parties still disagree as to the proposed modification of the Plan, either party may move the Court for relief, along with the Monitor's report and recommendation. In the absence of DLC's consent, Defendants shall not implement proposed changes to the Plan sooner than sixty (60) days following the issuance of the Defendants' Designated Representative's written notice required in this paragraph.

23. **Suspension of deadlines because of special circumstances –** Defendants' ability to perform their obligations under this Settlement Agreement in a timely manner may depend on special circumstances beyond their control. Subject to the following terms and conditions, the deadline in paragraph 19(a) (hereinafter the "Screening Deadline") and the deadlines in

paragraph 21 (hereinafter the "Maximum Allowable Wait Time Deadlines") may be suspended with respect to one or more Class members:

a. The Screening Deadline or the Maximum Allowable Wait Time Deadlines relating to an individual Class member may be temporarily suspended if Defendants conclude that they cannot meet the relevant deadlines because of factors beyond Defendants' control, including (but not limited to): orders of a court that will delay Defendants' performance; motions filed on behalf of the Class member that will delay Defendants' performance; a jail's failure or refusal to clear the Class member for admission to one of Defendants' facilities; a jail's failure or refusal to allow Outreach Program staff access in order to carry out its responsibilities with respect to a Class member; or medical conditions that prevent a Class member's admission to USH. Circumstances in this category shall be referred to as "Individual Special Circumstances."

b. The Screening Deadline or the Maximum Allowable Wait Time Deadlines relating to a group of Class members may be temporarily suspended if Defendants conclude that they cannot meet the relevant deadline because of factors beyond their control, including (but not limited to) a national or local disaster impacting admissions to one or more of Defendants' facilities, a labor action that substantially impedes the continued operation of a facility, or an extraordinary and unanticipated increase in the number of court-ordered competency restoration referrals. Circumstances in this category shall be referred to as "Departmental Special Circumstances."

The failure or refusal of the Utah Legislature to adequately fund Defendants' operations, programs, or the Plan shall not be considered a Departmental Special Circumstance for purposes of this Settlement Agreement.

c. If, at any time during the term of this Settlement Agreement, Defendants conclude they must suspend either the Screening Deadline or the Maximum Allowable Wait Time Deadlines on account of either an Individual Special Circumstance or a Departmental Special Circumstance, the Defendants' Designated Representative shall immediately give DLC and the Monitor written notice thereof. The notice shall state the nature of the special circumstance (that is, whether an Individual or Departmental Special Circumstance), names of all of Class members who will be affected by the proposed suspension, and all of the facts constituting the special circumstance. The notice shall also state which specific deadlines must be suspended and for what specific period.

d. Any suspension proposed in the notice shall begin on the date on which the notice is received by DLC and the Monitor and shall terminate at the end of the temporary period of suspension, as set forth in the notice, unless modified in accordance with subparagraphs f or g, below.

e. No suspension of any deadline shall last longer than is justified by the special circumstance identified in the notice.

f. If either DLC or the Monitor objects to the suspension, or the scope or duration of the suspension, DLC or the Monitor may notify Defendants'

Designated Representative of the objection in writing, and the parties shall promptly confer with each other in good faith to resolve the issue.

g. If the parties are unable to resolve the issue after the consultation required by subparagraph f above, they will submit the matter to the Monitor for mediation. In the absence of an emergency requiring immediate relief, none of the parties shall be entitled to file a motion in the Litigation to enforce this Settlement Agreement based upon the suspension until the expiration of thirty (30) days from the date on which the party notifies the other parties of the alleged violation based upon the suspension and efforts to resolve the situation, including Monitor-led mediation, have been exhausted. The parties shall equally share the costs of Monitor-led mediation.

Return 24. **Offsite Forensic Facility requirements** – As part of the Plan, Defendants are hereby authorized to develop and implement one or more Offsite Forensic Facilities consistent with the following principles:

Return a. Each Offsite Forensic Facility shall be a treatment program located in space that is suitable for Restoration Treatment. If the space is located in or leased from a county jail, the space and the residents shall be segregated from the jail's general inmate population.

b. Each Offsite Forensic Facility shall be operated by a multi-disciplinary treatment team consisting of full-time forensic professionals, employed by DHS or by a suitable contractor, of a number that is sufficient to provide those Class members transferred to the Offsite Forensic Facility with

Restoration Treatment. A sufficient number of staff members shall remain on-site during operational hours. Each Offsite Forensic Facility shall meet the best practices of professional and clinical standards governing the operation of, and delivery of, Restoration Treatment services at the USH Forensic Unit.

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c. Defendants shall establish and operate one or more Offsite Forensic Facilities with sufficient capacity to meet, in combination with other improvements, the Maximum Allowable Wait Time deadlines in paragraph 21.

d. The initial Offsite Forensic Facility should preferably be located in the Salt Lake County Metro Jail, in space previously inspected and approved by the representatives of the parties. The parties affirmatively represent that they are not presently aware of any deficiencies in the management or operation of the Salt Lake County Metro Jail that would preclude, impede, or otherwise interfere with Defendants' ability to establish and operate an Offsite Forensic Facility at the Salt Lake County Metro Jail, or that would preclude, impede, or otherwise interfere with Class members' ability to receive reasonable and adequate medical and mental health care and services while they are housed in the Offsite Forensic Facility at the Salt Lake County Metro Jail.

Return

e. Defendants will carefully evaluate and, if needed, seek additional funding for a comparable facility for Class members who are women.

Return 25. **Outreach Program duties** – Subject to the limits of paragraph 26, below, Outreach Program professionals shall conduct timely screening of Class members in accordance with paragraph 19 above and shall:

Return a. Treat Class members who, in the professional's judgment, are likely to show meaningful progress towards restoration of competency within 30 days, whose symptoms are stabilizing, and who are likely to be referred for re-evaluation and restored to competency within 60 days. Class members in the Outreach Program shall be re-assessed by Outreach Program professionals every two weeks to determine progress toward competency. Following 30 days of Restoration Treatment in the Outreach Program, Outreach Program professionals will re-assess each Class member to determine if the Outreach Program remains the most clinically appropriate and effective level of care. A Class member will be disqualified from Restoration Treatment in the Outreach Program if he or she exhibits repeated suicidal ideations with intent to harm, engages in repeated acts of self-harm, persistently refuses medications necessary for competency restoration with no rational basis, exhibits a significant decline in clinical stability, or is diagnosed with a moderate to severe intellectual or developmental disability. If the Outreach Program professional determines at screening that a Class member should be disqualified from consideration for Restoration Treatment in the Outreach Program, the Class member must be transferred to USH, an Offsite Forensic Facility, or an Alternative Therapeutic Unit within seventy-two (72) hours, excluding weekends and holidays. Similarly, if the Outreach Program professional determines that the Outreach Program is no longer

clinically appropriate or effective for a Class member, the Class member must be transferred to USH, an Offsite Forensic Facility, or an Alternative Therapeutic Unit within seventy-two (72) hours, excluding weekends and holidays, or referred to DSPD if appropriate;

b. Facilitate the prompt reevaluation of Class members by a Forensic Evaluator, if justified;

c. Monitor former Class members as clinically necessary who have been restored to competency and who await trial, to assist them in maintaining their competency until trial.

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26. **Determination of the Outreach Program's effectiveness** – The Outreach Program may be utilized by USH as an approved alternative method of Restoration Treatment under this Settlement Agreement for a period of one year from September 30, 2017. During this one-year period, the Monitor will gather and analyze information about the Outreach Program's effectiveness in providing Restoration Treatment to Class members, including the number of patients who are restored or are not restored within 60 days, together with any other factors the Monitor deems relevant. By the end of the one-year period, the Monitor will advise the parties either: (a) that the Outreach Program is effective as a method of Restoration Treatment, in which event the Outreach Program will become a permanent treatment option under this Settlement Agreement; or (b) that it is not effective, in which event its use as a treatment option under this Settlement Agreement will be promptly terminated unless the Monitor prescribes additional steps to improve the Outreach Program's efficacy and USH complies with and implements those steps.

Approval by the Court and Enforcement

Return 27. **Court approval and stay of the Litigation –** The parties will jointly move the Court in the Litigation for an order approving this Settlement Agreement and staying all proceedings in the Litigation pending successful implementation of the Plan and compliance with the terms hereof. This Settlement Agreement shall become effective upon the Court's issuance of an order approving it. The parties agree that the Court retains continuing jurisdiction over the Litigation to enforce the terms of this Settlement Agreement for five (5) years from the date on which the Court issues an order approving its terms. Subject to the requirements of paragraph 28 below, any party may move the Court for an order to enforce the Settlement Agreement and/or to lift the stay on the Litigation. Upon the expiration of the term of this Settlement Agreement, any party may move for dismissal with prejudice of all claims in the Litigation. If, at the end of the term, no party moves for dismissal, the Court shall enter an order to show cause why all claims should not be dismissed with prejudice.

Return 28. **Enforcement** – If any party concludes that another party has violated any material provision of this Settlement Agreement, the party will notify the Monitor and other parties, including Defendants' Designated Representative, of the alleged violation in writing. Thereafter the parties will promptly attempt to resolve the alleged violation by conferring with each other in good faith to resolve the issue. If the parties are unable to resolve the alleged violation, they will submit the matter to the Monitor for mediation. In the absence of an emergency requiring immediate relief, none of the parties shall be entitled to file a motion to enforce any provision of this Settlement Agreement until the expiration of thirty (30) days from the date on which the party notifies the other parties in writing of the alleged violation and

efforts to resolve the violation, including Monitor-led mediation, have been exhausted. The parties shall equally share the costs of Monitor-led mediation.

29. **Attorney fees and costs regarding enforcement –** Subject to the limitations contained in paragraph 28, any party that obtains an order of the Court enforcing a provision of this Settlement Agreement shall be entitled to an award of its reasonable attorney fees and costs incurred.

General Provisions

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30. **Term** – The term of this Settlement Agreement shall be five (5) years from the date on which the Court issues an order approving its terms.

31. **Persons bound** – This Settlement Agreement shall be binding on all Defendants and their successors, together with their officers, agents and employees, unless otherwise prohibited by state or federal law.

32. **Integration** – This Settlement Agreement constitutes the entire agreement among the parties on the matters raised herein, and no other statement, promise, or agreement, either written or oral, made by any party or agent of any party, shall be enforceable.

33. **Scope** – This Settlement Agreement is not intended to resolve any actual or potential violation of the rights of pretrial detainees other than those specifically addressed in the Litigation.

34. **Authority of signatories** – The persons signing this Settlement Agreement represent that they have the authority to do so.

35. **Representations and warranties** – Each party to this Settlement Agreement represents, warrants, and agrees as to itself as follows:

a. It has fully and carefully reviewed this Settlement Agreement prior to its execution by an authorized signatory.

b. It has consulted with its attorneys regarding the legal effect and meaning of this Settlement Agreement and all terms and conditions hereof, and that it is fully aware of the contents of this Settlement Agreement and its legal effect.

c. It has had the opportunity to make whatever investigation or inquiry it deems necessary or appropriate in connection with the subject matter of this Settlement Agreement.

d. It has not heretofore assigned or transferred, or purported to assign or transfer, to any person or entity any claims that it might have against the other.

e. It is executing this Settlement Agreement voluntarily and free from any undue influence, coercion, duress, or fraud of any kind.

36. **Waiver** – No waiver of any of the provisions of this Settlement Agreement shall be deemed or constitute a waiver of any other provision, whether or not similar, nor shall any waiver constitute a continuing waiver. No waiver shall be binding unless executed in writing by the party making the waiver.

37. **Counterparts** – This Settlement Agreement may be executed in identical counterparts, each of which for all purposes is deemed an original, and all of which constitute collectively one agreement. The parties intend that faxed signatures and electronically-imaged signatures such as PDF files shall constitute original signatures and are binding on all parties. An executed counterpart signature page delivered by facsimile or by electronic mail shall have

the same binding effect as an original signature page. This Settlement Agreement shall not be binding until all parties have signed and delivered a counterpart of this Settlement Agreement whether by mail, facsimile, or electronic mail.

38. **Modification** – Settlement Agreement may be modified if the parties are in agreement. Any modification to this Settlement Agreement shall be in writing.

39. **Attorney Fees** – Subject to the provisions in paragraph 29, above, each party shall bear his, her or their own attorney fees and costs of court incurred in the matter to the effective date of this Settlement Agreement.

40. **Notices** – Any notice or other communication required or permitted under this Settlement Agreement shall be in writing and shall be deemed to have been duly given when (a) mailed by United States registered or certified mail, return receipt requested, (b) mailed overnight express mail or other nationally recognized overnight or same-day delivery service, (c) sent as PDF attachment to electronic mail, or (d) delivered in person, to the parties at the following addresses:

If the Disability Center, to:

DISABILITY LAW CENTER
205 North 400 West
Salt Lake City, Utah 84103

Attention: Aaron M. Kinikini
Erin B. Sullivan
Email: akinikini@disabilitylawcenter.org
esullivan@disabilitylawcenter.org

With a copy to:

Alan L. Sullivan
Bret R. Evans
SNELL & WILMER L.L.P.
15 West South Temple, Suite 1200 Gateway Tower West
Salt Lake City, Utah 84101

Email: asullivan@swlaw.com
brevans@swlaw.com

If the Department, to:

DEPARTMENT OF HUMAN SERVICES
195 N. 1950 West, 4th Floor
Salt Lake City, Utah 84116

Attention: Ann Williamson
Lana Stohl

Email: annwilliamson@utah.gov
lstohl@utah.gov

If the Division, to:

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH
195 North 1950 West, 2nd Floor
Salt Lake City, Utah 84116

Attention: Douglas Thomas
Email: dothomas@utah.gov

If the State Hospital, to:

UTAH STATE HOSPITAL
1300 Center Street
Prove, Utah 84603

Attention: Dallas Earnshaw
Email: dearnshaw@utah.gov

With a copy to:

OFFICE OF THE UTAH ATTORNEY GENERAL
Parker Douglas (8924)
Laura Thompson (6328)
David Wolf (6688)
160 East 300 South, Sixth Floor
Salt Lake City, Utah 84114-0856

Email: pdouglas@agutah.gov
lathomps@utah.gov

dnwolf@agutah.gov

A party may change the names or address where notice is to be given by providing notice to the other parties of such change in accordance with this paragraph 40.

DATED this 9th day of June, 2017 on behalf of Plaintiffs:

ALAN L. SULLIVAN (3152)
Attorney for Plaintiffs

AARON M. KINIKINI (10225)
Attorney for Disability Law Center

DATED this 9th day of June, 2017 on behalf of Defendants:

LAURA THOMPSON
Utah Assistant Attorney General

ANN S. WILLIAMSON
Executive Director, Utah Department of Human Services

EXHIBIT
1

Return

A Strategic Plan for Providing Utah Adult Mental Health Competency Restoration Services

Revised June 9, 2017

INTRODUCTION

The State of Utah provides competency restoration services to individuals court-ordered to the Department of Human Services (DHS) as Not Competent to Proceed (NCP) under Utah Code Ann. §§. 77-15-1 *et. seq*. This plan outlines the process for how these services are delivered and contains information regarding the clinical programs provided. Utah's system of competency restoration services is based on best practices and successful endeavors in Utah and other states. Utah is addressing the increased demand for forensic services by building capacity and programs that are clinically appropriate and cost effective. A best practice model is in the developmental stages nationally. The traditional inpatient approach is no longer viewed as the sole recommended model of care, as evidenced by the fact that at least 10 states now have some form of competency restoration treatment that is conducted in a jail or adapted setting. Utah's model of care includes outpatient treatment; treatment at an offsite forensic facility; treatment at alternative therapeutic units; and inpatient competency restoration treatment programs. This comprehensive system of care includes vital components for processing court orders, assigning court-ordered evaluations to forensic examiners, screening individuals found NCP for appropriate program placement, treatment plan development, clinical and educational competency restoration services, evaluating clinical progress, tracking outcomes data, and discharge planning. Ongoing communication and collaboration with the courts, correctional facilities, and attorneys is vital to operational efficiency.

COMPETENCY RESTORATION OVERVIEW

Historically, competency restoration services have been provided at the Utah State Hospital's (USH) forensic inpatient unit. Over the past 30 years, the demand for forensic services in Utah and nationwide has experienced exponential growth, creating a strain on existing resources. Some of the circumstances that have contributed to this growth in Utah include an increase in 1) the number of competency petitions filed; 2) the number of people found NCP by the courts and referred to DHS; and 3) the acuity level of patients entering the system. Some states have converted non-forensic inpatient beds into forensic beds to respond to the increased demand. In many states, competency restoration services are being provided in non-inpatient settings allowing provision for a more efficient and appropriate level of care for those individuals not needing an inpatient level of competency restoration services. According to a report by the Washington State Institute for Public Policy (*Standardizing Protocols for Treatment to Restore Competency to Stand Trial: Interventions and Clinically Appropriate Time Periods*, January 2013), there are five treatment modalities in the literature to address the competency restoration needs of those found NCP that include:

(1) Medications;
(2) Treatment for individuals with developmental disabilities;
(3) Educational treatment programs;

(4) Specialized/individual treatment programs; and
(5) Cognitive remediation programs.

The study also describes incompetence as predicated on two components that are typically addressed in treatment: (1) a mental disorder or cognitive impairment and (2) a deficit in one or more competence-related abilities (i.e., understanding, appreciation, reasoning, assisting counsel) that occur as a result of the mental disorder or cognitive impairment. Improvement in the underlying mental disorder or cognitive impairment often results in the improvement in competence-related deficits. This forms the basis for psychotropic medications being one of the primary treatment modalities in competency restoration treatment. In addition, the use of educational approaches to increase the patient's factual understanding of the legal proceedings and to assist in participating with their defense counsel is beneficial.

The Washington State Institute for Public Policy report revealed limited success in competency restoration outcomes for individuals with intellectual and/or developmental disabilities. Most programs that have been studied demonstrate a 33 percent average competency restoration rate for individuals with intellectual disabilities compared to a 70 percent average for those with mental illness. The "Slater Method" is a competency restoration tool that is typically used to treat individuals with intellectual disabilities. Length of time to restoration is longer for people with intellectual disabilities than the time to restoration for people without intellectual disabilities. It has been DHS' experience that most individuals who require specialized services for intellectual disabilities do better when treated under the supervision of state agencies designed to treat the unique needs of this population. Utah identifies these individuals when referred to DHS and makes every effort to direct their competency restoration treatment to the Division of Services for People with Disabilities (DSPD).

Most research demonstrates that individuals who participate in education groups have a significantly higher rate of restoration than those who do not. Many states across the country have implemented education programs that are of varying structure and delivery styles. Yet, the basic components are similar. Programs in the North Coast Behavioral Healthcare System in Ohio; the Alton Mental Health and Development Center in Illinois; the Atascadero Hospital in California; the RISE program in Denver, Colorado; as well as others, include treatment modalities such as: educational groups; experiential modules, such as mock trials; medication management; and cognitive remediation. These best practice principles are incorporated into Utah's restoration program development. Another well recognized program used to inform Utah's model of care is the 'Comp-Kit' restoration program developed and implemented in 2006 by Florida's mental health forensic system.

Even though the literature is limited and does not specifically identify one national best practice model for competency restoration, current programs have similar components and outcomes. The National Judicial College in Reno, Nevada assembled a panel of experts to develop a Mental Competency Best Practice Program. Though the main tenet of their recommended approach is similar as that described above, it is recommended that clinicians assess the individual's need for competency restoration and tailor the program individually rather than placing all individuals into the same curriculum and treatment modalities.

SUMMARY of ESSENTIAL RESTORATION SYSTEM ELEMENTS:

1. Court-ordered competency restoration process
2. Court referral monitoring system
3. Initial treatment screening to determine appropriate level of service delivery
4. Initial mental health evaluation
5. Identification of barriers to competency restoration
6. Development of an individualized treatment plan
7. Engagement of treatment modalities
8. Ongoing progress towards competency assessments
9. Documentation of interventions and response to interventions
10. Re-evaluation of competency
11. Court Referral and reporting process

STRATEGIC ACTION PLAN

In order to ensure the State of Utah has adequate resources available to provide competency restoration services to individuals who have been court-ordered to DHS, it is imperative that a

strategic action plan be developed, implemented, and have ongoing evaluation to assure timely provision of treatment services.

A wider array of stakeholders must be engaged to more fully address the competency restoration needs of the citizens of Utah. Successful implementation of a strategic plan requires co-operation, communication and collaboration with a variety of stakeholders and participants involved in the competency restoration process, including, but not limited to: the district courts; referring county and municipal courts; prosecutors; the defense bar; the counties/Local Mental Health Authorities (LMHAs); local sheriffs' offices and jails; law enforcement; and the Utah Legislature.

Outcomes used to assist in this determination will include service access wait times, restoration rates, and length of time for restoration. Each service delivery option will be evaluated for efficiencies and appropriate patient placements.

Each year, DHS, in collaboration with other state leaders, will review these outcomes and make proposals when increased resources are necessary. Options may include: additional offsite forensic facilities; alternative therapeutic units located on or off the USH campus; additional beds at USH; and addressing timely and appropriate competency restoration treatment for women in a clinically appropriate setting. Counties are encouraged to consider pre-evaluation processes to facilitate access to mental health services for individuals with serious mental illness, prior to, or upon entering the criminal justice system, and redirect individuals from entering the forensic system when community services are more appropriate.

1. Purposes and Implementation of the Strategic Plan

The purposes of this strategic plan are as follows:

(a) Outline the specific steps to be taken to reduce the period of time during which patients committed to DHS must wait to receive competency restoration treatment;

(b) Comply with the timeframes established in the Settlement Agreement approved by the Court in the matter of *Disability Law Center, et. al. v. State of Utah, Department of Human Services, et. al., Case No. 2:15-cv-00645-RJS-BCW.*

(c) Implement a series of indicators that will measure the quality and efficiency of competency restoration treatment for patients committed to DHS for competency restoration treatment; and

(d) Monitor and adjust resource investment and allocation to achieve the purposes of the strategic plan.

The implementation of this strategic plan is to be contemporaneous with the establishment of the first offsite forensic facility proposed at the Salt Lake County Metro Jail, or September 30, 2017, whichever occurs later.

2. Service Delivery Options

Like many other states, Utah has recognized the need for additional cost-effective and clinically appropriate services to meet the demand for forensic services. In 2014, USH, in collaboration with the Division of Substance Abuse and Mental Health (DSAMH) and DHS, recommended four levels of treatment services that are appropriate for competency restoration. This was presented in response to a 2014 legislative audit. They are listed in order from the least to highest associated clinical need:

a) Outreach Program: Providing competency restoration treatment to patients:
   i. on release from the court in the community;
   ii. in jail within their home community; or
   iii. in prison.

b) Offsite Forensic Facility: Providing competency restoration treatment to patients in a specialized, structured competency restoration program within a jail or other secure setting.

c) Alternative Therapeutic Unit: Providing competency restoration treatment in any treatment unit established and operated by USH or under contract with DHS on or off of the USH campus for patients who do not require hospitalization level of care.

d) Inpatient Forensic Beds at USH: There is capacity but not infrastructure for expansion of inpatient hospital beds at the USH campus.

Not all patients referred to DHS for competency restoration treatment require hospital inpatient level of care and its associated interventions. Screening processes are designed to identify persons found NCP who can, within a reasonable timeframe, be restored to competence in the least restrictive, clinically appropriate environment and without requiring admission to an inpatient setting.

There are identifiable advantages to offering outpatient competency restoration services to individuals with lower psychiatric acuity levels including:

a) Decreased incarceration time
b) Decreased transportation costs
c) Improved supports to assist in treatment within their local communities
d) Enhanced access to community mental health treatments
e) Facilitated access into ongoing outpatient treatment support systems
f) Ongoing access to defense counsel, family, and other supports
g) Reduced stigma associated with psychiatric hospitalization.

If a patient is placed in any program or level of service based on screening criteria and later is determined to either be progressing faster or not progressing as expected to meet the required time frames, the patient will be transferred to the more appropriate level of care based on their clinical status.

3. Offsite Forensic Facilities

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(a) DHS is currently planning an offsite forensic facility with day competency restoration treatment in a county jail. This is a five days per week, eight hours per day program to provide competency restoration treatment to patients who need a structured environment, similar to a mental health unit, but do not need the services of an inpatient psychiatric hospital. Patients will be identified according to their acuity, and treatment will be individualized accordingly.

(b) Based on the success of this initial program and in the assessment of future program needs, DHS may request funding for additional offsite forensic facilities (including, but not limited to, a female only offsite forensic facility) to meet the needs of the population. DHS will determine funding and staffing patterns following a review of the current program outcomes and inflationary costs. If DHS determines that there is a greater number of patients needing inpatient care, DHS will request funding for additional beds at USH or another appropriate alternative therapeutic unit. This funding request would be similar to the funding at that time for one USH forensic unit (current cost is approximately $4.5 million dollars). Staffing levels would be similar to a current forensic unit based on this budget information.

(c) In 2017, the first offsite forensic program will be developed in partnership with Salt Lake County due to its Metro Jail's central geographic location and the large number of competency restoration referrals that arise from Salt Lake County. This program has an annual operating budget of approximately $3 million. Funding will be available by July 1, 2017. DHS will begin to develop and coordinate operational procedures, recruitment and implementation of the program as soon as funding is assured through the legislative process. It is intended that actual program implementation will begin no later than September 30, 2017.

In developing contracts for offsite forensic facilities, provisions will be included that address training for the correctional personnel including but not limited to: Crisis Intervention Team (CIT) training and training from the USH Psychiatric Technician training modules. The jail will provide 24-hour emergency psychiatric and emergency medical care of patients when forensic staff are not on site and forensic programming is not being conducted. Subject to the terms of the contract(s) for each offsite forensic facility and available funding, the anticipated staffing and training of the offsite forensic facility will be commensurate with their counterparts at the USH. Patient programming and staffing levels at each offsite forensic facility will be guided by a Program Manual that will soon be developed, subject to modification by the USH Forensic Director, based upon the physical environs of the facility, availability of security staff, and other contract provisions to be determined once each offsite forensic facility is identified.

4. Outreach Program Services

Since 2015, the Utah Legislature has recognized the value of DHS' Outreach Program whereby clinicians provide competency restoration treatment to patients by conducting weekly visits to

those who are: (1) released to the community by the court; (2) housed in their home community jail; or (3) in prison. These services are provided to patients whose screening indicates that they are likely to show meaningful progress towards restoration of competency within 30 days, whose symptoms are stabilizing, and who are likely to be referred for re-evaluation and restored to competency within sixty (60) days.

Some Outreach Program patients will remain in their own county based on the following factors: (a) closeness to family and other supports; (b) desire to stay in the area; (c) upcoming hearing and efficiency in time by not transporting to another area; (d) closeness to legal representation; (e) significant progress with current situation; or (f) gender as the offsite forensic facility programming is male only at this time.

5. **Projecting Future Needs**

(a) USH has projected that the annual number of pretrial detainees in Utah's county jails for which custody or commitment orders will have been issued will continue to increase. If the number of court-ordered pretrial detainees does not increase, USH will continue to monitor trends each year to revise projections.

(b) USH believes that, depending on system changes including the addition of new levels of care and program efficiencies decreasing length of stay in all programs and facilities, it may need additional competency restoration Outreach Program professionals who provide screening, assessment, and treatment services. This will be closely monitored and evaluated based on length of time to access these services and the length of stay in these services in the context of the entire system.

(c) USH believes that, depending on system changes including the addition of new levels of care and program efficiencies decreasing length of stay in all programs and facilities, it may need additional forensic evaluators who are employed to conduct evaluations for the Outreach Program if projections are accurate. This will be closely monitored and evaluated based on length of time to access these services and the length of stay in the Outreach Program in the context of the entire system.

(d) USH will annually evaluate the state's ability to meet the respective service level need and projected number of patients requiring competency restoration treatment, and request additional funding to adequately provide services to all those court-ordered to DHS for purposes of competency restoration treatment. The amount to be requested will be determined by the level of service required to meet the acuity needs of those committed to DHS, taking into consideration the outcomes of each program in meeting the timeframes for competency restoration in the Settlement Agreement and relevant statutes, inflationary costs, and other factors.

6. Expansion of USH Forensic Unit

In addition to the establishment of the offsite forensic facilities referenced in paragraph 3 of this strategic plan, the State projects that, depending on system changes including the addition of new levels of care and program efficiencies decreasing length of stay in all programs and facilities, there may be further need for increased inpatient treatment capacity. The current capacity of the USH forensic unit is 100 patients for all forensic commitments required by law, including NCP, guilty and mentally ill, and not guilty by reason of insanity. The current USH forensic unit was designed to expand by being able to add additional 25-bed units to the existing structure to a capacity of 200 beds. Based on the number of future court referrals and timeframes for competency restoration services, the State may need to request additional funding for the construction or procurement of another facility on or off the USH campus. This will be closely monitored and evaluated based on length of time to access inpatient services and the length of stay in the context of the entire system.

7. Post-Treatment Follow-up

DSAMH/USH will continue to evaluate the most efficient and cost-effective programs and interventions to assist pretrial detainees in maintaining their competency. USH staff will work with counties and provide case management to help monitor and support the patient in their restoration status and facilitate continuity of care.

8. Efficiency Improvements

Outcomes reflect operational efficiencies and clinical effectiveness. Utah's adult mental health competency restoration outcomes will be monitored monthly and evaluated on a quarterly basis at which time changes will be considered to strengthen the results. Adjustments in screening, assessment, treatment, monitoring, program placements, and delivery of services will be made where deficiencies are identified. Outcome indicators are as follows:

1. Length of time from court-ordered referral to treatment program admission;
2. Length of stay in any of USH's competency restoration treatment programs;
3. Percent of court-ordered referrals screened in a timely manner (*i.e.*, within seventy-two (72) hours, excluding weekends and holidays, of DHS's receipt of the district court order for competency restoration treatment);
4. Percent of patients screened into the Outreach Program who are restored or not restored within 60 days; and
5. Percent of patients treated within USH's forensic system who are found competent to proceed.

Targets are identified and adjusted based on best practice standards, baseline measurements and agreements made during system monitoring. Monitoring systems and outcome measures are utilized to ensure individuals within each level of service have been properly placed into programming and changes in status result in reassessment of

the patient. Monitoring also ensures that patients in each level of care are not "lost in the system." LOS and competency status data will receive ongoing utilization reviews to flag those patients who may not be responding appropriately as expected in each level of care. Nationally, outpatient and jail-based programs have shorter LOS than inpatient programs.

Ongoing utilization review means that treating clinicians are reassessing the appropriateness of the current treatment program for the patient with each treatment encounter, and making a determination about program placement or movement at the earliest and most appropriate time.

If at any time it is determined a patient is not progressing in treatment, USH will reassess for the appropriate level of service.

9. Forensic Evaluation System (FES)

When a district court judge orders a competency evaluation, the order should be entered into DHS' Forensic Evaluation System (FES), which is automated to coordinate with state examiners contracted to complete ordered evaluations. Some counties or courts may elect to assign evaluators independent of the FES. Regardless, all orders and evaluations are monitored in the FES. The examiners provide an initial report to the court and parties within 30 days of receipt of the court's order. The examiner may inform the court in writing that additional time is needed to complete the report. The examiner shall have up to an additional 30 days to provide the report if requested in writing. The examiner shall provide the report within 60 days from the receipt of the court's order unless, for good cause shown, the court authorizes an additional period of time to complete the report. If after reviewing the forensic evaluation the judge determines an individual is NCP, the court should send the order for competency restoration to DHS via email into the FES. USH and DSAMH monitor the FES to ensure that all components of the service delivery system are addressed and correspondence with the court and the parties is done in a timely manner under the current statutory scheme. Discovery and other documents and outcome data are also tracked through the FES.

10. Utah Competency Restoration Service Delivery System (See Flow Chart)

The district court should send orders for competency restoration to the USH Legal Service Office, which manages the FES system. Information regarding referrals and evaluations is managed in the FES. All patients ordered to DHS for competency restoration are screened to determine the appropriate level of care needed.

A. Screening Process

Within seventy-two (72) hours, excluding weekends and holidays, of receiving the court order, USH forensic staff shall determine which level of service is appropriate for the patient using a screening tool approved by the USH Forensic Director. The screening process utilizes best practice evaluation tools to determine whether:

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1. A patient is likely to be restored to competency through treatment available by the Outreach Program;
2. A patient is likely to be restored to competency through treatment available at an offsite forensic facility;
3. A patient needs inpatient hospital services at the USH forensic unit;
4. A patient is likely not restorable;
5. A patient requires referral to DSPD services; or
6. A patient has other dispositional needs, such as a nursing home placement.

The Initial Competency Restoration Screening tool to be used in the screening process is attached as Appendix A. The screening process may undergo further development and refinement, to include specific scoring guidelines for patient level of service.

Note: Female patients who have been found not competent to proceed will be referred to either the Outreach Program or USH unless and until another program is identified to meet the needs of females who would otherwise be screened to an offsite forensic facility, including, but not limited to, the establishment of a female only offsite forensic facility program.

B. Screening Criteria

The following represents general criteria used by USH Forensic Unit professionals to determine level of service needed:

a. Patient's attitude towards and consent to take medication;
b. Patient's response to medication treatment;
c. Level of risk (i.e., suicide, self-harm, harm to others, etc.);
d. Physical health/medical concerns;
e. Current progress towards competence; and
f. Patient's willingness to engage in treatment.

If an individual is placed in the Outreach Program, competency restoration treatment begins within 14 days of receiving the court order requiring such treatment, though Outreach Program clinicians strive to begin treatment services within 7 days or less of receiving the court order. Part of that treatment is the engagement of jail personnel to provide medication management services if such services are not already in place for patients in their home community jails. If the patient is screened for treatment in an offsite forensic facility or referred to USH's forensic unit, the patient is transferred into the first open bed within 14 days of receiving the court order requiring such treatment.

C. Treatment Disposition

If a patient is determined to be a candidate for the Outreach Program, an offsite forensic facility, an alternative therapeutic unit, or USH's forensic unit, an individualized treatment plan (ITP) is established.

If, at any time, a USH Forensic Unit professional determines that a patient is likely not restorable, the USH administrator will request a re-evaluation from a forensic evaluator. The forensic evaluator conducts the evaluation and a report is sent to the court for further disposition.

If, at any time, a USH Forensic Unit professional determines that a patient is not likely to restore to competency through the Outreach Program, at an offsite forensic facility, or at an alternative therapeutic unit, then coordination is made with the USH staff for admission to inpatient level of care at USH. The USH Forensic Outreach Competency Progress Assessment tool is attached as Appendix B.

If it is determined that a patient may meet the criteria for an intellectual disability, a referral is made within seventy-two (72) hours, excluding weekends and holidays, to DSPD for competency restoration services. If DSPD does not accept the referral, the patient is screened for USH treatment services and all timeframes apply.

If a patient is determined at any time throughout the screening or treatment process to meet the criteria to be found competent to proceed, the USH administrator will request a re-evaluation from a forensic evaluator. The forensic evaluator conducts the evaluation and a report is sent to the court for further disposition.

D. Treatment Services

The program administrators at each level of service coordinate with the treating staff and other agencies involved in the custody or care of the patient to develop an ITP and identify necessary treatment modalities. Types of competency restoration interventions may include, but are not limited to, individual instruction; individual therapy; group therapy; educational or psychoeducational materials; assignments; recreational therapy; occupational therapy; and medication management. Treatment staff may also coordinate services with jail treatment providers or LMHAs for medication management and other appropriate medical services. The competency curriculum is consistent with criteria in Utah's competency statutes. The following program outline describes the restoration treatment delivery system at each level of service:

1. Referral Screening Process

a. Each individual is screened by a qualified USH Forensic Unit professional within seventy-two (72) hours, excluding weekends and holidays, of receiving a court order for competency restoration.

b. A qualified USH Forensic Unit professional utilizes scoring guidelines from the initial screening tool (Appendix A) to identify the appropriate level of service to which the individual should be referred.

c. A qualified USH Forensic Unit professional will continue to visit with all referrals weekly while the individual is being evaluated for the appropriate program.

Return

2. Outreach Program

a. The Outreach Program is designed for patients who are likely to show meaningful progress towards restoration of competency within 30 days, whose symptoms are stabilizing, and who are likely to be referred for re-evaluation and restored to competency within 60 days.

b. If the Outreach Program clinician determines that the patient is appropriate for treatment through the Outreach Program and the county jail is deemed a sufficient location in which to provide competency restoration services, the Outreach Program clinician will commence treatment in the home community jail after considering the criteria outlined in Section 4 above, "Outreach Program Services."

c. Outreach Program staff will arrange weekly treatment encounters with patients who are on a release to the community by the court.

d. If the patient is female and is appropriate for the Outreach Program, weekly visits will occur in the home community jail.

e. An ITP is established for each Outreach Program patient based on individualized needs and identified barriers to competence.

f. Coordination among Outreach Program staff occurs weekly to evaluate treatment progress, modify the patient's ITP as indicated, and coordinate medication management with local county jails as required in Utah Code Ann. Sect. 17-43-301(5)(a)(i) or pursuant to a contract anticipated to be entered with Salt Lake County for an offsite forensic facility.

g. An Outreach Program clinician visits with the patient for at least 60 minutes weekly to provide competency restoration treatment and psychoeducational material from the Outreach Competency Training Program manual addressing barriers to competence identified in the ITP. The manual is attached as Appendix C.

h. Patients are reassessed minimally every two (2) weeks to determine progress towards competence.

i. Patients will be disqualified from competency restoration treatment in the Outreach Program if he or she exhibits suicidal ideations with intent to harm, engages in repeated acts of self-harm, persistently refuses medications necessary for competency restoration with no rational basis, exhibits a significant decline in clinical stability, or is diagnosed with a moderate to severe intellectual or developmental disability.

j. If an Outreach Program clinician determines that a patient should be disqualified from the Outreach Program, the patient will be transferred to USH's forensic unit, an Offsite Forensic Facility, or

an Alternative Therapeutic Unit within seventy-two (72) hours, excluding weekends and holidays.

k. Patients who are not ready to be referred for reevaluation for restoration status within sixty (60) days will be re-assessed by USH staff for the appropriate level of competency restoration services.

l. If a qualified USH Forensic Unit professional determines that the Outreach Program is no longer clinically appropriate or effective for a patient, the patient must be transferred to USH's forensic unit, an Offsite Forensic Facility, or an Alternative Therapeutic Unit within seventy-two (72) hours, excluding weekends and holidays.

3. Offsite Forensic Facility

Return

a. An offsite forensic facility is a competency restoration program administered by USH forensic personnel, or by similarly qualified professionals employed by DHS's contractor, at a location other than the USH Campus. Expected capacity at an offsite forensic facility is twenty-two (22) to forty (40) beds.

b. A competency restoration program can be established in any secure offsite facility that has the availability of security staff. This is typically a jail or other secure setting. Any site can be considered if it meets the need for a secure, structured environment. If the space is located in or leased from a county jail, the space and the residents must be segregated from the jail's general inmate population.

c. A competency restoration program at an offsite forensic facility is designed for patients that are in need of more comprehensive treatment than those referred to the Outreach Program and are likely to be restored within two to four months. These patients are not considered a risk of immediate harm to self or others, do not have high acuity medical needs, and are demonstrating that they are willing to engage in treatment, including accepting medication management.

d. Patients will be identified by psychiatric acuity for purposes of bunking assignments, safety assessment, and in creating an ITP.

e. Patients receive day treatment services Monday through Friday. Operational hours may vary but be minimally set from 8:00 a.m. to 5:00 p.m. DHS anticipates some programming may occur in the evenings and on weekends.

f. A treatment team assesses and develops an ITP for each patient based on individualized needs and identified barriers to competence.

g. It is anticipated that the treatment team will consist of a psychiatrist, psychologist, social workers, nursing staff, psychiatric technicians, recreation therapist, case worker, and office specialist,

whose training and credentials will be commensurate with their counterparts at the USH.

h. Treatment services may include any of the following: medication management, individual therapy, group therapy, psychoeducation, recreation therapy, occupational therapy and other modalities identified as necessary for the patient's ITP. A schedule of USH programming is attached as Appendix D as an exemplar. Appendix D.

i. Patient programming and staffing levels at each offsite forensic facility will be guided by a Program Manual that will soon be developed, subject to modification by the USH Forensic Director, based upon the physical environs of the facility, availability of security staff, and other contract provisions to be determined once each offsite forensic facility is identified.

j. It is anticipated that a contractual arrangement with a county jail or other appropriate offsite facility will provide the program with security personnel, medical services, food, clothing, medications, and medical and mental health crisis services after hours.

4. USH Inpatient Restoration Services

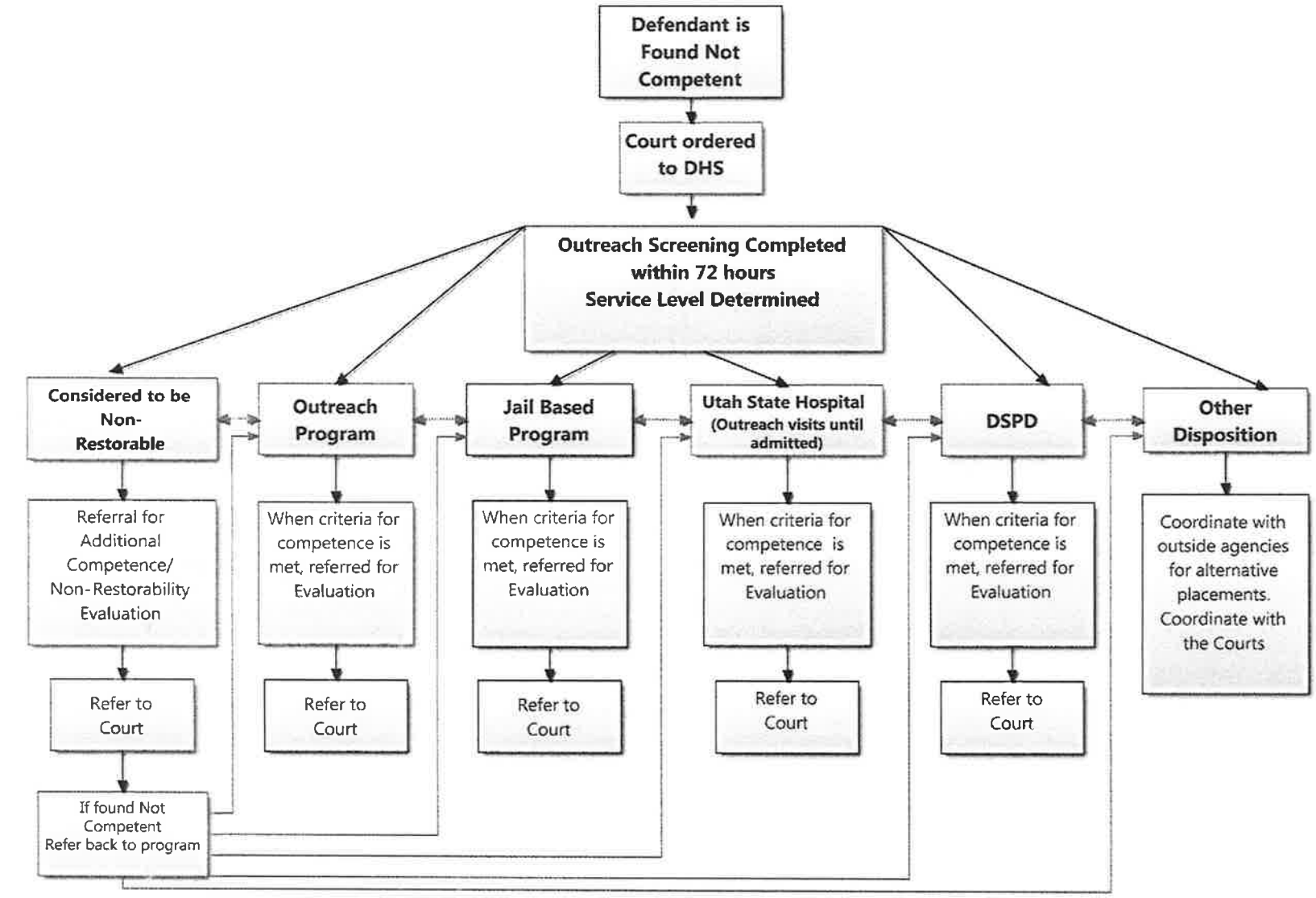
a. Patients who are not found to be appropriate for the Outreach Program or an offsite forensic facility treatment program are referred to USH for inpatient services within seventy-two (72) hours, excluding weekends and holidays.

E. Evaluations

All court-ordered NCP patients will have an initial assessment once they are screened and admitted to one of USH's treatment programs. A report will then be sent to the court pursuant to Utah Code Ann. Sect. 77-15-6. Any time after the patient is found NCP but is showing significant progress towards restoration, a referral can be made for competency re-evaluation by a forensic evaluator. The referral should be made within seventy-two (72) hours, excluding weekends and holidays, of the determination by USH Forensic Unit professionals that the individual has made significant progress towards restoration. Once a referral for follow-up evaluation is made to a forensic evaluator, the evaluation will be completed within fourteen (14) working days. The evaluation report is sent to the court promptly upon completion. The USH Clinical Director or designee certifies all reports recommending the individual be found competent to proceed according to Utah's competency statutes.

F. Collaboration

USH Forensic Unit professionals work in consultation with jail staff, court personnel, families, LMHAs, or others involved in the care, custody or treatment to ensure continuity of care and communication. The USH Legal Services Office and Forensic Director ensure that the courts are kept apprised of the progress and status of all individuals ordered to DHS consistent with Utah's statutory framework.



<--> At anytime a defendant is not progressing within a level of service a referral is made to the appropriate program that meets the needs of the individual

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EXHIBIT
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NOTICE OF PROPOSED CLASS ACTION SETTLEMENT

Disability Law Center, et al. v. State of Utah, et al.
Case No. 2:15-CV-00645-RJS-BCW

You will be affected by the settlement of a class action lawsuit called *Disability Law Center, et al. v. State of Utah, et al.*, Case No. 2:15-CV-00645-RJS-BCW. This notice summarizes the claim in the lawsuit, what the settlement entails, and your rights under the settlement.

The Court has scheduled a hearing to consider the settlement on [DATE] at [TIME] before the Honorable Judge Robert J. Shelby at Courtroom 7.300, United States District Court for the District of Utah, 351 South West Temple, Salt Lake City, Utah 84101. This hearing is referred to as the Final Settlement Approval Hearing.

SUMMARY OF THE LAWSUIT

The issue in this lawsuit is whether the Utah State Hospital (USH) has failed to timely provide court-ordered competency restoration treatment for individuals who have been found incompetent to stand trial.

A Class Member is any individual who is now, or will be in the future, (i) charged with a crime in Utah, (ii) determined by the court in which they are charged to be mentally incompetent to stand trial, and (iii) ordered to the custody of the executive director of the Utah Department of Human Services or a designee for the purpose of treatment intended to restore the defendant to competency, but who remain housed in a Utah county jail.

The lawyers representing class members ("Class Counsel") are Aaron M. Kinikini and Erin B. Sullivan of the Disability Law Center, 205 North, 400 West, Salt Lake City, UT 84103, and Alan L. Sullivan and Bret R. Evans of Snell & Wilmer, LLP, 15 W South Temple #1200, Salt Lake City, UT 84101.

DESCRIPTION OF THE PROPOSED SETTLEMENT AGREEMENT

The Plaintiffs and the State of Utah have reached a settlement that would release the State from any further liability related to this claim. The Settlement Agreement requires USH to do the following, subject to Court approval:

- Within 72 hours of learning that a criminal defendant is found incompetent to stand trial and ordered to the custody of the Utah Department of Human Services, a USH Forensic Unit professional must screen each class member to determine the appropriate level of competency restoration treatment;
- Within 6 months, provide court-ordered to competency restoration treatment to criminal defendants found incompetent to stand trial within 60 days;
- Within 12 months, provide court-ordered to competency restoration treatment to criminal defendants found incompetent to stand trial within 30 days; and
- Within 18 months, provide court-ordered to competency restoration treatment to criminal defendants found incompetent to stand trial within 14 days.

The settlement also creates a system to monitor USH's compliance with the Settlement Agreement and requires the State of Utah to pay fees to the court-approved monitor.

You have the right to learn more about the settlement. A copy of the preliminarily-approved Settlement Agreement is enclosed with this Notice. If you are unable to read or understand the Settlement Agreement, contact Class Counsel referred to in Question 6 below.

OBJECTIONS OR COMMENTS TO THE PROPOSED SETTLEMENT

The United States District Court for the District of Utah has preliminarily approved the Settlement Agreement but will hold a Final Settlement Approval Hearing to determine whether it is fair, reasonable, and adequate on [DATE] at [TIME] in Courtroom 7.300 of the federal courthouse located at 351 South West Temple, Salt Lake City, Utah 84101.

Class Members have a right to object to the terms of the settlement. If you have objections, comments, or statements about the proposed Settlement Agreement, you must make them in writing using the attached "Response to Proposed Class Action Settlement" form or your own paper. A self-addressed stamped envelope is included for your convenience. Written objections, comments, and statements should be sent to the following address: **Disability Law Center, 205 N 400 W, Salt Lake City, UT 84013**. Objections must be submitted or postmarked no later than [DATE].

Objections **must** include all of the following information:

(1) The objector's contact information (name, address, offender number);
(2) An explanation of the basis for the objector's objection to the Settlement Agreement; and
(3) Whether the objector intends to appear at the Final Settlement Approval Hearing on [DATE].

All information submitted to Class Counsel will be provided to counsel for the State of Utah and the District Court in advance of the Final Settlement Approval Hearing. It is not necessary for Class Members to appear at the Final Settlement Approval Hearing. Any Class Member who has submitted a timely objection as provided above and who wishes to appear at the Final Settlement Approval Hearing must give notice by calling the Disability Law Center, sending notice in writing, or using the attached "Response to Proposed Class Action Settlement" form. Objectors may withdraw their objections at any time. **Any objections, comments, or statements that do not comply with the above procedures and timeline will not be heard or considered by the Court.**

HOW TO GET MORE INFORMATION

This is a summary of the Settlement Agreement. If you have any questions about the matters contained in this notice or any questions regarding the settlement, you may write or call Class Counsel below:

DISABILITY LAW CENTER
205 North 400 West
Salt Lake City, UT 84103
(801) 363-1347
Toll Free: (800) 662-9080

RESPONSE TO PROPOSED CLASS ACTION SETTLEMENT

***DLC, et al. v. State of Utah, et al.*, Case No. 2:15-CV-00645-RJS-BCW**

Full Name: _____

Address: _____

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_____

Criminal Case No.: _____

Criminal Attorney: _____

Objections/Comments/Statements:

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Do you want to provide oral testimony to the Court regarding the settlement? Yes __ No __

Date: _____ Signature: _____

EXHIBIT
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Return

NOTICE OF PROPOSED CLASS ACTION SETTLEMENT

Disability Law Center, et al. v. State of Utah, et al.
Case No. 2:15-CV-00645-RJS-BCW

One or more of your clients will be affected by the settlement of a class action lawsuit called *Disability Law Center, et al. v. State of Utah, et al.*, Case No. 2:15-CV-00645-RJS-BCW. This notice summarizes the claim in the lawsuit, what the settlement entails, and your client's rights under the settlement. **Please share this notice and the proposed Settlement Agreement with your client's family members and any known legal guardian of your client, and encourage them to submit any objections, comments, and or statements that they may have regarding the proposed Settlement Agreement**.

The Court has scheduled a hearing to consider the settlement on [DATE] at [TIME] before the Honorable Judge Robert J. Shelby at Courtroom 7.300, United States District Court for the District of Utah, 351 South West Temple, Salt Lake City, Utah 84101. This hearing is referred to as the Final Settlement Approval Hearing.

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All information submitted to Class Counsel will be provided to counsel for the State of Utah and the District Court in advance of the Final Settlement Approval Hearing. It is not necessary for Class Members to appear at the Final Settlement Approval Hearing. Any Class Member who has submitted a timely objection as provided above and who wishes to appear at the Final Settlement Approval Hearing must give notice by calling the Disability Law Center, sending notice in writing, or using the attached "Response to Proposed Class Action Settlement" form. Objectors may withdraw their objections at any time. **Any objections, comments, or statements that do not comply with the above procedures and timeline will not be heard or considered by the Court.**

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205 North 400 West
Salt Lake City, UT 84103
(801) 363-1347

Toll Free: (800) 662-9080

RESPONSE TO PROPOSED CLASS ACTION SETTLEMENT

***DLC, et al. v. State of Utah, et al.*, Case No. 2:15-CV-00645-RJS-BCW**

Your Name: _____

Class Member's Name: _____

Criminal Case No.: _____

Relationship to Class Member: _____

Are you the Class Member's Legal Guardian? Yes ___ No ___

Your Mailing Address: _____

Your E-mail Address: _____

Your Telephone No.: _____

Objections/Comments/Statements:

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Do you want to provide oral testimony to the Court regarding the settlement? Yes __ No __

Date: _____ Signature: _____

EXHIBIT
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Return

CURRICULUM VITAE
Academic Year 2015-2016

NAME: Patrick K. Fox, M.D.

EDUCATION:

B.S., Rutgers University, New Brunswick, NJ 1990
M.D., UMDNJ-New Jersey School of Medicine, Newark, NJ 1994

CAREER:

September 2014-Present:
Colorado Department of Human Services
Chief Medical Officer

April 2013-Present:
Colorado Department of Human Services
Deputy Director of Clinical Services, Office of Behavioral Health

October 2013-July 2014 and December 2014-June 2015:
Colorado Department of Human Services
Acting Director, Office of Behavioral Health

April 1, 2012-March 31, 2013:
Denver Health and Hospital Authority
Attending Psychiatrist, Van Cise Simonet Detention Facility

July 1, 2007-March 31, 2012:
Yale University School of Medicine, Department of Psychiatry
Deputy Training Director, Forensic Psychiatry Fellowship

Director, Whiting Forensic Division, Connecticut Valley Hospital

July 1, 1999-June 30, 2007:
Yale University School of Medicine, Department of Psychiatry
Consulting Forensic Psychiatrist, DMHAS, state of Connecticut

July 1, 1997-March 31, 2012:
VA Connecticut Healthcare System
Employed as an Attending Psychiatrist on Duty, providing psychiatric care within the hospital, approximately fifteen hours per week.

June 1994-June 1999:
Yale University School of Medicine, Department of Psychiatry Post-Doctoral
-PGY V, Residency in Forensic Psychiatry, Law and Psychiatry Division, CMHC
-PGYIV, Chief Resident of PTSD/Anxiety Disorders Unit, West Haven VAMC
Psychiatrist for the New Haven Office of Court Evaluations
-PGYIII, West Haven Veterans Affairs Mental Hygiene Clinic
-PGY II, Inpatient Adult and Child Psychiatry Rotations
-PGY I, Transitional Medicine/Psychiatry/Neurology Program

ACADEMIC APPOINTMENTS:

Yale University School of Medicine, Department of Psychiatry
July 1, 1999-June 2008: Assistant Clinical Professor
July 1, 2008-April 2012: Assistant Professor

University of Colorado School of Medicine, Department of Psychiatry
April 1, 2012-Present: Senior Instructor

University of Denver, Graduate School of Professional Psychology
December 2012-Present: Adjunct Faculty

BOARD CERTIFICATION:

American Board of Psychiatry and Neurology, General Psychiatry: 1999, 2009
American Board of Psychiatry and Neurology, Forensic Psychiatry: 2001, 2011

PROFESSIONAL HONORS & RECOGNITION:

Recipient of the Laughlin Fellowship Award in Psychiatry-1998
Rutgers University Cooperative Academic Merit Scholarship-1990

DEPARTMENTAL, UNIVERSITY ACTIVITIES:

1999-2012: Weekly Supervisor for fellow/s, Fellowship in Forensic Psychiatry

1999-2012: Instructor, *Law & Psychiatry Seminar*, Fellowship in Forensic Psychiatry

1999-2012: Instructor, *Seminar in Law and Psychiatry*, Fellowship in Forensic Psychiatry

2000-2012: Coordinator/Instructor, *Public Sector Lecture Series*, Yale Forensic Psychiatry Fellowship

2000-2012: Member, Yale Department of Psychiatry Resident Selection Committee

2003-2007: Case write-up and interview tutor, Yale School of Medicine, Clerkship in Psychiatry

2004-2012: Instructor, *PGY II Seminar, Legal Regulation of Psychiatric Practice and Forensic Psychiatry*

2006-2012: Coordinator/Instructor, *Ethics in Research Module*, Scholarship Seminar, Fellowship in Forensic Psychiatry

2007-2012: Deputy Training Director, Fellowship in Forensic Psychiatry

2007-2012: Member, Yale University Graduate Medical Education, Program Director Committee

2008-2010: Coordinator, *Ethics in Research Seminar* for Yale Fellows in Public Sector Psychiatry and Research

2007-2012: Instructor, *Landmark Cases*, Fellowship in Forensic Psychiatry

2007-2012: Clinical Instructor, Yale Medical School Psychiatry ER Clerkship, West Haven VA

PROFESSIONAL SERVICE:

Professional Organizations

Member, American Psychiatric Association, 2008-present
Member, American Academy of Psychiatry and the Law, 2008-present
Member, Connecticut Psychiatric Society, 2008-2012
-Council Member, 2010-2012
Member, Colorado Psychiatric Society, 2012-present
Forensic Psychiatry Examination Committee, American Board of Psychiatry and Neurology, 2009-present

State of Colorado Committees

May 2013-July 2015: National Governors' Association, Prescription Drug Abuse Reduction Policy Academy

July 2013-October 2013: Co-chair, Civil Commitment Statute Review Task Force

August 2013-June 2015: National Governors' Association, Super-utilizer Policy Academy

January 2014-present: Governor's Marijuana Policy Workgroup

January 2015-present: Commissioner, Suicide Prevention Commission-Colorado

May 2016-present: Appointee, Mental Health/Point of Contact through Release from Jail Task Force, Commission on Criminal and Juvenile Justice

State of Connecticut Committees

1998-1999: Participant, Committee to Study Sexually Violent Persons, State of Connecticut Office of Policy and Management

1999-2000: Member, DMHAS Restraint/Seclusion Task Force, *Best Practices Report and Recommendations: Working Toward the Elimination of Restraint & Seclusion*.

1999-2000: DMHAS representative, Committee to Study Credentialing of Sexual Offender Treatment Providers, State of Connecticut Office of Policy and Management.

2000: Member, Committee for Psychosexual Evaluation and Treatment, DMHAS-state of Connecticut.

2000-2001: DMHAS representative, Sex Offender Policy and Advisory Committee, state of Connecticut, Office of Policy and Management.

2001: DMHAS representative, Special Populations Project: Model Development.

2002: DMHAS-Division of Forensic Services representative, Preferred Practices Committee: Providing Services to those with Problem Sexual Behaviors.

2002: DMHAS representative, Preferred Practices in Behavioral Health Workgroup.

2002: DMHAS, Commissioner's Policy Work Group*: Limits to Confidentiality*.

2002-2003: DMHAS representative, Sex Offender Policy and Advisory Committee, state of Connecticut, Office of Policy and Management.

2006-2012: Governor's Appointee: Sex Offender Risk Assessment Board, state of Connecticut Judiciary Committee.

2007-2012: Member, DMHAS, Forensic Steering Committee.

2007-2012: DMHAS Commissioner's Appointee, *Lawyers Concerned for Lawyers-Connecticut, Inc.*

PRESENTATIONS:

October 1999*: Jail Diversion, Balancing of the Court's Interests*, American Academy of Psychiatry and the Law, Annual Convention, Madelon Baranoski, Ph.D., Patrick K. Fox, M.D., Josephine Buchanan, Baltimore, MD

October 2000*: Outpatient Civil Commitment*, American Academy of Psychiatry and the Law, Annual Convention, Patrick K. Fox, M.D., Paul Amble, M.D., Vancouver, BC.

August 2001: DMHAS-Connecticut, Forensic Grand Rounds, *Substance Abuse Relapse Prevention for Insanity Acquittees, Recent Research Findings*, presented at Connecticut Valley Hospital.

January 2002: University of Connecticut, School of Medicine/Correctional Mental Health Conference, *Sex Offenders: Risk Assessment, Management & the Possibilities for Treatment*, presented at UCHC, December 2001 and at Cheshire Correctional Center.

June 2002: Veterans Administration-Connecticut Healthcare System, Forensic Committee Conference, *Violence Risk Assessment*, and *Violence Risk Management*, presented at the West Haven Veterans Administration Hospital.

April 2004*: Competency to be Executed*, Yale Medical Student Psychiatric Association.

October 2004*: Melissa's Project: Probate Court-Monitored Treatment*, American Academy of Psychiatry and the Law, Annual Convention, Patrick K. Fox, M.D., Paul Amble, M.D., Michael Makniak, J.D., Scottsdale, AZ.

March 2007: DMHAS Training Seminar-Sex Offender Training, *A Clinical Perspective on Problem Psychosexual Behaviors*, presented at Connecticut Mental Health Center.

Dec. 2008: *Problem Sexual Behavior*, Connecticut Valley Hospital Grand Rounds

January 2008*: Physiological Response to Situations of Uncontrollable Stress*, Connecticut Valley Hospital Trauma Initiative Series.

October 2009: *Civil Rights and the Insanity Defense*, Yale Medical Student Psychiatric Association.

April 2010: *Festschrift for Howard Zonana: Attorney-Physician Collaboration*, Yale Department of Psychiatry Grand Rounds

July 2010: *Psychopathy and Sociopathy*, Yale Department of Psychiatry Grand Rounds

October 2010*: You Got Personality: Diagnostic Challenges in Forensics*, American Academy of Psychiatry and the Law, Annual Convention, Howard Zonana, MD, Madelon Baranoski, PhD., Patrick K. Fox, M.D., Josephine Buchanan, Tucson, AZ.

Feb. 2011*:* Invited lecturer, *Police Intervention with Persons with Mental Illness*, Henry C. Lee Institute of Forensic Science, University of New Haven.

March 2011*:* Invited lecturer, *Police Intervention with Persons with Mental Illness*, Henry C. Lee Institute of Forensic Science, University of New Haven.

April 2011*:* Invited lecturer, *Psychopathy*, Eastern Connecticut State University.

July 2011: *Physician-Assisted Suicide*, Yale Department of Psychiatry Grand Rounds

October 2011: *Thinking Outside the Witness Box: Novel Forensic Psychiatry Training Strategies*, American Academy of Psychiatry and the Law, Annual Convention, Brian Cooke, M.D., Reena Kapoor, M.D., Patrick Fox, M.D., Boston, MA

October 2011: *Restraint and Seclusion Reduction: Implications and Outcomes*, American Academy of Psychiatry and the Law, Annual Convention, Patrick Fox, M.D., Traci Cipriano, Ph.D., J.D., Paul D. Whitehead, M.D., Charles Dike, M.D., Boston, MA

Feb. 2012: *Mental Health Policy in the United States*, distinguished presenter to delegates from Fudan University, Shanghai Province, China, as part of the Yale Global Health Initiative

January 2013: *Inside the Mind of the Mass Murderer*, the Vail Symposium.

January 2014: *Assessment and Management of Problem Sexual Behaviors*, Colorado Mental Health Institute at Pueblo Grand Rounds

Feb. 2014: *Trans-institutionalization: Treatment of Persons with a Behavioral Health Disorder within the Criminal Justice System*, A Workshop of the Forum

on Global Violence Prevention. Institute of Medicine of the National Academies.

April 2015: *The Times, They are a Changin': State and National Developments and Trends in Behavioral Health Care Delivery*, Colorado Psychiatric Society Annual Meeting, Denver, Colorado

July 2015: *Science and Conscience: The Role of Mental Health Evaluators in Death Penalty Cases*, XXXIVth International Congress on Law and Mental Health, Sigmund Freud University, Vienna, Austria

Sept. 2016: *Managing a Limited Resource: Trends in Competency to Stand Trial Evaluations in Colorado*, Colorado State Judicial Conference, Vail, CO.

Dec. 2016: *Mental Health Evaluators and the Death Penalty*, American Bar Association National Summit on Severe Mental Illness and the Death Penalty, Georgetown University.

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EXHIBIT
1

SETTLEMENT AGREEMENT

This Settlement Agreement is entered into by and between the Disability Law Center (hereinafter "DLC"), an individual identified as S.B., an individual identified as A.U., and an individual identified as S.W. (hereinafter collectively the "Named Plaintiffs"), on the one hand, and the Utah Department of Human Services (hereinafter "DHS"), Ann Williamson in her official capacity as Executive Director of DHS, the Utah Division of Substance Abuse and Mental Health (hereinafter the "Division"), Douglas Thomas in his official capacity as Director of the Division, the Utah State Hospital (hereinafter "USH"), and Dallas Earnshaw in his official capacity as Superintendent of USH (hereinafter collectively "Defendants"). Each of the foregoing parties is sometimes referred to as a "party" and collectively as "the parties."

Recitals

The parties jointly acknowledge the following undisputed facts, which form the background for this Settlement Agreement:

A. DHS has the statutory obligation under Title 77, Chapter 15 of the Utah Code to provide competency evaluations for persons charged with criminal offenses, and to provide Restoration Treatment (as defined below) for persons found incompetent to proceed.

B. On behalf of the class of plaintiffs described below, DLC and the other Named Plaintiffs filed a civil action against the Defendants in the United States District Court for the District of Utah (hereinafter the "Court") Disability Law Center, a Utah nonprofit corporation, et al., vs. State of Utah, et al., Case No. 2:15-CV-00645-RJS-BCW (hereinafter the "Litigation"), to challenge the length of time pretrial detainees in Utah's county jails must wait to receive Restoration Treatment.

C. The purposes of this Settlement Agreement are: (i) for the parties jointly to adopt and implement a strategic plan that will significantly reduce the wait time for Class members (as defined below) to be admitted to Restoration Treatment; (ii) to resolve all claims asserted by the Named Plaintiffs on behalf of the Class in the Litigation; (iii) to provide a mechanism for monitoring Defendants' compliance with this Settlement Agreement and the Plan; and (iv) to provide a mechanism for enforcement of this Settlement Agreement and the Plan.

D. As discussed below, the Named Plaintiffs claim on behalf of the Class that Defendants violate the rights of criminal defendants who have been found incompetent to stand trial under the Fourteenth Amendment to the United States Constitution and Article I, § 7 of the Utah Constitution, by infringing their liberty interests in being free from incarceration absent a criminal conviction. Defendants deny Plaintiffs' claims.

E. DLC is a federally authorized and funded nonprofit corporation established under the Protection and Advocacy for Individuals with Mental Illness Act of 1986, 42 U.S.C. § 10801 *et. seq*. Plaintiffs S. B., A. U., and S. W. were, at the time the complaint in the Litigation was filed, pretrial detainees who had been declared incompetent to stand trial in a criminal proceeding and committed to the custody of the executive director of DHS for the purpose of treatment intended to restore them to competency.

F. DHS is the agency of the State of Utah with responsibility to administer or supervise the administration of competency Restoration Treatment under Utah Code Ann. § 77-15-6(1). The Division is the division of the State of Utah charged with responsibility to ensure the availability of services for people with mental health disorders and substance abuse issues. USH, which operates under the direction of DHS and the Division, is the Utah state psychiatric hospital. Currently, USH is the only state facility providing Restoration Treatment to Class

members, although Restoration Treatment is also provided to Class members through the State's Outreach Program designed to restore competency to individuals housed in Utah county jails.

G. In entering into this Settlement Agreement, Defendants do not admit any wrongdoing or constitutional violation as to any Named Plaintiff or Class member. Defendants do not admit that their conduct, whether actual or alleged, constitutes a legitimate ground for liability against the State or any Defendant.

H. On September 27, 2016, the Court in the Litigation certified the following plaintiff class (the "Class"): all individuals who are now, or will be in the future, (i) charged with a crime in Utah, (ii) determined by the court in which they are charged to be incompetent to stand trial, and (iii) ordered to the custody of the executive director of DHS or a designee for the purpose of treatment intended to restore the defendant to competency, but who remain housed in a Utah county jail. On November 7, 2016, the United States Court of Appeals for the Tenth Circuit denied Defendants' petition for interlocutory review of the Court's certification of the Class.

I. Under Utah Code Ann. § 77-15-3(1), whenever a person charged with a public offense is, or becomes, mentally incompetent to proceed, a petition for inquiry may be filed in the state district court in which the charge is pending for the determination of the person's mental competency. If the court determines that the person is incompetent to stand trial, the court must order him or her committed to the custody of the executive director of DHS or a designee for competency restoration treatment.

J. As the result of limitations on space at USH and limitations on DHS's resources, some Class members have historically waited months after the state court orders restorative competency treatment to be admitted to USH for treatment. During this waiting period, Class

members were incarcerated in county jails, where they received little or no treatment to restore competency from professionals employed by the jail. As a general matter, Utah's county jails are not specifically designed to provide competency restoration treatment, and jail staff do not administer such treatment. Accordingly, since July 2014, the State has administered an Outreach Program designed to restore competency to individuals housed in Utah county jails.

K. With DLC's concurrence, Defendants have formulated and adopted a plan entitled "A Strategic Plan for Providing Utah Adult Mental Health Competency Restoration Services" (June 9, 2017) (the "Plan") to reduce the time during which Class members must wait to receive Restoration Treatment. A copy of the Plan is attached as Exhibit 1. The Plan consists of the following elements:

i. A process for promptly screening and identifying: (a) those Class members who, because of the acuity and nature of their mental illness, should be transferred from jail to the USH Forensic Unit for Restoration Treatment; (b) those Class members whose mental illness is less severe and should be transferred to an Alternative Therapeutic Unit, as defined below, which may be established by USH; (c) those Class members who may likely be restored to competency in a suitable Offsite Forensic Facility, as defined below, operated by USH or under contract with DHS; (d) those Class members who are likely to be restored to competency through the Outreach Program, as defined below, subject to the limits in paragraphs 25(a) and 26, below; (e) those Class members with intellectual or developmental disabilities who should be directed to the Division of Services for People with Disabilities for Restoration Treatment ("DSPD"); (f) those Class members whose mental

condition has stabilized since initial evaluation, with the result that a further evaluation should be made to determine if these Class members are now competent; and (g) those Class members who are unlikely to be restored to mental competence and should be released from DHS custody so that civil commitment, dismissal of charges, or other resolution can occur.

ii. USH's continued operation and further development of the Outreach Program, as defined below, to screen, treat, assess, and monitor Class members.

iii. USH's development of one or more Offsite Forensic Facilities for Restoration Treatment of Class members for whom such programs are likely to be a suitable means to restore competency.

iv. USH's development of one or more Alternative Therapeutic Units for Restoration Treatment of Class members for whom such programs are likely to be a suitable means to restore competency.

v. Measures to assure that all Class members begin receiving the timely provision of appropriate Restoration Treatment after the state court orders treatment for them.

vi. Measures to increase the efficient use of the USH Forensic Unit so as to maximize its existing capacity.

vii. Measures to manage the anticipated growth in the number of people who are likely to become Class members in years to come.

L. The Court has jurisdiction over the Litigation under 42 U.S.C. §§ 1331 and 1343. The parties agree that venue is proper under 28 U.S.C. § 1391(b)(2). The parties will

jointly submit this Settlement Agreement to the Court for approval, and its terms will not be effective until the Court approves it.

NOW, THEREFORE, in consideration of the mutual promises set forth below, the parties agree as follows:

Definitions

1. "**Alternative Therapeutic Unit** " means any treatment unit established and operated by USH or under contract with DHS for Restoration Treatment on or off of the USH Campus for Class members who, in USH's professional judgment, do not require hospitalization level of care, but are not appropriate for an Offsite Forensic Facility or the Outreach Program.

2. The "**Class**" means all individuals who are now or will in the future be:

   a. Charged with a crime in Utah state courts,

   b. Determined by the court in which they are charged to be mentally incompetent to stand trial,

   c. Ordered or committed by the court to the custody of the DHS executive director or a designee for the purpose of treatment intended to restore the individuals to competency, but who remain incarcerated in a county jail in Utah, and

   d. Waiting to begin Restoration Treatment.

3. "**Custody** or **Commitment Order**" means a written order, issued by a court and signed by a judge, which orders a Class member committed to the custody of the executive director of DHS or a designee for the purpose of treatment intended to restore the defendant to competency, as described in Utah Code Ann. § 77-15-6(1).

4. "**Defendants' Designated Representative**" is Dallas Earnshaw, who has been appointed by Defendants to perform the duties set forth in paragraph 18, below.

5. **"Forensic Evaluator"** means a licensed independent mental health professional qualified to conduct court-ordered mental illness evaluations of adults in the criminal justice system, who is familiar with and complies with the requirements of Utah Code Ann. § 77-15-1 et. seq., and who is not involved in the treatment of the Class member.

6. "**Incompetent to proceed**" has the same meaning as set forth in Utah Code Ann. § 77-15-2.

7. "**Maximum Allowable Wait Time**" means the largest number of days that any Class member is permitted to wait under paragraph 21 to be admitted into Restoration Treatment, as measured from the date on which USH received the Custody Order until the date on which the Class member began receiving Restoration Treatment at USH, at an Alternative Therapeutic Unit, at an Offsite Forensic Facility, through the Outreach Program, or from DSPD. For purposes of this Settlement Agreement, the wait times for class members who are already incarcerated when the Plan is implemented, or September 30, 2017, whichever is later, will be tracked, but the wait times associated with those current Class members will not count towards compliance with the deadlines established in paragraph 21, below.

8. The "**Monitor**" is Patrick K. Fox, M.D., who has been appointed by the Court based on the parties' stipulation to perform the duties set forth in paragraphs 20, 26 and 28 below. Defendants and the Monitor shall promptly negotiate and enter into a retention agreement pursuant to which Defendants shall pay the Monitor a reasonable hourly rate and all necessary expenses incurred in performing those duties, with the exception of the duties set forth

in paragraph 28, as the costs associated with Monitor-led mediation shall be shared by the parties equally.

9. The "**Monitoring Period**" means five (5) years from the date on which the Court approves this Settlement Agreement.

10. "**Offsite Forensic Facility**" means a program of Restoration Treatment administered by USH forensic personnel, or by similarly qualified professionals employed by DHS's contractor, at a location other than the USH Campus. Every Offsite Forensic Facility established by Defendants pursuant to this Settlement Agreement must comply with the requirements of paragraph 24 below.

11. "**Outreach Program**" means USH's program of screening, treating, assessing and monitoring Class members while they remain residents in county jails and are not residents in any Offsite Forensic Facility. Outreach Program professionals will screen Class members for the appropriate level of Restoration Treatment; treat Class members whose screening indicates that they are likely to show meaningful progress towards restoration of competency within 30 days, whose symptoms are stabilizing, and who are likely to be referred for re-evaluation and restored to competency within 60 days; assess Outreach Program patients' progress; and monitor Class members who have been restored to competency, wherever they are located, and assist them in remaining competent to stand trial. Subject to the terms of paragraph 26, below, USH may utilize the Outreach Program as an approved method of Restoration Treatment for a period of one year from the date on which the court approves this Settlement Agreement

12. "**Restoration Treatment**" in this Settlement Agreement means competency restoration treatment provided by USH forensic personnel or by similarly qualified professionals

employed by DHS's contractor, to Class members in an effort to restore them to competency, in accordance with Utah Code Ann. § 77-15-6(1), regardless of location or level of need.

13. "**Status Report**" means the written report issued by the Defendants' Designated Representative on a monthly basis during the Monitoring Period, pursuant to paragraph 18, below.

14. "**USH Forensic Unit**" has the same meaning as set forth in Utah Code Ann. § 62A-15-901.

15. "**Waitlist**" means the list of individuals committed to the custody of the executive director of DHS and waiting in jail for Restoration Treatment.

Objectives, Plan Implementation and Measures of Compliance

16. **Timely Restoration Treatment** – Defendants shall take all necessary steps to meet the objective of providing all Class members with timely and appropriate Restoration Treatment. Pursuant to the screening procedures referenced in paragraph 19, below, and without any unnecessary delay, Defendants shall transport or direct transportation consistent with Utah Code Ann. Sect. 77-15 et seq., of Class members to the appropriate program or location for Restoration Treatment.

17. **Implementation of the Plan** – Subject to the Court's approval of this Settlement Agreement, Defendants shall implement the Plan annexed hereto as Exhibit 1 no later than September 30, 2017, and shall take all steps necessary to diligently follow the Plan during the term of this Settlement Agreement.

18. **Duties of Defendants' Designated Representative** – No later than the tenth day of the month following the end of every month during the Monitoring Period, the Defendants' Designated Representative shall transmit to the Monitor and DLC a Status Report accurately

reporting the status of all Class members then waiting for Restoration Treatment. Each report must include the following information for each Class member:

a. The Class member's name and criminal case number;

b. The name of the court that entered the Class member's Custody Order;

c. The date of the court's Custody Order;

d. The date USH received the Custody Order;

e. The name of the jail where the Class member is being held;

f. The dates on which the Outreach Program screened the Class member and the results of the screenings, including the current disposition of the Class member for Restoration Treatment;

g. The date on which the Class member began receiving Restoration Treatment and the location of the Class member's Restoration Treatment;

h. The date, if any, on which the Class member was terminated from DHS custody for any reason;

i. The reasons for the Class member's termination from DHS custody, including the name and location of the facility or other setting to which the Class member was transferred, if that information is known to DHS; and,

j. The number of days the Class member has spent on the Waitlist.

The report shall also state: (1) the longest wait time as among all Class members then on the Waitlist; (2) whether the Defendants have complied with the requirements of paragraph 21, below, during the month; and, if applicable, (3) the reasons for Defendants' inability to comply with the requirements of paragraph 21.

Defendants' Designated Representative shall, on request, cooperate with the Monitor in gathering any additional information necessary for the Monitor's reports, which are required in paragraph 20, below.

19. **Screening deadlines and disposition of Class members** –

a. Within seventy-two (72) hours, excluding weekends and holidays, of DHS's receipt of the Custody Order with respect to a Class member, a qualified USH Forensic Unit professional shall screen the Class member using a screening tool approved by, and subject to modification and replacement as determined appropriate by, Defendant's Designated Representative and the Monitor. On the basis of the screening, the USH Forensic Unit professional shall determine whether the Class member: (i) should be transferred from jail to the USH Forensic Unit for Restoration Treatment due to the acuity and nature of the Class member's mental illness; (ii) should be transferred to an Alternative Therapeutic Unit; (iii) should be transferred to an Offsite Forensic Facility for Restoration Treatment; (iv) subject to the limits in paragraph 26, below, should be treated by the Outreach Program based on the standards set forth in subparagraph 25(a), below; (v) should be directed to DSPD for Restoration Treatment because of the Class member's intellectual or developmental disabilities; (vi) should be reevaluated by a Forensic Evaluator to determine if the Class member is now competent; or (vii) should be released from DHS custody because it is unlikely that Restoration Treatment would be effective.

b. As soon as the foregoing determination is made, Defendants shall take all steps necessary to promptly effectuate the appropriate disposition of the Class member.

c. If the qualified USH Forensic Unit professional determines that the Class member should be directed to DSPD for Restoration Treatment because of the Class member's intellectual or developmental disabilities, USH shall make the referral within 72 hours, excluding weekends and holidays, of the screening determination. DSPD shall make a determination about whether it is the agency best suited to provide Restoration Treatment to the Class member within 72 hours, excluding weekends and holidays, of the referral from USH. If DSPD does not accept the referral, USH shall place the Class member back on the Waitlist consistent with the date of the court's Custody Order and comply with the Maximum Allowable Wait Time deadlines in paragraph 21. The time spent towards the Class member's referral and assessment will not count in computing the Maximum Allowable Wait Time.

d. If the qualified USH Forensic Unit professional determines that the Class member should be reevaluated by a Forensic Evaluator to determine if the Class member is now competent, a referral to a Forensic Evaluator shall be made within 72 hours, excluding weekends and holidays, of the determination. If the reevaluation cannot be conducted within 72 hours, excluding weekends and holidays, of the referral, or if the Forensic Evaluator recommends that the Class member is still not competent to

proceed but there is a substantial likelihood that the Class member can be restored to competency in the foreseeable future, USH shall continue administering competency restoration services appropriate for the patient's level of need and shall have complied with the Maximum Allowable Wait Time deadlines in paragraph 21. The time spent towards the Class member's referral and assessment will not count in computing the Maximum Allowable Wait Time.

e. If, at any time, the qualified USH Forensic Unit professional identifies an emergent mental health need, the Defendant's Designated Representative shall expeditiously report the circumstances to DLC and the Monitor, describe any action taken by USH, and keep DLC and the Monitor apprised of any subsequent disposition of the Class member.

20. **Monitor's quarterly reports** – No later than the fifteenth day of the month after the end of each calendar quarter during the Monitoring Period, the Monitor shall report in writing to the Defendants and DLC on Defendants' progress during the preceding quarter in implementing each specific provision of the Plan and in complying with each specific term of this Settlement Agreement.

21. **Deadlines for reduction in Maximum Allowable Wait Time –**

a. By March 31, 2018, Defendants shall reduce the Maximum Allowable Wait Time to sixty (60) days.

b. By September 30, 2018, Defendants shall reduce the Maximum Allowable Wait Time to thirty (30) days.

c. By March 31, 2019, Defendants shall reduce the Maximum Allowable Wait Time to fourteen (14) days.

22. **Modification to the Plan** – If Defendants believe that to achieve compliance with the screening deadlines in paragraph 19 or the Maximum Allowable Wait Time deadlines in paragraph 21, above, they will require a modification of the Plan, the Defendants' Designated Representative shall provide the Monitor and DLC with a detailed written explanation of the necessary modification. If DLC objects to any proposed Plan modification, it will notify Defendants' Designated Representative of the objection in writing within fourteen (14) days of its receipt of the notice of modification. DLC and Defendants' Designated Representative shall thereafter confer in good faith to resolve their differences. If they are unable to resolve their differences in this manner, the parties will submit their differences to the Monitor for possible dispute resolution. If they are unable to resolve their differences in consultation with the Monitor, the Monitor will make a written report and recommendation to the parties. If, after conferring with the Monitor, the parties still disagree as to the proposed modification of the Plan, either party may move the Court for relief, along with the Monitor's report and recommendation. In the absence of DLC's consent, Defendants shall not implement proposed changes to the Plan sooner than sixty (60) days following the issuance of the Defendants' Designated Representative's written notice required in this paragraph.

23. **Suspension of deadlines because of special circumstances –** Defendants' ability to perform their obligations under this Settlement Agreement in a timely manner may depend on special circumstances beyond their control. Subject to the following terms and conditions, the deadline in paragraph 19(a) (hereinafter the "Screening Deadline") and the deadlines in

paragraph 21 (hereinafter the "Maximum Allowable Wait Time Deadlines") may be suspended with respect to one or more Class members:

a. The Screening Deadline or the Maximum Allowable Wait Time Deadlines relating to an individual Class member may be temporarily suspended if Defendants conclude that they cannot meet the relevant deadlines because of factors beyond Defendants' control, including (but not limited to): orders of a court that will delay Defendants' performance; motions filed on behalf of the Class member that will delay Defendants' performance; a jail's failure or refusal to clear the Class member for admission to one of Defendants' facilities; a jail's failure or refusal to allow Outreach Program staff access in order to carry out its responsibilities with respect to a Class member; or medical conditions that prevent a Class member's admission to USH. Circumstances in this category shall be referred to as "Individual Special Circumstances."

b. The Screening Deadline or the Maximum Allowable Wait Time Deadlines relating to a group of Class members may be temporarily suspended if Defendants conclude that they cannot meet the relevant deadline because of factors beyond their control, including (but not limited to) a national or local disaster impacting admissions to one or more of Defendants' facilities, a labor action that substantially impedes the continued operation of a facility, or an extraordinary and unanticipated increase in the number of court-ordered competency restoration referrals. Circumstances in this category shall be referred to as "Departmental Special Circumstances."

The failure or refusal of the Utah Legislature to adequately fund Defendants' operations, programs, or the Plan shall not be considered a Departmental Special Circumstance for purposes of this Settlement Agreement.

c. If, at any time during the term of this Settlement Agreement, Defendants conclude they must suspend either the Screening Deadline or the Maximum Allowable Wait Time Deadlines on account of either an Individual Special Circumstance or a Departmental Special Circumstance, the Defendants' Designated Representative shall immediately give DLC and the Monitor written notice thereof. The notice shall state the nature of the special circumstance (that is, whether an Individual or Departmental Special Circumstance), names of all of Class members who will be affected by the proposed suspension, and all of the facts constituting the special circumstance. The notice shall also state which specific deadlines must be suspended and for what specific period.

d. Any suspension proposed in the notice shall begin on the date on which the notice is received by DLC and the Monitor and shall terminate at the end of the temporary period of suspension, as set forth in the notice, unless modified in accordance with subparagraphs f or g, below.

e. No suspension of any deadline shall last longer than is justified by the special circumstance identified in the notice.

f. If either DLC or the Monitor objects to the suspension, or the scope or duration of the suspension, DLC or the Monitor may notify Defendants'

Designated Representative of the objection in writing, and the parties shall promptly confer with each other in good faith to resolve the issue.

g. If the parties are unable to resolve the issue after the consultation required by subparagraph f above, they will submit the matter to the Monitor for mediation. In the absence of an emergency requiring immediate relief, none of the parties shall be entitled to file a motion in the Litigation to enforce this Settlement Agreement based upon the suspension until the expiration of thirty (30) days from the date on which the party notifies the other parties of the alleged violation based upon the suspension and efforts to resolve the situation, including Monitor-led mediation, have been exhausted. The parties shall equally share the costs of Monitor-led mediation.

24. **Offsite Forensic Facility requirements** – As part of the Plan, Defendants are hereby authorized to develop and implement one or more Offsite Forensic Facilities consistent with the following principles:

a. Each Offsite Forensic Facility shall be a treatment program located in space that is suitable for Restoration Treatment. If the space is located in or leased from a county jail, the space and the residents shall be segregated from the jail's general inmate population.

b. Each Offsite Forensic Facility shall be operated by a multi-disciplinary treatment team consisting of full-time forensic professionals, employed by DHS or by a suitable contractor, of a number that is sufficient to provide those Class members transferred to the Offsite Forensic Facility with

Restoration Treatment. A sufficient number of staff members shall remain on-site during operational hours. Each Offsite Forensic Facility shall meet the best practices of professional and clinical standards governing the operation of, and delivery of, Restoration Treatment services at the USH Forensic Unit.

c. Defendants shall establish and operate one or more Offsite Forensic Facilities with sufficient capacity to meet, in combination with other improvements, the Maximum Allowable Wait Time deadlines in paragraph 21.

d. The initial Offsite Forensic Facility should preferably be located in the Salt Lake County Metro Jail, in space previously inspected and approved by the representatives of the parties. The parties affirmatively represent that they are not presently aware of any deficiencies in the management or operation of the Salt Lake County Metro Jail that would preclude, impede, or otherwise interfere with Defendants' ability to establish and operate an Offsite Forensic Facility at the Salt Lake County Metro Jail, or that would preclude, impede, or otherwise interfere with Class members' ability to receive reasonable and adequate medical and mental health care and services while they are housed in the Offsite Forensic Facility at the Salt Lake County Metro Jail.

e. Defendants will carefully evaluate and, if needed, seek additional funding for a comparable facility for Class members who are women.

25. **Outreach Program duties** – Subject to the limits of paragraph 26, below, Outreach Program professionals shall conduct timely screening of Class members in accordance with paragraph 19 above and shall:

a. Treat Class members who, in the professional's judgment, are likely to show meaningful progress towards restoration of competency within 30 days, whose symptoms are stabilizing, and who are likely to be referred for re-evaluation and restored to competency within 60 days. Class members in the Outreach Program shall be re-assessed by Outreach Program professionals every two weeks to determine progress toward competency. Following 30 days of Restoration Treatment in the Outreach Program, Outreach Program professionals will re-assess each Class member to determine if the Outreach Program remains the most clinically appropriate and effective level of care. A Class member will be disqualified from Restoration Treatment in the Outreach Program if he or she exhibits repeated suicidal ideations with intent to harm, engages in repeated acts of self-harm, persistently refuses medications necessary for competency restoration with no rational basis, exhibits a significant decline in clinical stability, or is diagnosed with a moderate to severe intellectual or developmental disability. If the Outreach Program professional determines at screening that a Class member should be disqualified from consideration for Restoration Treatment in the Outreach Program, the Class member must be transferred to USH, an Offsite Forensic Facility, or an Alternative Therapeutic Unit within seventy-two (72) hours, excluding weekends and holidays. Similarly, if the Outreach Program professional determines that the Outreach Program is no longer

clinically appropriate or effective for a Class member, the Class member must be transferred to USH, an Offsite Forensic Facility, or an Alternative Therapeutic Unit within seventy-two (72) hours, excluding weekends and holidays, or referred to DSPD if appropriate;

b. Facilitate the prompt reevaluation of Class members by a Forensic Evaluator, if justified;

c. Monitor former Class members as clinically necessary who have been restored to competency and who await trial, to assist them in maintaining their competency until trial.

26. **Determination of the Outreach Program's effectiveness** – The Outreach Program may be utilized by USH as an approved alternative method of Restoration Treatment under this Settlement Agreement for a period of one year from September 30, 2017. During this one-year period, the Monitor will gather and analyze information about the Outreach Program's effectiveness in providing Restoration Treatment to Class members, including the number of patients who are restored or are not restored within 60 days, together with any other factors the Monitor deems relevant. By the end of the one-year period, the Monitor will advise the parties either: (a) that the Outreach Program is effective as a method of Restoration Treatment, in which event the Outreach Program will become a permanent treatment option under this Settlement Agreement; or (b) that it is not effective, in which event its use as a treatment option under this Settlement Agreement will be promptly terminated unless the Monitor prescribes additional steps to improve the Outreach Program's efficacy and USH complies with and implements those steps.

Approval by the Court and Enforcement

27. **Court approval and stay of the Litigation –** The parties will jointly move the Court in the Litigation for an order approving this Settlement Agreement and staying all proceedings in the Litigation pending successful implementation of the Plan and compliance with the terms hereof. This Settlement Agreement shall become effective upon the Court's issuance of an order approving it. The parties agree that the Court retains continuing jurisdiction over the Litigation to enforce the terms of this Settlement Agreement for five (5) years from the date on which the Court issues an order approving its terms. Subject to the requirements of paragraph 28 below, any party may move the Court for an order to enforce the Settlement Agreement and/or to lift the stay on the Litigation. Upon the expiration of the term of this Settlement Agreement, any party may move for dismissal with prejudice of all claims in the Litigation. If, at the end of the term, no party moves for dismissal, the Court shall enter an order to show cause why all claims should not be dismissed with prejudice.

28. **Enforcement** – If any party concludes that another party has violated any material provision of this Settlement Agreement, the party will notify the Monitor and other parties, including Defendants' Designated Representative, of the alleged violation in writing. Thereafter the parties will promptly attempt to resolve the alleged violation by conferring with each other in good faith to resolve the issue. If the parties are unable to resolve the alleged violation, they will submit the matter to the Monitor for mediation. In the absence of an emergency requiring immediate relief, none of the parties shall be entitled to file a motion to enforce any provision of this Settlement Agreement until the expiration of thirty (30) days from the date on which the party notifies the other parties in writing of the alleged violation and

efforts to resolve the violation, including Monitor-led mediation, have been exhausted. The parties shall equally share the costs of Monitor-led mediation.

29. **Attorney fees and costs regarding enforcement –** Subject to the limitations contained in paragraph 28, any party that obtains an order of the Court enforcing a provision of this Settlement Agreement shall be entitled to an award of its reasonable attorney fees and costs incurred.

General Provisions

30. **Term** – The term of this Settlement Agreement shall be five (5) years from the date on which the Court issues an order approving its terms.

31. **Persons bound** – This Settlement Agreement shall be binding on all Defendants and their successors, together with their officers, agents and employees, unless otherwise prohibited by state or federal law.

32. **Integration** – This Settlement Agreement constitutes the entire agreement among the parties on the matters raised herein, and no other statement, promise, or agreement, either written or oral, made by any party or agent of any party, shall be enforceable.

33. **Scope** – This Settlement Agreement is not intended to resolve any actual or potential violation of the rights of pretrial detainees other than those specifically addressed in the Litigation.

34. **Authority of signatories** – The persons signing this Settlement Agreement represent that they have the authority to do so.

35. **Representations and warranties** – Each party to this Settlement Agreement represents, warrants, and agrees as to itself as follows:

a. It has fully and carefully reviewed this Settlement Agreement prior to its execution by an authorized signatory.

b. It has consulted with its attorneys regarding the legal effect and meaning of this Settlement Agreement and all terms and conditions hereof, and that it is fully aware of the contents of this Settlement Agreement and its legal effect.

c. It has had the opportunity to make whatever investigation or inquiry it deems necessary or appropriate in connection with the subject matter of this Settlement Agreement.

d. It has not heretofore assigned or transferred, or purported to assign or transfer, to any person or entity any claims that it might have against the other.

e. It is executing this Settlement Agreement voluntarily and free from any undue influence, coercion, duress, or fraud of any kind.

36. **Waiver** – No waiver of any of the provisions of this Settlement Agreement shall be deemed or constitute a waiver of any other provision, whether or not similar, nor shall any waiver constitute a continuing waiver. No waiver shall be binding unless executed in writing by the party making the waiver.

37. **Counterparts** – This Settlement Agreement may be executed in identical counterparts, each of which for all purposes is deemed an original, and all of which constitute collectively one agreement. The parties intend that faxed signatures and electronically-imaged signatures such as PDF files shall constitute original signatures and are binding on all parties. An executed counterpart signature page delivered by facsimile or by electronic mail shall have

the same binding effect as an original signature page. This Settlement Agreement shall not be binding until all parties have signed and delivered a counterpart of this Settlement Agreement whether by mail, facsimile, or electronic mail.

38. **Modification** – Settlement Agreement may be modified if the parties are in agreement. Any modification to this Settlement Agreement shall be in writing.

39. **Attorney Fees** – Subject to the provisions in paragraph 29, above, each party shall bear his, her or their own attorney fees and costs of court incurred in the matter to the effective date of this Settlement Agreement.

40. **Notices** – Any notice or other communication required or permitted under this Settlement Agreement shall be in writing and shall be deemed to have been duly given when (a) mailed by United States registered or certified mail, return receipt requested, (b) mailed overnight express mail or other nationally recognized overnight or same-day delivery service, (c) sent as PDF attachment to electronic mail, or (d) delivered in person, to the parties at the following addresses:

If the Disability Center, to:

DISABILITY LAW CENTER
205 North 400 West
Salt Lake City, Utah 84103

Attention: Aaron M. Kinikini
Erin B. Sullivan
Email: akinikini@disabilitylawcenter.org
esullivan@disabilitylawcenter.org

With a copy to:

Alan L. Sullivan
Bret R. Evans
SNELL & WILMER L.L.P.
15 West South Temple, Suite 1200 Gateway Tower West
Salt Lake City, Utah 84101

Email: asullivan@swlaw.com
brevans@swlaw.com

If the Department, to:

DEPARTMENT OF HUMAN SERVICES
195 N. 1950 West, 4th Floor
Salt Lake City, Utah 84116

Attention: Ann Williamson
Lana Stohl

Email: annwilliamson@utah.gov
lstohl@utah.gov

If the Division, to:

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH
195 North 1950 West, 2nd Floor
Salt Lake City, Utah 84116

Attention: Douglas Thomas
Email: dothomas@utah.gov

If the State Hospital, to:

UTAH STATE HOSPITAL
1300 Center Street
Prove, Utah 84603

Attention: Dallas Earnshaw
Email: dearnshaw@utah.gov

With a copy to:

OFFICE OF THE UTAH ATTORNEY GENERAL
Parker Douglas (8924)
Laura Thompson (6328)
David Wolf (6688)
160 East 300 South, Sixth Floor
Salt Lake City, Utah 84114-0856

Email: pdouglas@agutah.gov
lathomps@utah.gov

dnwolf@agutah.gov

A party may change the names or address where notice is to be given by providing notice to the other parties of such change in accordance with this paragraph 40.

DATED this 9th day of June, 2017 on behalf of Plaintiffs:

ALAN L. SULLIVAN (3152)
Attorney for Plaintiffs

AARON M. KINIKINI (10225)
Attorney for Disability Law Center

DATED this 9th day of June, 2017 on behalf of Defendants:

LAURA THOMPSON
Utah Assistant Attorney General

ANN S. WILLIAMSON
Executive Director, Utah Department of Human Services

EXHIBIT
1

A Strategic Plan for Providing Utah Adult Mental Health Competency Restoration Services

Revised June 9, 2017

INTRODUCTION

The State of Utah provides competency restoration services to individuals court-ordered to the Department of Human Services (DHS) as Not Competent to Proceed (NCP) under Utah Code Ann. §§. 77-15-1 *et. seq*. This plan outlines the process for how these services are delivered and contains information regarding the clinical programs provided. Utah's system of competency restoration services is based on best practices and successful endeavors in Utah and other states. Utah is addressing the increased demand for forensic services by building capacity and programs that are clinically appropriate and cost effective. A best practice model is in the developmental stages nationally. The traditional inpatient approach is no longer viewed as the sole recommended model of care, as evidenced by the fact that at least 10 states now have some form of competency restoration treatment that is conducted in a jail or adapted setting. Utah's model of care includes outpatient treatment; treatment at an offsite forensic facility; treatment at alternative therapeutic units; and inpatient competency restoration treatment programs. This comprehensive system of care includes vital components for processing court orders, assigning court-ordered evaluations to forensic examiners, screening individuals found NCP for appropriate program placement, treatment plan development, clinical and educational competency restoration services, evaluating clinical progress, tracking outcomes data, and discharge planning. Ongoing communication and collaboration with the courts, correctional facilities, and attorneys is vital to operational efficiency.

COMPETENCY RESTORATION OVERVIEW

Historically, competency restoration services have been provided at the Utah State Hospital's (USH) forensic inpatient unit. Over the past 30 years, the demand for forensic services in Utah and nationwide has experienced exponential growth, creating a strain on existing resources. Some of the circumstances that have contributed to this growth in Utah include an increase in 1) the number of competency petitions filed; 2) the number of people found NCP by the courts and referred to DHS; and 3) the acuity level of patients entering the system. Some states have converted non-forensic inpatient beds into forensic beds to respond to the increased demand. In many states, competency restoration services are being provided in non-inpatient settings allowing provision for a more efficient and appropriate level of care for those individuals not needing an inpatient level of competency restoration services. According to a report by the Washington State Institute for Public Policy (*Standardizing Protocols for Treatment to Restore Competency to Stand Trial: Interventions and Clinically Appropriate Time Periods*, January 2013), there are five treatment modalities in the literature to address the competency restoration needs of those found NCP that include:

(1) Medications;
(2) Treatment for individuals with developmental disabilities;
(3) Educational treatment programs;

(4) Specialized/individual treatment programs; and
(5) Cognitive remediation programs.

The study also describes incompetence as predicated on two components that are typically addressed in treatment: (1) a mental disorder or cognitive impairment and (2) a deficit in one or more competence-related abilities (i.e., understanding, appreciation, reasoning, assisting counsel) that occur as a result of the mental disorder or cognitive impairment. Improvement in the underlying mental disorder or cognitive impairment often results in the improvement in competence-related deficits. This forms the basis for psychotropic medications being one of the primary treatment modalities in competency restoration treatment. In addition, the use of educational approaches to increase the patient's factual understanding of the legal proceedings and to assist in participating with their defense counsel is beneficial.

The Washington State Institute for Public Policy report revealed limited success in competency restoration outcomes for individuals with intellectual and/or developmental disabilities. Most programs that have been studied demonstrate a 33 percent average competency restoration rate for individuals with intellectual disabilities compared to a 70 percent average for those with mental illness. The "Slater Method" is a competency restoration tool that is typically used to treat individuals with intellectual disabilities. Length of time to restoration is longer for people with intellectual disabilities than the time to restoration for people without intellectual disabilities. It has been DHS' experience that most individuals who require specialized services for intellectual disabilities do better when treated under the supervision of state agencies designed to treat the unique needs of this population. Utah identifies these individuals when referred to DHS and makes every effort to direct their competency restoration treatment to the Division of Services for People with Disabilities (DSPD).

Most research demonstrates that individuals who participate in education groups have a significantly higher rate of restoration than those who do not. Many states across the country have implemented education programs that are of varying structure and delivery styles. Yet, the basic components are similar. Programs in the North Coast Behavioral Healthcare System in Ohio; the Alton Mental Health and Development Center in Illinois; the Atascadero Hospital in California; the RISE program in Denver, Colorado; as well as others, include treatment modalities such as: educational groups; experiential modules, such as mock trials; medication management; and cognitive remediation. These best practice principles are incorporated into Utah's restoration program development. Another well recognized program used to inform Utah's model of care is the 'Comp-Kit' restoration program developed and implemented in 2006 by Florida's mental health forensic system.

Even though the literature is limited and does not specifically identify one national best practice model for competency restoration, current programs have similar components and outcomes. The National Judicial College in Reno, Nevada assembled a panel of experts to develop a Mental Competency Best Practice Program. Though the main tenet of their recommended approach is similar as that described above, it is recommended that clinicians assess the individual's need for competency restoration and tailor the program individually rather than placing all individuals into the same curriculum and treatment modalities.

SUMMARY of ESSENTIAL RESTORATION SYSTEM ELEMENTS:

1. Court-ordered competency restoration process
2. Court referral monitoring system
3. Initial treatment screening to determine appropriate level of service delivery
4. Initial mental health evaluation
5. Identification of barriers to competency restoration
6. Development of an individualized treatment plan
7. Engagement of treatment modalities
8. Ongoing progress towards competency assessments
9. Documentation of interventions and response to interventions
10. Re-evaluation of competency
11. Court Referral and reporting process

STRATEGIC ACTION PLAN

In order to ensure the State of Utah has adequate resources available to provide competency restoration services to individuals who have been court-ordered to DHS, it is imperative that a

strategic action plan be developed, implemented, and have ongoing evaluation to assure timely provision of treatment services.

A wider array of stakeholders must be engaged to more fully address the competency restoration needs of the citizens of Utah. Successful implementation of a strategic plan requires co-operation, communication and collaboration with a variety of stakeholders and participants involved in the competency restoration process, including, but not limited to: the district courts; referring county and municipal courts; prosecutors; the defense bar; the counties/Local Mental Health Authorities (LMHAs); local sheriffs' offices and jails; law enforcement; and the Utah Legislature.

Outcomes used to assist in this determination will include service access wait times, restoration rates, and length of time for restoration. Each service delivery option will be evaluated for efficiencies and appropriate patient placements.

Each year, DHS, in collaboration with other state leaders, will review these outcomes and make proposals when increased resources are necessary. Options may include: additional offsite forensic facilities; alternative therapeutic units located on or off the USH campus; additional beds at USH; and addressing timely and appropriate competency restoration treatment for women in a clinically appropriate setting. Counties are encouraged to consider pre-evaluation processes to facilitate access to mental health services for individuals with serious mental illness, prior to, or upon entering the criminal justice system, and redirect individuals from entering the forensic system when community services are more appropriate.

1. Purposes and Implementation of the Strategic Plan

The purposes of this strategic plan are as follows:

(a) Outline the specific steps to be taken to reduce the period of time during which patients committed to DHS must wait to receive competency restoration treatment;

(b) Comply with the timeframes established in the Settlement Agreement approved by the Court in the matter of *Disability Law Center, et. al. v. State of Utah, Department of Human Services, et. al., Case No. 2:15-cv-00645-RJS-BCW.*

(c) Implement a series of indicators that will measure the quality and efficiency of competency restoration treatment for patients committed to DHS for competency restoration treatment; and

(d) Monitor and adjust resource investment and allocation to achieve the purposes of the strategic plan.

The implementation of this strategic plan is to be contemporaneous with the establishment of the first offsite forensic facility proposed at the Salt Lake County Metro Jail, or September 30, 2017, whichever occurs later.

2. Service Delivery Options

Like many other states, Utah has recognized the need for additional cost-effective and clinically appropriate services to meet the demand for forensic services. In 2014, USH, in collaboration with the Division of Substance Abuse and Mental Health (DSAMH) and DHS, recommended four levels of treatment services that are appropriate for competency restoration. This was presented in response to a 2014 legislative audit. They are listed in order from the least to highest associated clinical need:

a) Outreach Program: Providing competency restoration treatment to patients:
   i. on release from the court in the community;
   ii. in jail within their home community; or
   iii. in prison.

b) Offsite Forensic Facility: Providing competency restoration treatment to patients in a specialized, structured competency restoration program within a jail or other secure setting.

c) Alternative Therapeutic Unit: Providing competency restoration treatment in any treatment unit established and operated by USH or under contract with DHS on or off of the USH campus for patients who do not require hospitalization level of care.

d) Inpatient Forensic Beds at USH: There is capacity but not infrastructure for expansion of inpatient hospital beds at the USH campus.

Not all patients referred to DHS for competency restoration treatment require hospital inpatient level of care and its associated interventions. Screening processes are designed to identify persons found NCP who can, within a reasonable timeframe, be restored to competence in the least restrictive, clinically appropriate environment and without requiring admission to an inpatient setting.

There are identifiable advantages to offering outpatient competency restoration services to individuals with lower psychiatric acuity levels including:

a) Decreased incarceration time
b) Decreased transportation costs
c) Improved supports to assist in treatment within their local communities
d) Enhanced access to community mental health treatments
e) Facilitated access into ongoing outpatient treatment support systems
f) Ongoing access to defense counsel, family, and other supports
g) Reduced stigma associated with psychiatric hospitalization.

If a patient is placed in any program or level of service based on screening criteria and later is determined to either be progressing faster or not progressing as expected to meet the required time frames, the patient will be transferred to the more appropriate level of care based on their clinical status.

3. Offsite Forensic Facilities

(a) DHS is currently planning an offsite forensic facility with day competency restoration treatment in a county jail. This is a five days per week, eight hours per day program to provide competency restoration treatment to patients who need a structured environment, similar to a mental health unit, but do not need the services of an inpatient psychiatric hospital. Patients will be identified according to their acuity, and treatment will be individualized accordingly.

(b) Based on the success of this initial program and in the assessment of future program needs, DHS may request funding for additional offsite forensic facilities (including, but not limited to, a female only offsite forensic facility) to meet the needs of the population. DHS will determine funding and staffing patterns following a review of the current program outcomes and inflationary costs. If DHS determines that there is a greater number of patients needing inpatient care, DHS will request funding for additional beds at USH or another appropriate alternative therapeutic unit. This funding request would be similar to the funding at that time for one USH forensic unit (current cost is approximately $4.5 million dollars). Staffing levels would be similar to a current forensic unit based on this budget information.

(c) In 2017, the first offsite forensic program will be developed in partnership with Salt Lake County due to its Metro Jail's central geographic location and the large number of competency restoration referrals that arise from Salt Lake County. This program has an annual operating budget of approximately $3 million. Funding will be available by July 1, 2017. DHS will begin to develop and coordinate operational procedures, recruitment and implementation of the program as soon as funding is assured through the legislative process. It is intended that actual program implementation will begin no later than September 30, 2017.

In developing contracts for offsite forensic facilities, provisions will be included that address training for the correctional personnel including but not limited to: Crisis Intervention Team (CIT) training and training from the USH Psychiatric Technician training modules. The jail will provide 24-hour emergency psychiatric and emergency medical care of patients when forensic staff are not on site and forensic programming is not being conducted. Subject to the terms of the contract(s) for each offsite forensic facility and available funding, the anticipated staffing and training of the offsite forensic facility will be commensurate with their counterparts at the USH. Patient programming and staffing levels at each offsite forensic facility will be guided by a Program Manual that will soon be developed, subject to modification by the USH Forensic Director, based upon the physical environs of the facility, availability of security staff, and other contract provisions to be determined once each offsite forensic facility is identified.

4. Outreach Program Services

Since 2015, the Utah Legislature has recognized the value of DHS' Outreach Program whereby clinicians provide competency restoration treatment to patients by conducting weekly visits to

those who are: (1) released to the community by the court; (2) housed in their home community jail; or (3) in prison. These services are provided to patients whose screening indicates that they are likely to show meaningful progress towards restoration of competency within 30 days, whose symptoms are stabilizing, and who are likely to be referred for re-evaluation and restored to competency within sixty (60) days.

Some Outreach Program patients will remain in their own county based on the following factors: (a) closeness to family and other supports; (b) desire to stay in the area; (c) upcoming hearing and efficiency in time by not transporting to another area; (d) closeness to legal representation; (e) significant progress with current situation; or (f) gender as the offsite forensic facility programming is male only at this time.

5. **Projecting Future Needs**

(a) USH has projected that the annual number of pretrial detainees in Utah's county jails for which custody or commitment orders will have been issued will continue to increase. If the number of court-ordered pretrial detainees does not increase, USH will continue to monitor trends each year to revise projections.

(b) USH believes that, depending on system changes including the addition of new levels of care and program efficiencies decreasing length of stay in all programs and facilities, it may need additional competency restoration Outreach Program professionals who provide screening, assessment, and treatment services. This will be closely monitored and evaluated based on length of time to access these services and the length of stay in these services in the context of the entire system.

(c) USH believes that, depending on system changes including the addition of new levels of care and program efficiencies decreasing length of stay in all programs and facilities, it may need additional forensic evaluators who are employed to conduct evaluations for the Outreach Program if projections are accurate. This will be closely monitored and evaluated based on length of time to access these services and the length of stay in the Outreach Program in the context of the entire system.

(d) USH will annually evaluate the state's ability to meet the respective service level need and projected number of patients requiring competency restoration treatment, and request additional funding to adequately provide services to all those court-ordered to DHS for purposes of competency restoration treatment. The amount to be requested will be determined by the level of service required to meet the acuity needs of those committed to DHS, taking into consideration the outcomes of each program in meeting the timeframes for competency restoration in the Settlement Agreement and relevant statutes, inflationary costs, and other factors.

6. Expansion of USH Forensic Unit

In addition to the establishment of the offsite forensic facilities referenced in paragraph 3 of this strategic plan, the State projects that, depending on system changes including the addition of new levels of care and program efficiencies decreasing length of stay in all programs and facilities, there may be further need for increased inpatient treatment capacity. The current capacity of the USH forensic unit is 100 patients for all forensic commitments required by law, including NCP, guilty and mentally ill, and not guilty by reason of insanity. The current USH forensic unit was designed to expand by being able to add additional 25-bed units to the existing structure to a capacity of 200 beds. Based on the number of future court referrals and timeframes for competency restoration services, the State may need to request additional funding for the construction or procurement of another facility on or off the USH campus. This will be closely monitored and evaluated based on length of time to access inpatient services and the length of stay in the context of the entire system.

7. Post-Treatment Follow-up

DSAMH/USH will continue to evaluate the most efficient and cost-effective programs and interventions to assist pretrial detainees in maintaining their competency. USH staff will work with counties and provide case management to help monitor and support the patient in their restoration status and facilitate continuity of care.

8. Efficiency Improvements

Outcomes reflect operational efficiencies and clinical effectiveness. Utah's adult mental health competency restoration outcomes will be monitored monthly and evaluated on a quarterly basis at which time changes will be considered to strengthen the results. Adjustments in screening, assessment, treatment, monitoring, program placements, and delivery of services will be made where deficiencies are identified. Outcome indicators are as follows:

1. Length of time from court-ordered referral to treatment program admission;
2. Length of stay in any of USH's competency restoration treatment programs;
3. Percent of court-ordered referrals screened in a timely manner (*i.e.*, within seventy-two (72) hours, excluding weekends and holidays, of DHS's receipt of the district court order for competency restoration treatment);
4. Percent of patients screened into the Outreach Program who are restored or not restored within 60 days; and
5. Percent of patients treated within USH's forensic system who are found competent to proceed.

Targets are identified and adjusted based on best practice standards, baseline measurements and agreements made during system monitoring. Monitoring systems and outcome measures are utilized to ensure individuals within each level of service have been properly placed into programming and changes in status result in reassessment of

the patient. Monitoring also ensures that patients in each level of care are not "lost in the system." LOS and competency status data will receive ongoing utilization reviews to flag those patients who may not be responding appropriately as expected in each level of care. Nationally, outpatient and jail-based programs have shorter LOS than inpatient programs.

Ongoing utilization review means that treating clinicians are reassessing the appropriateness of the current treatment program for the patient with each treatment encounter, and making a determination about program placement or movement at the earliest and most appropriate time.

If at any time it is determined a patient is not progressing in treatment, USH will reassess for the appropriate level of service.

9. Forensic Evaluation System (FES)

When a district court judge orders a competency evaluation, the order should be entered into DHS' Forensic Evaluation System (FES), which is automated to coordinate with state examiners contracted to complete ordered evaluations. Some counties or courts may elect to assign evaluators independent of the FES. Regardless, all orders and evaluations are monitored in the FES. The examiners provide an initial report to the court and parties within 30 days of receipt of the court's order. The examiner may inform the court in writing that additional time is needed to complete the report. The examiner shall have up to an additional 30 days to provide the report if requested in writing. The examiner shall provide the report within 60 days from the receipt of the court's order unless, for good cause shown, the court authorizes an additional period of time to complete the report. If after reviewing the forensic evaluation the judge determines an individual is NCP, the court should send the order for competency restoration to DHS via email into the FES. USH and DSAMH monitor the FES to ensure that all components of the service delivery system are addressed and correspondence with the court and the parties is done in a timely manner under the current statutory scheme. Discovery and other documents and outcome data are also tracked through the FES.

10. Utah Competency Restoration Service Delivery System (See Flow Chart)

The district court should send orders for competency restoration to the USH Legal Service Office, which manages the FES system. Information regarding referrals and evaluations is managed in the FES. All patients ordered to DHS for competency restoration are screened to determine the appropriate level of care needed.

A. Screening Process

Within seventy-two (72) hours, excluding weekends and holidays, of receiving the court order, USH forensic staff shall determine which level of service is appropriate for the patient using a screening tool approved by the USH Forensic Director. The screening process utilizes best practice evaluation tools to determine whether:

1. A patient is likely to be restored to competency through treatment available by the Outreach Program;
2. A patient is likely to be restored to competency through treatment available at an offsite forensic facility;
3. A patient needs inpatient hospital services at the USH forensic unit;
4. A patient is likely not restorable;
5. A patient requires referral to DSPD services; or
6. A patient has other dispositional needs, such as a nursing home placement.

The Initial Competency Restoration Screening tool to be used in the screening process is attached as Appendix A. The screening process may undergo further development and refinement, to include specific scoring guidelines for patient level of service.

Note: Female patients who have been found not competent to proceed will be referred to either the Outreach Program or USH unless and until another program is identified to meet the needs of females who would otherwise be screened to an offsite forensic facility, including, but not limited to, the establishment of a female only offsite forensic facility program.

B. Screening Criteria

The following represents general criteria used by USH Forensic Unit professionals to determine level of service needed:

a. Patient's attitude towards and consent to take medication;
b. Patient's response to medication treatment;
c. Level of risk (i.e., suicide, self-harm, harm to others, etc.);
d. Physical health/medical concerns;
e. Current progress towards competence; and
f. Patient's willingness to engage in treatment.

If an individual is placed in the Outreach Program, competency restoration treatment begins within 14 days of receiving the court order requiring such treatment, though Outreach Program clinicians strive to begin treatment services within 7 days or less of receiving the court order. Part of that treatment is the engagement of jail personnel to provide medication management services if such services are not already in place for patients in their home community jails. If the patient is screened for treatment in an offsite forensic facility or referred to USH's forensic unit, the patient is transferred into the first open bed within 14 days of receiving the court order requiring such treatment.

C. Treatment Disposition

If a patient is determined to be a candidate for the Outreach Program, an offsite forensic facility, an alternative therapeutic unit, or USH's forensic unit, an individualized treatment plan (ITP) is established.

If, at any time, a USH Forensic Unit professional determines that a patient is likely not restorable, the USH administrator will request a re-evaluation from a forensic evaluator. The forensic evaluator conducts the evaluation and a report is sent to the court for further disposition.

If, at any time, a USH Forensic Unit professional determines that a patient is not likely to restore to competency through the Outreach Program, at an offsite forensic facility, or at an alternative therapeutic unit, then coordination is made with the USH staff for admission to inpatient level of care at USH. The USH Forensic Outreach Competency Progress Assessment tool is attached as Appendix B.

If it is determined that a patient may meet the criteria for an intellectual disability, a referral is made within seventy-two (72) hours, excluding weekends and holidays, to DSPD for competency restoration services. If DSPD does not accept the referral, the patient is screened for USH treatment services and all timeframes apply.

If a patient is determined at any time throughout the screening or treatment process to meet the criteria to be found competent to proceed, the USH administrator will request a re-evaluation from a forensic evaluator. The forensic evaluator conducts the evaluation and a report is sent to the court for further disposition.

D. Treatment Services

The program administrators at each level of service coordinate with the treating staff and other agencies involved in the custody or care of the patient to develop an ITP and identify necessary treatment modalities. Types of competency restoration interventions may include, but are not limited to, individual instruction; individual therapy; group therapy; educational or psychoeducational materials; assignments; recreational therapy; occupational therapy; and medication management. Treatment staff may also coordinate services with jail treatment providers or LMHAs for medication management and other appropriate medical services. The competency curriculum is consistent with criteria in Utah's competency statutes. The following program outline describes the restoration treatment delivery system at each level of service:

1. **Referral Screening Process**
    a. Each individual is screened by a qualified USH Forensic Unit professional within seventy-two (72) hours, excluding weekends and holidays, of receiving a court order for competency restoration.
    b. A qualified USH Forensic Unit professional utilizes scoring guidelines from the initial screening tool (Appendix A) to identify the appropriate level of service to which the individual should be referred.

c. A qualified USH Forensic Unit professional will continue to visit with all referrals weekly while the individual is being evaluated for the appropriate program.

2. Outreach Program

a. The Outreach Program is designed for patients who are likely to show meaningful progress towards restoration of competency within 30 days, whose symptoms are stabilizing, and who are likely to be referred for re-evaluation and restored to competency within 60 days.

b. If the Outreach Program clinician determines that the patient is appropriate for treatment through the Outreach Program and the county jail is deemed a sufficient location in which to provide competency restoration services, the Outreach Program clinician will commence treatment in the home community jail after considering the criteria outlined in Section 4 above, "Outreach Program Services."

c. Outreach Program staff will arrange weekly treatment encounters with patients who are on a release to the community by the court.

d. If the patient is female and is appropriate for the Outreach Program, weekly visits will occur in the home community jail.

e. An ITP is established for each Outreach Program patient based on individualized needs and identified barriers to competence.

f. Coordination among Outreach Program staff occurs weekly to evaluate treatment progress, modify the patient's ITP as indicated, and coordinate medication management with local county jails as required in Utah Code Ann. Sect. 17-43-301(5)(a)(i) or pursuant to a contract anticipated to be entered with Salt Lake County for an offsite forensic facility.

g. An Outreach Program clinician visits with the patient for at least 60 minutes weekly to provide competency restoration treatment and psychoeducational material from the Outreach Competency Training Program manual addressing barriers to competence identified in the ITP. The manual is attached as Appendix C.

h. Patients are reassessed minimally every two (2) weeks to determine progress towards competence.

i. Patients will be disqualified from competency restoration treatment in the Outreach Program if he or she exhibits suicidal ideations with intent to harm, engages in repeated acts of self-harm, persistently refuses medications necessary for competency restoration with no rational basis, exhibits a significant decline in clinical stability, or is diagnosed with a moderate to severe intellectual or developmental disability.

j. If an Outreach Program clinician determines that a patient should be disqualified from the Outreach Program, the patient will be transferred to USH's forensic unit, an Offsite Forensic Facility, or

an Alternative Therapeutic Unit within seventy-two (72) hours, excluding weekends and holidays.

k. Patients who are not ready to be referred for reevaluation for restoration status within sixty (60) days will be re-assessed by USH staff for the appropriate level of competency restoration services.

l. If a qualified USH Forensic Unit professional determines that the Outreach Program is no longer clinically appropriate or effective for a patient, the patient must be transferred to USH's forensic unit, an Offsite Forensic Facility, or an Alternative Therapeutic Unit within seventy-two (72) hours, excluding weekends and holidays.

