# A MIXED METHODS STUDY OF COMPETENCY RESTORATION IN OREGON

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# Executive summary

## What is competency restoration or "Aid & Assist"?

When a person is charged with a crime, the court must ensure the person must be able to understand the charges brought against them, enter a plea, cooperate with attorneys, and "aid and assist" in their criminal defense. If the person's mental health challenges cause them to be found unable or unfit to participate or proceed with their criminal case, the court may issue an order (under Oregon Revised Statue (ORS) 161.370) for them to receive competency restoration services either at the Oregon State Hospital (OSH) or through a Community Mental Health Program (CMHP). The number of people who are ordered to receive competency restoration services has been growing significantly nationwide and has reached crisis levels in Oregon over the past seven years.

## What was the focus of this project?

The purpose of this project was to establish an overall picture of Oregon's competency restoration system and population by exploring these research questions:

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| Question 1 | What has happened in the lives of people in competency restoration? |
| Question 2 | What did restoration look like for people? |
| Question 3 | What happened in people's lives after going through the restoration process? |
| Question 4 | What can be learned from other states about people in competency restoration and their restoration process in general? |

## How did the research team address these questions?

This project sought to gather data from multiple perspectives, sectors and jurisdictions involved in competency restoration, so we used a mixed methods design. The quantitative data was received from six sources, each representing a different sector of the competency restoration process and/or systems that people in competency restoration encountered, including county/community-based behavioral health organizations, Oregon Health Authority (OHA), OSH, the courts, and criminal justice/corrections agencies. The project team conducted a total of 81 Subject Matter Experts (SMEs) and participant semi-structured interviews with 134 people who had professional and/or lived experience with competency restoration in Oregon.

Finally, we did a scan of the literature to identify jurisdictions and affiliated programs to inform the interview process with other states.

## What did we learn about competency restoration in Oregon?

People entering competency restoration are living with a wide range of behavioral health and social service needs that extend across multiple systems. Nearly one in four people in hospital or community restoration during our study period had at least one previous admission to OSH for any reason. Most of those individuals were admitted previously for hospital restoration, which participants called the "revolving door" of competency restoration.

> "*Every county does their aid and assist process a little bit different*" in Oregon. There did not appear to be a core set of community restoration services delivered consistently or equitably across the counties. Some counties had few resources and services while others created adaptive strategies and services to support people in community restoration. Depending on which county people were in when they were arrested and their fitness to proceed was questioned, people received different or inequitable restoration services. As one participant stated, "*The quality of services depends on your zip code."*
>
> *–OSH staff*

This uneven service delivery impacted people going through the process as well as cross-sector providers who lacked agreement on the purpose of competency restoration. The statutory purpose is clear – to restore someone's mental capacity so they are well enough to proceed with their criminal case – and the determination of fitness is made by the court. But the providers were not aligned on the overall purpose of competency restoration, calling the court-based process to address behavioral health issues a "broken system" that needs to be fixed. Providers questioned what "successful" competency restoration outcomes were at the individual and societal levels. The criminal case data supports that assessment, with charges dismissed for 38% of people in hospital restoration and 56% of people in community restoration.

System-level deficiencies contribute to the "revolving door" that has person-level impacts. There are no shared data systems tracking a person throughout their competency process to ensure they receive adequate aftercare services. Shared data systems do not track and report whether or not a person is considered restored and found "able" after they go through competency restoration. In other words, the lack of connection between data sources makes it impossible to know whether the competency restoration system is serving its intended purpose.

### What did we learn from other states?

Put simply, we learned that other states and jurisdictions have faced similar challenges and issues related to their competency restoration processes and systems. Many have implemented strategies, policies, and programming that appear to be making a positive difference.

### What opportunities exist to improve the competency restoration systems in Oregon?

This project identified some key opportunities for state and local systems to improve competency restoration for the people going through restoration and their families, the providers serving them, and the communities of Oregon.

1. Use a cross-sector multi-faceted approach to piece together the "broken system"

OHA cannot address the problems of competency restoration in isolation. We learned from state experts that a central convener is necessary to set up an integrated cross-sector system. Oregon does not currently have a centralized program or office with the authority and resources to convene cross-sector service providers and partners to support people throughout the competency restoration pathway. To mend this "broken system" requires statewide leadership to create shared responsibility and decision-making authority to clarify common goals and solidify relationships with cross-sector partners.

2. Support implementation of competency restoration with materials and technical assistance

There is an opportunity for clear supporting materials tailored to service providers, partners from other sectors, people going through restoration, and their families. For example, there is a need for a community restoration implementation manual to support counties and a companion manual for family members/support people/caregivers.

**What opportunities exist to improve the competency restoration systems in Oregon?**

1. Use a cross-sector multi-faceted approach to piece together the "broken system"
2. Support implementation of competency restoration with materials and technical assistance
3. Address workforce capacity, development, and training
4. Improve data systems and information sharing

Given the constraints and challenges with hiring and retaining staff within OHA, we see an opportunity to collaborate with a technical assistance provider to support implementation of robust community restoration and topic-specific experts who can provide implementation support.

3. Address workforce capacity, development, and training

Data confirmed considerable system-level barriers and resource constraints on staff and clinicians in both hospital and community settings and in many counties, particularly after the COVID-19 pandemic placed an unprecedented strain on individuals and organizations. There is no current capacity in the OHA workforce to do the relationship-building, communication, intentional planning, data system-building, workforce development, and contract management needed to create a shared sense of purpose and responsibility within OHA and across sectors.

4. Improve data systems and information sharing

We see numerous opportunities to improve data infrastructure within OHA and information sharing between OHA, Oregon Judicial Department (OJD), and interested parties who serve people in competency restoration. OHA does not currently maintain a real-time list or "roster" of people currently in competency restoration for basic data monitoring and reporting purposes. There are key data points that should be reflected in shared data systems for competency restoration to make the system meaningful. The system could include forensic evaluator findings, indicators of whether a person is returning to OSH after decompensating in jail waiting for their criminal case to proceed, and identifiers for people's criminal case(s) (i.e., Case Numbers) in the restoration records to track the outcomes of the case(s).

Currently, whether or not a person is considered restored and found "able" after they go through competency restoration is not information that is tracked in shared data systems. This lack of connection between data sources makes it impossible to know whether the competency restoration system is serving its intended purpose.

# Introduction

When a person is charged with a crime, the court must ensure the person is mentally competent enough to participate in the court's process and assist with their defense (Dusky v. United States, 1960).[1] More specifically, the person must be able to understand the charges brought against them, enter a plea, cooperate with attorneys, and "aid and assist" in their criminal defense. If the person's mental health challenges cause them to be found unable or unfit to participate or proceed with their criminal case, the court may issue an order (under Oregon Revised Statue (ORS) 161.370) for them to receive competency restoration services either at the Oregon State Hospital (OSH) or through a Community Mental Health Program (CMHP). The court's decision to order competency restoration services at OSH or in the community is influenced by a number of factors including the severity of the criminal charges; information from a forensic evaluation (if one is conducted); consultation from the CMHP related to the availability of appropriate services in the community; public safety concerns; and acuity of the individual's mental health challenges and symptoms. In Oregon, individuals who are ordered to receive hospital restoration services must be admitted to OSH within seven days of the judge's order (Oregon Advocacy Center v. Mink, 2003).

The number of people who are ordered to receive competency restoration services has been growing significantly nationwide and has reached crisis levels in Oregon over the past seven years. The state has relied on OSH as the primary service provider for competency restoration, but the rapidly growing population and high level of service needs has led to capacity challenges and caused the state to fall in and out of compliance with the court order that requires people be admitted within seven days of a judge's order. Community hospitals, emergency departments, law enforcement, and jails have reported stresses on their systems and have been vocal about their frustrations with the lack of service options.

Oregon has been involved in several recent court proceedings related to its competency restoration processes, including:

- Disability Rights Oregon's 2019 memorandum regarding contempt of the original Mink decision that requires people be admitted to OSH within 7 days of a judge's order to hospital restoration;
- A civil lawsuit filed by several health systems in U.S. District court that argues the state violated the civil rights of Oregonians with severe mental illness by not admitting civilly

[1] *Dusky v. United States* (1960) set the standard for competence and 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."

committed patients into OSH and instead requiring acute care hospitals to provide for their long term care. The lawsuit argues that acute care hospitals are not designed to treat people for longer than a few days, but have been forced to serve civilly committed people for months as they wait for a bed to open at OSH;

- The appointment of a neutral expert by a federal judge to assess and make recommendations to address OSH's capacity issues and advance the state's compliance with previous court orders; and
- A ruling by a federal judge requiring OSH to make changes to the patient discharge process that impacts the amount of time allowed for people to remain at OSH for competency restoration. The order was later amended to address public safety concerns and limit certain charge classifications from OSH admission.

To be sure, the lawsuits, reports, and heavy media coverage have highlighted the urgency of Oregon's competency restoration crisis. However, to date, resources have not allowed for an examination of the root causes of the dramatic increase in the numbers of people ordered to competency restoration or the fundamental issues in Oregon's management and treatment of this vulnerable population. Oregon's competency restoration process includes many players or sectors, who naturally approach the issue through their own lens and in service of their own agencies' mission. Each sector maintains expert knowledge, information, and oftentimes data about people who are in competency restoration, yet there has not been a systemic effort to compile that information to understand what is driving people's need for restoration, what happens to them while they are going through the process, and what happens to them after the process ends.

The Oregon Health Authority (OHA) partnered with Program Design and Evaluation Services (PDES) to help address these unknowns. PDES is an inter-agency applied research and evaluation unit shared between Multnomah County Health Department and the Oregon Public Health Division.

## Purpose

The purpose of this project was to establish an overall picture of Oregon's competency restoration population by examining:

1) people's pathways to and outcomes after restoration;
2) how Oregon compares to other states; and
3) what might be modified to improve the system so OHA can meet the needs of this growing population and decrease the strain on its behavioral health system.

Competency restoration is complex and spans work across many sectors, so the project team had to work to maintain the scope of this project. We worked to maintain a focus on the research questions throughout this report, noting when additional analysis was beyond the scope of this project and we recommend additional research to explore a specific topic. This

project does not cover the varied reasons for the increase in the number of people in competency restoration and does not stand in for a community health program needs assessment.

## Research questions

The original project scope included three main research questions: 1) What are the backgrounds of individuals determined to be incapacitated under ORS 161.370; 2) What are the outcomes of individuals who receive restoration services in Oregon, both at the OSH and in the community; and 3) What can be learned from other states about the successful management of the "aid and assist" population and the restoration process in general?

After more than two years spent learning from Oregon's subject matter experts and conducting interviews with people who have professional and lived experience with competency restoration services in Oregon and across the U.S., we believe the original wording of our research questions overemphasized the role of individuals with behavioral health challenges in "causing" their circumstances and Oregon's current crisis. To remedy this, we reframed our original research questions to deemphasize the role of individuals' characteristics and speak more to their lives, the systems they have interacted with, and the system-level issues that led them and Oregon into their current situations. Our modified, final research questions appear below.

### Question 1: What has happened in the lives of people in competency restoration?

Critical to establishing an overall picture of Oregon's competency restoration population is a better understanding of these individuals' backgrounds and histories of contact with various systems and services. Toward that end, our first research question asked, **"what has happened in the lives of people in competency restoration services?"** Embedded in this general research question were several more targeted sub-questions including:

- Where were they living and what was their housing status?
- What was their employment status prior to competency restoration?
- What were their behavioral health challenges prior to entering competency restoration?
- Where they previously known to law enforcement?
- What do we know about their behavioral health treatment history?
- Were they accessing benefit programs?

### Question 2: What did restoration look like for people?

Our second research question was not original to the scope of this project and came about while gathering and analyzing the qualitative interview data from people who have professional and lived experience with competency restoration in Oregon. During the interviews, we found that the conversation often shifted from the backgrounds and outcomes of people in

competency restoration services to more discussion around the system response and system drivers of the issues Oregon is facing. When we analyzed the interview data, we found it was saturated with people's thoughts and observations about Oregon's competency restoration process itself and the systems that are involved. We also found that it was difficult to make observations about the backgrounds and outcomes of people in competency restoration (the focus of our other research questions) without talking about systems which can, in part, shape people's backgrounds and determine their outcomes. To honor our data and capture this important piece, we added a research question that asked: **"What did restoration look like for people?"**

*It was difficult to make observations about the backgrounds and outcomes of people in competency restoration (the focus of our other research questions) without talking about systems which can, in part, shape people's backgrounds and determine their outcomes.*

## Question 3: What happened in people's lives after going through the restoration process?

We also sought to establish a better understanding of what happens to people after experiencing competency restoration and to describe the variety of possible outcomes. Our third research question asked: **"What happened in people's lives after going through the restoration process?"** Similar to our first research question on people's histories and backgrounds, our general question on outcomes included several more targeted lines of inquiry including:

- What were the outcomes for individuals who received restoration services?
- What was people's competency status at the end of restoration services?
- Were people convicted of the offense(s)?
- Were they sentenced to incarceration or community supervision?
- Were they arrested and/or charged with new offenses after competency restoration?
- Did they go back to the hospital or the community for additional competency restoration?
- What is the impact of the "revolving door"?
- What were the outcomes for individuals who received restoration services in the community versus the state hospital?

## Question 4: What can be learned from other states about people in competency restoration and their restoration process in general?

The increasing number of people who are court-ordered to competency restoration and correlated issues with behavioral health systems are not specific to Oregon. Similar trends can be found currently and historically in other states across the country. State laws, policies, and

practices differ significantly with regard to the management and coordination of services for people in competency restoration, and OHA seeks to learn more about helpful strategies used in other states. Therefore, our final research question asked: **"What can be learned from other states about people in competency restoration and their restoration process in general?"** Within this general question, we asked:

- Are Oregon's challenges similar to those in other states?
- What specific policies, rules, procedures, or programs have been successfully implemented in other states, and could these be useful in Oregon?

## Language and terminology in this report

Many terms are used throughout this report to describe the various aspects of competency restoration and the individuals who have professional and lived experience with the processes involved. Below is a list of terms along with a description of how they are defined and used in the report, including mention of whether they are used interchangeably with other terms.

- **".365":** A term used to refer to activities under ORS 161.365. Under ORS 161.365, a forensic evaluation is conducted by a psychologist to determine if a person is able to aid and assist in their defense so they can participate in court proceedings related to their criminal case. The term ".365" is used interchangeably in our report with ".365" order and ".365" evaluation.
- **".370":** Refers to when a court orders a person to receive competency restoration services at the Oregon State Hospital or in the community under the purview of a Community Mental Health Provider. Issued under ORS 161.370, the purpose of the .370 order is to provide services that restore a person's mental capacity and enable them to aid and assist in their defense. People who are in competency restoration are sometimes referred to as "the .370 population."
- **Arrest:** A term used to describe the act of law enforcement detaining a person who is suspected of committing a crime. The quantitative arrest data we received for this project includes arrests in Oregon where the person was fingerprinted by the arresting agency.
- **Competency restoration:** A term used to describe the process, system, series of events, and activities that a court may order when a person who is charged with a criminal offense exhibits a "qualifying mental disorder affecting their fitness to proceed" (ORS 161.360) and their ability to participate or "aid and assist" in their criminal defense. In Oregon, people can experience competency restoration – also referred to as "**Aid & Assist**" – in the community or they can be ordered to competency restoration at the Oregon State Hospital. Competency restoration is meant to restore the person's mental "fitness" so they can proceed with their criminal case and accompanying court processes.

- **Criminal case:** A formal accusation made by a prosecutor/district attorney asserting to the court that someone has committed a crime or multiple crimes.
- **Criminal charge:** Specific crimes a person is accused of committing that appear on a criminal case. A person does not have to be arrested to be charged with a crime, and a person is not always formally charged with a crime if they are arrested. A person who is arrested can be charged with multiple crimes on a single arrest and in a single criminal case.
- **Disposition:** A term used to describe the court outcome of a criminal charge specific to the culpability of the individual for the crime. In our analysis of the quantitative data we received for this project, we focused on the following dispositions:
    - *Convicted:* When the person pleads guilty or is found by the court to be guilty of the crime.
    - *Dismissed:* When the court or prosecutor has decided the criminal charge should no longer go forward and the case is terminated.
- **Fitness:** Fitness is the defendant's ability to understand or assist at various stages of the criminal justice process, it can be based on either a mental or physical state. In Oregon it is the judge who determines a defendant's fitness. May also be referred to as 'capacity' or 'competency' to understand the criminal justice process.
- **Sector:** A term used to describe the distinct points of contact, service areas, agencies, and staff that play a role in the implementation of competency restoration. These include but are not limited to law enforcement, jails, courts, defense attorneys, prosecutors, judges, forensic evaluators, community mental health programs (CMHPs), behavioral health treatment staff, Oregon State Hospital (OSH), Oregon Health Authority (OHA), Oregon Judicial Department (OJD), and local service agencies and support partners (e.g., shelters and housing).
- **Sentence:** A term used to describe the judgment that a court pronounces after convicting a person of a criminal charge. For example, people can be sentenced to a term of probation (community supervision), jail, or prison for more serious offenses (i.e., felonies). For less serious offenses (i.e., misdemeanors), people may receive a sentence that involves simply paying a fine.
- **System and process:** We use these terms somewhat interchangeably throughout the report to describe the collection of events and activities that competency restoration entails and the sectors that play a role in its implementation.
- **Substance use:** A term used to describe the use of substances that are illegal and the misuse of legal substances (e.g., alcohol, cannabis, and prescription medications).
- **People with a substance use disorder:** A term used to describe people whose use of legal and/or illegal substances leads to health issues or problems at work, school, or home. Substance use disorder can affect people's brains and behaviors.

# Methods

We chose a mixed methods approach to address our research questions that included gathering quantitative and qualitative data. We compiled quantitative data from many of the sectors and agencies that serve people in competency restoration. We collected qualitative data from interviews with various subject matter experts and people who have professional and/or lived experience with Oregon's competency restoration process and systems.

## Communication and reporting

Throughout this project we participated in regular meetings, led several presentations, and delivered various progress update reports in an effort to maintain communication with our contract administrator and OHA leadership. Specifically, we:

- Attended bi-monthly meetings with OHA staff to share progress updates and for briefings on legislative activities and policy changes related to Oregon's competency restoration system.
- Led a presentation to the Oregon Public Health Division's Science and Epi Council (SEC) and received feedback.
- Delivered and presented six interim research briefs describing our progress and initial findings to OHA's Behavioral Health Director and staff to support OHA's legislative and programming priorities.
- Conducted two report-back sessions with interview participants to confirm findings, which will be described in more detail below.

## Quantitative data

We received quantitative data from six sources, each representing a different sector of the competency restoration process and/or systems that people in competency restoration encounter.

### Data sources

Each sector involved in the competency restoration process—including county/community-based behavioral health organizations, OHA, OSH, the courts, and criminal justice/corrections agencies—compiles and tracks data about people in competency restoration for different purposes using different methods and software. Quantitative data sources containing

information about people in competency restoration are not connected to each other, including those that exist in the same agency (i.e., OHA).[2] To illustrate:

- Community-based restoration information is gathered by community mental health providers in each county or region and submitted quarterly to OHA's Contracts Unit using Microsoft Excel. OHA Intensive Services staff then condense and compile each county's quarterly report into a single Excel spreadsheet to describe the state's community restoration caseload.
- Hospital-based restoration information is collected by OSH using their in-house electronic health record system (i.e., Avatar). OSH's restoration records have not been combined with community-based restoration records before this project and although OSH is part of OHA, hospital restoration records are generally not accessible by non-hospital OHA staff without a data sharing agreement.
- The Oregon Judicial Department collects and compiles data on criminal cases handled in Oregon's circuit courts using the E-Court system. The E-Court system is not connected to any OSH or OHA data, nor to any other criminal justice data sources. Data analysts can connect criminal case data to sentencing data from the Oregon Department of Corrections using case identifiers such as Case Number and Charge Number, if available.
- The Oregon State Police track arrest data in their Law Enforcement Data System (LEDS), which is not connected to OSH or OHA data, nor to any other criminal justice data sources.
- The Oregon Department of Corrections collects and tracks data on probation, jail, and prison sentences, resulting primarily from felony convictions, using their own electronic system which is also not connected to OSH or OHA data, nor to any other criminal justice data sources. Data analysts can connect sentencing data to criminal case data from the Oregon Judicial Department using case identifiers such as Case Number and Charge Number, if available.

Despite the siloed nature of Oregon's quantitative data on people in competency restoration, data from each of these sectors was necessary to address our project questions. We negotiated data sharing agreements with OHA, OSH, the Oregon Judicial Department, and the Oregon Criminal Justice Commission (for arrest and sentencing data). We also requested data from OHA's Measures and Outcomes Tracking System (MOTS) related to individuals' receipt of community-based behavioral health services (separate from community-based restoration caseload data). The agreements allowed each entity to share individual identifiers which facilitated connecting records across each dataset. Therefore, our analytic dataset contained individual-level information about each person's hospital and community-based competency

[2] Efforts are underway to develop a Behavioral Health Data Warehouse that would connect behavioral health data systems within OHA. The intent of the Behavioral Health Data Warehouse is to facilitate OHA's ability to track people using behavioral health services at each system point and assess how people move throughout the system.

restoration treatment episodes, combined with their community-based behavioral health services records, arrests by law enforcement, criminal charges received in circuit courts, and any prison, jail, or probation sentences received in Oregon.

*Combining the quantitative data sources and creating the analytic datasets*

With the support of skilled data analysts at the Oregon Criminal Justice Commission, OSH, and OHA, we were able to connect each quantitative data source at the individual level. That is, OSH and OHA shared their lists of people in hospital and community-based restoration with the Criminal Justice Commission, who used data matching techniques to find each individual's data on arrests, circuit court cases, and sentences received in Oregon. The lists of people in hospital and community-based restoration were also shared with OHA's MOTS staff, who used data matching techniques to find community-based behavioral health treatment records for each individual on the list. Matched data sources were then shared back with the project team, who ran quality checks and identified any errors. The project team also matched individuals listed in the hospital restoration records with individuals listed in the community restoration records to identify those who had experienced both. Matching individuals and combining data sources resulted in a large compilation of cross-agency data that supported our project goals and observations.

To our knowledge, this collection of quantitative data concerning people in Oregon's competency restoration system is the first in the state's history. Table 1 lists each major dataset we received and notes the years records were available. A more detailed description of each dataset appears below Table 1.

**Table 1. Datasets received by the project team and the years included in each source.**

| Dataset Name and Source | Pre-2017 | 2017 | 2018 | 2018 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|---|
| **OSH Admission Records** *Source: Avatar (2017-2022) and manual review of patient records (2017-2018)* | X | X | X | X | X | X | X |
| **Community Restoration Records** *Source: CMHP Quarterly Reports* | | | | X | X | X | X |
| **Arrests** *Source: Law Enforcement Data System (LEDS)* | X | X | X | X | X | X | X |
| **Circuit Court Criminal Case Files** *Source: Oregon Judicial System (OJD)* | X | X | X | X | X | X | X |
| **Criminal Sentencing Records** | X | X | X | X | X | X | X |

**Table 1. Datasets received by the project team and the years included in each source.**

| Dataset Name and Source | Pre-2017 | 2017 | 2018 | 2018 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|---|
| *Source: Oregon Department of Corrections (DOC)* | | | | | | | |
| **Community-based Behavioral Health Services Records** *Source: Oregon Health Authority, Measures and Outcomes Tracking System (MOTS)* | X | X | X | X | X | X | X |

Descriptions of datasets listed in Table 1:

- **OSH Admission Records:** State hospital admission records for hospital restoration, civil commitment, and voluntary commitment by a guardian from 2017 through September 2022. Some limited information about other types of admissions was also included. All records included administrative data from Avatar and some included data gleaned from a manual review conducted by an OSH staff person of a limited set of patient records. Given the amount of labor required to conduct the manual review, only patient records for admissions in 2017 and 2018 were reviewed.
- **Community Restoration Records:** Records of community restoration episodes. All information was reported by community mental health providers. Included individual characteristics and some background information (e.g., living arrangement and employment status).
- **Arrests:** Counts of arrest events where the individual was fingerprinted in the 3 years prior to and the 3 years following competency restoration services.
- **Circuit Court Criminal Case Files:** Information related to criminal cases and charges filed by District Attorney's offices. Cases and charges were not always aligned with fingerprinted arrests in LEDS (i.e., some people did not have arrest records, but they did have records in the criminal case files). Information related to the court's orders pertaining to forensic evaluations and findings regarding people's fitness to proceed were available for a limited selection of people who were in hospital restoration.
- **Criminal Sentencing Records:** Information about sentencing (i.e., probation, jail, prison, and parole) resulting primarily from felony convictions and some misdemeanor convictions if the person is supervised by the county community corrections department. This data does not include sentences where the person is supervised by the court, which varies by county for misdemeanor convictions.
- **Community-based Behavioral Health Services Records:** Information about individual characteristics and episodes of care within community-based behavioral health services. The data we received regarding episodes of care included primarily dates and locations

of services and facilities where services were received. We did not receive information about the specific type of care or services that were delivered.

We created two analytic datasets – one anchored by hospital restoration episodes and the other anchored by community restoration episodes. For the hospital restoration analytic dataset, we isolated each person's hospital restoration episodes in the OSH admissions data and summarized information from previous and subsequent hospital admissions (if any). For each episode, we created summary variables that accounted for:

- The number of times the person was previously and subsequently admitted to OSH for court-ordered restoration, civil commitment, and/or voluntary commitment by a guardian;
- Information about the person's primary diagnosis and any co-occurring histories of substance use;
- Any current or historical involuntary medication orders for the person while at OSH; and
- Where available, information pertaining to the person's social characteristics including their housing status (i.e., housed or unhoused), employment status, and reported substance use leading up to their current hospital restoration episode.

We then inserted the admission and discharge dates for each individual's hospital restoration episodes into the other datasets containing information about their criminal cases, arrests, sentencing, and episodes of care in community behavioral health services. Information from each of these datasets was summarized up to the person's hospital admission date to capture key historical data such as their previous court cases and criminal charges, the number of times they had been arrested, information about previous community behavioral health episodes of care, and so on. Similar information was summarized after the person's discharge date to capture what happened after the hospital restoration episode ended (e.g., subsequent court cases and criminal charges, subsequent arrests, etc.). We also noted in the hospital restoration analytic dataset which individuals had records in the community restoration caseload data, indicating they had experienced both types of restoration.

We used a similar process to create the community restoration analytic dataset. First, we isolated each person's community restoration episode in the caseload data and summarized information from previous and subsequent community restoration episodes (if any). Summary variables included the number of times the person was previously and subsequently ordered to community restoration and information pertaining to the person's housing status. Identical to the procedures used while creating the hospital restoration analytic dataset, we then inserted the start and end dates for each person's community restoration episode into the other datasets and summarized information about their previous and subsequent criminal cases, arrests, sentencing, and episodes of care in community behavioral health services. Individuals who also had records in the OSH admissions data were noted in the community restoration analytic dataset as having experienced both types of restoration.

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|---|---|
| **Hospital restoration analytic dataset** | Included 3,086 people who experienced 3,929 court-ordered hospital restoration episodes between January 2017 to September 2022 |
| **Community restoration analytic dataset** | Included 971 people who experienced 1,039 community restoration episodes between January 2019 and July 2022 |

## Data analyses

We used primarily descriptive analyses to address our research questions. We present relevant frequencies, measures of central tendency (i.e., mean/average, median, mode), and measures of variation or dispersion (i.e., standard deviation) throughout this report in combination with our qualitative findings.

## Limitations

*Key information was inconsistent within and across data sources*

The data we needed to answer our research questions did not exist within all quantitative data sources listed in Table 1, nor was it available across each of the years in a given data source. For example, quantitative data on people's housing status (e.g., whether they were housed or unhoused) existed in a limited selection of OSH admission records, all of the community restoration records, and all of the community-based behavioral health treatment records, but the information was not collected nor recorded in the same way. This created unique analytical challenges.

To illustrate, the housing status of a limited selection of people who were in hospital restoration was collected manually by an OSH staff person who read through more than 1,000 patient files to determine where they were living prior to being admitted to OSH. The OSH staff person categorized this information based on the definition of homelessness regulated by the US Department of Housing and Urban Development (HUD), and entered it into people's hospital admission records using three categories: Housed, Unhoused, and Unknown. Due to resource constraints, the OSH staff person was only able to collect housing status for people who were admitted in 2017 and 2018—that is, we do not have data on housing status in the OSH admission records for anyone admitted to OSH in 2019, 2020, 2021, or 2022.

In contrast, CMHP staff gathered the housing status of people who were in community restoration during intake conversations with the person at the beginning of their restoration episode(s). Housing status was coded in the community restoration caseload data using six categories: Congregate, Homeless, Hotel/Motel, Private Residence, Secure Residential Treatment Facility, and Shelter. We did not receive a data dictionary with the definition of

houselessness used by CMHP staff to categorize people's housing status at intake. Data on housing status is available for everyone in the community restoration caseload data since the collection began in 2019.

Like the housing status data in community restoration records, the housing status data in community-based behavioral health treatment records (MOTS) was collected during intake conversations when people started services. However, housing status was coded in community-based behavioral health treatment records using an unknown set of definitions and many more categories and sub-categories. Table 2 on the following page shows a complete list of the categories used in the MOTS data collection, along with a side-by-side comparison of key differences between each of the data sources that contained data on housing status.

**Table 2. Data on housing status by source, data collection method, and years data were available.**

| | OSH Admission Records | Community Restoration Records | Community-based Behavioral Health Treatment Records | |
|---|---|---|---|---|
| **Years housing status data available** | 2017 -2018 | 2019-2022 | 1993-2023 | |
| **Housing status data collection method** | Manual review of patient records | Intake conversations with person in services | Intake conversations with person in services | |
| **Categories used to code housing status** | • Housed<br>• Unhoused<br>• Unknown | • Congregate<br>• Homeless<br>• Hotel/Motel<br>• Private Residence<br>• Shelter<br>• Security Residential Treatment Facility | • Alcohol and Drug Free Housing<br>• Behavior Rehabilitation Services Residential Facility<br>• Commercial Sexual Exploitation of Children Residential Facility<br>• Foster Home<br>• Jail<br>• Other Private Residence<br>• Oxford Home<br>• Prison<br>• Private Residence (at home)<br>• Private Residence (with non-relative)<br>• Private Residence (with relative)<br>• Psychiatric Residential Treatment Services Facility | • Residential Facility<br>• Residential Sub-Acute Care Facility<br>• Room and Board<br>• Residential Treatment Home for Youth at Risk<br>• Secure Residential Treatment Facility<br>• Secure Residential Treatment Facility for Youth at Risk<br>• Substance Use Disorder Residential Facility<br>• Supported Housing<br>• Supportive Housing (congregate)<br>• Supportive Housing (scattered site)<br>• Transient/ Homeless<br>• Unknown |

*Missing municipal court data*

Though most court cases involving competency restoration are handled through Oregon's circuit (county) court system, there are a few municipal (city) courts that handle misdemeanor cases where defendants' fitness to proceed can be raised. The largest municipal courts where this occurs are in Springfield and Eugene (both in Lane County) and Beaverton (in Washington County). OJD's E-Court system only includes data from circuit courts, therefore the court data OJD shared for our project does not reflect any municipal court cases connected to competency restoration orders. OJD partners indicated that the proportion of fitness-to-proceed cases handled in municipal courts is small relative to what is handled in circuit courts, however it is unknown what impact the exclusion of these data had on our analyses, results, and observations.

*Overlap of restoration episode dates*

When the project team matched individuals across the hospital and community restoration datasets, we noticed a pattern where the admission and discharge dates of a person's hospital restoration episode occurred inside of the start and end dates of a community restoration episode. For example, a person would have a community restoration record from 6/1/2021 to 12/1/2021 while also having a hospital restoration record from 7/1/2021 to 11/1/2021. This pattern did not occur in the opposite direction – that is, we found no instances where the start and end dates of a person's community restoration episode occurred inside the admission and discharge dates of their hospital restoration episode. This pattern did not occur in all counties, nor did it happen consistently across all community restoration records in counties where the pattern was detected. Because the hospital and community restoration records have never been combined prior to our project, this issue was not known to OHA staff until now.

After much consideration, we made the analytic decision to subtract the number of days recorded in the hospital restoration episode from the number of days recorded for the community restoration episode. This decision decreased the overall length of stay in community restoration for some individuals as well as the average length of stay for all individuals in community restoration. The episode count for both hospital restoration and community restoration was unchanged. That is, we did not increase the community restoration total episode count by one to reflect the pre-hospital admission time and the post-hospital discharge time. Since community mental health providers reported the community restoration episode as a single episode, we maintained that in the dataset.

It is important to note that the overlap in hospital and community restoration service dates created significant challenges for the project team in terms of being able to identify and describe people who received both community and hospital-based competency restoration services versus receiving one or the other. In the early stages of the project, we had hoped to be able to use the quantitative data to provide a detailed description of how people moved between hospital and community restoration. However, we were limited to simply determining

who had experience with both types of restoration and, to a minimal extent, the relative timing of each. We present this information later in the report.

*Unable to link all competency restoration episodes with exact criminal case*

Despite our large compilation of cross-agency quantitative data on people in competency restoration, there were meaningful gaps in the data that created challenges for our analysis and prevented us from arriving at some conclusions with a high degree of certainty. Specifically, there was no way for us to identify the *exact* criminal case or cases that prompted people's competency restoration episodes at OSH or in the community – that is, there were no shared data fields (e.g., Case Number or Case ID) that allowed us to crosswalk the competency restoration records with the criminal case records. OSH often tracks the criminal case numbers in the electronic records of people who are in hospital restoration, however the project team did not receive these fields in the data from OSH. Criminal case numbers are not required to be collected or tracked by community mental health providers and are therefore not reported in the community restoration caseload data. Having people's criminal case number(s) linked to the associated hospital and community restoration records would have allowed us to definitively identify the exact criminal charges that prompted a given restoration episode and the outcomes of those charges after restoration concluded. In the absence of a direct connection, the project team selected the criminal case that occurred in closest proximity to the start of people's hospital or community restoration episodes and conducted our analyses based on the assumption that the selected criminal case *likely* prompted the order for competency restoration. We discuss the impact that this data gap had on our analyses and the certainty of our findings where relevant in the report.

# Qualitative data

The qualitative data for this project was gathered from 81 individual or group interviews with 134 people, including subject matter experts (SME) and people who had professional and/or lived experience with competency restoration in Oregon.

## Sampling description and methods

We used two main approaches to sample interview participants and multiple recruitment methods to identify people in Oregon who could provide information about the competency restoration process and services in Oregon. The first was a purposive sampling method using maximum variation sampling based on the following characteristics: sector, role, and county.

For recruitment using this method, we sent emails to existing email groups and listservs to describe the study and offer details on how to participate. The project team worked with behavioral health advocacy groups and community mental health providers to distribute flyers tailored to people with lived experience and family members of people who have been through competency restoration. The team did outreach to professional organizations and sectors

serving people living with mental illness, people experiencing housing challenges, and people in forensic behavioral health.

Because we were also seeking to interview people with lived experience in the competency restoration system (either directly or as family members), we used a snowball sampling method to identify additional interview participants. At the end of each interview, we asked participants if there was someone they might recommend we recruit for participation in the study.

## Summary of participants and interviews

The project team first conducted individual and group interviews with 51 SMEs from various sectors and agencies who shared information about Oregon's competency restoration process and systems; these SMEs agreed to have the information they shared about forensic behavioral health in Oregon included in the project. Information we learned from SMEs was used to develop our interview guides and assist the project team in identifying interview participants. We asked for referrals at the end of each SME meeting and followed up with an email and link.

In addition to the SMEs, we conducted individual and group interviews with 83 participants, who all gave informed consent to participate in the project. We collected demographic data consistent with the OHA REALD/SOGI recommendations from 53% of these participants. Advocates and anyone we interviewed with lived experience in competency restoration (those not employed by OHA, community or county behavioral health, the courts, or law enforcement) were offered a $50 gift card as a thank you. The project team collected information from participants using a trauma-informed approach and had a list of support resources to offer participants, with information ranging from dental services and peer group support to food/meal services and housing. Since we conducted interviews during the COVID-19 pandemic, we offered COVID-specific resources as well.

The project team conducted a total of 81 SME and participant interviews with 134 people who had professional and/or lived experience with competency restoration in Oregon. Interviewees lived or worked in 28 of the 36 counties in Oregon and/or worked for organizations providing statewide services or for state agencies (e.g., OSH). Interview data represent people from the following sectors and experiences and many people also discussed their experiences from previous roles and past employment, which informed their perspectives but are not reflected in the list below:

- Aid & Assist Coordinators employed by the Oregon Judicial Department
- Circuit Court Judges
- County behavioral health/Community Mental Health Provider staff
- Defense Attorneys
- Deputy District Attorneys
- Family members of people who have been ordered to competency restoration
- Forensic evaluators working in private practice or at OSH

- Jail Commanders and law enforcement
- Local housing support staff
- Mental health and criminal justice advocates
- OSH staff and clinicians including psychologists, psychiatrists, and social workers
- People who have been ordered to competency restoration

The project team used a semi-structured interview guide that allowed the interviewers to focus on the most relevant information and experiences the SMEs and participants had to share with the team, so not every interview[3] followed the same script. Questions were open-ended, designed to draw out detailed descriptions related to their experience and thoughts about competency restoration in Oregon. The length of interviews ranged from 33 minutes to 3 hours and 45 minutes (spread across three interview times) with the average interview lasting roughly one hour. Most interviews were conducted with one to three members of the project team interviewing a single participant. The project team conducted eleven group interviews; those group interviews ranged from two participants to 34 participants all working in a similar role.

We conducted nearly all the interviews virtually using Teams or Zoom; two were conducted by phone and two were done in person. Except for a small number of interviews, we recorded 76 interviews and transcribed them verbatim, removing all identifying names and assigning a unique ID number. Two participants declined to be recorded (one provider and one person with lived experience) and four SME interviews were not recorded because the project team joined team meetings so the interviewers took extensive notes to capture the information shared.

## Protecting participant confidentiality

Given the sensitive and political nature of this project and to protect participant confidentiality, we have redacted any information from interviews that could identify participants, their family members, or specific organizations or agencies. For example, if someone mentioned a specific program name or county, we removed that name from the quote presented and added "[this] county" or "[XX] program." In addition, if we redacted any text because it was sensitive or may not have been focused specifically on the content discussed in that section of the report, we added an ellipsis (i.e. "…") to indicate a word or portion of text was removed.

## Analytic methods summary

Qualitative analytic planning and analysis began after most of the interview data had been collected. Qualitative data analysis (QDA) was conducted using a team approach with four team members with a wide range of skills and backgrounds, including one person with lived experience as a family member of someone who had gone through competency restoration.

[3] From this point forward in the report, interview data will encompass information shared by both Subject Matter Experts (SMEs) and participants and we will refer to both as "participants" and "interviewees" interchangeably.

The diverse team benefited the project through the ideas, insights, and connections we made throughout the project lifecycle, increasing reliability of findings by incorporating and addressing our different mental models throughout the process.

The qualitative team structure and overall approach was collaborative, with weekly or biweekly analytic team meetings. The purpose of the analytic meetings was to have time to deliberate, reflect upon and discuss the analytic process, from generating the codebook through identifying themes. The team informed the process throughout, improving and clarifying the procedures and the content. The lead QDA researcher supported the team and was responsible for:

- Conducting the onboarding process for team members
- Leading individualized and group analytic trainings and sharing resources with all analysts
- Developing protocols to document QDA questions and issues to ensure analysts were using codes consistently
- Reconciling coding differences and finalizing decisions throughout the collaborative process
- Holding bi-weekly QDA team meetings to discuss QDA issues/questions and emerging findings throughout coding and analysis

The analytic team used NVivo v12 to manage and analyze qualitative data. Every two weeks the QDA team lead would merge projects and reconcile coding between team members, noting items that needed discussion during analytic or full team meetings.

Two team members had past classroom and/or practice-based experience with QDA (one had experience with NVivo), and one person on the team was new to QDA; all team members received QDA and NVivo training and resources. The team was onboarded to the project September – December 2022, focusing first on transcribing the interviews to familiarize team members with the data before shifting to developing the codebook and coding.

*Developing the codebook*

The team developed the codebook through open coding a selection of the interview data, the list of research questions and the key constructs in the interview guide. The codebook went through three substantial changes before settling into the working version. We continued to refine codes throughout the analytic process and identify new codes that emerged during thematic or axial coding. We generated over 215 codes or labels, which includes “parent” and “child” codes such as the parent code “Aid & Assist pathway” and the child code “Aid & Assist pathway / Aid & Assist outcomes” then a child code under that “Aid & Assist pathway / Aid & Assist outcomes / never able” to capture dimensions within a construct or process. Each code had a description that offered a definition and clarified how the code would be used and when the analyst would not use this code. Some codes were developed during later stages of analysis as a result of queries we ran looking at how data had been coded; for example, analysis of “Aid

& Assist outcomes" and "broken system" codes and then doing a matrix query created a "success in restoration" code during thematic analysis.

*Primary coding*

The team started by conducting primary open line-by-line coding of all 81 interviews in the dataset once they were transcribed and uploaded to the NVivo project. Primary coding entails reading through or listening to the transcripts before assigning codes to familiarize ourselves with the data (Braun & Clarke, 2006). We believe this opportunity to observe and absorb the data reduces bias and allows for reflection that strengthens the coding process, an approach that has been cited by other QDA methodologists (Byrne, 2022).

The semi-structured interviews were conversational and focused on various aspects of the restoration pathway or procedures or systems, so the complexity of coding varied considerably across interviews. One interview might have 52 codes applied to it while another interview might have 166 codes applied. One way to understand those numbers is the second interview covered more topics or went more in-depth into a variety of content areas than the first interview. Both interviews can be valuable to our understanding since one person may have covered fewer topics but been more descriptive or offered more contextual information.

On average, each interview took roughly 5 hours to code, including the initial familiarization and the line-by-line coding. Primary coding of the interview data took the team approximately 400 chair hours, not accounting for time in team meetings, secondary coding of a sample of interviews to assess inter-rater reliability and refine the codebook, thematic analysis and axial coding or additional project activities. The team completed primary coding for all the interviews in June 2023.

*Secondary coding*

Secondary coding is the term we use when a second analyst coded data that had already been primary coded. This approach can be used as a training tool and a way to assess reliability, which we will discuss below. When analysts were onboarding, secondary coding was used during training so analysts could see how codes were applied to the text in practice and discuss questions or discrepancies. While we were building the codebook, we conducted visible secondary coding, so analysts could see the completed primary coding and make annotations (or notes) identifying any areas where clarification was needed, or we needed to discuss codes as a team. When the codebook was settled, we conducted blind secondary coding, so analysts did not see the primary coding.

On a biweekly basis when merging NVivo projects, the QDA team lead compared coding across analysts to assess which codes were used consistently, which codes some team members might not be using or might be using inconsistently and added coding clarifications to a shared "QDA questions and issues" document for QDA team meetings.

Resources and staff time did not allow for the level of line-by-line secondary initially planned for this project. The initial plan was to conduct full line-by-line secondary coding with 10% of the interviews, then do additional secondary coding with a random sample of 25% of the content of 20 interviews. That would have taken approximately 70 additional hours, which would have delayed thematic analysis. Given the extensive discussions during team meetings and the lack of staffing on the project, the team felt that level of secondary coding was not necessary.

### *Assessing coding reliability*

Since we had four analysts coding the data, we wanted to assess reliability and make sure analysts had the same understanding of the codes and were using codes in a similar way for the same concepts. We evaluated reliability of coding by exploring the data coded and running comparison coding queries. We did not run inter-rater reliability queries to generate a Kappa coefficient and assign a numeric value. Instead, reliability checks happened as part of our analytic process throughout the project to identify questions about specific codes or underlying concepts and clarify codes or discuss issues during team meetings.

*A note about reliability.* The aim in our project was for analysts to use the codes in the same way, applying codes or 'labels' consistently to similar concepts in the same text. The goal was not to have 100% 'agreement' between analysts or the expectation that every analyst would code every piece of text identically, but that we would have complementary coding across the QDA team. Reliability assessments were an exercise to facilitate conversations across our analytic team and uncover differences in mental models. A diverse and curious team created a stronger analytic process and a better product because one analyst might pick up on something the other analyst did not see since they each bring a different mental model or way of looking at the data (Fernald & Duclos, 2005). What we tried to do with secondary and reliability coding was create a more complete and full assessment of what concepts were in the dataset overall.

### *Axial coding and thematic analysis*

The team used 'axial' coding to identify two or three concepts or relationships in the data for this phase of analysis. In axial coding, the team explored the relationships between the codes and the underlying concepts, asking how they are (and are not) related to each other by using queries, analytic memos and then coding on existing codes. This helped to develop and expand our understanding of how the data fit together.

For this project, the team identified a couple of working principles for the axial coding. The team prioritized relationships in the data that were specific, concrete, and actionable so decision-makers would have detailed and strategic information they can actually use (not just concepts they found "interesting" or ideas to ponder). Themes that emerged were supported in the data and represented a patterned response that was relevant and important to our analytic questions (Braun & Clarke, 2006) and working principles. The team sought cross-sector themes that expanded the lens beyond OSH and built on the work other experts were doing so multiple

perspectives were included, such as county perspectives and people or families who have gone through the restoration process.

