



**NYSAC**  
— NEW YORK STATE —  
ASSOCIATION OF COUNTIES



# A Blueprint for Change

## Reforming Mental Health Competency Restoration in New York State

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**HON. JOHN F. MARREN**  
NYSAC President

**KATHERINE ALONGE-COONS, LCSW-R**  
CLMHD Chair

**STEPHEN J. ACQUARIO**  
NYSAC Executive Director

### Counties Working For You



515 Broadway, Suite 402  
Albany, NY 12207



[www.nysac.org](http://www.nysac.org)



518-465-1473

# Introduction

Beginning in the 1960s, New York State began to transition away from providing mental health services in large, inpatient institutional settings, toward community-based treatment. Spurred by the development of effective psychiatric medications, stricter civil commitment criteria and a societal and legal movement toward deinstitutionalization, this transition saw New York State's inpatient psychiatric population drop from 95,000 in 1955, to little more than 2,000 in 2018.<sup>1</sup>

As institutions closed over time and inpatient beds were reduced, the mental health care system began its transition to a community-based treatment model, where individuals are supposed to be served in more appropriate settings, closer to home.

The problem, however, was that funding from the state and federal governments for this transition was not adequate to meet the needs of this population. This in turn led to substantial increases in homelessness and ultimately to increased involvement with the criminal justice system. Indeed, in many cases local jails have become a primary, if not the primary, source of mental health treatment in some communities.

While many new services and programs have been developed to connect the mentally ill with treatment while they lived in a noninstitutional setting, including community mental health centers, supportive housing, assertive community treatment, and assisted outpatient treatment, the numbers of mentally ill people becoming involved with the criminal justice system remains stubbornly high.

When these defendants come before a court charged with a crime, the judge is required to determine whether they are competent to stand trial, i.e., that they understand the charges against them and can participate in their own defense. Those defendants charged with a felony who are determined to be incompetent are ordered to receive restoration services.



Clinton County Courthouse



Broome County Courthouse



Genesee County Courthouse



Onondaga County Courthouse

# What is Mental Health Competency Restoration?

Competency restoration is the process used when an individual charged with a crime is found by a court to be incompetent to stand trial, typically due to an active mental illness or an intellectual disability. A criminal defendant must be restored to competency before the legal process can continue.

To be considered restored and competent to stand trial, a defendant must be able to consult with his or her defense lawyer and have a rational and factual understanding of the legal proceedings.<sup>ii</sup>



People who enter the restoration process often have complex needs, which may include behavioral health conditions, cognitive and neurodevelopmental impairments, and an often-undiagnosed history of traumatic experiences. These health needs are also usually exacerbated by a lack of social and financial supports.

For example, a study of such patients in California’s Napa State Hospital’s Incompetent to Stand Trial program showed about 80 percent had a psychotic condition, 15 percent had mood disorders, and just under 10 percent had a substance use disorder as the primary diagnosis. Nearly half of these patients had also been homeless in the previous year, and 45 percent had 15 or more prior arrests.<sup>iii</sup>

Defendants involved in the competency restoration system in New York state are commonly called “730s,” referring to the state’s Criminal Procedure Law Section 730, which governs the process.

It is estimated that between one-quarter and two-thirds of all defendants committed for competency restoration under Section 730 end up going through the system multiple times on the same charge — hundreds of people each year.<sup>iv</sup>

In New York State, there are four mental health facilities operated by the Office of Mental Health that provide competency restoration treatment for felony defendants: Kirby Forensic Psychiatric Center (Manhattan), Mid-Hudson Forensic Psychiatric Center (Orange County) are the two largest, with Northeast Regional Forensic Unit (Oneida County), and Rochester Regional Forensic Unit (Monroe County) being the smallest.

Combined, there are 568 in-patient secure beds. These hospitals are what OMH calls “secure facilities;” although all psychiatric hospitals in the state take security measures — installing locks, gates and razor wire fences.