3. Offsite Forensic Facility

a. An offsite forensic facility is a competency restoration program administered by USH forensic personnel, or by similarly qualified professionals employed by DHS's contractor, at a location other than the USH Campus. Expected capacity at an offsite forensic facility is twenty-two (22) to forty (40) beds.

b. A competency restoration program can be established in any secure offsite facility that has the availability of security staff. This is typically a jail or other secure setting. Any site can be considered if it meets the need for a secure, structured environment. If the space is located in or leased from a county jail, the space and the residents must be segregated from the jail's general inmate population.

c. A competency restoration program at an offsite forensic facility is designed for patients that are in need of more comprehensive treatment than those referred to the Outreach Program and are likely to be restored within two to four months. These patients are not considered a risk of immediate harm to self or others, do not have high acuity medical needs, and are demonstrating that they are willing to engage in treatment, including accepting medication management.

d. Patients will be identified by psychiatric acuity for purposes of bunking assignments, safety assessment, and in creating an ITP.

e. Patients receive day treatment services Monday through Friday. Operational hours may vary but be minimally set from 8:00 a.m. to 5:00 p.m. DHS anticipates some programming may occur in the evenings and on weekends.

f. A treatment team assesses and develops an ITP for each patient based on individualized needs and identified barriers to competence.

g. It is anticipated that the treatment team will consist of a psychiatrist, psychologist, social workers, nursing staff, psychiatric technicians, recreation therapist, case worker, and office specialist,

whose training and credentials will be commensurate with their counterparts at the USH.

h. Treatment services may include any of the following: medication management, individual therapy, group therapy, psychoeducation, recreation therapy, occupational therapy and other modalities identified as necessary for the patient's ITP. A schedule of USH programming is attached as Appendix D as an exemplar. Appendix D.

i. Patient programming and staffing levels at each offsite forensic facility will be guided by a Program Manual that will soon be developed, subject to modification by the USH Forensic Director, based upon the physical environs of the facility, availability of security staff, and other contract provisions to be determined once each offsite forensic facility is identified.

j. It is anticipated that a contractual arrangement with a county jail or other appropriate offsite facility will provide the program with security personnel, medical services, food, clothing, medications, and medical and mental health crisis services after hours.

4. USH Inpatient Restoration Services

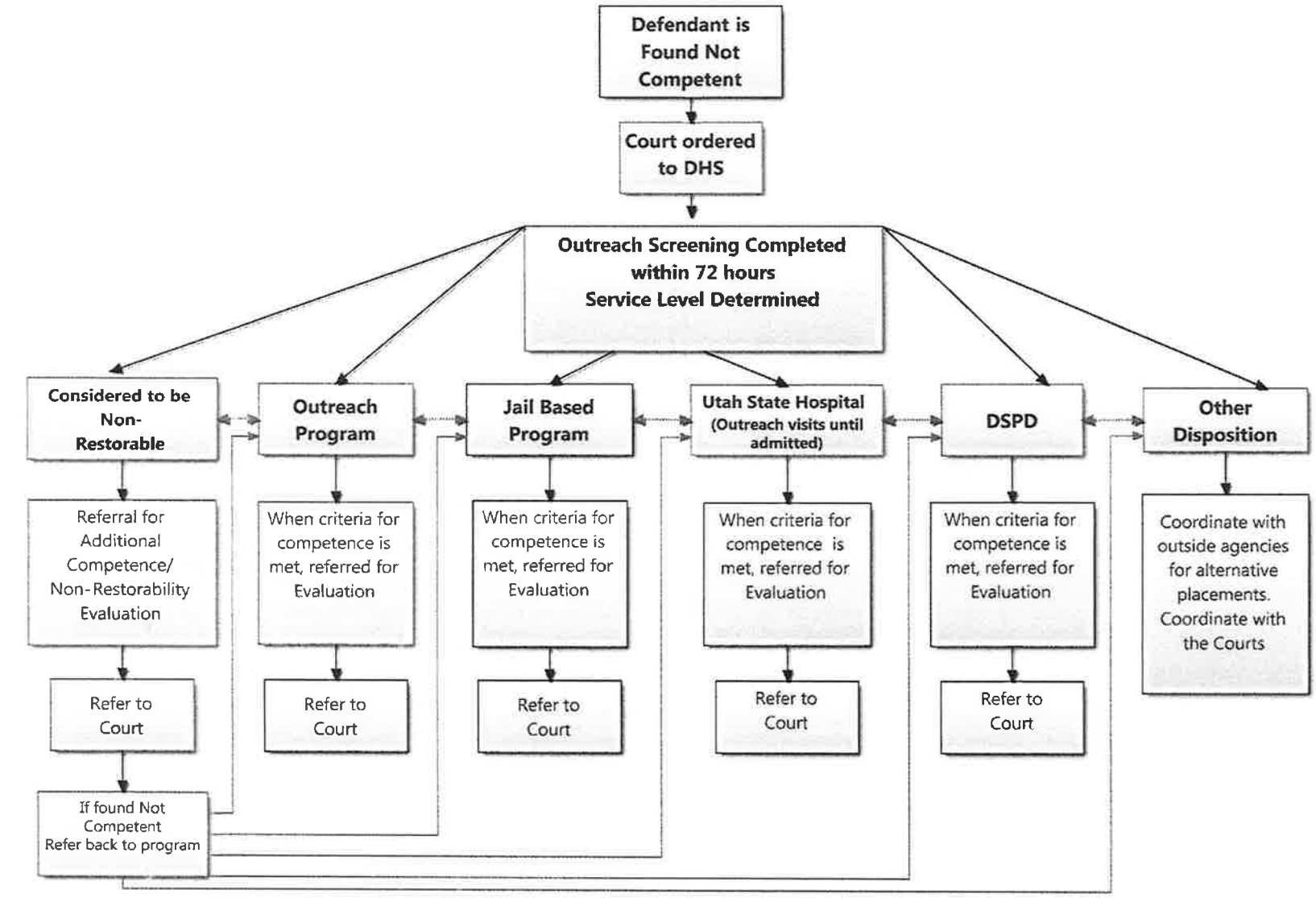
a. Patients who are not found to be appropriate for the Outreach Program or an offsite forensic facility treatment program are referred to USH for inpatient services within seventy-two (72) hours, excluding weekends and holidays.

E. Evaluations

All court-ordered NCP patients will have an initial assessment once they are screened and admitted to one of USH's treatment programs. A report will then be sent to the court pursuant to Utah Code Ann. Sect. 77-15-6. Any time after the patient is found NCP but is showing significant progress towards restoration, a referral can be made for competency re-evaluation by a forensic evaluator. The referral should be made within seventy-two (72) hours, excluding weekends and holidays, of the determination by USH Forensic Unit professionals that the individual has made significant progress towards restoration. Once a referral for follow-up evaluation is made to a forensic evaluator, the evaluation will be completed within fourteen (14) working days. The evaluation report is sent to the court promptly upon completion. The USH Clinical Director or designee certifies all reports recommending the individual be found competent to proceed according to Utah's competency statutes.

F. Collaboration

USH Forensic Unit professionals work in consultation with jail staff, court personnel, families, LMHAs, or others involved in the care, custody or treatment to ensure continuity of care and communication. The USH Legal Services Office and Forensic Director ensure that the courts are kept apprised of the progress and status of all individuals ordered to DHS consistent with Utah's statutory framework.



At anytime a defendant is not progressing within a level of service a referral is made to the appropriate program that meets the needs of the individual

2/17

EXHIBIT
2

NOTICE OF PROPOSED CLASS ACTION SETTLEMENT

Disability Law Center, et al. v. State of Utah, et al.
Case No. 2:15-CV-00645-RJS-BCW

You will be affected by the settlement of a class action lawsuit called *Disability Law Center, et al. v. State of Utah, et al.*, Case No. 2:15-CV-00645-RJS-BCW. This notice summarizes the claim in the lawsuit, what the settlement entails, and your rights under the settlement.

The Court has scheduled a hearing to consider the settlement on [DATE] at [TIME] before the Honorable Judge Robert J. Shelby at Courtroom 7.300, United States District Court for the District of Utah, 351 South West Temple, Salt Lake City, Utah 84101. This hearing is referred to as the Final Settlement Approval Hearing.

SUMMARY OF THE LAWSUIT

The issue in this lawsuit is whether the Utah State Hospital (USH) has failed to timely provide court-ordered competency restoration treatment for individuals who have been found incompetent to stand trial.

A Class Member is any individual who is now, or will be in the future, (i) charged with a crime in Utah, (ii) determined by the court in which they are charged to be mentally incompetent to stand trial, and (iii) ordered to the custody of the executive director of the Utah Department of Human Services or a designee for the purpose of treatment intended to restore the defendant to competency, but who remain housed in a Utah county jail.

The lawyers representing class members ("Class Counsel") are Aaron M. Kinikini and Erin B. Sullivan of the Disability Law Center, 205 North, 400 West, Salt Lake City, UT 84103, and Alan L. Sullivan and Bret R. Evans of Snell & Wilmer, LLP, 15 W South Temple #1200, Salt Lake City, UT 84101.

DESCRIPTION OF THE PROPOSED SETTLEMENT AGREEMENT

The Plaintiffs and the State of Utah have reached a settlement that would release the State from any further liability related to this claim. The Settlement Agreement requires USH to do the following, subject to Court approval:

- Within 72 hours of learning that a criminal defendant is found incompetent to stand trial and ordered to the custody of the Utah Department of Human Services, a USH Forensic Unit professional must screen each class member to determine the appropriate level of competency restoration treatment;
- Within 6 months, provide court-ordered to competency restoration treatment to criminal defendants found incompetent to stand trial within 60 days;
- Within 12 months, provide court-ordered to competency restoration treatment to criminal defendants found incompetent to stand trial within 30 days; and
- Within 18 months, provide court-ordered to competency restoration treatment to criminal defendants found incompetent to stand trial within 14 days.

The settlement also creates a system to monitor USH's compliance with the Settlement Agreement and requires the State of Utah to pay fees to the court-approved monitor.

You have the right to learn more about the settlement. A copy of the preliminarily-approved Settlement Agreement is enclosed with this Notice. If you are unable to read or understand the Settlement Agreement, contact Class Counsel referred to in Question 6 below.

OBJECTIONS OR COMMENTS TO THE PROPOSED SETTLEMENT

The United States District Court for the District of Utah has preliminarily approved the Settlement Agreement but will hold a Final Settlement Approval Hearing to determine whether it is fair, reasonable, and adequate on [DATE] at [TIME] in Courtroom 7.300 of the federal courthouse located at 351 South West Temple, Salt Lake City, Utah 84101.

Class Members have a right to object to the terms of the settlement. If you have objections, comments, or statements about the proposed Settlement Agreement, you must make them in writing using the attached "Response to Proposed Class Action Settlement" form or your own paper. A self-addressed stamped envelope is included for your convenience. Written objections, comments, and statements should be sent to the following address: **Disability Law Center, 205 N 400 W, Salt Lake City, UT 84013**. Objections must be submitted or postmarked no later than [DATE].

Objections **must** include all of the following information:

(1) The objector's contact information (name, address, offender number);
(2) An explanation of the basis for the objector's objection to the Settlement Agreement; and
(3) Whether the objector intends to appear at the Final Settlement Approval Hearing on [DATE].

All information submitted to Class Counsel will be provided to counsel for the State of Utah and the District Court in advance of the Final Settlement Approval Hearing. It is not necessary for Class Members to appear at the Final Settlement Approval Hearing. Any Class Member who has submitted a timely objection as provided above and who wishes to appear at the Final Settlement Approval Hearing must give notice by calling the Disability Law Center, sending notice in writing, or using the attached "Response to Proposed Class Action Settlement" form. Objectors may withdraw their objections at any time. **Any objections, comments, or statements that do not comply with the above procedures and timeline will not be heard or considered by the Court.**

HOW TO GET MORE INFORMATION

This is a summary of the Settlement Agreement. If you have any questions about the matters contained in this notice or any questions regarding the settlement, you may write or call Class Counsel below:

DISABILITY LAW CENTER
205 North 400 West
Salt Lake City, UT 84103
(801) 363-1347
Toll Free: (800) 662-9080

RESPONSE TO PROPOSED CLASS ACTION SETTLEMENT

***DLC, et al. v. State of Utah, et al.*, Case No. 2:15-CV-00645-RJS-BCW**

Full Name: _____

Address: _____

_____

_____

Criminal Case No.: _____

Criminal Attorney: _____

Objections/Comments/Statements:

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Do you want to provide oral testimony to the Court regarding the settlement? Yes __ No __

Date: _____ Signature: _____

EXHIBIT
3

NOTICE OF PROPOSED CLASS ACTION SETTLEMENT

Disability Law Center, et al. v. State of Utah, et al.
Case No. 2:15-CV-00645-RJS-BCW

One or more of your clients will be affected by the settlement of a class action lawsuit called *Disability Law Center, et al. v. State of Utah, et al.*, Case No. 2:15-CV-00645-RJS-BCW. This notice summarizes the claim in the lawsuit, what the settlement entails, and your client's rights under the settlement. **Please share this notice and the proposed Settlement Agreement with your client's family members and any known legal guardian of your client, and encourage them to submit any objections, comments, and or statements that they may have regarding the proposed Settlement Agreement**.

The Court has scheduled a hearing to consider the settlement on [DATE] at [TIME] before the Honorable Judge Robert J. Shelby at Courtroom 7.300, United States District Court for the District of Utah, 351 South West Temple, Salt Lake City, Utah 84101. This hearing is referred to as the Final Settlement Approval Hearing.

SUMMARY OF THE LAWSUIT

The issue in this lawsuit is whether the Utah State Hospital (USH) has failed to timely provide court-ordered competency restoration treatment for individuals who have been found incompetent to stand trial.

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If you have objections, comments, or statements about the proposed Settlement Agreement, you must make them in writing using the attached "Response to Proposed Class Action Settlement" form or your own paper. A self-addressed stamped envelope is included for your convenience. Written objections, comments, and statements should be sent to the following address: **Disability Law Center, 205 N 400 W, Salt Lake City, UT 84013**. Objections must be submitted or postmarked no later than [DATE].

Objections **must** include all of the following information:

(1) The objector's contact information (full name and address);
(2) An explanation of the basis for the objector's objection to the Settlement Agreement; and
(3) Whether the objector intends to appear at the Final Settlement Approval Hearing on [DATE].

All information submitted to Class Counsel will be provided to counsel for the State of Utah and the District Court in advance of the Final Settlement Approval Hearing. It is not necessary for Class Members to appear at the Final Settlement Approval Hearing. Any Class Member who has submitted a timely objection as provided above and who wishes to appear at the Final Settlement Approval Hearing must give notice by calling the Disability Law Center, sending notice in writing, or using the attached "Response to Proposed Class Action Settlement" form. Objectors may withdraw their objections at any time. **Any objections, comments, or statements that do not comply with the above procedures and timeline will not be heard or considered by the Court.**

HOW TO GET MORE INFORMATION

This is a summary of the Settlement Agreement. If you have any questions about the matters contained in this notice or any questions regarding the settlement, you may write or call Class Counsel below:

DISABILITY LAW CENTER
205 North 400 West
Salt Lake City, UT 84103
(801) 363-1347

Toll Free: (800) 662-9080

RESPONSE TO PROPOSED CLASS ACTION SETTLEMENT

***DLC, et al. v. State of Utah, et al.*, Case No. 2:15-CV-00645-RJS-BCW**

Your Name: _____

Class Member's Name: _____

Criminal Case No.: _____

Relationship to Class Member: _____

Are you the Class Member's Legal Guardian? Yes ___ No ___

Your Mailing Address: _____

Your E-mail Address: _____

Your Telephone No.: _____

Objections/Comments/Statements:

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Do you want to provide oral testimony to the Court regarding the settlement? Yes __ No __

Date: _____ Signature: _____

EXHIBIT
4

CURRICULUM VITAE
Academic Year 2015-2016

NAME: Patrick K. Fox, M.D.

EDUCATION:

B.S., Rutgers University, New Brunswick, NJ 1990
M.D., UMDNJ-New Jersey School of Medicine, Newark, NJ 1994

CAREER:

September 2014-Present:
Colorado Department of Human Services
Chief Medical Officer

April 2013-Present:
Colorado Department of Human Services
Deputy Director of Clinical Services, Office of Behavioral Health

October 2013-July 2014 and December 2014-June 2015:
Colorado Department of Human Services
Acting Director, Office of Behavioral Health

April 1, 2012-March 31, 2013:
Denver Health and Hospital Authority
Attending Psychiatrist, Van Cise Simonet Detention Facility

July 1, 2007-March 31, 2012:
Yale University School of Medicine, Department of Psychiatry
Deputy Training Director, Forensic Psychiatry Fellowship

Director, Whiting Forensic Division, Connecticut Valley Hospital

July 1, 1999-June 30, 2007:
Yale University School of Medicine, Department of Psychiatry
Consulting Forensic Psychiatrist, DMHAS, state of Connecticut

July 1, 1997-March 31, 2012:
VA Connecticut Healthcare System
Employed as an Attending Psychiatrist on Duty, providing psychiatric care within the hospital, approximately fifteen hours per week.

June 1994-June 1999:
Yale University School of Medicine, Department of Psychiatry Post-Doctoral
-PGY V, Residency in Forensic Psychiatry, Law and Psychiatry Division, CMHC
-PGYIV, Chief Resident of PTSD/Anxiety Disorders Unit, West Haven VAMC
Psychiatrist for the New Haven Office of Court Evaluations
-PGYIII, West Haven Veterans Affairs Mental Hygiene Clinic
-PGY II, Inpatient Adult and Child Psychiatry Rotations
-PGY I, Transitional Medicine/Psychiatry/Neurology Program

ACADEMIC APPOINTMENTS:

Yale University School of Medicine, Department of Psychiatry
July 1, 1999-June 2008: Assistant Clinical Professor
July 1, 2008-April 2012: Assistant Professor

University of Colorado School of Medicine, Department of Psychiatry
April 1, 2012-Present: Senior Instructor

University of Denver, Graduate School of Professional Psychology
December 2012-Present: Adjunct Faculty

BOARD CERTIFICATION:

American Board of Psychiatry and Neurology, General Psychiatry: 1999, 2009
American Board of Psychiatry and Neurology, Forensic Psychiatry: 2001, 2011

PROFESSIONAL HONORS & RECOGNITION:

Recipient of the Laughlin Fellowship Award in Psychiatry-1998
Rutgers University Cooperative Academic Merit Scholarship-1990

DEPARTMENTAL, UNIVERSITY ACTIVITIES:

1999-2012: Weekly Supervisor for fellow/s, Fellowship in Forensic Psychiatry

1999-2012: Instructor, *Law & Psychiatry Seminar*, Fellowship in Forensic Psychiatry

1999-2012: Instructor, *Seminar in Law and Psychiatry*, Fellowship in Forensic Psychiatry

2000-2012: Coordinator/Instructor, *Public Sector Lecture Series*, Yale Forensic Psychiatry Fellowship

2000-2012: Member, Yale Department of Psychiatry Resident Selection Committee

2003-2007: Case write-up and interview tutor, Yale School of Medicine, Clerkship in Psychiatry

2004-2012: Instructor, *PGY II Seminar, Legal Regulation of Psychiatric Practice and Forensic Psychiatry*

2006-2012: Coordinator/Instructor, *Ethics in Research Module*, Scholarship Seminar, Fellowship in Forensic Psychiatry

2007-2012: Deputy Training Director, Fellowship in Forensic Psychiatry

2007-2012: Member, Yale University Graduate Medical Education, Program Director Committee

2008-2010: Coordinator, *Ethics in Research Seminar* for Yale Fellows in Public Sector Psychiatry and Research

2007-2012: Instructor, *Landmark Cases*, Fellowship in Forensic Psychiatry

2007-2012: Clinical Instructor, Yale Medical School Psychiatry ER Clerkship, West Haven VA

PROFESSIONAL SERVICE:

Professional Organizations

Member, American Psychiatric Association, 2008-present
Member, American Academy of Psychiatry and the Law, 2008-present
Member, Connecticut Psychiatric Society, 2008-2012
-Council Member, 2010-2012
Member, Colorado Psychiatric Society, 2012-present
Forensic Psychiatry Examination Committee, American Board of Psychiatry and Neurology, 2009-present

State of Colorado Committees

May 2013-July 2015: National Governors' Association, Prescription Drug Abuse Reduction Policy Academy

July 2013-October 2013: Co-chair, Civil Commitment Statute Review Task Force

August 2013-June 2015:	National Governors' Association, Super-utilizer Policy Academy
January 2014-present:	Governor's Marijuana Policy Workgroup
January 2015-present:	Commissioner, Suicide Prevention Commission-Colorado
May 2016-present:	Appointee, Mental Health/Point of Contact through Release from Jail Task Force, Commission on Criminal and Juvenile Justice

State of Connecticut Committees

1998-1999:	Participant, Committee to Study Sexually Violent Persons, State of Connecticut Office of Policy and Management
1999-2000:	Member, DMHAS Restraint/Seclusion Task Force, *Best Practices Report and Recommendations: Working Toward the Elimination of Restraint & Seclusion*.
1999-2000:	DMHAS representative, Committee to Study Credentialing of Sexual Offender Treatment Providers, State of Connecticut Office of Policy and Management.
2000:	Member, Committee for Psychosexual Evaluation and Treatment, DMHAS-state of Connecticut.
2000-2001:	DMHAS representative, Sex Offender Policy and Advisory Committee, state of Connecticut, Office of Policy and Management.
2001:	DMHAS representative, Special Populations Project: Model Development.
2002:	DMHAS-Division of Forensic Services representative, Preferred Practices Committee: Providing Services to those with Problem Sexual Behaviors.
2002:	DMHAS representative, Preferred Practices in Behavioral Health Workgroup.
2002:	DMHAS, Commissioner's Policy Work Group*: Limits to Confidentiality*.
2002-2003:	DMHAS representative, Sex Offender Policy and Advisory Committee, state of Connecticut, Office of Policy and Management.
2006-2012:	Governor's Appointee: Sex Offender Risk Assessment Board, state of Connecticut Judiciary Committee.

2007-2012: Member, DMHAS, Forensic Steering Committee.

2007-2012: DMHAS Commissioner's Appointee, *Lawyers Concerned for Lawyers-Connecticut, Inc.*

PRESENTATIONS:

October 1999*: Jail Diversion, Balancing of the Court's Interests*, American Academy of Psychiatry and the Law, Annual Convention, Madelon Baranoski, Ph.D., Patrick K. Fox, M.D., Josephine Buchanan, Baltimore, MD

October 2000*: Outpatient Civil Commitment*, American Academy of Psychiatry and the Law, Annual Convention, Patrick K. Fox, M.D., Paul Amble, M.D., Vancouver, BC.

August 2001: DMHAS-Connecticut, Forensic Grand Rounds, *Substance Abuse Relapse Prevention for Insanity Acquittees, Recent Research Findings*, presented at Connecticut Valley Hospital.

January 2002: University of Connecticut, School of Medicine/Correctional Mental Health Conference, *Sex Offenders: Risk Assessment, Management & the Possibilities for Treatment*, presented at UCHC, December 2001 and at Cheshire Correctional Center.

June 2002: Veterans Administration-Connecticut Healthcare System, Forensic Committee Conference, *Violence Risk Assessment*, and *Violence Risk Management*, presented at the West Haven Veterans Administration Hospital.

April 2004*: Competency to be Executed*, Yale Medical Student Psychiatric Association.

October 2004*: Melissa's Project: Probate Court-Monitored Treatment*, American Academy of Psychiatry and the Law, Annual Convention, Patrick K. Fox, M.D., Paul Amble, M.D., Michael Makniak, J.D., Scottsdale, AZ.

March 2007: DMHAS Training Seminar-Sex Offender Training, *A Clinical Perspective on Problem Psychosexual Behaviors*, presented at Connecticut Mental Health Center.

Dec. 2008: *Problem Sexual Behavior*, Connecticut Valley Hospital Grand Rounds

January 2008*: Physiological Response to Situations of Uncontrollable Stress*, Connecticut Valley Hospital Trauma Initiative Series.

October 2009: *Civil Rights and the Insanity Defense*, Yale Medical Student Psychiatric Association.

April 2010: *Festschrift for Howard Zonana: Attorney-Physician Collaboration*, Yale Department of Psychiatry Grand Rounds

July 2010: *Psychopathy and Sociopathy*, Yale Department of Psychiatry Grand Rounds

October 2010*: You Got Personality: Diagnostic Challenges in Forensics*, American Academy of Psychiatry and the Law, Annual Convention, Howard Zonana, MD, Madelon Baranoski, PhD., Patrick K. Fox, M.D., Josephine Buchanan, Tucson, AZ.

Feb. 2011*:* Invited lecturer, *Police Intervention with Persons with Mental Illness*, Henry C. Lee Institute of Forensic Science, University of New Haven.

March 2011*:* Invited lecturer, *Police Intervention with Persons with Mental Illness*, Henry C. Lee Institute of Forensic Science, University of New Haven.

April 2011*:* Invited lecturer, *Psychopathy*, Eastern Connecticut State University.

July 2011: *Physician-Assisted Suicide*, Yale Department of Psychiatry Grand Rounds

October 2011: *Thinking Outside the Witness Box: Novel Forensic Psychiatry Training Strategies*, American Academy of Psychiatry and the Law, Annual Convention, Brian Cooke, M.D., Reena Kapoor, M.D., Patrick Fox, M.D., Boston, MA

October 2011: *Restraint and Seclusion Reduction: Implications and Outcomes*, American Academy of Psychiatry and the Law, Annual Convention, Patrick Fox, M.D., Traci Cipriano, Ph.D., J.D., Paul D. Whitehead, M.D., Charles Dike, M.D., Boston, MA

Feb. 2012: *Mental Health Policy in the United States*, distinguished presenter to delegates from Fudan University, Shanghai Province, China, as part of the Yale Global Health Initiative

January 2013: *Inside the Mind of the Mass Murderer*, the Vail Symposium.

January 2014: *Assessment and Management of Problem Sexual Behaviors*, Colorado Mental Health Institute at Pueblo Grand Rounds

Feb. 2014: *Trans-institutionalization: Treatment of Persons with a Behavioral Health Disorder within the Criminal Justice System*, A Workshop of the Forum

on Global Violence Prevention. Institute of Medicine of the National Academies.

April 2015: *The Times, They are a Changin': State and National Developments and Trends in Behavioral Health Care Delivery*, Colorado Psychiatric Society Annual Meeting, Denver, Colorado

July 2015: *Science and Conscience: The Role of Mental Health Evaluators in Death Penalty Cases*, XXXIVth International Congress on Law and Mental Health, Sigmund Freud University, Vienna, Austria

Sept. 2016: *Managing a Limited Resource: Trends in Competency to Stand Trial Evaluations in Colorado*, Colorado State Judicial Conference, Vail, CO.

Dec. 2016: *Mental Health Evaluators and the Death Penalty*, American Bar Association National Summit on Severe Mental Illness and the Death Penalty, Georgetown University.

BIBLIOGRAPHY:

Morgan III, C.A., Hill, S.R., Fox, P.K., Kingham, P., & Southwick, S.M. Anniversary Reactions in Gulf War Veterans: A Follow-up Inquiry Six Years After the War. American Journal of Psychiatry 156:1075-1079, July 1999.

Charles A. Morgan III, Sheila Wang, John Mason, Steven M. Southwick, Patrick Fox, Gary Hazlett, Dennis M. Charney, and Gary Greenfield, Hormone Profiles in Humans Experiencing Military Survival Training. Biological Psychiatry 47:891-901, May 2000.

Patrick K. Fox, Commentary: Biases that Affect the Decision to Conditionally Release an Insanity Acquittee. Journal of the American Academy of Psychiatry and the Law 36:337-9, 2008.

Patrick K. Fox, Commentary: Medicine, Law and Howard Zonana. Journal of the American Academy of Psychiatry and the Law 38:4:592-593 (2010)

Patrick K. Fox, Commentary: So the Pendulum Swings-Making Sense of the Duty to Protect. Journal of the American Academy of Psychiatry and the Law 38:4:474-478 (2010)

Faculty Reviewer: Stead L, Kaufman M, Yanofski J, First Aid for the Psychiatry Clerkship, third edition

Wasser, Tobias D., Fox, Patrick K. For Whom the Bell Tolls – Silver Alerts Raise Concerns Regarding Individual Rights and Governmental Interests. Journal of the American Academy of Psychiatry and the Law 170:9: (2013)

Martinez, R., Fox, P *Chapter 10: Confidentiality in Psychiatric Practice*, Textbook of Forensic Psychiatry, APA Publishing, In publication, (2016)

Aaron M. Kinikini (10225)
Erin B. Sullivan (15462)
DISABILITY LAW CENTER
205 North 400 West
Salt Lake City, Utah 84103
Telephone: (801) 363-1347
Fax: (801) 363-1437
Email: akinikini@disabilitylawcenter.org
esullivan@disabilitylawcenter.org

Alan L. Sullivan (3152)
Bret Evans (15131)
SNELL & WILMER L.L.P.
15 West South Temple, Suite 1200
Gateway Tower West
Salt Lake City, Utah 84101
Telephone: (801) 257-1900
Facsimile: (801) 257-1800
Email: asullivan@swlaw.com
brevans@swlaw.com

Attorneys for Plaintiffs

IN THE UNITED STATES DISTRICT COURT IN AND FOR

THE DISTRICT OF UTAH, CENTRAL DIVISION

DISABILITY LAW CENTER, a Utah nonprofit corporation; S.B., an individual, by and through his next friend Margaret Goodman; A.U., by and through his next friend Mary Eka; and S.W., an individual, Plaintiffs, vs. STATE OF UTAH; UTAH DEPARTMENT OF HUMAN SERVICES; ANN WILLIAMSON, in her official capacity as Executive Director of the Utah Department of Human Services; UTAH DIVISION OF	**ORDER** Case No. 2:15-CV-00645-RJS-BCW Judge Robert J. Shelby

SUBSTANCE ABUSE AND MENTAL HEALTH; DOUGLAS THOMAS, in his official capacity as Director of the Utah Division of Substance Abuse and Mental Health; UTAH STATE HOSPITAL; DALLAS EARNSHAW, in his official capacity as Superintendent of Utah State Hospital, Defendants.	

Based on the Joint Motion for (1) Approval of Settlement Agreement and Class Notices, (2) Appointment of Monitor, and (3) Stay of Proceedings (June 12, 2017) (hereinafter the "Joint Motion"), and good cause appearing therefor, the Court hereby orders as follows:

1. The Court preliminarily determines that the Settlement Agreement annexed as Exhibit 1 to the Joint Motion is fair, reasonable, and adequate.

2. The Court approves the notices annexed as Exhibits 2 and 3 to the Joint Motion.

3. The Court will hold a fairness hearing on the fairness, reasonableness, and adequacy of the Settlement Agreement on _____, 2017, at _____ a.m./p.m.

DATED this _____ day of _____, 2017.

BY THE COURT:

_____
Robert J. Shelby
United States District Court Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 11-CV-02285-NYW

CENTER FOR LEGAL ADVOCACY, d/b/a
DISABILITY LAW COLORADO,

Plaintiff,

v.

MICHELLE BARNES,
in her official capacity as Executive Director
of the Colorado Department of Human Services, and

JILL MARSHALL,
in her official capacity as Chief Executive Officer
of the Colorado Mental Health Institute at Pueblo,

Defendants.

CONSENT DECREE

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THIS MATTER comes before the Court pursuant to the Parties' Joint Motion for Approval and Entry of Consent Decree.

THE PARTIES, by and through their respective counsel, have jointly stipulated to all facts set forth herein and agreed to entry of a consent decree to resolve this Lawsuit under the terms and conditions set forth herein.

THE COURT, having reviewed the Parties' Joint Motion for Approval and Entry of Consent Decree and being fully advised in the matters contained therein, hereby FINDS that good cause exists for approval and entry of the Consent Decree as follows:

I. FINDINGS OF FACT AND CONCLUSIONS OF LAW REGARDING THE CONSENT DECREE

1. On August 31, 2011, Plaintiff, the Center for Legal Advocacy, d/b/a Disability Law Colorado ("DLC") commenced this action (the "Lawsuit") against Defendants Reggie Bicha, in his official capacity as Executive Director of the Colorado Department of Human Services, and Teresa Bernal, in her official capacity as Interim Superintendent of the Colorado Mental Health Institute at Pueblo ("CMHIP"), challenging Defendants' alleged failure to comply with the Due Process Clause of the Fourteenth Amendment to the United States Constitution, which requires Defendants to timely provide competency evaluations and restoration treatment to pretrial detainees in Colorado jails.

2. The Colorado Department of Human Services (the "Department") has a statutory obligation under C.R.S. §§ 16-8.5-101 *et seq*. (2018) to provide competency evaluations for persons charged with criminal offenses when the issue of competency is raised, and to provide restoration treatment for persons found incompetent to proceed.

3. The Parties settled the Lawsuit pursuant to a Settlement Agreement executed on April 6, 2012 (the "2012 Settlement Agreement"), which was incorporated into the Order of Dismissal entered by the District Court in the Lawsuit. Dkt. 52.

4. The 2012 Settlement Agreement included a provision called Special Circumstances, which recognized that to some extent the Department's ability to perform its statutory obligations and its obligations under the 2012 Settlement Agreement is based on factors beyond the Department's control. Dkt. 51-1.

5. The Department invoked Departmental Special Circumstances on August 3, 2015, citing: (1) the dramatic increase in court referrals for evaluations and treatment; and (2) unprecedented staffing shortages at CMHIP. DLC disputed the Department's invocation and filed a motion to reopen the litigation for enforcement of the 2012 Settlement Agreement, which this Court granted. Dkt. 62. After the Parties conducted settlement negotiations, they entered into an Amended and Restated Settlement Agreement which was filed with the Court on July 28, 2016 (the "2016 Settlement Agreement"). Dkt. 78.

6. Another dispute has arisen between the Parties. The Department invoked Departmental Special Circumstances for the second time on June 22, 2017, citing in support an unanticipated spike in court-ordered referrals for inpatient competency evaluations and restorations. On December 22, 2017, the day the Department's June 22, 2017 invocation was set to expire, the Department invoked Departmental Special Circumstances for a third time, citing a sustained increase in the number of court-ordered referrals for inpatient competency evaluations and restorations. DLC disputed the Department's second and third invocations as improper under the terms of the 2016 Settlement Agreement. Defendants' present inability to comply with the timeframes required by the 2016 Settlement Agreement has created a lengthy waitlist of pretrial

detainees, some of whom have been forced to wait in jail for more than 150 days for a competency evaluation or restoration treatment.

7. DLC moved to reopen the action for enforcement of the 2016 Settlement Agreement on June 13, 2018 (Dkt. 82), and this Court entered an order reopening that matter on June 14, 2018. Dkt. 83.

8. The parties filed cross-motions for summary judgment (Dkts. 96 and 97) and this Court held a September 28, 2018 hearing on them. This Court issued an order on November 9, 2018 granting in part and denying in part DLC's motion for summary judgment and denying Defendants' motion for summary judgment. Dkt. 113. This Court held that: (1) the 2016 Settlement Agreement permits Defendants to invoke Departmental Special Circumstances consecutively; and (2) the Defendants have been in breach of the 2016 Settlement Agreement's timeframes for inpatient restorations since June 2018. *Id.* The Court found that in each month from July 2017 through the present, Defendants have failed to maintain a 24-day monthly average for inpatient restoration treatment. The Court reserved ruling on whether Defendants breached the 2016 Settlement Agreement by their invocations of Departmental Special Circumstances in June 2017 and December 2017 and whether the Defendants acted in bad faith.

9. The Court set this matter for a five-day evidentiary hearing to commence on March 18, 2019 on whether Defendants properly invoked Departmental Special Circumstances in June 2017 and December 2017, so the Court can rule upon a forthcoming motion by DLC to enforce and to determine the appropriate scope and terms of an injunction going forward to address the Department's performance of inpatient restoration services. Dkt. 113.

10. After setting the case for hearing and commencing discovery, this Court granted DLC's motion for appointment of a Special Master. Dkts. 117 & 123. On December 28, 2018, the

Court appointed Groundswell Services and its team of Drs. Neil Gowensmith and Daniel Murrie as Special Master in this matter. Dkt. 130. Their duties, duration, and scope are outlined in the Order Appointing Special Master. Dkt. 130.

11. On January 28, 2019, pursuant to the Court's order, the Special Master submitted a report with a Review of the Department's Plan for Compliance and provided recommendations regarding the Plan. Dkt. 146.

12. On January 30, 2019, the Parties notified the Court that they agreed to mediate a resolution. The Court stayed discovery production, and the March 18, 2019 hearing was reset to commence on June 3, 2019, in the event mediation was unsuccessful. The Court set a March 15, 2019 deadline to produce a signed Consent Decree or to file a joint status report if the Parties cannot reach an agreement.

13. This Consent Decree resolves the Lawsuit. This Consent Decree is being entered in order to ensure that pretrial detainees obtain timely competency evaluation and restoration services, while both avoiding harming other persons with mental or developmental disabilities in the Department's care and avoiding protracted, costly and uncertain litigation. The terms of that resolution are embodied in this Consent Decree.

NOW, THEREFORE, with the consent of the Parties to this Decree, it is hereby ORDERED, ADJUDGED, AND DECREED that:

II. PARTIES, PURPOSE, INTENT

14. DLC is an independent nonprofit corporation headquartered in Denver, Colorado. DLC was designated in 1977 by Governor Richard Lamm as Colorado's protection and advocacy system ("P&A System") to protect and advocate for the rights of persons with mental illness and developmental disabilities under the Developmental Disabilities Assistance and Bill of Rights Act. 42 U.S.C. §§ 15041-45. Since 1986, DLC has received federal grants on an annual basis, and has

established and administered a P&A System in Colorado for individuals with mental illness pursuant to 42 U.S.C. §§ 10803 and 10805 of the Protection and Advocacy for Individuals with Mental Illness Act (the "PAIMI Act"). Since 1986, DLC has been and is currently the eligible P&A System for individuals with mental illness in Colorado as defined at 42 U.S.C. § 10802(2).

15. DLC has a governing board of directors which is composed of members who broadly represent and who are knowledgeable about the needs of individuals with mental illness. DLC's board of directors includes members who have received or are receiving mental health services or who have family members who have received or are receiving mental health services.

16. DLC's constituents include individuals with mental illness, who have been abused, neglected and/or suffered civil rights violations. DLC has established a PAIMI Advisory Council, over sixty percent (60%) of whose members themselves have received or are receiving mental health services or have family who have received or are receiving mental health services. The PAIMI Advisory Council advises the P&A System on the policies and priorities designed to protect and advocate for the rights of individuals with mental illness. The Chair of DLC's PAIMI Advisory Council, who is also a member of DLC's board of directors, has a family member who has received and is receiving mental health services.

17. Together, DLC's board of directors and PAIMI Advisory Council have developed the annual priorities and objectives of the P&A System for individuals with mental illness. DLC's PAIMI Program Priorities and objectives state that DLC will monitor facilities, including jails, and investigate reports/complaints of abuse, neglect and rights violations, and take action to remedy any abuse, neglect and/or civil rights violations. When the rights of its constituents are violated, DLC is authorized by statute to pursue legal remedies on their behalf, such as through litigation. 42 U.S.C. § 10805(a)(1)(A)(B) & (C). To the extent DLC expends its resources to protect the rights

of its constituents in county jails waiting for competency evaluations or restoration treatment, its resources are diverted away from assisting other constituents.

18. DLC has established a public opinion survey for constituents and interested persons, such as family members, to comment on DLC's priorities and objectives and a grievance procedure for clients or prospective clients, which allows its constituents with mental illness and family members of such individuals to assure them that DLC and the PAIMI Program are operating in compliance with the provisions of the PAIMI Act.

19. DLC's constituents who are detained and charged with crimes are hindered from asserting their own constitutional rights. Obstacles they face include the imminent mootness of individual claims as they are likely to be admitted to CMHIP for restoration treatment during the pendency of any case they might bring. In addition, pretrial detainees who are presumed or determined to be incompetent to proceed are often impaired and unable to direct or participate in litigation on their own behalf.

20. Defendant Michelle Barnes is sued in her official capacity as the Executive Director of the Colorado Department of Human Services. As relevant here, the Department is responsible under Colorado law for the operation of CMHIP and the provision of competency evaluations and restoration treatment. Forensic Services within the Department's Office of Behavioral Health provides court-ordered competency evaluations.

21. Defendant Jill Marshall is sued in her official capacity as the Chief Executive Officer of CMHIP. As relevant here, CMHIP currently is the state's principal forensic mental health hospital that accepts custody of pretrial detainees for competency evaluations and restoration treatment.

22. This Consent Decree will require the Department to ensure that thousands of future pretrial detainees will not be forced to wait in jail for months before receiving their court-ordered competency evaluations and restoration treatment in violation of their constitutional rights; at the same time, the Department will avoid negatively impacting other persons with mental health or developmental disabilities or juveniles in their care. In doing so, the Department will be required to implement concrete reforms that will allow for long-term compliance with this Consent Decree. The Parties believe that with the guidance of the Court and the Special Master (to be discussed *infra*) the Department will be able to:

(a) Develop a comprehensive, cohesive approach to planning to maintain compliance with this Consent Decree.

(b) Adhere to the admission timeframes for pretrial detainees, and at the same time avoid causing harm to and/or displacement to other people with mental or developmental disabilities in their care.

(c) Maximize the use of competency services in the community, by funding, developing, recruiting, and supporting a variety of community services. Dkt. 146.

(d) Create a team that will develop a centralized, data-driven system that captures, analyzes, and disseminates data in a reliable and meaningful manner to inform decisions and planning. *Id.*

(e) Develop and implement a triage system that considers clinical needs to assign individualized services. *Id.*

(f) Implement state-wide uniform standards for competency evaluators and evaluations and conduct rigorous training for forensic evaluators and restoration providers to ensure evaluations are of high quality. *Id.*

(g) Prepare budget requests and propose and support legislation which are calculated to meet the terms of the Consent Decree and take all necessary next steps and exert good faith efforts to obtain adequate funding from the Colorado General Assembly.

III. JURISDICTION, VENUE, AND STANDING

23. This Court has jurisdiction over this action pursuant to 28 U.S.C. §§ 1331 and 1343(a)(3) because it arises under the Fourteenth Amendment to the United States Constitution and 42 U.S.C. § 1983. This Court also has jurisdiction under the Declaratory Judgment Act, 28 U.S.C. §§ 2201-02.

24. Venue is appropriate in this Court under 28 U.S.C. § 1391(b)(2) because the events giving rise to this Complaint occurred in this District.

25. DLC has standing in the Lawsuit to assert due process claims on behalf of its constituents, persons within the State of Colorado with a mental illness and/or intellectual disability who have been charged with a criminal offense, ordered to receive a competency evaluation or restoration treatment, and who await the provision of that treatment in Colorado jails.

IV. PARTIES BOUND AND INTERPRETATION OF THIS AGREEMENT

26. In entering this Consent Decree, Defendants do not admit any violation of law. This Consent Decree shall not be interpreted in any court, administrative, or other proceeding as evidence of Defendants' liability.

27. The parties agree that the right to timely competency services implicates rights secured and protected by the Fourteenth Amendment of the United States Constitution, Article 1, and 42 U.S.C. §1983.

28. This Consent Decree is legally binding and judicially enforceable. This Consent Decree shall be applicable to and binding upon the parties, their officers, agents and employees, and their successors and assigns.

29. Until the Consent Decree is terminated, the parties hereby consent to the Court's continuing supervision in this matter, until further order of the Court, and to its authority to interpret the provisions of this Agreement, to review and adopt plans necessary to implementation of its terms, to modify its terms as may be needed to effect its purposes, and to take appropriate actions within its equitable powers to ensure its enforcement and the fulfillment of its terms and purposes.

30. The terms of this Consent Decree shall be interpreted consistent with its overall purposes and principles.

V. DEFINITIONS

31. The following terms shall have the meanings set forth below (the definitions to be applicable to both the singular and the plural forms of each term defined if both forms of such term are used in this Consent Decree):

(a) "Arrest Date" means the day, month, and year a Pretrial Detainee was arrested for the case in which competency has been raised.

(b) "Collateral Materials" means the relevant police incident reports and the charging documents, either the criminal information or indictment.

(c) "Community-Based Competency Evaluation" means a Competency Evaluation of a Community-Based Service Recipient that is ordered to be performed out of custody and in conjunction with a community-based mental health center or community organization.

(d) "Community-Based Restoration Treatment" means Restoration Treatment of a Community-Based Service Recipient that is ordered to be performed out of custody and in conjunction with a community-based mental health center or community organization.

(e) "Community-Based Services Recipient" means a defendant who has been ordered to receive a Community-Based Competency Evaluation or Restoration Treatment.

(f) "Competency Evaluation" means a court-ordered evaluation for competency to proceed, administered by the Department, and the accompanying report prepared by the Department and more fully described in C.R.S. §§ 16-8.5-103, 105.

(g) "Competency Services" means Competency Evaluations and Restoration Treatment.

(h) "Competency Services Recipient" means a Pretrial Detainee or a Community-Based Services Recipient.

(i) "Competent to Proceed" means that a court has ordered that a defendant in a criminal case does not have a mental disability or developmental disability that prevents the defendant from having sufficient present ability to consult with the defendant's lawyer with a reasonable degree of rational understanding in order to assist in the defense or prevents the defendant from having a rational and factual understanding of the criminal proceedings. C.R.S. § 16-8.5-101(4).

(j) "County Jail" means a jail or detention facility which houses a Pretrial Detainee. County Jail does not include a behavioral health unit located within a county jail (e.g., RISE).

(k) "Court Order" means a written order, issued by a court, and signed by a judge that directs the transfer of custody of a Pretrial Detainee to the Department.

(l) "Court Liaison" means a person who is hired by the Colorado Judicial Branch's State Court Administrator's Office as a dedicated behavioral health court liaison in each state judicial district, pursuant to C.R.S. §§ 16-11.9-203, 204, who facilitates

communication and collaboration between judicial and behavioral health systems, and keeps judges, district attorneys, and defense attorneys informed about the availability of community-based behavioral health services.

(m) "Days Waiting" means the number of days elapsed between the Ready for Admission date and the Offered Admission date.

(n) "Department" means the Colorado Department of Human Services. Any reference to the Department includes the Office of Behavioral Health and the Hospital, which are divisions of the Department and do not have independent authority or obligations under Title 16, Article 8.5, C.R.S.

(o) "Department Plan" mean the Department's comprehensive description of its efforts to achieve long-term compliance with this Consent Decree by providing timely competency services without undermining the broader system of mental health care.

(p) "Evaluator Signed Date" means the date the Jail Competency Evaluation is signed by the evaluator after having been completed.

(q) "Hold and Wait Evaluation" means an in-custody evaluation of a Pretrial Detainee that is conducted in another facility, after transport by the sheriff of the commitment county to the alternative facility. For example, a sheriff in a county in which there are no evaluation services may transport the Pretrial Detainee to the nearest county where these services are available, wait for the evaluator to complete the interview and examination, and return the Pretrial Detainee to the jail in the county of commitment.

(r) "Hospital" means the Colorado Mental Health Institute at Fort Logan (CMHIFL) or Colorado Mental Health Institute at Pueblo (CMHIP).

(s) "Inpatient Competency Evaluation" means a Competency Evaluation of a Pretrial Detainee that is ordered to be performed at the Hospital or in a separate locked facility that is established for the purpose of providing Inpatient Competency Evaluations and Restoration Treatment. This includes Competency Evaluations conducted at the RISE program or a similar program located on a dedicated behavioral health unit at a county jail.

(t) "Inpatient Restoration Treatment" means the Restoration Treatment of a Pretrial Detainee that is performed at the Hospital or at a separate locked facility that provides comprehensive Restoration Treatment to the Pretrial Detainee. This includes Restoration Treatment that is provided at the RISE program or a similar program located on a dedicated behavioral health unit at a county jail.

(u) "Interim Jail Mental Health Treatment" means mental health treatment of a Pretrial Detainee that is performed in the County Jail where the Pretrial Detainee is held while the Pretrial Detainee awaits Community-Based or Inpatient Restoration Treatment per Court Order consistent with the timeframes in the Consent Decree.

(v) "Jail Competency Evaluation" means a Competency Evaluation performed in the County Jail where the Pretrial Detainee is being held.

(w) "Medically Cleared" means that a Pretrial Detainee is, in the opinion of the Department's medical staff, appropriate for Inpatient Competency Evaluation or Inpatient Restoration Treatment.

(x) "Offered Admission Date" means the date the Department offers the Pretrial Detainee admission for Inpatient Restoration Treatment or Inpatient Competency Evaluation. Before the Department offers admission to a Pretrial Detainee, the following three criteria must be satisfied: (1) the Department has an open bed for the Pretrial Detainee

at the location for the Inpatient Evaluation or Inpatient Restoration Treatment; (2) the location for Inpatient Evaluation or Inpatient Restoration Treatment is ready to receive the Pretrial Detainee for admission; and (3) the Department notifies the County Jail of the same.

(y) "Pretrial Detainee" means a person who is being held in the custody of a County Jail and whom a court has ordered to undergo Competency Services. Persons serving a sentence in the Department of Corrections and juveniles are excluded from this Consent Decree.

(z) "Ready for Admission Date" means the date on which the Department has received the Court Order for Competency Services and, in the case of Competency Evaluations or Restoration Treatment when the Competency Evaluation was not conducted by the Department, the Department has also received the Collateral Materials.

(aa) "Restoration Treatment" means mental health care and treatment provided for the purpose of restoring a Competency Services Recipient.

(bb) "Settlement Payment" has the meaning set forth in Part XIII.

(cc) "Special Master" means Court-appointed Groundswell Services and its team of Drs. Neil Gowensmith and Daniel Murrie (Dkt. 130), or any successor appointee whose duties and authority are set forth in Dkt. 130 and in this Consent Decree.

(dd) "Tier 1" means a Pretrial Detainee who has been ordered to receive Inpatient Restoration Treatment and whom a competency evaluator has determined either: (1) appears to have a mental health disorder and, as a result of such mental health disorder, appears to be a danger to others or to himself or herself, or appears to be gravely disabled

or (2) has a mental health disorder, and as a result of either (1) or (2), delaying hospitalization beyond seven days would cause harm to the Pretrial Detainee or others.

(ee) "Tier 2" means a Pretrial Detainee who has been ordered to receive Inpatient Restoration Treatment and who does not meet Tier 1 criteria.

VI. TIMEFRAMES

32. Recent Compliance with Timeframes. The Department has been out of compliance with the 2016 Settlement Agreement Timeframes to provide timely restoration services since June 2017. The Department has complied with the required timeframes to provide competency evaluations since May 2018 but was out of compliance for those timeframes from June 2017 to April 2018. Dkt. 113 ¶ 39 & Chart 2.

33. Timeframes

(a) Admission of Pretrial Detainees for Inpatient Competency Evaluations and Restoration Treatment. The Department shall Offer Admission to Pretrial Detainees to the Hospital for Inpatient Restoration Treatment or Inpatient Competency Evaluations pursuant to the attached table (**Table 1**). Compliance with this measure shall be calculated based on the number of Days Waiting for each Pretrial Detainee.

(b) Performance of Jail Competency Evaluations. The Department shall complete all Jail Competency Evaluations of a Pretrial Detainee pursuant to the attached table (**Table 1**), after the Department's receipt of a Court Order directing the evaluation and receipt of Collateral Materials. This timeframe requirement shall apply to the following counties: Adams, Alamosa, Arapahoe, Boulder, Broomfield, Crowley, Custer, Denver, Douglas, El Paso, Elbert, Fremont, Huerfano, Jefferson, Larimer, Mesa, Otero, Pueblo, Teller, and Weld. Counties not specifically identified are counties that use the "Hold and Wait" court ordered process. Counties utilizing the Hold and Wait Evaluation process will

be offered a meeting date within 30 days of the Department's receipt of the Court Order and Collateral Materials, and the evaluation will be completed within 30 days of the meeting. Beginning January 1, 2020, counties utilizing the Hold and Wait Evaluation process will be offered a meeting date within 30 days of the Department's receipt of the Court Order and Collateral Materials, and the evaluation will be completed within 14 days of the meeting.

34. Interim Jail Mental Health Treatment. If the court does not release the Pretrial Detainee to Community-Based Restoration Treatment and the Pretrial Detainee is awaiting receipt of Inpatient Restoration Treatment, the Department shall work with the County Jails to develop a program to assist in the provision of coordinated services for individuals in accordance with C.R.S. §§ 27-60-105 *et seq.* to screen, treat, assess, and monitor for triage purposes Pretrial Detainees in the least restrictive setting possible. This paragraph does not toll or otherwise modify the Department's obligation to Offer Admission to the Pretrial Detainees for Inpatient Restoration Treatment. Interim Jail Mental Health Treatment shall not replace or be used as a substitute for Inpatient Restoration Treatment but does not preclude the Department from providing Restoration Treatment. A member of the Forensic Support Team shall report to the Court Liaison every 10 days concerning the clinical status and progress towards competency of the Pretrial Detainee.

35. Release of Pretrial Detainees for Community-Based Restoration Treatment. If the court releases the Pretrial Detainee on bond to commence Community-Based Restoration Treatment, the Department shall coordinate with the Court Liaison to develop a discharge plan (in a format approved by the Special Master) within seven days of the order to all parties involved in the Community-Based Services Recipient's case, and the Court Liaison and community-based provider.

36. Transportation of Pretrial Detainees. If a Pretrial Detainee is transported to the Hospital for an Inpatient Competency Evaluation and the Department or a medical professional opines that the Pretrial Detainee is incompetent and the provisions of C.R.S. § 27-65-125 have been met, the Department shall not transport the Pretrial Detainee back to his/her originating jail.

37. Daily Fines for Non-Compliance with Timeframes. Beginning on June 1, 2019, through the conclusion of the Consent Decree, the Department agrees to comply with timeframes and fines as set forth in the attached table (**Table 1**). Such fines shall be capped on a June 1 to May 31 timeframe at $10,000,000, indexed for inflation yearly pursuant to the CPI-U. The liquidated damages for material violations as set forth in Paragraph 60(c) shall not be counted toward this cap.

38. Notification of Non-Compliance with Timeframes. The Department shall notify the Special Master and DLC weekly regarding any non-compliance with timeframes.

(a) Only one notice per Pretrial Detainee shall be provided and should include:

(i) The name of the Pretrial Detainee;

(ii) The Pretrial Detainee's location;

(iii) The Pretrial Detainee's charges based on information available to the Department;

(iv) The Pretrial Detainee's bond amount based on information available to the Department;

(v) Whether a forensic assessment has been made on whether restoration in the community is appropriate;

(vi) Whether the Pretrial Detainee has previously been found incompetent;

(vii) What efforts are being made to provide timely Competency Services to the Pretrial Detainee, including communications with the court, Court Liaisons, and community mental health providers;

(b) The Department shall accompany its Monthly Data Report (*see* Paragraph 52) with a separate "Fines Report" which will include the names of the Pretrial Detainees for whom the Department has accrued a fine during the preceding month, the number of days each Pretrial Detainee waited in the County Jails past the timeframes for compliance, and the total fines owed by the Department for the preceding month.

(c) The Department shall pay the total fines owed on the date the Fines Report is submitted to the Special Master to be deposited in an interest-bearing account created for the purpose of funding non-Department services for persons with mental illness. The account will be managed by a third-party agreed upon by the parties; the parties will identify and agree to said third-party no later than **December 31, 2019**. Decisions concerning payments out of the account will be made by a committee consisting of a representative from the Plaintiff, a representative from the Department, and the Special Master. Any disputes regarding the fines or third-party account manager shall be handled through the dispute resolution process identified in Paragraph 59.

VII. ADDITIONAL REQUIRED ACTION FOR SUSTAINABLE LONG-TERM COMPLIANCE

39. Civil Bed Freeze. The Department's 2018 Plan included an effort to freeze civil admissions to its beds to devote Hospital beds to perform Inpatient Restoration Treatment services. On February 7, 2019, the Department agreed to stop this practice. The Department will continue to leave the state's civil and juvenile beds allocated as of the execution of this Consent Decree for civil and juvenile psychiatric admissions and will not freeze or convert those beds to provide competency services for Pretrial Detainees, unless the Department receives prior agreement from

the Special Master to use unutilized beds for such purposes. This strategy to facilitate compliance with the Consent Decree shall only be re-implemented in the future upon agreement of the Special Master.

40. Comprehensive and Cohesive Plan. The Special Master's first recommendation was to revise the Department's 2018 Plan into a more comprehensive and cohesive plan. Dkt. 146. By or about January 2020, the Department will produce an initial plan resulting from a long-term visioning process with DLC, the Special Master, and stakeholders that will consolidate disparate pieces of the Department's current plan, along with legislative initiatives, in a cohesive package for courts, administrators, service providers, and legislators to consider. As referenced in the Special Master's Recommendation Number 7, the 2020 Plan will highlight the methods to prioritize quality amid quantity and time pressures. Dkt. 146 at 42. On an annual basis thereafter, the Department will review and revise the plan as appropriate based upon data provided by the Department.

41. Increase Community Restoration Services. The Parties agree that the Department is responsible for directly providing or contracting with individuals or agencies to provide Competency Services. The Parties agree that County Jails are not the best place for Pretrial Detainees to wait for treatment or receive treatment. The Parties agree that it is in the best interests of some Pretrial Detainees to receive Competency Services in the community, as those Pretrial Detainees will avoid unnecessary institutionalization and will receive treatment in the least restrictive environment. Additionally, the movement of appropriate Pretrial Detainees to the community will lessen the need for more Hospital beds and hiring additional qualified staff by the Department. The Parties agree that increased community restoration is a key component to comply with the timeframes in this Consent Decree as to Competency Services. The Special Master's

Recommendation Number 2 is for the Department to "[r]educe emphasis on inpatient beds and increase emphasis on community services." Dkt. 146 at 17. The Special Master's Recommendation Number 3 is to "[f]urther prioritize outpatient competence restoration." Dkt. 146 at 23. As a result, the Department shall:

(a) Implement a coordinated wide-scale outpatient (community-based) competency restoration (OCR) system. This system shall be integrated and submitted with the "Comprehensive and Cohesive Plan" referenced in Paragraph 40 herein. This plan shall be approved by the Special Master.

(b) The Department may utilize private hospital beds to meet the needs of Pretrial Detainees meeting C.R.S. § 27-65-105(a) civil commitment criteria and with prioritization to Pretrial Detainees already residing within the same geographic location. The Department shall create a plan to implement this subsection (b) to be approved by the Special Master.

(c) The Department currently estimates that 10-20% of Pretrial Detainees admitted for inpatient restoration do not need hospital-level care. Dkt. 146 at 29. The Department will make best efforts to reduce inpatient restoration hospitalizations by 10% and increase community restorations by 10% in six-month increments beginning June 1, 2019. The baseline for the preceding sentence will be determined by the Special Master by June 1, 2019, utilizing data provided by the Department. On June 1, 2020, the Special Master will establish a modification of this guideline based upon a survey of the data collection and implementation of the Department's Plan.

42. Additional Department Hires. By June 1, 2019, the Department shall submit a plan to the Special Master and DLC to hire the following positions by August 1, 2019. The

Department's plans and job descriptions shall be guided by the recommendations of the Special Master and the January 28, 2019 Special Report. *See* Dkt. 146.

(a) Forensic Support Team. The Forensic Support Team will be formalized to follow the Special Master's Recommendation Number 6. Dkt. 146. The team will include a full-time Supervising Coordinator who is familiar with the Department's duties and obligations herein, as well as the Department's and Hospital's processes and procedures in providing services to Pretrial Detainees, and whose responsibilities will include to: (1) interface with the Colorado Department of Health Care Policy and Financing (HCPF) regarding persons ordered to be evaluated for competency and those determined to be incompetent; (2) confer with the Special Master; (3) focus on budget and cost of inpatient versus outpatient care; (4) work directly with Office of Behavioral Health staff to assist in reducing the waitlist and meeting the timeframes of the Consent Decree; and (5) interface with the Court Liaisons or representatives funded by the judiciary to interface with the courts, Department, and community mental health centers. The Supervising Coordinator will work directly with the Special Master to ensure the Department's compliance with the terms of this Consent Decree and to assist with other issues involving Pretrial Detainees on an individual or system-wide basis to increase the Department's performance with providing timely Competency Services. In addition, the Forensic Support Team will include an effective number of coordinators (to be approved by the Special Master) responsible for each judicial district who can provide a centralized structure for stakeholders to immediately access detailed information about programs, clients, and settings and can complement the Court Liaison Program.

(b) Data Management Team. The Data Management Team will be formalized in a plan on the schedule identified in Paragraph 42 to follow the Special Master's Recommendation Number 5. Dkt. 146. This team will be dedicated and designed to specifically assist with implementation of the Department's Plan by collecting specific data on which the Department will base its projections and recommendations, calculate inpatient bed space, assess community restoration capacity, and determine financial estimates. The team will be comprised of at least three full-time employees dedicated to collecting and analyzing data affecting the competency system. The Special Master shall approve of the type of employees that shall be hired to comprise the Data Management Team.

43. Develop and Implement a Triage System. The Special Master's Recommendation Number 4 recognizes a need for the Department to prioritize a triage approach over traditional waitlist approaches. Dkt. 146 at 27. Therefore, by June 1, 2019, the Department shall develop and implement a triage system to screen each Pretrial Detainee and make recommendations to the committing court as to the most clinically appropriate level of care to restore the Pretrial Detainee to competency. The Department shall seek suggestions from the Special Master on the development of a triage system, and two weeks prior to the implementation of the triage system it shall be approved by the Special Master. The Department shall continue to fine-tune the triage system with the assistance of the Special Master and shall include the progress of the triage system in its annual submission of the Department Plan.

44. Legislative Actions. The Parties agree that they will not propose, sponsor, or support any legislation that would violate the terms of this Consent Decree. The Department will provide DLC and the Special Master with all budget requests and proposed legislation affecting

this Consent Decree when they are sent to the Colorado General Assembly. The Special Master shall provide its opinion and recommendations on the proposed legislation and how it could impact the short- or long-term compliance with the Consent Decree. A copy of the final budget approved by the Colorado General Assembly shall be sent to the Special Master and DLC immediately following approval of the budget.

VIII. SPECIAL MASTER AND REPORTING OBLIGATIONS

45. Selection of a Special Master. The Court has appointed Groundswell Services and its team of Drs. Neil Gowensmith and Daniel Murrie as the Special Master. Dkt. 130.

46. Special Master Duties and Reporting. The Special Master's duties have been set forth by the Court in its Order appointing the Special Master and are fully incorporated and amended as set forth in this Consent Decree. Dkt. 113 at 6-7 §§ A(1)-(11); *id.* at 7-8 § B.

(a) Special Master Duties:

(i) Review and approve of the Department's Plans to increase timeliness of performance of Competency Services.

(ii) Recommend plans for the Department's consideration that propose methods for addressing short- and long-term compliance with the timeframes for Competency Services that may ultimately be adopted in whole or in part as part of the Court's injunctive relief to address the ongoing breach of the Amended and Restated Settlement Agreement, and compliance with the Consent Decree.

(iii) Develop a system of data collection, review, and analysis of Departmental data and continued monitoring related to Competency Services, to include reporting by the Department to the Special Master (timing identified below) and reporting by the Special Master (timing identified below) analyzing such data and making recommendations to the Court and the Parties based on such data.

(iv) Identify actual areas within the statewide system which have caused, are causing, or may cause non-compliance with the timeframe requirements of the Consent Decree concerning delivery of Competency Services.

(v) Make recommendations to the Department for improved performance in the timely delivery of Competency Services.

(vi) Assist and approve the Department's design of a plan to address compliance with the Consent Decree timeframes concerning delivery of Competency Services, support the Department's implementation of its plan, and monitor the Department's compliance with all terms of the Consent Decree during the duration of the Appointment.

(vii) Survey the Department's efforts to attain compliance with the Consent Decree's timeframe requirements concerning delivery of Competency Services and report to the Court and Parties (timing identified below) on the progress towards reaching compliance on those timeframes on a monthly basis, including documenting which efforts require action or approval by third parties.

(viii) Assist the Court in fashioning and evaluating compliance with any future sanctions or injunctive relief ordered by the Court.

(ix) Make other recommendations to the Court and the Parties on how to improve delivery of Competency Services for the purpose of effectuating compliance with the Consent Decree timelines concerning delivery of Competency Services, including how to audit the Department's performance.

(x) Approve of the Department's planning and implementation of Section VII above.

(xi) Submit reports to the Court and the Parties, as defined in Dkt. 130, the timing identified below.

(b) Special Master Reporting: In order for the Special Master to make such recommendations to the Court and the Department as specified above, the Department shall provide all information the Special Master seeks for the purpose of carrying out its specific duties and obligations or which are reasonably related to this Consent Decree.

(i) As part of the duties, the Special Master shall provide the Court and the Parties with status reports every other month for the first six months, and then quarterly thereafter. The Special Master's status report was submitted on January 28, 2019. Dkt. 146. The next report shall be submitted to the Court and the Parties on March 28, 2019, and then May 28, 2019, and then quarterly thereafter. Such reports shall address the Department's compliance with the timeframe requirements of the Consent Decree concerning Competency Services and shall provide a detailed summary of information and recommendations the Special Master believes the Court and Parties should consider relating to the Department's compliance with the Consent Decree timeframes concerning Competency Services.

(ii) The Special Master's report shall include, but is not limited to, reporting on the number of Pretrial Detainees ordered to receive Competency Services, an assessment of the Department's operations, systems, and admissions practices and policies relating to the Department's ability to comply with the Consent Decree timeframes, and guidance to the Department for improvement and increasing efficiencies in these areas.

(iii) The Special Master shall have reasonable access to, and the Department shall provide the Special Master with, all records that the Special Master requests within a reasonable timeframe from the date of such request. The Special Master shall be able to request the Department organize the data in a format which is necessary for the Special Master's efficient review. As a component of its reporting, the Special Master may select a sample of Pretrial Detainees from the Department's monthly reporting and audit the timeliness by the Department of that sample's Offered Admission dates for Competency Services. The Special Master shall include its findings of any such audit in its reports, and those reports shall be provided to the Parties and filed with the Court, with any private or confidential information redacted from the public filing. This Consent Decree meets the By Law exception to HIPAA's confidentiality mandates for the exchange of health care records and information.

(iv) The Special Master shall have the right to confer and subcontract with additional experts (but not allow double billing), as it determines in the exercise of its professional judgment would be helpful to the Court or the Parties, including for preparation of additional reports, studies, or research.

(v) The Special Master's report shall include the Department's responses to the Special Master's recommendations, at the Special Master's discretion.

47. Visitation and Access. The Special Master shall have the general authority and responsibility to: visit and access Colorado facilities; confer with stakeholders in the criminal justice and mental health systems; review documents, staff procedures, and records of individuals

who are subject to this Consent Decree; and access budget and resources available, and funding streams related to, the Department's duties under the Consent Decree and Competency Services. Neither the Special Master nor the Parties shall publicly disclose information obtained by the Special Master pursuant to this paragraph, which would otherwise be privileged or confidential, without consent of all the Parties and/or order of the Court.

48. Compensation. For the duration of this Consent Decree, the Special Master's invoices must be submitted to the Court for payment by the Department. The Department shall compensate the Special Master and its staff at the Special Master's standard rates. The Department shall reimburse all reasonable expenses of the Special Master and its staff consistent with the State's government rates, procurement guidelines, and Department policy, including for travel and accommodations.

49. Resignation or Replacement of Special Master. In the event the Special Master resigns or otherwise becomes unavailable, the Parties shall attempt to agree on a successor Special Master with relevant experience and shall jointly present the candidate to the Court for appointment. If the Parties are unable to agree, the Parties will submit a joint list of candidates to the Court for selection and appointment by the Court. If either Party has a concern with the Special Master, it may bring a motion before the Court under Federal Rule of Civil Procedure 53.

50. Duration of Engagement. The Special Master shall be engaged and paid for by the Department for the duration of the Consent Decree.

IX. REPORTING AND MEETING OBLIGATIONS

51. Compliance Plan Reports. The Department will provide monthly reports to DLC and the Special Master in compliance with the Order for Special Master. Dkt. 113 at A. 9. The first report was produced on February 28, 2019. The Parties agree that the reports shall be due seven days after the first of every month commencing April 1, 2019, or on the next business day if the

seventh day of the month falls on a weekend or holiday. The Special Master and the Parties will agree on the content and organization of those reports, which will include an update on all the aspects of compliance included in Sections VI and VII, as well as an update on the recommendations of the Special Master and the Department's efforts and responses to those recommendations.

52. Monthly Data Reports.

(a) In an organized format approved by the Special Master, as long as this Consent Decree remains in force, the Department's monthly data reports will identify:

(i) The Competency Services Recipient for whom a Court Order for Restoration Treatment, Competency Evaluation, or Collateral Materials has been received by the Department (even if no other data is available during that month) to include:

(1) The name of the referred Competency Services Recipient;

(2) The Competency Services Recipient's CMHIP Patient ID number, if applicable;

(3) The county or counties referring the Competency Services Recipient;

(4) The case number(s) of the criminal case(s) in which the Court Order was issued;

(5) The date of the Competency Services Recipient's arrest and bond amount, as shown in the Department's records;

(6) The date of the Court Order;

(7) The type and location of Competency Services ordered;

(8) The date the Court Order was received by the Hospital;

(9) The date that the Department learned that the Court Order was vacated or converted to another type of evaluation or restoration process;

(10) The date the Collateral Materials were received by the Department;

(11) The Evaluator Signed Date;

(12) The defense attorney's name if shown in the Department's records;

(13) The criminal charges filed against the Competency Services Recipient as shown in the Department's records;

(14) The Ready for Admission date;

(15) The Offered Admission date;

(16) The Hospital's Offered Admission deadline for that specific Pretrial Detainee, based on the Ready for Admission date;

(17) The date of admission;

(18) The type of Competency Service;

(19) The location of the Competency Service;

(20) The number of Days Waiting for each Pretrial Detainee;

(21) The number of days between the Ready for Admission Date and the date of the monthly report for each Pretrial Detainee awaiting admission;

(ii) A list of Pretrial Detainees for whom the Department has invoked Individual Special Circumstances and its reasons for doing so; and

(iii) If there is a wait list or backlog for Competency Services, a list of the Pretrial Detainees waiting the longest to the shortest number of days.

(b) The content and categories of the Monthly Report may be subject to change as programs are established or upon request from the Special Master.

53. Monthly Cumulative Information Report. The Department will generate another report monthly that will include cumulative information designed to allow the Special Master and DLC to monitor the historic areas that have caused delayed admissions in the past. Specifically,

the Department has cited dramatic increases in referrals and unprecedented staffing shortages. The Special Master also believes a lack of community restoration services has contributed to delayed admissions. In a format accepted by the Special Master, and possibly integrated into the Monthly Compliance Report, this report will include the following information: (1) the number of referrals for Competency Services each month, including the type and location for each; (2) the number of staff employed each month by category (nursing positions, security positions, mental health professionals, etc.) and how many vacancies remain in each staffing category; (3) the number of temporary staff and the number of security staff employed each month; and (4) the number of Pretrial Detainees identified for Community-Based Restoration Treatment and the movement of those Pretrial Detainees into the community. The Special Master shall also assist the Department at their request in developing reporting protocols, Competency Services Recipient data, and formats for updating the parties on Consent Decree activities.

54. Timing of Reports. The first report under this Consent Decree shall be made on April 8, 2019. Thereafter, monthly reports shall be provided on the seventh day of each month following the reporting month or on the next business day if the seventh day of the month falls on a weekend or holiday.

55. Distribution of Monthly Reports. The monthly report shall be provided to DLC and the Special Master in Microsoft Access format and PDF format, unless another format is agreed upon in writing by the Parties and the Special Master.

56. Meetings. The Special Master shall convene and chair meetings and disseminate a written summary of each meeting. The summary shall include action steps and agreements of the parties including timeframes for follow-up activities. During the first year after the Effective Date, meetings shall be held monthly, and quarterly thereafter, but may be scheduled at greater intervals

at the Special Master's discretion. The Parties shall treat the meetings as a serious opportunity to raise concerns or potential barriers with the system of institutions involved in achieving or maintaining full compliance with the Consent Decree. Each Party shall designate appropriate senior representatives, based on the agenda for each meeting, to participate in the meetings so that meaningful discussion can occur, and may include outside stakeholders, as appropriate based on the agenda. The first monthly meeting shall be scheduled for a mutually agreeable date in April 2019.

X. SPECIAL CIRCUMSTANCES

57. Special Circumstances. To some extent, the Department's ability to perform its statutory obligations and its obligations under this Consent Decree may be based on factors beyond its control. As a result, and subject to the terms and conditions of this Paragraph, the timeframe requirements of this Consent Decree may be temporarily suspended in the following circumstances:

(a) Special Circumstances Defined. The Department may invoke, under this Paragraph 57, two categories of Special Circumstances:

(i) "Individual Special Circumstances" means a situation that delays the Offer of Admission to a Pretrial Detainee, where the circumstances are not within the control of the Department. Individual Special Circumstances is a flexible concept. These situations may include, for example and without limitation, the following: (1) requests by a court, County Jail, defense counsel, or the Department that admission be delayed because additional information or testing required for the evaluation is outstanding; (2) a court has ordered a Hold and Wait Evaluation, and the sheriff must transport the Pretrial Detainee to the nearest county where there are services available; (3) the Pretrial Detainee is not Medically Cleared for admission

due to illness or other non-psychiatric medical need, but not a need that can be satisfied by a plan for a reasonable accommodation; or (4) when the Pretrial Detainee is approaching the deadline for transfer to an inpatient facility, restoration to competency is imminent, and treatment providers responsible for the Pretrial Detainee's care determine that transfer is not clinically appropriate. Upon resolution of the Individual Special Circumstance, the Pretrial Detainee must be Offered Admission for Competency Services immediately but no longer than three days, unless in derogation of a Tier 1 need, in which case the Pretrial Detainee will be offered the next available bed.

(ii) "Departmental Special Circumstances" means circumstances the Department could not reasonably foresee, prepare for, address through advanced planning, and that are beyond the control of the Department, which impact the Department's ability to comply with this Consent Decree. The failure or refusal of the Colorado General Assembly (or any other funding source) to adequately fund the Department's operations, programs, or plan shall not be considered a Departmental Special Circumstance. In order to invoke this paragraph, the Department would first need to obtain consent from DLC or seek relief and have such relief granted under the dispute resolution paragraph outlined below.

(b) Effect of Invocation of Individual Special Circumstances. DLC and the Special Master will review the reporting of Individual Special Circumstances. If DLC questions the Department's invocation of Individual Special Circumstances, the Parties will confer to review the reasons for invocation of Individual Special Circumstances and to determine issues for resolution. Additionally, the Department may proactively seek

confirmation that an event qualifies as an Individual Special Circumstance by contacting a representative of DLC or the Special Master in advance of formal reporting of the event. If the Department believes Individual Special Circumstances have become a systemic issue, it will follow the Departmental Special Circumstances procedure below. The Parties shall use good faith efforts to try and resolve any disputes concerning the invocation of Individual Special Circumstances. However, if the Parties do not reach an agreement through good faith efforts at resolution, the Parties will follow the dispute resolution process described in Section XII.

(i) If the Parties agree to the invocation of Individual Special Circumstances for a particular Pretrial Detainee, the timeframe requirements of this Consent Decree shall be suspended as to that individual Pretrial Detainee for a period to be determined by the Special Master.

(ii) The Department may invoke Individual Special Circumstances more than once for the same Pretrial Detainee, but it must follow the notification and conferral procedures in Paragraph 57(b) each time it seeks to invoke Individual Special Circumstances.

(c) Effect of Invocation of Departmental Special Circumstances. If the Department determines that Departmental Special Circumstances exist, it shall notify the Court, the Special Master, and DLC in writing, and in such notification, the Department shall provide a detailed explanation of the basis for invoking Departmental Special Circumstances, a plan to remedy the Departmental Special Circumstances, and the projected timeframe for resolution. The period of Departmental Special Circumstances shall commence on the date that the Notice of Departmental Special Circumstances is

provided to the Court. Upon the invocation of Departmental Special Circumstances, the timeframe requirements of this Consent Decree shall be automatically suspended for six months, unless the Department notifies DLC that a shorter time is sufficient to resolve Departmental Special Circumstances, commencing with the month in which the Notice of Departmental Special Circumstances is provided to the Court. The Department shall provide written notice to DLC of its intent to terminate Departmental Special Circumstances. Upon DLC's receipt of a Notice of Departmental Special Circumstances, it may request supporting documentation for the Department's notice, and the Parties shall confer to review the reasons for invocation of Departmental Special Circumstances, to resolve questions that the Special Master or DLC may have about the circumstances that triggered the notice, and to assess whether the Parties are able to resolve any disagreement concerning invocation of Departmental Special Circumstances. If DLC decides to challenge the invocation of Departmental Special Circumstances, it may do so by following the dispute resolution procedure identified in Section XII. The Department is prohibited from invoking Departmental Special Circumstances consecutively. The Department cannot invoke Departmental Special Circumstances any sooner than June 1, 2021.

(d) Effect on Reporting Requirements. A Notice of Departmental Special Circumstances shall not affect the Department's reporting obligations under this Consent Decree. In addition to such reporting obligations, the Department will provide a monthly written status report to DLC and the Special Master on its plans and progress to remedy Departmental Special Circumstances.

XI. DURATION

58. Duration and Certification. The terms and provisions of this Consent Decree shall remain in force until December 1, 2025, except that a sustained period of two years of compliance

by the Department with all terms of this Consent Decree, including the strictest timeframes identified herein, as certified by the Special Master, shall result in termination of this Consent Decree. In the event the Department complies with all terms of this Consent Decree and the strictest timeframes for one year, while concurrently reducing Tier 2 timeframes to 21 days for that one year period, such compliance shall result in termination of this Consent Decree.

XII. DISPUTE RESOLUTION AND REMEDIES

59. Dispute Resolution.

(a) Dispute Resolution Generally. Any dispute concerning the interpretation or implementation of this Consent Decree, other than those for which DLC seeks the remedy of contempt, shall first be submitted to the Special Master, who shall attempt to informally mediate and resolve the dispute. The Special Master may make use of such informal dispute resolution processes as it deems necessary, which may include, but are not limited to, informal suggestions or recommendations and compulsory conferences of the Parties.

(b) Dispute Resolution for Non-Contempt Proceedings. If informal attempts fail to resolve the matters identified in the preceding paragraph, or if the Special Master believes the Department has materially violated this Consent Decree or has in some other manner acted in bad faith, the Special Master or any Party may submit a written request to Judge Hegarty (or, in the event he is no longer serving as a magistrate judge in this District, a magistrate judge successor or someone mutually agreed upon by the parties) for an evidentiary hearing, requesting specific relief and a decision. A copy of this request shall be served upon opposing counsel and the Special Master. Judge Hegarty shall determine whether the dispute requires an evidentiary hearing, and, if so, schedule such hearing at the convenience of the Parties. Judge Hegarty shall file a written decision supported by written findings of fact and may impose any relief permitted by this Consent Decree. This includes,

but is not limited to, attorney's fees. Judge Hegarty's decision shall become final and binding upon the Parties.

(c) Dispute Resolution for Contempt Proceedings. In the event that DLC believes the Department's violation of this Consent Decree warrants contempt, DLC shall first attempt mediation through Judge Hegarty, who will conduct the proceeding on an expedited basis. Upon a finding by Judge Hegarty that the matter cannot be mediated, DLC may file a Motion for Order to Show Cause on the matter in controversy with this Court.

60. Remedies for Non-Contempt Violations of the Consent Decree.

(a) Timeframe Violations. The Parties agree that, in addition to the fines set forth in Paragraph 37 and the penalties set forth in Paragraph 60(b), DLC shall be entitled to seek its attorney's fees and costs for pursuing such violations. In no event, however, shall the Department be subject to contempt strictly for violations of the timeframes for the delivery of Competency Services, except that sustained and/or egregious violations of those timeframes may constitute a material violation of this Consent Decree.

(b) Material Violations. Upon a finding of a material violation, Judge Hegarty may order immediate enforcement of the agreement, order injunctive relief, impose liquidated damages (as detailed below), attorney's fees, or fashion any other relief deemed appropriate for the Department's violation of this Consent Decree.

(c) Liquidated Damages. The Parties further agree that if Judge Hegarty finds a material violation of this Consent Decree, the damages sustained by the Pretrial Detainees because of such violation would be difficult, if not impossible, to ascertain. The Parties agree to provide for damages rather than a penalty and agree that in addition to other remedies available to DLC, Judge Hegarty can award liquidated damages of up to $10,000

a day for each day Judge Hegarty determines the violation to have occurred and continuing until the violation is remedied.

(d) Non-Timeframe Violations Adjudicated by Contempt. Nothing set forth herein is intended to, or in any way shall, limit the Court's power to enforce the Department's compliance with this Consent Decree through contempt (except for a violation of the timeframes, which the parties have agreed is not subject to contempt). In such proceedings, the Court shall have all powers afforded by law to remedy the contempt and/or punish the Department for violation of this Consent Decree.

XIII. MISCELLANEOUS PROVISIONS

61. Effective Date of the Consent Decree. This Consent Decree shall become effective on the date of the Court's entry.

62. Remedies by Pretrial Detainees Not Precluded. Nothing in this Consent Decree limits a Pretrial Detainee, or his or her counsel, from bringing other court action, such as contempt of court proceedings, if the circumstances warrant such action. However, the provisions of this Consent Decree are intended to be enforced solely by the United States District Court for the District of Colorado. In any court action brought by a Pretrial Detainee for contempt of court, the Department retains all defenses to such action, including but not limited to those attending C.R.C.P. 107. Nevertheless, the Parties agree that the terms of this Consent Decree are not binding or enforceable as to individual Pretrial Detainees, because they are not parties to this Lawsuit.

63. Contempt Actions Against Other Agencies, Non-Complying Sheriff's Offices, District Attorney's Offices, and Defense Counsel Not Precluded. Nothing in this Consent Decree

precludes any court from issuing contempt citations to sheriffs for failing to comply with orders to transport Pretrial Detainees to or from the Hospital, district attorneys for violating timelines

ordered by courts to provide Collateral Materials, or defense attorneys who fail to comply with orders related to Competency Services.

64. Complete Consent Decree; Modification; and Waiver. This Consent Decree constitutes the entire agreement between the Parties and supersedes all prior and contemporaneous agreements, representations, warranties, and understandings of the Parties. This Consent Decree replaces and supersedes the Amended and Restated Settlement Agreement executed by the Parties on July 28, 2016 in its entirety. No supplement, modification, or amendment of this Consent Decree shall be binding unless entered by the Court.

65. Attorney's Fees and Costs. Part of the effect of this Consent Decree is to settle the specific matters outlined or referenced in this Consent Decree as to the Parties up to the date the Consent Decree is finalized. Accordingly, the Colorado State Office of Risk Management shall pay DLC's counsel the lump sum amount of $654,177.50 (the dollar amount is contingent upon the State Claims Board's approval of this amount on March 26, 2019) in full and final settlement of all costs and fees, including attorney's fees, incurred by DLC's counsel starting on June 1, 2017, up to and including the date this Consent Decree is finalized and signed by all Parties hereto (the "Settlement Payment"). When the final amount is approved by the State Claims Board, DLC's counsel shall enter a separately filed binding agreement related to the Settlement Payment, which agreement shall be on the then-current, Controller-approved standard settlement agreement. The Settlement Payment shall be paid to Eytan Nielsen LLC as follows: A warrant in the amount of $654,177.50 (or in the dollar amount approved by the State Claims board on March 26, 2019) will be made payable to Eytan Nielsen LLC. The warrant will be delivered to Eytan Nielsen LLC within 30 days from March 26, 2019, or as soon after March 26, 2019 as practicable. Prior to delivery of the warrant, the Controller-approved settlement document will be signed by all Parties and the

Controller. No withholding for payment of federal, state or local taxes will occur respecting any warrant issued pursuant to this Consent Decree other than those required by federal or state law or rules governing the Controller. Eytan Nielsen LLC will complete, execute and provide an original of I.R.S. form W-9 in conjunction with submitting the signed Consent Decree as an initial step in completing the arrangements described here. A Form 1099 will be issued to Eytan Nielsen LLC on the Settlement Payment. The Settlement Payment made hereunder shall not be designated as wages, salary or back pay, except to the extent required by federal or state law or by rules governing the Controller, but is instead made in compromise of all claims arising from or related to the subject matter of this Consent Decree for those matters up to and including the date this Consent Decree is fully executed and entered by the Court.

66. Written Notice. Any notice or other communication required or permitted under this Consent Decree shall be in writing and shall be deemed to have been duly given when (1) mailed by United States registered or certified mail, return receipt requested, (2) mailed by overnight express mail or other nationally recognized overnight or same-day delivery service, (3) sent as a PDF attachment to electronic mail, or (4) delivered in person, to the Parties at the following addresses:

If DLC, to:	Disability Law Colorado 455 Sherman Street, #130 Denver, Colorado 80203
Attention:	Mark Ivandick mivandick@disabilitylawco.org
	Jennifer Purrington jpurrington@disabilitylawco.org

With a copy to:	Iris Eytan, Esq. EYTAN NIELSEN LLC 3200 Cherry Creek South Drive Denver, CO 80209 iris@eytan-nielsen.com
If the Department, to:	Department of Human Services 1575 Sherman Street Denver, Colorado 80203
Attention:	Michelle Barnes michelle.barnes@state.co.us
If the Hospital, to:	Colorado Mental Health Institute at Pueblo 1600 West 24th Street Pueblo, Colorado 81003
Attention:	Jill Marshall, M.P.H. jill.marshall@state.co.us
With a copy to:	Office of the Attorney General Ralph L. Carr Colorado Judicial Center 1300 Broadway, 6th Floor Denver, CO 80203
Attention:	Tanja Wheeler tanja.wheeler@coag.gov Ann Pogue ann.pogue@coag.gov Sarah Richelson sarah.richelson@coag.gov

A Party may change the names or address where notice is to be given by providing notice to the other Parties of such change in accordance with this Paragraph.

XIV. RESERVATION OF JURISDICTION AND ENFORCEMENT

67. The Court hereby retains jurisdiction over this Consent Decree.

68. The Court hereby also retains jurisdiction to enforce the terms of this Consent Decree, upon Final Approval, until the Consent Decree is terminated and for 60 days after the Department provides the final monthly report.

69. Nothing in this Consent Decree requires or permits the Department to violate a court order.

70. Minor or transitory mistakes shall not be considered a violation of this Consent Decree.

XV. FINAL JUDGMENT

Based on the pleadings, counsels' stipulation of facts, and representations of counsel for both parties, the Court does find: The facts alleged in Paragraphs 1 through 13 warrant the Court's approval of this Consent Decree.

Upon entry of this Consent Decree by the Court, this Consent Decree shall constitute the final judgment between and among the Plaintiff and Defendants. The Court enters this judgment as a final judgment under Federal Rules of Civil Procedure 54 and 58 that is fully enforceable by all plenary powers of the Court.

IT IS SO ORDERED, this 2nd day of April, 2019.

Hon. Nina Y. Wang
United States Magistrate Judge

APPROVED FOR ENTRY:

/s/Mark Ivandick
Center for Legal Advocacy, d/b/a Disability Law Colorado
Name: Mark Ivandick
Title: Managing Attorney
Dated: March 27, 2019

/s/Michelle Barnes
Colorado Department of Human Services
Name: Michelle Barnes
Title: Executive Director, in her official capacity
Dated: March 27, 2019

/s/Jill Marshall
Colorado Mental Health Institute at Pueblo
Name: Jill Marshall
Title: Chief Executive Officer, in her official capacity
Dated: March 27, 2019

TABLE 1: Timeframes and Fines for Competency Services

Deadlines	**Tier 1: Maximum Timeframes to Offer Admission for Inpatient Restoration and Corresponding Fines**	**Tier 2: Maximum Timeframes to Offer Admission for Inpatient Restoration and Corresponding Fines**	**Maximum Timeframes to Offer Admission for Inpatient Competency Evaluations and Corresponding Fines**	**Maximum Timeframes to Complete Jail Competency Evaluations and Corresponding Fines**
June 1, 2019	7 days Fines: $500 per day for each Pretrial Detainee waiting more than 7 days	56 days Assess for admission every 10 days Fines: $100 per day for each Pretrial Detainee waiting 29-56 days, $500 per day for each Pretrial Detainee waiting more than 56 days	21 days Fines: $100 per day for each Pretrial Detainee waiting more than 21 days	28 days Fines: $100 per day for each Pretrial Detainee waiting more than 28 days
January 1, 2020	7 days Fines: $500 per day for each Pretrial Detainee waiting more than 7 days	49 days Assess for admission every 10 days Fines: $100 per day for each Pretrial Detainee waiting 29-49 days, $500 per day for each Pretrial Detainee waiting more than 49 days	21 days Fines: $100 per day for each Pretrial Detainee waiting more than 21 days	28 days Fines: $100 per day for each Pretrial Detainee waiting more than 28 days

Deadlines	**Tier 1: Maximum Timeframes to Offer Admission for Inpatient Restoration and Corresponding Fines**	**Tier 2: Maximum Timeframes to Offer Admission for Inpatient Restoration and Corresponding Fines**	**Maximum Timeframes to Offer Admission for Inpatient Competency Evaluations and Corresponding Fines**	**Maximum Timeframes to Complete Jail Competency Evaluations and Corresponding Fines**
July 1, 2020	7 days Fines: $500 per day for each Pretrial Detainee waiting more than 7 days	42 days Assess for admission every 10 days Fines: $100 per day for each Pretrial Detainee waiting 29-42 days, $500 per day for each Pretrial Detainee waiting more than 42 days	14 days Fines: $100 per day for each Pretrial Detainee waiting more than 14 days	21 days Fines: $100 per day for each Pretrial Detainee waiting more than 21 days
January 1, 2021	7 days Fines: $500 per day for each Pretrial Detainee waiting more than 7 days	35 days Assess for admission every 10 days Fines: $100 per day for each Pretrial Detainee waiting 29-35 days, $500 per day for each Pretrial Detainee waiting more than 35 days	14 days Fines: $100 per day for each Pretrial Detainee waiting more than 14 days	21 days Fines: $100 per day for each Pretrial Detainee waiting more than 21 days

Deadlines	**Tier 1: Maximum Timeframes to Offer Admission for Inpatient Restoration and Corresponding Fines**	**Tier 2: Maximum Timeframes to Offer Admission for Inpatient Restoration and Corresponding Fines**	**Maximum Timeframes to Offer Admission for Inpatient Competency Evaluations and Corresponding Fines**	**Maximum Timeframes to Complete Jail Competency Evaluations and Corresponding Fines**
July 1, 2021	7 days Fines: $500 per day for each Pretrial Detainee waiting more than 7 days	28 days Assess for admission every 10 days Fines: $500 per day for each Pretrial Detainee waiting more than 28 days	14 days Fines: $100 per day for each Pretrial Detainee waiting more than 14 days	21 days Fines: $100 per day for each Pretrial Detainee waiting more than 21 days

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

DEMONTRAY HUNTER, by and through his next friend, Rena Hunter; RUSSELL D. SENN, by and through his next friend, Irene Senn; TRAVIS S. PARKS, by and through his next friend, Catherine Young; VANDARIUS S. DARNELL, by and through his next friend, Bambi Darnell; FRANK WHITE, JR., by and through his next friend, Linda White; MARCUS JACKSON, by and through his next friend Michael P. Hanle; TIMOTHY D. MOUNT, by and through his next friend, Dorothy Sullivan; HENRY P. MCGHEE, by and through his next friend, Barbara Hardy, individually and on behalf of all others similarly situated; and the ALABAMA DISABILITIES ADVOCACY PROGRAM,

Plaintiffs,

v.

LYNN BESHEAR, in her official capacity as Commissioner of the Alabama Department of Mental Health,

Defendant.

CASE NO. 2:16-cv-00798-MHT-CSC

CLASS ACTION FOR DECLARATORY AND INJUNCTIVE RELIEF

(WO)

CONSENT DECREE

I. INTRODUCTION

1. On September 30, 2016, three of the individually-named Plaintiffs filed the above-styled action (the "Lawsuit") against Defendant James V. Perdue, in his official capacity as Commissioner of the Alabama Department of Mental Health ("the ADMH Commissioner"), challenging the AMDH Commissioner's failure to comply with the Due Process Clause of the Fourteenth Amendment to the United States Constitution with respect to his alleged failure to

provide court-ordered Mental Evaluations and Competency Restoration Treatment to Plaintiffs. Commissioner Lynn Beshear was substituted as Defendant in July 2017.

2. On December 23, 2016, the eight individually-named Plaintiffs and Plaintiff Alabama Disabilities Advocacy Program ("ADAP") (collectively, "Plaintiffs"), filed their First Amended Complaint against the ADMH Commissioner in his official capacity challenging his alleged failure to comply with the Due Process Clause of the Fourteenth Amendment to the United States Constitution with respect to his provision of court-ordered Inpatient Mental Evaluations and Competency Restoration Treatment to the individually-named Plaintiffs and the putative class of similarly situated persons represented by the individually-named Plaintiffs, and Plaintiff ADAP's constituents (whose claims it is asserting as a Plaintiff in this action).

3. The individually-named Plaintiffs, on behalf of themselves and all others similarly situated, Plaintiff ADAP, and the ADMH Commissioner engaged in mediation designed to resolve the claims asserted in the Lawsuit. The Parties believe that they have reached a resolution of the claims asserted in the Lawsuit and that, in order to avoid protracted, costly and uncertain litigation, it is in their respective best interests to resolve the issues to be tried in the Lawsuit.

4. Accordingly, the Parties, by and through their respective counsel, jointly stipulate and agree to the following provisions to resolve the Lawsuit.

II. PARTIES, PURPOSE, AND INTENT

1. Plaintiffs are suing Defendant Beshear in her official capacity as Commissioner of ADMH, the state agency charged under Alabama law and by relevant state circuit court orders with the provision of Outpatient and Inpatient Mental Evaluations to those suspected of being Incompetent to Stand Trial and Competency Restoration Treatment to persons found Incompetent to Stand Trial in Alabama.

2. The individually-named Plaintiffs and putative class members in the Lawsuit have been or are currently, and may in the future be incarcerated in an Alabama city or county jail awaiting receipt of court-ordered Outpatient Mental Evaluations, Inpatient Mental Evaluations, or Competency Restoration Treatment to be provided by or on behalf of the ADMH Commissioner.

3. Plaintiff ADAP is the duly authorized disabilities protection and advocacy agency in the State of Alabama under the nation's federally-funded protection and advocacy system. *Cf. Doe v. Stincer*, 175 F. 3d 879, 883 (11th Cir. 1999); *Alabama Disabilities Advocacy Program v. J.S. Tarwater Developmental Center*, 97 F. 3d 492, 495 (11th Cir. 1996), *aff'g* 894 F. Supp. 424, 426-27 (M.D. Ala. 1995); *Dunn v. Dunn*, Case No. 2:14-cv-00601-MHT-TFM, 2016 U.S. Dist. LEXIS 166251 (Nov. 25, 2016); *Alabama Disabilities Advocacy Program v. SafetyNet Youthcare, Inc*., 65 F. Supp. 3d 1312, 1321-22 (S.D. Ala. 2014), *on reconsideration in another part*, 2015 U.S. Dist. LEXIS 16343 (S.D. Ala. Feb. 22, 2015); *Alabama Disabilities Advocacy Program v. Wood*, 584 F. Supp. 2d 1314, 1315 (M.D. Ala. 2008).

4. The individually-named Plaintiffs, the Class, as defined herein, and Plaintiff ADAP are collectively referred to herein as "Plaintiffs."

5. The Plaintiffs and Defendant Beshear are collectively referred to herein as the "Parties."

6. The purposes of this Settlement Agreement (the "Agreement") are to (1) specify certain administrative and procedural changes to the provision of Outpatient Mental Evaluations, Inpatient Mental Evaluations and Competency Restoration Treatment by the ADMH Commissioner to ensure compliance with constitutional requirements for same; (2) to outline a plan for the implementation of such changes; and (3) to settle and resolve all claims that were or were required to have been asserted in the Lawsuit.

7. The Parties stipulate that nothing in this Agreement will be used for any purpose outside of the above-captioned action or against the ADMH Commissioner in any other litigation that has been or may be filed against him. Nothing in this Agreement will be construed to require the ADMH Commissioner to do more than what is specified in the Agreement or otherwise required by the United States Constitution, federal law, or Alabama law including, but not limited to, Rule 11 of the Alabama Rules of Criminal Procedure, with respect to the provision of court-ordered Mental Evaluations and Competency Restoration Treatment to persons charged with a criminal offense in Alabama.

8. Nothing in this Agreement shall be construed as an admission of liability by the ADMH Commissioner. To the contrary, the ADMH Commissioner denies every material allegation of the Complaint, as amended, as specifically set forth in his Answers to the Complaint and First Amended Complaint.

9. The Parties believe that this Agreement is fair, reasonable, and adequate to protect the interests of all Parties concerning the issues addressed herein. The Parties jointly file this Agreement with the Court and ask the Court to issue an order approving this Agreement as final. The Parties believe that compliance with this Agreement by the ADMH Commissioner will meet the ADMH Commissioner's obligations under United States Constitution with respect to the timelines of mental evaluations and competency restoration treatment. In the event that this Agreement is not approved by the Court such that it settles and resolves, on a class basis and, with respect to Plaintiff ADAP, all claims asserted in the Lawsuit, the Parties retain all of their pre-settlement litigation rights and defenses, including the individually-named Plaintiffs' right to seek class certification and Plaintiff ADAP's right to seek a ruling certifying its standing for all purposes relevant to the litigation of the Lawsuit and all defenses of the Commissioner, including mootness

of the Plaintiffs' claims, standing of each Plaintiff, objections to certification of any class and others. Additionally, the Parties shall return to the status quo ante in the Lawsuit as if the Parties had not entered into this Agreement. Any discussions, offers, or negotiations associated with this Agreement will not be discoverable or offered into evidence or used in the Lawsuit or any other action or proceeding for any purpose, without prejudice to the individually-named Plaintiffs' right to seek class certification and Defendant Beshear's right to oppose class certification. In such event, all Parties will stand in the same position as if the Agreement had not been negotiated, made or filed with the Court.

III. STIPULATION REGARDING CLASS ACTION FOR PURPOSES OF SETTLEMENT

1. For purposes of defining the class of persons intended to benefit from the Parties' Agreement, the ADMH Commissioner stipulates to the class of persons under Fed. R. Civ. P. 23(b)(2) to whom the administrative, structural, and procedural changes specified in Section VI below apply as follows:

a. All persons who have been, or will be during the period that this Agreement remains in effect, charged with a crime, within the meaning of Rule 1.4(b) of the Alabama Rules of Criminal Procedure, in a court of competent jurisdiction in the State of Alabama, and detained in an Alabama city or county jail or Alabama Department of Corrections facility while awaiting a court-ordered Mental Evaluation or court-ordered Competency Restoration Treatment;

i. For whom a Circuit Court has determined that reasonable grounds exist for a mental examination into the person's competency to stand trial under Rule 11 of the Alabama Rules of Criminal Procedure and committed the person to the custody of ADMH under Rule 11.3 of the Alabama Rules of Criminal Procedure by court order for an inpatient evaluation, whether or not the court's order references any provision of law in so ordering; or

ii. Who is found incompetent to stand trial under Rule 11 of the Alabama Rules of Criminal Procedure and committed to the custody of ADMH under Rule 11.6 of the Alabama Rules of Criminal Procedure by court order for Competency Restoration Therapy, whether or not the court's order references any provision of law in so ordering.

IV. STIPULATION REGARDING STANDING FOR PURPOSES OF SETTLEMENT

1. For purposes of this Agreement only, the ADMH Commissioner does not contest that Plaintiff ADAP has standing in the Lawsuit to assert due process claims on behalf of persons within the State of Alabama with a mental illness and/or intellectual disability who have been charged with a criminal offense, ordered to receive an Outpatient Mental Evaluation, Inpatient Mental Evaluation, or Competency Restoration Treatment, and who await the provision of that treatment in an Alabama city or county jail or an Alabama Department of Corrections facility.

V. DEFINITIONS

1. "ADMH Commissioner" means Defendant Lynn Beshear, acting in his official capacity as Commissioner of the Alabama Department of Mental Health, together with his successors, in his administration and supervision of the Alabama Department of Mental Health.

2. "Agreement" means this Settlement Agreement and any eventual Consent Decree entered by the Court that results, refers, or relates to the terms and conditions of this Settlement Agreement.

3. "Alabama Department of Mental Health" or "ADMH" means the state agency charged with providing Outpatient Mental Evaluations, Inpatient Mental Evaluations, and Competency Restoration Treatment to the persons defined in Sections III and IV above pursuant to relevant Alabama circuit court orders, Alabama Rule of Criminal Procedure 11, and, generally, Alabama Code Section 22-50-2.

4. "Calendar Days" means all days, except where the last day of any relevant time period falls on a federal holiday observed by the United States District Court for the Middle District of Alabama, and then the next day that is not a Sunday.

5. "Competency Restoration Treatment" means psychiatric therapy, treatment, medication, and/or education designed to restore a criminal defendant found incompetent to stand trial to competency as defined in Alabama Rule of Criminal Procedure 11.1, that is ordered by an Alabama circuit court pursuant to Alabama Rule of Criminal Procedure 11.6 or other applicable legal provision.

6. "Final Approval" means approval of this Settlement Agreement by the Court by a final and appealable order.

7. "Hospital Forensic Bed" means a duly licensed and certified bed in a state psychiatric hospital or contracted bed in an inpatient hospital or hospital-like setting. These beds may be provided through a contract between ADMH and a third-party provider, such as a Community Mental Health Center or designated Mental Health Center as provided by Ala. Code §§ 15-16-61(5), 22-51-1, *et seq*., 22-56-5 and 22-52-90(1).

8. "Community Forensic Bed" means a duly licensed and certified bed in a community setting with up to sixteen (16) beds where the community service is managed and delivered by ADMH or by a community mental health provider through a contract with ADMH. A Community Forensic Bed may not be located on the grounds of any existing state hospital.

9. "Incarcerated Person" means a person who has been arrested and charged with a criminal offense in a court of competent jurisdiction in Alabama who is incarcerated in an Alabama city or county jail or an Alabama Department of Corrections facility.

10. "Incompetent to Stand Trial" means a finding by an Alabama Circuit Court or other court of competent jurisdiction that the individual found incompetent is unable to assist in the preparation of his or her defense as defined in Alabama Rule of Criminal Procedure 11.1 or comparable statute.

11. "Inpatient Mental Evaluation" means a mental evaluation conducted within a state psychiatric hospital or comparable hospital-like facility into which the person being evaluated has been admitted for that purpose, and that is conducted by competent and adequately trained clinical personnel, including at a Community Mental Health Center.

12. "Licensure and Certification Standards" means those standards for the construction and operation of facilities that provide mental health care to persons in the State of Alabama which are set forth in the Alabama Administrative Code Section 580, *et seq*. or designated mental health facility by ADMH.

13. "Outpatient Mental Evaluation" means a mental evaluation conducted within the confines of a city or county jail or an Alabama Department of Corrections facility or within a therapeutic setting not requiring the admission and retention of the person being evaluated, and that is conducted by competent and adequately trained clinical personnel, in accordance with applicable professional standards.

14. "Registered Sex Offender" means an individual convicted of an offense, which under Alabama law requires his or her registration in the Sex Offender Registry. An individual charged with an offense that, if convicted, would be required to register as a sex offender is not a Registered Sex Offender for purposes of this Agreement.

15. "Substantial Compliance" means adhering to any plans or methods implemented by the ADMH Commissioner so as to comply with the terms of this Agreement. Isolated, acute,

non-substantive or immaterial deviations from the terms of this Agreement or from any plans or methods implemented by the ADMH Commissioner so as to comply with the terms of this Agreement will not prevent a finding of Substantial Compliance, provided that the ADMH Commissioner can demonstrate that he has: (A) implemented a system or systems (i) for assuring compliance, and (ii) for taking corrective measures in response to instances of non-compliance; and (B) instituted policies, practices, and resources that are capable of durable and sustained compliance. For purposes of the termination of this Agreement as provided in Section X below, however, Substantial Compliance requires that the ADMH Commissioner provide court-ordered Outpatient and Inpatient Mental Evaluations and Competency Restoration Treatment within the time frames specified in Sections VI.1.A through VI.1.E based on an average monthly compliance rate defined below in Section VI.

VI. SUBSTANTIVE PROVISIONS

1. **Timely Provision of Court-Ordered Mental Evaluations and Competency Restoration Treatment**. The ADMH Commissioner, by and through ADMH, will provide court-ordered Mental Evaluations and Competency Restoration Treatment within the time periods specified in Subsections VI.1.A through VI.1.E below.

A. Outpatient Mental Evaluations of Incarcerated Persons**.**

i. By twelve (12) months after Final Approval of this Agreement, Outpatient Mental Evaluations of persons who are incarcerated at the time that a court orders that they be evaluated shall be conducted within forty-five (45) calendar days of the date of ADMH's receipt of the order for such evaluation by the circuit court issuing such order, subject to the protocol for the ADMH Commissioner's obtaining such order set forth in Appendix A. The clinician performing such Outpatient Mental Evaluation shall submit a report containing the

findings of any such evaluation to the relevant circuit court within forty-five (45) calendar days of conducting such Outpatient Mental Evaluation.

ii. By twenty-four (24) months after Final Approval of this Agreement, Outpatient Mental Evaluations of persons who are incarcerated at the time that a court orders that they be evaluated shall be conducted within thirty (30) calendar days of the date ADMH's of receipt of the order for such evaluation by the circuit court issuing such order, subject to the protocol for the ADMH Commissioner's obtaining such order set forth in Appendix A. The clinician performing such Outpatient Mental Evaluation shall submit a report containing the findings of any such evaluation to the relevant circuit court within thirty (30) calendar days of conducting such Outpatient Mental Evaluation.

B. Inpatient Mental Evaluations of Incarcerated Persons.

i. By twelve (12) months after Final Approval of this Agreement**,** Inpatient Mental Evaluations of persons who are incarcerated at the time that a court orders that they be evaluated shall be conducted within forty-five (45) calendar days of the date of receipt of the order for such evaluation by the circuit court issuing such order, subject to the protocol for the ADMH Commissioner's obtaining such order set forth in Appendix A. The clinician performing such Inpatient Mental Evaluation shall submit a report containing the findings of any such evaluation to the relevant circuit court within forty-five (45) calendar days of conducting such Inpatient Mental Evaluation.

ii. By twenty-four (24) months after Final Approval of this Agreement, Inpatient Mental Evaluations of persons who are incarcerated at the time that a court orders that they be evaluated shall be conducted within thirty (30) calendar days of the date of receipt of the order for such evaluation by the circuit court issuing such order, subject to the protocol for the

ADMH Commissioner's obtaining such order set forth in Appendix A. The clinician performing such Inpatient Mental Evaluation shall submit a report containing the findings of any such evaluation to the relevant circuit court within thirty (30) calendar days of conducting such Inpatient Mental Evaluation.

C. Competency Restoration Therapy and Treatment for Incarcerated Persons.

i. By twelve (12) months after Final Approval of this Agreement, persons who are incarcerated at the time that they are found Incompetent to Stand Trial and committed to the custody of ADMH for Competency Restoration Treatment shall be admitted into an institution suitable for the provision of Competency Restoration Treatment within forty-five (45) calendar days of the date of the receipt of the order committing them to the custody of ADMH for restorative treatment, subject to the protocol for the ADMH Commissioner's obtaining such order set forth in Appendix A.

ii. By twenty-four (24) months after Final Approval of this Agreement, persons who are incarcerated at the time that they are found incompetent to stand trial and committed to the custody of ADMH for Competency Restoration Treatment shall be admitted into an institution suitable for the provision of Competency Restoration Treatment within thirty (30) calendar days of the date of receipt of the order committing them to the custody of ADMH for restorative treatment, subject to the protocol for the ADMH Commissioner's obtaining such order set forth in Appendix A.

D. Incarcerated Persons to be Evaluated and Treated According to Date of Order Receipt in the Absence of Exigent Circumstances.

i. Incarcerated persons whom ADMH has been ordered to evaluate or treat shall be provided services based on the date of receipt of any court order, subject to the protocol for the ADMH Commissioner's obtaining such order set forth in Appendix A.

ii. The ADMH Commissioner may not satisfy the time periods specified in Subsections B and C above by prioritizing, for purposes of admission into a state forensic hospital, persons who have been found Incompetent to Stand Trial and ordered to receive Competency Restoration Treatment over persons who have been found not guilty by reason of insanity and ordered to receive inpatient psychiatric services. The Parties acknowledge that in exceptional circumstances the ADMH Commissioner may need to "skip" persons found not guilty by reason of insanity ("NGRI") to provide services to a person awaiting a court-ordered Inpatient Mental Evaluation or Competency Restoration Treatment. The Parties acknowledge that each "skip" affects the Commissioner's monthly compliance rate. The Parties agree that the procedure in Subsection VI.1.E.iv below applies to individuals found NGRI who are "skipped" in favor of the ADMH Commissioner's provision of services to a person found Incompetent to Stand Trial, even though persons found NGRI ordinarily do not count in the calculation of the monthly compliance rate. Where a person found NGRI is "skipped" to provide services to a person deemed Incompetent to Stand Trial, the ADMH Commissioner shall have sixty (60) days to provide services to the "skipped" individual; if at the end of 60 days the ADMH Commissioner has not yet begun providing services to the person skipped, that person shall be included in the calculation of the average monthly compliance rate beginning on Day 61.

iii. The ADMH Commissioner may provide services to persons ordered to receive a Mental Evaluation or Competency Restoration Treatment outside of the order dictated by the date the ADMH Commissioner receives their respective court order, specifically, by providing services to particular individual earlier than would be dictated by the date of ADMH's receipt of the court order for their evaluation or treatment (i.e., "line jumping") or, where a demonstrable and compelling obstacle to providing services to a particular individual on the date

that would be dictated by date of the ADMH Commissioner's receipt of the court order for their evaluation or treatment requires the ADMH Commissioner to provide services later than that date (i.e., "skipping"), subject to the provisions set forth in Subsection E, and the calculation of Substantial Compliance with respect to persons provided court-ordered Mental Evaluations or Competency Restoration Treatment out of order shall be made in accordance with the provisions of Subsection E.

E. Substantial Compliance with Timelines for Incarcerated Persons.

i. By twelve (12) months after Final Approval of this Agreement, for persons incarcerated in the State of Alabama, the Substantial Compliance standard means that the ADMH Commissioner is in Substantial Compliance if, for each month, the average time period for the ADMH Commissioner's provision of Outpatient Mental Evaluations, Inpatient Mental Evaluations, and Competency Restoration Treatment does not exceed the applicable timeline by 20%, counting only whole days. Thus, the ADMH Commissioner is in Substantial Compliance for each deadline as follows: 30 days (36 days), 45 days (54 days), 60 days (72 days), and 90 days (108 days).

ii. By twenty-four (24) months after Final Approval of this Agreement, for persons incarcerated in the State of Alabama, the Substantial Compliance standard means that the ADMH Commissioner is in Substantial Compliance if, for each month, the average time period for the ADMH Commissioner's provision of Outpatient Mental Evaluations, Inpatient Mental Evaluations, and Competency Restoration Treatment does not exceed the applicable timeline by 12%, counting only whole days. Thus, the ADMH Commissioner is in Substantial Compliance for each deadline as follows: 30 days (34 days), 45 days (50 days), 60 days (67 days), and 90 days (101 days).

iii. If the ADMH Commissioner provides an Outpatient Mental Evaluation, Inpatient Mental Evaluation, or Competency Restoration Treatment to an individual prior to the date that would otherwise be dictated by the date that the ADMH Commissioner receives the court order directing same, the ADMH Commissioner's provision of services to that individual (i.e., the "line jumper") shall not be included in the calculation of the ADMH Commissioner's monthly average for purposes of calculating Substantial Compliance.

iv. If the ADMH Commissioner fails to provide an Outpatient Mental Evaluation, Inpatient Mental Evaluation, or Competency Restoration Treatment to an individual or individuals in a jail or an Alabama Department of Corrections facility when he or she reaches the first position on the waiting list for services ordered by the date of the ADMH Commissioner's receipt of the relevant order for same, based on a demonstrable and compelling obstacle to the provision of the ordered evaluation or treatment at that time, and instead, "skips" that person, that individual will not be counted for the purpose of calculating Substantial Compliance for a period of up to sixty (60) calendar days beyond the date of the skip. If the ADMH Commissioner "skips" an individual or individuals ordered to receive a Mental Evaluation or Competency Restoration Treatment, the ADMH Commissioner shall notify Plaintiffs' counsel, in writing, within ten (10) days of a "skip" that it has "skipped" that individual or individuals and describe the obstacle to the ADMH Commissioner's provision of the court-ordered service at the time that individual or for those individuals that reached the first position on the waiting list. If, upon receipt of the ADMH Commissioner's written explanation of a particular "skip," Plaintiffs' counsel disputes the existence of a demonstrable and compelling basis for the "skip," Plaintiffs' counsel may challenge the exclusion of the "skipped" person(s) from the calculation of the monthly compliance rate in accordance with the dispute resolution procedures in Section VIII of this Agreement. Not less

than five (5) days prior to the end of the sixty (60) day grace period, the ADMH Commissioner shall advise Plaintiffs' counsel, in writing, of (1) the reason(s) why the skipped individual or individuals has or have not yet been provided the court-ordered Mental Evaluation or Competency Restoration Treatment, and (2) any reason(s) why that person or persons should not be included in the calculation of the ADMH Commissioner's monthly compliance rate beginning on day sixty-one (61). Upon Plaintiffs' counsel's receipt of the ADMH Commissioner's written explanation of the continued deferral of the provision of the court-ordered evaluation or treatment to the "skipped" individual, the Parties shall meet and confer in good faith to resolve the issue of whether good grounds exist to justify the continued exclusion of the "skipped" individual from the calculation of the ADMH Commissioner's monthly compliance rate. In the event that the Parties agree that the skipped individual(s) should not be counted in the ADMH Commissioner's monthly compliance rate, the ADMH Commissioner shall provide periodic updates regarding the status of the skipped individual(s) on a timeline agreed upon by the Parties. In the event that the Parties are unable, after good faith discussions, to resolve the issue of whether the skipped individual(s) should be included in the ADMH Commissioner's monthly compliance rate, they shall submit the matter for resolution by the Court in accordance with the dispute resolution procedures set forth in Section VIII of this Agreement. If the ADMH Commissioner fails to provide Plaintiffs' counsel the written notice regarding any "skipped" individual(s) as specified above, that individual shall be included in the calculation of the ADMH Commissioner's monthly compliance rate on day sixty-one (61), and for purposes of this calculation, day 61 shall be treated as one day past the applicable deadline with subsequent days being the corresponding number of days past the deadline (i.e., day 62 is two days past the deadline, day 63 is three days past the deadline, and so on until the person or persons is or are provided the relevant court-ordered service).

v. Substantial Compliance will be determined on a monthly basis by the ADMH Commissioner in a monthly spreadsheet(s) and this spreadsheet should be provided to ADAP by the fifteenth calendar day of the month following the period covered by the monthly report. ADAP may request additional documentation necessary to the interpretation and verification of the spreadsheet data.

vi. If, after their review of the ADMH Commissioner's monthly spreadsheet(s), Plaintiffs assert or contend that the ADMH Commissioner is not in Substantial Compliance with this Agreement, Plaintiffs must articulate, in detail and in writing, the basis or bases for their assertions or contentions. The writing detailing Plaintiffs' assertions or contentions of non-compliance, and the factual basis or bases for the same, must be delivered to the ADMH Commissioner within fourteen (14) calendar days of Plaintiffs' review of the monthly spreadsheet(s).

F. Stipulation of Parties Regarding Calculation of Applicable Times

i. Upon approval of the proposed Settlement Agreement, the Defendant shall have 12 months to come into Substantial Compliance, as defined by Section V.15, with the timeframes set forth in Sections VI.A.i, VI.B.i, VI.C.i, and shall have 24 months to come into Substantial Compliance, as defined in Section V.15, with the timeframes set forth in Section VI.A.ii, VI.B.ii, and VI.C.ii. Pursuant to Section VII, the Monitor will begin monitoring in the fourth month following approval and will calculate the ADMH Commissioner's monthly compliance rate, in months 4-12, based upon the applicable 45 day timeframe, and then in months 13-24, based on the applicable 30 day timeframe.

ii. The method of calculating the ADMH Commissioner's average monthly compliance rate pursuant to Section V.15, excluding "jumpers" pursuant to Section VI.D.iii or Section VI.E.iii, will be as follows:

a. Outpatient mental evaluations. For each individual evaluated, the ADMH Commissioner will calculate the number of days between the date that the ADMH Commissioner received the order and the date that the outpatient mental evaluation was conducted. Then add together the total number of days and divide by the total number of persons evaluated on an outpatient basis.

b. Submission of reports of outpatient mental evaluations. For each report submitted, the ADMH Commissioner will calculate the number of days between the date that the evaluation was conducted and the date that the report regarding the evaluation was submitted to the circuit court. Then add together the total number of days and divide by the number of reports submitted to circuit courts.

c. Inpatient mental evaluations. For each individual admitted for an inpatient evaluation, the ADMH Commissioner will calculate the number of days between the date that the ADMH Commissioner received the order and the date the inpatient evaluation was conducted. Then the ADMH Commissioner will add together the total number of days and divide by the number of inpatient evaluations conducted.

d. Submission of reports of inpatient mental evaluations. For each report submitted, the ADMH Commissioner will calculate the number of days between the date that the evaluation was conducted and the date that the report regarding the evaluation was submitted to the circuit court. Then add together the total number of days and divide by the number of reports submitted to circuit courts.

e. Competency restoration treatment. For each individual admitted for competency restoration treatment, the ADMH Commissioner will calculate the number of days between the date that the ADMH Commissioner received the order and the date that the individual was admitted for competency restoration treatment. Then the ADMH Commissioner will add together the total number of days and divide by the number of persons admitted for competency restoration treatment.

f. The calculation for "skippers," shall be made pursuant to Section VI.E.iv.

g. Once the ADMH Commissioner calculates the average monthly rate of providing mental evaluations and competency restoration treatment, Substantial Compliance will be determined by whether the rate exceeds the relevant timeframes in Sections VI.A, VI.B, and VI.C.

h. Provisions for emergency treatment of class members are set forth in Section XV below.

2. **Increase in Capacity to Timely Provide Court-Ordered Mental Evaluations and Competency Restoration Treatment**.

A. Hospital Forensic Beds. The ADMH Commissioner, by and through ADMH and/or its contractors and/or other lawful providers, will add and operate, consistent with existing licensure and certification standards, hospital forensic beds for the provision of court-ordered Inpatient Mental Evaluations and Competency Restoration Treatment as follows:

i. Twenty-four (24) hospital forensic beds will be added and operational by twelve (12) months after Final Approval of this Agreement.

ii. Not fewer than twenty-five (25) additional hospital forensic beds will be added and operational by twenty-four (24) months after Final Approval of this Agreement.

iii. If the ADMH Commissioner determines that he or she can sustain Substantial Compliance as defined in Section VI.1.E with fewer operational Hospital Forensic Beds, the ADMH Commissioner may cease operating those beds that are not necessary to sustain the ADMH Commissioner's Substantial Compliance with the terms of this Agreement.

B. Community Forensic Beds. The ADMH Commissioner, by and through ADMH and/or its contractors and/or other lawful providers, will operate, or arrange for the operation of, fifty-two (52) community forensic beds consistent with existing licensure and certification standards, in group homes of no greater than 16 beds distributed throughout the state.

i. Twenty (20) community forensic beds shall be added and operational by twelve (12) months after Final Approval of this Agreement.

ii. A minimum of five (5) of the Community Forensic Beds added and operationalized by twelve (12) months after Final Approval of this Agreement shall be located where a Registered Sex Offender may be housed, and these 5 beds shall be used only to house Registered Sex Offenders unless there are fewer than 5 Registered Sex Offenders in need of a community forensic placement. These beds should be integrated within the beds associated with the preceding paragraph.

iii. Thirty-two (32) additional community forensic beds will be added and operational by twenty-four (24) months after Final Approval of this Agreement.