## Report back with participants

To validate some of the qualitative findings with interview participants, we conducted two confidential "report back" sessions with 33 participants (24.6% of sample) in July 2023. Eighteen participants attended the first session, and 15 participants attended the second session. Given the political nature of the content, we sought to maintain confidentiality of the participants by numbering attendees, rather than allowing names, and deactivating the video feature for all attendees. We presented some of our qualitative findings that were more nuanced, sensitive, or more challenging for the analytic team, and described the way the qualitative data would connect to the quantitative findings. We offered multiple methods to provide feedback on the findings, including privately messaging during the session, completing a feedback survey online, or having a private meeting with project staff. All three methods of feedback were utilized by participants that attended the sessions; responses were compiled and reviewed by the project team. All relevant feedback was incorporated into the language and findings as appropriate, though no major thematic changes were suggested by participants.

To protect the anonymity of interview participants we did not provide any identifiers for any of the quotes we provided in our presentation. We asked participants of the report back sessions if they felt this was necessary or if basic information about the speaker was needed to contextualize the quotes. The majority of those providing feedback indicated that they would prefer to have basic identifiers following anonymous quotes, in the final report. We have included roles and overall geographic description, based on the feedback.

## Limitations

As the quantitative methods section previously covered, this mixed methods project faced considerable challenges. We will describe some of the issues faced with the qualitative data and how those limitations may have impacted the analysis and findings.

### *Software*

NVivo v12 did not allow for synchronous coding as a team, which greatly hindered the QDA team's ability to share real-time "live" coding and see emergent themes across the team. The team lead spent 4-7 hours every two weeks merging and reconciling projects and analysis was paused during a merge. The software was also technically unable to keep up with the large project, causing freezing or corrupt project files that slowed progress.

These issues arose early in the process, so the team submitted an urgent request to OIS Asset Management in mid-November 2022 requesting the NVivo Collaboration Server, believing that might address many of the technical issues and allow for synchronous coding. In early January 2023, some of the analytic team members met with Business Engagement Services to continue

to pursue the Collaboration Server option and continued to meet and email with various members of OIS to discuss how to get the appropriate software to meet the team's needs.

During this time, NVivo was purchased by a company called Lumivero and a new version of the software was released (NVivo v14) with a new solution called the Collaboration Cloud. The team researched that software and met with Lumivero and industry experts, believing v14 and the Collaboration Cloud would be the optimal option. However, by mid-May OIS, DAS and OCP had still not approved the team to purchase and use NVivo v14 and the Collaboration Cloud so we conducted the analysis and reporting with v12 which limited our ability to do thematic analysis and axial coding as a team.

### *Amount of data, timeline, and staffing*

There is no sample size calculator for qualitative research methods to determine the number of semi-structured interviews needed to understand an experience or to create categories and explore relationships between those categories. Instead, researchers often talk about "reaching saturation" in the data, which comes from a grounded theory approach where data are collected at the same time as coding and analysis, which helps determine the amount and type of data needed. Theoretical sampling helps develop categories until no new ideas emerge in the data and saturation is reached (Glaser & Strauss, 1967). Qualitative researchers continued to clarify sampling guidelines and grounded theory procedures, but Charmaz (2006) called out how qualitative researchers had adopted the term "saturation" without defining or qualifying the meaning or being explicit about their theoretical approach.

For this project, we did not use a grounded theory approach, so we collected the data before the analytic team was assembled and different criteria were used to determine the number of interviews needed. Given the broad research questions, the subject matter and the sampling plan, the data collection team wanted to talk with people from OSH and across the state in a wide range of roles from a variety of sectors. This resulted in 81 interviews to transcribe, code and analyze starting in September 2022 with a very small analytic team. Qualitative analysis is very time-intensive, so this compressed timeline and limited staffing model meant the team had to prioritize analytic inquiries and identify research questions for future studies.

### *Limited data from people with lived experience*

The team conducted outreach and recruitment with organizations and providers serving people who have been ordered to competency restoration and their family members, friends, or other natural supports. We had limited success with recruitment of people with lived experience and their family members, interviewing six people with lived experience (7.5% of the total interviews). Though some of the people interviewed as part of their professional roles may have lived experience themselves or with family members, we had hoped to interview more people who had gone through Oregon competency restoration services to inform this project directly.

# State by state data

We collected targeted information from several states and one national organization to assess what Oregon could learn about the successes and challenges with competency restoration and the systems involved.

## Data collection approach and selection of jurisdictions

Given that all 50 states in the U.S. plus D.C. differ in their competency restoration processes, we began addressing our fourth research question by considering how to identify promising programs, policies, or practices. Throughout the qualitative interviews for research questions 1 – 3, SMEs referenced states they believed were implementing steps of the competency restoration process that showed promise for addressing the challenges that Oregon is facing. An in-depth internet search of these states suggested varying amounts and quality of information available online between states. Some states have data readily available on challenges faced and solutions attempted, while others lack any documentation of the competency restoration process beyond state statutes. The extreme variability in publicly available information proved challenging and we pursued a second strategy to identify promising processes.

Our second strategy for identifying states to pursue involved collecting recent reports written by researchers, advocacy organizations, and implementation experts about people with severe mental illness or behavioral health challenges who are in the criminal justice system. As the competency restoration crisis worsens and the number of states under litigation increases, the number of reports and research documenting strategies to alleviate the crisis grows as well. The reports we included were written by:

- Treatment Advocacy Center (Dailey, et al., 2020; Fuller, Sinclair, Geller, Quanbeck, & Snook, 2016; Fuller, Sinclair, Lamb, Cayce, & Snook, 2017; Torrey, Dailey, Lamb, Sinclair, & Snook, 2017)
- Policy Research Associates (Policy Research Associates; Inc., 2020)
- National Judicial Task Force to Examine State Courts' Response to Mental Illness (National Judicial Task Force to Examine State Courts' Response to Mental Illness, 2021)
- National Association of State Mental Health Program Directors (NASMHPD) (Wik, Hollen, & Fisher, Forensic Patients in State Psychiatric Hospitals: 1999-2016, 2017)
- The Council of State Governments Justice Center in partnership with American Psychiatric Association, NASMHPD, National Center for State Courts, and the National Conference of State Legislatures (Fader-Towe & Kelly, 2020)

We selected reports for inclusion because they addressed one of two areas:

1. Recommendations of promising practices, programs, or policies that addressed one or more elements of the competency restoration process, ranging from arrest to evaluation, restoration, and/or discharge.
2. Assessment of all 50 states in the U.S. plus D.C. on one or more constructs that are directly or indirectly related to the competency restoration process, such as number of forensic psychiatric beds or civic commitment laws.

Additionally, we included an unpublished database, created by an OHA employee, documenting each state's statutes for community-based (outpatient) competency restoration and jail-based competency restoration.

These reports revealed recommended programs, policies, and practices occurring throughout the U.S. There were many states with multiple recommendations that either applied state-wide or to a single jurisdiction. This step also illuminated that, like Oregon, many competency restoration processes differ in implementation and performance within each state and furthermore, a state or jurisdiction that excels in one part of the process may fall short in another. For example, one county may have exemplar evaluation practices but may lack any options for community restoration. Thus, focusing solely on exemplar states as models for success for the complete competency process was misaligned with reality. From this point forward we sought to identify discrete promising programs, policies, or practices within the competency restoration process at the state and jurisdiction levels.

In recognition of how state statutes and court orders affect the design and delivery of competency restoration processes, our final methodological strategy included cataloguing the most impactful statutes across all 50 states and D.C. to determine which states were most like Oregon from a legal standpoint. Legal alignment indicates there may be fewer opposing forces to making competency restoration process changes. With the help of competency restoration experts, we identified the following as the statutes and court orders that most affected the competency restoration process:

1. Do civil commitment laws make it challenging to have someone civilly committed due to one or more of the following:
    i. Requiring harm to self or others be imminent?
    ii. Requiring harm from failing to meet basic needs to be imminent?
    iii. Lacking a path to civil commitment for those who cannot meet their basic needs?
2. Is community-based restoration allowed?
3. Is jail-based restoration allowed?
4. Is there a court decision, agreement, decree, or a statute restricting the amount of time a person can wait in jail to be admitted after being ordered to competency restoration?

5. Is there a court decision, agreement, decree, or a statute restricting the amount of time a person can be in competency restoration to 6 months or shorter for either misdemeanors exclusively or for both misdemeanors and felonies?
6. Is the competency restoration process allowed for those accused of misdemeanors?
7. Does the state allow the insanity defense?

To answer these seven questions across all 50 states and D.C., we used reports written by the organizations listed above and additional research articles, court cases, and statutes, found by searching combinations of key terms including, "competency restoration," "waitlist," "litigation," "lawsuit," "misdemeanor," and "insanity defense."

Next, we looked at promising processes elevated in the national reports among the states most like Oregon legally. We selected programs, practices, and policies across the competency restoration continuum to explore further and began identifying and emailing potential contacts. We scheduled meetings with subject area and programmatic experts who replied and conducted semi-structured conversations with questions that were created based on the state or jurisdiction's unique competency process. Though we protected the information shared with us, these conversations were not considered to be interviews with consented participants like the other interviews described earlier with Oregon-based participants. Table 3 below describes the jurisdictions and descriptions of the affiliated programs that informed our state-by-state comparison.

**Table 3. Jurisdictions and programs that informed our state-by-state comparison**.

| Jurisdiction | Programmatic Description |
|---|---|
| Colorado State | Forensic Support Team |
| Colorado State | Bridges Court Liaison Program |
| Franklin County, Ohio | Office of Justice Policy & Programs, Stepping Up Program |
| Tennessee State | Office of Forensic and Juvenile Court Services State of Tennessee |
| Washington State | Washington State Health Care Authority, Division of Behavioral Health and Recovery, HARPS Program, Civil Discharge & Trueblood Programs, and Outpatient Competency Restoration |
| Washington State | Washington Department of Social and Health Services, Office of Forensic Mental Health Services, and Inpatient Competency Restoration |
| Wisconsin State | Community Forensic Services at State of Wisconsin, Forensic Mental Health Section overseeing Community-based Competency Restoration |
| Treatment Advocacy Center (National Advocacy Organization) | Assisted Outpatient Implementation Team |

In addition to these eight conversations, we reviewed a recorded presentation about Southern Arizona's Crisis Response System by the Chief of Quality and Clinical Innovation of Connections Health Solutions, the locally contracted crisis provider that was delivered to the Oregon Judicial Department's Behavioral Health Advisory Committee (Oregon Judicial Department, Chief Justice's Behavioral Health Advisory Committee, 2021).

Following each conversation, we identified key takeaways that were related to the challenges and opportunities surfaced in our qualitative and quantitative data and/or connected to the most common aspects of the national competency crisis. We summarize the key takeaways and relevant context across the conversations in this report.

# Background on competency restoration

This chapter offers a brief, simplistic overview of Oregon's competency restoration process and the sectors involved and highlights selected legislation that has shaped competency restoration over the past few years. This overview is not legal advice or an authoritative summary of the laws. Readers are encouraged to review the referenced statutes and administrative rules.

As stated in the Introduction to this report, when a person is charged with a crime they have the right to participate and be meaningfully involved in their defense. The court must ensure the person is mentally competent enough to understand the charges brought against them, enter a plea, communicate with and understand their attorneys, and make decisions about what happens in their criminal case. If the court finds that a person's mental health prohibits them from being able to "aid and assist" with their defense, the court may order them to receive competency restoration services at the Oregon State Hospital (OSH) or in the community. If a person is restored and found able to aid and assist, the court can proceed with the criminal case. If a person is not restored and found unable or never able to aid and assist with their defense, the criminal case cannot move forward.

Essentially, and per statute, the purpose of the competency restoration process is to achieve a level of capacity that allows the person's criminal case to proceed. Competency restoration is not meant to serve as an avenue for a person to receive mental health treatment for ongoing or persistent mental health issues beyond what is necessary for them to participate in their defense.

## Oregon's competency restoration process – a simplistic overview

Generally, concerns about a person's competency to aid and assist is raised early in someone's criminal case – though, it can be raised at any point in the criminal proceedings. Oftentimes the concern around someone's competency is raised by their **defense attorney**, though it could also be raised by the **law enforcement** officer who made the arrest, **jail personnel**, the **judge**, the **prosecutor**, or even the person's **family** or other **support people**. Once a concern is raised about the person's competency, a **forensic evaluator** might be hired by the defense attorney or appointed by the court to conduct an interview and thorough review of the person's mental health and capacity. Forensic evaluations can take place at **OSH**, in the community, or even in a jail setting. In Oregon, a forensic evaluation is not a required part of the process to determine someone's capacity. If a forensic evaluation is ordered, Oregon's Senate Bill 25 (2019) requires that courts send orders to OSH in a timely manner and allows evaluators access to a person's medical records to support issuing informed opinions to the court.

If the court finds that someone lacks competency and is unable to aid and assist with their defense, they may consider ordering the person to undergo competency restoration at OSH or in the community. Whether a person is ordered to hospital or community restoration is influenced by the severity of their criminal charges, the opinion of the forensic evaluator (if an evaluation is conducted), consultation from a **community mental health provider (CMHP)** about the availability of services in the community, public safety concerns, and the acuity of the individual's mental health challenges and symptoms. Oregon's Senate Bill 24 (2019) requires courts to consider ordering competency restoration in the least restrictive setting as possible, and Senate Bill 295 (2021) reorganizes Oregon's fitness to proceed statutes to encourage community placements for restoration. If a person is ordered to community restoration, they are typically under the jurisdiction of the county where they were charged with the offense (i.e., the **county of responsibility**), however they may reside in a different county (i.e., **county of residence**). The designated CMHP within the county of responsibility is charged with the person's competency restoration. A person might be placed in a **secure or non-secure residential treatment facility** if one is available, or they might remain in their own living arrangement. A person who remains in their own living arrangement might reside in a private residence, a hotel or motel, a shelter, or they might be unhoused.

Restoration services may include **medication management**, **legal skills training**, **medical treatment**, **case management**, **behavioral health treatment**, **peer-delivered services**, **crisis services**, and **care coordination**.

At various points during a person's hospital restoration or community restoration episode, the court may order another forensic evaluation or schedule hearings to determine whether the person has been restored and is able to proceed with their criminal case.[4] If the judge finds the person is unable to proceed, they may return the person to hospital or community restoration for continued restoration services until they are found able.[5] If the judge finds the person is able to proceed, the criminal case can move forward.

The criminal case moving forward can take many forms, including no trial in lieu of plea negotiations (i.e., entering a guilty plea for some charges in order to have other charges dismissed), a bench trial, or a public trial to determine the dispositions for the person's charges. The person may be convicted of one or more charges, acquitted of one or more charges, or they may have one or more charges dismissed. If a person is convicted, they might be sentenced to a term of **prison, jail, or probation**, or they may be ordered to pay a fine if they were convicted of a lesser charge. There are times when a person is found "never able" or

[4] It is important to note that at any point during a person's criminal proceedings or their time in competency restoration, the court could decide to dismiss all charges and rescind the restoration order.

[5] The limits on how long a person can remain at OSH for competency restoration have been the subject of recent court proceedings. It has been recommended by the federally-appointed neutral expert that limits be placed on the length of time people can remain in community restoration as well.

unlikely to be found able in the foreseeable future to proceed with their criminal case. Under these circumstances, the court may rescind the order, dismiss the charges, or initiate civil commitment proceedings.

After a person is out of competency restoration, their court case is concluded, and any sentence is served, they can return to their lives and communities.

## Oregon's competency restoration process – it's not so simple

Readers who are familiar with Oregon's competency restoration process and systems – either professionally or through lived experience – know that the above description is an oversimplification that inadequately captures what can happen in reality. For these readers, much of what is included in the following report will not be a surprise, but we hope the data presented affirms your experiences while offering the perspectives of those working across sectors.

For those readers who are unfamiliar with competency restoration in Oregon, we say again that the description above is a marked oversimplification of this complex process. We hope that our report will provide a more detailed overview of what can and does happen, along with a comprehensive understanding of the sectors involved.

We hope that all readers find this report enlightening and come away feeling encouraged to improve Oregon's competency restoration system and continue working to serve the vulnerable people within.

# Backgrounds of the people in competency restoration

The following chapter provides a detailed overview of our data on the backgrounds and histories of people in competency restoration. We present people's demographic information from our quantitative data (e.g., age, gender, race, and ethnicity), and findings from our quantitative and qualitative data related to people's lives and experiences leading up to competency restoration (e.g., housing situation, employment status, and behavioral health issues). Finally, we report findings from our quantitative and qualitative data related to the systems and services that people encountered in their lives, including law enforcement and the courts, behavioral health treatment services, and public benefit programs.

## What are the demographics of people who have gone through competency restoration?

We relied on the quantitative Oregon State Hospital (OSH) admissions data and community restoration caseload data contained in our analytic datasets to describe the demographics of people who have been in competency restoration. The tables and figures below display demographic information for the 3,086 people who were admitted one or more times to OSH for hospital restoration between early 2017 and Fall 2022 and the 971 people who were ordered to community restoration at least once between 2019 and Summer 2022.

### Gender

Gender was coded as either man/male or woman/female in hospital restoration records. People in community restoration also had the option of identifying as a gender other than man/male or woman/female. Table 4 shows the counts and percentages of people who were in hospital or community restoration by gender.

**Table 4. Gender of people who were in hospital restoration or community restoration during the study period (2017-2022), Oregon State Hospital and Oregon Health Authority.**

| Gender | Hospital Restoration (n=3,086 people) | | Community Restoration (n=971 people) | |
|---|---|---|---|---|
| | **Count** | **Percent** | **Count** | **Percent** |
| **Man/Male** | 2,319 | 75% | 685 | 71% |
| **Woman/Female** | 767 | 25% | 282 | 29% |
| **Other gender identity or not reported** | N/A | N/A | 4 | <1% |

Among those who were in hospital restoration and those who were in community restoration, the majority identified as men. The percent of people who identified as women was slightly higher in community restoration compared to hospital restoration.

## Race and Ethnicity

The race and ethnicity data we received for people who were in hospital restoration and community restoration were collected before the full implementation of Oregon's standards around the collection of Race, Ethnicity, Language, and Disability (REALD) data. Therefore, the race and ethnicity categories reported in Table 5 do not align with REALD standards, nor are the categories consistent between the hospital and community restoration data collections. "Not applicable" or N/A is entered for the counts and percentages in categories that were present in data for only one of the groups (either hospital or community restoration).

**Table 5. Race and ethnicity of people who were in hospital restoration or community restoration during the study period (2017-2022), Oregon State Hospital and Oregon Health Authority.**

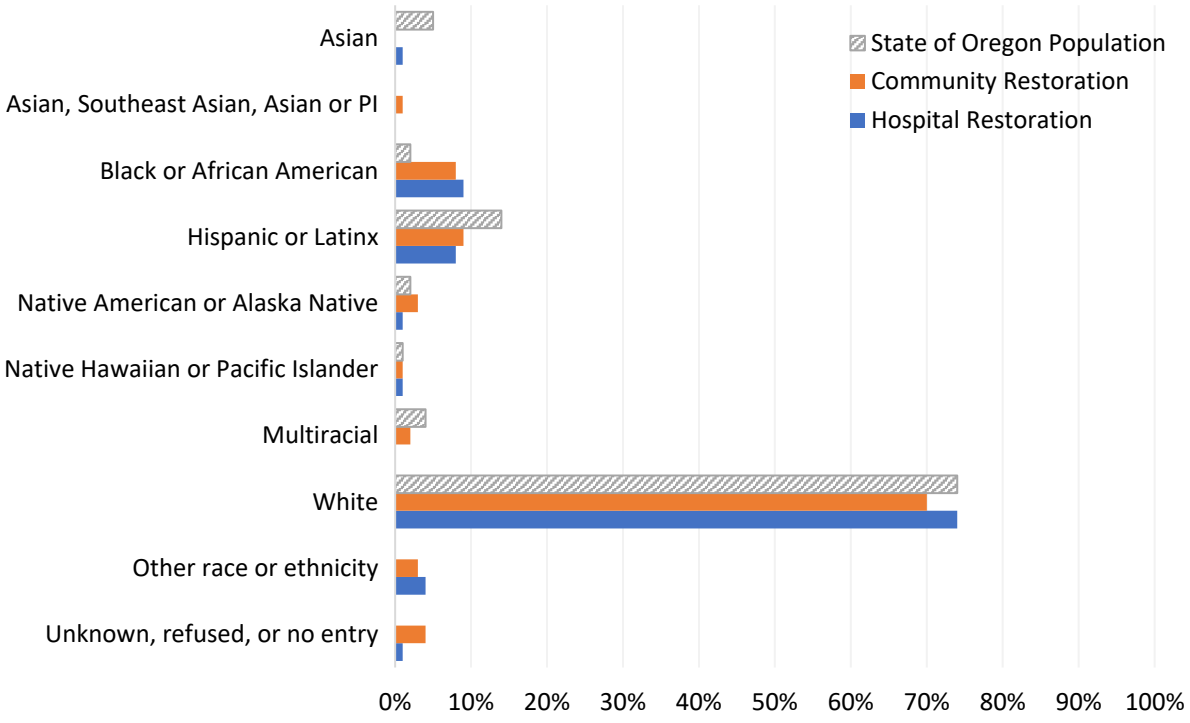
| Race and Ethnicity | Hospital Restoration (n=3,086 people) | | Community Restoration (n=971 people) | |
|---|---|---|---|---|
| | **Count** | **Percent** | **Count** | **Percent** |
| Asian | 48 | 1% | N/A | N/A |
| Asian, Southeast Asian, and Asian or Pacific Islander | N/A | N/A | 14 | 1% |
| Black or African American | 268 | 9% | 76 | 8% |
| Hispanic or Latina/o/x | 253 | 8% | 90 | 9% |
| Native American or Alaska Native | 44 | 1% | 29 | 3% |
| Native Hawaiian or Pacific Islander | 21 | <1% | 4 | <1% |
| Multiracial | N/A | N/A | 15 | 2% |
| White | 2,286 | 74% | 676 | 70% |
| Other race or ethnicity | 136 | 4% | 26 | 3% |
| Unknown, refused, or no entry | 30 | 1% | 41 | 4% |

For the most part, different racial and ethnic groups were equally represented among people in hospital and community restoration. The majority of people in both groups identified as White, and the percent of each group that identified as Black or African American or Hispanic or Latina/o/x varied only slightly between 8-9%. More people in community restoration identified as Native American or Alaska Native compared to those in hospital restoration (3% vs 1%) and the race and ethnicity was unknown for a larger percent of people in community restoration (4% vs 1%).

When we examined the racial and ethnic backgrounds of people who were in hospital and community restoration alongside the state of Oregon's population by race and ethnicity, it would seem that certain racial and ethnic groups were disproportionately represented in both types of restoration. Figure 1 shows that Black and African American people make up only 2% percent of Oregon's statewide population, but accounted for 9% of people in hospital restoration and 8% of people in community restoration. Figure 1 also shows that Hispanic or

Latina/o/x Oregonians make up 14% of the state's overall population and 8-9% of people who were in competency restoration. Given the lack of common standardized race and ethnicity categories (i.e., REALD) used across the different data collection systems it is possible that the demographic information we received for people in restoration is not entirely valid. Comparisons should be interpreted with extreme caution.

**Figure 1. Race and ethnicity of people who were in hospital restoration or community restoration during the study period (2017-2022) and race and ethnicity of Oregon's statewide population, Oregon State Hospital, Oregon Health Authority, US Census Bureau.**




## Primary Language

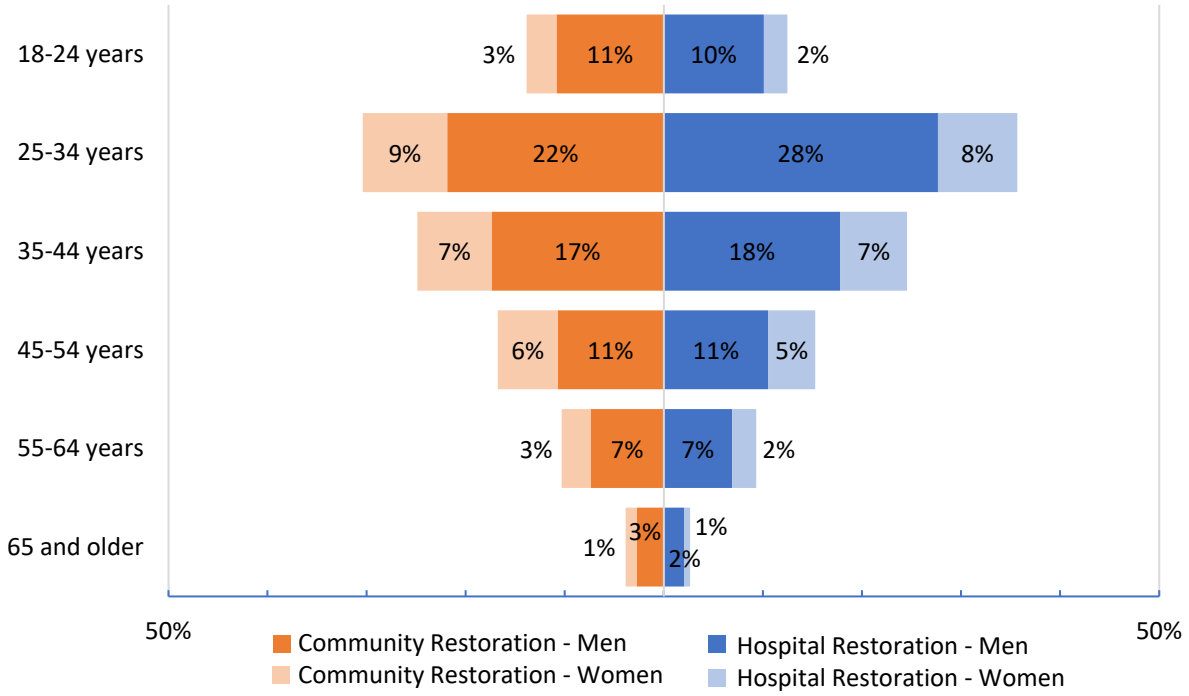
Information about primary language was not available for people who were in community restoration but was available for people who were in hospital restoration across all years of the study period (2017-2022). More than 95% reported English as their primary language and 2% reported their primary language was Spanish. Many other primary languages were reported, but not by more than a handful of people. These languages included: American Sign Language, Amharic, Arabic, Bosnian, Bulgarian, Burmese, Cambodian, Dutch, Estonian, French, Greek, Haitian Creole, Korean, Laotian, Mandarin (Chinese), Mien, Punjabi, Romanian, Russian, Somali, Swahili, Tagalog (Filipino), Tigrinya, Ukrainian, and Vietnamese.

## Age

We examined the ages of people in hospital and community restoration by gender. Men who were in hospital restoration between 2017 and 2022 were on average 37 years old at the time they were admitted,[6] with a median age of 34 years old. Men ranged in age from 18 to 83 years old. Women who were in hospital restoration averaged slightly older at 39 years old when they were admitted, with a median age of 37 years old. Women ranged in age from 18 to 81.

Men who were in community restoration between 2019 and 2022 were 38 years old on average, with a median age of 35 years old at the beginning of their first episode. Men ranged in age from 18 to 90 years old. Women who were in community restoration were older, with an average age of 40 years old and median age of 38 years old. Women in community restoration ranged in age from 18 to 74 years old. Figure 2 shows the percent of people in each type of restoration by gender and age group.

**Figure 2. People who were in hospital or community restoration during the study period (2017-2022) by gender and age group, Oregon State Hospital, Oregon Health Authority.**




[6] For people who were admitted to OSH for hospital restoration more than once between 2017 and 2022, only their age at the time of their first admission was included in our analysis.

## Educational Attainment

Information about people's education level was available in data we received from OHA's MOTS data source; therefore, we have this information for people who were in competency restoration and matched to a community-based behavioral health episode of care recorded in MOTS. Of the people who were in hospital restoration, 1,935 had community behavioral health treatment records in MOTS that preceded their hospital admission. Of the people who were in community restoration, 679 had records in MOTS that preceded their community restoration episode. Table 6 shows the highest grade level they had completed at the time of their most recent[7] episode of care with community-based behavioral health services prior to the start of competency restoration.

**Table 6. Highest grade level completed at the time of people's most recent episode of care with community-based behavioral health services prior to the start of their first hospital or community restoration episode during the study period (2017-2022), Oregon Health Authority.**

| Highest Grade Completed | Hospital Restoration (n=1,935 people) | | Community Restoration (n=679 people) | |
|---|---|---|---|---|
| | Count | Percent | Count | Percent |
| Less than grade 12 | 775 | 40% | 257 | 38% |
| Completed grade 12 | 844 | 44% | 314 | 46% |
| Completed grades 13-15 | 251 | 13% | 83 | 12% |
| Completed grade 16 | 48 | 3% | 20 | 3% |
| Completed grades beyond 16 | 17 | 1% | 5 | 1% |

[7] Defined as the MOTS record of community-based behavioral health services that occurred most recently relative to the start of their hospital or community restoration episode. The most recent community-based behavioral health services record was anywhere from a few weeks to a few years prior to the start of competency restoration. For the majority of people the most recent episode of care was within about two years. See Table 1 in the Methods section for more information.

As stated above and shown in Table 6, educational attainment is measured as the "highest grade completed" and is not aligned with specific educational degrees like a high school diploma or college degree. One assumes that a "highest grade completed" value of less than 12 indicates the person did not complete high school, but we cannot be sure that the person did not attain an alternative high school equivalency (e.g., a GED). The way the data are collected and reflected in MOTS creates challenges for interpretation. If a "highest grade completed" value of less than 12 does in fact indicate the person did not complete high school, then our data suggests that over one third of people who have experienced hospital or community restoration have less than a high school education. This is substantially different from the proportion of Oregon's statewide population who has less than a high school education, which is only about 13% among Oregonians who are 18 to 24 years old and around 8% for Oregonians who are 25 years and older.

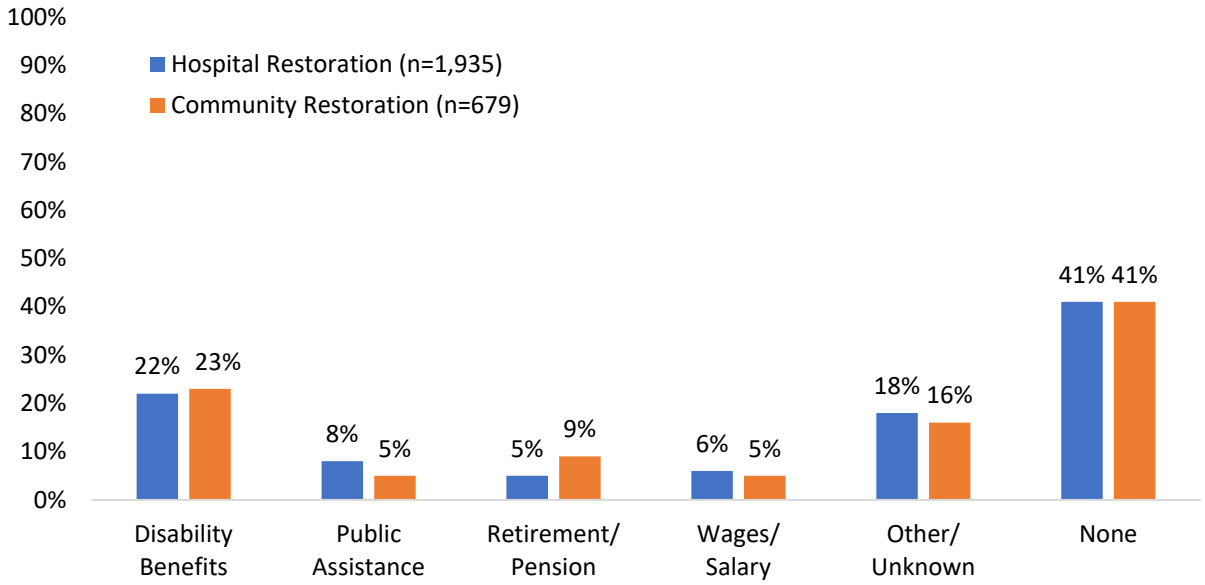
## Income Source

Like education level, information about people's income source was available in the data we received from MOTS. Figure 3 shows the income source for people who were in hospital or community restoration who matched to records in MOTS and had at least one episode of care for community-based behavioral health services prior to the start of competency restoration.

**Education Data**

Data on education for individuals who have been ordered to competency restoration is lacking potentially due to how it's recorded (and, presumably asked) during a person's first episode of care with community-based behavioral health services. The MOTS data dictionary asks practitioners to record the highest grade the person has completed. This approach may be effective up to high school but is confusing for completed years of education that are not "grade levels" (e.g., years of college or trade school) and does not necessarily equate with GEDs or high school equivalents. There is a wealth of evidence detailing the direct and indirect effects of educational attainment on people's employment opportunities, future income, and various health outcomes. A stronger measure of educational attainment is needed to better understand the experiences of people in competency restoration.

**Figure 3. Income source at the time of people's most recent episode of care with community-based behavioral health services prior to the start of their first hospital or community restoration episode during the study period (2017-2022), Oregon Health Authority.**



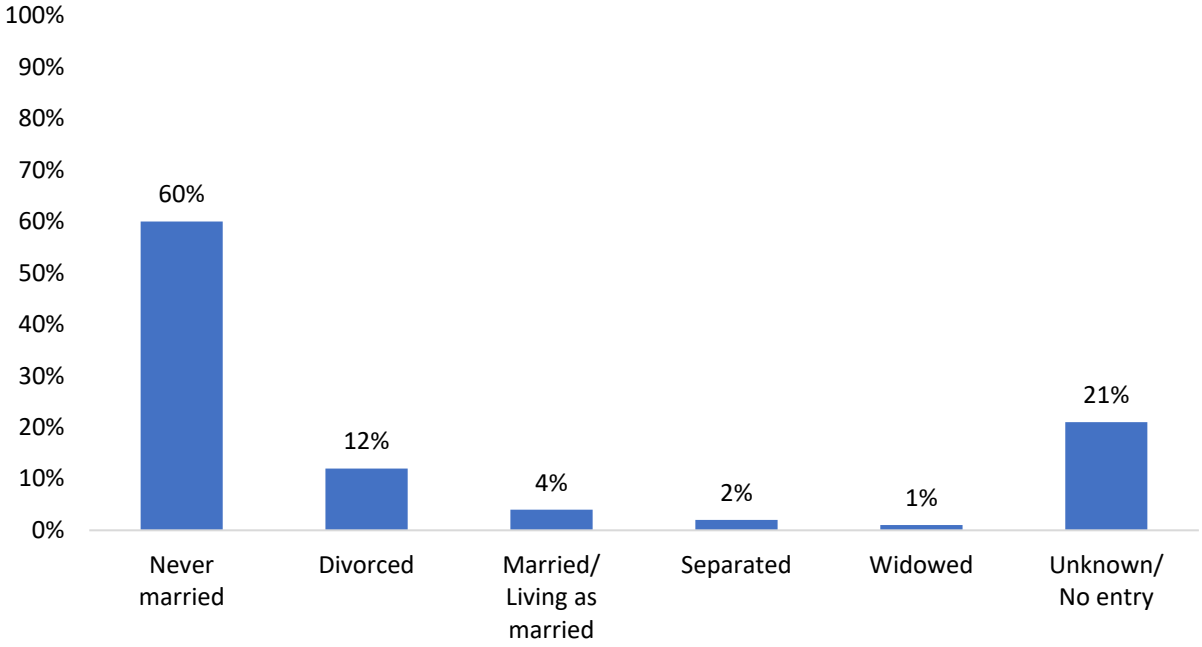

Nearly a quarter of people who were in hospital or community restoration reported social security disability benefits as their source of income. A few reported their income source was public assistance, others reported they relied on income from retirement or a pension, and a small percentage said they earned wages or a salary. For some, their income source was "other" or "unknown." Sadly, almost half of people in hospital and community restoration reported having no source of income at all.

## Marital Status

People's marital status is typically tracked by OSH but is not tracked by community mental health providers for people in community restoration.[8] Due to an oversight in our data request, we received information about the marital status only for people who were admitted to hospital restoration in 2017 and 2018. Figure 4 shows that the majority of these individuals reported they were never married.

[8] Marital status is a demographic variable that is also collected by community-based behavioral health providers using MOTS, but we did not receive this information from MOTS.

**Figure 4. Marital status of people who were admitted to hospital restoration in 2017 and 2018, Oregon State Hospital.**




# What has happened in the lives of people prior to entering competency restoration?

In this section we present findings from our quantitative and qualitative data related to people's lives and experiences leading up to competency restoration including what we learned about people's housing situations, their employment status, and the kinds of behavioral health issues they faced.

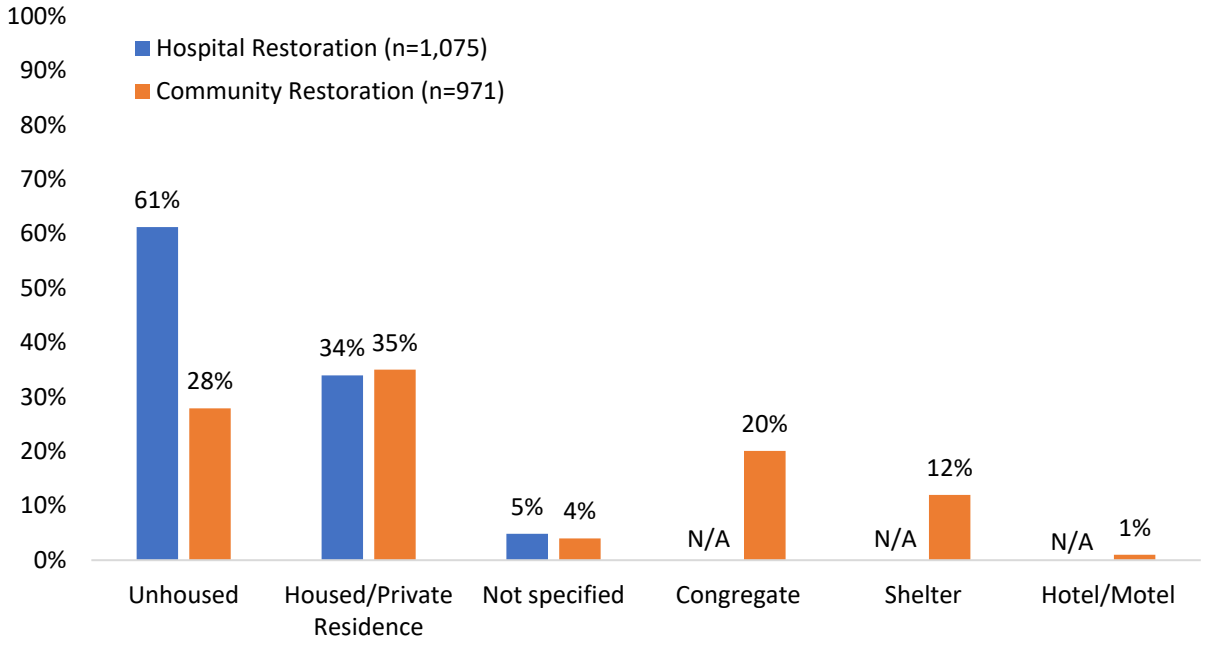
## Where were they living and what was their housing status?

Very early in the development of our scope of work and project direction, we learned that many subject matter experts were concerned about the significant housing challenges they observed among people who were in competency restoration. Subject matter experts indicated that people were likely to have been experiencing housing barriers and that houselessness was a frequent occurrence prior to people being ordered to competency restoration. Indeed, several subject matter experts suggested that some people's orders for competency restoration were the result of a criminal case that included charges related to their lack of housing (e.g., a trespassing charge because they were sleeping in a doorway). Subject matter experts' level of concern and the complexities of both housing and competency restoration motivated our exploration of these challenges in both the quantitative and qualitative data.

Quantitative data on people's housing situation or living arrangement is tracked by community mental health providers for those in community restoration. People's housing situation **prior** to

their admission to hospital restoration is not something that is usually tracked by OSH. However, prior housing status was one of the pieces of information that was gathered by an OSH staff person during a manual review of a limited selection of people in hospital restoration (see Table 1 in the Methods section for more information). Figure 5 shows the data we received on people's housing situation prior to their admission to OSH for hospital restoration between 2017 and 2018 and for people in community restoration between 2019 and 2022.[9]

**Figure 5. Prior housing situation among a limited selection of people who were admitted to hospital restoration in 2017 and 2018, compared to the housing situations of people who were in community restoration from 2019 to 2022, Oregon State Hospital, Oregon Health Authority.**




We are limited in our ability to interpret and compare the quantitative data on housing situation due to the lack of consistent information between the OSH and community restoration records. As shown in Figure 5, the housing status of people who were in community restoration was categorized into five types (unhoused, housed/private residence, not specified, congregate, shelter, and hotel/motel) and for people who were in hospital restoration there are only three types (unhoused, housed, and not specified). The OSH staff person who conducted the manual review of patients' records classified people's status as "unhoused" and "housed" based on the definition of homelessness regulated by the US Department of Housing and Urban

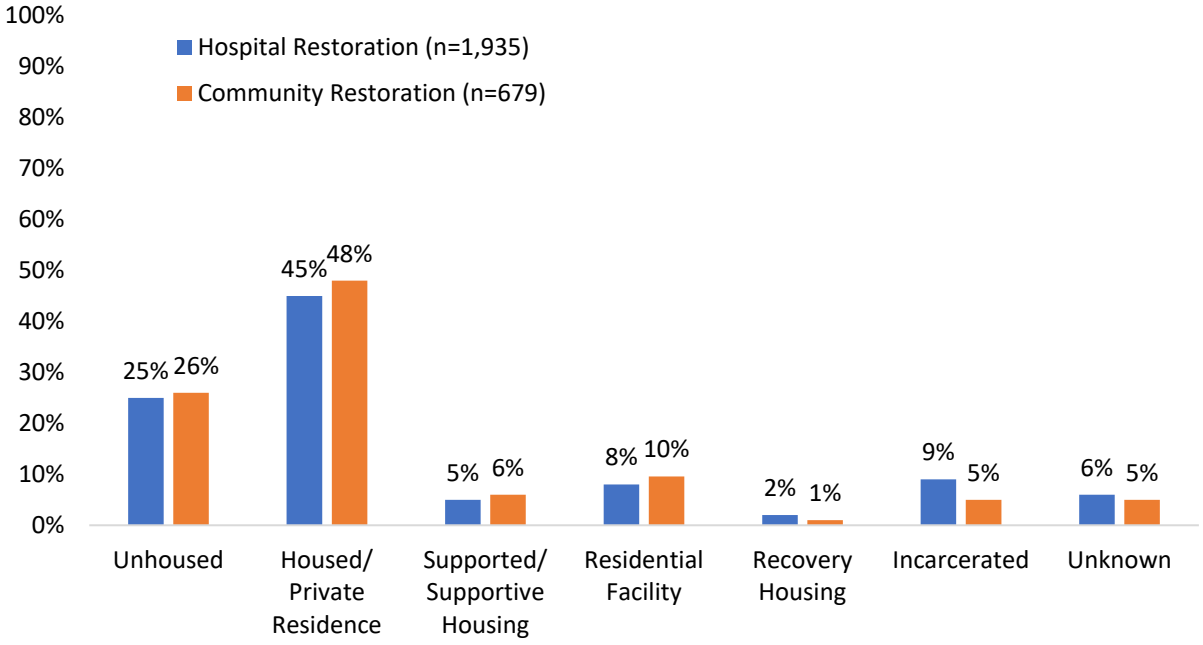
[9] For people who were admitted to OSH for hospital restoration more than once between 2017 and 2018 and people who had more than one community restoration episode between 2019 and 2022, only their housing situation recorded at the time of their first admission/episode was included in our analysis.

Development (HUD), and it is possible that the "unhoused" category in the community restoration records does not capture individuals who meet the same definition.

Depending on the individuals' circumstances, people whose housing situation was categorized in the community restoration records as "shelter" or "congregate" could be "unhoused" per HUD's definition, therefore it is difficult to compare the proportion of people in each type of restoration who were unhoused. What is notable, however, is that if the proportions of people in each of the "congregate," "shelter," and "hotel/motel" categories are added to the "unhoused" category in the community restoration data, the proportion is the same as the unhoused in the OSH data.

Information about people's housing situation or living arrangement is also collected by community-based behavioral health services providers and tracked in OHA's MOTS system, therefore we have additional quantitative data on housing for people in competency restoration who matched to MOTS records. Figure 6 shows the living arrangement reported by people at the time of their most recent episode of care with community-based behavioral health services prior to the start of competency restoration.

**Figure 6. Living arrangement at the time of people's most recent episode of care with community-based behavioral health services prior to the start of their first hospital or community restoration episode during the study period (2017-2022), Oregon Health Authority.**



Overall, more people reported having some kind of housing or shelter arrangement at the time of their most recent episode of care with community-based behavioral health services before starting hospital or community restoration. About one quarter of people in both groups reported being unhoused. Some of the MOTS housing categories are likely short-term arrangements (e.g., residential facility), which sometimes fall within HUD's definition of homelessness, therefore it is difficult to make assumptions about the permanency of people's housing situations based on this data.