There are also two facilities operated by the Office for People with Developmental Disabilities for Developmentally Disabled defendants deemed incompetent to stand trial: 105 beds at the Sunmount DC in Tupper Lake (Franklin County) and 45 beds at the Valley Ridge Center for Intensive Treatment in Norwich (Chenango County).

All felony defendants, violent and nonviolent, are “treated” at one of the four mental health hospitals.<sup>v vi</sup>

# A Shift in the Court System

In New York State, most felony criminal trials are held in County Courts (District Court in Nassau and Suffolk Counties) except in New York City where they are tried in Supreme Court. Prior to 1977, the county and district courts were paid for and controlled by the counties so when a judge in a county court committed a defendant for restoration to a State Hospital or Developmental Center, it could be said that the State was rendering a service to the county.

The theory was that since the county court, under its county-only jurisdiction, was committing the inmate for restoration, the county was essentially purchasing the services of the state psychiatric hospital from the state and therefore the county in which the court is located should bear the expense.

Effective April 1, 1977, New York adopted a unified court system. Under this system, the state took over the entire non-capital cost of the operation of all courts and court-related agencies of the unified court system, except town and village justice courts. Whereas formerly both state and local government sources had funded the affected courts in over 120 different court budgets, now the state funded them entirely in a single court budget.

Prior to 2020, notwithstanding the statutory authority to charge the counties 100 percent of the cost of such restoration services provided by state employees, the state agreed to charge only 50 percent of the mental health or developmentally disabled competency restoration costs.

# The 2021 State Budget Cost Shift to Counties

The SFY 21 Enacted Budget included an assumption requiring that from that point, the state would begin charging counties 100 percent of the costs of restoring mentally ill defendants to competency. This policy action resulted in tens of millions of dollars' worth of new expenses for county governments, without treatment plan consultation or input from the local county mental health department.



The history of the concept of this cost being a county responsibility goes back to 1896. Prior to that date counties had been responsible for all of the costs of confining poor and indigent people in state psychiatric hospitals. In 1896, the state assumed financial responsibility for all patients in state-operated psychiatric centers other than those confined in connection with a criminal proceeding.<sup>vii</sup>

In 1927, the state legislature passed a law that provided that “the maintenance of any inmate of a state hospital committed thereto upon a court order arising out of a criminal action, shall be paid by the county from which the inmate was committed.”<sup>viii</sup> This law was derived from Section 85 of the former Insanity Law, Chapter 32 of the Laws of 1909.

As noted earlier, up until last year, the state had always included a budget assumption that counties would only have to cover 50 percent of the competency restoration costs. This cost shift requiring counties (outside of New York City) to cover 100 percent of that cost amounts to a cost to counties of approximately \$22 million.

# Defining Restoration

While there may be a disagreement as to whether restoration services constitute treatment or not, it must be acknowledged that the main purpose of these services are to prepare a mentally ill or developmentally disabled person to stand trial.

This is different than the goal of mental health treatment which is intended to lead to recovery and the ability to lead an otherwise normal life. Judges who believe they are helping a mentally ill defendant to get “better” by ordering restoration are operating under a mistaken belief.

Numerous programs and special courts have been developed to divert mentally ill or developmentally disabled people from the criminal justice system and redirect them into community-based programs including supported housing, treatment, crisis services and other supports that may help them to become productive members of society.

Better use of such specialized programs can serve the dual benefit of both resurrecting lives and a substantial savings to government.



## Recommendations for Reform

### A National Perspective

The Council of State Governments Justice Center outlines ten strategies and recommendations for improving competency to stand trial (CST) policy. <sup>ix</sup>

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

“A joint partnership between state and local governments is vital to properly coordinating the varying responsibilities within the CST process, which can span different components of both levels of government. Once the stakeholders are gathered, they will need to establish a clear understanding of how individuals move through a jurisdiction’s courts, jails, hospitals, and community-based programs for evaluation and restoration.”