3. **Training to Relevant State Personnel**. The ADMH Commissioner, by and through ADMH, will offer initial and periodic training concerning the provisions of Alabama law and requirements of the Fourteenth Amendment to the United States Constitution with regard to persons ordered to receive Outpatient Mental Evaluations, Inpatient Mental Evaluations, and Competency Restoration Treatment to Alabama state circuit court personnel, county sheriffs, and

members of the Alabama State Bar regarding the procedures for the ADMH Commissioner's provision of Outpatient Mental Evaluations, Inpatient Mental Evaluations, and Competency Restoration Treatment to criminal defendants.

A. Court Personnel and Sheriffs. By twelve (12) months after Final Approval of this Agreement, the ADMH Commissioner, by and through ADMH, shall offer training to the circuit court personnel and sheriffs for each of Alabama's 67 counties regarding its obligation to provide timely Mental Evaluations and Competency Restoration Treatment to persons ordered to receive same in Alabama and the cooperation needed from court personnel and sheriffs in order for the ADMH Commissioner to meet the timelines specified in Sections VI.1.A through VI.1.E above.

B. Attorneys Representing Persons Affected by ADMH-Connected Orders. By twelve (12) months after Final Approval of this Agreement, the ADMH Commissioner shall distribute to each Alabama circuit court a publication, whose content is mutually agreed upon by the ADMH Commissioner and the undersigned counsel for Plaintiffs, for dissemination to attorneys representing persons ordered to receive Outpatient Mental Evaluations, Inpatient Mental Evaluations, or Competency Restoration Treatment.

C. Members of the Alabama Bar.

i. By twelve (12) months after Final Approval of this Agreement, the ADMH Commissioner shall distribute a letter or email to all members of the Alabama State Bar enclosing the publication specified in Section VI.3.B. above, to ensure that all attorneys representing persons ordered to receive Outpatient Mental Evaluations, Inpatient Mental Evaluations, and Competency Restoration Treatment are aware of the relevant time periods for the provision of same. ADMH shall also make reasonable efforts to have the publication (or its substance) distributed to the

criminal defense bar and prosecutors through electronic mail listservs (i.e., Alabama Criminal Defense Lawyers)**.**

ii. Beginning in calendar year 2017, and continuing for two years thereafter, the ADMH Commissioner shall offer annual training to members of the Alabama State Bar regarding the timelines governing the provision of court-ordered Outpatient Mental Evaluations, Inpatient Mental Evaluations, and Competency Restoration Treatment and its duty to comply with the same.

VII. MONITORING

1. The Parties agree that monitoring of the ADMH Commissioner's compliance, by and through ADMH, with the terms of this Agreement is necessary and that ADAP will serve as the monitor.

2. ADAP shall perform the monitoring provided for in this Agreement in accordance with the protocol set forth in Appendix B hereto.

3. The Parties agree that monitoring of the ADMH Commissioner's compliance, by and through ADMH, will be conducted by ADAP who will be recognized as the monitor in this case. ADAP will ensure that any monitoring activities undertaken by ADAP pursuant to its statutory access authority during the term of this Agreement (and any extension thereof) are separated from its monitoring activities under this Agreement, and shall not seek reimbursement under this Agreement for any monitoring activities undertaken pursuant to its statutory access authority. ADMH will allow ADAP, during its monitoring role, to have access to facilities, documents, staff, procedures, logs, records, and other similar information sources in order to ensure compliance. ADAP will further have access to persons in ADMH-operated facilities or facilities operated by ADMH-contractors who are ADAP's clients, persons who are members of

the certified class, or persons otherwise referred to in this Settlement Agreement. ADAP agrees to provide reasonable notice to ADMH facilities or staff before seeking said access in order to minimize disruptions to normal ADMH facility operations. ADAP will have its normal access to other persons in ADMH custody not involved in this Lawsuit under authority granted them by federal law as the protection and advocacy agency in Alabama. Nothing in this Settlement Agreement is intended to expand or restrict ADAP's existing access under federal law. ADAP will not charge monitoring fees for persons not covered by the terms of this Agreement. ADMH will assist to the extent possible if necessary to facilitate ADAP's reasonable access to persons held in the physical custody of county jails and resolve any challenges to ADAP's access to persons held in the physical custody of county jails. ADAP understands and agrees that access to county jails is not within the control of the Defendant or ADMH. The inability of ADAP to access persons held in county jail will not constitute a breach of this Agreement by ADMH.

4. ADAP agrees to be bound by any Protective or Court Orders entered in this case to protect the confidentiality of inmate records and sensitive security information.

5. ADAP will prepare a written report on ADMH's efforts to meet the requirements of this Agreement and any plan to effectuate the terms of this Agreement at least quarterly. Each report will indicate all areas in which the ADMH Commissioner is, or is not, in Substantial Compliance. Such report will be provided to ADMH and all counsel of record. If ADAP believes that the ADMH Commissioner is not in Substantial Compliance with the terms and provisions of this Agreement and/or any plan to effectuate its terms, ADAP will provide written recommendations for actions that it believes necessary to achieve Substantial Compliance with the terms of the provision or provisions. The ADMH Commissioner, by and through ADMH, will investigate the allegations and respond in writing with its comments, objections, or remedial action

plan(s) through its counsel within thirty (30) calendar days after receipt of the notification. The Parties will meet and confer in good faith to attempt to address deficiencies identified by ADAP.

6. In the event that Plaintiffs' counsel or the monitor discovers an exigent issue involving non-compliance, Plaintiffs' counsel or the monitor shall notify counsel for the ADMH Commissioner of same, in a writing designating the issue as exigent, without having to provide a complete report as to all areas in which the ADMH Commissioner is, or is not, in Substantial Compliance as specified in Section VII.5 above within ten (10) calendar days of the monitor's discovery of such exigent issue. The ADMH Commissioner, by and through ADMH, will investigate the allegations and respond in writing with its comments, objections, or remedial action plan(s) through its counsel within fourteen (14) calendar days after receipt of the notification. The Parties will meet and confer in good faith to attempt to address deficiencies identified by ADAP.

7. Monitoring will continue for a period that begins ninety (90) days after Final Approval of this Agreement and runs through the termination of the Agreement and the Court's jurisdiction over same, subject to the provisions of Section X below. The monitor shall not begin calculating the ADMH Commissioner's monthly compliance rate for ninety (90) days following Final Approval of this Agreement.

VIII. DISPUTE RESOLUTION PROCESS

1. During the implementation and monitoring periods of this Agreement (*see* Sections VI and VII, above), if Plaintiffs' counsel or the monitor believe that ADMH is not complying with some aspect of the Agreement, they will notify counsel for the Defendant ADMH Commissioner, as described in Sections VII.5 and VII.6 above. Defendant ADMH Commissioner, by and through ADMH, will respond as specified in Sections VII.5 and VII.6

above. Thereafter the Parties will meet and confer in good faith to resolve the issue as specified in Section VII.5 and VII.6 above.

2. In the event that the Parties are unable to resolve any issue(s) after attempting to do so in good faith, they shall submit their dispute to the magistrate judge assigned to the case or to the district court in the event no magistrate judge is assigned. Both parties shall have the right to appeal any magistrate judge's decision to the district court for review.

3. The award of any attorneys' fees to Plaintiffs in connection with any motion filed after engagement in the Dispute Resolution Process shall be governed by the provisions of Section XIII.5.

IX. RESERVATION OF JURISDICTION AND ENFORCEMENT

1. The Parties consent to the reservation and exercise of jurisdiction by the Court over disputes between the Parties and among the Parties arising out of this Agreement.

2. The Court will retain jurisdiction to enforce the terms of this Agreement, upon Final Approval, until the Agreement is terminated.

3. This Agreement may be enforced only by the Parties hereto and those intended to receive the Mental Evaluations and Competency Restoration Treatment provided for herein as specified in Sections III and IV above. Nothing contained in this Agreement is intended or will be construed to evidence an intention to confer any right or remedy upon any person other than the persons specified in this Section.

X. TERMINATION

1. The Parties agree that the term of this Agreement shall be three (3) years from the date of Final Approval by the Court, subject to the provisions below.

2. If Plaintiffs believe that the ADMH Commissioner has not achieved Substantial Compliance with the timelines for the provision of Outpatient Mental Evaluations, Inpatient Mental Evaluations, and Competency Restoration Treatment specified in Section VI.1.E above for at least the nine consecutive (9) months preceding the end date of the Agreement, Plaintiffs shall file a motion to extend jurisdiction and monitoring with the Court at least four (4) months prior to the end date of the Agreement. Upon the filing of a motion to extend jurisdiction and monitoring, the determination of whether the ADMH Commissioner has achieved Substantial Compliance as defined in Section VI.1.E shall be made by the Court after an evidentiary hearing. If the Court finds that the ADMH Commissioner has not achieved Substantial Compliance as defined in Section VI.1.E for at least the nine consecutive (9) months preceding the hearing on the extension of its jurisdiction and monitoring, the Court may retain jurisdiction for a period of time determined by the Court to ensure the ADMH Commissioner achieves Substantial Compliance. If the Court determines that ADMH has achieved Substantial Compliance as defined in Section VI.1.E, the Court may terminate jurisdiction and monitoring on the end date of the Agreement. If the ADMH Commissioner has not achieved Substantial Compliance as defined in Section VI.1.E, the ADMH Commissioner may, at any time following the end of the three (3) year term, petition the Court for termination of the Agreement and the Court's jurisdiction based on the status of the law at the time of such petition. In the event that the ADMH Commissioner seeks to terminate the Agreement and the Court's jurisdiction, the ADMH Commissioner shall bear the burden of proof to demonstrate that termination is appropriate and Plaintiffs shall have the right to respond to same prior to any determination by the Court that any such termination sought by the ADMH Commissioner is appropriate.

3. Three months prior to the end of the term of the Agreement, if the Parties agree that the ADMH Commissioner has not achieved Substantial Compliance, the Parties may agree in writing to extend the term of the Agreement for a specified period, and by joint motion, seek the Court's approval of their agreed-upon extension without an evidentiary hearing to determine compliance. During the extension period agreed upon by the Parties, the terms of the Agreement shall remain fully in effect and the parties will jointly request that the Court retain jurisdiction over the above-styled action.

4. If the term of Agreement is extended pursuant to Subsection X.2 above, Plaintiffs may seek additional extensions of the term of this Agreement by demonstrating that the ADMH Commissioner cannot demonstrate Substantial Compliance with the timelines for the provision of Outpatient Mental Evaluations, Inpatient Mental Evaluations, and Competency Restoration Treatment specified in Section VI.1 above for at least nine (9) consecutive months preceding any scheduled expiration or termination of the Agreement.

5. If the term of the Agreement is extended pursuant to Subsection X.2 above, the Court may order an additional term of monitoring commensurate with the period of time that the Court's jurisdiction is extended. If the monitoring period is extended, ADAP shall remain the monitor, and the hourly rate for additional monitoring and the total amount billable for such additional monitoring shall be the rates specified in Section XIII below, unless the Court determines that lower hourly rates and a lower annual cap is appropriate.

XI. AMENDMENTS

1. By mutual agreement, the Parties may change terms of this Agreement, including but not limited to the timelines for taking specific actions, provided that such modifications are memorialized in writing, signed by the Parties or through their counsel, and approved by the Court.

XII. FUNDING

1. The Parties acknowledge that implementation of the terms of this Agreement and any plan necessary to effectuate its terms are subject to the availability and receipt of appropriated funds.

2. The Parties further acknowledge that additional funding and the cooperation of third parties is necessary to the ADMH Commissioner's full performance in accordance with the terms of this Agreement, and that the lack of funding or third party cooperation does not preclude the Court from entering an Order to achieve compliance with this Agreement, and with other applicable law, provided that the ADMH Commissioner reserves the right to assert that the lack of funding and/or third party cooperation should be taken into account in any remedial order.

3. The ADMH Commissioner and ADAP agree to make all possible good faith efforts to seek all necessary funding to implement the terms of this Agreement, except that ADAP shall not be required to lobby in contravention of the federal prohibition on lobbying efforts by ADAP. In the event that the Parties are unable to agree as to whether there is sufficient funding to implement this Agreement, the Parties will meet and confer, and if necessary, consult with the Court. In the event that the Parties remain unable to agree, either party may seek the assistance of the Court.

4. The Parties stipulate that Section XII's provisions serve neither as a condition precedent to performance nor a basis for excusing the Parties' performance obligations under the Settlement Agreement. Section XII.1's acknowledgement that "implementation . . .[is] subject to the availability and receipt of appropriated funds" does not create a condition precedent to implementation, but acknowledges instead the practical reality that the ADMH Commissioner, in her administration of ADMH, is subject to an annual legislative appropriation process. Section

XII.2's acknowledgement that "additional funding and the cooperation of third parties is necessary to the ADMH Commissioner's full performance in accordance with the terms of the Agreement" likewise does not function as a condition precedent to the ADMH Commissioner's performance nor excuse her nonperformance, as made explicit in the further acknowledgement that "lack of funding or third party cooperation does not preclude the Court from entering an Order to achieve compliance with this Agreement.

XIII. ATTORNEYS' FEES AND EXPENSES

1. The ADMH Commissioner, by and through ADMH, agrees to pay attorneys' fees and associated costs to Plaintiffs' counsel in the amount of $275,000 for services rendered through March 13, 2017. From March 14, 2017, until Final Approval of this Agreement by the Court, the ADMH Commissioner, by and through ADMH, agrees to pay attorneys' fees to Plaintiffs' counsel in the amount of $275 per hour plus reasonable expenses. This payment shall be made to Henry F. Sherrod, III, P.C. The Plaintiffs' counsel shall be paid one-half (1/2) of said attorneys' fees within sixty (60) days of Final Approval of this Agreement by the Court. The balance shall be paid within sixty (60) days of the beginning of the 2019 Fiscal Year.

2. Plaintiffs' counsel agree that they will not seek nor petition the Court for an award of attorneys' fees and expenses for monitoring services greater than the following amounts. For purposes of describing the periods hereinafter, the time commences 90 days following the execution and Final Approval of this settlement by the Court. The fees amounts for monitoring services will be capped at, and shall not exceed, a total of the following amounts:

A. Year One (which runs from the date that monitoring begins): $48,000.00.

B. Year Two (which runs from the date that monitoring begins): $48,000.00.

C. Year Three (which runs from the date that monitoring begins): $48,000.00.

D. Additional periods of monitoring due to extension of the Agreement: $48,000 annually, unless a lower amount is Ordered by the Court or agreed to by the Parties.

3. Plaintiffs' counsel will provide itemized hours expended with detailed time entries to the ADMH Commissioner, in writing, on a quarterly basis.

4. The ADMH Commissioner, by and through ADMH, agrees to pay an hourly rate of $195.00 for services rendered by attorneys and $65.00 per hour for paralegals, law clerks, and members of ADAP's monitoring unit in the monitoring process. The Parties will meet and confer and attempt to agree upon payment for monitoring services rendered. In the event that the Parties are unable to agree upon the reasonable number of hours expended, either party may seek the assistance of the Court if the Parties remain unable to agree.

5. The annual caps and hourly rates described herein do not apply to (a) Plaintiffs' motions to enforce the terms of this Agreement, and (b) Plaintiffs' opposition to any motions filed by the ADMH Commissioner arising out of this Agreement. No fees and expenses will be awarded to Plaintiffs' counsel for such motions or oppositions unless the Court finds: (a) that the motion or opposition was necessary to enforce the terms of the Agreement; and (b) that Plaintiffs attempted to resolve the matter and or narrow the issues as much as possible by meeting and conferring with the ADMH Commissioner, taking full opportunity of recourse to the mediation process before presenting the issues to the Court.

XIV. ADDITIONAL PROVISIONS

1. The ADMH Commissioner waives the right to contest the enforceability of this Agreement by persons who have been charged with a crime in Alabama and ordered to receive an Outpatient Mental Evaluation as provided in Section VI.1.A. The Plaintiffs waive the right to contest, following Final Approval of the Agreement, the Constitutionality of this Agreement, any

of its terms, and the validity of this Agreement. Any person who is not part of settlement class who attempts to enforce this Agreement shall be deemed to be bound by this Agreement.

2. This Agreement constitutes the entire agreement between the Parties as to all claims contained herein. This Agreement supersedes all prior agreements, whether written, oral, or implied. Each party represents that it has full legal authority to enter into and execute this Agreement.

3. This Agreement completely resolves all claims in this Lawsuit that were brought or were required to have been brought in this Lawsuit with regard to the settlement class or any other beneficiary of this Agreement.

4. Unless expressly identified in this Agreement, the Parties do not intend for this Agreement to confer any benefit on any third party.

5. This Agreement may not be altered or amended, except in writing signed by all Parties or their representatives or by a Court order.

6. Nothing in this Agreement shall be construed to require the ADMH Commissioner or ADMH to disobey or violate any order of any court or any state or federal law in any way, subject to the Supremacy Clause of the United States Constitution.

7. This Agreement will be binding on all successors, employees, agents, and all others working on behalf of Plaintiffs and Defendant Lynn Beshear.

XV. IDENTIFICATION AND EMERGENCY TREATMENT OF CLASS MEMBERS

1. **Identification and Emergency Treatment of Class Members.** The Parties will implement the following process for identifying and treating class members who need emergency treatment prior to their admission into a facility operated by the Alabama Department of Mental Health ("ADMH"):

a. ***Notice to Relevant Persons***. The Parties, during the term of the proposed Settlement Agreement, and ADMH thereafter, will work with officials of the Alabama State Bar, with whom they have already begun conferring, to disseminate, on an annual basis, notice to members of the Alabama State Bar, which substantially comports with Appendix C hereto. The notice will be disseminated in a manner agreed to in cooperation with the Alabama State Bar, or alternatively, the Alabama Administrative Office of Courts, which may include publication. During the term of the proposed Settlement Agreement, the Parties, and ADMH thereafter, will also disseminate a notice to the circuit court judge in each Alabama county, on an annual basis, designating the ADMH official responsible for initiating the process of identifying and arranging emergency treatment for persons awaiting inpatient mental evaluations and/or competency restoration treatment prior to their admission into a facility operated by ADMH for that purpose, which will substantially comport with Appendix D hereto.

b. ***Procedure for Identifying Class Members in Need of Emergency Treatment.*** The ADMH Commissioner shall designate, annually, an ADMH official (the "ADMH Designee") to receive notice from current and future class members' criminal defense counsel and/or Alabama circuit court judges that a class member needs emergency treatment. Upon receipt of any such notice by the ADMH Designee, the ADMH Designee will provide notice of his or her receipt of notice to the Monitor, the Alabama Disabilities Advocacy Program ("ADAP"), within forty-eight (48) hours of receiving same during the term of the Settlement Agreement (ECF No. 60-1). Notification of the Monitor for this purpose may be made to the same individual designated according to Section III.1 of Appendix B (Monitoring Protocol) of the Settlement Agreement. Upon receiving notice from criminal defense counsel and/or an Alabama circuit court judge (or an agent acting on behalf of an Alabama circuit court judge) that an incarcerated criminal defendant

needs emergency psychiatric treatment, the ADMH Designee will first confirm that the individual is a class member to whom the ADMH Commissioner has a duty to provide care. If the individual concerning whom the ADMH Designee receives notice of a need for emergency treatment is not a class member, the Monitor shall transmit the notice to the Alabama Disabilities Advocacy Program operating as the State's protection and advocacy agency for prospective advocacy. If the individual concerning whom the ADMH Designee receives notice of a need for emergency treatment is a class member, the ADMH Designee will arrange for a clinical professional to visit the class member in person to conduct an assessment of the class member's need for emergency treatment within four (4) business days of the ADMH Designee's receipt of notice of the need for emergency treatment. If, in the clinical professional's judgment, the class member needs emergency treatment, the ADMH Commissioner shall arrange for the provision of emergency treatment to the class member or the class member's early admission into an ADMH operated facility for purposes of receiving the court-ordered inpatient mental evaluation or competency restoration treatment (*i.e.*, a "line jump" pursuant to Section VI.D.iii of the proposed Settlement Agreement) within seven calendar days of the clinical professional's in-person visit with the class member. The ADMH Designee will advise the Monitor of the clinical professional's determination whether the class member needs emergency treatment and any arrangements for such treatment within forty-eight (48) hours of the professional's in-person visit with the class member during the term of the Settlement Agreement. If after the ADMH Designee receives notice from a class member's defense counsel or a circuit court judge the Sheriff of the county and/or officials of the jail or Alabama Department of Corrections Facility in which the class member is incarcerated refuses ADMH officials, the ADMH-designated clinical professional, or the Monitor access to the class member, then within twenty-four (24) hours of the denial of access the ADMH

Designee will notify the Monitor of same and all Parties will meet and confer as to the appropriate motion to be filed with the Circuit Court for access to the class member. In the event of a dispute between the ADMH officials evaluating the class member for emergency treatment or a potential "line jump" and the Monitor concerning the need for same, the Monitor shall submit the dispute for formal resolution in accordance with the provisions for dispute resolution in Section VIII of the proposed Settlement Agreement.

c. ***Procedure for Responding to Class Members Who May Be Suicidal.*** Upon receipt of notice by the ADMH Designee that an incarcerated criminal defendant needs emergency treatment because he or she is believed to be suicidal, the ADMH Designee shall forward notice of same to the Monitor within twenty-four (24) hours of receipt, unless such notice is received on a Saturday or Sunday, in which case the ADMH Designee shall have until close of business the following Monday to forward the notice to the Monitor. Upon receipt of such notice, if the individual identified in the notice is a class member, the Monitor shall immediately notify the Sheriff of the county and officials of the jail or ADOC facility in which the individual is incarcerated that the individual is believed to be at risk of suicide. If the individual identified in the notice is not a class member, the Monitor shall transmit the notice to the State's protection and advocacy agency for prospective advocacy.

XVI. EFFECT OF SETTLEMENT AGREEMENT ON FEMALE CLASS MEMBERS

1. All provisions of the Settlement Agreement apply with equal force to male and female class members, including all timeframes for the provision of court-ordered inpatient mental evaluations and competency restoration treatment, Settlement Agreement, Section VI.1.A, VI.1.B, and VI.1.C, training to relevant state personnel, Settlement Agreement, Section VI.3, and monitoring, Settlement Agreement, Section VII, Appendix B (Monitoring protocol including

documents provided for monitoring include waiting lists for Taylor Hardin Secure Medical Facility and Bryce Hospital). The provisions of the Settlement Agreement related to the addition of forensic hospital and community beds likewise apply with equal force to female and male members of the settlement class, as the additional capacity required by the Settlement Agreement must be allocated so as to ensure that the timeframes for provision of court-ordered services to female class members are achieved.

2. As of August 7, 2017, there were no female class members on the waiting list for admission to Bryce Hospital for court-ordered inpatient mental evaluations or competency restoration treatment. The total number of female class members who have been ordered to receive an inpatient mental evaluation, and who awaited admission to Bryce Hospital for some period of time, since January 1, 2017 is 9. The total number of female class members who have been found incompetent to stand trial and ordered to receive competency restoration treatment, and who awaited admission to Bryce Hospital for some period of time, since January 1, 2017 is 8. The average number of days following ADMH's receipt of a circuit court order directing its provision of an inpatient mental evaluation or competency restoration treatment to a female class member has been 7 days, with the longest wait since January 1, 2017 being 10 days.

Dated, this the 25th day of January, 2018.

/s/ Myron H. Thompson
UNITED STATES DISTRICT JUDGE

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

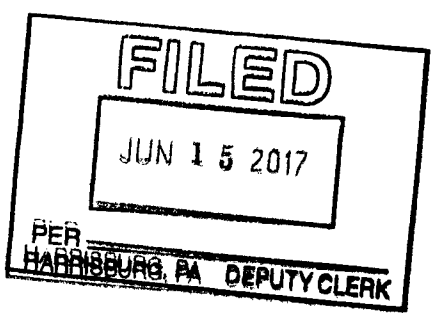
J.H., by and through his next friend, Flo Messier; L.C., by and through her next friend, Flo Messier; R.J.A., by and through his next friend, J.A.; Jane Doe, by and through her next friend Julia Dekovich; S.S., by and through his next friend, Marion Damick; G.C., by and through his next friend, Luna Pattela; R.M., by and through his next friend, Flo Messier; P.S., by and through his next friend M.A.S.; T.S., by and through his next friend Emily McNally; M.S., by and through his next friend Emily McNally; and all others similarly situated,

Plaintiffs

v.

Theodore Dallas in his official capacity as Secretary of the Pennsylvania Department of Human Services; Edna I. McCutcheon in her official capacity as the Chief Executive Officer of Norristown State Hospital; Robert Snyder in his official capacity as the Chief Executive Officer of Torrance State Hospital,

Defendants



Civil Action No. 1:15-cv-02057-SHR

Judge Sylvia H. Rambo

SECOND INTERIM SETTLEMENT AGREEMENT

WHEREAS Plaintiffs, individuals who have been declared incompetent by the courts to stand trial on criminal charges and who have been ordered committed to Norristown State Hospital ("NSH") or Torrance State Hospital ("TSH") for

treatment to help them attain competence, but who instead have remained in jail for extended lengths of time and in some cases for over a year, filed this civil rights class-action lawsuit on October 22, 2015 (*see* ECF No. 1), against officials of the Pennsylvania Department of Human Services ("DHS"), alleging that the delays in transferring them to one of the DHS hospitals for competency-restoration treatment violate the Due Process Clause of the Fourteenth Amendment to the United States Constitution; Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12131-12134; and Section 504 of the Rehabilitation Act ("RA"), 29 U.S.C. § 794;

WHEREAS the parties resolved Plaintiffs' Motion for Preliminary Injunction (ECF No. 4) by entering into an interim Settlement Agreement on January 27, 2016, to undertake actions designed to reduce the length of the wait lists and wait times of persons declared incompetent and awaiting treatment, i.e., Class A members (ECF No. 35);

WHEREAS DHS stipulated in the interim Settlement Agreement that there is sufficient evidence to establish that wait times of at least 60 days fail to comply with Fourteenth Amendment due process guarantees (ECF No. 35 at ¶ 1), and some federal courts have held that even wait times less than 30 days are unconstitutional;

WHEREAS since February 2016, the Defendants have invested resources to create 120 new slots for treatment in the community; 377 patients have been discharged from NSH and TSH; and 348 individuals have removed from the wait lists before admission to the hospitals, but the wait lists nonetheless have grown from 216 people awaiting treatment at the time of the interim Settlement Agreement on January 29, 2016, to 256 awaiting treatment on May 26, 2017;

WHEREAS, by way of example, of the 41 patients admitted from jails into NSH on the waiting lists dated from January 6 through May 26, 2017, 25 patients waited more than 300 days, and of those 25 patients, 17 waited at least 400 days, 5 waited over 500 days, 2 waited more than 600 days, and one waited over 788 days in jail before being admitted to NSH. As of May 26, 2017, 36 individuals awaiting admission to NSH have been waiting over 300 days, of whom 6 have been waiting more than 400 days;

WHEREAS, by way of example, of the 74 patients admitted from jails into TSH on the waiting lists dated from January 6 through May 26, 2017, 64 waited 30 days

or more, 51 of whom waited 90 days or more. As of May 26, 2017, 17 individuals awaiting admission to TSH have been waiting more than 60 days, 4 of whom have been waiting more than 100 days;

WHEREAS Plaintiffs have discussed with Defendants the reasons for the lack of progress under the interim Settlement Agreement in reducing the number of patients on the wait lists and the wait times since September 2016;

WHEREAS on May 11, 2017, Plaintiffs renewed and amended their original motion for preliminary injunction, initially filed on October 22, 2015 (*compare* ECF Nos. 4 and 9 with ECF Nos. 40 and 45);

WHEREAS the parties recognize that the protracted wait times serve neither the interests of justice nor the clinical needs of Class A members and that a comprehensive evaluation of the competency-restoration system and additional actions are currently needed to make progress toward permanently reducing wait lists and wait times to a constitutionally acceptable level;

THEREFORE, intending to be bound, the parties hereby agree as follows:

1. Defendants will hire the independent consultant identified by Plaintiffs in the agreement letter attached hereto as Exhibit "A." The consultants will, as more fully set forth in Exhibit A:

    a. conduct a thorough assessment of DHS's competency-restoration systems and processes, which will include a review of the individuals awaiting competency restoration treatment, the forensic population currently in treatment, competency restorations completed in 2016, the resources and processes in use and available to DHS, and the role of other stakeholders in the forensic criminal justice system; and

    b. produce a report that will identify a strategy and recommend tangible actions to reduce wait times for competency restoration treatment to constitutionally acceptable limits;

2. Defendants will make available the following resources, above those originally specified in the interim Settlement Agreement, to competency-restoration patients awaiting treatment within the time frames specified:

a. Within six months, a new "minimum security" unit consisting of 50 new forensic beds at NSH, which will be comprised of a combination of 28 brand new beds and 22 beds in existing civil units that will be converted for forensic use;

b. Within six months, DHS expects that an additional 29 DHS-funded treatment slots will become available in the community, comprised of 7 in Allegheny County (targeted for completion by September 2017), an additional 12 thereafter in Allegheny County, and 10 in Philadelphia; and

c. Within 9 months, at least 30 civil beds at NSH (in addition to those identified in subparagraph 2a, *supra*), which are currently occupied by civilly committed patients who will move to the community as specified in their Community Service Plans, will be converted into forensic beds, provided, however, that no patient who is currently in a civil bed will move to the community only to comply with this subparagraph if the community services have not yet been developed for that patient.

3. Defendants will implement the strategy identified in the independent consultant's final report to reduce wait times to a constitutionally acceptable level, unless, within 14 days of receiving the consultant's final report, Defendants submit to Plaintiffs a detailed, written description of why one or more action items recommended in the report are not achievable or warranted, and will propose alternative actions or explain why the action is unnecessary. If the parties are unable to agree within 30 days, Plaintiffs may at any time thereafter file a motion asking the Court to issue a preliminary or final injunction to enjoin DHS to take such steps as the Court determines necessary and appropriate to reduce wait times to a constitutionally acceptable level. DHS may assert all available defenses to Plaintiffs' motion.

4. Upon receipt of the final report, the parties will attempt to reach agreement on a maximum allowable wait time, an outstanding legal issue the parties reserved in the interim Settlement Agreement and which the parties reserve once again. If the parties are unable to agree upon a maximum allowable wait time after the consultant issues the final report, Plaintiffs retain their right from the interim Settlement Agreement to file a motion asking the Court to issue a declaratory judgment, preliminary injunction, or final

injunction setting the maximum allowable wait time and a deadline for Defendants to reduce wait times to that level as a remedy for the constitutional violations alleged in the Complaint.

5. This Second Interim Settlement Agreement resolves all issues outstanding in Plaintiffs' Motion to Renew and Amend Motion for Preliminary Injunction (ECF No. 40), except for the issues reserved in paragraph 4, *supra.*

6. This Second Interim Settlement Agreement does not negate or nullify any provision of, or obligation imposed on DHS contained by, the interim Settlement Agreement, which remains fully enforceable by this Court as specified in that Agreement.

7. Defendants agree to pay Plaintiffs' reasonable attorneys' fees, adjusted to Middle District of Pennsylvania rates, and costs incurred in the prosecution of Plaintiffs' Motion to Renew and Amend Motion for Preliminary Injunction (ECF 40) since May 5, 2016. If the parties are unable to agree to a negotiated amount of attorneys' fees and costs, Plaintiffs may submit a petition for decision by the presiding judge, who may in the first instance refer the matter for mediation.

8. In addition to Defendants' obligations under ¶ 11 of the interim Settlement Agreement, Defendants also agree to pay (a) reasonable costs and consulting fees for time incurred by Dr. Joel Dvoskin, up to $15,000 total, from the date of this agreement in consulting with the parties and independent consultant hired under paragraph 1 to facilitate the assessment and development of the consultant's final report or the requirements of this Second Interim Settlement Agreement, or both; and (b) Plaintiffs' reasonable attorneys' fees from the date of this agreement, to be billed at no higher than a $350 hourly rate, not to exceed a total of $100,000 during any twelve-month period, for monitoring the Second Interim Settlement Agreement. Subparagraph (b) does not apply if Plaintiffs move to enforce either the first or second interim Settlement Agreement or move for a declaratory judgment or preliminary or final injunction, at which point the usual Middle District Court rates will apply and fees will be resolved in accordance with paragraph 7.

9. The provisions of this Settlement Agreement will be subject to enforcement through specific performance after Plaintiffs provide Defendants with thirty-days written notice and an opportunity to cure. Plaintiffs do not waive any

available rights or remedies in the event Defendants fail to comply with an order for specific performance, and Defendants do not waive any defenses.

10. The parties will ask the Court to dismiss Plaintiffs' pending motion for preliminary injunction (ECF 40) as moot. This Court will retain jurisdiction, including the power and authority to enforce this Settlement Agreement and subsequent Settlement Agreements adopted by the parties, for 3 years from the date the Court approves the Agreement. Either party may petition the Court to shorten or lengthen the time for good cause.

For Defendants

By: */s/ Doris M Leisch*
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For Plaintiffs

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By: */s/ David P. Gersch*
David P. Gersch
ARNOLD & PORTER LLP
601 Massachusetts Ave., N.W.
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202-942-5000

Approved by the Court on this 15th day of June, 2017:

Hon. Sylvia H. Rambo, Senior U.S.D.J.

Interim Agreement

1. The parties agree that the *Mink* (3:02-cv-00339-MO) and *Bowman* (3:21-cv-01637-HZ) cases should be joined as related cases. The parties agree to suspend formal discovery in both cases, and will instead exchange information informally in accordance with the engagement of Dr. Pinals.

2. Defendants will stipulate to an amendment in the *Bowman* case to add the Metropolitan Public Defender as an appropriate institutional plaintiff.

3. Defendants will enter into a contract with neutral expert Dr. Debra Pinals on or before December 31, 2021. Upon consultation with Dr. Pinals, she will begin her work immediately but not later than January 3, 2022.

4. The parties will file a joint stipulation and order on or before December 15, 2021, appointing Dr. Pinals as a neutral expert in the joined cases and outlining her role.

5. The parties agree to request a deadline of January 31, 2022, for Dr. Pinals to file her initial Report and Recommendation with the Court, to address short-term compliance plan and a proposed global admissions protocol. The parties agree to participate in a renewed settlement conference with Magistrate Judge Stacie F. Beckerman on February 3, 2022, to resolve any disputes relating to Dr. Pinals's Report and Recommendation. If the parties are unable to resolve their disputes, or at the Court's request, the parties will appear at a hearing on Dr. Pinals's Report and Recommendation before the U.S. District Judge the week following the renewed settlement conference. If the parties agree with Dr. Pinals's Report and Recommendation, Defendants will follow her recommendations and will report their progress in their monthly reports to Dr. Pinals.

6. The parties agree to request a deadline of April 29, 2022, for Dr. Pinals to file her Report and Recommendation regarding a proposed long-term compliance plan. The parties agree to participate in a renewed settlement conference with Magistrate Judge Beckerman on May 4, 2022, to resolve any disputes relating to Dr. Pinals's Report and Recommendation. If the parties are unable to resolve their disputes, or at the Court's request, the parties will appear at a hearing on Dr. Pinals's Report and Recommendation before the U.S. District Judge the week following the renewed settlement conference. If the parties agree with Dr. Pinals's Report and Recommendation, Defendants will follow her recommendations and will report their progress in their monthly reports to Dr. Pinals.

7. Plaintiffs in the *Mink* and *Bowman* cases agree not to initiate contempt proceedings nor request temporary injunctive relief pending the Court's resolution of Dr. Pinals's April 29, 2022, Report and Recommendation, unless they believe that Defendants are not acting in good faith or are not complying with this Interim Agreement. If Plaintiffs intend to initiate contempt proceedings or request temporary injunctive relief during this interim time period, they will first attempt to resolve the dispute through mediation with Magistrate Judge Beckerman.

8. Defendants will provide Dr. Pinals with monthly reports throughout her engagement. Defendants' first report to Dr. Pinals is due on January 3, 2022 and must include: 1) a summary of Defendants' actions between December 10, 2021, and January 3, 2022, to achieve compliance; 2) what actions Defendants plan on taking in January 2022, to achieve compliance; and 3) barriers identified to completing those actions.

9. Defendants agree to designate a representative to participate in a January 2022 meeting with Multnomah County stakeholders to discuss the feasibility of a jail population and 9(b) review committees.

10. Between December 17, 2021 and the Court's adoption of a global admissions protocol, the parties agree that no individual found Guilty Except for Insanity will wait longer than four months for admission to the Oregon State Hospital.

11. The parties agree to draft a joint press release regarding this interim agreement.

Sheila H. Potter
Deputy Chief Trial Counsel
On behalf of Defendants

Emily Cooper
On behalf of Disability Rights Oregon

Jesse Merrithew
On behalf of Metropolitan Public Defender

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

PORTLAND DIVISION

DISABILITY RIGHTS OREGON et al.,

Plaintiffs,

v.

PATRICK ALLEN et al.,

Defendants,

No. 3:02-cv-00339-MO (Lead Case)
No. 3:21-cv-01637-MO (Member Case)

SECOND AMENDED ORDER TO IMPLEMENT NEUTRAL EXPERT'S RECOMMENDATIONS

JAROD BOWMAN et al.,

Plaintiffs,

v.

DOLORES MATTEUCCI et al.,

Defendants,

No. 3:21-cv-01637-MO (Member Case)

MOSMAN, J.,

THIS MATTER comes before the Court on Defendants' Unopposed Motion to Amend September 1, 2022 Order [ECF 367] and Plaintiffs' Unopposed Motion for Further Remedial Order [ECF 411]. Having reviewed the papers filed in support of these motions, the Court finds that Defendants are still not in compliance with this Court's permanent injunction in *Mink* and ORDERS the following which are necessary to move Defendants towards compliance with that injunction:

I. Neutral Expert

The Oregon State Hospital ("OSH"), the Oregon Health Authority ("OHA"), Disability Rights Oregon ("DRO"), and Metropolitan Public Defenders shall implement the recommendations in the Court's Neutral Expert's Reports. If necessary to comply with any part of this order, Dr. Pinals may grant extensions of other deadlines in her recommendations after conferring with the parties. Any such extensions shall be documented in Defendants' monthly progress reports.

II. Admissions

OSH shall not admit patients except as provided for by the recommendations in the Neutral Expert's Reports or as otherwise provided by this Court. Namely, Aid and Assist ("A&A") and Guilty Except Insane ("GEI") persons shall be admitted according to their place on the admissions wait list or pursuant to the expedited admissions policy attached to this order as Exhibit 1.[1] In addition, OSH:

a. may admit Psychiatric Security Review Board ("PSRB") GEI revocations and persons pursuant to ORS 426.701 (extremely dangerous persons);

b. shall not admit persons civilly committed or admit "voluntary by guardian" persons unless they meet the criteria in the expedited admissions policy attached as Exhibit 2 to this order;

c. shall not admit transfers from the Oregon Youth Authority except as provided by ORS 179.473(1)(c), OAR 309-120-0080, and OAR 416-425-0020; and

d. shall not admit transfers from the Oregon Department of Corrections unless they meet expedited admissions standards as articulated in the expedited admissions policy attached as Exhibit 1 to this order.

[1] The expedited admissions policies referenced in this order as Exhibits 1 and 2 can be found at: https://www.oregon.gov/oha/OSH/LEGAL/Pages/expeditedadmissions.aspx.

e. For persons found unable to aid and assist whose most serious charge is a misdemeanor, only those persons charged with a "person misdemeanor" may be committed to the custody of OSH for restoration. For purposes of this order, a "person misdemeanor" includes those crimes listed in OAR 213-003-0001(15), violation of an Extreme Risk Protective Order entered under ORS 166.525 et seq., and violation of any of the following in proceedings to impose punitive sanctions for contempt:

(1) a Family Abuse Prevention Act Restraining Order entered under ORS 107.700 et seq.;

(2) an Elderly Persons and Persons with Disabilities Abuse Prevention Act Restraining Order under ORS 124.005 et seq.;

(3) a Sexual Abuse Restraining Order under ORS 163.760 et seq.; or

(4) an Emergency Protection Order under ORS 133.035.

III. Maximum Times

OSH shall immediately implement the maximum time for inpatient restoration in the Neutral Expert's June 2022 report as follows:

a. For patients whose most serious charge is a misdemeanor, the maximum duration of commitment for restoration shall be the lesser of the maximum permissible sentence for the underlying offense or 90 days;

b. For patients whose most serious charge is a felony, the maximum duration of commitment for restoration shall be six (6) months, unless the felony is listed in ORS 137.700(2), in which case the maximum duration of commitment for restoration shall be one year.

c. For purposes of this order, restoration across multiple charges shall be consolidated and contiguous consecutive periods of restoration should be eliminated unless there are new charges incurred after an initial period of restoration has ended.

d. Before a patient reaches this maximum duration of commitment for restoration under this order and remains unfit to proceed, OSH shall notify the committing court of the patient's impending discharge 60 days before the date on which the hospital is required to discharge the patient pursuant to this order.

e. For purposes of this order, the maximum time for inpatient restoration runs from the date of admission to OSH.

f. Defendants shall consult with the Neutral Expert regarding operational and clinical aspects of implementing these limitations on the duration of inpatient restoration.

IV. Discharge Planning Extension

Additional time at OSH for care coordination and discharge planning to promote and protect the health and safety of the public upon state court order for a maximum of 30 days beyond the timelines described in this order after opportunity for objection by defense will be available in limited circumstances, if, according to OSH, the individual cannot be placed immediately in an identified placement after a referral has been submitted to that placement, but reasonably expects to be placed within 30 days. The extension will be considered when OSH receives any such court order at least 5 business days prior to the expiration of the restoration time period, or within 5 business days of entry of the remedial order if less than 5 days remain until expiration of the restoration time period at the time of entry of the remedial order. Failure to coordinate discharge planning by the Community Mental Health Program ("CMHP") will not constitute justification for this extended discharge planning exception.

V. Extending Duration of Hospital Restoration for Violent Felonies

Upon notice from OSH that a defendant is reaching the end of their restoration period (and such notice shall be provided at least 60 days prior to the end of their restoration period), a district attorney may petition for an exception to the maximum time for inpatient restoration established by this order. The petition shall be signed by the district attorney for the county and submitted within 30 days of receipt of the notice of discharge (or within 30 days of entry of the remedial order if less than 30 days remain until expiration of the restoration time period at the time of entry of the remedial order), and OSH must receive any order from the committing court prior to the expiration of the restoration time period (or within 30 days of the filing of the petition if less than 30 days remain until expiration of the restoration period at the time of entry of the remedial order). The court may grant the petition if it determines the following:

a. The defendant is charged with a "violent felony" pursuant to ORS 135.240(5),[2]

b. By clear and convincing evidence, there is a danger of physical injury or sexual victimization to the victim or a member of the public if the defendant is discharged from OSH,

c. The defendant meets the requirements of ORS 161.370(3), and

d. The court concludes that there is a substantial probability that continued commitment at OSH will lead to a determination that the defendant has gained or regained fitness to proceed within that 180 day extension. In making this determination, the court shall consider the following:

(1) clinical data of progress toward restoration,

[2] "Violent felony" means a felony offense in which there was an actual or threatened *serious physical injury* to the victim, or a felony sexual offense. A *serious physical injury* means a physical injury which creates a substantial risk of death or which causes serious and protracted disfigurement, protracted impairment of health, or protracted loss of impairment of the function of any bodily organ. ORS 161.015(8).

(2) evidence that the defendant's inability to aid and assist is not due to a condition that is unlikely to result in restoration such as a significant neurocognitive disorder (e.g., dementia or traumatic brain injury), or significant neurodevelopmental disability disorders,

(3) evidence regarding the outcome of prior efforts at restoration, and

(4) any other relevant information the court wishes to consider.

If the court grants a petition, the court shall conduct a review of the status of restoration efforts at intervals no greater than every 180 days in accordance with ORS 161.371. At such reviews, the court may continue the commitment for an additional 180 days if it makes the findings outlined above. The maximum total amount of commitment time shall not exceed the time period set by ORS 161.371(5).

OSH shall track the patients who are eligible for this exception by notice from the Oregon Judicial Department and shall track those for whom such exception has been requested and those who have been found by courts to fall within this exception and shall report aggregate data at least every two weeks on their data dashboard website.

VI. Competency Opinion Clarifications

If the defendant is under a competency restoration order, at the time of subsequent statutory forensic evaluations, the forensic evaluator shall notify the court that:

a. the defendant has present fitness to proceed;

b. there is no substantial probability that, in the foreseeable future, the defendant will gain or regain fitness to proceed and whether there is no substantial probability that, within the allowable commitment period for restoration at OSH, the defendant will gain or regain fitness to proceed; or

c. there is a substantial probability that, in the foreseeable future, the defendant will gain or regain fitness to proceed and whether there is a substantial probability that, within the allowable commitment period for restoration at OSH, the defendant will gain or regain fitness to procced.

If the probability exists, the superintendent, director, or designee shall give the court an estimate of the time in which the defendant, with appropriate treatment, is expected to gain or regain fitness to proceed.

VII. Supremacy Clause Disputes

If OSH identifies a conflict between this order and the committing jurisdiction's order during the pendency of this order, the parties to the criminal case and an OSH representative (and its counsel) are encouraged to participate in an expedited mediation (by video or phone, if necessary) with U.S. Magistrate Judge Stacie Beckerman, to resolve the conflict. OSH and the parties to the criminal case should meet and confer prior to the mediation in an effort to resolve any conflict between the court orders and clarify the issues subject to mediation. If any party to the criminal case refuses to participate in mediation or if mediation is unsuccessful, any *Mink/Bowman* party may petition this Court for an expedited ruling on whether the Supremacy Clause establishes that this order takes precedence over the conflicting state court order, and any responses from the parties or amici shall be filed within five business days.

VIII. Implementation

To the extent that aspects of this remedial order require updated forms and protocols by OHA, OSH, and amici, these updates shall be made with the assistance of amici and the parties, and there shall be up to a 30-day period from the date of this order to implement any such changes to relevant forms and to notify stakeholders impacted by these changes.

IX. Compliance

This order shall terminate upon the Neutral Expert reporting to this Court that OSH/OHA has timely admitted A&A and GEI patients for at least three consecutive months, and that the termination of this order would not cause the Defendants to fall back out of compliance. For purposes of this order "timely admission" means within seven days of a State Court order delivered to OSH ordering that the patient be admitted.

X. Termination

If this order is not terminated pursuant to Section IX, this order will expire on December 31, 2023, unless renewed by the Court prior to that time.

IT IS SO ORDERED.

DATED: _____July 3, 2023_____

____/s/ Michael W. Mosman_____

MICHAEL W. MOSMAN
Senior United States District Judge

EXHIBIT 1

OREGON STATE HOSPITAL
Office of the Superintendent
Kate Brown, Governor

Oregon Health Authority

2600 Center Street NE
Salem, OR, 97301
Voice: 503-945-2852
TTY: 800-735-2900
Fax: 503-947-2900
osh.oregon.gov

June 27, 2022

Request for Oregon State Hospital Expedited Consultation/Admission

PATIENTS ON THE OSH ADMISSION LIST UNDER FORENSIC COMMITMENTS

Purpose of this document:

This document sets forth protocols and processes for referral for expedited consultation and possible early admission of individuals under a forensic commitment awaiting admission to Oregon State Hospital from local jails. OSH and OHA are working in partnership with stakeholders to increase timely access to OSH. To achieve equitable efficiencies and maximum timeliness for all admissions, only in very limited circumstances would an expedited admission be approved.

Role of OSH for forensic patients:

OSH has a role in caring for individuals sent via courts who are either in need of restoration to competence to stand trial, are found Guilty Except for Insanity, or are committed under an Extremely Dangerous Persons civil commitment and are found to warrant care and treatment at OSH. These legal categories (A/A, GEI and EDP) are referred to as “forensic” as they involve criminal court processes. OSH treatment providers have substantial expertise in the treatment of people with severe and persistent mental illness and can provide helpful informal consultation by telephone regarding the management of individuals waiting for OSH admission.

Protocol:

Individuals eligible to request expedited clinical or systems consultation/admission: Courts, jail personnel, the individual’s assigned defense attorney(s), case prosecutor(s), or anyone who, in their professional capacity, has concerns about the mental health condition of individuals in the categories listed below.

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Individuals eligible for expedited consultation/admission: An individual being held in custody but ordered by a Court to OSH and placed on the OSH admission list, who are forensically committed pursuant to any of the following statutes:

- ORS 161.370: order for restoration of fitness to proceed;
- ORS 161.365: order for admission for up to 30 days' observation as initiated by OSH;
- ORS 161.327: An individual found guilty except for insanity (GEI); or
- ORS 426.701: An individual judicially committed as an extremely dangerous person with mental illness.

Qualifying Criteria for Expedited Admission: Individuals may be considered for expedited consultation/admission if they are currently at serious risk of harm to self, related to:

- Mental health symptoms compromising the immediate health and safety of the individual; and/or
- Active suicidal intent, actions such as suicide attempts, or serious self-injury*; and/or
- Inability to meet basic needs that puts the individual's immediate health and safety at risk**

**Serious injury includes injury requiring immediate medical attention OR averted injury which would have required immediate medical intervention if not for the intervention of jail staff. An individual who has received interventions such as limiting access to lethal means, use of suicide-resistant clothing, or other staff actions used to secure the immediate safety of the individual may still be referred for expedited consultation/ admission.*

***Risk to health and safety related to mental illness could include not eating or drinking for a period of time that could lead to medical consequences or placing oneself at risk of victimization due to apparent mental illness*

Disqualifying Criteria for Expedited Admission: An individual who meets the eligibility criteria above but who has *an active medical condition that requires stabilization at a primary medical center*. Once medical stabilization has occurred, if the individual still meets criteria, a request for consultation is encouraged. Consultation is also available while the individual is being stabilized to ensure timely transport and admission.

Process:

Rapid Response Consultation: a telephone consultation is encouraged when there is an immediate health and safety risk which meets the above criteria AND may require OSH admission within 24-48 hours, possibly following emergency stabilization at a primary medical center.

1. OSH response occurs within one (1) business day

2. Telephone consultation only, though OSH may contact the jail to provide additional documentation, as described below
3. **Contact the OSH Admissions Department at 503-945-9265 (phone) or OSH.Admissions@odhsoha.oregon.gov (email)**
4. If further assessment of the individual is needed before a determination can be made, OSH will work with jail personnel or, if appropriate, with OHA (who will engage community mental health providers) to conduct such an assessment.

Expedited Consultation: a consultation and/or referral for expedited admission is encouraged when there is a health and safety risk which meets the above criteria but is not likely to require OSH admission within 24-48 hours.

1. OSH response occurs within two (2) business days
2. If a telephone consult is preferred, contact the OSH Admissions Department as above. OSH may also contact the jail to provide additional documentation, as described below.
3. Written referrals must be sent to the OSH Admissions Department (contact information below) and include the following:
   a. a written explanation of
      - the clinical concerns that require more immediate attention; and
      - a description of interventions and supports that have already been implemented or attempted; and
   b. additional documentation provided by the jail as described below.

Additional documentation (which may be requested from the jail by the OSH Admissions Department to supplement a consultation):

- Medical and Psychiatric Records from the jail facility; and
- Medication administration records for the last month; and
- Logs for the duration of the inmate's current stay at the jail facility detailing restraint/seclusion, special observation, administrative segregation, or disciplinary segregation; and
- If available, the status of a court order for administration of involuntary medications

Requests for consultation/expedited admission will be reviewed by the Chief Medical Officer or designee during business hours (0800-1700) Monday through Friday. The reviewer may contact the submitting jail or referral source to arrange consult by phone or video if additional information is needed.

Within 24 hours of receiving all necessary information, the CMO or designee will communicate back to the referring party related to consultation/admission considerations.

A request for expedited admission is not meant to replace services that are currently required within jail facilities or emergency medical care. In a life-threatening emergency, the individual should be treated at the local site and taken for emergency medical care as needed.

Admissions Department contact information:
Phone: 503-945-9265
FAX: 503-945-9839
Email: OSH.Admissions@odhsoha.oregon.gov

Hours of operation:
Monday through Friday
8:00 AM to 5:00 PM

EXHIBIT 2

OREGON STATE HOSPITAL
Office of the Superintendent
Tina Kotek, Governor

Oregon Health Authority

2600 Center Street NE
Salem, OR, 97301
Voice: 503-945-2852
TTY: 800-735-2900
Fax: 503-947-2900
osh.oregon.gov

May 5, 2023

Request for Oregon State Hospital Expedited Admission

PATIENTS ON THE OSH ADMISSION LIST UNDER CIVIL COMMITMENT OR VOLUNTARY BY GUARDIAN / HEALTH CARE REPRESENTATIVE STATUS

Purpose of this document:

This document sets forth protocols and processes for referral for expedited admission to Oregon State Hospital (OSH) of individuals hospitalized at an acute care facility under a civil commitment or admitted voluntarily by guardian or health care representative (henceforth "civil admission" status). OSH and OHA are working in partnership with stakeholders to increase timely access to OSH.

Overarching Principled Approach to Expedited OSH Admission of Patients under Civil Admission Status:

OSH must balance the need for OSH admission for patients under civil admission status with constitutional requirements for admission to OSH for patients under forensic commitments (pursuant to federal litigation pertaining to admission to OSH of patients under forensic commitments).

Patients meeting criteria for civil admission to OSH are placed on the OSH Civil Admission list and are scheduled for admission based on bed availability. To achieve equitable efficiencies and maximum timeliness for all admissions, only in limited circumstances would an expedited admission for a patient under civil admission status be approved.

Protocol:

***Individuals eligible to refer a patient for civil expedited admission to OSH*:** Health care personnel involved in hospital management or provision of treatment to individuals in the categories listed below.

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NOTE: a referral may be initiated prior to civil commitment if there is a high likelihood that the patient will meet criteria for both civil commitment and OSH admission, and the qualifying criteria for expedited admission are met. However, a patient may not be admitted to OSH under a civil expedited admission until all eligibility criteria below are met.

***Patients eligible for civil expedited admission to OSH*:** An individual being treated at an acute care hospital is eligible if that patient:

1. Is civilly committed or admitted voluntarily by guardian or health care representative; and
2. Meets criteria for admission to OSH per OAR 309-091-0015 and has been placed on the OSH Civil Admission List; and
3. Meets the qualifying criteria below for Civil Expedited Admission and has been approved for expedited admission by the OSH Chief Medical Officer or designee.*

   * Placement on the OSH Civil Admission list can be simultaneous with approval by the OSH Chief Medical Officer or designee.

***Qualifying Criteria for Civil Expedited Admission*:** patients may be considered for civil expedited admission if, within the previous three weeks at the acute care hospital:

- they exhibit severe aggression directed toward other persons and/or property, or
- they are unable to meet their own basic nutritional needs such that their immediate health and safety are at risk, or
- they require biological therapies available to OSH but not to acute care hospitals; **AND**
- they remain at ongoing high risk to themselves or others due to mental illness despite adequate treatment; **and**
- acute care hospital leadership concurs with the treating clinical team that referral for expedited admission to OSH is appropriate and attests that all other avenues for treatment at the acute hospital or for discharge have been exhausted.

As evidenced by:

1. Hospital course documentation demonstrating that, due to symptoms of mental illness, at least two of the following are present:
   a. The patient has engaged in physical aggression resulting in harm or injury to others or lost time at work for an employee;
   b. The patient has engaged in substantial property destruction impacting patient care;
   c. The patient has required 1:1 security staffing to prevent harm or injury to other patients or staff for longer than 72 hours;

d. The patient has required recent frequent or prolonged seclusion** or restraint;
e. Two or more acute psychiatric beds have been closed to reduce the risk of the patient causing harm or injury to other patients or staff;
f. The patient cannot be safely treated on an acute psychiatric unit with available resources.

OR

2. Hospital course documentation demonstrating that, due to symptoms of mental illness, at least one of the following are present:
   a. The patient is unable to meet their own basic nutritional needs such that medical intervention has been necessary or is highly likely to become necessary in the near future.
   b. The patient requires a biological therapy (ex: court-ordered electroconvulsive therapy) that cannot be provided at the acute care hospital.

** Behavior management plans which require that a patient may leave their assigned room only following staff assessment are considered equivalent to seclusion. An individual who has received such interventions, which reduce incidents of aggression by limiting access to peers, may still be referred for civil expedited admission.

***Disqualifying Criteria for Expedited Admission*:** An individual who meets the criteria above but who *has an active medical condition which requires stabilization or treatment at a primary medical center*. Referral and consultation may occur while the individual is being medically stabilized.

Process:

A referral for civil expedited admission is encouraged when a patient exhibits behavior and ongoing safety risk that meets the above criteria. Note that historical behavior, while pertinent to clinical risk assessment generally, is insufficient to justify civil expedited admission in the absence of present behavioral concerns.

The acute care hospital may refer the patient to OSH for consideration of civil expedited admission by making available **to the OSH Admissions Department** by fax, email or via electronic medical records access:

- Medical records up to the current date, including
  - current progress notes
  - documentation of any seclusion and/or restraint
  - documentation describing any current behavior management plan
  - medication administration records
- A written explanation by the unit medical director of

  - the current clinical behaviors and/or concerns that may require expedited OSH admission; and
  - an explanation of what need cannot be met by the acute care hospital; and
  - a description of interventions and supports that have already been implemented or attempted (this may include a description of the physical structure of the unit or location where the individual is housed)
- Name and contact information for the attending and/or covering psychiatric practitioner
- An attestation by an administrative director at the acute care hospital of review and approval of the referral

Requests for consultation/expedited admission will be reviewed by the OSH Chief Medical Officer (CMO) or designee during business hours (0800-1700) Monday through Friday. The reviewer may contact the attending practitioner if additional information is needed.

Within 24 hours of receiving all necessary information, the CMO or designee will communicate back to the referring party related to consultation/admission considerations.

- If approved, OSH will admit the patient in a timeframe deemed appropriate to the circumstances and as soon as possible considering the expedited nature of the referral.
- If denied, the patient will maintain their current place on the OSH Civil Admission List.
  - In addition, OSH will participate in a patient care conference in collaboration with the acute care hospital and CMHP, including subsequent meetings as required and agreed upon, with the goal of identifying modifications to the care plan to promote the safety of the patient, other patients, and staff.
  - A patient may be referred again following a denial if additional safety considerations arise which meet the qualifying criteria.
  - All referrals, acceptances and denials, along with the rationale for such referrals, acceptances, and denials, shall be recorded in a de-identified tracking system kept by OSH and the private hospitals and reviewed on a quarterly basis in joint meetings with the private hospitals, OSH and OHA leadership representation and any other mutually agreed upon invitees to ascertain impact on compliance with federal court orders, impact on private hospitals, and any other factors of relevance to Oregon psychiatric hospital and community behavioral health system stakeholders. These quarterly reviews and lessons learned may result in further modifications of this protocol.

Admissions Department contact information:
Phone: 503-945-9265
FAX: 503-945-9839
Email: OSH.Admissions@odhsoha.oregon.gov

Hours of operation:
Monday through Friday
8:00 AM to 5:00 PM

Declaration of Nicholas Williamson

Attachment A

Washington State Department of Social & Health Services

Transforming lives

Trueblood Implementation Plan

Final

June 27, 2019

Background

All criminal defendants have the constitutional right to understand the nature of the charges against them and assist in their own defense. If a court believes a mental disability may prevent a defendant from understanding the charges against them or assisting in their own defense, the court puts the criminal case on hold while an evaluation is completed to determine the defendant's competency.

If the evaluation finds the defendant competent, they are returned to stand trial. However, if the evaluation shows the person is not competent, the court may order the defendant to receive care and treatment to restore competency.

In April 2015, the court found the Department of Social and Health Services (DSHS) was taking too long to provide these competency evaluation and restoration services. On December 11, 2018 the court approved a Settlement Agreement related to the contempt findings in this case. The settlement is designed to move the State closer to compliance with the Court's injunction. This is the Final Implementation Report as required by the Settlement Agreement.

The parties recognize that this plan sets forth markedly ambitious timelines to implement agreement elements within Phase 1. Many of these elements require the development of programs and services that have never existed in the state of Washington. Throughout this document, timelines have been proposed that will challenge the State, and leave little room for unforeseen roadblocks to implementation. As a consequence, the parties agree that the failure to meet these timelines will not constitute material breach, provided that the state has made all reasonable efforts to meet the timelines herein. Rather, the timelines outlined for specific elements should be considered in light of all other evidence in any future dispute as to whether the elements of the settlement agreement have been timely implemented within Phase 1.

Phased Implementation

The Trueblood Settlement Agreement (Agreement) includes a plan for phasing in programs and services. In each phase, the state will focus its efforts within specifically identified and agreed upon regions. The Agreement includes three phases of two years each, and can be expanded to include additional phases. Phases run parallel to the Legislative biennia beginning with the 2019-2021 biennium.

Phase 1:	July 1, 2019 – June 30, 2021	Pierce, Southwest, and Spokane regions
Phase 2:	July 1, 2021 – June 30, 2023	King region
Phase 3:	July 1, 2023 – June 30, 2025	Region to be determined

Regional Collaboration

Following the onboarding of the additional Project Managers to support the Trueblood Settlement Agreement implementation, the project management team will develop a collaboration model for regional implementation. The goal of the collaboration model is to ensure consistent implementation and communication across all regions.

While developing that plan, the team will ensure it:

- Encourages the surfacing of barriers and challenges
- Supports the efficient resolution of problems and addresses decision making processes
- Facilitates the sharing of information
- Engages appropriate members of the various Implementation Teams

The collaboration model will be included in the first semi-annual Monitoring Report.

Regional Stakeholder Engagement

Following the onboarding of additional Project Managers to support the Trueblood Settlement Agreement implementation, project managers will work with assigned agencies to develop stakeholder engagement plans targeted to each effort.

In advance of that activity, DSHS and the Health Care Authority convened regional Summits in the three Phase 1 Regions in March and April of 2019. These summits were intended to start conversations with regional partners about the work that lies ahead; both to solicit their participation and engagement and foster understanding about the content of the settlement agreement. Invitees covered a broad range of partners including behavioral health groups, law enforcement, courts, attorneys, jail leadership, community leaders, elected officials, housing partners, tribes, and many more. All three Summits were very well attended and attendees were appreciative of the opportunity to begin conversations.

Detailed plans and supporting documents prepared for the Summits have been shared with the Trueblood Executive Committee.

Additional engagements with the regions are also planned for June and July including:

- A webinar on SB 5444 and the budget passed to support Trueblood
- A webinar on the Final Implementation Plan
- In person meet and greets between the Project Management team and stakeholders and partners in all three regions.

Reporting

The status of the Agreement will be provided to the General Advisory Committee (GAC) via the semi-annual Monitoring Report required within the Agreement. That report will include:

- Data reporting
- Data analysis
- Updates on status of the phased programs
- Areas of concern in implementation and any resulting recommendations
- Areas of positive impact or programming in implementation

In order to support data reporting and analysis for Trueblood, a Data Workgroup comprised of data and Information Technology members from DSHS and the Health Care Authority (HCA) has been convened. The workgroup will:

- Identify business requirements around data for each of the elements
- Assess existing data collection and data storage processes and programs within DSHS and HCA to evaluate whether they will support the new data necessary for Trueblood
- Provide recommendations to agency management on data collection processes for Trueblood which can include manual tracking and/or programmatic changes to existing data collection processes and database systems, development of new data collection processes and database systems, etc. to support data collection and evaluation for Trueblood.

The first Monitoring Report will be provided to the GAC in March 2020, six months following the first GAC meeting, which is anticipated in September 2019.

Agreement Elements

1 Competency Evaluation – Additional Evaluators

1.1 Assigned Owner

The Department of Social and Health Services' Behavioral Health Administration's Office of Forensic Mental Health Services (OFMHS), is responsible for hiring and employing Forensic Evaluators and associated staff.

1.2 Statewide vs. Regional

Evaluators support the entire state of Washington and staff additions are part of the statewide effort with an emphasis on both placement in outstation and inpatient settings.

1.3 Requirements from the Agreement

a. DSHS will post and hire thirteen (13) evaluators, one supervisor, and two support staff between July 1, 2019 and June 30, 2020.
b. DSHS will post and hire five (5) evaluators and one support staff between July 1, 2020 and June 30, 2021.
c. Note: supervisor and support staff were not specified as a requirement in the agreement.

1.4 Education and Outreach

DSHS will notify regions impacted when newly hired evaluators are on-boarded via the agency's listserv.

Communication with identified outstation areas will occur once a determination of an outstation placement is made. Placement will be based on areas with the highest referrals through calendar year 2018 and half of the calendar year for 2019. Furthermore, in the event that resources are diverted in order to respond to an increase or spike in referrals, the areas impacted will be notified of this shift to Trueblood services using the DSHS listserv.

1.5 Action Plan and Timeline

Completed:

1. Updated existing position description forms for the evaluator, support staff, and supervisory positions by April 1, 2019
2. Submitted required documentation (request to hire/personnel action requests, updated organization charts, etc.) to human resources by April 30, 2019
3. Advertised the established positions by May 15, 2019
4. Began recruitment activities including screening and interviewing by May 30, 2019

Pending:

5. Hire and onboard the new employees, including expedited work with jails for jail clearances, beginning July 1, 2019 until all positions are filled.

2 Competency Restoration – Legislative Changes

2.1 Assigned Owner

Legislative changes affect multiple agencies. For this reason, this initiative is assigned to the Governor's Office, with secondary support from the Department of Social and Health Services and the Health Care Authority.

2.2 Statewide vs. Regional

Legislation impacts the state of Washington and is part of the statewide effort.

2.3 Requirements from the Agreement

1. The state will pursue changes in the 2019 legislative session with the intent to reduce the demand for competency services. This includes advancing requests for legislative changes through bill proposals, and could include supporting legislation proposed by others.
2. The state will seek statutory changes to implement a phased rollout of community outpatient restoration services in targeted areas, including residential supports as clinically appropriate.

2.4 Education and Outreach

N/A – The State completed this element prior to first semi-annual Monitoring Report submission.

2.5 Action Plan and Timeline

N/A – The State completed this element prior to first semi-annual Monitoring Report submission. SB 5444 passed by legislature and signed by the Governor on May 8, 2019. Part of the legislative work that occurred included joint department and OFM work to ensure sufficient investment by the legislature to support the implementation of the programs and services contemplated by the Settlement Agreement.

3 Competency Restoration – Community Outpatient Services

3.1 Assigned Owner

Competency restoration is a coordinated effort between the Department of Social and Health Services and the Health Care Authority.

3.2 Statewide vs. Regional

The state will implement this element of the settlement in selected regions in phases according to the plan outlined in the agreement.

3.3 Requirements from the Agreement

a. The state will seek funding for outpatient competency restoration (OCR) services in targeted areas (including residential supports as clinically appropriate) and a broader package of treatment and recovery services (including mental health treatment, substance use screening and treatment).
b. The state will identify and seek necessary statutory changes, and develop policies to fully implement outpatient restoration services in targeted areas.
c. Eligibility for outpatient restoration will be decided by the criminal court ordering restoration services.
d. For criminal defendants waiting in jail, an offer of admission to the community outpatient restoration services program will occur within the timelines for restoration as outlined by the Federal Court.
e. The process for outpatient restoration will provide sufficient information for the court to create tailored conditions for release.
f. Outpatient restoration providers will:
    i. Accept referrals from OFMHS in accordance with an algorithm that prioritizes the intake of class members.
    ii. Monitor the individual's compliance with the court order in conjunction with the Forensic Navigator.
    iii. Provide residential support solutions to those identified by a Forensic Navigator as unstably housed for the duration of their outpatient participation and up to 14 days following transmission of the competency evaluation that occurs at the end of restoration.
    iv. Have flexibility in providing residential support solutions which may include capital development through the Department of Commerce (COM) or third party source, housing voucher programs, existing housing programs, and/or scattered site housing programs.
g. The state will provide outreach and technical assistance upon request to support the implementation of community outpatient restoration services.

3.4 Education and Outreach

Initial Education and Messaging Stage:

The OCR workgroup will partner with DSHS and HCA communications staff, as well as an HCA contract oversight team, to begin collaboration with the Managed Care Organizations (MCOs), Administrative Service Organizations (ASOs), and Community Behavioral Health providers in the targeted areas.

The OCR workgroup will support the establishment of a stakeholder group with representation from each targeted regional area. Initial outreach to potential stakeholders and partners will include, but not be limited to, regional judges, attorneys, prosecutors, jails, courts, peer counselors, consumers, consumer advocacy groups, general public, managed-care entities, crisis providers, and community behavioral health providers.

Action Stage –Contracting:

DSHS and HCA will coordinate with stakeholder groups, MCOs, ASOs, and behavioral health administrative service organizations (BHASOs) to conduct outreach to the provider network. Education about new programs will be provided, as well as alerting potential contractors on upcoming contract opportunities.

In partnership with DSHS, HCA will execute a direct provider contract or will communicate the Request for Application (RFA) procurement process. If leveraging existing contracts, HCA will negotiate amendments to existing contracts.

DSHS and HCA will coordinate with stakeholder groups, MCOs, ASOs, and BHASOs to announce final contracts and contracting language.

Implementation Stage – Targeted Education and Technical Assistance:

DSHS and HCA, in partnership with the Forensic Navigator workgroup, will conduct outreach and provide technical assistance to criminal courts and other stakeholders, upon request, to support community outpatient restoration services. They will assist with issues such as:

- Determining eligibility for community outpatient restoration;
- The conditions of the class member's participation in outpatient restoration;
- Community outpatient restoration services; and,
- Using Residential Supports and other services to encourage community outpatient restoration services.

The OCR workgroup will partner with the Forensic Navigator workgroup, the Housing Supports workgroup, and the DSHS/HCA communications team to provide information to the key stakeholders, community partners, and program participants in the targeted regions.

Monitoring Stage:

HCA will monitor the early phase of implementation and contract adherence.

In partnership with DSHS, HCA will complete quality assurance monitoring of fidelity to the competency restoration treatment model.

DSHS/HCA will utilize information obtained from monitoring efforts to complete ongoing and targeted technical assistance.

3.5 Action Plan and Timeline

Completed:

1. Finalized the OCR workgroup charter by May 31, 2019.

Pending:

2. The OCR workgroup reviews applicable reports to include Groundswell Services' 2017 and other relevant national models by July 1, 2019.
3. The OCR workgroup collaborates with DSHS/HCA communications team to develop an outreach plan for stakeholders and partners by August 30, 2019.
4. Stakeholder groups established with representation from each of the targeted regions by October 1, 2019.
5. Using stakeholder and partner input, the OCR workgroup will finalize the program model, core elements and referral criteria by February 29, 2020.
6. Metrics will be determined in conjunction with data staff by March 31, 2020.
7. In partnership with HCA contracts team and DSHS, the OCR workgroup solidifies necessary contract language and processes by March 31, 2020.
8. The OCR workgroup coordinates with Forensic Navigator and Residential Support workgroups to coordinate contract efforts, if required, from January 1 – March 31, 2020. Note: Forensic Navigators will need to be hired and onboard before Outpatient Competency Restoration services can begin.
9. DSHS and HCA will provide ongoing messaging and technical assistance to the target areas May 1, 2019 – June 30, 2021. The OCR program providers will be given targeted training and technical assistance.
10. HCA will provide contract monitoring and oversight. OCR contracts will be finalized and operational within the Phase 1 regions by July 1, 2020. Note: As this is a brand new program in these regions, there may need to be a ramp-up period by the contracted providers before services are fully available.

4 Forensic Navigators

4.1 Assigned Owner

The Department of Social and Health Services is responsible for hiring and employing Forensic Navigators.

4.2 Statewide vs. Regional

The state will implement this element of the settlement in selected regions in phases according to the plan outlined in the agreement.

4.3 Requirements from the Agreement

a. The state will seek funding to implement forensic navigators.
b. Forensic Navigators:
    i. Will be assigned a caseload of no more than 25. Assignment will occur at the time a competency evaluation is ordered.
    ii. Upon assignment and before the hearing, the Forensic Navigator (FN) will gather and provide information to the criminal courts to assist with:
        - Understanding treatment options to divert members from the forensic mental health system.

- Determining whether a defendant is appropriate for community outpatient restoration services. This is not a clinical recommendation. Standardized tools or assessments for those not known to the system may be used.
- Recommending tailored release conditions for those ordered to community outpatient restoration services.

iii. Will prioritize their caseload to focus on diversion of high utilizers (as known to the system) and may provide less-intensive levels of service to those unknown and/or not yet found incompetent.

iv. Will conclude forensic navigator services when a client is found competent or incompetent but **not** ordered by the court into community outpatient restoration services.

v. For those clients assigned to community outpatient restoration, the FN will:

- Monitor compliance (in partnership with community outpatient providers) and provide periodic updates to the court. This may include appearing at court hearings.
- Inform providers if an assigned client is unstably housed and needs residential supports.
- Coordinate access to housing.
- Assist client with attending appointments and classes related to competency restoration.
- Meet individually with clients regularly; perform outreach as needed to stay in touch.
- Coordinate client access to community case-management services, mental health services, and follow up.
- Assist clients with obtaining and encourage adherence to prescribed medication.

vi. For those found incompetent and ordered into community outpatient restoration services, forensic navigator services will conclude and the FN will complete a coordinated transition when:

- Charges are dismissed pending a civil commitment hearing.
- Client receives a new or amended order directing inpatient admission.
- Client declines further services after restoration treatment ends.
- Client regains competency, is found guilty, and is sentenced to serve time.
- Community outpatient restoration order is revoked or new criminal charges cause a client to enter or return to jail.
- In any other situations not listed above, at the discretion of the state.

vii. A coordinated transition will include:

- Facilitated transfer to a case manager in the community mental health system using standards for coordinated transition as established through care coordination or similar agreements.
- Attempt to confirm meeting between client and community-based case manager following transition.
- Creation of summary of treatment provided during community outpatient restoration (including earlier-identified diversion options for the individual).
- Attempt check-in with client at least once per month for up to 60 days. During this period, the client **does not** count towards the Navigator's caseload.
- Attempt to connect identified high utilizers with available high-utilizer services.

viii. The state, through training and technical assistance, will encourage third parties (like jails and prisons where class members are serving sentences) to request the summary of treatment and related treatment records as allowed by RCW 10.77.210.

4.4 Education and Outreach

Educational Materials

Partner with DSHS/BHA Communications staff to develop the below materials:

- Program One-Pager
  - High level overview of the program
- Presentation driving "Train-the-Trainer" style seminars for relevant parties
  - May need multiple versions geared towards specific stakeholder groups

Relevant Parties

- Accused
- Potential clients and those at risk of arrest/re-arrest (Mental Health and related Social Service Agencies, CIT programs, individuals who have previously refused FN services, or are known to the system)
- Prosecutors
- Defense counsel
- Judges
- Administrative Office of the Courts (AOC)
- Legislators and staff
- General public
- Families of the accused and client advocates working on behalf of class members

Outreach

- Targeted communications to relevant parties
- Build database of key contacts and relevant parties for continued outreach and education
- Schedule and execute trainings at least annually
  - Solicit feedback on both the training itself, and the program overall
- On an ongoing basis, use feedback and program-evaluation analytics for constant program improvement

4.5 Action Plan and Timeline

Completed:

1. Submitted necessary human resource paperwork to create the FN Program Administrator by March 8, 2019.
2. Advertised the Administrator position by April 15, 2019.
3. Completed recruitment activities including screening, interviewing, and job offers by June 15, 2019.
4. Hired and completed new employee onboarding process by July 31, 2019.

Pending:

5. The Forensic Navigator Administrator will convene a workgroup and hold the first meeting by August 31, 2019.
6. Forensic Navigator (FN) Workgroup will complete final draft of Forensic Navigator Program Charter by September 30, 2019.
7. FN Workgroup will review other state and national models related to data and metrics for evaluation of program performance outcomes and quality control by November 30, 2019.
8. FN Workgroup will collaborate with DSHS/HCA communications team to develop a plan for stakeholders to identify and provide challenges and barriers with the workgroup by December 31, 2019.
9. The FN Workgroup will consult with RDA to ensure that the desired data and metrics for evaluation of program performance and quality control can be obtained through the proper database or reporting tool by December 31, 2019.
10. Submit necessary human resource paperwork to create the FN program positions in each region by January 31, 2020.
11. Advertise the forensic navigator positions by February 29, 2020.
12. Meet with partners (courts, AOC, jails, etc.) to develop processes and associated documentation and forms to be used by Forensic Navigators in the court system. Includes adjusting existing forms by March 31, 2020.
13. Meet with partners (newly established outpatient competency providers, evaluators, etc.) to develop processes and associated documentation needed for those in outpatient restoration. Includes treatment summary, release orders/conditions, etc. by March 31, 2020.
14. Complete recruitment activities including screening, interviewing, and job offers by April 30, 2020.
15. Hire and complete new employee onboarding process by June 15, 2020.
16. Day one of FN Program operations in all three Phase 1 regions expected July 1, 2020.

5 Competency Restoration – Additional Forensic Beds

5.1 Assigned Owner

The Department of Social and Health Services is responsible for managing forensic-bed capacity.

5.2 Statewide vs. Regional

Forensic beds are used by patients across Washington. Adding or converting beds is part of the statewide effort.

5.3 Requirements from the Agreement

a. Convert two wards at Eastern State Hospital into forensic wards containing a total of 50 beds by December 31, 2019.
b. Convert two Western State Hospital civil geriatric wards to two forensic wards containing a total of 42 beds by December 31, 2019.
c. If extensions are needed to either timeline, provide the Executive Committee information on the delay to receive an additional six months of time. If the state needs additional time beyond this six-month period, they may request a further extension of time from the court.

5.4 Education and Outreach

- Provide updates during Executive Leadership Team meetings
- Quarterly updates from the Project Manager and Sponsor
- Maintain a Project Team SharePoint or Website for communication
- Schedule, prepare for, and attend job fairs to advertise coming positions

5.5 Action Plan and Timeline – ESH Beds

Completed:

1. Evaluated contract bids and award contract by February 15, 2019.
2. Construction began by March 1, 2019.

Pending:

3. Create position description forms for program positions by August 1, 2019.
4. Submit required documentation (request to hire/personnel action requests, updated organization charts, etc.) to Human Resources by August 15, 2019.
5. Positions created and allocated by Class and Compensation Unit by October 1, 2019.
6. Develop equipment and supply list, obtain fiscal approval, and purchase necessary items by November 15, 2019.
7. Substantial completion of construction of 1N3 and 3N3 will occur between April 1 and May 1, 2020.
8. Final completion of construction and installation of furniture, equipment and supplies by June 1, 2020.

Note: This timeline will require notice to the Executive Committee because it is beyond the currently set deadline. This estimated completion is within the six-month grace period allowed under the Agreement. In the event there are any delays related to the development of these beds beyond the six-month period identified in the settlement agreement, defendants will consult with the Executive Committee and file a motion for an extension of time.

5.6 Action Plan and Timeline – WSH Beds

Completed:

1. Contract bids opened for E3 and E4 by June 20, 2019.

Pending:

2. If bids are within funding constraints, construction begins by July 15, 2019.
3. Create position description forms for program positions by August 1, 2019.
4. Submit required documentation (request to hire/personnel action requests, updated organization charts, etc.) to Human Resources by August 15, 2019.
5. Positions created and allocated by Class and Compensation Unit by October 1, 2019.
6. Develop equipment and supply list, obtain fiscal approval, and purchase necessary items by November 15, 2019.
7. Substantial completion of construction by March 11, 2020.

8. Final completion of construction and installation of furniture, equipment and supplies by April 8, 2020.

Note: This timeline will require notice to the Executive Committee because it is beyond the currently set deadline. This estimated completion is within the six-month grace period allowed under the Agreement. In the event there are any delays related to the development of these beds beyond the six-month period identified in the settlement agreement, defendants will consult with the Executive Committee and file a motion for an extension of time.

6 Competency Restoration – Ramp Down of Maple Lane & Yakima RTFs

6.1 Assigned Owner

The Department of Social and Health Services is responsible for Residential Treatment Facilities (RTFs). The Office of Forensic Mental Health Services oversees the facilities.

6.2 Statewide vs. Regional

Maple Lane and Yakima RTFs support patients across the state of Washington and the closure of those facilities is part of the statewide effort.

6.3 Requirements from the Agreement

a. Yakima RTF will be ramped down when Class Member wait times for inpatient competency services reaches a median of 13 days or less for four consecutive months based on mature data or no later than December 31, 2021.
b. Maple Lane RTF will be ramped down when Class Member wait times for inpatient competency services reaches a median of 9 days or less for four consecutive months based on mature date or no later than July 1, 2024.

6.4 Education and Outreach

At Start of Phase 1 – June 30, 2019

A letter to community partners and stakeholders will be sent explaining the closure dates for each facility and the median that would need to be met for an earlier closure. The letter, which will also be available online, will outline when the notification process will start.

The CRS will conduct staff meetings and information will be provided about the settlement, the metrics required for an earlier closure, what an earlier closure means, and the set closure date. Multiple meetings will occur to reach all line staff that work at both facilities and want to participate.

The OFMHS Website would include a section on the impending ramp down under the RTF section. The Competency Restoration Specialist (CRS) will work with DSHS Communications to determine if other outreach would be beneficial.

At Onset of Ramp Down (occurs when data has met threshold for two consecutive months)

At the onset of ramp down, a pre-planned e-mail would be delivered to key partners and stakeholders. The letter would outline the date of closure. A separate letter would be sent to parents/guardians of the patients currently at the facility, only as allowed by either releases of information signed by patients or court assigned guardianship.

CRS will work with the communication team on a press statement regarding the closure and the impacts for both staff and patients.

In-person meetings will occur (with a WebEx option for the facility and stakeholders) and be led by the CRS and the OFMHS leadership.

For the Maple Lane Program, coordinate with Human Resources and the Union to meet facility staff and answer questions regarding the closure and what rights they will have.

Other stakeholder groups that will need to be informed at the on-set of the implementation committee:

- Comprehensive Mental Health – they currently have the contract for the Yakima Facility. They will have representation on the ramp down team.
- Well Path Recovery Solutions – they currently have the contract for the Maple Lane Facility They will have representation on the ramp down team.
- Department of Corrections (DOC) – currently both facilities are leased from DOC. Maple Lane is leased from Washington State DOC and the Yakima Facility is leased from Yakima County DOC.
- Washington State Federation of Employees (WFSE) – For Maple Lane only. The union will need to be involved once the settlement is signed due to Maple Lane employing represented employees. The CRS will communicate with Kelly Rupert and ask for a union representative to be on the ramp down team. There will need to be clear timelines outlined from the union specifying when they need to be notified so the required notifications are sent timely for the represented employees at Maple Lane.
- Human Resources will work with the Residential Services Manager at Maple Lane and the union to ensure all represented employees receive the proper notifications. Depending on project length, per the contract, represented employees in project status longer than five years will have specific layoff rights outlined in Article 34.17. HR will have a representative on the ramp down team.
- Green Hill School (GHS) – For Maple Lane only. Currently the MOUs for food, laundry, maintenance, and the vehicle are through GHS. The CRS or designee will need to coordinate the impending closure with the facility. DSHS employs eight represented staff at GHS or on site through the project who will require union notification.
- Capital Projects – will need to be involved because DOC may require that we return both facilities to their original floorplan.
- Budget – will need to plan for restoration funds to return the facilities back to their original condition. A representative from Budget will serve on the ramp down team.
- Contracts Manager– Both contracts for the upcoming year should address the impending early closure if the required median is met. The CRS will work with the contract manager on this task.
- The Forensics Admission Coordinator (FAC) - will work with the CRS and serve on the ramp down team tapering down before they close. The FAC would be notified by the CRS if the median wait-time data met the requirements for two consecutive months.

- Western and Eastern State hospitals – will be kept informed as the closure dates get closer in case some patients in the RTF facilities need different placement upon facility closure. In event that were to happen, Western and Eastern State hospitals would work with the Forensic Admissions coordinator.
- All courts and county jails, defense attorneys, and prosecutorial attorneys – will receive the initial letter crafted by the CRS and the communication team. If the required median were met by a facility, a second letter would be sent preparing them for the earlier closure date and when to expect admissions to stop for that facility.
- Families of patients at both facilities where a signed release of information is in place or court assigned guardianship. – four months prior to closure, a form letter would be sent to the families of patients at the affected facility informing them of the closure and possible placement options for their family member. This letter would be crafted by the CRS and communications team.

6.5 Action Plan and Timeline

Completed:

1. Identified members and send invitations to potential ramp down team members by April 1, 2019.
2. Convened the first meeting for the ramp down team in April to provide an overview of the draft implementation plan by April 30, 2019.
3. Met with leadership at both sites to review the settlement and compile questions they may have for OFMHS and/or the AG's; complete by April 30, 2019.
4. Identified settlement stakeholders and community partners impacted by ramp down (starting list is above in Education and Outreach section) by May 1, 2019.
5. Organized meetings with DOC at Maple Lane and Yakima to discuss the condition they want the facilities returned to after closure; complete by May 31, 2019.

Pending:

6. Adjust contracts 1512-48444, Comprehensive Competency Restoration Services, 1612-55044, Correct Care Competency Restoration Services, 1561-52933, DOC, Use of Facilities at Maple Lane and 16-DBHR-001, Rehab Administration, Green Hills School Services for ML CR Program during next negotiation period to allow for ramp down during the extension process; complete by June 30, 2019.
7. Meet with budget and Capital Projects to discuss DOC's requirements and develop an estimated cost and timeline; complete by June 15, 2019.
8. Contact Labor Relations within Human Resources to plan for union notification for Maple Lane; triggered by meeting two months' of the median data threshold set by the Settlement Agreement.
9. Contact human resources for help messaging staff at Maple Lane; triggered by meeting two months' of the median data threshold set by the Settlement Agreement.
10. Develop adjusted intake and admission procedures and timelines for each RTF based on anticipated closure dates; complete by August 1, 2019.
11. Once mature data threshold met or no later than June 30, 2021, initiate adjusted intake procedures for Yakima.
12. Once mature data threshold met or no later than January 31, 2024, initiate adjusted intake procedures for Maple Lane.

13. For Maple Lane, contact the union and human resources once mature data is met or no later than January 31, 2024, initiate notification to all DSHS employees.
14. Once mature data is met or no later than six months prior to the established final closure date, all courts, jails, and families of patients will be sent a letter notifying them of the impending closure, only as allowed by either releases of information signed by patients or court assigned guardianship.
15. Prior to closure each facility should have a plan regarding where the equipment is to go. The plan should be complete six months prior to closure.
16. Four months prior to closure the RTF will work with the Forensic Admissions coordinator and the contractor to establish an end date for intakes and determine when the staffing pattern will begin to decrease. This will include a detailed flow chart.
17. One month prior to closure the RTF should be at minimum capacity of patients as defined by the adjusted intake procedures.
18. Closure will occur at least two weeks prior to the established date to allow remaining staff time to pack equipment and empty the building.
19. On the closure date, Capital Projects will begin restoring the building to the condition agreed upon by DOC.

7 Crisis Triage & Diversion – Additional Beds & Enhancements

7.1 Assigned Owner

The Health Care Authority (HCA) is responsible for Crisis Triage and Stabilization facilities in the state of Washington.

7.2 Statewide vs. Regional

The state will implement this element of the settlement in selected regions in phases according to the plan outlined in the agreement.

7.3 Requirements from the Agreement

a. Seek funding to increase crisis stabilization units and/or triage facilities by 16 beds within the Spokane Region. Beds will address both urban and rural needs.

b. Solicit requests for and make funds available to community providers of crisis stabilization and/or triage facilities for enhancements.

c. Complete an assessment of need for Crisis triage and stabilization capacity in King County and gaps in existing capacity in Pierce, Southwest, and Spokane regions. Provided report of assessment to the General Advisory Committee with recommendations to address any gaps found.

7.4 Education and Outreach

Initial Education and Messaging:

Crisis triage and diversion supports workgroup will partner with DSHS and HCA communications staff, as well as HCA contract oversight team, to collaborate with the MCOs, BHASOs, and community behavioral health providers in the targeted areas.

Request for Application (RFA) and Contracting:

HCA to coordinate with stakeholder groups and managed care entities to communicate to provider network. Education about upcoming increase to capacity provided, as well as preparation to potential contractors for upcoming opportunities. Ongoing technical assistance provided to target areas.

In partnership with DSHS, HCA to communicate RFA procurement process.

HCA to coordinate with stakeholder groups and managed care entities to announce successful bidders.

Needs Assessment:

HCA will work with partners to evaluate the gap analysis completed by the Public Consulting Group (PCG) and develop a plan for increasing capacity in the phased regions.

The PCG gap analysis report will be shared with the General Advisory Committee and with key stakeholders.

7.5 Action Plan and Timeline – Gap Analysis and Response

Completed:

1. Crisis triage and diversion supports workgroup charter finalized by May 31, 2019.

Pending:

2. Crisis triage and diversion supports workgroup, in collaboration with HCA Communications team and DSHS partners, will collaborate with key stakeholders, to include the Behavioral Health Administrative Service Organizations (BHASOs) and their contracted crisis facility providers for the targeted regions, on the goals of this element by October 31, 2019.
3. Crisis triage and diversion supports workgroup will share the PCG report at the first General Advisory Committee meeting.
4. HCA will develop recommendations on how to increase crisis capacity in phased regions. Recommendations will be shared with the General Advisory Committee and key stakeholders by March 30, 2020.
5. [GAP] HCA to seek funding for next biennium budget to increase capacity by October 31, 2020.

7.6 Action Plan and Timeline – Enhancements

Completed:

1. Crisis triage and diversion supports workgroup charter finalized by May 31, 2019.

Pending:

2. Crisis triage and diversion supports workgroup, in collaboration with HCA Communications team and DSHS partners, will collaborate with key stakeholders, to include the Behavioral Health Administrative Service Organizations (BHASOs) and their contracted crisis facility providers for

the targeted regions, on the goals of this element by October 31, 2019. Throughout this process, the State will be:

a. Identifying objectives that align with the requirements of the Trueblood contempt settlement.
b. Exploring the known needs of each community and available resources, including completing an inventory of existing providers and facilities
c. Identifying community agency(s) that will be willing to provide services as defined by the agreement and by the core objectives established by the internal work group.
d. Scheduling and holding separate core meeting for each region and identifying needs based on the strengths and weakness of each site within those regions.
e. Provide an update to the Executive Committee about the status of the stakeholdering work, including whether existing providers are likely able to meet the need.

3. By March 1, 2020, HCA will make a determination whether the desired outcomes can be accomplished by amending contracts with existing providers, or if a RFP process will be necessary, or whether some combination of an RFP and amendment is necessary.
4. Using stakeholder input, crisis triage and diversion supports workgroup will coordinate with the HCA contracts team to develop RFP language and/or amend current MCO/ASO contracts to allocate the funds by March 31, 2020. The timelines for each approach are:
    f. **Amendments with Existing Providers:** In regions with existing providers who are willing to enhance crisis triage/stabilization services, completion of contract amendments based on workgroup recommendations will occur by March 31, 2020. Funds deployed through contract amendments will also be complete by this date.
    g. **RFP Process:** If no current service provider is able to provide the necessary enhancements, HCA will complete a procurement through an RFP process, incorporating the requirements developed by the workgroup. The RFP process will be completed as required by RCW 39.26, and will take approximately three months. The RFP procurement process will be completed for enhancements and money deployed by July 1, 2020. Examples of why the RFP process could be used include:
        1. the sites identified do not meet the requirements of the Trueblood settlement;
        2. no physical site can be identified that can be enhanced to accomplish the objectives,
        3. no agency is willing to contract to be the provider for service.
5. Based on the enhancements identified in either the amendment process or the RFP process (4.a or 4.b), the State will propose to the Executive Committee timelines for implementation of the enhancements. The timelines will be set according to the time necessary to implement the specific contracted enhancements.

7.7 Action Plan and Timeline – 16 Bed Facility in Spokane Region

Completed:

1. Crisis triage and diversion supports workgroup charter finalized by May 31, 2019.

Pending:

2. Crisis triage and diversion supports workgroup, in collaboration with HCA Communications team and DSHS partners, will collaborate with key stakeholders, to include the Behavioral Health

Administrative Service Organizations (BHASOs) and their contracted crisis facility providers for the targeted regions, on the goals of this element by October 31, 2019.

3. Crisis triage and diversion supports workgroup will partner with Department of Commerce behavioral health facilities program to solidify how capital funding will be included in RFA and procurement process by October 31, 2019.
4. Using stakeholder input, crisis triage and diversion supports workgroup coordinates with HCA contracts team to develop RFA language or amend current MCO/ASO contracts to allocate the funds by March 1, 2020; this will be used in the July 2020 amendment window.
5. Communication plan – HCA to develop a plan by coordinating with stakeholder groups and managed care entities on how to reach entities within the provider network. The plan will include education about upcoming increases to capacity, as well as information for potential contractors about upcoming opportunities April 1 – July 1, 2020.
6. RFA procurement process completed for contracts amended or issued by July 1, 2020. The operating funds to support the increased bed capacity will be provided upon the completion of the capital construction phase of the project, with services provided no later than July 1, 2021.

8 Crisis Triage & Diversion – Residential Supports

8.1 Assigned Owner

The Health Care Authority (HCA) is responsible for crisis triage including housing and residential supports in the state of Washington.

8.2 Statewide vs. Regional

The state will implement this element of the settlement in selected regions in phases according to the plan outlined in the agreement.

8.3 Requirements from the Agreement

a. Technical assistance will be provided to criminal courts and other stakeholders and includes using residential supports and other services for Community Outpatient Restoration Services.
b. If a Forensic Navigator assesses someone participating in Community Outpatient Restoration Services as “unstably housed,” that person is eligible for residential supports for the duration of their participation in outpatient competency services. This will cease if referred to inpatient services. For those opined as competent it may continue for up to 14 days following transmission of the competency evaluation.
c. The state will develop Residential Supports using procurement. Providers procured through this process could deliver residential supports in a way that met the community needs which might have included capital development through Department of Commerce or a third party, housing voucher programs, leveraging existing local housing programs, or scattered site housing programs.
d. The state will seek funding to provide short-term housing vouchers for use in Crisis Triage and Stabilization facilities. Vouchers cover a maximum of 14 days but, at the discretion of the facility, could be extended an additional 14 days.
e. The state will seek funding to provide residential support capacity associated with Community Outpatient Competency Restoration in each region.
f. The state will seek an additional 10 percent more funding as described in e. to be used for funding g.

g. The state will implement residential support capacity per the phased schedule. This capacity offers housing support options that target individuals who are clinically assessed to need more intensive support immediately following discharge from Crisis Triage and Stabilization facilities. Eligibility requirements include:
   - Have had at least one prior contact with the forensic mental system in the past 24 months, or, were brought to a Crisis Triage or Stabilization Facility via arrest diversion under RCW 10.31.110 as determined by the crisis triage and stabilization provider;
   - Need assistance accessing independent living options and would benefit from short term housing assistance beyond the 14-day vouchers;
   - Are diagnosed with an acute behavioral health disorder and are assessed to need housing support beyond what is offered through the Crisis Triage and Stabilization Facilities or the short term voucher as described in § III.C.2.a;
   - Are unstably housed;
   - Are not currently in the community outpatient competency restoration program, and;
   - Do not meet Involuntary Treatment Act (RCW 71.05) commitment criteria.

h. The Housing and Recovery through Peer Services (HARPS) program is available to individuals clinically assessed to benefit from the HARPS program in Community Outpatient Restoration.

i. High Utilizers are provided access to residential supports.

8.4 Education and Outreach

- Coordination with the Washington State Department of Commerce will be conducted to leverage local coordinated entry, deed recording fees, and housing and essential needs resources.
- Principles of the SAMHSA Permanent Supportive Housing (PSH) model will be disseminated throughout all projects including Forensic Navigators.
- Training on PSH principles for all HARPS teams will be conducted prior to any services being provided.

8.5 Action Plan and Timeline

1. Identify regional forensic programs currently in existence in Pierce, SW Region and Spokane BHO Region by August 1, 2019.
2. Develop draft RFP by August 1, 2019
3. Hire HCA HARPS Program Manager by August 31, 2019.
4. Post finalized RFP by September 1,2019
5. Develop draft contracts and send out to potential providers for review and signature by December 1, 2019.
6. Short term housing voucher dollars will be available to existing crisis triage facilities beginning December 1, 2019.
7. HARPS teams hire staff and services are available by March 1, 2020.
8. PSH Principles training to all HARPS staff by June 30, 2020.
9. Ten (10) percent housing supports tied to outpatient competency restoration will be integrated into contracts by July 1, 2020.
10. Complete initial testing and modeling evaluation for effectiveness by October 1, 2020.

9 Crisis Triage & Diversion – Mobile Crisis & Co-Responders

9.1 Assigned Owner

The Health Care Authority (HCA) is responsible for community health care including mobile crisis and co-responder programs. The Washington Association of Sheriffs and Police Chiefs will administer the co-responder program.

9.2 Statewide vs. Regional

The state will implement this element of the settlement in selected regions in phases according to the plan outlined in the agreement.

9.3 Requirements from the Agreement

Co-responders

a. The state will seek funding to provide law enforcement agencies with dedicated qualified mental health professionals that assist officers in field response by diverting people experiencing mental health crisis from arrest and incarceration.
b. Within the 2019-2021 biennium, seek $3 million funding for Washington Association of Sheriffs and Police Chiefs (WASPC) to expand the mental health field response program they administer. This includes funding to cover reasonable administrative costs requested by WASPC to enable it to meet the requirements of III.C.3.a.2 and III.C.3.b.3.
c. Within Phase 1, assess law enforcement agency co-responder mental health staffing needs to guide future funding requests.
d. The state's implementation plan (as described in IV.D.) describes how the state supports and encourages integration of these programs in to the other elements of the agreement.

Mobile Crisis Response (MCR)

a. The state will request a recommendation from WASPC and regional MCR providers on reasonable response times for each region.
b. The state will seek funding to increase MCR services for each phased region.
c. The state will request from each phased region a plan for providing MCR services. This includes new MCR services and should include proposing numbers, credentialing and location of mental health professionals. Each plan was tailored to meet the needs of the region, considering the need for timely response throughout the region.
    - The plans and any resulting contracts for services, required providers make MCR services available 24/7.
    - Services are accessible without fully completing intake evaluations and/or other screening and assessment processes.
    - Contracting entities include response time targets, after considering the WASPC and regional MCR providers' recommendations.
d. During Phase 1, the state will institute reporting requirements to gather data on MCR response times.
e. In Phases 2 and 3, parties use this reported MCR data to inform future funding requests and potentially added contractual requirements to meet response-time targets.

f. Co-response teams of law enforcement and mental health professionals are encouraged to rely on MCRs to accept individuals identified as needing mental health services.

9.4 Education and Outreach

For each region, the following entities will require written education and outreach materials, webinars and regional presentations:

- Crisis teams
- Behavioral health providers
- Law enforcement agencies
- Emergency departments
- Crisis settings, such as: E&Ts, CSUs, Respite, Triage
- Tribes
- DSHS administrations (DDA and ALTSA) and other social service providers
- Ombudsmen and consumer-run organizations
- First responders and ambulance companies

Outreach and education will focus on creating awareness of the Mobile Crisis Response service and how to request those services. The HCA will include outreach and education expectations in their contract with the BHASO for the MCR service and provide oversight of outreach materials and community engagement strategies. These will commence at the start of the MCR contracts. The HCA will assist with messaging about MCR services in advance of the regional MCR contracts.

9.5 Action Plan and Timeline

1. WASPC will be invited to participate in the implementation process by July 1, 2019.
2. The state will conduct quarterly check-ins with WASPC to collaborate on integrating these programs within appropriate elements of the settlement agreement beginning August 1, 2019.
3. Selected regional partners will identify participants to collaborate in developing regional timeliness expectations by August 31, 2019.
4. Begin holding regional meetings by September 30, 2019.
5. Draft Request for Plans with timeliness standards for each region and post for BHASO response by November 30, 2019.
6. Develop Mobile Crisis Response draft contract language by December 30, 2019.
7. BHASO response to Request for Plan is due January 31, 2020.
8. HCA, DSHS, and WASPC delegates review Request for Plans by February 28, 2020.
9. BHASOs receive feedback and submit changes by April 30, 2020.
10. Negotiate MCR contract language with BHASO and execute contracts by May 31, 2020.
11. BHASOs hire MCR staff and begin providing services by July 1, 2020.
12. BHASOs and HCA provide outreach and education campaigns within the region to ensure local system partners are aware of the service and how to seek it by September 30, 2020.
13. First reporting of MCR data submitted to HCA by January 31, 2021.

10 Crisis Triage & Diversion – Intensive Case Management

10.1 Assigned Owner

The Health Care Authority (HCA) is responsible for community health care including intensive case management (ICM) for high utilizers of the forensic mental health system.

10.2 Statewide vs. Regional

The state will implement this element of the settlement in selected regions in phases according to the plan outlined in the agreement.

10.3 Requirements from the Agreement

a. Develop a model that identifies those most at risk of near-term referral for competency restoration (aka high utilizers). The model should use available data including factors such as prior referrals for competency evaluation or restoration, prior inpatient psychiatric treatment episodes, criminal justice system involvement, and homelessness.
b. Contract with community providers to provide ICM services to high utilizers. Develop strategies for assertive outreach and engagement. Develop a community collaboration effort to identify and coordinate services for those most at-risk.
c. Offer the following services to those identified as high utilizers for a six-month period:
    - Intensive case management (including outreach and engagement activities occurring outside a competency referral)
    - Engagement activities
    - Housing supports using the HARPS model which includes securing and maintaining housing, peer support, and rent or other housing subsidies in the amount of up to $1,200 per month for up to six months
    - Transportation assistance
    - Training or accessing resources and other independent living skills
    - Support for accessing healthcare services and other non-medical services
d. Create effective data tracking system and reporting structure to Trueblood coordinator for tracking coordination activities.
e. Reduce forensic referrals for competency evaluations.

10.4 Education and Outreach

Starting with state partners (DSHS, MCOs, BHASO, regionally funded forensic programs, HCA Trueblood Program contacts) determine appropriate integration of programs.

Outreach will be needed to community behavioral health and forensic service providers in Pierce County, SW Region and Spokane RSA who may be interested in providing services for this program. Targeted outreach will be done to current providers of outreach and engagement services once funding is allocated to the program.

The state will contact each agency and local consortiums to request participation in a stakeholder workgroup or conversation about becoming an ICM provider for high utilizers. In addition, the Health Care Authority will issue a public announcement in the event a RFA will be issued if sufficient agencies to deliver the services are not identified.

A program brochure will be available to contracted providers and community partners for disbursement.

Depending on the location of the high utilizer data from RDA, providers may have access to a remote site with information on potential participants.

HCA will coordinate with those entities who have access to the high utilizer list to assist with outreach and engagement services, coordinate services, and make appropriate referrals.

A sampling of participants will complete a satisfaction survey at program completion. Additionally, quarterly interviews will be conducted with contracted providers to assess program needs and observed program trends.

10.5 Action Plan and Timeline

1. Identify regional outreach and engagement programs currently in existence in Pierce, Southwest, and Spokane regions by July 1, 2019.
2. RDA finalizes the high utilizer algorithm and provides the first reports by July 1, 2019.
3. Assess the need to develop an RFP to contract directly with a provider in the region or with the BHASO by August 1, 2019.
4. Identify existing regional or community workgroups that can be used to strategize, communicate, and problem solve implementation challenges by August 1, 2019.
5. If able to contract with existing outreach and engagement programs, develop contracts to include Intensive Case Management services by October 1, 2019. If unable to contact with existing programs, RFP will be posted by October 1, 2019.
6. Identify existing regional/community workgroups to identify referral pathways, communicate information and problem solve implementation challenges by October 1, 2019. Communication with these workgroups will continue beyond October 1, 2019.
7. Contractors need to hire staff to include at least one peer support person no later than January 1, 2020. If RFP is required this date will need to be extended.
8. HCA will conduct specialized training for staff hired within all three regions by the end of February 2020. Training will focus on effective outreach and engagement strategies.
9. Complete initial testing and evaluation of modelling for effectiveness by October 1, 2020.

11 Education & Training – Crisis Intervention Training (CIT)

11.1 Assigned Owner

The Criminal Justice Training Center (CJTC) is responsible for conducting CIT training for law enforcement entities.

11.2 Statewide vs. Regional

The state will implement this element of the settlement in selected regions in phases according to the plan outlined in the agreement.

11.3 Requirements from the Agreement

a. The State will seek funding so that the CJTC provides the 40-hour enhanced Crisis Intervention Training (CIT) courses to 25 percent of officers on patrol duty in law enforcement agencies within the phased regions.
b. The State will seek funding so that the CJTC provides all corrections officers and 911 dispatchers employed by governmental entities within each phased region, except those employed by the Department of Corrections or federal entities, at least eight (8) hours of CIT.

11.4 Education and Outreach

Law enforcement agencies are already familiar with Crisis Intervention Team (CIT) training. The CJTC will contact agencies in Phase 1 areas to provide education on additional training opportunities, funding and the goal to send 25 percent of patrol officers to the enhanced CIT training. The 40-hour Enhanced CIT training is regionally specific and includes local resources, contacts and procedures for dealing with individuals in a behavioral or substance abuse emergency. We will meet with police chiefs, sheriffs and agency training managers to assist with coordinating training, budget and staffing needs for this settlement.

The CJTC has already reached out to the training unit of the state office of 911 telecommunications about how the settlement agreement will impact 911 training during the coming fiscal year.

County and local jail personnel need to complete at least 8 hours of CIT training as well. The 8-hour course focuses on signs, symptoms, and intervention strategies related to behavioral emergencies that they are most likely to come into contact with.

11.5 Action Plan and Timeline

Completed:

1. Contacted Law Enforcement Agency administrators in the Phase One areas by February 1, 2019.
2. Contacted state 911 training unit to plan FY 2020 trainings by April 1, 2019.
3. Contacted county and local jail administrators in Phase 1 regions by June 1, 2019.

Pending:

4. Finalize training deployment plan for each of the three regions in Phase 1 by July 10, 2019.
5. Review training deployment plan and evaluate staffing needs by December 1, 2019.
6. Conduct and complete a training audit of every LE agency in the Phase 1 regions by December 1, 2019.
7. Complete a minimum of 14 CIT for Dispatch/911 courses by June 30, 2021.
8. Complete a minimum of nine 40-hour enhanced CIT courses in the Phase 1 regions by June 30, 2021.
9. Complete a minimum of 24 CIT for Corrections courses by June 30, 2021.

12 Education & Training – Technical Assistance for Jails

12.1 Assigned Owner

The Department of Social and Health Services, Behavioral Health Administration, Office of Forensic Mental Health Services, is responsible for providing technical assistance to jails as part of the Trueblood agreement.

12.2 Statewide vs. Regional

The state will implement this element of the settlement in selected regions in phases according to the plan outlined in the agreement.

12.3 Requirements from the Agreement

a. The state will seek funding for positions to provide educational and technical assistance to jails.

b. The state will include the involvement of peer support specialists in providing this educational and technical assistance.
c. The state works with Disability Rights Washington, law enforcement agencies, and peer support specialists to develop guidance on mutually agreeable best practices for diversion and stabilization and produced a manual. This manual addressed:
    - Pre- and post-booking diversion, identification of need and access to treatment, guidelines for involuntary medication administration, continuity of care, use of segregation, and release planning.
d. In Phase 1, OFMHS will conduct a combination of on-site and tele video trainings for jails. DSHS will provide a website for jails that includes resources and a mailbox that jail staff can use to submit questions.

12.4 Education and Outreach

OFMHS team leads will solicit and approve workgroup membership from jails. As part of this work, the workgroup will develop a communications plan to inform the jails (and other stakeholders) of the status and availability of training and technical assistance materials.

12.5 Action Plan and Timeline

Completed:

1. Updated existing position description forms for two technical assistance positions by June 1, 2019.
2. Submit to human resources required documentation (request to hire/personnel action requests, updated organization charts, etc.) by June 15, 2019.

Pending:

3. Advertise the established positions by August 1, 2019.
4. Complete recruitment activities including screening, interviewing, and job offers by August 31, 2019.
5. Hire and onboard new employees by September 30, 2019.
6. By December 31, 2019, begin work with HCA to develop a plan to integrate peer support specialists into technical assistance.
7. Convene first workgroup by November 1, 2019.
    a. Conduct work groups with Washington's Designated Protection and Advocacy Agency and law enforcement entities to develop guidance on mutually agreeable best practices for diversion and stabilization of class members.
    b. Ensure HCA membership includes subject matter expert on peer support specialists.
8. Meet monthly, or as needed, to complete work on training manual and website.
9. Develop and conduct training needs assessments as part of the manual completion on best practices by November 1, 2019.
10. Training manual and website completed, trained on, and running by June 1, 2020.
    a. The peer support specialist enhancement curriculum will be reviewed as part of this process to ensure any and all technical assistance areas are addressed sufficiently.
11. As applicable trainings are finalized they will be made available, with all applicable trainings available beginning July 1, 2020.

13 Enhanced Peer Support

13.1 Assigned Owner

The Health Care Authority (HCA) is responsible for Peer Support Programs in the State of Washington.

13.2 Statewide vs. Regional

The state will implement this element of the settlement in selected regions in phases according to the plan outlined in the agreement.

13.3 Requirements from the Agreement

a. The state will create a peer counselor continuing education enhancement program for certified peer counselors that includes specialized training in criminal justice.
b. The state will provide ongoing training for these peer support specialists and targets the training and support to assist in establishing these positions in the programs outlined in the settlement agreement.
c. These enhanced peer support specialists are integrated into the following programs:
    - Technical assistance to jails.
    - Intensive case management for high utilizers.
    - Community outpatient competency restoration.
    - HARPS program.
d. The state will explore the possibility of federal funding for peer support specialists to encourage wider use of this role.

13.4 Education and Outreach

Outreach and education will focus on providing information about enhanced CPC roles and activities. The Enhanced Peer Supports Program Administrator will work in partnership with the regions and other Trueblood implementation teams to develop a FAQ, Factsheet, DBHR peer support webpage, Office of Consumer Partnership (OCP) distribution list, recorded webinars, and other communication materials as needed.

For each region, the following entities will require written education and outreach materials, webinars and regional presentations:

- Discussions on operationalizing enhanced certified peer counselors will occur with the technical assistance to jails, intensive case management, and community outpatient competency restoration teams.
- HARPS program
- Inform the peer community, stakeholders, jails, forensic navigators etc. about enhanced CPCs' roles and activities.
- WASPC.
- BHAs/BHASOs/MCOs.
- Other groups as needed and identified during initial outreach and education.

13.5 Action Plan and Timeline

1. Hire 1 staff (Program Administrator) by September 1, 2019.

a. Develop position description.
b. Recruitment.
c. Interviewing.
d. Candidate selection/background check/ reference check.
e. Candidate accepts and or repost.

2. Meet with partners (OFMHS, providers, etc.) to develop processes, education campaign, and associated documentation and forms to use by November 1, 2019.
   a. Environmental scan and key informant interviews.
   b. Integrate training components specific to serving individuals with prior criminal justice system contact.
3. Develop Curriculum by March 1, 2020.
   a. Train the trainers with new curriculum.
4. Implement and roll out trainings by May 1, 2020.
   a. Foundational enhancement training.
   b. Ongoing continuing education.
   c. Operationalizing enhanced peer support to host organizations.

14 Workforce Development

14.1 Assigned Owner

The Department of Social and Health Services is responsible for providing workforce development for DSHS staff and providing limited training resources to the forensic mental health community. HCA will be responsible for developing the enhancement curriculum for the certified peer counselors.

14.2 Statewide vs. Regional

Workforce development evaluation and support will be implemented as part of the statewide effort.

14.3 Requirements from the Agreement

a. Hire or contract workforce development specialists assigned to the functional areas of community, inpatient, and law enforcement. Duties include:
   I. Participate in workgroups
   II. Conduct training needs survey/gap analysis
   III. Develop master training plan(s)
   IV. Develop and coordinate training including standardized manuals and guidelines
   V. Collaborate with community-based organizational workforce development staff
   VI. Evaluate training programs
b. Prepare an annual report on a. above that includes recommendations about specific workforce development steps needed to ensure success of the Trueblood agreement. Distribute the report to Executive Committee, key and interested legislators.
c. Assess the need for and appropriate target areas of training, certification and possible degree programs. Include:
   I. Existing training, certification, and degree programs in WA for relevant professions
   II. Programs for relevant professions in other states
   III. Statewide staffing needs for all programs covered by this agreement for a period of ten years

d. Prepare a one-time report on c. above that is distributed to the appropriate legislative committees and includes:
    I. High, medium, and low cost recommendations
    II. Long, medium, and short-term recommendations for future actions regarding training and certification programs

14.4 Education and Outreach

Work with workgroup membership from various stakeholder groups to identify best communication pathways. Wherever possible, make recommendation reports public.

14.5 Action Plan and Timeline

Completed:

1. Updated existing position description forms for remaining Workforce Development position by June 1, 2019.
2. Submitted required documentation to human resources (request to hire/personnel action requests, updated organization charts, etc.) by June 15, 2019.

Pending:

3. Advertise the established positions by August 1, 2019.
4. Complete recruitment activities including screening, interviewing, and job offers by August 31, 2019.
5. Hire and onboard new employees by September 30, 2019. Onboarding will include orientation to the Trueblood Settlement Agreement and how their role is necessary to carrying out the objectives of the Agreement.
6. Begin organizing and conduct the first stakeholder workgroup meeting in each functional area by November 1, 2019.
7. Develop surveys to assess training needs in the identified functional areas by February 1, 2020.
8. Send surveys by February 15, 2020.
9. Evaluate survey results and develop training plans including requirements by May 1, 2020.
10. Develop training materials which can include guidebooks, presentations, etc. by June 1, 2020.
11. Deliver trainings through Phase 1 regions and complete by June 30, 2021.

Jail Training Needs Assessment Survey

In October 2018, DSHS developed and conducted a state-wide county jail training needs assessment survey. The survey included categories of training needs including psychiatric crisis de-escalation, general mental health awareness (for the jail setting), suicide risk assessment, management, and prevention, early admission (to state hospital) referral process, videoconferencing capabilities (for forensic evaluation services), competency restoration process, medication/involuntary medications. A total of eight jails responded to the survey. All jails indicated training needs in the aforementioned areas. The survey also provided information on training delivery preferences, including in-person and webinars.

Triage Training

In November of 2018, DSHS developed a webinar training for the Triage System. This training is presently under review and planned to be scheduled in the first half of 2019.

In Closing

The purpose of this Final Implementation Plan is to lay the foundation for implementation and overall planning. Because the plan sets out ambitious timelines, and because many of the elements of the plan embody new systems and programs never before used in the State of Washington, the Parties expect to learn as implementation proceeds. Any necessary changes or adjustments to the plans and timelines included in this document will be fully addressed with the committees created by the settlement agreement, as well as the Court.

Joint Motion for Preliminary Approval of Settlement Agreement Exhibit A

A.B., by and through TRUEBLOOD, et al., v. DSHS, et al., No. 14-cv-01178-MJP

Comprehensive Settlement Agreement

Contents

I. INTRODUCTION AND GOALS

In consideration of the Parties' commitment to uphold this Court's orders to provide timely competency evaluation and restoration services, the Parties enter into this Settlement Agreement. The Parties intend that implementation of this Agreement will bring Defendants into substantial compliance with this Court's orders. The elements of the Agreement aim to deliver an array of services to better deliver the right care, at the right time, in the right place, for the right cost. The ultimate goal of each element in this Agreement is to reduce the number of people who become or remain Class Members and to timely serve those who become Class Members.

The Parties recognize that there are multiple players in the forensic and broader mental health systems. This creates challenges in establishing continuity and coordination of care and forming long-term and sustainable solutions. In furtherance of the Parties' goals of diversion and providing timely services to Class Members, the Parties believe it is important to break down the silos between the system partners within the larger mental health system. To develop a plan that

yields successful outcomes for Class Members and enhances system collaboration and coordination, this Agreement acknowledges the value brought by every partner in the system and encourages full participation by all of its players.

In developing this Agreement, the Parties held dozens of meetings with hundreds of system partners over the six-month negotiations period.[1] This included meetings with:

- Class Members;
- Class Members' families;
- State Legislators;
- Mental health provider agencies and advocates;
- Behavioral Health Organizations and advocates;
- Law enforcement;
- Local jails;
- State and municipal courts and judges;
- Prosecuting attorneys;
- Defense attorneys;
- Homeless and housing providers and advocates;
- Employment support providers and advocates;
- Individual clinicians;
- Education programs for needed clinicians;
- Other departments of the administration outside DSHS;

[1] Input from these stakeholders is reflected in a publicly-available report, at: https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/Trueblood/2018Trueblood/2018-05-Tac-Report.pdf. After this report was drafted, the Parties, collectively and separately, continued to meet with system partners throughout the negotiation process.

- Local Legislators and Executives; and
- Washington residents.

The solutions in this Agreement focus on pursuing effective outcomes and often incorporate demonstrated successes in current programs, entities, and systems in Washington or from other jurisdictions. In crafting these solutions, the Parties recognize the fundamental goal of this Agreement is to provide timely competency services to Class Members pursuant to the Court's orders.

II. DEFINITIONS

1. Approval:
   a. Final Approval: the Court's approval of this Agreement following the notice period to Class Members, resolution of any objections, and the fairness hearing.
   b. Preliminary Approval: the Court's initial approval of this Agreement such that the notice period for Class Members begins.
2. BHA: Behavioral Health Administration.
3. CIT: Crisis Intervention Training.
4. CJTC: Criminal Justice Training Commission.
5. Class Member: All persons who are now, or will be in the future, charged with a crime in the State of Washington and: (a) who are ordered by a court to receive competency evaluation or restoration services through DSHS; (b) who are waiting in jail for those services; and (c) for whom DSHS receives the court order.

6. Co-responder program: The Mental Health Field Response Teams Program, currently administered by WASPC as a grant program, pursuant to Wash. Rev. Code § 36.28A.440.

7. Crisis triage and stabilization facility: means either a crisis stabilization unit or a triage facility as defined in Wash. Rev. Code 71.05.020.

8. Defendants: the named defendants in the lawsuit, including the Department of Social and Health Services, Eastern State Hospital, and Western State Hospital.

9. DSHS or Department: Department of Social and Health Services.

10. Executive Committee: A committee tasked with making ultimate recommendations to the Court, as specifically defined in § IV.B.4. This committee shall be composed of representatives from DSHS, OFMHS, HCA, and Plaintiffs' counsel. The use of this term in any section outside § IV.B.4 refers to the committee defined in § IV.B.4.

11. Forensic Data System: A software program designed by DSHS/BHA information technology to replace two legacy data systems at Western State Hospital and Eastern State Hospital which perform a variety of functions including tracking competency referral data consistently across state hospitals and competency restoration residential treatment facilities.

12. Forensic Risk Assessment: An assessment completed by a forensic evaluator that provides an opinion in regards to whether a criminal defendant meets the standard for not guilty by reason of insanity.

13. General Advisory Committee: The committee specifically defined in § IV.B.2-3 that will be comprised of the Court Monitor, DSHS, HCA, the Governor's office, OFMHS, Plaintiffs' counsel, and any applicable representative from outside

partners. The use of this term in any section outside § IV.B.2-3 refers to the committee defined in § IV.B.2-3.

14. HARPS: Acronym for Housing and Recovery through Peer Services. This term references a team generally consisting of one housing support specialist and two peer support specialists, all of whom have been trained in the permanent supportive housing model. HARPS teams also have access to housing bridge subsidies to facilitate maintaining or obtaining housing.

15. HCA: Health Care Authority.

16. Mature Data: Data that has been fully resolved. Distinct from "first look data" as identified in the monthly reports to the Court Monitor.

17. MCR: Mobile Crisis Responders.

18. Outstation: OFMHS offices and/or staff located in geographic regions somewhere other than the campuses of the two state hospitals.

19. OFMHS: Office of Forensic Mental Health Services; an office dedicated to forensic services within the Behavioral Health Administration of the Department of Social and Health Services.

20. Parties: the Plaintiffs and named Defendants in this case.

21. Peer Support Program: A program for providing a peer counselor certification, as described in Wash. Admin. Code § 182-538D-0200.