While the qualitative data could not address *where* individuals undergoing competency restoration were living prior to their arrest, it did highlight the experiences of houselessness or housing instability prior to being arrested and entering competency restoration. While many people undergoing competency restoration may have been unhoused or unstably housed prior to being arrested, some may have had housing or been in some type of shelter or group home or family housing. Even if they were housed at the time of their arrest, housing may have been unstable for many individuals in this population. In some instances where the individual was technically sheltered at the time of arrest, they may still be classified as homeless. The stability of housing can impact the restoration process.

> *"There's a high need for low barrier housing. We talk about clients having blown out of everything. They've got too many evictions on their record, they've not been successful at a range of group homes that they've been in, so they end up with access issues and that unfortunately leaves them in these very marginal residential settings where they're still going to meet the federal definition of homelessness. They're housed, they're sheltered, they've got a roof over their head at the motel but they're still meeting that federal definition for unhoused."*
>
> *–CMHP staff, large county*

The experience of housing instability is very common for individuals undergoing competency restoration, even for individuals who may be identified as housed in the quantitative data. Individuals who were stably housed directly before entering competency restoration may have experienced housing instability or being unhoused at some point in their recent past.

> *"I would say that most of the individuals have had a period of houselessness. I'm not saying that they were homeless or were without shelter, right before. Most have had some type of situation where they did not have an apartment or home and they were living on the street or in a tent or in some type of shelter situation."*
>
> *–OSH staff*

Interview data emphasized how experiences of homelessness can increase the likelihood that someone is arrested and subsequently enters the competency restoration process. Research has shown that individuals with behavioral health issues who are unhoused are more likely to interact with the criminal justice system than those who are stably housed (Roy, Crocker,

Nicholls, Latimer, & Ayllon, 2014). Participants supported that some charges were a direct result of interaction with law enforcement attempting to move unhoused individuals, rather than a premeditated crime.

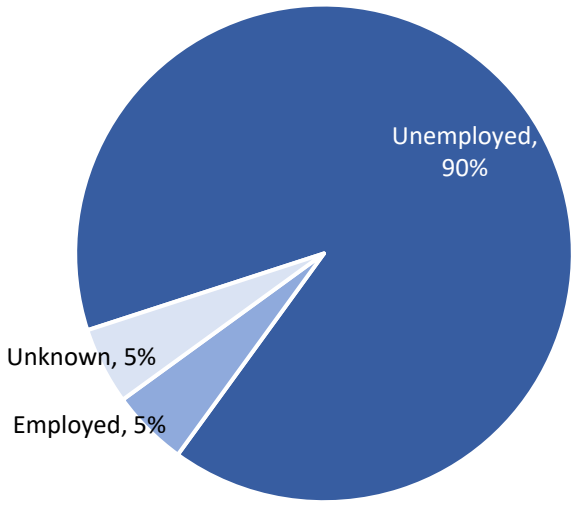
> *"We will talk about how we see a sweep and think, "Oh, they cleaned out a homeless camp." The patients are obviously symptomatic, and they arrested them. Of course, they resisted arrest. That's very common especially if you're paranoid and many patients have delusions about the military and police. They fight and then they go from sleeping on the street to getting a felony for assaulting a police officer. I know that police officers shouldn't be assaulted but tacking that charge on to someone who is psychotic just seems like piling it on."*
>
> *–OSH staff*

## What was their employment status prior competency restoration?

Employment plays an important role in people's overall health and wellbeing. Many aspects of being employed (e.g., job security and financial stability) can be beneficial for people's health, whereas being unemployed can often be harmful for people's health. Evidence suggests people who are unemployed are likely to report feeling depressed and anxious and experience lower self-esteem and even physical pain. Unemployment is also associated with increased frequency of stress-related illnesses like high blood pressure, stroke, and some heart conditions. The employment status of people who are ordered to competency restoration is an important feature of their backgrounds and experiences.

People's employment status is not information that is typically tracked by OSH or community mental health providers for people in competency restoration. However, we received information about the employment status of a limited selection of people in hospital restoration whose records were accessed as part of a manual review by an OSH staff person (see Table 1 in the Methods section for more information). Figure 7 shows that the overwhelming majority of people admitted to hospital restoration in 2017 and 2018 were not employed prior to their admission.

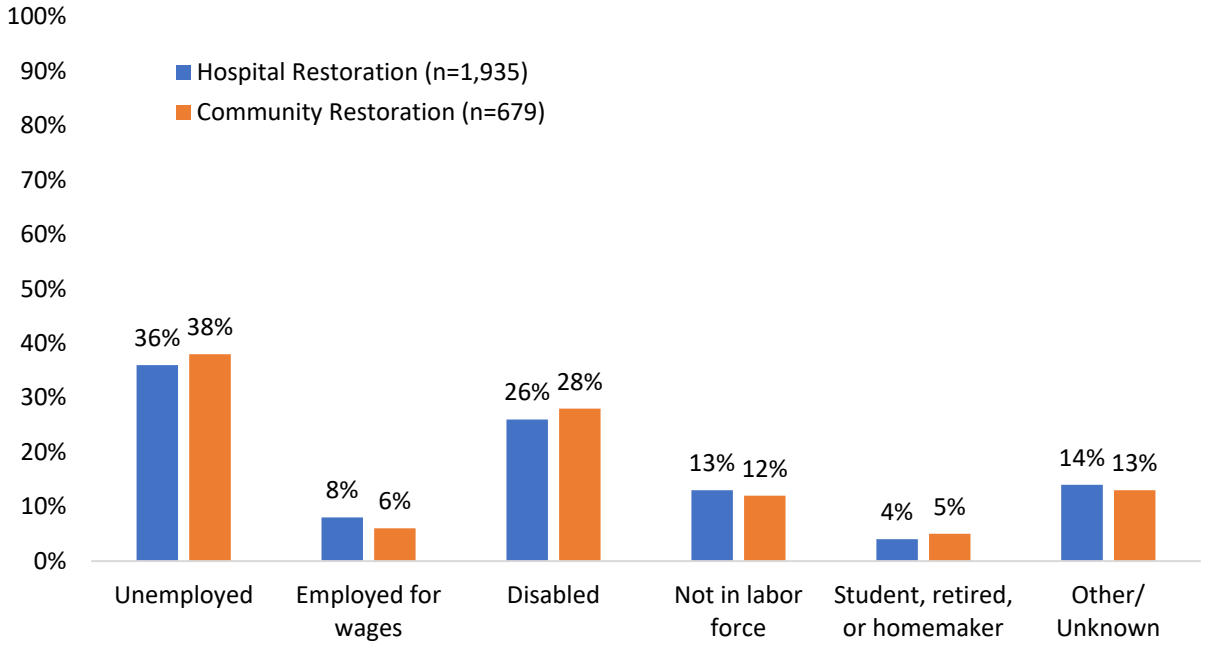
**Figure 7. Employment status of a limited selection of people who were admitted to hospital restoration in 2017 and 2018, Oregon State Hospital.**




Information about people's employment status is regularly tracked in the MOTS

system by community-based behavioral health services providers, therefore we have additional quantitative data on employment status for people in competency restoration who matched to MOTS records. Figure 8 shows what people reported for their employment during their most recent episode of care with community-based behavioral health services prior to the start of competency restoration.

**Figure 8. Employment status at the time of people's most recent episode of care with community-based behavioral health services prior to the start of their first hospital or community restoration episode during the study period (2017-2022), Oregon Health Authority.**




The proportion of people whose most recent MOTS record indicates they were unemployed prior to the start of either hospital or community restoration appears smaller than the data reported for the limited selection of OSH patients in Figure 7. However, the additional employment-related categories present in the MOTS data makes it difficult to compare the two figures. The detail in the MOTS data suggests people's employment status may be more nuanced prior to the start of competency restoration, and that the reasons people are potentially unemployed (e.g., due to disability or seeking opportunities and losing connections) are important to consider. The interview data provided that nuance and additional context for how employment fit into the backgrounds of people entering restoration.

> *"He just wanted a life. He came out here because of a girl who came out here from [the Southeast] to the coast. He loved it. He was working on a dock. He loved using his muscles and working in the outdoors."*
>
> *–Non-state agency staff*

*"I first worked under a guy named XX. He was teaching me how to spray with a pressure washer, so they said my work was good all through it. I wasn't late one time. And then I got another job, $14 an hour, 10 hours a day. The guy said, "If you keep this up we're going to keep you." So they planned on keeping me. But during that time, I stopped taking my medication again."*

*–Person with lived experience*

## What were their behavioral health issues prior to entering competency restoration?

Many individuals undergoing competency restoration were experiencing severe behavioral health issues prior to entering restoration, and it was not uncommon for individuals to be experiencing multiple issues or diagnosed with multiple disorders. Issues included severe and persistent mental illnesses (SPMI) such as schizophrenia and bipolar disorder; post-traumatic stress disorder (PTSD); substance and alcohol use disorders; and other neurocognitive and neurodevelopmental disorders like traumatic brain injuries (TBI), developmental disabilities (DD) and dementia.

*"I would say that I agree with the SPMI diagnosis of at least 75% of the people in this process. So something like schizophrenia, schizo-effective, bipolar, something with a psychotic feature element in it. So unhoused, have an SPMI."*

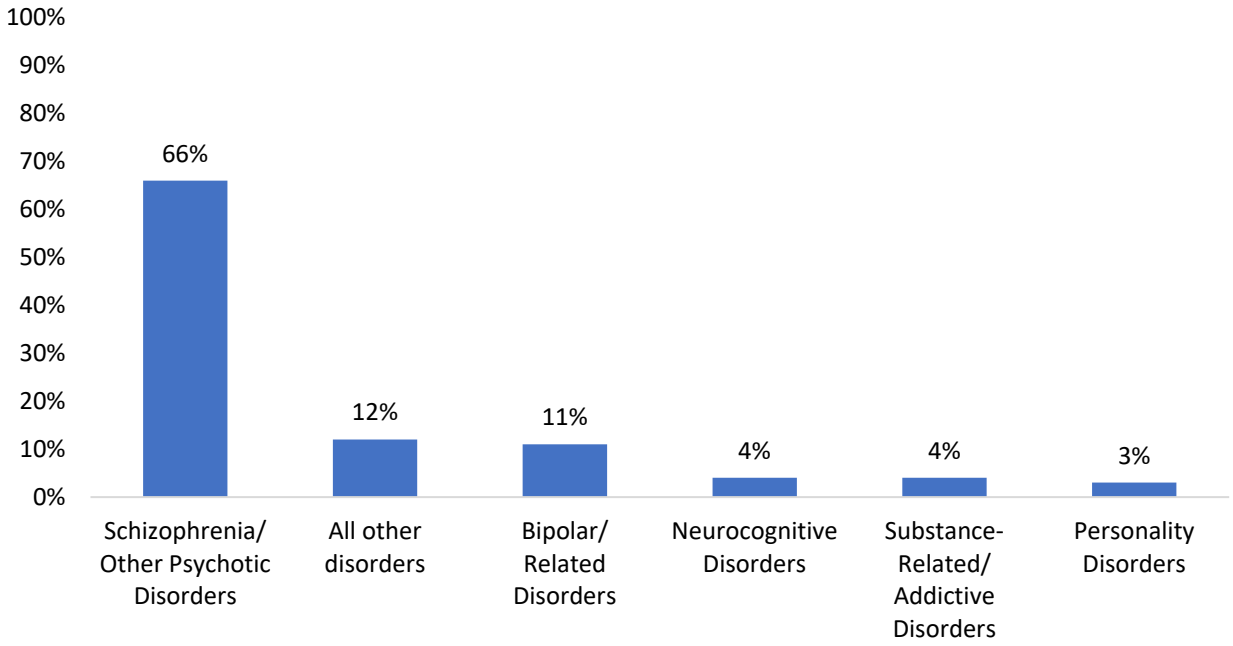
*–CMHP staff, large county*

The wide range of behavioral health issues people are facing when they enter competency restoration is important to consider because services and programming may need to be tailored to address the vastly different needs for this population. Expectations and outcomes may vary for the different groups going through competency restoration. In addition, some of the individuals entering competency restoration may never have been previously diagnosed or received behavioral health treatment services.

The quantitative data on behavioral health diagnoses that we received from OSH corroborates what was reported during interviews. Figure 9 shows data from OSH on primary diagnoses for people admitted for hospital restoration between 2017 and 2022.[10]

[10] For people who were admitted for hospital restoration more than once between 2017 and 2022, we report the primary diagnosis recorded at the time of their first admission during that period.

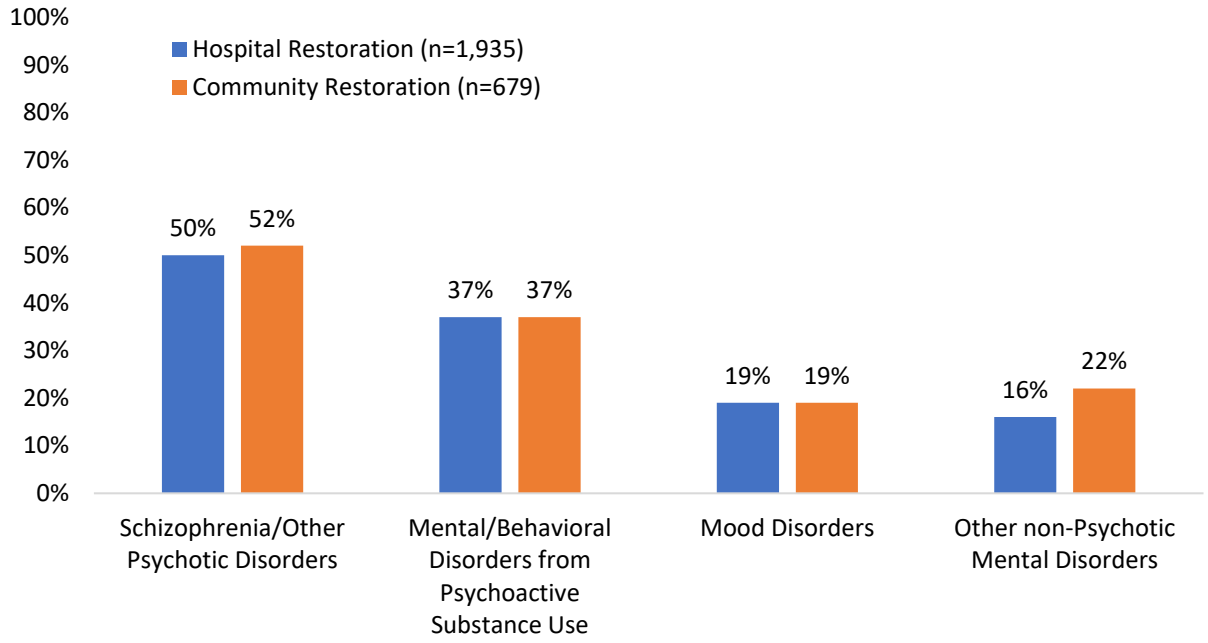
**Figure 9. Primary diagnosis for people who were admitted to hospital restoration at the time of their first admission during the study period (2017-2022), Oregon State Hospital.**




By far, the most frequent primary diagnosis among people who were in hospital restoration was schizophrenia or other psychotic disorders. Others had a primary diagnosis of bipolar or other related, non-psychotic disorders. Less than five percent each had primary diagnoses that were substance-related or addictive disorders, neurocognitive disorders, or personality disorders.

We also received quantitative data from MOTS related to the behavioral health issues and diagnoses of those who were in hospital or community restoration who had previous community-behavioral health services records. Unlike the data from OSH, the data from MOTS includes all behavioral health diagnoses and does not designate any one diagnosis as primary. Figure 10 displays the most frequent behavioral health diagnoses that were recorded at individuals' most recent episode of care with community-based behavioral health services prior to entering hospital or community restoration. Most individuals had more than one diagnosis in their records, therefore the sum of all categories exceeds 100%.

**Figure 10. Behavioral health diagnoses at the time of people's most recent episode of care with community-based behavioral health services prior to the start of their first hospital or community restoration episode during the study period (2017-2022), Oregon Health Authority.**

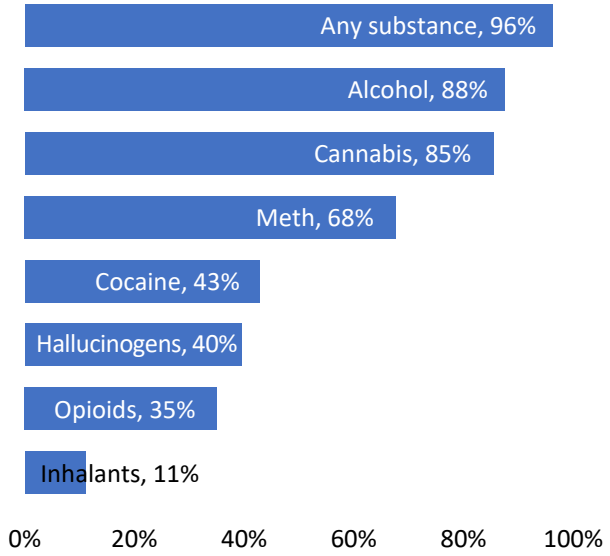



Since the data from MOTS includes information about all co-occurring diagnoses (not just primary diagnoses), we are able to see the frequency with which people who were in competency restoration were likely to have been dually diagnosed with a substance use disorder as well as mental health challenges. A little more than one third of people who were in hospital or community restoration had a co-occurring substance use disorder at their most recent episode of care with community-based behavioral health services prior to being ordered to restoration during the study period.

Co-occurring substance use is captured in the quantitative data for the limited selection of people admitted to hospital restoration between 2017 and 2018, but not as diagnoses. During the OSH staff person's manual review of records for this group, they found that 1,034 of the 1,075 or 96% had a documented history of substance use issues. Figure 11 shows that most individuals had problematic histories with alcohol and cannabis, and many people also had issues with meth, cocaine, hallucinogens, opioids, and inhalants.

The prominence of substance use disorders among people who have been in competency restoration was raised throughout our interviews. Many interviewees identified this as the most common behavioral health issue among this population.

**Figure 11. Substance use histories of a limited selection of people who were admitted to hospital restoration in 2017 and 2018, Oregon State Hospital.**




> *"It's the rare client that does not have a serious active substance use disorder."*
> *–CMHP staff, large county*

Substance use (including alcohol) was regularly discussed as one of the causes of the increase in the number of people going through competency restoration over the past few years. When we discussed the pressures facing competency restoration at the local and state level, interviewees focused on methamphetamine and alcohol in particular, and how those specific substances interacted with untreated mental illness to impact people going through restoration. One county tracked background issues for people entering their accelerated evaluation process for competency restoration and discussed the high rates of substance use disorders.

> *"It seems like we still don't want to acknowledge drugs and alcohol and how they're affecting our .370 population. I do know, at least here in [this] County, the data I have is that 86% of the people going through our RAPID docket have drugs and alcohol addictions."*
> *–CMHP staff, large county*

Many individuals entering competency restoration are in a state of active psychosis, and this is sometimes exacerbated by substance use or even directly caused by substance use. Several

interviewees discussed the common occurrence of substance-induced psychosis among this population, when first entering the competency restoration process.

> *"We always look at the substance history. It's almost like a given. The person is more likely to have some substance use that is contributing to their active psychosis."*
> *–OSH staff*

The interaction of substances and mental health issues makes it challenging to identify what issues individuals might be experiencing, so some jurisdictions mention they withhold behavioral health medication until it is easier to differentiate between substance-induced psychoses and some other ongoing mental health issue. Interviewees referred to this process as a "drying out" period that often takes place while the individual is in jail.

> *"...the attorneys may give it a day or two, or weekend, you know. "Hey, let's give them a few days and see if they're clearing up in jail," have another conversation with them and then decide, do I still think there's a mental health issue here, or were they just experiencing some use issues."*
> *–State agency staff, large county*

This drying out period varied in duration. Some jurisdictions waited a month before medicating individuals who they suspect of experiencing drug-induced psychosis. If an individual required medication to stabilize, this period of withholding may contribute to further decompensation.

## What systems had people interacted with prior to competency restoration?

In the final section of this chapter, we report findings from our quantitative and qualitative data related to the systems and services that people encountered in their lives, including law enforcement and the courts, behavioral health treatment services, and public benefit programs.

### Were they previously known to law enforcement?

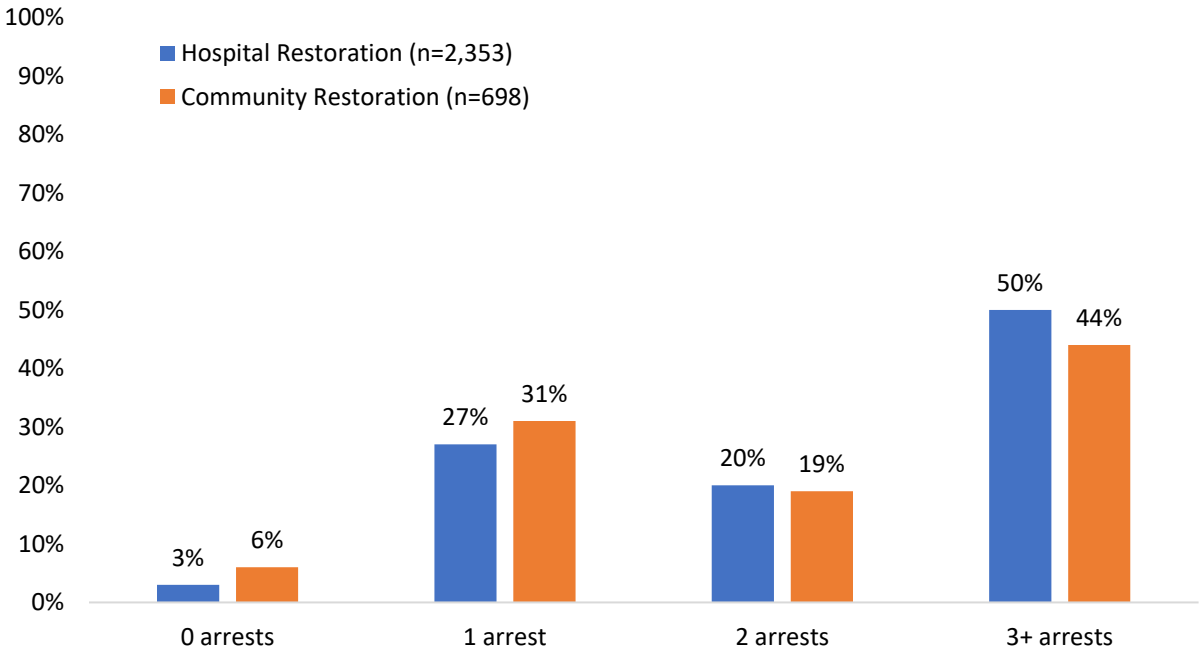
Both our quantitative and qualitative data suggested that it was not uncommon for individuals in competency restoration to have been previously known to law enforcement. Many individuals undergoing competency restoration have been previously arrested and/or charged with prior offenses; some may have gone through the restoration process before.

*"...the vast majority of them are people that the crisis team has had frequent interactions with, law enforcement has had interactions with, have been through the aid and assist program or through mental health court or jail diversion or something before. The vast majority of them, their names are pretty familiar."*
*–CMHP staff, large county*

We received quantitative data related to people's previous arrests, criminal charges and dispositions (e.g., convictions), and jail, prison, and probation sentences that occurred in Oregon. Data on the arrest histories for people who were in hospital or community restoration were received from the Law Enforcement Data System (LEDS) through a data sharing agreement with the Oregon Criminal Justice Commission (CJC). Arrest data were available for people in our study population who had a State Identification Number (SID number), which is typically acquired when someone is arrested and fingerprinted in Oregon. CJC found SID numbers for 2,353 out of 3,086 (76%) people who were in hospital restoration during the study period, and for 698 out of 971 (72%) people who were in community restoration during the study period. Arrest data included the number and types of arrests during the 3 years leading up to the start of the person's first hospital or community restoration episode during the study period.

Of the 2,353 people who were in hospital restoration and had a SID number, 2,283 (97%) experienced at least one arrest in the 3 years prior to their first admission during the study period. Among the 698 people who were in community restoration and had a SID number, 659 (94%) were arrested at least once in the 3 years leading up to their first episode during the study period. Figure 12 shows that most people experienced frequent arrests, with the majority having three or more in the 3 years leading up to the start of their first hospital or community restoration episode. Half of the people who were in hospital restoration were arrested at least three times prior to being admitted, and nearly half of people in community restoration were arrested at least three times before the start of their first episode.

**Figure 12. Number of times people were arrested in up to 3 years prior to the start of their first hospital or community restoration episode during the study period (2017-2022), Oregon State Police.**




From the qualitative data we learned that, in some cases, the jail and court systems can become familiar with an individual through multiple arrests and encounters before they are identified as possibly being incompetent to stand trial. Many of the individuals who have interacted with law enforcement or been previously arrested, may have also had previous restoration episodes as well. One respondent drew a direct connection between law enforcement interaction and recurring competency restoration episodes. This provider recounted that some OSH patients are encouraged to relocate given their long history with local law enforcement.

> *"I've worked with so many individuals. In fact, I'm working with an individual on my unit currently and I've worked with him four separate times within the last year. It's a revolving door. "Hello again. What brought you in this time?" Again, part of this is choice. I try to set things up, "What do you need to not come back here again? Is there something you need in the community? Do you maybe need to be in a different area?" Sometimes, you live in the area for a long time and the law enforcement legal system knows that individual very well. It's like a target on their back. We sometimes recommend maybe living someplace else. That might not be a bad idea."*
>
> *–OSH staff*

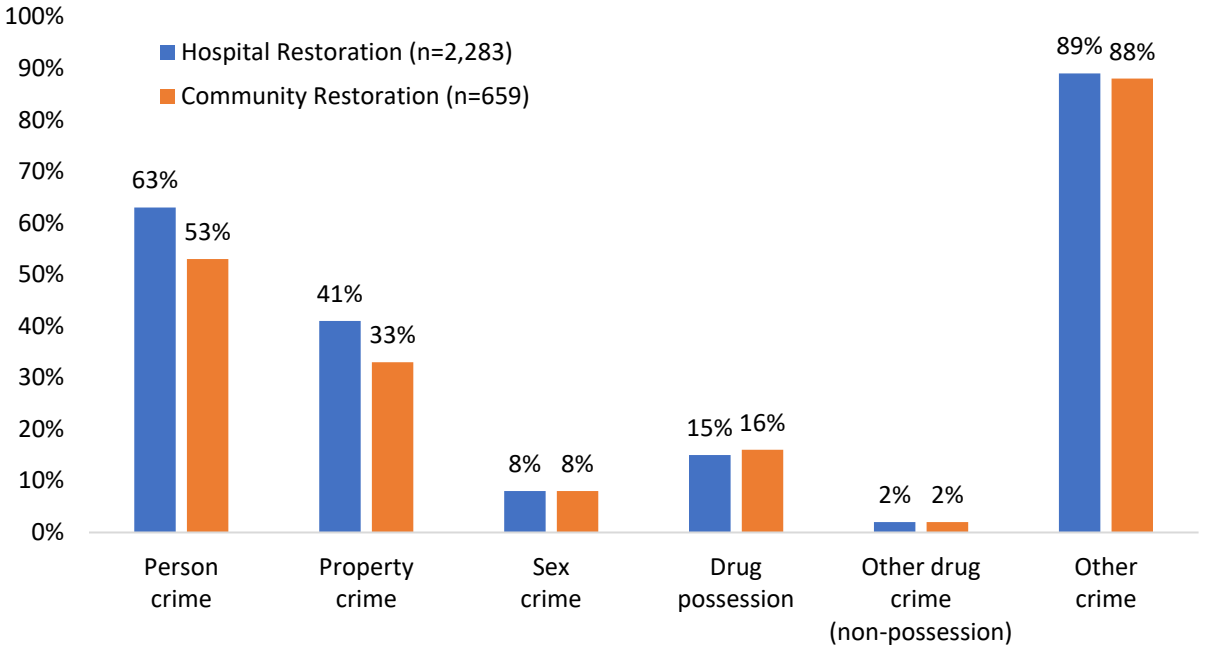
Conversely, participants also offered examples of individuals who were completely unknown to law enforcement prior to being arrested and entering hospital restoration.

*"One of them is a man in his early 60s who prior to this hospital admission, hadn't been hospitalized since the mid-90s. Since that time, he has been working for one of the county library systems, delivering books and has been employed. He has been on his medications for decades and was totally stable and fine. He was living with a mother who then developed dementia and subsequently died. He was seeing a psychiatrist in private practice and then eventually talked the psychiatrist into lowering medication doses. The mother had died, and she wasn't there anymore. Long story short, this guy went off his meds became extremely psychotic living in his own house in a rural property in X County. This resulted in his sister and county workers coming to his place and him firing on them with a pistol and the SWAT team extracting him from the house and doing great damage to the house. That's an example of someone who's been employed, not homeless at all, no criminal history, and he's a very sweet man who probably also has some form of autism in addition to schizophrenia."*

*–OSH staff*

We also received information about the types of criminal offenses for which people in competency restoration were most often arrested. Figure 13 displays all the crime types for which people were arrested in the 3 years leading up to hospital or community restoration (a person can be charged with more than one type of crime on a single arrest so total is more than 100%). Data indicated that about 50-60% of arrests were related to person crimes and between 30-40% of arrests were related to property crimes. About 15% of arrests were for drug

**Figure 13. Types of offenses people were arrested for in up to 3 years prior to the start of their first hospital or community restoration episode during the study period (2017-2022), Oregon State Police.**



possession,[11] and 2% were for other drug crimes. Less than 10% of arrests for people who were in community restoration or hospital restoration were related to sex crimes.

The arrest data shown in Figure 13 indicates that people who were arrested before going through hospital or community restoration were most frequently arrested for crimes in the "other" category during the 3 years before they were ordered to competency restoration. Within this category, the most common offenses included Trespass 2 (ORS 164.245), Disorderly Conduct 2 (ORS 166.025), Harassment (ORS 166.065), and Resisting Arrest (ORS 162.315).

The quantitative data we received related to people's previous criminal charges supplements the data on previous arrests. Criminal charge data were available for people in our study population who matched to the Oregon Judicial Department's records using name, date of birth, and SID number (for people who had a SID number). Of the 3,086 people who were in hospital restoration during the study period, 2,782 (90%) matched and had criminal charges that preceded their admission for hospital restoration. Of the 971 people who were in community restoration during the study period, 836 (86%) matched and had criminal charges that preceded the start of community restoration. We received data on people's criminal charges dating back as early as the mid-1980's, however the overwhelming majority of people did not have criminal charge records until 2015 or later.

Table 7 shows information about the criminal charge histories of the people who were in hospital restoration or community restoration and matched to the OJD data. People who were in hospital restoration and people who were in community restoration had very similar criminal charge histories. On average, both groups had 6 criminal cases (median = 3) filed against them prior to the first time they were admitted to hospital restoration or community restoration during the study period. Both groups averaged similar numbers of prior charges for any offense, prior charges for each type of offense, and counts of prior convictions and dismissed charges. Compared to people who were in hospital restoration, people who were in community restoration averaged one less felony and misdemeanor charge and one less charge for person-based offenses. People who were in community restoration also averaged one less conviction and one less dismissed charge. On average, both groups had a higher number of dismissed charges than convictions.

[11] The prevalence of arrests for drug possession may have been impacted by the implementation of Measure 110 which decriminalized most unlawful possession of a controlled substance offenses in Oregon. Measure 110 went into effect in February 2021, partway into our project's study period (2017-2022).

**Table 7. Summarized information about people's criminal cases and charges prior to the start of their first hospital or community restoration episode during the study period (2017-2022), Oregon Judicial Department.**

| | Hospital Restoration (n=2,782 people) | Community Restoration (n= 836 people) |
|---|---|---|
| Average number of prior **criminal cases** *(SD)* | *6 (8)* | *6 (9)* |
| Median prior criminal cases | *3* | *3* |
| Average number of prior **criminal charges, any offense** *(SD)* | *12 (16)* | *11 (16)* |
| Median prior criminal charges | *7* | *5* |
| Average number of prior **felony charges** *(SD)* | *3 (5)* | *2 (5)* |
| Median prior felony charges | *1* | *0* |
| Average number of prior **misdemeanor charges** *(SD)* | *9 (12)* | *8 (13)* |
| Median prior misdemeanor charges | 5 | 4 |
| Average number of prior **charges for person offenses** *(SD)* | 4 *(5)* | 3 *(4)* |
| Median prior person offense charges | 2 | 1 |
| Average number of prior **charges for property offenses** *(SD)* | 3 *(5)* | 3 *(6)* |
| Median prior property offense charges | 1 | 0 |
| Average number of prior **charges for statutory offenses** *(SD)* | 5 *(8)* | 5 *(9)* |
| Median prior statutory offense charges | 2 | 2 |
| Average number of prior **convicted charges** *(SD)* | 5 *(7)* | 4 *(7)* |
| Median prior convicted charges | 2 | 2 |
| Average number of prior **dismissed charges** *(SD)* | 7 *(9)* | 6 *(9)* |
| Median prior dismissed charges | 4 | 3 |

Our qualitative data suggests that many criminal charges faced by individuals entering competency restoration in Oregon are linked to being unhoused or housing instability. These charges often result from low-level "crimes of survival or houselessness" like urinating in public, disorderly conduct, trespassing, theft, and littering. Participants indicated that individuals who were homeless before entering competency restoration were more likely to be arrested for these types of charges.

> *"What we see with the homeless population are charges related to being homeless such as criminal trespass or theft. When we see "unauthorized use of a motor vehicle," it's because somebody climbed into what looked like an abandoned car to sleep. These aren't hardened criminals. They are grossly disorganized or psychotic people that are homeless. The housing situation in this county is really bad. I know it's bad everywhere in Oregon."*
>
> *–CMHP staff, large & small counties*

Additionally, unhoused individuals may be previously known to law enforcement before having committed any crimes. In some cases, interaction with law enforcement is what leads to the individual being charged with a crime such as resisting arrest or assaulting an officer.

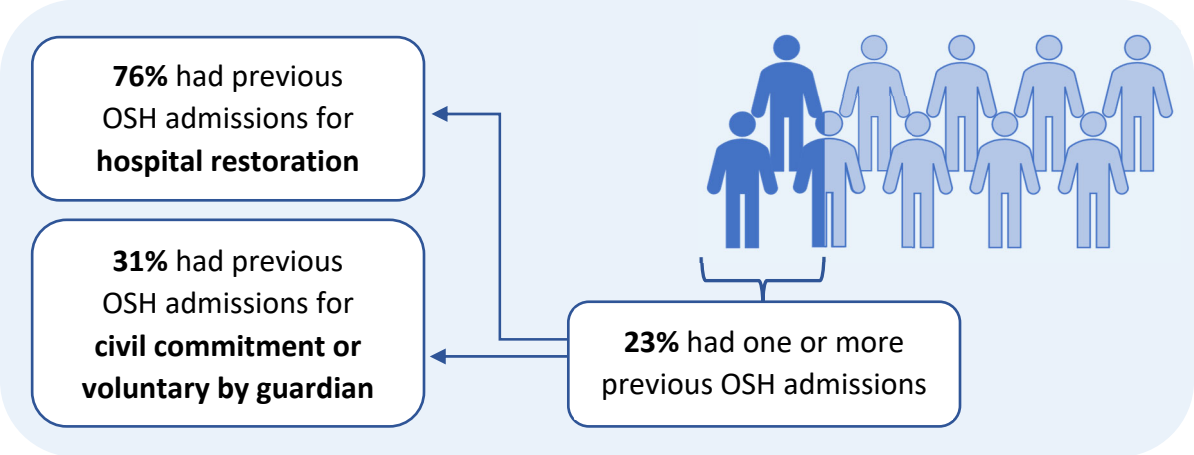
> *"There'd be a guy that was sort of camping out on the trail or under one of the overpasses for the trail or something. Neighbors complain about him. Cops know he is there. Cops go to check on him in mid to late November, because the temperature is starting to drop. They go in, they offer him a ride to the shelter or something like that. But because he's mentally ill, he sees two cops coming down and he gets defensive. He throws a beer bottle at them. Now he has an assaulting an officer charge. That's a felony and he's going to the hospital."*
>
> *–OSH staff*

## What do we know about their behavioral health treatment history?

We did not receive complete behavioral health treatment records for all people in competency restoration. For people who were in hospital restoration we received quantitative data on their previous admissions to OSH dating back to 1971. Information about their previous admissions for hospital restoration, civil commitment, and voluntary commitment by a guardian are presented in Figure 14.

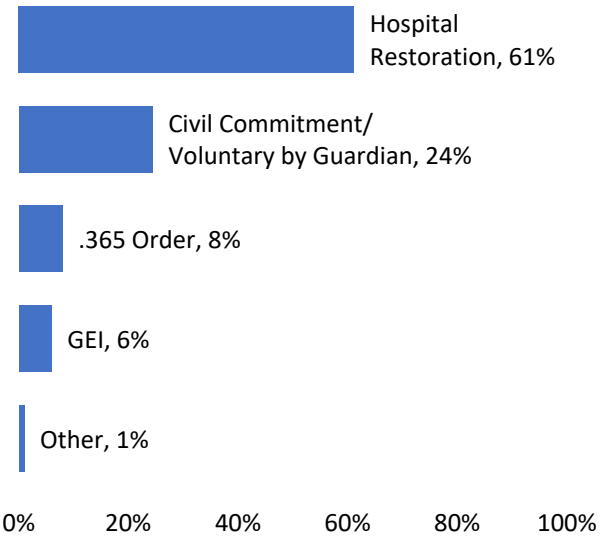
Of the 3,086 people who were in **hospital restoration** during our study period, 713 or 23% had at least one previous admission to OSH for any reason. More than three quarters of these individuals had one or more previous admissions for hospital restoration, and about one third had one or more previous admissions for either civil commitment or voluntary commitment by a guardian.

**Figure 14. Admissions for hospital restoration, civil commitment, and voluntary commitment by a guardian that occurred prior to the first time people were admitted to hospital restoration during the study period (2017-2022), Oregon State Hospital.**




For most of the individuals who were in hospital restoration and had previous OSH admissions, their most recent admission had also been for hospital restoration. Figure 15 shows that 61% of those who had previous OSH admissions were most recently admitted for hospital restoration. About 24% were at OSH for hospital restoration after most recently being admitted for civil commitment or voluntary commitment by a guardian, and about 6% had most recently been admitted for Guilty Except for Insanity (GEI). For about 8% their most recent hospital admission was for a court-ordered forensic evaluation, also known as a ".365 order."

**Figure 15. Type of most recent admission to the state hospital prior to the first time people were admitted to hospital restoration during the study period (2017-2022), Oregon State Hospital.**

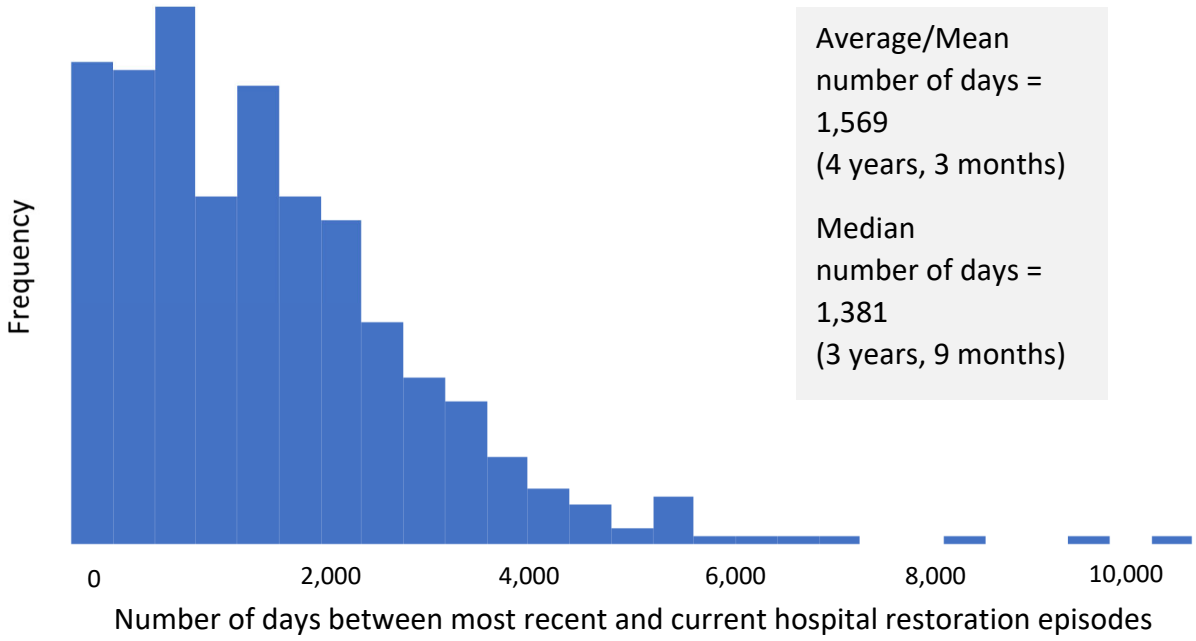



Throughout the development of our project and during interviews with OSH and CMHP staff, we heard concerns raised about the perceived rate at which people seemed to be readmitted to OSH for hospital restoration after being recently discharged from hospital restoration. Some wondered whether people who were discharged after being found competent were decompensating in jail or the community while waiting for their criminal trial

or case to proceed. Then, when their case was ready, they were found incompetent again and ordered back to OSH for further restoration.

To test this perception, we looked at the 481 people who were in hospital restoration during our study period whose most recent OSH admission had also been for hospital restoration. We calculated the time between their most recent admission's discharge date and their current admission's start date. Figure 16 shows the average (mean) and median number of days between the most recent and current hospital restoration episodes as well as the distribution.

**Figure 16. Distribution, average (mean), and median number of days between people's most recent admission to hospital restoration and their first admission to hospital restoration during the study period (2017-2022), Oregon State Hospital.**




On average, the data indicated that there were 1,569 days (about 4 years and 3 months) between the most recent discharge from hospital restoration and their current readmission to hospital restoration. The median length of time was roughly 6 months less, at 1,381 days or about 3 years and 9 months.

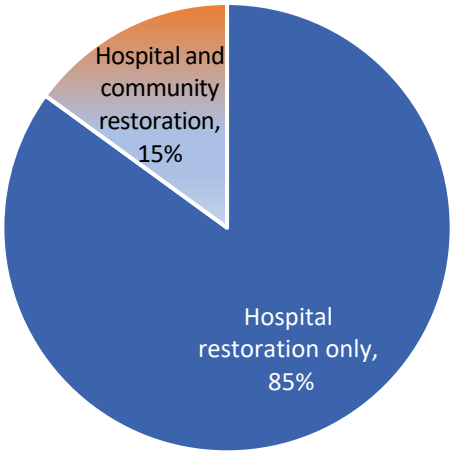
At the suggestion of OSH staff, we further examined the number of people who had been readmitted to hospital restoration within 60 days of being discharged from hospital restoration. The assumption was that if a person was readmitted within 60 days, it was possible that their readmission was for the same criminal charges and court order, which may confirm the suggestion that people were returning to OSH for hospital restoration after decompensating in

jail. The data indicated that for the overwhelming majority of people (98%), their most recent discharge from hospital restoration was more than 60 days prior to their current admission.

At best, this test was a crude estimation of whether people are readmitted to hospital restoration for the same criminal charges or court order potentially due to decompensating in jail after being found competent. Including the collection of this information in future data systems should be considered.

As noted earlier in the section of the Methods chapter on the limitations of our quantitative data, the project team experienced significant challenges combining the hospital and community restoration datasets. Despite these challenges, we were at least able to determine whether people who were in hospital restoration also experienced community restoration at any time during the study period. Senate Bill 24 was enacted in 2019 with the intent to "reduce the number of defendants committed to OSH and to increase community treatment and supervision of defendants." Figure 17 shows that 478 or 15% of the 3,086 people who were in hospital restoration during our study period also experienced community restoration at some point between 2019 and 2022.