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

“Florida developed an expansive report in 2007 that outlined the state’s problems at the intersection of mental health and criminal justice and established recommendations for change. This led to the development of local and state collaborations; the addition of training for all new judges on mental health and substance use; and the expansion of the state Criminal Justice, Mental Health, Substance Abuse Reinvestment Grant, among other changes.”

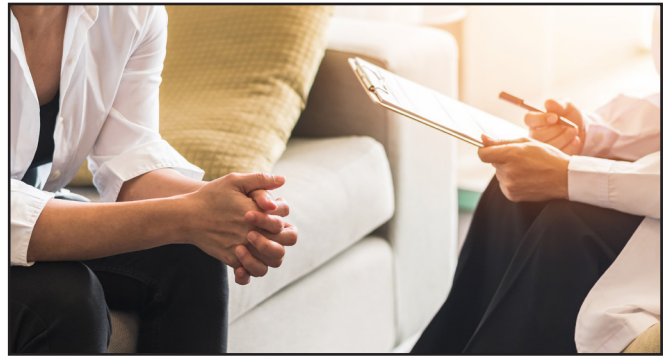
**Strategy 3:** Provide training for professionals working at the intersection of criminal justice and behavioral health.

“Criminal justice and behavioral health stakeholders need profession-specific training regarding CST. Attorneys and judges who understand the difference between the services to restore competency and those offered in a diversion program will be less likely to view CST as a gateway to treatment. A number of profession-specific standards and curricula exist nationally, such as the American Academy of Psychiatry and the Law’s guidelines on evaluation for CST and the American Bar Association’s criminal justice and mental health standards.”

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

“Robust community-based care and supports can help prevent criminal justice contact for people with behavioral health conditions. Such programs also provide opportunities for diversion once a person is involved in the criminal justice system. Because people with behavioral health needs are often those who become involved in the CST process, providing services in the community can limit the number of people entering the CST process in the first place.”

In many cases local jails have become a primary, if not the primary, source of mental health treatment in some communities.



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

“At the local level, Sequential Intercept Mapping and other process mapping approaches can help identify existing diversion efforts, as well as additional opportunities for diversion. Stakeholders from crisis services, law enforcement, jail, courts, pretrial services, community supervision, homeless services, community-based organizations, peer support programs, and housing and community-based treatment providers, as well as people with firsthand experiences and their loved ones, can help illustrate how people with behavioral health needs move through the criminal justice system and where opportunities for diversion currently exist or could be developed.

In Illinois, state officials worked with leaders in Cook County to analyze data and develop a range of new strategies for people with mental illnesses, including a misdemeanor diversion program.”

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

“The CST process should generally be used only when there is a compelling interest in ensuring that a person is restored to competency so that a criminal case can proceed. Members of the national advisory group noted that for many low-level cases, the CST process may take longer than the maximum potential

incarceration for the charged offense. Those scenarios appear to violate the U.S. Supreme Court’s ruling in *Jackson v. Indiana*, which states that ‘due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed.’”

**Strategy 7:** *Promote responsibility and accountability across systems.*

“States should designate a specific person, a multi-disciplinary team, or an agency to be responsible for ensuring that the CST process proceeds efficiently and effectively at each step. A designated person or agency can closely track each case to ensure that needed steps are taken and linkages across systems happen, whether in the form of paperwork or the physical transportation of people. This individual or agency is also best equipped to track trends and problem-solve any challenges that arise.”

**Strategy 8:** *Improve efficiency at each step of the CST process.*

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

“While detention may be required in certain cases, jurisdictions should consider conducting evaluations and restoration in the community to keep people close to home and in the least restrictive environment possible. Decisions about location should be made based on the clinical level of care needed.”