22. Phased Regions: the Washington State Managed Care Organizations (MCO) and Administrative Service Organizations (ASO) regions in which the changes contemplated by this Agreement will be implemented. Phase One Regions include the Spokane Region, Pierce County Region, and Southwest Washington Region.

Phase Two Regions include King County Region. Phase Three Regions may include additional regions with high rates of Class Member referral.

23. Regions: specific areas within the State of Washington as defined by the MCO/ASO boundaries/regions.

24. Residential supports: "Residential supports", as used within any section of this Agreement means only the residential supports as described within that section.

25. State:

a. Where describing an obligation or action under this Agreement: Executive branch agencies of the State of Washington.

b. Where describing a geographic region or level of government: the State of Washington.

26. Unstably Housed: As relevant to this Agreement, individuals are unstably housed if they:

a. are living in a place not meant for human habitation,

b. are living in an emergency shelter,

c. are living in transitional housing,

d. are exiting an institution where they temporarily resided, if they resided for up to 90 days and were in shelter or a place not meant for human habitation immediately prior to entering that institution, or,

e. are losing their primary nighttime residence within 14 days and lack resources or support networks to remain in housing.

27. Wait times: the maximum wait times for admission for inpatient competency services or completion of in-jail evaluations as set by the Federal Court in

Cassie Cordell Trueblood, next friend of A.B., an incapacitated person, et al., v. The Washington State Department Of Social And Health Services, et al., Cause No. 2:14-cv-01178-MJP.

28. WASPC: Washington Association of Sheriffs and Police Chiefs.

III. SUBSTANTIVE ELEMENTS

A. Competency Evaluation

1. The State will seek funding for 18 additional forensic evaluators needed to meet future predicted demand, to meet forensic evaluator demand created by the opening of additional forensic wards, to staff outstations, and to maintain compliance with the Court's injunction during periods of increased demand. The expanded evaluator capacity, when not needed to address periods of increased demand, will be used to perform the Department's other statutorily required evaluation functions, including:

   a. Out of custody evaluations;

   b. Forensic Risk Assessments;

   c. Civil commitment petitions for individuals found incompetent to stand trial under Wash. Rev. Code § 10.88.086 and referred for civil commitment under Wash. Rev. Code § 71.05.280(3);

   d. Other duties as assigned at the Department's sole and exclusive discretion;

   e. Provided that, during periods of increased demand, the Department will prioritize the completion of in-jail evaluations over the other duties outlined in a - d.

2. Approximately 13 of these positions shall be posted and recruited between July 1, 2019 - June 30, 2020, and the remaining positions shall be posted and recruited between July 1, 2020 - June 30, 2021.

3. The Department will complete the implementation of the Forensic Data System, and use that System to collect and utilize data to anticipate, and respond to, periods of increased demand.

4. The Department will collect and utilize data to determine if the increased evaluator capacity in § III.A.1 above maintains substantial compliance with the injunction with respect to in-jail competency evaluations, and whether capacity exists to respond to periods of increased demand. In the event the amount of evaluators is inconsistent with actual need, the Department will report the same in the semi-annual report as set forth in § IV.(B)(14). The report will include a plan to address the inconsistency going forward.

5. The State will continue the use of Outstations.

6. The State will complete the currently planned implementation of and will continue the use of telehealth for competency evaluations.

B. Competency Restoration

1. Legislative Changes

a. During the 2019 legislative session, the State will support and work to achieve legislative changes to reduce the number of people ordered into competency evaluation and restoration, and to use community based restoration services, which may include changes to Wash. Rev. Code § 10.31.110, Wash. Rev. Code § 10.77.086, and

Wash. Rev. Code § 10.77.088. These efforts may include advancing requests for legislative changes through bill proposals or supporting legislation that has been proposed by others that further the goal of reducing the number of individuals ordered to receive competency evaluation and restoration services.

b. If the State fails to pursue legislative changes intended to reduce demand for competency services to aid in reaching substantial compliance with the relevant portions of this Agreement, this will constitute material breach.

2. Community Outpatient Restoration Services

a. The State will seek funding and statutory changes to implement a phased roll out of community outpatient restoration services in targeted areas, including Residential Supports as clinically appropriate. These restoration services will be provided in community settings instead of inpatient units of state psychiatric hospitals or other inpatient restoration facilities.

b. Criminal defendant eligibility for community outpatient restoration services is determined by the criminal court that is making an order for restoration services pursuant to Wash. Rev. Code § 10.77.086 or 10.77.088.

(1) The forensic navigator, as described below in § III.B.3, will provide information, consistent with state and federal law, to the criminal court to assist the criminal court in determining whether a criminal defendant is appropriate for community outpatient restoration services.

(2) A criminal defendant's compliance will be monitored by the community outpatient restoration services provider and the forensic navigator. The forensic navigator will provide periodic updates to the criminal court about the criminal defendant's compliance in the community outpatient restoration program.

c. In accordance with state and federal law, the State will support processes to provide criminal courts with the information necessary to create tailored conditions for release of individuals into community outpatient restoration. The provision of this information will be primarily through the use of forensic navigators as described above in § III.B.3, however, the State may elect to use other means as appropriate.

d. The State will require community outpatient restoration service providers to accept referrals from OFMHS in accordance with an algorithm that prioritizes the intake of Class Members.

e. The State will conduct outreach and will provide technical assistance to criminal courts and other stakeholders, upon request, to support the implementation of community outpatient restoration services, to assist with issues such as:

(1) The determination of criminal defendant eligibility for community outpatient restoration;

(2) The conditions of the criminal defendant's participation in community outpatient restoration services; and,

(3) The use of Residential Supports and other services to encourage the use of community outpatient restoration services.

f. If a Class Member is otherwise determined to be eligible for community outpatient restoration services by the criminal court, but is assessed by the forensic navigator as Unstably Housed, the State shall provide Residential Supports, as specified in this Agreement, for the duration of participation in a community outpatient restoration program. The Residential Supports shall not continue for a Class Member referred for inpatient services. The Residential Supports may continue for a Class Member opined to be competent under Wash. Rev. Code § 10.77.065 for up to 14 days following transmission of the competency evaluation.

g. Forensic navigators will coordinate access to housing for all persons enrolled in community outpatient restoration services. Discharge planning for Class Members begins upon admission to the community outpatient restoration program. If HARPS services are deemed necessary, planning should begin as soon as practicable for post-discharge housing support

h. The State will develop Residential Supports for outpatient competency restoration, as specified in this Agreement, through a procurement process to fund community outpatient restoration providers. Providers will be given the flexibility to propose and deliver residential support solutions unique to the needs of the community in which the service is provided, which may include:

(1) Capital development through the Department of Commerce;

(2) Capital development through a third party source identified by the provider;

(3) Housing voucher programs;

(4) Leveraging existing housing programs locally;

(5) Scattered site housing programs.

i. The State will seek funding to support community outpatient restoration services with a broader package of treatment and recovery services, including mental health treatment, substance use screening and treatment. The restoration portion of these services may be provided in-person, remotely through live video, or via recorded video.

j. For criminal defendants waiting in jail, an offer of admission to the community outpatient restoration services program will occur within the constitutional timelines for restoration as outlined by the Federal Court.

3. Forensic Navigators

a. The State will seek funding to implement a new role within the forensic mental health system. This new role, called a forensic navigator, will assist Class Members in accessing services related to diversion and community outpatient competency restoration.

(1) Class Members will be assigned a forensic navigator at the time that a competency evaluation order is received by the Department in the Class Member's criminal case. The navigator will gather information specific to Class Members, including what services are available for that individual Class Member, and how a community

outpatient restoration order or other court order could be supported. This information will be provided to the criminal court prior to the hearing to determine whether competency restoration should be ordered. The navigator will not make a clinical recommendation to the criminal court.

(2) Forensic navigators will be given discretion to manage their caseload, but will do so using the following guiding principles:

(a) In recognition of the fact that there is a large portion of Class Members who are known to the system, and will have recently had contact with the criminal justice or forensic mental health system, forensic navigators may prioritize their efforts to divert these particular Class Members (or high utilizers as referenced in § III.C.4.a.). This prioritization may include beginning work on gathering information immediately upon being assigned the Class Member.

(b) In recognition of the fact that a large proportion of criminal defendants who are ordered to receive a competency evaluation will be found competent, forensic navigators may prioritize their efforts in order to provide a less intensive level of service until a finding that the Class Member is incompetent. This prioritization may include delaying intensive work on gathering information until more is

learned about the Class Member. Forensic navigators may use a standardized tool or assessment in order to assess Class Members unknown to the system.

(3) Forensic navigators will assist criminal court personnel with understanding diversion and treatment options for individual Class Members in order to support the entry of criminal court orders that may divert Class Members from the forensic mental health system.

(4) When a criminal court enters an order directing a criminal defendant to receive restoration services on an outpatient basis, the forensic navigator shall provide services to the criminal defendant ordered to community outpatient restoration, who shall be a client of the forensic navigators. These services will include:

(a) Assisting the client with attending appointments and classes related to outpatient competency restoration.

(b) Coordinating access to housing for the client.

(c) Meeting individually with each client on a regular basis.

(d) Performing outreach as needed to stay in touch with clients.

(e) Providing information to the criminal court concerning the client's progress and compliance with the court ordered conditions of the client's release. This may include appearing at criminal court hearings to provide information to the criminal court.

(f) Coordinating client access to community case management services, mental health services, and follow up.

(g) Assisting clients with obtaining and encouraging adherence to prescribed medication.

(5) The forensic navigator's services to the criminal defendant shall conclude as follows:

(a) If, after the navigator has advised the criminal court as described in § III.B.3.a.(3) above, the criminal court does not order the criminal defendant into community outpatient restoration services, the role of the forensic navigator shall end. The forensic navigator may facilitate a coordinated transition as described below if the circumstances warrant such coordination.

(b) If, after the forensic navigator has advised the criminal court as described in § III.B.3.a.(3) above, the criminal court does order the criminal defendant into community outpatient restoration services, the forensic navigator shall:

1) Prior to the conclusion of community outpatient restoration services, facilitate a coordinated transition of the criminal defendant's case to a case manager in the community mental health system.

a) The standards for this coordinated transition shall be established through the use of care

coordination agreements, or some similar agreement. To support these coordinated transitions, the forensic navigator shall attempt to follow up with the client to check whether the meeting between the client and community-based case manager took place, or when the client is an identified high utilizer, the forensic navigator shall attempt to connect the client to high utilizer services.

b) To support this coordinated transition, the forensic navigator will also attempt to check in with the Class Member at least once per month, for up to 60 days, but during this time, the client shall not count towards the navigator's caseload. The navigator will not duplicate the services provided by the community based case manager, but if the navigator believes the coordinated transition is not likely to be successful, the forensic navigator will follow up as appropriate.

2) In cases where a criminal defendant regains competency, is found guilty and is sentenced to serve a term of imprisonment in jail or prison, has criminal

charges dismissed pending a civil commitment hearing, enters or returns to jail due to a revocation of the community outpatient restoration order or the filing of new criminal charges, receives a new or amended order directing inpatient admission for restoration, or declines further services after the court ordered restoration treatment ends, the forensic navigator shall create a summary of treatment provided during community outpatient restoration, including earlier identified diversion options for the individual. Through training and technical assistance, the State will encourage third parties, including jails or prisons where a former Class Member is serving a sentence, to request this summary and related treatment records, as allowed by Wash. Rev. Code § 10.77.210.

(c) In other situations not contemplated by this Agreement, the State shall use it discretion in deciding when to end forensic navigator services, and how to accomplish a coordinated transition.

(6) A forensic navigator caseload will not exceed twenty-five Class Members at any given time.

4. Additional Forensic Bed Capacity

a. The State will open additional forensic beds at Western State Hospital and Eastern State Hospital, pursuant to existing funding authorized in the 2018 capital budget. The projected availability of additional forensic beds is as follows:

(1) Develop two forensic wards at Eastern State Hospital by December 31, 2019 (25 beds each for total of 50 beds)

(2) Convert two Western State Hospital civil geriatric wards to two forensic wards by December 31, 2019 (21 beds each for a total of 42 beds)

b. If the State is unable to open the beds in accordance with the projected schedule above, the State shall provide notice to the Executive Committee that additional time is needed, including the projected delay, and the reasons for the delay. This notice shall allow the State an additional six months of time to open the beds. If the State needs additional time beyond this six-month period, the State may request a further extension of time from the Court.

5. Closure of Maple Lane and Yakima

a. In the event wait times for Class Member admission for inpatient competency services reach a median of 13 days or less for four consecutive months, based on mature data, the State will begin ramp down of the Yakima Competency Restoration Program. The Yakima Competency Restoration Program will close, notwithstanding the median wait times

described in this paragraph, no later than December 31, 2021. Failure to close the Yakima Competency Restoration Program by December 31, 2021 constitutes a material breach of this Agreement.

b. In the event wait times for Class Member admission for inpatient competency services reach a median of 9 days or less for four consecutive months, based on mature data, the State will begin ramp down of the Maple Lane Competency Restoration Program. The Maple Lane Competency Restoration Program will close, notwithstanding the median wait times described in this paragraph, no later than July 1, 2024. Failure to close the Maple Lane Competency Restoration Program by July 1, 2024 constitutes a material breach of this Agreement

C. Crisis Triage and Diversion Supports

1. Crisis Triage and Diversion Capacity:

a. During Phase One of this Agreement, the State will seek funding to increase overall capacity for crisis stabilization units and/or triage facilities by 16 beds in the Spokane Region. These beds will address both urban and rural needs. During Phase One of this Agreement, the State will seek to make funds available for enhancements to similar existing or currently funded facilities in the Southwest and Pierce Regions, subject to the identification of appropriate enhancements by community providers in the Southwest and Pierce Regions.

b. In Phase One, the State will assess the need for Crisis Triage and Stabilization capacity for Phase Two Regions, and any gaps in existing

capacity in Phase One Regions, and will report the same to the General Advisory Committee. The report will identify existing resources in the Phased Regions, and will include a plan to increase capacity in the Phased Regions. The State will seek funding to increase capacity in accordance with this plan and the schedule set out in § IV.A and the implementation plan in § IV.D. This process will repeat for subsequent phases.

2. Residential Supports for Crisis Triage and Diversion

a. The State will seek funding to provide short-term housing vouchers to be deployed throughout Crisis Triage and Stabilization Facilities. These short-term vouchers will be disbursed in accordance with the phased schedule set forth in § IV.A. These short-term vouchers will:

(1) Be disbursed by the Crisis Triage and Stabilization Facilities, based on a clinical assessment of need.

(2) The initial housing voucher will cover up to a maximum of 14 days.

(3) At the discretion of the crisis triage and stabilization provider, the short-term housing voucher may be extended up to an additional 14 days.

b. The State will seek funding to create residential support capacity associated with the community outpatient competency restoration program in each Region. These Residential Supports will be implemented in accordance with the phased schedule set forth in § IV.A. In addition to the short-term vouchers described in § III.C.2.a. above, this residential support capacity must offer housing support options that are designed to target individuals

who are clinically-assessed to need more intensive support and stability immediately following discharge from Crisis Triage and Stabilization Facilities. These Residential Supports are intended to provide an individual with a better chance of remaining stable while awaiting more permanent housing solutions, including but not limited to the HARPS program.

(1) Individuals eligible to use this residential support capacity will meet all of the following criteria:

i. Have had at least one prior contact with the forensic mental system in the past 24 months, or, were brought to a Crisis Triage or Stabilization Facility via arrest diversion under Wash. Rev. Code § 10.31.110 as determined by the crisis triage and stabilization provider;

ii. Need assistance accessing independent living options and would benefit from short term housing assistance beyond the 14-day vouchers;

iii. Are diagnosed with an acute behavioral health disorder and are assessed to need housing support beyond what is offered through the Crisis Triage and Stabilization Facilities or the short term voucher as described in § III.C.2.a;

iv. Are Unstably Housed;

v. Are not currently in the community outpatient competency restoration program, and;

vi. Do not meet Involuntary Treatment Act (Wash. Rev. Code 71.05) commitment criteria.

(2) The State shall seek funding to add 10% more Residential Supports as described in § III.C.2.b to the community outpatient restoration program in each Region, with the 10% capacity to be used for this population. In Phase One, the Parties project that the anticipated capacity at any given time will be five individuals in the Pierce Region, three individuals in the Southwest Region, and two individuals in the Spokane Region.

(3) The HARPS housing support program shall also be made available to individuals within this population, for individuals clinically-assessed to benefit from the HARPS program.

(4) When high utilizers, as defined in § III.C.4.a., are identified through their use of the crisis triage and diversion system, they shall be provided access to the Residential Supports and services as described in § III.C.2.b above.

3. Mobile Crisis and Co-responder Response Programs

a. The State will seek funding for Co-Responder Programs as follows:

(1) The State shall seek funding to provide law enforcement agencies with dedicated qualified mental health professionals to assist officers in field response to promote diversion of people experiencing behavioral health crisis from arrest and incarceration.

(2) The Parties appreciate the leadership and affirmative efforts taken by the Legislature and the WASPC in establishing a mental health field response team program as described in Wash. Rev. Code § 36.28A.440. The Parties wish to build upon programs like these. Therefore, in the 2019-2021 biennium, the State shall seek $3 million in additional funding to expand the mental health field response program administered by WASPC pursuant to HB 2892 for the purpose of implementing or expanding response team programs in law enforcement or behavioral health agencies located in the Phase One Regions. In the event WASPC determines that the sum appropriated exceeds the needs of these three Regions during Phase One, WASPC may disburse some grant funding to support Phase Two implementation, including law enforcement or behavioral health agencies located in King County. The failure to secure $3 million in funding to expand Wash. Rev. Code § 36.28A.440 program grants as set forth in this paragraph shall not be deemed a material breach. § V.A.2 does not apply to this paragraph.

(3) The State's implementation plan, as described in § IV.D., shall describe how the State will support and encourage the integration of these programs into the reforms contemplated by this Agreement.

(4) During Phase One of this Agreement, the State shall perform an assessment of law enforcement agency co-responder mental health staffing needs in order to guide future funding requests.

(5) If, during the implementation of this Agreement, it becomes apparent that WASPC has not been appropriated funds for, or is otherwise unable to administer the Co-Responder Program in a manner consistent with, the phased implementation schedule outlined in § IV.A, the Executive Committee will meet and develop recommendations for future action by the Parties regarding use of co-responder programs.

b. The State will seek funding for Mobile Crisis Response ("MCR") behavioral health services as follows:

(1) The State will seek funding to increase MCR services to respond to people experiencing behavioral health crisis in the community. The State will request a plan for the provision of MCR services in each Phased Region, as required by the phased schedule identified in § IV.A. The State will seek funding for MCR services for each Phased Region. This process will be designed to create flexibility that will allow each Phased Region to tailor this resource to meet their local needs.

(2) Each Phased Region will be asked to propose new MCR service resources within their Region, including proposing the numbers, credentialing, and location of mental health professionals. Each

regional plan will be tailored to meet the urban and rural needs of the individual Region, considering the need for timely response throughout the entire Region.

(3) The regional plans, and the resulting contracts for services, will require that providers make available MCR services on a twenty-four (24) hour, seven (7) day per week basis that may be accessed without full completion of intake evaluations and/or other screening and assessment processes. The State will request a recommendation from WASPC and regional MCR providers as to reasonable response times in each Phased Region. In the regional plans and the resulting contracts for services, the contracting entities will include response time targets, after considering the WASPC and regional MCR providers' recommendations. During Phase One, the State will institute reporting requirements to gather data on response times of MCR services. In subsequent phases, the Parties will use this data to inform future funding requests, and possible contractual requirements to meet response time targets.

c. Co-response teams of law enforcement and mental health professionals will be encouraged to rely on MCRs to accept individuals they have identified as needing mental health services, including people eligible for mental health diversion pursuant to Wash. Rev. Code § 10.31.110.

d. The State will seek funding to cover reasonable administrative costs requested by WASPC to enable it to meet the requirements of § III.C.3.a.2 and§ III.C.3.b.3 above.

4. Intensive Case Management Program for High Utilizers

a. The State is developing a model to identify those most at risk of near-term referral for competency restoration. This identified population shall be referred to as high utilizers. The model is designed to identify persons who are likely to be referred for a competency service within the next six months. The model will use available data and include factors such as:

(1) Prior referrals for competency evaluation;

(2) Prior referrals for competency restoration;

(3) Prior inpatient psychiatric treatment episodes;

(4) Criminal justice system involvement, and;

(5) Homelessness.

b. In the semi-annual reports required under § IV.B.14, the State will report on whether or not the model is effective in identifying persons who are likely to be referred for a competency service in the next six months, and the status of outreach to identified high utilizers. This report shall be reviewed by the Oversight and Advisory Committees outlined in § IV.B., and the Executive Committee may make recommendations regarding adjustment of the model.

c. The services provided to this group shall include:

(1) Whenever an identified high utilizer is referred for competency evaluation, they shall be offered intensive case management services.

(2) The intensive case management program will be developed with a phased implementation as outlined in § IV.A that adheres to the following principles:

(a) The program will not duplicate services offered through health and behavioral health benefits provided under other programs, but will leverage services otherwise available and enhance the services available to the high utilizer.

(b) The program will have the ability to provide case management services for individuals who have significant barriers to accessing behavioral health and community supports.

(c) The initial participation period in the program for each individual will be six months.

d. Program services may be provided through community behavioral health agencies through direct contracts with the State. During the initial participation period, the program shall offer:

(1) Funding for engagement activities for those meeting the high utilizer definition.

(2) Housing supports, using the HARPS model, which includes:

(a) Securing and maintaining housing,

(b) Peer support,

(c) Rent or other housing support subsidies, in the amount of up to $1200 per month for up to six months.

(3) Transportation assistance.

(4) Training on accessing resources and other independent living skills.

(5) Support for accessing healthcare services and other non-medical services.

e. The case management program will include an outreach and engagement activities component for those currently identified as high utilizers, which may occur outside the context of a competency referral.

D. Education and Training

1. Crisis Intervention Training (CIT)

a. The State will seek funding to strengthen and expand behavioral health crisis training for law enforcement and corrections officers. At a minimum:

(1) The State shall seek funding to offer the 40 hour enhanced CIT course, to reach a target of 25% of officers on patrol duty in each law enforcement agency within the Phased Regions. The funding will be modeled after the existing funding model used by CJTC, including the current model for any backfill costs, which assumes a State contribution for 16 hours of backfill costs, out of the 40 hours. The 25% target will be measured as reported by CJTC. This target

may be limited by CJTC's ability to offer the necessary number of courses during each phase, so long as the reason is not strictly the unavailability of funding. If CJTC offers a training different from the 40 hour enhanced CIT course, the Parties may mutually agree that this training may count towards satisfying this target. Whenever possible, the State shall ensure that the agencies serving the areas of highest population density in the Phased Regions meet this training target before other agencies with lower population density.

(2) The State shall seek funding to ensure that corrections officers and 911 dispatchers employed by governmental entities within each Phased Region, except those employed by the Washington State Department of Corrections or Federal entities, receive at least eight hours of CIT provided by CJTC, or by an entity approved by CJTC for this purpose.

(3) In the semi-annual report, the State shall include data from CJTC on completion rates of training, and barriers to local jurisdictions to attending the training.

b. The State and Plaintiffs' counsel will invite WASPC and CJTC to meet and discuss how to better deliver behavioral health crisis training to officers employed by agencies with ten or fewer officers on staff.

c. All training efforts described in this section will be made in accordance with the phased implementation schedule set forth in § IV.A.

2. Technical Assistance

a. The State will seek funding for state or contracted resources to develop and provide educational and technical assistance to jails. These efforts will be made in accordance with the phased implementation schedule set forth in § IV.A. The State will include the involvement of peer support specialists in providing this educational and technical assistance.

b. The State will work with Washington's designated Protection and Advocacy System (as designated in Wash. Rev. Code § 71A.10.080), law enforcement entities and associations, and peer support specialists to develop guidance on mutually agreeable best practices for diversion and stabilization of Class Members and potential Class Members in jail during Phase One of this Agreement. To develop this guidance, initial best practices will be proposed by the State, and reviewed and approved by Washington's designated Protection and Advocacy System.

(1) These best practices will at minimum address pre and post-booking diversion, identification of need and access to treatment, guidelines for administration of involuntary medication, continuity of care, use of segregation, and release planning.

(2) In delivering education and technical assistance to jails, the State will develop a plan to proactively engage all jails in the State of Washington, in accordance with the phased implementation schedule set forth in § IV.A. This shall involve offering on-site

trainings to jails and a standard method for jails to seek technical assistance and receive timely responses.

c. The State may leverage the existing training and technical assistance work of law enforcement entities and associations, as appropriate.

E. Workforce Development

1. Enhanced Peer Support Specialists

a. The State will develop an enhanced Peer Support Program for individuals that includes specialized training in criminal justice. This program will include individuals participating in the core curriculum, and then participating in the specialized enhanced program for criminal justice. The State will provide ongoing training for enhanced peer support specialists and targeted training and support to assist with establishing these positions in programs purchased by the State.

b. The State will encourage the use of this enhanced Peer Support Program by integrating the enhanced peer role into the systems developed throughout this Agreement. The Department recognizes the challenges in employing peers with criminal justice lived experience, but is supportive when the nature of that past experience makes them an appropriate candidate for working with individuals with mental illness. This includes the use of enhanced peer support specialists in the intensive case management program (§ III.C.4.), the community outpatient competency restoration program (§ III.B.2), and the HARPS program (§ III.C.4.d.(2)). The State

will explore whether it is feasible to obtain any federal funding for enhanced peer support specialists, to encourage the wider use of this role.

2. Workforce Development; Degree and Certification Programs

a. The State will seek funding to hire, or contract with, workforce development specialists. The positions will be assigned to specific workforce functional areas to include:

(1) Community, including crisis response, homeless, in-home, residential, and clinic based services,

(2) In-patient, including residential treatment facilities, private hospitals, and state hospitals,

(3) Law enforcement and corrections, including jails and prisons.

b. Workforce development specialists may conduct or manage the following duties:

(1) Participate in workforce development workgroups with stakeholders such as state hospitals, community healthcare organizations, law enforcement, and jails;

(2) Conduct training needs surveys/gaps analysis;

(3) Assist in the development of a master training plan(s);

(4) Develop and coordinate training including standardized training manuals and guidelines;

(5) Collaborate with other community-based, organizational workforce development staff;

(6) Conduct training program(s) evaluations; and

(7) Other duties as assigned at the sole and exclusive discretion of the State.

c. The functions and duties outlined in this subsection may be implemented with direct hiring, contracting, or any combination thereof.

d. The workforce development specialists may collaborate with other workforce development efforts (for example, the workforce development efforts of the Economic Services Administration), as appropriate.

e. The State will produce a report annually describing the activities of the workforce development specialists outlined in this subsection, and making recommendations about the specific workforce development steps necessary to ensure success of this Agreement. The State will distribute this report to key and interested legislators. This report will also be distributed to the Executive Committee, and that Committee shall consider whether to adopt those recommendations for possible inclusion in future phases of the Agreement. The annual schedule for this report shall be set as to align with the phased approach of this Agreement, and to allow for consideration of the Executive Committee's recommendations in the established state budget process.

f. The State will assess the need and target areas for training programs, certification programs, and possible degree programs. The State may collaborate with colleges, including community and technical colleges, and universities to accomplish this task, but shall also have discretion to

accomplish this task through other means. This assessment shall include, but not be limited to, the following elements:

(1) Existing training, certifications, and degree programs in Washington for relevant professions; for example, nursing, psychiatry, psychology, counseling, law enforcement, or other professions determined at the discretion of the State.

(2) Programs for relevant professions in other states.

(3) Statewide staffing needs for all programs covered by this Agreement for a period of the subsequent ten years.

g. Upon completion of the assessment in § III.E.2.f. above, the State shall produce a report regarding that assessment that may be shared with appropriate committees of the Legislature. The report will include:

(1) High, medium, and low cost recommendations, and

(2) Long, medium, and short term recommendations for future action regarding training and certification programs.

h. While the State shall pursue the elements outlined this subsection in good faith, the State is not required to establish new degree or certification programs pursuant to this Agreement.

i. In addition to the requirements outlined in § III.E.2.a-h. above, the State will make all reasonable efforts to fill the positions required to timely implement all phases of this Agreement, as outlined in § IV.A. Reasonable efforts may include the use of incentives.

IV. PHASING, OVERSIGHT, AND IMPLEMENTATION

A. Phased Implementation

1. The Parties agree that the implementation of the programs and services described in this Agreement shall occur in phases. In each phase, the State will focus its efforts toward specifically identified and agreed upon Regions for each of the elements outlined in this Agreement. The Parties have agreed to at least three phases for purposes of implementation, which will run parallel to the Legislative biennia beginning with the 2019-2021 biennium. The Parties agree to the phased roll out to specific Regions as follows:

   a. Phase One: the State will focus implementation efforts in the Southwest, Spokane and Pierce Regions. This phase will run parallel with the 2019-2021 biennium.

   b. Phase Two: the State will focus implementation efforts in the King Region. This phase will run parallel with the 2021-2023 biennium.

   c. Phase Three: the Parties agree there will be a review of the progress during the 2021-2023 biennium of the Phase One and Two Regions. The Executive Committee will then make a decision as to whether the State should a) expand or modify the programs in Phases One and Two for purposes of Phase Three; or b) if Phase One and/or Two have been successful, identify and focus efforts in new high-referral Regions for purposes of Phase Three; or c) some combination of the above.

   d. Following Phase Three: The Executive Committee will determine as to whether the State should expand or modify programs in additional Regions

through the phasing process. This process shall continue until the termination of this Agreement.

2. In order to begin implementation in each of the Phased Regions as quickly as possible, upon approval of the Agreement the Parties agree to immediately seek approval from the Court to use contempt fines to staff project managers for the identified Regions in Phase One and Two, as well as a single administrative support position to support these project managers. The Parties shall also seek approval from the Court to use contempt fines to provide the funding necessary to begin development of components of this Agreement, which may include housing supports, provision of case management, high utilizer supports, and outreach and communications regarding implementation of the Agreement, as agreed upon by Parties. The use of contempt fines for this purpose is not meant to supplant or otherwise modify the State's obligations under this Agreement to seek funding for and implement programs and changes described in this Agreement, but instead to ensure that the implementation of Phase One may begin as quickly as possible and that elements of the Agreement have the best chance of overcoming unforeseen funding and implementation challenges. Disbursement of the fines will occur upon Final Approval of this Agreement by the Court.

B. Oversight and Advisory Structure

1. Defendants will use a sustainable oversight structure to inform and provide supervision for high-level policy-making, planning, and decision-making on targeted issues, and for the implementation of this Agreement. A description of this structure is set forth below.

2. The Parties agree to the appointment of a General Advisory Committee to be comprised of the Court Monitor, DSHS, HCA, Governor's office, OFMHS, and Plaintiffs' counsel, and the Parties agree to invite several representatives from local partners to join the General Advisory Committee, to include, but not limited to:

   a. A Judge Representative

   b. A Prosecutor Representative

   c. A Defender Representative

   d. Behavioral health treatment program Representative

   e. A Housing Provider Representative

   f. A Consumers and families Representative

   g. A Law Enforcement Representative and/or a CJTC Representative

   h. A Jail Representative

   i. Plaintiffs' Counsel Representative(s)

   j. Court Monitor Team Representative

3. The General Advisory Committee's main purpose shall be to provide local community feedback, to flag issues, to review data and outcomes, and to make recommendations at specific decision points during the implementation of this Agreement. The General Advisory Committee will be a consulting body to the Executive Committee, but will not be tasked with decision-making or making contact with the Court. Any recommendation of the General Advisory Committee shall be reviewed and considered by the Executive Committee. The General Advisory Committee shall be specifically empowered to make recommendations to the Executive Committee on the following decisions:

a. The nature of the Phase Three implementation as outlined in this Agreement, as contemplated in § IV.A.1.c. This includes whether Phase Three should proceed to expand into Regions not included in Phases One and Two, or whether Phase Three should focus on the expansion or modification of services in the Regions included in Phases One and Two, or some combination thereof.

b. Identification of areas or issues of concern in the implementation of the Agreement based on stakeholder feedback.

c. Reviewing implementation reports and implementation data, and based on that review, making recommendations for changes or modifications based on areas or issues of concern that have been identified in implementation.

4. There will also be a smaller Executive Committee that will be tasked with making decisions and ultimate recommendations to the Court. This Committee shall be composed of representatives from DSHS, OFMHS, HCA and Plaintiffs' counsel. The Executive Committee may elect to consult with others outside of the Executive Committee by agreement.

5. The Executive Committee shall be specifically empowered to make decisions regarding items 5.a., 5.c., and 5.d. below. The Executive Committee will make agreed upon recommendations to the Court regarding 5.b. below.

a. The nature of the Phase Three implementation as outlined in this Agreement, as contemplated in § IV.A.1.c. This includes whether Phase Three should proceed to expand into Regions not included in Phases One and Two, or whether Phase Three should instead be focused on the

expansion or modification of services in the Regions included in Phases One and Two.

b. Changes or modifications based on areas or issues of concern that have been identified in implementation.

c. Overseeing the commission of the semi-annual implementation reports and data collection. The Executive Committee may elect to expand or modify the elements for data collection beyond those expressly identified in this Agreement.

d. Whether the State should expand or modify programs in additional Regions through the phasing process beyond Phase Three. This process shall continue until the termination of this Agreement.

6. If the Executive Committee is unable to reach consensus on a particular issue, they may engage the use of an agreed upon neutral to resolve the issue. Issues not resolved through a neutral may be presented to the Court for consideration. This process is distinct from the process described regarding material breach below in § IV.C.

7. Each identified entity on the Executive Committee will be solely responsible for choosing its representative(s) to the Executive Committee.

8. Defendants are empowered to (1) provide guidance to state agencies and the Parties about implementation and (2) make decisions regarding the implementation of the Agreement not otherwise identified for review by the General Advisory Committee or Executive Committee.

9. The local partner representatives on the General Advisory Committee will be appointed as determined by the Executive Committee. The Executive Committee will also determine whether to make fixed term appointments or to rotate invitations.

10. The General Advisory Committee will meet quarterly. Twice per year the quarterly meeting will be focused on gathering input from stakeholders and community partners. Twice per year the quarterly meeting will be focused on reviewing the semi-annual report and data. This does not limit what may be covered in any quarterly meeting, but simply gives guidance on each meeting's focus.

    a. General Advisory Committee meetings shall be convened in person and via WebEx or a similar remote participation option.

11. The Executive Committee will meet quarterly in alignment with the General Advisory Committee. The Executive Committee may also meet on an as needed basis, and may be convened by the Court Monitor or by majority agreement of the Executive Committee.

    a. Executive Committee meetings shall be convened in person, via WebEx, or via a similar remote participation option.

12. The Parties may also meet with stakeholders independently on an as needed basis.

13. The General Advisory Committee will be supported by OFMHS, the Trueblood project manager, and Research and Data Analysis within DSHS.

    a. The Trueblood project manager will create a project plan, manage the General Advisory Committee and its meetings, and manage and schedule the Executive Committee meetings.

b. The regional project managers will support implementation of this Agreement through efforts such as support through technical assistance, outreach, trainings, summits, and education to local communities. These efforts shall be made in accordance with the phased implementation schedule in § IV.A. This may include incorporation of and cooperation with any work being done in support of the Trueblood Diversion Programs.

c. The State will support data collection and analysis. Data points for analysis shall be included in the implementation plan described below in § IV.D. Data points will be reviewed and refined over time based on the recommendations of the Executive Committee.

d. The raw data gathered pursuant to this Agreement shall be made publically available to the extent permitted by law.

14. The State shall produce a monitoring report semi-annually. This report shall include, at a minimum:

a. Data reporting as described throughout this Agreement

b. Data analysis of the various data elements

c. Updates on the status of the phase programs, based on each of the elements outlined in the Agreement

d. Areas of concern or struggle in implementation

e. Areas of positive impacts or programming in implementation

f. Recommendations for addressing areas of concern or struggle

C. Dispute Resolution

1. Where one Party believes that the other Party is in material breach of the Agreement, the Parties shall engage the Executive Committee in a good faith effort to resolve the allegation of material breach.

2. This process shall be initiated by one Party sending written notice to the other Party that they believe the Party has materially breached the Agreement. The written notice shall specify the section of the Agreement that the Party believes has been materially breached, and explain in detail how that section has been materially breached, and specify the facts and information that support the conclusion.

3. Within ten days, the responding Party shall provide a written response. This written response shall respond to each allegation of material breach, and explain in detail the responding Party's position on the alleged breach, and specify the facts and information that support that position.

4. Upon receipt of the written response, the Parties shall schedule a time to meet and confer within three business days in order to determine if the written response resolves the allegation of material breach.

5. If the allegation of material breach is not resolved by the written exchange and the subsequent meet and confer, the Parties shall schedule a mediation session with an agreed upon neutral. The mediation session must be held within 14 days, unless this timeline is modified by an agreement of the Parties, or if the Parties are unable to secure the services of an agreed neutral within that timeframe.

6. If, after completion of the mediation, the Parties have not resolved the allegation of material breach, the Party alleging a breach may seek relief from the Court.

7. At each of the identified steps regarding material breach, the opportunity to cure any alleged breach shall be considered.

D. Implementation Plan and Process Commitments

1. Defendants will develop an implementation plan beginning on the date the Court gives its Preliminary Approval of the Agreement. A preliminary plan to lay the foundation for implementation and overall planning will be completed within 90 days after the Court gives its Final Approval of this Agreement. A final implementation plan, which accounts for any funding or legislative changes accomplished by the Legislature in the 2019 session will be completed within 60 days from the end of the 2019 Legislative session. Certain tasks related to the implementation within each Region may be reserved to the project management plans to be implemented by each regional project manager.

2. Defendants will develop the preliminary and final implementation plans using input from Plaintiffs' Counsel and the Court Monitor. The implementation plan will:

   a. Identify and sequence tasks necessary to fulfill the commitments and ultimately achieve the exit criteria;

   b. Consider estimates produced by the TriWest Bed Flow Analysis, if available;

   c. Set clear and accountable timelines through the termination of this Agreement;

   d. Assign responsibility for achieving each task to the appropriate agency or entity;

e. Describe how reporting processes shall be established to report on the data elements specified under this Agreement, as well as the development of the ongoing implementation reports;

f. Develop collaboration models for regional project managers and regional implementations to problem-solve challenges encountered; and

g. Describe the communication and outreach activities to inform the community, stakeholders, and policy makers about the access to services and processes described in this Agreement, including development of documentation that provides sufficient information to explain the purpose of and use of services established by this Agreement, and encourage use of those services.

3. Defendants will submit to the Court for approval the preliminary and final implementation plans, which shall describe how the Defendants will fulfill the commitments of this Agreement.

4. Defendants will comply with the implementation plan that is approved by the Court, and any amendments, pursuant to this Agreement.

5. The Parties will repeat this process for creating a final implantation plan for each future Phased Region during subsequent phases of the Agreement.

V. COMPLIANCE AND TERMINATION

A. Contempt Mitigation and Substantial Compliance

1. Assuming the Court's Final Approval of this Agreement, contempt fines will be suspended beginning December 1, 2018. The fines will continue to be calculated,

but no payment on those fines shall be made. The suspended contempt fines shall be calculated using the current rates under the existing Court orders.

a. At the end of each phase, if the State is in substantial compliance, all suspended fines will be waived.

2. If the funding made available for this Agreement is inadequate to implement the identified elements during any phase, this will constitute material breach. In considering whether funding is inadequate, funds available from third party sources shall be considered, and supplemental budget requests made during any phase shall also be considered. No allegation of material breach based on inadequate funding may be made until after the completion of the 2019 Legislative Session.

3. Given the scope and breadth of this Agreement, the Parties agree that a material breach of a particular element does not necessarily constitute material breach of the entire Agreement, unless otherwise specified herein. For purposes of this Agreement, and unless otherwise specified herein, “material breach” is defined as a failure to be in "substantial compliance" with the Agreement, and substantial compliance means something less than strict and literal compliance with every provision of this Agreement. Rather, deviations from the terms of the Agreement may occur, provided any such deviations are unintentional and minor, so as not to substantially defeat the object which the Parties intend to accomplish, or to impair the structure of the Agreement as a whole. This Agreement is a product of extensive work with stakeholders and input from experts in their fields. It is an informed and thoughtful estimation of the best plan to resolve the ongoing constitutional crisis before the Court. However, the Parties recognize and acknowledge the need for

flexibility in developing the comprehensive changes proposed, and that the purpose and intent of each element could be achieved by alternative methods. The Parties further agree to give due consideration to the totality of any decisions or actions taken by the Legislature in implementing this Agreement to determine if the spirit of the Agreement, if not the letter, has been upheld before pursuing an allegation of material breach for any element that does not specifically identify what constitutes material breach.

4. Plaintiffs agree to engage in an ordered process in order to raise any allegation of material breach under this Agreement. The process is more fully described in § II.B.6 of the Oversight and Advisory Structure section, but at a minimum this will include (1) bringing the allegation to the attention of the Executive Committee for possible resolution, (2) engaging in a mediation session with an agreed upon neutral, and then (3) if the issue cannot be resolved, by bringing a motion in Court to seek payment of suspended fines, restart contempt fines, increase future contempt fines, or any other appropriate relief.

   a. If suspended fines are ordered to be paid by the Court, a reasonable schedule shall be set by the Court for payment of the suspended amount on an installment basis. The first installment payment of the suspended amount shall be made at the earliest opportunity after the Legislature has an opportunity to make an appropriation for this purpose.

   b. In assessing suspended contempt fines due to a finding of material breach, the Court may look to the magnitude and impact of any such breach to determine if a lesser or more proportionate sanction is appropriate.

B. Termination

1. This Agreement terminates when Defendants demonstrate substantial compliance with the following requirements:

   a. Completed evaluations for Class Members ordered to receive in-jail evaluations are filed with local criminal courts within the shorter of a) 14 days of the in-jail evaluation order being received by Defendants, or b) 21 days of the criminal court ordering the in-jail evaluation;

   b. Admission for inpatient evaluation services for Class Members ordered to receive inpatient evaluations within the shorter of a) 7 days of the inpatient evaluation order being received by Defendants or b) 14 days of the criminal court ordering the inpatient evaluation;

   c. Admission for inpatient restoration services for Class Members ordered to receive inpatient restoration within the shorter of a) 7 days of the inpatient restoration order being received by Defendants or b) 14 days of the criminal court ordering the inpatient restoration;

   d. Substantial compliance with § V.B.1.a-V.B.1.c has been achieved for nine consecutive months, and evidence does not establish that the State will be unable to continue compliance with the Court's injunction. Alternatively, the State has achieved substantial compliance in 14 of 16 months, and evidence can establish that the two months where substantial compliance was not achieved are outliers. If inpatient evaluations have such a low volume of referrals in any given month as to make substantial compliance with that category hinge on a small number of cases, due consideration will

be given to the totality of compliance rather than looking only to the rate of compliance.

(1) However, after six consecutive months of substantial compliance in any category, § V.B.1.a-V.B.1.c above, the State may request that certain obligations under this Agreement be suspended pending the full nine months of compliance.

VI. ADDITIONAL PROVISIONS

A. Contempt

Nothing in this Agreement shall be deemed to limit the Court's powers of contempt or any other power possessed by the Court.

B. Individual Rights

Nothing in this Agreement shall be deemed to limit the ability of any individual Class Member to obtain individual relief of any kind to which they would otherwise be entitled under state or federal law other than for the claims for systemic injunctive relief adjudicated by this action.

C. Protection and Advocacy Acts

Nothing in this Agreement shall be deemed to limit the ability of Disability Rights Washington (DRW) to fulfill its federal mandates pursuant to the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act, 42 U.S.C. § 10801, *et seq*., and the regulations promulgated thereto, 42 C.F.R. § 51 *et seq*., the Developmental Disabilities Assistance and Bill of Rights (DD) Act, 42 U.S.C. §15041, *et seq*., and the regulations promulgated thereto, 45 C.F.R. § 1386 *et seq*., and the Protection and Advocacy of Individual Rights (PAIR) Act, 29 U.S.C. § 794e.

D. Terms of Agreement

This Agreement contains all the terms and conditions agreed upon by the Parties. No other understandings, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the Parties hereto.

The Parties have participated, and had an equal opportunity to participate, in the drafting and approval of drafting of this Agreement. No ambiguity shall be construed against any Party based upon a claim that the Party drafted the ambiguous language.

E. Authority to Bind

Signors of this Agreement represent and warrant they have full power and authority to enter into this Agreement and to carry out all actions required of them to the extent allowed by law. Each of the signors warrants that he/she has fully read and agrees to all the terms and conditions contained herein.

F. Modifications

Distinct from the process set forth in the Oversight and Advisory structure section, § II.B.5, this Agreement may be amended by mutual agreement of the Parties and approval of the Court. In order to be binding, such amendments must be in writing, signed by persons authorized to bind each of the Parties, and approved by the Court. The Parties further agree to work in good faith to obtain Court approval of necessary amendments or modifications.

G. Waiver

The provisions of this Agreement may be waived only by an instrument in writing executed by the waiving Party and approved by the Court. The waiver by any Party of any breach of this Agreement shall not be deemed or be construed as a waiver of any other breach, whether prior, subsequent or contemporaneous of this Agreement.

H. Severability

The provisions of this Agreement are severable. If any court holds any provision of this Agreement invalid that invalidity shall not affect the other provisions of this Agreement.

I. Successors

This Agreement shall inure to the benefit of and be binding upon the legal representatives and any successor(s) of Plaintiffs and Defendants.

J. Non-Waiver of Arguments and Issues

This Agreement represents a compromise of the issues addressed herein. Neither party waives the right to assert legal or factual arguments in any future dispute arising during the term of this Agreement, or in the event that the Agreement ends, terminates, or becomes null and void, for any reason.

K. Effect of Court Denying Motion to Approve

If, for any reason, the Court does not ultimately approve this Agreement as a fair, reasonable, and adequate settlement of the Trueblood litigation as between the Plaintiffs and Defendants, this Agreement shall be null and void.

L. Execution

This Agreement may be executed in counterparts, each of which will be deemed to be an original and all of which taken together shall constitute a single instrument. This Agreement may be executed by signature via facsimile transmission or electronic mail which shall be deemed the same as an original signature.

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By: _____ Dated: 8/16/2018
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Disability Rights Washington

By: _____ Dated: 8/16/2018
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By: _____ Dated: 8/16/2018
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Disability Rights Washington

By: _____ Dated: 8/16/2018
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FOR THE DEFENDANTS:

By: _____ Dated: 8/16/2018
CHERYL STRANGE
Secretary
Washington State Department of Social and Health Services

COUNSEL FOR DEFENDANTS:

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By: _____ Dated: August 16, 2018
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By: _____ Dated: 8/16/18
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Trueblood, et al., v. Washington State Department of Social and Health Services, et al.
Case No. C14-1178 MJP
DEFENDANTS' PROPOSED PLAN

February 1, 2017

TABLE OF CONTENTS

I. INTRODUCTION

The Department of Social and Health Services (DSHS) submits this proposal in accordance with the January 24, 2017 order to present a plan to describe how DSHS would:

1. Admit class members to receive competency evaluation and restoration treatment services (hereafter referred to as "inpatient competency services") within seven days of signing of a court order; and
2. Provide in-custody evaluation services within 14 days of the signing of a court order.

DSHS engaged the hospital Chief Executive Officers (CEOs) and other staff in capital facilities, budget and operations; consulted the Court Monitor; and reviewed the proposal submitted by Plaintiffs on January 30, 2017 to formulate this proposal. DSHS's proposal includes three key components:

1. Increase evaluation capacity
2. Expand bed capacity for inpatient competency services
3. Continue to Implement and Improve Triage and Diversion

Finally, DSHS responds to the proposals made by Plaintiffs on January 30, 2017 that are not otherwise addressed as part of DSHS's own plan (See Dkt. # 358).

II. COMPONENT 1: INCREASE COMPETENCY EVALUATION CAPACITY

1. The Office of Forensic Mental Health Services (OFMHS) has made further progress on recruitment actions identified during status hearing testimony in January 2017. Dr. Kinlen extended an offer on January 27, 2017 for the Western State Hospital (WSH) scheduler/assistant position. The offer was accepted and the new employee will start on February 16, 2017. Dr. Kinlen also extended an offer on January 30, 2017 for the WSH jail-based evaluator supervisor position. This offer was accepted and the new supervisor will start on April 3, 2017. Two other offers were extended for the remaining forensic evaluator supervisor positions and decisions are pending at this time.

2. Ingrid Lewis with OFMHS will reach out to counties by February 10, 2017 to remind them of the opportunity to engage panel evaluators to conduct more timely evaluations at DSHS expense in accordance with state law. Ms. Lewis will begin this outreach to encourage use of panel evaluators in the regularly scheduled meeting with King County Stakeholders scheduled for February 1, 2017. Outreach to remaining counties will include targeted communications to counties where DSHS is not meeting the 14-Day timeline. Ms. Lewis will email a memo to the Washington Association of Counties, Administrative Office of the Courts, Washington Defense Association, and Washington Association of Prosecuting Attorneys, as well as all county commissioners in counties eligible for 5551 reimbursement.

3. OFMHS staff conducted an Internet search for a Locums Tenens company to provide contracted Forensic Evaluations. Staff did not identify a company that provided qualified examiners for competency to stand trial. Therefore, DSHS will issue a Request for Information (RFI) by February 10, 2017 to solicit potential providers of contracted Forensic Evaluators (which may include psychologists or other suitably qualified professionals) to reduce the current backlog of orders.

4. DSHS respectfully proposes the Court consider a systemic investment of $3.2 million from the fines being accrued to fund increased capacity to meet evaluation timeliness standards. DSHS would use this funding to hire 12 additional evaluators to yield an additional 144 evaluations per month. Based on the data analysis conducted by DSHS (see Attachment A), 12 evaluators for jail-based services would cover any current backlog of cases. This resource investment would also be sufficient to manage future spikes up to 25% higher than the most currently experienced peak in referrals (up to 386 referrals in a month's time). These evaluators would be responsible for completing any backlog cases, managing any increase in referrals throughout the state for in-custody evaluations, and providing evaluations at off-hour times. Seven of the positions would be out- stationed in locations with enough demand to support an out-station site while the remaining five would be stationed at WSH. Additionally, five forensic evaluator support positions would expedite patient access to care functions--such as scheduling, transcription, and treatment—while evaluator resources are focused on conducting evaluations. In anticipation of an approval of this action, DSHS issued a recruitment posting on January 30, 2017 to expedite the process.

Assuming current demand and recent peak referral experience, these actions are expected to eliminate backlog and achieve ongoing compliance once all actions are completed and resources are operational.

III. COMPONENT 2: EXPAND BED CAPACITY FOR INPATIENT COMPETENCY SERVICES

Following review of past recommendations from Dr. Mauch, Court Monitor as well as additional suggestions provided by her during a telephone call on January 27, 2017, DSHS proposes the following components for expansion of bed capacity to serve class members. DSHS respectfully proposes the Court consider a systemic investment of $600,000 dollars from the fines being accrued to fund the design effort to remodel Building 10 at the Washington Veterans Home in Retsil, the details of which are included in item 2d below.

To meet current and future capacity for inpatient competency services DSHS will:

1. Create short-term strategies to increase bed capacity to serve class members

a. Dr. Kinlen evaluated a proposal by Eastern State Hospitals which Dr. Strandquist spoke about during his testimony at the January status hearing. Analysis of this proposal, which would refurbish a ward for civilly committed former forensic patients would not create significant increases in bed capacity to serve class members. However, in the fall of 2016 DSHS funded the creation of 8 new forensic beds at Eastern State Hospital to directly serve patients from WSH thus freeing up bed capacity to serve class members at WSH without increasing census. Three beds at WSH were vacated by NGRI patients and will be used for competency services beginning January 31, 2017. The remaining five beds at ESH will be made available for inpatient competency services in February 2017.

b. Extend the alternate facilities
Contracts for the existing 24 beds at Yakima and 30 beds at Maple Lane will be extended until June 30, 2018.

c. Expand 24 beds at Yakima
DSHS will consult the Court Monitor and provide all planning documents to her for review.

2. Create long-term strategies to increase bed capacity to serve class members

a. During a January 27, 2017 phone call, Dr. Mauch recommended considering contracting with Evaluation and Treatment (E & T) Centers to provide restoration treatment services. Revised Code of Washington 71.05.020 defines and E & T as "any facility which can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is certified as such by the Department." Dr. Kinlen will work with the Attorney General's Office to explore the legal authority of E & T's to provide competency services under the forensic commitment statutes. If the facilities can be determined to have legal authority to operate such programs in accordance with their licensure and relevant statutory authorities, DSHS would conduct an RFI to solicit for consideration potential E & T providers willing and able to provide competency services. DSHS will complete this work and issue, and if viable, issue a Request for Information (RFI) by February 24, 2017.

b. Consider remodeling Yakima Valley School to serve up to 30 WSH discharged patients with Developmental or Intellectual disabilities who are low security and need a step down placement. DSHS Capital facilities staff, led by Bob Hubenthal, would clarify the requirements required to change current property obligations, confirm the population that could best be served, identify specific space availability and number of beds that could be created and remodeling costs, as well as associated time frames related to completing the remodel and on-boarding of staff. If this option is found to be viable, once patients are moved from WSH, space

currently vacant and remodeled to meet class member needs would be put in service to serve class members.

c. Consider using Building Number 10 at the Veterans Affairs Campus in Retsil, Washington. This facility was recently made available to DSHS and may offer up to 78 beds. It was not a site available for consideration during the initial review of alternate sites in 2015. DSHS anticipates this facility could be remodeled into a step down low acuity/low security option for patients who are discharged from WSH. We anticipate the facility would require extensive remodel which may not make it viable for operation any sooner than 24 months from project start. DSHS Capital facilities staff, led by Bob Hubenthal, would use the $600,000 systemic investment noted above to clarify the requirements for use of this property. This would include required changes to current property obligations, confirming the population that could best be served, identify specific space availability and number of beds that could be created and remodeling costs, as well as associated time frames related to completing the remodel and on-boarding of staff. If this option is found to be viable, once patients are moved from WSH, space currently vacant and remodeled to meet class member needs would be put in service to serve class members. DSHS would use the $600,000 proposed above to fund the predesign work.

While the specific operational start dates are to be determined by further work by DSHS Capital facilities, we wanted to reiterate that successful transition of patients from WSH to Yakima Valley School and/or Retsil would result in use of available forensic beds (up to 45 currently available) at WSH.

d. Upon successful completion of the Systems Improvement Agreement (SIA) or upon the approval of the CMS approved consultant, the DSHS will pursue expansion of bed capacity at Western State Hospital in accordance with the Governor's proposed budget. This would yield 205 additional forensic beds by 2023.

3. Increase alternatives to inpatient restoration for defendants not requiring hospitalization

a. Not all defendants adjudicated as incompetent to stand trial meet the clinical or security need for hospitalization. On January 31, 2017 Assistant Secretary Reyes approved OFMHS to move forward in its contract with Groundswell Associates to assist in creating demonstration projects in King, Pierce, and Spokane and assisting with required revisions to associated statutes and administrative codes as needed for implementation.
b. Ingrid Lewis contacted Groundswell to confirm interest on January 27, 2017; Groundswell replied with interest and willingness to engage in this work.
c. Dr. Kinlen will ensure contract is executed by February 17, 2017.

IV. COMPONENT 3: DIVERSION AND TRIAGE

The third component of DSHS's long-term plan is to reverse or at least stem the trend of increased demand for competency services through expanded use of Diversion and Triage.

1. Diversion

a. Prosecutorial diversion – Contracts were shared with the court monitor on January 27, 2017. A request for review and comments for the next contracting term were made with responses due from the Court Monitor to Ingrid Lewis by March 3, 2017.
   i. Current funding is available for the next two fiscal years (2018 and 2019).
   ii. Programs will continue to be evaluated and a decision on whether to continue funding current projects will be made by March 2017.

b. Use of contempt fines to fund diversion strategies
   i. On January 30, 2017, five programs were reviewed with two programs answering all remaining questions fully and three sites needed to provide additional feedback before a final funding recommendation will be made
   ii. The Court Monitor will brief the Court on the status of deliberations and timelines for final recommendations.
   iii. Applicants for consideration included Comprehensive (Yakima County), King County, Kitsap County, Great Rivers (Lewis, Cowlitz, Grays Harbor, Wahkiakum and Pacific), and Sunrise (Snohomish)

2. Triage

a. Ingrid Lewis will schedule a meeting with the Court Monitor to discuss Triage plans submitted in November 2016 and next steps.

b. Ms. Lewis will continue to engage with local DMHP offices to determine when class members may be triaged out of jail. DSHS will participate/present at the next DMHP meeting/conference scheduled in June 2017.

c. Ms. Lewis will continue to explore how outreach and triage will address holidays and weekends to ensure that class members have 24/7 access to triage when necessary to address their needs

d. Ms. Lewis will explore additional jail outreach options prior to Day 13

e. Ms. Lewis revised the Triage Memo that was distributed to stakeholders and requested input from the Court Monitor on January 31, 2017 for suggested changes. Ms. Lewis will send the revised Memo to stakeholders on February 3, 2017.

V. RESPONSES TO PLAINTIFFS' PROPOSAL

Here, DSHS responds to the proposals made by Plaintiffs on January 30, 2017. These responses are provided only for sections that are not otherwise addressed as part of DSHS's own plan above.

1. **PLAINTIFFS' RECOMMENDATION 1**: The CEOs of both state hospitals will be provided with the Court Monitor's recommendations and be encouraged to work directly with her to achieve compliance. Such communication shall include a review of the steps ESH has taken to come into compliance that should be adopted by WSH including hiring a dedicated RN recruiter, building or maximizing forensic beds, and hiring contract staff in all vacant positions across disciplines.
   a. DSHS does not fully support this recommendation by Plaintiffs and suggests the following revisions. DSHS/OFMHS will continue to share information and Dr. Kinlen will remain the designated point of contact and responsibility for Trueblood actions and implementation. As such, he is responsible to coordinate, as appropriate, with the hospital CEOs and other DSHS staff and leaders.
   b. In addition, DSHS has already taken steps to implement coordination between ESH and WSH. WSH has adopted similar steps to ESH to assist with recruitment including hiring a dedicated recruiter, etc.

2. **PLAINTIFFS' RECOMMENDATION 2**: Implement efficiencies in providing competency services to class members who cycle in and out of the system by creating an electronic system to flag a referral from a class member who has been evaluated or admitted for restoration services within the past five years. Defendants shall also develop methods for streamlining the provision of competency services
   a. DSHS agrees with this recommendation. DSHS/OFMHS will work on implementing efficiencies for class members who cycle in and out of the system within five years using electronic records once each hospital has an electronic medical record. In addition, DSHS/OFMHS will continue to explore methods to streamline provision of competency restoration services

3. **PLAINTIFFS' RECOMMENDATION 3**: Defendants must begin coordinating Trueblood diversion efforts with the Governor's diversion efforts. This includes involving the Court Monitor or her designee in all meetings regarding diversion efforts.
   a. DSHS does not fully support this recommendation by Plaintiffs and suggests the following revisions. DSHS/OFMHS commits to coordinating efforts and engaging the Court Monitor in Trueblood related projects or initiatives, including any diversion projects related to competency services. Diversion is a broad concept, not limited just to competency services and it would not be efficient or appropriate to incorporate the Court monitor into "all meetings regarding diversion efforts."

4. **PLAINTIFFS' RECOMMENDATION 4**: Defendants shall also secure the full $4.81 million to supplement current prosecutorial diversion programs. The data from those programs shall be provided to the Court Monitor
   a. DSHS does not fully support this recommendation by Plaintiffs and suggests the following revisions. DSHS/OFMHS has funding available for prosecutorial diversion in Fiscal Year 2018 and 2019. Additionally, the Governor's budget earmarks funding well in excess of $ 4.81 million dollars for additional diversion projects which may

fund prosecutorial diversion as well as other effective diversion initiatives and projects.

5. **PLAINTIFFS' RECOMMENDATION 5**: Defendants must submit a Second Revised Long Term Plan by February 10, 2017. Such a plan must have the Governor's approval and include all steps referenced in Plaintiffs proposal including a consideration of community based restoration as recommended by Groundswell. The Second Revised Long Term Plan will be reviewed by the Court Monitor who will provide a written response regarding the viability of the Plan and suggestions to expedite compliance with this Court's orders
   a. DSHS does not fully support this recommendation by Plaintiffs and suggests the following revisions. A Revised Long -Term plan will be provided within 30 days of the enacted budget and will be based on input from the Court following the submission of the Parties' respective plans. As noted above, consideration will be given to community based restoration and DSHS is pursuing this with Groundswell services (see item 3 above in Component 2).

6. **PLAINTIFFS' RECOMMENDATION 6**: Defendants' monthly reports should include a new section regarding status of compliance that includes both the Monitor's opinion "as to the sufficiency of Defendants' progress" and "recommendations for actions to remedy any lack of progress or performance by Defendants"
   a. DSHS agrees with this recommendation by Plaintiffs. DSHS/OFMHS will add a new section to the monthly reports to allow the Court Monitor to provide updates on the status of compliance.

7. **PLAINTIFFS' RECOMMENDATION 7**: Pursuant to RCW 10.77.084(b), Defendants shall determine if the class members' clinical presentation is such that the provision of competency restoration is a viable option necessitating admission rather than a court hearing to provide this finding.
   a. It is unclear what Plaintiffs' intended with this proposal as the suggestion that DSHS can facilitate admission for competency restoration outside the court process is not supported by statute. RCW 10.77.084(1)(b) states: "The court may order a defendant who has been found to be incompetent to undergo competency restoration treatment at a facility designated by DSHS if the defendant is eligible under RCW 10.77.086 or 10.77.088. At the end of each competency restoration period or at any time a professional person determines competency has been, or is unlikely to be, restored, the defendant shall be returned to court for a hearing, except that if the opinion of the professional person is that the defendant remains incompetent and the hearing is held before the expiration of the current competency restoration period, the parties may agree to waive the defendant's presence, to remote participation by the defendant at a hearing, or to presentation of an agreed order in lieu of a hearing. The facility shall promptly notify the court

and all parties of the date on which the competency restoration period commences and expires so that a timely hearing date may be scheduled."

b. As noted, the parties to the criminal matter and the criminal court may waive a defendant's presence if a professional person has determined the defendant remains incompetent and the hearing is held prior to the expiration of the commitment period. At this time, DSHS does provide information to the parties regarding the dates on which the competency period commences and expires pursuant to the statute. In addition, DSHS does conduct evaluations prior to the expiration of the commitment period and, to the extent possible, alerts the parties of a finding of continuing incompetence such that waiver is possible. Further, the standardized court orders developed by DSHS and other stakeholders includes a provision for the parties to preemptively activate this waiver provision in RCW 10.77.084(1)(b). See pg. 5 of form order MP 240. However, DSHS cannot unilaterally detain an individual beyond the expiration of the competency period absent action by the criminal parties and court within the required timeframe.

8. **PLAINTIFFS' RECOMMENDATION 8**: Defendants should utilize the Court Monitor and her experts as resources for developing compliance plans and ensuring that the actions they take will lead time to comply with this Court's injunction in a timely manner.
   a. DSHS largely agrees with this recommendation by Plaintiffs. DSHS/OFMHS will utilize the Court Monitor and experts as resources.

9. **PLAINTIFFS' RECOMMENDATION 9**: It may be useful for the Monitor to open and staff a local office and bill Defendants for these costs.
   a. DSHS does not fully support this recommendation by Plaintiffs. Before funds are expended on the opening and staffing of a local office, there are numerous steps that can be taken to improve communication and feedback between the Monitor and DSHS. Reinstituting the quarterly reports from the Monitor, the new Monitor's section in the monthly reports, the continued use of local experts, and leveraging technology (web meetings, email, phone, etc.) are all equally effective, and more cost conscious, options for ensuring that the Monitor is more accessible.

VI. CONCLUSION

DSHS is requesting a systemic investment of $3.8 million dollars from the court to hire additional evaluators and provide funds to complete the design effort of a 78-bed facility to provide step down placement for individuals in the community. This will move the system toward expanded capacity in the community and move the hospitals toward expanding services for forensic patients.

DSHS is committed to meeting the requirements of the *Trueblood* decision and continues to work toward that commitment.

Departments of Mental Health & of Disabilities, Aging, and Independent Living **Competency Restoration Program Plan**

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VERMONT

Contact Information

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Executive Summary

After conducting an extensive process, enriched by substantial input from key stakeholders, the Agency of Human Services strongly recommends the adoption of competency restoration as the optimal course of action in Vermont.

Supported by robust research and a review of clinical literature, we have concluded that competency restoration has demonstrated efficacy and has restorative value when implemented well. To optimize the use of limited resources, we recommend a competency restoration program be implemented only for those cases where there exists a compelling interest for the person to be restored to competency so that the criminal case proceeds. The focus would be on more serious crimes and cases where dismissal or diversion is inappropriate.

In light of the consensus derived from a thorough review of clinical literature and the efforts undertaken at the national level by both the Council of State Governments (CSG) and the National Judicial Task Force, this report outlines a set of best practice recommendations. [1] Furthermore, this report will provide recommendations for competency restoration programming in Vermont for individuals within the purview of both the Department of Mental Health (DMH) and the Department of Aging and Independent Living (DAIL) system of care.

Program Design

- Limit competency restoration to serious crimes and for the cases that are inappropriate for dismissal or diversion.
- Conduct evaluations and restoration in the most appropriate site, which may be a health care setting, DOC, or the community.
- Provide high quality and equitable evaluations and restoration services.

[1] Please note that while this report does not specifically relate to diversion for treatment, there are number of references about the importance of diversion. The CSG reviewed Vermont's array of diversion "offramps" for treatment in connection with the 2019-2020 Justice reinvestment study. It is important to note they found programming inconsistent across counties and data collection and outcome reports to be inconsistent and in some cases duplicative. [Justice Reinvestment in Vermont: Second Presentation - CSG Justice Center]. While competency restoration will be critical for addressing more serious offenses through the justice system, some focus on the effectiveness of diversion resources statewide will be necessary for addressing lower-level non-violent offenses in our communities. Further, a study that focused on court diversion participants between 2014 and 2016 found an overall recidivism rate (measured by new conviction) of 17 percent. Participants with no criminal history had a recidivism rate near zero (.68 percent), and participants with criminal histories had a recidivism rate close to 90 percent.

- Develop and impose rational timelines.
- Use data to inform decision making and system improvements.

Clinical Programming

- Offer a mix of clinical and educational programming
- Provide high-quality clinical care in the least restrictive setting possible
- Use involuntary medications when clinically indicated
- Evaluate in a timely manner (including determining when someone is not restorable and providing clinically based timelines for potential restoration)
- Reevaluate when clinically indicated

Reference Legislation

From Act 28 (2023) :

Sec. 7. COMPETENCY RESTORATION PROGRAM PLAN

(a)(1) On or before November 15, 2023, the Department of Mental Health and the Department of Disabilities, Aging, and Independent Living shall report to the Governor, the Senate Committees on Judiciary and on Health and Welfare, and the House Committees on Judiciary, on Health Care, and on Human Services on whether a plan for a competency restoration program should be adopted in Vermont.

(2) For purposes of the report required by the section:

(A) the Department of Mental Health and the Department of Disabilities, Aging, and Independent Living shall consult with:

(i) the Chief Superior Judge or designee;

(ii) the Commissioner of Corrections or designee;

(iii) the Executive Director of the Department of State's Attorneys and Sheriffs or designee;

(iv) the Executive Director of the Vermont Center for Crime Victim Services or designee;

(v) the Vermont Legal Aid Disability Law Project; and

(vi) the Defender General or designee; and

(B) consideration shall be given to providing notification and information to victims of record.

(b) If a competency restoration plan is recommended, the report shall include recommendations for best practices, any changes to law necessary to establish the program, estimated costs, and a proposal for implementing the program.

Competency Restoration Program Plan

Importance of Competency Restoration

Competency to stand trial (CST) is the constitutional requirement that individuals charged with crimes must be able to assist in their own defense, and a criminal case cannot proceed if someone has been found incompetent. The Sixth Amendment guarantees the fundamental right to trial.[2]

While many states have implemented a competency restoration program, no such program exists in Vermont. When someone who has committed a criminal offense is found incompetent in Vermont, the current outcomes are inconsistent -- their charges may or may not be dismissed, they may or may not get treatment and they may or may not ever regain competency. An individual's placement – whether in the custody of DAIL or DMH, whether on an inpatient or outpatient setting – is separate from their competency. Instead the determination of placement is contingent on an individual's clinical presentation, the level of services they need, and the threshold for getting services on an involuntary basis. No restoration services are provided to these individuals at any level of care.

Given the absence of a competency restoration program, many cases in Vermont fail to reach a resolution in the criminal court. Consequently, the lack of a competency program denies an individual the opportunity to present their own defense; this lack of resolution perpetuates stigma as often these individuals are presumed to be guilty but perceived as avoiding accountability. Competency restoration serves the interests of victims, communities, and alleged defendants.

Vermont has the unique opportunity to create a program from the ground up, to learn from others about what is not working, and to look towards research and other publications to design a limited yet successful program. The successes and failures of other states can serve to inform best practices in Vermont.

Existing Competency Restoration Programs

[2] Sixth Amendment of the U.S. Constitution: "In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial, by an impartial jury of the State and district wherein the crime shall have been committed, which district shall have been previously ascertained by law, and to be informed of the nature and cause of the accusation; to be confronted with the witnesses against him; to have compulsory process for obtaining witnesses in his favor, and to have the Assistance of Counsel for his defense."

States, generally, require that defendants who are found incompetent to stand trial begin competency restoration treatment within a certain time period, ranging from 7 to 30 days, after the finding of incompetency.[3]

In a recent review of literature, researchers found that 81% of mentally ill offenders initially found incompetent to stand trial were eventually restored to competency.[4] The median length of stay was 147 days in a treatment program. After removing outliers, the mean length of treatment was 175 days. Individuals who are at particularly high risk of being unrestorable include those with permanent brain damage, severe developmental and intellectual disabilities, and those with treatment-resistant psychosis.

Of the 51 studies on competency restoration programs reviewed by the above referenced researchers, only 29% used competency assessment instruments. There is no standard/best practice for assessment. Traditional psychological tests were also employed rarely (e.g., MMPI-2, WAIS-IV, BPRS). Due to lack of data and gross inconsistencies between studies on reporting practices, the researchers were unable to determine whether there was any relation between scores on these measures and restoration status.[5]

Competency restoration programs, for violent offenders and those cases inappropriate for diversion or dismissal, are typically provided in inpatient settings. While outpatient programs can be an alternative, participants in outpatient programs were typically restricted to individuals charged with misdemeanor offenses or nonviolent felonies, who did not have significant violent criminal histories, and did not present as being at high risk for violence at the time of referral. Understanding our goal of limiting the scope of these programs to the most violent offenders or those determined to be inappropriate for diversion or dismissal, outpatient programs would be inappropriate for implementation at this time.

Some states provide jail-based competency restoration programs as well. These generally are intensive, individualized programs delivered by a multidisciplinary team comprised of forensic psychiatrists, psychologists, social workers, rehabilitation therapists, and nurses.[6] Some states deliver these services out of specialized units, while in other states participants are housed in the general population. Outcome

[3] Heilbrun, K., Giallella, C., Wright, H. J., DeMatteo, D., Griffin, P. A., Locklair, B., & Desai, A. (2019). Treatment for restoration of competence to stand trial: Critical Analysis and policy recommendations. Psychology, Public Policy, and Law, 25(4), 266—283.

[4] Pirelli, G., & Zapf, P.A. (2020). An attempted meta-analysis of the competency restoration research: Important findings for future directions. Journal of Forensic Psychology Research and Practice, 20(2), 134—162.

[5] Id.

[6] Heilbrun et al., 2019.

studies on jail-based programs report a restoration rate ranging from as low as 33% to as high as 86.7%. Treatment periods were as short as 90 days as a standard treatment length to a mean of 82.5 days and seem to roughly correlate with restoration rates.[7]

Regardless of setting, restoration services can be provided by psychiatrists, psychologists, social workers, group therapists, nurses, and case managers.

There is no set standard for how long restoration treatment should be. About 72% of participants in CRT were restored within 6 months, and just under 84% were restored within a year.[8]

Mentally Ill Offenders

There is unfortunately a lack of empirically validated treatment programs. According to a recent review article, "the limited available research on IST restoration means that the field cannot yet establish empirically supported 'best practices' in this area."[9] However, most states do have competency restoration programs. (*But see* "The Council of State Governments and the National Judicial Task Force," and "Important Elements of the Program for Consideration," below.)

Medication is the most common form of treatment for those who are found incompetent to stand trial who experience severe mental illness. Some researchers have noted that, "the use of…medication (primarily 1st and 2nd generation antipsychotics) …is so widely accepted within the field of mental health that it approaches foundational."[10] The same researchers were not able to find any studies on CRT that did not include the use of medications for those with mental health diagnoses. They noted that programs that use involuntary medication treatment report good success across a range of diagnoses including delusional, cognitive, substance use, and psychotic disorders, with rates of restoration from 74% to 77%.

Most programs appear to provide various educational components in addition to medications. (See Appendix A)

Involuntary Medication for Restoration of Competence

[7] Id.

[8] Zapf, P.A., & Roesch, R. Future directions in the restoration of competency to stand trial (2011). Current Directions in Psychological Science, 20(1), 43—47.

[9] Heilbrun et al., at 269.

[10] Id., at 270.

Sell v. United States,[11] is a 2003 decision in which the United States Supreme Court held that four criteria must be met in order to involuntarily medicate a defendant who has who had been determined to be incompetent to stand trial for the sole purpose of restoring competency:

- Are important governmental interests at stake *(i.e.*, did the defendant commit a serious crime?)
- Is there a substantial likelihood that involuntary medication will restore the defendant's competence and do so without causing side effects that will significantly interfere with the defendant's ability to assist counsel?
- Is involuntary medication the least intrusive treatment for restoration of competence (i.e., that alternative, less intrusive treatments are unlikely to achieve substantially the same results), and
- Is the proposed treatment medically appropriate?[12]

In 2020, the Court of Appeals of Maryland heard the *Johnson v. Md. Dep't of Health*[13] case, which held that involuntary medication for competence restoration can be ordered by criminal courts or administrative agencies.

Intellectual Disabilities – The Slater Method

Restoration to competency is possible for persons with intellectual disabilities. One investigator found that people with an IQ of above 63.5 were much more likely to be restored to competency, whereas those with IQs below this cutoff were more likely to be found not restorable.[14] A program called *The Slater Method*, specifically designed for this population, has promising results and appears to be the most common program used.[15]

Services are delivered in structured, one-on-one sessions occurring weekly at minimum, and can be provided by psychologists, social workers, or case managers. A subject's progress is evaluated every 6 months, and training continues until an individual is found competent. If an individual does not appear to make clinically significant progress after

[11] 539 U.S. 166 (2003)

[12] Id, 181.

[13] 236 A.3d 574 (Md. 2020)

[14] Grabowksi, 2017, cited in Heilbrun et al., 2019.

[15] Wall, B. W., & Christopher, P. P. (2012). A training program for defendants with intellectual disabilities who are found incompetent to stand trial. The Journal of the American Academy of Psychiatry and the Law, 40, 366—373.

2 years, training ceases. In an initial outcome study by Wall and Christopher in 2013, participants who received The Slater Method were restored to competency at a much greater rate (61.1% of participants) than those who did not (16.7%).

Competence to Stand Trial Legal Standards

Dusky v. United States[16] is a 1960 United States Supreme Court case in which the Court affirmed a defendant's right to have a competency evaluation before proceeding to trial. The Court outlined the basic standards for determining competency:

[I]t is not enough for the district judge to find that 'the defendant (is) oriented to time and place and (has) some recollection of events,' but that the 'test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him.[17]

According to some researchers, "[d]efendants found incompetent to stand trial (IST) are most often those with psychotic disorders or acute mood disorders, followed by those with intellectual and developmental disabilities. Other populations include defendants with dementia and traumatic brain injury causing cognitive or behavioral impairments that impede their ability to participate meaningfully in pretrial proceedings."[18]

Jackson v. Indiana[19] is a 1972 decision of the United States Supreme Court that held it violates due process to involuntarily commit a criminal defendant for an indefinite period of time solely on the basis of his permanent incompetency to stand trial.

In this case, the defendant was ordered to be detained in an Indiana facility for competence restoration until his competence was able to be restored. His attorney appealed, arguing that it amounted to an indefinite commitment given that his CST was determined not to be restorable. The court determined that constitutional equal protection and due process rights require that a defendant found incompetent cannot be confined for CST restoration for longer than is necessary to determine whether restoration is possible. After that period, if restoration is not possible, any further

[16] 362 U.S. 402 (1960)

[17] Id., 402.

[18] Pinals, D. A., & Callahan, L. (2020). Evaluation and restoration of competence to stand trial: Intercepting the forensic system using the sequential intercept model. Psychiatric Services, 71(7), 698–705. https://doi.org/10.1176/appi.ps.201900484

[19] 406 U.S. 715 (1972)

involuntary commitment must be justified on other grounds, such as civil commitment for mental illness.

The Council of State Governments & the National Judicial Task Force

The Council of State Governments and the National Judicial Task Force have done significant work on competency restoration and can provide good information on designing a competency restoration program.

In October 2020, the Council of State Governments Justice Center published a report called "Just and Well: Rethinking How States Approach Competency to Stand Trial."[20] Their goal was to re-think the vision:

[T]he CST process would generally be reserved for cases where the criminal justice system had a strong interest in restoring competency so that a person may proceed to face their charges. Advisors noted that the justice system's interest in adjudicating a case tends to rise as the charges become more serious. In other situations, when the state interest in pursuing prosecution is lower, people would have their cases dismissed and/or would enter a diversion program in lieu of typical CST processes. If they were in need of treatment, they would be connected to care in a setting appropriate to their clinical level of need. In this vision, jurisdictions would also focus on preventing criminal justice involvement in the first place through the establishment of robust, community-based treatments and supports, with attention to structural factors—like access to housing and transportation—that may impact access to care. These community-based efforts would also help to reduce the number of people with mental illnesses entering into the criminal justice system and provide viable alternatives to jail-booking for first responders.[21]

To achieve this vision, they articulated ten strategies:

1. Convene diverse stakeholders to develop a shared understanding of the current CST process.

2. Examine system data and information to pinpoint areas for improvement.

3. Provide training for professionals working at the intersection of criminal justice and behavioral health.

[20] https://csgjusticecenter.org/wp-content/uploads/2020/10/Just-and-Well27OCT2020.pdf

[21] Id., at 8.

4. Create and fund a robust system of community-based care and supports that is accessible for all before, during, and after criminal justice contact.

5. Expand opportunities for diversion to treatment at all points in the criminal justice system, including after competency has been raised.

6. Limit the use of CST process to cases that are inappropriate for dismissal or diversion.

7. Promote responsibility and accountability across systems.

8. Improve efficiency at each step of the CST process.

9. Conduct evaluations and restoration in the community, when possible.

10. Provide high-quality and equitable evaluations and restoration services, and ensure continuity of clinical care before, during, and after restoration and upon release.

In July 2021, the National Judicial Task Force to Examine State Courts' Response to Mental Illness published "Leading Reform: Competence to Stand Trial Systems"[22] as a resource to state courts. As with the Council of State Governments, the Task Force saw the benefits in competency restoration but also stressed the importance of being thoughtful and purposeful about how it takes place. To that end, they also made ten recommendations:

1. Divert cases from the criminal justice system

2. Restrict which cases are referred for competency evaluations

3. Develop alternative evaluation sites

4. Develop alternative restoration sites

5. Revise restoration protocols

6. Develop and impose rational timelines

7. Address operational inefficiencies

8. Address training, recruitment, and retention of staff

9. Coordinate and use data

[22] https://www.ncsc.org/__data/assets/pdf_file/0019/66304/Leading_Reform-Competence_to_Stand_Trial.pdf

10. Develop robust community-based treatment and supports for diversion and re-entry

Important Elements of the Program for Consideration

Which Crimes are Eligible:

As the Legislature works with the Executive Branch to implement a competency restoration program, one of the most important elements is to determine which crimes are eligible. As noted above, we are recommending, and both the Council of State Governments and the National Judicial Task Force would recommend, limiting it to those crimes where there is a compelling state interest in restoration (*i.e.*, more serious crimes) as well as those crimes not appropriate for diversion or dismissal.

Diversion:

Another important element to consider, and one which both groups also stress, is the need for strong diversion programs, including once competency has already been raised.

As noted in the feedback from Court Diversion, there seems to be some confusion around when a person could be referred to diversion, especially once competency has been raised, so the Office of the Attorney General recently provided guidance:

Guidance to Court Diversion/Tamarack programs re competency

September 2023

If a case is referred to Court Diversion/Tamarack (CD/T) and the Court has not ordered that a competency evaluation be completed but you think the person is not competent, discuss this with the prosecutor and, if one has been assigned, the defense attorney. As an ethical matter, the person may not be able to understand enough to participate in the program and CD/T staff may not have the necessary skills or resources to work with someone who is not competent.

When a person is referred to CD/T and the Court has ordered that a competency evaluation be completed, meet with the person, and review the Initial Agreement. Just because a Court has ordered a competency evaluation does not mean the person is unable to complete Diversion. They may be competent under the law, or they may be able to understand the Diversion program and its requirements better than the more complex and high-stakes procedures and systems in our Courts. However, if you are concerned that the person does not understand the Diversion program or what you are explaining, inform the prosecutor and defense attorney, and return the case to Court. Indicate on the CD/T status form that the person is not accepted into the program because they are ineligible.

If you think the person understands what you are explaining and is able to participate in the program, proceed as with other program participants. If the participant successfully completes the program, the court order for a competency evaluation will be moot.

If the participant stops engaging or there are other indications that the person is struggling, contact the person's defense attorney and discuss your concerns. Do not consider the person to have failed the program as you might with other participants. The defense attorney can request that the case be returned to Court and the person's court case will be on hold until the competency evaluation is completed. On the CD/T status form, under Program Completion Status, check Requested return to Court.

Role of Evaluators:

One of the key pieces of a competency restoration program will be having qualified evaluators who can provide timely assessments, including determinations around if the evaluator thinks someone can be restored to competency and potential timelines around that restoration. DMH evaluators currently have the capacity to do this work. Under the changes in Act 28 (2023), DMH implemented a new evaluation scheduling process, and evaluations are being scheduled generally within 60 days. Backlogs in competency evaluations have been eliminated.

DMH would propose modifying the existing contract with our evaluators to:

- Conduct an Initial Competency Evaluation
- Provide an opinion on overall restorability which includes:
    - . An estimated restorability timeframe; and Treatment needs for restorability (medication with or without a court order, education, ID-focused education such as the Slater Method, longitudinal evaluation of malingering, etc.)

- Updated evaluations every 90 days.
  - Ideally assigned to same evaluator.
  - If not competent upon re-evaluation, recommend further restoration and either give rough timeline or determine them not competent/not restorable.

Potential Locations:

Best practice would be to have competency restoration programs available throughout the system.

One option might be for the legislature to consider a series of pilot projects in multiple locations – in a hospital (such as VPCH), in a forensic facility, in DOC and in a residential program (such as River Valley).

Further, existing law will need to change to allow someone to be held in a secure facility while undergoing competency restoration for a set period of time tied to restoration timelines.

Cost Estimates:

Recognizing Vermont is still in the preliminary planning stages, the financial advisors have developed cost estimates for two scenarios and two sizes.

Scenario 1: Located at a hospital, forensic facility, in DOC, or a residential program (such as River Valley).

	Scenario 1			
	9 Beds		**16 beds**	
Staffing:	# Staff	Cost	# Staff	Cost
Psychiatrist	0.5	301,600	1	603,200
Psychologist	1	121,200	1	121,200
Registered nurse	4	576,072	4	576,072
Activity Therapist	1	96,815	2	193,630

Social Worker	1	105,466	2	210,932
Mental health specialist	16	1,546,992	24	2,320,488
Subtotal (Staffing)	*23.5*	*2,748,145*	*34*	*4,025,522*
Operating:				
Laptops	4	8,000	4	8,000
Monitors	4	600	4	600
Printer/scanner	1	1,000	1	1,000
Other Supplies		3,000		3,000
Subtotal (Operating)		*12,600*		*12,600*
Final Total		**2,760,745**		**4,038,122**

Scenario 2: Located in DOC, with the assumption that correctional staff would be available (and therefore fewer mental health specialists).

	Scenario 2			
	9 Beds		**16 beds**	
Staffing:	# Staff	Cost	# Staff	Cost
Psychiatrist	0.5	301,600	1	603,200
Psychologist	1	121,200	1	121,200
Registered nurse	4	576,072	4	576,072
Activity Therapist	1	96,815	2	193,630

Social Worker	1	105,466	2	210,932
Mental health specialist	4	386,748	8	773,496
Subtotal (Staffing)	11.5	1,587,901	*18*	*2,478,530*
Operating:				
Laptops		8,000		8,000
Monitors		600		600
Printer/scanner		1,000		1,000
Other Supplies		3,000		3,000
Subtotal (Operating)		12,600		12,600
Final Total		**1,600,501**		**2,491,130**

Unique Vermont Considerations

Medications

As seen from the clinical literature, and from some stakeholder input, medication is a key component in the effectiveness of competency restoration programs. Currently, Vermont does not consider in statute medications to restore competency, leading to a potential gap in adequately serving a person in need.

We request the Legislature consider modifying existing law to allow for a compromise between the current involuntary medication standards in Title 18 and the Sell standard, explained above. One option would be to change the standard just for those in competency restoration programs whereby if someone is in a restoration program, will not take medications voluntarily but does not meet our current statutory standards, that person could be involuntarily medicated pursuant to the Sell standard if:

- It has been 45 days since the competency restoration program has started

- There is expert testimony from the treating physician that the individual could likely be restored with medication and otherwise meets the Sell criteria

The initial medication order could limit the use of medications for 90 days, with a requirement of additional clinical evidence supporting a continued medication order to extend the order – potentially for six-month periods after that.

Short Commitment Timelines

Currently, under Title 13, if someone is found incompetent, there is a very short period of time where the defendant can be held in Department of Corrections facilities before a commitment hearing must be held (it was 15 days, it was expanded to 21 days with Act 28 (2023)).

As discussed above, our existing laws will require further modification for someone to be held while they are restored to competency.

Stakeholder Input

DMH and DAIL reached out to the following to solicit input. Stakeholders were asked to provide input specifically in five areas, in addition to whatever else they would like us to consider. Those five areas were:

- Which crimes should be eligible?
- How can we better divert people from the criminal justice system?
- Timelines for restoring competency
- Use of medications in competency restoration
- Restoration locations

1. Department of Corrections

The Department of Corrections concurs with the recommendations of the Department of Mental Health and Agency of Human Services that competency restoration programming be formalized through legislative action in Vermont.

Several high-profile recent cases have raised questions about current pathways to competency restoration in Vermont. Given DOC continues to play a critical role in housing and serving many of these individuals, the Department strongly endorses further exploration of this topic within the Legislature and encourages lawmakers seek extensive testimony from State officials, subject matter experts and community stakeholders.

DOC further recommends these conversations encompass a wide consideration of clinically appropriate pilot sites and settings for competency evaluation and restoration. While the Department maintains extensive protocol and experience in housing individuals with complex needs, the carceral system is not by nature or design a therapeutic treatment environment. Rather, it is a vehicle of the justice system dedicated to criminal risk reduction.

2. Defender General

No feedback received.

3. State's Attorneys

Timothy Lueders-Dumont provided a memorandum included in its entirety as Appendix B.

4. Vermont Judiciary

Judge Zonay, Chief Superior Judge, provided the following feedback:

"I note that whether to enact legislation for a competency restoration program in Vermont, and what it should look like if enacted, are questions of policy for the Legislature. As such, I am not in a position to offer comment on whether a competency restoration program should be enacted.

Additionally, other states have taken various approaches in their competency restoration enactments in determining eligibility, the timelines which must be met, the use of medication, and the locations where the programs occur. As to these areas, I note that there have been numerous lawsuits, and claims in individual cases where a defendant is required to participate in a program, focusing on these types of issues. That being the case, I do not believe it appropriate for me to offer comment on these questions given that there is the potential, if not likelihood given what has occurred in other jurisdictions, for any enactment in Vermont to be the subject of court proceedings. Notwithstanding this, should a bill be submitted to the Legislature for establishing a program I would be in a position to offer testimony as to the bill's implementation and projected impact on the courts, including the effect potential litigation will have on our courts.

As to better diverting people from the criminal justice system, I assume this is directed at those with mental health needs. I believe that a critical component to better diverting those with mental health needs from the criminal justice system is the availability of mental health programs to assist those in need of treatment.

The one area which I am comfortable weighing in on relates to the question of how we may better divert people from the criminal justice system. As you are aware, Vermont has taken, and is continuing to engage in, significant steps relating to pretrial diversion programs. I will continue to work with the stakeholders regarding such programs."

5. Vermont Care Partners

DMH met with the CRT (Community Rehabilitation Treatment) directors on October 6, 2023, to discuss. Discussion focused around how to best serve individuals, how to better utilize court diversion, and how to meet people where they were at. The importance of housing was emphasized. Having a robust mental health court system was also discussed, similar to Alaska and Texas, as a better option to meet need.

In follow up discussions, several things happening in Texas were highlighted as good models. One, in Austin, Texas called the "Downtown Austin Community Court"[23] was referenced as a good example of a mental health court with wrap around services. Texas also has an Office of Forensic Coordination[24] and there is the Texas Behavioral Health and Justice Technical Assistance Center[25], which had online information and resources.

Sequential Intercept Mapping was also highlighted as a great way to think about how to better utilize diversion, at all points in the process.

6. Disability Rights Vermont

Lindsey Owen, Executive Director, provided a statement with related attachments included in its entirety as Appendix C.

7. Court Diversion Programs

Willa Farrell, Court Diversion & Pretrial Services Director, noted that the decision to refer someone to diversion rests with the prosecutors. However, there had been some misunderstanding around when someone could be referred to diversion when competency was at issue, so new guidance went out in September 2023 with the hope

[23] Community Court | AustinTexas.gov

[24] Office of Forensic Coordination | Texas Health and Human Services

[25] Texas Behavioral Health and Justice Technical Assistance Center / Home (txbhjustice.org)

of clarifying any misunderstandings and hopefully leading to more people being diverted. The new below guidance, for Court Diversion staff, was shared with the Judiciary, Dept. of State's Attorneys and Sheriffs, and the Defender General for distribution to their networks.

Guidance to Court Diversion/Tamarack programs re competency

September 2023

If a case is referred to Court Diversion/Tamarack (CD/T) and the Court has not ordered that a competency evaluation be completed but you think the person is not competent, discuss this with the prosecutor and, if one has been assigned, the defense attorney. As an ethical matter, the person may not be able to understand enough to participate in the program and CD/T staff may not have the necessary skills or resources to work with someone who is not competent.

When a person is referred to CD/T and the Court has ordered that a competency evaluation be completed, meet with the person and review the Initial Agreement. Just because a Court has ordered a competency evaluation does not mean the person is unable to complete Diversion. They may be competent under the law, or they may be able to understand the Diversion program and its requirements better than the more complex and high-stakes procedures and systems in our Courts. However, if you are concerned that the person does not understand the Diversion program or what you are explaining, inform the prosecutor and defense attorney, and return the case to Court. Indicate on the CD/T status form that the person is not accepted into the program because they are ineligible.

If you think the person understands what you are explaining and is able to participate in the program, proceed as with other program participants. If the participant successfully completes the program, the court order for a competency evaluation will be moot.

If the participant stops engaging or there are other indications that the person is struggling, contact the person's defense attorney and discuss your concerns. Do not consider the person to have failed the program as you might with other participants. The defense attorney can request that the case be returned to Court and the person's court case will be on hold until the competency evaluation is completed. On the CD/T status form, under Program Completion Status, check Requested return to Court.

8. Mad Freedom

No feedback received.

9. Center for Crime Victims Services

Jennifer Poehlmann, Executive Director of the Vermont Center for Crime Victim Services, provided the following feedback jointly with family members Kelly Carroll and Joanne Kortendick:

"Which crimes should be eligible? We agreed that there should be no absolute bar for consideration of competency restoration for any crime, especially when there is a victim involved. Ideally, cases would be treated individually, with consideration given to a defendant's prior history of charges, compliance history, and risk of harm to self, victim and/or community.

Recognizing that there is likely to be a limitation on available resources to provide competency restoration services in a timely manner, we strongly recommend that at a minimum, **all listed crimes, as defined in 13 VSA 5301(7), are eligible. Additionally, some serious crimes are not within 13 VSA 5301(7)** that we also recommend are included if there is to be a narrowing of crimes – notably:

- Aggravated animal cruelty (13 VSA sec.352(a)
- Countless researchers link animal abuse as a precursor or occurring in conjunction with serious, abusive, and violent crimes against the person.
- Voyeurism 13 VSA sec.2605(j) where the charge is for a second or subsequent offense in violation of 13 VSA sec.2605 (b)(d) or (e)
- Sexual exploitation of children 13 VSA Ch. 64
- Violating an extreme risk protection order 13 VSA sec.4058(b)(1)

How can we better divert people from the CJS?

We agreed that this was not a question addressing the situation in front of us relative to competency restoration. Utilization of our current "pre-charge/pre-trial" programs, such as diversion, restorative justice programming, and Tamarack, would seem to pose a problem if there is a threshold issue concerning competence. If competence is the issue, we are unclear as to how any of our current programming intended to address harm outside of the criminal justice system could provide a viable option until competency is restored. While we agree more resources can and should be provided in order to ideally prevent criminal behavior, once that behavior has occurred and there has been an impact on a victim(s) and communities, in our opinion, competency must be restored in order for the defendant to meaningful engage in any process outside the criminal justice process if meaningful outcomes for all affected parties are to be achieved.

Timelines for restoring competency.

We agreed that the process should start right away/immediately. In this way, we can:

- avoid unnecessary delays for the victim/survivor;
- acknowledge the defendant's constitutional rights to a speedy trial; and
- recognize the statutory rights victims have, which include the right to a speedy trial (13 VSA sec.5312) and the right to be heard.

We agreed that for all listed crimes and for the additional crimes we identified to be included (at a minimum), there should be NO time limit for restoring competency. We would consider supporting a time limit for non-violent misdemeanors and felonies. In our review, other states do have different time frames depending on the offense.

Use of medications in competency restoration.

This is necessary as we do not feel that competency restoration will often be successful without it. As we have referred to many times in testimony, a defense attorney who has participated in these conversations essentially said a defendant would have to be "incompetent" to agree to work toward "restoring" their competency and thereby be subjected to a criminal proceeding. That messages such as these are being sent to clients is deeply concerning to us and provides additional reasons to doubt the success of a competency restoration program where medications cannot be used.

Restoration Locations.

While we support additional locations in the community, it is IMPERATIVE that Vermont establish a forensic facility to address those individuals who cannot be adequately supervised or provided with programming in the community. We have actively participated in countless conversations and workgroups on this issue and continue to believe, even more so after the presentation of evidence and testimony from multiple professionals and experts in the field, that this remains the only feasible option for a VERY small number of individuals who cannot otherwise be safely contained – for their own safety and/or the safety of victims and communities.

Finally, we wish to underscore that the conversation must remain focused on the issue of restoration of competency as a legal standard for purposes of assisting in one's defense; it is not a standard that relates to treatment or larger issues that may be impacting that individual. The restoration that is contemplated is a far narrower standard that is linked to a very specific purpose and intent."

10. Victims/Family Members

See comments from the Center for Crime Victim Services, above.

11. Vermont Association of Hospitals and Health Systems (VAHHS)

Devon Green, Vice President of Government Relations, and Emma Harrigan, Vice President of Policy, provided the following comments:

- Restoration should take place the most appropriate setting for the individual, which is not necessarily the hospital.
- Risk should be taken into account in setting – how do you balance individuals with low treatment needs but high risk with those with high treatment needs and low risk? Especially with our current hospital system?
- While serious crimes should be a focus, often individuals come into the EDs who are committing multiple misdemeanors and their behavior is escalating. How do those individuals fit in?
- There should be a focus on what data we collect and what data we need to collect.

12. Vermont Medical Society

Dr. Simi Ravven helped with a lot of information gathering for this report and has a wealth of information and expertise in this area, so is certainly someone the Legislature may want to hear testimony from. In addition to the assistance she provided to this report, she noted the following:

- Jail-based competency restoration programs are controversial. “The concern is that any such program, in a correctional setting, is by virtue of its frame coercive.”
- As to which crimes should be eligible, “broadly speaking, crimes that pose a significant community safety threat.”
- How can we better divert people, “there are many intercepts it which to do this. The one that comes to mind first is having greater access to mental health courts throughout Vermont. I understand this is only available in Chittenden County currently.”
- Reasonable timelines, “on reviewing the literature, would be six months and then reevaluation. I think it would be reasonable for the evaluators to recommend if an individual has made significant progress and would likely be successfully restored given more time.”

- Medication: “It is difficult to imagine successful restoration without medication for people who experience serious mental illness, specifically psychotic spectrum disorders and bipolar disorders, though it is only one element of a restoration program.”

13. Vermont Legal Aid – both the Mental Health Law Project and Disability Law Project

Jack McCullough, Director of the Mental Health Law Project, provided the following comments:

“We do not support involuntary psychiatric treatment for the purpose of making someone competent to stand trial. Our view is that this kind of proposal would have the effect of keeping people tied up in the involuntary mental health system beyond the point at which it is necessary for the protection of the patient or the public. In addition, as I frequently mentioned in our work group meetings, I believe that forcing someone to undergo involuntary treatment so that they can be prosecuted and incarcerated is inimical to the stated values of medical treatment, which are to benefit the patient.

I should also point out that we are just wondering about what the purpose of this proposal is. Are you hoping to transfer the locus of treatment from the civil to the criminal context? That seems like a real problem.

For defendants charged with serious crimes, it’s been my observation that even without a competency restoration program they tend to be held in the involuntary system for a long time, thereby ensure public safety and keeping open the possibility of competency restoration.

One other thing. Although there aren’t too many cases like this, I suspect that in many of the cases that might be subject to this program, once the defendant is found competent they would still likely have a strong insanity defense, which again raises the question of whether anything has been gained.

14. Developmental Disabilities Counsel

No input provided.

Appendix A: Educational Program Components

Common educational components include:

- "general" psychosocial skills-building in the areas of communication, reasoning, and decision-making
- emotion-regulation training, particularly anxiety-reduction strategies
- group- and individual-based competence education training pertaining to the legal system
- videos and/or model courtrooms designed to demonstrate courtroom procedures
- presentation of common courtroom scenarios designed to facilitate problem-solving
- participation in a mock trial

An educational program used in Florida[26] is comprised of 8 sessions:

- Introduction, Module Objectives, Competency Pre-Test
- Appreciation of Charges
- Appreciation of Possible Penalties
- Understanding the Legal Process
- Understanding the Adversarial nature of the Legal Process
- Description of Courtroom Procedure
- Capacity to Disclose to Attorney
- Ability to Manifest Appropriate Courtroom Behavior.

Each session begins with a brief overview, basic information on the session's topic, and prompts the participant to provide their current understanding of the topic. The participant is routinely provided with short, hypothetical questions on the topic to be able to apply the information learned to possible courtroom scenarios. The facilitator is

[26] Florida Mental Health Law (unknown date). Competency Enhancement Program Manual (http://www.flmhlaw.com/wp-content/uploads/2017/01/CEP-Manual.pdf)

prompted to provide a summary and chance for the participant to ask questions at the end of each session.

A similar training program used in Virginia[27] is comprised of nine content areas:

- Explaining the Purpose of Restoration Services
- Explaining Legal Rights
- Explaining Charges, Penalties, and Evidence
- Explaining Pleas and Plea Bargains
- Explaining Criminal Penalties and Plea Outcomes
- Explaining Courtroom Personnel
- Assisting Your Defense Attorney
- Explaining the Trail Process
- Appropriate Courtroom Behavior.

Each module contains information that is presented to the participant followed by a short quiz to test their understanding of the material. A courtroom diagram is provided as a visual aid. Following completion of all modules, the participant is administered a post-test that includes all required elements for competency.

The Slater Method[28], referenced earlier for those with intellectual disabilities, contains 5 modules:

- purpose of training and review of charges, pleas, and potential consequences
- courtroom personnel
- courtroom proceedings, trail and plea bargaining
- communicating with the attorney, giving testimony, and assisting in the defense

[27] Virginia Department of Behavioral Health and Developmental Services (2018). Adult Outpatient Competency Restoration Manual for Community Services Boards and Behavioral Health Authorities (https://dbhds.virginia.gov/assets/doc/forensic/Adult-Outpatient-Restoration-Manual-for-CSBs-2018.pdf).

[28] Wall, B. W., & Christopher, P. P. (2012). A training program for defendants with intellectual disabilities who are found incompetent to stand trial. The Journal of the American Academy of Psychiatry and the Law, 40, 366—373.

- tolerating the stress of proceedings.

Appendix B: Memo from the State's Attorneys & Sheriffs

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STATE OF VERMONT
OFFICE OF THE EXECUTIVE DIRECTOR
DEPARTMENT OF STATE'S ATTORNEYS & SHERIFFS

TO: Karen Barber, Esq., General Counsel, Department of Mental Health ("DMH")
FROM: Timothy Lueders-Dumont, Esq., Deputy State's Attorney, Legislative & Assistant Appellate Attorney, Department of State's Attorneys and Sheriffs ("SAS")
DATE: October 16, 2023 (*responses collected from the Deputy State's Attorneys and State's Attorneys*)
RE: SAS Response on behalf of State's Attorneys Regarding Act No. 28, 2023 (S.91) Relating to Competency Restoration

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During the 2023 legislative session the legislature passed, and the governor signed, S.91 (Act 28)(2023). Section 7, "COMPETENCY RESTORATION PROGRAM PLAN" directed the Department of Mental Health ("DMH") and the Department of Disabilities, Aging, and Independent Living ("DAIL") to report to the Governor, the Senate Committees on Judiciary and on Health and Welfare, and the House Committees on Judiciary, on Health Care, and on Human Services on whether a plan for a competency restoration program should be adopted in Vermont. For purposes of the report required by Act 28, DMH and DAIL were directed to consult with a number of entities, including the Executive Director of the Department of State's Attorneys ("SAS").

Specifically, DMH requested that SAS provide responses to the five questions below:

- ***Question #1: Which crimes should be eligible?***
- ***Question #2: How can we better divert people from the criminal justice system?***
- ***Question #3: Timelines for restoring competency?***
- ***Question #4: Use of medications in competency restoration?***
- ***Question #5: Restoration locations?***

In response to questions posed by DMH, State's Attorneys provided feedback, compiled below:[1]

- ***Question #1: Which crimes should be eligible?***[2]
  - Many prosecutors believe that all crimes, on a case-by-case basis, should be eligible for competency restoration but if narrowing is needed then crimes involving violence to persons or destruction of property (both misdemeanors and felonies), all listed crimes, "Big-12" offenses (both now and in the future), crimes where there is danger to the community, or to the defendant, and, as a rule, any crime with a victim. Prosecutors also emphasized the importance of access to restoration for all felonies and all violent-related misdemeanors and stressed emphasis for repeat offenders where is an ongoing issue risk to community or victim safety.
  - Likewise, all responses emphasized the need to prioritize cases and individuals with ongoing risk to community safety. Prosecutors broadly agree that crimes involving victims should weigh heavily in the analysis concerning eligibility for competency restoration.
  - In sum, if there is to be a list, while all listed offenses and "Big-12" offenses should be included, the current enumerated "Big-12" and listed offenses are non-exhaustive. Thus, in addition to those offenses noted above, any list concerning eligibility for competency restoration should include the following serious crimes:
    - *Conspiracy to commit a listed offense. 13 V.S.A. 1404.*
    - *Accessory to a listed offense. 13 V.S.A. §§ 3-5.*
    - *Criminal use of anesthetics. 13 V.S.A. § 12.*
    - *Any Crime with a Hate Crime Enhancement / Hate-motivated crimes. 13 V.S.A. § 1455.*
      Animal cruelty (if another's animal). 13 V.S.A. § 352.
    - *Aggravated animal cruelty (if another's animal). 13 V.S.A. § 352a.*
    - *Interference with or cruelty to a guide dog (if another's service animal). 13 V.S.A. § 355.*
    - *First degree arson (burning someone's house). 13 V.S.A. § 502.*
    - *Second degree arson (burning someone's business). 13 V.S.A. § 503.*
    - *Law enforcement use of prohibited restraint. 13 V.S.A. § 1032.*
    - *Assault of protected professional; assault with bodily fluids (but not restricted to that form of assault). 13 V.S.A. § 1028.*
    - *Assault of correctional officer; assault with bodily fluids. 13 V.S.A. § 1028a.*

[1] Comments are provided here as compiled from responsive State's Attorneys and Deputy State's Attorneys and summarized in the interest of providing consultation pursuant to Act 28, 2023.

[2] There are policy concerns related to enumerating crimes eligible for restoration. Enumeration may leave out important contextual considerations that may be at issue, underneath the surface of a case (*e.g., How many pending cases? Victims and victim perspective? Bail status/HWB? Is Def currently being held? How many counties are involved? In-state vs. out-of-state record? Prior record? Prior record with ONH or OH? Housing access status? Substance use disorder? Violations of conditions of release? Dangerousness and violence considerations relating to public safety?*). Enumerating crimes could result in arbitrary exclusion for individuals that may well benefit from restoration programming.

- *Aggravated stalking. 13 V.S.A. §§ 1063(1) (violated court order), (2) (previous convictions), and (5) (deadly weapon).*
- *Abandonment or exposure of baby (if it is another's baby). 13 V.S.A. § 1303.*
- *Cruelty to a child. 13 V.S.A. § 1304.*
- *Cruelty by person having custody of another. 13 V.S.A. § 1305.*
- *Mistreatment of person with impaired cognitive function. 13 V.S.A. § 1306.*
- *Unlawful sheltering; aiding a runaway child. 13 V.S.A. § 1311.*
- *Abuse, neglect, and exploitation of vulnerable adults. 13 V.S.A. §§ 1376 (abuse), 1377 (unlawful restraint and confinement), 1378 (neglect), 1379 (sexual abuse), 1380 (financial exploitation), and 1381.*
- *Willful and malicious injuries caused by explosives (blowing up a house; setting a bomb). 13 V.S.A. § 1601.*
- *Injuries caused by destructive devices. 13 V.S.A. § 1605.*
- *Injuries caused by explosives. 13 V.S.A. § 1608.*
- *Definition and penalty (extorsion; could include sextortion). 13 V.S.A. § 1701.*
- *False alarms to agencies of public safety (death or bodily injury resulting). 13 V.S.A. § 1751(b).*
- *Employers without workers' compensation insurance; criminal sanction. 13 V.S.A. § 2025.*
- *Installation of object in lieu of air bag. 13 V.S.A. § 2026.*
- *Sale or trade of motor vehicle with an inoperable air bag. 13 V.S.A. § 2027.*
- *Identity theft. 13 V.S.A. § 2030.*
- *Poisoning food, drink, medicine, or water. 13 V.S.A. § 2306.*
- *Grand larceny. 13 V.S.A. § 2501.*
- *Larceny from the person. 13 V.S.A. § 2503.*
- *Embezzlement (at least when committed by a public/school employee). 13 V.S.A. §§ 2531, 2532, 2533, 2534, 2535, 2537, and 1538.*
- *Voyeurism. 13 V.S.A. § 2605.*
- *Disclosure of sexually explicit images without consent. 13 V.S.A. § 2606.*
- *Slave traffic (relating to prostitution). 13 V.S.A. § 2635.*
- *Disseminating indecent material to a minor in the presence of the minor (not the offense where a minor disseminates it). 13 V.S.A. § 2802.*
- *Disseminating indecent material to a minor outside the presence of the minor (not the offense where a minor disseminates it). 13 V.S.A. § 2802a.*
- *Sexual Exploitation of Children. 13 V.S.A. Ch. 64.*
- *Female genital mutilation or cutting. 13 V.S.A. § 3151.*
- *Sexual exploitation of an inmate. 13 V.S.A. 3257.*
- *Sexual exploitation of a minor. (e.g., school personnel). 13 V.S.A. § 3258.*
- *Sexual exploitation of a person in the custody of a law enforcement officer. 13 V.S.A. § 3259.*
- *Unlawful trespass of a dwelling. 13 V.S.A. § 3705(d).*
- *Unauthorized removal of human remains. 13 V.S.A. § 3761.*
- *Violating an extreme risk protection order. 13 V.S.A. § 4058(b)(1).*
- *Sexual intercourse when infected with venereal disease. 18 V.S.A. § 1106.*
- *Selling or dispensing a regulated drug with death resulting. 18 V.S.A. § 4250.*
- *Eluding a police officer with serious bodily injury or death resulting. 23 V.S.A. § 1133(b).*
- *Custodial Interference. 13 V.S.A. § 2451.*
- *Weapons of Mass Destruction. 13 V.S.A. §§ 3502, 3503.*
- *Domestic Terrorism. 13 V.S.A. § 1703.*
- *Any Crime with a Habitual Offender Enhancement.*

- ***Question #2: How can we better divert people from the criminal justice system?***
  - Expanded community-based intensive services and supportive housing.
  - More beds for higher-level residential care.
  - As needed and determined by proper analysis, increased use of long-acting, injectable anti-psychotics.
  - More in-home support for families.
  - Mental-health problem-solving courts.
  - More effective enforcement and staffing of ONHs.
  - More voluntary inpatient access.
  - More effective utilization of community organizations: police, DOC, local community organizations, and social workers to assist individuals in accessing services and voluntary admissions. Likewise, better resourced community partners to provide comprehensive services to those who are criminal justice involved.
  - Some noted that this inquiry/premise may be misguided as there are issues with sending incompetent people to Diversion or Tamarack. To engage with Diversion and Tamarack, restoration is still important. That said, if there is adequate staffing and resources, perhaps *misdemeanor-non-victim-cases* could be eligible for *diversion-esque* programming with a governmental entity monitoring for treatment and engagement

- ***Question #3: Timelines for restoring competency?***
  - Six months-1 year, depending on the context of a particular individual.
  - Six months for violent misdemeanors, one year for felonies.
  - No time limit for "Big-12" and listed offenses and those other serious offenses noted above (*e.g., those serious offenses not currently accounted for in the "Big-12" or "listed" offenses*).
  - A rubric whereby there is no time limit for serious offenses and a time limit for minor offenses (other states have this).

- ***Question #4: Use of medications in competency restoration?***
  - Yes, as needed, but how will it be enforced?
  - Yes, this is necessary – otherwise competency restoration will be unsuccessful in many cases.

- **Question #5: Restoration locations?**
  - Should be options for both community-based restoration and inpatient, depending on the needs and circumstances of the individual.
  - Inpatient setting run by the DMH or DAIL: should be inpatient or outpatient, depending on needs and circumstances. Setting must ensure security and safety.
  - For those that cannot remain in the community, a forensic facility and/or DOC facility (*if circumstances are such that someone is in a DOC facility then there should be access to restoration and other programming*).
  - Anything outside of jail or a forensic facility must be accompanied with housing support; we cannot have an outpatient program where people are living on the streets and self-medicating, being taken advantage of, and returning to behaviors

that brought them into contact with law enforcement in the first place (*this is what we have now, and it is not working*).
    - If outpatient, it must be structured with frequent check-ins and waivers for ability to check on compliance with medication and substance use or therapy and ability to issue AW if patient does not engage. Whether inpatient or outpatient, both settings must have case management to address complex life circumstances that contribute to incompetence (*poverty, substance use, housing instability*).
    - If inpatient, the facility should be run by the State, not private contractors.

- ***Other SAS Comments:***
    - State's Attorneys are in favor of Vermont establishing a competency restoration program as well as a forensic facility. Likewise, State's Attorneys believe that the Agency of Human Services ("AHS") should have a public safety mission that complements the existing duties of AHS departments.
    - Restitution is not available for cases when the case is dismissed for lack of competence. If the statute could provide a fix to assist in accessing restitution to non-business victims, it could go a long way in helping some victims with significant financial losses.

Appendix C: Disability Rights Vermont and Companion Materials

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To: The Vermont Department of Mental Health

c/o Karen Barber

Re: Competency Restoration Input

Date: October 19, 2023

Thank you for requesting input on the proposed inclusion of a competency restoration process for Vermont. As the Department of Mental Health is aware, Disability Rights Vermont is the Protection and Advocacy agency for the State of Vermont. Protection and Advocacy agencies across the country are tasked and funded to investigate abuse, neglect, and rights violations impacting individuals with disabilities, and seek remedies for those individuals. Where possible, Protection and Advocacy agencies also advocate for systemic changes to prevent future harm to disabled members of our communities.

Given our federal mandate, DRVT maintains that the question exists, as to whether competency restoration is even an appropriate process to address alleged criminal conduct in our communities by persons who are presumed to lack capacity or be able to be restored to capacity. We maintain that community-based supports for people experiencing mental illness would be far more effective in preventing or limiting their engagement with the criminal justice system, altogether. Considering the State's trajectory of proceeding with a Competency Restoration Treatment (CRT) process, DRVT's recommendations remain rooted in that obvious need for a more proactive and preventative approach to our system of care that would reduce the number of individuals impacted by CRT. We support the incorporation of diversion efforts and systems wherever possible. Furthermore, we would advocate that any CRT process incorporated into our system should be conducted in the least restrictive setting, using outpatient therapies and evaluations. Below are some brief responses to the Department's questions and some additional feedback. Thank you again for reaching out to DRVT.

1. What Crimes should be eligible for CRT:

DRVT believes anyone charged with a crime should be equally eligible for CRT, should we adopt a CRT process. However, the nature or severity of the crime may be a factor in what the process looks like in terms of placement, timing, etc. DRVT is including with these responses several settlement agreements from across the country that shed light on how some states have landed on these issues.

2. How can we better divert people from the criminal justice system?

As alluded to above, DRVT would recommend that DMH, in coordination with the other State Departments, and community partners, invest in preventative and proactive measures addressing the social determinants of health that inevitably impact and influence whether someone will find themselves in the criminal justice system. Extreme and intentional efforts to increase access to affordable and accessible housing; affordable and accessible healthcare- to include all types of care, physical and mental; affordable/livable and accessible employment; affordable and accessible childcare, would make an enormous positive difference for reducing individuals' involvement with the criminal justice system. Standing up a new system in an already resource depleted environment is financially irresponsible without simultaneously, or firstly, trying to address the need for such a system through less costly measures. A few years ago, DRVT published a report entitled Wrongly Confined. Within that report exists the costs of treating people across a variety of settings compiled by Vermont Care Partners in a 2018 report. The cost of living in a state-run inpatient psychiatric facility was $2,537/day and the cost of living with some services in a person's home was only $64/day. https://disabilityrightsvt.org/wp-content/uploads/2020/06/DRVT-Olmstead-Report.pdf. DRVT believes that these costs have increased significantly over the last five years, and that it would be fiscally irresponsible to create another system geared towards confining more individuals with disabilities instead of trying to address the basic needs of Vermonters to prevent the problem from occurring in the first place. DRVT does acknowledge that working towards these preventative and proactive measures will not stop all crimes from occurring and that there will continue to be questions around some people's competency, but for the focus and the resources to be on that small population when so many more could be served with those same resources in the community, that is where DRVT asserts the resources are best spent.

3. Timelines for restoring competency?

DRVT does not have any medical or psychiatric expertise to opine on this with any sort of specificity. However, some of the settlement agreements included with this statement demonstrate some reasonable ideas on this matter. For example, Oregon makes it clear that the restoration process cannot exceed the minimum sentence that the crime itself carries. DRVT acknowledges the efforts DMH has made to do some research into this, and we would defer to those experts and the settlement agreements attached hereto.

4. Use of medications in competency restoration.

Despite the Sell v. United States decision that found states *could* use involuntary medication for competency restoration, it certainly did not make involuntary medication a mandatory treatment option for CRT and DRVT strongly opposes the use of involuntary

medication for CRT in the state of Vermont, and DMH should as well. Currently, involuntary medication is only permissible as a last resort if someone is an imminent risk of serious bodily harm to themselves or others, or if it is court ordered for purposes of psychiatric treatment. DRVT does not believe that Vermont, a state that has declared a "policy of the General Assembly to work toward a mental health system that does not require coercion or the use of involuntary medication," should expand the opportunities to involuntarily medicate its residents. 18 V.S.A. 7629(c).

5. Restoration locations:

DRVT believes, and the Americans with Disabilities Act requires, that all people should reside in the least restrictive setting possible. Individuals in need of, or involved with, CRT services should not be treated any differently. Also, DRVT would refer to its earlier citation to the Wrongly Confined Report it authored regarding the costs associated with different living arrangements. There are also many due process concerns with confining individuals who have not been convicted of a crime, so DMH should be mindful of that, too.

Finally, after receiving the request for input, DRVT reached out to its national partners and engaged in brief research and derived the following general themes to keep in mind when creating a CRT process in Vermont.

1) Current State laws *re* competency to stand trial prevent people from receiving effective treatment and psychological care, and require only psychological evaluation.

2) CRT laws disproportionately delay due process for people with mental illness, and disenfranchises them from their right to a speedy resolution.

3) CRT prolongs detention in jails, prisons, and psychiatric facilities, for even minor offenses, amounting to cruel and unusual punishment, or incarceration without due process and conviction.

4) CRT adds additional strain to an already underfunded mental health system.

5) Current State Laws require that individuals receive treatment for indefinite periods of time, until competency is restored (potential Olmstead issues)

6) No current State outpatient system for individuals found to be incompetent to stand trial.

7) Inpatient and jail-based restoration models do not provide options for defendants to post bail, while awaiting evaluation and restoration, amounting to unequal treatment of people with disabilities.

Models used in other locations:

Conditional Release to Community-Based restoration program. Non-hospitalization. Preferred by DRVT

Inpatient Competency Restoration Program. Limited to serious felonies and threats of harm to self or others. Not for persons accused of misdemeanors, and lower level and non-violent felonies.

Jail-Based Competency Restoration Program. Not recommended by DRVT.

Alternative Models-

a) Mental Health Court-SAMHSA model. Expand the judiciary's Treatment and Specialty Courts by creating a specific Mental Health Court.
b) Sequential Intercept Model to divert people with Mental Health Disabilities away from the justice system. DRVT Advocates for more funding to be allocated to restorative justice service providers, statewide.

Sources:

https://rockefeller.dartmouth.edu/sites/rockefeller.prod/files/2122-12_forensic_mental_health_final.pdf

https://www.samhsa.gov/criminal-juvenile-justice/sim-overview

Thank you for your consideration of DRVT's input.

Respectfully,

Lindsey Owen, Esq., Executive Director

Laura Cushman, Esq., Legal Director

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

BRANDON COOPER, *et al.*,	*	
Plaintiffs	*	**CIVIL ACTION NO. 3:14-00507-SDD-RLB**
v.	*	**JUDGE DICK**
REBEKAH GEE, *et al.*,	*	**MAGISTRATE JUDGE BOURGEOIS**
Defendants	*	
Consolidated with	*	
ADVOCACY CENTER and MONICA JACKSON,	*	
Plaintiffs	*	**CIVIL ACTION NO. 3:15-00751-SDD-RLB**
v.	*	**JUDGE DICK**
REBEKAH GEE, *et al.*,	*	**MAGISTRATE JUDGE BOURGEOIS**
Defendants.	*	

SETTLEMENT AGREEMENT

I. Introduction:

In these consolidated actions, Plaintiffs, Brandon Cooper, Louis Davenport, Ron Gatlin, Kenny Swatt, Stephen Zeringue, William Pitzer, Tyrin Perkins, Dominick Perniciaro III, Scott Frye, and Ryan Kazemi are individuals who have been diagnosed with mental illness and found Not Guilty by Reason of Insanity (NGRI) of a criminal offense. Plaintiff Monica Jackson has been diagnosed with mental illness and was found incompetent to stand trial and ordered committed to Feliciana Forensic Facility, but was incarcerated in correctional facilities in Louisiana following that order. Plaintiff Advocacy Center is a private, federally-funded, non-

profit corporation, designated by Louisiana to serve as the State's protection and advocacy system for persons with disabilities and is a party in the instant consolidated cases as an associational plaintiff. Plaintiffs allege that Defendants have refused, and are continuing to refuse, to promptly accept physical custody of individuals found NGRI and Incompetent to Stand Trial who have been ordered to be admitted to an inpatient psychiatric facility for care and treatment. Plaintiffs allege that Defendants' refusal to accept physical custody has resulted and is resulting in prolonged and unconstitutional confinement in parish jails, in violation of Plaintiffs' rights to due process under the United States Constitution, Title II of the Americans with Disabilities Act of 1990, and Section 504 of the Rehabilitation Act of 1973.