**Figure 17. Percent of people who were in hospital restoration during our study period (2017-2022) who experienced hospital restoration only or both hospital and community restoration, Oregon State Hospital, Oregon Health Authority.**




We received additional quantitative data on people's histories of community-based behavioral health services from MOTS. Figure 18 indicates that 1,985 out of 3,086 (63%) people who were in hospital restoration during the study period had records of one or more episodes of care in community-based behavioral health services prior to their hospital admission. Among these individuals, an average of 4 years and 7 months transpired between their first known episode of care in community-based behavioral health services and their

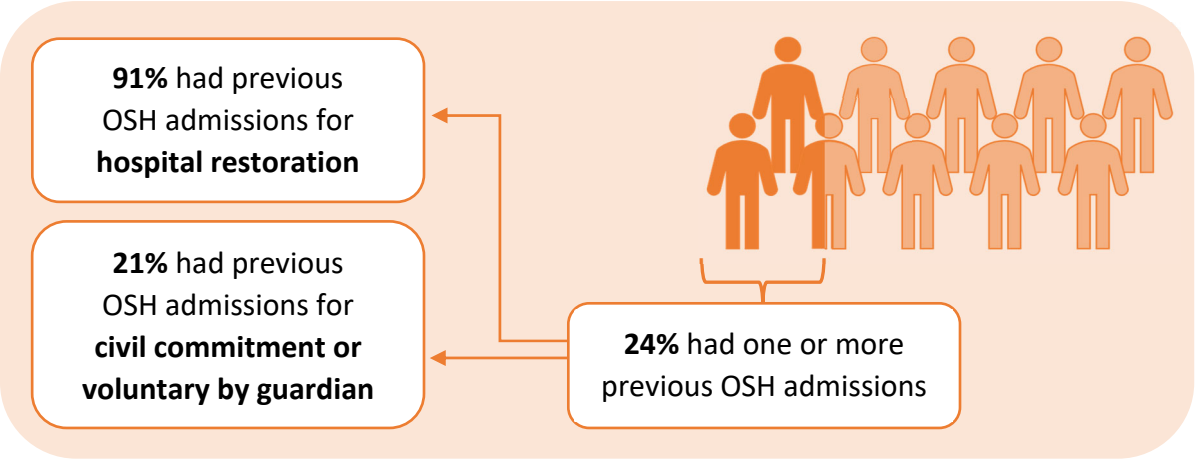
**Figure 18. Information about episodes of care with community-based behavioral health services prior to the first time people were admitted to hospital restoration during the study period (2017-2022), Oregon Health Authority.**

| | |
|---|---|
| 63% | Percent of people in hospital restoration who had previous episodes of care with community-based behavioral health services |
| 4 years, 7 months | Average number of years between people's first community-based behavioral health services episode of care and first admission for hospital restoration in our study period |
| 82% | Percent of people who had more than one episode of care with community-based behavioral health services before hospital restoration |

first admission for hospital restoration during our study period. More than 80% of people who experienced community-based behavioral health services prior to hospital restoration had records of more than one episode of care.

For people who were in **community restoration**, we were able to determine whether they had any prior admissions to OSH dating back to 1971 for hospital restoration, civil commitment, and voluntary commitment by a guardian. Figure 19 shows that of the 971 people who were in community restoration during the study period, 234 or about 24% had at least one admission to OSH before their first episode of community restoration. Of these individuals, 91% had one or more OSH admissions for hospital restoration and 21% had one or more admissions for civil commitment or voluntary commitment by a guardian.

**Figure 19. Admissions for hospital restoration, civil commitment, and voluntary commitment by a guardian that occurred prior to the start of people's first community restoration episode during the study period (2017-2022), Oregon State Hospital.**

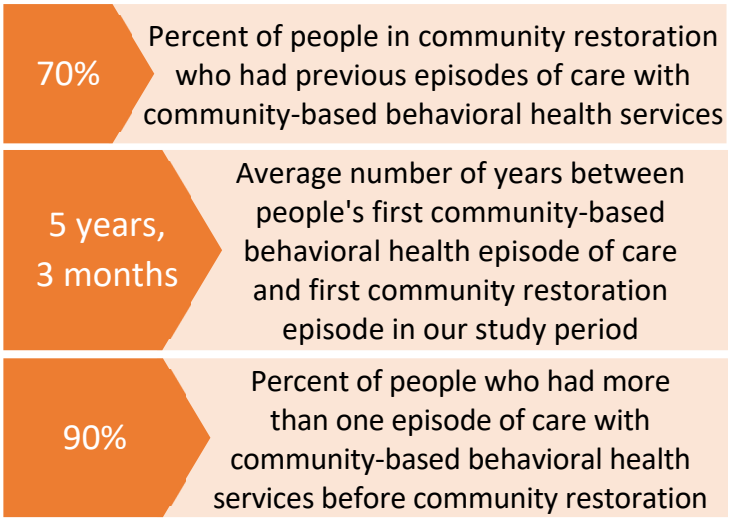



Just as we did with people who were in hospital restoration, we analyzed the community-based behavioral health services data we received from MOTS to assess the treatment histories of people who were in community restoration. Figure 20 indicates that of the 971 people who were in community restoration during the study period, 679 (70%) had records of one or more episodes of care in community-based behavioral health services.

The interview data supported that most individuals undergoing competency restoration had experienced some type of behavioral health treatment before. Providers confirmed that roughly one in four of the people going through restoration had been treated at the OSH before.

*"I would say that most people have a mental health history. They've been previously diagnosed and in some kind of outpatient treatment program. Many of them have been in the hospital."*
*–OSH staff*

**Figure 20. Information about episodes of care with community-based behavioral health services prior to the start of people's first community restoration episode during the study period (2017-2022), Oregon Health Authority.**




However, while the majority of individuals have a *history* of behavior health treatment, we heard during interviews that most people who end up in competency restoration were not engaged with treatment at the time of their arrest. Even for those who may have had extensive behavioral health treatment in their past, a recent period of disengagement may have led to destabilization and arrest then entry into competency restoration. Interview data enables us to see that cycle as a breakdown in systems instead of an individual's "failure to comply with treatment" or a single period of instability.

*"Some people entering the Aid & Assist population are well-known to clinicians or connected BH departments, sometimes with decades of BH involvement. What seems to have changed for them is not necessarily a deterioration of their mental health, but a deterioration in the support systems, safety nets and legal systems surrounding them as they age with their mental health issues. For example, one woman has a 30-year history with the local BH department and the only thing changed is her getting older."*
*–CMHP staff, medium county*

Providers mentioned the mobility of people moving in and out of Oregon and how that may contribute to people entering competency restoration. People coming to Oregon from other areas are less likely to be connected to community services or local support networks. Some providers reported seeing an increase in people entering competency restoration who may not have lived in Oregon for very long.

*"It feels to me like there are a lot more people who are in no way, shape, or form connected to community mental health. We always had some, but we had a lot of folks come in who were active with an agency, and that has plummeted. It's almost rare that we get someone who is open or had been open with a mental health agency prior to arrest. So, it seems to me that is the major way that I've seen a change in the past couple of years. … We seemed to have such a larger percentage of people who had grown up in this community, and were ingrained, had family here, had services. And now it's a lot more hit and miss someone has been in Oregon less than a year."*

*–State agency staff, large county*

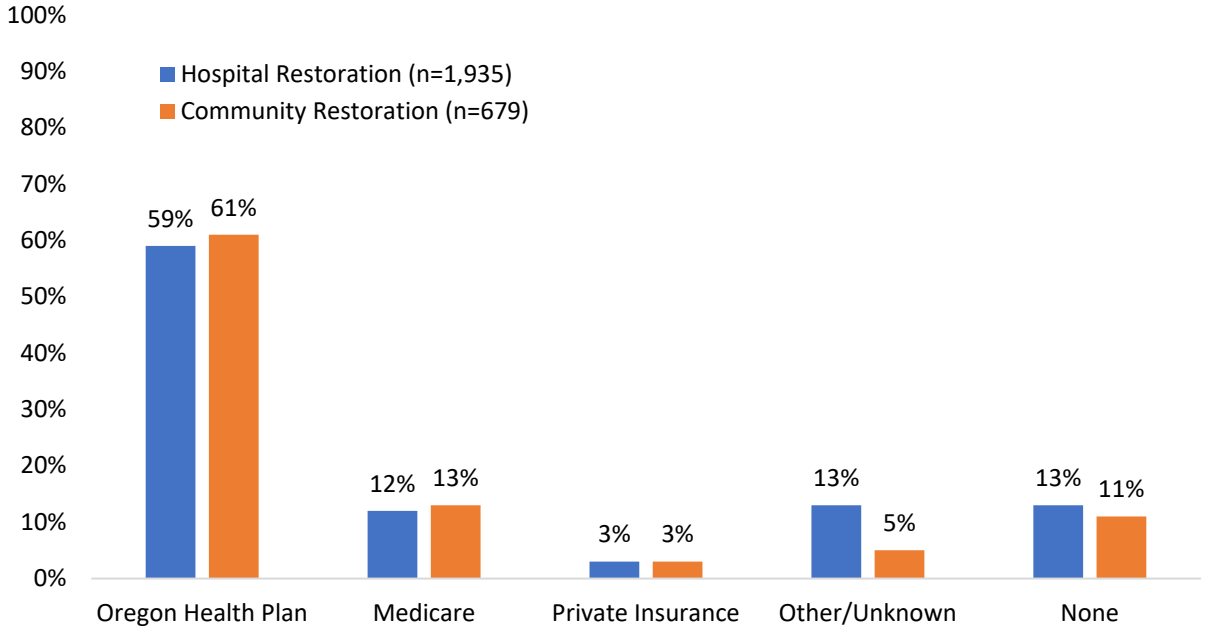
## Were they accessing benefit programs?

Quantitative data on people's access to other benefits programs (e.g. Medicaid/OHP, TANF, SNAP, etc.) at the time they entered restoration was limited, though we did receive data from MOTS[12] regarding the receipt of disability benefits and public assistance as well as enrollment in programs that provide health benefits. Figure 3 in the previous section shows that 22% of people who were in hospital restoration and 23% of those who were in community restoration reported disability benefits as their primary source of income, suggesting that these individuals may be connected to federal and/or state benefits programs for people experiencing disability. Figure 3 also shows that 8% of people who were in hospital restoration and 5% of people who were in community restoration indicated their main income source was public assistance, suggesting they may be accessing benefits programs like self-sufficiency and/or temporary assistance for needy families (TANF).

Other data we received from MOTS suggests that some people who were in hospital or community restoration were also accessing programs that provide health benefits like Medicare or the Oregon Health Plan (OHP), which is Oregon's Medicaid plan. Figure 21 shows that of the 1,935 people who were in hospital restoration and had MOTS records, 59% were enrolled in OHP and 12% were accessing Medicare at the time of their most recent episode of care with community-based behavioral health services prior to their hospital admission. Of the 679 people who were in community restoration and had MOTS records, 61% were enrolled in OHP and 13% had Medicare at the time of their most recent episode of care with community-based behavioral health services.

[12] As a reminder, MOTS data comes from information collected during the person's most recent episode of care with community-based behavioral health services prior to the start of competency restoration. MOTS data is only available for people who were in hospital restoration or community restoration who matched to MOTS records.

**Figure 21. Enrollment in health benefits programs at the time of people's most recent episode of care with community-based behavioral health services prior to the start of their first hospital or community restoration episode during the study period (2017-2022), Oregon Health Authority.**




What we heard in the interviews is aligned with the quantitative data, that many people entering competency restoration were not accessing benefits programs, even if they were eligible. While some individuals could have been covered by Medicare due to disabilities, most were likely to have the Oregon Health Plan/Medicaid or no healthcare coverage at all. The loss of previously existing coverage is often linked to the loss of support systems and/or housing.

Though individuals undergoing competency restoration may have OHP coverage or be OHP eligible, these benefits are postponed while these individuals are in custody in jail or at OSH. This loss of coverage happens with other benefits as well, such as social security. Benefit coverage is necessary for individuals in community restoration to access medication, healthcare and housing, and this can become a barrier to accessing these services for many individuals in community restoration.

> *"Another wrench that gets thrown into this all the time is the preposterous system we have where your Oregon Health Plan shuts off when you're in custody. And so we frequently, when we're trying to transfer people into community placements like that, run into that roadblock. Whether it's like a foster home or substance abuse program but it gets somebody out of custody and start transitioning into some community placement. The only way to pay is through OHP, and their OHP is off and you can't restart it until they get out of custody."*
>
> *–Court personnel, large county*

Since many people coming from OSH or entering restoration were not covered by health benefits, some CMHPs and county providers placed a high priority on getting people in community restoration health coverage and other benefits as a first step.

> *"So oftentimes a lot of the work that we're doing is getting OHP turned on, getting them food stamps, possibly getting to the point of getting them signed up for benefits and that kind of thing. But usually, they're not coming in with that stuff active beforehand."*
> *–CMHP staff, large county*

The lack of these system level supports and access to resources may contribute to someone struggling in the community restoration process. But some providers recognize it takes more than just "turning on" OHP, and people going through restoration need additional support to maintain stable engagement with their service providers.

> *"When you ask a person that comes back, "What were the barriers? What got in the way?" They always say that they didn't have access to their medications. That's very common. Also, most people here have OHP or Medicaid when they leave us and it's active. But, being able to go to the place to see the doctor and to give them their prescription, going to the pharmacy, and getting their prescription filled doesn't happen very often."*
> *–OSH staff*

> *"This person's barrier might be having access to food stamps and his social security income, which he has. But then he leaves and goes back to jail. They release him. Does he follow through and go into Social Security Administration and get his social security benefits restarted? Generally, not. They get put on hold while he's in jail. Some social security disability benefits can still stay active. However, do they have someone helping them out keep track of the income? Do they have a bank account? They've usually lost that information. They just go back to this fending for themselves the best they can."*
> *–OSH staff*

# What did competency restoration look like for people?

The restoration process is not linear and the decision-making to order someone into restoration is informed by many factors and is not standardized. This chapter reflects the data collected, including how the restoration process can look different from county to county and case to case. People can enter the "web" of competency restoration in different ways so this section may echo the complex and confusing pathway and present the relevant data from multiple points and perspectives throughout that pathway.

First, we will use our quantitative data to describe the specific types of offenses that likely brought people into competency restoration. We will then offer a theoretical simplified overview of the competency pathway, with the caveat that some components may not happen in this order or happen at all. After an arrest, a person's competence to stand trial may be questioned by various people including their defense attorney, the prosecuting attorney, a family member, or judge. Certified Forensic Evaluators provide recommendations to the court about someone's competence to stand trial as well as recommendations for the appropriate level of care needed for the person. Then the judge decides whether someone is able to aid and assist in their own defense.

If the court finds that the person is not competent to stand trial, the judge may order them to competency restoration. Once a judge has ordered someone to competency restoration, the judge will use the forensic evaluation and community consultation report to recommend that person to community restoration in the community or to hospital restoration at the Oregon State Hospital (OSH). Someone will then receive hospital and/or community-based competency services until the court issues a determination for that person to stand trial (e.g., finds them "able") or initiates a different court outcome (e.g., dismissing the charges). Again, this is a broad overview of the restoration pathway, and in this section of the report, we will explore why the process can look different from person to person.

## What were the specific charges that brought people into competency restoration?

A person enters the restoration process first by being arrested and charged with a criminal offense. In the previous chapter, we reported some general findings from our quantitative data about people's prior criminal cases and charges, and we will now report on the specific charges that likely brought people into competency restoration. As a reminder, we were unable to link people's criminal cases and charges with absolute certainty to their competency restoration episodes. We instead selected the criminal case that occurred in closest proximity to the start of people's hospital or community restoration episodes and report our findings with the assumption that the selected criminal case likely prompted the order for competency restoration.

Table 8 shows that the composition of the criminal cases and the types of charges that likely prompted people's entry into competency restoration are similar to what our quantitative data showed about their overall criminal case and charges histories (see Table 7 in the Backgrounds of the people in competency restoration section for more information). Table 8 also shows that there was little difference between the average number and type of charges that prompted people going to hospital versus community restoration. People who were in hospital restoration and people who were in community restoration during our study period averaged 3 criminal charges on their criminal case, and fewer felony charges relative to misdemeanor charges. Both groups averaged about the same number of charges for property and statutory offenses. People who were in community restoration averaged slightly fewer person offenses.

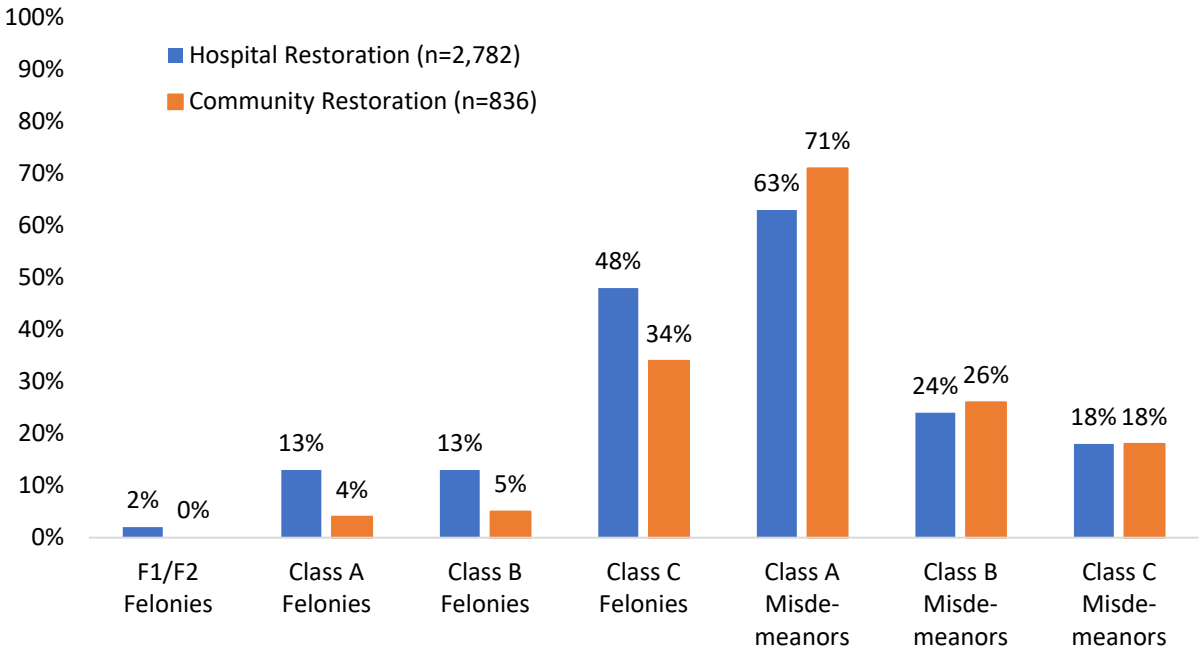
**Table 8. Summarized information about the criminal cases and charges that likely prompted people's first hospital or community restoration episode during the study period (2017-2022), Oregon Judicial Department.**

| | Hospital Restoration (n=2,782 people) | Community Restoration (n= 836 people) |
|---|---|---|
| Average number of **criminal charges, any offense** *(SD)* | 3 *(3)* | 3 *(2)* |
| Median number of criminal charges | 2 | 2 |
| Average number of **felony charges** *(SD)* | 1 *(2)* | 1 *(1)* |
| Median number of felony charges | 1 | 0 |
| Average number of **misdemeanor charges** *(SD)* | 2 *(2)* | 2 *(2)* |
| Median number of misdemeanor charges | 1 | 1 |
| Average number of **charges for person offenses** *(SD)* | 2 *(2)* | 1 *(2)* |
| Median number of person offense charges | 1 | 1 |
| Average number of **charges for property offenses** *(SD)* | 1 *(1)* | <1 *(1)* |
| Median number of property offense charges | 0 | 0 |
| Average number of **charges for statutory offenses** *(SD)* | 1 *(1)* | 1 *(1)* |
| Median number of statutory offense charges | 0 | 1 |

Figure 22 offers a more detailed look at the classes of offenses people were charged with that likely prompted their entry into competency restoration during the study period. People who were in community restoration and people who were in hospital restoration were charged with nearly the full range of offense classes including A, B, and C felonies and A, B, and C

misdemeanors.[13] People who were in community restoration did not have charges for the most serious class of felonies, labeled F1/F2 in Figure 22, which primarily included charges for Murder and Aggravated Murder. Charges for all classes of felony offenses were more prevalent for people who were in hospital restoration, and charges for nearly all classes of misdemeanor offenses were more prevalent for people who were in community restoration. The most frequent offense class charged against people who were in hospital restoration and people who were in community restoration was Class A misdemeanor.

**Figure 22. Offense classes of charges that were included on the criminal case that likely prompted people's first hospital or community restoration episode during the study period (2017-2022), Oregon Judicial Department.**




Finally, criminal justice entities typically identify the "most serious" charge or charges on a single criminal case. Table 9 shows that for 35% of people who were in hospital restoration, their most serious charge was a Class C felony. For 33%, their most serious charge was a Class A misdemeanor. For 12% their most serious charge was a Class A Felony, for 9% it was a Class B Felony, and for 6% and 4% their most serious charge was for a Class B or Class C misdemeanor, respectively. F1 or F2 felonies were only the most serious charge for about 1%. Added together, about 57% of people who were in hospital restoration had a felony as their most serious charge, and 43% had a misdemeanor as their most serious charge.

[13] A very small percentage of people who were in both types of competency restoration were charged with unclassified felonies and unclassified misdemeanors, which is not shown in Figure 22.

**Table 9. Offense class of the most serious charge on the criminal case that likely prompted people's first hospital or community restoration episode during the study period (2017-2022), Oregon Judicial Department.**

| Most Serious Offense Class | Hospital Restoration (n=2,782 people) | | Community Restoration (n=836 people) | |
|---|---|---|---|---|
| | Count | Percent | Count | Percent |
| F1/F2 Felony | 29 | 1% | 0 | 0% |
| Class A Felony | 342 | 12% | 33 | 4% |
| Class B Felony | 240 | 9% | 33 | 4% |
| Class C Felony | 963 | 35% | 250 | 30% |
| Class A Misdemeanor | 924 | 33% | 422 | 51% |
| Class B Misdemeanor | 168 | 6% | 56 | 7% |
| Class C Misdemeanor | 109 | 4% | 40 | 5% |

Table 9 also shows that over half of people who were in community restoration had a Class A misdemeanor as their most serious charge, and 30% had a Class C felony as their most serious charge. For 7% their most serious charge was for a Class B misdemeanor, for 5% it was a Class C misdemeanor, and for 4% each their most serious charge was for a Class A felony or a Class B felony. No one in community restoration had been charged with an F1 or F2 felony. In all, 63% of people who were in community restoration had a misdemeanor as their most serious charge, and for 38% their most serious charge was a felony.

The actual offenses that were determined to be the most serious for people who were in competency restoration ranged widely both for people who were in hospital restoration and people who were in community restoration. The top 10 most serious offense types[14] for people who were in hospital restoration were:

- Assault in the Fourth Degree (Class C felony)
- Unlawful Use of a Weapon (Class C felony)
- Burglary in the First Degree (Class A felony)
- Aggravated Harassment (Class A misdemeanor)
- Assault in the Second Degree (Class B felony)
- Criminal Mischief in the Second Degree (Class A misdemeanor)
- Assaulting a Public Safety Officer (Class C felony)
- Disorderly Conduct in the Second Degree (Class B misdemeanor)

[14] These Top 10 lists are listed in order of most to least common for people in hospital and community restoration, not listed in order of severity of the charges.

- Resisting Arrest (Class A misdemeanor), and
- Menacing (Class A misdemeanor)

The top 10 most serious offense types for people in community restoration were very similar to those of the people who were in hospital restoration:

- Assault in the Fourth Degree
- Criminal Mischief in the Second Degree
- Resisting Arrest
- Menacing
- Unlawful Use of a Weapon
- Harassment (Class B misdemeanor)
- Unlawful Possession of Methamphetamine (Class A misdemeanor)
- Criminal Mischief in the First Degree (Class C felony)
- Criminal Trespass in the Second Degree (Class C misdemeanor), and
- Aggravated Harassment

## How does someone get ordered into competency restoration?

When a person has been accused of committing a crime and is charged with the alleged crime, at any point before or during the trial, someone may question the defendant's ability to understand the charges or participate in their defense by reason of incapacity. If the defendant's competency has been questioned, the judge has multiple options to proceed, including competency restoration, civil commitment, protective proceedings (ORS 125.010) or dismissal of the charges (ORS 135.755).

For the purposes of this report, we will focus on what happens once the court has reason to doubt the defendant's ability to understand the charges or participate in their defense by reason of incapacity (a qualifying mental disorder as defined in ORS 161.360). At that point, the court may employ various resources and procedures to assess the person's fitness to proceed. Those sources can include CMHP community consultations, witnesses (e.g., law enforcement, family, service providers), or forensic evaluations as part of the ORS 161.365 order. Only the court can determine fitness to proceed. The procedures and criteria for determining fitness can vary widely depending on the jurisdiction and can happen fairly quickly or take a long time.

### Who can raise competency concerns?

Many different people can raise concerns about a person's competency, including the judge, the defense attorney, family members, jail staff, or other providers. The defense attorney is often the person who raises competency concerns to the court.

*"I've talked to many defense attorneys. They file fitness motions for their clients because they see their client deteriorating in jail, they won't talk to them, there's nothing they can do for them and so it's the only thing they can really do to try to help their client."*
*–Law enforcement, large county*

In some counties behavioral health staff are embedded within jail systems and help identify people in jail who are known to have a qualifying mental health disorder or who may not be able to proceed. Behavioral health staff may alert the judge or may inform the person's defense attorney about their concerns.

*"Well, we're a small community so a lot of times we know them, like I have a clinician on our team, on our crisis team, that's embedded in the jail. And she knows everybody at the jail. And if she thinks someone is unable to aid and assist, she'll kind of throw me a heads up, and I will look to see who the defense attorney is and put a little bug in the defense attorney's ear. So that's one way to do it, but usually our defense attorneys are pretty quick at going that direction."*
*–CMHP staff, large county*

Depending on the jurisdiction, the judge might be the one who raises the initial question of competency, even if the judge is the one who makes the final decision. The judge will likely seek additional sources of information but may also be the person who raises the competency concerns.

*"I think in most of these cases it's been the judge. I think there was at least one that was the attorney who was calling into question, but I think more often than not it's been the judge."*
*–CMHP staff, small county*

Family members may also advocate for their family member to be evaluated, which can bring its own set of challenges. One family member described how difficult it was to get information about her son's case without his consent. Eventually she was able to advocate to have him evaluated by sharing information about her son's mental health diagnosis or symptoms with the defense attorney.

*"We never got to that point where the attorney would talk to me about my son's case, but we got to the point where I basically told him you don't have to tell me anything, but I'm going to tell you some things. Just my experience with my son up to that point, and I highly encouraged him to have him evaluated."*
*–Person with lived experience*

Sometimes the defense attorney may wait to share competency concerns with the court, depending on what information they have about their client. When there isn't enough historical

information about a person or it is unclear if the behavior is due to a mental illness or substance use, the defense attorney may decide to see if the symptoms resolve before raising the concern to the court.

> *"A lot of times at arraignment there are signs that there are things going on. Depending on what kind of background we might have on someone, we may know that someone has a drug issue or an alcohol issue, but we also know that we have this historical diagnosis that we know that this is an issue. They have bipolar, they have schizophrenia, something that regardless of their drug problem, there's going to be something else presenting that could be a problem. For some people we don't have that historical information. They just present, and we don't know if they have a mental health issue or if they're experiencing a drug and alcohol issue. A lot of times the attorneys may give it a day or two, or weekend, you know. 'Hey, let's give them a few days and see if they're clearing up in jail, have another conversation with them and then decide, do I still think there's a mental health issue here, or were they just experiencing some use issues.'"*
>
> *–State agency staff, large county*

## How are community consultations used during the initial determination?

The court may ask the CMHP to conduct a community consultation to assess the defendant and make a recommendation to the court about the services needed to restore competency and whether those services are available in the community. The request for a community consultation can happen during the .365 process or be included with the .370 order. The temporal aspect of the consultation and *when* the report is requested varies by court and can be confusing to service providers as well as defendants.

> *"I get orders from a judge to do the community restoration consultation. Honestly, I think this is a point of confusion for me where sometimes I will get the community consultation order and a psychological evaluation will already have been done. And sometimes there isn't one done. It seems like it varies by attorney and if they want to move forward with getting the evaluation done, and I have asked multiple attorneys why that is and I haven't been able to get a very clear answer. But the process feels different and it's fairly confusing to assess somebody's level of need without that evaluation ahead of time. It's pretty hard."*
>
> *–CMHP staff, small county*

Some courts request the community consultation report before the court has received the forensic evaluation report and determined fitness. Though the consultation is not meant to determine fitness to proceed, it can happen during the initial determination and provide the court with important information. But we heard during the interviews how the timing of the consultation report can be confusing and frustrating to providers when the person has not yet been determined unable to aid and assist in their defense.

*"We get the order and we have five days to do the consultation and yet there's no evaluation. Talk about the cart before the horse. I mean we don't even know if they're going to be found unfit, and yet we have to go to a judge and say, 'If they are [found unable] these are the resources we would have to provide to get them the restoration.' And that's such a weird conversation and I testify to it all the time and the judge is like 'Well, what do you need to restore them?' Well, this, but we still don't know if they're unfit. I think they're fit. I think the person could sit, but I'm not able to because I only have a master's degree."*

*–CMHP staff, medium & small counties*

Other courts request the community consultation *after* the forensic evaluation report has been submitted to the court and may use the consultation report as a way to determine resources for placement decisions. We will explore this in the section on placement decisions, but the following quote demonstrates how relatively quickly the process can move in some cases once someone has been found not able.

*"So once the report is into the courts, everyone acknowledges this person's not able, then they'll typically order the community consult and then we have five days or so, a business week to get it back. And so typically those will be ordered Monday and then I'll have them done for the following Monday. And then that will let the courts know, give them more information on if this person was to enter community restoration what services do we have in community to support them."*

*–CMHP Staff, large county*

## Forensic evaluations and the competency process

Not everyone whose fitness to proceed is questioned will receive a forensic evaluation, while some people may receive multiple evaluations. The initial forensic evaluation someone receives can happen as a part of the .365 order or a .370 order but the purpose of each is different. Under the .365 order, the evaluation is conducted to provide information to the judge on the defendant's need for mental health treatment, the services needed to restore competency and need for hospital level of care. The court may include specifics about the evaluation in the .365 order. For example, the judge may specify if an evaluation should be conducted by a private certified forensic evaluator, by OSH's Forensic Evaluation Services (FES) unit, or if the defendant should be transported to OSH to get the evaluation.

A .370 forensic evaluation can be conducted by OSH's FES but that is not statutorily required and the timeline is after the court has determined the defendant unfit to proceed under ORS 161.365. The .370 evaluation is conducted per statute timeline for the purpose of determining if fitness has been regained. The .370 evaluations can also be completed by private evaluators, though we do not have data indicating how often that happens and if Oregon Public Defense Services (OPDS) is paying for those evaluations. In some cases, the .370 order is the first

forensic evaluation conducted with a defendant because the court may not have ordered a .365 evaluation and may have determined the person unfit to proceed without a forensic evaluation.

*Accessing a forensic evaluation*

Obtaining the forensic evaluation appeared to differ from case to case, with considerations made for the timing, location, and format of the evaluation (in-person or by video) as well as specific circumstances of the case. Some counties reported experiencing considerable wait times for the evaluations and noted that clients often decompensate even further while waiting in jail for their evaluation.

> *"Usually, if it's a .365 and it's their first one, they're usually in jail waiting for the things to bear out and most likely not taking their meds or not having the correct types of medication and not getting any other sort of mental health services."*
> *–Forensic evaluator*

Participants reported most defendants are in jail (i.e. in custody) when the evaluation is conducted, though we spoke with some people referencing times when someone might be out of custody (on bail or released for some other reason) during their evaluation. Some courts will order the defendant transported to OSH for evaluation by FES if the person is not able to or refuses to participate or there isn't enough information or records available to complete the evaluation. The transport to OSH for an evaluation can be one day or up to 30 days at OSH.[15]

> *"OSH evaluation is done when somebody is refusing to talk to an evaluator, and they won't participate or won't even come out of their cell. It's a last step. We don't have enough historic information about a diagnosis. They won't meet with an evaluator. Under those circumstances, we sign a .365, which is the order to get to the state hospital for an evaluation and continue to encourage the person and we'll revisit if the person begins to clear up a little bit."*
> *–Court personnel, large county*

**OSH Prioritization of Competency Evaluations**

OSH will conduct evaluations after OSH patient evaluations are completed, in the following order of priority:

- Defendants in jail with ORS 161.370 orders;
- Defendants in jail with ORS 161.365 orders;
- Defendants in jail with ORS 161.315 orders;
- Defendants in the community with ORS 161.370 orders;
- Defendants in the community with ORS 161.365 orders.

[15] At the time of this report, 30-day evaluations are not happening currently at OSH though they could happen again in the future, according to FES personnel. OSH notified its partners of the Prioritization of Competency Evaluations on May 26, 2023.

As previously described, many different people can question someone's competency to stand trial, but only the court can find someone unfit to proceed. When the defense attorney decides to have their client evaluated and a judge has not yet issued a .365 or .370 order, the evaluator must rely on their client participating in the evaluation and/or consenting to release their medical information and treatment history. If the defendant refuses to participate and there isn't enough information available without the defendant's consent to release records, then the defense may or may not request a .365 order for an evaluation because they might not have enough information.

> *"If we don't have records, we try to get them to sign releases of information. That way we can access those records, like the jail health records, if they've been to the state hospital, community mental health agencies where they might have received treatment, etc. Some people are able to sign those releases, some people don't even meet with us. They don't consent to the evaluation, much less to let us see the records. Then you go from there."*
>
> *–Forensic evaluator*

*Multiple initial evaluations*

A defense attorney may question their client's fitness to proceed and have their client examined by a private forensic evaluator as part of defense services before raising the issue to the courts. In those cases, the forensic evaluation report may or may not be filed with the court. We have not identified statewide data on the number of evaluations completed, how many are or are not filed with the court, or the evaluation opinion (able/not able/never able/medication never able). Participants pointed out that a system where multiple parties can request an initial evaluation for the same person is inefficient and problematic.

> *"In Oregon evaluations can be asked for privately by both the defense and the prosecution. And the courts can order any forensic evaluator, so it can include ones who don't work here in the forensic evaluation service and ones who do. And sometimes you have two or even three evaluators evaluating the same patient. And there is a very high concordance rates, and our diagnoses, and our opinions, so reducing that would be very helpful."*
>
> *–OHS staff*

Multiple forensic evaluations can burden the system and lead to delays with a decision from the court. Furthermore, repeated forensic examinations for someone experiencing untreated mental illness can be taxing and may exacerbate their symptoms and negatively affect their mental health.

*"An initial evaluation or .365 evaluation is not technically required, and I'm not suggesting it should be for a person to be found unable to aid and assist, but usually what happens is a defense attorney gets an initial evaluation. It says the person is unable to aid and assist, and what we frequently see, more often than not, in the 3-month period we looked at, it was over 90% of the time when the DA or the court wanted their own evaluation and ordered to complete another evaluation. The Evaluator at FES came to the same conclusion as the initial eval, so right there you've got a ton of extra work being done that doesn't need to be done. I mean, it's ridiculous how many times the FES has to do another eval when there was already a private eval done, with which they agree."*

*–OSH staff*

*Consequences of delays in getting an evaluation*

Throughout the interviews, we heard how a defendant's symptoms can worsen in jail due to the environment and without access to appropriate treatment and behavioral health services. Service providers and law enforcement personnel emphasized how long wait times for an evaluation to be completed and for the filing of the report to the court can cause further decompensation.

*"Yeah, it's no secret, the longer they stay here the more likely decompensating, especially prior to the .370, so it's just jails were not built for that. We're not hospitals."*

*–Law enforcement, large county*

The judge may skip over the .365 order due to the long wait times for private evaluators and/or the severity of symptoms a person is exhibiting. In that case, a judge may determine someone is incompetent to stand trial and send them to competency restoration with a .370 order so they can be removed from the jail setting. In this case, the judge would likely recommend hospital restoration as explained by the following provider.

*"...And so, he was on a .365 order but his evaluation was not scheduled for almost two months out. And so he's sitting in the jail, waiting for this evaluation. Well, our evaluator—the one that we generally use that comes to the jail to do it—had already tried to evaluate him but he was so violent they couldn't do the evaluation. So our argument was he is not going to be... he couldn't even come to the court hearings because officers couldn't even get him to the video arraignment room. So we're like, "How's he going to be able to do a video psych eval? That's just not a thing. That's not going to happen." So we actually went to our courts, the DA and his defense attorney, and said "look, he's decompensating badly. And he's not going to make it till the end of July to get his forensic evaluation, that's just not going to happen. How do we get him to the state hospital?" So, they did a .370 order."*

*–CMHP staff, small county*

The backlog of people waiting for evaluations is considerable and the FES workload has increased annually. For example, at this time of this report, FES is scheduling non-OSH evaluations into 2025 and is scheduling in-custody .365 evaluations approximately 3 months into the future. To reduce the burden for people waiting for .365 evaluations, that group is the first prioritized if all OSH residents are scheduled and openings remain for FES evaluations. These long wait times for both private evaluators as well as FES appointments takes a toll on system providers and defendants.

> *"…there's just sort of this sense of hopelessness that pervades the system when people are sitting in cells waiting, not knowing when they're going to go anywhere, not knowing where they're going to go. Defense attorneys are waiting on evaluations, prosecutors are waiting on evaluations. Nobody knows when the system is going to keep moving. And I think there's an extent to which getting faster evaluations lights a fire under everybody to say "Okay now that we know what's going on with this person, what are we going to do with them?" Instead of just being like "Well, someday we'll hear something and we'll just have to figure out the next steps."*
>
> *–Non-state agency staff*

*Rapid evaluations*

Five counties have instituted a rapid evaluation mechanism with the goal of decreasing the wait time for a forensic evaluation. Counties pay a reservation fee to hold a certain number of evaluation "slots" for that week to guarantee an expedited evaluation done by a private evaluator. One county said their jail pays the reservation fees, but since each county appears to have implemented rapid evaluations differently, we could not determine if other counties pay the reservation fee from a different source.

While rapid evaluations can potentially reduce a person's wait time, some participants reported that many of the rapid evaluations have been contested, resulting in additional evaluations being conducted following the rapid evaluation. The redundancy of evaluations negates the reason for the rapid evaluation model.

> *"I think it is absolutely a help if there's <u>not</u> also an order for us to evaluate them. Unfortunately what happens in many of these rapid evaluations is that they are still contested by one side or another. So another evaluator does it."*
>
> *–OHS staff*

To ensure people are evaluated as quickly as possible, in one county the Behavioral Health jail staff help identify people early for a rapid evaluation slot, communicating with the defense attorney to get the defendant evaluated and supporting the team getting the paperwork done.

*"If you have a great defense attorney, it can go fast. And sometimes we at the jail, behavioral health, will nudge the attorney to be like, "Where are we at here because your defendant is sitting here for 15 days and we don't see a rapid evaluation application, we don't see a .365. I go to the Aid & Assist docket every Monday." So we can nudge and help provide suggestions if we see it stalling and it's clear Aid & Assist is maybe a question then we'll reach out."*

*–CMHP Staff, large county*

Counties use different criteria for selecting people for the rapid evaluations. One county specified they prioritize individuals for rapid evaluations slots based on the severity of their charges and who they believe will move through the process quickly, particularly those with misdemeanors. Those with higher level charges especially around violent and M11 charges would go through the standard evaluation process.

*"So the goal of the rapid program is to take a category of cases that we feel we can do that process faster and which would be our misdemeanor cases and some of our non-person felony offenses. See if we can speed that process up so we don't have somebody with a mental health issue who is unable to aid and assist just sitting in the jail where a lot more time is going by waiting for the state hospital to get them."*

*–Court personnel, large county*

We do not have utilization data on the rapid evaluation mechanism across the five counties implementing this mechanism. A couple of the counties may use rapid evaluation more than other counties.

*"We just started with [X] County. It was like seven months ago. They've never missed a single week. We've had evaluations, every week with them. Even though we've worked with XX County a lot longer than that, we've done more evaluations for X, than we have with XX County. Whether that's because they have a slot, or whether they pay for a slot or not, I don't know, but I feel like if they were paying for it, they would probably find a way to use it. We get like a little bit of money from the county, and then the hourly rate is paid through PDSC [Public Defense Services Commission]. That guarantees the expedition of that evaluation with them. We have two weeks to do it, but we usually get it done in a week. Especially if they're not fit because we want to get them on the docket so that they can get to the next place."*

*–Forensic evaluator*

Based on the interview data, we were unable to determine how the reservation system worked across counties and how the payment system worked in each county using the rapid evaluation mechanism. The rapid evaluation mechanism was beyond the scope of this project but utilization, contested evaluations, and the demographics of rapid vs. standard evaluations are areas for future assessment and evaluation.

*"And also if we get multiple submissions, and we think these two people, the jail determines which one goes first. So, our priorities are obviously acuteness, and so, if they're an acute case they're going first. And we've pushed people ahead of other people who are in the process for that because we do feel that there's a medical issue."*

*–Law enforcement, large county*

*Funding the forensic evaluations*

The fiscal impact of forensic evaluations is considerable and may have influenced where evaluations are done. We spoke with some participants who believed counties have an interest in sending people to OSH for evaluations because the State pays for evaluations done at OSH by Forensic Evaluation Services (FES). Starting in June 2023, OSH leadership prioritized evaluations to reduce burden on FES staff, so the timeline in the following quote may not reflect the current status but the context up to the writing of this report.

*"When somebody is referred [to OSH] under a .370 order, it's paid for by the state and not the county. Suddenly, that county doesn't have to do anything. When they come here as a .365, they could potentially be held for 30 days on the county's dime but that almost never happen. .365s are usually here and gone in a day. The police bring them, we meet with them, and then they leave and go back to jail. If I was a county in Oregon and I had a population of mentally ill people who committed crimes, I definitely would want them to be paid for by the state rather than house them in my jail and pay for their food and somebody to watch them. There's a benefit to the counties to send people here."*

*–OSH staff*

Circuit court-ordered .365 forensic evaluations conducted by private certified forensic evaluators are paid for by Oregon Public Defense Services (OPDS). Court-ordered evaluations conducted by OSH FES are paid for by the state. Funding mechanisms for all other forensic evaluations are not clear, but counties have indicated they do not have a funding source to cover forensic evaluations.

*"There's always been this kind of question of could we do court ordered evaluations at the county level, rather than sending court ordered evaluations to the state hospital, but there's no pot of money associated with court ordered evaluations that don't go to the state hospital."*

*–Forensic evaluator*

*"It would be really nice to have funding, so that we could contract with somebody in the area…instead of them waiting to go to the state hospital and then they never go. So if we could pay for those evaluations, if we could have the money to pay for those evaluations, then all of this could happen quicker. And there wouldn't be this huge backlog."*

*–CMHP staff, small county*

### *Certification of forensic evaluators*

Forensic evaluations are conducted by certified forensic evaluators. In Oregon, evaluators complete a required training course to receive a forensic evaluation certification. Forensic evaluators are required to get recertified every two years. While providing details about the Oregon certification process and standards is beyond the scope of this report and the expertise of our project team, participants emphasized that education and certification alone is not sufficient.

*"Education can only do so much. We really need, this is what we tell people: it's not enough to come up with some trainings and learn like competency case law. You need supervision. The review, certification doesn't offer that. It should be up to people to only get certified in things that they're competent to do but that is not the case."*

*–Forensic evaluator*

Some participants feel the certification requirement bar needs to be raised. After the implementation of the certification program, a review board assessed reports for quality and gave feedback. We understand that review process was suspended and only recently were report reviews resumed. One evaluator we spoke with was certified in 2012 had not received a review until just before we conducted the interview in 2022.

*"It's been a bit of a train wreck. We've had certification for 10 years now, and the process, it's a low bar for certification. To become a certified forensic evaluator, you have to be a psychologist or psychiatrist, pay $250, you attend a training, take our open book, open note test at the end. Then you have to submit some work samples. But the way that the program was managed, in the past, I think was somewhat conflict avoidant. Evaluators did not take kindly to the idea of certification when it first came. People were really mad about it. It was for good reason, because they didn't tell anybody about it. It was just like all of a sudden, if you do these evals, now you got to go through this process. People became afraid. Are they going to lose their livelihood?"*

*–Forensic evaluator*

Some people we interviewed shared concerns about inter-rater reliability across evaluators. There did not appear to be a statewide quality control process to support evaluators and ensure they understood the purpose of the assessment within the context of competency restoration.

*"There are a lot of evaluations that the hospital does that are really good, but they also have a really high bar about what it means to be able to aid and assist. They also have a really low bar for risk. Great evaluations, but the risk mitigation isn't quite there. As a hospital, we have to mitigate risk. There are other people in the community who basically do crappy evaluations. When you read through it, it feels like I'm reading what the defense attorney is asking you to say, as opposed to like an objective clinical assessment that is meeting the criteria that's set forth by the state. I know that years ago that there was the board that was set up for the certified forensic evaluators and having a quality control as a part of that. I don't think that ever really developed. Honestly, that would be very beneficial."*

*–OSH staff*

## How are placement decisions made for people ordered to restoration?

If the judge finds the defendant unfit to proceed, the judge can pause the criminal proceedings with a .370 order which orders the defendant to receive competency restoration services in the community or at OSH. The order can include a request for a community consultation and a forensic evaluation if one was not done as a .365 to determine the required hospital level of care. ORS 161.370 requires the "least restrictive option appropriate for the defendant, needs of the defendant and the interests of justice" (ORS 161.370). The judge assesses the recommendations and determines whether the defendant should be placed in the community or at the state hospital.

*"A judge can just say, "Okay, this person is going to Oregon State Hospital for assessment and treatment" (a .370 order), or the attorney can order what's called a .365 evaluation, which is the evaluation that's done in jail, where an evaluator determines does this person need competency restoration services or not. And if they say "yes, this person is not able to aid and assist currently, and here's why, and they need to get more treatment," then they would be either sent to Oregon State Hospital for assessment and treatment at that point, and then get their first Oregon State hospital evaluation at that three-month mark."*

*–OSH staff*

Even with the statutory guidance, participants raised concerns during the interviews about how placement decisions were made and who was accountable for people throughout the restoration process. Some service providers shared frustration that there was no agency nor jurisdiction taking responsibility for people before, during or after restoration regardless of setting.