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

“When it is determined that evaluation and restoration are the appropriate course, these services should be available in a variety of settings and provided

consistently with the highest professional standards, including ensuring that services are performed in a manner appropriate for diverse subpopulations. It is also critical that attention is paid to developing clinical care plans that go beyond restoration and toward recovery. Clinical care plans need to be part of the CST process to ensure that whether a person is in jail, in a community-based program, or a hospital or forensic facility, their clinical needs are also addressed.”

## 10 Strategies for Improving CST Policy

1. Convene diverse stakeholders to develop a shared understanding of the current CST process
2. Examine system data and information to pinpoint areas for improvement.
3. Provide training for professionals working at the intersection of criminal justice and behavioral health.
4. Create and fund a robust system of community-based care and support that is accessible for all before, during, and after criminal justice contact.
5. Expand opportunities for diversion to treatment at all points in the criminal justice system, including after competency has been raised.
6. Limit the use of the CST process to cases that are inappropriate for dismissal or diversion.
7. Promote responsibility and accountability across systems.
8. Improve efficiency at each step of the CST process.
9. Conduct evaluations and restoration in the community, when possible.
10. Provide high-quality and equitable evaluations and restoration services, and ensure continuity of clinical care before, during, and after restoration and upon release.

# The County Mental Health Practitioner Recommendations for NYS Lawmakers:

## A Proposal for Reform

The New York State Association of Counties (NYSAC) in partnership with the Conference of Local Mental Hygiene Directors (CLMHD) have developed a series of statutory reforms which will help achieve the recommendations as set forth by the Council of State Governments Justice Center. The two associations engaged local practitioners throughout the state to establish a comprehensive outline for competency restoration reform.

Highlights of these statutory reforms and policy recommendations include the following proposals:

**PROPOSAL #1:** Reform CPL § 730.10 to make clear that restoration is not mental health treatment, so that the judiciary is better informed that a 730 order does not treat underlying mental health needs.

**PROPOSAL #2:** Establish specific criteria for 730 examiners, streamlining the process to establish equity across the system (CPL § 730.20).

**PROPOSAL #3:** Require that the psychiatrist or psychologist conducting the psychiatric exam tells the court whether there is a reasonable chance of restoration, thereby granting the court an opportunity to allow diversion to mental health treatment (CPL § 730.20).

**PROPOSAL #4:** Adjust the fee for reimbursing psychiatric examiners (CPL § 730.20).

**PROPOSAL #5:** Technical corrections to CPL § 730.30 and 730.40, that include language cleanup to grammar and changes based on court actions.

**PROPOSAL #6:** Limit the time of restoration services (CPL § 730.50).

**PROPOSAL #7:** Allow individuals to be transferred to Article 9 facilities (MHL § 9.33).

**PROPOSAL #8:** Require local government units (counties) to reinvest savings from these reforms into community mental health services (MHL § 43.03).