The parties mutually desire to settle all of the claims asserted by the Plaintiffs in these consolidated cases without the need for further litigation and have therefore agreed to enter into this Settlement Agreement.

It is, therefore, ORDERED, ADJUDGED, AND DECREED:

1. This Court has jurisdiction over Plaintiffs' claims against the Defendants set forth in the Complaint.

2. This Settlement Agreement applies to the individuals defined as follows:

> All individuals who, after having been found Not Guilty by Reason of Insanity or Incompetent to Stand Trial are remanded by a court to a mental health facility for treatment pursuant to Louisiana law.

II. Definitions:

3. For the purposes of this Settlement Agreement, the following definitions shall apply unless a contrary meaning is indicated by the text:

a. Incompetent Individual: a person who has been found to lack the mental capacity to proceed to trial, is being held in jail, and has been ordered committed to Feliciana Forensic Facility (a.k.a. ELMHS) or other mental health facility pursuant to La. Code Crim. P. art. 648.

b. NGRI : a person who has been found Not Guilty by Reason of Insanity ("NGRI") and has been ordered by a court to be committed to a mental health facility pursuant to La. Code Crim. P. art. 654.

c. NGRI Order: an order entered by a criminal court subsequent to a finding of NGRI, committing an individual to a mental health facility pursuant to La. Code Crim. P. art. 654.

d. Order for Competency Restoration: an order committing an Incompetent Individual to a mental health facility issued pursuant to La. Code Crim P. art. 648(A)(2)(a).

e. Mental health facility: The Feliciana forensic facility at ELMHS designated by La. R.S. 28:25.1 and any other facility to which NGRI or Incompetent Individual may be committed by an NGRI Order or an Order for Competency Restoration.

f. Jail: A parish or municipal detention facility in which NGRI and Incompetent Individuals are held, or may be held, pending admission to a mental health facility pursuant to an Order of Commitment or an Order

for Inpatient Treatment. This may include DOC facilities or facilities owned or operated by third-party contractors who have contracted with Parish Sheriffs to house pretrial detainees.

g. Waiting list: the list of individuals described in paragraph 4 below.

h. Diversion from the waiting list: Release from jail to a placement in the community.

i. Sanity Commission: a commission appointed by a State court pursuant to La. Code Crim. P. art. 644 to examine a criminal defendant whose mental capacity to proceed to trial is in question, and to make findings concerning his competency to proceed to trial; or pursuant to Art. 650 in cases in which a defendant enters a combined plea of "not guilty and not guilty by reason of insanity" in order to make an examination as to the defendant's mental condition at the time of the offense.

j. Sanity Commission Report: A report prepared by the Sanity Commission and submitted to the Court.

k. District Forensic Coordinator (DFC): a mental health professional employed by the Louisiana Department of Health with at least a master's degree in social work, psychology or related field, such as counseling or nursing, and who has been trained by and is under the active supervision of the Medical Director of Defendant's Forensic Program or other Board-certified forensic psychiatrist.

l. Brief Psychiatric Rating Scale (BPRS): a standardized 24-item psychiatric rating scale used to rate psychiatric symptoms and behaviors. The BPRS comprises 24 items that can be rated from not present (1) to extremely severe (7).

o. CAGE-AID questionnaire: a brief standardized questionnaire that is a widely used method of screening for alcoholism, adapted to include other types of substance abuse.

p. Behavioral Health Assessment: a face-to-face assessment by a psychiatrist, licensed psychologist, or District Forensic Coordinator for mental illness and addiction problems, using the Brief Psychiatric Rating Scale (BPRS) for mental health symptoms and the CAGE-AID for substance abuse issues. Also included in the term "Behavioral Health Assessment" is a review of any sanity commission report; medical and mental health history, if available; jail medical and mental health records; and assessment of other factors bearing on the acuity of the NGRI or Incompetent Individual's need for mental health and substance abuse treatment, including whether the NGRI or Incompetent Individual is receiving medication, whether the NGRI or Incompetent Individual is compliant with his or her medication, efficacy and side effects of medication, physical health needs, and extent to which he or she has received jail-based competency restoration services. The Behavioral Health Assessment will result in a determination as to whether an NGRI or Incompetent Individual has an Emergency Mental Health Need, as defined below.

q. Incompetent or NGRI Individual with Emergency Mental Health Needs: an Incompetent Individual or NGRI who has a BPRS total score that is 50 or greater; who is determined by a psychiatrist designated by the ELMHS Chief of Staff to need immediate hospital treatment; or who has engaged, or is likely to engage, in acts of serious self-harm, acts of violence toward others, or significant acts of violence toward property. These individuals shall be admitted pursuant to Paragraph 8 of this Agreement.

III. Actions Required of Defendants:

4. Defendants shall maintain an updated cumulative list of all NGRI and Incompetent Individuals who are or have been housed in parish jails in Louisiana awaiting transfer to the forensic unit at ELMHS or other mental health facility or placement, on or after the date of the entry of this Settlement Agreement. The summary or list shall include, for each NGRI and Incompetent Individual:

   a. The NGRI or Incompetent Individual's name and docket number.

   b. Whether the person is an NGRI or Incompetent Individual.

   c. The court that entered the NGRI Order or Order for Competency Restoration.

   d. The date of the Order.

   e. The date that LDH was notified of the Order.

   f. The dates and results of the Behavioral Assessment and whether the person was classified as an NGRI or Incompetent Individual with Emergency Mental Health Needs.

   g. The jail or other facility in which the NGRI or Incompetent Individual is being held, if known.

   h. The status of any paperwork that must be completed, pursuant to Louisiana Code of Criminal Procedure 648.1 and Louisiana Code of Criminal Procedure 654.1 prior to admission of the NGRI or Incompetent Individual to a mental health facility or community placement.

   i. The date of admission of the NGRI or Incompetent Individual to the forensic unit at ELMHS or other mental health facility or placement.

   j. Date of any NGRI or Incompetent Individual's removal from the list due to diversion or other reasons.

k. The reasons for the NGRI or Incompetent Individual's removal from the list, including identification of the facility or other setting to which the NGRI or Incompetent Individual was transferred.

5. Defendants shall maintain their current system for receiving Orders from criminal courts. Defendants previously notified all criminal courts in Louisiana that Orders should be sent promptly to ensure individuals can be quickly assessed. If any court sends an Order more than two days after it is signed, Defendants follow up with that court via letter to reinforce the importance of the timeliness of transmission.

6. Defendants shall provide all NGRI Incompetent Individuals a Behavioral Health Assessment, as defined above, within five (5) calendar days of notification of an order for inpatient treatment or order of commitment. If the Behavioral Health Assessment is conducted by a DFC, as opposed to a psychiatrist or psychologist, the DFC must send the BPRS and CAGE-AID test results and documentation, and all other documentation described above that has been obtained, to the Forensic Aftercare Clinic (FAC) Medical Director, or another psychiatrist on staff designated by the Eastern Louisiana Mental Health System's (ELMHS) Chief of Staff, to interpret the results of the Behavioral Health Assessment in order to determine if the client needs emergency services.

7. No later than two hundred forty-five days (245) from the date of this Order, Defendants shall have admitted all NGRI and Incompetent Individuals who are on the waiting list to ELMHS, another mental health facility, or community residential program, as of the date of this Order.

8. Following the signing of this Order, Defendants shall admit all new NGRI or Incompetent Individuals with Emergency Mental Health Needs to a Mental Health

Facility within two (2) business days following completion of a Behavioral Health Assessment.

9. No later than two hundred forty-five days (245) from the date of this Order, Defendants shall admit all NGRI or Incompetent Individuals to the forensic unit at ELMHS or other mental health facility, or to an appropriate community based program within fifteen (15) calendar days following receipt of an Order, except that if Defendants demonstrate that unusual and exigent circumstances make it is impossible for them to admit an NGRI or Incompetent Individual within fifteen (15) calendar days, Defendants may have up to thirty (30) calendar days to admit the NGRI or Incompetent Individual. If the monthly reporting provisions below demonstrate admission times regularly exceeding 15 calendar days, the Plaintiffs may, at their option, call a meeting with Defendants to devise a remedial action plan to bring admission times within the 15-day threshold. Such a meeting shall not limit Plaintiffs' enforcement rights under paragraph 23.

10. Within ninety (90) days of this Order, Defendants shall implement procedures to help provide NGRI or Incompetent Individuals who are incarcerated in parish jails with expedited admission in the event of emergent mental health needs. Such procedures shall include, at a minimum, the following:

a. Defendants shall establish and publicize to each sheriff or other personnel responsible for parish jails the name, telephone number, and email address of DHH personnel to contact in the cases concerning an Incompetent Individual or NGRI with Emergency Mental Health Needs. This publication shall further instruct each sheriff or other personnel responsible for parish jails of how to report an emergency to DHH

personnel and shall include a description of the factors that substantiate the emergency.

b. Within forty-eight (48) hours of the report of an emergency to LDH, the ELMHS Chief of Staff or his Designee shall make the determination as to whether there is an actual emergency, and whether to admit the NGRI or Incompetent Individual to a Mental Health Facility on an expedited basis or take other action except when such reports occur between the close of business on Friday and 12:00 a.m. Sunday in which case determinations shall be made within seventy-two (72) hours.

11. Defendants will continue their current intake assessment procedures as well as their post-admission assessment procedures to ensure appropriate placement for each individual. In the event of a discrepancy between Defendants' recommendation for an individual's placement and the court's order regarding that individual's placement, Defendants will provide the Plaintiffs with the individual's name and the information listed in Paragraph 4 of this agreement.

12. Within one hundred and eighty (180) days of this Order, Defendants shall confer and meet to develop a plan for providing less restrictive placement options in which NGRI and Incompetent Individuals can, with the appropriate permission of the criminal court, receive clinically appropriate competency restoration or mental treatment placement options. The parties will discuss potential legislative proposals to address needs or issues brought forth in this meeting. The implementation of any such plan shall be subject to concurrence of LDH executive management and budgetary appropriation by the legislature.

13. In developing the plan described in paragraph 12, Defendants shall coordinate

a meeting of Defendants, Plaintiffs' counsel, Plaintiffs' expert, Dr. Joel Dvoskin, and any stakeholders Defendants deem necessary to discuss (a) needed research and analysis beyond that identified in the preceding paragraph, and (b) necessary elements of the strategic plan. Defendants shall consider, in addition to the funding of new placements identified in paragraph 18, opportunities to divert NGRI and Incompetency Individuals from the criminal justice system and to improve efficiencies in existing operations. To facilitate that meeting, Defendants, in addition to the information contained in paragraph 4 of this agreement, will provide to Plaintiffs' counsel relevant data in Defendants' possession regarding patient wait times and recidivism rates for persons placed on conditional release or returned to jail to stand trial after a determination that his or her competency has been restored.

14. Plaintiffs shall seek alternate methods of funding Dr. Dvoskin's consultation, including but not limited to searching and applying for any grants. In the event alternate funding cannot be found, Defendants agree to pay Dr. Dvoskin his standard hourly rate of four hundred dollars ($400) per hour as well as travel expenses for a total of up to thirty-thousand dollars ($30,000). Dr. Dvoskin will not bill Defendants for any travel time.

15. Defendants agree as follows to allocate necessary resources to create new placement options, in addition to and not in lieu of current placement opportunities, at clinically and legally suitable locations. Said locations will include community-based settings. Defendants agree to allocate resources to provide less restrictive placement alternatives to NGRI or Incompetent Individuals currently housed at ELMHS or incarcerated in parish jails and to prevent future NGRI or

Incompetent Individuals from being unnecessarily confined in a Mental Health Facility or jail, or detained in jail beyond the time periods provided for in this agreement. To this end:

a. Within two hundred forty-five (245) days from the date of this Order, Defendants shall increase the number of available beds at ELMHS by an amount necessary to accommodate the placement of individuals within the time frame established in Paragraph 9 of this Agreement;

b. Within two hundred forty-five (245) days from the date of this agreement, Defendants shall develop a plan to create supportive housing opportunities with appropriate mental health services for NGRI and Incompetent Individuals in locations throughout the Louisiana, which shall include, but not be limited to, New Orleans, Baton Rouge, Lafayette, Lake Charles, and Shreveport, including the possibility of an increase in community based beds.

16. Jail-based competency restoration and mental health treatment provided in jails do not constitute new placement options required by the preceding paragraph.

IV. Reporting provisions:

17. Defendants shall submit a report to Plaintiffs' counsel on the first working day of each month beginning November 1, 2016. The report shall contain the information set forth in Paragraph 4 above, as well as the number of NGRI and Incompetent Individuals disaggregated by category of detention, gender, and the facility to which each Individual was admitted, and a description of any unusual and exigent circumstances that resulted in a delay in placement in excess of 15 days as

established in Paragraph 9. Such report shall also contain the name of any NGRI or Incompetent Individual for whom Defendants have received a report of a mental health emergency pursuant to paragraph 12 above, the facility in which the NGRI or Incompetent Individual was held at the time of the report, a description of the factors that were provided as substantiating the emergency, the identity of the ELMHS Chief of Staff or his Designee who made the determination as to whether there is an actual emergency, the time and date of such determination, and a description of any action taken by Defendants with regard to the claimed emergency.

18. Any current or future individual(s), as defined in Paragraph 2, shall have the right to seek enforcement of this Settlement Agreement in accordance with the procedures set forth herein, regardless of whether he or she was a named Plaintiff in this action. In the event that NGRI or Incompetent Individuals seek to enforce this settlement based on the belief that Defendants have failed to discharge any obligations under this settlement, they will give written notice of such failure to Defendants' counsel, specifying the grounds that demonstrate such failure, and the Defendants will have thirty (30) days from receipt of such notice to come into or establish compliance with this settlement. If an individual believes that the alleged failure has not been cured within the thirty (30) day period, they may seek in this Court specific performance of this settlement, together with attorneys' fees and/or costs recoverable under 42 U.S.C. §1988, but not contempt of court. The sole exception to the obligation of NGRI or Incompetent Individuals to provide the written notice required by this paragraph is a circumstance in which an alleged failure to comply with a term of this agreement warrants immediate injunctive relief. in which case defendants will receive the appropriate notice required when such

relief is sought.

19. The reporting provisions in this agreement shall terminate after four (4) continuous years of Defendants' substantial compliance with the terms of this agreement.

V. ATTORNEYS' FEES AND COSTS

20. Plaintiffs are a prevailing party. In full and final settlement of this matter, and within 90 days of the execution of this Settlement Agreement, Defendants will issue Plaintiff a settlement payment in the amount of $466,000 that will be inclusive of all attorneys' fees and costs incurred in connection with this action, up to and including the date of the entry of this Settlement Agreement.

21. The parties agree that Plaintiffs may recover attorneys' fees under §1988 after final approval of this Settlement Agreement and satisfaction of the initial claim for attorneys' fees referred to in Paragraph 20 above, subject to the provisions of Section V of this Agreement.

22. Such "future" claims for fees are limited to fees and costs for work performed in obtaining Defendants' compliance with the Settlement Agreement; obtaining attorney's fees merited under the Agreement; seeking a modification of the Settlement Agreement over Defendants' objection (if the Court modifies the Settlement Agreement at Plaintiff's Request), and/or opposing a modification requested by Defendants if the Court denies (or denies, in part) Defendants' request for a modification. If the Court denies Defendants' request for modification in part, Plaintiffs are only entitled to fees for the part(s) denied.

23. In the absence of a filing for judicial enforcement or modification of the Settlement Agreement, Plaintiffs may not recover attorneys' fees. In the event that such a

motion is filed and Plaintiffs are the prevailing party, Plaintiffs' reserve the right to seek a reasonable award of fees for all work done in connection with the particular motion. Defendants reserve the right to oppose any such request.

24. The Parties agree that Plaintiffs are entitled to reasonable attorneys' fees if Defendants are found out of compliance by the Court after Plaintiffs file a motion for judicial enforcement or modification of the Settlement Agreement, provided that Plaintiffs' have given Defendants' notice and an opportunity to come into compliance pursuant to Paragraph 18 of this Settlement Agreement prior to filing their motion.

25. Reasonable attorneys' fees shall be awarded only to counsel of record and/or to any paralegals employed by counsel of record, the Advocacy Center, and/or the MacArthur Justice Center. (The person(s) claiming reimbursement of attorneys' fees shall hereinafter be referred to as "Claimant(s).")

26. In accordance with precedent of the U.S. Fifth Circuit Court of Appeals, §1988 attorneys' fees and costs can only be awarded for the work of a legal assistant or paralegal if that work is legal, as opposed to clerical. Work that is legal in nature includes, for example, factual investigation, locating and interviewing witnesses, assistance with depositions, interrogatories and document production, compilation of statistical and financial data, checking legal citations and drafting correspondence. Activities that are purely clerical in nature include, for example, typing, copying, filing, or delivering pleadings. Pure clerical or secretarial work may not be billed at an attorney's or paralegal's rate.

27. The cost of services performed by paralegals or other persons supervised by counsel of record and/or the Advocacy Center are to be included in the assessment and award

of attorneys' fees if the following criteria are met:

a. The services performed must be legal in nature;

b. The performance of such services must be supervised by an attorney;

c. The qualifications of the person performing the services must be specified in the application or motion requesting an award of fees in order to demonstrate that the person is qualified by virtue of education, training, or work experience to perform substantive work;

d. The nature of the services performed by the person must be specified in the application/motion requesting an award of fees in order to permit a determination that the services performed were legal rather than clerical in nature;

e. The amount of time expended by the person in performing the services must be reasonable and must be set out in the motion; and

f. The amount charged for the time spent by the person must reflect reasonable community standards of remuneration.

28. Costs available under 28 U.S.C. §1920 will be reimbursed whenever Plaintiffs are entitled to recover attorneys' fees and costs as described above.

29. Other costs will only be reimbursed if the evidence accompanying the claim shows that they are of the type of costs that would normally be reimbursed by a fee-paying client and that the costs were necessarily incurred in the litigation.

30. Mileage for necessary travel will be reimbursed at the rate established annually (on a fiscal calendar) by the State Division of Administration and will be reimbursed at the rate in effect at the time of travel.

31. Attorneys' fees for travel time will be paid at 50% of the claimant's billable rate.

32. Counsel of record for the Plaintiffs, at the time the instant Settlement Agreement is entered, bill at the following rates (which are fixed for the calendar year 2016): Ronald Lospennato, $375/hour; Ellen Hahn, $375/hour; Katie Schwartzmann, $350/hour; Eric Foley, $240/hour; Kathryn Fernandez, $240/hour; Laura Thornton, $200/hour.

33. The billable rates of the above-named counsel may increase annually (beginning January 1, 2017) in accordance with commensurate increase in the relevant legal market (Baton Rouge, Louisiana).

34. However, counsels' billable rates (for purposes of claims in this case under §1988) shall not increase more than $25.00 in a calendar year.

35. Billable rates for any legal personnel other than current counsel of record, as listed above in paragraph 37, must comport with the prevailing rates in the relevant legal market (Baton Rouge, Louisiana), and may increase annually (beginning January 1, 2017) in accordance with commensurate increases in the relevant legal market, but not to exceed $25.00 in a calendar year.

36. Any annual increases by attorneys other than current of record, as listed above in paragraph 37, shall not exceed $25.00 in a calendar year.

37. Any annual increases by non-lawyers shall not exceed $12.50 in a calendar year.

38. Any future claims for attorneys' fees and costs and appropriate documentation supporting the claim shall be presented to counsel for defendants within thirty (30) days of entry of the applicable Judgment or Order, unless the parties agree on, or the Court by order permits, a longer period of time.

39. The evidence accompanying any and all claims for attorneys' fees and costs must expressly show and, if requested by defendants, certify under penalty of perjury, that all costs and hours claimed were incurred in this case and that no cost or hour claimed has been

previously reimbursed in this litigation or any other litigation against the State of Louisiana, any of its agencies, officials, and/or employees.

40. If the parties cannot amicably agree on a future claim of attorneys' fees and costs pursuant to paragraph 38 above, it shall be the responsibility to the Plaintiffs to document, via time and date stamped e-mail to defense counsel, the official end to the negotiation.

41. In the event that the parties cannot amicably resolve a future claim for attorneys' fees and costs, Plaintiffs must file a Motion for Attorneys' Fees and Costs within thirty (30) days of the end of the negotiation, as described in paragraph 40 above.

42. Defendants have and reserve their right to question and/or challenge the hours billed by any claimant, exercise of billing judgment by any claimant, and necessity of costs requested by any claimant.

43. Defendants have and reserve their rights to question and/or challenge the reasonableness of the billable hourly rates of any claimant.

CAP ON ATTORNEYS' FEES AND COSTS

44. In light of the four (4) year limit on this Settlement Agreement and so the State may budget accurately, the parties have agreed to a maximum amount of attorneys' fees and costs that may be awarded during the course of this litigation.

45. The total amount of attorneys' fees that may be awarded in this case after final approval of this Settlement Agreement and satisfaction of the initial claim for attorneys' fees referred to in Paragraph 20 above shall not exceed $300,000.

46. Counsel for Defendants shall include in each Receipt, Release, and Indemnity Agreement signed by Plaintiffs' counsel as described above, an accounting of how much has been paid in attorneys' fees and costs up to and including the sum received on that date and the remaining balance on the cap.

VI. Miscellaneous

47. This Settlement Agreement represents the entire agreement between the parties.

48. This Settlement Agreement is a settlement of disputed claims and shall not be considered to be an admission of liability by any party.

49. Each party to this Settlement Agreement was assisted by counsel, understands the meaning and consequences of the Settlement Agreement, and executes the Settlement Agreement of his, her, its, or their own free will.

50. This Court shall retain jurisdiction to enforce this Settlement Agreement until this matter is dismissed after four (4) continuous years of Defendants' substantial compliance with this Settlement Agreement.

51. Each party to this Settlement Agreement has cooperated in the preparation and drafting of this Settlement Agreement. Accordingly, the Settlement Agreement shall not be construed more strictly against any party than it is against any other party.

52. The claims compromised, settled, and resolved by this Settlement Agreement include all claims that were raised in the Original or Amended Complaints filed in this action, as well as all claims precluded by governing law, on behalf of the Plaintiffs defined in Section I above. This agreement does not compromise, settle or resolve, and shall in no way impair, any claims that may arise after the end of this Settlement Agreement.

53. In consideration of the commitment contained herein, and the benefits provided or to be provided hereunder, this Settlement Agreement shall fully resolve, extinguish, and finally and forever bar, and the Plaintiffs' hereby release, all claims described in paragraph 51 above. Upon final approval by the court, this Settlement Agreement

shall be fully binding on, and fully extinguish and release the claims of, all Plaintiffs, and may be plead as a full and complete defense to any subsequent action or other proceeding that arises out of the claims released and discharged by this Settlement Agreement.

54. Nothing in this Settlement Agreement is intended to affect any rights of any party or non-party other than to the extent specifically addressed by the terms of this Settlement Agreement.

SO ORDERED this 16th day of November, 2016, in Baton Rouge, Louisiana.

SHELLY D. DICK
UNITED STATES DISTRICT JUDGE

Approved:

s/ Ronald K. Lospennato

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IN THE UNITED STATES DISTRICT COURT IN AND FOR

THE DISTRICT OF UTAH, CENTRAL DIVISION

DISABILITY LAW CENTER, a Utah nonprofit corporation; S.B., an individual, by and through his next friend Margaret Goodman; A.U., by and through his next friend Mary Eka; and S.W., an individual, Plaintiffs, vs. STATE OF UTAH; UTAH DEPARTMENT OF HUMAN SERVICES; ANN WILLIAMSON, in her official capacity as Executive Director of the Utah Department of	**JOINT MOTION FOR (1) APPROVAL OF SETTLEMENT AGREEMENT AND CLASS NOTICES, (2) APPOINTMENT OF MONITOR, AND (3) STAY OF PROCEEDINGS** Case No. 2:15-CV-00645-RJS-BCW Judge Robert J. Shelby

Human Services; UTAH DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH; DOUGLAS THOMAS, in his official capacity as Director of the Utah Division of Substance Abuse and Mental Health; UTAH STATE HOSPITAL; DALLAS EARNSHAW, in his official capacity as Superintendent of Utah State Hospital, Defendants.	

Pursuant to Rule 23(e)(3), Federal Rules of Civil Procedure, Plaintiffs S.B., A.U., S.W., and Disability Law Center ("DLC") (collectively "Plaintiffs") and Defendants State of Utah, the Utah Department of Human Services, Ann Williamson, the Utah Division of Substance Abuse and Mental Health, Douglas Thomas, the Utah State Hospital ("USH"), and Dallas Earnshaw (collectively "Defendants") jointly move the Court for an order: (1) approving the proposed Settlement Agreement and the joint proposals for notice and comment attached to this motion as Exhibits 1, 2, and 3; (2) appointing Patrick K. Fox, M.D., as Monitor under the Settlement Agreement; and (3) staying all proceedings in this action during the five-year term of the proposed Settlement Agreement, with the Court retaining enforcement jurisdiction during that period.

Background

1. On September 8, 2015, Plaintiffs initiated this class action against Defendants for allegedly failing to admit mentally incompetent pretrial detainees to USH's Forensic Unit for competency restoration treatment in a reasonably timely manner. (Docket No. 1).

2. On October 3, 2015, Defendants moved to dismiss the complaint, arguing that it failed to state a plausible claim for relief under the Fourteenth Amendment's Due Process Claim and Article I, section 7 of the Utah Constitution. (Docket No. 37). The Court denied Defendants' motion to dismiss on April 7, 2016. (Docket No. 51).

3. The Court later certified the plaintiff class ("the Class") to include all individuals who are now, or will be in the future, (i) charged with a crime in Utah, (ii) determined by the court in which they are charged to be mentally incompetent to stand trial, and (iii) ordered to the custody of the executive director of DHS or a designee for the purpose of treatment intended to restore the defendant to competency, but who remain housed in a Utah county jail. (Docket No. 71). On November 7, 2016, the United States Court of Appeals for the Tenth Circuit denied Defendants' petition for interlocutory review of the Court's certification of the Class. (Docket No. 75).

4. Since May 2016, the parties have been engaged in settlement discussions aimed at resolving all of the constitutional and remedial issues in this case. In their discussions, the parties have been assisted by two experts in the field, Dr. Patrick Fox of Colorado and Dr. Andrew Phillips of Washington. On June 9, 2017, the parties reached an agreement to resolve all claims, subject to this Court's approval of the terms of settlement.

The Proposed Settlement Agreement and Strategic Plan

5. If approved, the proposed Settlement Agreement will be enforceable in this Court for a period of five years from the date of its approval. *Settlement Agr.* ¶ 30. The Settlement Agreement will establish a maximum allowable wait time – measured from the date on which USH receives the custody order to the date on which the Class member begins restoration

treatment – for all Class members. Under the terms of the proposed Settlement Agreement, Defendants will adopt and implement a series of measures reflected in a Strategic Plan, a copy of which is annexed as Exhibit 1 to the Settlement Agreement, in order to reduce the time during which Class members must wait to receive competency restoration treatment, taking into consideration likely future increases in the number of pretrial detainees requiring treatment. Plaintiffs believe that the proposed Settlement Agreement and Strategic Plan will, if fully implemented, resolve all claims asserted by Plaintiffs, subject to the monitoring of Defendants' compliance for the next five years.

6. The next seven paragraphs highlight the most critical features of the proposed Settlement Agreement and the Strategic Plan.

7. The proposed Settlement Agreement will establish a 72-hour screening deadline for all pretrial detainees who have been determined by a Utah state court to be mentally incompetent to stand trial. *Settlement Agr*. ¶ 19(a). It will also provide specific screening standards for the USH professionals who make treatment decisions so that Class members will be directed to the Utah State Hospital's Forensic Unit or to one of several other defined treatment options, based on uniform diagnostic criteria. *Id*. *See also Strat. Plan* at p. 10.

8. One of the treatment options designated in the proposed Settlement Agreement is treatment in an "Offsite Forensic Facility," one of which USH is now in the process of establishing in space to be leased from the Salt Lake County Metro Jail. *Settlement Agr*. ¶¶ 19(a) and 24. USH will build and operate this new facility with an appropriation of $3 million from the 2017 Utah Legislature. The facility will have capacity to treat 22 or more patients and will be operated by a multidisciplinary team consisting of a psychiatrist and other full-time

professionals. *Strat. Plan* at pp. 6-7, 13-14. "[T]he anticipated staffing and training of the offsite forensic facility will be commensurate with their counterparts at the USH." *Id*. at p. 6. Class members assigned to the facility will be segregated from the general jail population. *Settlement Agr*. ¶ 24(a). Under the Settlement Agreement, "Defendants shall establish and operate one or more Offsite Forensic Facilities with sufficient capacity to meet, in combination with other improvements, the Maximum Allowable Wait Time deadlines in paragraph 21." *Id*. ¶ 24(c).

9. Another treatment option designated in the proposed Settlement Agreement will be in-jail treatment through USH's "Outreach Program." *Settlement Agr*. ¶¶ 19(a) and 25. Under the proposed Settlement Agreement, Class members may be provided treatment under this option only if a qualified USH professional concludes, at the time of screening, that the Class member "is likely to show meaningful progress toward restoration of competency within 30 days, [that the Class member's] symptoms are stabilizing, and [that the Class member is] likely to be referred for re-evaluation and restored to competency within 60 days." *Id*. ¶ 25(a); *see also Strat. Plan* at pp. 12-13. Class members may be disqualified from the Outreach Program based on specific diagnostic criteria and will instead be directed to USH, an Offsite Forensic Facility, or an Alternative Therapeutic Facility. *Id*.

10. DLC has previously raised questions concerning the efficacy of the Outreach Program. For this reason, the program's performance will be watched carefully and re-evaluated by the Monitor (discussed below) at the end of the first year of the term of the proposed Settlement Agreement. If, after one year, the Monitor determines that the Outreach Program has not been effective, it will be terminated as a treatment option unless "the Monitor prescribes

additional steps to improve [its] efficacy and USH complies with and implements those steps." *Id*. ¶ 26.

11. Looking into the future, the Settlement Agreement and the Strategic Plan require the study of additional treatment options to address the needs of female members of the Class, and likely increases in general Class membership over time. *See, e.g., Settlement Agr*. ¶¶ 1 and 24(e).

12. The central requirement of the Settlement Agreement is that the maximum number of days during which Class members must wait to begin treatment must be dramatically reduced in several stages. When this case was filed in September 2015, wait time for Class members, as measured from the date of the custody order to the date on which treatment at USH or elsewhere begins, was about six months. Compl. ¶ 4. Under the proposed Settlement Agreement, the maximum wait time for all Class members will be reduced to 60 days within six months of the Court's approval of the Settlement Agreement, to 30 days within twelve months of approval, and to 14 days within eighteen months of approval. *Settlement Agr*. ¶ 21.

13. Defendants' compliance with these and all other requirements of settlement will be overseen by the Monitor, who will report quarterly to the parties. *Settlement Agr*. ¶ 20. The Monitor will base his reports on detailed monthly compliance reports from Defendants' Designated Representative, together with any additional information brought to his attention. *Id*. ¶¶ 4 and 18.

14. Subject to the Court's approval, the parties have named Patrick K. Fox, M.D. as Monitor. *Settlement Agr*. ¶ 8. Dr. Fox's credentials are summarized in Exhibit 4. Dr. Fox is a trained psychiatrist with extensive experience in competency restoration and correctional

psychiatry in the States of Connecticut and Colorado. He is the Chief Medical Officer of the Colorado Department of Human Services and one of the two professionals selected by the parties to advise them during negotiation of the Settlement Agreement.

15. The Settlement Agreement will provide a mechanism for dispute resolution and enforcement before this Court during its five-year term. *Settlement Agr*. ¶ 28. Thereafter, any party may move for dismissal of this case. *Id.* at ¶ 27. The present motion is brought pursuant to paragraph 27, which requires the parties jointly to move the Court for an order staying this case pending implementation of the Plan and compliance with the Settlement Agreement.

Compliance with Rule 23(a)

16. Rule 23(e) provides that "claims, issues, or defenses of a certified class may be settled, voluntarily dismissed, or compromised only with the court's approval." The Court must "direct notice in a reasonable manner to all class members who would be bound by the proposal" and "[i]f the proposal would bind class members, the court may approve it only after a hearing and on finding that it is fair, reasonable, and adequate." Fed. R. Civ. P. 23(e)(1) and (2). Finally, because settlement of this case requires court approval, class members must be given the opportunity to object to the proposal. *Id.* 23(e)(5).

17. The parties jointly propose that the forms of notice attached to this motion as Exhibits 2 and 3 be used to give Class members notice of the proposed settlement under the following terms:

a. To provide notice of the proposed settlement agreement to existing Class members, the parties will rely on the waiting list for admission to the Utah State Hospital in effect at the time the Court grants the present motion.

b. The parties will send, by first-class U.S. mail, a copy of the proposed "Notice of Proposed Class Action Settlement" attached to this motion as Exhibit 2 as well as a copy of the proposed Settlement Agreement attached to this motion as Exhibit 1 to all class members on the waitlist. The proposed "Notice of Proposed Class Action Settlement" allows class members affected by the proposed Settlement Agreement to make objections to the proposed Settlement Agreement, submit comments concerning the proposed Settlement Agreement, and indicate whether they intend to appear at the final settlement approval hearing. The parties will include a self-addressed stamped envelope for class members to submit written objections or comments to the Disability Law Center.

c. The parties will mail a copy of the proposed "Notice of Proposed Class Action Settlement" attached to this motion as Exhibit 3 and a copy of the proposed Settlement Agreement to counsel of record for each class member. The parties will use Utah Courts' Xchange Case Search to identify counsel of record for each class member at the time the "Notice of Proposed Class Action Settlement" is mailed. The proposed "Notice of Proposed Class Action Settlement" attached to this motion as Exhibit 3 allows defense counsel for class members to make objections to the proposed Settlement Agreement, submit comments concerning the proposed Settlement Agreement, and indicate whether they intend to appear at the final settlement approval hearing. The "Notice of Proposed Class Action Settlement" attached to this motion as Exhibit 3 expressly requests that defense counsel share the Notice and proposed Settlement Agreement with known family

members and any known legal guardian of the class member and to encourage those individuals to submit any objections or comments to the proposed Settlement Agreement.

d. All comments or objections to the proposed Settlement Agreement received by the Disability Law Center will be consolidated and saved in a separate file until the end of the comment period. Copies of the comments will be provided to counsel for Plaintiffs and counsel for Defendants. The original comments and objections regarding the proposed Settlement Agreement will be submitted in a single, hard copy filing with the Clerk of Court for the United States District Court for the District of Utah no later than two weeks before the fairness hearing.

18. After notice has been given, the parties respectfully request the Court to schedule a hearing regarding the fairness, reasonableness, and adequacy of the proposed Settlement Agreement.

Based on the above, the parties request that this Court enter an order: (1) making a preliminary determination to ensure that the proposed Settlement Agreement attached to this motion as Exhibit 1 is fair, reasonable, and adequate; (2) approving the "Notice of Proposed Class Action Settlement" to class members, attached as Exhibit 2 to this motion; (3) approving the "Notice of Proposed Class Action Settlement" to defense counsel for class members, attached as Exhibit 3 to this motion; (4) scheduling a fairness hearing under Federal Rule of Civil Procedure 23(e), and thereafter (5) approving the Settlement Agreement, appointing Dr. Fox as Monitor, and staying all proceedings in this action during the five-year term of the proposed Settlement Agreement.

Dated: June 12, 2017

SNELL & WILMER L.L.P.

/s/ Alan L. Sullivan
Alan L. Sullivan
Bret R. Evans
Attorneys for Plaintiff

DISABILITY LAW CENTER

/s/ Erin B. Sullivan
Aaron M. Kinikini
Erin B. Sullivan
Attorneys for Plaintiff

UTAH ATTORNEY GENERAL

/s/ Laura K. Thompson
Laura K. Thompson
David N. Wolf
Parker Douglas
Assistant Attorneys General for Defendants

Exhibits to Joint Motion for Approval of Settlement Agreement

1. Settlement Agreement (June 9, 2017)

2. Notice of Proposed Class Action Settlement (to Class members)

3. Notice of Proposed Class Action Settlement (to counsel for Class members)

4. Curriculum Vitae of Patrick K. Fox, M.D.

EXHIBIT
1

Return

SETTLEMENT AGREEMENT

This Settlement Agreement is entered into by and between the Disability Law Center (hereinafter "DLC"), an individual identified as S.B., an individual identified as A.U., and an individual identified as S.W. (hereinafter collectively the "Named Plaintiffs"), on the one hand, and the Utah Department of Human Services (hereinafter "DHS"), Ann Williamson in her official capacity as Executive Director of DHS, the Utah Division of Substance Abuse and Mental Health (hereinafter the "Division"), Douglas Thomas in his official capacity as Director of the Division, the Utah State Hospital (hereinafter "USH"), and Dallas Earnshaw in his official capacity as Superintendent of USH (hereinafter collectively "Defendants"). Each of the foregoing parties is sometimes referred to as a "party" and collectively as "the parties."

Recitals

The parties jointly acknowledge the following undisputed facts, which form the background for this Settlement Agreement:

A. DHS has the statutory obligation under Title 77, Chapter 15 of the Utah Code to provide competency evaluations for persons charged with criminal offenses, and to provide Restoration Treatment (as defined below) for persons found incompetent to proceed.

B. On behalf of the class of plaintiffs described below, DLC and the other Named Plaintiffs filed a civil action against the Defendants in the United States District Court for the District of Utah (hereinafter the "Court") Disability Law Center, a Utah nonprofit corporation, et al., vs. State of Utah, et al., Case No. 2:15-CV-00645-RJS-BCW (hereinafter the "Litigation"), to challenge the length of time pretrial detainees in Utah's county jails must wait to receive Restoration Treatment.

C. The purposes of this Settlement Agreement are: (i) for the parties jointly to adopt and implement a strategic plan that will significantly reduce the wait time for Class members (as defined below) to be admitted to Restoration Treatment; (ii) to resolve all claims asserted by the Named Plaintiffs on behalf of the Class in the Litigation; (iii) to provide a mechanism for monitoring Defendants' compliance with this Settlement Agreement and the Plan; and (iv) to provide a mechanism for enforcement of this Settlement Agreement and the Plan.

D. As discussed below, the Named Plaintiffs claim on behalf of the Class that Defendants violate the rights of criminal defendants who have been found incompetent to stand trial under the Fourteenth Amendment to the United States Constitution and Article I, § 7 of the Utah Constitution, by infringing their liberty interests in being free from incarceration absent a criminal conviction. Defendants deny Plaintiffs' claims.

E. DLC is a federally authorized and funded nonprofit corporation established under the Protection and Advocacy for Individuals with Mental Illness Act of 1986, 42 U.S.C. § 10801 *et. seq*. Plaintiffs S. B., A. U., and S. W. were, at the time the complaint in the Litigation was filed, pretrial detainees who had been declared incompetent to stand trial in a criminal proceeding and committed to the custody of the executive director of DHS for the purpose of treatment intended to restore them to competency.

F. DHS is the agency of the State of Utah with responsibility to administer or supervise the administration of competency Restoration Treatment under Utah Code Ann. § 77-15-6(1). The Division is the division of the State of Utah charged with responsibility to ensure the availability of services for people with mental health disorders and substance abuse issues. USH, which operates under the direction of DHS and the Division, is the Utah state psychiatric hospital. Currently, USH is the only state facility providing Restoration Treatment to Class

members, although Restoration Treatment is also provided to Class members through the State's Outreach Program designed to restore competency to individuals housed in Utah county jails.

G. In entering into this Settlement Agreement, Defendants do not admit any wrongdoing or constitutional violation as to any Named Plaintiff or Class member. Defendants do not admit that their conduct, whether actual or alleged, constitutes a legitimate ground for liability against the State or any Defendant.

H. On September 27, 2016, the Court in the Litigation certified the following plaintiff class (the "Class"): all individuals who are now, or will be in the future, (i) charged with a crime in Utah, (ii) determined by the court in which they are charged to be incompetent to stand trial, and (iii) ordered to the custody of the executive director of DHS or a designee for the purpose of treatment intended to restore the defendant to competency, but who remain housed in a Utah county jail. On November 7, 2016, the United States Court of Appeals for the Tenth Circuit denied Defendants' petition for interlocutory review of the Court's certification of the Class.

I. Under Utah Code Ann. § 77-15-3(1), whenever a person charged with a public offense is, or becomes, mentally incompetent to proceed, a petition for inquiry may be filed in the state district court in which the charge is pending for the determination of the person's mental competency. If the court determines that the person is incompetent to stand trial, the court must order him or her committed to the custody of the executive director of DHS or a designee for competency restoration treatment.

J. As the result of limitations on space at USH and limitations on DHS's resources, some Class members have historically waited months after the state court orders restorative competency treatment to be admitted to USH for treatment. During this waiting period, Class

members were incarcerated in county jails, where they received little or no treatment to restore competency from professionals employed by the jail. As a general matter, Utah's county jails are not specifically designed to provide competency restoration treatment, and jail staff do not administer such treatment. Accordingly, since July 2014, the State has administered an Outreach Program designed to restore competency to individuals housed in Utah county jails.

K. With DLC's concurrence, Defendants have formulated and adopted a plan entitled "A Strategic Plan for Providing Utah Adult Mental Health Competency Restoration Services" (June 9, 2017) (the "Plan") to reduce the time during which Class members must wait to receive Restoration Treatment. A copy of the Plan is attached as Exhibit 1. The Plan consists of the following elements:

i. A process for promptly screening and identifying: (a) those Class members who, because of the acuity and nature of their mental illness, should be transferred from jail to the USH Forensic Unit for Restoration Treatment; (b) those Class members whose mental illness is less severe and should be transferred to an Alternative Therapeutic Unit, as defined below, which may be established by USH; (c) those Class members who may likely be restored to competency in a suitable Offsite Forensic Facility, as defined below, operated by USH or under contract with DHS; (d) those Class members who are likely to be restored to competency through the Outreach Program, as defined below, subject to the limits in paragraphs 25(a) and 26, below; (e) those Class members with intellectual or developmental disabilities who should be directed to the Division of Services for People with Disabilities for Restoration Treatment ("DSPD"); (f) those Class members whose mental

condition has stabilized since initial evaluation, with the result that a further evaluation should be made to determine if these Class members are now competent; and (g) those Class members who are unlikely to be restored to mental competence and should be released from DHS custody so that civil commitment, dismissal of charges, or other resolution can occur.

ii. USH's continued operation and further development of the Outreach Program, as defined below, to screen, treat, assess, and monitor Class members.

iii. USH's development of one or more Offsite Forensic Facilities for Restoration Treatment of Class members for whom such programs are likely to be a suitable means to restore competency.

iv. USH's development of one or more Alternative Therapeutic Units for Restoration Treatment of Class members for whom such programs are likely to be a suitable means to restore competency.

v. Measures to assure that all Class members begin receiving the timely provision of appropriate Restoration Treatment after the state court orders treatment for them.

vi. Measures to increase the efficient use of the USH Forensic Unit so as to maximize its existing capacity.

vii. Measures to manage the anticipated growth in the number of people who are likely to become Class members in years to come.

L. The Court has jurisdiction over the Litigation under 42 U.S.C. §§ 1331 and 1343. The parties agree that venue is proper under 28 U.S.C. § 1391(b)(2). The parties will

jointly submit this Settlement Agreement to the Court for approval, and its terms will not be effective until the Court approves it.

NOW, THEREFORE, in consideration of the mutual promises set forth below, the parties agree as follows:

Definitions

Return 1. "**Alternative Therapeutic Unit** " means any treatment unit established and operated by USH or under contract with DHS for Restoration Treatment on or off of the USH Campus for Class members who, in USH's professional judgment, do not require hospitalization level of care, but are not appropriate for an Offsite Forensic Facility or the Outreach Program.

2. The "**Class**" means all individuals who are now or will in the future be:

   a. Charged with a crime in Utah state courts,

   b. Determined by the court in which they are charged to be mentally incompetent to stand trial,

   c. Ordered or committed by the court to the custody of the DHS executive director or a designee for the purpose of treatment intended to restore the individuals to competency, but who remain incarcerated in a county jail in Utah, and

   d. Waiting to begin Restoration Treatment.

3. "**Custody** or **Commitment Order**" means a written order, issued by a court and signed by a judge, which orders a Class member committed to the custody of the executive director of DHS or a designee for the purpose of treatment intended to restore the defendant to competency, as described in Utah Code Ann. § 77-15-6(1).

Return 4. "**Defendants' Designated Representative**" is Dallas Earnshaw, who has been appointed by Defendants to perform the duties set forth in paragraph 18, below.

5. **"Forensic Evaluator"** means a licensed independent mental health professional qualified to conduct court-ordered mental illness evaluations of adults in the criminal justice system, who is familiar with and complies with the requirements of Utah Code Ann. § 77-15-1 et. seq., and who is not involved in the treatment of the Class member.

6. "**Incompetent to proceed**" has the same meaning as set forth in Utah Code Ann. § 77-15-2.

7. "**Maximum Allowable Wait Time**" means the largest number of days that any Class member is permitted to wait under paragraph 21 to be admitted into Restoration Treatment, as measured from the date on which USH received the Custody Order until the date on which the Class member began receiving Restoration Treatment at USH, at an Alternative Therapeutic Unit, at an Offsite Forensic Facility, through the Outreach Program, or from DSPD. For purposes of this Settlement Agreement, the wait times for class members who are already incarcerated when the Plan is implemented, or September 30, 2017, whichever is later, will be tracked, but the wait times associated with those current Class members will not count towards compliance with the deadlines established in paragraph 21, below.

Return 8. The "**Monitor**" is Patrick K. Fox, M.D., who has been appointed by the Court based on the parties' stipulation to perform the duties set forth in paragraphs 20, 26 and 28 below. Defendants and the Monitor shall promptly negotiate and enter into a retention agreement pursuant to which Defendants shall pay the Monitor a reasonable hourly rate and all necessary expenses incurred in performing those duties, with the exception of the duties set forth

in paragraph 28, as the costs associated with Monitor-led mediation shall be shared by the parties equally.

9. The "**Monitoring Period**" means five (5) years from the date on which the Court approves this Settlement Agreement.

10. "**Offsite Forensic Facility**" means a program of Restoration Treatment administered by USH forensic personnel, or by similarly qualified professionals employed by DHS's contractor, at a location other than the USH Campus. Every Offsite Forensic Facility established by Defendants pursuant to this Settlement Agreement must comply with the requirements of paragraph 24 below.

11. "**Outreach Program**" means USH's program of screening, treating, assessing and monitoring Class members while they remain residents in county jails and are not residents in any Offsite Forensic Facility. Outreach Program professionals will screen Class members for the appropriate level of Restoration Treatment; treat Class members whose screening indicates that they are likely to show meaningful progress towards restoration of competency within 30 days, whose symptoms are stabilizing, and who are likely to be referred for re-evaluation and restored to competency within 60 days; assess Outreach Program patients' progress; and monitor Class members who have been restored to competency, wherever they are located, and assist them in remaining competent to stand trial. Subject to the terms of paragraph 26, below, USH may utilize the Outreach Program as an approved method of Restoration Treatment for a period of one year from the date on which the court approves this Settlement Agreement

12. "**Restoration Treatment**" in this Settlement Agreement means competency restoration treatment provided by USH forensic personnel or by similarly qualified professionals

employed by DHS's contractor, to Class members in an effort to restore them to competency, in accordance with Utah Code Ann. § 77-15-6(1), regardless of location or level of need.

13. "**Status Report**" means the written report issued by the Defendants' Designated Representative on a monthly basis during the Monitoring Period, pursuant to paragraph 18, below.

14. "**USH Forensic Unit**" has the same meaning as set forth in Utah Code Ann. § 62A-15-901.

15. "**Waitlist**" means the list of individuals committed to the custody of the executive director of DHS and waiting in jail for Restoration Treatment.

Objectives, Plan Implementation and Measures of Compliance

16. **Timely Restoration Treatment** – Defendants shall take all necessary steps to meet the objective of providing all Class members with timely and appropriate Restoration Treatment. Pursuant to the screening procedures referenced in paragraph 19, below, and without any unnecessary delay, Defendants shall transport or direct transportation consistent with Utah Code Ann. Sect. 77-15 et seq., of Class members to the appropriate program or location for Restoration Treatment.

17. **Implementation of the Plan** – Subject to the Court's approval of this Settlement Agreement, Defendants shall implement the Plan annexed hereto as Exhibit 1 no later than September 30, 2017, and shall take all steps necessary to diligently follow the Plan during the term of this Settlement Agreement.

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18. **Duties of Defendants' Designated Representative** – No later than the tenth day of the month following the end of every month during the Monitoring Period, the Defendants' Designated Representative shall transmit to the Monitor and DLC a Status Report accurately

reporting the status of all Class members then waiting for Restoration Treatment. Each report must include the following information for each Class member:

a. The Class member's name and criminal case number;

b. The name of the court that entered the Class member's Custody Order;

c. The date of the court's Custody Order;

d. The date USH received the Custody Order;

e. The name of the jail where the Class member is being held;

f. The dates on which the Outreach Program screened the Class member and the results of the screenings, including the current disposition of the Class member for Restoration Treatment;

g. The date on which the Class member began receiving Restoration Treatment and the location of the Class member's Restoration Treatment;

h. The date, if any, on which the Class member was terminated from DHS custody for any reason;

i. The reasons for the Class member's termination from DHS custody, including the name and location of the facility or other setting to which the Class member was transferred, if that information is known to DHS; and,

j. The number of days the Class member has spent on the Waitlist.

The report shall also state: (1) the longest wait time as among all Class members then on the Waitlist; (2) whether the Defendants have complied with the requirements of paragraph 21, below, during the month; and, if applicable, (3) the reasons for Defendants' inability to comply with the requirements of paragraph 21.

Defendants' Designated Representative shall, on request, cooperate with the Monitor in gathering any additional information necessary for the Monitor's reports, which are required in paragraph 20, below.

19. **Screening deadlines and disposition of Class members** –

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a. Within seventy-two (72) hours, excluding weekends and holidays, of DHS's receipt of the Custody Order with respect to a Class member, a qualified USH Forensic Unit professional shall screen the Class member using a screening tool approved by, and subject to modification and replacement as determined appropriate by, Defendant's Designated Representative and the Monitor. On the basis of the screening, the USH Forensic Unit professional shall determine whether the Class member: (i) should be transferred from jail to the USH Forensic Unit for Restoration Treatment due to the acuity and nature of the Class member's mental illness; (ii) should be transferred to an Alternative Therapeutic Unit; (iii) should be transferred to an Offsite Forensic Facility for Restoration Treatment; (iv) subject to the limits in paragraph 26, below, should be treated by the Outreach Program based on the standards set forth in subparagraph 25(a), below; (v) should be directed to DSPD for Restoration Treatment because of the Class member's intellectual or developmental disabilities; (vi) should be reevaluated by a Forensic Evaluator to determine if the Class member is now competent; or (vii) should be released from DHS custody because it is unlikely that Restoration Treatment would be effective.

b. As soon as the foregoing determination is made, Defendants shall take all steps necessary to promptly effectuate the appropriate disposition of the Class member.

c. If the qualified USH Forensic Unit professional determines that the Class member should be directed to DSPD for Restoration Treatment because of the Class member's intellectual or developmental disabilities, USH shall make the referral within 72 hours, excluding weekends and holidays, of the screening determination. DSPD shall make a determination about whether it is the agency best suited to provide Restoration Treatment to the Class member within 72 hours, excluding weekends and holidays, of the referral from USH. If DSPD does not accept the referral, USH shall place the Class member back on the Waitlist consistent with the date of the court's Custody Order and comply with the Maximum Allowable Wait Time deadlines in paragraph 21. The time spent towards the Class member's referral and assessment will not count in computing the Maximum Allowable Wait Time.

d. If the qualified USH Forensic Unit professional determines that the Class member should be reevaluated by a Forensic Evaluator to determine if the Class member is now competent, a referral to a Forensic Evaluator shall be made within 72 hours, excluding weekends and holidays, of the determination. If the reevaluation cannot be conducted within 72 hours, excluding weekends and holidays, of the referral, or if the Forensic Evaluator recommends that the Class member is still not competent to

proceed but there is a substantial likelihood that the Class member can be restored to competency in the foreseeable future, USH shall continue administering competency restoration services appropriate for the patient's level of need and shall have complied with the Maximum Allowable Wait Time deadlines in paragraph 21. The time spent towards the Class member's referral and assessment will not count in computing the Maximum Allowable Wait Time.

e. If, at any time, the qualified USH Forensic Unit professional identifies an emergent mental health need, the Defendant's Designated Representative shall expeditiously report the circumstances to DLC and the Monitor, describe any action taken by USH, and keep DLC and the Monitor apprised of any subsequent disposition of the Class member.

Return 20. **Monitor's quarterly reports** – No later than the fifteenth day of the month after the end of each calendar quarter during the Monitoring Period, the Monitor shall report in writing to the Defendants and DLC on Defendants' progress during the preceding quarter in implementing each specific provision of the Plan and in complying with each specific term of this Settlement Agreement.

Return 21. **Deadlines for reduction in Maximum Allowable Wait Time –**

a. By March 31, 2018, Defendants shall reduce the Maximum Allowable Wait Time to sixty (60) days.

b. By September 30, 2018, Defendants shall reduce the Maximum Allowable Wait Time to thirty (30) days.

c. By March 31, 2019, Defendants shall reduce the Maximum Allowable Wait Time to fourteen (14) days.

22. **Modification to the Plan** – If Defendants believe that to achieve compliance with the screening deadlines in paragraph 19 or the Maximum Allowable Wait Time deadlines in paragraph 21, above, they will require a modification of the Plan, the Defendants' Designated Representative shall provide the Monitor and DLC with a detailed written explanation of the necessary modification. If DLC objects to any proposed Plan modification, it will notify Defendants' Designated Representative of the objection in writing within fourteen (14) days of its receipt of the notice of modification. DLC and Defendants' Designated Representative shall thereafter confer in good faith to resolve their differences. If they are unable to resolve their differences in this manner, the parties will submit their differences to the Monitor for possible dispute resolution. If they are unable to resolve their differences in consultation with the Monitor, the Monitor will make a written report and recommendation to the parties. If, after conferring with the Monitor, the parties still disagree as to the proposed modification of the Plan, either party may move the Court for relief, along with the Monitor's report and recommendation. In the absence of DLC's consent, Defendants shall not implement proposed changes to the Plan sooner than sixty (60) days following the issuance of the Defendants' Designated Representative's written notice required in this paragraph.

23. **Suspension of deadlines because of special circumstances –** Defendants' ability to perform their obligations under this Settlement Agreement in a timely manner may depend on special circumstances beyond their control. Subject to the following terms and conditions, the deadline in paragraph 19(a) (hereinafter the "Screening Deadline") and the deadlines in

paragraph 21 (hereinafter the "Maximum Allowable Wait Time Deadlines") may be suspended with respect to one or more Class members:

a. The Screening Deadline or the Maximum Allowable Wait Time Deadlines relating to an individual Class member may be temporarily suspended if Defendants conclude that they cannot meet the relevant deadlines because of factors beyond Defendants' control, including (but not limited to): orders of a court that will delay Defendants' performance; motions filed on behalf of the Class member that will delay Defendants' performance; a jail's failure or refusal to clear the Class member for admission to one of Defendants' facilities; a jail's failure or refusal to allow Outreach Program staff access in order to carry out its responsibilities with respect to a Class member; or medical conditions that prevent a Class member's admission to USH. Circumstances in this category shall be referred to as "Individual Special Circumstances."

b. The Screening Deadline or the Maximum Allowable Wait Time Deadlines relating to a group of Class members may be temporarily suspended if Defendants conclude that they cannot meet the relevant deadline because of factors beyond their control, including (but not limited to) a national or local disaster impacting admissions to one or more of Defendants' facilities, a labor action that substantially impedes the continued operation of a facility, or an extraordinary and unanticipated increase in the number of court-ordered competency restoration referrals. Circumstances in this category shall be referred to as "Departmental Special Circumstances."

The failure or refusal of the Utah Legislature to adequately fund Defendants' operations, programs, or the Plan shall not be considered a Departmental Special Circumstance for purposes of this Settlement Agreement.

c. If, at any time during the term of this Settlement Agreement, Defendants conclude they must suspend either the Screening Deadline or the Maximum Allowable Wait Time Deadlines on account of either an Individual Special Circumstance or a Departmental Special Circumstance, the Defendants' Designated Representative shall immediately give DLC and the Monitor written notice thereof. The notice shall state the nature of the special circumstance (that is, whether an Individual or Departmental Special Circumstance), names of all of Class members who will be affected by the proposed suspension, and all of the facts constituting the special circumstance. The notice shall also state which specific deadlines must be suspended and for what specific period.

d. Any suspension proposed in the notice shall begin on the date on which the notice is received by DLC and the Monitor and shall terminate at the end of the temporary period of suspension, as set forth in the notice, unless modified in accordance with subparagraphs f or g, below.

e. No suspension of any deadline shall last longer than is justified by the special circumstance identified in the notice.

f. If either DLC or the Monitor objects to the suspension, or the scope or duration of the suspension, DLC or the Monitor may notify Defendants'

Designated Representative of the objection in writing, and the parties shall promptly confer with each other in good faith to resolve the issue.

g. If the parties are unable to resolve the issue after the consultation required by subparagraph f above, they will submit the matter to the Monitor for mediation. In the absence of an emergency requiring immediate relief, none of the parties shall be entitled to file a motion in the Litigation to enforce this Settlement Agreement based upon the suspension until the expiration of thirty (30) days from the date on which the party notifies the other parties of the alleged violation based upon the suspension and efforts to resolve the situation, including Monitor-led mediation, have been exhausted. The parties shall equally share the costs of Monitor-led mediation.

Return 24. **Offsite Forensic Facility requirements** – As part of the Plan, Defendants are hereby authorized to develop and implement one or more Offsite Forensic Facilities consistent with the following principles:

Return a. Each Offsite Forensic Facility shall be a treatment program located in space that is suitable for Restoration Treatment. If the space is located in or leased from a county jail, the space and the residents shall be segregated from the jail's general inmate population.

b. Each Offsite Forensic Facility shall be operated by a multi-disciplinary treatment team consisting of full-time forensic professionals, employed by DHS or by a suitable contractor, of a number that is sufficient to provide those Class members transferred to the Offsite Forensic Facility with

Restoration Treatment. A sufficient number of staff members shall remain on-site during operational hours. Each Offsite Forensic Facility shall meet the best practices of professional and clinical standards governing the operation of, and delivery of, Restoration Treatment services at the USH Forensic Unit.

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c. Defendants shall establish and operate one or more Offsite Forensic Facilities with sufficient capacity to meet, in combination with other improvements, the Maximum Allowable Wait Time deadlines in paragraph 21.

d. The initial Offsite Forensic Facility should preferably be located in the Salt Lake County Metro Jail, in space previously inspected and approved by the representatives of the parties. The parties affirmatively represent that they are not presently aware of any deficiencies in the management or operation of the Salt Lake County Metro Jail that would preclude, impede, or otherwise interfere with Defendants' ability to establish and operate an Offsite Forensic Facility at the Salt Lake County Metro Jail, or that would preclude, impede, or otherwise interfere with Class members' ability to receive reasonable and adequate medical and mental health care and services while they are housed in the Offsite Forensic Facility at the Salt Lake County Metro Jail.

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e. Defendants will carefully evaluate and, if needed, seek additional funding for a comparable facility for Class members who are women.

Return 25. **Outreach Program duties** – Subject to the limits of paragraph 26, below, Outreach Program professionals shall conduct timely screening of Class members in accordance with paragraph 19 above and shall:

Return a. Treat Class members who, in the professional's judgment, are likely to show meaningful progress towards restoration of competency within 30 days, whose symptoms are stabilizing, and who are likely to be referred for re-evaluation and restored to competency within 60 days. Class members in the Outreach Program shall be re-assessed by Outreach Program professionals every two weeks to determine progress toward competency. Following 30 days of Restoration Treatment in the Outreach Program, Outreach Program professionals will re-assess each Class member to determine if the Outreach Program remains the most clinically appropriate and effective level of care. A Class member will be disqualified from Restoration Treatment in the Outreach Program if he or she exhibits repeated suicidal ideations with intent to harm, engages in repeated acts of self-harm, persistently refuses medications necessary for competency restoration with no rational basis, exhibits a significant decline in clinical stability, or is diagnosed with a moderate to severe intellectual or developmental disability. If the Outreach Program professional determines at screening that a Class member should be disqualified from consideration for Restoration Treatment in the Outreach Program, the Class member must be transferred to USH, an Offsite Forensic Facility, or an Alternative Therapeutic Unit within seventy-two (72) hours, excluding weekends and holidays. Similarly, if the Outreach Program professional determines that the Outreach Program is no longer

clinically appropriate or effective for a Class member, the Class member must be transferred to USH, an Offsite Forensic Facility, or an Alternative Therapeutic Unit within seventy-two (72) hours, excluding weekends and holidays, or referred to DSPD if appropriate;

b. Facilitate the prompt reevaluation of Class members by a Forensic Evaluator, if justified;

c. Monitor former Class members as clinically necessary who have been restored to competency and who await trial, to assist them in maintaining their competency until trial.

Return

26. **Determination of the Outreach Program's effectiveness** – The Outreach Program may be utilized by USH as an approved alternative method of Restoration Treatment under this Settlement Agreement for a period of one year from September 30, 2017. During this one-year period, the Monitor will gather and analyze information about the Outreach Program's effectiveness in providing Restoration Treatment to Class members, including the number of patients who are restored or are not restored within 60 days, together with any other factors the Monitor deems relevant. By the end of the one-year period, the Monitor will advise the parties either: (a) that the Outreach Program is effective as a method of Restoration Treatment, in which event the Outreach Program will become a permanent treatment option under this Settlement Agreement; or (b) that it is not effective, in which event its use as a treatment option under this Settlement Agreement will be promptly terminated unless the Monitor prescribes additional steps to improve the Outreach Program's efficacy and USH complies with and implements those steps.

Approval by the Court and Enforcement

Return 27. **Court approval and stay of the Litigation –** The parties will jointly move the Court in the Litigation for an order approving this Settlement Agreement and staying all proceedings in the Litigation pending successful implementation of the Plan and compliance with the terms hereof. This Settlement Agreement shall become effective upon the Court's issuance of an order approving it. The parties agree that the Court retains continuing jurisdiction over the Litigation to enforce the terms of this Settlement Agreement for five (5) years from the date on which the Court issues an order approving its terms. Subject to the requirements of paragraph 28 below, any party may move the Court for an order to enforce the Settlement Agreement and/or to lift the stay on the Litigation. Upon the expiration of the term of this Settlement Agreement, any party may move for dismissal with prejudice of all claims in the Litigation. If, at the end of the term, no party moves for dismissal, the Court shall enter an order to show cause why all claims should not be dismissed with prejudice.

Return 28. **Enforcement** – If any party concludes that another party has violated any material provision of this Settlement Agreement, the party will notify the Monitor and other parties, including Defendants' Designated Representative, of the alleged violation in writing. Thereafter the parties will promptly attempt to resolve the alleged violation by conferring with each other in good faith to resolve the issue. If the parties are unable to resolve the alleged violation, they will submit the matter to the Monitor for mediation. In the absence of an emergency requiring immediate relief, none of the parties shall be entitled to file a motion to enforce any provision of this Settlement Agreement until the expiration of thirty (30) days from the date on which the party notifies the other parties in writing of the alleged violation and

efforts to resolve the violation, including Monitor-led mediation, have been exhausted. The parties shall equally share the costs of Monitor-led mediation.

29. **Attorney fees and costs regarding enforcement –** Subject to the limitations contained in paragraph 28, any party that obtains an order of the Court enforcing a provision of this Settlement Agreement shall be entitled to an award of its reasonable attorney fees and costs incurred.

General Provisions

Return 30. **Term** – The term of this Settlement Agreement shall be five (5) years from the date on which the Court issues an order approving its terms.

31. **Persons bound** – This Settlement Agreement shall be binding on all Defendants and their successors, together with their officers, agents and employees, unless otherwise prohibited by state or federal law.

32. **Integration** – This Settlement Agreement constitutes the entire agreement among the parties on the matters raised herein, and no other statement, promise, or agreement, either written or oral, made by any party or agent of any party, shall be enforceable.

33. **Scope** – This Settlement Agreement is not intended to resolve any actual or potential violation of the rights of pretrial detainees other than those specifically addressed in the Litigation.

34. **Authority of signatories** – The persons signing this Settlement Agreement represent that they have the authority to do so.

35. **Representations and warranties** – Each party to this Settlement Agreement represents, warrants, and agrees as to itself as follows:

a. It has fully and carefully reviewed this Settlement Agreement prior to its execution by an authorized signatory.

b. It has consulted with its attorneys regarding the legal effect and meaning of this Settlement Agreement and all terms and conditions hereof, and that it is fully aware of the contents of this Settlement Agreement and its legal effect.

c. It has had the opportunity to make whatever investigation or inquiry it deems necessary or appropriate in connection with the subject matter of this Settlement Agreement.

d. It has not heretofore assigned or transferred, or purported to assign or transfer, to any person or entity any claims that it might have against the other.

e. It is executing this Settlement Agreement voluntarily and free from any undue influence, coercion, duress, or fraud of any kind.

36. **Waiver** – No waiver of any of the provisions of this Settlement Agreement shall be deemed or constitute a waiver of any other provision, whether or not similar, nor shall any waiver constitute a continuing waiver. No waiver shall be binding unless executed in writing by the party making the waiver.

37. **Counterparts** – This Settlement Agreement may be executed in identical counterparts, each of which for all purposes is deemed an original, and all of which constitute collectively one agreement. The parties intend that faxed signatures and electronically-imaged signatures such as PDF files shall constitute original signatures and are binding on all parties. An executed counterpart signature page delivered by facsimile or by electronic mail shall have

the same binding effect as an original signature page. This Settlement Agreement shall not be binding until all parties have signed and delivered a counterpart of this Settlement Agreement whether by mail, facsimile, or electronic mail.

38. **Modification** – Settlement Agreement may be modified if the parties are in agreement. Any modification to this Settlement Agreement shall be in writing.

39. **Attorney Fees** – Subject to the provisions in paragraph 29, above, each party shall bear his, her or their own attorney fees and costs of court incurred in the matter to the effective date of this Settlement Agreement.

40. **Notices** – Any notice or other communication required or permitted under this Settlement Agreement shall be in writing and shall be deemed to have been duly given when (a) mailed by United States registered or certified mail, return receipt requested, (b) mailed overnight express mail or other nationally recognized overnight or same-day delivery service, (c) sent as PDF attachment to electronic mail, or (d) delivered in person, to the parties at the following addresses:

If the Disability Center, to:

DISABILITY LAW CENTER
205 North 400 West
Salt Lake City, Utah 84103

Attention: Aaron M. Kinikini
Erin B. Sullivan
Email: akinikini@disabilitylawcenter.org
esullivan@disabilitylawcenter.org

With a copy to:

Alan L. Sullivan
Bret R. Evans
SNELL & WILMER L.L.P.
15 West South Temple, Suite 1200 Gateway Tower West
Salt Lake City, Utah 84101

Email: asullivan@swlaw.com
brevans@swlaw.com

If the Department, to:

DEPARTMENT OF HUMAN SERVICES
195 N. 1950 West, 4th Floor
Salt Lake City, Utah 84116

Attention: Ann Williamson
Lana Stohl

Email: annwilliamson@utah.gov
lstohl@utah.gov

If the Division, to:

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH
195 North 1950 West, 2nd Floor
Salt Lake City, Utah 84116

Attention: Douglas Thomas
Email: dothomas@utah.gov

If the State Hospital, to:

UTAH STATE HOSPITAL
1300 Center Street
Prove, Utah 84603

Attention: Dallas Earnshaw
Email: dearnshaw@utah.gov

With a copy to:

OFFICE OF THE UTAH ATTORNEY GENERAL
Parker Douglas (8924)
Laura Thompson (6328)
David Wolf (6688)
160 East 300 South, Sixth Floor
Salt Lake City, Utah 84114-0856

Email: pdouglas@agutah.gov
lathomps@utah.gov

dnwolf@agutah.gov

A party may change the names or address where notice is to be given by providing notice to the other parties of such change in accordance with this paragraph 40.

DATED this 9th day of June, 2017 on behalf of Plaintiffs:

ALAN L. SULLIVAN (3152)
Attorney for Plaintiffs

AARON M. KINIKINI (10225)
Attorney for Disability Law Center

DATED this 9th day of June, 2017 on behalf of Defendants:

LAURA THOMPSON
Utah Assistant Attorney General

ANN S. WILLIAMSON
Executive Director, Utah Department of Human Services

EXHIBIT
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A Strategic Plan for Providing Utah Adult Mental Health Competency Restoration Services

Revised June 9, 2017

INTRODUCTION

The State of Utah provides competency restoration services to individuals court-ordered to the Department of Human Services (DHS) as Not Competent to Proceed (NCP) under Utah Code Ann. §§. 77-15-1 *et. seq*. This plan outlines the process for how these services are delivered and contains information regarding the clinical programs provided. Utah's system of competency restoration services is based on best practices and successful endeavors in Utah and other states. Utah is addressing the increased demand for forensic services by building capacity and programs that are clinically appropriate and cost effective. A best practice model is in the developmental stages nationally. The traditional inpatient approach is no longer viewed as the sole recommended model of care, as evidenced by the fact that at least 10 states now have some form of competency restoration treatment that is conducted in a jail or adapted setting. Utah's model of care includes outpatient treatment; treatment at an offsite forensic facility; treatment at alternative therapeutic units; and inpatient competency restoration treatment programs. This comprehensive system of care includes vital components for processing court orders, assigning court-ordered evaluations to forensic examiners, screening individuals found NCP for appropriate program placement, treatment plan development, clinical and educational competency restoration services, evaluating clinical progress, tracking outcomes data, and discharge planning. Ongoing communication and collaboration with the courts, correctional facilities, and attorneys is vital to operational efficiency.

COMPETENCY RESTORATION OVERVIEW

Historically, competency restoration services have been provided at the Utah State Hospital's (USH) forensic inpatient unit. Over the past 30 years, the demand for forensic services in Utah and nationwide has experienced exponential growth, creating a strain on existing resources. Some of the circumstances that have contributed to this growth in Utah include an increase in 1) the number of competency petitions filed; 2) the number of people found NCP by the courts and referred to DHS; and 3) the acuity level of patients entering the system. Some states have converted non-forensic inpatient beds into forensic beds to respond to the increased demand. In many states, competency restoration services are being provided in non-inpatient settings allowing provision for a more efficient and appropriate level of care for those individuals not needing an inpatient level of competency restoration services. According to a report by the Washington State Institute for Public Policy (*Standardizing Protocols for Treatment to Restore Competency to Stand Trial: Interventions and Clinically Appropriate Time Periods*, January 2013), there are five treatment modalities in the literature to address the competency restoration needs of those found NCP that include:

(1) Medications;
(2) Treatment for individuals with developmental disabilities;
(3) Educational treatment programs;

(4) Specialized/individual treatment programs; and
(5) Cognitive remediation programs.

The study also describes incompetence as predicated on two components that are typically addressed in treatment: (1) a mental disorder or cognitive impairment and (2) a deficit in one or more competence-related abilities (i.e., understanding, appreciation, reasoning, assisting counsel) that occur as a result of the mental disorder or cognitive impairment. Improvement in the underlying mental disorder or cognitive impairment often results in the improvement in competence-related deficits. This forms the basis for psychotropic medications being one of the primary treatment modalities in competency restoration treatment. In addition, the use of educational approaches to increase the patient's factual understanding of the legal proceedings and to assist in participating with their defense counsel is beneficial.

The Washington State Institute for Public Policy report revealed limited success in competency restoration outcomes for individuals with intellectual and/or developmental disabilities. Most programs that have been studied demonstrate a 33 percent average competency restoration rate for individuals with intellectual disabilities compared to a 70 percent average for those with mental illness. The "Slater Method" is a competency restoration tool that is typically used to treat individuals with intellectual disabilities. Length of time to restoration is longer for people with intellectual disabilities than the time to restoration for people without intellectual disabilities. It has been DHS' experience that most individuals who require specialized services for intellectual disabilities do better when treated under the supervision of state agencies designed to treat the unique needs of this population. Utah identifies these individuals when referred to DHS and makes every effort to direct their competency restoration treatment to the Division of Services for People with Disabilities (DSPD).

Most research demonstrates that individuals who participate in education groups have a significantly higher rate of restoration than those who do not. Many states across the country have implemented education programs that are of varying structure and delivery styles. Yet, the basic components are similar. Programs in the North Coast Behavioral Healthcare System in Ohio; the Alton Mental Health and Development Center in Illinois; the Atascadero Hospital in California; the RISE program in Denver, Colorado; as well as others, include treatment modalities such as: educational groups; experiential modules, such as mock trials; medication management; and cognitive remediation. These best practice principles are incorporated into Utah's restoration program development. Another well recognized program used to inform Utah's model of care is the 'Comp-Kit' restoration program developed and implemented in 2006 by Florida's mental health forensic system.

Even though the literature is limited and does not specifically identify one national best practice model for competency restoration, current programs have similar components and outcomes. The National Judicial College in Reno, Nevada assembled a panel of experts to develop a Mental Competency Best Practice Program. Though the main tenet of their recommended approach is similar as that described above, it is recommended that clinicians assess the individual's need for competency restoration and tailor the program individually rather than placing all individuals into the same curriculum and treatment modalities.

SUMMARY of ESSENTIAL RESTORATION SYSTEM ELEMENTS:

1. Court-ordered competency restoration process
2. Court referral monitoring system
3. Initial treatment screening to determine appropriate level of service delivery
4. Initial mental health evaluation
5. Identification of barriers to competency restoration
6. Development of an individualized treatment plan
7. Engagement of treatment modalities
8. Ongoing progress towards competency assessments
9. Documentation of interventions and response to interventions
10. Re-evaluation of competency
11. Court Referral and reporting process

STRATEGIC ACTION PLAN

In order to ensure the State of Utah has adequate resources available to provide competency restoration services to individuals who have been court-ordered to DHS, it is imperative that a

strategic action plan be developed, implemented, and have ongoing evaluation to assure timely provision of treatment services.

A wider array of stakeholders must be engaged to more fully address the competency restoration needs of the citizens of Utah. Successful implementation of a strategic plan requires co-operation, communication and collaboration with a variety of stakeholders and participants involved in the competency restoration process, including, but not limited to: the district courts; referring county and municipal courts; prosecutors; the defense bar; the counties/Local Mental Health Authorities (LMHAs); local sheriffs' offices and jails; law enforcement; and the Utah Legislature.

Outcomes used to assist in this determination will include service access wait times, restoration rates, and length of time for restoration. Each service delivery option will be evaluated for efficiencies and appropriate patient placements.

Each year, DHS, in collaboration with other state leaders, will review these outcomes and make proposals when increased resources are necessary. Options may include: additional offsite forensic facilities; alternative therapeutic units located on or off the USH campus; additional beds at USH; and addressing timely and appropriate competency restoration treatment for women in a clinically appropriate setting. Counties are encouraged to consider pre-evaluation processes to facilitate access to mental health services for individuals with serious mental illness, prior to, or upon entering the criminal justice system, and redirect individuals from entering the forensic system when community services are more appropriate.

1. Purposes and Implementation of the Strategic Plan

The purposes of this strategic plan are as follows:

(a) Outline the specific steps to be taken to reduce the period of time during which patients committed to DHS must wait to receive competency restoration treatment;

(b) Comply with the timeframes established in the Settlement Agreement approved by the Court in the matter of *Disability Law Center, et. al. v. State of Utah, Department of Human Services, et. al., Case No. 2:15-cv-00645-RJS-BCW.*

(c) Implement a series of indicators that will measure the quality and efficiency of competency restoration treatment for patients committed to DHS for competency restoration treatment; and

(d) Monitor and adjust resource investment and allocation to achieve the purposes of the strategic plan.

The implementation of this strategic plan is to be contemporaneous with the establishment of the first offsite forensic facility proposed at the Salt Lake County Metro Jail, or September 30, 2017, whichever occurs later.

2. Service Delivery Options

Like many other states, Utah has recognized the need for additional cost-effective and clinically appropriate services to meet the demand for forensic services. In 2014, USH, in collaboration with the Division of Substance Abuse and Mental Health (DSAMH) and DHS, recommended four levels of treatment services that are appropriate for competency restoration. This was presented in response to a 2014 legislative audit. They are listed in order from the least to highest associated clinical need:

a) Outreach Program: Providing competency restoration treatment to patients:
   i. on release from the court in the community;
   ii. in jail within their home community; or
   iii. in prison.

b) Offsite Forensic Facility: Providing competency restoration treatment to patients in a specialized, structured competency restoration program within a jail or other secure setting.

c) Alternative Therapeutic Unit: Providing competency restoration treatment in any treatment unit established and operated by USH or under contract with DHS on or off of the USH campus for patients who do not require hospitalization level of care.

d) Inpatient Forensic Beds at USH: There is capacity but not infrastructure for expansion of inpatient hospital beds at the USH campus.

Not all patients referred to DHS for competency restoration treatment require hospital inpatient level of care and its associated interventions. Screening processes are designed to identify persons found NCP who can, within a reasonable timeframe, be restored to competence in the least restrictive, clinically appropriate environment and without requiring admission to an inpatient setting.

There are identifiable advantages to offering outpatient competency restoration services to individuals with lower psychiatric acuity levels including:

a) Decreased incarceration time
b) Decreased transportation costs
c) Improved supports to assist in treatment within their local communities
d) Enhanced access to community mental health treatments
e) Facilitated access into ongoing outpatient treatment support systems
f) Ongoing access to defense counsel, family, and other supports
g) Reduced stigma associated with psychiatric hospitalization.

If a patient is placed in any program or level of service based on screening criteria and later is determined to either be progressing faster or not progressing as expected to meet the required time frames, the patient will be transferred to the more appropriate level of care based on their clinical status.

3. Offsite Forensic Facilities

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(a) DHS is currently planning an offsite forensic facility with day competency restoration treatment in a county jail. This is a five days per week, eight hours per day program to provide competency restoration treatment to patients who need a structured environment, similar to a mental health unit, but do not need the services of an inpatient psychiatric hospital. Patients will be identified according to their acuity, and treatment will be individualized accordingly.

(b) Based on the success of this initial program and in the assessment of future program needs, DHS may request funding for additional offsite forensic facilities (including, but not limited to, a female only offsite forensic facility) to meet the needs of the population. DHS will determine funding and staffing patterns following a review of the current program outcomes and inflationary costs. If DHS determines that there is a greater number of patients needing inpatient care, DHS will request funding for additional beds at USH or another appropriate alternative therapeutic unit. This funding request would be similar to the funding at that time for one USH forensic unit (current cost is approximately $4.5 million dollars). Staffing levels would be similar to a current forensic unit based on this budget information.

(c) In 2017, the first offsite forensic program will be developed in partnership with Salt Lake County due to its Metro Jail's central geographic location and the large number of competency restoration referrals that arise from Salt Lake County. This program has an annual operating budget of approximately $3 million. Funding will be available by July 1, 2017. DHS will begin to develop and coordinate operational procedures, recruitment and implementation of the program as soon as funding is assured through the legislative process. It is intended that actual program implementation will begin no later than September 30, 2017.

In developing contracts for offsite forensic facilities, provisions will be included that address training for the correctional personnel including but not limited to: Crisis Intervention Team (CIT) training and training from the USH Psychiatric Technician training modules. The jail will provide 24-hour emergency psychiatric and emergency medical care of patients when forensic staff are not on site and forensic programming is not being conducted. Subject to the terms of the contract(s) for each offsite forensic facility and available funding, the anticipated staffing and training of the offsite forensic facility will be commensurate with their counterparts at the USH. Patient programming and staffing levels at each offsite forensic facility will be guided by a Program Manual that will soon be developed, subject to modification by the USH Forensic Director, based upon the physical environs of the facility, availability of security staff, and other contract provisions to be determined once each offsite forensic facility is identified.

4. Outreach Program Services

Since 2015, the Utah Legislature has recognized the value of DHS' Outreach Program whereby clinicians provide competency restoration treatment to patients by conducting weekly visits to

those who are: (1) released to the community by the court; (2) housed in their home community jail; or (3) in prison. These services are provided to patients whose screening indicates that they are likely to show meaningful progress towards restoration of competency within 30 days, whose symptoms are stabilizing, and who are likely to be referred for re-evaluation and restored to competency within sixty (60) days.

Some Outreach Program patients will remain in their own county based on the following factors: (a) closeness to family and other supports; (b) desire to stay in the area; (c) upcoming hearing and efficiency in time by not transporting to another area; (d) closeness to legal representation; (e) significant progress with current situation; or (f) gender as the offsite forensic facility programming is male only at this time.

5. **Projecting Future Needs**

(a) USH has projected that the annual number of pretrial detainees in Utah's county jails for which custody or commitment orders will have been issued will continue to increase. If the number of court-ordered pretrial detainees does not increase, USH will continue to monitor trends each year to revise projections.

(b) USH believes that, depending on system changes including the addition of new levels of care and program efficiencies decreasing length of stay in all programs and facilities, it may need additional competency restoration Outreach Program professionals who provide screening, assessment, and treatment services. This will be closely monitored and evaluated based on length of time to access these services and the length of stay in these services in the context of the entire system.

(c) USH believes that, depending on system changes including the addition of new levels of care and program efficiencies decreasing length of stay in all programs and facilities, it may need additional forensic evaluators who are employed to conduct evaluations for the Outreach Program if projections are accurate. This will be closely monitored and evaluated based on length of time to access these services and the length of stay in the Outreach Program in the context of the entire system.

(d) USH will annually evaluate the state's ability to meet the respective service level need and projected number of patients requiring competency restoration treatment, and request additional funding to adequately provide services to all those court-ordered to DHS for purposes of competency restoration treatment. The amount to be requested will be determined by the level of service required to meet the acuity needs of those committed to DHS, taking into consideration the outcomes of each program in meeting the timeframes for competency restoration in the Settlement Agreement and relevant statutes, inflationary costs, and other factors.

6. Expansion of USH Forensic Unit

In addition to the establishment of the offsite forensic facilities referenced in paragraph 3 of this strategic plan, the State projects that, depending on system changes including the addition of new levels of care and program efficiencies decreasing length of stay in all programs and facilities, there may be further need for increased inpatient treatment capacity. The current capacity of the USH forensic unit is 100 patients for all forensic commitments required by law, including NCP, guilty and mentally ill, and not guilty by reason of insanity. The current USH forensic unit was designed to expand by being able to add additional 25-bed units to the existing structure to a capacity of 200 beds. Based on the number of future court referrals and timeframes for competency restoration services, the State may need to request additional funding for the construction or procurement of another facility on or off the USH campus. This will be closely monitored and evaluated based on length of time to access inpatient services and the length of stay in the context of the entire system.

7. Post-Treatment Follow-up

DSAMH/USH will continue to evaluate the most efficient and cost-effective programs and interventions to assist pretrial detainees in maintaining their competency. USH staff will work with counties and provide case management to help monitor and support the patient in their restoration status and facilitate continuity of care.

8. Efficiency Improvements

Outcomes reflect operational efficiencies and clinical effectiveness. Utah's adult mental health competency restoration outcomes will be monitored monthly and evaluated on a quarterly basis at which time changes will be considered to strengthen the results. Adjustments in screening, assessment, treatment, monitoring, program placements, and delivery of services will be made where deficiencies are identified. Outcome indicators are as follows:

1. Length of time from court-ordered referral to treatment program admission;
2. Length of stay in any of USH's competency restoration treatment programs;
3. Percent of court-ordered referrals screened in a timely manner (*i.e.*, within seventy-two (72) hours, excluding weekends and holidays, of DHS's receipt of the district court order for competency restoration treatment);
4. Percent of patients screened into the Outreach Program who are restored or not restored within 60 days; and
5. Percent of patients treated within USH's forensic system who are found competent to proceed.

Targets are identified and adjusted based on best practice standards, baseline measurements and agreements made during system monitoring. Monitoring systems and outcome measures are utilized to ensure individuals within each level of service have been properly placed into programming and changes in status result in reassessment of

the patient. Monitoring also ensures that patients in each level of care are not "lost in the system." LOS and competency status data will receive ongoing utilization reviews to flag those patients who may not be responding appropriately as expected in each level of care. Nationally, outpatient and jail-based programs have shorter LOS than inpatient programs.

Ongoing utilization review means that treating clinicians are reassessing the appropriateness of the current treatment program for the patient with each treatment encounter, and making a determination about program placement or movement at the earliest and most appropriate time.

If at any time it is determined a patient is not progressing in treatment, USH will reassess for the appropriate level of service.

9. Forensic Evaluation System (FES)

When a district court judge orders a competency evaluation, the order should be entered into DHS' Forensic Evaluation System (FES), which is automated to coordinate with state examiners contracted to complete ordered evaluations. Some counties or courts may elect to assign evaluators independent of the FES. Regardless, all orders and evaluations are monitored in the FES. The examiners provide an initial report to the court and parties within 30 days of receipt of the court's order. The examiner may inform the court in writing that additional time is needed to complete the report. The examiner shall have up to an additional 30 days to provide the report if requested in writing. The examiner shall provide the report within 60 days from the receipt of the court's order unless, for good cause shown, the court authorizes an additional period of time to complete the report. If after reviewing the forensic evaluation the judge determines an individual is NCP, the court should send the order for competency restoration to DHS via email into the FES. USH and DSAMH monitor the FES to ensure that all components of the service delivery system are addressed and correspondence with the court and the parties is done in a timely manner under the current statutory scheme. Discovery and other documents and outcome data are also tracked through the FES.

10. Utah Competency Restoration Service Delivery System (See Flow Chart)

The district court should send orders for competency restoration to the USH Legal Service Office, which manages the FES system. Information regarding referrals and evaluations is managed in the FES. All patients ordered to DHS for competency restoration are screened to determine the appropriate level of care needed.

A. Screening Process

Within seventy-two (72) hours, excluding weekends and holidays, of receiving the court order, USH forensic staff shall determine which level of service is appropriate for the patient using a screening tool approved by the USH Forensic Director. The screening process utilizes best practice evaluation tools to determine whether:

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1. A patient is likely to be restored to competency through treatment available by the Outreach Program;
2. A patient is likely to be restored to competency through treatment available at an offsite forensic facility;
3. A patient needs inpatient hospital services at the USH forensic unit;
4. A patient is likely not restorable;
5. A patient requires referral to DSPD services; or
6. A patient has other dispositional needs, such as a nursing home placement.

The Initial Competency Restoration Screening tool to be used in the screening process is attached as Appendix A. The screening process may undergo further development and refinement, to include specific scoring guidelines for patient level of service.

Note: Female patients who have been found not competent to proceed will be referred to either the Outreach Program or USH unless and until another program is identified to meet the needs of females who would otherwise be screened to an offsite forensic facility, including, but not limited to, the establishment of a female only offsite forensic facility program.

B. Screening Criteria

The following represents general criteria used by USH Forensic Unit professionals to determine level of service needed:

a. Patient's attitude towards and consent to take medication;
b. Patient's response to medication treatment;
c. Level of risk (i.e., suicide, self-harm, harm to others, etc.);
d. Physical health/medical concerns;
e. Current progress towards competence; and
f. Patient's willingness to engage in treatment.

If an individual is placed in the Outreach Program, competency restoration treatment begins within 14 days of receiving the court order requiring such treatment, though Outreach Program clinicians strive to begin treatment services within 7 days or less of receiving the court order. Part of that treatment is the engagement of jail personnel to provide medication management services if such services are not already in place for patients in their home community jails. If the patient is screened for treatment in an offsite forensic facility or referred to USH's forensic unit, the patient is transferred into the first open bed within 14 days of receiving the court order requiring such treatment.

C. Treatment Disposition

If a patient is determined to be a candidate for the Outreach Program, an offsite forensic facility, an alternative therapeutic unit, or USH's forensic unit, an individualized treatment plan (ITP) is established.

If, at any time, a USH Forensic Unit professional determines that a patient is likely not restorable, the USH administrator will request a re-evaluation from a forensic evaluator. The forensic evaluator conducts the evaluation and a report is sent to the court for further disposition.

If, at any time, a USH Forensic Unit professional determines that a patient is not likely to restore to competency through the Outreach Program, at an offsite forensic facility, or at an alternative therapeutic unit, then coordination is made with the USH staff for admission to inpatient level of care at USH. The USH Forensic Outreach Competency Progress Assessment tool is attached as Appendix B.

If it is determined that a patient may meet the criteria for an intellectual disability, a referral is made within seventy-two (72) hours, excluding weekends and holidays, to DSPD for competency restoration services. If DSPD does not accept the referral, the patient is screened for USH treatment services and all timeframes apply.

If a patient is determined at any time throughout the screening or treatment process to meet the criteria to be found competent to proceed, the USH administrator will request a re-evaluation from a forensic evaluator. The forensic evaluator conducts the evaluation and a report is sent to the court for further disposition.

D. Treatment Services

The program administrators at each level of service coordinate with the treating staff and other agencies involved in the custody or care of the patient to develop an ITP and identify necessary treatment modalities. Types of competency restoration interventions may include, but are not limited to, individual instruction; individual therapy; group therapy; educational or psychoeducational materials; assignments; recreational therapy; occupational therapy; and medication management. Treatment staff may also coordinate services with jail treatment providers or LMHAs for medication management and other appropriate medical services. The competency curriculum is consistent with criteria in Utah's competency statutes. The following program outline describes the restoration treatment delivery system at each level of service:

1. Referral Screening Process

a. Each individual is screened by a qualified USH Forensic Unit professional within seventy-two (72) hours, excluding weekends and holidays, of receiving a court order for competency restoration.

b. A qualified USH Forensic Unit professional utilizes scoring guidelines from the initial screening tool (Appendix A) to identify the appropriate level of service to which the individual should be referred.

c. A qualified USH Forensic Unit professional will continue to visit with all referrals weekly while the individual is being evaluated for the appropriate program.

Return

2. Outreach Program

a. The Outreach Program is designed for patients who are likely to show meaningful progress towards restoration of competency within 30 days, whose symptoms are stabilizing, and who are likely to be referred for re-evaluation and restored to competency within 60 days.

b. If the Outreach Program clinician determines that the patient is appropriate for treatment through the Outreach Program and the county jail is deemed a sufficient location in which to provide competency restoration services, the Outreach Program clinician will commence treatment in the home community jail after considering the criteria outlined in Section 4 above, "Outreach Program Services."

c. Outreach Program staff will arrange weekly treatment encounters with patients who are on a release to the community by the court.

d. If the patient is female and is appropriate for the Outreach Program, weekly visits will occur in the home community jail.

e. An ITP is established for each Outreach Program patient based on individualized needs and identified barriers to competence.

f. Coordination among Outreach Program staff occurs weekly to evaluate treatment progress, modify the patient's ITP as indicated, and coordinate medication management with local county jails as required in Utah Code Ann. Sect. 17-43-301(5)(a)(i) or pursuant to a contract anticipated to be entered with Salt Lake County for an offsite forensic facility.

g. An Outreach Program clinician visits with the patient for at least 60 minutes weekly to provide competency restoration treatment and psychoeducational material from the Outreach Competency Training Program manual addressing barriers to competence identified in the ITP. The manual is attached as Appendix C.

h. Patients are reassessed minimally every two (2) weeks to determine progress towards competence.

i. Patients will be disqualified from competency restoration treatment in the Outreach Program if he or she exhibits suicidal ideations with intent to harm, engages in repeated acts of self-harm, persistently refuses medications necessary for competency restoration with no rational basis, exhibits a significant decline in clinical stability, or is diagnosed with a moderate to severe intellectual or developmental disability.

j. If an Outreach Program clinician determines that a patient should be disqualified from the Outreach Program, the patient will be transferred to USH's forensic unit, an Offsite Forensic Facility, or

an Alternative Therapeutic Unit within seventy-two (72) hours, excluding weekends and holidays.

k. Patients who are not ready to be referred for reevaluation for restoration status within sixty (60) days will be re-assessed by USH staff for the appropriate level of competency restoration services.

l. If a qualified USH Forensic Unit professional determines that the Outreach Program is no longer clinically appropriate or effective for a patient, the patient must be transferred to USH's forensic unit, an Offsite Forensic Facility, or an Alternative Therapeutic Unit within seventy-two (72) hours, excluding weekends and holidays.

3. Offsite Forensic Facility

Return

a. An offsite forensic facility is a competency restoration program administered by USH forensic personnel, or by similarly qualified professionals employed by DHS's contractor, at a location other than the USH Campus. Expected capacity at an offsite forensic facility is twenty-two (22) to forty (40) beds.

b. A competency restoration program can be established in any secure offsite facility that has the availability of security staff. This is typically a jail or other secure setting. Any site can be considered if it meets the need for a secure, structured environment. If the space is located in or leased from a county jail, the space and the residents must be segregated from the jail's general inmate population.

c. A competency restoration program at an offsite forensic facility is designed for patients that are in need of more comprehensive treatment than those referred to the Outreach Program and are likely to be restored within two to four months. These patients are not considered a risk of immediate harm to self or others, do not have high acuity medical needs, and are demonstrating that they are willing to engage in treatment, including accepting medication management.

d. Patients will be identified by psychiatric acuity for purposes of bunking assignments, safety assessment, and in creating an ITP.

e. Patients receive day treatment services Monday through Friday. Operational hours may vary but be minimally set from 8:00 a.m. to 5:00 p.m. DHS anticipates some programming may occur in the evenings and on weekends.

f. A treatment team assesses and develops an ITP for each patient based on individualized needs and identified barriers to competence.

g. It is anticipated that the treatment team will consist of a psychiatrist, psychologist, social workers, nursing staff, psychiatric technicians, recreation therapist, case worker, and office specialist,

whose training and credentials will be commensurate with their counterparts at the USH.

h. Treatment services may include any of the following: medication management, individual therapy, group therapy, psychoeducation, recreation therapy, occupational therapy and other modalities identified as necessary for the patient's ITP. A schedule of USH programming is attached as Appendix D as an exemplar. Appendix D.

i. Patient programming and staffing levels at each offsite forensic facility will be guided by a Program Manual that will soon be developed, subject to modification by the USH Forensic Director, based upon the physical environs of the facility, availability of security staff, and other contract provisions to be determined once each offsite forensic facility is identified.

j. It is anticipated that a contractual arrangement with a county jail or other appropriate offsite facility will provide the program with security personnel, medical services, food, clothing, medications, and medical and mental health crisis services after hours.

4. USH Inpatient Restoration Services

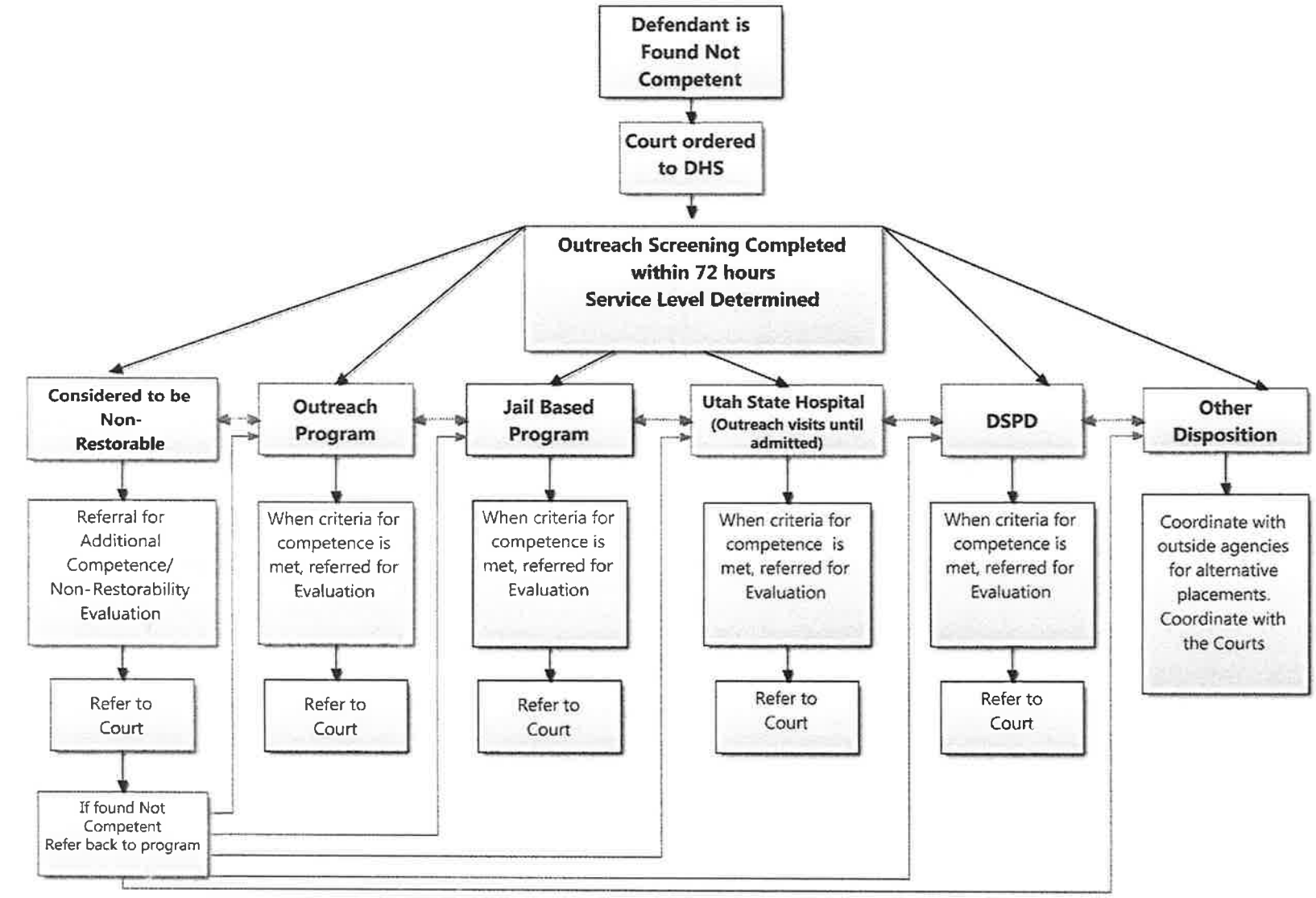
a. Patients who are not found to be appropriate for the Outreach Program or an offsite forensic facility treatment program are referred to USH for inpatient services within seventy-two (72) hours, excluding weekends and holidays.

E. Evaluations

All court-ordered NCP patients will have an initial assessment once they are screened and admitted to one of USH's treatment programs. A report will then be sent to the court pursuant to Utah Code Ann. Sect. 77-15-6. Any time after the patient is found NCP but is showing significant progress towards restoration, a referral can be made for competency re-evaluation by a forensic evaluator. The referral should be made within seventy-two (72) hours, excluding weekends and holidays, of the determination by USH Forensic Unit professionals that the individual has made significant progress towards restoration. Once a referral for follow-up evaluation is made to a forensic evaluator, the evaluation will be completed within fourteen (14) working days. The evaluation report is sent to the court promptly upon completion. The USH Clinical Director or designee certifies all reports recommending the individual be found competent to proceed according to Utah's competency statutes.

F. Collaboration

USH Forensic Unit professionals work in consultation with jail staff, court personnel, families, LMHAs, or others involved in the care, custody or treatment to ensure continuity of care and communication. The USH Legal Services Office and Forensic Director ensure that the courts are kept apprised of the progress and status of all individuals ordered to DHS consistent with Utah's statutory framework.



<--> At anytime a defendant is not progressing within a level of service a referral is made to the appropriate program that meets the needs of the individual

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EXHIBIT
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Return

NOTICE OF PROPOSED CLASS ACTION SETTLEMENT

Disability Law Center, et al. v. State of Utah, et al.
Case No. 2:15-CV-00645-RJS-BCW

You will be affected by the settlement of a class action lawsuit called *Disability Law Center, et al. v. State of Utah, et al.*, Case No. 2:15-CV-00645-RJS-BCW. This notice summarizes the claim in the lawsuit, what the settlement entails, and your rights under the settlement.

The Court has scheduled a hearing to consider the settlement on [DATE] at [TIME] before the Honorable Judge Robert J. Shelby at Courtroom 7.300, United States District Court for the District of Utah, 351 South West Temple, Salt Lake City, Utah 84101. This hearing is referred to as the Final Settlement Approval Hearing.

SUMMARY OF THE LAWSUIT

The issue in this lawsuit is whether the Utah State Hospital (USH) has failed to timely provide court-ordered competency restoration treatment for individuals who have been found incompetent to stand trial.

A Class Member is any individual who is now, or will be in the future, (i) charged with a crime in Utah, (ii) determined by the court in which they are charged to be mentally incompetent to stand trial, and (iii) ordered to the custody of the executive director of the Utah Department of Human Services or a designee for the purpose of treatment intended to restore the defendant to competency, but who remain housed in a Utah county jail.

The lawyers representing class members ("Class Counsel") are Aaron M. Kinikini and Erin B. Sullivan of the Disability Law Center, 205 North, 400 West, Salt Lake City, UT 84103, and Alan L. Sullivan and Bret R. Evans of Snell & Wilmer, LLP, 15 W South Temple #1200, Salt Lake City, UT 84101.

DESCRIPTION OF THE PROPOSED SETTLEMENT AGREEMENT

The Plaintiffs and the State of Utah have reached a settlement that would release the State from any further liability related to this claim. The Settlement Agreement requires USH to do the following, subject to Court approval:

- Within 72 hours of learning that a criminal defendant is found incompetent to stand trial and ordered to the custody of the Utah Department of Human Services, a USH Forensic Unit professional must screen each class member to determine the appropriate level of competency restoration treatment;
- Within 6 months, provide court-ordered to competency restoration treatment to criminal defendants found incompetent to stand trial within 60 days;
- Within 12 months, provide court-ordered to competency restoration treatment to criminal defendants found incompetent to stand trial within 30 days; and
- Within 18 months, provide court-ordered to competency restoration treatment to criminal defendants found incompetent to stand trial within 14 days.

The settlement also creates a system to monitor USH's compliance with the Settlement Agreement and requires the State of Utah to pay fees to the court-approved monitor.

You have the right to learn more about the settlement. A copy of the preliminarily-approved Settlement Agreement is enclosed with this Notice. If you are unable to read or understand the Settlement Agreement, contact Class Counsel referred to in Question 6 below.

OBJECTIONS OR COMMENTS TO THE PROPOSED SETTLEMENT

The United States District Court for the District of Utah has preliminarily approved the Settlement Agreement but will hold a Final Settlement Approval Hearing to determine whether it is fair, reasonable, and adequate on [DATE] at [TIME] in Courtroom 7.300 of the federal courthouse located at 351 South West Temple, Salt Lake City, Utah 84101.

Class Members have a right to object to the terms of the settlement. If you have objections, comments, or statements about the proposed Settlement Agreement, you must make them in writing using the attached "Response to Proposed Class Action Settlement" form or your own paper. A self-addressed stamped envelope is included for your convenience. Written objections, comments, and statements should be sent to the following address: **Disability Law Center, 205 N 400 W, Salt Lake City, UT 84013**. Objections must be submitted or postmarked no later than [DATE].

Objections **must** include all of the following information:

(1) The objector's contact information (name, address, offender number);
(2) An explanation of the basis for the objector's objection to the Settlement Agreement; and
(3) Whether the objector intends to appear at the Final Settlement Approval Hearing on [DATE].

All information submitted to Class Counsel will be provided to counsel for the State of Utah and the District Court in advance of the Final Settlement Approval Hearing. It is not necessary for Class Members to appear at the Final Settlement Approval Hearing. Any Class Member who has submitted a timely objection as provided above and who wishes to appear at the Final Settlement Approval Hearing must give notice by calling the Disability Law Center, sending notice in writing, or using the attached "Response to Proposed Class Action Settlement" form. Objectors may withdraw their objections at any time. **Any objections, comments, or statements that do not comply with the above procedures and timeline will not be heard or considered by the Court.**

HOW TO GET MORE INFORMATION

This is a summary of the Settlement Agreement. If you have any questions about the matters contained in this notice or any questions regarding the settlement, you may write or call Class Counsel below:

DISABILITY LAW CENTER
205 North 400 West
Salt Lake City, UT 84103
(801) 363-1347
Toll Free: (800) 662-9080

RESPONSE TO PROPOSED CLASS ACTION SETTLEMENT

***DLC, et al. v. State of Utah, et al.*, Case No. 2:15-CV-00645-RJS-BCW**

Full Name: _____

Address: _____

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Criminal Case No.: _____

Criminal Attorney: _____

Objections/Comments/Statements:

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Do you want to provide oral testimony to the Court regarding the settlement? Yes __ No __

Date: _____ Signature: _____

EXHIBIT
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Return

NOTICE OF PROPOSED CLASS ACTION SETTLEMENT

Disability Law Center, et al. v. State of Utah, et al.
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One or more of your clients will be affected by the settlement of a class action lawsuit called *Disability Law Center, et al. v. State of Utah, et al.*, Case No. 2:15-CV-00645-RJS-BCW. This notice summarizes the claim in the lawsuit, what the settlement entails, and your client's rights under the settlement. **Please share this notice and the proposed Settlement Agreement with your client's family members and any known legal guardian of your client, and encourage them to submit any objections, comments, and or statements that they may have regarding the proposed Settlement Agreement**.

The Court has scheduled a hearing to consider the settlement on [DATE] at [TIME] before the Honorable Judge Robert J. Shelby at Courtroom 7.300, United States District Court for the District of Utah, 351 South West Temple, Salt Lake City, Utah 84101. This hearing is referred to as the Final Settlement Approval Hearing.

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All information submitted to Class Counsel will be provided to counsel for the State of Utah and the District Court in advance of the Final Settlement Approval Hearing. It is not necessary for Class Members to appear at the Final Settlement Approval Hearing. Any Class Member who has submitted a timely objection as provided above and who wishes to appear at the Final Settlement Approval Hearing must give notice by calling the Disability Law Center, sending notice in writing, or using the attached "Response to Proposed Class Action Settlement" form. Objectors may withdraw their objections at any time. **Any objections, comments, or statements that do not comply with the above procedures and timeline will not be heard or considered by the Court.**

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DISABILITY LAW CENTER
205 North 400 West
Salt Lake City, UT 84103
(801) 363-1347

Toll Free: (800) 662-9080

RESPONSE TO PROPOSED CLASS ACTION SETTLEMENT

***DLC, et al. v. State of Utah, et al.*, Case No. 2:15-CV-00645-RJS-BCW**

Your Name: _____

Class Member's Name: _____

Criminal Case No.: _____

Relationship to Class Member: _____

Are you the Class Member's Legal Guardian? Yes ___ No ___

Your Mailing Address: _____

Your E-mail Address: _____

Your Telephone No.: _____

Objections/Comments/Statements:

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Do you want to provide oral testimony to the Court regarding the settlement? Yes __ No __

Date: _____ Signature: _____

EXHIBIT
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Return

CURRICULUM VITAE
Academic Year 2015-2016

NAME: Patrick K. Fox, M.D.

EDUCATION:

B.S., Rutgers University, New Brunswick, NJ 1990
M.D., UMDNJ-New Jersey School of Medicine, Newark, NJ 1994

CAREER:

September 2014-Present:
Colorado Department of Human Services
Chief Medical Officer

April 2013-Present:
Colorado Department of Human Services
Deputy Director of Clinical Services, Office of Behavioral Health

October 2013-July 2014 and December 2014-June 2015:
Colorado Department of Human Services
Acting Director, Office of Behavioral Health

April 1, 2012-March 31, 2013:
Denver Health and Hospital Authority
Attending Psychiatrist, Van Cise Simonet Detention Facility

July 1, 2007-March 31, 2012:
Yale University School of Medicine, Department of Psychiatry
Deputy Training Director, Forensic Psychiatry Fellowship

Director, Whiting Forensic Division, Connecticut Valley Hospital

July 1, 1999-June 30, 2007:
Yale University School of Medicine, Department of Psychiatry
Consulting Forensic Psychiatrist, DMHAS, state of Connecticut

July 1, 1997-March 31, 2012:
VA Connecticut Healthcare System
Employed as an Attending Psychiatrist on Duty, providing psychiatric care within the hospital, approximately fifteen hours per week.

June 1994-June 1999:
Yale University School of Medicine, Department of Psychiatry Post-Doctoral
-PGY V, Residency in Forensic Psychiatry, Law and Psychiatry Division, CMHC
-PGYIV, Chief Resident of PTSD/Anxiety Disorders Unit, West Haven VAMC
Psychiatrist for the New Haven Office of Court Evaluations
-PGYIII, West Haven Veterans Affairs Mental Hygiene Clinic
-PGY II, Inpatient Adult and Child Psychiatry Rotations
-PGY I, Transitional Medicine/Psychiatry/Neurology Program

ACADEMIC APPOINTMENTS:

Yale University School of Medicine, Department of Psychiatry
July 1, 1999-June 2008: Assistant Clinical Professor
July 1, 2008-April 2012: Assistant Professor

University of Colorado School of Medicine, Department of Psychiatry
April 1, 2012-Present: Senior Instructor

University of Denver, Graduate School of Professional Psychology
December 2012-Present: Adjunct Faculty

BOARD CERTIFICATION:

American Board of Psychiatry and Neurology, General Psychiatry: 1999, 2009
American Board of Psychiatry and Neurology, Forensic Psychiatry: 2001, 2011

PROFESSIONAL HONORS & RECOGNITION:

Recipient of the Laughlin Fellowship Award in Psychiatry-1998
Rutgers University Cooperative Academic Merit Scholarship-1990

DEPARTMENTAL, UNIVERSITY ACTIVITIES:

1999-2012: Weekly Supervisor for fellow/s, Fellowship in Forensic Psychiatry

1999-2012: Instructor, *Law & Psychiatry Seminar*, Fellowship in Forensic Psychiatry

1999-2012: Instructor, *Seminar in Law and Psychiatry*, Fellowship in Forensic Psychiatry

2000-2012: Coordinator/Instructor, *Public Sector Lecture Series*, Yale Forensic Psychiatry Fellowship

2000-2012: Member, Yale Department of Psychiatry Resident Selection Committee

2003-2007: Case write-up and interview tutor, Yale School of Medicine, Clerkship in Psychiatry

2004-2012: Instructor, *PGY II Seminar, Legal Regulation of Psychiatric Practice and Forensic Psychiatry*

2006-2012: Coordinator/Instructor, *Ethics in Research Module*, Scholarship Seminar, Fellowship in Forensic Psychiatry

2007-2012: Deputy Training Director, Fellowship in Forensic Psychiatry

2007-2012: Member, Yale University Graduate Medical Education, Program Director Committee

2008-2010: Coordinator, *Ethics in Research Seminar* for Yale Fellows in Public Sector Psychiatry and Research

2007-2012: Instructor, *Landmark Cases*, Fellowship in Forensic Psychiatry

2007-2012: Clinical Instructor, Yale Medical School Psychiatry ER Clerkship, West Haven VA

PROFESSIONAL SERVICE:

Professional Organizations

Member, American Psychiatric Association, 2008-present
Member, American Academy of Psychiatry and the Law, 2008-present
Member, Connecticut Psychiatric Society, 2008-2012
-Council Member, 2010-2012
Member, Colorado Psychiatric Society, 2012-present
Forensic Psychiatry Examination Committee, American Board of Psychiatry and Neurology, 2009-present

State of Colorado Committees

May 2013-July 2015: National Governors' Association, Prescription Drug Abuse Reduction Policy Academy

July 2013-October 2013: Co-chair, Civil Commitment Statute Review Task Force

August 2013-June 2015: National Governors' Association, Super-utilizer Policy Academy

January 2014-present: Governor's Marijuana Policy Workgroup

January 2015-present: Commissioner, Suicide Prevention Commission-Colorado

May 2016-present: Appointee, Mental Health/Point of Contact through Release from Jail Task Force, Commission on Criminal and Juvenile Justice

State of Connecticut Committees

1998-1999: Participant, Committee to Study Sexually Violent Persons, State of Connecticut Office of Policy and Management

1999-2000: Member, DMHAS Restraint/Seclusion Task Force, *Best Practices Report and Recommendations: Working Toward the Elimination of Restraint & Seclusion*.

1999-2000: DMHAS representative, Committee to Study Credentialing of Sexual Offender Treatment Providers, State of Connecticut Office of Policy and Management.

2000: Member, Committee for Psychosexual Evaluation and Treatment, DMHAS-state of Connecticut.

2000-2001: DMHAS representative, Sex Offender Policy and Advisory Committee, state of Connecticut, Office of Policy and Management.

2001: DMHAS representative, Special Populations Project: Model Development.

2002: DMHAS-Division of Forensic Services representative, Preferred Practices Committee: Providing Services to those with Problem Sexual Behaviors.

2002: DMHAS representative, Preferred Practices in Behavioral Health Workgroup.

2002: DMHAS, Commissioner's Policy Work Group*: Limits to Confidentiality*.

2002-2003: DMHAS representative, Sex Offender Policy and Advisory Committee, state of Connecticut, Office of Policy and Management.

2006-2012: Governor's Appointee: Sex Offender Risk Assessment Board, state of Connecticut Judiciary Committee.

2007-2012: Member, DMHAS, Forensic Steering Committee.

2007-2012: DMHAS Commissioner's Appointee, *Lawyers Concerned for Lawyers-Connecticut, Inc.*

PRESENTATIONS:

October 1999*: Jail Diversion, Balancing of the Court's Interests*, American Academy of Psychiatry and the Law, Annual Convention, Madelon Baranoski, Ph.D., Patrick K. Fox, M.D., Josephine Buchanan, Baltimore, MD

October 2000*: Outpatient Civil Commitment*, American Academy of Psychiatry and the Law, Annual Convention, Patrick K. Fox, M.D., Paul Amble, M.D., Vancouver, BC.

August 2001: DMHAS-Connecticut, Forensic Grand Rounds, *Substance Abuse Relapse Prevention for Insanity Acquittees, Recent Research Findings*, presented at Connecticut Valley Hospital.

January 2002: University of Connecticut, School of Medicine/Correctional Mental Health Conference, *Sex Offenders: Risk Assessment, Management & the Possibilities for Treatment*, presented at UCHC, December 2001 and at Cheshire Correctional Center.

June 2002: Veterans Administration-Connecticut Healthcare System, Forensic Committee Conference, *Violence Risk Assessment*, and *Violence Risk Management*, presented at the West Haven Veterans Administration Hospital.

April 2004*: Competency to be Executed*, Yale Medical Student Psychiatric Association.

October 2004*: Melissa's Project: Probate Court-Monitored Treatment*, American Academy of Psychiatry and the Law, Annual Convention, Patrick K. Fox, M.D., Paul Amble, M.D., Michael Makniak, J.D., Scottsdale, AZ.

March 2007: DMHAS Training Seminar-Sex Offender Training, *A Clinical Perspective on Problem Psychosexual Behaviors*, presented at Connecticut Mental Health Center.

Dec. 2008: *Problem Sexual Behavior*, Connecticut Valley Hospital Grand Rounds

January 2008*: Physiological Response to Situations of Uncontrollable Stress*, Connecticut Valley Hospital Trauma Initiative Series.

October 2009: *Civil Rights and the Insanity Defense*, Yale Medical Student Psychiatric Association.

April 2010: *Festschrift for Howard Zonana: Attorney-Physician Collaboration*, Yale Department of Psychiatry Grand Rounds

July 2010: *Psychopathy and Sociopathy*, Yale Department of Psychiatry Grand Rounds

October 2010*: You Got Personality: Diagnostic Challenges in Forensics*, American Academy of Psychiatry and the Law, Annual Convention, Howard Zonana, MD, Madelon Baranoski, PhD., Patrick K. Fox, M.D., Josephine Buchanan, Tucson, AZ.

Feb. 2011*:* Invited lecturer, *Police Intervention with Persons with Mental Illness*, Henry C. Lee Institute of Forensic Science, University of New Haven.

March 2011*:* Invited lecturer, *Police Intervention with Persons with Mental Illness*, Henry C. Lee Institute of Forensic Science, University of New Haven.

April 2011*:* Invited lecturer, *Psychopathy*, Eastern Connecticut State University.

July 2011: *Physician-Assisted Suicide*, Yale Department of Psychiatry Grand Rounds

October 2011: *Thinking Outside the Witness Box: Novel Forensic Psychiatry Training Strategies*, American Academy of Psychiatry and the Law, Annual Convention, Brian Cooke, M.D., Reena Kapoor, M.D., Patrick Fox, M.D., Boston, MA

October 2011: *Restraint and Seclusion Reduction: Implications and Outcomes*, American Academy of Psychiatry and the Law, Annual Convention, Patrick Fox, M.D., Traci Cipriano, Ph.D., J.D., Paul D. Whitehead, M.D., Charles Dike, M.D., Boston, MA

Feb. 2012: *Mental Health Policy in the United States*, distinguished presenter to delegates from Fudan University, Shanghai Province, China, as part of the Yale Global Health Initiative

January 2013: *Inside the Mind of the Mass Murderer*, the Vail Symposium.

January 2014: *Assessment and Management of Problem Sexual Behaviors*, Colorado Mental Health Institute at Pueblo Grand Rounds

Feb. 2014: *Trans-institutionalization: Treatment of Persons with a Behavioral Health Disorder within the Criminal Justice System*, A Workshop of the Forum

on Global Violence Prevention. Institute of Medicine of the National Academies.

April 2015: *The Times, They are a Changin': State and National Developments and Trends in Behavioral Health Care Delivery*, Colorado Psychiatric Society Annual Meeting, Denver, Colorado

July 2015: *Science and Conscience: The Role of Mental Health Evaluators in Death Penalty Cases*, XXXIVth International Congress on Law and Mental Health, Sigmund Freud University, Vienna, Austria

Sept. 2016: *Managing a Limited Resource: Trends in Competency to Stand Trial Evaluations in Colorado*, Colorado State Judicial Conference, Vail, CO.

Dec. 2016: *Mental Health Evaluators and the Death Penalty*, American Bar Association National Summit on Severe Mental Illness and the Death Penalty, Georgetown University.

BIBLIOGRAPHY:

Morgan III, C.A., Hill, S.R., Fox, P.K., Kingham, P., & Southwick, S.M. Anniversary Reactions in Gulf War Veterans: A Follow-up Inquiry Six Years After the War. American Journal of Psychiatry 156:1075-1079, July 1999.

Charles A. Morgan III, Sheila Wang, John Mason, Steven M. Southwick, Patrick Fox, Gary Hazlett, Dennis M. Charney, and Gary Greenfield, Hormone Profiles in Humans Experiencing Military Survival Training. Biological Psychiatry 47:891-901, May 2000.

Patrick K. Fox, Commentary: Biases that Affect the Decision to Conditionally Release an Insanity Acquittee. Journal of the American Academy of Psychiatry and the Law 36:337-9, 2008.