*"It feels like a hot potato, and everyone's kind of like, "we can't take him," or "we can't take her" and everyone is trying to bounce this poor person around. No one wanting to take responsibility for the person. In the hospital's case, we're kind of like, "they don't require this level of care," and the counties are saying "yes they do" or "we don't have the resources here to take care of them, and you have to do it."*

*–OSH staff*

Given this "hot potato" scenario, courts can be required to make difficult decisions about people who may be in a liminal space – not quite meeting a clinical threshold for hospital level of care, but needing more structure, resources, and support than the community can provide. The placement decisions can be very different from one jurisdiction to the next based on several factors we will explore in this section.

*"Ultimately the choice in Aid & Assist is community restoration or State Hospital. And so if a client is decompensated in the community but has been found to not meet the threshold of requiring State Hospital level of care … the families are going like, "What the hell, why aren't you guys doing anything about this and why can't the court do anything about this?" And I think in the court's mind like the alternative is sending somebody to the state hospital and sort of not feeling as though the person meets that threshold. And so you know as I think so often happens in our work, we're sort of put in this position of telling a family, in so many words, we have to wait for something worse to happen, we have to wait for something really, really bad to happen to be able to step in and intervene."*

*–CMHP staff, large county*

## The role of community consultations and placement decisions

Community consultation reports are prepared by service providers in the jurisdiction to assess and inform the court of resources available for community restoration. These reports are not associated with the forensic evaluations and may happen before or after the forensic evaluation, depending on the court and other factors. We heard during the interviews that community consultation reports can help inform placement decisions.

*"The consultation is only to answer the question: if this person is to remain in the community and be restored to competency, what are the services [they] need? So the community consultation provider is not making a recommendation for the state hospital."*

*–CMHP staff, large county*

The courts use community consultation reports to determine if someone can be restored to competency in community-based level of care. The evaluation may have recommended

services, but the judge needed to understand what resources were available to support and restore the person if they were to stay in the community.

> *"…it is our job to go in—after the [initial forensic evaluation] report has been written and the unable finding is on the record—to go in and then determine are the resources that the evaluator is recommending actually available in the community. And as time has gone by, we have access to fewer and fewer resources and clients with more needs than ever. So we are not connecting people with the level of care that they need in the community right now because the resources simply aren't there."*
> *–CMHP staff, large county*

We heard throughout the interviews that some counties lack the appropriate resources to deliver community-based restoration services. Some people felt the lack of resources is pushing people into hospital-based care and preventing counties from meeting the statutory expectation to keep people in the "least restrictive option" because they are not able to deliver the services needed even when ordered by the court.

> *"… well according to a fairly recent law that counties have to screen people to determine hospital level care or if they need competency restoration services that cannot be provided in the community. You can be sent to the hospital, even if you don't need hospital level of care, because your community doesn't have anything."*
> *–OSH staff (interview conducted May 2022)*

## Placement in hospital level of care (HLOC)

Interviews provided many reasons why the court may recommend someone for hospital level of care (HLOC) and the additional context behind that decision. An obvious reason was the clinical need to provide someone with hospital level of care needed for stabilization. Some of the additional reasons to place someone in hospital restoration were a lack of resources to serve people adequately in community restoration, often housing and treatment or services. Other reasons included safety concerns with keeping people in the community and funding concerns.

We heard from clinicians and service providers that courts order people to hospital restoration primarily due to the severity of their symptoms. Counties confirmed that there are some instances when they don't feel they have the appropriate resources needed to engage someone in the community who has severe symptoms and believe OSH is the appropriate placement to stabilize someone.

*"The aid and assist piece, the community restoration part, we actually have not had a whole lot of people in community restoration. We've had more recently, but the majority of our people were going to Oregon State Hospital because their level of psychosis was so high and so unmanaged and uncontrolled that there was no way we could do anything with them in the community."*

*–CMHP staff, small county*

In particular, some service providers confirmed that people were placed in hospital restoration to get medication management as well as supportive services and care that is not available in the community. Some participants believed adherence to medication was needed prior to someone being placed in the community to receive competency services.

*"Well, I think one of the primary pieces there, it's the willingness component, and I think one of the challenges we've encountered with clients at the state hospital is med noncompliance, people just refusing to take medication. So we don't see them stabilize and most of these people have psychotic disorders. So medication is very appropriate in those situations and we don't see it. So I would say those would not be individuals that would be appropriate for community restoration. I think we have to have some level of willingness and compliance, particularly around medication. Not that it's needed for everyone, but when we're looking at aid and assist situations, it's likely that medications would be beneficial for those individuals…"*

*–CMHP staff, medium & small counties*

In addition to clinical reasons we heard for hospital level of care, housing appeared to be a key resource that courts used to determine placement in hospital restoration. The challenges of finding beds or safe and stable housing options for someone in community restoration can be untenable when someone has a substance use disorder and needs co-occurring treatment, causing someone to be placed at OSH.

*"We have community restoration which is fantastic, but it is very limited and it is really difficult for judges to say ok, this person is going to be homeless, they have a substance abuse condition, a lot of the housing in Oregon is dry, and so you are asking someone with a substance use issue to now stop taking substances in order to get housing, which is problematic. And let's say it's a person crime, or someone is constantly getting called on, and law enforcement is constantly getting called on this person, and now you are asking the judge to put them in this one place in community restoration, which they have nowhere to go, they are going to be homeless, and we are expecting restoration to happen. And then of course, you are not going to gamble on that. Judges are getting a lot better at gambling on that, but it is a gamble. And it is understandable. The DA, the CMHP, the judge, that is really difficult to watch. So folks end up at the state hospital."*

*–Non-state agency staff*

Participants repeatedly emphasized the need for more community-based substance use treatment facility beds in more counties across the state and that these beds need to be open to people in community restoration. During interviews, service providers mentioned the importance of being able to access detox centers as well as inpatient residential treatment, but they are struggling to find local beds or openings across the state.

> *"We have no residential treatment facilities here, we have no detox centers here, nothing in our community. So when I send my report to the judge, even if I recommend somebody have a higher level of care, it's not available here in our community so we can't access that. And then somebody usually ends up going to the state hospital even if they could have accessed a lower level of treatment. We don't have anything available for them here."*
>
> *–CMHP staff, small county*

A similar challenge discussed was finding an available bed in a secure residential treatment facility (SRTF) willing to take someone in community restoration. A person might not need the level of care provided at OSH, but given the limited number of SRTF beds across the state, many courts resorted to hospital restoration as the secure alternative.

> *"I could even say for those that get ordered into, let's say lower level of care, if we have one that we say can be placed in the SRTF -- I could show you right now a spreadsheet that one of our ENCCs put together for a person that we were trying to place and she's marking in red all the places that are not accepting -- it's a stoplight, right? So even if let's say we take OSH out of the equation, we have somebody in jail but they need that secure residential treatment... So it's the placement that is the issue. Having a bed for that person is an issue."*
>
> *–CMHP staff, medium & small counties*

During the interviews, we heard additional reasons a person might be recommended for hospital level of care or secure facilities, even if that placement is not clinically needed. Some participants believed that safety concerns may drive placement decisions and that courts are working to diminish or mitigate risk in their county. They may be working with "a lot of 'not in my backyard' mentality" (OSH staff) and addressing competing concerns and political interests. One participant discussed how comfort levels differ from one jurisdiction to another and that the level of safety may increase over time as sectors work together, but noted the balancing act that courts are doing when making a placement decision.

*"It probably varies from community to community. I think, the longer we are doing our work and instill confidence, both in terms of the judicial branch, but also the DA's office, as you raise that confidence, then people are not as risk averse, but when you first start out as risk averse, and you have no confidence in the system, it makes it a really tough spot and then I can see how that wouldn't be the easiest decision to make. You certainly don't want to put a community member at risk."*

*–Law Enforcement*

While public safety was an issue raised throughout the interviews, not all service providers supported the court's decision to send someone to OSH. Some providers we interviewed believed certain people could benefit from community restoration while still maintaining public safety. But they were clear that the court makes the placement decisions even if clinicians or other service providers disagree.

*"I've been saying this since 2008. They made me responsible for a system that I had no authority in. I'm constantly being lambasted because our numbers are going up in [County], and I keep telling them that I have no authority in that courtroom. People come and go to the OSH on a court order. It's plain and simple. We have people that we feel we can do community restoration with. However, if the judge and DA don't agree, they send them to OSH. If a person has charges that are dangerous to somebody else, they get sent to OSH whether we've worked with them or not."*

*–CMHP staff, large county*

An additional mechanism for someone being ordered to OSH were the charges someone faces when arrested. Service providers and clinicians we interviewed raised concerns around intentional exaggeration of an offense to justify sending someone to the OSH. Sometimes this placement is due to safety concerns and sometimes this may be to get someone the care they may not be able to get in the community.

*"The Oregon Legislature has helped recently changing the laws for who can refer to the hospital and looking for a felony rather than a misdemeanor unless a person is profoundly mentally ill and is a danger to themselves or others. That is a higher bar than from what I've experienced. We're seeing individuals are consistently being charged with resisting arrest. You read the police report and it says that they pulled their hands from the handcuffs. That's not always true; it's sometimes violent and deserving of that charge. But I think some counties are using that as a way of getting people here if they wouldn't otherwise qualify."*

*–OSH staff*

Finally, we heard during the interviews that counties do not pay for restoration services when they are provided at OSH and some providers question how much that influences placement decisions. We do not have data to explore how much funding impacts the decision, but lack of

funding and resources for community restoration was an issue raised throughout the interviews.

> *"Counties were sending everybody to the hospital saying that we don't have the resources to provide care because this person was arrested for substance abuse. This person is not taking their medication, you know, whatever it was. They still sent to hospital. … They're not a danger to themselves or to others, they are needing mental health treatment. And then counties, they don't get the bill. My understanding is that if they send their residents to the hospital, now it becomes the hospital's responsibility to take care of them."*
>
> *–OSH staff*

## Community restoration and housing issues

Early in our project, subject matter experts shared how some people in community restoration experienced housing challenges while they were undergoing restoration, including barriers that would arise due to their criminal charges. We learned from many interviewees that it was not uncommon for someone to be unhoused while also being expected to engage in community restoration services. Interviewees shared their concerns about the complexities of both housing and competency restoration and how system-level factors impacted placement decisions for individuals.

We heard repeatedly about the shortage of housing options and how that impacted the ability to deliver effective community restoration services. The lack of local housing options means county providers feel they do not have the resources to serve people in community restoration if they are unhoused. They also mentioned challenges finding real-time, accurate information on available beds that might accept someone during community restoration.

> *"We still wouldn't have the resources to serve them, is the bottom line for [our] county. Would we see a decline? Probably. But I still don't have a placement if they are needing a placement off of the street. It's just not there, you look at the wiki site and nobody is taking referrals. I called 17 places yesterday on the wiki site even though it says that they're not accepting referrals. I thought you know what, I got this person, I need to get them placed, I'm going to call them and just see if maybe I can slide one in. None of them. None of them were even…their waitlists are full. They said we can't, we're not taking any more referrals, we're full. No more referrals. We don't have - and that's across the state of Oregon. That is from corner to corner. I was calling every county. Multiple facilities."*
>
> *–CMHP staff, medium & small counties*

Interviewees discussed how housing slots or "beds" were often reserved or offered first to someone with no behavioral health issues or someone who has been civilly committed over someone in competency restoration because of funding restrictions or safety concerns. Bias against this population is an important barrier for placement in the community and providers rarely have training or resources to support people in community restoration. With limited beds, community-based housing facilities can select who gets a bed and who does not. Preference for beds or housing slots often goes to those without criminal justice involvement and lower-level needs.

*With limited beds, community-based housing facilities can select who gets a bed and who does not. Preference for beds or housing slots often goes to those without criminal justice involvement and lower-level needs.*

> *"Yeah, we're all competing for the same resources. There's not enough to go around and for our clients with the forensic judicial involvement I think there are stigma barriers. If a program is looking at two folks referred in, and one of them is a forensic client and one of them is a civilly committed client without the judicial involvement or without the criminal history, they're going to be inclined to take the one who's not judicially involved. There's that thought that folks with judicial involvement are perceived as more dangerous. And it may be that the civilly committed person was committed for very similar behaviors, but somehow they got civilly committed instead of arrested. But yeah, there's a disinclination for programs to serve folks who are judicially involved. And I think there are instances where combining the populations within a residential treatment facility…it may not be a good mix. So yeah, our clients need that intensive wraparound because they're so resource poor. I mean, they're just scrambling for the most basic needs, and have been for a long time."*
>
> *–CMHP staff, large county*

## Step-down from hospital to community restoration

Once someone has been ordered to hospital restoration, the Interdisciplinary Treatment Team (IDT) at OSH conducts an assessment every 30 days to assess the person's progress and stability. OSH clinical staff, Forensic Evaluators, and county providers may disagree on the level of care someone needs and if they should remain at OSH.

*"No one could agree on what hospital level of care meant. Our criteria for hospital level of care that we go through is different from the community's criteria for hospital level of care. We're telling the community they don't need hospital level care. The community is telling us, "Yes they do" based on their criteria. Based on our criteria, they don't. We're arguing with the communities about these individuals and whether or not they need to be in the hospital, and we are using totally different criteria."*

*–OSH staff*

Whether someone stays at the OSH can differ depending on the county that person is coming from and some of the factors previously discussed around placement decisions. Once someone has been at OSH, the court will have additional data from the IDT assessments done by OSH clinicians and possibly a Level of Care Utilization System (LOCUS) assessment once the person has been recommended for community restoration. The CMHPs do not have a formalized role with the level of care assessments, even if they have been engaged in the IDT meetings, though some CMHPs may provide information that can get included in recommendations. If OSH clinicians recommend a hospital level of care is no longer required, they will submit a "9B packet" or "9B letter" to the judge and – ideally – the CMHP. Ultimately, the decision remains with the judge who would issue transport orders back to the county if the court is considering community restoration as the next level of care.

*"They don't need hospital level of care because they're not in immediate danger, they haven't assaulted anybody in the past 30 days, they are not suicidal. According to the county though, yes they need hospital level of care because they're still psychotic, they're not adherent to their meds. They're not engaging in treatments. We're using totally different criteria when talking about patients. And so again, this creates more miscommunication when we're talking about them in court or having a 9B community restoration hearing. Because we don't even have the same criteria or terminology for these things. What we mean by hospital level care is different. Of course, there's going to be chaos and miscommunication and differences of opinion, if we're not using the same guidelines."*

*–OSH staff*

Before transferring from the hospital, someone ideally receives wraparound services at OSH to plan the step-down to community restoration (or discharge). But a lack of resources in the community impacts the ability to step-down from OSH when the person needs supportive services and/or secure housing even if they are clinically stable.

*"There's a lack of services in the community which is what you probably hear from a number of people. There're just not enough placements, or there are not enough services. Counties don't feel like they're equipped to provide services for patients, especially if they have higher needs. They need a secure residential facility, or they need medication monitoring or whatever it is. Or they are at risk for substance abuse or whatever. They end up staying in the hospital, even if they don't need hospital level care really."*

*–OSH staff*

As previously described, there are waitlists for beds across the state, and a high need for community-based Secure Residential Treatment Facilities ready to take people directly from hospital restoration. Service providers indicated people were released from OSH to a shelter bed or houselessness depending on the county. OSH clinicians confirmed that people can be released to community restoration without stable housing depending on the judge, the community restoration agreement and certain criteria.

*"Typically, we try to work with the county to have a placement identified and have a way for them to get to the placement so we knew they would be safe. But I've had where the plan was to have a shelter bed that we could put them in, and the court has accepted that. There have been times where the counties have had to say they don't have anything, but they could give them a tent and a safe place to go. They'll provide case management and will check in on them. Sometimes, the courts will approve that plan, and some won't… Some of the patients we send on community restoration, they're not very stable. We have three criteria we look at to see if they can be treated in the community: harm to self, harm to others, and gravely disabled. If they are meeting those very low standards of criteria, we say that their needs can be met in the community."*

*–OSH staff*

## What are the competency restoration pathways?

In this section we will visit the complex restoration pathways we have previously discussed, including what proportion of people experience hospital restoration alone, community restoration or a combination of both as part of their restoration pathway.

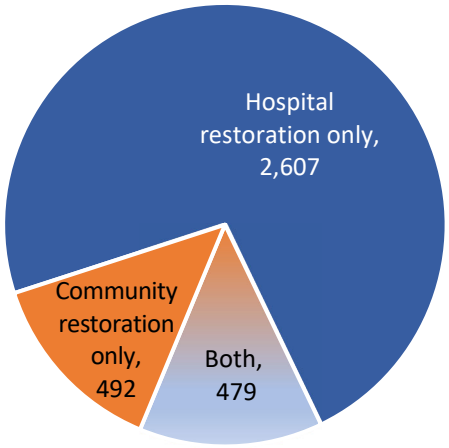
### What proportion of people are only in hospital restoration? Community restoration? A combination of both?

As noted in the previous chapter, the quantitative data we obtained allowed us to determine who had been in hospital restoration, who had been in community restoration, and who had been in both. The previous chapter covered people's histories of hospital and community restoration before the study period, and this section is focused on people's experiences with restoration during the study period.

As a reminder, our study group in the quantitative data included people who were ordered to either hospital restoration, community restoration, or both during the study period. We received hospital restoration records for the 3,086 people who were admitted between January 2017 and September 2022, and we received community restoration records for the 971 people who were served between January 2019 and July 2022. During these years, some individuals experienced only hospital restoration or community restoration, while others had records of experiencing both.

Figure 23 shows that of the 3,086 people who were in hospital restoration during the study period, 2,607 experienced only hospital restoration in those years. Of the 971 people who were in community restoration during the study period, 492 experienced only community restoration in those years. There were 479 people who experienced both hospital and community restoration during the study period. The 479 people who experienced both community and hospital restoration represent about 16% of the 3,086 people who were in hospital restoration during the study period, and about 49% of the people who were in community restoration during the study period.

**Figure 23. Number of people who experienced hospital restoration, community restoration, or both types of restoration during the study period (2017-2022), Oregon State Hospital and Oregon Health Authority.**




The amount of time people spent in restoration (i.e., their length of stay) differed somewhat between hospital and community restoration. Table 10 shows the average, median, and mode length of stay across all hospital restoration and community restoration episodes during the study period. Only episodes for which there was a recorded discharge or end date are included.

**Table 10. Average, median, and mode length of stay for hospital and community restoration episodes during the study period (2017-2022), Oregon State Hospital and Oregon Health Authority.**

| | Hospital Restoration (n=3,860 episodes) | Community Restoration (n=805 episodes) |
|---|---|---|
| **Average length of stay** *(Standard Deviation)* | 144 days *(131 days)* | 191 days *(173 days)* |
| **Median length of stay** | 88 days | 139 days |
| **Mode length of stay** | 70 days | 77 days |

Community restoration episodes averaged about 191 days and hospital restoration episodes averaged around 144 days, which is a difference of approximately 47 days. This means that during the study period, people's community restoration episodes were nearly 7 weeks longer than people's hospital restoration episodes. The median amount of time that people stayed in community restoration was also longer at 139 days, compared to the median of 88 days people stayed in hospital restoration. The mode or most common number of days spent in community restoration was 77 days, only 7 days longer than the most common length of stay among people who were in hospital restoration (70 days).

## What services are provided to people during competency restoration?

During data collection for this study, Oregon did not have a standardized implementation manual or procedural guide to describe and support competency services. The need for a community restoration program manual has been recommended by Dr. Pinals (Pinals, Neutral Expert Second Report Regarding the Consolidated Mink and Bowman Cases, 2022) as well as many of the community-based service providers we interviewed. In the absence of an implementation manual, we looked to the Oregon Administrative Rules (OARs) to define and describe the range of competency services that may be delivered to people whose fitness to proceed has been questioned.

Beyond the possible services listed as part of administrative rules, we wanted to understand which services were discussed during the interviews as part of the restoration process *in practice*. We wanted to assess what competency services were being delivered overall to understand if there was an Oregon "competency restoration program" happening statewide, regardless of geographic location or setting.

The OARs were written broadly so services **may be** included or added to community-based competency services even if they have not been specified in the OARs. OAR 309-088-0115 defines community restoration services as services and treatment that allows a defendant to gain fitness to proceed in the community and may include:

(a) Behavioral health treatment;
(b) Case management;
(c) Incidental supports;
(d) Legal skills training;
(e) Linkages to benefits;
(f) Medical treatment related to capacity;
(g) Medication management;
(h) Peer-delivered services; and
(i) Vocational services.

We heard discussion of many of these community restoration services during interviews, especially in certain counties. Interview data provided the context and insight into additional factors that allowed us to understand which services happened during the restoration process **in practice**, not just what was written in rules or statute.

> *"This Aid & Assist population was growing… And we're like, well what's community restoration? Like you want us to do it but like there's no guidance, we don't know what it is."*
>
> *–Court personnel, large county*

While this provider was seeking guidance for community restoration, we heard a similar refrain from providers about hospital restoration as they discussed what services they believed were expected, mandated or feasible at OSH. The OSH website lists services that **may be** provided during hospital-based restoration. We did not, however, hear people talk about most of the hospital services listed below, which we will discuss in the subsequent hospital restoration services section.

- Psychiatric and psychological assessments and treatment, including diagnoses, medications and therapy.
- Benefit eligibility and coordination, transition planning for discharge.
- Legal skills, teaching basic legal terminology and ideas that will help most people become able to aid and assist.
- Rehabilitation services to engage people in therapeutic activities aligned with their interests and strengths.
- Occupational therapy to assist with people's daily living skills such as cooking, personal finance and public transit.
- Medical and dental services, physical therapy.
- GED classes for people ages 18-21.

## Are there "core" or "essential" services in competency restoration?

We sought to identify if there were core or "essential" services delivered to all people in competency restoration regardless of geographic location or whether they were in hospital or community-based settings. In the interview data, only legal skills training and medication management were discussed consistently as a core service provided in both hospital and community-based settings across the counties. As supported by the OARs, not every person receiving competency services necessarily received legal skills training, but that was the service discussed most often and the service many people needed to gain/regain fitness to proceed. Medication management was also a core service for competency restoration but medication management differed greatly depending on the setting, so we will present how participants during interviews discussed medication within hospital and community restoration sections.

Forensic evaluations could be considered a service, and participants consistently discussed evaluations throughout the interviews, but this component is listed separately in statute and people discussed evaluations differently than services. So, we considered evaluations a core program component to determine fitness to proceed and hospital level of care instead of a service intended to provide therapeutic benefit or a positive change. Therefore, we presented data on forensic evaluations in a separate section of the report and are not including evaluations as a restoration service.

*Legal skills training*

A core service component for people in competency restoration involves legal skills training. The intent of legal skills training is to provide information needed to navigate the court process, which is a critical part of determining someone's fitness to proceed. Some providers or people we interviewed from various sectors believed that legal skills training was the **only** required service as part of restoration services, regardless of community or hospital setting.

> *"Even if somebody doesn't want any of their services, their team still comes and meets with people regularly. And they have to do legal skills, so they have to meet with them but they don't have to do all the rest of the stuff."*
> *–Non-state agency staff, large county*

At times, the content of the legal skills training did not align with what behavioral health providers in community or hospital settings felt was needed or possible for their clients, or was exacerbated by system and resource constraints, leaving medication and legal skills training what one provider called the "bare bones" service in competency restoration.

> *"Yeah so it's gotten that bad. So there's a lot of like, I can't transfer them to a therapist because we don't have one. So I would focus on meds and legal skills training, teach to do the test, and swallow your medications."*
> *– CMHP staff, large county*

Multiple providers mentioned the challenges with getting someone to connect their understanding of the legal system with their specific case, particularly in the short amount of time to stabilize and restore someone to competency. Some people going through competency restoration are able to understand the general legal skills trainings in a group setting but struggle to "apply it rationally to their case" because of the underlying and untreated behavioral health issues that need to be addressed individually or in long-term treatment.

*"…things like legal skills flashcards—I know the hospital has put in a lot of effort to design materials for the communities. I also know that when I meet with patients who are in the community and I ask, "Have you been studying your legal skills?" they frequently tell me, "No." The barrier to competency was delusions about the case. That person needs an individual therapist, counselor, a case manager, or some staff to sit with them, review the police report, and talk to them about the delusion. That's not happening. That person might have flawless legal skills knowledge, but it's still telling me that they will be acquitted, because the aliens are controlling the Justice Department's decisions."*

*–Forensic Evaluator*

Legal skills training was **discussed** consistently across the counties, but that did not mean legal skills training was **delivered** consistently across the counties. Implementation appeared to vary considerably, from someone having legal skills training every couple of days to someone receiving a packet with information and flash cards to pass the "test" for competency.

*"I've learned quite a lot about the actual statutes and what is required by those statutes while doing this because I don't want my client to be sitting there for six months without a forensic evaluation when he's been going to legal skills every couple days for months and not having any opportunity to prove his knowledge. I mean that's what we're here for."*

*–CMHP staff, medium county*

Some counties have used the legal skills training component as the foundation for engaging clients and built their Community Restoration Program around the materials. Instead of the legal skills materials and concepts being something a person has to "pass" or "check off" the legal skills training became the core of a larger program.

*"[We have] our legal skills groups, twice a week. I have created a curriculum that is rotating, based on the legal skills packet, that I've created. So, we have the curriculum that we follow and it goes week by week, and then we have a facilitator packet which has all of the answer keys. And I give everyone that comes into community restoration a Welcome Packet. It's got the legal skills workbook, plus it also has a lot more information. So we don't just give them a workbook when they step into the program."*

*–CMHP staff, medium county*

Some behavioral health providers expressed frustration that legal skills training was required in cases where they felt people primarily needed psychiatric medication for stabilization, not legal skills training. To be clear, we did not talk with anyone who stated that people in competency restoration do not need to understand their legal rights. Instead, some service providers emphasized that part of the "broken system" was the focus on getting someone to pass a legal

skills test instead of addressing their complex medication management issues or active psychosis.

> *"This person's never going to be restored because they're either not getting the treatment in the community or they're not getting it at the hospital, and this is pointless. I'm not going to keep the patient at the hospital, when they are not getting competency restoration services. They may get legal skills, but the client is factually competent, I'm not worried about their legal skills. I need their medications to be adjusted appropriately. They've been on one medication for a year, it's not working, they're still symptomatic. We have to medicate them for competency restoration purposes. And psychiatrists are not changing their medications. The psychologists are not given the time to provide individual competency restoration services."*
>
> *–OSH staff*

In hospital restoration, some providers discussed the "*overemphasis on just legal skills*" and medication instead of the full range of therapeutic and educational services that may be delivered as part of hospital-based restoration.

> *"When you're trying to do personalized patient-centered care, you can't do that in this system. The Aid & Assist folks are getting a disservice. I've watched the light go off in their eyes when they realize they're not going to get a therapist. Nobody is going to go talk to them. They're only going to go talk to you about your legal skills and your medications because they're trying to chemically restore you which basically means they want you to chill out and go in there and answer yes or no."*
>
> *–Non-state agency staff*

Notably, some providers believed legal skills training was a **required** service. We heard from some providers that they believed legal skills training was the only core service they needed to provide in a community restoration setting. If someone refuses other services or if staff capacity and resources are constrained, a provider might only deliver legal skills if they believe that is the only required service as part of community restoration.

> *"Even if somebody doesn't want any of their services, their team still comes and meets with people regularly. And they <u>have to do</u> legal skills, so they have to meet with them but they don't have to do all the rest of the stuff."*
>
> *–Non-state agency staff, large county*

## Hospital-based restoration services

There seemed to be a lack of agreement about what services were truly available at OSH for people going through the competency restoration process. The publicly available materials about hospital-based restoration services indicated people receive occupational therapy to

assist with daily living skills, GED classes, physical therapy, and care coordination as well as transition planning for discharge (Oregon State Hospital, Oregon Health Authority, 2019). This list of services did not align with what we gathered in the interview data from OSH staff and county providers, family members and patients at OSH as far as what is consistently available for people being restored to competency.

> *"I worked on the Aid & Assist docket for some time before I found out that when someone goes to the Oregon State Hospital on an Aid & Assist order, they're not receiving all around treatment, they're receiving Aid & Assist treatments and that's typically medications and legal skills. While that's a great band aid fix to temporarily get somebody through a planned sentencing, I'm not really sure what we're doing to help them."*
>
> *–State agency staff, large county*

> *"It's not the case that when judges send patients to the hospital, it's not the case that they're going to get all these things that they think they're going to get at the hospital. They'll get medication, they might get involuntary medication if they're acutely at risk for hurting themselves or others. They could get legal skills, groups, maybe they'll get individual therapy for a few patients. But I don't know if there's a good understanding in the community what they are going to get in the hospital versus what they can get in the community. And then you have patients coming in, and they're so confused, and they're being told different things from their communities, and their lawyers, from us, their teams. You know, if we're confused, they are sure as hell confused."*
>
> *–OSH staff*

One OSH staff member reframed and reconciled the lack of agreement about the services available during hospital-based restoration as an approach that is consistent with mental health treatment in general. Not all people in hospital-based restoration will need the entire menu of options available, so services might be tailored to each person going through restoration at OSH. Yet the core of the options listed by this provider were medication management and legal skills training.

> *"[Services] can be really broad, for most patients they need to have psychotropic medication. And for most patients they need some sense of stability in terms of managing symptoms of the qualifying mental disorder. For many patients they need to learn basic facts about the legal skills such as what a plea of no contest means, but it really varies individually, just like mental health treatment in general varies individually."*
>
> *–OHS staff*

*Forensic units at OSH*

Some of the units at OSH were once specifically designated as ".370 units, where the staff are trained in the .370 population." In these units the focus was on providing competency

restoration services specifically for the forensic behavioral health population and staff were trained in how to address the needs of the forensic population. As the quantitative data has demonstrated, however, the number of people in hospital restoration has grown substantially at OSH, so there are more people ordered to hospital-based competency restoration than there are beds in the hospital's ".370" units which has caused miscommunication about hospital-based services and constraints on services and staff.

> *"There's not even in the hospital really good, clear communication about what people can get between the different groups within the hospital. And administration doesn't understand what we can provide either. We have to kind of push back and say this is not possible. And especially not possible if you don't have a training to provide those things."*
> *–OSH staff*

The high numbers of patients in hospital restoration resulted in treatment units being converted into "split units" with people on .370 orders mixed in with Guilty Except for Insanity (GEI) or Civil commitment patients, each requiring their own set of services, terminology, and staff training. These split units reportedly cause difficulty and confusion for the staff and patients alike since the patient groups had different treatment goals and accompanying services.

> *"The units where they have not been traditional .370 units, it's been very, very difficult to work with them because the staff are not familiar with the legal terms that they're expected to know and the different plea options. When you have split populations on a unit, you also have split expectations. … You have the splits and so we have staff that are trying to do everything, and they want to support these patients. I have never worked where they don't want to support the patients, but when you have such conflicting needs, it is very difficult."*
> *–OSH staff*

*Individual or group therapy in hospital-based restoration*

We heard conflicting information about the levels of therapeutic services provided to people in hospital restoration at OSH. This may indicate delivery of individualized treatment plans and services, but also may indicate services have been inconsistently delivered or were not available to all patients. Some of the inconsistent reports about therapeutic services for people in hospital-based restoration may have varied by the interviewee's role, their therapeutic approach, or what year they received services or worked at OSH.

*"There was various one-on-ones you could do. But yeah, sometimes it was with my psychologist and stuff, which is really cool, being able to communicate your problems, or at least try to figure it out together. … One on one sessions seem to be very beneficial to me. … There was all sorts of groups. And some of them were, you know, behavioral, mental health type groups and things like that where we would get to, you know, talk about that type of stuff. So, yeah, I found the various groups very helpful."*

*–Person with lived experience*

*"I prefer to take the more holistic type of approach because a lot of people say, "Oh, this person's here because they're probably not able to aid and assist so all they need is legal skills." I personally think there's a load of crap because, do they need to understand their part in the process and where they're at, what that means? Yes, but if someone's actively mentally ill, you need to help them with understanding their mental illness, how to cope with that, be able to practice learning skills for emotional regulation or distress tolerance and to be able to do that in real life outside the state hospital."*

*–OSH staff*

*Constraints on hospital-based restoration services*

Two issues were raised that prevent OSH clinicians from offering more individual or group therapy and other services during hospital-based restoration. The first issue constraining services was clinician and staff capacity. Providers repeatedly raised the issue that they did not have time or enough clinicians to deliver therapeutic services to all the individuals in OSH on .370 orders.

*"There are some individuals who might require a little bit more individual work. It feels like there is just not a lot of time for individual work. I try to cap my individual work at five people. I also do three groups, but I also supervise two people and then I'm the head of the X program and then I have 6000 meetings. If I could get out of half of those meetings, I would absolutely see more people. It always feels like there's a juggle between going to meetings that are either required or recommended versus seeing a few more people. We're down vacancies and so I have to cover for different things."*

*–OSH staff*

OSH clinicians identified the challenges around prioritizing clinical services over meetings and administrative tasks. There were clear tensions from OSH clinicians around wanting to focus on patient care and provide clinical services but needing to address other OSH expectations.

*"That is my ultimate biggest frustration at my job. I'm not doing the work of a therapist, as a psychologist. It's a lot of meetings, documentation, meetings about meetings, document about documenting."*

*–OSH staff*

The second issue that emerged related to constraints on services at OSH was the need for specific staff training on what hospital restoration entails and skills to address the needs of the forensic behavioral health population. Interview data identified training needs around increasing staff comfort with forensic populations, safety issues, and specific clinical issues such as identifying and addressing co-occurring disorders among people in competency restoration.

> *"With .370s on GEI units and units that used to be civil commitment units, those staff don't possess restoration skills. They don't understand the restoration process. What the hospital is doing is broadcasting their .370 clients throughout the hospital."*
> *–Non-state agency staff*

One clinician believed the lack of staff training about forensic behavioral health contributes to the length of stay for people in hospital-based restoration. We cannot address that hypothesis without testing a training intervention and gathering additional data.

> *"Every unit now in Salem has been basically converted to a .370 unit. There's really no GEI or civil units, really left, really it's just predominately .370 patients on every unit now, and staff have had to adjust. I would say that the training is lacking across the board, working with this population, which I think is one of the reasons why it might take longer to get people out of the hospital."*
> *–OSH staff*

## Community restoration services

Beyond legal skills training, when we tried to understand what community restoration looked like in practice, the interviewees in many counties made generic references to "services" or "treatment," making it difficult to identify and operationalize the restoration services available across Oregon. Some service providers were more specific, discussing "therapy" and even specific therapeutic models like Assertive Community Treatment (ACT) that might be available to people undergoing restoration in that county.

Instead of describing specific therapeutic services, people in the interviews focused on people's unmet needs and what services were not offered in community restoration, or the challenges of engaging with people in community restoration settings. When discussing what services were needed in community restoration to restore a person to competency, there was a gap between people's needs and what services were available in most counties. Participants pointed out that many people might not meet the criteria for hospital level of care, but they still had high needs for behavioral health and social services and counties do not always have the resources, programming, and staff to meet those needs.

*"As time has gone by, we have access to fewer and fewer resources and clients with more needs than ever. So we are not connecting people with the level of care that they need in the community right now because the resources simply aren't there. Generally speaking, our people qualify—because of the severity and acuity of their mental illness and substance use disorders—for a very high level of services in the community, like ACT team. But unfortunately, we're just not able to access those services right now."*

*–CMHP staff, large county*

There did not appear to be a core set of community restoration services delivered consistently or equitably across the counties in Oregon. Instead, some counties created adaptive strategies and services to support people in community restoration, but these were above and beyond what other counties provided in the community restoration process. So depending on which county people were in when they were arrested and their fitness to proceed was questioned, people received different or inequitable restoration services. As one participant stated, "*The quality of services depends on your zip code." (OSH staff)*

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*"There's a lot of differences from county to county in terms of what services are available and how easily and how willing or - not 'willing' maybe is the wrong word - but how <u>able</u> CMHPs are to serve people in the community."*

*–State agency staff*

*Peer supportive services*

Some county agencies provide peer supportive services to people in community restoration. The peer support services varied depending on the agency plus the background and experience of the peer support specialists but are often focused on connection and working across sectors. We heard about peer supportive services that included prevention or diversion services, or transition services following discharge from hospital-based restoration into community restoration. Some agencies offered outreach and engagement services for people newly in community restoration, focusing on medication and treatment adherence. Many of the peer

supportive services focused on connecting people to other services in the county and filling in the many gaps in the service system.

> *"We see ourselves as diversion services and it is intensive services. We're doing legal skills training where we're doing everything that we can to help the person resolve any criminal charges and help them move forward with their housing stability. People don't stabilize until they can be a part of our community. That means physical and mental health treatment, having a place that they feel connected to, having a community that they feel connected to. Our peers and case managers do a great job at that."*
> *–CMHP staff, large county*

*Intensive case management, community navigation or wraparound services*

As described in the background section, many people in competency restoration need services to access "the most basic needs" like housing, food, transportation, and support to engage with their treatment plan in a community setting. Many community mental health programs (CMHPs) and other agencies across Oregon provide wraparound services, intensive case management or community navigators, but we heard that those services are often unavailable to people in community restoration. Sometimes these services are not accessible to people in competency restoration because they are "reserved" for people who qualify for specific programs or simply because there are so many people with behavioral health needs.

> *"Our clients are competing for the slots with the non-forensic clients - civilly committed clients. The State Hospital stopped taking civilly committed folks over two years ago because they needed to shift to meeting the forensic demands. … we don't have quick enough access to an ACT slot or intensive case management services, we can't get them what they need on a timely basis. And that backs up our system… There's just a big trickle down. Yeah, we're all competing for the same resources."*
> *–CMHP staff, large county*

System providers also discussed that tight resources means that people in competency restoration might be less likely to get the "program slot" than someone who is not involved with the judicial system.

*Medication in community restoration*

Many people we interviewed discussed the challenges of medication adherence for people in community restoration, especially since many people were unhoused. Some counties had adaptive strategies for administering medication to people in community restoration. Some strategies were tangible like giving people medication boxes or procedural like making sure they immediately established someone on OHP and connected them to a prescriber when stepping down from OSH.

*"We have a prescriber, we have a pharmacy, we have their therapists that can meet with them. I couldn't imagine if we didn't have all of that just right there. … When they're court ordered into the program … we're going by their community restoration plan so if that plan, and most of the time it does say, "client will engage in treatment, and if ordered by a provider take medications, client will stay where they're court ordered in the placement." So we'll have one of our therapists on the team do a mental health assessment and a treatment plan with legal skills group in it."*

*–CMHP staff, medium county*

In the prior example, the built environment supported medication management and overall therapeutic treatment planning for people in community restoration. Having a pharmacy able to dispense medication at the same location where people come for therapy and legal skills training increased the chance that someone might follow their court-ordered treatment plan. This structural and integrated strategy for co-located services appeared to be particularly important for unhoused people and people experiencing transportation challenges.

## How do system providers and sectors work together to provide competency services?

In counties, the system providers and sectors developed their own pathways, procedures, roles and expectations for competency restoration. We heard throughout the interviews that "*every county does their Aid & Assist process a little bit different*" which makes evaluating the restoration process challenging.

*"I know a lot of places are on their own but everybody seems to be sort of reinventing the wheel. You've seen Aid & Assist at one CMHP, you've only seen Aid & Assist at one CMHP."*

*–CMHP staff, medium & small counties*

Competency restoration pathways differed considerably depending on the county and evolved over time. A few county providers and leadership teams charged with developing competency restoration programs connected with people in other counties to share information and cross-pollinate promising practices.

*"I talked to my supervisor a lot, and I know that they had reached out to [this] County. Obviously they are a bigger county. They have a lot more cases than we do. But we saw the rise in [our] County and so we had to take that initiative and get in front of it because we couldn't keep kind of piecing together what we were supposed to do."*

*–CMHP staff, medium county*

In county systems, some providers built connections between the key providers serving people in competency restoration across sectors – the CMHPs, the court, the District Attorney(s), the

defense attorneys, law enforcement, and OSH when possible. As they were developing their restoration pathways, these counties created communication and local tracking systems for people in hospital and community restoration to "keep everyone in the loop" and anticipate transitions between assessment to hospital and community restoration or court dates. Other counties have struggled to build cross-sector communication and tracking systems with OSH and/or local jails, noting how the lack of information sharing impeded their ability to serve people in restoration.

> *"They [OSH] don't communicate. It seems like that would be a crucial piece of communication so that we have a cohesive system. Can't even figure out the dates unless we track it on our end. We don't even know the number of days that they're waiting in our jail unless we track it on our end. They won't give us their waitlist."*
> *–CMHP staff, medium county*

The CMHP management and staff described the "steep learning curve" they experienced as they became familiar with the legislation, statutes, and rules for competency restoration. They started to identify the various steps in the restoration pathway for their county, plus the various roles and sectors involved in restoration. Some counties identified or reconfigured the role(s) or credentialed person(s) involved in community consultation and who would be part of the treatment team to better serve forensic behavioral health populations or communicate across sectors.

> *"Aid & Assist was something that we knew as a county we've always had this obligation to do but I think we never actually sat down and wrote out procedures and things like that of exactly <u>how</u>. How we can work and most effectively serve the population within our county it was basically one person doing the legal skills training and it was usually the court coming to us and saying [your] County is responsible for this… We actually sat down and read the .370, .360, .365, and everything as far as like where our responsibility as a community health provider lies. And it's something that we are continuously improving."*
> *–CMHP staff, medium county*

## What adaptive strategies emerged across system providers?

Most counties experienced system constraints, staff capacity issues, and identifying resources to deliver restoration services so they primarily delivered those 'core components' of legal skills training and medication when indicated. But even with these system-level constraints and structural barriers, some jurisdictions were able to take advantage of the undefined programmatic space and create adaptive strategies to deliver more robust competency restoration services.

**Adaptive Strategies**

Across the interview data, certain characteristics emerged as system drivers that enabled some jurisdictions to deliver more robust community restoration services:

- Maximize existing, flexible, or new resources
- Reflect intentional service planning
- Create local competency restoration procedures
- Emphasize communication
- Identify specific roles for competency restoration
- Build or expand cross-sector relationships

These adaptive strategies appear to be interdependent and related, with strategies supporting and building upon each other as an overall approach to competency restoration. For example, in order to maximize existing resources or generate new funding, a county needed to expand their cross-sector relationships and rely on good communication with community partners while using the intentional service planning they had done around competency restoration for their county.

*Adaptive strategy: Maximize existing, flexible, or new resources*

There have been a limited number of funding mechanisms for counties to support competency restoration in their jurisdiction. Four "focus counties" were part of a pilot project in the mid-2000s and received funding to expand community-based services, though the pilot was not originally focused on restoration services and reducing the number of people at OSH for hospital restoration. Other counties used funds through their IMPACTS grant, which was intended to address the shortage of comprehensive community supports and services for individuals with mental health or substance use disorders. Then counties were awarded funds through "the RFA" in 2022, which was specifically intended to address competency restoration and divert the number of people going to OSH.

Even with these various funding sources, we repeatedly heard from some counties that they receive a "ridiculously small" amount of funding and that competency restoration is an "unfunded mandate" trying to fill gaps across multiple systems. Interview data highlighted the tensions that "there's no secure funding" and yet some counties have chosen not to seek additional funds because they were concerned about sustainability issues. Counties spoke of needing to hire staff or wanting to expand services but were concerned about grant funding that would expire in a few years. The inequitable distribution of funds across counties and the lack of sustainable funds to deliver community-based restoration services was discussed throughout the interviews.

> *"The minimally funded mandate we have for this – that's one of the challenges most certainly…Again, it's grant funding. So the sustainability of what we put in place is a concern and how we keep those things once we get them."*
> *–CMHP staff, medium & small counties*

Some counties used a variety of adaptive strategies to address sustainability, restrictions on funding or low levels of funding for competency restoration services. Strategies included maximizing existing funds from other funding mechanisms or using flexible funds like the RFA funds to offer expanded restoration services they feel are necessary for successful competency restoration. Participants spoke of counties that sought additional funding opportunities from other sectors like housing or community development, from county or regional decision-makers, or from local or federal grants. Some participants spoke about writing grants themselves or working with grant writing staff at nonprofits or other organizations to provide content for the grants they were submitting.

Whether counties sought new funding or maximized existing dollars or braided funding across sectors to create local sustainability plans for competency services, this adaptive strategy sought out ways to embed competency restoration in multiple programs, funding opportunities and cross-sector activities. Participants from housing, law enforcement, CMHPs, and other sectors talked about how they proactively looked for creative ways to fund pieces of competency restoration in work they were already planning or doing and "crossover" opportunities. Often these opportunities arose from having built strong relationships with cross-sector partners in the county or region.

Even the counties that took a countywide cross-sector approach to competency restoration and sought funding from multiple sectors and decision-makers to deliver more of the competency services listed in the OARs recognized that effective community-based restoration needs more than just a bootstrap mentality to seeking funding. This adaptive strategy needs additional structures and resources to support counties to improve countywide the community-based restoration model.