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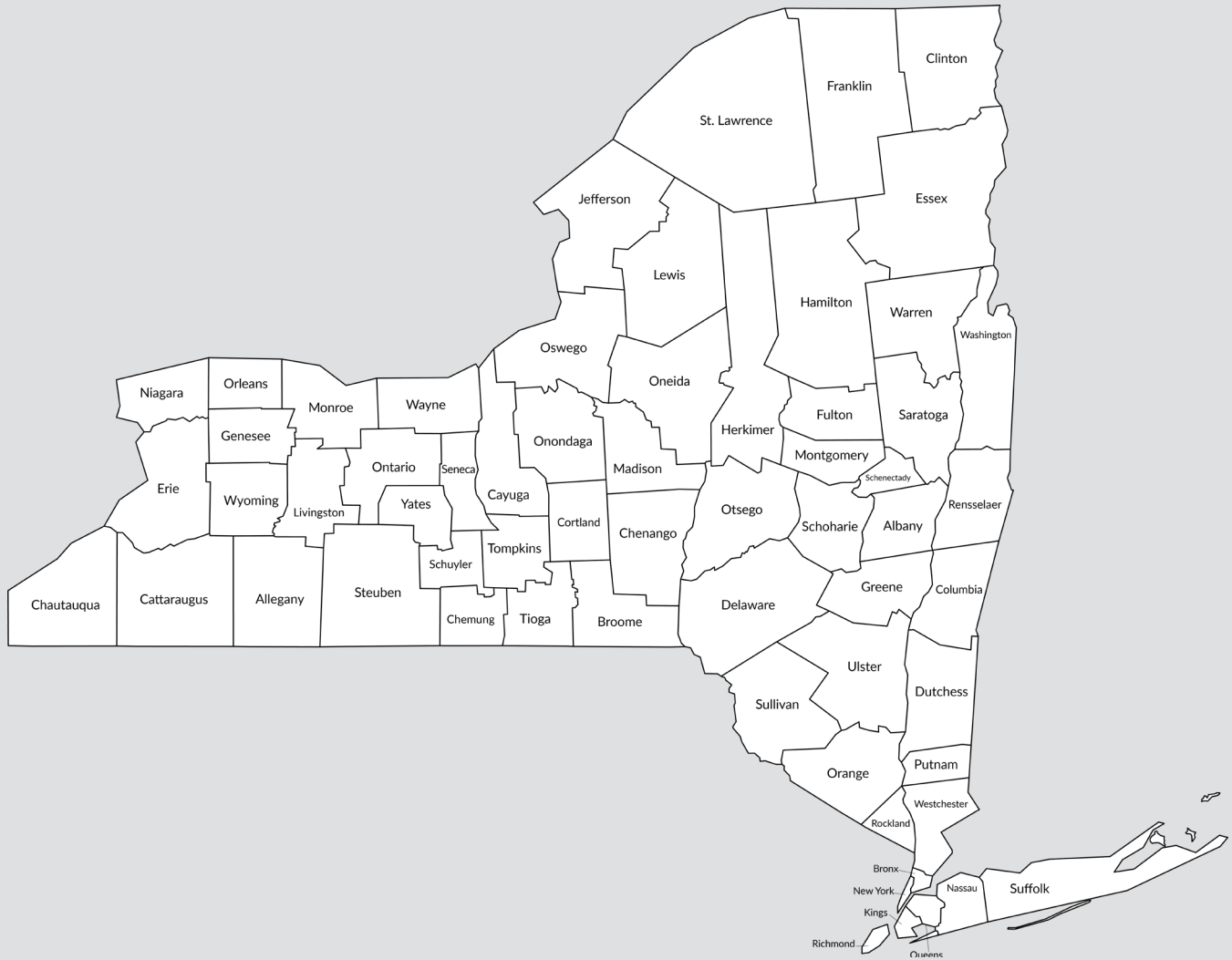
# Sources

- i. <https://www.nysna.org/sites/default/files/attach/ajax/2020/08/Psych%20Whitepaper%20NYSNA.pdf>
- ii. Hogg Foundation for Mental Health: <https://hogg.utexas.edu/project/competency-restoration-policy-brief>
- iii. <https://csgjusticecenter.org/wp-content/uploads/2020/10/Just-and-Well27OCT2020.pdf>
- iv. <https://www.nyaprs.org/e-news-bulletins/2015/aljazeera-how-ny-s-mentally-ill-get-lost-in-courts-jails-and-hospitals>
- v. <https://www.nyaprs.org/e-news-bulletins/2015/aljazeera-how-ny-s-mentally-ill-get-lost-in-courts-jails-and-hospitals>
- vi. Jefferson County v. Oswego County, 102 App.Div. 232, 92 N.Y.S. 709, affirmed 186 N.Y. 555, 79 N.E. 1108
- vii. Chap. 426 of the Laws of 1927
- viii. <https://csgjusticecenter.org/wp-content/uploads/2020/10/Just-and-Well27OCT2020.pdf>



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