Patrick K. Fox, Commentary: Medicine, Law and Howard Zonana. Journal of the American Academy of Psychiatry and the Law 38:4:592-593 (2010)

Patrick K. Fox, Commentary: So the Pendulum Swings-Making Sense of the Duty to Protect. Journal of the American Academy of Psychiatry and the Law 38:4:474-478 (2010)

Faculty Reviewer: Stead L, Kaufman M, Yanofski J, First Aid for the Psychiatry Clerkship, third edition

Wasser, Tobias D., Fox, Patrick K. For Whom the Bell Tolls – Silver Alerts Raise Concerns Regarding Individual Rights and Governmental Interests. Journal of the American Academy of Psychiatry and the Law 170:9: (2013)

Martinez, R., Fox, P *Chapter 10: Confidentiality in Psychiatric Practice*, Textbook of Forensic Psychiatry, APA Publishing, In publication, (2016)

EXHIBIT
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SETTLEMENT AGREEMENT

This Settlement Agreement is entered into by and between the Disability Law Center (hereinafter "DLC"), an individual identified as S.B., an individual identified as A.U., and an individual identified as S.W. (hereinafter collectively the "Named Plaintiffs"), on the one hand, and the Utah Department of Human Services (hereinafter "DHS"), Ann Williamson in her official capacity as Executive Director of DHS, the Utah Division of Substance Abuse and Mental Health (hereinafter the "Division"), Douglas Thomas in his official capacity as Director of the Division, the Utah State Hospital (hereinafter "USH"), and Dallas Earnshaw in his official capacity as Superintendent of USH (hereinafter collectively "Defendants"). Each of the foregoing parties is sometimes referred to as a "party" and collectively as "the parties."

Recitals

The parties jointly acknowledge the following undisputed facts, which form the background for this Settlement Agreement:

A. DHS has the statutory obligation under Title 77, Chapter 15 of the Utah Code to provide competency evaluations for persons charged with criminal offenses, and to provide Restoration Treatment (as defined below) for persons found incompetent to proceed.

B. On behalf of the class of plaintiffs described below, DLC and the other Named Plaintiffs filed a civil action against the Defendants in the United States District Court for the District of Utah (hereinafter the "Court") Disability Law Center, a Utah nonprofit corporation, et al., vs. State of Utah, et al., Case No. 2:15-CV-00645-RJS-BCW (hereinafter the "Litigation"), to challenge the length of time pretrial detainees in Utah's county jails must wait to receive Restoration Treatment.

C. The purposes of this Settlement Agreement are: (i) for the parties jointly to adopt and implement a strategic plan that will significantly reduce the wait time for Class members (as defined below) to be admitted to Restoration Treatment; (ii) to resolve all claims asserted by the Named Plaintiffs on behalf of the Class in the Litigation; (iii) to provide a mechanism for monitoring Defendants' compliance with this Settlement Agreement and the Plan; and (iv) to provide a mechanism for enforcement of this Settlement Agreement and the Plan.

D. As discussed below, the Named Plaintiffs claim on behalf of the Class that Defendants violate the rights of criminal defendants who have been found incompetent to stand trial under the Fourteenth Amendment to the United States Constitution and Article I, § 7 of the Utah Constitution, by infringing their liberty interests in being free from incarceration absent a criminal conviction. Defendants deny Plaintiffs' claims.

E. DLC is a federally authorized and funded nonprofit corporation established under the Protection and Advocacy for Individuals with Mental Illness Act of 1986, 42 U.S.C. § 10801 *et. seq*. Plaintiffs S. B., A. U., and S. W. were, at the time the complaint in the Litigation was filed, pretrial detainees who had been declared incompetent to stand trial in a criminal proceeding and committed to the custody of the executive director of DHS for the purpose of treatment intended to restore them to competency.

F. DHS is the agency of the State of Utah with responsibility to administer or supervise the administration of competency Restoration Treatment under Utah Code Ann. § 77-15-6(1). The Division is the division of the State of Utah charged with responsibility to ensure the availability of services for people with mental health disorders and substance abuse issues. USH, which operates under the direction of DHS and the Division, is the Utah state psychiatric hospital. Currently, USH is the only state facility providing Restoration Treatment to Class

members, although Restoration Treatment is also provided to Class members through the State's Outreach Program designed to restore competency to individuals housed in Utah county jails.

G. In entering into this Settlement Agreement, Defendants do not admit any wrongdoing or constitutional violation as to any Named Plaintiff or Class member. Defendants do not admit that their conduct, whether actual or alleged, constitutes a legitimate ground for liability against the State or any Defendant.

H. On September 27, 2016, the Court in the Litigation certified the following plaintiff class (the "Class"): all individuals who are now, or will be in the future, (i) charged with a crime in Utah, (ii) determined by the court in which they are charged to be incompetent to stand trial, and (iii) ordered to the custody of the executive director of DHS or a designee for the purpose of treatment intended to restore the defendant to competency, but who remain housed in a Utah county jail. On November 7, 2016, the United States Court of Appeals for the Tenth Circuit denied Defendants' petition for interlocutory review of the Court's certification of the Class.

I. Under Utah Code Ann. § 77-15-3(1), whenever a person charged with a public offense is, or becomes, mentally incompetent to proceed, a petition for inquiry may be filed in the state district court in which the charge is pending for the determination of the person's mental competency. If the court determines that the person is incompetent to stand trial, the court must order him or her committed to the custody of the executive director of DHS or a designee for competency restoration treatment.

J. As the result of limitations on space at USH and limitations on DHS's resources, some Class members have historically waited months after the state court orders restorative competency treatment to be admitted to USH for treatment. During this waiting period, Class

members were incarcerated in county jails, where they received little or no treatment to restore competency from professionals employed by the jail. As a general matter, Utah's county jails are not specifically designed to provide competency restoration treatment, and jail staff do not administer such treatment. Accordingly, since July 2014, the State has administered an Outreach Program designed to restore competency to individuals housed in Utah county jails.

K. With DLC's concurrence, Defendants have formulated and adopted a plan entitled "A Strategic Plan for Providing Utah Adult Mental Health Competency Restoration Services" (June 9, 2017) (the "Plan") to reduce the time during which Class members must wait to receive Restoration Treatment. A copy of the Plan is attached as Exhibit 1. The Plan consists of the following elements:

i. A process for promptly screening and identifying: (a) those Class members who, because of the acuity and nature of their mental illness, should be transferred from jail to the USH Forensic Unit for Restoration Treatment; (b) those Class members whose mental illness is less severe and should be transferred to an Alternative Therapeutic Unit, as defined below, which may be established by USH; (c) those Class members who may likely be restored to competency in a suitable Offsite Forensic Facility, as defined below, operated by USH or under contract with DHS; (d) those Class members who are likely to be restored to competency through the Outreach Program, as defined below, subject to the limits in paragraphs 25(a) and 26, below; (e) those Class members with intellectual or developmental disabilities who should be directed to the Division of Services for People with Disabilities for Restoration Treatment ("DSPD"); (f) those Class members whose mental

condition has stabilized since initial evaluation, with the result that a further evaluation should be made to determine if these Class members are now competent; and (g) those Class members who are unlikely to be restored to mental competence and should be released from DHS custody so that civil commitment, dismissal of charges, or other resolution can occur.

ii. USH's continued operation and further development of the Outreach Program, as defined below, to screen, treat, assess, and monitor Class members.

iii. USH's development of one or more Offsite Forensic Facilities for Restoration Treatment of Class members for whom such programs are likely to be a suitable means to restore competency.

iv. USH's development of one or more Alternative Therapeutic Units for Restoration Treatment of Class members for whom such programs are likely to be a suitable means to restore competency.

v. Measures to assure that all Class members begin receiving the timely provision of appropriate Restoration Treatment after the state court orders treatment for them.

vi. Measures to increase the efficient use of the USH Forensic Unit so as to maximize its existing capacity.

vii. Measures to manage the anticipated growth in the number of people who are likely to become Class members in years to come.

L. The Court has jurisdiction over the Litigation under 42 U.S.C. §§ 1331 and 1343. The parties agree that venue is proper under 28 U.S.C. § 1391(b)(2). The parties will

jointly submit this Settlement Agreement to the Court for approval, and its terms will not be effective until the Court approves it.

NOW, THEREFORE, in consideration of the mutual promises set forth below, the parties agree as follows:

Definitions

1. "**Alternative Therapeutic Unit** " means any treatment unit established and operated by USH or under contract with DHS for Restoration Treatment on or off of the USH Campus for Class members who, in USH's professional judgment, do not require hospitalization level of care, but are not appropriate for an Offsite Forensic Facility or the Outreach Program.

2. The "**Class**" means all individuals who are now or will in the future be:

   a. Charged with a crime in Utah state courts,

   b. Determined by the court in which they are charged to be mentally incompetent to stand trial,

   c. Ordered or committed by the court to the custody of the DHS executive director or a designee for the purpose of treatment intended to restore the individuals to competency, but who remain incarcerated in a county jail in Utah, and

   d. Waiting to begin Restoration Treatment.

3. "**Custody** or **Commitment Order**" means a written order, issued by a court and signed by a judge, which orders a Class member committed to the custody of the executive director of DHS or a designee for the purpose of treatment intended to restore the defendant to competency, as described in Utah Code Ann. § 77-15-6(1).

4. "**Defendants' Designated Representative**" is Dallas Earnshaw, who has been appointed by Defendants to perform the duties set forth in paragraph 18, below.

5. **"Forensic Evaluator"** means a licensed independent mental health professional qualified to conduct court-ordered mental illness evaluations of adults in the criminal justice system, who is familiar with and complies with the requirements of Utah Code Ann. § 77-15-1 et. seq., and who is not involved in the treatment of the Class member.

6. "**Incompetent to proceed**" has the same meaning as set forth in Utah Code Ann. § 77-15-2.

7. "**Maximum Allowable Wait Time**" means the largest number of days that any Class member is permitted to wait under paragraph 21 to be admitted into Restoration Treatment, as measured from the date on which USH received the Custody Order until the date on which the Class member began receiving Restoration Treatment at USH, at an Alternative Therapeutic Unit, at an Offsite Forensic Facility, through the Outreach Program, or from DSPD. For purposes of this Settlement Agreement, the wait times for class members who are already incarcerated when the Plan is implemented, or September 30, 2017, whichever is later, will be tracked, but the wait times associated with those current Class members will not count towards compliance with the deadlines established in paragraph 21, below.

8. The "**Monitor**" is Patrick K. Fox, M.D., who has been appointed by the Court based on the parties' stipulation to perform the duties set forth in paragraphs 20, 26 and 28 below. Defendants and the Monitor shall promptly negotiate and enter into a retention agreement pursuant to which Defendants shall pay the Monitor a reasonable hourly rate and all necessary expenses incurred in performing those duties, with the exception of the duties set forth

in paragraph 28, as the costs associated with Monitor-led mediation shall be shared by the parties equally.

9. The "**Monitoring Period**" means five (5) years from the date on which the Court approves this Settlement Agreement.

10. "**Offsite Forensic Facility**" means a program of Restoration Treatment administered by USH forensic personnel, or by similarly qualified professionals employed by DHS's contractor, at a location other than the USH Campus. Every Offsite Forensic Facility established by Defendants pursuant to this Settlement Agreement must comply with the requirements of paragraph 24 below.

11. "**Outreach Program**" means USH's program of screening, treating, assessing and monitoring Class members while they remain residents in county jails and are not residents in any Offsite Forensic Facility. Outreach Program professionals will screen Class members for the appropriate level of Restoration Treatment; treat Class members whose screening indicates that they are likely to show meaningful progress towards restoration of competency within 30 days, whose symptoms are stabilizing, and who are likely to be referred for re-evaluation and restored to competency within 60 days; assess Outreach Program patients' progress; and monitor Class members who have been restored to competency, wherever they are located, and assist them in remaining competent to stand trial. Subject to the terms of paragraph 26, below, USH may utilize the Outreach Program as an approved method of Restoration Treatment for a period of one year from the date on which the court approves this Settlement Agreement

12. "**Restoration Treatment**" in this Settlement Agreement means competency restoration treatment provided by USH forensic personnel or by similarly qualified professionals

employed by DHS's contractor, to Class members in an effort to restore them to competency, in accordance with Utah Code Ann. § 77-15-6(1), regardless of location or level of need.

13. "**Status Report**" means the written report issued by the Defendants' Designated Representative on a monthly basis during the Monitoring Period, pursuant to paragraph 18, below.

14. "**USH Forensic Unit**" has the same meaning as set forth in Utah Code Ann. § 62A-15-901.

15. "**Waitlist**" means the list of individuals committed to the custody of the executive director of DHS and waiting in jail for Restoration Treatment.

Objectives, Plan Implementation and Measures of Compliance

16. **Timely Restoration Treatment** – Defendants shall take all necessary steps to meet the objective of providing all Class members with timely and appropriate Restoration Treatment. Pursuant to the screening procedures referenced in paragraph 19, below, and without any unnecessary delay, Defendants shall transport or direct transportation consistent with Utah Code Ann. Sect. 77-15 et seq., of Class members to the appropriate program or location for Restoration Treatment.

17. **Implementation of the Plan** – Subject to the Court's approval of this Settlement Agreement, Defendants shall implement the Plan annexed hereto as Exhibit 1 no later than September 30, 2017, and shall take all steps necessary to diligently follow the Plan during the term of this Settlement Agreement.

18. **Duties of Defendants' Designated Representative** – No later than the tenth day of the month following the end of every month during the Monitoring Period, the Defendants' Designated Representative shall transmit to the Monitor and DLC a Status Report accurately

reporting the status of all Class members then waiting for Restoration Treatment. Each report must include the following information for each Class member:

a. The Class member's name and criminal case number;

b. The name of the court that entered the Class member's Custody Order;

c. The date of the court's Custody Order;

d. The date USH received the Custody Order;

e. The name of the jail where the Class member is being held;

f. The dates on which the Outreach Program screened the Class member and the results of the screenings, including the current disposition of the Class member for Restoration Treatment;

g. The date on which the Class member began receiving Restoration Treatment and the location of the Class member's Restoration Treatment;

h. The date, if any, on which the Class member was terminated from DHS custody for any reason;

i. The reasons for the Class member's termination from DHS custody, including the name and location of the facility or other setting to which the Class member was transferred, if that information is known to DHS; and,

j. The number of days the Class member has spent on the Waitlist.

The report shall also state: (1) the longest wait time as among all Class members then on the Waitlist; (2) whether the Defendants have complied with the requirements of paragraph 21, below, during the month; and, if applicable, (3) the reasons for Defendants' inability to comply with the requirements of paragraph 21.

Defendants' Designated Representative shall, on request, cooperate with the Monitor in gathering any additional information necessary for the Monitor's reports, which are required in paragraph 20, below.

19. **Screening deadlines and disposition of Class members** –

a. Within seventy-two (72) hours, excluding weekends and holidays, of DHS's receipt of the Custody Order with respect to a Class member, a qualified USH Forensic Unit professional shall screen the Class member using a screening tool approved by, and subject to modification and replacement as determined appropriate by, Defendant's Designated Representative and the Monitor. On the basis of the screening, the USH Forensic Unit professional shall determine whether the Class member: (i) should be transferred from jail to the USH Forensic Unit for Restoration Treatment due to the acuity and nature of the Class member's mental illness; (ii) should be transferred to an Alternative Therapeutic Unit; (iii) should be transferred to an Offsite Forensic Facility for Restoration Treatment; (iv) subject to the limits in paragraph 26, below, should be treated by the Outreach Program based on the standards set forth in subparagraph 25(a), below; (v) should be directed to DSPD for Restoration Treatment because of the Class member's intellectual or developmental disabilities; (vi) should be reevaluated by a Forensic Evaluator to determine if the Class member is now competent; or (vii) should be released from DHS custody because it is unlikely that Restoration Treatment would be effective.

b. As soon as the foregoing determination is made, Defendants shall take all steps necessary to promptly effectuate the appropriate disposition of the Class member.

c. If the qualified USH Forensic Unit professional determines that the Class member should be directed to DSPD for Restoration Treatment because of the Class member's intellectual or developmental disabilities, USH shall make the referral within 72 hours, excluding weekends and holidays, of the screening determination. DSPD shall make a determination about whether it is the agency best suited to provide Restoration Treatment to the Class member within 72 hours, excluding weekends and holidays, of the referral from USH. If DSPD does not accept the referral, USH shall place the Class member back on the Waitlist consistent with the date of the court's Custody Order and comply with the Maximum Allowable Wait Time deadlines in paragraph 21. The time spent towards the Class member's referral and assessment will not count in computing the Maximum Allowable Wait Time.

d. If the qualified USH Forensic Unit professional determines that the Class member should be reevaluated by a Forensic Evaluator to determine if the Class member is now competent, a referral to a Forensic Evaluator shall be made within 72 hours, excluding weekends and holidays, of the determination. If the reevaluation cannot be conducted within 72 hours, excluding weekends and holidays, of the referral, or if the Forensic Evaluator recommends that the Class member is still not competent to

proceed but there is a substantial likelihood that the Class member can be restored to competency in the foreseeable future, USH shall continue administering competency restoration services appropriate for the patient's level of need and shall have complied with the Maximum Allowable Wait Time deadlines in paragraph 21. The time spent towards the Class member's referral and assessment will not count in computing the Maximum Allowable Wait Time.

e. If, at any time, the qualified USH Forensic Unit professional identifies an emergent mental health need, the Defendant's Designated Representative shall expeditiously report the circumstances to DLC and the Monitor, describe any action taken by USH, and keep DLC and the Monitor apprised of any subsequent disposition of the Class member.

20. **Monitor's quarterly reports** – No later than the fifteenth day of the month after the end of each calendar quarter during the Monitoring Period, the Monitor shall report in writing to the Defendants and DLC on Defendants' progress during the preceding quarter in implementing each specific provision of the Plan and in complying with each specific term of this Settlement Agreement.

21. **Deadlines for reduction in Maximum Allowable Wait Time –**

a. By March 31, 2018, Defendants shall reduce the Maximum Allowable Wait Time to sixty (60) days.

b. By September 30, 2018, Defendants shall reduce the Maximum Allowable Wait Time to thirty (30) days.

c. By March 31, 2019, Defendants shall reduce the Maximum Allowable Wait Time to fourteen (14) days.

22. **Modification to the Plan** – If Defendants believe that to achieve compliance with the screening deadlines in paragraph 19 or the Maximum Allowable Wait Time deadlines in paragraph 21, above, they will require a modification of the Plan, the Defendants' Designated Representative shall provide the Monitor and DLC with a detailed written explanation of the necessary modification. If DLC objects to any proposed Plan modification, it will notify Defendants' Designated Representative of the objection in writing within fourteen (14) days of its receipt of the notice of modification. DLC and Defendants' Designated Representative shall thereafter confer in good faith to resolve their differences. If they are unable to resolve their differences in this manner, the parties will submit their differences to the Monitor for possible dispute resolution. If they are unable to resolve their differences in consultation with the Monitor, the Monitor will make a written report and recommendation to the parties. If, after conferring with the Monitor, the parties still disagree as to the proposed modification of the Plan, either party may move the Court for relief, along with the Monitor's report and recommendation. In the absence of DLC's consent, Defendants shall not implement proposed changes to the Plan sooner than sixty (60) days following the issuance of the Defendants' Designated Representative's written notice required in this paragraph.

23. **Suspension of deadlines because of special circumstances –** Defendants' ability to perform their obligations under this Settlement Agreement in a timely manner may depend on special circumstances beyond their control. Subject to the following terms and conditions, the deadline in paragraph 19(a) (hereinafter the "Screening Deadline") and the deadlines in

paragraph 21 (hereinafter the "Maximum Allowable Wait Time Deadlines") may be suspended with respect to one or more Class members:

a. The Screening Deadline or the Maximum Allowable Wait Time Deadlines relating to an individual Class member may be temporarily suspended if Defendants conclude that they cannot meet the relevant deadlines because of factors beyond Defendants' control, including (but not limited to): orders of a court that will delay Defendants' performance; motions filed on behalf of the Class member that will delay Defendants' performance; a jail's failure or refusal to clear the Class member for admission to one of Defendants' facilities; a jail's failure or refusal to allow Outreach Program staff access in order to carry out its responsibilities with respect to a Class member; or medical conditions that prevent a Class member's admission to USH. Circumstances in this category shall be referred to as "Individual Special Circumstances."

b. The Screening Deadline or the Maximum Allowable Wait Time Deadlines relating to a group of Class members may be temporarily suspended if Defendants conclude that they cannot meet the relevant deadline because of factors beyond their control, including (but not limited to) a national or local disaster impacting admissions to one or more of Defendants' facilities, a labor action that substantially impedes the continued operation of a facility, or an extraordinary and unanticipated increase in the number of court-ordered competency restoration referrals. Circumstances in this category shall be referred to as "Departmental Special Circumstances."

The failure or refusal of the Utah Legislature to adequately fund Defendants' operations, programs, or the Plan shall not be considered a Departmental Special Circumstance for purposes of this Settlement Agreement.

c. If, at any time during the term of this Settlement Agreement, Defendants conclude they must suspend either the Screening Deadline or the Maximum Allowable Wait Time Deadlines on account of either an Individual Special Circumstance or a Departmental Special Circumstance, the Defendants' Designated Representative shall immediately give DLC and the Monitor written notice thereof. The notice shall state the nature of the special circumstance (that is, whether an Individual or Departmental Special Circumstance), names of all of Class members who will be affected by the proposed suspension, and all of the facts constituting the special circumstance. The notice shall also state which specific deadlines must be suspended and for what specific period.

d. Any suspension proposed in the notice shall begin on the date on which the notice is received by DLC and the Monitor and shall terminate at the end of the temporary period of suspension, as set forth in the notice, unless modified in accordance with subparagraphs f or g, below.

e. No suspension of any deadline shall last longer than is justified by the special circumstance identified in the notice.

f. If either DLC or the Monitor objects to the suspension, or the scope or duration of the suspension, DLC or the Monitor may notify Defendants'

Designated Representative of the objection in writing, and the parties shall promptly confer with each other in good faith to resolve the issue.

g. If the parties are unable to resolve the issue after the consultation required by subparagraph f above, they will submit the matter to the Monitor for mediation. In the absence of an emergency requiring immediate relief, none of the parties shall be entitled to file a motion in the Litigation to enforce this Settlement Agreement based upon the suspension until the expiration of thirty (30) days from the date on which the party notifies the other parties of the alleged violation based upon the suspension and efforts to resolve the situation, including Monitor-led mediation, have been exhausted. The parties shall equally share the costs of Monitor-led mediation.

24. **Offsite Forensic Facility requirements** – As part of the Plan, Defendants are hereby authorized to develop and implement one or more Offsite Forensic Facilities consistent with the following principles:

a. Each Offsite Forensic Facility shall be a treatment program located in space that is suitable for Restoration Treatment. If the space is located in or leased from a county jail, the space and the residents shall be segregated from the jail's general inmate population.

b. Each Offsite Forensic Facility shall be operated by a multi-disciplinary treatment team consisting of full-time forensic professionals, employed by DHS or by a suitable contractor, of a number that is sufficient to provide those Class members transferred to the Offsite Forensic Facility with

Restoration Treatment. A sufficient number of staff members shall remain on-site during operational hours. Each Offsite Forensic Facility shall meet the best practices of professional and clinical standards governing the operation of, and delivery of, Restoration Treatment services at the USH Forensic Unit.

c. Defendants shall establish and operate one or more Offsite Forensic Facilities with sufficient capacity to meet, in combination with other improvements, the Maximum Allowable Wait Time deadlines in paragraph 21.

d. The initial Offsite Forensic Facility should preferably be located in the Salt Lake County Metro Jail, in space previously inspected and approved by the representatives of the parties. The parties affirmatively represent that they are not presently aware of any deficiencies in the management or operation of the Salt Lake County Metro Jail that would preclude, impede, or otherwise interfere with Defendants' ability to establish and operate an Offsite Forensic Facility at the Salt Lake County Metro Jail, or that would preclude, impede, or otherwise interfere with Class members' ability to receive reasonable and adequate medical and mental health care and services while they are housed in the Offsite Forensic Facility at the Salt Lake County Metro Jail.

e. Defendants will carefully evaluate and, if needed, seek additional funding for a comparable facility for Class members who are women.

25. **Outreach Program duties** – Subject to the limits of paragraph 26, below, Outreach Program professionals shall conduct timely screening of Class members in accordance with paragraph 19 above and shall:

a. Treat Class members who, in the professional's judgment, are likely to show meaningful progress towards restoration of competency within 30 days, whose symptoms are stabilizing, and who are likely to be referred for re-evaluation and restored to competency within 60 days. Class members in the Outreach Program shall be re-assessed by Outreach Program professionals every two weeks to determine progress toward competency. Following 30 days of Restoration Treatment in the Outreach Program, Outreach Program professionals will re-assess each Class member to determine if the Outreach Program remains the most clinically appropriate and effective level of care. A Class member will be disqualified from Restoration Treatment in the Outreach Program if he or she exhibits repeated suicidal ideations with intent to harm, engages in repeated acts of self-harm, persistently refuses medications necessary for competency restoration with no rational basis, exhibits a significant decline in clinical stability, or is diagnosed with a moderate to severe intellectual or developmental disability. If the Outreach Program professional determines at screening that a Class member should be disqualified from consideration for Restoration Treatment in the Outreach Program, the Class member must be transferred to USH, an Offsite Forensic Facility, or an Alternative Therapeutic Unit within seventy-two (72) hours, excluding weekends and holidays. Similarly, if the Outreach Program professional determines that the Outreach Program is no longer

clinically appropriate or effective for a Class member, the Class member must be transferred to USH, an Offsite Forensic Facility, or an Alternative Therapeutic Unit within seventy-two (72) hours, excluding weekends and holidays, or referred to DSPD if appropriate;

b. Facilitate the prompt reevaluation of Class members by a Forensic Evaluator, if justified;

c. Monitor former Class members as clinically necessary who have been restored to competency and who await trial, to assist them in maintaining their competency until trial.

26. **Determination of the Outreach Program's effectiveness** – The Outreach Program may be utilized by USH as an approved alternative method of Restoration Treatment under this Settlement Agreement for a period of one year from September 30, 2017. During this one-year period, the Monitor will gather and analyze information about the Outreach Program's effectiveness in providing Restoration Treatment to Class members, including the number of patients who are restored or are not restored within 60 days, together with any other factors the Monitor deems relevant. By the end of the one-year period, the Monitor will advise the parties either: (a) that the Outreach Program is effective as a method of Restoration Treatment, in which event the Outreach Program will become a permanent treatment option under this Settlement Agreement; or (b) that it is not effective, in which event its use as a treatment option under this Settlement Agreement will be promptly terminated unless the Monitor prescribes additional steps to improve the Outreach Program's efficacy and USH complies with and implements those steps.

Approval by the Court and Enforcement

27. **Court approval and stay of the Litigation –** The parties will jointly move the Court in the Litigation for an order approving this Settlement Agreement and staying all proceedings in the Litigation pending successful implementation of the Plan and compliance with the terms hereof. This Settlement Agreement shall become effective upon the Court's issuance of an order approving it. The parties agree that the Court retains continuing jurisdiction over the Litigation to enforce the terms of this Settlement Agreement for five (5) years from the date on which the Court issues an order approving its terms. Subject to the requirements of paragraph 28 below, any party may move the Court for an order to enforce the Settlement Agreement and/or to lift the stay on the Litigation. Upon the expiration of the term of this Settlement Agreement, any party may move for dismissal with prejudice of all claims in the Litigation. If, at the end of the term, no party moves for dismissal, the Court shall enter an order to show cause why all claims should not be dismissed with prejudice.

28. **Enforcement** – If any party concludes that another party has violated any material provision of this Settlement Agreement, the party will notify the Monitor and other parties, including Defendants' Designated Representative, of the alleged violation in writing. Thereafter the parties will promptly attempt to resolve the alleged violation by conferring with each other in good faith to resolve the issue. If the parties are unable to resolve the alleged violation, they will submit the matter to the Monitor for mediation. In the absence of an emergency requiring immediate relief, none of the parties shall be entitled to file a motion to enforce any provision of this Settlement Agreement until the expiration of thirty (30) days from the date on which the party notifies the other parties in writing of the alleged violation and

efforts to resolve the violation, including Monitor-led mediation, have been exhausted. The parties shall equally share the costs of Monitor-led mediation.

29. **Attorney fees and costs regarding enforcement –** Subject to the limitations contained in paragraph 28, any party that obtains an order of the Court enforcing a provision of this Settlement Agreement shall be entitled to an award of its reasonable attorney fees and costs incurred.

General Provisions

30. **Term** – The term of this Settlement Agreement shall be five (5) years from the date on which the Court issues an order approving its terms.

31. **Persons bound** – This Settlement Agreement shall be binding on all Defendants and their successors, together with their officers, agents and employees, unless otherwise prohibited by state or federal law.

32. **Integration** – This Settlement Agreement constitutes the entire agreement among the parties on the matters raised herein, and no other statement, promise, or agreement, either written or oral, made by any party or agent of any party, shall be enforceable.

33. **Scope** – This Settlement Agreement is not intended to resolve any actual or potential violation of the rights of pretrial detainees other than those specifically addressed in the Litigation.

34. **Authority of signatories** – The persons signing this Settlement Agreement represent that they have the authority to do so.

35. **Representations and warranties** – Each party to this Settlement Agreement represents, warrants, and agrees as to itself as follows:

a. It has fully and carefully reviewed this Settlement Agreement prior to its execution by an authorized signatory.

b. It has consulted with its attorneys regarding the legal effect and meaning of this Settlement Agreement and all terms and conditions hereof, and that it is fully aware of the contents of this Settlement Agreement and its legal effect.

c. It has had the opportunity to make whatever investigation or inquiry it deems necessary or appropriate in connection with the subject matter of this Settlement Agreement.

d. It has not heretofore assigned or transferred, or purported to assign or transfer, to any person or entity any claims that it might have against the other.

e. It is executing this Settlement Agreement voluntarily and free from any undue influence, coercion, duress, or fraud of any kind.

36. **Waiver** – No waiver of any of the provisions of this Settlement Agreement shall be deemed or constitute a waiver of any other provision, whether or not similar, nor shall any waiver constitute a continuing waiver. No waiver shall be binding unless executed in writing by the party making the waiver.

37. **Counterparts** – This Settlement Agreement may be executed in identical counterparts, each of which for all purposes is deemed an original, and all of which constitute collectively one agreement. The parties intend that faxed signatures and electronically-imaged signatures such as PDF files shall constitute original signatures and are binding on all parties. An executed counterpart signature page delivered by facsimile or by electronic mail shall have

the same binding effect as an original signature page. This Settlement Agreement shall not be binding until all parties have signed and delivered a counterpart of this Settlement Agreement whether by mail, facsimile, or electronic mail.

38. **Modification** – Settlement Agreement may be modified if the parties are in agreement. Any modification to this Settlement Agreement shall be in writing.

39. **Attorney Fees** – Subject to the provisions in paragraph 29, above, each party shall bear his, her or their own attorney fees and costs of court incurred in the matter to the effective date of this Settlement Agreement.

40. **Notices** – Any notice or other communication required or permitted under this Settlement Agreement shall be in writing and shall be deemed to have been duly given when (a) mailed by United States registered or certified mail, return receipt requested, (b) mailed overnight express mail or other nationally recognized overnight or same-day delivery service, (c) sent as PDF attachment to electronic mail, or (d) delivered in person, to the parties at the following addresses:

If the Disability Center, to:

DISABILITY LAW CENTER
205 North 400 West
Salt Lake City, Utah 84103

Attention: Aaron M. Kinikini
Erin B. Sullivan
Email: akinikini@disabilitylawcenter.org
esullivan@disabilitylawcenter.org

With a copy to:

Alan L. Sullivan
Bret R. Evans
SNELL & WILMER L.L.P.
15 West South Temple, Suite 1200 Gateway Tower West
Salt Lake City, Utah 84101

Email: asullivan@swlaw.com
brevans@swlaw.com

If the Department, to:

DEPARTMENT OF HUMAN SERVICES
195 N. 1950 West, 4th Floor
Salt Lake City, Utah 84116

Attention: Ann Williamson
Lana Stohl

Email: annwilliamson@utah.gov
lstohl@utah.gov

If the Division, to:

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A party may change the names or address where notice is to be given by providing notice to the other parties of such change in accordance with this paragraph 40.

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EXHIBIT
1

A Strategic Plan for Providing Utah Adult Mental Health Competency Restoration Services

Revised June 9, 2017

INTRODUCTION

The State of Utah provides competency restoration services to individuals court-ordered to the Department of Human Services (DHS) as Not Competent to Proceed (NCP) under Utah Code Ann. §§. 77-15-1 *et. seq*. This plan outlines the process for how these services are delivered and contains information regarding the clinical programs provided. Utah's system of competency restoration services is based on best practices and successful endeavors in Utah and other states. Utah is addressing the increased demand for forensic services by building capacity and programs that are clinically appropriate and cost effective. A best practice model is in the developmental stages nationally. The traditional inpatient approach is no longer viewed as the sole recommended model of care, as evidenced by the fact that at least 10 states now have some form of competency restoration treatment that is conducted in a jail or adapted setting. Utah's model of care includes outpatient treatment; treatment at an offsite forensic facility; treatment at alternative therapeutic units; and inpatient competency restoration treatment programs. This comprehensive system of care includes vital components for processing court orders, assigning court-ordered evaluations to forensic examiners, screening individuals found NCP for appropriate program placement, treatment plan development, clinical and educational competency restoration services, evaluating clinical progress, tracking outcomes data, and discharge planning. Ongoing communication and collaboration with the courts, correctional facilities, and attorneys is vital to operational efficiency.

COMPETENCY RESTORATION OVERVIEW

Historically, competency restoration services have been provided at the Utah State Hospital's (USH) forensic inpatient unit. Over the past 30 years, the demand for forensic services in Utah and nationwide has experienced exponential growth, creating a strain on existing resources. Some of the circumstances that have contributed to this growth in Utah include an increase in 1) the number of competency petitions filed; 2) the number of people found NCP by the courts and referred to DHS; and 3) the acuity level of patients entering the system. Some states have converted non-forensic inpatient beds into forensic beds to respond to the increased demand. In many states, competency restoration services are being provided in non-inpatient settings allowing provision for a more efficient and appropriate level of care for those individuals not needing an inpatient level of competency restoration services. According to a report by the Washington State Institute for Public Policy (*Standardizing Protocols for Treatment to Restore Competency to Stand Trial: Interventions and Clinically Appropriate Time Periods*, January 2013), there are five treatment modalities in the literature to address the competency restoration needs of those found NCP that include:

(1) Medications;
(2) Treatment for individuals with developmental disabilities;
(3) Educational treatment programs;

(4) Specialized/individual treatment programs; and
(5) Cognitive remediation programs.

The study also describes incompetence as predicated on two components that are typically addressed in treatment: (1) a mental disorder or cognitive impairment and (2) a deficit in one or more competence-related abilities (i.e., understanding, appreciation, reasoning, assisting counsel) that occur as a result of the mental disorder or cognitive impairment. Improvement in the underlying mental disorder or cognitive impairment often results in the improvement in competence-related deficits. This forms the basis for psychotropic medications being one of the primary treatment modalities in competency restoration treatment. In addition, the use of educational approaches to increase the patient's factual understanding of the legal proceedings and to assist in participating with their defense counsel is beneficial.

The Washington State Institute for Public Policy report revealed limited success in competency restoration outcomes for individuals with intellectual and/or developmental disabilities. Most programs that have been studied demonstrate a 33 percent average competency restoration rate for individuals with intellectual disabilities compared to a 70 percent average for those with mental illness. The "Slater Method" is a competency restoration tool that is typically used to treat individuals with intellectual disabilities. Length of time to restoration is longer for people with intellectual disabilities than the time to restoration for people without intellectual disabilities. It has been DHS' experience that most individuals who require specialized services for intellectual disabilities do better when treated under the supervision of state agencies designed to treat the unique needs of this population. Utah identifies these individuals when referred to DHS and makes every effort to direct their competency restoration treatment to the Division of Services for People with Disabilities (DSPD).

Most research demonstrates that individuals who participate in education groups have a significantly higher rate of restoration than those who do not. Many states across the country have implemented education programs that are of varying structure and delivery styles. Yet, the basic components are similar. Programs in the North Coast Behavioral Healthcare System in Ohio; the Alton Mental Health and Development Center in Illinois; the Atascadero Hospital in California; the RISE program in Denver, Colorado; as well as others, include treatment modalities such as: educational groups; experiential modules, such as mock trials; medication management; and cognitive remediation. These best practice principles are incorporated into Utah's restoration program development. Another well recognized program used to inform Utah's model of care is the 'Comp-Kit' restoration program developed and implemented in 2006 by Florida's mental health forensic system.

Even though the literature is limited and does not specifically identify one national best practice model for competency restoration, current programs have similar components and outcomes. The National Judicial College in Reno, Nevada assembled a panel of experts to develop a Mental Competency Best Practice Program. Though the main tenet of their recommended approach is similar as that described above, it is recommended that clinicians assess the individual's need for competency restoration and tailor the program individually rather than placing all individuals into the same curriculum and treatment modalities.

SUMMARY of ESSENTIAL RESTORATION SYSTEM ELEMENTS:

1. Court-ordered competency restoration process
2. Court referral monitoring system
3. Initial treatment screening to determine appropriate level of service delivery
4. Initial mental health evaluation
5. Identification of barriers to competency restoration
6. Development of an individualized treatment plan
7. Engagement of treatment modalities
8. Ongoing progress towards competency assessments
9. Documentation of interventions and response to interventions
10. Re-evaluation of competency
11. Court Referral and reporting process

STRATEGIC ACTION PLAN

In order to ensure the State of Utah has adequate resources available to provide competency restoration services to individuals who have been court-ordered to DHS, it is imperative that a

strategic action plan be developed, implemented, and have ongoing evaluation to assure timely provision of treatment services.

A wider array of stakeholders must be engaged to more fully address the competency restoration needs of the citizens of Utah. Successful implementation of a strategic plan requires co-operation, communication and collaboration with a variety of stakeholders and participants involved in the competency restoration process, including, but not limited to: the district courts; referring county and municipal courts; prosecutors; the defense bar; the counties/Local Mental Health Authorities (LMHAs); local sheriffs' offices and jails; law enforcement; and the Utah Legislature.

Outcomes used to assist in this determination will include service access wait times, restoration rates, and length of time for restoration. Each service delivery option will be evaluated for efficiencies and appropriate patient placements.

Each year, DHS, in collaboration with other state leaders, will review these outcomes and make proposals when increased resources are necessary. Options may include: additional offsite forensic facilities; alternative therapeutic units located on or off the USH campus; additional beds at USH; and addressing timely and appropriate competency restoration treatment for women in a clinically appropriate setting. Counties are encouraged to consider pre-evaluation processes to facilitate access to mental health services for individuals with serious mental illness, prior to, or upon entering the criminal justice system, and redirect individuals from entering the forensic system when community services are more appropriate.

1. Purposes and Implementation of the Strategic Plan

The purposes of this strategic plan are as follows:

(a) Outline the specific steps to be taken to reduce the period of time during which patients committed to DHS must wait to receive competency restoration treatment;

(b) Comply with the timeframes established in the Settlement Agreement approved by the Court in the matter of *Disability Law Center, et. al. v. State of Utah, Department of Human Services, et. al., Case No. 2:15-cv-00645-RJS-BCW.*

(c) Implement a series of indicators that will measure the quality and efficiency of competency restoration treatment for patients committed to DHS for competency restoration treatment; and

(d) Monitor and adjust resource investment and allocation to achieve the purposes of the strategic plan.

The implementation of this strategic plan is to be contemporaneous with the establishment of the first offsite forensic facility proposed at the Salt Lake County Metro Jail, or September 30, 2017, whichever occurs later.

2. Service Delivery Options

Like many other states, Utah has recognized the need for additional cost-effective and clinically appropriate services to meet the demand for forensic services. In 2014, USH, in collaboration with the Division of Substance Abuse and Mental Health (DSAMH) and DHS, recommended four levels of treatment services that are appropriate for competency restoration. This was presented in response to a 2014 legislative audit. They are listed in order from the least to highest associated clinical need:

a) Outreach Program: Providing competency restoration treatment to patients:
   i. on release from the court in the community;
   ii. in jail within their home community; or
   iii. in prison.

b) Offsite Forensic Facility: Providing competency restoration treatment to patients in a specialized, structured competency restoration program within a jail or other secure setting.

c) Alternative Therapeutic Unit: Providing competency restoration treatment in any treatment unit established and operated by USH or under contract with DHS on or off of the USH campus for patients who do not require hospitalization level of care.

d) Inpatient Forensic Beds at USH: There is capacity but not infrastructure for expansion of inpatient hospital beds at the USH campus.

Not all patients referred to DHS for competency restoration treatment require hospital inpatient level of care and its associated interventions. Screening processes are designed to identify persons found NCP who can, within a reasonable timeframe, be restored to competence in the least restrictive, clinically appropriate environment and without requiring admission to an inpatient setting.

There are identifiable advantages to offering outpatient competency restoration services to individuals with lower psychiatric acuity levels including:

a) Decreased incarceration time
b) Decreased transportation costs
c) Improved supports to assist in treatment within their local communities
d) Enhanced access to community mental health treatments
e) Facilitated access into ongoing outpatient treatment support systems
f) Ongoing access to defense counsel, family, and other supports
g) Reduced stigma associated with psychiatric hospitalization.

If a patient is placed in any program or level of service based on screening criteria and later is determined to either be progressing faster or not progressing as expected to meet the required time frames, the patient will be transferred to the more appropriate level of care based on their clinical status.

3. Offsite Forensic Facilities

(a) DHS is currently planning an offsite forensic facility with day competency restoration treatment in a county jail. This is a five days per week, eight hours per day program to provide competency restoration treatment to patients who need a structured environment, similar to a mental health unit, but do not need the services of an inpatient psychiatric hospital. Patients will be identified according to their acuity, and treatment will be individualized accordingly.

(b) Based on the success of this initial program and in the assessment of future program needs, DHS may request funding for additional offsite forensic facilities (including, but not limited to, a female only offsite forensic facility) to meet the needs of the population. DHS will determine funding and staffing patterns following a review of the current program outcomes and inflationary costs. If DHS determines that there is a greater number of patients needing inpatient care, DHS will request funding for additional beds at USH or another appropriate alternative therapeutic unit. This funding request would be similar to the funding at that time for one USH forensic unit (current cost is approximately $4.5 million dollars). Staffing levels would be similar to a current forensic unit based on this budget information.

(c) In 2017, the first offsite forensic program will be developed in partnership with Salt Lake County due to its Metro Jail's central geographic location and the large number of competency restoration referrals that arise from Salt Lake County. This program has an annual operating budget of approximately $3 million. Funding will be available by July 1, 2017. DHS will begin to develop and coordinate operational procedures, recruitment and implementation of the program as soon as funding is assured through the legislative process. It is intended that actual program implementation will begin no later than September 30, 2017.

In developing contracts for offsite forensic facilities, provisions will be included that address training for the correctional personnel including but not limited to: Crisis Intervention Team (CIT) training and training from the USH Psychiatric Technician training modules. The jail will provide 24-hour emergency psychiatric and emergency medical care of patients when forensic staff are not on site and forensic programming is not being conducted. Subject to the terms of the contract(s) for each offsite forensic facility and available funding, the anticipated staffing and training of the offsite forensic facility will be commensurate with their counterparts at the USH. Patient programming and staffing levels at each offsite forensic facility will be guided by a Program Manual that will soon be developed, subject to modification by the USH Forensic Director, based upon the physical environs of the facility, availability of security staff, and other contract provisions to be determined once each offsite forensic facility is identified.

4. Outreach Program Services

Since 2015, the Utah Legislature has recognized the value of DHS' Outreach Program whereby clinicians provide competency restoration treatment to patients by conducting weekly visits to

those who are: (1) released to the community by the court; (2) housed in their home community jail; or (3) in prison. These services are provided to patients whose screening indicates that they are likely to show meaningful progress towards restoration of competency within 30 days, whose symptoms are stabilizing, and who are likely to be referred for re-evaluation and restored to competency within sixty (60) days.

Some Outreach Program patients will remain in their own county based on the following factors: (a) closeness to family and other supports; (b) desire to stay in the area; (c) upcoming hearing and efficiency in time by not transporting to another area; (d) closeness to legal representation; (e) significant progress with current situation; or (f) gender as the offsite forensic facility programming is male only at this time.

5. **Projecting Future Needs**

(a) USH has projected that the annual number of pretrial detainees in Utah's county jails for which custody or commitment orders will have been issued will continue to increase. If the number of court-ordered pretrial detainees does not increase, USH will continue to monitor trends each year to revise projections.

(b) USH believes that, depending on system changes including the addition of new levels of care and program efficiencies decreasing length of stay in all programs and facilities, it may need additional competency restoration Outreach Program professionals who provide screening, assessment, and treatment services. This will be closely monitored and evaluated based on length of time to access these services and the length of stay in these services in the context of the entire system.

(c) USH believes that, depending on system changes including the addition of new levels of care and program efficiencies decreasing length of stay in all programs and facilities, it may need additional forensic evaluators who are employed to conduct evaluations for the Outreach Program if projections are accurate. This will be closely monitored and evaluated based on length of time to access these services and the length of stay in the Outreach Program in the context of the entire system.

(d) USH will annually evaluate the state's ability to meet the respective service level need and projected number of patients requiring competency restoration treatment, and request additional funding to adequately provide services to all those court-ordered to DHS for purposes of competency restoration treatment. The amount to be requested will be determined by the level of service required to meet the acuity needs of those committed to DHS, taking into consideration the outcomes of each program in meeting the timeframes for competency restoration in the Settlement Agreement and relevant statutes, inflationary costs, and other factors.

6. Expansion of USH Forensic Unit

In addition to the establishment of the offsite forensic facilities referenced in paragraph 3 of this strategic plan, the State projects that, depending on system changes including the addition of new levels of care and program efficiencies decreasing length of stay in all programs and facilities, there may be further need for increased inpatient treatment capacity. The current capacity of the USH forensic unit is 100 patients for all forensic commitments required by law, including NCP, guilty and mentally ill, and not guilty by reason of insanity. The current USH forensic unit was designed to expand by being able to add additional 25-bed units to the existing structure to a capacity of 200 beds. Based on the number of future court referrals and timeframes for competency restoration services, the State may need to request additional funding for the construction or procurement of another facility on or off the USH campus. This will be closely monitored and evaluated based on length of time to access inpatient services and the length of stay in the context of the entire system.

7. Post-Treatment Follow-up

DSAMH/USH will continue to evaluate the most efficient and cost-effective programs and interventions to assist pretrial detainees in maintaining their competency. USH staff will work with counties and provide case management to help monitor and support the patient in their restoration status and facilitate continuity of care.

8. Efficiency Improvements

Outcomes reflect operational efficiencies and clinical effectiveness. Utah's adult mental health competency restoration outcomes will be monitored monthly and evaluated on a quarterly basis at which time changes will be considered to strengthen the results. Adjustments in screening, assessment, treatment, monitoring, program placements, and delivery of services will be made where deficiencies are identified. Outcome indicators are as follows:

1. Length of time from court-ordered referral to treatment program admission;
2. Length of stay in any of USH's competency restoration treatment programs;
3. Percent of court-ordered referrals screened in a timely manner (*i.e.*, within seventy-two (72) hours, excluding weekends and holidays, of DHS's receipt of the district court order for competency restoration treatment);
4. Percent of patients screened into the Outreach Program who are restored or not restored within 60 days; and
5. Percent of patients treated within USH's forensic system who are found competent to proceed.

Targets are identified and adjusted based on best practice standards, baseline measurements and agreements made during system monitoring. Monitoring systems and outcome measures are utilized to ensure individuals within each level of service have been properly placed into programming and changes in status result in reassessment of

the patient. Monitoring also ensures that patients in each level of care are not "lost in the system." LOS and competency status data will receive ongoing utilization reviews to flag those patients who may not be responding appropriately as expected in each level of care. Nationally, outpatient and jail-based programs have shorter LOS than inpatient programs.

Ongoing utilization review means that treating clinicians are reassessing the appropriateness of the current treatment program for the patient with each treatment encounter, and making a determination about program placement or movement at the earliest and most appropriate time.

If at any time it is determined a patient is not progressing in treatment, USH will reassess for the appropriate level of service.

9. Forensic Evaluation System (FES)

When a district court judge orders a competency evaluation, the order should be entered into DHS' Forensic Evaluation System (FES), which is automated to coordinate with state examiners contracted to complete ordered evaluations. Some counties or courts may elect to assign evaluators independent of the FES. Regardless, all orders and evaluations are monitored in the FES. The examiners provide an initial report to the court and parties within 30 days of receipt of the court's order. The examiner may inform the court in writing that additional time is needed to complete the report. The examiner shall have up to an additional 30 days to provide the report if requested in writing. The examiner shall provide the report within 60 days from the receipt of the court's order unless, for good cause shown, the court authorizes an additional period of time to complete the report. If after reviewing the forensic evaluation the judge determines an individual is NCP, the court should send the order for competency restoration to DHS via email into the FES. USH and DSAMH monitor the FES to ensure that all components of the service delivery system are addressed and correspondence with the court and the parties is done in a timely manner under the current statutory scheme. Discovery and other documents and outcome data are also tracked through the FES.

10. Utah Competency Restoration Service Delivery System (See Flow Chart)

The district court should send orders for competency restoration to the USH Legal Service Office, which manages the FES system. Information regarding referrals and evaluations is managed in the FES. All patients ordered to DHS for competency restoration are screened to determine the appropriate level of care needed.

A. Screening Process

Within seventy-two (72) hours, excluding weekends and holidays, of receiving the court order, USH forensic staff shall determine which level of service is appropriate for the patient using a screening tool approved by the USH Forensic Director. The screening process utilizes best practice evaluation tools to determine whether:

1. A patient is likely to be restored to competency through treatment available by the Outreach Program;
2. A patient is likely to be restored to competency through treatment available at an offsite forensic facility;
3. A patient needs inpatient hospital services at the USH forensic unit;
4. A patient is likely not restorable;
5. A patient requires referral to DSPD services; or
6. A patient has other dispositional needs, such as a nursing home placement.

The Initial Competency Restoration Screening tool to be used in the screening process is attached as Appendix A. The screening process may undergo further development and refinement, to include specific scoring guidelines for patient level of service.

Note: Female patients who have been found not competent to proceed will be referred to either the Outreach Program or USH unless and until another program is identified to meet the needs of females who would otherwise be screened to an offsite forensic facility, including, but not limited to, the establishment of a female only offsite forensic facility program.

B. Screening Criteria

The following represents general criteria used by USH Forensic Unit professionals to determine level of service needed:

a. Patient's attitude towards and consent to take medication;
b. Patient's response to medication treatment;
c. Level of risk (i.e., suicide, self-harm, harm to others, etc.);
d. Physical health/medical concerns;
e. Current progress towards competence; and
f. Patient's willingness to engage in treatment.

If an individual is placed in the Outreach Program, competency restoration treatment begins within 14 days of receiving the court order requiring such treatment, though Outreach Program clinicians strive to begin treatment services within 7 days or less of receiving the court order. Part of that treatment is the engagement of jail personnel to provide medication management services if such services are not already in place for patients in their home community jails. If the patient is screened for treatment in an offsite forensic facility or referred to USH's forensic unit, the patient is transferred into the first open bed within 14 days of receiving the court order requiring such treatment.

C. Treatment Disposition

If a patient is determined to be a candidate for the Outreach Program, an offsite forensic facility, an alternative therapeutic unit, or USH's forensic unit, an individualized treatment plan (ITP) is established.

If, at any time, a USH Forensic Unit professional determines that a patient is likely not restorable, the USH administrator will request a re-evaluation from a forensic evaluator. The forensic evaluator conducts the evaluation and a report is sent to the court for further disposition.

If, at any time, a USH Forensic Unit professional determines that a patient is not likely to restore to competency through the Outreach Program, at an offsite forensic facility, or at an alternative therapeutic unit, then coordination is made with the USH staff for admission to inpatient level of care at USH. The USH Forensic Outreach Competency Progress Assessment tool is attached as Appendix B.

If it is determined that a patient may meet the criteria for an intellectual disability, a referral is made within seventy-two (72) hours, excluding weekends and holidays, to DSPD for competency restoration services. If DSPD does not accept the referral, the patient is screened for USH treatment services and all timeframes apply.

If a patient is determined at any time throughout the screening or treatment process to meet the criteria to be found competent to proceed, the USH administrator will request a re-evaluation from a forensic evaluator. The forensic evaluator conducts the evaluation and a report is sent to the court for further disposition.

D. Treatment Services

The program administrators at each level of service coordinate with the treating staff and other agencies involved in the custody or care of the patient to develop an ITP and identify necessary treatment modalities. Types of competency restoration interventions may include, but are not limited to, individual instruction; individual therapy; group therapy; educational or psychoeducational materials; assignments; recreational therapy; occupational therapy; and medication management. Treatment staff may also coordinate services with jail treatment providers or LMHAs for medication management and other appropriate medical services. The competency curriculum is consistent with criteria in Utah's competency statutes. The following program outline describes the restoration treatment delivery system at each level of service:

1. **Referral Screening Process**
    a. Each individual is screened by a qualified USH Forensic Unit professional within seventy-two (72) hours, excluding weekends and holidays, of receiving a court order for competency restoration.
    b. A qualified USH Forensic Unit professional utilizes scoring guidelines from the initial screening tool (Appendix A) to identify the appropriate level of service to which the individual should be referred.

c. A qualified USH Forensic Unit professional will continue to visit with all referrals weekly while the individual is being evaluated for the appropriate program.

2. Outreach Program

a. The Outreach Program is designed for patients who are likely to show meaningful progress towards restoration of competency within 30 days, whose symptoms are stabilizing, and who are likely to be referred for re-evaluation and restored to competency within 60 days.

b. If the Outreach Program clinician determines that the patient is appropriate for treatment through the Outreach Program and the county jail is deemed a sufficient location in which to provide competency restoration services, the Outreach Program clinician will commence treatment in the home community jail after considering the criteria outlined in Section 4 above, "Outreach Program Services."

c. Outreach Program staff will arrange weekly treatment encounters with patients who are on a release to the community by the court.

d. If the patient is female and is appropriate for the Outreach Program, weekly visits will occur in the home community jail.

e. An ITP is established for each Outreach Program patient based on individualized needs and identified barriers to competence.

f. Coordination among Outreach Program staff occurs weekly to evaluate treatment progress, modify the patient's ITP as indicated, and coordinate medication management with local county jails as required in Utah Code Ann. Sect. 17-43-301(5)(a)(i) or pursuant to a contract anticipated to be entered with Salt Lake County for an offsite forensic facility.

g. An Outreach Program clinician visits with the patient for at least 60 minutes weekly to provide competency restoration treatment and psychoeducational material from the Outreach Competency Training Program manual addressing barriers to competence identified in the ITP. The manual is attached as Appendix C.

h. Patients are reassessed minimally every two (2) weeks to determine progress towards competence.

i. Patients will be disqualified from competency restoration treatment in the Outreach Program if he or she exhibits suicidal ideations with intent to harm, engages in repeated acts of self-harm, persistently refuses medications necessary for competency restoration with no rational basis, exhibits a significant decline in clinical stability, or is diagnosed with a moderate to severe intellectual or developmental disability.

j. If an Outreach Program clinician determines that a patient should be disqualified from the Outreach Program, the patient will be transferred to USH's forensic unit, an Offsite Forensic Facility, or

an Alternative Therapeutic Unit within seventy-two (72) hours, excluding weekends and holidays.

k. Patients who are not ready to be referred for reevaluation for restoration status within sixty (60) days will be re-assessed by USH staff for the appropriate level of competency restoration services.

l. If a qualified USH Forensic Unit professional determines that the Outreach Program is no longer clinically appropriate or effective for a patient, the patient must be transferred to USH's forensic unit, an Offsite Forensic Facility, or an Alternative Therapeutic Unit within seventy-two (72) hours, excluding weekends and holidays.

3. Offsite Forensic Facility

a. An offsite forensic facility is a competency restoration program administered by USH forensic personnel, or by similarly qualified professionals employed by DHS's contractor, at a location other than the USH Campus. Expected capacity at an offsite forensic facility is twenty-two (22) to forty (40) beds.

b. A competency restoration program can be established in any secure offsite facility that has the availability of security staff. This is typically a jail or other secure setting. Any site can be considered if it meets the need for a secure, structured environment. If the space is located in or leased from a county jail, the space and the residents must be segregated from the jail's general inmate population.

c. A competency restoration program at an offsite forensic facility is designed for patients that are in need of more comprehensive treatment than those referred to the Outreach Program and are likely to be restored within two to four months. These patients are not considered a risk of immediate harm to self or others, do not have high acuity medical needs, and are demonstrating that they are willing to engage in treatment, including accepting medication management.

d. Patients will be identified by psychiatric acuity for purposes of bunking assignments, safety assessment, and in creating an ITP.

e. Patients receive day treatment services Monday through Friday. Operational hours may vary but be minimally set from 8:00 a.m. to 5:00 p.m. DHS anticipates some programming may occur in the evenings and on weekends.

f. A treatment team assesses and develops an ITP for each patient based on individualized needs and identified barriers to competence.

g. It is anticipated that the treatment team will consist of a psychiatrist, psychologist, social workers, nursing staff, psychiatric technicians, recreation therapist, case worker, and office specialist,

whose training and credentials will be commensurate with their counterparts at the USH.

h. Treatment services may include any of the following: medication management, individual therapy, group therapy, psychoeducation, recreation therapy, occupational therapy and other modalities identified as necessary for the patient's ITP. A schedule of USH programming is attached as Appendix D as an exemplar. Appendix D.

i. Patient programming and staffing levels at each offsite forensic facility will be guided by a Program Manual that will soon be developed, subject to modification by the USH Forensic Director, based upon the physical environs of the facility, availability of security staff, and other contract provisions to be determined once each offsite forensic facility is identified.

j. It is anticipated that a contractual arrangement with a county jail or other appropriate offsite facility will provide the program with security personnel, medical services, food, clothing, medications, and medical and mental health crisis services after hours.

4. USH Inpatient Restoration Services

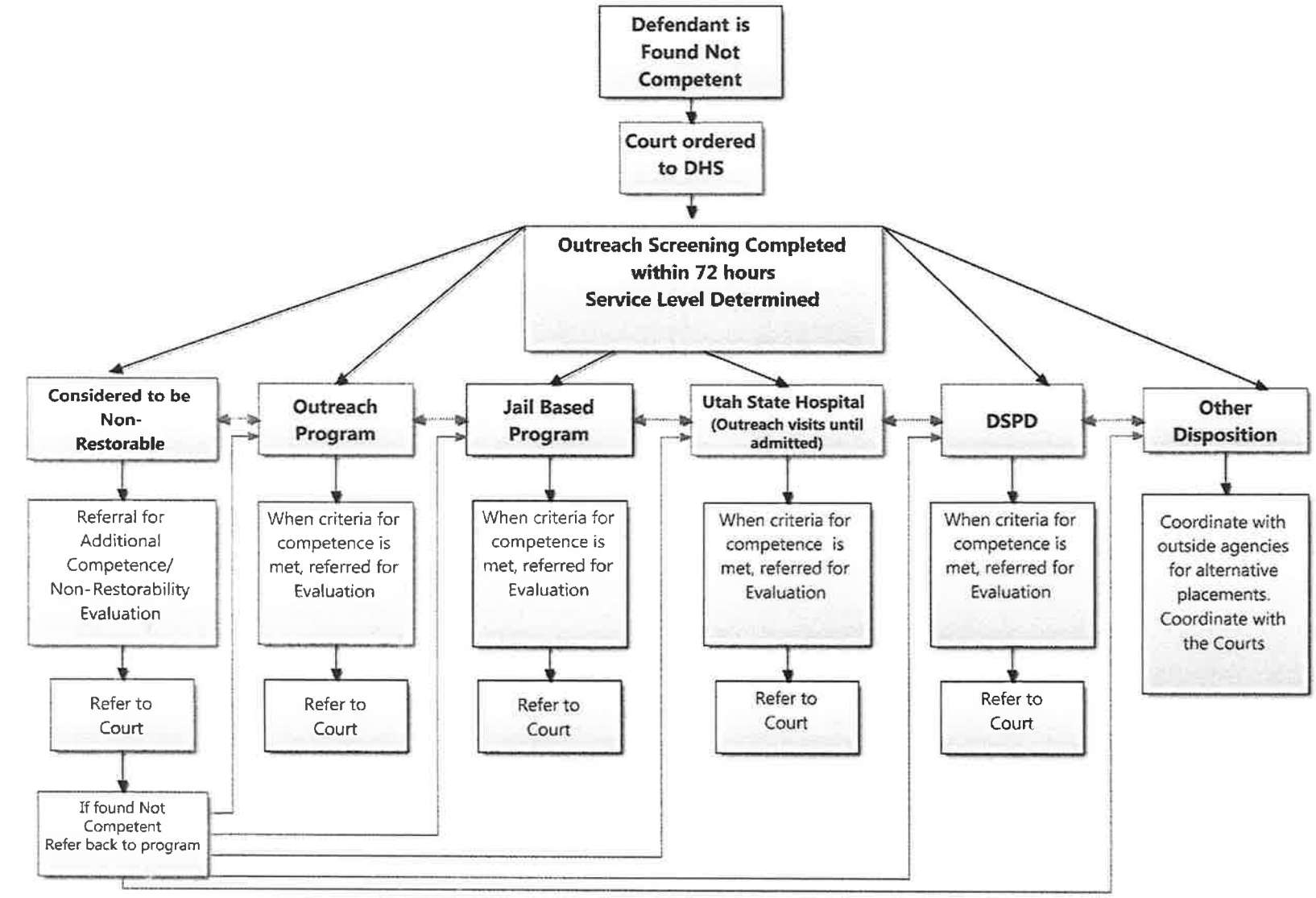
a. Patients who are not found to be appropriate for the Outreach Program or an offsite forensic facility treatment program are referred to USH for inpatient services within seventy-two (72) hours, excluding weekends and holidays.

E. Evaluations

All court-ordered NCP patients will have an initial assessment once they are screened and admitted to one of USH's treatment programs. A report will then be sent to the court pursuant to Utah Code Ann. Sect. 77-15-6. Any time after the patient is found NCP but is showing significant progress towards restoration, a referral can be made for competency re-evaluation by a forensic evaluator. The referral should be made within seventy-two (72) hours, excluding weekends and holidays, of the determination by USH Forensic Unit professionals that the individual has made significant progress towards restoration. Once a referral for follow-up evaluation is made to a forensic evaluator, the evaluation will be completed within fourteen (14) working days. The evaluation report is sent to the court promptly upon completion. The USH Clinical Director or designee certifies all reports recommending the individual be found competent to proceed according to Utah's competency statutes.

F. Collaboration

USH Forensic Unit professionals work in consultation with jail staff, court personnel, families, LMHAs, or others involved in the care, custody or treatment to ensure continuity of care and communication. The USH Legal Services Office and Forensic Director ensure that the courts are kept apprised of the progress and status of all individuals ordered to DHS consistent with Utah's statutory framework.



At anytime a defendant is not progressing within a level of service a referral is made to the appropriate program that meets the needs of the individual

2/17

EXHIBIT
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NOTICE OF PROPOSED CLASS ACTION SETTLEMENT

Disability Law Center, et al. v. State of Utah, et al.
Case No. 2:15-CV-00645-RJS-BCW

You will be affected by the settlement of a class action lawsuit called *Disability Law Center, et al. v. State of Utah, et al.*, Case No. 2:15-CV-00645-RJS-BCW. This notice summarizes the claim in the lawsuit, what the settlement entails, and your rights under the settlement.

The Court has scheduled a hearing to consider the settlement on [DATE] at [TIME] before the Honorable Judge Robert J. Shelby at Courtroom 7.300, United States District Court for the District of Utah, 351 South West Temple, Salt Lake City, Utah 84101. This hearing is referred to as the Final Settlement Approval Hearing.

SUMMARY OF THE LAWSUIT

The issue in this lawsuit is whether the Utah State Hospital (USH) has failed to timely provide court-ordered competency restoration treatment for individuals who have been found incompetent to stand trial.

A Class Member is any individual who is now, or will be in the future, (i) charged with a crime in Utah, (ii) determined by the court in which they are charged to be mentally incompetent to stand trial, and (iii) ordered to the custody of the executive director of the Utah Department of Human Services or a designee for the purpose of treatment intended to restore the defendant to competency, but who remain housed in a Utah county jail.

The lawyers representing class members ("Class Counsel") are Aaron M. Kinikini and Erin B. Sullivan of the Disability Law Center, 205 North, 400 West, Salt Lake City, UT 84103, and Alan L. Sullivan and Bret R. Evans of Snell & Wilmer, LLP, 15 W South Temple #1200, Salt Lake City, UT 84101.

DESCRIPTION OF THE PROPOSED SETTLEMENT AGREEMENT

The Plaintiffs and the State of Utah have reached a settlement that would release the State from any further liability related to this claim. The Settlement Agreement requires USH to do the following, subject to Court approval:

- Within 72 hours of learning that a criminal defendant is found incompetent to stand trial and ordered to the custody of the Utah Department of Human Services, a USH Forensic Unit professional must screen each class member to determine the appropriate level of competency restoration treatment;
- Within 6 months, provide court-ordered to competency restoration treatment to criminal defendants found incompetent to stand trial within 60 days;
- Within 12 months, provide court-ordered to competency restoration treatment to criminal defendants found incompetent to stand trial within 30 days; and
- Within 18 months, provide court-ordered to competency restoration treatment to criminal defendants found incompetent to stand trial within 14 days.

The settlement also creates a system to monitor USH's compliance with the Settlement Agreement and requires the State of Utah to pay fees to the court-approved monitor.

You have the right to learn more about the settlement. A copy of the preliminarily-approved Settlement Agreement is enclosed with this Notice. If you are unable to read or understand the Settlement Agreement, contact Class Counsel referred to in Question 6 below.

OBJECTIONS OR COMMENTS TO THE PROPOSED SETTLEMENT

The United States District Court for the District of Utah has preliminarily approved the Settlement Agreement but will hold a Final Settlement Approval Hearing to determine whether it is fair, reasonable, and adequate on [DATE] at [TIME] in Courtroom 7.300 of the federal courthouse located at 351 South West Temple, Salt Lake City, Utah 84101.

Class Members have a right to object to the terms of the settlement. If you have objections, comments, or statements about the proposed Settlement Agreement, you must make them in writing using the attached "Response to Proposed Class Action Settlement" form or your own paper. A self-addressed stamped envelope is included for your convenience. Written objections, comments, and statements should be sent to the following address: **Disability Law Center, 205 N 400 W, Salt Lake City, UT 84013**. Objections must be submitted or postmarked no later than [DATE].

Objections **must** include all of the following information:

(1) The objector's contact information (name, address, offender number);
(2) An explanation of the basis for the objector's objection to the Settlement Agreement; and
(3) Whether the objector intends to appear at the Final Settlement Approval Hearing on [DATE].

All information submitted to Class Counsel will be provided to counsel for the State of Utah and the District Court in advance of the Final Settlement Approval Hearing. It is not necessary for Class Members to appear at the Final Settlement Approval Hearing. Any Class Member who has submitted a timely objection as provided above and who wishes to appear at the Final Settlement Approval Hearing must give notice by calling the Disability Law Center, sending notice in writing, or using the attached "Response to Proposed Class Action Settlement" form. Objectors may withdraw their objections at any time. **Any objections, comments, or statements that do not comply with the above procedures and timeline will not be heard or considered by the Court.**

HOW TO GET MORE INFORMATION

This is a summary of the Settlement Agreement. If you have any questions about the matters contained in this notice or any questions regarding the settlement, you may write or call Class Counsel below:

DISABILITY LAW CENTER
205 North 400 West
Salt Lake City, UT 84103
(801) 363-1347
Toll Free: (800) 662-9080

RESPONSE TO PROPOSED CLASS ACTION SETTLEMENT

***DLC, et al. v. State of Utah, et al.*, Case No. 2:15-CV-00645-RJS-BCW**

Full Name: _____

Address: _____

_____

_____

Criminal Case No.: _____

Criminal Attorney: _____

Objections/Comments/Statements:

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Do you want to provide oral testimony to the Court regarding the settlement? Yes __ No __

Date: _____ Signature: _____

EXHIBIT
3

NOTICE OF PROPOSED CLASS ACTION SETTLEMENT

Disability Law Center, et al. v. State of Utah, et al.
Case No. 2:15-CV-00645-RJS-BCW

One or more of your clients will be affected by the settlement of a class action lawsuit called *Disability Law Center, et al. v. State of Utah, et al.*, Case No. 2:15-CV-00645-RJS-BCW. This notice summarizes the claim in the lawsuit, what the settlement entails, and your client's rights under the settlement. **Please share this notice and the proposed Settlement Agreement with your client's family members and any known legal guardian of your client, and encourage them to submit any objections, comments, and or statements that they may have regarding the proposed Settlement Agreement**.

The Court has scheduled a hearing to consider the settlement on [DATE] at [TIME] before the Honorable Judge Robert J. Shelby at Courtroom 7.300, United States District Court for the District of Utah, 351 South West Temple, Salt Lake City, Utah 84101. This hearing is referred to as the Final Settlement Approval Hearing.

SUMMARY OF THE LAWSUIT

The issue in this lawsuit is whether the Utah State Hospital (USH) has failed to timely provide court-ordered competency restoration treatment for individuals who have been found incompetent to stand trial.

A Class Member is any individual who is now, or will be in the future, (i) charged with a crime in Utah, (ii) determined by the court in which they are charged to be mentally incompetent to stand trial, and (iii) ordered to the custody of the executive director of the Utah Department of Human Services or a designee for the purpose of treatment intended to restore the defendant to competency, but who remain housed in a Utah county jail.

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- Within 18 months, provide court-ordered to competency restoration treatment to criminal defendants found incompetent to stand trial within 14 days.

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You have the right to learn more about the settlement. A copy of the preliminarily-approved Settlement Agreement is enclosed with this Notice. If you are unable to read or understand the Settlement Agreement, contact Class Counsel referred to in Question 6 below.

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If you have objections, comments, or statements about the proposed Settlement Agreement, you must make them in writing using the attached "Response to Proposed Class Action Settlement" form or your own paper. A self-addressed stamped envelope is included for your convenience. Written objections, comments, and statements should be sent to the following address: **Disability Law Center, 205 N 400 W, Salt Lake City, UT 84013**. Objections must be submitted or postmarked no later than [DATE].

Objections **must** include all of the following information:

(1) The objector's contact information (full name and address);
(2) An explanation of the basis for the objector's objection to the Settlement Agreement; and
(3) Whether the objector intends to appear at the Final Settlement Approval Hearing on [DATE].

All information submitted to Class Counsel will be provided to counsel for the State of Utah and the District Court in advance of the Final Settlement Approval Hearing. It is not necessary for Class Members to appear at the Final Settlement Approval Hearing. Any Class Member who has submitted a timely objection as provided above and who wishes to appear at the Final Settlement Approval Hearing must give notice by calling the Disability Law Center, sending notice in writing, or using the attached "Response to Proposed Class Action Settlement" form. Objectors may withdraw their objections at any time. **Any objections, comments, or statements that do not comply with the above procedures and timeline will not be heard or considered by the Court.**

HOW TO GET MORE INFORMATION

This is a summary of the Settlement Agreement. If you have any questions about the matters contained in this notice or any questions regarding the settlement, you may write or call Class Counsel below:

DISABILITY LAW CENTER
205 North 400 West
Salt Lake City, UT 84103
(801) 363-1347

Toll Free: (800) 662-9080

RESPONSE TO PROPOSED CLASS ACTION SETTLEMENT

***DLC, et al. v. State of Utah, et al.*, Case No. 2:15-CV-00645-RJS-BCW**

Your Name: _____

Class Member's Name: _____

Criminal Case No.: _____

Relationship to Class Member: _____

Are you the Class Member's Legal Guardian? Yes ___ No ___

Your Mailing Address: _____

Your E-mail Address: _____

Your Telephone No.: _____

Objections/Comments/Statements:

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(If you need additional space, you may continue writing on the other side of the page or attach additional pages.)

Do you want to provide oral testimony to the Court regarding the settlement? Yes __ No __

Date: _____ Signature: _____

EXHIBIT
4

CURRICULUM VITAE
Academic Year 2015-2016

NAME: Patrick K. Fox, M.D.

EDUCATION:

B.S., Rutgers University, New Brunswick, NJ 1990
M.D., UMDNJ-New Jersey School of Medicine, Newark, NJ 1994

CAREER:

September 2014-Present:
Colorado Department of Human Services
Chief Medical Officer

April 2013-Present:
Colorado Department of Human Services
Deputy Director of Clinical Services, Office of Behavioral Health

October 2013-July 2014 and December 2014-June 2015:
Colorado Department of Human Services
Acting Director, Office of Behavioral Health

April 1, 2012-March 31, 2013:
Denver Health and Hospital Authority
Attending Psychiatrist, Van Cise Simonet Detention Facility

July 1, 2007-March 31, 2012:
Yale University School of Medicine, Department of Psychiatry
Deputy Training Director, Forensic Psychiatry Fellowship

Director, Whiting Forensic Division, Connecticut Valley Hospital

July 1, 1999-June 30, 2007:
Yale University School of Medicine, Department of Psychiatry
Consulting Forensic Psychiatrist, DMHAS, state of Connecticut

July 1, 1997-March 31, 2012:
VA Connecticut Healthcare System
Employed as an Attending Psychiatrist on Duty, providing psychiatric care within the hospital, approximately fifteen hours per week.

June 1994-June 1999:
Yale University School of Medicine, Department of Psychiatry Post-Doctoral
-PGY V, Residency in Forensic Psychiatry, Law and Psychiatry Division, CMHC
-PGYIV, Chief Resident of PTSD/Anxiety Disorders Unit, West Haven VAMC
Psychiatrist for the New Haven Office of Court Evaluations
-PGYIII, West Haven Veterans Affairs Mental Hygiene Clinic
-PGY II, Inpatient Adult and Child Psychiatry Rotations
-PGY I, Transitional Medicine/Psychiatry/Neurology Program

ACADEMIC APPOINTMENTS:

Yale University School of Medicine, Department of Psychiatry
July 1, 1999-June 2008: Assistant Clinical Professor
July 1, 2008-April 2012: Assistant Professor

University of Colorado School of Medicine, Department of Psychiatry
April 1, 2012-Present: Senior Instructor

University of Denver, Graduate School of Professional Psychology
December 2012-Present: Adjunct Faculty

BOARD CERTIFICATION:

American Board of Psychiatry and Neurology, General Psychiatry: 1999, 2009
American Board of Psychiatry and Neurology, Forensic Psychiatry: 2001, 2011

PROFESSIONAL HONORS & RECOGNITION:

Recipient of the Laughlin Fellowship Award in Psychiatry-1998
Rutgers University Cooperative Academic Merit Scholarship-1990

DEPARTMENTAL, UNIVERSITY ACTIVITIES:

1999-2012: Weekly Supervisor for fellow/s, Fellowship in Forensic Psychiatry

1999-2012: Instructor, *Law & Psychiatry Seminar*, Fellowship in Forensic Psychiatry

1999-2012: Instructor, *Seminar in Law and Psychiatry*, Fellowship in Forensic Psychiatry

2000-2012: Coordinator/Instructor, *Public Sector Lecture Series*, Yale Forensic Psychiatry Fellowship

2000-2012: Member, Yale Department of Psychiatry Resident Selection Committee

2003-2007: Case write-up and interview tutor, Yale School of Medicine, Clerkship in Psychiatry

2004-2012: Instructor, *PGY II Seminar, Legal Regulation of Psychiatric Practice and Forensic Psychiatry*

2006-2012: Coordinator/Instructor, *Ethics in Research Module*, Scholarship Seminar, Fellowship in Forensic Psychiatry

2007-2012: Deputy Training Director, Fellowship in Forensic Psychiatry

2007-2012: Member, Yale University Graduate Medical Education, Program Director Committee

2008-2010: Coordinator, *Ethics in Research Seminar* for Yale Fellows in Public Sector Psychiatry and Research

2007-2012: Instructor, *Landmark Cases*, Fellowship in Forensic Psychiatry

2007-2012: Clinical Instructor, Yale Medical School Psychiatry ER Clerkship, West Haven VA

PROFESSIONAL SERVICE:

Professional Organizations

Member, American Psychiatric Association, 2008-present
Member, American Academy of Psychiatry and the Law, 2008-present
Member, Connecticut Psychiatric Society, 2008-2012
-Council Member, 2010-2012
Member, Colorado Psychiatric Society, 2012-present
Forensic Psychiatry Examination Committee, American Board of Psychiatry and Neurology, 2009-present

State of Colorado Committees

May 2013-July 2015: National Governors' Association, Prescription Drug Abuse Reduction Policy Academy

July 2013-October 2013: Co-chair, Civil Commitment Statute Review Task Force

August 2013-June 2015:	National Governors' Association, Super-utilizer Policy Academy
January 2014-present:	Governor's Marijuana Policy Workgroup
January 2015-present:	Commissioner, Suicide Prevention Commission-Colorado
May 2016-present:	Appointee, Mental Health/Point of Contact through Release from Jail Task Force, Commission on Criminal and Juvenile Justice

State of Connecticut Committees

1998-1999:	Participant, Committee to Study Sexually Violent Persons, State of Connecticut Office of Policy and Management
1999-2000:	Member, DMHAS Restraint/Seclusion Task Force, *Best Practices Report and Recommendations: Working Toward the Elimination of Restraint & Seclusion*.
1999-2000:	DMHAS representative, Committee to Study Credentialing of Sexual Offender Treatment Providers, State of Connecticut Office of Policy and Management.
2000:	Member, Committee for Psychosexual Evaluation and Treatment, DMHAS-state of Connecticut.
2000-2001:	DMHAS representative, Sex Offender Policy and Advisory Committee, state of Connecticut, Office of Policy and Management.
2001:	DMHAS representative, Special Populations Project: Model Development.
2002:	DMHAS-Division of Forensic Services representative, Preferred Practices Committee: Providing Services to those with Problem Sexual Behaviors.
2002:	DMHAS representative, Preferred Practices in Behavioral Health Workgroup.
2002:	DMHAS, Commissioner's Policy Work Group*: Limits to Confidentiality*.
2002-2003:	DMHAS representative, Sex Offender Policy and Advisory Committee, state of Connecticut, Office of Policy and Management.
2006-2012:	Governor's Appointee: Sex Offender Risk Assessment Board, state of Connecticut Judiciary Committee.

2007-2012: Member, DMHAS, Forensic Steering Committee.

2007-2012: DMHAS Commissioner's Appointee, *Lawyers Concerned for Lawyers-Connecticut, Inc.*

PRESENTATIONS:

October 1999*: Jail Diversion, Balancing of the Court's Interests*, American Academy of Psychiatry and the Law, Annual Convention, Madelon Baranoski, Ph.D., Patrick K. Fox, M.D., Josephine Buchanan, Baltimore, MD

October 2000*: Outpatient Civil Commitment*, American Academy of Psychiatry and the Law, Annual Convention, Patrick K. Fox, M.D., Paul Amble, M.D., Vancouver, BC.

August 2001: DMHAS-Connecticut, Forensic Grand Rounds, *Substance Abuse Relapse Prevention for Insanity Acquittees, Recent Research Findings*, presented at Connecticut Valley Hospital.

January 2002: University of Connecticut, School of Medicine/Correctional Mental Health Conference, *Sex Offenders: Risk Assessment, Management & the Possibilities for Treatment*, presented at UCHC, December 2001 and at Cheshire Correctional Center.

June 2002: Veterans Administration-Connecticut Healthcare System, Forensic Committee Conference, *Violence Risk Assessment*, and *Violence Risk Management*, presented at the West Haven Veterans Administration Hospital.

April 2004*: Competency to be Executed*, Yale Medical Student Psychiatric Association.

October 2004*: Melissa's Project: Probate Court-Monitored Treatment*, American Academy of Psychiatry and the Law, Annual Convention, Patrick K. Fox, M.D., Paul Amble, M.D., Michael Makniak, J.D., Scottsdale, AZ.

March 2007: DMHAS Training Seminar-Sex Offender Training, *A Clinical Perspective on Problem Psychosexual Behaviors*, presented at Connecticut Mental Health Center.

Dec. 2008: *Problem Sexual Behavior*, Connecticut Valley Hospital Grand Rounds

January 2008*: Physiological Response to Situations of Uncontrollable Stress*, Connecticut Valley Hospital Trauma Initiative Series.

October 2009: *Civil Rights and the Insanity Defense*, Yale Medical Student Psychiatric Association.

April 2010: *Festschrift for Howard Zonana: Attorney-Physician Collaboration*, Yale Department of Psychiatry Grand Rounds

July 2010: *Psychopathy and Sociopathy*, Yale Department of Psychiatry Grand Rounds

October 2010*: You Got Personality: Diagnostic Challenges in Forensics*, American Academy of Psychiatry and the Law, Annual Convention, Howard Zonana, MD, Madelon Baranoski, PhD., Patrick K. Fox, M.D., Josephine Buchanan, Tucson, AZ.

Feb. 2011*:* Invited lecturer, *Police Intervention with Persons with Mental Illness*, Henry C. Lee Institute of Forensic Science, University of New Haven.

March 2011*:* Invited lecturer, *Police Intervention with Persons with Mental Illness*, Henry C. Lee Institute of Forensic Science, University of New Haven.

April 2011*:* Invited lecturer, *Psychopathy*, Eastern Connecticut State University.

July 2011: *Physician-Assisted Suicide*, Yale Department of Psychiatry Grand Rounds

October 2011: *Thinking Outside the Witness Box: Novel Forensic Psychiatry Training Strategies*, American Academy of Psychiatry and the Law, Annual Convention, Brian Cooke, M.D., Reena Kapoor, M.D., Patrick Fox, M.D., Boston, MA

October 2011: *Restraint and Seclusion Reduction: Implications and Outcomes*, American Academy of Psychiatry and the Law, Annual Convention, Patrick Fox, M.D., Traci Cipriano, Ph.D., J.D., Paul D. Whitehead, M.D., Charles Dike, M.D., Boston, MA

Feb. 2012: *Mental Health Policy in the United States*, distinguished presenter to delegates from Fudan University, Shanghai Province, China, as part of the Yale Global Health Initiative

January 2013: *Inside the Mind of the Mass Murderer*, the Vail Symposium.

January 2014: *Assessment and Management of Problem Sexual Behaviors*, Colorado Mental Health Institute at Pueblo Grand Rounds

Feb. 2014: *Trans-institutionalization: Treatment of Persons with a Behavioral Health Disorder within the Criminal Justice System*, A Workshop of the Forum

on Global Violence Prevention. Institute of Medicine of the National Academies.

April 2015: *The Times, They are a Changin': State and National Developments and Trends in Behavioral Health Care Delivery*, Colorado Psychiatric Society Annual Meeting, Denver, Colorado

July 2015: *Science and Conscience: The Role of Mental Health Evaluators in Death Penalty Cases*, XXXIVth International Congress on Law and Mental Health, Sigmund Freud University, Vienna, Austria

Sept. 2016: *Managing a Limited Resource: Trends in Competency to Stand Trial Evaluations in Colorado*, Colorado State Judicial Conference, Vail, CO.

Dec. 2016: *Mental Health Evaluators and the Death Penalty*, American Bar Association National Summit on Severe Mental Illness and the Death Penalty, Georgetown University.

BIBLIOGRAPHY:

Morgan III, C.A., Hill, S.R., Fox, P.K., Kingham, P., & Southwick, S.M. Anniversary Reactions in Gulf War Veterans: A Follow-up Inquiry Six Years After the War. American Journal of Psychiatry 156:1075-1079, July 1999.

Charles A. Morgan III, Sheila Wang, John Mason, Steven M. Southwick, Patrick Fox, Gary Hazlett, Dennis M. Charney, and Gary Greenfield, Hormone Profiles in Humans Experiencing Military Survival Training. Biological Psychiatry 47:891-901, May 2000.

Patrick K. Fox, Commentary: Biases that Affect the Decision to Conditionally Release an Insanity Acquittee. Journal of the American Academy of Psychiatry and the Law 36:337-9, 2008.

Patrick K. Fox, Commentary: Medicine, Law and Howard Zonana. Journal of the American Academy of Psychiatry and the Law 38:4:592-593 (2010)

Patrick K. Fox, Commentary: So the Pendulum Swings-Making Sense of the Duty to Protect. Journal of the American Academy of Psychiatry and the Law 38:4:474-478 (2010)

Faculty Reviewer: Stead L, Kaufman M, Yanofski J, First Aid for the Psychiatry Clerkship, third edition

Wasser, Tobias D., Fox, Patrick K. For Whom the Bell Tolls – Silver Alerts Raise Concerns Regarding Individual Rights and Governmental Interests. Journal of the American Academy of Psychiatry and the Law 170:9: (2013)

Martinez, R., Fox, P *Chapter 10: Confidentiality in Psychiatric Practice*, Textbook of Forensic Psychiatry, APA Publishing, In publication, (2016)

Aaron M. Kinikini (10225)
Erin B. Sullivan (15462)
DISABILITY LAW CENTER
205 North 400 West
Salt Lake City, Utah 84103
Telephone: (801) 363-1347
Fax: (801) 363-1437
Email: akinikini@disabilitylawcenter.org
esullivan@disabilitylawcenter.org

Alan L. Sullivan (3152)
Bret Evans (15131)
SNELL & WILMER L.L.P.
15 West South Temple, Suite 1200
Gateway Tower West
Salt Lake City, Utah 84101
Telephone: (801) 257-1900
Facsimile: (801) 257-1800
Email: asullivan@swlaw.com
brevans@swlaw.com

Attorneys for Plaintiffs

IN THE UNITED STATES DISTRICT COURT IN AND FOR

THE DISTRICT OF UTAH, CENTRAL DIVISION

DISABILITY LAW CENTER, a Utah nonprofit corporation; S.B., an individual, by and through his next friend Margaret Goodman; A.U., by and through his next friend Mary Eka; and S.W., an individual, Plaintiffs, vs. STATE OF UTAH; UTAH DEPARTMENT OF HUMAN SERVICES; ANN WILLIAMSON, in her official capacity as Executive Director of the Utah Department of Human Services; UTAH DIVISION OF	**ORDER** Case No. 2:15-CV-00645-RJS-BCW Judge Robert J. Shelby

SUBSTANCE ABUSE AND MENTAL HEALTH; DOUGLAS THOMAS, in his official capacity as Director of the Utah Division of Substance Abuse and Mental Health; UTAH STATE HOSPITAL; DALLAS EARNSHAW, in his official capacity as Superintendent of Utah State Hospital, Defendants.	

Based on the Joint Motion for (1) Approval of Settlement Agreement and Class Notices, (2) Appointment of Monitor, and (3) Stay of Proceedings (June 12, 2017) (hereinafter the "Joint Motion"), and good cause appearing therefor, the Court hereby orders as follows:

1. The Court preliminarily determines that the Settlement Agreement annexed as Exhibit 1 to the Joint Motion is fair, reasonable, and adequate.

2. The Court approves the notices annexed as Exhibits 2 and 3 to the Joint Motion.

3. The Court will hold a fairness hearing on the fairness, reasonableness, and adequacy of the Settlement Agreement on _____, 2017, at _____ a.m./p.m.

DATED this _____ day of _____, 2017.

BY THE COURT:

_____
Robert J. Shelby
United States District Court Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 11-CV-02285-NYW

CENTER FOR LEGAL ADVOCACY, d/b/a
DISABILITY LAW COLORADO,

Plaintiff,

v.

MICHELLE BARNES,
in her official capacity as Executive Director
of the Colorado Department of Human Services, and

JILL MARSHALL,
in her official capacity as Chief Executive Officer
of the Colorado Mental Health Institute at Pueblo,

Defendants.

CONSENT DECREE

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THIS MATTER comes before the Court pursuant to the Parties' Joint Motion for Approval and Entry of Consent Decree.

THE PARTIES, by and through their respective counsel, have jointly stipulated to all facts set forth herein and agreed to entry of a consent decree to resolve this Lawsuit under the terms and conditions set forth herein.

THE COURT, having reviewed the Parties' Joint Motion for Approval and Entry of Consent Decree and being fully advised in the matters contained therein, hereby FINDS that good cause exists for approval and entry of the Consent Decree as follows:

I. FINDINGS OF FACT AND CONCLUSIONS OF LAW REGARDING THE CONSENT DECREE

1. On August 31, 2011, Plaintiff, the Center for Legal Advocacy, d/b/a Disability Law Colorado ("DLC") commenced this action (the "Lawsuit") against Defendants Reggie Bicha, in his official capacity as Executive Director of the Colorado Department of Human Services, and Teresa Bernal, in her official capacity as Interim Superintendent of the Colorado Mental Health Institute at Pueblo ("CMHIP"), challenging Defendants' alleged failure to comply with the Due Process Clause of the Fourteenth Amendment to the United States Constitution, which requires Defendants to timely provide competency evaluations and restoration treatment to pretrial detainees in Colorado jails.

2. The Colorado Department of Human Services (the "Department") has a statutory obligation under C.R.S. §§ 16-8.5-101 *et seq*. (2018) to provide competency evaluations for persons charged with criminal offenses when the issue of competency is raised, and to provide restoration treatment for persons found incompetent to proceed.

3. The Parties settled the Lawsuit pursuant to a Settlement Agreement executed on April 6, 2012 (the "2012 Settlement Agreement"), which was incorporated into the Order of Dismissal entered by the District Court in the Lawsuit. Dkt. 52.

4. The 2012 Settlement Agreement included a provision called Special Circumstances, which recognized that to some extent the Department's ability to perform its statutory obligations and its obligations under the 2012 Settlement Agreement is based on factors beyond the Department's control. Dkt. 51-1.

5. The Department invoked Departmental Special Circumstances on August 3, 2015, citing: (1) the dramatic increase in court referrals for evaluations and treatment; and (2) unprecedented staffing shortages at CMHIP. DLC disputed the Department's invocation and filed a motion to reopen the litigation for enforcement of the 2012 Settlement Agreement, which this Court granted. Dkt. 62. After the Parties conducted settlement negotiations, they entered into an Amended and Restated Settlement Agreement which was filed with the Court on July 28, 2016 (the "2016 Settlement Agreement"). Dkt. 78.

6. Another dispute has arisen between the Parties. The Department invoked Departmental Special Circumstances for the second time on June 22, 2017, citing in support an unanticipated spike in court-ordered referrals for inpatient competency evaluations and restorations. On December 22, 2017, the day the Department's June 22, 2017 invocation was set to expire, the Department invoked Departmental Special Circumstances for a third time, citing a sustained increase in the number of court-ordered referrals for inpatient competency evaluations and restorations. DLC disputed the Department's second and third invocations as improper under the terms of the 2016 Settlement Agreement. Defendants' present inability to comply with the timeframes required by the 2016 Settlement Agreement has created a lengthy waitlist of pretrial

detainees, some of whom have been forced to wait in jail for more than 150 days for a competency evaluation or restoration treatment.

7. DLC moved to reopen the action for enforcement of the 2016 Settlement Agreement on June 13, 2018 (Dkt. 82), and this Court entered an order reopening that matter on June 14, 2018. Dkt. 83.

8. The parties filed cross-motions for summary judgment (Dkts. 96 and 97) and this Court held a September 28, 2018 hearing on them. This Court issued an order on November 9, 2018 granting in part and denying in part DLC's motion for summary judgment and denying Defendants' motion for summary judgment. Dkt. 113. This Court held that: (1) the 2016 Settlement Agreement permits Defendants to invoke Departmental Special Circumstances consecutively; and (2) the Defendants have been in breach of the 2016 Settlement Agreement's timeframes for inpatient restorations since June 2018. *Id.* The Court found that in each month from July 2017 through the present, Defendants have failed to maintain a 24-day monthly average for inpatient restoration treatment. The Court reserved ruling on whether Defendants breached the 2016 Settlement Agreement by their invocations of Departmental Special Circumstances in June 2017 and December 2017 and whether the Defendants acted in bad faith.

9. The Court set this matter for a five-day evidentiary hearing to commence on March 18, 2019 on whether Defendants properly invoked Departmental Special Circumstances in June 2017 and December 2017, so the Court can rule upon a forthcoming motion by DLC to enforce and to determine the appropriate scope and terms of an injunction going forward to address the Department's performance of inpatient restoration services. Dkt. 113.

10. After setting the case for hearing and commencing discovery, this Court granted DLC's motion for appointment of a Special Master. Dkts. 117 & 123. On December 28, 2018, the

Court appointed Groundswell Services and its team of Drs. Neil Gowensmith and Daniel Murrie as Special Master in this matter. Dkt. 130. Their duties, duration, and scope are outlined in the Order Appointing Special Master. Dkt. 130.

11. On January 28, 2019, pursuant to the Court's order, the Special Master submitted a report with a Review of the Department's Plan for Compliance and provided recommendations regarding the Plan. Dkt. 146.

12. On January 30, 2019, the Parties notified the Court that they agreed to mediate a resolution. The Court stayed discovery production, and the March 18, 2019 hearing was reset to commence on June 3, 2019, in the event mediation was unsuccessful. The Court set a March 15, 2019 deadline to produce a signed Consent Decree or to file a joint status report if the Parties cannot reach an agreement.

13. This Consent Decree resolves the Lawsuit. This Consent Decree is being entered in order to ensure that pretrial detainees obtain timely competency evaluation and restoration services, while both avoiding harming other persons with mental or developmental disabilities in the Department's care and avoiding protracted, costly and uncertain litigation. The terms of that resolution are embodied in this Consent Decree.

NOW, THEREFORE, with the consent of the Parties to this Decree, it is hereby ORDERED, ADJUDGED, AND DECREED that:

II. PARTIES, PURPOSE, INTENT

14. DLC is an independent nonprofit corporation headquartered in Denver, Colorado. DLC was designated in 1977 by Governor Richard Lamm as Colorado's protection and advocacy system ("P&A System") to protect and advocate for the rights of persons with mental illness and developmental disabilities under the Developmental Disabilities Assistance and Bill of Rights Act. 42 U.S.C. §§ 15041-45. Since 1986, DLC has received federal grants on an annual basis, and has

established and administered a P&A System in Colorado for individuals with mental illness pursuant to 42 U.S.C. §§ 10803 and 10805 of the Protection and Advocacy for Individuals with Mental Illness Act (the "PAIMI Act"). Since 1986, DLC has been and is currently the eligible P&A System for individuals with mental illness in Colorado as defined at 42 U.S.C. § 10802(2).

15. DLC has a governing board of directors which is composed of members who broadly represent and who are knowledgeable about the needs of individuals with mental illness. DLC's board of directors includes members who have received or are receiving mental health services or who have family members who have received or are receiving mental health services.

16. DLC's constituents include individuals with mental illness, who have been abused, neglected and/or suffered civil rights violations. DLC has established a PAIMI Advisory Council, over sixty percent (60%) of whose members themselves have received or are receiving mental health services or have family who have received or are receiving mental health services. The PAIMI Advisory Council advises the P&A System on the policies and priorities designed to protect and advocate for the rights of individuals with mental illness. The Chair of DLC's PAIMI Advisory Council, who is also a member of DLC's board of directors, has a family member who has received and is receiving mental health services.

17. Together, DLC's board of directors and PAIMI Advisory Council have developed the annual priorities and objectives of the P&A System for individuals with mental illness. DLC's PAIMI Program Priorities and objectives state that DLC will monitor facilities, including jails, and investigate reports/complaints of abuse, neglect and rights violations, and take action to remedy any abuse, neglect and/or civil rights violations. When the rights of its constituents are violated, DLC is authorized by statute to pursue legal remedies on their behalf, such as through litigation. 42 U.S.C. § 10805(a)(1)(A)(B) & (C). To the extent DLC expends its resources to protect the rights

of its constituents in county jails waiting for competency evaluations or restoration treatment, its resources are diverted away from assisting other constituents.

18. DLC has established a public opinion survey for constituents and interested persons, such as family members, to comment on DLC's priorities and objectives and a grievance procedure for clients or prospective clients, which allows its constituents with mental illness and family members of such individuals to assure them that DLC and the PAIMI Program are operating in compliance with the provisions of the PAIMI Act.

19. DLC's constituents who are detained and charged with crimes are hindered from asserting their own constitutional rights. Obstacles they face include the imminent mootness of individual claims as they are likely to be admitted to CMHIP for restoration treatment during the pendency of any case they might bring. In addition, pretrial detainees who are presumed or determined to be incompetent to proceed are often impaired and unable to direct or participate in litigation on their own behalf.

20. Defendant Michelle Barnes is sued in her official capacity as the Executive Director of the Colorado Department of Human Services. As relevant here, the Department is responsible under Colorado law for the operation of CMHIP and the provision of competency evaluations and restoration treatment. Forensic Services within the Department's Office of Behavioral Health provides court-ordered competency evaluations.

21. Defendant Jill Marshall is sued in her official capacity as the Chief Executive Officer of CMHIP. As relevant here, CMHIP currently is the state's principal forensic mental health hospital that accepts custody of pretrial detainees for competency evaluations and restoration treatment.

22. This Consent Decree will require the Department to ensure that thousands of future pretrial detainees will not be forced to wait in jail for months before receiving their court-ordered competency evaluations and restoration treatment in violation of their constitutional rights; at the same time, the Department will avoid negatively impacting other persons with mental health or developmental disabilities or juveniles in their care. In doing so, the Department will be required to implement concrete reforms that will allow for long-term compliance with this Consent Decree. The Parties believe that with the guidance of the Court and the Special Master (to be discussed *infra*) the Department will be able to:

(a) Develop a comprehensive, cohesive approach to planning to maintain compliance with this Consent Decree.

(b) Adhere to the admission timeframes for pretrial detainees, and at the same time avoid causing harm to and/or displacement to other people with mental or developmental disabilities in their care.

(c) Maximize the use of competency services in the community, by funding, developing, recruiting, and supporting a variety of community services. Dkt. 146.

(d) Create a team that will develop a centralized, data-driven system that captures, analyzes, and disseminates data in a reliable and meaningful manner to inform decisions and planning. *Id.*

(e) Develop and implement a triage system that considers clinical needs to assign individualized services. *Id.*

(f) Implement state-wide uniform standards for competency evaluators and evaluations and conduct rigorous training for forensic evaluators and restoration providers to ensure evaluations are of high quality. *Id.*

(g) Prepare budget requests and propose and support legislation which are calculated to meet the terms of the Consent Decree and take all necessary next steps and exert good faith efforts to obtain adequate funding from the Colorado General Assembly.

III. JURISDICTION, VENUE, AND STANDING

23. This Court has jurisdiction over this action pursuant to 28 U.S.C. §§ 1331 and 1343(a)(3) because it arises under the Fourteenth Amendment to the United States Constitution and 42 U.S.C. § 1983. This Court also has jurisdiction under the Declaratory Judgment Act, 28 U.S.C. §§ 2201-02.

24. Venue is appropriate in this Court under 28 U.S.C. § 1391(b)(2) because the events giving rise to this Complaint occurred in this District.

25. DLC has standing in the Lawsuit to assert due process claims on behalf of its constituents, persons within the State of Colorado with a mental illness and/or intellectual disability who have been charged with a criminal offense, ordered to receive a competency evaluation or restoration treatment, and who await the provision of that treatment in Colorado jails.

IV. PARTIES BOUND AND INTERPRETATION OF THIS AGREEMENT

26. In entering this Consent Decree, Defendants do not admit any violation of law. This Consent Decree shall not be interpreted in any court, administrative, or other proceeding as evidence of Defendants' liability.

27. The parties agree that the right to timely competency services implicates rights secured and protected by the Fourteenth Amendment of the United States Constitution, Article 1, and 42 U.S.C. §1983.

28. This Consent Decree is legally binding and judicially enforceable. This Consent Decree shall be applicable to and binding upon the parties, their officers, agents and employees, and their successors and assigns.

29. Until the Consent Decree is terminated, the parties hereby consent to the Court's continuing supervision in this matter, until further order of the Court, and to its authority to interpret the provisions of this Agreement, to review and adopt plans necessary to implementation of its terms, to modify its terms as may be needed to effect its purposes, and to take appropriate actions within its equitable powers to ensure its enforcement and the fulfillment of its terms and purposes.

30. The terms of this Consent Decree shall be interpreted consistent with its overall purposes and principles.

V. DEFINITIONS

31. The following terms shall have the meanings set forth below (the definitions to be applicable to both the singular and the plural forms of each term defined if both forms of such term are used in this Consent Decree):

(a) "Arrest Date" means the day, month, and year a Pretrial Detainee was arrested for the case in which competency has been raised.

(b) "Collateral Materials" means the relevant police incident reports and the charging documents, either the criminal information or indictment.

(c) "Community-Based Competency Evaluation" means a Competency Evaluation of a Community-Based Service Recipient that is ordered to be performed out of custody and in conjunction with a community-based mental health center or community organization.

(d) "Community-Based Restoration Treatment" means Restoration Treatment of a Community-Based Service Recipient that is ordered to be performed out of custody and in conjunction with a community-based mental health center or community organization.

(e) "Community-Based Services Recipient" means a defendant who has been ordered to receive a Community-Based Competency Evaluation or Restoration Treatment.

(f) "Competency Evaluation" means a court-ordered evaluation for competency to proceed, administered by the Department, and the accompanying report prepared by the Department and more fully described in C.R.S. §§ 16-8.5-103, 105.

(g) "Competency Services" means Competency Evaluations and Restoration Treatment.

(h) "Competency Services Recipient" means a Pretrial Detainee or a Community-Based Services Recipient.

(i) "Competent to Proceed" means that a court has ordered that a defendant in a criminal case does not have a mental disability or developmental disability that prevents the defendant from having sufficient present ability to consult with the defendant's lawyer with a reasonable degree of rational understanding in order to assist in the defense or prevents the defendant from having a rational and factual understanding of the criminal proceedings. C.R.S. § 16-8.5-101(4).

(j) "County Jail" means a jail or detention facility which houses a Pretrial Detainee. County Jail does not include a behavioral health unit located within a county jail (e.g., RISE).

(k) "Court Order" means a written order, issued by a court, and signed by a judge that directs the transfer of custody of a Pretrial Detainee to the Department.

(l) "Court Liaison" means a person who is hired by the Colorado Judicial Branch's State Court Administrator's Office as a dedicated behavioral health court liaison in each state judicial district, pursuant to C.R.S. §§ 16-11.9-203, 204, who facilitates

communication and collaboration between judicial and behavioral health systems, and keeps judges, district attorneys, and defense attorneys informed about the availability of community-based behavioral health services.

(m) "Days Waiting" means the number of days elapsed between the Ready for Admission date and the Offered Admission date.

(n) "Department" means the Colorado Department of Human Services. Any reference to the Department includes the Office of Behavioral Health and the Hospital, which are divisions of the Department and do not have independent authority or obligations under Title 16, Article 8.5, C.R.S.

(o) "Department Plan" mean the Department's comprehensive description of its efforts to achieve long-term compliance with this Consent Decree by providing timely competency services without undermining the broader system of mental health care.

(p) "Evaluator Signed Date" means the date the Jail Competency Evaluation is signed by the evaluator after having been completed.

(q) "Hold and Wait Evaluation" means an in-custody evaluation of a Pretrial Detainee that is conducted in another facility, after transport by the sheriff of the commitment county to the alternative facility. For example, a sheriff in a county in which there are no evaluation services may transport the Pretrial Detainee to the nearest county where these services are available, wait for the evaluator to complete the interview and examination, and return the Pretrial Detainee to the jail in the county of commitment.

(r) "Hospital" means the Colorado Mental Health Institute at Fort Logan (CMHIFL) or Colorado Mental Health Institute at Pueblo (CMHIP).

(s) "Inpatient Competency Evaluation" means a Competency Evaluation of a Pretrial Detainee that is ordered to be performed at the Hospital or in a separate locked facility that is established for the purpose of providing Inpatient Competency Evaluations and Restoration Treatment. This includes Competency Evaluations conducted at the RISE program or a similar program located on a dedicated behavioral health unit at a county jail.

(t) "Inpatient Restoration Treatment" means the Restoration Treatment of a Pretrial Detainee that is performed at the Hospital or at a separate locked facility that provides comprehensive Restoration Treatment to the Pretrial Detainee. This includes Restoration Treatment that is provided at the RISE program or a similar program located on a dedicated behavioral health unit at a county jail.

(u) "Interim Jail Mental Health Treatment" means mental health treatment of a Pretrial Detainee that is performed in the County Jail where the Pretrial Detainee is held while the Pretrial Detainee awaits Community-Based or Inpatient Restoration Treatment per Court Order consistent with the timeframes in the Consent Decree.

(v) "Jail Competency Evaluation" means a Competency Evaluation performed in the County Jail where the Pretrial Detainee is being held.

(w) "Medically Cleared" means that a Pretrial Detainee is, in the opinion of the Department's medical staff, appropriate for Inpatient Competency Evaluation or Inpatient Restoration Treatment.

(x) "Offered Admission Date" means the date the Department offers the Pretrial Detainee admission for Inpatient Restoration Treatment or Inpatient Competency Evaluation. Before the Department offers admission to a Pretrial Detainee, the following three criteria must be satisfied: (1) the Department has an open bed for the Pretrial Detainee

at the location for the Inpatient Evaluation or Inpatient Restoration Treatment; (2) the location for Inpatient Evaluation or Inpatient Restoration Treatment is ready to receive the Pretrial Detainee for admission; and (3) the Department notifies the County Jail of the same.

(y) "Pretrial Detainee" means a person who is being held in the custody of a County Jail and whom a court has ordered to undergo Competency Services. Persons serving a sentence in the Department of Corrections and juveniles are excluded from this Consent Decree.

(z) "Ready for Admission Date" means the date on which the Department has received the Court Order for Competency Services and, in the case of Competency Evaluations or Restoration Treatment when the Competency Evaluation was not conducted by the Department, the Department has also received the Collateral Materials.

(aa) "Restoration Treatment" means mental health care and treatment provided for the purpose of restoring a Competency Services Recipient.

(bb) "Settlement Payment" has the meaning set forth in Part XIII.

(cc) "Special Master" means Court-appointed Groundswell Services and its team of Drs. Neil Gowensmith and Daniel Murrie (Dkt. 130), or any successor appointee whose duties and authority are set forth in Dkt. 130 and in this Consent Decree.

(dd) "Tier 1" means a Pretrial Detainee who has been ordered to receive Inpatient Restoration Treatment and whom a competency evaluator has determined either: (1) appears to have a mental health disorder and, as a result of such mental health disorder, appears to be a danger to others or to himself or herself, or appears to be gravely disabled

or (2) has a mental health disorder, and as a result of either (1) or (2), delaying hospitalization beyond seven days would cause harm to the Pretrial Detainee or others.

(ee) "Tier 2" means a Pretrial Detainee who has been ordered to receive Inpatient Restoration Treatment and who does not meet Tier 1 criteria.

VI. TIMEFRAMES

32. Recent Compliance with Timeframes. The Department has been out of compliance with the 2016 Settlement Agreement Timeframes to provide timely restoration services since June 2017. The Department has complied with the required timeframes to provide competency evaluations since May 2018 but was out of compliance for those timeframes from June 2017 to April 2018. Dkt. 113 ¶ 39 & Chart 2.

33. Timeframes

(a) Admission of Pretrial Detainees for Inpatient Competency Evaluations and Restoration Treatment. The Department shall Offer Admission to Pretrial Detainees to the Hospital for Inpatient Restoration Treatment or Inpatient Competency Evaluations pursuant to the attached table (**Table 1**). Compliance with this measure shall be calculated based on the number of Days Waiting for each Pretrial Detainee.

(b) Performance of Jail Competency Evaluations. The Department shall complete all Jail Competency Evaluations of a Pretrial Detainee pursuant to the attached table (**Table 1**), after the Department's receipt of a Court Order directing the evaluation and receipt of Collateral Materials. This timeframe requirement shall apply to the following counties: Adams, Alamosa, Arapahoe, Boulder, Broomfield, Crowley, Custer, Denver, Douglas, El Paso, Elbert, Fremont, Huerfano, Jefferson, Larimer, Mesa, Otero, Pueblo, Teller, and Weld. Counties not specifically identified are counties that use the "Hold and Wait" court ordered process. Counties utilizing the Hold and Wait Evaluation process will

be offered a meeting date within 30 days of the Department's receipt of the Court Order and Collateral Materials, and the evaluation will be completed within 30 days of the meeting. Beginning January 1, 2020, counties utilizing the Hold and Wait Evaluation process will be offered a meeting date within 30 days of the Department's receipt of the Court Order and Collateral Materials, and the evaluation will be completed within 14 days of the meeting.

34. Interim Jail Mental Health Treatment. If the court does not release the Pretrial Detainee to Community-Based Restoration Treatment and the Pretrial Detainee is awaiting receipt of Inpatient Restoration Treatment, the Department shall work with the County Jails to develop a program to assist in the provision of coordinated services for individuals in accordance with C.R.S. §§ 27-60-105 *et seq.* to screen, treat, assess, and monitor for triage purposes Pretrial Detainees in the least restrictive setting possible. This paragraph does not toll or otherwise modify the Department's obligation to Offer Admission to the Pretrial Detainees for Inpatient Restoration Treatment. Interim Jail Mental Health Treatment shall not replace or be used as a substitute for Inpatient Restoration Treatment but does not preclude the Department from providing Restoration Treatment. A member of the Forensic Support Team shall report to the Court Liaison every 10 days concerning the clinical status and progress towards competency of the Pretrial Detainee.

35. Release of Pretrial Detainees for Community-Based Restoration Treatment. If the court releases the Pretrial Detainee on bond to commence Community-Based Restoration Treatment, the Department shall coordinate with the Court Liaison to develop a discharge plan (in a format approved by the Special Master) within seven days of the order to all parties involved in the Community-Based Services Recipient's case, and the Court Liaison and community-based provider.

36. Transportation of Pretrial Detainees. If a Pretrial Detainee is transported to the Hospital for an Inpatient Competency Evaluation and the Department or a medical professional opines that the Pretrial Detainee is incompetent and the provisions of C.R.S. § 27-65-125 have been met, the Department shall not transport the Pretrial Detainee back to his/her originating jail.

37. Daily Fines for Non-Compliance with Timeframes. Beginning on June 1, 2019, through the conclusion of the Consent Decree, the Department agrees to comply with timeframes and fines as set forth in the attached table (**Table 1**). Such fines shall be capped on a June 1 to May 31 timeframe at $10,000,000, indexed for inflation yearly pursuant to the CPI-U. The liquidated damages for material violations as set forth in Paragraph 60(c) shall not be counted toward this cap.

38. Notification of Non-Compliance with Timeframes. The Department shall notify the Special Master and DLC weekly regarding any non-compliance with timeframes.

(a) Only one notice per Pretrial Detainee shall be provided and should include:

(i) The name of the Pretrial Detainee;

(ii) The Pretrial Detainee's location;

(iii) The Pretrial Detainee's charges based on information available to the Department;

(iv) The Pretrial Detainee's bond amount based on information available to the Department;

(v) Whether a forensic assessment has been made on whether restoration in the community is appropriate;

(vi) Whether the Pretrial Detainee has previously been found incompetent;

(vii) What efforts are being made to provide timely Competency Services to the Pretrial Detainee, including communications with the court, Court Liaisons, and community mental health providers;

(b) The Department shall accompany its Monthly Data Report (*see* Paragraph 52) with a separate "Fines Report" which will include the names of the Pretrial Detainees for whom the Department has accrued a fine during the preceding month, the number of days each Pretrial Detainee waited in the County Jails past the timeframes for compliance, and the total fines owed by the Department for the preceding month.

(c) The Department shall pay the total fines owed on the date the Fines Report is submitted to the Special Master to be deposited in an interest-bearing account created for the purpose of funding non-Department services for persons with mental illness. The account will be managed by a third-party agreed upon by the parties; the parties will identify and agree to said third-party no later than **December 31, 2019**. Decisions concerning payments out of the account will be made by a committee consisting of a representative from the Plaintiff, a representative from the Department, and the Special Master. Any disputes regarding the fines or third-party account manager shall be handled through the dispute resolution process identified in Paragraph 59.

VII. ADDITIONAL REQUIRED ACTION FOR SUSTAINABLE LONG-TERM COMPLIANCE

39. Civil Bed Freeze. The Department's 2018 Plan included an effort to freeze civil admissions to its beds to devote Hospital beds to perform Inpatient Restoration Treatment services. On February 7, 2019, the Department agreed to stop this practice. The Department will continue to leave the state's civil and juvenile beds allocated as of the execution of this Consent Decree for civil and juvenile psychiatric admissions and will not freeze or convert those beds to provide competency services for Pretrial Detainees, unless the Department receives prior agreement from

the Special Master to use unutilized beds for such purposes. This strategy to facilitate compliance with the Consent Decree shall only be re-implemented in the future upon agreement of the Special Master.

40. Comprehensive and Cohesive Plan. The Special Master's first recommendation was to revise the Department's 2018 Plan into a more comprehensive and cohesive plan. Dkt. 146. By or about January 2020, the Department will produce an initial plan resulting from a long-term visioning process with DLC, the Special Master, and stakeholders that will consolidate disparate pieces of the Department's current plan, along with legislative initiatives, in a cohesive package for courts, administrators, service providers, and legislators to consider. As referenced in the Special Master's Recommendation Number 7, the 2020 Plan will highlight the methods to prioritize quality amid quantity and time pressures. Dkt. 146 at 42. On an annual basis thereafter, the Department will review and revise the plan as appropriate based upon data provided by the Department.

41. Increase Community Restoration Services. The Parties agree that the Department is responsible for directly providing or contracting with individuals or agencies to provide Competency Services. The Parties agree that County Jails are not the best place for Pretrial Detainees to wait for treatment or receive treatment. The Parties agree that it is in the best interests of some Pretrial Detainees to receive Competency Services in the community, as those Pretrial Detainees will avoid unnecessary institutionalization and will receive treatment in the least restrictive environment. Additionally, the movement of appropriate Pretrial Detainees to the community will lessen the need for more Hospital beds and hiring additional qualified staff by the Department. The Parties agree that increased community restoration is a key component to comply with the timeframes in this Consent Decree as to Competency Services. The Special Master's

Recommendation Number 2 is for the Department to "[r]educe emphasis on inpatient beds and increase emphasis on community services." Dkt. 146 at 17. The Special Master's Recommendation Number 3 is to "[f]urther prioritize outpatient competence restoration." Dkt. 146 at 23. As a result, the Department shall:

(a) Implement a coordinated wide-scale outpatient (community-based) competency restoration (OCR) system. This system shall be integrated and submitted with the "Comprehensive and Cohesive Plan" referenced in Paragraph 40 herein. This plan shall be approved by the Special Master.

(b) The Department may utilize private hospital beds to meet the needs of Pretrial Detainees meeting C.R.S. § 27-65-105(a) civil commitment criteria and with prioritization to Pretrial Detainees already residing within the same geographic location. The Department shall create a plan to implement this subsection (b) to be approved by the Special Master.

(c) The Department currently estimates that 10-20% of Pretrial Detainees admitted for inpatient restoration do not need hospital-level care. Dkt. 146 at 29. The Department will make best efforts to reduce inpatient restoration hospitalizations by 10% and increase community restorations by 10% in six-month increments beginning June 1, 2019. The baseline for the preceding sentence will be determined by the Special Master by June 1, 2019, utilizing data provided by the Department. On June 1, 2020, the Special Master will establish a modification of this guideline based upon a survey of the data collection and implementation of the Department's Plan.

42. Additional Department Hires. By June 1, 2019, the Department shall submit a plan to the Special Master and DLC to hire the following positions by August 1, 2019. The

Department's plans and job descriptions shall be guided by the recommendations of the Special Master and the January 28, 2019 Special Report. *See* Dkt. 146.

(a) Forensic Support Team. The Forensic Support Team will be formalized to follow the Special Master's Recommendation Number 6. Dkt. 146. The team will include a full-time Supervising Coordinator who is familiar with the Department's duties and obligations herein, as well as the Department's and Hospital's processes and procedures in providing services to Pretrial Detainees, and whose responsibilities will include to: (1) interface with the Colorado Department of Health Care Policy and Financing (HCPF) regarding persons ordered to be evaluated for competency and those determined to be incompetent; (2) confer with the Special Master; (3) focus on budget and cost of inpatient versus outpatient care; (4) work directly with Office of Behavioral Health staff to assist in reducing the waitlist and meeting the timeframes of the Consent Decree; and (5) interface with the Court Liaisons or representatives funded by the judiciary to interface with the courts, Department, and community mental health centers. The Supervising Coordinator will work directly with the Special Master to ensure the Department's compliance with the terms of this Consent Decree and to assist with other issues involving Pretrial Detainees on an individual or system-wide basis to increase the Department's performance with providing timely Competency Services. In addition, the Forensic Support Team will include an effective number of coordinators (to be approved by the Special Master) responsible for each judicial district who can provide a centralized structure for stakeholders to immediately access detailed information about programs, clients, and settings and can complement the Court Liaison Program.

(b) Data Management Team. The Data Management Team will be formalized in a plan on the schedule identified in Paragraph 42 to follow the Special Master's Recommendation Number 5. Dkt. 146. This team will be dedicated and designed to specifically assist with implementation of the Department's Plan by collecting specific data on which the Department will base its projections and recommendations, calculate inpatient bed space, assess community restoration capacity, and determine financial estimates. The team will be comprised of at least three full-time employees dedicated to collecting and analyzing data affecting the competency system. The Special Master shall approve of the type of employees that shall be hired to comprise the Data Management Team.

43. Develop and Implement a Triage System. The Special Master's Recommendation Number 4 recognizes a need for the Department to prioritize a triage approach over traditional waitlist approaches. Dkt. 146 at 27. Therefore, by June 1, 2019, the Department shall develop and implement a triage system to screen each Pretrial Detainee and make recommendations to the committing court as to the most clinically appropriate level of care to restore the Pretrial Detainee to competency. The Department shall seek suggestions from the Special Master on the development of a triage system, and two weeks prior to the implementation of the triage system it shall be approved by the Special Master. The Department shall continue to fine-tune the triage system with the assistance of the Special Master and shall include the progress of the triage system in its annual submission of the Department Plan.

44. Legislative Actions. The Parties agree that they will not propose, sponsor, or support any legislation that would violate the terms of this Consent Decree. The Department will provide DLC and the Special Master with all budget requests and proposed legislation affecting

this Consent Decree when they are sent to the Colorado General Assembly. The Special Master shall provide its opinion and recommendations on the proposed legislation and how it could impact the short- or long-term compliance with the Consent Decree. A copy of the final budget approved by the Colorado General Assembly shall be sent to the Special Master and DLC immediately following approval of the budget.

VIII. SPECIAL MASTER AND REPORTING OBLIGATIONS

45. Selection of a Special Master. The Court has appointed Groundswell Services and its team of Drs. Neil Gowensmith and Daniel Murrie as the Special Master. Dkt. 130.

46. Special Master Duties and Reporting. The Special Master's duties have been set forth by the Court in its Order appointing the Special Master and are fully incorporated and amended as set forth in this Consent Decree. Dkt. 113 at 6-7 §§ A(1)-(11); *id.* at 7-8 § B.

(a) Special Master Duties:

(i) Review and approve of the Department's Plans to increase timeliness of performance of Competency Services.

(ii) Recommend plans for the Department's consideration that propose methods for addressing short- and long-term compliance with the timeframes for Competency Services that may ultimately be adopted in whole or in part as part of the Court's injunctive relief to address the ongoing breach of the Amended and Restated Settlement Agreement, and compliance with the Consent Decree.

(iii) Develop a system of data collection, review, and analysis of Departmental data and continued monitoring related to Competency Services, to include reporting by the Department to the Special Master (timing identified below) and reporting by the Special Master (timing identified below) analyzing such data and making recommendations to the Court and the Parties based on such data.

(iv) Identify actual areas within the statewide system which have caused, are causing, or may cause non-compliance with the timeframe requirements of the Consent Decree concerning delivery of Competency Services.

(v) Make recommendations to the Department for improved performance in the timely delivery of Competency Services.

(vi) Assist and approve the Department's design of a plan to address compliance with the Consent Decree timeframes concerning delivery of Competency Services, support the Department's implementation of its plan, and monitor the Department's compliance with all terms of the Consent Decree during the duration of the Appointment.

(vii) Survey the Department's efforts to attain compliance with the Consent Decree's timeframe requirements concerning delivery of Competency Services and report to the Court and Parties (timing identified below) on the progress towards reaching compliance on those timeframes on a monthly basis, including documenting which efforts require action or approval by third parties.

(viii) Assist the Court in fashioning and evaluating compliance with any future sanctions or injunctive relief ordered by the Court.

(ix) Make other recommendations to the Court and the Parties on how to improve delivery of Competency Services for the purpose of effectuating compliance with the Consent Decree timelines concerning delivery of Competency Services, including how to audit the Department's performance.