*"You've made all of these decisions and all of these laws that focus on a community-centric approach, but you haven't funded that community-centric approach. And you haven't provided the resources to make that community centric approach effective. So lofty goals without building the foundation to make that happen. So I think like, I don't know what the ideal system looks like, but I know right now the foundation, just even that foundation isn't there for it."*

*–Court personnel, large county*

*Adaptive strategy: Reflect intentional service planning*

Counties using this adaptive strategy took a person-centered approach and were thoughtful about what services, resources and materials people needed to be successful throughout the competency restoration process. Intentional service planning resulted in local restoration programs ready to meet smaller needs like medication boxes or bus vouchers to larger needs like housing and health coverage. Counties employing this strategy were prepared to deliver whatever services people needed to "know what guilty means" while also getting their needs met.

*"There's this big catch all of services where people need more support but don't have anybody to help them with that. Like today, we just got somebody on Monday from OSH. He's had to go to the bank, he's had to get food stamps, he's had to go apply to make sure all his insurance is on. Today I took him back down to the jail to get a release agreement signed because he came to us instead of the jail, so he went from OSH to us instead of OSH to jail to us. So we have to take him down to get that, we took him to get food, he doesn't have clothing, he needs to bring all his discharge paperwork to Social Security Office - there is just so much stuff that has to be done."*

*–Non-state agency staff, large county*

When planning how to meet people's needs and provide the wide range of services and resources for people in restoration, county providers identified and engaged the sectors that could provide and deliver those services and resources. One county described how they went through the statutes and considered the restoration pathway and then planned how to connect sectors and providers when possible.

*"We went from Aid & Assist being something that we know we need to do but no one ever really took the time to sit down and come up with like, what really does it mean when someone's getting a .370 order? Where do our responsibilities lie when we're receiving the .365 [order]? You know, who do we send it to, what are they looking for in the community findings report, like how do we effectively communicate? This is what we have in the community versus not. And then even, one of the biggest things that I actually am really proud of and things that we've done is the aftercare. So instead of just dropping someone off when they become able, making sure that we're like using Aid & Assist like a vehicle to be a liaison to other services. So technically you're off Aid & Assist... But instead of just saying, okay I'm done, well let's talk: Do you want mental health services? Is substance use something you want to do? Housing? I mean … housing is a big crisis everywhere. Even though I can't get you housing, can I connect you with our ENCC, to see if maybe a higher level of care is needed?"*

*–CMHP staff, medium county*

*Adaptive strategy: Create local competency restoration procedures*

In the absence of statewide implementation guides, a few counties we interviewed were very transparent about their challenges with "losing track" of people in competency restoration and that people were "kind of getting lost" between the public defender's office, the District Attorney's office and the mental health providers. One county clarified that their initial lack of procedures meant "there was no real accountability, no real keeping them kind of on track and in check." *(Court personnel, large county)*

As a response, some counties developed local procedures and protocols for community restoration in their jurisdiction, from identifying meeting protocols and clarifying procedures for community consultation to creating an Aid & Assist court docket or rapid assessment procedures for the county. Protocols included having a specific judge or District Attorney assigned to the Aid & Assist court docket so they understand the unique needs and varied issues for people ordered to competency restoration. The quotes in this section demonstrate how the adaptive strategies are interdependent and creating procedures relies on cross-sector relationships and excellent communication between partners.

*"So everybody's on that docket who is pending community restoration. But I do think we have a lot of success with that program, and rarely do we have somebody not come to court. And for the population, who has so many challenges anyway, to get themselves to court or to [the local mental health clinic] and engage, I think it's really amazing. So we're lucky to have really good partners, our local mental health program, and we communicate very well. There's a dedicated DA who just handles the Aid & Assist docket basically, doesn't do commitments or mental health, we have a different DA for mental health court. For our Aid & Assist population, it's a dedicated DA and there are dedicated defense attorneys too. So I think the success rate is really good…anecdotally I would say that probably 90% of our docket is eventually restored."*

*–Court personnel, large county*

Other procedures included consistent days for the Aid & Assist docket so county partners, OSH staff and people going through restoration would know when any court actions would happen related to competency restoration. This improved communication and efficiency and appeared to provide stability for the defense attorneys, family members and cross-sector providers involved.

*"So for every person who is put into our fitness to proceed or aid and assist status, once the defense attorney has filed their initial fitness concerns, it gets placed on our Aid & Assist docket which is every Thursday and Friday in front of the same judge - unless she's in trial and occasionally our presiding judge will handle it - but it goes in front of the same judge. So every aid and assist hearing, whether it's the initial .365 hearing, a .370 hearing, or status checks on somebody who's in community restoration or at the state hospital being treated until fit, all of those status checks appear in front of the same judge on a weekly basis. And that includes the "ready to place" letters, anything like that. All of that happens in the same place in front of the same judge every week."*

*–Court personnel, large county*

*Adaptive strategy: Emphasize communication*

Counties employing this strategy used multiple channels and modes of communication to serve and support people at various points of the restoration process. Emphasizing communication might include providers picking up the phone to introduce themselves people they might not typically interact with from different sectors across the county, emailing people to follow up on unresolved items for people in community restoration, and showing up consistently to meetings at OSH for people in hospital restoration.

*"Ever since I had taken [the role of liaison] over, we made sure to attend every single treatment care plan meeting. Although we weren't actively participating, especially if someone had just recently gotten into the hospital, we just wanted to attend those meetings to keep our presence there to allow the state hospital and the treatment team to see that, you know, as a liaison even if our role wasn't very active, we were still there. Then we would take the updates and all of the documents that the state hospital would provide us every 30 days. Basically condense the information and then send a status report to the court, defense and DA, just to kind of keep everyone in the loop, especially for those folks that are in there longer term."*

*–CMHP staff, medium county*

Emphasizing communication goes beyond just using multiple channels like emails and phone calls or showing up to meetings – it is about the process, content, and quality of the communication. The provider in this next quote emphasized honest and transparent communication between county partners by talking openly about issues and frustrations, so they were able to identify and address problems in how they delivered restoration services.

*"We recently began quarterly meetings. We had our first quarterly meeting around Aid & Assist in May that we thought included all the partners, but we hadn't invited our jail partners. So the next quarterly meeting we have, our jail partners will also be there. But we had the DA's office, public defender, the courts were there, represented, we had one of our judges attend, which was nice. And then our staff that's involved in that activity. We just shared information, we talked about barriers, we talked about some easy reaches that we could change like on the forms and consistency in the orders that would help us. And there was a lot of, I think there's a lot of receptiveness to all those parties working together. But there's a lot of frustration voiced in those meetings when we're all together, because we all feel some part of that frustration in what feels like a very broken process. Just the flow of clients is not what it should be and people get stuck places, like stuck at the jail."*

*–CMHP staff, medium & small counties*

This adaptive strategy includes creating communication channels with people going through competency restoration and their family members, working to explain and demystify the complex restoration process and ensure that people have someone to contact when needed. One provider even mentioned they felt this emphasis on communication and directly engaging people might interrupt the revolving door of competency restoration.

*"When they've got people from the courts who can say, "Hey, so and so just passed through. We need to get them whatever if X is going to happen." They can then send a responder out to go engage that person who already knows them. "Hey, how's your dog's foot? I know you were trying to get them to the emergency vet." With that kind of connection, you can solve problems by the inch out in the world. Things that unattended, are going to spin out and end up in the Aid & Assist process."*

*–Non-state agency staff*

*Adaptive strategy: Identify specific roles for competency restoration*

The counties implementing adaptive strategies have identified roles to support people either throughout the restoration process or at key transition points in the restoration process. These roles might include an Aid & Assist Coordinator assigned by Oregon Judicial Department (OJD), integrating Exceptional Needs Care Coordinators in the Aid & Assist process, or specifically creating a peer support role for people in community restoration. Notably, these roles emerged as adaptive strategies in our interview data, and are consistent with the recommendation made by Dr. Pinals (Pinals, Neutral Expert Second Report Regarding the Consolidated Mink and Bowman Cases, 2022) for a Community Navigator to support people as they transition from OSH to community settings.

This strategy may be as much about the intentional service planning, the communication, and the cross-sector relationships people in these roles are building, but having people in these roles responsible for <u>implementing and utilizing</u> these adaptive strategies may be essential for creating a robust county infrastructure for competency restoration.

<u>Aid & Assist Manager</u>

This position is often located in the CMHP, and the person may or may not work directly with clients in competency restoration. Managing the competency restoration program might be just one part of the person's role with one or more staff or team members working directly with people in competency restoration. We were unable to determine through interview data if all jurisdictions have an Aid & Assist Manager position.

*"Among other programs, Aid & Assist is one that I oversee, and I manage staff who work directly with Oregon State Hospital, Oregon Health Authority, the court, providers, and the clients. So my role is a little bit more oversight. I generally don't work with the clients directly, but I have two staff, two members of my team who, one is a Oregon State Hospital liaison between the CMHP and the Oregon State Hospital. And then I have a peer who does a lot of work with people who are in community restoration, from legal skills to supporting trying to get people housing or other resources for example."*

*–CMHP staff, large county*

OJD Aid & Assist Coordinator

This position is funded by OJD and is intended to support and promote implementation of local competency restoration. In the 2021/23 biennium, there were ten positions requested (8.75 FTE) through OJD. The Aid & Assist Coordinator has access to the OJD Aid & Assist Coordinator Dashboards developed by the Behavioral Health Advisory Committee (BHAC) and are not publicly accessible data. The dashboards include information on the number of people in competency restoration over time, the most recent placement for people found unfit to proceed, information on hearings held, and disposition information.

> *"I'm a coordinator. And I'm not really sure, like I get the impression that we don't all do the exact same things in every county. I think everybody kind of has their own way of handling their coordinator position to an extent. I tend to take a pretty hands-on role. I handle all of the docketing, all of the orders and I handle all evaluations that come in, anything like a protective order that needs to come in for signing I handle all of it. …So I'm kind of like the gatekeeper as far as the County Courthouse is concerned for Aid & Assist docket."*
>
> *–State agency staff, large county*

Aid & Assist Liaison

Some people we interviewed referred to a "liaison" position that was different from the OJD-funded Aid & Assist Coordinator position. Instead, the liaison role seems to have been developed by counties to fill a similar coordination need, and work to connect the various sectors serving and supporting people going through restoration but not as a position funded by OJD and sitting in the courts. This position typically works directly with people going through competency restoration and can have a therapeutic role or more of a case management role.

> *"I currently work for the CMHP…as the forensic therapist, so I primarily have the role of being the .370 liaison, which means that I'm the one that coordinates all of the .370 Aid & Assist stuff with the circuit court and with the state hospital. I provide therapy for individuals that are on community restoration, legal skills training, connecting them to additional resources in the community if they need it, arranging discharges, testifying in court if needed... I have a caseload of about 40 active clients and then an additional 10 that are either pending evals or still in custody or things like that."*
>
> *–CMHP staff, large county*

ENCC

Oregon developed the Exceptional Needs Care Coordinator (ENCC) role, a type of specialized case manager, roughly 25 years ago to support people enrolled in the Oregon Health Plan (Walsh, French, & Bentley, 2000). Some counties have adapted this role to support people throughout the competency restoration process, or at key transition periods during restoration

like discharge planning. Someone serving in an ENCC role may deliver support to people in competency restoration as well as in other programs.

> *"I'm an exceptional needs care coordinator (ENCC) for [XX organization], that is the community mental health provider for [this] County. And in my role, I am the ENCC for the Aid & Assist population. What my role is that when a county person enters into a .365 or a .370 then I start following them. If they are admitted to OSH I attend IDTs, coordination of care, discharge planning. I call into their hearings, because there's just not enough time to be able to be there in person, but I do call in to the hearings to stay updated. Yeah, I'm just the county liaison for Aid & Assist for [our] County."*
> *–CMHP staff, medium & small counties*

<u>Peer support specialist</u>

We described some of the peer supportive services delivered during community restoration in the previous section, but the role of the peer support specialist deserves additional description. Beyond the services, we heard repeatedly about the importance and impact of having a peer support specialist on the team. As one manager stated, "*if they're only going to let me get one person I'm probably going to get the full time peer*." (*CMHP staff, medium county)*

The ongoing communication, consistent follow-up and non-judgmental approach meant peer supports were able to build trusted relationships with people in community restoration and cross-sector service providers. Peer support specialists attended team meetings, went to court, and "coached" people in community restoration to meet their court-ordered treatment goals, providing services across settings and sectors.

> *"We just got a new peer support... [they are] amazing. And [they are] now on our crisis team. In my opinion, [they are] the key. Having a peer support involved in Aid & Assist is the key to community restoration, because [they] had daily contact with this [person]. And this particular [person], I have known for seven years because I dealt with [them] when [they were] in the jail, [they've] been in jail multiple times. So I have a long history of working with [them], and not once [have they] ever engaged with our agency, ever, until now. [They are] stable [and] staying in our shelter, [they are] taking [their] meds [and] sees our peer support [person] every day. [They are] on the ACT team now."*
> *–CMHP staff, small county*

*Adaptive strategy: Build or expand cross-sector relationships*

Creating, building, expanding, and repairing relationships across sectors appeared to be an important factor in delivering robust community restoration services. Throughout the interviews, we heard how important positive relationships were between the judge, DA, defense attorneys, CMHPs, and law enforcement to implementing competency restoration. In some jurisdictions, people built on past relationships formed through "wellness courts" or problem solving courts such as mental health courts or treatment courts. New positive

relationships were built in other counties because the courts were working towards the same goal and did not take an adversarial approach to restoration, as demonstrated in the following quote.

> *"I've realized over the years, that [our] County is a little different from the other counties because the prosecution and the defense actually work very well together. They have a mutual respect for each other because a lot of our defense attorneys used to be prosecutors and vice versa. And we actually have a very good working relationship in our county, which is great. When I've had clients in other counties I was like whoa, you guys aren't friends. I'm not used to that. In this county they discuss all the time because it's in everybody's best interest to move forward in the legal process. And so we kind of work together on stuff."*
>
> *–CMHP staff, large county*

A relationship that many counties worked to expand, rebuild or repair was between various county providers and OSH staff and clinicians. As noted by Dr. Pinals, the neutral expert, there are "gaps in coordination between OSH and the community" (Pinals, Neutral Expert Fifth Report Regarding the Consolidated Mink and Bowman Cases, 2023) that would benefit from cross-sector relationship-building as well as other adaptive strategies. In the absence of clear discharge planning procedures and communication systems that share crucial data and information, many counties rely on relationships with OSH staff and clinicians (and vice versa) to know the status of someone in hospital or community restoration.

But these cross-sector relationships between OSH and the counties have been more difficult to build, repair and maintain because of bad experiences and high staff turnover at both the community organizations and OSH. The following quote shows how these adaptive strategies are inter-related and stable cross-sector relationships rely on communication, intentional service planning, and people in specific roles to support discharge planning and community restoration.

> *"Even within the same hospital, you have silos. And then you bring in the legal team, you bring in the counties, you bring in the court system, and it's a mess because everyone is on a different page. You're constantly having to educate people over and over again … You just have total miscommunication and chaos, and things are constantly changing. So, it's hard to keep up."*
>
> *–OSH staff*

To address these challenges, some jurisdictions worked to engage providers in housing, substance use disorder treatment (especially those treating co-occurring disorders) and other sectors that are crucial for meeting people's needs before, during and after competency restoration.

*"I mentioned [this] County where they've got beds available and on reserve. They've got crisis workers in the street mingling with this. They're dealing with people coming in and out of the jail system. They've got an ally in the courts cuing them in. There's somebody helping them in the streets. When that crisis worker goes and meets somebody at the door of the courthouse and say, "So and so gave me a warm hand off and says you need help." You can take them from there and put them in a bed where there's drug and alcohol rehab access. There are those things that can snatch you out of the chaos and plant you some place to at least give you the tools to go forward."*

*–Non-state agency staff*

Some providers focused on the benefits of being in a more rural or a smaller geographic county so providers were more likely to know each other and prioritize relationships over bureaucracy. This quote reflects the person-centered approach and intentional service planning strategy as well as cross-sector relationships.

*"We have bus passes, we've got access to food stamps, but I think that's also a benefit to being a smaller county so instead of going through a whole process to get someone a food box … I can call up someone and say 'hey can I get this food box real quick' or the people at the clothing closet, if there's clothing at the Resource Center, I can just call up. So as far as like material things, I think, for how small we are and how limited our funds are, we have very good rapport and relationships with a lot of community partners that if we have a specific need for an individual, we can more or less get it covered."*

*–CMHP staff, medium county*

# What happened in people's lives after going through the restoration process?

The following chapter provides a detailed overview of our data on what happened in people's lives after going through the competency restoration process. We present findings from a limited set of quantitative data that included forensic evaluators' determinations of people's competency at the end of hospital restoration, along with qualitative data about the meaning of certain competency categories. We then report findings from our quantitative data on whether people were convicted of the offenses that brought them to competency restoration, whether they were sentenced to prison, jail, or probation, and the frequency with which people were arrested after being discharged from restoration. Finally, we describe findings from our quantitative data on how many people returned to hospital or community restoration and discuss what our interview participants called the "revolving door."

## What were the outcomes for individuals who received restoration services?

The **original** intent of this question was to compare the outcomes for individuals during the study period in community versus hospital-based restoration using quantitative datasets then offer context through our interview data. But even before we received the quantitative datasets, it was clear through interviews and talking with people in different roles and sectors, that the outcomes data and categories would be much more nuanced than we initially anticipated. Once we received some of the quantitative data and started cleaning and merging those datasets, we realized we would not have "able vs. not able" outcomes for all of the individuals in our study period, and we began to understand the complexity of the competency restoration process and datasets overall. Our questions around the outcomes data shifted to accommodate the reality of the restoration process and datasets provided.

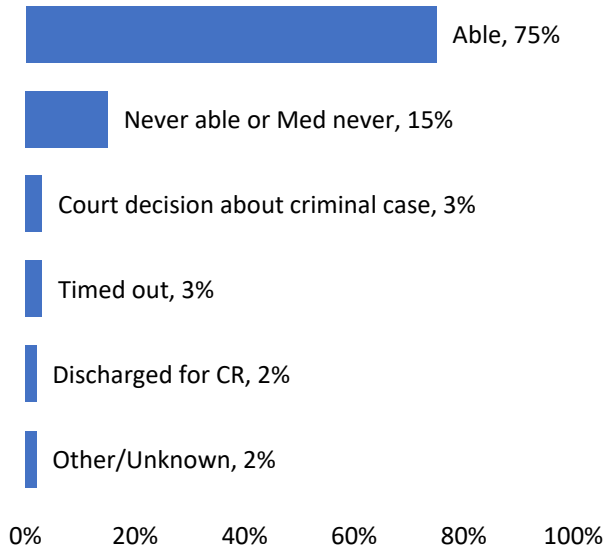
### What was people's competency status at the end of restoration services?

Per Oregon statute, the purpose of competency restoration for people who have been charged with a crime is to restore their mental capacity so they are well enough to proceed with their criminal case and aid and assist their attorneys in their defense. Oftentimes the court or a defense attorney will solicit an examination by a forensic evaluator to help determine someone's competency, and the evaluator's findings can be used by the court to inform their decision. Ultimately, the determination of whether someone is "able" to proceed with their criminal case is made by the court.

Whether or not a person is considered restored and found "able" after they go through competency restoration is not information that is tracked in shared data systems. The Forensic Evaluation Services (FES) unit at the Oregon State Hospital (OSH) tracks their evaluators'

competency findings in a spreadsheet, however the information is not easy to access or extract for use by internal or external partners or for systematic assessment or research purposes. CMHPs are not required to track or maintain competency findings, and OHA does not track or maintain this information either. Whether or not the courts track and maintain this information in their data systems is unknown.

**Figure 24. Forensic Evaluation Services' determinations of competency at the end of hospital restoration for a limited selection of people who were admitted in 2017 and 2018, Oregon State Hospital.**




For our purposes, we received information about FES-determined competency status for a limited selection of people who were in hospital restoration whose records were accessed as part of a manual review by an OSH staff person (see Table 1 in the Methods section for more information). Figure 24 shows that the majority of people who were admitted for hospital restoration in 2017 or 2018 received a FES determination of "able" at the end of their hospital episode. About 15% were found "never able" or "medication never," which refers to individuals who do not meet criteria for involuntary medications, but the evaluator speculates will not be found able without medications. A small proportion were discharged from the hospital to community restoration. The rest of these individuals had a variety of outcomes that were unrelated to their competence and instead had to do with either the legal limits for hospital restoration or a court decision about their criminal case. Specifically, 3% of people were legally required to be discharged from the hospital regardless of their competency status (i.e., they "timed out"), and another 3% were discharged due to their criminal case being dismissed, charges being dropped, or the court order being rescinded or vacated. As a reminder, this data covers people's competency status as determined by FES and not the court. The individuals reflected in Figure 24 who were found "able" by FES could have been found "unable" by the judge assigned to their case, or had their charges dismissed after being found "able." The project team did not receive quantitative data within any of our data sources that noted the court's final determinations of people's fitness to proceed.

The interview data helps us understand that each of the categories presented in the Figure 24 above are more nuanced than they may appear. To be found "never able" is not a permanent or static state, but a determination on a specific charge. We heard frustrations about how "never able" outcomes contributed to the "broken system" of restoration.

*"Never able means never able for this charge. Okay, it's not like never able, it's just, you're never able today. So they can come in on a different crime, and then go through the process again three weeks later."*
*–CMHP Staff, medium county*

A "competent to stand trial" or "able" outcome might not be as straightforward as some people external to the system might expect for someone to stand trial. The complexity raises the central issue of medication for competency discussed earlier and is a major factor in placement decisions and determining level of care.

*".370 patients can be actively psychotic. As long as they are able to make independent decisions from their symptoms, they can pass their evaluations and go back to court. Just because they're not on their medications, that's not a reason to be found not able. We do what we can, but they have more autonomy to take their medications or not."*
*–OSH staff*

## Were people convicted of the offense(s)?

As previously mentioned, we received a large amount of data related to the criminal offenses people were charged with prior to and after experiencing competency restoration. Also previously mentioned, the state's many data systems that contain information about people who are in competency restoration are not connected to each other—that is, hospital and community restoration records are not linked with each other or with criminal justice data systems. Because of this, we were unable to link people's exact criminal cases and charges with absolute certainty to their associated competency restoration episodes. We instead selected the criminal case that occurred in closest proximity to the start of people's hospital or community restoration episodes and report our findings with the assumption that the selected criminal case *likely* prompted the order for competency restoration. We examined the outcomes of the charges associated with the selected criminal case to assess whether people were convicted of the offenses that brought them to competency restoration.

Figure 25 shows findings for people who were in hospital restoration by offense class. Overall, the proportion of people who were charged with each type of offense did not equal the proportion of people who were convicted or the proportion of people whose charges were dismissed. For the felony offense classes, about the same proportion of people had their charges dropped as were convicted of the charges. Within the misdemeanor offense classes, a smaller proportion of people were convicted and a higher proportion of people had their charges dismissed.

**Figure 25. Charges, convictions, and charges dismissed by offense class from the criminal case that likely prompted people's first hospital admission during the study period (2017-2022), Oregon Judicial Department.**

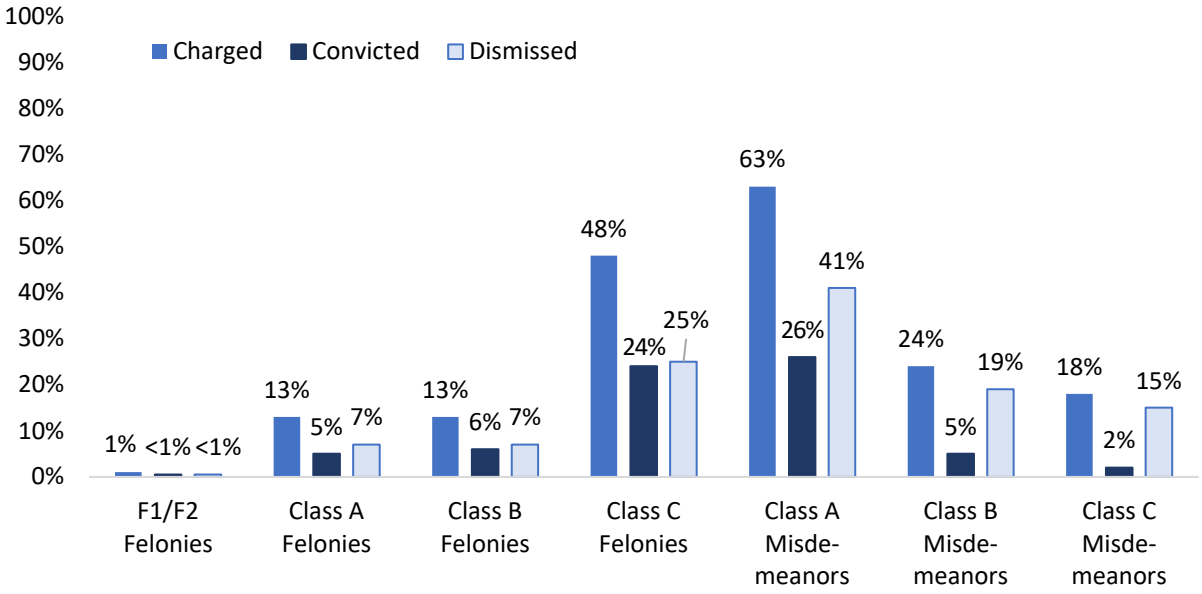
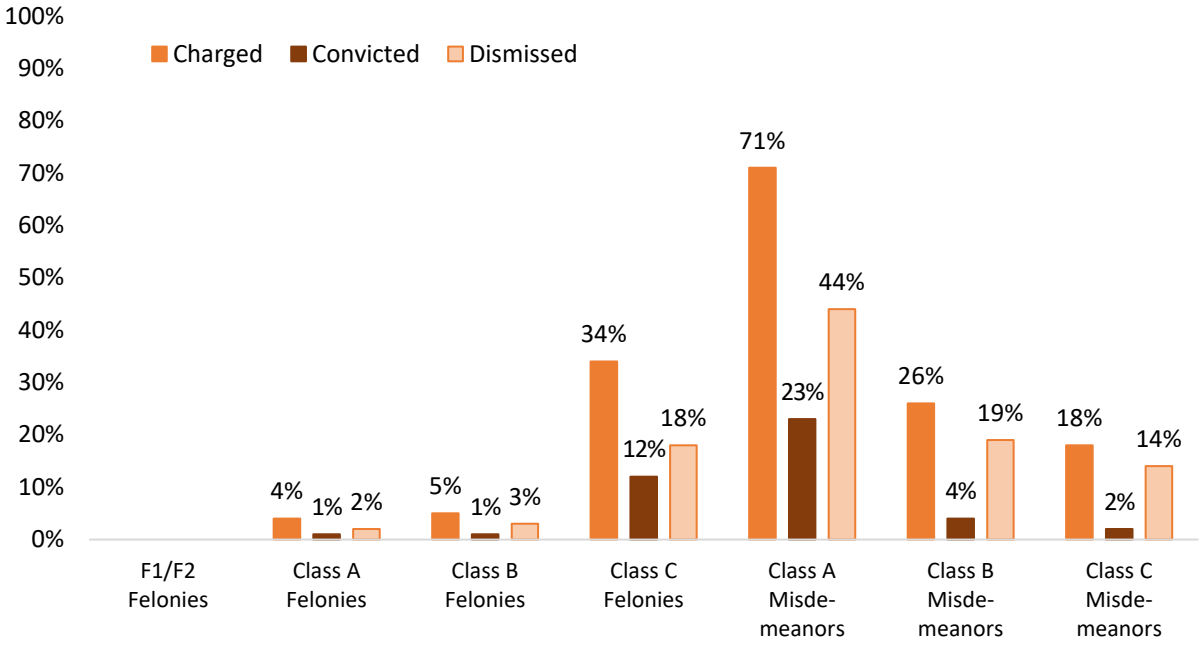



Figure 26 shows the original charges, convicted charges, and dismissed charges for people who were in community restoration. Similar to what the data showed for people who were in hospital restoration, more people who were in community restoration were charged with each type of offense than were convicted or had their charges dismissed. Within the felony offense classes, more people who were in community restoration appeared to have had the charges dismissed than were convicted. A similar pattern was observed for the misdemeanor offenses, where more people had their charges dismissed than were convicted as well.

**Figure 26. Charges, convictions, and charges dismissed by offense class from the criminal case that likely prompted people's first community restoration episode during the study period (2017-2022), Oregon Judicial Department.**

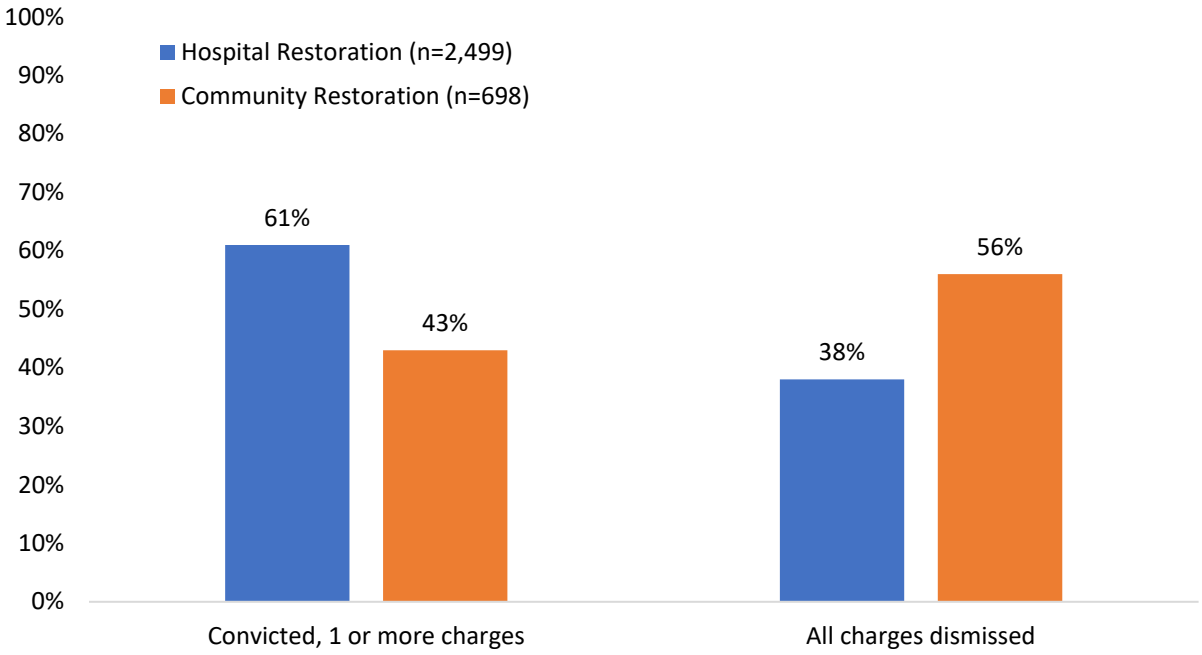



Another way to assess whether people were convicted or had their charges dismissed is to examine these outcomes at the case level rather than the charge level. That is, a person would be considered "convicted" if they were convicted of any of the charges on their criminal case, and a person would be counted as having their "charges dismissed" only if every charge on the case were dismissed. To examine the data this way, we considered everyone who was in hospital restoration or community restoration who had dispositions for every charge on the criminal case that likely prompted their restoration episode. That is, we only analyzed the cases of the 2,499 people who were in hospital restoration and the 698 people who were in community restoration whose charges had been settled (i.e., disposed). Figure 27 shows that, under this case-level interpretation of "convicted" vs. "charges dismissed," 61% of people who were in hospital restoration were convicted and 38% had their charges dismissed. Among people who were in community restoration, the data indicated that 43% were convicted and 56% had their charges dismissed.

As we have repeated throughout this report, it is important to interpret the data and findings around criminal cases, charges, and dispositions (i.e., convictions and dismissed charges) with a degree of caution. Because we were unable to link criminal cases with certainty to their associated hospital or community restoration episodes, we cannot definitively conclude that the charges and dispositions summarized in Figures 25-27 are the ones that prompted people's entry into competency restoration. It is not uncommon for prosecutors and courts to combine or merge multiple criminal cases into a single competency restoration order and process, and it

is possible that not all of the criminal cases we selected for analysis (i.e., the case that occurred in closest proximity to people's restoration episode) were the exact cases that prompted the hospital or community restoration episodes we examined for this report. Had we been able to connect criminal cases with their associated competency restoration episodes or had we chosen a different method of selecting criminal cases for analysis, our findings may have been different. Our confidence in the findings presented in these Figures is strengthened by what the data showed for people's histories of criminal cases and charges. That is, in an earlier chapter we presented data that indicated people had more prior charges that had been dismissed and fewer charges for which they had been convicted (see Table 7 in the Backgrounds of the people in competency restoration section for more information). Still, we are hopeful that future research and analysis will involve a way to connect criminal cases to their exact competency restoration episodes so that the state can be more certain in the results.

**Figure 27. Percent of people who were convicted of one or more charges and who had all charges dismissed on the criminal case that likely prompted their first hospital or community restoration episode during the study period (2017-2022), Oregon Judicial Department.**

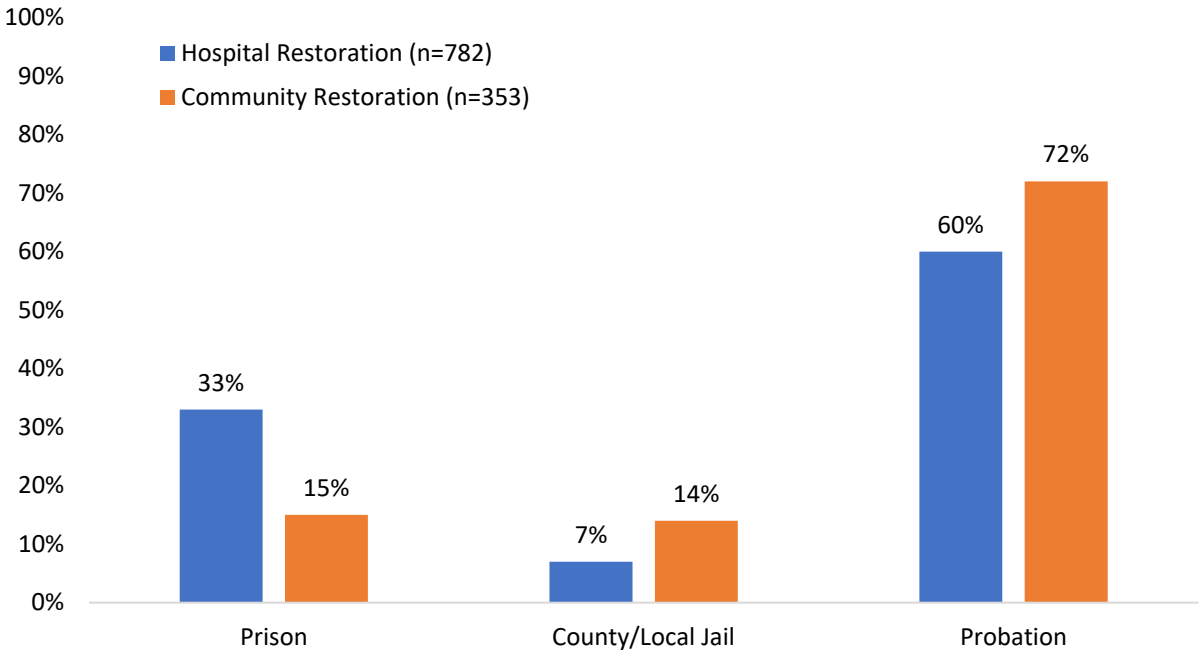



## Were they sentenced to incarceration, jail, or probation?

We received data from the Oregon Department of Corrections related to sentences people received from their criminal case(s). As a reminder, the DOC data primarily included sentences for felony convictions and some sentences for misdemeanor convictions if the person was supervised by the county's community corrections department.

Because the DOC data primarily included sentences for felony convictions and perhaps because of the lower number of felony convictions observed in the criminal case data, only 782 people who were in hospital restoration during our study period had sentencing records that matched to the criminal case that likely prompted their admission. Only 353 of the people who were in community restoration during our study period had sentencing records that matched to the criminal case that likely prompted their community restoration episode, perhaps because fewer people who were in community restoration were charged with a felony and fewer still were convicted of a felony.[16] Figure 28 shows the proportion of people who were in both types of restoration who were sentenced to prison, county/local jail, or probation.

**Figure 28. Percent of people who were sentenced to prison, jail, or probation as a result of the criminal case that likely prompted their first hospital or community restoration episode during the study period (2017-2022), Oregon Department of Corrections.**




The data indicate a larger proportion of people who were in hospital restoration received prison sentences compared to people who were in community restoration, and a larger proportion of people who were in community restoration received probation

> For both people who were in hospital restoration and people who were in community restoration, the most common type of sentence was probation.

[16] As with people who were in hospital restoration, more people who were in community restoration had sentencing records in the DOC data that matched to other criminal cases they had, but they were not as likely to have prompted their community restoration episode and were therefore not included in the analysis.

sentences. This is likely due to the differences in people's charge levels – that is, felony charges were more frequent among people who were in hospital restoration compared to those in community restoration, and felony charges are more likely to result in more serious sentences (i.e., prison).

Information about the length of time people spent in prison, jail, or on probation is presented in Table 11. The length of stay for each type of sentence is limited to those who had a sentence release date at the time of data extraction. We did not receive information about the length of time the court originally attached to the sentence – we calculated the amount of time between sentence start dates and release dates that were recorded in the DOC data.

**Table 11. Information about the length of time people spent in prison, jail, or on probation after being sentenced on the criminal case that likely prompted their first hospital or community restoration episode during the study period (2017-2022), Oregon Department of Corrections.**

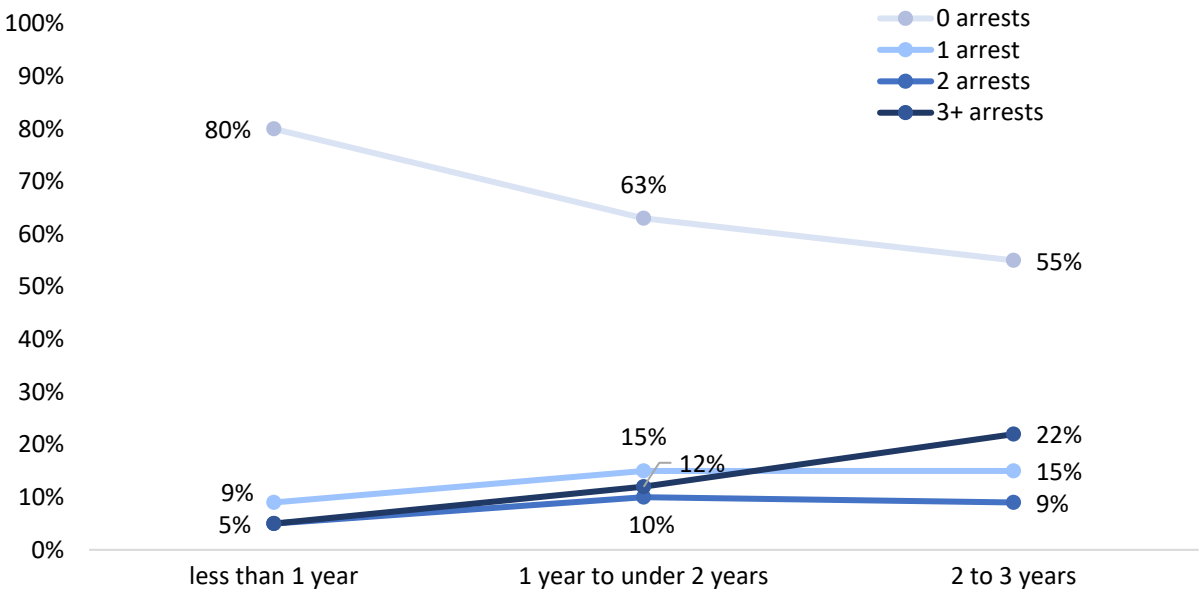
| | Hospital Restoration (n=418 people with release dates) | Community Restoration (n=280 people with release dates) |
|---|---|---|
| **Prison sentences (with release dates)** | 160 | 47 |
| Average length of stay in prison<br>*(Standard Deviation)* | 1 year<br>*(1 year, 1 month)* | 1 year, 9 months<br>*(1 year, 10 months)* |
| Median length of stay in prison | 9 months | 1 year, 1 month |
| Prison length of stay <6 months | 43% | 23% |
| Prison length of stay 6 months - 1 year | 18% | 20% |
| Prison length of stay 1 - 2 years | 25% | 34% |
| Prison length of stay >2 years | 14% | 23% |
| | | |
| **Jail sentences (with release dates)** | 53 | 48 |
| Average length of stay in jail<br>*(Standard Deviation)* | 20 days<br>*(39 days)* | 44 days<br>*(71 days)* |
| Median length of stay in jail | 0 days | 6 days |
| Jail length of stay <30 days | 76% | 63% |
| Jail length of stay 30 - 60 days | 9% | 12% |
| Jail length of stay 60 - 150 days | 15% | 15% |
| Jail length of stay >150 days | 0% | 10% |
| | | |
| **Probation sentences (with release dates)** | 255 | 185 |
| Average length of stay on probation<br>*(Standard Deviation)* | 1 year, 11 months<br>*(1 year, 1 month)* | 2 years, 3 months<br>*(1 year, 6 months)* |
| Median length of stay on probation | 1 year, 8 months | 2 years |
| Probation length of stay <1 year | 16% | 16% |
| Probation length of stay 1 - 2 years | 49% | 43% |
| Probation length of stay 2 - 3 years | 22% | 21% |
| Probation length of stay <3 years | 13% | 20% |

Notably, the data in Table 11 suggests that people who were in community restoration stayed in prison, jail, and on probation for longer than people who were in hospital restoration. The average length of stay in prison was about 9 months longer for people who were in community restoration compared to people who were in hospital restoration, and the median length of stay in prison was about 4 months longer. People who were in community restoration served jail sentences that averaged about two weeks longer than those served by people who were in hospital restoration. The data indicated that people in community restoration also served longer probation sentences, with the average and median probation sentences lasting about 4 months longer than probation sentences among people who were in hospital restoration. These findings are somewhat surprising, given that the criminal case data suggested people who were in community restoration were charged and convicted with relatively less serious offenses than people who were in hospital restoration (i.e., fewer felonies). These findings may be due to the statutory criteria for crediting time served for most charges when individuals are committed to OSH (ORS 161.371), though additional exploration of these data is warranted.

## Were they arrested after going through competency restoration?

We examined quantitative data to determine whether people were arrested after going through competency restoration. For people who had been in hospital restoration, arrest data were available for those who had a SID number and a hospital discharge date (i.e., they had been discharged from OSH by the time the arrest data were pulled by CJC). Of the 3,086 people who were in hospital restoration during the study period, 2,261 (73%) had a SID number and a discharge date. CJC shared information about arrests that occurred in the 3 years after the person's discharge date, or less if fewer than 3 years had passed since they were discharged. The amount of follow up time for people after their discharge from OSH varied from 1 month to the full 3 years, with an average of just over 2 years (26 months) and median of just under 3 years (34 months). Because not everyone who had been in hospital restoration had the same amount of follow up time during which arrests could occur, we examined post-discharge arrest data by 1-, 2-, and 3-year time frames. Figure 29 shows the frequency of new arrests after people's discharge from hospital restoration by the length of follow up time.

**Figure 29. Frequency of new arrests by length of follow up time after people's discharge from their first admission to hospital restoration during the study period (2017-2022), Oregon State Police.**



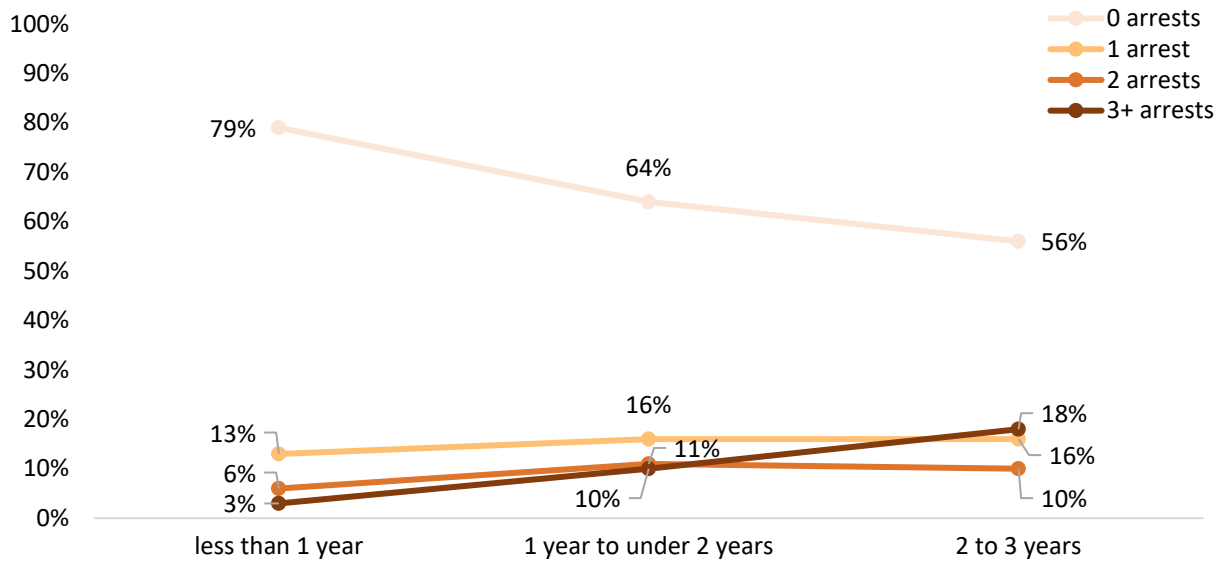

Arrest data suggests there is an association between the length of follow up time and the proportion of people who experienced new arrests after being discharged from hospital restoration. About 20% of people who had less than 1 year of follow up time after hospital restoration experienced new arrests, and the proportion of people who experienced 1, 2, and 3 or more new arrests increased with each year of available follow up time. That is, the longer a person had been out of the hospital, the more likely they were to have experienced new arrests.[17] Still, arrest data also suggest that the majority of people who were in hospital restoration did not experience new arrests after they were discharged. Even among those who had a full 3-year follow up period during which arrests could occur, more than half had zero new arrests. It is critical to interpret this finding with caution, however, because the exact timing of people's arrests relative to people's circumstances after being discharged from hospital restoration are unknown. As we just learned in the previous section, some of these individuals were convicted of the criminal charges that likely initiated their hospital restoration episode and were incarcerated for a time after being discharged. Their incarceration would naturally lead the data to show zero new arrests if they were incarcerated for the entire follow up period. Others may have been discharged from the hospital and housed in a secure

[17] This pattern was confirmed with a simple bivariate correlation analysis, which indicated a statistically significant association between the number of new arrests and length of follow up time (Pearson's r = .182, p < .001).

residential treatment facility or moved to different state, which would again result in a finding of zero new arrests. We know that others returned to OSH either under a continuation of their court-ordered restoration, a new court order for restoration, or for a different type of commitment (e.g., civil or Guilty Except for Insanity). A clear and conclusive picture of whether people who were in hospital restoration experience new arrests after restoration would require more time and data to tease apart people's specific circumstances (e.g., location, incarceration status, etc.) after they are discharged.

We examined arrest outcomes for people who were in community restoration exactly as we did for people who were in hospital restoration. Arrest outcome data was available for 543 (56%) of the 971 people who were in community restoration during the study period (i.e., they had a SID number and an episode end date). CJC shared information about arrests that occurred after the person's episode end date for up to 3 years (or less if their community restoration episode was more recent). The amount of follow up time people had after the end of their community restoration episode ranged from 6 months to the full 3 years, with an average of 2 years and a median of 1 year and 1 month. As we did with people who were in hospital restoration, we examined arrest data for people who were in community restoration by 1-, 2-, and 3-year follow up time frames. Figure 30 shows the frequency of new arrests after community restoration ended, by the length of follow up time.

**Figure 30. Frequency of new arrests by length of follow up time after the end of people's first community restoration episode during the study period (2017-2022), Oregon State Police.**



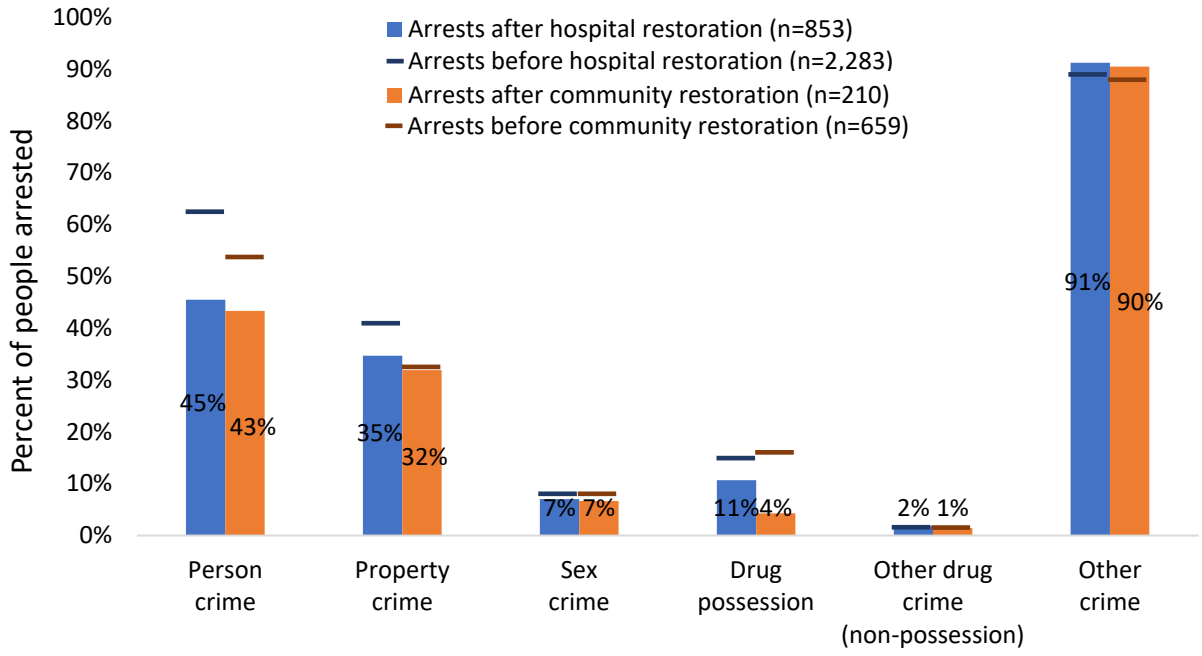

The frequency and timing of arrests among people who were in community restoration were nearly identical to patterns found among people who were in hospital restoration.

About 20% of people who had less than 1 year of follow up time after community restoration experienced new arrests, and the proportion of people who experienced 1, 2, and 3 or more new arrests increased with each year of available follow up time. We also found that, just as it was with people who were in hospital restoration, the majority of people who were in community restoration did not experience new arrests in the 3 years following the end of their episode. We still advise caution in interpreting this finding, however, given the same unknowns about people's circumstances following restoration relative to the timing of their arrests. We know that some people who were in community restoration were convicted of the charges that likely prompted their community restoration and that some were sentenced to prison or jail, and we know that some were admitted to OSH for further restoration, civil commitment, or because they were found Guilty Except for Insanity. Again, more time and high-quality data are needed to fully be able to understand and make conclusions about people's outcomes after they experience hospital or community restoration.

People in community and hospital restoration 1) appear to have similar post-restoration arrest records, and 2) they are arrested for the same kinds of crimes as prior to restoration.

Arrest data further shows that those who experienced arrests after going through hospital or community restoration were arrested largely for the same kinds of crimes that people were arrested for prior to entering competency restoration. Figure 31 shows that most people who were arrested before going through hospital or community restoration were charged with offenses in the "other" crime category, and most people who were arrested after going through hospital or community restoration were charged with the same category of offenses. The most common offenses in this category were identical to what people were arrested for prior to going through competency restoration, and included Trespass 2 (ORS 164.245), Disorderly Conduct 2 (ORS 166.025), Harassment (ORS 166.065), and Resisting Arrest (ORS 162.315).

**Figure 31. Types of offenses for which people were arrested following the end of their first hospital or community restoration episode in the study period (2017-2022) compared to the types of offenses for which they were arrested prior to the start of the episode, Oregon State Police.**

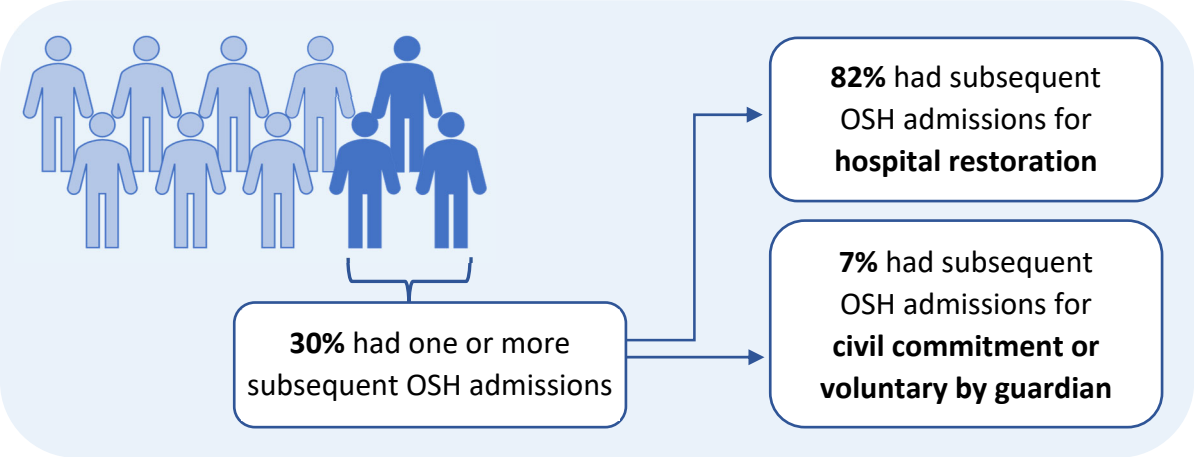



## Did they return for additional competency restoration?

We examined the quantitative data we received for people who were in hospital restoration and community restoration during our study period to determine how often people experienced additional competency restoration. To determine whether any of the people who were in hospital restoration experienced subsequent admissions to OSH for hospital restoration or any other reason, we isolated people's first hospital restoration record during the study period and assessed what occurred after they were discharged. Figure 32 shows that of the 3,037 people who were discharged, 906 or about 30% experienced one or more subsequent admissions to OSH for any reason during the study period.[18] Of those individuals, 746 or 82% had subsequent OSH admissions for hospital restoration and 61 or about 7% had subsequent admissions for civil commitment or voluntary commitment by a guardian.

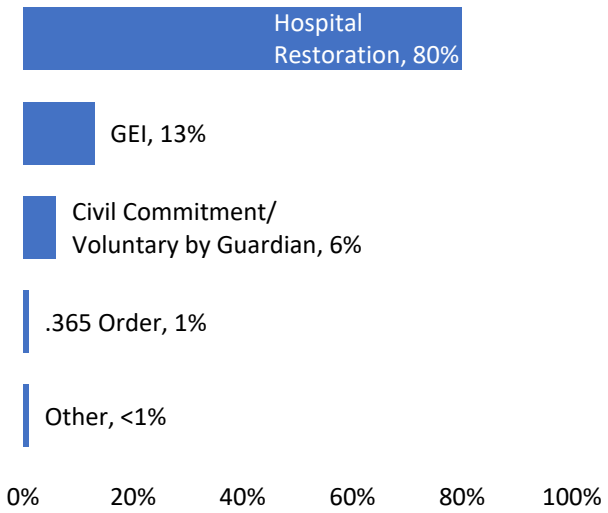
[18] As a reminder, people's first hospital restoration admission could have occurred at any time throughout the study period (2017-2022) and everyone's length of stay was different, so the amount of follow up time to determine whether people were readmitted to OSH varied. The amount of follow up time after people were discharged from their first hospital restoration episode during the study period ranged from 0 days to about 5 ½ years, with an average of about 2 years and 9 months.

**Figure 32. Subsequent admissions for hospital restoration, civil commitment, and voluntary commitment by a guardian that occurred after people were discharged from their first hospital restoration episode during the study period (2017-2022), Oregon State Hospital.**




For most of the individuals who were discharged from hospital restoration and had subsequent OSH admissions, their most immediate readmission was also for hospital restoration. Figure 33 indicates that, for 80% of people who were readmitted to OSH after being discharged from hospital restoration, their next OSH admission was also for hospital restoration. For about 13%, their next admission to OSH was for Guilty Except for Insanity (GEI), and for 6% their next admission was for civil commitment or voluntary commitment by a guardian. For less than 2% of people, their next admission to OSH was for a court-ordered forensic evaluation to assess competency (i.e., a ".365 order") or "Other."

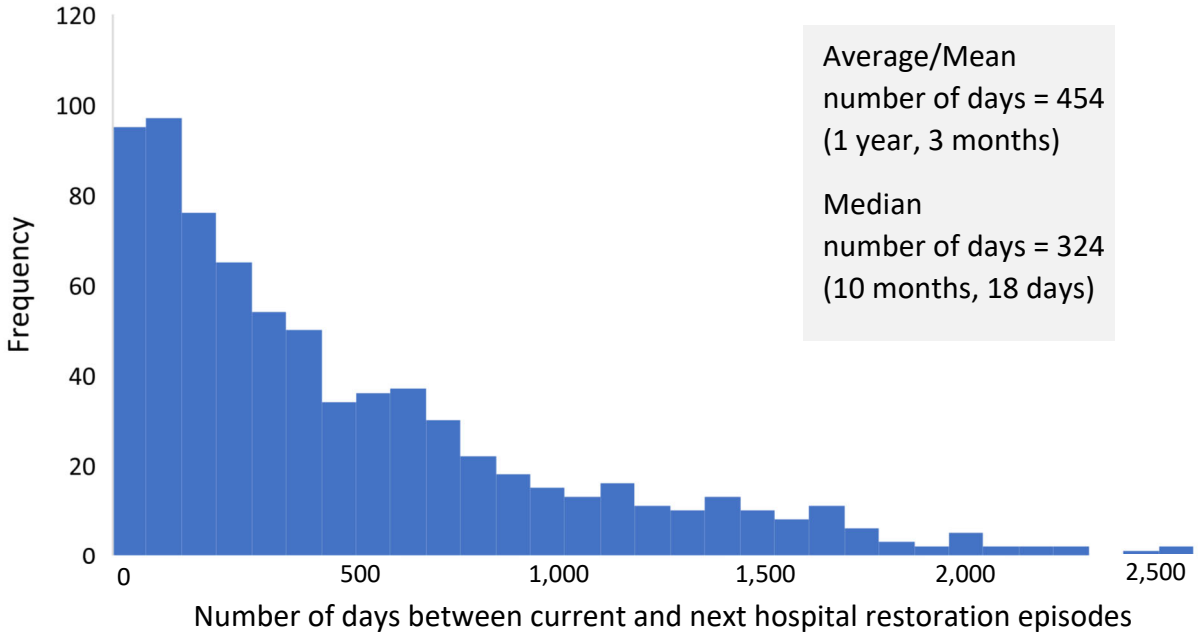
**Figure 33. Type of most immediate readmission to the state hospital after people were discharged from their first hospital restoration episode during the study period (2017-2022), Oregon State Hospital.**




Just as we did when we looked at people's previous admissions for hospital restoration, we examined the time that elapsed between people's discharge from their first hospital restoration episode and their next admission for hospital restoration during the study period. As a reminder, our interviewees raised concerns about the perceived rate at which people seemed to be readmitted to OSH for hospital restoration after being recently discharged from hospital restoration.

As a further test of this perception, we looked at the 746 people who were readmitted to hospital restoration after being discharged from their first hospital restoration episode during our study period. We calculated the time between their first hospital restoration episode's discharge date and their next hospital restoration episode's admission date. Figure 34 shows the average (mean) and median number of days between the most recent and current hospital restoration episodes as well as the distribution.

**Figure 34. Distribution, average (mean), and median number of days between people's discharge from their first admission to hospital restoration during the study period (2017-2022) and their subsequent admission to hospital restoration, Oregon State Hospital.**




On average, the data indicated that there were 454 days (about 1 year and 3 months) between the time people were discharged from their first hospital restoration episode and their next admission to hospital restoration during the study period. The median length of time was 324 days or about 10 months and 18 days. The majority of people (89%) were readmitted to hospital restoration more than 60 days after they were discharged from their first hospital restoration episode in the study period.

For people who were in **community restoration**, we assessed whether they experienced subsequent community restoration episodes during the study period after their first episode ended. As we did for those who were in hospital restoration, we isolated people's first community restoration episode and examined what occurred after the end date. Of the 971 people who were in community restoration, 755 had an episode end date. Of these individuals, 65 or about 9% had at least one more community restoration episode during the study period.

## What is the impact of the revolving door?

The term "revolving door" was used during interviews to describe the person-level impacts of the system deficiencies. Providers described how people are discharged without services and often without the housing they had before their arrest and are soon back "on the radar" of local law enforcement and back in jail. The quantitative data shows that a subset of people face similar charges they faced on their previous restoration episode, indicating the restoration process may have contributed to this revolving door phenomenon.

Specifically, the arrest data indicates that people who went through competency restoration were most often arrested for crimes that our interviewees described as "nuisance" crimes or "crimes of homelessness" (i.e., Trespass 2 (ORS 164.245), Disorderly Conduct 2 (ORS 166.025), Harassment (ORS 166.065), and Resisting Arrest (ORS 162.315)). Figure 31 shows that the overwhelming majority of people who were arrested both before and after going through competency restoration were arrested for these kinds of offenses. If people continue to be arrested for the same types of "nuisance" offenses that they were prior to going through competency restoration, what does that suggest about the impact of going through the competency restoration process? Did their ongoing mental health challenges improve? Did restoration connect them to more supports and services that could potentially prevent them from further contact with law enforcement? Although these are not technically the intended outcomes for competency restoration, this and other findings we have presented here beg the question – what should the intended outcomes be?

The revolving door of going through competency restoration, getting back on the radar of law enforcement and arrested for the same types of offenses, and then potentially returning to competency restoration on new charges may actually contribute to longer hospital admissions. Indeed, our quantitative hospital restoration data indicated that people who were previously admitted to one or more hospital restoration episodes had significantly[19] longer lengths of stay in subsequent hospital restoration episodes. For people with prior hospital restoration admissions, the average length of stay was 155 days (*SD* = 139 days) and the median length of stay was 93 days. This is just over two weeks longer than the average length of stay among those who had no prior hospital restoration admissions, which was 138 days (*SD* = 126 days; Median = 63 days). This finding could suggest that going through multiple rounds of competency restoration may cause further instability for people with regard to their mental health challenges and their lives after discharge, particularly if they are not connected with adequate supports in the community.

[19] A t-test confirmed that the differences between the lengths of stay among people with and without prior hospital restoration episodes was statistically significant, $p < .05$.

The sheer number of people who were discharged and then returned to hospital restoration during our study period suggests people continued to experience mental health challenges and instability when they went back to their lives and routines. As a reminder, about 25% of people who were discharged from their first hospital restoration episode in the study period were readmitted for another hospital restoration episode during the study period. This could be confirmation that after being discharged people returned to the same circumstances they were in before (e.g., unhoused and not connected to services or supports), destabilized again, committed another offense, and were caught up again in the revolving door.

At many critical moments, the behavioral health, justice, and housing systems are not supporting prevention, transitions or aftercare which seems to perpetuate the revolving door for some of the individuals in competency restoration.

> *"A lot of the people who we are working with are "frequent flyers" on the Aid & Assist docket. It's a lot of the same people coming back through the system because one of the things that we haven't been doing, that we are working towards is sustained diversion from the criminal justice system. Unfortunately we've just been very narrowly focused on the restoration piece, just the hospital diversion piece and not the entire spectrum of the criminal justice system and diverting people, long term. So I think that people are starting to realize that that's what needs to happen, and that's what we're working towards. But it's definitely a lot of the same people. We have people down at the state hospital right now who were on my caseload 14 years ago."*
>
> *–CMHP staff, large county*

# State by state comparison

In the following chapter we present a detailed overview of the data and information collected to explore what could potentially be learned from national groups and other states about people in competency restoration and others' general restoration processes. We first describe findings from our review of existing reports that summarized the challenges faced by other states and compare them to Oregon's current situation. We also compare Oregon's legal and statutory similarities to those of other jurisdictions and the presence of "model" programs in some states and counties. We then summarize common themes we discovered across states, and then provide more detailed information about what we learned regarding successful policies, rules, and procedures, implemented across the U.S.

## Are Oregon's challenges similar to those in other states?

In 2019 Warburton and colleagues (Warburton, McDermott, Gale, & Stahl, 2020) surveyed the 50 U.S. states plus D.C. regarding recent trends in the competency process. Among the 50 respondents, 82% of states reported an increase in the number of individuals referred for competency evaluation, while 78% of respondents indicated an increase in orders for competency restoration.

Competency restoration is most commonly inpatient-based and takes place within state psychiatric facilities. In Oregon as in other states, the increase in the demand for restoration is occurring against the backdrop of the most limited supply of state psychiatric beds in modern history. According to the Treatment Advocacy Center (TAC), as of 2017 the recommended benchmark for number of forensic beds per capita was 50 psychiatric beds per 100,000 people. Across the U.S. there were only 11.7 beds per 100,000 people, with some states falling above or below this national statistic. In 2017, Oregon had 16.2 beds per 100,000 meeting 32.4% of the recommended supply and ranking 9th in the U.S. for greatest supply of psychiatric beds per capita while still falling woefully short of the recommended ratio (Fuller, Sinclair, Geller, Quanbeck, & Snook, 2016). At the time of this report, Oregon was among 6 states that diverted civil beds to forensic beds based on need (Bloom, Hansen, & Blekic, 2022) and among 15 states with forensic patients occupying more than 50% of the remaining state hospital beds (Fuller, Sinclair, Geller, Quanbeck, & Snook, 2016).

Across the U.S., bed supply was unable to keep up with the increase in orders for inpatient competency restoration, leading many states to experience growing waitlists of people waiting in jail, pretrial to be admitted to state hospitals. In their nationwide survey, Warburton and colleagues learned that 70.8% of states had a waitlist for admittance to inpatient competency restoration or evaluation (Warburton, McDermott, Gale, & Stahl, 2020). In March of 2023, the Wall Street Journal surveyed all 50 state health authorities regarding the number of people in jail awaiting admission for inpatient competency restoration (Frosch & Findell, 2023). Of the 39 respondents, 34 respondents (87%) reported that the waitlist for admission had grown over the

past four years. Since 2019, Oregon's waitlist has increased at the third highest rate in the U.S., behind West Virginia and Louisiana. Despite this rapid increase, Oregon's waitlist has fewer people and they are waiting less time than in many other states. In February 2023, 450 people were awaiting admission for competency restoration in Colorado, some having waited as long as 226 days. In Texas the number has reached 2,466 with an average wait time of 8 months. In Missouri, there are 229 defendants waiting an average of 6 months for admission. In Kentucky, people are waiting as long as 10-12 months for the initial competency evaluation,[20] an increase from the 60 days it took only a few years ago. As of February and March of 2023, Texas (2466), California (1169), Washington (750), Colorado (442), and Georgia (417) had the highest numbers of people in jail awaiting admission for competency restoration and/or evaluation (Frosch & Findell, 2023).

In Oregon, as in other states, individuals and advocacy organizations have challenged the constitutionality of individuals waiting in jail, pre-trial for admission to fulfill competency evaluation or restoration orders. In 2003, the Mink Decision mandated that when a person is ordered to Oregon State Hospital (OSH) for competency restoration after being found incompetent to stand trial, they must be admitted to OSH within 7 days (Oregon Advocacy Center v. Mink, 2003). At least 20 additional states have faced litigation related to the competency evaluation and restoration processes (Fuller, Sinclair, Lamb, Cayce, & Snook, 2017; Fuller, Sinclair, Geller, Quanbeck, & Snook, 2016). Like Oregon, some of these rulings held state-wide consequences while others singularly affected the plaintiffs. In some states, the litigation led to consent decrees which were timebound and have since concluded. In others, the consent decrees or settlement agreements have placed ongoing or permanent mandates on the competency restoration process, some of which have also led to being held in contempt of court and ongoing fines when not met. In at least 9 states, court rulings and legislative action have led to Mink-like restrictions on the length of time an individual can wait in jail to be admitted to competency restoration services (Maryland Department of Health, 2018; ACLU Alabama, 2018; Hopkins, 2021; ACLU Pennsylvania, 2017; Colorado Department of Human Services, 2019; State of Illinois, 1963; Washington State Department of Social and Health Services, n.d.; MacArthur Justice Center, 2016; Gilna, 2018). Oregon and Washington are the only states that have a 7-day mandate for all persons once they have been ordered to restoration. Colorado triages those ordered to inpatient restoration and requires admittance within 7 days for the most acute individuals. Maryland is the next closest with a mandate of admittance within 10 days.

The ruling in *Oregon Advocacy Center v. Mink* targets the time spent waiting to be admitted to Oregon State Hospital for competency restoration. Most reporting on waitlists nationwide similarly track this datapoint versus waiting for a competency evaluation. Importantly, there is

[20] Evaluations are a different step in the restoration process and therefore this is a different metric – tracking people awaiting evaluations vs. awaiting admission to the hospital.

no mandate in Oregon regarding the amount of time an individual can be held in jail while awaiting a competency evaluation. In an interview, Disability Rights Oregon identified that evaluations are often backed up to such a degree that individuals can be left waiting multiple months to undergo evaluations, time that is not factored into *Oregon Advocacy Center v. Mink* compliance and waitlist reporting (KBOO, 2022). It was not possible to compare Oregon to other states on this metric as limited information was available on timelines for evaluation, except that in at least 4 states court decisions demanded that individuals be evaluated within a specific timeframe, ranging from 72 hours to 30 days (Maryland Department of Health, 2018; ACLU Alabama, 2018; Hopkins, 2021; ACLU Pennsylvania, 2017; Colorado Department of Human Services, 2019; State of Illinois, 1963; Washington State Department of Social and Health Services, n.d.; MacArthur Justice Center, 2016; Gilna, 2018).

## Legal or statutory similarities

In addition to shared challenges, we sought to compare the legal landscape related to the competency process between Oregon and other states in the U.S., plus Washington D.C. (referred to as "states" going forward). We wanted to understand Oregon's statutes in the context of the broader U.S., as well as which states with similar statutes so that any promising programs would have less obstacles to working in Oregon. Competency restoration experts helped us identify the following as the statutes and court orders that most affect the competency restoration process:

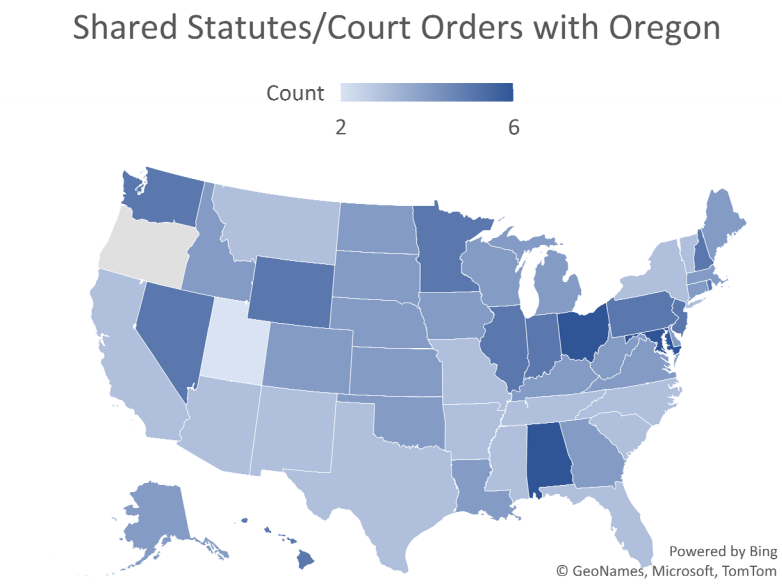
1. Do civil commitment laws make it challenging to have an individual civilly committed due to one or more of the following:
    a. Requiring harm to self or others be imminent?
    b. Requiring harm from failing to meet basic needs to be imminent?
    c. Lacking a path to civil commitment for those who cannot meet their basic needs?
2. Is community-based restoration allowed?
3. Is jail-based restoration allowed?
4. Is there a court decision, agreement, or decree, or a statute restricting the amount of time a person can wait in jail to be admitted after being ordered to inpatient competency restoration?
5. Is there a court decision, agreement, or decree, or statute restricting the amount of time a person can be in competency restoration to 6 months or shorter, for either misdemeanors exclusively or for both misdemeanors and felonies?
6. Is the competency restoration process allowed for those accused of misdemeanors?
7. Does the state allow the insanity defense?

When auditing how states compare to Oregon's legal landscape, there were zero states that matched Oregon on all seven statutes/court orders. As seen in Figure 35, 30% of states share more than four statutes/orders with Oregon, 40% of states share exactly four statutes/orders,

and 30% share fewer than four statutes/orders. This distribution illustrates the variability of legal conditions affecting the competency restoration process across the U.S.

More specifically, Alabama, Ohio, and Maryland, were legally most similar to Oregon, sharing six statutes/court orders. Washington, which is one of the states most frequently reported on due to long waitlists and ensuing litigation is among the 12 states that share five statutes/orders with Oregon.

**Figure 35. The number of statutes and court orders related to competency restoration that other states share with Oregon.**




Fourteen states shared 3 statutes/ court cases with Oregon including Texas, Florida, and California. Utah has a legal landscape that is least alike Oregon's, sharing only two statutes/court orders. Figure 35 illustrates how states legally alike and unlike Oregon are dispersed across the U.S.

When it comes to specific statutes/ orders, Oregon is among 48 states that allow people charged with misdemeanors to be restored to competency (Gowensmith, 2019). In July 2023, the U.S. District Court for Oregon limited the misdemeanor crimes that are eligible for restoration at OSH (Oregon Health Authority, 2023). This change doesn't affect how we have captured this data point because Oregon remains different from California, New York, and Florida, which prohibit hospital and community-based restoration to competency for low-level misdemeanor charges and instead require that charges be dismissed (Committee on Revision of the Penal Code, 2022).

Oregon is among 47 jurisdictions that allow the insanity defense. Four states have abolished the insanity defense. Thirty-nine jurisdictions, including Oregon, allow for community-based restoration in their statutes (Miranda, Unpublished). In 2018, one researcher found that 16 out of 35 states (46%) had formalized programs, though what constitutes a "formalized program" is not clearly defined (Wik, Alternatives to inpatient competency restoration programs: Community-based competency restoration programs, 2018). Oregon is among 35 states that do not have jail-based restoration programs (Miranda, Unpublished).

There were 20 states that have experienced legal action related to the competency restoration process, most commonly due to length of time defendants are held pre-trial in jails awaiting admission to a state facility for competency evaluation or restoration. Of these 20 states,

Oregon is among the 50% where the lawsuits have resulted in statewide rulings for the competency process. For the remaining 10 states, either the lawsuits concluded without state-wide orders, or the orders were time-bound and have since concluded (Maryland Department of Health, 2018; ACLU Alabama, 2018; Hopkins, 2021; ACLU Pennsylvania, 2017; Colorado Department of Human Services, 2019; State of Illinois, 1963; Washington State Department of Social and Health Services, n.d.; MacArthur Justice Center, 2016; Gilna, 2018; Fuller, Sinclair, Geller, Quanbeck, & Snook, 2016).

There were nine other states where the amount of time an individual could wait in jail to be admitted to restoration after being adjudicated incompetent to stand trial is restricted. For some states, this applies to both inpatient and community-based restoration while in others the rule was like Oregon's, applying to inpatient restoration only. Similarly, there were 9 other states that restricted the amount of time an individual could be in competency restoration (Miranda, Unpublished). This datapoint is specific to inpatient competency restoration which is how Oregon's order is structured. These conditions were enacted primarily through court orders though in some states they were the result of legislation. We noted that these two legal conditions, regarding restricting the length of competency restoration and length of time spent waiting in jail for inpatient admission were shared with the fewest number of states. Oregon is among a minority of states in which court cases have imposed state-wide changes to competency restoration processes. At the time of data collection, Washington was the only other state to have restrictions on both length of restoration and length of time awaiting admission.

In the Treatment Advocacy Center's *Grading the States: An Analysis of U.S. Psychiatric Treatment Laws* (Dailey, et al., 2020), Oregon is among 20 states with barriers to civil commitment. The barriers include:

- lacking a pathway to civil commitment for those who cannot meet their basic needs,
- requiring imminent harm to self or others, including for failing to meet one's basic needs,
- requiring unreasonably severe harm when failing to meet one's basic needs,
- or requiring that friends and family refuse assistance.

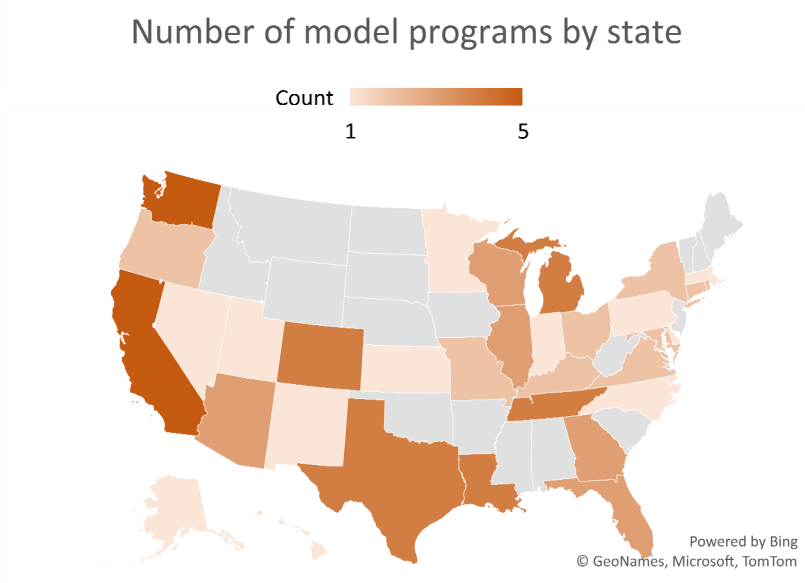
Oregon along with 6 other states requires imminent harm to qualify for civil commitment when failing to meet basic needs (Dailey, et al., 2020).

## Promising programs, policies and processes in other states and counties

We looked at model programs, policies, and processes (referred to as model programs going forward) that were elevated in national reports, as described in the Methods chapter of this report. Figure 36 illustrates the distribution of model programs across the U.S. The states implementing the highest number of model programs includes Washington and California with five each, then Colorado, Louisiana, Tennessee, Michigan, and Texas with four. Five states were

recognized for three model programs and Oregon was among nine states recognized for implementing two model programs. Twelve states had one model program and 18 had zero.

**Figure 36. Number of model programs related to competency restoration implemented, by state.**




Oregon was recognized for the competency dockets in Multnomah County and the work of the Oregon Behavioral Health Justice Reinvestment Steering Committee to connect cross-sector data to identify people with complex behavioral health needs who were cycling through local criminal justice systems (Justice Center, The Council of State Governments, 2020).

When comparing the overlap in legal landscape with Oregon and quantity of model programs, we found that jurisdictions that shared 2 or 3 statutes/court orders with Oregon (n=15) had an average of 1.4 model programs, those that shared four (n=20) statutes/court orders also had an average of 1.4 model programs, and those that shared 5 or 6 statutes/court orders with Oregon (n=15) had an average of 1.3 model programs. These similar averages indicate that model programs are found across a diverse range of legal landscapes and that the legal landscape of Oregon did not appear to be associated with the number of model programs.

# Emergent themes across states

## Tension between court processes and human services

In the interviews with experts from other states, subject matter experts across several states described an inherent tension with competency restoration: the court systems are responsible for implementing and overseeing a human service or behavioral health program. This tension took multiple forms including:

- differing beliefs about who should have decision making authority,
- misalignment with the purpose and intention of the competency restoration process,
- disagreement with competency decisions dictating who receives services and
- misunderstanding of the services provided during restoration.

Multiple state experts described tension arising from the fact that in the competency restoration process courts have authority over clinical decisions and legal processes take

precedence over health concerns. One of the state experts described a decades-long career spanning forensic mental health appointments in multiple states. In at least one of the states in which they worked, mental health providers had decision making authority in the competency process. In this state expert's assessment, one of the two primary drivers of the competency crisis is that in most jurisdictions across the U.S., the courts have authority over mental health decisions instead of mental health providers. This person commented that unless authority changes there will never be enough forensic beds to meet the demand. Another state expert stated that the whole competency system improved in their state when they created a support team and program that centered people instead of court orders. Though authority didn't shift away from the courts in this state, the approach to the competency process began directing more resources towards the mental health response and less emphasis to the legal process.

Relatedly, multiple state experts described how courts and mental health providers lacked agreement about purpose of competency evaluation and restoration as well as placement decisions for competency restoration. This created tension, particularly when the courts use orders for competency restoration as a means of providing mental health treatment, regardless of the intention to pursue the charges. This opinion was offered across states regardless of the robustness of their competency restoration services.

*Multiple state experts described how courts and mental health providers lacked agreement about purpose of competency evaluation and restoration as well as placement decisions for competency restoration. This created tension, particularly when the courts use orders for competency restoration as a means of providing mental health treatment, regardless of the intention to pursue the charges. This opinion was offered across states regardless of the robustness of their competency restoration services.*

Another state expert described the tension for behavioral health providers working within the competency process. They conveyed providers are committed to rehabilitating people which is at odds with preparing people to participate in a process that may conclude with a prison sentence. There is a fundamental misalignment between the competency process and the way behavioral health providers want to work and what they want to work towards which has created challenges both in hiring and developing partnerships in this state. Well-established organizations and providers do not want to work with the competency restoration process.

In Ohio, this tension is explicitly discussed in their competency restoration training guide. There is section of the guide titled Forensic Ethics: Clinical vs Forensic Assessment and Treatment – an inherent conflict of roles, where they detail the differences between the relationship of the treatment team and patients when working with a civilly-committed patient versus a forensically-committed patient. In this document, they identify the objective for civil patients is assessing, diagnosing, and treating, whereas with forensic patients, the courts are the true

clients, not the patients, and the objective is to answer a court question (Medical Director's Office, Bureau of Forensic Services, 2021).

Finally, one state expert did not agree that the court process should determine who is and is not deserving of behavioral health services. In this person's state, as in many others, those who are determined incompetent to stand trial and ordered to restoration receive services not available to those found competent or who have their case immediately dismissed due to lower-level charges. This state expert believed individuals who have their competency questioned, due to behavioral, developmental, and mental health challenges, are part of the same community and experience the same needs, regardless of whether they are found competent or incompetent. This expert believed that those who are found competent or have charges dismissed are equally deserving of services and should not be left to cycle back through the competency system.

### States need stronger community mental health services

Subject matter experts in multiple states asserted that a main driver of the competency crisis is lack of community mental health services. This aligns with results from a survey conducted with 50 out of 51 U.S. states and D.C., where respondents ranked inadequate general mental health services in the community as the number one factor contributing to the rise in referrals for competency restoration. Inadequate crisis services were ranked second, followed by inadequate psychiatric beds and inadequate Assertive Community Treatment services in the community as third and fourth (Warburton, McDermott, Gale, & Stahl, 2020).

Two state experts reflected that in the context of inadequate community mental health services, when services are created in the forensic system it incentivizes use of this system because it is where services are available. Like Oregon, Colorado and Washington have faced lawsuits challenging the constitutionality of pretrial waiting periods for competency services. In these two states settlement agreements, consent decrees, and legislation have created robust services throughout the competency process to address growing referrals to competency evaluation and restoration. Both Washington and Colorado reflected that the increasing referrals, which persist despite the addition of services to address the crisis, may be occurring in part due to the concentration of services in the forensic system. They expressed an "if you build it, they will come" scenario where courts use the competency process because of the availability and quality of services compared to a dearth in the community.

## What policies, rules, procedures, or programs have other states implemented that have been successful?

In the final section of this chapter we provide more detailed information about what we learned regarding successful policies, rules, and procedures implemented across the U.S.

## Crisis Stabilization, Pima County Arizona

In conversations with state experts, Tennessee, Ohio, and Wisconsin mentioned the important upstream role of crisis stabilization centers in diverting people away from the competency restoration process. Arizona's crisis care system is nationally recognized as a model for integrated, effective care. We reviewed a webinar (Oregon Judicial Department, Chief Justice's Behavioral Health Advisory Committee, 2021) in which Dr. Margie Balfour, Chief of Quality & Clinical Innovation at Connections Health Solutions, a contracted crisis stabilization center operator for Pima County, Arizona describes the crisis system in Arizona. She emphasized the following critical aspects to the system:

- The system is united across the state under a singular shared goal of reducing the criminal justice costs for people with severe mental illness.
- Clinical and financial metrics are aligned under this primary goal across all stakeholders in the system, from Medicaid Managed Care Organizations to law enforcement. These metrics include decrease criminal justice involvement, increase community stabilization, and increase engagement in treatment.
- Each year a regional convener brings all stakeholders together to review the crisis protocol and recommit to shared goals.

Within the crisis continuum, the crisis response centers are a necessary feature for the function of the broader system. Dr. Balfour emphasized the following critical aspects of the crisis response center:

- The crisis response center is a 24-hour receiving center for people in crisis as an alternative to jail, emergency departments and hospitals.
- There is a "no wrong door" policy, meaning no one is turned away for agitation, acuity, payment challenges or intoxication.
- The crisis response centers are certified as evaluating facilities, to which law enforcement officers are required to bring someone when they present an immediate threat to self or others. Under Arizona psychiatric treatment law, the evaluating facility has 24 hours to file or drop an order for a continued involuntary hold. After supportive services at the crisis response center, most cases are dropped within 24-hours, following which they try to engage the individual in continued treatment outside the crisis system. If an individual continues to meet criteria for involuntary hold, then they involve the courts and hospital.
- Importantly, the crisis response centers operate with a philosophy of "figure out how to say yes, versus looking for reasons to say no" and "assume we can and will resolve the crisis in 24 hours."
- In Pima County, which has a population of 1 million, the crisis stabilization center receives 12,000 adults and 2,400 youth per year.

- Studies have shown this model is critical for prearrest diversion, reducing visits to the emergency room, and reducing hospitalizations.

Dr. Balfour suggested that when setting up an integrated system like this, it is necessary to have a central convener. This could be a county or a judge who unites all stakeholders, including law enforcement, coordinated care organizations, hospitals, etc.

## Assisted Outpatient Therapy with The Treatment Advocacy Center

The Treatment Advocacy Center (TAC) is a national nonprofit that promotes laws, policies and practices that create access to timely and effective psychiatric care, including the development of innovative treatments. They are strong advocates for the use of Assisted Outpatient Therapy (AOT) which they define as the practice of providing community-based mental health treatment under civil court commitment, as a means of:

> (1) motivating an adult with mental illness who struggles with voluntary treatment adherence to engage fully with their treatment plan; and
>
> (2) focusing the attention of treatment providers on the need to work diligently to keep the person engaged in effective treatment." (Treatment Advocacy Center, 2018)

To address the growing competency crisis and psychiatric bed shortage they promote the implementation of AOT as an alternative to competency restoration for nonviolent offenders. In this scenario criminal charges are dismissed or held in abeyance while an application for civil commitment is filed. If granted, the individual would be discharged to the AOT Program for community treatment and monitoring (Treatment Advocacy Center).

According to TAC,

> *When implemented effectively, AOT increases treatment adherence, which translates into reduced use of hospitals, crisis services and jails, improved quality of life for individuals with mental illness, increased public safety and overall reduced costs to society.*

It's important to note that those opposed to AOT cite concerns about treatment coercion, deflecting resources away from voluntary mental health programs, and the generalizability of AOT research (Meldrum, Kelly, Calderon, Brekke, & Braslow, 2016). One of the state experts we spoke with questioned AOT's relevance, given there is no reason to suspect that someone who is found incompetent to stand trial is a danger to self or others (a requirement for involuntary commitment) and that there is very little overlap between the two populations. In addressing these concerns, TAC emphasized that across the U.S. people are in jail awaiting competency services for months or years and AOT as a diversion strategy for nonviolent charges affords greater freedom than languishing in jail, particularly since most AOT policies do not force medication involuntarily, use physical restraint, and do not use jail time as consequence for noncompliance.

AOT is a growing legal practice across the U.S. at the state and county level.

- Ohio introduced legislation to make it easier to use AOT as an alternative to certain criminal charges.
- Georgia has allocated funding to pilot AOT in 5 counties.
- Kansas, Kentucky, and New York are rolling out AOT across their states with the help of federal grants and local legislative funding.
- 88 counties across the U.S. are implementing AOT, demonstrating its applicability across cultures, legal landscapes, and existing service offerings.
- TAC administers an AOT learning network with 1200 participants, including practitioners, champions, family members, etc.

When considering AOT in Oregon, TAC offered the following reflections and suggestions:

- The purpose of AOT is fundamentally different from that of competency restoration. It is about patient engagement and helping people to reach their goals.
- The team sees no legal barriers to implementing AOT in Oregon.
- Other states, like Ohio, have a history of laws like those in Oregon that make civil commitment challenging, and have found ways to implement AOT.
- Two jurisdictions in Oregon have contacted TAC regarding AOT, demonstrating existing interest.
- AOT is a legal process, not a service delivery, and therefore requires existing services in the community to be successful. Many U.S. communities have these treatment services with existing funding channels.
- Implementation of AOT does not necessarily require new funding; indeed, 31 counties in the U.S. were able to begin AOT without additional funding sources.