(x) Approve of the Department's planning and implementation of Section VII above.

(xi) Submit reports to the Court and the Parties, as defined in Dkt. 130, the timing identified below.

(b) Special Master Reporting: In order for the Special Master to make such recommendations to the Court and the Department as specified above, the Department shall provide all information the Special Master seeks for the purpose of carrying out its specific duties and obligations or which are reasonably related to this Consent Decree.

(i) As part of the duties, the Special Master shall provide the Court and the Parties with status reports every other month for the first six months, and then quarterly thereafter. The Special Master's status report was submitted on January 28, 2019. Dkt. 146. The next report shall be submitted to the Court and the Parties on March 28, 2019, and then May 28, 2019, and then quarterly thereafter. Such reports shall address the Department's compliance with the timeframe requirements of the Consent Decree concerning Competency Services and shall provide a detailed summary of information and recommendations the Special Master believes the Court and Parties should consider relating to the Department's compliance with the Consent Decree timeframes concerning Competency Services.

(ii) The Special Master's report shall include, but is not limited to, reporting on the number of Pretrial Detainees ordered to receive Competency Services, an assessment of the Department's operations, systems, and admissions practices and policies relating to the Department's ability to comply with the Consent Decree timeframes, and guidance to the Department for improvement and increasing efficiencies in these areas.

(iii) The Special Master shall have reasonable access to, and the Department shall provide the Special Master with, all records that the Special Master requests within a reasonable timeframe from the date of such request. The Special Master shall be able to request the Department organize the data in a format which is necessary for the Special Master's efficient review. As a component of its reporting, the Special Master may select a sample of Pretrial Detainees from the Department's monthly reporting and audit the timeliness by the Department of that sample's Offered Admission dates for Competency Services. The Special Master shall include its findings of any such audit in its reports, and those reports shall be provided to the Parties and filed with the Court, with any private or confidential information redacted from the public filing. This Consent Decree meets the By Law exception to HIPAA's confidentiality mandates for the exchange of health care records and information.

(iv) The Special Master shall have the right to confer and subcontract with additional experts (but not allow double billing), as it determines in the exercise of its professional judgment would be helpful to the Court or the Parties, including for preparation of additional reports, studies, or research.

(v) The Special Master's report shall include the Department's responses to the Special Master's recommendations, at the Special Master's discretion.

47. Visitation and Access. The Special Master shall have the general authority and responsibility to: visit and access Colorado facilities; confer with stakeholders in the criminal justice and mental health systems; review documents, staff procedures, and records of individuals

who are subject to this Consent Decree; and access budget and resources available, and funding streams related to, the Department's duties under the Consent Decree and Competency Services. Neither the Special Master nor the Parties shall publicly disclose information obtained by the Special Master pursuant to this paragraph, which would otherwise be privileged or confidential, without consent of all the Parties and/or order of the Court.

48. Compensation. For the duration of this Consent Decree, the Special Master's invoices must be submitted to the Court for payment by the Department. The Department shall compensate the Special Master and its staff at the Special Master's standard rates. The Department shall reimburse all reasonable expenses of the Special Master and its staff consistent with the State's government rates, procurement guidelines, and Department policy, including for travel and accommodations.

49. Resignation or Replacement of Special Master. In the event the Special Master resigns or otherwise becomes unavailable, the Parties shall attempt to agree on a successor Special Master with relevant experience and shall jointly present the candidate to the Court for appointment. If the Parties are unable to agree, the Parties will submit a joint list of candidates to the Court for selection and appointment by the Court. If either Party has a concern with the Special Master, it may bring a motion before the Court under Federal Rule of Civil Procedure 53.

50. Duration of Engagement. The Special Master shall be engaged and paid for by the Department for the duration of the Consent Decree.

IX. REPORTING AND MEETING OBLIGATIONS

51. Compliance Plan Reports. The Department will provide monthly reports to DLC and the Special Master in compliance with the Order for Special Master. Dkt. 113 at A. 9. The first report was produced on February 28, 2019. The Parties agree that the reports shall be due seven days after the first of every month commencing April 1, 2019, or on the next business day if the

seventh day of the month falls on a weekend or holiday. The Special Master and the Parties will agree on the content and organization of those reports, which will include an update on all the aspects of compliance included in Sections VI and VII, as well as an update on the recommendations of the Special Master and the Department's efforts and responses to those recommendations.

52. Monthly Data Reports.

(a) In an organized format approved by the Special Master, as long as this Consent Decree remains in force, the Department's monthly data reports will identify:

(i) The Competency Services Recipient for whom a Court Order for Restoration Treatment, Competency Evaluation, or Collateral Materials has been received by the Department (even if no other data is available during that month) to include:

(1) The name of the referred Competency Services Recipient;

(2) The Competency Services Recipient's CMHIP Patient ID number, if applicable;

(3) The county or counties referring the Competency Services Recipient;

(4) The case number(s) of the criminal case(s) in which the Court Order was issued;

(5) The date of the Competency Services Recipient's arrest and bond amount, as shown in the Department's records;

(6) The date of the Court Order;

(7) The type and location of Competency Services ordered;

(8) The date the Court Order was received by the Hospital;

(9) The date that the Department learned that the Court Order was vacated or converted to another type of evaluation or restoration process;

(10) The date the Collateral Materials were received by the Department;

(11) The Evaluator Signed Date;

(12) The defense attorney's name if shown in the Department's records;

(13) The criminal charges filed against the Competency Services Recipient as shown in the Department's records;

(14) The Ready for Admission date;

(15) The Offered Admission date;

(16) The Hospital's Offered Admission deadline for that specific Pretrial Detainee, based on the Ready for Admission date;

(17) The date of admission;

(18) The type of Competency Service;

(19) The location of the Competency Service;

(20) The number of Days Waiting for each Pretrial Detainee;

(21) The number of days between the Ready for Admission Date and the date of the monthly report for each Pretrial Detainee awaiting admission;

(ii) A list of Pretrial Detainees for whom the Department has invoked Individual Special Circumstances and its reasons for doing so; and

(iii) If there is a wait list or backlog for Competency Services, a list of the Pretrial Detainees waiting the longest to the shortest number of days.

(b) The content and categories of the Monthly Report may be subject to change as programs are established or upon request from the Special Master.

53. Monthly Cumulative Information Report. The Department will generate another report monthly that will include cumulative information designed to allow the Special Master and DLC to monitor the historic areas that have caused delayed admissions in the past. Specifically,

the Department has cited dramatic increases in referrals and unprecedented staffing shortages. The Special Master also believes a lack of community restoration services has contributed to delayed admissions. In a format accepted by the Special Master, and possibly integrated into the Monthly Compliance Report, this report will include the following information: (1) the number of referrals for Competency Services each month, including the type and location for each; (2) the number of staff employed each month by category (nursing positions, security positions, mental health professionals, etc.) and how many vacancies remain in each staffing category; (3) the number of temporary staff and the number of security staff employed each month; and (4) the number of Pretrial Detainees identified for Community-Based Restoration Treatment and the movement of those Pretrial Detainees into the community. The Special Master shall also assist the Department at their request in developing reporting protocols, Competency Services Recipient data, and formats for updating the parties on Consent Decree activities.

54. Timing of Reports. The first report under this Consent Decree shall be made on April 8, 2019. Thereafter, monthly reports shall be provided on the seventh day of each month following the reporting month or on the next business day if the seventh day of the month falls on a weekend or holiday.

55. Distribution of Monthly Reports. The monthly report shall be provided to DLC and the Special Master in Microsoft Access format and PDF format, unless another format is agreed upon in writing by the Parties and the Special Master.

56. Meetings. The Special Master shall convene and chair meetings and disseminate a written summary of each meeting. The summary shall include action steps and agreements of the parties including timeframes for follow-up activities. During the first year after the Effective Date, meetings shall be held monthly, and quarterly thereafter, but may be scheduled at greater intervals

at the Special Master's discretion. The Parties shall treat the meetings as a serious opportunity to raise concerns or potential barriers with the system of institutions involved in achieving or maintaining full compliance with the Consent Decree. Each Party shall designate appropriate senior representatives, based on the agenda for each meeting, to participate in the meetings so that meaningful discussion can occur, and may include outside stakeholders, as appropriate based on the agenda. The first monthly meeting shall be scheduled for a mutually agreeable date in April 2019.

X. SPECIAL CIRCUMSTANCES

57. Special Circumstances. To some extent, the Department's ability to perform its statutory obligations and its obligations under this Consent Decree may be based on factors beyond its control. As a result, and subject to the terms and conditions of this Paragraph, the timeframe requirements of this Consent Decree may be temporarily suspended in the following circumstances:

(a) Special Circumstances Defined. The Department may invoke, under this Paragraph 57, two categories of Special Circumstances:

(i) "Individual Special Circumstances" means a situation that delays the Offer of Admission to a Pretrial Detainee, where the circumstances are not within the control of the Department. Individual Special Circumstances is a flexible concept. These situations may include, for example and without limitation, the following: (1) requests by a court, County Jail, defense counsel, or the Department that admission be delayed because additional information or testing required for the evaluation is outstanding; (2) a court has ordered a Hold and Wait Evaluation, and the sheriff must transport the Pretrial Detainee to the nearest county where there are services available; (3) the Pretrial Detainee is not Medically Cleared for admission

due to illness or other non-psychiatric medical need, but not a need that can be satisfied by a plan for a reasonable accommodation; or (4) when the Pretrial Detainee is approaching the deadline for transfer to an inpatient facility, restoration to competency is imminent, and treatment providers responsible for the Pretrial Detainee's care determine that transfer is not clinically appropriate. Upon resolution of the Individual Special Circumstance, the Pretrial Detainee must be Offered Admission for Competency Services immediately but no longer than three days, unless in derogation of a Tier 1 need, in which case the Pretrial Detainee will be offered the next available bed.

(ii) "Departmental Special Circumstances" means circumstances the Department could not reasonably foresee, prepare for, address through advanced planning, and that are beyond the control of the Department, which impact the Department's ability to comply with this Consent Decree. The failure or refusal of the Colorado General Assembly (or any other funding source) to adequately fund the Department's operations, programs, or plan shall not be considered a Departmental Special Circumstance. In order to invoke this paragraph, the Department would first need to obtain consent from DLC or seek relief and have such relief granted under the dispute resolution paragraph outlined below.

(b) Effect of Invocation of Individual Special Circumstances. DLC and the Special Master will review the reporting of Individual Special Circumstances. If DLC questions the Department's invocation of Individual Special Circumstances, the Parties will confer to review the reasons for invocation of Individual Special Circumstances and to determine issues for resolution. Additionally, the Department may proactively seek

confirmation that an event qualifies as an Individual Special Circumstance by contacting a representative of DLC or the Special Master in advance of formal reporting of the event. If the Department believes Individual Special Circumstances have become a systemic issue, it will follow the Departmental Special Circumstances procedure below. The Parties shall use good faith efforts to try and resolve any disputes concerning the invocation of Individual Special Circumstances. However, if the Parties do not reach an agreement through good faith efforts at resolution, the Parties will follow the dispute resolution process described in Section XII.

(i) If the Parties agree to the invocation of Individual Special Circumstances for a particular Pretrial Detainee, the timeframe requirements of this Consent Decree shall be suspended as to that individual Pretrial Detainee for a period to be determined by the Special Master.

(ii) The Department may invoke Individual Special Circumstances more than once for the same Pretrial Detainee, but it must follow the notification and conferral procedures in Paragraph 57(b) each time it seeks to invoke Individual Special Circumstances.

(c) Effect of Invocation of Departmental Special Circumstances. If the Department determines that Departmental Special Circumstances exist, it shall notify the Court, the Special Master, and DLC in writing, and in such notification, the Department shall provide a detailed explanation of the basis for invoking Departmental Special Circumstances, a plan to remedy the Departmental Special Circumstances, and the projected timeframe for resolution. The period of Departmental Special Circumstances shall commence on the date that the Notice of Departmental Special Circumstances is

provided to the Court. Upon the invocation of Departmental Special Circumstances, the timeframe requirements of this Consent Decree shall be automatically suspended for six months, unless the Department notifies DLC that a shorter time is sufficient to resolve Departmental Special Circumstances, commencing with the month in which the Notice of Departmental Special Circumstances is provided to the Court. The Department shall provide written notice to DLC of its intent to terminate Departmental Special Circumstances. Upon DLC's receipt of a Notice of Departmental Special Circumstances, it may request supporting documentation for the Department's notice, and the Parties shall confer to review the reasons for invocation of Departmental Special Circumstances, to resolve questions that the Special Master or DLC may have about the circumstances that triggered the notice, and to assess whether the Parties are able to resolve any disagreement concerning invocation of Departmental Special Circumstances. If DLC decides to challenge the invocation of Departmental Special Circumstances, it may do so by following the dispute resolution procedure identified in Section XII. The Department is prohibited from invoking Departmental Special Circumstances consecutively. The Department cannot invoke Departmental Special Circumstances any sooner than June 1, 2021.

(d) Effect on Reporting Requirements. A Notice of Departmental Special Circumstances shall not affect the Department's reporting obligations under this Consent Decree. In addition to such reporting obligations, the Department will provide a monthly written status report to DLC and the Special Master on its plans and progress to remedy Departmental Special Circumstances.

XI. DURATION

58. Duration and Certification. The terms and provisions of this Consent Decree shall remain in force until December 1, 2025, except that a sustained period of two years of compliance

by the Department with all terms of this Consent Decree, including the strictest timeframes identified herein, as certified by the Special Master, shall result in termination of this Consent Decree. In the event the Department complies with all terms of this Consent Decree and the strictest timeframes for one year, while concurrently reducing Tier 2 timeframes to 21 days for that one year period, such compliance shall result in termination of this Consent Decree.

XII. DISPUTE RESOLUTION AND REMEDIES

59. Dispute Resolution.

(a) Dispute Resolution Generally. Any dispute concerning the interpretation or implementation of this Consent Decree, other than those for which DLC seeks the remedy of contempt, shall first be submitted to the Special Master, who shall attempt to informally mediate and resolve the dispute. The Special Master may make use of such informal dispute resolution processes as it deems necessary, which may include, but are not limited to, informal suggestions or recommendations and compulsory conferences of the Parties.

(b) Dispute Resolution for Non-Contempt Proceedings. If informal attempts fail to resolve the matters identified in the preceding paragraph, or if the Special Master believes the Department has materially violated this Consent Decree or has in some other manner acted in bad faith, the Special Master or any Party may submit a written request to Judge Hegarty (or, in the event he is no longer serving as a magistrate judge in this District, a magistrate judge successor or someone mutually agreed upon by the parties) for an evidentiary hearing, requesting specific relief and a decision. A copy of this request shall be served upon opposing counsel and the Special Master. Judge Hegarty shall determine whether the dispute requires an evidentiary hearing, and, if so, schedule such hearing at the convenience of the Parties. Judge Hegarty shall file a written decision supported by written findings of fact and may impose any relief permitted by this Consent Decree. This includes,

but is not limited to, attorney's fees. Judge Hegarty's decision shall become final and binding upon the Parties.

(c) Dispute Resolution for Contempt Proceedings. In the event that DLC believes the Department's violation of this Consent Decree warrants contempt, DLC shall first attempt mediation through Judge Hegarty, who will conduct the proceeding on an expedited basis. Upon a finding by Judge Hegarty that the matter cannot be mediated, DLC may file a Motion for Order to Show Cause on the matter in controversy with this Court.

60. Remedies for Non-Contempt Violations of the Consent Decree.

(a) Timeframe Violations. The Parties agree that, in addition to the fines set forth in Paragraph 37 and the penalties set forth in Paragraph 60(b), DLC shall be entitled to seek its attorney's fees and costs for pursuing such violations. In no event, however, shall the Department be subject to contempt strictly for violations of the timeframes for the delivery of Competency Services, except that sustained and/or egregious violations of those timeframes may constitute a material violation of this Consent Decree.

(b) Material Violations. Upon a finding of a material violation, Judge Hegarty may order immediate enforcement of the agreement, order injunctive relief, impose liquidated damages (as detailed below), attorney's fees, or fashion any other relief deemed appropriate for the Department's violation of this Consent Decree.

(c) Liquidated Damages. The Parties further agree that if Judge Hegarty finds a material violation of this Consent Decree, the damages sustained by the Pretrial Detainees because of such violation would be difficult, if not impossible, to ascertain. The Parties agree to provide for damages rather than a penalty and agree that in addition to other remedies available to DLC, Judge Hegarty can award liquidated damages of up to $10,000

a day for each day Judge Hegarty determines the violation to have occurred and continuing until the violation is remedied.

(d) Non-Timeframe Violations Adjudicated by Contempt. Nothing set forth herein is intended to, or in any way shall, limit the Court's power to enforce the Department's compliance with this Consent Decree through contempt (except for a violation of the timeframes, which the parties have agreed is not subject to contempt). In such proceedings, the Court shall have all powers afforded by law to remedy the contempt and/or punish the Department for violation of this Consent Decree.

XIII. MISCELLANEOUS PROVISIONS

61. Effective Date of the Consent Decree. This Consent Decree shall become effective on the date of the Court's entry.

62. Remedies by Pretrial Detainees Not Precluded. Nothing in this Consent Decree limits a Pretrial Detainee, or his or her counsel, from bringing other court action, such as contempt of court proceedings, if the circumstances warrant such action. However, the provisions of this Consent Decree are intended to be enforced solely by the United States District Court for the District of Colorado. In any court action brought by a Pretrial Detainee for contempt of court, the Department retains all defenses to such action, including but not limited to those attending C.R.C.P. 107. Nevertheless, the Parties agree that the terms of this Consent Decree are not binding or enforceable as to individual Pretrial Detainees, because they are not parties to this Lawsuit.

63. Contempt Actions Against Other Agencies, Non-Complying Sheriff's Offices, District Attorney's Offices, and Defense Counsel Not Precluded. Nothing in this Consent Decree

precludes any court from issuing contempt citations to sheriffs for failing to comply with orders to transport Pretrial Detainees to or from the Hospital, district attorneys for violating timelines

ordered by courts to provide Collateral Materials, or defense attorneys who fail to comply with orders related to Competency Services.

64. Complete Consent Decree; Modification; and Waiver. This Consent Decree constitutes the entire agreement between the Parties and supersedes all prior and contemporaneous agreements, representations, warranties, and understandings of the Parties. This Consent Decree replaces and supersedes the Amended and Restated Settlement Agreement executed by the Parties on July 28, 2016 in its entirety. No supplement, modification, or amendment of this Consent Decree shall be binding unless entered by the Court.

65. Attorney's Fees and Costs. Part of the effect of this Consent Decree is to settle the specific matters outlined or referenced in this Consent Decree as to the Parties up to the date the Consent Decree is finalized. Accordingly, the Colorado State Office of Risk Management shall pay DLC's counsel the lump sum amount of $654,177.50 (the dollar amount is contingent upon the State Claims Board's approval of this amount on March 26, 2019) in full and final settlement of all costs and fees, including attorney's fees, incurred by DLC's counsel starting on June 1, 2017, up to and including the date this Consent Decree is finalized and signed by all Parties hereto (the "Settlement Payment"). When the final amount is approved by the State Claims Board, DLC's counsel shall enter a separately filed binding agreement related to the Settlement Payment, which agreement shall be on the then-current, Controller-approved standard settlement agreement. The Settlement Payment shall be paid to Eytan Nielsen LLC as follows: A warrant in the amount of $654,177.50 (or in the dollar amount approved by the State Claims board on March 26, 2019) will be made payable to Eytan Nielsen LLC. The warrant will be delivered to Eytan Nielsen LLC within 30 days from March 26, 2019, or as soon after March 26, 2019 as practicable. Prior to delivery of the warrant, the Controller-approved settlement document will be signed by all Parties and the

Controller. No withholding for payment of federal, state or local taxes will occur respecting any warrant issued pursuant to this Consent Decree other than those required by federal or state law or rules governing the Controller. Eytan Nielsen LLC will complete, execute and provide an original of I.R.S. form W-9 in conjunction with submitting the signed Consent Decree as an initial step in completing the arrangements described here. A Form 1099 will be issued to Eytan Nielsen LLC on the Settlement Payment. The Settlement Payment made hereunder shall not be designated as wages, salary or back pay, except to the extent required by federal or state law or by rules governing the Controller, but is instead made in compromise of all claims arising from or related to the subject matter of this Consent Decree for those matters up to and including the date this Consent Decree is fully executed and entered by the Court.

66. Written Notice. Any notice or other communication required or permitted under this Consent Decree shall be in writing and shall be deemed to have been duly given when (1) mailed by United States registered or certified mail, return receipt requested, (2) mailed by overnight express mail or other nationally recognized overnight or same-day delivery service, (3) sent as a PDF attachment to electronic mail, or (4) delivered in person, to the Parties at the following addresses:

If DLC, to:	Disability Law Colorado 455 Sherman Street, #130 Denver, Colorado 80203
Attention:	Mark Ivandick mivandick@disabilitylawco.org
	Jennifer Purrington jpurrington@disabilitylawco.org

With a copy to:	Iris Eytan, Esq. EYTAN NIELSEN LLC 3200 Cherry Creek South Drive Denver, CO 80209 iris@eytan-nielsen.com
If the Department, to:	Department of Human Services 1575 Sherman Street Denver, Colorado 80203
Attention:	Michelle Barnes michelle.barnes@state.co.us
If the Hospital, to:	Colorado Mental Health Institute at Pueblo 1600 West 24th Street Pueblo, Colorado 81003
Attention:	Jill Marshall, M.P.H. jill.marshall@state.co.us
With a copy to:	Office of the Attorney General Ralph L. Carr Colorado Judicial Center 1300 Broadway, 6th Floor Denver, CO 80203
Attention:	Tanja Wheeler tanja.wheeler@coag.gov Ann Pogue ann.pogue@coag.gov Sarah Richelson sarah.richelson@coag.gov

A Party may change the names or address where notice is to be given by providing notice to the other Parties of such change in accordance with this Paragraph.

XIV. RESERVATION OF JURISDICTION AND ENFORCEMENT

67. The Court hereby retains jurisdiction over this Consent Decree.

68. The Court hereby also retains jurisdiction to enforce the terms of this Consent Decree, upon Final Approval, until the Consent Decree is terminated and for 60 days after the Department provides the final monthly report.

69. Nothing in this Consent Decree requires or permits the Department to violate a court order.

70. Minor or transitory mistakes shall not be considered a violation of this Consent Decree.

XV. FINAL JUDGMENT

Based on the pleadings, counsels' stipulation of facts, and representations of counsel for both parties, the Court does find: The facts alleged in Paragraphs 1 through 13 warrant the Court's approval of this Consent Decree.

Upon entry of this Consent Decree by the Court, this Consent Decree shall constitute the final judgment between and among the Plaintiff and Defendants. The Court enters this judgment as a final judgment under Federal Rules of Civil Procedure 54 and 58 that is fully enforceable by all plenary powers of the Court.

IT IS SO ORDERED, this 2nd day of April, 2019.

Hon. Nina Y. Wang
United States Magistrate Judge

APPROVED FOR ENTRY:

/s/Mark Ivandick
Center for Legal Advocacy, d/b/a Disability Law Colorado
Name: Mark Ivandick
Title: Managing Attorney
Dated: March 27, 2019

/s/Michelle Barnes
Colorado Department of Human Services
Name: Michelle Barnes
Title: Executive Director, in her official capacity
Dated: March 27, 2019

/s/Jill Marshall
Colorado Mental Health Institute at Pueblo
Name: Jill Marshall
Title: Chief Executive Officer, in her official capacity
Dated: March 27, 2019

TABLE 1: Timeframes and Fines for Competency Services

Deadlines	**Tier 1: Maximum Timeframes to Offer Admission for Inpatient Restoration and Corresponding Fines**	**Tier 2: Maximum Timeframes to Offer Admission for Inpatient Restoration and Corresponding Fines**	**Maximum Timeframes to Offer Admission for Inpatient Competency Evaluations and Corresponding Fines**	**Maximum Timeframes to Complete Jail Competency Evaluations and Corresponding Fines**
June 1, 2019	7 days Fines: $500 per day for each Pretrial Detainee waiting more than 7 days	56 days Assess for admission every 10 days Fines: $100 per day for each Pretrial Detainee waiting 29-56 days, $500 per day for each Pretrial Detainee waiting more than 56 days	21 days Fines: $100 per day for each Pretrial Detainee waiting more than 21 days	28 days Fines: $100 per day for each Pretrial Detainee waiting more than 28 days
January 1, 2020	7 days Fines: $500 per day for each Pretrial Detainee waiting more than 7 days	49 days Assess for admission every 10 days Fines: $100 per day for each Pretrial Detainee waiting 29-49 days, $500 per day for each Pretrial Detainee waiting more than 49 days	21 days Fines: $100 per day for each Pretrial Detainee waiting more than 21 days	28 days Fines: $100 per day for each Pretrial Detainee waiting more than 28 days

Deadlines	**Tier 1: Maximum Timeframes to Offer Admission for Inpatient Restoration and Corresponding Fines**	**Tier 2: Maximum Timeframes to Offer Admission for Inpatient Restoration and Corresponding Fines**	**Maximum Timeframes to Offer Admission for Inpatient Competency Evaluations and Corresponding Fines**	**Maximum Timeframes to Complete Jail Competency Evaluations and Corresponding Fines**
July 1, 2020	7 days Fines: $500 per day for each Pretrial Detainee waiting more than 7 days	42 days Assess for admission every 10 days Fines: $100 per day for each Pretrial Detainee waiting 29-42 days, $500 per day for each Pretrial Detainee waiting more than 42 days	14 days Fines: $100 per day for each Pretrial Detainee waiting more than 14 days	21 days Fines: $100 per day for each Pretrial Detainee waiting more than 21 days
January 1, 2021	7 days Fines: $500 per day for each Pretrial Detainee waiting more than 7 days	35 days Assess for admission every 10 days Fines: $100 per day for each Pretrial Detainee waiting 29-35 days, $500 per day for each Pretrial Detainee waiting more than 35 days	14 days Fines: $100 per day for each Pretrial Detainee waiting more than 14 days	21 days Fines: $100 per day for each Pretrial Detainee waiting more than 21 days

Deadlines	**Tier 1: Maximum Timeframes to Offer Admission for Inpatient Restoration and Corresponding Fines**	**Tier 2: Maximum Timeframes to Offer Admission for Inpatient Restoration and Corresponding Fines**	**Maximum Timeframes to Offer Admission for Inpatient Competency Evaluations and Corresponding Fines**	**Maximum Timeframes to Complete Jail Competency Evaluations and Corresponding Fines**
July 1, 2021	7 days Fines: $500 per day for each Pretrial Detainee waiting more than 7 days	28 days Assess for admission every 10 days Fines: $500 per day for each Pretrial Detainee waiting more than 28 days	14 days Fines: $100 per day for each Pretrial Detainee waiting more than 14 days	21 days Fines: $100 per day for each Pretrial Detainee waiting more than 21 days

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

DEMONTRAY HUNTER, by and through his next friend, Rena Hunter; RUSSELL D. SENN, by and through his next friend, Irene Senn; TRAVIS S. PARKS, by and through his next friend, Catherine Young; VANDARIUS S. DARNELL, by and through his next friend, Bambi Darnell; FRANK WHITE, JR., by and through his next friend, Linda White; MARCUS JACKSON, by and through his next friend Michael P. Hanle; TIMOTHY D. MOUNT, by and through his next friend, Dorothy Sullivan; HENRY P. MCGHEE, by and through his next friend, Barbara Hardy, individually and on behalf of all others similarly situated; and the ALABAMA DISABILITIES ADVOCACY PROGRAM,

Plaintiffs,

v.

LYNN BESHEAR, in her official capacity as Commissioner of the Alabama Department of Mental Health,

Defendant.

CASE NO. 2:16-cv-00798-MHT-CSC

CLASS ACTION FOR DECLARATORY AND INJUNCTIVE RELIEF

(WO)

CONSENT DECREE

I. INTRODUCTION

1. On September 30, 2016, three of the individually-named Plaintiffs filed the above-styled action (the "Lawsuit") against Defendant James V. Perdue, in his official capacity as Commissioner of the Alabama Department of Mental Health ("the ADMH Commissioner"), challenging the AMDH Commissioner's failure to comply with the Due Process Clause of the Fourteenth Amendment to the United States Constitution with respect to his alleged failure to

provide court-ordered Mental Evaluations and Competency Restoration Treatment to Plaintiffs. Commissioner Lynn Beshear was substituted as Defendant in July 2017.

2. On December 23, 2016, the eight individually-named Plaintiffs and Plaintiff Alabama Disabilities Advocacy Program ("ADAP") (collectively, "Plaintiffs"), filed their First Amended Complaint against the ADMH Commissioner in his official capacity challenging his alleged failure to comply with the Due Process Clause of the Fourteenth Amendment to the United States Constitution with respect to his provision of court-ordered Inpatient Mental Evaluations and Competency Restoration Treatment to the individually-named Plaintiffs and the putative class of similarly situated persons represented by the individually-named Plaintiffs, and Plaintiff ADAP's constituents (whose claims it is asserting as a Plaintiff in this action).

3. The individually-named Plaintiffs, on behalf of themselves and all others similarly situated, Plaintiff ADAP, and the ADMH Commissioner engaged in mediation designed to resolve the claims asserted in the Lawsuit. The Parties believe that they have reached a resolution of the claims asserted in the Lawsuit and that, in order to avoid protracted, costly and uncertain litigation, it is in their respective best interests to resolve the issues to be tried in the Lawsuit.

4. Accordingly, the Parties, by and through their respective counsel, jointly stipulate and agree to the following provisions to resolve the Lawsuit.

II. PARTIES, PURPOSE, AND INTENT

1. Plaintiffs are suing Defendant Beshear in her official capacity as Commissioner of ADMH, the state agency charged under Alabama law and by relevant state circuit court orders with the provision of Outpatient and Inpatient Mental Evaluations to those suspected of being Incompetent to Stand Trial and Competency Restoration Treatment to persons found Incompetent to Stand Trial in Alabama.

2. The individually-named Plaintiffs and putative class members in the Lawsuit have been or are currently, and may in the future be incarcerated in an Alabama city or county jail awaiting receipt of court-ordered Outpatient Mental Evaluations, Inpatient Mental Evaluations, or Competency Restoration Treatment to be provided by or on behalf of the ADMH Commissioner.

3. Plaintiff ADAP is the duly authorized disabilities protection and advocacy agency in the State of Alabama under the nation's federally-funded protection and advocacy system. *Cf. Doe v. Stincer*, 175 F. 3d 879, 883 (11th Cir. 1999); *Alabama Disabilities Advocacy Program v. J.S. Tarwater Developmental Center*, 97 F. 3d 492, 495 (11th Cir. 1996), *aff'g* 894 F. Supp. 424, 426-27 (M.D. Ala. 1995); *Dunn v. Dunn*, Case No. 2:14-cv-00601-MHT-TFM, 2016 U.S. Dist. LEXIS 166251 (Nov. 25, 2016); *Alabama Disabilities Advocacy Program v. SafetyNet Youthcare, Inc*., 65 F. Supp. 3d 1312, 1321-22 (S.D. Ala. 2014), *on reconsideration in another part*, 2015 U.S. Dist. LEXIS 16343 (S.D. Ala. Feb. 22, 2015); *Alabama Disabilities Advocacy Program v. Wood*, 584 F. Supp. 2d 1314, 1315 (M.D. Ala. 2008).

4. The individually-named Plaintiffs, the Class, as defined herein, and Plaintiff ADAP are collectively referred to herein as "Plaintiffs."

5. The Plaintiffs and Defendant Beshear are collectively referred to herein as the "Parties."

6. The purposes of this Settlement Agreement (the "Agreement") are to (1) specify certain administrative and procedural changes to the provision of Outpatient Mental Evaluations, Inpatient Mental Evaluations and Competency Restoration Treatment by the ADMH Commissioner to ensure compliance with constitutional requirements for same; (2) to outline a plan for the implementation of such changes; and (3) to settle and resolve all claims that were or were required to have been asserted in the Lawsuit.

7. The Parties stipulate that nothing in this Agreement will be used for any purpose outside of the above-captioned action or against the ADMH Commissioner in any other litigation that has been or may be filed against him. Nothing in this Agreement will be construed to require the ADMH Commissioner to do more than what is specified in the Agreement or otherwise required by the United States Constitution, federal law, or Alabama law including, but not limited to, Rule 11 of the Alabama Rules of Criminal Procedure, with respect to the provision of court-ordered Mental Evaluations and Competency Restoration Treatment to persons charged with a criminal offense in Alabama.

8. Nothing in this Agreement shall be construed as an admission of liability by the ADMH Commissioner. To the contrary, the ADMH Commissioner denies every material allegation of the Complaint, as amended, as specifically set forth in his Answers to the Complaint and First Amended Complaint.

9. The Parties believe that this Agreement is fair, reasonable, and adequate to protect the interests of all Parties concerning the issues addressed herein. The Parties jointly file this Agreement with the Court and ask the Court to issue an order approving this Agreement as final. The Parties believe that compliance with this Agreement by the ADMH Commissioner will meet the ADMH Commissioner's obligations under United States Constitution with respect to the timelines of mental evaluations and competency restoration treatment. In the event that this Agreement is not approved by the Court such that it settles and resolves, on a class basis and, with respect to Plaintiff ADAP, all claims asserted in the Lawsuit, the Parties retain all of their pre-settlement litigation rights and defenses, including the individually-named Plaintiffs' right to seek class certification and Plaintiff ADAP's right to seek a ruling certifying its standing for all purposes relevant to the litigation of the Lawsuit and all defenses of the Commissioner, including mootness

of the Plaintiffs' claims, standing of each Plaintiff, objections to certification of any class and others. Additionally, the Parties shall return to the status quo ante in the Lawsuit as if the Parties had not entered into this Agreement. Any discussions, offers, or negotiations associated with this Agreement will not be discoverable or offered into evidence or used in the Lawsuit or any other action or proceeding for any purpose, without prejudice to the individually-named Plaintiffs' right to seek class certification and Defendant Beshear's right to oppose class certification. In such event, all Parties will stand in the same position as if the Agreement had not been negotiated, made or filed with the Court.

III. STIPULATION REGARDING CLASS ACTION FOR PURPOSES OF SETTLEMENT

1. For purposes of defining the class of persons intended to benefit from the Parties' Agreement, the ADMH Commissioner stipulates to the class of persons under Fed. R. Civ. P. 23(b)(2) to whom the administrative, structural, and procedural changes specified in Section VI below apply as follows:

a. All persons who have been, or will be during the period that this Agreement remains in effect, charged with a crime, within the meaning of Rule 1.4(b) of the Alabama Rules of Criminal Procedure, in a court of competent jurisdiction in the State of Alabama, and detained in an Alabama city or county jail or Alabama Department of Corrections facility while awaiting a court-ordered Mental Evaluation or court-ordered Competency Restoration Treatment;

i. For whom a Circuit Court has determined that reasonable grounds exist for a mental examination into the person's competency to stand trial under Rule 11 of the Alabama Rules of Criminal Procedure and committed the person to the custody of ADMH under Rule 11.3 of the Alabama Rules of Criminal Procedure by court order for an inpatient evaluation, whether or not the court's order references any provision of law in so ordering; or

ii. Who is found incompetent to stand trial under Rule 11 of the Alabama Rules of Criminal Procedure and committed to the custody of ADMH under Rule 11.6 of the Alabama Rules of Criminal Procedure by court order for Competency Restoration Therapy, whether or not the court's order references any provision of law in so ordering.

IV. STIPULATION REGARDING STANDING FOR PURPOSES OF SETTLEMENT

1. For purposes of this Agreement only, the ADMH Commissioner does not contest that Plaintiff ADAP has standing in the Lawsuit to assert due process claims on behalf of persons within the State of Alabama with a mental illness and/or intellectual disability who have been charged with a criminal offense, ordered to receive an Outpatient Mental Evaluation, Inpatient Mental Evaluation, or Competency Restoration Treatment, and who await the provision of that treatment in an Alabama city or county jail or an Alabama Department of Corrections facility.

V. DEFINITIONS

1. "ADMH Commissioner" means Defendant Lynn Beshear, acting in his official capacity as Commissioner of the Alabama Department of Mental Health, together with his successors, in his administration and supervision of the Alabama Department of Mental Health.

2. "Agreement" means this Settlement Agreement and any eventual Consent Decree entered by the Court that results, refers, or relates to the terms and conditions of this Settlement Agreement.

3. "Alabama Department of Mental Health" or "ADMH" means the state agency charged with providing Outpatient Mental Evaluations, Inpatient Mental Evaluations, and Competency Restoration Treatment to the persons defined in Sections III and IV above pursuant to relevant Alabama circuit court orders, Alabama Rule of Criminal Procedure 11, and, generally, Alabama Code Section 22-50-2.

4. "Calendar Days" means all days, except where the last day of any relevant time period falls on a federal holiday observed by the United States District Court for the Middle District of Alabama, and then the next day that is not a Sunday.

5. "Competency Restoration Treatment" means psychiatric therapy, treatment, medication, and/or education designed to restore a criminal defendant found incompetent to stand trial to competency as defined in Alabama Rule of Criminal Procedure 11.1, that is ordered by an Alabama circuit court pursuant to Alabama Rule of Criminal Procedure 11.6 or other applicable legal provision.

6. "Final Approval" means approval of this Settlement Agreement by the Court by a final and appealable order.

7. "Hospital Forensic Bed" means a duly licensed and certified bed in a state psychiatric hospital or contracted bed in an inpatient hospital or hospital-like setting. These beds may be provided through a contract between ADMH and a third-party provider, such as a Community Mental Health Center or designated Mental Health Center as provided by Ala. Code §§ 15-16-61(5), 22-51-1, *et seq*., 22-56-5 and 22-52-90(1).

8. "Community Forensic Bed" means a duly licensed and certified bed in a community setting with up to sixteen (16) beds where the community service is managed and delivered by ADMH or by a community mental health provider through a contract with ADMH. A Community Forensic Bed may not be located on the grounds of any existing state hospital.

9. "Incarcerated Person" means a person who has been arrested and charged with a criminal offense in a court of competent jurisdiction in Alabama who is incarcerated in an Alabama city or county jail or an Alabama Department of Corrections facility.

10. "Incompetent to Stand Trial" means a finding by an Alabama Circuit Court or other court of competent jurisdiction that the individual found incompetent is unable to assist in the preparation of his or her defense as defined in Alabama Rule of Criminal Procedure 11.1 or comparable statute.

11. "Inpatient Mental Evaluation" means a mental evaluation conducted within a state psychiatric hospital or comparable hospital-like facility into which the person being evaluated has been admitted for that purpose, and that is conducted by competent and adequately trained clinical personnel, including at a Community Mental Health Center.

12. "Licensure and Certification Standards" means those standards for the construction and operation of facilities that provide mental health care to persons in the State of Alabama which are set forth in the Alabama Administrative Code Section 580, *et seq*. or designated mental health facility by ADMH.

13. "Outpatient Mental Evaluation" means a mental evaluation conducted within the confines of a city or county jail or an Alabama Department of Corrections facility or within a therapeutic setting not requiring the admission and retention of the person being evaluated, and that is conducted by competent and adequately trained clinical personnel, in accordance with applicable professional standards.

14. "Registered Sex Offender" means an individual convicted of an offense, which under Alabama law requires his or her registration in the Sex Offender Registry. An individual charged with an offense that, if convicted, would be required to register as a sex offender is not a Registered Sex Offender for purposes of this Agreement.

15. "Substantial Compliance" means adhering to any plans or methods implemented by the ADMH Commissioner so as to comply with the terms of this Agreement. Isolated, acute,

non-substantive or immaterial deviations from the terms of this Agreement or from any plans or methods implemented by the ADMH Commissioner so as to comply with the terms of this Agreement will not prevent a finding of Substantial Compliance, provided that the ADMH Commissioner can demonstrate that he has: (A) implemented a system or systems (i) for assuring compliance, and (ii) for taking corrective measures in response to instances of non-compliance; and (B) instituted policies, practices, and resources that are capable of durable and sustained compliance. For purposes of the termination of this Agreement as provided in Section X below, however, Substantial Compliance requires that the ADMH Commissioner provide court-ordered Outpatient and Inpatient Mental Evaluations and Competency Restoration Treatment within the time frames specified in Sections VI.1.A through VI.1.E based on an average monthly compliance rate defined below in Section VI.

VI. SUBSTANTIVE PROVISIONS

1. **Timely Provision of Court-Ordered Mental Evaluations and Competency Restoration Treatment**. The ADMH Commissioner, by and through ADMH, will provide court-ordered Mental Evaluations and Competency Restoration Treatment within the time periods specified in Subsections VI.1.A through VI.1.E below.

A. Outpatient Mental Evaluations of Incarcerated Persons**.**

i. By twelve (12) months after Final Approval of this Agreement, Outpatient Mental Evaluations of persons who are incarcerated at the time that a court orders that they be evaluated shall be conducted within forty-five (45) calendar days of the date of ADMH's receipt of the order for such evaluation by the circuit court issuing such order, subject to the protocol for the ADMH Commissioner's obtaining such order set forth in Appendix A. The clinician performing such Outpatient Mental Evaluation shall submit a report containing the

findings of any such evaluation to the relevant circuit court within forty-five (45) calendar days of conducting such Outpatient Mental Evaluation.

ii. By twenty-four (24) months after Final Approval of this Agreement, Outpatient Mental Evaluations of persons who are incarcerated at the time that a court orders that they be evaluated shall be conducted within thirty (30) calendar days of the date ADMH's of receipt of the order for such evaluation by the circuit court issuing such order, subject to the protocol for the ADMH Commissioner's obtaining such order set forth in Appendix A. The clinician performing such Outpatient Mental Evaluation shall submit a report containing the findings of any such evaluation to the relevant circuit court within thirty (30) calendar days of conducting such Outpatient Mental Evaluation.

B. Inpatient Mental Evaluations of Incarcerated Persons.

i. By twelve (12) months after Final Approval of this Agreement**,** Inpatient Mental Evaluations of persons who are incarcerated at the time that a court orders that they be evaluated shall be conducted within forty-five (45) calendar days of the date of receipt of the order for such evaluation by the circuit court issuing such order, subject to the protocol for the ADMH Commissioner's obtaining such order set forth in Appendix A. The clinician performing such Inpatient Mental Evaluation shall submit a report containing the findings of any such evaluation to the relevant circuit court within forty-five (45) calendar days of conducting such Inpatient Mental Evaluation.

ii. By twenty-four (24) months after Final Approval of this Agreement, Inpatient Mental Evaluations of persons who are incarcerated at the time that a court orders that they be evaluated shall be conducted within thirty (30) calendar days of the date of receipt of the order for such evaluation by the circuit court issuing such order, subject to the protocol for the

ADMH Commissioner's obtaining such order set forth in Appendix A. The clinician performing such Inpatient Mental Evaluation shall submit a report containing the findings of any such evaluation to the relevant circuit court within thirty (30) calendar days of conducting such Inpatient Mental Evaluation.

C. Competency Restoration Therapy and Treatment for Incarcerated Persons.

i. By twelve (12) months after Final Approval of this Agreement, persons who are incarcerated at the time that they are found Incompetent to Stand Trial and committed to the custody of ADMH for Competency Restoration Treatment shall be admitted into an institution suitable for the provision of Competency Restoration Treatment within forty-five (45) calendar days of the date of the receipt of the order committing them to the custody of ADMH for restorative treatment, subject to the protocol for the ADMH Commissioner's obtaining such order set forth in Appendix A.

ii. By twenty-four (24) months after Final Approval of this Agreement, persons who are incarcerated at the time that they are found incompetent to stand trial and committed to the custody of ADMH for Competency Restoration Treatment shall be admitted into an institution suitable for the provision of Competency Restoration Treatment within thirty (30) calendar days of the date of receipt of the order committing them to the custody of ADMH for restorative treatment, subject to the protocol for the ADMH Commissioner's obtaining such order set forth in Appendix A.

D. Incarcerated Persons to be Evaluated and Treated According to Date of Order Receipt in the Absence of Exigent Circumstances.

i. Incarcerated persons whom ADMH has been ordered to evaluate or treat shall be provided services based on the date of receipt of any court order, subject to the protocol for the ADMH Commissioner's obtaining such order set forth in Appendix A.

ii. The ADMH Commissioner may not satisfy the time periods specified in Subsections B and C above by prioritizing, for purposes of admission into a state forensic hospital, persons who have been found Incompetent to Stand Trial and ordered to receive Competency Restoration Treatment over persons who have been found not guilty by reason of insanity and ordered to receive inpatient psychiatric services. The Parties acknowledge that in exceptional circumstances the ADMH Commissioner may need to "skip" persons found not guilty by reason of insanity ("NGRI") to provide services to a person awaiting a court-ordered Inpatient Mental Evaluation or Competency Restoration Treatment. The Parties acknowledge that each "skip" affects the Commissioner's monthly compliance rate. The Parties agree that the procedure in Subsection VI.1.E.iv below applies to individuals found NGRI who are "skipped" in favor of the ADMH Commissioner's provision of services to a person found Incompetent to Stand Trial, even though persons found NGRI ordinarily do not count in the calculation of the monthly compliance rate. Where a person found NGRI is "skipped" to provide services to a person deemed Incompetent to Stand Trial, the ADMH Commissioner shall have sixty (60) days to provide services to the "skipped" individual; if at the end of 60 days the ADMH Commissioner has not yet begun providing services to the person skipped, that person shall be included in the calculation of the average monthly compliance rate beginning on Day 61.

iii. The ADMH Commissioner may provide services to persons ordered to receive a Mental Evaluation or Competency Restoration Treatment outside of the order dictated by the date the ADMH Commissioner receives their respective court order, specifically, by providing services to particular individual earlier than would be dictated by the date of ADMH's receipt of the court order for their evaluation or treatment (i.e., "line jumping") or, where a demonstrable and compelling obstacle to providing services to a particular individual on the date

that would be dictated by date of the ADMH Commissioner's receipt of the court order for their evaluation or treatment requires the ADMH Commissioner to provide services later than that date (i.e., "skipping"), subject to the provisions set forth in Subsection E, and the calculation of Substantial Compliance with respect to persons provided court-ordered Mental Evaluations or Competency Restoration Treatment out of order shall be made in accordance with the provisions of Subsection E.

E. Substantial Compliance with Timelines for Incarcerated Persons.

i. By twelve (12) months after Final Approval of this Agreement, for persons incarcerated in the State of Alabama, the Substantial Compliance standard means that the ADMH Commissioner is in Substantial Compliance if, for each month, the average time period for the ADMH Commissioner's provision of Outpatient Mental Evaluations, Inpatient Mental Evaluations, and Competency Restoration Treatment does not exceed the applicable timeline by 20%, counting only whole days. Thus, the ADMH Commissioner is in Substantial Compliance for each deadline as follows: 30 days (36 days), 45 days (54 days), 60 days (72 days), and 90 days (108 days).

ii. By twenty-four (24) months after Final Approval of this Agreement, for persons incarcerated in the State of Alabama, the Substantial Compliance standard means that the ADMH Commissioner is in Substantial Compliance if, for each month, the average time period for the ADMH Commissioner's provision of Outpatient Mental Evaluations, Inpatient Mental Evaluations, and Competency Restoration Treatment does not exceed the applicable timeline by 12%, counting only whole days. Thus, the ADMH Commissioner is in Substantial Compliance for each deadline as follows: 30 days (34 days), 45 days (50 days), 60 days (67 days), and 90 days (101 days).

iii. If the ADMH Commissioner provides an Outpatient Mental Evaluation, Inpatient Mental Evaluation, or Competency Restoration Treatment to an individual prior to the date that would otherwise be dictated by the date that the ADMH Commissioner receives the court order directing same, the ADMH Commissioner's provision of services to that individual (i.e., the "line jumper") shall not be included in the calculation of the ADMH Commissioner's monthly average for purposes of calculating Substantial Compliance.

iv. If the ADMH Commissioner fails to provide an Outpatient Mental Evaluation, Inpatient Mental Evaluation, or Competency Restoration Treatment to an individual or individuals in a jail or an Alabama Department of Corrections facility when he or she reaches the first position on the waiting list for services ordered by the date of the ADMH Commissioner's receipt of the relevant order for same, based on a demonstrable and compelling obstacle to the provision of the ordered evaluation or treatment at that time, and instead, "skips" that person, that individual will not be counted for the purpose of calculating Substantial Compliance for a period of up to sixty (60) calendar days beyond the date of the skip. If the ADMH Commissioner "skips" an individual or individuals ordered to receive a Mental Evaluation or Competency Restoration Treatment, the ADMH Commissioner shall notify Plaintiffs' counsel, in writing, within ten (10) days of a "skip" that it has "skipped" that individual or individuals and describe the obstacle to the ADMH Commissioner's provision of the court-ordered service at the time that individual or for those individuals that reached the first position on the waiting list. If, upon receipt of the ADMH Commissioner's written explanation of a particular "skip," Plaintiffs' counsel disputes the existence of a demonstrable and compelling basis for the "skip," Plaintiffs' counsel may challenge the exclusion of the "skipped" person(s) from the calculation of the monthly compliance rate in accordance with the dispute resolution procedures in Section VIII of this Agreement. Not less

than five (5) days prior to the end of the sixty (60) day grace period, the ADMH Commissioner shall advise Plaintiffs' counsel, in writing, of (1) the reason(s) why the skipped individual or individuals has or have not yet been provided the court-ordered Mental Evaluation or Competency Restoration Treatment, and (2) any reason(s) why that person or persons should not be included in the calculation of the ADMH Commissioner's monthly compliance rate beginning on day sixty-one (61). Upon Plaintiffs' counsel's receipt of the ADMH Commissioner's written explanation of the continued deferral of the provision of the court-ordered evaluation or treatment to the "skipped" individual, the Parties shall meet and confer in good faith to resolve the issue of whether good grounds exist to justify the continued exclusion of the "skipped" individual from the calculation of the ADMH Commissioner's monthly compliance rate. In the event that the Parties agree that the skipped individual(s) should not be counted in the ADMH Commissioner's monthly compliance rate, the ADMH Commissioner shall provide periodic updates regarding the status of the skipped individual(s) on a timeline agreed upon by the Parties. In the event that the Parties are unable, after good faith discussions, to resolve the issue of whether the skipped individual(s) should be included in the ADMH Commissioner's monthly compliance rate, they shall submit the matter for resolution by the Court in accordance with the dispute resolution procedures set forth in Section VIII of this Agreement. If the ADMH Commissioner fails to provide Plaintiffs' counsel the written notice regarding any "skipped" individual(s) as specified above, that individual shall be included in the calculation of the ADMH Commissioner's monthly compliance rate on day sixty-one (61), and for purposes of this calculation, day 61 shall be treated as one day past the applicable deadline with subsequent days being the corresponding number of days past the deadline (i.e., day 62 is two days past the deadline, day 63 is three days past the deadline, and so on until the person or persons is or are provided the relevant court-ordered service).

v. Substantial Compliance will be determined on a monthly basis by the ADMH Commissioner in a monthly spreadsheet(s) and this spreadsheet should be provided to ADAP by the fifteenth calendar day of the month following the period covered by the monthly report. ADAP may request additional documentation necessary to the interpretation and verification of the spreadsheet data.

vi. If, after their review of the ADMH Commissioner's monthly spreadsheet(s), Plaintiffs assert or contend that the ADMH Commissioner is not in Substantial Compliance with this Agreement, Plaintiffs must articulate, in detail and in writing, the basis or bases for their assertions or contentions. The writing detailing Plaintiffs' assertions or contentions of non-compliance, and the factual basis or bases for the same, must be delivered to the ADMH Commissioner within fourteen (14) calendar days of Plaintiffs' review of the monthly spreadsheet(s).

F. Stipulation of Parties Regarding Calculation of Applicable Times

i. Upon approval of the proposed Settlement Agreement, the Defendant shall have 12 months to come into Substantial Compliance, as defined by Section V.15, with the timeframes set forth in Sections VI.A.i, VI.B.i, VI.C.i, and shall have 24 months to come into Substantial Compliance, as defined in Section V.15, with the timeframes set forth in Section VI.A.ii, VI.B.ii, and VI.C.ii. Pursuant to Section VII, the Monitor will begin monitoring in the fourth month following approval and will calculate the ADMH Commissioner's monthly compliance rate, in months 4-12, based upon the applicable 45 day timeframe, and then in months 13-24, based on the applicable 30 day timeframe.

ii. The method of calculating the ADMH Commissioner's average monthly compliance rate pursuant to Section V.15, excluding "jumpers" pursuant to Section VI.D.iii or Section VI.E.iii, will be as follows:

a. Outpatient mental evaluations. For each individual evaluated, the ADMH Commissioner will calculate the number of days between the date that the ADMH Commissioner received the order and the date that the outpatient mental evaluation was conducted. Then add together the total number of days and divide by the total number of persons evaluated on an outpatient basis.

b. Submission of reports of outpatient mental evaluations. For each report submitted, the ADMH Commissioner will calculate the number of days between the date that the evaluation was conducted and the date that the report regarding the evaluation was submitted to the circuit court. Then add together the total number of days and divide by the number of reports submitted to circuit courts.

c. Inpatient mental evaluations. For each individual admitted for an inpatient evaluation, the ADMH Commissioner will calculate the number of days between the date that the ADMH Commissioner received the order and the date the inpatient evaluation was conducted. Then the ADMH Commissioner will add together the total number of days and divide by the number of inpatient evaluations conducted.

d. Submission of reports of inpatient mental evaluations. For each report submitted, the ADMH Commissioner will calculate the number of days between the date that the evaluation was conducted and the date that the report regarding the evaluation was submitted to the circuit court. Then add together the total number of days and divide by the number of reports submitted to circuit courts.

e. Competency restoration treatment. For each individual admitted for competency restoration treatment, the ADMH Commissioner will calculate the number of days between the date that the ADMH Commissioner received the order and the date that the individual was admitted for competency restoration treatment. Then the ADMH Commissioner will add together the total number of days and divide by the number of persons admitted for competency restoration treatment.

f. The calculation for "skippers," shall be made pursuant to Section VI.E.iv.

g. Once the ADMH Commissioner calculates the average monthly rate of providing mental evaluations and competency restoration treatment, Substantial Compliance will be determined by whether the rate exceeds the relevant timeframes in Sections VI.A, VI.B, and VI.C.

h. Provisions for emergency treatment of class members are set forth in Section XV below.

2. **Increase in Capacity to Timely Provide Court-Ordered Mental Evaluations and Competency Restoration Treatment**.

A. Hospital Forensic Beds. The ADMH Commissioner, by and through ADMH and/or its contractors and/or other lawful providers, will add and operate, consistent with existing licensure and certification standards, hospital forensic beds for the provision of court-ordered Inpatient Mental Evaluations and Competency Restoration Treatment as follows:

i. Twenty-four (24) hospital forensic beds will be added and operational by twelve (12) months after Final Approval of this Agreement.

ii. Not fewer than twenty-five (25) additional hospital forensic beds will be added and operational by twenty-four (24) months after Final Approval of this Agreement.

iii. If the ADMH Commissioner determines that he or she can sustain Substantial Compliance as defined in Section VI.1.E with fewer operational Hospital Forensic Beds, the ADMH Commissioner may cease operating those beds that are not necessary to sustain the ADMH Commissioner's Substantial Compliance with the terms of this Agreement.

B. Community Forensic Beds. The ADMH Commissioner, by and through ADMH and/or its contractors and/or other lawful providers, will operate, or arrange for the operation of, fifty-two (52) community forensic beds consistent with existing licensure and certification standards, in group homes of no greater than 16 beds distributed throughout the state.

i. Twenty (20) community forensic beds shall be added and operational by twelve (12) months after Final Approval of this Agreement.

ii. A minimum of five (5) of the Community Forensic Beds added and operationalized by twelve (12) months after Final Approval of this Agreement shall be located where a Registered Sex Offender may be housed, and these 5 beds shall be used only to house Registered Sex Offenders unless there are fewer than 5 Registered Sex Offenders in need of a community forensic placement. These beds should be integrated within the beds associated with the preceding paragraph.

iii. Thirty-two (32) additional community forensic beds will be added and operational by twenty-four (24) months after Final Approval of this Agreement.

3. **Training to Relevant State Personnel**. The ADMH Commissioner, by and through ADMH, will offer initial and periodic training concerning the provisions of Alabama law and requirements of the Fourteenth Amendment to the United States Constitution with regard to persons ordered to receive Outpatient Mental Evaluations, Inpatient Mental Evaluations, and Competency Restoration Treatment to Alabama state circuit court personnel, county sheriffs, and

members of the Alabama State Bar regarding the procedures for the ADMH Commissioner's provision of Outpatient Mental Evaluations, Inpatient Mental Evaluations, and Competency Restoration Treatment to criminal defendants.

A. Court Personnel and Sheriffs. By twelve (12) months after Final Approval of this Agreement, the ADMH Commissioner, by and through ADMH, shall offer training to the circuit court personnel and sheriffs for each of Alabama's 67 counties regarding its obligation to provide timely Mental Evaluations and Competency Restoration Treatment to persons ordered to receive same in Alabama and the cooperation needed from court personnel and sheriffs in order for the ADMH Commissioner to meet the timelines specified in Sections VI.1.A through VI.1.E above.

B. Attorneys Representing Persons Affected by ADMH-Connected Orders. By twelve (12) months after Final Approval of this Agreement, the ADMH Commissioner shall distribute to each Alabama circuit court a publication, whose content is mutually agreed upon by the ADMH Commissioner and the undersigned counsel for Plaintiffs, for dissemination to attorneys representing persons ordered to receive Outpatient Mental Evaluations, Inpatient Mental Evaluations, or Competency Restoration Treatment.

C. Members of the Alabama Bar.

i. By twelve (12) months after Final Approval of this Agreement, the ADMH Commissioner shall distribute a letter or email to all members of the Alabama State Bar enclosing the publication specified in Section VI.3.B. above, to ensure that all attorneys representing persons ordered to receive Outpatient Mental Evaluations, Inpatient Mental Evaluations, and Competency Restoration Treatment are aware of the relevant time periods for the provision of same. ADMH shall also make reasonable efforts to have the publication (or its substance) distributed to the

criminal defense bar and prosecutors through electronic mail listservs (i.e., Alabama Criminal Defense Lawyers)**.**

ii. Beginning in calendar year 2017, and continuing for two years thereafter, the ADMH Commissioner shall offer annual training to members of the Alabama State Bar regarding the timelines governing the provision of court-ordered Outpatient Mental Evaluations, Inpatient Mental Evaluations, and Competency Restoration Treatment and its duty to comply with the same.

VII. MONITORING

1. The Parties agree that monitoring of the ADMH Commissioner's compliance, by and through ADMH, with the terms of this Agreement is necessary and that ADAP will serve as the monitor.

2. ADAP shall perform the monitoring provided for in this Agreement in accordance with the protocol set forth in Appendix B hereto.

3. The Parties agree that monitoring of the ADMH Commissioner's compliance, by and through ADMH, will be conducted by ADAP who will be recognized as the monitor in this case. ADAP will ensure that any monitoring activities undertaken by ADAP pursuant to its statutory access authority during the term of this Agreement (and any extension thereof) are separated from its monitoring activities under this Agreement, and shall not seek reimbursement under this Agreement for any monitoring activities undertaken pursuant to its statutory access authority. ADMH will allow ADAP, during its monitoring role, to have access to facilities, documents, staff, procedures, logs, records, and other similar information sources in order to ensure compliance. ADAP will further have access to persons in ADMH-operated facilities or facilities operated by ADMH-contractors who are ADAP's clients, persons who are members of

the certified class, or persons otherwise referred to in this Settlement Agreement. ADAP agrees to provide reasonable notice to ADMH facilities or staff before seeking said access in order to minimize disruptions to normal ADMH facility operations. ADAP will have its normal access to other persons in ADMH custody not involved in this Lawsuit under authority granted them by federal law as the protection and advocacy agency in Alabama. Nothing in this Settlement Agreement is intended to expand or restrict ADAP's existing access under federal law. ADAP will not charge monitoring fees for persons not covered by the terms of this Agreement. ADMH will assist to the extent possible if necessary to facilitate ADAP's reasonable access to persons held in the physical custody of county jails and resolve any challenges to ADAP's access to persons held in the physical custody of county jails. ADAP understands and agrees that access to county jails is not within the control of the Defendant or ADMH. The inability of ADAP to access persons held in county jail will not constitute a breach of this Agreement by ADMH.

4. ADAP agrees to be bound by any Protective or Court Orders entered in this case to protect the confidentiality of inmate records and sensitive security information.

5. ADAP will prepare a written report on ADMH's efforts to meet the requirements of this Agreement and any plan to effectuate the terms of this Agreement at least quarterly. Each report will indicate all areas in which the ADMH Commissioner is, or is not, in Substantial Compliance. Such report will be provided to ADMH and all counsel of record. If ADAP believes that the ADMH Commissioner is not in Substantial Compliance with the terms and provisions of this Agreement and/or any plan to effectuate its terms, ADAP will provide written recommendations for actions that it believes necessary to achieve Substantial Compliance with the terms of the provision or provisions. The ADMH Commissioner, by and through ADMH, will investigate the allegations and respond in writing with its comments, objections, or remedial action

plan(s) through its counsel within thirty (30) calendar days after receipt of the notification. The Parties will meet and confer in good faith to attempt to address deficiencies identified by ADAP.

6. In the event that Plaintiffs' counsel or the monitor discovers an exigent issue involving non-compliance, Plaintiffs' counsel or the monitor shall notify counsel for the ADMH Commissioner of same, in a writing designating the issue as exigent, without having to provide a complete report as to all areas in which the ADMH Commissioner is, or is not, in Substantial Compliance as specified in Section VII.5 above within ten (10) calendar days of the monitor's discovery of such exigent issue. The ADMH Commissioner, by and through ADMH, will investigate the allegations and respond in writing with its comments, objections, or remedial action plan(s) through its counsel within fourteen (14) calendar days after receipt of the notification. The Parties will meet and confer in good faith to attempt to address deficiencies identified by ADAP.

7. Monitoring will continue for a period that begins ninety (90) days after Final Approval of this Agreement and runs through the termination of the Agreement and the Court's jurisdiction over same, subject to the provisions of Section X below. The monitor shall not begin calculating the ADMH Commissioner's monthly compliance rate for ninety (90) days following Final Approval of this Agreement.

VIII. DISPUTE RESOLUTION PROCESS

1. During the implementation and monitoring periods of this Agreement (*see* Sections VI and VII, above), if Plaintiffs' counsel or the monitor believe that ADMH is not complying with some aspect of the Agreement, they will notify counsel for the Defendant ADMH Commissioner, as described in Sections VII.5 and VII.6 above. Defendant ADMH Commissioner, by and through ADMH, will respond as specified in Sections VII.5 and VII.6

above. Thereafter the Parties will meet and confer in good faith to resolve the issue as specified in Section VII.5 and VII.6 above.

2. In the event that the Parties are unable to resolve any issue(s) after attempting to do so in good faith, they shall submit their dispute to the magistrate judge assigned to the case or to the district court in the event no magistrate judge is assigned. Both parties shall have the right to appeal any magistrate judge's decision to the district court for review.

3. The award of any attorneys' fees to Plaintiffs in connection with any motion filed after engagement in the Dispute Resolution Process shall be governed by the provisions of Section XIII.5.

IX. RESERVATION OF JURISDICTION AND ENFORCEMENT

1. The Parties consent to the reservation and exercise of jurisdiction by the Court over disputes between the Parties and among the Parties arising out of this Agreement.

2. The Court will retain jurisdiction to enforce the terms of this Agreement, upon Final Approval, until the Agreement is terminated.

3. This Agreement may be enforced only by the Parties hereto and those intended to receive the Mental Evaluations and Competency Restoration Treatment provided for herein as specified in Sections III and IV above. Nothing contained in this Agreement is intended or will be construed to evidence an intention to confer any right or remedy upon any person other than the persons specified in this Section.

X. TERMINATION

1. The Parties agree that the term of this Agreement shall be three (3) years from the date of Final Approval by the Court, subject to the provisions below.

2. If Plaintiffs believe that the ADMH Commissioner has not achieved Substantial Compliance with the timelines for the provision of Outpatient Mental Evaluations, Inpatient Mental Evaluations, and Competency Restoration Treatment specified in Section VI.1.E above for at least the nine consecutive (9) months preceding the end date of the Agreement, Plaintiffs shall file a motion to extend jurisdiction and monitoring with the Court at least four (4) months prior to the end date of the Agreement. Upon the filing of a motion to extend jurisdiction and monitoring, the determination of whether the ADMH Commissioner has achieved Substantial Compliance as defined in Section VI.1.E shall be made by the Court after an evidentiary hearing. If the Court finds that the ADMH Commissioner has not achieved Substantial Compliance as defined in Section VI.1.E for at least the nine consecutive (9) months preceding the hearing on the extension of its jurisdiction and monitoring, the Court may retain jurisdiction for a period of time determined by the Court to ensure the ADMH Commissioner achieves Substantial Compliance. If the Court determines that ADMH has achieved Substantial Compliance as defined in Section VI.1.E, the Court may terminate jurisdiction and monitoring on the end date of the Agreement. If the ADMH Commissioner has not achieved Substantial Compliance as defined in Section VI.1.E, the ADMH Commissioner may, at any time following the end of the three (3) year term, petition the Court for termination of the Agreement and the Court's jurisdiction based on the status of the law at the time of such petition. In the event that the ADMH Commissioner seeks to terminate the Agreement and the Court's jurisdiction, the ADMH Commissioner shall bear the burden of proof to demonstrate that termination is appropriate and Plaintiffs shall have the right to respond to same prior to any determination by the Court that any such termination sought by the ADMH Commissioner is appropriate.

3. Three months prior to the end of the term of the Agreement, if the Parties agree that the ADMH Commissioner has not achieved Substantial Compliance, the Parties may agree in writing to extend the term of the Agreement for a specified period, and by joint motion, seek the Court's approval of their agreed-upon extension without an evidentiary hearing to determine compliance. During the extension period agreed upon by the Parties, the terms of the Agreement shall remain fully in effect and the parties will jointly request that the Court retain jurisdiction over the above-styled action.

4. If the term of Agreement is extended pursuant to Subsection X.2 above, Plaintiffs may seek additional extensions of the term of this Agreement by demonstrating that the ADMH Commissioner cannot demonstrate Substantial Compliance with the timelines for the provision of Outpatient Mental Evaluations, Inpatient Mental Evaluations, and Competency Restoration Treatment specified in Section VI.1 above for at least nine (9) consecutive months preceding any scheduled expiration or termination of the Agreement.

5. If the term of the Agreement is extended pursuant to Subsection X.2 above, the Court may order an additional term of monitoring commensurate with the period of time that the Court's jurisdiction is extended. If the monitoring period is extended, ADAP shall remain the monitor, and the hourly rate for additional monitoring and the total amount billable for such additional monitoring shall be the rates specified in Section XIII below, unless the Court determines that lower hourly rates and a lower annual cap is appropriate.

XI. AMENDMENTS

1. By mutual agreement, the Parties may change terms of this Agreement, including but not limited to the timelines for taking specific actions, provided that such modifications are memorialized in writing, signed by the Parties or through their counsel, and approved by the Court.

XII. FUNDING

1. The Parties acknowledge that implementation of the terms of this Agreement and any plan necessary to effectuate its terms are subject to the availability and receipt of appropriated funds.

2. The Parties further acknowledge that additional funding and the cooperation of third parties is necessary to the ADMH Commissioner's full performance in accordance with the terms of this Agreement, and that the lack of funding or third party cooperation does not preclude the Court from entering an Order to achieve compliance with this Agreement, and with other applicable law, provided that the ADMH Commissioner reserves the right to assert that the lack of funding and/or third party cooperation should be taken into account in any remedial order.

3. The ADMH Commissioner and ADAP agree to make all possible good faith efforts to seek all necessary funding to implement the terms of this Agreement, except that ADAP shall not be required to lobby in contravention of the federal prohibition on lobbying efforts by ADAP. In the event that the Parties are unable to agree as to whether there is sufficient funding to implement this Agreement, the Parties will meet and confer, and if necessary, consult with the Court. In the event that the Parties remain unable to agree, either party may seek the assistance of the Court.

4. The Parties stipulate that Section XII's provisions serve neither as a condition precedent to performance nor a basis for excusing the Parties' performance obligations under the Settlement Agreement. Section XII.1's acknowledgement that "implementation . . .[is] subject to the availability and receipt of appropriated funds" does not create a condition precedent to implementation, but acknowledges instead the practical reality that the ADMH Commissioner, in her administration of ADMH, is subject to an annual legislative appropriation process. Section

XII.2's acknowledgement that "additional funding and the cooperation of third parties is necessary to the ADMH Commissioner's full performance in accordance with the terms of the Agreement" likewise does not function as a condition precedent to the ADMH Commissioner's performance nor excuse her nonperformance, as made explicit in the further acknowledgement that "lack of funding or third party cooperation does not preclude the Court from entering an Order to achieve compliance with this Agreement.

XIII. ATTORNEYS' FEES AND EXPENSES

1. The ADMH Commissioner, by and through ADMH, agrees to pay attorneys' fees and associated costs to Plaintiffs' counsel in the amount of $275,000 for services rendered through March 13, 2017. From March 14, 2017, until Final Approval of this Agreement by the Court, the ADMH Commissioner, by and through ADMH, agrees to pay attorneys' fees to Plaintiffs' counsel in the amount of $275 per hour plus reasonable expenses. This payment shall be made to Henry F. Sherrod, III, P.C. The Plaintiffs' counsel shall be paid one-half (1/2) of said attorneys' fees within sixty (60) days of Final Approval of this Agreement by the Court. The balance shall be paid within sixty (60) days of the beginning of the 2019 Fiscal Year.

2. Plaintiffs' counsel agree that they will not seek nor petition the Court for an award of attorneys' fees and expenses for monitoring services greater than the following amounts. For purposes of describing the periods hereinafter, the time commences 90 days following the execution and Final Approval of this settlement by the Court. The fees amounts for monitoring services will be capped at, and shall not exceed, a total of the following amounts:

A. Year One (which runs from the date that monitoring begins): $48,000.00.

B. Year Two (which runs from the date that monitoring begins): $48,000.00.

C. Year Three (which runs from the date that monitoring begins): $48,000.00.

D. Additional periods of monitoring due to extension of the Agreement: $48,000 annually, unless a lower amount is Ordered by the Court or agreed to by the Parties.

3. Plaintiffs' counsel will provide itemized hours expended with detailed time entries to the ADMH Commissioner, in writing, on a quarterly basis.

4. The ADMH Commissioner, by and through ADMH, agrees to pay an hourly rate of $195.00 for services rendered by attorneys and $65.00 per hour for paralegals, law clerks, and members of ADAP's monitoring unit in the monitoring process. The Parties will meet and confer and attempt to agree upon payment for monitoring services rendered. In the event that the Parties are unable to agree upon the reasonable number of hours expended, either party may seek the assistance of the Court if the Parties remain unable to agree.

5. The annual caps and hourly rates described herein do not apply to (a) Plaintiffs' motions to enforce the terms of this Agreement, and (b) Plaintiffs' opposition to any motions filed by the ADMH Commissioner arising out of this Agreement. No fees and expenses will be awarded to Plaintiffs' counsel for such motions or oppositions unless the Court finds: (a) that the motion or opposition was necessary to enforce the terms of the Agreement; and (b) that Plaintiffs attempted to resolve the matter and or narrow the issues as much as possible by meeting and conferring with the ADMH Commissioner, taking full opportunity of recourse to the mediation process before presenting the issues to the Court.

XIV. ADDITIONAL PROVISIONS

1. The ADMH Commissioner waives the right to contest the enforceability of this Agreement by persons who have been charged with a crime in Alabama and ordered to receive an Outpatient Mental Evaluation as provided in Section VI.1.A. The Plaintiffs waive the right to contest, following Final Approval of the Agreement, the Constitutionality of this Agreement, any

of its terms, and the validity of this Agreement. Any person who is not part of settlement class who attempts to enforce this Agreement shall be deemed to be bound by this Agreement.

2. This Agreement constitutes the entire agreement between the Parties as to all claims contained herein. This Agreement supersedes all prior agreements, whether written, oral, or implied. Each party represents that it has full legal authority to enter into and execute this Agreement.

3. This Agreement completely resolves all claims in this Lawsuit that were brought or were required to have been brought in this Lawsuit with regard to the settlement class or any other beneficiary of this Agreement.

4. Unless expressly identified in this Agreement, the Parties do not intend for this Agreement to confer any benefit on any third party.

5. This Agreement may not be altered or amended, except in writing signed by all Parties or their representatives or by a Court order.

6. Nothing in this Agreement shall be construed to require the ADMH Commissioner or ADMH to disobey or violate any order of any court or any state or federal law in any way, subject to the Supremacy Clause of the United States Constitution.

7. This Agreement will be binding on all successors, employees, agents, and all others working on behalf of Plaintiffs and Defendant Lynn Beshear.

XV. IDENTIFICATION AND EMERGENCY TREATMENT OF CLASS MEMBERS

1. **Identification and Emergency Treatment of Class Members.** The Parties will implement the following process for identifying and treating class members who need emergency treatment prior to their admission into a facility operated by the Alabama Department of Mental Health ("ADMH"):

a. ***Notice to Relevant Persons***. The Parties, during the term of the proposed Settlement Agreement, and ADMH thereafter, will work with officials of the Alabama State Bar, with whom they have already begun conferring, to disseminate, on an annual basis, notice to members of the Alabama State Bar, which substantially comports with Appendix C hereto. The notice will be disseminated in a manner agreed to in cooperation with the Alabama State Bar, or alternatively, the Alabama Administrative Office of Courts, which may include publication. During the term of the proposed Settlement Agreement, the Parties, and ADMH thereafter, will also disseminate a notice to the circuit court judge in each Alabama county, on an annual basis, designating the ADMH official responsible for initiating the process of identifying and arranging emergency treatment for persons awaiting inpatient mental evaluations and/or competency restoration treatment prior to their admission into a facility operated by ADMH for that purpose, which will substantially comport with Appendix D hereto.

b. ***Procedure for Identifying Class Members in Need of Emergency Treatment.*** The ADMH Commissioner shall designate, annually, an ADMH official (the "ADMH Designee") to receive notice from current and future class members' criminal defense counsel and/or Alabama circuit court judges that a class member needs emergency treatment. Upon receipt of any such notice by the ADMH Designee, the ADMH Designee will provide notice of his or her receipt of notice to the Monitor, the Alabama Disabilities Advocacy Program ("ADAP"), within forty-eight (48) hours of receiving same during the term of the Settlement Agreement (ECF No. 60-1). Notification of the Monitor for this purpose may be made to the same individual designated according to Section III.1 of Appendix B (Monitoring Protocol) of the Settlement Agreement. Upon receiving notice from criminal defense counsel and/or an Alabama circuit court judge (or an agent acting on behalf of an Alabama circuit court judge) that an incarcerated criminal defendant

needs emergency psychiatric treatment, the ADMH Designee will first confirm that the individual is a class member to whom the ADMH Commissioner has a duty to provide care. If the individual concerning whom the ADMH Designee receives notice of a need for emergency treatment is not a class member, the Monitor shall transmit the notice to the Alabama Disabilities Advocacy Program operating as the State's protection and advocacy agency for prospective advocacy. If the individual concerning whom the ADMH Designee receives notice of a need for emergency treatment is a class member, the ADMH Designee will arrange for a clinical professional to visit the class member in person to conduct an assessment of the class member's need for emergency treatment within four (4) business days of the ADMH Designee's receipt of notice of the need for emergency treatment. If, in the clinical professional's judgment, the class member needs emergency treatment, the ADMH Commissioner shall arrange for the provision of emergency treatment to the class member or the class member's early admission into an ADMH operated facility for purposes of receiving the court-ordered inpatient mental evaluation or competency restoration treatment (*i.e.*, a "line jump" pursuant to Section VI.D.iii of the proposed Settlement Agreement) within seven calendar days of the clinical professional's in-person visit with the class member. The ADMH Designee will advise the Monitor of the clinical professional's determination whether the class member needs emergency treatment and any arrangements for such treatment within forty-eight (48) hours of the professional's in-person visit with the class member during the term of the Settlement Agreement. If after the ADMH Designee receives notice from a class member's defense counsel or a circuit court judge the Sheriff of the county and/or officials of the jail or Alabama Department of Corrections Facility in which the class member is incarcerated refuses ADMH officials, the ADMH-designated clinical professional, or the Monitor access to the class member, then within twenty-four (24) hours of the denial of access the ADMH

Designee will notify the Monitor of same and all Parties will meet and confer as to the appropriate motion to be filed with the Circuit Court for access to the class member. In the event of a dispute between the ADMH officials evaluating the class member for emergency treatment or a potential "line jump" and the Monitor concerning the need for same, the Monitor shall submit the dispute for formal resolution in accordance with the provisions for dispute resolution in Section VIII of the proposed Settlement Agreement.

c. ***Procedure for Responding to Class Members Who May Be Suicidal.*** Upon receipt of notice by the ADMH Designee that an incarcerated criminal defendant needs emergency treatment because he or she is believed to be suicidal, the ADMH Designee shall forward notice of same to the Monitor within twenty-four (24) hours of receipt, unless such notice is received on a Saturday or Sunday, in which case the ADMH Designee shall have until close of business the following Monday to forward the notice to the Monitor. Upon receipt of such notice, if the individual identified in the notice is a class member, the Monitor shall immediately notify the Sheriff of the county and officials of the jail or ADOC facility in which the individual is incarcerated that the individual is believed to be at risk of suicide. If the individual identified in the notice is not a class member, the Monitor shall transmit the notice to the State's protection and advocacy agency for prospective advocacy.

XVI. EFFECT OF SETTLEMENT AGREEMENT ON FEMALE CLASS MEMBERS

1. All provisions of the Settlement Agreement apply with equal force to male and female class members, including all timeframes for the provision of court-ordered inpatient mental evaluations and competency restoration treatment, Settlement Agreement, Section VI.1.A, VI.1.B, and VI.1.C, training to relevant state personnel, Settlement Agreement, Section VI.3, and monitoring, Settlement Agreement, Section VII, Appendix B (Monitoring protocol including

documents provided for monitoring include waiting lists for Taylor Hardin Secure Medical Facility and Bryce Hospital). The provisions of the Settlement Agreement related to the addition of forensic hospital and community beds likewise apply with equal force to female and male members of the settlement class, as the additional capacity required by the Settlement Agreement must be allocated so as to ensure that the timeframes for provision of court-ordered services to female class members are achieved.

2. As of August 7, 2017, there were no female class members on the waiting list for admission to Bryce Hospital for court-ordered inpatient mental evaluations or competency restoration treatment. The total number of female class members who have been ordered to receive an inpatient mental evaluation, and who awaited admission to Bryce Hospital for some period of time, since January 1, 2017 is 9. The total number of female class members who have been found incompetent to stand trial and ordered to receive competency restoration treatment, and who awaited admission to Bryce Hospital for some period of time, since January 1, 2017 is 8. The average number of days following ADMH's receipt of a circuit court order directing its provision of an inpatient mental evaluation or competency restoration treatment to a female class member has been 7 days, with the longest wait since January 1, 2017 being 10 days.

Dated, this the 25th day of January, 2018.

/s/ Myron H. Thompson
UNITED STATES DISTRICT JUDGE

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

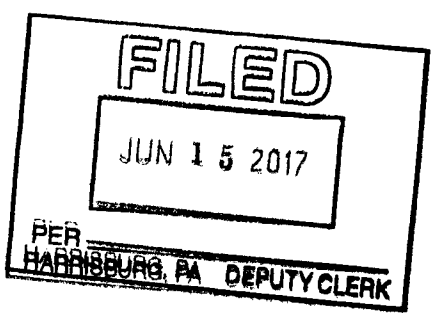
J.H., by and through his next friend, Flo Messier; L.C., by and through her next friend, Flo Messier; R.J.A., by and through his next friend, J.A.; Jane Doe, by and through her next friend Julia Dekovich; S.S., by and through his next friend, Marion Damick; G.C., by and through his next friend, Luna Pattela; R.M., by and through his next friend, Flo Messier; P.S., by and through his next friend M.A.S.; T.S., by and through his next friend Emily McNally; M.S., by and through his next friend Emily McNally; and all others similarly situated,

Plaintiffs

v.

Theodore Dallas in his official capacity as Secretary of the Pennsylvania Department of Human Services; Edna I. McCutcheon in her official capacity as the Chief Executive Officer of Norristown State Hospital; Robert Snyder in his official capacity as the Chief Executive Officer of Torrance State Hospital,

Defendants



Civil Action No. 1:15-cv-02057-SHR

Judge Sylvia H. Rambo

SECOND INTERIM SETTLEMENT AGREEMENT

WHEREAS Plaintiffs, individuals who have been declared incompetent by the courts to stand trial on criminal charges and who have been ordered committed to Norristown State Hospital ("NSH") or Torrance State Hospital ("TSH") for

treatment to help them attain competence, but who instead have remained in jail for extended lengths of time and in some cases for over a year, filed this civil rights class-action lawsuit on October 22, 2015 (*see* ECF No. 1), against officials of the Pennsylvania Department of Human Services ("DHS"), alleging that the delays in transferring them to one of the DHS hospitals for competency-restoration treatment violate the Due Process Clause of the Fourteenth Amendment to the United States Constitution; Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12131-12134; and Section 504 of the Rehabilitation Act ("RA"), 29 U.S.C. § 794;

WHEREAS the parties resolved Plaintiffs' Motion for Preliminary Injunction (ECF No. 4) by entering into an interim Settlement Agreement on January 27, 2016, to undertake actions designed to reduce the length of the wait lists and wait times of persons declared incompetent and awaiting treatment, i.e., Class A members (ECF No. 35);

WHEREAS DHS stipulated in the interim Settlement Agreement that there is sufficient evidence to establish that wait times of at least 60 days fail to comply with Fourteenth Amendment due process guarantees (ECF No. 35 at ¶ 1), and some federal courts have held that even wait times less than 30 days are unconstitutional;

WHEREAS since February 2016, the Defendants have invested resources to create 120 new slots for treatment in the community; 377 patients have been discharged from NSH and TSH; and 348 individuals have removed from the wait lists before admission to the hospitals, but the wait lists nonetheless have grown from 216 people awaiting treatment at the time of the interim Settlement Agreement on January 29, 2016, to 256 awaiting treatment on May 26, 2017;

WHEREAS, by way of example, of the 41 patients admitted from jails into NSH on the waiting lists dated from January 6 through May 26, 2017, 25 patients waited more than 300 days, and of those 25 patients, 17 waited at least 400 days, 5 waited over 500 days, 2 waited more than 600 days, and one waited over 788 days in jail before being admitted to NSH. As of May 26, 2017, 36 individuals awaiting admission to NSH have been waiting over 300 days, of whom 6 have been waiting more than 400 days;

WHEREAS, by way of example, of the 74 patients admitted from jails into TSH on the waiting lists dated from January 6 through May 26, 2017, 64 waited 30 days

or more, 51 of whom waited 90 days or more. As of May 26, 2017, 17 individuals awaiting admission to TSH have been waiting more than 60 days, 4 of whom have been waiting more than 100 days;

WHEREAS Plaintiffs have discussed with Defendants the reasons for the lack of progress under the interim Settlement Agreement in reducing the number of patients on the wait lists and the wait times since September 2016;

WHEREAS on May 11, 2017, Plaintiffs renewed and amended their original motion for preliminary injunction, initially filed on October 22, 2015 (*compare* ECF Nos. 4 and 9 with ECF Nos. 40 and 45);

WHEREAS the parties recognize that the protracted wait times serve neither the interests of justice nor the clinical needs of Class A members and that a comprehensive evaluation of the competency-restoration system and additional actions are currently needed to make progress toward permanently reducing wait lists and wait times to a constitutionally acceptable level;

THEREFORE, intending to be bound, the parties hereby agree as follows:

1. Defendants will hire the independent consultant identified by Plaintiffs in the agreement letter attached hereto as Exhibit "A." The consultants will, as more fully set forth in Exhibit A:

    a. conduct a thorough assessment of DHS's competency-restoration systems and processes, which will include a review of the individuals awaiting competency restoration treatment, the forensic population currently in treatment, competency restorations completed in 2016, the resources and processes in use and available to DHS, and the role of other stakeholders in the forensic criminal justice system; and

    b. produce a report that will identify a strategy and recommend tangible actions to reduce wait times for competency restoration treatment to constitutionally acceptable limits;

2. Defendants will make available the following resources, above those originally specified in the interim Settlement Agreement, to competency-restoration patients awaiting treatment within the time frames specified:

a. Within six months, a new "minimum security" unit consisting of 50 new forensic beds at NSH, which will be comprised of a combination of 28 brand new beds and 22 beds in existing civil units that will be converted for forensic use;

b. Within six months, DHS expects that an additional 29 DHS-funded treatment slots will become available in the community, comprised of 7 in Allegheny County (targeted for completion by September 2017), an additional 12 thereafter in Allegheny County, and 10 in Philadelphia; and

c. Within 9 months, at least 30 civil beds at NSH (in addition to those identified in subparagraph 2a, *supra*), which are currently occupied by civilly committed patients who will move to the community as specified in their Community Service Plans, will be converted into forensic beds, provided, however, that no patient who is currently in a civil bed will move to the community only to comply with this subparagraph if the community services have not yet been developed for that patient.

3. Defendants will implement the strategy identified in the independent consultant's final report to reduce wait times to a constitutionally acceptable level, unless, within 14 days of receiving the consultant's final report, Defendants submit to Plaintiffs a detailed, written description of why one or more action items recommended in the report are not achievable or warranted, and will propose alternative actions or explain why the action is unnecessary. If the parties are unable to agree within 30 days, Plaintiffs may at any time thereafter file a motion asking the Court to issue a preliminary or final injunction to enjoin DHS to take such steps as the Court determines necessary and appropriate to reduce wait times to a constitutionally acceptable level. DHS may assert all available defenses to Plaintiffs' motion.

4. Upon receipt of the final report, the parties will attempt to reach agreement on a maximum allowable wait time, an outstanding legal issue the parties reserved in the interim Settlement Agreement and which the parties reserve once again. If the parties are unable to agree upon a maximum allowable wait time after the consultant issues the final report, Plaintiffs retain their right from the interim Settlement Agreement to file a motion asking the Court to issue a declaratory judgment, preliminary injunction, or final

injunction setting the maximum allowable wait time and a deadline for Defendants to reduce wait times to that level as a remedy for the constitutional violations alleged in the Complaint.

5. This Second Interim Settlement Agreement resolves all issues outstanding in Plaintiffs' Motion to Renew and Amend Motion for Preliminary Injunction (ECF No. 40), except for the issues reserved in paragraph 4, *supra.*

6. This Second Interim Settlement Agreement does not negate or nullify any provision of, or obligation imposed on DHS contained by, the interim Settlement Agreement, which remains fully enforceable by this Court as specified in that Agreement.

7. Defendants agree to pay Plaintiffs' reasonable attorneys' fees, adjusted to Middle District of Pennsylvania rates, and costs incurred in the prosecution of Plaintiffs' Motion to Renew and Amend Motion for Preliminary Injunction (ECF 40) since May 5, 2016. If the parties are unable to agree to a negotiated amount of attorneys' fees and costs, Plaintiffs may submit a petition for decision by the presiding judge, who may in the first instance refer the matter for mediation.

8. In addition to Defendants' obligations under ¶ 11 of the interim Settlement Agreement, Defendants also agree to pay (a) reasonable costs and consulting fees for time incurred by Dr. Joel Dvoskin, up to $15,000 total, from the date of this agreement in consulting with the parties and independent consultant hired under paragraph 1 to facilitate the assessment and development of the consultant's final report or the requirements of this Second Interim Settlement Agreement, or both; and (b) Plaintiffs' reasonable attorneys' fees from the date of this agreement, to be billed at no higher than a $350 hourly rate, not to exceed a total of $100,000 during any twelve-month period, for monitoring the Second Interim Settlement Agreement. Subparagraph (b) does not apply if Plaintiffs move to enforce either the first or second interim Settlement Agreement or move for a declaratory judgment or preliminary or final injunction, at which point the usual Middle District Court rates will apply and fees will be resolved in accordance with paragraph 7.

9. The provisions of this Settlement Agreement will be subject to enforcement through specific performance after Plaintiffs provide Defendants with thirty-days written notice and an opportunity to cure. Plaintiffs do not waive any

available rights or remedies in the event Defendants fail to comply with an order for specific performance, and Defendants do not waive any defenses.

10. The parties will ask the Court to dismiss Plaintiffs' pending motion for preliminary injunction (ECF 40) as moot. This Court will retain jurisdiction, including the power and authority to enforce this Settlement Agreement and subsequent Settlement Agreements adopted by the parties, for 3 years from the date the Court approves the Agreement. Either party may petition the Court to shorten or lengthen the time for good cause.

For Defendants

By: */s/ Doris M Leisch*
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For Plaintiffs

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By: */s/ David P. Gersch*
David P. Gersch
ARNOLD & PORTER LLP
601 Massachusetts Ave., N.W.
Washington, D.C. 20001
202-942-5000

Approved by the Court on this 15th day of June, 2017:

Hon. Sylvia H. Rambo, Senior U.S.D.J.

Interim Agreement

1. The parties agree that the *Mink* (3:02-cv-00339-MO) and *Bowman* (3:21-cv-01637-HZ) cases should be joined as related cases. The parties agree to suspend formal discovery in both cases, and will instead exchange information informally in accordance with the engagement of Dr. Pinals.

2. Defendants will stipulate to an amendment in the *Bowman* case to add the Metropolitan Public Defender as an appropriate institutional plaintiff.

3. Defendants will enter into a contract with neutral expert Dr. Debra Pinals on or before December 31, 2021. Upon consultation with Dr. Pinals, she will begin her work immediately but not later than January 3, 2022.

4. The parties will file a joint stipulation and order on or before December 15, 2021, appointing Dr. Pinals as a neutral expert in the joined cases and outlining her role.

5. The parties agree to request a deadline of January 31, 2022, for Dr. Pinals to file her initial Report and Recommendation with the Court, to address short-term compliance plan and a proposed global admissions protocol. The parties agree to participate in a renewed settlement conference with Magistrate Judge Stacie F. Beckerman on February 3, 2022, to resolve any disputes relating to Dr. Pinals's Report and Recommendation. If the parties are unable to resolve their disputes, or at the Court's request, the parties will appear at a hearing on Dr. Pinals's Report and Recommendation before the U.S. District Judge the week following the renewed settlement conference. If the parties agree with Dr. Pinals's Report and Recommendation, Defendants will follow her recommendations and will report their progress in their monthly reports to Dr. Pinals.

6. The parties agree to request a deadline of April 29, 2022, for Dr. Pinals to file her Report and Recommendation regarding a proposed long-term compliance plan. The parties agree to participate in a renewed settlement conference with Magistrate Judge Beckerman on May 4, 2022, to resolve any disputes relating to Dr. Pinals's Report and Recommendation. If the parties are unable to resolve their disputes, or at the Court's request, the parties will appear at a hearing on Dr. Pinals's Report and Recommendation before the U.S. District Judge the week following the renewed settlement conference. If the parties agree with Dr. Pinals's Report and Recommendation, Defendants will follow her recommendations and will report their progress in their monthly reports to Dr. Pinals.

7. Plaintiffs in the *Mink* and *Bowman* cases agree not to initiate contempt proceedings nor request temporary injunctive relief pending the Court's resolution of Dr. Pinals's April 29, 2022, Report and Recommendation, unless they believe that Defendants are not acting in good faith or are not complying with this Interim Agreement. If Plaintiffs intend to initiate contempt proceedings or request temporary injunctive relief during this interim time period, they will first attempt to resolve the dispute through mediation with Magistrate Judge Beckerman.

8. Defendants will provide Dr. Pinals with monthly reports throughout her engagement. Defendants' first report to Dr. Pinals is due on January 3, 2022 and must include: 1) a summary of Defendants' actions between December 10, 2021, and January 3, 2022, to achieve compliance; 2) what actions Defendants plan on taking in January 2022, to achieve compliance; and 3) barriers identified to completing those actions.

9. Defendants agree to designate a representative to participate in a January 2022 meeting with Multnomah County stakeholders to discuss the feasibility of a jail population and 9(b) review committees.

10. Between December 17, 2021 and the Court's adoption of a global admissions protocol, the parties agree that no individual found Guilty Except for Insanity will wait longer than four months for admission to the Oregon State Hospital.

11. The parties agree to draft a joint press release regarding this interim agreement.

Sheila H. Potter
Deputy Chief Trial Counsel
On behalf of Defendants

Emily Cooper
On behalf of Disability Rights Oregon

Jesse Merrithew
On behalf of Metropolitan Public Defender

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

PORTLAND DIVISION

DISABILITY RIGHTS OREGON et al.,

Plaintiffs,

v.

PATRICK ALLEN et al.,

Defendants,

No. 3:02-cv-00339-MO (Lead Case)
No. 3:21-cv-01637-MO (Member Case)

SECOND AMENDED ORDER TO IMPLEMENT NEUTRAL EXPERT'S RECOMMENDATIONS

JAROD BOWMAN et al.,

Plaintiffs,

v.

DOLORES MATTEUCCI et al.,

Defendants,

No. 3:21-cv-01637-MO (Member Case)

MOSMAN, J.,

THIS MATTER comes before the Court on Defendants' Unopposed Motion to Amend September 1, 2022 Order [ECF 367] and Plaintiffs' Unopposed Motion for Further Remedial Order [ECF 411]. Having reviewed the papers filed in support of these motions, the Court finds that Defendants are still not in compliance with this Court's permanent injunction in *Mink* and ORDERS the following which are necessary to move Defendants towards compliance with that injunction:

I. Neutral Expert

The Oregon State Hospital ("OSH"), the Oregon Health Authority ("OHA"), Disability Rights Oregon ("DRO"), and Metropolitan Public Defenders shall implement the recommendations in the Court's Neutral Expert's Reports. If necessary to comply with any part of this order, Dr. Pinals may grant extensions of other deadlines in her recommendations after conferring with the parties. Any such extensions shall be documented in Defendants' monthly progress reports.

II. Admissions

OSH shall not admit patients except as provided for by the recommendations in the Neutral Expert's Reports or as otherwise provided by this Court. Namely, Aid and Assist ("A&A") and Guilty Except Insane ("GEI") persons shall be admitted according to their place on the admissions wait list or pursuant to the expedited admissions policy attached to this order as Exhibit 1.[1] In addition, OSH:

a. may admit Psychiatric Security Review Board ("PSRB") GEI revocations and persons pursuant to ORS 426.701 (extremely dangerous persons);

b. shall not admit persons civilly committed or admit "voluntary by guardian" persons unless they meet the criteria in the expedited admissions policy attached as Exhibit 2 to this order;

c. shall not admit transfers from the Oregon Youth Authority except as provided by ORS 179.473(1)(c), OAR 309-120-0080, and OAR 416-425-0020; and

d. shall not admit transfers from the Oregon Department of Corrections unless they meet expedited admissions standards as articulated in the expedited admissions policy attached as Exhibit 1 to this order.

[1] The expedited admissions policies referenced in this order as Exhibits 1 and 2 can be found at: https://www.oregon.gov/oha/OSH/LEGAL/Pages/expeditedadmissions.aspx.

e. For persons found unable to aid and assist whose most serious charge is a misdemeanor, only those persons charged with a "person misdemeanor" may be committed to the custody of OSH for restoration. For purposes of this order, a "person misdemeanor" includes those crimes listed in OAR 213-003-0001(15), violation of an Extreme Risk Protective Order entered under ORS 166.525 et seq., and violation of any of the following in proceedings to impose punitive sanctions for contempt:

(1) a Family Abuse Prevention Act Restraining Order entered under ORS 107.700 et seq.;

(2) an Elderly Persons and Persons with Disabilities Abuse Prevention Act Restraining Order under ORS 124.005 et seq.;

(3) a Sexual Abuse Restraining Order under ORS 163.760 et seq.; or

(4) an Emergency Protection Order under ORS 133.035.

III. Maximum Times

OSH shall immediately implement the maximum time for inpatient restoration in the Neutral Expert's June 2022 report as follows:

a. For patients whose most serious charge is a misdemeanor, the maximum duration of commitment for restoration shall be the lesser of the maximum permissible sentence for the underlying offense or 90 days;

b. For patients whose most serious charge is a felony, the maximum duration of commitment for restoration shall be six (6) months, unless the felony is listed in ORS 137.700(2), in which case the maximum duration of commitment for restoration shall be one year.

c. For purposes of this order, restoration across multiple charges shall be consolidated and contiguous consecutive periods of restoration should be eliminated unless there are new charges incurred after an initial period of restoration has ended.

d. Before a patient reaches this maximum duration of commitment for restoration under this order and remains unfit to proceed, OSH shall notify the committing court of the patient's impending discharge 60 days before the date on which the hospital is required to discharge the patient pursuant to this order.

e. For purposes of this order, the maximum time for inpatient restoration runs from the date of admission to OSH.

f. Defendants shall consult with the Neutral Expert regarding operational and clinical aspects of implementing these limitations on the duration of inpatient restoration.

IV. Discharge Planning Extension

Additional time at OSH for care coordination and discharge planning to promote and protect the health and safety of the public upon state court order for a maximum of 30 days beyond the timelines described in this order after opportunity for objection by defense will be available in limited circumstances, if, according to OSH, the individual cannot be placed immediately in an identified placement after a referral has been submitted to that placement, but reasonably expects to be placed within 30 days. The extension will be considered when OSH receives any such court order at least 5 business days prior to the expiration of the restoration time period, or within 5 business days of entry of the remedial order if less than 5 days remain until expiration of the restoration time period at the time of entry of the remedial order. Failure to coordinate discharge planning by the Community Mental Health Program ("CMHP") will not constitute justification for this extended discharge planning exception.

V. Extending Duration of Hospital Restoration for Violent Felonies

Upon notice from OSH that a defendant is reaching the end of their restoration period (and such notice shall be provided at least 60 days prior to the end of their restoration period), a district attorney may petition for an exception to the maximum time for inpatient restoration established by this order. The petition shall be signed by the district attorney for the county and submitted within 30 days of receipt of the notice of discharge (or within 30 days of entry of the remedial order if less than 30 days remain until expiration of the restoration time period at the time of entry of the remedial order), and OSH must receive any order from the committing court prior to the expiration of the restoration time period (or within 30 days of the filing of the petition if less than 30 days remain until expiration of the restoration period at the time of entry of the remedial order). The court may grant the petition if it determines the following:

a. The defendant is charged with a "violent felony" pursuant to ORS 135.240(5),[2]

b. By clear and convincing evidence, there is a danger of physical injury or sexual victimization to the victim or a member of the public if the defendant is discharged from OSH,

c. The defendant meets the requirements of ORS 161.370(3), and

d. The court concludes that there is a substantial probability that continued commitment at OSH will lead to a determination that the defendant has gained or regained fitness to proceed within that 180 day extension. In making this determination, the court shall consider the following:

(1) clinical data of progress toward restoration,

[2] "Violent felony" means a felony offense in which there was an actual or threatened *serious physical injury* to the victim, or a felony sexual offense. A *serious physical injury* means a physical injury which creates a substantial risk of death or which causes serious and protracted disfigurement, protracted impairment of health, or protracted loss of impairment of the function of any bodily organ. ORS 161.015(8).

(2) evidence that the defendant's inability to aid and assist is not due to a condition that is unlikely to result in restoration such as a significant neurocognitive disorder (e.g., dementia or traumatic brain injury), or significant neurodevelopmental disability disorders,

(3) evidence regarding the outcome of prior efforts at restoration, and

(4) any other relevant information the court wishes to consider.

If the court grants a petition, the court shall conduct a review of the status of restoration efforts at intervals no greater than every 180 days in accordance with ORS 161.371. At such reviews, the court may continue the commitment for an additional 180 days if it makes the findings outlined above. The maximum total amount of commitment time shall not exceed the time period set by ORS 161.371(5).

OSH shall track the patients who are eligible for this exception by notice from the Oregon Judicial Department and shall track those for whom such exception has been requested and those who have been found by courts to fall within this exception and shall report aggregate data at least every two weeks on their data dashboard website.

VI. Competency Opinion Clarifications

If the defendant is under a competency restoration order, at the time of subsequent statutory forensic evaluations, the forensic evaluator shall notify the court that:

a. the defendant has present fitness to proceed;

b. there is no substantial probability that, in the foreseeable future, the defendant will gain or regain fitness to proceed and whether there is no substantial probability that, within the allowable commitment period for restoration at OSH, the defendant will gain or regain fitness to proceed; or

c. there is a substantial probability that, in the foreseeable future, the defendant will gain or regain fitness to proceed and whether there is a substantial probability that, within the allowable commitment period for restoration at OSH, the defendant will gain or regain fitness to procced.

If the probability exists, the superintendent, director, or designee shall give the court an estimate of the time in which the defendant, with appropriate treatment, is expected to gain or regain fitness to proceed.

VII. Supremacy Clause Disputes

If OSH identifies a conflict between this order and the committing jurisdiction's order during the pendency of this order, the parties to the criminal case and an OSH representative (and its counsel) are encouraged to participate in an expedited mediation (by video or phone, if necessary) with U.S. Magistrate Judge Stacie Beckerman, to resolve the conflict. OSH and the parties to the criminal case should meet and confer prior to the mediation in an effort to resolve any conflict between the court orders and clarify the issues subject to mediation. If any party to the criminal case refuses to participate in mediation or if mediation is unsuccessful, any *Mink/Bowman* party may petition this Court for an expedited ruling on whether the Supremacy Clause establishes that this order takes precedence over the conflicting state court order, and any responses from the parties or amici shall be filed within five business days.

VIII. Implementation

To the extent that aspects of this remedial order require updated forms and protocols by OHA, OSH, and amici, these updates shall be made with the assistance of amici and the parties, and there shall be up to a 30-day period from the date of this order to implement any such changes to relevant forms and to notify stakeholders impacted by these changes.

IX. Compliance

This order shall terminate upon the Neutral Expert reporting to this Court that OSH/OHA has timely admitted A&A and GEI patients for at least three consecutive months, and that the termination of this order would not cause the Defendants to fall back out of compliance. For purposes of this order "timely admission" means within seven days of a State Court order delivered to OSH ordering that the patient be admitted.

X. Termination

If this order is not terminated pursuant to Section IX, this order will expire on December 31, 2023, unless renewed by the Court prior to that time.

IT IS SO ORDERED.

DATED: _____July 3, 2023_____

____/s/ Michael W. Mosman_____

MICHAEL W. MOSMAN
Senior United States District Judge

EXHIBIT 1

OREGON STATE HOSPITAL
Office of the Superintendent
Kate Brown, Governor

Oregon Health Authority

2600 Center Street NE
Salem, OR, 97301
Voice: 503-945-2852
TTY: 800-735-2900
Fax: 503-947-2900
osh.oregon.gov

June 27, 2022

Request for Oregon State Hospital Expedited Consultation/Admission

PATIENTS ON THE OSH ADMISSION LIST UNDER FORENSIC COMMITMENTS

Purpose of this document:

This document sets forth protocols and processes for referral for expedited consultation and possible early admission of individuals under a forensic commitment awaiting admission to Oregon State Hospital from local jails. OSH and OHA are working in partnership with stakeholders to increase timely access to OSH. To achieve equitable efficiencies and maximum timeliness for all admissions, only in very limited circumstances would an expedited admission be approved.

Role of OSH for forensic patients:

OSH has a role in caring for individuals sent via courts who are either in need of restoration to competence to stand trial, are found Guilty Except for Insanity, or are committed under an Extremely Dangerous Persons civil commitment and are found to warrant care and treatment at OSH. These legal categories (A/A, GEI and EDP) are referred to as “forensic” as they involve criminal court processes. OSH treatment providers have substantial expertise in the treatment of people with severe and persistent mental illness and can provide helpful informal consultation by telephone regarding the management of individuals waiting for OSH admission.

Protocol:

Individuals eligible to request expedited clinical or systems consultation/admission: Courts, jail personnel, the individual’s assigned defense attorney(s), case prosecutor(s), or anyone who, in their professional capacity, has concerns about the mental health condition of individuals in the categories listed below.

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Individuals eligible for expedited consultation/admission: An individual being held in custody but ordered by a Court to OSH and placed on the OSH admission list, who are forensically committed pursuant to any of the following statutes:

- ORS 161.370: order for restoration of fitness to proceed;
- ORS 161.365: order for admission for up to 30 days' observation as initiated by OSH;
- ORS 161.327: An individual found guilty except for insanity (GEI); or
- ORS 426.701: An individual judicially committed as an extremely dangerous person with mental illness.

Qualifying Criteria for Expedited Admission: Individuals may be considered for expedited consultation/admission if they are currently at serious risk of harm to self, related to:

- Mental health symptoms compromising the immediate health and safety of the individual; and/or
- Active suicidal intent, actions such as suicide attempts, or serious self-injury*; and/or
- Inability to meet basic needs that puts the individual's immediate health and safety at risk**

**Serious injury includes injury requiring immediate medical attention OR averted injury which would have required immediate medical intervention if not for the intervention of jail staff. An individual who has received interventions such as limiting access to lethal means, use of suicide-resistant clothing, or other staff actions used to secure the immediate safety of the individual may still be referred for expedited consultation/ admission.*

***Risk to health and safety related to mental illness could include not eating or drinking for a period of time that could lead to medical consequences or placing oneself at risk of victimization due to apparent mental illness*

Disqualifying Criteria for Expedited Admission: An individual who meets the eligibility criteria above but who has *an active medical condition that requires stabilization at a primary medical center*. Once medical stabilization has occurred, if the individual still meets criteria, a request for consultation is encouraged. Consultation is also available while the individual is being stabilized to ensure timely transport and admission.

Process:

Rapid Response Consultation: a telephone consultation is encouraged when there is an immediate health and safety risk which meets the above criteria AND may require OSH admission within 24-48 hours, possibly following emergency stabilization at a primary medical center.

1. OSH response occurs within one (1) business day

2. Telephone consultation only, though OSH may contact the jail to provide additional documentation, as described below
3. **Contact the OSH Admissions Department at 503-945-9265 (phone) or OSH.Admissions@odhsoha.oregon.gov (email)**
4. If further assessment of the individual is needed before a determination can be made, OSH will work with jail personnel or, if appropriate, with OHA (who will engage community mental health providers) to conduct such an assessment.

Expedited Consultation: a consultation and/or referral for expedited admission is encouraged when there is a health and safety risk which meets the above criteria but is not likely to require OSH admission within 24-48 hours.

1. OSH response occurs within two (2) business days
2. If a telephone consult is preferred, contact the OSH Admissions Department as above. OSH may also contact the jail to provide additional documentation, as described below.
3. Written referrals must be sent to the OSH Admissions Department (contact information below) and include the following:
   a. a written explanation of
      - the clinical concerns that require more immediate attention; and
      - a description of interventions and supports that have already been implemented or attempted; and
   b. additional documentation provided by the jail as described below.

Additional documentation (which may be requested from the jail by the OSH Admissions Department to supplement a consultation):

- Medical and Psychiatric Records from the jail facility; and
- Medication administration records for the last month; and
- Logs for the duration of the inmate's current stay at the jail facility detailing restraint/seclusion, special observation, administrative segregation, or disciplinary segregation; and
- If available, the status of a court order for administration of involuntary medications

Requests for consultation/expedited admission will be reviewed by the Chief Medical Officer or designee during business hours (0800-1700) Monday through Friday. The reviewer may contact the submitting jail or referral source to arrange consult by phone or video if additional information is needed.

Within 24 hours of receiving all necessary information, the CMO or designee will communicate back to the referring party related to consultation/admission considerations.

A request for expedited admission is not meant to replace services that are currently required within jail facilities or emergency medical care. In a life-threatening emergency, the individual should be treated at the local site and taken for emergency medical care as needed.

Admissions Department contact information:
Phone: 503-945-9265
FAX: 503-945-9839
Email: OSH.Admissions@odhsoha.oregon.gov

Hours of operation:
Monday through Friday
8:00 AM to 5:00 PM

EXHIBIT 2

OREGON STATE HOSPITAL
Office of the Superintendent
Tina Kotek, Governor

Oregon Health Authority

2600 Center Street NE
Salem, OR, 97301
Voice: 503-945-2852
TTY: 800-735-2900
Fax: 503-947-2900
osh.oregon.gov

May 5, 2023

Request for Oregon State Hospital Expedited Admission

PATIENTS ON THE OSH ADMISSION LIST UNDER CIVIL COMMITMENT OR VOLUNTARY BY GUARDIAN / HEALTH CARE REPRESENTATIVE STATUS

Purpose of this document:

This document sets forth protocols and processes for referral for expedited admission to Oregon State Hospital (OSH) of individuals hospitalized at an acute care facility under a civil commitment or admitted voluntarily by guardian or health care representative (henceforth "civil admission" status). OSH and OHA are working in partnership with stakeholders to increase timely access to OSH.

Overarching Principled Approach to Expedited OSH Admission of Patients under Civil Admission Status:

OSH must balance the need for OSH admission for patients under civil admission status with constitutional requirements for admission to OSH for patients under forensic commitments (pursuant to federal litigation pertaining to admission to OSH of patients under forensic commitments).

Patients meeting criteria for civil admission to OSH are placed on the OSH Civil Admission list and are scheduled for admission based on bed availability. To achieve equitable efficiencies and maximum timeliness for all admissions, only in limited circumstances would an expedited admission for a patient under civil admission status be approved.

Protocol:

***Individuals eligible to refer a patient for civil expedited admission to OSH*:** Health care personnel involved in hospital management or provision of treatment to individuals in the categories listed below.

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NOTE: a referral may be initiated prior to civil commitment if there is a high likelihood that the patient will meet criteria for both civil commitment and OSH admission, and the qualifying criteria for expedited admission are met. However, a patient may not be admitted to OSH under a civil expedited admission until all eligibility criteria below are met.

***Patients eligible for civil expedited admission to OSH*:** An individual being treated at an acute care hospital is eligible if that patient:

1. Is civilly committed or admitted voluntarily by guardian or health care representative; and
2. Meets criteria for admission to OSH per OAR 309-091-0015 and has been placed on the OSH Civil Admission List; and
3. Meets the qualifying criteria below for Civil Expedited Admission and has been approved for expedited admission by the OSH Chief Medical Officer or designee.*

   * Placement on the OSH Civil Admission list can be simultaneous with approval by the OSH Chief Medical Officer or designee.

***Qualifying Criteria for Civil Expedited Admission*:** patients may be considered for civil expedited admission if, within the previous three weeks at the acute care hospital:

- they exhibit severe aggression directed toward other persons and/or property, or
- they are unable to meet their own basic nutritional needs such that their immediate health and safety are at risk, or
- they require biological therapies available to OSH but not to acute care hospitals; **AND**
- they remain at ongoing high risk to themselves or others due to mental illness despite adequate treatment; **and**
- acute care hospital leadership concurs with the treating clinical team that referral for expedited admission to OSH is appropriate and attests that all other avenues for treatment at the acute hospital or for discharge have been exhausted.

As evidenced by:

1. Hospital course documentation demonstrating that, due to symptoms of mental illness, at least two of the following are present:
   a. The patient has engaged in physical aggression resulting in harm or injury to others or lost time at work for an employee;
   b. The patient has engaged in substantial property destruction impacting patient care;
   c. The patient has required 1:1 security staffing to prevent harm or injury to other patients or staff for longer than 72 hours;

d. The patient has required recent frequent or prolonged seclusion** or restraint;
e. Two or more acute psychiatric beds have been closed to reduce the risk of the patient causing harm or injury to other patients or staff;
f. The patient cannot be safely treated on an acute psychiatric unit with available resources.

OR

2. Hospital course documentation demonstrating that, due to symptoms of mental illness, at least one of the following are present:
   a. The patient is unable to meet their own basic nutritional needs such that medical intervention has been necessary or is highly likely to become necessary in the near future.
   b. The patient requires a biological therapy (ex: court-ordered electroconvulsive therapy) that cannot be provided at the acute care hospital.

** Behavior management plans which require that a patient may leave their assigned room only following staff assessment are considered equivalent to seclusion. An individual who has received such interventions, which reduce incidents of aggression by limiting access to peers, may still be referred for civil expedited admission.

***Disqualifying Criteria for Expedited Admission*:** An individual who meets the criteria above but who *has an active medical condition which requires stabilization or treatment at a primary medical center*. Referral and consultation may occur while the individual is being medically stabilized.

Process:

A referral for civil expedited admission is encouraged when a patient exhibits behavior and ongoing safety risk that meets the above criteria. Note that historical behavior, while pertinent to clinical risk assessment generally, is insufficient to justify civil expedited admission in the absence of present behavioral concerns.

The acute care hospital may refer the patient to OSH for consideration of civil expedited admission by making available **to the OSH Admissions Department** by fax, email or via electronic medical records access:

- Medical records up to the current date, including
  - current progress notes
  - documentation of any seclusion and/or restraint
  - documentation describing any current behavior management plan
  - medication administration records
- A written explanation by the unit medical director of

  - the current clinical behaviors and/or concerns that may require expedited OSH admission; and
  - an explanation of what need cannot be met by the acute care hospital; and
  - a description of interventions and supports that have already been implemented or attempted (this may include a description of the physical structure of the unit or location where the individual is housed)
- Name and contact information for the attending and/or covering psychiatric practitioner
- An attestation by an administrative director at the acute care hospital of review and approval of the referral

Requests for consultation/expedited admission will be reviewed by the OSH Chief Medical Officer (CMO) or designee during business hours (0800-1700) Monday through Friday. The reviewer may contact the attending practitioner if additional information is needed.

Within 24 hours of receiving all necessary information, the CMO or designee will communicate back to the referring party related to consultation/admission considerations.

- If approved, OSH will admit the patient in a timeframe deemed appropriate to the circumstances and as soon as possible considering the expedited nature of the referral.
- If denied, the patient will maintain their current place on the OSH Civil Admission List.
  - In addition, OSH will participate in a patient care conference in collaboration with the acute care hospital and CMHP, including subsequent meetings as required and agreed upon, with the goal of identifying modifications to the care plan to promote the safety of the patient, other patients, and staff.
  - A patient may be referred again following a denial if additional safety considerations arise which meet the qualifying criteria.
  - All referrals, acceptances and denials, along with the rationale for such referrals, acceptances, and denials, shall be recorded in a de-identified tracking system kept by OSH and the private hospitals and reviewed on a quarterly basis in joint meetings with the private hospitals, OSH and OHA leadership representation and any other mutually agreed upon invitees to ascertain impact on compliance with federal court orders, impact on private hospitals, and any other factors of relevance to Oregon psychiatric hospital and community behavioral health system stakeholders. These quarterly reviews and lessons learned may result in further modifications of this protocol.

Admissions Department contact information:
Phone: 503-945-9265
FAX: 503-945-9839
Email: OSH.Admissions@odhsoha.oregon.gov

Hours of operation:
Monday through Friday
8:00 AM to 5:00 PM

Declaration of Nicholas Williamson

Attachment A

Washington State Department of Social & Health Services

Transforming lives

Trueblood Implementation Plan

Final

June 27, 2019

Background

All criminal defendants have the constitutional right to understand the nature of the charges against them and assist in their own defense. If a court believes a mental disability may prevent a defendant from understanding the charges against them or assisting in their own defense, the court puts the criminal case on hold while an evaluation is completed to determine the defendant's competency.

If the evaluation finds the defendant competent, they are returned to stand trial. However, if the evaluation shows the person is not competent, the court may order the defendant to receive care and treatment to restore competency.

In April 2015, the court found the Department of Social and Health Services (DSHS) was taking too long to provide these competency evaluation and restoration services. On December 11, 2018 the court approved a Settlement Agreement related to the contempt findings in this case. The settlement is designed to move the State closer to compliance with the Court's injunction. This is the Final Implementation Report as required by the Settlement Agreement.

The parties recognize that this plan sets forth markedly ambitious timelines to implement agreement elements within Phase 1. Many of these elements require the development of programs and services that have never existed in the state of Washington. Throughout this document, timelines have been proposed that will challenge the State, and leave little room for unforeseen roadblocks to implementation. As a consequence, the parties agree that the failure to meet these timelines will not constitute material breach, provided that the state has made all reasonable efforts to meet the timelines herein. Rather, the timelines outlined for specific elements should be considered in light of all other evidence in any future dispute as to whether the elements of the settlement agreement have been timely implemented within Phase 1.

Phased Implementation

The Trueblood Settlement Agreement (Agreement) includes a plan for phasing in programs and services. In each phase, the state will focus its efforts within specifically identified and agreed upon regions. The Agreement includes three phases of two years each, and can be expanded to include additional phases. Phases run parallel to the Legislative biennia beginning with the 2019-2021 biennium.

Phase 1:	July 1, 2019 – June 30, 2021	Pierce, Southwest, and Spokane regions
Phase 2:	July 1, 2021 – June 30, 2023	King region
Phase 3:	July 1, 2023 – June 30, 2025	Region to be determined

Regional Collaboration

Following the onboarding of the additional Project Managers to support the Trueblood Settlement Agreement implementation, the project management team will develop a collaboration model for regional implementation. The goal of the collaboration model is to ensure consistent implementation and communication across all regions.

While developing that plan, the team will ensure it:

- Encourages the surfacing of barriers and challenges
- Supports the efficient resolution of problems and addresses decision making processes
- Facilitates the sharing of information
- Engages appropriate members of the various Implementation Teams

The collaboration model will be included in the first semi-annual Monitoring Report.

Regional Stakeholder Engagement

Following the onboarding of additional Project Managers to support the Trueblood Settlement Agreement implementation, project managers will work with assigned agencies to develop stakeholder engagement plans targeted to each effort.

In advance of that activity, DSHS and the Health Care Authority convened regional Summits in the three Phase 1 Regions in March and April of 2019. These summits were intended to start conversations with regional partners about the work that lies ahead; both to solicit their participation and engagement and foster understanding about the content of the settlement agreement. Invitees covered a broad range of partners including behavioral health groups, law enforcement, courts, attorneys, jail leadership, community leaders, elected officials, housing partners, tribes, and many more. All three Summits were very well attended and attendees were appreciative of the opportunity to begin conversations.

Detailed plans and supporting documents prepared for the Summits have been shared with the Trueblood Executive Committee.

Additional engagements with the regions are also planned for June and July including:

- A webinar on SB 5444 and the budget passed to support Trueblood
- A webinar on the Final Implementation Plan
- In person meet and greets between the Project Management team and stakeholders and partners in all three regions.

Reporting

The status of the Agreement will be provided to the General Advisory Committee (GAC) via the semi-annual Monitoring Report required within the Agreement. That report will include:

- Data reporting
- Data analysis
- Updates on status of the phased programs
- Areas of concern in implementation and any resulting recommendations
- Areas of positive impact or programming in implementation

In order to support data reporting and analysis for Trueblood, a Data Workgroup comprised of data and Information Technology members from DSHS and the Health Care Authority (HCA) has been convened. The workgroup will:

- Identify business requirements around data for each of the elements
- Assess existing data collection and data storage processes and programs within DSHS and HCA to evaluate whether they will support the new data necessary for Trueblood
- Provide recommendations to agency management on data collection processes for Trueblood which can include manual tracking and/or programmatic changes to existing data collection processes and database systems, development of new data collection processes and database systems, etc. to support data collection and evaluation for Trueblood.

The first Monitoring Report will be provided to the GAC in March 2020, six months following the first GAC meeting, which is anticipated in September 2019.

Agreement Elements

1 Competency Evaluation – Additional Evaluators

1.1 Assigned Owner

The Department of Social and Health Services' Behavioral Health Administration's Office of Forensic Mental Health Services (OFMHS), is responsible for hiring and employing Forensic Evaluators and associated staff.

1.2 Statewide vs. Regional

Evaluators support the entire state of Washington and staff additions are part of the statewide effort with an emphasis on both placement in outstation and inpatient settings.

1.3 Requirements from the Agreement

a. DSHS will post and hire thirteen (13) evaluators, one supervisor, and two support staff between July 1, 2019 and June 30, 2020.
b. DSHS will post and hire five (5) evaluators and one support staff between July 1, 2020 and June 30, 2021.
c. Note: supervisor and support staff were not specified as a requirement in the agreement.