## Reducing waitlists for evaluation and restoration in Tennessee

Unlike the other states we spoke with, Tennessee does not have a waitlist for inpatient competency evaluation or restoration. The state expert credited Tennessee's statutes which 1) give mental health experts decision making authority in the competency process, 2) mandate outpatient competency evaluations initially and 3) create natural bed churn through the admission processes. Other critical features of their system include:

- Mental health experts have decision making authority over whether a person is ordered to inpatient competency evaluation and inpatient or outpatient restoration.
- All competency evaluations are required to be conducted on an outpatient basis. If this formal evaluation concludes that further, inpatient evaluation is warranted, an admission date is scheduled within 60 days and the person will be admitted for a full 30 days during which they will receive treatment and evaluation. This is still pre-adjudication of competence or incompetence.

- An emergency admittance can be performed under involuntary civil commitment during that time if an individual requires immediate stabilization and services.
- Following inpatient evaluation, the individual can be adjudicated as incompetent to stand trial and be ordered to inpatient or outpatient treatment.
- Judicial approval is not required for discharging a patient from an inpatient setting.
- Tennessee conducts 1,800-2,200 outpatient evaluations per year and has referral rate of 24-33% for inpatient evaluation.

## Forensic Evaluators, Tennessee and Washington

The Office of Forensic and Juvenile Court Services within the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) oversees forensic evaluation across the state. They contract with nine community agencies that employ 25 forensic evaluators to cover all jurisdictions. TDMHSAS centralizes outpatient services by training, certifying, and reimbursing all evaluators, a practice they recommend for streamlined evaluation. They also link reimbursement to data collection which has facilitated a central database containing all competency cases statewide.

In the state of Washington, all forensic evaluators are state employees. There are currently 77 forensic evaluators and the legislature recently asked for additional positions. To meet the settlement agreement, which requires competency evaluations be conducted within 7 days of being raised, the state has had to ensure an adequate supply of forensic evaluators. Washington has emphasized workforce development and supported this pipeline by developing an internship and post-doc program as a direct pathway for psychologists to join as full-time forensic evaluators. Once an employee reaches fulltime employment, they already have two years' experience in the state and a background in the relevant policies and laws. The program has high rates of retention with 85% of interns joining as post-docs and 90% continuing as employees which has equaled 4-5 new employees each year. Washington has also incentivized retention by paying a competitive salary.

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Washington has also created supportive infrastructure for evaluators which includes:

- Enhanced technology that makes it easy to travel, including laptops, electronic dictation tools, and a Forensic Data System that can be accessed remotely
- Creating community outstations near jails that evaluators can work from
- Hiring support staff to assist evaluators with tasks like requesting and processing records

Through supporting a strong recruitment and retention pipeline and enabling outpatient evaluations:

- As of May 2023, 92% of competency evaluations were completed within 14 days of receiving the order.
- 97%-98% of competency evaluations are completed within 30 days.

The preceding examples illustrate that creating effective solutions within the competency process is complex and involve interwoven factors. For example, in Tennessee, achieving a streamlined competency continuum without a waitlist was facilitated by both the requirement to initially evaluate competency in an outpatient setting and by giving authority on placement decisions to mental health providers. Washington conducts 90% of competency evaluations within 7 days by fostering a forensic navigator pipeline and paying these positions adequately, creating satellite sites for evaluation near the jails, and supporting the process with relevant technology and infrastructure. A multi-faceted approach is required to achieve these positive outcomes.

### Forensic Support Team, Colorado

In 2019, Colorado passed Senate Bill 223 which created the Forensic Support Team within the Office of Behavioral Health. This team has 20 staff, including 16 Forensic Navigators, who work within all 55 jails across the 22 judicial districts in Colorado. Like other Colorado programs serving individuals in the competency process, the Forensic Support Team receives funding through the accumulation of fines Colorado pays when it is out of compliance with a consent decree that was agreed upon following a lawsuit challenging the constitutionality of waiting in jail for competency evaluation and restoration. Important features of the Forensic Support Team include:

- Its mission is to coordinate care and communicate the needs of the clients to all stakeholders to ensure an effective competency system.
- Forensic Navigators assist in prioritizing and triaging admissions to inpatient restoration.
- They also identify individuals who may be better suited for outpatient restoration and make referrals to outpatient programs.
- The FST coordinates care for individuals returning to jail from inpatient restoration, including medication access.

According to the state expert, the biggest benefit of this program is the Forensic Support Team which has been able to shift the focus of the system to following people instead of the timeline of the court orders. For example, previously when a person was found competent, they were no longer recognized as anyone's responsibility within the system and when released from jail without resources would cycle back through the competency process. In Colorado, as in many states, this expert assessed,

> *We had legal processes in place that was dictating what was mostly clinical and mental health concerns which was not a way to get any sort of fidelity to any sort of program that was going to be supporting or diverting or offboarding them from the criminal justice system.*

Over the past four years, the Forensic Support Team has built relationships with competency stakeholders spanning the entire state to educate disparate sectors on their roles within the broader competency process and build buy-in for using the system intentionally to facilitate better clinical and criminal justice outcomes. For example, now when someone has been found competent, they have already engaged with the forensic support team while waiting for their evaluation and there is a plan in place for catching them in the community or the next step of the criminal justice process.

With the help of the Forensic Support Team, various sectors are playing an active role in the process. For example, instead of releasing individuals found never able without follow up resources, jails will now release them on an emergency mental health hold. Judges are proactively reaching out to the Forensic Support Team to co-create competency dockets and can identify the off-boarding ramps available in their communities. This expert summarized,

> *When we stopped following court orders and started following people the entire system changed.*

## Bridges Program, Colorado

Established in 2018 by Senate Bill 18-251, the Colorado Bridges Program placed 29 Court Liaisons across Colorado's 22 judicial districts. Liaisons are court appointed to serve 2,400 participants in the criminal justice system who have significant mental health needs. The Bridges program can serve anyone but prioritizes participants in the competency restoration process, particularly those in custody who are likely to be released for outpatient evaluation or restoration if stability is addressed. Liaisons provide person-centered case management, including assessing needs, connecting participants to services, tracking data and keeping courts updated on available services which could impact court decisions. The Bridges Program has been operating for 5 years and in that time has captured the following outcomes:

- 91% of Colorado's criminal trial judges refer participants to the program
- 20% of participants are released immediately upon enrolling in the Bridges program

- An additional 40% of participants are released by the case disposition
- Bridges received approval to expand the team to 100 liaisons

Both Bridges and the Forensic Support Team emphasized the critical components to programmatic success including:

- Neither program takes power away from the courts and instead work collaboratively with or within that sector.
- Participant-centered case management.
- Building buy-in with every sector as all are involved in the competency process.

Finally, both state experts highlighted that dividing their responsibilities between two distinct teams is challenging and leads to duplication of efforts and additional coordination. Though both suggested a single team would be preferred, they each communicated the importance of the team they had created, with one emphasizing that placing the services in the courts, as Bridges is structured, is imperative because it builds greater rapport and trust with judges, while the Forensic Support Team stressed the important of the case management and mental health experience of their team.

## Multivitamin approach, Washington

During 2017-2018 Washington was out of compliance with the timelines for competency evaluation and restoration required by Trueblood v Washington. Together with stakeholders, including those with lived experience, they investigated the drivers behind the many referrals for competency evaluation and restoration. They looked upstream of and across the competency continuum and ended up with 16 different elements to address the crisis. These elements are monitored and guided by a Contempt Settlement Agreement for Trueblood v Washington and state legislation (Washington State Department of Social and Health Services, n.d.). The programs are being rolled out across the state in phased regions between 2019 – 2025 and include:

- **Crisis triage and diversion** which includes additional bed capacity at crisis stabilization facilities, emergency housing vouchers, establishing Forensic Housing and Recovery through Peer Services (FHARPS) teams, establishing Forensic Projects for Assistance in Transition from Homelessness (FPATH) for high utilizers, and enhancing mobile crisis and co-response services.
- **Education and training** including emphasis on Crisis Intervention Training and technical assistance for jails to work effectively with persons living with mental illness.
- Establishing an Outpatient Competency Restoration Program
- Creating multiple Peer Support Teams
- **Workforce development** with sectors across the competency continuum
- Creating a Forensic Navigator Program
- Hiring additional Forensic Evaluators

Washington refers to these programs as a "multivitamin approach," meant to emphasize the interdependence of the efforts and confirm that no single program can be evaluated for stand-alone efficacy. Washington is studying the long-term impacts of the "multivitamin approach" and as of Spring 2023 has found the following outcomes among the phases where Trueblood Programs have been operating:

- Significant decrease in the number of referrals for competency evaluation.
- Significant increase in the proportion of individuals with a history of at least one competency evaluation order who are receiving mental health treatment and substance use treatment. This outcome is consistent with the intent of the Trueblood Programs to better address the treatment needs of individuals who have been involved with the competency process.
- No differences on measures of homelessness, incarceration, state hospital admissions, emergency department visits, or hospitalizations.
- A small, insignificant increase in the rate of competency restoration orders.

## Centralized, standardized outpatient restoration, Wisconsin

Wisconsin serves 20% of individuals ordered to competency restoration through outpatient services. Relative to other states, the state serves a high proportion in outpatient settings, which is true in Oregon as well. Wisconsin has centralized outpatient restoration services that are supervised by the Wisconsin Department of Human Services (DHS) and paid for by the state through tax revenue. In Wisconsin, DHS has decision-making authority in the competency restoration process, similar to Tennessee. When an individual is adjudicated incompetent, they are committed to the care of DHS which has purview over placement decisions for restoration.

DHS contracts with Behavioral Consultants Inc. to deliver a standardized Outpatient Competency Restoration Program (OCRP) across the state. The process begins with a clinical and environmental (housing, support system) assessment for appropriateness for OCRP. Once approved for outpatient restoration, each participant is assigned a Behavioral Specialist who provides treatment to competency and a Case Manager who addresses community-based needs in the home environment, both of which meet with the participant at least once per week (Behavioral Consultants Inc.).

OCRP in Wisconsin faces similar challenges to those in Oregon and elsewhere. Housing and staffing present challenges to increasing the number of participants, which would help alleviate Wisconsin's waitlist for accessing inpatient restoration services, which grows as the orders for evaluation and restoration increase. Wisconsin's state experts spoke about the tension between ensuring community safety and accepting participants likely to be successful, and the need and desire to serve more participants, including those with more risk factors, like unstable housing or substance use.

## Expand forensic housing options, Washington

Nearly every state expert we spoke with identified housing as a significant challenge that contributes to the competency crisis. Unstable housing is a risk factor for recidivism and ongoing engagement with the criminal justice system and is a barrier to outpatient restoration placement. Washington has been tasked with creating residential supports through the *Trueblood v Washington* settlement agreement. In response it is implementing Trueblood programs targeting housing and developing innovative solutions to create more housing stock.

Washington uses the (FHARPS) to connect individuals in the competency system with temporary, transitional, and permanent supportive housing. In addition to peer support the program provides housing subsidies, security deposits, application fees, and current or overdue rent assistance.

To date FHARPS has demonstrated the following results (Washington State Healthcare Authority, 2023):

- In all regions where Trueblood programs have begun, except for the newest region, there are opportunities for people to be housed immediately in low barrier housing, with certified peer support.
- It has enrolled 834 people between March 1, 2020-Dec 31, 2022.
- 63% of participants were homeless at the time of enrollment.
- The program has discharged 65% of participants at the time of data collection. Among those discharged:
    - 32% were stably housed
    - 14% were homeless
    - 13% were in a facility
    - 33% were lost to follow up

Though accessing enough housing remains challenging, FHARPS providers have deployed innovative solutions to increase their portfolio of housing options. They have used old hotels and motels to shelter and transitionally house program participants. And, they have had success using master leasing agreements to create additional permanent supportive housing (see call out box).

### What is Master Leasing?

According to the National Alliance to End Homelessness, a master lease gives the lessee the right to control and sublease the property during the lease, while the owner retains the legal title. In this case, a FHARPS would be the lessee, allowing them to sublease the property to their chosen clients. The lessee assumes all responsibility for maintenance, repairs, taxes, and insurance.

For individuals experiencing homelessness and/or with a history of involvement with criminal justice, the benefits of master leasing are substantial (Freed, 2022), and include:

- giving opportunities to prospective renters deemed "high risk" (without reliable income, with previous evictions or no rental history, criminal histories, etc.);
- reducing barriers and lowering the cost to house people, including saving money on application fees, credit checks, and more;
- enabling the expansion of shared housing by normalizing split leases; and
- decentralizing where low-income people live by opening neighborhoods where they have historically been priced out.

## Alignment and collaboration across criminal justice stakeholders, Franklin County, Ohio

The Ohio Revised Code established planning committees, including the Franklin County Criminal Justice Planning Board which is responsible for improving the quality of criminal justice systems in the county. Board members are appointed by the Franklin County Board of Commissioners Office of Justice Policy and Programs (OJPP) which serves as both the administrator and fiduciary agent for the planning committees. Through this revised code, board members are appointed to serve and statutorily mandated to address the collective interests of the criminal justice systems rather than their own siloed organizations or sectors. OJPP can direct funding to local priorities based on the input of the Criminal Justice Planning Board versus relying on the on the State to direct funding. The revised code has facilitated strong collaboration and alignment across sectors, enabling Franklin County to advance important programs with the goal of decreasing the number of people with severe and persistent mental illness in jails. These programs include:

- Building a one-stop mental health crisis center that includes residential services and will open in two years.
- Creating a Bridge Housing program for people released from jails and prisons that were unhoused at the time of booking. This includes peer support and will evolve into a broader housing continuum of care.
- Facilitating information sharing and centralized data collection. Franklin County has MOUs from all but one sector to participate in Justice Counts, a national model for collecting and reporting data in criminal justice systems.
- Prioritizing peer support positions across all five intercepts in the Sequential Intercept Model.
- Bringing together stakeholders for care conferencing and jail population reviews to expedite the release of people who are severely struggling or who don't need to be in jail.

# Key themes about competency restoration

We took a system-level perspective of the competency restoration process and saw the human-level consequences of the "broken system" discussed throughout the Oregon interviews. Competency restoration requires providers and specialists from many sectors to engage with people throughout the process before, during and after someone's competency has been questioned and – ideally – restored. Yet the data demonstrated a lack of shared purpose and goals for restoration which impacted the overall system as well as the person who is often lost in this legal "solution" to a behavioral health crisis.

The interviews with programmatic and content experts from other states confirmed that some of the challenges Oregon is facing are not unique to this state. We can look to the strategies and promising solutions other states and jurisdictions have employed to improve our statewide and local implementation including diverting and supporting people throughout the competency process with housing and intensive services, reducing the time to evaluation and admission, reducing the length of stay, and building transparent, reliable, and shared data systems.

Competency restoration is a complex process impacted by many factors, so this report does not contain The Answer or a single solution to fix competency restoration in Oregon. But there are three key themes that are reflected across the data sources that can help support agencies and partners working to transform the behavioral health system and improve the lives of the most vulnerable people in Oregon.

## Competency restoration is a legal "solution" to a behavioral health issue that has human consequences

There is conflict built into the fact that competency restoration is a court-based process yet the sectors responsible for implementation are behavioral health and human service providers who approach restoration using a very different lens than judges and DAs. In Oregon, and most other states, the decision to order someone to competency restoration and the placement of that person in community or hospital level of care, rests with the court. However, it is the healthcare and social service sector that is responsible for implementing competency restoration and those providers. These sectors and systems may not be using shared language or viewing competency restoration in the same way and the "solution" has human consequences for the people going through restoration as well as the providers.

Healthcare (including behavioral health) and social service providers are trained, licensed, and hired to serve *people*, not the courts. The expectation is to provide resources and support to help people address problems and improve their lives. The mission of the court and judicial system is to interpret and enforce the rule of law and ensure that all Oregonians receive fair and accessible justice by providing due process. These sectors use very different frameworks,

resulting in a court process that requires service providers who approach the issue using a very different framework.

> *"So some people cycle through a couple times, or two or three times. And they've already been identified as never able. So they go up to the state hospital, they're committed there for however long, go through the process. Discharged with a never able. Consequently, all the charges are dropped and there's no obligation on their part at all to follow through with services. So they haven't had any insight, or, or really benefited from what they've just been through. And it kind of seems like sometimes they've just been abducted by aliens and taken to a place, and then they come back and they're free to go and maybe two years have passed. And so, what happened? Really nothing beneficial to the person happened. They're in a weird legal mental health system that's moving them around."*
>
> *–CMHP staff, large county*

## Lack of shared purpose and goals for restoration

On the surface, the overall goal of competency restoration seems clear – to provide a defendant whose capacity has been questioned with the necessary services to gain or regain fitness to proceed (ORS 161.370). Yet throughout the interviews with participants in Oregon and experts from other states, the data confirmed that service providers and decision-makers did not have a shared purpose or set of goals for competency restoration. Though many of the providers expressed a similar understanding of the larger problem, they often used their own lens to address the problem within the context of restoration.

The goal is to restore a person's competency so they can address their criminal charges in court. During interviews with state experts and Oregon participants, we found that courts and behavioral health providers did not always agree about the purpose of competency evaluation and restoration nor about placement decisions for competency restoration. There was an inherent disagreement between many courts and service providers because they fundamentally approached competency restoration with a different purpose. This was particularly the case when restoration orders were used as a mechanism to provide behavioral health treatment, regardless of the intention to pursue the charges.

Participants providing services for people in competency restoration repeatedly raised the issue that the stated definition of competency restoration is preparing someone for jail but not providing treatment, person-centered care, discharge planning or long-term stability. We did identify some jurisdictions providing more robust and expansive care, but providers from various sectors expressed frustration with the "broken system" overall and the inherent tension in the stated purpose of the restoration process.

*"We're getting that person's head fit for a trial that's never going to happen. Or they come back from the state hospital permanently unfit, never able to stand trial, they timeout and just get released and they're released from jail no better than they came to jail because we never dealt with the underlying issue of their mental health disorder… I think what they're hoping to do is get them to state hospital and they take medication and maybe they help themselves a little bit. But when they come back, the only reason they're coming back is to be fit for that trial, and the system it's just broken."*
*–Law enforcement, large county*

## Competency restoration has not been operationalized

Competency restoration is not an OHA Program with clearly defined outcomes and a list of enrolled clients who start the program, receive an established or understood set of services, and then are discharged at the end of treatment. Instead, competency restoration is a process that people "enter" in various ways with an opaque start date, then they receive a black box of possible services that are not tracked or shared in a meaningful way, they may move between hospital and community settings without systematic or shared documentation of the episodes, and then terminate or leave restoration for a number of reasons that are not systematically tracked across systems.

## What is a "successful" restoration process and outcome?

Because providers did not agree on the intended purpose of competency restoration, "success" was difficult to define both as a process and as an outcome. Some county-based service providers were looking for more guidance around what a "successful" restoration process looked like and what "successful" engagement looked like in the restoration process. Providers raised questions about how much interaction between the "client" and judge was the right amount, what accountability looked like, what the best level of services might be, and how long restoration should last, given limited County resources.

County providers who offered more robust community restoration services used person-centered approaches and engaged people by explaining the restoration services beyond basic legal skills training. These providers emphasized clear communication throughout the process, offering people the chance to ask questions about what they were doing, why they were doing it, and what next steps they could expect.

*"We try to really let them know, because … a lot of people who are in Aid & Assist don't really even understand what it is. You have to explain it quite a bit. And I'm trying to give them all of the tools that they can have to be successful in the program."*
*–CMHP staff, medium county*

Providers also questioned what "successful" competency restoration outcomes were at the individual and societal levels. People going through competency restoration might be found

able at the end of their restoration episode but continue to cycle through the "revolving door" of Aid & Assist. If someone went through competency restoration multiple times, that was difficult to count as a success for the person or the community.

> *"I told you about the one we just had that was successful for Aid & Assist purposes because he took his meds until he passed his forensic evaluation, but refused to come in for an assessment, refused to engage with our agency, other than peer support… He doesn't think he's mentally ill, he only took the medications because they told him he had to until he passed forensic evaluation, and then he said "I don't need them anymore." But he did at least get through that process and he's never been able to do that before. And he's been on Aid & Assist many times."*
>
> *–CMHP staff, small county*

When "success" for competency restoration is defined solely as an individual being found able, then service providers highlighted the challenges of providing successful community restoration without housing, transportation, and other supportive services offered as part of restoration. Throughout the interviews, we heard providers indicate that people might be sent to hospital-based restoration primarily to get them off the street and stabilized.

> *"I would say that most of the people that we've had that have been found able, it's happened while they've been at the state hospital. We haven't had a ton of clients who have been found able while they've been in the community and when they have it's been usually with people who have been at some type of residential placement… we've had very little success trying to restore somebody in the community when there's other unstable factors involved."*
>
> *–CMHP staff, large county*

## Access to adequate restoration services is dependent on your zip code

Some counties have implemented adaptive strategies which may not necessarily create "successful" restoration pathways or outcomes, but these strategies appear to create a less chaotic and more supportive experience for someone going through restoration. The adaptive strategies did not mend the broken system, but were implemented as a multi-faceted approach to ameliorate the lack of funding and need for additional resources, services, and staffing.

While additional funding will not address or resolve the forensic behavioral health crisis, there was a notable funding difference across the counties to deliver community restoration. Over the years, there have been multiple funding mechanisms to distribute funds to counties for competency restoration, resulting in some counties receiving much more than others. In addition to varying levels of funding, some counties have more extensive service delivery

infrastructure and programming, leaving them better prepared to address community restoration, though even these counties are overburdened and understaffed.

These differences in resources mean a person ordered to competency restoration in one county may have a very different experience than someone in another county. In a county with more robust competency restoration, someone may be offered additional services, may receive a higher level of care coordination between Oregon State Hospital (OSH) and CMHP staff, and benefit from aftercare planning with a local service agency. In a different county, someone may be offered a booklet focused on legal skills training.

Providers are affected by the inequitable distribution of resources and system constraints as well as the people going through restoration. We heard from overburdened service providers, frustrated clinicians and disheartened law enforcement personnel who noted the lack of resources across their counties.

### Competency restoration does not happen in isolation of the other behavioral health and social services

Social service and behavioral health providers have been delivering services under the constraints of a "broken system" after deinstitutionalization and the lack of promised investment in community mental health (United States General Accounting Office, 1976) – all exacerbated by the COVID-19 pandemic. Compared to most other states, Oregon has a higher prevalence of behavioral health problems (Kaiser Family Fund, 2023), and the system of care is fragmented and complex.

Working across these systems are providers interacting with people in competency restoration. While behavioral health providers are at the heart of the services delivered, many different sectors provide services and interact with people going through restoration given their wide range of behavioral health and social services needs. A portion of the population – roughly one in three to one in four based on the quantitative data – needs a high level of support following restoration to have their basic needs met and a safe and stable place to live.

As we described in the adaptive strategies section, some counties recognize that restoration does not happen in isolation of the other behavioral health and social service needs. As a response, these counties have coordinated with multiple service providers to offer cross-sector services to people going through competency restoration. In these counties that have been able to patch together more robust community restoration services, restoration may include access to rapid evaluations, an Aid & Assist court docket, housing services, transportation options and access to aftercare planning including crisis services. Some counties also work with diversion services to prevent people from entering restoration in the first place.

# Lack of data transparency and information sharing across sectors

Overall, the lack of data transparency and information sharing across sectors prevents providers from doing their jobs and prevents people from getting the services they need. We saw human consequences to the siloed data systems and the lack of data systems to monitor competency restoration as a whole system. There is no unified data system tracking people through competency restoration regardless of hospital or community setting. No tracking system prevents OHA from having real-time data on how many people are in restoration overall and how many are in hospital vs community restoration at any point in time. Without a roster of people in restoration, OHA is unable to routinely monitor the number of hospital or community restoration "episodes" someone experiences in a single restoration order, providing the length of stay by person and by setting as well as their outcome. These are basic metrics needed by decision-makers and program staff to assess the health of the system and track progress in meeting agency goals.

## Data sources are siloed

One of the largest barriers to monitoring and assessing Oregon's competency restoration process is the complete separation of data systems. No agency, including OHA, has the ability to see how individuals move through the competency restoration process or identify common historical trends or outcomes. This barrier, combined with a lack of research staff to analyze data, makes it virtually impossible to evaluate how competency restoration impacts individuals' behavioral health and criminal justice outcomes.

Certainly, connecting data sources across systems is not easy. People we spoke with who are familiar with OHA's Behavioral Health Data Warehouse indicated that joining data across agencies (e.g., between OHA and OJD) would require statutory authority and legislative action. However, no agency taking charge of connecting competency restoration-related data sources across agencies is additional evidence of a system that does not perceive competency restoration as a shared responsibility and one that does not know who is ultimately responsible for these vulnerable Oregonians.

# Observations and opportunities

Our intention is to offer observations grounded in the data then summarize concrete and specific opportunities to OHA and other agencies and providers who serve people in competency restoration. The goal is for OHA to have a document that provides them with data to be both responsive and reflective. This document allows OHA to be prepared to respond to court orders and legislative and communication requests and can facilitate planning and partnership-building.

We are offering observations and opportunities instead of the usual "recommendations" because competency restoration is a complex process implemented by many different types of providers representing multiple sectors who may have varied perspectives. Throughout this project, there were many topics and issues that did not have a single answer or perspective or pathway. Instead of trying to resolve or smooth away those differences, we want to reflect the complexity of the issues that emerged. There are no easy answers or straightforward recommendations with competency restoration, but there are some opportunities to improve the work and the services for people experiencing this system.

## A cross-sector multi-faceted approach is necessary to piece together the "broken system"

There is no quick fix to the "broken system" of competency restoration, as we have learned from jurisdictions in Oregon and other states using promising strategies to address the challenges. The common thread in these states and counties was their commitment to using a cross-sector multi-faceted approach to make progress and achieve positive outcomes in competency restoration.

Other states are using policies, legislation, procedures and programs to address system-level issues to improve the lives of people in competency restoration. In Washington state they specifically call out their "multivitamin approach" to addressing the problems in the competency restoration system, using an upstream approach as well as crisis services to support people before and after competency restoration.

OHA cannot address the problems of competency restoration in isolation. We learned from state experts that a central convener is necessary to set up an integrated cross-sector system. Oregon does not have a centralized program or office with the authority and resources to convene cross-sector service providers and partners to support people throughout the competency restoration pathway.

There have been behavioral health, housing and homelessness, crisis system, judicial, cross-sector workgroups and advisory councils issuing reports and recommendations that are directly applicable and aligned with this population. We are not recommending more workgroups and

additional multi-year planning periods. Instead, we see an opportunity to use these various reports and workgroup products to create a Competency Restoration Improvement Plan that looks beyond Oregon State Hospital (OSH) and OHA to encompass the recommendations from these cross-sector workgroups and create a timeline and accountability matrix for the various partners and systems.

There are many opportunities to build and solidify relationships and to identify immediate and future work by assessing status of the recommendations and workplans in these various documents. This cross-sector Competency Restoration Improvement Plan could be updated annually to assess progress and identify new partners or emerging initiatives.

## Mending the "broken system" requires statewide leadership to create shared responsibility

Unlike other states, Oregon does not have a program or office with resources and authority to convene cross-sector partners, identify shared goals and accountability metrics, create the data systems, and implement or oversee the trainings and technical assistance needed to improve the overall system. In short, our qualitative and quantitative data suggest that no single group seems to take ownership or responsibility for people undergoing competency restoration *regardless* of hospital or community setting, which results in fractured service delivery and data systems.

We need statewide leadership to create shared responsibility and set expectations for competency restoration including relationship-building across sectors and identifying the purpose of competency restoration, including how and when competency restoration should and should not be used. As a state committed to "reimagining and rebuilding" our behavioral health system, OHA is well-positioned to lead this cross sector work by identifying an office or program to convene OJD and other partners, build relationships and hold OHA and partners accountable. Yet the responsibility for repairing the competency restoration system cannot rest with one person or a single OHA program – addressing these cross-sector challenges must be a shared responsibility. This cross-sector team with shared responsibility for competency restoration can look for opportunities where work is already underway to support and enhance competency restoration.

## Decision-making authority to clarify shared goals and solidify relationships with partners

A state-level program or team needs decision-making authority to work with cross-sector partners to clarify the purpose and goals of competency restoration and create resources and materials to support implementation in hospital and community settings. As we learned from the Bridges and the Forensic Support Teams in Colorado, they were intentional with their relationship-building and worked collaboratively across sectors and made programmatic decisions while still recognizing and maintaining the authority of the courts. They also spent a

considerable amount of time building relationships across the state and getting buy-in from partners in every sector that supports and serves people involved in the competency process.

The competency restoration system in Oregon would benefit from expanded and solidified cross-sector relationships at the state and local level. The jurisdictions implementing adaptive strategies in Oregon have done local-level planning and service implementation by partnering with programs and agencies that serve people *throughout* competency restoration including law enforcement and social services. Some partners we expected to hear about – such as Coordinated Care Organizations, Oregon Department of Human Services (ODHS), substance use disorder treatment facilities and housing agencies – were not discussed much or at all during the interviews. Building, repairing, and maintaining cross-sector relationships takes time and honest communication but is critical for creating a shared purpose and goals for implementing successful restoration.

| Concrete opportunity |
| --- |
| • **Conduct a brief stakeholder analysis** at the state and local level to identify cross-sector partners whose work is aligned with competency restoration, particularly housing, CCOs, ODHS and substance use disorder (SUD) treatment facilities addressing co-occurring disorders. |
| • **Create a Competency Restoration Improvement Plan** by reviewing existing reports from workgroups and advisory councils; select recommendations aligned with competency restoration and create a statewide cross-sector accountability matrix. |

## Support implementation of competency restoration with materials and technical assistance

The OHA Behavioral Health Services team and OSH staff and leadership have created some fact sheets and materials that offer an overview of "Aid & Assist" or guidance on reporting for community restoration. But there is an opportunity for clear supporting materials tailored to service providers, partners from other sectors, people going through restoration or their families. Given the constraints and challenges with hiring and retaining staff within OHA, we see an opportunity to collaborate with topic-specific experts who can provide technical assistance and implementation support.

### Implementation manual for community restoration

The data were clear that "every county does their Aid & Assist process a little bit different" which can make the services and programming responsive to local context and strengths, but statewide implementation is uneven and opaque. Service providers and county partners would benefit from an implementation guide that provides clear explanation for the statutes,

expectations, and procedures for implementing community restoration. This guide would also promote a shared language across jurisdictions and partners implementing community restoration and facilitate the shared purpose around competency restoration statewide.

As legislation continues to be passed and judicial orders are issued that affect competency restoration, we see a crucial need for an up-to-date and user-friendly guide intended for county users.

### Companion manual for support people/family members/caregivers

Family members and people who offer support to individuals going through competency restoration may not know the basic facts about competency restoration, what their role might be, and what they can expect. We see an opportunity for OHA to create a brief companion manual for family members and caregivers about the competency restoration process, services, and expectations. We heard during interviews that family members may be estranged or excluded or left out of the restoration process for many reasons. A companion manual that uses plain language and clear visuals can offer family members and caregivers a way to reconnect or understand what is happening during a complex and confusing process.

### Technical assistance provider to support implementation of robust community restoration

Competency restoration requires multi-sectoral partners delivering services independently and across a system, communicating effectively, and working together to maximize resources. That type of effective system engagement takes time and resources to develop and maintain. OHA is acting as the funder for most of the competency restoration activities through various funding mechanisms, but the data has shown that OHA cannot do this work alone. We see an opportunity to contract with technical assistance (TA) providers to support successful implementation of robust community restoration.

OHA and counties would benefit from partnering with a single TA provider to support implementation of a shared vision for successful implementation of robust community restoration. The scope of work could include identifying a shared set of goals and purpose for competency restoration, how to use the community restoration implementation manual, data collection and reporting expectations, plus building effective connections between hospital and community restoration.

We also see an opportunity for topic-specific TA providers who can support workforce development, building data systems and data collection tools, implementing CQI in jurisdictions that are struggling to meet expectations, and facilitators to build relationships between the courts, behavioral health, law enforcement and other key partners in competency restoration.

| Concrete opportunity |
| --- |
| • **Create a community restoration implementation guide** that provides clear explanation of the statutes, expectations for the different roles (CMHP, judge, DA, defense attorney, OSH, etc.), possible services, and procedures to support people throughout restoration including aftercare planning. |
| • **Create a brief companion manual for family members and caregivers** about the competency restoration process, what to expect, the various providers and what their role might be in the process. |
| • **Contract with a TA provider to work with cross-sector providers** responsible for delivering competency restoration and identify a set of goals and shared purpose for competency restoration. |
| • **Identify additional resources, materials and TA needs** from the various sectors, funded partners and geographic regions and consider contracting with topic-specific TA providers to meet those needs. |

## Address workforce capacity, development, and training

We heard about considerable system-level barriers and resource constraints on staff and clinicians in both hospital and community settings and in many counties. Systems were described as "bare bones" and providers were either overburdened or entirely unavailable, particularly after the COVID-19 pandemic placed an unprecedented strain on individuals and organizations. At OSH, staff and clinicians emphasized **wanting** to meet people's basic needs and treat their mental illness while also feeling the pressure to get people through the system and out the door quickly. In community settings, behavioral health and social service staff reported being understaffed throughout interviews, and a recent report found behavioral health professionals were relatively underrepresented throughout the rest of the state outside of Multnomah County (Office of Health Analytics, OHA, 2023).

At the state level, we see an opportunity for additional staff within OHA to coordinate and lead the programmatic work to bring together the key partners and align planning and implementation within OHA and across sectors. Currently, there is no capacity in the OHA workforce to do the relationship-building, communication, intentional planning, and contract management needed to create a shared sense of purpose and responsibility. In addition, the Health Systems Division (HSD) would benefit from a data scientist and/or analyst positions to expand in-house data capacity, provide TA to grantees / counties around data and reporting and build data systems specifically for competency restoration.

### Workforce development and staff training in forensic behavioral health

In both hospital and community settings, providers emphasized the need for staff training in forensic behavioral health. We know from the data that people going through competency

restoration have a wide range of behavioral health needs and clinical histories, from dual diagnoses to neurodevelopmental and neurocognitive disorders to issues associated with aging and dementia. The forensic behavioral health population is not a homogenous group, and they deserve tailored or specialized programming and services. But few providers have that level of training and agencies are rarely able to offer tailored programming for people with the diversity of needs in this population.

One specific example is housing providers who may work with people with traumatic brain injuries (TBI) or developmental disabilities. We heard during interviews that housing providers may have beds that could be used for people in community restoration, but they were hesitant to serve the forensic population. This group of providers would benefit from basic information about people going through restoration and a tailored training about how to engage and serve this population. This is a timely example because OHA has distributed funds for more than 1,000 new residential and supportive housing units and beds. These housing options are expected to become available by July 2025 across the state and some of them may be available to people during or after competency restoration. But supportive housing providers may need additional training, resources, and support to serve the forensic population, especially if they are already serving special populations like people with traumatic brain injuries or developmental disabilities.

| Concrete opportunity |
| --- |
| • **Continue funding to expand the capacity and diversity of the behavioral health workforce** across Oregon, offering specialized training in forensic behavioral health and the competency restoration process as well as the needs of people going through competency restoration in hospital or community settings. |
| • **Seek opportunities to train providers, such as housing providers and peer support specialists**, in forensic behavioral health and competency restoration. |
| • **Hire additional OHA staff** to coordinate the key partners, align planning and implementation within OHA and across sectors and create a shared sense of purpose and responsibility. |
| • **Expand data capacity within the Health Systems Division (HSD)** by hiring data scientist and/or analyst positions to build data systems, provide TA to grantees / counties and oversee data reporting and summaries. |

## Improve data systems and information sharing

As noted by Dr Pinals in various reports to OHA (Pinals, Neutral Expert Second Report Regarding the Consolidated Mink and Bowman Cases, 2022), we see numerous opportunities to improve data infrastructure within OHA and information sharing between OHA, OJD, and interested parties who serve people in competency restoration. We observed and experienced

considerable needs around reporting, data standardization, transparency and information sharing. Challenges accessing data and connecting data systems greatly hampered our ability to complete this project. More importantly, these challenges are experienced regularly by providers and agency staff seeking timely, useful information.

## Invest in OHA data infrastructure for competency restoration

To improve the overall competency restoration system and truly transform the behavioral health system, this is the time to continue investing in OHA data infrastructure specifically for competency restoration. The Compass Modernization initiative has been underway for nearly four years. This effort is focused on replacing the Measures and Outcomes Tracking System (MOTS) with ROADS and building out the Behavioral Health Data Warehouse. We see an opportunity to ensure that data specific to competency restoration is captured in these systems for **both** the hospital and community settings.

In addition, OHA could explore building data infrastructure for competency restoration beyond the Compass Modernization initiative. For example, OHA does not currently maintain a real-time list or "roster" of people in competency restoration for basic data monitoring and reporting purposes. Other jurisdictions worked together to identify information that would improve their work and then centralized data collection across partners. For example, in Franklin County, Ohio, partners signed MOUs to collect and report data from across sectors to improve the overall process. In Oregon, one example for how we would understand our competency restoration system better is by linking criminal case numbers to the list of people in competency restoration so we could reliably and routinely identify outcomes.

## Identify key metrics for competency restoration

As part of clarifying the purpose of competency restoration and identifying what "successful" restoration looks like, there is an opportunity to identify a key set of metrics for competency restoration overall. This process would set expectations for real-time statewide data collection and what is needed to generate meaningful information from routinely reported data. By collecting, analyzing, and reporting key metrics like demographics, the jurisdictions using specific components of competency restoration like rapid assessment would be able to assess utilization patterns by race/ethnicity or other characteristics.

There are key data points that should be reflected in shared data systems for competency restoration to make the system meaningful. For example, the system should include forensic evaluator findings, indicators of whether person is returning to OSH after decompensating in jail waiting for their criminal case to proceed, and their criminal case identifiers like Case Number in the restoration records to track the outcomes of the case(s). Currently, whether or not a person is considered

> *The lack of connection between data sources makes it impossible to know whether the competency restoration system is serving its intended purpose.*

restored and found "able" after they go through competency restoration is not information that is tracked in shared data systems. The lack of direct connection between the data on people's criminal cases and the data on people's competency restoration episodes makes it nearly impossible to assess the impact of restoration on criminal case outcomes. In other words, the lack of connection between data sources makes it impossible to know whether the competency restoration system is serving its intended purpose.

## Improve data coordination and reporting systems

We experienced a need to strengthen the overall data coordination within OHA and across agencies and funded partners. Currently a limited set of data specific to community restoration are collected as part of reporting requirements and contract management, but there is not routine coordination of data across agencies (OHA and OJD) and the data collected do not allow OHA to report meaningful information about who has been in competency restoration, in what setting (hospital or community), and what their status was when they left or "discharged from" restoration.

Creating a data reporting system would improve the transparency of data and help build buy-in across partners and a shared sense of purpose for competency restoration. There is a need for real-time data that is transparent and accessible to service providers – not just one specific role. Providers need accessible data to provide clients with housing options or monitor the number of people from their county in hospital restoration.

**Concrete opportunity**

**Work with cross-sector partners to identify the key metrics for competency restoration metrics.**

- At a minimum based on this project, create a deidentified real-time roster of people in restoration (including dates for entering and leaving hospital and/or community restoration as a single pathway), basic demographics, the length of stay for hospital restoration and community restoration episodes, and the outcome status at end of restoration episode.
- Create a data dictionary of the data elements, the data source(s) and definitions.
- Align the data collection and data elements with REALD when feasible.

**Create a Competency Restoration Annual Report that reflects accurate cross-sector data and summarizes key metrics.**

- Start with a subset of the data collected for the quarterly community restoration reports, working towards consistency across data elements and integration with OSH data.

# Limitations with this project

Not unlike all projects, this project encountered a number of challenges and significant barriers that limited our time and capacity to explore and leverage our mixed methods dataset to the extent we desired. Below is a brief summary of some of the more significant challenges we faced, including barriers around data sharing, difficulty recruiting people with lived experience for interviews, and project staffing issues.

## Data sharing

We experienced considerable system barriers around shared data systems, establishing data sharing agreements, and obtaining data through data requests. These data sharing barriers prevented us from answering some of our basic research questions and from doing basic subgroup analysis (e.g., county-by-county, analysis by crime type, etc.), and more sophisticated analysis, mostly due to the time required to establish data sharing agreements. One of the primary deliverables for the project was the creation of the mixed methods dataset – indeed, we received a key dataset merely two weeks before the report was finalized and submitted – so the team was not able to maximize the mixed methods dataset to answer important questions about competency restoration.

For a concrete example of how data sharing limited our ability to answer the study questions, we do not know if someone is returning to Oregon State Hospital (OSH) on the same charge. Under Mosman (Oregon Health Authority, 2023), once someone has reached their term of commitment, they cannot return to OSH on the same criminal case and charges. But for data prior to Mosman, we cannot tell if someone returned to OSH on the same criminal case because we were unable to link criminal cases to their associated competency restoration episodes.

## Limited participation in interviews by people with lived experience

To identify people who had been through the competency restoration system, we conducted outreach with organizations serving families and people living with behavioral health issues, clinicians and staff at OSH, county behavioral health programs, and advocacy organizations. We were able to successfully recruit and interview only a handful of people with direct lived experience (i.e., they experienced competency restoration firsthand) and a couple of people whose family member(s) experienced the competency restoration system. The voices of those with lived experience would be critical to capture in any future research and certainly for any implementation of changes to Oregon's competency restoration system.

## Project team staffing issues

We encountered a number of staffing issues and barriers to hiring new staff that were beyond our control. The sheer amount of qualitative and quantitative data we compiled required a more robust staffing plan and, ideally, the same staff for the duration of the project. Still, the project team is exceedingly proud of what we accomplished despite significant staffing shortages.

# Opportunities for future research

In our final chapter, we outline our thoughts on possible opportunities for future research on Oregon's competency restoration system. Our ideas are primarily borne from our analysis of the qualitative interview data and findings from our quantitative data.

## Mixed methods, linked database for cross-sector improvements of competency restoration

This project has resulted in a mixed methods set of data that includes quantitative data from across multiple agencies in Oregon, interview data from 81 semi-structured interviews and information from conversations with experts in other states. This type of data has never been collected in Oregon and could yield important additional information about how to strengthen the competency restoration system in counties and across Oregon.

Given the barriers and the considerable delays to receiving and analyzing the data in this dataset and the relatively limited scope of this project, there are still many research questions to explore in this set of data including:

- County-specific analyses and reports, subgroup analyses (e.g. length of stay in competency restoration by county and subgroups)
- Examine the changing patterns of admissions for civil commitment against recent patterns of admissions for hospital restoration
- Assess trends of key metrics over time to evaluate the impact of funding or policy changes during the study period
- Analyze the interview data for workforce capacity and training needs, exploring the data by sector and region
- Explore the impact of grouping multiple criminal cases into a single inquiry into a person's fitness to proceed
- Assess the utility of the case numbers reported to Oregon State Hospital (OSH) for exploring hospital restoration outcomes
- Conduct a deeper exploration of the restoration outcomes, particularly focusing on the dismissed cases

Given the dates associated with the datasets received and the rapidly changing context for competency restoration in Oregon, we urge decision-makers to prioritize this research before this set of data becomes outdated.

## Systematically assess adaptive strategies across the counties

We identified the adaptive strategies as emergent factors in the interview data, and they appear to be promising local approaches to implementing competency restoration even in the

midst of considerable system-level constraints. These interview data indicate these strategies work together as an overall approach to competency restoration. OHA leadership and decision-makers would benefit from a more systematic assessment of which counties are using these adaptive strategies and how the strategies work together and independently to impact restoration outcomes.

## Assess specific components used in competency restoration

Counties need the flexibility to adapt components of competency restoration to their local context, partnerships, and available resources, but some like rapid forensic evaluation and the Aid & Assist dockets deserve a deeper assessment.

For example, the rapid evaluation mechanism has been implemented in some counties to decrease wait times, but the model has been implemented differently in each county and we don't know if some models are more successful than others. Equally important, we do not know if some models are more equitable than others. We also heard during interviews that many of the rapid evaluations were contested, resulting in multiple evaluations done, which negates the point of the rapid evaluation process. An assessment of how many rapid evaluations were contested, why they were contested, and what the outcomes were for each case would benefit the overall system to understand if this is a viable and equitable mechanism for reducing wait times.

## Analyze medication and orders for the administration of involuntary medication at OSH

Medications and medication management were mentioned as key issues in competency restoration. The team obtained a limited dataset of individuals at OSH for whom the "informed consent" process was initiated. However, the informed consent process is so nuanced that it was difficult to draw meaningful conclusions from the data and deserves more analysis. The informed consent process applies when a provider believes an individual would benefit from medications, but lacks the capacity to consent to medications. Sometimes, this means that an individual agrees to the medication but does not have capacity. Thus, "involuntary medications" can be a misnomer, which causes confusion between OSH, the community, and the courts. Medications administered under emergency situations and medications administered under a *Sell* order (court ordered medications for the sole purpose of competency restoration) follow different processes.

## Conduct an “equity audit” of specific points in the restoration process

Systematic data are not collected across the counties for whose competency is questioned and who received a forensic evaluation. We recommend an audit of the .365 and the .370 process to explore geographic, racial/ethnic, gender and age differences to determine if some groups are more likely to have their competency questioned or receive an evaluation. This rich dataset provides the opportunity to act as a foundation for an equity audit to ensure all Oregonians have the same opportunity to reach their full health potential and well-being.

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