1.4 Education and Outreach

DSHS will notify regions impacted when newly hired evaluators are on-boarded via the agency's listserv.

Communication with identified outstation areas will occur once a determination of an outstation placement is made. Placement will be based on areas with the highest referrals through calendar year 2018 and half of the calendar year for 2019. Furthermore, in the event that resources are diverted in order to respond to an increase or spike in referrals, the areas impacted will be notified of this shift to Trueblood services using the DSHS listserv.

1.5 Action Plan and Timeline

Completed:

1. Updated existing position description forms for the evaluator, support staff, and supervisory positions by April 1, 2019
2. Submitted required documentation (request to hire/personnel action requests, updated organization charts, etc.) to human resources by April 30, 2019
3. Advertised the established positions by May 15, 2019
4. Began recruitment activities including screening and interviewing by May 30, 2019

Pending:

5. Hire and onboard the new employees, including expedited work with jails for jail clearances, beginning July 1, 2019 until all positions are filled.

2 Competency Restoration – Legislative Changes

2.1 Assigned Owner

Legislative changes affect multiple agencies. For this reason, this initiative is assigned to the Governor's Office, with secondary support from the Department of Social and Health Services and the Health Care Authority.

2.2 Statewide vs. Regional

Legislation impacts the state of Washington and is part of the statewide effort.

2.3 Requirements from the Agreement

1. The state will pursue changes in the 2019 legislative session with the intent to reduce the demand for competency services. This includes advancing requests for legislative changes through bill proposals, and could include supporting legislation proposed by others.
2. The state will seek statutory changes to implement a phased rollout of community outpatient restoration services in targeted areas, including residential supports as clinically appropriate.

2.4 Education and Outreach

N/A – The State completed this element prior to first semi-annual Monitoring Report submission.

2.5 Action Plan and Timeline

N/A – The State completed this element prior to first semi-annual Monitoring Report submission. SB 5444 passed by legislature and signed by the Governor on May 8, 2019. Part of the legislative work that occurred included joint department and OFM work to ensure sufficient investment by the legislature to support the implementation of the programs and services contemplated by the Settlement Agreement.

3 Competency Restoration – Community Outpatient Services

3.1 Assigned Owner

Competency restoration is a coordinated effort between the Department of Social and Health Services and the Health Care Authority.

3.2 Statewide vs. Regional

The state will implement this element of the settlement in selected regions in phases according to the plan outlined in the agreement.

3.3 Requirements from the Agreement

a. The state will seek funding for outpatient competency restoration (OCR) services in targeted areas (including residential supports as clinically appropriate) and a broader package of treatment and recovery services (including mental health treatment, substance use screening and treatment).
b. The state will identify and seek necessary statutory changes, and develop policies to fully implement outpatient restoration services in targeted areas.
c. Eligibility for outpatient restoration will be decided by the criminal court ordering restoration services.
d. For criminal defendants waiting in jail, an offer of admission to the community outpatient restoration services program will occur within the timelines for restoration as outlined by the Federal Court.
e. The process for outpatient restoration will provide sufficient information for the court to create tailored conditions for release.
f. Outpatient restoration providers will:
    i. Accept referrals from OFMHS in accordance with an algorithm that prioritizes the intake of class members.
    ii. Monitor the individual's compliance with the court order in conjunction with the Forensic Navigator.
    iii. Provide residential support solutions to those identified by a Forensic Navigator as unstably housed for the duration of their outpatient participation and up to 14 days following transmission of the competency evaluation that occurs at the end of restoration.
    iv. Have flexibility in providing residential support solutions which may include capital development through the Department of Commerce (COM) or third party source, housing voucher programs, existing housing programs, and/or scattered site housing programs.
g. The state will provide outreach and technical assistance upon request to support the implementation of community outpatient restoration services.

3.4 Education and Outreach

Initial Education and Messaging Stage:

The OCR workgroup will partner with DSHS and HCA communications staff, as well as an HCA contract oversight team, to begin collaboration with the Managed Care Organizations (MCOs), Administrative Service Organizations (ASOs), and Community Behavioral Health providers in the targeted areas.

The OCR workgroup will support the establishment of a stakeholder group with representation from each targeted regional area. Initial outreach to potential stakeholders and partners will include, but not be limited to, regional judges, attorneys, prosecutors, jails, courts, peer counselors, consumers, consumer advocacy groups, general public, managed-care entities, crisis providers, and community behavioral health providers.

Action Stage –Contracting:

DSHS and HCA will coordinate with stakeholder groups, MCOs, ASOs, and behavioral health administrative service organizations (BHASOs) to conduct outreach to the provider network. Education about new programs will be provided, as well as alerting potential contractors on upcoming contract opportunities.

In partnership with DSHS, HCA will execute a direct provider contract or will communicate the Request for Application (RFA) procurement process. If leveraging existing contracts, HCA will negotiate amendments to existing contracts.

DSHS and HCA will coordinate with stakeholder groups, MCOs, ASOs, and BHASOs to announce final contracts and contracting language.

Implementation Stage – Targeted Education and Technical Assistance:

DSHS and HCA, in partnership with the Forensic Navigator workgroup, will conduct outreach and provide technical assistance to criminal courts and other stakeholders, upon request, to support community outpatient restoration services. They will assist with issues such as:

- Determining eligibility for community outpatient restoration;
- The conditions of the class member's participation in outpatient restoration;
- Community outpatient restoration services; and,
- Using Residential Supports and other services to encourage community outpatient restoration services.

The OCR workgroup will partner with the Forensic Navigator workgroup, the Housing Supports workgroup, and the DSHS/HCA communications team to provide information to the key stakeholders, community partners, and program participants in the targeted regions.

Monitoring Stage:

HCA will monitor the early phase of implementation and contract adherence.

In partnership with DSHS, HCA will complete quality assurance monitoring of fidelity to the competency restoration treatment model.

DSHS/HCA will utilize information obtained from monitoring efforts to complete ongoing and targeted technical assistance.

3.5 Action Plan and Timeline

Completed:

1. Finalized the OCR workgroup charter by May 31, 2019.

Pending:

2. The OCR workgroup reviews applicable reports to include Groundswell Services' 2017 and other relevant national models by July 1, 2019.
3. The OCR workgroup collaborates with DSHS/HCA communications team to develop an outreach plan for stakeholders and partners by August 30, 2019.
4. Stakeholder groups established with representation from each of the targeted regions by October 1, 2019.
5. Using stakeholder and partner input, the OCR workgroup will finalize the program model, core elements and referral criteria by February 29, 2020.
6. Metrics will be determined in conjunction with data staff by March 31, 2020.
7. In partnership with HCA contracts team and DSHS, the OCR workgroup solidifies necessary contract language and processes by March 31, 2020.
8. The OCR workgroup coordinates with Forensic Navigator and Residential Support workgroups to coordinate contract efforts, if required, from January 1 – March 31, 2020. Note: Forensic Navigators will need to be hired and onboard before Outpatient Competency Restoration services can begin.
9. DSHS and HCA will provide ongoing messaging and technical assistance to the target areas May 1, 2019 – June 30, 2021. The OCR program providers will be given targeted training and technical assistance.
10. HCA will provide contract monitoring and oversight. OCR contracts will be finalized and operational within the Phase 1 regions by July 1, 2020. Note: As this is a brand new program in these regions, there may need to be a ramp-up period by the contracted providers before services are fully available.

4 Forensic Navigators

4.1 Assigned Owner

The Department of Social and Health Services is responsible for hiring and employing Forensic Navigators.

4.2 Statewide vs. Regional

The state will implement this element of the settlement in selected regions in phases according to the plan outlined in the agreement.

4.3 Requirements from the Agreement

a. The state will seek funding to implement forensic navigators.
b. Forensic Navigators:
    i. Will be assigned a caseload of no more than 25. Assignment will occur at the time a competency evaluation is ordered.
    ii. Upon assignment and before the hearing, the Forensic Navigator (FN) will gather and provide information to the criminal courts to assist with:
        - Understanding treatment options to divert members from the forensic mental health system.

- Determining whether a defendant is appropriate for community outpatient restoration services. This is not a clinical recommendation. Standardized tools or assessments for those not known to the system may be used.
- Recommending tailored release conditions for those ordered to community outpatient restoration services.

iii. Will prioritize their caseload to focus on diversion of high utilizers (as known to the system) and may provide less-intensive levels of service to those unknown and/or not yet found incompetent.

iv. Will conclude forensic navigator services when a client is found competent or incompetent but **not** ordered by the court into community outpatient restoration services.

v. For those clients assigned to community outpatient restoration, the FN will:

- Monitor compliance (in partnership with community outpatient providers) and provide periodic updates to the court. This may include appearing at court hearings.
- Inform providers if an assigned client is unstably housed and needs residential supports.
- Coordinate access to housing.
- Assist client with attending appointments and classes related to competency restoration.
- Meet individually with clients regularly; perform outreach as needed to stay in touch.
- Coordinate client access to community case-management services, mental health services, and follow up.
- Assist clients with obtaining and encourage adherence to prescribed medication.

vi. For those found incompetent and ordered into community outpatient restoration services, forensic navigator services will conclude and the FN will complete a coordinated transition when:

- Charges are dismissed pending a civil commitment hearing.
- Client receives a new or amended order directing inpatient admission.
- Client declines further services after restoration treatment ends.
- Client regains competency, is found guilty, and is sentenced to serve time.
- Community outpatient restoration order is revoked or new criminal charges cause a client to enter or return to jail.
- In any other situations not listed above, at the discretion of the state.

vii. A coordinated transition will include:

- Facilitated transfer to a case manager in the community mental health system using standards for coordinated transition as established through care coordination or similar agreements.
- Attempt to confirm meeting between client and community-based case manager following transition.
- Creation of summary of treatment provided during community outpatient restoration (including earlier-identified diversion options for the individual).
- Attempt check-in with client at least once per month for up to 60 days. During this period, the client **does not** count towards the Navigator's caseload.
- Attempt to connect identified high utilizers with available high-utilizer services.

viii. The state, through training and technical assistance, will encourage third parties (like jails and prisons where class members are serving sentences) to request the summary of treatment and related treatment records as allowed by RCW 10.77.210.

4.4 Education and Outreach

Educational Materials

Partner with DSHS/BHA Communications staff to develop the below materials:

- Program One-Pager
  - High level overview of the program
- Presentation driving "Train-the-Trainer" style seminars for relevant parties
  - May need multiple versions geared towards specific stakeholder groups

Relevant Parties

- Accused
- Potential clients and those at risk of arrest/re-arrest (Mental Health and related Social Service Agencies, CIT programs, individuals who have previously refused FN services, or are known to the system)
- Prosecutors
- Defense counsel
- Judges
- Administrative Office of the Courts (AOC)
- Legislators and staff
- General public
- Families of the accused and client advocates working on behalf of class members

Outreach

- Targeted communications to relevant parties
- Build database of key contacts and relevant parties for continued outreach and education
- Schedule and execute trainings at least annually
  - Solicit feedback on both the training itself, and the program overall
- On an ongoing basis, use feedback and program-evaluation analytics for constant program improvement

4.5 Action Plan and Timeline

Completed:

1. Submitted necessary human resource paperwork to create the FN Program Administrator by March 8, 2019.
2. Advertised the Administrator position by April 15, 2019.
3. Completed recruitment activities including screening, interviewing, and job offers by June 15, 2019.
4. Hired and completed new employee onboarding process by July 31, 2019.

Pending:

5. The Forensic Navigator Administrator will convene a workgroup and hold the first meeting by August 31, 2019.
6. Forensic Navigator (FN) Workgroup will complete final draft of Forensic Navigator Program Charter by September 30, 2019.
7. FN Workgroup will review other state and national models related to data and metrics for evaluation of program performance outcomes and quality control by November 30, 2019.
8. FN Workgroup will collaborate with DSHS/HCA communications team to develop a plan for stakeholders to identify and provide challenges and barriers with the workgroup by December 31, 2019.
9. The FN Workgroup will consult with RDA to ensure that the desired data and metrics for evaluation of program performance and quality control can be obtained through the proper database or reporting tool by December 31, 2019.
10. Submit necessary human resource paperwork to create the FN program positions in each region by January 31, 2020.
11. Advertise the forensic navigator positions by February 29, 2020.
12. Meet with partners (courts, AOC, jails, etc.) to develop processes and associated documentation and forms to be used by Forensic Navigators in the court system. Includes adjusting existing forms by March 31, 2020.
13. Meet with partners (newly established outpatient competency providers, evaluators, etc.) to develop processes and associated documentation needed for those in outpatient restoration. Includes treatment summary, release orders/conditions, etc. by March 31, 2020.
14. Complete recruitment activities including screening, interviewing, and job offers by April 30, 2020.
15. Hire and complete new employee onboarding process by June 15, 2020.
16. Day one of FN Program operations in all three Phase 1 regions expected July 1, 2020.

5 Competency Restoration – Additional Forensic Beds

5.1 Assigned Owner

The Department of Social and Health Services is responsible for managing forensic-bed capacity.

5.2 Statewide vs. Regional

Forensic beds are used by patients across Washington. Adding or converting beds is part of the statewide effort.

5.3 Requirements from the Agreement

a. Convert two wards at Eastern State Hospital into forensic wards containing a total of 50 beds by December 31, 2019.
b. Convert two Western State Hospital civil geriatric wards to two forensic wards containing a total of 42 beds by December 31, 2019.
c. If extensions are needed to either timeline, provide the Executive Committee information on the delay to receive an additional six months of time. If the state needs additional time beyond this six-month period, they may request a further extension of time from the court.

5.4 Education and Outreach

- Provide updates during Executive Leadership Team meetings
- Quarterly updates from the Project Manager and Sponsor
- Maintain a Project Team SharePoint or Website for communication
- Schedule, prepare for, and attend job fairs to advertise coming positions

5.5 Action Plan and Timeline – ESH Beds

Completed:

1. Evaluated contract bids and award contract by February 15, 2019.
2. Construction began by March 1, 2019.

Pending:

3. Create position description forms for program positions by August 1, 2019.
4. Submit required documentation (request to hire/personnel action requests, updated organization charts, etc.) to Human Resources by August 15, 2019.
5. Positions created and allocated by Class and Compensation Unit by October 1, 2019.
6. Develop equipment and supply list, obtain fiscal approval, and purchase necessary items by November 15, 2019.
7. Substantial completion of construction of 1N3 and 3N3 will occur between April 1 and May 1, 2020.
8. Final completion of construction and installation of furniture, equipment and supplies by June 1, 2020.

Note: This timeline will require notice to the Executive Committee because it is beyond the currently set deadline. This estimated completion is within the six-month grace period allowed under the Agreement. In the event there are any delays related to the development of these beds beyond the six-month period identified in the settlement agreement, defendants will consult with the Executive Committee and file a motion for an extension of time.

5.6 Action Plan and Timeline – WSH Beds

Completed:

1. Contract bids opened for E3 and E4 by June 20, 2019.

Pending:

2. If bids are within funding constraints, construction begins by July 15, 2019.
3. Create position description forms for program positions by August 1, 2019.
4. Submit required documentation (request to hire/personnel action requests, updated organization charts, etc.) to Human Resources by August 15, 2019.
5. Positions created and allocated by Class and Compensation Unit by October 1, 2019.
6. Develop equipment and supply list, obtain fiscal approval, and purchase necessary items by November 15, 2019.
7. Substantial completion of construction by March 11, 2020.

8. Final completion of construction and installation of furniture, equipment and supplies by April 8, 2020.

Note: This timeline will require notice to the Executive Committee because it is beyond the currently set deadline. This estimated completion is within the six-month grace period allowed under the Agreement. In the event there are any delays related to the development of these beds beyond the six-month period identified in the settlement agreement, defendants will consult with the Executive Committee and file a motion for an extension of time.

6 Competency Restoration – Ramp Down of Maple Lane & Yakima RTFs

6.1 Assigned Owner

The Department of Social and Health Services is responsible for Residential Treatment Facilities (RTFs). The Office of Forensic Mental Health Services oversees the facilities.

6.2 Statewide vs. Regional

Maple Lane and Yakima RTFs support patients across the state of Washington and the closure of those facilities is part of the statewide effort.

6.3 Requirements from the Agreement

a. Yakima RTF will be ramped down when Class Member wait times for inpatient competency services reaches a median of 13 days or less for four consecutive months based on mature data or no later than December 31, 2021.
b. Maple Lane RTF will be ramped down when Class Member wait times for inpatient competency services reaches a median of 9 days or less for four consecutive months based on mature date or no later than July 1, 2024.

6.4 Education and Outreach

At Start of Phase 1 – June 30, 2019

A letter to community partners and stakeholders will be sent explaining the closure dates for each facility and the median that would need to be met for an earlier closure. The letter, which will also be available online, will outline when the notification process will start.

The CRS will conduct staff meetings and information will be provided about the settlement, the metrics required for an earlier closure, what an earlier closure means, and the set closure date. Multiple meetings will occur to reach all line staff that work at both facilities and want to participate.

The OFMHS Website would include a section on the impending ramp down under the RTF section. The Competency Restoration Specialist (CRS) will work with DSHS Communications to determine if other outreach would be beneficial.

At Onset of Ramp Down (occurs when data has met threshold for two consecutive months)

At the onset of ramp down, a pre-planned e-mail would be delivered to key partners and stakeholders. The letter would outline the date of closure. A separate letter would be sent to parents/guardians of the patients currently at the facility, only as allowed by either releases of information signed by patients or court assigned guardianship.

CRS will work with the communication team on a press statement regarding the closure and the impacts for both staff and patients.

In-person meetings will occur (with a WebEx option for the facility and stakeholders) and be led by the CRS and the OFMHS leadership.

For the Maple Lane Program, coordinate with Human Resources and the Union to meet facility staff and answer questions regarding the closure and what rights they will have.

Other stakeholder groups that will need to be informed at the on-set of the implementation committee:

- Comprehensive Mental Health – they currently have the contract for the Yakima Facility. They will have representation on the ramp down team.
- Well Path Recovery Solutions – they currently have the contract for the Maple Lane Facility They will have representation on the ramp down team.
- Department of Corrections (DOC) – currently both facilities are leased from DOC. Maple Lane is leased from Washington State DOC and the Yakima Facility is leased from Yakima County DOC.
- Washington State Federation of Employees (WFSE) – For Maple Lane only. The union will need to be involved once the settlement is signed due to Maple Lane employing represented employees. The CRS will communicate with Kelly Rupert and ask for a union representative to be on the ramp down team. There will need to be clear timelines outlined from the union specifying when they need to be notified so the required notifications are sent timely for the represented employees at Maple Lane.
- Human Resources will work with the Residential Services Manager at Maple Lane and the union to ensure all represented employees receive the proper notifications. Depending on project length, per the contract, represented employees in project status longer than five years will have specific layoff rights outlined in Article 34.17. HR will have a representative on the ramp down team.
- Green Hill School (GHS) – For Maple Lane only. Currently the MOUs for food, laundry, maintenance, and the vehicle are through GHS. The CRS or designee will need to coordinate the impending closure with the facility. DSHS employs eight represented staff at GHS or on site through the project who will require union notification.
- Capital Projects – will need to be involved because DOC may require that we return both facilities to their original floorplan.
- Budget – will need to plan for restoration funds to return the facilities back to their original condition. A representative from Budget will serve on the ramp down team.
- Contracts Manager– Both contracts for the upcoming year should address the impending early closure if the required median is met. The CRS will work with the contract manager on this task.
- The Forensics Admission Coordinator (FAC) - will work with the CRS and serve on the ramp down team tapering down before they close. The FAC would be notified by the CRS if the median wait-time data met the requirements for two consecutive months.

- Western and Eastern State hospitals – will be kept informed as the closure dates get closer in case some patients in the RTF facilities need different placement upon facility closure. In event that were to happen, Western and Eastern State hospitals would work with the Forensic Admissions coordinator.
- All courts and county jails, defense attorneys, and prosecutorial attorneys – will receive the initial letter crafted by the CRS and the communication team. If the required median were met by a facility, a second letter would be sent preparing them for the earlier closure date and when to expect admissions to stop for that facility.
- Families of patients at both facilities where a signed release of information is in place or court assigned guardianship. – four months prior to closure, a form letter would be sent to the families of patients at the affected facility informing them of the closure and possible placement options for their family member. This letter would be crafted by the CRS and communications team.

6.5 Action Plan and Timeline

Completed:

1. Identified members and send invitations to potential ramp down team members by April 1, 2019.
2. Convened the first meeting for the ramp down team in April to provide an overview of the draft implementation plan by April 30, 2019.
3. Met with leadership at both sites to review the settlement and compile questions they may have for OFMHS and/or the AG's; complete by April 30, 2019.
4. Identified settlement stakeholders and community partners impacted by ramp down (starting list is above in Education and Outreach section) by May 1, 2019.
5. Organized meetings with DOC at Maple Lane and Yakima to discuss the condition they want the facilities returned to after closure; complete by May 31, 2019.

Pending:

6. Adjust contracts 1512-48444, Comprehensive Competency Restoration Services, 1612-55044, Correct Care Competency Restoration Services, 1561-52933, DOC, Use of Facilities at Maple Lane and 16-DBHR-001, Rehab Administration, Green Hills School Services for ML CR Program during next negotiation period to allow for ramp down during the extension process; complete by June 30, 2019.
7. Meet with budget and Capital Projects to discuss DOC's requirements and develop an estimated cost and timeline; complete by June 15, 2019.
8. Contact Labor Relations within Human Resources to plan for union notification for Maple Lane; triggered by meeting two months' of the median data threshold set by the Settlement Agreement.
9. Contact human resources for help messaging staff at Maple Lane; triggered by meeting two months' of the median data threshold set by the Settlement Agreement.
10. Develop adjusted intake and admission procedures and timelines for each RTF based on anticipated closure dates; complete by August 1, 2019.
11. Once mature data threshold met or no later than June 30, 2021, initiate adjusted intake procedures for Yakima.
12. Once mature data threshold met or no later than January 31, 2024, initiate adjusted intake procedures for Maple Lane.

13. For Maple Lane, contact the union and human resources once mature data is met or no later than January 31, 2024, initiate notification to all DSHS employees.
14. Once mature data is met or no later than six months prior to the established final closure date, all courts, jails, and families of patients will be sent a letter notifying them of the impending closure, only as allowed by either releases of information signed by patients or court assigned guardianship.
15. Prior to closure each facility should have a plan regarding where the equipment is to go. The plan should be complete six months prior to closure.
16. Four months prior to closure the RTF will work with the Forensic Admissions coordinator and the contractor to establish an end date for intakes and determine when the staffing pattern will begin to decrease. This will include a detailed flow chart.
17. One month prior to closure the RTF should be at minimum capacity of patients as defined by the adjusted intake procedures.
18. Closure will occur at least two weeks prior to the established date to allow remaining staff time to pack equipment and empty the building.
19. On the closure date, Capital Projects will begin restoring the building to the condition agreed upon by DOC.

7 Crisis Triage & Diversion – Additional Beds & Enhancements

7.1 Assigned Owner

The Health Care Authority (HCA) is responsible for Crisis Triage and Stabilization facilities in the state of Washington.

7.2 Statewide vs. Regional

The state will implement this element of the settlement in selected regions in phases according to the plan outlined in the agreement.

7.3 Requirements from the Agreement

a. Seek funding to increase crisis stabilization units and/or triage facilities by 16 beds within the Spokane Region. Beds will address both urban and rural needs.

b. Solicit requests for and make funds available to community providers of crisis stabilization and/or triage facilities for enhancements.

c. Complete an assessment of need for Crisis triage and stabilization capacity in King County and gaps in existing capacity in Pierce, Southwest, and Spokane regions. Provided report of assessment to the General Advisory Committee with recommendations to address any gaps found.

7.4 Education and Outreach

Initial Education and Messaging:

Crisis triage and diversion supports workgroup will partner with DSHS and HCA communications staff, as well as HCA contract oversight team, to collaborate with the MCOs, BHASOs, and community behavioral health providers in the targeted areas.

Request for Application (RFA) and Contracting:

HCA to coordinate with stakeholder groups and managed care entities to communicate to provider network. Education about upcoming increase to capacity provided, as well as preparation to potential contractors for upcoming opportunities. Ongoing technical assistance provided to target areas.

In partnership with DSHS, HCA to communicate RFA procurement process.

HCA to coordinate with stakeholder groups and managed care entities to announce successful bidders.

Needs Assessment:

HCA will work with partners to evaluate the gap analysis completed by the Public Consulting Group (PCG) and develop a plan for increasing capacity in the phased regions.

The PCG gap analysis report will be shared with the General Advisory Committee and with key stakeholders.

7.5 Action Plan and Timeline – Gap Analysis and Response

Completed:

1. Crisis triage and diversion supports workgroup charter finalized by May 31, 2019.

Pending:

2. Crisis triage and diversion supports workgroup, in collaboration with HCA Communications team and DSHS partners, will collaborate with key stakeholders, to include the Behavioral Health Administrative Service Organizations (BHASOs) and their contracted crisis facility providers for the targeted regions, on the goals of this element by October 31, 2019.
3. Crisis triage and diversion supports workgroup will share the PCG report at the first General Advisory Committee meeting.
4. HCA will develop recommendations on how to increase crisis capacity in phased regions. Recommendations will be shared with the General Advisory Committee and key stakeholders by March 30, 2020.
5. [GAP] HCA to seek funding for next biennium budget to increase capacity by October 31, 2020.

7.6 Action Plan and Timeline – Enhancements

Completed:

1. Crisis triage and diversion supports workgroup charter finalized by May 31, 2019.

Pending:

2. Crisis triage and diversion supports workgroup, in collaboration with HCA Communications team and DSHS partners, will collaborate with key stakeholders, to include the Behavioral Health Administrative Service Organizations (BHASOs) and their contracted crisis facility providers for

the targeted regions, on the goals of this element by October 31, 2019. Throughout this process, the State will be:

a. Identifying objectives that align with the requirements of the Trueblood contempt settlement.
b. Exploring the known needs of each community and available resources, including completing an inventory of existing providers and facilities
c. Identifying community agency(s) that will be willing to provide services as defined by the agreement and by the core objectives established by the internal work group.
d. Scheduling and holding separate core meeting for each region and identifying needs based on the strengths and weakness of each site within those regions.
e. Provide an update to the Executive Committee about the status of the stakeholdering work, including whether existing providers are likely able to meet the need.

3. By March 1, 2020, HCA will make a determination whether the desired outcomes can be accomplished by amending contracts with existing providers, or if a RFP process will be necessary, or whether some combination of an RFP and amendment is necessary.
4. Using stakeholder input, crisis triage and diversion supports workgroup will coordinate with the HCA contracts team to develop RFP language and/or amend current MCO/ASO contracts to allocate the funds by March 31, 2020. The timelines for each approach are:
    f. **Amendments with Existing Providers:** In regions with existing providers who are willing to enhance crisis triage/stabilization services, completion of contract amendments based on workgroup recommendations will occur by March 31, 2020. Funds deployed through contract amendments will also be complete by this date.
    g. **RFP Process:** If no current service provider is able to provide the necessary enhancements, HCA will complete a procurement through an RFP process, incorporating the requirements developed by the workgroup. The RFP process will be completed as required by RCW 39.26, and will take approximately three months. The RFP procurement process will be completed for enhancements and money deployed by July 1, 2020. Examples of why the RFP process could be used include:
        1. the sites identified do not meet the requirements of the Trueblood settlement;
        2. no physical site can be identified that can be enhanced to accomplish the objectives,
        3. no agency is willing to contract to be the provider for service.
5. Based on the enhancements identified in either the amendment process or the RFP process (4.a or 4.b), the State will propose to the Executive Committee timelines for implementation of the enhancements. The timelines will be set according to the time necessary to implement the specific contracted enhancements.

7.7 Action Plan and Timeline – 16 Bed Facility in Spokane Region

Completed:

1. Crisis triage and diversion supports workgroup charter finalized by May 31, 2019.

Pending:

2. Crisis triage and diversion supports workgroup, in collaboration with HCA Communications team and DSHS partners, will collaborate with key stakeholders, to include the Behavioral Health

Administrative Service Organizations (BHASOs) and their contracted crisis facility providers for the targeted regions, on the goals of this element by October 31, 2019.

3. Crisis triage and diversion supports workgroup will partner with Department of Commerce behavioral health facilities program to solidify how capital funding will be included in RFA and procurement process by October 31, 2019.
4. Using stakeholder input, crisis triage and diversion supports workgroup coordinates with HCA contracts team to develop RFA language or amend current MCO/ASO contracts to allocate the funds by March 1, 2020; this will be used in the July 2020 amendment window.
5. Communication plan – HCA to develop a plan by coordinating with stakeholder groups and managed care entities on how to reach entities within the provider network. The plan will include education about upcoming increases to capacity, as well as information for potential contractors about upcoming opportunities April 1 – July 1, 2020.
6. RFA procurement process completed for contracts amended or issued by July 1, 2020. The operating funds to support the increased bed capacity will be provided upon the completion of the capital construction phase of the project, with services provided no later than July 1, 2021.

8 Crisis Triage & Diversion – Residential Supports

8.1 Assigned Owner

The Health Care Authority (HCA) is responsible for crisis triage including housing and residential supports in the state of Washington.

8.2 Statewide vs. Regional

The state will implement this element of the settlement in selected regions in phases according to the plan outlined in the agreement.

8.3 Requirements from the Agreement

a. Technical assistance will be provided to criminal courts and other stakeholders and includes using residential supports and other services for Community Outpatient Restoration Services.
b. If a Forensic Navigator assesses someone participating in Community Outpatient Restoration Services as “unstably housed,” that person is eligible for residential supports for the duration of their participation in outpatient competency services. This will cease if referred to inpatient services. For those opined as competent it may continue for up to 14 days following transmission of the competency evaluation.
c. The state will develop Residential Supports using procurement. Providers procured through this process could deliver residential supports in a way that met the community needs which might have included capital development through Department of Commerce or a third party, housing voucher programs, leveraging existing local housing programs, or scattered site housing programs.
d. The state will seek funding to provide short-term housing vouchers for use in Crisis Triage and Stabilization facilities. Vouchers cover a maximum of 14 days but, at the discretion of the facility, could be extended an additional 14 days.
e. The state will seek funding to provide residential support capacity associated with Community Outpatient Competency Restoration in each region.
f. The state will seek an additional 10 percent more funding as described in e. to be used for funding g.

g. The state will implement residential support capacity per the phased schedule. This capacity offers housing support options that target individuals who are clinically assessed to need more intensive support immediately following discharge from Crisis Triage and Stabilization facilities. Eligibility requirements include:
   - Have had at least one prior contact with the forensic mental system in the past 24 months, or, were brought to a Crisis Triage or Stabilization Facility via arrest diversion under RCW 10.31.110 as determined by the crisis triage and stabilization provider;
   - Need assistance accessing independent living options and would benefit from short term housing assistance beyond the 14-day vouchers;
   - Are diagnosed with an acute behavioral health disorder and are assessed to need housing support beyond what is offered through the Crisis Triage and Stabilization Facilities or the short term voucher as described in § III.C.2.a;
   - Are unstably housed;
   - Are not currently in the community outpatient competency restoration program, and;
   - Do not meet Involuntary Treatment Act (RCW 71.05) commitment criteria.

h. The Housing and Recovery through Peer Services (HARPS) program is available to individuals clinically assessed to benefit from the HARPS program in Community Outpatient Restoration.

i. High Utilizers are provided access to residential supports.

8.4 Education and Outreach

- Coordination with the Washington State Department of Commerce will be conducted to leverage local coordinated entry, deed recording fees, and housing and essential needs resources.
- Principles of the SAMHSA Permanent Supportive Housing (PSH) model will be disseminated throughout all projects including Forensic Navigators.
- Training on PSH principles for all HARPS teams will be conducted prior to any services being provided.

8.5 Action Plan and Timeline

1. Identify regional forensic programs currently in existence in Pierce, SW Region and Spokane BHO Region by August 1, 2019.
2. Develop draft RFP by August 1, 2019
3. Hire HCA HARPS Program Manager by August 31, 2019.
4. Post finalized RFP by September 1,2019
5. Develop draft contracts and send out to potential providers for review and signature by December 1, 2019.
6. Short term housing voucher dollars will be available to existing crisis triage facilities beginning December 1, 2019.
7. HARPS teams hire staff and services are available by March 1, 2020.
8. PSH Principles training to all HARPS staff by June 30, 2020.
9. Ten (10) percent housing supports tied to outpatient competency restoration will be integrated into contracts by July 1, 2020.
10. Complete initial testing and modeling evaluation for effectiveness by October 1, 2020.

9 Crisis Triage & Diversion – Mobile Crisis & Co-Responders

9.1 Assigned Owner

The Health Care Authority (HCA) is responsible for community health care including mobile crisis and co-responder programs. The Washington Association of Sheriffs and Police Chiefs will administer the co-responder program.

9.2 Statewide vs. Regional

The state will implement this element of the settlement in selected regions in phases according to the plan outlined in the agreement.

9.3 Requirements from the Agreement

Co-responders

a. The state will seek funding to provide law enforcement agencies with dedicated qualified mental health professionals that assist officers in field response by diverting people experiencing mental health crisis from arrest and incarceration.
b. Within the 2019-2021 biennium, seek $3 million funding for Washington Association of Sheriffs and Police Chiefs (WASPC) to expand the mental health field response program they administer. This includes funding to cover reasonable administrative costs requested by WASPC to enable it to meet the requirements of III.C.3.a.2 and III.C.3.b.3.
c. Within Phase 1, assess law enforcement agency co-responder mental health staffing needs to guide future funding requests.
d. The state's implementation plan (as described in IV.D.) describes how the state supports and encourages integration of these programs in to the other elements of the agreement.

Mobile Crisis Response (MCR)

a. The state will request a recommendation from WASPC and regional MCR providers on reasonable response times for each region.
b. The state will seek funding to increase MCR services for each phased region.
c. The state will request from each phased region a plan for providing MCR services. This includes new MCR services and should include proposing numbers, credentialing and location of mental health professionals. Each plan was tailored to meet the needs of the region, considering the need for timely response throughout the region.
    - The plans and any resulting contracts for services, required providers make MCR services available 24/7.
    - Services are accessible without fully completing intake evaluations and/or other screening and assessment processes.
    - Contracting entities include response time targets, after considering the WASPC and regional MCR providers' recommendations.
d. During Phase 1, the state will institute reporting requirements to gather data on MCR response times.
e. In Phases 2 and 3, parties use this reported MCR data to inform future funding requests and potentially added contractual requirements to meet response-time targets.

f. Co-response teams of law enforcement and mental health professionals are encouraged to rely on MCRs to accept individuals identified as needing mental health services.

9.4 Education and Outreach

For each region, the following entities will require written education and outreach materials, webinars and regional presentations:

- Crisis teams
- Behavioral health providers
- Law enforcement agencies
- Emergency departments
- Crisis settings, such as: E&Ts, CSUs, Respite, Triage
- Tribes
- DSHS administrations (DDA and ALTSA) and other social service providers
- Ombudsmen and consumer-run organizations
- First responders and ambulance companies

Outreach and education will focus on creating awareness of the Mobile Crisis Response service and how to request those services. The HCA will include outreach and education expectations in their contract with the BHASO for the MCR service and provide oversight of outreach materials and community engagement strategies. These will commence at the start of the MCR contracts. The HCA will assist with messaging about MCR services in advance of the regional MCR contracts.

9.5 Action Plan and Timeline

1. WASPC will be invited to participate in the implementation process by July 1, 2019.
2. The state will conduct quarterly check-ins with WASPC to collaborate on integrating these programs within appropriate elements of the settlement agreement beginning August 1, 2019.
3. Selected regional partners will identify participants to collaborate in developing regional timeliness expectations by August 31, 2019.
4. Begin holding regional meetings by September 30, 2019.
5. Draft Request for Plans with timeliness standards for each region and post for BHASO response by November 30, 2019.
6. Develop Mobile Crisis Response draft contract language by December 30, 2019.
7. BHASO response to Request for Plan is due January 31, 2020.
8. HCA, DSHS, and WASPC delegates review Request for Plans by February 28, 2020.
9. BHASOs receive feedback and submit changes by April 30, 2020.
10. Negotiate MCR contract language with BHASO and execute contracts by May 31, 2020.
11. BHASOs hire MCR staff and begin providing services by July 1, 2020.
12. BHASOs and HCA provide outreach and education campaigns within the region to ensure local system partners are aware of the service and how to seek it by September 30, 2020.
13. First reporting of MCR data submitted to HCA by January 31, 2021.

10 Crisis Triage & Diversion – Intensive Case Management

10.1 Assigned Owner

The Health Care Authority (HCA) is responsible for community health care including intensive case management (ICM) for high utilizers of the forensic mental health system.

10.2 Statewide vs. Regional

The state will implement this element of the settlement in selected regions in phases according to the plan outlined in the agreement.

10.3 Requirements from the Agreement

a. Develop a model that identifies those most at risk of near-term referral for competency restoration (aka high utilizers). The model should use available data including factors such as prior referrals for competency evaluation or restoration, prior inpatient psychiatric treatment episodes, criminal justice system involvement, and homelessness.
b. Contract with community providers to provide ICM services to high utilizers. Develop strategies for assertive outreach and engagement. Develop a community collaboration effort to identify and coordinate services for those most at-risk.
c. Offer the following services to those identified as high utilizers for a six-month period:
    - Intensive case management (including outreach and engagement activities occurring outside a competency referral)
    - Engagement activities
    - Housing supports using the HARPS model which includes securing and maintaining housing, peer support, and rent or other housing subsidies in the amount of up to $1,200 per month for up to six months
    - Transportation assistance
    - Training or accessing resources and other independent living skills
    - Support for accessing healthcare services and other non-medical services
d. Create effective data tracking system and reporting structure to Trueblood coordinator for tracking coordination activities.
e. Reduce forensic referrals for competency evaluations.

10.4 Education and Outreach

Starting with state partners (DSHS, MCOs, BHASO, regionally funded forensic programs, HCA Trueblood Program contacts) determine appropriate integration of programs.

Outreach will be needed to community behavioral health and forensic service providers in Pierce County, SW Region and Spokane RSA who may be interested in providing services for this program. Targeted outreach will be done to current providers of outreach and engagement services once funding is allocated to the program.

The state will contact each agency and local consortiums to request participation in a stakeholder workgroup or conversation about becoming an ICM provider for high utilizers. In addition, the Health Care Authority will issue a public announcement in the event a RFA will be issued if sufficient agencies to deliver the services are not identified.

A program brochure will be available to contracted providers and community partners for disbursement.

Depending on the location of the high utilizer data from RDA, providers may have access to a remote site with information on potential participants.

HCA will coordinate with those entities who have access to the high utilizer list to assist with outreach and engagement services, coordinate services, and make appropriate referrals.

A sampling of participants will complete a satisfaction survey at program completion. Additionally, quarterly interviews will be conducted with contracted providers to assess program needs and observed program trends.

10.5 Action Plan and Timeline

1. Identify regional outreach and engagement programs currently in existence in Pierce, Southwest, and Spokane regions by July 1, 2019.
2. RDA finalizes the high utilizer algorithm and provides the first reports by July 1, 2019.
3. Assess the need to develop an RFP to contract directly with a provider in the region or with the BHASO by August 1, 2019.
4. Identify existing regional or community workgroups that can be used to strategize, communicate, and problem solve implementation challenges by August 1, 2019.
5. If able to contract with existing outreach and engagement programs, develop contracts to include Intensive Case Management services by October 1, 2019. If unable to contact with existing programs, RFP will be posted by October 1, 2019.
6. Identify existing regional/community workgroups to identify referral pathways, communicate information and problem solve implementation challenges by October 1, 2019. Communication with these workgroups will continue beyond October 1, 2019.
7. Contractors need to hire staff to include at least one peer support person no later than January 1, 2020. If RFP is required this date will need to be extended.
8. HCA will conduct specialized training for staff hired within all three regions by the end of February 2020. Training will focus on effective outreach and engagement strategies.
9. Complete initial testing and evaluation of modelling for effectiveness by October 1, 2020.

11 Education & Training – Crisis Intervention Training (CIT)

11.1 Assigned Owner

The Criminal Justice Training Center (CJTC) is responsible for conducting CIT training for law enforcement entities.

11.2 Statewide vs. Regional

The state will implement this element of the settlement in selected regions in phases according to the plan outlined in the agreement.

11.3 Requirements from the Agreement

a. The State will seek funding so that the CJTC provides the 40-hour enhanced Crisis Intervention Training (CIT) courses to 25 percent of officers on patrol duty in law enforcement agencies within the phased regions.
b. The State will seek funding so that the CJTC provides all corrections officers and 911 dispatchers employed by governmental entities within each phased region, except those employed by the Department of Corrections or federal entities, at least eight (8) hours of CIT.

11.4 Education and Outreach

Law enforcement agencies are already familiar with Crisis Intervention Team (CIT) training. The CJTC will contact agencies in Phase 1 areas to provide education on additional training opportunities, funding and the goal to send 25 percent of patrol officers to the enhanced CIT training. The 40-hour Enhanced CIT training is regionally specific and includes local resources, contacts and procedures for dealing with individuals in a behavioral or substance abuse emergency. We will meet with police chiefs, sheriffs and agency training managers to assist with coordinating training, budget and staffing needs for this settlement.

The CJTC has already reached out to the training unit of the state office of 911 telecommunications about how the settlement agreement will impact 911 training during the coming fiscal year.

County and local jail personnel need to complete at least 8 hours of CIT training as well. The 8-hour course focuses on signs, symptoms, and intervention strategies related to behavioral emergencies that they are most likely to come into contact with.

11.5 Action Plan and Timeline

Completed:

1. Contacted Law Enforcement Agency administrators in the Phase One areas by February 1, 2019.
2. Contacted state 911 training unit to plan FY 2020 trainings by April 1, 2019.
3. Contacted county and local jail administrators in Phase 1 regions by June 1, 2019.

Pending:

4. Finalize training deployment plan for each of the three regions in Phase 1 by July 10, 2019.
5. Review training deployment plan and evaluate staffing needs by December 1, 2019.
6. Conduct and complete a training audit of every LE agency in the Phase 1 regions by December 1, 2019.
7. Complete a minimum of 14 CIT for Dispatch/911 courses by June 30, 2021.
8. Complete a minimum of nine 40-hour enhanced CIT courses in the Phase 1 regions by June 30, 2021.
9. Complete a minimum of 24 CIT for Corrections courses by June 30, 2021.

12 Education & Training – Technical Assistance for Jails

12.1 Assigned Owner

The Department of Social and Health Services, Behavioral Health Administration, Office of Forensic Mental Health Services, is responsible for providing technical assistance to jails as part of the Trueblood agreement.

12.2 Statewide vs. Regional

The state will implement this element of the settlement in selected regions in phases according to the plan outlined in the agreement.

12.3 Requirements from the Agreement

a. The state will seek funding for positions to provide educational and technical assistance to jails.

b. The state will include the involvement of peer support specialists in providing this educational and technical assistance.
c. The state works with Disability Rights Washington, law enforcement agencies, and peer support specialists to develop guidance on mutually agreeable best practices for diversion and stabilization and produced a manual. This manual addressed:
    - Pre- and post-booking diversion, identification of need and access to treatment, guidelines for involuntary medication administration, continuity of care, use of segregation, and release planning.
d. In Phase 1, OFMHS will conduct a combination of on-site and tele video trainings for jails. DSHS will provide a website for jails that includes resources and a mailbox that jail staff can use to submit questions.

12.4 Education and Outreach

OFMHS team leads will solicit and approve workgroup membership from jails. As part of this work, the workgroup will develop a communications plan to inform the jails (and other stakeholders) of the status and availability of training and technical assistance materials.

12.5 Action Plan and Timeline

Completed:

1. Updated existing position description forms for two technical assistance positions by June 1, 2019.
2. Submit to human resources required documentation (request to hire/personnel action requests, updated organization charts, etc.) by June 15, 2019.

Pending:

3. Advertise the established positions by August 1, 2019.
4. Complete recruitment activities including screening, interviewing, and job offers by August 31, 2019.
5. Hire and onboard new employees by September 30, 2019.
6. By December 31, 2019, begin work with HCA to develop a plan to integrate peer support specialists into technical assistance.
7. Convene first workgroup by November 1, 2019.
    a. Conduct work groups with Washington's Designated Protection and Advocacy Agency and law enforcement entities to develop guidance on mutually agreeable best practices for diversion and stabilization of class members.
    b. Ensure HCA membership includes subject matter expert on peer support specialists.
8. Meet monthly, or as needed, to complete work on training manual and website.
9. Develop and conduct training needs assessments as part of the manual completion on best practices by November 1, 2019.
10. Training manual and website completed, trained on, and running by June 1, 2020.
    a. The peer support specialist enhancement curriculum will be reviewed as part of this process to ensure any and all technical assistance areas are addressed sufficiently.
11. As applicable trainings are finalized they will be made available, with all applicable trainings available beginning July 1, 2020.

13 Enhanced Peer Support

13.1 Assigned Owner

The Health Care Authority (HCA) is responsible for Peer Support Programs in the State of Washington.

13.2 Statewide vs. Regional

The state will implement this element of the settlement in selected regions in phases according to the plan outlined in the agreement.

13.3 Requirements from the Agreement

a. The state will create a peer counselor continuing education enhancement program for certified peer counselors that includes specialized training in criminal justice.
b. The state will provide ongoing training for these peer support specialists and targets the training and support to assist in establishing these positions in the programs outlined in the settlement agreement.
c. These enhanced peer support specialists are integrated into the following programs:
    - Technical assistance to jails.
    - Intensive case management for high utilizers.
    - Community outpatient competency restoration.
    - HARPS program.
d. The state will explore the possibility of federal funding for peer support specialists to encourage wider use of this role.

13.4 Education and Outreach

Outreach and education will focus on providing information about enhanced CPC roles and activities. The Enhanced Peer Supports Program Administrator will work in partnership with the regions and other Trueblood implementation teams to develop a FAQ, Factsheet, DBHR peer support webpage, Office of Consumer Partnership (OCP) distribution list, recorded webinars, and other communication materials as needed.

For each region, the following entities will require written education and outreach materials, webinars and regional presentations:

- Discussions on operationalizing enhanced certified peer counselors will occur with the technical assistance to jails, intensive case management, and community outpatient competency restoration teams.
- HARPS program
- Inform the peer community, stakeholders, jails, forensic navigators etc. about enhanced CPCs' roles and activities.
- WASPC.
- BHAs/BHASOs/MCOs.
- Other groups as needed and identified during initial outreach and education.

13.5 Action Plan and Timeline

1. Hire 1 staff (Program Administrator) by September 1, 2019.

a. Develop position description.
b. Recruitment.
c. Interviewing.
d. Candidate selection/background check/ reference check.
e. Candidate accepts and or repost.

2. Meet with partners (OFMHS, providers, etc.) to develop processes, education campaign, and associated documentation and forms to use by November 1, 2019.
   a. Environmental scan and key informant interviews.
   b. Integrate training components specific to serving individuals with prior criminal justice system contact.
3. Develop Curriculum by March 1, 2020.
   a. Train the trainers with new curriculum.
4. Implement and roll out trainings by May 1, 2020.
   a. Foundational enhancement training.
   b. Ongoing continuing education.
   c. Operationalizing enhanced peer support to host organizations.

14 Workforce Development

14.1 Assigned Owner

The Department of Social and Health Services is responsible for providing workforce development for DSHS staff and providing limited training resources to the forensic mental health community. HCA will be responsible for developing the enhancement curriculum for the certified peer counselors.

14.2 Statewide vs. Regional

Workforce development evaluation and support will be implemented as part of the statewide effort.

14.3 Requirements from the Agreement

a. Hire or contract workforce development specialists assigned to the functional areas of community, inpatient, and law enforcement. Duties include:
   I. Participate in workgroups
   II. Conduct training needs survey/gap analysis
   III. Develop master training plan(s)
   IV. Develop and coordinate training including standardized manuals and guidelines
   V. Collaborate with community-based organizational workforce development staff
   VI. Evaluate training programs
b. Prepare an annual report on a. above that includes recommendations about specific workforce development steps needed to ensure success of the Trueblood agreement. Distribute the report to Executive Committee, key and interested legislators.
c. Assess the need for and appropriate target areas of training, certification and possible degree programs. Include:
   I. Existing training, certification, and degree programs in WA for relevant professions
   II. Programs for relevant professions in other states
   III. Statewide staffing needs for all programs covered by this agreement for a period of ten years

d. Prepare a one-time report on c. above that is distributed to the appropriate legislative committees and includes:
    I. High, medium, and low cost recommendations
    II. Long, medium, and short-term recommendations for future actions regarding training and certification programs

14.4 Education and Outreach

Work with workgroup membership from various stakeholder groups to identify best communication pathways. Wherever possible, make recommendation reports public.

14.5 Action Plan and Timeline

Completed:

1. Updated existing position description forms for remaining Workforce Development position by June 1, 2019.
2. Submitted required documentation to human resources (request to hire/personnel action requests, updated organization charts, etc.) by June 15, 2019.

Pending:

3. Advertise the established positions by August 1, 2019.
4. Complete recruitment activities including screening, interviewing, and job offers by August 31, 2019.
5. Hire and onboard new employees by September 30, 2019. Onboarding will include orientation to the Trueblood Settlement Agreement and how their role is necessary to carrying out the objectives of the Agreement.
6. Begin organizing and conduct the first stakeholder workgroup meeting in each functional area by November 1, 2019.
7. Develop surveys to assess training needs in the identified functional areas by February 1, 2020.
8. Send surveys by February 15, 2020.
9. Evaluate survey results and develop training plans including requirements by May 1, 2020.
10. Develop training materials which can include guidebooks, presentations, etc. by June 1, 2020.
11. Deliver trainings through Phase 1 regions and complete by June 30, 2021.

Jail Training Needs Assessment Survey

In October 2018, DSHS developed and conducted a state-wide county jail training needs assessment survey. The survey included categories of training needs including psychiatric crisis de-escalation, general mental health awareness (for the jail setting), suicide risk assessment, management, and prevention, early admission (to state hospital) referral process, videoconferencing capabilities (for forensic evaluation services), competency restoration process, medication/involuntary medications. A total of eight jails responded to the survey. All jails indicated training needs in the aforementioned areas. The survey also provided information on training delivery preferences, including in-person and webinars.

Triage Training

In November of 2018, DSHS developed a webinar training for the Triage System. This training is presently under review and planned to be scheduled in the first half of 2019.

In Closing

The purpose of this Final Implementation Plan is to lay the foundation for implementation and overall planning. Because the plan sets out ambitious timelines, and because many of the elements of the plan embody new systems and programs never before used in the State of Washington, the Parties expect to learn as implementation proceeds. Any necessary changes or adjustments to the plans and timelines included in this document will be fully addressed with the committees created by the settlement agreement, as well as the Court.

Joint Motion for Preliminary Approval of Settlement Agreement Exhibit A

A.B., by and through TRUEBLOOD, et al., v. DSHS, et al., No. 14-cv-01178-MJP

Comprehensive Settlement Agreement

Contents

I. INTRODUCTION AND GOALS

In consideration of the Parties' commitment to uphold this Court's orders to provide timely competency evaluation and restoration services, the Parties enter into this Settlement Agreement. The Parties intend that implementation of this Agreement will bring Defendants into substantial compliance with this Court's orders. The elements of the Agreement aim to deliver an array of services to better deliver the right care, at the right time, in the right place, for the right cost. The ultimate goal of each element in this Agreement is to reduce the number of people who become or remain Class Members and to timely serve those who become Class Members.

The Parties recognize that there are multiple players in the forensic and broader mental health systems. This creates challenges in establishing continuity and coordination of care and forming long-term and sustainable solutions. In furtherance of the Parties' goals of diversion and providing timely services to Class Members, the Parties believe it is important to break down the silos between the system partners within the larger mental health system. To develop a plan that

yields successful outcomes for Class Members and enhances system collaboration and coordination, this Agreement acknowledges the value brought by every partner in the system and encourages full participation by all of its players.

In developing this Agreement, the Parties held dozens of meetings with hundreds of system partners over the six-month negotiations period.[1] This included meetings with:

- Class Members;
- Class Members' families;
- State Legislators;
- Mental health provider agencies and advocates;
- Behavioral Health Organizations and advocates;
- Law enforcement;
- Local jails;
- State and municipal courts and judges;
- Prosecuting attorneys;
- Defense attorneys;
- Homeless and housing providers and advocates;
- Employment support providers and advocates;
- Individual clinicians;
- Education programs for needed clinicians;
- Other departments of the administration outside DSHS;

[1] Input from these stakeholders is reflected in a publicly-available report, at: https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/Trueblood/2018Trueblood/2018-05-Tac-Report.pdf. After this report was drafted, the Parties, collectively and separately, continued to meet with system partners throughout the negotiation process.

- Local Legislators and Executives; and
- Washington residents.

The solutions in this Agreement focus on pursuing effective outcomes and often incorporate demonstrated successes in current programs, entities, and systems in Washington or from other jurisdictions. In crafting these solutions, the Parties recognize the fundamental goal of this Agreement is to provide timely competency services to Class Members pursuant to the Court's orders.

II. DEFINITIONS

1. Approval:
   a. Final Approval: the Court's approval of this Agreement following the notice period to Class Members, resolution of any objections, and the fairness hearing.
   b. Preliminary Approval: the Court's initial approval of this Agreement such that the notice period for Class Members begins.
2. BHA: Behavioral Health Administration.
3. CIT: Crisis Intervention Training.
4. CJTC: Criminal Justice Training Commission.
5. Class Member: All persons who are now, or will be in the future, charged with a crime in the State of Washington and: (a) who are ordered by a court to receive competency evaluation or restoration services through DSHS; (b) who are waiting in jail for those services; and (c) for whom DSHS receives the court order.

6. Co-responder program: The Mental Health Field Response Teams Program, currently administered by WASPC as a grant program, pursuant to Wash. Rev. Code § 36.28A.440.

7. Crisis triage and stabilization facility: means either a crisis stabilization unit or a triage facility as defined in Wash. Rev. Code 71.05.020.

8. Defendants: the named defendants in the lawsuit, including the Department of Social and Health Services, Eastern State Hospital, and Western State Hospital.

9. DSHS or Department: Department of Social and Health Services.

10. Executive Committee: A committee tasked with making ultimate recommendations to the Court, as specifically defined in § IV.B.4. This committee shall be composed of representatives from DSHS, OFMHS, HCA, and Plaintiffs' counsel. The use of this term in any section outside § IV.B.4 refers to the committee defined in § IV.B.4.

11. Forensic Data System: A software program designed by DSHS/BHA information technology to replace two legacy data systems at Western State Hospital and Eastern State Hospital which perform a variety of functions including tracking competency referral data consistently across state hospitals and competency restoration residential treatment facilities.

12. Forensic Risk Assessment: An assessment completed by a forensic evaluator that provides an opinion in regards to whether a criminal defendant meets the standard for not guilty by reason of insanity.

13. General Advisory Committee: The committee specifically defined in § IV.B.2-3 that will be comprised of the Court Monitor, DSHS, HCA, the Governor's office, OFMHS, Plaintiffs' counsel, and any applicable representative from outside

partners. The use of this term in any section outside § IV.B.2-3 refers to the committee defined in § IV.B.2-3.

14. HARPS: Acronym for Housing and Recovery through Peer Services. This term references a team generally consisting of one housing support specialist and two peer support specialists, all of whom have been trained in the permanent supportive housing model. HARPS teams also have access to housing bridge subsidies to facilitate maintaining or obtaining housing.

15. HCA: Health Care Authority.

16. Mature Data: Data that has been fully resolved. Distinct from "first look data" as identified in the monthly reports to the Court Monitor.

17. MCR: Mobile Crisis Responders.

18. Outstation: OFMHS offices and/or staff located in geographic regions somewhere other than the campuses of the two state hospitals.

19. OFMHS: Office of Forensic Mental Health Services; an office dedicated to forensic services within the Behavioral Health Administration of the Department of Social and Health Services.

20. Parties: the Plaintiffs and named Defendants in this case.

21. Peer Support Program: A program for providing a peer counselor certification, as described in Wash. Admin. Code § 182-538D-0200.

22. Phased Regions: the Washington State Managed Care Organizations (MCO) and Administrative Service Organizations (ASO) regions in which the changes contemplated by this Agreement will be implemented. Phase One Regions include the Spokane Region, Pierce County Region, and Southwest Washington Region.

Phase Two Regions include King County Region. Phase Three Regions may include additional regions with high rates of Class Member referral.

23. Regions: specific areas within the State of Washington as defined by the MCO/ASO boundaries/regions.

24. Residential supports: "Residential supports", as used within any section of this Agreement means only the residential supports as described within that section.

25. State:

a. Where describing an obligation or action under this Agreement: Executive branch agencies of the State of Washington.

b. Where describing a geographic region or level of government: the State of Washington.

26. Unstably Housed: As relevant to this Agreement, individuals are unstably housed if they:

a. are living in a place not meant for human habitation,

b. are living in an emergency shelter,

c. are living in transitional housing,

d. are exiting an institution where they temporarily resided, if they resided for up to 90 days and were in shelter or a place not meant for human habitation immediately prior to entering that institution, or,

e. are losing their primary nighttime residence within 14 days and lack resources or support networks to remain in housing.

27. Wait times: the maximum wait times for admission for inpatient competency services or completion of in-jail evaluations as set by the Federal Court in

Cassie Cordell Trueblood, next friend of A.B., an incapacitated person, et al., v. The Washington State Department Of Social And Health Services, et al., Cause No. 2:14-cv-01178-MJP.

28. WASPC: Washington Association of Sheriffs and Police Chiefs.

III. SUBSTANTIVE ELEMENTS

A. Competency Evaluation

1. The State will seek funding for 18 additional forensic evaluators needed to meet future predicted demand, to meet forensic evaluator demand created by the opening of additional forensic wards, to staff outstations, and to maintain compliance with the Court's injunction during periods of increased demand. The expanded evaluator capacity, when not needed to address periods of increased demand, will be used to perform the Department's other statutorily required evaluation functions, including:

   a. Out of custody evaluations;

   b. Forensic Risk Assessments;

   c. Civil commitment petitions for individuals found incompetent to stand trial under Wash. Rev. Code § 10.88.086 and referred for civil commitment under Wash. Rev. Code § 71.05.280(3);

   d. Other duties as assigned at the Department's sole and exclusive discretion;

   e. Provided that, during periods of increased demand, the Department will prioritize the completion of in-jail evaluations over the other duties outlined in a - d.

2. Approximately 13 of these positions shall be posted and recruited between July 1, 2019 - June 30, 2020, and the remaining positions shall be posted and recruited between July 1, 2020 - June 30, 2021.

3. The Department will complete the implementation of the Forensic Data System, and use that System to collect and utilize data to anticipate, and respond to, periods of increased demand.

4. The Department will collect and utilize data to determine if the increased evaluator capacity in § III.A.1 above maintains substantial compliance with the injunction with respect to in-jail competency evaluations, and whether capacity exists to respond to periods of increased demand. In the event the amount of evaluators is inconsistent with actual need, the Department will report the same in the semi-annual report as set forth in § IV.(B)(14). The report will include a plan to address the inconsistency going forward.

5. The State will continue the use of Outstations.

6. The State will complete the currently planned implementation of and will continue the use of telehealth for competency evaluations.

B. Competency Restoration

1. Legislative Changes

a. During the 2019 legislative session, the State will support and work to achieve legislative changes to reduce the number of people ordered into competency evaluation and restoration, and to use community based restoration services, which may include changes to Wash. Rev. Code § 10.31.110, Wash. Rev. Code § 10.77.086, and

Wash. Rev. Code § 10.77.088. These efforts may include advancing requests for legislative changes through bill proposals or supporting legislation that has been proposed by others that further the goal of reducing the number of individuals ordered to receive competency evaluation and restoration services.

b. If the State fails to pursue legislative changes intended to reduce demand for competency services to aid in reaching substantial compliance with the relevant portions of this Agreement, this will constitute material breach.

2. Community Outpatient Restoration Services

a. The State will seek funding and statutory changes to implement a phased roll out of community outpatient restoration services in targeted areas, including Residential Supports as clinically appropriate. These restoration services will be provided in community settings instead of inpatient units of state psychiatric hospitals or other inpatient restoration facilities.

b. Criminal defendant eligibility for community outpatient restoration services is determined by the criminal court that is making an order for restoration services pursuant to Wash. Rev. Code § 10.77.086 or 10.77.088.

(1) The forensic navigator, as described below in § III.B.3, will provide information, consistent with state and federal law, to the criminal court to assist the criminal court in determining whether a criminal defendant is appropriate for community outpatient restoration services.

(2) A criminal defendant's compliance will be monitored by the community outpatient restoration services provider and the forensic navigator. The forensic navigator will provide periodic updates to the criminal court about the criminal defendant's compliance in the community outpatient restoration program.

c. In accordance with state and federal law, the State will support processes to provide criminal courts with the information necessary to create tailored conditions for release of individuals into community outpatient restoration. The provision of this information will be primarily through the use of forensic navigators as described above in § III.B.3, however, the State may elect to use other means as appropriate.

d. The State will require community outpatient restoration service providers to accept referrals from OFMHS in accordance with an algorithm that prioritizes the intake of Class Members.

e. The State will conduct outreach and will provide technical assistance to criminal courts and other stakeholders, upon request, to support the implementation of community outpatient restoration services, to assist with issues such as:

(1) The determination of criminal defendant eligibility for community outpatient restoration;

(2) The conditions of the criminal defendant's participation in community outpatient restoration services; and,

(3) The use of Residential Supports and other services to encourage the use of community outpatient restoration services.

f. If a Class Member is otherwise determined to be eligible for community outpatient restoration services by the criminal court, but is assessed by the forensic navigator as Unstably Housed, the State shall provide Residential Supports, as specified in this Agreement, for the duration of participation in a community outpatient restoration program. The Residential Supports shall not continue for a Class Member referred for inpatient services. The Residential Supports may continue for a Class Member opined to be competent under Wash. Rev. Code § 10.77.065 for up to 14 days following transmission of the competency evaluation.

g. Forensic navigators will coordinate access to housing for all persons enrolled in community outpatient restoration services. Discharge planning for Class Members begins upon admission to the community outpatient restoration program. If HARPS services are deemed necessary, planning should begin as soon as practicable for post-discharge housing support

h. The State will develop Residential Supports for outpatient competency restoration, as specified in this Agreement, through a procurement process to fund community outpatient restoration providers. Providers will be given the flexibility to propose and deliver residential support solutions unique to the needs of the community in which the service is provided, which may include:

(1) Capital development through the Department of Commerce;

(2) Capital development through a third party source identified by the provider;

(3) Housing voucher programs;

(4) Leveraging existing housing programs locally;

(5) Scattered site housing programs.

i. The State will seek funding to support community outpatient restoration services with a broader package of treatment and recovery services, including mental health treatment, substance use screening and treatment. The restoration portion of these services may be provided in-person, remotely through live video, or via recorded video.

j. For criminal defendants waiting in jail, an offer of admission to the community outpatient restoration services program will occur within the constitutional timelines for restoration as outlined by the Federal Court.

3. Forensic Navigators

a. The State will seek funding to implement a new role within the forensic mental health system. This new role, called a forensic navigator, will assist Class Members in accessing services related to diversion and community outpatient competency restoration.

(1) Class Members will be assigned a forensic navigator at the time that a competency evaluation order is received by the Department in the Class Member's criminal case. The navigator will gather information specific to Class Members, including what services are available for that individual Class Member, and how a community

outpatient restoration order or other court order could be supported. This information will be provided to the criminal court prior to the hearing to determine whether competency restoration should be ordered. The navigator will not make a clinical recommendation to the criminal court.

(2) Forensic navigators will be given discretion to manage their caseload, but will do so using the following guiding principles:

(a) In recognition of the fact that there is a large portion of Class Members who are known to the system, and will have recently had contact with the criminal justice or forensic mental health system, forensic navigators may prioritize their efforts to divert these particular Class Members (or high utilizers as referenced in § III.C.4.a.). This prioritization may include beginning work on gathering information immediately upon being assigned the Class Member.

(b) In recognition of the fact that a large proportion of criminal defendants who are ordered to receive a competency evaluation will be found competent, forensic navigators may prioritize their efforts in order to provide a less intensive level of service until a finding that the Class Member is incompetent. This prioritization may include delaying intensive work on gathering information until more is

learned about the Class Member. Forensic navigators may use a standardized tool or assessment in order to assess Class Members unknown to the system.

(3) Forensic navigators will assist criminal court personnel with understanding diversion and treatment options for individual Class Members in order to support the entry of criminal court orders that may divert Class Members from the forensic mental health system.

(4) When a criminal court enters an order directing a criminal defendant to receive restoration services on an outpatient basis, the forensic navigator shall provide services to the criminal defendant ordered to community outpatient restoration, who shall be a client of the forensic navigators. These services will include:

(a) Assisting the client with attending appointments and classes related to outpatient competency restoration.

(b) Coordinating access to housing for the client.

(c) Meeting individually with each client on a regular basis.

(d) Performing outreach as needed to stay in touch with clients.

(e) Providing information to the criminal court concerning the client's progress and compliance with the court ordered conditions of the client's release. This may include appearing at criminal court hearings to provide information to the criminal court.

(f) Coordinating client access to community case management services, mental health services, and follow up.

(g) Assisting clients with obtaining and encouraging adherence to prescribed medication.

(5) The forensic navigator's services to the criminal defendant shall conclude as follows:

(a) If, after the navigator has advised the criminal court as described in § III.B.3.a.(3) above, the criminal court does not order the criminal defendant into community outpatient restoration services, the role of the forensic navigator shall end. The forensic navigator may facilitate a coordinated transition as described below if the circumstances warrant such coordination.

(b) If, after the forensic navigator has advised the criminal court as described in § III.B.3.a.(3) above, the criminal court does order the criminal defendant into community outpatient restoration services, the forensic navigator shall:

1) Prior to the conclusion of community outpatient restoration services, facilitate a coordinated transition of the criminal defendant's case to a case manager in the community mental health system.

a) The standards for this coordinated transition shall be established through the use of care

coordination agreements, or some similar agreement. To support these coordinated transitions, the forensic navigator shall attempt to follow up with the client to check whether the meeting between the client and community-based case manager took place, or when the client is an identified high utilizer, the forensic navigator shall attempt to connect the client to high utilizer services.

b) To support this coordinated transition, the forensic navigator will also attempt to check in with the Class Member at least once per month, for up to 60 days, but during this time, the client shall not count towards the navigator's caseload. The navigator will not duplicate the services provided by the community based case manager, but if the navigator believes the coordinated transition is not likely to be successful, the forensic navigator will follow up as appropriate.

2) In cases where a criminal defendant regains competency, is found guilty and is sentenced to serve a term of imprisonment in jail or prison, has criminal

charges dismissed pending a civil commitment hearing, enters or returns to jail due to a revocation of the community outpatient restoration order or the filing of new criminal charges, receives a new or amended order directing inpatient admission for restoration, or declines further services after the court ordered restoration treatment ends, the forensic navigator shall create a summary of treatment provided during community outpatient restoration, including earlier identified diversion options for the individual. Through training and technical assistance, the State will encourage third parties, including jails or prisons where a former Class Member is serving a sentence, to request this summary and related treatment records, as allowed by Wash. Rev. Code § 10.77.210.

(c) In other situations not contemplated by this Agreement, the State shall use it discretion in deciding when to end forensic navigator services, and how to accomplish a coordinated transition.

(6) A forensic navigator caseload will not exceed twenty-five Class Members at any given time.

4. Additional Forensic Bed Capacity

a. The State will open additional forensic beds at Western State Hospital and Eastern State Hospital, pursuant to existing funding authorized in the 2018 capital budget. The projected availability of additional forensic beds is as follows:

(1) Develop two forensic wards at Eastern State Hospital by December 31, 2019 (25 beds each for total of 50 beds)

(2) Convert two Western State Hospital civil geriatric wards to two forensic wards by December 31, 2019 (21 beds each for a total of 42 beds)

b. If the State is unable to open the beds in accordance with the projected schedule above, the State shall provide notice to the Executive Committee that additional time is needed, including the projected delay, and the reasons for the delay. This notice shall allow the State an additional six months of time to open the beds. If the State needs additional time beyond this six-month period, the State may request a further extension of time from the Court.

5. Closure of Maple Lane and Yakima

a. In the event wait times for Class Member admission for inpatient competency services reach a median of 13 days or less for four consecutive months, based on mature data, the State will begin ramp down of the Yakima Competency Restoration Program. The Yakima Competency Restoration Program will close, notwithstanding the median wait times

described in this paragraph, no later than December 31, 2021. Failure to close the Yakima Competency Restoration Program by December 31, 2021 constitutes a material breach of this Agreement.

b. In the event wait times for Class Member admission for inpatient competency services reach a median of 9 days or less for four consecutive months, based on mature data, the State will begin ramp down of the Maple Lane Competency Restoration Program. The Maple Lane Competency Restoration Program will close, notwithstanding the median wait times described in this paragraph, no later than July 1, 2024. Failure to close the Maple Lane Competency Restoration Program by July 1, 2024 constitutes a material breach of this Agreement

C. Crisis Triage and Diversion Supports

1. Crisis Triage and Diversion Capacity:

a. During Phase One of this Agreement, the State will seek funding to increase overall capacity for crisis stabilization units and/or triage facilities by 16 beds in the Spokane Region. These beds will address both urban and rural needs. During Phase One of this Agreement, the State will seek to make funds available for enhancements to similar existing or currently funded facilities in the Southwest and Pierce Regions, subject to the identification of appropriate enhancements by community providers in the Southwest and Pierce Regions.

b. In Phase One, the State will assess the need for Crisis Triage and Stabilization capacity for Phase Two Regions, and any gaps in existing

capacity in Phase One Regions, and will report the same to the General Advisory Committee. The report will identify existing resources in the Phased Regions, and will include a plan to increase capacity in the Phased Regions. The State will seek funding to increase capacity in accordance with this plan and the schedule set out in § IV.A and the implementation plan in § IV.D. This process will repeat for subsequent phases.

2. Residential Supports for Crisis Triage and Diversion

a. The State will seek funding to provide short-term housing vouchers to be deployed throughout Crisis Triage and Stabilization Facilities. These short-term vouchers will be disbursed in accordance with the phased schedule set forth in § IV.A. These short-term vouchers will:

(1) Be disbursed by the Crisis Triage and Stabilization Facilities, based on a clinical assessment of need.

(2) The initial housing voucher will cover up to a maximum of 14 days.

(3) At the discretion of the crisis triage and stabilization provider, the short-term housing voucher may be extended up to an additional 14 days.

b. The State will seek funding to create residential support capacity associated with the community outpatient competency restoration program in each Region. These Residential Supports will be implemented in accordance with the phased schedule set forth in § IV.A. In addition to the short-term vouchers described in § III.C.2.a. above, this residential support capacity must offer housing support options that are designed to target individuals

who are clinically-assessed to need more intensive support and stability immediately following discharge from Crisis Triage and Stabilization Facilities. These Residential Supports are intended to provide an individual with a better chance of remaining stable while awaiting more permanent housing solutions, including but not limited to the HARPS program.

(1) Individuals eligible to use this residential support capacity will meet all of the following criteria:

i. Have had at least one prior contact with the forensic mental system in the past 24 months, or, were brought to a Crisis Triage or Stabilization Facility via arrest diversion under Wash. Rev. Code § 10.31.110 as determined by the crisis triage and stabilization provider;

ii. Need assistance accessing independent living options and would benefit from short term housing assistance beyond the 14-day vouchers;

iii. Are diagnosed with an acute behavioral health disorder and are assessed to need housing support beyond what is offered through the Crisis Triage and Stabilization Facilities or the short term voucher as described in § III.C.2.a;

iv. Are Unstably Housed;

v. Are not currently in the community outpatient competency restoration program, and;

vi. Do not meet Involuntary Treatment Act (Wash. Rev. Code 71.05) commitment criteria.

(2) The State shall seek funding to add 10% more Residential Supports as described in § III.C.2.b to the community outpatient restoration program in each Region, with the 10% capacity to be used for this population. In Phase One, the Parties project that the anticipated capacity at any given time will be five individuals in the Pierce Region, three individuals in the Southwest Region, and two individuals in the Spokane Region.

(3) The HARPS housing support program shall also be made available to individuals within this population, for individuals clinically-assessed to benefit from the HARPS program.

(4) When high utilizers, as defined in § III.C.4.a., are identified through their use of the crisis triage and diversion system, they shall be provided access to the Residential Supports and services as described in § III.C.2.b above.

3. Mobile Crisis and Co-responder Response Programs

a. The State will seek funding for Co-Responder Programs as follows:

(1) The State shall seek funding to provide law enforcement agencies with dedicated qualified mental health professionals to assist officers in field response to promote diversion of people experiencing behavioral health crisis from arrest and incarceration.

(2) The Parties appreciate the leadership and affirmative efforts taken by the Legislature and the WASPC in establishing a mental health field response team program as described in Wash. Rev. Code § 36.28A.440. The Parties wish to build upon programs like these. Therefore, in the 2019-2021 biennium, the State shall seek $3 million in additional funding to expand the mental health field response program administered by WASPC pursuant to HB 2892 for the purpose of implementing or expanding response team programs in law enforcement or behavioral health agencies located in the Phase One Regions. In the event WASPC determines that the sum appropriated exceeds the needs of these three Regions during Phase One, WASPC may disburse some grant funding to support Phase Two implementation, including law enforcement or behavioral health agencies located in King County. The failure to secure $3 million in funding to expand Wash. Rev. Code § 36.28A.440 program grants as set forth in this paragraph shall not be deemed a material breach. § V.A.2 does not apply to this paragraph.

(3) The State's implementation plan, as described in § IV.D., shall describe how the State will support and encourage the integration of these programs into the reforms contemplated by this Agreement.

(4) During Phase One of this Agreement, the State shall perform an assessment of law enforcement agency co-responder mental health staffing needs in order to guide future funding requests.

(5) If, during the implementation of this Agreement, it becomes apparent that WASPC has not been appropriated funds for, or is otherwise unable to administer the Co-Responder Program in a manner consistent with, the phased implementation schedule outlined in § IV.A, the Executive Committee will meet and develop recommendations for future action by the Parties regarding use of co-responder programs.

b. The State will seek funding for Mobile Crisis Response ("MCR") behavioral health services as follows:

(1) The State will seek funding to increase MCR services to respond to people experiencing behavioral health crisis in the community. The State will request a plan for the provision of MCR services in each Phased Region, as required by the phased schedule identified in § IV.A. The State will seek funding for MCR services for each Phased Region. This process will be designed to create flexibility that will allow each Phased Region to tailor this resource to meet their local needs.

(2) Each Phased Region will be asked to propose new MCR service resources within their Region, including proposing the numbers, credentialing, and location of mental health professionals. Each

regional plan will be tailored to meet the urban and rural needs of the individual Region, considering the need for timely response throughout the entire Region.

(3) The regional plans, and the resulting contracts for services, will require that providers make available MCR services on a twenty-four (24) hour, seven (7) day per week basis that may be accessed without full completion of intake evaluations and/or other screening and assessment processes. The State will request a recommendation from WASPC and regional MCR providers as to reasonable response times in each Phased Region. In the regional plans and the resulting contracts for services, the contracting entities will include response time targets, after considering the WASPC and regional MCR providers' recommendations. During Phase One, the State will institute reporting requirements to gather data on response times of MCR services. In subsequent phases, the Parties will use this data to inform future funding requests, and possible contractual requirements to meet response time targets.

c. Co-response teams of law enforcement and mental health professionals will be encouraged to rely on MCRs to accept individuals they have identified as needing mental health services, including people eligible for mental health diversion pursuant to Wash. Rev. Code § 10.31.110.

d. The State will seek funding to cover reasonable administrative costs requested by WASPC to enable it to meet the requirements of § III.C.3.a.2 and§ III.C.3.b.3 above.

4. Intensive Case Management Program for High Utilizers

a. The State is developing a model to identify those most at risk of near-term referral for competency restoration. This identified population shall be referred to as high utilizers. The model is designed to identify persons who are likely to be referred for a competency service within the next six months. The model will use available data and include factors such as:

(1) Prior referrals for competency evaluation;

(2) Prior referrals for competency restoration;

(3) Prior inpatient psychiatric treatment episodes;

(4) Criminal justice system involvement, and;

(5) Homelessness.

b. In the semi-annual reports required under § IV.B.14, the State will report on whether or not the model is effective in identifying persons who are likely to be referred for a competency service in the next six months, and the status of outreach to identified high utilizers. This report shall be reviewed by the Oversight and Advisory Committees outlined in § IV.B., and the Executive Committee may make recommendations regarding adjustment of the model.

c. The services provided to this group shall include:

(1) Whenever an identified high utilizer is referred for competency evaluation, they shall be offered intensive case management services.

(2) The intensive case management program will be developed with a phased implementation as outlined in § IV.A that adheres to the following principles:

(a) The program will not duplicate services offered through health and behavioral health benefits provided under other programs, but will leverage services otherwise available and enhance the services available to the high utilizer.

(b) The program will have the ability to provide case management services for individuals who have significant barriers to accessing behavioral health and community supports.

(c) The initial participation period in the program for each individual will be six months.

d. Program services may be provided through community behavioral health agencies through direct contracts with the State. During the initial participation period, the program shall offer:

(1) Funding for engagement activities for those meeting the high utilizer definition.

(2) Housing supports, using the HARPS model, which includes:

(a) Securing and maintaining housing,

(b) Peer support,

(c) Rent or other housing support subsidies, in the amount of up to $1200 per month for up to six months.

(3) Transportation assistance.

(4) Training on accessing resources and other independent living skills.

(5) Support for accessing healthcare services and other non-medical services.

e. The case management program will include an outreach and engagement activities component for those currently identified as high utilizers, which may occur outside the context of a competency referral.

D. Education and Training

1. Crisis Intervention Training (CIT)

a. The State will seek funding to strengthen and expand behavioral health crisis training for law enforcement and corrections officers. At a minimum:

(1) The State shall seek funding to offer the 40 hour enhanced CIT course, to reach a target of 25% of officers on patrol duty in each law enforcement agency within the Phased Regions. The funding will be modeled after the existing funding model used by CJTC, including the current model for any backfill costs, which assumes a State contribution for 16 hours of backfill costs, out of the 40 hours. The 25% target will be measured as reported by CJTC. This target

may be limited by CJTC's ability to offer the necessary number of courses during each phase, so long as the reason is not strictly the unavailability of funding. If CJTC offers a training different from the 40 hour enhanced CIT course, the Parties may mutually agree that this training may count towards satisfying this target. Whenever possible, the State shall ensure that the agencies serving the areas of highest population density in the Phased Regions meet this training target before other agencies with lower population density.

(2) The State shall seek funding to ensure that corrections officers and 911 dispatchers employed by governmental entities within each Phased Region, except those employed by the Washington State Department of Corrections or Federal entities, receive at least eight hours of CIT provided by CJTC, or by an entity approved by CJTC for this purpose.

(3) In the semi-annual report, the State shall include data from CJTC on completion rates of training, and barriers to local jurisdictions to attending the training.

b. The State and Plaintiffs' counsel will invite WASPC and CJTC to meet and discuss how to better deliver behavioral health crisis training to officers employed by agencies with ten or fewer officers on staff.

c. All training efforts described in this section will be made in accordance with the phased implementation schedule set forth in § IV.A.

2. Technical Assistance

a. The State will seek funding for state or contracted resources to develop and provide educational and technical assistance to jails. These efforts will be made in accordance with the phased implementation schedule set forth in § IV.A. The State will include the involvement of peer support specialists in providing this educational and technical assistance.

b. The State will work with Washington's designated Protection and Advocacy System (as designated in Wash. Rev. Code § 71A.10.080), law enforcement entities and associations, and peer support specialists to develop guidance on mutually agreeable best practices for diversion and stabilization of Class Members and potential Class Members in jail during Phase One of this Agreement. To develop this guidance, initial best practices will be proposed by the State, and reviewed and approved by Washington's designated Protection and Advocacy System.

(1) These best practices will at minimum address pre and post-booking diversion, identification of need and access to treatment, guidelines for administration of involuntary medication, continuity of care, use of segregation, and release planning.

(2) In delivering education and technical assistance to jails, the State will develop a plan to proactively engage all jails in the State of Washington, in accordance with the phased implementation schedule set forth in § IV.A. This shall involve offering on-site

trainings to jails and a standard method for jails to seek technical assistance and receive timely responses.

c. The State may leverage the existing training and technical assistance work of law enforcement entities and associations, as appropriate.

E. Workforce Development

1. Enhanced Peer Support Specialists

a. The State will develop an enhanced Peer Support Program for individuals that includes specialized training in criminal justice. This program will include individuals participating in the core curriculum, and then participating in the specialized enhanced program for criminal justice. The State will provide ongoing training for enhanced peer support specialists and targeted training and support to assist with establishing these positions in programs purchased by the State.

b. The State will encourage the use of this enhanced Peer Support Program by integrating the enhanced peer role into the systems developed throughout this Agreement. The Department recognizes the challenges in employing peers with criminal justice lived experience, but is supportive when the nature of that past experience makes them an appropriate candidate for working with individuals with mental illness. This includes the use of enhanced peer support specialists in the intensive case management program (§ III.C.4.), the community outpatient competency restoration program (§ III.B.2), and the HARPS program (§ III.C.4.d.(2)). The State

will explore whether it is feasible to obtain any federal funding for enhanced peer support specialists, to encourage the wider use of this role.

2. Workforce Development; Degree and Certification Programs

a. The State will seek funding to hire, or contract with, workforce development specialists. The positions will be assigned to specific workforce functional areas to include:

(1) Community, including crisis response, homeless, in-home, residential, and clinic based services,

(2) In-patient, including residential treatment facilities, private hospitals, and state hospitals,

(3) Law enforcement and corrections, including jails and prisons.

b. Workforce development specialists may conduct or manage the following duties:

(1) Participate in workforce development workgroups with stakeholders such as state hospitals, community healthcare organizations, law enforcement, and jails;

(2) Conduct training needs surveys/gaps analysis;

(3) Assist in the development of a master training plan(s);

(4) Develop and coordinate training including standardized training manuals and guidelines;

(5) Collaborate with other community-based, organizational workforce development staff;

(6) Conduct training program(s) evaluations; and

(7) Other duties as assigned at the sole and exclusive discretion of the State.

c. The functions and duties outlined in this subsection may be implemented with direct hiring, contracting, or any combination thereof.

d. The workforce development specialists may collaborate with other workforce development efforts (for example, the workforce development efforts of the Economic Services Administration), as appropriate.

e. The State will produce a report annually describing the activities of the workforce development specialists outlined in this subsection, and making recommendations about the specific workforce development steps necessary to ensure success of this Agreement. The State will distribute this report to key and interested legislators. This report will also be distributed to the Executive Committee, and that Committee shall consider whether to adopt those recommendations for possible inclusion in future phases of the Agreement. The annual schedule for this report shall be set as to align with the phased approach of this Agreement, and to allow for consideration of the Executive Committee's recommendations in the established state budget process.

f. The State will assess the need and target areas for training programs, certification programs, and possible degree programs. The State may collaborate with colleges, including community and technical colleges, and universities to accomplish this task, but shall also have discretion to

accomplish this task through other means. This assessment shall include, but not be limited to, the following elements:

(1) Existing training, certifications, and degree programs in Washington for relevant professions; for example, nursing, psychiatry, psychology, counseling, law enforcement, or other professions determined at the discretion of the State.

(2) Programs for relevant professions in other states.

(3) Statewide staffing needs for all programs covered by this Agreement for a period of the subsequent ten years.

g. Upon completion of the assessment in § III.E.2.f. above, the State shall produce a report regarding that assessment that may be shared with appropriate committees of the Legislature. The report will include:

(1) High, medium, and low cost recommendations, and

(2) Long, medium, and short term recommendations for future action regarding training and certification programs.

h. While the State shall pursue the elements outlined this subsection in good faith, the State is not required to establish new degree or certification programs pursuant to this Agreement.

i. In addition to the requirements outlined in § III.E.2.a-h. above, the State will make all reasonable efforts to fill the positions required to timely implement all phases of this Agreement, as outlined in § IV.A. Reasonable efforts may include the use of incentives.

IV. PHASING, OVERSIGHT, AND IMPLEMENTATION

A. Phased Implementation

1. The Parties agree that the implementation of the programs and services described in this Agreement shall occur in phases. In each phase, the State will focus its efforts toward specifically identified and agreed upon Regions for each of the elements outlined in this Agreement. The Parties have agreed to at least three phases for purposes of implementation, which will run parallel to the Legislative biennia beginning with the 2019-2021 biennium. The Parties agree to the phased roll out to specific Regions as follows:

   a. Phase One: the State will focus implementation efforts in the Southwest, Spokane and Pierce Regions. This phase will run parallel with the 2019-2021 biennium.

   b. Phase Two: the State will focus implementation efforts in the King Region. This phase will run parallel with the 2021-2023 biennium.

   c. Phase Three: the Parties agree there will be a review of the progress during the 2021-2023 biennium of the Phase One and Two Regions. The Executive Committee will then make a decision as to whether the State should a) expand or modify the programs in Phases One and Two for purposes of Phase Three; or b) if Phase One and/or Two have been successful, identify and focus efforts in new high-referral Regions for purposes of Phase Three; or c) some combination of the above.

   d. Following Phase Three: The Executive Committee will determine as to whether the State should expand or modify programs in additional Regions

through the phasing process. This process shall continue until the termination of this Agreement.

2. In order to begin implementation in each of the Phased Regions as quickly as possible, upon approval of the Agreement the Parties agree to immediately seek approval from the Court to use contempt fines to staff project managers for the identified Regions in Phase One and Two, as well as a single administrative support position to support these project managers. The Parties shall also seek approval from the Court to use contempt fines to provide the funding necessary to begin development of components of this Agreement, which may include housing supports, provision of case management, high utilizer supports, and outreach and communications regarding implementation of the Agreement, as agreed upon by Parties. The use of contempt fines for this purpose is not meant to supplant or otherwise modify the State's obligations under this Agreement to seek funding for and implement programs and changes described in this Agreement, but instead to ensure that the implementation of Phase One may begin as quickly as possible and that elements of the Agreement have the best chance of overcoming unforeseen funding and implementation challenges. Disbursement of the fines will occur upon Final Approval of this Agreement by the Court.

B. Oversight and Advisory Structure

1. Defendants will use a sustainable oversight structure to inform and provide supervision for high-level policy-making, planning, and decision-making on targeted issues, and for the implementation of this Agreement. A description of this structure is set forth below.

2. The Parties agree to the appointment of a General Advisory Committee to be comprised of the Court Monitor, DSHS, HCA, Governor's office, OFMHS, and Plaintiffs' counsel, and the Parties agree to invite several representatives from local partners to join the General Advisory Committee, to include, but not limited to:

   a. A Judge Representative

   b. A Prosecutor Representative

   c. A Defender Representative

   d. Behavioral health treatment program Representative

   e. A Housing Provider Representative

   f. A Consumers and families Representative

   g. A Law Enforcement Representative and/or a CJTC Representative

   h. A Jail Representative

   i. Plaintiffs' Counsel Representative(s)

   j. Court Monitor Team Representative

3. The General Advisory Committee's main purpose shall be to provide local community feedback, to flag issues, to review data and outcomes, and to make recommendations at specific decision points during the implementation of this Agreement. The General Advisory Committee will be a consulting body to the Executive Committee, but will not be tasked with decision-making or making contact with the Court. Any recommendation of the General Advisory Committee shall be reviewed and considered by the Executive Committee. The General Advisory Committee shall be specifically empowered to make recommendations to the Executive Committee on the following decisions:

a. The nature of the Phase Three implementation as outlined in this Agreement, as contemplated in § IV.A.1.c. This includes whether Phase Three should proceed to expand into Regions not included in Phases One and Two, or whether Phase Three should focus on the expansion or modification of services in the Regions included in Phases One and Two, or some combination thereof.

b. Identification of areas or issues of concern in the implementation of the Agreement based on stakeholder feedback.

c. Reviewing implementation reports and implementation data, and based on that review, making recommendations for changes or modifications based on areas or issues of concern that have been identified in implementation.

4. There will also be a smaller Executive Committee that will be tasked with making decisions and ultimate recommendations to the Court. This Committee shall be composed of representatives from DSHS, OFMHS, HCA and Plaintiffs' counsel. The Executive Committee may elect to consult with others outside of the Executive Committee by agreement.

5. The Executive Committee shall be specifically empowered to make decisions regarding items 5.a., 5.c., and 5.d. below. The Executive Committee will make agreed upon recommendations to the Court regarding 5.b. below.

a. The nature of the Phase Three implementation as outlined in this Agreement, as contemplated in § IV.A.1.c. This includes whether Phase Three should proceed to expand into Regions not included in Phases One and Two, or whether Phase Three should instead be focused on the

expansion or modification of services in the Regions included in Phases One and Two.

b. Changes or modifications based on areas or issues of concern that have been identified in implementation.

c. Overseeing the commission of the semi-annual implementation reports and data collection. The Executive Committee may elect to expand or modify the elements for data collection beyond those expressly identified in this Agreement.

d. Whether the State should expand or modify programs in additional Regions through the phasing process beyond Phase Three. This process shall continue until the termination of this Agreement.

6. If the Executive Committee is unable to reach consensus on a particular issue, they may engage the use of an agreed upon neutral to resolve the issue. Issues not resolved through a neutral may be presented to the Court for consideration. This process is distinct from the process described regarding material breach below in § IV.C.

7. Each identified entity on the Executive Committee will be solely responsible for choosing its representative(s) to the Executive Committee.

8. Defendants are empowered to (1) provide guidance to state agencies and the Parties about implementation and (2) make decisions regarding the implementation of the Agreement not otherwise identified for review by the General Advisory Committee or Executive Committee.

9. The local partner representatives on the General Advisory Committee will be appointed as determined by the Executive Committee. The Executive Committee will also determine whether to make fixed term appointments or to rotate invitations.

10. The General Advisory Committee will meet quarterly. Twice per year the quarterly meeting will be focused on gathering input from stakeholders and community partners. Twice per year the quarterly meeting will be focused on reviewing the semi-annual report and data. This does not limit what may be covered in any quarterly meeting, but simply gives guidance on each meeting's focus.

    a. General Advisory Committee meetings shall be convened in person and via WebEx or a similar remote participation option.

11. The Executive Committee will meet quarterly in alignment with the General Advisory Committee. The Executive Committee may also meet on an as needed basis, and may be convened by the Court Monitor or by majority agreement of the Executive Committee.

    a. Executive Committee meetings shall be convened in person, via WebEx, or via a similar remote participation option.

12. The Parties may also meet with stakeholders independently on an as needed basis.

13. The General Advisory Committee will be supported by OFMHS, the Trueblood project manager, and Research and Data Analysis within DSHS.

    a. The Trueblood project manager will create a project plan, manage the General Advisory Committee and its meetings, and manage and schedule the Executive Committee meetings.

b. The regional project managers will support implementation of this Agreement through efforts such as support through technical assistance, outreach, trainings, summits, and education to local communities. These efforts shall be made in accordance with the phased implementation schedule in § IV.A. This may include incorporation of and cooperation with any work being done in support of the Trueblood Diversion Programs.

c. The State will support data collection and analysis. Data points for analysis shall be included in the implementation plan described below in § IV.D. Data points will be reviewed and refined over time based on the recommendations of the Executive Committee.

d. The raw data gathered pursuant to this Agreement shall be made publically available to the extent permitted by law.

14. The State shall produce a monitoring report semi-annually. This report shall include, at a minimum:

a. Data reporting as described throughout this Agreement

b. Data analysis of the various data elements

c. Updates on the status of the phase programs, based on each of the elements outlined in the Agreement

d. Areas of concern or struggle in implementation

e. Areas of positive impacts or programming in implementation

f. Recommendations for addressing areas of concern or struggle

C. Dispute Resolution

1. Where one Party believes that the other Party is in material breach of the Agreement, the Parties shall engage the Executive Committee in a good faith effort to resolve the allegation of material breach.

2. This process shall be initiated by one Party sending written notice to the other Party that they believe the Party has materially breached the Agreement. The written notice shall specify the section of the Agreement that the Party believes has been materially breached, and explain in detail how that section has been materially breached, and specify the facts and information that support the conclusion.

3. Within ten days, the responding Party shall provide a written response. This written response shall respond to each allegation of material breach, and explain in detail the responding Party's position on the alleged breach, and specify the facts and information that support that position.

4. Upon receipt of the written response, the Parties shall schedule a time to meet and confer within three business days in order to determine if the written response resolves the allegation of material breach.

5. If the allegation of material breach is not resolved by the written exchange and the subsequent meet and confer, the Parties shall schedule a mediation session with an agreed upon neutral. The mediation session must be held within 14 days, unless this timeline is modified by an agreement of the Parties, or if the Parties are unable to secure the services of an agreed neutral within that timeframe.

6. If, after completion of the mediation, the Parties have not resolved the allegation of material breach, the Party alleging a breach may seek relief from the Court.

7. At each of the identified steps regarding material breach, the opportunity to cure any alleged breach shall be considered.

D. Implementation Plan and Process Commitments

1. Defendants will develop an implementation plan beginning on the date the Court gives its Preliminary Approval of the Agreement. A preliminary plan to lay the foundation for implementation and overall planning will be completed within 90 days after the Court gives its Final Approval of this Agreement. A final implementation plan, which accounts for any funding or legislative changes accomplished by the Legislature in the 2019 session will be completed within 60 days from the end of the 2019 Legislative session. Certain tasks related to the implementation within each Region may be reserved to the project management plans to be implemented by each regional project manager.

2. Defendants will develop the preliminary and final implementation plans using input from Plaintiffs' Counsel and the Court Monitor. The implementation plan will:

   a. Identify and sequence tasks necessary to fulfill the commitments and ultimately achieve the exit criteria;

   b. Consider estimates produced by the TriWest Bed Flow Analysis, if available;

   c. Set clear and accountable timelines through the termination of this Agreement;

   d. Assign responsibility for achieving each task to the appropriate agency or entity;

e. Describe how reporting processes shall be established to report on the data elements specified under this Agreement, as well as the development of the ongoing implementation reports;

f. Develop collaboration models for regional project managers and regional implementations to problem-solve challenges encountered; and

g. Describe the communication and outreach activities to inform the community, stakeholders, and policy makers about the access to services and processes described in this Agreement, including development of documentation that provides sufficient information to explain the purpose of and use of services established by this Agreement, and encourage use of those services.

3. Defendants will submit to the Court for approval the preliminary and final implementation plans, which shall describe how the Defendants will fulfill the commitments of this Agreement.

4. Defendants will comply with the implementation plan that is approved by the Court, and any amendments, pursuant to this Agreement.

5. The Parties will repeat this process for creating a final implantation plan for each future Phased Region during subsequent phases of the Agreement.

V. COMPLIANCE AND TERMINATION

A. Contempt Mitigation and Substantial Compliance

1. Assuming the Court's Final Approval of this Agreement, contempt fines will be suspended beginning December 1, 2018. The fines will continue to be calculated,

but no payment on those fines shall be made. The suspended contempt fines shall be calculated using the current rates under the existing Court orders.

a. At the end of each phase, if the State is in substantial compliance, all suspended fines will be waived.

2. If the funding made available for this Agreement is inadequate to implement the identified elements during any phase, this will constitute material breach. In considering whether funding is inadequate, funds available from third party sources shall be considered, and supplemental budget requests made during any phase shall also be considered. No allegation of material breach based on inadequate funding may be made until after the completion of the 2019 Legislative Session.

3. Given the scope and breadth of this Agreement, the Parties agree that a material breach of a particular element does not necessarily constitute material breach of the entire Agreement, unless otherwise specified herein. For purposes of this Agreement, and unless otherwise specified herein, “material breach” is defined as a failure to be in "substantial compliance" with the Agreement, and substantial compliance means something less than strict and literal compliance with every provision of this Agreement. Rather, deviations from the terms of the Agreement may occur, provided any such deviations are unintentional and minor, so as not to substantially defeat the object which the Parties intend to accomplish, or to impair the structure of the Agreement as a whole. This Agreement is a product of extensive work with stakeholders and input from experts in their fields. It is an informed and thoughtful estimation of the best plan to resolve the ongoing constitutional crisis before the Court. However, the Parties recognize and acknowledge the need for

flexibility in developing the comprehensive changes proposed, and that the purpose and intent of each element could be achieved by alternative methods. The Parties further agree to give due consideration to the totality of any decisions or actions taken by the Legislature in implementing this Agreement to determine if the spirit of the Agreement, if not the letter, has been upheld before pursuing an allegation of material breach for any element that does not specifically identify what constitutes material breach.

4. Plaintiffs agree to engage in an ordered process in order to raise any allegation of material breach under this Agreement. The process is more fully described in § II.B.6 of the Oversight and Advisory Structure section, but at a minimum this will include (1) bringing the allegation to the attention of the Executive Committee for possible resolution, (2) engaging in a mediation session with an agreed upon neutral, and then (3) if the issue cannot be resolved, by bringing a motion in Court to seek payment of suspended fines, restart contempt fines, increase future contempt fines, or any other appropriate relief.

   a. If suspended fines are ordered to be paid by the Court, a reasonable schedule shall be set by the Court for payment of the suspended amount on an installment basis. The first installment payment of the suspended amount shall be made at the earliest opportunity after the Legislature has an opportunity to make an appropriation for this purpose.

   b. In assessing suspended contempt fines due to a finding of material breach, the Court may look to the magnitude and impact of any such breach to determine if a lesser or more proportionate sanction is appropriate.

B. Termination

1. This Agreement terminates when Defendants demonstrate substantial compliance with the following requirements:

   a. Completed evaluations for Class Members ordered to receive in-jail evaluations are filed with local criminal courts within the shorter of a) 14 days of the in-jail evaluation order being received by Defendants, or b) 21 days of the criminal court ordering the in-jail evaluation;

   b. Admission for inpatient evaluation services for Class Members ordered to receive inpatient evaluations within the shorter of a) 7 days of the inpatient evaluation order being received by Defendants or b) 14 days of the criminal court ordering the inpatient evaluation;

   c. Admission for inpatient restoration services for Class Members ordered to receive inpatient restoration within the shorter of a) 7 days of the inpatient restoration order being received by Defendants or b) 14 days of the criminal court ordering the inpatient restoration;

   d. Substantial compliance with § V.B.1.a-V.B.1.c has been achieved for nine consecutive months, and evidence does not establish that the State will be unable to continue compliance with the Court's injunction. Alternatively, the State has achieved substantial compliance in 14 of 16 months, and evidence can establish that the two months where substantial compliance was not achieved are outliers. If inpatient evaluations have such a low volume of referrals in any given month as to make substantial compliance with that category hinge on a small number of cases, due consideration will

be given to the totality of compliance rather than looking only to the rate of compliance.

(1) However, after six consecutive months of substantial compliance in any category, § V.B.1.a-V.B.1.c above, the State may request that certain obligations under this Agreement be suspended pending the full nine months of compliance.

VI. ADDITIONAL PROVISIONS

A. Contempt

Nothing in this Agreement shall be deemed to limit the Court's powers of contempt or any other power possessed by the Court.

B. Individual Rights

Nothing in this Agreement shall be deemed to limit the ability of any individual Class Member to obtain individual relief of any kind to which they would otherwise be entitled under state or federal law other than for the claims for systemic injunctive relief adjudicated by this action.

C. Protection and Advocacy Acts

Nothing in this Agreement shall be deemed to limit the ability of Disability Rights Washington (DRW) to fulfill its federal mandates pursuant to the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act, 42 U.S.C. § 10801, *et seq*., and the regulations promulgated thereto, 42 C.F.R. § 51 *et seq*., the Developmental Disabilities Assistance and Bill of Rights (DD) Act, 42 U.S.C. §15041, *et seq*., and the regulations promulgated thereto, 45 C.F.R. § 1386 *et seq*., and the Protection and Advocacy of Individual Rights (PAIR) Act, 29 U.S.C. § 794e.

D. Terms of Agreement

This Agreement contains all the terms and conditions agreed upon by the Parties. No other understandings, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the Parties hereto.

The Parties have participated, and had an equal opportunity to participate, in the drafting and approval of drafting of this Agreement. No ambiguity shall be construed against any Party based upon a claim that the Party drafted the ambiguous language.

E. Authority to Bind

Signors of this Agreement represent and warrant they have full power and authority to enter into this Agreement and to carry out all actions required of them to the extent allowed by law. Each of the signors warrants that he/she has fully read and agrees to all the terms and conditions contained herein.

F. Modifications

Distinct from the process set forth in the Oversight and Advisory structure section, § II.B.5, this Agreement may be amended by mutual agreement of the Parties and approval of the Court. In order to be binding, such amendments must be in writing, signed by persons authorized to bind each of the Parties, and approved by the Court. The Parties further agree to work in good faith to obtain Court approval of necessary amendments or modifications.

G. Waiver

The provisions of this Agreement may be waived only by an instrument in writing executed by the waiving Party and approved by the Court. The waiver by any Party of any breach of this Agreement shall not be deemed or be construed as a waiver of any other breach, whether prior, subsequent or contemporaneous of this Agreement.

H. Severability

The provisions of this Agreement are severable. If any court holds any provision of this Agreement invalid that invalidity shall not affect the other provisions of this Agreement.

I. Successors

This Agreement shall inure to the benefit of and be binding upon the legal representatives and any successor(s) of Plaintiffs and Defendants.

J. Non-Waiver of Arguments and Issues

This Agreement represents a compromise of the issues addressed herein. Neither party waives the right to assert legal or factual arguments in any future dispute arising during the term of this Agreement, or in the event that the Agreement ends, terminates, or becomes null and void, for any reason.

K. Effect of Court Denying Motion to Approve

If, for any reason, the Court does not ultimately approve this Agreement as a fair, reasonable, and adequate settlement of the Trueblood litigation as between the Plaintiffs and Defendants, this Agreement shall be null and void.

L. Execution

This Agreement may be executed in counterparts, each of which will be deemed to be an original and all of which taken together shall constitute a single instrument. This Agreement may be executed by signature via facsimile transmission or electronic mail which shall be deemed the same as an original signature.

COUNSEL FOR PLAINTIFFS

By: _____ Dated: 8/16/2018
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Disability Rights Washington

By: _____ Dated: 8/16/2018
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By: _____ Dated: 8/16/2018
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By: _____ Dated: 8/16/2018
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FOR THE DEFENDANTS:

By: _____ Dated: 8/16/2018
CHERYL STRANGE
Secretary
Washington State Department of Social and Health Services

COUNSEL FOR DEFENDANTS:

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By: _____ Dated: August 16, 2018
NICHOLAS A. WILLIAMSON
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By: _____ Dated: 8/16/18
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Assistant Attorney General
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Trueblood, et al., v. Washington State Department of Social and Health Services, et al.
Case No. C14-1178 MJP
DEFENDANTS' PROPOSED PLAN

February 1, 2017

TABLE OF CONTENTS

I. INTRODUCTION

The Department of Social and Health Services (DSHS) submits this proposal in accordance with the January 24, 2017 order to present a plan to describe how DSHS would:

1. Admit class members to receive competency evaluation and restoration treatment services (hereafter referred to as "inpatient competency services") within seven days of signing of a court order; and
2. Provide in-custody evaluation services within 14 days of the signing of a court order.

DSHS engaged the hospital Chief Executive Officers (CEOs) and other staff in capital facilities, budget and operations; consulted the Court Monitor; and reviewed the proposal submitted by Plaintiffs on January 30, 2017 to formulate this proposal. DSHS's proposal includes three key components:

1. Increase evaluation capacity
2. Expand bed capacity for inpatient competency services
3. Continue to Implement and Improve Triage and Diversion

Finally, DSHS responds to the proposals made by Plaintiffs on January 30, 2017 that are not otherwise addressed as part of DSHS's own plan (See Dkt. # 358).

II. COMPONENT 1: INCREASE COMPETENCY EVALUATION CAPACITY

1. The Office of Forensic Mental Health Services (OFMHS) has made further progress on recruitment actions identified during status hearing testimony in January 2017. Dr. Kinlen extended an offer on January 27, 2017 for the Western State Hospital (WSH) scheduler/assistant position. The offer was accepted and the new employee will start on February 16, 2017. Dr. Kinlen also extended an offer on January 30, 2017 for the WSH jail-based evaluator supervisor position. This offer was accepted and the new supervisor will start on April 3, 2017. Two other offers were extended for the remaining forensic evaluator supervisor positions and decisions are pending at this time.

2. Ingrid Lewis with OFMHS will reach out to counties by February 10, 2017 to remind them of the opportunity to engage panel evaluators to conduct more timely evaluations at DSHS expense in accordance with state law. Ms. Lewis will begin this outreach to encourage use of panel evaluators in the regularly scheduled meeting with King County Stakeholders scheduled for February 1, 2017. Outreach to remaining counties will include targeted communications to counties where DSHS is not meeting the 14-Day timeline. Ms. Lewis will email a memo to the Washington Association of Counties, Administrative Office of the Courts, Washington Defense Association, and Washington Association of Prosecuting Attorneys, as well as all county commissioners in counties eligible for 5551 reimbursement.

3. OFMHS staff conducted an Internet search for a Locums Tenens company to provide contracted Forensic Evaluations. Staff did not identify a company that provided qualified examiners for competency to stand trial. Therefore, DSHS will issue a Request for Information (RFI) by February 10, 2017 to solicit potential providers of contracted Forensic Evaluators (which may include psychologists or other suitably qualified professionals) to reduce the current backlog of orders.

4. DSHS respectfully proposes the Court consider a systemic investment of $3.2 million from the fines being accrued to fund increased capacity to meet evaluation timeliness standards. DSHS would use this funding to hire 12 additional evaluators to yield an additional 144 evaluations per month. Based on the data analysis conducted by DSHS (see Attachment A), 12 evaluators for jail-based services would cover any current backlog of cases. This resource investment would also be sufficient to manage future spikes up to 25% higher than the most currently experienced peak in referrals (up to 386 referrals in a month's time). These evaluators would be responsible for completing any backlog cases, managing any increase in referrals throughout the state for in-custody evaluations, and providing evaluations at off-hour times. Seven of the positions would be out- stationed in locations with enough demand to support an out-station site while the remaining five would be stationed at WSH. Additionally, five forensic evaluator support positions would expedite patient access to care functions--such as scheduling, transcription, and treatment—while evaluator resources are focused on conducting evaluations. In anticipation of an approval of this action, DSHS issued a recruitment posting on January 30, 2017 to expedite the process.

Assuming current demand and recent peak referral experience, these actions are expected to eliminate backlog and achieve ongoing compliance once all actions are completed and resources are operational.

III. COMPONENT 2: EXPAND BED CAPACITY FOR INPATIENT COMPETENCY SERVICES

Following review of past recommendations from Dr. Mauch, Court Monitor as well as additional suggestions provided by her during a telephone call on January 27, 2017, DSHS proposes the following components for expansion of bed capacity to serve class members. DSHS respectfully proposes the Court consider a systemic investment of $600,000 dollars from the fines being accrued to fund the design effort to remodel Building 10 at the Washington Veterans Home in Retsil, the details of which are included in item 2d below.

To meet current and future capacity for inpatient competency services DSHS will:

1. Create short-term strategies to increase bed capacity to serve class members

a. Dr. Kinlen evaluated a proposal by Eastern State Hospitals which Dr. Strandquist spoke about during his testimony at the January status hearing. Analysis of this proposal, which would refurbish a ward for civilly committed former forensic patients would not create significant increases in bed capacity to serve class members. However, in the fall of 2016 DSHS funded the creation of 8 new forensic beds at Eastern State Hospital to directly serve patients from WSH thus freeing up bed capacity to serve class members at WSH without increasing census. Three beds at WSH were vacated by NGRI patients and will be used for competency services beginning January 31, 2017. The remaining five beds at ESH will be made available for inpatient competency services in February 2017.

b. Extend the alternate facilities
Contracts for the existing 24 beds at Yakima and 30 beds at Maple Lane will be extended until June 30, 2018.

c. Expand 24 beds at Yakima
DSHS will consult the Court Monitor and provide all planning documents to her for review.

2. Create long-term strategies to increase bed capacity to serve class members

a. During a January 27, 2017 phone call, Dr. Mauch recommended considering contracting with Evaluation and Treatment (E & T) Centers to provide restoration treatment services. Revised Code of Washington 71.05.020 defines and E & T as "any facility which can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is certified as such by the Department." Dr. Kinlen will work with the Attorney General's Office to explore the legal authority of E & T's to provide competency services under the forensic commitment statutes. If the facilities can be determined to have legal authority to operate such programs in accordance with their licensure and relevant statutory authorities, DSHS would conduct an RFI to solicit for consideration potential E & T providers willing and able to provide competency services. DSHS will complete this work and issue, and if viable, issue a Request for Information (RFI) by February 24, 2017.

b. Consider remodeling Yakima Valley School to serve up to 30 WSH discharged patients with Developmental or Intellectual disabilities who are low security and need a step down placement. DSHS Capital facilities staff, led by Bob Hubenthal, would clarify the requirements required to change current property obligations, confirm the population that could best be served, identify specific space availability and number of beds that could be created and remodeling costs, as well as associated time frames related to completing the remodel and on-boarding of staff. If this option is found to be viable, once patients are moved from WSH, space

currently vacant and remodeled to meet class member needs would be put in service to serve class members.

c. Consider using Building Number 10 at the Veterans Affairs Campus in Retsil, Washington. This facility was recently made available to DSHS and may offer up to 78 beds. It was not a site available for consideration during the initial review of alternate sites in 2015. DSHS anticipates this facility could be remodeled into a step down low acuity/low security option for patients who are discharged from WSH. We anticipate the facility would require extensive remodel which may not make it viable for operation any sooner than 24 months from project start. DSHS Capital facilities staff, led by Bob Hubenthal, would use the $600,000 systemic investment noted above to clarify the requirements for use of this property. This would include required changes to current property obligations, confirming the population that could best be served, identify specific space availability and number of beds that could be created and remodeling costs, as well as associated time frames related to completing the remodel and on-boarding of staff. If this option is found to be viable, once patients are moved from WSH, space currently vacant and remodeled to meet class member needs would be put in service to serve class members. DSHS would use the $600,000 proposed above to fund the predesign work.

While the specific operational start dates are to be determined by further work by DSHS Capital facilities, we wanted to reiterate that successful transition of patients from WSH to Yakima Valley School and/or Retsil would result in use of available forensic beds (up to 45 currently available) at WSH.

d. Upon successful completion of the Systems Improvement Agreement (SIA) or upon the approval of the CMS approved consultant, the DSHS will pursue expansion of bed capacity at Western State Hospital in accordance with the Governor's proposed budget. This would yield 205 additional forensic beds by 2023.

3. Increase alternatives to inpatient restoration for defendants not requiring hospitalization

a. Not all defendants adjudicated as incompetent to stand trial meet the clinical or security need for hospitalization. On January 31, 2017 Assistant Secretary Reyes approved OFMHS to move forward in its contract with Groundswell Associates to assist in creating demonstration projects in King, Pierce, and Spokane and assisting with required revisions to associated statutes and administrative codes as needed for implementation.
b. Ingrid Lewis contacted Groundswell to confirm interest on January 27, 2017; Groundswell replied with interest and willingness to engage in this work.
c. Dr. Kinlen will ensure contract is executed by February 17, 2017.

IV. COMPONENT 3: DIVERSION AND TRIAGE

The third component of DSHS's long-term plan is to reverse or at least stem the trend of increased demand for competency services through expanded use of Diversion and Triage.

1. Diversion

a. Prosecutorial diversion – Contracts were shared with the court monitor on January 27, 2017. A request for review and comments for the next contracting term were made with responses due from the Court Monitor to Ingrid Lewis by March 3, 2017.
   i. Current funding is available for the next two fiscal years (2018 and 2019).
   ii. Programs will continue to be evaluated and a decision on whether to continue funding current projects will be made by March 2017.

b. Use of contempt fines to fund diversion strategies
   i. On January 30, 2017, five programs were reviewed with two programs answering all remaining questions fully and three sites needed to provide additional feedback before a final funding recommendation will be made
   ii. The Court Monitor will brief the Court on the status of deliberations and timelines for final recommendations.
   iii. Applicants for consideration included Comprehensive (Yakima County), King County, Kitsap County, Great Rivers (Lewis, Cowlitz, Grays Harbor, Wahkiakum and Pacific), and Sunrise (Snohomish)

2. Triage

a. Ingrid Lewis will schedule a meeting with the Court Monitor to discuss Triage plans submitted in November 2016 and next steps.

b. Ms. Lewis will continue to engage with local DMHP offices to determine when class members may be triaged out of jail. DSHS will participate/present at the next DMHP meeting/conference scheduled in June 2017.

c. Ms. Lewis will continue to explore how outreach and triage will address holidays and weekends to ensure that class members have 24/7 access to triage when necessary to address their needs

d. Ms. Lewis will explore additional jail outreach options prior to Day 13

e. Ms. Lewis revised the Triage Memo that was distributed to stakeholders and requested input from the Court Monitor on January 31, 2017 for suggested changes. Ms. Lewis will send the revised Memo to stakeholders on February 3, 2017.

V. RESPONSES TO PLAINTIFFS' PROPOSAL

Here, DSHS responds to the proposals made by Plaintiffs on January 30, 2017. These responses are provided only for sections that are not otherwise addressed as part of DSHS's own plan above.

1. **PLAINTIFFS' RECOMMENDATION 1**: The CEOs of both state hospitals will be provided with the Court Monitor's recommendations and be encouraged to work directly with her to achieve compliance. Such communication shall include a review of the steps ESH has taken to come into compliance that should be adopted by WSH including hiring a dedicated RN recruiter, building or maximizing forensic beds, and hiring contract staff in all vacant positions across disciplines.
   a. DSHS does not fully support this recommendation by Plaintiffs and suggests the following revisions. DSHS/OFMHS will continue to share information and Dr. Kinlen will remain the designated point of contact and responsibility for Trueblood actions and implementation. As such, he is responsible to coordinate, as appropriate, with the hospital CEOs and other DSHS staff and leaders.
   b. In addition, DSHS has already taken steps to implement coordination between ESH and WSH. WSH has adopted similar steps to ESH to assist with recruitment including hiring a dedicated recruiter, etc.

2. **PLAINTIFFS' RECOMMENDATION 2**: Implement efficiencies in providing competency services to class members who cycle in and out of the system by creating an electronic system to flag a referral from a class member who has been evaluated or admitted for restoration services within the past five years. Defendants shall also develop methods for streamlining the provision of competency services
   a. DSHS agrees with this recommendation. DSHS/OFMHS will work on implementing efficiencies for class members who cycle in and out of the system within five years using electronic records once each hospital has an electronic medical record. In addition, DSHS/OFMHS will continue to explore methods to streamline provision of competency restoration services

3. **PLAINTIFFS' RECOMMENDATION 3**: Defendants must begin coordinating Trueblood diversion efforts with the Governor's diversion efforts. This includes involving the Court Monitor or her designee in all meetings regarding diversion efforts.
   a. DSHS does not fully support this recommendation by Plaintiffs and suggests the following revisions. DSHS/OFMHS commits to coordinating efforts and engaging the Court Monitor in Trueblood related projects or initiatives, including any diversion projects related to competency services. Diversion is a broad concept, not limited just to competency services and it would not be efficient or appropriate to incorporate the Court monitor into "all meetings regarding diversion efforts."

4. **PLAINTIFFS' RECOMMENDATION 4**: Defendants shall also secure the full $4.81 million to supplement current prosecutorial diversion programs. The data from those programs shall be provided to the Court Monitor
   a. DSHS does not fully support this recommendation by Plaintiffs and suggests the following revisions. DSHS/OFMHS has funding available for prosecutorial diversion in Fiscal Year 2018 and 2019. Additionally, the Governor's budget earmarks funding well in excess of $ 4.81 million dollars for additional diversion projects which may

fund prosecutorial diversion as well as other effective diversion initiatives and projects.

5. **PLAINTIFFS' RECOMMENDATION 5**: Defendants must submit a Second Revised Long Term Plan by February 10, 2017. Such a plan must have the Governor's approval and include all steps referenced in Plaintiffs proposal including a consideration of community based restoration as recommended by Groundswell. The Second Revised Long Term Plan will be reviewed by the Court Monitor who will provide a written response regarding the viability of the Plan and suggestions to expedite compliance with this Court's orders
   a. DSHS does not fully support this recommendation by Plaintiffs and suggests the following revisions. A Revised Long -Term plan will be provided within 30 days of the enacted budget and will be based on input from the Court following the submission of the Parties' respective plans. As noted above, consideration will be given to community based restoration and DSHS is pursuing this with Groundswell services (see item 3 above in Component 2).

6. **PLAINTIFFS' RECOMMENDATION 6**: Defendants' monthly reports should include a new section regarding status of compliance that includes both the Monitor's opinion "as to the sufficiency of Defendants' progress" and "recommendations for actions to remedy any lack of progress or performance by Defendants"
   a. DSHS agrees with this recommendation by Plaintiffs. DSHS/OFMHS will add a new section to the monthly reports to allow the Court Monitor to provide updates on the status of compliance.

7. **PLAINTIFFS' RECOMMENDATION 7**: Pursuant to RCW 10.77.084(b), Defendants shall determine if the class members' clinical presentation is such that the provision of competency restoration is a viable option necessitating admission rather than a court hearing to provide this finding.
   a. It is unclear what Plaintiffs' intended with this proposal as the suggestion that DSHS can facilitate admission for competency restoration outside the court process is not supported by statute. RCW 10.77.084(1)(b) states: "The court may order a defendant who has been found to be incompetent to undergo competency restoration treatment at a facility designated by DSHS if the defendant is eligible under RCW 10.77.086 or 10.77.088. At the end of each competency restoration period or at any time a professional person determines competency has been, or is unlikely to be, restored, the defendant shall be returned to court for a hearing, except that if the opinion of the professional person is that the defendant remains incompetent and the hearing is held before the expiration of the current competency restoration period, the parties may agree to waive the defendant's presence, to remote participation by the defendant at a hearing, or to presentation of an agreed order in lieu of a hearing. The facility shall promptly notify the court

and all parties of the date on which the competency restoration period commences and expires so that a timely hearing date may be scheduled."

b. As noted, the parties to the criminal matter and the criminal court may waive a defendant's presence if a professional person has determined the defendant remains incompetent and the hearing is held prior to the expiration of the commitment period. At this time, DSHS does provide information to the parties regarding the dates on which the competency period commences and expires pursuant to the statute. In addition, DSHS does conduct evaluations prior to the expiration of the commitment period and, to the extent possible, alerts the parties of a finding of continuing incompetence such that waiver is possible. Further, the standardized court orders developed by DSHS and other stakeholders includes a provision for the parties to preemptively activate this waiver provision in RCW 10.77.084(1)(b). See pg. 5 of form order MP 240. However, DSHS cannot unilaterally detain an individual beyond the expiration of the competency period absent action by the criminal parties and court within the required timeframe.

8. **PLAINTIFFS' RECOMMENDATION 8**: Defendants should utilize the Court Monitor and her experts as resources for developing compliance plans and ensuring that the actions they take will lead time to comply with this Court's injunction in a timely manner.
   a. DSHS largely agrees with this recommendation by Plaintiffs. DSHS/OFMHS will utilize the Court Monitor and experts as resources.

9. **PLAINTIFFS' RECOMMENDATION 9**: It may be useful for the Monitor to open and staff a local office and bill Defendants for these costs.
   a. DSHS does not fully support this recommendation by Plaintiffs. Before funds are expended on the opening and staffing of a local office, there are numerous steps that can be taken to improve communication and feedback between the Monitor and DSHS. Reinstituting the quarterly reports from the Monitor, the new Monitor's section in the monthly reports, the continued use of local experts, and leveraging technology (web meetings, email, phone, etc.) are all equally effective, and more cost conscious, options for ensuring that the Monitor is more accessible.

VI. CONCLUSION

DSHS is requesting a systemic investment of $3.8 million dollars from the court to hire additional evaluators and provide funds to complete the design effort of a 78-bed facility to provide step down placement for individuals in the community. This will move the system toward expanded capacity in the community and move the hospitals toward expanding services for forensic patients.

DSHS is committed to meeting the requirements of the *Trueblood* decision and continues to work toward that commitment.